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

NHS
Norfolk and Norwich University Hospitals
NHS Foundation Trust

MEETING OF THE TRUST BOARD IN PUBLIC
WEDNESDAY 4 NOVEMBER 2020

A meeting of the Trust Board will take place at 9.30am on Wednesday 4 November 2020 by MS Teams (details at www.nnuh.nhs.uk) or at Norfolk & Norwich University Hospital

Due to the Covid 19 pandemic and associated government guidance, members of public will not be admitted to the meeting but Board papers will be posted on the Trust's website and remote access to the meeting will be arranged, if possible.

AGENDA

	Item	Lead	Purpose	Page
1	Apologies, Declarations of Interest and Chairman's Introduction	Chair	Information	
2	Minutes of the Board meeting held in public on 05.08.20	Chair	Approval	**2**
3	Matters arising and update on actions	Chair	Discussion	
4	Chief Executive's Report	CEO	Discussion	**Verbal**
5	**Reports for Information and Assurance:**		Information and Assurance	
	(a) Quality and Safety Committee (27.10.20)	GOS		**11**
	(b) IPR – Quality, Safety and Patient Experience data	ED/NF		**13**
	(c) Finance, Investments and Performance Committee (28.10.20)	TS		**27**
	(d) IPR – Finance, Performance and Productivity data	CC/RC		**29/59**
	(e) People & Culture Committee (26.10.20)	DR		**78**
	(f) IPR – Workforce data	PJ		**80**
6	Modern Slavery Act Statement	JPG	Approval	**89**
7	Questions from members of the public	Chair	Discussion	
8	Any other business	Chair	Discussion	

Date and Time of next Board meeting in public
The next Board meeting in public will be at 9.30am on Wednesday 3 February 2020 – location/arrangements TBC

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

NHS
Norfolk and Norwich University Hospitals
NHS Foundation Trust

MINUTES OF TRUST BOARD MEETING IN PUBLIC

HELD ON 5 AUGUST 2020

Present:	Mr D White	- Chairman
	Dr P Chrispin	- Non-Executive Director
	Mr R Clarke	- Chief Finance Officer
	Mr C Cobb	- Chief Operating Officer
	Prof E Denton	- Medical Director
	Ms S Dinneen	- Non-Executive Director
	Prof N Fontaine	- Chief Nurse
	Mr J Foster	- Non-Executive Director
	Mrs J Hannam	- Non-Executive Director
	Mr S Higginson	- Chief Executive
	Mr P Jones	- Chief People Officer
	Dr G O'Sullivan	- Non-Executive Director
	Mr T Spink	- Non-Executive Director
In attendance:	Ms F Devine	- Director of Communications
	Mr J P Garside	- Board Secretary
	Mr A Lundrigan	- Chief Information Officer
	Ms V Rant	- Assistant to Board Secretary
	Members of the public and press	

20/032 **APOLOGIES, DECLARATIONS OF INTEREST AND CHAIRMAN'S INTRODUCTION**

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

20/033 **PATIENT/FAMILY REFLECTIONS**

Mr White welcomed Mr Graham Browne and Mrs Sue Browne to the Board to outline their experience following Mr Browne's heart attack. Also in attendance were Ms Tanya Moon (Divisional Director of Nursing for Medicine), Ms Claudine Turnbull (Occupational Therapist), Ms Helen Huson (Matron for Cardiology/Medicine) and Ms Sarah Higson (Lead for Patient Engagement and Experience).

Sue informed the Board that Graham suffered a hypoxic brain injury following a cardiac arrest at home in November 2015. He had been transferred to NNUH for PPCI (Primary Percutaneous Coronary Intervention) and the care provided to Graham was considered to have been excellent. Unfortunately, the experience had an emotional and psychological impact on his wife and family and they found that the available support had been insufficient. This seems to be a particular issue for younger patients surviving cardiac arrest and to prepare/support families before and after discharge.

Sue explained that they had been unprepared for the changes to Graham's personality and he had also been mentally and emotionally different. Graham indicated that psychological support had been provided at quite an early stage in his recovery but there had been no follow-up to provide additional support at a later stage in his recovery.

Professor Fontaine explained that the hospital's focus had been directed towards resuscitation and care prior to discharge. It has been recognised that the survival rate from cardiac arrest has increased and a Quality Improvement Project is underway to consider long-term support. Sue and Graham have agreed to be 'experts by experience' to support the Cardiology Team to improve the pathway/support for future patients.

Ms Huson informed the Board that recovery for these patients is often complicated by cognitive impairment and an increasing number of families are having to live with long-term consequences after discharge. It was also found that there are no formal rehabilitation pathways in place for this group of patients and there is a gap in psychological support for patients and their families. The Quality Improvement Project aims to put in place a structured rehabilitation pathway, starting at the point of admission and continuing through to post-discharge rehabilitation. This pathway will include physical and cognitive assessment and psychological support.

Mr Higginson thanked Sue and Graham for sharing their experience and asked about their observations of primary and community services and the link with acute services. Sue explained that Graham had been discharged from hospital two days prior to Christmas and they had been unable to access support in the community until the end of January and provision of support pre-discharge would have helped the family to be better prepared.

Non-executives reflected on the need to provide joined up care pathways and emphasised the need to work together with healthcare partners in the community. Ms Turnbull indicated that we will be working with the Colman Hospital Rehabilitation Unit on this QI Project and linking community care with periodic follow-ups in the days, weeks and months after discharge will also help to avoid people feeling that they are on their own.

Mr White thanked Sue and Graham for sharing their experience. The learning from this experience is extremely valuable as it will help to improve services for future patients and promotes the benefits of working closer with our healthcare partners. Introduction of an Electronic Patient Record will provide organisations with the ability to share information and lead to improved pathways of care for patients across Norfolk and Waveney.

20/034 **MINUTES OF PREVIOUS MEETING HELD ON 3 JUNE 2020**

The minutes of the meeting held on 3 June 2020 were agreed as a true record and approved for signing by the Chairman.

20/035 **MATTERS ARISING**

There were no formal Action Points arising from the meeting held on 3 June 2020.

20/036 **CHIEF EXECUTIVE REPORT**

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

Mr Higginson informed the Board that no Covid positive patients have been admitted to hospital since 30 June 2020 and there is one inpatient who is currently recovering from the virus. This contrasts with the position in April when there were 85 Covid patients in hospital. In total the hospital has admitted 446 patients with Covid and 123 patients have sadly died from the virus whilst in hospital.

As we move into the next phase of recovery, we must not lose sight of the efforts of our staff and the public, which has enabled us to reach this position by following guidance/protocols, maintaining social distancing and hand hygiene.

It is important that we all continue to maintain our efforts over the coming months in order to limit cases. This will assist in creating a safe environment to enable staff who have been shielding to return to work and for the new junior doctors who will be joining the Trust in the next few months. We are also looking forward to welcoming our volunteers back to the site towards the end of August.

National guidance has been published outlining requirements in phase 3 for the restoration of services. Over the next three months we will be focusing our work to increase capacity to enable services to recommence and increase activity to treat the large numbers of patients who are waiting for care. We have commissioned external support to work with our Emergency Teams to improve our performance against the 4 hour standard.

As we move into the Autumn, we will be focusing on promoting our staff flu vaccination campaign and we are hoping to exceed the 87% achieved last year.

The Trust's Strategy is nearing its fifth year and we have commenced work to renew the Strategy to outline our objectives/priorities over the next five years. We will be engaging widely with stakeholders, staff and the public to seek views on what the future shape and vision of the hospital will be for the next five years.

Work is progressing on the Electronic Patient Record (EPR) programme. We will be looking at learning from the issues experienced in implementation of EPR systems in other Trusts across the country. We will be aiming to implement a system that will assist communication and system-wide working across Norfolk and Waveney.

The NNUH, James Paget University Hospital and Queen Elizabeth Hospital in Kings Lynn have set up Committees in Common to open up discussion on how services can be delivered across the region. The Committees in Common are sub-committees of the Acute Trust Boards and we anticipate that this will be a positive way forward, towards improving outcomes for patients across Norfolk and Waveney.

We are grateful to all our staff for their hard work over the last few months and it is important to encourage staff to take time out to have a break to refresh themselves. Time will be taken to reflect on experiences during the pandemic emergency and to identify learning outcomes so that we can adapt and make preparations in the event of a second wave later in the year.

There was non-executive questioning on emergency preparations and work to prepare for the second wave of the pandemic. Mr Cobb confirmed that there is a national expectation of a second wave and preparation for a second surge will form a key part of our usual Winter planning. The Trust's Flu Plan guided us through the first wave of the pandemic but we will be looking to modify our Plan to incorporate learning outcomes from the first wave.

Our operational planning for the second wave, will base response times on results being available within two hours. In order to lessen pressure, elective patients will have home testing for Covid prior to admission. The number of people with the virus in Norfolk has been lower than that in other parts of the country but our revised pandemic response will be in place by the end of September so that we are ready. Elective beds will be ring fenced in order that treatment can be maintained for waiting patients.

Professor Fontaine informed the Board that we are in much closer contact with Public Health Norfolk and we are looking at how our Infectious Diseases Unit can be used most effectively. Over 2,000 staff have been trained in preparation for the hospital to become a Super Surge Centre.

20/037 **REPORTS FOR INFORMATION AND ASSURANCE**

(a) Integrated Performance Report Overview

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

Professor Fontaine reported that Infection Prevention and Control measures are being maintained and are fully embedded across the organisation. There have been no in-hospital transmissions of the Covid virus and this is a positive indication of the success of the measures in place. We are maintaining focus on limiting risks for staff. Much work has been undertaken to prepare for increased numbers of elective patients who will be coming in for treatment. Visiting restrictions are being lifted in a phased way in order to ensure we keep our patients, staff and visitors safe. We have worked with the local community to provide guidance on PPE and hand hygiene procedures.

Mr Cobb indicated that operational capacity will be at increased risk if we are unable to return staff to the site and we are looking at how we can optimise use of the time we have prior to the second wave.

Mr Jones reported that a series of initiatives have been identified in our workforce restoration plan. Individual risk assessments have been developed to help in assessing the risks to patients and staff.

(b) Quality and Safety Committee (28.07.20)

The Board was updated by Dr O'Sullivan as Chair of the Quality & Safety Committee with regard to its meeting on 28 July 2020.

Dr O'Sullivan reported that the Committee had reviewed the MBRRACE-UK Annual Report of the Confidential Enquiry into Maternal Deaths and Morbidity. Further work is being undertaken on the timeliness of investigations and reporting of perinatal mortality reviews into stillbirths and neonatal deaths. Progress will continue to be overseen by the Committee. Professor Fontaine highlighted that the Trust's perinatal mortality rate has been maintained in line with the national average rate.

The Committee reviewed the recently published Cumberledge report concerning the treatment of women over the last 60 years. Four actions are suggested in the report relating to how complaints are managed. We already follow the relevant practice in three areas and, to satisfy the fourth, Mrs Hannam has been identified as the lead Non-Executive Director for complaints, patient experience & engagement.

(c) IPR – Quality, Safety and Patient Experience

Professor Fontaine informed the Board that 2,229 incidents had been reported in June which is an increase compared to the number reported in June last year (2,080). The rise in the number of recorded incidents is a good indication of an improving safety culture within our organisation and 98% are no or low harm incidents. The number of incidents being reported is a good indication that staff feel comfortable reporting incidents and feel confident that this will result in improvements being made.

The Board was informed that there has been a small rise in the number of Grade 2 pressure ulcers and this may be linked to the acuity of post-Covid patients and the

delay in patients coming to the hospital. A Quality Improvement Programme will focus on implementing actions towards improvement.

The main subjects of enquiries through the Patient Advice and Liaison Service (PALS) concerned appointment cancellations and delays, communication and clinical treatment (General Medicine). Neonatal performance remains good and no care/service delivery issues have been identified in unplanned admissions. The number of midwifery led deliveries increased from 32% in May to 34% in June.

Professor Denton reported that we are awaiting publication of national mortality data. The Trusts HSMR mortality rate is lower than expected at 85 and the SHMI rate is within the expected range at 112 (February 2020). We are continuing to work with community colleagues to look at actions that can be taken to reduce the SHMI rate.

(d) Finance, Investments and Performance Committee (29.07.20)

The Board was updated by Mr Spink as Chair of the FI&P Committee with regard to its meetings on 22 and 29 July 2020.

Mr Spink informed the Board that the Committee had discussed the Outline Business Case for the Electronic Patient Record and assessed the strategic/clinical rationale for the project. The EPR Outline Business Case and associated approaches to business planning/procurement were recommended to the Board for approval.

The Committee also reviewed the draft Operational Plan and agreed to recommend this to the Board for approval.

A number of risks associated with fire safety measures, were highlighted to the Committee in the report from the Health and Safety Committee. The FI&P Committee received assurance that the level of risk was now lower than reported and the position will be monitored going forward.

Performance against activity and contractual standards continues to be adversely impacted by the pandemic and there is growing concern that the elective waiting list continues to increase.

(e) IPR – Finance, Performance and Productivity

Mr Cobb reported that two week wait cancer performance was achieved in June at 90%. The increase in performance is thought to be due, at least in part, to the reduction in two-week wait referrals during the pandemic.

Referral to Treatment (RTT) performance has continued to decline. Focus during Phase 2 has been toward delivery of urgent and two-week wait activity and routine activity was significantly impacted.

Following recommencement of data collection in the Sentinel Stroke National Audit Programme (SSNAP), the Trust's SSNAP score for stroke services in June was 80 (B).

Work on segregation of areas and implementation of PPE guidance has been challenging but we anticipate that performance will start to show improvement. Confirmation is awaited of modifications to national performance standards which are expected to move away from percentage metrics towards metrics weighted in favour of reducing harm and waiting times.

Professor Denton highlighted that we continue to review waiting lists in order to ensure that action is taken to prevent harm to those patients who are waiting. Each patient will be contacted by the hospital to discuss their condition and to determine if their

symptoms indicate that they should be seen sooner. Our waiting list review process is to be used as a template for use in other hospitals in this region.

Non-Executives praised the work underway to restore services for patients and asked if additional support was available and whether clinical staff/volunteers could be utilised, to provide additional support for people coming into the hospital. Professor Denton confirmed that our teams are providing support to patients and issues are also being highlighted to the public through the media. The national requirement for patients and their households to isolate for 14 days prior to admission for treatment proves too challenging for some patients to achieve. The isolation period has now been shortened to 3 days in line with revised national guidance and it is anticipated that this will be easier for patients.

Mr Clarke reported a breakeven position at the end of month 3. This was generated through a £1.1m surplus in operating income/expenditure, £3.6m Covid costs offset by £2.5m top up income.

Activity is 28% lower than the Plan (ED attendances 21% lower, outpatients 35% lower and day case activity 44% lower) but activity is showing a 34% increase compared with Month 2.

The cash flow forecast shows an improvement due to timing of working capital movements and assumption of block funding one month in advance for July and August. Mr Clarke highlighted that the level of productivity that we can deliver during the pandemic is the key risk to achieving our financial plan.

(f) <u>People and Culture Committee (24.07.20)</u>

In the absence of Professor Richardson, the Board was updated by Ms Dinneen regarding the People and Culture Committee meeting on 24 July 2020.

The Committee discussed the ongoing work to enable staff to return to the site in order to move services forward.

The review of the appraisal process continues. The work aims to simplify and transform the process into a more positive experience for both appraisee and appraiser. To avoid delay, the renamed process will be launched in advance of implementation of the electronic appraisal system which will be replacing the existing paper-based process.

Progress is continuing in order to address issues in equality, diversity and inclusion and our strategy is targeting improvement work in key areas of recruitment, employment and health.

Freedom to Speak Up Champions are being appointed to improve accessibility for staff but there is more work in order to ensure that the burden is eased on the Lead Freedom to Speak Up Guardian.

Non-Executives reported that the Committee had been updated on the work to expand the Trust's Leadership Development programme. The online availability of leadership development and focus on positive behaviours is being increased.

The Committee also discussed the staff network groups for BAME staff and additional resourcing for equality and diversity was welcomed.

Mr Higginson referred to the National People Plan which had recently been published. The Plan is due to be reviewed at the next meeting of the People and Culture

Committee, after which the Board will have an opportunity to consider the Trust's response.

Mr Jones indicated there are good indications that our work to shape and develop culture across the organisation, is having a positive impact. The NGO Freedom to Speak Up Index Report indicates that the Trust's freedom to speak up score has improved by 2.5% and now matches the national average rate. There has been a reduction in the number of vacancies since November/December 2019. There will be a significant number of people who have lost their jobs as a consequence of the Covid pandemic and there is an opportunity to actively promote job employment with the Trust.

Mr Jones reported that the NHS Reservist Scheme has been developed in order to retain high numbers of staff who were recruited to help the Trust during the pandemic emergency. Recruitment to the scheme will be commencing in September. Discussions have commenced with the UEA regarding development of an internship programme for undergraduate/graduate students which would provide students with experience in healthcare to help with their careers.

(g) IPR - Workforce

A collaborative staff bank is being established to combine staff banks in a number of healthcare organisations to form one temporary staffing solution. The bank will allow cross cover and level rates of pay across organisations.

The revised appraisal process is aimed at introducing a more discussion-based review with increased emphasis on career development and support for staff.

The Board was informed that mandatory training compliance is just below 90%.

20/038 **INFECTION PREVENTION AND CONTROL ANNUAL REPORT 2019/20**

The Board received a report from Professor Fontaine concerning the Infection Prevention and Control Annual Report for 2019/20. Ms Sarah Morter (Deputy Director of Infection Prevention and Control for NNUH and QEHKL) and Dr Catherine Tremlett (Infection Control Doctor) were also in attendance to present the report.

Ms Morter informed the Board that the Report has been prepared in line with the requirements outlined in the Health and Social Care Act 2008 Code of Practice on prevention and control of infection. The format of the report is designed so that its information is educational for members of the public and can be accessed via the Trust's website.

66 cases of Clostridioides Difficile (formerly Clostridium Difficile) Infection were reported in 2019/20. The increase in the number of cases reported compared to the previous year, is due to introduction of new categories which reassigned cases from the community to the hospital.

There were no 'hospital origin' cases of MRSA in 2019/20.

Infection Prevention and Control Link Practitioners continue to work with the wards and undertake audits in a wide range of areas including equipment, environmental cleanliness, hand hygiene and commode/bed pans.

The IP&C Team received an award for 'outstanding contribution to the Trust' at the annual Staff Awards in 2019, in recognition of their enthusiasm, motivation and constant scrutiny to reduce infection and assistance to wards/departments in managing and improving standards.

The Board was informed that a risk has arisen in relation to the ICNet software system which is used to manage alert organism results and suspected infections. The software will no longer be supported from April 2021. Options to replacing the system are being explored to mitigate this risk.

Non-Executives complimented the format of the report which had been designed to raise awareness and to be educational to help people learn about infection prevention and control issues across the community. Suggestions were made to enhance the executive summary in next year's report. The OWLS method of communication was also praised. Ms Morter explained that the monthly OWLS circular serves to raise staff awareness of key issues across the organisation and this month had focused on the rise in the number of C Difficile cases.

The Covid pandemic emergency will obviously require comprehensive review in the Annual Report for 2020/21. Professor Fontaine indicated that a number of C Difficile cases have arisen as people have delayed coming into hospital and/or been treated in the community with multiple courses of antibiotics. The consequence of this delay or treatment with antibiotics in the community, has meant that patients are more ill when they come into hospital. Our awareness campaign is therefore being targeted across organisations in the community so that these issues are highlighted.

The Board **approved** the Infection Prevention and Control 2019/20 Annual Report.

20/039 **REPORT FROM STRATEGY WORKING GROUP (04.08.20)**

The Board received a report from Mr Hackwell concerning the work of the Board Strategy Working Group.

Mr Higginson reminded the Board that the Group will be driving refresh of the Trust's Strategy. The first stage of development is internal stakeholder engagement and data is being reviewed to gain an understanding of historical trends in order to build an evidence based strategic case.

The Medicine and Surgery Divisions have provided their views on plans for services and the options for how delivery of services might be reshaped in the future. The Surgery Division have also considered how more complex surgery can be delivered on-site and how this might be delivered differently. Further evaluation is to be undertaken to consider feedback from patient journeys (inpatients, outpatients and day-case). There will be liaison with external stakeholders to gain feedback which will be used to inform further development of the strategy.

Mr White referred to the proposed 18 month Priorities covering the period up to March 2022. It is recognised that prolonged operational challenges arising from the Covid Pandemic will impact on our ability to achieve the objectives.

The Board **agreed** the 18-month Priorities and noted that uncertainties around operational, contractual and regulatory circumstances, may require the Priorities to be reviewed.

20/040 **QUALITY REPORT 2019/20**

The Board received a report from Professor Fontaine and Professor Denton concerning the draft Quality Report for 2019/20. The Report has been reviewed through the Quality & Safety Committee and Management Board.

The Board was informed that the Quality Report incorporates achievements against Quality Priorities in 2019/20 and sets out the Quality Priorities for 2020/21.

Performance and monitoring arrangements have been revised to improve the process for overseeing the Priorities for 2020/21 in combination with existing improvement work (Use of Resources review and CQUIN indicators).

Mr Foster was concerned to note the lapse in organisation oversight of 2019/20 Quality Priorities. It was explained that focus over the last year has been towards addressing concerns raised by the CQC and quality improvements that would take us out of Special Measures. The Quality Programme Board will ensure there is a robust governance and oversight process in place for monitoring progress.

Professor Denton, Professor Fontaine and their teams were thanked for their work over the last couple of years, to improve quality and learning across our organisation.

The Board **approved** the 2019/20 Quality Report and Quality Priorities for 2020/21.

20/041 **QUESTIONS FROM MEMBERS OF THE PUBLIC**
There were no questions from members of the public.

20/042 **ANY OTHER BUSINESS**
Mr White indicated that it had been good to welcome a number of governors to the public meeting of the Board and that other governors would similarly be encouraged to attend.

20/043 **DATE AND TIME OF NEXT MEETING**
The next meeting of the Trust Board in public will be at 9.30am on 4 November 2020 in the Boardroom of the Norfolk and Norwich University Hospital.

Signed by the Chairman: …… Date: ……

Decisions Taken:

20/038 – 18-month priorities	The Board **agreed** the 18-month Priorities and noted that uncertainties around operational, contractual and regulatory circumstances, may require the Priorities to be reviewed.
20/040 – Quality Report 2019/20	The Board **approved** the 2019/20 Quality Report and Quality Priorities for 2020/21.

Action Points Arising:

There were no formal actions arising.

REPORT TO THE TRUST BOARD

Date	**4 November 2020**
Title	**Chair's key Issues from Quality and Safety Committee Meeting on 27.10.20**
Lead	**Dr Geraldine O'Sullivan – Non-Executive Director (Committee Chair)**
Purpose	**For Information and assurance**

1 Background/Context

The Quality and Safety Committee met on 27 October 2020. Papers for the meeting were made available to all Board members for information in the usual way. The meeting was quorate and was held by MS Teams. Erica Betts (Public Governor) attended as observer. Due to the Covid 19 pandemic, the meeting was not preceded by clinical/departmental visits.

2 Key Issues/Risks/Actions

Three key issues to highlight to the Board were identified as follows:

Key issues to highlight and escalate:		
1	Internal professional standards for medical review of patients.	The Committee reviewed the Internal Professional Standards for medical staff that have been issued Trust-wide, to ensure safe management of patients attending the Emergency Department. The document sets out 13 principles to standardise practice within the ED for assessment, treatment and referral of patients to specialties across the hospital in a timely fashion. They are relevant to addressing issues identified through a number of SI Root Cause Analysis investigations. This is an updated set of principles and work will be undertaken to monitor and measure compliance and impact through a quality improvement project.
2	Quality and Safety – Current Performance – Extract from IPR	It is obvious that the hospital and ED are under significant operational pressure. The Committee was assured with regard to the measures in place relating to patient safety in the Emergency Department. The impact of delays in the ED on patient experience is however apparent from a number of data sources.

3	Infection Control	The Committee discussed recent correspondence from the Regional Director about measures to prevent and monitor nosocomial Covid infection in hospitals. The Committee agreed to review the arrangements in place in the Trust as an item on each meeting agenda to obtain assurance on behalf of the Board with regard to promoting the safety of patients and staff.
4	CQIA Update	The Committee reviewed the regular update from the PMO on Clinical Quality Impact Assessment (CQIA) of cost improvement schemes. The Committee suggested that it would be helpful to integrate this element of CIP reporting, so that FIP and Q&S Committees see the CIP programme 'in the round'.
5	Care of patients with eating disorders	The Committee received an update on arrangements in the Trust for the care of seriously ill patients with eating disorders, as highlighted by an inquest into the very sad death of a patient in 2012. The Committee was assured with regard to the steps that have been taken to introduce new improved processes, training for staff and documentation to improve our services for this patient group, whilst recognising that there are systemic issues relating to the provision of specialist mental health (including Child and Adolescent) services across the NHS. This is a subject to which we will return as the Committee and Board review our draft Mental Health Strategy in coming months.

3 Conclusions/Outcome/Next steps

The next Committee meeting is scheduled for 24 November 2020 at which it will consider the draft Mental Health Strategy and review quality and safety in the Medical Division.

Recommendation:

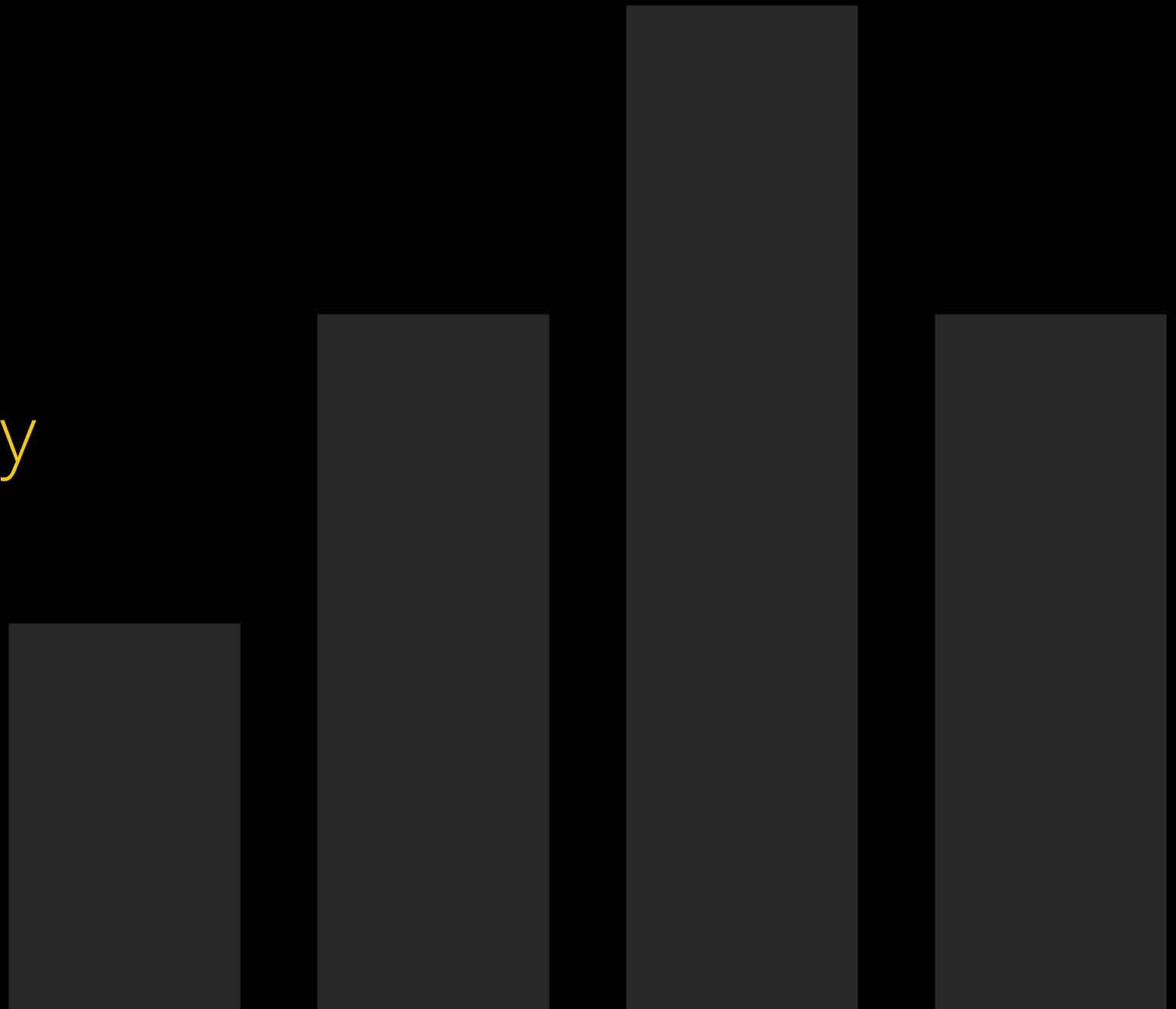
The Board is recommended to **note** the work of its Quality & Safety Committee.

Microsoft | Power BI

Quality & Safety

View in Power BI

Last data refresh:
21/10/2020 08:31:21 GMT Standard Time
Downloaded at:
21/10/2020 12:18:38 GMT Standard Time



Quality Summary

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

NNUH Digital Health
business intelligence

Topic	Metric Name	Date	Result	Variation	Assurance
Complaints	Complaints - Trust	Sep 2020	83	Improvement (Low)	No Target
Patient Concerns	PALS Enquiries	Sep 2020	429	Improvement (High)	No Target
Safer Staffing	Safe Staffing CHPPD	Sep 2020	8.4	Improvement (High)	No Target
Patient Experience	Compliments	Sep 2020	165	Concern (Low)	No Target
Safer Staffing	Safe Staffing Fill Rates	Sep 2020	85.40%	Concern (Low)	Unreliable
Patient Safety	Incidents	Sep 2020	2,645	Concern (High)	No Target

SPC Variation Icons

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

SPC Assurance Icons

Capable | Not capable | Unreliable

Patient Safety

NNUH Digital Health
business intelligence

Serious Incidents

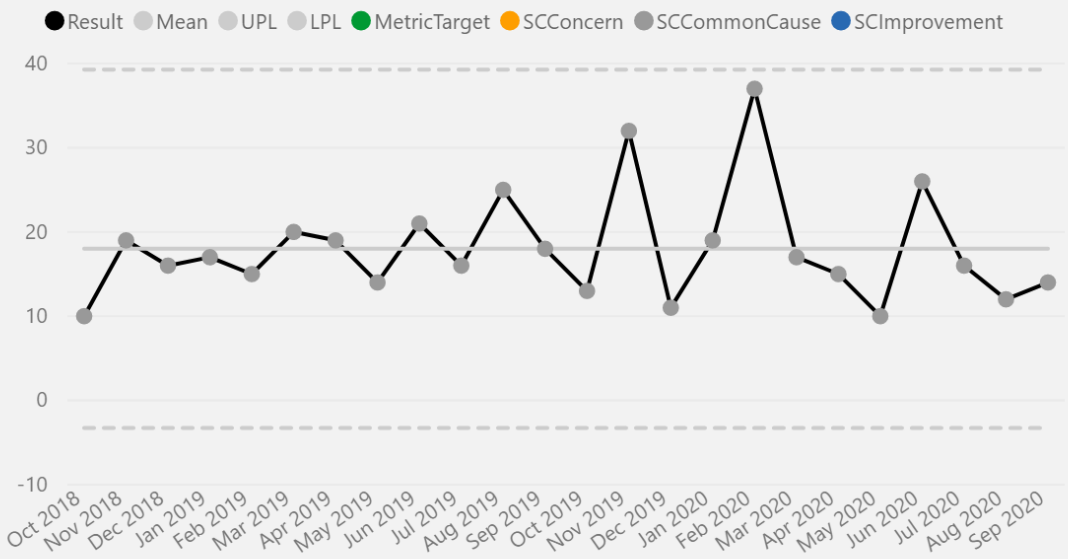
Sep 2020

Variation	Assurance
14 Result	39 UPL
N/A Target	18 Mean
	-3 LPL

Analytical Commentary

Variation is Common Cause

Serious Incidents



Assurance Commentary

There were 13 SI's reported during September: 2 commissioning incidents, 2 injurous falls, 4 HAPU (2 device related (trachyostomy) being reviewed thematically), 1 suicide post discharge, 1 maternity incident referred to HSIB, 2 sub optimal care (delay in review and a missed stroke diagnosis), 1 delay in treatment. Duty of candour compliance has reduced to 62% at time of reporting. 3 CEO assurance panels were held in September. A misconnection of air instead of oxygen Never Event, life changing injuries following a surgical procedure and a follow up panel to review progress of actions following a death from DKA.

