Norfolk and Norwich University Hospitals NHS Foundation Trust

MEETING OF THE TRUST BOARD IN PUBLIC

FRIDAY 30 NOVEMBER 2018

A meeting of the Trust Board in public will take place at 9am on Friday 30 November 2018 in the Boardroom of the Norfolk and Norwich University Hospital

AGENDA

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1	Apologies and Declarations of Interest			
2	Minutes of the Board meeting held in public on 28.09.18	Chair	Approval	**2**
3	Matters arising	Chair	Discussion	
4	Chief Executive's Report *inc draft Joint Health and Wellbeing Strategy*	CEO	Discussion	**14**
5	Winter Preparedness update **(BAF 1.3)**	RP	Discussion	**22**
6	Infection Prevention and Control Annual Report *(Dr Catherine Tremlett (Consultant Microbiologist and Ms Sarah Morter (Lead Nurse) to attend at 10am)*	NF	Information	**27**
7	Draft Digital Strategy **(BAF 3.1)**	AL	Approval	**69**
8	Reports from Board Committees: (i) Quality Programme Board (06.11.18)	MD	Information	**72**
9	Annual Medical Appraisal Report	ED	Information	**88**
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12	Any other business			

Date and Time of next Board meeting in public
The next Board meeting in public will be at 9am on Friday 25 January 2019 in the Boardroom of the Norfolk and Norwich University Hospital

Norfolk and Norwich University Hospitals NHS Foundation Trust

MINUTES OF TRUST BOARD MEETING IN PUBLIC

HELD ON 28 SEPTEMBER 2018

Present:	Mr J Fry	- Chairman
	Mr M Davies	- Chief Executive
	Professor E Denton	- Medical Director
	Professor N Fontaine	- Chief Nurse
	Mr T How	- Non-Executive Director
	Mr M Jeffries	- Non-Executive Director
	Mr J Hennessey	- Chief Finance Officer
	Mr J Over	- Director of Workforce
	Dr G O'Sullivan	- Non-Executive Director
	Mr R Parker	- Chief Operating Officer
	Professor D Richardson	- Non-Executive Director
	Mrs A Robson	- Non-Executive Director
	Miss S Smith QC	- Non-Executive Director
In attendance:		
	Ms F Devine	- Director of Communications
	Mr J P Garside	- Board Secretary
	Mr S Hackwell	- Director of Strategy
	Mr A Lundrigan	- Chief Information Officer
	Ms V Rant	- Assistant to Board Secretary
	Ms P Slinger	- NHSI Improvement Director
	Members of the public	

18/033 **APOLOGIES AND DECLARATIONS OF INTEREST**

No apologies were received. No conflicts of Interest were declared in relation to matters for consideration by the Board. The meeting was attended by representatives from PWC as part of a Board review.

18/034 **CARE AT THE END OF LIFE**

The Board received a presentation from Dr Nicola Holtom (Service Director Palliative Medicine), Dr Caroline Barry (Palliative Care Consultant) and Mr Siji Sebastian (Charge Nurse, Elsing Ward) concerning care of patients at the end of life.

Mr Sebastian conveyed to the Board the story of a 90 year old patient with dementia who had been admitted to hospital with acute confusion. Following the patient's death, her family had written to express their gratitude for the care their mother had received whilst in hospital. The family commented particularly on the compassionate care provided by staff on the end of life care pathway.

Another letter was highlighted in which another family thanked staff for their care of another patient at the end of life. The family had been particularly grateful that they had been able to visit as needed and had had the opportunity to stay overnight.

Dr Holtom reflected on the outcome of the CQC inspection in 2017, which had rated end of life care as 'requiring improvement'. The CQC had identified two 'must do' and five 'should do' areas for improvement. Dr Holtom outlined what has happened since then and further aspirations for the future.

Dr Holtom updated the Board on actions taken to address the CQC recommendations. In October 2017, a Business Case was agreed to significantly increase palliative care service staffing and additional staff were in place by August 2018. The Palliative Care Directorate was also established.

In order to address issues under the CQC responsiveness domain, our service operating hours have increased from 6 days per week to 7 days (9am to 5pm) with a 24 hour consultant telephone advice service. The number of referrals to the Supportive and Palliative Care Team has increased significantly over the last year.

Performance of the Supportive and Palliative Care Team is monitored via a number of quality outcome measures every month. On average 89% of patients were assessed within 24 hours of referral and documentation of the patient's preferred place of death was consistently achieved.

Our oncology outpatient service has been expanded to run 8 clinics per week and to see complex JPUH and QEH patients. A consultant DECT phone has been introduced to enable rapid response to AOS, ED and AMU. A motor neurone disease service has been established and outreach clinics were introduced in Cromer and Beccles in December 2017. The Supportive and Palliative Care Team service now also provides a specialist psychological support service for patients.

Following a consultation involving patients, relatives and staff, the Palliative Care Clinic has been rebranded as the 'Symptom Management and Supportive Care Clinic'. This reflects the work of the team with patients with non-malignant diseases such as motor neurone disease.

Palliative care resource folders have been introduced on all wards for use by nursing staff and a laminated flow chart of anticipatory medications is in place on all drug trolleys. All staff can access palliative care guidelines via the desktop palliative care poppy icon. To enhance oversight, the Ward View system has been enhanced to display EOL patients with a blue border and a palliative care icon. A palliative care dashboard has been produced to monitor performance against complaints/incidents, inpatient/outpatient referrals, contacts/response times, sickness, mandatory training compliance and appraisals.

Focus on the Caring domain has included introduction of comfort packs for relatives, carer passports, beds for relatives, syringe drivers for outpatient use and nebulisers/TENS.

We have also increased patient/relative participation through events such as 'dying matters' week, satisfaction surveys and representation on End of Life Care groups.

Audits on end of life care are undertaken every 3 months. Performance of written evidence of recognition of dying patients has increased from 86% in May 2017 to 95% in March 2018. The percentage DNAR discussions with patients and their relatives has also improved from 57% to 65% (patient discussion) and 76% to 90% (relative discussion).

The End of Life Integrated Care Plan (ICP) was first developed in May 2017 and is now in use on all wards and clinical areas. It was subsequently adopted for use in the Priscilla Bacon Lodge, QEHKL and NCH&C. In April 2018 a revised version of the ICP was launched and is now being used as evidence of good practice elsewhere. An integral component of the ICP are the prompts to complete Mental Capacity Act and best interest decisions.

A number of clinical incidents reported in 2016/17 concerned a lack of syringe drivers and 40 additional syringe drivers were purchased in 2017. The Supportive and Palliative Care Team took responsibility for tracking the location of the syringe drivers in November 2017. The new tracking system has been effective and there have been no clinical incidents due to a lack of syringe drivers.

A pathway has been introduced for step-down of end of life patients from the Critical Care Complex to the wards. An audit of pathway performance indicates that 100% of patients were seen within 24 hours of referral.

Dr Holtom informed the Board that our palliative care service has been extended into the Emergency Department due to the increasing number of end of life patients attending the Emergency Department (1 in 4 emergency admissions are for patients in the last year of their life). A rapid response DECT phone has been introduced so that patients are seen within 30 minutes of their arrival and end of life drugs are now available in the Emergency Department. A QIPP is being established to measure outcomes of the actions for improving the care of end of life patients attending ED.

End of life educators were appointed in 2017, the range of staff trained in end of life was widened and mandatory education was introduced for all staff in 2018. Dr Barry informed the Board that a programme of work had also been implemented to improve DNACPR (do not attempt cardio pulmonary resuscitation) processes.

A high number of DNACPR complaints have related to communication of decisions. A review has also found that there are a number of CPR attempts that could be inappropriate. A trust wide audit of DNACPR processes and documentation has been undertaken and an action plan has been developed to deliver improvement.

There are a number of challenges for achieving the Preferred Place of Care for dying patients, such as insufficient palliative care beds to support choice at end of life and delays in fast track processes. Ensuring achievement of a patient's preferred place of death will require a system wide approach and we are working in collaboration with system partners to develop Advance Care Planning (ACP) processes and training programmes.

The Recommended Summary Plan for Emergency Care and Treatment (RESPECT) form is due to be launched in 2019 and will be introduced across the STP to focus on patients and their preferred outcomes at the end of life.

Professor Fontaine highlighted that system partners had received the same presentation at the Oversight and Assurance Group and the importance of a Norfolk-wide approach to palliative care reforms was highlighted.

Dr Holtom highlighted that access to community beds for dying patients is restricted under the current commissioning criteria. This is unhelpful in developing a comprehensive service. Mr Davies reported that the STP Executives had agreed that palliative care should be a priority for the county and a Clinic Reference Group will be undertaking a review of services in order to identify what further actions need to be taken.

Dr Holtom emphasised that there is a need to introduce planning documents for the preferred place of care for dying patients and work is underway to redesign the current documents and explore introduction of nurse led advice clinics/outreach clinics in the community.

Miss Smith asked about the number of patients attending the Emergency Department in the last year of their life. Dr Holtom reported that we are looking to introduce a framework which will help GPs to identify patients who are near to death so that advance care planning can be discussed.

Mr Jeffries asked if additional space or staff would be required if the team is to provide a county-wide service. Professor Denton explained that a change in the systems for accessing beds will help patients to receive the care they need in a more appropriate setting. Dr Barry added that we are hoping to be able to develop our services in order to provide our teams with the ability to undertake domiciliary visits.

18/035 **MINUTES OF PREVIOUS MEETING HELD ON FRIDAY 27 JULY 2018**

The minutes of the meeting held on 27 July 2018 were agreed as a true record and signed by the Chairman.

18/036 **MATTERS ARISING**

The Board reviewed the Action Points arising from its meeting held on 27 July 2018 as follows:

18/024 Carried forward. Mr How noted that around 20% of cancelled operations had been due to 'equipment failure/unavailability' (IPR Additional Slide 22b) and asked if these two issues could be reported separately to assist review of issues with equipment failure in particular, given the constraints on our capital expenditure.

Action: Mr Parker

18/024 Mr Lundrigan reported that the format of the IPR is being revised and should be ready for review in January. **Action: Mr Lundrigan**

18/037 **CHIEF EXECUTIVE REPORT**

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

Mr Davies informed the Board that the Quality Programme Board and Oversight and Assurance Group are fully established and are working well. At its meeting, the OAG received the presentation on Care at the End of Life.

The 'Leading with PRIDE' leadership programme commenced in September and has received positive feedback. The programme is focused on equipping line managers with the skills to create the right team cultures and values-led leadership across the organisation.

Mr Davies highlighted a letter from the Secretary of State for Defence informing the Trust that the Ministry of Defence Employer Recognition Scheme had selected NNUH to receive a Gold Award and recognised the Trust as an exemplar employer for its support of former military personnel. Mr Over highlighted that the Trust had held the Silver Award for a number of years and recognised the work and effort of Ms Julia Watling (Programme Manager – Workforce Development) to achieve this award.

Mr Davies commented on the recent approval of the loan to fund creation of the Interventional Radiology Unit. The facility will benefit vascular, stroke and cardiology patients and is expected to be operational late in 2019. This will also enable creation of the thrombectomy service. NNUH will be one of two hubs in the east of England to provide this service.

Mr Davies reported that he has been asked to lead the Acute Transformation Team working together with the other STP partners to develop consistent, quality and cost

effective acute hospital services for patients across Norfolk and Waveney. This programme will enable introduction of standard operating procedures and treatment protocols to improve care across organisations.

The Quadram Institute building works are nearing completion. The Clinical Research Facility has relocated to the new building and the unit has been receiving its first patients. Occupation of the building will be staggered and the Endoscopy Unit is expected to open around Christmas.

18/038 **REPORTS FROM BOARD COMMITTEES**

(a) Audit Committee

The Board received a report from Mrs Robson as Chair of the Audit Committee concerning its meeting held on 12 September 2018.

The Committee reviewed progress on the Internal Audit programme and emphasised the need to ensure earlier finalisation of reports and implementation of recommendations. The Management Board was specifically asked to monitor the position on implementation of IA recommendations to ensure that we are learning as an organisation. Mr Hennessey reported that he will report regularly on Internal Audit recommendations to the Management Board. Professor Denton explained that Clinical Governance Leads have now been appointed in all Divisions and formal processes have been implemented for reporting on learning and follow-up of recommendations.

The Committee reviewed the advisory report on Theatre Productivity and it was noted that there were financial/productivity opportunities through ensuring consistency in compliance of processes by staff.

At its meeting the Committee also considered a report concerning a self-assessment of emergency preparedness, resilience, response and business continuity. The accuracy of our self-assessment is under peer review at regional level. We are fully compliant with the national standards other than in one area which is outside the Trust's control and is subject to national mitigation.

The Charitable Funds Annual Report and Accounts and Letter of Representation were reviewed and approved for recommendation to the Board for approval in its capacity as Corporate Trustee.

An update will be provided to the next meeting of the Committee concerning the actions being taken to improve Risk Maturity and Risk Register procedures/staff knowledge.

Mr Parker highlighted the importance of identifying a connection between operational issues and audit findings. A strong message arising from the Theatre Productivity review was around lack of compliance with policies and procedures. Mr Fry asked how assurance would be gained that the recommendations had been implemented and that there had been an improvement. Mr Parker explained that a project lead had been appointed in the Surgical Division to ensure this work is carried out. Mrs Robson explained that the Audit Committee receives regular updates on High and Medium rated recommendations. The Internal Auditors will undertake a follow up review to ensure that the recommendations have been put in place and to provide the Board with assurance on this.

(b) Quality and Safety Committee

The Board received a report from Miss Smith as Chair of the Quality and Safety Committee concerning its meeting held on 14 September 2018.

Miss Smith informed the Board that half of the Committee members had visited the new ED 'quiet room' facility and the other half had visited the Radiology/IRU Department. This has been successful in increasing the number of areas visited and visibility of members. The feedback by each group following the visit had been both informative and reassuring.

Miss Smith reported that the Terms of Reference of the Committee had been reviewed and amended in light of the establishment of the Quality Programme Board. This has been successful in removing some of the burden of work away from the Committee.

The frequency of the Quality and Safety Committee meetings is to be one of the subjects for discussion by the Board at its Strategy Away Day in October.

The next meeting of the Committee is scheduled to take place in November and Dr O'Sullivan will be taking over as Chair of the Committee.

The Board **approved** the revised Terms of Reference for its Quality and Safety Committee.

(c) Quality Programme Board

The Board received a report from Mr Davies as Chair of the Quality Programme Board (QPB) concerning its meetings held on 7 August and 11 September 2018.

Mr Davies highlighted the position of the QPB within the Trust's accountability and reporting structure. The meetings are Chaired by Mr Davies and membership includes members of the Management Board, Mr Fry (as Non-Executive Director) and Ms Philippa Slinger (NHSI Improvement Director). The meetings are held every month in advance of the Oversight and Assurance Group meetings. There have been 3 meetings to date and there is clear evidence that the Divisions are getting increasing traction towards delivering their objectives. Focus is also being maintained on ensuring that our data is accurate.

The Oversight and Assurance Group (OAG) will be meeting monthly and is made up of key stakeholders and the NHSI Improvement Director, Ms Philippa Slinger. The group will be holding the Trust to account for delivery of the Quality Improvement Plan and a schedule of deep dives has been developed to ensure we are improving in the right areas. A crucial element of this work will be how information arising out of the deep dives is fed back into our organisation effectively and one route identified is the regular Viewpoint sessions. The Board will also receive updates on the outcomes of the deep dive reviews once they have been completed.

Mr Over reported that the Mental Health Team had given a very powerful presentation on the developments their clinical teams are leading.

Mr Jeffries asked if the Quality Improvement Strategy would be presented to a future meeting of the Board. Mr Davies explained that the QPB will be focusing on development of the Strategy, looking not only at policies and actions but also looking to improve quality in a much more strategic way. The Strategy will be presented to the Board for review and approval once it has been finalised.

Professor Fontaine indicated that there will be a process of engagement with staff to help inform development of the Strategy. The Quality Improvement Plan is designed to take the Trust from a CQC rating of 'Requires Improvement' to 'Good' and the Quality Improvement Strategy will then take the Trust from a rating of 'Good' to 'Outstanding'. It is anticipated that the Quality Improvement Strategy will be ready for

the Board to review in December and it may be necessary to dedicate a significant part of the meeting to focus on its review.

Dr O'Sullivan asked how deep dives were being undertaken and how in-depth these reviews were. Professor Fontaine explained that the areas identified for deep dive reviews are those that had been highlighted in the CQC report.

Dr O'Sullivan asked how the deep dive reviews will be linked into data and targets. Mr Davies explained that a reporting tool for the QIP is being developed by Mr Lundrigan and Mr Pete Best (Information Services Manager).

Mr Davies reported that from an organisational development point of view, we are continuing to focus on clinical leadership with senior clinicians looking at what they can do to improve the services in their areas.

(d) Finance and Investments Committee

The Board received a report from Mr How as Chair of the Finance and Investments Committee concerning its meeting held on 17 September 2018.

Mr How informed the Board that the cycle of Committee focus on Divisional finance is going well as part of an annual schedule of reviews. At its meeting, the Committee received a presentation on finance and activity in the Medicine Division from Mr Chris Cobb (Divisional Operations Director). Mr Cobb was congratulated on his work.

The Committee was updated on the financial position, progress in CIP development and the increasing need to use contingency funds to support our winter planning and quality improvement. There is a high risk that the financial targets will not be achieved if the CIP programme is not developed further without delay.

No provision has been made in the financial plan for penalties and there is a significant financial risk that CCG fines will be imposed if we do not meet our performance targets this year.

A project timeline has been established for the IRU to be operational by the end of 2019 and the outcome is awaited for the capital bid which was submitted via the STP, to create additional radiology capacity for Norfolk (Diagnostic and Assessment Centre).

18/039 **INTEGRATED PERFORMANCE REPORT**

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

(a) Quality, Safety and Effectiveness

Professor Denton reported that the HSMR is continuing to improve and was 96.8 in August 2018.

The aspirations highlighted by the End of Life Care Team are expected to bring further improvement to our mortality rates. We will be closely monitoring mortality rates as we increasingly work in partnership with neighbouring Trusts that have higher mortality rates and need to ensure that this does not negatively impact on our performance.

Professor Fontaine reported that she is co-chairing the recently established Serious Incident Group with Professor Denton. The group is meeting daily to review all moderate harm incidents and medication errors. Although there has been an increase in the number of medication incidents reported the incidents have been recorded as causing no harm to patients. It is anticipated that as the changes to safety/quality

governance are embedded, we will see an improvement in the quality of investigations following incidents.

Reporting of HAI and CAI pressure ulcers continues to improve. We are active participants in the national 'Stop the Pressure' campaign launched by NHSI to promote methods of prevention and we have seen a gradual improvement in numbers. The number of Grade 2 pressure ulcers has shown an increase but it is hoped that numbers will reduce as we increase focus on learning outcomes.

There has been one case of pseudomonas aeruginosa meningitis reported on NICU. A number of preventative measures have been put in place but this remains an area of high focus.

There has been one MRSA bacteraemia reported in the year to date which occurred due to cross contamination. We had good involvement from our Commissioners in the review of this incident and learning outcomes have been shared with the teams involved.

Mr How expressed concern that there was too much data included in Core Slide 11 and it was difficult to determine what is good or bad. Professor Fontaine explained that our Maternity Services are currently performing well but recognised that this is not apparent from the dashboard. The caesarean section rate has fallen and we are also performing well in terms of 1:1 care in labour (92%). A review is undertaken for all stillbirths to ensure that learning outcomes are identified. We are also currently providing support to the QEHKL maternity unit.

Miss Smith expressed concern about the figure reported for Duty of Candour compliance on Core Slide 2 which appears to have fallen. Professor Denton agreed that the reported figure appeared to be incorrect and Professor Fontaine confirmed that this would be reviewed. **Action: Professor Fontaine**

Dr O'Sullivan referred to Core Slide 2 and highlighted that the number of patient moves had been raised as a concern by the CQC. It would be helpful if the report could clearly define and report both clinical and non-clinical patient moves.
Action: Professor Denton/Professor Fontaine

Mr Jeffries asked if establishment of the new Serious Incident Group had been successful in reducing the number of staff concerns being raised directly with the CQC. Professor Fontaine confirmed that there has been a reduction in the number of whistleblowing concerns raised with CQC in August. There has been an increase in internal incident reporting, which is what we want – to provide opportunities for ongoing improvement.

Professor Richardson asked if we had sufficient capacity to provide the QEHKL maternity unit with support. Professor Fontaine explained that the support being provided related to clinical leadership and processes/policies and this was not impacting our capacity. Mr How indicated that it would seem appropriate that the Trust should be compensated financially for provision of support to other Trusts given that there is no slack in our financial position. Mr Hennessey confirmed that we are not charging for support at this time but this will be kept under review depending on what is asked of us.

(b) <u>Caring and Patient Experience</u>
Professor Fontaine reported that the Friends and Family Test score in August was 95%. Performance remains high against the Quality Priority 'treat patients with dignity and respect' (96%). The Patient Advice and Liaison Service report a high number of

enquiries as a result of operational delays. The total number of compliments outweighs the number of complaints received by the Trust.

(c) High Risk Tracker

The Board reviewed the risks on the High Risk Tracker rated 15 and above.

Dr O'Sullivan noted that it has been suggested that a risk concerning Special Measures should be added to the Risk Register. **Action: Professor Fontaine**

Professor Fontaine reported that external consultants had been commissioned to undertake a review of the Trust's risk policies/procedures and to help in cleansing the Risk Register. Part of this work will involve Board Development Training and this will then be rolled out across the organisation.

Mr Fry noted that the dates for resolution/reduction on four of the risks on the High Risk Tracker were past their review date. Mrs Robson emphasised that there is a need to continue maintaining the existing system and processes whilst these are under review. The Board will receive an updated High Risk Tracker at its next meeting as part of the IPR. **Action: Professor Fontaine**

(d) Performance and Productivity

Mr Parker reported that the sustained increase in the number of 2 week wait referrals has had an impact on all pathways. Lower activity during August has deferred backlog clearance into September.

A review is underway in ED looking at flow through the department. The Medicine Team have introduced a scheme to assist patient flow and there is early indication that this is proving successful. The IST are also assisting us to review ambulance handovers and our service provision for patients with mental health difficulties.

The continued increase of 2 week wait referrals has impacted on our ability to recover RTT performance and we are working with commissioners to look at schemes to utilise capacity across the county. We remain focused on reducing the number of patients who have waited longest and our ambition is to eliminate 52 week waits by the end of this year.

The Internal Sentinel Stroke Audit Programme (SSNAP) rating for August has dropped to B (76%). This drop in performance is as a result of a reduction in therapy domain performance. The diagnostic target has been achieved consistently for more than two years.

The national target is to reduce the number of super-stranded patients who have been in hospital for more than 21 days. Our aim has been to reduce the number of patients who have been in hospital for more than 14 days to less than 200 patients and performance in August was 175 patients.

Mr Parker noted that the increased level of non-elective activity has continued and is 8% above planned levels.

Mr Jeffries asked if the Vanguard theatres would still be needed if theatre productivity was increased to optimal levels. Mr Parker indicated that this had been considered. Whilst refurbishment of two theatres is undertaken the continued use of the Vanguard theatres is necessary but it is proposed that this will be reviewed again once Turnstone Court is operational and theatre productivity is improved.

Mr Hennessey indicated that we are behind on income from theatre activity. Mr Parker reported productivity in main theatres is close to where we want it to be but there is still more work to be done to increase productivity in the Day Procedure Unit.

(e) Workforce

Mr Over reported that appraisal compliance was showing an improvement across all divisions. Mandatory training compliance is also showing improvement across most divisions. Ability to release staff to attend training is a significant obstacle to achieving compliance.

The Leading with PRIDE development programme commenced in September, with 700 line managers attending. The training is focused on building a culture we can be proud of, supporting safe and high quality care for patients.

The selection process for recruitment of the full-time Lead Freedom to Speak Up Guardian is expected to conclude shortly. The 2018 Staff Survey will commence in the first week of October. It is not clear at this time if staff opinion about the organisation will be influenced by Quality Special Measures but we are continuing to share good news with our staff. The initial results of the survey are expected in December.

Mr Jeffries asked what tactics are being considered in order to improve mandatory training performance. Mr Over explained that we are looking at ways to make it as easy as possible for staff to attend/undertake their training. A 'one stop shop' programme is now firmly established for staff to receive training on a number of topics and this has been well received. The biggest issue has been time and the Management Board will be looking at incentives to help departments release staff for training.

(f) Finance

Mr Hennessey reported that the deficit in the year to date was £23.3m and (£0.1m better than budget). Income and expenditure performance in August is a deficit of £4.1m against the planned deficit of £4m and is £23.3m in the year to date.

Clinical income is £993k worse than budget accounting for £629k penalties and challenges worse than budget - cancelled operations £200k, £350k challenges and £520k specialised block adjustment. Work is continuing on development of more detailed financial reporting for the Divisions. Further work is underway with the Divisions to ensure CIP schemes continue to be progressed in months to come.

Key risks to the financial plan arise from achievement of CIP Plans and our exposure to penalty fines for RTT and emergency performance as we did not agree the Control Total at the start of the year. We are also being encouraged to agree a block contract with Commissioners but there is a risk that we will not be paid for the levels of activity we perform above levels agreed with the Commissioners.

Miss Smith asked what actions are being taken to increase focus on CIP performance. Mr Hennessey explained that agency spend has started to increase in some areas and we are working with the Divisions to address this and ensure that tight controls continue to be applied. Another area of focus is procurement and a review is underway to determine if we are overpaying on items and whether we can work in partnership with other Trusts to obtain a better price on purchases.

18/040 **FTSU SELF-REVIEW TOOL**

The Board received a report from Mr Over concerning the Freedom to Speak Up self-review tool for NHS Trusts.

The self-review tool was developed by the national Freedom to Speak Up Guardian's office for NHS Trusts to use in assessing their status against best practice guidance and we have used the tool as a baseline and indicator for improvement.

A key step for promoting a speak up culture at NNUH will be the appointment of a full-time Lead Freedom to Speak Up Guardian and interviews are being held in October and a key part of their role will be oversight of our actions for improvement.

A further assessment against the self-review tool will be undertaken in 4-6 months' time and the Board will be updated following that review.

Dr O'Sullivan asked how the progress will be measured in order to provide the Board with assurance of improvement. Mr Over explained that a good indication of progress will be if our staff feel more confident/safe to raise concerns internally and with their own line managers.

Professor Denton reported a shift in behaviour at daily lunchtime meetings and staff are increasingly raising issues which may previously have been raised with the CQC. The lunchtime meetings have given staff an opportunity to share their experiences. Work is also being undertaken to look at senior medical staff engagement and exploring opportunities to introduce leadership for change training as a CPD requirement.

Mr Davies informed the Board that he will be commencing 'Chat with the Chief' Surgeries to provide staff with an opportunity to have a 1:1 chat about any concerns they may have.

Mr Jeffries asked how we define the group of staff as senior leaders for leadership training. Professor Denton explained that this term referred to staff that lead other staff and this includes a significant number of our clinical staff, including consultants, nursing sisters, matrons and senior AHPs. If we can get our senior leaders to clearly understand our objectives, then they will be able to promote these ideals to all staff in their areas.

Professor Denton reported that the Clinical Leaders Forum will be an opportunity to get to know our staff and understand the issues they are faced with so that we can work with them to make things better.

Mr Fry noted that the staff survey will be commencing shortly and highlighted that it will be important to analyse and compare the results as quickly as possible to assess improvements that have been achieved from this work.

18/041 **FEEDBACK FROM THE COUNCIL OF GOVERNORS**

Mr Fry informed the Board that there has been a recent informal meeting at which the governors were updated on developments in the Trust.

18/042 **ANY OTHER BUSINESS**

Professor Fontaine informed the Board that there has been reasonable feedback following a recent MHRA inspection of our clinical trials processes but this is still to be confirmed.

18/043 **DATE AND TIME OF NEXT MEETING**

The next meeting of the Trust Board in public will be at 9am on Friday 30 November 2018 in the Boardroom of the Norfolk and Norwich University Hospital.

Signed by the Chairman: …… Date: ……

Action Points Arising:

	Action
18/024	Carried forward. Mr How noted that around 20% of cancelled operations had been due to 'equipment failure/unavailability' (IPR Additional Slide 22b) and asked if these two issues could be reported separately to assist review of issues with equipment failure in particular, given the constraints on our capital expenditure. **Action: Mr Parker**
18/024	Mr Lundrigan reported that the format of the IPR is being revised and should be ready for review in January. **Action: Mr Lundrigan**
18/039(a)	Miss Smith expressed concern about the figure reported for Duty of Candour compliance on Core Slide 2 which appears to have fallen. Professor Denton agreed that the reported figure appeared to be incorrect and Professor Fontaine confirmed that this would be reviewed. **Action: Professor Fontaine**
18/039(a)	Dr O'Sullivan referred to Core Slide 2 and highlighted that the number of patient moves had been raised as a concern by the CQC. It would be helpful if the report could clearly define and report both clinical and non-clinical patient moves. **Action: Professor Denton/Professor Fontaine**
18/039(c)	Dr O'Sullivan noted that it has been suggested that a risk concerning special measures should be added to the Risk Register. **Action: Professor Fontaine**
18/039(c)	Mr Fry noted that the dates for resolution/reduction on four of the risks on the High Risk Tracker were past their review date. Mrs Robson emphasised that there is a need to continue maintaining the existing system and processes whilst these are under review. The Board will receive an updated High Risk Tracker at its next meeting as part of the IPR. **Action: Professor Fontaine**

REPORT TO THE TRUST BOARD (in public)

Date	**30 November 2018**
Title	**Chief Executive's Report**
Purpose	**To update the Board on matters relating to the Trust that are not covered elsewhere in the papers**

Summary:
The intention of this report is to cover key issues and matters not addressed elsewhere in the papers.

Core issues will be covered through the IPR and reports on the extensive work of the Board committees. Other matters to draw particularly to the attention of the Board include:

(i) Correspondence from NHS Improvement regarding infection prevention and control;
(ii) Central Norfolk Winter Assurance Visit – 14 November 2018;
(iii) JACIE Accreditation of NNUH Haematology Services;
(iv) HEE East of England Hub for Educator Training;
(v) Veterans Covenant Hospital Alliance;
(vi) MoD Gold Alumni;
(vii) Health and Wellbeing Board - Sign up to the Joint Health and Wellbeing Strategy;
(viii) Single Management Team for the 5 Norfolk and Waveney CCGs.

Recommendation
The Board is recommended to **note** recent matters relating to the Trust as highlighted and to **support** the objectives of the Health and Wellbeing Board Strategy.

CHIEF EXECUTIVE'S REPORT TO TRUST BOARD 30 November 2018

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

1 FOCUS ON QUALITY & SAFETY

1.1 Correspondence from NHS Improvement

The **attached** letter was circulated to all providers from Dale Bywater (Executive Regional Managing Director – NHSI Midlands and East). The letter highlights the importance of maintaining high focus/standards for infection prevention and control, particularly over the winter and in light of increasing numbers of antibiotic resistant organisms identified across the country. This reminder is relevant to the presentation that the Board will receive on infection prevention and control at its meeting and is something about which we may wish to ask the IP&C Team.

1.2 Central Norfolk Winter Assurance Visit

On 14 November we hosted a Winter Assurance Visit – carried out by teams from NHSI, NHSE and a number of other organisations across the healthcare system. The outcome letter is **attached.**

Within the context of the anticipated challenges facing the NHS this winter, this letter is very positive. A number of areas of good practice and strong performance were identified including:

- the recognition by staff that emergency department performance is a whole hospital issue;
- winter planning and triumvirate leadership structure;
- introduction of the discharge/reablement facility; and
- virtual ward, OPED and Children's ED.

A number of system-wide actions were identified to further strengthen our winter readiness/capacity and the Board will receive an update on delivery of our Winter Plan as part of its agenda.

1.3 JACIE Accreditation of NNUH Haematology Services

We have been notified that our Haematology service has received Accreditation from the Joint Accreditation Committee of the European Society of Blood and Marrow Transplantation. The service was assessed as compliant against all standards with the exception of one which could not be satisfied because we work with the cell processing unit at Addenbrookes Hospital which is not currently JACIE accredited. This is a fantastic achievement by the team and all the staff involved, led by Dr Matt Lawes (Consultant Haematologist).

2 STAFF MATTERS

2.1 HEE East of England Hub for Educator Training

Health Education England East of England has asked NNUH to be the Hub for provision of Educational and Supervisor Training for clinical and educational supervisors from QEHKL, JPUH, and for GPs in Norfolk and Suffolk. This is a positive reinforcement of the role of the hospital in supporting County-wide development of healthcare staff. Miss Medha Sule (Consultant Obstetrics & Gynaecology and Director of Postgraduate Medical Education) will be the lead director for this training programme.

Miss Sule has also recently led creation of a Simulation Suite for clinical skills training based in the Centrum Building. This is a further step forward in building our clinical skills training capability and is something that we may wish to build on in future.

2.2 Veterans Covenant Hospital Alliance - Veteran Aware hospital accreditation letter

The Trust has received accreditation as a 'Veteran Aware' hospital by the Veterans Covenant Hospital Alliance in recognition of our work identifying and sharing best practice in care for members of the Armed Forces community.

2.3 Gold Alumni Winner

The Trust was recently selected for a Gold Award under the Ministry of Defence Employer Recognition Scheme for its work in supporting Defence People. The Trust has been invited to join the Gold Alumni Association. A copy of the relevant letter is **attached** and the distribution list of other organisations involved makes interesting reading.

3 SYSTEM AND PARTNERSHIP WORKING

3.1 Health and Wellbeing Board - Sign up to the Joint Health and Wellbeing Strategy

A Joint Health and Wellbeing Strategy for 2018-2022 has been agreed by the Norfolk Health and Wellbeing Board (copy **attached**). The Trust has been asked to gain Board support for the Strategy and a commitment to work collaboratively to deliver its objectives. The Board is accordingly asked to consider the Strategy with a view to supporting its objectives.

3.2 Single Management Team for the 5 Norfolk and Waveney CCGs

The CCGs in Norfolk and Waveney have agreed to form a single management team with one Accountable Officer, Chief Finance Officer and a joint Executive Team structure. At the moment there is no anticipated change to the way CCGs currently work.

4 RECOMMENDATION

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

From the office of Dale Bywater
Executive Regional Managing Director – Midlands and East

Cardinal Square – 4th Floor
10 Nottingham Road
Derby
T: 0300 123 2605
E: nhsi.enquiries@nhs.net
W: improvement.nhs.uk

13th November 2018

All Midlands & East Provider CEOs & Chairs

Sent by email

Dear Colleagues

As winter approaches I wanted to remind you all of the importance of maintaining high standards of infection control across all of our provider organisations. It is imperative that every Board has focus and grip on the infection, prevention and control agenda all year round. It is my expectation that each Board is receiving regular assurance reports in relation to their compliance with the complete Hygiene Code, in addition to the trajectory for C Dif and MRSA. Boards have a duty under the Hygiene Code to ensure robust infection control practices and procedures are in place, along with appropriate and timely cleaning when outbreaks occur and are declared over. Every opportunity to deep clean all clinical areas should be taken when capacity pressures allow in order to eradicate infection risks associated with environments that are not thoroughly clean.

You may be aware that across the region we have seen the emergence of some extremely resistant organisms for which there are limited antibiotic treatment options. This means it is really important that we follow good infection control practice and have in place high standards of cleaning to maintain the safety of patients and flow throughout the system.

I am aware that your flu campaigns are now in progress and I would like to thank you for your leadership in encouraging staff to take up the offer of vaccination to protect themselves and others. Early indications suggest that uptake is higher this year than it was at the same point last year in a number of our organisations. What we do know is the providers with strong executive leadership supporting the campaign have the highest level of uptake so your continued support of this is much appreciated.

Finally, thank you for your continued support and I'm sure we all agree that this is an important priority. If any of you wish to have any Board development sessions in regard to responsibilities under the Hygiene Code than please don't hesitate to contact Siobhan Heafield, Regional Nurse: siobhanheafield@nhs.net or Dr Debra Adams, Senior Infection Control Lead: debra.adams2@nhs.net who will be happy to discuss with you any support that may be of help.

Yours sincerely

D. Bywater

Dale Bywater
Executive Regional Managing Director – Midlands & East

NHS Improvement is the operational name for the organisation that brings together Monitor, NHS Trust Development Authority, Patient Safety, the National Reporting and Learning System, the Advancing Change team and the Intensive Support Teams.

Fulbourn Cambridge
CB21 5XB

T: 0300 123 2806
E: nhsi.enquiries@nhs.net
W: improvement.nhs.uk

21 November 2018

By Email

Dear colleagues

Central Norfolk Winter Assurance Visit 14 November 2018

Thank you all for your input and contribution to the Central Norfolk Winter Assurance visit which was held at Norfolk and Norwich University Hospital. Thank you also to the Trust for making arrangements for the walk-throughs of the various areas we visited and to its staff on those areas for their time and constructive engagement. I am writing to feed back on the key issues identified during the day.

In our discussions and on the walk-throughs we identified some areas of strong performance and good practice. These included, but were not restricted to, a real sense amongst staff across the hospital that the performance of the emergency department is a whole-hospital issue, and that all the departments and wards have a key role to play – although we did find some areas where there was less awareness of the trust's winter strategy and we suggested that the trust may want to consider a more proactive communication strategy. The introduction of the trust winter room, with a triumvirate leadership structure looked to be a positive development, and we were particularly encouraged by the EEAST representation in the function. We welcomed the implementation of the discharge and reablement facility, and the engagement with SERCO to secure co-production, with staff and patients, of the plans for how the facility should operate. The virtual ward should also be a significant development, including the trialling of IVAB through that service. The additional RATS spaces should also make a significant contribution. There was a strong paediatric ED service and an effective OPED short stay area. We welcomed the work being done with ECIST. We were all impressed by the positive commitment of the staff we met.

There were a number of areas we identified where the system should consider further action to improve the readiness and capacity to deliver safe and effective care though the winter. The key areas we discussed at the feedback session on 14 November are:

- Formalisation and agreement of EEAST staff to be the trusted assessor for fit to sit
- Red to green – consider utilising a process and system whereby initial EDDs are not changed on the system but instead are 'held' at the original date and there is tracking of elapsed days since that date until discharge
- A review of the robustness of Internal professional standards and the effectiveness of their implementation – in some wards there was no strong sense of IPs and a reliance on staff expertise to challenge delays or lack of action
- The system and the trust should put increased emphasis on working together to reviewing and reducing longer length of stay patients

- The system should consider further options for improving discharge or admission avoidance to the acute, for example providing enhanced community-based respiratory services
- We were concerned to hear about the apparent practice of moving some patients to the acute trust from neighbouring acutes at the weekend and then repatriating them. The acute trust was going to look into why this happens and consider how to reduce or eliminate it wherever possible.
- There was some evidence of challenges to effective communication between the ED and some wards – wards pressed the importance of extending access and user capability for the symphony system, which could help with pull from the ED
- Enhanced ultrasound capacity at weekends could help with admission avoidance and discharge
- Concern expressed that the tracking of outliers can be patchy, and can result in outlier patients being seen as lower priority and discharge being delayed unnecessarily
- A need to make progress on the work across system partners to more clearly understand delays on the mental health pathway in ED (not just 12-hour breaches) and to improve the escalation process to minimise these delays.
- System to review the options for ambulances to convey to other end-points than the acute, such as Cromer, to reduce pressure on both EEAST and the acute
- Work needed across the system to improve the performance of non-emergency patient transport
- Delays in agreeing packages of care and that there could be enhanced engagement from social services - the trust was also to look into a reported practice whereby if no capacity was immediately available from NFS, the OPED short stay ward had to wait 72 hours and re-apply to social care for support
- The system to review challenges around EOL, where there was concern that some patients are discharged to care homes but unnecessarily referred back into ED and the short stay area; and delirium where it was reported that there is a significant lack of community based capacity
- The acute trust to meet with the NHS E winter room team to consider how to secure the most efficient reporting of winter pressures and to explore how to improve predictive feedback back out to the system.

We will seek updates on responses to these areas of concern through our regular PRM meetings with the individual trusts and through reports to the local A&E SOAR board and the Norfolk and Waveney Board. Please let us know if there is any support that NHSI or NHSE can provide.

Kind regards,

Signed and agreed remotely
Dr Melanie Iles (Clements)
Associate Regional Medical Director NHS Improvement, Midlands and East

cc Simon Evans-Evans, Locality Director for Cambridgeshire & Peterborough and Norfolk NHS England - Midlands & East (East)

The Armed Forces Covenant Gold Alumni Association

The Chairman
Gold Alumni Association
c/o Serco Group
100 Victoria Street
London
SW1E 5JL

The 'new 51' Gold Award winners

The Gold Alumni Association – here to help you as Gold Winners

Dear fellow Gold Award winner

Many congratulations on collecting your Gold certificate on Monday evening, which is both hard-earned and well deserved. It is recognition of the high levels of support that you and your organisation, whether large or small, give to the UK's Armed Forces' regular and reservist personnel, as well as to veterans and armed forces families.

The 51 companies, public sector organisations and charities who have been awarded Gold today join 78 existing Gold Award winners, and we provide an example of what is possible to the 2,500 other signatories to the Armed Forces Covenant (AFC). It is a testament to the success of the Armed Forces Covenant that the last 3 years have seen a rapid acceleration in the numbers achieving Gold, with demonstrations of our commitment to the military 'family' on a daily basis.

To help enhance these efforts, the Gold Alumni Association (GAA) was started in 2016 to link the increasing numbers of like-minded, military friendly organisations who had been awarded Gold under the MOD's Employer Recognition Scheme. The GAA is simply a regional and national network of Gold winners. We aim to provide assistance to bronze and silver award winners to make the step to Gold, whilst spreading best practice and good ideas across the Gold Alumni. We also act as a critical friend to the military, providing input (if asked) to new initiatives or policies. Critically, the GAA is both independent of the MOD, and very low-maintenance, with no joining or other costs, and a desire to provide local approaches to supporting the AFC.

The GAA physically meets twice a year at the Partnering With Defence conference in March, and at a convenient location for as many as possible in the autumn, but we aim to have regional groupings getting together more regularly. We also run a series of Webinars to spread the knowledge and experience of others to help you save time, money and effort in your AFC support.

I am fortunate to be the Chairman of the GAA this year, with my aim being to encourage the full participation of every one of the expanded group of 131 Gold winners in the GAA. This letter contains a list of the regional leads across the country, and all I ask is that you get in touch with the local GAA lead to benefit from the network that already exists, as well as to add to it.

With best wishes

Jamie

Jamie Black
Chairman of the Gold Alumni Association
07736 089457
Jamie.black@serco.com

Trevor Winn-Morgan
Deputy Chairman of the Gold Alumni Association
07805 910199
trevor.winn-morgan@atos.net

Distribution:

1. Alexander Mann Solutions
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15. Ernst & Young (EY)
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21. Kent County Council
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24. Leonardo
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27. London Southbank University
28. MBDA UK
29. Newcastle City Council
30. Newcastle upon Tyne Hospitals NHS Foundation Trust
31. NHS Hastings and Rother CCG and NHS Eastbourne, Hailsham and Seaford CCG
32. NHS Orkney
33. Norfolk and Norwich University Hospitals NHS Foundation Trust
34. Northumberland County Council
35. Portsmouth City Council
36. Raytheon Systems Limited
37. The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust
38. Royal Surrey County Hospital NHS Trust
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40. SaluteMyJob
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42. SkillForce
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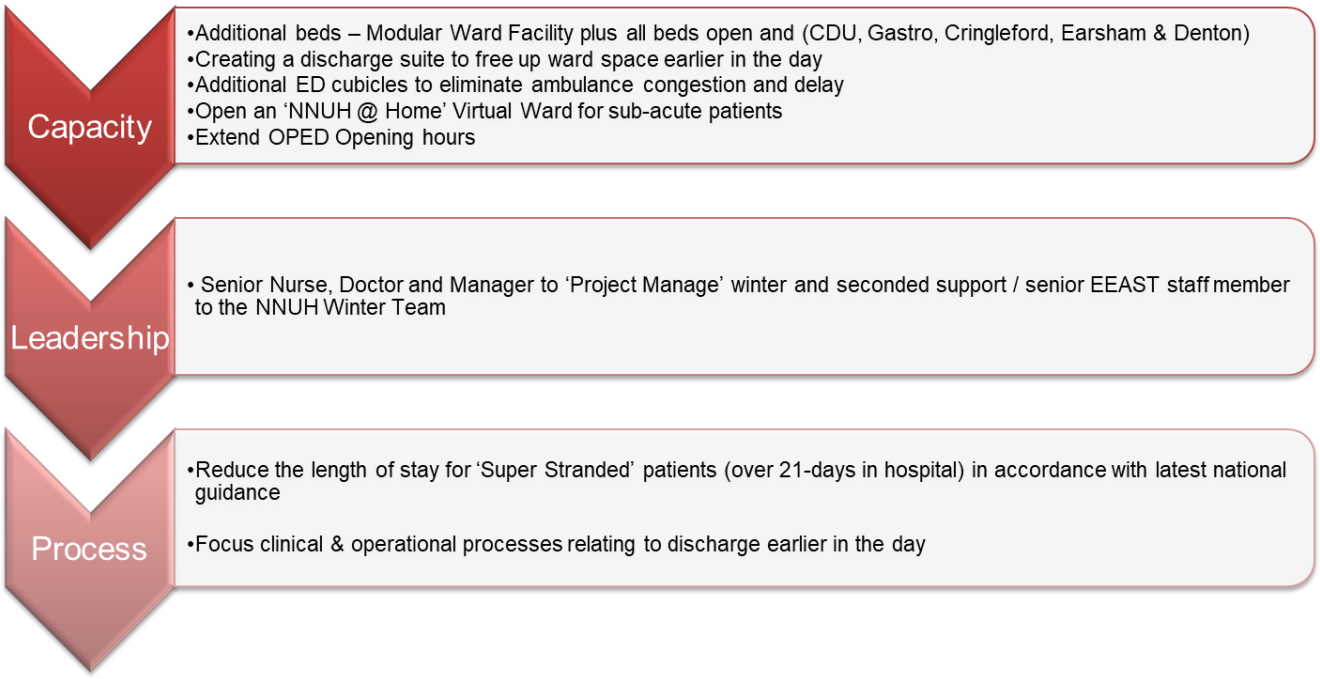
44. Sovini
45. Standard Life Aberdeen Plc
46. Stoll
47. Swansea Council
48. University Hospitals of Leicester NHS Trust
49. University of Lincoln
50. University of South Wales
51. WYG

REPORT TO THE TRUST BOARD OF DIRECTORS	
Date	**30 November 2018**
Title	**Winter Planning Update**
Author & Exec lead	**Richard Parker, Chief Operating Officer** **Cursty Pepper, Winter Director**
Purpose	**For Information**

1. Background/Context

1.1 The purpose of this paper is to provide a progress update against the NNUH Winter Plan. The 8 point plan shown below was developed in conjunction with the wider Norfolk system based upon learning from prior years and National best practice guidance.

1.2 NNUH 8 Point Winter Plan:



1.3 The plan has 3 overarching themes: Capacity, Leadership and Process and this paper gives an overview of progress to date against each of these areas.

2. Progress Update

2.1 Capacity: This is the most high impact change within the plan. Bed modelling identified we needed a minimum of 40 additional beds to meet the forecasted pressures on the basis that when we are at or below 92% occupancy we have improved patient flow. To ensure we have enough capacity to meet the known fluctuations in demand, we have planned for a higher number and will have an extra 57 physical bed spaces and the equivalent of a further 76 beds through our virtual ward and transformation projects;

Scheme		Gain	Bed No's
Capacity	1. Additional Beds	• Modular ward for use as escalation at times of peak pressure • Establishing and opening all / any closed areas (inc Gastro and CDU plus mitigation for QEH demand) • Specifically to limit or eliminate the use of Day Procedure areas for in-patients	57
	2. Discharge Suite	• Earlier flow to limit out-of-hours escalation	23 *
	3. Additional ED cubicles	• Additional 8 spaces focussed on Rapid Assessment & Treatment (RATS) • Designed to cope with high and variable ambulance arrivals	0
	4. NNUH @ Home	• Virtual Ward to care for patients at home with sub-acute clinical needs	30
	5. OPED hours increase	• Enhances the delivery of an effective service • 7-day working, 12-hrs per day	0
Leadership	6. Winter Team	• Enhanced capacity to deliver all other associated Winter Schemes • Additional capacity to oversee day-to-day performance during winter • Link to system and national structures	0
Process	7. Super - Stranded	• Delivery of a suite of actions to comply with the national initiative to reduce super-stranded numbers	23*
	8. Early Discharge processes	• Improve systems and processes to support the discharge lounge and reduce out-of-hours escalation	(supports No. 2)
		Totals	**133** (Actual 87 + 46* Transformational)

2.2 In terms of the additional capacity there are 3 main schemes one being a new discharge suite facility adjoined to a dedicated medical elective daycase unit, the second is reconfiguring our existing space and the third relates to the creation of a virtual ward caring for patients in their own homes. The final 2 schemes are focused on the front door to improve patient flow and access. All projects are on track for completion next month as per the original plan:

2.3 *No1 & 2 - Additional Beds & Discharge Suite*: The Modular Portakabin building has been delivered on site located adjacent to the Jenny Lind. The new building will be called the Aylsham Suite and it is on track for opening mid-December. It will create a specially designed facility for patients to wait in comfort as they prepare to be discharged. Adjoined to the discharge suite is a dedicated medical elective ward. These beds will be managed by the Medical Division; releasing inpatient capacity and preventing elective patients converting to emergency admissions or being cancelled, which was a challenge we faced last year. Staff will start in advance of the unit opening to support the process changes and receive training; this facility will mean we can transfer patients earlier in the day to create capacity for the assessment units and ED therefore preventing the current long delays. Having a dedicated pharmacy team will also speed up the discharge process so patients do not have to wait as long for their medications.

2.4 Redesigning existing space – The opening of the Quadrum Institute facilitates the reconfiguration of our current wards and departments to create additional medical and surgical beds. This is being achieved by using the vacated gastro space for cardiology meaning we can collocate all of respiratory together and increase out Haematology/Oncology capacity whilst creating a designated escalation ward for medical patients. Surgery is also able to increase their capacity to support the elective programme over winter as the research teams are moving to the QI. Overall this means we will have more of the right types of beds this winter, especially respiratory capacity. As such, patients will not need to be moved as much and they should have shorter lengths of stay; the moves are on track to start from 10 December.

2.5 *No. 3 – Additional ED cubicles:* The Rapid Assessment and Treatment facility is also a modular building, which has been delivered outside the Emergency Department and is being fitted out to create an addition 8 ED cubicles. This means we will have enough capacity to receive 32 patients an hour meaning the ambulances will not need to wait in queues for a cubicle to be free. This is a significant benefit as it will not only radically improve patient experience but as a system we will also be able to respond to our 999 and other ambulance calls more quickly. The new unit will open from 14 December 2018 and recruitment has already taken place to facilitate this.

2.6 *No. 4 – Virtual Ward Trial 'NNUH @ Home'*: A 3rd Party Provider has been engaged to establish a 30-bed virtual ward meaning patients can be cared for in their own homes whilst remaining under the care of the hospital. This 9-month Trial will allow NNUH and system partners to assess what a sustainable model could look like in future – either to be run in house or in partnership. The pilot will initially focus on providing long term antibiotic therapy as we have up to 70 patients in a hospital bed at any one time only needing antibiotics – they can therefore have a fuller life living at home and still receive their treatment instead of being in hospital. The teams have been recruited to start treating patients the week of 10 December.

2.7 *No. 5 – OPED extension*: The Older People's Emergency Department opened last year and has been a huge success in reducing the number of admissions by having early specialist intervention. This is the first unit of its kind and has been highly praised by many national teams including NHS England and NHS Improvement who recently visited the department. This scheme has already commenced as we have started to open out of hours. This means patients arriving after 5pm are able to attend OPED, which better aligns with the patterns of referrals we receive from GPs and ambulance arrivals.

2.8 No. 6 - Leadership: The primary element of this part of the 8 point plan is the introduction of a dedicated Winter Room and team. NHSE established their rooms last year and recommended the model be adopted nationally. As such, we have created a physical strategic level command and control room next to our tactical operations centre. The NNUH decided to enhance the model by having a full triumvirate comprising the Winter Room Director, Winter Nurse Director and Winter Associate Medical Director. Collectively this ensures we focus on a full Quality Improvement Programme not just operational performance. The primary aim is to deliver the 8 point plan but the team will also be creating a longer term sustainable transformation programme i.e. a plan for future years based on current learnings. The full team have been recruited, which is also supplemented by having a manager from the ambulance trust as part of the team.

2.9 *No. 7 & 8 – Process (discharge improvement):* The aim of these schemes is to reduce length of stay and change our processes to support improved flow earlier in the day to prevent ED queuing. Significant work is underway, led by the Winter Team and supported by the NHSI improvement team ECIST. The teams are reviewing all aspects of the patient pathway from coming into the hospital, their main stay and discharge out. This work is being done in collaboration with system partners to ensure a holistic approach. An example of progress to date is the significant reduction in delayed transfers of care by increasing focus and engaging director level support from social services; we have reduced DTOCs from 40 patients to 20 or less.

3. Winter Assurance

3.1 As part of the national winter assurance process NHSE and NHSI are conducting winter preparedness reviews of each healthcare system. These are detailed on-site inspections designed to ensure that all acute trusts and associated local systems have robust plans in place to address the challenges associated with winter pressures. The NNUH and central Norfolk review took place on 14 November.

3.2 Overall, the visit went very well and the Trust received some very positive feedback which included the following highlights:

Positive Feedback

"We identified some areas of strong performance and good practice"

"A real sense amongst staff across the hospital that the performance of the emergency department is a whole-hospital issue, and that all the departments and wards have a key role to play"

"The trust winter room, with a triumvirate leadership structure looked to be a positive development"

"We were particularly encouraged by the EEAST representation in the [winter room] function"

"We welcomed the implementation of the discharge and reablement facility, and the engagement with SERCO to secure co-production, with staff and patients, of the plans for how the facility should operate"

"The virtual ward should also be a significant development, including the trialling of IVAB through that service"

"The additional RATS spaces should also make a significant contribution"

"There was a strong paediatric ED service and an effective OPED short stay area"

"We welcomed the work being done with ECIST"

"We were all impressed by the positive commitment of the staff we met"

PRIDE Values observed in practice – highly commended

3.3 This demonstrated clear support for the 8 point plan and assurance that is in line with the expectations of the national team. The visit also constructively allowed us to discuss some of the more challenging areas and we received guidance on areas we now need to focus our efforts on to ensure we are fully prepared:

Areas for Improvement/Focus

- Further work with EEAST re ambulance delays
- Red 2 Green and SAFER – roll out further and focus on planned discharge dates
- Review the Internal Professional Standards and application
- Build on existing system working generally including understanding of wider schemes outside of the hospital
- Need support with winter reporting – team to work with NHSE/I
- Enhanced ultrasound capacity at weekends to help admission avoidance and discharge
- Better patient tracking systems
- Improved non-emergency patient transport
- Review repatriation processes across Norfolk
- The system should consider further options for improving discharge or admission avoidance to the acute, for example providing enhanced community-based respiratory services

3.4 Whilst it was acknowledged that as a system we are already working on a number of the above, it was useful to have external recommendations to focus all organisations on these priority areas.

4. **Conclusions/Outcome/Next steps**

4.1 In summary, the NNUH Winter Plan is making good progress and all schemes are on track through robust project management and executive oversight. The impact of the changes will not only improve performance and flow over winter, but more importantly patient experience will be enhanced.

4.2 In terms of next steps, the focus of the winter team will be to rapidly rollout the discharge improvement change initiatives and also to take forward the finding of the NHSE/I inspection. Each of the recommendations above will be incorporated into the main Quality Improvement Programme. The NNUH Winter Director will liaise with the STP Winter Director to coordinate a system wide response and actions. This will feed into the existing STP wide A&E Delivery Board.

Recommendation:
The Board is recommended to note the progress to date and the findings of the winter assurance and preparedness review.

