Our Vision
The best care for every patient

NHS
Norfolk and Norwich University Hospitals
NHS Foundation Trust

MEETING OF THE TRUST BOARD IN PUBLIC
WEDNESDAY 1 NOVEMBER 2023

A meeting of the Trust Board will take place at 9am on Wednesday 1 November 2023 in the Boardroom Norfolk & Norwich University Hospital

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

AGENDA

	Item	Timing	Lead	Purpose
1	- Apologies & Declarations of Interest - Chairman's Introduction	09.00-09.05	Chair	Information/ Discussion
2	Minutes of the Board meeting held in public on 13.09.23	09.05-09.10	Chair	Approval
3	Matters arising and update on actions		Chair	Discussion
4	Experience of Care – accessible information standards *– Sarah Higson presenting*	09.10-09.25	NF	Discussion
5	Chief Executive's Update - verbal	09.25-09.40	CEO	Discussion
6	Committees in Common (09.10.23) - verbal	09.40-09.45	Chair	Information
7	Focus on Medical Examiner Service *- Professor Jason Payne-James*	09.45-10.05	BB	Discussion
	Break	10.05-10.25		
8	**Reports for Information and Assurance:**			
	(a) Audit Committee (11.10.23)	10.25-10.30	JF	Information, Assurance & Approval as specified
	(b) Quality and Safety Committee (24.10.23) -inc IP&C Annual Report 2022/23 for approval (c) IPR – Quality, Safety and Patient Experience data	10.30-10.45	PC BB/NF	
	(d) Finance, Investments and Performance Committee (25.10.23) (e) i) IPR – Performance and Productivity data ii) Finance – YTD report	10.45-11.00	TS CC RC	
	(f) People & Culture Committee (25.10.23) – inc Diversity Inclusion & Belonging Strategy for approval	11.00-11.15	SD	
	(g) IPR – Workforce data		SG	
	(h) Major Projects Assurance Committee (25.10.23)	11.15-11.25	TS	
9	Update from Council of Governors (12.10.23) - verbal	11.25-11.30	Chair	Information
10	Questions from members of the public	11.30-11.35	Chair	Discussion
11	Any other business			
12	***In its capacity as Corporate Trustee*** N&N Hospitals Charity Annual Report & Accounts 2022/23: inc Letter of Representation	11.35-11.45	JPG & RC	Approval

*** Documents uploaded to Resource Centre**

Date and Time of next Board meeting in public

The next Board meeting in public will be at 9.30am on Wednesday 7 February 2023 in the Boardroom of the Norfolk and Norwich University Hospital

REPORT TO TRUST BOARD

Date	**1 November 2023**			
Title	**Experience of Care Story – Accessible Information Standards**			
Author & Exec Lead	**Rosie Bloomfield, Patient and Experience Facilitator & Professor Nancy Fontaine, Chief Nurse**			
Purpose	**For Information and Discussion**			
Relevant Strategic Commitment	**1. Together, we will develop services so that everyone has the best experience of care and treatment**			
Are there any quality, operational, workforce and financial implications of the decision requested by this report? If so explain where these are/will be addressed.	**Quality**	**Yes✓ No☐**		
	Operational	**Yes✓ No☐**		
	Workforce	**Yes✓ No☐**		
	Financial	**Yes☐ No✓**		
Identify which Committee/Board/Group has reviewed this document:	**Board/Committee:** Patient Engagement and Experience Group (PEEG).		**Outcome:** A short summary of experiences shared by other people from the d/Deaf community was shared at the Patient Engagement and Experience Group (PEEG).	

1 Background/Context

1.1 An 'Experience of Care' story is where a patient or family member describes their experience of healthcare in their own words. The idea is to gain an understanding of what it is like for them and their family and/or carers. It provides information on what was positive, what was sub-optimal and what would have made the experience more positive.

1.2 Listening to Experience of Care stories gives us the opportunity to learn about the things that we do well and consider where we can make improvements. It helps put patients at the heart of service development and improvements.

1.3 Veronica is a deaf lip reader and she visits the NNUH for her audiology care. She is thankful for the care received, the amazing staff and believes as her hearing has deteriorated the equipment she's been supplied has helped her greatly. However Veronica faces challenges across the Trust and wider health system in general due to how we communicate with her and the expectation that everybody will use a phone to make appointments.

a. The story highlights some of the challenges Veronica faces as a deaf lip reader, how this impacts on her and suggestions on how this could be improved in relation to the Accessible Information Standards (AIS).
b. A short summary of experiences shared by other people from the d/Deaf community was shared at the Patient Engagement and Experience Group (PEEG). We believe further learning could be gained from listening to Veronica and the Ear of Hear Group's experiences at Trust Board.

2 Key issues, risks and actions

2.1 Background

As a Trust we are continuing to make efforts to improve how we communicate with d/Deaf people and people with hearing loss as well as people with language barriers and other accessibility needs.

We have recently authorized an Accessible Information Standards (AIS) policy to support further awareness of the Accessible Information Standards requirement trust wide. The policy aims to provide all staff with the information they require to effectively meet the requirements of the AIS Standard and to ensure that patients with communication or information needs relating to a disability, impairment or sensory loss have their needs met.

However, we do acknowledge our journey on implementing this policy. There are gaps in awareness and knowledge across the Trust and we have a plan in place to improve on this. Similarly, there are constraints to our Patient Administration System (PAS) with regards to effective and simple 'flagging' of communication needs. This is something that the introduction of the new Electronic Patient Record (EPR) will improve on, through essential and targeted procurement of a system with AIS in mind. Meanwhile, the Patient Experience team and colleagues are supporting the roll out of the AIS policy; working with individual departments and wards to ensure we can do the best we can now, working around the existing constraints.

Members from our Patient Experience team attended a recent Deaf Connexions event, alongside colleagues from the Integrated Care Board (ICB) listening to peoples' concerns and understanding their frustration. It is our intention to work with the ICB and those with lived experience to further embed and improve how we support and enable access to all patients with additional requirements, including those who are d/Deaf, right across all providers within the ICS to achieve consistency and fairness to all.

In addition, we are monitoring the trends within complaints and feedback received via our Patient Advice and Liaison Service to identify areas that need addressing whilst the ongoing improvement work continues. An example of this being a review of opportunities to extend skills within team and raise deaf awareness amongst colleagues and volunteers as well as ensuring roll out of the AIS policy, resources and training for implementation. For example, there is information, advice and guidance on the Trust's staff platform – The Beat – as well as links to a range of support services, 'Apps' and other technology to support implementing Reasonable Adjustments.

We welcome involvement and collaboration to ensure we are able to co-produce further improvements with key community groups as well as individuals with lived experience. And are proactively continuing to reach out to Voluntary & Community groups and individuals as well as working with NNUH Staff Networks.

2.2 Key learning/actions:

• Some Audiology appointments are booked by the Audiology department directly and some by the Outpatient Booking Team creating inconsistencies in approach. The Audiology department advertises both a phone number and an email address for contacting the service and books many appointments via email. It is our understanding that the outpatient booking team advertises a phone number as standard but has used email or SMS to book appointments upon request. The Trust Cyber Code of Conduct requires patients to sign a consent form to communicate with the Trust via email and this is inconsistent across the Trust. There needs to be more consistency in our approach to recording and actioning a patient's communication method.

- All access to and communication with NNUH should be by the channel most accessible to the patient – whether that be phone, email or text. Giving patients the choice to choose what method is most accessible for them.

- Improved training and awareness of patient communication support is needed amongst staff. There is an ESR training module available which needs greater promotion, for example via inclusion in Induction information.

- Improved awareness and knowledge of what reasonable adjustments are and our responsibility to ask all people if they need them. For example, in terms of reasonable adjustments within a meeting setting, we'd need to consider the lighting, the seating set up and the need to speak slowly and clearly for example. Reasonable adjustments are very personal, so it is vital we ask people for any reasonable adjustments to help them join conversations during meetings or appointments.

- Improved systems to assist staff with providing reasonable adjustments is needed. There is a new reasonable adjustments flag to be rolled out with the Oliver McGowen LD and Autism Awareness Training so work on developing these systems has changed focus. An approach to a 'highly visible' flagging and alert system to support providing reasonable adjustments to be confirmed within policy review cycle.

3 Conclusions/Outcome/Next steps

3.1 The experiences shared in this story have provided valuable learning.

3.2 Work is due to begin on reviewing our Trust AIS Policy and identifying the gaps to improve, consistent and comprehensive compliance with the policy.

3.3 Following a review of the policy a refreshed communications campaign is needed to promote the benefits of clear communications across the Trust and the need to provide reasonable adjustments to support people who are covered by the Accessible Information Standards as well as promote the resource and support available via The Beat and training.

3.4 Involvement of the Patient Experience Team in the further development of DrDoctor and the EPR to ensure we fully utilise these systems and make sure they assist our seldom heard communities when it comes to accessible communications with the Trust.

Recommendations:

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

Experience of Care – Patient Story – Board Meeting	
Brief outline of the "story"	
Veronica is a deaf lip reader and she visits the NNUH for her audiology care. She is thankful for the care received, the amazing staff and believes that as her hearing has deteriorated the equipment she's been supplied has helped her greatly. However Veronica faces challenges across the Trust and wider health system in general due to how we communicate with her and the expectation that everybody will use a phone to make appointments. Veronica no longer uses the phone because hearing times and dates over the phone is one of the most difficult things for someone with hearing loss. She would like for all access to be equally by phone, email or text and for the staff at the hospital to know which is the preferred method for everybody to us. To do this every member of staff has to have training at their induction, not relying on patches of staff training. Staff turnover does not allow for education to be consistent otherwise. Another problem Veronica faces is getting 'do not reply' text messages asking her to phone the Hospital when she's told us that she cannot use the phone and then it's difficult for her to contact anybody. Veronica doesn't want to complain but is aware that she does have a voice and many of her other deaf friends don't have the voice or the confidence to do that.	
What "point" it is trying to convey	
The story highlights: • The need to giving patients the choice to choose what method of communication is most accessible for them to contact us. If a patient states a contact method preference due to a protected characteristic, we must meet this need under the Accessible Information Standards. • Accessibility is the responsibility of **all** staff members at NNUH. Improved training and awareness of patient communication support and the Accessible Information Standards is needed amongst staff. The challenge is to ensure we meet the requirements of the Accessible Information Standard and NNUH AIS Policy - this is a prime time to discuss this as the policy is up for review. • Improved systems to assist staff with providing reasonable adjustments need consistent establishment and embedding.	
Who will be "speaking"	
Patient	Veronica within attached video clip
Staff	Patient Engagement & Experience Facilitator – Rosie Bloomfield Head of Patient Experience - James Dudley
Time allocation for each element	
Film	https://www.youtube.com/watch?v=ZtXXHXrB4Aw (2.17 minutes)
Questions	5 mins

REPORT TO TRUST BOARD

Date	**1 November 2023**
Title	**Chair's Key Issues from Audit Committee Meeting on 11.10.23**
Lead	**Julian Foster – Non-Executive Director (Committee Chair)**
Purpose	**For Information & Assurance as specified**

The Audit Committee met on 11 October 2023. Papers for the meeting were made available to all Board members for information in the usual way. The meeting was quorate and Mrs Ines Grote and Mr Tim How (Public Governors) attended as observers.

Both external and internal auditors (KPMG and RSM) had been appointed for a minimum three-year term from 1 April 2021 with options to extend by a further two years. The Committee approved the recommendation from Mr Clarke to extend their respective appointments for a further two-year period.

In addition, the Committee identified the following matters to highlight to the Board:

Issues to Highlight and escalate:		
1	Internal audit - FTSU	The Committee received an internal audit report on "Freedom to Speak Up" which yielded a partial assurance grading based largely on a disappointing response to the audit survey (consistent with the staff survey). The report has been referred to People and Culture Committee for further review.
2	Counter Fraud report	The Committee expressed concern at the poor response to fraud awareness surveys – although there is no evidence that this is due to complacency and the Reactive Fraud Benchmarking Report demonstrated a good level of fraud and bribery awareness across the Trust. In respect of referrals, the Trust generally benchmarks in line with other Acute Trusts and there is evidence that staff feel comfortable raising concerns without having to escalate internally. Further work to encourage reporting is to be discussed following Fraud Awareness week in November.
3	Use of Resources update	The Committee reviewed the latest Use of Resources update including the Tactical Action Plan and GIRFT progress review. There is evidence that the Trust's position has improved since the 2022 UoR self-assessment. There is some evidence of improved outcomes in several domains but not yet at a level that would secure an improved assessment overall. A high proportion of actions from the Tactical Action Plan had been completed but there are some overdue actions, notably the delay to Transformation Programme actions. It was noted that this has been affected by the current recruitment freeze and it is hoped that completion of current recruitment will assist in the achievement of some of the remaining Transformation actions.
4	Conflicts of interest – decision makers' declarations	The Committee commended further good performance on declarations of interests for decision makers, which had already achieved a minimum level of 93% in each division.

5	N&N Hospitals Charity Annual Report and Accounts – 2022/23	The Committee reviewed the annual report and accounts of the N&N Hospitals Charity and:- • reviewed the report from KPMG with respect to their audit of the draft Annual report and Accounts; • **agreed** presentation of the audited report and accounts of the N&N Hospitals Charity for the year ended 31 March 2023 to the Board of the Corporate Trustee for approval; • **recommended** the Letter of Representation for approval by the Corporate Trustee.

The next Committee meeting is scheduled for 10am to 12pm on 13 December 2023.

Recommendations: The Board is recommended to:

- **note** the ongoing work of its Audit Committee
- **receive** the recommendation of the Audit Committee to approve the Annual Report & Accounts of the N&N Hospitals Charity and associated Letter of Representation.

Our Vision
The best care for every patient

NHS
Norfolk and Norwich University Hospitals
NHS Foundation Trust

Infection Prevention and Control Annual Report 2022-23 and Annual Plan 2023-24

Director of Infection Prevention and Control: - Professor Nancy Fontaine

Deputy Director of Infection Prevention and Control: - Dawn Cursons

Infection Control Doctor: - Dr Catherine Tremlett

Infection Prevention and Control Team

Infection Prevention and Control Annual Report 2022-23

Infection Prevention and Control Annual Report 2022-23

Executive Summary

This annual report incorporates information and data pertaining to Healthcare associated infections (HCAI) during the period 1st April 2022 until 31st March 2023. It provides a summary of the Infection Prevention and Control (IP&C) work undertaken, the management and governance structures and the assurance processes.

The format follows the 10 hygiene code criteria detailed in the Health and Social Care Act 2008: code of practice on the prevention and control of infections and related guidance, updated December 2022. The annual report will be released publicly by the Director of Infection Prevention and Control (DIPC) as outlined in the code.

The Infection Prevention & Control (IP&C) team undertake and monitor alert organism, audit and surgical site surveillance programmes in partnership with the divisions.

Official alert organism government objectives were set in April 2022 and the Trust continued to monitor against objectives throughout this period:

- There were 87 total cases of *Clostridioides difficile* infection (CDI) against an objective of 83.
- There were 0 cases of Hospital Attributable Meticillin Resistant *Staphylococcus aureus* (MRSA) blood stream infection (BSI) deemed unavoidable, against an objective of zero cases.

The COVID-19 pandemic declared by the World Health Organisation (WHO) March 2020 was on-going throughout this period. Throughout 2022-23 government guidance continued to change due to prevalence and severity of the virus. Outbreak reports and Post Infection Reviews (PIR) relating to COVID-19 continued to provide learning and promote quality patient care. This report will include the fourth wave of this pandemic.

Within 2022-23, there was an unprecedented epidemic of avian influenza affecting poultry and wild birds in the United Kingdom and internationally (Influenza A/H5N1). The United Kingdom Health and Social Agency (UKHSA) closely monitored and assessed the risk of avian influenza to human health. In January 2023, UKHSA updated its technical risk assessment for avian influenza and assessed the outbreak as remaining at risk level 3 (out of 6). Guidance regarding investigation and management of possible human cases of avian influenza was provided for all staff.

The IP&C team recognise the hard work and commitment of staff across the healthcare community who have collaboratively continued to strive for the highest quality IP&C standards, promoting patient and staff safety and reduce the risk of nosocomial transmission of infection. Recognising that this has been a challenging period with the ongoing pandemic and increased demand operationally.

The authors of this report would also like to acknowledge the contribution of other teams and colleagues in compiling this report.

- **Chief Nurse and Director of Infection Prevention and Control:** Nancy Fontaine
- **Deputy Director of Infection Prevention and Control:** Dawn Cursons
- **Infection Control Doctor and Consultant Microbiologist:** Catherine Tremlett

Infection Prevention and Control Annual Report 2022-23

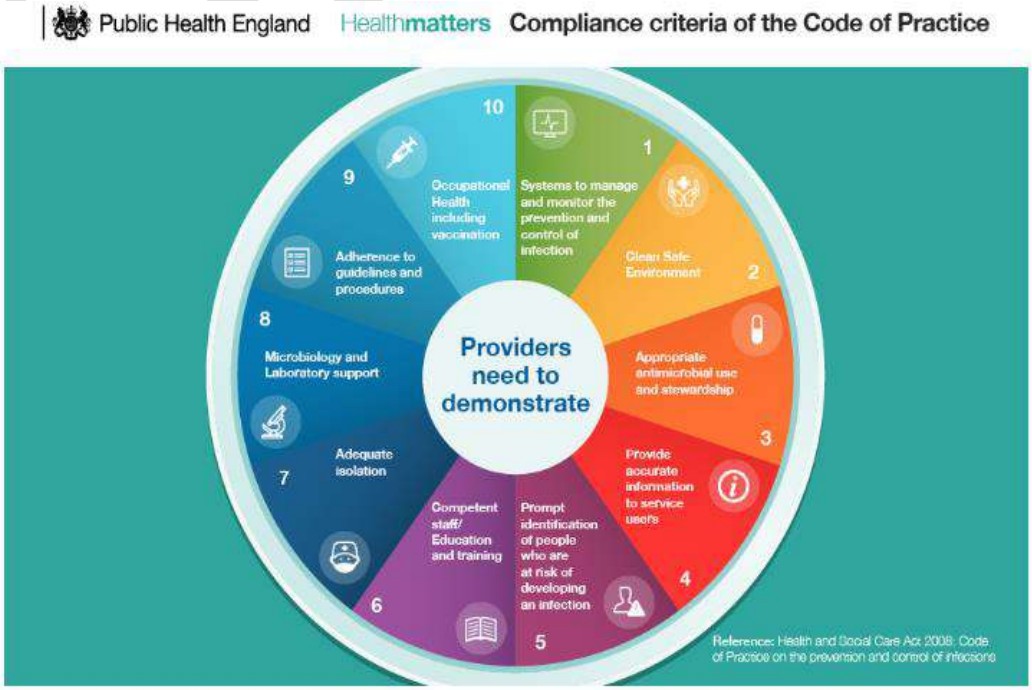
Abbreviations

AMS	Antimicrobial Stewardship
AMU	Acute Medical Unit
BSI	Bloodstream infection
CDI	Clostridioides difficile Infection
C. difficile	Clostridioides difficile
CEO	Chief Executive Officer
COCA	Community Onset Community Associated
COHA	Community Onset Healthcare Associated
COIA	Community Onset Indeterminate Association
CPD	Continuing Professional Development
CPE	Carbapenemase-producing Enterobacteriaceae
CPO	Carbapenemase-producing organisms
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
CVC	Central Venous Catheter
DDD	Defined Daily Dose
DGSA	Dangerous Goods Safety Advisor
DH	Department of Health
DIPC	Director of Infection Prevention & Control
E. coli	Escherichia coli
EAUS	Emergency Assessment Unit Surgical
EPA	Eastern Pathology Alliance
ESBL	Extended Spectrum Beta Lactamase
FFP	Filtering face Piece
FM	Facilities Management
FR	Functional Risk
GRE	Glycopeptide Resistant Enterococcus
H&S	Health and Safety
HBN	Health Building Notes
HCAI	Health Care Associated Infection
HICC	Hospital Infection Control Committee
HII	High Impact Intervention
HOHA	Hospital Onset Healthcare associated
HTM	Health Technical Memorandum
ICB	Integrated Care Board (previously Clinical Commissioning Group)
ICD	Infection Control Doctor
ICS	Integrated Care System
IGAS	Invasive group A Streptococcus
IMT	Incident Management Team
IP&C	Infection Prevention & Control
IS	Information Services
ITU	Intensive Care Unit
LFT	Lateral Flow Tests
MDR TB	Multidrug-Resistant Tuberculosis
MRSA	Meticillin Resistant Staphylococcus aureus
MSSA	Meticillin Sensitive Staphylococcus aureus
NaNOC	The Norfolk and Norwich Orthopaedic Centre
NHS	National Health Service

Infection Prevention and Control Annual Report 2022-23

NHSE/I	National Health Service England and National Health Service Improvement
NHSI	National Health Service Improvement
NICE	National Institute for Health and Care Excellence
NICU	Neonatal Intensive Care Unit
NNUH	Norfolk and Norwich University Hospital Foundation Trust
NRPIC	Norwich Research Park Innovation Centre
OPM	Older People's Medicine
OWL	Organisation Wide Learning
PFI	Private Finance Initiative
PICC	Peripherally Inserted Central Catheter
PII	Period of Increased Incidence
PIR	Post Infection Review
PLACE	Patient-led assessments of the care environment
POU	Point of Use
PPE	Personal Protective Equipment
PPM	Pre-planned maintenance
PVL	Panton-Valentine Leukocidin
RSV	Respiratory Syncytial Virus
SARS-CoV2	Severe Acute Respiratory Syndrome - Coronavirus 2
SOP	Standard Operating Procedure
SSI	Surgical Site Infection
UEA	University of East Anglia
UKHSA	United Kingdom Health Security Agency
UTI	Urinary tract infection
VRE	Vancomycin Resistant Enterococcus
VZV	Varicella zoster virus
WHO	World Health Organisation
WHWB	Workplace Health and Well-Being
WSG	Water Safety Group

Image 1



Infection Prevention and Control Annual Report 2022-23

Hygiene Code Compliance Criteria 1:
Systems to manage and monitor the prevention and control of infection.
These systems use risk assessments and consider how susceptible service users are and any risks that their environment and other users may pose to them.

Governance and Monitoring

Overall responsibility for IP&C is held by the Chief Executive Officer (CEO).

The Board of Directors collectively work within the Norfolk and Norwich University Hospital NHS Foundation Trust (NNUH) Healthcare Governance Framework to ensure that high quality and safe services are in place for patients, visitors, and staff to minimise the risk of infection.

The Hospital Infection Control Committee (HICC) is a key element of the assurance process and reports to the Clinical Safety and Effectiveness Board, see chart 1. HICC ensures that effective systems and processes are in place to reduce the risk of hospital acquired infections and provide assurance to the board. External members from UKHSA and the Integrated Care Board (ICB), along with patient representatives are invited to meetings held monthly, with exception of August and December. HICC is responsible for the strategic planning and monitoring of the Trusts IP&C programme.

The DIPC role is undertaken by the Chief Nurse with the support of the IP&C team.

The DIPC provides strategic direction and leadership to the Trust on all IP&C matters. During this period members of IP&C team, seconded into the Deputy DIPC and Senior IP&C nurse role gained substantive posts. This provided further opportunities for the development of existing IP&C staff, enabling them to move to a more senior position. Secondment opportunities have been embraced by new and existing members of the team, allowing further development and experience to be gained.

IP&C Reporting Processes

The IP&C team provides a comprehensive monthly IP&C report which is widely distributed to senior managers, divisional leads, governance leads, matrons, ward managers and ICB IP&C nurses. This report provides graphical evidence of alert organism figures and trends alongside UKHSA benchmarking data, screening, antimicrobial reports and details of any outbreaks or incidents and highlights any risks.

The IP&C team report on all key aspects of IP&C at the HICC meetings with reports from internal and external representatives, see chart 2. The Chief Nurse, who is DIPC and executive lead for IP&C, reports key performance indicators monthly to the Trust board.

The DIPC/Deputy DIPC reports to the clinical safety and effectiveness sub-board monthly.

Infection Prevention and Control Annual Report 2022-23

Chart 1

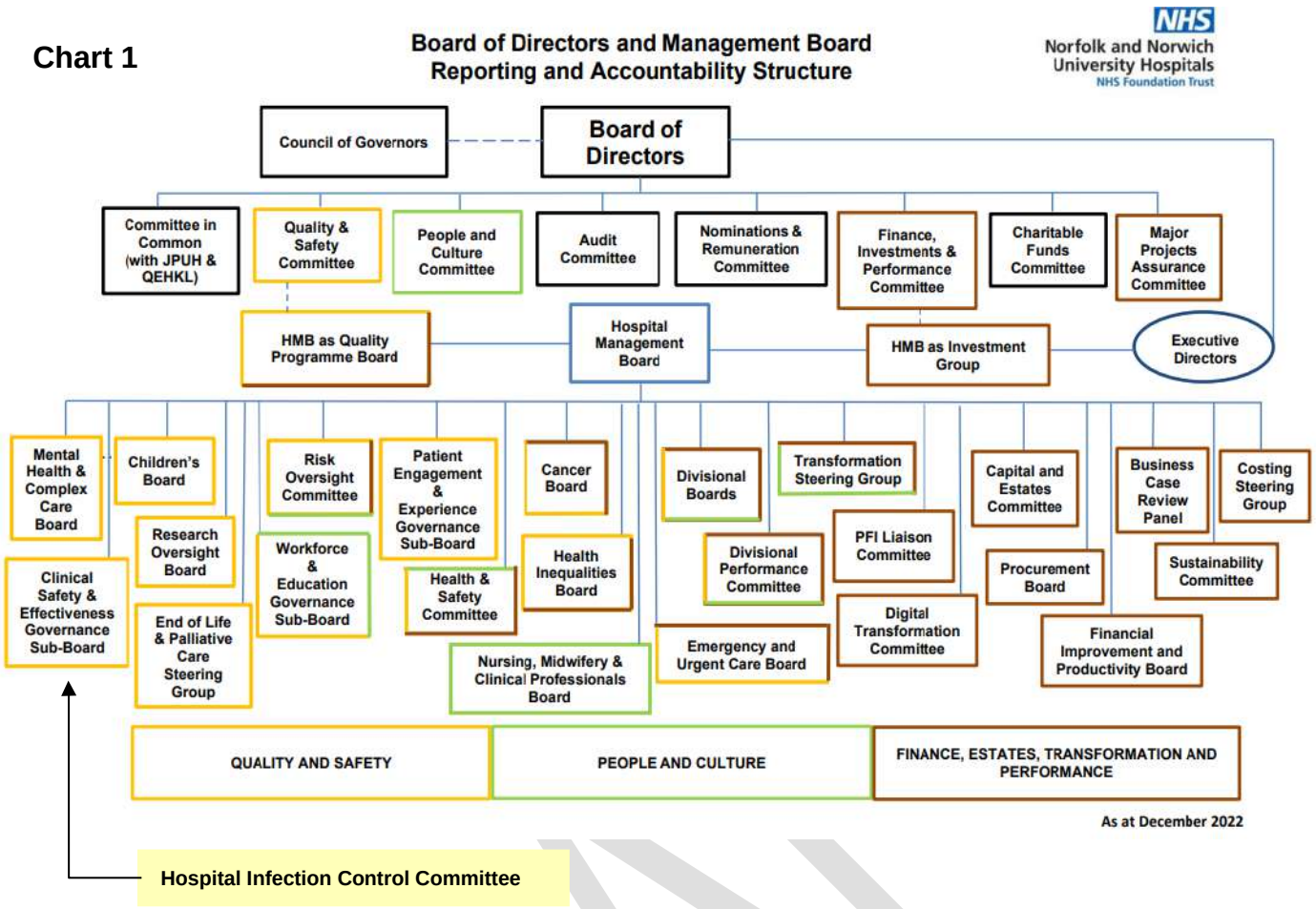


Chart 2

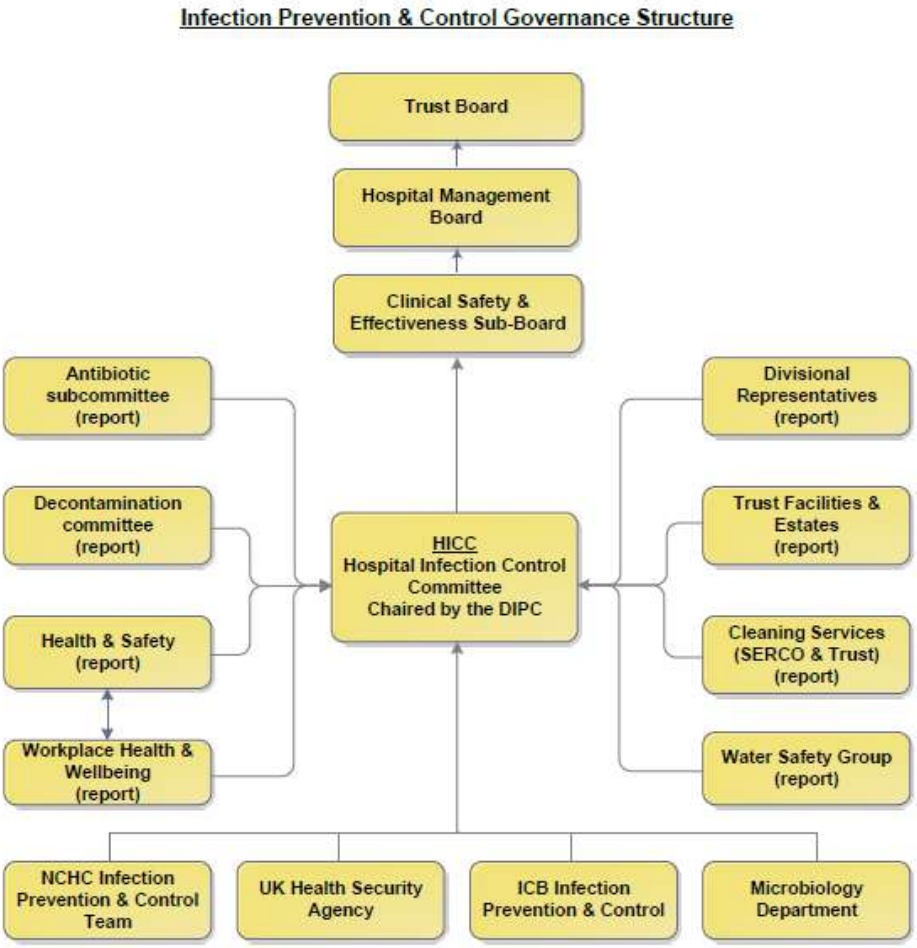
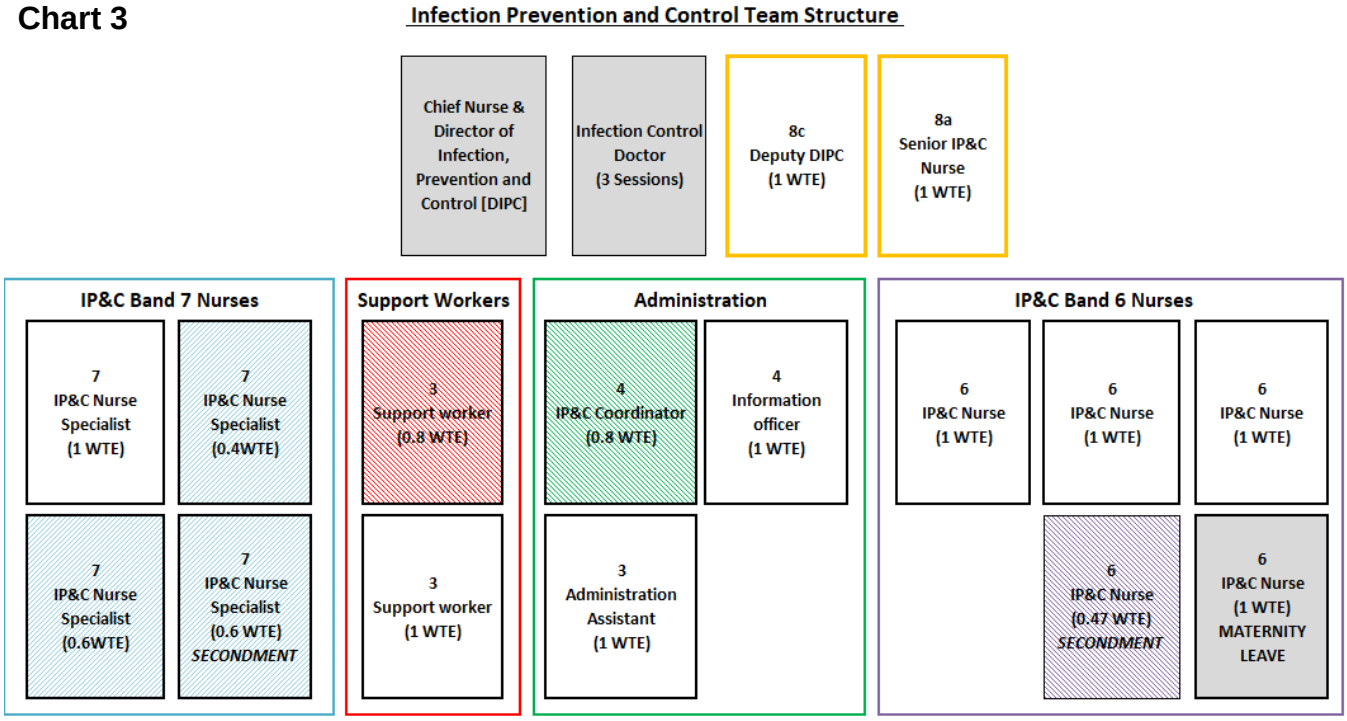


Chart 3



An on-call out of hours service provided by the IP&C team provides 24 hour, 7 day a week cover for the Trust. The team is supported by a team of Consultant Microbiologists and Virologists, who also undertake on-call.

Integrated Care Board (ICB)

IP&C at NNUH is monitored by the ICB IP&C team. This is via attendance at HICC, participation in environmental inspections, contributing to Incident Management Team (IMT) meetings and the PIR's for all patients who develop an MRSA bacteraemia or CDI in line with national guidance.

Water Safety Group (WSG)

As part of the Trust's Governance Structure, a WSG has been established as per the Health Technical Memoranda (HTM), Safe Water in Healthcare Premises 04-01 and The Health Care Associated Infection (HCAI) Code of Practice.

Meeting quarterly, the aim of the WSG is to ensure the safety of all water used by patients, staff and visitors, and to minimise the risk of infection associated with waterborne pathogens.

NNUH has an appointed water authorising engineer who is a pivotal member of the WSG which ensures that decisions affecting the safety and integrity of the water systems and associated equipment do not go ahead without being agreed by them. This includes consultations relating to decisions on the procurement, design, installation and commissioning of water services, equipment, and associated treatment processes.

In October 2022, three members of the IP&C team completed the Legionella/water quality risk management responsible persons course, with a further two members of the team attending a study day in water safety in March 2023.

Water Safety Management Group Report provided by Chair of the Trust Water Safety Group

The WSG meets on a monthly basis and provides assurance and actions to ensure that the Health and Safety at work act 1974 and control of substances hazards to health regulations 2002 actions are taken forward to prevent and control harmful effects of contaminated water – Legionella and *Pseudomonas Aeruginosa* by reviewing practices, programmes, on-going operational procedures, extent of management responsibility in line with operational and legislative compliance, HTM's and overall risk management.

Monthly WSG attendees include representatives from NNUH Facilities, Octagon, Serco, Norse, IP&C Deputy DIPC and IP&C Consultant, divisional representatives, Health and Safety (H&S) manager, authorising engineer from Hydrop and clinical engineering.

Monthly reports are completed by providers providing assurance on water safety as identified in the Water Safety Plan including Quadram, Norfolk and Norwich Kidney Centre, the Innovation centre and all off site premises. The Group aim to collate Water safety assurance from all on-site and off-site areas that provide care to our patients.

Water safety Assurance Dashboard areas covered and attendance at the monthly WSG

The aim is to achieve Water safety assurance from all on-site and off-site areas that provide care to our patients.

Table 1
Water Safety Group Assurance Dashboard

Checklist of areas of compliance covered	Water safety testing premises	April 22	May 22	June 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23
Current Governance/Management documents in place Responsible people identified and trained Pre-planned maintenance (PPM) Temperature control Bacterial sampling and contamination sites Major remedial works Capital Planning Scheme Flushing unused outlets Area for concern identified Risk Review	NNUH												
	Innovation centre												
	Renal centre												
	Cellular pathology												
	Cromer												
	NNUH Accommodation block												
	Quadram												
	Off-site clinics premises												
Assurance of WSG Attendees	Chair of WSG	-							-				
	Authorising Water safety engineer	-							-				

	NNUH Facilities water lead	-							-				
	Representative of Facilities estates and capital projects	-							-				
	Facilities off site premises lead	-							-				
	Serco representative	-							-				
	Serco cleaning representative	-							-				
	Norse representative	-							-				
	Medicine Division representative	-							-				
	Surgery/Emergency Department Division representative	-							-				
	Women and Children representative	-							-				
	Clinical Support Services representative	-							-				
	IP&C representative	-							-				
	IP&C Doctor	-							-				
	Clinical engineering representative	-							-				

Key

Assurance gained / attendance	
Assurance pending/ nonattendance	
No meeting held	-

The Water Safety lead for the Trust was a vacancy post for some months, during which time the role was covered by the Facilities lead. A Water lead is now in post.

Water Quality audit 2023

A water quality audit was completed in September 2021 by Samuel Rollins, water authorising engineer from Hydrop and reaudited in 2022. The 2022 audit reviewed Legionella and Pseudomonas aeruginosa management and controls in line with the following standards:

- Legionnaires' disease - The Control of Legionella bacteria in water systems Approved Code of Practice and guidance on regulations L8 (Fourth Edition) 2013.
- Health and Safety Guidance 274 Parts 1-3 2013.
- Department of Health - Water Systems Health Technical Memorandum 04-01: Safe Water in Healthcare Premises: Parts A, B, C & Supplement: 2016.
- Department of Health - Health Technical Memorandum 00: Policies and principles of healthcare engineering: 2014.

The outcome of the audit demonstrated an improvement on the 2021 audit results and provided a clear action plan to review and update records and processes.

Actions are addressed in monthly water safety operational subgroups, the groups are attended by Sam Rollins, water safety engineer from Hydrop, and representatives from Serco, and Norse, reporting to the monthly WSG.

Audit actions cover the following areas:

- Management responsibilities, appointments, WSG membership, training programme for all staff.
- Water safety plan review update.
- Reporting structure from Norse/Serco to the WSG and assurance from external facility providers.
- Review of operational procedures including remedial works.
- Review of *Pseudomonas* sampling and action plans to avoid repeated fails.
- Sampling review of water coolers and drinking water points across sites.
- Governance reporting and escalation, including incident reporting and risk management/risk register compliance.

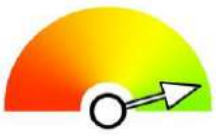
Audit action outcome Sept 2022

Table 2

INDICATOR	ASSESSED LEVEL OF OVERALL GOVERNANCE ASSURANCE
	• Management Committees/Groups • Pre-planned Maintenance Programmes and Log book Management – SERCO • Pre-planned Maintenance Programmes and Log book Management – NORSE Community Sites • Risk Assessments – SERCO and NORSE • Pre-planned Maintenance Programmes and Log book Management – Hospital Accommodation • Risk Assessments – Hospital Accommodation • Infrastructure Management Documentation
	• Management Responsibilities appropriate Appointments & Inter-departmental Arrangements • Contractual agreements with Water Treatment / Water Hygiene Contractors / Consultants • Pre-planned Maintenance Programmes and Log book Management – NORSE Cromer Hospital • On-going Operational Procedures including Remedial Works • Governance Reporting Processes / Escalation Processes • Training & Competency Checks • Usage Evaluation & Flushing

Infection Prevention and Control Annual Report 2022-23

Table 3

RATING	INDICATOR	DEFINITION
SUBSTANTIAL ASSURANCE		The Organisation can take **substantial assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Few matters require attention and are compliance or advisory in nature with **low impact on residual risk** exposure.
REASONABLE ASSURANCE		The Organisation can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with **low to moderate impact on residual risk** exposure until resolved.
LIMITED ASSURANCE		The Organisation can take **limited assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **moderate impact on residual risk** exposure until resolved.
NO ASSURANCE		The Organisation has **no assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Action is required to address the whole control framework in this area with **high impact on residual risk** exposure until resolved.

Water Safety Audit action plan, April 2023 update

Table 4

Area	Number	Priority	Action	Owner	Status
Management responsibility and Inter-Department arrangements	6.1.1	High	Appointment of clinical lead for water hygiene from Facilities. Introduce appointment within WSG.	WSG	
	6.1.3	Medium	All nurse leads complete water training.	Norse	
	6.2.1	Low	Processes in water safety enforced across the Trust.	WSG	
		Medium	Processes in water safety embedded within Serco.	Serco	
		High	Processes in water safety embedded within Norse.	Norse	
	6.2.4	Medium	Set up hydrotherapy pool meeting. Improve hydrotherapy pool documentation.	WSG	
	6.2.5	Medium	Third party invited to WSG meeting. Review of providers.	WSG	

Infection Prevention and Control Annual Report 2022-23

Management Committees/Groups	6.3.1	Low	Ensure all Divisional representatives attend monthly WSG meetings.	WSG	
Contractual agreements with water treatment/water hygiene contractors/consultants	6.4.1	Low	PPM processes are reviewed against parameters in Water Safety Plan.	Serco	
	6.4.2	High	Review all water processes in Cromer.	Norse	
PPM and programmes logbook management	6.5.1	Medium	Update of Sentinel points across NNUH.	Serco	
	6.5.2	Medium	Determine target temperature for domestic hot water system 50 or 55 degrees.	Serco	
	6.5.3	Medium	Review of collection process for temperature across site.	Serco	
	6.5.4	Low	Introduce processes to identify including temperature samples collected across cold water systems in Summer.	Serco	
	6.5.6	High	Identification of electric water heaters across the site – Facilities team covering heaters.	All providers	
	6.5.8	Medium	Review processes for tank inspections including photographic evidence.	All providers	
	6.5.9	Medium	Review of temperature returns across the site.	All providers	
	6.5.11	Medium	Review process for collection of relevant Thermostatic Mixing Valves supply temperatures.	All providers	
	6.5.12	Low	Shower – time stamp on pirana not working.	Serco	
	6.5.13	Medium	Assurance to ascertain that calorifiers and building management system are operating accordingly.	All providers	
	6.5.14		Review domestic hot water temperatures.	Serco	
	6.5.15	High	Cromer – full review of PPM filing to ensure.	Norse	

			documents are easy to obtain.		
	6.5.16	High	Cromer – hot and cold water system review.	Norse	
	6.5.16	Low	Cromer – Sentinel point review.	Norse	
	6.5.18	Low	Review of Sentinel points in community properties.	Facilities / Norse	
Ongoing Operational procedures including remedial works	6.6.1	High	Increase sampling across the site and raise Legionella sampling.	Serco / Facilities	
	6.6.2	Medium	Continue to review ongoing Pseudomonas failures with works plan.	Serco	
	6.6.6	Medium	Drinking water sampling points decided and implemented.	Serco / Facilities	
	6.6.7	Medium	On going review of plastic pipework – sampling frequency.	Serco / Facilities	
	6.6.8	Medium	Review all water features, remove if not necessary.	Facilities	
	6.6.9	Medium	Implement a suitable scalding assessment to be conducted prior to removal of Thermostatic Mixing Valves.	Serco	
	6.6.14	Medium	Review hydrotherapy pool chlorine levels – monitor against Pool Water Treatment Advisory Group.	Serco	
	6.6.15	High	Gissing added to sampling regime.	Serco / Facilities	
	6.6.16	High	Cromer – review tank drop test. Review Macmillan Unit reading.	Norse	
Risk Assessments	6.7.3	Medium	Pseudomonas risk assessment.	WSG	
	6.7.4	Medium	Hydrotherapy pool risk assessment.	WSG	
	6.7.6	Medium	Cromer – remedial action risk assessment.	Norse	
Governance reporting processes/escalation process	6.8.1	Medium	Full escalation pathway to allow issues to be escalated.	WSG	
Training and competency checks	6.9.3	High	All representatives who attend WSG attend water training.	WSG	

	6.9.34	High	All providers managing water hygiene attend water training.	Norse	
Usage evaluations and flushing	6.10.2	Medium	Ensure flushing regime is carried out across the Trust.	Wards/ Divisions	

Key	
Green	Complete
Yellow	In progress
Red	Not started

Water Trust wide Risks

Table 5

ID	Opened	Title	Current	Potential Cause (If)	Potential Effect (Then)	Potential Consequence (Resulting in)	Target
876	09/2019	Risk of *Pseudomonas* cross infection	4	If *Pseudomonas* is isolated in the water supply on Neonatal Intensive Care Unit (NICU)	Then there is a risk of cross contamination to babies	Resulting in significant harm	4
Controls in place		1) Enhanced frequency of water testing 2) Use of Point of Use (POU) filters on taps 3) Fixed cleanable screens fitted between sinks and incubators 4) IP&C policies and procedures - Use of Personal Protective Equipment (PPE) - Hand washing protocols - IP&C Perfect Ward Audits 5) Sinks in bays used for handwashing only (not personal cares)					
1130	05/2020	Replacement of existing taps to model able to accept POU filters for water hygiene control	5	If there is a shortage of taps within the Trust and availability is not good from suppliers	Then there could be a shortage of taps which are able to accept POU in high-risk patient areas (Augmented care)	Resulting in the risk of compromised water hygiene	5
Controls in place		1) We are currently holding enough POU in stock to serve 2 wards.					
2093	08/2022	Legionella in water outlets across the Trust	5	If Legionella is isolated in the water supply	Then there is a risk of infection to patients and staff	Resulting in significant harm to both patients and staff	5

Controls in place		1) Rolling programme of water testing and ad-hoc if deemed appropriate by IP&C team. 2) Use of POU filters on taps where appropriate (where test positive). 3) Isolation of taps where POU are not possible. 4) Markwik 21+ taps currently preferred tap for new installation or replacements. 5) Heat sanitisation where appropriate and available. 6) Temperature monitoring and control of water in place (below 20^{c} or above 60^{c} at source). 7) IP&C and facilities involved in design and commissioning of new buildings and renovations. 8) Education through mandatory training. 9) Water safety policies and procedures in place. 10) Cleaning of outlets according to HTM 04.01. 11) Flushing carried out for outlets not in use or that have been isolated. 12) Cleaners carry out regular draw offs from all outlets. 13) Authorised engineer appointed. 14) WSG formalised. 15) Planned maintenance of water tanks and calorifiers carried out.					
2341	05/2023	Risk of Mycobacterium abscessus infections related to water supply	5	If the water supplies within the trust become colonised with Mycobacterium abscessus	Then this could cause Mycobacterium abscessus infections in patients - of particularly concern are patients who are severely immuno-suppressed	Resulting in lung infection and in the worst case scenario, fatalities for those who are severely immuno-suppressed	5
Controls in place		1) Monitoring of new Mycobacterium abscessus to identify any concerns around hospital acquisition. 2) WSG to ensure that for all new builds, correct disinfection protocols are followed as part of the commissioning process, which includes sign off sheets in water safety plan.					
2028	06/2022	*Pseudomonas aeruginosa* in water outlets in augmented care areas	5	If *Pseudomonas* is isolated in the water supply in augmented care areas	Then there is a risk of cross contamination to patients	Resulting in significant harm	5
Controls in place		1) Regular frequency of water testing (3-6 monthly) and ad hoc if deemed appropriate by IP&C team. 2) Use of POU filters on taps where appropriate (where test positive). 3) Isolation of taps where POU are not possible. 4) Markwik 21+ taps currently preferred tap for new installation or replacements. 5) Heat sanitisation where appropriate and available. 6) Other remedial actions as appropriate. 7) 3 monthly heat sanitisation where appropriate (NICU). 8) Education through mandatory training and ad hoc re handwashing sinks.					

	9) Clear separation of handwashing sinks and other sinks. 10) Water safety policies and procedures in place. 11) Cleaning of outlets according to HTM 04.01. 12) Flushing carried out for outlets not in use or that have been isolated. 13) Cleaners carry out regular draw offs from all outlets. 14) Authorised engineer appointed. 15) WSG formalised.	

Since the Water report period, two further risks have been identified. These risks have been added to the report to demonstrate ongoing assurance.

Domestic cleaning assurance

A monthly report from Serco is provided to provide assurance that 100% flushing of unused outlets is completed as part of the Domestic cleaning regime and documented.

Decontamination Committee

The Decontamination Committee oversee NNUH compliance with the Health and Social Care Act (2008) Code of Practice on the Prevention and Control of Infections and HTM 01-01, and 01-06.

Decontamination Committee Report – provided by Chair of the Trust Decontamination Group

This report provides a highlight summary of the Trust Decontamination Group's activities over the financial year 2022-23.

Audit and Governance

The 2022-23 annual sterile services department audit took place in September 2022; this resulted in 5 minor actions for correction. There were no major actions. An 'Extension to Scope' audit was also carried out due to the installation of 4 x washer disinfectors and 1 x autoclave. No corrective actions were required.

The bi-monthly report on decontamination operational performance continues to be monitored by the Decontamination Committee Meeting to ensure full oversight and is reported directly to HICC.

Quadram Institute (QI)

There have been no further problems with Mycobacteria or general water quality. There are currently no adverse operational issues to report.

Operational highlights

The sterile services department continues to get busier as COVID-19 recovery continues. Weekend working remains a feature of this recovery. Typically, backlogs of work increase during the working week and are resolved over the weekend. These backlogs are manageable and have not yet reached pre-COVID-19 levels.

The project to install 4 x Belimed washer disinfectors and 1 x MMM autoclave was completed in 2022. All equipment is commissioned, validated and in service.

Risks

Three of the sterilizers installed when the hospital was opened remain in situ. One of those is completely unserviceable, and the remaining two must be withdrawn from use in July when the pressure vessel insurance certificate expires. This leaves the department with only 5/8ths of the planned sterilizer capacity. Replacement sterilizers are on order and will be installed in September (x1) and October (x2). Until those replacement sterilizers are commissioned and signed off for use there will be a shortage of sterilizer capacity. This risk will be mitigated by further delays in the Paediatric Theatre development and particularly the opening of The Norfolk and Norwich Orthopaedic Centre (NaNOC). A contingency arrangement is in place to use external departments' spare sterilizer capacity if it becomes necessary.

Ventilation

The establishment of a ventilation committee is still necessary. We are currently in the process of developing this committee and are working on procuring an authorising engineer. The tender for this position was released in March 2023.

The supply and extract air handling unit underwent an overhaul, clean and renewal of controls. The filters were renewed, the supply and extract ductwork were cleaned, as shown in table 6.

Table 6

Area/Department	Report received	Contractor	Completion date
Ophthalmic 1 & 2	Y	H2O	15/02/2022
Cath lab 5	Y	H2O	06/04/2022
Main kitchen	Y	H2O	13/04/2022
Aps 1, 2 & 3	Y	H2O	26/06/2022
Endoscopy 1, 2 & 3	Y	H2O	19/06/2022

ICNet (IP&C Software system)

The IP&C team use a commercial software system, called ICNet to manage alert organism results, suspected infections, monitor for Periods of Increased Incidence (PII) and minimise risk of outbreaks. ICNet served notice on the existing software due to its age. Since approval was granted to purchase the newer version 7 of ICNet, a team within the region have worked collaboratively across the Integrated Care System (ICS), to implement this. The project is currently in progress, and it is anticipated that it will be completed by October 2023.

Building

The IP&C team continue to participate in a multitude of refurbishment and new developments across the different sites as the Trust reconfigures to expand and improve facilities. IP&C offer support and advice from the design stage to ensure compliance with Health Building Notes (HBN) and Heath technical memorandum (HTM). Human factor issues can also be addressed when considering new projects working together with department users, facilities, project teams and contractors. When projects are near completion, IP&C join the snagging team to ensure the finished product meets requirements and safety standards.

Some of the building projects IP&C have been involved in during the year are as follows:

- Continuing construction of NaNOC (image 2 and 3).
- New Paediatric theatres (image 4 and 5).

- Conversion of existing space in Weybourne day unit to increase capacity for provision of Chemotherapy.
- Radiotherapy bunker refurbishment and CT replacement.
- Creation of two further triage rooms in Emergency Department Ambulatory majors.

Image 2

Image 3

Image 4

Image 5

Healthcare Inspections

During the period of 2022-23 there were no IP&C external healthcare inspections undertaken.

Mandatory Surveillance of Healthcare Associated Infection to UK Health Security Agency

Clostridioides difficile infection (CDI)

In line with NHS England - NHS Standard Contract to minimise instances of *Clostridioides difficile* (*C. difficile*). Both hospital-onset healthcare associated (HOHA) and community-onset healthcare associated (COHA) *C. difficile* cases are required to be reported to UKHSA.

The C. *difficile* attribution for 2022-23 is 83.

Table 7 shows all C. *difficile* cases within NNUH 2022-23. Table 8 shows NNUH C. *difficile* figures (COHA & HOHA) compared to the East of England.

Hospital onset healthcare associated (HOHA): cases where specimen date is >2 days after current admission (where day of admission is 0)

Community onset healthcare associated (COHA): cases that occur in the community (or <2 days after admission) when the patient has been an inpatient in the trust reporting the case in the previous 28 days.

Community onset indeterminate association: cases that occur in the community (or <2 days after admission) when the patient has been an inpatient in the trust reporting the case between 29 and 84 days prior to the specimen date.

Community onset community associated: cases that occur in the community (or <2 days after admission) when the patient has not been an inpatient in the trust reporting the case in the previous 84 days.

Table 7

NNUH *C. difficile* 2022-23 – number of cases

Financial Year	NNUH Objective	Community Origin (sampled before day 3)		Hospital Origin (Sampled on or after day 4)		Total
2022-23	83	COIA 28	COCA 103	HOHA 56	COHA 31	218
		131		Total 87 cases of which 68 had no lapses, leaving **19** with lapses in care.		
2021-22	57	COIA 31	COCA 121	HOHA 49	COHA 40	241
		152		Total 89 cases of which 66 had no lapses so not counting towards final objective, leaving **23** with lapses in care counting towards the objective.		
2020-21	35	COIA 25	COCA 114	HOHA 42	COHA 28	209
		139		Total 70 cases of which 46 had no lapses so not counting towards final objective, leaving 24 with lapses in care counting towards the objective		

https://www.gov.uk/government/statistics/clostridium-difficile-infection-monthly-data-by-nhs-acute-trust

Infection Prevention and Control Annual Report 2022-23

Table 8

UK Health Security Agency

Clostridium difficile

Count of healthcare associated cases per month

Trust Code	Acute Trust Name	Trajectory*	2022 April	May	June	July	August	September	October	November	December	2023 January	February	March	Total
RC9	Bedfordshire Hospitals NHS Foundation Trust	58	5	6	6	8	8	9	5	3	4	6	7	10	77
RGT	Cambridge University Hospitals NHS Foundation Trust	110	12	11	16	11	20	8	13	12	6	5	6	9	129
RWH	East & North Hertfordshire NHS Trust	59	10	3	7	8	9	0	10	8	2	3	7	7	74
RDE	East Suffolk and North Essex NHS Foundation Trust	102	7	6	7	10	11	14	22	5	9	9	8	3	111
RGP	James Paget University Hospitals NHS Foundation Trust	33	0	1	4	3	2	3	4	1	4	6	2	1	31
RAJ	Mid and South Essex NHS Foundation Trust	175	24	22	25	28	32	23	23	15	19	11	11	14	247
RD8	Milton Keynes Hospital NHS Foundation Trust	14	4	2	3	0	1	6	3	4	2	4	5	1	35
RM1	Norfolk & Norwich University Hospitals NHS Foundation Trust	83	10	7	8	11	5	6	8	3	10	9	5	5	87
RGN	North West Anglia NHS Foundation Trust	114	5	9	5	9	22	10	8	10	14	6	9	10	117
RGM	Papworth Hospital NHS Foundation Trust	12	0	0	0	0	1	2	0	2	1	0	0	1	7
RQW	Princess Alexandra Hospital NHS Trust	56	6	2	7	4	6	2	0	1	1	0	3	4	36
RCX	The Queen Elizabeth Hospital King's Lynn NHS Trust	60	8	11	2	3	5	3	4	4	5	4	7	16	72
RWG	West Hertfordshire Hospitals NHS Trust	58	7	7	8	7	6	3	4	1	7	6	3	6	65
RGR	West Suffolk Hospitals NHS Trust	55	2	2	5	0	6	8	5	2	5	4	6	7	52
	East of England Total		**100**	**89**	**103**	**102**	**134**	**95**	**109**	**71**	**89**	**73**	**79**	**94**	**1140**

A thorough PIR investigation is completed for each hospital attributable CDI case using a standardised PIR process including the sharing of learning and good practice at governance meetings. The investigating group includes the clinical team responsible for the patient, Antimicrobial Pharmacist, Microbiologist, and IP&C team. At the meeting the ICB decide whether there have been any lapses in care and share any learning for community partners.

Following PIR meetings with the ICB IP&C team, 1 COHA and 18 HOHA cases were reviewed as trajectory (with lapses in care) against an objective of 83 cases. 30 COHA and 38 HOHA cases were deemed non-trajectory (no lapses in care), see table 9.

Table 9

NNUH lapses in care identified from 18 HOHA and 1 COHA trajectory cases of *C. difficile* 2022-23	
Lapses	**Number of times lapse occurred**
Delay in isolation (placing in single room)	8
Delay in sampling	8
Gaps in stool chart	6
Inappropriate sampling	6
Hand hygiene audit fails	2
Period of Increased Incidence	2
Inappropriate antimicrobial prescribing	1
Some trajectory cases had more than one lapse. Lapses are included in the learning outcomes.	

A weekly multidisciplinary team ward round of CDI patients is led by a consultant microbiologist. *Clostridioides difficile* can be carried asymptomatically and may be present prior to admission becoming apparent when toxin production is triggered by administration of antibiotics after admission. Possible sources are asymptomatic colonisation prior to admission or via cross infection in a healthcare setting e.g., from contaminated equipment or hands of staff. It is notable that some patients who are colonised with *Clostridioides difficile* may excrete the bacteria and spores without showing symptoms of infection.

Recognised risk factors for CDI include antibiotic use, proton pump inhibitors, use of laxatives, iron, and bowel procedures along with age >65, presence of co-morbidities such as malignancy, diabetes, kidney and liver disease and immunosuppression from treatment or cancer.

Despite thorough investigations using timelines, tracking patients' movements in the preceding 3 months and molecular typing, it is often difficult to prove conclusively where a patient acquired the *C. difficile* organism.

Treatment guidelines for CDI are in accordance with National Institute for Health and Care Excellence (NICE) guidance, the antibiotic Fidaxomicin is available on the NNUH formulary.

Glycopeptide-resistant Enterococcus (GRE) BSI

The Trust continues to record very low rates of GRE BSI. Patient identified as having a GRE are nursed in a single room with enhanced IP&C precautions. Antibiotics are prescribed based on the sensitivity of the particular strain.

Enterococci are organisms that reside in the gastrointestinal tract, GRE are multi-drug resistant Enterococci which are resistant to the Glycopeptide antibiotics Vancomycin and sometimes Teicoplanin.

There were 10 cases of GRE/Vancomycin Resistant Enterococcus (VRE) BSI in 2022-23.

Carbapenemase-producing Enterobacteriaceae (CPE)

In the UK, over the last few years there has been a rapid rise in the incidence of infection and colonisation by multi-drug resistant Carbapenemase-producing organisms (CPO) with an increase in the number of clusters and outbreaks reported in England. Unless action is taken and lessons are learnt from experiences elsewhere in the world, rapid spread of CPE will pose an increasing threat to public health and medical treatment pathways in the UK. These resistant bacteria can spread rapidly in healthcare settings. Almost all acute healthcare providers in England have identified at least one new patient colonised with CPE in the last year (Freeman, R et al, 2020 as cited in UKHSA, 2022). The CPE policy has been updated to reflect the most recent UKHSA guidance published September 2022.

Table 10

Carbapenemase-producing Enterobacteriaceae - Cases identified

Financial Year	New cases tested positive on admission	New positive cases	Previously positive patients tested negative on admission
2022-23	**0**	• 1 new case identified. (Preadmission screening due to hospital admission in Sudan)	**4**
2021-22	**4**	• 2 x clinical samples • Screened due to hospital admission in Spain • Screened due to recent exposure to Tazocin	**3**

2020-21	**3**	• Previous positive from Addenbrookes Hospital • Previous positive from Norfolk Community Health and Care • Previous CPO now CPE	**5**

Gram-Negative Bacteraemia/BSI

In 2016, the Department of Health and Social Care set an ambition for England to halve the number of healthcare associated Gram-negative BSI by March 2021.

Recognising this as a complex challenge with more than 50% of infections occurring in people outside of hospital settings, the NHS Long Term Plan supports a 50% reduction across the healthcare economy by 2024-25.

UKHSA expanded their mandatory surveillance of Gram-negative BSI from *Escherichia coli* (*E. coli*) bacteraemia (mandated for reporting in June 2011) to include *Pseudomonas aeruginosa* and *Klebsiella species* (Public Health England, 2017).

This is the sixth year of UKHSA reporting for *Klebsiella species and Pseudomonas aeruginosa* and therefore we now have comparative figures for *E. coli, Klebsiella species* and *Pseudomonas aeruginosa*. See tables 11, 12, 13, 14, 15 & 16.

The 2022-23 objectives set were inclusive of both COHA cases and HOHA cases.

Escherichia coli

Often referred to as *E. coli*, this is part of the normal gut flora and can commonly cause urinary, biliary, or gastrointestinal tract related infection leading to BSI (*E. coli* BSI). Some *E. coli* produce enzymes known as extended spectrum beta lactamase (ESBL) which increase the resistance to multiple antibiotics.

The IP&C team developed a Standard Operating Procedure (SOP) to reduce Urinary tract infections and Gram-negative blood stream infections in 2019-20 and continue to work collaboratively to promote these resources in relation to urine sampling, mid-stream urine collection, hydration, patient information and catheter prevention. The IP&C team have been working collaboratively with IP&C colleagues, across the Norfolk and Waveney ICS, participating in workstreams to reduce Gram-negative bacteraemia, initially focussing upon *E. coli* urinary catheter infections.

54.3% of the 92 Hospital origin *E. coli* BSI were considered to have a urinary tract primary focus, 14.1% had an unknown focus, 14.1% were considered hepatobiliary, 12.0% gastrointestinal or intraabdominal collection, lower respiratory tract 2.17%, skin/soft tissue 1.09%, genital system 1.09% and cardiovascular/vascular 1.09%.

Infection Prevention and Control Annual Report 2022-23

Table 11

NNUH *Escherichia coli* BSI – number of cases

Financial Year	Community Origin	Hospital Origin	Total
2022-23	**214 COCA**	**49 HOHA & 43 COHA**	**306**
2021-22	283 COCA	51 HOHA & 48 COHA	382
2020-21	335 (87.92%)	46 (12.08%)	381

Table 12

UK Health Security Agency

Escherichia coli

Count of healthcare associated cases per month

Trust Code	Acute Trust Name	Trajectory*	2022 April	May	June	July	August	September	October	November	December	2023 January	February	March	Total
RC9	Bedfordshire Hospitals NHS Foundation Trust	64	10	6	11	9	6	8	9	7	8	9	7	7	97
RGT	Cambridge University Hospitals NHS Foundation Trust	157	13	25	15	12	14	15	16	19	20	19	9	14	191
RWH	East & North Hertfordshire NHS Trust	46	4	6	9	6	1	7	3	5	4	3	4	3	55
RDE	East Suffolk and North Essex NHS Foundation Trust	119	13	7	11	11	12	18	10	8	13	11	9	13	136
RGP	James Paget University Hospitals NHS Foundation Trust	55	5	8	4	6	9	4	2	6	8	8	2	4	66
RAJ	Mid and South Essex NHS Foundation Trust	220	19	13	18	18	25	25	16	22	11	13	18	23	221
RD8	Milton Keynes Hospital NHS Foundation Trust	28	3	1	5	6	9	5	4	3	8	4	4	9	61
RM1	Norfolk & Norwich University Hospitals NHS Foundation Trust	96	10	6	7	10	10	10	5	6	10	4	3	11	92
RGN	North West Anglia NHS Foundation Trust	74	10	3	5	14	9	7	9	9	9	6	6	16	103
RGM	Papworth Hospital NHS Foundation Trust	16	2	1	0	0	0	0	1	0	0	1	2	1	8
RQW	Princess Alexandra Hospital NHS Trust	35	7	3	1	2	6	6	7	2	0	6	2	3	45
RCX	The Queen Elizabeth Hospital King's Lynn NHS Trust	59	2	4	5	8	6	3	6	5	4	2	5	1	51
RWG	West Hertfordshire Hospitals NHS Trust	64	6	5	6	7	5	6	10	5	5	5	6	9	75
RGR	West Suffolk Hospitals NHS Trust	36	2	2	10	4	8	4	4	4	4	1	3	7	53
	East of England Total		**106**	**90**	**107**	**113**	**120**	**118**	**102**	**101**	**104**	**92**	**80**	**121**	**1254**

Klebsiella species

The IP&C team undertake surveillance investigation of hospital origin Gram-negative BSI. Of the 27 Hospital origin *Klebsiella species* BSI, 29.6% were considered lower urinary tract, 25.9% had an unknown primary focus, 22.2% Gastrointestinal or Intraabdominal collection, 3.70% Bone and joint, 3.70% Genital system, 7.4% Intravascular device and 7.4% hepatobiliary.

Table 13

NNUH *Klebsiella species* BSI – number of cases

Financial Year	Community Origin	Hospital Origin	Total
2022-23	**45 COCA**	**21 HOHA, 6 COHA**	**72**
2021-22	73 COCA	28 HOHA, 12 COHA	113
2020-21	79 (73.1%)	29 (26.9%)	108

Infection Prevention and Control Annual Report 2022-23

Table 14

UK Health Security Agency

Klebsiella spp.

Count of healthcare associated cases per month

Trust Code	Acute Trust Name	Trajectory*	2022 April	May	June	July	August	September	October	November	December	2023 January	February	March	Total
RC9	Bedfordshire Hospitals NHS Foundation Trust	17	8	5	1	1	2	4	4	5	2	3	2	3	40
RGT	Cambridge University Hospitals NHS Foundation Trust	101	5	5	8	3	4	7	12	5	9	12	8	6	84
RWH	East & North Hertfordshire NHS Trust	22	0	1	2	3	1	2	2	4	1	2	0	0	18
RDE	East Suffolk and North Essex NHS Foundation Trust	44	1	3	3	4	4	4	4	1	2	5	7	2	40
RGP	James Paget University Hospitals NHS Foundation Trust	36	2	0	0	6	5	2	6	0	3	0	2	0	26
RAJ	Mid and South Essex NHS Foundation Trust	89	12	9	16	9	8	15	4	11	10	15	14	14	137
RD8	Milton Keynes Hospital NHS Foundation Trust	15	2	1	4	0	3	2	1	5	2	0	4	2	26
RM1	Norfolk & Norwich University Hospitals NHS Foundation Trust	48	0	1	2	5	4	1	1	3	3	1	3	3	27
RGN	North West Anglia NHS Foundation Trust	36	5	3	1	2	6	1	5	4	1	4	0	6	38
RGM	Papworth Hospital NHS Foundation Trust	16	1	1	0	1	0	1	1	2	2	3	2	1	15
RQW	Princess Alexandra Hospital NHS Trust	18	3	2	0	2	1	2	2	0	1	0	1	5	19
RCX	The Queen Elizabeth Hospital King's Lynn NHS Trust	24	1	1	1	1	0	4	1	2	3	0	3	0	17
RWG	West Hertfordshire Hospitals NHS Trust	34	3	6	2	4	6	7	1	6	3	5	5	6	54
RGR	West Suffolk Hospitals NHS Trust	10	2	1	1	1	2	1	3	4	1	1	0	1	18
	East of England Total		**45**	**39**	**41**	**42**	**46**	**53**	**47**	**52**	**43**	**51**	**51**	**49**	**559**

Pseudomonas aeruginosa

Following investigation by the IP&C team 27.8% of the 18 Hospital origin *Pseudomonas* BSI, were considered to have a primary focus of urinary tract, 33.3% had an unknown focus, 16.7% were considered hepatobiliary, 11.1% line infection, 5.6% cardiovacscular/vascular and 5.6% skin/soft tissue.

Table 15

NNUH *Pseudomonas aeruginosa* BSI – number of cases

Financial Year	Community Origin	Hospital Origin	Total
2022-23	**27 COCA**	**10 HOHA & 8 COHA**	**45**
2021-22	21 COCA	17 HOHA & 12 COHA	50
2020-21	40 (75.5%)	13 (24.5%)	53

Table 16

UK Health Security Agency

Pseudomonas aeruginosa

Count of healthcare associated cases per month

Trust Code	Acute Trust Name	Trajectory*	2022 April	May	June	July	August	September	October	November	December	2023 January	February	March	Total
RC9	Bedfordshire Hospitals NHS Foundation Trust	14	3	0	4	1	0	1	0	1	0	3	1	0	14
RGT	Cambridge University Hospitals NHS Foundation Trust	38	1	1	5	4	4	8	4	9	3	5	5	2	51
RWH	East & North Hertfordshire NHS Trust	11	2	1	0	1	0	1	1	2	1	1	2	2	14
RDE	East Suffolk and North Essex NHS Foundation Trust	20	2	2	2	0	2	4	4	3	1	1	0	2	23
RGP	James Paget University Hospitals NHS Foundation Trust	10	0	1	0	2	2	1	3	1	0	0	1	0	11
RAJ	Mid and South Essex NHS Foundation Trust	47	1	6	5	3	4	2	5	9	3	5	5	6	54
RD8	Milton Keynes Hospital NHS Foundation Trust	10	1	1	2	0	0	0	0	2	3	0	0	1	10
RM1	Norfolk & Norwich University Hospitals NHS Foundation Trust	26	1	1	1	4	0	0	2	4	2	3	0	0	18
RGN	North West Anglia NHS Foundation Trust	16	1	3	2	2	4	3	2	4	3	1	3	0	28
RGM	Papworth Hospital NHS Foundation Trust	6	0	0	0	0	1	0	0	1	0	0	0	0	2
RQW	Princess Alexandra Hospital NHS Trust	9	0	0	1	1	1	0	1	0	2	0	1	0	7
RCX	The Queen Elizabeth Hospital King's Lynn NHS Trust	10	0	0	0	1	2	1	0	0	0	1	5	2	12
RWG	West Hertfordshire Hospitals NHS Trust	12	1	1	0	0	2	2	1	1	2	1	2	1	14
RGR	West Suffolk Hospitals NHS Trust	3	0	0	0	1	4	1	0	1	2	0	1	0	10
	East of England Total		**13**	**17**	**22**	**20**	**26**	**24**	**23**	**38**	**22**	**21**	**26**	**16**	**268**

Meticillin Susceptible and Meticillin Resistant *Staphylococcus aureus*

The bacterium *Staphylococcus aureus* is commonly found colonising the skin and mucous membranes of the nose and throat. It can cause a wide range of infections from minor boils to serious wound infections; however, most people carry this organism harmlessly. In hospitals, it can cause surgical wound infections and bloodstream infections. Mandatory reporting includes all isolates, whether true infections or contaminated blood cultures and will initially be attributed to the Trust if the positive specimen is taken on or after day 2 of admission (where day of admission is 0)

Meticillin Susceptible *Staphylococcus aureus* (MSSA)

There remains no national objective currently for MSSA. See table 17 & 18.

69.5% of MSSA BSI were of community origin. Of the 35-hospital origin 60% had an unknown primary focus, 22.8% with a skin and soft tissue primary focus, 8.57% urinary tract, 2.86% line infection, 2,86% chest infection and 2.86% cellulitis.

Table 17

NNUH Meticillin Susceptible Staphylococcus aureus BSI - number of cases

Financial Year	Community Origin	Hospital Origin on or after day 3	Total
2022-23	**80 (69.5%)**	**35 (30.5%)**	**115**
2021-22	81 (72.9%)	30 (27.1%)	111
2020-21	94 (71.8%)	37 (28.2%)	131

Table 18

UK Health Security Agency

Methicillin-sensitive Staphylococcus aureus

Count of healthcare associated cases per month

Trust Code	Acute Trust Name	Trajectory*	2022 April	May	June	July	August	September	October	November	December	2023 January	February	March	Total
RC9	Bedfordshire Hospitals NHS Foundation Trust	N/A	5	3	2	5	4	2	3	6	1	1	3	4	39
RGT	Cambridge University Hospitals NHS Foundation Trust	N/A	6	5	6	4	6	6	3	4	6	6	5	8	65
RWH	East & North Hertfordshire NHS Trust	N/A	5	2	4	1	3	4	3	1	2	0	3	0	28
RDE	East Suffolk and North Essex NHS Foundation Trust	N/A	2	1	4	7	1	4	8	4	7	7	9	5	59
RGP	James Paget University Hospitals NHS Foundation Trust	N/A	1	0	1	0	0	1	1	0	0	1	1	1	7
RAJ	Mid and South Essex NHS Foundation Trust	N/A	14	12	5	9	10	3	10	7	4	4	1	9	88
RD8	Milton Keynes Hospital NHS Foundation Trust	N/A	2	1	3	3	1	1	2	3	5	1	1	0	23
RM1	Norfolk & Norwich University Hospitals NHS Foundation Trust	N/A	4	5	1	5	6	2	3	6	4	2	2	1	41
RGN	North West Anglia NHS Foundation Trust	N/A	3	0	1	6	5	3	3	1	0	4	2	3	31
RGM	Papworth Hospital NHS Foundation Trust	N/A	2	2	1	1	2	1	0	2	0	1	0	2	14
RQW	Princess Alexandra Hospital NHS Trust	N/A	1	1	1	2	0	1	3	1	4	1	2	2	19
RCX	The Queen Elizabeth Hospital King's Lynn NHS Trust	N/A	1	1	1	2	3	4	1	0	4	4	3	2	26
RWG	West Hertfordshire Hospitals NHS Trust	N/A	3	6	2	2	5	3	1	1	2	1	4	2	32
RGR	West Suffolk Hospitals NHS Trust	N/A	1	2	1	4	2	2	3	3	0	1	1	1	21
	East of England Total		50	41	33	51	48	37	44	39	39	34	37	40	493

*UKHSA data includes community data with patients with prior Trust exposure within 28 days.

Meticillin Resistant *Staphylococcus aureus* (MRSA)

All *Staphylococcus aureus* BSI are reported. They are categorised according to their resistance to antibiotics and are then reported separately as MSSA and MRSA. Surveillance and reporting of MRSA BSI continues with the limit set at 0 avoidable cases. See tables 19 & 20.

There was no hospital origin MRSA BSI during 2022-23.

Table 19

NNUH MRSA BSI - number of cases

Financial Year	Community Origin	Hospital Origin (on or after day 3)	Total
2022-23	**0**	**0**	**0**
2021-22	**2**	**1**	**3**
2020-21	4	0	4

Table 20

UK Health Security Agency

Methicillin-resistant Staphylococcus aureus

Count of healthcare associated cases per month

Trust Code	Acute Trust Name	Trajectory*	2022 April	May	June	July	August	September	October	November	December	2023 January	February	March	Total
RC9	Bedfordshire Hospitals NHS Foundation Trust	N/A	1	1	0	0	0	0	0	2	0	2	0	0	6
RGT	Cambridge University Hospitals NHS Foundation Trust	N/A	0	1	0	0	0	1	1	0	0	0	0	0	3
RWH	East & North Hertfordshire NHS Trust	N/A	0	0	1	0	0	0	0	0	0	0	0	0	1
RDE	East Suffolk and North Essex NHS Foundation Trust	N/A	2	0	0	0	0	0	1	0	1	0	0	0	4
RGP	James Paget University Hospitals NHS Foundation Trust	N/A	0	0	0	0	0	0	0	0	0	1	0	0	1
RAJ	Mid and South Essex NHS Foundation Trust	N/A	2	1	2	2	0	2	2	1	1	1	0	1	15
RD8	Milton Keynes Hospital NHS Foundation Trust	N/A	0	1	0	1	0	0	0	0	0	0	1	0	3
RM1	Norfolk & Norwich University Hospitals NHS Foundation Trust	N/A	0	0	0	0	0	0	0	0	0	0	0	0	0
RGN	North West Anglia NHS Foundation Trust	N/A	0	1	1	0	0	0	1	0	1	1	0	0	5
RGM	Papworth Hospital NHS Foundation Trust	N/A	0	0	0	0	0	0	1	0	0	0	0	0	1
RQW	Princess Alexandra Hospital NHS Trust	N/A	0	0	0	0	0	0	0	0	0	0	0	0	0
RCX	The Queen Elizabeth Hospital King's Lynn NHS Trust	N/A	0	0	0	0	0	0	0	0	0	0	1	0	1
RWG	West Hertfordshire Hospitals NHS Trust	N/A	0	0	0	1	1	1	0	0	1	0	0	0	4
RGR	West Suffolk Hospitals NHS Trust	N/A	0	0	0	0	0	0	0	0	0	0	0	1	1
	East of England Total		5	5	4	4	1	4	6	3	4	5	2	2	45

Audit Programme

Throughout the year, the IP&C team provided assistance for a range of audits, including those related to hand hygiene, commodes, mattresses, environmental factors, isolation rooms, and the auditing of indwelling devices such as cannulas, urinary catheters, and central venous catheters.

The IP&C team, work in partnership with link practitioners and ward staff across the Trust. This ranges from teaching ward staff how to undertake their own audits to help them understand the standards of practice required; to overseeing an ongoing programme of audits, sharing learning, and supporting to drive improvement and provide assurance. Once a year the IP&C team work with link practitioners to audit the isolation rooms across the Trust.

Staff undertake monthly High Impact Intervention audits within their departments, of peripheral cannula, urinary catheter, central venous catheter, and ventilator associated pneumonia care bundle practice. Peer auditing is encouraged, and results are fed back in divisional reports at HICC.

Infection Prevention and Control Annual Report 2022-23

Image 6

In each area staff undertake weekly Tendable IP&C audits using handheld devices. This inspection app provides opportunity to record photographs and comments to evidence decisions made (image 6). There are also IP&C questions within the daily safety check audit; validation audits are undertaken to monitor quality and provide assurance. Results and reports are available on completion and provide performance comparisons and trends across individual areas, divisions, and the Trust as a whole. Staff are required to act on any learning from these audits to continually drive improvement.

Audit results are also shared with clinical areas and can be accessed via the intranet on the IP&C electronic dashboard where they can be viewed by individual area, division, or whole trust. See chart 4 below.

Chart 4

Audit results Dashboard (May 2023)

			YTD	Quarter				2022									2023		
		21/22	22/23	1	2	3	4	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
IP&C Audits																			
Commode	Number Pass	1837	1772	534	416	419	403	211	192	131	141	131	144	117	136	166	79	125	199
	Number Fail	274	175	55	53	36	31	23	12	20	16	23	14	15	13	8	8	9	14
	% Pass	87%	91%	91%	89%	92%	93%	90%	94%	87%	90%	85%	91%	89%	91%	95%	91%	93%	93%
Bed Pans	Number Pass	2450	2146	652	544	500	450	268	212	172	190	159	195	155	175	170	100	162	188
	Number Fail	59	67	24	24	13	6	6	2	16	9	13	2	6	6	1	2	1	3
	% Pass	98%	97%	96%	96%	97%	99%	98%	99%	91%	95%	92%	99%	96%	97%	99%	98%	99%	98%
Hand Hygiene (HH) & Dress Code (DC)	No of audits	758	1051	229	285	287	250	85	66	78	102	96	87	96	101	90	85	63	102
	Staff Audited	6766	9336	2094	2588	2451	2203	758	620	716	982	845	761	877	875	699	760	577	866
	HH Pass %	96%	96%	95%	97%	98%	96%	97%	93%	94%	97%	97%	97%	98%	98%	97%	97%	97%	96%
	DC Pass %	99%	99%	99%	99%	99%	99%	99%	98%	98%	99%	99%	99%	99%	99%	99%	99%	99%	99%
High Impact Intervention Audits																			
HII 1 Central Venous Catheter	Insertion Obs	1155	1260	255	325	340	340	95	115	45	85	125	115	95	125	120	115	120	105
	Pass %	100%	99%	100%	100%	97%	100%	100%	100%	100%	100%	100%	100%	89%	100%	100%	100%	99%	100%
	Ongoing obs	5437	6016	1481	1554	1443	1538	446	538	497	400	586	568	488	511	444	531	457	550
	Pass %	95%	93%	94%	93%	94%	89%	95%	95%	92%	93%	93%	93%	94%	93%	96%	85%	91%	91%
HII 2 Peripheral Intravenous Cannula	Insertion Obs	13297	13080	3360	3155	3225	3340	1130	1145	1085	900	1150	1105	1115	1035	1075	1125	1035	1180
	Pass %	98%	98%	98%	98%	99%	98%	98%	98%	97%	99%	98%	98%	98%	98%	99%	98%	98%	97%
	Ongoing obs	11659	12167	3313	2817	2954	3083	1049	1218	1046	801	1026	990	1091	954	909	1015	969	1099
	Pass %	93%	90%	92%	89%	91%	88%	94%	92%	92%	89%	90%	89%	92%	91%	91%	89%	89%	87%
HII 5 Ventilated patients	Obs	818	685	177	154	166	188	45	70	62	16	61	77	37	57	72	54	72	62
	Pass %	97%	98%	99%	98%	99%	97%	100%	100%	97%	100%	95%	100%	100%	100%	97%	98%	99%	95%
HII 6 Urinary catheter	Insertion Obs	3585	4004	1120	872	972	1040	376	400	344	240	340	292	400	300	272	388	328	324
	Pass %	98%	98%	99%	98%	99%	96%	98%	100%	99%	95%	100%	100%	99%	100%	100%	97%	95%	96%
	Ongoing obs	9470	10263	2671	2214	2375	3003	853	1008	810	675	770	769	852	790	733	984	837	1182
	Pass %	93%	90%	92%	90%	91%	88%	92%	92%	92%	89%	93%	87%	93%	91%	88%	87%	88%	89%

Staff Training and Supervision

Due to COVID-19 guidance in 2021 large scale in person mandatory training sessions were not able to be delivered. Throughout 2022-23 most of the training continued to be delivered via Microsoft Teams and the national IP&C e-learning package. The revision of COVID-19 guidance in 2022 provided the team with the opportunity to deliver some face-to-face training, whilst the e-learning package and presenting on Teams continued.