Business Process Changes

A review of the recording of duty of candour reporting is currently underway to explore the reduction in compliance and to identify improvements.

Supplementary Metrics

Metric Name	Date	Result		Variation		Assurance
Duty of Candour Compliance	Sep 2020	61.5%		Common Cause		Unreliable
Incidents	Sep 2020	2,645		Concern (High)		No Target

Pressure Ulcers

NNUH Digital Health
business intelligence

Hospital Acquired Pressure Ulcers per 1,000 bed days

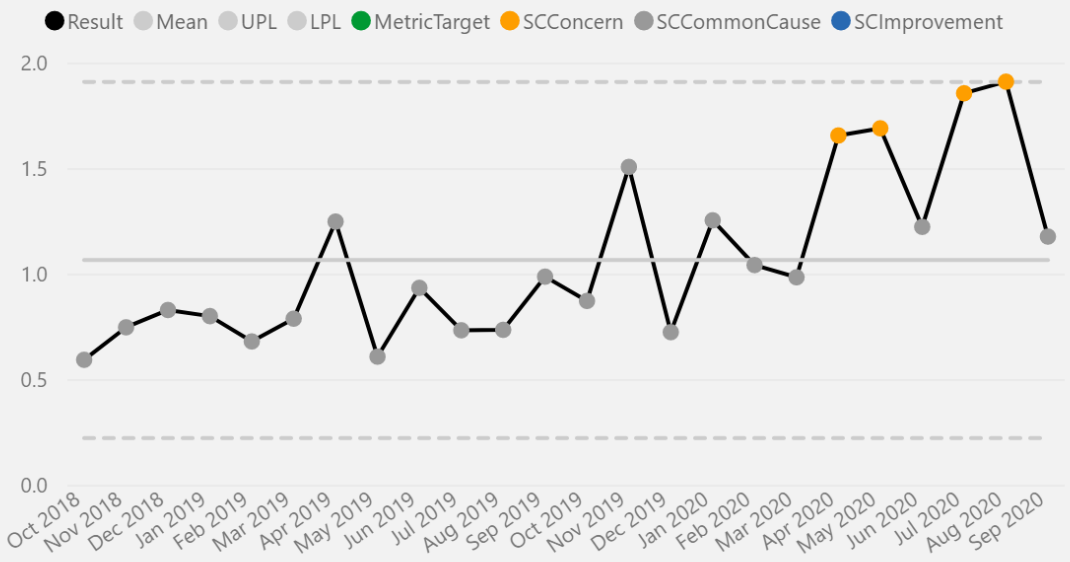
Sep 2020

Variation	Assurance		
		1.2 Result	1.9 UPL
		N/A Target	1.1 Mean
			0.2 LPL

Analytical Commentary

Variation is Common Cause

Hospital Acquired Pressure Ulcers per 1,000 bed days



Assurance Commentary

There is a Trust-wide QI programme To achieve a 20% reduction in hospital acquired pressure ulcers (Cat 2-4) with identified lapses of care by April 2021.
The Essential Care Scrutiny Panel is being re focussed to draw out themes that will be used to share learning and identify improvement actions.
There are 4 registered QI projects in progress
Maternity
Theatres and DPU
Denton Ward
Orthopaedics (plaster room)
We are linking these into the trust wide improvement programme to share learning between the different projects.
New TVN appointments due to start end of October and November

Business Process Changes

Patient Falls

NNUH Digital Health
business intelligence

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

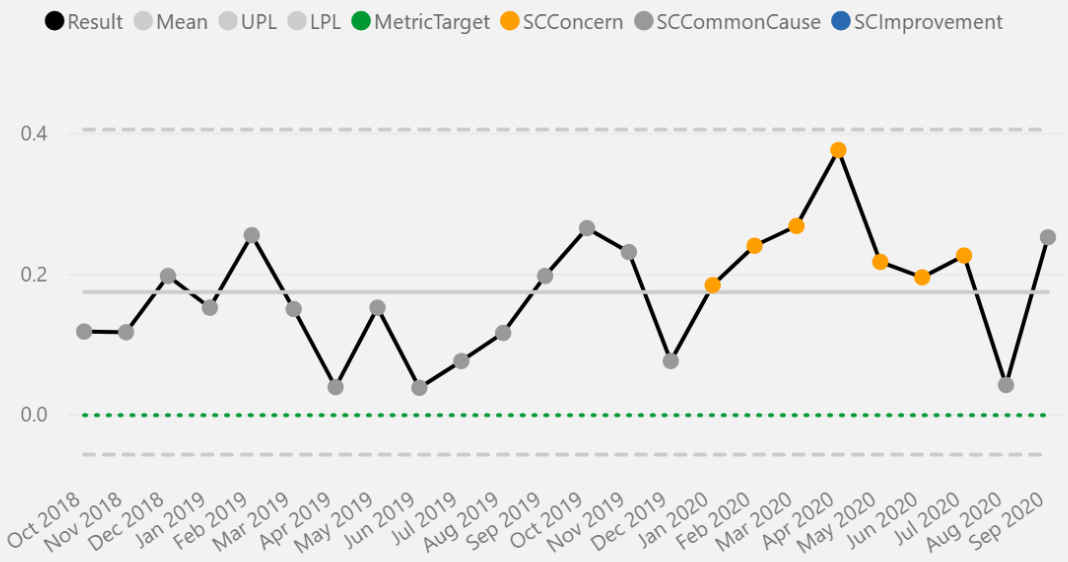
Sep 2020

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

Analytical Commentary

Variation is Common Cause

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



Assurance Commentary

The Trust-wide Falls QI project aims to :
Reduce the number of Trust wide falls by 25% by July 2021.
Reduce the rate of harms from falls (moderate, severe and catastrophic) by 20% by July 2021
We will achieve this by developing and implementing :
Person centred falls risk assessment and care planning that is based on the patients clinical conditions, health needs and care setting (Phase 1)
Promoting mobilisation and meaningful activity to enhance physical and cognitive functioning (Phase 2).

Business Process Changes

Patient Experience

NNUH Digital Health
business intelligence

Friends & Family Score

Sep 2020

Variation	Assurance
	

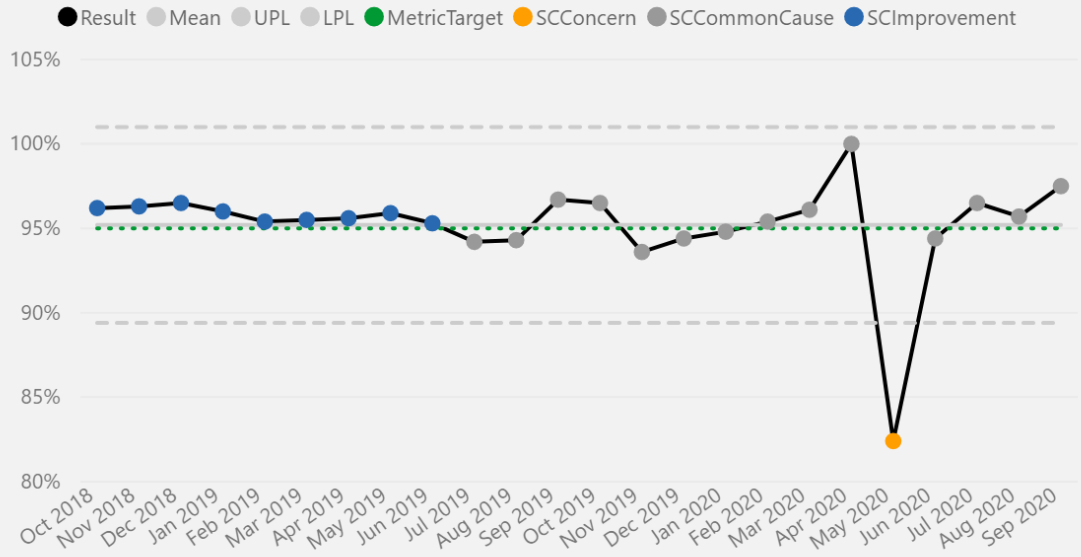
97.50% Result
95.00% Target

101.00% UPL
95.20% Mean
89.40% LPL

Analytical Commentary

Variation is Common Cause

Friends & Family Score



Assurance Commentary

Reinstating cards for FFT completion in clinics. Promotion of surveys via website, social media, QR codes and posters continues.

Business Process Changes

Low numbers of surveys completed will mean that variance is much starker shown in May data. Covid restrictions due to IPC and volunteer suspension mean very limited numbers of surveys completed.

Supplementary Metrics

Metric Name	Date	Result		Variation		Assurance
Compliments	Sep 2020	165		Concern (Low)		No Target

Patient Concerns

NNUH Digital Health
business intelligence

PALS % Closed within 48hours

Sep 2020

Variation	Assurance

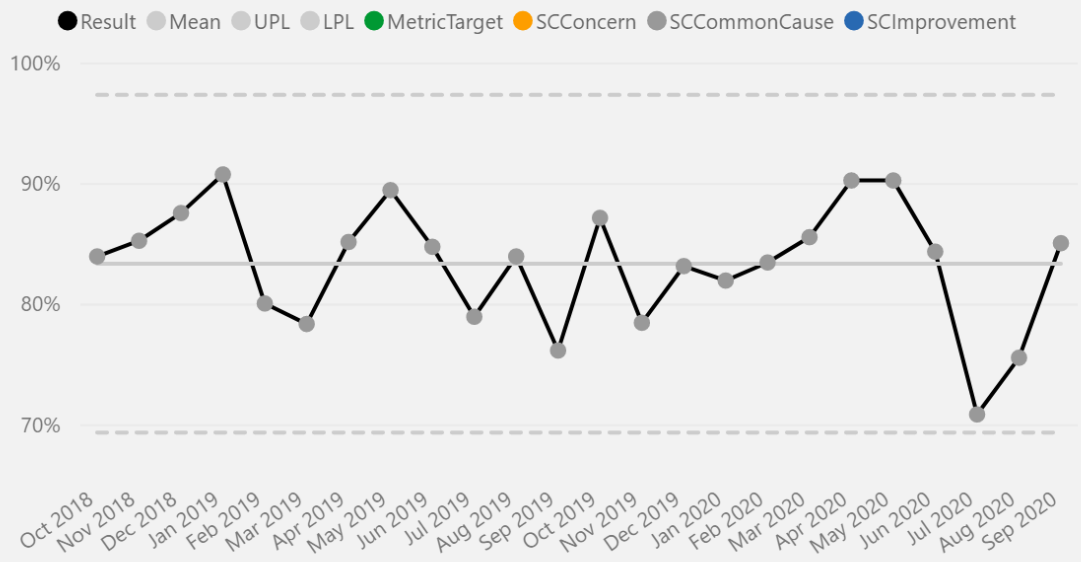
85.1% Result
N/A Target

97.4% UPL
83.4% Mean
69.4% LPL

Analytical Commentary

Variation is Common Cause

PALS % Closed within 48hours



Assurance Commentary

Complexity of cases being dealt with through PALS reflected in fluctuation in 48 hour resolution %. During Covid there have been delays in responsiveness from colleagues back to PALS.

Business Process Changes

Complexity of cases being dealt with through PALS reflected in fluctuation in 48 hour resolution %. During Covid there have been delays in responsiveness from colleagues back to PALS.

Supplementary Metrics

Metric Name	Date	Result		Variation		Assurance
PALS Enquiries	Sep 2020	429		Improvement (High)		No Target

Complaints

NNUH Digital Health
business intelligence

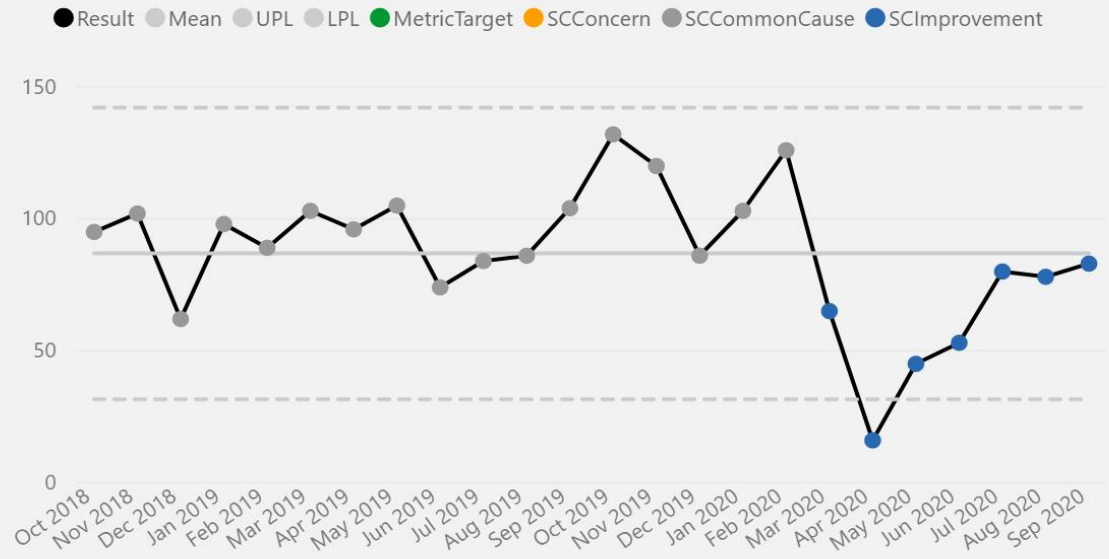
Complaints - Trust

Sep 2020

Variation | Assurance

83 Result
N/A Target
142 UPL
87 Mean
32 LPL

Complaints - Trust



Business Process Changes

(Blank)

Analytical Commentary

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

Assurance Commentary

Metric	Performance	Status
We aim to acknowledge >95% of complaints within 3 days	98%	Achieved
We aim to investigate >90% complaints within 25 days or other agreed timescale	96%	Achieved
We aim for number of post-investigation enquiries to be <20	2	Achieved

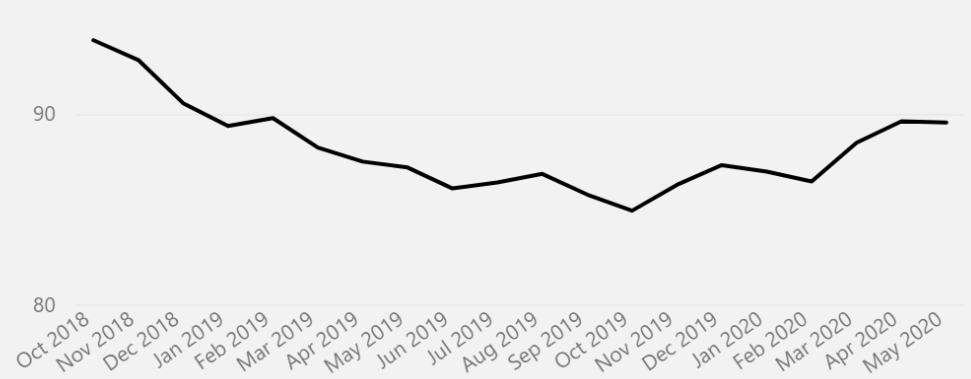
(Blank)

Mortality Rate

NNUH Digital Health
business intelligence

MetricName	Date	Result
HSMR	May 2020	89.58
SHMI	May 2020	113

HSMR



SHMI

Supplementary Metrics

Metric Name	Date	Result		Variation		Assurance
Crude Mortality Rate	Aug 2020	4.30%		Common Cause		No Target

Assurance Commentary

An action plan has been drawn up to address the higher than expected SHMI. The Sickle Cell Anaemia CUSUM was triggered by 1 death. This is undergoing SJR. A review of all deaths triggering the Heart Valve disorders mortality outlier alert has been arranged. It is worth noting that all adjusted mortality models such as HSMR and SHMI assume stabiliy and are not set up to cope with a pandemic. During the pandemic, there have been extensive changes to the way hospitals operate resulting in substantial changes in activity and we are now seeing the impact of this on adjusted mortality indicators. Spells in April and May dropped substantially whereas observed number of deaths did not reduce as notably. The drop in denominator spells may explain the rise in HSMR value and further increase in SHMI over this period.

Safer Staffing

NNUH Digital Health
business intelligence

Safe Staffing Fill Rates

Sep 2020

Variation	Assurance
L	?

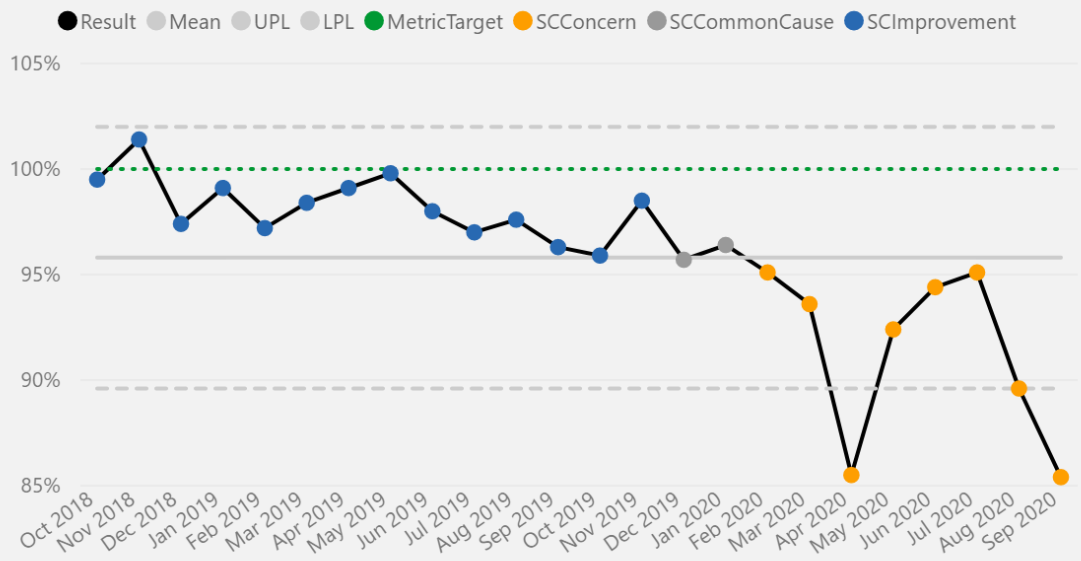
85.40% Result
100.00% Target

102.00% UPL
95.80% Mean
89.60% LPL

Analytical Commentary

Data point fell outside of process limits, Data is consistently below mean, and therefore the variation is Special Cause Variation - Concern (Low)

Safe Staffing Fill Rates



Assurance Commentary

The overall recorded RN/ RM fill rates in September 2020 remained under 90% and for the first time the HCA fill rates also dropped below this threshold. However, CHHPD in August and September was 8.4 with 4.4 - 4.5 hours delivered by RN's. This remains higher than the average of 7.8 from the pre Covid period.

Next steps include the continuation of workforce planning to support a potential future peak in Covid cases, progression of the recruitment to the "reservist programme" and further training sessions and consolidation of learning from the NHSI/E Safer Nursing Care Tool (SNCT) training.

Business Process Changes

Work streams continue in preparation for further Covid peaks. NHSi Safer Nursing Care team are presenting virtually to senior nursing teams at the end of September, which will allow cascade training and assurance of organisational foundation for patient dependencies. Progression continues for a Collaborative Bank with the STP steering group. A Mental Health Care Assistant job advert is now now live for the bank.

Supplementary Metrics

Metric Name	Date	Result		Variation		Assurance
Safe Staffing CHPPD	Sep 2020	8.4		Improvement (High)		No Target

Infection Prevention & Control

NNUH Digital Health
business intelligence

MetricName	Date	Result	Target	Mean
C. difficile Cases Total	Sep 2020	7	35	6
CPE positive screens	Sep 2020	2	N/A	1
E. Coli trust apportioned	Sep 2020	2	N/A	4
HOHA C. difficile Cases	Sep 2020	3	0	1
Hospital Acquired MRSA bacteraemia	Sep 2020	0	0	0
Klebsiella trust apportioned	Sep 2020	1	N/A	1
MSSA HAI	Sep 2020	6	N/A	2
Pseudomonas trust apportioned	Sep 2020	2	N/A	1

Hospital Acquired MRSA bacteraemia

E. Coli trust apportioned

C. difficile Cases Total

HOHA C. difficile Cases

MSSA HAI

Klebsiella trust apportioned

CPE positive screens

Pseudomonas trust apportioned

Assurance Commentary

September: 3 cases of trajectory C.difficile (5 HOHA & 2 COHA). PIR completed for every case learning has been discussed with the teams and will be shared via an Organisation Wide Learning communication. 0 cases of MRSA bacteraemia. Surveillance completed to establish sources for MSSA and gram negative bacteraemia and any learning points fed back to teams.

Maternity: Mothers

NNUH Digital Health
business intelligence

Caesarean Deliveries

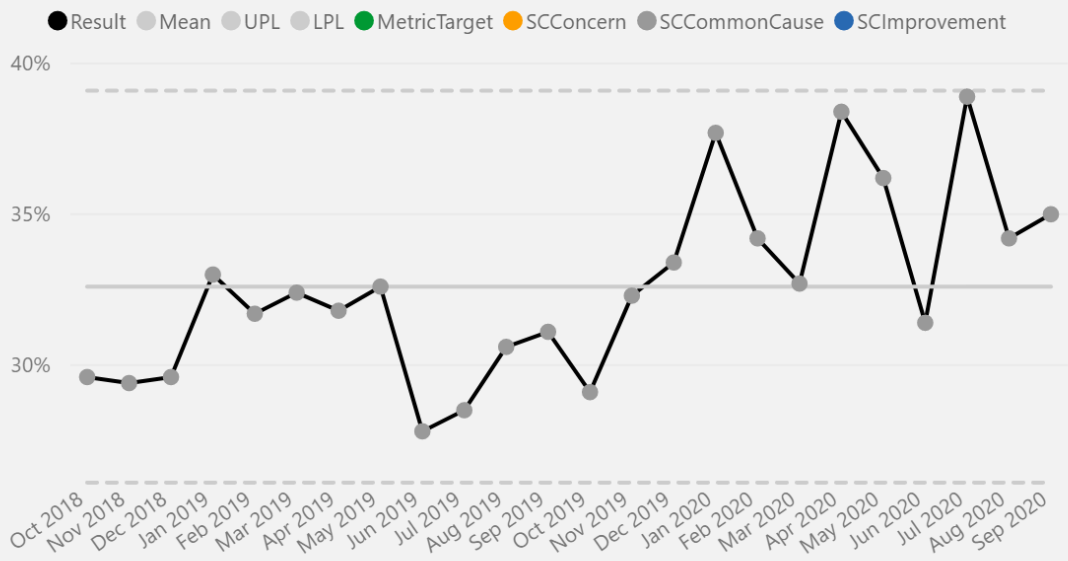
Sep 2020

Variation	Assurance
35.0% Result	39.1% UPL
N/A Target	32.6% Mean
	26.1% LPL

Analytical Commentary

Variation is Common Cause

Caesarean Deliveries



Assurance Commentary

There were 5 babies born before arrival of health professional/ place of birth this month. On review 3 were seen to be unavoidable, for 2 cases the review indicates that the activity in the dleivery suite/ MLBU potentially had an impact and so these may have been avoidable. In 1 case the community midwife was delayed in being able to attend promtly due to activity levels in the unit and arrived after the birth of the baby. In the second case the woman was asked to attend the maternity unit as due to high activity levels it was not possible for a midwife to be released to support the home birth. The implementation of continuity of care and revised ways of working for community midwifery services in coming months will assist in preventing such delays in the future.

Business Process Changes

Supplementary Metrics

Metric Name	Date	Result	Variation	Assurance
1:1 Care in Labour	Sep 2020	99.1%	Improvement (High)	No Target
3rd & 4th Degree Tears	Sep 2020	3.1%	Common Cause	Unreliable
Births Before Arrival	Sep 2020	5	Common Cause	No Target
Post Partum Haemorrhage ≥1500mls	Sep 2020	3.3%	Common Cause	No Target

Mothers Delivered

452

Babies Delivered

463

Maternity: Babies

NNUH Digital Health
business intelligence

Unplanned NICU ≥37 week Admissions (E3)

Sep 2020

Variation

Assurance

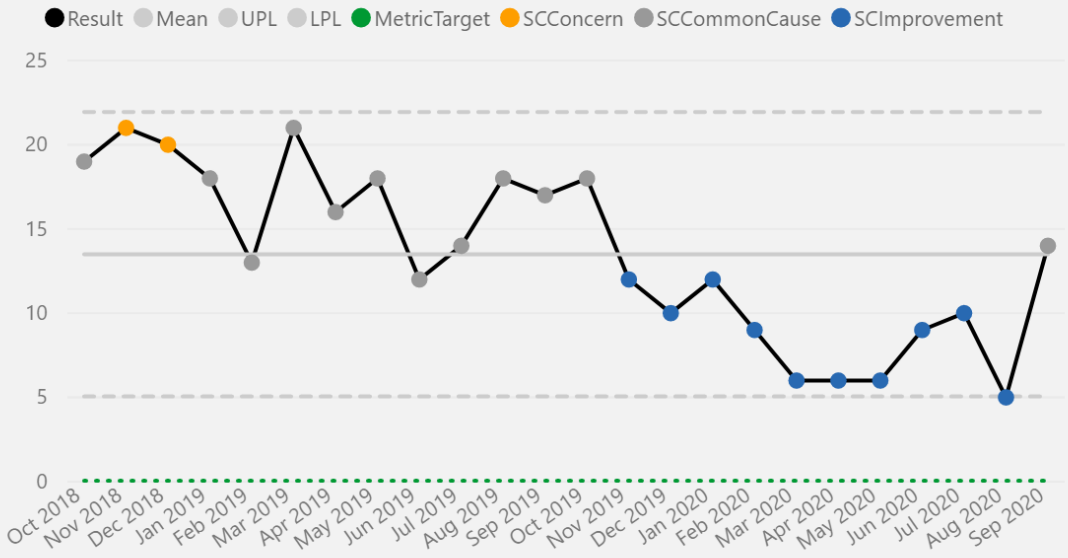
14 Result
0 Target

22 UPL
14 Mean
5 LPL

Analytical Commentary

Variation is Common Cause

Unplanned NICU ≥37 week Admissions (E3)



Assurance Commentary

There were 14 unanticipated term admissions to NICU out of 463 deliveries (3%) .

2 Category 1 Caesareans
3 Category 2 Caesareans
4 Elective Caesareans
2 Normal deliveries
2 Instrumental deliveries.

9 were respiratory distress
1 was an unrecordable blood sugar with seizures – this has been referred to HSIB
1 Absent respiratory effort and poor tone – suspected HIE
1 low cord gases
1 Severe jaundice in the first 24 hours
1 <2.2kg at birth Theme emerging was a lack of situa...

Business Process Changes

Supplementary Metrics

Metric Name	Date	Result		Variation		Assurance
Adjusted Still Births	Sep 2020	1		Common Cause		No Target
Apgar score <7 @5, ≥37 weeks	Sep 2020	2		Common Cause		No Target
Early Neonatal Death	Sep 2020	0		Common Cause		No Target
Mothers Transferred Out of Unit	Sep 2020	3		Common Cause		No Target

Maternity incentive scheme- year three

CNST Update

- The new NHS LA year 3 standards were released at the beginning of October.
- Oversight of progress of these ten steps needs to be reported monthly to the Trust board.
- Compliance and evidence to support this will be monitored via the Trust wide evidence group.
- Initial meetings for this have been organised to occur in November 2020.
- Current assessment of compliance (prior to formal evidence group) is detailed to the right.
- Leads for every domain have been identified.

10 Steps-to-safety		
1	Perinatal review tool	
2	MSDS	
3	ATAIN	
4	Medical Workforce	
5	Midwifery Workforce	
6	SBLCB	
7	Patient Feedback	
8	Multi-professional training	
9	Safety Champions	
10	Early notification scheme	

REPORT TO THE TRUST BOARD	
Date	**4 November 2020**
Title	**Chair's Key Actions from Finance, Investments and Performance Committee meeting on 28 October 2020**
Lead	**Tom Spink – Non-Executive Director (Committee Chair)**
Purpose	**For Information and assurance**

1 Background/Context

The Finance, Investments and Performance Committee met on 28 October 2020. Papers for the meeting were circulated to Board members for information in the usual way. The meeting was quorate and was attended by Ines Grote (Public Governor) and Mark Hitchcock (Partner Governor) as observers.

2 Key Issues

The following issues were identified to highlight to the Board:		
1	Operational Position – increase in Covid cases	The Committee received a report on the current operational position and noted that the number of COVID-19 cases is increasing at a faster rate than previously anticipated
2	Winter plan	The Committee considered the Trust's Winter Plan and associated draft performance targets. The HMB would discuss further then bring back in November for agreement.
3	Update on Phase III Operational Plan (Aug '20 – March '21)	The Committee received an update on the Phase III Operational Plan. The Committee noted the action taken under delegated authority to move the Trust's Operating Plan to an improved £15.4 deficit. Should the Trust not receive identified Out-of-System funding the deficit will deteriorate to £29.9m.
4	Use of Resources	The Committee discussed progress in implementing actions relating to the Use of Resources. The Committee encouraged early action with regard to streamlining the structure and work of the two change teams.
5	HR capacity	The Committee asked that the Capacity of the HR team should be considered as part of the 2021/22 budget setting, as this is an important component of delivering our productivity challenge.
6	Process for Review of Benefits Realisation on Investments	The Committee reviewed the follow-up of benefits realisation in Business Cases. It was **agreed** that further consideration should be given to 'benefits realisation' of new Consultant positions, given that they represent a significant investment by the Trust. The Committee asked that all future benefit cases should have an increased focus on benefits identification as well as realisation.
7	Procurement Update	Following a recent audit, it has been flagged that two contracts were not submitted for Board approval. These are now recommended to the Board elsewhere in the meeting agenda.

8	Financial Governance Review	The Committee reviewed the final report from the independent Financial Governance Review which is or discussion by the Board elsewhere on the Agenda. The Committee will receive regular reports on progress in implementing relevant actions.
9	Sleep Service Business Case	The Committee reviewed a business case for a Sleep Service contract. The cost of this 5-year contract is £1.4M per annum, and will accommodate 2,700 patients per year. This business case was **agreed** for recommendation to the Board.
10	Corporate Risk Register – FI&P	The Committee reviewed the FI&P extract from the Corporate Risk Register. It was **agreed** that too many of these risks have 'TBC' timeframes and need to be reviewed with a time line to return to acceptable tolerance

3 Conclusions/Outcome/Next steps

The next Committee meeting is scheduled for 25 November 2020.

Recommendation: The Board is recommended to:

- **note** the work of its Finance, Investments and Performance Committee and receive its recommendations with regard to items on the Board Agenda as specified.

