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MEETING OF THE TRUST BOARD IN PUBLIC
WEDNESDAY 3 NOVEMBER 2021

A meeting of the Trust Board will take place at 9.30am on Wednesday 3 November 2021 in the John Innes Centre Auditorium TBC

Attendance at the meeting by members of public is by MS Teams only - details at www.nnuh.nhs.uk.

AGENDA

	Item	Lead	Purpose
0	**Due to pandemic precautions, the meeting will not be preceded by clinical and departmental visits**		
1	- Apologies, Declarations of Interest - Chairman's Introduction	Chair	Information/ Discussion
2	Experience of Care – Patient/Family Reflections (09.35 – 10.05 hrs) - *update on previous stories and reflection on next steps*	NF	Information
3	Minutes of the Board meeting held in public on 04.08.21	Chair	Approval
4	Matters arising and update on actions	Chair	Discussion
5	Chief Executive's Update	CEO	Discussion
6	**Reports for Information and Assurance:**		Information, Assurance & Approval as specified
	(a) Quality and Safety Committee (26.10.21) - inc NHSE/I HTA Standards Return (for approval)* - inc IP&C Annual Report 2020/21 (for approval) (b) IPR – Quality, Safety and Patient Experience data	GOS NF ED/NF	
	(c) Finance, Investments and Performance Committee (27.10.21)* (d) i) IPR – Performance and Productivity data ii) Finance – Month 6 report iii) UOR Update and FGR Actions	TS CC RC RC	
	(e) IPR – Workforce data	PJ	
7	Feedback from Council of Governors meeting (07.10.21)	Chair	Information
8	Questions from members of the public	Chair	Discussion
9	Any other business	Chair	Discussion
10	**In its capacity as Corporate Trustee** i) Annual Report of N&N Hospitals Charity 2020/21 ii) Letter of Representation	JPG	Approval

*** Documents uploaded to Diligent Resource Centre**

Date and Time of next Board meeting in public
The next Board meeting in public will be at 9.30am on Wednesday 2 February 2022 – location/arrangements TBC

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REPORT TO TRUST BOARD	
Date	**03 November 2021**
Title	**Experience of Care Stories To Board – Update on the programme to date and future plans.**
Author & Exec Lead	**Sarah Higson, AD for Patient Engagement & Experience; Ruby Allen, Patient Engagement & Experience Facilitator Prof Nancy Fontaine, Chief Nurse**
Purpose	**For Information**

1. Background/Context

1.1 The Trust commenced experience of care stories to Board using a new process and template in May 2019.

1.2 A patient story is where a patient or family member describes their experience of healthcare in their own words. The idea is to gain an understanding of what it is like for them and or their family / carers; what was positive; what was sub-optimal and what would have make the experience more positive.

1.3 Listening to patient stories gives us the opportunity to learn about the things that we do well and consider where we can make improvements.

1.4 A structured approach and supporting guidance is used across the Trust ensuring each story reflects a journey for the Trust in terms of listening, learning and improving.

1.5 A range of stories have been presented previously at Board and used / embedded within Patient Engagement & Experience Group (PEEG) and other forums within divisions.

1.6 This report highlights 3 key stories with latest updates for Board information demonstrating the learning into action resulting from these powerful experience of care stories and therefore their potential for wider use to underpin education, training, QI projects and larger service redesign.

2. Experience of care stories shared - updates

2.1 August 2021 – 'Information Matters'

Our Values People focused Respect Integrity Dedication Excellence

In August, the Board heard a short recording from Joy, a patient with visual impairment. It reflected on the experience of care for Joy, as a patient with information and communication support requirements, over three instances of her care at the NNUH.

Key learning at the time:

- To ensure patients' information and communication support needs are identified and recorded in patient notes
- To improve staff awareness of how information and communication support needs can be met, to ensure the provision of accessible information and equality to patients with specific needs due to disability
- To improve Trust processes for identifying and meeting patients' information and communication support needs.

Update November 2021:
Since sharing Joy's story, the Trust has initiated a number of improvement projects as part of its Accessible Information Standard Implementation Group, including:

- Development of an up to date Accessible Information Standard (AIS) policy
- A further piece of work is being undertaken, regarding reasonable adjustments that our colleagues can make to meet the accessibility needs of patients with disabilities/sensory loss and/or communication support needs
- A new arrangement is being explored with a local organisation that supports members of the local community with visual impairment, to ensure that digital content produced by the Trust for the website has been user-tested by service users who use screen-reader technologies. This arrangement is considered to be a positive step forward in improving the accessibility of the Trust's website.
- The potential for deafblind awareness sessions for colleagues is being explored to support good experience of care for people who are deafblind

In addition, supporting some wider issues of accessibility – the Trust is updating the information supplied via AccessAble – a website that provides factual information for people to find out about the accessibility of the hospital environment. More information here - Norfolk and Norwich University Hospital | AccessAble
The Trust is also working with Card Medic – available via all Trust i-pads – a website and App - which is an emergency communication aide – more information here - CardMedic | Reduce Health Inequalities & Improve Patient Safety

2.2 April 2021 – James's Young Carers Story


James shared his story via a short animated film – available here - https://t.co/LJkfJezExx?amp=1

It reflected on the experience of care for James, as a young carer of his mother during her admission, stay and at discharge.

Key learning at the time:

- To embed within the development of electronic patient record, a way to identify/record carers, including young carers
- To improve staff awareness of who young carers are and the support we should be providing to enable them to continue their caring role whilst their cared for person is in the care of the hospital.
- To engage with the young carers within our local communities to understand their experiences and learn about the issues they face.

Update November 2021:

Since sharing James' Young Carer Story in March this year, we have started a number of projects to improve the experience of Young Carers:

- **Offering Carer Awareness Training** (which includes a focus on Young Carers and their needs) opportunities more frequently has ensured that understanding and awareness of Young Carers has spread across the Trust – these training sessions continue to be available on a monthly basis to all colleagues and can be arranged to suit individual teams upon request.
- **Working with Norfolk Young Carers Forum** to ensure that Young Carers' voices are heard within all decisions and discussions regarding carers at NNUH.
- **Asking Young Carers to give feedback** via the 2021 NNUH Carers Survey. Responses from Young Carers specifically will be analysed to identify improvements that Young Carers would like to see at NNUH in relation to carer identification and support.
- **Collaborative working with the other acute hospitals in Norfolk and Waveney to improve consistency for carers' experiences**. A joint Carers Conference was held in collaboration with QEHKL and JPUH in Carers Week (June) this year. The outcomes of the conference are being addressed and delivered on collaboratively with the other Acutes, within a co-production project, funded via the ICS and led by Norfolk Carers' charities. It is envisaged the co-production project will result in a shared Carers Passport and Carers Policy for the hospitals in Norfolk and Waveney. Norfolk and Norwich University Hospitals NHS Foundation Trust » Norfolk and Waveney Hospitals Carers Conference 1 (nnuh.nhs.uk)

2.3 August 2020 – 'Patient Story to Quality Improvement (QI) Project' – utilising experience of care as a catalyst for improvements via a structured QI approach.

Graham and Sue shared an emotional and powerful story, which, working with the Cardiology team, acted as a catalyst for improvements. Graham had a heart attack and received excellent care. The impact emotionally, cognitively and psychologically was particularly key as well as involvement and support of his wife and family, emphasizing the holistic impact necessitating a holistic and rounded treatment response.

Key learning at the time:

- Survival rate from cardiac arrest has increased
- Some patients will survive with mild or no long-term deficit. As many as 25% will go on to live with severe cognitive, emotional and

physical problems, sometimes as severe as post traumatic stress disorder.
- No formal rehab pathway for this group of patients
- Recovery often complicated due to cognitive impairment
- There is a recognised gap of psychological support for these patients and their families
- Impact on patient and family is wider than just physical/clinical and response and recovery needs to reflect this more holistic approach – patients and families have to live with the longer term consequences and more can be done for them

Follow up – the formation of a QI project.
The cardiac team have instigated a QI project directly linked to the increase in survival and longer term outcome recognition and reflecting the experience of Graham and Sue
Graham and Sue have agreed to be 'experts by experience' and work with the team to develop the initiative and approach

Update November 2021:
- To support the psychological and emotional impact on patients and families the N&N Hospitals Charity has awarded £76K to support recruitment of a Clinical Psychologist for Cardiology for two years (match-funded by the Norfolk Heart Trust).

3. Future plans for using shared experiences of care - 'storytelling'

The Patient Engagement & Experience Team continue to are collaborate with the Patient Panel, Maternity Voices Partnership, Clinical Support Services Divisional Patient Panel and Quality Improvement (QI) colleagues to develop the model for storytelling further to support and drive improvements.

The team are also working closely with the Practice Development team to utilise experiences of care as key tools for learning, bringing key themes alive for empathic education.

This close collaboration will enable us to achieve our ambitions highlighted in the update report to Board, especially:

- Storytelling should be fostered and promoted to benefit high-quality, design and delivery of services.
- Creation of an experience of care toolkit to support colleagues and embed into QI, education and redesign processes.

Recommendations: The Board is recommended to receive this report for information and to note plans for embedding experience of care stories within education, QI and service redesign.

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MINUTES OF TRUST BOARD MEETING IN PUBLIC

HELD ON 4 AUGUST 2021

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
	Mr J Foster	- Non-Executive Director
	Mrs J Hannam	- Non-Executive Director
	Mr S Higginson	- Chief Executive
	Dr G O'Sullivan	- Non-Executive Director
	Mr T Spink	- Non-Executive Director
In attendance:	Ms Y Christley	- Deputy Chief Nurse (Deputising for Prof Fontaine)
	Ms F Devine	- Director of Communications
	Mr J P Garside	- Board Secretary
	Mr S Hackwell	- Director of Strategy
	Mr A Lundrigan	- Chief Information Officer
	Ms A Prem	- Associate Non-Executive Director
	Ms V Rant	- Assistant to Board Secretary
	Members of the public and press	

21/033 **APOLOGIES AND DECLARATIONS OF INTEREST**

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

Due to operational pressure, the planned clinical/departmental visits were postponed.

21/034 **EXPERIENCE OF CARE - PATIENT/FAMILY REFLECTIONS**

The Board was joined by Ms Sarah Higson and Ms Ruby Allen of the Trusts' Patient Experience Team who presented the experience of a patient 'Joy' as someone with visual impairment. Joy had needed the services of the Trust following a broken ankle but had experienced difficulties in obtaining information in accessible format for her needs. Joy's story highlights that timely provision of this information in an accessible format would assist patients and reduce their anxiety.

Ms Allen informed the Board that this story had highlighted the need to increase staff understanding of requirements for patients with particular needs. Patients with support needs will be highlighted through alerts that will be added to medical records. The need for guidance to support staff in knowing how and what can be accessed was also indicated.

Ms Rachel Emberson (Eye Clinic Sister) confirmed that Joy's story is being shared at Clinical Governance meetings attended by multi-disciplinary teams. We are also liaising with Vision Norfolk on production of audio CDs for patients. A policy for providing information securely by email is being introduced

Ms Christley indicated that a steering group has been established to look at opportunities for using assistive technology and developing accessible information formats for all patient groups. Developing person centred services is a key cultural aim and we are continuing to work with clinical teams across the organisation to ensure this is embedded

Non-Executives indicated a need to prioritise key areas of focus and to empower staff to fix issues locally. It is also important for a system-wide approach to be taken to ensure consistency across organisations. Ms Christley indicated that a programme of training is being rolled out as a core component of improvement work and will be incorporated into new starter sessions to provide guidance as to the experience we want for our patients. This is an NHS wide issue and there are opportunities to share with and learn from colleagues in the community.

Non-Executives questioned whether staff are able to respond flexibly when patients have particular needs and the Board will be updated on actions that can be implemented relatively quickly and cheaply. **Action: Mrs Higson**

Mr White thanked Joy for sharing her experiences. We recognise that this is a trust-wide challenge and we are continuing to work to improve and develop patient centred services.

21/035 **MINUTES OF PREVIOUS MEETING HELD ON 2 JUNE 2021**

The minutes of the meeting held on 2 June 2021 were agreed as a true record and signed by the Chairman.

21/036 **MATTERS ARISING**

The Board reviewed the Action Points arising from its meeting held on 2 June 2021 as follows:

21/028 – Carried forward - Workforce IPR targets & trajectories - Non-Executives suggested that inclusion of targets and trajectories for key workforce metrics in the IPR would enable better oversight of the current position on performance and to identify those areas requiring further attention. **Action: Mr Jones**

Mr Foster asked about the role of Well-Being Guardian and whether that should form a specific action. Mr White explained that the discussion is ongoing with respect to what is achievable and this will be reviewed through the People & Culture Committee to achieve resolution.

21/037 **FREEDOM TO SPEAK UP UDPATE**

The Board received a report and presentation from Ms Fran Dawson – Lead Freedom To Speak-Up Guardian. Whilst previous reports have been made to the People and Culture Committee they will be scheduled to come directly to the Board on a six-monthly basis.

Ms Dawson explained that since joining the Trust two years ago she has been working to establish a Speak Up service that is trusted, consistent and offers support to staff. Embedding a Speak Up culture requires a multifactorial approach consisting of both reactive and proactive elements. The service is focusing on recruiting and training Freedom to Speak Up Champions, who will actively promote a healthy speak up culture across the organisation.

60% of staff reported feeling safe to speak up about concerns (national average 65%) and although growth in this number is slowing, it is showing an upward trend annually.

Non-Executives reflected on rotation of doctors across the Trust and asked how they will be reassured about speaking up. Professor Denton explained that speak up has been incorporated into induction and welcome sessions for doctors. There are now fewer whistle blowing events which is a good indication that conversations within teams to identify and address issues.

Ms Dawson highlighted that concern or issues regarding working relationships is one of the main themes identified in speak up. Fear of detriment is challenge for NHS Trusts and further work is underway to look at how this can be addressed.

As the Nominated NED for FTSU, Ms Dinneen thanked Ms Dawson for her report and work within the Trust, which forms a key part of promoting cultural change. The importance of demonstrating action and change in response to feedback was emphasised, as part of role-modelling a listening culture and also to emphasise the value of speaking-up.

It was suggested that Board members may undertake additional FTSU training and this will be scheduled as part of forward planning. **Action: Mr Garside**

21/038 **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 reported that the number of Covid patients has increased over the last few weeks to around 15-20 patients. The number of cases is projected to remain high for some time and we are continuing to work in line with our pandemic plan. As we approach winter, it is expected that the number of patients will increase. The Hospital is further challenged as there have been an increased number of staff who are having to isolate.

We are continuing to focus on elective recovery and remain on track with planned activity. The back log of patients who are waiting for treatment however continues to grow as referral rates are high. The financial position is in line with our financial plan.

The CQC has now published its report of the unannounced inspection of the Emergency Department in June 2021. The Emergency Department was rated 'Good' by the CQC in the domains of Safe and Well-led. In the domain of Responsive, the rating was 'requires improvement' and work continues to address ongoing challenges in reducing waiting times and addressing the needs of patients with mental health needs.

In response to Non-Executive questioning, Professor Denton explained that some training, such as advanced life support, needs to be undertaken 'face to face' and this has been impacted adversely by the pandemic. Space for provision of training on site has been restricted but we are working to identify additional space to recommence our training programme.

Mr White welcomed the positive report from the CQC - it is good evidence of a positive shift in culture. Long standing vacancies are being filled and team working is strengthening. The ongoing challenges in the responsive domain will form part of system-wide discussion as partners work together to address issues. All the staff involved were thanked for their work and efforts in this achievement.

21/039 **REPORTS FOR INFORMATION AND ASSURANCE**

(a) Quality and Safety Committee (27.07.21)

The Board received an update from Dr O'Sullivan with respect to key issues arising from the Quality & Safety Committee, notably:

- the Committee was informed that the E-obs system has now been implemented across 9 wards. The benefits of the system will be monitored as part of the roll-out programme and a report will be provided to a future meeting of the Committee;

- the Committee had approved an 'easy read' summary version of the Quality Report for 2020/21;

- the risk regarding follow-up of investigation results is being carefully managed and is governed by an SOP emphasising that results should be followed up by individual requestors. The associated risks will reduce once the Electronic Patient Record has been introduced. In the meantime the SOP will be reviewed;

- the Maternity Team provided a quarterly update on maternity services. The continuity of carer programme has been impacted by staffing challenges and the roll-out will now be taking place incrementally. Recruitment of midwives has been successful and 38 midwives have been appointed;

- robust processes are in place for allocation of capital, including clinicians/divisions in decisions for balancing priorities of quality and finance.

(b) IPR – Quality, Safety and Patient Experience

Mrs Christley highlighted:

- *Pressure ulcers* – we are introducing a more sophisticated risk assessment tool to replace the traditional Waterlow score;
- *Patient falls* – multidisciplinary Policy being piloted for management and prevention of falls;
- *Safer staffing* – metrics have been agreed to optimise deployment of staff. The Red-Flag position is reviewed three times a day and a revised assurance process around rosters is being implemented in the coming weeks.

Non-Executives highlighted the ongoing issue highlighted in the IPR with respect to mental health patients. Mr White explained that this will be picked up further in Board discussion. Enhancement of the assurance commentary on serious incidents was also encouraged.

Professor Denton reported that the national mortality rate has increased during the pandemic and the Trust is therefore not an outlier in experiencing increased HSMR and SHMI. The number of patients admitted to hospital with palliative care diagnostic codes is high at NNUH and this indicates a need for additional palliative care capacity in the community.

Non-Executives questioned the reference in the IPR to the problems cross-referencing Covid testing with the HR Electronic Staff Record. Mr Lundrigan explained that work is continuing in order to establish links between existing electronic HR systems, such as e-roster and ESR.

(c) Finance, Investments and Performance Committee (28.07.21)

The Board received an update from Mr Spink with respect to key issues arising from the Finance, Investments & Performance Committee.

Mr Spink highlighted a number of operational challenges for the Trust as reported to the Commuttee. Treatment of elective patients continues to be a very high priority and the number of referrals remains high. Non-Elective demand is challenged by increasing Covid admissions and staff absences due to isolation.

The Committee had received an updated Elective Access Policy, as a common policy for Norfolk and Waveney acute providers, and was recommended to the Board for approval. Accepting the recommendation of the FIP Committee, the Board **approved** the Elective Access Policy.

The financial position is ahead of plan in the year to date and CIP delivery is also ahead of plan. Non-Executives commended this performance.

Digital Health Business Cases (Digital Aspirant Programme and Digital Capital Programme) were recommended to the Board for approval. Accepting the recommendation of the FIP Committee, the Board **approved** the Elective Access Policy and **approved** the Business Cases for the 2021/22 Digital Aspirant Programme and Digital Capital Programme.

(d) IPR – Performance and Productivity

Mr Cobb provided an update on the operational position. The Hospital continues to experience high levels of attendance at ED and ongoing disruption associated with Covid. Many people attending the ED are of higher acuity and pressure across the organisation is high.

Planning and learning implemented from analysis of the first wave has put us in a good position to manage the next challenge. Staff having to isolate is however causing additional pressure on services and flow out of ED and through the Hospital remains challenged.

We have maintained ring fencing of 88 elective beds and good progress has been made in treating the backlog of P2 patients. This progress has however now been impacted by workforce absence. Activity levels were delivered against H1 requirements in June with elective admitted care at 84%, outpatient appointments 94% and diagnostic activity 98%. Work is underway to identify measures to maintain and increase activity over the next few months.

Non-Executives asked about advice to members of the public who are experiencing Covid symptoms. It was explained that they should not to come direct to the ED but rather use the NHS Choices website for advice and directions on what to do if they have symptoms.

(e) Finance – Month 3

Mr Clarke reported the financial position was £4.9m surplus being £3.8m favourable to plan. CIP delivery is £1.1m ahead of plan and we are on track to deliver £13.1m CIP savings. The cash balance at the end of June was £51.3m and is £4.5m ahead of plan. The capital programme is currently underspent by £200k due to an underspend on the CT and MRI replacement programme.

(f) Use of Resources Update

The Board was updated with regard to progress against the Use of Resources Action Plan. 61 actions from the Financial Governance Review have now been completed. It is anticipated that the remaining 7 actions will be closed in Q2.

Mr Higginson commended the oversight of Mr Clark and his team in driving the work to achieve this improved position.

(g) People and Culture Committee (26.07.21)

The Board received an update with respect to key issues arising from the People & Culture Committee.

The Committee visited the Benjamin Gooch Lecture Theatre which is currently being used as a PPE store. The Supplies team are doing a vital and very important job but returning that space back to staff training will be important practically. It will also send an important message about our commitment to education and training for staff.

The Committee recognised the work to improve retention of staff but challenged the reduced risk rating on the Corporate Risk Register. It was felt that this may be premature and it will be revisited.

Staff engagement has been undertaken to inform development of the People & Culture Strategy but there is a need to establish actions and a structured approach to systematically target improvement. It may be helpful to identify a reduced list of priority actions and the Committee will consider this at its next meeting.

(h) IPR - Workforce

The Board received the Workforce IPR for information.

21/040 **FEEDBACK FROM COUNCIL OF GOVERNORS**

The Chairman reported that the Council had held its meeting in the Roy Snelling Lecture Theatre in the Bob Champion Research and Education Building.

Non-Executives commented that it had been a very positive meeting, with Governors providing appropriate challenge and questions. Feedback from Governors is that they welcome Non-Executive attendance at Council meetings.

A number of questions were asked following the Maternity Unit presentation by Miss Anna Haestier (Consultant in Obs & Gynae) and these were followed up after the meeting.

21/041 **QUESTIONS FROM MEMBERS OF THE PUBLIC**

Questions were asked in relation to staff isolating due to Covid – where possible staff who are required to isolate are working remotely - undertaking remote clinics, audits, training etc.

Breast cancer has seen an extraordinary increase in referrals, which has created a backlog. The team are working over weekends to try to catch-up but it is unknown how many other referrals may yet be to come.

21/042 **ANY OTHER BUSINESS**

There was no other business.

21/043 **DATE AND TIME OF NEXT MEETING**

The next meeting of the Trust Board in public will be at 9.30am on 3 November 2021.

Signed by the Chairman: …… Date: ……
Confirmed and approved for signature by the Board on 03.11.21 [TBC]

Decisions Taken:

21/039c - RTT Access Policy	Accepting the recommendation of the FIP Committee, the Board **approved** the Elective Access Policy
21/039c - Digital Aspirant Business Case	Accepting the recommendation of the FIP Committee, the Board **approved** the Business Cases for the 2021/22 Digital Aspirant Programme
21/039c - Digital Capital Programme – business case	Accepting the recommendation of the FIP Committee, the Board **approved** the business case for the digital element of the Trust's Capital Programme.

Action Points Arising:

	Action
21/028 - Workforce IPR targets & trajectories	Carried forward - Non-Executives suggested that inclusion of targets and trajectories for key workforce metrics in the IPR would enable better oversight of the current position on performance and to identify those areas requiring further attention. **Action: Mr Jones**
21/034 – patient story – response to patients with support needs	Non-Executives questioned whether staff are able to respond flexibly when patients have particular needs and the Board will be updated on actions that can be implemented relatively quickly and cheaply. **Action: Mrs Higson**
21/037 – FTSU	It was suggested that Board members may undertake additional FTSU training and this will be scheduled as part of forward planning. **Action: Mr Garside**

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Action Points Arising from Trust Board meeting (public) – 04.08.21

Item	Action	Update – November
21/028 - Workforce IPR targets & trajectories	Carried forward - Non-Executives suggested that inclusion of targets and trajectories for key workforce metrics in the IPR would enable better oversight of the current position on performance and to identify those areas requiring further attention. **Action: Mr Jones**	Workforce IPR to be reviewed at People & Culture Committee to agree any further areas of key focus/priority. **Carried forward**
21/034 – patient story – response to patients with support needs	Non-Executives questioned whether staff are able to respond flexibly when patients have particular needs and the Board will be updated on actions that can be implemented relatively quickly and cheaply. **Action: Mrs Higson**	Update included in papers 03.11.21 **Action complete**
21/037 – FTSU	It was suggested that Board members may undertake additional FTSU training and this will be scheduled as part of forward planning. **Action: Mr Garside**	We are experiencing some 'diary congestion' but this is in the schedule to be confirmed in liaison with FTSU Guardian. **Carried forward**

JPG 29 October 2021

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REPORT TO THE TRUST BOARD

Date	**3 November 2021**
Title	**Chair's key Issues from Quality and Safety Committee Meeting on 26.10.21**
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 26 October 2021. Papers for the meeting were made available to all Board members for information in the usual way via Diligent. The meeting was quorate and was held on site and by MS Teams. The meeting was attended by Ines Grote (Public Governor) as observer via MS Teams. The meeting Agenda was full and the Committee identified the following matters to highlight to the Board.

2 Key Issues/Risks/Actions

Key issues to highlight to the Board were identified as follows:		
1	Clinical Visit – Mortuary and Assessment against HTA standards	The meeting began with a visit to the Mortuary – led by Lee Gibbs (Chief Anatomical Pathology Technologist) and Mark Lankester (Histopathology & Mortuary Services Manager & HTA Designated Individual). Refurbishment work is currently underway in the Department. Whilst short/medium term arrangements are in place to ensure sufficient capacity, the long-term plan needs further attention and it may be helpful for the Finance, Investments & Performance Committee to be updated on this. The Committee received a report from the Division of Clinical Support Services concerning a national return to be submitted to NHSE/I with regard to arrangements in place in the Mortuary for i) security; ii) monitoring; iii) risk assessment; and iv) DBS checks. On behalf of the Board, the Committee considered the position against each of these areas and informed by the physical visit to the facility. The Committee will receive updates against the actions identified by the Division and requested specific additional work with respect to clarifying the DBS arrangements. The draft return has been uploaded to the Resource Centre for information. The Committee **agreed to confirm** to the Board that the evidence in relation to each of the 4 identified areas has been reviewed and it is satisfied that the appropriate responses have been/are being taken.
2	Quality & Safety – Current Performance – Extract from IPR	The Committee was updated with regard to performance in quality and safety and discussed data relating to nurse staffing in particular. Whilst reduced fill-rates are not reflected in increased falls, pressure ulcers or incidents, the high turnover rate of Healthcare Assistants was noted. A report concerning the HCA role, feedback from exit interviews and opportunities for improvement will be prepared and the Committee requested that this be considered at the People and Culture Committee.

3	QPB Quarterly Update	The Committee reviewed the latest position against the CQC Action Plan and was assured with regard to progress and the process for assessing evidence of implementation of requisite changes.
4	CIP and CQIA Update	The Committee received its regular update in relation to implementation of the Clinical Quality Impact Assessment (CQIA) process. The Committee directly questioned and was assured that the process incorporates an appropriate balance between finance and quality.
5	Clinical Consent	The Committee received an update regarding a common consent policy and paperwork that is to be introduced across the Norfolk acute hospitals. This was considered to be a noteworthy example of joint working.
6	Managing patient moves	The Committee received a report regarding the frequency and processes around the movement of patients within the hospital. It is recognised that there can be good reasons for moving patients but it can have a negative impact on continuity of care and patient experience. The Committee requested a further update at its next meeting to continue assessment of the position.

3 Conclusions/Outcome/Next steps: The next Committee meeting is scheduled for 23 November 2021.

Recommendation:

The Board is recommended to:

- **note** the work of its Quality & Safety Committee;
- **approve** submission of the HTA/Mortuary standards submission to NHSE/I;
- **note** referral to FIPC regarding the Mortuary Estate and to P&C regarding the HCA review.

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REPORT TO THE TRUST BOARD OF DIRECTORS

Date	**3 November 2021**
Title	**Infection Prevention and Control (IP&C) Annual Report 2020-21 and Annual Programme 2021-22**
Author & Exec lead	**Professor Nancy Fontaine, DIPC and Chief Nurse** **Elizabeth Morrison, Head of Infection Prevention and Control**
Purpose	**For Approval**

1. Background/Context

1.1 Annual report provided by IP&C on behalf of the DIPC as a requirement of the Trust Board and as outlined in the Health and Social Care Act 2008: Code of practice on the prevention and control of infections and related guidance, updated July 2015 (Hygiene Code). This is to provide assurance on IP&C activity during the financial year of 2020-2021.

2. Key issues, risks and actions

2.1 This report covers a period during the SARS CoV2 pandemic, including the first and second wave. The IP&C team wish to recognise the hard work and commitment of staff across the healthcare community who have collaboratively strived for the highest quality IP&C standards to promote patient and staff safety and reduce risk of nosocomial transmission during challenging times.

2.2 The IP&C software system ICNet will be decommissioned in December 2021. Work is ongoing with Digital Health colleagues and Web V to prepare and develop a replacement system. This remains on the Trust Risk Register.

2.3 A Quality Improvement pilot was undertaken with innovative design creating a bespoke utility sink utilised in the new ward block providing a safe place for staff to dispose of waste water and protecting hand hygiene sinks.

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

3.1 Annual programme for IP&C to be followed and monitored via the Hospital Infection Control Committee (HICC) throughout the year.

Recommendation:

The Board is recommended to:

- Approve this report as an assurance of IP&C practice within the Trust

Infection Prevention and Control Annual Report 2020-21 and Annual Plan 2021-22

Norfolk and Norwich University Hospitals NHS Foundation Trust

Director of Infection Prevention and Control: - Professor Nancy Fontaine

Head of Infection Prevention and Control: - Liz Morrison

Infection Control Doctor: - Dr Catherine Tremlett

Infection Prevention and Control Team

Norfolk and Norwich University Hospitals NHS Foundation Trust

Infection Prevention and Control Annual Report 2020-21

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Executive Summary

This annual report incorporates information and data pertaining to healthcare associated infections during the period 1st April 2020 until 31st March 2021. It provides a summary of the Infection Prevention and Control (IP&C) work undertaken, the management and governance structures and the assurance processes.

The format follows the 10 hygiene code criteria detailed in the Health and Social Care Act 2008: code of practice on the prevention and control of infections and related guidance, updated July 2015. The annual report will be released publicly by the Director of Infection Prevention and Control (DIPC) as outlined in the code.

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

There were no official government objectives set during this report period and therefore the Trust continued to monitor against the previous year's objectives.

- There were 70 total cases of *Clostridioides difficile* infection (CDI) of which after the post infection reviews 24 had lapses in care and therefore counted towards this set objective of 35.
- There were 0 cases of Methicillin Resistant *Staphylococcus aureus* (MRSA) blood stream infection (BSI) against an objective of zero cases.

The SARS CoV2 pandemic declared by the World Health Organisation (WHO) March 2020 was on-going throughout this period. This report will include the first and second wave of this pandemic.

There was an external inspection visit to the Emergency Department (ED) in December 2020. This was during the height of the second wave. The CQC published a report in February 2021 in which the overall Trust rating was requires improvement.

The IP&C team wish to recognise the hard work and commitment of staff across the healthcare community who have collaboratively continued to strive for the highest quality IP&C standards promoting patient and staff safety and reduce the risk of nosocomial transmission of infection during this challenging period of pandemic.

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

- Chief Nurse and **Director of Infection Prevention and Control**
- **Head IP&C Nurse**
- **Infection Control Doctor** and Consultant Microbiologist

Norfolk and Norwich University Hospitals NHS Foundation Trust

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Abbreviations

AMR	Antimicrobial Resistance
BSI	Bloodstream infection
C4C	Cleaning for Credits
CCG	Clinical Commissioning Group
CDI	*Clostridioides difficile* Infection
CEO	Chief Executive Officer
COCA	Community Onset Community Associated (C. difficile)
COHA	Community Onset Healthcare Associated (C. difficile)
COIA	Community Onset Indeterminate Association (C. difficile)
CO	Community Onset (SARS CoV2)
COO	Chief Operating Officer
CPD	Continuing Professional Development
CPE	Carbapenemase-producing Enterobacteriaceae
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
CVC	Central Venous Catheter
DH	Department of Health
DIPC	Director of Infection Prevention & Control
DTMM	Drugs, Therapeutics and Medicines Management Committee
E. coli	*Escherichia coli*
EPA	Eastern Pathology Alliance
EPMA	E-prescribing & Medicines Administration
ESBL	Extended Spectrum Beta Lactamase
FM	Facilities Management
GRE	Glycopeptide Resistant Enterococcus
HCAI	Health Care Associated Infection
HODA	Hospital Onset Definate Healthcare Associated (SARS CoV2)
HOHA	Hospital Onset Healthcare associated (C.difficile)
HOIA	Hospital Onset Indeterminate Healthcare Associated (SARS CoV2)
HOPA	Hospital Onset Probable Healthcare Associated (SARS CoV2)
HOUDINI	A tool designed for health professionals to consider if a urinary catheter is required. **H**aematuria, **O**bstructed**, U**rological surgery, **D**ecubitus Ulcers, **I**nput/output monitoring, **N**ot for resus/End of Life, **I**mmobility)
HICC	Hospital Infection Control Committee
ICD	Infection Control Doctor
ICN	Infection Control Nurse
IP&C	Infection Prevention & Control
MHRA	Medicines and Healthcare Products Regulatory Agency
MRSA	Methicillin Resistant *Staphylococcus aureus*
MSSA	Methicillin Sensitive *Staphylococcus aureus*
NHSE/I	National Health Service England and National Health Service Improvement
NHSI	National Health Service Improvement
NICU	Neonatal Intensive Care Unit
NNUH	Norfolk and Norwich University Hospital Foundation Trust
OWL	Organisation Wide Learning
PCR	Polymerase Chain Reaction
PFI	Private Finance Initiative
PICC	Peripherally Inserted Central Catheter
PHE	Public Health England
PIR	Post Infection Review

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PLACE	Patient-led assessments of the care environment
PMS	Performance Measurement System
PPE	Personal Protective Equipment
RCA	Root Cause Analysis
SARS CoV2	Severe acute respiratory syndrome coronavirus 2
SSI	Surgical Site Infection
SOP	Standard Operating Procedure
VRE	Vancomycin Resistant Enterococcus
WHWB	Workplace Health and Well-Being

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

Governance and Monitoring

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

The Board of Directors collectively work within the NNUH Healthcare Governance Framework to ensure that high quality and safe services are in place for patients, visitors and staff to minimise the risk of infection.

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

The DIPC role is undertaken by the Chief Nurse with the support of the IP&C team. The deputy DIPC retired after a long commitment to excellence within the team and a new deputy DIPC was employed to start with immediate effect. The deputy DIPC was later seconded to the Queen Elizabeth hospital in Kings Lynn and the Senior IP&C nurse undertook the Head of Infection Control team role from February 2021. The DIPC provides strategic direction and leadership to the Trust on all IP&C matters.

IP&C Reporting Processes

- The IP&C team provides a comprehensive monthly IP&C report which is widely distributed to senior managers, Divisional leads, Governance leads, Matrons, Ward managers, CCG and CCG IP&C nurses. This report provides graphical evidence of the alert organism figures and trends alongside PHE benchmarking data, screening, antimicrobial reports and details of any outbreaks or incidents and highlights any risks.
- The IP&C team report on all key aspects of IP&C at the HICC meetings with reports from internal and external representatives, see chart 2.The Chief Nurse, who is DIPC and executive lead for IP&C reports key performance indicators monthly to the Trust board.
- The DIPC/deputy DIPC/ Head of IP&C reports to the clinical safety sub-board monthly.

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Chart 1

Norfolk and Norwich University Hospitals NHS Foundation Trust

Board of Directors and Management Board Reporting and Accountability Structure

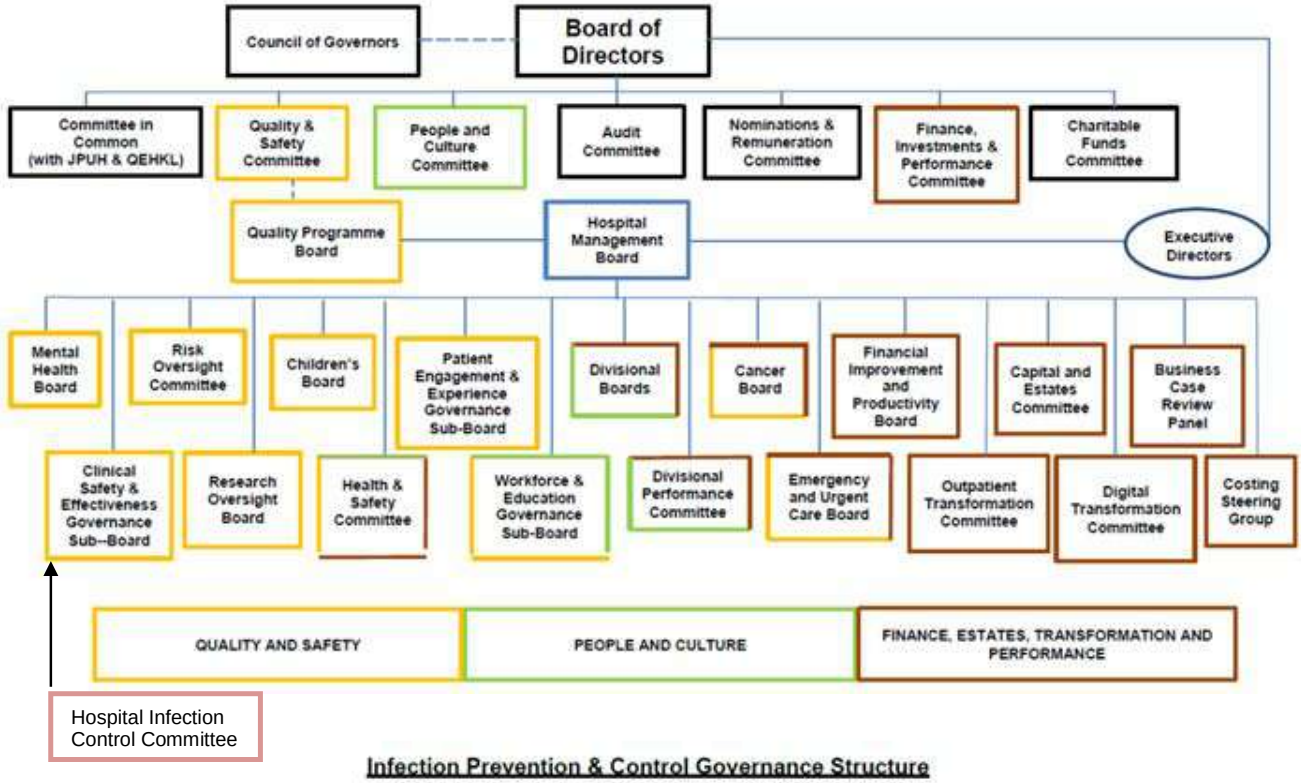
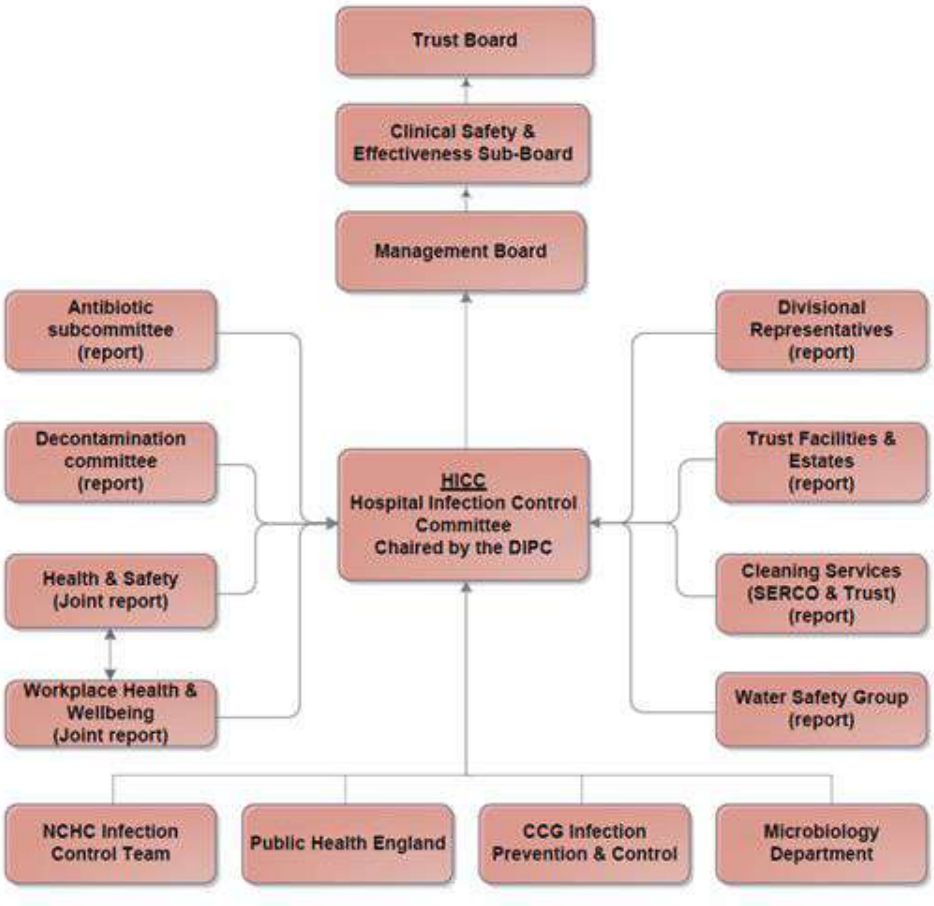


Chart 2

Infection Prevention & Control Governance Structure



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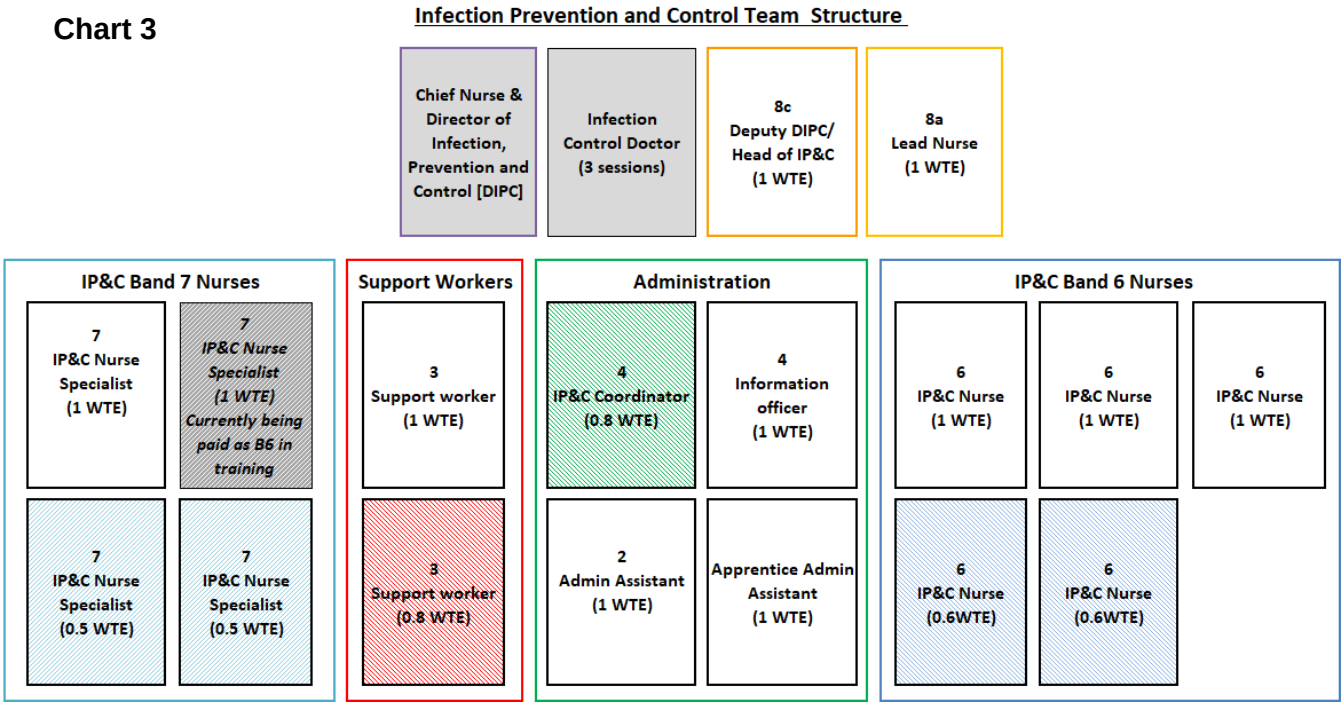
The IP&C Team Structure

An on-call out of hours service provided by the IP&C team provides 24 hour, 7 day a week cover for the Trust. The team is supported by a team of Consultant Microbiologists and Virologists, who also undertake on-call, see chart 3.

Chart 3



Clinical Commissioning Groups (CCG)

IP&C at NNUH is monitored by the commissioning IP&C team. This is via attendance at HICC, participation in environmental inspections, contributing in incident management meetings and the Post Infection Review (PIR) for all patients who develop an MRSA bacteraemia or CDI in line with national guidance.

Decontamination and Water Safety Groups

During 2020-21, the Water Safety and Decontamination Groups met to address the requirements of current guidelines and the clinical service.

Decontamination Group

This report provides a highlight summary of the Trust Decontamination Group's activities over the financial year 2020-21.

Audit and Governance

The 20-21 annual audit took place in October; this resulted in x1 major and x0 minor actions for correction. The major was for failure to successfully close out a minor from the previous year's audit. The 20-21 audit was an improvement on previous years; 19-20 saw x0 major and x7 minor, whilst 18-19 saw x6 major and x11 minor actions.

A bi-monthly report on decontamination operational performance was instigated in Q3 and is monitored by the Theatre Management Group which sits monthly.

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Mycobacterium neoaurum detection at the Quadram Institute (QI)
Routine weekly testing at the QI endoscopy unit suggested the presence of Mycobacterium in mid-January. Precautionary measures were implemented by way of the transfer to the main hospital facility of scoping for immune-compromised patients, as well as the decontamination of 'upper' scopes. Readings for Mycobacterium returned to normal parameters when the surrogate device used in testing was replaced with a new surrogate and test soil was replaced with a sterile product. The protocols for testing were also reviewed and signed off.

Operational highlights
During the year x3 replacement washer disinfectors and x2 sterilisers were installed and commissioned in line with the rolling capital replacement program.

Decontamination activity fell in all areas during both peaks of COVID. During the first peak a series of important renovations of the flooring and the drainage system in the main sterilisation unit were expedited and successfully completed.

Risks
The Group has made tangible progress in the governance of areas performing remote decontamination. The issue of local decontamination was flagged as a corporate risk with a rating of 12 throughout 20-21. In response to this a sub group was initiated in Q4. This group now maintains a schedule of remote decontamination activity and reviews local SOPs to ensure compliance. The list of areas will be refreshed every six months.

The rating for this risk is under review as at April 2021. There are no other decontamination risks on the register.

Anthony Mutti, Divisional Operations Director, Surgery
Chair of the Trust Decontamination Group
Norfolk and Norwich University Hospitals NHS Foundation Trust

Water Safety Management Group Report

1st April 2020 – 31st March 2021

The Water Safety Management Group is held on a monthly basis and stakeholders include NNUH facilities management, NNUH Divisional representation, external facility providers and external responsible person for water compliance.

Under the Health and Safety at work act 1974 and control of substances hazards to health regulations 2002, actions are taken to prevent and control harmful effects of contaminated water – Legionella and Pseudomonas aeruginosa in order to ensure the safety of our staff, patients and other persons – this includes safe hot water, cold water and drinking water.

The Water Safety Group provides assurance that areas of non-compliance and risks are identified, action plans and mitigations are in place; ensuring that IP&C procedures are maintained and monitored and approval for changes in procedure are agreed and approved.

A Trustwide report is completed on a monthly basis providing assurance on legionella testing and pseudomonas testing and outcomes of testing, the report is shared and presented to HICC.