The IP&C Team continued to support clinical teams across the organisation in their response to COVID-19, including those wards on supportive measures for a period of increased incidence.

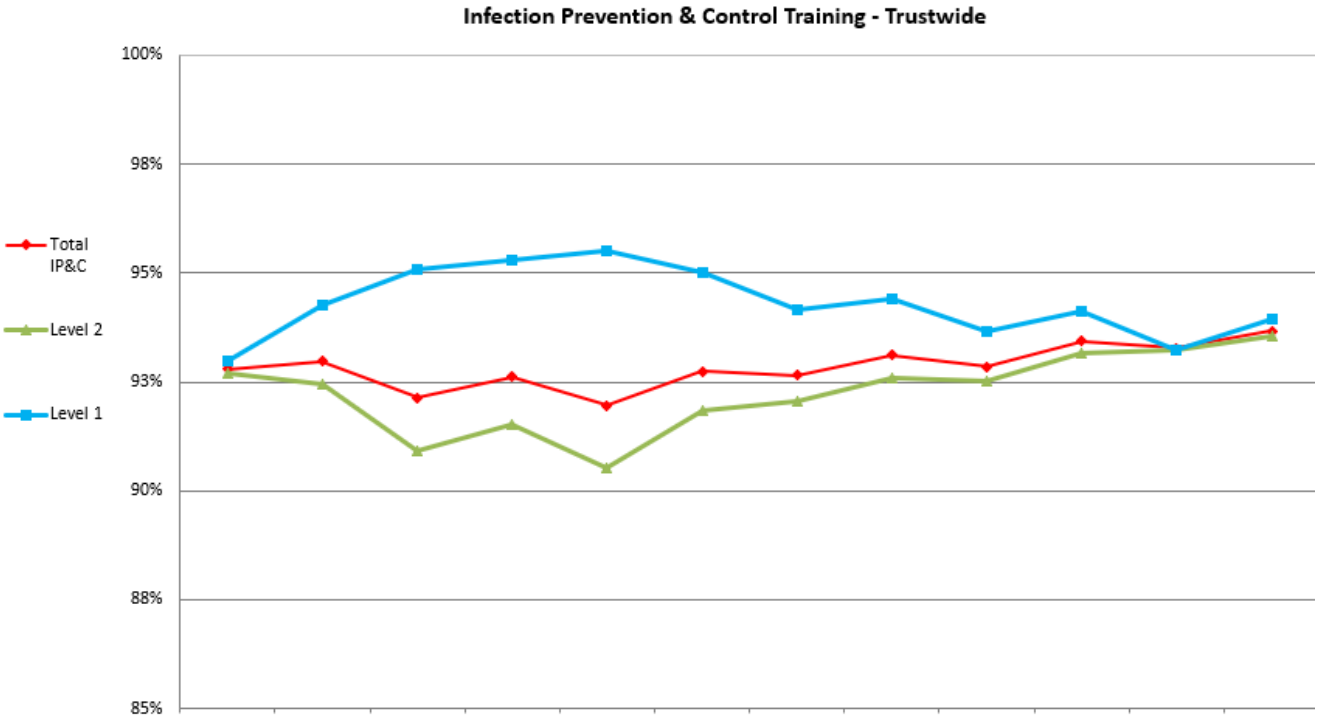
We have welcomed new staff from overseas to the Trust and delivered corporate induction for them.

IP&C took part in the Junior Doctor induction which encompassed hand hygiene, infection prevention and control in practice and multi drug resistant organisms.

Trust overall IP&C mandatory compliance was between 93% and 95% (see graph 1).

Infection Prevention and Control Annual Report 2022-23

Graph 1



IP&C Level	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Level 1	93.0%	94.2%	95.1%	95.3%	95.5%	95.0%	94.1%	94.4%	93.7%	94.1%	93.2%	94.0%
Level 2	92.7%	92.5%	90.9%	91.5%	90.5%	91.8%	92.1%	92.6%	92.5%	93.2%	93.2%	93.6%
Total IP&C	**92.8%**	**93.0%**	**92.1%**	**92.6%**	**92.0%**	**92.7%**	**92.7%**	**93.1%**	**92.8%**	**93.4%**	**93.3%**	**93.7%**

Compliance % figures exclude Honorary, Locums and Bank staff

University of East Anglia (UEA) Healthcare student training

Although not directly in partnership with the UEA during this period, students are encouraged to spend time with the IP&C team. Whilst on placement nursing students joined the team to gain a greater understanding of the principles of IP&C and the diverse role of the team and how this supports the NNUH and wider healthcare systems.

IP&C team training

The IP&C team have taken advantage of numerous opportunities to engage in internal and external development opportunities, in the form of postgraduate diplomas, leadership opportunities, webinars, and e-conferences. These have been more accessible; many have been free and a great opportunity to hear from leading experts in their fields from our desks between other clinical and management commitments. Study days involving IP&C colleagues from across the East of England region, and NHSE/I have enabled face to face networking and learning.

Hand Hygiene Day

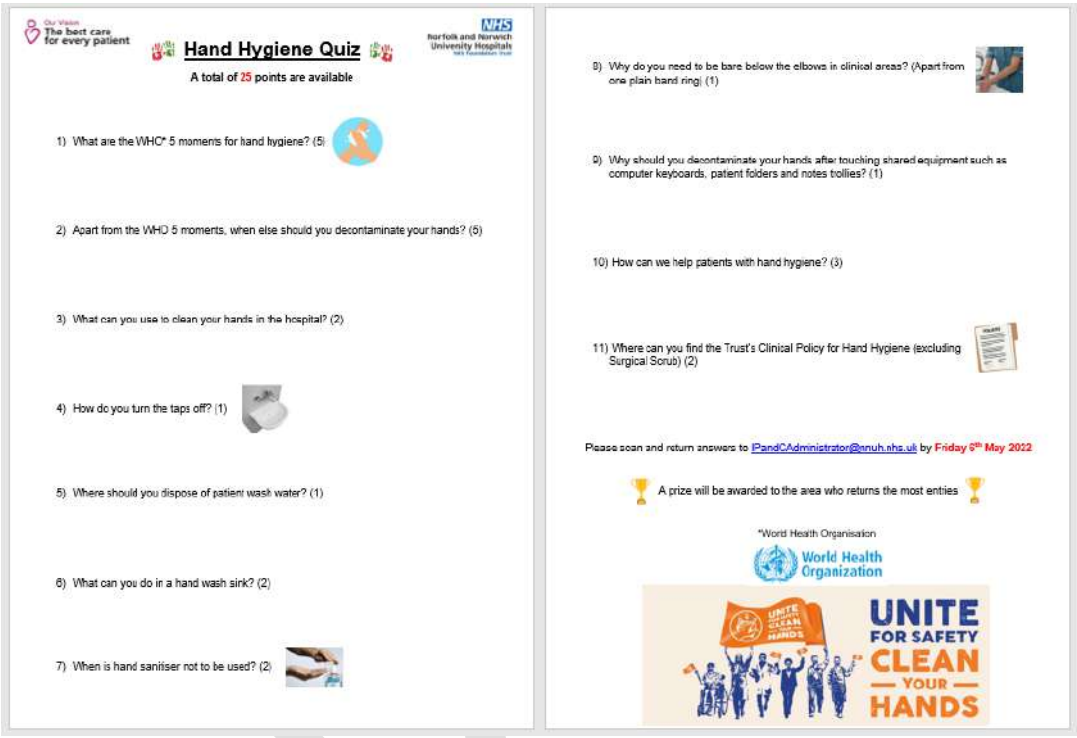
The 5th of May was World Hand Hygiene Day. This year's theme for World Hand Hygiene Day, focused on recognizing that we can add to a facility's climate or culture of safety and quality through cleaning our hands (image 7). A strong quality and safety culture will encourage people to clean hands at the right times and with the right products.

Image 7

IP&C composed a Hand Hygiene Quiz and invited all staff across the Trust to participate (image 8). Gateley (image 9) and Earsham (image 10) ward staff were presented with prizes for submitting the most entries.

SC Johnson (who provide the hospital's hand sanitiser) were invited to visit the hospital to follow up on a hand hygiene audit that they completed earlier in the year. This assisted with reinforcing the need to use the right technique when decontaminating hands.

Image 8



Hand Hygiene Quiz

A total of 25 points are available

1) What are the WHO* 5 moments for hand hygiene? (5)

2) Apart from the WHO 5 moments, when else should you decontaminate your hands? (5)

3) What can you use to clean your hands in the hospital? (2)

4) How do you turn the taps off? (1)

5) Where should you dispose of patient wash water? (1)

6) What can you do in a hand wash sink? (2)

7) When is hand sanitiser not to be used? (2)

8) Why do you need to be bare below the elbows in clinical areas? (Apart from one plain hand ring) (1)

9) Why should you decontaminate your hands after touching shared equipment such as computer keyboards, patient folders and notes trollies? (1)

10) How can we help patients with hand hygiene? (3)

11) Where can you find the Trust's Clinical Policy for Hand Hygiene (excluding Surgical Scrub) (2)

Please scan and return answers to IPandCAdministrator@nnuh.nhs.uk by Friday 6th May 2022

A prize will be awarded to the area who returns the most entries

*World Health Organisation

World Health Organization

UNITE FOR SAFETY CLEAN YOUR HANDS

Image 9

Image 10

IP&C International awareness week

Every year, the IP&C team actively participates in raising awareness regarding IP&C issues during International Infection Prevention Week. This year, the event fell in October 2022. Despite the challenge posed by the ongoing pandemic, colleagues engaged with the team. The theme of the week was promoting the appropriate use of gloves and PPE see image 11 and 12.

The IP&C team created a competition, '*guess how many dispenser keys in the jar'* for staff to enter and this was won by a Health Care Assistant in Nuclear Medicine who was presented with a certificate and Amazon voucher see image 13.

Image 11

Image 12

Image 13

IP&C link practitioners

The IP&C team continued to provide support to the IP&C link practitioners in the Trust during 2022-23.

Meetings took place throughout the year with a variety of topics covered. These were attended by IP&C link practitioners from across the organisation, who were encouraged to use these hours towards their Continuing Professional Development (CPD). Refer to table 21 for an overview of the meeting agendas. Image 14 is an example of the meeting poster which was circulated to staff members.

Table 21

IP&C Link Practitioner meetings 2022-23	
Date	**Agenda**
24th June 2022	• Gloves off • Gram negative reduction • Monkey pox • Commissioning for quality and innovation
20th September 2022	• Hand Hygiene • Monkey Pox • Isolation Audit • How dirty is your QWERTY? • National Cleaning Standards

6th December 2022	• Presentation from SC Johnson 'Hand Health' • Are you ready for Flu and Noro • Cleaning – Trust Responsibilities • Diphtheria
23rd March 2023	• Community IP&C Team to talk about the work being done to reduce glove use in the community. • The switch from Actichlor to ChloroSan • The leadership council and how link staff could become involved in an IP&C council. • New linen bagging procedure

Image 14

Organisation Wide Learning (OWL)

The IP&C team continues to produce a monthly organisational wide learning (OWL). The OWL is sent out in the form of a poster, sharing Trust wide IP&C information, and learning such as:

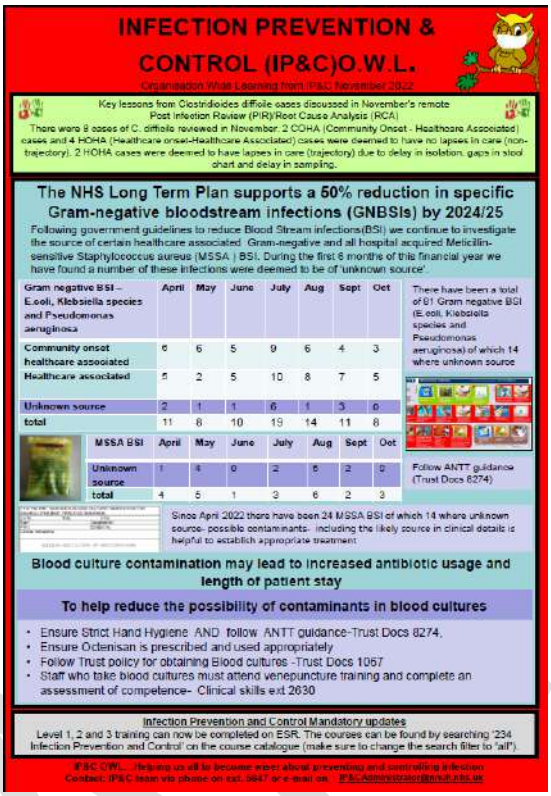
- Monthly learning from *C. difficile* PIR
- Key IP&C messages
- Current or upcoming IP&C topics
- Highlighting areas of good practice
- Highlighting areas of improvement

Infection Prevention and Control Annual Report 2022-23

Examples of the OWL's from the year are shown in image 15 & 16.

Image 15

Image 16



Movement of Service Users

The IP&C and operational teams utilise electronic boards to assist staff in highlighting areas with confirmed/suspected COVID-19, Influenza or Norovirus and include information on community hospitals or care homes with suspected or known cases.

During the COVID-19 pandemic the IP&C team worked closely with Information Services (IS) and the IMT to ensure that suitable reports were available to identify contacts and isolate and cohort patients safely.

This partnership has continued, working closely with the digital reporting team and divisions, developing operational dashboards, whilst supporting departments with screening compliance to ensure data is captured in the most effective and accurate way.

Assisting with safe placement of patients with potential, suspected or confirmed infections is paramount to prevent nosocomial transmission. The IP&C team work closely with the Operational Management Team and IMT to utilise the reports provided to manage patient pathways as safely as possible. The IP&C team provide an on-call service and attend daily operational meetings to support and provide advice.

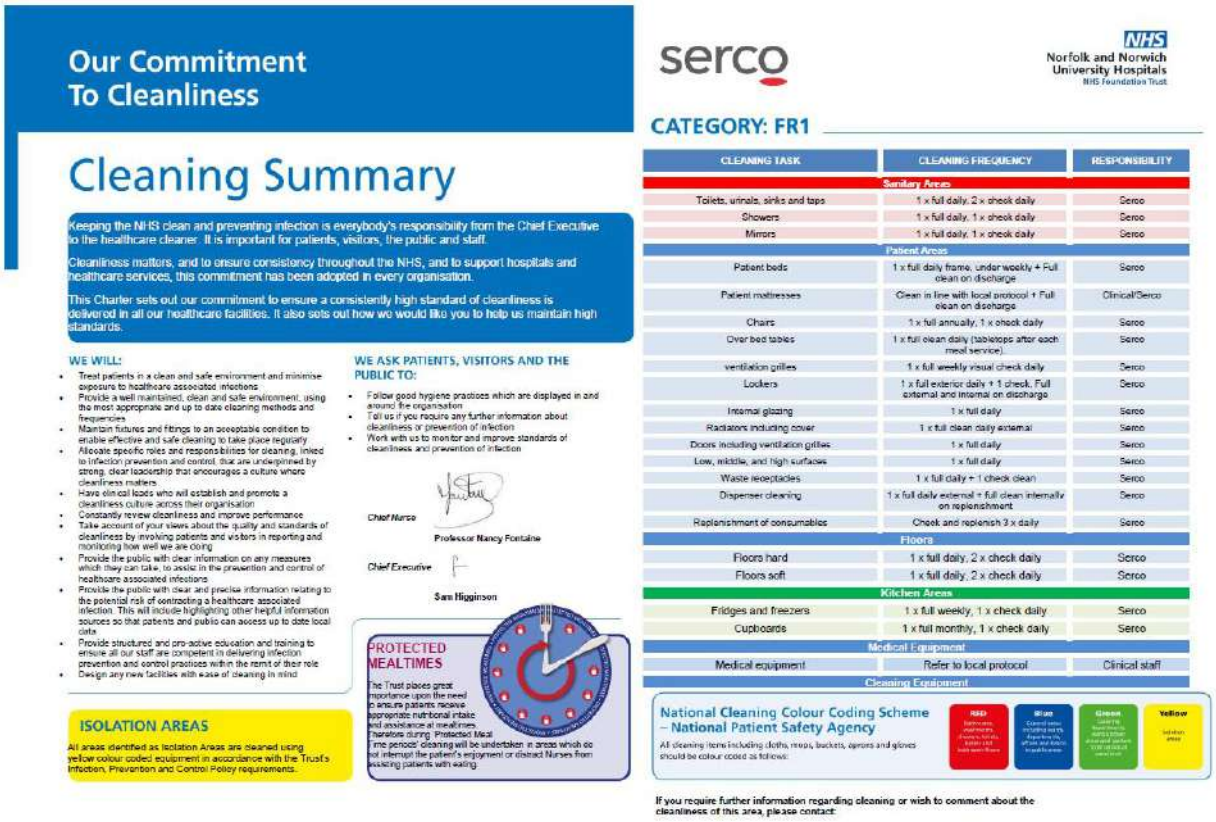
There are also individual patient alerts in place on the Patient Administration System and ICE system to assist in single room planning for patients with known previous infections/alert organisms.

Hygiene Code Compliance Criteria 2:
The provision and maintenance of a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.

Cleaning

The IP&C team work in partnership to deliver a clean safe environment for patients. Cleaning schedules/charters are displayed in each area. The National Cleaning standards (2021) were implemented April 2022. All areas have been categorised in one of the 6 Functional risk categories. A matrix of cleaning responsibilities remains in place, with commitment to the Cleanliness charter being made. Audits of all areas provide assurance and are displayed (see Image 17). Star ratings are in place in line with the national guidance.

Image 17



Cleaning Audits

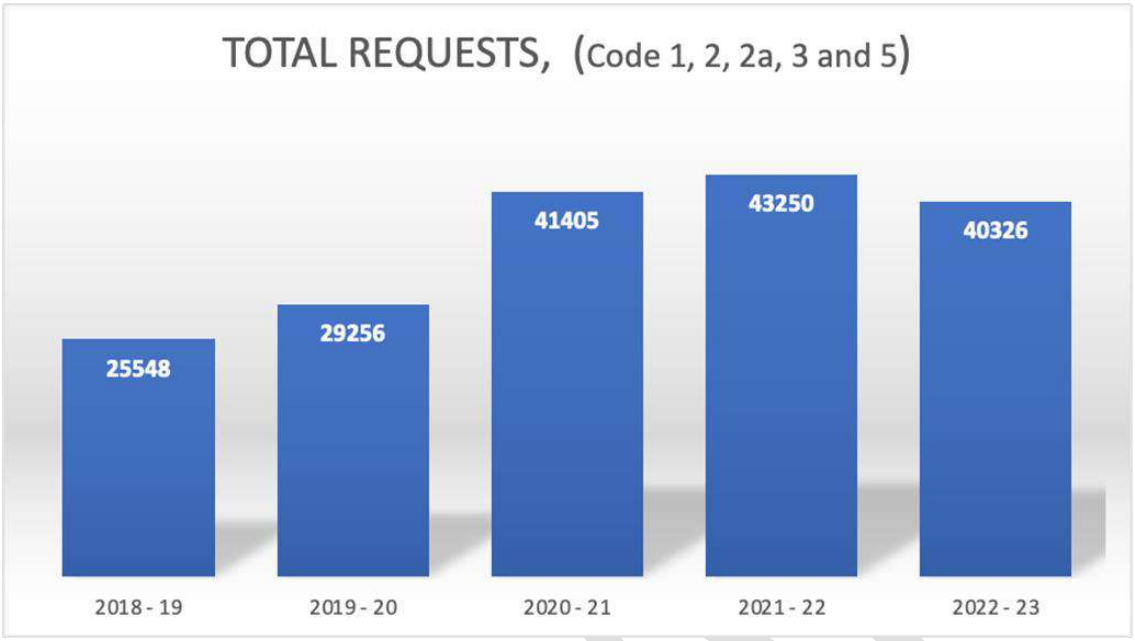
Cleaning of the environment, equipment and estates are monitored through regular joint audits attended by both Trust and Provider staff using FM First software. See tables 22, 23 & 24.

Cleaning Services have adopted the latest National Cleaning Standards 2021. Not only did the team implement these across the organisation our FM specialist for Cleaning, Serco Health also supported the National Review and formulation of the standards. These updated standards also include considerations for cleaning during a pandemic and collaboration or organisations cleaning. The service also invested in replacement of its service trolleys across the inpatients, new and replacement machinery, and a new vacuum system which allows cleaning of hard to reach areas enabling the team to respond to cleaning requirements outside the normal set frequencies as required. Cleaning Services also invested in an additional full time environmental auditor to support the National Cleaning audit assurance, and trained members of the team in the new efficacy audit requirements introduced within the National Cleaning Standards, these

requirements help to ensure the methodology of cleaning is maintained to optimise consistency and correct levels of cleanliness across the organisation.

The period noted high volumes of reactive requests for cleaning trending above the 5 year average. Though lower than the previous year these demands remain higher than pre-pandemic volumes (graph 2).

Graph 2



Serco Health has also introduced a new rating system for the type of clean required for infectious cleaning and discharge cleaning which has also been very successful in improving the correct categorisation, staff education and expedition of patient flow.

Functional Risk (FR) Categories

There are 6 Functional Risk Categories FR1 to FR6:

- FR1 replaces Very High Risk with an audit target score of 98% and weekly audit frequency.
- FR2 replaces High Risk with an audit target of 95% and monthly audit frequency.
- FR3 is a new risk category for long term wards and treatment centres with an audit target of 90% and Bi-monthly audit frequency.
- FR4 replaces Significant Risk with an audit target of 85% and quarterly audit frequency.
- FR5 is a new risk category for high use areas such as receptions and prayer rooms with an audit target of 80% and 6 monthly audit frequency.
- FR6 replaces Low Risk with an audit target of 75% and annual audit frequency.
- Functional Risk Categories have been identified for all functional areas

Star ratings

The star rating is derived from the original audit score at the time of audit and can only be updated following the next full re-audit.

Table 22 - NNUH audit scores 2022 - 2023			
Functional risk	**Number of audits**	**Average score**	**TARGET**
FR 1	1920	98.98%	98%
FR 2	635	97.56%	95%
FR 3	7	98.31%	90%
FR 4	236	95.57%	85%
FR 5	63	95.43%	80%

Table 23 - Cromer Hospital audit scores 2022 - 2023			
Functional risk	**Number of audits**	**Average score**	**Target**
FR 1	175	96.64%	98%
FR 2	109	95.25%	95%
FR 3	0	N/A	90%
FR 4	21	96.03%	85%
FR 5	1	98%	80%

The cleaning scores across the FR1 areas have improved in all areas apart from MIU, where we are hopeful that the issues will improve shortly. This has been impacted by vacancies & sickness across Norse (Cleaning provider). Cromer team have worked very closely with Norse to rectify the issues across the site & additional training has been provided.

Table 24 - Offsite areas audit scores 2022 – 2023 *Rouen Road, Cotman Centre, Central Eye Clinic, Francis Centre, Norwich Kidney Centre*			
Functional risk	**Number of audits**	**Average score**	**Target**
FR 1	12	99.73%	98%
FR 2	180	99.07%	95%

Patient led, focus on the environment (PLACE)

The national PLACE Assessment results have been published. 1,046 assessments were undertaken nationally in 2022 compared to 1,144 in 2019. 110 assessments were excluded due to missing mandatory assessment components (e.g., external areas) or an insufficient number of patient assessors. National findings are based on the 936 remaining assessments and results are not comparable with previous years.

National averages for each domain are listed below:

- Cleanliness – 98.01%
- Condition, appearance, and maintenance – 95.79%
- Dementia – 80.60%
- Disability - 82.49%
- Food and hydration – 90.23%
- Privacy, dignity and wellbeing – 86.08%

The NNUH's results for each domain are listed below:

- Cleanliness - 94.96%
- Condition, appearance and maintenance – 94.02%

- Dementia – 75.40%
- Disability – 76.67%
- Food and hydration – 79.87%
- Privacy, dignity and wellbeing – 72.67%

Therefore, we can summarise due to the overhaul and breadth of changes to the questions and forms completed ahead of the 2019 we are unable to compare our performance this year to previous years. However, this year we have seen an increase in our scores for dementia and disability. We have also seen a decrease in our scores for cleanliness, food (both organisation and ward), privacy/dignity/wellbeing and condition/appearance/maintenance.

Our performance in comparison to the national scores is also lower than the median in all domains.

In terms of the picture across the East of England our score for Dementia (75.4%) is higher than the average across the East of England (74.8%) and our scores for Condition, appearance and maintenance and Disability are very similar to the average across the East of England.

Report and Action Plans to be shared and monitored via Patient Engagement & Experience group and Estate/Facilities Governance and contract management routes.

Commode and Bedpan Cleanliness

The IP&C support workers maintain a continuous programme of commode and bedpan audits Trust wide with practical training provided. See table 25.

Table 25

Number of commodes audited and average percentage pass across NNUH sites

Financial Year	Total No. of Commodes audited	Percentage Pass
2022-23	**1772**	**91%**
2021-22	1837	87%
2020-21	1401	89%

Environmental Authority

No visits to the hospital were conducted by the authority during 2022-23.

Face Fit Testing

During 2022-23 the Trust continued to utilise the National resource for Fit Testing and this service has since ceased on the 31st March 2023 as the country goes back to business as usual. During this tenure starting June 2021 a total of circa 3500 tests had been completed.

The trust continues to complete Face fit testing for staff within mandatory areas and these are completed in line with The Department of Health and Social Care correspondence released in

June 2021. This focused on FFP3 (Filtering Face Piece) Resilience in the Acute Setting which informed of 5 key resilience principles that Trusts are asked to consider and implement:

- Item 1: All FFP3 users should be fit tested and using at least two different masks (ideally three): Current risk status Low; and Risk Appetite: Tolerate
- Item 2: FFP3 users should interchangeably wear the masks they are fit tested to. Current risk status Low; and Risk Appetite: Tolerate
- Item 3: Trusts should ensure that a range of FFP3 masks are available to users on the frontline and overall should not exceed 25% usage on any one type of FFP3. Current risk status Low; Risk Appetite: Tolerate
- Item 4: Frontline stocks will be managed at no more than 7-10 days per SKU. Current risk status Low; Risk Appetite: Tolerate
- Item 5: Trusts will register FFP3 users and fit test results in ESR and review individual usage every quarter. Current risk status Medium; Risk Appetite: Treat

Waste Policy

The policy for Waste Management applies to all sites within the Trust remit although the Facilities Management (FM) companies with operational responsibility differ across the sites.

The policy is approved by the Health and Safety Committee. The policy was recently reviewed in January 2023 then again in February 2023 as there was an amendment to the Category A waste flow process. The document is due its biannual review in January 2025, but this may be sooner where there is a change of legislation, process etc.

The current responsibility for the management and control of clinical waste sits with various departments:

- Trust Facilities department manage the contracts via FM providers. All clinical waste is currently collected by an appointed external service provider.
- Trust Health & Safety (H&S) team leads on waste policy and participate in monitoring with Facilities team. The policy is based on the document HTM 07-01 Safe Management of Healthcare Waste.
- During period 2022-23 the Safety Team continued with the services of the external contractor Independent Safety Services Ltd to act in the role of Dangerous Goods Safety Advisor on behalf of the Trust.
- Nuclear Medicine department oversee the management process of radioactive waste.

The Trust has recently appointed a new Sustainability Manager, who has focus of improving the sustainability of our waste processes.

Waste Monitoring and Measurement

The following monitoring takes place in relation to waste and dangerous goods:

- The Dangerous Goods Safety Advisor has a provision of 6 days over the 12-month period which includes report writing.
- Clinical waste is monitored on a daily basis by the FM companies to ensure it has been placed in the correct stream before leaving site. This involves a visual check of bin and

content and observation of items entering the compactors. Waste bags are never decanted or opened unless there is any suspicion of them containing incorrect waste.

- On site monitoring of correct clinical waste segregation via pre-acceptance audits (annually) this was completed in August 2022 by Stericycle.
- Security of clinical waste is monitored by the FM contractor and Trust Private Finance Initiative (PFI) contract manager.

Duty of Care Visits

Non-clinical Waste

In December 2022, representatives from Trust Estates, IP&C and H&S along with soft FM provider representatives attended the Shred Station Limited facility in Norwich. The waste carrier deals with confidential, domestic, and recycling waste streams.

It was identified during the visit that the domestic and recycling waste streams are then transferred to a separate waste facility next door which is managed by PSH Environmental Ltd. Findings of the visit has been completed in report format by the Health and Safety Lead Advisor with 1 observation noted in regard to insurance document being out of date.

Clinical Waste

In March 2023 representative from Trust H&S, PFI Landlord and soft FM provider representatives attended the Stericycle Waste Facility which houses the incinerator in Ipswich.

Findings of the visit has been completed in report format by the Health and Safety Lead Advisor with 1 observation noted in regard to the certificate for Dangerous Goods Safety Advisor had expired.

The visit reports have been shared with all parties including the Trust Dangerous Goods Safety Advisor.

Dangerous Goods Safety Advisor (DGSA)

The DGSA has completed site visits and audits in the following areas:

Year 2 2021/22

Previous visits had been completed in September & October 2022 and January 2022 with the final visit scheduled for May 2022 below:

Table 26
17/05/22
Nuclear Medicine
Theatres – Radiation Protection
Brachytherapy
Hazardous Waste Documentation

The annual report has been received which identified 30 observations over the audit period. These have all been closed down with sign off by the DGSA in November 2022.

Infection Prevention and Control Annual Report 2022-23

Year 3 2022-23

Visits completed at the following departments: Awaiting the report for 25/04/23 visit.

Table 27			
30/11/22	**22/02/23**	**28/03/23**	**25/04/23**
Main waste compound	Stericycle Vehicle Audit	Microbiology	Pharmacy
Internal waste storage areas	Medical Gases	The Cotman Centre (Cytology & Histopathology)	Waste Documentation
Battery Storage	Sterile Services	Pathology	Mortuary
Chemical Storage		Chemical Storage	External Formalin Store
Endoscopy			

18 issues were observed during these 3 sites visits which have been incorporated into an action plan and monitored by the Health and Safety Lead Advisor. Currently 13 issues have been closed.

Sharps

The safe handling and disposal of sharps is covered by the Trust policy for Prevention and Management of Needlestick (inoculation), Sharps Injuries, and Blood exposure incidents which also sit within the Health & Safety Team remit. This was reviewed in January 2022 with the next full review scheduled for January 2024.

Compliance with the policy is monitored on a frequent basis by the following routes: Collaborative approach by the Health & Wellbeing and H&S Teams via incidents raised by the electronic reporting system Datix.

- The Inoculation Incident Group meets on a quarterly basis and monitors incident trends. This forum also provides the opportunity for each of the division to discuss risk assessments in place for non-safety sharps that are in use.
- Trends of incidences are highlighted through the H&S Committee and HICC to disseminate to divisional areas to aid learning and prevent future incidents as well as highlighting at the Workforce and Education Sub-Board

Minimising blood splashes is also a main focus of the Inoculation Incident group members. The purpose of the group still continues to change the culture and that PPE is not just for COVID-19 and that eye protection is to be worn to where a blood splash could occur.

The Hospital Management Board is fully supportive of ensuring staff safety, protection from blood or bodily fluid splashes. Management at all levels should be promote to colleagues that eye protection should be worn where there is a potential for a blood/body exposure to occur. The Health and Safety Team from COVID-19 PPE stock have been providing areas where these types of incidents could occur safety glasses which can be kept and used by individuals when completing procedures.

Currently sharps bins used with in the Trust are the disposable type but in early 2023 there have been discussions with another supplier into the introduction of reusable bins, but this is in very early stages.

Laundry

Trust PFI Contract Performance Manager informed that during the reporting year COVID-19 did unfortunately impact the Duty of Care visit. The Trust had also recently had a change in provider. The Soft FM provider has been tasked with arranging one with the provider as soon as possible.

- In terms of monitoring, the monthly inspections continue with on average 100 items being reviewed at the time with contractor, Soft FM provider and a Member of the Trust monitoring team in attendance. Additionally, the service elements are all monitored throughout the course of the month, which includes HTM 01-04 Decontamination of linen for health and social care.

Hygiene Code Compliance Criteria 3: Appropriate antimicrobial use and stewardship to optimise outcomes and to reduce the risk of adverse events and antimicrobial resistance.

Prudent Use of Antibiotics (information provided by Specialist Antimicrobial Pharmacist)

Antimicrobial Consumption Surveillance

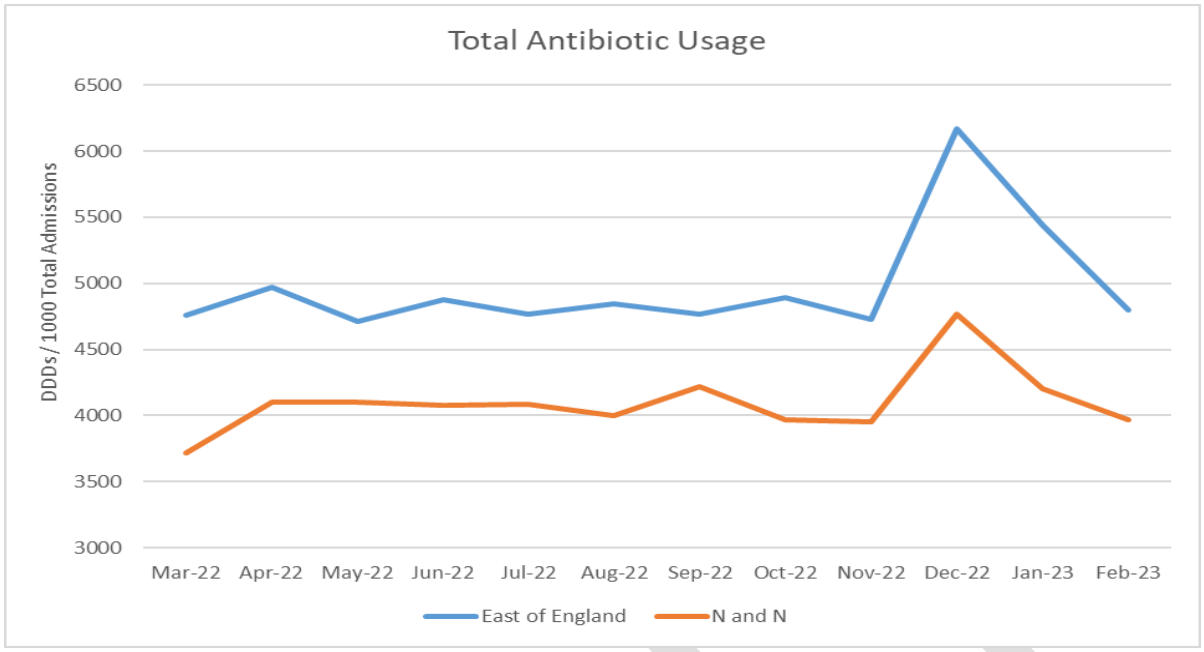
For the purposes of surveillance and monitoring, antimicrobial consumption is reported in units of Defined Daily Dose (DDD) per 1000 total admissions (including day case). DDD is the WHO standard unit and is based on the average daily dose of a medicine used for its main indication in adults. Standardisation in this manner enables comparison between trusts of different size and range of specialties and against the average for the East of England region. Data for surveillance is obtained from RxInfo Define as this is the source used by UKHSA for monitoring antibiotic consumption within the NHS Standard Contract.

The figures below show the 12-month rolling trend of antimicrobial usage within the Trust compared with the NHS East of England average.

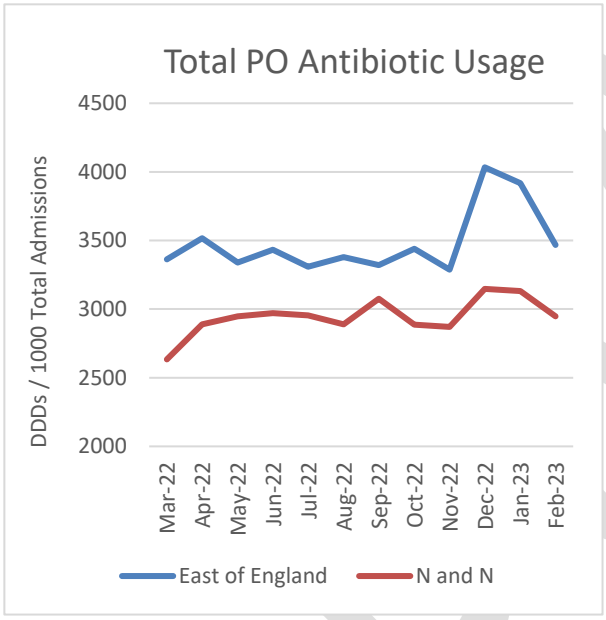
Total Antibiotic Consumption

Total antibiotic consumption over the most recent period appears to be consistent with use from previous months and is broadly in-line with the trend of the region. NNUH continues to use considerably fewer antibiotics when compared to the rest of the region . We should continue to focus our efforts on minimising broad-spectrum antibiotic use and on timely IV to oral switching. Graph 3, 4 and 5 show a spike in consumption around December 2022 due to the National increase in infections caused by Group A Streptococcus.

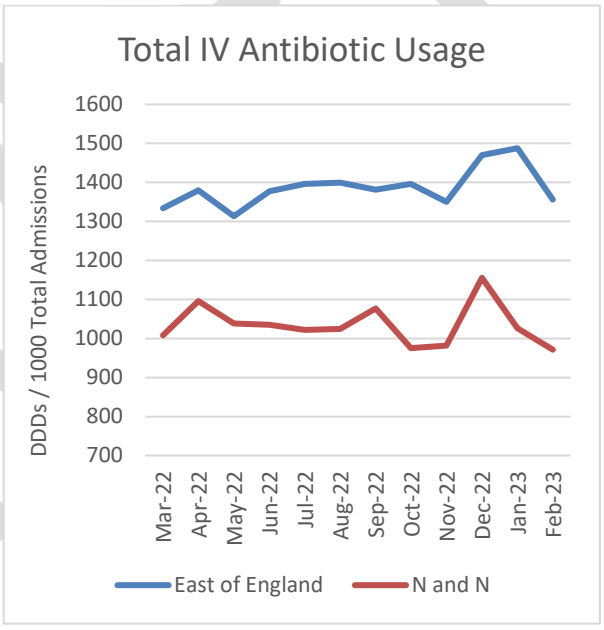
Graph 3



Graph 4



Graph 5



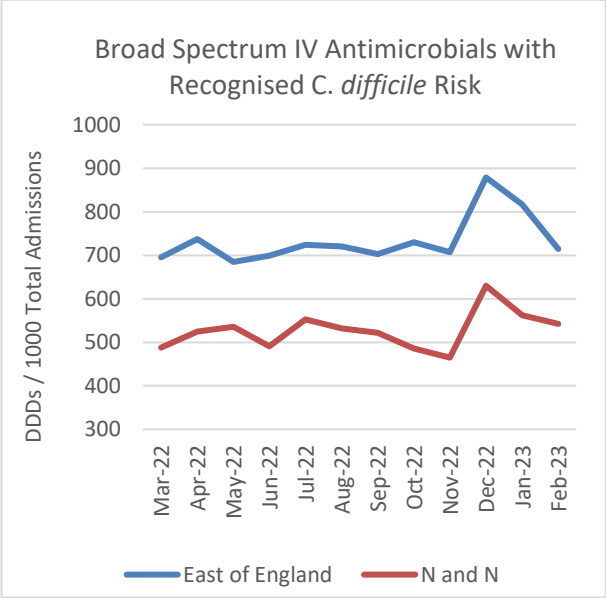
Broad-Spectrum Antibiotic Consumption

The Trust continues to use significantly fewer broad-spectrum antibiotics than the regional average except for doxycycline and cephalosporins. These figures will be monitored to ensure that any increase in prescribing is appropriate, and that action is taken to reduce unnecessary use of broad-spectrum agents.

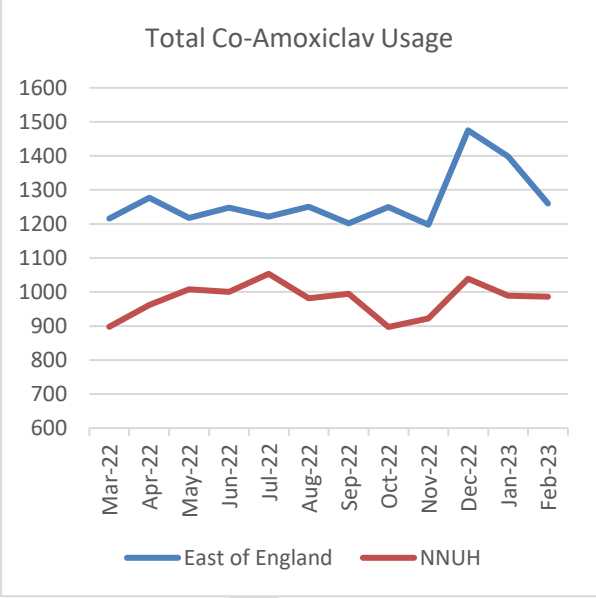
Doxycycline use is higher as we recommend this in the Antibiotic policy in place of Co-amoxiclav (which has a higher likelihood of causing C. *difficile* infection).

Infection Prevention and Control Annual Report 2022-23

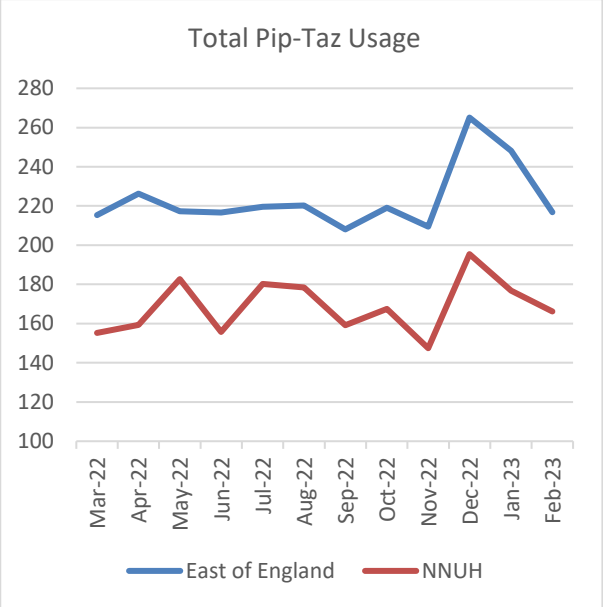
Graph 6



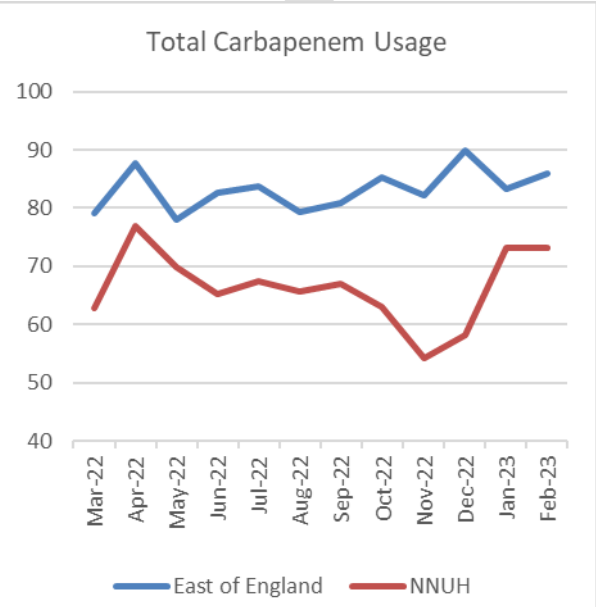
Graph 7



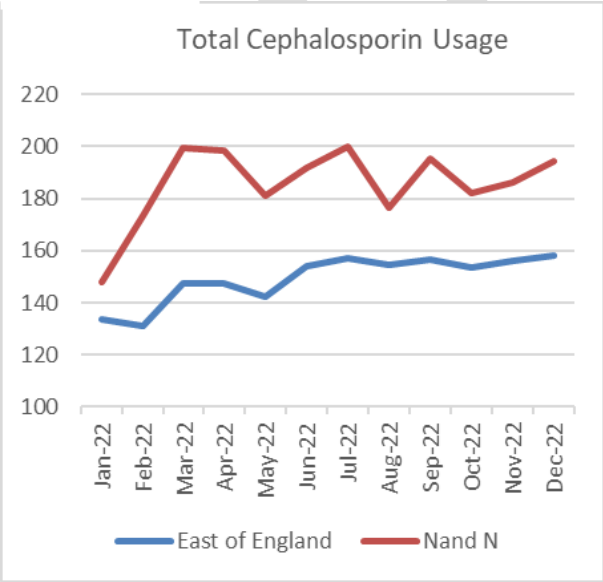
Graph 8



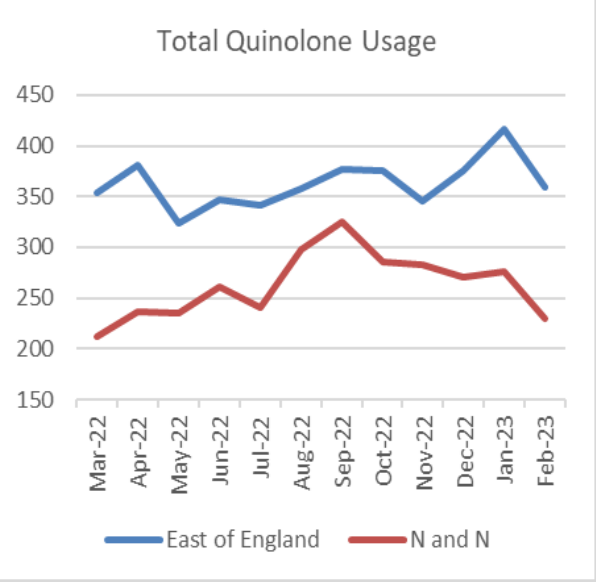
Graph 9



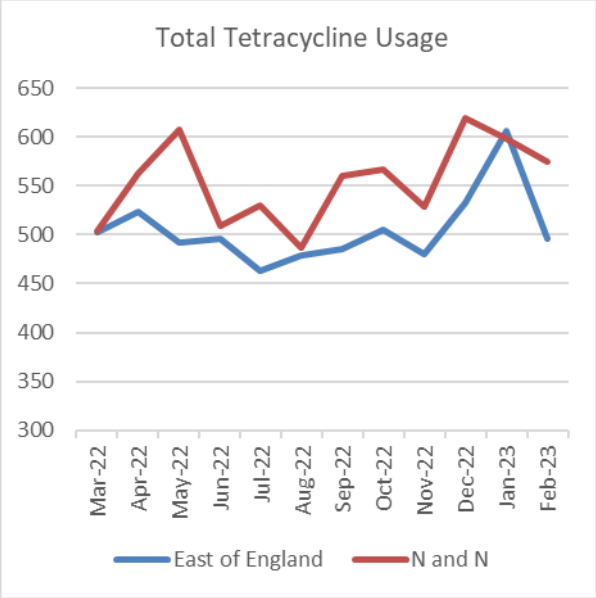
Graph 10



Graph 11



Graph 12



Antibiotic Audits

Point Prevalence Survey

The last point prevalence audit was carried out in February 2023. The next audit is scheduled for May 2023.

Data from February 2023 shows a reduction in antibiotics given by the IV route, which is encouraging as we are now working towards a Commissioning for Quality and Innovation (CQUIN) looking at the timely IV to oral switch of antibiotics. See section 3.2

Table 28					
Trust Wide Data					
Date	**% of patients on Antibiotics**	**% given by oral route**	**% given by IV route**	**Tazocin use as % of Ab use**	**Co-amoxiclav use as % of Ab use**
July 22	40	46	54	16	7
October 22	40	49	51	13	7
February 23	42	55	45	13	6

Table 29				
Surgery Data				
Date	**Number of Antibiotics prescribed**	**% given by oral route**	**% given by IV route**	**Tazocin use as % of Ab use**
July 22	145	33	67	20
October 22	170	40	60	13
February 23	176	51	49	14

Table 30			
OPM Data			
Date	**Number of Antibiotics prescribed**	**% given by oral route**	**% given by IV route**
July 22	71	58	42
October 22	99	60	40
February 23	78	72	28

Table 31			
Medicine Data			
Date	**Number of Antibiotics prescribed**	**% given by oral route**	**% given by IV route**
July 22	180	56	44
October 22	163	52	48
February 23	182	60	40

Other Audit

We have recently audited antibiotic use in Respiratory and Gastroenterology and are in the process of feeding the results back to each department.

Antimicrobial Stewardship (AMS) CQUIN

CQUIN 2022-23

As part of the national CQUIN scheme for 2022-23 Pharmacy have been undertaking an audit on appropriate antibiotic prescribing for Urinary tract infection (UTI) (in adults aged 16+) - CQUIN CCG2: appropriate antibiotic prescribing for UTI in adults.

The methodology to complete the audit involves identifying patients diagnosed with UTI and completing the audit questions using patients' medical notes.

The audit questions include:

1. What diagnosis is the antibiotic prescribed for?
2. Was the diagnosis based on documented clinical signs or symptoms in accordance with local guidance and/or UKHSA UTI diagnosis guidelines?
3. Was a urine dipstick test used to diagnose the UTI?
4. Was the antibiotic prescribed compliant with NICE/local Guidelines?
5. Has a urine sample been taken at time of diagnosis and sent to microbiology in line with UKHSA/NICE guidance?

A patient will fail the audit if answers to **any** of the audit criteria to not adhere with national/local guidance. A patient will only pass the audit if **all** of the audit criteria can be answered correctly. This CQUIN requires us to audit 100 patients per quarter (400 patients in total for 2022-23).

Target compliance is set at 40-60%.

- Q1 - 46% compliance was achieved
- Q2 - 56% compliance was achieved
- Q3 – 52% compliance was achieved

- Q4 – 40% compliance was achieved

Common audit failure points include:

1. Patients **>65** tested for UTI with urine dipstick
2. Patients being prescribed broad-spectrum antibiotics for UTI
3. Patients **not** receiving MSU
4. Patients with indwelling catheter tested for UTI with urine dipstick

CQUIN 2023-24

Antimicrobial Stewardship (AMS) CQUIN for 2023-24: Data collection will start in April 2023. Data for 100 patients will be collected across varying specialities.

Table 32

CQUIN04: Prompt switching of intravenous (IV) antimicrobial treatment to the oral route of administration as soon as patients meet switch criteria	
Applicability: Acute **CQUIN goal:** 60% to 40% (NB lower % = more compliant) **Supporting ref:** NICE NG15[4]	There are significant benefits to IVOS interventions demonstrated in research literature including: increasing hospital bed capacity to support recovery from the COVID-19 pandemic; reducing exposure to broad-spectrum antibiotics; increasing nursing workforce capacity; reducing drug expenditure; reducing carbon footprint of medicines; and reducing healthcare-associated bloodstream infections. This CQUIN aligns with a commitment in NHS England's 2022-23 Priorities and Operational Planning Guidance to support reduced lengths of hospital stays by ensuring that intravenous antibiotics are only used for as long as clinically necessary.

The aim is that patients will be switched to oral antibiotics sooner, and/or have reduced course lengths. This coincides with multiple benefits including reduced lengths of hospital stay, improved patient experience, fewer line-related adverse events, reduced carbon footprint, and reduced expenditure.

Guidelines and Policies

Updates

The Urology and Vascular surgical prophylaxis guidelines have been updated in the past year. The Antifungal guideline is up for review and is in the process of being updated.

MicroGuide

Funding for Microguide has been continued for another 3 years as of February 2023.

Formulary Updates

Applications

New formulary applications for Ceftazidime with Avibactam for the treatment of severe drug-resistant Gram-negative bacterial infections have been discussed and approved at Drugs & Therapeutics Committee.

Supply Chain

Nil to report currently.

Antimicrobial Stewardship Ward Rounds

Ward Round Update

As previously weekly ward rounds included Vascular and General Surgery Ward, Surgical Wards and all Older People's Medicine (OPM) Wards and Gastroenterology. These are in addition to a number of other well established clinical rounds that include antimicrobial review – e.g. NICU, Critical Care Units and Haematology and Oncology.

Hygiene Code Compliance Criteria 4:
The provision of suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/medical care in a timely fashion.

Information for Service Users, Visitors and Carers

The IP&C team regularly update the information and have continued to work closely with the communications department updating information in line with current IP&C guidance. IP&C information is shared in several ways including:

- Face to face discussion
- Via IP&C link practitioners
- Awareness campaigns
- Information leaflets
- Posters
- Trust information booklet
- Noticeboards
- Switchboard answer phone messages
- Press statements via the NNUH website

As the national picture and local COVID-19 levels were reduced, normal visiting was reinstated any SOPS, policies and guidelines were reviewed and updated.

Hygiene Code Compliance Criteria 5:
That there is a policy for ensuring that people who have or at risk of developing an infection are identified promptly and receive the appropriate treatment and care to reduce the risk of transmission of infection to other people.

Patient Alerts and Surveillance of Alert Organisms e.g. MRSA, *C. difficile*

The IP&C team use software to monitor patient alerts. This assists in the early detection of a patient re-admitted with an alert organism/infection or a cluster of the same alert organism in the same area allowing for timely intervention. The non-urgent alert organisms are monitored at a weekly surveillance meeting with the ICD and IP&C team.

Infection Prevention and Control Annual Report 2022-23

Screening is undertaken on all emergency and elective admissions for MRSA colinisation. This enables any patients found to be positive whilst in the Trust to have topical decolonisation and if required antimicrobial treatment, see Table 33.

Table 33

MRSA Screening for Emergency and Elective Patients - numbers of Patient Screened		
Financial Year	**Emergency Screened Patients**	**Elective Screened Patients**
2022-23	**89.2%**	**92.2%**
2021-22	96.1%	94.8%
2020-21	96.8%	90.1%

There are 3 electronic boards designed by the IP&C team which are available on the intranet for staff to see if there is Norovirus, Influenza or COVID-19 in any areas of the hospital and community healthcare settings that have suspected or confirmed Norovirus, Influenza or COVID-19 outbreaks.

A winter dashboard created by collaborative working between the IP&C team and digital health team, is accessible to Trust staff and provides a live overview of inpatients with Influenza, COVID-19, Norovirus & Respiratory Syncytial Virus (RSV).

There is also a screening process in place for patients that may be at risk of colonisation with CPE or are a previously known case, see Table 34. CPE risk assessment updated in May 2022, to reflect isolation requirements.

Table 34

Carbapenemase-Producing Enterobacteriaceae - numbers of Patient Screened				
Financial Year	**Admission in UK high risk hospital in last year**	**Hospital admission abroad in last year**	**Screened for other reasons (e.g., Holiday for Renal Dialysis patients)**	**Total**
2022-23	**431**	**73**	**1541**	**2045**
2021-22	459	36	541	1036
2020-21	162	28	119	309

Period of Increased Incidence (PII) and Supportive Measures

A PII is declared when 2 or more hospital acquired organisms of concern e.g. *C. difficile* toxin, MRSA or ESBL results are received from the same ward in 28 days. The IP&C team commence supportive measures, working closely with the ward team to support and educate staff via a programme of audits and training opportunities. This enables the staff to have a clearer understanding of all the different ways they can work together to prevent the spread of infection and promote the high standards that they expect in their area. The IP&C Link practitioners can

help to support and lead their teams by role modelling good IP&C practice, leading to the successful conclusion of the PII.

These audit results are monitored weekly by the IP&C team and additional interventions planned with the ward management team to provide an action plan.

Table 35

Number of new episodes of supportive measures due to a PII				
Financial Year	**MRSA**	***C. difficile***	**Influenza**	**ESBL**
2022-23	0	3	0	1
2021-22	1	4	0	1
2020-21	0	2	0	0

During this reporting year there were 3 PII's for *C. difficile* which triggered supportive measures, see table 35. These were on Heydon (2 patients), Earsham (2 patients) and Guist (2 patients) wards. NICU also triggered a PII with two babies presenting with ESBL *E. coli*.

The IP&C team supported the staff throughout this period, supportive measures were continued until there had been 28 days with no further cases and IP&C Tendable, Hand Hygiene, Environmental and isolation room audits were all in acceptable range. The team established strong engagement at all levels, as the clinical teams actively participated in the enhanced interventions, training, auditing, and improvement initiatives.

COVID-19

On the 12th of January 2020 the World Health Organization (WHO) announced that a novel coronavirus had been identified in samples obtained from Wuhan City, Hubei Province, China. This virus is now referred to as SARS-CoV-2 and the associated disease as COVID-19. WHO declared a pandemic on the 11th March 2020. Throughout this reportable year 2022-23, Government guidance and prevalence of disease dictated the need for COVID-19 specific areas along with the need for routine staff and patient testing.

In March 2022 the national NHS COVID-19 alert was reduced to level 3 and NNUH visiting restrictions were lessened. In June 2022, collaborative working with the digital health team and clinicians enabled Lateral Flow Tests (LFT) to be recorded onto ICE providing organisational and external oversight of results, increasing promotion of patient safety.

Throughout the year, the IP&C team continued to advise staff on the UKHSA guidance. Support was provided to the Trust IMT, advising on mitigations during times of extreme pressure.
The COVID-19 situation continues to be monitored, regular IP&C ICS meetings and regular information from colleagues at NHSEI and NHS England provide information upon regional and national prevalence and updates.

Graph 13 provides NNUH COVID-19 by attribution April 2022-March 2023.

Graph 13

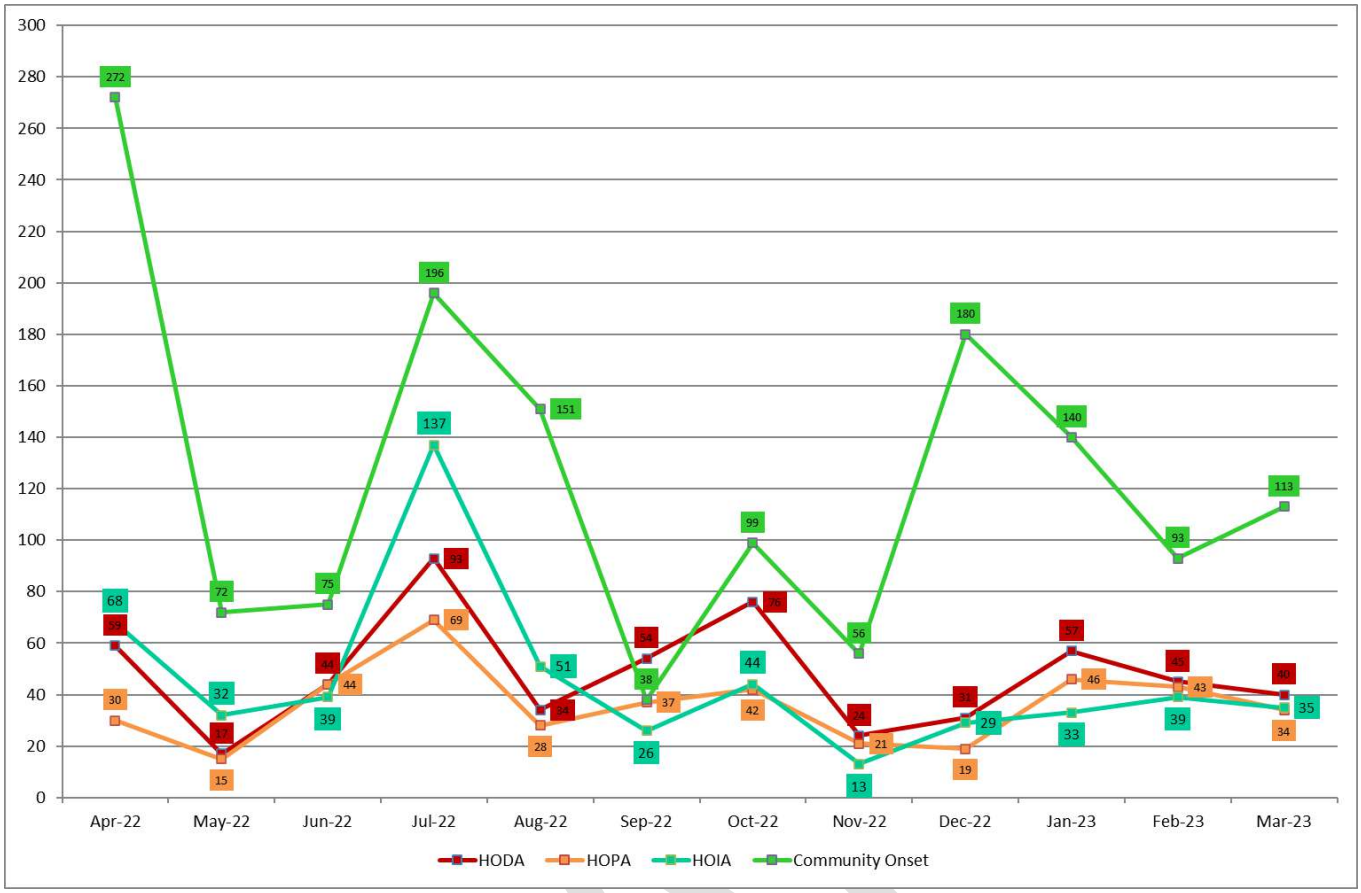


Image 18

Attribution Short Name	Attribution Full Name	Definition
HODA	Hospital-Onset Definite Healthcare-Associated	First positive SARS-CoV2 sample taken at day 15 or more after admission to hospital
HOPA	Hospital-Onset Probable Healthcare-Associated	First positive SARS-CoV2 sample taken between day 8 - 14 after admission to hospital
HOIA	Hospital-Onset Indeterminate Healthcare-Associated	First positive SARS-CoV2 sample taken between day 3 - 7 after admission to hospital
Community Onset	Community -Onset	First positive SARS-CoV2 sample taken between admission and day 2 after admission to hospital

During 2022-23 Omicron continued to be the dominant variant in NNUH. At the beginning of the fourth wave in July 2022 we had 511 new cases of COVID-19. 18.2% of these were Hospital Onset Definite Healthcare-Associated and 13.5% were Probable Healthcare-Associated.

Outbreaks and Serious Incidents

Table 36

Number of episodes of outbreak or serious incident

Financial Year	MRSA	*C. difficile*	Influenza Ward closure	Norovirus Ward closure	COVID-19 Outbreaks
2022-23	**0**	**0**	**1**	**4**	**111**
2021-22	0	0	0	8	46
2020-21	0	0	0	0	22

Infection Prevention and Control Annual Report 2022-23

Between April 2022 and March 2023, according to NHSE COVID-19 outbreak definition there were 111 COVID-19 outbreaks. These outbreaks continued to be reported centrally as a requirement from NHS England. Outbreaks involved between 2 and 37 patients. The duration of these lasted between 28 and 110 days. Within these outbreaks there were two ward closures with a total of 39 and 7 positive patients respectively. The closure of an outbreak continued to be signified by no test-confirmed cases with illness onset dates in the previous 28 days in the outbreak setting as per UKHSA guidance.

The IP&C team offered assistance to the affected areas during each outbreak by providing educational support and conducting audits. They also held regular meetings with ICB IP&C colleagues to discuss outbreak management to minimise nosocomial transmission.

Patient asymptomatic screening, previously undertaken upon day 0, 3 & 6 ceased in inpatient areas, with the exemption of Mulbarton ward who continued to screen as before.

Collaborative working with the digital team enabled Lateral Flow tests to be recorded onto ICE, providing visibility of results across the Trust. The results are required to be inputted manually by staff. IP&C provided support communicating the process face to face and via the IP&C department page, OWL and internal communications.

Staff testing requirements were reduced and routine asymptomatic testing ceased. Staff only required to test for COVID-19 if symptomatic.

PPE continued to be accessible through the procurement team, who designated a specific collection point for PPE. The H&S team has coordinated fit testing for staff members. Furthermore, regular audits are conducted to ensure compliance with PPE requirements in our wards via Tendable, thereby maintaining a safe and secure working environment.

Following national guidance in June 2022 the reduction of wearing surgical masks was initiated across the Trust. A local decision was made to continue wearing masks on Mulbarton due to the ward caring for patients who are often immunocompromised. However, the increased prevalence of cases in July 2022, necessitated the need to reinstate the use of surgical facemasks across the Trust at this time.

Image 19

Image 20

Indwelling device audit

The High Impact Intervention (HII) care bundles are designed to highlight critical elements of each procedure or care process and the key actions required, providing a way of demonstrating reliability through the audit process. The care bundles at the NNUH are available to access electronically on the IP&C department page. The IP&C team support auditors in each area with training and advice.

Table 37

High Impact Intervention Audit Scores			
High Impact Intervention care bundle audit	2020-21	2021-22	**2022-23**
Central venous catheter care	96%	95%	**93%**
Peripheral intravenous cannula	94%	93%	**90%**
Ventilated patients	98%	97%	**98%**
Urinary catheter	94%	93%	**90%**

Audit of Compliance with Isolation Guidelines and Single Room Use

An annual audit of compliance with the Isolation guidelines was undertaken in October 2022 to provide assurance that practice aligns with the guidance (Health and Social Care Act, 2008) and that clinical practice is in line with the Trust Isolation guideline.

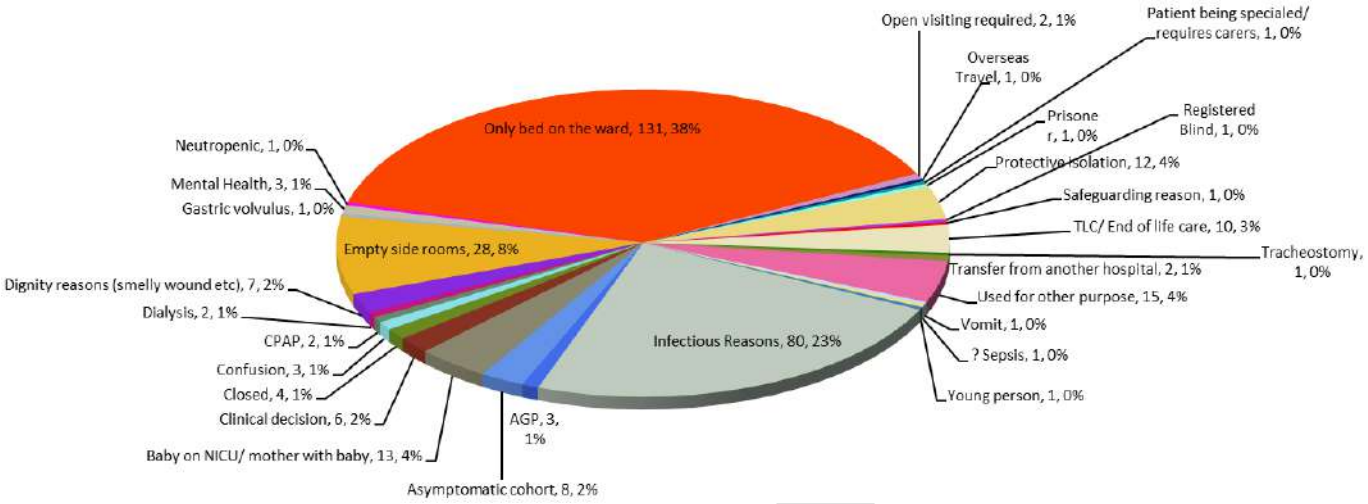
All patients with confirmed or suspected infection require isolation. At the time of audit 38% of patients were in a single room for IP&C reasons in comparison to 23% in 2021. 85.5% of patients requiring isolation for IP&C reasons were provided with a single room, however some patients are risk assessed as unsafe to isolate for a variety of reasons and in these situations the risks are mitigated with alternative measures. The electronic ward view system highlights those requiring isolation for IP&C reasons facilitating correct placement of these patients.

Overall compliance with the audit of single isolation rooms was 83% compared to 80% in 2021. The main issue was single room doors being open with lack of documentation to support this, compliance had reduced since last year from 67.3% to 38.1%. The results were shared Trust wide along with actions for continuing to facilitate improvement, see table 38 & chart 5.

Table 38

NNUH - Isolation and Single Room Use Audits	
Financial Year	**Overall Compliance %**
2022-23	**83%**
2021-22	80%
2020-21	81%

Chart 5 – Single room isolation audit reasons



Central Venous Catheter (CVC) Surveillance

A continuous surveillance programme monitors the CVC infection rates in adults. The overall infection rate remains below the Matching Michigan reference point of 1.4 per 1000 line days. Quarterly results are shared with Trust staff and in the IP&C monthly report, see Table 39.

Table 39

NNUH CVC related infections			
CVC infections are measured by rate per 1000 line days	2020-21	2021-22	**2022-23**
Renal	0.5	0.24	**0.37**
Haematology	2.53	2.55	**0.93**
Other areas	0.14	Data not complete	**Nil**
Overall	0.6	0.40 (other areas not included)	**0.41**

Surgical Site Surveillance (SSI) Committee

A SSI surveillance committee was initiated to help structure and promote the Surgical Site Infection Surveillance within the Trust, in line with recommendations Government guidance Protocol for the Surveillance of Surgical Site Infection commencing January 2023. The committee meet every quarter with the objective of aiding in the development and supervision of a well-structured surveillance program. Additionally, the committee strive to encourage the adoption of surveillance practices throughout the organisation, identify and address any training gaps, assist in the formulation and monitoring of action plans to improve practices whenever necessary based on surveillance findings, and review, analyse, and consider the implementation of new guidance and recommendations as they become available.

Orthopaedic Surgical Site Surveillance (*information contributed by Orthopaedic Senior Surgical Assistant)*

Hip, Knee and Fracture Neck of Femur: mandatory submission

The Trauma and Orthopaedic department undertake continuous Surgical Site Surveillance for Hip and Knee replacements and Fractured Neck of Femur procedures.

Mandatory UKHSA data are now submitted each quarter for one of the categories.

Surgical teams adapting to new upgraded theatres, with excellent outcomes.

COVID-19 effect on elective surgery, increased trauma commitment and increased number of high-risk patients, are key influence factors in this report.

The validated rates of infection (identified prior to discharge and on readmission) for Orthopaedic categories were: See Table 40.

Table 40

Orthopaedic Surgical Site Surveillance - Percentage of SSI detected post op (mandatory submission)

Calendar Year	Hip – UKHSA 0.5%	Knee – UKHSA 0.4%	Repair # Neck of Femur – UKHSA 0.9%
2022 SSI %	**0.19%**	**0.34%**	**0.43%**
2021 SSI %	0.48%	0.53%	0.71%
2020 SSI %	0.7%*	0.0%	0.47%

Spinal Surgery: Voluntary submission

UKHSA data submission for Spinal SSI was undertaken for April-June 2022. See table 41.

Table 41

Spinal Surgical Site Surveillance - Percentage of SSI detected post op (voluntary submission)

Calendar Year	Spinal SSI %	UKHSA SSI %
2022 SSI%	**0%**	**1.4%**
2021 SSI %	0.32%	1.3%
2020 SSI %	1.14%	1.5%

Other Surgical Site Surveillance

Vascular surgery surveillance

There has been continuous systematic SSI surveillance in vascular surgery since 2009. During 2022-23 the SSI rates have been between 5.9% and 3.9%. See table 42.

Table 42

Post vascular surgery surgical site infection rates

Year	April-June SSI %	July-Sept SSI %	Oct-Dec SSI %	Jan-March SSI %
2022-23	**5.9%**	**5.5%**	**3.9%**	**3.9%**
2021-22	6.7%	3.4%	4.0%	4.4%
2020-21	1.8%	7.5%	3.9%	8.1%

Caesarean section surgery

There has been continuous systematic SSI surveillance following C-section since 2010. Collaborative working between the obstetric department and IP&C provides an on-going cycle of feedback and review at clinical governance meetings.

During 2022-23 the SSI rates have been between 0.8% and 1.7%. See table 43.

Table 43

Post caesarean section surgical site infection rates

Year	April-June SSI %	July-Sept SSI %	Oct-Dec SSI %	Jan-March SSI %
2022-23	**0.8%**	**1.7%**	**1.2%**	**0.8%**
2021-22	2.5%	2.2%	2.0%	1.8%
2020-21	2.3%	3.1%	1.0%	1.5%

Audit Programme

Hand Hygiene and Dress Code Audits

The IP&C undertake a continuous programme of Hand Hygiene audits across the Trust.

These audits assess compliance with the Hand Hygiene policy and observe the opportunity for the WHO 5 moments of hand hygiene in clinical areas throughout the Trust. If scores are below 95% guidance is provided on actions required to improve. Audit scores are displayed on the IP&C electronic dashboard by ward/department, division, and overall Trust.

All IP&C mandatory training includes Hand Hygiene guidance. Staff are encouraged to strive for 100% compliance and act as role models, challenging and educating others in best practice. See table 44.

Table 44

Number of hand hygiene and related dress code audits and average percentage pass in NNUH

Financial Year	Number of Audits	Percentage Pass	
		Hand Hygiene	Dress code
2022-23	**1051**	**96%**	**99%**
2021-22	758	96%	99%
2020-21	736	97%	98%
Scores <95% lead to a re-audit within 1 week.			

The IP&C team has been conducting discussions regarding the implementation of reasonable adjustments in hand hygiene practices for situations where the exposure of forearms may not be deemed acceptable based on religious beliefs.

Hygiene Code Compliance Criteria 6:
Systems are in place to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.

All staff including volunteers joining the Trust are required to attend an IP&C induction session and thereafter mandatory IP&C training. Compliance with IP&C training is monitored by the training department.

In addition, there are other opportunities for raising staff awareness such as link practitioner meetings, ad-hoc education, teaching, planned study and awareness days.

Image 21

The Trust official visitors and contractors' procedure document, along with all policies and guidelines, are available to staff via the intranet. There are also IP&C specific documents available on the intranet, IP&C department page or as a shortcut on the desktop screen of each PC monitor that can be accessed by clicking on the NNUH IP&C symbol (image 21). IP&C have worked together with SERCO, providing information to complement existing IP&C training provided.

Hygiene Code Compliance Criteria 7:
The provision or ability to secure adequate isolation facilities. The provision or ability to secure adequate isolation facilities.

The IP&C team undertake an annual isolation room audit to assess why patients are in the single rooms across the Trust, how many patients who require isolation facilities are in single rooms and how those in isolation are managed. See Table 38 (page 52) and Chart 5 (page 53).

Most of the single room accommodation on each ward is en-suite and can be used for isolation of infectious and suspected infectious patients. In addition, the respiratory ward has two single en-suite rooms that have negative pressure ventilation for severe respiratory disease e.g. multi-drug resistant Tuberculosis. Areas such as Paediatrics where there is a recognised lack of side rooms for isolation have added this as a risk to the Trust risk register. The Hoveton unit, has 9

isolation rooms with the capacity to be used as negative pressure. This was opened on 31/03/21.

An electronic system called Ward view is in operation for ward staff and the operations centre staff to track patient placement and identify why patients are in a single room. This system allows easily accessible reports to determine how many single rooms are in use for isolation reasons, clinical reasons, end of life care and no reason recorded. This system allows rapid assessment of the allocation of isolation facilities and fewer referrals to IP&C out of hours for advice with risk assessment of isolation.

Hygiene Code Compliance Criteria 8:
The ability to Secure adequate access to laboratory support as appropriate.

Laboratory, information contributed by Chief Biomedical Scientist

The laboratory services for NNUH are provided by the Eastern Pathology Alliance (EPA). EPA is a county-wide pathology network service providing Clinical Biochemistry, Immunology, Toxicology, Haematology, Blood Transfusion, Andrology and Microbiology services to primary and secondary care providers across Norfolk and Waveney. The network operates a hub and spoke model with blood science laboratories at the 3 acute hospitals in Norfolk.

Microbiology is centralised at the Norwich Research Park Innovation Centre (NRPIC) close to the main NNUH site and provides services to all three acute Trusts in Norfolk including NNUH and to all GPs within Norfolk and Waveney. It is divided into Bacteriology, TB, Mycology, Virology, Serology and Molecular Sections.

Microbiology provides a 7-day service which includes MRSA, *C. difficile*, CPE, ESBL, Influenza and Norovirus etc. as follows:

Laboratory Operational Hours

Monday – Friday	08:00 – 21:00hrs
Saturday, Sunday & Bank Holidays	08:00 – 16:00hrs

Out of operational hours is covered by an on-call agreement for both technicians and Microbiology Consultants.

Following recent audits, the laboratory is compliant with the 4-hour bleed to load time target for blood cultures.

There are service improvement plans in place as well as verifications of new tests and repatriated tests in order to provide a higher quality service to the users.

The department continues to evaluate and act on as appropriate, new clinical guidance to remain as up to date as possible with recommendations and developments.

There has been a large increase in work over the last year for example there are more than 5000 more urines per year.

Several members of the IP&C staff have recently visited the laboratory for informative tours. This experience has fostered a sense of unity as well as helping open ability communication lines to work more effectively together. These visits will continue as part of the induction program for new IP&C nurses.

Hygiene Code Compliance Criteria 9:
Have and adhere to policies, designed for the individual's care, and provider organisations that will help to prevent and control infections.

IP&C Policies

NNUH has a robust process for keeping guidelines and policies up to date. The IP&C team share new and reviewed documents via the weekly communications bulletins. They widely consult when developing new documents and they are signed off by the HICC.

All IP&C and associated policies and guidelines are easily accessible to staff via several electronic routes.

Hygiene Code Compliance Criteria 10:
Providers have a system or process in place to manage staff health and wellbeing, and organisational obligation to manage infection, prevention and control

Workplace Health and Wellbeing (WHWB) Report provided by Head of WHWB

All staff have access via self-referral route to gain appropriate occupational health advice. Ordinarily this is available Monday - Friday 08:30– 17:00hrs. Out of hours infection related advice continues to be available via the 24/7 website on our intranet.

COVID-19 Isolation advice and guidance

From the start of the COVID-19 pandemic, the WHWB team have kept up to date with the ever-changing advice from the government regarding isolation. This started in the early days advising when staff were returning from trips abroad but responded to develop a full in-house test and trace service for staff. It was vital that our staff had timely advice regarding any contacts they had in the workplace from colleagues and patient contact. As government restrictions lifted and national changes surrounding healthcare worker contacts, the team developed robust guidance documents in the form of an Isolation exemption policy, risk assessment template and quick reference guide so staff and managers can implement without the need for occupational health guidance. The team have been available to assist if guidance has been required.

COVID-19 Individual Risk assessment

Our electronic COVID-19 individual risk assessment tool has continued to be used for all new starters and those workers who have changing health situations so that they can be individually assessed surrounding their personal risk factors to COVID-19. This tool has been updated to reflect the evidence and guidance provided by the government and was designed to protect our NHS staff and prevent them becoming our ventilated patients whilst also appreciating the need for the NHS services having sufficient staff to deliver care in a global pandemic situation. This tool became a very efficient, effective and consistent evidenced based assessment for all staff. This COVID-19 risk assessment tool is now being used by many NHS Trusts around the country. https://rainbird.ai/case-study/assessing-covid-19-risk-for-thousands/

WHWB have maintained their full suite of in-house procedures and Trust guidelines in relation to prevention and management of communicable infections. Easily accessible advice for staff is found via the 24/7 pages. Policies created by the infection control team are reviewed by WHWB to consider the staff implications.

Immunisation Services

Immunisations for staff are available and provided in line with Green Book. The Green Book The green book has the latest information on vaccines and vaccination procedures for all the vaccine preventable infectious diseases that may occur in the UK.

All staff who have patient contact (clinical & non-clinical) are required to have an immunisation review. This commences with their pre-placement health questionnaire. If immunisations for their specific role are not complete, then they are required to attend WHWB for an immunisation assessment. Their immunisations are recorded on their individual record on the dedicated occupational health system. At the time of the assessment the relevant immunisations are offered whilst advising the worker the importance of complying with UKHSA guidance. The WHWB team keep up to date with new guidance and review both Trust guidelines and WHWB procedures accordingly. If any new guidance requires to review the immunisation status of existing staff, then this is undertaken.