Norfolk and Norwich University Hospitals NHS Foundation Trust

Integrated Performance Report:
Performance Domain

September 2020

Performance Summary

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

NNUH Digital Health
business intelligence

Topic	Metric Name	Date	Result	Variation	Assurance
Cancer Waiting List: 2ww	2WW Waiting List Profile (Cancer)	Sep 2020	877	Improvement (Low)	No Target
Ambulance Handovers	Ambulance Handovers Over 60mins	Sep 2020	126	Improvement (Low)	Unreliable
DM01 Performance	Diagnostics DM01 - Performance	Sep 2020	53.00%	Concern (Low)	Not capable
RTT Performance	RTT Performance	Sep 2020	53.6%	Concern (Low)	Not capable
Theatre Utilisation	Theatre Utilisation (Main Theatres)	Sep 2020	78.2%	Concern (Low)	Unreliable
DM01 Waiting List	Diagnostics DM01 - Waiting list	Sep 2020	17,106	Concern (High)	No Target
RTT Long Waiters	RTT 40 Weeks Wait	Sep 2020	9,703	Concern (High)	No Target
RTT Waiting List	RTT Waiting List	Sep 2020	54,195	Concern (High)	No Target

SPC Variation Icons

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

SPC Assurance Icons

Capable | Not capable | Unreliable

ED Performance

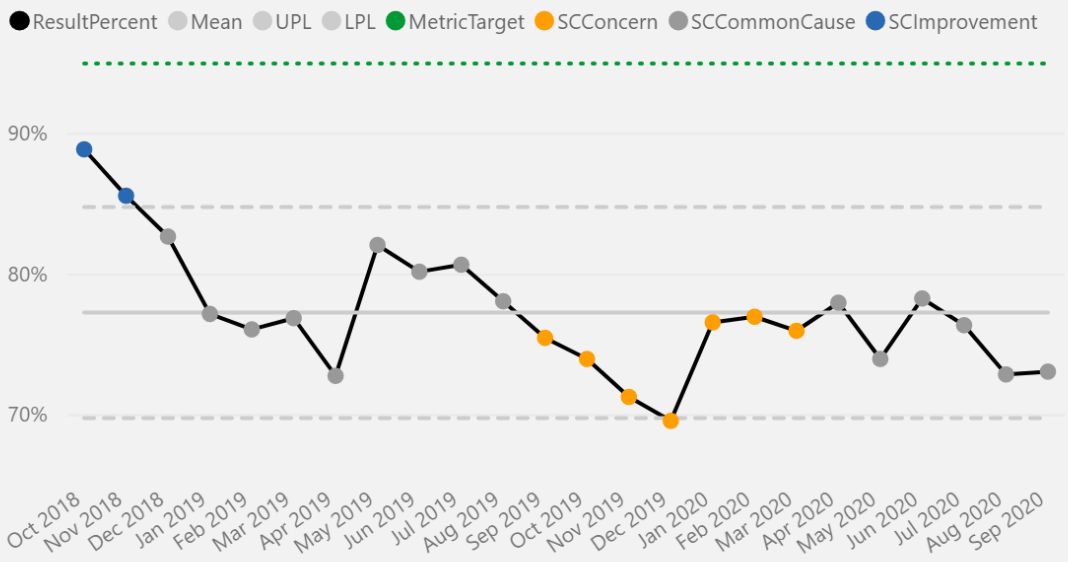
NNUH Digital Health
business intelligence

ED 4hr Target

Sep 2020

Variation	Assurance		
	F	73.1% Result	84.8% UPL
		95.0% Target	77.3% Mean
			69.8% LPL

ED 4hr Target



Business Process Changes

Reduction on clinical staff on rotas through changes to HEE Rotation.
Removal of 2nd Registrar overnight due to lack of fill from Deanery.
Enhanced GP streaming pilot commenced.

Analytical Commentary

Variation is Common Cause

Assurance Commentary

Performance in September remained in line with August, Medical staffing shortfalls are the primary driver behind the performance position. An increase in majors attendances and reduction in minors created bottlenecks in main ED trolley bay. The Prism improvement programme continued and will run a 2 week test and challenge review of the 4 workstreams in October.

Ambulance Handovers

NNUH Digital Health
business intelligence

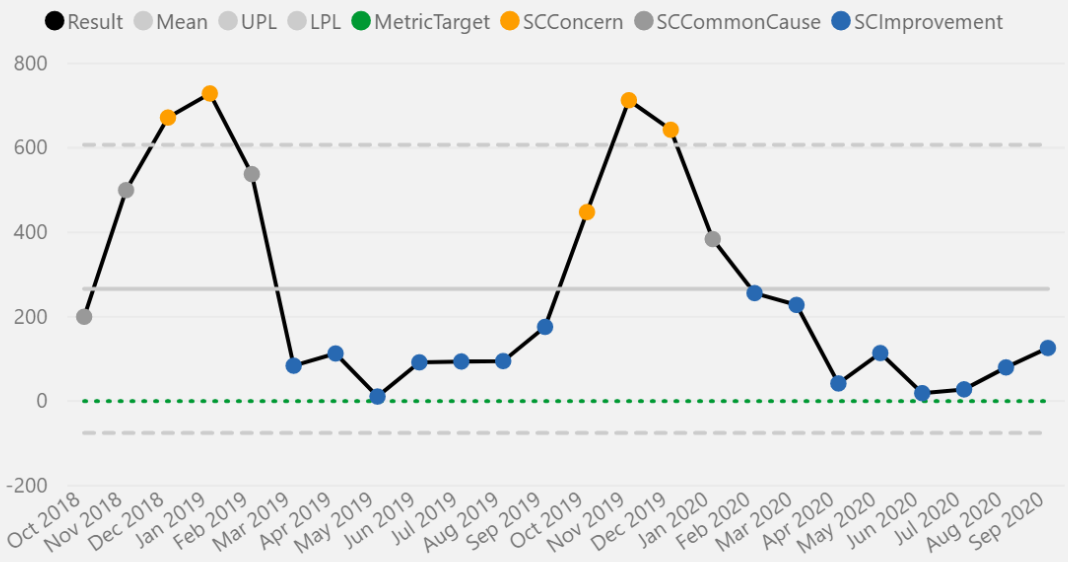
Ambulance Handovers Over 60mins

Sep 2020

Variation	Assurance
L	?

126 Result
0 Target
607 UPL
266 Mean
-75 LPL

Ambulance Handovers Over 60mins



Business Process Changes

The Prism workstream will run a 2 week test and challenge process to evaluate the improvement plan in October 20.

Analytical Commentary

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

Assurance Commentary

The year-on year Ambulance handovers > 1 Hour reduced from 176 in September 19 to 126 in September 20.
The number of ambulances that achieved the <15 minute standard also increased to 52.6% compared to 41.8% in September 2019.
The overall position continues to improve with delays restricted to days of extreme pressure and high volumes of attendance. Thr Prism workstream is aiming for further improvement to 60% in October.

Bed Occupancy

NNUH Digital Health
business intelligence

Bed Occupancy Rate (GAB & ESC)

Sep 2020

Variation

Assurance

89.10% Result

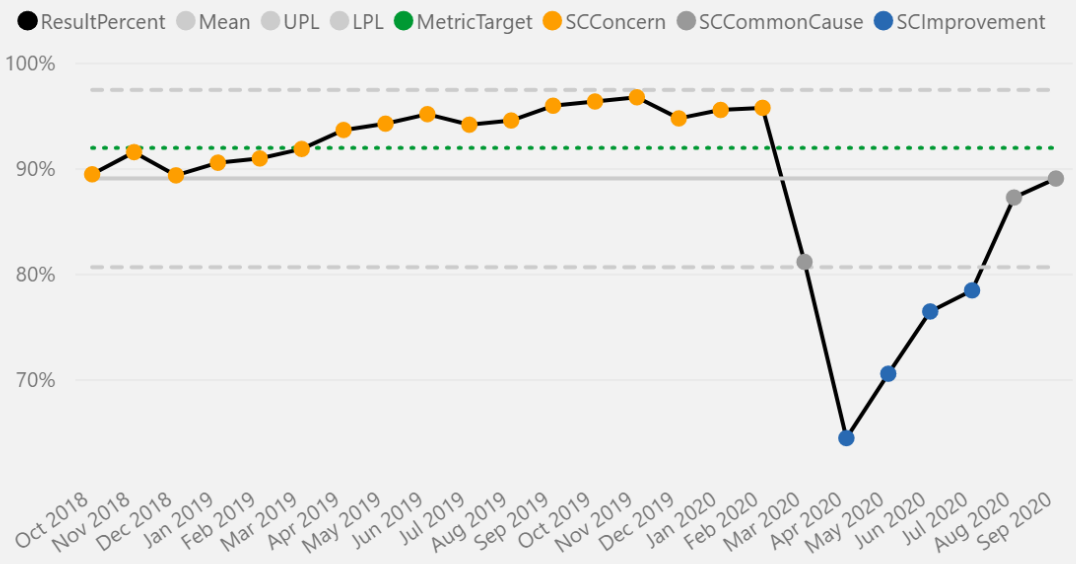
92.00% Target

97.50% UPL

89.10% Mean

80.70% LPL

Bed Occupancy Rate (GAB & ESC)



Analytical Commentary

Variation is Common Cause

Assurance Commentary

Adult bed occupancy increased to pre-covid levels and exceeded the 92% target at the end of September. The available capacity was on Childrens wards therefore the organisations was operating at a higher occupancy level for its adult non-elective workload. This resulted in congested hospital towards the end of the month.

Business Process Changes

The Ward Block levels 1 and 2 opened to provide 68 additional beds in September 2020 with a revised flow process from ED.

Length of Stay

NNUH Digital Health
business intelligence

Avg LoS (Including 0 LoS)

Sep 2020

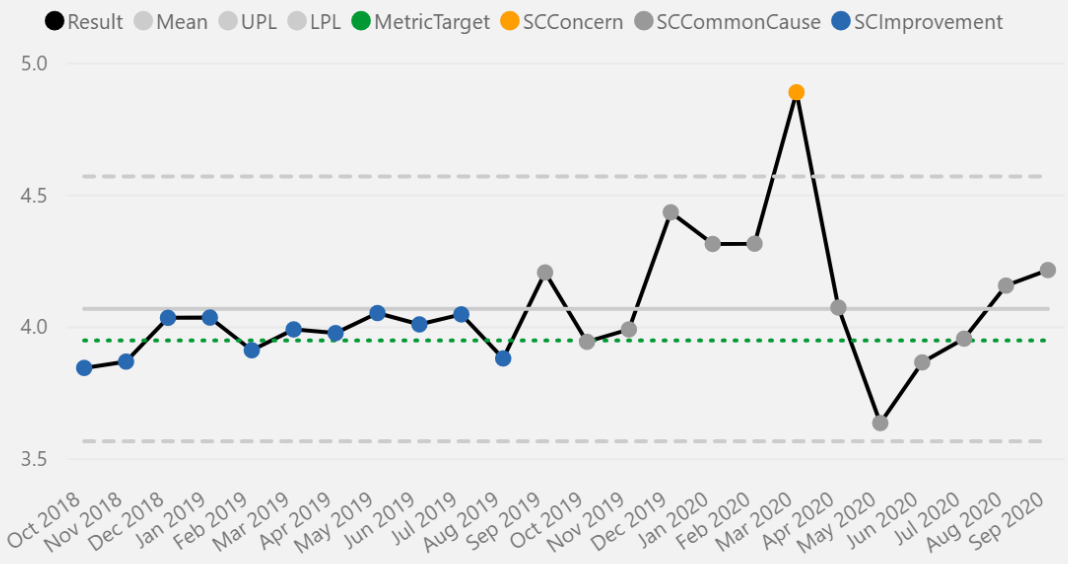
Variation | Assurance

4.2 Result
4.0 Target
4.6 UPL
4.1 Mean
3.6 LPL

Analytical Commentary

Variation is Common Cause

Avg LoS (Including 0 LoS)



Assurance Commentary

The average Length of Stay in September increased from the August position and finished the month at the highest level since April but broiadly in line with seasonal variation. There was noticeable increase in patient acuity towars the end of the month although the Super stranded >21 patient numbers remain below target.

Business Process Changes

Prism workstream review of LLOS processes

Boarders

NNUH Digital Health
business intelligence

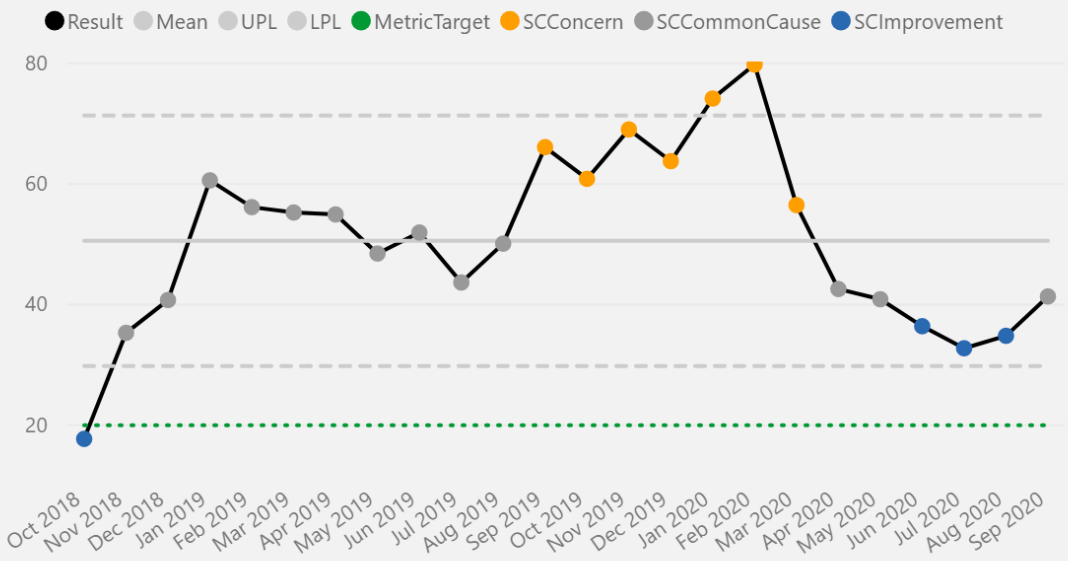
Avg. Patients Boarding

Sep 2020

Variation	Assurance
	

41.4 Result	71.4 UPL
20.0 Target	50.6 Mean
	29.8 LPL

Avg. Patients Boarding



Business Process Changes

Bed Base review ongoing due for completion October 2020

Analytical Commentary

Variation is Common Cause

Assurance Commentary

The number of medical patients occupying surgical beds increased in September as a result of adult non-elective capacity issues. The ringfenced surgical beds on level 4 were protected despite the emergency demand pressures.

Theatre Utilisation

NNUH Digital Health
business intelligence

Theatre Utilisation (Main Theatres)

Sep 2020

Variation	Assurance
L	?

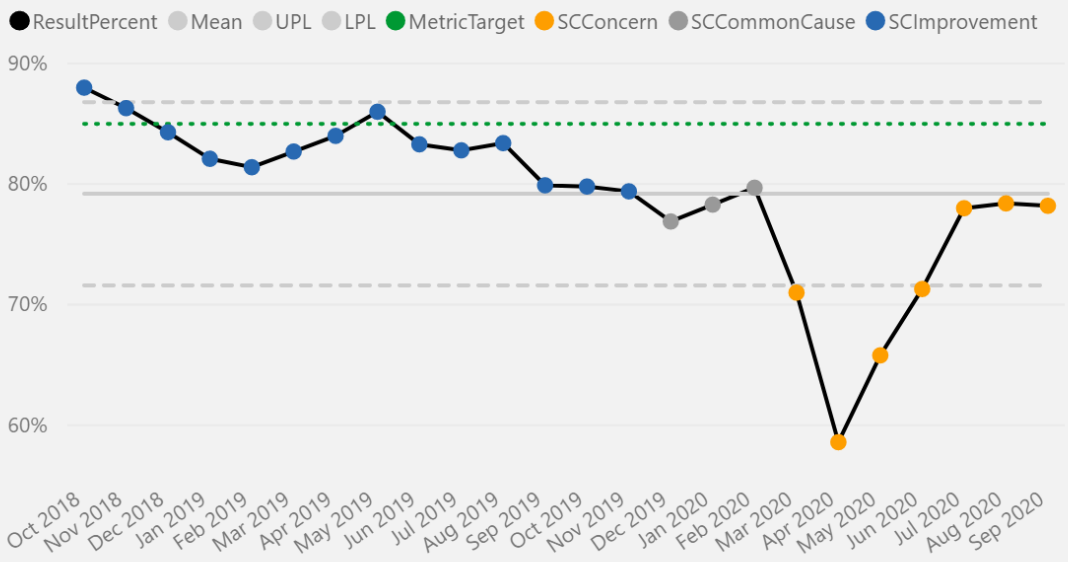
78.2% Result
85.0% Target

86.8% UPL
79.2% Mean
71.6% LPL

Analytical Commentary

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

Theatre Utilisation (Main Theatres)



Assurance Commentary

Theatre utilisation remained consistent at 78% in September. Additional theatres were brought back on line towards the end of the month as staffing levels increased. The continued requirement for additional cleaning and enhanced IP&C measures impacted on utilisation and theatre efficiency.

Business Process Changes

Theatre Cancellations

NNUH Digital Health
business intelligence

OTD Cancellations

Sep 2020

Variation | Assurance

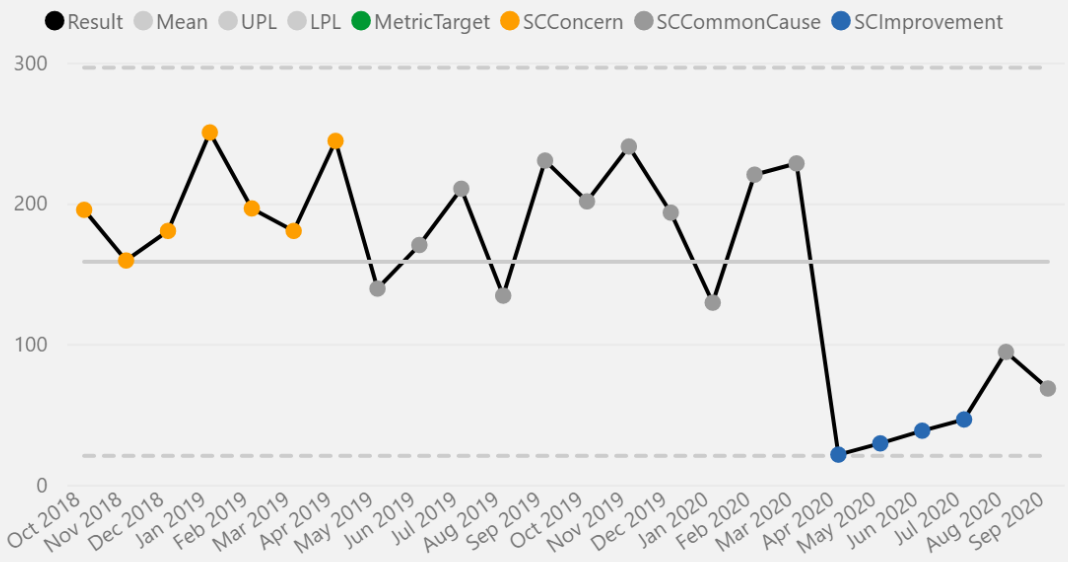
69 Result
N/A Target

297 UPL
159 Mean
21 LPL

Analytical Commentary

Variation is Common Cause

OTD Cancellations



Assurance Commentary

The cancellation rate for September was consistent with activity levels. The only identified outliying variations were due to Covid 19 related guidance and patient choice.

Business Process Changes

RTT Performance

NNUH Digital Health
business intelligence

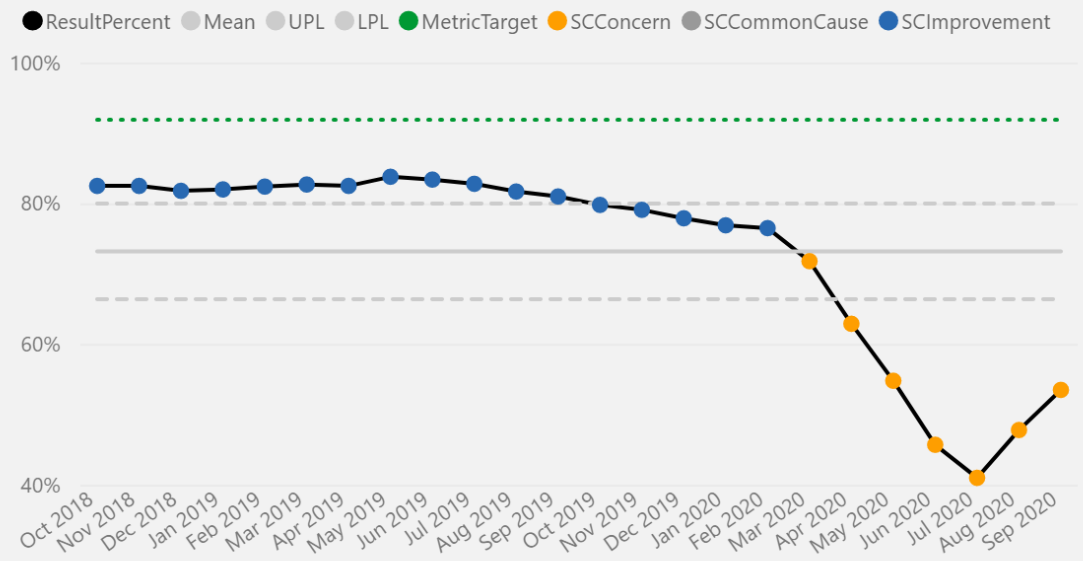
RTT Performance

Sep 2020

Variation	Assurance
L	F

53.6% Result	80.1% UPL
92.0% Target	73.3% Mean
	66.5% LPL

RTT Performance



Analytical Commentary

Data point fell outside of process limits, Data is consistently below mean, and therefore the variation is Special Cause Variation - Concern (Low)

Assurance Commentary

After a continued reduction in performance the last two months have shown a steady improvement to RTT performance. The improvement of RTT performance will continue to be a gradual process in light of the challenges due to Covid management and IP&C guidance .

Business Process Changes

Additional lists, with focus on cancer and long waiting patients agreed for September and October.
Four week day case pilot commenced.
continued increase in theatre provision should support the continued improvement.

RTT Waiting List

NNUH Digital Health
business intelligence

RTT Waiting List

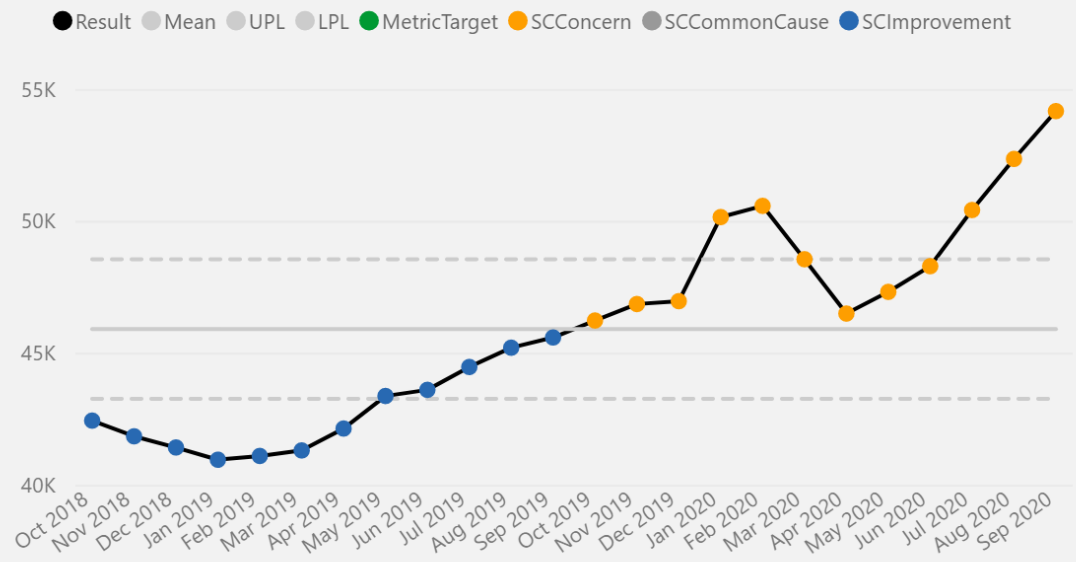
Sep 2020

Variation | Assurance

54,195 Result
N/A Target

48,579 UPL
45,935 Mean
43,290 LPL

RTT Waiting List



Business Process Changes

During August the NNUH took part in a national validation scheme to test the data quality of the Patient tracking list (PTL) which includes all waiting list patients on an RTT pathway.
The outcome was good with only around 14% opportunity for improvement (national average is circa 35%). Following local validation and further discussion with the national team the opportunity reduced to 5% . Work is ongoing on this opportunity.

Analytical Commentary

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

Assurance Commentary

The waiting list continues to grow as referrals are returning to close to pre-covid levels. The last two months have seen a slight reduction in the growth as the work to restore service capacity to pre-covid levels continues.
We are undertaking the NHSE Clinical Harm Validation process for all of our admitted patients.

RTT Long Waiters

NNUH Digital Health
business intelligence

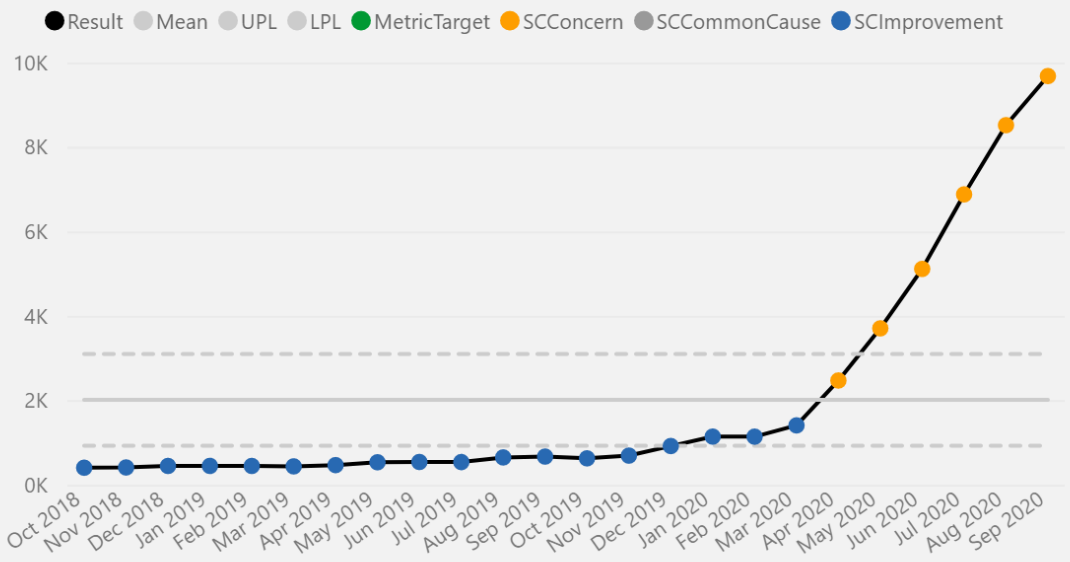
RTT 40 Weeks Wait

Sep 2020

Variation	Assurance
H	

9,703 Result	3,117 UPL
N/A Target	2,031 Mean
	944 LPL

RTT 40 Weeks Wait



Business Process Changes

Additional lists for high risk patients in place.
A 4-week trial of single case-mix day surgery has commenced in high volume specialties to maximise day theatre utilisation.
Revised guidance on 3 day isolation pre surgery implemented.
SEPT/OCT - continued increase in theatre provision should provide more options for our routine longer waits.

Analytical Commentary

Data point fell outside of process limits, Data point is part of an upwards trend, and therefore the variation is Special Cause Variation - Concern (High)

Assurance Commentary

A significant increase on pre-covid longer wait levels as Cancer and more clinically urgent patients continue to be prioritised. The last two months are showing a levelling off of the rate of increase. In light of the increased longer waits enhanced measures for assessing clinical harm and prioritising patients are now in place. The increasing theatre capacity will help reduce the rate of growth and reduce the routine longer waiters.

DM01 Performance

NNUH Digital Health
business intelligence

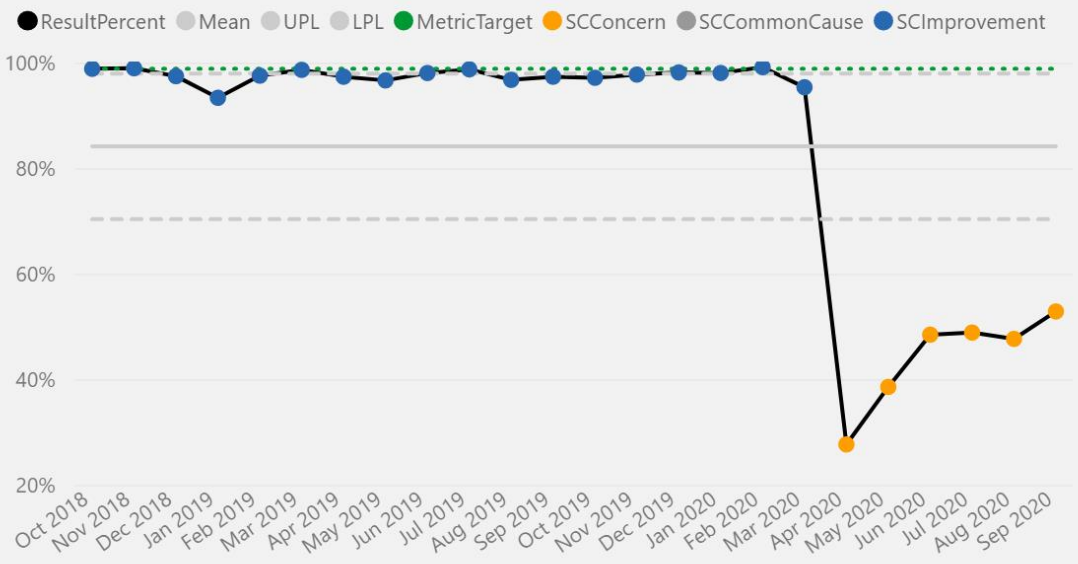
Diagnostics DM01 - Performance

Sep 2020

Variation	Assurance
L	F

53.00% Result	98.10% UPL
99.00% Target	84.30% Mean
	70.50% LPL

Diagnostics DM01 - Performance



Business Process Changes

DM01 performance is expected to return to pre covid levels by the end of Phase III in March 2021

Analytical Commentary

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

Assurance Commentary

The diagnostic DM01 performance continued to recover in September. The volume of patients in the backlog will continue to impact the performance going forwards however gradual improvement is expected to continue in coming months. Prioritisation is being given to cancer, urgent and emergency patients.

DM01 Waiting List

NNUH Digital Health
business intelligence

Diagnostics DM01 - Waiting list

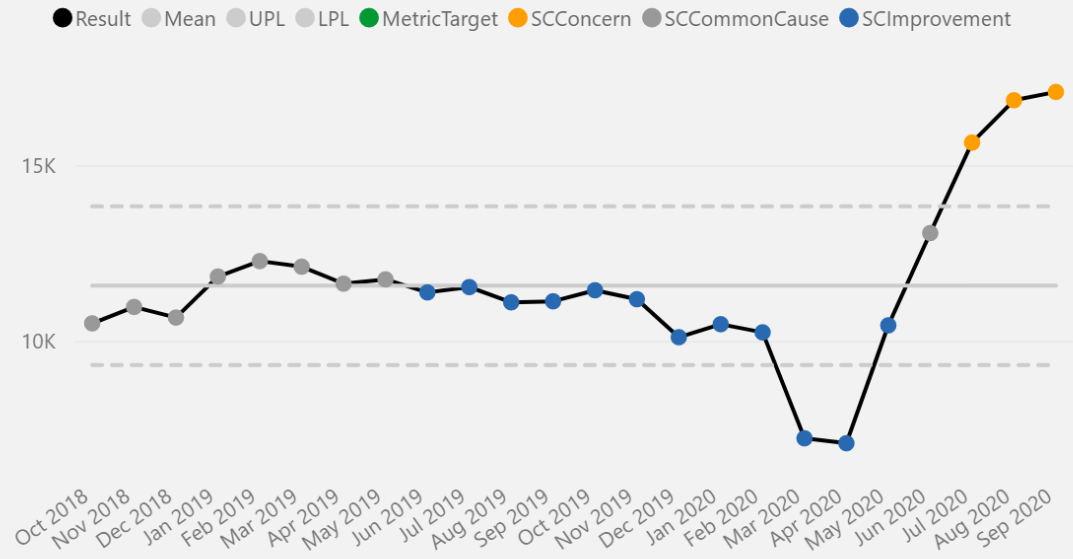
Sep 2020

Variation: H

Assurance: N/A

17,106 Result	13,854 UPL
N/A Target	11,598 Mean
	9,342 LPL

Diagnostics DM01 - Waiting list



Business Process Changes

Endoscopy has adapted the new guidance re: PPE and air flow, which has enabled more slots to be allocated and turnaround times to be reduced; the impact is that slots are returning to almost pre-covid levels. Additional insourcing has been agreed in endoscopy to clear all long waiting patients during august and September. Some additional activity has been agreed for imaging out of hours, Sleep and Neurophysiology are revising recovery plans around available workforce.