Strategic Objective: 1: We will be a provider of high quality health and care services to our local population

Threat 1.3	**High level and unpredictability of emergency demand creates circumstances that threaten quality of service**
Desired outcome or deliverable: We can avoid those operational circumstances that result in unacceptable deterioration in quality	
Associated indicators or measures of success 1. Minimised ambulance handover delays or 4hr breaches in ED 2. Minimised use of escalation areas 3. Rate of bed moves & boarders 4. Minimise cancelled ops and disruption to elective surgical programme 5. Quality indicators maintained - FFT, QAA, IP&C, incidents, safety thermometer	**Review Process and Dates:** Board of Directors 29/6/2018 & 28/9/2018 Quality & Safety Committee 5/4/18 & 14/9/18 Audit Cmttee: 12/09/18 Management Board: 25/9/18 & 20/11/18

How assured is the Board that controls are adequate & effective?	
R	A
↔	

Key controls, inputs & actions (policies / procedures / structures etc)	**Sources of assurance (+ve)** (i.e. evidence that the controls are effective – e.g. reports from assurance committees, surveys, internal or external audits and reports)	**Gaps in control/assurance (-ve)** (concerns or evidence that existing controls are not wholly effective)
• Oversight of CAPE and Clinical Safety Sub-boards Monthly reporting through IPR CAPE, Clinical Safety, Effectiveness and Performance sections • Mortality Reduction Strategy approved (Sept 17) with HSMR target established for April 2018 (90) and 2019 (85) • Creation of OPED and Paediatric ED (Dec '17) • Expansion of HDU capacity (Dec '17) • Winter Planning added to Q&SC Work Programme (Feb '18) • Building expansion of ED front door (June '18) • TB approval of 8 Point Winter Plan (July '18) • Agreed plans for creating Discharge Lounge (Sept '18) • Notification of Central funding for ED RATs (Sept '18) • Schedule of regular reporting established to HMB on Winter preparedness (Oct '18)	• Repeat Internal Audit review of 4-hr target data collection ("*reasonable assurance*") (April 17 & Sept '18) • Stroke SNAAP rating 'A' (Aug & Nov '18) • 'Graduation' from ECIP programme (Oct '17) • HSMR 'lower than expected' - 92.1 (Nov '18) • Update report to Q&S Cmtee regarding monitoring of non-clinical bed moves (Sept '18) • Board approval of Winter expansion plans (Sept '18) • Emergency Preparedness - compliance with EPRRBC standards confirmed by self-assessment and regional peer review (Sept 18) • System review of Winter Plans provides positive feedback on preparedness (Nov '18)	• Use of multiple escalation areas to accommodate non-elective patients is rated 16 on High Risk Tracker (May '18) • Multiple episodes of whistleblowing to CQC concerning use of escalation areas (Mar '18) • CQC concern over incidence of non-clinical bed moves March '18) • Ongoing NHSI concern over A&E performance (Sept '18) • Ward refurbishment programme suspended (Sept '18)

Any additional actions planned or required:	**Timescale**	**Lead**	**Update**
1. Escalation Policy under review – to reflect Winter Plan	Nov '18	RP/NF/ED	Scheduled for HMB review 27.11.18
2.			

Norfolk and Norwich University Hospitals NHS Foundation Trust

REPORT TO THE TRUST BOARD	
Date	**30 November 2018**
Title	**Infection Prevention and Control Annual Report 2017-18**
Author & Exec lead	**Author - Sarah Morter (Senior IP and C Nurse) on behalf of Dr Ngozi Elumogo (DIPC 2017-18) and Current Executive Lead - Professor Nancy Fontaine (DIPC since August 2018))**
Purpose	**For Information and Approval**

1. Background/Context

- Annual report provided by IP and C on behalf of the DIPC as a requirement of the Trust Board and as outlined in Health and Social Care Act 2008: code of practice on the prevention and control of infections and related guidance, updated July 2015 [Hygiene Code]. This is to provide assurance on Infection Control activity for the Financial Year 2017-18

2. Key issues, risks and actions

- The Trust received the highest quality Escalation Level Green rating for Infection Control through an external NHSI assessment in February 2018 and against the Hygiene Code
- Based on NHSI recommendations this annual report is presented for the first time in a new format assessed against the Hygiene Code
- The Trust was fully compliant with PHE HCAI targets over Clostridium difficile and MRSA blood stream infections

3. **Conclusions/Outcome/Next steps**

- The IP and C Team have achieved the highest rating possible for IPCT though external assessment by NHSI
- Trust recommissioning of the ICNet system by July 2019 is crucial to maintenance of this high level of Infection Control Practice
- Maintaining adequate levels of IP and C staffing and resource are also key to ongoing delivery of essential Trust Infection Control targets and ability to support additional requirements such as Winter pressures, education and mandatory training, building work and other new initiatives

Recommendation:

The Board is recommended to:

- Approve this report as an assurance of excellent Infection Control practice within the Trust and as endorsed by a top Green rating from NHSI
- Support necessary ongoing resource for IP and C to maintain this excellent level of performance

Infection Prevention & Control Annual Report

April 2017 – March 2018

Director of Infection, Prevention & Control:
Dr N. Elumogo

Written & Compiled by:
Infection Prevention & Control Team

August 2018

Infection Prevention and Control Annual Report 2017-2018

Contents

Infection Prevention and Control Annual Report 2017-2018

Executive Summary

This annual report provides an overview of Infection Prevention and Control (IP&C) activities for the Norfolk and Norwich University Hospital NHS Foundation Trust (NNUHFT), hereafter maybe referred to as the Trust. It covers the period from 1st April 2017 to 31st March 2018.

On the advice of the Senior Infection, Prevention and Control Advisor (Midlands and East), National Health Service Improvement, Dr Debra Adams, the report format has been changed this year. It now follows the 10 criteria as detailed in the Health and Social Care Act 2008: code of practice on the prevention and control of infections and related guidance, updated July 2015. This report summarises the Trust's performance against the key mandatory healthcare infection targets, work undertaken during the year and provides assurance against the criteria in the code of practice.

The year was again busy, in particular with a high number of patients admitted with influenza and influenza like symptoms over the winter period, as was the case throughout England. The workplace health and well-being (WHWB) team again had an excellent uptake of staff receiving the influenza vaccine.

At the end of the year the Director of Infection Prevention and Control (DIPC) resigned to take up the post of chief of service of Laboratory Medicine & Eastern Pathology Alliance within the Trust. The Executive lead for IP&C, the Director of Nursing left to work with National Health Service Improvements (NHSI).

The high IP&C standards achieved are due to the continuing commitment throughout the Trust and the IP&C team would like to extend their thanks to all those who played a part. This report provides a reminder of the extensive scope of work in order to maintain the high quality and safety in patient care that the IP&C team strive for.

Further evidence of this was following the Infection Prevention (IP) review visit led by Dr Adams, NHSI when the Trust was assessed as escalation level Green. We were delighted with the outcome of this external inspection which took place in February 2018 and Dr Adams was accompanied by the Clinical Commissioning Group IP&C nurse.

http://www.edp24.co.uk/news/health/norfolk-and-norwich-university-hospital-receives-highest-grade-for-infection-control-1-5514067

Infection Prevention and Control Annual Report 2017-2018

Abbreviations

AMR	Antimicrobial Resistance
C4C	Cleaning for Credits
CCG	Clinical Commissioning Group
CDI	*Clostridium difficile* Infection
CEO	Chief Executive Officer
CPE	Carbapenemase-producing Enterobacteriaceae
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
DH	Department of Health
DIPC	Director of Infection Prevention & Control
E. coli	*Escherichia coli*
EPA	Eastern Pathology Alliance
ESBL	Extended Spectrum Beta Lactamase
GRE	Glycopeptide Resistant Enterococcus
HCAI	Health Care Associated Infection
HTM	Health Technical Memorandum
ICD	Infection Control Doctor
ICON	Infection Control On NICU
IP&C	Infection Prevention & Control
HICC	Hospital Infection Prevention & Control Committee
IPCN	Infection Prevention & Control Nurse
IPCT	Infection Prevention & Control Team
JPS	Joint Patient Services
MGNB	Multi Resistant Gram Negative bacilli
MHRA	Medicines and Healthcare Products Regulatory Agency
MRSA	Meticillin Resistant *Staphylococcus aureus*
MSSA	Meticillin Susceptible *Staphylococcus aureus*
NHSI	National Health Service Improvements
NICU	Neonatal Intensive Care Unit
NNUHFT	Norfolk and Norwich University Hospital Foundation Trust
OWL	Organisation Wide Learning
PCR	Polymerase Chain Reaction
PFI	Private Finance Initiative
PHE	Public Health England
PIR	Post Infection Review
PLACE	Patient-led assessments of the care environment
PPE	Personal Protective Equipment
RAG	Red, Amber, Green
RCA	Root Cause Analysis
SSI	Surgical Site Infection
UEA	University of East Anglia
VRE	Vancomycin Resistant Enterococcus
WHWB	Workplace Health and Well-Being

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Introduction

This annual report provides an account of the NNUHFT IP&C main activities during the year from April 2017-March 2018. It aims to provide assurance to all stakeholders including the patients and service users, the general public, commissioners and the Trust board members and staff.

During this period the Trust met the 2 key national objectives for infection prevention;

- No cases of hospital onset Methicillin Resistant Staphylococcus aureus blood stream infections.
- To remain below the objective for NNUHFT of 49 hospital onset cases of Clostridium difficile infections.

NNUHFT remains committed to continuous improvement of quality and care so that we have the best outcome for our patients. This includes IP&C being high on the safety agenda with monitoring of adherence against best IP&C practice, compliance with policies and guidelines and reviewing and updating documents, learning from our post infection reviews and effective communication to all levels of staff to strengthen understanding and ownership of infections in all clinical areas.

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

Below NNUHFT Executives Supporting IP&C Awareness Week

Hygiene Code Compliance Criteria 1:

Systems to manage and monitor the prevention and control of infection

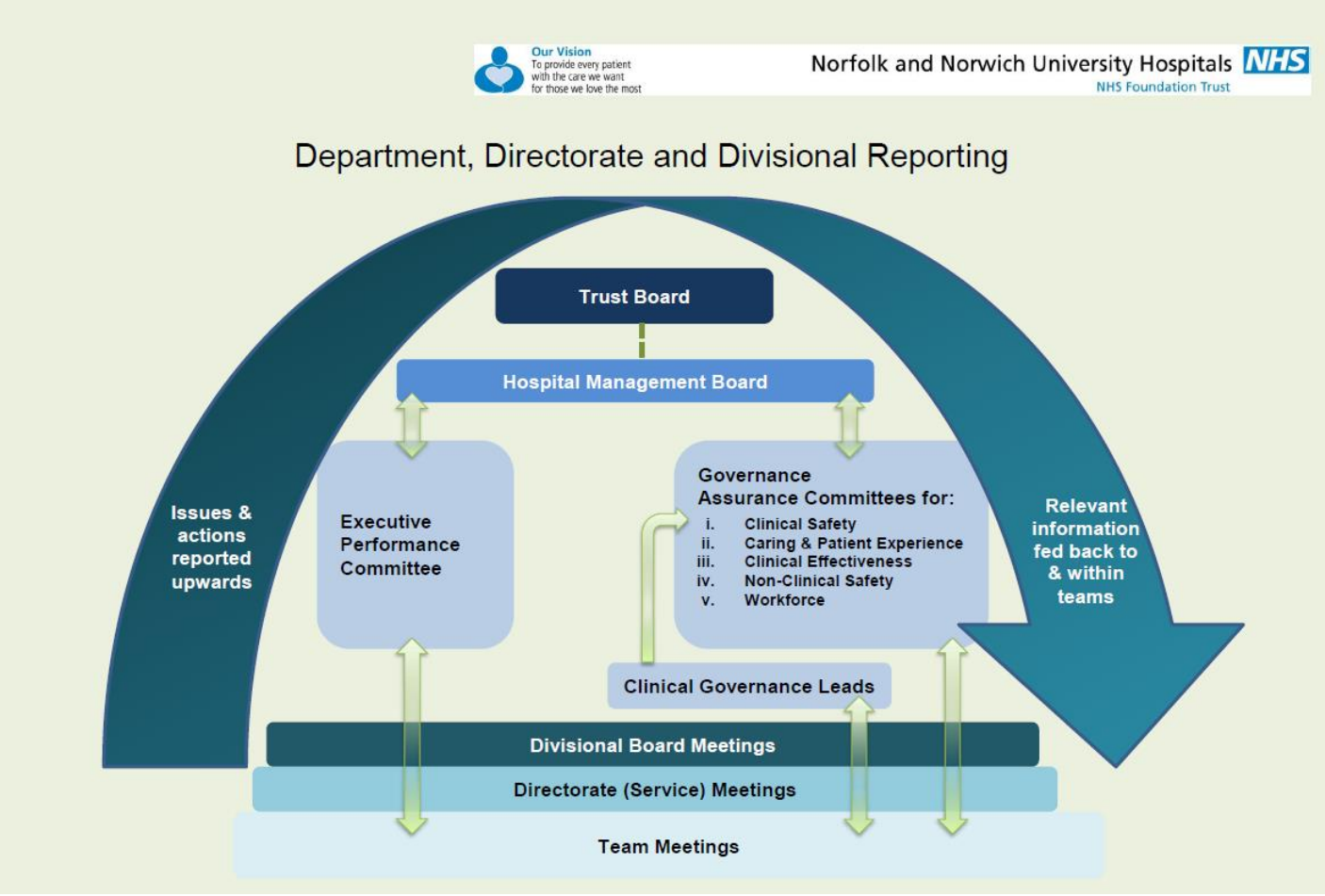
These systems use risk assessments and consider how susceptible service users are and any risks that their environment and other users may pose to them.

Trust Governance Assurance Structure

The Trust has a Healthcare Governance Framework that supports the Board of Directors in discharging its responsibilities for ensuring that high quality and safe services are in place for patients, visitors and staff.

The Chief Executive Officer (CEO) has overall responsibility for IP&C whilst the DIPC provides strategic direction and leadership to the Trust on all IP&C matters and reports to the CEO, Medical Director and Director of Nursing who is also the designated executive lead for IP&C.

During the year the IP&CT completed a review of NNUHFT's compliance with the Health and Social Care Act 2008, Code of Practice on the prevention and control of infection and related guidance (updated 2015). The senior IP&C nurse took the report to the Hospital Management Board.



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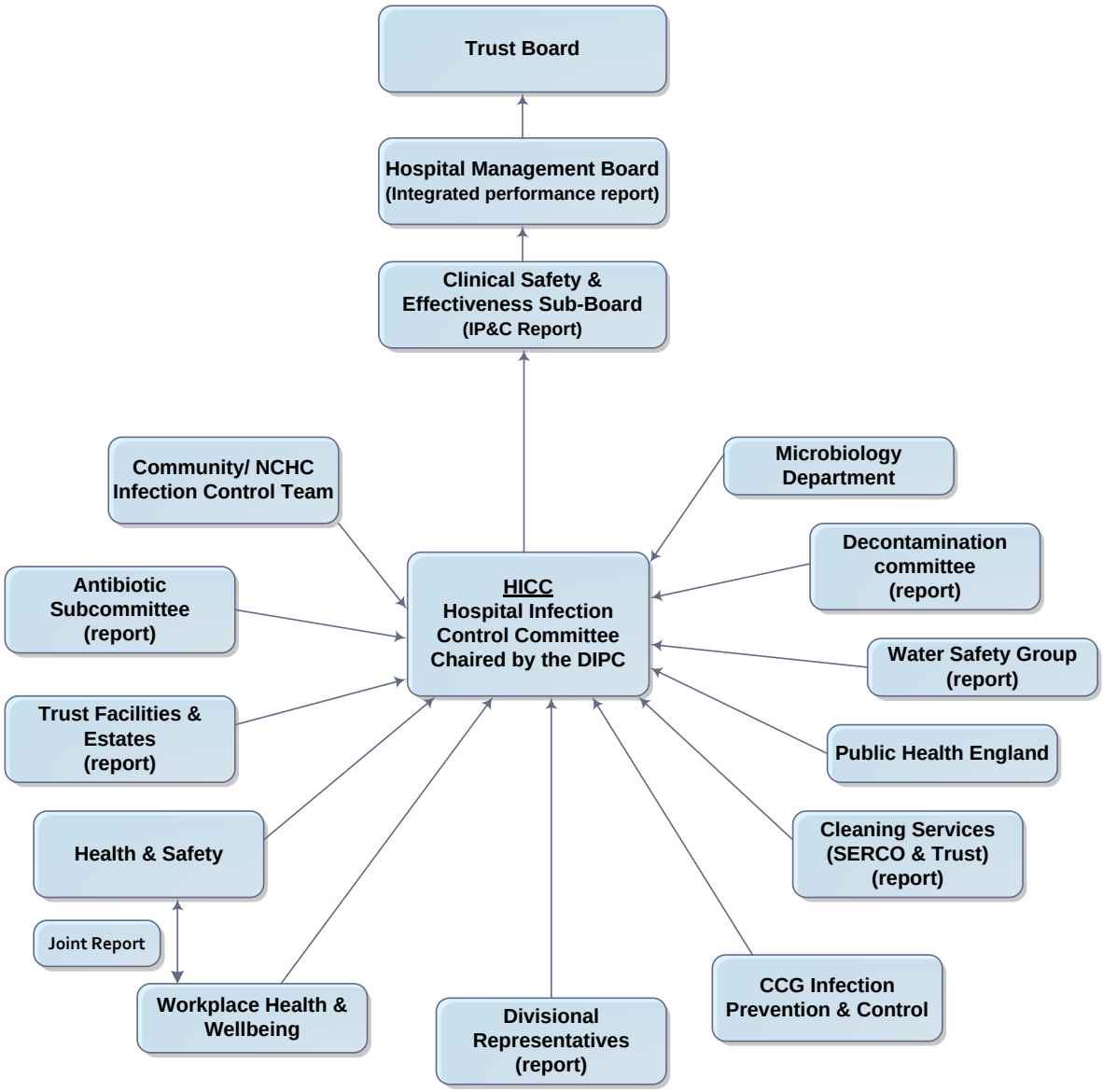
IP&C Reporting Process

- The executive lead for IP&C (Director of Nursing) report key performance indicators monthly to the Trust board
- The Director of Nursing/deputy oversees the IP&C elements of the nursing dashboard monthly.
- The DIPC reports to the clinical safety sub-board monthly.
- The DIPC provides a monthly IP&C report which is widely distributed to senior managers, Divisional leads, Governance leads, Matrons, Ward managers, CCG and CCG IP&C nurse. This report is detailed and contains the current position of IP&C in the Trust.
- The DIPC provides regular updates to consultant Microbiologists.
- The IP&C team report on all key aspects of IP&C at the quarterly HICC meeting with internal and external representatives.

Our Vision
To provide every patient with the care we want for those we love the most
Norfolk and Norwich University Hospitals NHS
NHS Foundation Trust

Infection Prevention & Control Governance Structure



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Decontamination Meetings

These are scheduled quarterly throughout the year and are chaired by the decontamination lead who is the Chief Operating Officer.

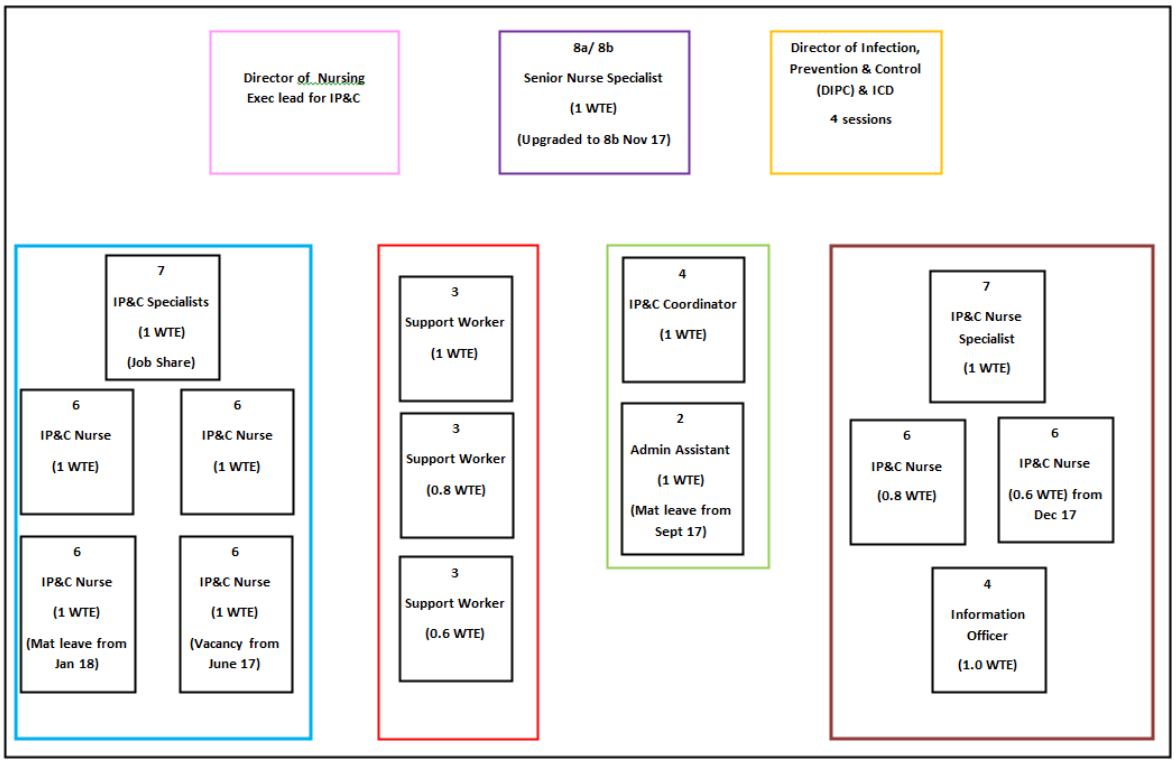
Water Safety Group

These are scheduled quarterly throughout the year and are chaired by the Head of Facilities. The Trust follows the standards in Health Technical Memorandum 04-01, Safe water in healthcare premises for testing water for Legionella species and Pseudomonas aeruginosa.

In addition to HICC the IP&C team is represented or receives updates from the following committees and groups thus ensuring that infection prevention and control is considered by these forums:-

- Tuberculosis clinical review meetings
- IP&C on Neonatal Intensive Care Unit group (ICON)
- Norfolk wide system Healthcare Associated Infection Group (Community and acute hospitals with provider and commissioner representation)
- Health Protection Advisory Group, PHE
- Norfolk Community Health and Care NHS Trust Infection Control Committee
- East of England Regional Medical Microbiologists' Development Group
- Norfolk Acute hospitals & Eastern Pathology Alliance (EPA) joint Infection Control group
- Emergency Preparedness group
- Health and Safety committee
- Facilities management meeting
- Joint Patient Services (JPS)
- Matrons & Ward Sisters Quality & Patient Safety Review Meeting/Committee

The IP&C Team



To ensure 24 hour support and advice for staff in the Trust the IP&C registered nurses provided an on-call service out of hour's service covering evenings, weekends and bank holidays for any urgent IP&C issues. The IP&C nurses on-call are supported by the Consultant Microbiologists on call (ICD is a named Consultant person/role). Virology and Microbiology cover is provided by a team of Consultant Microbiologists/Virologists.

Mandatory Surveillance of Healthcare Associated Infection to Public Health England

Clostridium difficile (C. *difficile*)

The laboratory uses a 2 stage algorithm for C. *difficile* testing as recommended by the Department of Health (DH). C. *difficile* can cause a mild illness or a severe life threatening infection. The incidence of C. *difficile* at NNUHFT has continued to fall.

The Microbiology laboratory complies with PHE unrestricted testing protocol for C. *difficile* whereby all diarrhoeal stool samples received in the laboratory from in-patients are automatically tested for C. *difficile*.

All cases of C. *difficile* that occur on or after the 4th day of admission in hospital are reported to PHE as hospital acquired (HAI). There were 35 HAI cases in total in 2017-18, with 11 being trajectory (lapse in care) cases and 24 non-trajectories (no lapses in care). NNUHFT has consistently met its national C. *difficile* objectives since 2011.

NNUHFT performance for *C. difficile* –number of cases				
Financial Year	**Community Origin**	**NNUHFT Objective**	**Hospital Origin (on or after day 4)**	**Total**
2017-18	**139**	**49**	**24** (no lapses, deducted from final total) 11 (lapses in care) 35 cases	**174**
2016-17	128	49	**22** (no lapses, deducted from final total final total) 20 (lapses in care) 42 *Cases*	148
2015-16	145	49	**24** (no lapses, deducted from final total final total) 32 (lapses in care) 56 *Cases*	177

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East of England Trust assigned *C. difficile*

Count of acute trust apportioned cases per month

Trust Code	Acute Trust Name	Trajectory	2017 April	May	June	July	August	September	October	November	December	2018 January	February	March	Total
RGM	Papworth Hospital NHS Foundation Trust	5	0	0	0	0	0	0	2	0	0	0	1	2	5
RC9	Luton & Dunstable Hospital NHS Foundation Trust	6	1	2	1	1	1	1	1	0	1	0	0	0	9
RC1	Bedford Hospitals NHS Trust	10	0	1	1	0	1	2	0	1	1	2	0	2	11
RD8	Milton Keynes Hospital NHS Foundation Trust	39	1	0	0	1	3	0	1	0	1	3	2	0	12
RQW	Princess Alexandra Hospital NHS Trust	10	1	0	1	4	0	3	0	1	0	2	0	2	14
RGP	James Paget University Hospitals NHS Foundation	17	0	2	3	3	1	0	2	2	0	1	1	1	16
RDE	Colchester Hospitals University NHS Foundation T	18	0	3	3	1	1	2	0	1	4	3	0	0	18
RGR	West Suffolk Hospitals NHS Trust	16	3	0	0	1	0	2	6	4	0	1	0	2	19
RGQ	Ipswich Hospital NHS Trust	18	1	3	1	8	2	1	1	1	0	0	2	3	23
RWH	East & North Hertfordshire NHS Trust	11	2	2	2	4	2	2	1	2	0	3	4	2	26
RDD	Basildon & Thurrock University Hospitals NHS Fou	31	5	1	2	1	1	2	1	1	5	2	4	3	28
RWG	West Hertfordshire Hospitals NHS Trust	23	1	1	4	0	0	0	3	5	1	6	6	1	28
RAJ	Southend University Hospital NHS Foundation Trus	30	5	2	4	1	3	1	1	4	7	2	3	0	33
RM1	Norfolk & Norwich University Hospitals NHS Found	49	2	1	6	3	3	3	4	4	2	3	3	1	35
RCX	The Queen Elizabeth Hospital King's Lynn NHS Tru	53	2	3	4	5	3	5	7	4	1	3	5	6	48
RQ8	Mid Essex Hospital Services NHS Trust	13	8	3	2	5	7	3	2	4	5	5	3	8	55
RGN	North West Anglia NHS Foundation Trust	40	7	4	4	4	3	8	3	6	2	1	5	12	59
RGT	Cambridge University Hospitals NHS Foundation T	49	1	11	4	7	5	8	5	4	6	2	8	6	67
	East of England Total	438	40	39	42	49	36	43	40	44	36	39	47	51	506
	England Total	2945	345	372	412	464	399	407	408	389	352	384	380	426	4738

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

Each hospital acquired case is thoroughly investigated in a multi-disciplinary root cause analysis (RCA) post infection review (PIR) meeting. Attendees include the clinical team responsible for the patient, Antibiotic Pharmacist, Microbiologist and IP&C team. The CCG IP&C team also attend and make the final decision as to whether there have been any lapses in care and ensure any learning for community partners within the CCG is also shared accordingly.
If no lapses in care are identified, the case is recorded as non-trajectory. Cases where lapses are identified (trajectory) are followed up by the relevant divisional teams with an action plan and dissemination of the lessons learnt.

NNUHFT lapses in care identified from 11 trajectory cases of *C. difficile* 2017- 2018	
Lapses	Number of times lapse occurred
Delay in sampling	9
Delay in isolation (placing in single room)	7
Hand hygiene score below 95%	3
Poor communication	2
Antibiotic review not clearly documented	1
Stool chart not completed daily	1
Some trajectory cases had > one lapse. Lapses are included in the learning outcomes	

C. difficile patients are transferred to the *C. difficile* cohort ward, where they are cared for by a multi-disciplinary team so that *C. difficile* is managed as “a disease in its own right” as recommended by DH (*C. difficile* how to deal with the problem”, 2009).

A Consultant Microbiologist leads a multi-disciplinary team C. *difficile* weekly ward round which includes an ICN and antimicrobial pharmacist. The team has access to gastroenterologists input when required.

There are many recognised risk factors for *C. difficile* infection, some of which are antibiotic use, proton pump inhibitors, use of laxatives, medication 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 was often difficult to prove conclusively where the patient acquired the *C. difficile* organism. This is because *C. difficile* can be carried asymptomatically prior to admission and only become apparent with development of symptoms when the organism is triggered by administration of antibiotics during admission. Possible sources are asymptomatic colonisation prior to admission or acquisition from an unidentified, asymptomatic in-patient either directly or via hospital equipment and hands of staff. It is notable that some patients who are colonised with *C. difficile* may excrete the spores without showing symptoms.

Glycopeptide-resistant Enterococcus (GRE) Blood Stream Infection

Enterococci are organisms that reside in the gastrointestinal tract, GRE are multi-drug resistant Enterococci which are resistant to the Glycopeptide antibiotics Vancomycin and Teicoplanin. The Trust continues to record very low rates of GRE blood stream infection. These have remained stable in single figures annually over the last four years. A patient identified with GRE is nursed in a single room with enhanced IP&C precautions. Antibiotics are prescribed based on the sensitivity of the particular strain.

There were 6 cases of GRE/VRE blood stream infection in 2017-18; none were due to transmission within the hospital.

Carbapenemase-producing Enterobacteriaceae (CPE)

In 2013 PHE put together a Toolkit for acute Trusts with practical advice for clinicians and staff at the frontline and advice and information for the patients. This toolkit served as the basis of a Trust guideline on the management of CPE.

There has been a rapid increase in the incidence of infection and colonisation by multi-drug resistant carbapenemase-producing organisms In the UK, over the last six years with a number of clusters and outbreaks in England reported. The north west of England has seen ongoing and persistent problems with CPE but generally England has not reached the numbers of cases as seen in some other countries.

A new highly sensitive and specific molecular screening method (PCR) test for the detection of CPE has been available locally from 18/07/2016. PCR can rapidly identify presence or absence of carbapenemase genes in faecal specimen to aid decisions on patient management and infection control measures.

Carbapenamase-producing Enterobacteriaceae - Cases identified			
1 case identified from a GP sample then admitted & status confirmed.	1 case had hospital contact in India and London hospital and identified positive prior to transfer	1 case medically transferred from Turkey, positive on admission screening at NNUHFT	1 case with recent admission in a London hospital, positive on admission screening at NNUHFT
4 identified 2017-18 - No cases of hospital origin CPE attributed to NNUHFT			

Gram Negative Bacteraemia/ Blood Stream Infections

There is an ambition set by NHSI that the number of Gram negative blood stream infections (BSI) will be reduced by 50% across the whole healthcare economy by March 2021. This includes the following organisms *Escherichia coli (E. coli), Klebsiella species and Pseudomonas aeruginosa.* Currently the focus for reduction is aimed at *E. coli* however reporting for *Klebsiella species and Pseudomonas aeruginosa* commenced in this year.

Escherichia coli

Escherichia coli is often referred to as *E. coli*. It is part of the normal gut flora and commonly causes infection of the urinary tract and can cause blood stream infection (E. coli blood stream infection).
Some E. coli are able to produce enzymes, extended spectrum beta lactamase (ESBL) that confer resistance to multiple antibiotics.

Several detailed analysis and audits of E. coli blood stream infection have been conducted to better understand the causes of E. coli blood stream infection and inform appropriate prevention strategy. These showed co-morbidities such as diabetes and renal failure were significant risk factors. Attention to insertion and care of catheters, audits, education and reporting of Catheter associated urinary tract infection are directed to further reduce HAI E. coli blood stream infections.

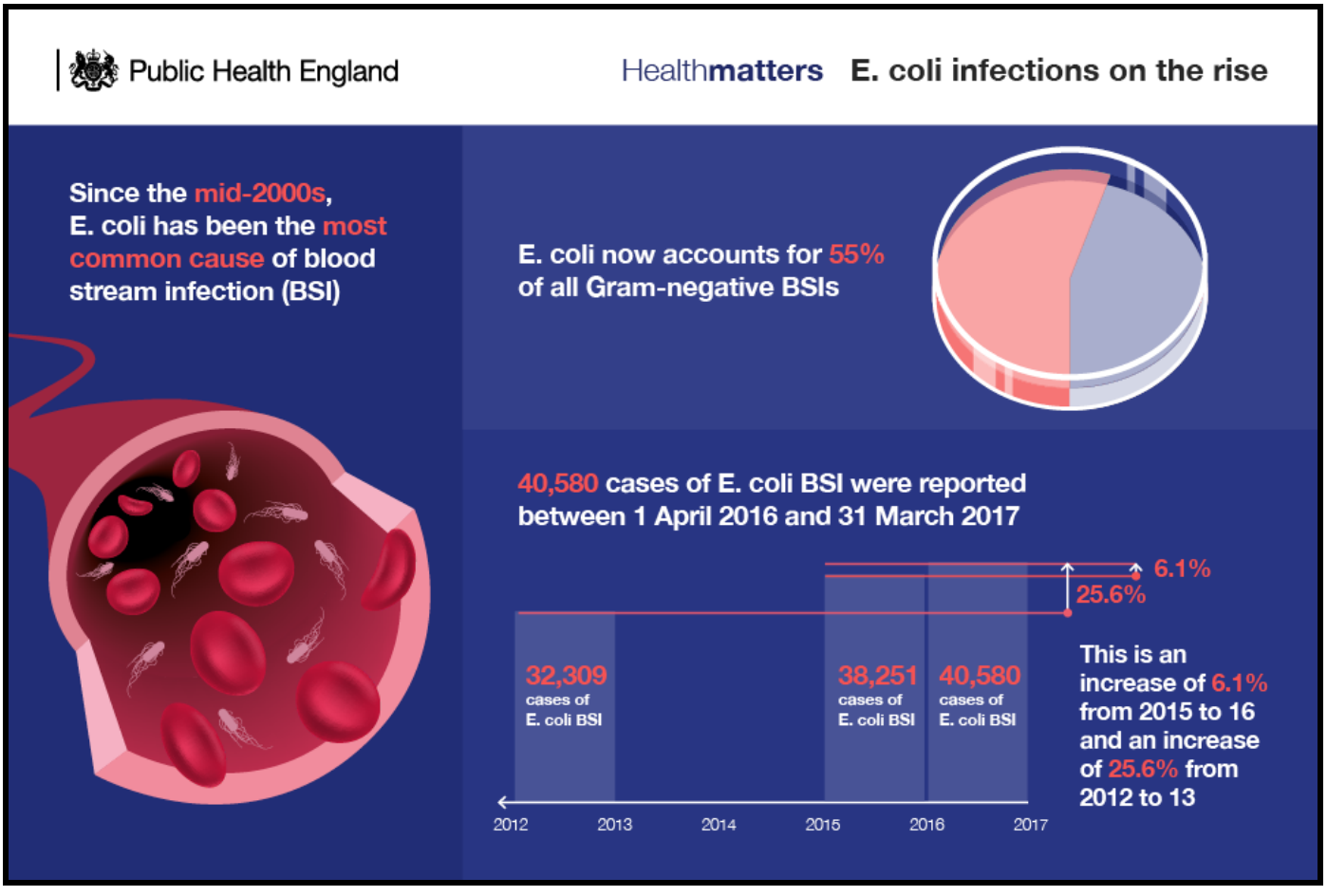
NNUHFT performance for *Escherichia coli* BSI – number of cases			
Financial Year	**Community Origin**	**Hospital Origin (on or after day 3)**	**Total**
2017-18	**314 (85%)**	**56 (15%)**	**370**
2016-17	321 (87%)	49 (13%)	370
2015-16	301 (80%)	76 (20%)	377

Klebsiella species and Pseudomonas aeruginosa

It is the first year of reporting for *Klebsiella species and Pseudomonas aeruginosa* and therefore comparative figures aren't available for previous years.

NNUHFT performance for *Klebsiella* BSI– number of cases			
Financial Year	**Community Origin**	**Hospital Origin (on or after day 3)**	**Total**
2017-18	**64 (75%)**	**21 (25%)**	**85**

NNUHFT performance for *Pseudomonas* BSI – number of cases			
Financial Year	**Community Origin**	**Hospital Origin (on or after day 3)**	**Total**
2017-18	**33 (77%)**	**10 (23%)**	**43**



Methicillin Susceptible and Methicillin Resistant Staphylococcus aureus

Staphylococcus aureus is a bacterium commonly found colonising the skin and mucous membranes of the nose and throat. Although most people carry this organism harmlessly, it is capable of causing a wide range of infections from minor boils to serious wound infections and from food poisoning to toxic shock syndrome. In hospitals, it can cause surgical wound infections and bloodstream infections.

MRSA Blood Stream Infection

Mandatory reporting is for all *Staphylococcus aureus* blood stream infection which are then split according to resistance and reported separately as Methicillin Sensitive *Staphylococcus aureus* (MSSA) and Methicillin Resistant *Staphylococcus aureus* (MRSA). Surveillance and reporting of MRSA blood stream infection continues with the limit set at 0 avoidable cases.

NNUHFT MRSA BSI attribution and number of cases				
Financial Year	**Community Origin**	**Hospital Origin (on or after day 3)**	**Third Party+**	**Total**
2017-18	**1**	**0**	**2**	**3**
2016-17	1	0	2	3
2015-16	0	2*	0	2

**** The 2 MRSA blood stream infection hospital cases in 2015-16 included 1 contaminate i.e. pseudo blood stream infection.***

+ After arbitration was found to be not attributable to CCG or NNUHFT

MSSA Blood Stream Infection

There is no national objective for MSSA. Reports include 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 3.

NNUHFT MSSA BSI attribution and number of cases			
Financial Year	**Community Origin**	**Hospital Origin on or after day 3**	**Total**
2017-18	**63** (76.8%)	**19** (23.2%)	**82**
2016-17	73 (80.2%)	18 (19.8%)	91
2015-16	85 (85.9%)	14 (14.1%)	99

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Audit Programme

The IP&C team oversee a rolling programme of audits across the Trust. These include:-

Hand Hygiene
Commode and Bedpan
Environment
Beverage Bay
Dirty Utility
Isolation
Environmental audits
Indwelling Device Management and Practice

These audits are undertaken by the IP&C team, ward nurses and IP&C link nurses. Results are shared with the clinical areas and also on available on the intranet via the electronic IP&C dashboard.

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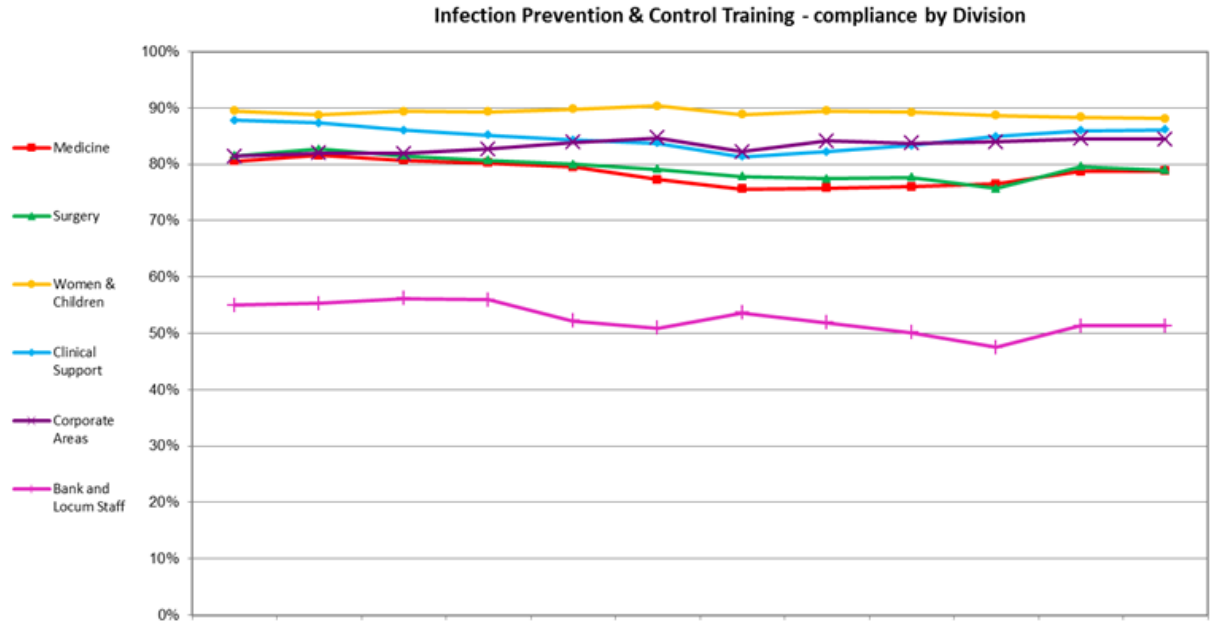
Staff Training and Supervision

The IP&C team support and undertake the following staff training:-

- Mandatory training
  - Non-clinical staff IP&C updates available via nationally accredited e-learning package bi-annually
  - Clinical staff IP&C training is delivered via face to face training sessions from the IP&C nurses and support workers bi-annually
- Corporate induction for all new starters
- Nursing Assistant training course
- Bespoke departmental training
- Offer Weekly face to face training sessions in lecture theatre
- Junior doctors preparation for professional practise course each August
- Monthly Invasive device and enhanced practice study sessions
- Awareness campaigns and study sessions
- Delivered IP&C training in partnership with UEA for undergraduate nurses, physiotherapists, occupational therapists & Speech and Language therapists and return to practice student nurses



Division	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Medicine	80.5%	81.6%	80.7%	80.3%	79.5%	77.3%	75.6%	75.7%	76.0%	76.5%	78.7%	78.8%
Surgery	81.5%	82.7%	81.5%	80.7%	80.0%	79.1%	77.8%	77.4%	77.7%	75.7%	79.6%	78.9%
Women & Children	89.4%	88.7%	89.4%	89.3%	89.8%	90.3%	88.8%	89.4%	89.2%	88.7%	88.4%	88.1%
Clinical Support	87.8%	87.3%	86.1%	85.2%	84.3%	83.7%	81.3%	82.2%	83.3%	84.9%	86.0%	86.1%
Corporate Areas	81.4%	81.9%	81.9%	82.7%	83.9%	84.7%	82.2%	84.1%	83.8%	83.9%	84.5%	84.4%
Bank and Locum Staff	55.0%	55.3%	56.2%	55.9%	52.2%	50.9%	53.7%	51.9%	50.1%	47.5%	51.3%	51.4%

Training department has set up a working group reviewing bank staff mandatory training with a view to raising the compliance. Also a review of locum doctors to request access to their substantive post learning records utilising the inter-authority transfer to update their learning records with NNUHFT. Part of this group will be to increase communication on the availability of remote access.

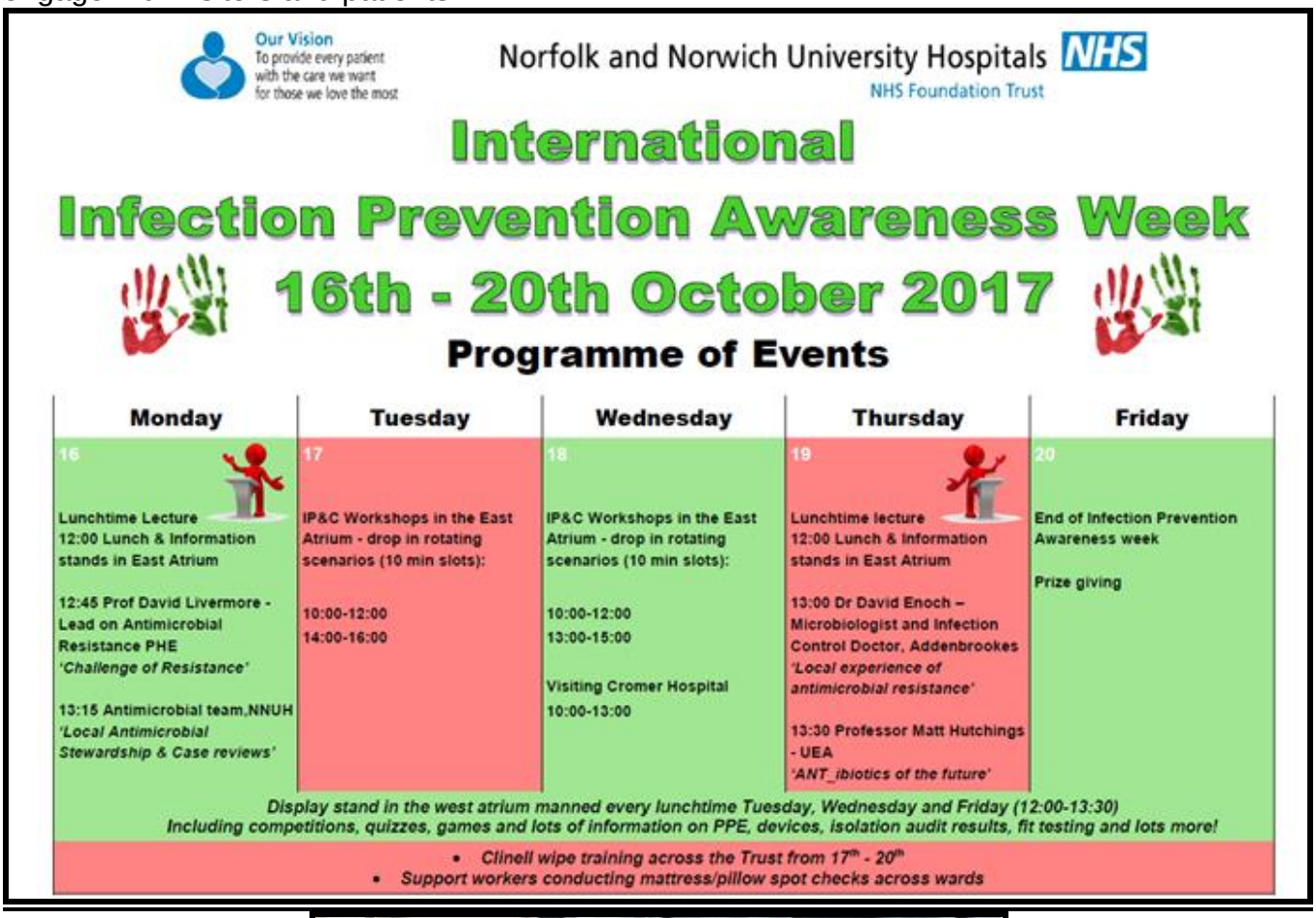
IP&C Team Training

1. Three IP&C nurses attended Infection Prevention Society (IPS) Writers workshop in Birmingham on 13th November 2017.

2. Three IP&C nurses attended One Together Assessment Conference in Birmingham on 23rd November 2017.

Awareness Week

Annually the IP&C team participate in international awareness week and offer a diverse programme for all staff at NNUHFT with a number of activities. There are also opportunities to engage with visitors and patients.



Superbug being evicted from Cromer hospital

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Colleagues Gaining IP&C Experience With The Team

We are always pleased to share our specialist knowledge and skills with colleagues who want to visit the team whether it is for a day or longer. During the year we had attachments from 2 doctors, a virology registrar and a microbiology registrar.

There were also 20 student nurses that came for 1 or 2 days to get a broad understanding of IP&C and fulfil their pre agreed objectives by shadowing various members of the team.

IP&C Link Staff Scheme

The IP&C Team continued to provide support to the IP&C link staff in the Trust.

IP&CT updated the link staff profile and ran link staff meetings every three months throughout the year with a variety of topics covered. These were attended by IP&C link practitioners from across the organisation.

IP&C Link staff meetings 2017-18			
22/06/2017	**14/09/2017**	**14/12/2017**	**29/03/2018**
Agenda • Everything MRSA • World hand hygiene day NNUHFT survey results	**Agenda** • IP&C awareness week • Isolation • Patient-led assessments of the care environment (PLACE) IP&C feedback • Poster competition • Varicella Zoster	**Agenda** • Link staff roles and responsibilities • Beverage bay and dirty utility audits • Single room isolation audit results • IP&C documents update • Wipes presentation	**Agenda** • NHSI visit feedback • IP&C link staff profile • Summary of IP&C for the year (C. diff, MRSA, CPE, incidents) • Disinfection training by Q&A, sharing good practice

The aims of the link staff role are;

- To establish networks of appropriately trained links within NNUHFT.
- To use the network to monitor standards and improve the care of service users within their area.
- To share, monitor and promote safe evidence based practice in their area, using current guidance i.e. epic 3
- Act as the IP&C liaison and support person for their team
- Provide positive feedback to members of their team to support celebration of success (RCN 2012)
- Improve knowledge/awareness of policies/guidelines & new legislation

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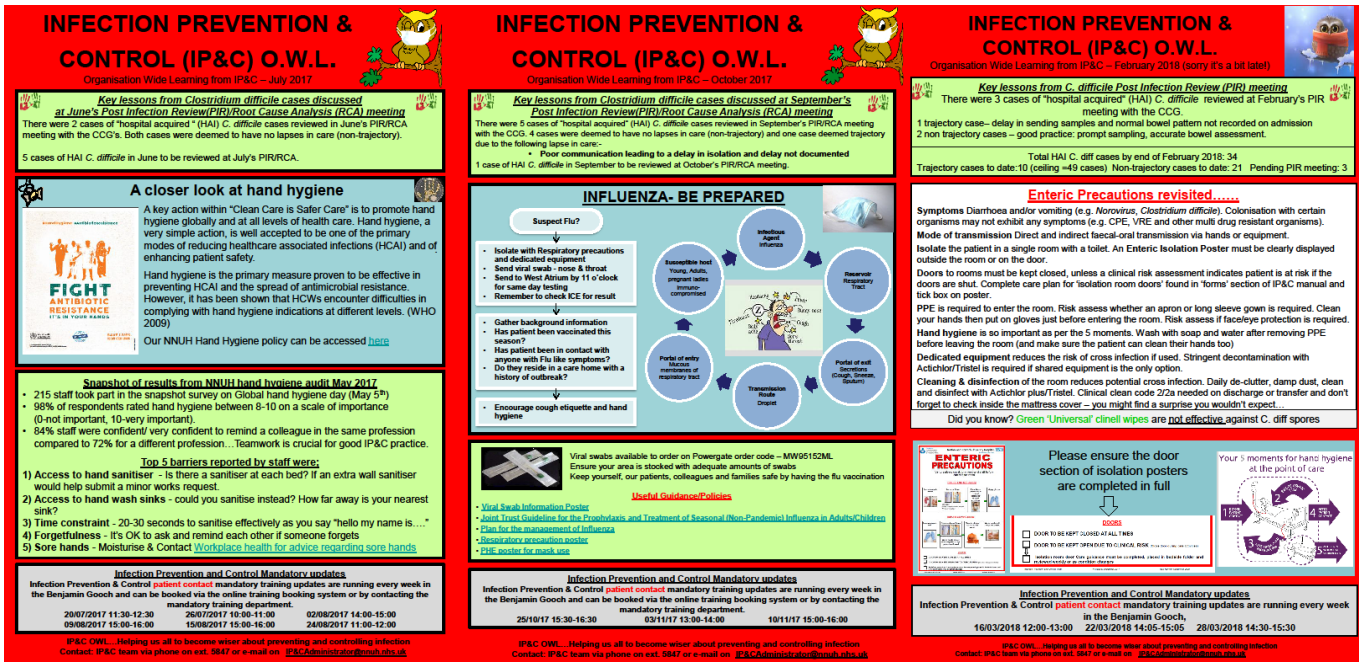
Organisation Wide Learning (OWL)

The IP&CT produces monthly organisational wide learning (OWL) providing Trust wide infection prevention and control information such as;

- Monthly learning from post infection reviews (PIR)
- Key IP&C messages
- Current or upcoming IP&C issues such as preparedness for influenza
- Highlighting good practice
- Highlighting areas of improvement

3 examples of the OWL from the year are shown below:-



Mask Fit Testing

The Health and Safety team oversee the programme of mask fit testing for staff that have direct patient contact using a train the trainer approach.

Movement of Service Users

The IP&C team work closely with the site Operations Team, in particular when there is increased numbers of Influenza or Norovirus cases within the Trust and during times of on-call.

There are daily operational department meetings that the IP&C nurses attend if there are any IP&C concerns that impact operationally. The IP&C team have developed electronic boards to highlight to staff wards that have confirmed/suspected Influenza or Norovirus and any community hospitals or care homes that have cases. Via the electronic ward view the ward teams show the reason for a single room being in use which both the operations and IP&C teams have access to view.

Via the patient administration system there are individual patient alerts in place to assist in single room planning for patients with known previous infections.

Hygiene Code Compliance Criteria 2:

Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.

Cleaning Services

There is a senior matron appointed as the cleaning lead who oversees cleaning within the Trust. Cleaning and estates issues are monitored through regular joint cleaning audits attended by both Trust and Provider staff using Cleaning for Credits (C4C) software. Whilst the Trust staff are responsible for cleaning medical equipment the environmental cleaning is outsourced. The IP&C team work closely with the cleaning providers to agree, monitor and advise on cleaning standards.

NNUHFT sites - Cleaning for Credits (C4C) audit scores

Area	Number of Audits		Average Score		Target Range
	2016-17	**2017-18**	2016-17	**2017-18**	
Cotman Centre admin	54	**72**	95%	**97%**	95-100%
Francis Centre admin	11	**12**	87%	**90%**	95-100%
Grove Road	7	**12**	96%	**98%**	95-100%
Rouen Road	54	**72**	95%	**97%**	95-100%

Cromer Hospital - Cleaning for Credits [C4C] audit scores

Area	Number of Audits		Average Score		Target Range
	2016-17	**2017-18**	2016-17	**2017-18**	
Wards	24	**27**	98%	**97%**	95-100%
A&E (MIU)	12	**12**	98%	**97%**	95-100%
Theatres	24	**25**	99%	**98%**	95-100%
Clinics/Admin	43	**50**	98%	**97%**	95-100%

Norfolk and Norwich Hospital - Cleaning for Credits [C4C] audit scores					
Area	**Number of Audits**		**Average Score**		**Target Range**
	2016-17	**2017-18**	2016-17	**2017-18**	
Wards	**412**	**420**	**95.87%**	**96.22%**	90% - 95%
A&E	**48**	**48**	**96.16%**	**95.75%**	90% - 95%
Theatres	**264**	**264**	**96.95%**	**97.26%**	90% - 95%
Clinics/Admin/Public Areas	**1215**	**1220**	**96.45%**	**96.80%**	90% - 95%

Commode and Bedpan Cleanliness Audits

The IP&C Support workers assist staff with education on cleaning and the expectations required for good standards of cleanliness. They maintain a programme of commode and bedpan audits throughout.

Number of commodes audited and average percentage pass in NNUHFT		
Financial Year	**Total No of Commodes audited**	**Percentage Pass**
2017-18	**2282**	**94%**
2016-17	2377	93%
2015-16	2374	91%

As part of the International IP&C awareness week in October 2017 a number of inpatient and outpatient departments were presented with Golden Commode award certificates for maintaining 100% audit scores for at least 12 consecutive months thereby demonstrating fantastic and consistent practice..

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Waste *(information contributed by Health & Safety Lead Advisor)*

The overall responsibility for correct processing of waste in the Trust sits with the Health and Safety team. The Trust Waste Policy applies to all sites although the Facilities Management (FM) companies with operational responsibility differ across the sites.
Monitoring and audit of the policy is done through various channels:

- Clinical waste streams are audited by the FM companies on sites where more than 5,000 tonnes of clinical waste is produced annually.
- 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 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.

Sharps (*information contributed by Health & Safety Lead Advisor)*

The safe handling and disposal of sharps is covered by the Trust Prevention of Injury from Needle sticks and Sharps Injuries policy which also sits with the Health and Safety team.

Audit of sharps waste is carried out by the sharps container provider on an annual basis; the last audit was completed in January 2018 and the results disseminated to Trust departments and reported through the Inoculation Incident group.

- Compliance with the policy is monitored on an ongoing basis by the H&S team and workplace Health and Wellbeing team via Datix incident reports.
- The Inoculation Incident group monitors incident trends and receives any risk assessment generated in respect of non-compliance.

Laundry

Laundry is managed by a provider at an off-site facility. In July 2017 two of the IP&C team consisting of a nurse and a support worker were part of a group that undertook a duty of care visit to the laundry in Derby. The purpose of the visit was to gain assurance that the proper procedures were being followed in managing the linen.