Due to the pandemic, there remains a significant backlog of staff who are outstanding in various immunisation requirements. Whilst the WHWB are attempting to resolve this, without significant additional resource being allocated to the team, this will remain for several years.

COVID-19 Autumn Boosters/Influenza Vaccinations

The launch of the COVID-19 autumn booster and annual influenza vaccination commenced in September. This year due to the co-administration of the COVID-19 booster and Influenza vaccination, a clinical facility was provided to deliver this activity. Therefore, the departmental peer vaccinator model was not utilised and all staff had the opportunity to receive their influenza & COVID-19 booster via the vaccine hub. A separate programme was made available to those staff based at Cromer to prevent travelling to Norwich and the vaccination team made visits to off-site locations as well as using the flu trolley on the main site to increase participation.

Figures at close of January 2023:

Table 45 – NNUH Staff Compliance with COVID-19 and Influenza Vaccine				
All staff number 9693	**COVID-19 Booster**	**COVID-19%**	**Influenza**	**Flu %**
All staff (without bank)	6047	62%	6039	64%
All staff (with bank)	6617	64%	6629	66%
All Staff (with Bank & Contractors)	7047	65%	7124	68%

Contact Tracing undertaken 2022-23

Below is a summary of the various contact tracing activities that WHWB have undertaken in the last year.

Multidrug-Resistant Tuberculosis (MDR TB)

WHWB were alerted to a MDR TB case in the organisation, however on reviewing the information and PPE measures in place, no contact tracing of staff was required.

Invasive group A Streptococcus (IGAS)

Three separate contact tracings were conducted for Acute Medical Unit (AMU) in July, August, and September 2022. From July to September, contact tracing was performed for Gissing Ward

and Mattishall Ward. In November and December, contact tracing was carried out for ED, AMU, and Loddon Ward. Additionally, from January to March, contact tracing was conducted for 13 areas during the reporting period for IGAS infection. These areas included ED, AMU, Emergency Assessment Unit for Surgery (EAUS), Theatres, Intensive Care Unit (ITU), Buxton Ward, Colitishall Ward, Kimberly Ward, Gately Ward, and Loddon Ward.

Monkey Pox

In August 2022, WHWB were alerted to a case who had been an inpatient and had transited through ED, EAUS and Rheumatology day unit.

WHWB liaised closely with the Consultant Virologist and based on information and evidence, contact tracing was implemented for those areas as it was determined on initial investigation that staff had not worn appropriate PPE.

Appropriate PPE is a fit tested FFP3 respirator, eye protection, long sleeved, fluid repellent disposable gown, and gloves per the National IP&C manual for England.

No staff were required to isolate as a result of contact with the patient, however three staff were advised to isolate due to the level of contact with each other, as one staff member developed a rash within the time frame/level of contact and monkey pox had to be excluded. Monkey pox infection was subsequently ruled out.

In October 2022, the individual had been assessed in ED and then discharged home. Unfortunately the nurse taking the swab had forgotten a piece of equipment and had removed the FFP3 mask whilst going to collect it. She had then forgotten to put this back on when she went in the room and took the swab with a surgical mask only. As a result this staff member became a category 3 contact. However, the patient swab result was subsequently negative and so no action needed. All other staff in the room had appropriate PPE and so no action was requried.

In November 2022, this case was suspected in the community but had been admitted via ED just prior. Meeting held between ED, Virology, IP&C and WHWB. Advised no swab obtained in the community and due to timeline UKHSA had closed case. As an additional protective measure WHWB contact traced 7 staff members resulting in Category 1, 2 or no expsoure outcomes. As a result no action was taken.

Varicella Zoster Virus (VZV)

WHWB were alerted by IP&C to a positive VZV patient on Childrens Assessment Unit/Buxton, contact tracing implemented no action required by WHWB as all staff contacts Immune to VZV.

Notification of positive Varicella lesion identified on patient in Coltishall Ward. No staff contact action requried.

WHWB were notified of positive Varicella patient on Hethel Ward. Contact trace information sent to Ward manager. No response received therefore the incident was closed due to date of index case.

Notification of positive Varicella patient on AMUI. Contact trace information sent to Ward manager. No response from ward manager so closed due to time frame/time elapsed.

Panton-Valentine Leukocidin (PVL) Staphylococcus aureus (MSSA)

WHWB were alerted by IP&C of a patient who tested positive on blood cultures. Patient was nursed in isolation and appropriate PPE was worn by staff, so no contact tracing/follow up was required.

Meningitis (all between October – December 2022)

Notification from doctor in ED of suspected Meningitis case prior to bank holiday weekend. Advised of defintion of close contact. Did not meet definition of close contact as wearing PPE.

It was confirmed after the bank holiday weekend that all staff had been wearing PPE so no prophylaxis requried.

Notification from IP&C regarding postive Meningitis case. Patient was isolated and nursed with appropriate PPE so no staff contact trace action required

Summary of contact tracing

The wearing of PPE by staff has reduced the level of contact tracing requried by WHWB during this year. The impact of the relaxation of mask wearing will be assessed as we progress into the next year.

Blood Borne Virus

In line with UKHSA guidance all staff can access a test for Hepatitis B/C or HIV if requested. Those staff who are 'Exposure Prone Procedure' workers will have the appropriate tests prior to undertaking this activity in line with the 'Integrated guidance on health clearance of healthcare workers and the management of healthcare workers infected with bloodborne viruses (Hepatitis B, Hepatitis C & HIV)'. Any staff member found to be positive will have a consultation with the Consultant Occupational Health Physician who will advise on fitness for work and further monitoring and refer to Hepatologist or Sexual health services if required for further monitoring and treatment. For those 'Exposure Prone Procedure' workers who have a blood borne virus, strict monitoring is undertaken by the occupational health department and monitoring recorded via UKAP – Occupational Health Register. Currently we have 3 individuals who are being monitored in this way.

Blood exposure incidents

All staff are required to contact WHWB in the event of an accidental occupational exposure to blood and body fluids. A risk assessment is undertaken by our duty nurse and appropriate follow screening and treatment is undertaken.

Staff members who require emergency treatment following an accidental occupational exposure to blood/body fluids will be assessed by the Consultant occupational health physician. If the incident occurs out of hours then this is undertaken by the ED department and then advised to contact WHWB for further support and follow up the next working day.

144 needlestick incidents were reported in this last year and occurred at the following stages of the activity:

- During procedure (70)
- During disposal (52)
- Incorrect disposal (22)

Key themes resulting in injury were:

- Lapse of concentration (57)
- Safety device not being implemented correctly/Not adhering to safety of sharp (42)
- Unexpected movement of patient (16)
- Incorrect disposal by colleague (12)

30 Blood exposure incidents (splash were also reported of which 21 could have been avoided if correct PPE was worn).

References and further reading

Department of Health (2007) Saving Lives: reducing infection, delivering clean and safe care, available at: http://webarchive.nationalarchives.gov.uk/+/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_078134 Last accessed 24/07/23

Department of Health and Social Care (2022), The Health and Social Care Act 2008. Available at: https://www.gov.uk/government/publications/the-health-and-social-care-act-2008-code-of-practice-on-the-prevention-and-control-of-infections-and-related-guidance/health-and-social-care-act-2008-code-of-practice-on-the-prevention-and-control-of-infections-and-related-guidance Last accessed 01/09/23.

Department of Health and Social Care (2022) Code of Practice on the prevention and control of infections and related guidance, available at: https://www.gov.uk/government/publications/the-health-and-social-care-act-2008-code-of-practice-on-the-prevention-and-control-of-infections-and-related-guidance/health-and-social-care-act-2008-code-of-practice-on-the-prevention-and-control-of-infections-and-related-guidance Last accessed 24/07/23

Department of Health (2021) Health Technical Memorandum 01-01 Decontamination of surgical instruments. Available from: https://www.england.nhs.uk/publication/decontamination-of-surgical-instruments-htm-01-01/ Last accessed 01/09/23.

Department of Health (2021) Health Technical Memorandum 01-06 Management and decontamination of flexible endoscopes. Available from: https://www.england.nhs.uk/publication/management-and-decontamination-of-flexible-endoscopes-htm-01-06/ Last accessed 01/09/23.

Department of Health (2016) Health Technical Memorandum 04-01 Safe Water in Healthcare Premises: Parts A, B, C & Supplement. Available at: https://www.england.nhs.uk/publication/safe-water-in-healthcare-premises-htm-04-01/ Last accessed 01/09/23.

Department of Health (2014) - Health Technical Memorandum 00 Policies and principles of healthcare engineering. Available at: https://www.england.nhs.uk/wp-content/uploads/2021/05/HTM_00.pdf Last accessed 01/09/23.

Department of Health (2016) Health Technical Memorandum 01-04 Decontamination of linen for health and social care. Available from: https://www.england.nhs.uk/wp-content/uploads/2021/05/BS_EN14065.pdf Last accessed 01/09/23.

GOV.UK (2020) Collection Staphylococcus aureus: guidance data and analysis. available at: https://www.gov.uk/government/collections/staphylococcus-aureus-guidance-data-and-analysis Last accessed 24/07/23

Health and Safety Executive (2013) Health and Safety Guidance 274 Parts 1-3. Available from: https://legionellacontrol.com/wp-content/uploads/2018/08/hsg274-part-1-control-of-legionella-in-evaporative-cooling-systems.pdf Last accessed 01/09/23.

Health and Safety Executive (2013) Legionnaires' disease - The Control of Legionella bacteria in water systems Approved Code of Practice and guidance on regulations L8 (Fourth Edition). Available from: https://www.hse.gov.uk/pubns/priced/l8.pdf Last accessed 01/09/23.

Infection Prevention Society (2019) One Together Infection Assessment Toolkit. available at: https://www.ips.uk.net/professional-practice/onetogether-infection-control-assessment-toolkit/ Last accessed 24/07/23

NHS England (2023) Health Technical Memorandum 07-01 Management and disposal of healthcare waste
Available from: https://www.england.nhs.uk/publication/management-and-disposal-of-healthcare-waste-htm-07-01/ Last accessed 04/09/23.

NHS England (2023) Minimising Clostridiodes difficile and Gram-negative Bloodstream infections, available at:
https://www.england.nhs.uk/publication/minimising-clostridioides-difficile-and-gram-negative-bloodstream-infections/ Last accessed 24/07/23.

NHS England (2023), National infection prevention and control manual for England. available at:
https://www.england.nhs.uk/publication/national-infection-prevention-and-control/
Last accessed 24/07/23.

NHS England (2021) NHS National Standards of Healthcare Cleanliness, available at:
https://www.england.nhs.uk/publication/national-standards-of-healthcare-cleanliness-2021/ Last accessed 24/07/23.

NHS England, Preventing Healthcare associated Gram-negative bloodstream infections (GNBSI), ND available at:
https://www.england.nhs.uk/patient-safety/preventing-gram-negative-bloodstream-infections/ Last accessed 07/08/23.

Public Health England (2017) Guidance for the laboratory investigation, management and infection prevention and control for cases of *Candida auris.* available at:
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/637685/Updated_Candida_auris_Guidance_v2.pdf Last accessed 24/07/23

RCN (2021) The role of the link nurse in infection prevention and control (IPC): developing a link nurse framework.
https://www.rcn.org.uk/professional-development/publications/rcn-role-of-the-link-nurse-in-infection-prevention-and-control-uk-pub-009595 Last accessed 24/07/23

UKHSA (2022) Actions to contain carbapenemase-producing Enterobacterales. Available at
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1107705/Framework_of_actions_to_contain_CPE.pdf Last accessed 04/09/23

UKHSA (2013) Protocol for the surveillance of surgical site infection, available at:
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1048707/Protocol_for_the_Surveillance_of_Surgical_Site_Infection.pdf Last accessed 29/08/23.

UKHSA (2023) Technical risk assessment as of 30 January 2023 for avian influenza (human health): influenza AH5N1 2.3.4.4B. Available at: https://www.gov.uk/government/publications/avian-influenza-influenza-a-h5n1-risk-to-human-health/technical-risk-assessment-as-of-30-january-2023-for-avian-influenza-human-health-influenza-a-h5n1-2344b Last accessed 29/08/23.

Infection Prevention & Control

Annual Programme

April 2023 – March 2024

Written & compiled by:

Infection Prevention & Control Team

April 2023

NHS
Norfolk and Norwich University Hospitals
NHS Foundation Trust

Infection Prevention and Control Annual Programme 2023-24

Drivers	Actions	Evidence or Anticipated Outcome	Lead	By when/ Frequency	RAG Comments
DH - The Health and Social Care Act 2008 Code of Practice on the prevention and control of infections and related guidance, July 2015	Review and update NNUH compliance with the Code of Practice on the prevention and control of infections and related guidance, July 2015	• To monitor elements via HICC quarterly • Board minutes • HICC minutes	IP&C team/DND's and Governance leads	Quarterly	
Contract with ICB	Required to send the board approved IP&C plan and annual report to Integrated Care Board (ICB) IP&C team. Electronic version of both documents to be sent to ICB once ratified by board	• Board minutes • HICC minutes • Acknowledgement of receipt from ICB	DIPC	Annually	
Contract with ICB	IP&C monthly report - to include: Antibiotic policy Trust audit results or similar antibiotic review process HII Audit programme compliance results and Hand Hygiene/Dress Code audit results dashboard	• Email evidence of sending report to ICB	DIPC	Monthly	
Contract with ICB	The provider will be required to send any copies of all external IP&C focus visits/inspections that are not publicly available to ICB IP&C team.	• Email evidence of sending to ICB • HICC minutes	DIPC	Within 5 working days from receipt of final report	
Code of Practice – Criterion 1 1.5 Activities to demonstrate that infection prevention and cleanliness are an integral part of quality assurance	Report Key IP&C performance indicators to the board via the Integrated Performance Report [IPR]. IS prepares report with input from IP&C	• Board minutes	Exec for IP&C/DIPC	Monthly	

Infection Prevention and Control Annual Programme 2023-24

***C. difficile* specific Drivers**	**Actions**	**Evidence or Anticipated Outcome**	**Lead**	**By when/ Frequency**	**RAG Comments**
NHS England and NHS Improvement ***C. difficile* objective** New attribution of cases according to 2019-20 guidelines (HOHA and COHA attributable to the Trust).	*C. difficile* case threshold *77* cases Continue work proven to result in low rates of *C. difficile* infection (CDI) as described in *C. difficile* policy and annual report.	**No more than 19 HAI *C. difficile* cases per quarter** **Q1 =** **Q2 =** **Q3 =** **Q4 =** • Published by UKHSA (government national statistics) • HICC minutes • Monthly IPR board minutes • Monthly IP&C report • IP&C dashboard for Trust staff • Learning disseminated by OWL	IP&C Team	Throughout	
Contract with ICB Complete a PIR for all cases of HOHA and COHA *Clostridioides difficile*	Joint PIR undertaken monthly with ICB and NNUH staff for each CDI diagnosed by toxin EIA identified on or after day 3 of admission or toxin positive cases who have been an inpatient within the last 4 weeks. ICB to agree those that are non-trajectory (no lapses in care).	***C. difficile* trajectory cases per quarter** **Q1 =** **Q2 =** **Q3 =** **Q4 =** • HICC minutes • Monthly IPR board minutes • Monthly IP&C report • Email to ICB showing summary of PIR meeting showing outcome	Admin co-ordinator	Monthly	
	Lessons learnt and any action plans will be monitored by relevant divisional governance groups with updates on progress to HICC quarterly by division	• HICC minutes • Divisional Governance minutes	Matrons and divisional governance leads	Quarterly	

Infection Prevention and Control Annual Programme 2023-24

MRSA specific Drivers	Actions	Evidence or Anticipated Outcome	Lead	By when/ Frequency	RAG Comments
NHS England and NHS Improvement MRSA objective	No avoidable MRSA bacteraemia Maintain a 'zero tolerance' approach to hospital attributable MRSA bacteraemia Continue work proven to result in low rates of MRSA bacteraemia described in MRSA guidelines and annual report.	**NNUH attributable MRSA bacteraemia cases per quarter** **Q1 = Q2 = Q3 = Q4 =** • Published by UKHSA (government national statistics) • Quarterly HICC meeting minutes • Monthly IPR board minutes • Monthly IP&C report • IP&C dashboard for Trust staff • Divisional Governance minutes	IP&C Team If a case occurs actions and any learning shared by Divisional Triumvirates	Throughout	
Contract with ICB Assist in the supply of information for MRSA bacteraemia Post-infection Review (PIR) process where the patient has had healthcare contact with the Provider	ICB informed of an MRSA bacteraemia within 3 working days from reported result PIR undertaken for any cases identified on or after day 3 of admission. Assist in completing PIR with ICB for cases identified on pre day 3 of admission or had recent hospital contact.	• Email of draft copy of completed PIR form sent to ICB • MRSA bacteraemia meeting minutes.	DIPC/Lead IP&C Nurse IP&C nurses	Within 3 working days from a positive result	
Contract with ICB Implement the agreed Post Infection Review (PIR) action plan	Lessons learnt and any action plans will be monitored by relevant divisional governance groups with updates on progress to HICC quarterly by division	• Quarterly HICC meeting minutes • Monthly IPR board minutes • Monthly IP&C report • IP&C dashboard for Trust staff • Divisional Governance minutes	Matrons and divisional governance leads	As a case occurs	

Infection Prevention and Control Annual Programme 2023-24

MSSA specific Drivers	Actions	Evidence or Anticipated Outcome	Lead	By when/ Frequency	RAG Comments
NHS England and NHS Improvement	Minimise the number of cases of MSSA bacteraemia identified on or after day 3 of admission.	**MSSA HAI bacteraemia cases per quarter** **Q1 = Q2 = Q3 = Q4 =** • Published by UKHSA [government national statistics] • Quarterly HICC meeting minutes • Monthly IPR to board • Monthly IP&C report • IP&C dashboard for Trust staff	IP&C Team If a case occurs actions and any learning shared with Divisions	Monthly	
	PIR currently undertaken by IP&C team for any MSSA bacteraemia cases identified on or after day 3 of admission. Determine whether there were any associated lapses in care.	• Quarterly HICC meeting minutes • IP&C dashboard for Trust staff • Divisional Governance reports	IP&C Team		

Infection Prevention and Control Annual Programme 2023-24

Other alert organism Drivers	Actions	Evidence or Anticipated Outcome	Lead	By when/ Frequency	RAG Comments
UKHSA reporting • *E. coli* bacteraemias • *Klebsiella* spp. bacteraemias • *Pseudomonas* aeruginosa bacteraemia's	*E. coli* case threshold 91 cases *Klebsiella* spp. case threshold 24 cases *Pseudomonas* case threshold 19 cases Minimise the number of cases of Gram-negative bacteraemia cases identified on or after day 3 of admission	**Less than 23 HAI *E. coli* bacteraemia cases per quarter** **Q1 =** **Q2 =** **Q3 =** **Q4 =**	IP&C Team	Monthly	
	Any significant themes will be identified, and improvement measures will be planned with clinical teams.	**No more than 6 HAI *Klebsiella spp*. bacteriemia cases per quarter** **Q1 =** **Q2 =** **Q3 =** **Q4 =**	IP&C Team	Monthly	
	Lessons learnt and any action plans will be monitored by relevant divisional governance groups with updates on progress to HICC quarterly by division	**Less than 5 HAI *Pseudomonas aeruginosa* bacteraemia cases per quarter** **Q1 =** **Q2 =** **Q3 =** **Q4 =**	IP&C Team	Monthly	
	Plan to promote appropriate UTI diagnosis, along with correct antimicrobial prescribing and reminder of guidance for urine sampling: ICD to work with ICS AMS group. Participation in 2022-23 CQUIN on diagnosis and management of UTI in patients >16 years led by AMS pharmacist IP&C team to work with Reduction of Gram-negative ICS group.	• Rates published by UKHSA (government national statistics) • HICC meeting minutes • Monthly IPR to board • Monthly IP&C report • IP&C dashboard	IP&C Team	Ongoing	

Infection Prevention and Control Annual Programme 2023-24

Surveillance Drivers	Actions	Evidence/Feedback	Lead	By when/ Frequency	RAG Comments
Code of Practice Criterion 1 Systems to manage and monitor the prevention and control of infection.	Vascular surgical site infection voluntary surveillance scheme using UKHSA protocol	• HICC meeting minutes • Divisional Governance minutes	IP&C	Ongoing	
	C section surgical site infection voluntary surveillance scheme	• HICC meeting minutes • Divisional Governance minutes	IP&C	Ongoing	
Mandatory to report 1 quarter a year	Continuous surveillance of hip and knee replacement and spinal surgical site infection through participation in the UKHSA national mandatory surveillance scheme	• Rates published by UKHSA • HICC meeting minutes • Divisional Governance minutes	Orthopaedic SSIS lead	Ongoing	
	Advice and support the Dermatology division with Dermatology Surgical Site Surveillance at Cromer and NNUH	• HICC meeting minutes • Divisional Governance minutes	Surgery	Ongoing	
MRSA Bacteraemia reduction	Continuous surveillance of Central line related blood stream and exit site infections in adults outside the Critical Care Complex	• HICC meeting minutes • Divisional Governance minutes	IP&C	Ongoing	

Infection Prevention and Control Annual Programme 2023-24

Surveillance Drivers	Surveillance/Actions	Evidence/Feedback	Lead	By when/ Frequency	RAG Comments
Code of Practice – Criterion 9 m. Reporting of infection to UKHSA or local authority and mandatory reporting of healthcare associated infection to UKHSA **NHS England and NHS Improvement -** *E. coli* Objectives **UKHSA** of *Klebsiella spp*. and *Pseudomonas* bacteraemia's	Enhanced surveillance and continuous data collection and data entry via United Kingdom Health Security Agency (UKHSA) HCAI data capture system (DCS) - of *C. difficile,* MRSA, MSSA, *E. coli*, *Klebsiella spp* and *Pseudomonas* bacteraemia	• CEO signs off data monthly • Rates published by UKHSA (government national statistics)	IP&CT, ICD and Microbiology	Monthly Throughout	
	Continuous mandatory surveillance by lab: VRE	• CEO signs off data monthly • Rates published by UKHSA (government national statistics]	Microbiology	Monthly Throughout	
	Surveillance of confirmed Gram-negative bacteraemia cases undertaken	• CEO signs off data monthly • Rates published by UKHSA (government national statistics)	IP&CT & ICD	Monthly Throughout	

Infection Prevention and Control Annual Programme 2023-24

Audit Drivers	Audit/Actions	Evidence/Feedback	Lead audit & actions	By when/ Frequency	RAG Comments
Code of Practice Criterion 1 Systems to manage and monitor the prevention and control of infection. Matrons Charter	FM First audits in line with National Cleaning Standards Trust staff undertake audits in conjunction with SerCo and Trust Facilities	• HICC minutes • Monthly IPR board minutes • Nursing Dashboard • Divisional Governance minutes	Matrons	Monthly	
	Tendable IP&C Audits	• HICC minutes • Monthly IPR board minutes • Nursing Dashboard • Divisional Governance minutes	Matrons, ward sisters/ charge nurses, IP&C Team	As per the SOP or more frequently if required	
DH Saving Lives Delivering clean safe care	High Impact Intervention care bundle audits, CVC. Peripheral cannula, urinary catheter, renal catheter, and prevention of ventilator associated pneumonia	• HICC minutes • IP&C dashboard for Trust staff • Nursing Dashboard • Divisional Governance minutes	Matrons	Monthly	

Infection Prevention and Control Annual Programme 2023-24

Audit Drivers	Audit/Actions	Evidence/Feedback	Lead audit & actions	By when/ Frequency	RAG Comments
Contract with ICB 90% of eligible cases are screened for MRSA according to provider's guideline **Code of Practice – Criterion 1** 1.5 Activities to demonstrate that infection prevention quality assurance should include: an audit programme to ensure that policies have been implemented	Elective and emergency admission screening compliance audits - MRSA guidelines Electronic audit provided by IS, Trust requires compliance to be >95%	• HICC minutes • Monthly IPR board minutes • Monthly IP&C report • Nursing Dashboard • Divisional Governance minutes	Electronic audit Actions undertaken by Matrons	Monthly report emailed out from Information services	
	Inpatient isolation audit - Isolation guidelines Undertaken across the whole Trust on a single day	• HICC minutes • Email to divisional Triumvirates, matrons and ward managers • Divisional Governance minutes	IP&C undertake audits Actions signed off by divisional Triumvirates or Governance leads	Annually	
	Hand Hygiene audit - Hand Hygiene policy	• Divisional HICC reports • IP&C dashboard for Trust staff • Nursing Dashboard • HICC meeting minutes • Divisional Governance minutes		Ward areas audited 2 monthly Outpatient areas audited 3 monthly	
	Commode & bed pans audit - C. *difficile,* Assessment and Management of diarrhoea and cleaning guidelines	• Divisional HICC reports • IP&C dashboard for Trust staff • Nursing Dashboard • Divisional Governance minutes		Monthly	
Code of Practice – Criterion 1 CQC report recommendations	Cohort audits where patients with the same infectious organism are nursed in a multiple bed bay When cohorting is being undertaken	• Divisional Governance minutes	Matrons/ ward staff undertake audits Actions signed off by divisional Triumvirates	As required	
	Side room used for isolation to have doors shut or completed risk assessment	• Annual isolation audit report and divisional feed back • Immediate feedback to Individual wards at time of audit where they are not compliant	IP&C Team	As required	

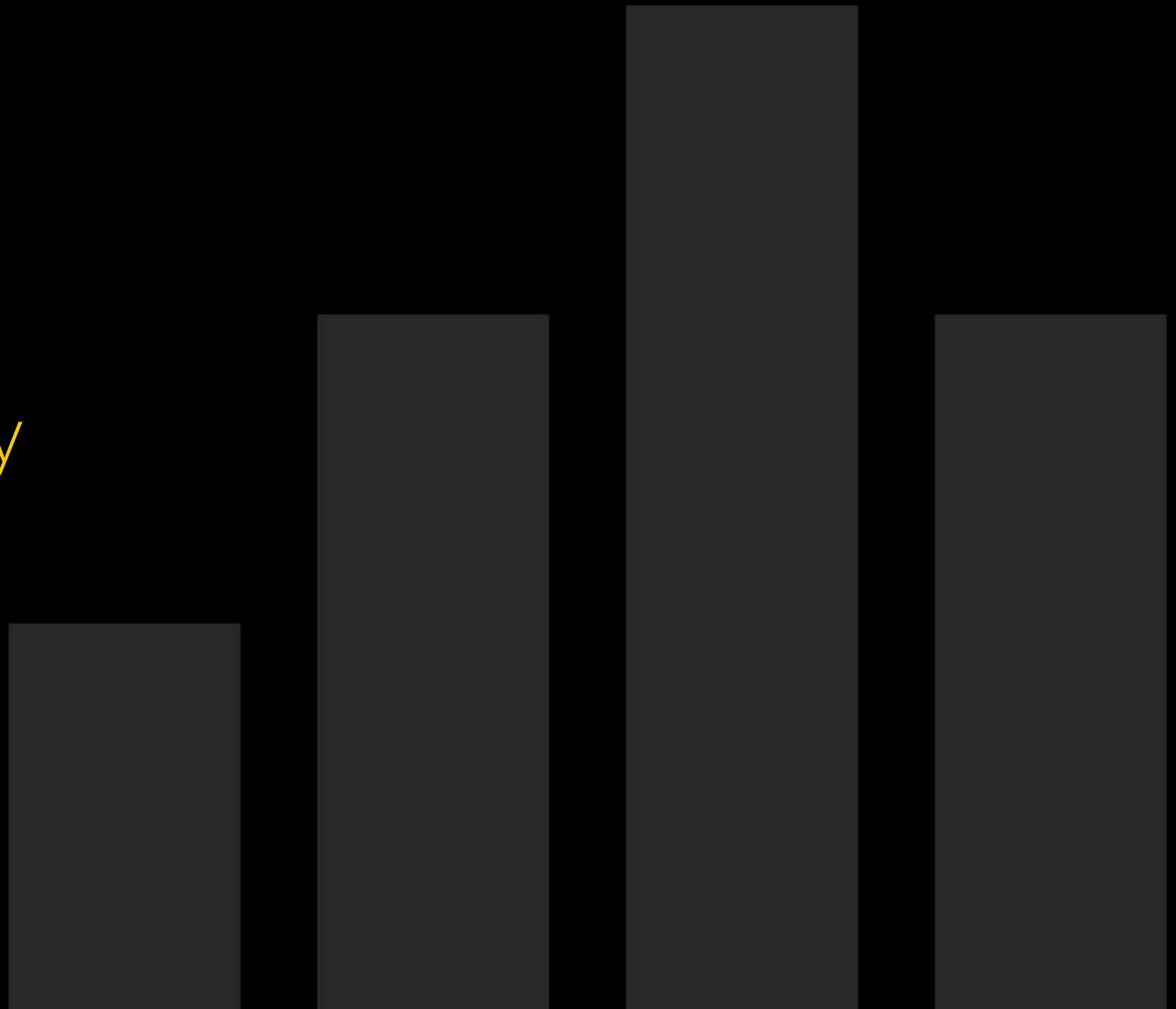
Microsoft | Power BI

Quality & Safety

View in Power BI

Last data refresh:
16/10/2023 15:41:38 UTC

Downloaded at:
16/10/2023 16:13:41 UTC



Quality Summary

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

NNUH Digital Health
business intelligence

Topic	Metric Name	Date	Result	Variation	Assurance
Safer Staffing	Safe Staffing Care Hours Per Patient Per Day	Sep 2023	7.2	Improvement (High)	No Target
Safer Staffing	Safe Staffing Fill Rates	Sep 2023	87.30%	Improvement (High)	Not capable
Pressure Ulcers (AIMS)	Pressure Ulcers (AIMS)	Sep 2023	97.4%	Improvement (High)	No Target
Patient Experience	Friends & Family Score	Sep 2023	92.40%	Improvement (High)	Not capable
Patient Concerns	PALS % Closed within 48 hours - Trust	Sep 2023	36.9%	Concern (Low)	No Target
Patient Concerns	PALS Contacts - Trust	Sep 2023	369	Concern (Low)	No Target
Nutrition and Hydration (AIMS)	Nutrition and Hydration (AIMS)	Sep 2023	93.8%	Improvement (High)	No Target
Maternity: Babies	Mothers Transferred Out of Unit	Sep 2023	7	Concern (High)	No Target
IPC Audit	IPC Audit	Sep 2023	95.9%	Concern (Low)	Not capable
Falls (AIMS)	Falls (AIMS)	Sep 2023	89.0%	Improvement (High)	No Target
Daily Safety Check	Daily Safety Check	Sep 2023	98.4%	Concern (High)	Capable

SPC Variation Icons

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

SPC Assurance Icons

Capable | Not capable | Unreliable

Patient Safety Incident Investigations (PSIRP)

	Incident Type	September 2023
National Priorities	Maternity & Neonatal incidents which meet the 'Each Baby Counts' criteria referred to HSIB	1
	Maternal deaths referred to Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRRACE)[PMRT]	(1) [8]
	Child Death referred to local Child Death Overview Panel (CDOP)	1
	Death involving patient with Learning Disability referred to local LeDeR reviewer. (A local mortality review is also completed)	0
	Safeguarding incidents referred to Complex Health Hub for review and safeguarding referral	0
	Information Governance incidents referred to Trust IG Lead for Data Security and Protection Toolkit completion	0
	Incidents related to National Screening Programmes referred to local Screening Quality Assurance Team	0
	Deaths of patients in custody, in prison or on probation referred to Prison and Probation Ombudsman	0
	Incidents meeting Never Event Criteria to undergo PSII	0
	Incidents resulting in death, assessed as more likely than not due to problems in care following Structured Judgement Review to undergo PSII	1
Trust PSII Priorities	Missed / Delay in Diagnosis to undergo PSII	0
	Sub – optimal care to undergo PSII	1
Local Level PSR	Incidents to undergo another Patient Safety Review (PSR) to provide a proportionate learning response.	67

Analytical commentary

The priorities for Patient Safety Incident Investigation (PSII) are based on national requirements of the NHS Patient Safety Incident Response Framework (PSIRF) and our highest local patient safety risks identified through situational analysis of local sources of insight. Therefore is it not possible to benchmark activity as each provider's patient safety incident response plan (PSIRP) is specific to them.

Assurance Commentary

This gives the number of incidents reported against each of the categories in the Trust Patient Safety Incident Response Plan (PSIRP). Only incidents meeting referral criteria to National bodies are included (eg HSIB,) or where a PSII level investigation has been commissioned in month. The number of Patient Safety Reviews is also reported.

Action Commentary

Daily Triage process continues to be embedded as BAU,
Complex Case Review Group meetings escalated 2 incidents for PSII. (see next page)

Supplementary metrics

Duty of candour compliance 100% for September

Pressure Ulcers

NNUH Digital Health
business intelligence

Hospital Acquired Pressure Ulcers per 1,000 bed days

Sep 2023

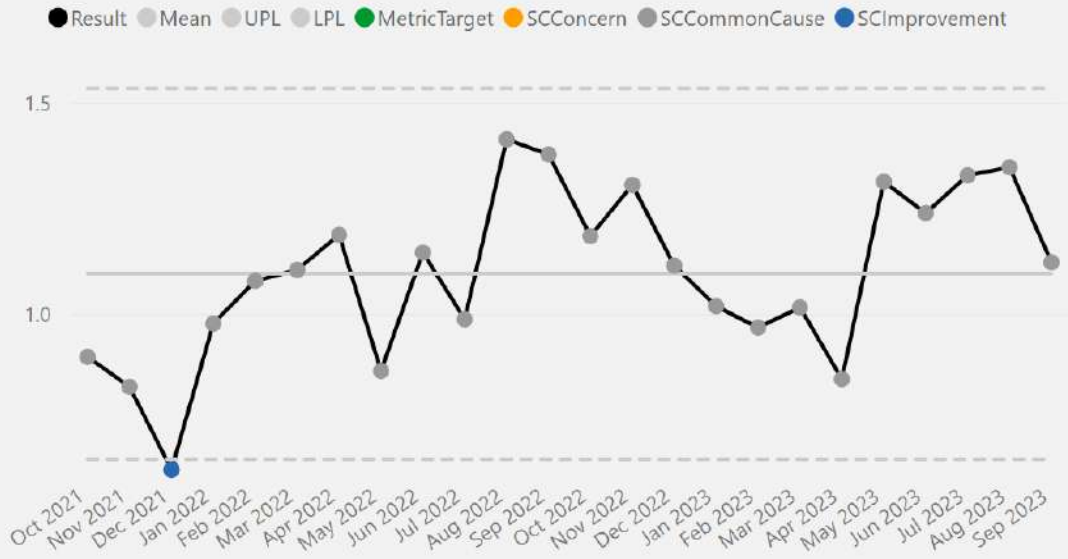
Variation | Assurance

1.1 Result	1.5 UPL
N/A Target	1.1 Mean
	0.7 LPL

Analytical Commentary

Variation is Common Cause

Hospital Acquired Pressure Ulcers per 1,000 bed days



Assurance Commentary

September saw a reduciton in pressure ulcer numbers. 23 Category 2 pressure ulcers (3 were device related). We did have 6 category 3 pressure ulcers but two were deep tissue injuries that broke down and all were shallow low harm. We had 3 mucosal ulcer sfom devices that are not nationally considered and 3 unstageable pressure ulcers. This gives a total of 32 reportable hospital acquired pressue ulcers. We did however have 27 reported suspected deep tissue injuries which continues an upward trend over the last 4 - 5 months with no underlying cause or lapses in care, but if felt to be a reflection of improved checking and reporting but significant frailty of the patient groups.

Improvement Actions

The Tissue Viability Service continues to provide support, advice and guidance to clinical areas where and when required where TVS staffing allows.
Medicine has been doing a twice weekly QI meeting on PU (Falls and nutrition) focus which has aided in the reduction of PU's in medicine this month and easily highlights areas of concern or focus.
Participating in the Pressure Ulcer Risk Assessment CQUIN for 2023 – 2024 which will focus staff on Risk Assessments, documentation and care plans. Q2 has seen an improvement on Q1.

Patient Falls

NNUH Digital Health
business intelligence

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

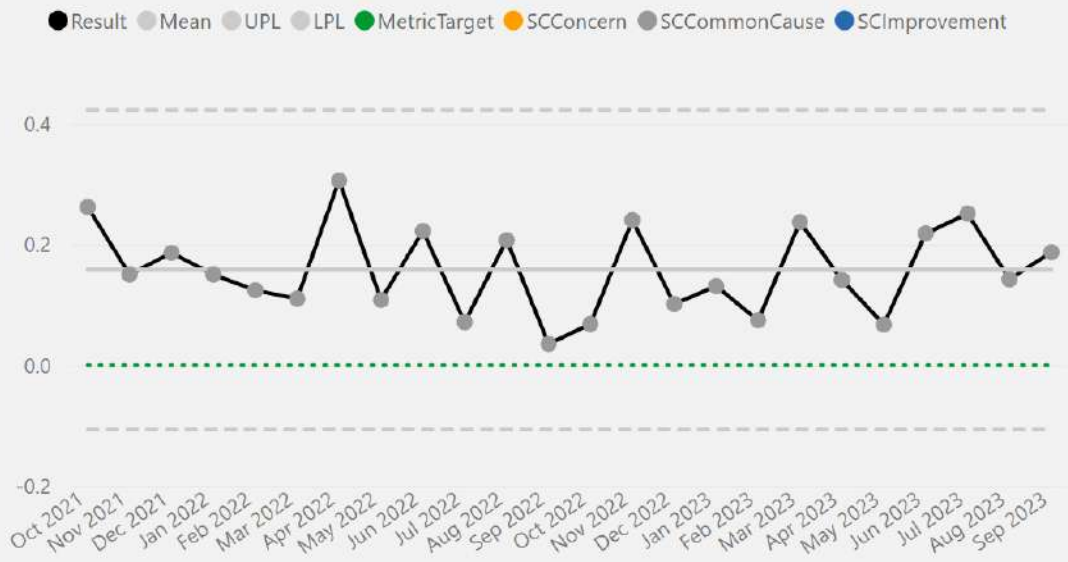
Sep 2023

Variation	Assurance		
		0.2 Result	0.4 UPL
		0.0 Target	0.2 Mean
			-0.1 LPL

Analytical Commentary

Variation is Common Cause

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



Assurance Commentary

Variation remains common cause with 0.2 falls per thousand bed days for moderate harm and above. Total falls with moderate harm and above is 7. Falls per thousand bed days is at 7.1 and total falls numbers across the trust 187 with 54% being unobserved. Improvements in falls numbers align with the special cause variation (improvement) seen for both sfae staffing care hours per patient per day and also safe staffing fill rates.

Improvement Actions

Weybourne Unit MFRA being integrated with Aria and Paediatric Falls Risk Assessment being reviewed. Assistive Technology Equipment with Procurement awaiting Powergate Implementation. Nurse, Physio, Dr & Housekeepers training booked. Falls leaflet versions on Trust Docs and awaiting upload to PowerGate. Work to add standing blood pressure to e-Obs dashboard on Power BI in progress to enable generation of a daily report to ensure clinical compliance. Patient/Carer/Family Co-Production Falls Stories being planned. Falls specific datix page being devised to integrate hot debrief & swarm detail

Patient Experience

NNUH Digital Health
business intelligence

Friends & Family Score

Sep 2023

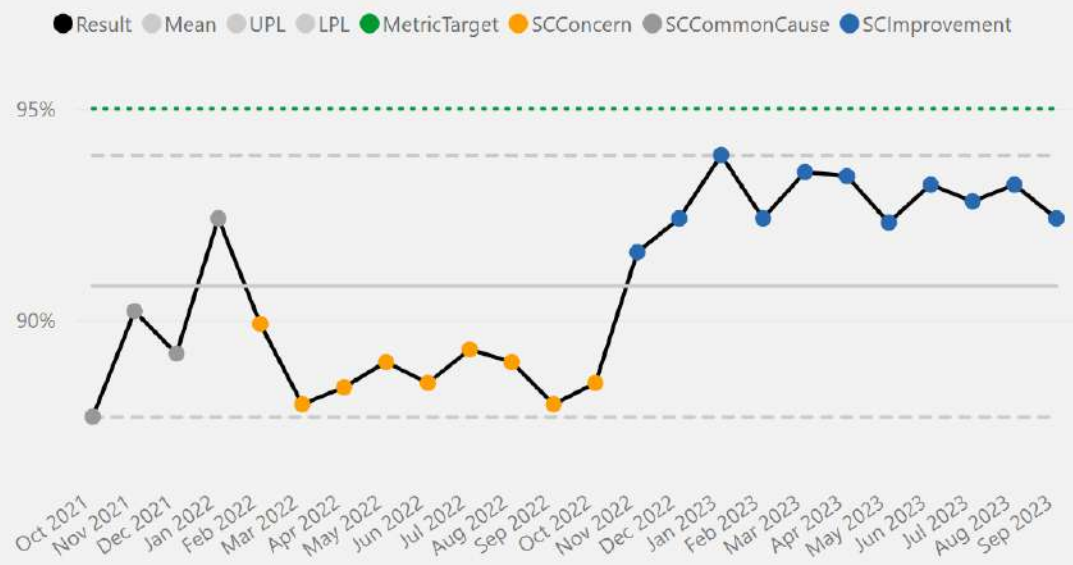
Variation	Assurance
H	F

92.40% Result
95.00% Target
93.90% UPL
90.80% Mean
87.70% LPL

Analytical Commentary

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

Friends & Family Score



Assurance Commentary

3320 Friends & Family Test (FFT) response were received in September which has given us an overall score of 92% score. This remains within our usual limits and we are continuing to see common cause variation.
Top feedback themes for September continue to include staff attitude, waiting times, communication, implementation of care and environment for both positive and negative sentiment.
We continue to consistently hear far more positive themes than negative within FFT feedback.

Improvement Actions

A plan is in place for SMS allocation. ED agreed budget to be re-allocated across divisions with further support given to them to implement other methods, which will start when team is back to full resource. Updated postcards to support the medicine division improvement plan to be delivered to areas when volunteer support is available. The impact of this will be reported to the task and finish group. FFT update been drafted to be shared via the Beat instead of email, with support from Comms.

Supplementary Metrics

Metric Name	Date	Result		Variation		Assurance
Compliments	Sep 2023	138		Common Cause		No Target

Patient Concerns

NNUH Digital Health
business intelligence

PALS % Closed within 5 days - Trust

Sep 2023

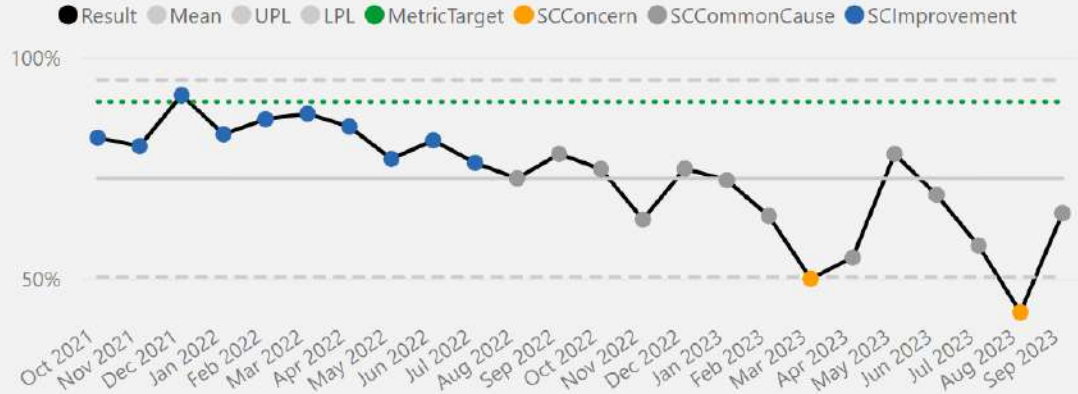
Variation

Assurance

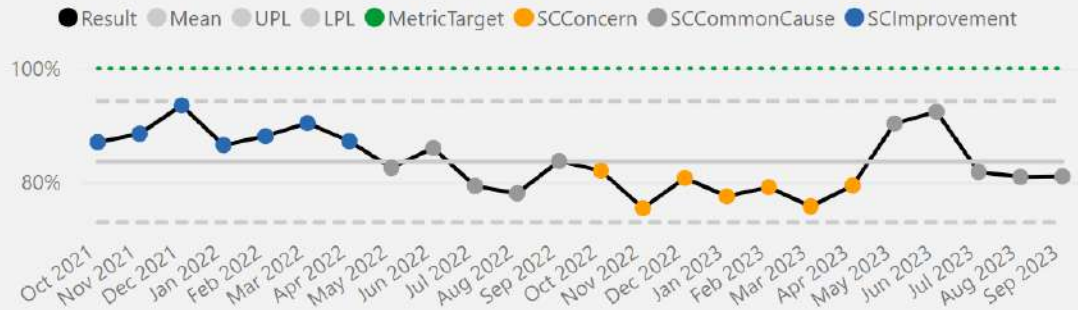
64.8% Result
90.0% Target

95.0% UPL
72.7% Mean
50.4% LPL

PALS % Closed within 5 days - Trust



PALS % Closed within 7 days - Trust



Supplementary Metrics

Metric Name	Date	Result		Variation		Assurance
PALS Contacts - Trust	Sep 2023	369		Concern (Low)		No Target

Analytical Commentary

Variation is Common Cause

Assurance Commentary

All staff have returned to work, with Band 4 member of staff starting employment 16 October.

Number are consisted with 365 matters raised. Issue relating to Power BI and Datix has been identified.

Slight increase in PALS numbers since August, appointments delays and cancellations main theme of Pals enquiries.

Improvement Actions

Band 4 staff starts on 16/10/2023 to assist with front end customer focusing early resolution concerns.
Best wishes procedure has been updated to utilise family liaison service and help build better communication with families.
Work ongoing to promote Dr Doctor for patients to manage appointments rather than directed to PALS.

Complaints

NNUH Digital Health
business intelligence

Complaints (Trust)

Sep 2023

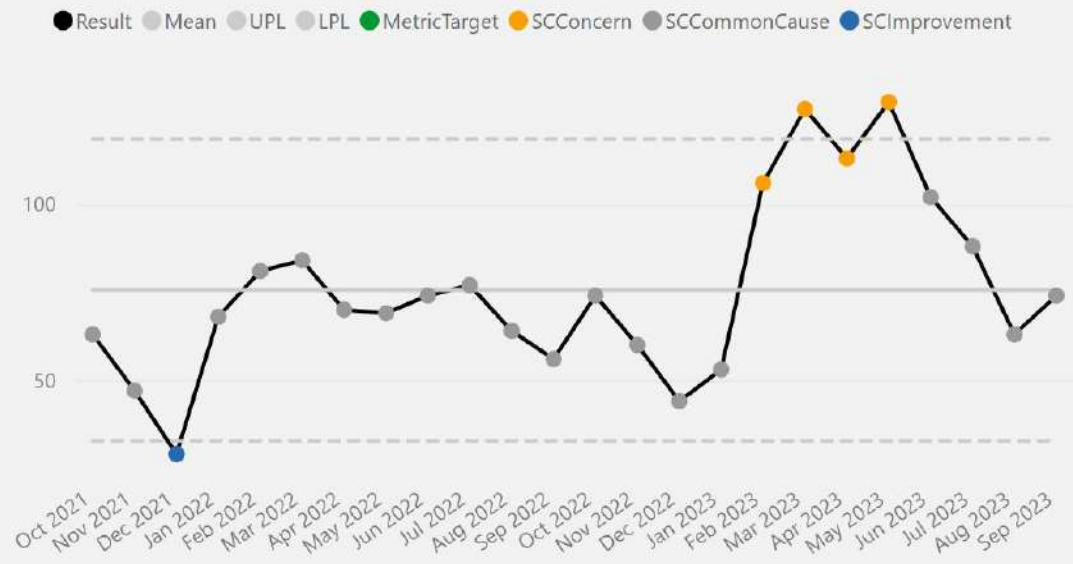
Variation | Assurance

74 Result
N/A Target
119 UPL
76 Mean
33 LPL

Analytical Commentary

Variation is Common Cause

Complaints (Trust)



Assurance Commentary

99 Complaints received this month, 41 Level 2 and 19 Level 3.

SCEC and Medical largest numbers although in comparison to number of patients seen overall number are low.

Communication is top theme of complaints. Complaints Manager and 1 handlers have been off long term sick for entire month. Team have support Head of Service brilliantly and managed urgent cases well.

Backlog continues to reduce and now this approach is bets practise for case management has been adapted to ongoing to prevent future backlog. Team are becoming more proactive at closing cases.

Staff are still under pressure and working will within resource they have.

Improvement Actions

Sickness managed within trust policies, current absence will lead to longer term better service resilience and reduce single points of failure.
Band 6 member of staff been incredible helpful in assisting team to manage caseload and reduce historic.
Team reflections session planed for October to map existing processes and populate improvement plan.
Further work need to map "floating complaints" and develop clearer picture of current status of team.

Supplementary Metrics

Metric Name	Date	Result		Variation		Assurance
Complaints - Acknowledgement	Sep 2023	100%		Common Cause		Unreliable
Complaints - Response Times - Trust	Sep 2023	91%		Common Cause		Unreliable
Post-investigation enquiries	Sep 2023	3		Common Cause		Capable

Palliative Care

NNUH Digital Health
business intelligence

Palliative Care Seen Within 48 Hours

Sep 2023

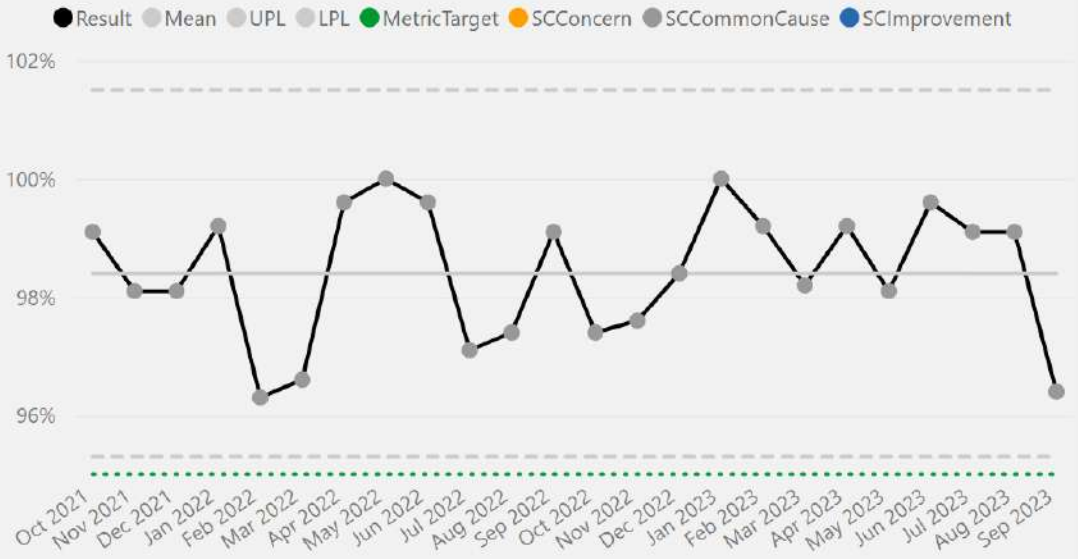
Variation	Assurance
	

96.4% Result	101.5% UPL
95.0% Target	98.4% Mean
	95.3% LPL

Analytical Commentary

Variation is Common Cause

Palliative Care Seen Within 48 Hours



Assurance Commentary

The new Service Director and the team are undertaking a review of the service specification and model as the number and the complexity of the referrals received by the team has significantly increased when figures have been compared. The team had 41 patients on their daily caseload in 2022, which has increased to 67 in 2023.

Improvement Actions

To support staff and workload to manage workload and referrals in response to high levels of staff sickness.
To complete service review and take appropriate next steps.

Supplementary Metrics

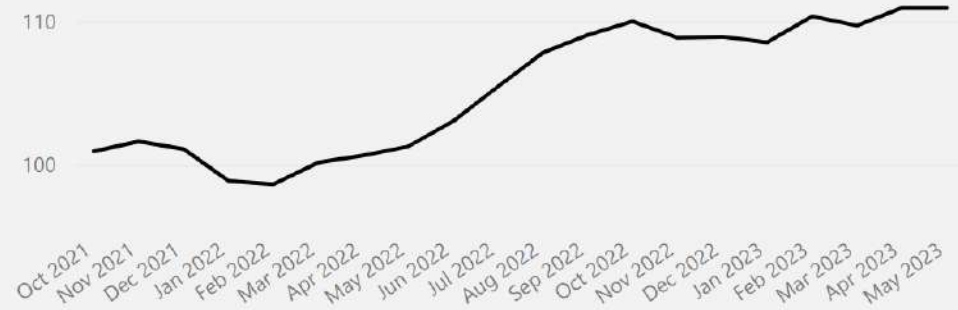
Metric Name	Date	Result		Variation		Assurance
Palliative Care Died in Trust and Seen by SPCT	Sep 2023	53.8%		Common Cause		No Target
Palliative Care IP Referrals Accepted	Sep 2023	194.0		Common Cause		No Target

Mortality Rate

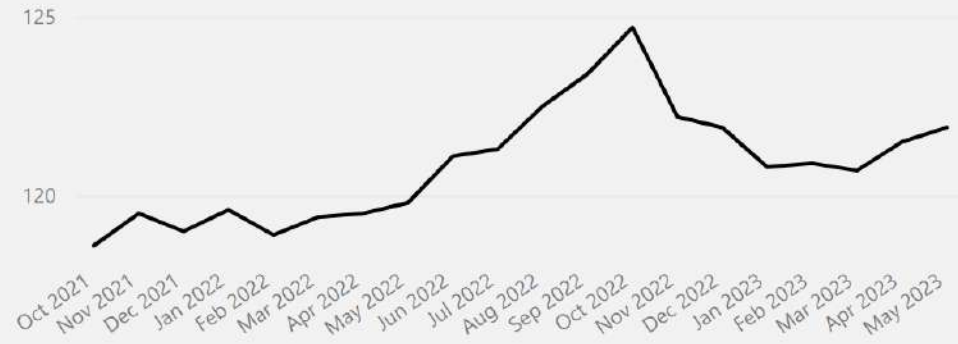
NNUH Digital Health
business intelligence

MetricName	Date	Result
HSMR	May 2023	110.97
SHMI	May 2023	122

HSMR



SHMI



Supplementary Metrics

Metric Name	Date	Result		Variation		Assurance
Crude Mortality Rate	Aug 2023	4.70%		Common Cause		No Target

Assurance Commentary

An update and timeline of when the Royal College of Physicians (RCP) will complete the invited mortality review has been requested by the Interim Medical Director to be able to update the Board and Council of Governors.
External coding review being undertaken by Grant Thornton. An update of key findings will be given to Mortality Surveillance Group in October
HSMR/SHMI both remain statistically higher than expected as previously reported.
Industrial action, operational pressures and elective recovery continue to impact on the resources available to complete Structured Judgement Reviews, undertake casenote reviews for mortality outlier alerts, and for divisions to attend mortality & morbidity meetings, mortality surveillance or learning from deaths committee.

Improvement Actions

Walk/talk through exercise to assess compliance with sepsis protocols completed in ED and AMU, outcomes will be discussed at mortality surveillance in November.
Support the RCP to complete the external invited review
Progress with planned mortality alert reviews
Continue to seek engagement with clinical teams at all levels regarding SJRs
Support Divisions in implementing a governance structure for mortality surveillance

Safer Staffing

NNUH Digital Health
business intelligence

Safe Staffing Fill Rates

Sep 2023

Variation	Assurance
H	F

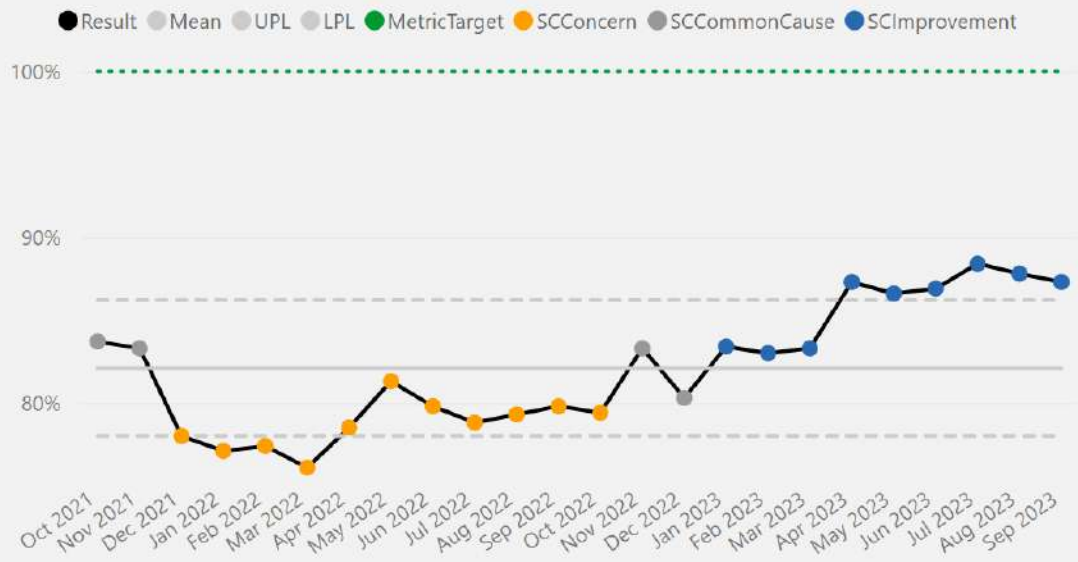
87.30% Result
100.00% Target

86.20% UPL
82.10% Mean
78.00% LPL

Analytical Commentary

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

Safe Staffing Fill Rates



Assurance Commentary

The Trust-wide RN/M vacancy rate decreased from 12.9% (n=354.6) in Aug to 10.9% (n=298.2) in Sept. The Trust turnover rate for RN/M was 0.5% (n=11.5 leavers) with 57.27 WTE new starters. The average Trust-wide RN/M fill rate increased from 88.4% in Aug to 88.7 in Sept with only MLBU falling below 75%. The Trust-wide HCSW vacancy rate decreased from 17.3% (n=244.0) in Aug to 15.7% (n=221.8) with a turnover rate of 1.4% (15.0 WTE leavers) & 29.48 WTE new starters. The HCSW average Trust-wide fill rates decreased from 87.8% in Aug to 85.7% in Sept, with 2 areas falling below 75% (Mulbarton & CHED). Finance reported 3 areas with a 20% vacancy rate in both RN and HCSW. The Trust wide CHPPD increased slightly from 7.1 to 7.2 which is a significant improvement from 6.3 last year. Red flags increased slightly by 43 in September to 1,715 with 88% remaining open. 892 of these were raised for shortfall in RN time. Patient falls reported causing low harm & above remains static at 91 in both Aug and Sept. 57 of these were unobserved with 4 recorded as moderate harm & above.

Improvement Actions

Recruitment with international nursing continues. Part 2 of the "Nursing Establishment" is completed and now in the professional consultation aligning with divisions and finance. In-Shift redeployment SOP has been revised and resubmitted to the NMCOP forum for approval. RCN Workforce gap analysis is underway and due to be presented at NMCOP Forum in October. Cost avoidance identified and implemented with agency staff. Check and confirm of rosters continue divisionally.

Supplementary Metrics

Metric Name	Date	Result		Variation		Assurance

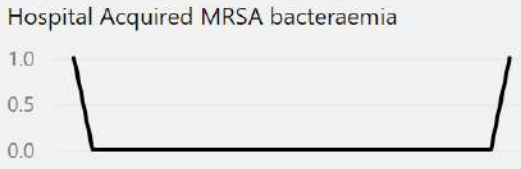
Infection Prevention & Control

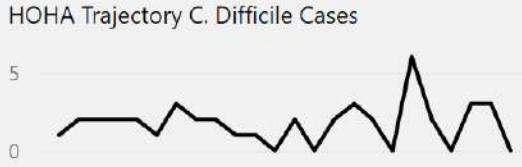
NNUH Digital Health
business intelligence

MetricName	Date	Result	Target	Mean
C. difficile Cases Total	Sep 2023	8	77	7
CPE positive screens	Sep 2023	0	N/A	0
E. Coli trust apportioned	Sep 2023	7	91	4
HOHA Trajectory C. Difficile Cases	Sep 2023	0	0	2
Hospital Acquired MRSA bacteraemia	Sep 2023	1	0	0
Klebsiella trust apportioned	Sep 2023	5	24	3
MSSA HAI	Sep 2023	2	N/A	3
Pseudomonas trust apportioned	Sep 2023	3	19	1

Assurance Commentary

C. difficile = Total 8, 4 x HOHA, 4 x COHA, 6 cases pending RCA, 2 cases non trajectory
Gram negative surveillance.
E. coli = Total 13 7 x HOHA cases -sources: 4 x Lower urinary tract, 1 Upper urinary tract, 2 x gastrointestinal /intrabdominal collection. 6 x COHA –, 2 x unknown & 1 x upper urinary tract, 3 lower urinary tract.
Klebsiella = Total 5, 5 X HOHA cases- sources 2 x unknown, 1x Lower respiratory tract, 2x Gastrointestinal/intrabdominal collection.
Pseudomonas aeruginosa = Total 4, 3 x HOHA cases – source 1x Lower respiratory tract, 1x Unknown source, 1 x intravascular device. 1x COHA cases – source 1x Lower urinary tract.
COVID-19 (SARS CoV-2) - 2 outbreaks reported in September.
MSSA HAI Total cases x 2 – sources 1x unknown source, 1 Bone/joint.
MRSA Blood stream infections – One case, blood culture taken on day 3, defined as HAI. PIR completed – outcome- case unavoidable as patient admitted with infection.
CPE –Nil new cases.





Improvement Actions

C.difficile Post Infection Review (PIR) meetings held monthly with clinical staff and Norfolk & Waveney ICB to establish lapses in care. Delay in sampling remains the main lapse to date. Lapses are disseminated in the monthly OWL and is now integrated within datix. Providing access to divisional governance teams, ensuring actions and learning is discussed and disseminated appropriately.
A review of the current RCA process is being discussed with colleagues across Norfolk and Waveney to align with introduction of the Patient Safety Incident Response Plan PSIRF.
Surveillance undertaken on each Healthcare Associated Gram-negative Blood Stream Infection to ascertain the potential sources.
COVID-19 outbreak reporting/monitoring continues to be a requirement from NHS England.
Klebsiella gram negative cases have exceeded the 2023/24 threshold of 24, this threshold was reduced by 50%, from the previous 2022/23 threshold of 48. This has been escalated at CSESB.

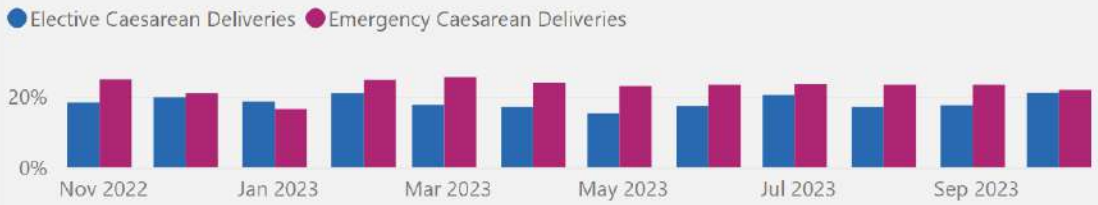
Maternity Activity

NNUH Digital Health
business intelligence

31/10/2022 30/09/2023

Sep 2023	0.00	0.00
Latest Month	Maternal Deaths	Unplanned Admissions to Critical Care

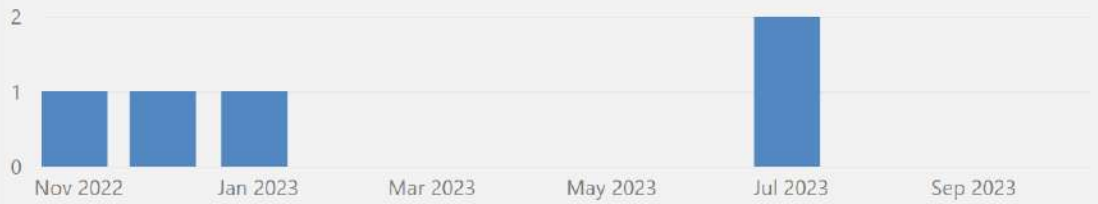
Caesarean Deliveries



Inductions of Labour

Maternal Deaths

Unplanned Adm. to Critical Care



Latest Assurance Commentary

The number of women requiring admission for induction of labour remains high and is of concern due to demand vs capacity. Women are induced as per updated local and national guidance which has given rise to increasing numbers. Admissions occur 7 days a weeks and daily lists are created as per order of clinical priority. Due to demand vs capacity issues, delays to admission and care can occur. Admissions and flow is managed daily with an MDT approach. Delays to admission and/or care are discussed daily and a Datix submitted to reflect delays. Although there is no national QCIM or target related to induction of labour, the NNUH do not sit as an outlier in comparison to other Trusts within our Local Maternity and Neonatal System. In 2023, the percentage of women requiring induction of labour has varied from 32-40%.

Latest Improvement Actions

To use the National Maternity Dashboard to review NNUH performance at a Local Maternity & Neonatal System (LMNS), Regional and National level against Clinical Quality Improvement metrics (CQIMs) and National Maternity Indicators (NMIs). Noting that a number of the CQIMS are mapped to the Robson Criteria.

Maternity: Mothers

NNUH Digital Health
business intelligence

Mothers Delivered

Sep 2023

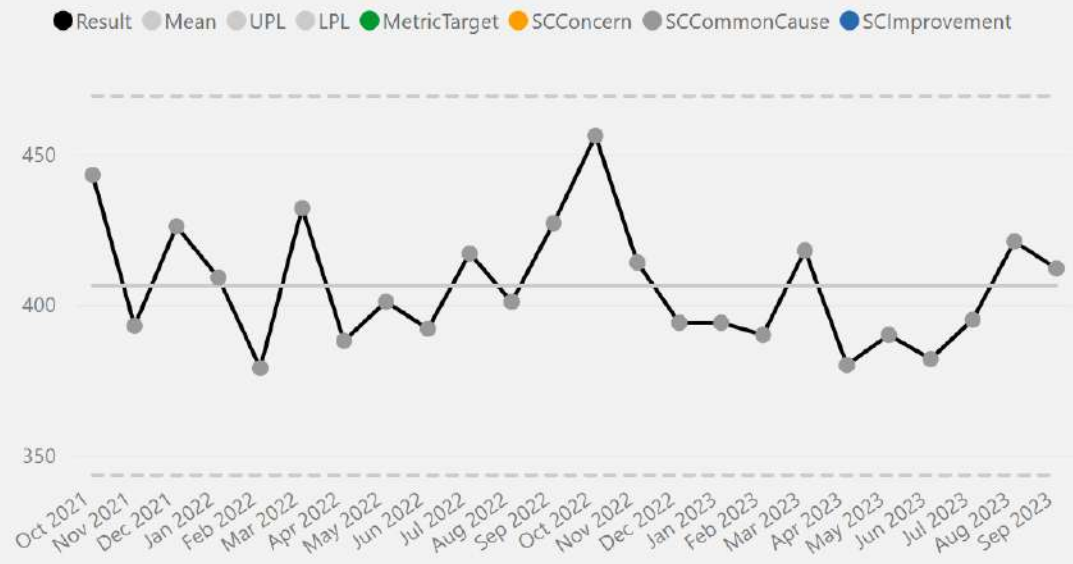
Variation | Assurance

412 Result
N/A Target
469 UPL
406 Mean
344 LPL

Analytical Commentary

Variation is Common Cause

Mothers Delivered



Assurance Commentary

412 mothers delivered this month. The number of 3rd and 4th degree tears experienced by women at birth remains consistent and we are not an outlier. We had 2.6% which remains in range. The NNUH sit in the middle 50% of the national target range of 0.5-52.5 women per 1000 births and remain low in comparison to other Trusts within region.
The number of births before arrival (4) remains in line with previous months and there has not been excessive increase.
We are not an outlier for postpartum haemorrhage and the national parameters are 2-58 per 1000 women. 2.2% of women experienced at postpartum haemorrhage in September which is in range.
1:1 care in labour was achieved in 98.6% of all cases.

Improvement Actions

All BBA's reviewed by the community matron and lessons learnt is shared.
All 3rd/4th degree tears and PPH are discussed at the weekly incident review meeting. To reduce the number of 3rd and 4th degree tears, we are looking to introduce a package of education around episiotomy and hands on delivery.
Discussions are in place regarding the unit taking forward the Obstetric Anal Sphincter Injury (OASI) care package.

Supplementary Metrics

Metric Name	Date	Result		Variation		Assurance
1:1 Care in Labour	Sep 2023	98.6%		Common Cause		No Target
3rd & 4th Degree Tears	Sep 2023	2.5%		Common Cause		Unreliable
Births Before Arrival	Sep 2023	4		Common Cause		No Target
Post Partum Haemorrhage ≥1500mls	Sep 2023	2.2%		Common Cause		No Target

Mothers Delivered
412
Babies Delivered
417

Maternity: Babies

NNUH Digital Health
business intelligence

Unplanned NICU ≥37 week Admissions (E3)

Sep 2023

Variation	Assurance
	

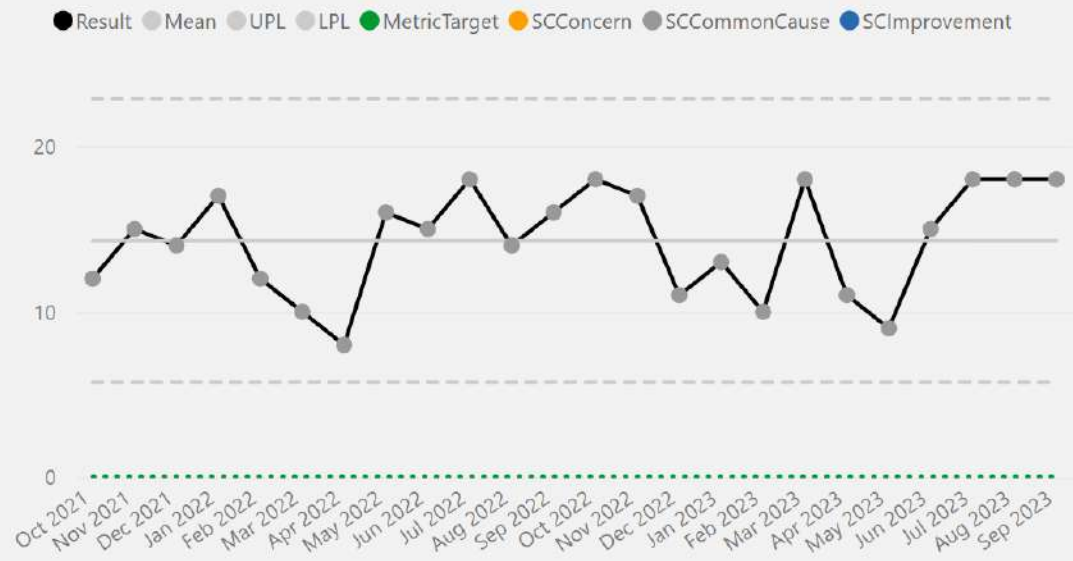
18 Result
0 Target

23 UPL
14 Mean
6 LPL

Analytical Commentary

Variation is Common Cause

Unplanned NICU ≥37 week Admissions (E3)



Assurance Commentary

The team have been working hard to maintain babies' temperatures following delivery in order to avoid unplanned admissions to NICU.
In early November we are launching the Kaiser Permanente Neonatal Early Onset Sepsis Calculator. The tool will be used as a quantitative, risk-based approach to the management of neonatal early onset sepsis.
All 18 unplanned admissions to NICU have been reviewed and care appropriate. These are also included in the monthly Avoiding Term Admissions into Neonatal (ATAIN) review.
We remain within the target range for babies with an Apgar score of >7 at 5 minutes and are not an outlier. The national range is 0-27.5 babies per 1000 births. In September there were three babies with an Apgar score of >7 at 5 minutes.
The one neonatal death in September will be reviewed in line with guidance.
Seven mothers were transferred out of the unit due to demand vs capacity for induction of labour. Transfers were to neighbouring units with the ability to accept mothers and the induction process could be commenced/continued in a timely manner.

Improvement Actions

To continue to use the strengthened MDT approach to review all NICU admissions, identify any themes and ensure lessons learnt are shared.

Supplementary Metrics

Metric Name	Date	Result		Variation		Assurance
Adjusted Still Births	Sep 2023	1		Not Applicable		No Target
Apgar score <7 @5, ≥37 weeks	Sep 2023	2		Common Cause		No Target
Early Neonatal Death	Sep 2023	1		Not Applicable		No Target
Mothers Transferred Out of Unit	Sep 2023	7		Concern (High)		No Target

Saving Babies Lives

NNUH Digital Health
business intelligence

Topic	Metric Name	Date	Result		Variation		Assurance
Smoking Awareness	Smoking Status at Delivery	Sep 2023	7.5%		Common Cause		Unreliable
Fetal Growth Restriction	Less Than 3rd centile born > 37+6 weeks	Sep 2023	3%		Common Cause		Not capable
Fetal Growth Restriction	SGA detected Antenatally	Sep 2023	120%		Common Cause		No Target
Reducing Preterm Birth	Singleton Births Preterm	Sep 2023	7%		Common Cause		Unreliable
Reducing Preterm Birth	Singleton live births < 34 wks (AN corticosteroids within 7 days PN)	Sep 2023	33%		Common Cause		Unreliable
Effective Fetal Monitoring	CTG Training and Human factors situational awareness compliance	Sep 2023	81%		Common Cause		Unreliable

Assurance Commentary

Our first Saving Babies Lives Care Bundle version 3 evidence submission has been uploaded to the NHS Futures Platform and sent to the LMNS for review. We are currently on track to achieve all elements of the Saving Babies Lives care bundle.
Smoking cessation project work is on-going across the LMNS and in September 7.8% of women were still smoking at the time of delivery.
Fetal monitoring training compliance figures have decreased to 81% this month. There has been an active drive for completion of this training with additional dates arranged.

Improvement Actions

For the diabetes midwifery and consultant team to review Version 3 of Saving Babies Lives Care Bundle (SBLCB) as this now includes a new element of compliance for diabetes.
To complete a series of audits for CO2 monitoring performance; Risk assessment, prevention, and surveillance of pregnancies at risk of fetal growth restriction (FGR); raising awareness of reduced fetal movement (RFM) and the use of steroids for fetal optimisation to maintain our compliance for 2023/24 and for our Year 5 submission.

Adult Safeguarding

NNUH Digital Health
business intelligence

Safeguarding Adults

Sep 2023

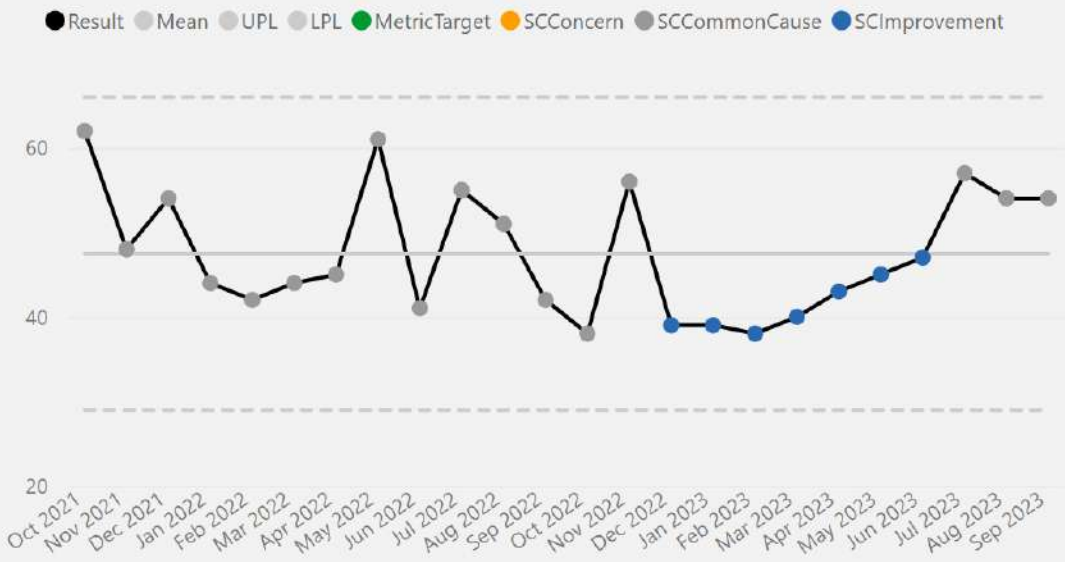
Variation | Assurance

54 Result
N/A Target
66 UPL
47 Mean
29 LPL

Analytical Commentary

Variation is Common Cause

Safeguarding Adults



Assurance Commentary

The monthly meetings between NNUH Adult Safeguarding team and Senior Leads in Social Care continue, with the proposal to move them to bi-monthly from 2024. This has helped with improving multi-agency working and identify points of escalation early. Some of the SG team has access to Liquid Logic social care IT system. This access has been beneficial for coordinating quick responses and action plans where ordinarily we`d have to wait or chase the local authority. It will be useful in discharge and care plans for our service users. NHS Digital put a ban on the autoforward tool from NHS organisations to other agencies. This has had an impact on the way the SG team receives and sends AA1 referrals to the local authority, however, we are trying to identify solutions with the help of Norfolk County Council. It does not impact on patient care.

Improvement Actions

The Norfolk Safeguarding Adults Board is awaiting funding approval before launching the pilot of the Local Authority and Health framework. The purpose of the framework is to support decision making about whether to raise a safeguarding or not, the focus is on 4 key areas: Unwitnessed falls; pressure areas; incidents between 2 adults who have care and support needs; and medication errors. Once go ahead is given, the safeguarding team will disseminate the framework to targeted groups and ensure it`s utilised.

Children & Midwifery Safeguarding

NNUH Digital Health
business intelligence

Safeguarding Children and Midwife...

Sep 2023

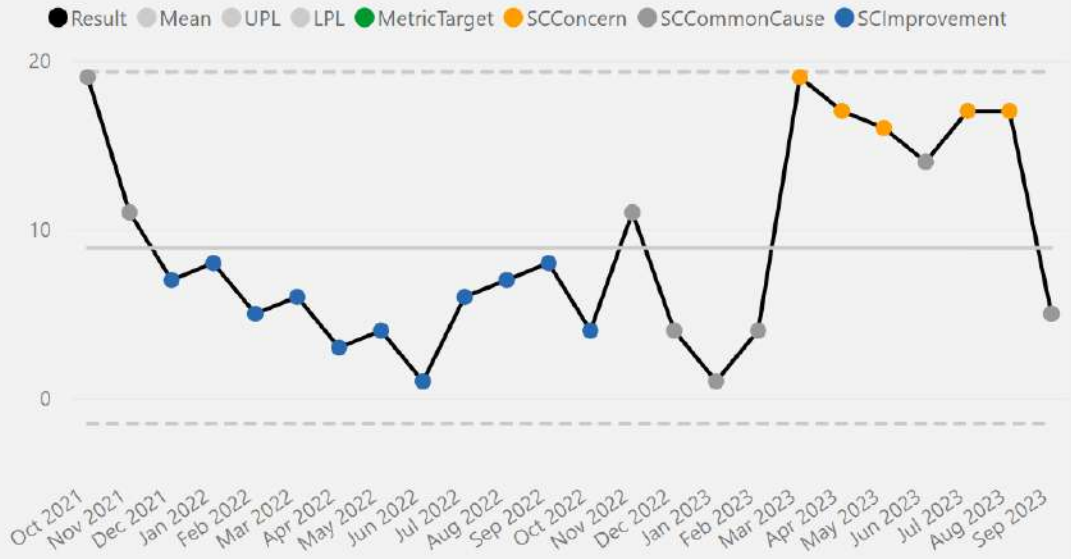
Variation	Assurance
	

5 Result	19 UPL
N/A Target	9 Mean
	-1 LPL

Analytical Commentary

Variation is Common Cause

Safeguarding Children and Midwifery



Assurance Commentary

By the end of September 2023, 83% of midwives have received at least one supervision session. This is a notable success from 0% in July 2022 when the rollout began. In addition to supervision, the use of the Norfolk graded care profile tool is being disseminated to midwives in the Trust, starting with community and the leadership teams. This tool will help in assessments where neglect has been identified. Group supervision within the paediatric departments has begun and so far being positively received. The safeguarding team is also working alongside the paediatric clinical educators to support new starters and students to gain insight and better understanding into safeguarding.

Improvement Actions

The Norfolk Safeguarding Children Partnership Continuum of Needs Guidance (CONG) was published in September. This replaces the Threshold Guide and will assist staff in making decisions about what kind of support a child or young person and their family requires. The framework is set out to ensure that children and young people receive the right services at the right time. It will be accessible to our staff via the NSCP website. We have moved the process of informing the SG team of referrals made to CADS from DATIX to ICE as this was identified to be easier for staff.