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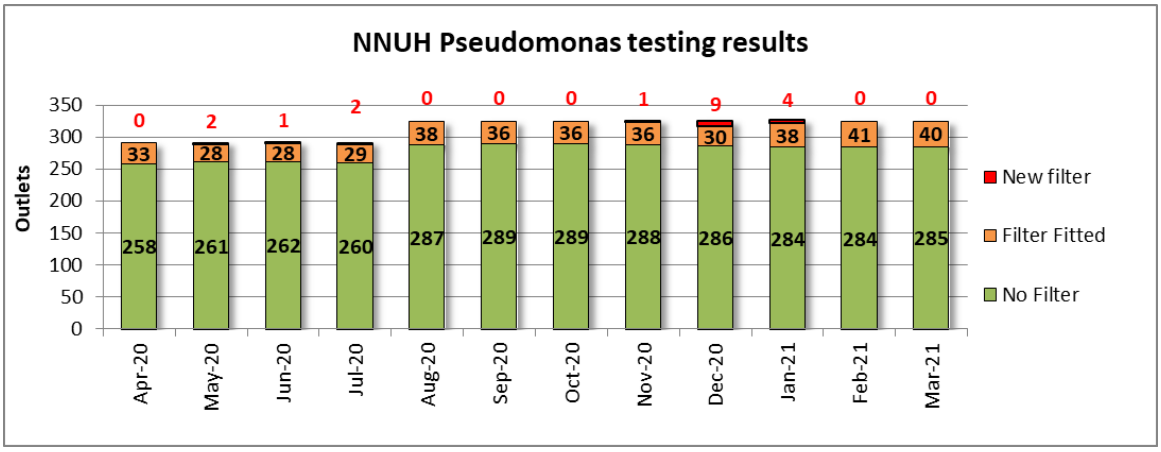
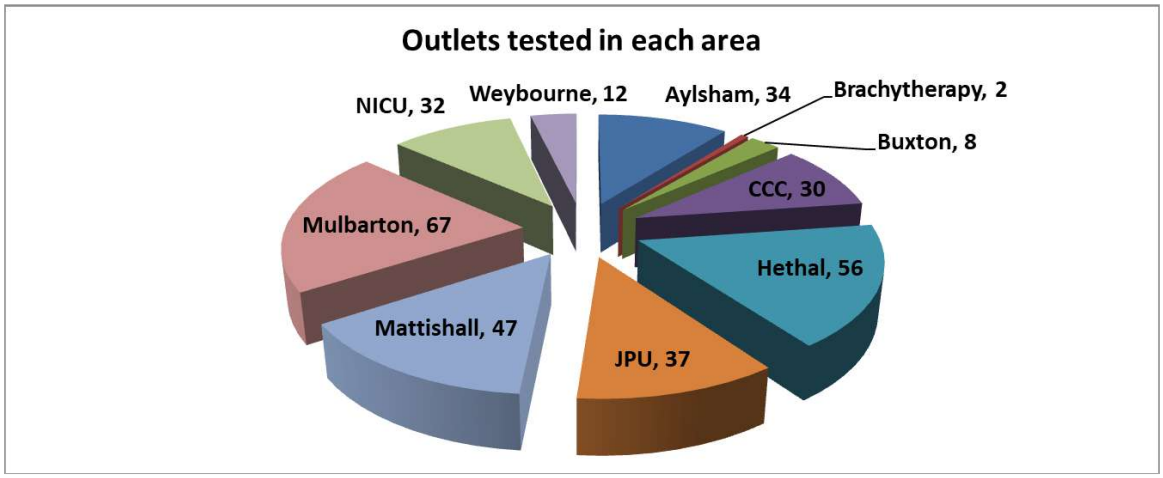
Graph 1

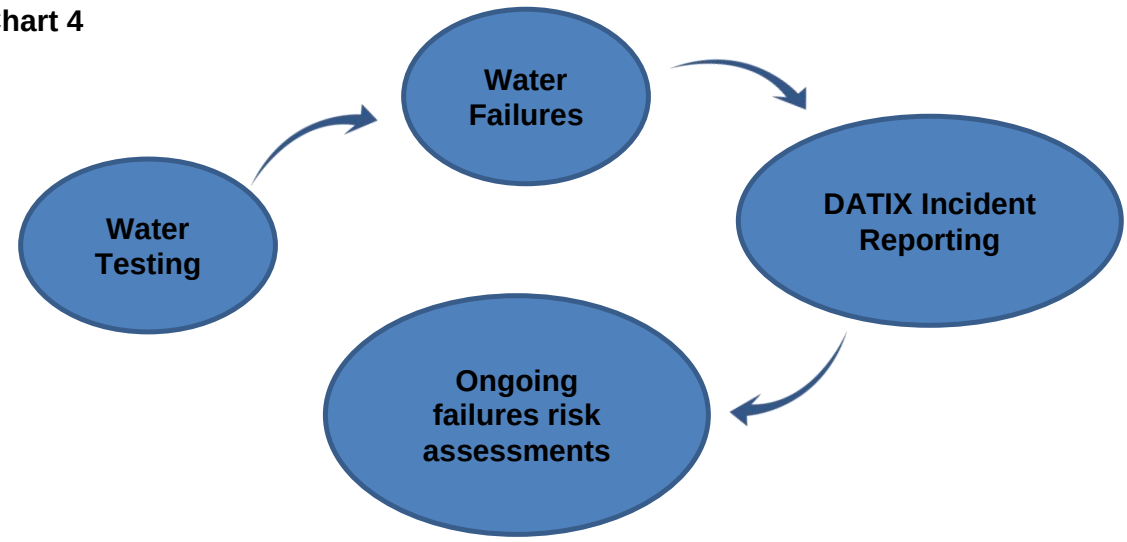


Graph 2



Divisional water safety reports are now provided monthly which clearly identifies unused water outlets on flushing schedule and usage of filters. The Divisional reports provide Division specific information that will drive ownership and collaborative work with Serco and Facilities to provide water safety assurance

Chart 4



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Offsite clinic areas hosted by NNUH and water safety.

Over 50 off site areas are used by NNUH staff to host clinics for patients.
All facility managers of external organisations are contracted to provide assurance of testing and provide assurance that NNUH facilities managers will be contacted re failures/concerns.

NNUH vehicles providing clinic areas across Norfolk & Waveney follow Standard Operating Procedures to ensure water safety.

Water Safety Management Group 2021-2022 development.

- Divisional water safety reports further developed and understood to ensure that all unused water outlets are identified and flushed (water outlets that are used less than twice weekly for more than 5 working days)
- Ongoing use of filters on outlets is investigated collectively between Divisional staff and Serco/Facilities.
- Incident/risk recording is clarified and implemented.
- Ward water safety guidelines / checklist in place and a staff training/education package is available for all staff, providing clear guidance on rates and responsibilities.

Tracey Fleming
Chair of Water Safety Management Group
Divisional Director Clinical Support Services
Norfolk and Norwich University Hospitals NHS Foundation Trust

Ventilation

Full ventilation cleans were undertaken in Theatre 1, 14, 15 and the Critical Care Complex during this period.

ICNet (IP&C Software system)

For the last 14 years the IP&C team have used a commercial software system, called ICNet to manage alert organism results, suspected infections, monitor for Periods of Increased Incidence (PII) and minimise risk of outbreaks. However ICNet has served notice on the existing software and will no longer support from July 2021 due to its age. A Sustainability Transformation Partnership (STP) bid for a system wide ICNet upgrade was unsuccessful. Over the last year we have been working with our Digital Health colleagues to assess, prepare and develop a replacement system called WebV which links to our eOBS package and other systems that are due to be implemented.

Building

It has been another busy year for building projects across the different sites, with the IP&C team participating in a variety of refurbishment and new developments across the organisation to improve and increase the facilities available to treat patients. Our role is multifaceted but includes informing the design phase to ensure compliance with guidance documents and also addresses human factor challenges that can be rectified with a new project. We work as part of the project team with the department users, facilities department, project teams and the contractors. Towards the end of the projects we are part of the snagging and sign off team to ensure the finished product meets requirements and is safe for patient care to commence.

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Some of the projects IP&C have been involved in this year are as below:-

- Construction commenced on the Macmillan centre at Cromer Hospital
- New Interventional Radiography Unit completed
- 3 storey New ward block completed including a critical care unit on level 3 in response to Covid-19. Image 2 shows initial CCC structural work.
- Hoveton Isolation unit completed
- Foetal medicine unit development
- Theatre refurbishment programme ongoing
- Nuclear Medicine redevelopment
- Radiology department reconfiguration
- Ambulatory Procedures Unit – redesign of gastroenterology suites.

Image 1

Image 2

Image 1 shows Level 1 AMUI MDT inspection of progress and snagging.

Image 3

Image 4

Image 5

Part of our role includes placement of dispensers considering human factors, visibility and accessibility (image 2 & 3).

The IP&C team are key to developing creative solutions to address risks in the built environment mid/post construction.

Image 5 shows one of the IP&C nurses about to enter IRU on level 4 of the roof having climbed the scaffolding staircase.

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Quality Improvement work

As part of our involvement in the new 3 level ward block we conducted a Quality Improvement pilot project to address some human factor issues through innovative design. One of the key interventions was to create bespoke utility sinks in the multi occupancy bays to provide a safe place for staff to dispose of waste water to protect the hand washing sinks.

Image 6

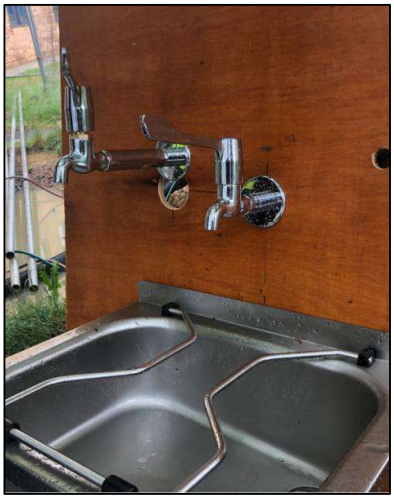

Image 7

Image 6 shows a Prototype utilty sink and image 7 is a f*inished bay.*

Image 8

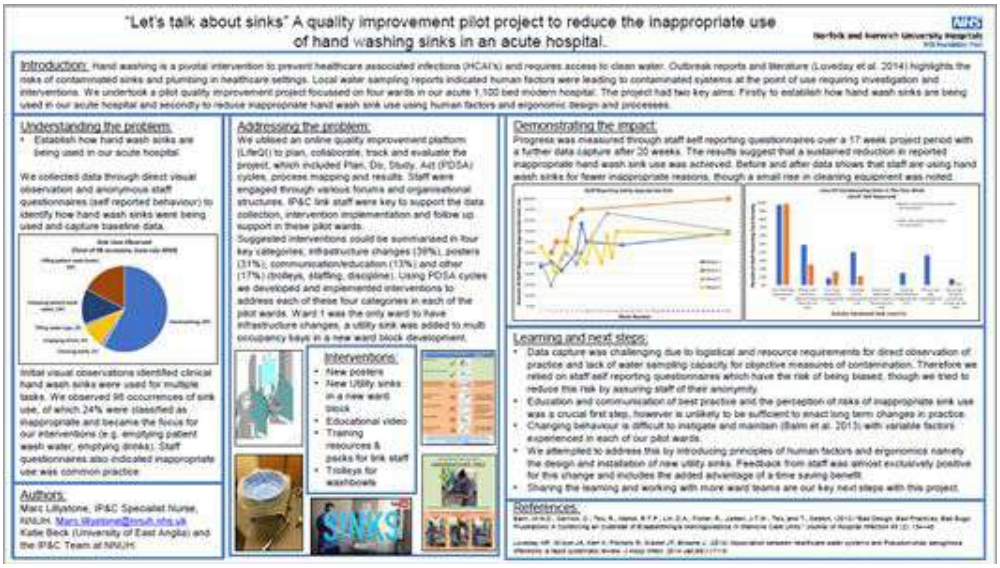

Image 8 is the Quality Improvement poster presented at European BMJ/IHI Patient Safety Conference June 2021.

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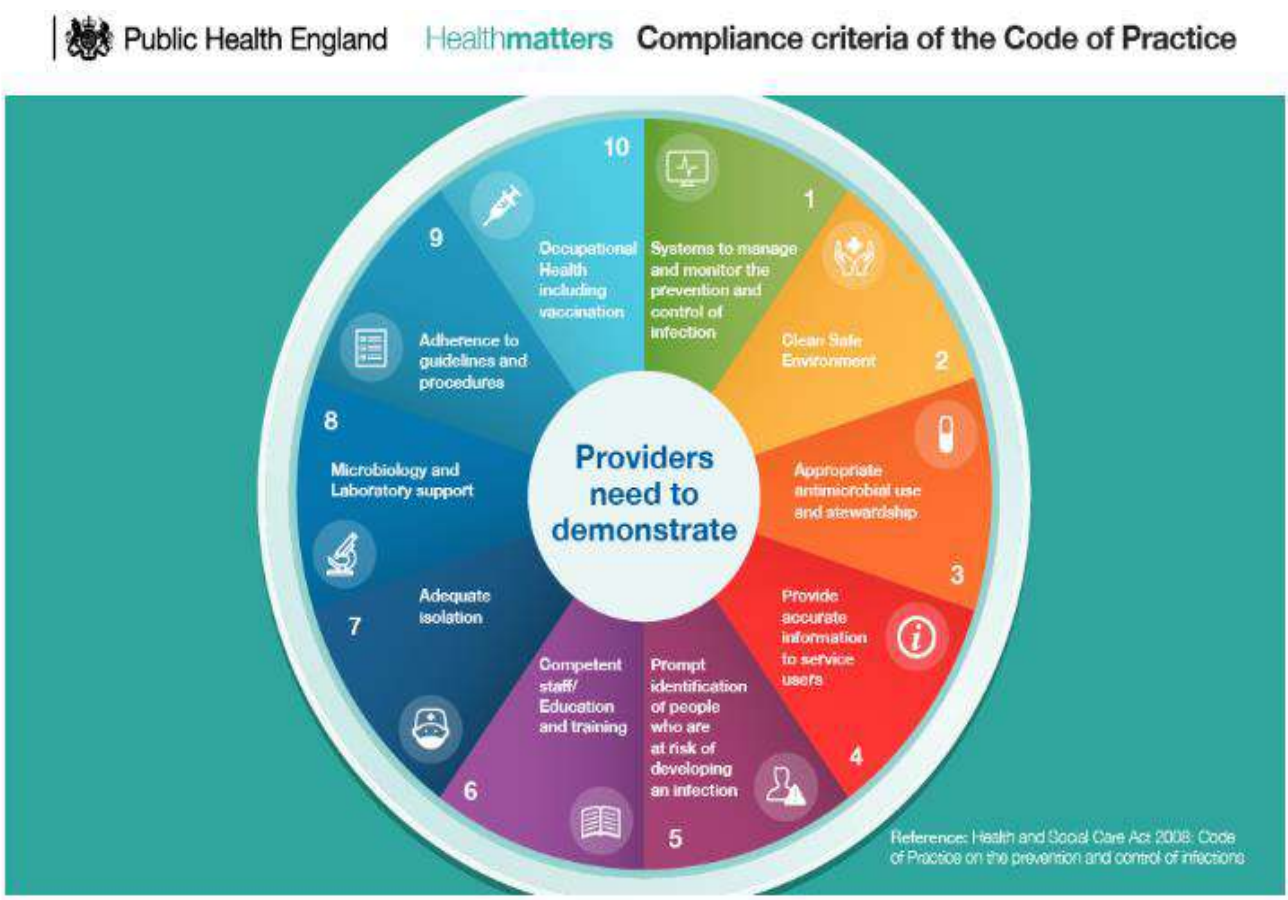
Healthcare Inspections

On the 17th April 2020 CQC published a report recommending the Trust was removed from special measures.

An unannounced CQC inspection of ED was carried out in December 2020. During the inspection there were concerns around delays in triage, consistency of controlling infection risk and staffing. However, the trust took mitigating actions to address the staffing shortfalls. A Warning Notice under Section 29A of the Health and Social Care Act 2008 was issued. The rating of services remained as requires improvement as in the previous inspection of ED in December 2019. The ED has developed an action plan and has an extensive IP&C link practitioner group led by a matron overseeing IP&C practice in the department.

Image 9



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Mandatory Surveillance of Healthcare Associated Infection to Public Health England

Clostridioides difficile infection (CDI)

In line with Public Health guidance, *Clostridium difficile* is known as *Clostridioides difficile* and IP&C & Microbiology have reported accordingly since 22/08/2019.

C. *difficile* attribution for 2020-21 is as follows:

Acute providers:
Hospital onset healthcare associated (HOHA): cases that are detected in the hospital two or more days after admission.

Community onset healthcare associated (COHA): cases that occur in the community (or within two days of admission) when the patient has been an inpatient in the trust reporting the case in the previous four weeks.

Community:
Community onset indeterminate association: cases that occur in the community (or within two days of admission) when the patient has been an inpatient in the trust reporting the case in the previous 12 weeks but not the most recent four weeks.

Community onset community associated: cases that occur in the community (or within two days of admission) when the patient has not been an inpatient in the trust reporting the case in the previous 12 weeks.

Table 1

NNUH C.*difficile* 2020-21 – number of cases

Financial Year	NNUH Objective	Community Origin (sampled before day 2)		Hospital Origin (sampled on or after day 3)		Total
2020-21	35	COIA 25	COCA 114	HOHA 42	COHA 28	209
		139		Total 70 cases of which 46 had no lapses so not counting towards final objective, leaving 24 with lapses in care counting towards the objective		
2019-20	35	COIA 24	COCA 75	HOHA 32	COHA 34	165
		99		Total 66 cases of which 44 had no lapses so not counting towards final objective, leaving 22 with lapses in care counting towards the objective		
2018-19	48	114		Total 31 cases of which 17 with no lapses deducted from final total leaving 14 with lapses in care counting towards the objective		145

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

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Table 2

Public Health England

Clostridium difficile

Count of Healthcare Associated Cases

Trust Code	Acute Trust Name	Trajectory*	2020 April	May	June	July	August	September	October	November	December	2021 January	February	March	Total
RC9	Bedfordshire Hospitals NHS Foundation Trust	33	4	5	4	6	4	3	4	4	4	4	5	3	50
RGT	Cambridge University Hospitals NHS Foundation Trust	95	4	3	5	5	9	5	6	5	3	9	9	8	71
RWH	East & North Hertfordshire NHS Trust	52	3	4	2	3	3	2	10	0	4	5	2	2	40
RDE	East Suffolk and North Essex NHS Foundation Trust	107	9	7	4	6	12	10	11	8	7	6	11	10	101
RGP	James Paget University Hospitals NHS Foundation Trust	24	2	1	0	2	2	1	0	3	2	2	3	1	19
RAJ	Mid and South Essex NHS Foundation Trust	185	11	8	13	13	14	14	11	15	11	10	7	9	136
RD8	Milton Keynes Hospital NHS Foundation Trust	22	1	0	1	3	0	2	2	2	0	2	1	3	17
RM1	Norfolk & Norwich University Hospitals NHS Foundation Trust	35	4	6	8	10	6	7	3	7	4	5	3	6	69
RGN	North West Anglia NHS Foundation Trust	68	3	6	6	7	14	3	14	9	6	8	8	7	91
RGM	Papworth Hospital NHS Foundation Trust	11	0	1	0	1	0	0	0	0	1	1	0	1	5
RQW	Princess Alexandra Hospital NHS Trust	27	1	2	1	4	8	4	3	2	6	9	4	10	54
RCX	The Queen Elizabeth Hospital King's Lynn NHS Trust	44	2	3	5	6	3	2	4	4	5	5	2	8	49
RWG	West Hertfordshire Hospitals NHS Trust	34	3	2	0	6	1	7	4	4	2	4	6	7	46
RGR	West Suffolk Hospitals NHS Trust	20	2	1	3	5	1	4	3	3	3	5	5	7	42
	East of England Total		**49**	**49**	**52**	**77**	**77**	**64**	**75**	**66**	**58**	**75**	**66**	**82**	**790**

*The C. difficile infection objectives for 2020/21 have not yet been published, so objectives for 2019/20 are shown. Objectives for Bedfordshire Hospitals NHS FT, Mid and South Essex NHS FT, and Norfolk and Waveney CCG have been estimated using the 2019/20 objectives for the original organisations prior to each merge

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

Following PIR meetings with the CCG IP&C team, 2 COHA and 22 HOHA cases were reviewed as trajectory (with lapses in care) against an objective of 35 cases. 26 COHA and 20 HOHA cases were deemed non-trajectory (no lapses in care), see table 3.

NNUH has consistently met its national CDI objectives since 2011.

Table 3

NNUH lapses in care identified from 22 HOHA and 2 COHA trajectory cases of *C. difficile* 2020-21	
Lapses	Number of times lapse occurred
Gaps in stool chart	4
Delay in sampling	13
Delay in isolation (placing in single room)	13
Poor communication issues	2
Inappropriate prescribing	1
Sample not sent on previous Admission	1
Some trajectory cases had more than one lapse. Lapses are included in the learning outcomes.	

A weekly multidisciplinary team ward round of CDI patients is led by a consultant microbiologist.

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

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

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

Glycopeptide-resistant Enterococcus (GRE) BSI

The Trust continues to record very low rates of GRE BSI. These have remained stable in single figures annually since 2013-14. Patient identified as having a GRE are nursed in a single room with enhanced IP&C precautions. Antibiotics are prescribed based on the sensitivity of the particular strain.

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

There were 11 cases of GRE/VRE BSI in 2020-21.

Carbapenemase-producing Enterobacteriaceae (CPE)

In the UK, over the last seven or so years there has been a rapid rise in the incidence of infection and colonisation by multi-drug resistant carbapenemase-producing organisms (CPO) with an increase in the number of clusters and outbreaks reported in England.

Table 4

Carbapenemase-producing Enterobacteriaceae - Cases identified			
Financial Year	New cases tested positive on admission	New positive cases	Previously positive patients tested negative on admission
2020-21	**3**	• Previous positive from Addenbrookes Hospital, • Previous positive from NCH&C • Previous CPO now CPE	**5**
2019- 20	5	3 Screened due to hospital admissions in Greece, London and S. Africa 2 x clinical samples	3
2018-19	4	Screened due to hospital admissions in United Arab Emirates, Greece, Egypt and London	3
3 new cases identified 2020-21			

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Gram Negative Bacteraemia/BSI

In 2016, the Department of Health and Social Care set an ambition for England to halve the number of healthcare associated Gram negative Blood Stream Infections (BSI) by March 2021. Recognising this as a complex challenge with more than 50% of infections occurring in people outside of hospital settings, the NHS Long Term Plan supports a 50% reduction across the healthcare economy by 2024/25.

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

This is the third year of PHE reporting for *Klebsiella species and Pseudomonas aeruginosa* and therefore we now have comparative figures for E.coli, Klebsiella and Pseudomonas aeruginosa. See tables 5, 6, 7, 8, 9 & 10.

Escherichia coli

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

The IP&C team developed a Standard Operating Procedure (SOP) to reduce Urinary tract infections and gram negative blood stream infections in 2019-20 and have worked collaboratively to promote these resources in relation to urine sampling, mid-stream urine collection, hydration, patient information and catheter prevention. The IP&C team are keen to do further collaborative work across the whole healthcare economy to prevent Gram negative bacteraemia.

33% of the 46 Hospital origin E.coli BSI were considered to have a lower urinary tract primary focus. 33% of these had E.coli reported in a Catheter Specimen Urine or Mid-stream Specimen of Urine. 73% had a urinary catheter in the past 28 days.

Table 5

NNUH *Escherichia coli* BSI – number of cases

Financial Year	Community Origin	Hospital Origin (on or after day 3)	Total
2020-21	335 (87.92%)	46 (12.08%)	381
2019- 20	293 (87.21%)	43 (12.79%)	336
2018-19	295 (83%)	57 (17%)	352

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Table 6

Public Health England

Escherichia coli

Count of Healthcare Associated Cases

Trust Code	Acute Trust Name	Trajectory*	2020 April	May	June	July	August	September	October	November	December	2021 January	February	March	Total
RC9	Bedfordshire Hospitals NHS Foundation Trust	N/A	0	3	3	6	2	3	3	1	2	5	2	2	32
RGT	Cambridge University Hospitals NHS Foundation Trust	N/A	4	10	7	8	12	10	9	13	9	11	6	9	108
RWH	East & North Hertfordshire NHS Trust	N/A	3	1	1	2	1	2	1	2	3	1	0	4	21
RDE	East Suffolk and North Essex NHS Foundation Trust	N/A	4	0	8	6	6	4	5	6	4	7	4	9	63
RGP	James Paget University Hospitals NHS Foundation Trust	N/A	1	4	3	3	5	3	2	2	3	2	4	5	37
RAJ	Mid and South Essex NHS Foundation Trust	N/A	9	9	17	7	6	8	4	8	5	12	3	5	93
RD8	Milton Keynes Hospital NHS Foundation Trust	N/A	1	2	1	2	1	1	0	0	2	4	1	0	21
RM1	Norfolk & Norwich University Hospitals NHS Foundation Trust	N/A	5	1	8	7	3	2	3	3	2	2	7	3	46
RGN	North West Anglia NHS Foundation Trust	N/A	4	5	2	7	4	4	4	9	2	2	3	4	50
RGM	Papworth Hospital NHS Foundation Trust	N/A	1	1	0	1	1	0	0	0	2	4	3	1	14
RQW	Princess Alexandra Hospital NHS Trust	N/A	1	1	1	2	0	2	1	1	0	1	2	0	12
RCX	The Queen Elizabeth Hospital King's Lynn NHS Trust	N/A	0	1	0	2	2	0	4	3	3	4	3	1	23
RWG	West Hertfordshire Hospitals NHS Trust	N/A	0	3	1	2	3	3	2	3	4	3	1	2	27
RGR	West Suffolk Hospitals NHS Trust	N/A	0	0	0	1	2	4	1	2	5	1	1	1	18
	East of England Total		33	41	52	56	48	46	45	53	46	59	40	46	565

*The C. difficile infection objectives for 2020/21 have not yet been published, so objectives for 2019/20 are shown. Objectives for Bedfordshire Hospitals NHS FT, Mid and South Essex NHS FT, and Norfolk and Waveney CCG have been estimated using the 2019/20 objectives for the original organisations prior to each merge

Table 7

NNUH *Klebsiella* BSI – number of cases

Financial Year	Community Origin	Hospital Origin (on or after day 3)	Total
2020-21	79 (73.1%)	29 (26.9%)	108
2019- 20	68 (83%)	14 (17%)	82
2018-19	55 (80%)	14 (20%)	69

Table 8

Public Health England

Klebsiella spp.

Count of Healthcare Associated Cases

Trust Code	Acute Trust Name	Trajectory*	2020 April	May	June	July	August	September	October	November	December	2021 January	February	March	Total
RC9	Bedfordshire Hospitals NHS Foundation Trust	N/A	1	0	2	2	3	3	4	4	1	0	1	1	22
RGT	Cambridge University Hospitals NHS Foundation Trust	N/A	10	2	4	6	4	7	6	7	6	10	10	1	73
RWH	East & North Hertfordshire NHS Trust	N/A	0	1	0	0	0	0	2	1	0	1	1	2	8
RDE	East Suffolk and North Essex NHS Foundation Trust	N/A	2	3	1	3	3	0	2	3	5	2	1	3	28
RGP	James Paget University Hospitals NHS Foundation Trust	N/A	1	0	2	1	2	1	4	2	3	1	1	4	22
RAJ	Mid and South Essex NHS Foundation Trust	N/A	6	7	4	4	0	2	6	8	8	8	5	4	62
RD8	Milton Keynes Hospital NHS Foundation Trust	N/A	2	0	1	0	1	0	0	0	0	1	1	2	8
RM1	Norfolk & Norwich University Hospitals NHS Foundation Trust	N/A	2	2	1	1	0	1	3	5	1	6	3	4	29
RGN	North West Anglia NHS Foundation Trust	N/A	3	2	2	0	0	2	2	1	4	2	0	1	19
RGM	Papworth Hospital NHS Foundation Trust	N/A	4	0	2	0	0	1	1	3	2	4	4	0	21
RQW	Princess Alexandra Hospital NHS Trust	N/A	1	0	2	0	0	1	0	1	0	1	1	1	8
RCX	The Queen Elizabeth Hospital King's Lynn NHS Trust	N/A	1	1	1	2	0	0	0	3	0	2	0	1	11
RWG	West Hertfordshire Hospitals NHS Trust	N/A	1	0	1	2	1	1	3	2	1	3	0	3	18
RGR	West Suffolk Hospitals NHS Trust	N/A	0	0	0	0	1	0	1	2	0	2	1	0	7
	East of England Total		36	19	25	25	17	19	34	42	31	43	29	27	347

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Table 9

NNUH *Pseudomonas aeruginosa* BSI – number of cases			
Financial Year	**Community Origin**	**Hospital Origin (on or after day 3)**	**Total**
2020-21	40 (75.5%)	13 (24.5%)	53
2019- 20	35 (71.5%)	14 (28.5%)	49
2018-19	30 (67%)	15 (33%)	45

Table 10

Public Health England

Pseudomonas aeruginosa

Count of Healthcare Associated Cases

Trust Code	Acute Trust Name	Trajectory*	2020 April	May	June	July	August	September	October	November	December	2021 January	February	March	Total
RC9	Bedfordshire Hospitals NHS Foundation Trust	N/A	0	0	1	0	0	0	0	1	0	0	0	1	3
RGT	Cambridge University Hospitals NHS Foundation Trust	N/A	2	4	2	4	4	3	2	2	0	4	5	4	36
RWH	East & North Hertfordshire NHS Trust	N/A	0	0	0	1	0	3	1	1	0	0	0	1	7
RDE	East Suffolk and North Essex NHS Foundation Trust	N/A	1	0	0	2	0	3	1	1	0	1	1	2	12
RGP	James Paget University Hospitals NHS Foundation Trust	N/A	0	0	1	0	0	1	2	0	2	0	0	1	7
RAJ	Mid and South Essex NHS Foundation Trust	N/A	0	3	1	1	0	3	1	3	1	0	2	1	16
RD8	Milton Keynes Hospital NHS Foundation Trust	N/A	0	0	1	1	0	2	0	0	0	1	0	0	5
RM1	Norfolk & Norwich University Hospitals NHS Foundation Trust	N/A	1	0	3	1	3	2	0	0	2	0	1	0	13
RGN	North West Anglia NHS Foundation Trust	N/A	0	0	0	1	1	0	1	1	1	0	0	0	5
RGM	Papworth Hospital NHS Foundation Trust	N/A	0	0	1	0	0	0	0	1	1	0	1	1	5
RQW	Princess Alexandra Hospital NHS Trust	N/A	0	1	0	0	0	1	0	0	1	0	0	0	3
RCX	The Queen Elizabeth Hospital King's Lynn NHS Trust	N/A	1	0	2	3	3	0	0	0	0	0	0	0	9
RWG	West Hertfordshire Hospitals NHS Trust	N/A	0	0	0	0	1	0	1	2	0	1	0	1	6
RGR	West Suffolk Hospitals NHS Trust	N/A	0	0	0	0	0	0	1	0	0	0	0	0	1
	East of England Total		5	8	12	14	12	18	10	12	8	7	10	12	128

Methicillin Susceptible and Methicillin Resistant *Staphylococcus aureus*

The bacteria *Staphylococcus aureus* is commonly found colonising the skin and mucous membranes of the nose and throat. It is capable of causing a wide range of infections from minor boils to serious wound infections, however most people carry this organism harmlessly. In hospitals, it can cause surgical wound infections and bloodstream infections. Mandatory reporting includes all isolates, whether true infections or contaminated blood cultures and will initially be attributed to the Trust if the positive specimen is taken on or after day 3 of admission.

MSSA BSI

There is no national objective currently for MSSA. See table 11 & 12.

72% of MSSA BSI were of community origin. Of the 37 hospital origin 43% had an unknown primary focus, followed by 13% with a skin and soft tissue primary focus. A safer practice notice was communicated to promote ANTT for blood culture collection (image 10) since it was thought that some of the unknown source may be contaminants.

Image 10

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Table 11

NNUH MSSA BSI - number of cases			
Financial Year	**Community Origin**	**Hospital Origin on or after day 3**	**Total**
2020-21	**94 (71.8%)**	**37 (28.2%)**	**131**
2019-20	74 (77.9%)	21 (22.1%)	95
2018-19	87 (88.8%)	11 (11.2%)	98

Table 12

Public Health England

Methicillin-sensitive Staphylococcus aureus

Count of Healthcare Associated Cases

Trust Code	Acute Trust Name	Trajectory*	2020 April	May	June	July	August	September	October	November	December	2021 January	February	March	Total
RC9	Bedfordshire Hospitals NHS Foundation Trust	N/A	2	0	1	1	2	1	5	1	0	1	0	1	15
RGT	Cambridge University Hospitals NHS Foundation Trust	N/A	0	2	0	1	2	5	3	0	2	1	4	1	21
RWH	East & North Hertfordshire NHS Trust	N/A	0	0	2	0	2	2	4	2	1	1	1	1	16
RDE	East Suffolk and North Essex NHS Foundation Trust	N/A	1	5	1	1	4	4	2	1	2	3	5	5	34
RGP	James Paget University Hospitals NHS Foundation Trust	N/A	0	0	1	1	1	3	1	1	1	2	2	1	14
RAJ	Mid and South Essex NHS Foundation Trust	N/A	9	4	4	3	4	5	8	4	3	3	2	9	58
RD8	Milton Keynes Hospital NHS Foundation Trust	N/A	1	1	1	1	3	2	2	1	0	1	0	0	13
RM1	Norfolk & Norwich University Hospitals NHS Foundation Trust	N/A	0	3	4	1	2	6	3	4	4	4	5	1	37
RGN	North West Anglia NHS Foundation Trust	N/A	2	2	1	0	3	2	0	1	0	2	0	0	13
RGM	Papworth Hospital NHS Foundation Trust	N/A	1	0	0	0	1	0	0	1	1	0	0	1	5
RQW	Princess Alexandra Hospital NHS Trust	N/A	1	2	0	1	0	0	0	0	1	1	1	0	7
RCX	The Queen Elizabeth Hospital King's Lynn NHS Trust	N/A	1	0	0	2	0	1	3	1	2	1	0	2	13
RWG	West Hertfordshire Hospitals NHS Trust	N/A	1	0	0	0	1	0	1	1	1	0	1	0	6
RGR	West Suffolk Hospitals NHS Trust	N/A	1	0	0	1	1	4	0	2	0	1	0	1	11
	East of England Total		20	19	15	13	26	35	32	20	18	21	21	23	263

MRSA BSI

All *Staphylococcus aureus* BSI are reported. They are categorised according to their resistance to antibiotics and are then reported separately as Methicillin Sensitive *Staphylococcus aureus* (MSSA) and Methicillin Resistant *Staphylococcus aureus* (MRSA). Surveillance and reporting of MRSA BSI continues with the limit set at 0 avoidable cases. See tables 13 & 14.

There were no hospital origin MRSA BSI during 2020-21.

Table 13

NNUH MRSA BSI - number of cases			
Financial Year	**Community Origin**	**Hospital Origin (on or after day 3)**	**Total**
2020-21	**4**	**0**	**4**
2019- 20	2	0	2
2018-19	2	1 (likely contaminant)	3

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Table 14

Public Health England

Methicillin-resistant Staphylococcus aureus

Count of All Cases

Trust Code	Acute Trust Name	Trajectory*	2020									2021			Total
			April	May	June	July	August	September	October	November	December	January	February	March	
RC9	Bedfordshire Hospitals NHS Foundation Trust	N/A	0	0	1	0	0	0	0	0	0	2	1	0	4
RGT	Cambridge University Hospitals NHS Foundation Trust	N/A	0	0	0	1	1	0	0	0	2	2	2	0	8
RWH	East & North Hertfordshire NHS Trust	N/A	2	1	0	0	2	1	0	0	0	0	0	0	6
RDE	East Suffolk and North Essex NHS Foundation Trust	N/A	2	3	2	1	0	0	0	0	1	0	1	1	11
RGP	James Paget University Hospitals NHS Foundation Trust	N/A	0	0	1	0	0	0	0	1	0	0	0	0	2
RAJ	Mid and South Essex NHS Foundation Trust	N/A	0	3	1	4	1	3	1	3	3	0	1	2	22
RD8	Milton Keynes Hospital NHS Foundation Trust	N/A	0	0	0	0	0	0	0	1	0	0	0	0	1
RM1	Norfolk & Norwich University Hospitals NHS Foundation Trust	N/A	0	0	1	0	1	0	0	0	0	2	0	0	4
RGN	North West Anglia NHS Foundation Trust	N/A	0	0	1	0	0	0	1	1	0	0	0	1	4
RGM	Papworth Hospital NHS Foundation Trust	N/A	0	0	1	0	0	0	0	0	1	1	0	0	3
RQW	Princess Alexandra Hospital NHS Trust	N/A	1	1	0	1	0	0	0	0	0	1	0	0	4
RCX	The Queen Elizabeth Hospital King's Lynn NHS Trust	N/A	0	0	1	0	1	0	0	0	0	0	0	0	2
RWG	West Hertfordshire Hospitals NHS Trust	N/A	0	0	0	0	0	0	0	2	0	1	2	0	5
RGR	West Suffolk Hospitals NHS Trust	N/A	0	1	0	0	0	0	1	1	0	1	1	0	5
	East of England Total		**5**	**9**	**9**	**7**	**6**	**4**	**3**	**9**	**7**	**10**	**8**	**4**	**81**

Audit Programme

The IP&C team continue to work collaboratively with a variety of Trust staff and IP&C link practitioners to provide a wide range of audits. These cover IP&C practice, equipment and environmental cleanliness, hand hygiene, commode and bedpans, beverage bay and dirty utility areas. The aim is to provide assurance, sharing of any learning and good practice to promote continuous improvement. An annual isolation audit was also undertaken across the Trust.

Peripheral cannula, central venous catheter and urinary catheter care bundle practice is audited along with the practice to prevent ventilator associated pneumonia. The divisional areas and link practitioners take ownership of these audits and are encouraged to use peer auditing where possible.

The Perfect ward smart inspection app introduced in 2019 replaced a number of paper audits, enabling staff to carry out and report inspections using hand held devices. Peer audits are also conducted to enable staff to validate scores. This is an effective way of monitoring quality across the Trust's clinical areas. The audit system provides opportunity for photographic evidence and free-text comments. Results and reports are available on completion. These reports are utilised to provide performance comparisons and trends for individual areas, across divisions and as a Trust as a whole, highlighting any improvements required. Development of the action planning function to this system began during this period.

Image 11

Image 12

The IP&C Perfect ward audits are completed weekly at a minimum with the ability to increase frequency as required. Bespoke COVID audits provided the ability to monitor the areas on the low, medium and high risk pathways. See chart 4 for annual IP&C summary.

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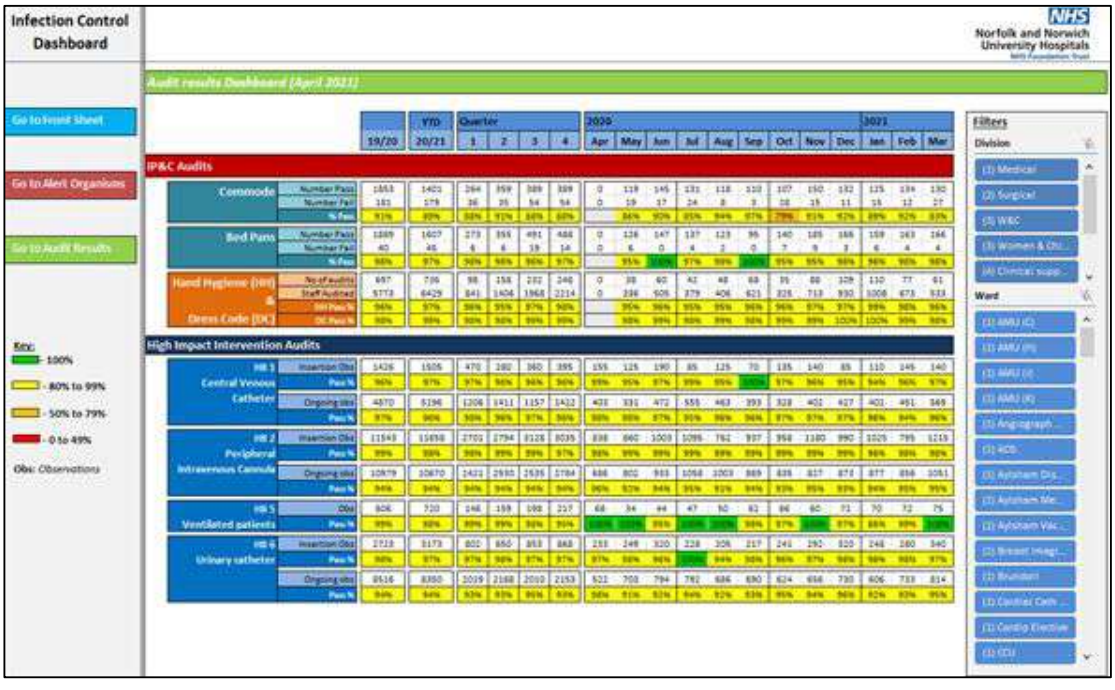
Chart 5

Divisional representatives discuss all audit results in their report at the monthly HICC meetings. These reports also provide details of any areas of non-compliance and the actions that are being instigated to drive any improvements required.

Audit results are also shared with clinical areas and can be accessed via the intranet on the IP&C electronic dashboard where they can be viewed by individual area, division or whole trust. See chart 6.

Image 13

Chart 6



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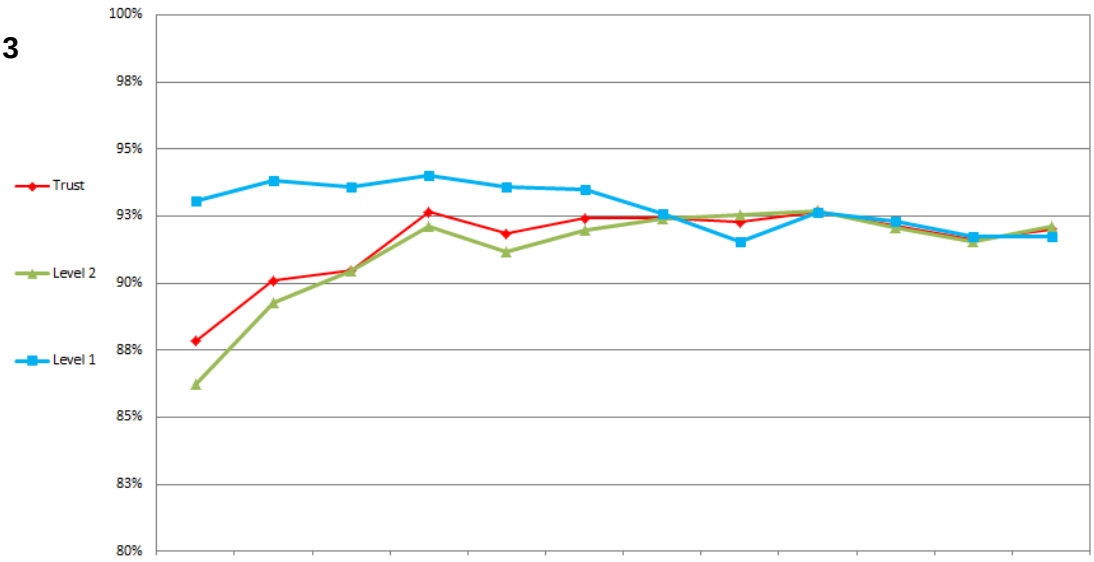
Staff Training and Supervision

Training and Education:

During this last year the majority of our attention has been focussed on COVID. We stopped large scale in person mandatory training sessions and pivoted to delivering our training via Microsoft Teams and also making the national IP&C e-learning package available as an option for staff. Both of these delivery methods had advantages and challenges but certainly allowed staff the flexibility to maintain their IP&C training compliance which as Trust overall rose from 88% up to 92%.

We were able to deliver some COVID secure in person IP&C training sessions, particularly in June 2020 when we were invited to participate in surge training for 259 healthcare assistants and for our newly recruited international nurses (Graph 4). Alongside this the IP&C team were involved in supporting our clinical teams across the organisation in their response to COVID -19 and the remobilisation of services.

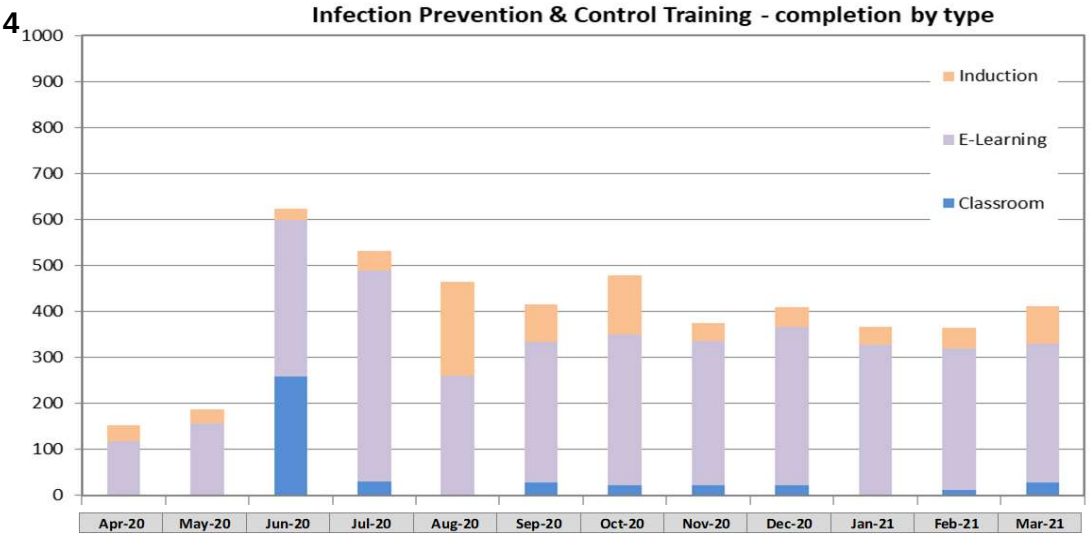
Graph 3



IP&C Level	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
All levels	87.8%	90.1%	90.5%	92.6%	91.8%	92.4%	92.4%	92.3%	92.7%	92.1%	91.6%	92.0%
Level 1	93.0%	93.8%	93.6%	94.0%	93.6%	93.5%	92.6%	91.6%	92.6%	92.3%	91.8%	91.7%
Level 2	86.2%	89.3%	90.4%	92.1%	91.1%	92.0%	92.4%	92.6%	92.7%	92.0%	91.6%	92.1%
Level 3	82.9%	85.0%	82.9%									

Compliance % figures exclude Honorary, Locums and Bank staff
Note: From July 2020 Level 3 IP&C is no longer a requirement, those staff with Level 3 now require Level 2

Graph 4



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University of East Anglia (UEA) Healthcare student training

In partnership with the UEA we continue to support the training of undergraduate healthcare students (nursing, occupational therapy, speech and language therapy and physiotherapy). This year the sessions were delivered virtually as in person skills sessions were significantly restricted based on COVID guidance for universities.

IP&C team training

The IP&C team have taken advantage of numerous opportunities to engage with training and development opportunities in the form of webinars and e-conferences. These have been more accessible, largely free and a great opportunity to hear from leading experts in their fields from our desks between other clinical and management commitments.

IP&C International awareness week

Each year the whole IP&C team get involved in raising awareness about key IP&C matters during international Infection Prevention Week which in this period was during October 2020. Planning for this event was challenging given the pandemic but we were pleased to see wards and link staff engaging in our programme of activities (image 14), particularly the challenge of making their IP&C staff notice board eye catching to highlight key issues in their area. Congratulations to Cley ward (Gynaecology) who won the prize of a Nespresso coffee machine for their staff rest area, presented by our DIPC Professor Nancy Fontaine (image 15 & 16).

Image 14

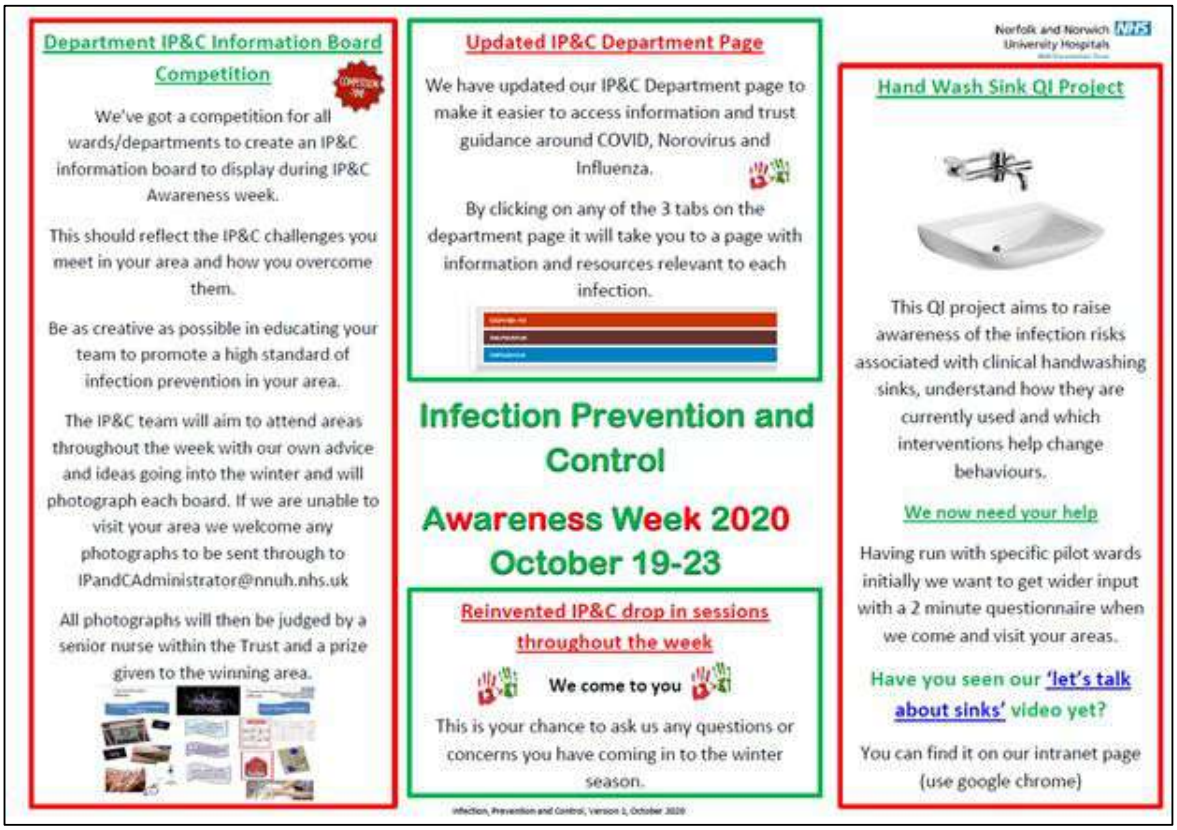

Image 15

Image 16

IP&C link practitioners

The IP&C Team continued to provide support to the IP&C link practitioners in the Trust during 2020-21.

Meetings took place throughout the year with a variety of topics covered. These were attended by IP&C link practitioners from across the organisations, who were encouraged to use these hours towards their Continuing Professional Development (CPD). See table 15.

Table 15

IP&C Link Practitioner meetings 2020-21			
23/06/2020	**23/09/2020**	**03/12/2020**	**16/03/21**
Agenda • IP&C reflections from COVID wave 1 • C. *difficile* annual summary (2019/20) • New buildings update and IP&C innovations • Patient wash water Quality Improvement Programme	**Agenda** • COVID update • C. *difficile* • Hand hygiene • Hand wash sink Quality Improvement Programme • Ecolab	**Agenda** • COVID update • IP&C notice boards • COVID and staff (IP&C considerations) • Mattress checking • A ward sister's experience of supportive measures	**Agenda** • IT and Infection Control • An assistant practitioner's experience relocated to IP&C during COVID wave 2 • PPE, safe mask use • Feedback and learning from COVID outbreaks

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Organisation Wide Learning (OWL)

The IP&C team continues to produce a monthly organisational wide learning (OWL). December 2020 was the only month an OWL was not produced due to the organisational and team pressures of the COVID -19 pandemic at that time. The OWL is sent out in the form of a poster, sharing Trust wide IP&C information and learning such as:

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

Three examples of the OWL from the year are shown below (see image 17).