Hygiene Code Compliance Criteria 3:

Ensure appropriate antibiotic use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.

Prudent Use of Antibiotics *(information contributed by Specialist Antimicrobial Pharmacist)*

Antimicrobial Report 2017-2018

We have continued our programme of regular audits, policy review and ward rounds. We have worked towards achieving the targets laid out by reducing the impact of serious infections (Antimicrobial resistance and Sepsis) CQUIN. The Antimicrobial Subgroup Committee meets quarterly to review antimicrobial prescribing issues and reports to the Drugs, Therapeutics and Medicines Management Committee. The Lead Antimicrobial Pharmacist, assisted by Specialist Antimicrobial Pharmacist (Maternity Leave September 2017 onwards). Whilst the Specialist Antimicrobial Pharmacist has been on maternity leave we have had pharmacy support from a Band 6 pharmacist. A Consultant Microbiologist provides medical support.

Antimicrobial Ward Rounds

Weekly ward rounds included Acute Medical Unit, Vascular and General Surgery Ward, Surgical Wards and all Older People's Medicine (OPM) Wards and Orthopaedic Wards (Rounds on hold February 2018 due to staff shortages in Microbiology). These in addition to a number of other well established clinical rounds that include antimicrobial review - Critical Care Units and Haematology and Oncology.

The antimicrobial rounds review patients who are on IV antibiotics, two or more antibiotics, β-lactam/inhibitor combinations, cephalosporins, quinolones, gentamicin or vancomycin and these patients are discussed with clinical teams if any concerns are identified. The rounds also provide opportunity to promote IV to oral switch where appropriate, and encourage review of prescription in terms of rational choice and duration of the course.

In addition to the above, daily review of patients being treated with meropenem including attending the wards has taken place. Review of patients on piperacillin/tazobactum takes place when time allows.

Antimicrobial Consumption

Antimicrobial consumption is measured in defined daily doses (DDDs). This allows comparison across time and across institutions. We have a well-developed programme that allows us to monitor antibiotic use over time for anywhere in the hospital and prescribing statistics and trends are reviews as part of the standing agenda of the Antimicrobial Subgroup. There have been numerous national antibiotic shortages this year shortages, including piperacillin/tazobactum, meropenem and gentamicin which has been challenging. These combined with reduction in the reduction of use of broad spectrum antibiotics as part of the CQUIN have resulted in an overall increase in antimicrobial consumption in 2017-2018, with a corresponding reduction in consumption of piperacillin/tazobactum and carbapenems.

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Audit

Trust wide antibiotic audits to monitor and improve antimicrobial prescribing and use were carried out in January 2017, June 2017, November 2017 and May 2018.

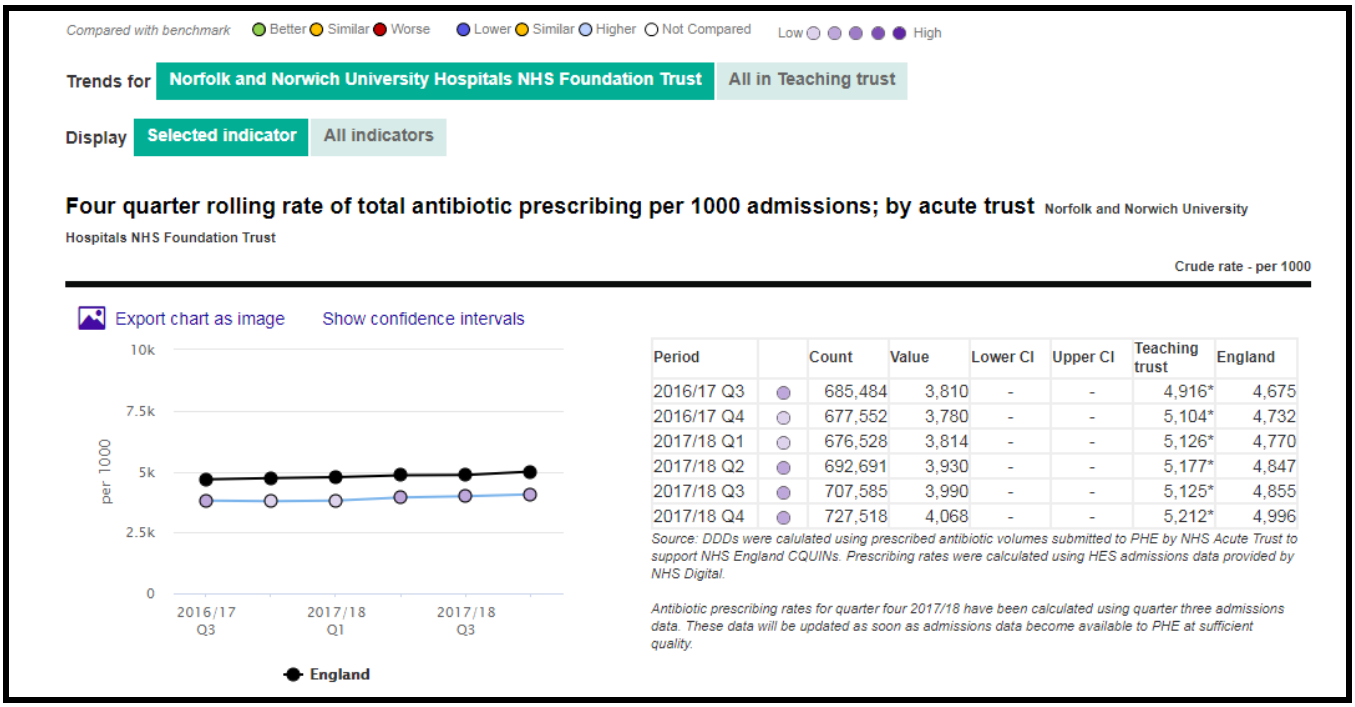
CQUIN

Since April 2016 antimicrobial stewardship has been a priority in the form of the Antimicrobial Resistance and Stewardship (AMR) CQUIN 2016-2017 and has been continued to be a part of the Sepsis CQUIN 2017-2018. The AMR section of the Sepsis CQUIN 2017-2018

1) Submission of consumption data to Public Health England for years 2017/18.
2) Reduction of 1% or more in total antibiotic consumption against the baseline (data collected quarterly with the final indicator value and reporting date being end of Quarter 4)
3) Reduction of 1% or more in carbapenem (data collected quarterly with the final indicator value and reporting date being end of Quarter 4)
4) Reduction of 1% or more in piperacillin-tazobactam (data collected quarterly with the final indicator value and reporting date being end of Quarter 4)

The final outcome decision from the CCG for 2017/18 is awaited. The graphs below are available from the Public Health England fingertips website and provide a graphical representation of the Trust's performance against these criteria.

Total antibiotic consumption



Period		Count	Value	Lower CI	Upper CI	Teaching trust	England
2016/17 Q3		685,484	3,810	-	-	4,916*	4,675
2016/17 Q4		677,552	3,780	-	-	5,104*	4,732
2017/18 Q1		676,528	3,814	-	-	5,126*	4,770
2017/18 Q2		692,691	3,930	-	-	5,177*	4,847
2017/18 Q3		707,585	3,990	-	-	5,125*	4,855
2017/18 Q4		727,518	4,068	-	-	5,212*	4,996

Source: DDDs were calulated using prescribed antibiotic volumes submitted to PHE by NHS Acute Trust to support NHS England CQUINs. Prescribing rates were calculated using HES admissions data provided by NHS Digital.

Antibiotic prescribing rates for quarter four 2017/18 have been calculated using quarter three admissions data. These data will be updated as soon as admissions data become available to PHE at sufficient quality.

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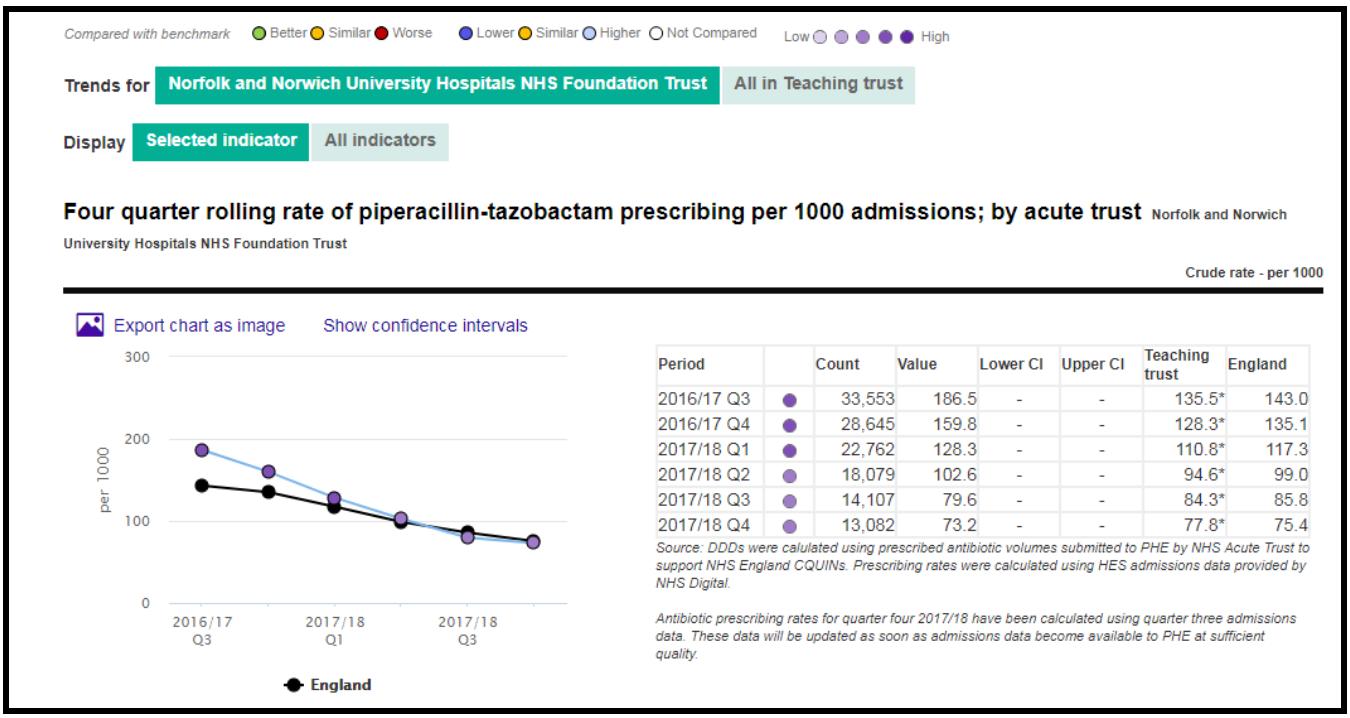
Pipercillin/Tazobactam consumption

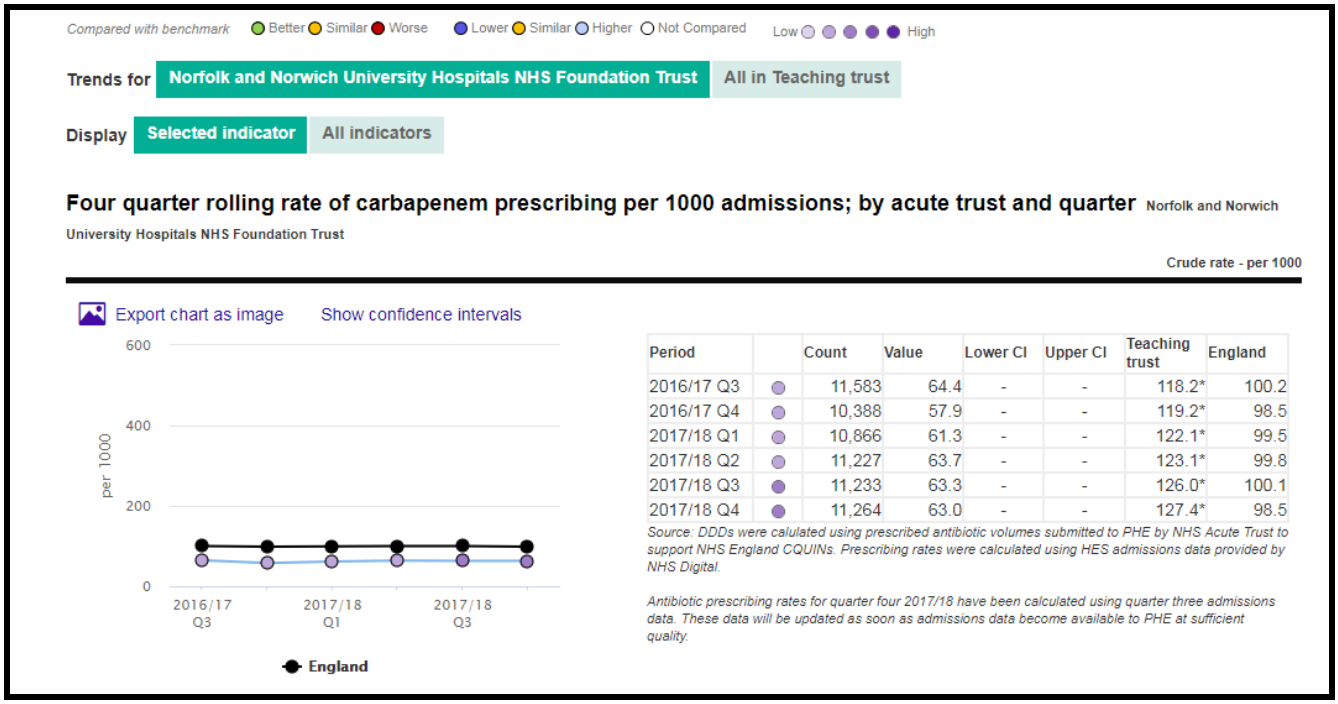


Period		Count	Value	Lower CI	Upper CI	Teaching trust	England
2016/17 Q3		33,553	186.5	-	-	135.5*	143.0
2016/17 Q4		28,645	159.8	-	-	128.3*	135.1
2017/18 Q1		22,762	128.3	-	-	110.8*	117.3
2017/18 Q2		18,079	102.6	-	-	94.6*	99.0
2017/18 Q3		14,107	79.6	-	-	84.3*	85.8
2017/18 Q4		13,082	73.2	-	-	77.8*	75.4

Source: DDDs were calulated using prescribed antibiotic volumes submitted to PHE by NHS Acute Trust to support NHS England CQUINs. Prescribing rates were calculated using HES admissions data provided by NHS Digital.

Antibiotic prescribing rates for quarter four 2017/18 have been calculated using quarter three admissions data. These data will be updated as soon as admissions data become available to PHE at sufficient quality.

Carbapenem consumption



Period		Count	Value	Lower CI	Upper CI	Teaching trust	England
2016/17 Q3		11,583	64.4	-	-	118.2*	100.2
2016/17 Q4		10,388	57.9	-	-	119.2*	98.5
2017/18 Q1		10,866	61.3	-	-	122.1*	99.5
2017/18 Q2		11,227	63.7	-	-	123.1*	99.8
2017/18 Q3		11,233	63.3	-	-	126.0*	100.1
2017/18 Q4		11,264	63.0	-	-	127.4*	98.5

Source: DDDs were calulated using prescribed antibiotic volumes submitted to PHE by NHS Acute Trust to support NHS England CQUINs. Prescribing rates were calculated using HES admissions data provided by NHS Digital.

Antibiotic prescribing rates for quarter four 2017/18 have been calculated using quarter three admissions data. These data will be updated as soon as admissions data become available to PHE at sufficient quality.

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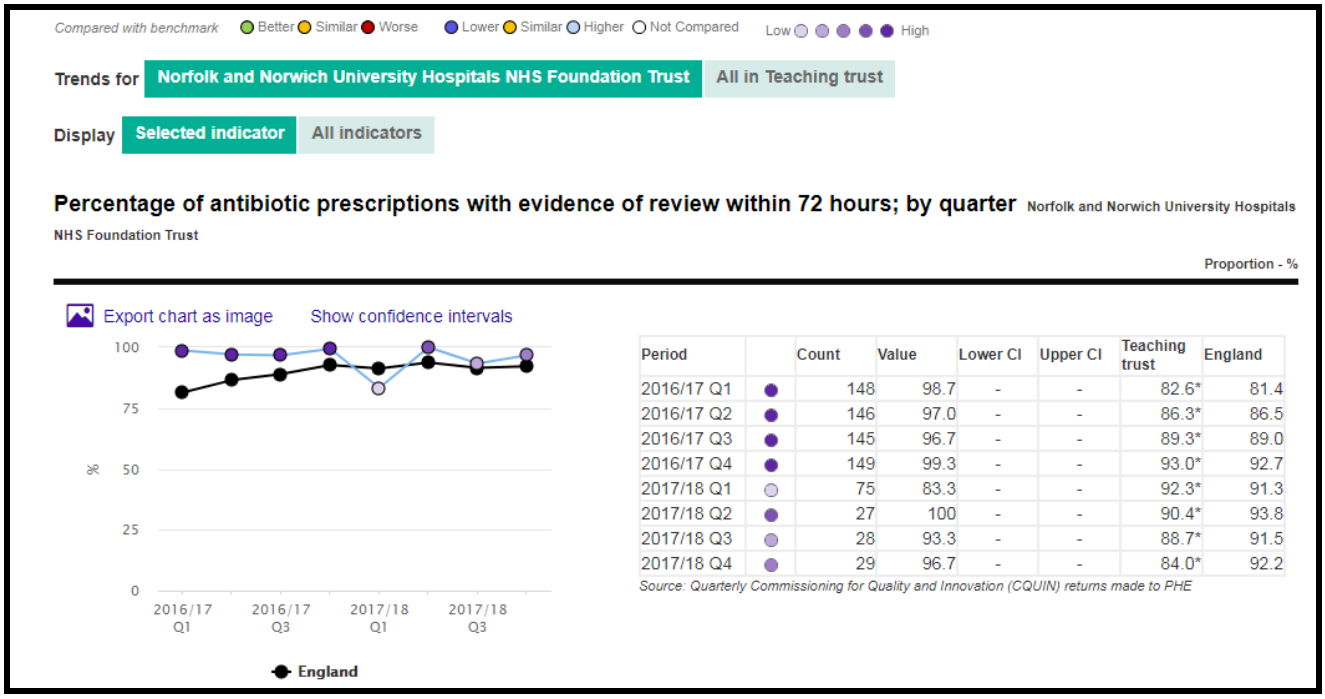
Evidence of 72 hour review



Period		Count	Value	Lower CI	Upper CI	Teaching trust	England
2016/17 Q1		148	98.7	-	-	82.6*	81.4
2016/17 Q2		146	97.0	-	-	86.3*	86.5
2016/17 Q3		145	96.7	-	-	89.3*	89.0
2016/17 Q4		149	99.3	-	-	93.0*	92.7
2017/18 Q1		75	83.3	-	-	92.3*	91.3
2017/18 Q2		27	100	-	-	90.4*	93.8
2017/18 Q3		28	93.3	-	-	88.7*	91.5
2017/18 Q4		29	96.7	-	-	84.0*	92.2

Source: Quarterly Commissioning for Quality and Innovation (CQUIN) returns made to PHE

A number of activities were undertaken to support the delivery of the CQUIN in 2017-2018

- **Attendance at Clinical MDT Meetings and Clinical Governance Meetings**
- **Presentations on Antimicrobial resistance**

The audiences were medical and clinical staff.

- **Attendance at national meetings**

The Consultant Microbiologist and Senior Antimicrobial Pharmacist attended National PHE Meetings on Antimicrobial Stewardship and the CQUIN. These were attended with a view to sharing and receiving ideas in relation to best practice.

- **Launch of Microguide™**

Microguide™ was launched in September 2017. Microguide™ is an app that can be that can be downloaded which contains the Norfolk and Norwich University Hospital Antibiotic Prescribing. The aim is to improve Antibiotic Stewardship as Clinicians will have to be up to date Antibiotic prescribing advice on their smart phone.

- **Trust-wide audits**

Whole Trust Point Prevalence Audits have been undertaken to inform the antimicrobial team of prescribing practices in January 2017, June 17, November 17 and May 18 and results circulated via HICC, Monthly Infection control report and AMSC.

- **Use of EPMA and IT**

Antibiotic reports are generated for the wards. Passwords are made available for clinical staff to log in and review these reports. Emails are sent to clinical staff to prompt their reviewing of these reports. We are currently in the process of developing lists of antibiotics per consultant which should be more useful for the medical staff.

- **Revisions to Antibiotic Policies and development of new Policies**

All existing Trust Antimicrobial Policies have been reviewed and relaunched to provide alternative choices to the use of pipercillin/tazobactam and meropenem where clinically safe. In addition we have reviews the policy to reduce the use of Clarithromycin and Co-amoxiclav which are in the watch category. Wherever appropriate, the antimicrobial team have met with specialty Consultants to discuss and agree modifications to policy.

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- **Representation at appropriate committees**

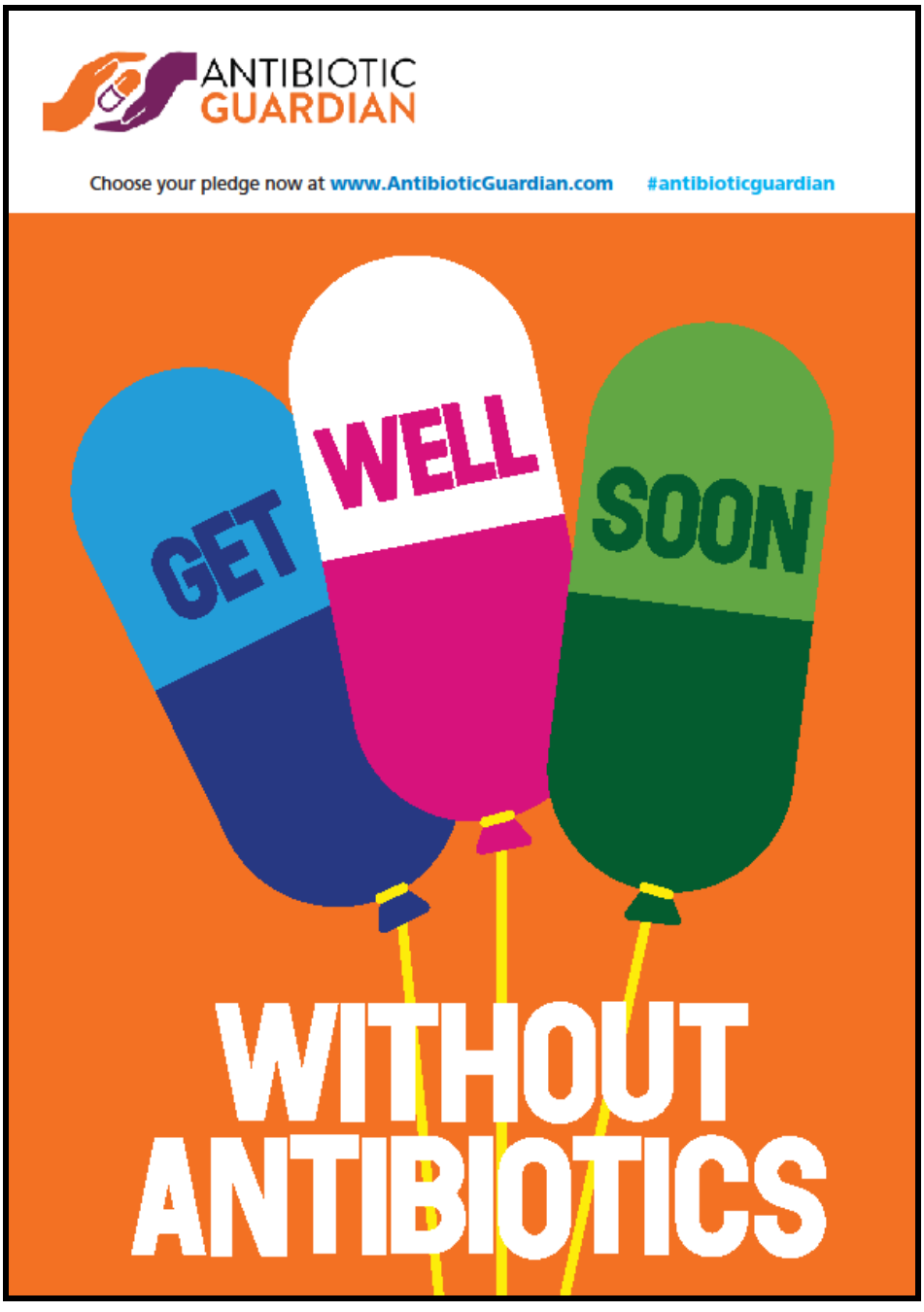
Drugs, Therapeutics and Medicines Management Committee (DTMM), Hospital Infection Control Committee (HICC) and CCG Antimicrobial Subcommittee.

Forward Planning

Team plans for 2017-18 include:

- Continuation of antimicrobial ward rounds
- Supporting the Sepsis CQUIN including continuation of ward rounds aimed at reducing the use of piperacillin/tazobactam and meropenem
- Trust wide audits

Antibiotic Guardian, developed in 2014 by Public Health England.



Hygiene Code Compliance Criteria 4:

Provide 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

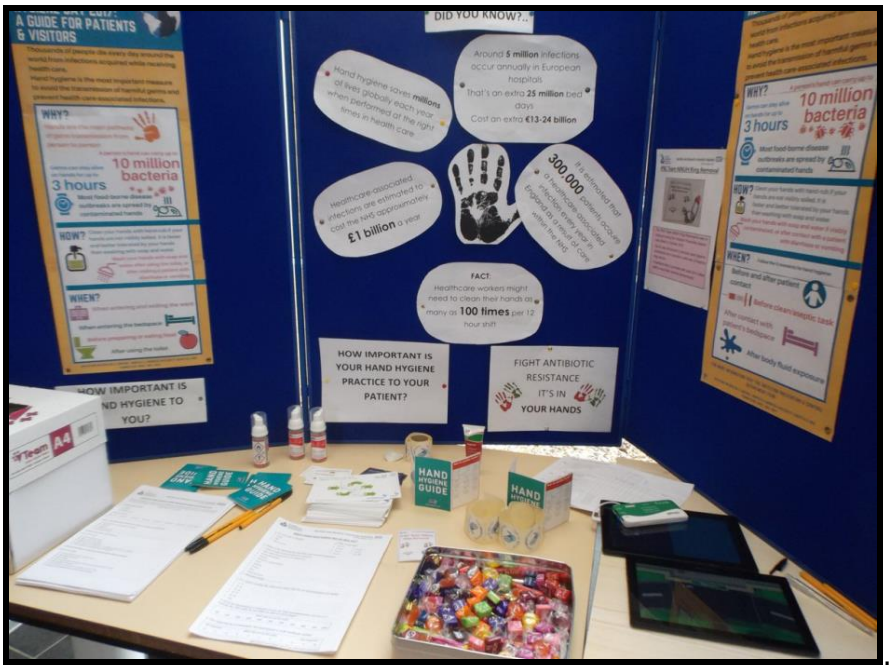
Information for Service Users, Visitors and Carers

The IP&C team work closely with the communications department especially over the winter when Norovirus and Influenza are circulating in the community. IP&C information is shared in a number of ways including:-

- Face to face discussion
- Awareness campaigns
- Information leaflets
- Trust information booklet
- Noticeboards
- Switchboard answer phone messages
- Press statements via the NNUHFT web site
- Via local radio and media
- Social networking e.g. Twitter and Facebook

The IP&C team have developed a number of information leaflets for service users, visitors and carers to cover all the main infections and infection prevention. These and other information about IP&C can be found on the NNUHFT website.

When promoting awareness campaigns the IP&C team include service users, visitors and carers and make themselves easily accessible to the public by siting themselves in a public areas as well as attending clinical areas.



Hand Hygiene day stand in Public Area, May 2017

Hygiene Code Compliance Criteria 5:

Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people.

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

Alerts allow for prompt management of patients from the outset of their contact with the hospital where a previous alert organism has been detected. Alerts are set as an icon on the patient administration system which is used widely throughout the Trust. There are also alerts on the pathology system where staff can order tests and review results, plus a specific software package with alerts set to inform the IP&C team of potential risks or an increase in numbers of a given organism in one clinical area. Non-urgent results are reviewed at a weekly surveillance meeting with the ICD.

There are 2 electronic boards designed by the IP&C team which are available on the intranet and staff at a glance can see if any areas of the Trust have. It also shows community healthcare settings that have suspected or confirmed Norovirus or Influenza outbreaks.

The Trust has a policy to screen all emergency and elective admissions for MRSA. This enables any patients found to be positive whilst in the Trust to have topical decolonisation and if required antimicrobial treatment.

MRSA Screening for Emergency and Elective Patients for 2017-18	
	Total Percentage Screened
Elective Screened Patients	94.1%
Non- Elective Screened Patients	96.3%

As discussed earlier there is a screening process in place for patients that may be at risk of CPE or are a previously known case.

Carbapenamase-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
2017-18	**161**	**129**	**28**	**318**
2016-17	**138**	**91**	**4**	**233**

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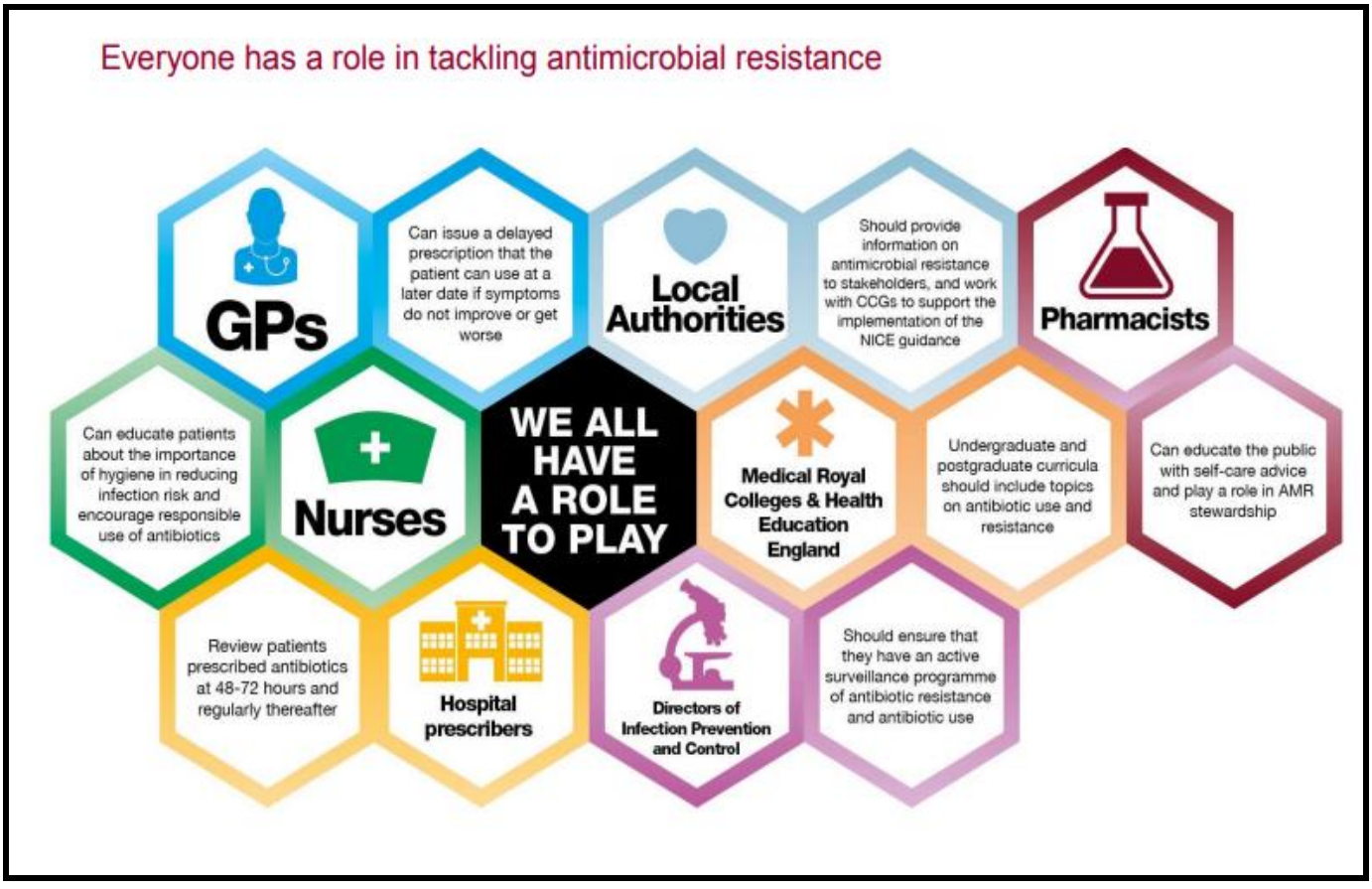
Period of Increased Incidence (PII) and Supportive Measures

IP&C Supportive Measures are undertaken for areas having a PII, 2 or more HAI *C. difficile* or MRSA results are received from the same ward within 28 days the IP&C team support ward areas with additional audits and education. These measures aim to support and educate staff to reduce PII of infection. Ward staff are encouraged to become involved early in the intervention so that they understand clearly what measures are required to reduce the risks of cross infection. These audit results are monitored weekly by the IP&C team and additional interventions planned with the ward management team if required.

In 2017/18 we created a set of respiratory supportive measures audits and checks for wards affected by multiple cases of HAI Influenza.

Number of episodes of supportive measures due to a PII			
Financial Year	**MRSA**	***C. difficile***	**Influenza**
2017-18	**0**	**5**	**4**
2016-17	2	3	N/A
2015-16	4	6	N/A

Antibiotic Awareness Key Messages 2017, PHE



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Indwelling Device and Surgical Site Care Bundle Audits

Care bundles aim to improve care standards and patient outcomes by promoting the consistent implementation of a group of effective interventions. Care bundle audits are carried out regularly across the Trust for insertion and ongoing care of indwelling devices. This provides assurance and reduces risk of device associated infection. These audits included peripheral cannulas, central venous catheters, renal catheters and urinary catheters and the care bundle to prevent ventilator associated pneumonia is also audited. Any areas of non-compliance are highlighted so that action to improve can be taken.

Comparison of NNUHFT high impact intervention scores		
High Impact Intervention care bundle audit	2016/17	**2017/18**
Central venous catheter care	89%	**93%**
Peripheral intravenous cannula	82%	**84%**
Renal dialysis catheter	95%	**100%**
Ventilated patients	91%	**98%**
Urinary catheter	90%	**90%**
Surgical site infection	71%	**67.5%**

The care bundle to prevent SSI was also audited in a various specialities. Results of practice audits were fed back along with SSI rates for those areas with SSI Surveillance in place, continuing to promote the reduction of SSI.

In 2017 the One Together Assessment toolkit was used as a collaborative initiative between orthopaedic theatres and Infection Prevention & Control. Reducing SSI remains a priority for the Trust

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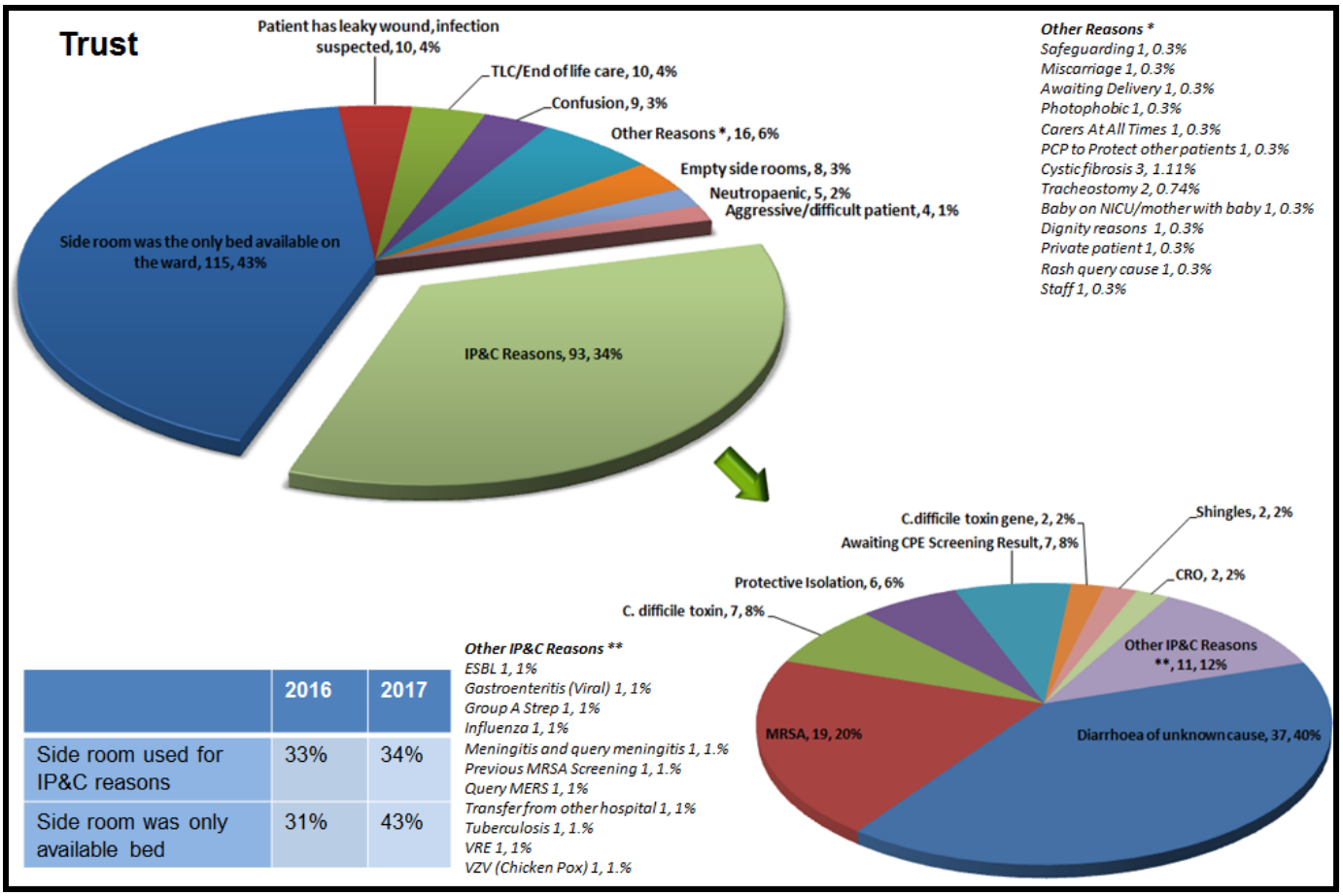
Audit of Compliance with Isolation Guidelines and Single Room Use

The IP&C team undertook the annual audit of compliance with isolation guidelines and single room use in September 2017. This involved an audit of the isolation of all patients with suspected or confirmed infection. As single rooms are required for the isolation of these patients this audit also looked at the percentage used for IP&C purposes. This has remained consistent at 30-40%. A number of patients go into a single room from the outset e.g. patients admitted with diarrhoea until an infectious cause can be ruled out.

99% of patients requiring isolation for IP&C reasons were placed in a single room. There will be a small group of patients any one-time that for various reasons isolation in a single room may not be in their best interests and this will be risk assessed and alternative measures will be implemented.

Compliance against the audit standards was 79% with the main issues being doors left open and rooms not having dedicated observation equipment. Audit results were shared with the clinical staff via meetings and reports. Action plans were sent to ward managers.

The Ward view bed management system used across the Trust enables documentation of who requires an isolation room and therefore helps facilitate getting the patient into the correct bed.



	2016	2017
Side room used for IP&C reasons	33%	34%
Side room was only available bed	31%	43%

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Central Venous Catheter (CVC) Surveillance

Ongoing surveillance of CVCs in adults continued during 2017-18 and infection rates have remained consistently below the Matching Michigan reference point of 1.4 per 1000 line days. These results are fed back via the IP&C monthly report and also at sessions provided to educate staff on the best evidence based practice when managing these lines.

The renal unit have not reported any blood stream or exit site infections during 2017-18.

Comparison of NNUHFT CVC related infections		
CVC infections are measured per 1000 line days	2016/17	**2017/18**
Renal	0.85%	**0%**
Haematology	1.7%	**2.4%**
Other areas	1.09%	**1.1%**
Overall	0.31%	**0.46%**

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

Hip, Knee and Fracture Neck of Femur

The Trauma and Orthopaedic department undertakes continuous SSI Surveillance for Hip and Knee replacements and fracture neck of femur procedures. One quarter is reported each year to PHE. October– December 2017 was the mandatory quarter completed during this period.

The validated rate of infection (identified prior to discharge and on readmission) for orthopaedic hip replacement surgery in 2016/17 was 0.32% (2016/17 PHE bench mark 0.6%) and in year 2017 it was 0.63%.

The validated rate of surgical site infection for knee replacement surgery in 2016/17 was 1.1% in 2016/17 (PHE bench mark 0.6%) and in year 2017 it was 0.39%.

The validated rate of infection following repair of neck of femur in 2016/17 was 0.12% (PHE bench mark 1.0%) and in year 2017 it was 0.57%.

The 2017/18 PHE bench mark was not available at time of report.

Spinal Surgery

Quarter 1 and 4 of spinal SSI Surveillance were undertaken during 2017.One post discharge SSI was identified during this time, 0.58% Incidence (PHE bench mark 1.4%).

Other Surgical Site Surveillance

Vascular surgery surveillance

The vascular SSI has been ongoing since 2009, with rates between 3.2 and 10.8% throughout 2017-18. Only 2 out of 25 SSIs were identified during a hospital stay with the remainder detected post discharge. 84% of these SSIs were superficial. A Post Discharge Programme (PDS) aims to identify true levels of SSI as patients often have short hospital stays. The SSI Surveillance programme runs in conjunction with an audit programme to promote a high standard of clinical practice.

Post vascular surgery surgical site infection rates				
Year	**April-June SSI %**	**June-July SSI %**	**Oct-Dec SSI %**	**Jan-March SSI %**
2017-18	**7.7%**	**10.8%**	**6%**	**3.2%**
2016-17	3.4%	2.4%	0%	3.7%

Caesarean section surgery

A Caesarean section SSI surveillance programme was developed and piloted in June 2010. Infection rates have been reduced substantially from an initial 19% to 5.2%. Joint working between IP&C and the obstetric teams along with feedback of results and staff education have helped to sustain this. The SSI care bundle audits were audited alongside this to promote best practice.

Post caesarean section surgical site infection rates				
Year	**April-June SSI %**	**June-July SSI %**	**Oct-Dec SSI %**	**Jan-March SSI %**
2017-18	**5.5%**	**2.4%**	**1.7%**	**5.2%**
2016-17	3.4%	4.8%	3.8%	1.7%

PHE reported 9.6% Caesarean section wound infections; the Trust continues to remain well below this national average.

Audit Programme

As referred to elsewhere in sections of this report a comprehensive programme of audits is in place across the Trust with the aim to promote high standards and reduce infection risk.

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Hand Hygiene and Dress Code Audits

Hand hygiene audits involve direct observation throughout the Trust. Results are fed back at the time of audit and displayed on the intranet for comparison. An action plan is sent to areas scoring less than 95%. Support and education from the IP&C team along with leadership in clinical areas work together to achieve 100% compliance. Where there was a breach in the World Health Organization (WHO) 5 moments of hand hygiene, staff are encouraged to utilise an interactive 5 moments of care game.

http://www.npsa.nhs.uk/cleanyourhands/resource-area/wi-five-game/

Number of hand hygiene and related dress code audits and average percentage pass in NNUHFT			
Financial Year	Number of Audits	Percentage Pass	
		Hand Hygiene	Dress code
2017-18	**737**	**97%**	**99%**
***2016-17**	569	97%	99%
2015-16	703	98%	99%
***Frequency of re-auditing for scores >95% changed in 2016-17 from monthly to 2 monthly. Scores <95% lead to a re-audit within 1 week.**			

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Hygiene Code Compliance Criteria 6:

Systems to ensure that all care workers (including contractors and volunteers) are aware of the discharged 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 staff meetings, ad hoc education and teaching and planned study and awareness raising days.

There is in place the Trust official visitors and contractors procedure document and along all with all policies and guidelines is available to staff via the intranet. IP&C specific documents are on the intranet, IP&C department page or as a shortcut on the desktop screen of each PC monitor and can be accessed by clicking on the NNUHFT IP&C symbol.

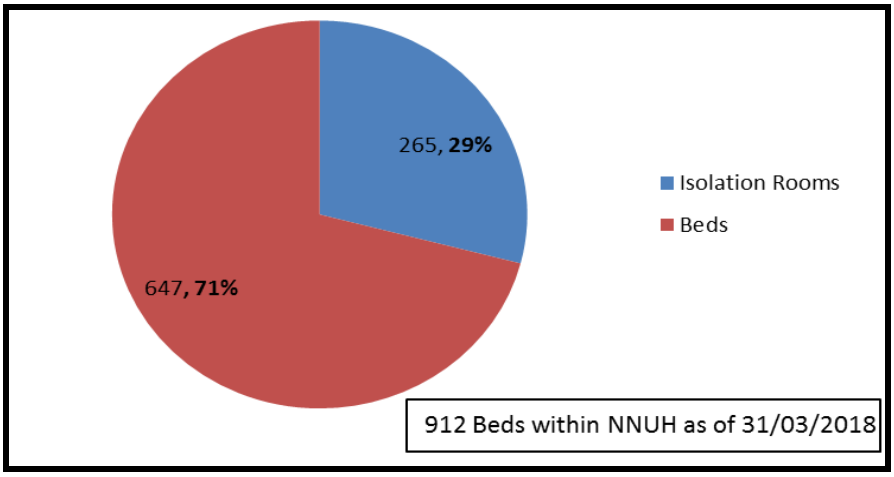
Hygiene Code Compliance Criteria 7:

Provide or secure adequate isolation facilities.

When carrying out our annual isolation audit we found that over 99% of patients who should have been isolated due to IP&C reasons were in a single room.

NNUHFT has a number of single rooms of which the majority are en-suite on each ward 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.

The operations team have an electronic board for monitoring single room usage and there is a priority chart in the isolation guidelines to assist staff in making the safest decision should there be a shortage of single rooms.



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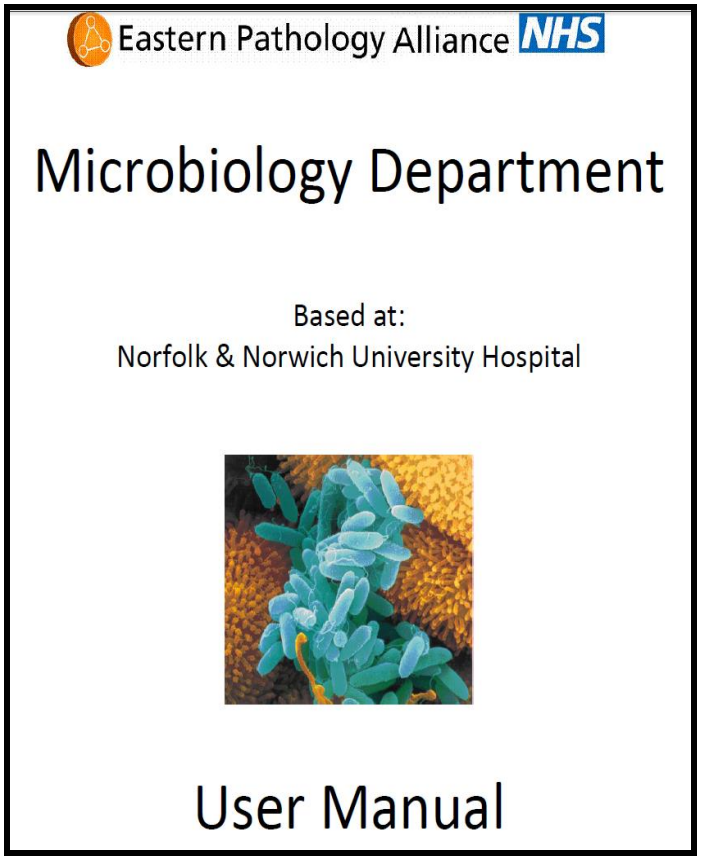
Hygiene Code Compliance Criteria 8:

Secure adequate access to laboratory support as appropriate.

Laboratory (Information taken from Eastern Pathology Quality Manual, November 2017)

The laboratory services for NNUHFT 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 labs at the 3 acute hospitals in Norfolk. Microbiology is centralised at the Norwich Research Park Innovation Centre (NRPIC) close to the main NNUHFT site and provides services to all three Trusts and to GPs. It is divided into Bacteriology, Virology, Serology and Molecular Sections.



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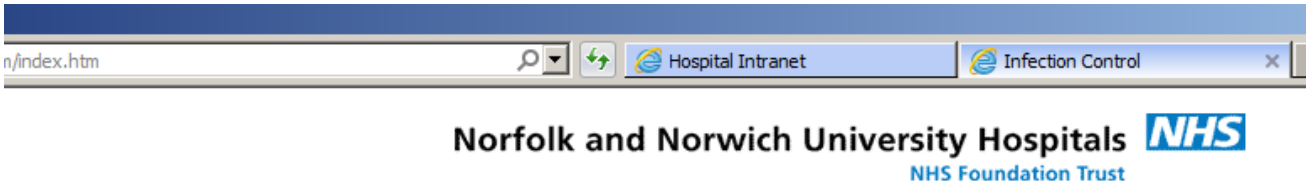
Hygiene Code Compliance Criteria 9:

Have and adhere to policies, designed for the individual's care and provider organisations that help to prevent and control infections.

IP&C Policies

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

There is a robust process within the Trust for monitoring review dates and following review the IP&C team communicate via the communications bulletins that a document has been reviewed. The status of IP&C documents is also reported at the hospital infection control committee meetings.



Policies and Guidelines

- Audit and Surveillance, reporting for Infectious Disease, Healthcare Associated Infection and Post Infection Review
- Carbapenemase-producing Enterobacteriaceae (CPE) Management
- Cleaning and Disinfection of Hospitals
- Cleaning and Disinfection of Mattresses, Dynamic Pressure Relieving Systems, Pillows and Bedframes
- Clostridium Difficile
- Diarrhoea Assessment & Management
- Hand Hygiene
- IGAS Management
- Isolation Procedures
- Lice
- Major Outbreaks Management
- Meningitis Management
- Middle East Respiratory Syndrome-Coronavirus (MERS-CoV)
- MRSA Management
- MRSA Screening
- Prevention and Control of Multidrug Resistant Organisms
- Plan for Management of Seasonal Influenza
- Prion Disease (Transmissible Spongiform Encephalopathy) Management
- PVL Staphylococcus aureus in Adults - screening and treatment
- Scabies Management
- Tuberculosis
- Trust Guidelines for the Prophylaxis and Treatment of Seasonal (Non-Pandemic) Influenza in Adults/Children
- Viral Gastroenteritis (eg Norovirus, Rotavirus) Management
- VHF Management
- VZV Management

Hygiene Code Compliance Criteria 10:

Providers have a system in place to manage the occupational health needs of staff in relation to infection.

Workplace Health and Well-Being (*information contributed by head of WHWB)*

All staff have access via self-referral route to gain appropriate occupational health advice. Monday - Friday 08.30am - 17.00 OH advice is available via our OH Duty nurse. Out of hours infection related OH advice is available via the 24/7 website on our intranet.

Full suite of WHWB in house procedures available in relation to prevention and management of communicable infections. Trust guidelines are also present. Examples of some guidelines enclosed. Easy accessible advice for staff is found via the 24_7 pages . Policies created by the infection control team are reviewed by WHWB. Immunisations for staff are available and provided in line with Green Book

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. At the time of the assessment the relevant immunisations are offered whilst advising the worker the importance of complying with Public Health England 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.

In line with PHE guidance all staff can access a test for Hep B / C or HIV if requested. Those staff who are Exposure Prone procedure workers will have the appropriate tests prior to undertaking this activity. 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.

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

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

The annual flu vaccination programme is co-ordinated by WHWB each year. This vaccination is offered to all staff and in 2017-18 a total of 77% of Trust staff received the vaccine.

Conclusion

There has been a high level of engagement from staff who again worked collaboratively with the IP&C team to maintain the high standards we strive for. This year successes to note are:-

- Highest rating of green for NNUH following NHSI IP&C inspection
- No hospital attributable MRSA bacteraemias
- *C. difficile* objective met
- Central line associated infections remained at a low level

Pets as therapy dogs

IP&C were involved from the outset of this project and offered support and guidance to address infection prevention concerns so that within certain areas of the hospital some of the patients (and staff) could benefit from this service.

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References

Clostridium difficile infection objectives for NHS organisations in 2017/18 and guidance on sanction implementation, NHSI, March 2017, available at: https://improvement.nhs.uk/uploads/documents/CDI_objectives_201718_final_2.pdf

Guidance on the reporting and monitoring arrangements and post infection review process for MRSA bloodstream infections from April 2014 (version 2), NHS England, April 2014, available at: https://improvement.nhs.uk/uploads/documents/post-infection-guidance.pdf

Guidance for the laboratory investigation, management and infection prevention and control for cases of *Candida auris,* PHE, August 2017 v2.0 available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/637685/Updated_Candida_auris_Guidance_v2.pdf

Infection Prevention and Control Commissioning Toolkit Guidance and information for nursing and commissioning staff in England, RCN and IPS, January 2016, available at: file:///C:/Users/SJM7/Downloads/005375%20(1).pdf

One Together Infection Assessment Toolkit, AfPP, IPS, CODP, RCN, 3M available at: https://www.ips.uk.net/professional-practice/onetogether-infection-control-assessment-toolkit/

Preventing healthcare associated Gram-negative bloodstream infections: an improvement resource, PHE, May 2017 available at:
https://improvement.nhs.uk/uploads/documents/Gram-negative_IPCresource_pack.pdf

Saving Lives: reducing infection, delivering clean and safe care, DH, June 2007, available at: http://webarchive.nationalarchives.gov.uk/+/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_078134

The Health and Social Care Act 2008 Code of Practice on the prevention and control of infections and related guidance, DH, July 2015 available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/449049/Code_of_practice_280715_acc.pdf

REPORT TO THE TRUST BOARD OF DIRECTORS

Date	**30 November 2018**
Title	**NNUH Digital Strategy 2018 – 2022**
Author & Exec lead	**Anthony Lundrigan CIO**
Purpose	**For Approval**

1. Background/Context

The NNUH digital strategy outlines the Trusts ambition to deliver care in new and innovative ways. Digital health refers to transforming the way we deliver care to our patients in a sustainable, efficient and effective way utilizing technology, infrastructure, devices and information. The challenges we face in the health service are well known – we strive to improve our clinical quality, operational performance and financial management. Now is the time to think in a different way to deliver our ambition.

This document sets out what you can expect from the Digital Health Team in 2018-2022. It is based on a series of sessions and interviews with a range of staff and patients, which took place in the summer of 2018.

2. Key issues, risks and actions

a. BAF 3.1
b. Improving clinical safety
c. Improving efficiencies in process
d. Improving capability for research
e. Meeting NHS Standard Contract obligations
f. Improved activity and income opportunities
g. Supports CIP delivery
h. Improved activity and income opportunities
i. Protection of patient data
j. Supports new models of care
k. Continuity of hospital services

3. **Conclusions/Outcome/Next steps**

a. The attached draft Strategy has been produced through a period of consultation with clinical and non-clinical teams and it has been discussed by the Hospital Management Board.
b. It also reflects ongoing discussions with partner organisations in the STP and is consistent with our joint ambition to develop digital maturity across the county.
c. If approved by the Board, we will develop plans for implementation of the various elements of the Strategy. It is anticipated that this will be overseen by the Clinical Informatics and Technology Committee which reports to the Hospital Management Board.
d. Progress reports and business cases will be submitted to the Finance and Investments Committee in accordance with its Work Programme
e. The Board will be kept updated with reports through the Finance and Investments Committee and otherwise as delegated authority limits require;
f. It is suggested that an overarching progress review should be scheduled for the Board to receive in 6 or 12 months' time.

Recommendation:

The Board is recommended to:
- consider and approve the draft Digital Health Strategy 2018-2022
- advise as to when it wishes to receive a formal update on progress on implementing the Strategy.