Supplementary Metrics

Metric Name	Date	Result	Variation	Assurance
Safeguarding Children	Sep 2023	4	Common Cause	No Target
Safeguarding Midwifery	Sep 2023	1	Common Cause	No Target

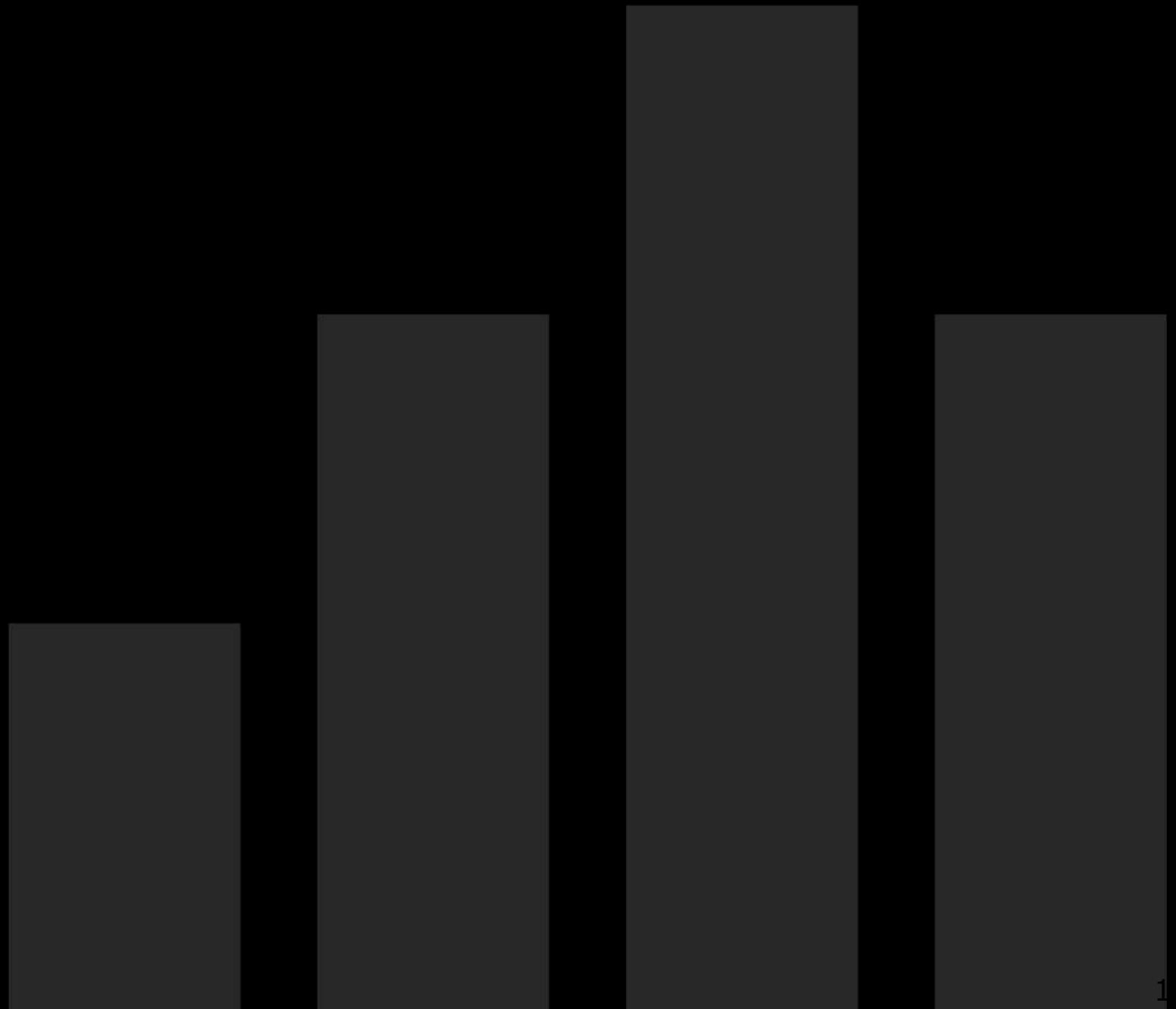
Microsoft | Power BI

Stroke

View in Power BI

Last data refresh:
23/10/2023 06:30:30 UTC

Downloaded at:
23/10/2023 09:20:03 UTC



Stroke

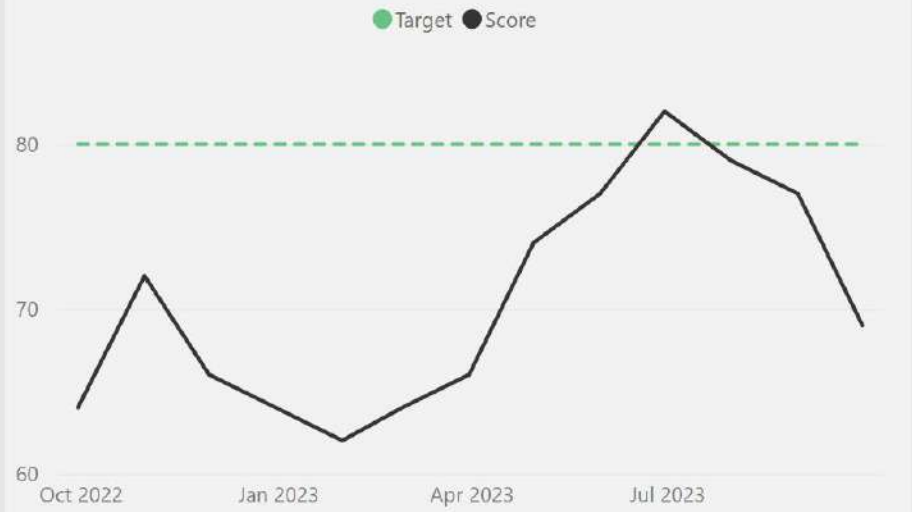
NNUH Digital Health
business intelligence

Date Range

30/09/2022

30/09/2023

Overall SSNAP Score



September 2023

SSNAP Grade

C

SSNAP - Score

69

Potential Strokes

272

Diagnosed Strokes

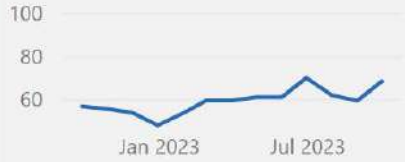
84

Latest Grade (Domain)

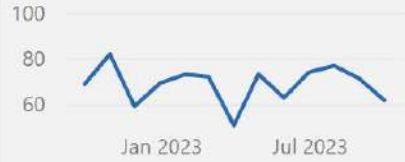
Domain	Grade
Domain 1 - Grade	A
Domain 2 - Grade	D
Domain 3 - Grade	C
Domain 4 - Grade	B
Domain 5 - Grade	C
Domain 6 - Grade	C
Domain 7 - Grade	E
Domain 8 - Grade	D
Domain 9 - Grade	B
Domain 10 - Grade	A

Domain 1 - Scanning

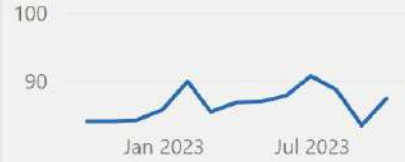
Domain 2 - Stroke Unit



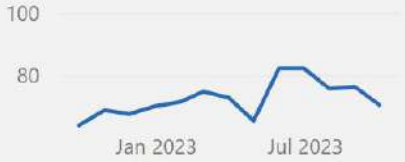
Domain 3 - Thrombolysis



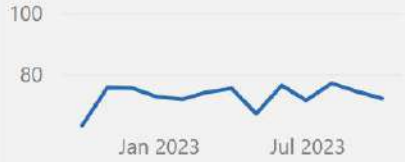
Domain 4 - Specialist Assessment



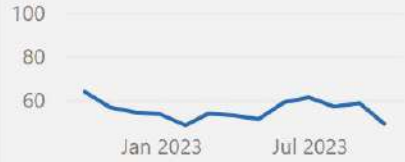
Domain 5 - Occupational Therapy



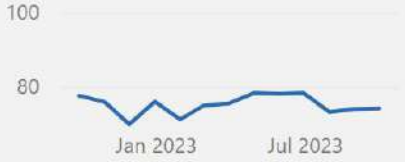
Domain 6 - Physiotherapy



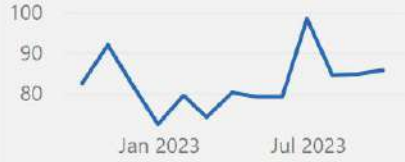
Domain 7 - Speech & Lang. Therapy



Domain 8 - MDT Working

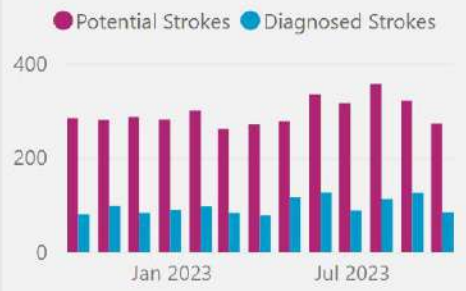


Domain 9 - Standards by Discharge



Domain 10 - Discharge Processes

Stroke Occurrence



Stroke

NNUH Digital Health
business intelligence

MetricRelation	MetricName	MetricDescription	MetricTechSpec
Primary	SSNAP - Score	Total Key Indicator Score is calculated from the 10 Domain grades using a points system, A=100, B=80,C=60,D=40,E=20. Average of these points = Overall rating	N.B. For PAF reporting purposes this data is not pinned to a division, in the PAF SSNAP score is presented both for the Medical Division and Clinical Support Services Division.
Secondary	SSNAP - Grade	Based on the Overal SSNAP rating/score whereby A>80, B >70, C>60, D>40, E<40.	
Secondary	Domain 1 - Score	Scanning: % patients scanned within 1 hour,12 hours of clock start and median time	Scanning 1.1 Proportion of patients scanned within 1 hour of clock start 1.2 Proportion of patients scanned within 12 hours of clock start 1.3 Median time between clock start and scan (hours:mins)
Secondary	Domain 1 - Grade	Grades A-E based on score, calculation varies for each domain	Scanning 1.1 Proportion of patients scanned within 1 hour of clock start 1.2 Proportion of patients scanned within 12 hours of clock start 1.3 Median time between clock start and scan (hours:mins)
Secondary	Domain 2 - Score	Stroke Unit: % patients admitted direct to stroke unit within 4 hours clock start and median time. % patients spent 90% LOS on stroke unit	Stroke Unit 2.1 Proportion of patients directly admitted to a stroke unit within 4 hours of clock start 2.2 Median time between clock start and arrival on stroke unit (hours:mins) 2.3 Proportion of patients who spent at least 90% of their stay on stroke unit
Secondary	Domain 2 - Grade	Grades A-E based on score, calculation varies for each domain	Stroke Unit 2.1 Proportion of patients directly admitted to a stroke unit within 4 hours of clock start 2.2 Median time between clock start and arrival on stroke unit (hours:mins) 2.3 Proportion of patients who spent at least 90% of their stay on stroke unit
Secondary	Domain 3 - Score	Thrombolysis: % of all patients given thrombolysis, % of eligible patients thrombolysed, % thrombolysed within 1 hour clock start, % admitted stroke unit within 4 hrs and thrombolysed or justifiable reason why not, median time	Thrombolysis 3.1 Proportion of all stroke patients given thrombolysis (all stroke types) 3.2 Proportion of eligible patients (according to the RCP guideline minimum threshold) given thrombolysis 3.3 Proportion of patients who were thrombolysed within 1 hour of clock start 3.4 Proportion of applicable patients directly admitted to a stroke unit within 4 hours of clock start AND who either receive thrombolysis or have a pre-specified justifiable reason ('no but') for why it could not be given 3.5 Median time between clock start and thrombolysis (hours:mins)
Secondary	Domain 3 - Grade	Grades A-E based on score, calculation varies for each domain	Thrombolysis 3.1 Proportion of all stroke patients given thrombolysis (all stroke types) 3.2 Proportion of eligible patients (according to the RCP guideline minimum threshold) given thrombolysis 3.3 Proportion of patients who were thrombolysed within 1 hour of clock start 3.4 Proportion of applicable patients directly admitted to a stroke unit within 4 hours of clock start AND who either receive thrombolysis or have a pre-specified justifiable reason ('no but') for why it could not be given 3.5 Median time between clock start and thrombolysis (hours:mins)
Secondary	Domain 4 - Score	Specialist Assessments: % patients assessed by stroke	Specialist Assessment

REPORT TO THE TRUST BOARD

Date	**01 November 2023**
Title	**Chair's Key Actions Report from Finance, Investments and Performance Committee on 25.10.23**
Lead	**Mr T Spink (Chair)**
Purpose	**For Information and agreement**

1 Background/Context

The Finance, Investments and Performance Committee met on 25 October 2023 and discussed matters in accordance with its Terms of Reference. Papers for the meeting have been made available to all Board members for information in the usual way via Admin Control. The meeting was quorate and was attended by Mrs Betts and Dr Fleming (public governors) as Observers.

Committee members visited Acute Medical Unit (H) immediately in advance of the meeting (Mr Foster, Dr Chrispin, Ms Dinneen, Mr Spink) with Mrs Betts & Dr Fleming.

2 Key Issues/Risks/Actions

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

	Issues considered	Outcomes/decisions/actions
1	Operational challenges and balancing demand in the emergency and elective pathways	The Committee reviewed the Performance IPR and was updated with regard to the operational position and the challenging position with particular regard to elective waiting, cancer waits and ambulance handover times. Committee members were encouraged to hear of the forward improvement plans but are acutely aware of the challenges facing the Trust in delivering all the improvements. The Committee requested: - an update with regard to the Capacity Plan and mitigations to address the shortfall resulting from the non-opening of additional capacity on the Unthank Road site; - greater specificity on differential rates of pre-noon discharge, by speciality and location; - increased focus at committee on the corrective plans The Committee was updated that whilst we have moved out of '7 in 6' it is proving necessary to accommodate additional patients in ward corridors, in an effort to maintain flow out of ED to limit ambulance delays. Previous reorganisation of the bed base had involved a reduction of the allocation of beds to Surgery, supported by 'ring fencing' of that reduced capacity. The Committee was

		advised that we are under significant pressure to reconsider that protection of surgical capacity. The Board has previously discussed that this involves a difficult balancing of risks, given the length of some ambulance delays alongside the extent of elective waiting and nature of patients who need treating. The difficulty and implications of these decisions was recognised and it was **agreed** that Board members would be available between scheduled meetings for discussion if it is proposed to relax the surgical ring-fence.
2	N&N Orthopaedic Centre(2)	The Committee was updated on progress in developing the business case for the next stage in developing our capacity to treat elective patients. A series of options have been reviewed to establish a design that is affordable within the available capital and that will still support a sustainable business model. The Committee is scheduled to review the FBC at its next meeting.
3	Operational Planning Framework 2024/25	The Committee considered the planning framework for 2024/25. This process has started earlier than has been the case historically, to provide additional time to establish plans. The Committee **agreed to recommend** that the Board should approve the Operational Planning Framework and associated delegation of authority.
4	Financial challenge	The Committee received the regular finance reports and noted that it is still forecast to achieve the financial breakeven plan (subject to compensation from NHSE for the impact of industrial action to date). It was acknowledged that the position will be affected by any further industrial action. The impact of operational disruption is complex, reflecting associated additional costs and changes to subsequent case mix – with rebooking of cases tending result in a more urgent and complex caseload. The Committee requested to receive an update on specific actions, at its next meeting with reference to limiting premium pay/agency spend.
5	DAC Turnkey Contracts	The Committee reviewed proposed agreements for specified 'fit-out' elements of the Diagnostic & Assessment Centre (DAC) programme – notably fit out of MRI rooms to make them ready to accommodate the scanners. The Committee **agreed to recommend** these to the Board.

3 Conclusions/Outcome/Next steps

The Committee is scheduled to meet again on 29 November 2023, at which meeting the Committee is due to consider:

- Electronic Patient Record RBC
- NANOC(2) FBC
- ED reconfiguration SOC
- Off-site premises assurance

Recommendation:

The Board is recommended to:

- **note** the work of its Finance, Investments and Performance Committee
- **receive** the recommendations with regard to Operational Planning Framework and DAC contracts
- **re-confirm** its willingness to hold meet on an extraordinary basis should this be required if it is proposed to make material change to policy on management of operational capacity.

REPORT TO BOARD OF DIRECTORS

Date	**1 November 2023**
Title	**Performance and Activity IPR**
Author & Exec Lead	**Chris Cobb – Chief Operating Officer**
Purpose	**For Information**
Relevant Strategic Objective	**BAF 1.2 and BAF 1.3**

The attached report provides an update on compliance against the new Operational Priorities 2023-24:

i) Urgent and Emergency Care:
- A&E Waiting Times – 'Improve A&E waiting times so that no less than 76% of patients are seen within 4 hours by March 2024 with further improvement in 2024/25': **On Track**
- Increase Ambulance handover delays under 30 minutes – 'Reduce handover delays to support the management of clinical risk across the system': **Off Track**
- Bed occupancy – 'Reduce adult general and acute (G&A) bed occupancy to 92% or below': **Off Track**

ii) Elective Care:
- 65 Week Waits – 'Eliminate waits of over 65 weeks for elective care by March 2024 (except where patients choose to wait longer or in specific specialties)': **Off Track**
- Day Cases – 'Meet the 85% day case expectations using GIRFT and moving procedures to the most appropriate setting': **On Track**
- Theatre Utilisation – 'Meet the 85% theatre utilisation expectations, using GIRFT and moving procedures to the most appropriate settings': **Off Track**
- Outpatient follow-ups – 'Deliver an appropriate reduction in outpatient follow-up (OPFU) in line with the national ambition to reduce OPFU activity by 25% against the 2019/20 baseline by March 2024': **Off Track**

iii) Cancer:
- 62 day Backlog – 'Continue to reduce the number of patients waiting over 62 days': **Off Track**
- 28-Day Faster Diagnosis Standard – 'Meet the Cancer Faster Diagnosis Standard by March 2024 so that 75% of patients who have been urgently referred by their GP for suspected Cancer are diagnosed or have Cancer ruled out within 28 days'*:* **Off Track**
- Lower GI Referrals with a FIT Test – 'Implement and maintain priority pathway changes for lower GI (at least 80% of FDS lower GI referrals are accompanied by a FIT result), skin (Teledermatology) and prostate cancer (best practice timed pathway): **On Track.**

iv) Diagnostics:
- Diagnostic Test Within 6 Weeks – 'Increase the percentage of patients that receive a diagnostic test within 6 weeks in line with the March 2025 ambition of 95%': **Off Track**

Recommendations: The Board is recommended to: **Note** the paper and latest position for information.

Our Vision
The best care for every patient

Integrated Performance Report:

Norfolk and Norwich University Hospitals
NHS Foundation Trust

Performance & Activity Domains

September 2023

Key 2023-24 Operational Priorities

- Urgent and Emergency Care: –
  - A&E Waiting Times – '*Improve A&E waiting times so that no less than 76% of patients are seen within 4 hours by March 2024 with further improvement in 2024/25*': **On Track – Sustained delivery since January 2023.**
  - Increase Ambulance handover delays under 30 minutes – '*Reduce handover delays to support the management of clinical risk across the system*': **Off Track – Ambulance handovers continue to be off track. A Taskforce has been created to increase awareness and focus on 3 areas: A) ED to assessment, B) Assessment to Ward, C) Earlier Discharge. We are working with colleagues at EEAST to generate additional discharges before midday to improve patient waiting times. The ambition is to have significant improvement within 6 weeks.**
  - Bed occupancy – '*Reduce adult general and acute (G&A) bed occupancy to 92% or below*': **Off Track – It is unlikely that bed occupancy will reduce to pressure on both alternative and non-elective beds. The original plan included 22 additional NANOC beds and running Cringleford (20) and Gunthorpe (28) empty (70 of 1000). None of these beds are available in the calculation.**
- Elective Care: –
  - 65 Week Waits – '*Eliminate waits of over 65 weeks for elective care by March 2024 (except where patients choose to wait longer or in specific specialties)':* **Off Track – Industrial Action has significantly reduced the run rate of 65 week activity before, during and after periods of IA. The original forecast of 900 patients waiting over 65 weeks on 31st March 2024 is currently forecast to be circa 2,300.**
  - Day Cases – '*Meet the 85% day case expectations using GIRFT and moving procedures to the most appropriate setting*': **On Track**
  - Theatre Utilisation – '*Meet the 85% theatre utilisation expectations, using GIRFT and moving procedures to the most appropriate settings*': **Off Track – September performance reduced by 0.4% compared to August. Flow around elective areas including PACU, ITU and wards has presented challenges to session utilisation through late starts.**
  - Outpatient follow-ups – '*Deliver an appropriate reduction in outpatient follow-up (OPFU) in line with the national ambition to reduce OPFU activity by 25% against the 2019/20 baseline by March 2024*': **Off Track – Improvements in September but remain behind the target of 75%. Meetings have been undertaken with Divisions and individual specialties to discuss the future management of patients over 12 months past their follow up target date.**

Key 2023-24 Operational Priorities

- Cancer: –
  - 62 day Backlog – '*Continue to reduce the number of patients waiting over 62 days*': **Off Track – Fair Shares Requirement was to have no more than 225 patients waiting over 62 days by 31st March 2024. The Trust are currently 270 away from this. This is predominantly from 152 patients within Skin, 44 within Gynaecology and 67 within Lower GI. The main reasons for this are detailed below.**
    - **Skin – Summer increase in referrals coupled with Industrial Action and competing priorities against achieving the 78 week objective.**
    - **Gynaecology – Theatre capacity for GA Hysteroscopy and treatments, increased referrals into the Post Menopausal Bleeding service.**
    - **Lower GI – Capacity issues for CTC and Endoscopy.**

    Trajectories for the end of December 2023 are for each body site to have achieved their individual Fair Shares Requirement following several interventions within Skin, Lower GI and Gynaecology, as detailed within the pack.

  - 28-Day Faster Diagnosis Standard – '*Meet the Cancer Faster Diagnosis Standard by March 2024 so that 75% of patients who have been urgently referred by their GP for suspected Cancer are diagnosed or have Cancer ruled out within 28 days':* **Off Track – Currently the Trust is not meeting this standard due to under performance in Skin, Gynaecology, Lower GI (for reasons above) and Breast. Breast is experiencing a peak in referrals pushing first appointment wait (one stop service) beyond 28 days. Additional activity in October and November will recover the position. Following the interventions, the trajectory is for the target to be achieved by the end of December 2023.**

  - Lower GI Referrals with a FIT Test – '*Implement and maintain priority pathway changes for lower GI (at least 80% of FDS lower GI referrals are accompanied by a FIT result), skin (Teledermatology) and prostate cancer (best practice timed pathway)':* **On Track.**

- Diagnostics: –
  - Diagnostic Test Within 6 Weeks – '*Increase the percentage of patients that receive a diagnostic test within 6 weeks in line with the March 2025 ambition of 95%':* **Off Track – working towards 95% target in CT, MRI, Ultrasound and Echo by March 2025.**

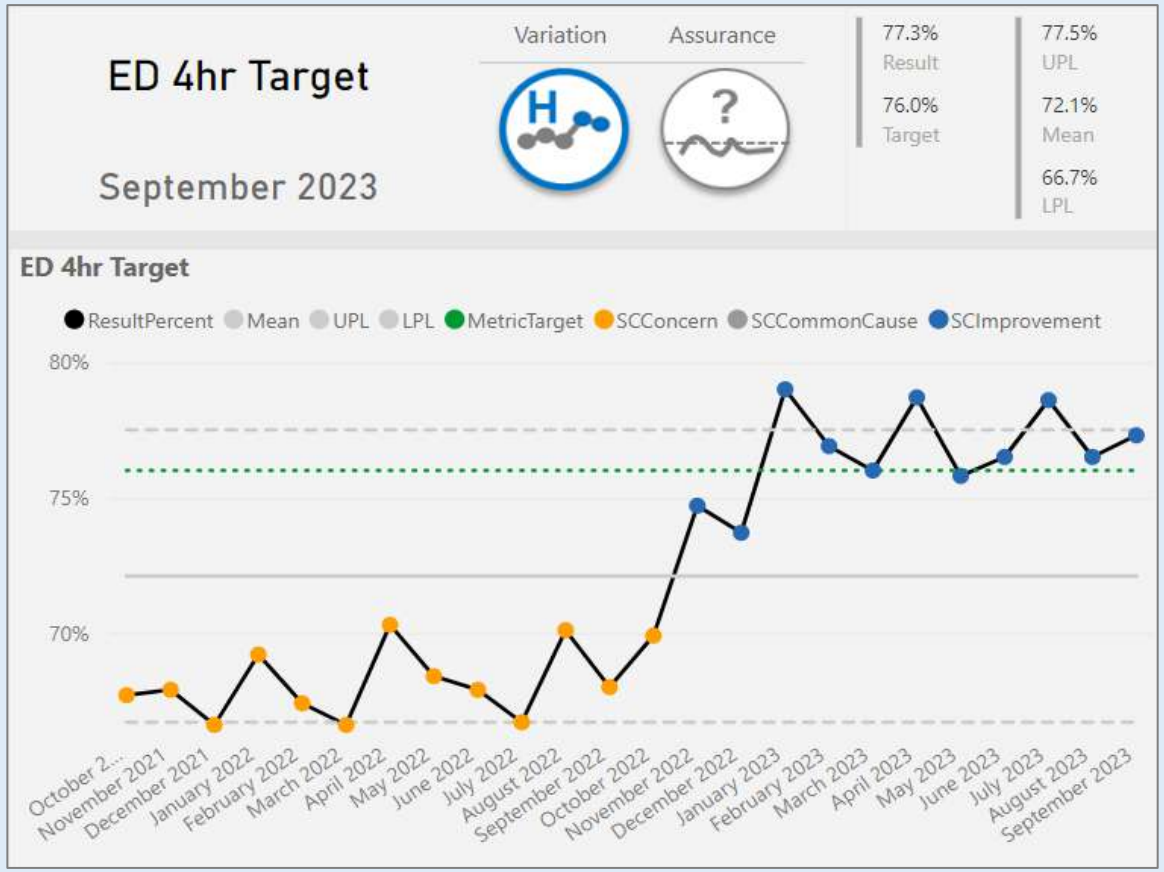
Urgent and Emergency Care

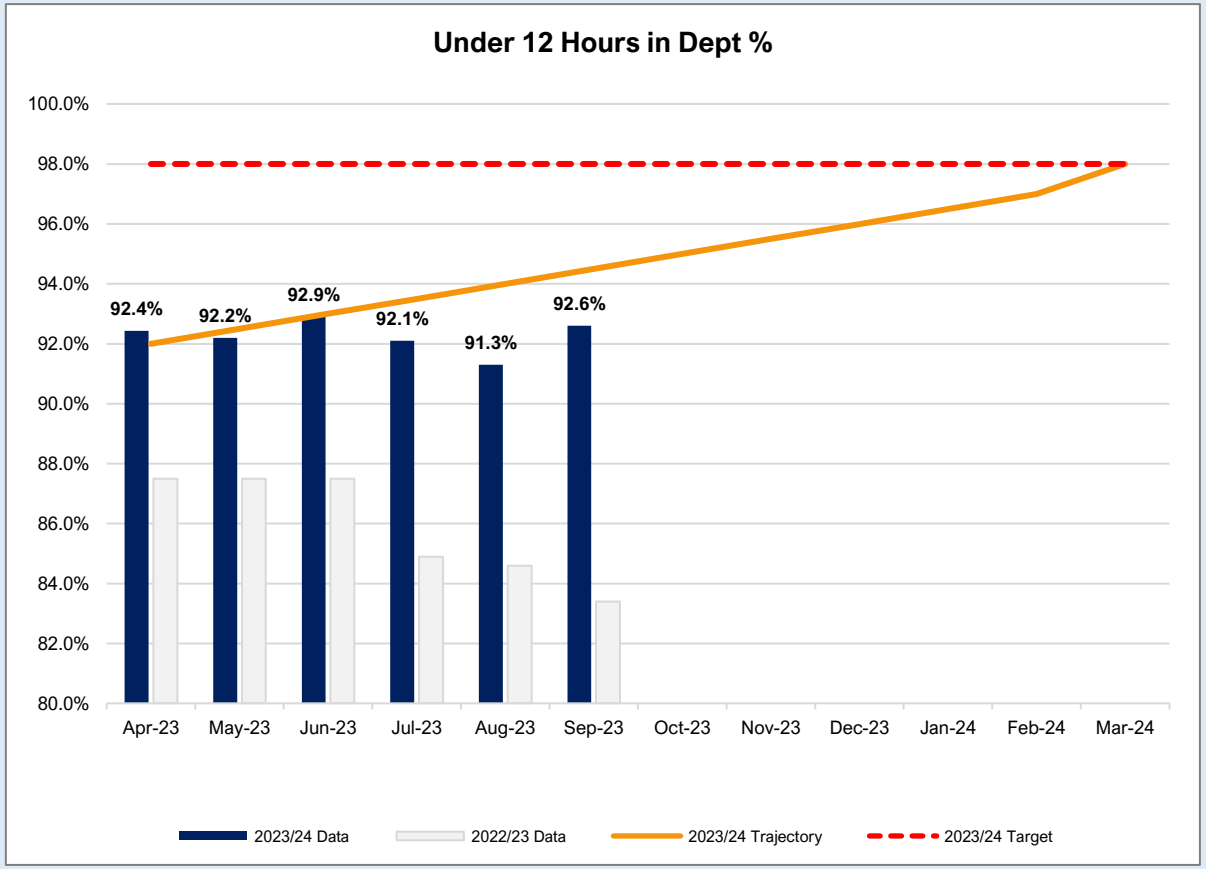
Performance – ED Waiting Times

Commentary

The overall position reflects the extremely challenging situation with the trust remaining in OPEL 4 status in September. Improved ED 4 hour performance compared to August: **Trust only = 60.5% / WIC = 99.9% / Combined = 77.3%.**

The chart below details the 23/24 monthly performance for the percentage of patients that spend less than 12 hours in ED at NNUH. For September, performance increased compared to August, but remains behind trajectory for the year.

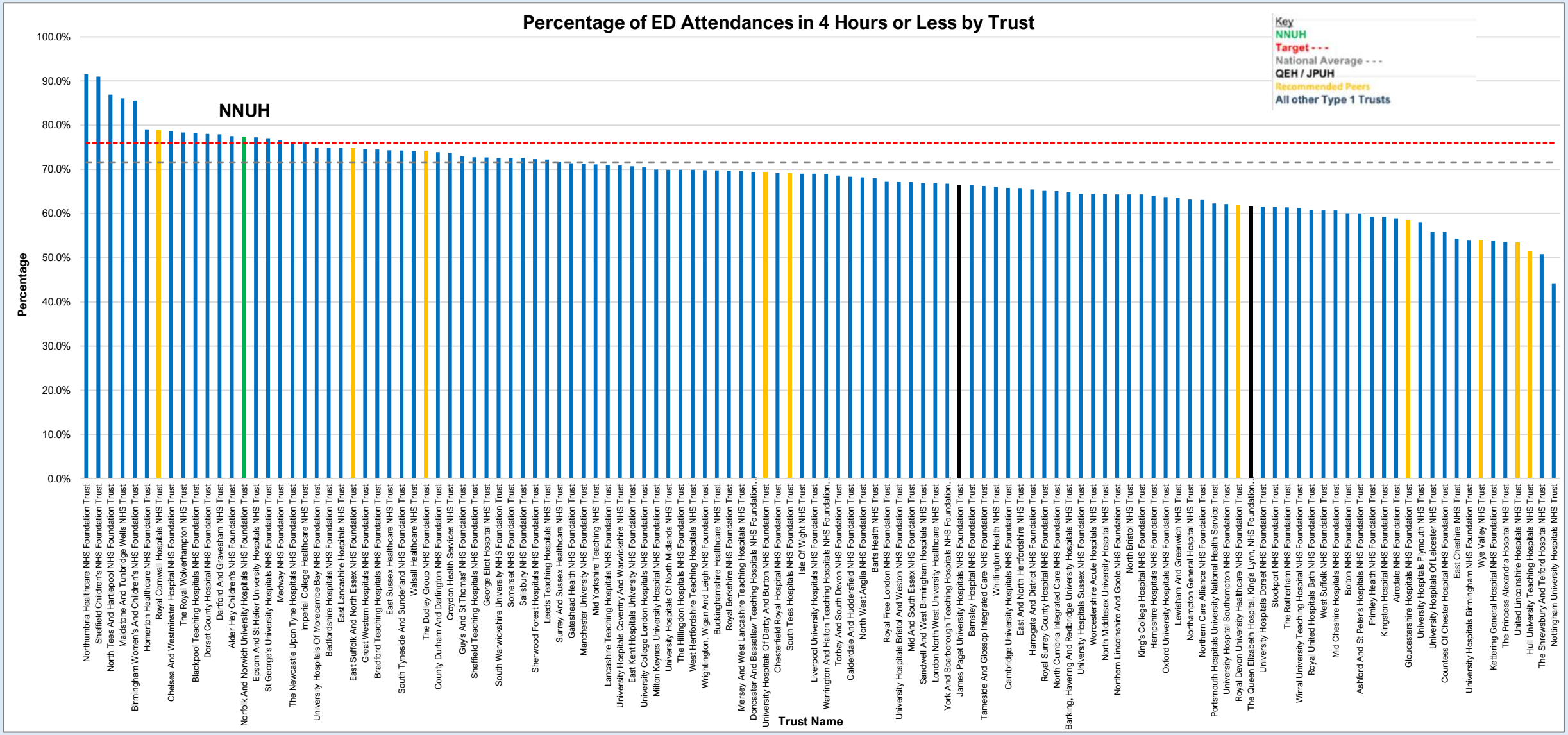




Our Vision
The best care for every patient

ED Waiting Times <4 hours – National Position (August 2023)

NHS
Norfolk and Norwich University Hospitals
NHS Foundation Trust

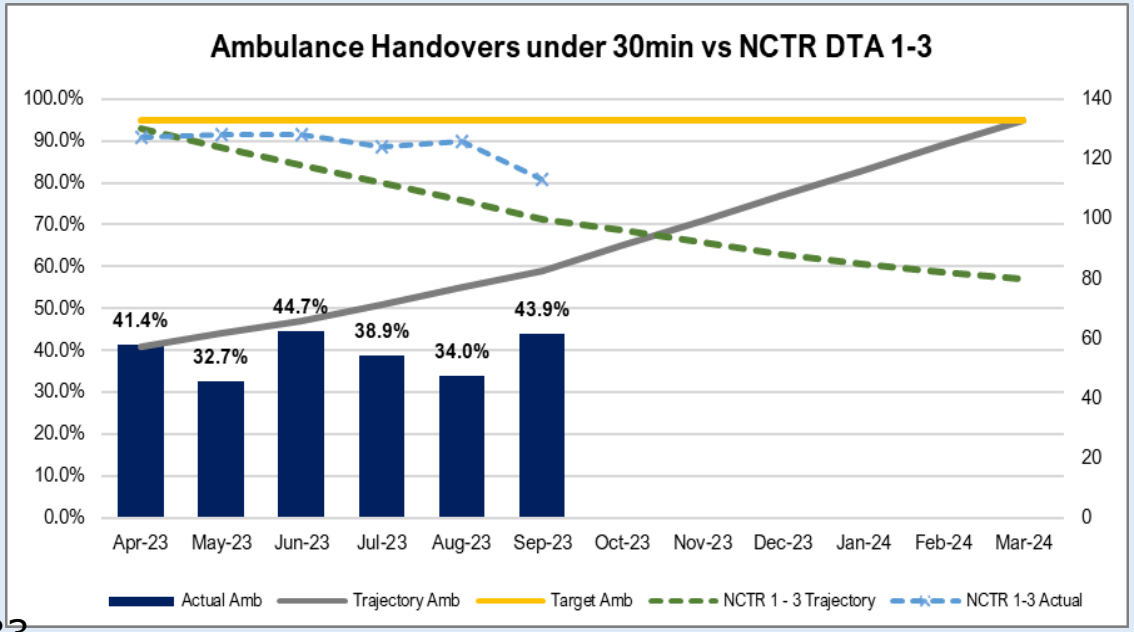


Commentary

In August, NNUH were ranked 14th across all Type 1 NHS Trusts and the second best performing amongst our recommended peers (for most similar attributes), with 77.3% of ED patients either admitted, transferred or discharged within 4 hours of arrival. This is an improvement on the previous month (76.5%), ahead of the national target of 76%, and the national average of 71.6%.

Performance – Ambulance Performance < 30 Minutes

Hospital Name	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Total
Addenbrookes Hospital	79.01%	65.64%	87.17%	62.39%	87.22%	92.57%	86.95%	93.34%	98.54%	97.64%	99.31%	95.92%	98.30%	88.00%
Basildon & Thurrock Hospital	47.10%	39.49%	47.93%	38.53%	58.16%	54.17%	59.44%	70.33%	74.18%	79.41%	84.79%	81.15%	88.18%	63.30%
Bedford Hospital South Wing	85.42%	87.86%	87.40%	76.62%	86.07%	94.21%	89.11%	96.84%	96.69%	91.98%	97.77%	97.31%	94.84%	90.93%
Broomfield Hospital	59.28%	51.90%	59.34%	32.11%	60.84%	61.95%	73.86%	87.42%	91.19%	87.42%	84.80%	76.99%	78.17%	69.64%
Colchester General Hospital	68.85%	37.67%	39.48%	44.83%	78.06%	81.59%	48.04%	85.30%	91.02%	81.15%	89.91%	72.21%	84.89%	69.46%
Hinchingbrooke Hospital	78.10%	74.66%	85.88%	61.42%	81.96%	81.67%	78.47%	87.60%	87.97%	91.24%	92.67%	93.47%	91.61%	83.59%
Ipswich Hospital	71.34%	52.89%	62.46%	48.21%	67.83%	67.35%	64.22%	73.41%	75.60%	69.37%	76.96%	76.83%	74.91%	67.80%
James Paget Hospital	32.98%	26.39%	38.08%	26.01%	43.36%	42.75%	43.40%	67.25%	56.43%	69.14%	79.86%	51.68%	48.67%	48.15%
Lister Hospital	23.62%	18.90%	22.97%	21.70%	43.06%	42.02%	38.36%	51.42%	43.52%	43.32%	62.68%	51.62%	49.64%	39.45%
Luton And Dunstable Hospital	73.31%	68.50%	72.68%	62.21%	71.24%	76.04%	65.36%	73.35%	70.38%	69.31%	70.04%	68.68%	68.15%	69.94%
Norfolk & Norwich University Hospital	28.24%	21.32%	33.38%	31.18%	39.62%	35.55%	22.75%	40.44%	41.40%	32.70%	44.70%	38.90%	34.00%	34.17%
Peterborough City Hospital	46.09%	41.79%	45.15%	33.41%	47.91%	58.64%	50.39%	56.88%	62.27%	69.74%	65.25%	70.48%	63.36%	54.72%
Princess Alexandra Hospital	36.58%	34.84%	31.81%	32.72%	48.60%	38.63%	37.81%	60.43%	50.86%	52.66%	48.27%	45.06%	44.36%	43.28%
Queen Elizabeth Hospital	42.15%	30.68%	34.81%	27.29%	41.08%	53.83%	41.57%	62.29%	47.58%	45.01%	55.33%	49.14%	47.68%	44.50%
Southend University Hospital	41.49%	37.74%	37.92%	30.34%	58.64%	71.57%	64.10%	74.19%	65.77%	61.10%	67.36%	80.62%	86.11%	59.77%
Watford General Hospital	48.18%	39.27%	39.31%	38.06%	48.16%	56.21%	55.89%	59.29%	72.22%	77.57%	76.10%	69.97%	70.81%	57.77%
West Suffolk Hospital	86.85%	70.12%	68.04%	57.05%	73.26%	70.94%	68.21%	91.57%	92.28%	93.24%	93.59%	87.59%	82.53%	79.64%
Total	**55.80%**	**47.04%**	**52.58%**	**42.59%**	**60.89%**	**63.51%**	**58.11%**	**72.43%**	**71.64%**	**71.29%**	**75.85%**	**71.04%**	**70.95%**	**62.59%**



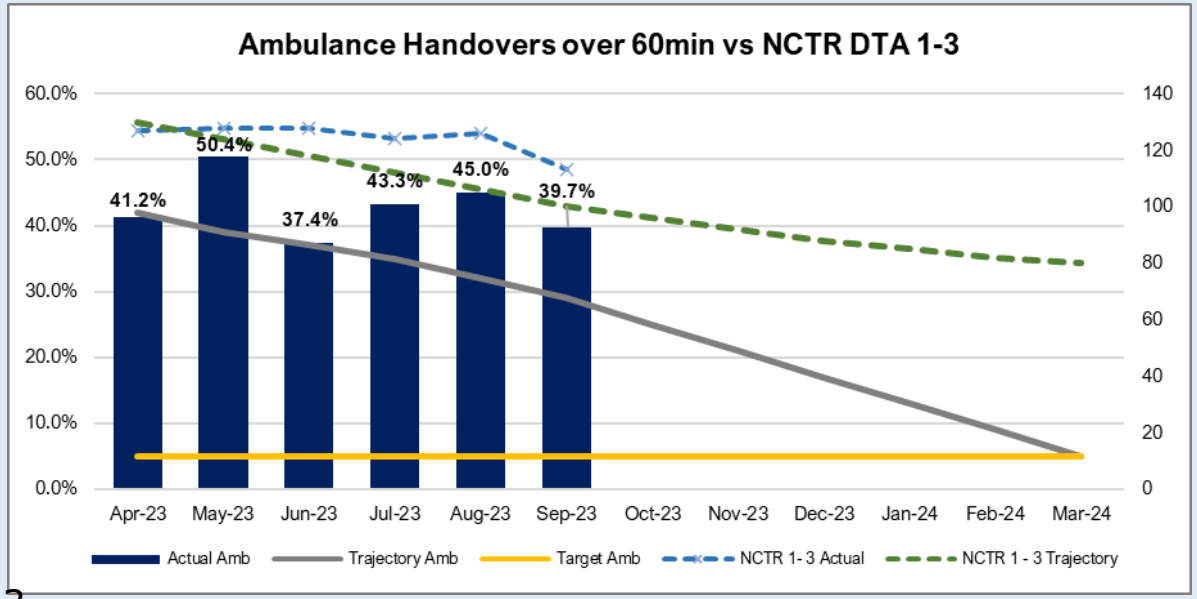
Commentary

Ranking 17th in the region from September 2022 to September 2023 and for the month (September 2023). Improved performance from August.

An Ambulance Taskforce has been created with the aim for no patients to wait longer than 45 minutes in an ambulance by 31st December and no patient on an admitted pathway to wait longer than 1 hour by 1st November.

Performance – Ambulance Performance > 60 Minutes

Hospital Name	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Total
Addenbrookes Hospital	8.09%	16.56%	1.78%	23.49%	3.23%	1.16%	3.90%	1.21%	0.00%	0.08%	0.00%	0.73%	0.24%	4.13%
Basildon & Thurrock Hospital	32.00%	38.30%	28.24%	35.35%	21.18%	25.23%	22.86%	12.90%	9.25%	6.64%	3.01%	6.61%	2.58%	16.85%
Bedford Hospital South Wing	6.74%	4.71%	5.55%	14.15%	6.90%	1.96%	6.27%	1.24%	0.48%	2.67%	0.56%	0.67%	1.52%	4.01%
Broomfield Hospital	21.05%	27.88%	18.72%	42.52%	18.41%	15.41%	7.35%	5.20%	1.96%	3.61%	4.53%	7.64%	5.99%	12.84%
Colchester General Hospital	14.08%	40.32%	40.97%	32.36%	5.88%	8.71%	35.91%	3.33%	1.56%	9.50%	3.22%	11.21%	3.81%	13.96%
Hinchingbrooke Hospital	8.07%	9.55%	4.94%	25.19%	9.56%	8.00%	11.26%	4.35%	4.83%	2.40%	2.49%	1.55%	3.65%	7.13%
Ipswich Hospital	14.30%	29.08%	21.33%	32.78%	15.30%	16.19%	18.60%	10.99%	10.45%	14.82%	8.06%	7.97%	10.59%	15.43%
James Paget Hospital	46.15%	58.01%	41.43%	57.11%	34.73%	29.86%	35.47%	16.35%	26.33%	15.14%	9.11%	31.34%	34.58%	31.77%
Lister Hospital	47.23%	52.55%	50.60%	52.81%	26.91%	29.71%	32.97%	19.62%	25.98%	26.58%	10.45%	17.85%	22.78%	29.35%
Luton And Dunstable Hospital	10.43%	16.83%	11.35%	22.29%	12.00%	7.72%	17.21%	8.60%	11.49%	12.05%	10.97%	11.53%	11.78%	12.51%
Norfolk & Norwich University Hospital	53.18%	62.66%	49.94%	57.00%	44.79%	48.47%	63.57%	41.20%	50.40%	37.40%	43.30%	45.00%	39.70%	48.97%
Peterborough City Hospital	20.52%	26.14%	21.47%	33.88%	21.11%	11.98%	16.74%	11.86%	12.01%	9.09%	8.51%	7.07%	10.79%	15.53%
Princess Alexandra Hospital	35.15%	34.84%	39.22%	40.68%	24.84%	36.81%	39.94%	16.60%	23.65%	22.42%	25.20%	26.70%	27.85%	29.30%
Queen Elizabeth Hospital	42.77%	56.08%	52.11%	60.07%	43.43%	28.94%	42.99%	20.94%	37.80%	37.60%	28.28%	33.99%	34.65%	38.91%
Southend University Hospital	38.05%	40.32%	37.15%	47.13%	20.00%	11.08%	13.29%	7.45%	13.20%	12.82%	10.32%	6.04%	2.75%	16.48%
Watford General Hospital	23.50%	28.96%	32.07%	31.84%	18.29%	12.43%	18.40%	12.72%	4.04%	2.20%	2.25%	4.61%	4.28%	12.21%
West Suffolk Hospital	4.66%	14.11%	15.64%	23.10%	12.68%	13.75%	16.04%	0.18%	0.99%	0.59%	0.65%	1.94%	4.13%	7.81%
Total	**23.77%**	**32.76%**	**27.79%**	**37.16%**	**19.96%**	**18.08%**	**23.69%**	**11.46%**	**13.79%**	**12.68%**	**10.05%**	**13.09%**	**13.04%**	**18.66%**



Commentary

Ranking 17th in the region from September 2022 to September 2023 and for the most recent month (September 2023). Improved performance from August.

An Ambulance Taskforce has been created with the aim for no patients to wait longer than 45 minutes in an ambulance by 31st December and no patient on an admitted pathway to wait longer than 1 hour by 1st November.

45 Minute Ambulance Taskforce

ED to assessment

No patient to wait in ambulance longer than 45min

No patient on admitted pathway to wait longer than 1 hr

- Pull model to assessment/SDEC
- GP direct admissions – alternative route
- Alternatives: Virtual ward for adults /hot clinics
- Medical SDEC: 24/7 , demand and capacity model ringfence bay 8, dedicated team, Imaging solution

Assessment to ward

Create flow from AMU to wards which support delivery of objectives in box 1

- Morning report: leadership allocation of patients to specialties
- AMU – operating model to be revised and consistent application and delivery of IPS (Sr triage)
- Frequent triage, live triage lists, articulation of operating model

Earlier Discharge

30% of all patients to be discharged before noon 7 days a week

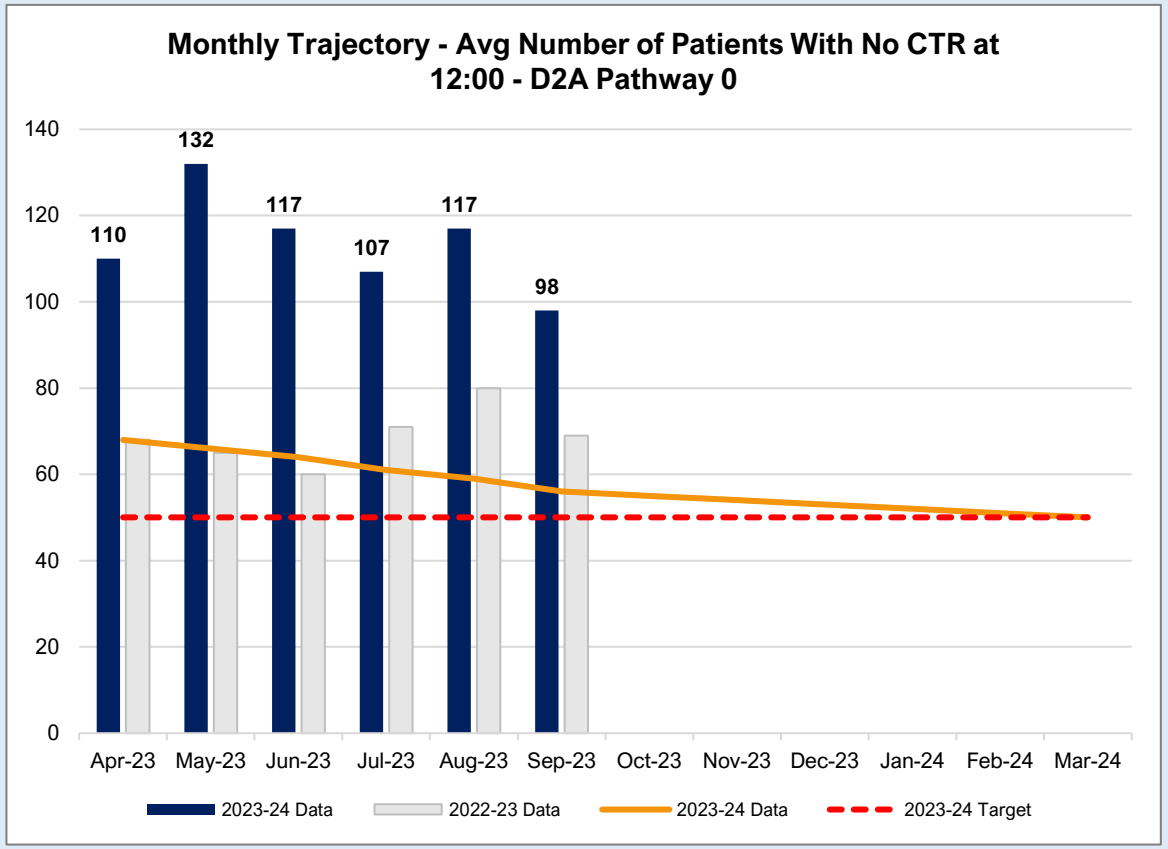
- Wards to provide daily confirmation of discharges for the following day
- Revise red to green – use performance metrics
- Criteria led discharges/clear discharge plans Senior decision making - right support and training for staff
- TTOs, bloods and transport issues to be addressed – day before

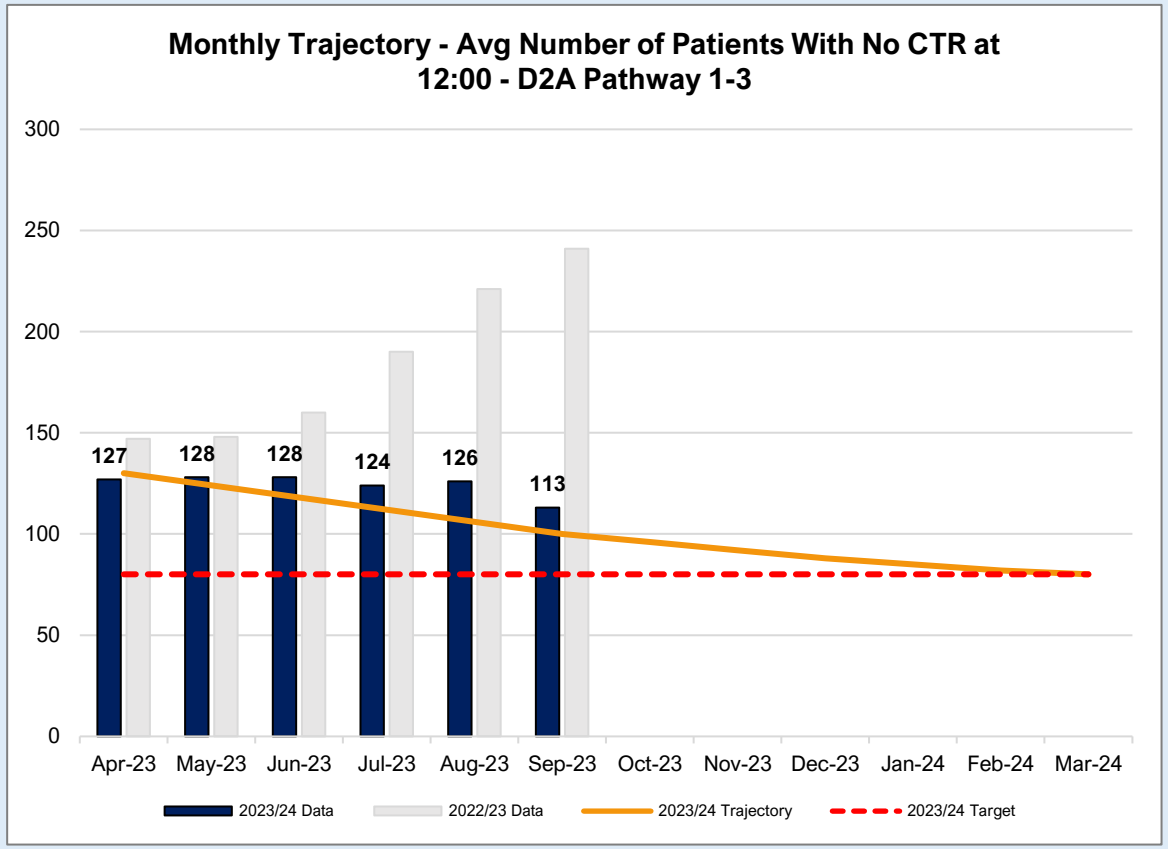
Trust wide action

No patient to wait in an ambulance

- Reset the narrative
  Staff development and training, celebrate success
- Internal professional standards – revised and accepted, used and monitored
- Diagnostic revised internal sla (imaging and pathology)

No Criteria to Reside





Commentary

Both No Criteria to Reside D2A Pathways 0 (P0) and Pathways 1-3 (P1-3) for September has reduced from August but remains behind trajectory. The sustained improvement against the same month of 22/23 continued on D2A pathways 1-3. The Trust is now in a position to improve flow without additional community interventions.

Virtual Ward Activity

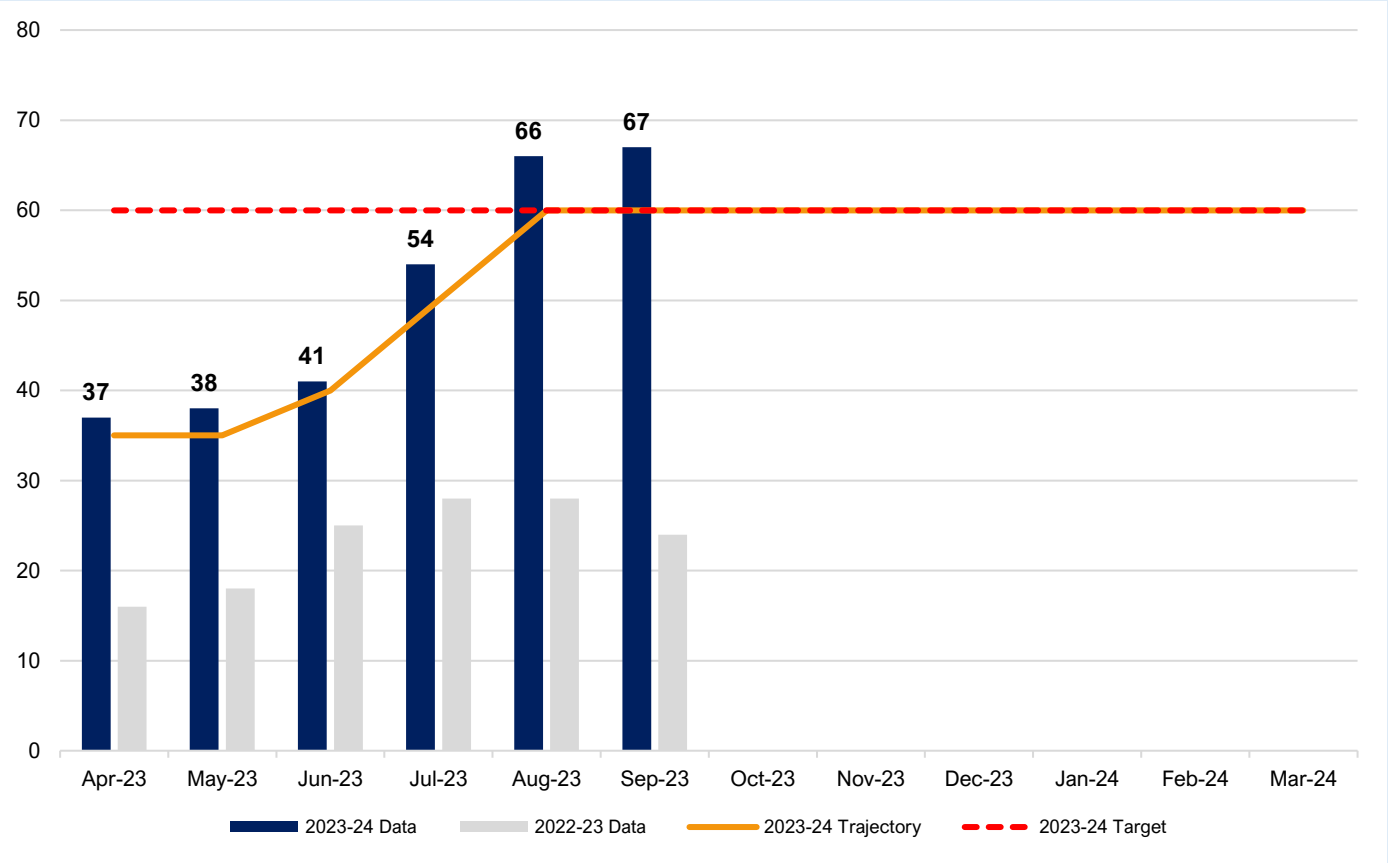
Our Vision
The best care for every patient

Norfolk and Norwich University Hospitals
NHS Foundation Trust

Commentary

September 2023 Performance

In September, the average number of patients on the Virtual Ward was 67, compared to 66 in August and remaining above the target of 60.



Elective Care

Performance – RTT 78-Week Breaches

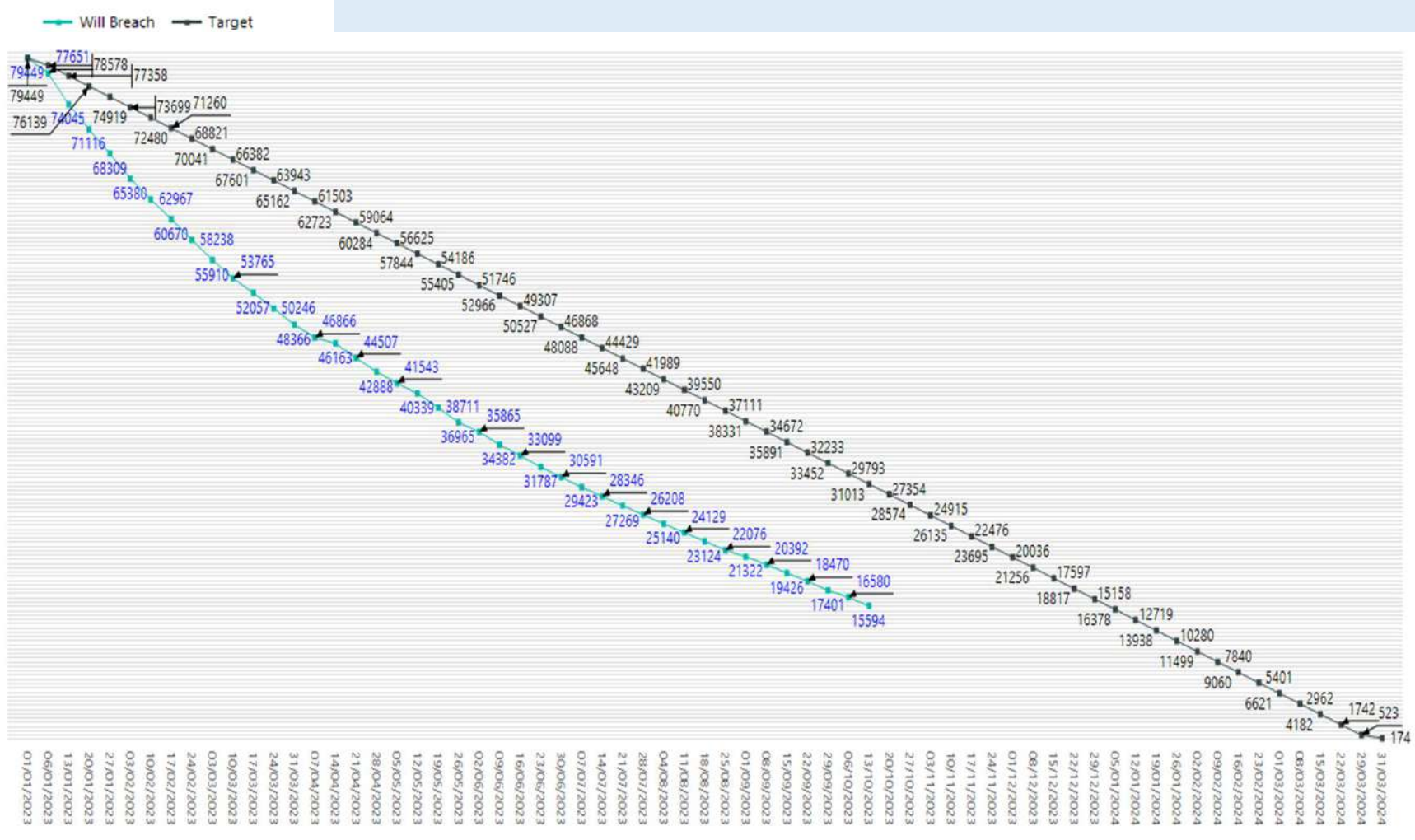
No TCI, TCI booked after deadline, or a provisional TCI booked	Intended Management				Grand Total
Specialty (Top 10)	New	Follow up	Day Case	Inpatient	
502 - Gynaecology	1	6	94	66	167
110 - Trauma and Orthopaedic	1	11	55	77	144
108 - Spinal Surgery	1	26	8	7	42
130 - Ophthalmology	0	1	41	0	42
100 - General Surgery	0	18	9	11	38
160 - Plastic Surgery	3	7	13	12	35
330 - Dermatology	1	11	13	0	25
120 - Ear Nose and Throat	0	7	6	6	19
216 - Paediatric Ophthalmology	0	0	13	0	13
215 - Paediatric Ear Nose and Throat	0	2	2	2	6
Other Combined	5	4	3	5	17
Grand Total	**12**	**93**	**257**	**186**	**548**

As of 17th October, there are 548 patients due to become 78 Week breaches by 1st November. These are patients with the criteria of no TCI, with a TCI but booked after 31st October or only a provisional TCI booked. The table above highlights the 10 specialties with the highest number of patients that meet this criteria. Of the 548 breaches, 314 patients have no TCI. The other 234 patients have a TCI booked after 31st October or only a provisional TCI booked.

There was 12% less 78 Week activity on Industrial Action dates in October based on historic activity on the same day of the week.

The overall impact on the 65-week position is much greater with 40% less activity on Industrial Action dates in September (71 inpatients and 288 Outpatients).

Performance – RTT 65-Week Breaches



Commentary

For the overarching requirement of 65 week delivery by 31st March 2024, delivery is ahead of trajectory at a Trust level, with 15,594 patients remaining in the cohort against a target of 29,793.

NNUH's planning submission predicted 900 breaches. However, the impact of Industrial Action has increased the forecast number of breaches on 1st April 2024 to 2,348.

Recovery actions:

1) Go Further Faster
2) Additional IS in Q3
3) DMAS / PIDMAS
4) Additional Theatres from December 2023.

Our Vision
The best care for every patient

Performance – RTT 65-Weeks (Specialty Level Forecast)

NHS
Norfolk and Norwich University Hospitals
NHS Foundation Trust

Specialty		Weekly Averages	25/08/2023 (Industrial Action)	01/09/2023 (Public Holiday)	08/09/2023	15/09/2023	22/09/2023 (Industrial Action)	29/09/2023	06/10/2023 (Industrial Action)	13/10/2023	20/10/2023	27/10/2023	03/11/2023	10/11/2023	17/11/2023	24/11/2023	01/12/2023	08/12/2023	15/12/2023	22/12/2023 (Public Holiday)	29/12/2023 (Public Holiday)	05/01/2024 (Public Holiday)	12/01/2024 (IS Funds Expire)	19/01/2024	26/01/2024	02/02/2024	09/02/2024	16/02/2024	23/02/2024	01/03/2024	08/03/2024	15/03/2024	22/03/2024	31/03/2024 (Public Holiday)
110 - Trauma and Orthopaedic	Starting Cohort	-	9,387	9,387	9,387	9,387	9,387	9,387	9,387	9,387	9,387	9,387	9,387	9,387	9,387	9,387	9,387	9,387	9,387	9,387	9,387	9,387	9,387	9,387	9,387	9,387	9,387	9,387	9,387	9,387	9,387	9,387	9,387
	Will Breach	-	3,953	3,827	3,715	3,584	3,459	3,341	3,211	3,073	2,947	2,822	2,696	2,570	2,445	2,319	2,193	2,068	1,942	1,892	1,841	1,791	1,729	1,667	1,605	1,543	1,481	1,419	1,357	1,295	1,233	1,171	1,109	1,065
	Weekly Removals	126	129	126	112	131	125	118	130	138	126	126	126	126	126	126	126	126	126	50	50	50	62	62	62	62	62	62	62	62	62	62	62	43
	Target	128	4,529	4,385	4,241	4,097	3,952	3,808	3,664	3,520	3,376	3,232	3,088	2,944	2,800	2,656	2,511	2,367	2,223	2,079	1,935	1,791	1,647	1,503	1,359	1,215	1,070	926	782	638	494	350	206	21
	Difference	-	-576	-558	-526	-513	-493	-467	-453	-447																								
	Future TCIs	567									121	121	101	92	56	39	37																
	Provisional TCIs	8									2	0	1	1	2	1	1																
330 - Dermatology	Starting Cohort	-	8,153	8,153	8,153	8,153	8,153	8,153	8,153	8,153	8,153	8,153	8,153	8,153	8,153	8,153	8,153	8,153	8,153	8,153	8,153	8,153	8,153	8,153	8,153	8,153	8,153	8,153	8,153	8,153	8,153	8,153	8,153
	Will Breach	-	2,916	2,877	2,808	2,724	2,676	2,582	2,490	2,389	2,312	2,235	2,158	2,081	2,004	1,927	1,850	1,773	1,696	1,665	1,634	1,604	1,527	1,450	1,373	1,296	1,219	1,142	1,065	988	911	834	757	703
	Weekly Removals	77	91	39	69	84	48	94	92	101	77	77	77	77	77	77	77	77	77	31	31	31	77	77	77	77	77	77	77	77	77	77	77	54
	Target	100	3,933	3,808	3,683	3,558	3,433	3,308	3,183	3,057	2,932	2,807	2,682	2,557	2,432	2,306	2,181	2,056	1,931	1,806	1,681	1,556	1,430	1,305	1,180	1,055	930	805	679	554	429	304	179	18
	Difference	-	-1,017	-931	-875	-834	-757	-726	-693	-668																								
	Future TCIs	242									108	59	42	8	10	13	2																
	Provisional TCIs	1									1	0	0	0	0	0	0																
257 - Paediatric Dermatology	Starting Cohort	-	808	808	808	808	808	808	808	808	808	808	808	808	808	808	808	808	808	808	808	808	808	808	808	808	808	808	808	808	808	808	808
	Will Breach	-	390	386	373	366	363	353	348	339	332	325	318	311	304	297	290	283	276	273	270	268	261	254	247	240	233	226	219	212	205	198	191	186
	Weekly Removals	7	8	4	13	7	3	10	5	9	7	7	7	7	7	7	7	7	7	3	3	3	7	7	7	7	7	7	7	7	7	7	7	5
	Target	14	390	377	365	353	340	328	315	303	291	278	266	253	241	229	216	204	191	179	167	154	142	129	117	105	92	80	67	55	43	30	18	2
	Difference	-	0	9	8	13	23	25	33	36																								
	Future TCIs	28									4	16	5	3																				
	Provisional TCIs	0									0	0	0	0																				
160 - Plastic Surgery	Starting Cohort	-	2,358	2,358	2,358	2,358	2,358	2,358	2,358	2,358	2,358	2,358	2,358	2,358	2,358	2,358	2,358	2,358	2,358	2,358	2,358	2,358	2,358	2,358	2,358	2,358	2,358	2,358	2,358	2,358	2,358	2,358	2,358
	Will Breach	-	967	954	902	872	825	800	790	771	741	710	680	649	619	588	558	527	497	484	472	459	429	398	368	337	307	276	246	215	185	154	124	102
	Weekly Removals	31	52	13	52	30	47	25	10	19	31	31	31	31	31	31	31	31	31	12	12	12	31	31	31	31	31	31	31	31	31	31	31	22
	Target	32	1,138	1,101	1,065	1,029	993	957	920	884	848	812	776	739	703	667	631	595	558	522	486	450	414	377	341	305	269	233	197	160	124	88	52	5
	Difference	-	-171	-147	-163	-157	-168	-157	-130	-113																								
	Future TCIs	91									31	23	20	5	6	3	3																
	Provisional TCIs	40									11	12	6	6	4	1	0																
108 - Spinal Surgery	Starting Cohort	-	1,799	1,799	1,799	1,799	1,799	1,799	1,799	1,799	1,799	1,799	1,799	1,799	1,799	1,799	1,799	1,799	1,799	1,799	1,799	1,799	1,799	1,799	1,799	1,799	1,799	1,799	1,799	1,799	1,799	1,799	1,799
	Will Breach	-	829	804	780	740	703	663	635	602	569	536	503	470	437	404	371	338	305	292	279	265	251	237	223	209	195	181	167	153	139	125	111	102
	Weekly Removals	33	40	25	24	40	37	40	28	33	33	33	33	33	33	33	33	33	33	13	13	13	14	14	14	14	14	14	14	14	14	14	14	10
	Target	25	868	840	813	785	757	730	702	675	647	619	592	564	537	509	481	454	426	398	371	343	316	288	260	233	205	178	150	122	95	67	39	4
	Difference	-	-39	-36	-33	-45	-54	-67	-67	-73																								
	Future TCIs	119									30	27	29	11	6	12	4																
	Provisional TCIs	2									0	0	1	0	0	1	0																

Our Vision
The best care for every patient

Performance – RTT 65-Weeks (Specialty Level Forecast)

NHS
Norfolk and Norwich University Hospitals
NHS Foundation Trust

Specialty		Weekly Averages	25/08/2023 (Industrial Action)	01/09/2023 (Public Holiday)	08/09/2023	15/09/2023	22/09/2023 (Industrial Action)	29/09/2023	06/10/2023 (Industrial Action)	13/10/2023	20/10/2023	27/10/2023	03/11/2023	10/11/2023	17/11/2023	24/11/2023	01/12/2023	08/12/2023	15/12/2023	22/12/2023 (Public Holiday)	29/12/2023 (Public Holiday)	05/01/2024 (Public Holiday)	12/01/2024 (IS Funds Expire)	19/01/2024	26/01/2024	02/02/2024	09/02/2024	16/02/2024	23/02/2024	01/03/2024	08/03/2024	15/03/2024	22/03/2024	31/03/2024 (Public Holiday)
107 - Vascular Surgery	Starting Cohort	-	799	799	799	799	799	799	799	799	799	799	799	799	799	799	799	799	799	799	799	799	799	799	799	799	799	799	799	799	799	799	799
	Will Breach	-	137	124	123	120	118	115	115	109	107	104	102	99	97	94	92	89	87	86	85	84	81	79	76	74	71	69	66	64	61	59	56	54
	Weekly Removals	3	-2	13	1	3	2	3	0	6	3	3	3	3	3	3	3	3	3	1	1	1	3	3	3	3	3	3	3	3	3	3	3	2
	Target	5	385	373	361	349	336	324	312	300	287	275	263	251	238	226	214	202	189	177	165	152	140	128	116	103	91	79	67	54	42	30	18	2
	Difference	-	-248	-249	-238	-229	-218	-209	-197	-191																								
	Future TCIs	16									7	1	2	2	4																		
	Provisional TCIs	8									3	3	0	2	0																		
840 - Audiology	Starting Cohort	-	77	77	77	77	77	77	77	77	77	77	77	77	77	77	77	77	77	77	77	77	77	77	77	77	77	77	77	77	77	77	77	77
	Will Breach	-	36	43	42	55	70	62	65	72	71	70	69	68	67	66	65	64	63	62	61	60	59	58	57	56	55	54	53	52	51	50	49	48
	Weekly Removals	1	-3	-7	1	-13	-15	8	-3	-7	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
	Target	3	37	36	35	34	32	31	30	29	28	27	25	24	23	22	21	19	18	17	16	15	14	12	11	10	9	8	6	5	4	3	2	0
	Difference	-	-1	7	7	21	38	31	35	43																								
	Future TCIs	50									8	18	17	3	2	1	1																
	Provisional TCIs	0									0	0	0	0	0	0	0																
214 - Paediatric Trauma and Orthopaedic	Starting Cohort	-	623	623	623	623	623	623	623	623	623	623	623	623	623	623	623	623	623	623	623	623	623	623	623	623	623	623	623	623	623	623	623	623
	Will Breach	-	132	131	129	122	119	117	112	108	105	102	99	96	93	90	87	84	81	80	79	78	75	72	69	66	63	60	57	54	51	48	45	43
	Weekly Removals	3	6	1	2	7	3	2	5	4	3	3	3	3	3	3	3	3	3	1	1	1	3	3	3	3	3	3	3	3	3	3	3	2
	Target	5	301	291	281	272	262	253	243	234	224	214	205	195	186	176	167	157	148	138	128	119	109	100	90	81	71	61	52	42	33	23	14	1
	Difference	-	-169	-160	-152	-150	-143	-136	-131	-126																								
	Future TCIs	17									3	2	5		2	4	1																
	Provisional TCIs	0									0	0	0		0	0	0																
219 - Paediatric Plastic Surgery	Starting Cohort	-	251	251	251	251	251	251	251	251	251	251	251	251	251	251	251	251	251	251	251	251	251	251	251	251	251	251	251	251	251	251	251	251
	Will Breach	-	72	73	71	65	63	63	62	59	58	57	56	55	54	53	52	51	50	49	48	47	46	45	44	43	42	41	40	39	38	37	36	35
	Weekly Removals	1	2	-1	2	6	2	0	1	3	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
	Target	2	121	117	113	110	106	102	98	94	90	86	83	79	75	71	67	63	59	56	52	48	44	40	36	32	29	25	21	17	13	9	6	1
	Difference	-	-49	-44	-42	-45	-43	-39	-36	-35																								
	Future TCIs	6										4	0		2																		
	Provisional TCIs	7										5	2		0																		
143 - Orthodontic	Starting Cohort	-	291	291	291	291	291	291	291	291	291	291	291	291	291	291	291	291	291	291	291	291	291	291	291	291	291	291	291	291	291	291	291	291
	Will Breach	-	70	66	62	63	63	59	54	50	48	46	44	42	40	38	36	34	32	31	30	29	27	25	23	21	19	17	15	13	11	9	7	6
	Weekly Removals	2	3	4	4	-1	0	4	5	4	2	2	2	2	2	2	2	2	2	1	1	1	2	2	2	2	2	2	2	2	2	2	2	1
	Target	2	140	136	131	127	123	118	114	109	105	100	96	91	87	82	78	73	69	64	60	56	51	47	42	38	33	29	24	20	15	11	6	1
	Difference	-	-70	-70	-69	-64	-60	-59	-60	-59																								
	Future TCIs	23									7		5	3	6	2																	
	Provisional TCIs	0									0		0	0	0	0																	

Our Vision
The best care for every patient

Performance – RTT 65-Weeks (Specialty Level Forecast)

NHS
Norfolk and Norwich University Hospitals
NHS Foundation Trust

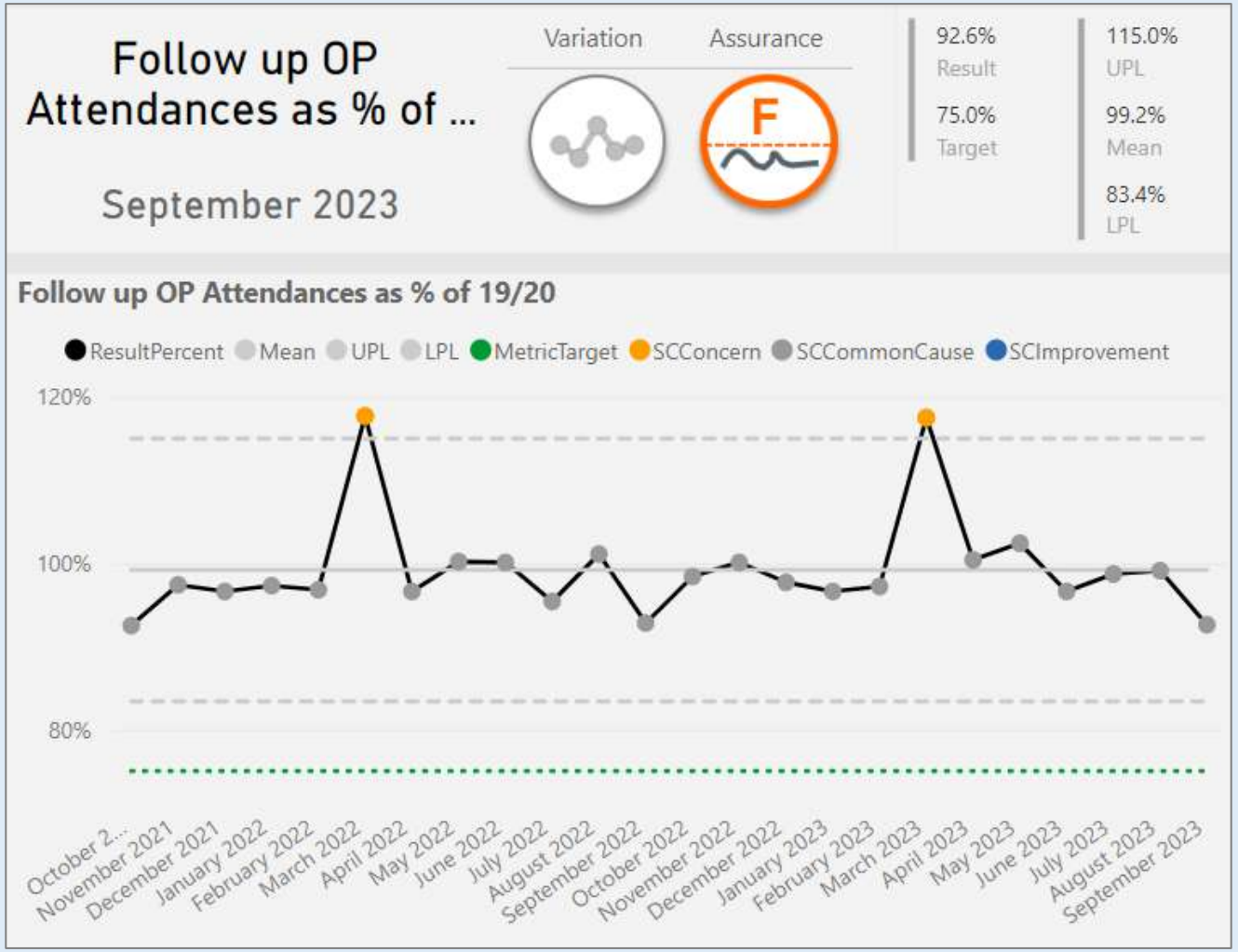
Specialty		Weekly Averages	25/08/2023 (Industrial Action)	01/09/2023 (Public Holiday)	08/09/2023	15/09/2023	22/09/2023 (Industrial Action)	29/09/2023	06/10/2023 (Industrial Action)	13/10/2023	20/10/2023	27/10/2023	03/11/2023	10/11/2023	17/11/2023	24/11/2023	01/12/2023	08/12/2023	15/12/2023	22/12/2023 (Public Holiday)	29/12/2023 (Public Holiday)	05/01/2024 (Public Holiday)	12/01/2024 (IS Funds Expire)	19/01/2024	26/01/2024	02/02/2024	09/02/2024	16/02/2024	23/02/2024	01/03/2024	08/03/2024	15/03/2024	22/03/2024	31/03/2024 (Public Holiday)
310 - Audio Vestibular Medicine	Starting Cohort	-	43	43	43	43	43	43	43	43	43	43	43	43	43	43	43	43	43	43	43	43	43	43	43	43	43	43	43	43	43	43	43	43
	Will Breach	-	15	13	8	18	17	22	26	28	27	26	25	24	23	22	21	20	19	18	17	16	15	14	13	12	11	10	9	8	7	6	5	4
	Weekly Removals	1	8	2	5	-10	1	-5	-4	-2	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
	Target	1	21	20	19	19	18	17	17	16	15	15	14	13	13	12	12	11	10	10	9	8	8	7	6	6	5	4	4	3	2	2	1	0
	Difference	-	-6	-7	-11	-1	-1	5	9	12																								
	Future TCIs	21									6	3	7	4		1																		
	Provisional TCIs	0									0	0	0	0		0																		
502 - Gynaecology	Starting Cohort	-	7,045	7,045	7,045	7,045	7,045	7,045	7,045	7,045	7,045	7,045	7,045	7,045	7,045	7,045	7,045	7,045	7,045	7,045	7,045	7,045	7,045	7,045	7,045	7,045	7,045	7,045	7,045	7,045	7,045	7,045	7,045	7,045
	Will Breach	-	1,899	1,856	1,798	1,721	1,643	1,560	1,511	1,431	1,363	1,295	1,227	1,159	1,091	1,023	955	887	819	792	765	737	669	601	533	465	397	329	261	193	125	57	0	0
	Weekly Removals	68	82	43	58	77	78	83	49	80	68	68	68	68	68	68	68	68	68	27	27	27	68	68	68	68	68	68	68	68	68	68	68	48
	Target	60	3,399	3,291	3,183	3,074	2,966	2,858	2,750	2,642	2,534	2,426	2,317	2,209	2,101	1,993	1,885	1,777	1,669	1,560	1,452	1,344	1,236	1,128	1,020	912	803	695	587	479	371	263	154	15
	Difference	-	-1,500	-1,435	-1,385	-1,353	-1,323	-1,298	-1,239	-1,211																								
	Future TCIs	213									53	69	41	20	11	16	3																	
	Provisional TCIs	94									13	19	10	16	12	18	6																	
100 - General Surgery	Starting Cohort	-	5,482	5,482	5,482	5,482	5,482	5,482	5,482	5,482	5,482	5,482	5,482	5,482	5,482	5,482	5,482	5,482	5,482	5,482	5,482	5,482	5,482	5,482	5,482	5,482	5,482	5,482	5,482	5,482	5,482	5,482	5,482	5,482
	Will Breach	-	1,525	1,485	1,457	1,391	1,317	1,257	1,204	1,134	1,078	1,022	966	910	854	798	742	686	630	608	585	563	507	451	395	339	283	227	171	115	59	3	0	0
	Weekly Removals	56	61	40	28	66	74	60	53	70	56	56	56	56	56	56	56	56	56	22	22	22	56	56	56	56	56	56	56	56	56	56	56	39
	Target	47	2,645	2,561	2,477	2,392	2,308	2,224	2,140	2,056	1,972	1,887	1,803	1,719	1,635	1,551	1,467	1,383	1,298	1,214	1,130	1,046	962	878	793	709	625	541	457	373	289	204	120	12
	Difference	-	-1,120	-1,076	-1,020	-1,001	-991	-967	-936	-922																								
	Future TCIs	202									97	50	24	21	3	3	4																	
	Provisional TCIs	2									0	0	1	0	1	0	0																	
171 - Paediatric Surgery	Starting Cohort	-	1,082	1,082	1,082	1,082	1,082	1,082	1,082	1,082	1,082	1,082	1,082	1,082	1,082	1,082	1,082	1,082	1,082	1,082	1,082	1,082	1,082	1,082	1,082	1,082	1,082	1,082	1,082	1,082	1,082	1,082	1,082	1,082
	Will Breach	-	267	263	257	244	231	221	208	201	191	180	170	160	149	139	129	118	108	104	100	96	86	75	65	55	44	34	24	13	3	0	0	0
	Weekly Removals	10	14	4	6	13	13	10	13	7	10	10	10	10	10	10	10	10	10	4	4	4	10	10	10	10	10	10	10	10	10	10	10	7
	Target	8	522	505	489	472	456	439	422	406	389	373	356	339	323	306	289	273	256	240	223	206	190	173	157	140	123	107	90	74	57	40	24	2
	Difference	-	-255	-242	-232	-228	-225	-218	-214	-205																								
	Future TCIs	20									8	7	3	0	0	1	1																	
	Provisional TCIs	19									3	3	6	2	2	2	1																	
217 - Paediatric Oral and Maxillofacial Surgery	Starting Cohort	-	78	78	78	78	78	78	78	78	78	78	78	78	78	78	78	78	78	78	78	78	78	78	78	78	78	78	78	78	78	78	78	78
	Will Breach	-	49	50	48	48	43	43	39	38	36	34	32	30	28	26	24	22	20	19	18	17	15	13	11	9	7	5	3	1	0	0	0	0
	Weekly Removals	2	5	-1	2	0	5	0	4	1	2	2	2	2	2	2	2	2	2	1	1	1	2	2	2	2	2	2	2	2	2	2	2	1
	Target	2	38	36	35	34	33	32	30	29	28	27	26	24	23	22	21	20	18	17	16	15	14	12	11	10	9	8	7	5	4	3	2	0
	Difference	-	11	14	13	14	10	11	9	9																								
	Future TCIs	8										4	1	2	1	0																	
	Provisional TCIs	5										1	0	1	1	2																	

Assumptions:

Predicted Breaches: 2,348

1. 30% reduction in weeks of Public Holidays
2. 60% reduction at Xmas/New Year
3. IS activity at Spire ends 1st January 2024
4. No further Industrial Action

Performance – Follow Up Reduction



Commentary

September 2023 Performance

Trust wide performance for September has improved (from 99.1% in August to 92.6% in September), against the target of 75% of 2019/20 follow up activity.