Image 17

Movement of Service Users

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

During the COVID pandemic the IP&C team worked closely with Information Services (IS) and the Incident Management Team (IMT) to ensure that suitable reports were available to identify contacts and isolate and cohort patients safely. This partnership working helped to facilitate the safe management of patients in the Trust in line with COVID-19: Guidance for maintaining services within healthcare settings Infection prevention and control recommendations and prior to this the PHE Guidance for the remobilisation of services within healthcare settings and the COVID-19: Infection Prevention and Control Guidance. These detailed the high, medium and low risk pathways.

The safe placement of patients with suspected or confirmed infections is paramount to prevent nosocomial transmission. The IP&C team work closely with the Operational management team and IMT to utilise the reports provided to manage the patient pathways as safely as possible.

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The IP&C team provide an on call service and attend daily operational meetings to support and provide advice.

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

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

Cleaning

The IP&C team work in partnership to deliver a clean safe environment for patients. Cleaning schedules are displayed in each area.

Image 18

Cleaning Audits

Cleaning of the environment, equipment and estates are monitored through regular joint audits attended by both Trust and Provider staff using FM First software. See tables 16, 17 & 18.

Table 16

NNUH Cromer Hospital site- Cleaning for Credits (C4C) audit scores							
Area	**Number of Audits**			**Average Score**			**Target Range**
	2018-19	2019-20	**2020-21**	2018-19	2019-20	**2020-21**	
Wards	29	24	**26**	97%	97%	**95%**	95-100%
A&E (MIU)	12	15	**14**	97%	94%	**96%**	95-100%
Theatres	25	12	**12**	98%	98%	**95%**	95-100%
Clinics/Admin	47	60	**60**	97%	98%	**97%**	95-100%

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Table 17

NNUH remote sites - Cleaning for Credits (C4C) audit scores							
Area	**Number of Audits**			**Average Score**			**Target Range**
	2018-19	2019-20	**2020-21**	2018-19	2019-20	**2020-21**	
Cotman Centre admin	72	72	**72**	97%	98%	**99%**	95-100%
Francis Centre admin	12	12	**12**	94%	93%	**93%**	75% (Low risk)
Eye Clinic Grove Road*	12	12	**11**	98%	99%	**99%**	95-100%
Rouen Road	72	72	**72**	96%	97%	**98%**	95-100%
Kidney Centre**	0	0	**32**	0	0	**97%**	98-100%
* Eye clinic – closed April 2020. ** The kidney centre was not operational between January 2020 – July 2020							

Cleaning Services throughout the period responded to the organisational pressure in combatting the pandemic whilst maintaining core service delivery, and working in conjunction of significant capital works requirements. During the period additional investment of equipment included ‘e-mobile’ cleaning which improved oversight of the clinical clean process for management teams and the site operations team. FM first, the new bespoke audit tool which was also introduced within the period supporting the quality assurance of national cleaning standards, with training commencing during the third and fourth quarter. Further investment in supervisory support was also introduced during the period and refresher training for the cleaning team commenced over with over 90% completion at the end of the period.

Table 18

NNUH Colney Site - Cleaning for Credits (C4C) audit scores							
Area	**Number of Audits**			**Average Score**			**Target Range**
	2018-19	2019-20	**2020-21**	2018-19	2019-20	**2020-21**	
Wards	419	408	**405**	96%	96%	**97%**	90%-95%
A&E	52	72	**96**	96%	96%	**97%**	90%-95%
Theatres	156	228	**154**	98%	98%	**98%**	90%-95%
Clinics/Admin &Public Areas	1080	1084	**1228**	97%	97%	**97%**	90%-95%

Patient led, focus on the environment (PLACE)

The annual PLACE inspection last took place in November 2019. It did not go ahead during this year due to the COVID pandemic.

Commode and Bedpan Cleanliness

The IP&C support workers maintain a continuous programme of commode and bedpan audits Trust wide with practical training provided. See table 19.

Table 19

Number of commodes audited and average percentage pass across NNUH sites

Financial Year	Total No. of Commodes audited	Percentage Pass
2020-21	**1401**	**89%**
2019- 20	1853	91%
2018-19	1992	91%

Waste Management including Sharps

Environmental Authority

During 2020 the enforcing authority Environment Agency was scheduled to visit the Colney Site to complete a Healthcare Waste Audit via the local Norwich Waste Team. Part of this comprised of a desktop audit and a number of documents were shared which included the policy, internal audits, training and pre-acceptance audits. Unfortunately due to the ongoing COVID-19 pandemic the audit was postponed as site visits could not be completed, at the current time no revised date has been received.

Face Mask Fit Testing

During the COVID Pandemic the focus of the Health and Safety Team diverted to incorporating the overseeing and managing of the Face Fit Testing Clinics. The clinics utilised an in-house team of testers within the trust to provide competent fit testing to colleagues who would need to wear enhanced Personal Protective Equipment such as FFP3, Respirator. The First clinic was implemented from April to June 2020 and a further clinic was arranged from January to Mid-February 2021 which also included a roaming team which carried on until March 2021.

Waste Policy

The main policy for Waste Management is located on Trust Docs as ID: 609. This policy applies to all sites within the Trust remit although the Facilities Management (FM) companies with operational responsibility differ across the sites.

The policy is approved by Health and Safety Committee and Non Clinical Safety Sub board. The policy was reviewed in January 2021 and included comments for best practice from the Environment Agency Senior Officer and Dangerous Goods Safety Advisor. It is reviewed biannually with the next full review scheduled for January 2023.

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

- Trust Facilities department manage the contracts via facilities management (FM) providers. All clinical waste is currently collected by an appointed external service provider.
- Trust H&S team leads on waste policy and participate in monitoring with Facilities team. The policy is based on the document HTM 07-01 Safe Management of Healthcare Waste.

- During period 2020-21 the Safety Team appointed external contractor Independent Safety Services Ltd to act in the role of Dangerous Goods Safety Advisor on behalf of the Trust.
- Nuclear Medicine department oversee the management process of radioactive waste.

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

- The Dangerous Goods Safety Advisor has a provision of 6 days over the 12 month period which includes report writing.
- Clinical waste is monitored on a daily basis by the FM companies to ensure it has been placed in the correct stream before leaving site. This involves a visual check of bin and content and observation of items entering the compactors. Waste bags are never decanted or opened unless there is any suspicion of them containing incorrect waste.
- On site monitoring of correct clinical waste segregation via pre-acceptance audits (annually) this was completed on the 26th August 2020 by SRCL.
- Security of clinical waste is monitored by the FM contractor and Trust PFI Contract manager.

Duty of Care Visit (Incinerator)
The Duty of Care visit where the clinical waste is processed was completed in September 2019. Due to the COVID -19 pandemic this did not take place during 20-21 due to restrictions on travel, attending site. Trust Health and Safety Lead Advisor has been in contact with the Account Manager at the operator who has informed at the moment site visits are looking at the earliest to be allowed from May 2021. As a temporary measure a desk top audit can be completed and documentation will be provided which is relevant to the Duty of Care process.

Dangerous Goods Safety Advisor (DGSA)
During the contract for 2020-21 the DGSA has visited the Trust on 3 occasions 12th August, 24th November 2020 and 30th March 2021 and has observed the following departments/areas. A further site visit is scheduled for the 28th April 2021.

Table 20

12/08/2020	24/11/2020	30/03/2021
Main waste compound	Pharmacy	Mortuary
Internal and external waste stores;	Endoscopy	Community Nurses
Battery Storage	Sterile Services;	Theatres – Radiation Supervisor
Chemical Storage	Medical Gases;	Nuclear Medicine - Radiation
Transport Documentation.	Service Corridor Waste Storage.	Radiotherapy (Brachytherapy Suite) – Verbal
		Hazardous Waste Documentation

Any issues observed will be incorporated into an action plan and monitored by the Health and Safety Lead Advisor. The completed action plan will be provided back to the DGSA for approval and sign off. Details will also form part of the H&S Quarterly Report which is presented at the H&S Committee.

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Sharps
The safe handling and disposal of sharps is covered by policy Trust Doc ID: 585 Prevention and Management of Needlestick (inoculation), Sharps Injuries, and Blood exposure incidents which also sit within the Health & Safety Team remit.

Compliance with the policy is monitored on an ongoing basis by the following routes: Collaborative approach by the Health & Wellbeing and Health & Safety Team via incidents raised by the electronic reporting system Datix.

- The inoculation Incident Group meets on a quarterly basis and monitors incident trends. This forum also provides the opportunity for each of the division to discuss risk assessments in place for non-safety sharps that are in use.
- Trends of incidences are highlighted through the Health & Safety Committee and Infection Prevention & Control Committee to disseminate to divisional areas to aid learning and prevent future incidents.

The provider of sharps bins has remained the same in this last year with the majority from the supplier Frontier and a small range 1 or 2 from supplier Daniels.

Laundry (information contributed by FM Customer Support Manager)
Unfortunately the duty of care that was due to take place has been cancelled due the COVID - 19 pandemic. Going forwards the Linen team will be looking to arrange all duty of cares for subcontractors for the summer months.

Other measures that the team have in place are as follows.

- Monthly joint inspection which forms part of the PMS evidence, which happens between Serco, Trust and Synergy. This is conducted on a couple of areas and 20 or so pieces across a variety of stock lines are inspected to ensure good standards.
- During COVID this was restricted to be conducted only in linen room to reduce contact with linen and reduce footfall in the ward environment.

Hygiene Code Compliance Criteria 3:
Ensure appropriate antibiotic use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.

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

This year due to COVID -19 we have not had to work towards a CQUIN as per previous years. The Antimicrobial Subgroup Committee meets quarterly to review antimicrobial prescribing issues and reports to the Drugs, Therapeutics and Medicines Management Committee. The team comprises of a Consultant Microbiologist, Lead Antimicrobial Pharmacist and Specialist Antimicrobial Pharmacist.

We have continued our programme of policy review, however COVID -19 has meant the ward rounds have been conducted remotely for much of the year. We have carried out one whole hospital Antibiotic Audit in October 2020.

Antimicrobial Ward Rounds
As previously weekly ward rounds included Vascular and General Surgery Ward, Surgical Wards and all Older People's Medicine (OPM) Wards. Additional areas have been added to the

weekly review programme covering the Gastroenterology and Respiratory wards. These are in addition to a number of other well established clinical rounds that include antimicrobial review – e.g. NICU, Critical Care Units and Haematology and Oncology.

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

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

During April 2020 the antimicrobial team also started to include ongoing ward rounds (remotely) on wards with COVID-19 patients and from October 2020 to March 2021 these wards were the priority for antimicrobial review. The team has also been actively involved in maintaining a safe environment for antibiotic use throughout the trust with liaison regarding NICE guidance for superinfected bacterial pneumonias in COVID-19 positive patients.

Audit
Trust wide antibiotic audits to monitor and improve antimicrobial prescribing and use were carried out in February 2020 and October 2020 and results circulated via HICC, Monthly Infection control report and AMSC.

CQUIN
Since April 2016 antimicrobial stewardship has been a priority in the form of the Antimicrobial Resistance and Stewardship (AMR) CQUIN 2016-2017 and has been continued to be a part of the Sepsis CQUIN 2018-2019. The AMR CQUIN 2019-20 was specifically concentrated on improving the management of lower urinary tract infections in older people (Part CCG1a) and improving surgical prophylaxis in elective colorectal surgery (Part CCG1b). The CQUIN programme was suspended in March 2020 as a result of the COVID-19 pandemic and we have not had to formally work towards a CQUIN during 2020/2021.

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

Forward Planning
Team plans for 2021-22 include:

- Continuation and development of antimicrobial ward rounds
- Trust wide audits
- Supporting the Trust in the management of the COVID-19 pandemic and the maintenance of good antimicrobial stewardship in relation to the pandemic and any future waves.

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

Information for Service Users, Visitors and Carers

The IP&C team regularly update the information and have worked closely with the communications department throughout the pandemic. IP&C information is shared in a number of ways including:

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

During the COVID pandemic patients and visitors have been encouraged to wear face coverings/masks when on the hospital site to protect themselves and others. Posters have been developed to empower patients to help us stop the spread with of COVID-19, hands, face, space and tidy.

Image 19

Image 20

Image 21

The Trust has had a robust visiting SOP in place throughout the pandemic. It has reflected the national picture and the local COVID level states. Visiting is managed via the booking line and ward view to ensure ward staff know who to expect – and there is clarity for visitors on rules via the phone conversations which is supportive for them and the wards. The named visitor provides evidence of a negative lateral flow test within the last 72 hours. There is a clear awareness of who is expected which enables better management of space and conversations with families.

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Hygiene Code Compliance Criteria 5:
Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people.

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

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

Screening is undertaken on all emergency and elective admissions for MRSA. This enables any patients found to be positive whilst in the Trust to have topical decolonisation and if required antimicrobial treatment, see table 21.

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

Table 21

MRSA Screening for Emergency and Elective Patients - numbers of Patient Screened		
Financial Year	**Emergency Screened Patients**	**Elective Screened Patients**
2020-21	**96.8%**	**90.1%**
2019- 20	95.6%	95.4%
2018-19	96.1%	96.5%

There is also a screening process in place for patients that may be at risk of CPE or are a previously known case, see table 22.

Table 22

Carbapenamase-Producing Enterobacteriaceae - numbers of Patient Screened				
Financial Year	Admission in UK high risk hospital in last year	Hospital admission abroad in last year	Screened for other reasons (e.g. Holiday for Renal Dialysis patients)	Total
2020-21	**162**	**28**	**119**	**309**
2019-20	146	143	6	295
2018-19	166	125	57	348

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Period of Increased Incidence (PII) and Supportive Measures

IP&C Supportive Measures are undertaken for areas having a PII, (2 or more hospital acquired *C. difficile,* MRSA or ESBL results received from the same ward within 28 days). The IP&C team support ward areas with additional audits and education. These measures aim to support and educate staff to reduce the PII of infection. Ward staff are trained to undertake the audits so they understand clearly what measures are required to reduce the risks of cross infection.

These audit results are monitored weekly by the IP&C team and additional interventions planned with the ward management team, see table 23 & 24.

Table 23

Number of new episodes of supportive measures due to a PII				
Financial Year	**MRSA**	***C. difficile***	**Influenza**	**ESBL**
2020-21	**0**	**2**	**0**	**0**
2019- 20	1	2	0	0
2018-19	4	*2*	0	1

During this reporting year we had 2 PII's for *Clostridioides difficile* which triggered supportive measures. Both occasions were on Elsing ward (older peoples medicine ward) though separated by 6 months (June-July 2020 and January-March 2021). The clinical teams engaged with the increased interventions, training, auditing and improvement work. On both occasions there were 2 patients involved triggering the PII but no further cases were linked subsequently. On both occasions the ward was decanted and underwent enhanced cleaning as one of the key interventions.

COVID -19

On the 12th of January 2020 the World Health Organization (WHO) announced that a novel coronavirus had been identified in samples obtained from Wuhan City, Hubei Province, China. This virus is now referred to as SARS-CoV-2 and the associated disease as COVID-19. WHO declared a pandemic on the 11th March 2020 and a COVID control room was opened at the NNUH where senior Doctors, Nurses and Managers came together three times a day to review and discuss how to implement the latest guidance and respond to learning points locally that were identified to keep patients and staff as safe as possible. This worked well and has been used throughout the pandemic with the frequency of meetings determined by the local and national COVID state levels.

On 2nd April 2020 the Trust was zoned to provide clear pathways for patients in line with PHE guidance. The Pandemic Infectious Respiratory Disease plan provides IP&C guidance and action cards for each of the 6 local COVID states.

Patients are risk assessed on admission to ensure that they are placed in the correct area. COVID screening prior to discharge to care homes was commenced in April 2020. In the second wave COVID admission and 5-7 day screening was also commenced as it became apparent that there is significant asymptomatic carriage of COVID. This was changed to 0, 3 and 6 day screening in December 2020.

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Image 22

Image 23

Throughout the year staff followed the PHE guidance which changed frequently as more information on the virus became available. In June 2020 facemasks became mandatory in healthcare settings. In October 2020 the PHE IP&C guidance was launched with high, medium and low risk pathways with the aim to support organisations to separate COVID risk at local level and enable service restoration.

Graph 5 below provides NNUH SARS CoV2 by attribution March 2020- March 2021 and clearly shows the peaks for NNUH, wave 1 in April 2020 and wave 2 January 2021.

Graph 5

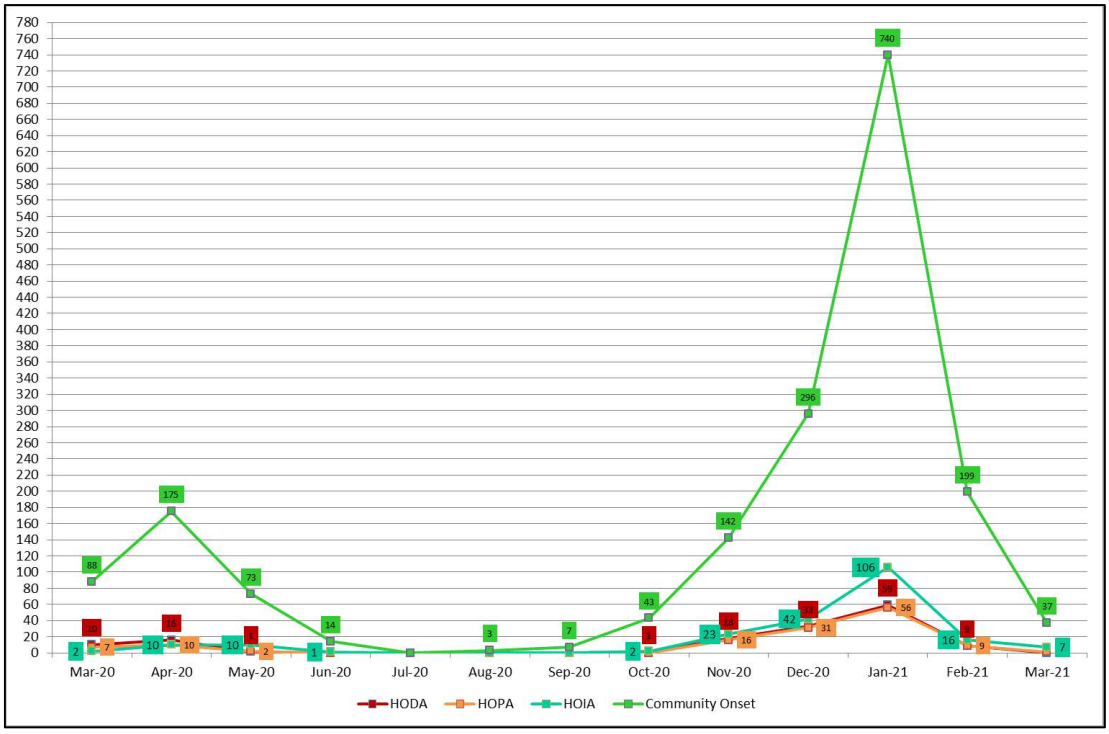

Image 16

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

On 15th December 2020, a new variant of SARS CoV2 was declared by PHE, now referred to as the Alpha variant and this quickly became the dominant virus in NNUH. At the height of the second wave in January we had 961 new cases of SARS-CoV2. 6.1% of these were Hospital Onset Definite Healthcare-Associated and 5.8% were Probable Healthcare-Associated.

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In wave 2 the NNUH was a surge centre for critical care patients. Many staff were asked to support patients that were transferred from other areas, receiving additional training to look after patients on ventilators and within enhanced care settings such as Critical Care, Respiratory wards etc. We also trained up non clinical staff to be able to support patients with mealtime support.

National vaccinations commenced on the 8th December 2020 and on the 9th December 2020 the NNUH became a centre for vaccinating staff and also the community.

Image 24

Outbreaks and Serious Incidents

Table 24

Number of episodes of outbreak or serious incident						
Financial Year	**MRSA**	***C. difficile***	**Influenza**	***Pseudomonas aeruginosa***	**Norovirus Ward closure**	**COVID-19**
2020-21	**0**	**0**	**0**	**0**	**0**	**22**
2019-20	0	1	1	0	7	N/A
2018-19	1	0	0	1	7	N/A

In June 2020 NHSE provided guidance on COVID outbreak process. At the NNUH there were 22 COVID outbreaks between 5th November and 19th March 2021. Outbreaks involved between 3 and 24 patients and between 1 and 38 staff. They lasted between 20 and 68 days. The closure of an outbreak was signified by no test-confirmed cases with illness onset dates in the last 28 days in the outbreak setting.

At the height of the second wave daily outbreak meetings were held in accordance with the SOP for COVID outbreak management and PHE guidance. Meetings were attended by NHSE/I,

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IP&C CCG, Chief/deputy chief nurse, IP&C, matrons and clinical staff from the areas. Learning was shared and communicated across the Trust in order to minimise nosocomial transmission. Staff were tested twice weekly with lateral flow tests from November 2020. Patient screening increased to day 0, 3 and 6. Ward view icons and email reminders are sent to highlight those requiring screening.

PPE guidance was provided by the PPE panel, IP&C team and Health and Safety organised fit testing for staff. Perfect ward audits monitored PPE compliance.

At times the usual supplies were unavailable and alternative products were sourced to the correct standard. Due to the demand for hand sanitiser there was a national shortage from our normal suppliers so we were helped by our colleagues from Norfolk Research Park who manufactured hand sanitiser for us which ensured we had a good supply. We also learnt that the placement of hand sanitiser was key to facilitate high levels of compliance with hand decontamination and we increased the number of places that it was available. All cleaning regimes were managed in accordance with national guidance.

Storage was challenging and ward areas were encouraged to de-clutter, manage stock levels and rearrange to maximise capacity. Keeping areas as de-cluttered as possible makes it easier to thoroughly clean. Extra touch point cleaning was instigated in outbreak areas.
Break rooms and changing rooms were rearranged to promote social distancing and posters detail numbers allowed in each room.

Image 25

Image 26

Image 27

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Indwelling device audit

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

Table 25

High Impact Intervention Audit Scores			
High Impact Intervention care bundle audit	2018-19	2019- 20	**2020-21**
Central venous catheter care	95%	97%	**96%**
Peripheral intravenous cannula	90%	94%	**94%**
Ventilated patients	98%	99%	**98%**
Urinary catheter	92%	94%	**94%**

Audit of Compliance with Isolation Guidelines and Single Room Use

An annual audit of compliance with the Isolation guidelines was undertaken in October 2020 to provide assurance that practice aligns with the guidance (Health and Social Care Act, 2008) and that clinical practice is in line with the Trust Isolation guideline.

All patients with confirmed or suspected infection require isolation. At the time of audit 24% of patients were in a single room for IP&C reasons in comparison to 25% in 2019. 99% of patients requiring isolation for IP&C reasons were provided with a single room, however some patients are risk assessed as unsafe to isolate for a variety of reasons and in these situations the risks are mitigated with alternative measures. The electronic ward view system highlights those requiring isolation for IP&C reasons facilitating correct placement of these patients.

Overall compliance with the audit of single isolation rooms was 81% unchanged from 2019. The main issue was insufficient dedicated observation equipment. The results were shared Trust wide along with an action plan to facilitate improvement, see table 26 & chart 7.

Table 26

NNUH - Isolation and Single Room Use Audits	
Financial Year	**Overall Compliance %**
2020-21	**81%**
2019-20	81%
2018-19	77%

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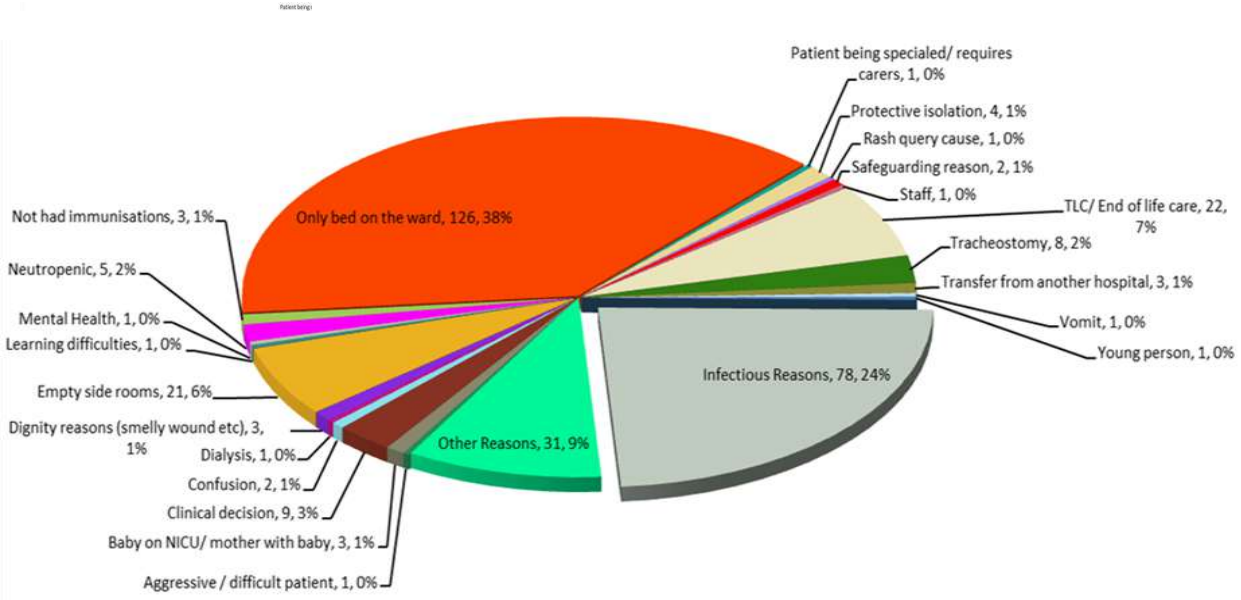
Chart 7



Central Venous Catheter (CVC) Surveillance

A continuous surveillance programme monitors the CVC infection rates in adults. The overall infection rate remains below the Matching Michigan reference point of 1.4 per 1000 line days. Quarterly results are shared with Trust staff at practice development training sessions and in the IP&C monthly report, see table 27.

Table 27

NNUH CVC related infections			
CVC infections are measured by rate per 1000 line days	2018-19	**2019-20**	**2020-21**
Renal	0.68	**0.44**	**0.5**
Haematology	1.57	**2.21**	**2.53**
Other areas	1.05	**2.29**	**0.14**
Overall	0.68	**0.79**	**0.6**

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

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

Mandatory Public Health England data is **now submitted each quarter** for one of the categories. Hip (Q4/19-Q1/20) High SSI Rates, were fully investigated as part of a five year review, to establish burden of joint infections on department's patients and resources.

COVID –19 effect on elective surgery and increased trauma commitment, a key influence factor in this report.

The validated rates of infection (identified prior to discharge and on readmission) for Orthopaedic categories were: See table 28.

Table 28

Orthopaedic Surgical Site Surveillance			
Calendar Year	**Hip – PHE 0.5%**	**Knee – PHE 0.5%**	**Repair # Neck of Femur – PHE 1.0%**
2020 SSI %	**0.7%***	**0.0%**	**0.47%**
2019 SSI %	**0.6%***	**1.8%***	0.34%
2018 SSI %	0.36% / 0.6%	0.68% / 0.4%	0.71% / 1.1%
2017 SSI %	0.63%	0.39% / 0.4%	0.57%
*** Increased Hip & Knee SSI rates were identified Q4/19 - Q1/20 Investigated and clinical governance review completed.**			

Spinal Surgery: Voluntary submission

PHE **Continuous data submission** was undertaken this year. PHE High Outlier Report for July-September SSI Rate* investigated by spinal consultant team and practice changes implemented by surgical care teams as part of service improvement process. Small numbers of cases can lead to wide variance. See table 29.

Table 29

Spinal Surgical Site Surveillance: Voluntary submission		
Calendar Year	**Spinal SSI %**	**PHE SSI %**
2020 SSI %	**1.14%***	**1.5%**
2019 SSI %	1.66%	1.5%
2018 SSI %	1.70%	1.4%
2017 SSI %	0.58%	1.4%
***PHE High Outlier Report Q3 Jul – Sept 5.4% : On PHE review reduced to 3.6%**		

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Other Surgical Site Surveillance

Vascular surgery surveillance
There has been continuous systematic SSI surveillance in vascular surgery since 2009. So far during 2020-21 the SSI rates have been between 1.8% and 8.1%.

Table 30

Post vascular surgery surgical site infection rates				
Year	**April-June SSI %**	**July-Sept SSI %**	**Oct-Dec SSI %**	**Jan-March SSI %**
2020-21	**1.8%**	**7.5%**	**3.9%**	**8.1%**
2019- 20	5.1%	4.1%	2.7%	3.1%
2018-19	8.5%	2.3%	4.2%	7.2%

Caesarean section surgery
There has been continuous systematic SSI surveillance following C section since 2010. Collaborative working between the obstetric department and IP&C has reduced SSI rates from 19.1% to 1.5%.

An on-going cycle of feedback and review at clinical governance meetings and IP&C training sessions for midwives continues to sustain improvement. See table 31.

Table 31

Post caesarean section surgical site infection rates				
Year	**April-June SSI %**	**July-Sept SSI %**	**Oct-Dec SSI %**	**Jan-March SSI %**
2020-21	**2.3%**	**3.1%**	**1%**	**1.5%**
2019- 20	**4.2%**	**4.4%**	**3.1%**	**2.2%**
2018-19	2.4%	3.8%	1.1%	4.2%

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Audit Programme

Hand Hygiene and Dress Code Audits

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

All IP&C mandatory training includes Hand Hygiene advice and a screen saver is consistently visible in ward areas reminding staff of the importance of the 5 moments. Staff are encouraged to strive for 100% compliance and act as role models, challenging and educating others in best practice. See table 32.

Table 32

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

Financial Year	Number of Audits	Percentage Pass	
		Hand Hygiene	Dress code
2020-21	**736**	**97%**	**98%**
2019-20	697	96%	98%
2018-19	840	97%	99%
Scores <95% lead to a re-audit within 1 week.			

Beverage bay and dirty utility audits were not completed by the IP&C team in 2019-20 as these have now been incorporated into the perfect ward daily checklist.

Global Hand Hygiene Day

Due to the first wave of the pandemic we did not have a day of campaigning. However the importance of hand decontamination has never been more important and this message has been frequently communicated across the Trust and also world during this year.

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

All staff including volunteers joining the Trust are required to attend an IP&C induction session and thereafter mandatory IP&C training. Compliance with IP&C training is monitored by the training department. There were a reduced number of volunteers during this period due to COVID restrictions.

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

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

Image 28

Hygiene Code Compliance Criteria 7:
Provide or secure adequate isolation facilities.

We undertake an annual isolation room audit to assess why patients are in single rooms, how many patients who require isolation facilities are not in single rooms and how those in isolation are managed see Table 6 and Chart 7.

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

During this period we also procured an isolation building named the Hoveton unit, with 9 isolation rooms with the capacity to be used as negative pressure. This was opened on 31/03/21.

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

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

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

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

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

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Laboratory Operational Hours

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

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

Image 29

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

IP&C Policies

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

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

Hygiene Code Compliance Criteria 10:
Providers have a system in place to manage the occupational health needs of staff in relation to infection.

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

All staff have access via self-referral route to gain appropriate occupational health advice. Ordinarily this is available Monday - Friday 08.30am - 17.00, 2020-21 has seen the challenges of the global pandemic facing COVID-19. As such the occupational health team have adapted their ways of working and ensured that appropriate advice has been provided and due to the flexibility and dedication of the team, provided a 7 day service during the various peak waves. Out of hours infection related OH advice continues to be available via the 24/7 website on our intranet.

Isolation advice and guidance

From the start of this pandemic, the team have kept up to date with the ever-changing advice from the government regarding isolation. This started in the early days with just advising when staff were returning from trips abroad, but over the year this has developed into a full in-house

test and trace service for staff. It was vital that our staff had timely advice regarding any contacts they had in the workplace from colleagues and patient contact. The team have been and continue at present to provide a 7-day service ensuring any positive staff results are contacted and if necessary ensuring contacts in the workplace commence isolation if COVID secure measures have not been in place. We have worked closely with the Infection Prevention and Control team in ensuring any ward outbreaks include staff contacts and appropriate testing has been undertaken.

COVID–19 Testing

Whilst not directly responsible for the staff testing service, we have worked with our Clinical Support Services team to provide governance advice and support in establishing both the swab and antibody services. We have worked in partnership with the testing team and the WHWB team have been contacting staff if positive results or any other queries in relation to the testing elements.

COVID-19 Individual Risk assessment

In late March 2020, the emerging evidence surrounding the COVID19 virus identified that there would be individuals who would be personally more vulnerable and have a significant risk of serious ill health should they contract the virus. It became apparent that this evidence would impact some of the staff who worked within our organisation and others and due to the nature of their roles and these individuals would not be ordinarily able to comply with the governments 'stay at home' message. This evidence led to the development of a risk matrix and risk assessment process which needed to be considered for all staff. The team spoke to literally thousands of our staff in those weeks that followed – many who needed advice and guidance surrounding their own personal health situations as well as their personal concerns for loved ones who were being placed in a 'shielding' group. As we undertook these conversations, our focus was to protect our NHS staff and prevent them becoming our ventilated patients whilst also appreciating the need for the NHS services having sufficient staff to deliver care in a global pandemic situation.

As evidence emerged and changed, so our assessments of individuals needed to be reviewed. The team had a senior nurse constantly reviewing all the changes in evidence to ensure we as a team remained knowledgeable with this ever changing situation. These assessments were both emotive for all concerned and many staff were advised to be relocated from their original areas of work to ensure they remained protected. As the early months progressed, our Lead Consultant and a Senior Nurse worked with a technological company which enabled the risk assessment process to be undertaken electronically. The team provided the medical information and evidence base whilst using the expertise of technology to develop the tool. Once the tool was launched, all staff could be risk assessed in minutes with outcomes of the assessment being sent to line managers and the occupational health team. This was particularly useful as restrictions following the first wave in the summer arrived to review risk assessments in preparation for shielding individuals returning and also further reviews in preparation for Wave 2 in November with the associated changes to Public Health England guidance surrounding patient pathways. This tool became a very efficient, effective and consistent evidenced based assessment for all staff. This COVID risk assessment tool is now being used by many NHS Trusts around the country. https://rainbird.ai/case-study/assessing-COVID-19-risk-for-thousands/

In addition, the department have developed Workplace risk assessments for clinical areas so that managers can assess and implement COVID risk mitigation measures for individuals in their work areas to support the documentation provided by the Health & Safety team on general office / area COVID risk mitigation measures

WHWB have maintained their full suite of in-house procedures available in relation to prevention and management of communicable infections. And this has been expanded in the last year to include COVID-19. Trust guidelines are also present. Easy accessible advice for staff is found via the 24_7 pages. Policies created by the infection control team are reviewed by WHWB.

Immunisation Services

Immunisations for staff are available and provided in line with Green Book
All staff who have patient contact (clinical & non clinical) are required to have an immunisation review. This commences with their pre-placement health questionnaire. If immunisations for their specific role are not complete then they are required to attend WHWB for an immunisation assessment. Their immunisations are recorded on their individual record on the dedicated occupational health system. At the time of the assessment the relevant immunisations are offered whilst advising the worker the importance of complying with Public Health England guidance. The WHWB team keep up to date with new guidance and review both Trust guidelines and WHWB procedures accordingly. If any new guidance requires to review the immunisation status of existing staff then this is undertaken. At the commencement of this pandemic, immunisation services were suspended to ensure that WHWB services were adhering to the national government guidance, however, following appropriate COVID secure risk assessments and developing sufficient control measures, these have now resumed and any residual backlog is being undertaken.

Influenza Vaccination

A full influenza vaccination campaign was undertaken from late September 2020 – November 2020 – this was shorter than normal due to the implementation of the COVID vaccination programme as well as the significant early uptake received this year. 95% of our frontline staff received their vaccination. Due to social distancing requirements, we set up an online booking system which was extremely successful in complying with COVID secure measures as well as reminding staff of their vaccination appointment. We increased the number of nurses available to deliver the programme and invested in a further ‘flu tent’ so the areas could be cleaned between each staff member receiving the vaccination. The programme was also supported by over 120 local peer vaccinators in their area. This is the highest level of uptake that our organisation has achieved in this area. Flu vaccination availability continued to be available via routine WHWB immunisation clinics after the main programme concluded

Our success in this programme, was undoubtedly as a result of increased resource to ensure high accessibility of the vaccines being available to all staff, alongside strong medical and nursing leadership together with the support of a dedicated software programme and prominent communication plan.

COVID Vaccination

Building on the success of our staff flu vaccination campaigns, in November, the WHWB team became involved in planning the COVID vaccination programme. It was anticipated initially that we would be vaccinating all our staff as quickly as we could and so planning for this commenced using an IT booking system and the core staff flu vaccine flu team. A change of direction was given by NHS England with literally days before our launch that we would now commence vaccinating the ‘Over 80’s community’ & ‘Care Home staff’ out of the hospital hub with only a small proportion of vaccines available to our NHS staff initially. However, the team rose to the challenge and within days a dedicated hub in the hospital was created and the health & wellbeing team have been supporting both staff vaccinations and the wider community vaccinations since December 2020. The hub could vaccinate over 1000 individuals a day and has contributed significantly to the vaccination programme of the Norfolk Community.

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Blood Borne Virus

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

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

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

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References and further reading

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Guidance on the reporting and monitoring arrangements and post infection review process for MRSA bloodstream infections from March 2018, NHS England, March 2018, available at:
https://improvement.nhs.uk/documents/2512/MRSA_post_infection_review_2018_changes.pdf

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

Infection Prevention and Control Commissioning Toolkit Guidance and information for nursing and commissioning staff in England, RCN and IPS, January 2016, available at:
https://www.rcn.org.uk/professional-development/publications/pub-005375

Limon, E., Shaw, E., Bardia, J.M., Piriz, M., Escofet, R., Guidol,F & Pujol,M (2014) Post-discharge surgical site infections after uncomplicated elective colorectal surgery: impact and risk factors. The experience of the VINCat Program. *Journal of Hospital Infection* 86 127-132.

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https://www.ips.uk.net/professional-practice/onetogether-infection-control-assessment-toolkit/

Preventing healthcare associated Gram-negative bloodstream infections: an improvement resource, PHE, May 2017 available at:
https://improvement.nhs.uk/documents/984/Gram-negative_IPCresource_pack.pdf

COVID-19: Guidance for maintaining services within health and care settings Infection prevention and control recommendations, PHE 2021 available at:
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2. COVID-19 infection prevention and control guidance: introduction - GOV.UK (www.gov.uk)

RCN (2012) The role of the link nurse in infection prevention and control (IPC): developing a link nurse framework.
https://www.rcn.org.uk/professional-development/publications/pub-004310

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

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

Infection Prevention & Control

Annual Programme

April 2021 – March 2022

Written & Compiled by:

Infection Prevention & Control Team

APRIL 2021

NHS
Norfolk and Norwich University Hospitals
NHS Foundation Trust

Norfolk and Norwich University Hospitals NHS Foundation Trust

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

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***C. difficile* specific Drivers**	**Actions**	**Evidence or Anticipated Outcome**	**Lead**	**By when/ Frequency**	**RAG Comments**
NHS England and NHS Improvement ***C. difficile* objective** New attribution of cases according to 2019-20 guidelines (HOHA and COHA attributable to the Trust).	*C. difficile* cases attributed to NNUH to remain below last year's objective of 35.* Continue work proven to result in low rates of *C. difficile* infection (CDI) as described in *C. difficile* policy and annual report. *at the time of writing due to COVID-19 pandemic, Govt. has not published objective.	**No more than 8 HAI C. difficile cases per quarter** **Q1 =** **Q2 =** **Q3 =** **Q4 =** • Published by PHE [government national statistics] • HICC minutes • Monthly IPR board minutes • Monthly IP&C report • IP&C dashboard for Trust staff • Learning disseminated by OWL	IP&C Team	Throughout	
Contract with CCG Complete a Root Cause Analysis/PIR for all cases of HOHA and COHA *Clostridioides difficile*	Joint PIR undertaken monthly with CCG and NNUH staff for each CDI diagnosed by toxin EIA identified on or after day 3 of admission or toxin positive cases who have been an inpatient within the last 4 weeks. CCG to agree those that are non-trajectory [no lapses in care].	**C. difficile trajectory cases per quarter** **Q1 = Q2 = Q3 = Q4 =** • HICC minutes • Monthly IPR board minutes • Monthly IP&C report • Email to CCG showing summary of PIR meeting showing outcome	Admin co-ordinator	Monthly	
	Lessons learnt and any action plans will be monitored by relevant divisional governance groups with updates on progress to HICC quarterly by division	• HICC minutes • Div Governance minutes	Matrons and divisional governance leads	Quarterly	

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

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

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Other alert organism Drivers	Actions	Evidence or Anticipated Outcome	Lead	By when/ Frequency	RAG Comments
PHE reporting • E. coli bacteraemias • Klebsiella spp. bacteraemias • Pseudomonas aeruginosa bacteraemia's	Reduce the number of cases of gram negative bacteraemia cases identified on or after day 3 of admission	**E. coli bacteraemia [all cases]** **Q1 =** **Q2 =** **Q3 =** **Q4 =** **Klebsiella spp. Bacteraemia [all cases]** **Q1 =** **Q2 =** **Q3 =** **Q4 =** **Pseudomonas aeruginosa bacteraemia [all cases]** **Q1 =** **Q2 =** **Q3 =** **Q4 =** • Rates published by PHE [government national statistics] • HICC meeting minutes • Monthly IPR to board • Monthly IP&C report • IP&C dashboard	IP&C Team	Monthly	
	Any significant themes will be identified and improvement measures will be planned with clinical teams.		IP&C Team		
	Lessons learnt and any action plans will be monitored by relevant divisional governance groups with updates on progress to HICC quarterly by division		IP&C Team		
	Plan to reduce catheter usage and reduce UTI's along with correct antimicrobial prescribing and improved guidance for urine sampling		IP&C Team		

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

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

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Audit Drivers	Audit/Actions	Evidence/Feedback	Lead audit & actions	By when/ Frequency	RAG Comments
Code of Practice Criterion 1 Systems to manage and monitor the prevention and control of infection. Matrons Charter	FM First (Credit for cleaning, C4C) audits Trust staff undertake audits in conjunction with SerCo and Trust Facilities	• HICC minutes • Monthly IPR board minutes • Nursing Dashboard • Div Governance minutes	Matrons	Monthly	
	Perfect ward IP&C Audits	• HICC minutes • Monthly IPR board minutes • Nursing Dashboard • Div Governance minutes	Matrons, ward sisters/ charge nurses, IP&C Team	As per the SOP or more frequently if required	
DH Saving Lives Delivering clean safe care	High Impact Intervention care bundle audits, CVC. Peripheral cannula, urinary catheter, renal catheter and prevention of ventilator associated pneumonia	• IP&C dashboard for Trust staff • Nursing Dashboard • Div Governance minutes	Matrons	Monthly	

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


Microsoft | Power BI
Quality & Safety
View in Power BI
Last data refresh:
22/10/2021 15:20:01 UTC
Downloaded at:
22/10/2021 15:32:33 UTC

Quality Summary

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

NNUH Digital Health
business intelligence

Topic	Metric Name	Date	Result	Variation	Assurance
Maternity: Mothers	Babies Delivered	Sep 2021	451	Improvement (High)	No Target
Maternity: Mothers	Caesarean Deliveries	Sep 2021	36.0%	Concern (High)	No Target
Maternity: Mothers	Mothers Delivered	Sep 2021	447	Improvement (High)	No Target
Patient Concerns	PALS % Closed within 48hours	Sep 2021	39.3%	Concern (Low)	No Target
Patient Experience	Friends & Family Score	Sep 2021	84.50%	Concern (Low)	Unreliable
Patient Falls	Patient falls per 1,000 bed days (moderate harm or above)	Sep 2021	0.0	Improvement (Low)	Unreliable
Pressure Ulcers	Hospital Acquired Pressure Ulcers per 1,000 bed days	Sep 2021	1.0	Improvement (Low)	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 2021

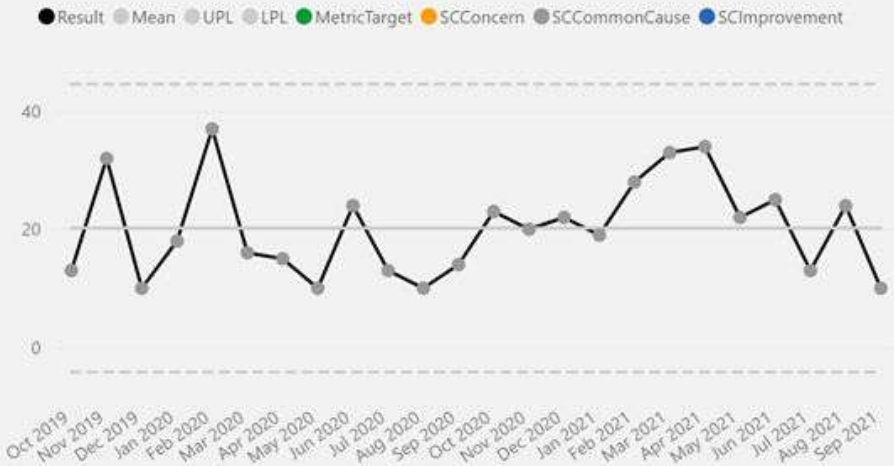
Variation | Assurance

10 Result
N/A Target
45 UPL
20 Mean
-4 LPL

Analytical Commentary

Variation is Common Cause

Serious Incidents



Assurance Commentary

The number of reported Serious Incidents continues within the expected range .
A portal for sharing learning from incidents has been developed and is available via the Staff Hub.

Improvement Actions

Incidents continue to be discussed and assessed through peer review at the Serious Incident Group.
To continue to develop and update the 'Sharing our Learning' page.

Supplementary Metrics

Metric Name	Date	Result	Variation	Assurance
Duty of Candour Compliance	Sep 2021	92%	Common Cause	Unreliable
Incidents	Sep 2021	2,310	Common Cause	No Target

Pressure Ulcers

NNUH Digital Health
business intelligence

Hospital Acquired Pressure Ulcers per 1,000 bed days

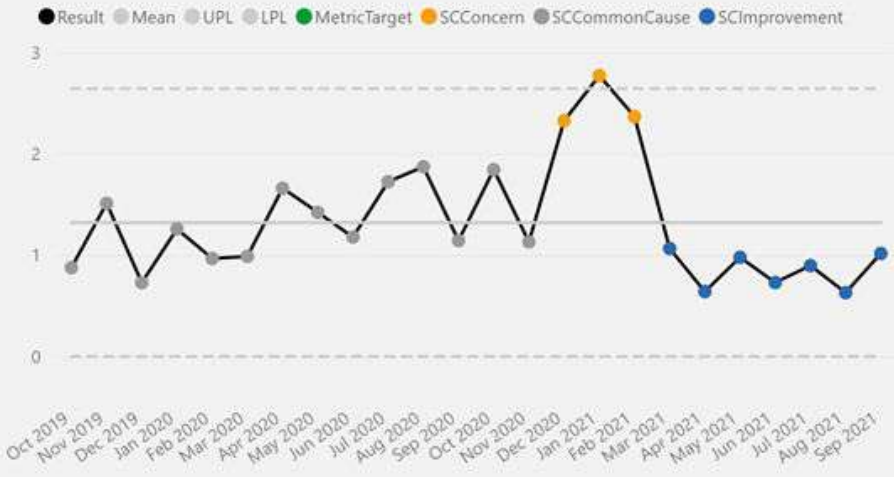
Sep 2021

Variation	Assurance		
L		1.0 Result	2.6 UPL
		N/A Target	1.3 Mean
			0.0 LPL

Analytical Commentary

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

Hospital Acquired Pressure Ulcers per 1,000 bed days



Assurance Commentary

September saw a significant amount of device related pressure damage linked with patients who were in a poor state of health on admission and remained critical during their stay for several weeks (45% of reported PU's were device related). Not all patients were covid positive but 95% were in critical care and despite all efforts damage occurred due to their underlying status on admission from their community settings.
Staff on all wards remain vigilant as can be seen in the amount of reporting of damage, but occurrence of HAPU remains at stable level and has not increased relative to the increase in Covid or acutely unwell respiratory patients. Ward led Pressure Ulcer improvement projects continue to be rolled out across divisions.

Improvement Actions

Purpose T risk assessment. Plan is to start with Surgical Division with the first wave of roll out at the end of November then progressing to Medicine admissions areas in December.
Documentation group will incorporate it into the new admission paperwork along with revised linked documentation.
Clinical Photography Risk remains high on the Risk register with admission numbers being high and external providers submitting Safeguarding referrals.
Tissue Viability Team continue to work with wards but staffing shortage in the team in October/November will impact on educational delivery.

Patient Falls

NNUH Digital Health
business intelligence

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

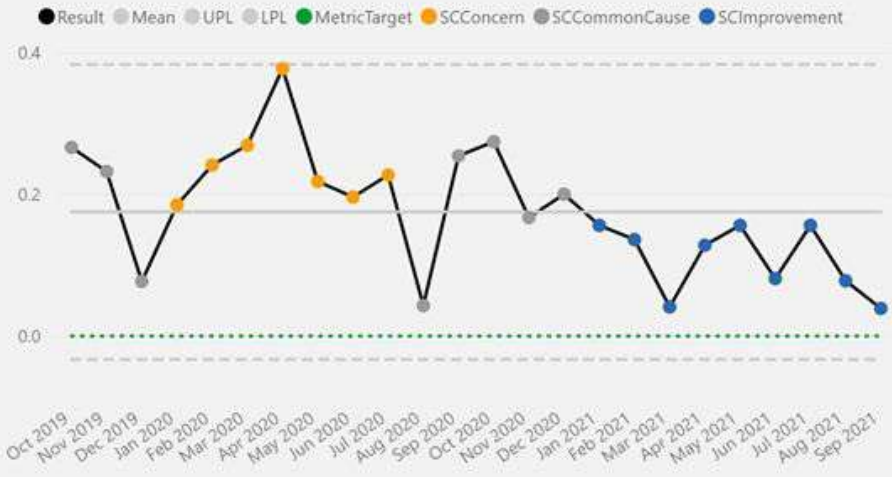
Sep 2021

Variation	Assurance		
L	?	0.0 Result	0.4 UPL
		0.0 Target	0.2 Mean
			0.0 LPL

Analytical Commentary

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

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



Assurance Commentary

The number of falls causing moderate harm or above continues to show an improvement over the last 9 months.