Strategic Objective 3 - We will be a centre of excellence for research, education and innovation

Threat 3.1 Limited functionality of integrated IM&T threatens to restrict research potential and clinical innovation		How assured is the Board that controls are adequate & effective?
Desired outcome or deliverable: Plans are established to increase use of IM&T and take maximum advantage of available opportunities and funding for IM&T development		A
Associated indicators or measures of success 1. Increased use of electronic communication with patients 2. Increased use of electronic communication with GPs 3. Increased connectivity with QI, UEA & NRP 4. Increased availability of remote working opportunities 5. Increased capacity for joint working with East Anglian Trusts	**Review Process and Dates:** Board of Directors 28/9/2018 Finance and Investments Committee 25/6/18 & 17/9/18 Audit Cmttee: 12/09/18 Management Board: 25/9/18	↔

Key controls, inputs & actions (policies / procedures / structures etc)	**Sources of assurance (+ve)** (i.e. evidence that the controls are effective – e.g. reports from assurance committees, surveys, internal or external audits and reports)	**Gaps in control/assurance (-ve)** (concerns or evidence that existing controls are not wholly effective)
• Increased usage of scanning to convert current paper records to digital • 5-yr IM&T Strategy (2015-20) in place • Remote working policy and solution to support off -site, NRP and home workers. • Joint CIO recruited with STP (October 2017) • Project to explore options on EDMS approved by HMB (31.11.17) • Project to implement electronic referral system in 2018 underway & subject to MB monitoring (July 2017) • Migration to Microsoft Office 365 (December 2017) • HMB review of plans for £7m STP funding for digital projects (Oct '18) • HMB approval for core cyber security investments • Draft Digital Strategy reviewed by Trust Board (Nov 18)	• Benefits derived from EPMA investment demonstrated in report to MB (May 17) • Corporate Trustee agrees charitable funding for Community Midwives lap-tops (April 17)	• No identified funding for major investment in IM&T • We do not have a timetable for ePR procurement. • IA review of IT Disaster Recovery arrangements provides only '*partial assurance*' (Dec 17) • Ageing IT infrastructure rated 20 on High Risk Tracker (Sept '18) • Model Hospital data demonstrates extreme digital immaturity of all acute hospitals in Norfolk (Nov 18)

Any additional actions planned or required:	**Timescale**	**Lead**	**Update**
1. Updated ToRs for Clinical Informatics and Technology Committee to be established	December 18	AL	For HMB review

REPORT TO THE TRUST BOARD

Date	**30th November 2018**
Title	**Quality Programme Board update following 6th November meeting**
Author **Exec lead**	**Jane Robey, Head of Improvement** **Nancy Fontaine, Chief Nurse**
Purpose	**For Information**

1 Background/Context

The Quality Programme Board met on 6th November 2018.

The following documents are attached:

a) Agenda
b) Change Control Report
c) Evidence Group Outcome Report

2 Key Issues/Risks/Actions

Items of note considered at the meeting included:

	Issues considered	Outcomes/decisions/actions
1	Highlight reports from exec and functional areas	In October, of the 82 Must do & Should do actions, we have : 5 (7%) Blue 4 (6%) Red 28 (42%) Amber 25 (37%) Green
2.	Change control process	• During October, all 300+ subsidiary actions underpinning the original 82 'must do' and 'should do' recommendations were reviewed for relevance and appropriateness. Actions that did not address the original 82 recommendations were either closed or moved to the stage 2 plan. • A similar review was conducted on the target completion dates. The review determined that many of original target completion dates were unrealistically optimistic. Where this was the case, the original date was retained as an audit trail, but a supplementary 'Outcome Target Date' was also set. The Quality Programme Board approved these changes.
3.	Outcome of the Evidence Group	• The inaugural QIP Evidence Group met on 1st November, to review the evidence in respect of ten recommendations. The group included Trust and External partners, including the Chief Nurse, Medical Director, NHSi Associate Director of Improvement and a CCG representative. • The group reviewed the evidence provided for suitability, relevance, and completeness, using an appreciative enquiry approach. The aim was to assess if the evidence supplied by the SRO and action leads provided sufficient assurance that the Recommendation and Outcome Statement had been met. • Six of the ten recommendations were approved as BLUE, and review dates were set for each to monitor that the improvement is sustainably embedded.

4.	Routine Provider information Return (RPIR) request	The CQC Routine Provider information Return (RPIR) request was received by the Trust on 16th October; the deadline for submission of the completed return was 6th November. Our submission was returned within this deadline. The group discussed the self-assessment ratings and agreed some amendments. The return was submitted within the deadline.
5.	Risk register	No new risks we added to the Risk Register.

3 Conclusions/Outcome/Next steps

The Quality Programme Board is scheduled to meet again at 9am on Tuesday 11th December 2018, at which meeting the Committee will review:

- Highlight reports from Trust-wide and functional areas for November
- Recommendations assured as 'Complete and Evidenced' by the Evidence Group

Recommendation:

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

QUALITY PROGRAMME BOARD AGENDA

Tuesday 06th November 2018 Boardroom 0900-12:00 Hours

	Item	Lead	Purpose	Format
1.	Apologies and declarations of interest	CEO		Verbal
2.	Review of actions, minutes and matters arising	Exec Directors and CODs	To note and discuss	Document
3.	Review of OAG agenda and minutes (if ready in time for this meeting)	CEO	Discussion	Document
4.	Routine Provider information Return (RPIR) request	Rosemary Raeburn Smith	Discussion	Document
5.	Change Control Process	Rosemary Raeburn Smith	Discussion	Document
6.	Outcome of Evidence Group	Rosemary Raeburn Smith	Discussion	Document
7.	Power Bi presentation of latest data	Pete Best	Discussion	Live presentation
BREAK				
8.	Highlight reports from Trust-wide and functional areas, focusing on: - Blue recommendations (complete and evidenced) - Red recommendations (Off track) Any successes or concerns that SROs wish to particularly highlight	Exec Directors and CODs	To note and discuss	Slide presentation
9.	Risks and issues	CEO	Discussion	Document
10.	AOB			

Date and Time of next meeting: Tuesday 11th December 2018, 09:00 hours, Boardroom

Change Control – November QPB

Actions closed in November

Recommendation	Action	Status
TW 2.1.12 Review existing temporary role of Matron and Named Doctor for MCA and DoLs	TW 2.1.12 Review existing temporary role of Matron and Named Doctor for MCA and DoLs TW 2.1.13 Identify a clinical champion for MCA & DOLS in each Division	Substantive matron appointed Named Doctor identified Work ongoing to identify divisional clinical champions
TW 4a.1: The trust must ensure that there is an effective process for quality improvement and risk management in all departments	TW 4a.1.2 Build a QI faculty to include Improvement coaches, data analysts, training packages and provide support & facilitation to teams to deliver QI projects linked to leadership development & achievement of Trust objectives TW 4a.1.3 Maintain a central record of QI projects mapped to department / division & strategic objectives TW 4a.1.4 Build / source a reporting system to enable teams to clearly demonstrate improvements TW 4a.1.5 Develop a robust plan for spread & sustainability through the QI faculty TW 4a.1.6 Create a QI faculty	The original action is a longer term goal and will span a period of three to five years and will form part of stage 2. Once the QI strategy and implementation plan are agreed there will be a mobilisation plan. Moved to Stage 2 of plan Moved to Stage 2 of plan Moved to Stage 2 of plan Moved to Stage 2 of plan
TW 5.1 The trust must ensure that local audit findings are utilised to identify actions for improvement and that these are monitored, and reviewed.	TW 5.1.3 Effective and timely implementation of clinical audit outcomes will be reviewed at Divisional Management Board meetings	Combined with TW5.1.2
TW 13.1: Ensure that there are effective systems and processes in place to ensure assessing the risk of, and preventing, detecting and controlling the spread of infections, including those that are healthcare associated	TW 13.1.4 Internal self assessment against IPC Governance processes and action taken in accordance with findings	Action closed covered in action plan arising from 13.1.1

Recommendation	Action	Status
TW 16.1The trust must ensure that patient venous thromboembolism (VTE) risk assessments are completed	TW 16.1.1 Trust thrombosis lead to review Trust Policy to ensure VTE risk assessment requirements for ambulatory patients is explicit. TW 16.1.4 Monitor compliance monthly to include analysis of individual performance	No mention of VTE assessment of ambulatory patients can be found in the CQC documentation. Covered by other actions
TW 19.1: The trust must ensure that the healthcare records for patients' (requiring assessment for restrictive intervention) *subject to restraint* are complete and in line with the trust's policy and procedure.	TW 19.1.2 Review current documentation and risk assessment in use to determine whether it is easy to use and fit for purpose	Action closed
TW 20.1: The trust must ensure that lessons learnt from concerns and complaints are used to improve the quality of care. This will integrate the 'Patient Voice'	New action: Patient Experience and Engagement team co designs service improvements with patients and carers	Moved to Stage 2 of plan
TW 22.1 Review 'do not attempt cardio-pulmonary resuscitation' (DNACPR) forms to ensure they are completed fully and in line with trust policy and national guidance.	TW 22.1.6 External review of progress to date since CQC recommendations of 2015.	Move to stage 2 plan DNACPR improvements presented to OAG September 18.
TW 23.1: The trust must ensure that incidents are reported and investigated in a timely way by trained investigators.	TW 23.1.6 Ensure learning is shared via Governance groups and outpatient forum.	Action closed. Part of SIG work. Learning will be shared via Safety Matters Wise OWLs.
TW 27.1: The trust should ensure that the management of referrals into the organisation reflects national guidance in order that the backlog of patients on an 18-week pathway are seen.	TW 27.1.1 Develop Outpatient Productivity Programme TW 27.1.4 Deliver the Remedial Action Plan for RTT as agreed with CCGs	Added as new action to Outpatients section Moved to Stage 2 Plan
TW 30.1: Ensure morbidity and mortality meeting minutes include sufficient detail of background information, discussions and those in attendance.	TW 30.1.3 Discuss output from specialty M&M to the Divisional Governance group and Trust Mortality group to ensure learning is shared.	Moved to stage 2 plan
TW 29.1: The Trust should ensure that complaints are responded to in line with the complaints policy deadline of 25 working days	TW 29.1.1 Trust review of Complaints policy and reporting TW 29.1.2 Review current processes in place with recommendations for improvement and escalation	Action complete Action complete

Recommendation	Action	Status
	TW 29.1.3 Implement recommendation TW 29.1.4 Regular audit of compliance TW 29.1.5 Agree improvement trajectory	Action closed Action complete Action complete
TW 32.1: The trust should continue to monitor and actively recruit to ensure that there is an adequate number of nursing staff with the appropriate skill mix to care for patients in line with national guidance.	TW 32.1.2 Review e-rostering policy	Action removed covered in e-Roster project
TW 36.1: The trust should review its communication aids available to assist staff to communicate with patients living with a sensory loss, such as hearing loss	TW 36.1.3 Procure required equipment TW 36.1.4 Review process of enhanced care provision Trust wide via Mental Health Board	Moved to Stage 2 of plan Action removed covered in MH section
S 1.1: The Trust must ensure that leadership, culture and behaviours within the operating theatre department are actively addressed.	S 1.1.2 Embed theatre governance processes S 1.1.8 Source, obtain funding and support then complete culture survey (SCORE) within Theatres S 1.1.11 Put processes in place for regular culture survey.	Remove action - Covered in S 2.1 Moved to Stage 2 of plan Moved to Stage 2 of plan
S 2.1: The trust must ensure patients are treated with dignity & respect at all times.	S 2.1.1 Ensure leadership team and structure in place	Move to 1.1
S 3.1: The Trust must ensure that the WHO and five steps to safer surgery checklist is completed appropriately, and that learning from incidents and regular monitoring processes become embedded to empower staff to challenge and report any poor practice.	3.1.6 Surgical teams to do Human Factors training to improve communication/team work 3.1.7 SCORE survey	Action removed as covered in S1.1.9 Action removed as covered in S1.1.8.
S 4.1: The trust should ensure that theatre staff adhere to the dress code policy.	S 4.1.2 Complete baseline assessment of non theatre environments across the Division for smart scrubs and/or junior doctor provision of specific coloured scrubs	Remove - wider QIP plan
U 1.1 & 8.1: The Trust must ensure that the premises for urgent and emergency services protect patients	U1.1.5 Share Learning with Trust Resus committee and review if ligature cutters should be available in all resus	Moved to Stage 2 of plan

Recommendation	Action	Status
from potential harm and used for the intended purpose. This includes all areas of the service for both children & adults. The trust must ensure emergency equipment, including ligature cutters and children's resuscitation equipment is readily available.	trolleys U 1.1.6 Audit completion of resus trolley checks in all ED areas	 Moved to Stage 2 of plan
U 2.1: Ensure that there is a system in place, which is adequately resourced, to ensure that patients are assessed, treated and managed in a time frame to suit their individual needs. Review its use of the Rapid Assessment and Treatment (RAT) system and ensure this is embedded into practice.	U 2.1.4 CoDs to ensure specialty teams are able to meet Internal Professional Standards	Moved to Stage 2 of plan
U 10.1: Ensure there is a medical lead appointed for the service	U 10.1.2 Provide structured support for the new Medical Lead. U 10.1.3 Undertake a training needs analysis to inform a leadership and management training programme to enable them to have the capability and capacity to undertake the role effectively.	Moved to Stage 2 of plan Moved to Stage 2 of plan

Proposed Outcome Achievement Dates

ID	Recommendation	Original Date submitted to CQC	Target Completion Date
DI 1.1	The trust must ensure that observational audits of the quality of the World Health Organisation (WHO) and five steps to safer surgery checklists are undertaken.	01/10/2018	31/12/2018
DI 2.1	The trust must ensure that specialist personal protective equipment, such as the integrity of lead aprons, is checked on a regular basis.	01/09/2018	31/12/2018
DI 3.1	The trust must ensure that the call bell system within nuclear medicine is fit for purpose.	01/12/2018	31/12/2019
DI 4.1	The trust must ensure that the environment, equipment storage, medicines management and infection control procedures are appropriate in the interventional radiology unit. (S)	01/12/2018	01/12/2018
DI 5.1	The trust should ensure effective processes are in place for the timely completion of diagnostic reports.	01/12/2018	31/03/2020
DI 6.1	The trust should ensure that diagnostic imaging equipment remains fit for use through the implementation of a capital replacement programme.	01/03/2019	31/03/2020
DI 7.1	The trust should ensure that diagnostic imaging services are provided on a seven-day basis, in line with national guidance.	01/06/2019	31/03/2020
O 1.1	The trust should ensure that there is ongoing monitoring of the outpatient service, including the re-development of an outpatient dashboard.	01/10/2018	31/12/2019
S 1.1	The trust must ensure that leadership, culture and behaviours within the operating theatre department are actively addressed.	01/05/2019	01/05/2019
S 2.1	The trust must ensure that there is effective governance, safety and quality assurance processes within the theatre department that are structured, consistent, and monitored to improve practice and reduce risk to patients.	01/03/2019	01/03/2019
S 3.1	The trust must ensure that the World Health Organisation (WHO) and five steps to safer surgery checklist is completed appropriately, and that learning from incidents and regular monitoring processes become embedded to empower staff to challenge and report any poor practice.	01/03/2019	01/03/2019
S 4.1	The trust should ensure that theatre staff adhere to the dress code policy.	01/10/2018	30/03/2019
TW 1.1	The trust must ensure that mandatory training attendance improves to ensure that all staff are aware of current practices. (TW)	02/01/2019	31/03/2019
TW 2.1	The trust must review the knowledge, competency and skills of staff in relation to the Mental Capacity Act and Deprivation of Liberty safeguards.	02/01/2019	31/03/2019
TW 3.1	The Trust must ensure that staff annual appraisal completion improves	01/02/2019	01/02/2019
TW 4a.1	The trust must ensure that there is an effective process for quality improvement and risk management in all departments	Strategy completed and	31/01/2019

		agreed by 1 October 2018 - other dates to be set against the implementation plan that will be within the strategy	
TW 4b. 1	The trust must ensure that there is an effective process for quality improvement and risk management in all departments.	External Governance review completed by 1 November 2019. Risk Registers reviewed and refreshed by 2 January 2019. Revised Governance structure in place together with Risk management procedures by 1 March 2019	01/03/2019
TW 5.1	The trust must ensure that local audit findings are utilised to identify actions for improvement and that these are monitored, and reviewed.	01/04/2019	31/01/2019
TW 6.1	The trust must review the bed management and site management processes within the organisation to increase capacity and flow and ensure effective formalised processes are in place to ensure patient safety in all escalation areas.	External review August 2018. Discharge Lounge open by 1 November 2018	01/12/2019

TW 7.1	The trust must improve the relationship and culture between the site management team and the Senior Nursing and Clinical teams to ensure open dialogue where patient safety is equally weighted to operational pressure to reduce risks to patients and staff.	31/12/2018	31/03/2019
TW 8.1	The trust must review process for whistleblowing and take definitive steps to improve the culture, openness and transparency throughout the organisation.	Clarity regarding approach to staff engagement by 1 September with expected start of implementation of a Trust wide programme by 2 January 2019	02/01/2019
TW 9.1	The trust must improve the functionality of the board and ensure formalised processes are in place for the development and support of both current and new executive directors. The trust must improve the level of oversight, scrutiny and challenge from the chair and non-executive directors (NEDS). (The trust should ensure that regular review of the executive portfolio takes place to ensure capacity and capability to deliver requirements.)	01/03/2019	01/03/2019
TW 10.1	The Trust must ensure consistency processes are in place for recruitment, fit and proper persons regulation and line management at executive level.	01/08/2018	30/11/2018
TW 11.1	The trust must ensure that resuscitation equipment is checked in accordance with trust policy.	01/10/2018	31/12/2018
TW 12.1	The trust must ensure that action plans are monitored and that action is taken following the investigation of serious incidents	01/10/2018	31/03/2019
TW 13.1	The trust must ensure that there are effective systems and processes in place to ensure assessing the risk of, and preventing, detecting and controlling the spread of infections, including those that are healthcare associated.	01/08/2018	31/12/2018
TW 14.1	The trust must ensure staff compliance improves for major incident training	01/12/2018	31/12/2018
TW 15.1	The trust must ensure that oxygen cylinders are stored safely, that oxygen is readily available in all patient areas, and that this equipment is properly maintained.	01/10/2018	31/12/2018
TW 16.1	The trust must ensure that patient venous thromboembolism (VTE) risk assessments are completed.	01/12/2018	31/03/2019
TW 17.1	The trust must ensure that necessary risk assessments and healthcare records are complete for mental health patients.	01/11/2018	01/05/2019
TW 18.1	The trust must ensure that computers are locked and that patient healthcare records are stored securely.	01/12/2018	31/03/2019
TW 19.1	The trust must ensure that the healthcare records for patients' subject to restraint are complete and in line with	01/10/2018	30/06/2019

	the trust's policy and procedure.		
TW 20.1	The trust must ensure that lessons learnt from concerns and complaints are used to improve the quality of care.	01/02/2019	30/04/2019
TW 21.1	The trust must ensure that patients are treated with dignity and respect at all times.	01/04/2019	01/04/2019
TW 22.1	The trust must review 'do not attempt cardio-pulmonary resuscitation' (DNACPR) forms to ensure they are completed fully and in line with trust policy and national guidance.	01/03/2019	01/04/2019
TW 23.1	The trust must ensure that incidents are reported and investigated in a timely way by trained investigators	01/03/2019	01/03/2019
TW 24.1	The trust must ensure that medicines and contrast media are stored securely and in line with national guidance	02/01/2019	28/02/2019
TW 25.1	The trust must ensure that equipment is maintained and fit for use	01/05/2019	01/05/2019
TW 26.1	The trust must ensure temperature charts for blood and medicine fridges are appropriately completed and records held in line with national requirements.	01/11/2018	31/12/2018
TW 27.1	The trust should ensure that the management of referrals into the organisation reflects national guidance in order that the backlog of patients on an 18-week pathway are seen.	01/10/2018	31/10/2019
TW 28.1	The trust should ensure that effective processes are in place for correct handling and disposal of clinical waste, including sharps bins, and that storage of chemicals is secure in line with the Control of Substances Hazardous to Health (COSSH) guidelines.	01/11/2018	01/11/2018
TW 29.1	Ensure complaints are responded to in line with the complaints policy deadline of 25 working days.	01/09/2018	30/11/2018
TW 30.1	The trust should ensure morbidity and mortality meeting minutes include sufficient detail of background information, discussions and those in attendance.	01/09/2018	30/06/2019
TW 31.1	The trust should ensure that specialist personal protective equipment is checked on a regular basis and worn appropriately by staff.	01/09/2018	01/12/2018
TW 32.1	The trust should continue to monitor and actively recruit to ensure that there is an adequate number of nursing staff with the appropriate skill mix to care for patients in line with national guidance.	01/04/2019	01/04/2019
TW 33.1	The Trust should review the support managers provide to support staff in times of increased demand	01/08/2018	31/03/2019
TW 34.1	The trust should ensure that staff carrying out Root Cause Analysis (RCA) investigations for serious incidents receive appropriate RCA training.	01/12/2018	01/12/2018
TW 35.1	The trust should ensure that staff carrying out Duty of Candour applications receive appropriate training.	02/01/2019	02/01/2019
TW 36.1	The trust should review its communication aids available to assist staff to communicate with patients living with a sensory loss, such as hearing loss.	01/04/2019	01/04/2019
U 1.1	The trust must ensure that the premises for urgent and emergency services protect patients from potential harm and used for the intended purpose. This includes all areas of the service for both children and adults.	01/10/2018	01/11/2018
U 2.1	The trust must ensure that there is a system in place, which is adequately resourced, to ensure that patients are assessed, treated and managed in a time frame to suit their individual needs. (The trust should review its use of the Rapid Assessment and Treatment (RAT) system and ensure this is embedded into practice.)	01/11/2018	01/10/2019

U 3.1	The trust must action its plans to expand the children's and adults emergency department, including the provision of a high dependency unit for children outside of the resuscitation department.	01/09/2018	01/11/2018
U 4.1	The trust must review its nursing and medical staffing numbers for the urgent and emergency services and plan staffing acuity accordingly	01/10/2018	01/10/2019
U 4.2	The trust must review its nursing and medical staffing numbers for the urgent and emergency services and plan staffing acuity accordingly	01/10/2018	01/10/2019
U 5.1	The trust must ensure that there is one registered children's nurse at all times within the children's emergency department and take necessary action to increase the number of registered children's nurses employed.	01/10/2018	01/10/2019
U 6.1	The trust must ensure a good skill mix within the children's ED nursing workforce.	01/12/2018	01/10/2019
U 7.1	The trust must ensure audio and visual separation between adults and children being assessed and waiting within the emergency department and minor injuries unit.	31/03/2019	31/03/2019
U9.1	The trust must improve its performance times in relation to national time of arrival to receiving treatment (which is no more than one hour), four-hour target and monthly median total time in A&E.	01/08/2018	01/08/2019
U 10.1	The trust must ensure that there is a medical lead appointed for the service.	01/08/2018	01/08/2018
U11.1	The trust must ensure that there is a local audit programme in place for the service, that action plans are in place and necessary improvements are made to practice following audit.	01/09/2018	31/03/2019
U 12.1	The trust should ensure that regular and minuted mortality and morbidity meetings take place for urgent and emergency services.	01/09/2018	01/11/2018
U 13.1	The trust should ensure that a safety thermometer is implemented for children's and adult urgent and emergency services.	01/10/2018	31/03/2019
U 14.1	The trust should ensure that sepsis training is available to all staff providing urgent and emergency care.	01/12/2018	01/12/2018

REPORT TO THE QUALITY PROGRAMME BOARD	
Date	**6th November**
Title	**Outcome of Evidence Group**
Author & Lead	**Jane Robey** **Rosemary Raeburn Smith**
Purpose	**For Information**

1 Background/Context

The inaugural QIP Evidence Group met on 1st November, to review the evidence in respect of ten recommendations. The Agenda, Terms of Reference and Evidence Reports presented at the meeting are attached.

The group membership includes Trust and External partners, including the Chief Nurse, Medical Director, NHSi Director of Improvement, QIP Programme Director, 3 Staff members, Governor, Patient representative, CCG representative and other partners as agreed.

The group reviewed the evidence for suitability, relevance, and completeness, using an appreciative enquiry approach, assessing if the evidence supplied by the SRO and action leads provided sufficient assurance that the Recommendation and Outcome Statement has been met.

2 Outcome

For six of the ten recommendations, the group agreed that there was sufficient evidence to categorise the recommendation as BLUE (complete and evidenced). In respect of the remaining four recommendations, the group provided guidance as to the additional evidence required and offered suggestions how this could be achieved. These four recommendations will be brought back to the December meeting, when the supplementary evidence will be reviewed.

3 Conclusions/Outcome/Next steps

The Committee is scheduled to meet again at 9am on 29th November 2018, at which meeting the Committee is due to consider:

- New blue recommendations
- Bring back actions from October evidence

Recommendation:

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

1.1 Persons in attendance

The following people attended the inaugural meeting:

- Nancy Fontaine (NF), Chief Nurse NNUH
- Erika Denton (ED), Medical Director, NNUH
- Alison Leather (AL), Chief Quality Officer, SN CCG
- Jo James (JJ), Associate Improvement Director, NHSI
- Rosemary Raeburn-Smith (RRS), QIP Programme Director, NNUH
- Karen Kemp (KK), Associate Director of Quality and Safety, NNUH
- Gemma Lynch (GL), Governance Compliance Manager, NNUH
- Joel Fiddy (JF), Theatre Governance and Risk Management Facilitator, NNUH
- Jane Robey (JR), Head of Improvement Team, NNUH
- Stacy Hartshorn (SH), Improvement Manager, NNUH
- Abbe Swain (AS), Improvement Manager, NNUH
- Graham Bunting (GB), Senior Improvement Officer, NNUH
- Glynis Wivell (GW), Assistant to Medical Director, NNUH

2.1 Terms of Reference

A small amendment was made to item 7.5, and these were then approved. The approved version is attached.

3.1 Outcome of evidence reviews

Ref.	Recommendation	Outcome of Review
U1.1 **U8.1**	The trust must ensure that the premises for urgent and emergency services protect patients from potential harm and used for the intended purpose. This includes all areas of the service for both children and adults. The trust must ensure emergency equipment, including ligature cutters and children's resuscitation equipment is readily available.	BLUE – review in 1 month.
U3.1	The trust must action its plans to expand the children's and adults emergency department, including the provision of a high dependency unit for children outside of the resuscitation department.	BLUE – review in 1 month
U10.1	The trust must ensure that there is a medical lead appointed for the service.	BLUE – review if staffing changes occur
U11.1	The trust must ensure that there is a local audit programme in place for the service, that action plans are in place and necessary improvements are made to practice following audit.	NOT BLUE– rate as AMBER pending further evidence
DI1.1	The trust must ensure that observational audits of the quality of the World Health Organisation (WHO) and five steps to safer surgery checklists are undertaken.	NOT BLUE– rate as GREEN pending further evidence
DI2.1	The trust must ensure that specialist personal protective equipment, such as the integrity of lead aprons, is checked on a regular basis.	BLUE – no review date set
DI6.1	The trust should ensure that diagnostic imaging equipment remains fit for use through the implementation of a capital replacement programme.	NOT BLUE- rate as GREEN pending further evidence

TW27.1	The trust should ensure that the management of referrals into the organisation reflects national guidance in order that the backlog of patients on an 18-week pathway are seen.	BLUE – review monthly
TW28.1	The trust should ensure that effective processes are in place for correct handling and disposal of clinical waste, including sharps bins, and that storage of chemicals is secure in line with the Control of Substances Hazardous to Health (COSSH) guidelines.	NOT BLUE- rate as GREEN pending further evidence

4.1 Actions

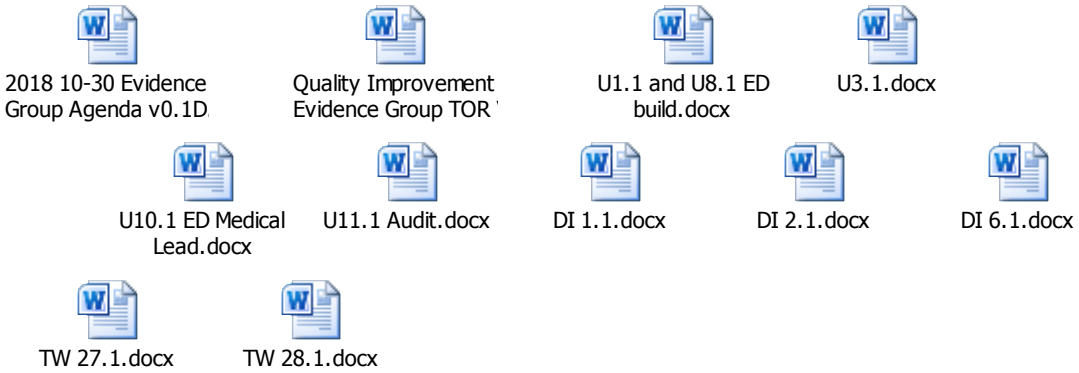
Ref.	Action	Owner

U1.1 & U8.1	• Confirm quiet rooms are functional and in use
	• Place a spare key to the roller shutter with the Ops Team or other appropriate back up method.
	• Ensure there is audited evidence of compliance with checklists in respect of:
	  • Cleaning of clinical equipment
	  • Resus trolleys
	  • Cleaning of Toys
	• Ensure that the mental health risk assessment is signed off at a medical Divisional Board
	• Ensure that the ChED SOP has a Trust Docs ID
	• Gather photographic evidence of the sluice improvements and the piped oxygen being in place across all clinical areas in the emergency department.
	• Evidence group to carry out a site inspection and write a report to confirm that all works have been completed, and add to evidence repository. JF was nominated by the group to conduct this inspection.
	• Provide feedback from meeting to SRO
		SH
		SH
		SH
		SH
		SH
		SH
		JF/SH
		SH

U3.1	• Ensure that the ChED SOP has a Trust Docs ID • Provide feedback from meeting to SRO	SH SH
U10.1	• Get a photo of the quartet of departmental leaders and add to the evidence repository. • Provide feedback from meeting to SRO	SH SH
U11.1	• Create an Audit Briefing to educate teams in what a good governance assurance process looks like, and the expectations in terms of membership and attendance at governance meetings, and dissemination of learning. The learning points should be shared widely across the MDT and other areas where appropriate. • Distribute this Audit Briefing to all governance leads and nurse leads, and to Stuart Williams and Amanda Williamson • Review TOR for ED CG meetings to ensure MDT attendance is encouraged. • Improve the documentation of audits reviewed in line with guidance which will be provided via KK. • Provide feedback from meeting to SRO	KK SH KK KK KK SH
DI1.1	• Ensure that the WHO checklist evidence is site/modality specific and bring back to the next meeting	GB/JW

	• Provide evidence on how frequently the audits are carried out. • Provide evidence to show how the learning is disseminated • Glynis Wivell to provide get WHO compliance figures to Joel Fiddy • To review the number of records included in audits particularly for smaller areas as 10% may not provide a representative sample. • Provide feedback from meeting to SRO	GB/JW GB/JW GW JF GB/JW
DI2.1	• Provide evidence to show how staff are trained in the use of PPE • Provide feedback from meeting to SRO	GB/JW GB/JW
DI6.1	• To support the business continuity plans a robust plan is required for replacing capital equipment. JW to request input from Simon Hackwell re the setting up of a rolling capital programme • Review the submitted Business Continuity Plan and assess if this is fit for purpose • Provide feedback from meeting to SRO	GB/JW GB/JW GB/JW
TW28.1	• Arrange audits in respect of Sharps and COSHH • Provide feedback from meeting to SRO	KK RRS
General	• Invite the DODs to attend future meetings on a rota basis • On future evidence reports, reference back to the original CQC report to indicate where the concern had been raised and in respect of what failing in particular • For 'Bring Back' reviews, invite members of the clinical team to come along to participate in the discussion	RRS RRS RRS

5.1 Date and Time of Next Meeting
Thursday 29th November 09:00 – 10:00 Holkham Room



REPORT TO THE TRUST BOARD OF DIRECTORS

Date	**30 November 2018**
Title	**Medical Appraisal and Revalidation Annual Board report**
Author & Exec lead	**Dr Caroline Kavanagh, Professor Erika Denton**
Purpose	**For Information**

1. Background/Context

1.1 All doctors must engage with a high quality medical appraisal annually.
1.2 Doctors are subject to revalidation every 5 years.
1.3 Appraisers must be trained and up to date with changes in the appraisal process.

2. Key issues, risks and actions

2.1 Medical Appraisal rates are 96.2 %.
2.2 Quality assurance demonstrated that 86 % of appraisals were excellent and 14 % were good which is an improvement from the previous year.
2.3 94.7% of appraisers are up to date with their training.
2.4 All revalidation recommendations were made on time.

3. **Conclusions/Outcome/Next steps**

3.1 The Medical Appraisal Office manages the appraisal process extremely efficiently.
3.2 Most doctors are engaged with the process.
3.3 The standard of medical appraisals is very high.
3.4 Appraisers are well trained.
3.5 Dr Kavanagh to step down as lead for appraisal and a new Clinical Appraisal lead will be appointed in Jan 2019.

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

A Framework of Quality Assurance for Responsible Officers and Revalidation

Norfolk and Norwich University Hospital Foundation Trust

Annual Board Report 2017-2018

NHS England INFORMATION READER BOX		
Directorate		
Medical	Commissioning Operations	Patients and Information
Nursing	Trans. & Corp. Ops.	Commissioning Strategy
Finance		

Publications Gateway Reference:	**03551**
Document Purpose	Guidance
Document Name	A Framework of Quality Assurance for Responsible Officers and Revalidation, Annex D - Annual Board Report Template
Author	Gary Cooper, Project Manager Quality and Assurance, Professional Standards Team
Publication Date	16 June 2015
Target Audience	All Responsible Officers in England
Additional Circulation List	Foundation Trust CEs , NHS Trust Board Chairs, Medical Appraisal Leads, CEs of Designated Bodies in England, NHS England Regional Directors, NHS England Directors of Commissioning Operations, All NHS England Employees, Directors of HR, NHS Trust CEs
Description	A template board report for use by designated bodies to monitor their organisation's progress in implementing the Responsible Officer Regulations.
Cross Reference	The Medical Profession (Responsible Officers) Regulations, 2010 (as amended 2013) and the GMC (Licence to Practise and Revalidation) Regulations 2012
Superseded Docs (if applicable)	A Framework of Quality Assurance for Responsible Officers and Revalidation, Annex D - Annual Board Report Template, version 4 April 2014.
Action Required	Designated Bodies to receive annual board reports on the implementation of revalidation and submit an annual statement of compliance to their higher level responsible officers.
Timing / Deadlines (if applicable)	**From June 2015**
Contact Details for further information	england.revalidation-pmo@nhs.net http://www.england.nhs.uk/revalidation/

Document Status

This is a controlled document. Whilst this document may be printed, the electronic version posted on the intranet is the controlled copy. Any printed copies of this document are not controlled. As a controlled document, this document should not be saved onto local or network drives but should always be accessed from the intranet. **NB:** The National Health Service Commissioning Board was established on 1 October 2012 as an executive non-departmental public body. Since 1 April 2013, the National Health Service Commissioning Board has used the name NHS England for operational purposes.

Contents

1. Executive summary

Dr Caroline Kavanagh is the AMD and leads on Medical Appraisal and Revalidation. She works in conjunction with Mrs. Joanne Hart, the Medical Appraisal and Revalidation Officer who is supported by Mrs Raquel O Connell, the medical workforce administrator. They were accountable, during the duration covered in this report, to Mr. Peter Chapman, the Medical Director.

The number of doctors working at the Trust who require annual appraisals has increased from 576 doctors in the financial year 2016-17 to 628 in 2017-18.

628 doctors had a prescribed connection to NNUHFT on 1st April 2018.

The Medical NNUHFT appraisal rate for the year 2017-2018 was 96.2%

563 had completed their appraisal within the previous 12 months.

40 doctors had their appraisal postponed for valid reasons agreed by the Associate Medical Director for Medical Workforce (AMD).

24 doctors did not have an appraisal within the last 12 months and where postponement was not agreed.

94.7 % of appraisers were up to date with appraiser training

Quality assurance of the appraisal process highlighted that 86% of completed appraisals were to an excellent standard compared to 62% the previous year. This will be due to provision of high quality, quarterly appraiser update training.

The Medical Appraisal Office has brought about changes in the last three years to the appraisal process at the Trust. These changes have been timely and have facilitated compliance with GMC recommendations following the Pearson Report (Taking Revalidation forward 2017) and UMbRELLA report (2016).

These include:

- Changes to timeframes for appraisal meetings and submission
- More frequent reminders of appraisal due dates
- Introduction of an updated appraisal form
- Appointment of appraisers to appraisees

- Assurance that all appraisers are up to date with training
- Equity in the numbers of appraisals undertaken by appraisers each year
- Appointment of new appraisers as needed by a selection process
- Feedback to appraisers from appraisees is ensured

- Compilation of clinical incidents provided to appraiser/appraisee prior to appraisal

- Patient survey analysis undertaken by the medical appraisal office
- Introduction of clear methods for QA of appraisers using the NHSE ASPAT tool.

Feedback from doctors following their appraisal has been good and a Quality Assurance audit shows good performance across the Trust.

2. Purpose of the Paper

This report is to assure the executive board that:

· Medical appraisal has been conducted according to NHS England requirements.

· Medical staff are compliant with their obligations to the GMC.

· The appraisal process is sufficiently robust to underpin the revalidation recommendations made to the GMC by the responsible officer.

· There are processes in place to underpin the duties of the Responsible officer in terms of responding to concerns.

3. Background

This annual Board report relates to the year 1st April 2017 to 31st March 2018. The Annual Organisational Audit was completed, submitted and presented to the Executive and Trust Boards for approval in November 2018. In addition to AOA, quarterly self-assessments summaries have been completed and submitted on time during the year to NHSE.

Medical Revalidation was launched in 2012 to strengthen the way that doctors are regulated, to improve the quality of patient care, improve patient safety and increase public trust and confidence in the medical system.

Provider organisations have a statutory duty to support their Responsible Officers in discharging their duties under the Responsible Officer Regulations[1] and it is expected that Trust boards will oversee compliance by:

· Monitoring the frequency and quality of medical appraisals.

· Ensuring effective systems are in place for monitoring doctors conduct and performance.

· Ensuring feedback from patients is sought within each revalidation cycle;

· Ensuring appropriate pre-employment background checks (including pre-engagement for Locums) are carried out to ensure that medical practitioners have qualifications and experience appropriate to the work performed.

4. Governance Arrangements

Dr Caroline Kavanagh ensures, in collaboration with the Medical Appraisal Office, that the processes for appraisal and revalidation recommendations are appropriate, robust and timely.
Dr Kavanagh chairs the Revalidation Decision Making Group on a monthly basis, where all doctors due for a revalidation recommendation are discussed and their appraisals and supporting evidence are reviewed.
Dr Kavanagh has taken over the role of Responsible Officer for the Trust in July 2018.

Quality Assurance of the process, using the NHSE ASPAT tool, was undertaken examining a random sample of 10% of medical appraisals undertaken at the Trust.

A post appraisal survey of the appraisee is undertaken after every appraisal.

An accurate list of all doctors with a prescribed connection is maintained by the Appraisal and Revalidation Officer by reference to ESR employment records and correlated every month with GMC Connect.

Quarterly appraisal and revalidation reports and all policies for approval are submitted to the Workforce Sub-Board and Executive Board.

The medical appraisal policy is updated annually in light of new regulations or developments to the NNUHFT processes. The NNUHFT Responding to Concerns policy was completed in October 2015. Dr Kavanagh will update the responding to concerns guidance in line with recent NHSE guidance.

5.Medical Appraisal

a. Appraisal and Revalidation Performance Data

Medical Appraisal 2017-18

Department	***No of doctors***	***No of completed appraisals***	***%***
A&E	*33*	*25*	*76%*
Acute Medicine	*15*	*11*	*73%*
Anaesthetics	*72*	*70*	*97%*
Cardiology	*21*	*19*	*90%*
Clinical Biochemistry	*3*	*3*	*100%*
Dermatology	*20*	*17*	*85%*
Endocrinology	*17*	*16*	*94%*
ENT	*10*	*10*	*100%*
Gastroenterology	*22*	*20*	*91%*
Surgery	*28*	*22*	*79%*
Haematology	*9*	*9*	*100%*
Histopathology	*22*	*18*	*82%*
Microbiology	*12*	*11*	*92%*
Neurology	*9*	*9*	*100%*
NICU	*13*	*10*	*77%*
Obs & Gynae	*37*	*35*	*95%*
Occupational Health	*1*	*1*	*100%*
Oncology & palliative	*27*	*25*	*93%*
OPM	*27*	*26*	*96%*
Ophthalmology	*23*	*20*	*87%*
Oral Surgery	*4*	*3*	*75%*
Paediatric Medicine	*22*	*20*	*91%*
Paediatric Surgery	*10*	*9*	*90%*

Plastic Surgery	*18*	*16*	*89%*
Radiology	*37*	*34*	*92%*
Renal Medicine	*10*	*8*	*80%*
Respiratory Medicine	*17*	*16*	*94%*
Rheumatology	*11*	*10*	*91%*
Stroke Medicine	*11*	*10*	*91%*
T&O	*35*	*33*	*94%*
Thoracic Surgery	*3*	*3*	*100%*
Urology	*18*	*15*	*83%*
Vascular Surgery	*7*	*6*	*86%*
Misc	*4*	*4*	*100%*
Total	*628*	*563*	*89.6%**

* When adjusted due to approved incomplete or missed appraisal this is 96%

All missed appraisals are discussed monthly at the Revalidation Decision Making Group. Annual Report Appendix A details the position for this at 1st April 2018.

Four Rev6 forms (for appraisals late by greater than 3 months) were completed and sent to the GMC. This form results in a letter from the GMC informing the doctor that they have 4 weeks to complete their appraisal, otherwise an investigation will commence which can potentially result in a doctor losing their licence to practise. Three of these appraisals were subsequently completed within 4 weeks of the submission of this Rev 6 form and no further action was needed.
The fourth doctor left the Trust and a Rev 9 form non-engagement form was completed for the GMC.

No recommendations of non-engagement with appraisal were made.

b. Appraisers

NNUHFT has 113 trained medical appraisers, and 107 of these appraisers are currently up to date with their appraiser training. This is a sufficient number for the needs of the organisation.
All appraisers have undergone initial appraiser training compliant with GMC requirements which was delivered by an experienced trainer who also provides such training across Midlands and East.
We have made our training available to neighbouring Trusts (JPUH and NCHC) at cost.

Dr Kavanagh has introduced the requirement for all appraisers to attend an annual update to ensure they are all familiar with current developments in appraisal and revalidation. Dr Kavanagh is providing these sessions and this includes discussion of the GMC Pearson Report.

c. Quality Assurance

Appraisal training provides consistency in the way medical appraisals are conducted at the Trust. NNUHFT uses the MAG V4.2 form for medical appraisals.
The appraisee ensures that the form has been completed, all appropriate information has been attached (or provided separately where applicable) and sent to the appraiser two weeks before the appraisal occurs.

The appraiser ensures that the outputs from the appraisal are properly completed and that the appraisal is submitted within 28 days of the appraisal meeting.
The appraiser also completes an appraisal summary form (Appendix B) that details the necessary documentation that has been seen and confirms that the output is satisfactory.
The Medical Appraisal Office checks the output statements and informs Dr Kavanagh if these are incomplete. They also complete the relevant sections of the RO dashboard at this time.

A feedback exercise is conducted through survey monkey following every appraisal. The results inform the appraiser training and are fed back to individual appraisers through Dr Kavanagh where possible.

Dr Kavanagh currently reviews 10% of all appraisals, chosen at random by the appraisal office using the ASPAT tool. This audit highlighted that the standard of appraisal has improved with 86% of appraisals deemed excellent compared to 62% the previous year. 14% were deemed good. This is an Improvement due to high quality appraiser update training provided by Dr Kavanagh and Mrs Hart.

It is now standard practice that all doctors are provided with a list of any complaints or serious incidents that relates to them, 3 months prior to their appraisal date.

<u>Revalidation Decision making group</u>
Appraisals are reviewed by the Revalidation Decision Making Group up to 3 months before a revalidation recommendation is due and any problems noted are provided in writing to the doctor concerned.
This group is a diverse, inclusive group whose membership included Mr Peter Chapman (Medical Director), Dr Kavanagh, Mrs. Hart, Mrs O' Connell, Mr Smith (Director of Medical Education) and several appraisers on a rotational basis. It has become policy that appraisers attend this meeting once every 18 months to improve their understanding of the revalidation process. The impact of this has been visible. The meetings are minuted.

Positive feedback is given to all doctors, for whom a revalidation recommendation is made. They are thanked on behalf of the Trust for their valued contribution.

d. Access, Security and Confidentiality

No information governance breaches have been detected or reported in 2017-18 in relation to medical appraisal and revalidation.
Guidance associated with the MAG form makes it clear that patient identifiable information should not be included in the MAG form.
The Medical Appraisal Policy states who can access appraisal documents and for what purpose.
Medical Appraisal forms are be submitted to a specific NNUHFT email address (medical.appraisal@nnuh.nhs.uk) with access limited to the Clinical Appraisal Lead, and Medical Appraisal and Revalidation officer and the Responsible Officer.
All appraisal information is stored on a password-protected folder on the hospital 'S' drive.

e. Clinical governance

Some of the supporting information that a doctor presents at appraisal will be, in part, provided for them by the Medical Appraisal Office 3 months prior to their appraisal.

All clinical departments at NNUHFT hold regular monthly clinical governance meetings and participation in these is required for appraisal. These meetings are organised against a defined template ensuring that the required items are covered, discussed, and reported to the relevant divisional board. This information would include morbidity and mortality review, NICE guideline compliance, review of department audit register and progress, complaints, incidents, and a review of the risk register for that department. An attendance register is kept and doctors are expected to provide proof of participation at appraisal.

6. Revalidation Recommendations

43 recommendations were made between 1st April 2017 and 31st March 2018.
All were completed on time.
No recommendations were submitted late.
38 positive recommendations were made.
5 recommendations to defer revalidation were made.

7. Recruitment and engagement background checks

NNUHFT medical workforce ensures that all doctors coming to work in the Trust have completed the required range of pre-employment checks. These include Right to Work Check, Work Health Assessments, Employment History, Reference checks, Professional registration and qualifications checks, and Disclosure and Barring Service checks.
In addition all new doctors complete a form on arrival to provide details of their previous designated body, and previous appraisal date.
A process for Transfer of Information for doctors has been agreed. The previous designated body (where this exists) and RO are contacted to obtain information regarding previous appraisal, previous fitness to practice concerns, unresolved significant incidents and complaints, and significant health issues.
For trainees we require a copy of the ARCP on commencement of employment at the Trust.
For Trust grade doctors we require a copy of their previous appraisal and we contact their RO for completion of an MPIT form.

8. Monitoring Performance

The Responsible Officer reviews and monitors the performance of individual doctors and teams through the Trust Governance structure and in particular through the Clinical Safety and Clinical Effectiveness sub-boards.
Significant incidents and risks are reviewed monthly through directorate meetings, divisional boards, sub-boards and the executive board depending upon the level of that risk.
Mr Chapman and Dr Kavanagh met with the GMC Employment Liaison Adviser every three months to discuss concerns or issues raised about doctors within the Trust.
There is a nominated team for all MHPS investigations and the Trust Board is updated on the progress of these.
NNUHFT operates a consistent system of mortality review, recorded electronically, through its mortality committee. This reports monthly into the Clinical Governance Leads meeting where mortality, significant incidents, never events and the action plans resulting from the RCAs that have been performed for these events are reviewed and messages for organisation wide learning disseminated through governance leads to individual departments.
The Clinical Governance Leads meeting currently reports into the Clinical and Safety Effectiveness Board.

9. Responding to Concerns and Remediation

NNUHFT follows an established Responding to Concerns protocol and a remediation policy is in place. This policy was updated by Mr Chapman in October 2015.

One doctor was formally undergoing remediation in 2017-2018 under GMC fitness to practise arrangements. Three doctors were excluded during this period, two of which were doctors in training.
Dr Kavanagh will update this guidance next year in line with recent NHSE guidance.

10. Risks and Issues

Improved Appraisal Rate of all doctors within the Trust
96.3% of doctors, who were due an appraisal, had an appraisal on time.

Doctors who do not engage with appraisal

There is a clearly defined escalation process for non-engagement within the Medical Appraisal Policy. Reminders are sent 6, 3 and 1 months before the appraisal is due and on the date the appraisal becomes overdue.

Where no appraisal has been received within 6-8 weeks after the appraisal due date, doctors are asked to contact the AMD for discussion. This email reminds the doctor of the need for annual appraisals in keeping with the GMC requirements for revalidation. It also makes the doctor aware that if the appraisal becomes three months late then a Rev 6 form will be completed and sent to the GMC. This deadline date is highlighted in an email.

This process has been communicated widely and frequently to the doctors in the Trust by Dr Kavanagh, and is in a clear pathway in the Medical Appraisal Policy.

Where doctors consistently have not engaged then the GMC are informed through the Employer Liaison Advisor (ELA) and a Rev6 form is completed.
This process been followed more consistently through 2017-2018.

Consistency of Appraisals performed

There is Quality Assurance using the ASPAT tool, which is conducted by the AMD. Dr Kavanagh has shared the criteria of the ASPAT tool with all of the doctors in the Trust.

We request appraisal feedback from appraisees on receipt of their appraisal form. The AMD will aim to provide individual feedback to appraisers in 2018-2019.

The training for new appraisers, and the update sessions for established appraisers emphasizes the requirement for reflection, and the appraisal summary form defines what is required in each section in terms of supporting information.

Appraisal of Educators

The Director of Post-graduate Education (Miss Sule) oversees an Appraisal of Educational Roles form that is attached to the MAG form which is available on the intranet. This should be completed by all named educational supervisors.

Appointment of New Appraisers

The Trust is now training the service directors to be appraisers as they need to undertake departmental appraisals once every 5 years and are responsible for the appraisals of the doctors in their departments who are employed under short –term contracts. There was an adequate number of trained appraisers in the Trust.

Medical Workforce Resource

Mrs. Joanne Hart, is the Medical Appraisal and Revalidation Officer and she is supported by Mrs Raquel O Connell, the medical workforce administrator.

Medical Management of Appraisal and Revalidation

Mr. Peter Chapman was the Responsible Officer and Medical Director for the timeframe of this report.

Dr Caroline Kavanagh is the Associate Medical Director for Medical Workforce and is responsible for appraisal and revalidation. She had undertaken RO training, to support the Medical Director, and deputized when required.

Dr Kavanagh reviews all of the appraisals and outputs required prior to a revalidation recommendation and prior to the Decision Making Group meeting. She presents the information to the Group for discussion. Dr Kavanagh submits the revalidation recommendation via GMC Connect.

Dr Kavanagh attends the GMC ELA meetings. She also attends the Service Directors meetings to ensure Appraisal and Revalidation issues are highlighted regularly.
Dr Kavanagh has subsequently taken over the role of Responsible Officer for the Trust in July 2018

Transfer of Information / Recruitment check audit

Appropriate recruitment checks are conducted on all doctors before they start work at NNUHFT and processes are in place to ensure that this happens though an audit has not been performed to demonstrate this is the case.

Laboratory Extended Quality Surveillance of Medical Staff
The Appraisal Framework for Eastern Pathology Alliance (EPA) roles for laboratory medical staff was introduced last year and is now embedded.

11. Corrective Actions, Improvement Plan and Next Steps

- Updated Medical Appraisal policy and guide completion by AMD.
- AMD to review the process for appraiser appointment if more appraisers are required. This would be via a process based upon more formal application and interview with regular performance review and mentoring during the first year of appointment for each appraiser.
- AMD to develop a system whereby appropriate feedback is given to appraisers after they have undertaken appraisals. This would be provided on an annual basis.
- AMD to develop a Statement of no concerns form to be completed in other medical establishments where our doctors practise, to include private work.
- RO to update the Responding to Concerns policy in keeping with recent NHSE guidance.

12. Recommendations

The Board is asked to accept this report. It will be shared, along with the annual audit, with the higher level Responsible Officer.
The Board is asked to consider the recommendations and support the developments required to reduce risks and increase the effectiveness of appraisal and revalidation in NNUHFT.
It is recommended that the Executive Board approves the “statement of compliance” confirming that NNUHFT, as a designated body, is in compliance with the regulations.