Division	September 2023
Surgery	87.6%
Medicine	98.2%
Women and Children	103.1%
Clinical Support Services	81.7%

Improvement Actions

Following further analysis of the services by Divisions, with a view to reduce their follow up numbers to the levels detailed in their activity plans. DCSS and Women and Children's Divisions feel confident that they will achieve the 75% target by 31st March, but Surgery and Medicine Division do not believe that this will be possible due to the increased new activity and corresponding follow up activity required to achieve the 65 week ask.

Meetings have been undertaken with the COO/COD's/DOD's and specialty managerial and clinical teams to discuss how they intend to manage any patient that is over 12 months past their follow up target date. Divisions to focus on follow up backlog.

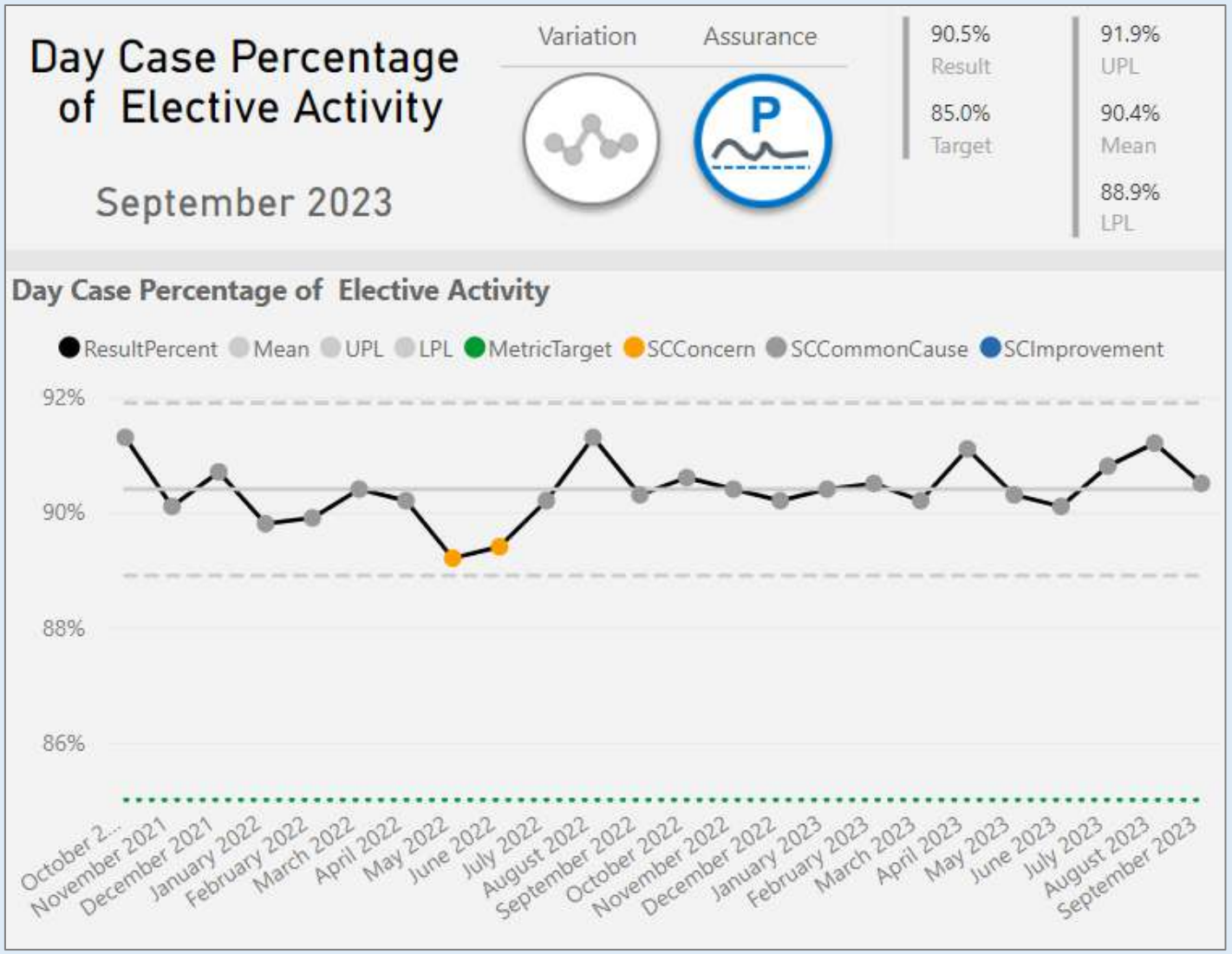
Follow up activity continues to be closely tracked through the weekly Elective Priorities Divisional meetings with focus on delivery against Commissioned targets.

Risk To Delivery

Due to the size of the follow up backlog and the focus on increased new appointments, it is unlikely that the Trust will achieve 75% of 2019/20 follow up activity.

RED

Performance – 85% Day Case



Commentary

September 2023 Performance

Despite the Industrial Action, the Trust has continuously achieved the 85% target, with significant activity rearranged at short notice. In September, NNUH delivered 90.5% of elective activity as day cases against the 85% target. This is a slight reduction from August (91.2%).

Risk To Delivery

GREEN

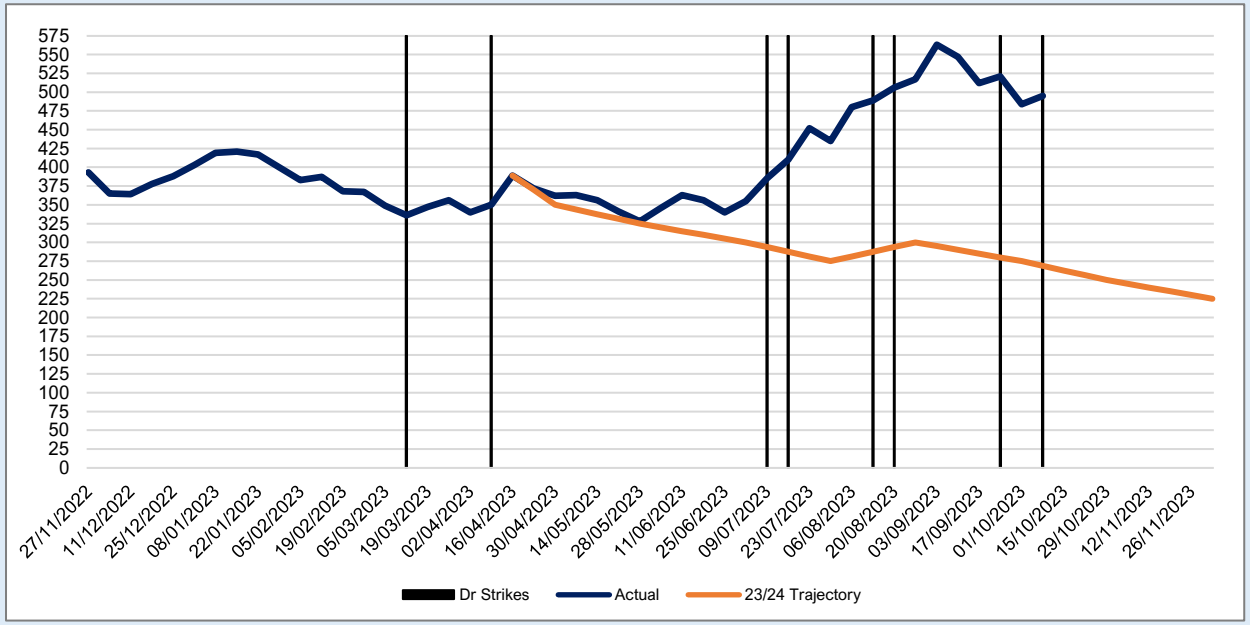
Cancer

Cancer – 62-Day Backlog Profile

Our Vision
The best care for every patient

Norfolk and Norwich University Hospitals
NHS Foundation Trust

62 Day Backlog – NNUH Actuals Vs Trajectory (w/e 8th October 2023)



Suspected Tumour Type	Number Past Day 62	Change in number past day 62 (1 week)	Change in number past day 62 (4 weeks)	Change in number past day 62 (12 weeks)
Skin	180	-10	-34	45
Gynaecology	80	9	-24	-20
Lower GI	101	1	20	49
Head and Neck	29	2	-9	12
Sarcoma	15	0	1	0
Children's	1	0	0	0
Other	1	0	-1	0
Brain	0	0	0	0
Haematology	2	0	-1	-3
Lung	5	1	2	-4
Upper GI	5	2	-1	-9
Breast	16	3	3	11
Urology	60	3	9	-13
All Suspected Cancers	495	11	-35	68

Commentary

September 2023 Performance

The 62-day backlog saw a net decrease of 37 during the week ending 1st October compared to the previous week – improving the Trust's Tier 1 position by 2 places to 5th. Week ending 8th October saw this rise by 11 patients to 495 on the backlog, however the last 4 weeks (up to 8th October) shows a reduction of 35 patients.

The largest contributors to the 62 day backlog are Skin, Gynaecology and Lower GI – further information and interventions to improve the backlog within these body sites are detailed on the following 2 slides.

Improvement Actions

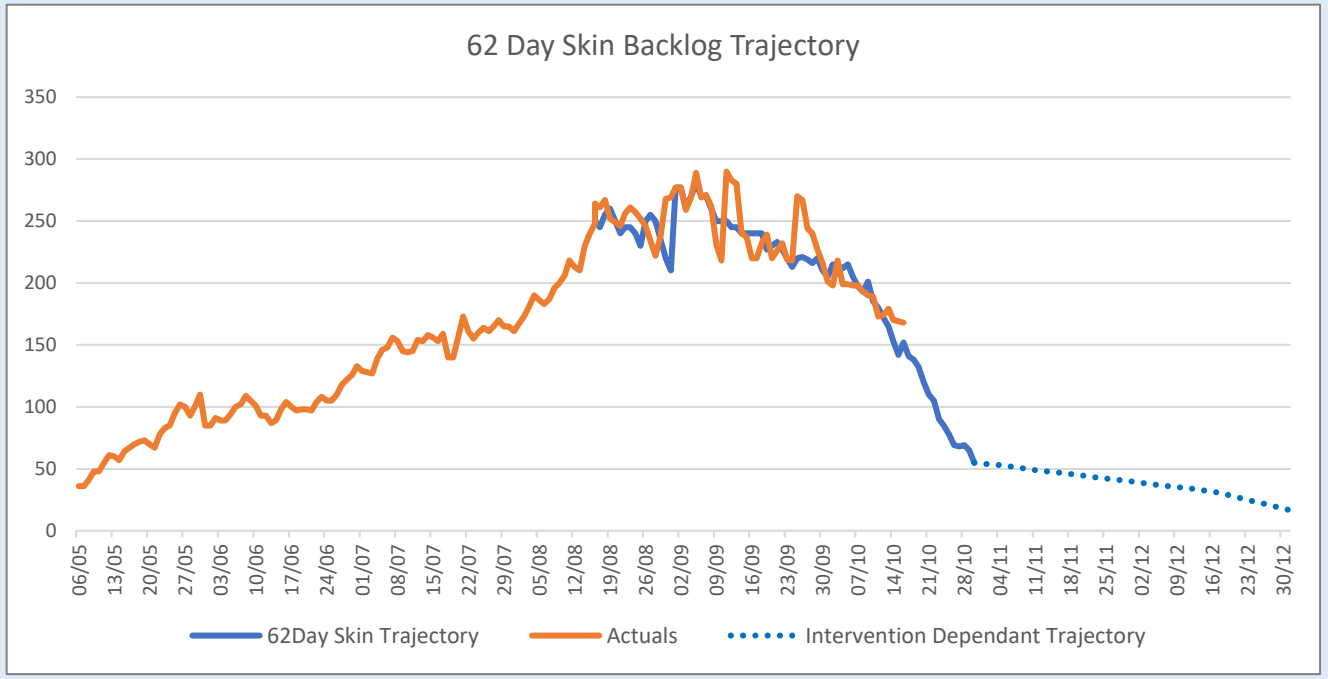
1. eDerma capacity increases from October 2023 – 7 additional eDerma nurse led clinics being set up (totalling 288 slots in October).
2. 12 additional 2ww WLI clinics secured for October 2023 (80 patients per clinic) within Skin.
3. 1000 outsourced cut samples and histology reporting is to be outsourced in November for Skin.
4. Multi-divisional taskforce to address internal pathway delays in Lower GI. Endoscopy and Radiology are main delays – funding required.
5. Gynaecology Medacs List on Weekends – November 5th – 10 weekends to EO year – using either 23/24 alliance underspend and/or successful regional bid.
6. Paediatric Theatres open 01/12/23 – All Gynaecology backfill lists to support Cancer Recovery
7. Increase outsourcing of Histopathology to match increased activity and improve turnaround times – 300 cases across Lower GI and Gynae

Risk To Delivery

There are still risks to ongoing recovery performance if funding allocations bids are unsuccessful. Industrial action still poses a risk in terms of cancellation of activity.

RED

Cancer –Skin Recovery



The 62-day Skin backlog continues to reduce and is slightly ahead of trajectory.

Interventions

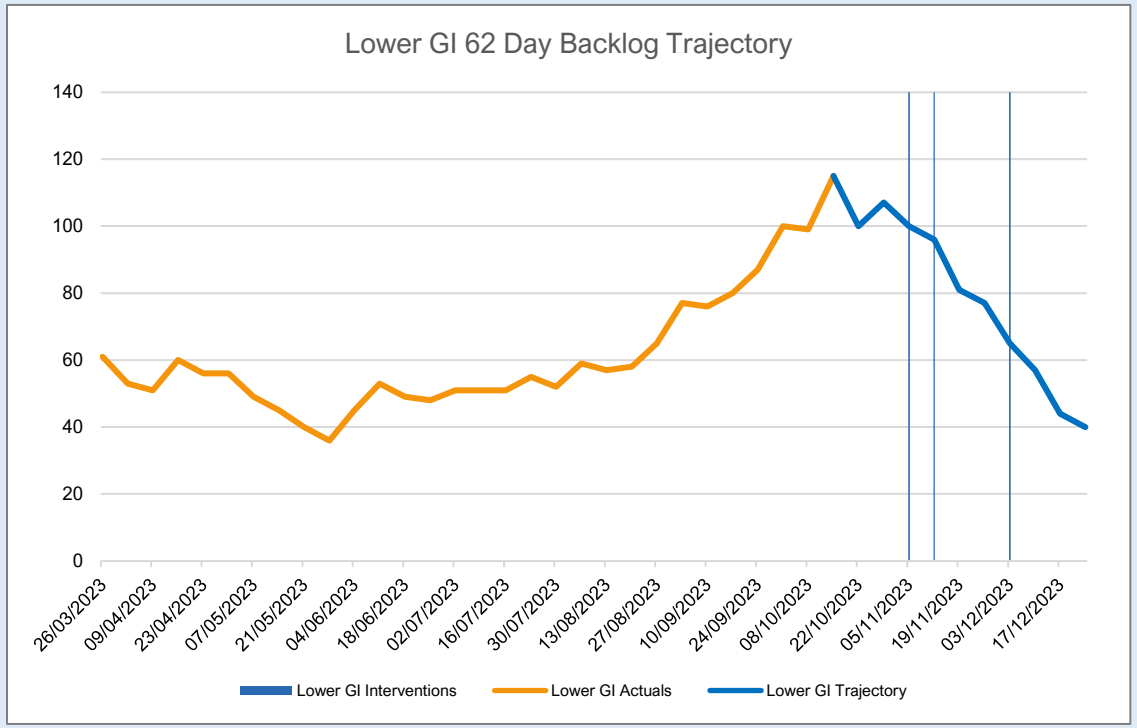
- eDerma capacity increases from October 2023 – 7 additional eDerma nurse led clinics being set up (totalling 288 slots in October) – in place.
- 12 additional 2ww WLI clinics secured for October 2023 (80 patients per clinic) – in place.
- 1000 outsourced cut samples and histology reporting is to be outsourced – November.

Next Steps – Portland Clinical

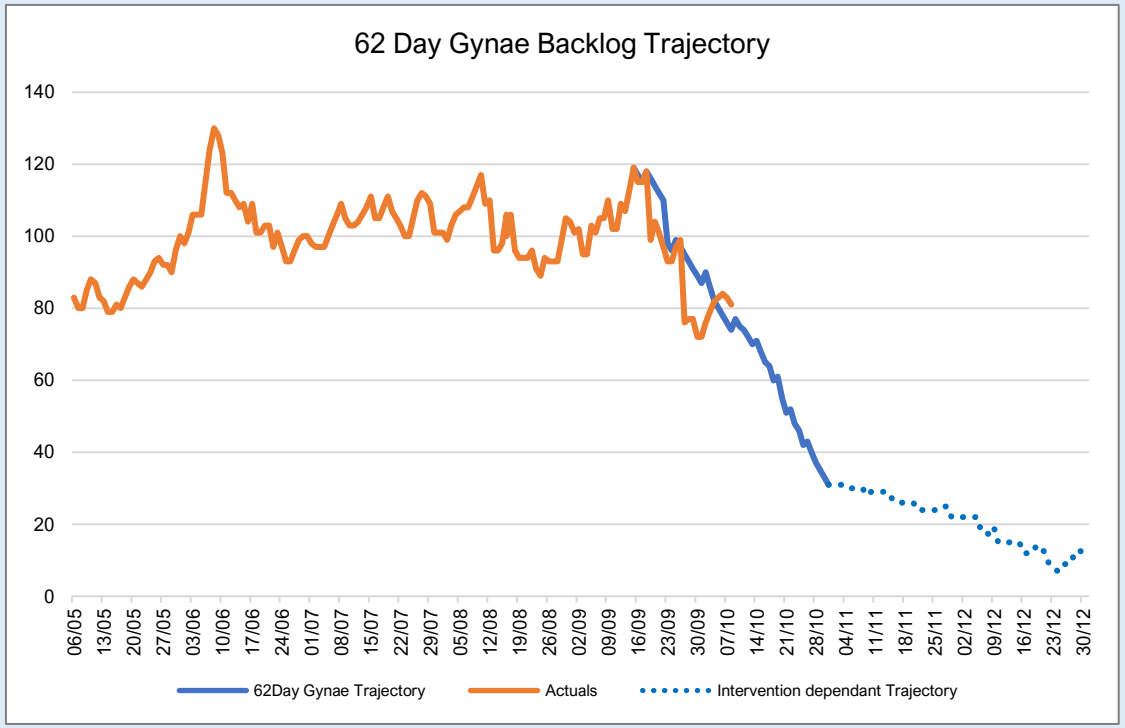
- Service specification being finalised which will follow signing of contract and PO going live on the system.
- Clinical staff identified – just waiting for CVs of Plastic Surgeons (to offer a one-stop clinic service)
- Quote for Admin support requested
- Request access to NNUH IT systems
- Induction pack in place
- Following all the above are in place – aim for 2-3 weeks mobilisation.

Cancer – Lower GI and Gynaecology Recovery

Lower GI



Gynaecology



Lower GI Interventions

- Multi-divisional taskforce to address internal pathway delays. Endoscopy and Radiology are main delays – funding required.
- Agreed with national team on 19th October one-to-one peer support for Lower GI improvement pathway.

Gynaecology Interventions

- Medacs List on Weekends – November 5th – 10 weekends to EO year – using either 23/24 alliance underspend and/or successful regional bid.
- Paediatric Theatres open 01/12/23 – All Gynaecology backfill lists to support Cancer Recovery
- Increase outsourcing of Histopathology to match increased activity and improve turnaround times – 300 cases across Lower GI and Gynae

Cancer – 28-Day Faster Diagnosis Standard

Commentary

September 2023 Performance (provisional)

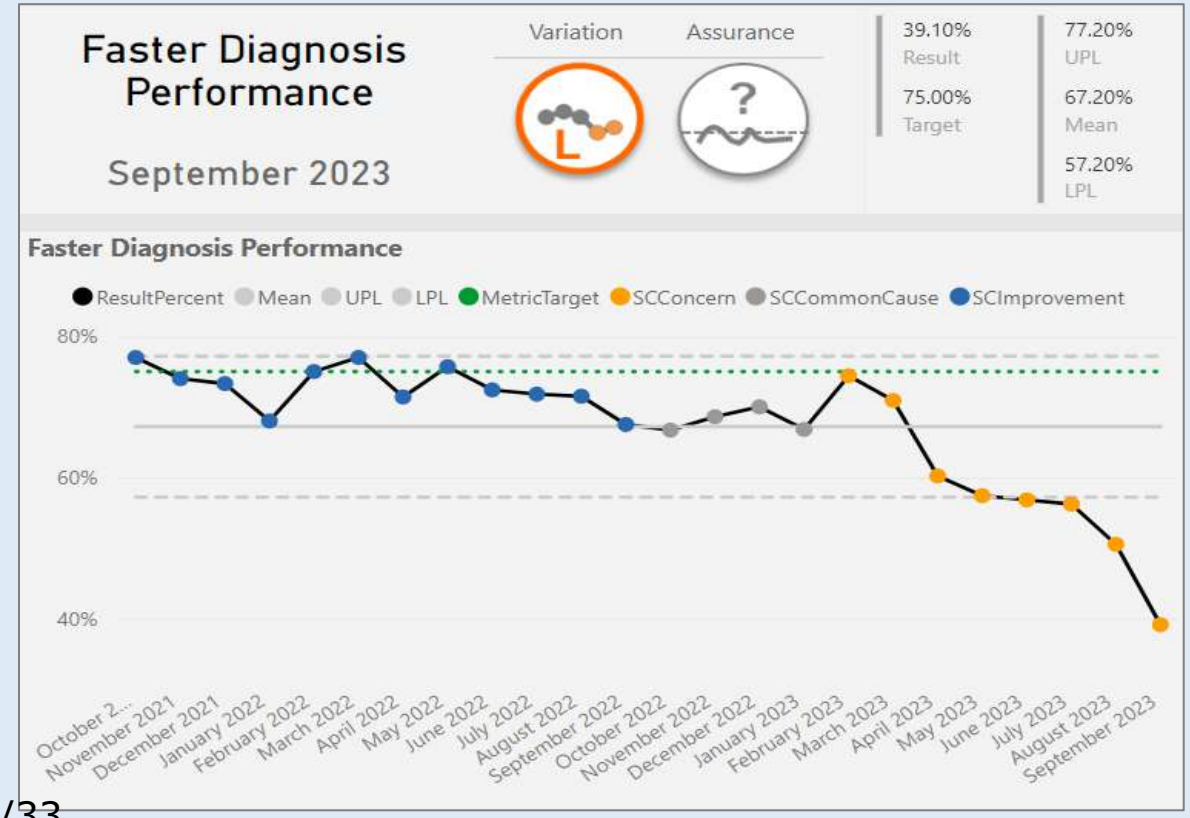
The provisional Faster diagnosis performance in September was 39.1%. This has further reduced compared to August (50.5%) and July (56.2%).

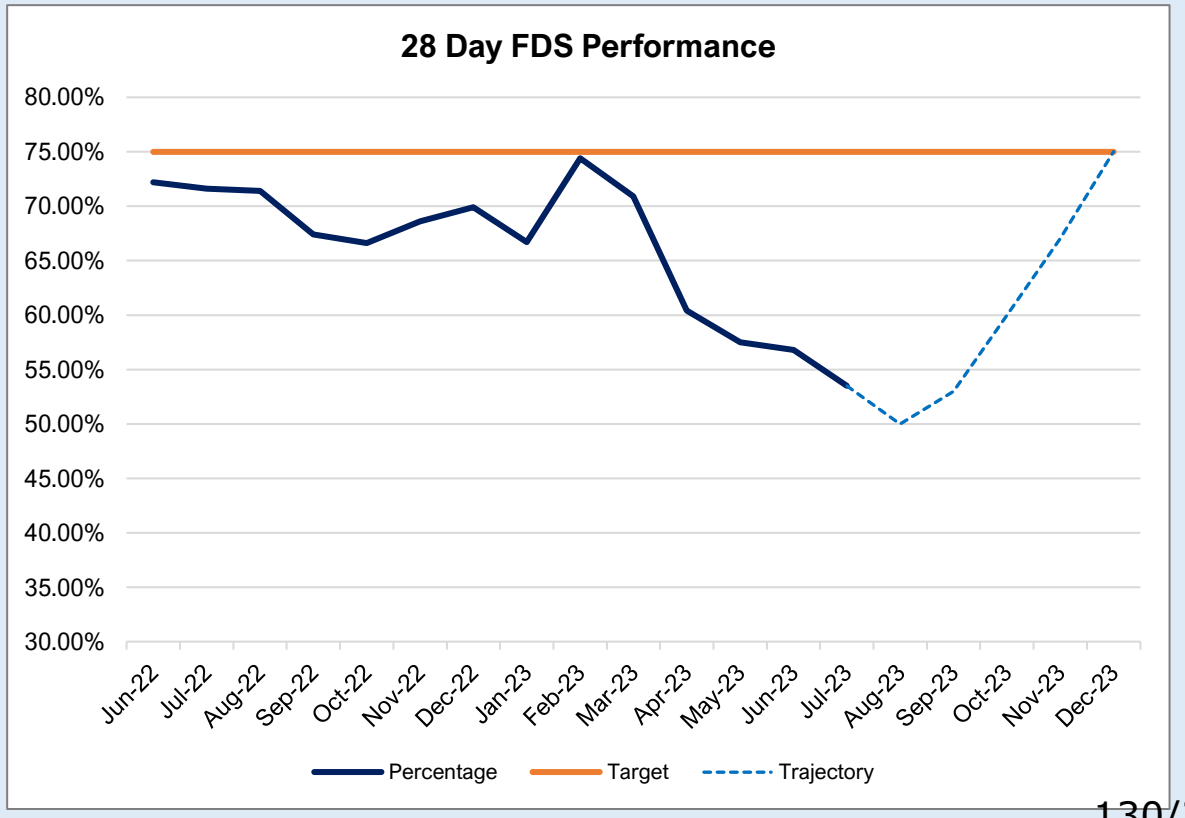
Skin, Gynaecology and Lower GI are the main contributors to the Faster Diagnosis Standard under performance. However, following implementation of the interventions outlined on the previous slides, the trajectory for the end of December 2023 is to achieve the 75% target (below right).

Improvement Actions

1. Interventions for Skin, Gynaecology and Lower GI, as outlined in the previous 2 slides.

Risk To Delivery RED

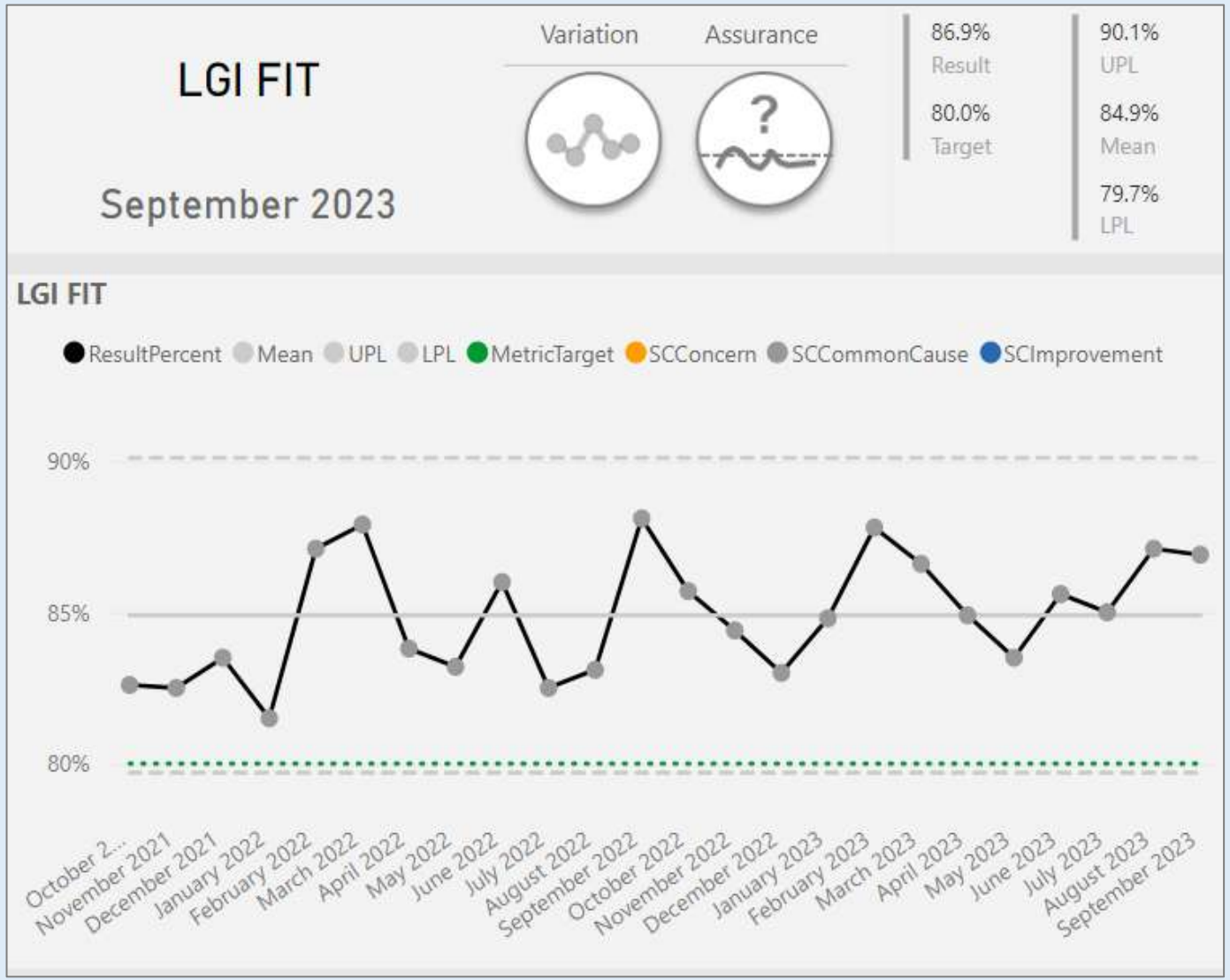




Our Vision
The best care for every patient

Cancer – Lower GI Referrals with a FIT Test

NHS
Norfolk and Norwich University Hospitals
NHS Foundation Trust



Commentary

September 2023 Performance

Performance reduced compared to August (87.1%) but remains ahead of target for all LGI referrals having an accompanying FIT result, enabling effective triage and straight to test investigations where criteria met.

Improvement Actions

1. FIT negative service led in Primary Care continues.

Risk To Delivery

GREEN

Cancer – Additional Regional Allocation Bids

NNUH Funding Bids for Additional Cancer Alliance Allocation October 23

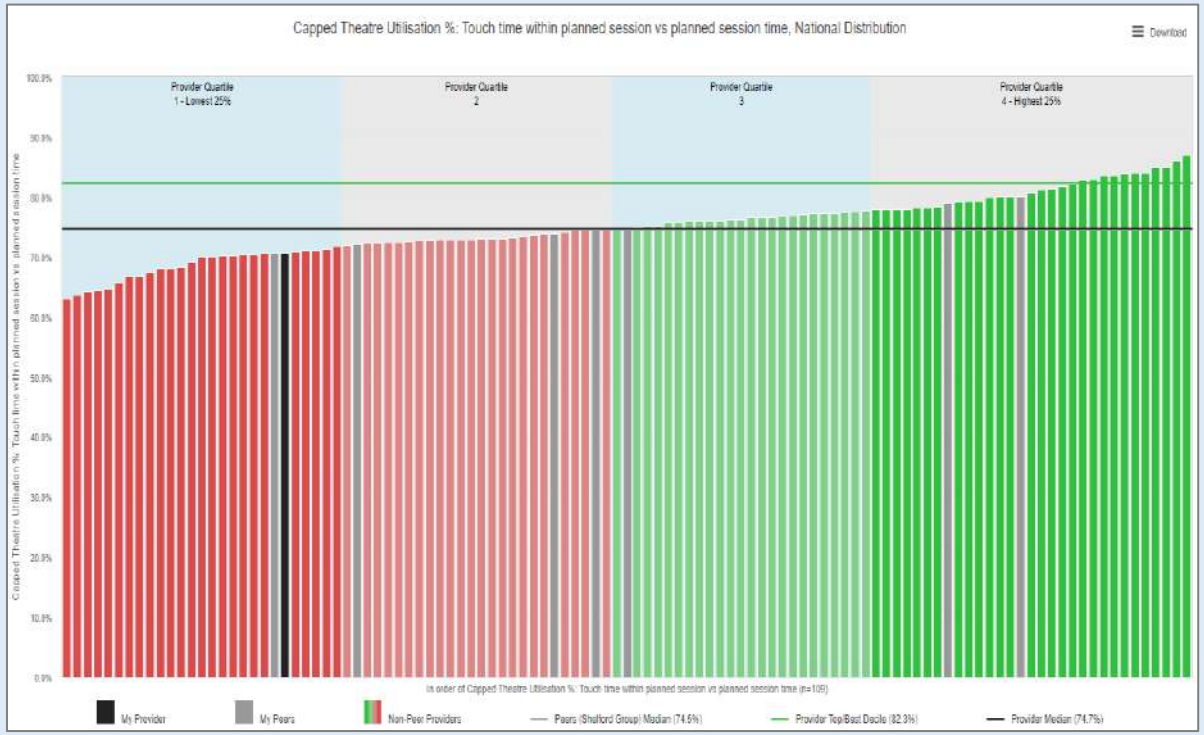
Additional Funding Bid	Request	Frequecy	Total Cases	Initial Bid Request
1. Skin	Outsourcing Appointments and Derm/Plastics Ops to private provider	-	1350 Appointments, 675 Minor Ops	779,130
2. Endoscopy	Additional Insourcing of Colonoscopies for 5 months	24 lists a month	1320	670,000
3. Oncology	Outsourcing Breast Oncology OPA, Chemo and follow up	24 patients per month	120	480,000
4. Gynaecology	Insourcing Weekend Capacity for GA Hysteroscopy / Procedures	2 Weekends a Month	48	138,000
5. Histology	Outsourcing of Samples for Skin, Lower GI and	50 Patients per week	1000	106,000
6. Admin Support	Additional OP Bookings Team and Data Administration	-	-	117,100
7. Prostate	Insourcing Weekend Robotic Surgery	3 Weekends a month	30	184,654
8. Radiology Staffing	Consultant PAs to support Lower GI Pathway & 5 month Bank booking staff			73,000
9. Radiology Insourcing	Insourcing of Scanning and Outsourcing of CT reporting,	Daily	3200	927,000
Total				**3,474,884**

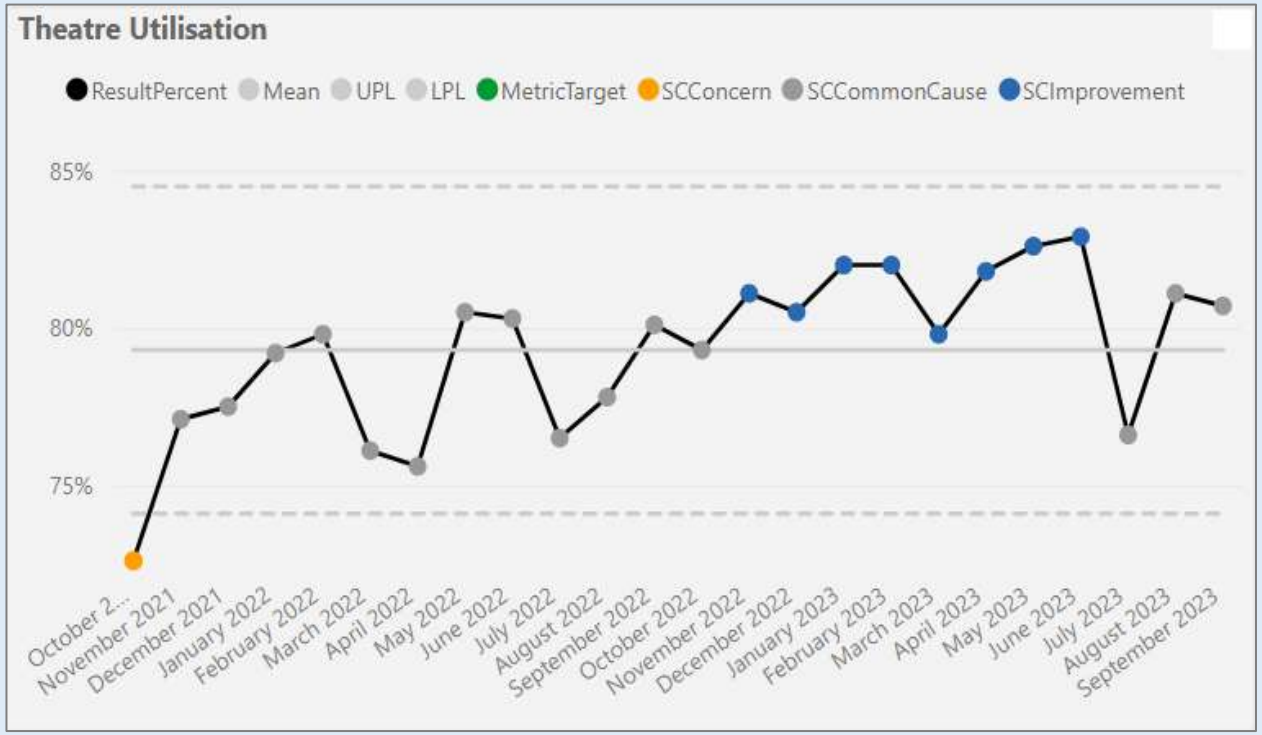
At the Tier 1 meeting on 19th October, regional colleagues confirmed that the NNUH funding bids for Skin, Endoscopy, Gynaecology and Histology had been put forward to the national team for approval.

Our Vision
The best care for every patient

Performance – Theatre Utilisation

NHS
Norfolk and Norwich University Hospitals
NHS Foundation Trust





September 2023 Performance

The touch time delivery across all theatres showed a reduction to 70.8% on 24th September for the previous 2 weeks (above left), compared to 81.1% on 27th August. The reduction is predominantly due to a number of sessions running Local Anaesthetic cases during Industrial Action, these cases are excluded from Model Hospital calculations. Theatre utilisation overall for September (above right) remained above 80% but showed a reduction from 81.1% in August to 80.7% in September. Level 3 theatres delivered 79.69% across September, compared to 81.41% in August, while Level 2 utilisation was 80.17% in September compared to 81.7% in August.

Flow around elective areas including PACU, ITU and wards has also presented challenges to session utilisation through late starts. On the day cancellations also increased during this period. Increased demand on emergency and trauma theatres over the last 6 weeks, leading to on the day elective cancellations to appropriately generate extra emergency theatre type capacity, which is not counted for in the Model Hospital data (above left). The Critical Care unit has been at capacity on several days over the last 6 weeks which has led to delayed starts for many lists whilst cases are prioritised for the beds that are available.

Improvement Actions

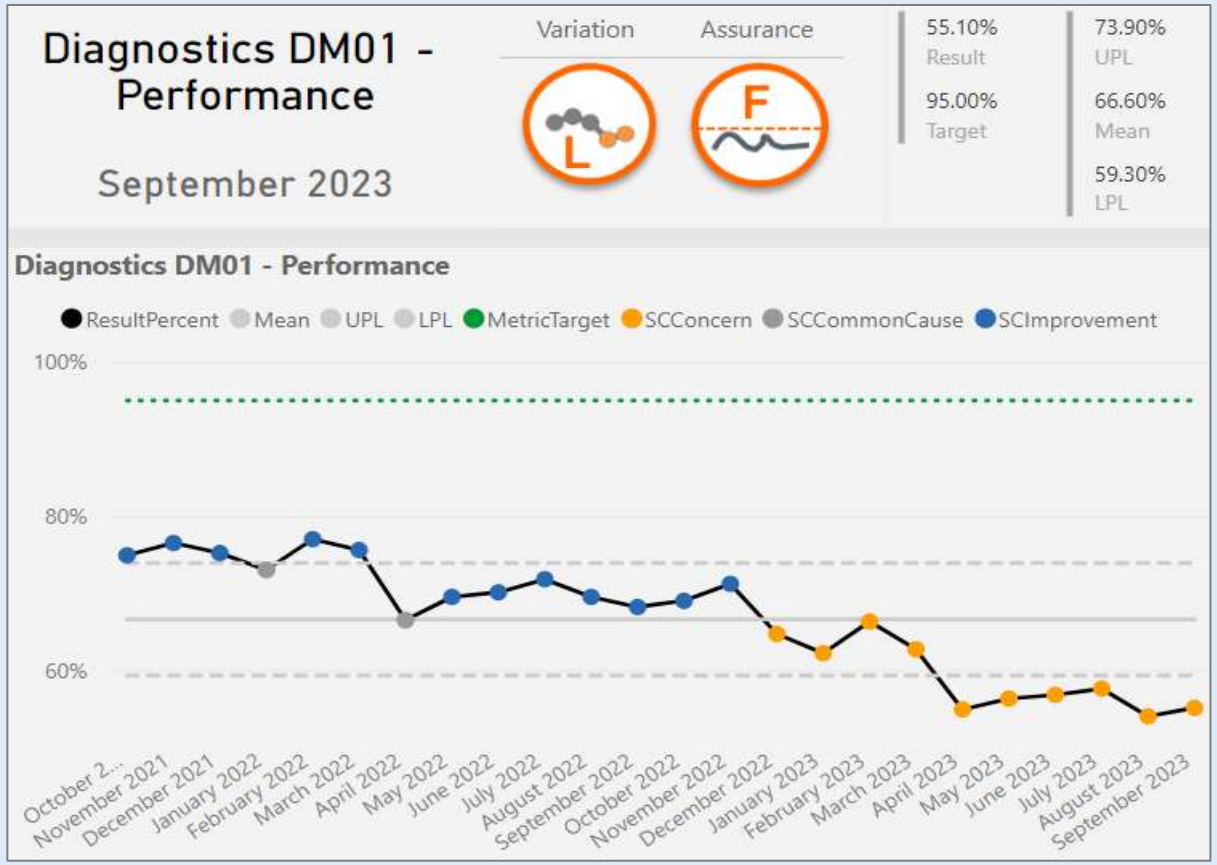
1. Plans in progress to address the emergency theatre capacity such as cohorting in the recovery area to maximise flow when ward beds are tight. Reviewing with Divisions regarding shifting the ward discharge profile earlier in the day.
2. Work continues on the development of the electronic POA system; integration with Infinity and DrDoctor is ongoing, however there has been a further delay with enabling the live patient links; these are now anticipated to be ready mid-November.
3. The issue with the Theatre tracker remains unresolved and is impacting on our ability to fully deploy the 6-4-2 process. Work to update the remaining system has been commissioned and stakeholder groups are currently being consulted.

Risk To Delivery AMBER

Our Vision
The best care for every patient

Diagnostic Test Within 6 Weeks

NHS
Norfolk and Norwich University Hospitals
NHS Foundation Trust



Commentary

September 2023 Performance

Gastro and Echo: Improved DM01 performance. Gastro ahead of recovery trajectories. Insourcing in place to reduce backlogs.

CT: Approximately 4 CT Radiographer vacancies exist with delays with next interview dates in October. Almost completed Procurement process for external recruitment supplier contract. Covid sickness has impacted CT for September. Introduction of evening 5pm to 7pm Monday to Thursday Inpatient sessions started in September to improve Inpatient waiting times, this has displaced Outpatient activity.

MRI: New arrivals onboarding in September as well as internal recruitment of current Radiographers to train in MRI. Cromer MRI reopened for 5 days per week from mid-September. All in-house scanners expected to run for 7 days per week from January 2024. Current mobile MRI van has been extended until 30th November 2023.

September 2023 Performance

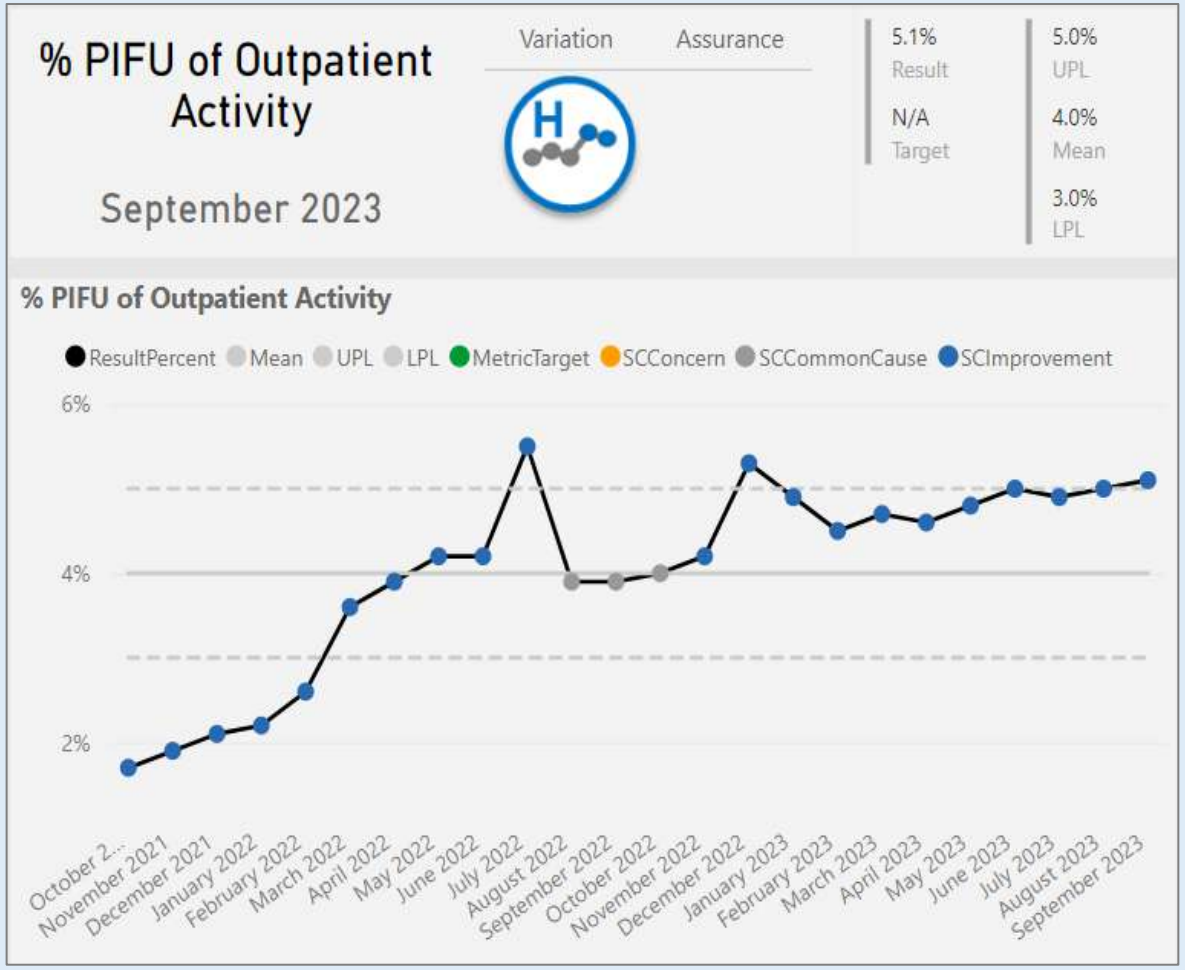
Specialty	Radiology					Cardiology	Gastroenterology		
Specialty Percentage	50.97%					61.73%	74.95%		
Exam Type	Barium Enema	DEXA Scan	CT	MRI	Ultrasound	Echocardiography	Flexi Sigmoidoscopy	Gastroscopy	Colonoscopy
Exam Type Percentage	96.92%	80.13%	36.89%	58.29%	67.85%	61.73%	87.85%	79.60%	70.35%

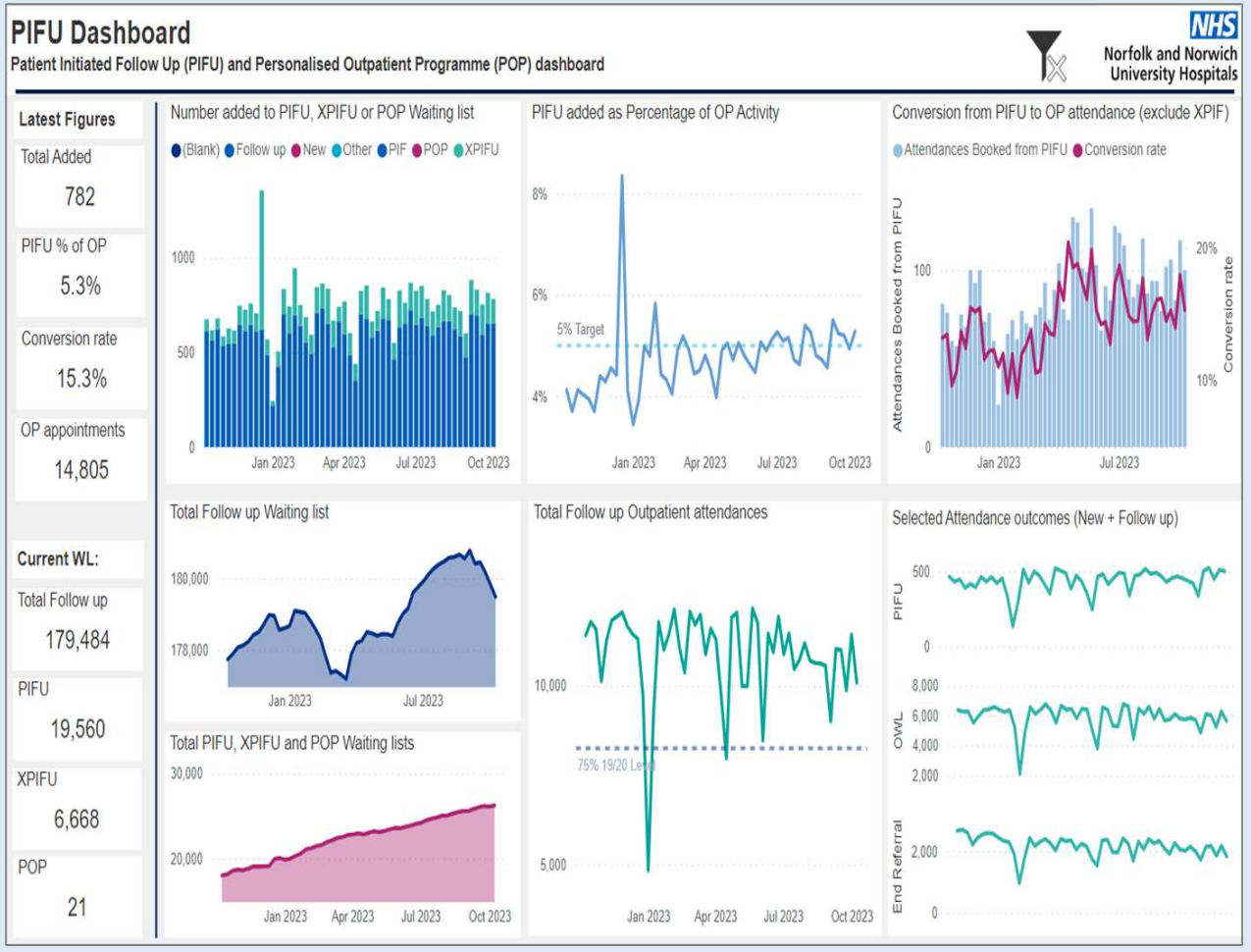
Patient Initiated Follow Up (PIFU)

Commentary

September 2023 Performance

The number of patients added to a PIFU list as a percentage of the monthly outpatient activity improved from 5% in August to 5.1% in September. The most recent position (13th October) illustrates improved performance to 5.3%, with a 15.3% conversion from PIFU to Outpatient attendance (below right).

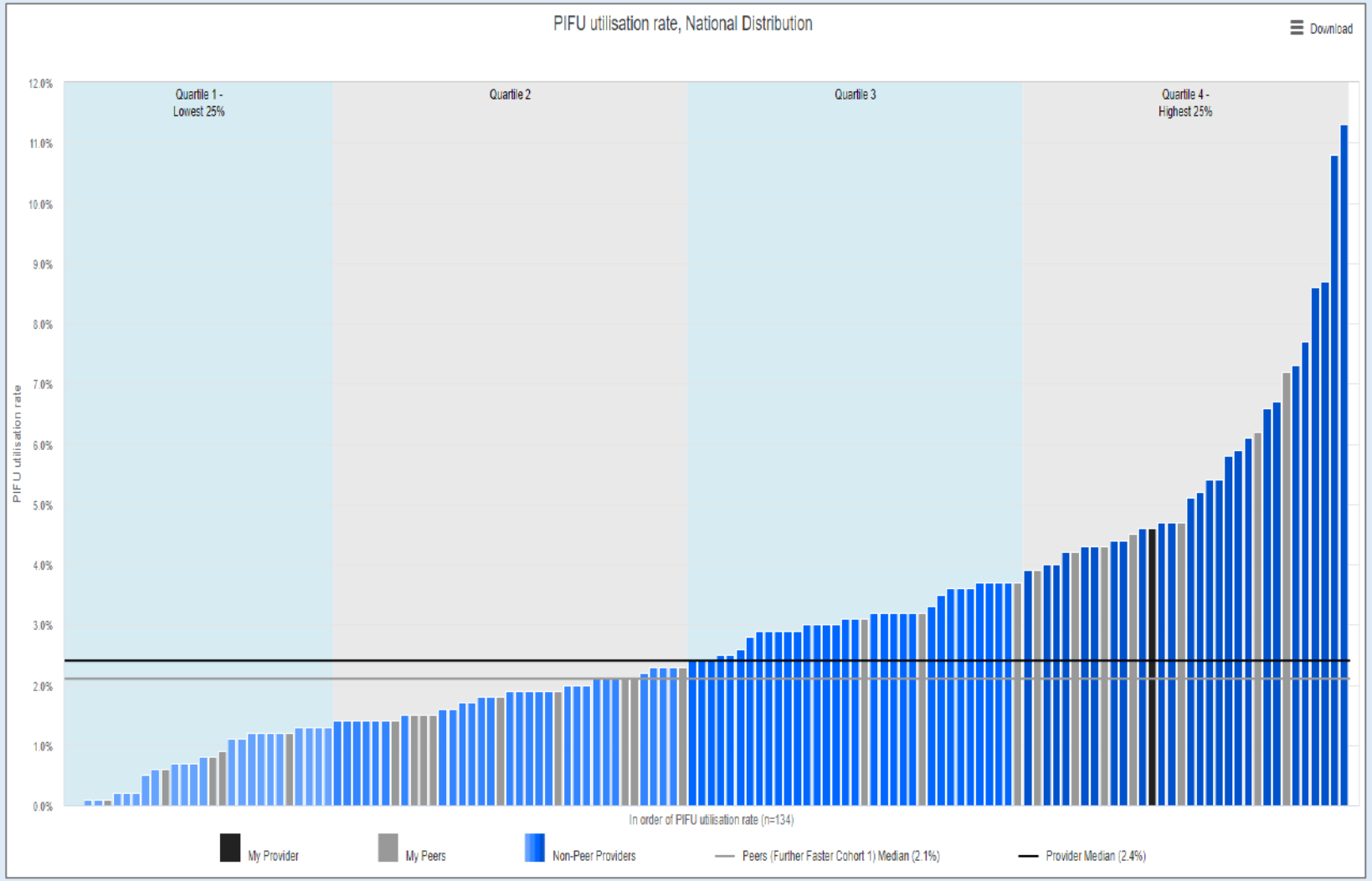




Our Vision
The best care for every patient

PIFU Utilisation – Comparison Nationally and with Further Faster Providers (August 2023)

NHS
Norfolk and Norwich University Hospitals
NHS Foundation Trust



Go Further Faster Organisation Name	Provider Value
Torbay and South Devon NHS Foundation Trust	7.2%
Homerton Healthcare NHS Foundation Trust	6.2%
Northumbria Healthcare NHS Foundation Trust	4.7%
Norfolk and Norwich University Hospitals NHS Foundation Trust	4.6%
Calderdale and Huddersfield NHS Foundation Trust	4.5%
University Hospitals Plymouth NHS Trust	4.3%
Nottingham University Hospitals NHS Trust	4.2%
South Warwickshire NHS Foundation Trust	3.9%
Maidstone and Tunbridge Wells NHS Trust	3.7%
Royal Devon University Healthcare NHS Foundation Trust	3.2%
Wye Valley NHS Trust	3.1%
University Hospitals of Leicester NHS Trust	2.3%
Manchester University NHS Foundation Trust	2.1%
Hull University Teaching Hospitals NHS Trust	2.1%
Royal National Orthopaedic Hospital NHS Trust	1.9%
Barking, Havering and Redbridge University Hospitals NHS Trust	1.8%
George Eliot Hospital NHS Trust	1.5%
Walsall Healthcare NHS Trust	1.5%
Royal Wolverhampton NHS Trust	1.5%
United Lincolnshire Hospitals NHS Trust	1.4%
Barts Health NHS Trust	1.2%
Northern Care Alliance NHS Foundation Trust	0.9%
Medway NHS Foundation Trust	0.8%
Dudley Group NHS Foundation Trust	0.6%
Sandwell and West Birmingham Hospitals NHS Trust	0.1%

NNUH's PIFU Utilisation rate for all outpatient appointments was 4.6% in August. This remained the same as July and the 4th highest across the organisations in the Go Further Faster programme.

Data taken from Model Hospital on 11.10.2023

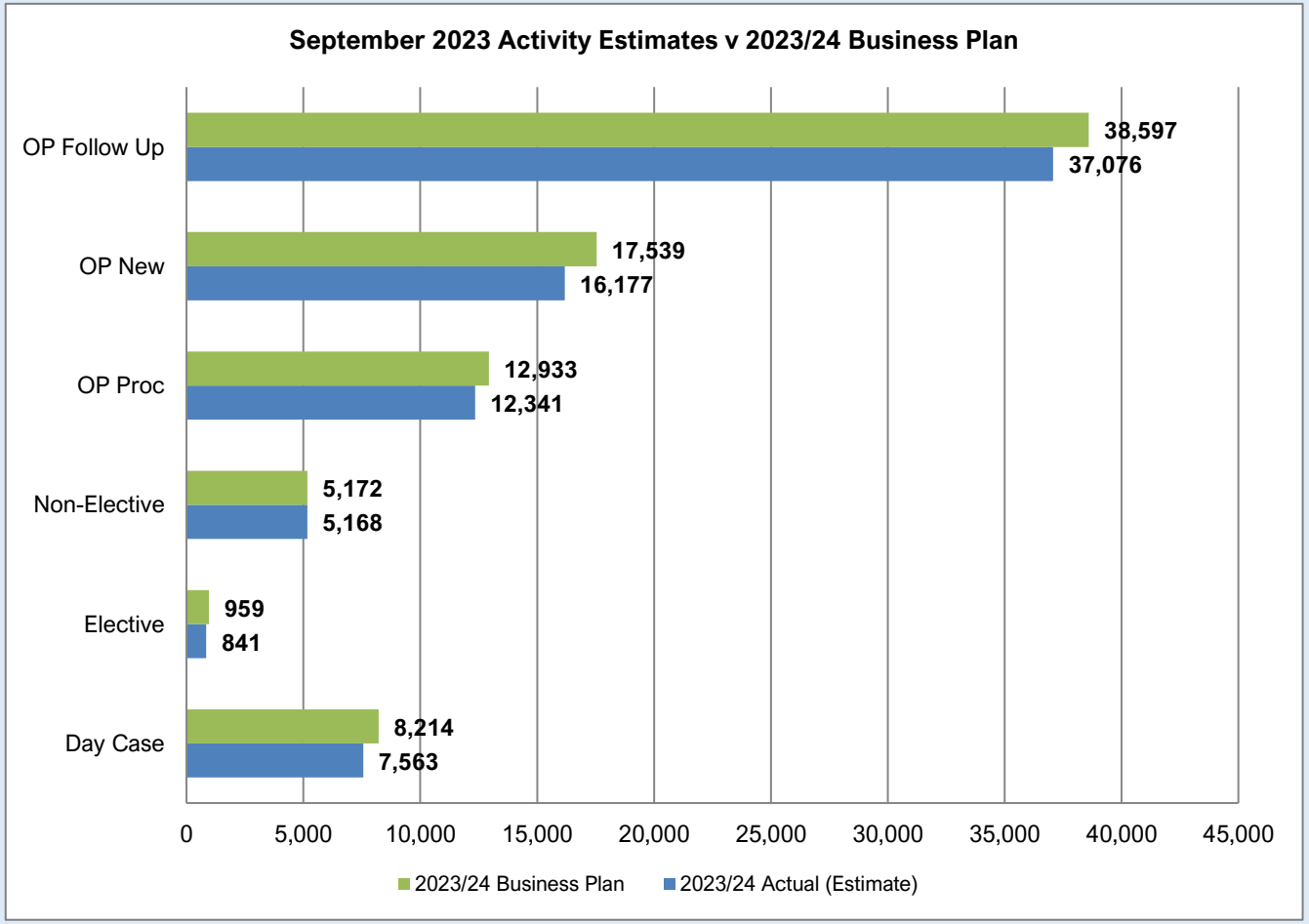
Activity Planning Run Rate

Commentary

September 2023 Performance (provisional)

September's activity was further impacted by Industrial Action. The table below (left) details the top 5 specialties (across Daycases, Elective and Non-Elective) that delivered above their plan in September. The graph below (right) summarises the activity versus plan. The subsequent slides provide a detailed position for each specialty.

Activity Type	Specialty	Positive Variance
Daycase	Clinical Haematology	46
	Urology	32
	Rheumatology	24
	Trauma and Orthopaedics	19
	Paediatric Maxillo-facial Surgery	10
Elective	Obstetrics	73
	Gastroenterology	17
	Spinal Surgery	11
	Clinical Haematology	7
	Clinical Oncology	6
Non-Elective	General Medicine	149
	Cardiology	56
	Respiratory Medicine	48
	General Surgery	44
	Geriatric Medicine	33



Our Vision
The best care for every patient

Activity Planning Run Rate

NHS
Norfolk and Norwich University Hospitals
NHS Foundation Trust

Medicine Division		Daycase				Elective				Non Elective				OP - Procedure				OP - New (Exc Procedure)				OP - Follow Up (Exc Procedure)				Total			
		Estimate	Plan	Var	% Achieved	Estimate	Plan	Var	% Achieved	Estimate	Plan	Var	% Achieved	Estimate	Plan	Var	% Achieved	Estimate	Plan	Var	% Achieved	Estimate	Plan	Var	% Achieved	Estimate	Plan	Var	% Achieved
300	General Medicine	0	0	0	0.0%	0	0	0	0.0%	335	186	149	180.0%	0	0	0	0.0%	439	357	82	123.0%	246	197	49	124.9%	1,020	740	280	137.8%
301	Gastroenterology	1,831	2,211	(379)	82.8%	23	5	17	427.2%	256	284	(27)	90.4%	5	6	(1)	86.9%	373	524	(151)	71.2%	593	580	13	102.3%	3,082	3,610	(528)	85.4%
302	Endocrinology	9	9	0	100.0%	1	1	0	193.1%	88	110	(22)	79.8%	0	1	(1)	0.0%	218	219	(1)	99.5%	414	641	(228)	64.5%	729	981	(252)	74.4%
303	Clinical Haematology	996	950	46	104.8%	13	6	7	213.4%	43	64	(21)	66.6%	0	0	0	0.0%	523	508	15	102.9%	1,907	2,021	(114)	94.4%	3,482	3,549	(68)	98.1%
306	Hepatology	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	101	167	(66)	60.5%	557	401	156	138.9%	658	568	90	115.8%
307	Diabetic Medicine	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	0	3	(3)	0.0%	284	326	(42)	87.1%	2,138	1,990	148	107.4%	2,422	2,319	103	104.4%
308	Blood and Marrow Transplantation	7	5	2	141.0%	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	0	1	(1)	0.0%	36	47	(11)	76.6%	43	53	(10)	81.2%
315	Palliative Medicine	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	201	206	(5)	97.6%	601	547	54	109.8%	802	753	49	106.5%
320	Cardiology	283	330	(47)	85.8%	26	21	5	123.8%	320	264	56	121.0%	995	1,227	(232)	81.1%	1,127	920	206	122.4%	1,707	1,967	(260)	86.8%	4,457	4,729	(272)	94.2%
326	Acute Internal Medicine	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%
328	Stroke Medicine	0	0	0	0.0%	0	0	0	0.0%	124	110	14	113.2%	0	0	0	0.0%	0	0	0	0.0%	19	12	7	158.3%	143	122	21	117.6%
329	TIA	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	0	26	(26)	0.0%	88	84	4	104.8%	0	0	0	0.0%	88	110	(22)	80.0%
331	Congenital Heart Disease Service	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	10	24	(14)	41.7%	91	80	11	113.2%	101	104	(3)	96.7%
340	Respiratory Medicine	49	96	(47)	51.0%	6	9	(4)	60.3%	243	195	48	124.6%	332	372	(40)	89.3%	270	352	(82)	76.7%	904	812	92	111.3%	1,804	1,837	(33)	98.2%
341	Respiratory Physiology	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	45	0	45	0.0%	130	159	(29)	81.9%	169	259	(90)	65.1%	343	418	(75)	82.1%
343	Adult Cystic Fibrosis	0	0	0	0.0%	1	0	1	400.0%	0	0	0	0.0%	0	0	0	0.0%	1	0	1	0.0%	43	48	(5)	88.9%	45	48	(4)	92.6%
350	Infectious Diseases	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%
361	Nephrology	34	38	(4)	88.5%	18	30	(12)	60.3%	70	94	(24)	74.5%	25	19	6	133.4%	98	164	(66)	59.8%	640	560	80	114.2%	885	905	(20)	97.8%
370	Medical Oncology	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%
400	Neurology	141	132	9	106.8%	0	1	(1)	0.0%	99	110	(11)	89.9%	8	11	(3)	68.5%	414	604	(190)	68.6%	816	968	(152)	84.3%	1,478	1,826	(348)	80.9%
401	Clinical Neurophysiology	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	327	254	73	128.7%	47	72	(25)	65.6%	1	0	1	0.0%	375	326	49	115.0%
410	Rheumatology	225	201	24	111.9%	0	0	0	0.0%	4	5	(1)	80.0%	20	23	(3)	85.8%	264	423	(159)	62.4%	1,669	1,733	(63)	96.3%	2,182	2,385	(203)	91.5%
430	Geriatric Medicine	13	10	3	130.0%	0	0	0	0.0%	586	553	33	106.0%	0	0	0	0.0%	124	118	6	105.1%	59	60	(1)	98.3%	782	741	41	105.6%
653	Podiatry	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	59	101	(42)	58.4%	410	499	(89)	82.1%	469	600	(131)	78.2%
800	Clinical Oncology	1,847	1,879	(32)	98.3%	24	19	6	130.6%	164	180	(16)	91.3%	5	6	(1)	90.4%	496	465	31	106.7%	3,525	3,572	(47)	98.7%	6,061	6,120	(59)	99.0%
Total - Medicine (NNUH)		**5,435**	**5,861**	**(426)**	**92.7%**	**112**	**92**	**20**	**121.4%**	**2,331**	**2,154**	**177**	**108.2%**	**1,762**	**1,948**	**(186)**	**90.4%**	**5,267**	**5,794**	**(527)**	**90.9%**	**16,543**	**16,994**	**(451)**	**97.3%**	**31,450**	**32,843**	**(1,393)**	**95.8%**

Women & Children's Division		Daycase				Elective				Non Elective				OP - Procedure				OP - New (Exc Procedure)				OP - Follow Up (Exc Procedure)				Total			
		Estimate	Plan	Var	% Achieved	Estimate	Plan	Var	% Achieved	Estimate	Plan	Var	% Achieved	Estimate	Plan	Var	% Achieved	Estimate	Plan	Var	% Achieved	Estimate	Plan	Var	% Achieved	Estimate	Plan	Var	% Achieved
171	Paediatric Surgery	43	43	(0)	100.0%	14	12	2	116.7%	33	36	(3)	91.0%	86	99	(13)	86.5%	129	144	(15)	89.9%	292	176	117	166.3%	597	510	87	117.1%
242	Paediatric Intensive Care	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%
251	Paediatric Gastroenterology	11	4	7	275.0%	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	24	30	(6)	80.0%	147	90	57	162.8%	182	124	58	146.4%
252	Paediatric Endocrinology	19	14	5	135.7%	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	30	20	10	150.0%	101	67	34	150.1%	150	101	49	148.1%
253	Paediatric Clinical Haematology	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	3	2	1	150.0%	16	8	8	200.0%	19	10	9	190.0%
258	Paediatric Respiratory Medicine	4	0	4	0.0%	0	0	0	0.0%	2	0	2	0.0%	0	0	0	0.0%	40	22	18	181.1%	105	82	23	128.0%	151	104	47	145.2%
260	Paediatric Medical Oncology	27	25	2	108.0%	0	0	0	0.0%	3	9	(6)	30.8%	0	0	0	0.0%	2	1	1	200.0%	107	104	3	102.9%	139	139	(0)	99.8%
262	Paediatric Rheumatology	17	8	9	212.5%	0	0	0	0.0%	1	0	1	0.0%	0	0	0	0.0%	21	18	3	116.7%	125	94	31	132.5%	164	120	44	136.3%
263	Paediatric Diabetic Medicine	0	0	0	0.0%	0	0	0	0.0%	0	1	(1)	0.0%	0	0	0	0.0%	2	4	(2)	50.0%	91	102	(11)	89.2%	93	107	(14)	86.9%
264	Paediatric Cystic Fibrosis	0	0	0	0.0%	0	0	0	0.0%	0	1	(1)	0.0%	0	0	0	0.0%	0	0	0	0.0%	27	15	12	180.0%	27	16	11	168.7%
321	Paediatric Cardiology	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	24	33	(9)	72.7%	56	54	2	103.5%	80	87	(7)	91.8%
420	Paediatrics	31	58	(27)	53.5%	1	2	(1)	45.4%	105	204	(98)	51.7%	0	0	0	0.0%	498	328	170	151.9%	294	221	73	133.2%	930	813	117	114.4%
421	Paediatric Neurology	0	0	(0)	0.0%	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	44	55	(11)	80.0%	94	116	(22)	80.6%	138	171	(34)	80.3%
422	Neonatology	0	0	0	0.0%	0	0	0	0.0%	242	240	2	100.6%	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	242	240	2	100.6%
424	Well Babies	0	0	0	0.0%	0	0	0	0.0%	195	232	(37)	84.1%	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	195	232	(37)	84.1%
501	Obstetrics	0	0	0	0.0%	73	0	73	0.0%	713	795	(82)	89.7%	0	0	0	0.0%	438	554	(116)	79.0%	1,505	1,704	(199)	88.3%	2,728	3,053	(325)	89.4%
502	Gynaecology	67	102	(35)	65.7%	82	115	(33)	71.5%	207	200	7	103.5%	1,001	1,203	(202)	83.2%	704	1,010	(306)	69.7%	790	718	72	110.1%	2,851	3,348	(497)	85.2%
503	Gynaecological Oncology	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	7	14	(7)	50.5%	40	67	(27)	59.0%	236	186	51	127.2%	283	267	16	106.1%
505	Fetal Medicine Service	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	55	56	(1)	98.2%	31	46	(15)	67.4%	86	102	(16)	84.3%
560	Midwife Episode	0	0	0	0.0%	0	0	0	0.0%	285	287	(2)	99.3%	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	285	287	(2)	99.3%
Total - Women & Children (NNUH)		**219**	**254**	**(35)**	**86.1%**	**170**	**129**	**41**	**131.8%**	**1,785**	**2,005**	**(219)**	**89.1%**	**1,093**	**1,315**	**(222)**	**83.1%**	**2,054**	**2,344**	**(290)**	**87.6%**	**4,016**	**3,783**	**233**	**106.2%**	**9,338**	**9,830**	**(492)**	**95.0%**
Women & Children (NNUH) Exc. Maternity		**219**	**254**	**(35)**	**86.1%**	**97**	**129**	**(32)**	**75.3%**	**788**	**923**	**(135)**	**85.3%**	**1,093**	**1,315**	**(222)**	**83.1%**	**1,616**	**1,790**	**(174)**	**90.3%**	**2,511**	**2,079**	**433**	**120.8%**	**6,325**	**6,490**	**(166)**	**97.4%**

Our Vision
The best care for every patient

Activity Planning Run Rate

NHS
Norfolk and Norwich University Hospitals
NHS Foundation Trust

Surgery Division		Daycase				Elective				Non Elective				OP - Procedure				OP - New (Exc Procedure)				OP - Follow Up (Exc Procedure)				Total			
		Estimate	Plan	Var	% Achieved	Estimate	Plan	Var	% Achieved	Estimate	Plan	Var	% Achieved	Estimate	Plan	Var	% Achieved	Estimate	Plan	Var	% Achieved	Estimate	Plan	Var	% Achieved	Estimate	Plan	Var	% Achieved
100	General Surgery	161	198	(37)	81.3%	79	92	(13)	86.0%	273	229	44	119.0%	117	87	30	134.9%	1,625	1,562	63	104.0%	2,431	2,620	(189)	92.8%	**4,686**	**4,788**	**(102)**	**97.9%**
101	Urology	341	309	32	110.4%	109	199	(90)	54.8%	108	140	(32)	77.0%	844	769	75	109.8%	897	867	30	103.5%	1,686	1,436	250	117.4%	**3,985**	**3,720**	**265**	**107.1%**
107	Vascular Surgery	34	49	(15)	69.9%	39	50	(11)	77.6%	66	56	10	117.7%	42	57	(15)	73.5%	192	176	16	109.1%	189	220	(31)	85.9%	**562**	**608**	**(46)**	**92.4%**
108	Spinal Surgery Service	2	5	(3)	40.0%	20	9	11	222.4%	12	12	0	100.4%	0	0	0	0.0%	91	156	(65)	58.3%	253	222	31	114.0%	**378**	**404**	**(26)**	**93.6%**
110	Trauma & Orthopaedics	119	100	19	119.0%	126	134	(8)	93.9%	252	224	28	112.5%	17	20	(3)	85.6%	1,697	1,462	235	116.1%	2,085	2,315	(230)	90.1%	**4,297**	**4,255**	**42**	**101.0%**
120	ENT	74	109	(35)	67.9%	37	86	(49)	43.1%	64	90	(26)	71.5%	969	1,282	(313)	75.6%	425	416	9	102.2%	427	509	(82)	83.8%	**1,996**	**2,492**	**(496)**	**80.1%**
130	Ophthalmology	258	365	(107)	70.7%	2	3	(1)	66.7%	14	10	4	140.0%	3,449	3,573	(124)	96.5%	775	1,023	(248)	75.8%	1,654	2,058	(404)	80.4%	**6,153**	**7,032**	**(879)**	**87.5%**
140	Oral Surgery	217	260	(43)	83.5%	10	18	(8)	57.6%	17	30	(13)	56.2%	0	3	(3)	5.6%	355	424	(69)	83.7%	465	510	(45)	91.1%	**1,064**	**1,245**	**(181)**	**85.5%**
141	Restorative Dentistry	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	9	9	0	101.6%	1	5	(4)	12.9%	22	9	13	246.8%	**32**	**23**	**9**	**139.1%**
143	Orthodontics	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	312	300	12	104.1%	6	30	(24)	18.5%	142	227	(85)	62.6%	**460**	**557**	**(97)**	**82.6%**
144	Maxillo-facial Surgery	0	0	0	0.0%	0	0	0	0.0%	8	3	5	262.5%	6	40	(34)	15.4%	25	20	5	124.4%	137	136	1	100.7%	**176**	**199**	**(23)**	**88.4%**
150	Neurosurgery	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	6	0	6	0.0%	2	0	2	0.0%	**8**	**0**	**8**	**0.0%**
160	Plastic Surgery	150	167	(17)	89.8%	32	39	(7)	81.0%	147	149	(3)	98.1%	496	455	41	109.0%	326	285	41	114.3%	482	551	(69)	87.5%	**1,632**	**1,647**	**(14)**	**99.1%**
173	Thoracic Surgery	2	1	1	200.0%	35	37	(2)	93.3%	17	17	0	101.5%	0	0	0	0.0%	22	24	(2)	91.7%	69	90	(21)	76.2%	**145**	**169**	**(24)**	**85.5%**
180	Accident & Emergency	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	13	13	0	100.0%	7	19	(12)	36.8%	**20**	**32**	**(12)**	**62.5%**
190	Anaesthetics	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	473	542	(69)	87.3%	**473**	**542**	**(69)**	**87.3%**
191	Pain Management	164	164	(0)	99.8%	0	1	(1)	0.0%	0	0	0	0.0%	33	59	(26)	55.5%	157	219	(61)	72.0%	605	533	72	113.6%	**959**	**976**	**(17)**	**98.3%**
192	Critical Care Medicine	0	0	0	0.0%	0	1	(1)	0.0%	48	39	9	122.4%	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	**48**	**40**	**8**	**119.3%**
214	Paediatric Trauma and Orthopaedics	10	19	(9)	52.6%	10	9	1	107.8%	10	9	1	107.7%	6	6	0	101.1%	223	295	(72)	75.7%	370	542	(172)	68.3%	**629**	**880**	**(251)**	**71.5%**
215	Paediatric Ear Nose and Throat	8	10	(2)	80.0%	2	10	(8)	20.9%	4	0	4	0.0%	62	84	(22)	74.4%	120	65	55	185.3%	39	56	(17)	69.4%	**236**	**225**	**11**	**104.8%**
216	Paediatric Ophthalmology	8	6	2	133.3%	0	0	0	0.0%	0	0	0	0.0%	29	33	(4)	86.6%	139	168	(29)	82.9%	373	491	(118)	76.0%	**549**	**698**	**(149)**	**78.6%**
217	Paediatric Maxillo-facial Surgery	16	6	10	266.7%	0	0	0	0.0%	4	0	4	0.0%	0	0	0	0.0%	1	0	1	0.0%	0	0	0	0.0%	**21**	**6**	**15**	**350.0%**
219	Paediatric Plastic Surgery	9	11	(2)	81.5%	1	2	(1)	62.7%	7	3	4	225.0%	31	24	7	128.6%	21	27	(6)	76.6%	39	25	14	154.7%	**108**	**92**	**15**	**116.7%**
254	Paediatric Audiological Medicine	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	269	219	50	122.8%	59	125	(66)	46.9%	40	68	(28)	59.3%	**368**	**412**	**(44)**	**89.3%**
257	Paediatric Dermatology	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	27	13	14	204.2%	26	31	(5)	82.5%	27	47	(20)	56.6%	**79**	**91**	**(12)**	**86.5%**
304	Clinical Physiology	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	132	123	9	107.7%	36	25	11	142.8%	42	48	(6)	87.2%	**210**	**196**	**14**	**107.1%**
310	Audiological Medicine	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	162	127	35	127.5%	42	47	(5)	89.9%	287	196	91	146.3%	**491**	**370**	**121**	**132.7%**
317	Allergy	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	**0**	**0**	**0**	**0.0%**
330	Dermatology	291	304	(13)	95.7%	0	0	0	0.0%	2	2	0	100.0%	2,196	2,067	129	106.2%	274	332	(57)	82.7%	618	702	(84)	88.1%	**3,381**	**3,407**	**(25)**	**99.3%**
658	Orthotics	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	85	84	1	101.2%	286	250	36	114.5%	**371**	**334**	**37**	**111.2%**
840	Audiology	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	143	241	(98)	59.3%	102	145	(43)	70.5%	306	321	(15)	95.2%	**551**	**707**	**(156)**	**77.9%**
Total - Surgery & Emergency (NNUH)		**1,864**	**2,084**	**(219)**	**89.5%**	**501**	**690**	**(189)**	**72.7%**	**1,051**	**1,013**	**38**	**103.7%**	**9,353**	**9,591**	**(239)**	**97.5%**	**7,742**	**8,025**	**(284)**	**96.5%**	**13,557**	**14,743**	**(1,186)**	**92.0%**	**34,068**	**36,146**	**(2,078)**	**94.2%**

Clinical Support Services Division		Daycase				Elective				Non Elective				OP - Procedure				OP - New (Exc Procedure)				OP - Follow Up (Exc Procedure)				Total			
		Estimate	Plan	Var	% Achieved	Estimate	Plan	Var	% Achieved	Estimate	Plan	Var	% Achieved	Estimate	Plan	Var	% Achieved	Estimate	Plan	Var	% Achieved	Estimate	Plan	Var	% Achieved	Estimate	Plan	Var	% Achieved
311	Clinical Genetics	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	**0**	**0**	**0**	**0.0%**
650	Physiotherapy	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	19	27	(8)	71.2%	569	686	(117)	83.0%	1,454	1,794	(340)	81.1%	**2,043**	**2,507**	**(464)**	**81.5%**
651	Occupational Therapy	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	112	50	62	224.6%	212	342	(130)	61.9%	590	734	(144)	80.3%	**913**	**1,126**	**(213)**	**81.1%**
652	Speech & Language Therapy	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	1	1	(0)	51.5%	35	40	(5)	87.5%	117	118	(1)	99.6%	**153**	**159**	**(6)**	**96.2%**
654	Dietetics	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	265	270	(5)	98.1%	336	318	18	105.7%	**601**	**588**	**13**	**102.2%**
656	Clinical Psychology	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	**0**	**0**	**0**	**0.0%**
711	Child and Adolescent Psychiatry	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	13	8	5	162.5%	55	41	14	134.1%	**68**	**49**	**19**	**138.8%**
713	Medical Psychotherapy	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	**0**	**0**	**0**	**0.0%**
811	Interventional Radiology	4	4	0	100.0%	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	18	29	(11)	62.1%	34	72	(38)	47.2%	**56**	**105**	**(49)**	**53.3%**
812	Diagnostic Imaging	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	2	0	2	0.0%	0	0	0	0.0%	**2**	**0**	**2**	**0.0%**
822	Chemical Pathology	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	**0**	**0**	**0**	**0.0%**
Total - Clinical Support (NNUH)		**4**	**4**	**0**	**100.0%**	**0**	**0**	**0**	**0.0%**	**0**	**0**	**0**	**0.0%**	**132**	**78**	**54**	**169.3%**	**1,114**	**1,375**	**(261)**	**81.0%**	**2,586**	**3,077**	**(491)**	**84.1%**	**3,836**	**4,534**	**(698)**	**84.6%**

REPORT TO TRUST BOARD

Date	**1 November 2023**
Title	**Month 6 IPR – Finance**
Author & Exec Lead	**Roy Clarke (Chief Finance Officer)**
Purpose	**For Information**
Relevant Strategic Commitment	**1 Together, we will develop services so that everyone has the best experience of care and treatment** **5 Together, we will use public money to maximum effect.**

Are there any quality, operational, workforce and financial implications of the decision requested by this report? If so explain where these are/will be addressed.	**Quality**	**Yes✓ No☐**	**Delivery of the financial plan supports the delivery of operational, quality and workforce plans**
	Operational	**Yes✓ No☐**	**Delivery of the financial plan supports the delivery of operational, quality and workforce plans**
	Workforce	**Yes✓ No☐**	**Delivery of the financial plan supports the delivery of operational, quality and workforce plans**
	Financial	**Yes✓ No☐**	**Delivery of the financial plan supports the delivery of operational, quality and workforce plans**
Identify which Committee/Board/Group has reviewed this document:	**Board/Committee: FIPC & HMB**		**Outcome: Report for information only, no decisions required.**

1 Background/Context

The Trust operational plan for FY23/24 as outlined in Cycle 4 of the 2023/24 planning process is breakeven.