Improvement Actions

Ward led improvements continue with a focus on improving the recording of lying and standing blood pressures.
Working with therapy teams around documentation of discussions with patients around fear of falling. 'Baywatch' - uninterrupted monitoring of vulnerable patients in a designated part of the ward 24/7.
'Get up get dressed get moving' initiative continues with The Trust participating in the East of England 'Winter Deconditioning Games' supporting patients to improve mobility & preventing deconditioning. The new Falls Risk Assessment pilot is complete and is being implemented.

Patient Experience

NNUH Digital Health
business intelligence

Friends & Family Score

Sep 2021

Variation	Assurance
L	?

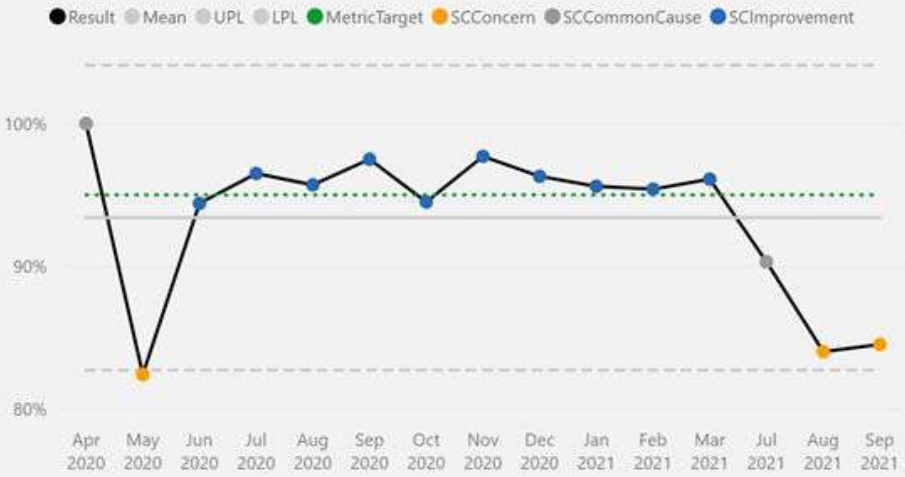
84.50% Result
95.00% Target

104.10% UPL
93.40% Mean
82.70% LPL

Analytical Commentary

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

Friends & Family Score



Assurance Commentary

Please note the SPC chart is now available and includes all of the historic data allowing an analysis for the past calendar or financial year.
SMS snagging issues resolved, which has seen an increased response from ED. Outpatients implementation commenced in September.
The increased responses from ED has impacted on the overall 95% target, the thematic analysis suggests long wait times to be seen is a significant factor. This is reflected in the ED performance dashboard.

Improvement Actions

To continue implementation meetings with Maternity for SMS use within their speciality.
Ongoing support provided to the Divisions from the Patient experience team in how to use their data to implement change.
Processes reviewed and under implementation, which includes education for Volunteers on PPE/being 'safe' in clinical areas/wards to assist inpatient in completing their FFT questionnaires, with the hope to improve responses.

Supplementary Metrics

Metric Name	Date	Result	Variation	Assurance
Compliments	Feb 2021	113	Common Cause	No Target

Patient Concerns

NNUH Digital Health
business intelligence

PALS % Closed within 48hours

Sep 2021

Variation	Assurance
L	

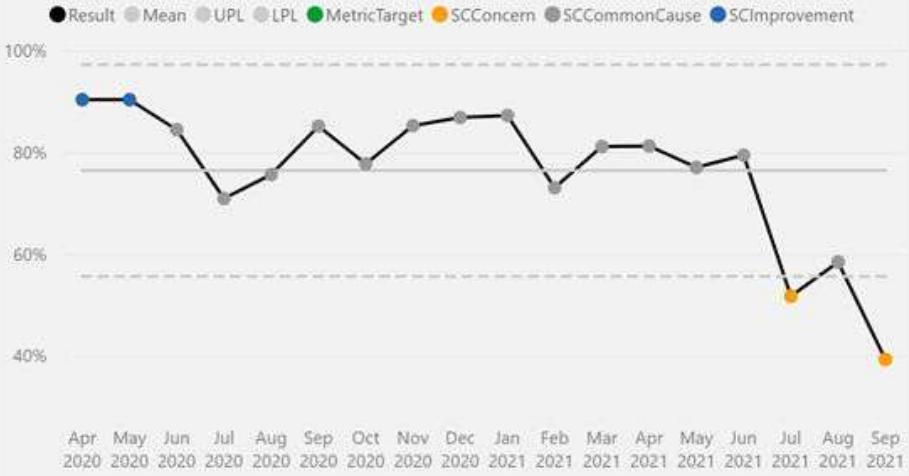
39.3% Result
N/A Target

97.2% UPL
76.4% Mean
55.6% LPL

Analytical Commentary

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

PALS % Closed within 48hours



Assurance Commentary

Total PALS matters received 491

Concerns = 258
Enquiries = 118
Signposting = 75
Best Wishes =40
Suggestions = 0

Main Subjects (Top 3)
Appointment delays and cancellations
Communications
Waiting times

Improvement Actions

The PALS and Complaints team continue to review the current PALS processes to align with PHSO Framework with the Patient Panel.

Supplementary Metrics

Metric Name	Date	Result	Variation	Assurance
PALS Enquiries	Sep 2021	491	Common Cause	No Target

Complaints

NNUH Digital Health
business intelligence

Complaints - Trust

Sep 2021

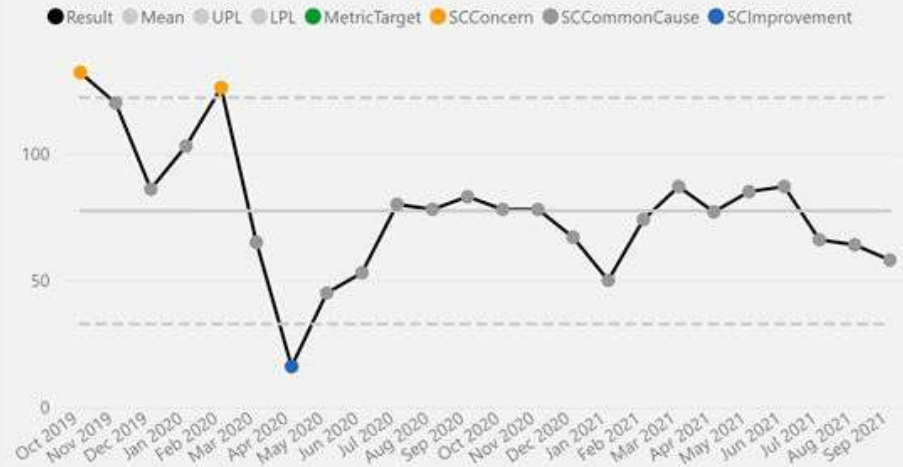
Variation	Assurance

58 Result
N/A Target
122 UPL
77 Mean
33 LPL

Analytical Commentary

Variation is Common Cause

Complaints - Trust



Assurance Commentary

Complaints received from September onwards are being processed by the PALS & Complaints team using the KPI timeframes.

Improvement Actions

Legal Services are taking action to close the remaining few open cases they have been managing.
The PALS & Complaints team continue to review the current processes against the new PHSO framework with the Patient Panel.
The PALS & Complaints team have an developed an action plan to close a number of contacts that are outside of the KPI timeframes, due to them being received during the handover process between teams in July/August.

Supplementary Metrics

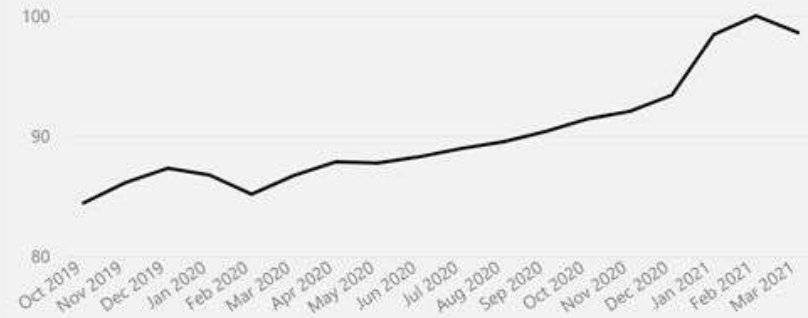
Metric Name	Date	Result	Variation	Assurance
Complaints - Acknowledgement	Sep 2021	95%	Common Cause	Unreliable
Complaints - Response Times - Trust	Sep 2021	74%	Not Applicable	Not Applicable
Post-investigation enquiries	Sep 2021	1	Common Cause	Capable

Mortality Rate

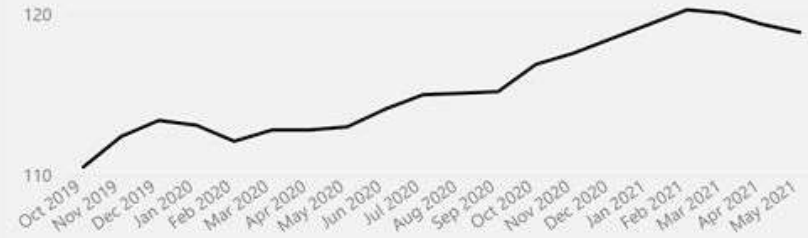
NNUH Digital Health
business intelligence

MetricName	Date	Result
HSMR	Mar 2021	98.60
SHMI	May 2021	119

HSMR



SHMI



Supplementary Metrics

Metric Name	Date	Result		Variation		Assurance
Crude Mortality Rate	Aug 2021	4.50%		Common Cause		No Target

Assurance Commentary

Dr Foster Intelligence has experienced fundamental data quality and modelling issues which has resulted in delays to the updating and publishing of mortality statistics. HSMR remains 'as expected'. Available data suggests this may be on a downward trend as spell count recovers post wave 2 of the pandemic.
SHMI remains statistically 'higher than expected. SHMI adjusted for palliative care (using HED system adjustment) is 99.4 (95.9 - 103.0) and statistically 'as expected'.

Improvement Actions

The format of automated reports (using mortality data from the Trust Mortality Governance System), to support Divisional reporting into LFD committee has been agreed. This will improve oversight of the Medical Examiner office, Trust M&M process and Trust SJR process
Actions plans remain in progress for NNUH SHMI and the SJR back log. Work continues to complete the SJR cohort review of SHMI 30 day deaths and the SJR cohort review of Covid Deaths for the second wave.

Safer Staffing

NNUH Digital Health
business intelligence

Safe Staffing Fill Rates

Sep 2021

Variation

Assurance

F

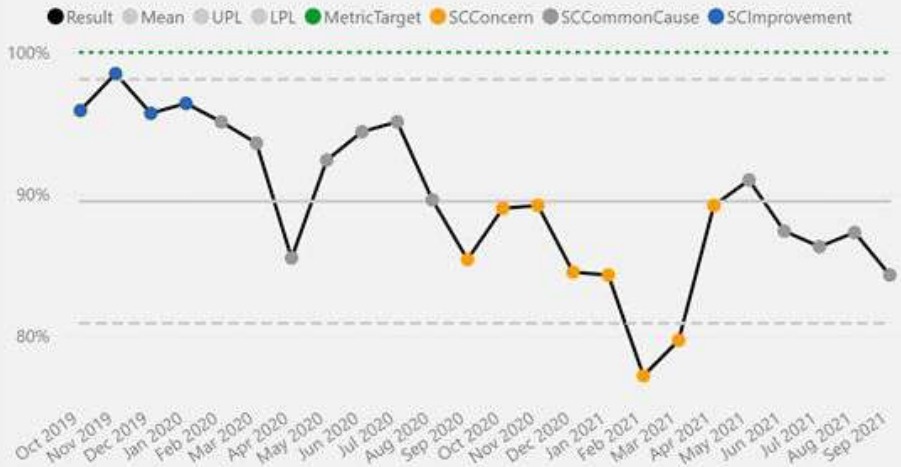
84.30% Result
100.00% Target

98.10% UPL
89.50% Mean
80.90% LPL

Analytical Commentary

Variation is Common Cause

Safe Staffing Fill Rates



Assurance Commentary

The Trust calculates staffing fill rates by the percentage of staff on duty against the planned establishment. The overall Trust wide fill rate was 84.4 % in September however there were 4 inpatient areas where the RN/M fill rate was below 75% and 9 inpatient areas where the HCA fill rate was below 75%. The Trust has in place daily Safer Staffing meetings that respond to live staffing escalations and reduce risks to safety across the organisation by assessing and mitigating staffing risk based on patient acuity. In September, 1855 red flags were raised, 495 were mitigated and 1278 remained open.

Improvement Actions

A daily operational report is sent to DNDs & their teams highlighting safer staffing compliance on SafeCare, staff redeployments, red flag mitigation & temporary staffing. Business case is in the final stages to deliver a cohort of 96 internationally recruited nurses. Recruitment plans are in place for RN/M & HCAs.
Roster clinics are underway to maximise roster efficiency & effectiveness.
Masterclass on Safer Staffing & Roster Scrutiny for DNDs & Matrons.
Review relevant policy & procedures.

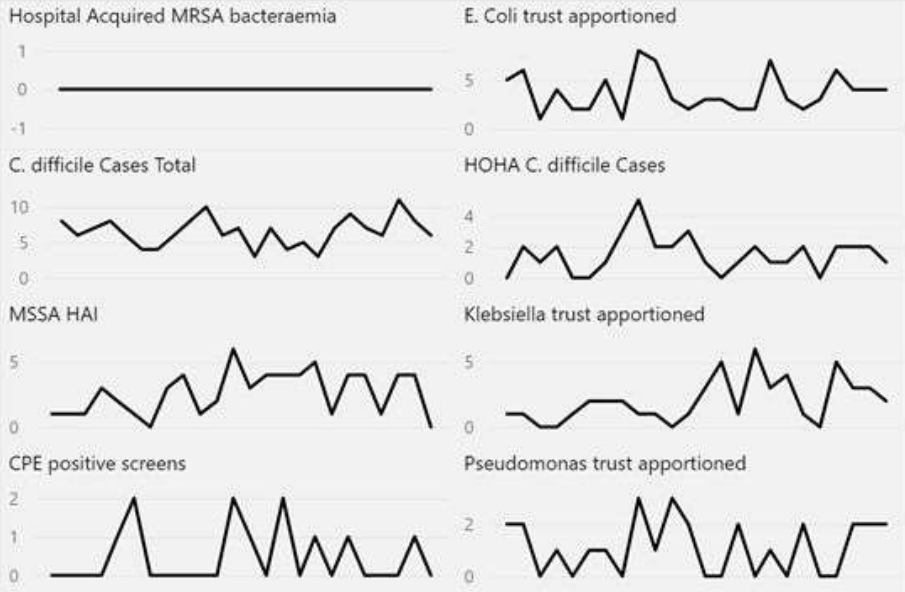
Supplementary Metrics

Metric Name	Date	Result	Variation	Assurance
Safe Staffing CHPPD	Sep 2021	7.1	Common Cause	No Target

Infection Prevention & Control

NNUH Digital Health
business intelligence

MetricName	Date	Result	Target	Mean
C. difficile Cases Total	Sep 2021	6	N/A	7
CPE positive screens	Sep 2021	0	N/A	0
E. Coli trust apportioned	Sep 2021	4	119	4
HOHA C. difficile Cases	Sep 2021	1	57	2
Hospital Acquired MRSA bacteraemia	Sep 2021	0	0	0
Klebsiella trust apportioned	Sep 2021	2	25	2
MSSA HAI	Sep 2021	0	N/A	3
Pseudomonas trust apportioned	Sep 2021	2	24	1



Assurance Commentary

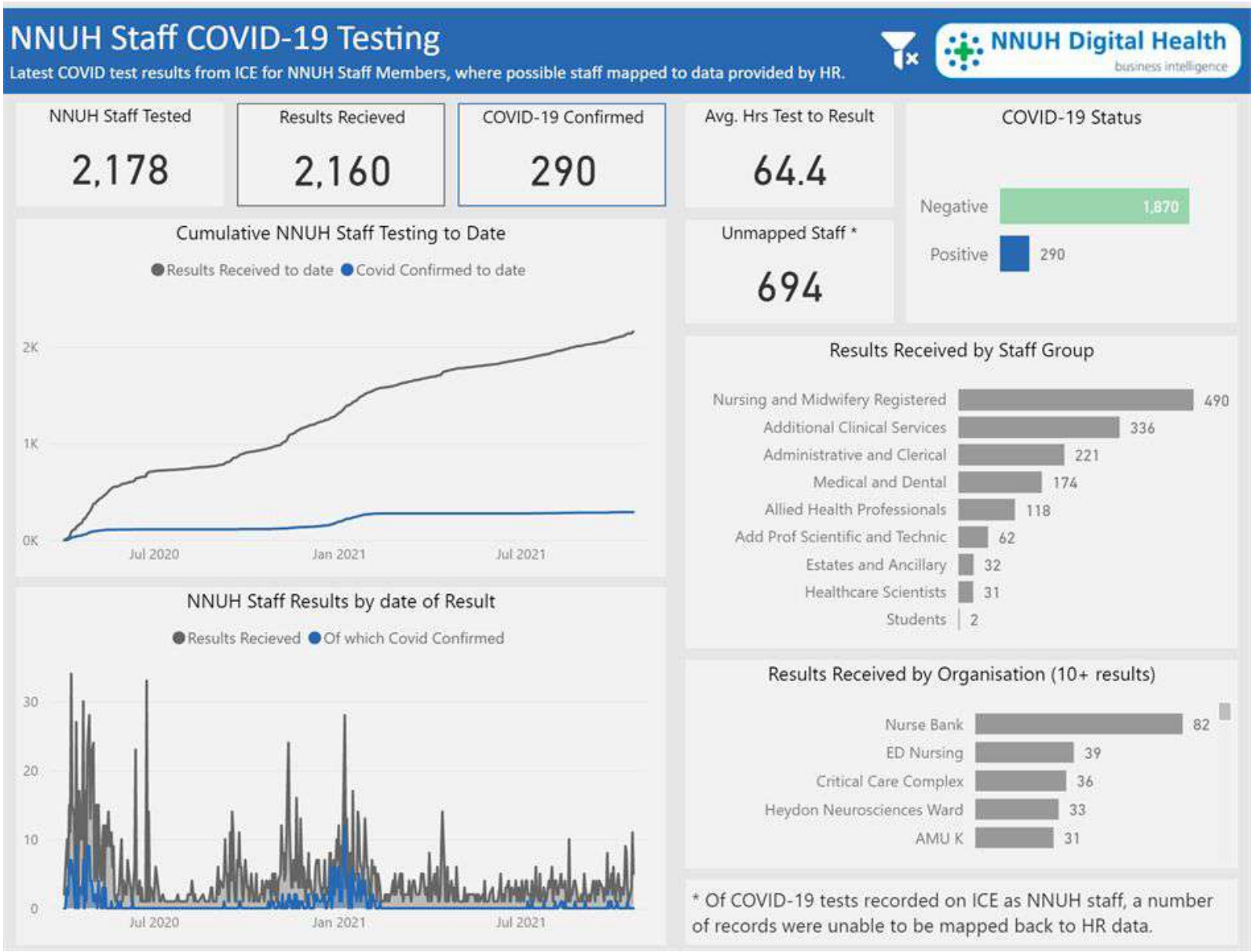
Improvement Actions

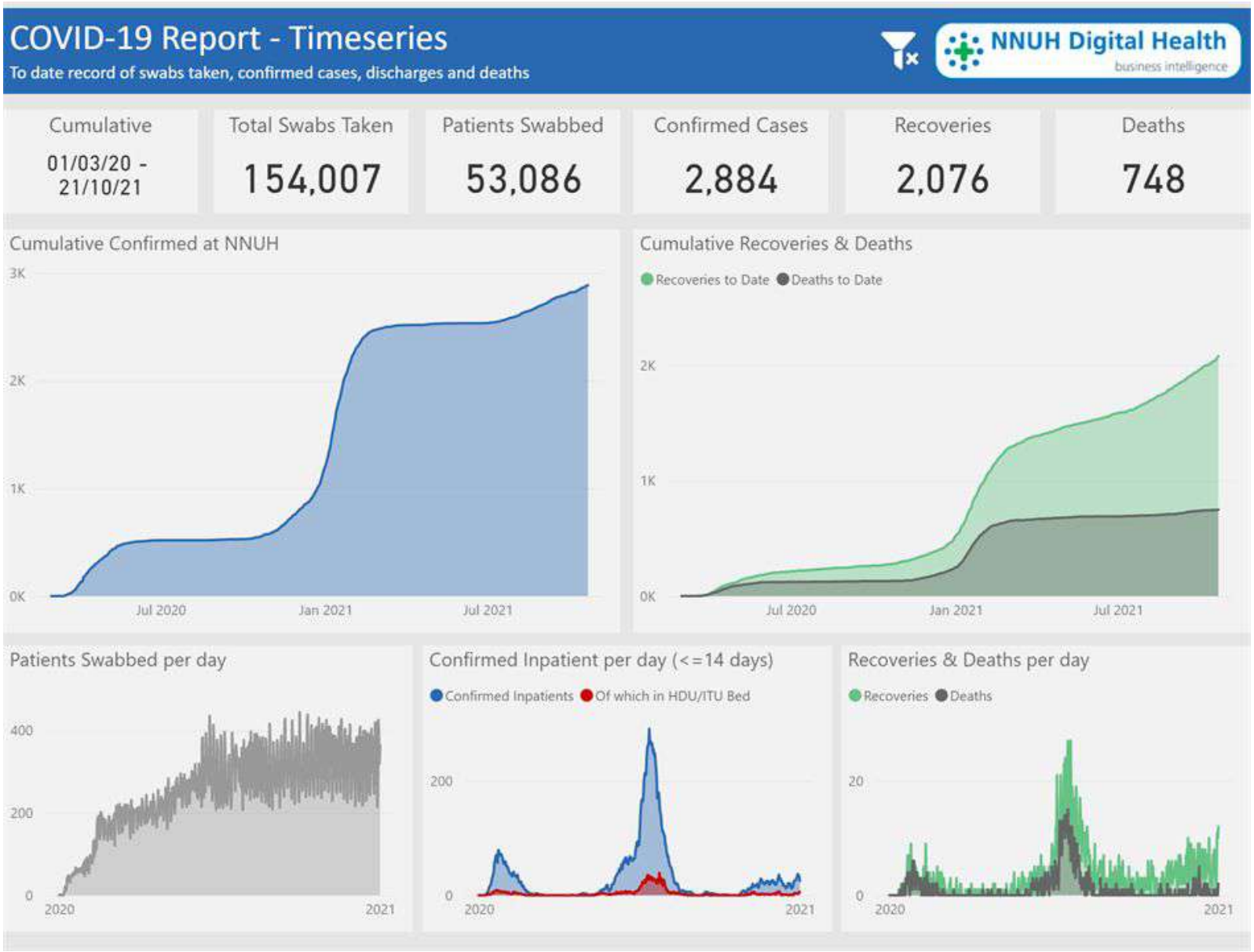
During September Mattishall & Docking ward C.diff supportive measures were closed, with no further cases upon the areas within 28 days.

COVID-19 outbreaks – Mattishall ward – all 3 outbreaks closed, no further cases identified related to these. No further areas of concern.

WebV – IP&C module – daily discussions ongoing regarding development and implementation, go live date 02.11.2021.

Updated recommendations on COVID-19 control measures published by UK HSA (27.09.2021) to support the ongoing recovery of elective care, available from: https://www.gov.uk/government/publications/ukhsa-review-info-ipc-guidance


NNUH Staff COVID-19 Testing
Latest COVID test results from ICE for NNUH Staff Members, where possible staff mapped to data provided by HR.
NNUH Digital Health
business intelligence
NNUH Staff Tested
2,178
Results Recieved
2,160
COVID-19 Confirmed
290
Avg. Hrs Test to Result
64.4
Unmapped Staff *
694
COVID-19 Status
Negative 1,870
Positive 290
Cumulative NNUH Staff Testing to Date
Results Received to date
Covid Confirmed to date
2K
1K
0K
Jul 2020
Jan 2021
Jul 2021
Results Received by Staff Group
Nursing and Midwifery Registered 490
Additional Clinical Services 336
Administrative and Clerical 221
Medical and Dental 174
Allied Health Professionals 118
Add Prof Scientific and Technic 62
Estates and Ancillary 32
Healthcare Scientists 31
Students 2
NNUH Staff Results by date of Result
Results Recieved
Of which Covid Confirmed
30
20
10
0
Jul 2020
Jan 2021
Jul 2021
Results Received by Organisation (10+ results)
Nurse Bank 82
ED Nursing 39
Critical Care Complex 36
Heydon Neurosciences Ward 33
AMU K 31
* Of COVID-19 tests recorded on ICE as NNUH staff, a number of records were unable to be mapped back to HR data.


COVID-19 Report - Timeseries
To date record of swabs taken, confirmed cases, discharges and deaths
NNUH Digital Health
business intelligence
Cumulative
01/03/20 - 21/10/21
Total Swabs Taken
154,007
Patients Swabbed
53,086
Confirmed Cases
2,884
Recoveries
2,076
Deaths
748
Cumulative Confirmed at NNUH
3K
2K
1K
0K
Jul 2020
Jan 2021
Jul 2021
Cumulative Recoveries & Deaths
Recoveries to Date
Deaths to Date
2K
1K
0K
Jul 2020
Jan 2021
Jul 2021
Patients Swabbed per day
400
200
0
2020
2021
Confirmed Inpatient per day (<=14 days)
Confirmed Inpatients
Of which in HDU/ITU Bed
200
0
2020
2021
Recoveries & Deaths per day
Recoveries
Deaths
20
0
2020
2021

Maternity: Mothers

NNUH Digital Health
business intelligence

Caesarean Deliveries

Sep 2021

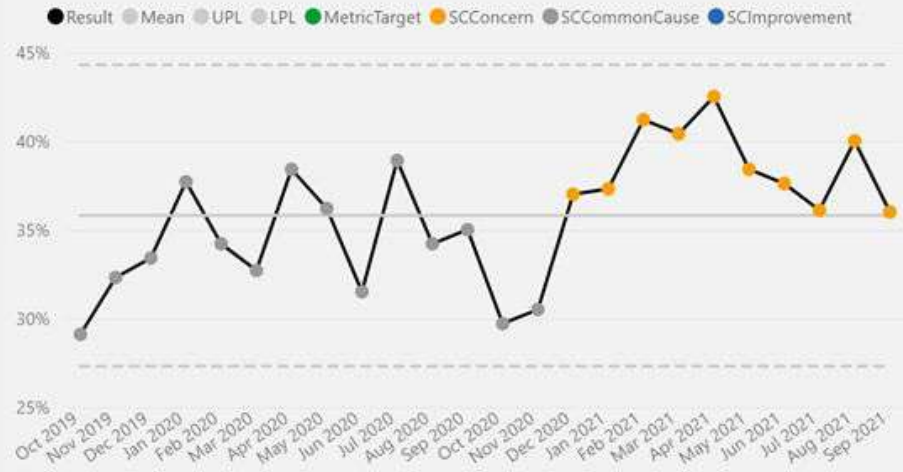
Variation	Assurance
H	

36.0% Result
N/A Target
44.3% UPL
35.8% Mean
27.3% LPL

Analytical Commentary

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

Caesarean Deliveries



Assurance Commentary

In September 451 babies were born to 447 mothers. We saw an increase in planned and unplanned homebirths - 31 in total. Nine of these deliveries were Born Before Arrivals (BBAs), none were preventable. 1:1 care in labour during September was 99.7%. The target of 100% was not achieved due to the coordinator not being able to maintain supernumerary status during periods of high acuity.
There were three women transferred out to other units for continuing induction of labour. This was due to a backlog of women being induced and capacity within the unit. The caesarean section rate fell to 36% - a decrease from 40% in August. Third and fourth degree tears occurred in 2.4% of all deliveries, and postpartum haemorrhage of >1500mls occurred in 3.6% of all deliveries.

Improvement Actions

Continue to share Learning with the teams. Women to be reminded of the importance of making contact with their Midwife when in labour.
Documentation around the circumstances of BBA's has significantly improved. Continue to monitor Caesareans clinical appropriateness via weekly CTG meetings chaired by Intrapartum Lead Consultant. Awaiting outcome of funding bid for fetal monitoring lead clinician.

Supplementary Metrics

Metric Name	Date	Result	Variation	Assurance
1:1 Care in Labour	Sep 2021	99.7%	Common Cause	No Target
3rd & 4th Degree Tears	Sep 2021	2.4%	Common Cause	Unreliable
Births Before Arrival	Sep 2021	9	Common Cause	No Target
Post Partum Haemorrhage ≥1500mls	Sep 2021	3.6%	Common Cause	No Target

Mothers Delivered
447
Babies Delivered
451

Maternity: Babies

NNUH Digital Health
business intelligence

Unplanned NICU ≥37 week Admissions (E3)

Sep 2021

Variation

Assurance

F

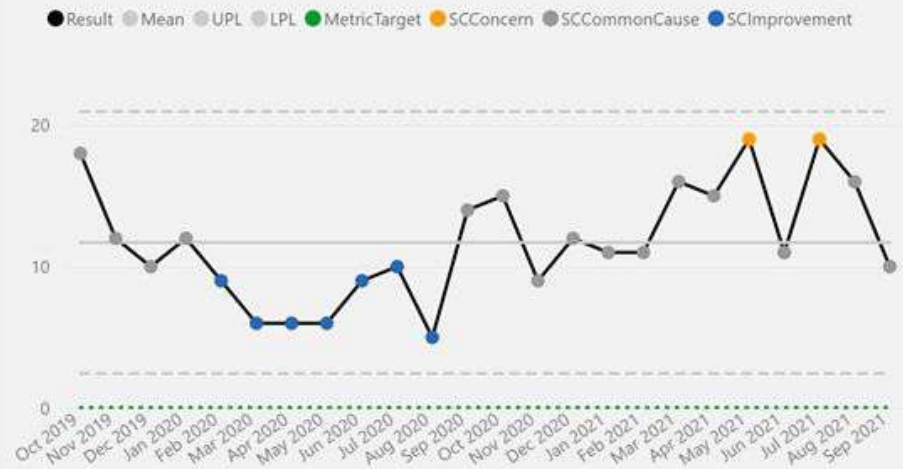
10 Result
0 Target

21 UPL
12 Mean
2 LPL

Analytical Commentary

Variation is Common Cause

Unplanned NICU ≥37 week Admissions (E3)



Assurance Commentary

In September there were 10 unanticipated admissions to NICU. This is a decrease from the number of admissions in August (16).

Improvement Actions

All cases have been discussed at Avoidable Term Admissions In Neonates (ATAIN). Learning points:
1. Importance of defining baseline of fetal heart, and documentation of method used to auscultate.
2. When babies are born with significant meconium and good Apgar's, cord gases are required in all cases.
3. Report on Datix all unanticipated admissions to NICU in a timely manner.

Supplementary Metrics

Metric Name	Date	Result	Variation	Assurance
Adjusted Still Births	Sep 2021	0	Not Applicable	No Target
Apgar score <7 @5, ≥37 weeks	Sep 2021	7	Common Cause	No Target
Early Neonatal Death	Sep 2021	0	Not Applicable	No Target
Mothers Transferred Out of Unit	Sep 2021	3	Not Applicable	No Target

Saving Babies Lives

NNUH Digital Health
business intelligence

Topic	Metric Name	Date	Result		Variation		Assurance
Smoking Awareness	Smoking Status at Delivery	Sep 2021	11.0%		Common Cause		Unreliable
Fetal Growth Restriction	Less Than 3rd centile born > 37+6 weeks	Sep 2021	3%		Common Cause		Unreliable
Fetal Growth Restriction	SGA detected Antenatally	Sep 2021	82%		Common Cause		No Target
Reducing Preterm Birth	Singleton Births Preterm	Sep 2021	5%		Common Cause		Unreliable
Reducing Preterm Birth	Singleton live births < 34 wks (AN corticosteroids within 7 days PN)	Sep 2021	0%		Common Cause		Unreliable
Effective Fetal Monitoring	CTG Training and Human factors situational awareness compliance	Sep 2021	88%		Common Cause		Unreliable

Assurance Commentary

Reminder sent to midwifery staff regarding the need for CO2 monitoring to take place at every antenatal encounter.
New appointments to Fetal monitoring lead midwife - started 17/10/2021 and Digital midwife who starts 1/11/2021.

Improvement Actions

New fetal monitoring lead midwife has action plan to improve GAP training compliance, commenced post 17/10/2021.
Review data pull for <30week deliveries to confirm correct details are being pulled across. Data being reviewed by Digital maternity team.

Adult Safeguarding

NNUH Digital Health
business intelligence

Safeguarding Adults

Sep 2021

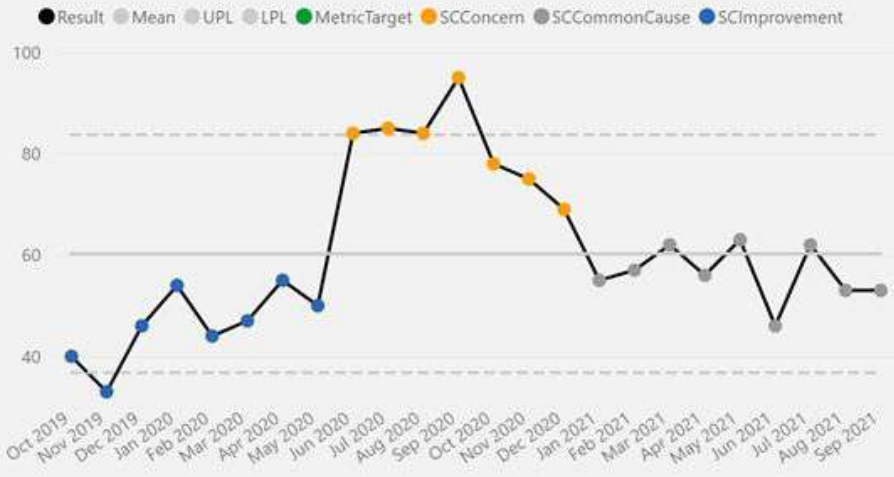
Variation	Assurance

53 Result
N/A Target
84 UPL
60 Mean
37 LPL

Analytical Commentary

Variation is Common Cause

Safeguarding Adults



Assurance Commentary

There has been an increase over recent months in the number of Section 42's raised against the hospital. On average up to 5 are received in a month, however more recently this has increased to 8 - 10.

Improvement Actions

The NNUH Safeguarding team and local authority are undertaking a thematic review of the referrals, and will look to develop an action plan to streamline this process.

The Local Authority and Designated Safeguarding Adult Team (DSAT) from CCGs have been invited to the Safeguarding Assurance Meeting due to take place in November, to provide feedback/actions on historical safeguarding concerns raised against NNUH

The implementation plan for the Mental Health Emergency Responder role has progressed with a 'go live' on 6th November.

Children & Midwifery Safeguarding

NNUH Digital Health
business intelligence

Safeguarding Children and Midwife...

Sep 2021

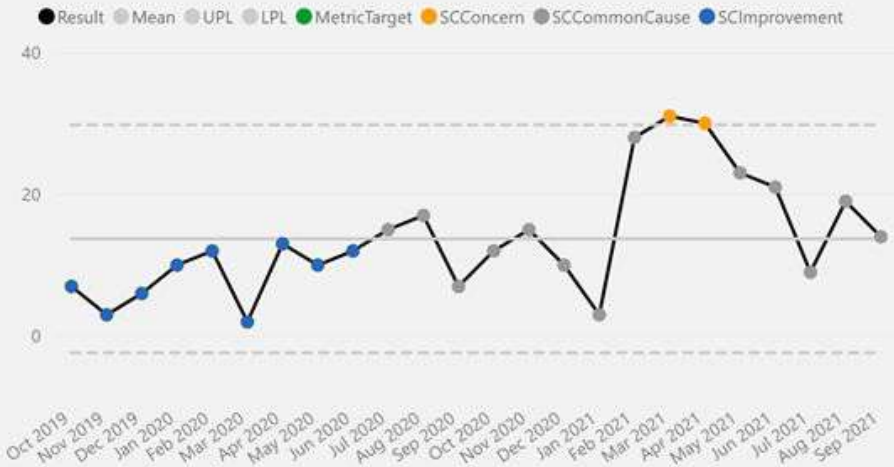
Variation	Assurance
	

14 Result
N/A Target
30 UPL
14 Mean
-2 LPL

Analytical Commentary

Variation is Common Cause

Safeguarding Children and Midwifery



Assurance Commentary

There is a recognised link between increased Mental Health presentations in young people and adverse experiences. Effective collaborative working is taking place between NNUH, Children's Services and NSFT to manage these complexities. All escalations are being managed appropriately.

Improvement Actions

Staff will continue to be reminded of the need to complete a Datix for each safeguarding referral made to the Local Authority.

Discussion are in progress to develop the service specifications and pathways of care for Children's Mental Health.

Staff are being supported through supervision to manage these complex cases.

Supplementary Metrics

Metric Name	Date	Result	Variation	Assurance
Safeguarding Children	Sep 2021	11	Common Cause	No Target
Safeguarding Midwifery	Sep 2021	3	Not Applicable	No Target

REPORT TO THE TRUST BOARD	
Date	**3 November 2021**
Title	**Chair's Key Actions from Finance, Investments and Performance Committee meeting on 27 October 2021**
Lead	**Tom Spink – Non-Executive Director (Committee Chair)**
Purpose	**For Information, assurance and approval as specified**

1 Background/Context

The Finance, Investments and Performance Committee met on 27 October 2021. The meeting was quorate and was attended by Jackie Hammond (Public Governor) and Richard Smith (Staff Governor) as observers. Papers for the meetings were circulated to Board members for information in the usual way via Diligent.

The Committee considered the usual suite of information regarding operational and financial performance and actions to improve the Use of Resources position. The items below were identified by the Committee for highlighting to the Board:

2 Key Issues

The following issues were identified to highlight and escalate to the Board		
1	Performance & Productivity IPR	The Committee reviewed the position on operational performance and: - commended the excellent performance in addressing P2 waiting times and in skin and breast cancer waits; - noted the escalation to Covid state 3 with all the associated operational difficulties; - noted the real concern regarding the number of attendances at ED, with flow impeded by delayed discharges out of the hospital; - noted the corrective actions to address internal flow & discharge issues in urgent care and late starts and early finishes for theatres; - received assurance with regard to the elective recovery plan and commitment to achieve the 104 week target, whilst recognising the ongoing risks around bed capacity and staffing. - noted the additional focus the HMB will be bringing to the Trust Workforce plan.
2	Regular Finance Reports	The Committee noted the positive position regarding financial performance in YTD. Additional management action is however needed to ensure progress in delivering the capital plan.
3	Financial Planning – H2 and 2022/23	The Committee received reports regarding the Financial Plan 2021/22 Cycle 5 (H2 Final) and the Financial Planning framework for 2022-23. The Committee agreed to recommend both to the Board for approval and they appear as separate reports on the Board Agenda. Committee members were pleased to hear that additional focus would be placed on execution of the financial recovery plan.
4	N&N Orthopaedic	The Committee has arranged to receive regular updates on progress in delivery of the NANOC project. There are a number of identified

	Centre	risks around supply chain delays and workforce. At its next meeting the Committee will review the Project Risk Register.
5	MRI scanning agreement	The Committee reviewed an agreement for provision of additional mobile MRI scanner further to a business case approved by the Management Board in August 2019. Approval has been given for a seven day scanner to be on site until March 2022. The Committee **agree to recommended** that the Board should give retrospective approval to the agreement inherent to the Business Case approved by the Management Board.
6	PFI Contract	The Committee commended the excellent progress with the contract management of the PFI contract.

3 Conclusions/Outcome/Next steps

The next Committee meeting is scheduled for 24 November 2021.

Recommendation:

The Board is recommended to:

- **note** the work the Finance, Investments & Performance Committee; and to
- give **retrospective approval to** the MRI scanning agreement as specified.

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NHS Foundation Trust

COVID-19 Update

September 2021

Current position: Local Covid State 2 – Low prevalence of Covid-19 within the Hospital

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NHS Foundation Trust

Executive Summary – September 2021

COVID-19

The Trust remained in Local COVID State 2 throughout the month. All COVID (+) admissions were managed through Brundall ward and the virtual ward. Plans have been drafted to dynamically open Dunston ward if there was a requirement to escalate outside of the 35 beds on Brundall ward. Green areas for elective care will remain protected.

Non-Elective Care

Non-elective performance remained challenged in September mostly as a result of a sustained rise in the number of patients without a criteria to reside, causing poor flow out of ED and the need for escalation capacity daily. This is being addressed as a system with an internal reset for the Safer, Better, Faster programme targeting zero tolerance for ambulance delays, 12hr breaches and transfer out within 1hr of clinically ready to proceed. SDEC was actively progressed and we were well above the national minimum of 30%, which was a positive improvement.

Elective Care

The Trust saw improvements in most elective standards in September. The delivery of P2s over 28 days was achieved in September, but the impact of this was an increase in long waiting patients. Plans are now in place to address this with a clear focus on addressing the 104 week waiting patients, as highlighted in the H2 guidance.

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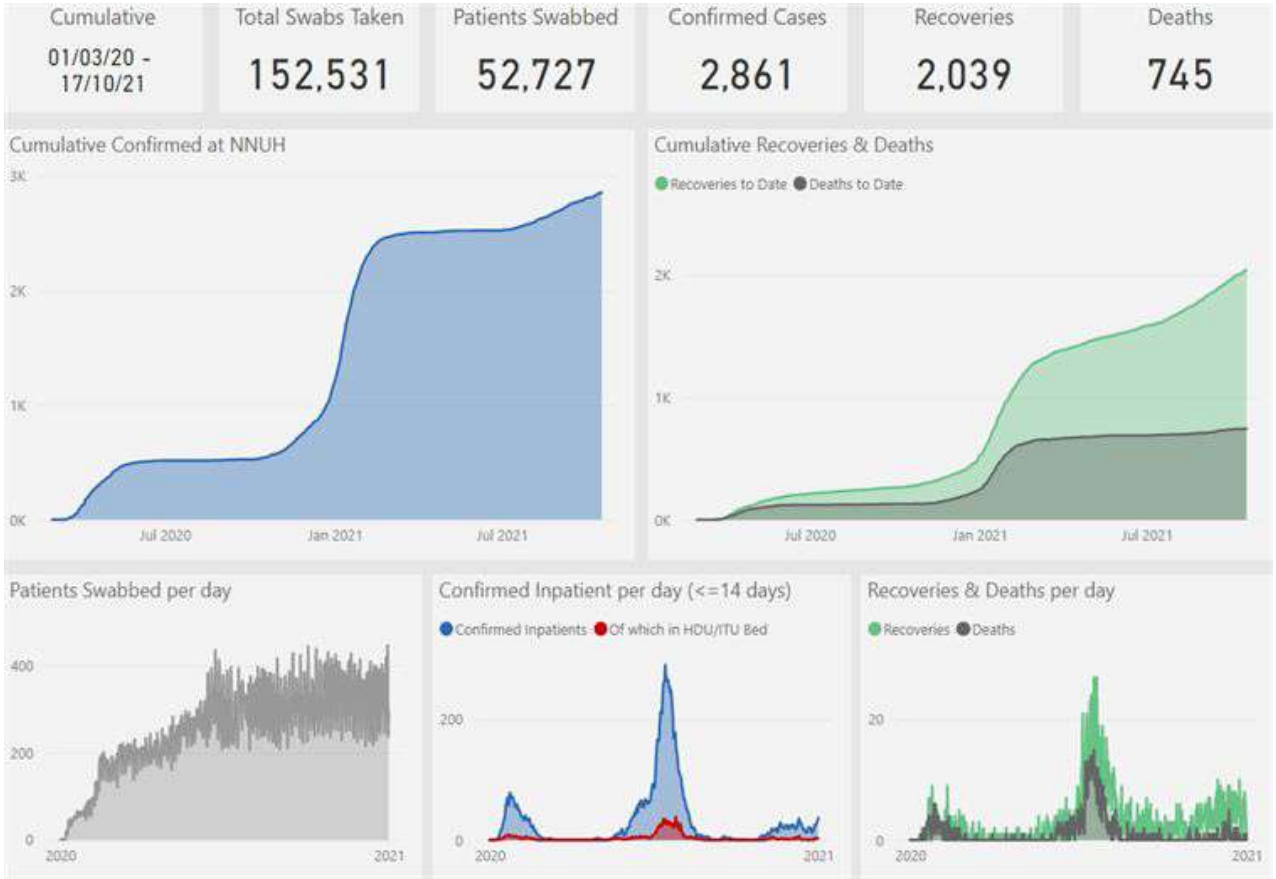
Norfolk and Norwich University Hospitals NHS Foundation Trust

COVID-19 Report: Time Series



Commentary

The Trust remained in Local COVID State 2 throughout the month.

All COVID (+) admissions were managed through Brundall ward and the virtual ward. Plans have been drafted to dynamically open Dunston ward if there was a requirement to escalate outside of the 35 beds on Brundall ward. Green areas for elective care will remain protected.

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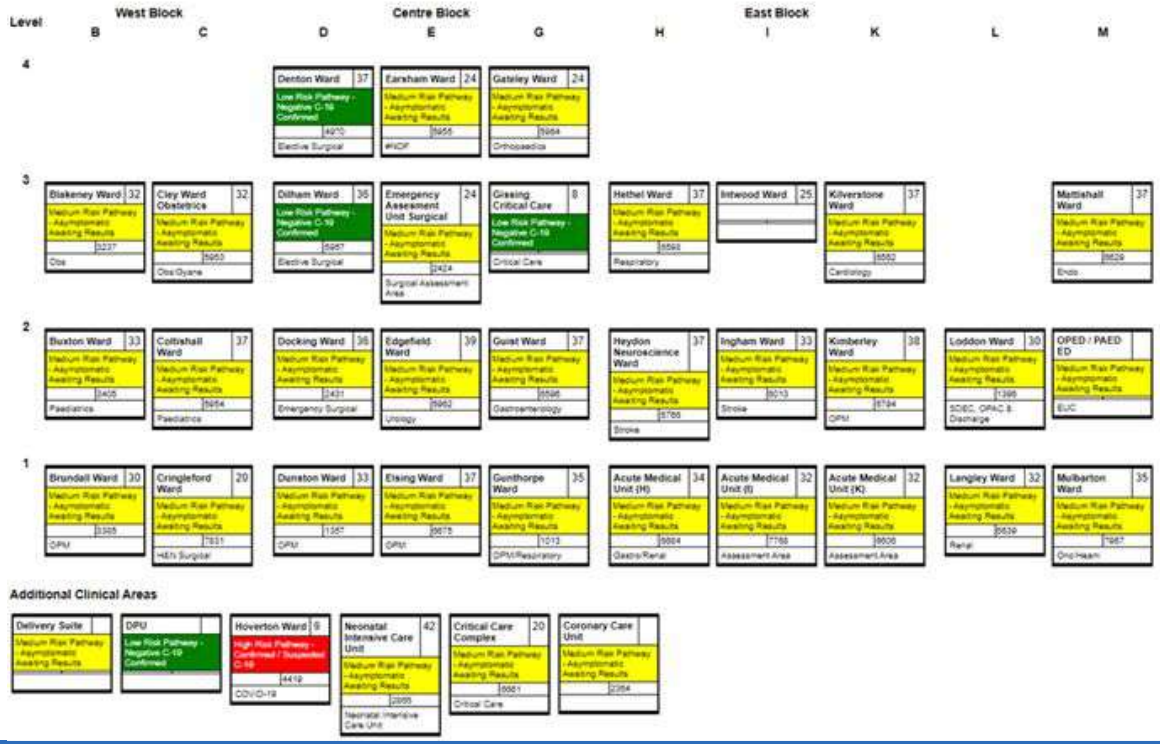
NHS Foundation Trust

COVID-19 Report: Current Local Covid State



LOCAL COVID STATE 2 (2-30 C-19 Patients)

Key:

- High Risk Pathway - Confirmed / Suspected C-19
- Medium Risk Pathway - Asymptomatic Awaiting Results
- Low Risk Pathway - Negative C-19 Confirmed

Commentary

The Trust remains on Local COVID State 2. There are currently 24 COVID-19 patients (< 14 days). Fifteen patients are being tested (data as of 21st October 21). Dunston is the next designated red area if the number of positive cases grows.