Analytical Commentary

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

Assurance Commentary

The last two months have shown a reduction in the total numbers on the DM01 waiting list. Increased activity due to WLI's are taking place to return activity levels very close to pre-covid levels. The numbers of patients waiting over 6 weeks has reduced by just over 1000 in September.

Cancer Performance: 2ww

NNUH Digital Health
business intelligence

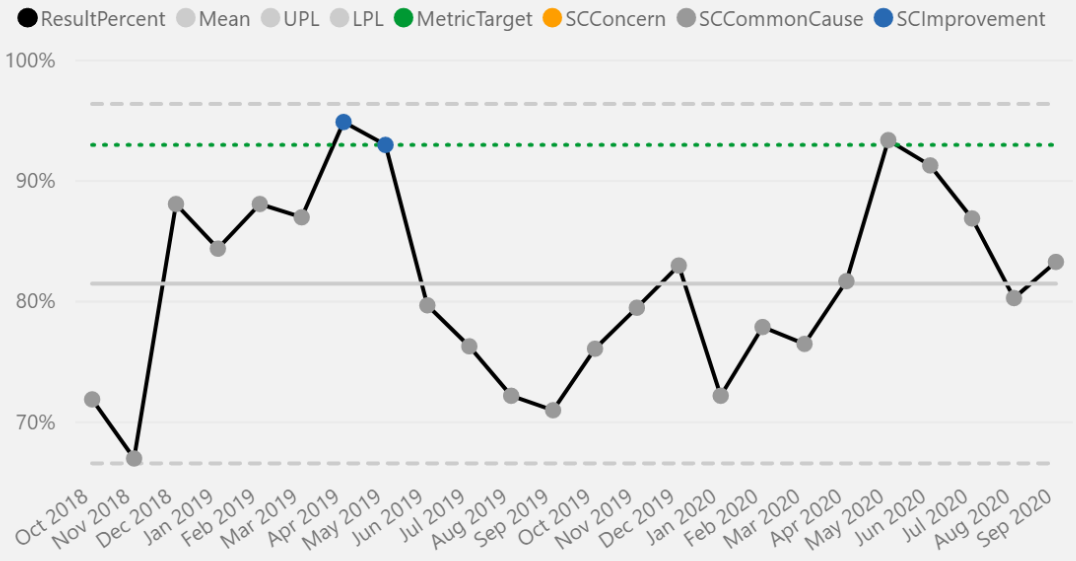
2WW Performance (signed off figures)

Sep 2020

Variation | Assurance

83.30% Result	96.40% UPL
93.00% Target	81.50% Mean
	66.60% LPL

2WW Performance (signed off figures)



Business Process Changes

Analytical Commentary

Variation is Common Cause

Assurance Commentary

Two Week Wait performance continued to recover in September. However, Trust performance is still below the standard due to underperformance in Breast. Clinical Support Services and the Surgical Division are working on providing robust One-Stop Capacity to meet demand, to ensure patients only need to attend site once for their diagnosis - 2 meter social distancing is impacting on the number of patients that are seen daily. Despite failing the two week wait standard, the 28 day faster diagnosis performance is still at 99%.

Cancer Waiting List: 2ww

NNUH Digital Health
business intelligence

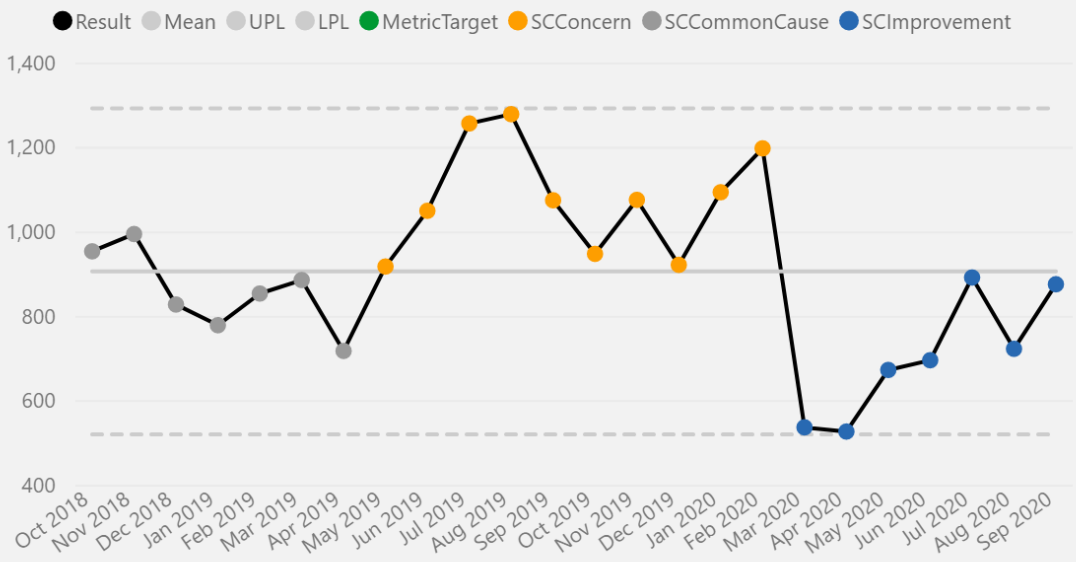
2WW Waiting List Profile (Cancer)

Sep 2020

Variation | Assurance

877 Result
N/A Target
1,294 UPL
907 Mean
521 LPL

2WW Waiting List Profile (Cancer)



Business Process Changes

Analytical Commentary

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

Assurance Commentary

Two Week Wait referrals have been above pre-covid levels for the past 4 weeks, with increases in Breast and Skin. Despite the increase in referrals we have not seen a large increase in the waiting list due to provision of additional clinics.

Cancer Performance: 62 Day

NNUH Digital Health
business intelligence

62 Day GP Performance (signed off figures)

Sep 2020

Variation	Assurance
	

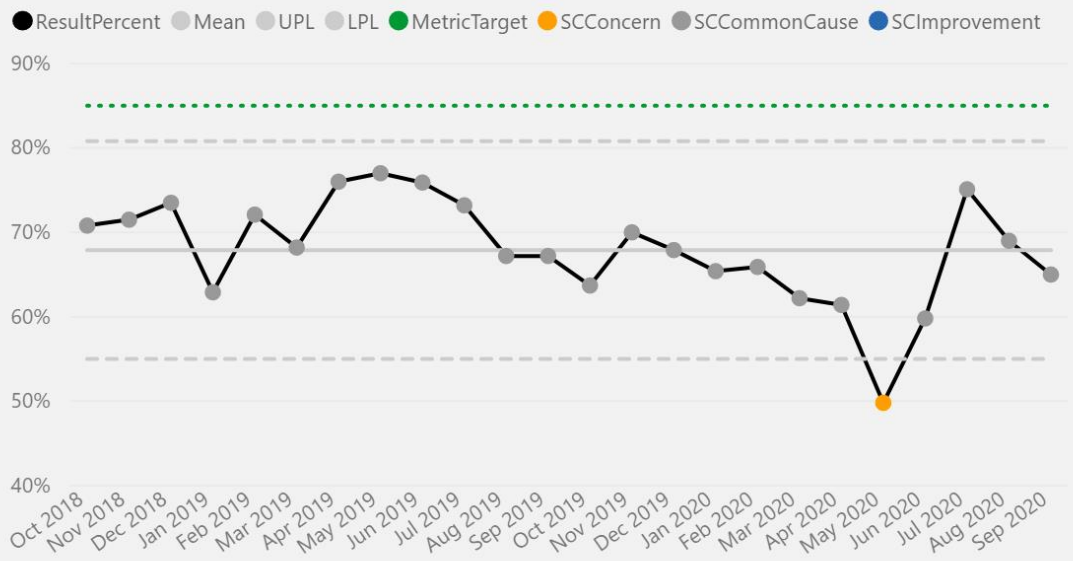
65.00% Result
85.00% Target

80.80% UPL
67.90% Mean
55.00% LPL

Analytical Commentary

Variation is Common Cause

62 Day GP Performance (signed off figures)



Assurance Commentary

62 day performance continues at around 70%. The focus on working through the backlog of patients that have already breached the 62 and 104 standards reduced the performance in month and will continue to do so during October.

Business Process Changes

Cancer Waiting List: 62 Day

NNUH Digital Health
business intelligence

62 Day Waiting List Profile

Sep 2020

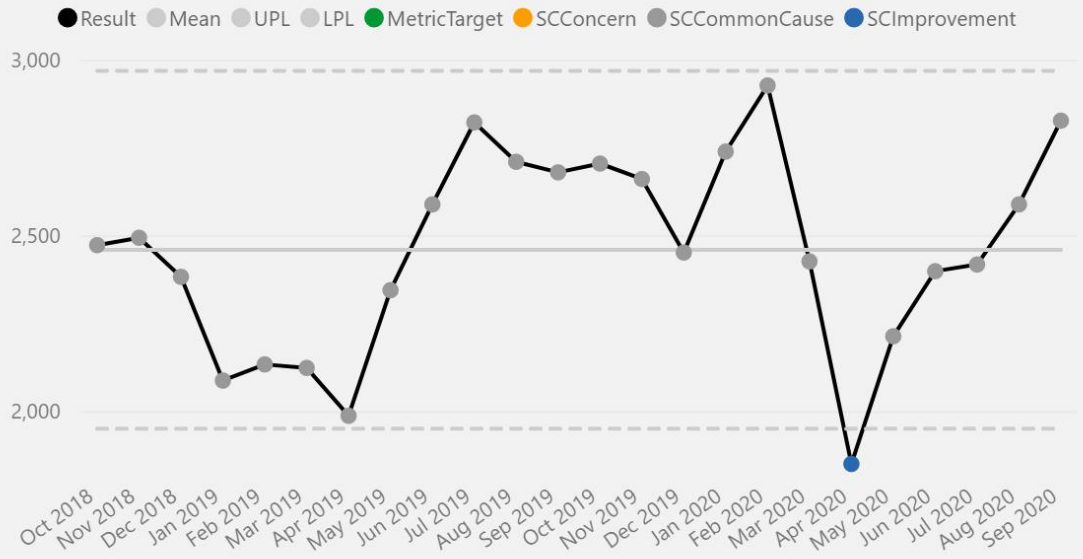
Variation | Assurance

2,829 Result	2,971 UPL
N/A Target	2,462 Mean
	1,953 LPL

Analytical Commentary

Variation is Common Cause

62 Day Waiting List Profile



Assurance Commentary

The waiting list for treatment has increased as we are receiving and actioning two week wait referral numbers in excess of pre-covid levels. The majority of the patients on the waiting list are still suspected cancer and between day 0 and 28 days.

Business Process Changes

Cancer Long Waiters

NNUH Digital Health
business intelligence

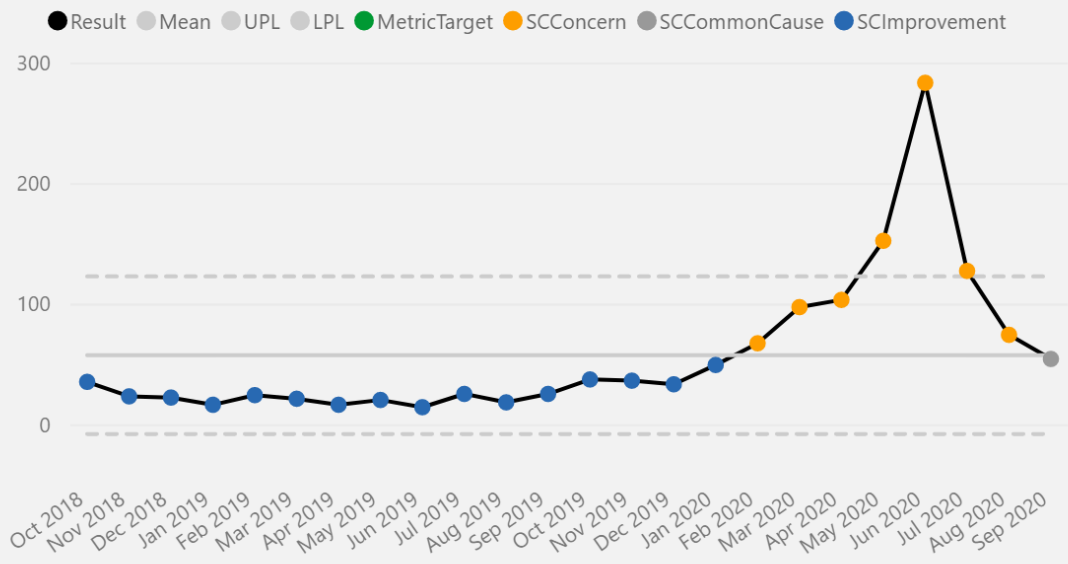
62 Day waits over 104 Days

Sep 2020

Variation | Assurance

55.0 Result
N/A Target
123.5 UPL
58.1 Mean
-7.2 LPL

62 Day waits over 104 Days



Business Process Changes

Process in place for daily escalation of individual patients on the list to COO and DoDs

Analytical Commentary

Variation is Common Cause

Assurance Commentary

Patients waiting 104 days continued to reduce. Body sites with the majority of patients left in the backlog are Urology and Lower GI. Focussed patient managment at weekly PTL meetings and daily updates to the COO and Chiefs of Division have assisted in reducing the backlog. Patient choice and transfers from other hospitals after the target date continue to form a significant proportion of the total waiting.

Stroke: SSNAP

NNUH Digital Health
business intelligence

SSNAP - Score

Sep 2020

Variation

Assurance

74.0 Result

80.0 Target

89.2 UPL

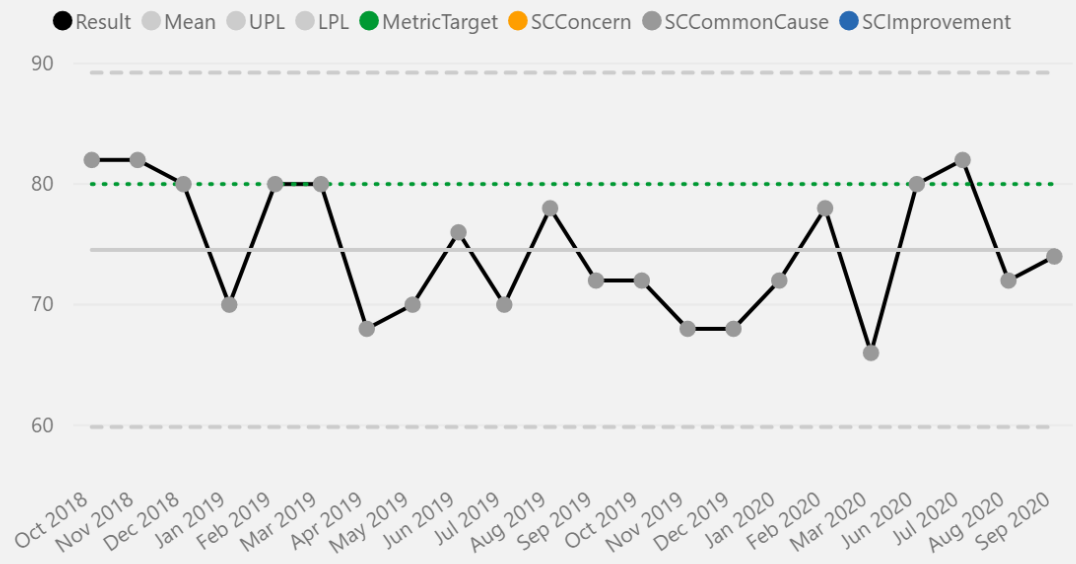
74.5 Mean

59.9 LPL

Analytical Commentary

Variation is Common Cause

SSNAP - Score



Assurance Commentary

The stroke service was rated B in September with an overall score of 74% against the SSNAP quality standards. This was slightly above the 12 month average of 72.8% and a 2% increase from August. The pathway treated 245 patients referred as potential strokes, against a 12 month average of 279. Of the 245 patients 98 were diagnosed with stoke, against a 12 month average of 97.

Of the ten domains two improved their ratings, as follows: D7 Speech and Language Therapy improved from a D to a C, and D9 Standards by Discharge from a C to a B. Seven domains maintained their ratings, as follows: D1 CT scanning B, D2 Stroke Unit D, D4 specialist assessments B, D5 occupational therapy A, D6 physiotherapy A, D8 MDT working C, D9 Standards by discharge C, and D10 discharge process A. One domain's rating decreased, which was D3 Thrombolysis from a C to a D.

Business Process Changes

To improve the rating the Stroke team continue to focus on pre-alerting the ambulance service and emergency department.
Projects within the Five Year Neurosciences Plan and Five Year STP Stroke Plan hahve comenced to support pre-alerting. An example of this is the feasibility testing of a Mobile Stroke Unit with East of England Ambulance Service NHS Trust and Saarland University.

Stroke: Stroke Unit

NNUH Digital Health
business intelligence

Domain 2 - Score

Sep 2020

Variation | Assurance

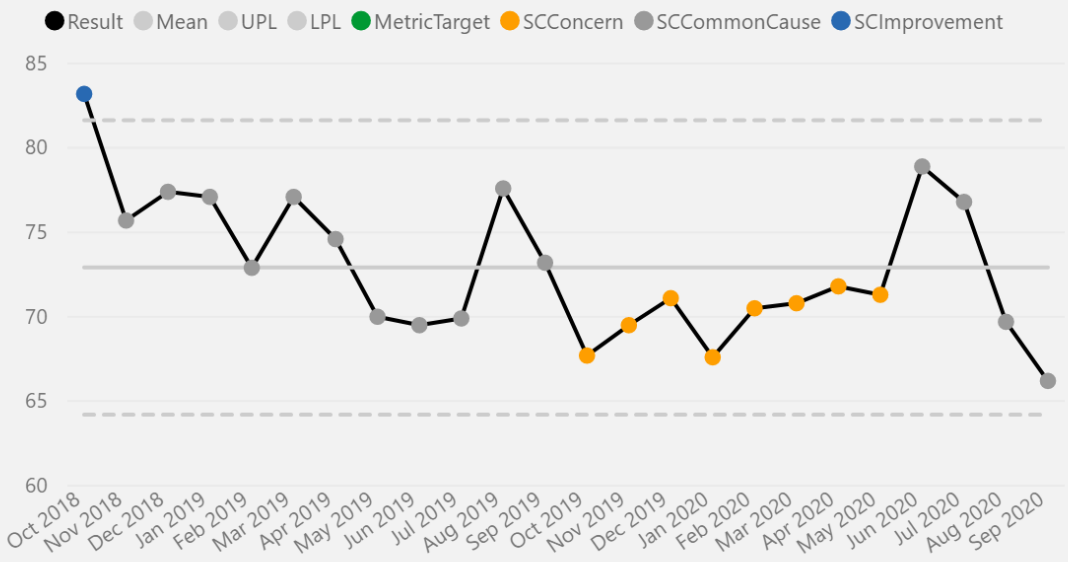
66.2 Result
N/A Target

81.6 UPL
72.9 Mean
64.2 LPL

Analytical Commentary

Variation is Common Cause

Domain 2: Stroke Unit (inc. 4hr)



Assurance Commentary

In September the SSNAP domain for our Stroke Unit was rated D with a score of 66.2%. This is a 3.5% reduction on last month's score, meaning we are middle of a D rating. The twelve month average for our Stroke Unit score is 71%. The variation in our score and rating is a direct consequence of pre-alerting and availability of direct admission beds on our Stroke Unit. In September 28 of the 38 breaches were due to the Stroke Team not being alerted, with the remaining 10 breaches evenly split across Stroke Unit capacity, stroke not diagnosed and clinical need to remain elsewhere.

Business Process Changes

To improve the rating we have established regular meetings with EEAST to support pre-alerting. These are combined with the heart attack team to identify and discuss learning and good practice. In addition the availability of beds is the main focus for the Stroke Team through their shifts, moving patients along the pathway to maintain availability of direct admission beds.

Stroke: Thrombolysis

NNUH Digital Health
business intelligence

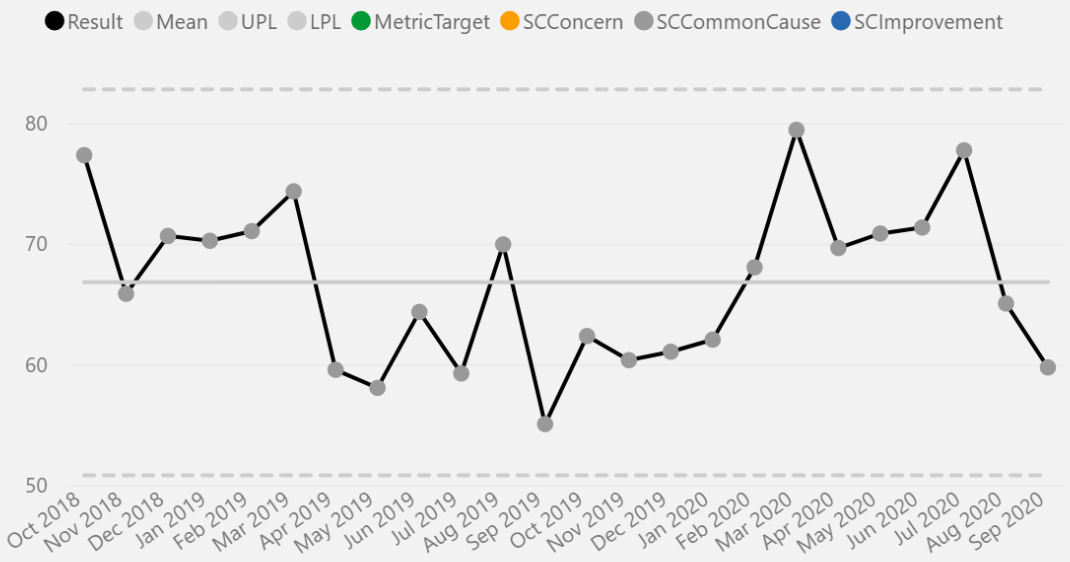
Domain 3 - Score

Sep 2020

Variation	Assurance

59.8 Result	82.9 UPL
N/A Target	66.9 Mean
	50.9 LPL

Domain 3: Thrombolysis (inc. 1hr)



Business Process Changes

To improve the rating the stroke continue to audit breeches of thrombolysis, with findings and themes discussed at Clinical Governance. In addition we have established regular meetings with EEAST to identify and discuss learning and good practice for stroke and heart attack.

A Stroke Consultant is auditing patients that arrived within 4 and half hours of onset and are not thrombolysed to ensure we are following NNUH stroke guidan...

Analytical Commentary

Variation is Common Cause

Assurance Commentary

In September the SSNAP domain for thrombolysis was rated D with a score of 59.8%, a decrease of 5.3% and drop in rating from C to D. The threshold for a C rating is 60%. The twelve month average for thrombolysis score is 67.3%, which is a high C rating, as the threshold for a B rating is 70%. The underlying reason for this domain not scoring higher is due to the proportion of patients thrombolysed.

Cardiology: NSTEMI

NNUH Digital Health
business intelligence

NSTEMI

Sep 2020

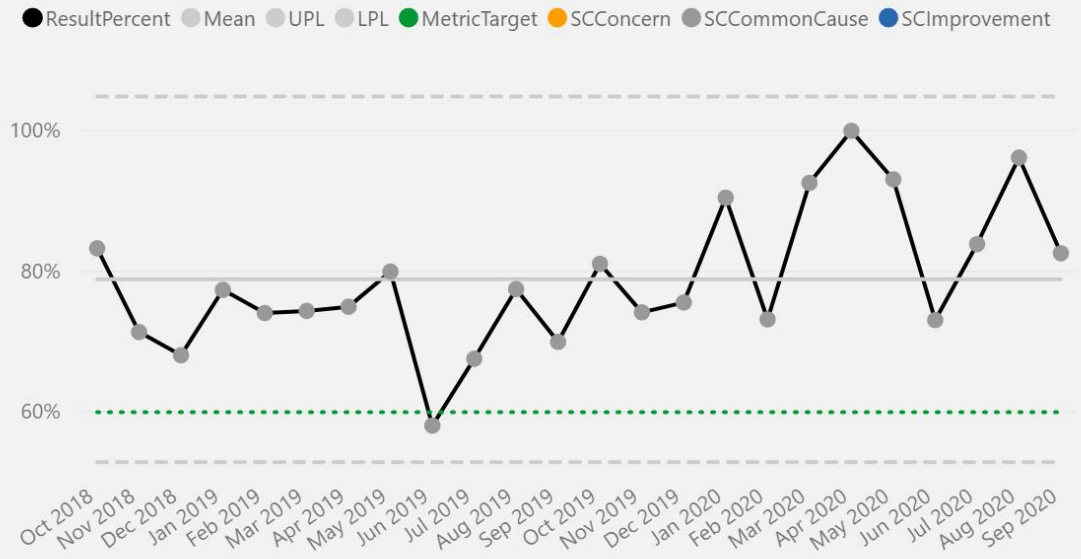
Variation	Assurance
	

82.60% Result	104.90% UPL
60.00% Target	78.90% Mean
	52.90% LPL

Analytical Commentary

Variation is Common Cause

NSTEMI



Assurance Commentary

There were 46 patients in this group, of which 8 did not meet the standard. 1 of the 8 patients had co-morbidities which delayed their treatment. The remaining 7 were a result of extreme demand on Cardiology Wards.

Business Process Changes

Cardiology: Call to Balloon

NNUH Digital Health
business intelligence

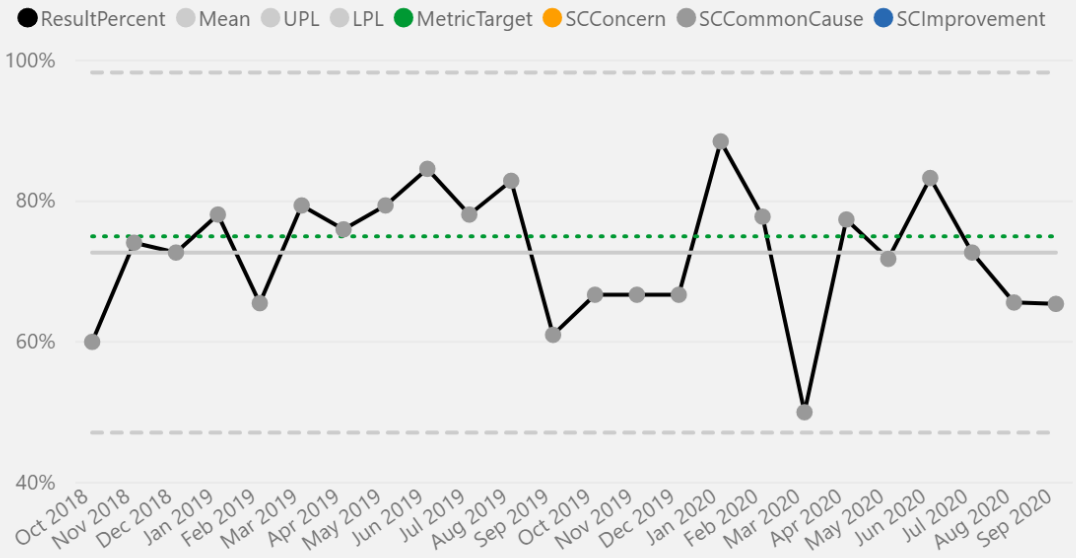
Call to Balloon

Sep 2020

Variation	Assurance
	

65.40% Result	98.30% UPL
75.00% Target	72.70% Mean
	47.10% LPL

Call to Balloon



Business Process Changes

Bi-monthly meeting with Stroke team and EEAST. (Next meeting Nov 20) Dr Sawh has provided a webinar training session. Dr Sawh liaising with Eeast to provide specialist online training for paramedics.

Analytical Commentary

Variation is Common Cause

Assurance Commentary

There were 26 patients in this group. The standard was not met for 9 patients. For 1 patient this was due to an out of hospital arrest (requiring treatment prior to transportation), long ambulance times accounted for 5 patient delays, 2 patients needed further investigations prior to treatment and 1 procedure was more complex than anticipated.

Cardiology: Door to Balloon

NNUH Digital Health
business intelligence

Door to Balloon

Sep 2020

Variation	Assurance
	

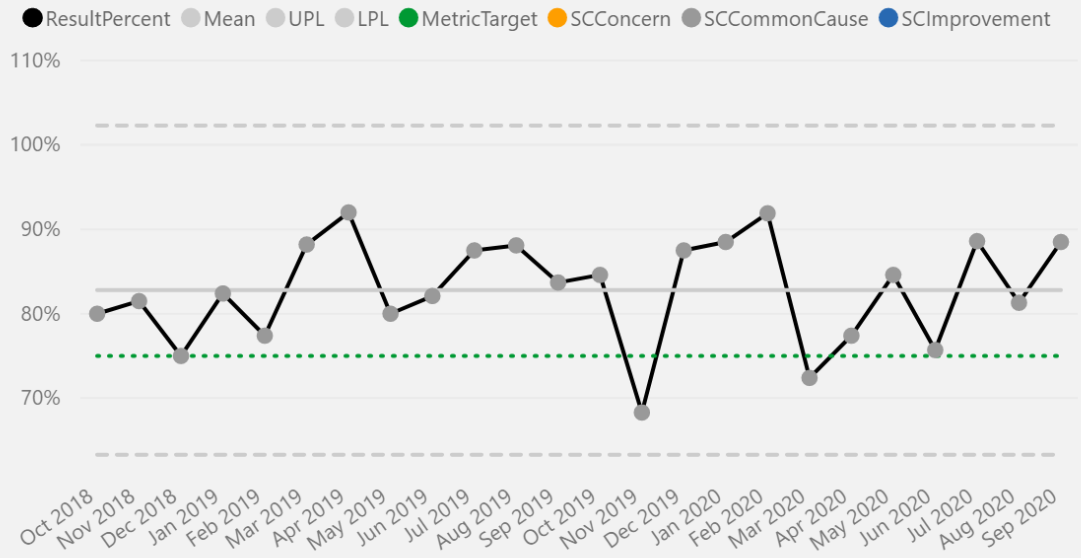
88.50% Result
75.00% Target

102.30% UPL
82.80% Mean
63.30% LPL

Analytical Commentary

Variation is Common Cause

Door to Balloon



Assurance Commentary

There were 26 patients in this group. For the 3 patients where the standard was not delivered, 1 was a complex procedure and 2 patients needed further investigations prior to treatment.

Business Process Changes

Bi-monthly meeting with Stroke team and EEAST. (Next meeting Nov 20) Dr Sawh has provided a webinar training session. Dr Sawh liaising with Eeast to provide specialist online training for paramedics.