2 Key issues, risks and actions

For September 2023, the Trust delivered a £0.2m deficit, which on a control total basis is on plan. The API adjustment in month is £0.2m adverse with September activity £1.1m adverse offset by a £0.9m case mix improvement for August against activity reported in August. CIP under delivery in month was £0.9m offset by additional interest income, reduced PDC charge and other non-recurrent savings, of which the Financial Recovery Plan has contributed £0.3m.

Year to date, position is a £7.8m deficit on a control total basis, which is £4.8m adverse to plan. £4.1m relates to Industrial Action with £2.4m of direct pay costs, £2.7m due to increased use of the independent sector to maintain activity levels and a £2.5m reduction in income due to activity under delivery, offset by increased income of £3.5m due to the 2% ERF reduction. CIP under delivery is £5.9m, additional interest income received of £2.2m, forecast reduction in PDC charge of £0.7m and non-recurrent underspends of £2.3m, of which the Financial Recovery Plan has contributed £0.8m.

Forecast Outturn: Risks totalling £17.0m and mitigations totalling £12.2m have crystalised year to date; a net impact of £4.8m adverse variance. Further crystallisation of these risks is forecast at £22.2m in year, requiring a further £27.0m of mitigation (via a Recovery Intervention) to achieve the breakeven plan. Appendix E sets out the Board approved list of identified mitigations and performance against these.

ERF Income: As a result of Industrial Action in April and May a 2% adjustment has been made to provider ERF values, which results in an increase in income of £3.5m. In line with guidance this adjustment is reflected in the year-to-date position. This additional income offsets the YTD activity based under performance of £2.5m and contributes a favourable £1.0m to the Trust's financial position.

Cash: Cash held on 30th September 2023 was £104.0m, £22.7m higher than the FY23/24 submitted forecast as result of the phasing to the capital programme and higher than planned creditors and accruals. Cash balances are forecast to remain favourable in 2023/24.

Capital Expenditure: In month the core programme was underspent by £0.8m. The current forecast outturn of £16.6m results in an adverse variance of £1.1m. This relates to Surgical Elective Centre costs not included within plan. The total programme is underspent by £2.4m Year to Date.

3 Conclusions/Outcome/Next steps

Year to date, the Trust delivered a £7.8m deficit against the planned £3.0m deficit, £4.8m adverse. Forecast Outturn remains Breakeven. The Trust underspent Capital Expenditure by £0.8m for the month. The latest Capital Forecast is an overspend of £1.1m.

Recommendations: The Board is recommended to **NOTE** the contents of the report

Norfolk and Norwich University Hospitals NHS Foundation Trust

Finance Report September 2023

1 November 2023

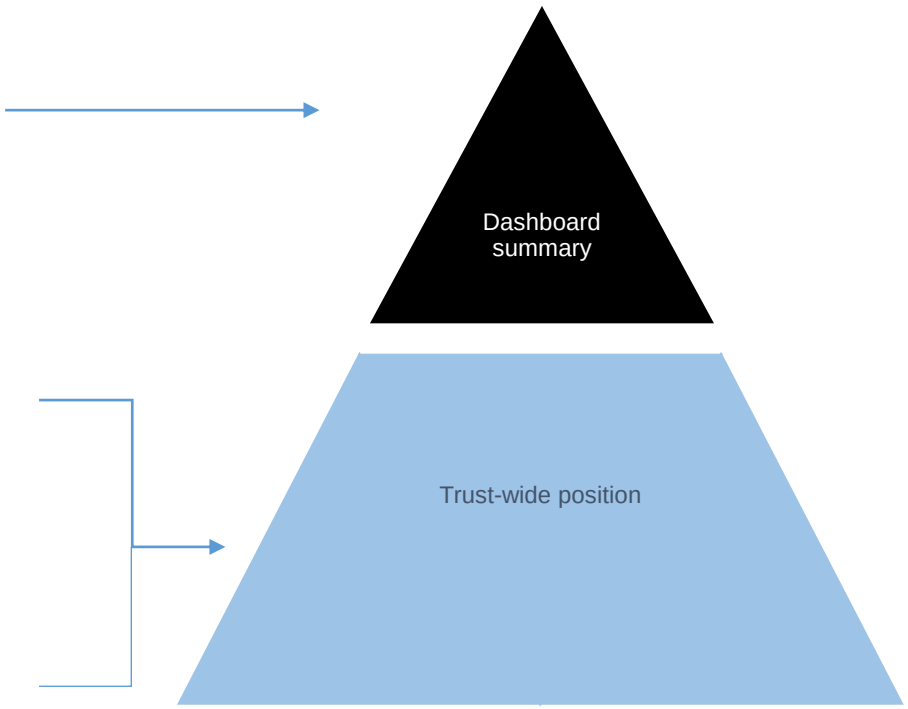
Roy Clarke, Chief Finance Officer

Norfolk and Norwich University Hospitals NHS Foundation Trust

Contents

This report sets out the Trust's financial performance and forms part of the Trust's performance reporting suite.

The report has been structured to provide the reader with an overview of the Trust's financial performance using the following framework.



Norfolk and Norwich University Hospitals NHS Foundation Trust

1.1 Executive Dashboard

The Trust operational plan for FY23/24 as outlined in Cycle 4 of the 2023/24 planning process is breakeven.

For September 2023, the Trust delivered a £0.2m deficit, which on a control total basis is on plan. The API adjustment in month is £0.2m adverse with September activity £1.1m adverse offset by a £0.9m case mix improvement for August against activity reported in August. CIP under delivery in month was £0.9m offset by additional interest income, reduced PDC charge and other non-recurrent savings, of which the Financial Recovery Plan has contributed £0.3m.

Year to date, position is a £7.8m deficit on a control total basis, which is £4.8m adverse to plan. £4.1m relates to Industrial Action with £2.4m of direct pay costs, £2.7m due to increased use of the independent sector to maintain activity levels and a £2.5m reduction in income due to activity under delivery, offset by increased income of £3.5m due to the 2% ERF reduction. CIP under delivery is £5.9m, additional interest income received of £2.2m, forecast reduction in PDC charge of £0.7m and non-recurrent underspends of £2.3m, of which the Financial Recovery Plan has contributed £0.8m.

ERF Income: As a result of Industrial Action in April and May a 2% adjustment has been made to provider ERF values, which results in an increase in income of £3.5m. In line with guidance this adjustment is reflected in the year-to-date position. This additional income offsets the YTD activity based under performance of £2.5m and contributes a favourable £1.0m to the Trust's financial position.

Forecast Outturn: Risks totalling £17.0m and mitigations totalling £12.2m have crystalised year to date; a net impact of £4.8m adverse variance. Further crystallisation of these risks is forecast at £22.2m in year, requiring a further £27.0m of mitigation (via a Recovery Intervention) to achieve the breakeven plan. **Appendix E sets out the Board approved list of identified mitigations and performance against these.**

Cash: Cash held on 30th September 2023 was £104.0m, £22.7m higher than the FY23/24 submitted forecast as result of the phasing to the capital programme and higher than planned creditors and accruals. Cash balances are forecast to remain favourable in 2023/24.

Capital Expenditure: In month the core programme was underspent by £0.8m. The current forecast outturn of £16.6m results in an adverse variance of £1.1m. **This relates to Surgical Elective Centre costs not included within plan.** The total programme is underspent by £2.4m Year to Date.

	In Month			Year to date		
	Actual	Plan	Variance	Actual	Plan	Variance
SOCI	£m	£m	£m	£m	£m	£m
Clinical Income	63.2	63.0	0.2	376.0	374.0	2.0
Other Income	9.1	9.5	(0.4)	51.6	48.7	2.9
TOTAL INCOME	**72.3**	**72.5**	**(0.2)**	**427.6**	**422.7**	**4.9**
Pay	(42.7)	(43.3)	0.6	(258.2)	(256.4)	(1.8)
Non Pay	(20.9)	(20.1)	(0.9)	(122.1)	(113.8)	(8.3)
Drugs (Net Expenditure)	(3.0)	(2.8)	(0.2)	(19.1)	(16.2)	(2.9)
TOTAL EXPENDITURE	**(66.5)**	**(66.2)**	**(0.4)**	**(399.3)**	**(386.3)**	**(13.0)**
Non Opex	(6.0)	(6.6)	0.6	(36.1)	(39.4)	3.2
Reported Surplus / (Deficit)	(0.2)	(0.2)	0.0	(7.8)	(3.0)	(4.8)
Other Financial Metrics	£m	£m	£m	£m	£m	£m
Cash at Bank (before support funding)	104.0	81.3	22.7	104.0	81.3	22.7
Capital Programme Expenditure	2.8	6.2	(3.4)	12.7	15.2	(2.4)
CIP Delivery	1.1	2.1	(0.9)	5.3	11.3	(5.9)
Activity Metrics*	%	%	%	%	%	%
Day Case*	92%		(8%)	96%		(4%)
Elective Inpatient*	80%		(20%)	87%		(13%)
Outpatients - New & Procedures*	94%		(6%)	97%		(3%)
Activity performance v baseline*	93%		(7%)	96%		(4%)
Value based Activity performance v baseline**	93%		(7%)	101%		1%

** Activity count as a % of 23/24 Planned Delivery and not adjusted for the 2% as the adjustment impacts the fixed and variable financial value and not the contracted activity plan*

*** Adjusted for the 2% reduction to ERF*

Norfolk and Norwich University Hospitals NHS Foundation Trust

1.2 Executive Dashboard

Risk

The strategic financial risks remain the same as Cycle 4 Business planning Process in nature. The Risks will remain beyond tolerable levels should the underlying issues not be resolved.

As part of FY23/24 annual planning there were 13 key strategic and operational risks identified with an initial score of ≥ 9. The Finance Directorate continues to formally review the Financial Risk Register on a monthly basis, reviewing the risks and adding new risks which have been identified across the finance portfolio.

There are nine risks rated as 'Extreme' on the risk register which have a potential risk assessed financial impact of £46.6m, of which £17.0m has crystalised YTD. A further £22.2m is forecast to crystallise.

The YTD crystalised risks are:

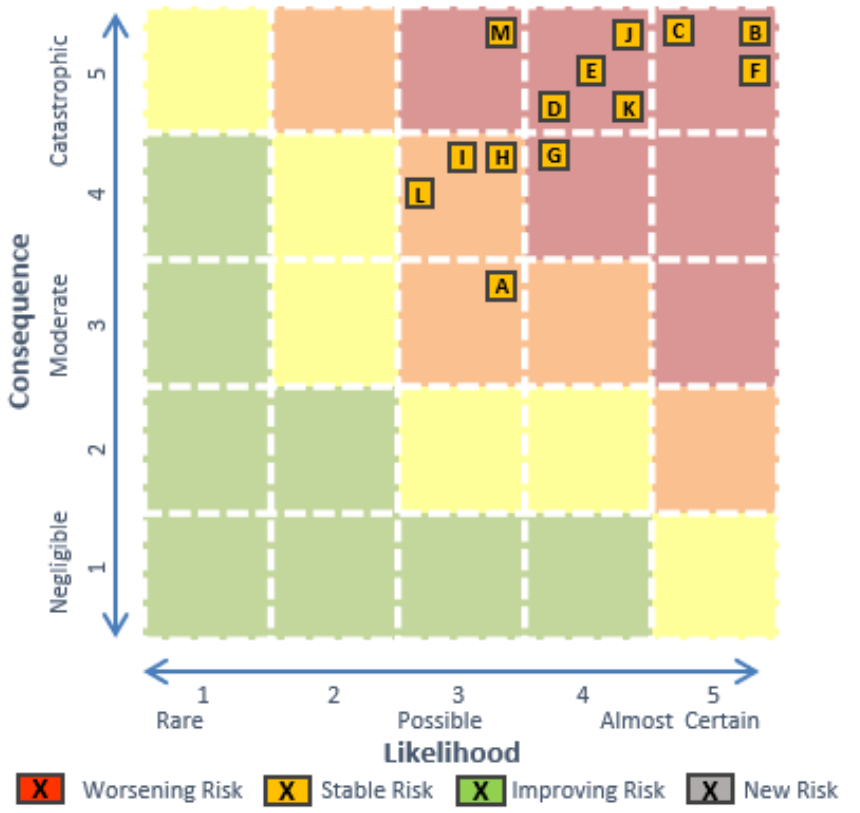
CIP Under Delivery (Risk B) is £5.9m adverse year to date - £5.3m delivered against the budgeted plan of £11.2m, comprising of a planning variance of £5.8m and an adverse performance variance of £0.1m, which equates to an underperformance of c. 55%. The risk adjusted forecast outturn CIP delivery is currently £16.0m against a target of £28.0m presenting a significant risk to achievement.

Failure to control expenditure in line with plan (Risk C) has a crystalised impact of £5.8m YTD, comprising £2.4m of spend to cover Industrial Action in April, June, July & September and overspends in Pay and Drugs.

The Trust creating additional capacity at additional cost to the Trust beyond the level allowed for in the plan (Risk G) has a crystalised impact of £2.7m YTD. This is as a result of having to bring forward the use of the Independent Sector to deliver activity lost as a result of Industrial Action.

Financial Recovery Plan (FRP): Performance against the agreed mitigations in Month 6 was £0.3m against a planned £0.7m. The main drivers of the variance was failure to implement mitigations. The revised Forecast Outturn results in the change control movements identified in the updated recovery intervention table in Appendix E.

Risk Rating		Risks	Financial Impact FY23/24 (Cycle 4) £m	Financial Impact FY23/24 (Revised) £m	YTD Crystallised Impact £m
Extreme	15+	B, C, D, E, F,G , J, K, M	45.4	46.6	17.0
High	9-14	A, H, I, L	15.3	15.3	0.0
Moderate	5-8	-	0.0	0.0	0.0
Low	1-4	-	0.0	0.0	0.0
Total			60.7	61.9	17.0
Risk mitigated through Non Recurrent YTD underspends & Release of Expenditure Reserves					(12.2)
Total			60.7	61.9	4.8



Norfolk and Norwich University Hospitals NHS Foundation Trust

1.3 Executive Dashboard – Forecast Outturn

The impact of Industrial Action, failure to deliver the Trust's elective activity plan and under-delivery of CIP has led to forecast risks of £38.7m full year. Continuing to focus on implementation of the Financial Recovery plan will ensure the Trust remains on track to deliver a breakeven position.

Industrial Action

The costs and loss of income from activity under-delivery in relation to the Industrial Action that has either occurred, or has been announced has been off-set by some additional funding adjustments in the year-to-date position, but leaves an unfunded residual cost to the Trust of £5.6m, including the forecast costs and lost activity relating to future announced action.

Activity Plan Expectations

The planned levels of activity approved in the Cycle 4 2023/24 Business Plan sees a marked increase in the second half of the year. Assuming the activity lost to industrial action is recovered, without further capacity or improved efficiency the additional activity in the plan is unlikely to be delivered, crystalising a risk in the Trusts income plan of c£7.1m. As this income is through the variable element of the Trusts contracts with its various commissioners, without a material change in delivery performance the likelihood is that this income will not be earned by the Trust, creating a further significant financial pressure.

The delivery of activity in the year to date has been supported by the early and accelerated utilisation of capacity in the Independent Sector (IS), which would be expected to reduce over future periods as this delivery has been about bringing forward activity to over-achieve the plan. The ability to deliver the increased activity plan for the second half of the year without continued use of the IS has not been evidenced, which has led to the financial risk assessment in the Forecast Outturn for the year that the additional activity will not be delivered and therefore the income associated with this will not be received.

There has been an assumption in the proposed forecast outturn that to manage this Independent Sector activity will continue in Quarter 3, before ceasing in Quarter 4.

Recovery Plan Interventions

The Trust Board approved a series of Recovery Interventions as part of the financial assessment after month two of the financial year. It is clear from tracking these interventions that the central and corporate interventions have been delivered, but the interventions in the clinical divisions have not met the pace of change required, compounding the financial impact. The under-delivery of the recovery plan up to Month 6 was £1.6m.

Cross divisional interventions in relation to the control of temporary staffing spend and the delivery of in-year Cost Improvement Plans have also failed to deliver to the pace or value required and as approved in the recovery interventions.

Additional Interventions

Due to the failure to deliver the non-central recovery interventions, and the continued use of the independent sector, coupled with the low confidence in the delivery of the required levels of activity over the second half of the year to deliver the planned income for elective activity, additional interventions totalling £11.8m are required. The revised assumptions are:

1. Extend IS activity to the end of Quarter 3, but cease for Quarter 4 pending outcome of further national funding
2. Deliver remaining recovery plan including FYE CIP
3. Use of non-recurrent funding available of £10.0m
4. Additional Support of £1.8m

Risk and Scenario Planning

There continue to be a number of volatile planning assumptions in the revised forecast position, and scenario planning for alternative forecast outturns has been undertaken, which give a range of outturn positions from a surplus of £3.2m to a deficit of £27.2m. This volatility is driven by further Industrial Action, delivery of different levels of activity and use of the independent sector, and different levels of additional support.

Outstanding Management Actions:

- **Deliver outstanding FRP actions:** Divisions and Corporate areas including identifying 100% of FYE CIP by as soon as practically possible as noted in bullet points 1 & 2 above;
- **Revised Financial Recovery Plan (FRP) mitigations:** as noted in bullet points 3 & 4 above
- **NANOC 2:** Resolve the funding gap through completion of the FBC

Completed Management Actions:

- **Capital Programme:** Variation to meet break even requirement

Norfolk and Norwich University Hospitals NHS Foundation Trust

2.1 Financial Performance – September 2023

For September 2023, the Trust delivered a £0.2m deficit, which on a control total basis is on plan. The API adjustment in month is £0.2m adverse with September activity £0.9m adverse offset by a £1.1m case mix improvement for August against activity reported in August. CIP under delivery in month was £0.9m offset by additional interest income, reduced PDC charge and other non-recurrent savings, of which the Financial Recovery Plan has contributed £0.3m.

Income: The API adjustment in month is £0.2m adverse with September activity £1.1m adverse offset by a £0.9m case mix improvement for August against activity reported in August. This has resulted in a £0.2m adverse position. £0.3m of additional income relating to pass through devices expenditure is offset by reduced EPA activity.

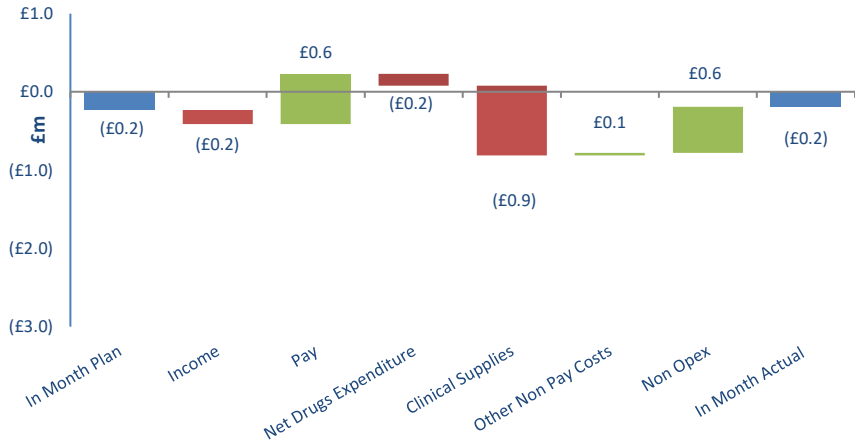
Pay: Pay is underspent in September by £0.6m. This variance is due to £0.5m of underspends in Corporate, Nursing and Admin & Clerical roles and £0.6m underspends in R&D and Clinical Trails partially offset by £0.5m of unidentified CIP. Pay control in clinical divisions requires additional focus as the pay recovery processes implemented in the last quarter of 2022/23 have not been sustained. This is particularly in relation to Medical and Other pay across all divisions. September agency spend was 3.56%, an increase from 3.29% in August and 0.15% lower than the NHSE threshold of 3.7%.

Net Drugs Cost: The net drugs position for September is £0.2m adverse to plan. This is due to overspends in Surgery on ophthalmology drugs of £0.1m and Oncology increased costs of Lanreotide, Palbociclib and Doxorubicin accounting for the remainder of the variance.

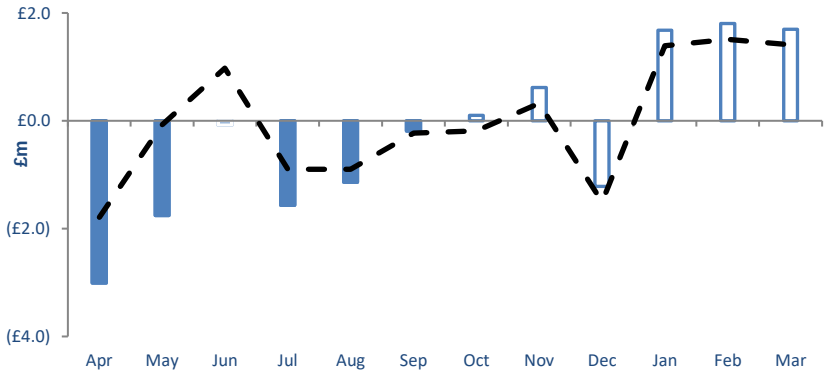
Non-Pay: There is a £0.8m adverse variance across non-pay in September. This is made up of £0.3m as a result of unidentified CIP, and £0.3m of pass-through costs for devices (which are offset by income) and £0.2m overspends in theatres.

Non-Operating Expenditure: There is a £0.6m favourable variance in September. This is due to additional interest income received of £0.4m, £0.1m less depreciation than plan and £0.1m reduction in PDC dividend.

Financial Recovery Plan (FRP): In Month 6 performance against the agreed mitigations was £0.3m against a planned £0.7m. The main drivers of the variance were a failure to implement reductions in locum use in AMU & Respiratory; nursing premium fill rate, which continues behind plan. Mitigations 5 and 6 are adverse by c. £0.5m predominantly as a result of increased underlying expenditure in Surgery (£0.7m), offset by a favourable performance in Corporate



Monthly Reported Surplus/(Deficit)



Norfolk and Norwich University Hospitals

2.2 Financial Performance – Year to date

Year to date, position is a £7.8m deficit on a control total basis, which is £4.8m adverse to plan. £4.1m relates to Industrial Action with £2.4m of direct pay costs, £2.7m due to increased use of the independent sector to maintain activity levels and a £2.5m reduction in income due to activity under delivery, offset by increased income of £3.5m due to the 2% ERF reduction. CIP under delivery is £5.9m, additional interest income received of £2.2m, forecast reduction in PDC charge of £0.7m and non-recurrent underspends of £2.3m, of which the Financial Recovery Plan has contributed £0.8m.

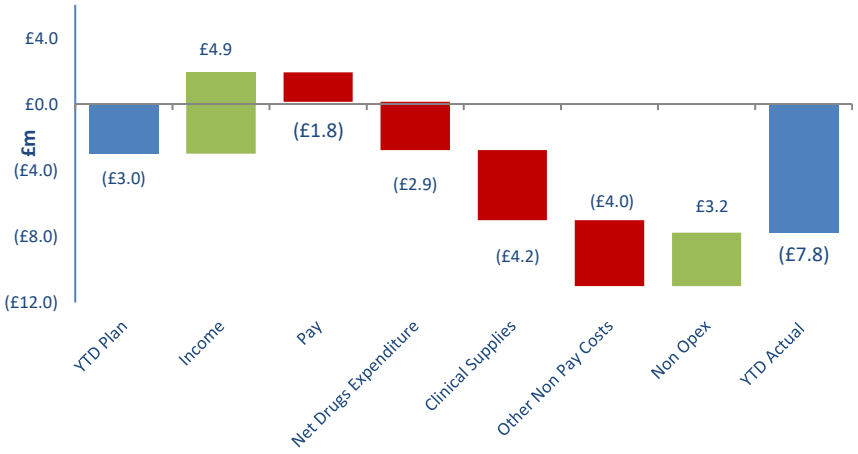
Income: Income is reporting a favourable variance of £4.9m year to date. This is predominantly due to £3.5m for the 2% adjustment to ERF offset by a £2.5m reduction in income due to under performance, The remaining variance is due to increased pass through income for R&D (£1.4m), high-cost devices £1.0m, E&T and consultant recharges.

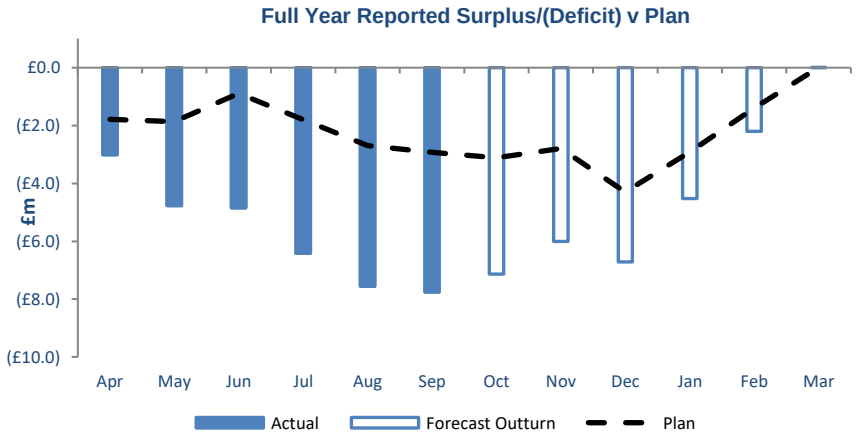
Pay: Pay is overspent by £1.8m year to date. This is due to additional pay for industrial action of £2.4m, and £3.5m of unidentified CIP, of which £2.2m is in Surgery, offset by underspends across Corporate, Nursing and A&C, and delayed investments totalling £4.1m. Pay control in clinical divisions requires additional focus with the overspend in pay evident despite investment in the 2023/24 approved budgets. Pay is overspending in medical staffing in all divisions, and in nursing in Medicine and Clinical Support. Year to date agency spend is 3.55%, 0.15% lower than the set threshold of 3.7%. Registered Nursing is the largest user of agency spend, being 4.46% of total nursing spend.

Net Drugs Cost: Year to date net drugs position is £2.9m adverse. This is due to increased expenditure on drugs included within block agreements (£2.8m) and unachieved CIP of £0.1m. Average price increases are estimated to be c.6% resulting in a c. £0.6m pressure. Usage of Adalimumab, Lanreotide & Dalteparin have increased by c.29% in the past 12 months and these drugs are included within tariff thus no offsetting income is received. Work is ongoing with Pharmacy to assess if the change in usage is commensurate with the clinical need.

Non-Pay: Year to date non pay is £8.2m adverse to plan. This is due to £2.7m additional expenditure on the independent sector to sustain activity levels, R&D expenditure which is offset by income of £1.4m, £2.0m overspends in clinical supplies (including pass through devices)with the remainder of the variance, £2.3m, being unidentified CIP, of which £1.3m is Surgery.

Non-Operating Expenditure: Year to date non-operating expenditure is showing a £3.2m favourable variance predominantly due to additional interest income received and a forecast reduction in PDC charge, both because of higher cash balances.



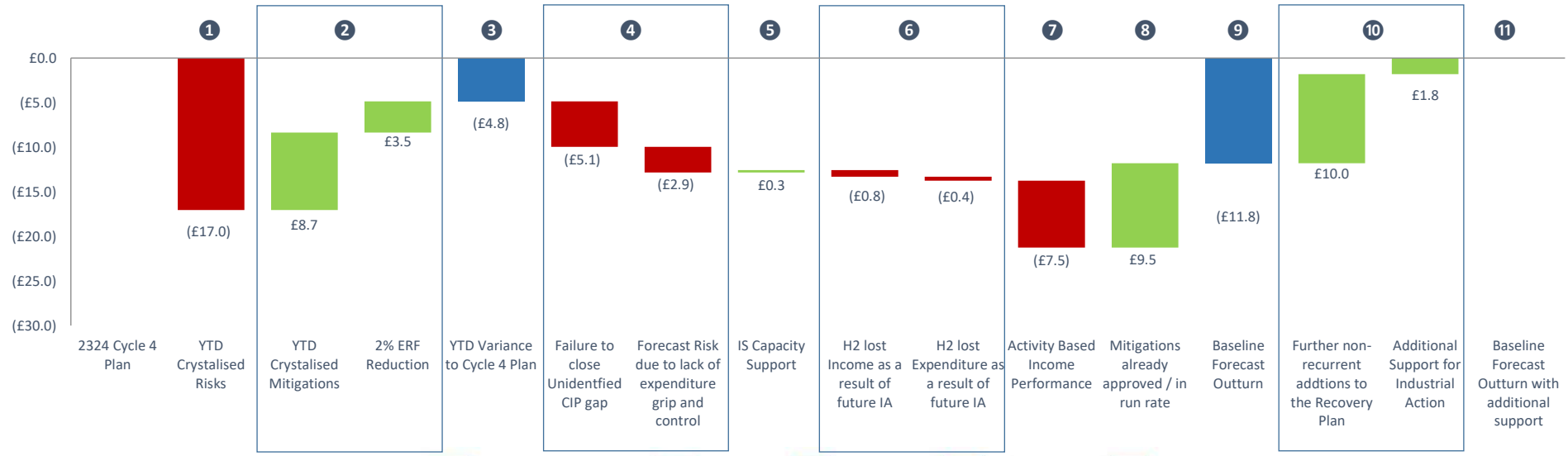


Norfolk and Norwich University Hospitals NHS Foundation Trust

2.3 23/24 Forecast Outturn (FOT) by variance from Plan

Forecast Outturn: The 23/24 plan was breakeven with identified risks totalling £60.7m offset by assumed mitigations totalling £60.7m. Risks totalling £17.0m and mitigations totalling £12.2m have crystalised year to date, a net impact of £4.8m adverse variance. Further crystallisation of these risks is forecast at £22.2m in year, requiring a further £27.0m of mitigations to achieve the breakeven plan. Further mitigations totalling £27.0m have been identified, primarily being use of reserves and other non-recurrent funds, plus additional support of £1.8m forecast to be received from NHSE, resulting in a breakeven forecast outturn.

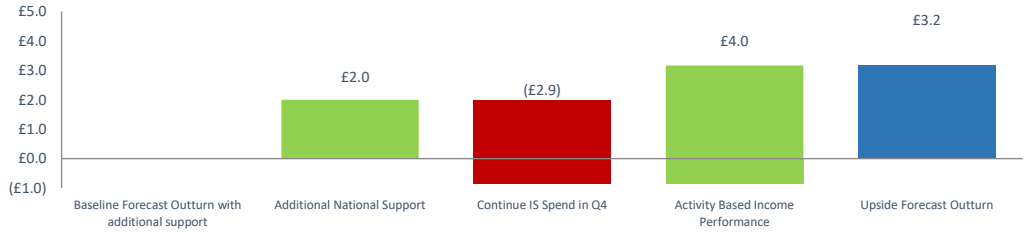
1. Year to date crystalised risk of £17.0m, £7.6m relating to Industrial Action with £2.4m as a result of direct pay costs, £2.7m due to increased use of independent sector capacity to maintain activity levels and £2.5m of lost Income. CIP Under-delivery is £5.9m
2. Year to date crystalised mitigations of £12.2m, of which £3.5m relates to the 2% reduction in ERF and £8.7m of non-recurrent underspends.
3. Year to date performance £4.8m adverse to plan
4. Further run rate risk of £8.0m forecast to crystallise through remainder of the year based on current run rates
5. IS Capacity support to continue at current rates (c. £0.9m per month) until December and ceasing in Q4. This creates an overspend in Months 7-9 of £1.2m and a saving of £1.5m in Months 10-12
6. Forecast impact of planned industrial action Oct of £1.2m, of which £0.4m is expenditure and £0.8m is due to lost income
7. Future variable activity under performance against the plan of £7.5m due to non-delivery of stepped increase in the agreed activity plan
8. Identified mitigations totalling £9.5m assumed in run rate including use of Reserves
9. Baseline Forecast Outturn of £11.8m deficit, £11.8m adverse to the breakeven plan
10. Additional mitigations of £11.8m to deliver breakeven plan, of which £10.0m relates to the release of non-recurrent funds held and additional £1.8m of support from NHSE
11. Baseline Forecast Outturn with additional support of breakeven



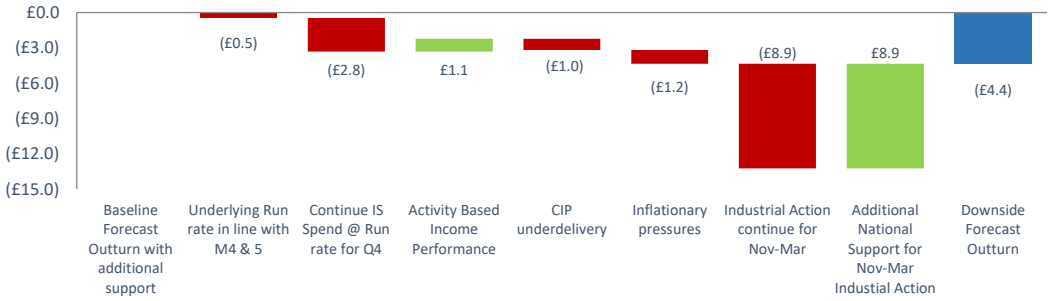
Norfolk and Norwich University Hospitals NHS Foundation Trust

2.4 23/24 Forecast Outturn (FOT) by variance from Plan

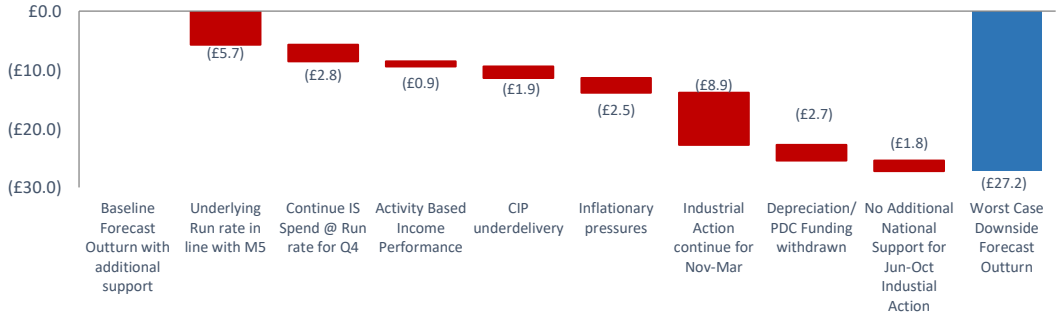
Forecast Outturn: Baseline Forecast Outturn is breakeven with an upside forecast outturn of a £3.2m surplus and a downside forecast outturn of a £4.4m deficit. Worst Case downside Forecast Outturn is a deficit of £27.2m. The total range of the Upside to Worst Case Downside Forecast is £30.4m



Upside Forecast Outturn is a surplus of £3.2m. This increase is assuming £2.0m of additional support from NHSE (Total £3.8m) and a £4.0m reduction in the assumed under-delivery of activity offset by additional expenditure in IS capacity of £2.8m.



Downside Forecast Outturn is a deficit of £4.3m. This decrease is due a worsening of the underlying run rate of £0.5m, additional expenditure in IS capacity of £2.8m offset by a £1.1m reduction in the assumed under-delivery of activity. CIP delivery variance of £0.9m and additional inflationary pressures of £1.2m are also included. £8.9m of additional costs relating to continued industrial action is offset by £8.9m of support funding in line with regional planning guidance.



Worst Case Downside Forecast Outturn is a deficit of £27.2m. This decrease is due to a worsening of the underlying run rate of £5.7m, additional expenditure in IS capacity of £2.8m and a £1.1m increase in the assumed under-delivery of activity. CIP delivery variance of £1.9m and additional inflationary pressures of £2.5m are also included. £8.9m of additional costs relating to continued industrial action is not offset by £8.9m of support funding as well both the £1.8m of additional funding assumed in the Baseline Forecast and £2.8m of depreciation funding included with in the System contract not being received.

Our Vision
The best care for every patient

NHS
Norfolk and Norwich University Hospitals
NHS Foundation Trust

Diversity, Inclusion & Belonging Strategy

Our plan for the next 5 years...

Welcome

"Our Diversity, Inclusion and Belonging strategy for the next five years has been developed with and for the more than 11,000 people who work and volunteer in our hospitals and other NNUH services as well as our patients. We all have different backgrounds, lived experiences, needs and expectations, but together we are Team NNUH and we aim to provide the best care to every patient."

In April 2022 we published our five year Caring with PRIDE plan, which shows how we will deliver our five commitments that, together, will help us give the best care for every patient. Our new purpose statement "working together, continuously improving for all" underpins our commitment to teamwork, collaboration, inclusivity and quality.

"Together, we will support each other to be the best that we can be, to be valued and proud of our hospital for all."

Our hospital for all

The National Context

A number of national reports, plans and policies support improving diversity, inclusion and belonging for staff, patients and our communities. These include:

The NHS People Plan

"The NHS People Plan aims to have more people, working differently, in a compassionate and inclusive culture across healthcare. It sets out actions to support transformation across the whole NHS, focusing on how we must continue to look after each other and foster a culture of inclusion and belonging. This is supported by actions to grow our workforce, train our people and work together differently to deliver excellent patient care. The NHS People Plan also aligns with the NHS England EDI Improvement Plan which was launched in June 2023. The EDI Improvement Plan consists of six high impact actions which aim to: address discrimination, increase accountability for all leaders, support the levelling up agenda and make opportunities for progression equitable."

The NHS People Promise

"This sets out what NHS staff say would make the greatest difference to their working lives and has seven themes. Our strategy will take into consideration how each of the people promise themes align to our objectives and specifically the theme 'compassionate and inclusive'."

People Promise

CORE20plus5

Health inequalities within and between populations groups have been highlighted during the pandemic, in particular people from Black Asian and Ethnic Minority communities. However we have known for many years that people living in the poorest circumstances have significantly poorer health outcomes and experiences of care.

NHS England have therefore introduced the CORE20plus5 approach, which aims to help organisations prioritise and focus on key clinical areas to reduce health inequalities. These cover Adults and Children.

CORE20 refers to the most deprived 20% of the population

Plus refers to Integrated Care System (ICS) identified populations or communities that are not thriving, and explicitly may include inclusion health groups.

5 refers to the five clinical areas of focus, where there are particular inequalities.

Adults

The following clinical areas are being focused on for adult patients:

- Maternity, focusing on continuity of care
- Severe mental illness, facilitating annual health checks
- Chronic respiratory disease, increasing the uptake on vaccines (Flu etc.) to reduce emergency admissions to hospital
- Early cancer diagnosis
- Hypertension (High Blood pressure) to allow for interventions to optimise blood pressure and minimise the risk of myocardial infarction (Heart Attack) and stroke.

Children

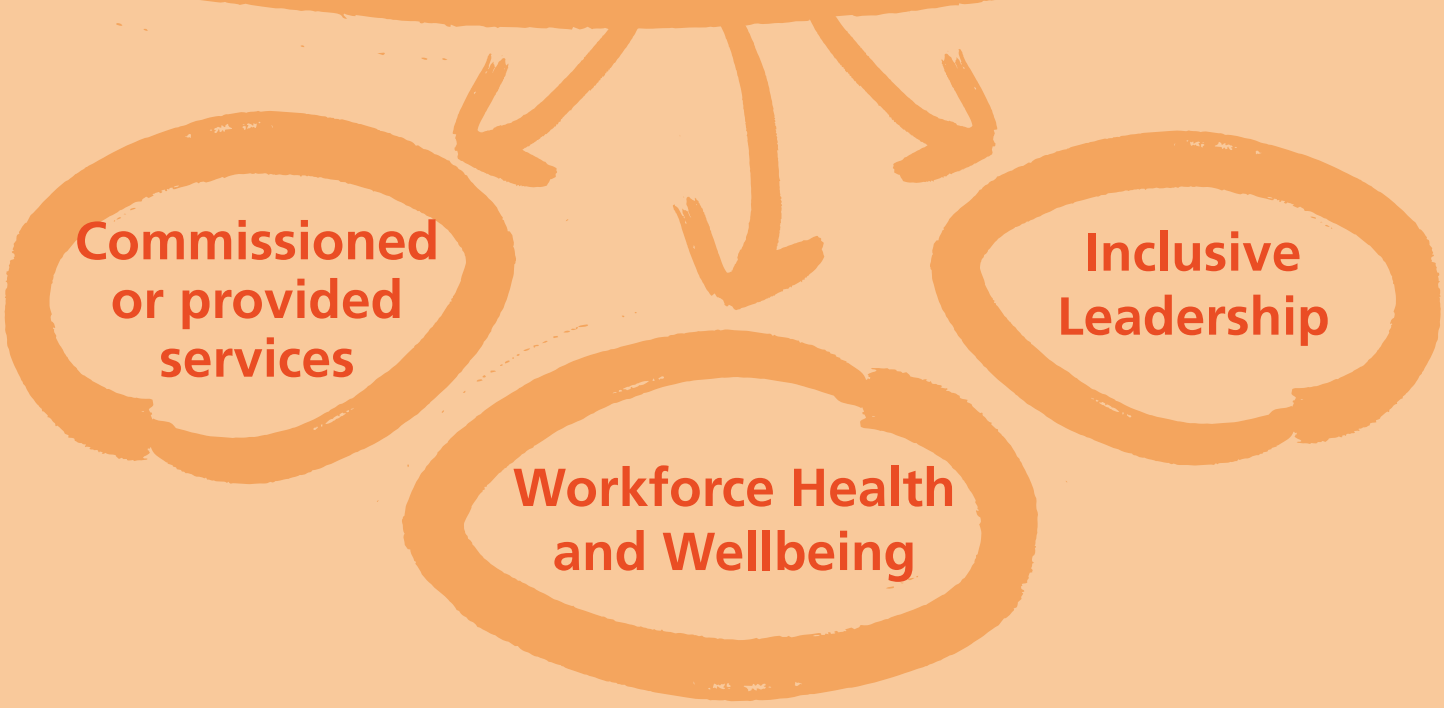
The following clinical areas are being focused on for children and young people:

- Asthma, review the use of medication to improve the prevention of emergency episodes
- Diabetes, improve access to health checks and tools to manage the condition
- Epilepsy, improve access to support
- Oral health, decrease the waiting lists
- Mental health, improve access to services.

What is the Equality Delivery System 2022?

The Equality Delivery System (EDS) is a system that helps NHS organisations improve the services they provide for their local communities and provide better working environments, free of discrimination, for those who work in the NHS, while meeting the requirements of the Equality Act 2010. The EDS was developed by the NHS, for the NHS, taking inspiration from existing work and good practice.

The Equality Delivery System 2022 is split into three domains:



"Following engagement with key stakeholders it was felt that referring to the EDS2022 would be a helpful reference to steer our Diversity, Inclusion and Belonging strategy and so it has been agreed that we would form these domains into our commitment areas – tailoring where it was deemed appropriate."

Our Diversity and Inclusion Vision

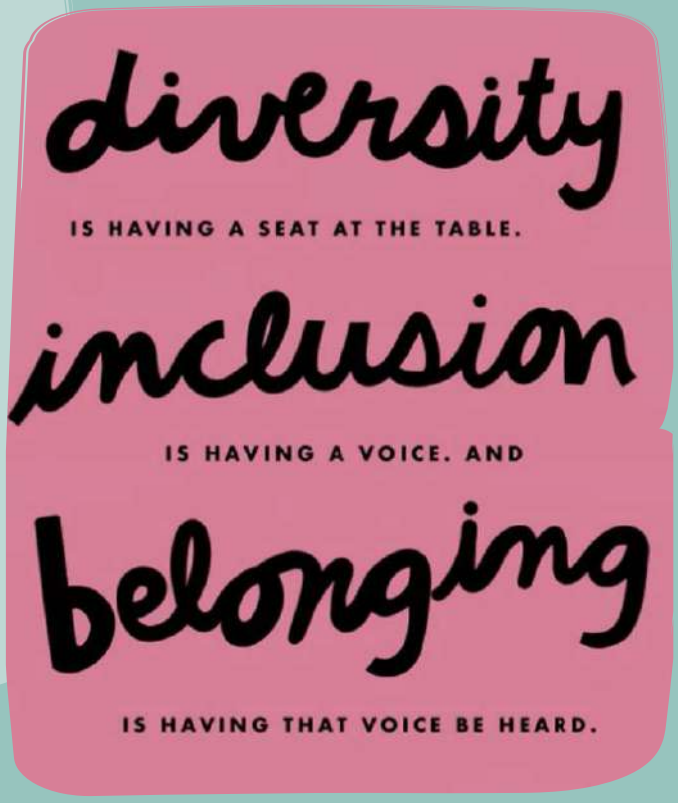
Our Diversity and Inclusion vision is to create a hospital for all people. Where everyone feels a sense of belonging.

Belonging is having a voice that can be heard.

We want to embed a culture where every team member and patient feels they can bring their true authentic selves to work or when seeking treatment at our hospital, without judgement or fear.

Embedding such a culture has a direct impact on the experiences of our staff and patients and so therefore aligns to our overarching corporate vision; to provide the best care to every patient.

We have developed the overarching objectives and actions in this plan to be intersectional. This recognises that people have complex and multiple identities, and that multiple forms of inequality or disadvantage sometimes combine to create obstacles that cannot be addressed through the lens of a single characteristic in isolation.

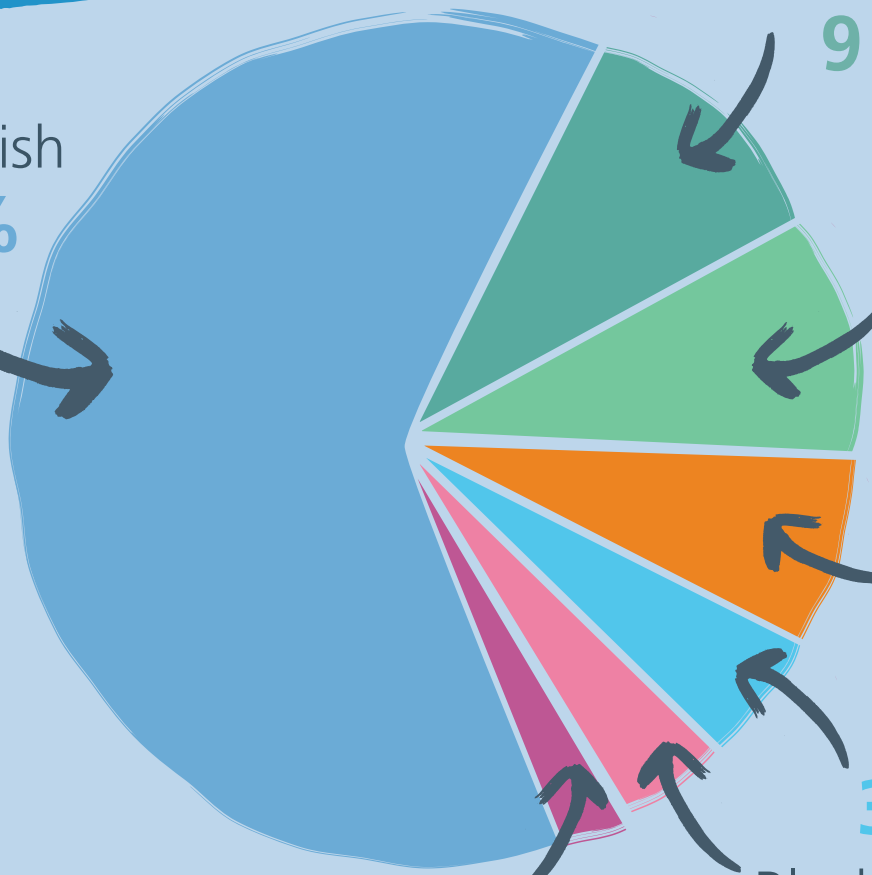


Our Local Context

- Where diversity - across the whole workforce - is underpinned by inclusion, staff engagement, retention, innovation and productivity improve. Inclusive environments create psychological safety and release the benefits of diversity - for individuals and teams, and in turn efficient, productive and safe patient care.
- The Diversity, Inclusion and Belonging Strategy supports delivery of the Trust's 5-Year Strategy: Caring with PRIDE and People & Culture Strategy.
- The Caring with PRIDE Strategy specifically outlines what NNUH needs to address and action to ensure that all patients are treated with respect and equity. Since the creation of the Caring with PRIDE Strategy, the Patient Engagement and Experience team have undertaken consultation and feedback with seldom heard community groups, Carers and Veterans to better understand their needs and their opinions of the services provided to them at NNUH.
- Staff survey and workforce data reflecting the lived experience of our staff demonstrates that we have more to do before we can say inclusive workplace environments are the norm across our hospital.
- For example, 15% of the workforce are from Black, Asian and Minority Ethnic (B.A.M.E) backgrounds but face discrimination across many aspects of their working lives.
- The 2023 Workforce Race Equality Standard data showed that 35.6% of Black and minority ethnic (BME) staff experienced bullying, harassment or abuse from other staff.
- The NHS Staff Survey along with the Workforce Disability Equality Standard shows that 31.8% of disabled staff have experienced bullying from their colleagues, compared to 21.9% of non-disabled staff.
- Similarly, 34.5% of our LGBT+ colleagues face bullying and harassment at work from other colleagues compared to 23.6% of heterosexual staff.

Our Workforce

Ethnicity



Asian/
Asian British
9%

White British
69.2%

Not
Stated
7.5%

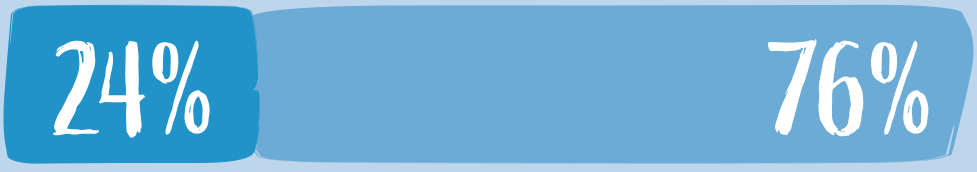
White
Other
6.7%

Other
3.1%

Black/
Black British
3%

Mixed
1.5%

Gender

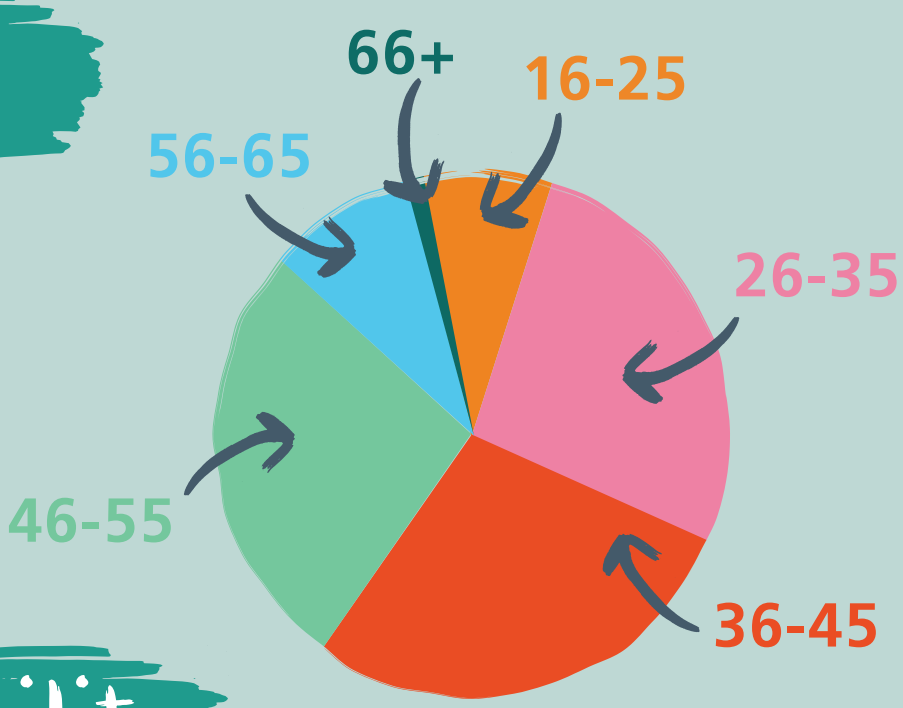


Male
24%

Female
76%

Our Workforce

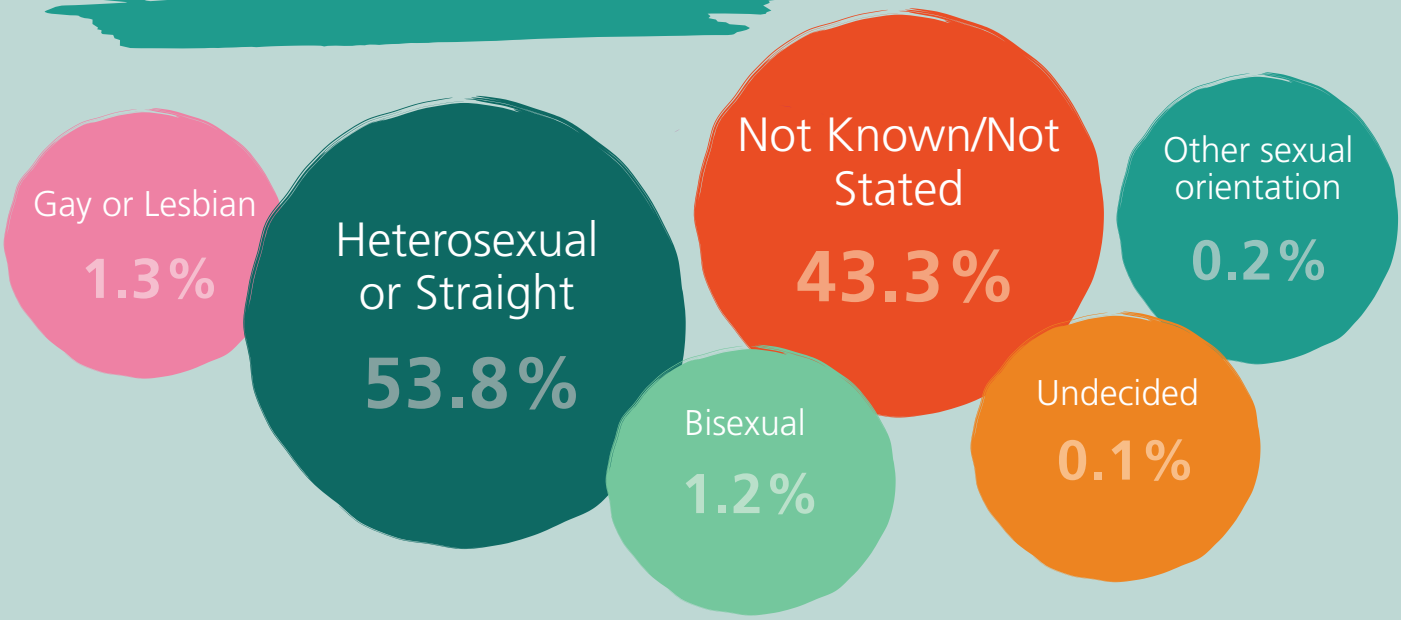
Age



Disability

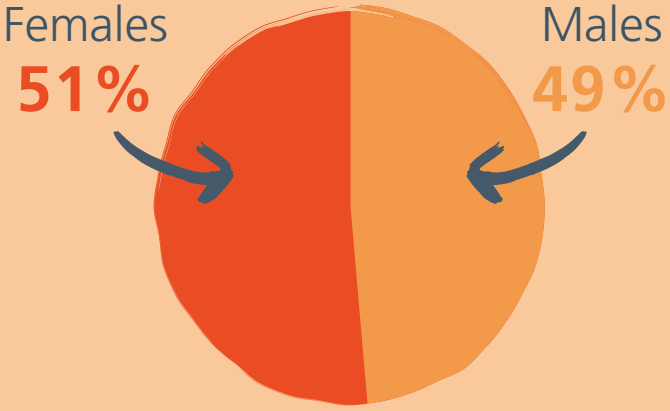
Yes	No	Unknown
3%	50.3%	46.7%

Sexual Orientation

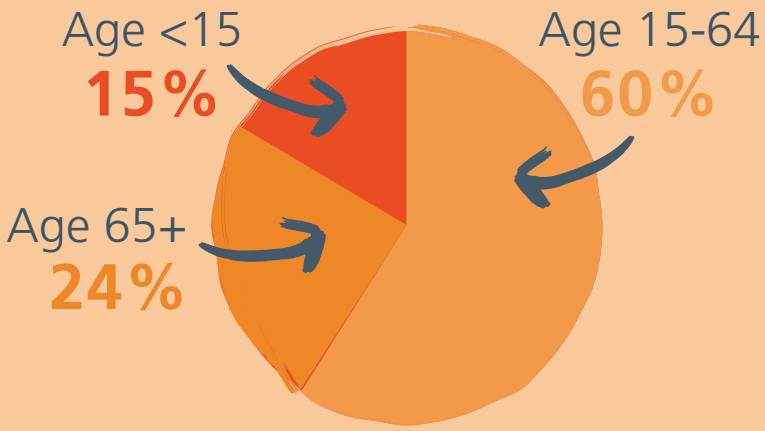


Norfolk Demographics

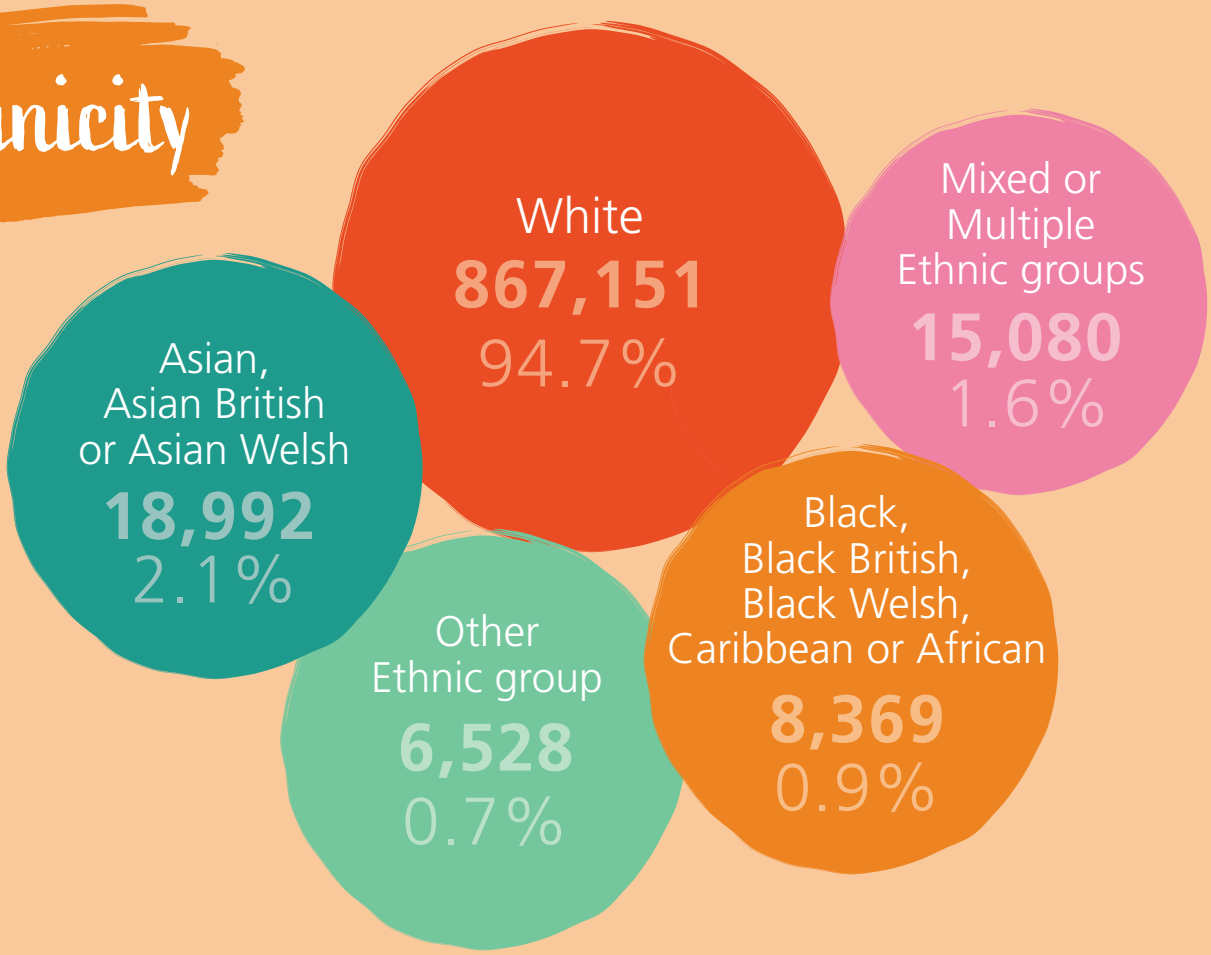
Population by sex for Norfolk (2021)



Population by broad age group for Norfolk (2021)



Ethnicity



Commissioned or Provided Services

Equality, diversity and inclusion is the golden thread that ties all of our Trust's patient experience work together. We believe that the Diversity, Inclusion and Belonging Strategy is the heart of Caring with PRIDE. With evidence collated from community outreach, Friends and Family Tests (FFTs), Local Equality and Diversity Groups (LEDGes) and the Patient Panel.

This strategy reflects the needs and wants of patients and staff at the NNUH.

We are an acute teaching hospital and aspire to provide the best care to every patient. Our patients all have their own individual needs and have different backgrounds, religions and beliefs.

National evidence suggests some patients and communities' experiences of accessing and using services can be less positive and may result in poorer health outcomes due to their socio-economic and demographic backgrounds. The Trust needs to consider these differences to ensure all patients receive equitable healthcare and have the best chance to achieve optimum clinical outcomes.

To properly guide our goals, we must look at the limitations in patient data. An overarching aim of continued engagement of patients with protected characteristics and from seldom heard groups will be present throughout years 1 to 5 and beyond, continually informing the goals for commissioned and provided services.

Over the next 5 years we will...

For experience of care

Year 1

Develop and introduce our Accessible Information Standards Policy (AIS).

Reach out, engage and develop partnerships with seldom heard community groups (1-5).

Improve how we collate demographic data from our patients (1-5).

Re-evaluate the Carer's Passport and Policy with co-production from carers.

Support the development of accessible care plans.

Support the development of the Patient Safety Partner role.

Investigate the development of an expanded EDI training package for staff.

Year 2

Educate service developers and patient/service user policy authors on equality impact assessments (EIA).

Ensure relevant papers presented to the Board have been impact assessed.

Investigate a reporting dashboard for bringing all feedback together including FFTs, PALS and Complaints, online feedback etc.

Year 3

Work with the Learning and Development team to ensure EDI is embedded within other training courses.

Year 4-5

See improvements in demographical data from patients with protected characteristics and from seldom heard groups.

See improved patient experience outcomes for patients from seldom heard groups.

Fully embed the AIS Policy and evaluate impact on experience for patients within the remit of the AIS Standards.

For health inequalities

Year 1-2

Strengthen and embed the newly combined Equality, Diversity, Inclusion and Health Inequalities Group. To apply the same focus to the local groups.

Complete a baseline assessment against CORE20plus5 for NNUH patients and communities with a focus on elective recovery.

Continue to work with the Integrated Care System (ICS) regarding the wider system agenda related to health inequalities (1- 5).

Year 3-5

Review outcomes of the baseline assessment and develop an improvement plan where gaps have been identified, prioritising elective recovery.

Increase engagement with patients and communities to co-design future services to reduce health inequalities.

Ensure data collection and systems are compatible to measure the demographics and outcomes related to health inequalities.

Workforce Health & Wellbeing

The health of our workforce is critical, and NHS organisations are best placed to support healthy living and lifestyles. Thestrategy will recognise that our NHS staff are also our patients, who belong to various community groups; the very same community groups that we serve. We want to ensure we address the causes of ill health and support resilience with divisions by introducing educational resources including menopause awareness training and implementing appropriate facilities aimed to support colleagues at work.

Another component to this theme is experiences of unfair treatment and inappropriate behaviour. Unfortunately, colleagues report that they face unfair treatment and experience discrimination from their peers or managers. Allyship is key to creating an inclusive culture free from inappropriate behaviour which is why we are committed to support staff to be active allies enabling staff to be able to challenge behaviours appropriately and supporting each other as our NNUH Team. This will be supported by each division within their local Equality, Diversity and Inclusion Groups, known as LEDGe. These groups provide another opportunity for staff voices to be heard in a safe environment.

Over the next 5 years we will...

Year 1

- Deliver active bystander training and resources to help people understand the importance of allyship, impacts of microagressions and how to challenge microagressions in the workplace.
- Expand the support and resources available to staff under our "No Excuse for Abuse" campaign.
- Implementation of Civility and Respect policy and supporting guidance (to replace Dignity at Work).
- Launch an infant feeding room for staff.
- Rebrand the chaplaincy to ensure it is inclusive for all to feel able to use the service.
- Introduce menopause training for managers and staff.
- Establish a Staff Wellbeing Hub with access to key support services for colleagues.
- Review terms of reference for each of our staff networks to enable protected time for colleagues attending staff network meetings.

Year 2

- Review our reasonable adjustments process and produce an action plan to address areas for improvement.
- Improve our disability declaration on ESR so we have a clearer understanding of our staff and their individual needs.
- Become an accredited Carers Employer.

Year 3

- Become an accredited employer on the Stonewall Workplace Equality Index.
- Implement refurbishment of the chaplaincy.
- Provide gender neutral facilities for staff.

Year 4-5

- See significant improvement in our staff survey results specifically a reduction in staff experiencing bullying and harassment.
- Explore working with a commercial partner to establish a dedicated Wellness Centre for staff and families using the Norwich Research Park.
- Continue to embrace difference through hosting events and conferences for staff.
- See increased attendance and engagement with these events.

Representative Workforce & Inclusive leadership

We have strong diverse staff networks - NNUH Together, Women's Network, Diverse Ability and LGBT+. Each Division has a Local Equ ality and Diversity Group (LEDGe) and a Trust wide equality steering group supporting measures to create a more inclusive hospital for all, with alternate meetings considering employment and patient diversity issues. Despite this, we know there are still evident inequalities in our patient and staff experience.

Inclusive leadership is about Board members and management routinely demonstrating their understanding of and commitment to equality and health inequalities. We have included representative workforce within this domain because we felt it is crucial to recognise diversity within our leaders in order to truly embed inclusive leadership. To achieve this we will be implementing improved recruitment practices as well as monitor the progression of our staff so that we can address any barriers colleagues may be experiencing.

Working with our leaders to ensure they have oversight on EDI matters and holding them to account to identify improvements is e ssential. We will provide support through delivering training and providing guidance on Equality Impact Assessments to ensure all functions, policies and service developments hav e b een appropriately assessed and presented to the Board. Actions will also be embedded within our LEDGe's and will be monitored on the progress regularly.

Over the next 5 years we will...

Year 1

Implement balanced interview panels in respect of ethnicity for Band 8a and above roles and introduce positive action statements onto job adverts for Band 8a and above roles.

Improve the induction process for our international recruits.

Publish our first ethnicity pay gap audit with improvement plan.

Appoint Board Champions for each of our staff networks.

Review our divisional governance framework for EDI. Work with divisions to embed EDI objectives/ initatives for each division.

Year 2

Review our recruitment policy and process to ensure a de-bias approach and governance of unfair practices.

Work with managers to undertake meaningful career conversations with all staff. Monitor the progression of BAME/international nursing staff specifically.

Have an improved CEA process where female colleagues feel confident in applying for the award.

Educate service developers and policy authors on equality impact assessments (EIA) and ensure they are presented to the Board where applicable.

Implement a clear process to enable staff to be able to shadow senior leaders or be coached by them.

Year 3

Work with the Norfolk and Waveney system to develop an EDI dashboard which will allow organisations to evaluate and benchmark against experiences of EDI across the system.

Deliver a suite of essential Diversity, Inclusion and Belonging training packages which includes lived experiences from staff and patients.

Year 4-5

See improvements in the percentage of staff believing that the trust provides equal opportunities for career progression or promotion.

Managers are able to demonstrate that they are active allies and are accountable for the progress made towards embedding an inclusive culture.

Commissioned or Provided Services

We will...	Because...	The key things we will do to measure progress	Timescale (Yrs) 1 2 3 4 5	What will be different in the future
Hear your voice	By listening to what you, your families, and Carers tell us about your experience of our services will better meet your needs.	Develop the key 'Patient Safety Partners' role to support the delivery of our Patient Safety Strategy.		Patients, Carers and service users will be involved from the start of any service change all project initiation documents and processes will reflect this; it will be the norm for Carer/patient representatives /leaders to be embedded in committees and divisions and work as 'equal partners' with colleagues to improve patient experience and safety.
		Create a reporting dashboard for bringing all feedback together including the Friends and Family Test, Patient Advice and Liaison and complaints, online feedback, and compliments.		Patient feedback and stories will drive our Quality Improvement projects. Improvements achieved will be measured in changes to feedback and identified themes, reductions and complaints, and increases in compliments.
		Co-design and implement a range of support for Carers including the Carer's Policy, partnership agreement and Carers' Passport.		Patients and clinicians collaborate to reach joint decisions around care and treatment; they feel empowered to make the right decisions at the right time for them.
		Reach out, engage and develop partnerships with seldom heard community groups. Utilise Equality Delivery System and deliver NHS CORE20PLUS5 to identify health inequalities, and utilising Equality, Diversity and Inclusion (EDI) approaches to maximize impact.		Increased equity in service provision; better engagement from diverse people/ communities in service improvements and redesign.

Commissioned or Provided Services

We will...	Because...	The key things we will do to measure progress	Timescale (Yrs) 1 2 3 4 5	What will be different in the future
Design our services with you	By working with you to review and design the services that we offer they will better meet your needs and expectations.	Increase evidence of Equality Impact Assessments that ensure services/ improvements are fair and equitable, by linking with staff networks and community links/engagement.		Improved health and experience outcomes of those who experience health inequalities.
Know your story	By ensuring that your health record is always with the person looking after you, you will not have to repeat yourself.	Make sure patient accessible information needs and reasonable adjustments are included in planning the care by developing and introducing our Accessible Information Standards Policy (AIS).		Improved health and experience outcomes of those who experience health inequalities.

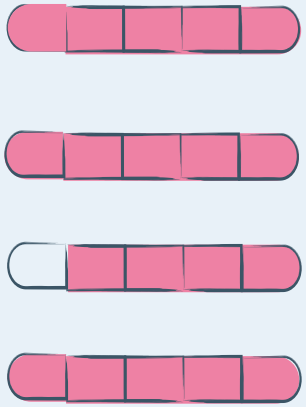
Commissioned or Provided Services

We will...	Because...	The key things we will do to measure progress	Timescale (Yrs) 1 2 3 4 5	What will be different in the future
reduce unfair and avoidable differences in care (known as health inequalities).	by working with seldom heard groups we will ensure that everyone has equitable care.	Provide a suite of EDI educational resources and training in order for staff to become more aware of the needs for seldom heard patients and patients with protected characteristics.		All staff and volunteers will have the opportunity to learn more about the patients and communities who we serve, and grow their knowledge and empathy. This will lead to reductions in discrimination and microaggressions. Measureable reduction in known differences in care for seldom heard groups linking to the NHS CORE20PLUS55 strategy and the Equality Delivery System.

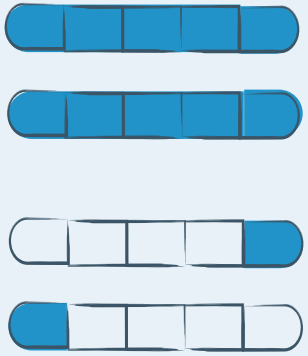
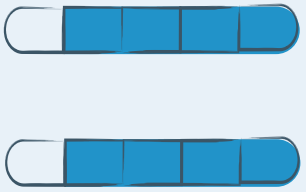
Health Inequalities

We will...	Because...	The key things we will do to measure progress	Timescale (Yrs) 1 2 3 4 5	What will be different in the future
Strengthen and embed the newly combined Equality, Diversity, Inclusion and Health Inequalities Group.	We wished to capture all aspects of EDI and Health Inequalities under one umbrella.	Be able to evidence the work of the group through meeting papers and the workstreams for the LEDGES.		Streamlined communications collating EDI and HI information from our patients, staff and stakeholders to inform future service design.
Complete a baseline assessment against CORE20plus5 for NNUH patients and communities with a focus on elective recovery.	We wish to identify if any of our patients or our communities have been negatively impacted due to EDI and HI whilst on a waiting list.	Have completed the baseline assessment.		We will have an improvement plan for elective recovery and waiting list management that is fair & equitable.
Continue to work with the Integrated Care System (ICS) regarding the wider system agenda related to health inequalities (1- 5).	We wish to offer equitable health care across Norfolk and Waveney.	Be able to evidence engagement from across the system.		We will be working as one system.
Review outcomes of the baseline assessment and develop an improvement plan where gaps have been identified, prioritising elective recovery.	We wish to identify if any of our patients or our communities have been negatively impacted due to EDI and HI whilst on a waiting list.	Have an improvement plan in place.		We are able to evidence that elective recovery and waiting list management is fair & equitable.
Increase engagement with patients and communities to co-design future services to reduce health inequalities.	The views and involvement of our patients and communities are integral to future service design.	Evidence of proactive engagement with our patients and communities.		We are to evidence services have co-designed with patients and communities.
Ensure data collection and systems are compatible to measure the demographics and outcomes related to health inequalities.	Without this information we will not be able measure and understand patient experiences and outcomes based on their demographics.	We will have an Electronic Patient Record with integrated systems that record patient demographics, diagnosis, treatment and outcomes.		We are able to holistically analyse our patient and their care to enable continuous improvement.