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Integrated Performance Report:

Performance & Activity Domains

September 2021

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NHS Foundation Trust

Non-Elective Care Standards

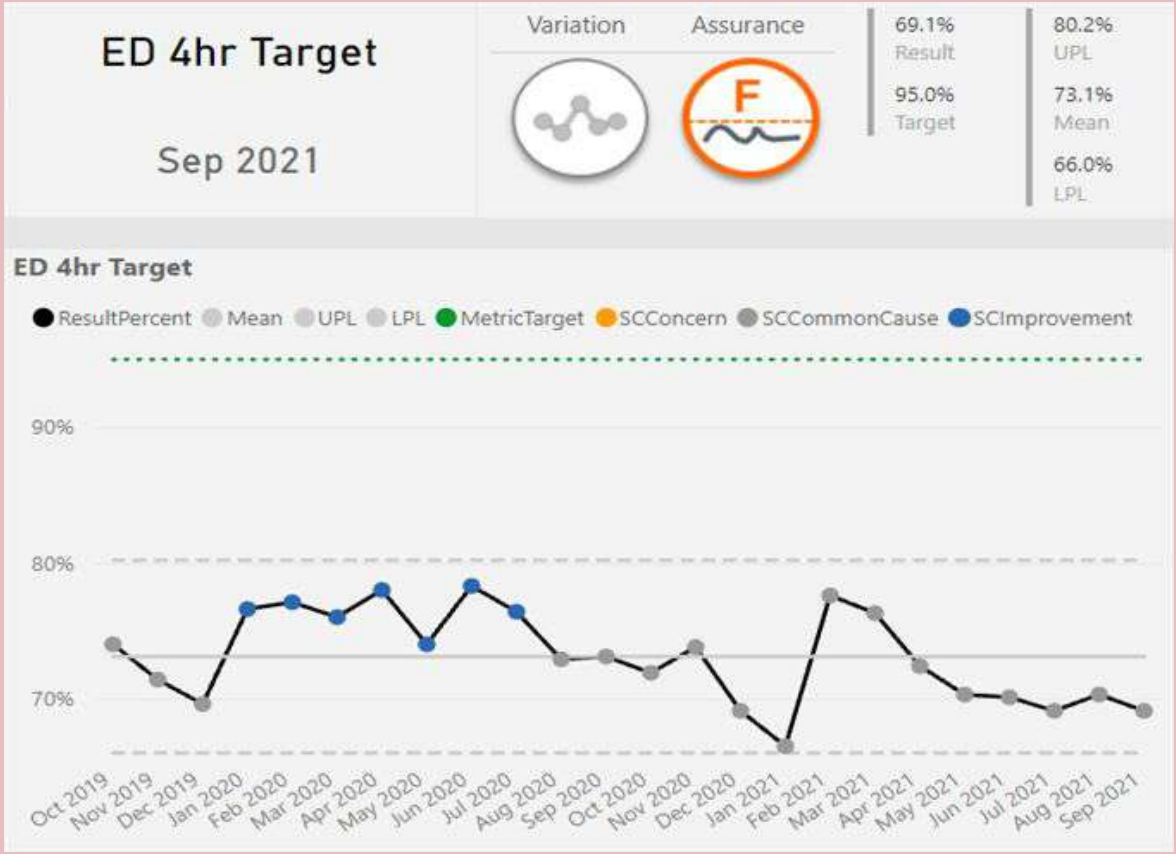
The non-elective performance remained challenged in September mostly as a result of a sustained rise in the number of patients without a criteria to reside, causing poor flow out of ED and the need for escalation capacity daily. This is being addressed as a system with an internal reset for the Safer, Better, Faster programme targeting zero tolerance for ambulance delays, 12hr breaches and transfer out within 1hr of clinically ready to proceed. SDEC was actively progressed and we were well above the national minimum of 30%, which was a positive improvement.

Safer, Better, Faster (SBF) Performance Dashboard

Ref	KPI	Target		Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
1	4hr Standard	95% (N)	Actual	76.34%	72.33%	70.51%	70.16%	69.06%	70.32%	69.11%
			Trajectory	78.51%	79.43%	80.67%	82.87%	83.45%	85.78%	85.99%
2	Initial Assessment <15 mins (ED)	85% (N)	Actual	57.16%	61.02%	57.57%	53.14%	52.71%	56.78%	45.97%
			Trajectory	52.90%	54.06%	56.89%	58.02%	60.90%	64.80%	69.43%
3	Avg Time in ED (Non-Admitted)	<220 (N) <180 (L)	Actual	208	221	230	234	243	236	250
			Trajectory	182	181	180	178	175	175	175
4	Avg Time in ED (Admitted)	<220 (N) <200 (L)	Actual	365	373	410	415	468	454	546
			Trajectory	314	311	308	298	285	278	268
5	Admitted within 1 hour of clinically ready to proceed*	100% (N)	Actual	18.07%	18.57%	47.45%	48.51%	33.51%	38.39%	24.70%
			Trajectory	9.50%	30.00%	45.00%	50.00%	55.00%	60.00%	65.00%
6	Total Time in ED <12 hours	100% (N)	Actual	97.05%	97.84%	96.53%	96.86%	95.36%	95.50%	92.50%
			Trajectory	97.10%	97.90%	98.01%	98.90%	99.00%	99.00%	99.00%
7	Ambulance Handovers <=15mins	90% (N)	Actual	60.37%	63.51%	56.85%	47.80%	43.32%	44.91%	34.35%
			Trajectory	56.80%	57.00%	58.76%	59.05%	61.24%	65.98%	70.65%
8	>21 Days LLoS Patients	86 (N) 80 (L)	Actual	82.6	93.6	81.7	93.0	99.5	105.8	138.5
			Trajectory	96	88	86	85	82	81	80
9	14-20 Days LLoS Patients	TBC (N) 49 (L)	Actual	70.1	61.6	69.0	67.4	75.1	71.4	81.3
			Trajectory	84	87	82	75	70	65	60
10	SDEC as % of Emergency Attendances	>30% (N)	Actual	45.42%	47.35%	43.82%	44.35%	51.15%	51.24%	51.14%
			Trajectory	22.68%	23.85%	24.00%	24.86%	25.78%	26.85%	27.83%
11	Triage	<60 mins (L)	Actual	91.92%	95.08%	94.51%	91.79%	89.69%	91.17%	84.68%
			Trajectory	98.10%	98.90%	99.00%	99.00%	99.00%	99.10%	99.42%
12	GP Streaming	TBC (N)	Actual	17.62%	16.28%	17.63%	17.82%	16.46%	17.63%	13.76%
			Trajectory	17%	17%	17%	20%	20%	20%	22%

Key:
More than 10% away from Trajectory
Within 10% of Trajectory
National target or trajectory hit
National target and trajectory hit

Performance – ED 4 Hour Standard



Ref	KPI	Target		Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
1	4hr Standard	95% (N)	Actual	76.34%	72.33%	70.51%	70.16%	69.06%	70.32%	69.11%
			Trajectory	78.51%	79.43%	80.67%	82.87%	83.45%	85.78%	85.99%

Commentary

September 2021 Performance

ED attendances decreased in September with 11,270 patients attending the department, this is a fall from August's demand of 14,015. Mondays and Tuesdays are consistently seeing much higher levels of attendances than any other day.

ED 4-hour performance declined to 69% for Sept 21 and it remains extremely challenged. This challenge is generated at the start of the day with 4hr performance often starting below 20% and compounded by a large volume of patients in ED from 07:00, with the majority awaiting admission. The exit block from ED has also been compounded by sustained high levels of attendances both ambulatory and via ambulance conveyances. September daily attendances have reached up to 454 attendances at ED. Staffing has been a major concern with COVID and short notice sickness being the main reason for the shortfall.

Improvement Actions

1. Role and pathway development - Senior Clinician at the front door to reduce both time to first clinician and divert inappropriate attendances from mid-November. This is in conjunction with a reconfiguration of the triage and clinical space for ambulatory patients - build starts December

2. Bookable appointments: ambition is to move as quickly as possible to bookable only attendances for minors. Requested support from regional NHSEI EUC Lead via CSORT; STP UEC Programme Manager to support too. To be implemented in Q4 at the latest with the IPad pilot running throughout October and November.

3. System support has been required to expedite plans for ED navigator to stream patients directly to GP Front Door service, currently trialling the ED staff streaming to the GPFD team. Pilot running for the next 6weeks with weekly evaluations using PDSA methodology to refine.

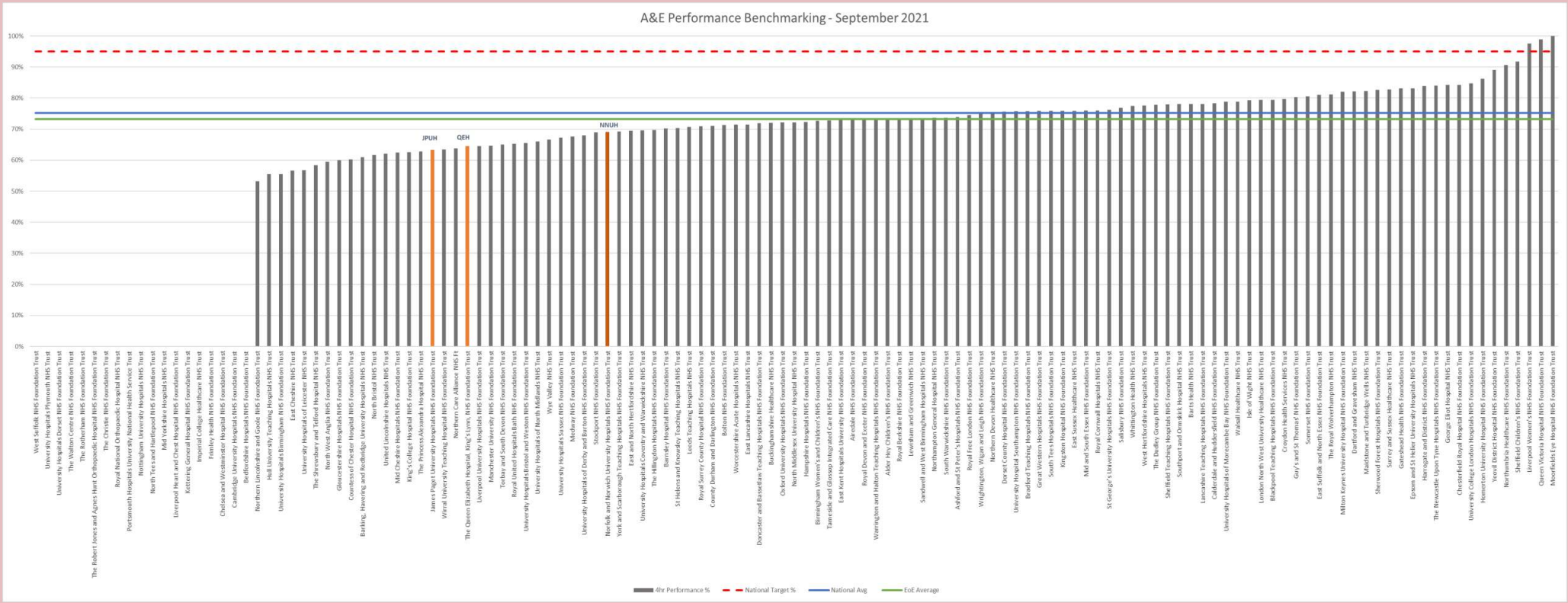
4. Trust selected for the ''Recovery Unit''.

5. Immediate actions include modifying the progress tracker role to prevent avoidable breaches within 15 mins of targets, extended day senior manager oversight and SBF reset

Risk To Delivery

RED

Performance – ED 4 Hour Standard Benchmarking



Comments

NNUH was ranked 82 out of 112 submitting Trusts for England A&E 4-hour performance in September 2021. This was slightly below the EoE regional average performance of 73.2% and the national average of 75.2%. The JPUH and QEH hospitals also struggled in September and the levels of performance were below the NNUH.

Performance – ED Assessed Within 15 Mins %

Ref	KPI	Target		Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
2	Initial Assessment <15 mins (ED)	85% (N)	Actual	57.16%	61.02%	57.57%	53.14%	52.71%	56.78%	45.97%
			Trajectory	52.90%	54.06%	56.89%	58.02%	60.90%	64.80%	69.43%

Commentary

September 2021 Performance

Assessment within 15mins % has declined in September as a result of a congested department with no physical space to see and assess patients, high volumes of ambulance attendances and staffing shortfalls due to short term sickness. The GP Streaming pilot will support improved use of resource and demand management releasing more capacity.

Focus remains on ensuring safe and effective front door assessment in-line with patients arrival time and source.

The main risk to delivery of this trajectory remains a shortage of physical capacity to place staff and patients in the appropriate area within ED.

Improvement Actions

1. Improved monitoring process of performance on a live basis to enable real time decision making and actions driven by dashboard.

2. A proposed initial reconfiguration of ED, ahead of a major phased building programme, will address some of the physical space issues; creating 2 additional assessment spaces, the reconfiguration of the hub room into clinical space for the early assessment by the clinical team, the development of an ambulatory CDU and the reconfiguration of the Portakabin into an effective RATS location..

3. Enhanced escalation of this standard to ED matron and Operational Manager to explore mitigations in real time.

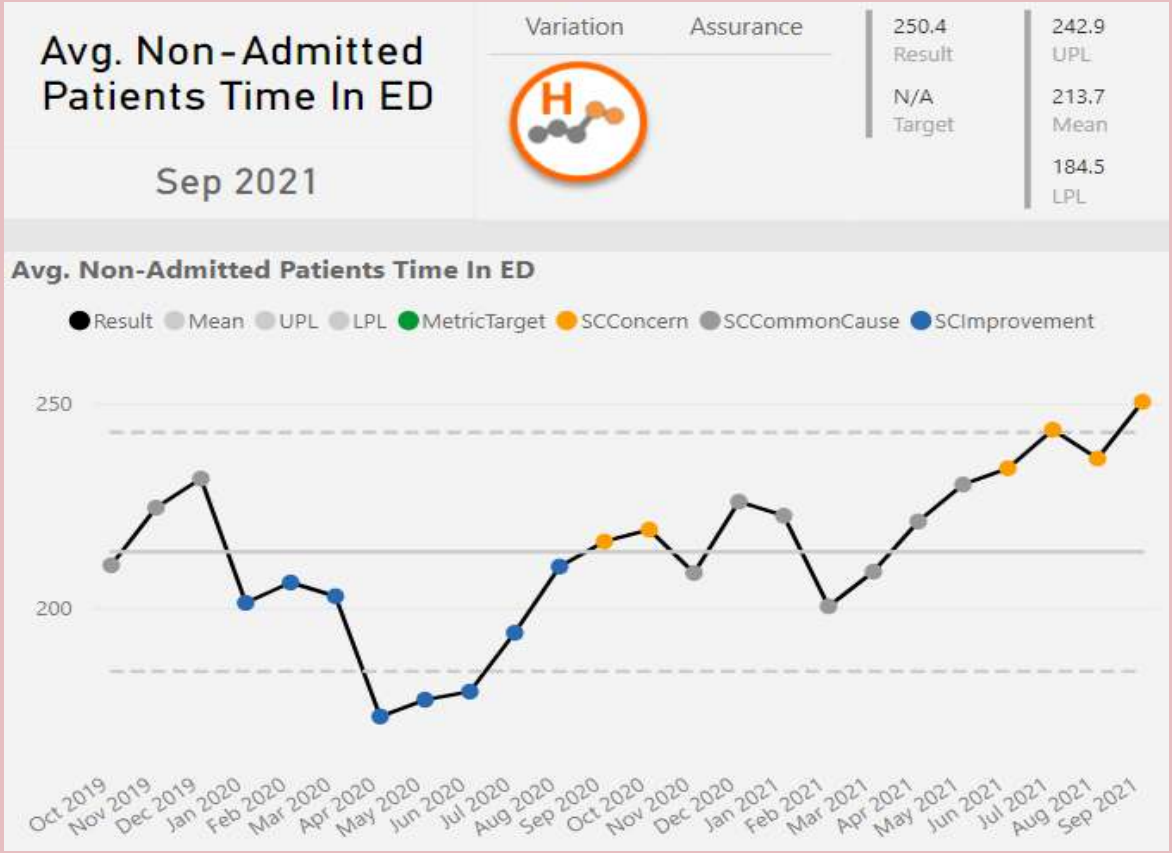
4. Place a Senior Clinician at the front door to reduce both time to first clinician and divert inappropriate attendances and further developed shared learn between the nursing and clinician teams.

Risk To Delivery

AMBER

9

Performance – Average non admitted patient time in ED



Ref	KPI	Target		Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
3	Avg Time in ED (Non-Admitted)	<220 (N)	Actual	208	221	230	234	243	236	250
		<180 (L)	Trajectory	182	181	180	178	175	175	175

Commentary

September 2021 Performance

Both data indicators for ambulatory pathways indicate a decline in performance against targets and remain off-trajectory. Demand profile remains similar with higher walk-in arrivals between (10:00-15:00) this subsequently compounds significant physical capacity issues across the department including in the waiting room and other areas.

Recruitment is underway to facilitate addition ENPs to release the medical team to work in the other areas of the department leaving the NNUH Minors to be run like the Cromer MIU

Improvement Actions

1. Action plan to re-evaluate space and improve turnover of Ambulatory patients once they have been assessed to allow for more rapid and effective utilisation of space. Work has started to review the use of the Minors locations to increase capacity for the ambulatory minor illness cohort of patients

2. Improved use of GP Streaming – trial of the ED staff steaming patient to the GP team

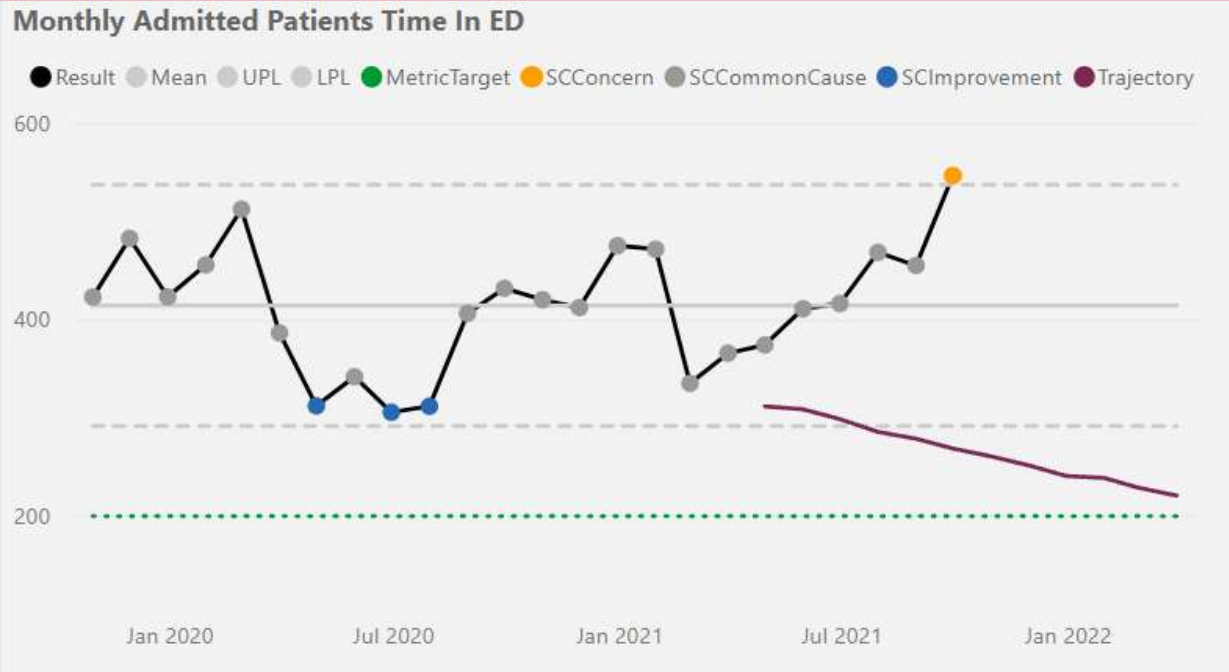
3.SDEC to be reinforced with additional clinicians from July 2021.

4. Complete the recruitment of the ENPs.

Risk To Delivery

RED

Performance – Average admitted patient time in ED



Ref	KPI	Target		Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
4	Avg Time in ED (Admitted)	<220 (N)	Actual	365	373	410	415	468	454	546
		<200 (L)	Trajectory	314	311	308	298	285	278	268

Commentary

September 2021 Performance

Decline in performance through September with an average of 527 minutes, performance remains off trajectory. The exit block is the main contributory factor to the admitted time within ED. The Trust is progressing Clinically Ready to Proceed into business as usual.

Improvement Actions

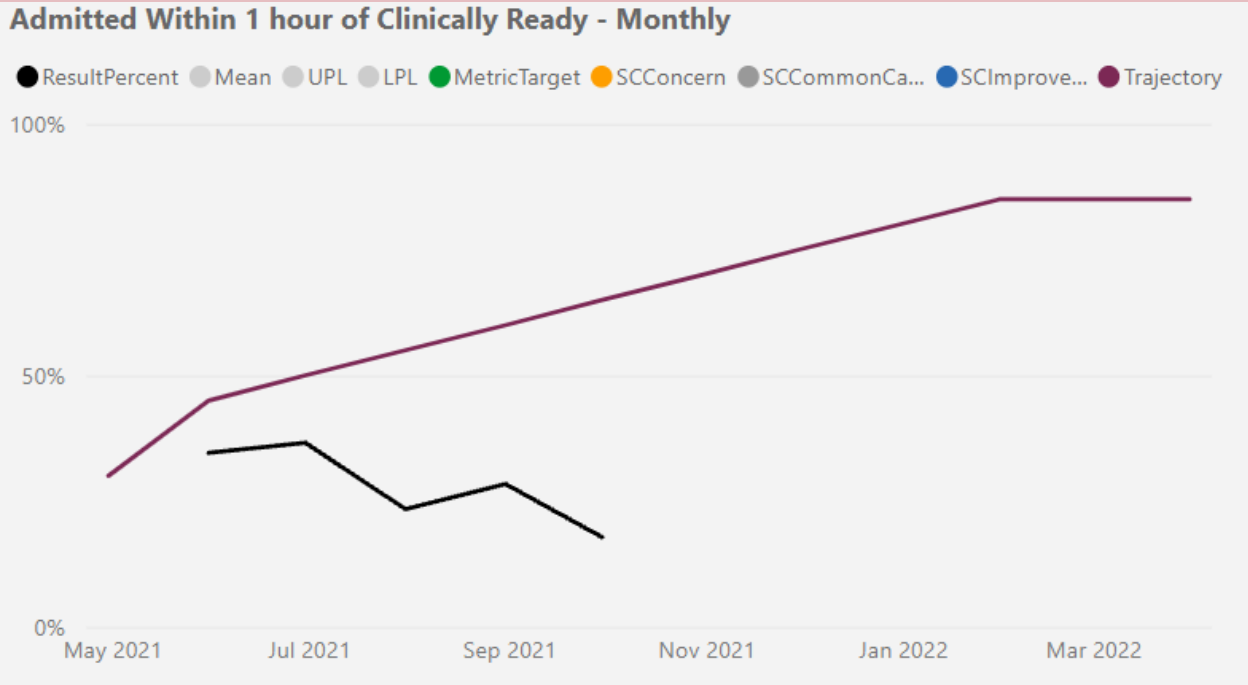
1. Convert the test of change process and learning to BAU once the policy / SOP is formally adopted by the trust

2. Prepare for national reporting of this metric from October 2021.

Risk To Delivery

RED

Performance – Admitted within 1 hour of Clinically Ready to Proceed



Ref	KPI	Target		Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
5	Admitted within 1 hour of clinically ready to proceed*	100% (N)	Actual	18.07%	18.57%	47.45%	48.51%	33.51%	38.39%	24.70%
			Trajectory	9.50%	30.00%	45.00%	50.00%	55.00%	60.00%	65.00%

Commentary

September 2021 Performance

The clinically ready to proceed within 60mins % decreased as we moved into September and remains the most challenged area of the new access standards. Delayed discharges and the number of patients without a criteria to reside have increased to unprecedented levels and are subsequently causing a congested hospital. All possible escalation areas have been utilised and OPEL 4 actions triggered on multiple days during September. Significant staffing issues have also contributed to difficulty in opening additional physical capacity.

Improvement Actions

1. MADE Events have occurred in the community and a 'War Room' set up with NCHC and system partners in order to resolve exit block in the community.

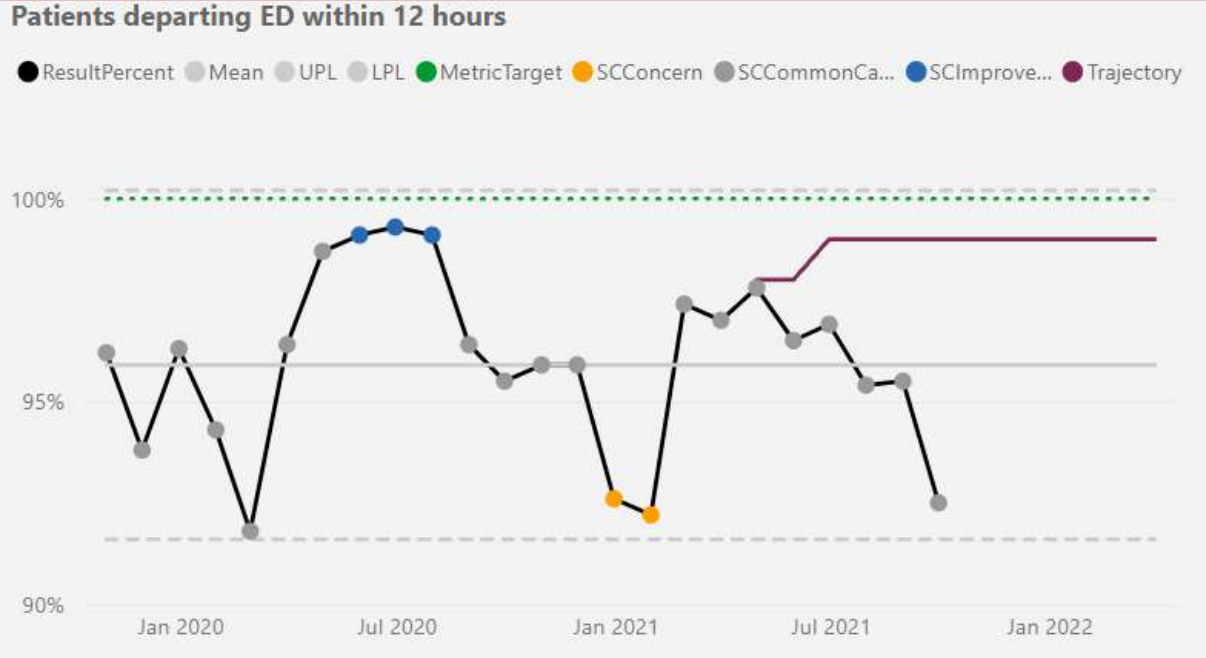
2. Daily escalations and calls are in place for the ICS to alleviate pressures where possible.

3. EEAST remaining on REAP 3-4 continues to reduce the numbers of patients that would otherwise be re-directed on admission avoidance pathways.

Risk To Delivery

RED

Performance – Patients Departing ED within 12 hours



Ref	KPI	Target		Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
6	Total Time in ED <12 hours	100% (N)	Actual	97.05%	97.84%	96.53%	96.86%	95.36%	95.50%	92.50%
			Trajectory	97.10%	97.90%	98.01%	98.90%	99.00%	99.00%	99.00%

Commentary

September 2021 Performance

There is no system resolution to enable ED to achieve 100% due to the continued capacity issues for mental health patients. We had 66 x Trust 12 hour DTA breaches within September 2021 and 9x 12 Hours Mental Health breaches.

Daily monitoring of numbers of patients with an ED episode of 12 hrs or more via site flow meetings and by the ED Triumvirate – the daily challenge is to ensure this is a single figure number with a view to improve this as work develops.

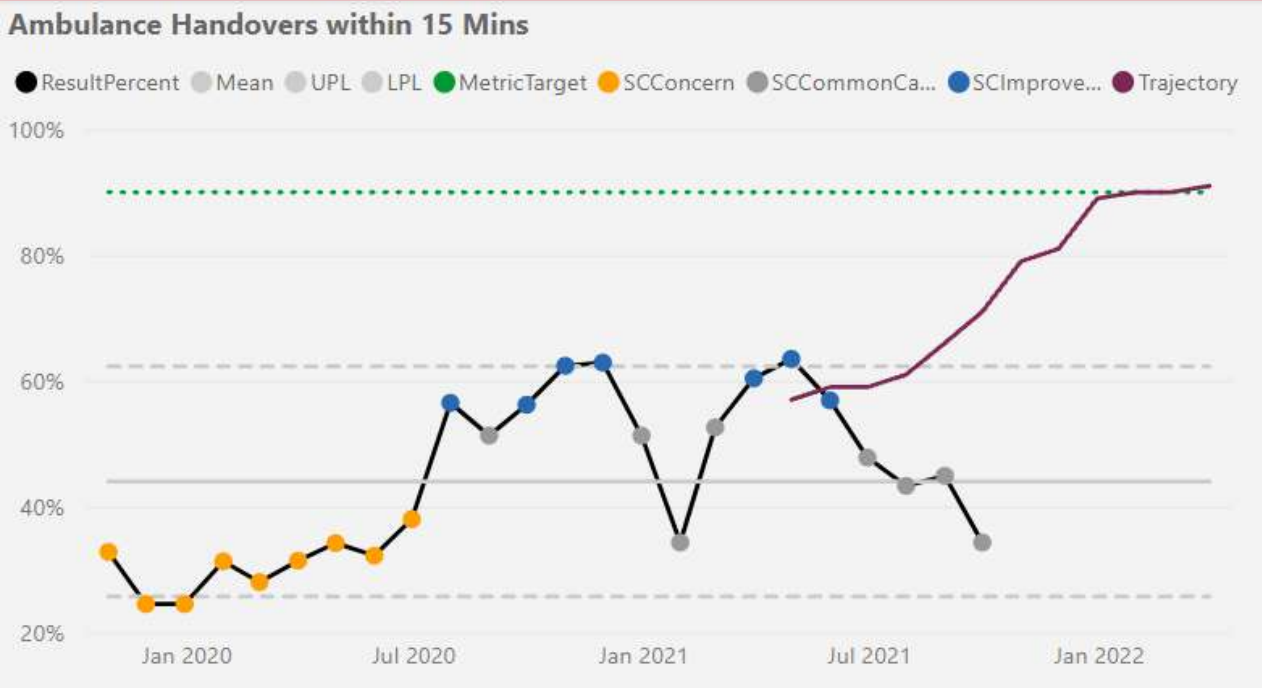
Improvement Actions

1. Ongoing liaison and engagement with Norfolk & Suffolk Foundation Trust, Norfolk County Council, NHS England and other partner organisations involved with the delivery of Mental Health services.

Risk To Delivery

RED

Performance – Ambulance Handovers <15 mins



Ref	KPI	Target		Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
7	Ambulance Handovers <=15mins	90% (N)	Actual	60.37%	63.51%	56.85%	47.80%	43.32%	44.91%	34.35%
			Trajectory	56.80%	57.00%	58.76%	59.05%	61.24%	65.98%	70.65%

Commentary

September 2021 Performance

Handovers remain severely challenged during September. The % of ambulances offloaded within 15mins has fallen as we moved into September. The Trusts position reflects the wider regional picture of difficulties in sustaining performance and number of ambulances breaching 60 minutes with the ambulance cohort opened on multiple occasions throughout September and as we moved onto October.

Physical capacity issues cited across ED access standards has also impacted handovers. A plan to redesign ED space is being prepared ahead of 22/23 capital planning and other interim, short term actions and minor works are being made to alleviate the problems.

Improvement Actions

1. Continued work with the region, EEAST and ICS on resilience planning and daily/weekly escalation calls.

2. Working across the ICS to standardise expectations and role of the HALOs.

Risk To Delivery

RED

Performance – 15 Minute Handover % Trends EoE

NNUH Digital Health business intelligence

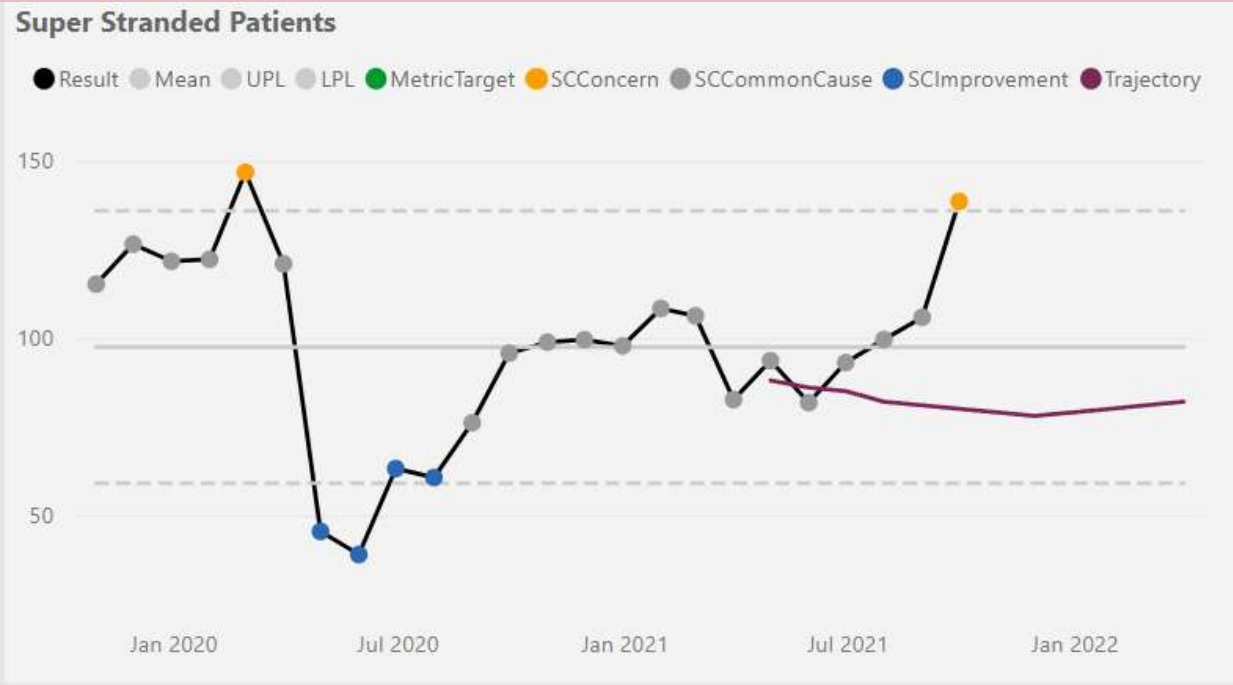
Ambulance Handovers <15mins %														
Hospital Name	**Sep-20**	**Oct-20**	**Nov-20**	**Dec-20**	**Jan-21**	**Feb-21**	**Mar-21**	**Apr-21**	**May-21**	**Jun-21**	**Jul-21**	**Aug-21**	**Sep-21**	**Total**
Addenbrookes Hospital	41.20%	41.42%	41.97%	36.58%	37.31%	37.28%	42.67%	42.13%	38.95%	31.43%	27.66%	29.52%	24.45%	36.45%
Basildon & Thurrock Hospital	63.40%	58.31%	55.66%	41.42%	52.59%	67.97%	69.22%	68.44%	66.29%	55.60%	54.18%	50.11%	44.82%	57.60%
Bedford Hospital South Wing	44.21%	41.02%	40.66%	37.85%	33.11%	48.91%	60.26%	57.65%	65.66%	60.42%	60.24%	53.22%	48.02%	50.32%
Broomfield Hospital	37.88%	40.10%	40.98%	31.03%	33.23%	44.31%	50.06%	44.24%	42.54%	66.86%	54.47%	47.73%	37.46%	44.06%
Colchester General Hospital	28.61%	31.98%	30.93%	24.96%	21.65%	29.73%	35.56%	33.22%	30.25%	30.88%	23.01%	14.77%	14.84%	27.03%
Hinchingbrooke Hospital	26.70%	30.48%	34.05%	31.96%	27.55%	28.06%	27.79%	23.37%	22.77%	21.05%	15.11%	13.27%	14.30%	24.14%
Ipswich Hospital	41.29%	38.80%	40.17%	31.59%	29.23%	41.16%	44.14%	39.89%	41.09%	35.26%	25.13%	27.23%	31.64%	35.91%
James Paget Hospital	51.53%	43.97%	27.74%	21.39%	19.43%	33.45%	48.38%	44.76%	36.36%	31.09%	31.93%	21.29%	24.28%	33.87%
Lister Hospital	27.33%	26.54%	23.51%	20.09%	21.57%	26.61%	25.70%	21.96%	19.20%	13.26%	14.75%	10.61%	6.90%	20.11%
Luton And Dunstable Hospital	42.36%	47.22%	50.70%	41.45%	41.13%	48.15%	47.54%	47.93%	47.89%	48.68%	46.28%	44.67%	44.18%	46.06%
Norfolk & Norwich University	56.31%	62.25%	62.97%	51.17%	34.45%	52.68%	60.31%	63.51%	57.12%	47.83%	43.56%	45.06%	34.32%	52.30%
Peterborough City Hospital	27.09%	20.39%	17.15%	12.31%	10.95%	20.50%	18.05%	18.93%	16.26%	9.83%	6.97%	4.86%	5.91%	14.90%
Princess Alexandra Hospital	30.50%	32.20%	28.97%	22.19%	9.32%	11.74%	17.14%	30.11%	25.43%	23.45%	21.50%	20.50%	19.01%	22.80%
Queen Elizabeth Hospital	33.59%	39.38%	37.17%	33.57%	45.24%	55.17%	59.19%	58.86%	52.50%	49.97%	46.31%	42.45%	37.76%	45.71%
Southend University Hospital	27.29%	23.99%	22.01%	17.83%	21.98%	23.15%	21.40%	21.04%	22.16%	21.53%	23.49%	19.15%	15.21%	21.56%
Watford General Hospital	35.60%	32.98%	33.39%	15.33%	15.19%	30.76%	31.06%	40.66%	34.81%	29.27%	25.90%	29.38%	28.06%	29.73%
West Suffolk Hospital	47.11%	39.01%	43.36%	39.61%	38.49%	50.70%	50.63%	52.47%	47.88%	46.01%	42.95%	41.25%	40.30%	44.60%
Total	**40.07%**	**39.61%**	**38.71%**	**31.29%**	**29.93%**	**39.59%**	**42.90%**	**42.88%**	**40.20%**	**37.44%**	**33.97%**	**31.35%**	**28.42%**	**36.79%**
NNUH Rank	**2**	**1**	**1**	**1**	**6**	**3**	**2**	**2**	**3**	**6**	**6**	**4**	**7**	**2**

Comments

Linked to the issues with the exit block and the congestion in the department, the performance deteriorated back to levels in January 2021. Additionally, the Trust has frequently supported with ''load levelling'' from other acute N&W Trusts and consequently impacted performance. Although the performance has fallen during September, an improved system approach to balance the risk and improve the safer management of patients is starting to embed.

15

Performance – Long Length of Stay >21 Day Patients



Ref	KPI	Target		Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
9	14-20 Days LLoS Patients	TBC (N)	Actual	70.1	61.6	69.0	67.4	75.1	71.4	81.3
		49 (L)	Trajectory	84	87	82	75	70	65	60

Commentary

September 2021 Performance

The number of super stranded patients has significantly increased over the past month. This pressure is being felt across the system and is driven by increasing delays of patients on pathways 1-3. The lack of package of care provision (pathway 1) is also preventing patients being discharged from community settings with the knock-on consequences of delays in pathways 2 and 3. This has had a knock on effect to other performance measures including time to admit as flow out of the organisation daily correlates with admission metrics.

Improvement Actions

1. MADE Events have occurred in the community and a War Room set up with NCHC and system partners in order to resolve exit block in the community. Daily escalations and calls are in place for the ICS to alleviate pressures, where possible. EEAST remaining on REAP 3-4 continues to reduce the numbers of patients that would otherwise be re-directed on admission avoidance pathways.

2. Re-introduced weekly executive review meeting with IDT, SS & Operational Managers. These provide a different perspective to unblock issues that are often not escalated to the right individual at the right time. Attendance and timings have been implemented to seek maximum value for progressing patients pathways.

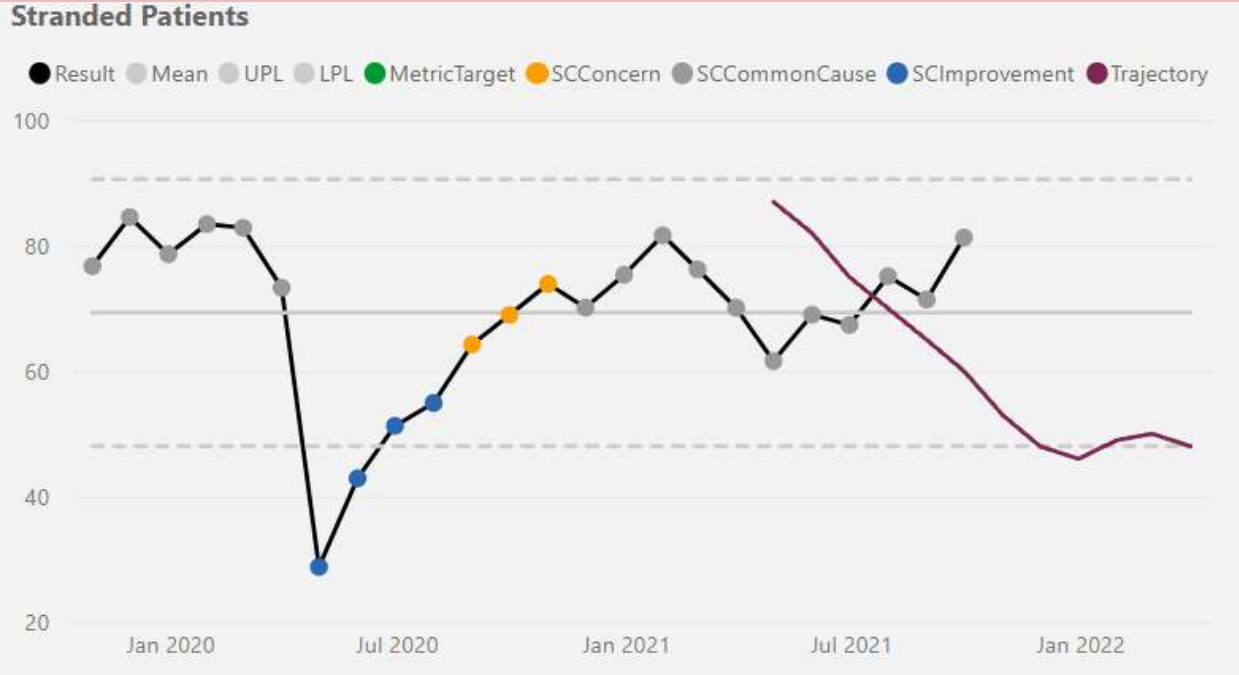
3. Clear, assigned actions are circulated pre- and post- meeting and during the week with either Red (Not Complete) or Green (Complete).
Planned discharges, any LLoS patients planned for discharge to ensure plans are followed and prevent additional delays.

4. Escalations – specific patients requiring intervention not highlighted in the above two categories.

Risk To Delivery

RED

Performance – Long Length of Stay 14-20 Day Patients



Ref	KPI	Target		Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
8	>21 Days LLoS Patients	86 (N)	Actual	82.6	93.6	81.7	93.0	99.5	105.8	138.5
		80 (L)	Trajectory	96	88	86	85	82	81	80

Commentary

September 2021 Performance

Discharge pressures have been seen across the system. Further downstream, a lack of capacity to meet demand is also leading to community beds being blocked with an inability to obtain packages of care. This theme continues as we approach winter.

Improvement Actions

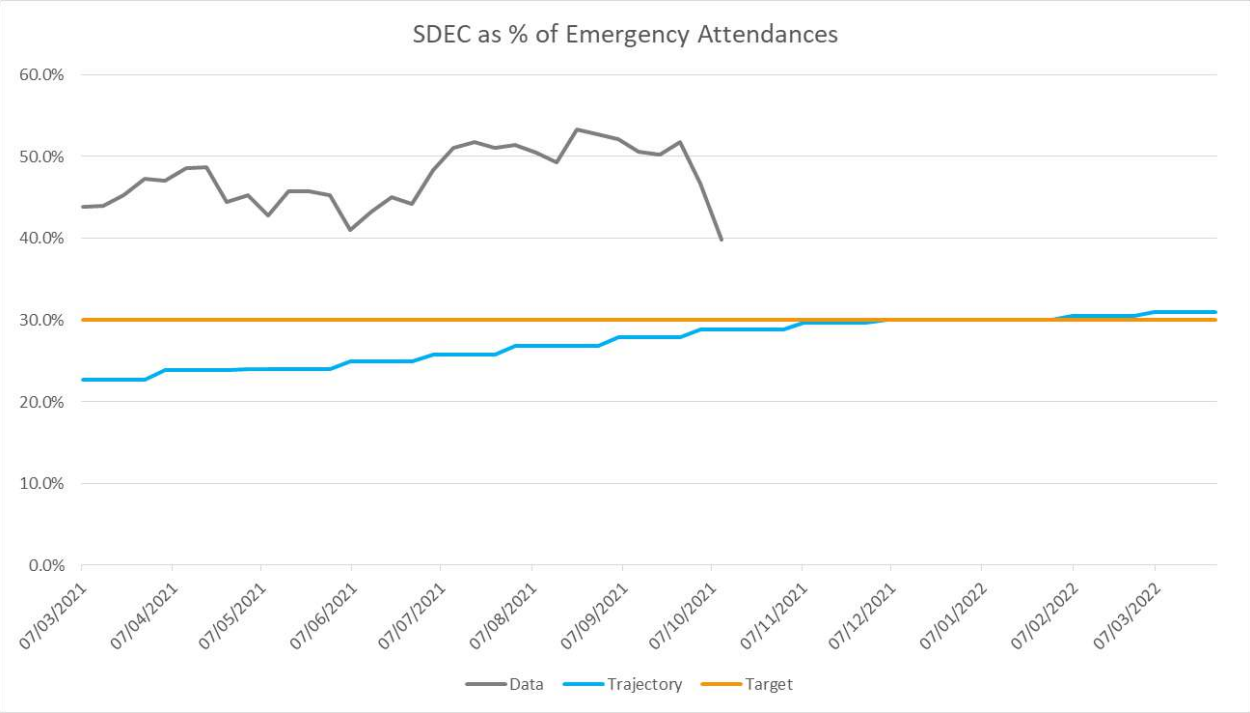
1. Focus on patients with no criteria to reside and rationale.

2. Expand use of Virtual Ward – standard operating procedures for patients that can automatically meet the criteria for virtual ward due to be produced.

Risk To Delivery

GREEN

Performance – SDEC as % of Emergency Attendances



Ref	KPI	Target		Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
10	SDEC as % of Emergency Attendances	>30% (N)	Actual	45.42%	47.35%	43.82%	44.35%	51.15%	51.24%	51.14%
			Trajectory	22.68%	23.85%	24.00%	24.86%	25.78%	26.85%	27.83%

Commentary

September 2021 Performance

51% is amongst the highest % in the Eastern region.
Medical SDEC capacity has been challenged due to the increasing volume of inpatients which has led to escalating inpatients into the area dedicated to SDEC. This has reduced the ability to see SDEC patients and pull further patients from ED. SDEC is a key focus of the SBF programme and increased use of surgical SDEC is a priority.

Improvement Actions

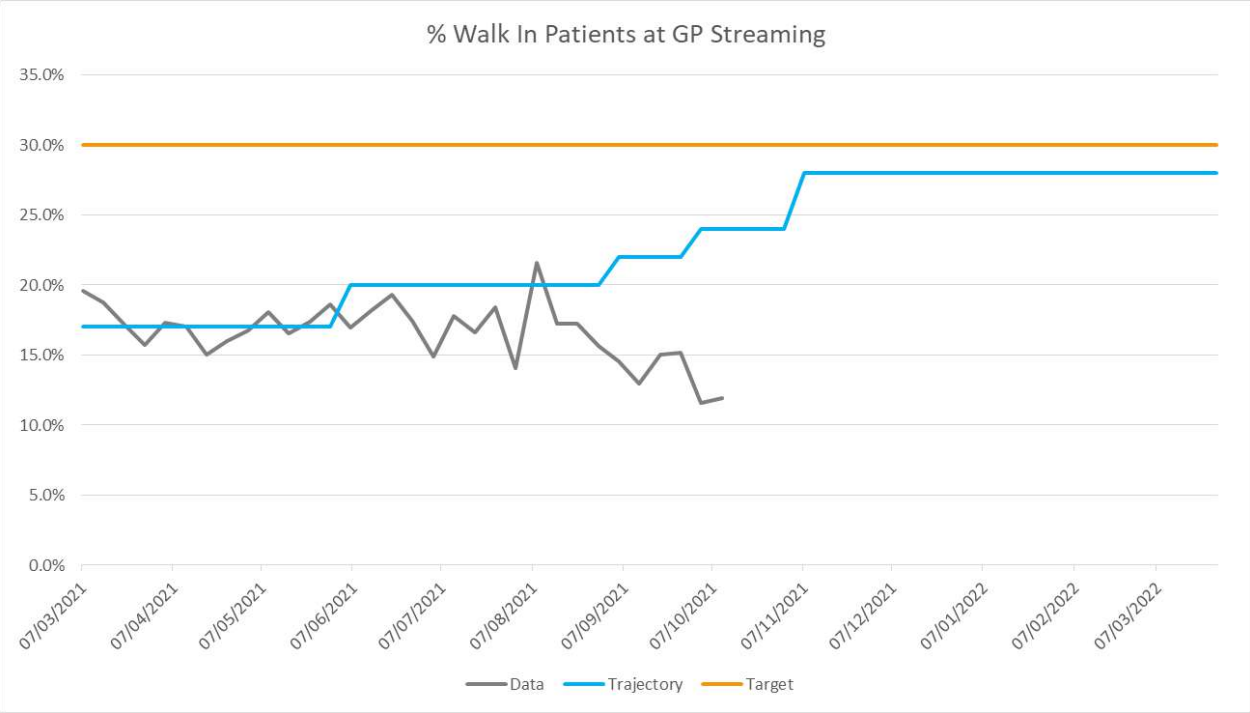
1. Medical SDEC has a new lead for the work stream run via the SBF programme. The aim is to identify and standardise further pathways.

2. A focus on patient discharge to reduce bed occupancy will prevent escalation into the SDEC area.

Risk To Delivery

GREEN

Performance – GP Streaming



Ref	KPI	Target		Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
12	GP Streaming	TBC (N)	Actual	17.62%	16.28%	17.63%	17.82%	16.46%	17.63%	13.76%
			Trajectory	17%	17%	17%	20%	20%	20%	22%

Commentary

September 2021 Performance

Due to staffing pressures Primary Care have been unable to supply 3 members of staff consistently. This is being addressed by a pilot of ED streaming to the GPs to release more capacity as they will not be double navigating. This started Monday, 27th September and has had mixed success with criteria changes leading to changes in performance week to week. This is now being closely managed by the work stream lead. Risks include availability of GPs and as yet unknown impact of the 10 point plan.