Activity: Day Case Elective

NNUH Digital Health
business intelligence

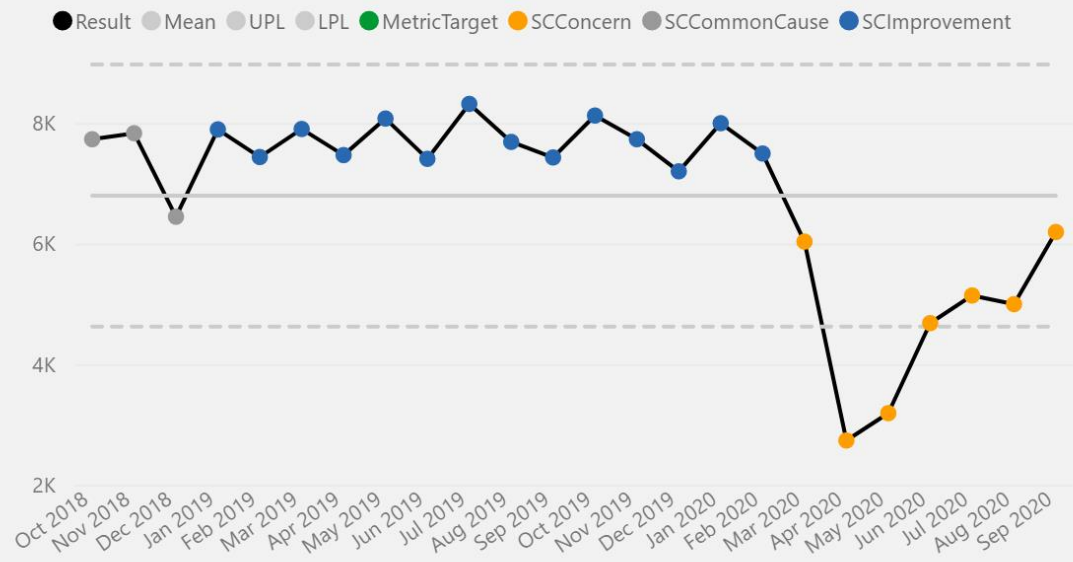
Activity (DC)

Sep 2020

Variation	Assurance
L	

6,206 Result
N/A Target
8,983 UPL
6,810 Mean
4,637 LPL

Activity (DC)



Business Process Change

As of August 2020, regular day attenders are no longer in included in figures in line with NHSE recovery plan guidance.

Analytical Commentary

Data is consistently below mean, 2 out of 3 data points have been close to the process limits, and therefore the variation is Special Cause Variation - Concern (Low)

Assurance Commentary

There were a total of 6,206 day cases in September 2020, which equates to 84% of average number in 2019/20.

Activity within Medicine was 152 less than September 2019 (driven by Clinical Oncology and Rheumatology), whilst surgery were 733 cases behind (mostly Ophthalmology, Pain Management and ENT). W&C were 53 behind, driven by Paediatric Medicine/Respiratory.

Performance exceeded the NHSE Phase 3 trajectory of 5,714 (80% of September 2019 activity), but fell short of the trust's internal phase III plan of 6,484.

Activity: Inpatient Elective

NNUH Digital Health
business intelligence

Activity (IP)

Sep 2020

Variation	Assurance

569 Result

N/A Target

1,075 UPL

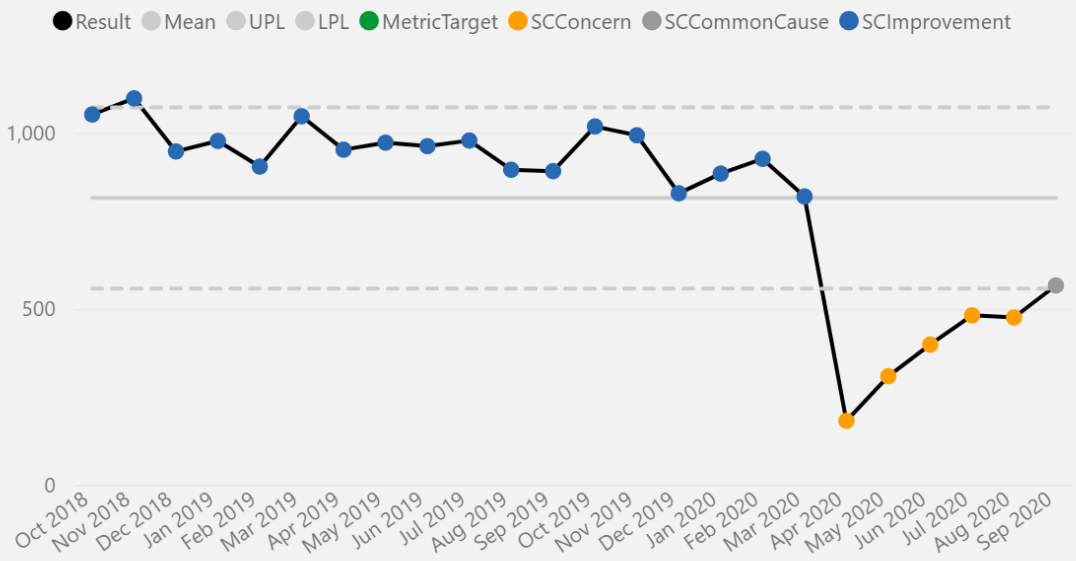
818 Mean

560 LPL

Analytical Commentary

Variation is Common Cause

Activity (IP)



Assurance Commentary

There were a total of 569 elective inpatient discharges in September 2020, which equates to 61% of average monthly number in 2019/20.

Activity within Medicine was 82 less than September 2019 (driven by Nephrology and Clinical Oncology) whilst surgery were 225 cases behind (mostly ENT, T&O/Spinal and Urology). W&C were 18 behind, driven by Gynae.

Performance did not meet the NHSE Phase 3 trajectory of 715 (80% of September 2019 activity), but was in line with the trust's internal phase 3I plan of 570.

Business Process Change

Activity: Non-Elective Discharges

NNUH Digital Health
business intelligence

Activity (Non-Elective)

Sep 2020

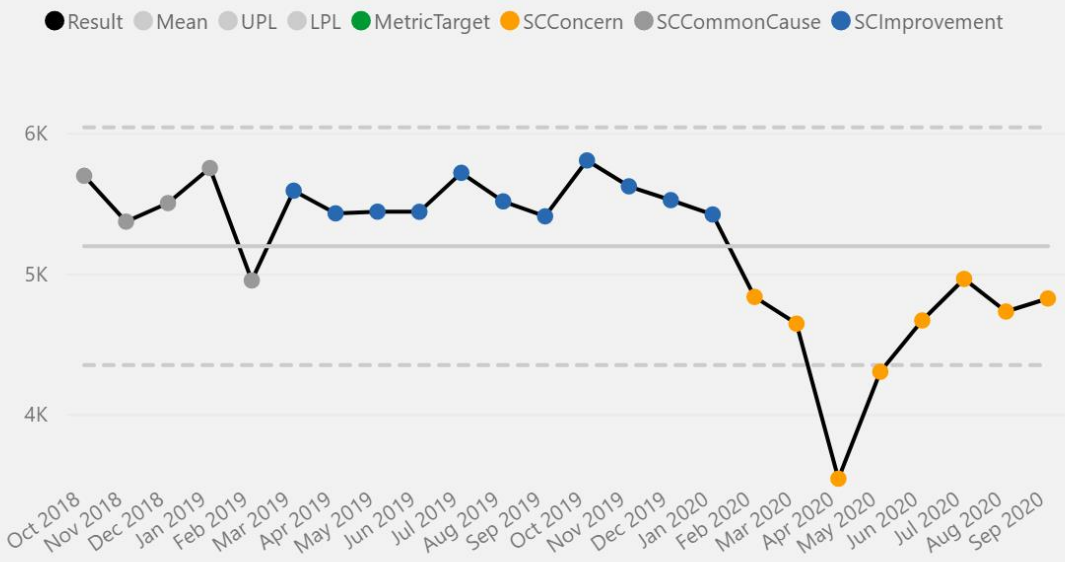
Variation | Assurance

4,830 Result	6,047 UPL
N/A Target	5,202 Mean
	4,356 LPL

Analytical Commentary

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

Activity (Non-Elective)



Assurance Commentary

There were a total of 4,830 non elective discharges in September 2020 (Including maternity activity), which equates to 88% of average monthly number in 2019/20, and 584 fewer than September 2019.

Activity within Medicine exceeded September 2019 by 26 cases. Surgery were 629 cases behind although much of this is driven by changes in EAUS where activity is now being recorded as outpatients. W&C levels were similar to September 2019, with an increase in paediatrics offset against decreases in neonatology and obstetrics.

Business Process Change

As of December 2019 most EAUS activity shifted from admitted to outpatient recording (as part of a transition to Same Day Emergency Care (SDEC) recording).

Activity: Outpatient

NNUH Digital Health
business intelligence

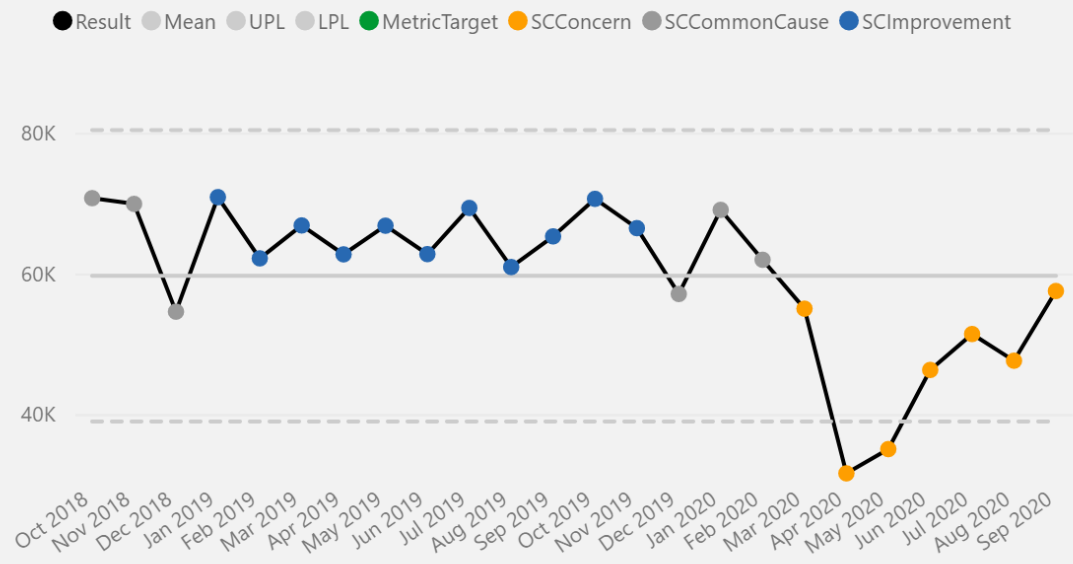
Activity (OP)

Sep 2020

Variation | Assurance

57,661 Result
N/A Target
80,548 UPL
59,831 Mean
39,114 LPL

Activity (OP)



Business Process Change

From December 2019, shift in recording for EAUS activity from admission to outpatient

Analytical Commentary

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

Assurance Commentary

There were 13,548 new consultant led appointments in Sep 2020, which is 77% of Sep2019 levels. 3,339 [25%] were telephone/video, compared to an average of 888 [5%] in 2019/20. Activity exceeded the trust's internal phase 3 plan by 468.

There were 36,453 follow up consultant led appointments in Sep2020, which is 95% of Sep 2019 activity. 16,734 [46%] were telephone/video, compared to an average of 3,503 [9%] in 2019/20. Activity exceeded the trust's internal phase 3 plan by 6,291.

There were 7,660 non-consultant appointments in Sep 2020, which is 81% of Sep 2019 activity. 5,258 [69%] were telephone/video, compared to an average of 1,130 [12%] in 2019/20. Activity exceeded the trust's internal phase 3 plan by 305.

There were 9,464 outpatient procedures in Sep2020, compared with the NHSE phase 3 recovery expectation of 10,423 (80% of Sep 2019 activity)

There were 48,197 attendances (excluding procedures) and non face to face appointments, falling short of the NHSE phase 3 recovery expectation of 52,448 (100% of Sep 2019 activity).

Activity: ED Attendances

NNUH Digital Health
business intelligence

Activity (ED)

Sep 2020

Variation	Assurance

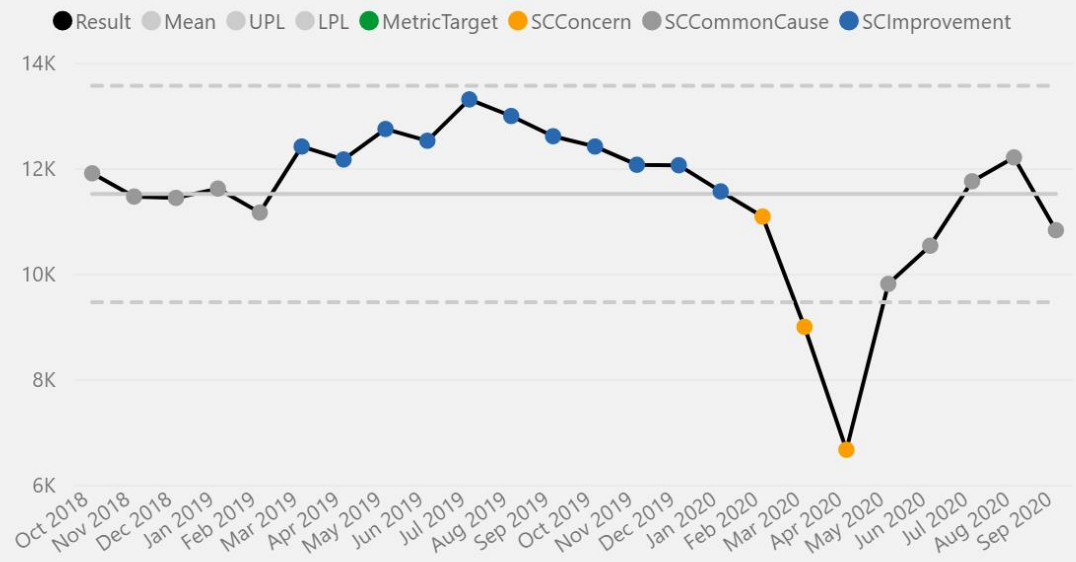
10,841 Result
N/A Target

13,579 UPL
11,527 Mean
9,475 LPL

Analytical Commentary

Variation is Common Cause

Activity (ED)



Assurance Commentary

There were 10,841 A&E attendances in September 2020, compared to 12,622 in September 2019. 953 (9%) of these were for Cromer MIU, whilst 1,314 were for Children.

Business Process Change

Norfolk and Norwich University Hospitals NHS Foundation Trust

Finance Report September-2020

22 October 2020

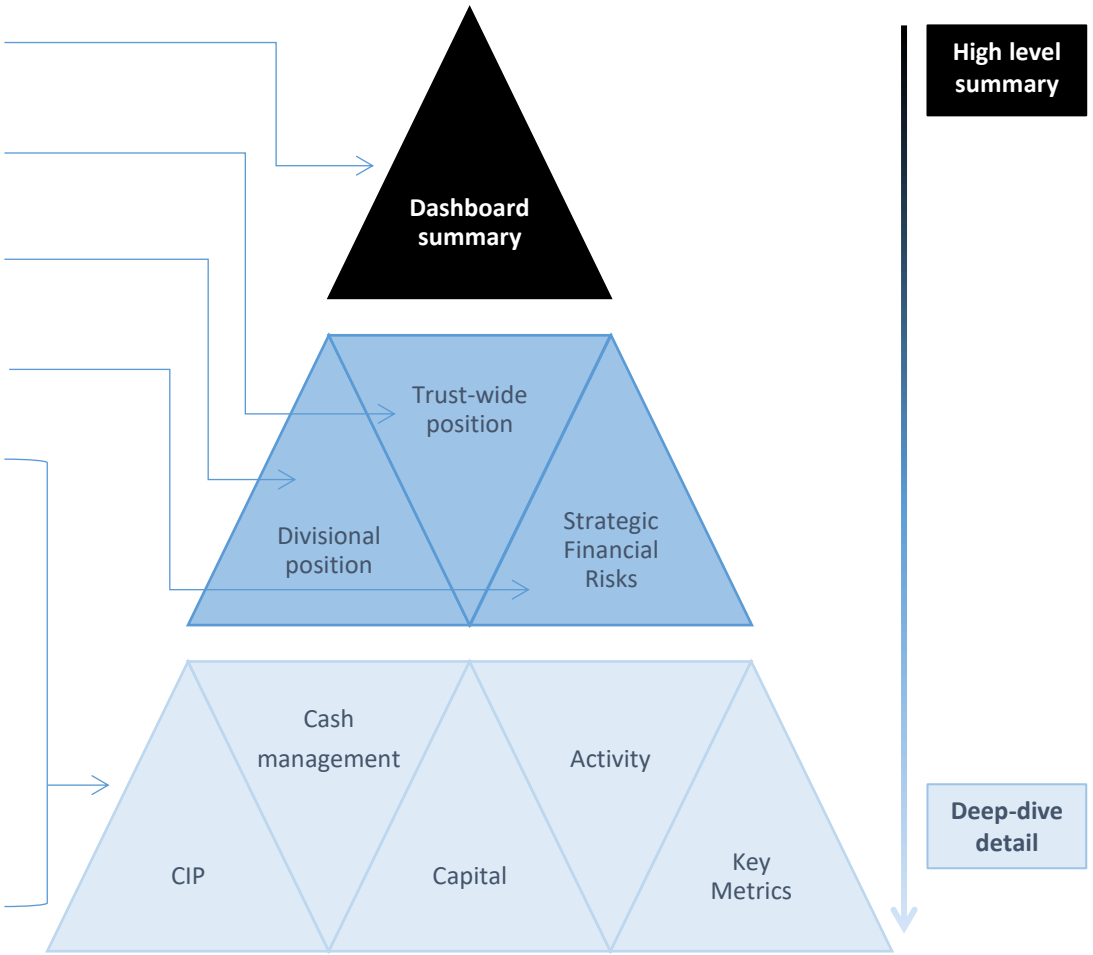
Roy Clarke, Chief Finance Officer

Norfolk and Norwich University Hospitals NHS Foundation Trust

Contents

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

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



Norfolk and Norwich University Hospitals NHS Foundation Trust

1. Executive Dashboard

The Reported Year to Date Position for September 2020 is breakeven. This consists of a £6m operating surplus before COVID, COVID costs of £15.8m and top income of £9.8m. The £6m operating surplus before COVID expenditure and top up income is £9m favourable against the planned deficit of £3.0m.

The main driver of the favourable position is a £7.9m favourable Non Pay variance, predominantly in Clinical Supplies , due to reduced activity levels as shown in the table to the right where both inpatient and outpatient activity were c. 70% of prior year activity levels.

Forecast Outturn:
Forecast Outturn for October 2020- March 2021 is a deficit of £15.4m. This is a nil variance against the planned deficit of £15.4m

Activity:
Year to date activity for both inpatients and outpatients is c. 70% 2019/20 levels. Activity across all points of delivery has increased over August & September however remains adverse against the NHSE Phase III trajectory. The Trust plan is behind the Phase III trajectory, particularly outpatients which is c. 84% of the required level. Increased efforts will still be needed if the Trust is to meet the Phase III NHSE requirements from October onwards and avoid financial penalty through the Elective Incentive Scheme

Areas of concern/Risk to Outturn:
The Trusts ability to hit the activity trajectory and the incremental costs to achieve this are the main risks to the outturn. The additional expenditure required to open additional escalation beds to accommodate COVID patients whilst achieving activity levels, along with higher than planned Staff sickness/isolation levels may force an increase in the premium pay expenditure. The Trust is forecasting a need for distressed funding support of £10.8m by March 2020. The forecasted CIP delivery gap after RAG adjustment is £7.8m

Cash:
The cash balance as at 30 September is £74.7m reflecting the one month in advance payment arrangements. This is assumed to unwind in March 2021 exposing a need for distressed funding support of c. £10.8m. This aligns to the operational plan. The twelve month forecast based on the underlying deficit of £114.4m full year means that - unmitigated – the Trust will require additional distressed PDC funding of £67m in the period to 30 September 2021

Capital:
Each scheme within the £106.4 Plan (Plan A) has been reviewed and an assessment made. Overall, the Trust has high confidence of £68.5.m (61%) of the forecast plan as being deliverable. This includes £31.8m (28% of Plan value) of spend related to PFI lifecycle capitalisation. However, deliverability is linked to the timing of funding approvals. Delays in approvals could result in slippage to the Plan.

Month 6 (Sep-2020)	April - September 2020 YTD Actual £m	YTD Plan £m	Variance £m	October20 - March21 Forecast Outturn £m	Plan £m	Variance £m	RAG
Clinical Income	282.4	282.7	(0.2)	278.1	278.1	0.0	
Other Income	74.4	75.3	(0.9)	85.0	85.0	0.0	
Pay	(203.5)	(206.4)	2.9	(212.4)	(212.4)	0.0	
Non Pay	(86.2)	(94.0)	7.9	(101.6)	(101.6)	0.0	
Net Drugs Cost	(38.8)	(38.0)	(0.8)	(39.1)	(39.1)	0.0	
Non Opex	(22.3)	(22.5)	0.2	(25.4)	(25.4)	0.0	
Surplus /Deficit	6.0	(3.0)	9.0	(15.4)	(15.4)	0.0	
COVID Expenditure	(15.8)	-	-	(31.3)	(31.3)	0.0	
COVID Top Up Income	9.8	-	-	31.3	31.3	0.0	
Reported Surplus /Deficit	0.0	-	-	(15.4)	(15.4)	0.0	
Cash at Bank	74.7	1.2	73.5	(10.8)	(10.8)	0.0	
Borrowings	0.0	0.0	0.0	0.0	0.0	0.0	
Capital Programme	27.2	47.9	(20.7)	106.4	106.4	0.0	
CIP	1.2	1.4	(0.2)	11.3	11.3	0.0	
Inpatients* (000's)	56.5	83.1	(26.6)	74.5	75.5	(1.0)	
Outpatients* (000's)	270.3	389.0	(118.6)	324.2	386.4	(62.2)	
A&E* (000's)	61.9	76.4	(14.5)	76.1	76.1	0.0	

Norfolk and Norwich University Hospitals NHS Foundation Trust

1. Executive Dashboard

Strategic Financial Risks

The Trust has recently undertaken a formal review of the Financial Risk Register, refreshing all risks and adding new risks which have been identified across the finance portfolio. This is subject to formal review on a monthly basis.

The Finance Risk Register currently consists of 31 risks, of which 10 have a risk score of equal to or greater than 15 and RAG rated red. No risks have changed risk scoring in the month.

Strategic Financial Risks	Extreme (15-25)	High (8-12)	Moderate (4-6)	Low (1-3)
Total This Month	10	6	0	0
Total Last Month	10	6	0	0
Overall Trend	↔	↔	↔	↔

Divisional Performance

All six divisions (incl. Corporate) reported favourable positions against plan for Apr2020-Sep2020 predominantly due to the reduced activity levels against the prior year resulting in decreased expenditure on clinical supplies. However due to the underlying expenditure and activity levels all divisions are currently either Amber or Red RAG rated.

No specific risks to forecast outturn have been raised within divisions, however expenditure required to open additional escalation beds to accommodate COVID patients whilst achieving activity levels, along with higher than planned Staff sickness/isolation levels may force an increase in the premium pay expenditure

Divisional Performance YTD Sep-2020	Medicine		Emergency & Urgent Care		Surgery		Women's & Children's		CSS		Corporate		Other		Total	
	Act. £m	Var. £m	Act. £m	Var. £m	Act. £m	Var. £m	Act. £m	Var. £m	Act. £m	Var. £m	Act. £m	Var. £m	Act. £m	Var. £m	Act. £m	Var. £m
YTD Surplus /Deficit	(102.8)	1.7	(14.1)	0.7	(68.9)	4.7	(25.9)	0.3	(43.6)	2.6	(46.8)	0.6	308.1	(1.6)	6.0	9.0
FOT (M7-12)*	(105.5)	0.0	(14.7)	0.0	(71.4)	0.0	(26.9)	0.0	(45.6)	0.0	(47.0)	0.0	295.8	0.0	(15.4)	0.0
Inpatients**	36.4	(9.7)	0.0	(0.0)	11.8	(15.5)	8.3	(1.4)	0.0	(0.0)	-	-	-	-	56.5	(26.6)
Outpatients**	116.9	(18.9)	0.2	(0.1)	113.6	(82.2)	23.8	(6.0)	15.8	(11.1)	-	-	-	-	270.3	(118.6)
A&E**	-	-	61.9	(14.5)	-	-	-	-	-	-	-	-	-	-	61.9	(14.5)
CIP RAG																
FINANCE RAG***																
PAF RAG***																

Divisional FOT excludes Intervention 3&4 budget allocation

***Activity variance against 2019/20 actuals*

**** Prior Month PAF Rating*

CIP Performance

The Trust has delivered £1.2m of CIPs against a FIP Board approved plan of £1.3m, an under-performance of £0.1m due to adverse performance of pay schemes across temporary spend and planned vacancies.

The risk adjusted forecast outturn CIP delivery is currently £3.5m against a CIP target of £11.3m. This presents a significant risk to achievement of the target.

CIP Plan Development

As at 15 October 2020, the programme consists of £6.2m of Gateway 2 approved schemes (of which £0.4m is contractually guaranteed), £4.1m of Gateway 1 approved schemes and £1.0m of unidentified schemes.

The FIP Board continues to work with divisions to identify further opportunities for transformation and efficiency to both reduce the in year CIP gap and plan for future years.

FY20/21 CIP Plan - Divisional Breakdown	FY20/21 Indicative Target £m	FY20/21 FIP Board Approved £m	Gap £m	FY20/21 RAG Adj. Forecast Delivery £m	Gap £m
Medicine	3.1	1.5	(1.6)	0.9	(2.2)
Emergency & Urgent Care	0.2	0.1	(0.1)	0.1	(0.1)
Surgery	3.3	3.3	0.0	1.8	(1.5)
Women's & Children's	1.2	0.5	(0.7)	0.3	(0.9)
CSS	1.8	0.3	(1.5)	0.2	(1.6)
Corporate	1.8	0.5	(1.3)	0.2	(1.6)
Total	11.3	6.2	(5.1)	3.5	(7.8)

Norfolk and Norwich University Hospitals NHS Foundation Trust

2.1 Financial Performance – September 2020

The Reported Position for September 2020 is breakeven. This consists of a £0.3m operating surplus before COVID, COVID costs of £1.4m and top income of £1.1m.
The £0.3m operating surplus before COVID expenditure and top up income is £0.3m favourable against the planned breakeven position

Clinical Income:
Clinical Income is reported £0.25m adverse to plan due to the forecasted block amendment for inflationary pressures not commencing until October 2020. Funding to support these additional pressures continues to be through breakeven top up regime

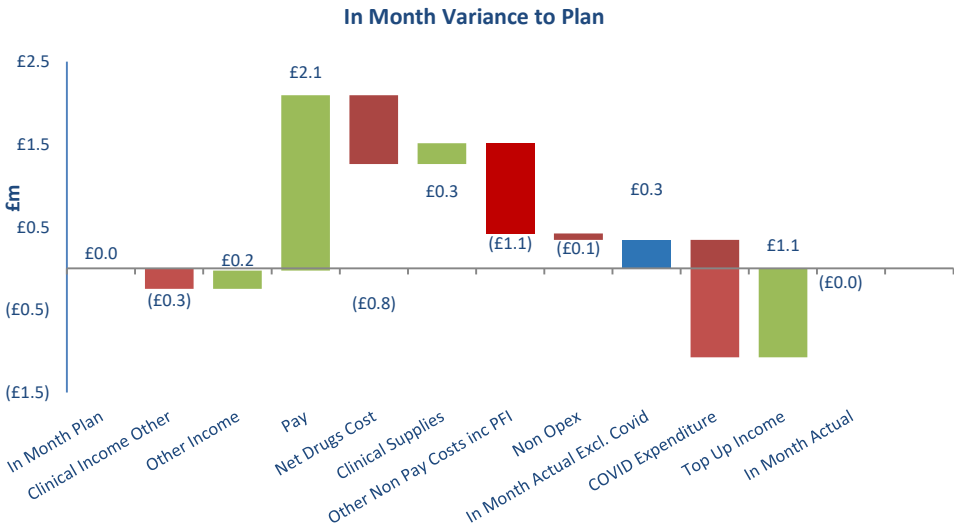
Other Income:
The Trust is reporting a 0.26m favourable variance to plan for September 2020. This is due to additional R&D income of £0.44m which is matched by offsetting Non pay Costs, offset by reduced E&T Income (£0.1m) and non receipt of CEA Income (£0.1m) due to being included within Income block. £0.3m relates to the delayed opening of the new ward block & ED are underspent by £0.2m

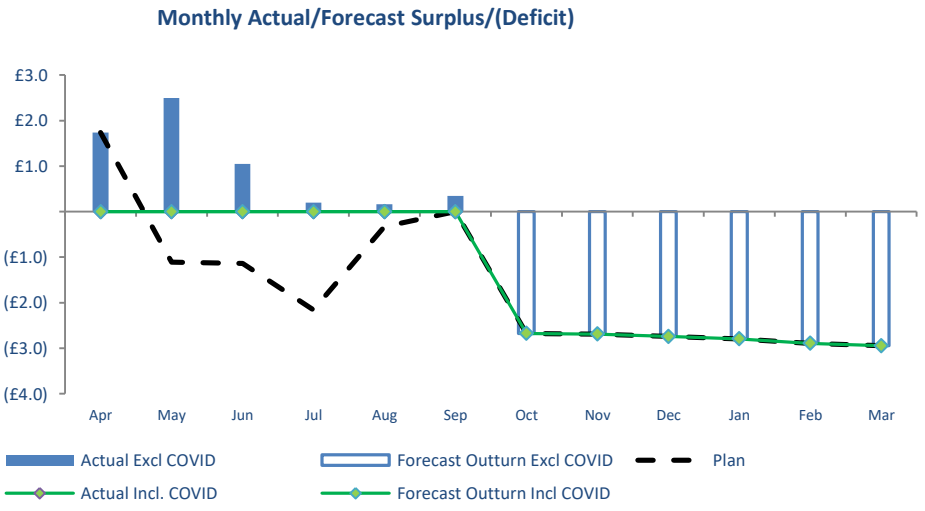
Pay:
The Trust is reporting a £1.2m favourable position against plan for September 2020. £0.9m relates to reversal of Annual Leave provision in line with NHSEI guidance. Medicine are £0.5m underspent of which £0.3m relates to the delayed opening of the ward block & ED are underspent by £0.2m due shortages of available locum and agency staff. Further savings seen across the Trust due to reduced WLI and newly qualified Nurses joining late in the month

Non Pay:
The Trust is reporting a £0.8m adverse variance to plan for September 2020. This is due to £0.4m offsetting costs against the additional R&D income recognised and associated costs of International Recruitment. This offset by £0.3m of reduced Clinical Supplies expenditure due to ongoing reduced activity levels.

Non Operating Expenditure:
The Trust is reporting a £0.1m adverse variance to plan for September 2020.

COVID 19 Expenditure:
The Trust is reporting a £1.4m of COVID-19 Expenditure and for September 2020 and a £0.1m shortfall of car parking income resulting in a net cost to the Trust of £1.5m

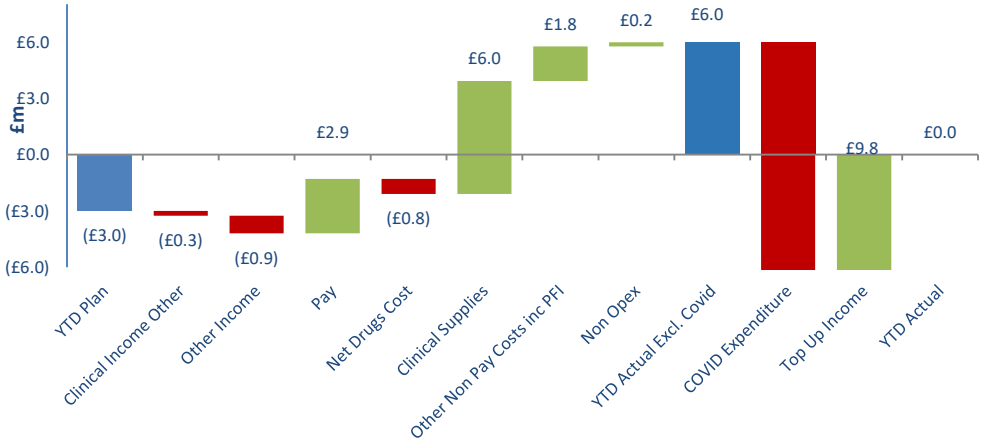




Norfolk and Norwich University Hospitals NHS Foundation Trust

2.2 Financial Performance – April - September 2020

The Reported Year to Date Position for April 2020 – September 2020 is breakeven. This consists of a £6.0m operating surplus before COVID, COVID costs of £15.8m and top up income of £9.8m.
The £6.0m operating surplus before COVID expenditure and top up income is £9.0m favourable against the planned deficit of £3.0m



Year to Date Performance:
Year to date the Trust is reporting a £6m surplus, this is £9m favourable, before COVID, against the Trust plan.