Dr Caroline Kavanagh
Associate Medical Director for Medical Workforce
16th November 2018

14. Annual Report Template Appendix A - Audit of all missed or incomplete appraisals audit

Doctor factors (total)	**81**
Maternity leave during the majority of the 'appraisal due window'	3
Sickness absence during the majority of the 'appraisal due window'	6
Prolonged leave during the majority of the 'appraisal due window'	
Ongoing HR process	1
New starter within 3 months of 31.3.18 cut off date for annual NHS England report.	17
New starter within 3-6 months of 31.3.18 cut off date for annual NHS England report.	9
Postponed due to incomplete portfolio/insufficient supporting information	0
Appraisal outputs not signed off by doctor within 28 days	
Lack of engagement of doctor	25
Other doctor factors	
Career break	1
Appraiser factors	
Unplanned absence of appraiser	
Appraisal outputs not signed off by appraiser within 28 days	17
Lack of time of appraiser	
Other appraiser factors (describe)	
- Coordinating joint academic appraisal	
Organisational factors	
Administration or management factors	2
Failure of electronic information systems	0
Insufficient numbers of trained appraisers	0

Other organisational factors (describe)	0

14.Annual Report Template Appendix B – Quality assurance of appraisal inputs and outputs

Total Number of Appraisals completed	563
Total Number of Appraisals sampled (to demonstrate adequate sample size)	57
No. of sampled Appraisals scoring as excellent (%)	49
No. of sampled Appraisals scoring as good (%)	8
No. of sampled Appraisals scoring as satisfactory (%)	0
No. of sampled Appraisals scoring as unsatisfactory (%)	0

15.Annual Report Template Appendix C – Audit of revalidation recommendations

Audit of revalidation recommendations

Revalidation recommendations between 1 April 2017 to 31 March 2018	
Recommendations completed on time (within the GMC recommendation window)	43
Late recommendations (completed, but after the GMC recommendation window closed)	0
Missed recommendations (not completed)	0
TOTAL	43
Primary reason for all late/missed recommendations For any late or missed recommendations only one primary reason must be identified	
No responsible officer in post	0

New starter/new prescribed connection established within 2 weeks of revalidation due date	0
New starter/new prescribed connection established more than 2 weeks from revalidation due date	0
Unaware the doctor had a prescribed connection	0
Unaware of the doctor's revalidation due date	0
Administrative error	0
Responsible officer error	0
Inadequate resources or support for the responsible officer role	0
Other	
Describe other. Appraisals submitted too late to complete recommendation by date.	
TOTAL	43

Integrated Performance Report

November 2018 (October 2018 data)

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

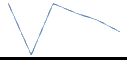
Quality & Safety		Target	July 2017 to June 2018	July 2016 to June 2017
Mortality	Core Slide 3			
1 SHMI*		N/A	107.64	106.52

Quality & Safety		Outturn 2017/18	Monthly Target	Oct-18	6 month trend	YTD 2017/18	YTD 2018/19
Mortality	Core Slide 3-4						
1 HSMR**			100	94.9			
2 Crude Mortality Rate***		5.07	n/a	3.94		5.07	3.84
Incidents	Core Slide 5-7						
3 Serious Incidents		138	n/a	12		71	96
4 Incident Reporting		17171	n/a	1869		9442	11644
5 Insulin errors causing NPSA category moderate harm or above		1	0	0		1	0
6 Medication Errors		1204	n/a	125		693	850
7 Patient Falls causing moderate harm or above		33	n/a	4		22	14
8 Never Events		7	0	0		5	3
Pressure Ulcers	Core Slide 8						
9 Grade 2 hospital acquired pressure ulcers		217	n/a	12		103	137
10 Grade 3 hospital acquired pressure ulcers		56	n/a	3		25	37
11 Grade 4 hospital acquired pressure ulcers		2	0	0		1	0
Infection Control	Core Slide 9						
12 HAI C. difficile Cases (excluding non-trajectory and pending cases)		11	n/a	1		6	6
13 Hospital Acquired MRSA bacteraemia		0	0	0		0	1
14 CPE screens taken		n/a	n/a	73		n/a	389
15 CPE positive screens		n/a	n/a	0		n/a	0
16 CPE screens of patients positive from other hospitals		n/a	n/a	0		n/a	1
17 E.coli trust apportioned		n/a	n/a	5		36	34
18 E. Coli community apportioned		n/a	n/a	20		187	183
19 Klebsiella trust apportioned		n/a	n/a	0		n/a	8
20 Klebsiella community apportioned		n/a	n/a	5		n/a	31
21 Pseudomonas trust apportioned		n/a	n/a	0		n/a	10
22 Pseudomonas community apportioned		n/a	n/a	1		n/a	20
Other							
23 EDL to be completed within 24 hours in 95% of discharges		76.72%	95.00%	79.14%		76.11%	76.84%
24 Harm Free Care		90.95%	n/a	92.00%		92.93%	86.06%
25 Patients 'extremely likely' or 'likely' to recommend our service to friends and family		96.73%	100.00%	96.58%		96.71%	96.30%
26 Complaints		890	n/a	96		497	612

* SHMI data is updated quarterly by NHS Digital
** HSMR data is the latest available and reported three months in arrears
*** Crude Mortality Rate is reported one month in arrears, in order to include deaths within 30 days of discharge from hospital

Core Slide 2

Quality Priorities – Patient Safety

	Quality Priorities - Patient Safety	Measure	Lead	Outturn 2017/18	Monthly Target	Oct-18	6 month trend	YTD 2017/18	YTD 2018/19
1	Reduction in medication errors	Insulin errors causing NPSA category moderate harm or above	Erika Denton	1	0	0		1	0
2	Prompt recognition and treatment of sepsis**	% of Sepsis patients screened	Erika Denton	86.17%	90.00%	72.00%		88.29%	80.00%
		% of Sepsis patients treated	Erika Denton	92.61%	90.00%	92.21%		93.43%	92.53%
3	Keeping patients safe from hospital acquired thrombosis	95% compliance with TRA assessment as evidenced on EPMA. (and audit of appropriate actions)	Erika Denton	98.93%	95.00%	98.91%		98.92%	98.89%
4	Incident reporting and management	NNUH duty of candour compliance	Erika Denton	99.48%	100.00%	85.00%		100.00%	92.00%

**Reported in arrears – current value is for September 2018

Quality Priorities – Patient Experience

	Quality Priorities - Patient Experience	Measure	Lead	Outturn 2017/18	Monthly Target	Oct-18	6 month trend	YTD 2017/18	YTD 2018/19
1	Treat Patients with privacy and dignity	Patients 'extremely likely' or 'likely' to recommend our service to friends and family	Nancy Fontaine	96.73%	100.00%	96.58%		96.71%	96.30%
2	Improved continuity of care and experience through reduced ward moves and reduced numbers of outliers	No more than 20 patients recorded as boarders. Monthly average	Richard Parker	42.65	20.00	18.00		42.65	20.51
3	Improved discharge processes	EDL to be completed within 24 hours in 95% of discharges	Richard Parker	76.72%	95.00%	79.14%		76.11%	76.84%

Quality Priorities – Clinical Effectiveness

	Quality Priorities - Clinical Effectiveness	Measure	Lead	Outturn 2017/18	Monthly Target	Oct-18	6 month trend	YTD 2017/18	YTD 2018/19
1	Keeping patients safe from infection	HAI C. difficile Cases (excluding non-trajectory and pending cases)	Nancy Fontaine	11	0	1		6	6
2	Keeping patients safe from infection	Hospital Acquired MRSA bacteraemia	Nancy Fontaine	0	0	0		0	1
3	Improve quality of care through research	Year on year increase in patients recruited into research studies. Aim to recruit 5000 into research studies in 2016-17.	Erika Denton	3500	417	199		2141	3260
4	Timely medical review of all patients	Average number of patients with LoS >14 days	Richard Parker	196.6	200	176		196.6	186.2

Core Slide 3

Mortality Dashboard - Inpatient Monitoring

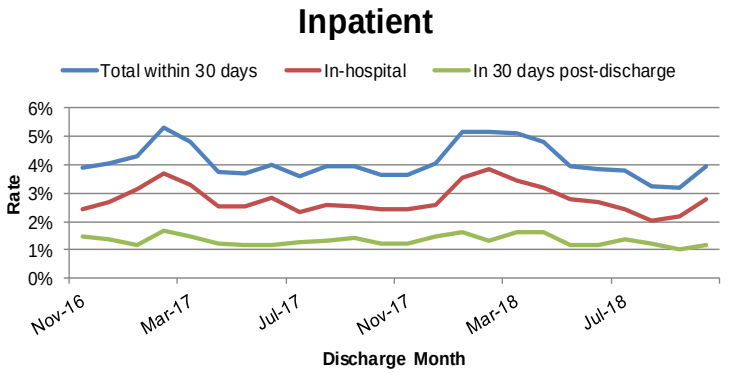
Crude Mortality	
Month	Rate
May-18	3.95%
Jun-18	3.87%
Jul-18	3.80%
Aug-18	3.24%
Sep-18	3.22%
Oct-18	3.94%

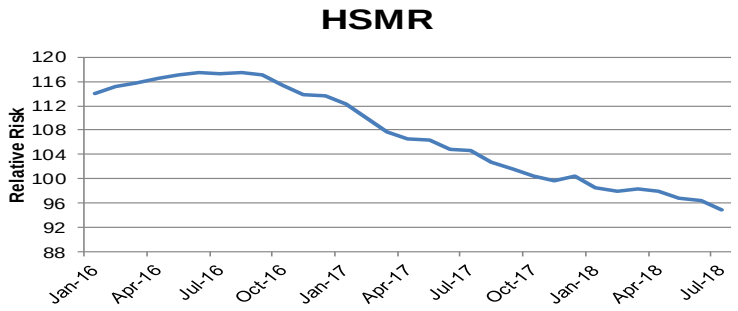
(Crude Mortality is reported one month in arrears)

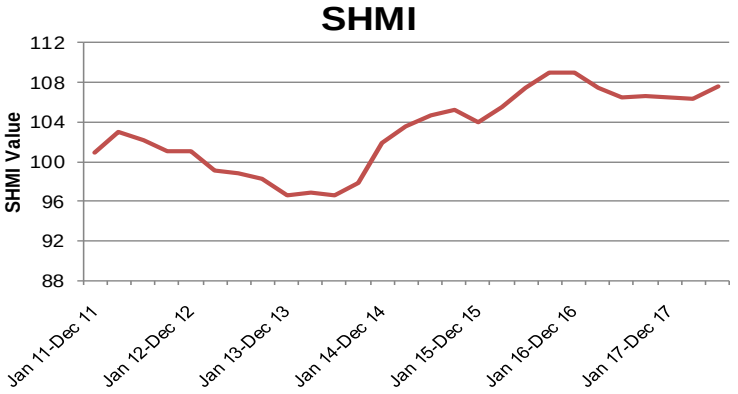
HSMR	
May-18	96.85
Jun-18	96.45
Jul-18	94.92

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

SHMI	
Jul 17-Jun 18	107.64



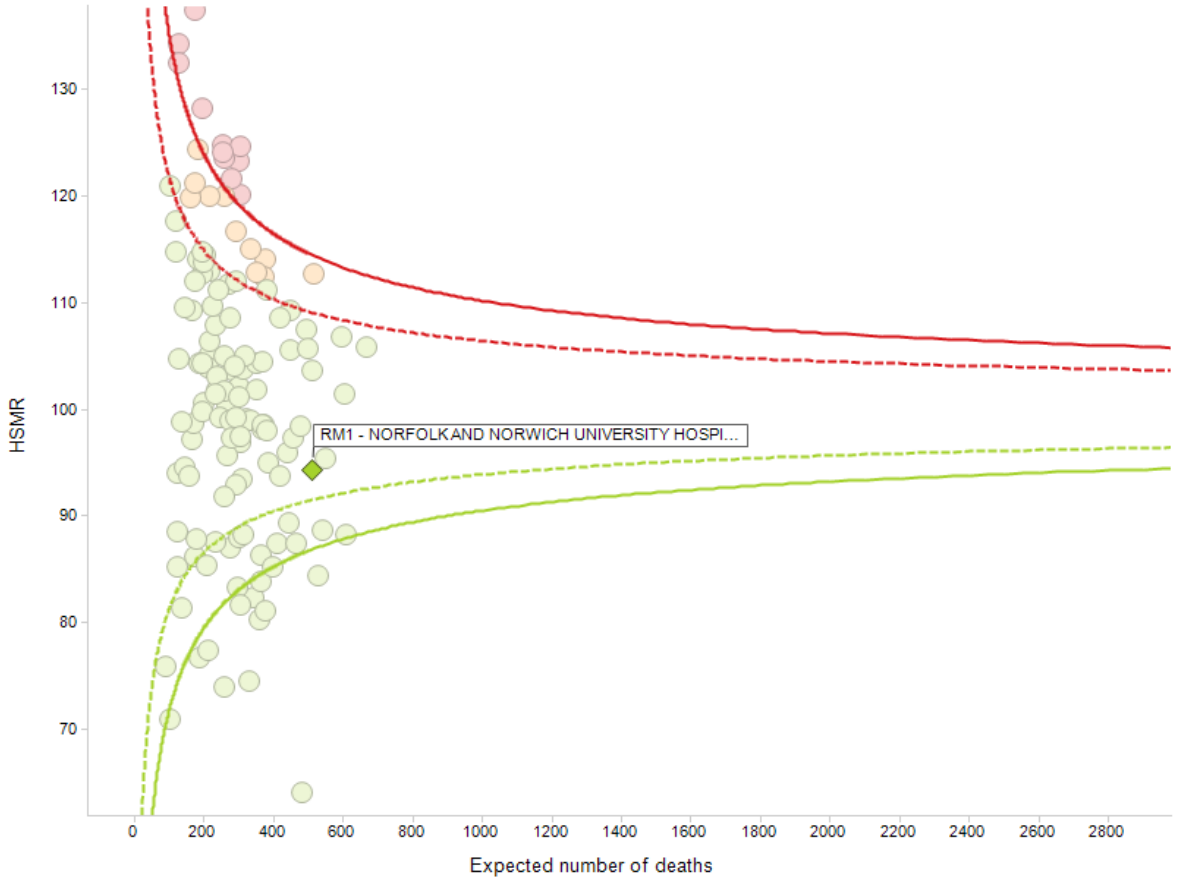




	2017/18	2018/19		
	Q4	Q1	Q2	Q3
Total deaths excluding ED	1083	871	776	247
Total deaths for ED	62	28	45	8
Number of in-hospital deaths	752	591	520	174
Number of deaths within 30 days of discharge	331	280	256	73
Number of reviews completed	419	385	300	34
Number of deaths on review considered potentially preventable	2	4	2	1
Percentage of deaths considered as potentially preventable	0.48%	1.04%	0.67%	2.94%
Numbers of deaths considered under SI process	3	6	6	1
Maternity deaths reviewed	0	0	0	0
Deaths in Learning disability reviewed (LeDeR)	4	4	2	0
Paediatric deaths reviewed	0	0	0	0
Mental Health deaths reviewed	0	0	0	0
Themes identified from mortality reviews and investigations	A need has been identified for strengthened mortality surveillance processes for improved accuracy of information form all sources so we can identify themes and trends in a consistent way.			
Actions taken	Work with Karen Kemp, Berenice Lopez and Angela Adams to establish assurance processes.			

Core Slide 4

HED - HSMR Overview – May 2018 to July 2018

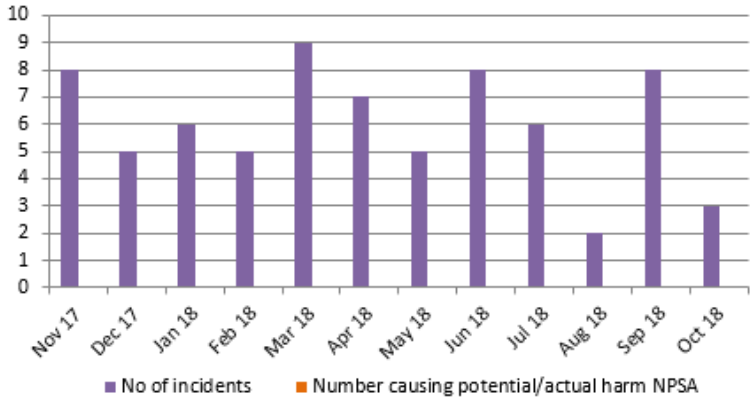


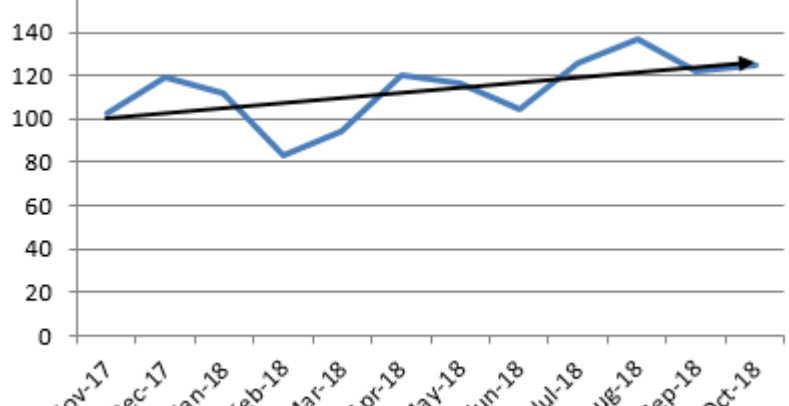
Organisation (provider): RM1 - NORFOLK AND NORWICH UNIVERSITY HOSPITALS NHS FOUNDATION TRUST
Trust Group: 1. My Trust
Alert Level: Green
HSMR: 94.26
HSMR 95% CI: (86.01,103.09)
Number of super-spells: 18023.00
Number of observed deaths: 479.00
Expected number of deaths: 508.16

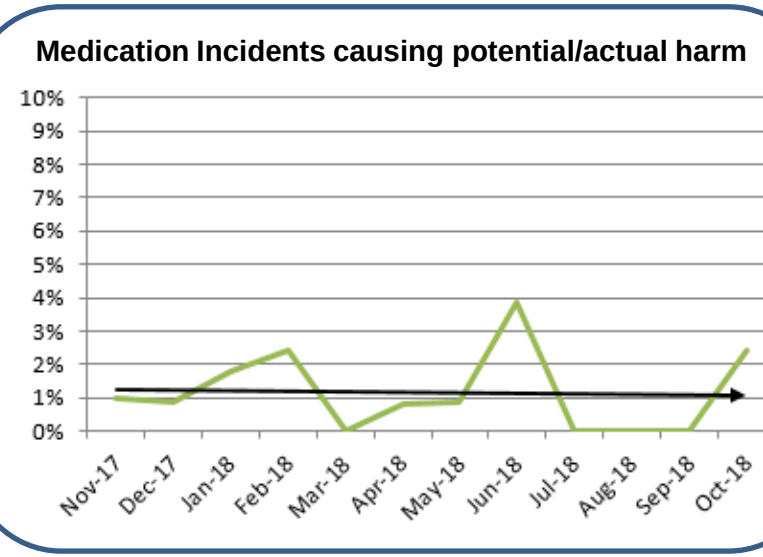
Core Slide 5 Safety and effectiveness - Lead Directors Nancy Fontaine / Erika Denton

- Spring 2018 7 day services survey (results published Aug 2018) showed improvement in all priority clinical standards; next survey for Autumn 2018 underway
- Cellular Pathology ISO 15189 has accreditation to 2020
- Trust Improvement Plan agreed at Quality Performance Board on 6 November.
- The Pressure Ulcer Collaborative team have won peer nominated award for the most innovative pressure ulcer reduction initiative

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





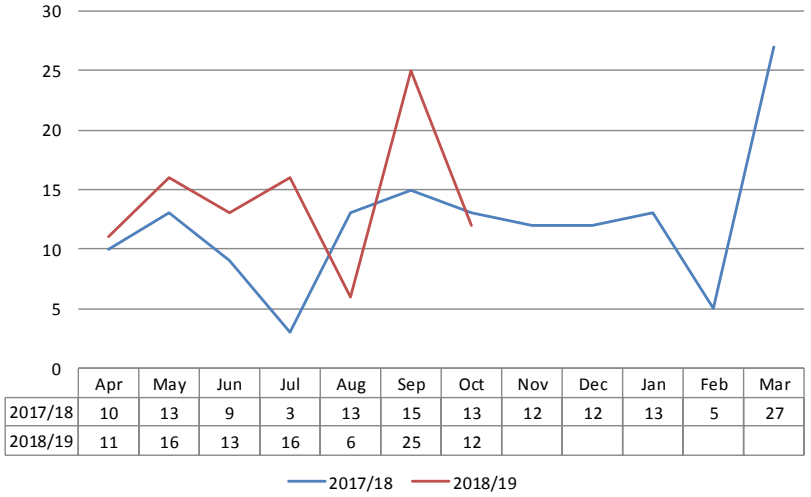


- Medication error reporting continues to rise but the severity remains mainly no or low harm
- There were 125 medication incidents reported in October.
- 11 of these incidents were graded as low harm severity incidents, 4 moderate harm and the remainder graded as no harm incidents

Core Slide 7

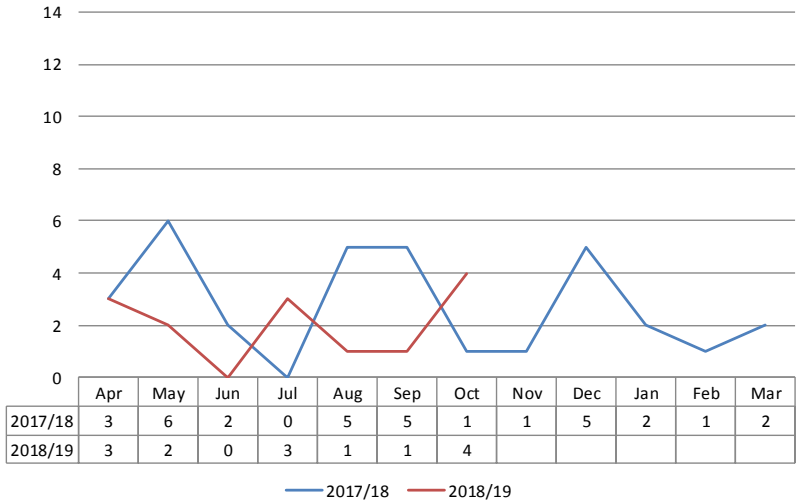
Quality & Safety (Incidents) – Lead Directors Nancy Fontaine / Erika Denton

Serious Incidents and Never Events (reported onto STEIS)



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

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



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

Individual Serious Incidents
(These are serious incidents reported onto STEIS which impact patients directly)

- 2 patients acquired G3 pressure ulcers
- 1 Near miss involving a delay in emergency theatre for an obstetric patient
- 5 patient falls resulting in severe harm (one patient sustained catastrophic harm. One fall occurred in September but was reported as an SI in October).
- 3 patients experienced treatment delay resulting in harm

Organisational Serious Incidents
(These are serious incidents reported onto STEIS that may indirectly affect patient safety)

- 1 12hr breach in ED for patients awaiting Mental Health bed allocation outside of the Trust

Compliance with the Duty of Candour has breached in 3 cases

In October 2018 there were 162 patient falls reported. The trend over the past three years is reducing with almost 700 less patient falls reported compared to the same 12 month period in 2015/2016.

Falls per Occupied Bed Day (OBD)

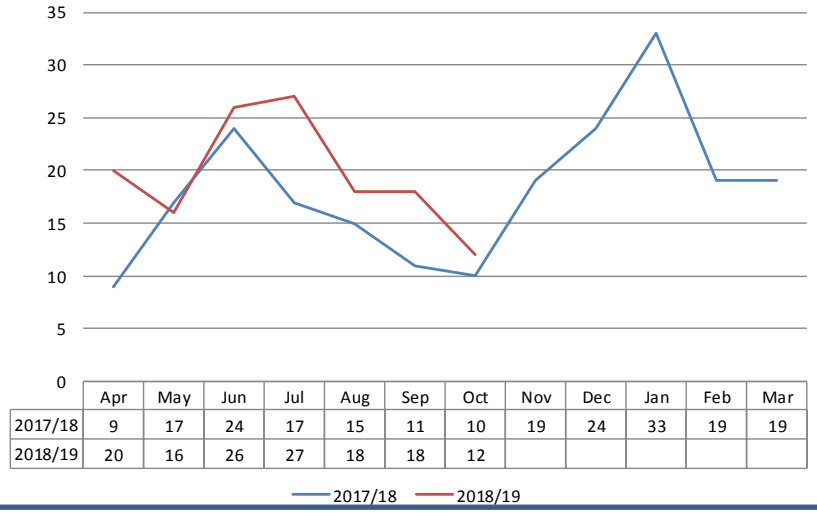
The Trust data for September 2018 (October data is not yet available) indicates that the NNUH inpatient falls rate is **6.04** falls per 1000 patient bed days – this is in line with usual reporting for the Trust.

Moderate harm (or greater severity) falls for September 2018 were recorded as **0.04** which is again within usual Trust reporting levels.

Core Slide 8

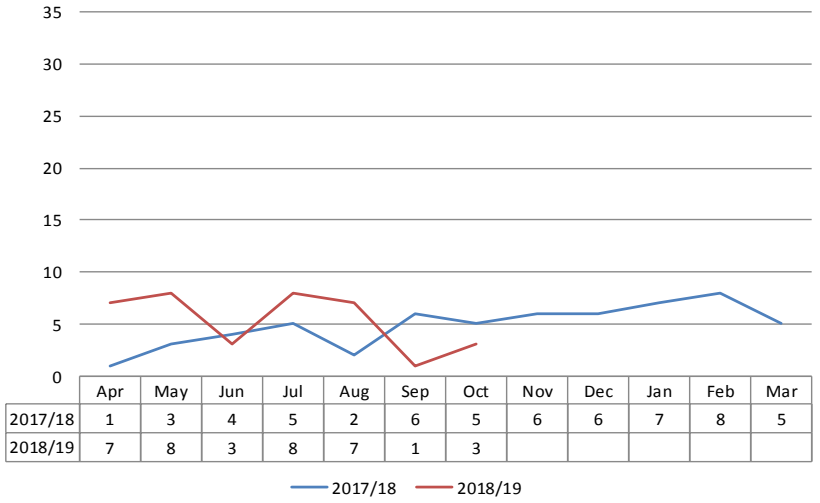
Quality & Safety (Pressure Ulcers) – Lead Director Nancy Fontaine

Grade 2 hospital acquired pressure ulcers



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

Grade 3/4 hospital acquired pressure ulcers



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

Category 2 PU

- A total of 13 patients developed a Category 2 HAPU whilst in our care in October 2018.1

- **Category 3 & 4 HAPU**
- A total of 3 patients developed a Category 3 hospital acquired pressure ulcer whilst in our care in October 2018. 2 of these were reported as SI's and the third will appear in November SI data. No patients developed a Grade 4 pressure ulcer in our care.

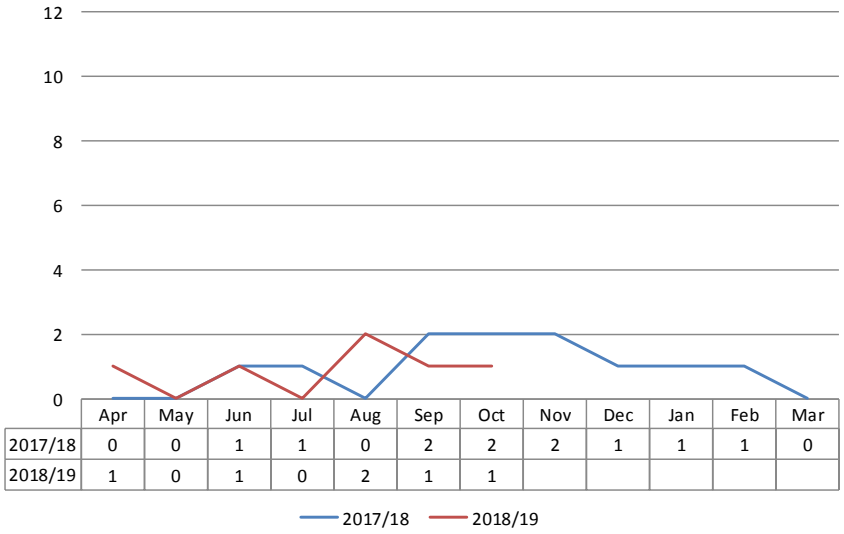
Learning from recently completed RCA's

The learning from the RCA's is reviewed by the TVN's: Ongoing actions include the following

- A greater emphasis on ward based education across the Trust.
- Earsham Ward have taken up the chief Nurse's challenge to be the first ward to 100 days without a patient developing a pressure ulcer.
- Dilham Ward are now conducting daily audits on the accuracy of skin reviews.
- Trust-wise "Stop the Pressure" Day in early November 2019 to raise awareness across all teams.

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

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



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

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

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

Gram Negative Hospital Attributable Bacteraemia 2018 (YTD)
- E. coli 34
  Pseudomonas aeruginosa 10
- Klebsiella sp. 8

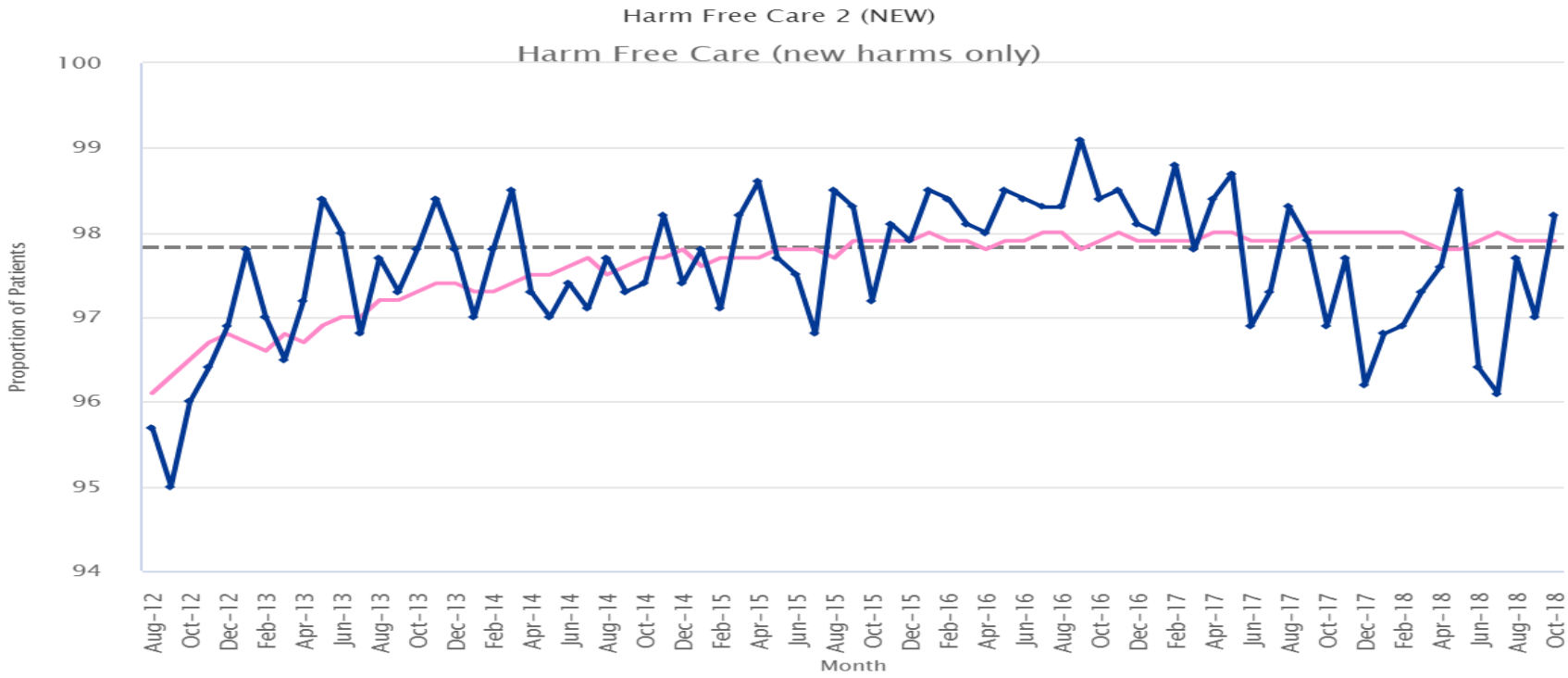
Following the post infection review [PIR] meeting with Trust and CCG's representatives each hospital acquired case of C. difficile is:-	
Trajectory	deemed to have lapses in care
Non-Trajectory	Deemed to have no lapses in care

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

Summary Table		Non-Trajectory	Trajectory	Pending	Total
Quarter	4				
	3	0	1	1	2
	2	8	3	0	11
	1	6	2	0	8
Year to date 18/19		14	6	1	21
Previous year 2017/18 Total		*24*	*11*	*0*	*35*

Core Slide 10

Safety Thermometer – Lead Director Nancy Fontaine



The Patient Safety Thermometer Data published on the website contains information that relates to all data collection until October 2018. The above data compares “Harm Free Care – New Harms” since data collection began. The graph has been taken from the PST website and demonstrates NNUH NHSFT Harm Free Care (All new harms) of 98.2% for October 2018 against a national average reported of 97.9%. The graph provides data since Safety Thermometer collection commenced in 2012.

Core Slide 11

Maternity Safety Dashboard – Lead Director Nancy Fontaine

		NNUH Maternity 2018/19	April	May	June	July	Aug	Sept	Oct	Total
Activity	Mothers Delivered	Mothers delivered	438	479	460	475	470	475	486	3283
	Babies Delivered	Total Births	443	488	466	479	479	482	496	3333
		Live Births	439	483	463	478	477	479	494	3313
		Stillbirths	4	4	3	1	1	3	2	18
		Adjusted Stillbirths Total SB less TOP ≥24wks & SB with severe anomalies	*4*	*0*	*3*	*1*	*0*	*3*	*1*	*16*
	Early NND	NNUH born alive & die ≤ 7days	0	1	0	0	1	0	1	3
	Bookings	Total number of Bookings	487	517	491	483	456	473	521	3428
		% Bookings ≤12+6 Weeks	93.0%	92.1%	90.6%	93.2%	91.2%	93.0%	85.8%	91.2%
	Inductions of labour	% Total IOLs	37.0%	35.3%	36.7%	35.2%	30.6%	30.7%	31.5%	33.8%
	Normal Vaginal Deliveries	% Total Cephalic & Other Cephalic & Breech	61.4%	65.8%	60.7%	57.7%	59.4%	62.3%	61.1%	61.2%
	Instrumental Deliveries	% Total Ventouse / Forceps	9.8%	10.0%	12.0%	11.4%	11.7%	10.9%	10.1%	10.8%
		% Forceps	7.5%	6.3%	8.3%	8.2%	7.2%	7.8%	6.0%	7.3%
		% Ventouse	2.3%	3.8%	3.7%	3.2%	4.5%	3.2%	4.1%	3.5%
	Caesarean Sections	% Total CS (Elective & Emergency)	29.2%	26.5%	28.5%	31.8%	30.9%	27.6%	30.9%	29.3%
		% Emergency (CS1, CS2, CS3)	16.9%	12.3%	15.9%	17.1%	13.2%	14.9%	18.1%	15.5%
		% Elective (CS4)	12.3%	14.2%	12.6%	14.7%	17.7%	12.6%	12.8%	13.9%
		% Robson 1: Primip single cephalic ≥37 wks spont. onset	1.6%	2.5%	2.4%	1.5%	2.3%	3.2%	4.1%	2.5%
		% Robson 2: Primip single cephalic ≥ 37 wks IOL / ELCS	9.8%	8.8%	12.4%	14.7%	10.6%	9.3%	10.9%	10.9%
		% Robson 5: Multip Prev CS, single cephalic ≥37 wks	8.0%	5.0%	5.7%	5.9%	5.1%	5.5%	4.5%	5.6%
Place	MLBU Births	MLBU Births	18.9%	18.4%	16.7%	18.1%	17.4%	18.7%	16.9%	17.9%
	Homebirths	Home births (Planned & Unplanned & Intransit)	2.1%	2.5%	2.0%	1.7%	1.7%	0.8%	3.1%	2.0%
Professionals	Care in Labour	Number BBA's (No MW or Obstetrician in attendance)	5	8	3	2	2	0	11	31
		% 1:1 Care in Labour	91.9%	92.2%	92.5%	93.1%	93.8%	91.6%	88.4%	91.9%
	Lead professional	% MW Led at birth	41.6%	39.9%	34.8%	38.5%	34.0%	26.7%	27.0%	34.5%
		% Cons Led at birth	58.7%	0.6033403	65.2%	61.5%	66.2%	73.3%	73.0%	65.5%
	Cons Hrs	Wkly dedicated Cons hrs on Labour ward	60	60	60	60	60	60	98	60
	MW Hrs	Midwife : Birth Ratio excl. band 3 MCA	1:30	1:30	1:30	1:30	1:30	1:30	1:30	1:30
		Midwife : Birth Ratio inc. band 3 MCA's	1:28	1:28	1:28	1:28	1:28	1:28	1:28	1:28
Wellbeing	Smoking status	% Mothers smoking at Booking	10.5%	11.5%	12.8%	11.4%	10.0%	12.0%	9.9%	11.1%
		% Mothers smoking at Delivery	10.7%	10.6%	10.2%	9.9%	8.7%	9.5%	8.6%	9.7%
	Breastfeeding	% Initiation: Breast milk < 48hrs	83.1%	80.4%	79.3%	78.5%	79.1%	78.3%	80.0%	79.8%
		% Exclusive BF @ transfer to community	62.3%	63.7%	62.2%	61.3%	64.0%	64.0%	63.4%	63.0%
		% Breast + Mixed feeding @ transfer to community	72.6%	71.6%	70.9%	69.5%	72.3%	72.8%	70.6%	71.5%
Risk Management	Maternal	% 3rd & 4th degree tears (per vaginal births)	2.2%	3.9%	4.2%	3.7%	4.2%	2.6%	1.7%	3.2%
		% PPH ≥1500mls	3.7%	2.9%	3.3%	3.8%	2.3%	5.1%	3.3%	3.5%
		Number Unplanned Admission To Critical Care Complex	0	0	0	0	1	1	0	2
		Number Emerg readmissions ≤30 days of delivery	6	10	4	12	4	6	5	47
		Number Maternal Death	0	0	0	0	0	0	0	0
	Neonatal	Number of Hypoxic Encephalopathy (Grades 2 & 3)	0	0	0	0	0	0	0	0
		Number Unplanned NICU ≥37wk Admissions (E3)	19	19	13	19	27	23	19	139
		Number Apgar score <7 @5, ≥37wk	3	7	5	0	8	2	4	29
	Serious Incidents	Number Number of SI's	0	0	0	1	1	2	0	4
	Closures & Diverts	Number Unit closures	0	0	0	0	0	1	0	1
		Number Mothers transferred out of unit	2	0	0	0	3	5	2	12
HoM Comments:		BBA rate – all cases being reviewed. More accurate data re: smoking at time of delivery, pleasing reduction may be resulting from collaborative work with SmokeFree Norfolk and Public Health Norfolk.								

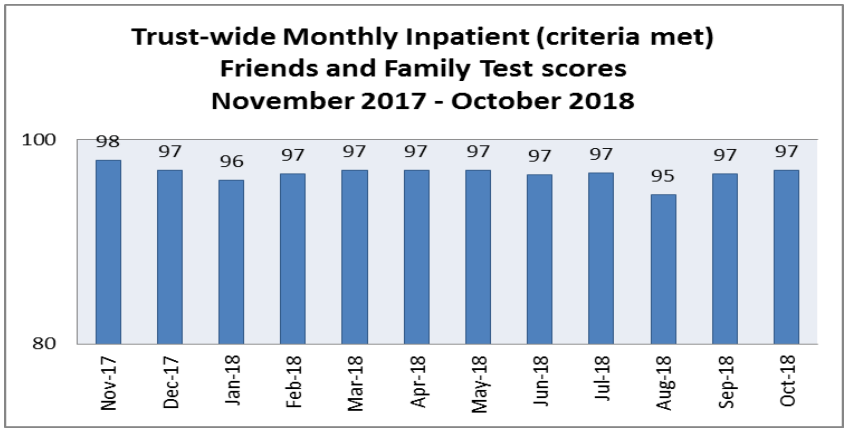
Core Slide 12

Quality and Safety Dashboard – Lead Director Nancy Fontaine

		Outrun 2017/18	Monthly Target	Sep-18	6 Month Trend	YTD 2017/18*	YTD 2018/19
Caring and Patient Experience							
1	Same Sex Breach	62	0	0		8	32
Infection Prevention and Control							
2	C Diff cases (hospital acquired)	35	N/A	2		18	19
3	MRSA bacteraemias (hospital acquired)	0	0	0		0	1
4	Norovirus (confirmed cases)	88	N/A	2		54	29
5	Elective MRSA Screening compliance	93.7%	>=95.0%	96.4%		93.3%	95.8%
6	Emergency MRSA Screening compliance	96.4%	>=95.0%	96.6%		96.8%	96.5%
7	Hand Hygiene Compliance	94.8%	>98.0%	98.8%		96.1%	96.1%
8	Dress Code Compliance	98.1%	>98.0%	99.2%		98.3%	98.6%
9	Commode Audits	95.3%	>98.0%	97.1%		95.8%	95.2%
Health & Safety							
10	Needlestick Incidents	114	N/A	5		57	44
Incident Reporting							
11	Total Number of Datix Incidents in month	12368	N/A	1188		5885	6784
12	Datix Incidents (reported in month) Finally Approved	6089	N/A	561		3104	3465
13	Number of Datix Incidents reported in month not closed	6270	0	627		2772	3320
Cleaning							
14	Cleaning Audit Results	96.1%	>=95.0%	96.3%		96.1%	96.1%
15	Cleaning Audit Results if Re-Audited	96.3%	>=95.0%	96.7%		95.9%	96.7%
Call Bell Waits							
16	Day Call Bell: Patient Call	02 min 07 sec	02 min 30 sec	02 min 04 sec		02 min 04 sec	02 min 03 sec
17	Day Call Bell: Bathroom Call	01 min 23 sec	02 min 00 sec	01 min 26 sec		01 min 19 sec	01 min 24 sec
18	Night Call Bell: Patient Call	01 min 20 sec	02 min 30 sec	01 min 11 sec		01 min 20 sec	01 min 18 sec
19	Night Call Bell: Bathroom Call	01 min 02 sec	02 min 00 sec	00 min 57 sec		00 min 58 sec	00 min 54 sec
Staffing							
20	Number of red flags for the month	12342	N/A	611		7147	3279

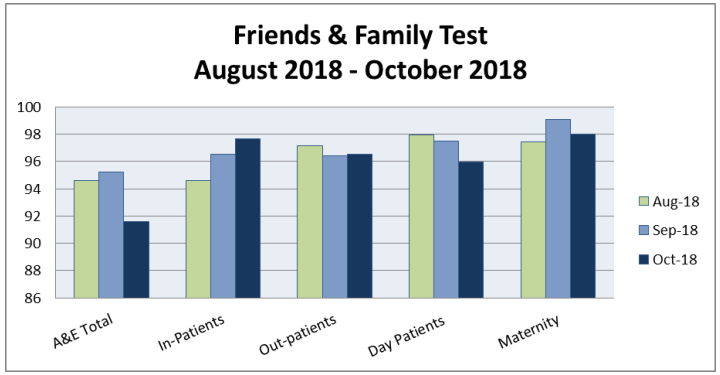
**YTD 2017/18 refers to the YTD figure at this point last year*

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



Patient Feedback

Overall Trust-wide performance remained at 97% in October. The scores for the individual areas are listed below.



Quarterly Report from Medicine Directorate:

Two examples of initiatives being implemented within the Medical Directorate to support patient experience include:

Leadership and Culture:

Within Medicine 1 and Medicine 2 the Senior Matron's have commenced feedback sessions from the production of the Nursing Dashboard. This allows areas to share good practice and learn from each other. The first feedback session took place in October following publication of the Dashboard

Outcomes: There was sharing of good practice regarding MRSA screening. Shared learning from falls. Identification of Safety Huddles practices to support the development of a template to record this information.

Actions: Focus on Mandatory training especially PMA/Tracheostomy and Resuscitation.

Engaging with Patients and their Families :

"The Singing Club" was established in 2012 by one of Respiratory Medicine's Specialist Nurses. There are now 2 sessions per month for patients and their relatives who have respiratory conditions. Each session is attended by 40 patients. The positive impact on patients includes the increase in lung function; reduce reliance on medication; endorphin release and cortisol production; and the socialisation and bonding it provides in bringing patients together.

Outcome: Positive patient experience

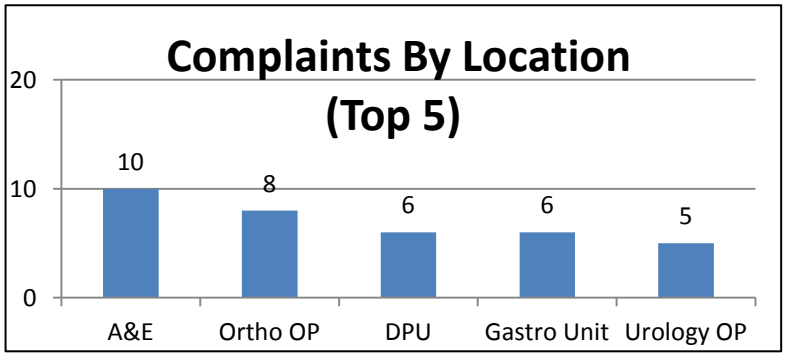
Patient X: "*I have managed to come off oxygen 16 hours a day and have a much improved quality of life. I have learnt how to better use my drugs and breathing techniques to reduce my breathlessness*"

Actions: To train more staff to be able to complete these sessions

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

Complaints Summary

96 complaints were received in October 2018. This compares to an average monthly figure of 81 complaints (average over the past 5 years)



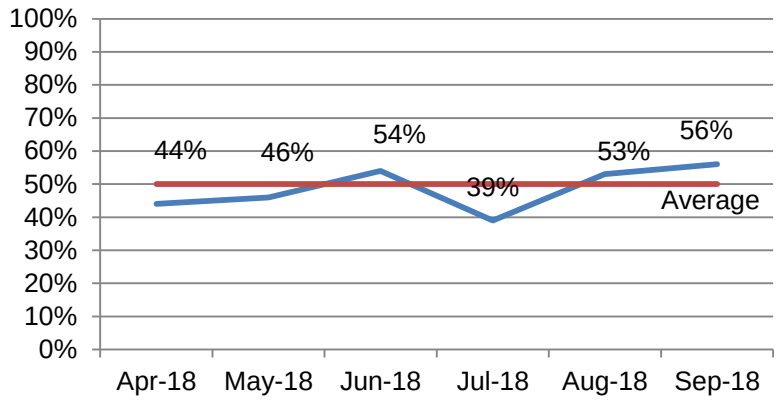
There are three new entries in the top five areas for complaints: Orthopaedic OP, which last featured in August 2018; DPU, which last featured in April 2018; and, Urology OP, which last featured in June 2018.

A clear theme emerging from these complaints is that patients are dissatisfied with the waiting time for surgical procedures across departments. In accordance with standard processes, each complaint is referred to the relevant department & clinical team to review for lessons to be learnt where possible and to be entered into the relevant clinical governance processes.

Focused Review:
A review has been undertaken of those complaints that relate to patients who have issues associated with meeting their mental health needs. There were 7 such complaints in 2017 (0.8%). So far in 2018 we have received 13 such complaints (representing 1.4% of all complaints received).

A review of these cases shows that all issues have been shared with NSFT and joint responses provided where appropriate. There are no clear themes or trends that emerge from these complaints but they each individually provide opportunities for reflection and feedback on our services

The organisation aims to complete the investigation of complaints within 25 days. The table below indicates current performance against this standard. Although the duration of the investigation is dependant on the complexity of the concerns raised, further actions are required to improve this performance.



Core Slide 15 High Risk Tracker Lead Director Nancy Fontaine

Risk Register HIGH RISK Tracker 15+ Risks **Date of Update** **06/11/2018**

This high risk tracker highlights all current risks on the Risk Register that have a Residual Risk Rating of 15+. Each risk is summarised below together with its current score and direction of travel over the last 3 months. The final column details the anticipated date for the reduction or resolution of the risk.

Ref	Risk Name	Current Risk score			3 month risk trend			Date Risk added	Executive Lead	Date of Last review	Latest Status report
		Cons.	Freq.	Risk Score	1mth ago	2mth ago	3mth ago				
ID 604	Sustainability of Cardiology catheterisation laboratory services due to equipment failure	4	4	16	16	16	16	03/05/2018	R.Parker	05/11/2018	Mitigation plan being worked up for additional cath lab. IRU expansion has been given consent from DH
ID 572	Financial sustainabilty	4	5	20	20	20	20	13/10/2015	J. Hennessey	01/10/2018	Risk of financial penalties both from 16/17 not resolved and 18/19 penalties due to the Trust not accepting its control total
ID 576	Nuclear Medicine - loss/disruption of service and regulatory compliance due to equipment failure, design of facilites and access to medical physics resource.	4	4	16	16	16	16	18/01/2018	R.Parker	03/08/2018	Business case progressing
ID 571	Failure to achieve key local and national operational performance targets	4	4	16	16	16	16	13/10/2015	R.Parker	25/07/2018	52wk RTT plans meet the 18/19 NHS Planning Guidance. ED 4 hour target remains challenging, and achievement of this fluctuates, however improving against NHSE plan.
ID 387	IRU capacity	4	4	16	16	16	16	03/06/2014	R.Parker	05/11/2018	Clinical mitigation plan in place lead by MD. IRU expansion has been given consent from DH
ID 404	Cardiology pacing waiting lists	4	4	16	16	16	16	10/11/2017	R.Parker	05/11/2018	Mitigation plan being worked up for additional cath lab. IRU expansion has been given consent by DH.
ID 568	Non -compliance with mandatory training	3	5	15	10	10	10	02/09/2015	J.Over	25/07/2018	Oversight rests with WESB with data and analysis provided to HMB and Board via IPR. This has been expanded recently in the light of CQC Must do's. Activities and interventions in place to increase have included: bespoke training days, non clinical mandatory compliance 1 day sessions, introduction of ESR portal and ESR app for remote distance learning, bank staff paid for training time, review of capacity of certain topics eg Resus. Score amended - current to 15 to reflect the impact on non compliance
ID 610	Ageing IT infrastructure	5	4	20	20	20	20	02/08/2018	A. Lundigran	05/11/2018	Existing controls will cease to have effect after December 2018. Mandate to proceed to Procurement. Business case for investment in IT infrastructure being developed. Move to virtual servers with failover functionality
ID 611	Ageing Sterile Services Equipment	4	4	16	16	16	16	14/08/2018	R.Parker	05/11/2018	Replacement programme to commence immediately with two replacement machines Old machines to be decommissioned and used for spares to maintain the remaining machines pending replacement. Replacement programme to continue with two machines per year until all 7 have been replaced. Cost approximately £70k per machine
ID 619	CQC Rating	4	5	20	20	New	New	02/10/2018	N. Fontaine	01/11/2018	Additional resource secured and appointed Programme Director who has oversight of the QIP Existing internal resource identified and redirected to support the programme management of the QIP
ID 363	Opthalmology capacity for follow up appointments	4	4	16	16	12	12	20/03/2013	R. Parker	05/11/2018	Risk raised to 16 as lilkelihood has increased and there have been some harm identified as a result of waiting times in 3 cases. HII Remedial action plan in place
ID 623	Non delivery of financial plan 2018/19	4	4	16	New	New	New	31/10/2018	J. Hennessey	31/10/2018	Financial plan in place. Regular financial forecasting reported through Trust Governance structure to the Board. Accountability meetings with Divisional Triumvirates
ID 624	Medium term financial strategy	4	5	20	New	New	New	31/10/2018	J.Hennessey	31/10/2018	Plan being worked up by end Q3. This will include reasonable assumptions about structural and national funding. Plan will be stress tested
ID 625	Equipment replacement programme	5	3	15	New	New	New	31/10/2018	S. Hackwell	31/10/2018	Divisions asked for list of urgent equipment replacement risk rated for both clinical risk and business risk impact. This went through Divisional Governance processes and was approved via Divisional boards.All those scoring >12 were included on the Capital loan application to NHSi. NHSi asked for Trust to rationalise the value of the application therefore risks scoring >16 have been put forward. Still awaiting NHSi decision on loan

Core Slide 16

Performance – Monitor KPI's - Lead Director Richard Parker

Performance		Outturn 2017/18	Monthly Target	Oct-18	6 month trend	YTD 2017/18	YTD 2018/19
Cancer	Core Slide 18-20						
1 Cancer 62 day target for referral to treatment - GP Referral *		81.52%	85.00%	69.69%		81.79%	71.87%
2 Reallocated Cancer 62 day target for referral to treatment (Previous Month) - GP Referral * +		83.04%	85.00%	70.27%		82.37%	74.16%
3 Cancer 2 week wait - all cancers *		94.29%	93.00%	71.96%		92.79%	79.74%
4 Cancer - 62 day screening *		87.41%	90.00%	66.67%		85.38%	81.59%
6 Cancer 31 day target compliance		98.59%	96.00%	94.29%		98.65%	96.10%
7 Cancer 31 day target for subsequent treatments - Surgery *		95.33%	94.00%	80.65%		97.31%	85.07%
8 Cancer 31 day target for subsequent treatments - Anti Cancer Drugs *		99.77%	98.00%	98.45%		100.00%	99.35%
9 Cancer 31 day target for subsequent treatments - Radiotherapy *		98.32%	94.00%	97.20%		98.14%	97.29%
A&E	Core Slide 21						
10 A&E 4 hour target compliance		80.67%	90.00%	84.27%		88.71%	82.93%
11 A&E 4 hour target compliance combined (inc WiC)***		n/a	90.00%	88.90%			88.22%
12 Number of 30 minute handover breaches		6196	0	773		2184	4430
13 Number of 60 minute handover breaches		3698	0	200		871	1632
14 Arrival to Handover time (>15 minutes)		48.9%		60.5%		31.6%	61.1%
RTT	Core Slide 22						
15 18 week RTT target - Patients on an incomplete pathway		83.91%	92.00%	82.65%		84.58%	84.43%
16 Admitted Backlog		3995.0	n/a	3977		3995	3864
17 Incomplete Non Admitted Backlog		2423	n/a	3125		2423	2540
Stroke	Core Slide 23						
18 Stroke internal overall SSNAP rating		B	B	A	BBABBA	B	B
Patient Flow							
19 Diagnostics		99.14%	99.00%	99.04%		99.16%	99.19%
20 Cancelled Operations		1354	n/a	112		620	639
21 Number of 28 day breaches		231	0	18		113	102
22 Average Delayed Transfers of Care		36	n/a	27		36	36
23 30 Day Readmission Rates**		12.43%	n/a	12.71%		12.29%	12.94%
24 Length of Stay (Elective)		3.10	n/a	3.29		3.10	3.29
25 Length of Stay (Non-Elective)		4.23	n/a	3.94		4.23	4.03
26 Average number of patients with LoS >14 days		197	200	176		197	186
*Please note these figures are provisional							
** Reporting one months in arrears							

+ *This metric has been calculated in accordance to NHSI and East of England Cancer Alliance Reallocation policy, which displays the Trust's reallocated position. Please note that this policy came in to affect for August 2017's data. Therefore, all data predating August 2017 should be considered as the Trust's pre-reallocated position.* October's 2018's data is subject to final validation and agreement from tertiary provider trusts.

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

Core Slide 17

Performance Summary - Lead Director Richard Parker

Performance – key issues

1. **Cancer** – High demand for 2WW referrals continues however bottlenecks in pathways easing as remedial actions take effect. 62 day backlog reducing, including halving of Urology backlog. Formal RAP drafted, awaiting CCG approval.

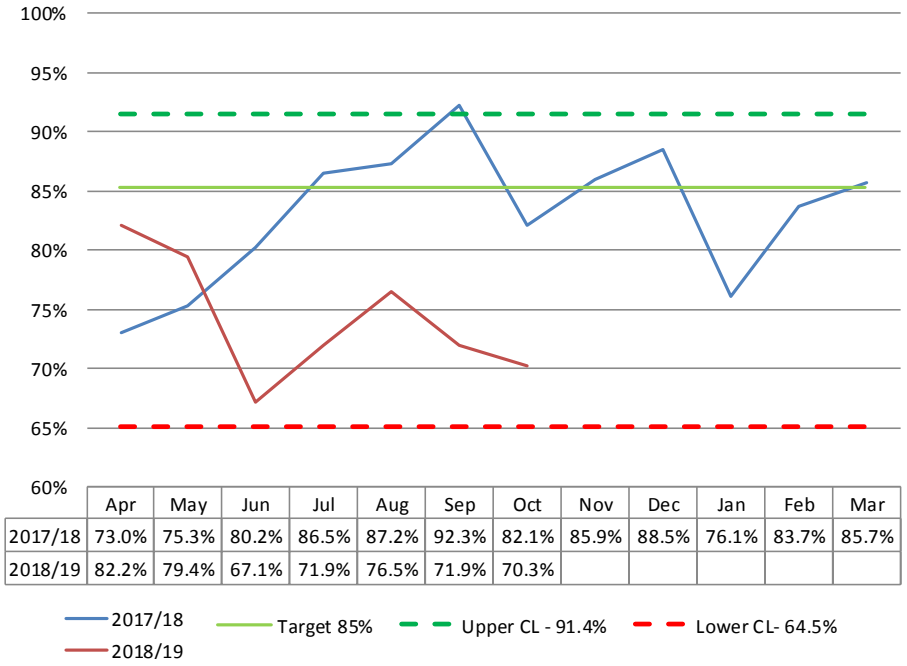
2. **ED –** System performance below recovery trajectory at 89%. ED demand increased by 5.8% on October 2018 with ambulance arrivals up by 4.1% on October 2018. Bed pressures, variability in process and human factors contributed to the under delivery of this trajectory.

3. **RTT –** A continued increase in 2ww referral impacting on RTT. Reduction schemes continue to be explored with commissioners as part of mitigating actions within and additional to the RAP. Known issues of an ageing waiting list remain, with greater clinical urgency displacing long routine waits. Long waits continue to be clinically reviewed and the PTL manages prospective risk.

4. **Stroke** – Overall SSNAP rating of 'A' for October – second time in 3 months. Achieved a 'B' in Stroke Unit for the first time. 10% improvement in CT scanning score.

Core Slide 18 Performance (Cancer) - Lead Director Richard Parker

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



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2017/18	73.0%	75.3%	80.2%	86.5%	87.2%	92.3%	82.1%	85.9%	88.5%	76.1%	83.7%	85.7%
2018/19	82.2%	79.4%	67.1%	71.9%	76.5%	71.9%	70.3%					

Issues

- Significant increase in 2ww referrals impacting on capacity and recovery. Backlog reduction still a priority to reduce breaches and regain performance with progress demonstrated in November.
- Capacity constraints in template biopsies and robotic surgery impacting on waiting times for surgery and overall urology performance.
- Significant increase in 2ww referrals impacting on Dermatology leading to temporary increase in 62 day breaches. 2WW waiting times reduced to average of 18 days.

Actions

- Micromanagement of cancer PTL continues with second weekly escalation PTL meetings in place for challenged specialties as required.
- Increased diagnostic/treatment capacity in Urology in place via weekend working for November and through change in weekday list allocation.
- Trial of template biopsies under LA commenced.
- STP focus on lung and urology pathways with additional posts for both pathways approved.
- Cancer transformation funding allocated for projects to commence and recruitment now underway. Capital funding allocation still outstanding.

This metric has been calculated in accordance to NHSI and East of England Cancer Alliance Reallocation policy, which displays the Trust's reallocated position. Please note that this policy came in to affect for August 2017's data. Therefore, all data predating August 2017 should be considered as the Trust's pre-reallocated position. October's 2018's data is subject to final validation and agreement from tertiary provider trusts. Final position will be confirmed in December 2018.