Workforce Health and Wellbeing

We will...	Because...	The key things we will do to measure progress	Timescale (Yrs) 1 2 3 4 5	What will be different in the future
Create a culture of civility and respect.	By meaningfully changing our culture, everyone will be heard and contribute to a better workplace for all.	Provide a suite of EDI educational resources and training in order for staff to become active allies. Update our dignity at work policy to ensure everyone is clear on how we will address inappropriate behaviours.		Through the NHS Staff Survey we will see a 5% year on year reduction in reported instances of bullying and harassment. Increase membership of each of our staff networks by 20% each year. Reducing the 'unknown' disability status to 12%. Ensure our international staff report positive experiences upon starting at the Trust.
Put our wellbeing first.	By doing this we will be best placed to support each other with our daily challenges and feel that we can bring our true selves to work.	Enhance our processes to allow for staff to be able to request reasonable adjustments as well as protected time to attend wellbeing events.		An increased awareness and use of the Health and Wellbeing Passport. Staff are able to request time to attend work events that are important to them and their wellbeing e.g. staff networks.
Provide better education and awareness of inclusion.	By having a better understanding of how we can all influence an inclusive culture will lead to positive experiences for all our colleagues.	Expand the support and resources available to staff under our No Excuse for Abuse approach.		There will be a measurable increase in the number of concerns openly reported by Team NNUH and a reduction in people reporting fear of consequences of raising concerns.

Representative Workforce and Inclusive Leadership

We will...	Because...	The key things we will do to measure progress	Timescale (Yrs) 1 2 3 4 5	What will be different in the future
Improve the representation of our diverse staff.	By actively being a diverse organisation with an inclusive culture our hospitals will be a better place for everyone to work and visit.	Embed fair and inclusive recruitment processes and talent management strategies that target under-representation and lack of diversity.		Year on Year improvement in race and disability representation in senior leadership roles. Staff feel that the Trust acts fairly in regards to career progression/ promotion regardless of their protected characteristics. Reduce gender pay gap by 10% Undertake a race pay gap review and deliveran associated action plan.
Enable employee voices to be heard.	By meaningfully changing our culture, everyone will be heard and contribute to a better workplace for all.	Provide a suite of EDI educational resources and training in order for staff to become active allies. Expand our No Excuse for Abuse package.		EIA's are embedded within every Trust policy. Staff networks each have a Board champion. Year on year improvemenmt of the WRES and WDES outcomes.
Develop our talent and leadership.	By giving everyone an equal chance to reach their full potential, we will have the best team giving the best care.	Work with managers to ensure meaningful career conversations have taken place. Monitor progression of our staff on a regular basis. Line managers and teams who welcome international recruits must maintain their own cultural awareness to create inclusive team cultures that embed psychological safety.		Staff feel that the Trust acts fairly in regards to career progression/ promotion regardless of their protected characteristics. See a measurable increase in the diversity of our management and leadership role.

REPORT TO THE BOARD OF DIRECTORS

Date	**1 November 2023**		
Title	**Workforce Integrated Performance Report**		
Author & Exec lead	**Sarah Gooch, Acting Chief People Officer**		
Purpose	**For Information and Discussion**		
Relevant Strategic Objective	- Our Patients: Together, we will develop services so that everyone has the best experience of care and treatment. - Our NNUH Team: Together, we will support each other to be the best that we can be, to be valued and proud of our hospital for all. - Our Resources: Together, we will use public money to maximum effect.		
Are there any quality, operational, workforce or financial implications of the decision requested by this report?	**Quality**	**Yes✓ No☐**	Improved patient care
	Operational	**Yes✓ No☐**	Improved service delivery and support addressing waiting time
	Workforce	**Yes✓ No☐**	Reduction in vacancies, turnover, and improved morale
	Financial	**Yes✓ No☐**	Reducing bank, agency, overtime, and incentive payments

1. Background/Context

1.1 The Workforce Integrated Performance Report highlights key performance indicators for workforce for the Trust in the September 2023 reporting month.

1.2 This report informs the Trust Board on the key highlights and risks and the improvement actions in place, where necessary.

2. Key issues, risks and actions

Key Highlights

2.1 As at the end of September, the overall compliance rate for mandatory training is 91.5% which is slight dip on last month of 0.5%. The Trust has maintained 90% compliance rate for 10 consecutive months. The key focus remains on the face to face training. A second manual handler trainer is currently being recruited to, which will double the resource. As part of the CQC Evidence Group, all Divisions have the target of increasing their compliance rate for face to face subjects, to 90%, by December 2023. An action to increase the compliance rate, has been to focus on Do Not Attends (DNA). Processes are currently being put in place, within Divisions, to ensure that the DNA's are as limited as possible, to ensure that the training space and the capacity is being maximised.

2.2 The monthly turnover rate for September 2023 is 0.9% which is 0.1% above targeted monthly rate to achieve a reduction of the 12-month average turnover rate target below 10%. This compares to 1.3% in September 2022. The 12-month average turnover rate is 10.9%, compared to 14.7% September 2022. The Surgery Division has now achieved the turnover rate of under 10% for the first month. The turnover is establishing with the

average leavers since April 2023 being at 58.7 which equates to the monthly turnover rate of 0.8%. If the leaver rate is maintained in October, this will see the 12 month average turnover rate reduce to under 10%.

2.3 Further to feedback received, a review of the stay/exit interviews will be undertaken, led by the Surgical Division. It is currently felt that the stay interview form is largely being used for exit interviews rather than conversations on how the employer could remain at the Trust.

2.4 The Trust 12 month rolling sickness absence is 4.9%, which compares to 5.7% for September 2022. Each Division has seen a steady decline in the last year. The monthly absence rate has reported under 5% since February 2023. When comparing to the NHS sickness absence data (May 2023 reportable), the rates are 4.46% for the NHS, 4.22% for the East of England and 4.77% for Norfolk and Waveney. The Trust reported 4.5% for the same month. The Trust sickness absence rate is therefore comparable but still over the target of 3.9%. It should be noted that it is expected that short term absence, may increase heading into the winter months, due to covid and flu in the community. The flu and covid vaccination compare is underway to mitigate this.

Key Risks

2.5 In the 12 months to September 2023, 84.2% of eligible staff (Non-Medical appraisals) had an appraisal. The Medicine Division have achieved 90.2% for this month and met the target of over 90% by September. Due to the cascade approach, it is anticipated that this will be maintained for the rest of the financial year. As part of the Performance Assurance Framework, Surgery, CSS and Women and Children's Divisions have not met the 90% target. An action agreed to mitigate this risk, is that a revised trajectory of reaching the 90% target by December 2023 has been agreed.

2.6 The Trust's vacancy rate for September 2023 is 11.6% which is an increase from 9.8% September 2023. This is due to an increase in establishment and reporting of a lower staff in post of 8,411, compared to 8,501 in August 2023. This may be due to the junior doctors rotation in August but other factors may also be impacting on the staff in post and therefore the vacancy rate. To mitigate the risk of an unexpected increase in vacancy and other potential factors, it was agreed at the Performance Assurance Framework meeting that Finance, HR and Nursing will meet to agree principles and an in depth exploration of the data will occur in the next month.

2.7 In relation to vacancies, a key risk remains the Healthcare Assistant vacancy. A current vacancy trajectory projects that the Healthcare Assistant vacancy rate will reduce to 12.2% by March 2024. However, Surgery Division have undertaken a skills mix review which has increased their vacancy rate to 22%. This further increasing the risk to the Trust on the ability to fill these vacancies. To mitigate this risk an action was agreed at the Performance Assurance Framework meeting to undertake a review and agree what actions will be taken to mitigate this.

2.8 Time to hire, for the first month in since January 2023, has increased above the target of 38 working days, at 40.2 days. This is due to the level of the activity in the Recruitment Team, a reduction in temporary resource, supporting the Healthcare Assistant recruitment and recruiting over 100 newly qualified nurses. There is a risk that this increased time to hire may continue going into the Winter. To mitigate this, a further review will be undertaken of the internal recruitment, as this month's this accounts for 60% of the recruitment processes. Additional external funding will be explored to enhance

the Team to support the Healthcare Assistant recruitment. Robot technology is also being explored to remove the manual processing behind the recruitment processes to improve the service for our staff and the Recruitment Team.

3. Next steps

3.1 To monitor the improvement actions and report back to the People and Culture Committee in six months.

Recommendation: The Board is recommended to discuss and note the contents of this report

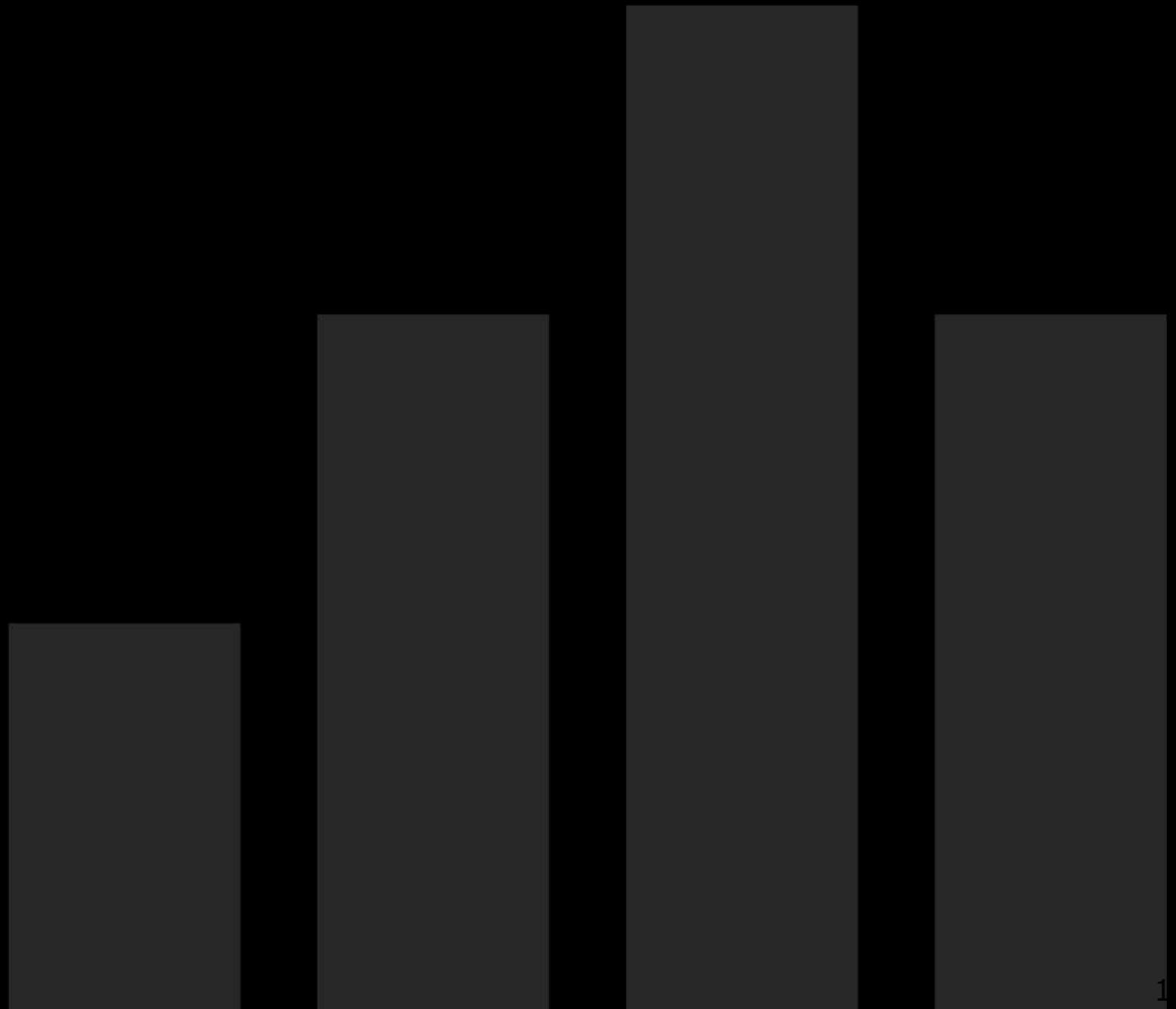
Microsoft | Power BI

Workforce

View in Power BI

Last data refresh:
19/10/2023 07:30:36 UTC

Downloaded at:
19/10/2023 08:22:21 UTC



Workforce Summary

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

NNUH Digital Health
business intelligence

Topic	Metric Name	Date	Result	Variation	Assurance
Sickness Absence	Monthly Sickness Absence %	Sep 2023	4.5%	Improvement (Low)	Unreliable
Staff in Post	Actual Substantive Headcount (WTE)	Sep 2023	8,411	Improvement (High)	No Target
Mandatory Training	Mandatory Training	Sep 2023	91.5%	Improvement (High)	Unreliable
Job Planning	Job Plans Signed Off % (Within 12months)	Sep 2023	47.6%	Concern (Low)	Not capable

SPC Variation Icons

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

SPC Assurance Icons

Capable | Not capable | Unreliable

Mandatory Training

NNUH Digital Health
business intelligence

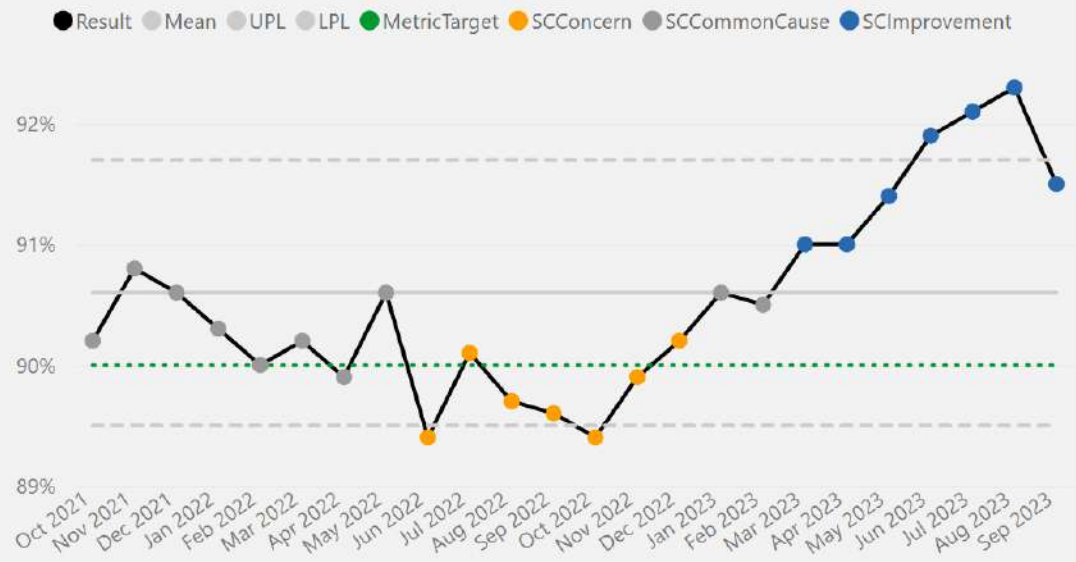
Mandatory Training

Sep 2023

Variation	Assurance
H	?

91.5% Result	91.7% UPL
90.0% Target	90.6% Mean
	89.5% LPL

Mandatory Training



Analytical Commentary

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

Assurance Commentary

As at the end of September, the overall compliance rate was 91.5%. For Medical staff, the compliance rate for permanent staff was 92.0% - this figure reduces to 83.7% including the fixed term rotational junior doctors.

This is the tenth consecutive month achieving the trust compliance target of above 90%.

Classroom based training remains the primary area of lower compliance. There had been some progress for these topics in recent months but this has regressed slightly for September.

The recruitment of a new Manual Handling trainer is in progress, which will improve the Trust compliance capability.

Data has been provided to Divisions for staff who have booked and then not attended their class-room training session. Once we have clarity over the best data to share, a regular report will be prepared to help Divisions to improve the management of this to minimise the spaces not being taken on the day.

Improvement Actions

September 2023 - Targeted messages continue to be sent to staff who have fallen below on their compliance for Resus, Fire and Safeguarding.

September 2023 – The recruitment for a new manual handling trainer is in progress

Non-Medical Appraisals

NNUH Digital Health
business intelligence

Non-Medical Appraisal

Sep 2023

Variation | Assurance

F

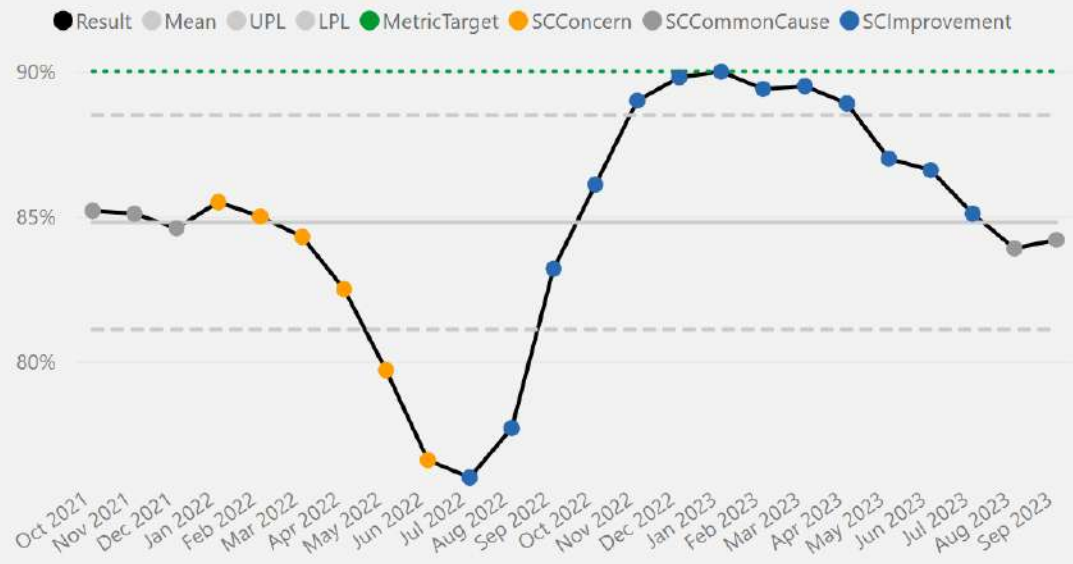
84.2% Result
90.0% Target

88.5% UPL
84.8% Mean
81.1% LPL

Analytical Commentary

Variation is Common Cause

Non-Medical Appraisal



Assurance Commentary

In the 12 months to September 2023, 84.2% of eligible staff (non-medical appraisals) had an appraisal (inclusive of the new PDR or the previous appraisal process). This represents a 0.4% increase in performance compared to the previous month.

Women & Children's division have achieved the target (93.6%), and the Medicine division has also achieved the target for the second consecutive month at 90.1%. Protected time for Wards Managers has been key to achieving this target. However, the other divisions and the corporate directorate have fallen below the 90% target. CSS and Surgery Division have revised trajectories in place to achieve 90% by the end of December.

This revised trajectory will be monitored by the Performance Assurance Framework Board.

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

Improvement Actions

September 2023 – Divisional trajectories for the 23/24 cascade have been revised as part of October's Performance Assurance Framework, with plans established to mitigate risk.

September 2023 - HR Business Partner team supporting discussion and review of performance at divisional boards and sub-boards with actions agreed to improve performance in line with the cascade model.

Sickness Absence

NNUH Digital Health
business intelligence

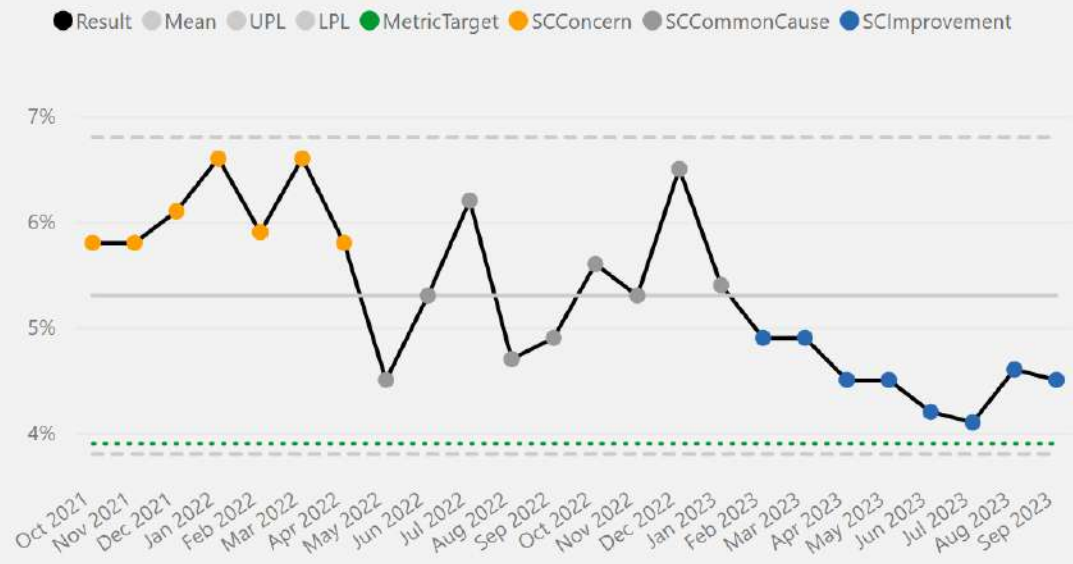
Monthly Sickness Absence %

Sep 2023

Variation	Assurance
L	?

4.5% Result	6.8% UPL
3.9% Target	5.3% Mean
	3.8% LPL

Monthly Sickness Absence %



Improvement Actions

September 2023 – A Schwartz round to support staff was conducted in September.

September 2023 - New Rest and Restore days have been advertised to support staff.

September 2023 – A new peer support group is planned to commence in October to support staff with Neurodiverse conditions. In addition, events to support World Menopause day are planned to raise the profile of supporting staff affected by this condition.

Analytical Commentary

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

Assurance Commentary

The Trust's 12 month rolling average target for sickness absence is 3.9%. As at 30 September 2023, that rate is 4.9%.

Latest national NHS sickness data (May 2023) reports the NHS England monthly average as 4.46%. The East of England reports a monthly average of 4.22% and Norfolk and Waveney reports at 4.77%. The Trust reports the lowest monthly sickness absence rate for Trusts in Norfolk and Waveney, 4.50% for the same period.

The monthly absence rate has stabilised at 4.5% in August and September. Short and medium term absence has seen an slight increase in month of 0.1%. With the community prevalence of Covid increasing, it is anticipated that this may result in an increase in short term absence.

The main issues cited within Workplace Health & Wellbeing referrals in September continue to be work demands, work relationships, including perceived bullying by colleagues, concerns regarding an individual's role (not happy, location of work and performance issues). Of note in relation to work demands is increase in Consultants seeking support. In addition, there is an increase in the number of staff from corporate services.

Staff Turnover

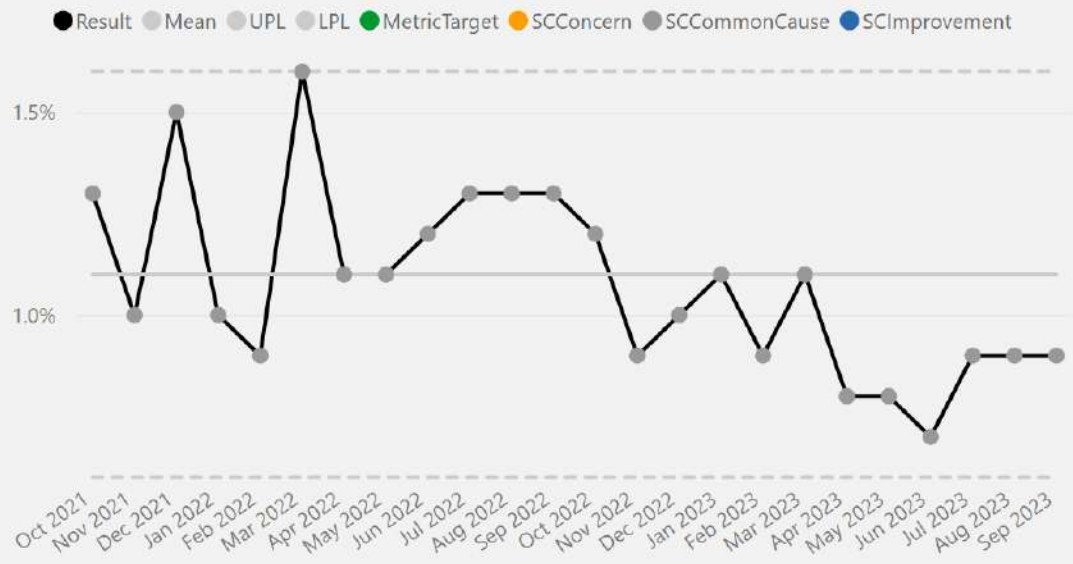
NNUH Digital Health
business intelligence

Monthly Turnover

Sep 2023

Variation	Assurance
0.9% Result	1.6% UPL
N/A Target	1.1% Mean
	0.6% LPL

Monthly Turnover



Analytical Commentary

Variation is Common Cause

Assurance Commentary

The monthly turnover rate for September 2023 is 0.9% which is equal to August 2023 (0.9%) and lower than September 2022 (1.3%). The 12-month average turnover rate is 10.9%, a reduction of 0.5% from August 2023. Turnover has consecutively fallen for the last 9 months, comparing also to a high of 15% in August 2022.

To reduce turnover to 10% per annum, a monthly turnover rate of 0.83% needs to be achieved and maintained. This equates to 58 WTE leaving per month. In September 2023, 64.3 WTE left the Trust which is an increase from August 2023. This compares to 95.4 leavers in the month of September 2022. Within the last six months, the leavers have averaged 58.7 WTE.

The number of Stay Conversations is currently averaging 20% (84/423 leavers since April) against the target of 40%. A training video is also now available on The Beat for line managers to give them increased confidence with discussions. The use of stay conversations and the feedback loop will be reviewed to optimise the impact of which Surgery Division will lead.

Improvement Actions

September 2023 - Continued support for junior doctor and Consultant colleagues with their right to take industrial action, ensuring all colleagues are treated in accordance with our PRIDE values.
September 2023 - The number of staff leaving in their first 12 months of service has reduced by 11.5% (Jan-Sept) compared to 2022. To help reduce this further, a new framework has been introduced in September 2023 to replace the Probation Policy.

September 2023 – Communications plan being developed to promote the new flexibilities within the NHS Pension Scheme as a key retention tool.

Staff in Post

NNUH Digital Health
business intelligence

Actual Substantive Headcount (WTE)

Sep 2023

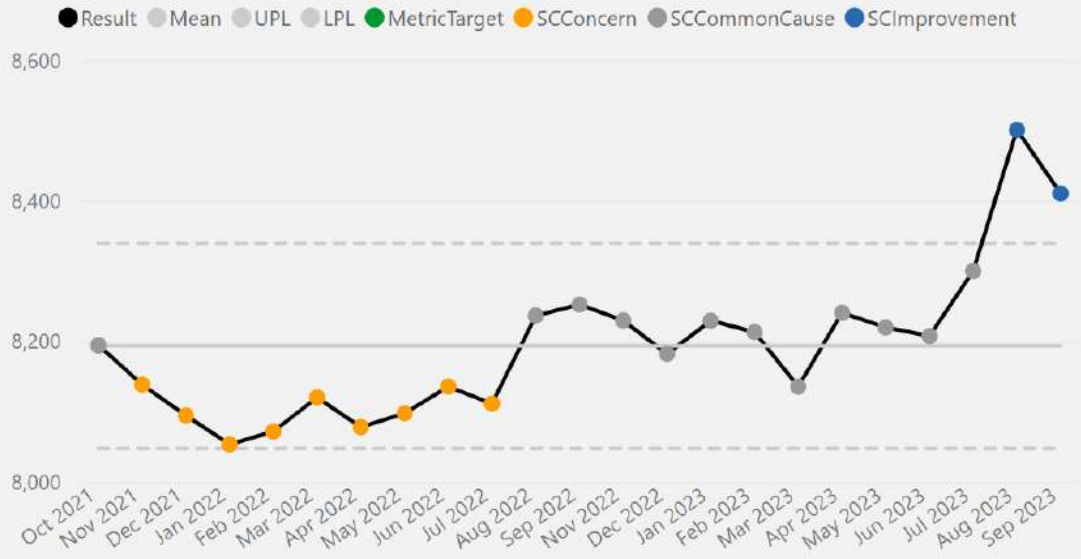
Variation | Assurance

8,411 Result	8,340 UPL
N/A Target	8,194 Mean
	8,048 LPL

Analytical Commentary

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

Actual Substantive Headcount (WTE)



Assurance Commentary

Substantive staff in post is 8,411 for September 2023, a decrease of 90 from August 2023 (8,501). This compares to substantive staff in post of 8,252 for September 2022. This has been impacted by the junior doctor rotation.

Increasing headcount requires vacancy reduction and turnover reduction to be achieved. Vacancy rate is at 11.0% for September 2023, which is an increase from August 2023 (9.8%).

Through the Performance Assurance Framework, performance against trajectories for nursing vacancies in Medicine, Surgery, Midwifery and Paediatrics are reviewed on a monthly basis. Current trajectories are to achieve a 7.7% vacancy rate for registered nurses by March 2024, from a high point of 18.3% in April 2023. It has been agreed at Performance Assurance Framework meeting that all Divisions will review their finance against their establishment within the next month to ensure accuracy of reporting.

International nursing recruitment is a key enabler for our recruitment plans for 2023/24. Current trajectories are to achieve a 7.7% vacancy rate for Registered Nurses by March 2024. Healthcare Assistant recruitment continues, with a trajectory to achieve a 12.2% vacancy rate by March 2024, from a highpoint of 25% in March 2023. With skills mix changes in surgery, this has increased the vacancy % and this remains a key risk to the Trust.

Preference rostering, which aims to provide staff with greater flexibility and influence in how rosters are created, has been successfully piloted in Docking Ward and consultation is under way with colleagues and other Trusts to consider the challenges and opportunities this will bring.

Improvement Actions

Sep 2023 – Phase 1 of the Culture Change programme is nearing completion. A draft Culture Change Roadmap has now been prepared by our partners, t-three, which is planned to be presented to the People and Culture Committee in October.

Sep 2023 – Preparation for the new NHS Draw Down completed, which provides new pensions flexibilities enabling staff to take their NHS pension benefits and continue working. This will become available from 1st October for all three schemes (1995, 2008 and 2015).

Vacancies

NNUH Digital Health
business intelligence

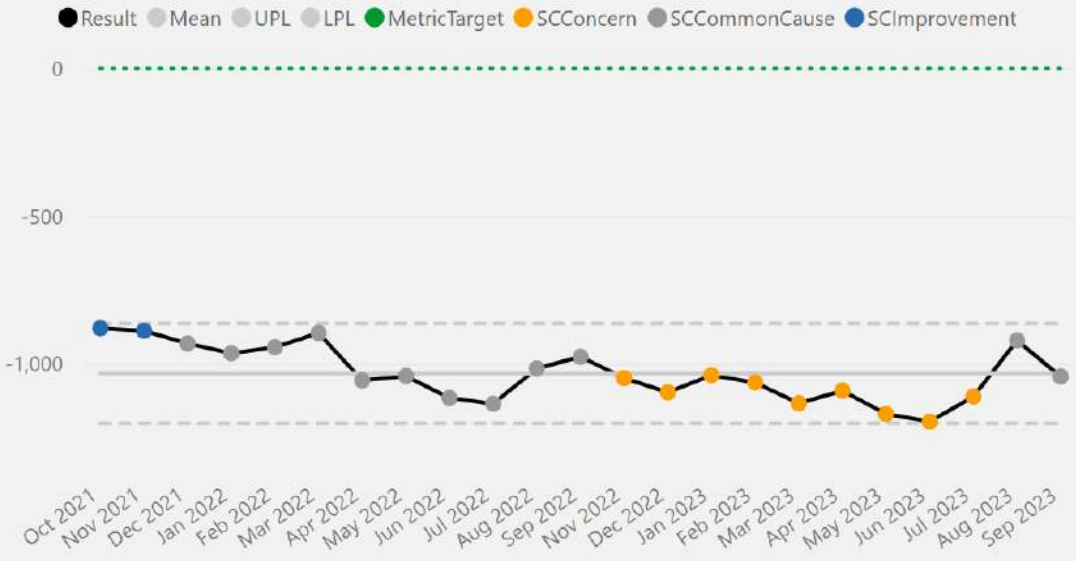
Variance: Headcount (WTE)

Sep 2023

Variation | Assurance

-1,044 Result	-864 UPL
0 Target	-1,033 Mean
	-1,202 LPL

Variance: Headcount (WTE)



Improvement Actions

September 23 - 29 commenced their HCA induction training (1 CSS, 21 Medicine, 5 Surgery, 2 W&C). A further 16 HCAs are due to start (13 Medicine, 3 Surgery) in October.

September 23 – 12 Nurses arrived in September via the International Recruitment Hub.

September 23 - 118 FPQs (First post qualified) Registered Nurses and Midwives are in offer/starting stages (1 CSS, 28 Medicine, 41 Surgery, 48 W&C).

September 23 - 33 HCAs are planned to commence Trainee Nursing Associate apprenticeships in

Analytical Commentary

Variation is Common Cause

Assurance Commentary

The Trust vacancy rate for September 2023 is 11.0% which is an increase from 9.8% in August 2023 and 10.6% of September 2022.

Trust wide trajectories are in place for key clinical posts that span the next two years, inclusive of data relating to internal promotions, so that we can monitor the progress of our recruitment planning to achieve a reduction in the vacancy gap. It has been agreed at Performance Assurance Framework meeting that all

Divisions will review their finance against their establishment within the next month to ensure accuracy of reporting.

International RN recruitment via the IR Hub continues with 168 Nurses expected to arrive as part of the commitment to NHSEI by November 2023. 12 Nurses arrived in September.

Following completion of the career discussions for third year student nurses, 120 FPQ conditional offers have been made (91 student nurses and 27 midwifery students have received conditional offers. The students will be graduating and starting in post between July and October 2023.

The recruitment trajectory for Health Care Assistant roles is reporting ahead of the projection however the risk for delivering 5% by March 2024, remains.

Recruitment (Non-Medical)

NNUH Digital Health
business intelligence

Time to Hire - Total

Sep 2023

Variation | Assurance

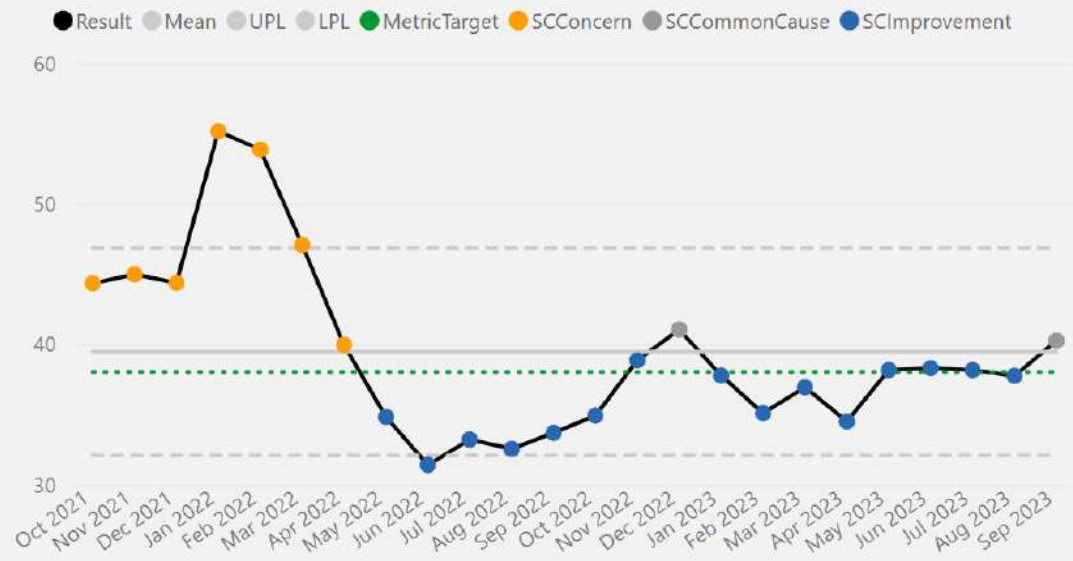
40.3 Result
38.0 Target

46.9 UPL
39.5 Mean
32.1 LPL

Analytical Commentary

Variation is Common Cause

Time to Hire - Total



Assurance Commentary

The September Time to Hire was 40.2 working days, which is above the Trust KPI of 38 days. The increase is as a result of the temporary resource within the recruitment team ending (this was funded by NHS England to support with HCSW recruitment).

Previously, TTH had been under the Trust target since January 2023. For reporting purposes, this has seen 118 candidates recruited to roles within the Trust, 47 of which were external to the Trust (which equates to 40%).

Time to Offer is at 2.8 working days, above the target of 2 days. The average Time to Select was 12 working days. This is above the target time of 10 days. Managers will be reminded of the need to complete selection exercises within 10 days. Time to check was 28.2 working days which is above the internal target of 26 days. The Team have processed checks for over 100 newly qualified nurses at the Trust.

Feedback has been sought by Divisions regarding the recruitment processes, and this is being collated for review.

Improvement Actions

Sep 2023 - 29 commenced their HCA induction training (1 CSS, 21 Medicine, 5 Surgery, 2 W&C). A further 16 HCAs are due to start (13 Medicine, 3 Surgery) in October.

Sep 2023 – 12 Nurses arrived in September via the International Recruitment Hub.

Sep 2023 - 118 FPQs (First post qualified) Registered Nurses and Midwives are in

Supplementary Metrics

Metric Name	Date	Result	Variation	Assurance
Time to Hire - Time To Select	Sep 2023	12.0	Common Cause	No Target

Job Planning

NNUH Digital Health
business intelligence

Job Plans Signed Off % (Within 12months)

Sep 2023

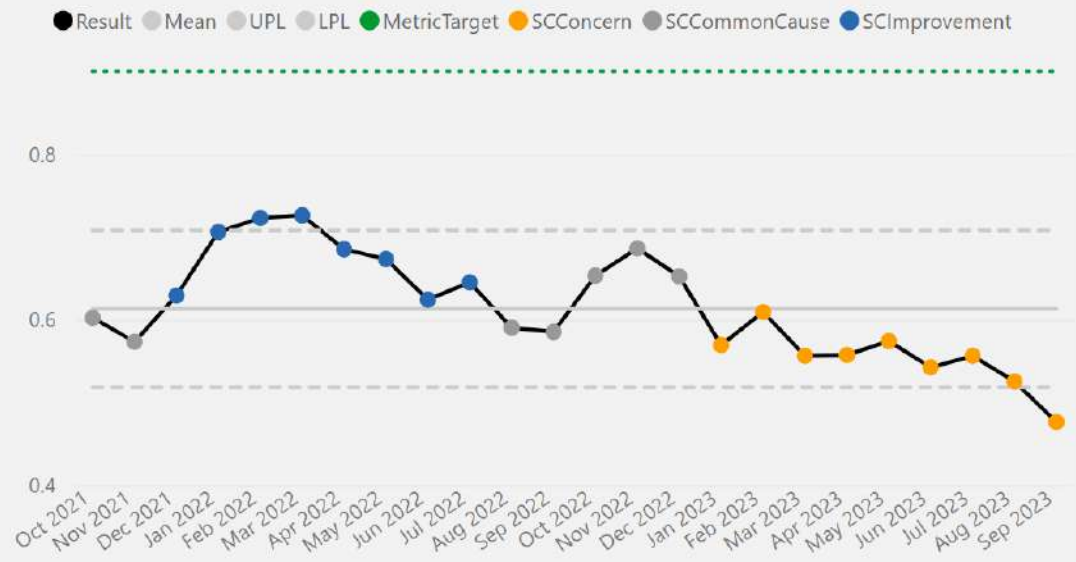
Variation	Assurance
L	F

47.6% Result	70.8% UPL
90.0% Target	61.3% Mean
	51.8% LPL

Analytical Commentary

Data point fell outside of process limits, Data is consistently below mean, and therefore the variation is Special Cause Variation - Concern (Low)

Job Plans Signed Off % (Within 12months)



Assurance Commentary

Performance has dropped due to competing operational pressures, industrial action, elective recovery and annual leave. This has led to an adjusted status of red for the Use of Resources improvement plan as 7 points of improvement for performance are required before the end of March.
New reporting to provide greater level of scrutiny approved at Medical and Dental Governance Committee, which will be available in PowerBI.

Improvement Actions

To continue to provide support to Service Directors and End Users

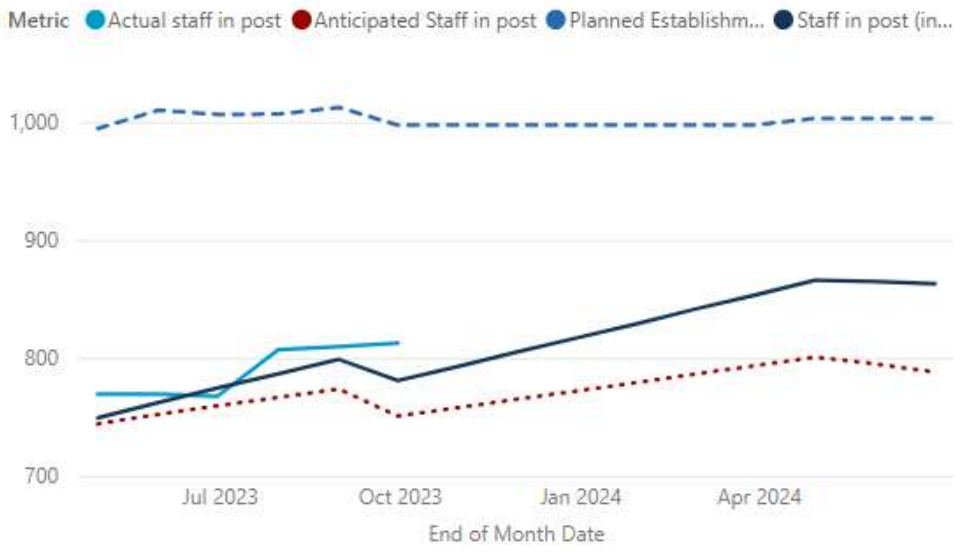
To complete the update of job planning information on the Beat

To implement the new reports into PowerBI

Recruitment Trajectories

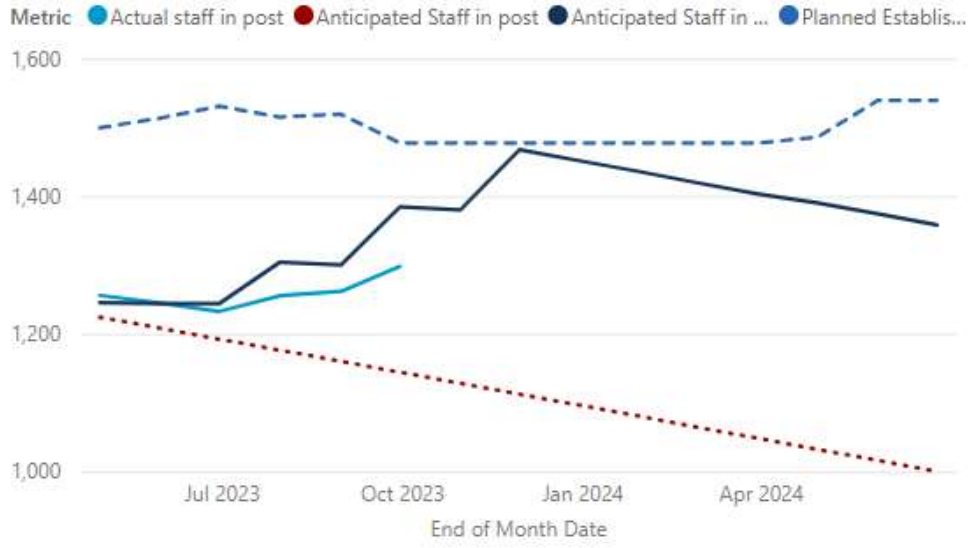
NNUH Digital Health
business intelligence

Recruitment Trajectory - Trust Band 2 Healthcare Assistant



Metric	Jul-23	Aug-23	Sep-23	Oct-23
Actual staff in post	806.83	809.41	812.40	
Anticipated Staff in post	766.52	773.65	750.78	757.9
Anticipated Vacancy %	23.8%	23.6%	24.7%	24.0%
Anticipated Vacancy % (increased capacity)	21.9%	21.1%	21.7%	20.5%
Increased Capacity	5.00	5.00	5.00	5.0
Internal Promotions	0.87	0.87	0.87	0.8
Other Leavers	16.00	16.00	46.00	16.0
Planned Establishment	1,006.54	1,012.22	997.15	997.1
Planned Establishment %	00.0%	00.0%	00.0%	00.0%
Recruitment Activity	24.00	24.00	24.00	24.0
Staff in post (increased capacity)	786.52	798.65	780.78	792.9

Recruitment Trajectory - Trust Band 5 Nurse



Metric	Jul-23	Aug-23	Sep-23	Oct-23
Vacancy % (INR)	13.9%	14.4%	06.3%	06.6%
Recruitment Activity	6.00	6.00	6.00	6.00
Promotions	7.00	7.00	7.00	7.00
Planned Establishment %	00.0%	00.0%	00.0%	00.0%
Planned Establishment	1,514.58	1,518.79	1,477.03	1,477.03
Leavers	15.00	15.00	15.00	15.00
Increased Capacity	76.00	12.00	100.00	12.00
Anticipated Vacancy FTE (INR)	210.58	218.79	93.03	97.03
Anticipated Vacancy FTE	338.54	358.75	332.99	348.99
Anticipated Vacancy %	22.4%	23.6%	22.5%	23.6%
Anticipated Staff in post (INR)	1,304.00	1,300.00	1,384.00	1,380.00
Anticipated Staff in post	1,176.04	1,160.04	1,144.04	1,128.04
Actual staff in post	1,255.35	1,261.34	1,297.64	

Staff Survey

Current View: Trust 2022

Division: All | Promise / Theme: All | Question: All | Year: 2022

Hold CTRL to select multiple selections. Please be aware Promise and Theme scores only show on individual divisions.

Norfolk and Norwich University Hospitals NHS Foundation Trust

6.8 Promise 1: We are compassionate and inclusive

5.2 Promise 2: We are recognised and rewarded

6.1 Promise 3: We each have a voice that counts

5.4 Promise 4: We are safe and healthy

5.1 Promise 5: We are always learning

5.8 Promise 6: We work flexibly

6.3 Promise 7: We are a team

6.1 Theme: Staff Engagement

5.1 Theme: Morale

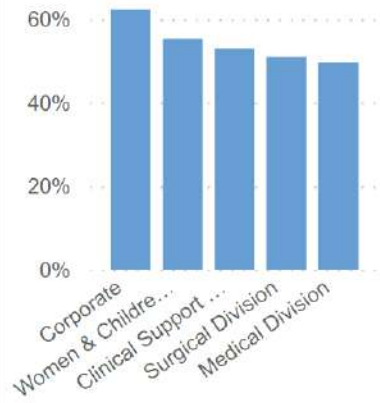
Hover to find out more:

People Promise and Theme Scores by Year and Comparators

Year on Year Difference

People Promise/Theme	21 & 22 Diff
We are always learning	0.24
We are a team	0.04
We work flexibly	-0.02
We are compassionate and inclusive	-0.09
We are safe and healthy	-0.10
We each have a voice that counts	-0.13
We are recognised and rewarded	-0.14
Morale	-0.15
Staff engagement	-0.21

% Scored Positively by Division



% Scored Positively by Question Breakdown

Division	% Scored Positively	Avg Acute %	21 & 22 Diff
Clinical Support Division			
We are compassionate and inclusive	63.8%	70.12%	-2.2%
We are recognised and rewarded	48.4%	50.61%	-2.9%
We each have a voice that counts	56.7%	64.37%	-1.2%
We are safe and healthy	47.7%	51.57%	-1.4%
We are always learning	42.2%	49.96%	2.1%
We work flexibly	47.3%	53.75%	0.0%
We are a team	58.8%	64.42%	-0.9%
Staff engagement	53.4%	64.31%	-3.4%
Morale	44.3%	51.02%	-1.0%
Corporate			
We are compassionate and inclusive	70.9%	70.12%	-0.3%
We are recognised and rewarded	58.1%	50.61%	0.4%
We each have a voice that counts	65.8%	64.37%	0.0%
We are safe and healthy	56.4%	51.57%	0.0%
We are always learning	52.8%	49.96%	5.2%
We work flexibly	67.4%	53.75%	6.7%
We are a team	68.6%	64.42%	2.6%
Staff engagement	63.2%	64.31%	-1.6%
Morale	54.5%	51.02%	-0.3%
Medical Division			
We are compassionate and inclusive	60.4%	70.12%	-2.9%
We are recognised and rewarded	39.9%	50.61%	-1.6%
We each have a voice that counts	53.6%	64.37%	-3.5%
We are safe and healthy	42.4%	51.57%	-1.9%
We are always learning	42.9%	49.96%	1.6%

REPORT TO THE TRUST BOARD

Date	**1 November 2023**
Title	**Chair's Key Issues report from Major Projects Assurance Committee: 25 Oct 2023**
Lead	**Tom Spink - Chair**
Purpose	**For Information**

The Major Projects Assurance Committee met on 25 Oct 2023 and discussed matters in accordance with its Terms of Reference. Papers for the meeting have been made available to all Board members for information in the usual way via Admin Control. The focus of this meeting was specified major estates projects and an overview of progress in the Transformation Programme.

The following issues were identified to highlight to the Board:

	Issues considered	Outcomes/decisions/actions
1	Major Project - Jenny Lind Children's Hospital (JLCH) – Paediatric Theatres	The Committee was delighted to receive an update report which confirmed that the construction of the new paediatric theatre complex is on track for the facility to be ready for operational use by 30th November 2023. The Committee requested further information on the booking schedule, by way of assurance that the new facility will be fully utilised as soon as possible. Formal opening of the theatre complex will take place in 2024, as part of celebrating the 170th anniversary of the Jenny Lind Children's Hospital.
2	Major Project - Norfolk and Norwich Orthopaedic Centre (NANOC)	The Committee was updated regarding the timetable for completion of the NANOC – with an in-use date of 1 April. In future reports the Committee requested to receive updates on plans to ensure optimal utilisation of the NANOC, as part of operational planning for 2024.25.
3	Major Project – Diagnostic & Assessment Centre (DAC)	The Committee received updates on the DAC Programme with dashboard reports to monitor onward progress. Substructure works and construction of the steel superstructure are ahead of schedule. Target date for first patient in the NNUH DAC remains 26 February 2025.
4	Update on Transformation Programme **– BAF 5.2**	The Committee was updated with regard to the Transformation Programme and RAG-rated progress in the 5 key strategic programmes. The Executive Summary page is **attached** indicating: i) Length of Stay: Amber ii) Diagnostics: Red iii) Outpatients: Green

		iv) Business Process Automation: Red v) Theatres: Amber The importance of developing enhanced efficiency in these key areas is evident if the Trust is to achieve its Strategic Objectives and the Committee is awaiting development of a draft strategic plan for the next stages in transformation activity. The Committee discussed whether there are obvious additional or different areas of focus that may be included in an updated programme. The insights from Model Health System (incorporating Model Hospital) indicate that we are focussed on the right areas. The Committee discussed that there is opportunity for focus on premium pay but perhaps not as part of the transformation programme. Enhancing a culture of innovation, efficiency, empowerment and openness to change was also recognised as an important output from our ongoing cultural development.

Conclusions/Outcome/Next steps
The Committee is scheduled to meet again on 29 November 2023.

Recommendation: The Board is recommended to note the work of its Major Projects Assurance Committee.

Norfolk and Norwich University Hospitals NHS Foundation Trust

1. Executive Summary

The purpose of this paper is to provide an update on the delivery of the Trusts five key transformation programmes for 2023/24, together with an update on the CIP delivery programme and a brief summary of new programmes of work that have been brought forward and agreed at TSG.

Key headlines for the five main transformation programmes

- Length of Stay: Key milestones and financial metrics are mostly on track for September 2023; recovery activity is taking place to refocus efforts for those areas where performance is not in the expected direction of travel. Therefore, the programme is reporting AMBER with renewed focus on increasing the number of discharges before noon, pushing red to green and virtual wards.
- Diagnostics: Delay in 6 key milestones this month has impacted on the financial, activity and productivity plans. The programme has remained RED. A recovery plan has been produced by the division with weekly assurance meetings now in place. It is unlikely that the financial savings expected from the programme will deliver for 23/24. Capital bid for additional CT capacity being considered by HMB.
- Theatres: Recruitment and retention activity underway with turnover falling below 10%. Audits of inpatient work to identify further day cases opportunities. Industrial action and sickness led to high on the day cancellations. Delays to DPOA to November. Programme remains AMBER
- Outpatients: Key milestones on track programme reporting Green with continued improvement in PIFU rates from last month with Trust report 5.1% against 5% target. Push required on A&G as targets for 48 hour response consistently below targets.
- BPA: Programme remains RED . Benchmarking continues but limited financial opportunities identified.

Other Key headlines – progressed in August

- developing a frailty model – being progressed by the medicine team
- Developing a COPD/Asthma pathway with PCNs – respiratory team
- Progressing a pharmacy transformation programme – with the pharmacy team
- Progressing the development of the private patient unit

Programme	Description	Month on month change	Program Status
Length of Stay (LOS) SRO: Bernard Brett	Reducing average inpatient length of stay to deliver baseline activity with lower bed base releases 3 bedded wards by end of 23/24 Levers: (1) Red to Green, (2) Clinical practice & variation, (3) Integrated discharge, (4) Virtual wards	⇔	
Diagnostics SRO Chris Cobb	Focus on increasing utilisation & productivity by repatriating activities from scanner vans Levers: (1) Repatriation of van activity, (2), Improved booking capacity, (3) Dedicated cannulation CT, (4) Improved portering and ward prep, (5) High volume/single procedure lists	⇔	
Theatres SRO Chris Cobb	Improve theatre productivity and throughput Levers: (1) Supporting and building our team, (2) Deployment of electronic POA system, (3) Booked well, (4) Day case by default, (5) High volume cataract	⇔	
Outpatients SRO Chris Cobb	Reduce OPFUs to support increasing 1sts and tackling 65-week waitlist Levers: (1) PIFU / XPIFU, (2) Transformation and standardization of clinical pathways, (3) Addressing of clinical variation, (4) Change in clinic templates	⇔	
Review of Business Administration Processes SRO Ed Prosser-Snelling	Reduce duplicated work and increase admin productivity Levers: (1) Centralise admin staff, (2) Simplify processes to increase productivity, (3) Leverage automation to increase productivity	⇑	

CIP pipeline and delivery

The budgeted CIP plan is £28.0m, this is made up of £25m recurrent savings requirements and £3.0m non-recurrent. As at 11th October 2023, the programme consists of £17.4 m of Gateway 2 approved schemes; £0.6m of Gateway 1 approved schemes and £1.5m at Gateway 0 . The FY effect of approved schemes has increased from £20.6m to £22.1m with £5.3m CIP delivered YTD.

REPORT TO TRUST BOARD	
Date	**1 November 2023**
Title	**N&N Hospitals Charity Annual Report and Accounts 2022/23 (and associated Letter of Representation)**
Author & Exec Lead	**John Paul Garside – Executive Lead for N&N Hospitals Charity**
Purpose	**For approval**

1. Background/Context

The Charity's Annual Report and Accounts 2022/23 have been prepared and subject to audit by KPMG as part of the agreed External Audit Plan. This work has been led by Julie Cooper (Charity Head of Grants) with support from senior members of the Finance Team. The draft Report and Accounts have been formally reviewed by the Audit Committee and they are recommended to the Board for approval. The draft is **attached**.

2. Key Issues, risks and actions

The report from the External Auditors to the Corporate Trustee is set out on pages 29-32 of the draft Annual Report and this confirms KPMG's Opinion that the financial statements have been properly prepared and:

- *give a true and fair view of the state of the charity's affairs as of 31 March 2023 and of its incoming resources and application of resources for the year then ended.*

KPMG also confirm that they have *'nothing to report'* from their consideration of the Annual Report.

As detailed in the Report, 2022/23 was another record-breaking year for the Charity. Key highlights are summarised in the first four pages of the Annual Report (notably the *Year at a Glance*) and in the financial summaries on pages 34-36:

- income for the year totalled £2.6m, whilst total expenditure was £3.8m of which £3.6m was Charitable expenditure;
- 612 grants were awarded by the Charity during 2022/23 and in the last 10 years the Charity has contributed over £21m in charitable expenditure to benefit patients in the Trust.
- the Charity's running costs are low and, for every £1 spent, 96p was on charitable activities.

Ongoing plans as detailed in our Annual Plan 2023/34 are summarised in the Key Priorities section and include providing support for specialities and services across the Trust.

3. Next steps

Once approved by the Corporate Trustee, the Annual Report and Accounts will be submitted to the Charity Commission and made public. As in previous years, the *Year at a Glance* summary will be prepared as a separate leaflet, for use in publicity and fundraising. Separate Impact Reports will be prepared highlighting

the benefits achieved through grants made by the Charity – the next edition will focus particularly on the Charity's support of Trust staff through educational grants.

Recommendations:

In its capacity as Corporate Trustee, the Board is recommended to:

- **approve** the audited report and accounts of the N&N Hospitals Charity for the year ended 31 March 2023;
- **approve** the associated Letter of Representation to KPMG;
- **note** our ongoing gratitude to all our donors and supporters who make the work of the Charity possible.

Norfolk & Norwich Hospitals Charity

Annual Report & Accounts 2022/23

Registered Charity no: 1048170

Annual Report 2022/23

Norfolk & Norwich Hospitals Charity

Contents

2022/23 - Our year at a glance:

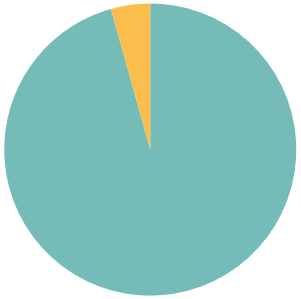
Our Vision: *Supporting our hospitals to provide the best care for every patient*

Our Charity is growing and doing more to support patients

We have been actively growing our Charity – making more grants and increasing our income generation so that we have more funds to support more grants.

Each year the Charity makes hundreds of grants (over 600 in 2022/23). Some are large, others small – but all intended to make a positive difference for patients.

FOR EVERY £1



96p was spent on Charitable Activities

only 4p was spent on Raising Funds

We focus our resources on charitable activities and providing Value for Money

We supported research in glaucoma, liver medicine & cancer – all to benefit patients

We purchased specialist equipment for eye clinics in Norwich and Cromer

We facilitated specialist education and training – developing staff to provide even better care

We funded festive meals for hospital staff working over Christmas ..... and much, much more.

In an economic downturn, we have diversified our income streams:

- We opened two new Charity Cafes for NHS staff and patients at NNUH and Cromer Hospitals
- We received 27 legacy notifications and £1.2m in legacy income
- We raised lottery income – over £30,000 since it was started in 2021

Our year at a glance. In 2022/23 we:

raised a total of £2.6m, thanks to our generous supporters

spent a total of £3.8m to benefit patients

awarded 612 new grants totalling £2.6m

celebrated the opening of our new cafe at Cromer Hospital

approved £174k to support additional training for over 1400 Trust staff members

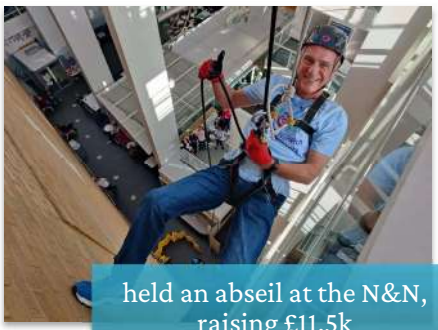
agreed grant funding of £1.6m for new scanners

celebrated 250 years of N&N at the Bishop's Garden

received £1.2m from gifts in wills

opened our Mobile Charity Cafe at the N&N Hospital

launched our N&N Imaging Appeal



held an abseil at the N&N, raising £11.5k

received a special Christmas delivery for NICU

Our support for our local hospitals is only possible thanks to our incredibly generous supporters. To everyone who has helped us, we say a huge 'THANK YOU' – from the charity and from our NHS Trust.

Foreword from the Corporate Trustee

Welcome to the 2022/23 Annual Report and Accounts for the N&N Hospitals Charity - the principal charity associated with the Norfolk & Norwich University Hospitals NHS Foundation Trust.

The underlying purpose of our Charity is to have a positive impact on the services received by patients using our hospitals. This Report gives examples of how we have used donations to good effect, to fund improvement and the additional projects and initiatives beyond what the NHS can provide. The Report illustrates that we have made a real difference for patients, families, carers and the NHS staff who care for them. We hope you enjoy reading it.

Our Charity is growing and doing more to support patients. Each year the Charity awards hundreds of grants (612 in 2022/23). Some are large, others small, but all are intended to make a positive difference for our patients. As detailed in the Report, last year we raised a total of £2.6m, thanks to our generous supporters and this has enabled us to spend a total of £3.6m on charitable activities, delivering more benefit for patients than could be achieved by NHS funding alone. As reflected in this Annual Report, the Charity continues to make a significant positive contribution to the life and services of our hospitals.

During 2022/23 we documented the Charity's overarching Vision: *Supporting our hospitals to provide the best care for every patient.* Our Strategy (*Supporting Better Care)* sets out the framework through which we intend to continue to develop and grow our Charity - all to the benefit of patients, now and into the future.

This Annual Report provides examples of how we have been working in accordance with our 4 strategic objectives:

- Objective 1 - Supporting the care of NHS patients
- Objective 2 - Supporting the development & wellbeing of Trust staff
- Objective 3 - Enabling Research – for patient benefit
- Objective 4 - Maximising our contribution and impact

In line with our commitment to use donations to their best effect, we follow-up grants, to check that they are supporting better care in the way intended. This Report contains numerous examples of the impact of our grants. A recent example includes the specialist service provided to patients in the Trust's Interventional Radiology Unit (IRU), opened in 2020 with a grant of £220k from the Charity. This year the IRU treated its 6,000th patient and was awarded Exemplar Unit status by the British Society of Interventional Radiologists.

None of the good work and benefits for hospital patients that you can read about in this report would be possible without the continuing generosity of our supporters and donors. Thanks are due to each and every one of you for helping make this work happen. As you can see, your donations really do make a positive difference to peoples' lives. So once again, we say a very big 'thank you.'

John-Paul Garside
Charity Director

Joanna Hannam
Chair of the Charitable Funds Committee

About the N&N Hospitals Charity

The Norfolk and Norwich Hospitals Charity (referred to in this report as "the Charity") is registered with the Charity Commission (registration number 1048170). By securing donations, legacies and income, the Charity provides support for additional equipment and projects above and beyond what is available through normal NHS funding. In this way we make a real difference for patients, families and staff and support the Trust to achieve its vision of providing every patient with the best care.

The Charity is overseen and managed by the Norfolk & Norwich University Hospitals NHS Foundation Trust as Corporate Trustee, acting through the Trust's Board of Directors. The Board has been explicit in stating that the N&N Hospitals Charity is the principal charity associated with the Trust and that the Charity is to be promoted and supported as such.

Our mission

The Objects of the N&N Hospitals Charity require that it should act to benefit NHS patients. These Objects are reflected in the Charity's Strategy - *Supporting Better Care* - in accordance with which the Charity funds services and facilities that are additional, more accessible, or more readily available than those that can be offered by the NHS alone.

Grants are awarded by the Charity in accordance with charity law, and with regard to the Charity Commission's guidance on public benefit. In spending our funds, we endeavour to reflect the wishes of patients and staff by directing expenditure towards those areas they tell us are most in need and focussed on our strategic objectives:

- Supporting the care of NHS patients
- Supporting the development & wellbeing of Trust staff
- Enabling Research – for patient benefit
- Maximising our contribution and impact

The Charity's Strategy details the Charity's direction and how we intend it to develop and grow, to ensure that it is impactful, sustainable, innovative, efficient and well-governed – all to the benefit of patients, now and into the future.

Our hospitals

The **Norfolk & Norwich University Hospital** (NNUH) is a 1200 bed teaching hospital offering a range of specialist and tertiary services and state-of-the-art facilities. It works closely with the University of East Anglia to train health professionals and undertake clinical research. Based on the Norwich Research Park, the NNUH works closely with its partners in the Norwich Medical School and Quadram Institute Partners. Facilities at NNUH are expanding with creation of the Norfolk Centre for Interventional Radiology, Norfolk & Norwich Orthopaedic Centre and a new Diagnostic Centre.

The **Jenny Lind Children's Hospital** (JLCH) is located on the site of the Norfolk & Norwich University Hospital, providing services for children and young people. First established in 1854, the Jenny Lind is one of the longest established children's hospitals in the country. Its creation was funded by the proceeds of fundraising concerts held in Norwich by the international soprano Jenny Lind. In 2024 we will mark the 170th anniversary of the JLCH, with the opening of a new £6.5m operating theatre complex.

The **Cromer and District Hospital** serves the population of North Norfolk and beyond, with many services provided in Cromer by Norwich-based clinical teams. The Hospital provides a Minor Injuries Unit and a wide range of outpatient and day-case services, including surgery and chemotherapy. The Hospital was rebuilt in 2012 using charitable funds including extremely generous legacy donations. A new Cancer Centre was opened in 2021 partially funded by a £1.8m grant from the N&N Hospitals Charity.

Key Priorities

2022/23 was another year of growth and development for the Charity – focussed on achieving even more benefit for patients. This is evident in the financial figures with £2.6m in income received and £2.6m of new grants approved.

A major focus for 2022/23 included support of the Trust's proposals to develop a Diagnostic Assessment Centre on the Norwich Research Park. The Charity was able to use its financial assets to underwrite a key element of the Trust's DAC business case and, in July 2022, granted funds to support purchase of scanners particularly for patients with cancer and cardiac disease.

In addition to supporting the DAC, our further priorities for 2022/23 included:

- targeted support to benefit patients of our Ophthalmology Department – funding enhanced equipment at NNUH, Cromer Hospital and the Central Norwich Eye Clinic;
- further developing our diversified income streams, opening a mobile catering facility at NNUH and the *Mardle* Charity Café at Cromer – providing an improved range of facilities for staff, patients and visitors;

The priorities of the Charity have been set out in its Strategy *Supporting Better Care*. These remain consistent –

- Supporting the care of NHS patients
- Supporting the development & wellbeing of Trust staff
- Enabling Research – for patient benefit
- Maximising our contribution and impact

These Strategic Priorities are reflected in our Annual Plan for 2023/24 with further projects to include:

- support to benefit patients of our Spinal Surgery team – with major investment in specialist surgical equipment to enhance the service for patients;
- further developing our diversified income streams, with launch of a regular raffle structure, a Winter & Summer Appeal and enhanced facilities to support the Charity Café at NNUH – providing an improved service for staff, patients and visitors;
- targeted fundraising to support our Stroke & Neurosciences team, in preparation for introduction of a stroke thrombectomy service;
- continuing our support for staff through educational opportunities;
- implementing our commitment to enabling research;
- developing specialty-specific fundraising plans, to enable future grant awards.

If you would like to help us by raising funds for the Charity, then please visit **nnhospitalscharity.org.uk** or contact our team at **charity@nnuh.nhs.uk**, or on **01603 287107**.

Celebrating 250 years of Norfolk philanthropy

The Norfolk & Norwich Hospital first opened its doors for patients in July 1772. It had been built thanks to the generosity of the local community and has touched the lives of every local family in the years since then. The cost of the original hospital was £13,323, which is equivalent to £1.7m today. Benevolence and charitable giving is therefore built into the very foundations of our hospital, which moved to its current location at Colney in 2001.

The generosity of our local community continues, and through donations, grants, fundraising and gifts in wills, the Norfolk & Norwich Hospitals Charity has been able to provide grants of **£21m over the last 10 years** to support even better care at the N&N, Cromer and Jenny Lind Children's Hospitals.

Organisers of 250th celebratory events during 2022 faced the challenges associated with the Covid pandemic and the death of HRH Queen Elizabeth II. We were however able to enjoy a fine Open Garden event, thanks to the Bishop of Norwich, with the opportunity for a walk round the Bishop's private garden, with homemade refreshments and live music from the Saxonettes. The event was well attended and we offer our thanks to all our supporters who helped on the day, and to Bishop Graham and Mrs Usher for welcoming us to their garden and showing their support for our hospitals.

Fundraising to build the N&N began with a concert in Norwich Cathedral. The concert became established as an annual event, which led to the internationally renowned Norfolk & Norwich Festival. 250 years later the Festival held a special concert to mark that connection and celebrate Jenny Lind, the Swedish soprano, whose philanthropy in Norwich funded the Jenny Lind Children's Hospital (JLCH). The Fairytales & Nightingales concert was preceded by a talk on the life of Jenny Lind, given by Mr Richard England, consultant paediatric surgeon at JLCH. We are extremely grateful to the Festival teams and audiences for their longstanding and faithful support of our hospitals.

At the end of 2022 a Christmas Carol Concert was held at Norwich Cathedral for current and former members of the Trust's staff, patients and Charity supporters. The event was a wonderful end to the 250th celebrations for the N&N Hospital, and we hope to see the Concert established as an annual event in future. Refreshments were provided thanks to the team operating the Charity's mobile N&N café.

Preparing for the future & strengthening our sustainability

The Corporate Trustee has set an ambitious growth target for the Charity, to ensure that it is sustainable and maximizes its impact, to the benefit of patients, now and into the future. The Charity currently has no endowment assets (which provide long-term security and income), and it is therefore reliant on fundraising, the ongoing generosity of its supporters and diversified income streams.

We have an agreed Fundraising and Income Generation Strategy intended to harness and work with the fabulous energy, enthusiasm, creativity and generosity of all our supporters and fundraisers. We also recognize that mixed motive investments can be a powerful and effective means for the Charity to deliver public benefit while enhancing its sustainability through income generation. To this end the Corporate Trustee has agreed to invest in two catering facilities, at NNUH and Cromer & District Hospital, to provide service to staff and patients whilst providing a diversified source of income.

Accordingly, a mobile Charity Café was opened in July 2022 on the NNUH site in Norwich. The mobile café is run in partnership with Norfolk Cafes Ltd and the Charity benefits from every sale, providing funds that we can reinvest in supporting the Trust. The Charity has funded wooden chairs and tables to provide additional seating for staff and visitors near to the café (see right), and we plan to install canopies in 2023 to provide year-round shelter.

Meanwhile in Cromer, the Trust asked the Charity to assist in providing enhanced café facilities, not least in anticipation of the additional patients using the Hospital's new Cancer Centre. The Charity has funded an extension at the front of the hospital to accommodate a dedicated café so that staff, patients and visitors have more space and a much improved environment. The aim was to provide a café that had a 'bistro' feel rather than a hospital canteen and the feedback is that this has been achieved.

The Mardle Café opened in October 2022. The name was suggested by Sharon – receptionist in the Minor Injuries Unit. *Mardle* is an old Norfolk term for a 'chat' or 'gathering' and the café can be accessed without needing to enter the main hospital building – so it is available for use by the local community, as well as staff, patients and visitors to the hospital.

Our future plans are to open a further café in the new Diagnostic Assessment Centre, currently under construction on the Norwich Research Park. Please do visit our cafes, enjoy the refreshments and support the work of our Charity now and into the future.

Our Grants

This year our charitable expenditure of £3.6m has supported many projects designed to benefit patients. The following pages highlight some of the new projects we have agreed to fund. There are also examples of the various ways in which charitable grants have already improved the hospital experience for patients, funded new and better equipment, and supported research and staff education. Some of our grants are for millions of pounds, whereas others are for much smaller sums – **donations of all sizes can make a real difference**:

Supporting staff development, improving care for NHS patients

£8,450 **Investing in our NHS Trust staff** **2019**

In 2019 the Charity approved a grant for Diagnostic Radiographer Louise Cooper to undertake a Master's Degree in Breast Evaluation.

Louise's Masters modules have trained her to report mammograms, perform breast ultrasound, perform clinical examination and undertake biopsies under stereotactic and ultrasound control.

We were very pleased to congratulate Louise when she graduated in January 2023 after passing with Distinction. Louise is now working as a Consultant Radiographer.

Louise said "***Without the Charity's help and support I would never have been able to achieve this. My training has allowed me to work autonomously in clinics, enabling me to contribute to the ever-increasing workload in Breast Imaging***."

"***Having another trained consultant increases the department's appointment capacity, reducing patient waiting times and patient anxiety and I hope that my training will lead to a quicker diagnosis and treatment for some of our patients***."

Louise completed a research project for her dissertation which she hopes to get published, and as part of her new role will continue undertaking research projects to make positive contributions to both the department and breast research in general.

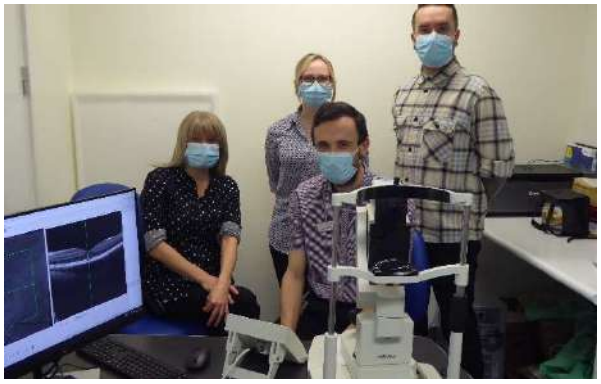
Director of Breast Screening, Dr Arne Juette said "***One really big difference this has made is that Louise will now be able to work as a consultant radiographer, thus helping the Boudicca Breast Unit to provide excellent and more timely care to our patients.***"

Norfolk & Norwich Hospitals Charity
BOUDICCA Breast Cancer Appeal

Our Boudicca Breast Cancer Appeal aims to provide this sort of development support for members of the Breast Team in future. To find out more, please visit our website at **www.nnhospitalscharity.org.uk**.

Investment in Eye Care for Norfolk patients

£230,000 **Life-saving equipment & new technology** **2022**



In 2022 the Charity agreed to provide £230k funding for the purchase of new and improved Optical Coherence Tomography (OCT) devices for the eye clinics at NNUH, Central Norwich Eye Clinic and Cromer Allies Eye Unit.

OCT is a non-invasive imaging test that helps with the diagnosis of a multitude of eye conditions such as glaucoma, age related macular degeneration and diabetic eye disease. It uses light waves to take a cross-section of pictures of the retina, allowing the ophthalmologist to map the distinctive layers in the eye. Scans are carried out without dilating the eye, meaning less discomfort for patients and less time for vision to return to normal.

OCT devices have revolutionised the quick and efficient diagnostic ability for eye patients, in addition to being able to offer sight-saving treatment. The equipment can also diagnose lesions within the eye and be life-saving if an eye tumour is diagnosed quickly.

The purchase of additional and improved OCT devices has allowed for a higher number of patients to be seen across the three clinics, as well as offering far superior diagnostic capability than previously available in the Trust.

Chris Grayston, Operations Manager for Cromer said: ***"We are always looking for opportunities to improve our services, and having access to the latest technology is a great benefit to our patients."***

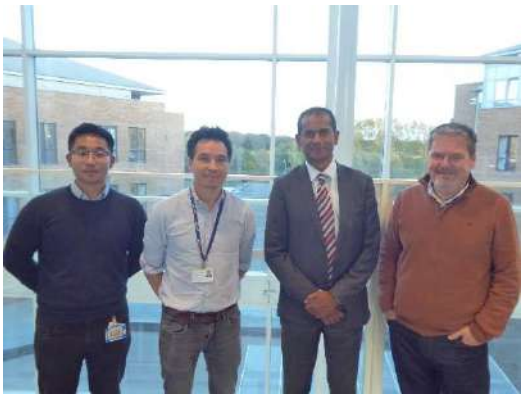
John Paul Garside, Charity Director said: ***"It is so good to see patients in North Norfolk benefit from new technology thanks to the support that our charity receives from the local community".***

To support our Eye Clinics Campaign, and help provide even better care for patients at our three Norfolk Eye Clinics, please visit our website at **www.nnhospitalscharity.org.uk**, or our Just Giving page at **www.justgiving.com/campaign/eye**.

Thank you to everyone who made this Grant possible.

Access to gene data provides breakthrough in Acute Pancreatitis knowledge

£7,200 **Research** **2022**



In April 2022 the Charity approved a grant of £7,200 to fund access to data from the UK Biobank, supporting research on clinical and genetic risk factors for severe pancreatitis. The intended outcome was for a validated risk scoring system to improve patient outcomes in pancreatitis.

Pancreatitis (inflammation of the pancreas) can be mild, but one in four affected people develop a severe form of the disease, which often requires critical care admission and long hospital stays.

Despite intensive support many people develop irreversible organ failure, life-threatening lung infections, and almost half of such patients will not survive. Little is known about what causes severe acute pancreatitis and treatment in hospital has largely remained unchanged for over half a century. There are currently no drug treatments for pancreatitis, and existing research is limited.

In the research project made possible by our grant funding, the team conducted a large-scale project studying the genes of individuals across the UK. They were able to discover an assocation between a mutation in a gene responsible for dampening down inflammation and more severe pancreatitis. They also found a network of interactions between these genetic mutations which may increase the likelihood of severe acute pancreatitis. This research sheds light on why some people do poorly with acute pancreatitis and may also form the foundation for future development of new medicines to treat this debilitating disease.

Mr Bhaskar Kumar, Consultant Oesophagogastric and Laparoscopic Surgeon at NNUH said:

"I am delighted with this collaborative research which has revealed novel findings about acute pancreatitis. I am very grateful for the support given to us by the Norfolk & Norwich Hospitals Charity. I hope this is the start of further collaborations between UEA, Norwich Medical School and NNUH helping to develop research themes based on clinical problems, which ultimately will help the patients and families we serve."

Research active hospitals have been shown to provide better care for their patients. The Norfolk & Norwich Hospitals Charity is committed to supporting research at our NHS Trust, but we can only do this with your support.

Please visit www.justgiving.com/campaign/norfolkresearch

for more information on how you can help.

Providing safe bed space for children with complex needs

£8,408 | **Patients and their families** | **2023**

In January 2023 the Charity agreed to fund the purchase of a Safe Space Bed for children with complex needs staying overnight in the Jenny Lind Children's Hospital.

Teresa Miles, Deputy Divisional Nursing Director said: ***"The Jenny Lind team look after many children who require care in an adjusted environment and have needs which cannot be met by a standard hospital bed, such as children with mobility, sensory or safety needs. Many of these children have a Safe Space Bed at home, so to be able to provide this familiarity for them at hospital, enabling the children to be safe and sleep is a massive advantage. This also allows their parents to have rest, which is really important. Having this Safe Space Bed emphasises the importance of permitting a safe and adaptable environment for all of our patients who come to the Jenny Lind Children's Hospital.***

Thank you to all of our fundraisers and supporters for enabling this to happen."

Laura Palmer, a parent and frequent visitor to the Jenny Lind Children's Hospital said:

"As a parent of complex children, this Safe Space Bed is essential to keep my children safe while they are in the hospital. This means that I am able to sleep knowing my children can keep themselves safe.

The difference this bed will have not only on my children, but many others, is huge."

JENNY LIND CHILDREN'S HOSPITAL
Specialist care since 1854

The Jenny Lind Children's Hospital is the second oldest dedicated children's hospital in the country and it has been providing specialist care for children in Norfolk since it was opened in 1854.

The hospital was made possible thanks to the fundraising concerts featuring the Swedish opera singer Jenny Lind. Nicknamed the "Swedish Nightingale", Jenny was one of the most popular entertainers in mid-19th century Europe – you may have seen her feature as a character in the hit film The Greatest Showman starring Hugh Jackman.

Please visit our Jenny Lind Children's Hospital Children & Families Appeal page on Just Giving to find out more:

www.justgiving.com/campaign/children-families

Providing opportunities for anaesthesia training simulations

£3,650 **Investing in our NHS Trust staff** **2021**

In 2021 the Charity was asked to provide funding to purchase an Epidural Training Simulator to enhance training for trainee anaesthetists in epidural placement.

The purchase of a Genesis epidural training simulator has provided opportunities for teaching and acquiring ultrasound guided regional anaesthesia skills for Epidural and Spinal procedures in a safe and efficient manner. The device allows trainee anaesthetists to practice and hone their skills in a safe environment before actual patient exposure. It also allows for experienced anaesthetists to maintain their skills with practice.

Dr Siddarth Adyanthaya, Lead Consultant for Obstetric Anaesthesia told us:

"We are grateful to the N&N Hospitals Charity for helping us procure the Genesis Epidural-Spinal Injection Simulator. It is a valuable teaching and training tool that will help many Anaesthetists to practice and hone their skills in a safe environment."