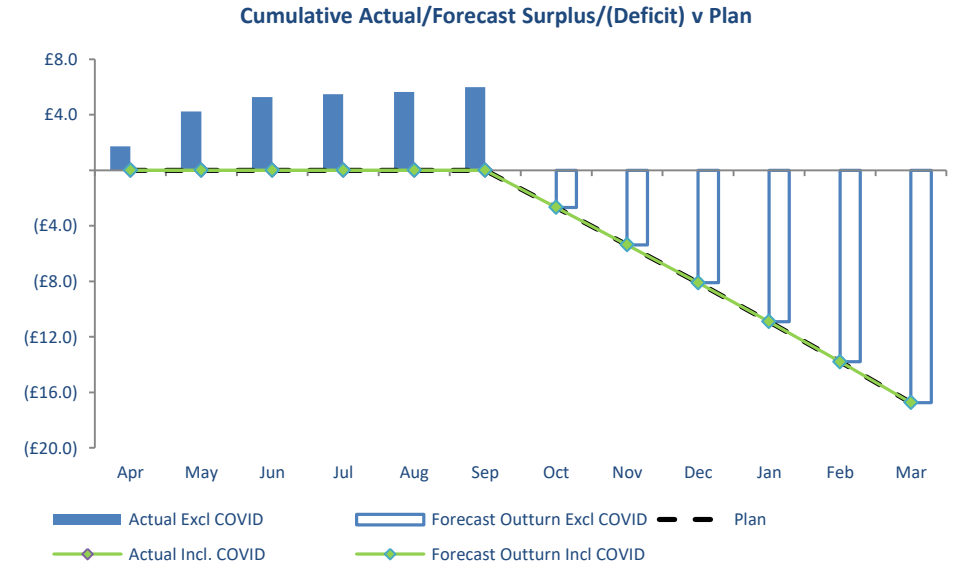
The main drivers behind the £9m favourable position are £6m reduced expenditure on clinical supplies as a result of the reduced activity, most notably in Surgery. Furthermore the Trust has reported a £2.9m favourable position on pay. This is part due to the delayed openings of the New Ward Block and IRU contributing c. £1.2m. Emergency are £0.5m favourable due to reduced activity levels early in year followed by shortages of available locum and agency staff in the latter half of the first six months. Savings are seen across all operational divisions as activity remains significantly behind prior year levels.

Forecast outturn for October 2020 - March 2021 is a deficit of £15.4m. This is a nil variance against the planned deficit of £15.4m

Forecast Outturn :

The Trust is currently forecasting to plan for October 2020-March 2021. Risks are as detailed in Section 4 of the report

However there is risk to outturn based on capacity to deliver the Trust planned trajectory if additional escalation wards are required to accommodate Non Elective/COVID patients whilst maintaining Elective and Inpatient programmes. There is also potential risk if staff sickness/isolation levels are higher than planned requiring additional expenditure on premium pay.



Norfolk and Norwich University Hospitals NHS Foundation Trust

2.3 Forecast Outturn & Underlying Run Rate Analysis

Forecast outturn remains on plan – a deficit of £15.4m. The annualised underlying deficit for the Trust is £114.4m as a result of reversing block income to the previously planned PbR income, adjusting COVID expenditure and including FYE of 2020/21 service developments and service developments held as a part of Intervention 2 of the Trust plan for October 2020-March 2021.

1 **Reversal of Block Income: Total £358.7m** removed from the plan for Clinical income Block (£278.1m), Top Up Funding (£45.6m), additional funding for High Cost Drugs & Devices (£5.2m), In & Out system COVID support funding (£26.0m) and Growth Support funding of £5.3m. **Underlying deficit excluding Block income of £375.5m**

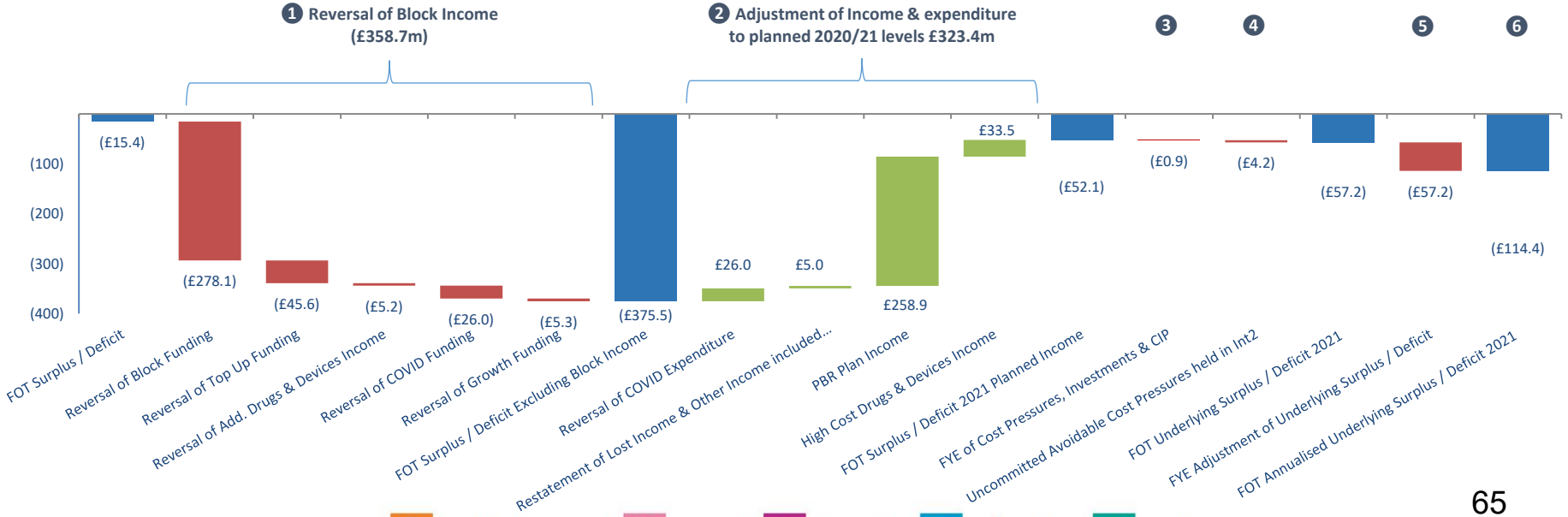
2 **Adjustment of Income & expenditure to planned 2020/21 levels: Total £323.4m** added back due to the reversal of planned COVID expenditure including testing (£26.0m) , reinstatement of lost Non NHS Income e.g. private patients & car parking £6.0m), PbR income based on planned 2020/21 activity and tariff (£258.9m) and High cost Drugs and devices income on planned 2020/21 activity and tariff (£33.5m). **Underlying deficit adjusting income and relating expenditure to planned 2020/21 activity levels £52.1m**

3 **Full year 2020/21 Service Developments: Total £0.9m** from full year effect of 2020/21 service developments e.g. recruitment of Mental Health Nurses, HPV Contract and other recruitment to establishment.

4 **Cost Pressures held as part of Intervention 2: Total £4.2m** predominately from delayed recruitment into establishment with no offsetting premium pay reduction, along with investments in IT, EDMS, Paediatric safer staffing and other 2020/21 cost pressure on hold due to COVID Pandemic

5 **Additional six months of underlying deficit to reflect a full year plan: Total £57.2** The above adjustments move the Trust plan for the six month period October – March. A further £57.2m is added to reflect a full 12 month period

6 **Annualised Underlying Deficit of £114.4m**



Norfolk and Norwich University Hospitals NHS Foundation Trust

3.1 Divisional Performance - Summary

All six divisions (incl. Corporate) reported favourable positions against plan for April to September 2020 predominantly due to the reduced activity levels against the prior year resulting in decreased expenditure on clinical supplies. However due to the underlying expenditure as activity levels all divisions are currently either Amber or RED RAG rated.

Clinical Income: Clinical Income subject to the block agreement has not been allocated to the divisions and therefore the divisional positions do not reflect the value of work done. The Clinical Income Block is reflected in 'Other'

Medicine:
Net deficit of £102.8m, £1.7m favourable against plan. The delayed opening of the New Ward block has contributed a savings of £0.7m, with savings across Non Pay of £1.3m predominantly as a result of the reduced levels of activity. Drugs is adverse to plan for the period due to the use of the drug Ivacafator for CF patients.

Emergency
Net deficit of £14.1m, £0.7m favourable against plan. The main driver behind the favourable position being reduced pay spend due to reduced activity levels early in year followed by shortages of available locum and agency staff in the latter half of the first six months.

Surgery
Net deficit of £68.9m, £4.7m favourable against plan. Reduced activity during the period has impacted clinical supplies usage seeing a favourable position of £4.2m v plan

Women's & Children's
Net deficit of £25.9m, £0.3m favourable against plan. Small savings across Pay & Non Pay off set by additional drugs costs through use of the Ivacafator Drug

Clinical Support
Net deficit of £43.6m, £2.6m favourable against plan. Reduced activity during the period has impacted clinical supplies usage seeing a favourable position of £2.2m.

Corporate
Net deficit of 46.8m, £0.6m favourable against plan. The main driver being PFI, utilities & rates savings through the delayed openings of the New Ward Block and IRU.

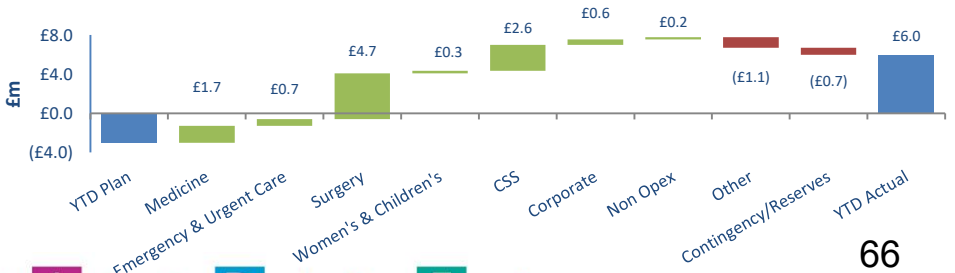
Divisional Performance YTD Sep-2020	Medicine		Emergency & Urgent Care		Surgery		Women's & Children's		CSS		Corporate		Other		Total	
	Act. £m	Var. £m	Act. £m	Var. £m	Act. £m	Var. £m	Act. £m	Var. £m	Act. £m	Var. £m	Act. £m	Var. £m	Act. £m	Var. £m	Act. £m	Var. £m
Clinical Income	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	282.4	(0.2)	282.4	(0.2)
Other Income	1.2	(0.2)	0.1	0.1	2.6	0.1	0.4	0.0	6.1	0.1	2.9	0.2	61.1	(1.3)	74.4	(0.9)
Pay	(57.5)	0.9	(12.8)	0.5	(58.3)	0.3	(22.6)	0.4	(34.4)	0.3	(15.3)	(0.1)	(2.5)	0.5	#######	2.9
Non Pay	(15.3)	1.3	(1.3)	0.1	(9.3)	4.2	(1.5)	0.2	(14.3)	2.2	(34.3)	0.4	(10.2)	(0.5)	(86.2)	7.9
Net Drugs Cost	(31.2)	(0.4)	(0.2)	0.0	(3.8)	0.1	(2.2)	(0.4)	(1.0)	0.0	(0.0)	0.0	(0.4)	(0.3)	(38.8)	(0.8)
Non Opex	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	(22.3)	0.2	(22.3)	0.2
YTD Surplus /Deficit	(102.8)	1.7	(14.1)	0.7	(68.9)	4.7	(25.9)	0.3	(43.6)	2.6	(46.8)	0.6	308.1	(1.6)	6.0	9.0
FOT (M7-12)*	(105.5)	0.0	(14.7)	0.0	(71.4)	0.0	(26.9)	0.0	(45.6)	0.0	(47.0)	0.0	295.8	0.0	(15.4)	0.0
CIP	0.25	0.02	0.03	0.00	0.56	(0.07)	0.13	0.03	0.08	0.04	0.17	(0.06)	0.00	(0.03)	1.22	(0.07)
Inpatients**	36.4	(9.7)	0.0	(0.0)	11.8	(15.5)	8.3	(1.4)	0.0	(0.0)	-	-	-	-	56.5	(26.6)
Outpatients**	116.9	(18.9)	0.2	(0.1)	113.6	(82.2)	23.8	(6.0)	15.8	(11.1)	-	-	-	-	270.3	(118.6)
A&E**	-	-	61.9	(14.5)	-	-	-	-	-	-	-	-	-	-	61.9	(14.5)
CIP RAG																
FINANCE RAG***																
PAF RAG***																

Divisional FOT excludes Intervention 3&4 budget allocation

**Activity variance against 2019/20 actuals*

*** Prior Month PAF Rating*

Year to date Variance to Plan by Division



Norfolk and Norwich University Hospitals NHS Foundation Trust

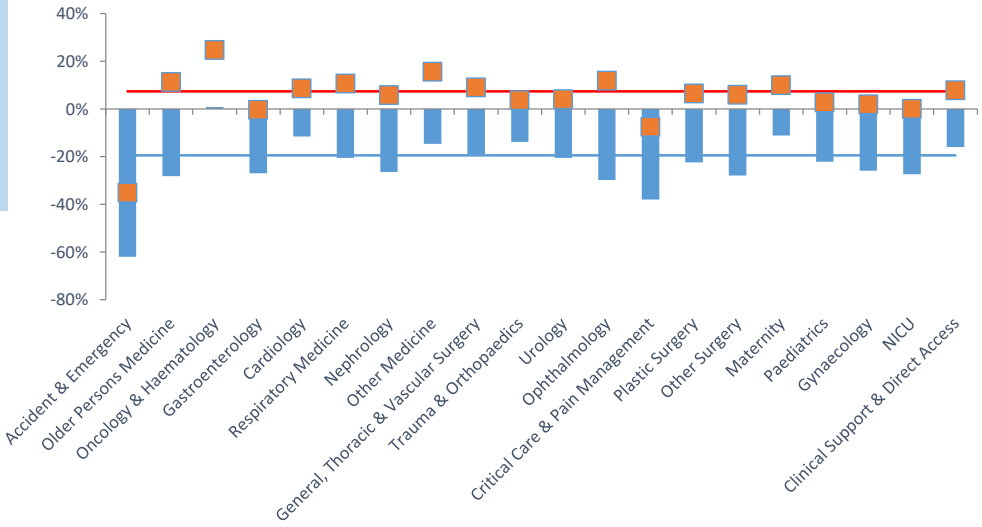
3.2 Divisional Performance - Service Line Reporting 2019/20

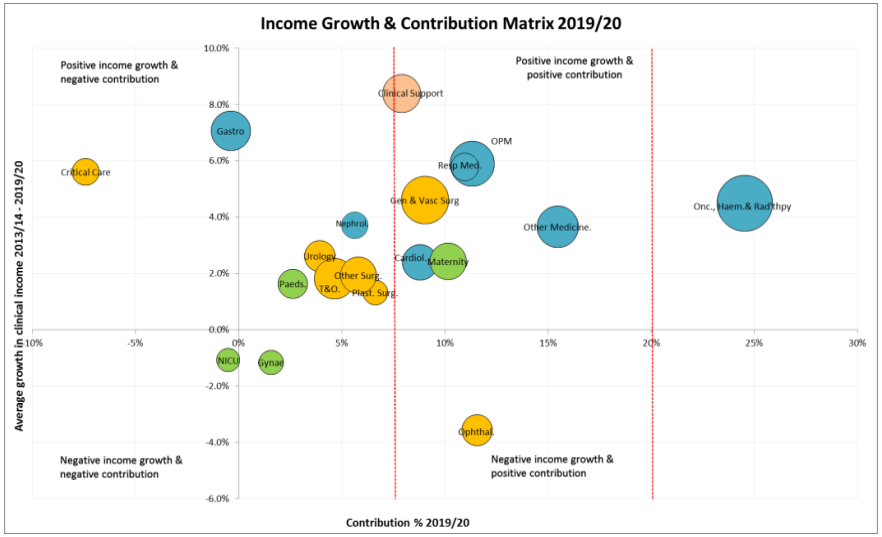
In 2019/20 the trust reported a £56.8 (12%) deficit with all divisions reporting a deficit. Medicine contributed the most with £22.7 (12%) but after allocation of overheads made a loss of £31.2m (17%). Emergency made a £7.3m (35%) negative contribution before allocation of overheads worsened the position to a deficit of £12.9m (62%).

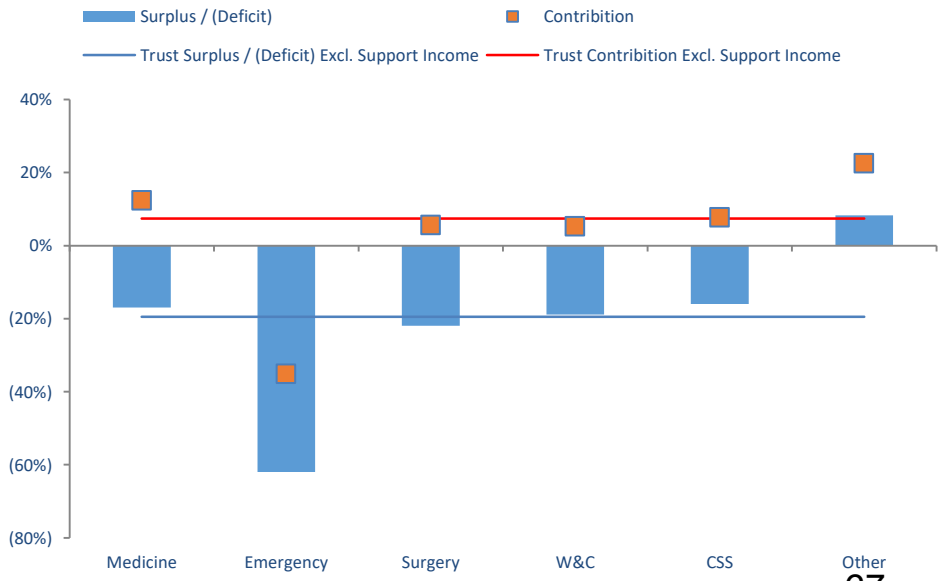
In SLR all costs are allocated to services, including overheads, which are generally around 20% of total costs. Non-overhead costs are more directly controllable, so looking at 'contribution' (income less controllable costs) can be a useful way to review performance. Contribution was **7%** in 2019/20 (before support income), some way short the 20% that needs to be achieved to break even financially.

In the graph to the right the largest directorates are shown individually, with the balance of the division as the final row for medicine & surgery.

The table below shows how the Trusts reported 2019/20 12% deficit was made up by Division using Service Line Reporting:







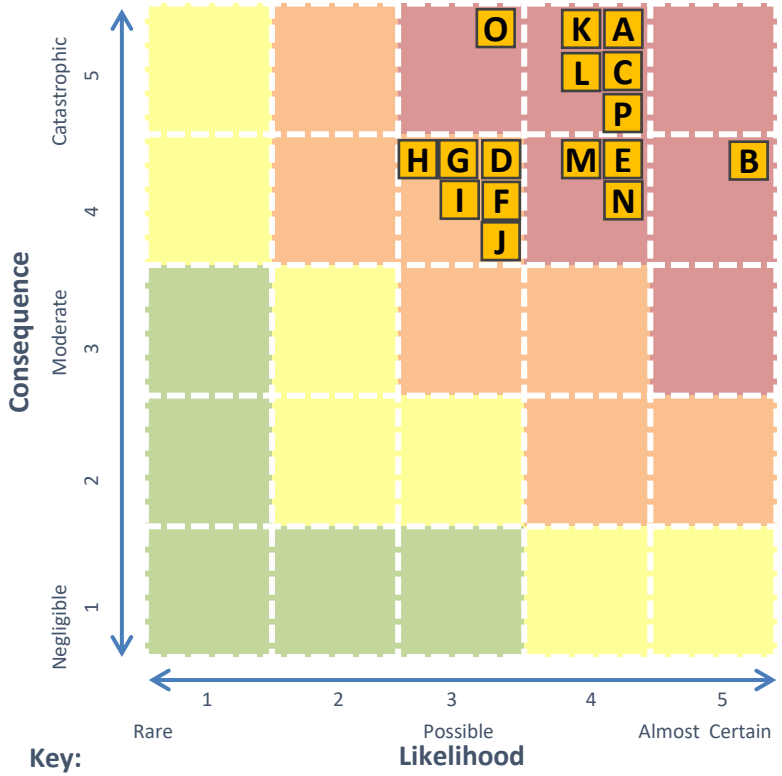
Norfolk and Norwich University Hospitals NHS Foundation Trust

4. Strategic Financial Risks

There are currently 16 risks on the strategic financial risk register of which 10 have a risk score greater or equal to 15 and thus have a red RAG rating. This in unchanged from the prior month.

The Trust has recently undertaken a formal review of the Financial Risk Register, refreshing all risks and adding new risks which have been identified across the finance function.

The Finance Risk Register currently consists of 31 risks, and all risks scoring 12 or greater are included as a Strategic Finance Risk within the table and grid below. No risks have changed risk score in the month.



Key:

X Worsening Risk X Stable Risk X Improving Risk

	Description	Risk Score	*Prior Month*
A	If the Trust does not have a detailed financial strategy in place to deliver financial sustainability then the Trust will fail to achieve its strategic and operational priorities.	20	*20*
B	If the efficiency requirement is not identified and delivered then the Trust is at risk of significantly failing its I&E and cash plans, alongside delivery of the Trust's Control Total.	20	*20*
C	If the trust fails to achieve the interventions reflected in the draft M5-M12 operating plan, then budget will not be achieved, distressed funding will be required and reputation will be damaged.	20	*20*
D	If the Trust fails to coordinate restoration plans in a collaborative and system wide approach, then there is a risk of failure to meet regulatory guidance and pose a risk to financial performance.	12	*12*
E	If coding staffing levels remain as they currently are there is a risk that national coding monthly deadlines (which drive clinical income and contractual processes) are not met or that the depth of coding is reduced, adversely impacting on future tariffs and mortality indicators.	16	*16*
F	If standards are not maintained in Trust wide processes to record all patient complexities, procedures and co-morbidities, then there is a risk that the full depth of coding is reduced. This can adversely impact on future tariffs; benchmarking data and mortality indicators.	12	*12*
G	If the Trust is unable to approve Consultant Job Plans, then this provides a risk of costs being in excess of planned levels.	12	*12*
H	If the Trust does not achieve its Control Total then it will lose any PSF/FRF funding available and this will result in Distress Funding being required.	12	*12*
I	If the Trust's capacity plan does not reflect the available clinical space, there is a risk that activity assumptions underpinning the FY20/21 plan are not valid, potentially leading to lower levels of income or higher levels of costs than planned through the use of expensive third party capacity, e.g. Spire, SBS.	12	*12*
J	If the Trust is unable to manage its financial performance in line with the Operational Plan, then there is a risk that it will be unable to maintain its planned cash balance and require Distress Funding.	12	*12*
K	IF the national standards require greater throughput of activity than in the Trusts indicative activity plan THEN the Trust will be unable to meet those standards.	20	*20*
L	IF the directorates do not control their establishment costs in line with the plan (including the reduction of COVID-19 absence), i.e. escalation into areas such as JPU THEN the Trust will be unable to meet a breakeven position.	20	*20*
M	IF the COVID-19 Capital applications are not approved by NHSE/I THEN the Trust will overshoot its Capital limit (CDEL) and programme by £2.6m if not mitigated.	16	*16*
N	IF the Trust deliver the budgetary plan THEN the Trust will have a cash shortfall.	16	*16*
O	IF the Trust delay recruitment of overseas nurses THEN the Trust may fail to meet Safer Staffing levels.	15	*15*
P	IF the directorates deliver the July 2020 planned activity over the remainder of the period with a fixed capacity THEN the Trust's waiting list will increase due to the continued loss of productivity.	20	*20*

Norfolk and Norwich University Hospitals NHS Foundation Trust

5. Cash

The cash funds at 30 September are £74.7m reflecting the one month in advance funding arrangements. This is assumed to unwind in March 2021 exposing a need for distressed funding support of c. £10.8m. This aligns to the operational plan. The twelve month forecast based on the underlying deficit of £114.4m full year means that - unmitigated – the Trust will need additional distressed PDC funding of £67m in the period to 30 September 2021

Cash Financial Arrangements - financial envelope for months 7-12 2020/21 confirmed by NHSE/I on 15 September 2020.

This is system based, designed to fund achievement of Phase 3 goals and provide resource to meet additional costs of COVID-19 response and recovery - excluding testing costs. It is expected that the system will achieve financial balance within its allocated envelope. There will be no retrospective top up.
The Trust's revised 'block' and top up is £53.9m per month. The allocation of COVID-19 funding within the envelope to the Trust is £18.8m consistent with our budget.
The Trust Phase 3 operational plan for the six months to 31 March 2021 shows a net deficit of £15.4m, excluding fines for elective performance. If no further funding is forthcoming this will mean that we will need cash support in Q4, forecast at c. £10.8m

Month 6 cash position
The closing balance at 30 September is £74.7m, reflecting the one month in advance block and-top up funding and timing differences in working capital and capital expenditure.

Cash Flow Forecast

Operational - The Trust's cash flow forecast reflects the revised block and top-up cash amounts and assumes it continues to be received one month in advance until 28th February 2021, thus unwinding in March 2021. There is therefore no expected cash requirement in the short-term. Cash support at 31 march forecast to be £10.8m

The rolling twelve month forecast to 30 September 2021, based on the underlying deficit position of £114.4m full year, shows a cash balance of the minimum allowed of £1m. This forecast assumes receipt of distressed funding for that additional six month period of £67m.

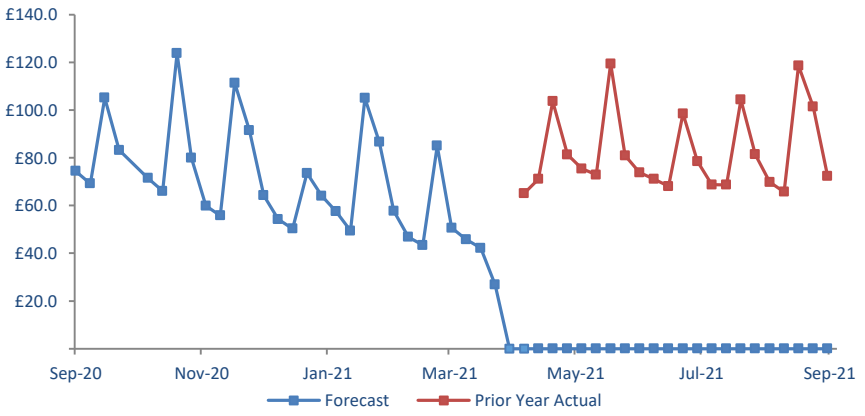
Capital - The Trusts approved capital plan includes identified funding streams for all expenditure. The receipt of the funding is subject to a national process which to date has been slow, in turn our expenditure plan has been delayed in order to prevent cash pressures and risk. Therefore the cash flow forecast for capital expenditure and associated funding is based on best understanding on the timing of funding approvals. Accordingly this may change, however it should not impact the cash flow overall as expenditure can be managed to align with funding.

Note: The Nationally directed 'Debt / PDC 'swap' was transacted on 9 September 2020. £195.1m of NHS borrowings on our balance sheet were 'repaid' and replaced with £195.1m of PDC – quasi' Capital Debt'.

Aged Debt:
Debtors at September 2020 is £9.54m, of which £5.82m is over 90 days. Of the NHS debt greater than 90 days, £0.78m is JPUH, down from £1.07m the prior month. Of the Non NHS debt greater than 90 days £2.12m relates to TPW, £0.54m relates to Big C and £0.85 relates to private/overseas patients. The trust continues to focus on resolving these debts.

Debtors by Type	Total Debt			Debt > 90 days		
	Jul-20 £m	Aug-20 £m	Sep-20 £m	Jul-20 £m	Aug-20 £m	Sep-20 £m
NHS	5.41	4.51	4.06	3.48	1.96	1.44
Non NHS	5.97	6.05	5.48	4.94	4.79	4.38
Total	11.38	10.56	9.54	8.42	6.75	5.82

Weekly Closing Cash Forecast (£m) as at 9th September 2020



Norfolk and Norwich University Hospitals NHS Foundation Trust

6.1 Activity (Income PbR)

Year to date activity for both inpatients and outpatients is c. 70% 2019/20 levels.
Activity across all points of delivery is showing signs of returning to pre-COVID levels with a much improved performance in September. Surgical Division in particular has seen increased levels of activity in September, compared to previous months. Increased efforts will still be needed if the Trust is to meet the Phase III NHSE requirements from October onwards and avoid financial penalty through the Elective Incentive Scheme

In response to the COVID-19 pandemic, clinical income was set nationally. For the first four months of FY20/21 (April to July), a monthly block payment of £47.1m has been provided to the Trust, with a further top-up payment of £6.4m also being made. This block payment was rolled forward into months 5 and 6 as a result of revised guidance.

As a result of the Phase III of COVID-19 recovery planning guidance, it has been confirmed that block payments will continue, however, activity expectations have been set by NHSE/I. Where these expectations are not met, at a Norfolk & Waveney Health and Care System level, the Trust will face potential financial penalties. Conversely, additional income is available for systems which deliver in excess of the prescribed activity levels

Performance v 2020/21 Plan

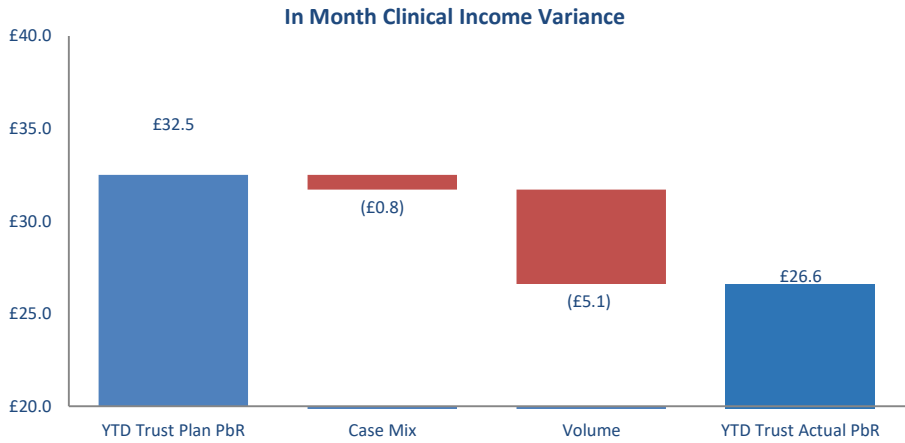
Despite being block funded, full contract monitoring processing and reporting is still being completed so that true levels of activity, and income can be derived – i.e. had the Trust been paid on a Payment by Results (PbR) basis.

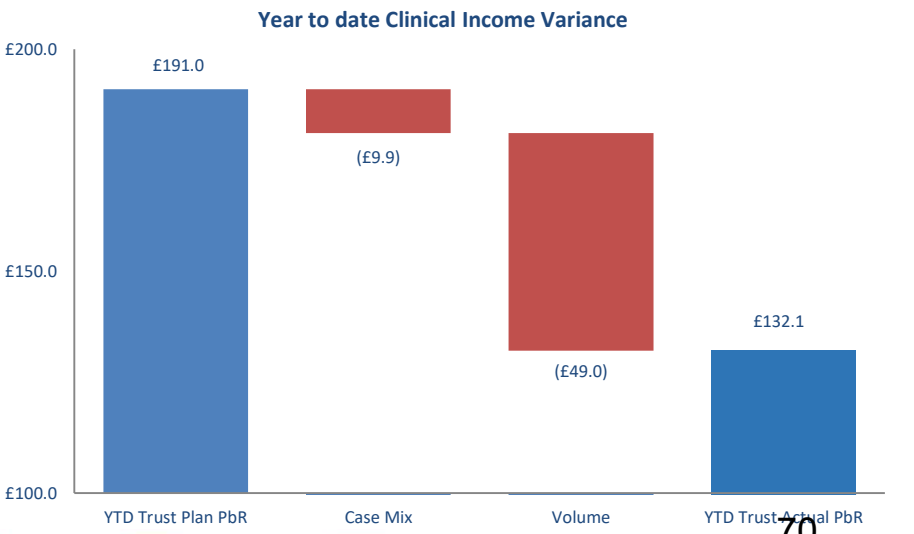
The charts to the right show September and Year to Date Income variances against 2020/21 plan bridged by case mix and volume. Both graphs show the significant effect the COVID pandemics has had on activity levels.