Improvement Actions

1. Launch of IPAD pilot at front door.

2. Project manager will focus on the GPFD across the ICS and acute trusts with an aim to standardise the processes.

Risk To Delivery

AMBER

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

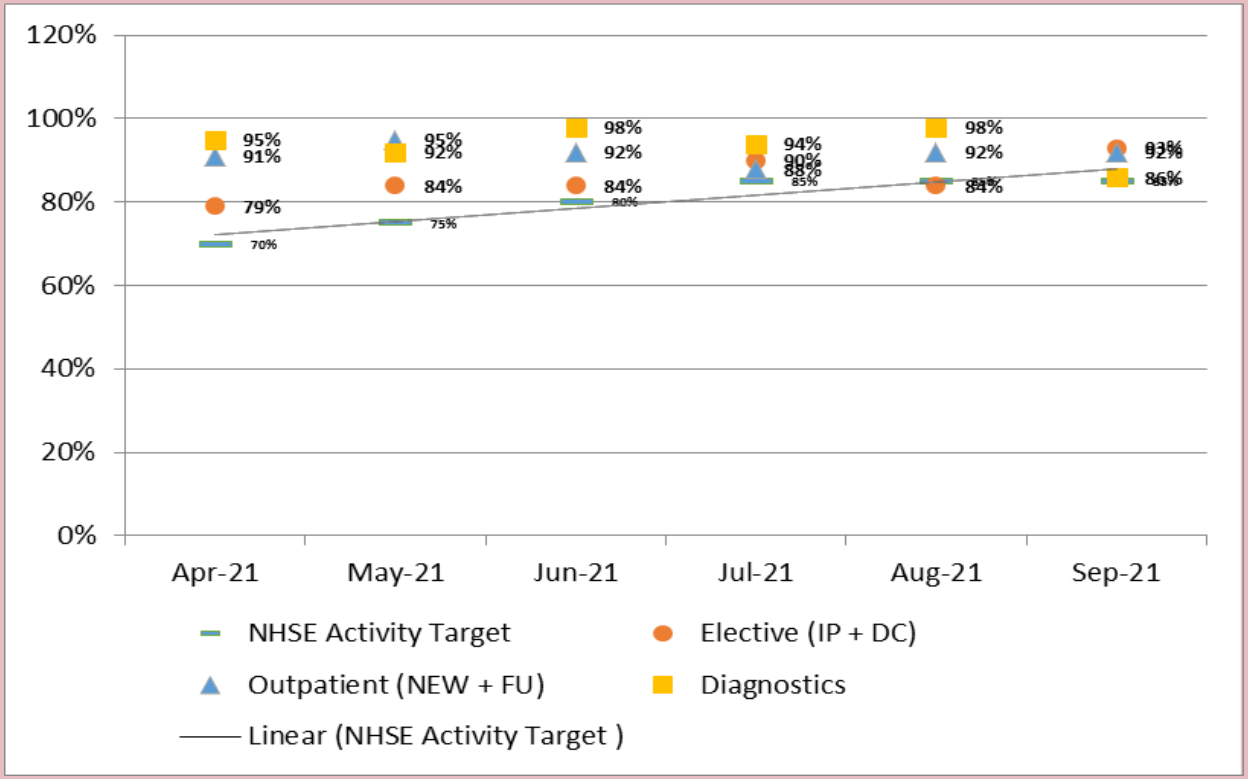
Elective Care Standards

The Trust saw improvements in most elective standards in September. The delivery of P2s over 28 days was achieved in September, but the impact of this was an increase in long waiting patients. Plans are now in place to address this with a clear focus on addressing the 104 week waiting patients, as highlighted in the H2 guidance.

Safer, Efficient, Productive (SET) Performance Dashboard

Ref	KPI	Target		Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
1	Cancer 2WW Performance	93% (N)	Actual	85.8%	62.0%	62.5%	53.5%	54.0%	43.0%	55.6%						
			Trajectory		76.4%	75.3%	82.0%	85.0%	86.0%	90.0%	92.6%	93.3%	93.0%	89.3%	93.0%	92.8%
2	Cancer 2WW Backlog	38 (Feb 20)	Actual	47	264	448	731	931	499	186						
			Trajectory		264	353	225	131	93	77	48	23	27	76	41	22
3	Cancer 62 Day Performance	74% National Avg (Feb 20)	Actual	60.2%	62.0%	54.2%	55.8%	53.6%	39.8%	43.4%						
			Trajectory		64.3%	67.0%	64.5%	66.3%	70.2%	74.3%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%
4	Cancer 62 Day Backlog	184 (Feb 20)	Actual	316	223	273	279	432	535	503						
			Trajectory		223	222	219	217	196	205	174	146	145	181	159	143
5	Cancer 62 Day Waits >104 Days	0	Actual	126	73	41	55	54	68	101						
			Trajectory		73	60	34	29	21	28	26	16	12	27	19	9
6	Cancer Faster Diagnosis Standard	75% (N)	Actual	80.4%	76.0%	73.6%	64.4%	54.5%	56.7%	76.5%						
			Trajectory		75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%
7	RTT 52 Week Breaches		Actual	11339	10764	10235	10054	10268	10902	11432						
			Trajectory													
8	RTT 104 Week Breaches	0	Actual													
			Forecast								4395	3595	2595	1795	995	0
9	P2 Patients Waiting >28 Days for Theatre	0	Actual	879	780	580	434	358	332	26						
			Trajectory		841	630	372	106	0	0	0	0	0	0	0	0
10	Waiting List - Health Inequality Indicators	Variation	Ethnicity		No	No	No	No	No	No						
			IMD		No	No	No	No	No	No						
11	Activity Targets	70% (A) 75% (M) 80% (J) 85% J-S)	OP		91%	96%	93%	90%	92%	92%						
			Electives		79%	84%	84%	88%	84%	93%						
			Diagnostics		95%	92%	98%	94%	98%	86%						
			Trajectory		70%	75%	80%	85%	85%	85%						
12	Virtual Outpatients	25% (N)	Actual	44.2%	39.4%	37.8%	36.2%	34.6%	32.5%	31.2%						
			Trajectory		25.0%	25.0%	25.0%	25.0%	25.0%	25.0%	25.0%	25.0%	25.0%	25.0%	25.0%	25.0%
13	PIFU	Implement in 3 specialties	Actual	28	28	31	30	31	31	30						
			Trajectory		3	3	3	3	3	3	3	3	3	3	3	3
14	Advice and Guidance	1000	Actual	1074	929	1006	1048	988	967	1052						
			Trajectory		800	800	800	800	800	800	800	800	800	800	800	800
15	Achieve Upper Decile: Orthopaedics	Touchtime 85% (N) Cases 1.9 (N)	Touchtime	84%	59%	73%	66%	74%	79%							
			Cases Per Session	1.7	1.3	1.4	1.5	1.6	1.5							
16	Achieve Upper Decile: Ophthalmology	Touchtime 85% (N) Cases 3.8 (N)	Touchtime	68%	64%	71%	66%	76%	72%							
			Cases Per Session	3.5	3.40	4.4	5.4	4.7	5.1							
17	Theatre Utilisation	Touchtime (Elective incl. Day Case) 89%	Actual					80.4%	79.7%	82.0%						
			Trajectory					74.0%	75.0%	78.0%	80.0%	82.0%	84.0%	86.0%	88.0%	89.0%
18	Theatre Cancellations	On Day Cancellations (15)	Actual					131	90	97						
			Trajectory					22	22	22	20	20	18	18	15	15
19	Theatre Sessions	Late Starts (30%)	Actual					90.4%	89.7%	92.05%						
			Trajectory					65.0%	60.0%	58.0%	55.0%	50.0%	45.0%	40.0%	35.0%	30.0%
		Early Finishes (25%)	Actual					59.8%	58.1%	51.14%						
			Trajectory					40.0%	38.0%	36.0%	34.0%	30.0%	28.0%	28.0%	25.0%	25.0%
		Av. Cases per List (2)	Actual					3.35	3.3	3.3						
			Trajectory					1.98	1.98	1.98	1.99	1.99	1.99	2.00	2.00	2.00

Performance – H1 Activity Requirements



Ref	KPI	Target		Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
11	Activity Targets	70% (A) 75% (M) 80% (J) 85% J-S)	OP		91%	96%	93%	90%	92%	92%
			Electives		79%	84%	84%	88%	84%	93%
			Diagnostics		95%	92%	98%	94%	98%	86%
			Trajectory		70%	75%	80%	85%	85%	85%

Commentary

August 2021 Performance

The activity threshold level is set against a baseline value of all elective activity delivered in 2019/20:
April 70%
May 75%
June 80%
July – September 85%

In September 2021, the Trust over-delivered against September 19/20 levels:
93% Elective Admitted Care (Inpatient and Day case)
92% Outpatient Appointments (New and Follow Up)
86% Diagnostic Activity (DM01 Definitions)

The H2 Operational Planning Guidance were released on the 30th September 2021.

Improvement Actions

1. Implement Model Hospital efficiency measures to increase productivity August -September.

2. Increased use of out-of-hours and weekends.

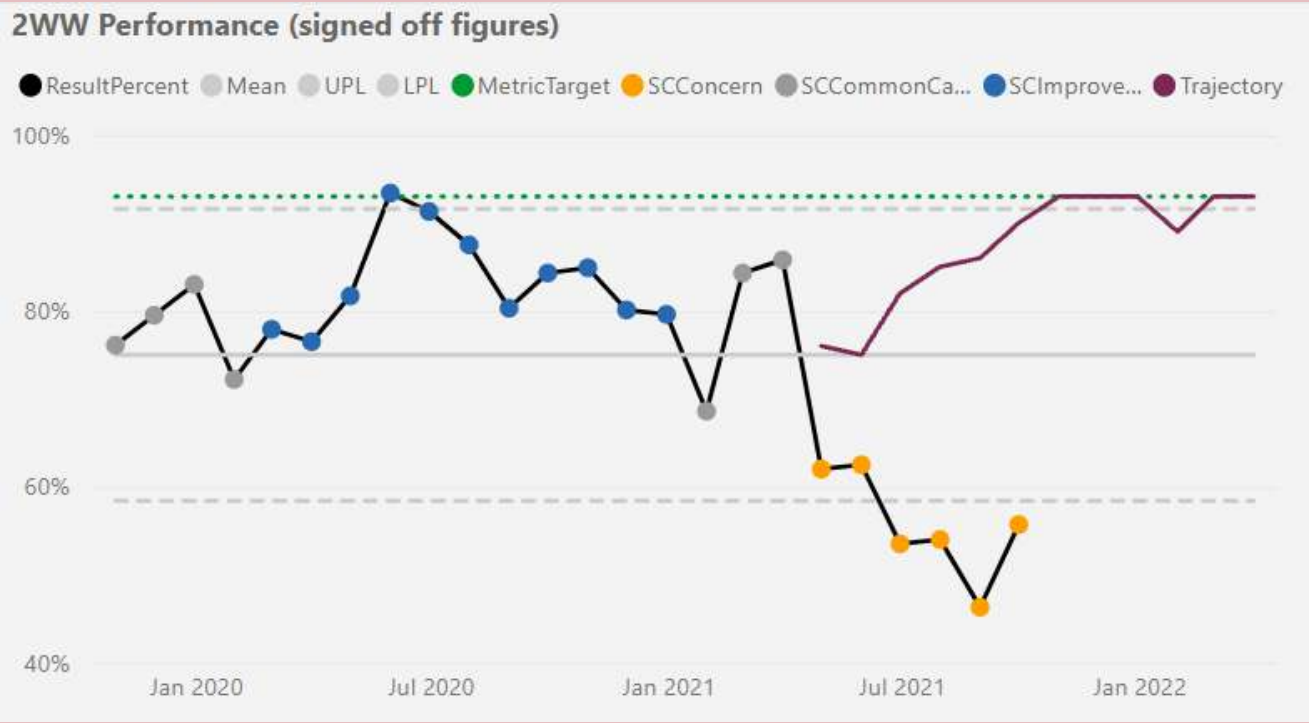
3. Maximise use of IS.

4. Engage with system on transformation of key pathways.

Risk To Delivery

GREEN

Performance – Cancer 2WW Performance



Ref	KPI	Target		Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
1	Cancer 2WW Performance	93% (N)	Actual	85.8%	62.0%	62.5%	53.5%	54.0%	43.0%	55.6%
			Trajectory		76.4%	75.3%	82.0%	85.0%	86.0%	90.0%

Commentary

September 2021 Performance

Breast and Skin have successfully resolved their backlogs for patients awaiting first appointment. An improvement in performance in September has been seen with a further rise expected in October.

The body sites with an outstanding two week wait backlog are Lower GI and Gynaecology.

Improvement Actions

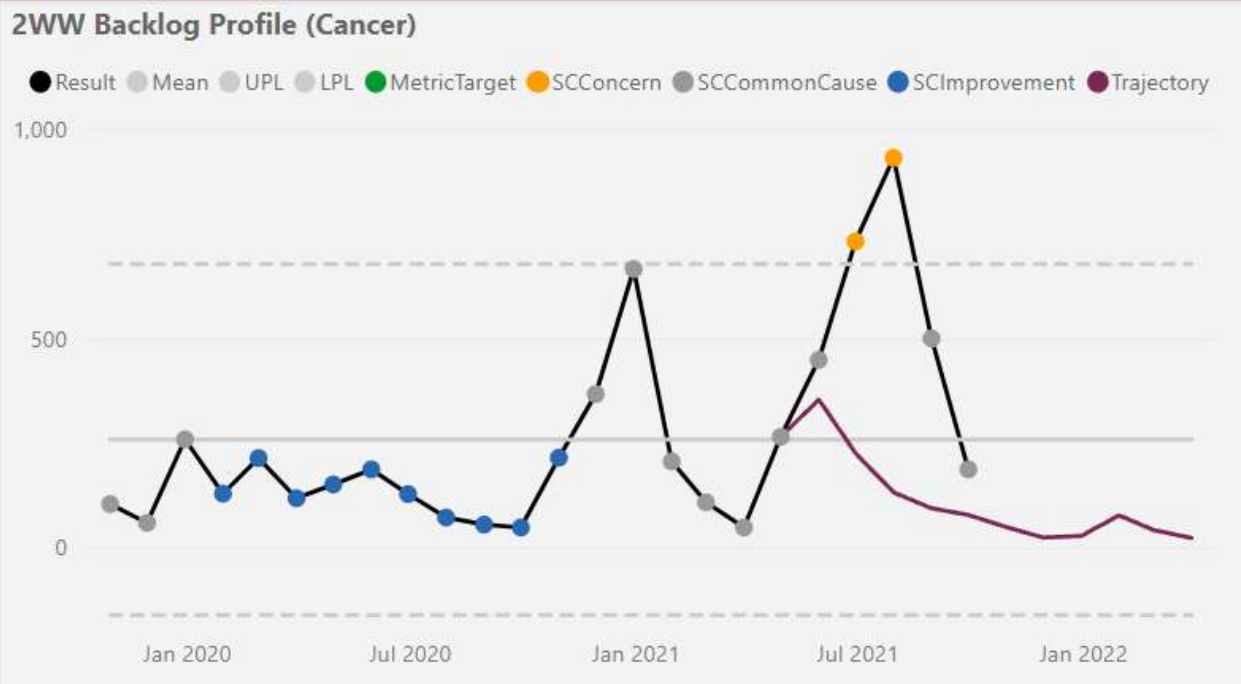
Lower GI – Not enough CNS capacity against referral demand to provide enough telephone triage appointments for patients that cannot go straight to test., Funding has been identified within the nursing budget for an additional CNS to support the service
Additional face to face clinics run by Middle Grade Drs using WLI will fill the gap until a sustainable solution is found. These clinics commence week of the 1st November and will provide an additional 20 clinic appointments

Gynaecology – The Benign team have lost two week wait slots due to a recent retiree. Additional activity through altering current clinics has been identified and is being agreed by the specialty. These clinics commence w/c 25th October and a trajectory is under development for delivery.

Risk To Delivery

AMBER

Performance – Cancer 2WW Backlog



Ref	KPI	Target		Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
2	Cancer 2WW Backlog	38 (Feb 20)	Actual	47	264	448	731	931	499	186
			Trajectory		264	353	225	131	93	77

Commentary

September 2021 Performance

Backlog numbers continue to plummet with the continuation of the backlog clearance programme within Skin and Breast.

Improvement Actions

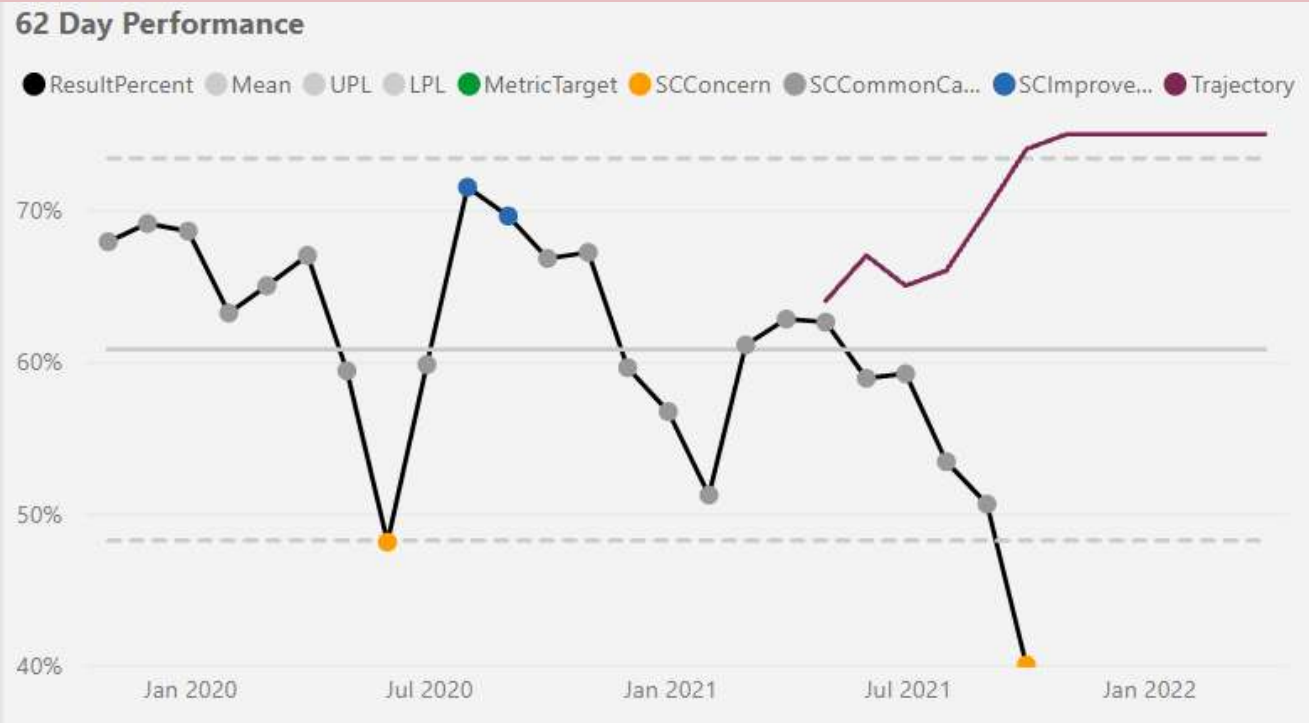
1. Additional clinics within Lower GI from Middle Grade Drs to clear current backlog. These Clinics are planned to start from the 1st of November and contain an additional 20 clinic appointments.

2. Implementation of clinic template changes within Gynaecology to increase baseline two week wait capacity. Clinic changes start from 25th October with further discussions for a second weekly additional clinic in November 2021.

Risk To Delivery

AMBER

Performance – Cancer 62 Day Performance



Ref	KPI	Target		Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
3	Cancer 62 Day Performance	74% National Avg (Feb 20)	Actual	60.2%	62.0%	54.2%	55.8%	53.6%	39.8%	43.4%
			Trajectory		64.3%	67.0%	64.5%	66.3%	70.2%	74.3%

Commentary

September 2021 Performance

Performance has reduced due to the volume of patients over 62 days. This has plateaued in recent weeks with a large scale reduction planned through to 01/01/22. Poor 62 day performance will continue until we have significantly reduced our backlog.

Improvement Actions

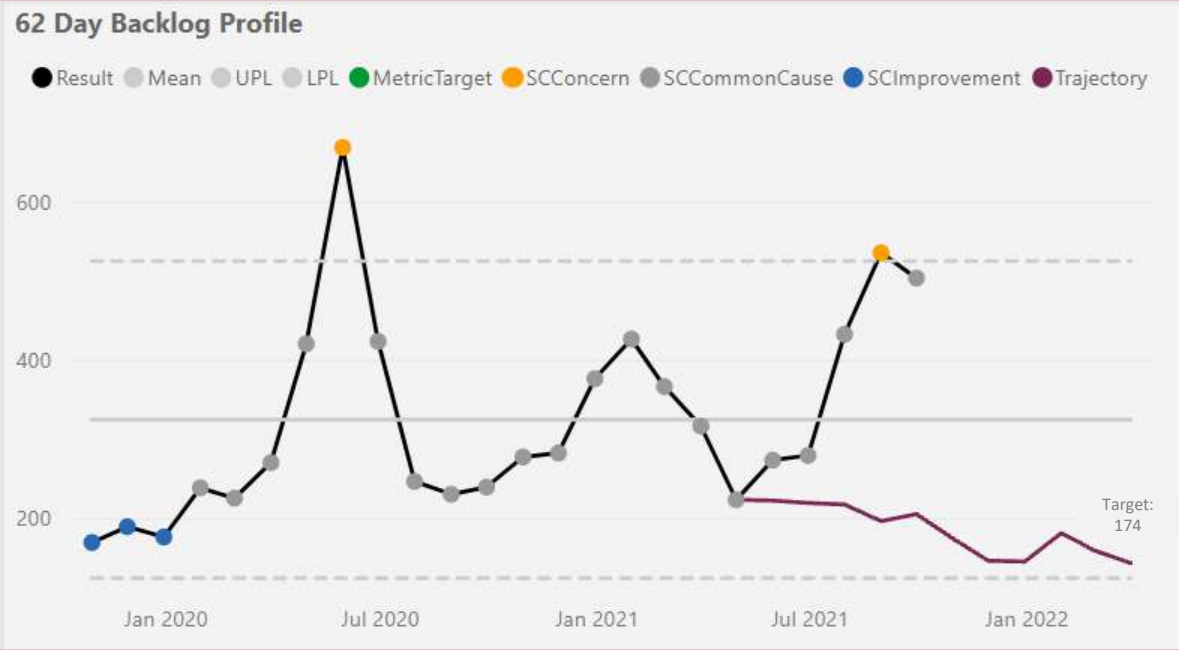
1. Implementation of the ''62 in 62'' initiative with Trust Wide buy in and support to deliver whole scale change from 31st October 2021 to 1st January 2022.

2. Any issues / blockers that may impact the success of the initiative will be highlighted to the Exec team for assistance in resolving.

Risk To Delivery

RED

Performance – Cancer 62 Day Backlog Profile



Ref	KPI	Target		Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
4	Cancer 62 Day Backlog	184 (Feb 20)	Actual	316	223	273	279	432	535	503
			Trajectory		223	222	219	217	196	205

Commentary

September 2021 Performance

The number of patients on a 62 day pathway is still high due to a high volume of referrals this year. Although there has been a large reduction in the number of patients from circa 4000 to 3450 in recent months, this is still higher than pre-COVID levels and has caused patients to roll over into the over 62 day backlog.

The new *'62 in 62'* initiative will be focused on reducing the number of patients waiting over 62 days within a distinct time period (01/10/21 to 01/01/22 – 62 days). With key actions for each body site and support service to allow timely progression of all patients along their pathways. Clinical and Operational Leads are being nominated to drive this process to ensure it is successful.

Improvement Actions

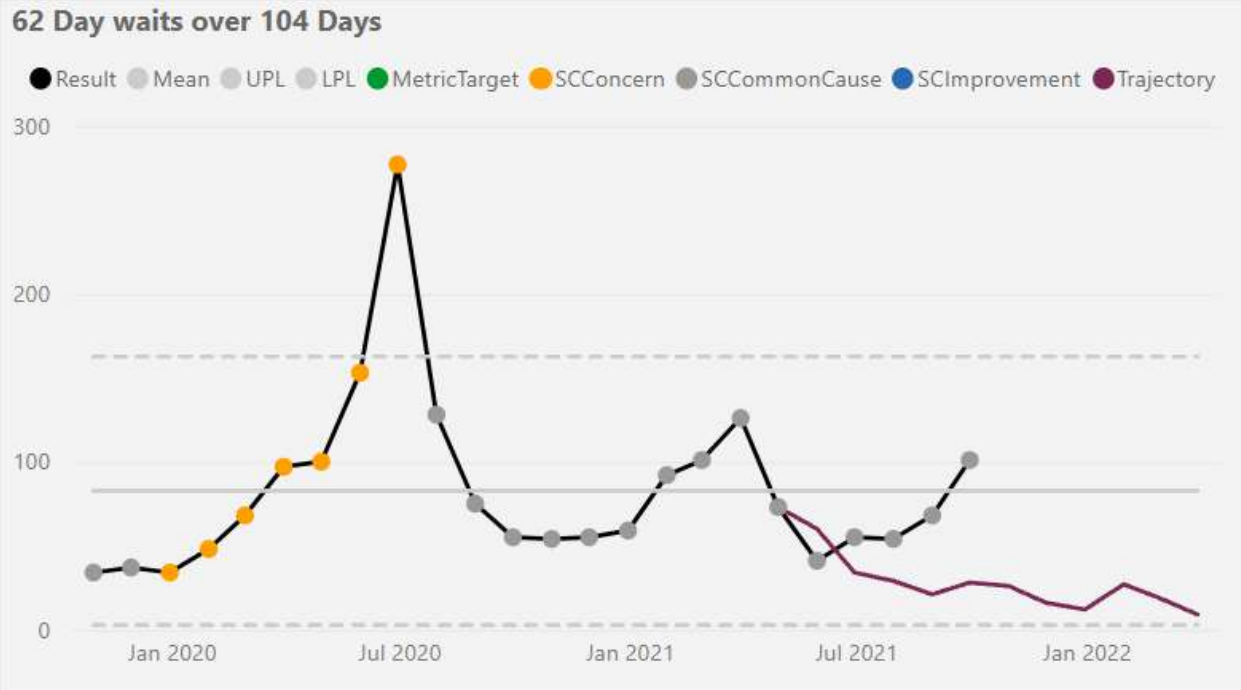
1. Implementation of the 62 in 62 initiative with Trust Wide buy in and support to deliver whole scale change

2. Any issues / blockers that may impact the success of the initiative will be highlighted to the Exec team for assistance in resolving.

Risk To Delivery

RED

Performance – Cancer 62 Day Waits over 104 Days



Ref	KPI	Target		Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
5	Cancer 62 Day Waits >104 Days	0	Actual	126	73	41	55	54	68	101
			Trajectory		73	60	34	29	21	28

Commentary

September 2021 Performance

The number of patients waiting over 104 days has continued to increase due to the high volumes of patients waiting over 62 days. With the largest volume of the backlog within Lower GI and Urology.

Lower GI - Radiology have a clear plan for reduction of their CTC waits from 8 weeks total (4 Weeks Booking, 4 Weeks Reporting) to 3 weeks by January 2022. So far this plan is on track with the overall delay reduced from 8 to 6 in September.

Urology – Late Decisions to treat and delays with booking Template Biopsies due to equipment malfunctions have been the main reasons for the long waits.

Improvement Actions

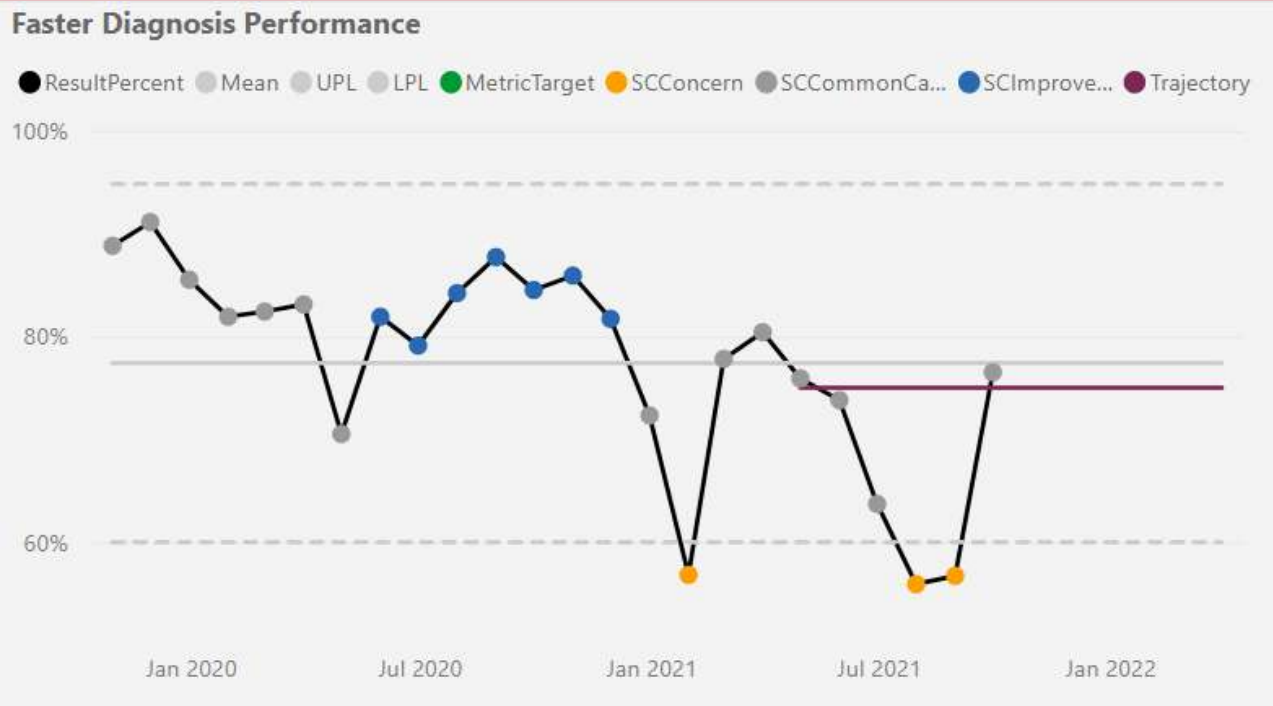
1. Review of Diagnostic capacity within Urology to ensure capacity meets demand for Template Biopsy.

2. Delivery of the 62 in 62 initiative will bring a reduction in over 104 day waits.

Risk To Delivery

RED

Performance – Faster Diagnosis Standard



Ref	KPI	Target		Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
6	Cancer Faster Diagnosis Standard	75% (N)	Actual	80.4%	76.0%	73.6%	64.4%	54.5%	56.7%	76.5%
			Trajectory		75.0%	75.0%	75.0%	75.0%	75.0%	75.0%

Commentary

September 2021 Performance

Skin and Breast are now seeing patients for their first appointment within 14 days, both are high volume body sites with the majority of patients being diagnosed at first attendance, this is evident in the large upturn in performance within September. Our focus will be on data completeness for October when the FDS will be formally reported.

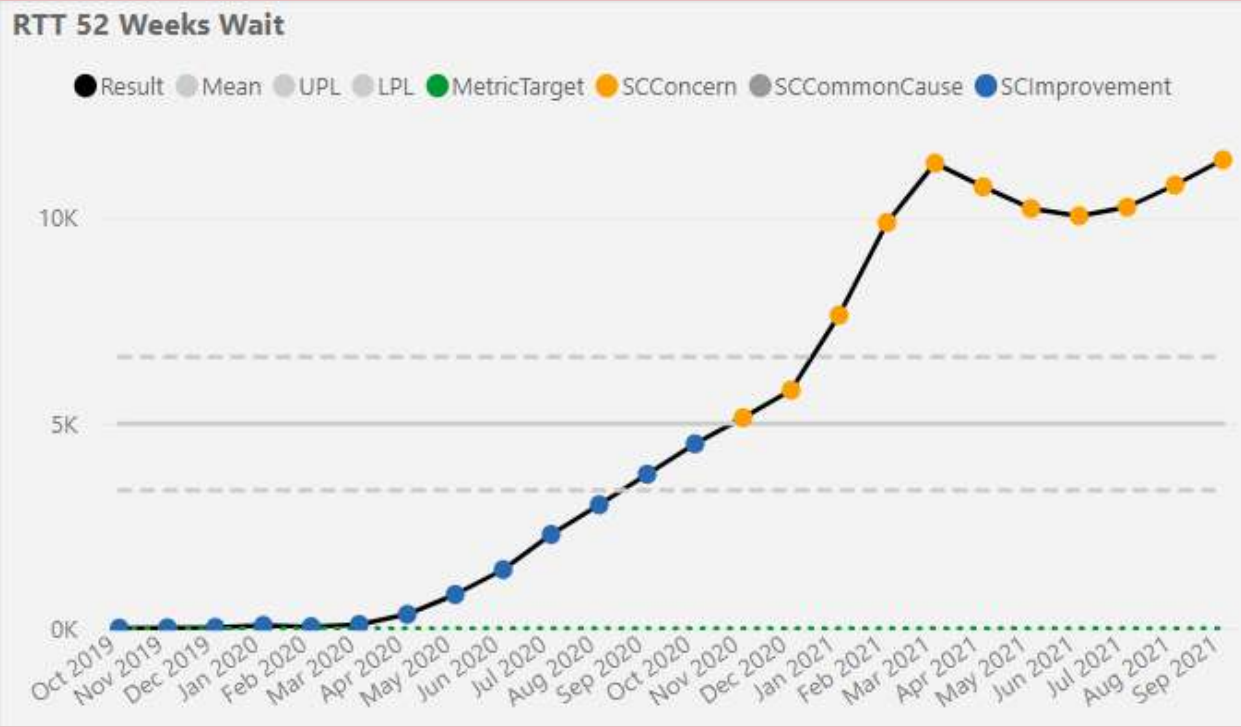
Improvement Actions

Dedicated Patient Pathway Resource to ensure high Data Completeness for October Submission.

Risk To Delivery

AMBER

Performance – RTT 52 Week Breaches



Ref	KPI	Target		Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
7	RTT 52 Week Breaches		Actual	11339	10764	10235	10054	10268	10902	11432
			Trajectory							

Commentary

September 2021 Performance

Priority continued to be to treat the sickest patients first; those on a cancer or urgent pathway and clearing the P2 backlog. Some progress has been made on reducing the outpatient waiting times in some specialities. However, a large backlog still remains in a number of high volume specialities.

After some modest reductions, partly linked to reduced referrals during the first lockdown, but also due to increased activity levels, the numbers are starting to increase again slowly.

Improvement Actions

1. Continued focus on creating additional capacity (WLI at weekends) to treat most urgent patients to then focus on longer waiting patients.

2. Insourcing and independent sector solutions being explored.

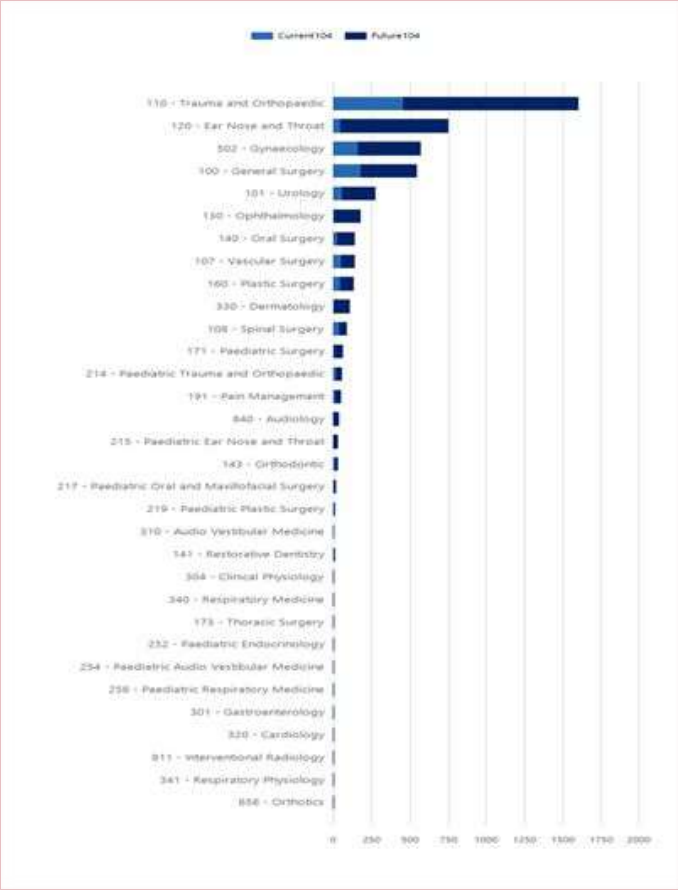
3. Development of 5 interventions to increase theatre capacity is ongoing.

4. Efficiency and productivity initiatives being included in H2 planning.

Risk To Delivery

RED

Performance – RTT 104 Week Breaches



Ref	KPI	Target		Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
8	RTT 104 Week Breaches	0	Actual													
			Forecast								4563	3731	2691	1859	1027	0

Commentary

September 2021 Performance

The NNUH has the 5th largest Orthopaedics waiting list in England. The improvement actions below will help improve the situation. The plan will see numbers rise before they reduce to achieve 0 weeks > 104 by 31st Match 2022.

As expected, with the focus being on P2 urgent and P3 patients who have become urgent, the waiting list size and the number of patients waiting over 104 weeks has grown.

Trauma Orthopaedics are undertaking P3 and P4 long waiting patients as they have cleared the P2 patients from the orthopaedic waiting list . Over 50% of the long waiting patients sit in Trauma Orthopaedics with the remaining in General Surgery and Gynaecology. All of the patients over 104 weeks are in the P3/P4 category.

Improvement Actions

1. Complete removal of P2 backlog.

2. Move to upper quartile performance in Theatres.

3. Create additional theatre capacity through agreed interventions.

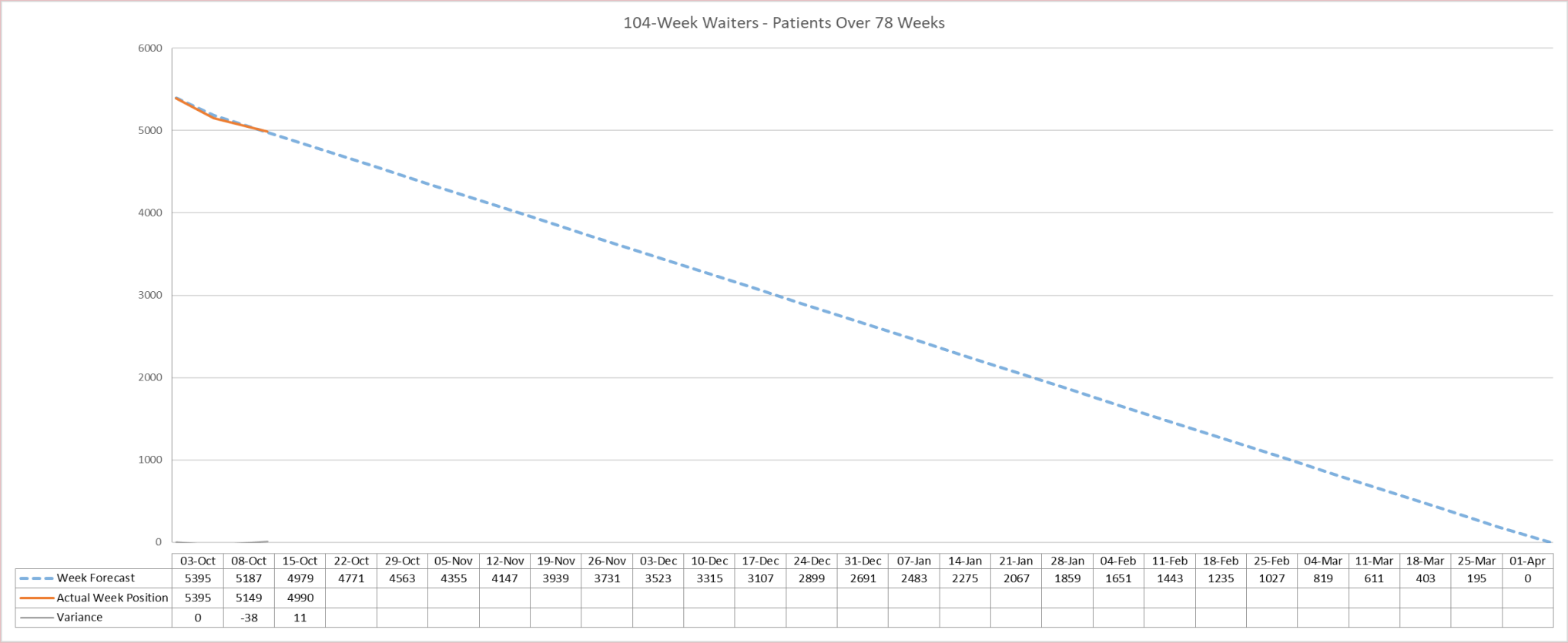
4. Improve use of Independent Sector and out of hours.

Risk To Delivery

RED

Performance – RTT 104 Week Trajectory

NNUH Digital Health
business intelligence



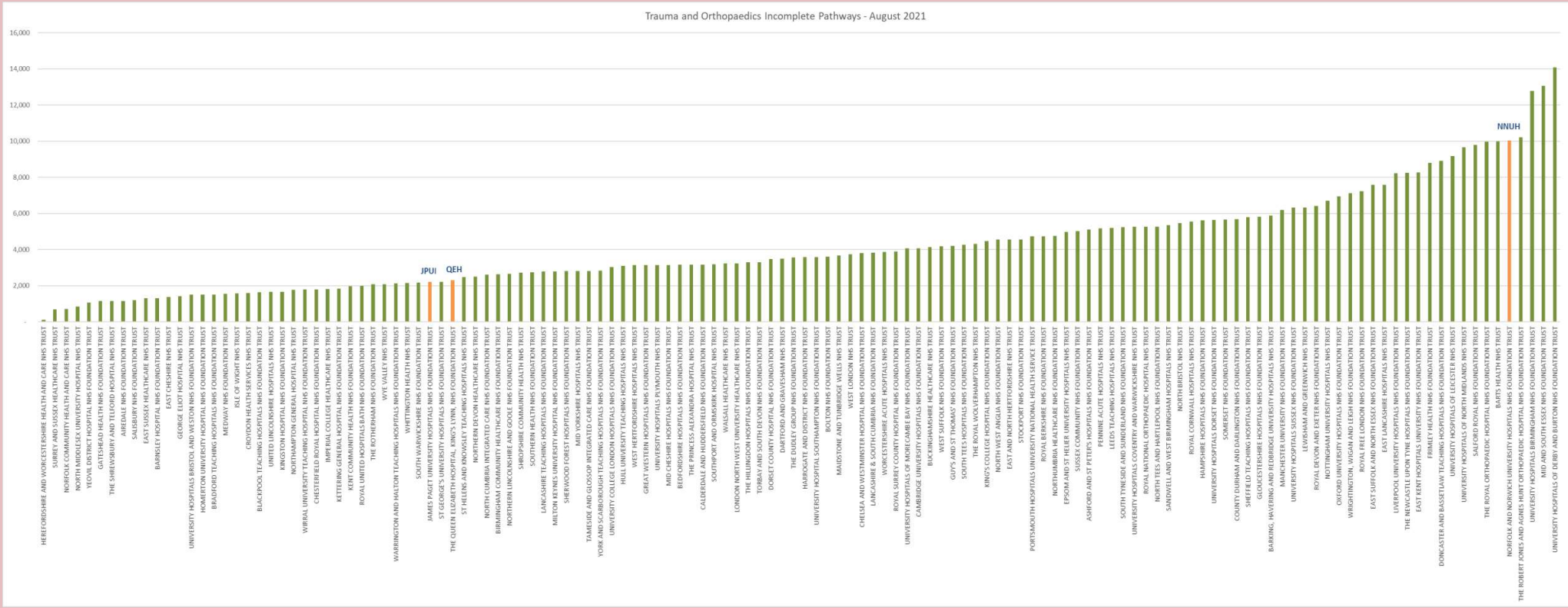
	03-Oct	08-Oct	15-Oct	22-Oct	29-Oct	05-Nov	12-Nov	19-Nov	26-Nov	03-Dec	10-Dec	17-Dec	24-Dec	31-Dec	07-Jan	14-Jan	21-Jan	28-Jan	04-Feb	11-Feb	18-Feb	25-Feb	04-Mar	11-Mar	18-Mar	25-Mar	01-Apr
Week Forecast	5395	5187	4979	4771	4563	4355	4147	3939	3731	3523	3315	3107	2899	2691	2483	2275	2067	1859	1651	1443	1235	1027	819	611	403	195	0
Actual Week Position	5395	5149	4990																								
Variance	0	-38	11																								

Comments

Discussions with Professor Tim Briggs and National and Regional Colleagues in Gynaecology and other challenged specialities are working towards a plan that will provide the capacity to eliminate 104 week waits. However, a sizeable risk remains with this cohort of patients and will require weekly monitoring.

30

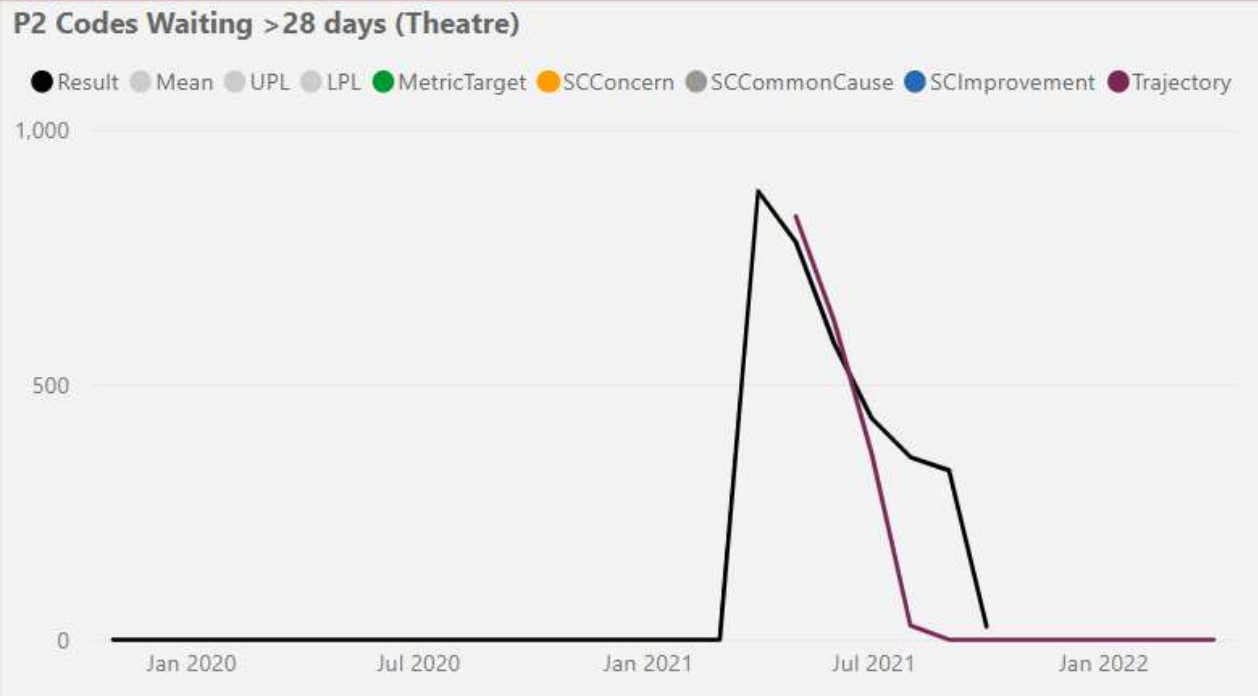
Performance – T&O Waiting List Benchmarking



Comments

NNUH had the 5th largest Orthopaedics Waiting List in England as of September 2021 with 10,051 patients. The Trust also had 307 patients waiting over 104 weeks in T&O.

Performance – P2 Patients Waiting > 28 Days for Theatre



Ref	KPI	Target		Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
9	P2 Patients Waiting >28 Days for Theatre	0	Actual	879	780	580	434	358	332	26
			Trajectory		841	630	372	106	0	0

Commentary

September 2021 Performance

In accordance with the P1/P2 planning guidance, the Trust dedicated almost all available theatre time to patients from April 2021. September saw an increased focus with all theatre sessions being pre-approved prior to booking to ensure all available capacity was being deployed for the clearance of the P2 backlog.

The numbers of P2s waiting >28 days reached 26 on 01/10/2021. This number included patients unable to attend and **X** achievement of the primary elective goal of H1.

Improvement Actions

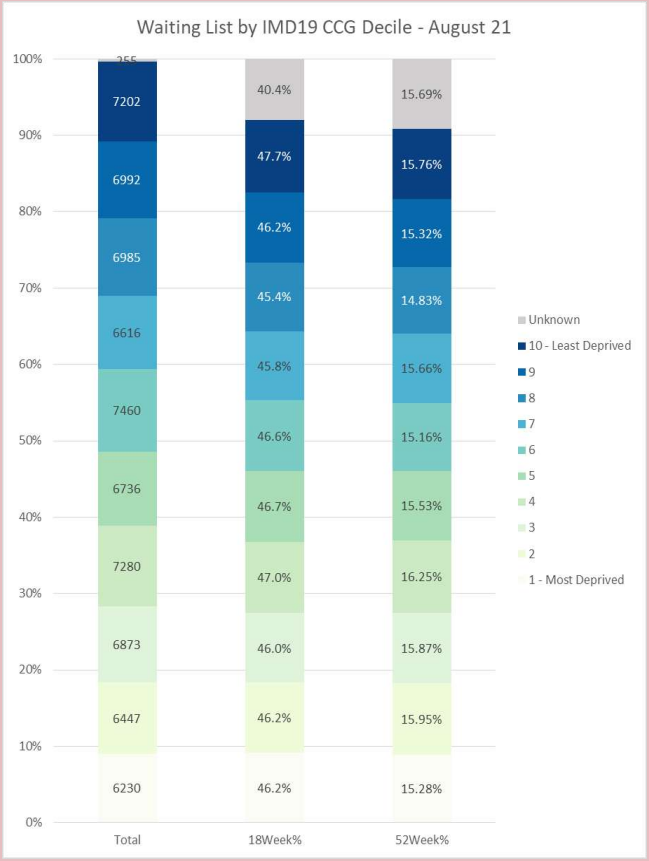
1. Speciality owned timetable being returned in October.
2. P2 sessions to be prioritised for staffing when gaps in theatre workforce reduce number of working theatres.