Core Slide 18a

Performance (Cancer) - Lead Director Richard Parker

62 Day GP Breaches – September (Open)

	Breast	Gynaecology	Haematology	Head and Neck	Lower GI	Lung	Sarcoma	Skin	Upper GI	Urology	Grand Total
Administrative delay (e.g. failed to be rebooked after Did Not Attend, lost referral)		0.5		1.5	1	0.5			1	1.5	6
Complex diagnostic pathway (many or complex diagnostic tests required)	1		1						1	1	4
Elective capacity inadequate (Patient unable to be scheduled for treatment within standard time)	0.5			1.5	2	2		2		3	11
Health care provider initiated delay to diagnostic test or treatment planning					0.5		0.5		3	10	14
Out-patient capacity inadequate (i.e. no cancelled clinic, but not enough slots for this patient)								3		2	5
Patient choice (patient declined or cancelled an offered appointment date for treatment)										2	2
Patient choice (patient declined or cancelled an offered appointment date for follow up appointment)	1										1
Grand Total	**2.5**	**0.5**	**1**	**3**	**3.5**	**2.5**	**0.5**	**5**	**5**	**19.5**	**43**

	Cancer Waiting Times	East of England Reallocation
Activity	153	153
Breaches	44	43
Performance	71.24%	71.90%

Urology contributes highest number of breaches, Prostate pathway remains an area of focus to reduce number of breaches.
Colorectal has multiple pathway delays including outpatients, surgery and oncology
Late tertiary referrals and delays to surgery for lung pathway.

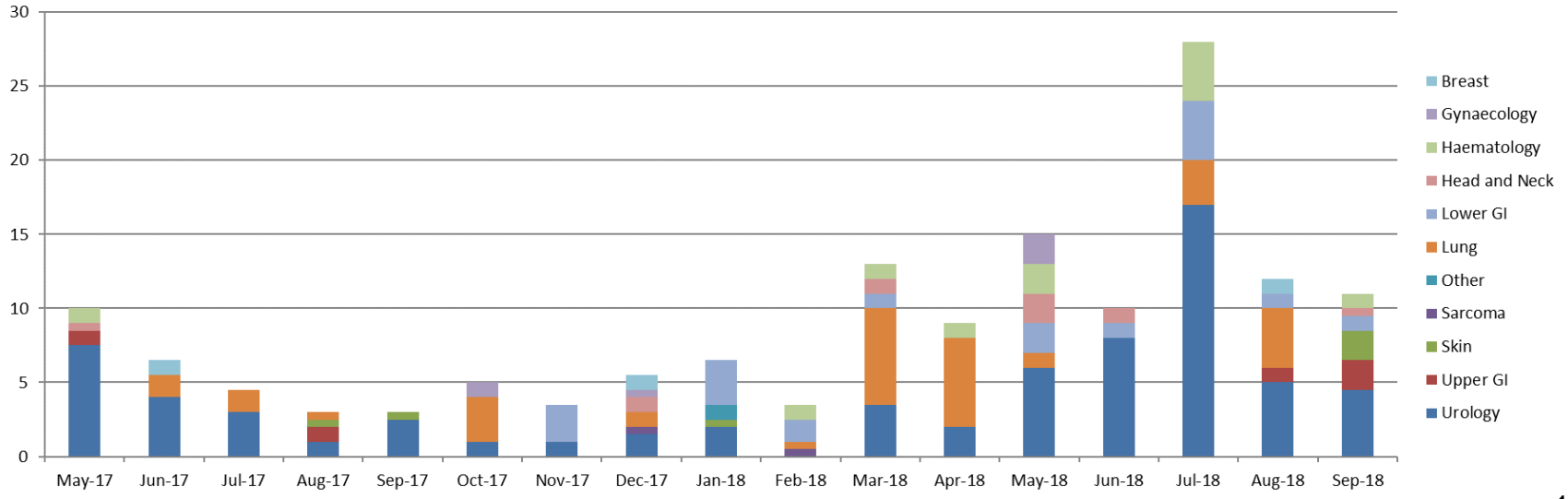
Core Slide 18b

Performance (Cancer) - Lead Director Richard Parker

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

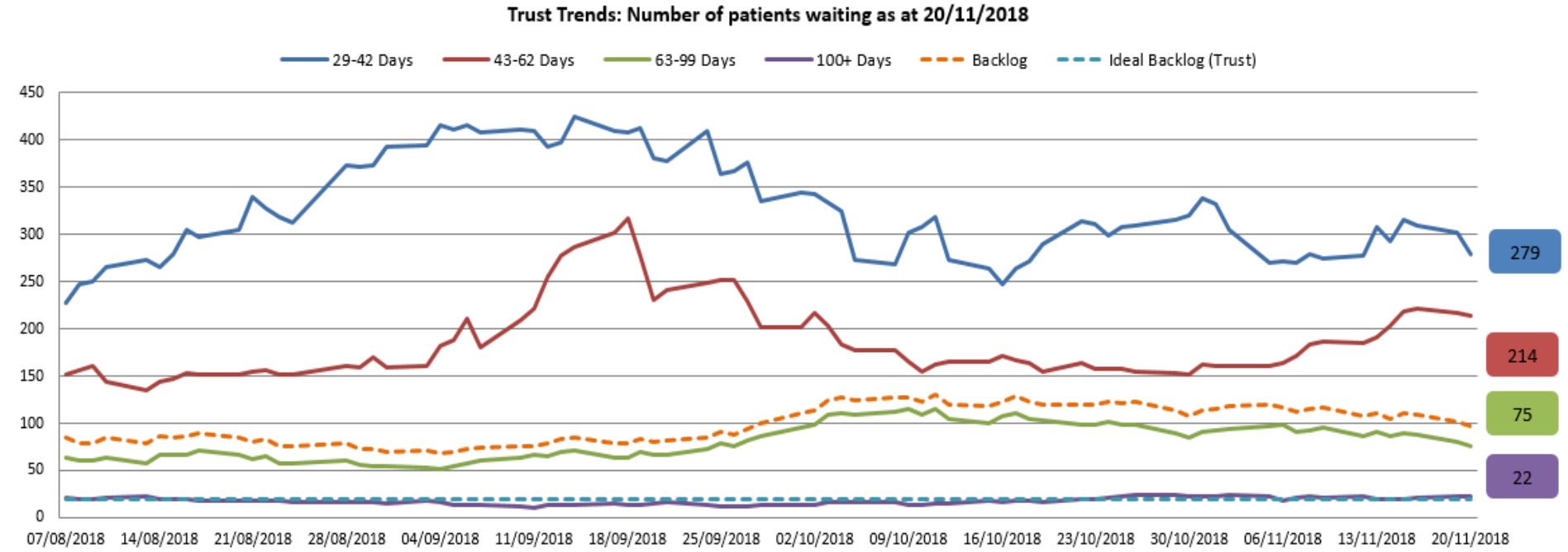
	Haematology	Head and Neck	Lower GI	Skin	Upper GI	Urology	Grand Total
Administrative delay (e.g. failed to be rebooked after Did Not Attend, lost referral)		0.5	1			0.5	2
Complex diagnostic pathway (many or complex diagnostic tests required)	1				1		2
Elective capacity inadequate (Patient unable to be scheduled for treatment within standard time)				2		1	3
Health care provider initiated delay to diagnostic test or treatment planning					1	3	4
Grand Total	**1**	**0.5**	**1**	**2**	**2**	**4.5**	**11**

Urology represents most long waiters consisting primarily of Prostate patients. All harm reviews have shown no harm caused.



Core Slide 19

Performance (Cancer) - Lead Director Richard Parker



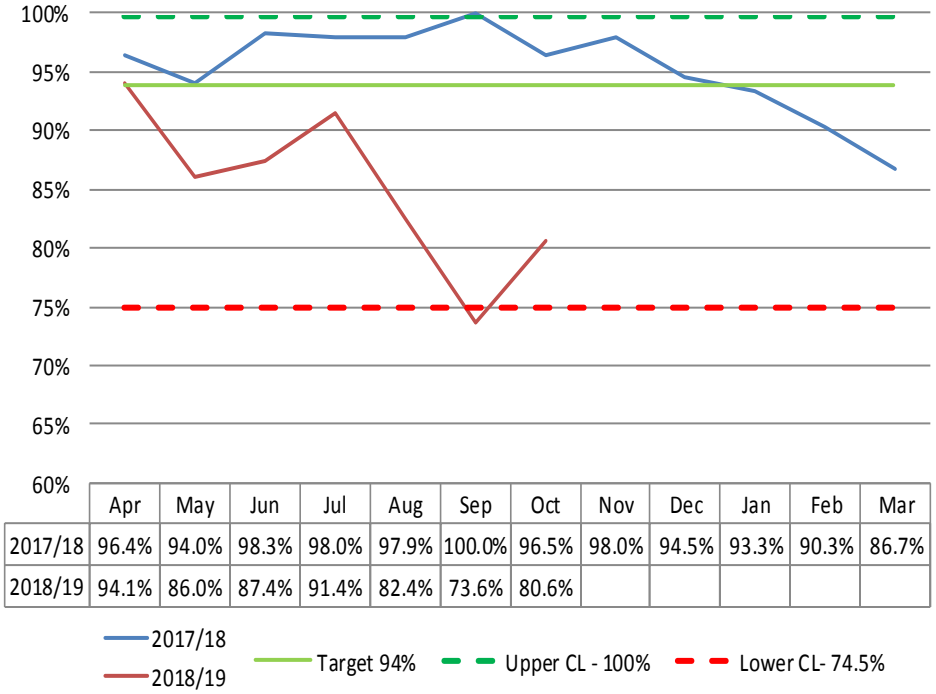
TOTAL	0-14 Days	15-28 Days	29-42 Days	43-62 Days	63-99 Days	100+ Days	Backlog	Rollovers*
2,307	1,064	653	279	214	75	22	97	31

Backlog increased due to Dermatology pathology reporting delays, these patients have been treated and are waiting for histology results. Waiting times for Dermatology reducing and will have significant improvement on backlog numbers. Urology backlog halved during November (42 to 21).

Core Slide 20

Performance (Cancer) – Lead Director Richard Parker

Cancer 31 day target for subsequent treatments - Surgery *



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

Issues

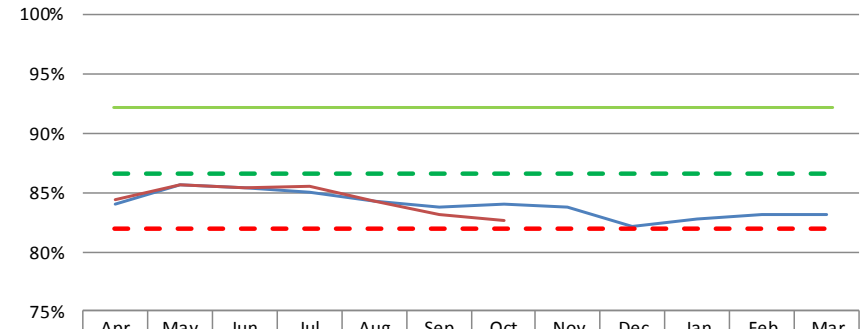
- Competing targets and pressures in Urology and Plastic Surgery continue to depress performance.
- Actions in place to increase capacity in plastics (from December 18) and Urology.

Actions

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

Core Slide 21 — Performance (RTT and A&E) – Lead Director Richard Parker

18 week RTT target - Patients on an incomplete pathway

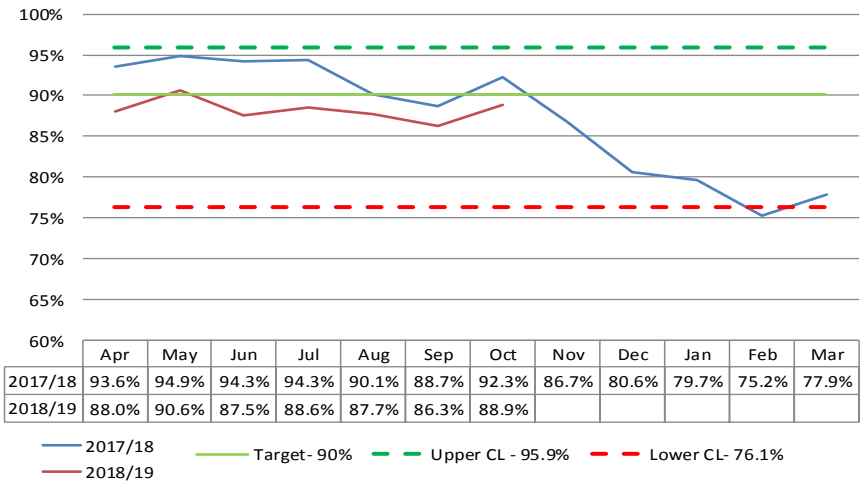


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2017/18	84.0%	85.6%	85.4%	85.0%	84.3%	83.8%	84.1%	83.7%	82.2%	82.7%	83.2%	83.1%
2018/19	84.3%	85.7%	85.4%	85.5%	84.3%	83.1%	82.6%					

Issues
- Expected increase in waiting list with an increase in over 18 weeks due to increase in demand and Cancer
- Corresponding increase in 40+weeks
- 52 week waits expected due to IRU capacity Issues

Actions
- RTT trajectory revised to model impact of cancellations and take new operating guidance into account.
- Additional demand management schemes from CCG's and potential capacity increase from Turnstone Court now included and RAP awaiting sign off by CCG's
- Full capacity and demand modelling refresh underway to inform future RAP and business planning

System Performance



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

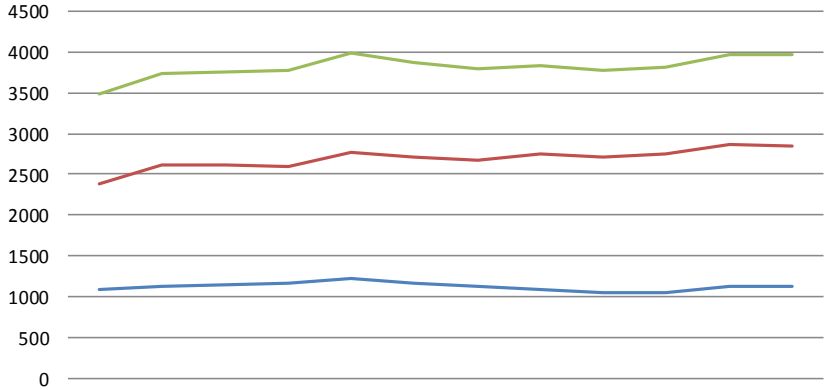
Issues
- NNUH performance 84.3% compared to 88.1% last October
- System wide performance 89% compared to 92.3% last October. 0.1% behind trajectory
- Attendances up by 5.8% with ambulance arrivals up by 4.1% compared to last October

Actions
- Winter Plan developed.
- Winter Room triumvirate appointed
- Oversight Assurance Group Deep Dive – 15th November 2018

Core Slide 22

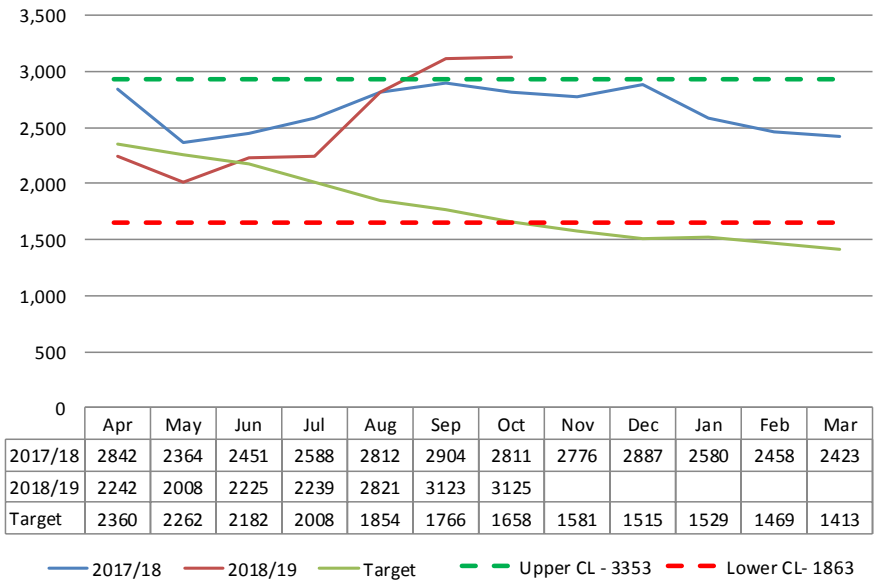
Performance (RTT) – Lead Director Richard Parker

Admitted Backlog



	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18
Admitted IP Backlog	1088	1133	1139	1174	1224	1172	1126	1095	1059	1055	1119	1129
Admitted DC Backlog	2392	2611	2608	2596	2771	2707	2667	2744	2720	2751	2858	2853
Admitted Backlog	3481	3747	3748	3770	3995	3879	3793	3839	3779	3806	3978	3977

Incomplete Non Admitted Backlog



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

Issues
- Backlog increased over winter and subsequent cancer demand impacting on recovery back to pre winter levels.
- Theatre refurb programme delayed by three weeks, has impacted October activity

Actions
- Theatre efficiency programme in place, week on week improvements seen in a number of specialities .
- Focus on cancellation prevention, booking levels and in session coordination
- Case to utilise Turnstone court theatres in development

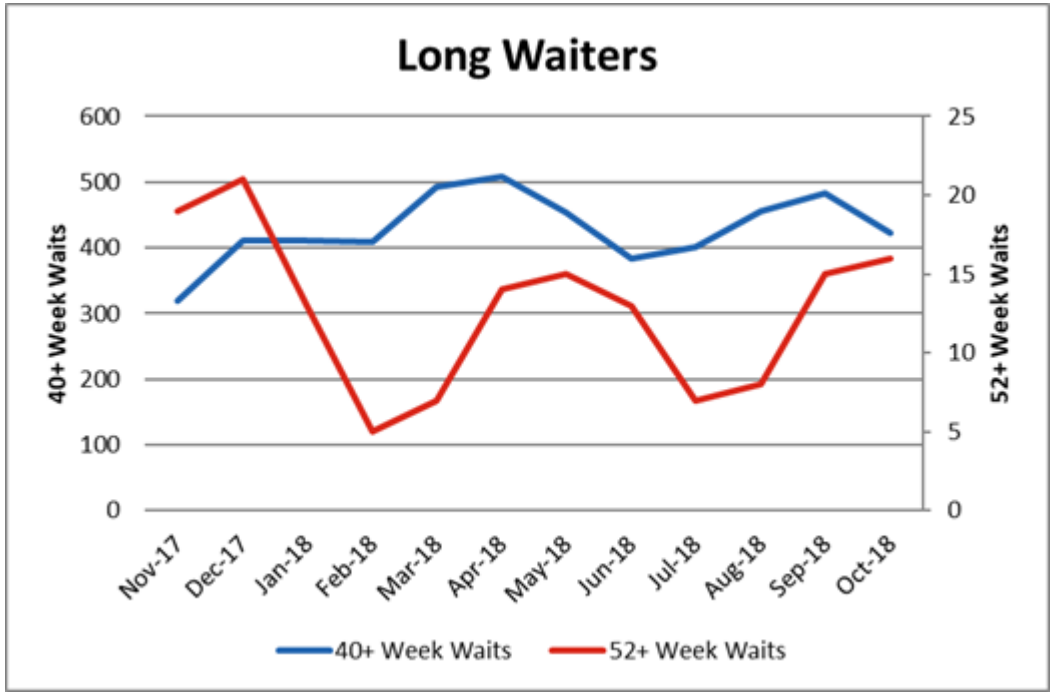
Issues
- Increase in non admitted waiting list continues, driven by increase demand and 2ww referrals
- Increase in 2ww referrals impacting on overall waiting list size and will continue to impact on backlog in future months

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

Additional Slide 22a

Performance (RTT) – Lead Director Richard Parker

Long Waiters - Over 40 and 52 weeks



Comments

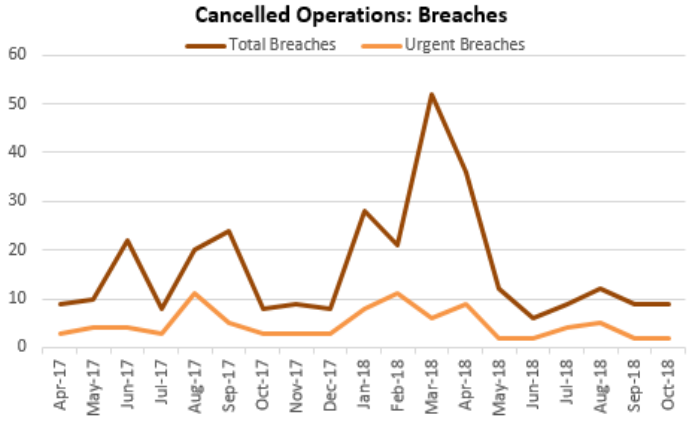
- increase in 52wk patient numbers due to IRU capacity and 40wks waits have decreased. Interim plans being developed to increase IRU capacity
- Rigorous monitoring of clinical harm in place
- Proactive management of long-waiting patients continues but with an increasing spread across several specialities.

Additional Slide 22b

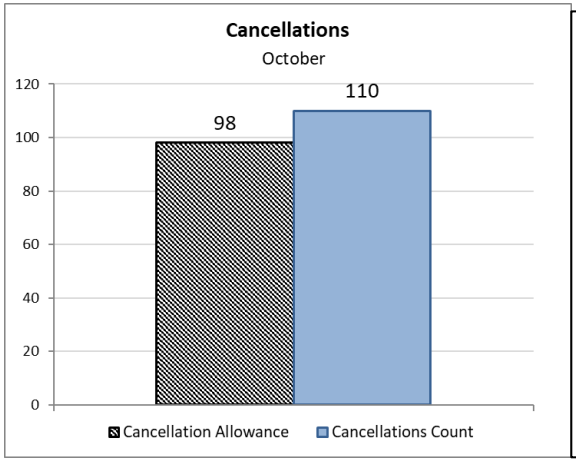
Performance (RTT) – Lead Director Richard Parker

Cancelled Operations

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

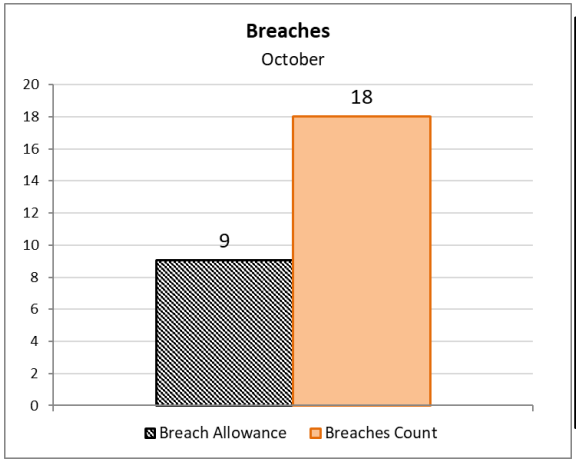


Month	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18
Total Breaches	9	10	22	8	20	24	8	9	8	28	21	52	36	12	6	9	12	9	9
Urgent Breaches	3	4	4	3	11	5	3	3	3	8	11	6	9	2	2	4	5	2	2



Target: NHS England's last minute cancelled operations rate is c. **1.1%** of all elective activity.

- Based on September's elective activity this would equate to **98** cancellations.
- NNUH saw **110** cancellations.
- This represented **1.2%** of elective activity.



Target: NHS England's breach percentage is c. **9.2%** of last minute cancelled operations.

- Based on September's last minute cancellations this would equate to **9** breaches.
- NNUH saw **18** breaches.
- This represented **16.4%** of cancellations.

Core Slide 23

Internal Sentinel Stroke Audit Programme (SSNAP) Dashboard

PERIOD	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18
OVERALL SSNAP SCORE	77.0	77.0	74.5	72.0	66.0	84.0	74.0	72.0	74.0	82.0	76.0	80.0	82.0
OVERALL SSNAP RATING	B	B	B	B	C	A	B	B	B	A	B	B	A
POTENTIAL STROKES	288	297	309	297	296	310	310	311	283	281	299	287	279
DIAGNOSED STROKES	99	91	97	98	107	112	106	93	80	103	91	91	104
DOMAIN 1 score	86.6	86.6	85.3	84.0	73.5	96.7	87.7	93.3	82.5	96.7	93	82.59	92.4
CT Scanning													
DOMAIN 1 rating	B	B	B	C	C	A	B	B	C	A	A	C	B
DOMAIN 2 score	65.9	65.9	60.9	55.9	49.7	60.8	69.5	69	67	74.5	74.9	73.6	83.2
Stroke Unit													
DOMAIN 2 rating	D	D	D	E	E	D	D	D	D	C	C	C	B
DOMAIN 3 score	71.6	71.6	70.6	69.6	63.4	71	55.3	66.4	65.7	75.8	75.4	72.4	77.4
Thrombolysis													
DOMAIN 3 rating	B	B	B	C	D	B	D	C	C	B	B	B	B
DOMAIN 4 Score	90	90	90.5	91	83.3	89.3	86.7	88	85.1	88	91	88.7	92.2
Specialist Assessments													
DOMAIN 4 Rating	A	A	A	A	B	B	B	B	B	B	A	B	A
DOMAIN 5 Score	73.7	73.7	77.1	80.4	74.5	82.5	76.2	67	75.9	77.2	74.7	83.62	76.6
Occupational Therapy													
DOMAIN 5 Rating	C	C	B	A	C	A	B	C	B	B	C	A	B
DOMAIN 6 Score	79.5	79.5	74.7	69.8	76.3	80.2	78.6	73.2	75	76	75.1	80.21	78.5
Physiotherapy													
DOMAIN 6 Rating	B	B	C	C	B	B	B	C	B	B	C	B	B
DOMAIN 7 Score	60.2	60.2	58.8	57.3	63.6	70.5	65.7	62.8	62.5	59.5	53.6	56.59	63.6
SALT													
DOMAIN 7 Rating	C	C	C	C	C	B	B	C	C	C	D	C	C
DOMAIN 8 Score	80	80	78.8	77.6	78.2	82	79.5	75.8	80.9	81.9	79.2	81.0	81.0
MDT Working													
DOMAIN 8 Rating	B	B	C	C	C	B	C	C	B	B	C	B	B
DOMAIN 9 Score	93.5	93.5	95.8	98.0	97.7	97.9	98.7	95.7	97.9	98.3	92.0	98.5	91.0
Standards by Discharge													
DOMAIN 9 Rating	A	A	A	A	A	A	A	A	A	A	B	A	B
DOMAIN 10 Score	99	99	99.5	100.0	100	100	100	100	100	100	98.3	100	100
Discharge Process													
DOMAIN 10 Rating	A	A	A	A	A	A	A	A	A	A	A	A	A

Internal overall SSNAP Rating for October 2018

A 82%

Overall Summary:

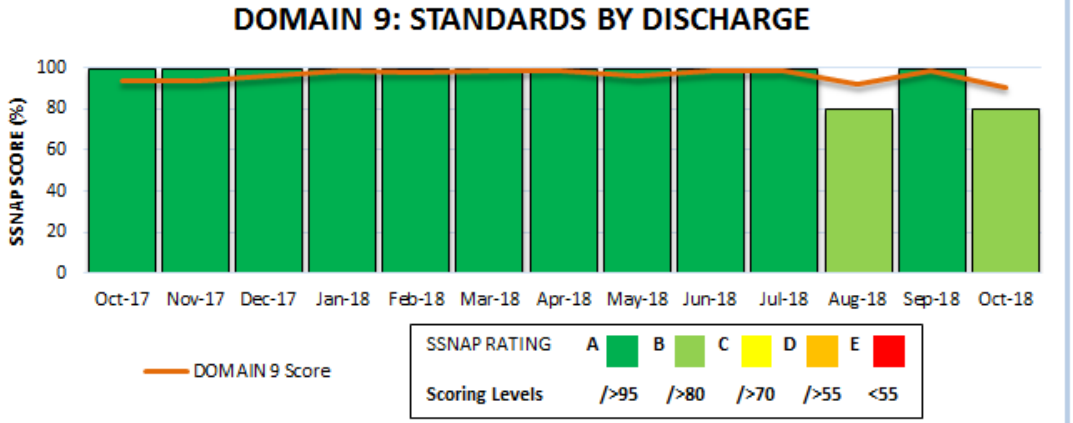
- Achieved a B in Stroke unit for the first time (up from a C in the last 3 months).
- 10% Improvement in CT Scanning score
- The SSNAP QUIP team has been developing targeted interventions to improve SSNAP ratings consistently.

Action:

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

Core Slide 23a

Exceptions:

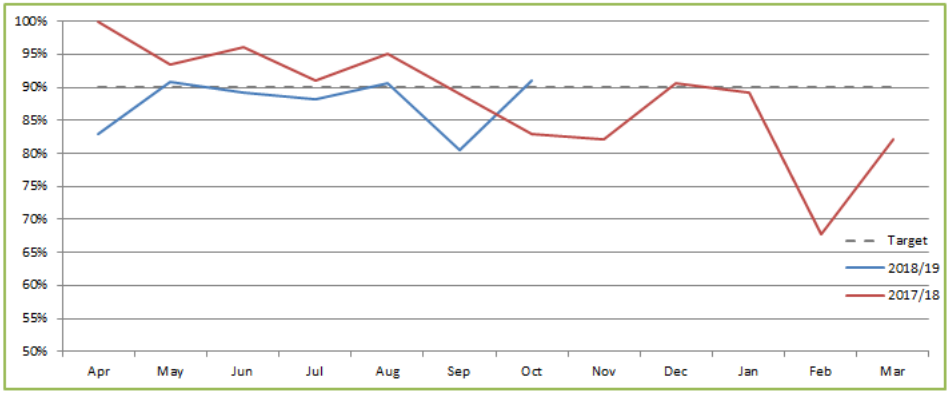


Summary

Consistency of requests for Mood Screening and Nutritional Screening to be discussed to ensure we maintainn an 'A' rating.

Transient Ischaemic Attack (TIA):

NNUH Transient Ischaemic Attack (TIA)
% of high risk patients treated within 24 hrs of first contact



Summary

The TIA performance has improved. The E-referral system came online in September which has improved delays at weekends Ongoing disucussions with Radiology Doppler capacity.

Breach Reasons:

Doppler delays = 4

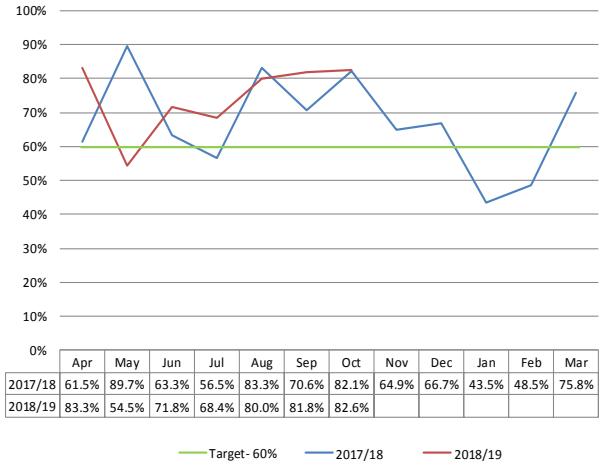
Stroke Team Capacity = 0

Total = 4

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2018/19	83.0%	90.9%	89.1%	88.2%	90.6%	80.5%	91.1%					
2017/18	100.0%	93.5%	96.0%	91.0%	95.0%	89.0%	83.0%	82.2%	90.6%	89.2%	67.7%	82.1%

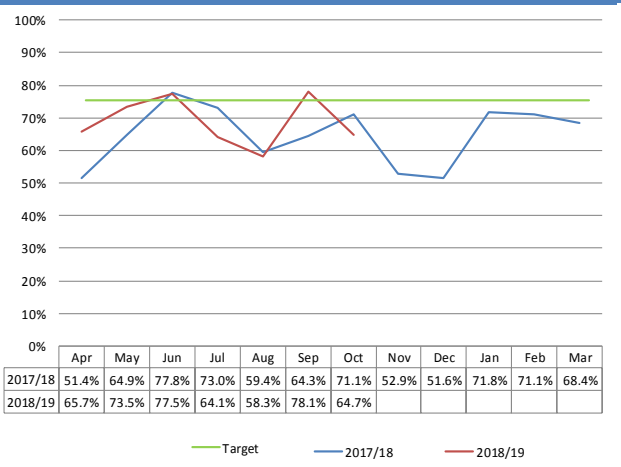
Core Slide 24 Performance (Cardiology) - Lead Director Richard Parker

% NSTEMI Time to Procedure < 72 Hours



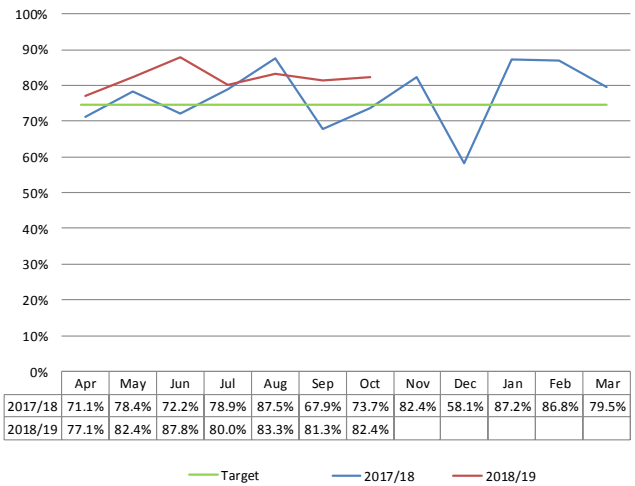
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2017/18	61.5%	89.7%	63.3%	56.5%	83.3%	70.6%	82.1%	64.9%	66.7%	43.5%	48.5%	75.8%
2018/19	83.3%	54.5%	71.8%	68.4%	80.0%	81.8%	82.6%					

% PPCI Call to Balloon < 150 Minutes



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2017/18	51.4%	64.9%	77.8%	73.0%	59.4%	64.3%	71.1%	52.9%	51.6%	71.8%	71.1%	68.4%
2018/19	65.7%	73.5%	77.5%	64.1%	58.3%	78.1%	64.7%					

% PPCI Door to Balloon < 60 Minutes



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2017/18	71.1%	78.4%	72.2%	78.9%	87.5%	67.9%	73.7%	82.4%	58.1%	87.2%	86.8%	79.5%
2018/19	77.1%	82.4%	87.8%	80.0%	83.3%	81.3%	82.4%					

Standard Delivered

Breach Reasons:

- Required additional treatment pre PPCI
- Ambulance ECG not diagnostic of STEMI, another PT on table, delay in A&E (NNUH)
- Cardiac arrest, delay in A&E, emergency treatment required pre PPCI,
- Long journey time >60 mins
- Long on scene time, another PT already on table
- Technically difficult procedure
- Short activation time
- Self presented at non interventional hospital
- ECG misinterpreted, lab equipment malfunction, delay in A&E, another PT already on table

Standard Delivered

Core Slide 25 Performance (Productivity) Summary – Lead Director Richard Parker

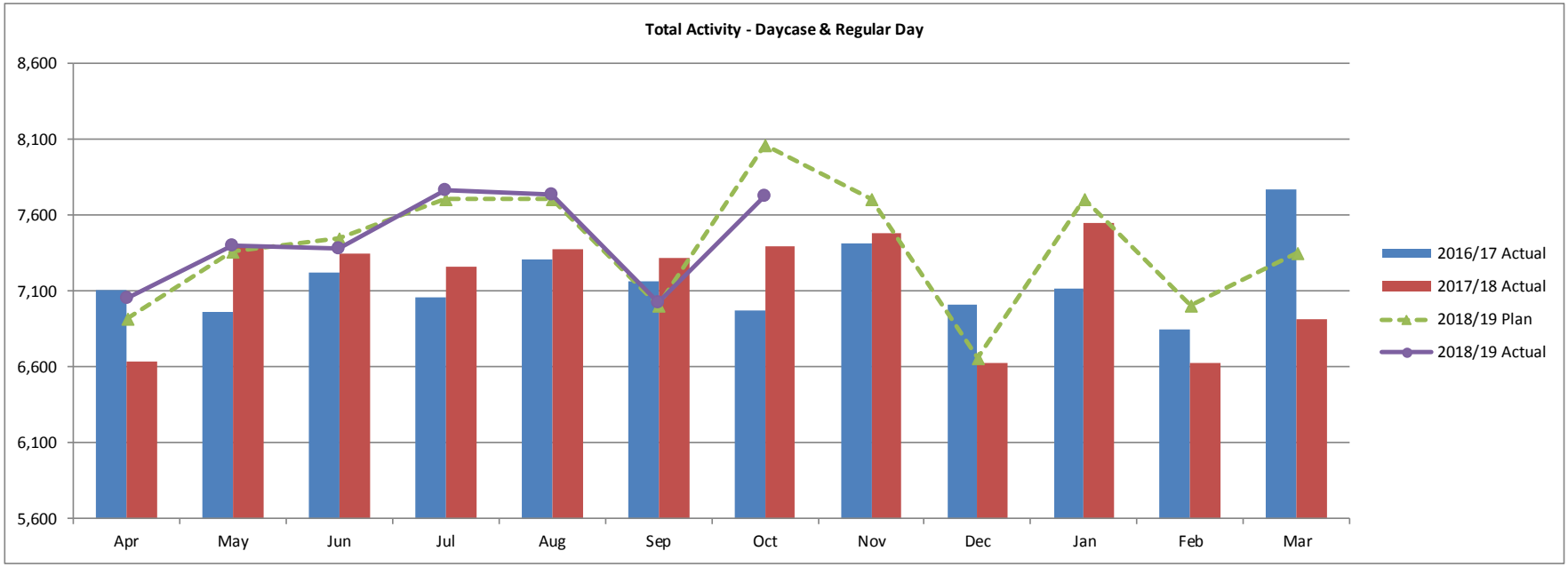
Productivity		Outturn 2017/18	Monthly Target	Oct-18	6 month trend	YTD 2017/18	YTD 2018/19
A&E Activity (attendances)		131235	11534	11949		78396	83810
Elective Activity - Day case spells	Core Slide 26	85923	8064	7731		50735	52104
Elective Activity - Elective inpatient spells	Core Slide 26a	13330	1282	1054		8014	7566
Emergency Admissions	Core Slide 26b	56018	4473	5094		32093	34056
Outpatient Activity (consultant led & non-consultant led)	Core slide 26c	725710	67457	70367		422086	449131

Core Slide 26

Performance (Productivity) – Lead Director Richard Parker

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

Activity	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Full Year
2016/17 Actual	7,111	6,959	7,219	7,063	7,311	7,161	6,970	7,419	7,013	7,113	6,846	7,774	**49,794**	**85,959**
2017/18 Actual	6,636	7,402	7,346	7,263	7,372	7,316	7,400	7,481	6,627	7,546	6,623	6,912	**50,735**	**85,924**
2018/19 Plan	6,920	7,360	7,449	7,709	7,709	7,006	8,064	7,707	6,656	7,708	7,010	7,356	**52,217**	**88,654**
2018/19 Actual	7,053	7,398	7,385	7,770	7,738	7,029	7,731						**52,104**	**52,104**
Variance to 2017/18	417	(4)	39	507	366	(287)	331						**1,369**	**1,369**
Variance to 2017/18 %	6.3%	-0.1%	0.5%	7.0%	5.0%	-3.9%	4.5%						**2.70%**	
Variance to Plan	133	38	(64)	61	29	23	(333)						**(113)**	**(113)**
Variance to Plan %	1.9%	0.5%	-0.9%	0.8%	0.4%	0.3%	-4.1%						**-0.22%**	



Issues and Comment

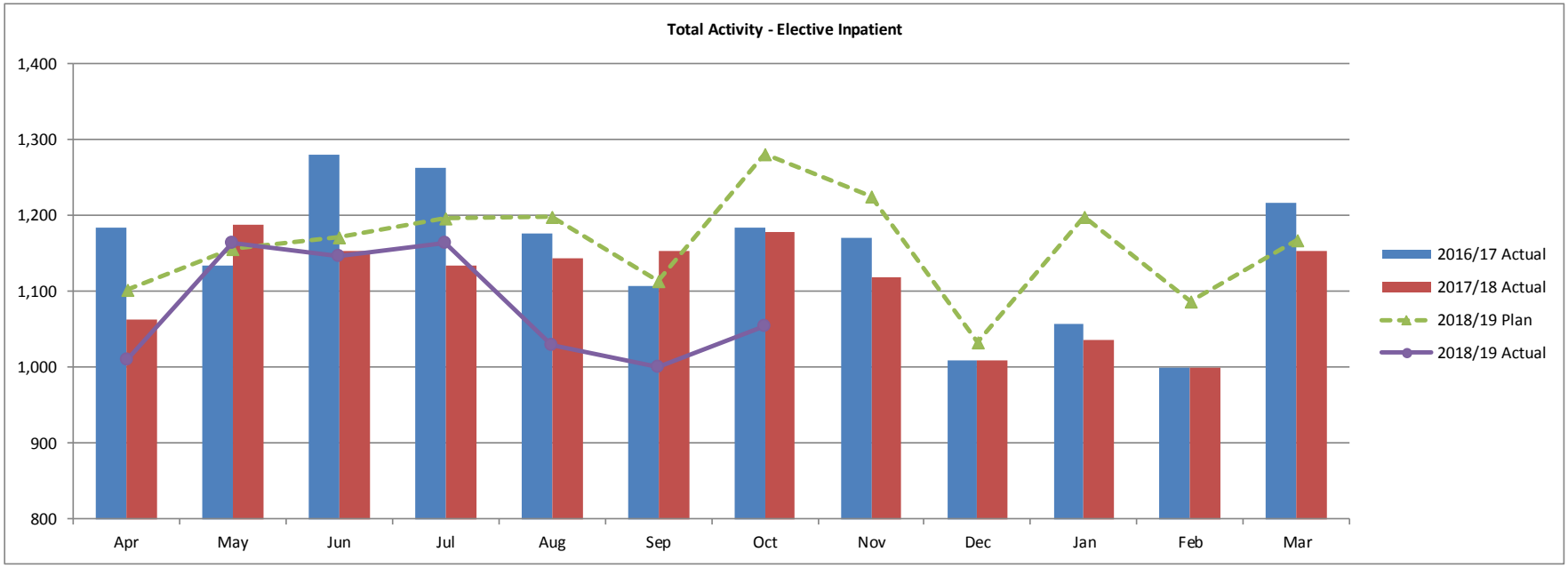
- Overall daycase performance was under plan by 333 cases (-4.1%) but 331 more than October 2017 (+4.5%)
- This performance was again a mixed picture with medicine underperforming by 69 cases (mainly gastro and clinical oncology) and surgery 260 cases down compared to plan (mainly dermatology, general surgery and ophthalmology). Dermatology have an ongoing challenge with capacity and demand, new outpatients prioritised to manage 2ww referrals, full compliment of Junior doctors from September will see an improving picture. Dermatology accounted for 153 cases behind the plan in surgery.
- Case mix shift in Surgery work with a high level of non-elective activity particularly in general surgery, plastics and urology, limiting over performance in day cases and electives as a result of theatre productivity programme

Additional Slide 26a

Performance (Productivity) – Lead Director Richard Parker

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

Activity	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Full Year
2016/17 Actual	1,184	1,134	1,280	1,263	1,177	1,107	1,184	1,171	1,009	1,057	999	1,217	8,329	13,782
2017/18 Actual	1,063	1,188	1,153	1,134	1,143	1,154	1,179	1,118	1,009	1,036	1,000	1,153	8,014	13,330
2018/19 Plan	1,101	1,156	1,172	1,197	1,198	1,114	1,282	1,225	1,033	1,199	1,087	1,167	8,220	13,933
2018/19 Actual	1,010	1,163	1,147	1,163	1,029	1,000	1,054						7,566	7,566
Variance to 2017/18	(53)	(25)	(6)	29	(114)	(154)	(125)						(448)	(448)
Variance to 2017/18 %	-5.0%	-2.1%	-0.5%	2.6%	-10.0%	-13.3%	-10.6%						-5.59%	
Variance to Plan	(91)	7	(25)	(34)	(169)	(114)	(228)						(654)	(654)
Variance to Plan %	-8.3%	0.6%	-2.2%	-2.8%	-14.1%	-10.2%	-17.8%						-7.96%	



Issues and Comment

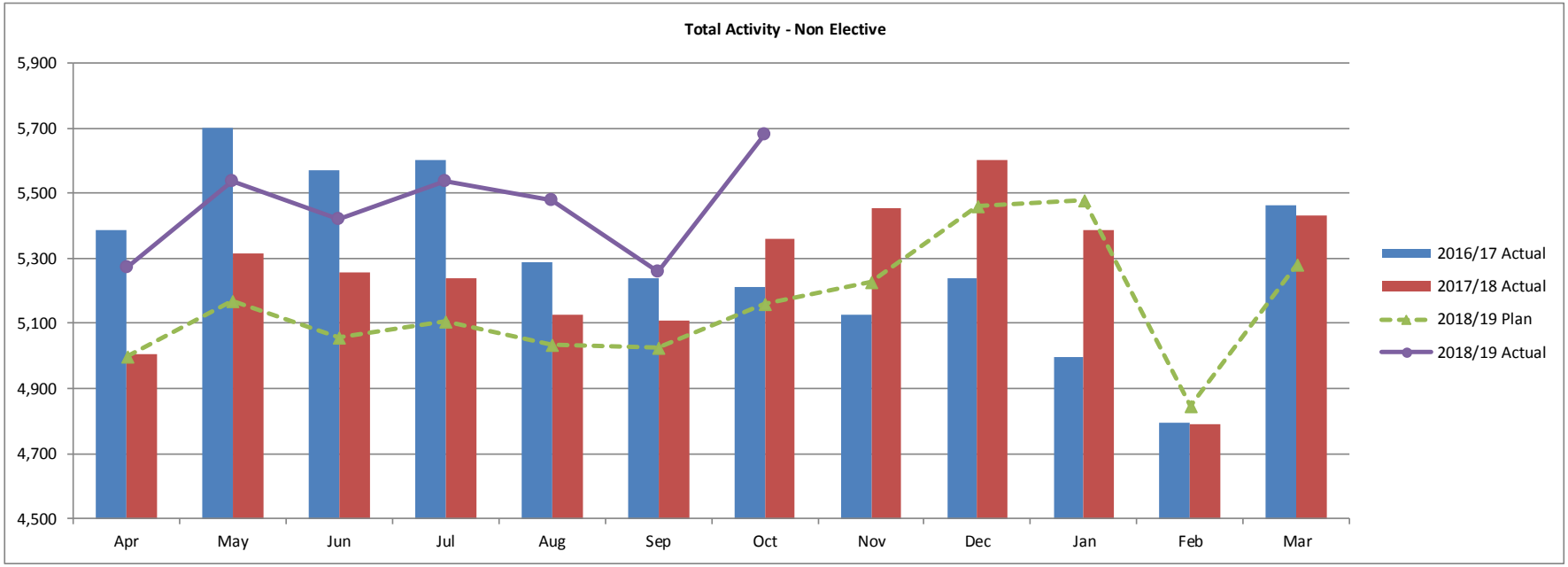
- Elective activity was 228 cases behind plan (-17.8%) and 125 cases (-10.6%) behind October 2017 levels.
- Surgery were 82 cases behind plan in month (due to general surgery ,urology and T&O). Cardiology were also 74 cases behind plan. High levels of non-elective activity within the hospital and surgical specialities has had a knock on impact on electives. Gynaecology activity was also 48 less than plan.
- Theatre productivity programme focusses on d/c electives. This is not reflected in current reporting therefore the plan will be corrected for future months i.e. the elective plan reduces and the day-case plan increases

Additional Slide 26b

Performance (Productivity) – Lead Director Richard Parker

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

Activity	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Full Year
2016/17 Actual	5,385	5,703	5,572	5,602	5,289	5,240	5,212	5,128	5,240	4,998	4,794	5,464	38,003	63,627
2017/18 Actual	5,006	5,314	5,255	5,239	5,127	5,111	5,359	5,453	5,601	5,388	4,788	5,432	36,411	63,073
2018/19 Plan	5,000	5,169	5,057	5,107	5,034	5,025	5,162	5,229	5,460	5,478	4,845	5,280	35,554	61,847
2018/19 Actual	5,274	5,539	5,421	5,539	5,478	5,261	5,683						38,195	38,195
Variance to 2017/18	268	225	166	300	351	150	324						1,784	1,784
Variance to 2017/18 %	5.4%	4.2%	3.2%	5.7%	6.8%	2.9%	6.0%						4.90%	
Variance to Plan	274	370	364	432	444	236	521						2,641	2,641
Variance to Plan %	5.5%	7.2%	7.2%	8.5%	8.8%	4.7%	10.1%						7.43%	



Issues and Comment

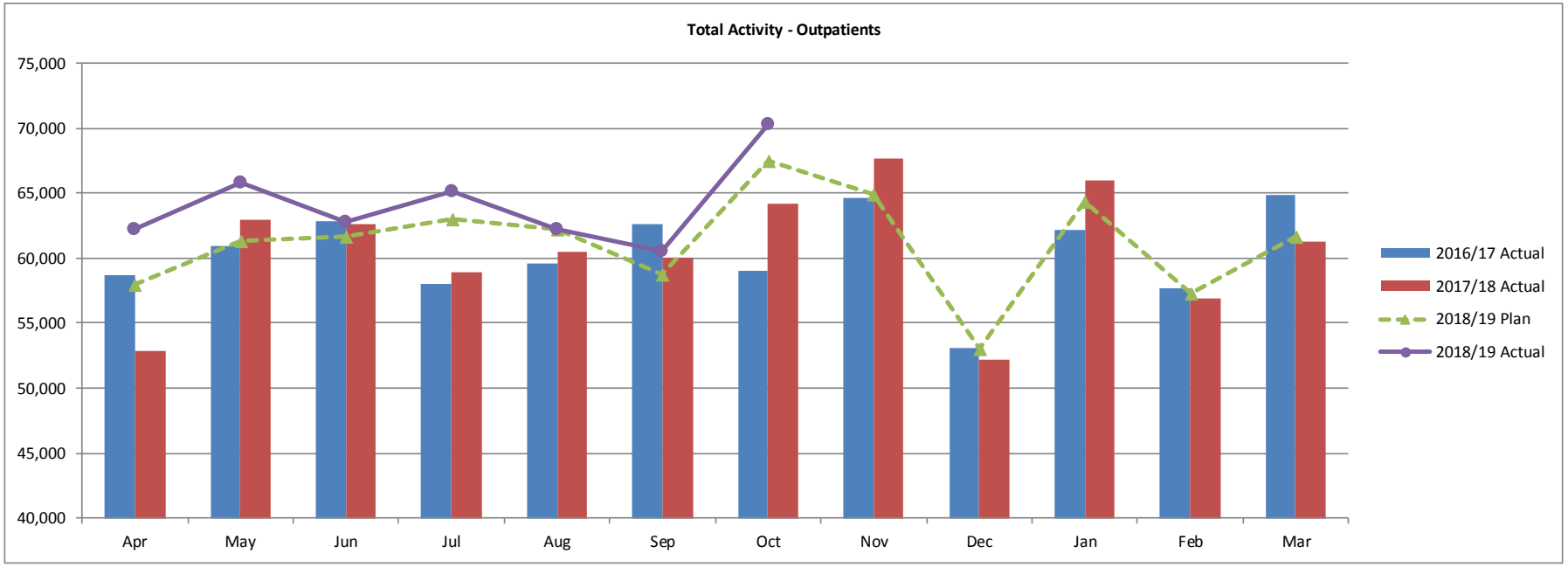
- Non-electives were 10.1% (521 cases) above business plan and 6.0% (324 cases) above prior year levels. The levels of non-elective admissions remain a cause for concern re the impact on elective capacity.
- An early warning contract notice has been issued to commissioners to highlight concern around growing levels of non-elective demand.
- The main areas of over performance were across surgery (+149 cases) as well as women & children (+126 cases) – with the worst hit specialities being OPM (Stroke) / General Surgery and Paediatrics.

Additional Slide 26c

Performance (Productivity) – Lead Director Richard Parker

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

Activity	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Full Year
2016/17 Actual	58,647	60,971	62,885	58,054	59,595	62,622	59,078	64,679	53,131	62,166	57,652	64,853	**421,852**	**724,333**
2017/18 Actual	52,854	63,012	62,641	58,913	60,491	60,005	64,170	67,685	52,135	65,980	56,915	61,313	**422,086**	**726,114**
2018/19 Plan	58,005	61,327	61,643	63,068	62,229	58,746	67,457	64,977	53,084	64,342	57,259	61,639	**432,476**	**733,777**
2018/19 Actual	62,223	65,871	62,750	65,151	62,216	60,553	70,367						**449,131**	**449,131**
Variance to 2017/18	9,369	2,859	109	6,238	1,725	548	6,197						**27,045**	**27,045**
Variance to 2017/18 %	17.7%	4.5%	0.2%	10.6%	2.9%	0.9%	9.7%						**6.41%**	
Variance to Plan	4,218	4,544	1,107	2,083	(13)	1,807	2,910						**16,655**	**16,655**
Variance to Plan %	7.3%	7.4%	1.8%	3.3%	0.0%	3.1%	4.3%						**3.85%**	

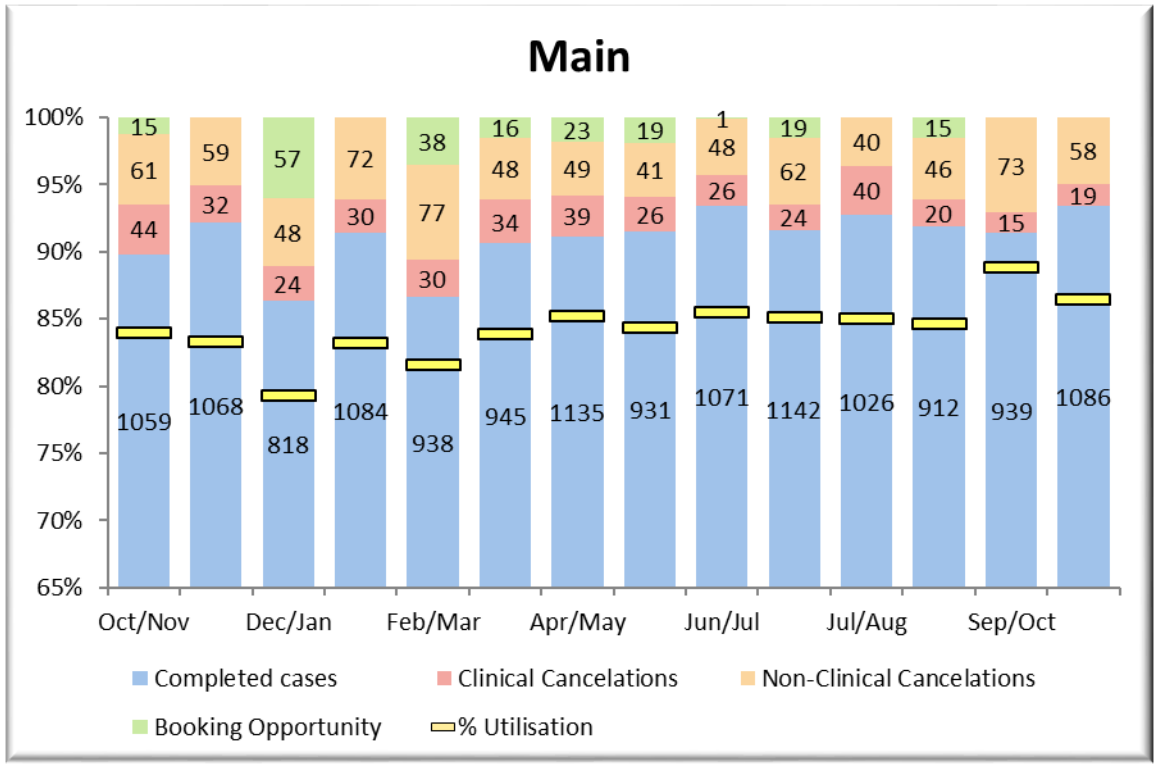


Issues and Comment

- OP activity performance for September was 4.3% ahead of plan and 9.7% ahead of October 2017 levels
- Overall consultant OP news were behind plan by 246 driven by shortfalls in surgery (particularly Ophthalmology, T&O/Spinal and Oral Surgery) and Gynaecology (-123 cases). Staffing gaps in surgical specialities the main driver for the shortfall.
- Overall consultant follow-ups were over plan (+3,099) with gains in medicine (+2,571) and surgery (+389). The biggest area of over performance is in cardiology (+1,156)

Additional Slide 26d

Theatre Productivity (Main) – Lead Director Richard Parker



Issues

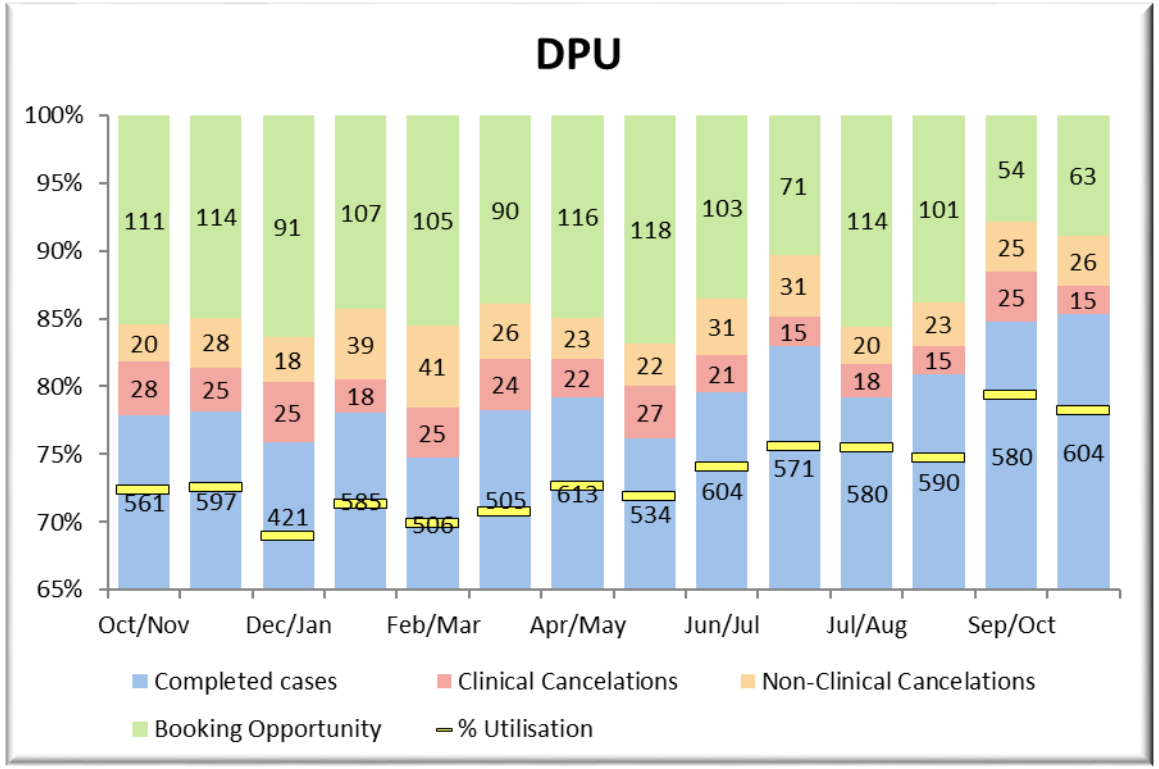
- Good month for productivity in Main – joint highest performance over last 12months.
- Non elective demand in surgery impacting on patient flow.
- SD attendance at theatre meetings in place.