When looking at comparisons between actual income on a PbR basis and the draft annual plan it is also noticeable that the impact has been felt more on activity commissioned by Clinical Commissioning Groups (CCGs) that it has for NHSE Specialised.

It should be made clear that the actual performance does not include activity that has been transferred to the independent sector as part of the national agreement between independent providers and NHSE.

Elective Incentive Scheme
In the absence of a financial baseline being published by NHSE, full clarity cannot yet been given on possible financial impact of this scheme. The Trusts; interpretation of the guidance suggest a total impact of £2m, with an estimate for September of £0.3m.





Norfolk and Norwich University Hospitals NHS Foundation Trust

6.2 Activity - POD

Elective, incl. Day Cases

Day Case and Elective inpatient activity has been impacted by the Covid pandemic, but recent months have seen activity levels increase significantly to those seen in the early part of the financial year. Medical Specialties have been able to increase activity and exceed the Trust's Phase 2 trajectory much more than other Divisions, although performance improved in September across all Divisions. The NHSE Phase 3 requirements look to have been met for September (80% of 2019/20 levels), but the targets increase from here onwards (90% of 2019/20 levels). The Elective Incentive Scheme is however calculated on financial value, and therefore much is dependant on case-mix. Bowel Screening activity is not included in the chart opposite but is part of the activity count by NHSE.

Non Elective

Non Elective activity significantly reduced as a consequence of the Covid pandemic, but activity has been on an upward trend month on month since April 2020, with September 2020 activity being almost 90% of September 2019 levels, albeit with a differing number of working days.

Medical Specialties overall have seen activity levels revert back to 2019/20 levels since April, whereas Surgical Specialties have seen activity drop to less than 60% of 2019/20 levels each and every month. Women and Children Specialties have also seen activity levels in 2020/21 that are not dissimilar to those in 2019/20. No formal expectations or requirements have been set by NHSE for Non Elective activity, the Trust did set out its own trajectory as part of the Phase 2 planning round.

Outpatients

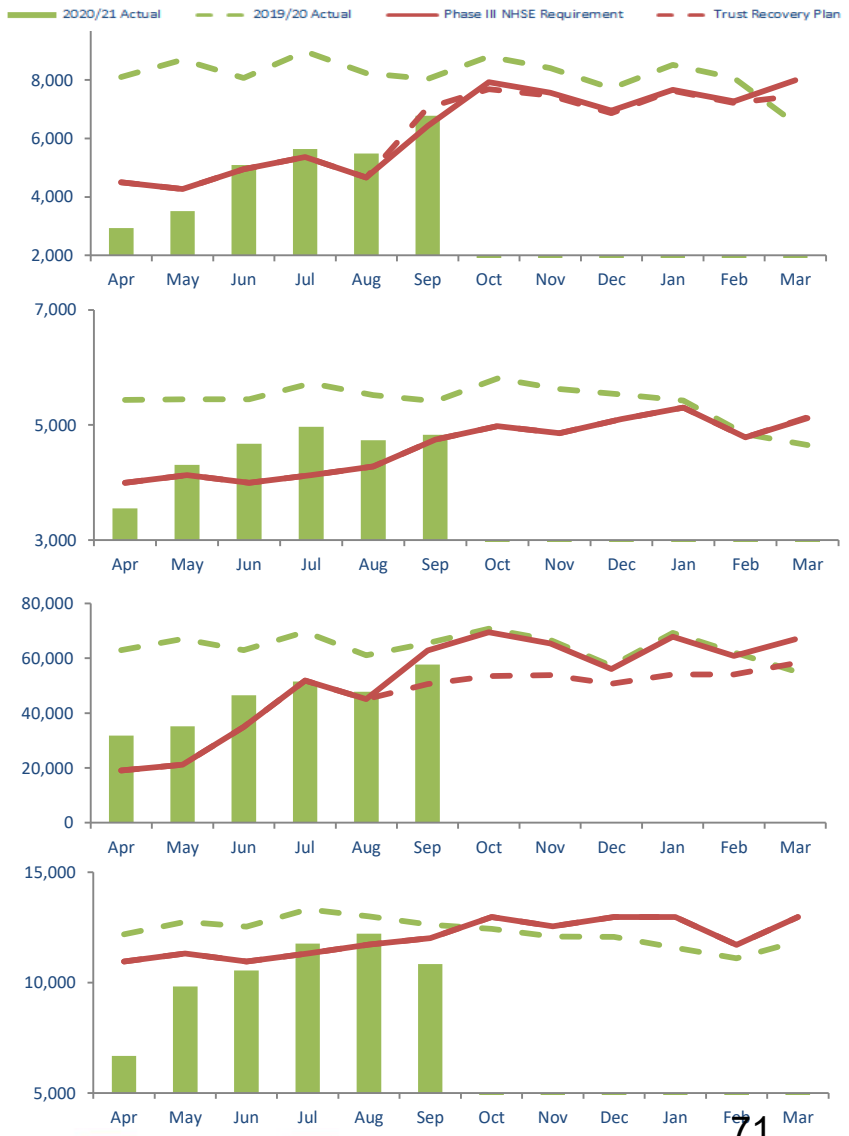
The NHSE Phase 3 requirements are essentially for all outpatient activity to return to 100% of levels seen in 2019/20, the exception being activity where a procedure takes place where the expectation is 80% of 2019/20 levels in September and 90% for the remainder of the financial year.

Despite the procedure target being lower this is the target proving more difficult to achieve (September 73%), partly as a result of implications of Covid. The non-procedure activity requirements can be met using either face to face, or non face to face methods, with a significant change in case-mix to more non face to face activity being evident. Whilst good progress has been made indications are that activity levels in September will not meet the targets (New 79% and Follow Up 97%).

A&E Attendances

As with Non Elective activity no formal expectations or requirements have been set by NHSE as part of the Phase 3 planning, the Trust did however create a trajectory for the Phase 2 planning round.

Attendances in April were only 53% of April 2019 activity levels, but had been on an upward trend since and had been above the Trust's Phase 2 trajectory. However, activity in September has taken a noticeable drop, being some 1,380 attendances less than that seen in August 2020, and nearly 1,200 attendances less than September 2019.



Norfolk and Norwich University Hospitals NHS Foundation Trust

7. CIP

The trust has delivered £1.2m of CIPs against a FIP board approved plan of £1.3m, an under-performance of £0.1m due to adverse performance of pay schemes. The risk adjusted forecast outturn CIP delivery is currently £3.5m against a CIP target of £11.3m presenting a significant risk to achievement of the target.

FY20/21 Year to date CIP Performance:

The Trust has delivered £1.2m of CIPs against a FIP Board approved plan of £1.3m, an under-performance of £0.1m arising through adverse performance in temporary spend or planned vacancy schemes not progressing as planned.

The risk adjusted forecast outturn CIP delivery for FY20/21 is currently calculated as £3.5m based on the latest forecast financial performance of Gateway 2 schemes, progress against milestone delivery and performance against quality and performance indicators.

FY20/21 CIP Plan Development

The programme has been reinitiated through the reconstituted Financial Improvement and Productivity (FIP) Board with a confirmed CIP challenge of £11.3m.

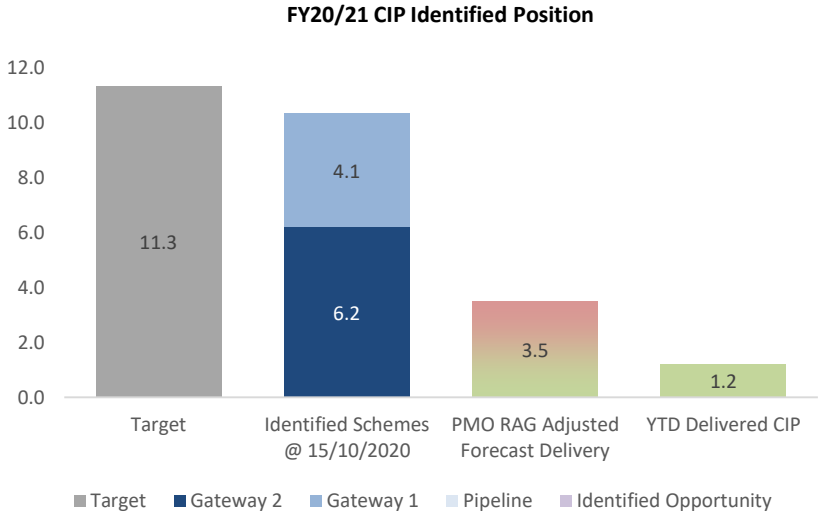
Due to the significant risk surrounding the CIP Programme as the Trust continues to develop plans as part of Phase III restoration, alongside a lack of detailed approved schemes, a contingency of £10.9m has been offset against the programme within the Operational Plan.

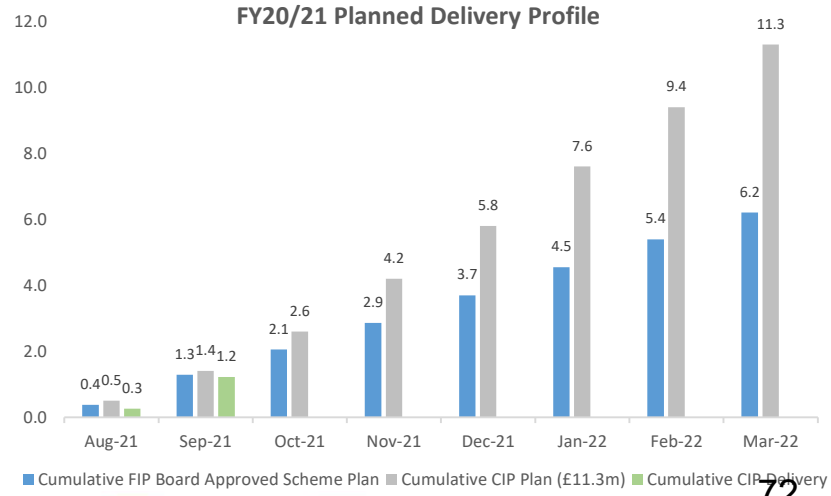
As at 15 October 2020, the programme consists of £6.2m of Gateway 2 approved schemes (of which £0.4m is contractually guaranteed), £4.1m of Gateway 1 approved schemes and £1.0m of unidentified schemes.

The initiatives that comprise these values are subject to revision as a result of any revisions to COVID-19 restoration planning guidance.

Note: The plan submitted to the STP & NHSEI includes £5.3m Non Recurrent included within Intervention 2 of the Trust plan

FY20/21 CIP Plan - Divisional Breakdown	FY20/21 Indicative Target £m	FY20/21 FIP Board Approved £m	Gap £m	FY20/21 RAG Adj. Forecast Delivery £m	Gap £m
Medicine	3.1	1.5	(1.6)	0.9	(2.2)
Emergency & Urgent Care	0.2	0.1	(0.1)	0.1	(0.1)
Surgery	3.3	3.3	0.0	1.8	(1.5)
Women's & Children's	1.2	0.5	(0.7)	0.3	(0.9)
CSS	1.8	0.3	(1.5)	0.2	(1.6)
Corporate	1.8	0.5	(1.3)	0.2	(1.6)
Total	11.3	6.2	(5.1)	3.5	(7.8)





8.1 Capital

Norfolk and Norwich University Hospitals NHS Foundation Trust

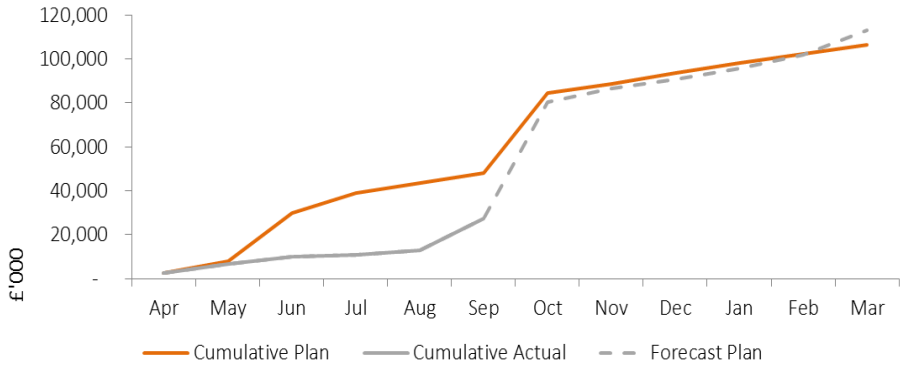
Introduction and Background

This report provides an update on the delivery of the Trust's capital plan as at Month 6.

The Trust currently has two Capital Programmes, Plan A reflecting the submission to NHSE/I in May 2020 which includes both the ward block buy out and capitalisation of the finance lease and Plan B which represents a revised plan should the Trust secure the ward block buy out funding releasing £11.7m which could be utilised to deliver additional capital projects. Appendix One provides details of the Plans at a summary level.

This report monitors the Trust's performance against the NHSE/I Plan.

M6 Plan £'000	M6 Actual £'000	Variance £'000	Year to date Plan £'000	Year to date Actual £'000	Year to date Variance £'000	Annual Plan £'000	FOT £'000	Variance £'000
4,407	14,287	9,880	47,900	27,306	(20,594)	106,417	113,019	6,602



Year to date performance – Month 6

Adverse variance to NHSE/I Plan of £20.6m Year to date.

Key driver of the Year to date variance is the New Ward Block (NWB) buyout of £15.7m, the funding for which has not yet been formally approved.

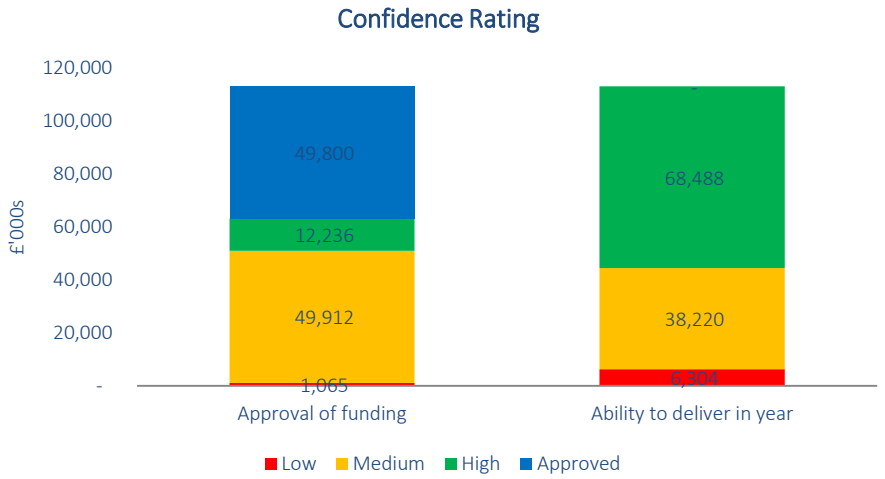
Forecast Outturn:

The Trust is forecasting an overspend to agreed Plan of £6.6m. This reflects additional funding awarded since the Plan was submitted on 29 May 2020. A breakdown of this funding is shown in Appendix 2. Funding will be provided via PDC and a corresponding adjustment made to the Trust's CDEL.

Confidence rating for delivery of the Trust's Plan - the chart to the right provides detail of ratings by value across two domains:

- An assessment based on approval of funding
- An assessment based on the ability to deliver the projects.

The two are inextricably linked as delays in the approval process or non-approval of funding will impact on the Trust to deliver its financial plan.



Each scheme within the Plan has been reviewed and an assessment made. Overall, the Trust has high confidence of £68.5.m (61%) of the forecast plan as being deliverable. This includes £31.8m (28% of Plan value) of spend related to PFI lifecycle capitalisation. However, as noted above, deliverability is linked to the timing of funding approvals. Delays in approvals could result in slippage to the Plan.

A further key issue to note is that the buyout of the Ward Block (£15.8m) has been assessed as medium confidence for both approval of funding and ability to deliver the Plan whilst an approval decision is awaited.

Key risks to delivery of the Capital Plan are detailed on Page 4 of this report.

8.2 Capital

Norfolk and Norwich University Hospitals NHS Foundation Trust

Key risks to delivery

The Table below identifies key risks to the delivery of the 2020/21 Capital Plan and planned actions and mitigations to against these risks. As reflected throughout this report and in the table below, the timing of approval of funding is critical to the Trust being able to deliver its Plan for the year.

Key Risks	Actions	Owner/Date	Link to Strategic Risk Register
Funding approvals: as at month 6, only £48.7m of the Plan funding has been approved with approvals for major areas of spend including STP funding of (£27.0m) and the Ward Block Buy-Out (£15.7m) with NHSE/I for approval. Delays in approval may result in in slippage to delivery of the Plan.	• Application for STP funding is pending NHSE/I approval. • Application for Critical Care Resilience Funding (Ward Block) is pending NHSE/I approval • All queries on the Trust's application are responded to within 24 hours.	Chief Finance Officer On-going	M - If pending capital applications are not approved by NHSE/I THEN the Trust will overshoot its Capital limit (CDEL) and programme by £2.6m if not mitigated.
Potential breach of CDEL: If the Trust's application for Critical Care resilience funding to buyout the Ward Block is unsuccessful it is at risk of breaching its allocated CDEL. Further, it will not be able to deliver its Plan B capital plan as it will be unable to repurpose the £11.7m of capital funds currently allocated against financing the ward block lease. This will result in urgent and emergency capital schemes being either cancelled or deferred.	• Application for New Ward Block Buyout (£15.7m) is pending NHSE/I approval. • No spend on capital schemes in advance of funding being approved. • There will be a further iteration of the capital plan dependent upon the outcome of the funding application to ensure compliance with CDEL limits. Any future version of the Capital Plan will be subject to Board approval.	Chief Finance Officer On-going	M - If pending capital applications are not approved by NHSE/I THEN the Trust will overshoot its Capital limit (CDEL) and programme by £2.6m if not mitigated.
Plan profile: Excluding Year to date spend of £27.3m and lifecycle costs of £31.7m, due to be paid in October 2020, £45.0m (83%) of the remaining £54.0m Capital Plan is profiled to be delivered in Q4. The profile of the Plan may result in lack of resource (people/equipment) to deliver projects.	• Where required, business cases are in the process of going through the approvals process to ensure implementation can commence on approval of funding. • Resource requirements (people and equipment) have been identified as part of the business case development process and will be reviewed as funding is approved. • Monthly reviews of capital programme to identify issues with deliverability of projects and escalate as required.	Director of Strategy Monthly	M - If pending capital applications are not approved by NHSE/I THEN the Trust will overshoot its Capital limit (CDEL) and programme by £2.6m if not mitigated.

Norfolk and Norwich University Hospitals NHS Foundation Trust

9.1 Statement of Comprehensive Income

The Reported Position for September 2020 is breakeven (Year to date breakeven). This consists of a £0.3m (Year to date £6.0m) operating surplus before COVID, COVID costs of £1.4m (Year to date £15.8m) and top income of £1.1m (Year to date £9.8m). The £0.3m (Year to date £6.0m) operating surplus before COVID expenditure and top up income is £0.3m (Year to date £9.0m) favourable against the planned breakeven position. Plan & forecast outturn for October 2020 – March 2021 is a deficit of £15.4m

Month 06 (Sep-2020)	In Month Month 06 - September 2020			Apr 2020 - September 2020			October 2020 - March 2021 October 2020 - to Date			Year to Date			Forecast Outturn October 2020 - March 2021		
	Actual £m	Trust Plan £m	Variance £m	Actual £m	Trust Plan £m	Variance £m	Actual £m	Trust Plan £m	Variance £m	Actual £m	Trust Plan £m	Variance £m	FOT £m	Trust Plan £m	Variance £m
Clinical Income	47.1	47.3	(0.2)	282.4	282.7	(0.2)			0.0	282.4	282.7	(0.2)	278.1	278.1	0.0
NT Drugs Income	(0.4)	0.0	(0.4)	(0.4)	0.0	(0.4)			0.0	(0.4)	0.0	(0.4)	3.8	3.8	0.0
Total Clinical Income	**46.7**	**47.3**	**(0.6)**	**282.0**	**282.7**	**(0.6)**	**0.0**	**0.0**	**0.0**	**282.0**	**282.7**	**(0.6)**	**281.8**	**281.8**	**0.0**
Other Income Incl. Non NHS Clinical Income	13.1	12.8	0.2	74.4	75.3	(0.9)			0.0	74.4	75.3	(0.9)	85.0	85.0	0.0
Total Operating Income	**60**	**60**	**(0)**	**356.4**	**358.0**	**(1.6)**	**0.0**	**0.0**	**0.0**	**356.4**	**358.0**	**(1.6)**	**366.9**	**366.9**	**0.0**
Medical Staff	(10.9)	(11.5)	0.6	(64.4)	(64.9)	0.5			0.0	(64.4)	(64.9)	0.5	(65.9)	(65.9)	0.0
Nursing	(12.7)	(13.7)	1.0	(77.6)	(81.0)	3.4			0.0	(77.6)	(81.0)	3.4	(82.1)	(82.1)	0.0
A&C	(3.9)	(4.0)	0.1	(23.9)	(24.1)	0.2			0.0	(23.9)	(24.1)	0.2	(24.2)	(24.2)	0.0
Other Staffing Groups	(6.1)	(6.2)	0.1	(36.2)	(36.8)	0.6			0.0	(36.2)	(36.8)	0.6	(37.2)	(37.2)	0.0
Other Employee Expenses	0.7	0.3	0.3	(1.8)	(0.0)	(1.8)			0.0	(1.8)	(0.0)	(1.8)	(3.1)	(3.1)	0.0
Total Employee Expenses	**(33.0)**	**(35.1)**	**2.1**	**(203.8)**	**(206.4)**	**2.9**	**0.0**	**0.0**	**0.0**	**(203.8)**	**(206.4)**	**2.9**	**(212.4)**	**(212.4)**	**0.0**
Drugs Costs	(6.7)	(6.3)	(0.5)	(38.4)	(38.0)	(0.4)			0.0	(38.4)	(38.0)	(0.4)	(42.8)	(42.8)	0.0
Clinical Supplies	(5.1)	(5.3)	0.3	(29.3)	(35.3)	6.0			0.0	(29.3)	(35.3)	6.0	(41.4)	(41.4)	0.0
Non Clinical Supplies	(8.6)	(7.4)	(1.2)	(44.0)	(44.9)	1.0			0.0	(44.0)	(44.9)	1.0	(46.8)	(46.8)	0.0
PFI	(2.1)	(2.2)	0.1	(12.6)	(13.5)	0.9			0.0	(12.6)	(13.5)	0.9	(13.4)	(13.4)	0.0
Total Expenditure Excl. Employee Expenses	**(22.5)**	**(21.2)**	**(1.3)**	**(124.3)**	**(131.8)**	**7.4**	**0.0**	**0.0**	**0.0**	**(124.3)**	**(131.8)**	**7.4**	**(144.4)**	**(144.4)**	**0.0**
Total Operating Expenditure	**(55.5)**	**(56.3)**	**0.8**	**(328.2)**	**(338.2)**	**10.3**	**0.0**	**0.0**	**0.0**	**(328.2)**	**(338.2)**	**10.3**	**(356.8)**	**(356.8)**	**0.0**
Total Operating Surplus/(Deficit)	**4.3**	**3.8**	**0.4**	**28.3**	**19.8**	**8.8**	**0.0**	**0.0**	**0.0**	**28.3**	**19.8**	**8.8**	**10.0**	**10.0**	**0.0**
Total Non Operating Expenditure	(4.0)	(3.9)	(0.1)	(22.9)	(23.0)	0.1			0.0	(22.9)	(23.0)	0.1	(25.9)	(25.9)	0.0
Total Surplus/(Deficit)	**0.2**	**(0.1)**	**0.3**	**5.4**	**(3.2)**	**8.9**	**0.0**	**0.0**	**0.0**	**5.4**	**(3.2)**	**8.9**	**(15.9)**	**(15.9)**	**0.0**
Control Total Adjustments															
Donated Assets Dep'n	0.1	0.1	0.0	0.6	0.5	0.1			0.0	0.6	0.5	0.1	0.5	0.5	0.0
Control Total	**0.3**	**0.0**	**0.3**	**6.0**	**(2.7)**	**9.0**	**0.0**	**0.0**	**0.0**	**6.0**	**(2.7)**	**9.0**	**(15.4)**	**(15.4)**	**0.0**
COVID Expenditure	(1.4)			(15.8)						(15.8)			(31.3)	(31.3)	0.0
Top Up Payment (to Breakeven)	1.1			9.8						9.8			31.3	31.3	0.0
Net Surplus / (Deficit) (Excl. COVID)	**(0.0)**			**0.0**			**0.0**	**0.0**	**0.0**	**0.0**			**(15.4)**	**(15.4)**	**0.0**

Norfolk and Norwich University Hospitals NHS Foundation Trust

9.2 Pay Expenditure

Year to date Pay expenditure is £203.5m, a favourable position to plan of £2.9m. This is part due to the delayed openings of the New Ward Block and IRU contributing c. £1.2m. Emergency are £0.5m favourable due to reduced activity levels early in year followed by shortages of available locum and agency staff in the latter half of the first six months.

Pay Expenditure	Apr-20 £m	May-20 £m	Jun-20 £m	Jul-20 £m	Aug-20 £m	Sep-20 £m	Oct-20 £m	Nov-20 £m	Dec-20 £m	Jan-21 £m	Feb-21 £m	Mar-21 £m
Substantive staff	**30.1**	**30.5**	**30.4**	**30.0**	**30.5**	**30.6**						
Medical External Locum Staff	0.1	0.2	0.4	0.3	0.3	0.2						
Medical Internal Locum Staff	0.6	0.7	0.7	0.6	0.6	0.6						
Additional Medical Sessions	0.2	0.2	0.1	0.3	0.1	0.2						
Nursing Agency Staff	0.2	0.2	0.1	0.1	0.2	0.2						
Nursing Bank Staff	1.2	1.3	1.2	1.2	1.2	1.2						
Other Agency (AHPs/A&C)	0.2	0.2	0.4	0.3	0.3	0.3						
Other Bank (AHPs/A&C)	0.2	0.2	0.2	0.2	0.2	0.2						
Overtime	0.6	0.5	0.5	0.3	0.3	0.3						
Premium Pay	**3.3**	**3.5**	**3.5**	**3.2**	**3.1**	**3.0**						
Total Direct Pay Costs	**33.4**	**34.1**	**33.9**	**33.2**	**33.6**	**33.6**						
Redundancy	0.0	0.0	0.0	0.1	0.0	0.0						
Apprenticeship Levy	0.1	0.1	0.1	0.1	0.1	0.1						
Local CEA	0.1	0.1	0.1	0.1	0.1	0.1						
Central provision	0.0	0.0	0.4	0.0	0.7	(0.9)						
Total Other Pay Costs	**0.2**	**0.2**	**0.6**	**0.3**	**1.0**	**(0.7)**						
Total Pay Costs Excl COVID - Actual	**33.6**	**34.3**	**34.6**	**33.6**	**34.6**	**33.0**						
Total Pay Costs Excl COVID - Plan	**33.9**	**34.0**	**34.2**	**34.4**	**34.9**	**35.1**						
Favourable / (Adverse) v Plan	**0.3**	**(0.4)**	**(0.3)**	**0.8**	**0.3**	**2.1**						

Substantive WTE	Apr-20 WTE	May-20 WTE	Jun-20 WTE	Jul-20 WTE	Aug-20 WTE	Sep-20 WTE	Oct-20 WTE	Nov-20 WTE	Dec-20 WTE	Jan-21 WTE	Feb-21 WTE	Mar-21 WTE
A&C	1,574	1,577	1,583	1,578	1,578	1,598						
Medical	1,074	1,115	1,108	1,097	1,226	1,164						
Nursing	3,456	3,544	3,499	3,521	3,547	3,559						
Other	1,664	1,656	1,656	1,665	1,665	1,689						
Total	**7,768**	**7,891**	**7,846**	**7,862**	**8,016**	**8,010**	**0**	**0**	**0**	**0**	**0**	**0**

Norfolk and Norwich University Hospitals NHS Foundation Trust

9.3 Statement of Financial Position

Property, plant and equipment
The key items are capital expenditure of £20.1m offset in part by depreciation of £7.2m.

Trade and Other Receivables – non current
This balance is £3.5m higher than the opening balance, with the key item being an increase in PFI lifecycle maintenance prepayment.

Inventories
Inventories are £0.5m lower than the opening balance, relating to pharmacy stock.

Trade and Other Receivables - current
This balance is £10.0m lower than the opening balance. Debt being settled and not reinstated due to block contract.

Cash
Cash is £61.3m higher than the opening balance. The key reason is the payment of two months of clinical income & top-up income in April – this totals £53.4m. This is expected to reverse in March, however, guidance is pending which will clarify this.

Trade and other payables
This is £6.0m higher than the opening balance. The opening balance was abnormally low because an extra payment run was made to suppliers at the end of 2019/20 due to COVID and the Octagon payment was made in advance offset in part by high capital accruals. Since then the capital accruals have been largely settled and the Octagon payment has unwound and is accrued as normal at end September. The closing balance reflects the above.

Borrowings
The £195.1m decrease in current borrowings relates to a debt to equity switch detailed in the PDC section below. The £8.9m increase in non-current borrowings compared to the opening balance is the recognition of the new ward block lease, offset in part by repayments relating to the PFI contract and Fuji PACS finance lease.

Deferred Income
This balance is £52.5m higher than the opening balance. The key item is the deferral of the receipt of October's clinical income & top-up income of £53.4m received in September.

Public Dividend Capital (PDC)
This balance is £202.4m higher than the opening balance. The key item is the receipt of £195.1m of funding to repay DHSC revenue and capital borrowings as part of a mandated debt to equity switch.

September 2020	Actual Mar-20 £m	Actual Sep-20 £m	Movement £m	Prior Month £m
Property, plant and equipment	268.1	288.2	20.1	275.3
Trade and other receivables	84.0	87.5	3.5	86.9
Total non-current assets	**352.1**	**375.7**	**23.6**	**362.2**
Inventories	11.9	11.4	(0.5)	11.6
Trade and other receivables	36.4	26.4	(10.0)	29.8
cash and cash equivalents	13.4	74.7	61.3	72.3
Total Current assets	**61.6**	**112.5**	**50.9**	**113.7**
Trade and other payables	(73.0)	(79.0)	(6.0)	(76.7)
Borrowing repayable within 1 year	(195.1)	0.0	195.1	(195.1)
Provisions	(0.3)	(0.8)	(0.5)	(0.3)
Deferred Income	(14.6)	(67.1)	(52.5)	(67.6)
Total current liabilities	**(283.0)**	**(146.9)**	**136.1**	**(339.8)**
Total assets less current liabilities	**130.8**	**341.3**	**210.5**	**136.0**
Borrowings - PFI & Finance Lease	(187.4)	(196.3)	(8.9)	(186.0)
Borrowings - Revenue Support	0.0	0.0	0.0	0.0
Borrowings - Capital Support	0.0	0.0	0.0	0.0
Provisions	(4.7)	(4.5)	0.2	(4.5)
Deferred Income	(3.5)	(3.5)	0.0	(3.5)
Total non-current liabilities	**(195.6)**	**(204.3)**	**(8.7)**	**(194.1)**
Total assets employed	**(64.8)**	**137.0**	**201.8**	**(58.0)**
Financed by				
Public dividend capital	38.4	240.8	202.4	45.7
Retained Earnings (Accumulated Losses)	(128.6)	(129.0)	(0.4)	(129.0)
Revaluation reserve	25.3	25.2	(0.1)	25.2
Total Taxpayers' and others' equity	**(64.8)**	**137.0**	**201.8**	**(58.0)**

REPORT TO THE TRUST BOARD

Date	**4 November 2020**
Title	**Chair's Key Issues from People and Culture Committee Meeting on 26.10.20**
Lead	**Professor David Richardson (Committee Chair)**
Purpose	**For Information and assurance**

1 Background/Context

The People and Culture Committee held its latest meeting on 26 October 2020. Papers for the meeting were circulated to Board members for information in the usual way. The meeting was quorate and was held via MS Teams. It was attended by Diane DeBell (Public Governor) as observer. Due to the Covid 19 pandemic, the meeting was not preceded by clinical/departmental visits.