3. Clinical review of remaining backlog being completed.

Risk To Delivery

GREEN

Performance – Waiting List Health Inequalities



Commentary

Trust Waiting List: Deprivation

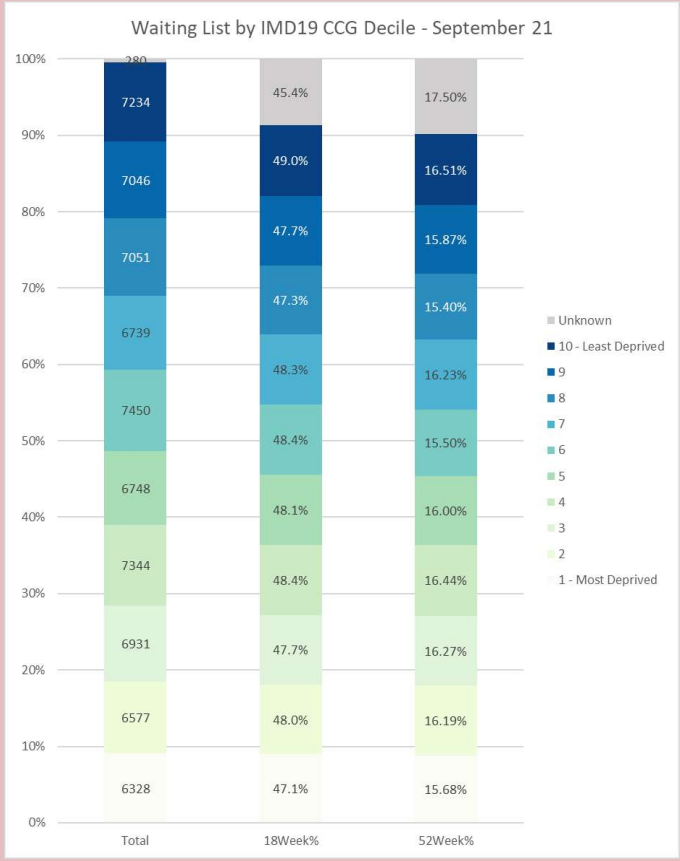
As part of the monitoring of health inequalities, the Trusts waiting list is monitored for variation in demographics.

The table below summarises any change in the Trusts waiting list profile by Ethnicity from May to August 2021.

The Index of Multiple Deprivation (IMD)

The indices rank 32,844 small areas (neighbourhoods) across England. The indices comprise 39 indicators organised across 7 domains which are combined and weighted to calculate the overall Index of Multiple Deprivation. Outputs displayed in deciles (10 equal groups) of deprivation (1-10) and quintiles (5 equal groups of 20%).

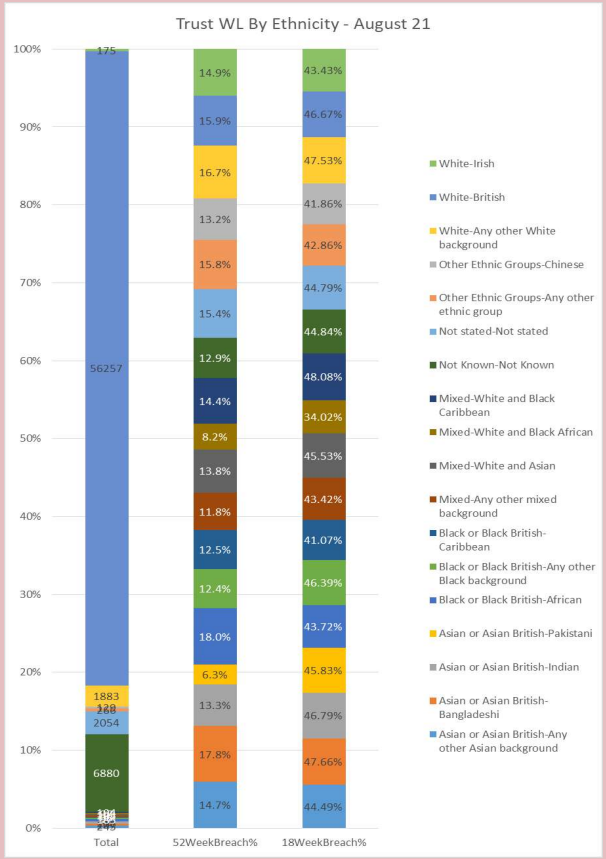
There was no significant variation or concern in September 2021.



Ref	KPI	Target		Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
10	Waiting List - Health Inequality Indicators	Variation	Ethnicity		No	No	No	No	No	No
			IMD		No	No	No	No	No	No

33

Performance – Waiting List Health Inequalities

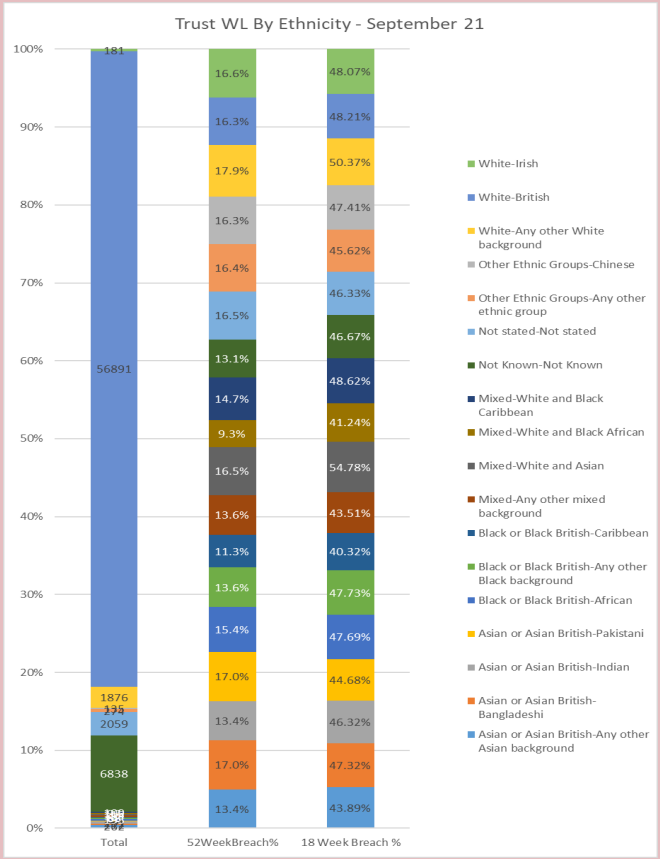


Commentary

Trust Waiting List: Ethnicity

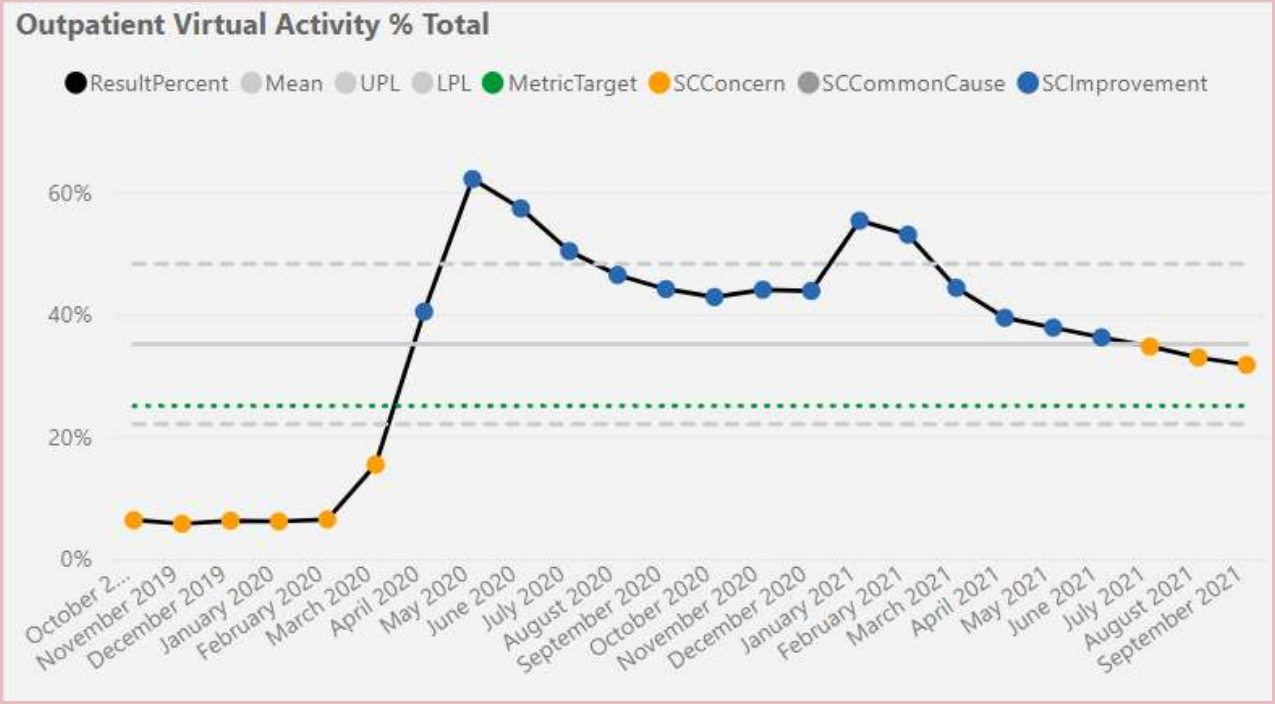
As part of the monitoring of health inequalities, the Trusts waiting list is monitored for variation in demographics. The table below summarises any change in the Trusts waiting list profile by Ethnicity from May to August 2021

There was no significant variation or concern in September 2021.



Ref	KPI	Target		Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
10	Waiting List - Health Inequality Indicators	Variation	Ethnicity		No	No	No	No	No	No
			IMD		No	No	No	No	No	No

Performance – Remote Outpatients



Ref	KPI	Target		Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
12	Virtual Outpatients	25% (N)	Actual	44.2%	39.4%	37.8%	36.2%	34.6%	32.5%	31.2%
			Trajectory		25.0%	25.0%	25.0%	25.0%	25.0%	25.0%

Commentary

September 2021 Performance

The Trust delivered 31% of outpatient appointments remotely during September, ahead of the 25% national target.

The number of outpatient appointments delivered during September was 66,876 an increase of 4322 from 62,554 in May. The number of virtual outpatients delivered however has decreased from 23,662 in May to 20,982 in September. The number of mandatory face-to-face outpatient attendances continues to increase due to clinical reasons and 'catching up' with patients of concern who have previously had a number of virtual appointments during COVID.

The Trust remains in the upper decile nationally for numbers and % of outpatient appointments delivered virtually during September 2021. We also remain ahead of other Trusts locally.

Improvement Actions

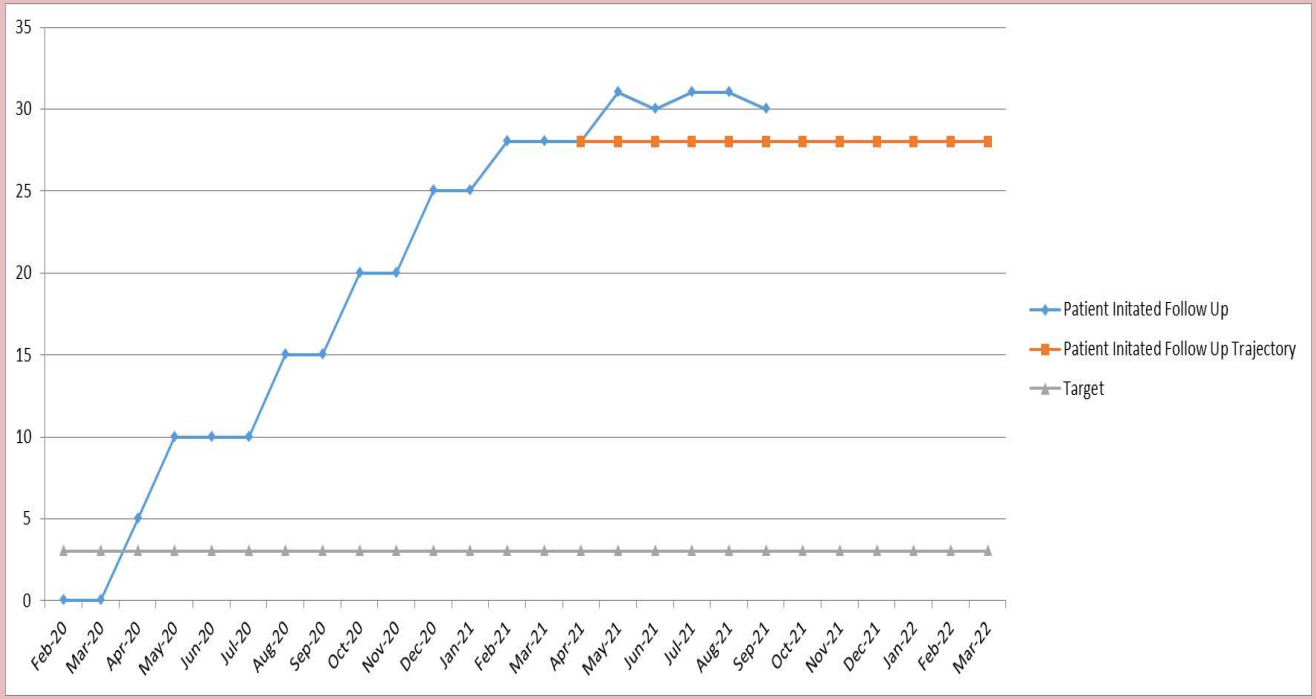
1. Ongoing transformation initiatives to review national best practice models for delivering remote care in each speciality.

2. Dedicated programme and project manager now in place.

Risk To Delivery

GREEN

Performance – Patient Initiated Follow Up (PIFU)



Ref	KPI	Target		Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
13	PIFU	Implement in 3 specialties	Actual	28	28	31	30	31	31	30
			Trajectory		3	3	3	3	3	3

Commentary

September 2021 Performance

PIFU activity continues to perform well.

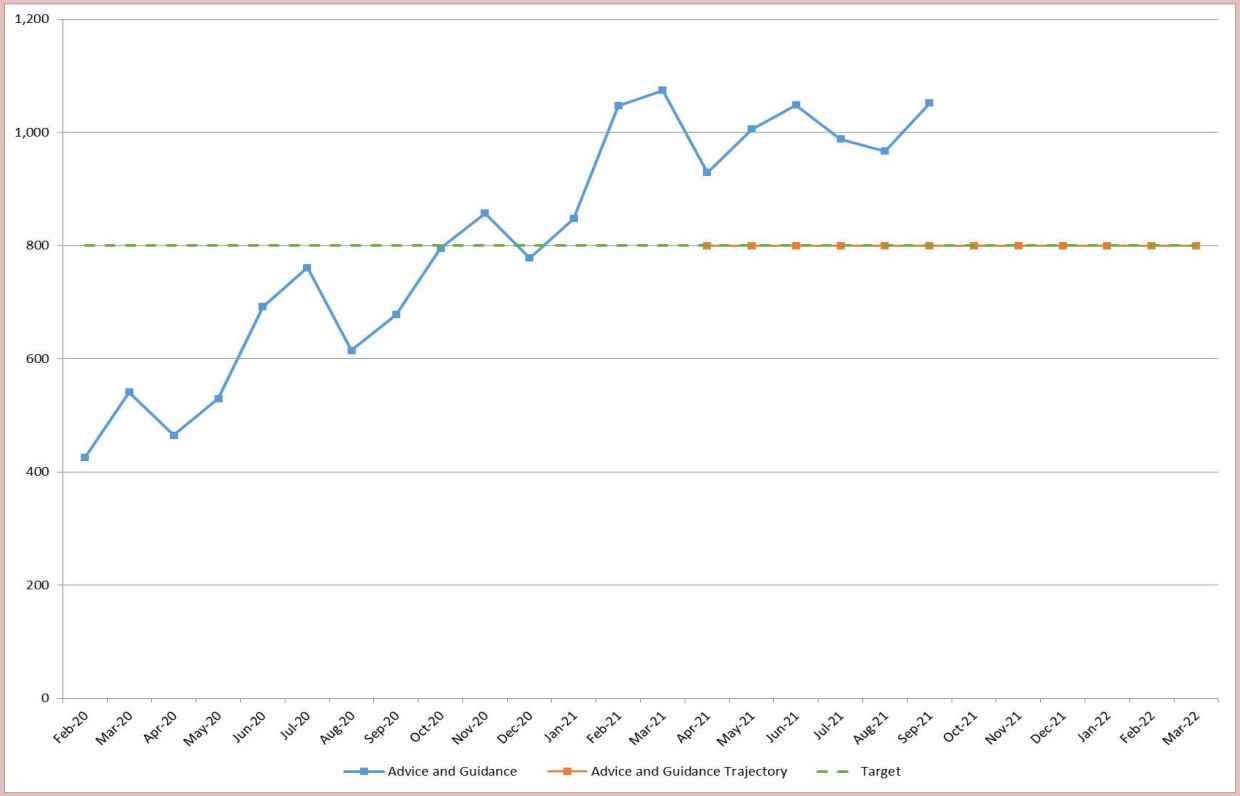
Improvement Actions

Continue to roll out project plan.

Risk To Delivery

GREEN

Performance – Advice & Guidance



Ref	KPI	Target		Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
14	Advice and Guidance	1000	Actual	1074	929	1006	1048	988	967	1052
			Trajectory		800	800	800	800	800	800

Commentary

September 2021 Performance

Performance remains above trajectory in September.

Improvement Actions

1. Individual deep dives into specialties looking at reasons for poor performance. Improvements in engagement have already been made in some specialties (for example, general surgery) where these deep dives have taken place.

2. Review of national case studies to be undertaken to identify and implement best practice

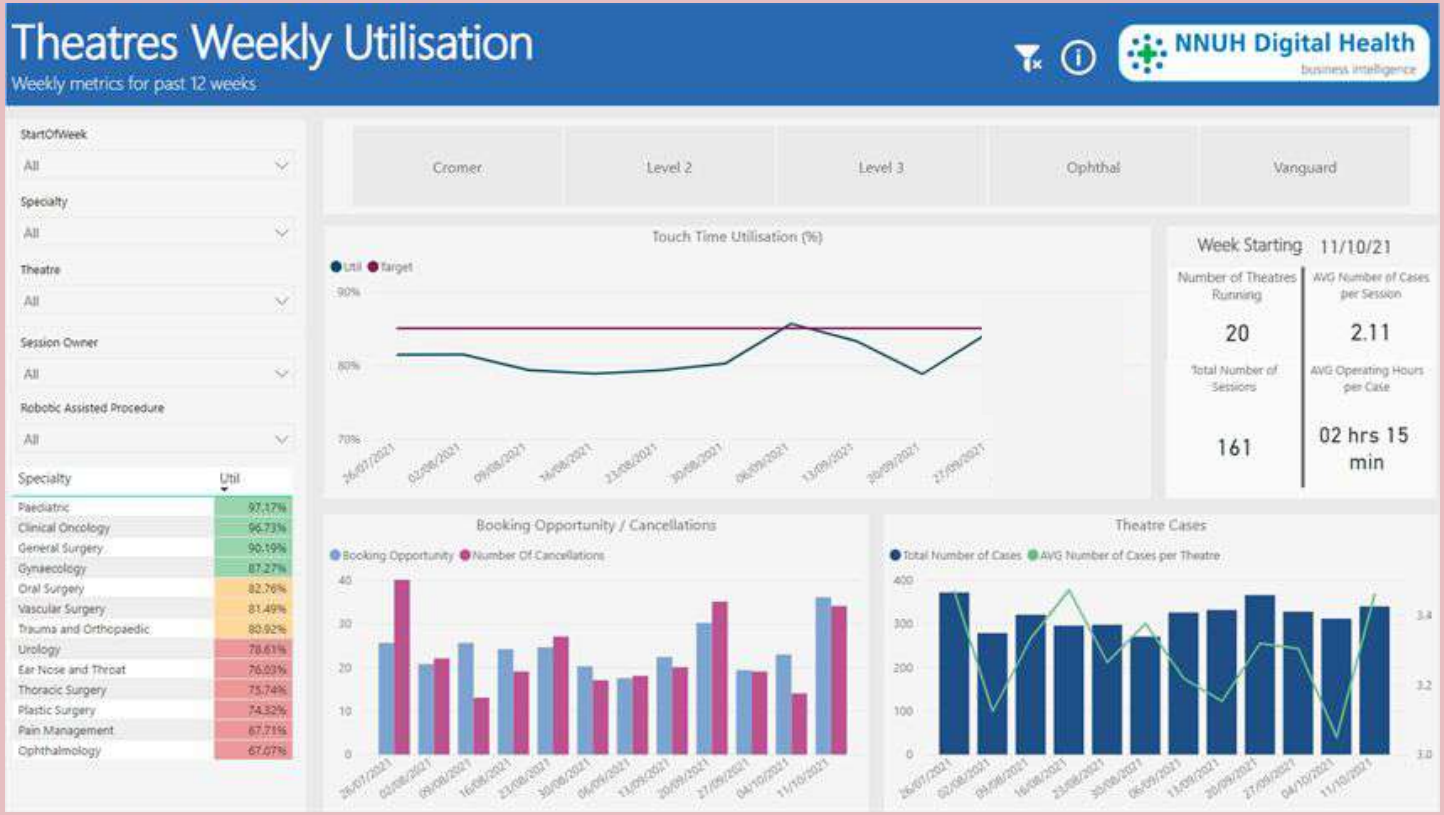
3. Continue to progress the A&G work stream actions.

4. Identify which services would benefit from a RAS.

Risk To Delivery

GREEN

Performance – Theatre Dashboard: Utilisation



Ref	KPI	Target		Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
17	Theatre Utilisation	Touchtime (Elective incl. Day Case) 89%	Actual					80.4%	79.7%	82.0%
			Trajectory					74.0%	75.0%	78.0%

Commentary

September 2021 Performance

Touch time delivery saw further improvement at 81% throughout September. Utilisation improvements seen within ENT, Urology and Orthopaedics and previous improvements held across Paediatrics, General Surgery and Gynaecology.

Improvement Actions

1. Prospective POA bookings to have ready to go patients to support late filling of cancelled slots.

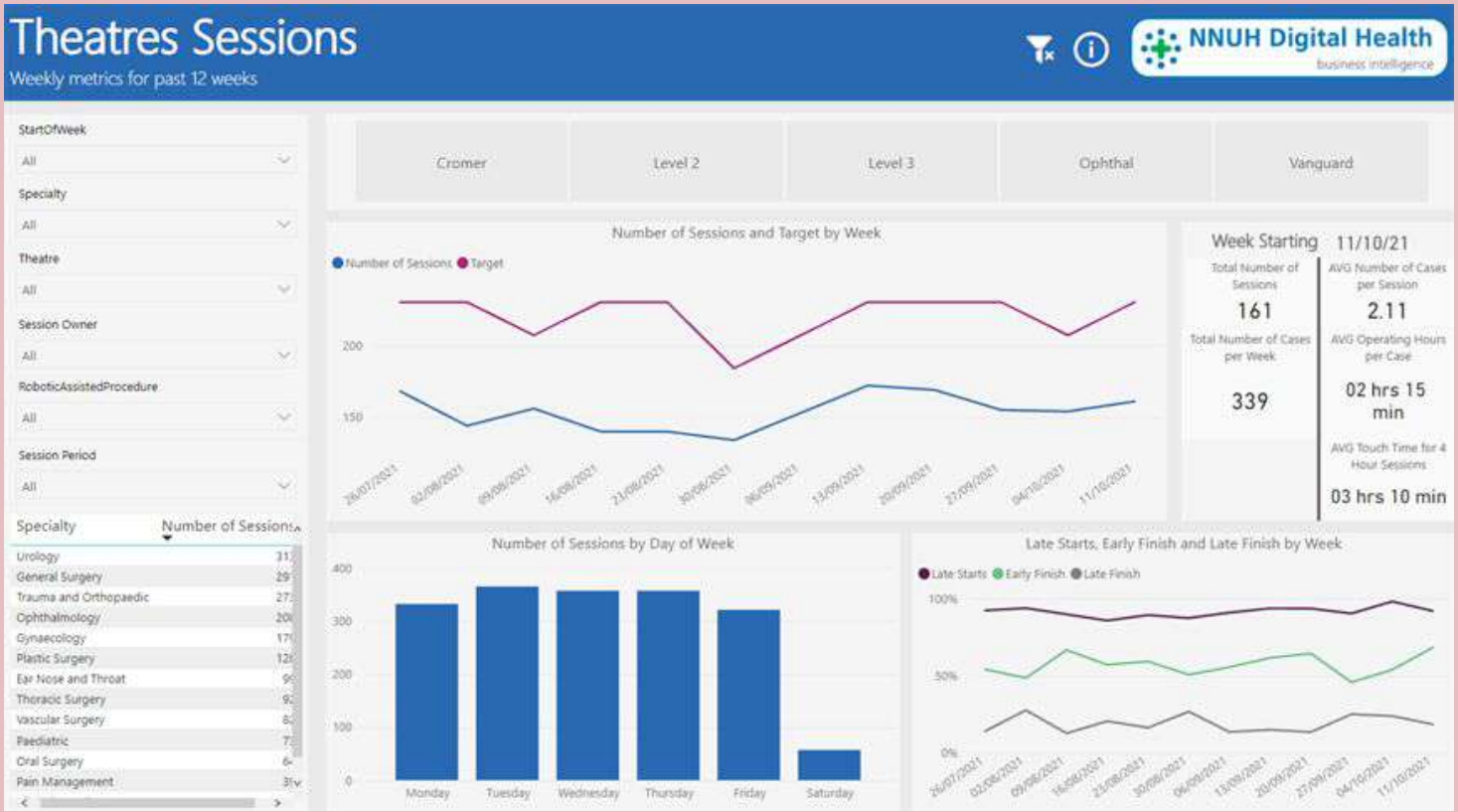
2. Weekly review meeting continues with focus on review of performance and prospective booking levels.

3. Focussed working groups to support the continued improvement to 85% introduced.

Risk To Delivery

GREEN

Performance – Theatre Dashboard: Sessions



Ref	KPI	Target		Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
19	Theatre Sessions	Late Starts (30%)	Actual					90.4%	89.7%	92.05%
			Trajectory					65.0%	60.0%	58.0%
		Early Finishes (25%)	Actual					59.8%	58.1%	51.14%
			Trajectory					40.0%	38.0%	36.0%
		Av. Cases per List (2)	Actual					3.35	3.3	3.3
			Trajectory					1.98	1.98	1.98

Commentary

September 2021 Performance

Challenges around theatre staffing continues to impact on ability to open all areas. September saw a P2 only timetable, this resulted in a number of sessions reallocated to different specialties.
Weekly average of 162 sessions achieved, peaking at 172 during week commencing 13/09/2021.

Improvement Actions

1. Theatre productivity group continues to work on improvements to late starts and early finishes .
2. Focus on decreasing turnaround in-between cases also driving improvement in list utilisation.

3. Elective review meetings to refocus on review of prior week and list challenge to ensure maximised productivity.

4. Hard stop return to application of theatre 6-4-2 policy to reduce last minute cancellation of sessions through.

Risk To Delivery

RED

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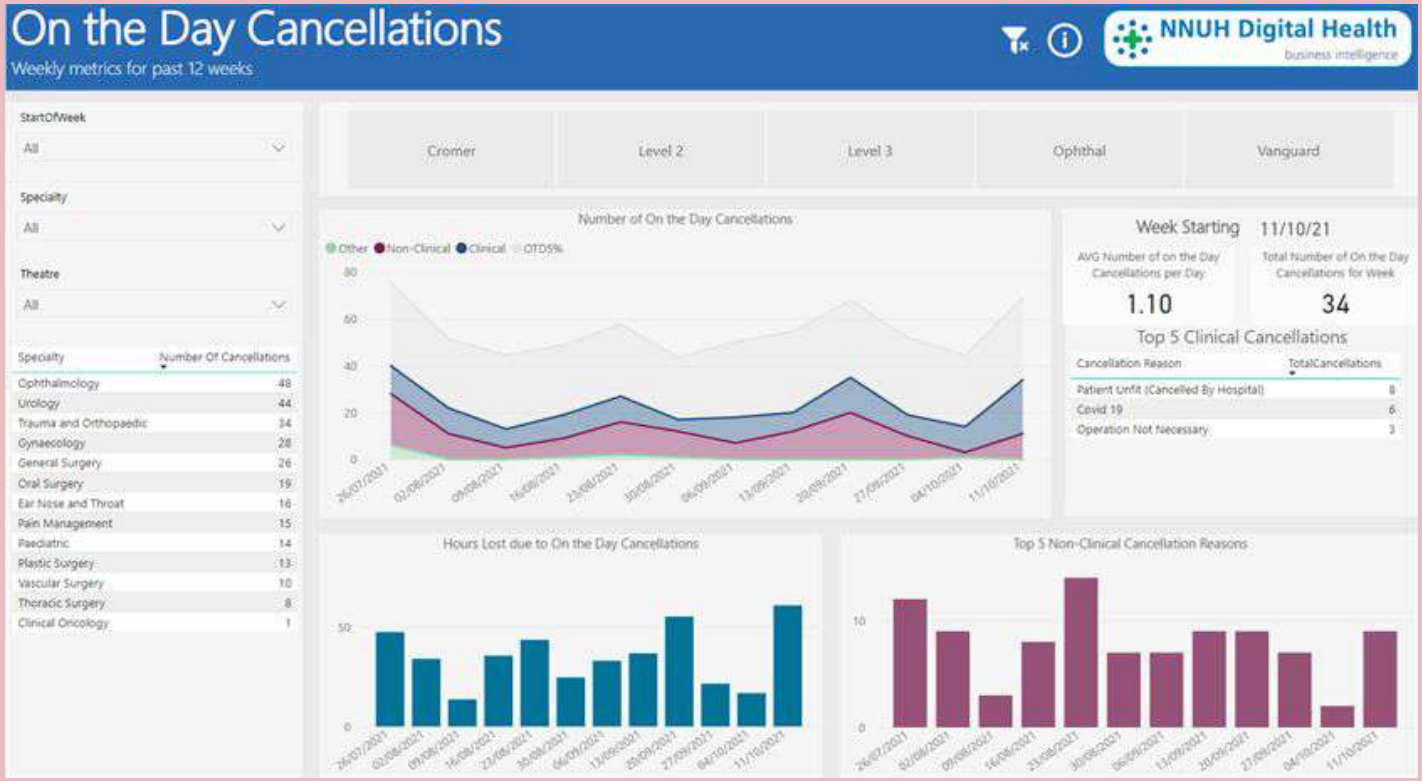
Performance – Theatre Dashboard: Cancellations



Ref	KPI	Target		Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
18	Theatre Cancellations	On Day Cancellations (15)	Actual					131	90	97
			Trajectory					22	22	22

Commentary

September 2021 Performance

Cancellation rate steadied throughout September with clinical cancellations due to patients being unfit the key trend. We saw a reduction in the number of non clinical cancellations, with a lack of theatre time due to complexity of patients the main theme.

Improvement Actions

1.Cancellation prevention calls to be reintroduced to prospectively call patients and remind them of requirement to isolate.

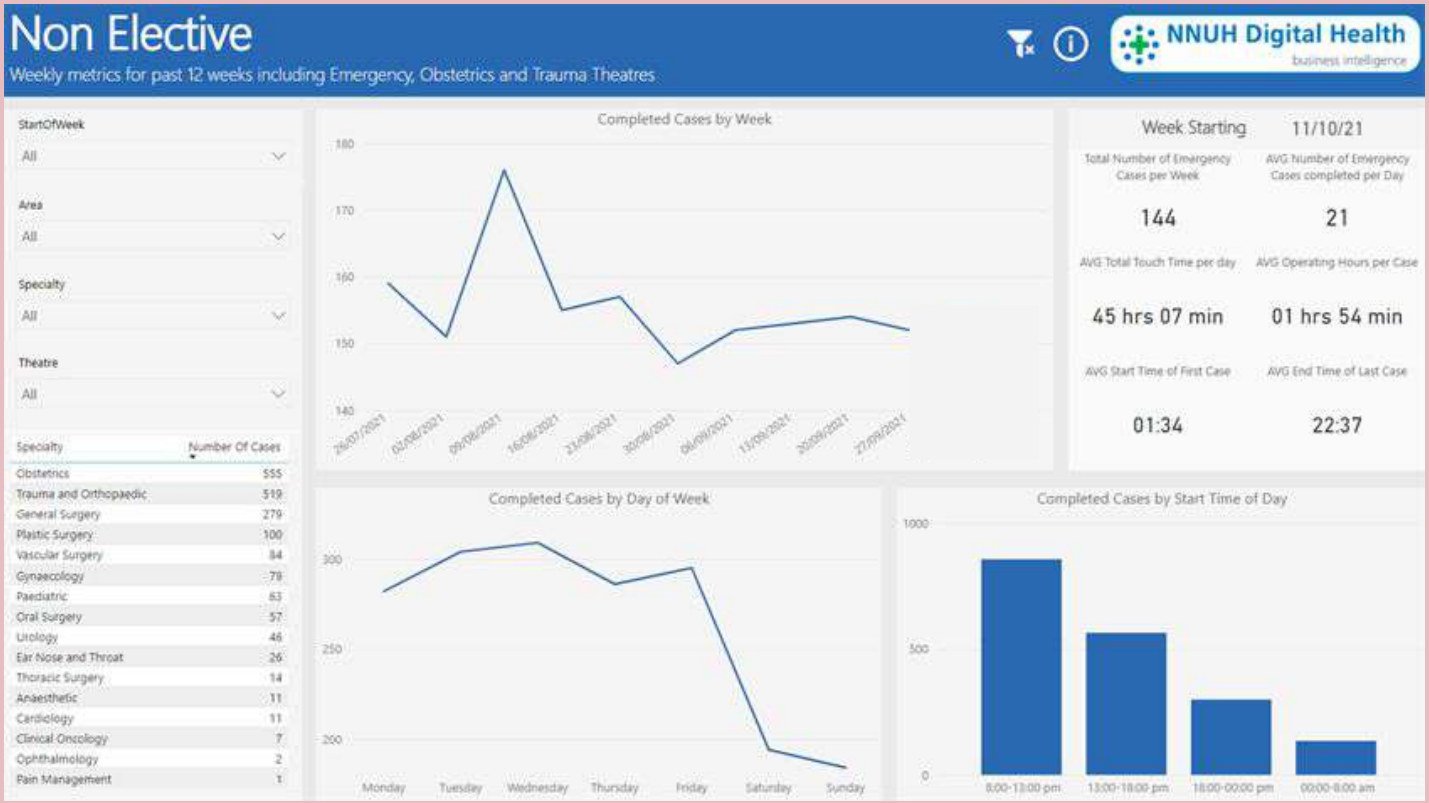
2. Further data analysis of cancellation reasons to be audited – pre-op and booking pathways to be scrutinised.

3. As productivity is being driven – a higher chance of cancellation is introduced through fully booked theatre lists (no room for complexity on day).

Risk To Delivery

RED

Performance – Theatre Dashboard: Emergency Theatres



Commentary

September 2021 Performance

Activity delivered in line with demand (P1a and b cases). Demand for C-Section capacity continued through September which was managed.
The relocation of Plastics trauma to the new Procedure rooms has had a positive impact on NCEPOD capacity.

Improvement Actions

1. Requirement for additional section capacity to be progressed.

2. Review of theatre allocation and demands – increased trauma capacity has impacted on elective provision; modelling to be undertaken to understand continued value of this offer.

Risk To Delivery

AMBER

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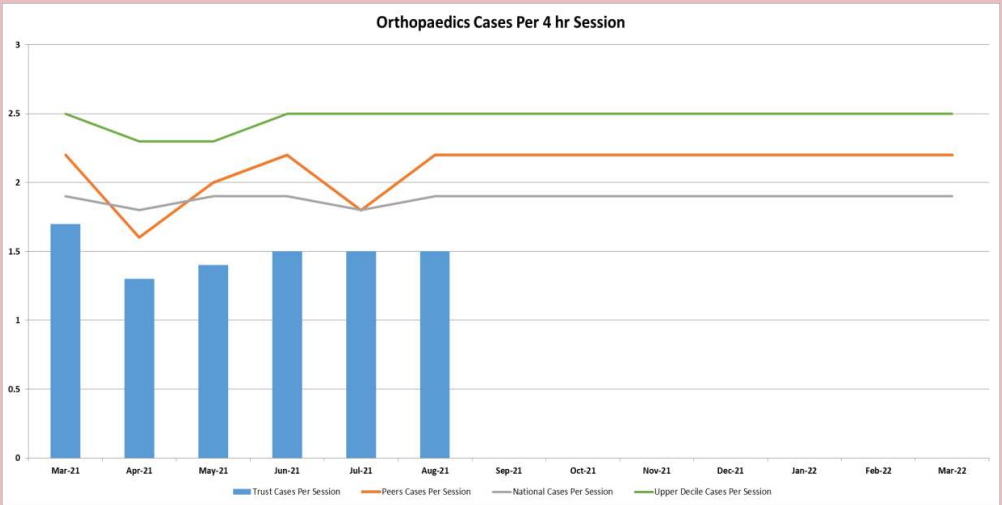
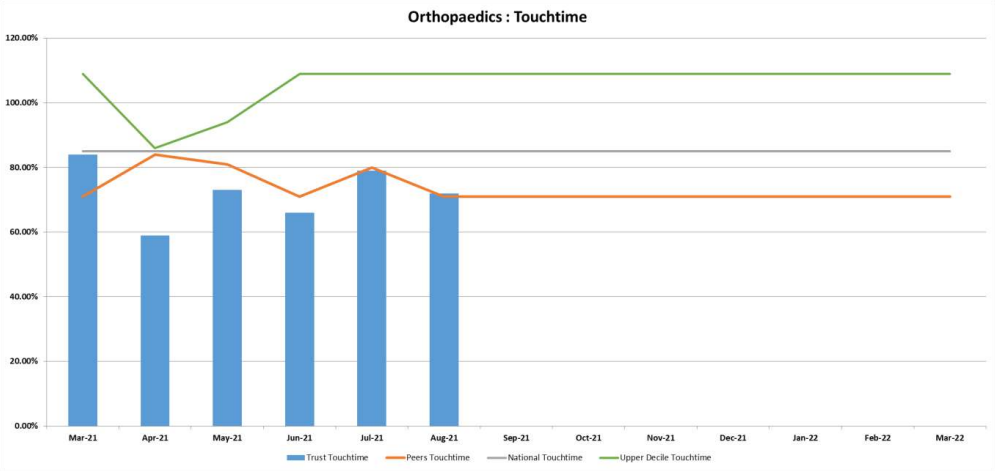
Performance – Model Hospital Orthopaedics





Commentary

September 2021 Performance

The average number of cases per 4-hour session remained at 1.5 which is reflective of the patient complexity of patients being treated. Touch time utilisation ran at 72% compared to peer average of 81%. There was 14% more capacity available, this represents a strong performance compared to our region.

Improvement Actions

1. Plans to work closely with the Orthopaedics Service Director and senior clinicians to implement the recommended interventions and practices to increase activity.

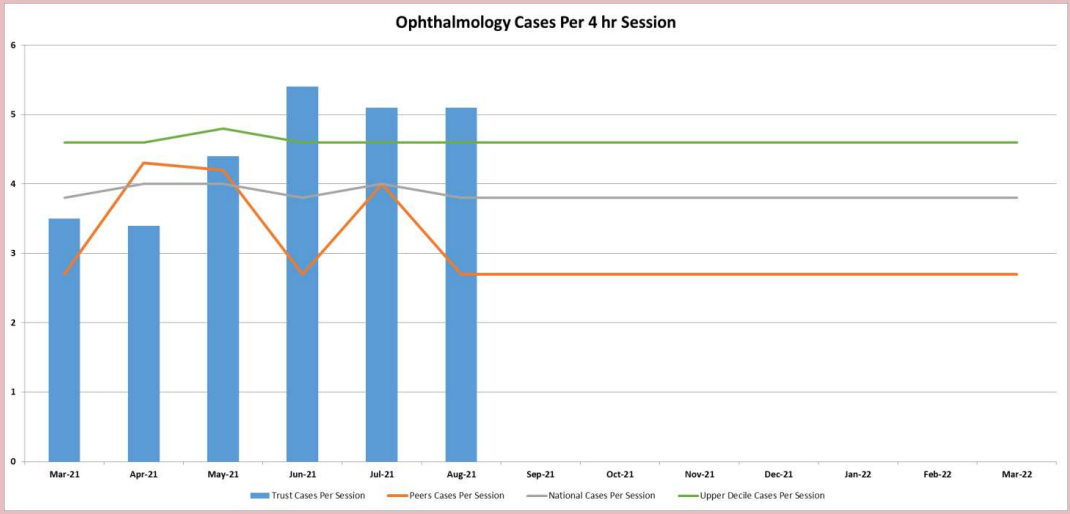
2. Use the new theatres dashboard and data to inform and drive efficiency improvement.

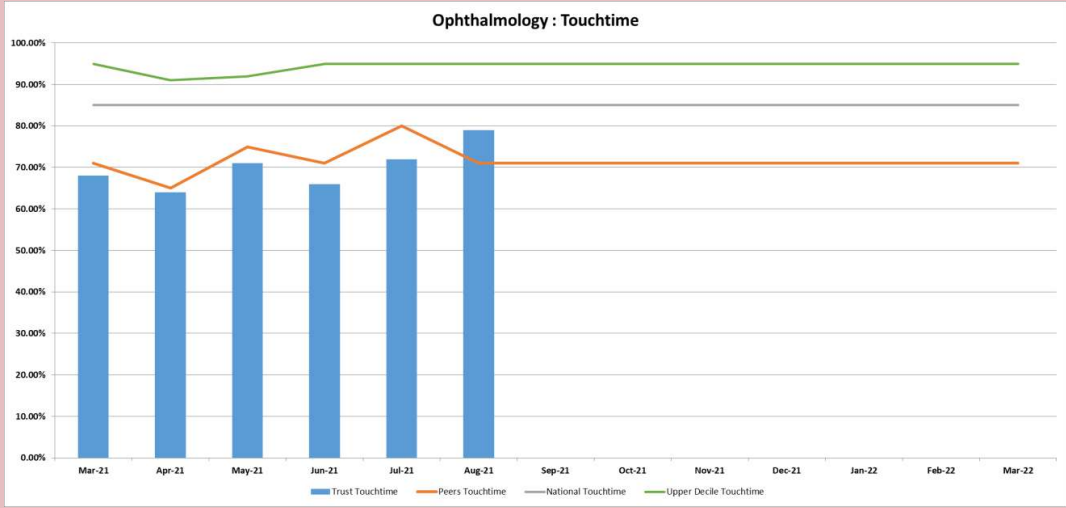
3. Potential to increase capacity via a cold-elective site.

Risk To Delivery

RED

Performance – Model Hospital Ophthalmology





Commentary

September 2021 Performance

The average number of cases per 4-hour session remained at 5.1 placing us in the highest quartile. Supported by an improvement of touch time utilisation of 79%. There was capacity to treat an additional 31 patients (using touch time indicators) and the average number of cases per 4-hour session.

Improvement Actions

1. Work with the team to understand reasons for late starts as we remain an outlier.

2. Use the new theatres dashboard and data to inform and drive efficiency improvement.

3. CQIA/Risk Assessments on clinic space.

Risk To Delivery

AMBER

Norfolk and Norwich University Hospitals NHS Foundation Trust

Finance Report September 2021

3 November 2021

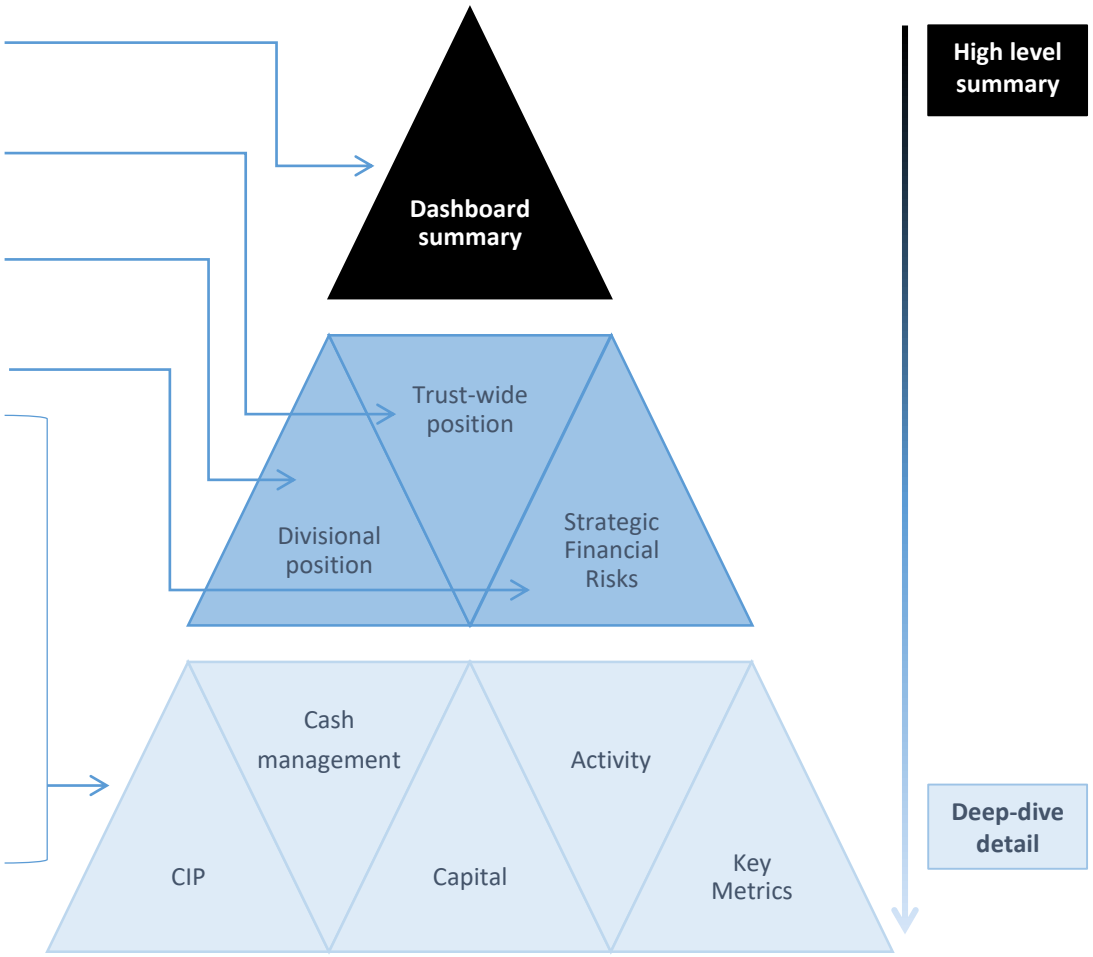
Roy Clarke, Chief Finance Officer

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



Our Values People focused Respect Integrity Dedication Excellence

Norfolk and Norwich University Hospitals NHS Foundation Trust

1.1 Executive Dashboard

On the 25th March 2021, the FY21/22 Priorities and Operational Planning Guidance was released, which outlined the key national priorities and deadlines for the plan submission for the first six months of 2021/22 - (H1) FY21/22. These were reported within Cycle 4 of the financial plan. The H2 guidance was published on 30th September and forms a further cycle (Cycle 5) which is broadly in line with the internal estimations.

The Trust operational plan position at Cycle 4 was:

- A 21/22 deficit of £55m, comprising of a breakeven position for H1 and a £55m interim forecast deficit for H2.
- An underlying full year deficit of £110.1m, requiring improvement through further management action.

The year to date position on a control total basis as at September 2021 is a surplus of £7.1m. This is a £7.1m favourable variance to the breakeven plan. The favourable variance of £7.1m is made up of an underspend in Pay of £3.5m, clinical income of £2.9m and depreciation of £1.1m.

H2: A fixed system level financial envelope with a system breakeven expectation continues in H2 (as per H1), the breakeven assessment will be made based on H1 and H2 combined performance. The key features of the H2 interim plan are:

A CIP delivery requirement of £6.9m in H2, which is the balance yet to deliver to achieve £12.6m requirement for the 21/22 year (£5.7m delivered to date); £2.3m of non-recurrent COVID response costs; £1.6m additional funding for Critical Care expansion; and £7.1m of technical interventions which are carry forward of CIP over-achievement (£2.2m) and other surpluses (£4.9m) from H1.

Management action is required to deliver the planned breakeven position for the year ensuring the non recurrent underspend in H1 due to the reduced activity levels does not create additional recurrent expenditure in H2, worsening the underlying deficit.

HMB approved the Cycle 5 H2 Final Plan on 12 October 2021 delegating authority to the finance team to conclude the H2 settlement discussions with the system.

Activity: The Trust continues to be measured against the activity targets set by NHSE for 2021/22 H1. The target for September 2021 being 85% of 2019/20 activity levels. The Elective Recovery Fund criteria was amended from 1st July 2021 so that additional funds will only be payable if the value of activity in 2021 is more than 95% of the value of 2019 levels. Whilst activity levels overall look to exceed the 85% activity target, provisional figures indicate activity levels will not exceed 95% of 2019 levels, and therefore expectations are that no additional funding will be available for September 2021.