Actions

-Theatre reconfiguration review completed for implementation in January

Additional Slide 26e

Theatre Productivity (DPU) – Lead Director Richard Parker



Issues
- Good recovery from winter period; both % opportunity realised and % utilisation climbing steadily.
- Significantly improved performance for Oct/Nov period compared to last year.

Actions
- Prioritise lock down of lists at 4 weeks and patients booked by 2 weeks
- Clinical cancellations under review in urology and processes changes in place.

Core Slide 27

Workforce Summary – Lead Director Jeremy Over

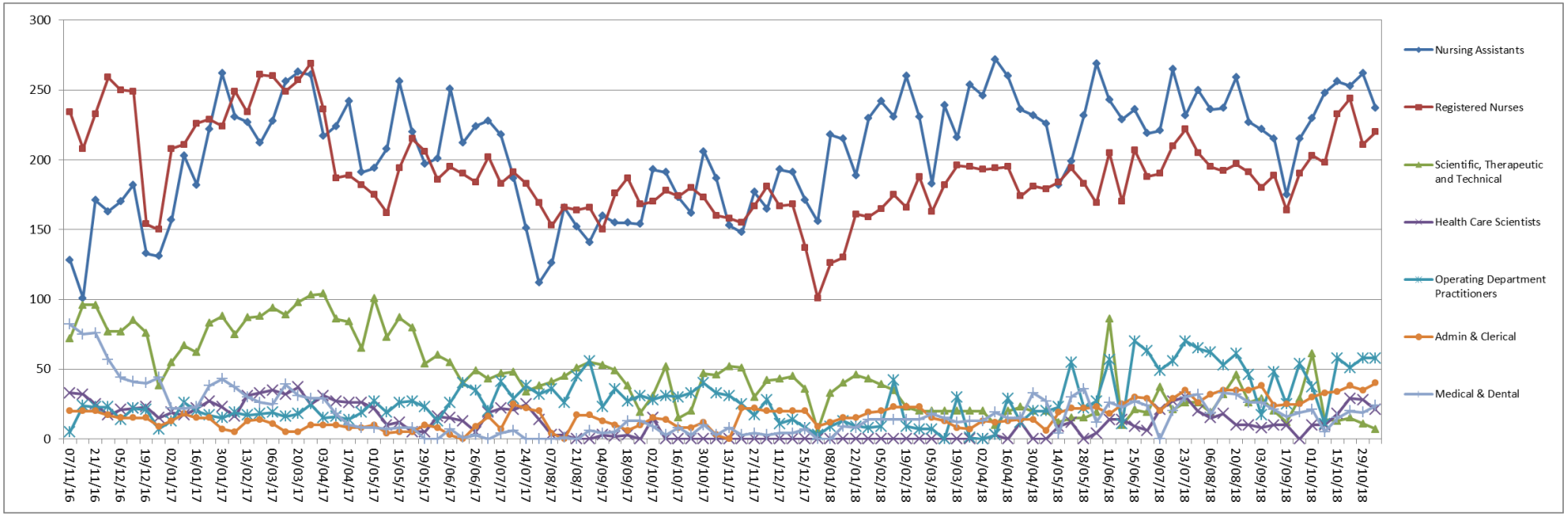
Workforce		Outturn 2017/18	Monthly Target	Oct-18	6 month trend	YTD 2017/18	YTD 2018/19
Payroll							
1 Budgeted WTE*		7360	n/a	TBC		7360	TBC
2 Actual WTE*		6830	n/a	TBC		6830	TBC
3 Vacancy maximum (%)		7.20%	10.00%			7.20%	
Pay Spend							
4 Pay spend - % employed (%)*		90.13%	n/a	89.19%		90.20%	89.43%
5 Pay spend - % bank (%)*		3.29%	n/a	3.70%		3.27%	3.67%
6 Pay spend - % agency (%)*		2.56%	n/a	2.49%		2.46%	2.58%
7 Pay Spend - % Medical Locum (%)*		2.38%	n/a	1.78%		2.38%	2.42%
Staffing Numbers	Core Slide 36						
8 % of registered nurse day hours filled as planned		92.30%	n/a	88.20%		92.58%	88.74%
9 % of unregistered care staff day hours filled as planned		123.25%	n/a	102.61%		127.95%	109.46%
10 % of registered nurse night hours filled as planned		93.85%	n/a	92.46%		93.47%	92.15%
11 % of unregistered care staff night hours filled as planned		138.08%	n/a	131.92%		139.12%	141.27%
12 RGN % Actual to planned		92.96%	n/a	89.98%		92.96%	90.16%
13 HCA % Actual to planned		129.30%	n/a	113.77%		132.61%	121.55%
14 Care hours per patient day (registered)		3.9	n/a	4.2		3.9	4.1
15 Care hours per patient day (Non-registered)		3.3	n/a	3.5		3.3	3.6
16 Care hours per patient day (Total)		7.3	n/a	7.7		7.3	7.7
Other							
17 Appraisals completed	Core Slide 32	65.80%	80.00%	78.34%		66.27%	72.88%
18 Staff Turnover rate	Core Slide 33	10.43%	10.00%	10.83%		10.56%	10.48%
16 Mandatory Training	Core Slide 34	83.13%	90.00%	84.17%		82.62%	82.89%
17 Sickness levels**	Core Slide 35	4.02%	3.50%	4.27%		3.62%	3.77%
18 Time to Hire (All)		68.5	n/a	81.4		68.5	74.8
Staff Survey							
19 Staff FFT – recommendation of NNUH as a place to receive care		72%	n/a	76%		TBC	TBC
20 Staff FFT – recommendation of NNUH as a place to work		56%	n/a	61%		TBC	TBC

* Please note these figures are provisional

** Reported one month in arrears

Core Slide 28 — Workforce - Lead Director Jeremy Over

Agency and Locum Shifts Booked

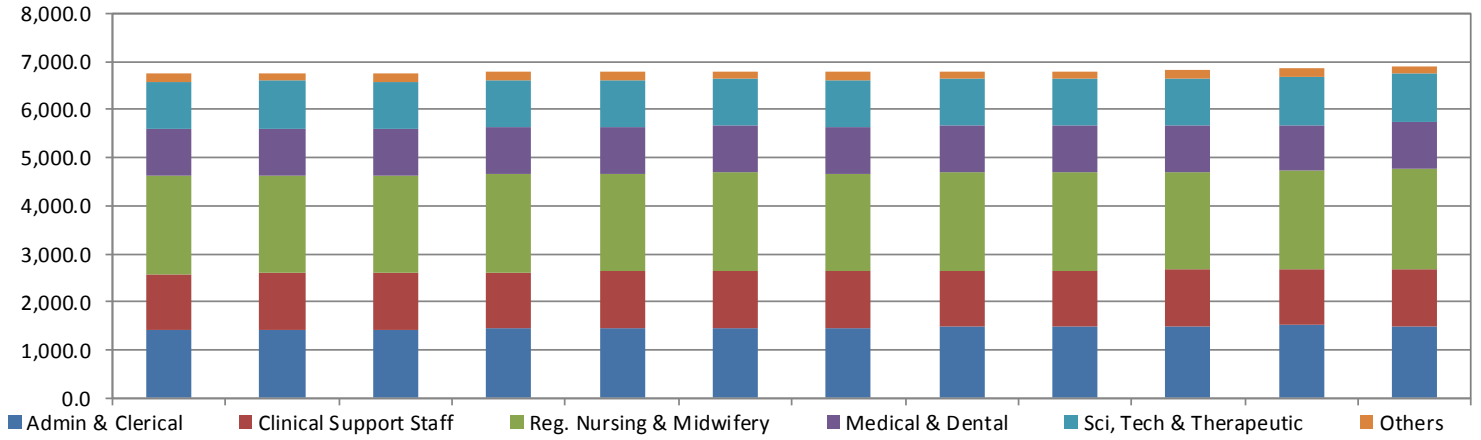


Commentary

- The latest monthly agency expenditure is detailed in the Finance IPR section
- Controls continue to be effective and responsive to situations where temporary workers are absolutely required based on clinical need and safety grounds.
- The Finance section of the IPR details the expenditure for the month.
- Break glass arrangements only for exceptional safety grounds (with executive level sign off).
- Pre-authorisation checklist and daily scrutiny by Medical Director for all locum requests has been very effective.
- Recruitment Oversight Group is in operation and applies controls to avoid cost pressures and assists with speedy recruitment.
- Bank incentives have had a positive impact on RN ‘bank hours worked’.

Core Slide 29 — Workforce - Lead Director Jeremy Over

Workforce Staff in Post - WTE



Staff Group	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Difference	*% change*
Admin & Clerical	1,424.2	1,429.9	1,429.8	1,444.1	1,452.0	1,458.5	1,461.7	1,478.8	1,481.3	1,490.1	1,505.8	1,503.7	1,505.3	81.2	*5.7*
Clinical Support Staff	1,151.8	1,159.9	1,160.7	1,168.7	1,170.4	1,171.0	1,167.3	1,169.3	1,171.8	1,173.5	1,171.9	1,175.0	1,184.1	32.2	*2.8*
Reg. Nursing & Midwifery	2,052.5	2,045.5	2,021.3	2,055.1	2,043.7	2,048.1	2,045.0	2,035.7	2,031.2	2,040.1	2,036.6	2,079.3	2,088.1	35.6	*1.7*
Medical & Dental	978.6	978.1	975.9	967.5	966.1	973.5	965.3	970.7	968.8	955.3	971.2	985.9	988.0	9.5	*1.0*
Sci, Tech & Therapeutic	977.8	982.9	980.9	984.8	983.3	978.9	973.8	977.3	978.1	983.9	997.6	1,003.1	1,011.9	34.1	*3.5*
Others	166.5	171.0	168.3	166.8	164.9	164.9	161.0	161.6	163.4	162.0	160.0	158.0	156.8	-9.7	*-5.8*
Grand Total	**6,751.2**	**6,767.2**	**6,736.9**	**6,787.0**	**6,780.4**	**6,794.9**	**6,774.0**	**6,793.4**	**6,794.5**	**6,804.9**	**6,843.2**	**6,905.0**	**6,934.2**	**182.9**	***2.7***

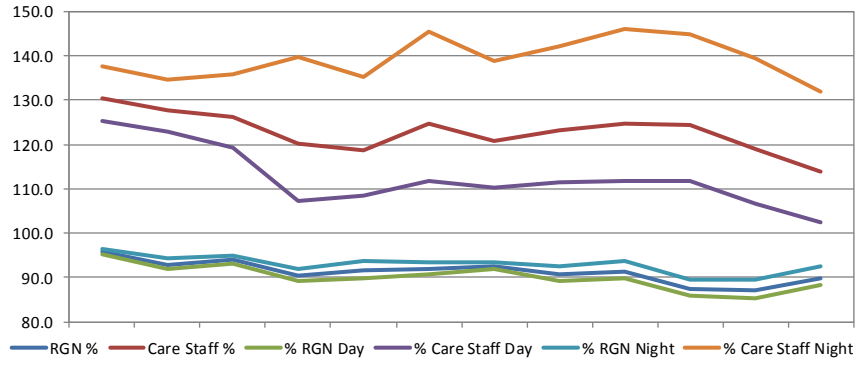
Commentary

- This slide / graph details the numbers of staff in post (WTE) at month end.
- The graph stacks the staff in post by staff group.
- Overall, in the last twelve months, there are 182.9 additional staff, an increase of 2.7% across NNUH as a result of service developments and capacity and quality investments.
- The rate of growth has halved compared to 12 months ago (5.5%).

Core Slide 30

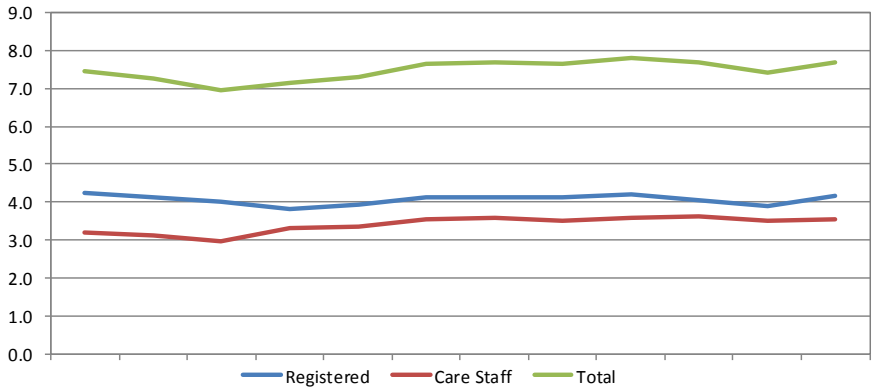
Workforce - Lead Director Jeremy Over

Ward Nursing fill-rate Analysis



	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct
RGN %	95.8	92.9	94.0	90.5	91.6	91.9	92.7	90.7	91.4	87.4	87.1	90.0
Care Staff %	130.4	127.7	126.2	120.1	118.8	124.7	120.8	123.3	124.8	124.4	119.1	113.8
% RGN Day	95.3	91.8	93.3	89.3	89.9	90.6	92.1	89.3	89.7	85.8	85.4	88.2
% Care Staff Day	125.4	122.9	119.3	107.4	108.4	111.9	110.2	111.5	111.7	111.7	106.6	102.6
% RGN Night	96.6	94.4	95.0	92.1	93.9	93.6	93.5	92.7	93.7	89.7	89.5	92.5
% Care Staff Night	137.6	134.6	135.9	139.9	135.1	145.3	138.9	142.2	146.1	145.0	139.4	131.9

Care Hours per Patient Day - CHPPD



	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct
Registered	4.3	4.1	4.0	3.8	3.9	4.1	4.1	4.1	4.2	4.0	3.9	4.2
Care Staff	3.2	3.1	3.0	3.3	3.3	3.5	3.6	3.5	3.6	3.6	3.5	3.5
Total	7.4	7.2	7.0	7.2	7.3	7.6	7.7	7.7	7.8	7.7	7.4	7.7

Escalations

<80% RN fill rate for October:

Ward	RN Fill Rate %
Denton	72.8
GMDU	71.4

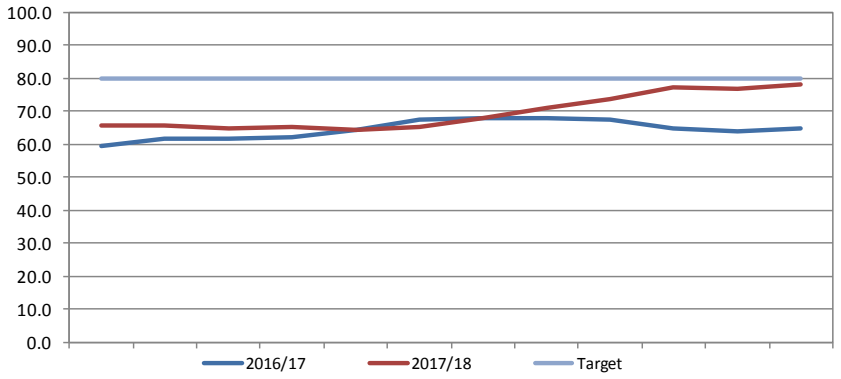
Commentary

- The first graph (Ward nursing fill rate) shows our planned nursing versus actual staffing levels in percentage terms.
- The percentage of shift hours worked versus planned may be greater than 100% where additional staff have been deployed to meet the needs of patients requiring 1-to-1 care (e.g. a third nursing assistant, compared with a staffing plan of 2 for the shift will result in a fill-rate of 150%).
- The fill rate for unregistered staff in day time hours remains above 100%.
- Care hours per patient day is calculated as: The total number of patient days in the month (Using the actual number of patients on the ward at 23:59 each day) / Total hours worked in the month (Total combined number of hours worked for both registered staff and care staff)

Core Slide 31

Workforce - Lead Director Jeremy Over

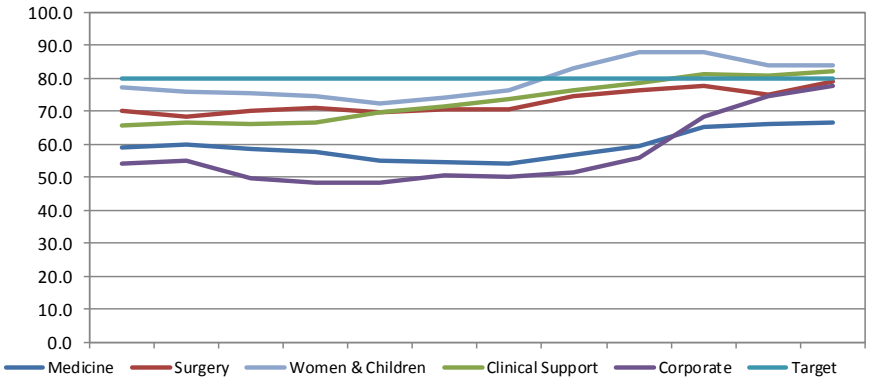
Appraisals completed - Trust



Division	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct
2016/17	59.6	61.6	61.8	62.1	64.4	67.3	67.8	67.8	67.5	64.9	64.0	64.6
2017/18	65.6	65.5	65.0	65.1	64.5	65.3	68.0	71.2	73.6	77.0	76.6	78.3
Target	80.0	80.0	80.0	80.0	80.0	80.0	80.0	80.0	80.0	80.0	80.0	80.0

*2016/2017 Trust figures based on Non-medical appraisals & 2017/18 based on all appraisals

Appraisals completed - Divisions



Division	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct
Medicine	59.2	59.8	58.7	57.6	55.0	54.5	54.3	56.9	59.5	65.1	65.9	66.4
Surgery	69.9	68.4	70.0	70.9	69.9	70.6	70.8	74.7	76.5	77.6	74.8	79.2
Women & Children	77.2	75.7	75.5	74.5	72.5	74.1	76.5	83.1	88.0	88.0	83.7	83.7
Clinical Support	65.8	66.5	66.3	66.7	69.7	71.6	73.6	76.6	78.4	81.3	80.9	82.2
Corporate	54.0	54.8	49.8	48.2	48.2	50.5	50.3	51.5	55.7	68.2	74.6	77.6
Target	80.0	80.0	80.0	80.0	80.0	80.0	80.0	80.0	80.0	80.0	80.0	80.0

Commentary

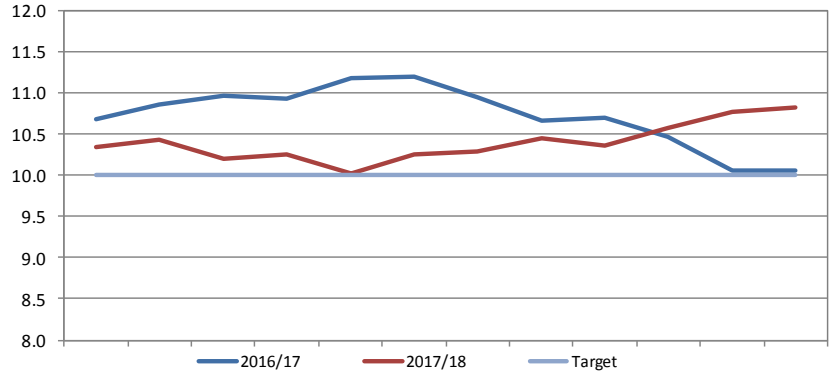
- Improvement of the annual appraisal completion rate is a must do from the CQC inspection.
- 78.3% of eligible staff (Non medical and Medical Staff) have had an appraisal during the last 12 months.
- Furthermore the rate of non-medical only appraisals has increased from 65% to 76.4% in the past 4 months
- Two divisions (Women & Children and CSS) are consistently exceeding 80%. Surgery Division and Corporate departments are almost at target level. The outlier is Medicine Division where the triumvirate is pushing hard for confirmation that appraisals have been scheduled for completion.
- The NHS Staff Survey results suggest that 83% of our staff have responded that they have been appraised in the last 12 months (up from 82% in 2016). Also, the survey reports an increase in the quality of appraisals from 2016 to 2017 (the 'rating' increasing from 2.90 to 3.03 of a scale of 1-5).

Corporate Breakdown	Eligible	Current	Compliance %
Communications	3	3	100.0%
Complaints & Legal	13	13	100.0%
Clinical Effectiveness & Audit	10	10	100.0%
Practice Development	18	17	94.4%
Workplace Health & Wellbeing	33	31	93.9%
Commisioning, Data Quality, Coding	53	49	92.5%
Safeguarding	8	7	87.5%
Finance	32	28	87.5%
Improvement Team	7	6	85.7%
Information Technology	58	49	84.5%
Ops Centre	25	21	84.0%
Human Resources	60	50	83.3%
Training, Learning & Development	28	23	82.1%
Integrated Discharge	43	35	81.4%
Infection Control	14	11	78.6%
PMO	4	3	75.0%
Estates & Facilities	37	24	64.9%
Research*	94	57	60.6%
Risk Mgt & Incident Reporting	6	3	50.0%
Other**	44	18	40.9%
Corporate	**590**	**458**	**77.6%**

Core Slide 32

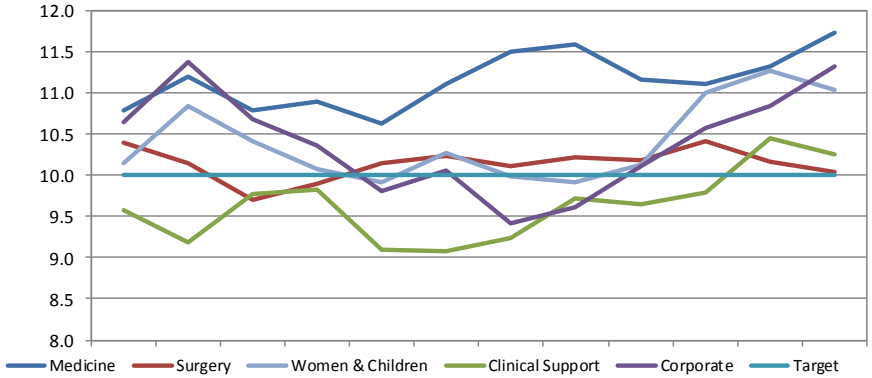
Workforce - Lead Director Jeremy Over

Annualised Staff Turnover rate - Trust



Division	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct
2016/17	10.7	10.9	11.0	10.9	11.2	11.2	11.0	10.7	10.7	10.5	10.0	10.0
2017/18	10.3	10.4	10.2	10.2	10.0	10.2	10.3	10.5	10.4	10.6	10.8	10.8
Target	10.0	10.0	10.0	10.0	10.0	10.0	10.0	10.0	10.0	10.0	10.0	10.0

Annualised Staff Turnover rate - Divisions



Division	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct
Medicine	10.79	11.19	10.79	10.89	10.63	11.11	11.50	11.58	11.16	11.10	11.31	11.72
Surgery	10.40	10.15	9.70	9.90	10.14	10.23	10.10	10.21	10.18	10.42	10.16	10.04
Women & Children	10.15	10.84	10.42	10.08	9.91	10.27	9.99	9.91	10.13	11.01	11.27	11.04
Clinical Support	9.57	9.18	9.77	9.82	9.10	9.07	9.24	9.72	9.65	9.80	10.45	10.25
Corporate	10.64	11.38	10.68	10.35	9.81	10.05	9.42	9.61	10.11	10.57	10.84	11.32
Target	10.00	10.00	10.00	10.00	10.00	10.00	10.00	10.00	10.00	10.00	10.00	10.00

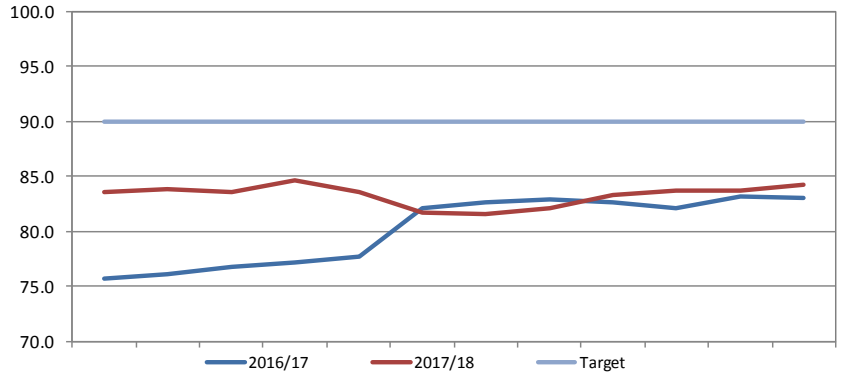
Commentary

- The Turnover rate is the percentage of the workforce that has left NNUH over the past twelve months. It is a 12-month rolling figure.
- The calculation excludes fixed-term contracts, (for instance junior doctors on rotational training programmes).
- The turnover rate for October 2018 remains the same as September. The increase in the annual rate reflects a greater number of leavers in September and October, when compared to 12 months previously.
- Positively, the numbers of Registered Nursing and Midwifery leavers reduced in October to 12-month average levels.
- Reduced turnover means greater retention of knowledge and skill in our teams, and reduced volume of replacement recruitment activity and induction / on-boarding.

Core Slide 33

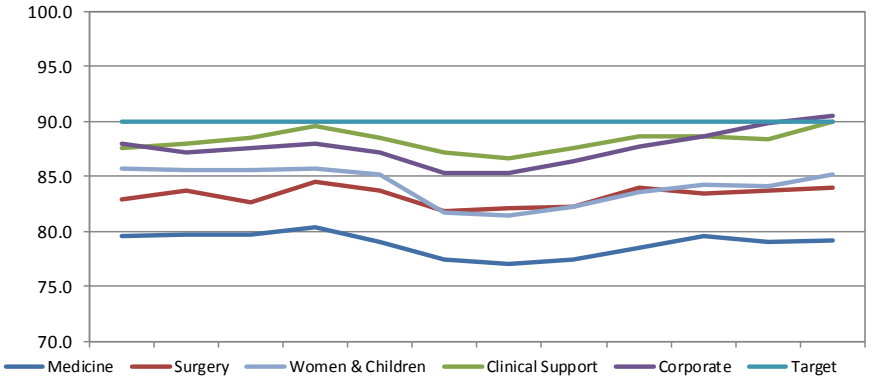
Workforce - Lead Director Jeremy Over

Mandatory Training - Trust



Division	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct
2016/17	75.7	76.1	76.8	77.1	77.6	82.0	82.6	82.9	82.6	82.1	83.2	83.0
2017/18	83.5	83.8	83.6	84.6	83.6	81.7	81.6	82.1	83.3	83.7	83.6	84.2
Target	90.0	90.0	90.0	90.0	90.0	90.0	90.0	90.0	90.0	90.0	90.0	90.0

Mandatory Training - Divisions



Division	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct
Medicine	79.60	79.73	79.67	80.38	79.00	77.46	77.06	77.45	78.50	79.60	79.09	79.15
Surgery	82.85	83.70	82.67	84.54	83.72	81.81	82.15	82.21	83.90	83.40	83.73	83.91
Women & Children	85.68	85.51	85.55	85.73	85.20	81.71	81.40	82.20	83.60	84.27	84.07	85.13
Clinical Support	87.63	88.00	88.50	89.57	88.52	87.12	86.66	87.56	88.57	88.68	88.42	90.00
Corporate	87.95	87.16	87.61	88.02	87.17	85.27	85.27	86.41	87.69	88.70	89.83	90.48
Target	90.00	90.00	90.00	90.00	90.00	90.00	90.00	90.00	90.00	90.00	90.00	90.00

Commentary

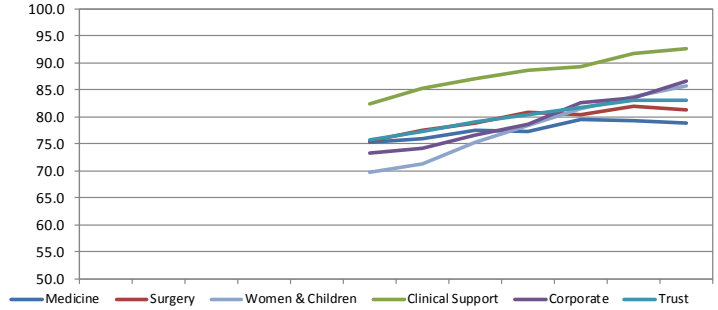
- Improvement of mandatory training attendance is a must do from the CQC inspection.
- The overall compliance rate has remained above 80% since April 2017.
- For the first month two divisions are now achieving the target level of 90%+ (Clinical Support Services and Corporate departments).
- A series of improvements and interventions are in place to support enhanced compliance. These include training days/events where support is available to maximise mandatory training and a range of support options for staff accessing eLearning.
- Divisional level mandatory training rates are discussed at divisional performance committee.
- The Head of OD & Learning is leading on a project to address the capacity and system constraints that need to be overcome in order to enable greater take-up of mandatory training which is resulting in ongoing improvements.
- The 'one-stop-shop' training events for staff to receive updates on a number of training topics in one sitting has been running since September 2017 and continues to be well received by our staff.

Additional Slide 33a

Workforce - Lead Director Jeremy Over

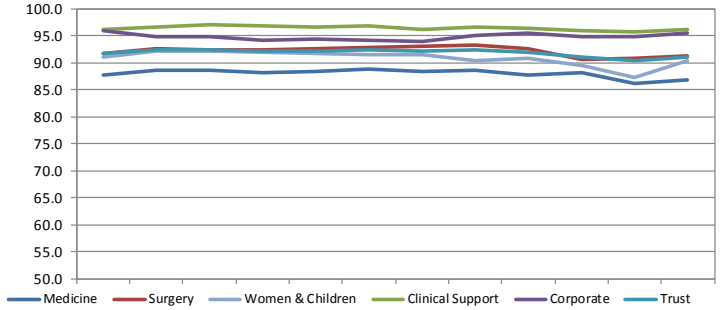
Mandatory Training – CQC 'must do'

MCA/DoLS Training - Divisions



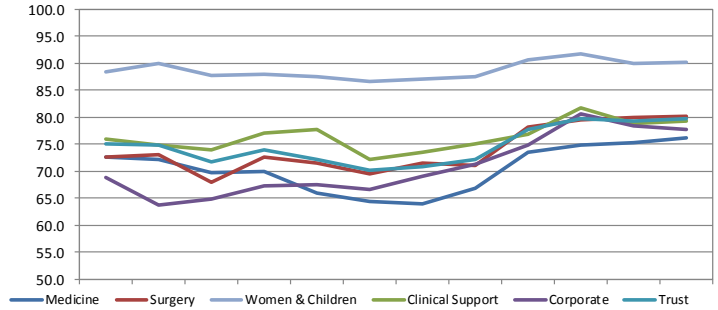
Division	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct
Medicine						75.37	76.01	77.45	77.36	79.56	79.26	78.78
Surgery						75.44	77.50	78.84	80.87	80.44	82.02	81.21
Women & Children						69.81	71.33	75.17	78.29	81.41	83.80	85.71
Clinical Support						82.46	85.29	86.97	88.53	89.27	91.80	92.59
Corporate						73.33	74.07	76.69	78.68	82.61	83.58	86.67
Trust						75.72	77.29	79.12	80.49	81.83	82.95	83.04

Safeguarding Children Training - Divisions



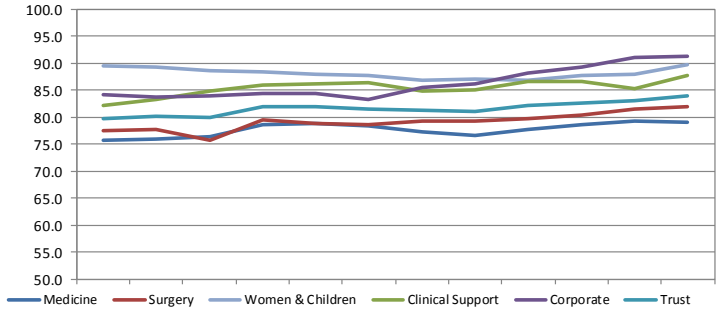
Division	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct
Medicine	87.84	88.53	88.56	88.17	88.38	88.91	88.50	88.55	87.72	88.13	86.17	86.83
Surgery	91.85	92.72	92.38	92.39	92.57	92.79	93.08	93.22	92.67	90.55	90.95	91.27
Women & Children	91.16	92.22	92.22	92.04	91.66	91.60	91.53	90.41	90.92	89.44	87.19	90.37
Clinical Support	96.29	96.62	97.09	96.96	96.73	96.89	96.11	96.71	96.50	95.88	95.83	96.15
Corporate	95.96	94.84	94.92	94.22	94.45	94.15	94.04	95.02	95.56	94.89	94.95	95.56
Trust	91.79	92.36	92.38	92.15	92.19	92.42	92.19	92.33	91.96	91.16	90.36	91.12

Resus (Adult) Training - Divisions



Division	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct
Medicine	72.66	72.15	69.60	69.97	66.00	64.43	63.97	66.90	73.53	74.85	75.36	76.27
Surgery	72.56	72.99	67.93	72.55	71.53	69.45	71.44	70.98	78.16	79.39	79.88	80.23
Women & Children	88.50	89.88	87.69	88.00	87.60	86.72	87.17	87.52	90.65	91.71	89.94	90.19
Clinical Support	75.97	74.79	74.01	77.02	77.71	72.22	73.40	75.04	76.89	81.83	78.83	79.20
Corporate	68.85	63.64	64.92	67.37	67.57	66.49	68.95	71.28	74.87	80.61	78.31	77.78
Trust	74.96	74.75	71.82	74.02	72.26	70.09	70.87	72.16	77.72	79.64	79.23	79.73

Infection Control Training - Divisions



Division	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct
Medicine	75.73	75.96	76.47	78.71	78.76	78.31	77.24	76.52	77.81	78.70	79.23	79.07
Surgery	77.45	77.66	75.71	79.57	78.94	78.66	79.27	79.34	79.74	80.37	81.44	82.02
Women & Children	89.45	89.19	88.67	88.37	88.06	87.73	86.88	87.12	86.81	87.70	87.95	89.84
Clinical Support	82.22	83.30	84.88	85.98	86.13	86.34	84.81	84.98	86.57	86.52	85.21	87.79
Corporate	84.11	83.75	83.93	84.50	84.44	83.23	85.60	86.25	88.13	89.18	91.07	91.39
Trust	79.77	80.11	80.00	82.04	81.86	81.55	81.19	81.11	82.07	82.72	83.07	83.93

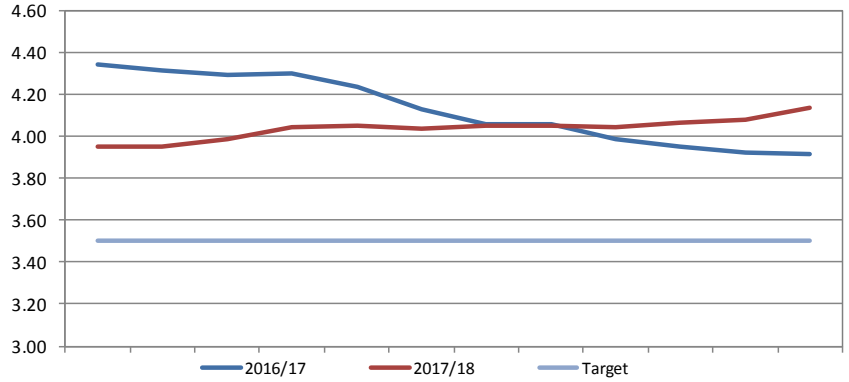
Commentary

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

Core Slide 34

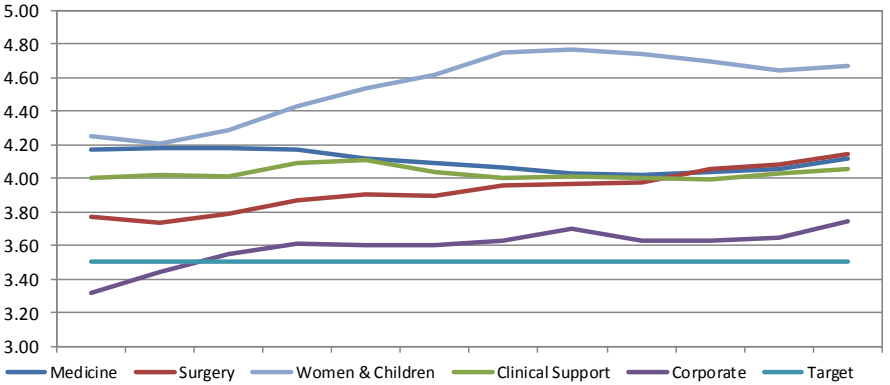
Workforce - Lead Director Jeremy Over

Sickness levels (12 month rolling average)



Division	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
2016/17	4.34	4.32	4.30	4.30	4.23	4.13	4.06	4.06	3.99	3.95	3.93	3.92
2017/18	3.95	3.95	3.98	4.04	4.05	4.03	4.05	4.05	4.04	4.06	4.08	4.14
Target	3.50	3.50	3.50	3.50	3.50	3.50	3.50	3.50	3.50	3.50	3.50	3.50

Sickness levels (12 month rolling average)



Division	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
Medicine	4.17	4.18	4.18	4.17	4.12	4.09	4.07	4.03	4.02	4.04	4.05	4.12
Surgery	3.77	3.74	3.78	3.87	3.90	3.90	3.96	3.96	3.98	4.05	4.08	4.14
Women & Children	4.26	4.21	4.29	4.43	4.54	4.62	4.75	4.76	4.74	4.70	4.65	4.67
Clinical Support	4.00	4.02	4.01	4.09	4.11	4.04	4.01	4.01	4.00	4.00	4.03	4.06
Corporate	3.32	3.45	3.55	3.61	3.60	3.60	3.63	3.70	3.63	3.62	3.65	3.74
Target	3.50	3.50	3.50	3.50	3.50	3.50	3.50	3.50	3.50	3.50	3.50	3.50

** Reported one month in arrears

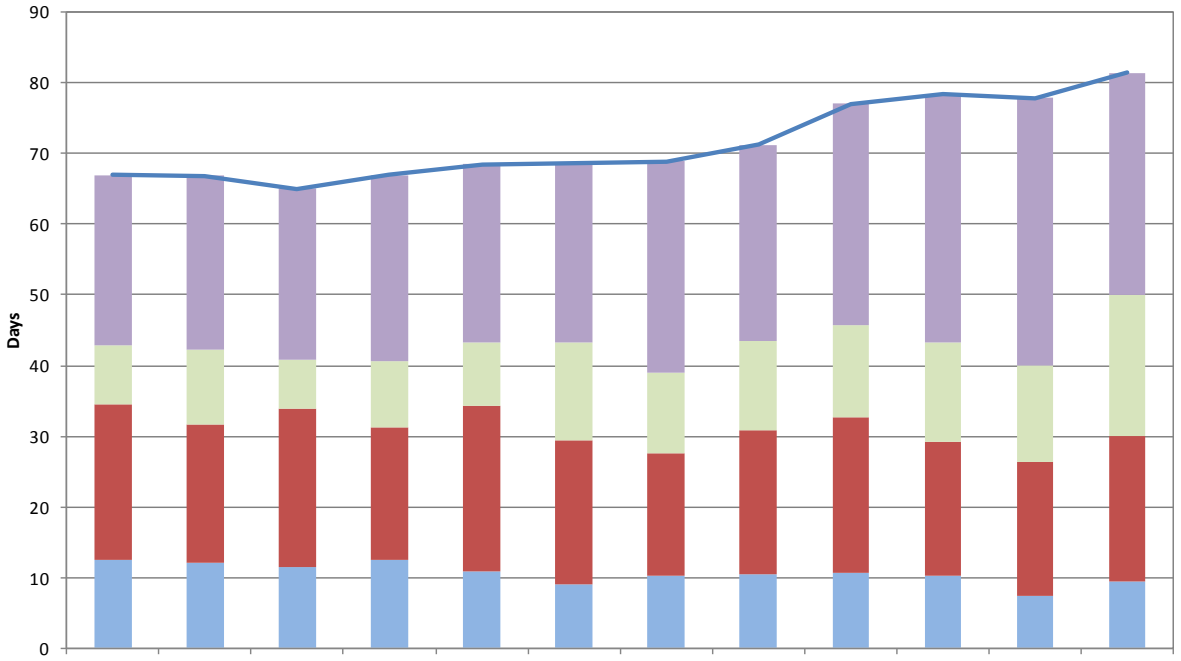
Commentary

- The most significant indicator is the rolling 12-month average sickness rate.
- As at 30 September 2018, the rate is 4.14%.
- This still represents a significant reduction in excess of 6% on the peak from August 2016 and equates to the equivalent of approximately 21 additional staff (headcount) being available every day.
- Analysis confirms the vast majority of sickness absence is longer term and HRBP's are supporting divisional colleagues to intervene to support returns to work.
- Data recently published by the Department of Health for the calendar year of 2017 indicates that on average there were 9.1 lost working days per staff member.
- This 'ranks' NNUH as 83rd out of 224 Trusts. For comparison, QEH has 11.2 days, NCHC has 10.9 days, JPH has 9.3 days and Cambridge 7.3 days.
- NB. For data accuracy and reliability purposes, sickness figures are reported one-month in arrears.

Core Slide 35

Workforce - Lead Director Jeremy Over

Recruitment Time to Hire



Recruitment Stage	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18
Total Time to Hire	67.0	66.9	65.1	67.0	68.5	68.6	68.9	71.2	77.0	78.4	77.9	81.4
Checks Complete	24.2	24.7	24.2	26.4	25.2	25.3	29.9	27.8	31.3	35.0	37.9	31.4
Time to Offer	8.4	10.5	6.8	9.2	9.1	13.9	11.4	12.5	13.0	14.1	13.7	20.0
Time with Manager	21.9	19.7	22.5	18.8	23.3	20.3	17.4	20.5	22.2	19.0	18.8	20.6
Time to advert close	12.5	12.0	11.5	12.6	10.9	9.1	10.3	10.5	10.6	10.2	7.5	9.4
Number at checks complete	151	107	134	112	109	105	130	140	122	111	123	185

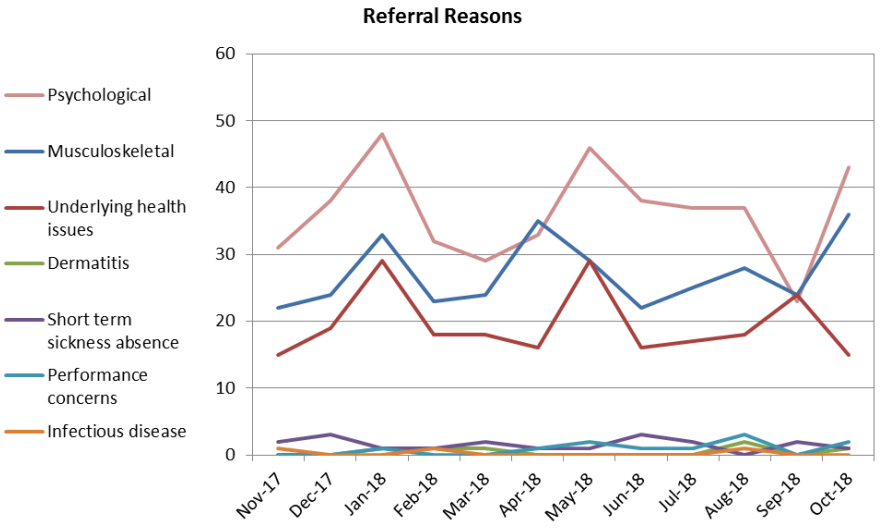
Commentary

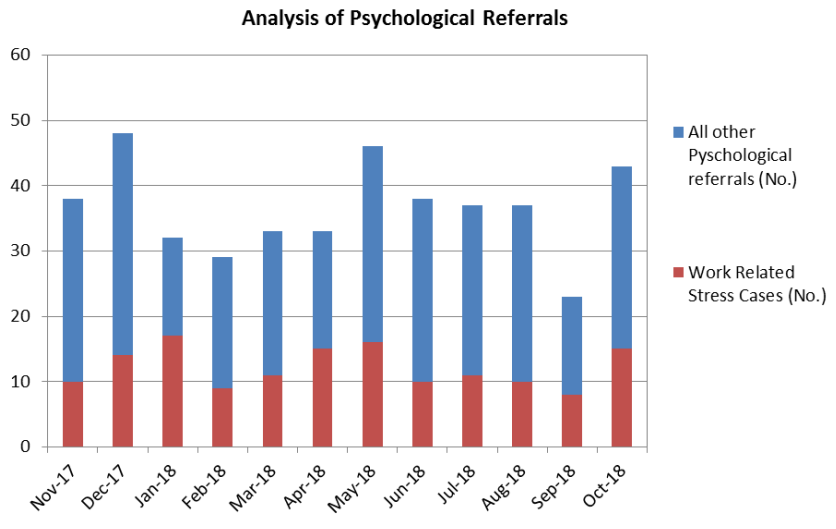
- This data reflects all substantive recruitment through our Trac system.
- As reported previously, the Recruitment team has received support to help it resolve processing difficulties associated with significant increases in recruitment volumes in the last 12 months. Positively, the time to offer was returned to service level by the end of October. However, the improvement in time to offer will only be seen in the November figures where we would anticipate the figure reducing from 20 days to less than 10 days.
- Despite the processing difficulties in recent months, at no stage has there been any breach of service level for any post associated with 'winter pressures'.

Core Slide 36

Workforce - Lead Director Jeremy Over

Staff Health, Safety and Wellbeing





Commentary

- The first graph reflects the trend in respect of all referrals (by managers, or self-referral) to Workplace, Health and Wellbeing.
- There were 98 referrals assessments undertaken in October 2018 which is an increase from the previous month (+25). In this month there is an increase in the number of psychological and musculoskeletal but a decrease in underlying health conditions.
- The second graph reflects the trend for psychological referrals (by managers, or self-referral) received by Workplace, Health and Wellbeing.
- Of the 43 new psychological referrals seen in this month, 15 were considered to be work caused which is an increase in comparison to September (8), August (10), July 2018 (11) and June 2018 (10).

Additional Slide 36a

Workforce - Lead Director Jeremy Over

Consultant Job Plans

Stage	Trust	Medicine	Surgery	Women & Children	Clinical Support	Other
Total Consultants	476	158	188	58	70	2
Job plans signed off	191	54	83	6	48	0
	40.1%	34.2%	44.1%	10.3%	68.6%	0.0%
In discussion stage/ draft stage	130	51	35	33	9	2
	27.3%	32.3%	18.6%	56.9%	12.9%	100.0%
Awaiting sign off	155	53	70	19	13	0
	32.6%	33.5%	37.2%	32.8%	18.6%	0.0%

Commentary

- The above chart reflects progress in respect of the introduction of Electronic Job Planning for Consultants as at 4 November 2018
- E-job planning was introduced from April 2017 with extensive engagement and consultation with Consultants.
- Oversight of e-job planning sits with an E-job Planning Advisory Panel which reports into the Medical Workforce Group, chaired by the Director of Workforce, and attended by senior clinicians from each Division.
- There is a need to accelerate the sign off of the first round of e-job plans.

Core Slide 37 – Workforce – supplementary briefing

Communicating with PRIDE

Leading and Communicating with PRIDE is how we continue to improve our culture, drawing on feedback from staff through the annual survey and the King's Fund work. More than 500 staff across our Hospitals have already attended 45 minute briefing sessions on Communicating with PRIDE where we have shared:

- An understanding of our journey and our desire to build a culture we can all be proud of.
- Some of the key elements from the Leading with PRIDE masterclasses, including:
  - ❑ The ABC of appreciation
  - ❑ The BUILD feedback model
  - ❑ 'Know your staff'
- The expectation that all staff should 'Communicate with PRIDE', whether face-to-face, on the telephone, or in writing.
- The new CwP approach to empowering our staff to have the confidence to raise and resolve issues themselves, or with the support of colleagues.
- An introduction to the ten leaflets designed with our staff, which replaces the Dignity at Work policy.

Twenty sessions have already taken place and a further 25 are scheduled with the offer to deliver bespoke sessions for individual teams.

Staff Survey 2018

The 2018 national staff survey has commenced and will run until 30th November. All of our eligible staff have been issued with a paper questionnaire and our aspiration is to improve on last year's response rate of 47%.

As at 19th November, 36% of our staff have already completed and returned their survey. A final reminder enclosing a questionnaire has been issued, and we continue to support participation. The survey period closes at the end of November.

'Flu vaccination programme

This has commenced in October and, at the time of writing, has already seen the highest ever levels of take-up amongst staff during the first six weeks of the programme – we are currently at 67% of staff having benefitted from a 'flu jab. The programme continues with daily clinics available.

Lead Freedom to Speak Up Guardian

Our next interview date for a Lead Freedom to Speak Up Guardian is 28 November 2018, following a recruitment campaign that attracted a strong level of interest. The Board will be kept updated.

Core Slide 38

Finance - Lead Director John Hennessey

Executive Summary

- The actual deficit for the year to date is £32.4m, being £0.4m worse than budget.
- The in-month position, before mitigation is £1.4m worse than budget, mainly due to clinical income being £1.3m worse than budget (Surgery down £1.1m). This has been primarily mitigated releasing £0.77m from the income risk reserve,
- Clinical Income at end M7 is £3.6m worse then budget. This is offset by operating expenditure underspend, which at end M7, net of drugs income, is £1.5m better than budget (0.5% small fav variance) comprising: Pay of £0.0m (0.0%), Drugs-net of £0.38m, Clinical Supplies of £0.6m (1.5%) and Non Clinical Supplies of £0.7m (1.3%).
- The CIP target is £30m. The YTD CIP budget is £12.75m with actual YTD being £14.52m. The profile of CIPs is £10m in the first half year and £20m in the second half, creating significant pressure in second half.

Key Risks

- Delivering the £30m CIP and identifying the remaining £2.7m yet to reach Gateway 2.
- Income – delivery of plan - surgery is underperforming.
- Income - Commissioner challenges and CQUIN delivery risks.
- AfC reform underfunding of Serco staff @ £0.6m. No cost has been included pending NHSI confirmation.
- Winter cost pressures – containing the expenditure to the budget of £3.8m

Forecast - No change to the forecast has been made

There are a number of unbudgeted risks and whilst the cost run rate is positive, income is adverse. Clinical income risk and an increase in CIPs create significant pressure on second half year performance.

FINANCIAL SUMMARY

I&E Performance YTD	(£32.4m)	
I&E Variance against budget YTD	(£0.4m)	Adverse
In month variance to in month budget	(£0.5m)	Adverse
Cash at bank – actual	£5.9m	£3.8m Fav
Borrowings - actual	£82.5m	£11m Fav
CIP Variance against budget YTD	£1.8m	Favourable
Full Year CIP Target of £30m identified	£27.3m	£2.7m remaining

SUMMARY INCOME AND EXPENDITURE ACCOUNT	In Month			Year to Date			Full Year Forecast		
	Actual £m	Budget £m	Variance (adv)/fav £m	Actual £m	Budget £m	Variance (adv)/fav £m	Forecast £m	Budget £m	Variance (adv)/fav £m
Clinical Income excluding NT Drugs	39.0	40.3	(1.3)	260.6	264.1	(3.5)	454.9	454.9	0.0
NT Drugs	6.1	5.8	0.3	39.8	40.4	(0.6)	69.2	69.2	0.0
Other Income	7.3	6.0	1.3	46.5	45.7	0.8	76.3	76.3	0.0
TOTAL OPERATING INCOME	**52.4**	**52.1**	**0.3**	**346.9**	**350.2**	**(3.3)**	**600.4**	**600.4**	**0.0**
Pay Costs	(29.8)	(29.2)	(0.6)	(205.4)	(205.3)	(0.1)	(351.0)	(351.0)	0.0
Drugs	(7.2)	(6.8)	(0.4)	(47.1)	(48.1)	1.0	(82.3)	(82.3)	0.0
Other Non Pay Costs	(14.9)	(14.8)	(0.1)	(102.4)	(103.6)	1.2	(177.7)	(177.7)	0.0
TOTAL OPERATING EXPENSES	**(51.9)**	**(50.8)**	**(1.1)**	**(354.9)**	**(357.0)**	**2.1**	**(611.0)**	**(611.0)**	**0.0**
EBITDA	**0.5**	**1.3**	**(0.8)**	**(8.0)**	**(6.8)**	**(1.2)**	**(10.6)**	**(10.6)**	**0.0**
Depreciation	(0.8)	(0.9)	0.1	(6.0)	(6.2)	0.2	(11.0)	(11.0)	0.0
Finance Costs	(2.6)	(2.8)	0.2	(18.5)	(19.0)	0.5	(33.4)	(33.4)	0.0
Other - PDC, Disposals & Interest Income	0.0	0.0	0.0	0.1	0.0	0.1	0.0	0.0	0.0
(Deficit)/surplus after tax excluding Donated Additions	**(2.9)**	**(2.4)**	**(0.5)**	**(32.4)**	**(32.0)**	**(0.4)**	**(55.0)**	**(55.0)**	**0.0**

Core Slide 39

Finance - Lead Director John Hennessey

Income and Expenditure Summary as at October 2018

The reported I&E position for October is a deficit of £2.9m, against a planned deficit of £2.4m. This results in a £0.5m adverse variance in month (adverse variance of £0.4m YTD). The reported position is after recognising £0.888m of budgeted 'reserve' and in year accrual releases. Without this, the in-month position would have been £1.4m worse than budget.

Clinical Income, is £1.3m worse than budget in month, being the main driver of the adverse in-month position, before mitigation.