2 Key Issues/Risks/Actions

The following items were identified to highlight to the Board:

- The Committee was informed that there are difficulties in identifying appropriate space in which training can take place – due to the requirements of social distancing and as previous locations have been repurposed for operational purposes. This is having an impact on delivery of some mandatory training and courses that are not amenable to delivery on-line.

Other items of note considered at the meeting included:

Items received for information and assurance:		
1	Workforce IPR	The Committee discussed the difficulties with gaining assurance around some metrics due to the unusual situation this year. Executives were asked to identify areas of the greatest concern. The Committee was advised that there are vulnerabilities with regard to areas in which there are limited numbers of key staff with particular skill sets. It is also a challenge to motivate and promote resilience in the staff body suffering from fatigue. Some staff in certain specialities have been under particular pressure due to efforts at service restoration between the two waves. These risks have been incorporated into our plans for the second wave but this remains a matter of concern.
2	Medical Engagement Survey Update	There are signs of improvement in the medical engagement follow-up survey and divisional action plans are in development. The results of the survey have not identified any unexpected issues and consideration is being given as to the frequency with which repeating the survey is helpful. There is a risk of 'survey fatigue' and it is important to utilise our 'business as usual' processes such as exit interviews and appraisals to gather feedback.

3	National People Plan	The Committee requested a gap analysis to be conducted of the actions outlined in the National People Plan in order that the most significant and beneficial actions can be identified. This is to be discussed at the next meeting – in January.
4	Freedom to Speak Up Report	Freedom to speak up reports continue to be reviewed by the Hospital Management Board and People & Culture Committee. The Committee was assured with regard to the work being undertaken to develop a culture of openness in the Trust and safety in raising concerns.

3 Conclusions/Outcome/Next steps

The next Committee meeting is scheduled for 28 January 2021 and will consider our response to the National People Plan, a review of our Workforce & Education Strategy and workforce planning.

Recommendation:

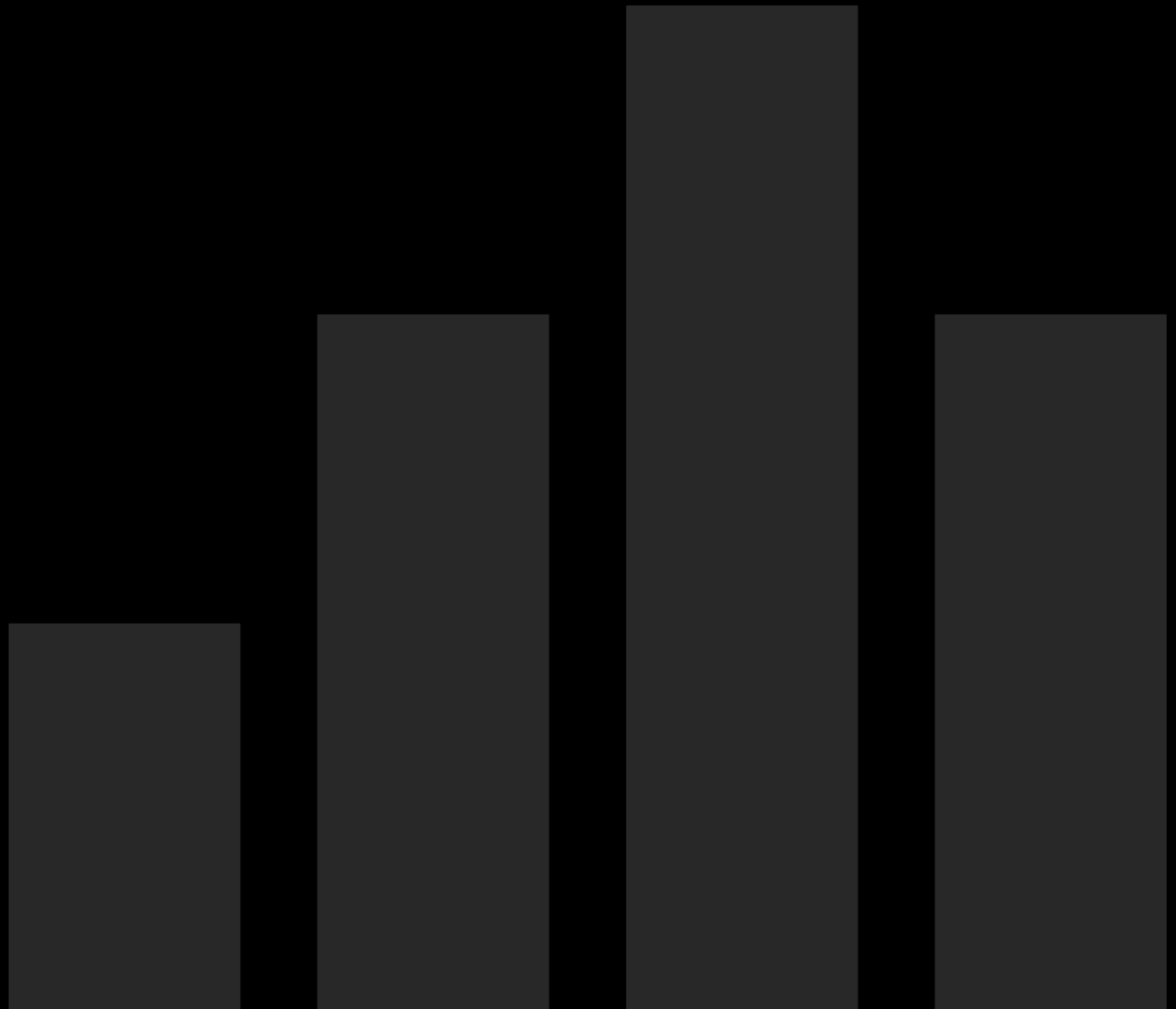
The Board is recommended to **note** the work of its People and Culture Committee.

Microsoft | Power BI

Workforce

View in Power BI

Last data refresh:
16/10/2020 08:31:19 GMT Standard Time
Downloaded at:
16/10/2020 11:57:18 GMT Standard Time



Workforce Summary

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

NNUH Digital Health
business intelligence

Topic	Metric Name	Date	Result	Variation	Assurance
Sickness Absence	Monthly Sickness Absence %	Aug 2020	3.5%	Improvement (Low)	Unreliable
Staff in Post	Actual Substantive Headcount (WTE)	Sep 2020	8,103	Improvement (High)	No Target
Mandatory Training	Mandatory Training	Sep 2020	89.7%	Improvement (High)	Unreliable
Vacancies	Variance: Headcount (WTE)	Sep 2020	-629	Improvement (High)	Not capable

SPC Variation Icons

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

SPC Assurance Icons

Capable | Not capable | Unreliable

Mandatory Training

NNUH Digital Health
business intelligence

Mandatory Training

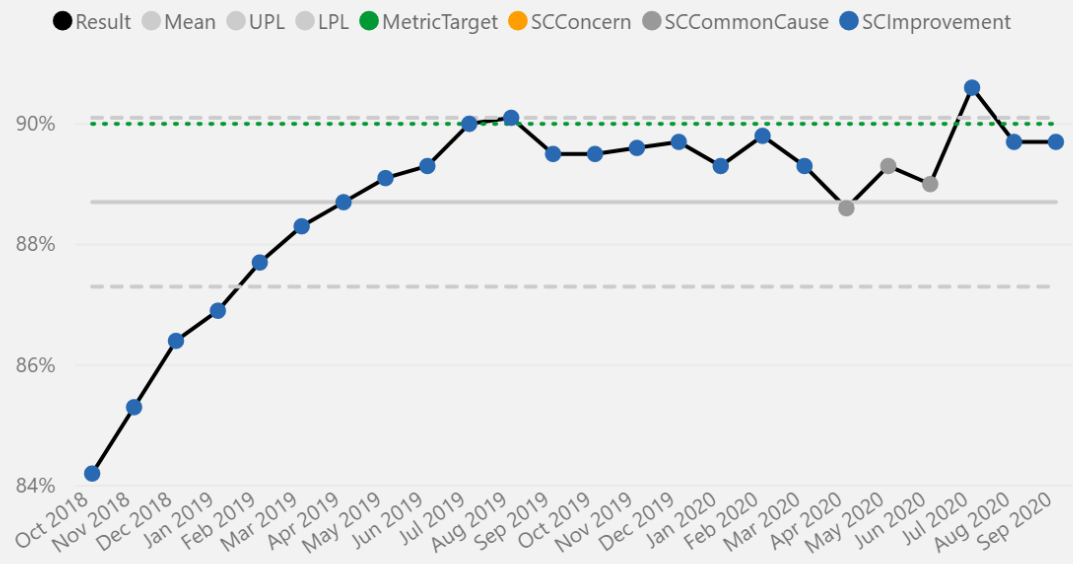
Sep 2020

Variation	Assurance
H	?

89.7% Result
90.0% Target

90.1% UPL
88.7% Mean
87.3% LPL

Mandatory Training



Business Process Changes

Analytical Commentary

2 out of 3 data points have been close to the process limits, and therefore the variation is Special Cause Variation - Improvement (High)

Assurance Commentary

As at the end of September, the compliance rate was 89.7%

A series of improvements and interventions have been in place to support mandatory training compliance. To help prioritise releasing staff to frontline duties to cope with the pandemic, we have suspended mandatory refresher training.

A recovery plan is being developed, and more training topics are being made available by eLearning and targeted messages are being sent to non-compliant staff to advise them to complete this learning on-line.

Non-Medical Appraisals

NNUH Digital Health
business intelligence

Non-Medical Appraisal

Sep 2020

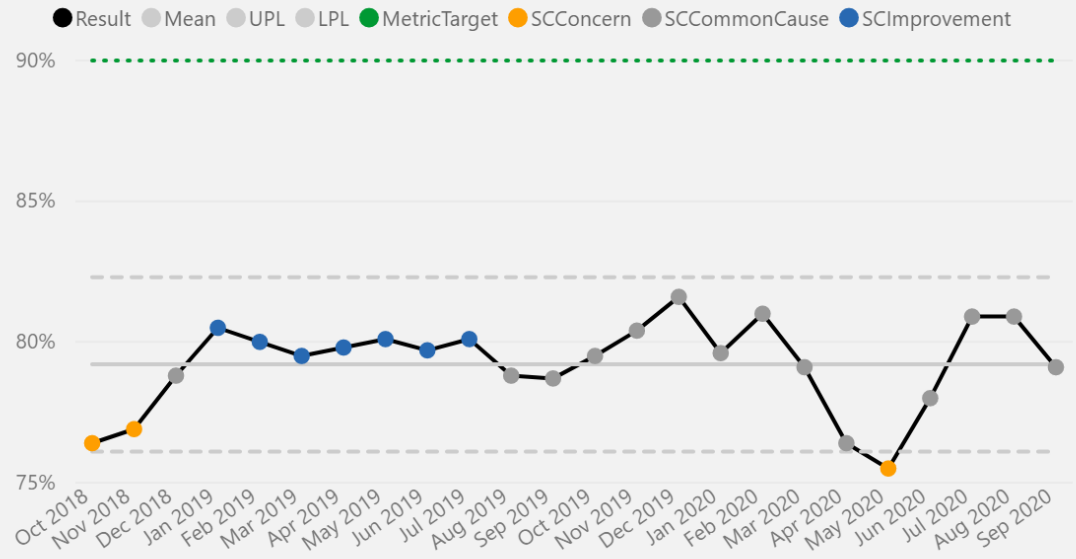
Variation	Assurance
	

79.1% Result	82.3% UPL
90.0% Target	79.2% Mean
	76.1% LPL

Analytical Commentary

Variation is Common Cause

Non-Medical Appraisal



Assurance Commentary

For appraisals, the Operating Plan for 2020/21 reflects an aspiration for 90% compliance but accepting that consistently exceeding 85% compliance would represent excellent progress.

79.1% of eligible staff (Non-Medical appraisals) had an appraisal during the last 12 months.

The new 'appraisal' process, Check In Check Out (CICO), was launched on 21st September. This replaces the appraisal process and simplifies the approach from both a manager and staff perspective. We expect to see compliance increase during October onwards.

Business Process Changes

21/09/2020 – A replacement to appraisal introduced – Check In Check Out.

Sickness Absence

NNUH Digital Health
business intelligence

Monthly Sickness Absence %

Aug 2020

Variation	Assurance
L	?

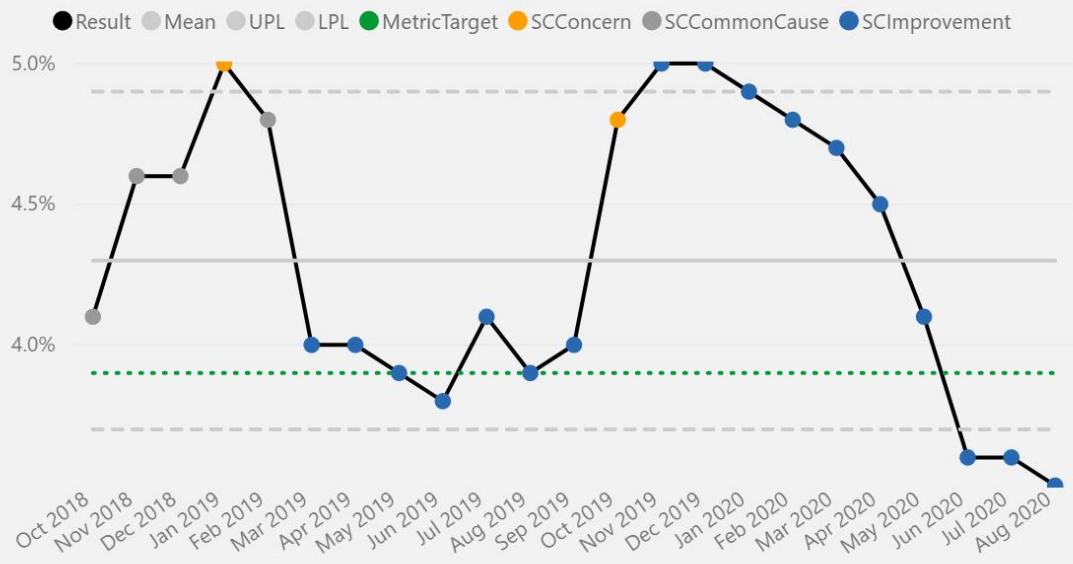
3.5% Result
3.9% Target

4.9% UPL
4.3% Mean
3.7% LPL

Analytical Commentary

Data point fell outside of process limits, Data point is part of a downwards trend, and therefore the variation is Special Cause Variation - Improvement (Low)

Monthly Sickness Absence %



Assurance Commentary

The Operating Plan for 2020/21 has set a challenging 12 month rolling average target of 3.9% for sickness. As at 31 August 2020, that rate is 4.36%. The monthly absence figure for August 2020 is 3.51%. This is the eighth consecutive month on month reduction.

Provisional indication of the monthly sickness for September is in the region of 3.9% or lower, which will be a reduction on September 2019.

All figures since March include Covid related sickness absence. Had Covid been excluded the rates from March would have been significantly lower – March (4.06%) April (3.19%) May (3.28%) June (3.27%), and July (3.38%) August (3.36%) September (3.7% - provisional).

As previously reported, there is clear evidence to suggest that 60% of lost days are due to staff absent for more than 28 days. Also, the golden rule is that if an absence exceeds 7 days it is more likely than not to become a long term absence, with the average being 7 weeks. Accordingly, efforts continue to be focused on reducing and minimising the occasions for longer term sickness.

Business Process Changes

Jan-2020 – Sickness Absence – a focus at Performance Committees

Mar-2020 – Covid impact on sickness absence

Jul-2020 - HMB Paper highlighting interventions focused on minimising and preventing long term sickness absences

Oct-2020 – A refresh of the attendance policy and toolkits were approved at PACS...

Staff Turnover

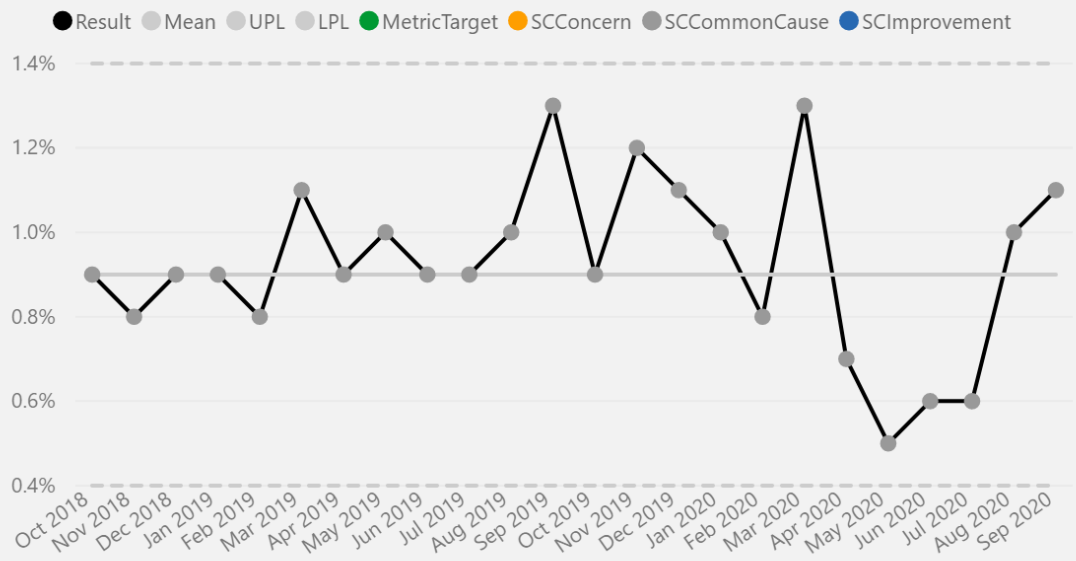
NNUH Digital Health
business intelligence

Monthly Turnover

Sep 2020

Variation	Assurance
1.1% Result	1.4% UPL
N/A Target	0.9% Mean
	0.4% LPL

Monthly Turnover



Business Process Changes

Mar-2020 – Covid-19 pandemic

Analytical Commentary

Variation is Common Cause

Assurance Commentary

The monthly turnover rate for September 2020 is 1.06% . Although this is an increase, it is noted that the numbers of leavers (WTE) is actually fewer than for September 2019.

Please note that the turnover rates are inflated for the NNUH and CSS Division due to 38 leavers as a result of TUPE implementation (21 with regard to HPV, and 17 in respect of Community Dietetics). The impact is to inflate the monthly turnover figure for the NNUH by 0.04% per month. This staff alignment will remain in the monthly turnover figures until November 2020.

Staff in Post

NNUH Digital Health
business intelligence

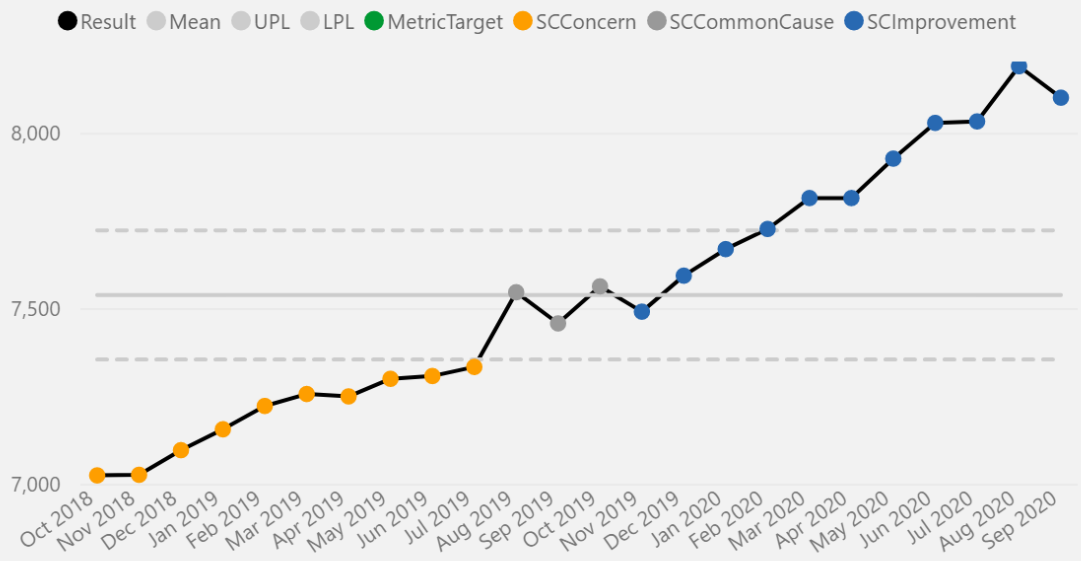
Actual Substantive Headcount (WTE)

Sep 2020

Variation	Assurance
H	

8,103 Result	7,725 UPL
N/A Target	7,541 Mean
	7,357 LPL

Actual Substantive Headcount (WTE)



Business Process Changes

Analytical Commentary

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

Assurance Commentary

The reduction in the staff in post figure is largely attributable to the end of fixed term contracts, including for temporary Covid support workers.

Since April 2020 there has been an increase of 3.1%, 2236.4 WTE (7,730.2 staff in post 31-Mar-20)

Since April 2019 there has been an increase of 11.0% 789.0 WTE (7,177.5 staff in post 31-Mar-19)

Since April 2018 there has been an increase of 17.4% 1,179.5 WTE (6,787.1 staff in post 31-Mar-18)

Since April 2017 there has been an increase of 23.6% 1,519.0 WTE (6,447.6 staff in post 31-Mar-17)

Vacancies

NNUH Digital Health
business intelligence

Variance: Headcount (WTE)

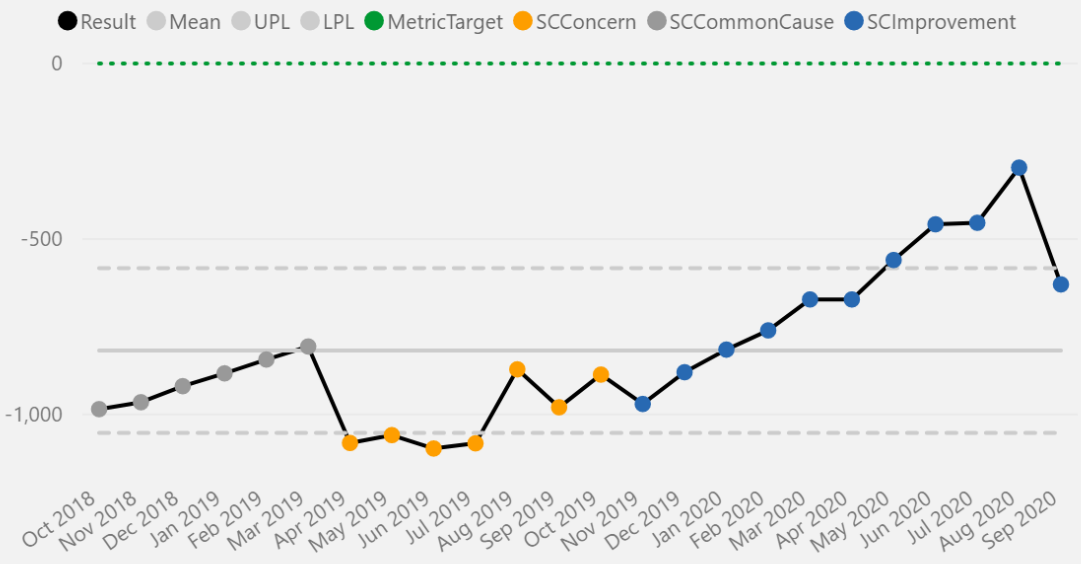
Sep 2020

Variation	Assurance
H	F

-629 Result
0 Target

-583 UPL
-818 Mean
-1,053 LPL

Variance: Headcount (WTE)



Business Process Changes

Analytical Commentary

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

Assurance Commentary

Please note that the finance establishment for September has been revised to 8,732.1 which represents an increase of 243.2 (which includes 111 posts for the new ward block).

There was also a reduction in the staff in post figure which was largely attributable to the end of fixed term contracts, including for temporary Covid support workers. Accordingly, the vacancy number increased in September.

Since April 2020 there has been an increase of 3.1%, 2236.4 WTE (7,730.2 staff in post 31-Mar-20)

Since April 2019 there has been an increase of 11.0% 789.0 WTE (7,177.5 staff in post 31-Mar-19)

Since April 2018 there has been an increase of 17.4% 1,179.5 WTE (6,787.1 staff in post 31-Mar-18)

Since April 2017 there has been an increase of 23.6% 1,519.0 WTE (6,447.6 staff in post 31-Mar-17)

Recruitment (Non-Medical)

NNUH Digital Health
business intelligence

Time to Hire - Total

Sep 2020

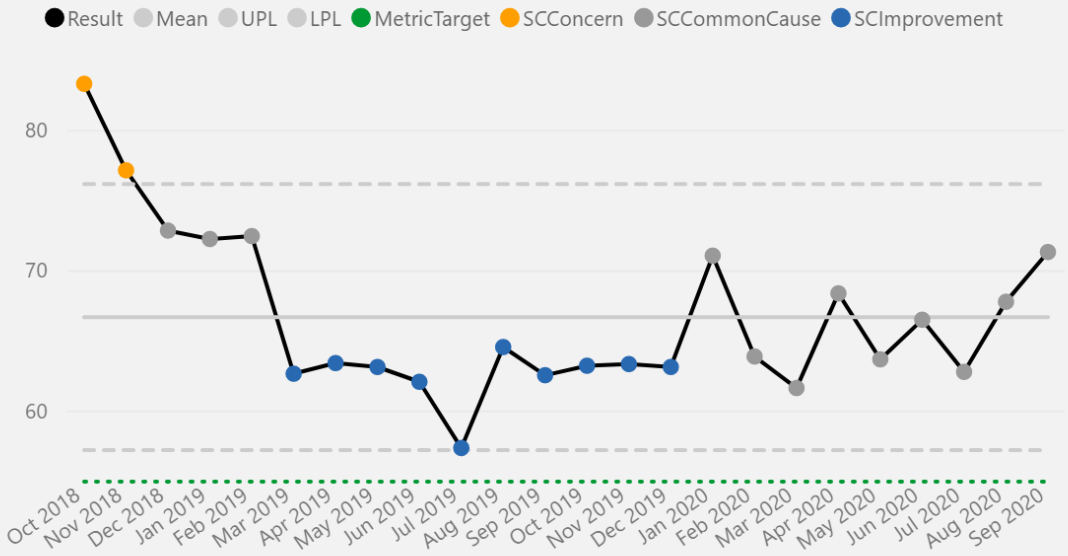
Variation	Assurance
	

71.4 Result	76.2 UPL
55.0 Target	66.7 Mean
	57.2 LPL

Analytical Commentary

Variation is Common Cause

Time to Hire - Total



Assurance Commentary

There is an ambitious time to hire target of 55 days with time with manager set at 15 days. The performance committees include a focus on time to hire and supportive measures to enable improvements.

For August and September the impact of OH clearance has inflated the time to hire figure by at least 7 days. This has been flagged at the Performance Committees and the Workforce and Education Sub-Board.

Business Process Changes

Oct-2018 – Additional resources approved for the Recruitment team in HR.

Aug-2020 – Resourcing pressures on WHWB due to Covid has led to delays in completing OH checks

Supplementary Metrics

Metric Name	Date	Result		Variation		Assurance
Time to Hire - Time with Manager	Sep 2020	20.3		Common Cause		No Target

REPORT TO THE TRUST BOARD OF DIRECTORS	
Date	**4 November 2020**
Title	**Modern Slavery Act Statement**
Author & Exec lead	**John Paul Garside, Board Secretary**
Purpose	**For Approval**

1. Background/Context

1.1 The Trust is required to update its Modern Slavery statement annually and to demonstrate that it has met the minimum legal requirements of the Modern Slavery Act 2015.

1.2 The **attached** Statement has been prepared by the Named Nurse for Safeguarding Adults and Associate Director for Complex Health and Safeguarding

2. **Conclusions/Outcome/Next steps**

2.1 Once approved the Modern Slavery Statement should then be published on the Trust's website.

Recommendation:
The Board is recommended to **approve** the Modern Slavery Act Statement.

Modern Slavery Act statement: 2019/20.

Our organisation:
The Norfolk and Norwich University Hospital is a 960 bed teaching hospital with state of-the-art facilities for modern patient care. The Trust works closely with the University of East Anglia's Faculty of Medicine and Health Sciences to train health professionals and undertake clinical research. Cromer Hospital on the North Norfolk coast is also a very Important Trust facility for providing high volumes of care to the relatively isolated, predominantly older population of North Norfolk.

The Trust has more than 7,810 staff who care for and support patients who are referred by around 100 local GP practices and from other acute hospitals and from GPs around the country. The Trust also has a team of 600 dedicated and active volunteers involved in providing support to patients and staff across both the NNUH and Cromer Hospital. There is a range of more specialist services such as cancer care and radiotherapy, orthopaedics, plastic surgery, ophthalmology, rheumatology, children's medicine and surgery, specialist care for sick and premature babies. The hospital has world class facilities, highly skilled staff and low infection rates.

The Trust was authorised as an NHS Foundation Trust on 1st May 2008 in accordance with the National Health Service Act 2006. The NHS Foundation Trust succeeded the NHS Trust formed in 1994. The NNUH is one of the busiest teaching hospitals in England, serving a population of over 900,000.

Arrangements to prevent slavery and human trafficking:
The Norfolk & Norwich University Hospital supports the Government's objectives to eradicate modern slavery and human trafficking and recognises the significant role the NHS has to play in both combatting it, and supporting victims. In particular, we are strongly committed to ensuring our supply chains and business activities are free from ethical and labour standards abuses. Steps taken to date include:

Our arrangements:

People

- We confirm the identities of all new employees and their right to work in the United Kingdom, and pay all our employees above the National Living Wage
- Our Freedom to Speak Up: Raising Concerns Policy, Provides a platform for our employees to raise concerns about poor working practices
- We undertake awareness training to support our staffing teams to understand and respond to modern slavery and human trafficking. Including how to identify potential victims and the impact that each employee at the NNUH can have on keeping present and potential future victims of modern slavery and human trafficking safe.
- Trust staff will contact and work with the Procurement department when looking to work with new suppliers, so that appropriate checks can be undertaken.

Safeguarding:
Our commitment to ensure no modern slavery is reflected in a number of our policies and procedures. These include our Adults and Children Safeguarding Policy and the Procurement Strategy.

Suppliers/tenders:
The Trust complies with the Public Contracts Regulations 2015 and uses mandatory Crown Commercial Services (CCS) Pre-Qualification Questionnaire on procurement, which exceed the prescribed threshold, whereby bidders are required to confirm their compliance with the Modern Slavery Act.

Our procurement team and contracting team are qualified and experienced in managing healthcare contracts and have received the appropriate briefing on the requirements of the Modern Slavery Act 2015, which includes:

- Confirming compliance of their plans and arrangements to prevent slavery in their activities and supply chain.
- Implementing any relevant clauses contained within the Standard NHS Contract.
- We will not award contracts where suppliers do not demonstrate their commitment to ensuring that slavery and human trafficking are not taking place in their own business or supply chains.
- We will adopt best practice advice by The Chartered Institute of Procurement and Supply.

This statement is made pursuant to section 54(1) of the Modern Slavery Act 2015 and constitutes our slavery and human trafficking statement for the financial year 2019/20.

Sam Higginson
Chief Executive Officer

Dated:

As approved by the Board on 04.11.20 (TBC)