Improving health through play

£2,347 **Patients and their families** **2020-2022**

For young children visiting the hospital the NNUH Play Team form a pillar of support in what can be an intimidating environment. Play adds a familiar and comforting element, and the Play Team work as effective intermediaries between child patients and the clinical staff they are here to see.

The Charity has provided several grants for sensory and self-soothe items to help calm and distract anxious young patients.

Kelly Alderton, who the Charity supported to qualify as a Play Specialist, said: ***"Play is a child's natural way of helping them to explore and understand what is happening to and around them and having appropriate resources for all ages and developmental abilities is essential in promoting a positive experience. Thank you"***

Creating knowledge through support for staff development

£8,400 **Investing in our NHS Trust staff** **2019**

Radiographers will often train into sub-specialties to offer the department a broad range of specific expertise. In October 2019 the Charity was able to offer grant funding to support Jessica Whitpen, a Radiographer in the Oncology Department, to undertake specialist training in the form of a Master's Degree in Clinical Skin Integrity and Wound Management.

The programme combined the related specialties of wound management and dermatology, and helped Jessica to develop a deeper understanding of chronic wound healing and conditions that affect skin integrity. Jessica was able to further specialise in skin cancer in her role as a radiographer.

Jessica's studies have allowed for widening the pool of expertise in the Radiotherapy Department and ensuring that skin cancer patients have access to a high quality of care, extending into aftercare beyond hospital treatment.

Since completing the course Jessica has been able to take on a dual role as a project manager for cancer services in addition to her role as a radiographer.

Jessica said "***The Charity has funded my entire MSc, which I completed earlier in the year and passed with Distinction. I am most grateful to the Charity for giving me this opportunity***."

"***As part of my cancer services role I am working on implementing best practice timed pathways. These enable the patient to meet key milestone points along their cancer diagnosis and treatment journey. This involves using the research, project planning and critical thinking skills that were gained as part of the modules delivered across the MSc"***

The MSc has given Jessica the knowledge and context of how the NHS runs with differing styles of leadership and management to meet project aims and objectives.

Did you know....

that individual legacies can fund specialist training for nurses to allow them to develop and improve healthcare in your local hospitals?

What our supporters have achieved

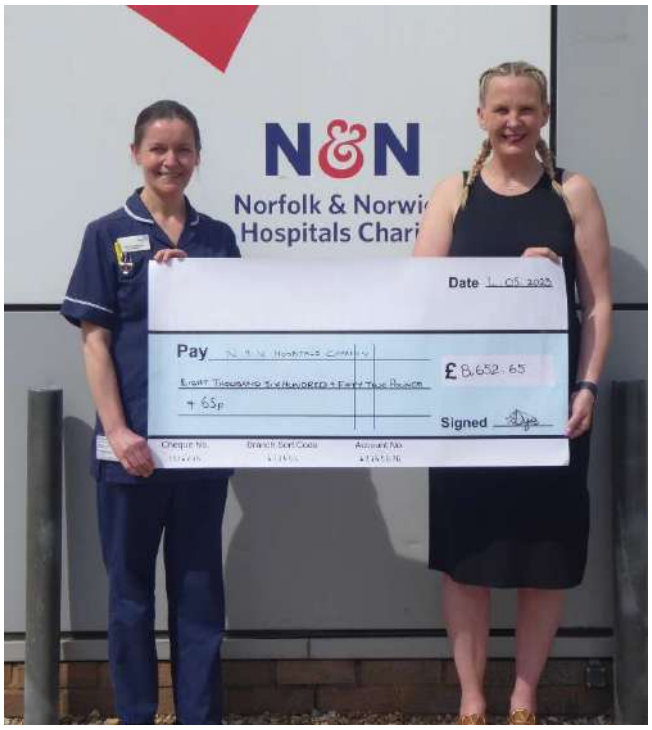
The support for our Charity continues to grow with patients, friends, family, staff, and the local community making donations, leaving gifts in wills, organising and taking part in events. Here are just some of the highlights of the year but we know there are many more unsung heroes, and we thank you all for your support.

500 cheers for fabulous fundraiser Louisa

With a good luck message from Scottish music duo The Proclaimers still ringing in her ears, fundraiser Louisa Dye completed her 500-mile walk challenge.

Louisa, from Sprowston, battled shin splints, blisters and every imaginable weather condition to raise more than £7,600 for the N&N Hospitals Charity, to support cancer services at the N&N.

The challenge throughout March was in memory of her parents – Stuart Clarke, who died from pancreatic cancer in 2006 and mother, Christine, who died after being diagnosed with breast cancer in 2021.



Louisa was joined on her daily walks by Cockapoo, Stanley, and dozens of friends and family, as well as pupils from Langley Prep School at Taverham Hall.

Louisa said: "In 2020, I started including walking into my fitness routine, anything from 5 miles to 24 miles.

"Since losing my mum, walking has kept me occupied and filled a gap in my life that mum filled. On one of my many walks on route to Whitlingham in November 2022, I came up with an idea to use walking as an advantage, to raise money for the oncology fund.

"This supports patients at the Weybourne Day Unit where patients receive chemotherapy and Mulbarton ward – the focus is on the treatment and care of those suffering from and living with cancer, both close to my heart as both my mum and dad used these facilities."

NICU dads complete epic trek to raise thousands

Two dads have completed a gruelling 190-mile challenge, raising thousands of pounds for the N&N where their babies spent their first days.

Matt Dyke and Martin Church braved howling wind, torrential rain, blisters and muscle strains in an epic trek from Cumbria to Yorkshire in just five days.

So far, they have raised more than £8,500 for the N&N Hospitals Charity neo-natal intensive care fund.

The NICU is close to the hearts of both men – Martin's first child, Charlie, arrived eight weeks early in 2018, then his second, Mabel, was 14 weeks premature in December 2021, while Matt's daughter Rosa was five weeks premature in 2014. All three babies were treated on the unit.

Their route took them through the Lake District, over the Pennines, across the North York Moors ascending a total height twice as high as Mount Everest's base camp to the summit.

Martin, from Horsford, said after reaching the end: "I am just so tired – I just want to get home, see the family, have a pizza and a good night's sleep.

"The highlights were some stunning scenery, especially in the Lake District which was full of lambs, and the team camaraderie. The lowlights were a knee injury which meant I let Matt go on at his own pace, and the tough terrain which was bleak at times."

Matt added: "It was much harder than we imagined. Even the flatter bits, where we thought we would make up time were tricky – boggy, slippery and you were having to jump over or walk around obstructions, mud and water.

"Our bodies are battered, bruised, blistered and swollen but we're completely overwhelmed by the support, words of encouragement and donations received.

Both men paid tribute to their support team – driver Colm McGilway and sports therapists Sally Ling and Lisa Payne from Up and Running Treatments plus various friends and guests who joined them for stretches of the walk to boost sometimes flagging morale. They also thanked Stebbings Car Superstore at King's Lynn for donating a crew van and tank of fuel.

To find out how you can help us to do more at your local hospitals, please visit our website at nnhospitalscharity.org.uk to find out more.

Staff join public in hospital abseil challenge

Thousands of pounds were raised by more than 60 brave fundraisers who took part in a charity abseil at the Norfolk & Norwich Hospital.

Organised by the N&N Hospitals Charity, more than 60 people took on the challenge in October 2022, which started 40 feet up on the fourth floor of the East Atrium.

Dave Talbot, from Adventure Events, provided full training and calmed the nerves before the abseilers made their descent.

Among those taking part were Chief Nurse Nancy Fontaine, Chairman Tom Spink, head of Chaplaincy Rev Adrian Woodbridge, and Chaplain Rev Penny Warner, along with fellow staff members and members of the public.

The event raised at least £7,000 which will benefit staff and patients at the N&N.

Charity Champions 2022

In October 2022, N&N Hospitals Charity celebrated the achievements of its supporters by presenting our annual Charity Champions Awards.

Charity Champion Inspiration Award

Easton Ward Deputy Sister Natasha Adams: Natasha has been involved with the charity since she was a staff nurse and is always looking for new ways to encourage staff and patients to raise money while having fun. Last year, she organised a 73-kilometre walking challenge, raising almost £1,500 for her ward, and a Great Easton Bake Off, raising hundreds of pounds more.

Young Person's Charity Champion Award

Evie Youngs: Evie was diagnosed with Hodgkin's Lymphoma earlier this year aged 15 and has been treated at the Jenny Lind Children's Hospital. Since then, she has raised more than £6,000 for the department, through fundraising events and inspiring others to do the same.

Sofia Honey Adcock: Sofia has successfully completed Oncology treatment at the Jenny Lind Children's Hospital, finally ringing the end-of-treatment-bell this summer. Sofia and her family and friends have raised more the £5,000 for Jenny Lind Hospital from a variety of events.

Charity Champion Staff Award

Richard Wharton: Consultant surgeon Richard has been a stalwart supporter of the Charity and has been instrumental in bringing talented young musicians to the hospital, and fundraising events.

Charity Champion Director's Award

The Forum: The Forum in Norwich has supported us for a number of years, from the launch of the Boudicca Breast Cancer Appeal, sponsoring our Boudicca Christmas tree for two years in the St Peter Mancroft Christmas Tree Festival and hosting our first abseil event.

Charity Champion Community Award

Simon Game and Sainsbury's Longwater: Simon raised £4,548 for the £1m appeal to create a Norfolk and Norwich Orthopaedic Centre (NANOC). Simon, who works as a personal shopper in the Longwater branch, dressed up as Santa Claus and collected donations from shoppers, while the store itself had charity buckets on each checkout.

Charity Champion Corporate Award

Fireworks Ltd: The company has organised a series of events over the past 12 months, including holding a summer fete and movie night among other activities, raising more than £5,000.

Charity Champion Schools Award

Town Close School: From a Christmas Fair to a French breakfast, the whole school went above and beyond to support the Jenny Lind Children's Hospital after choosing us as their charity of the year, raising more than £9,000.

THANK YOU

for all the support you have given to us and to our Trust's NHS staff

Gifts in Wills

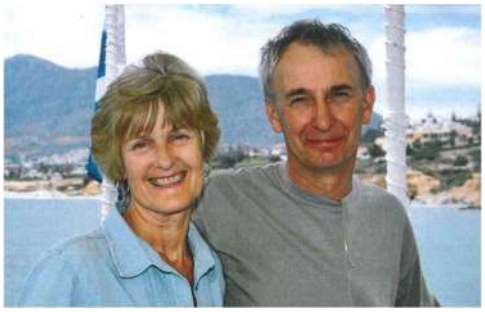
Legacy gifts can have a huge impact, funding the latest medical equipment, providing staff development opportunities, creating welcoming environments and funding pioneering research.

Legacies received in 2022-23 ranged from £500 to more than £400,000 and have enabled us to provide funding where it is needed most. Some were cash gifts while others were a portion of the remaining estate, after family and friends had been taken care of.

Projects funded by legacies recently include:

- state-of-the-art imaging equipment for the new Diagnostic Assessment Centre;
- additional equipment for Respiratory Medicine patients;
- creation of a new café facility at Cromer Hospital.

Every gift, large or small, makes a real, lasting difference for local patients.



In 2022-23 we received a legacy gift from Susan Wilkins for improvements at Cromer Hospital and for cancer services at the Norfolk & Norwich University Hospital. Susan's partner Herbert told us that she was a lady who was always busy helping others via WRVS, Meals on Wheels, the Red Cross, giving blood and helping with tea and biscuits at blood donor sessions, being a volunteer driver, gardening club treasurer and caring for her local community.

Susan, known as Sue or Susie, moved from Banbury to Roughton with her family in 1952. In 1965 Susie married Bob Wilkins, while working at Norwich Union, and moved to North Walsham. Bob died in 1995 after two years of cancer treatment, but Susie carried on looking out for others even through such a hard time.

In 1997 Susie and Herbert became partners, and although they never married Susie told a friend that Herbert was as good as any husband because he came trained!

Susie was diagnosed with cancer in 2011 but carried on living her life to the fullest. Susie loved to travel, and her own diagnosis encouraged her to pack even more into her life. Even appointments at the hospital were made into days out with shopping, visiting friends, etc.

Susie died in May 2020, during the global Covid Pandemic, but she and Herbert were grateful to the 'wonderful staff at NNUH and a team of carers, who made sure Susie was able to be in her home of 55 years for her final few days'. Susie encountered cancer in many ways during her life, and Herbert tells us that she was able to see how important the staff and treatment are for patients, so she decided to leave a gift to her two local hospitals in her will.

We are incredibly grateful for Susan Wilkins' generous gift and will use it to support even better care for patients at NNUH and Cromer Hospitals.

Legacy to support cancer and eye services

We were very grateful to receive a legacy from Leona Levine, supporting our cancer and eye services.

Leona's partner Bruce told us that Leona was the last Levine to run the 150 year old Norwich family jewellery business started by her great grandfather. She was a generous supporter of charities and good causes and was one of the founding members of the Norwich Young Farmers Club.

Bruce told us that Leona was diagnosed with breast cancer about 20 years ago and was successfully treated at that time. Cancer returned in Leona's breast and liver, but despite the 'second to none' care Leona received from the NNUH Oncology team, Leona passed away in July 2021.

Leona had to wear glasses from an early age, with thick lenses. When her eyes developed cataracts and were operated on successfully, she was so pleased to be able to see when getting out of bed without having to find her glasses for the first time in years.

In thanks for the excellent care she received at the Norfolk & Norwich University Hospital, Leona left a gift in her will, that will be used to support even better care for future patients with cancer and for those needing care for their eyes.

We are very grateful for Leona's generous gift, which will be used to benefit NHS patients for many years to come.

A gift to support cardiac care for Norfolk patients

A legacy gift from June Middleton will be used to support establishing a dedicated cardiac MRI scanner in the new Diagnostic Assessment Centre on the Norwich Research Park. This scanner will benefit Norfolk patients, who must currently travel to Cambridge or London for specialist heart imaging.

June was born in High Spen, County Durham in June 1929, and having worked at various jobs June moved to Norwich in around 1975 to be a Court Usher. June was the eldest of three girls and from a very young age had epilepsy and then progressively worsening deafness. Following the death of her mother in 1988 June's health continued to deteriorate, with frequent hospital visits meaning that she needed to move into a care home, where she died in August 2022.

We are very grateful to have received a legacy from Miss Middleton that will benefit her friends, neighbours and local community for many years to come.

For more information about leaving a legacy to your local hospitals, after taking care of your family, please contact legacy@nnuh.nhs.uk.

Financial Review

The following key figures are taken from the 2022/23 Accounts, which carry an unqualified audit report:

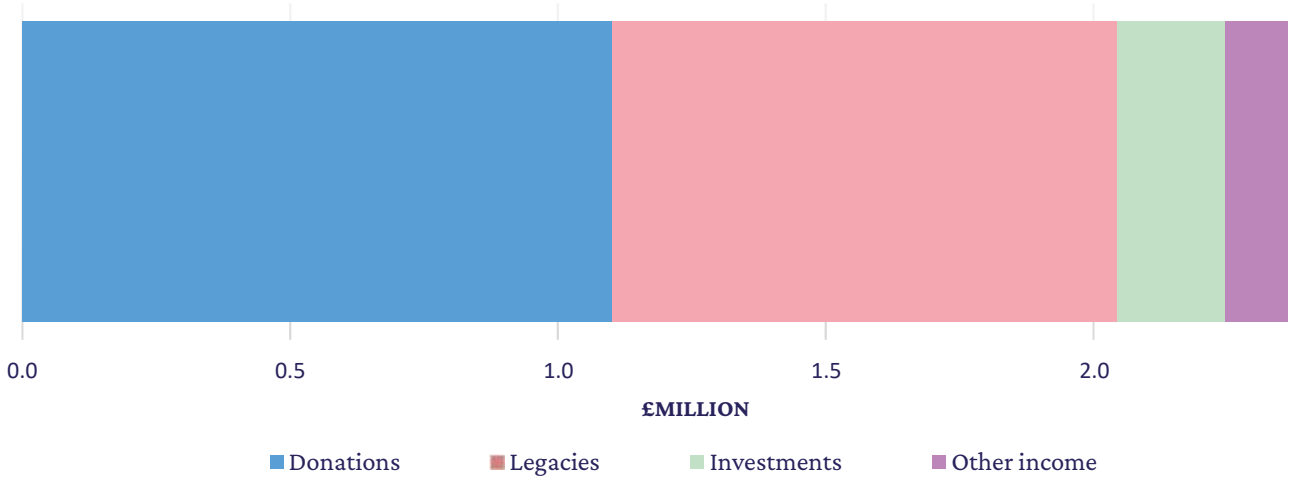
Funds received in the year (£2.6m)

Donations received (£1,102k)

The Charity was privileged to benefit from the continued support for NHS hospitals, with donated income totalling £1,102k (£1,088k in the previous year). This includes £351k received in grant funding, primarily from the NHS Charities Together Covid Emergency Appeal, and £751k from donations made by our local community, including sponsorship from sporting events, cake sales and raffles, as well as donations made in memory of loved ones.

Legacy gifts (£1,169k)

A gift in a will really is an investment in the future of our charity, and we are fortunate to be supported in this way by so many people each year. Income from legacies is expected to vary from year to year but it continues to make an important contribution to the Charity with £1,169k received in 2022/23 (£979k in 2021/22).



Investment income (£201k)

Through application of a formal Investment Policy, this year the Charity used its funds to generate a further £201k of investment income (£229k in 2021/22). This was achieved in the form of dividends and bank interest. The Investment Policy and performance are regularly monitored by the Corporate Trustee through its Charitable Funds Committee.

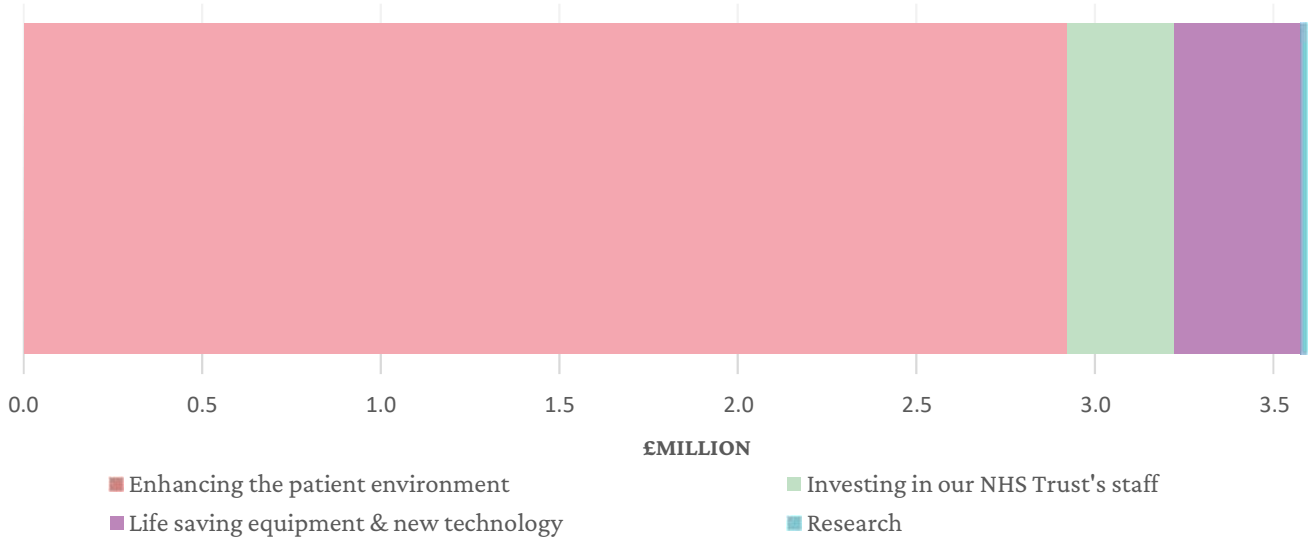
Other income (Total £116k)

The Charity's lottery continued to develop successfully in 2022/23, raising a further £13k over the course of its second year. Income from course fees has continued at a similar level to the prior year, as we return towards pre-pandemic levels, with £74k received from this source, together with sponsorship of study days (2021/22: £87k)

Money spent in the year (£3.8m)

Expenditure on Charitable Activities (£3.6m)

The expenditure for the year on charitable activities was £3.6m (£3.2m in the previous year). The breakdown of expenditure on the Charity's four key areas of focus in 2022/23 is shown below:



Examples of expenditure and funding committed for expenditure include:

- £2m to support the new Norfolk and Norwich Orthopaedic Centre;
- £230k to purchase new OCT scanners for Cromer Allies Unit, the Central Norwich Eye Clinic and NNUH;
- £18k to update the Nelson Day Unit waiting area;
- £50k to fund a new Interstitial Lung Disease Clinical Nurse Specialist for one year;
- £31k to extend the lease of two wheelchair accessible vehicles to help patients get home from hospital;
- £10k to purchase four paediatric mannequins for Advanced Life Support Training for NHS staff;
- £45k to fund two research analyst posts for one year, supporting Liver and Gastrointestinal research.

Expenditure on Raising Funds (£163k)

Expenditure on raising funds includes the cost of fundraising staff as well as promotional material, the purchase of leaflets, donation boxes and envelopes. The Charity's aim is to keep fundraising costs as low as possible whilst appropriately promoting the Charity and its work. In this way our supporters can be confident that the maximum possible portion of their donation is being spent on charitable activities. For 2022/23 expenditure on raising funds equated to 4p for each £1 spent, compared to 96p on charitable activities. The amount spent on fundraising has fallen over the last year, due to changes in the Charity Team's structure, however it is expected to increase over the next few years as the Charity grows. Our intention is to keep it as low as possible, maximising funds available for supporting better care for patients.

Fund balance (£9.6m) and reserves

The Corporate Trustee has set a minimum reserve level of £0.5m in unrestricted funds, to ensure that ongoing costs for running the Charity can be met, as well as providing a buffer for fluctuations in the value of investments.

At 31 March 2023, the total funds of the Charity amounted to £9.6m (£11.4m at the end of 2021/22). Of these:

- £0.3m was held in restricted funds including for use in the Jenny Lind Children's Hospital; to support NHS staff and for a Baby Bereavement Nurse. £0.2m has been committed for expenditure from these funds;
- £8.7m was held in unrestricted (designated) funds where money has been donated for particular purposes, but no binding trust has been created. We aim to follow donor's wishes on the focus of expenditure when it is practicable to do so. £2.7m has been committed for expenditure from these funds;
- £0.6m in unrestricted general funds. (£0.8m in 2021/22). Less than £0.1m has been committed for expenditure from these funds.

The Charity's Head of Grants works with individual fund advisers to plan expenditure of funds. In addition, the Charity has established a series of strategic plans for expenditure of the Charity's funds in the years ahead, aimed at maximising beneficial impact and promoting sustainability of the charity. The timing of major expenditure is under the control of the Corporate Trustee (and Charitable Funds Committee under delegated authority).

At the end of 2022/23, £40k of unrestricted funds had been agreed for future projects, leaving £0.6m in free reserves. All available unrestricted funds over and above the £0.5m minimum reserve level will be used to fund the Charity's 2023/24 running costs.

The total amount of funding agreed for future expenditure from all funds is £2.9m.

Investment policy and performance

The Charity has a formal Investment Policy and Investment Mandate, approved and overseen by its Charitable Funds Committee. The objective of this Policy is to ensure that there is a diversified portfolio of investments (thereby spreading exposure to risk) with an intention to maximise financial return to the Charity within a 'medium risk' investment profile.

At the end of 2022/23, £8.1m of the Charity's funds were invested in the diversified portfolio of investments, managed by Barratt & Cooke stockbrokers regulated by the Financial Conduct Authority (2021/22: £8.7m). In 2022/23, the administration charge for management of the Charity's investments was £804 (2021/22: £816).

During the year, there was a net loss of £0.5m on investments (£0.7m gain in 2021/22). This was made up of a realised loss of £44k from disposal of investments (loss of £10k in 2021/22), and an unrealised loss of £468k on the investment portfolio held at the year-end (gain of £733k in 2021/22).

The Charity uses professional and regulated investment services to manage its investment portfolio. Investment performance is kept under review by the Charity Team and Charitable Funds Committee, and the Investment Manager meets with the Committee on an annual basis to discuss performance and strategy. Barratt and Cooke were reappointed in 2019/20 to provide Investment Manager services to the Charity for the period to 2022.

Trustee arrangements

The Norfolk and Norwich University Hospitals NHS Foundation Trust (the Trust) is the sole corporate trustee of the Charity and the Trust's Board of Directors is tasked with exercising all powers and duties of the Trust, including the responsibility of corporate trustee. Membership of the Board of Directors is detailed in the Trust's Annual Report and Accounts and on its website (www.nnuh.nhs.uk).

The Trust Audit Committee and Trust Board have considered whether the Charity accounts should be consolidated with those of the Trust. Whilst the Charity may be considered to be 'under the control' of the Trust Board, it is not considered to be financially material to the Trust and the accounts are therefore not consolidated.

The Board has established a Charitable Funds Committee with formal Terms of Reference which are reviewed and updated on a regular basis. The purpose of the Committee is to:

- provide assurance oversight of the management of the Charity;
- oversee investment of the Charity's assets;
- assist the Board in meeting its responsibilities as Corporate Trustee;
- support the Corporate Trustee in strategic overview of the Charity.

During 2022/23 the members of the Charitable Funds Committee were:

Joanna Hannam	Non-Executive Director and Chair of Committee
Roy Clarke	NNUHFT Chief Finance Officer
Julian Foster	Non-Executive Director
John Paul Garside	Company Secretary - Executive Lead for the Charity
Simon Hackwell	NNUHFT Director of Strategy
Sam Higginson	NNUHFT Chief Executive
Tom Spink	Non-Executive Director

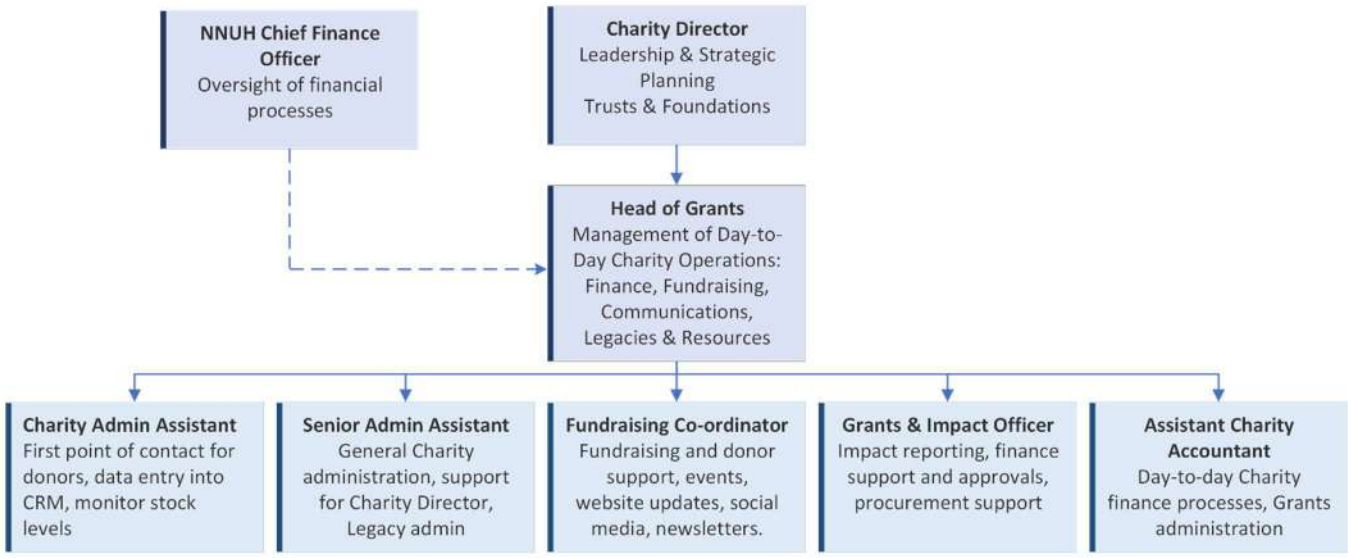
The Charitable Funds Committee has been active on behalf of the Corporate Trustee in overseeing and encouraging the work and development of the Charity during 2022/23. Work undertaken by the Committee during the year has included:

- establishing the Charity's Annual Plan and Ambitions – to continue growth of the Charity with an agreed budget and ambitions for income generation and expenditure;
- approval of the Charity's Fundraising and Income Generation Strategic Plan (2023-2027) aimed at supporting growth and development in the Charity;
- reviewing options and plans to raise funds, leading to award in June '22 of a £1.6m grant to purchase specified equipment for the new Diagnostic Assessment Centre (DAC);
- receiving updates on development of a new Charity-funded café at Cromer Hospital, to benefit staff, patients and public;
- encouraging the ongoing development of our impact reporting processes – following-up on grants to monitor that they are delivering the intended benefits;
- working with clinical and managerial teams to identify funding priorities and expenditure plans including funding for additional clinical equipment, staff rest areas and enhanced facilities across the Trust and including the Jenny Lind Children's Hospital

In accordance with the scheme of delegation and standing financial instructions, the Trust Board delegates responsibility for the day-to-day management of the N&N Hospitals Charity to the Executive Lead for Charitable Funds.

Our staff and advisors

Executive oversight of the Charity is undertaken by John Paul Garside, Company Secretary for the Trust. Management and operation of the Charity was carried out during 2022/23 by:



Plans are in place to grow the Charity Team, with additional fundraising co-ordinators and financial reporting support for the Head of Grants.

Professional Advisers

Investment managers:

Messrs. Barratt & Cooke
5/6 Opie Street
Norwich
NR1 3DW

Bankers:

Barclays Corporate Services
PO Box 729
1 Capability Green
Luton
Bedfordshire
LU1 3US

External auditors:

KPMG LLP (UK)
Dragonfly House
2 Gilders Way
NR3 1UB

Risk Management

As part of its regular business, the Charitable Funds Committee identifies the Annual Plan and Ambitions for the Charity and receives reports on progress and risks to achievement. The key risks and uncertainties that face the Charity are:

A. Financial risks in a post-Covid economic downturn

There is a possibility that the Charity will encounter 'fallow ground' for fundraising and communication messaging due to an economic downturn.

The Charity, through its Corporate Trustee and Charitable Funds Committee has identified that the most effective way of fundraising and encouraging support is through the effective and impactful expenditure of donated funds. An expanded and targeted expenditure programme, supplemented by enhanced impact reporting, demonstrates the value of giving to the Charity.

Approved Communications and Legacy strategies raise the profile of giving to the Charity and publicise the value of doing so. Further steps to enhance the profile and presence of the Charity include the systematic consideration of donor recognition as part of capital spending approvals.

B. Financial risk through reliance on voluntary income and 'at risk' investments

B.1 With no endowments, the Charity is very heavily reliant on voluntary income which is subject to unpredictable variation.

Uncertainty over future donations is mitigated by an approved Legacy Strategy, with actions targeted to increase our legacy income stream. Diversification of income streams has also been encouraged through launch of a Charity Lottery and establishing Charity café at both Cromer Hospital and Norfolk & Norwich University Hospital. Further income streams will be enhanced through development of a café in the Diagnostic & Assessment Centre (DAC) and through sales of Charity-related merchandise.

B.2 Vulnerability through lack of diversification in modes of investment.

Fluctuation in the value of the Charity's investments in the stock market can lead to swings in the value in of the Charity's fund. This is mitigated by the utilisation of a professional Funds Manager, operating under a 'Medium Risk' investment mandate, and with targets to achieve performance better than industry benchmarks over a 5-year period. Taking this longer-term view, in combination with advance planning of major expenditure, mitigates against detrimental effects of short-term fluctuation in share values.

Related parties

The Norfolk and Norwich University Hospitals NHS Foundation Trust is the corporate trustee of the N&N Hospitals Charity and is therefore a related party.

Our relationship with the wider community

The ability of the N&N Hospitals Charity to continue its work is dependent on its ability to maintain donations from the general public. The N&N Hospitals Charity continues to forge strong relationships with members of staff of the hospital without whose co-operation the ability to make an effective contribution would be much diminished.

Volunteers

The Charity pays tribute to:

- our volunteers for their time, support and commitment;
- the members of staff who give of their time out of hours in support of the work of the N&N Hospitals Charity;
- our fundraisers who do so much to enrich lives through donations and fundraising activities;
- the many external organisations, companies, trusts, and foundations that have supported our work.

Fundraising Compliance Report

Donors to the Norfolk and Norwich Hospitals Charity can be assured that we comply with the regulatory standards for fundraising.

We are registered with the Fundraising Regulator and are committed to the Fundraising Promise and adherence to the Code of Fundraising Practice. This report covers the requirements charities must follow as set out in the Charities Act 2016.

The Charity's fundraising has been carried out mainly by employee fundraisers, or by members of the local community fundraising in aid of our Charity. A small amount of fundraising is carried out on the Trust's premises by volunteers acting on behalf of our Charity. These volunteers receive in-house training and are recruited and monitored by the Trust's Voluntary Services team. There have been no issues of non-compliance with the Code of Fundraising Practice during 2022/23. There were none in the previous year.

Complaints are dealt with in line with the Norfolk & Norwich University Hospitals NHS Foundation Trust complaints policy, which can be found on their website. We received zero complaints in the 2022/23 financial year. In the previous year, we received zero complaints. Any complaints received are investigated, and responses made.

The Charity follows the Trust's Safeguarding Policy, which is in place to protect people in vulnerable circumstances. We also adhere to industry guidelines and regulations and are here to talk to individuals about our work, or to answer any questions. Contact can be made via our website, social media, emails, phone or by post.

Signed on behalf of the trustee:

Statement of the Corporate Trustee's responsibilities in respect of the Corporate Trustee's annual report and the financial statements

Under the trust deed of the charity and charity law, the corporate trustee is responsible for preparing a Corporate Trustee's Annual Report and the financial statements in accordance with applicable law and regulations. The corporate trustee is required to prepare the financial statements in accordance with UK Accounting Standards, including FRS 102 *The Financial Reporting Standard applicable in the UK and Republic of Ireland.*

The financial statements are required by law to give a true and fair view of the state of affairs of the charity and of the incoming resources and application of resources for that period.

In preparing these financial statements, generally accepted accounting practice entails that the corporate trustee:

- select suitable accounting policies and then apply them consistently;
- make judgements and estimates that are reasonable and prudent;
- state whether applicable UK Accounting Standards and the Statement of Recommended Practice have been followed, subject to any material departures disclosed and explained in the financial statements;
- assess the charity's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and
- use the going concern basis of accounting unless they either intend to liquidate the charity or to cease operations or have no realistic alternative but to do so.

The corporate trustee is required to act in accordance with the trust deed of the charity, within the framework of trust law. They are responsible for keeping accounting records which are sufficient to show and explain the charity's transactions and disclose at any time, with reasonable accuracy, the financial position of the charity at that time, and to enable the corporate trustee to ensure that, where any statements of accounts are prepared by them under section 132(1) of the Charities Act 2011, those statements of accounts comply with the requirements of regulations under that provision. They are responsible for such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error, and have general responsibility for taking such steps as are reasonably open to them to safeguard the assets of the charity and to prevent and detect fraud and other irregularities.

The corporate trustee is responsible for the maintenance and integrity of the financial and other information included on the charity's website. Legislation in the UK governing the preparation and dissemination of financial statements may differ from legislation in other jurisdictions.

These financial statements were approved on 1 November 2023 and signed on behalf of the corporate trustee by:

Board member: ..... Name: .....

Date: .....

Independent auditor's report to the Corporate Trustee of Norfolk and Norwich Hospitals Charity

Opinion

We have audited the financial statements of Norfolk and Norwich Hospitals Charity ("the charity") for the year ended 31 March 2023 which comprise the Statement of Financial Activities, Balance Sheet, Statement of Cash Flows and related notes, including the accounting policies in note 1.

In our opinion the financial statements:

- give a true and fair view of the state of the charity's affairs as of 31 March 2023 and of its incoming resources and application of resources for the year then ended.
- have been properly prepared in accordance with UK accounting standards, including FRS 102 *The Financial Reporting Standard applicable in the UK and Republic of Ireland*; and
- have been prepared in accordance with the requirements of the Charities Act 2011.

Basis for opinion

We have been appointed as auditor under section 144 of the Charities Act 2011 (or its predecessors) and report in accordance with regulations made under section 154 of that Act.

We conducted our audit in accordance with International Standards on Auditing (UK) ("ISAs (UK)") and applicable law. Our responsibilities are described below. We have fulfilled our ethical responsibilities under, and are independent of the charity in accordance with, UK ethical requirements including the FRC Ethical Standard. We believe that the audit evidence we have obtained is a sufficient and appropriate basis for our opinion.

Going concern

The corporate trustee has prepared the financial statements on the going concern basis as they do not intend to liquidate the charity or to cease its operations, and as they have concluded that the charity's financial position means that this is realistic. They have also concluded that there are no material uncertainties that could have cast significant doubt over its ability to continue as a going concern for at least a year from the date of approval of the financial statements ("the going concern period").

In our evaluation of the corporate trustee's conclusions, we considered the inherent risks to the charity's business model and analysed how those risks might affect the charity's financial resources or ability to continue operations over the going concern period.

Our conclusions based on this work:

- we consider that the corporate trustee's use of the going concern basis of accounting in the preparation of the financial statements is appropriate;
- we have not identified, and concur with the corporate trustee's assessment that there is not, a material uncertainty related to events or conditions that, individually or collectively, may cast significant doubt on the charity's ability to continue as a going concern for the going concern period.

However, as we cannot predict all future events or conditions and as subsequent events may result in outcomes that are inconsistent with judgements that were reasonable at the time they were made, the above conclusions are not a guarantee that the charity will continue in operation.

Fraud and breaches of laws and regulations – ability to detect

To identify risks of material misstatement due to fraud ("fraud risks"), we assessed events or conditions that could indicate an incentive or pressure to commit fraud or provide an opportunity to commit fraud. Our risk assessment procedures included:

- Enquiring of management and inspection of documentation as to the entity's high level policies and procedures to prevent and detect fraud.
- Reading Board meeting minutes.
- Using analytical procedures to identify any unusual or unexpected relationships.

We communicated identified fraud risks throughout the audit team and remained alert to any indications of fraud throughout the audit.

As required by auditing standards, we perform procedures to address the risk of management override of controls and the risk of fraudulent revenue recognition. However, due to the nature of the income received by the charity we have rebutted the fraud risk in relation to revenue recognition.

Within the Charities sector, auditors also consider the risk that material misstatements due to fraudulent financial reporting may arise from the manipulation of expenditure recognition and therefore an additional risk has been identified in relation to this.

We performed procedures including:

- Identifying journal entries and other adjustments to test based on risk criteria and comparing the identified entries to supporting documentation. These included unusual cash journals;
- Agreeing a sample of expense transactions back to relevant invoices and supporting documentation.
  Identifying and responding to risks of material misstatement due to non-compliance with laws and regulations

We identified areas of laws and regulations that could reasonably be expected to have a material effect on the financial statements from our general commercial and sector experience and through discussion with the corporate trustee and other management (as required by auditing standards). We discussed with the corporate trustee and other management the policies and procedures regarding compliance with laws and regulations. We communicated identified laws and regulations throughout our team and remained alert to any indications of noncompliance throughout the audit.

The potential effect of these laws and regulations on the financial statements varies considerably.

The Charity is subject to laws and regulations that directly affect the financial statements, including the Charities SORP and financial reporting legislation. We assessed the extent of compliance with these laws and regulations as part of our procedures on the related financial statement items.

Whilst the Charity is subject to many other laws and regulations, we did not identify any others where the consequences of non-compliance alone could have a material effect on amounts or disclosures in the financial statements.

Context of the ability of the audit to detect fraud or breaches of law or regulation

Owing to the inherent limitations of an audit, there is an unavoidable risk that we may not have detected some material misstatements in the financial statements, even though we have properly planned and performed our audit in accordance with auditing standards. For example, the further removed non-compliance with laws and regulations is from the events and transactions reflected in the financial statements, the less likely the inherently limited procedures required by auditing standards would identify it.

In addition, as with any audit, there remains a higher risk of non-detection of fraud, as these may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal controls. Our audit procedures are designed to detect material misstatement. We are not responsible for preventing non-compliance or fraud and cannot be expected to detect non-compliance with all laws and regulations.

Other information

The corporate trustee is responsible for the other information, which comprises the Corporate Trustee's Annual Report. Our opinion on the financial statements does not cover the other information and, accordingly, we do not express an audit opinion or, except as explicitly stated below, any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether, based on our financial statements audit work, the information therein is materially misstated or inconsistent with the financial statements or our audit knowledge. We are required to report to you if:

- based solely on that work, we have identified material misstatements in the other information; or
- in our opinion, the information given in the Corporate Trustee's Annual Report is inconsistent in any material respect with the financial statements.

We have nothing to report in these respects.

Matters on which we are required to report by exception

Under the Charities Act 2011 we are required to report to you if, in our opinion:

- the charity has not kept sufficient accounting records; or
- the financial statements are not in agreement with the accounting records; or
- we have not received all the information and explanations we require for our audit.

We have nothing to report in these respects.

Corporate Trustee's responsibilities

As explained more fully in their statement set out on page 28, the corporate trustee is responsible for: the preparation of financial statements which give a true and fair view; such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due

to fraud or error; assessing the charity's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and using the going concern basis of accounting unless they either intend to liquidate the charity or to cease operations, or have no realistic alternative but to do so.

Auditor's responsibilities

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue our opinion in an auditor's report. Reasonable assurance is a high level of assurance, but does not guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements.

A fuller description of our responsibilities is provided on the FRC's website at www.frc.org.uk/auditorsresponsibilities.

The purpose of our audit work and to whom we owe our responsibilities

This report is made solely to the charity's corporate trustee as a body, in accordance with section 144 of the Charities Act 2011 (or its predecessors) and regulations made under section 154 of that Act. Our audit work has been undertaken so that we might state to the charity's corporate trustee those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the charity and its corporate trustee, as a body, for our audit work, for this report, or for the opinions we have formed.

Emma Larcombe for and on behalf of KPMG LLP, Statutory Auditor

Chartered Accountants

20 Station Road

Cambridge

CB1 2JD

How to contact us

Further information about the Charity is available via our website at **www.nnhospitalscharity.org.uk**

The charity office and working address of the N&N Hospitals Charity:

N&N Hospitals Charity

East Atrium

Norfolk & Norwich University Hospital

Norwich

NR4 7UY

Telephone - 01603 287107

Email - charity@nnuh.nhs.uk

The corporate trustee, Norfolk and Norwich University Hospitals NHS Foundation Trust, principal address: The Chief Executive

Norfolk and Norwich University Hospital

Norwich Research Park

Norwich

NR4 7UY

Telephone - 01603 286286

Statement of Financial Activities

The Statement of Financial Activities is a financial report detailing the change in the charity's net assets during the financial year.

It provides an analysis of the income received and expenditure by the charity on its activities and presents a reconciliation of the movements in a charity's funds for the reporting period, which runs from 1 April 2022 to 31 March 2023.

		2022/23			2021/22		
		Unrestricted Funds	Restricted Funds	Total Funds	Unrestricted Funds	Restricted Funds	Total Funds
	Note	£000s	£000s	£000s	£000s	£000s	£000s
Income from:							
Donations and Legacies	3	2,003	268	2,271	1,843	224	2,067
Investments	4	201	0	201	229	0	229
Charitable Activities		46	0	46	63	0	63
Other Trading Activities	5	43	0	43	14	0	14
Other Income		27	0	27	10	0	10
Total Income		**2,320**	**268**	**2,588**	**2,159**	**224**	**2,383**
Expenditure On:							
Charitable Activities	7&8	3,320	276	3,596	2,840	385	3,225
Raising Funds	9	163	0	163	196	0	196
Total Expenditure		**3,483**	**276**	**3,759**	**3,036**	**385**	**3,421**
Net Gains/(Losses) on Investments	15	(512)	0	(512)	723	0	723
Transfers between funds		0	0	0	8	(8)	0
Net Movement in Funds		**(1,675)**	**(8)**	**(1,683)**	**(146)**	**(169)**	**(315)**
Reconciliation of funds							
Total Funds Brought Forward	21	11,044	326	11,370	11,190	495	11,685
Total Funds Carried Forward		**9,369**	**318**	**9,687**	**11,044**	**326**	**11,370**

The notes on pages 34 to 48 form part of these financial statements.

Balance Sheet

The balance sheet provides a view of the charity's assets and liabilities and how these are represented by the different classes of funds held by the charity. The objective of the balance sheet is to show the resources available to the charity and whether these are available for all purposes of the charity or must be used for specific purposes because of legal restrictions placed on their use.

		2022/23			2021/22		
		Unrestricted Funds	Restricted Funds	Total Funds	Unrestricted Funds	Restricted Funds	Total Funds
	Note	£000s	£000s	£000s	£000s	£000s	£000s
Fixed Assets							
Intangible Assets	13	0	0	0	4	0	4
Non-Current Assets	14	190	0	190	87	0	87
Non-Current Assets (WIP)		0	0	0	100	0	100
Investments	16	8,066	0	8,066	8,714	0	8,714
Total Fixed Assets		**8,256**	**0**	**8,256**	**8,905**	**0**	**8,905**
Current Assets							
Stocks	17	3	0	3	7	0	7
Debtors	18	930	32	962	805	12	817
Cash At Bank And In Hand	19	3,178	408	3,586	1,837	391	2,228
Total Current Assets		**4,111**	**440**	**4,551**	**2,649**	**403**	**3,052**
Creditors							
Creditors: Amounts Falling Due Within One Year	20	(2,998)	(122)	(3,120)	(510)	(77)	(587)
Net Current Assets		**1,113**	**318**	**1,431**	**2,139**	**326**	**2,465**
Total Net Assets		**9,369**	**318**	**9,687**	**11,044**	**326**	**11,370**
Total Funds							
Restricted		0	318	318	0	326	326
Unrestricted	21	631	0	631	808	0	808
Unrestricted (designated)		8,738	0	8,738	10,236	0	10,236
Total Funds		**9,369**	**318**	**9,687**	**11,044**	**326**	**11,370**

The financial statements on pages 34 to 48 were approved by the Board of the Trustee on 1 November 2023 and signed on its behalf by:

Signed:

Name: Date:

Statement of Cash Flows

The Statement of Cash Flows aims to show how changes in balance sheet accounts and income affect cash and cash equivalents, and breaks the analysis down to operating, investing, and financing activities. The cash flow statement is concerned with the flow of cash in and out of the charity during the financial year, which runs from 1 April 2022 to 31 March 2023.

	Note	2022/23 £000s	2021/22 £000s
Cash flows from operating activities			
Net cash (used in)/provided by operating activities		**1,076**	**(1,780)**
Cash flows from investing activities			
Dividends and interest from investment	4	201	229
Purchase of investments	16	(694)	(929)
Purchase of non-current assets	14	(55)	(209)
Proceeds on disposal of investments		830	2,568
Net cash provided/(used in) by investing activities		**282**	**1,659**
Change in cash and cash equivalents in the reporting period		**1,358**	**(121)**
Cash and cash equivalents at the beginning of the reporting period		2,228	2,349
Cash and cash equivalents at the end of the reporting period	19	**3,586**	**2,228**
Reconciliation of net movement in funds to net cash flow from operating activities			
Net movement in funds (statement of financial activities)		(1,683)	(361)
Losses/(Gains) on investments	15	512	(723)
Income from investments	4	(201)	(229)
Amortisation of intangible assets	13	4	5
Depreciation	14	52	22
Decrease/(Increase) in stocks	17	4	7
(Increase)/Decrease in debtors	18	(145)	(757)
Increase/(Decrease) in creditors	20	2,533	256
Cash inflow/(outflow) from operating activities		**1,076**	**(1,780)**

The notes on pages 34 to 48 form part of these financial statements.

1. Accounting Policies

(a) Basis of preparation

The financial statements have been prepared under the historic cost convention, except for investments which are included at fair value.

The accounts (financial statements) have been prepared in accordance with the Statement of Recommended Practice: Accounting and Reporting by Charities preparing their accounts in accordance with the Financial Reporting Standard applicable in the UK and Republic of Ireland (FRS 102) issued in October 2019 and the Financial Reporting Standard applicable in the United Kingdom and Republic of Ireland (FRS 102) and the Charities Act 2011 and UK Generally Accepted Practice as it applies from 1 January 2019.

The charity is a public benefit entity as defined by FRS 102.

The trustee considers that there are no material uncertainties about the Norfolk and Norwich Hospitals Charity's ability to continue as a going concern.

(b) Funds structure

Where there is a legal restriction on the purpose to which a fund may be put, the fund is classified either as a restricted fund or an endowment fund.

Restricted funds are those where the donor has provided for the donation to be spent in furtherance of a specified charitable purpose. N&N Hospitals Charity's restricted funds typically result from grants received for specific projects.

Endowment funds arise when the donor has expressly provided that the gift is to be invested and only the income of the fund may be spent. The N&N Hospitals Charity currently has no endowment funds.

Those funds which are neither endowment nor restricted funds, are unrestricted funds which are sub analysed between designated (earmarked) funds where the trustee has set aside amounts to be used for specific purposes or which reflect the non-binding wishes of donors, and unrestricted funds which are at the trustee's discretion. Unrestricted funds include the general fund and represent the charity's reserves. The major funds held in each of these categories are disclosed in note 21.

(c) Incoming resources

All incoming resources are recognised once the charity has entitlement to the resources, it is probable (more likely than not) that the resources will be received, and the monetary value of incoming resources can be measured with sufficient reliability.

Where there are terms or conditions attached to incoming resources, particularly grants, then these terms or conditions must be met before the income is recognised, as the entitlement condition will not be satisfied until that point. Where terms or conditions have not been met or uncertainty exists as to whether they can be met then the relevant income is not recognised in the year but deferred and shown on the balance sheet as deferred income.

(d) Incoming resources from legacies

Legacies are accounted for as incoming resources either upon receipt or where the receipt of the legacy is probable. Receipt is probable when:

- confirmation has been received from the representatives of the estate(s) that probate has been granted;
- the executors have established that there are sufficient assets in the estate to pay the legacy; and
- all conditions attached to the legacy have been fulfilled or are within the charity's control.

If there is uncertainty as to the amount of the legacy, and it cannot be reliably estimated, then the legacy is shown as a contingent asset until all the conditions for income recognition are met.

(e) Gifts in Kind

Gifts in kind such as food and care packages are not accounted for when they are accepted and immediately distributed unless a single donation is material.

Gifts of tangible assets such as microwaves and fridges, and Amazon Wish List donations, are recognised as a donation at fair value (market price) on receipt, and charitable expenditure when they are distributed.

Where gifts in kind are held before being distributed to beneficiaries they are recognised at fair value as stock until they are distributed.

(f) Resources expended and irrecoverable VAT

All expenditure is accounted for on an accruals basis and is recognised when the following criteria are met:

- there is a present legal or constructive obligation resulting from a past event
- it is more likely than not that a transfer of benefits (usually a cash payment) will be required in settlement
- the amount of the obligation can be measured or estimated reliably.

Irrecoverable VAT is charged against the category of resources expended for which it was incurred.

(g) Recognition of expenditure and associated liabilities because of grant

Grants payable are payments made to linked, related party, or third-party NHS bodies and non-NHS bodies, in furtherance of the charitable objectives of the funds held on trust, primarily relief of those who are ill.

Grant payments are recognised as expenditure when the conditions for their payment have been met or where there is a constructive obligation to make a payment.

A constructive obligation arises when:

- We have communicated our intention to award a grant to a recipient who then has a reasonable expectation that they will receive a grant; or
- We have made a public announcement about a commitment which is specific enough for the recipient to have a reasonable expectation that they will receive a grant;

The trustee has control over the amount and timing of grant payments and consequently where approval has been given by the trustee and any of the above criteria have been met then a liability is recognised. Grants are awarded on condition that the Charity is acknowledged as the funder, and a report on the impact of expenditure is provided within six months of payment being made.

If a grant has been offered but there is uncertainty as to whether it will be accepted or whether conditions will be met, then no liability is recognised, but an appropriate designation is made in the relevant fund. Grant commitments are shown in Note 22.

(h) Support and governance costs

Support costs are those costs which do not relate directly to a single charitable activity. These include some staff costs, costs of administration and IT support. Governance costs include audit, and any other regulatory fees. The analysis of support and governance costs are shown in note 8.

(i) Fundraising costs

The costs of generating funds are those costs attributable to generating income for the charity, other than those costs incurred in undertaking charitable activities or the costs incurred in undertaking trading activities in furtherance of the charity's objects. The costs of generating funds represent fundraising costs together with the salaries for the charity's fundraising team and are shown in note 9.

(j) Charitable activities

Costs of charitable activities comprise all costs incurred in the pursuit of the charitable objects of the charity. These costs, where not wholly attributable, are apportioned between the categories of charitable expenditure in addition to the direct costs. The total costs of each category of charitable expenditure include an apportionment of support costs as shown in note 7.

(k) Intangible assets

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the charity's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to the charity, and where the cost of the asset can be measured reliably. Intangible fixed assets are amortised at rates calculated to write them down to estimated residual values on a straight-line basis over their estimated useful lives. Computer software is expected to have a useful life of 5 years.

(l) Fixed asset investments

Investments are a form of basic financial instrument. Fixed asset investments are initially recognised at their transaction value and are subsequently measured at their fair value (market value) as at the balance sheet date. The Statement of Financial Activities includes the net gains and losses arising on revaluation and disposals throughout the year. Quoted stocks and shares are included in the Balance Sheet at the current market value quoted by the investment analyst, excluding dividend. Other investments are included at the trustee's best estimate of market value.

The main form of financial risk faced by the charity is that of volatility in equity markets and investment markets due to wider economic conditions, the attitude of investors to investment risk, and changes in sentiment concerning equities and within particular sectors or sub sectors. Further information on the N&N Hospitals Charity's investments can be found in note 15.

(m) Non-Current assets

Non-Current assets that are held by the charity and cost more than £5,000 are capitalised and valued at historic cost. Depreciation is charged on furniture and equipment, which is written off on a straight-line basis over their estimated useful life of five years.

Non-Current assets (WIP) refer to Work-in-Progress on non-current assets for the Charity. No depreciation is charged until the assets are brought into use.

(n) Stock

Stock held for resale is valued at the lower of cost and net realisable value. Stocks of non-perishable gift in kind items held at the year end are recorded at fair value.

(o) Debtors

Debtors are amounts owed to the charity. They are measured based on their recoverable amount.

(p) Cash and cash equivalents

Cash at bank and in hand is held to meet the day to day running costs of the charity as they fall due. Cash equivalents are short term, highly liquid investments, usually in 90-day notice interest bearing savings accounts.

(q) Creditors

Creditors are amounts owed by the charity. They are measured at the amount that the charity expects to have to pay to settle the debt. The Charity has no amounts which are owed in more than a year.

(r) Realised gains and losses

All gains and losses are taken to the Statement of Financial Activities as they arise. Realised gains and losses on investments are calculated as the difference between sales proceeds and carrying value in the previous month (or purchase date). Unrealised gains and losses are calculated as the difference between the market value at the year end and opening carrying value (or purchase date if later).

(s) Staff costs and pensions

Norfolk and Norwich University Hospitals NHS Foundation Trust (the Trust) fully re-charged the N&N Hospitals Charity for the members of staff who work for the charity.

Staff members belong to the NHS Pension Scheme which is an unfunded defined benefit scheme accounted for as a defined contribution scheme. The recharge from the Trust includes the employee contributions to that scheme. For more information on the NHS Pension Scheme refer to the Trust's annual report and accounts.

2. Related party transactions

The Charity has a related party relationship with the Norfolk and Norwich University Hospitals NHS Foundation Trust. The Trust is the Corporate Trustee for the Charity as well as its main grant beneficiary.

Transactions between the Charity and the Trust during the year were in relation to salary payments for its staff, income invoiced by the Trust for the Charity, payment of Charity supplier invoices that were processed through the Trust's procurement and payment systems and refunded by the Charity, and for administrative and management costs.

The Trust recharged £227,068 to the Charity (2021/22 £244,114) for its staffing and administration costs.

The services of the Norfolk and Norwich University Hospitals NHS Foundation Trust have benefited from payments of £2,274,725 (2021/22 £1,741,758) from the Charity for enhancement of the patient environment, investment in staff, additional equipment and research.

During 2022/23 capital assets to the value of £850,589 (2021/22 £130,298) were purchased by the Charity and donated to the Trust. No cash grants were made to the Trust for the purchase of further capital assets (2021/22 £999,473).

None of the members of the Trust board or parties related to them have undertaken any transactions with the N&N Hospitals Charity or received any benefit from the charity in payment or kind. Board members received no honoraria, emoluments, or expenses in the year.

At the end of the financial year £1,092,673 was owed by the Charity to the Trust. (2021/22 £552,636). £2,000,000 was accrued by the Charity for a grant funding commitment for confirmed costs related to the Norfolk and Norwich Orthopaedic Centre, which is under construction.

3. Income from donations and legacies

	2022/23			2021/22
	Unrestricted Funds	Restricted Funds	Total Funds	Total Funds
	£000s	£000s	£000s	£000s
Voluntary Income				
General donations	605	10	615	651
Corporate donations	136	0	136	63
Legacies	1,169	0	1,169	979
Grants	93	258	351	374
Total Voluntary Income	**2,003**	**268**	**2,271**	**2,067**

4. Income from investments

	2022/23			2021/22
	Unrestricted Funds	Restricted Funds	Total Funds	Total Funds
	£000s	£000s	£000s	£000s
Investment Income				
Interest on deposits	10	0	10	0
Fixed asset equity investments	191	0	191	229
Total Investment Income	**201**	**0**	**201**	**229**

5. Analysis of other income

	2022/23			2021/22
	Unrestricted Funds	Restricted Funds	Total Funds	Total Funds
	£000s	£000s	£000s	£000s
Incoming Resources from Charitable Activities				
Training Income	46	0	46	63
Total Incoming Resources from Charitable Activities	**46**	**0**	**46**	**63**
Activities for Generating Funds				
Fundraising events	5	0	5	1
Lotteries and raffles	13	0	13	13
External fundraisers	0	0	0	0
Trading income	25	0	25	0
Total Activities for Generating Funds	**43**	**0**	**43**	**14**
Other Incoming Resources				
Other Income	27	0	27	10
Total Other Incoming Resources	**27**	**0**	**27**	**10**

6. Role of volunteers

Like all charities, the N&N Hospitals Charity is reliant on a team of volunteers for our smooth running. Our volunteers perform two roles:

- Fund advisors – there are about 400 Trust staff who support the charitable funds committee when deciding how the charity's designated funds should be spent. These funds are designated (or earmarked) by the charitable funds committee to be spent for a particular purpose or in a ward or department. Each fund advisor submits grant applications and monitors the financial status of their fund.

- Fundraisers – there are many local volunteers who actively fundraise for the N&N Hospitals Charity by running events.

In accordance with the SORP, due to the absence of any reliable measurement basis, the contribution of these volunteers is not recognised in the accounts.

7. Analysis of charitable expenditure

The charity did not undertake any direct charitable activities on its own account during the year. Charitable expenditure was in the form of grant funding to the Trust to carry out activities or to purchase equipment that will benefit NHS patients and their families.

	2022/23			2021/22
	Support Costs	Grant funded activity	Total	Total
	£000s	£000s	£000s	£000s
Charitable Activities				
Enhancing the patient environment	154	2770	2924	2089
Investing in our staff	16	283	299	345
Life saving equipment & new technology	19	337	356	677
Research	1	16	17	114
Total Charitable Activities	**190**	**3,406**	**3,596**	**3,225**

8. Analysis of support costs and governance costs

Support costs are back-office costs related to the day-to-day running of the charity, including depreciation on the Charity Hub. Governance costs are those support costs which relate to the strategic management of the charity.

	2022/23			2021/22
	Unrestricted Funds	Restricted Funds	Total Funds	Total Funds
	£000s	£000s	£000s	£000s
Charity Staff Costs	92	0	92	98
Management and Administration Costs	34	3	37	38
Total Support Costs	**126**	**3**	**129**	**136**
Audit	13	0	13	15
Staff costs	47	0	47	38
Other Governance Costs	1	0	1	1
Total Governance Costs	**61**	**0**	**61**	**54**
Total Support and Governance Costs	**187**	**3**	**190**	**190**

9. Analysis of expenditure on raising funds

	2022/23			2021/22
	Unrestricted Funds	Restricted Funds	Total Funds	Total Funds
	£000s	£000s	£000s	£000s
Cost of Raising Funds				
Fundraising staff costs	80	0	80	102
Fundraising expenditure	83	0	83	94
Total Costs of Generating Funds	**163**	**0**	**163**	**196**

Fundraising expenditure includes depreciation on equipment used to generate trading income.

10. Trustee remuneration, benefits, and expenses

Members of the Trust board give their time freely and receive no remuneration for the work that they undertake in relation to the N&N Hospitals Charity. They can claim expenses, however, to reimburse them for costs that they incur in fulfilling their duties relating to N&N Hospitals Charity – these include travelling specifically for charitable funds committee meetings and charity specific training events.

No expenses were claimed from the Charity by committee members (2021/22 nil)

11. Analysis of staff costs

The average number of full-time equivalent employees during the year was 4.6 (2021/22 5.3).

Staff Costs	2022/23	2021/22
	£000s	£000s
Salaries and Wages	147	166
Social Security Costs	14	14
Other Pension Costs	20	23
Total	**181**	**203**

A further recharge of time spent by Finance Department Managers was made by the Trust. This related to time spent authorising payments, reviewing reconciliations, and checking the annual accounts. The amount recharged was £4k (2021/22 £4k).

The N&N Hospitals Charity considers its key management personnel to be the Charity Director, who is the Board Secretary for the Norfolk and Norwich University Hospitals NHS Foundation Trust. A recharge of time spent by the Charity Director and his administrative support was made by the Trust. The amount recharged was £38k (2021/22 £32k).

No employees had emoluments in excess of £60,000 (2021/22 nil)

12. Auditor's remuneration

The auditor's remuneration of £11,000 (2021/22: £11,000) related solely to the audit with no other additional work being undertaken (2021/22 nil). These figures are exclusive of VAT, however because the Charity is not able to reclaim VAT it is included in Note 8 figures.

13. Intangible assets

This relates to the donor database and accounting software which has now been fully amortised.

	2022/23	2021/22
Intangible Fixed Assets	**£000s**	**£000s**
Opening balance	4	9
Additions	0	0
Amortisation	(4)	(5)
Closing balance	**0**	**4**

14. Non-Current assets

Fixtures, fittings and equipment relates to the new Charity Hub and two Charity Cafes, opened in 2022/23.

	2022/23			2021/22
	Fixtures, Fittings & Equipment	Non-Current Assets (Work in Progress)	Total Non-Current Assets	Total Non-Current Assets
	£000s	£000s	£000s	£000s
Cost or valuation				
Balance at start of year	109	100	209	0
Additions/(Disposals)	155	(100)	55	209
Closing Balance	**264**	**0**	**264**	**209**
Accumulated Depreciation				
Balance at start of year	22	0	22	0
Charge for year	52	0	52	22
Closing Balance	**74**	**0**	**74**	**22**
Carrying value at start of year	***87***	***100***	***187***	***0***
Carrying value at end of year	**190**	**0**	**190**	**187**

Depreciation charges related to trading income are recorded as fundraising expenditure on the SOFA. All other depreciation is recorded as support costs within charitable expenditure

15. Analysis of gains/losses on investments

	2022/23	2021/22
	£000s	**£000s**
Realised (loss)/gain	(44)	197
Unrealised (loss)/gain	(468)	526
Total (loss)/gain on investments	**(512)**	**723**

16. Fixed asset investments

All investments are carried at their fair value and are managed by expert advisors. Cash held by our asset managers is available on request, and is included in the investment split for comparison, but is included in the cash and cash equivalents figure on the balance sheet.

Movement in Fixed Asset Investments	**2022/23**	**2021/22**
	£000s	**£000s**
Market Value at Start of Financial year	8,714	9,630
Less: Disposals at Carrying Value	(874)	(2,371)
Add: Acquisitions at Cost	694	929
Net Gain/(Loss) on Revaluation	(468)	526
Market Value at End of Financial Year	**8,066**	**8,714**

Fixed Asset Investment Split	**2022/23**	**2021/22**
Cash	18.20%	15.87%
Gilts/Fixed Interest	12.92%	12.40%
Investment/Unit Trusts	14.12%	12.87%
Equities	54.76%	58.86%
	100%	**100%**

17. Stock

	2022/23	**2021/22**
Stock	**£000s**	**£000s**
Online shop stock	1	4
Gifts in Kind stock	2	3
Total stock	**3**	**7**

18. Analysis of current debtors

	2022/23	**2021/22**
Amounts Falling Due Within One Year	**£000s**	**£000s**
Prepayments	2	9
Accrued Income	960	752
Other Debtors	0	56
Total Debtors Falling Due Within One Year	**962**	**817**

Accrued Income includes £928k legacy income received between the financial year end and signing of the accounts, where receipt was probable at year end, but amount and timing were unknown.

19. Analysis of cash and cash equivalents

	2022/23	**2021/22**
Cash & Cash Equivalents	**£000s**	**£000s**
Cash in hand & at bank	3,586	2,228
Total	**3,586**	**2,228**

20. Analysis of liabilities

	2022/23	2021/22
Amounts Falling Due Within One Year	**£000s**	**£000s**
Trade Creditors	15	21
Amounts Due to NNUH NHS Foundation Trust	1,092	553
Accruals	2,013	13
Total	**3,120**	**587**

21. Analysis of charitable funds

Unrestricted funds	Balance Apr 2022	Incoming resources	Resources expended	Gains and losses	Transfers	**Balance Mar 2023**
	£000s	**£000s**	**£000s**	**£000s**	**£000s**	**£000s**
N&N General Fund	**681**	404	338	(512)	275	**510**
Cromer General Fund	**119**	2	0	0	0	**121**
Others (2 funds)	**8**	0	0	0	(8)	**0**
Total	**808**	**406**	**338**	**(512)**	**267**	**631**

Name of fund	**Description of the purpose of each fund**
Norfolk and Norwich General	For the benefit of staff and patients
Cromer General	For the benefit of staff and patients at the Cromer site

Restricted Funds:	Balance Apr 2022	Incoming resources	Resources expended	Transfers	**Balance Mar 2023**
	£000s	**£000s**	**£000s**	**£000s**	**£000s**
NHS Charities Together Stage 3 Fund	137	0	33	0	**104**
Friends Fund	63	0	0	0	**63**
Chloe Blossom Fund	62	0	5	0	**57**
NHS Charities Together Stage 1 Fund	46	0	6	0	**40**
NHS Charities Together Development Fund	0	35	2	0	**33**
The Macleod Fund	18	0	7	0	**11**
Harry Hammerbeck Prize Fund	0	10	0	0	**10**
NHS Charities Together Stage 2 Fund	0	223	223	0	**0**
Total	**326**	**268**	**276**	**0**	**318**

Name of fund	**Description of the purpose of each fund**
NHS Charities Together Stage 3 Fund	For Covid recovery and wellbeing for NHS staff and patients
Friends Fund	For the benefit of patients and staff within the Trust
Chloe Blossom Fund	To fund a bereavement nurse to support early pregnancy loss
NHS Charities Together Stage 1 Fund	For Covid support projects for NHS staff and patients
NHS Charities Together Development Fund	To support development and sustainability of NHS charities
The Macleod Fund	For the benefit of paediatric patients within the Trust
Henry Hammerbeck Prize Fund	For sustainability prizes
NHS Charities Together Stage 2 Fund	For Covid recovery support projects across Norfolk & Waveney

The NHS Charities Together Stage 1 and 3 Funds have been fully committed for the provision of additional support for NHS staff at NNUH over the next 12 months.

Designated Funds	Balance Apr 2022	Incoming resources	Resources expended	Transfers	**Balance Mar 2023**
	£000s	£000s	£000s	£000s	£000s
N&N Imaging Fund	50	454	0	1,109	**1,613**
Cancer Legacy Fund	633	406	0	(151)	**888**
Cromer Legacy Fund	712	77	179	21	**631**
Radiotherapy & Oncology Fund	366	65	39	0	**392**
AOS Legacy Fund	499	1	0	(154)	**346**
Children's Cancer Fund	204	0	0	0	**204**
Cardiology Fund	226	15	42	0	**199**
Kidney Fund	197	0	0	0	**197**
Renal Fund	376	1	6	(178)	**193**
Orthopaedics Fund	296	0	68	(49)	**179**
Boudicca Breast Cancer Fund	0	143	42	64	**165**
Eye Legacy Fund	197	54	86	0	**165**
Upper Gastrointestinal Fund	75	3	11	77	**144**
Critical Care Fund	137	10	13	0	**134**
Ear, Nose & Throat Fund	125	1	0	0	**126**
Eye Department Fund	202	4	93	0	**113**
NICU Fund	64	83	41	6	**112**
Neurosciences Fund	130	1	21	0	**110**
Others (153 funds)	5,747	596	2,504	(1,012)	**2,827**
Total	**10,236**	**1,914**	**3,145**	**(267)**	**8,738**

Name of fund	**Description of the purpose of each fund**
N&N Imaging Fund	For provision of additional imaging equipment for NNUH
Cancer Legacy Fund	Cause, prevention, treatment, cure & defeat of cancer
Cromer Legacy Fund	For the benefit of patients at the Cromer Hospital
Radiotherapy & Oncology Fund	Cause, prevention, treatment, cure & defeat of cancer
AOS Legacy Fund	Cause, prevention, treatment, cure & defeat of cancer
Children's Cancer Fund	Cause, prevention, treatment, cure & defeat of cancer in children
Cardiology Fund	For the benefit of cardiology patients
Kidney Fund	Cause, prevention, treatment, and cure of renal illness
Renal Fund	For the benefit of renal patients
Orthopaedics Fund	For the benefit of orthopaedic patients
Boudicca Breast Cancer Fund	To support better Breast Cancer care at NNUH
Eye Legacy Fund	To support better care for Eye Patients at NNUH
Upper Gastrointestinal Fund	To support better care for Upper GI patients at NNUH
Critical Care Fund	For the benefit of critical care patients
Ear, Nose & Throat Fund	For the benefit of ENT patients
Eye Department Fund	For the benefit of ophthalmology patients
NICU Fund	To support better care for patients of NICU at NNUH
Neurosciences Fund	For the benefit of neurology patients

Total funds	**11,370**	**2,588**	**3,759**	**(512)**	**9,687**

22. Grant commitments

The Charity provides grants for the Trust, and as such does not have direct control over when, or if, grant funding will be drawn down. For this reason, grant commitments are not recorded in the charity's accounts until there is certainty that the grant funding is needed, and that the terms and conditions for payment have been met.

The effect of the grant commitments outstanding at the year end on each fund balance is detailed below:

Unrestricted funds	**Balance Mar 2022 £000s**	**Grant Commitments £000s**	**Available Balance Mar 2022 £000s**
N&N General Fund	510	40	470
Cromer General Fund	121	0	121
Total	**631**	**40**	**591**

Restricted Funds:	**Balance Mar 2022 £000s**	**Grant Commitments £000s**	**Available Balance Mar 2022 £000s**
NHS Charities Together Stage 3 Fund	104	104	0
Friends Fund	63	30	33
Chloe Blossom Fund	57	50	7
NHS Charities Together Stage 1 Fund	40	39	1
NHS Charities Together Development Fund	33	0	33
The Macleod Fund	11	0	11
Harry Hammerbeck Prize Fund	10	0	10
NHS Charities Together Stage 2 Fund	0	0	0
Total	**318**	**223**	**95**

Designated Funds	**Balance Mar 2022 £000s**	**Grant Commitments £000s**	**Available Balance Mar 2022 £000s**
N&N Imaging Fund	1,613	1,613	0
Cancer Legacy Fund	888	0	888
Cromer Legacy Fund	631	124	507
Radiotherapy & Oncology Fund	392	76	316
AOS Legacy Fund	346	0	346
Children's Cancer Fund	204	0	204
Cardiology Fund	199	46	153
Kidney Fund	197	0	197
Renal Fund	193	1	192
Orthopaedics Fund	179	5	174
Boudicca Breast Cancer Fund	165	115	50
Eye Legacy Fund	165	0	165
Upper Gastrointestinal Fund	144	0	144
Critical Care Fund	134	5	129
Ear, Nose & Throat Fund	126	0	126
Eye Department Fund	113	2	111
NICU Fund	112	22	90
Neurosciences Fund	110	1	109
Others (153 funds)	2,827	655	2,172
Total	**8,738**	**2,665**	**6,073**
Total funds	**9,687**	**2,928**	**6,759**

Norfolk & Norwich Hospitals Charity

KPMG LLP
20 Station Road
Cambridge CB1 2JD
United Kingdom

(c/o Ms E Larcombe – Audit Director)

1 November 2023

Dear Emma

This representation letter is provided in connection with your audit of the financial statements of Norfolk and Norwich Hospitals Charity ("the Charity"), for the year ended 31 March 2023, for the purpose of expressing an opinion:

i. as to whether these financial statements give a true and fair view of the state of the Charity's affairs as at 31 March 2023 and of its surplus or deficit for the financial year then ended;
ii. whether the financial statements have been properly prepared in accordance with UK Generally Accepted Accounting Practice (including Charities SORP FRS 102: Statement of Recommended Practice applicable to charities preparing their accounts in accordance with the Financial Reporting Standard applicable in the UK and Republic of Ireland (FRS 102)); and
iii. whether the financial statements have been prepared in accordance with the Charities Act 2011.

These financial statements comprise the Balance Sheet, the Statement of Financial Activities, the Cash Flow Statement, and notes, comprising a summary of significant accounting policies and other explanatory notes.

The Corporate Trustee confirms that the Charity is exempt from the requirement to also prepare consolidated financial statements.

The Corporate Trustee confirms that the representations they make in this letter are in accordance with the definitions set out in the Appendix to this letter.

The Corporate Trustee confirms that, to the best of their knowledge and belief, having made such inquiries as it considered necessary for the purpose of appropriately informing themselves:

Financial statements

1. The Corporate Trustee has fulfilled their responsibilities, as set out in the terms of the audit engagement dated 12 May 2021, for the preparation of financial statements that:

i. give a true and fair view of the state of the Charity's affairs as at the end of its financial year and of its surplus or deficit for that financial year;
ii. have been properly prepared in accordance with UK Generally Accepted Accounting Practice ("UK GAAP") (including Charities SORP FRS 102: Statement of Recommended Practice

applicable to charities preparing their accounts in accordance with the Financial Reporting Standard applicable in the UK and Republic of Ireland (FRS 102)); and

iii. have been prepared in accordance with the Charities Act 2011.

The financial statements have been prepared on a going concern basis.

2. The methods, the data and the significant assumptions used in making accounting estimates and their related disclosures are appropriate to achieve recognition, measurement or disclosure that is reasonable in the context of the applicable financial reporting framework.

3. All events subsequent to the date of the financial statements and for which section 32 of FRS 102 requires adjustment or disclosure have been adjusted or disclosed.

Information provided

4. The Corporate Trustee has provided you with:

- access to all information of which they are aware, that is relevant to the preparation of the financial statements, such as records, documentation and other matters;
- additional information that you have requested from the Corporate Trustee for the purpose of the audit; and
- unrestricted access to persons within the Charity from whom you determined it necessary to obtain audit evidence.

5. All transactions have been recorded in the accounting records and are reflected in the financial statements.

6. The Corporate Trustee confirms the following:

i) The Corporate Trustee has disclosed to you the results of their assessment of the risk that the financial statements may be materially misstated as a result of fraud.

Included in the Appendix to this letter are the definitions of fraud, including misstatements arising from fraudulent financial reporting and from misappropriation of assets.

ii) The Corporate Trustee has disclosed to you all information in relation to:

a) Fraud or suspected fraud that it is aware of and that affects the Charity and involves:
   - management;
   - employees who have significant roles in internal control; or
   - others where the fraud could have a material effect on the financial statements; and

b) allegations of fraud, or suspected fraud, affecting the Charity's financial statements communicated by employees, former employees, analysts, regulators or others.

In respect of the above, the Corporate Trustee acknowledges their responsibility for such internal control as they determines necessary for the preparation of financial statements that are free from material misstatement, whether due to fraud or error. In particular, the Corporate Trustee acknowledges their responsibility for the design, implementation and maintenance of internal control to prevent and detect fraud and error.

7. The Corporate Trustee has disclosed to you all known instances of non-compliance or suspected non-compliance with laws and regulations whose effects should be considered when preparing the financial statements.

8. The Corporate Trustee has disclosed to you and has appropriately accounted for and/or disclosed in the financial statements, in accordance with section 21 of FRS 102 all known actual or possible litigation and claims whose effects should be considered when preparing the financial statements.

9. The Corporate Trustee has disclosed to you the identity of the Charity's related parties and all the related party relationships and transactions of which it is aware. All related party relationships and transactions have been appropriately accounted for and disclosed in accordance with section 33 of FRS 102.

   Included in the Appendix to this letter are the definitions of both a related party and a related party transaction as we understand them and as defined in FRS 102.

10. The Corporate Trustee confirms that:

    a) The financial statements disclose all of the key risk factors, assumptions made and uncertainties surrounding the charity's ability to continue as a going concern as required to provide a true and fair view and to comply with FRS 102.
    b) No events or circumstances exist that may cast significant doubt on the ability of the Charity to continue as a going concern.

This letter was tabled and agreed at the meeting of the Corporate Trustee on 1 November 2023.

Yours faithfully,

[Chair]

[Corporate Trustee]

Appendix to the Corporate Trustee's Representation Letter of Norfolk and Norwich Hospitals Charity: Definitions

[Criteria for applying the disclosure exemptions within Financial Reporting Standard 102 for the Charity's Financial Statements

- The Charity discloses in the notes to its financial statements:
  - o A brief narrative summary of the disclosure exemptions adopted; and o The name of the parent of the group in whose consolidated financial statements its financial statements are consolidated, and from where those financial statements may be obtained]

Financial Statements
A complete set of financial statements (before taking advantage of any of the FRS 102 exemptions) comprises:

- a Balance Sheet as at the end of the period;
- a Statement of Financial Activities for the period;
- a Cash Flow Statement for the period; and
- notes, comprising a summary of significant accounting policies and other explanatory information.

Material Matters
Certain representations in this letter are described as being limited to matters that are material.

FRS 102 states that:

Omissions or misstatements of items are material if they could, individually or collectively, influence the economic decisions of users taken on the basis of the financial statements. Materiality depends on the size and nature of the omission or misstatement judged in the surrounding circumstances. The size or nature of the item, or combination of both, could be the determining factor.

Fraud
Fraudulent financial reporting involves intentional misstatements including omissions of amounts or disclosures in financial statements to deceive financial statement users.

Misappropriation of assets involves the theft of an entity's assets. It is often accompanied by false or misleading records or documents in order to conceal the fact that the assets are missing or have been pledged without proper authorisation.

Error
An error is an unintentional misstatement in financial statements, including the omission of an amount or a disclosure.

Prior period errors are omissions from, and misstatements in, the entity's financial statements for one or more prior periods arising from a failure to use, or misuse of, reliable information that:

a) was available when financial statements for those periods were authorised for issue; and
b) could reasonably be expected to have been obtained and taken into account in the preparation and presentation of those financial statements.

Such errors include the effects of mathematical mistakes, mistakes in applying accounting policies, oversights or misinterpretations of facts, and fraud.

Management
For the purposes of this letter, references to “management” should be read as “management and, where appropriate, those charged with governance”.

Qualifying Entity
A member of a group where the parent of that group prepares publicly available consolidated financial statements which are intended to give a true and fair view (of the assets, liabilities, financial position and profit or loss) and that member is included in the consolidation by means of full consolidation.

Related Party and Related Party Transaction

Related party:
A related party is a person or entity that is related to the entity that is preparing its financial statements (referred to in FRS 102 as the “reporting entity”).

a) A person or a close member of that person’s family is related to a reporting entity if that person:
    i. has control or joint control over the reporting entity;
    ii. has significant influence over the reporting entity; or
    iii. is a member of the key management personnel of the reporting entity or of a parent of the reporting entity.
b) An entity is related to a reporting entity if any of the following conditions apply:
    i. The entity and the reporting entity are members of the same group (which means that each parent, subsidiary and fellow subsidiary is related to the others).
    ii. One entity is an associate or joint venture of the other entity (or an associate or joint venture of a member of a group of which the other entity is a member).
    iii. Both entities are joint ventures of the same third party.
    iv. One entity is a joint venture of a third entity and the other entity is an associate of the third entity.
    v. The entity is a post-employment benefit plan for the benefit of employees of either the reporting entity or an entity related to the reporting entity. If the reporting entity is itself such a plan, the sponsoring employers are also related to the reporting entity.
    vi. The entity is controlled, or jointly controlled by a person identified in (a).
    vii. A person identified in (a)(i) has significant influence over the entity or is a member of the key management personnel of the entity (or of a parent of the entity).
    viii. The entity, or any member of a group of which is is a part, provides key management personnel services to the reporting entity or to the parent of the reporting entity.

Related party transaction:
A transfer of resources, services or obligations between a reporting entity and a related party, regardless of whether a price is charged.