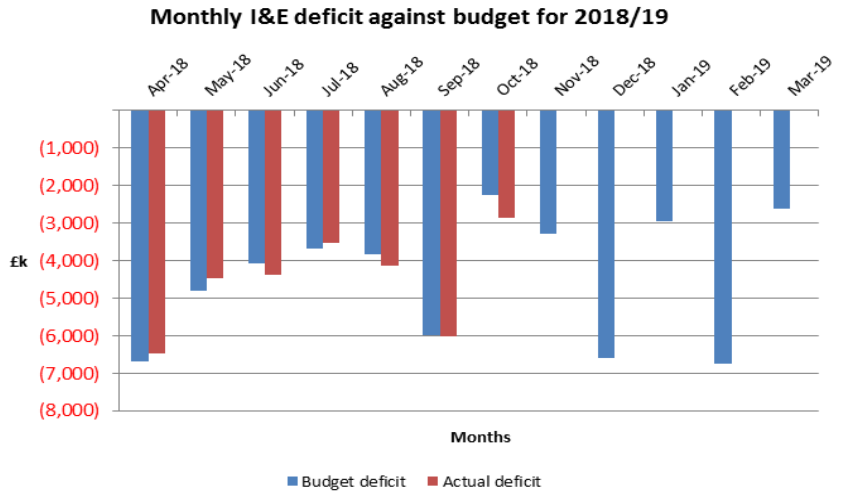
At end M7 there remains £0.82m of the risk accrual built up in M1 to M4. The accrual is reported within non clinical income.

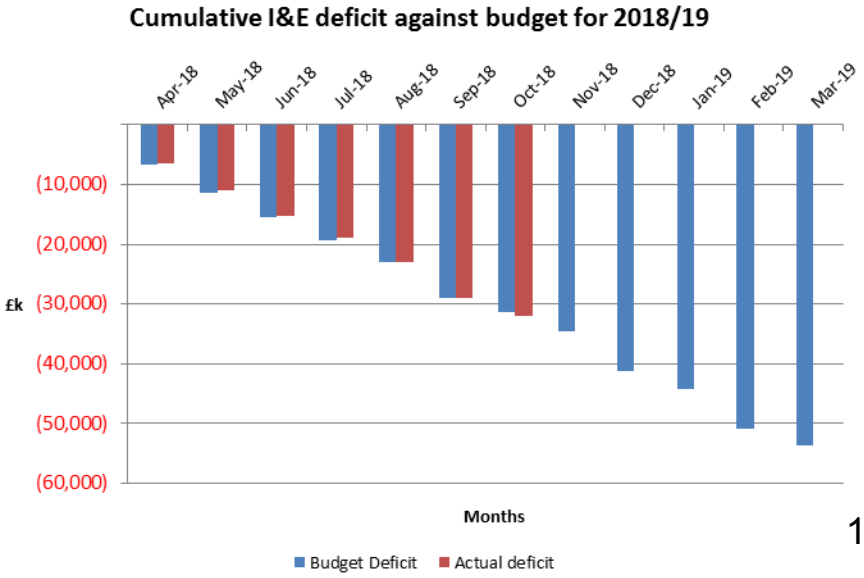
Summary of I&E Indicators

Income and Expenditure	Actual / Forecast £'000	Budget / Target £'000	Variance to Budget (adv) / fav £'000	Direction of travel (variance)	RAG
In month (deficit) / surplus	(2,886)	(2,406)	(480)	↓	Red
YTD (deficit) / surplus	(32,415)	(31,994)	(421)	↓	Red
Forecast (deficit) / surplus	(55,000)	(55,000)	0	↔	Green
NHS Clinical Income (exc Drugs) YTD	260,651	264,089	(3,438)	↓	Red
Non Clinical Income YTD	44,635	43,897	738	↑	Green
Pay YTD	(205,394)	(205,345)	(49)	↓	Amber
Non Pay YTD	(149,526)	(151,629)	2,103	↓	Green
Non Opex YTD	(24,521)	(25,254)	733	↑	Green
CIP Target YTD	14,523	12,753	1,769	↓	Green

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

↑ In month improvement and YTD favourable
↑ In month improvement and YTD adverse
↔ No change
↓ In month deterioration and YTD favourable
↓ In month deterioration and YTD adverse



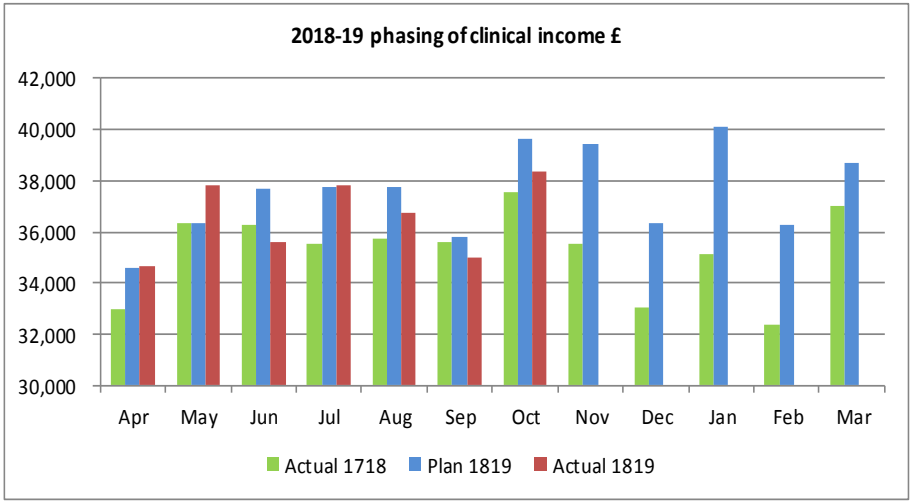


Core Slide 40

Finance - Lead Director John Hennessey

Income Analysis

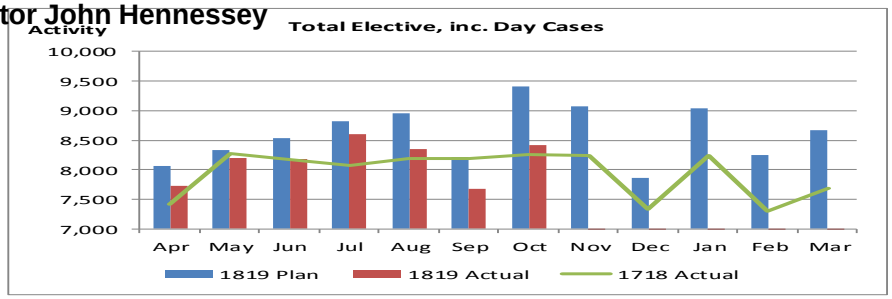
The chart below sets out the monthly phasing of the clinical income plan (exc. Spire to aid prior year comparison) for 2018/19. This phasing is in line with activity phasing which is how the income is recognised. The phasing is responsive to actual days and working days, hence the monthly variation.

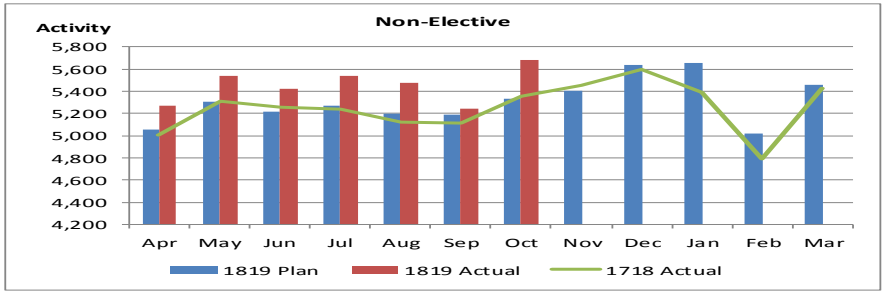


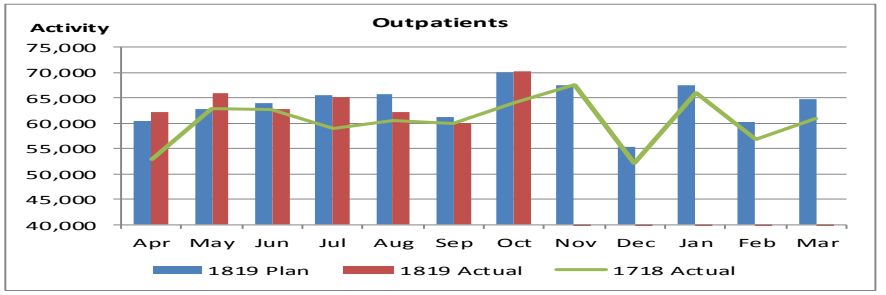
The income position was behind plan for October, with the under-performance mainly within Surgery (£1.09m) & Centralised (£0.32m). Electives have under-performed by £494k, DC by 344k. Non-Electives (inc. marginal rate) have over-performed by £643k.

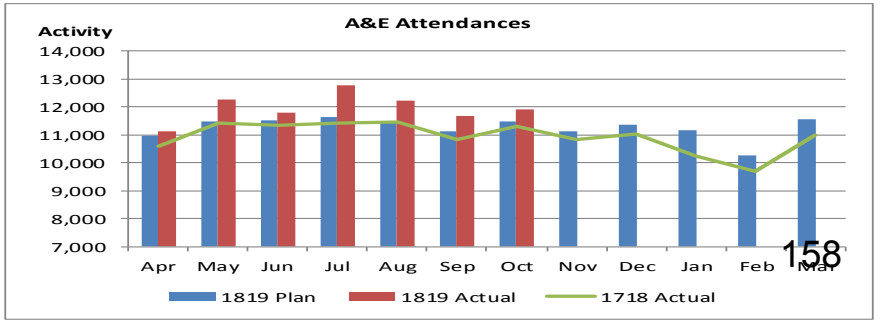
	Current month			Year to date		
Income (£'000s)	**Plan**	**Actual**	**Variance**	**Plan**	**Actual**	**Variance**
Daycase	4,777	4,432	-344	30,313	29,465	-848
Elective	4,314	3,821	-494	28,085	26,136	-1,949
Non Elective	11,766	12,597	832	80,983	85,388	4,405
Marginal Rate Reduction	-720	-909	-189	-4,942	-6,101	-1,159
Accident & Emergency	1,431	1,521	90	9,938	10,367	429
Outpatients	7,212	7,166	-46	46,332	45,754	-577
CQUIN	853	860	7	5,654	4,123	-1,531
C&V	6,343	6,049	-294	41,631	41,352	-278
Other*	4,324	3,489	-835	26,095	24,167	-1,929
Total	**40,292**	**39,026**	**-1,266**	**264,089**	**260,651**	**-3,438**

* includes M7 YTD adverse variance on block (£0.8m) & a non finalised clinical income CIP target YTD (£1.2m)



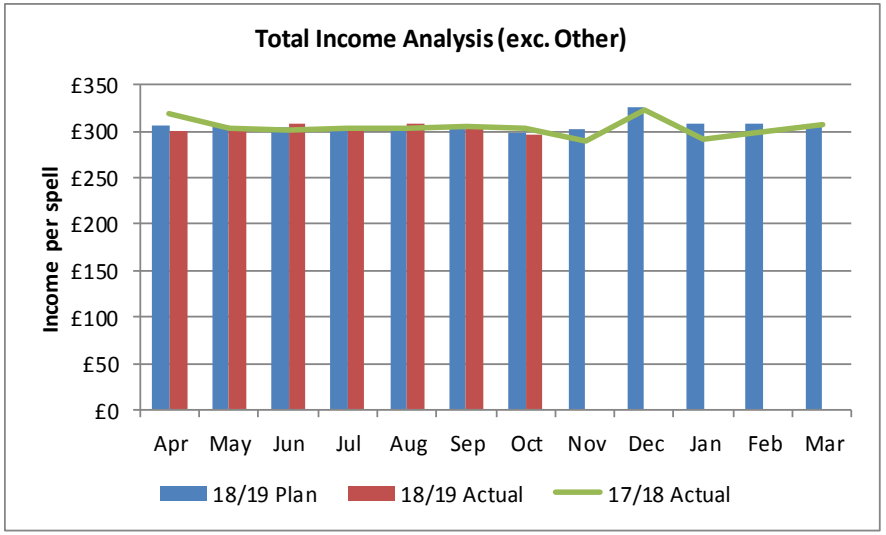


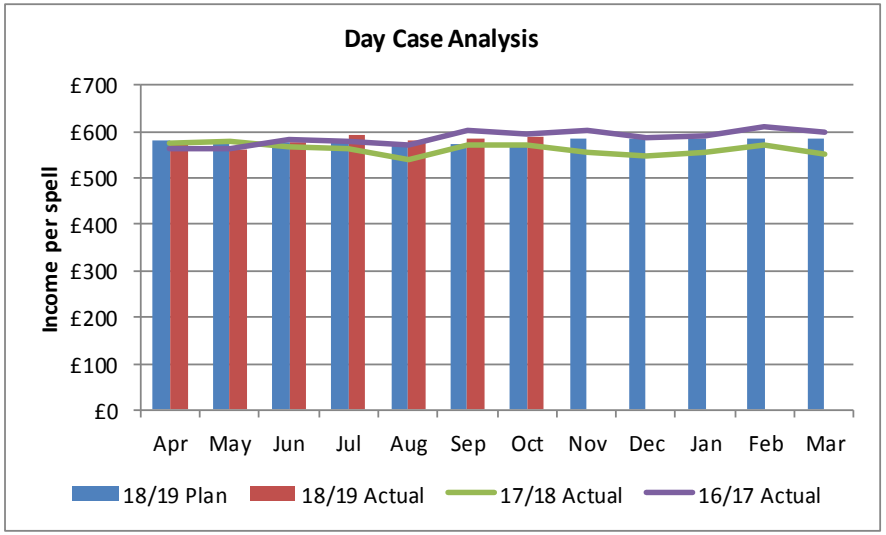


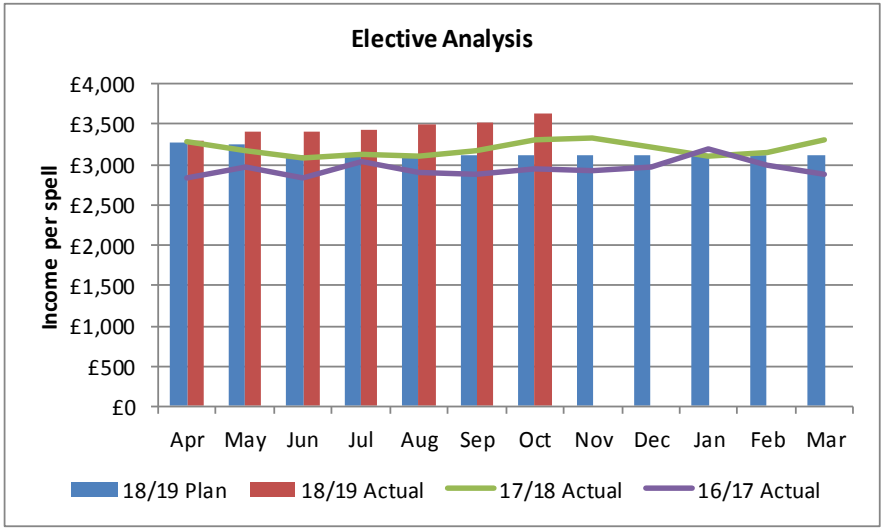


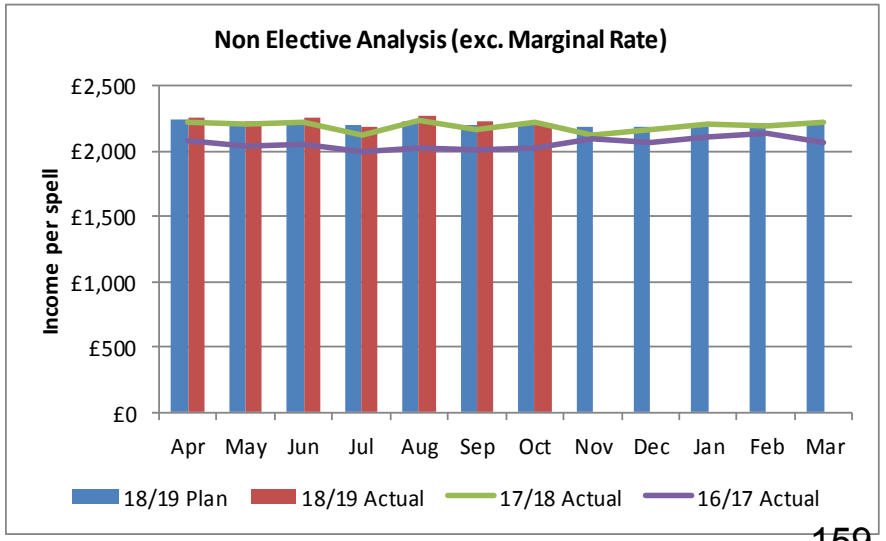
Core Slide 41

Finance - Lead Director John Hennessey









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Finance - Lead Director John Hennessey

Pay cost by 'type'

Monthly Expenditure (£)				
As at October 2018	Oct-18	Sep-18	Oct-17	YTD 2018-19
	£'000	£'000	£'000	£'000
Budgeted costs in month	**29,198**	**29,407**	**27,374**	**205,345**
Actuals:				
Substantive staff	**26,174**	**25,679**	**24,930**	**178,977**
Medical External Locum Staff*	143	175	108	1,437
Medical Internal Locum Staff	473	722	525	4,024
Additional Medical Sessions	464	446	471	3,150
Nursing Agency Staff*	557	580	482	3,916
Nursing Bank Staff	932	953	722	6,520
Other Agency Staff (AHPs/A&C)*	184	131	229	1,392
Other Bank Staff (AHPs/A&C)	169	141	170	1,026
Overtime	476	464	-	3,610
On Call	199	195	202	1,342
Total temporary expenditure	**3,596**	**3,807**	**2,910**	**26,417**
Total Pay costs	**29,770**	**29,486**	**27,840**	**205,394**
Variance Fav / (Adv)	(572)	(79)	(466)	(49)
Temp Staff costs % of Total Pay	**12%**	**13%**	**10%**	
Memo: Total agency spend in month*	**883**	**887**	**819**	**6,745**

Headcount

Monthly Whole Time Equivalents (WTE)			
As at October 2018	Oct-18	Sep-18	Oct-17
	WTE	WTE	WTE
Budgeted WTE in month	**8,012**	**7,984**	**7,297**
Employed substantive WTE in month	**6,946**	**6,930**	**6,729**
Medical External Locum Staff*	6	9	5
Medical Internal Locum Staff	73	95	77
Additional Sessions	15	12	13
Nursing Agency*	70	82	70
Nursing Bank	73	67	64
Other Agency (AHPs/A&C)*	110	88	91
Other Bank (AHPs/A&C)	352	321	339
Overtime	141	139	158
On Call Worked	39	38	40
Total equivalent temporary WTE	**878**	**850**	**856**
Total equivalent WTE	**7,824**	**7,781**	**7,585**
Variance Fav / (Adv)	188	203	(289)
Temp Staff WTE % of Total WTE	**11%**	**11%**	**11%**
Memo: Total agency WTE in month*	**186.32**	**177.88**	**165.72**
Sickness Rates	**4.27%**	**3.92%**	**3.88%**
Mat Leave	**2.46%**	**2.32%**	**2.28%**

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

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

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

Additional sessions, overtime & on call sourced from payroll.

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

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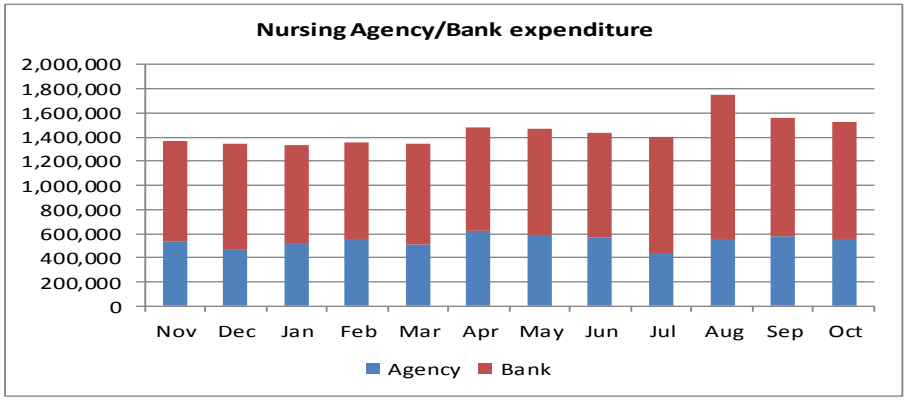
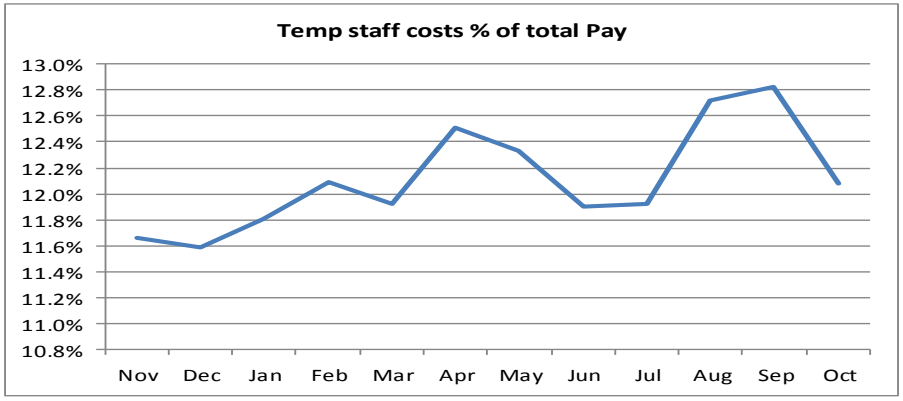
Finance - Lead Director John Hennessey

Pay Trends & Analysis

Medical staff premium Pay YTD (source: budget statements)	WLI	Internal Locum	External Locum & NAG	Total
Emergency	0	1,680,254	398,170	**2,078,424**
Surgical Support	565,555	71,111	496,326	**1,132,992**
General Surgery	242,321	187,462	116,693	**546,476**
Older Peoples Medicine	38,490	448,860	20,573	**507,923**
Imaging	417,111	3,358	0	**420,469**
Oral Surgery	15,370	247,624	113,592	**376,586**
Ophthalmology	296,103	34,306	9,372	**339,781**
Urology	227,750	105,031	0	**332,781**
Plastic Surgery	103,453	172,652	21,321	**297,426**
Gastroenterology	221,466	27,748	0	**249,214**
Cellular Pathology	94,468	5,709	140,532	**240,709**
Obs & Gynae	54,622	178,523	7,472	**240,617**
Dermatology	191,036	35,709	0	**226,744**
Paediatrics	106,267	114,533	5,845	**226,645**
T&O	137,964	66,285	-4,143	**200,106**
Cardiology	91,998	96,027	652	**188,677**
Service	117,131	26,526	44,046	**187,703**
Neurosciences	105,087	78,259	0	**183,346**
Respiratory Medicine	108,073	54,564	15,294	**177,931**
Ear Nose And Throat	0	156,223	17,886	**174,109**
Oncology & Haematology	11,141	126,501	4,031	**141,672**
Laboratory Medicine	0	44,231	0	**44,231**
Palliative Care	0	18,694	23,758	**42,452**
Endocrinology	3,662	26,741	5,332	**35,736**
Therapies & Support Services	0	14,633	0	**14,633**
Renal	0	2,068	0	**2,068**
Rheumatology	1,174	556	0	**1,730**
Total	**3,150,241**	**4,024,189**	**1,436,752**	**8,611,182**





- The Pay budget YTD is £205.3m v £205.4m actual cost delivering an overspend of £49k.
- Emergency has overspent in the YTD by £1,445k through additional Locum spend, additional floor coordinators & doctor cover in the evening of circa two doctors. The locum overspend is being reviewed within the division.
- Premium pay (all temp costs exc. on-call) is currently running at circa £3.6m per month (£3.4m in M7), & totals £25.0m YTD. Key areas of focus is control on overtime payments (£3.6m YTD, £0.47m per month), Agency (£5.3m YTD; £0.75m pm) & Locum incl. NAG spend (£5.5m YTD; £0.8m pm).

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Finance - Lead Director John Hennessey

CIP Performance

CIP Plan Development

- To date £27.3m of cost improvement initiatives have been approved through Gateway 2 and into delivery against the £30.0m CIP target with further schemes continuing to be developed through the governance process, with £1.5m through 'Gateway 1' and £0.1m sitting within the Trust's CIP Pipeline.

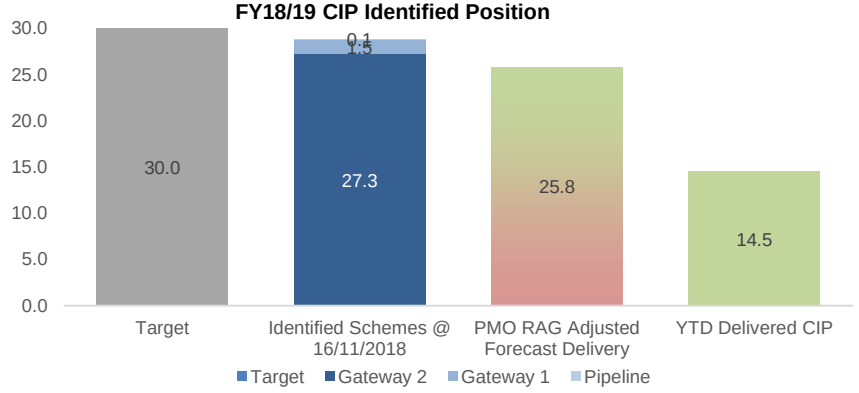
- A concerted effort is required to convert further initiatives into approved schemes as soon as practical to provide assurance over the deliverability of the £30.0m CIP target.

CIP Performance

- YTD the Trust has delivered £14.5m of CIPs against a FIP Board approved YTD plan of £13.2m (YTD plan per annual plan is £12.8m), an over-performance of £1.3m arising due to significant additional delivery in day case and outpatient productivity schemes within Medicine, offset by minor elements of underachievement in elective income generation initiatives in surgery.

- The risk adjusted forecast delivery for Gateway 2 schemes is currently £25.8m based on the YTD financial performance of 'in delivery' CIPs, progress against milestone delivery and performance against quality and performance indicators. This presents a significant risk to achievement of the £30.0m target.

FY18/19 CIP Identified Position



Category	Annual Plan £'000	FIP Approved Plan YTD £'000	Actual YTD £'000	Variance £'000
Clinical Income	17,580.3	8,342.0	9,326.6	984.6
Pay*	8,530.8	4,298.5	4,430.0	131.5
Non-pay*	2,191.3	(28.8)	490.9	519.7
Other Income*	1,000.2	455.0	102.9	(352.1)
Non-Opex	697.4	172.1	172.1	-
	30,000.0	**13,238.9**	**14,522.6**	**1,283.7**

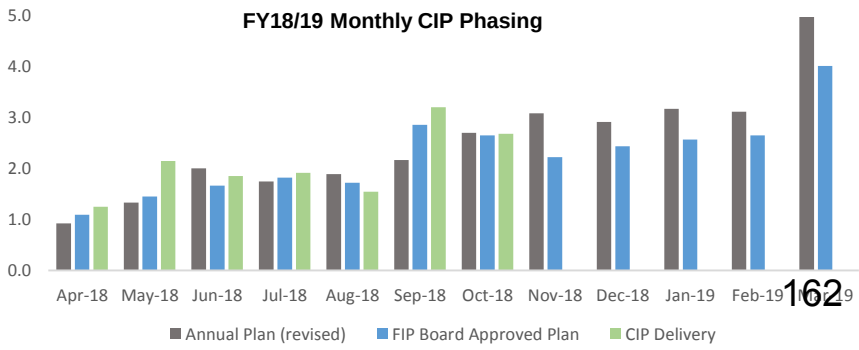
*Information is shown as the savings identified net of any costs associated with the delivery of clinical income initiatives, which is £2.1m across the categories.

FY18/19 Performance by Division

Division	Number of schemes 'In Delivery'	CIP Delivery		
		YTD FIP Board Approved Plan £'000	YTD Actual £'000	YTD Variance £'000
Medicine	34	4,107.0	5,459.8	1,352.8
Surgery	30	4,326.3	4,136.0	(190.2)
Women & Children's	15	1,336.4	1,729.0	392.6
Clinical Support Services	19	2,111.9	2,063.3	(48.6)
Corporate	13	1,357.2	1,134.4	(222.8)
Cross-Divisional*	2	-	-	-
	113	**13,238.9**	**14,522.6**	**1,283.7**
YTD per Annual Plan		12,753.4		
Variance to Annual Plan		**485.5**		

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

FY18/19 Monthly CIP Phasing



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Finance - Lead Director John Hennessey

Summary by Division

DIRECTORATES INCOME & EXPENDITURE	Oct-18 Budget £k	Oct-18 Actual £k	Oct-18 Variance F/(A) £k	Year to date Budget £k	Year to date Actual £k	Year to date Variance F/(A) £k
MEDICINE						
Total Income	20,179	21,034	855	134,513	139,705	5,192
Pay Costs	-9,370	-9,791	-420	-65,894	-67,422	-1,528
Non-Pay Costs	-7,324	-7,928	-605	-50,255	-52,442	-2,187
Total Expenditure	-16,694	-17,719	-1,025	-116,149	-119,864	-3,715
SURPLUS/(DEFICIT)	**3,485**	**3,315**	**-170**	**18,364**	**19,841**	**1,477**
SURGERY						
Total Income	16,084	14,681	-1,403	103,590	98,728	-4,862
Pay Costs	-8,770	-8,797	-27	-60,755	-60,606	148
Non-Pay Costs	-4,280	-3,980	300	-29,424	-27,966	1,458
Total Expenditure	-13,049	-12,776	273	-90,178	-88,572	1,607
SURPLUS/(DEFICIT)	**3,035**	**1,905**	**-1,130**	**13,412**	**10,157**	**-3,255**
WOMENS & CHILDREN						
Total Income	5,661	5,852	192	37,781	37,652	-128
Pay Costs	-3,195	-3,288	-92	-22,661	-22,586	75
Non-Pay Costs	-560	-675	-115	-4,171	-4,067	103
Total Expenditure	-3,755	-3,963	-207	-26,831	-26,654	178
SURPLUS/(DEFICIT)	**1,906**	**1,890**	**-16**	**10,949**	**10,999**	**49**
CLINICAL SUPPORT						
Total Income	4,270	4,291	20	28,378	29,129	752
Pay Costs	-5,152	-5,223	-71	-37,133	-36,468	665
Non-Pay Costs	-2,302	-2,744	-442	-17,018	-18,601	-1,583
Total Expenditure	-7,454	-7,967	-513	-54,151	-55,070	-919
SURPLUS/(DEFICIT)	**-3,184**	**-3,677**	**-493**	**-25,774**	**-25,941**	**-167**
SERVICES						
Total Income	620	664	44	4,652	4,552	-100
Pay Costs	-2,331	-2,323	9	-16,179	-15,750	429
Non-Pay Costs	-5,318	-5,430	-112	-35,377	-35,825	-448
Total Expenditure	-7,650	-7,753	-103	-51,556	-51,575	-19
SURPLUS/(DEFICIT)	**-7,029**	**-7,089**	**-59**	**-46,904**	**-47,023**	**-119**
OTHER						
Total Income*	5,312	6,011	700	38,924	37,160	-1,764
Pay Costs	-379	-349	30	-2,723	-2,561	162
Non-Pay Costs*	-5,550	-4,891	659	-38,243	-35,047	3,195
Total Expenditure	-5,930	-5,241	689	-40,965	-37,608	3,358
SURPLUS/(DEFICIT)	**-618**	**770**	**1,389**	**-2,041**	**-448**	**1,593**
TOTAL						
Total Income	52,127	52,533	407	347,838	346,928	-910
Pay Costs	-29,198	-29,770	-572	-205,345	-205,394	-49
Non-Pay Costs	-25,334	-25,649	-315	-174,487	-173,949	538
Total Expenditure	-54,532	-55,419	-887	-379,831	-379,342	489
SURPLUS/(DEFICIT)	**-2,406**	**-2,886**	**-480**	**-31,993**	**-32,415**	**-421**

*Drugs inflation cost pressure & associated income budgets netted in the Year to Date budget column by £2.4m

Medicine

Performance YTD the Medicine and Emergency division remains strong; ahead of plan by £1.5m.Total Income is £5.2m ahead of which Clinical Income is £3.2m ahead of plan YTD net of FIPs, which is driving the divisional over performance.

Pay remains a concern in the Emergency & OPM sub-division with overspend YTD of £1.4m, out of a total Divisional pay overspend of £1.5m; off set minimally with underspend elsewhere. Increased activity has driven the requirement to increase Internal and External Locum spend of which a subset of this is an additional two junior doctors on the night rota to ensure the trust meets the NHSI targets. The on boarding of Doctors from the overseas recruitment is gathering pace with six of the eight recruits now in role. From month 7 we have seen a reduction of locum usage as these doctors become non-supernumerary.

Surgery

Performance YTD for the Surgical Division is behind plan by £3.3m, a deterioration of £1,130k in the month. Total Income is £4.9m behind plan YTD of which clinical income has driven the YTD variance, as it is circa £4.6m behind plan.

The trend relating to General Surgery has continued in the period with increased non- elective income through the increase A&E activity, impacting on the elective activity which is a higher income generating area. Vacancies and long term sickness in Plastics, Dermatology and T&O has resulted in is still impacting the performance against plan. Typing backlogs & the new pensions taxation continues to limit the willingness of consultants to perform WLI sessions.

Pay costs YTD are underspent against plan by £148k, due to reduced spend against vacancies as described above.

Non-Pay is £1.5m underspent resulting from the delay in opening the additional Critical Care beds and a general reduction in spend due to reduced activity.

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Finance - Lead Director John Hennessey

Summary by Directorate (cont.)

Women's and Children's

Performance YTD is slightly ahead of plan by £49k. Total Income is £128k behind plan YTD this is all variance in clinical income. Outpatients are the significant driver of the deterioration.

Pay is behind spend YTD by £75k vacancies in Paeds nursing and Student Midwives is the main explanation but this has decreased from prior months driven by the commencement of the unidentified pay CIP in M07 of £90k. Non pay expenditure is behind budget YTD but £246k behind due to no spend on SHS and Medinet being lower than plan, this underspend is reduced by the increase in drugs spend which mainly flows through into income

Clinical Support

Divisional performance for CSSC has deteriorated in M07, with an under performance against plan of £167k YTD.

Total Income is ahead of plan by £752k, with increased activity seen in the radiology department and an increase in the EPA alliance income, and drugs income.

Pay remains behind plan YTD by £665k, with underspend across the directorates.

Non pay remains a concern, as this is over spent against budget by £1.6m. £375k variance relates relating to the Abbotts contract CIP, other significant variances relate to additional expenditure on Hods testing, maintenance contracts. We also saw a significant increase in the cost of consumables on the Abbotts contract in M07, driven by the testing and commissioning of the new Haematology equipment.

Corporate Services

YTD services are behind plan by £119k. This has been driven through the non-achievement of a CIP of £300k in relation fund raising re the QI building.

Pay is £429k underspent against budget YTD, and was £9k underspent in month. Pay is anticipated to carry on in line with budget due to savings at the start of the year being non-recurrent.

Non-Pay however is overspent YTD against budget by £448k, this mainly relates to the procurement strategic services cost arrangement not in budget.

Other - ytd

Clinical Income is where contract risks and issues are posted - away from the divisional performance. It is worse than plan by £1.8m being; Specialised Block where we have done more work than the block contract will pay - £0.8m, Readmissions costs £0.2m worse than plan, Cancelled Operations £0.23m, Cancer 62 day target penalties £0.35m and other risks provided.

Other Income is a net £20k fav, key items being the 'risk' accrual of £820k – adverse, the release of £770k from the 'income reserve accrual - fav, R&D of £0.53m adverse and £315k fav re Education and training budget update.

Non-Pay is £3.2m better than budget being: £1.2m general inflation cost pressure not allocated to specific costs, £0.6 under on R&D – matches under on related income, £0.83m fav on non opex – see below and other slippage

Non-Opex is £0.83m better than budget: Depreciation £0.23m from slippage in spend, Interest on borrowings £0.37m from interest rate and borrowing variances and Contingent Rent £0.13m from RPI being less than assumed and £0.1m on interest rec'ble and asset disposals.

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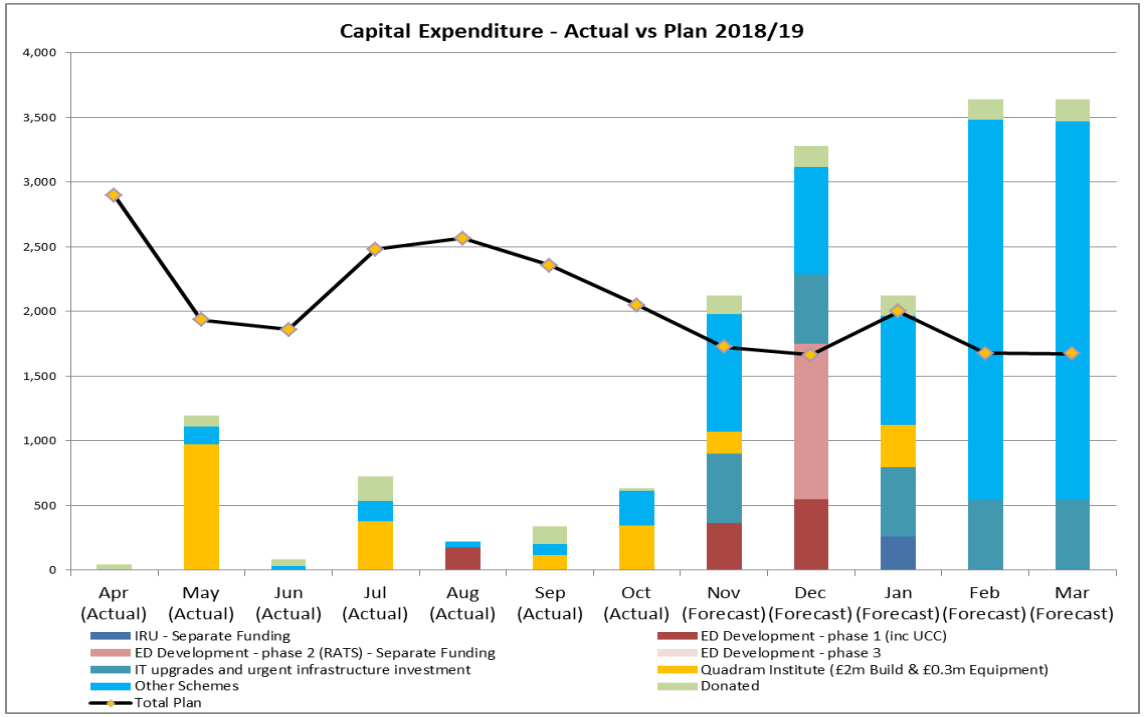
Finance - Lead Director John Hennessey

Capital Progress Report



The capital programme for the year of £24.8m and its monthly phasing is shown in the graph to the left.

Year to date the overall expenditure of £3.2m is behind the plan of £16.1m. A variance of £12.9m.

This is primarily due to the delay in receiving confirmation of the £17.6m of capital funding support requested from DHSC, being:

- £7.0m IRU (loan application – approved)
- £1.2m RATS (central funding – approved)
- £9.455m Various (loan application – pending approval)

Of the above, £11.7m of capital support and spend was assumed YTD.

The forecast below of £18,010k assumes all projects planned for this financial year will continue to be completed in year – except for IRU – and will recover the slippage to date. This depends on the confirmation of the £9.455m of loan funding. The forecast will be reassessed in Q3.

Internally generated funding for capital is £7,305k, comprising, depreciation net of balance sheet cash items of £1,296k, STF of £4,504k, and capital assets disposals of £1,505k as part of our move to a managed service relating to QI.

	Apr Actual £'000	May Actual £'000	Jun Actual £'000	Jul Actual £'000	Aug Actual £'000	Sep Actual £'000	Oct Actual £'000	Nov Forecast £'000	Dec Forecast £'000	Jan Forecast £'000	Feb Forecast £'000	Mar Forecast £'000	TOTAL Forecast £'000
IRU - Separate Funding	0	0	0	0	0	0	0	0	0	258	0	0	**258**
ED Development - phase 1 (inc UCC)	0	0	0	0	175	0	0	363	548	0	0	0	**1,085**
ED Development - phase 2 (RATS) - Separate Fundin	0	0	0	0	0	0	0	0	1,200	0	0	0	**1,200**
ED Development - phase 3	0	0	0	0	0	0	0	0	0	0	0	0	**0**
IT upgrades and urgent infrastructure investment	0	0	0	0	0	0	0	540	540	540	540	540	**2,700**
Quadram Institute (£2m Build & £0.3m Equipment)	0	975	0	375	0	116	343	166	0	325	0	0	**2,300**
Other Schemes	0	133	30	158	44	85	272	911	829	841	2,941	2,925	**9,170**
Donated	42	86	50	188	0	135	14	139	159	159	155	170	**1,297**
Total Actual to Date / Forecast	42	1,194	80	721	220	335	629	2,119	3,276	2,123	3,636	3,635	18,010
Cumulative Actual to Date	42	1,236	1,317	2,038	2,258	2,593	3,222						
Total Plan	2,896	1,933	1,858	2,479	2,566	2,356	2,050	1,726	1,664	2,001	1,677	1,674	24,880

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Finance - Lead Director John Hennessey

Statement of Financial Position at 31st October 2018

	Opening Balance as at 1 April 2018 £'000	Plan 31 March 2019 £'000	Plan YTD 31 October 18 £'000	Actual YTD 31 October 18 £'000	Variance YTD 31 October 18 £'000
Property, plant and equipment	234,749	249,516	244,717	231,961	(12,756)
Trade and other receivables	71,245	77,940	75,133	75,334	201
Other financial assets	0	0	0	0	0
Total non-current assets	**305,994**	**327,456**	**319,850**	**307,295**	**(12,555)**
Inventories	9,369	9,369	9,369	10,129	760
Trade and other receivables	28,621	24,040	26,178	30,858	4,680
Non-current assets for sale	0	0	0	0	0
cash and cash equivalents	5,733	1,681	2,177	5,931	3,754
Total Current assets	**43,723**	**35,090**	**37,724**	**46,918**	**9,194**
Trade and other payables	(61,085)	(61,256)	(61,011)	(65,536)	(4,525)
Borrowing repayable within 1 year	0	0	0	0	0
Current provisions	(308)	(307)	(307)	(308)	(1)
Deferred Income	(5,138)	(4,764)	(4,764)	(8,942)	(4,178)
Total current liabilities	**(66,531)**	**(66,327)**	**(66,082)**	**(74,786)**	**(8,704)**
Total assets less current liabilities	**283,186**	**296,219**	**291,492**	**279,427**	**(12,065)**
Borrowings - PFI & Finance Lease	(193,856)	(190,761)	(192,218)	(192,219)	(1)
Borrowings - Revenue Support	(52,393)	(103,493)	(81,853)	(82,544)	(691)
Borrowings - Capital Support	0	(18,601)	(11,679)	0	11,679
Provisions	(2,159)	(1,892)	(2,003)	(2,097)	(94)
Deferred Income	(4,606)	(4,875)	(4,918)	(4,295)	623
Total non-current liabilities	**(253,014)**	**(319,622)**	**(292,671)**	**(281,155)**	**11,516**
Total assets employed	**30,172**	**(23,403)**	**(1,179)**	**(1,728)**	**(549)**
Financed by					
Public dividend capital	28,408	28,408	28,408	28,408	0
Retained Earnings (Accumulated Losses)	(13,239)	(66,814)	(44,590)	(45,136)	(546)
Revaluation reserve	15,003	15,003	15,003	15,000	(3)
Total Taxpayers' and others' equity	**30,172**	**(23,403)**	**(1,179)**	**(1,728)**	**(549)**

Non-Current Assets

There is some slippage on the capital programme primarily due to a delay in receiving capital support from DHSC of £11.7m YTD.

Trade and Other Receivables

This balance is £4.7m higher than plan YTD. Various - key driver is timing.

Cash

Cash is £3.8m higher than plan at the end of October due to short term timing differences. Loan drawdowns continue to be delayed as long as possible.

Trade and other payables

This is £4.5m higher than plan YTD.

£0.5m is YTD accrual of £2m contingency reserve.

Increased levels of general trade payables – timing difference.

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

Deferred Income

This balance is £3.6m higher than plan YTD. £1.5m relates to the sale of endoscopy equipment and is a short term timing difference. £0.6m relates to risk on assumed VAT recovery relating to the QI. The remainder are small timing differences.

Borrowings

Total overall borrowings are £11.0m lower than plan.

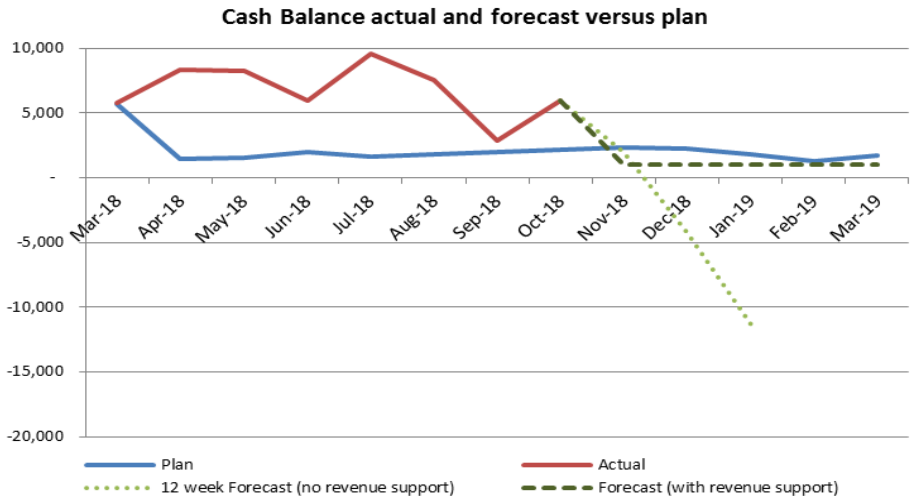
In year revenue borrowings are £30.2m against a YTD plan of £29.5m. Being £0.7m higher than plan.

In year capital borrowings are £0m against a YTD plan of £11.7m. Being £11.7m lower than plan. This is primarily due to the lengthy DHSC process of approving the revised capital loan applications of £16.5m and the funding being released.

Core Slide 49

Finance - Lead Director John Hennessey

Cash Balance and Forecast for the Year



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

- The graph shows the cash levels since the end of March 2018. Short term timing differences drive the difference between actual and plan.
- The Trust is required to keep a minimum balance of £1 million, hence the closing cash plan every month is @ £1m.
- The future cash loan requirements on current projections are - £5.8m in November & £5.2m in December.
- The borrowings of £82.5m at the end of M7 comprise: £16m in 2016/17, £36.4m in 2017/18 & £30.1m in 2018/19.
- The interest rates are: 3.5% on £31.0m. 1.5% on the remainder of £51.5m.

NOTE:

- The plan for 2018/19 assumes additional borrowings of £51.1m for revenue.
- The Trust Board approved borrowing 'limit' is £100m revenue and £25m capital. This was confirmed at the April 2018 Trust Board meeting.
- The need for the funds is driven by our operational performance.

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

Income Statement Comparison - for the Month of October

	For the month			Variances Fav / (Adv)			
	Actual	Budget	Prior year	To Budget		To prior year	
	£'000	£'000	£'000	£'000	%	£'000	%
INCOME							
NHS clinical income							
Clinical Income	38,364	39,661	37,527	(1,297)	(3%)	837	2%
Clinical Income - Spire Contract	662	632		31	5%	662	
NT Drugs	6,059	5,771	5,911	288	5%	148	3%
Total NHS clinical income	**45,085**	**46,063**	**43,438**	**(978)**	**(2%)**	**3,425**	**8%**
Non NHS clinical income							
Private patients	194	158	213	36	23%	(19)	(9%)
Other - RTA	149	110	50	39	35%	99	198%
Total Non NHS clinical income	**343**	**268**	**263**	**75**	**28%**	**80**	**30%**
Other Income							
R&D	1,727	1,809	1,907	(82)	(5%)	(180)	(9%)
Education & Training	2,270	1,929	2,213	341	18%	57	3%
STF Income			1,329			(1,329)	(100%)
Other non patient care income	3,108	2,058	2,293	1,050	51%	815	36%
Total other Income	**7,105**	**5,796**	**7,742**	**1,309**	**23%**	**(637)**	**(8%)**
TOTAL OPERATING INCOME	**52,533**	**52,127**	**51,443**	**406**	**1%**	**2,868**	**6%**
EXPENDITURE							
Employee benefit expenses	(29,770)	(29,199)	(27,840)	(571)	(2%)	(1,930)	(7%)
Drugs	(7,160)	(6,834)	(6,937)	(326)	(5%)	(223)	(3%)
Clinical supplies	(5,608)	(5,388)	(5,834)	(220)	(4%)	226	4%
Non clinical supplies	(7,504)	(7,549)	(6,498)	45	1%	(1,006)	(15%)
- Fixed	*(1,785)*	*(1,785)*	*(1,607)*		*0%*	*(178)*	*(11%)*
- Capacity	*(569)*	*(569)*	*(440)*		*0%*	*(129)*	*(29%)*
- Income Backed including Spire	*(2,447)*	*(2,476)*	*(1,762)*	*29*	*1%*	*(685)*	*(39%)*
- £2m Contingency Reserve	*(180)*	*(180)*			*0%*	*(180)*	
- Variable	*(2,523)*	*(2,539)*	*(2,689)*	*16*	*1%*	*166*	*6%*
PFI operating expenses	(1,818)	(1,817)	(1,719)	(1)	(0%)	(99)	(6%)
TOTAL OPERATING EXPENSES	**(51,860)**	**(50,787)**	**(48,828)**	**(1,073)**	**(2%)**	**(3,032)**	**(6%)**
Profit/(loss) from operations	**673**	**1,340**	**2,615**	**(667)**	**(50%)**	**(164)**	**(6%)**
Non-operating income							
Interest	17	3	3	14	(467%)	14	467%
Profit/(loss) on asset disposals	4	(3)	2	7	233%	2	100%
Total non-operating income	**21**		**5**	**21**		**16**	**320%**
Non-operating expenses							
Interest on PFI and Finance leases	(1,419)	(1,419)	(1,439)		0%	20	(1%)
Interest on Non Commercial Borrowing	(160)	(251)	(71)	91	36%	(89)	125%
Depreciation	(861)	(924)	(889)	63	7%	28	(3%)
PDC			(25)			25	(100%)
Other - Contingent Rent	(1,140)	(1,152)	(1,047)	12	1%	(93)	9%
Total non operating expenses	**(3,580)**	**(3,746)**	**(3,471)**	**166**	**4%**	**(109)**	3%
Surplus (deficit) after tax from continuing operations	**(2,886)**	**(2,406)**	**(851)**	**(480)**	**(20%)**	**(257)**	**(30%)**
Memo:							
Donated Asset Additions	14	139	75	(125)	(90%)	(61)	(81%)
Surplus (deficit) after tax and Donated Asset Additions	**(2,872)**	**(2,267)**	**(776)**	**(605)**	**(27%)**	**(318)**	**(41%)**

Notes:

Calendar Days	31	31	31
Working Days	23	23	22

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

Income Statement Comparison - Year to 31 October 2018

	FULL YEAR BUDGET	Year to date			Variances Fav / (Adv)			
		Actual	Budget	Prior year	To Budget		To prior year	
	£'000	£'000	£'000	£'000	£'000	%	£'000	%
INCOME								
NHS clinical income								
Clinical Income	447,320	256,041	259,669	250,025	(3,628)	(1%)	6,016	2%
Clinical Income - Spire Contract	7,578	4,610	4,421		190	4%	4,610	
NT Drugs	69,230	39,775	40,375	37,330	(600)	(1%)	2,445	7%
Total NHS clinical income	**524,128**	**300,426**	**304,464**	**287,355**	**(4,038)**	**(1%)**	**13,071**	**5%**
Non NHS clinical income								
Private patients	1,899	896	1,108	1,048	(212)	(19%)	(152)	(15%)
Other - RTA	1,318	971	769	709	202	26%	262	37%
Total Non NHS clinical income	**3,217**	**1,867**	**1,877**	**1,757**	**(10)**	**(1%)**	**110**	**6%**
Other Income								
R&D	21,644	12,145	12,595	12,257	(450)	(4%)	(112)	(1%)
Education & Training	23,267	13,939	13,624	13,286	315	2%	653	5%
STF Income				5,979			(5,979)	(100%)
Other non patient care income	28,176	18,551	17,678	28,820	873	5%	(10,269)	(36%)
Total other Income	**73,087**	**44,635**	**43,897**	**60,342**	**738**	**2%**	**(15,707)**	**(26%)**
TOTAL OPERATING INCOME	**600,432**	**346,928**	**350,238**	**349,454**	**(3,310)**	**(1%)**	**(2,526)**	**(1%)**
EXPENDITURE								
Employee benefit expenses	(351,045)	(205,394)	(205,345)	(190,095)	(49)	(0%)	(15,299)	(8%)
Drugs	(82,270)	(47,101)	(48,076)	(44,535)	975	2%	(2,566)	(6%)
Clinical supplies	(65,909)	(37,655)	(38,236)	(38,395)	581	2%	740	2%
Non clinical supplies	(90,707)	(52,106)	(52,783)	(42,860)	677	1%	(9,246)	(22%)
- Fixed	(21,366)	(12,444)	(12,444)	(10,219)		0%	(2,225)	(22%)
- Capacity	(6,213)	(3,964)	(3,591)	(3,695)	(373)	(10%)	(269)	(7%)
- Income Backed including Spire	(29,720)	(16,928)	(17,337)	(12,305)	409	2%	(4,623)	(38%)
- £2m Contingency Reserve	(2,000)	(1,000)	(1,000)				(1,000)	
- Variable	(31,408)	(17,770)	(18,411)	(16,641)	641	3%	(1,129)	(7%)
PFI operating expenses	(21,091)	(12,664)	(12,534)	(12,075)	(130)	(1%)	(589)	(5%)
TOTAL OPERATING EXPENSES	**(611,022)**	**(354,920)**	**(356,974)**	**(327,960)**	**2,054**	**1%**	**(26,960)**	**(8%)**
Profit/(loss) from operations	**(10,590)**	**(7,992)**	**(6,736)**	**21,494**	**(1,256)**	**19%**	**(29,486)**	**(137%)**
Non-operating income								
Interest	32	85	19	20	66	(347%)	65	325%
Profit/(loss) on asset disposals	(40)	13	(23)	6	36	157%	7	117%
Total non-operating income	**(8)**	**98**	**(4)**	**26**	**102**	**(2550%)**	**72**	**277%**
Non-operating expenses								
Interest on PFI and Finance leases	(17,085)	(9,990)	(9,992)	(10,159)	2	0%	169	(2%)
Interest on Non Commercial Borrowing	(2,799)	(912)	(1,280)	(452)	368	29%	(460)	102%
Depreciation	(11,021)	(6,009)	(6,243)	(6,114)	234	4%	105	(2%)
PDC				(173)			173	(100%)
Other - Contingent Rent	(13,497)	(7,610)	(7,739)	(6,960)	129	2%	(650)	9%
Total non operating expenses	**(44,402)**	**(24,521)**	**(25,254)**	**(23,858)**	**733**	**3%**	**(663)**	3%
Surplus (deficit) after tax from continuing operations	**(55,000)**	**(32,415)**	**(31,994)**	**(2,338)**	**(421)**	**(1%)**	**(30,077)**	**(1286%)**
Memo:								
Donated Asset Additions	1,425	515	643	1,220	(128)	(20%)	(705)	(58%)
Surplus (deficit) after tax and Donated Asset Additions	**(53,575)**	**(31,900)**	**(31,351)**	**(1,118)**	**(549)**	**(2%)**	**(30,782)**	**(2753%)**

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

Deficit on a control total basis - reportable to NHSI:								
Surplus (deficit) after tax and Donated Asset Additions	(53,575)	(31,900)	(31,351)	(1,118)	(549)	(2%)	(30,782)	2753%
Remove: Donated Asset Additions	(1,425)	(515)	(643)	(1,220)	128	(20%)	705	(58%)
Add back: Donated Depreciation	807	495	471	366	24	5%	129	35%
Adjusted financial performance surplus/(deficit)	**(54,193)**	**(31,920)**	**(31,523)**	**(1,972)**	**(397)**	**(1%)**	**(29,948)**	**1519%**
CONTROL TOTAL	**10,683**	**6,315**	**6,315**	**(1,487)**		**0%**	**7,802**	**(525%)**
Performance against control total	**(64,876)**	**(38,235)**	**(37,838)**	**(485)**	**(397)**	**(1%)**	**(37,750)**	**7784%**

Notes:

Calendar Days	214	214	214
Working Days	149	149	147