Cash held at 30 September 2021 is £64.7m. The closing balance is £24.0m above plan for the following main reasons: cumulative operational underspends in 2020/21, exceptional capital creditors, accruals and levels of general debt. The cash flow plan for this period showed a closing cash balance at 31 March 2022 of £21.1m.

Capital: As at 30 September the Trust has underspent against plan by £5.5m (17%). This significant underspend is caused by an increasing number of schemes missing planned milestones that were set out in M2.
The current formal forecast outturn is to deliver an outturn of £52.9m (increased from the previous month), against the initial plan of £52.4m.

Management action is required to ensure the delivery of Capital Expenditure in line with the plan. Failure to deliver the planned programme on the approved trajectory creates a risk of an ICS reduction in the CDEL and this could compromise delivery of operational improvements.

	YTD			
	Actual £m	Plan £m	Variance £m	RAG
Clinical Income	285.2	282.3	2.9	
Other Income	113.9	113.5	0.4	
Pay	(219.0)	(222.5)	3.5	
Non Pay	(107.7)	(108.1)	0.4	
Net Drugs Cost	(37.1)	(36.0)	(1.1)	
Non Opex	(28.1)	(29.2)	1.1	
Surplus / (Deficit)	7.1	0.0	7.1	
COVID (Out of System) Expenditure	3.4	0.0	3.4	
COVID (Out of System) Income	(3.4)	0.0	(3.4)	
Reported Surplus / (Deficit)	7.1	0.0	7.1	
Headline Surplus / (Deficit)*	8.8	2.2	6.6	
Cash at Bank (before support funding)	64.7	40.7	24.0	
Capital Programme	52.9	52.4	0.6	
CIP	6.4	3.5	2.9	
Inpatients** (000's)	77.0	70.4	6.6	
Outpatients** (000's)	361.7	345.3	16.4	
A&E** (000's)	148.2	147.5	0.7	

** Headline surplus / (deficit) reflects impact of donated income and donated asset depreciation in line with statutory reporting*

*** Activity for Apr-Sep: Plan is Trust Activity plan*

Norfolk and Norwich University Hospitals NHS Foundation Trust

1.2 Executive Dashboard

Risks

Following the monthly review of the Financial Risk Register the Trust's overall risk profile remains stable, with no changes in risk scoring in month.

Strategic Financial Risks	Extreme (15-25)	High (8-14)	Moderate (4-6)	Low (1-3)
Total This Month	7	8	0	0
Total Last Month	7	6	0	0
Overall Trend	↔	↑	↔	↔

Divisional Performance

The Medicine division is overspent YTD as a result of increased drug expenditure although this is offset by additional income centrally managed in the 'other' division. Women's & Children's has a small adverse variance for the same reason. The CSS division is underspent mostly as a result of vacancies. Surgery and Corporate have small favourable variances.

The Medicine division is showing an adverse position to plan of £4.7m, this is as a result of increased expenditure on high cost drugs & devices. The NHSEI commissioned drugs & devices are offset by additional income centrally managed in the 'other' division. The CSS Division is showing a favourable position of £3.5m, mostly relating to vacancies against their establishment. Surgery is underspent by £0.6m as result of reduced clinical supplies expenditure however is overspent in pay as a result of locum expenditure covering vacant ED shifts. Corporate has a small favourable variance and Women's & Children's is broadly on plan.

As actual activity is significantly lower than prior year and the reduced expenditure is not proportional to this, all divisions are RAG-rated either amber or red.

'Other' includes Clinical Income block and Top up funding along with R&D and the Trust Reserves. The net favourable variance of £7.8m is driven by £4.0m from additional income relating to cost & volume drugs income (recognised based on usage), £2.2m of CIP early achievement and £1.1m reduced depreciation as a result of the capital spend being behind plan.

YTD Divisional Performance Excl. COVID	Medicine		Surgery		Women's & Children's		CSS		Corporate Incl. COVID		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
YTD Surplus / (Deficit)	(114.5)	(4.7)	(87.7)	0.6	(28.3)	(0.2)	(46.8)	3.5	(64.1)	0.1	348.6	7.8	7.1	7.1
CIP*	2.3	0.2	0.9	(0.0)	0.2	(0.0)	0.2	0.0	0.2	(0.3)	2.7	3.0	6.4	2.9
Inpatients**	45.6	3.3	18.7	(0.8)	12.7	4.0	0.0	0.0	-	-	-	-	77.0	6.6
Outpatients**	139.8	8.2	166.1	3.6	35.3	5.2	20.4	(0.8)	-	-	-	-	361.6	16.3
A&E**	0.0	0.0	74.1	0.3	0.0	0.0	0.0	0.0	-	-	-	-	74.1	0.3

CIP RAG					
FINANCE RAG***					
PAF RAG***					

**Divisional variance against H1 plan submitted to regulator*

***Activity variance against H1 Draft Activity plans (000's)*

**** Prior Quarter PAF Rating*

Cost Improvement Programme

YTD the Trust has delivered £6.4m of CIPs against a budgeted plan of £3.5m, a favourable variance of £2.9m.

The favourable variance of £2.9m is comprised of a planning variance of nil and a performance variance of £2.9m. The performance variance has arisen through £2.6m of accelerated CIP delivery above budgeted plan; £0.8m of additional delivery through schemes developed since finalising the plan; offset by £0.5m of adverse performance against budgeted schemes across pay and discretionary spend initiatives.

The risk adjusted forecast outturn CIP delivery for FY21/22 is currently calculated as £13.8m based on the latest forecast financial performance of Gateway 2 schemes, progress against milestone delivery and performance against quality and performance indicators.

FY21/22 CIP Plan - Divisional Breakdown	FY21/22 Indicative Target £m	FY21/22 FIP Board Approved £m	FYE FY20/21 £m	Gap £m	FY21/22 RAG Adj. Forecast Delivery £m	Gap £m
Medicine	7.2	6.0	2.4	1.2	7.3	0.1
Surgery	8.7	2.6	1.7	(4.4)	3.8	(4.9)
Women's & Children's	2.7	0.6	0.2	(1.9)	0.6	(2.1)
CSS	4.1	0.6	0.5	(3.0)	1.0	(3.1)
Corporate	3.7	1.2	0.3	(2.2)	1.2	(2.5)
Total	26.4	11.0	5.1	(10.3)	13.8	(12.6)

FY21/22 CIP Plan Development

As at 18 October 2021, the programme consists of £10.9m of Gateway 2 approved schemes; £5.2m of FYE of FY20/21 schemes; £2.8m of Gateway 1 approved schemes, which are being reviewed and developed to be progressed or removed from the programme; and £0.7m of schemes within the CIP development pipeline (Gateway 0).

Norfolk and Norwich University Hospitals NHS Foundation Trust

2.1 Financial Performance – September 2021

For the month of September 2021, the position on a control total basis is a surplus of £0.7m. This is a £1.1m favourable variance to the planned £0.4m deficit for the month. The favourable variance of £1.1m is made up of an underspend in Pay of £0.4m, Clinical Income of £0.7m and depreciation of £0.4m offset by £0.3m overspend on net drugs costs.

Clinical Income:
Clinical Income is reporting a favourable variance of £0.7m in September 2021 due to increased High Cost Devices recharged based on usage and is offset by additional clinical supplies expenditure.

Other Income:
Other Income is reporting a favourable variance of £1.5m. Of this, £1.0m relates to R&D is matched by additional non pay expenditure. There is also £0.4m of pass through income relating to Ockenden funding for JPUH.

Pay:
The operational pay variance excluding COVID is £0.7m favourable for September 2021, predominantly as a result of net vacancies against establishment mainly in CSS. In September there were c. 849 vacancies across the Trust with c. 756 premium WTE thus a net 93 WTE vacancy. Of the net vacancy the majority are AHP/Scientific where less premium staffing is available support the substantive staff base. Including COVID there is a £0.4m favourable position against plan for September 2021.

Net Drugs Cost:
There is a £0.2m adverse variance in September 2021. This is increased costs of £1.0m predominantly across ophthalmology, neurosciences and respiratory, offset by additional income of £1.2m for those drugs classed as cost and volume. Ophthalmology drugs are CCG funded and therefore in block and additional income in line with usage is not received.

Non Pay:
There is a £1.5m adverse variance in September 2021, this is predominantly as a result of £1.0m R&D expenditure and £0.4m pass through expenditure relating to Ockenden funding to JPUH both offset by additional income.

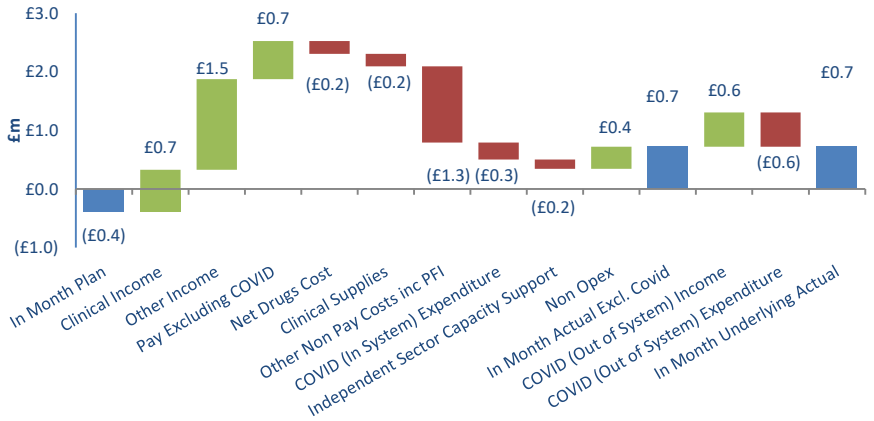
In System COVID 19 Expenditure:
In System COVID expenditure is £0.3m favourable to plan for September 2021.

Independent Sector Capacity Support:
Independent Sector Capacity Support is £0.2m adverse to plan for September 2021. Actual spend in September was £2.1m, an increase of £0.2m v August

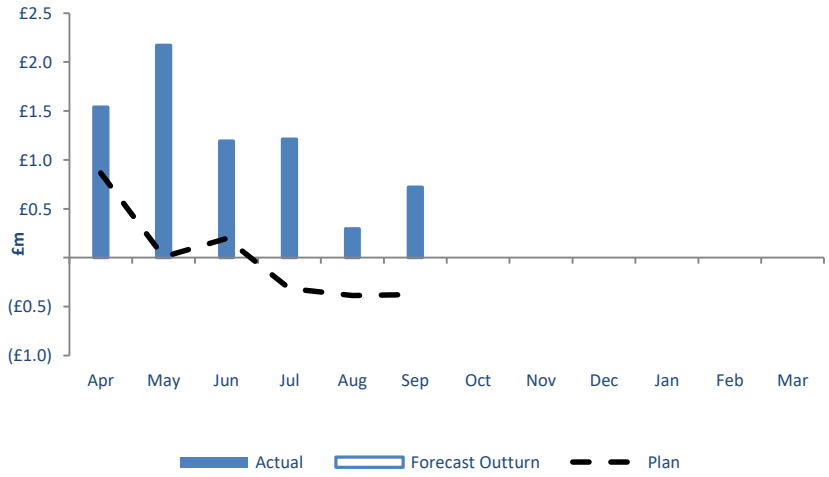
Non Operating Expenditure:
Non operating expenditure is £0.4m favourable to plan for September 2021. This is as a result of reduced depreciation expenditure due to phasing of the capital programme .

Out of System COVID 19 Expenditure:
The COVID-19 expenditure in month is £0.6m, with offsetting income of £0.6m and therefore an in month breakeven position. The main area of expenditure remains testing.

In Month Variance



Monthly Reported Surplus/(Deficit)



Norfolk and Norwich University Hospitals NHS Foundation Trust

2.2 Financial Performance – Year to Date

The year to date position on a control total basis as at September 2021 is a surplus of £7.1m. This is a £7.1m favourable variance to the breakeven plan. The favourable variance of £7.1m is made up of an underspend in Pay of £3.5m, clinical income of £2.9m and depreciation of £1.1m.

Clinical Income:
Clinical Income is reporting a favourable variance of £2.9m year to date due to increased High Cost Devices recharged based on usage and is offset by additional clinical supplies expenditure.

Other Income:
There is a £0.4m Favourable variance to plan year to date. £1.0m relates to R&D is matched by additional non pay expenditure. There is also £0.4m of pass through income relating to Ockenden funding for JPUH, offset by £0.6m relating to a debit to income relating to vaccination expenditure which has been challenged by NHSE. The remaining balance relates to a number of small adverse variances including reduced Education & Training and ASI both matched by reduced expenditure.

Pay:
Including COVID, there is a £3.9m favourable position against plan year to date. This comprises of a £0.6m adverse variance for In System COVID and IS capacity support, and an operational variance of £4.5m favourable relating to net vacancies against establishment, mainly in CSS. Year to date, the average monthly number of net vacancies after offsetting premium staff is 140. This has consistently reduced through the year as a result targeted recruitment, mostly in the last month as newly qualifieds join the Trust

Net Drugs Cost:
There is a £1.1m adverse variance year to date This is increased costs of £5.1m predominantly across neurosciences and respiratory, offset by additional income of £4.0m for those drugs classed as cost and volume.

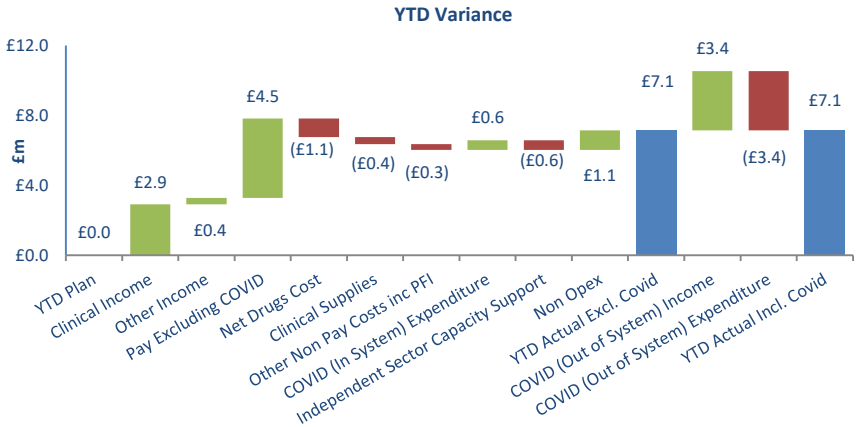
Non Pay:
Including COVID, there is a £0.4m favourable position against plan year to date. This comprises of a £1.1m favourable variance for COVID, and an adverse operational variance of £0.7m. The adverse operational variance is predominantly as a result pass through expenditure on R&D and Ockenden funding offset by early achievement of CIP.

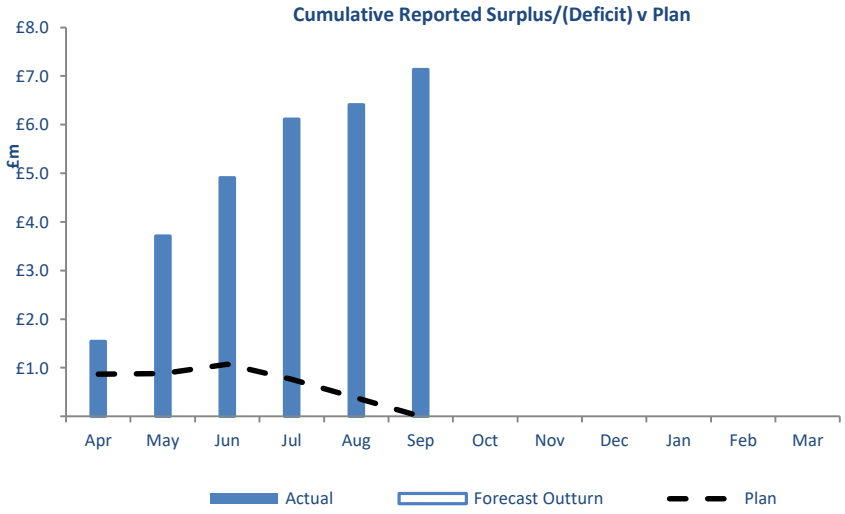
In System COVID 19 Expenditure:
In System COVID expenditure is £0.6m favourable to plan year to date. This is due to fewer than expected COVID patients and surge funding not being required.

Independent Sector Capacity Support:
Independent Sector Capacity Support is overspent by £0.6m year to date.

Non Operating Expenditure:
Non operating expenditure is £1.1m favourable to plan year to date. this is as a result of reduced depreciation expenditure due to phasing of the capital programme .

Out of System COVID 19 Expenditure:
The COVID-19 expenditure year to date is £3.4m, with offsetting income of £3.4m and therefore breakeven. Of this £0.9m has been spent in the vaccination programme and £2.2m on Testing.





Norfolk and Norwich University Hospitals NHS Foundation Trust

2.3 Bridge H1 to H2 – Surplus/(Deficit)

The planning guidance confirms that Business Rules for H2 FY21/22 are the same as H1 FY21/22, with block top up funding arrangements to continue for six months. This guidance resulted in an updated plan - Cycle 5, being a break even position for the full year 2021/22. Analysis below bridges the H1 plan to the FY 21/22 plan

1 Change to Cost Base: - £19.1m This is the combined effect of:
- £11.6m Cost of national AfC/medical pay award (H1 backdated and H2)
- £5.8m Reinstatement of consumable budgets to 100% of 19/20 baseline
- £1.6m Critical care expansion costs, moving from 20 to 28 beds in H2.

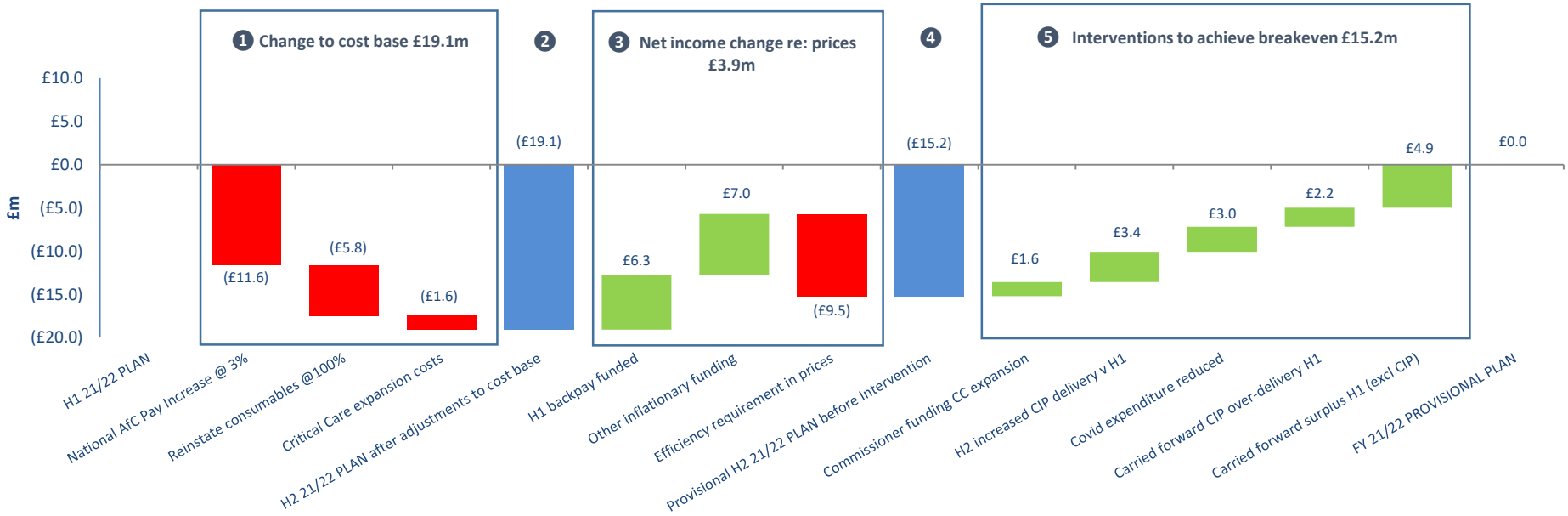
2 H2 21/22 PLAN after adjustments to cost base – £19.1m Deficit

3 Net income change re: prices - £3.9m. This is the expected impact of the confirmed financial framework on the Trust, comprising:
- **£6.3m Specific funding for the backdated H1 national pay award**
- **£7.0m Other inflationary funding per national tariff 0.98%**
- **£9.5m Efficiency requirement in prices** - comprising national tariff requirement of 0.82% plus other targeted income reductions

4 Provisional H2 21/22 PLAN before Intervention £15.2m

4 Provisional H2 21/22 PLAN before Intervention £15.2m

5 Interventions to achieve Breakeven position - £15.2m:
- **Commissioner funding for CC Expansion £1.6m –** This agreed funding would offset the increased Critical Care costs included within block (1).
- **Increased CIP delivery £3.4m** - H2 requires increased CIP delivery of £3.4m compared to the £3.5m planned in H1.
- **Carried forward CIP over-delivery £2.2m** – Combined with the increased CIP delivery vs H1 plan above, a £12.6m total CIP would be delivered for FY21/22.
- **Carried Forward Surplus from H1 (excl. CIP) £4.9m** – Financial framework confirms that the M6 actual surplus delivery can be carried forward to support performance in H2
- **Reduction in COVID expenditure budget - £3.0m** – Moves the non-recurrent COVID budget from £5.3m to £2.3m.



Norfolk and Norwich University Hospitals NHS Foundation Trust

2.4 Underlying Plan Analysis

The planning guidance confirms that Business Rules for H2 FY21/22 are the same as H1 FY21/22, with block top up funding arrangements to continue for six months. This guidance resulted in an updated plan - Cycle 5, being a break even position for the full year 2021/22. This is based on an underlying planned deficit of £110.1m for 2021/22. Analysis below bridges the FY plan to the underlying deficit.

1 **Cycle 5 FY Plan:** Breakeven

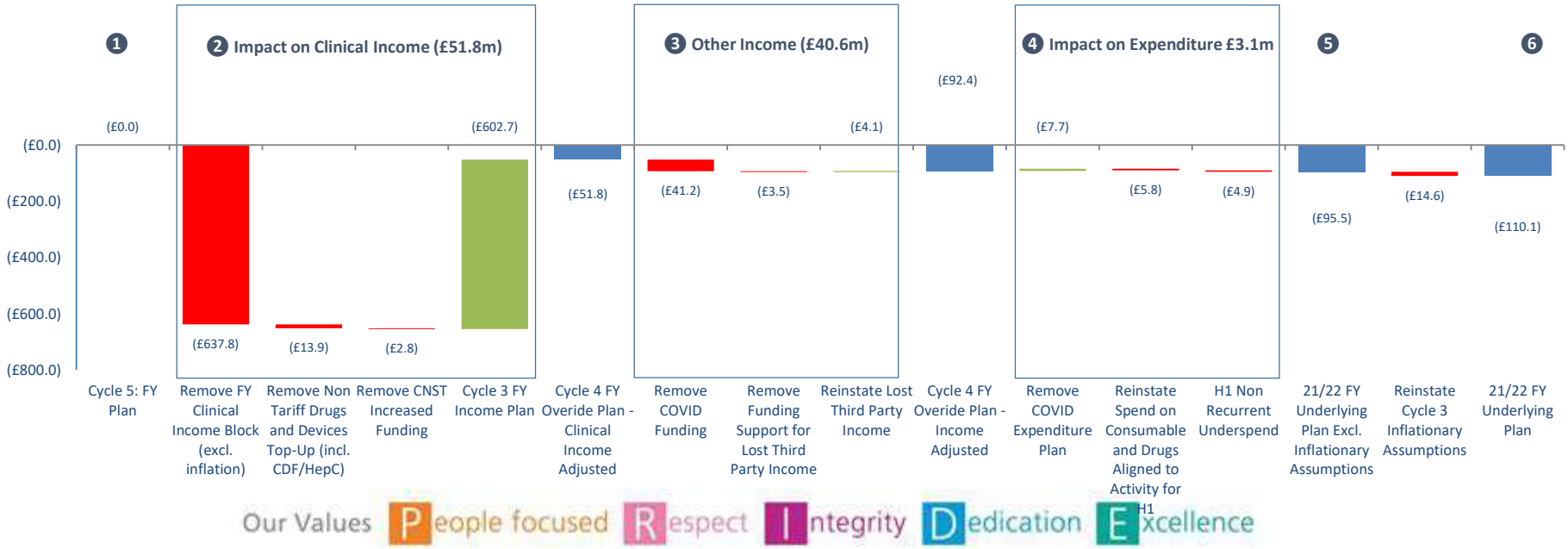
2 **Impact on Clinical Income** – The underlying plan included £602.7m of clinical income across commissioning contracts, including non tariff drugs. This has been replaced by £654.5m of system allocated block funding. **Reverting back to the underlying plan is a £51.8m adverse movement.**

3 **Other Income** - The system financial allocation includes £41.2m for In-system COVID, £3.5m of funding support for income loss, which is matched by a forecast reduction of £2.0m for private patient income and £2.0m for car parking, clinical excellence awards and small elements of provider to provider charges. **Reverting back to the underlying plan is a £40.6m adverse movement.**

4 **Impact on Expenditure** – FY plan includes £7.7m of in-system COVID expenditure offset by reduction in cost of £10.8m. Of which £5.8m was planned, this was calculated through a review of the variable non-pay expenditure included within H1 Cycle 3, in line with the activity trajectories outlined within the planning guidance and £4.9m of reduced H1 expenditure as a result of the profile of restoration and non recurrent efficiencies due to very low numbers of COVID in patients . **Reverting to back the underlying plan is a £3.1m adverse movement.**

5 **Inflationary Impact** – The planning guidance assumptions surrounding inflation resulted in a £14.6m positive impact. This was as a result of the removal of cycle 3 pay inflation of 2.9% (£12.3m) offset by £15.3m of inflation at 3.0%, and additional tariff of £2.5m in H1 and £15.2m in H2. **Reverting to back the underlying plan is a £14.6m adverse movement.**

6 **Annualised Underlying Deficit of £110.1m**



Norfolk and Norwich University Hospitals NHS Foundation Trust

3.1 Divisional Performance - Summary

The Medicine division is overspent YTD as a result of increased drug expenditure although this is offset by additional income centrally managed in the 'other' division. Women's & Children's has a small adverse variance for the same reason. The CSS division is underspent mostly as a result of vacancies. Surgery and Corporate have small favourable variances.

The below commentary is against the year to date position:

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

Medicine:
Net expenditure of £114.5m, £4.7m adverse variance against plan. Pay has a favourable variance of £0.4m year to date. Non Pay has an adverse variance of £5.5m, predominantly as a result of an increase in expenditure on specialised commissioned high cost drugs, which is offset by an increase in drugs income held centrally. Other income has a favourable variance of £0.4m, reflecting the income for non-pay costs billed to Phillips as a result of a worldwide product recall of Sleep Apnoea equipment.

Surgery & EUC:
Net expenditure of £87.7m resulting in a £0.6m favourable variance against plan for the Year to Date. Clinical Supplies & drugs on plan YTD which correlates with the internal activity delivery. Non Clinical Supplies are underspent by £0.4m due to capacity being procured via COVID budgets. Within Pay, the Division is reporting a £0.3m adverse Year to Date position as a result of high medical vacancies being covered by locums in ED.

Women's & Children's:
Net expenditure of £28.3m, £0.2m adverse against plan.

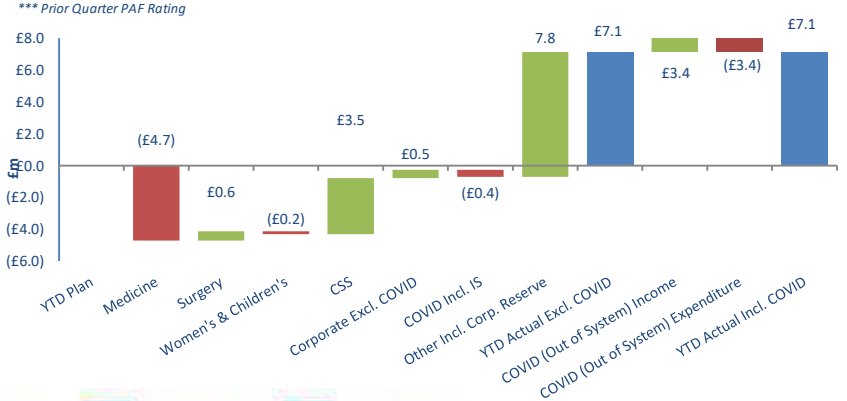
Clinical Support:
Net expenditure of £46.8m, £3.5m favourable variance against plan. £2.9m of this is within Pay due to the number of vacancies across the division (notably within Therapies Imaging, and Cellular Pathology), and £0.5m underspends in clinical supplies, due to reduced activity within Cytology and Interventional Radiology.

Corporate Incl. COVID:
Net expenditure of £64.1m, £0.1m favourable to plan year to date.

Other:
Other includes Clinical Income block and Top up funding along with R&D and the Trust Reserves. Net favourable variance of £7.8m mostly being £4.0m from additional income relating to cost & volume drugs income recognised based on usage, £2.2m of CIP early achievement and £1.1m favourable to plan as a result of reduced depreciation expenditure due to phasing of the capital programme .

YTD Divisional Performance Excl. COVID	Medicine		Surgery		Women's & Children's		CSS		Corporate Incl. COVID		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
Clinical Income	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	285.2	2.9	285.2	2.9
Other Income	1.6	0.4	3.2	0.2	0.9	0.5	6.9	0.4	4.1	(0.5)	97.2	(0.6)	113.9	0.4
Pay	(60.4)	0.4	(72.3)	(0.3)	(24.1)	0.4	(35.7)	2.9	(23.4)	(0.5)	(3.0)	0.6	(219.0)	3.5
Non Pay	(18.2)	(1.0)	(13.5)	0.6	(2.1)	(0.5)	(17.0)	0.3	(44.7)	1.1	(12.2)	(0.2)	(107.7)	0.4
Net Drugs Cost	(37.5)	(4.5)	(5.1)	0.1	(2.9)	(0.7)	(1.0)	(0.1)	(0.1)	(0.0)	9.6	4.0	(37.1)	(1.1)
Non Opex	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	(28.1)	1.1	(28.1)	1.1
YTD Surplus / (Deficit)	(114.5)	(4.7)	(87.7)	0.6	(28.3)	(0.2)	(46.8)	3.5	(64.1)	0.1	348.6	7.8	7.1	7.1
CIP*	2.3	0.2	0.9	(0.0)	0.2	(0.0)	0.2	0.0	0.2	(0.3)	2.7	3.0	6.4	2.9
Inpatients**	45.6	3.3	18.7	(0.8)	12.7	4.0	0.0	0.0	-	-	-	-	77.0	6.6
Outpatients**	139.8	8.2	166.1	3.6	35.3	5.2	20.4	(0.8)	-	-	-	-	361.6	16.3
A&E**	0.0	0.0	74.1	0.3	0.0	0.0	0.0	0.0	-	-	-	-	74.1	0.3
CIP RAG														
FINANCE RAG***														
PAF RAG***														

*Divisional variance against H1 plan submitted to regulator
**Activity variance against H1 Draft Activity plans (000's)
*** Prior Quarter PAF Rating



Norfolk and Norwich University Hospitals NHS Foundation Trust

3.2 Divisional Performance - Service Line Reporting Q1 2021/22

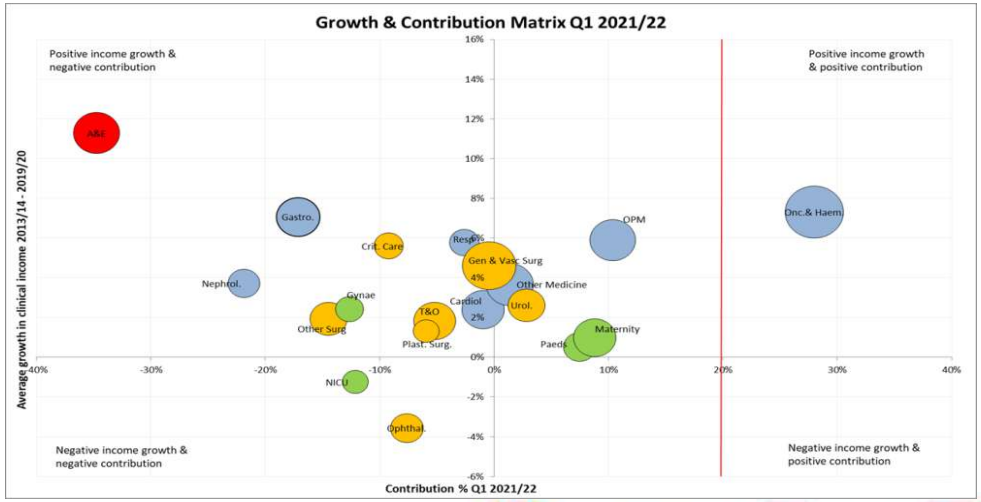
SLR data for the period April 2021 - June 2021 reflects some recovery in activity levels towards pre-COVID levels. In turn this has led to an improvement in levels of contribution (income less costs before overheads) compared to 2020/21.

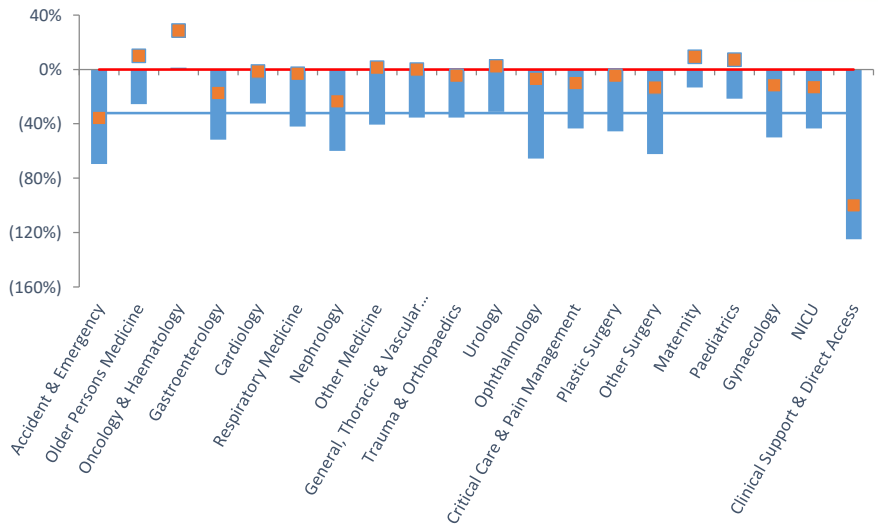
Levels of activity in the first three months of the year returned to pre-COVID levels, except for Surgery which remains lower. In turn the level of income that would be earned (using Payment by Results (PbR) prices) is only slightly lower than it was in 2019/20. However, costs have risen above 2019/20 levels and so the levels of contribution being made are not yet at 2019/20 levels:

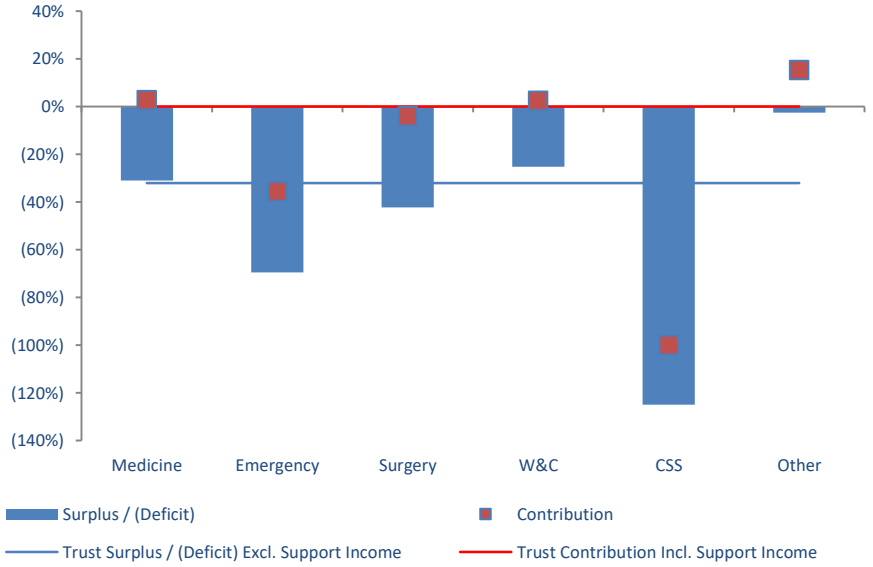
Division	% of 'PbR' Income	Contribution		
		19/20	20/21	Q1 21/22
Medicine	42.7%	14%	(10%)	3%
Emergency	5.9%	(35%)	(58%)	(35%)
Surgery	34.4%	6%	(29%)	(4%)
Women & Children's	16.6%	5%	(8%)	2%
Clinical Support	0.4%	(61%)	(138%)	(79%)

Income has been priced under PBR; the top up from PBR-pricing to actual income received is not allocated to divisions in these SLR reports.

The tables below show how the Divisions' activity, costs and income are reflected in SLR, prior to support income:







Our Values: People focused | Respect | Integrity | Dedication | Excellence

Norfolk and Norwich University Hospitals NHS Foundation Trust

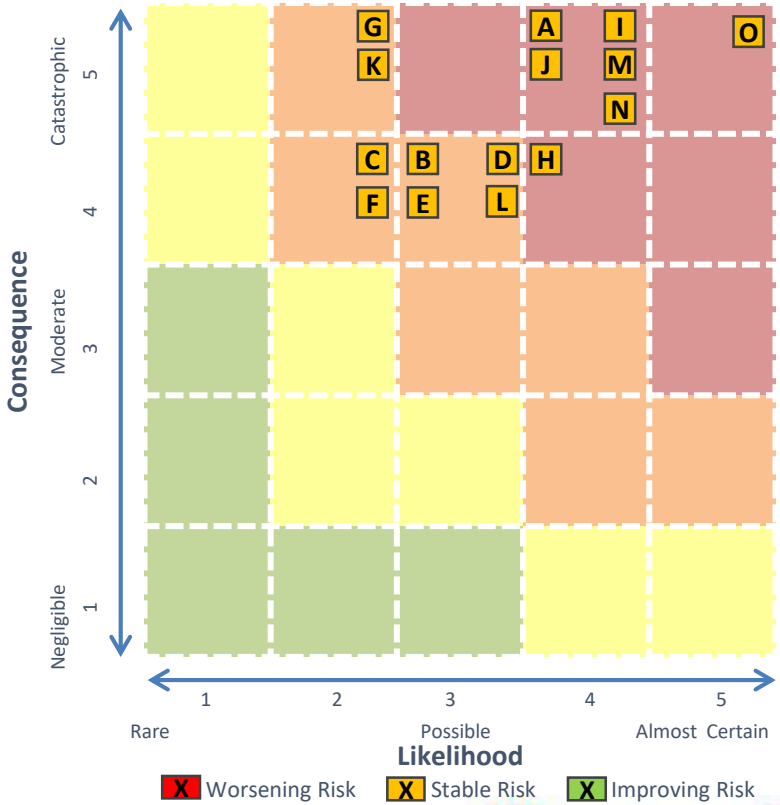
4. Strategic Financial Risks

Following the monthly review of the Financial Risk Register the Trust's overall risk profile remains stable, with no changes in risk scoring in month.

As part of FY21/22 annual planning 13 key strategic and operational risks with an initial score of ≥ 12. A further two risks have been added as part of on-going monthly risk reviews.

The Finance Directorate continues to formally review the Financial Risk Register, on a monthly basis, reviewing the risks and adding new risks which have been identified across the finance portfolio.

As part of the monthly review of the Financial Risk Register, there were no changes in risk scoring in the month.



	ID	Description	Risk Score	*Prior Month*
A	624	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	1534	IF the Trust is unable to generate the FY21/22 planned activity and case mix, THEN the income generated may be lower than planned levels.	12	12
C	1535	IF the Trust is unable to deliver the FY21/22 required activity levels per the national recovery framework, THEN additional funding available through the Elective Recovery Fund may not be available to invest back in recovering activity.	8	8
D	1536	IF the Trust's capacity plan does not reflect the available clinical space and workforce effective hours, THEN there is a risk that activity assumptions underpinning the FY21/22 plan are not valid, potentially leading to lower levels of income or higher levels of costs than planned through the use of third party capacity.	12	12
E	1539	IF the Trust does not deliver forecast activity growth levels within the identified cost envelope or IF there is a change in case mix to less profitable procedures, THEN this will lead to lower income as a proportion of cost levels driving a higher deficit than planned.	12	12
F	1540	IF the Trust creates additional capacity at additional cost to the Trust in order to reduce the waiting list, and does not secure the financial resources for this, THEN this will create additional cost pressures which will need to be mitigated through additional efficiency delivery, or the Trust will incur a higher deficit than planned.	8	8
G	1532	IF the Trust fails to control expenditure in line with the plan, including mitigation of identified but unfunded cost pressures, THEN the Trust will fail to deliver to plan, negatively impacting the I&E and cash position and increasing the distress funding requirement.	10	10
H	1533	IF the Trust enacts service developments or changes that result in an increase in cost that is not mitigated by a corresponding increase in the value of the Trust's income contracts, THEN the financial position will be negatively impacted.	16	16
I	1527	IF the efficiency requirement is not identified and delivered on an annual basis THEN the Trust is at risk of significantly failing its I&E and cash plans, alongside delivery of the Trust's Financial Strategy.	20	20
J	1529	IF the Trust does not deliver the financial improvements within its own control, THEN the access to technical solutions, including FRF, may no longer be available.	20	20
K	1526	IF the Trust is unable to manage its financial performance in line with the Operational Plan, THEN there is a risk that the Trust will require additional distress funding to meet its financial obligations.	10	10
L	1528	IF the Trust cannot secure sufficient emergency capital PDC to support the delivery of the capital programme, THEN the planned capital programme will be delayed, negatively impacting the ability to deliver planned activity levels and increasing costs leading to additional pressure to financial performance.	12	12
M	1548	IF additional or revised regulatory requirements do not align with the framework utilised in developing the Financial Strategy THEN additional financial pressures may arise, negatively impacting the Trust's ability to deliver sustainable financial improvement.	20	20
N	1724	IF the rebased nursing and midwifery rosters are not uploaded in a timely manner on to Allocate THEN the Trust will not utilise its nursing and midwifery resources efficiently to deliver effective patient care.	20	20
O	1725	IF programme management arrangements in place to deliver the capital programme fail to deliver in line with plan THEN the capital programme may underspend resulting in failure to improve operational capacity at the level required to deliver patient care and be at risk of reputational damage.	25	25

Norfolk and Norwich University Hospitals NHS Foundation Trust

5. Cash

Cash held at 30 September 2021 is £64.7m. The closing balance is £24.0m above plan for the following main reasons: cumulative operational underspends in 2020/21, exceptional capital creditors, accruals and levels of general debt. The cash flow plan for this period showed a closing cash balance at 31 March 2022 of £21.1m.

Cash Financial Arrangements - financial envelope for 2021/22 – first half year to 30 September 2021

A financial settlement for the NHS has been agreed for the full year of 2021/22. It is a fixed system envelope arrangement as was in place for the second six months of 2020/21. Our financial allocation has been confirmed and is consistent with that received in 2020/21, increased for inflation, growth and efficiency.

The Trust draft operational plan for the 21/22 shows a break even position. As a result it is not expected that any revenue cash support will be required during the year. The cash flow plan for this period showed a closing cash balance at 31 March 2022 of £21.1m.

The twelve month rolling cash flow forecast before revenue funding support shows the cash balance reducing during the second half year to negative funds of £43.9m at end September 2022, thus revenue support would be required in 2022/23.

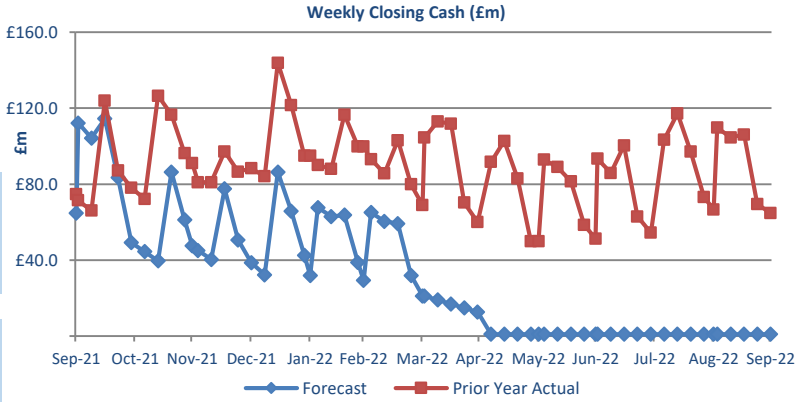
Cash balances are forecast to reduce by c. £43.6m however remain positive in March 2022 thus no revenue support would be required. This has been assumed and is reflected in the cash forecast graph alongside.
The deterioration in cash position in the second half year relates to the assumption that the block funding and top up arrangements will reduce in line with the increased efficiency assumptions, but for H2 there would be a break even position, with this arrangement ceasing for 2022/23 and reverting to PbR. This accounts for c. £38m of the reduction in funding assumed.

The availability of funding has been properly considered and guidance issued by NHSE/I in March 2021 stated that 'where providers do require supplementary revenue cash support providers will be able to apply for revenue cash support from DHSC via the NHSE/I capital and Cash team. Therefore should the Trust require additional support , there are mechanisms in place to access this.

The forecast will further firm up as funding arrangements become more clear.

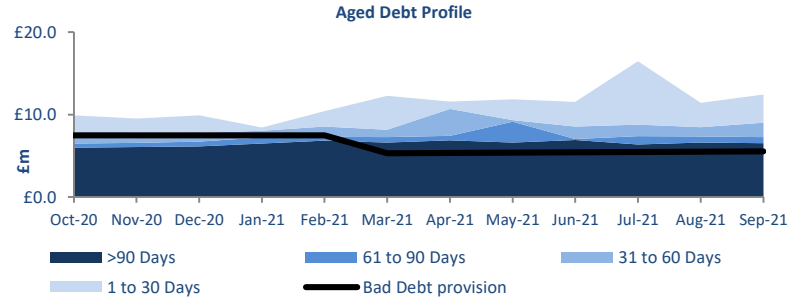
Capital - The Trust's draft capital plan includes identified funding streams for all expenditure. The receipt of funding is subject to a national process, therefore the cash flow forecast for capital is based on best understanding on the timing of approvals. Accordingly this may change, however it should not impact the cash flow significantly overall as expenditure can mostly be managed to align with funding.

Aged Debt - Debtors at September 2021 are £12.4m, of which £6.5m is over 90 days. Of the NHS debt greater than 90 days, £1.4m is JPUH, increase of £0.1m from the prior month. Of the Non NHS debt greater than 90 days £2.1m relates to TPW, £0.5m relates to Big C and £1.0m relates to private/overseas patients. The Trust continues to focus on resolving these debts.



Debtors by Type	Total Debt			Debt > 90 days		
	Jul-21 £m	Aug-21 £m	Sep-21 £m	Jul-21 £m	Aug-21 £m	Sep-21 £m
NHS	9.70	4.46	5.53	1.75	1.51	1.70
Non NHS	6.75	6.95	6.91	4.64	5.09	4.82
Total	16.46	11.41	12.43	6.38	6.60	6.52

Better Payments Practice Code YTD	No. of Invoices			£m		
	Total Invoices Paid	Total Invoices paid within target	Performance %	Total Invoices Paid	Total Invoices paid within target	Performance %
NHS	1,605	1,374	85.6%	40,901	37,013	90.5%
Non NHS	63,326	60,470	95.5%	165,686	152,210	91.9%
Total	64,931	61,844	95.2%	206,588	189,223	91.6%



Norfolk and Norwich University Hospitals NHS Foundation Trust

6.1 Activity (Income PbR)

The Trust continues to be measured against the activity targets set by NHSE for 2021/22 H1. The target for September 2021 being 85% of 2019/20 activity levels. The Elective Recovery Fund criteria was amended from 1st July 2021 so that additional funds will only be payable if the value of activity in 2021 is more than 95% of the value of 2019 levels. Whilst activity levels overall look to exceed the 85% activity target, provisional figures indicate activity levels will not exceed 95% of 2019 levels, and therefore expectations are that no additional funding will be available for September 2021.

Income for the first half of 2021/22 continues to be set nationally, in the form of block (fixed) funding. Guidance for the second half of 2021/22 has now been published, and as expected funding will be in a similar form to that for the first half of the year. One significant change is that Elective Recovery Funding will be paid based on achievement of RTT clock stops, compared to 2019/20, not units of activity as it has been in Half 1. Block funding remains in place for September, and activity expectations have been set by NHSE/I, with targets for September being 85% of 2019/20 activity levels – across Elective (including Day Case) and Outpatients areas. However, the target for the Elective Recovery Fund is for the financial value of September 2021 activity to exceed 95% of the financial value of activity in September 2019.

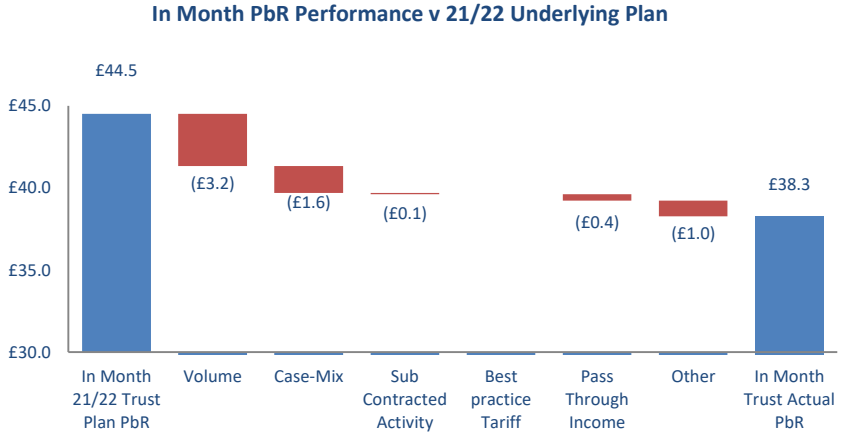
Performance v 2021/22 Base Plan

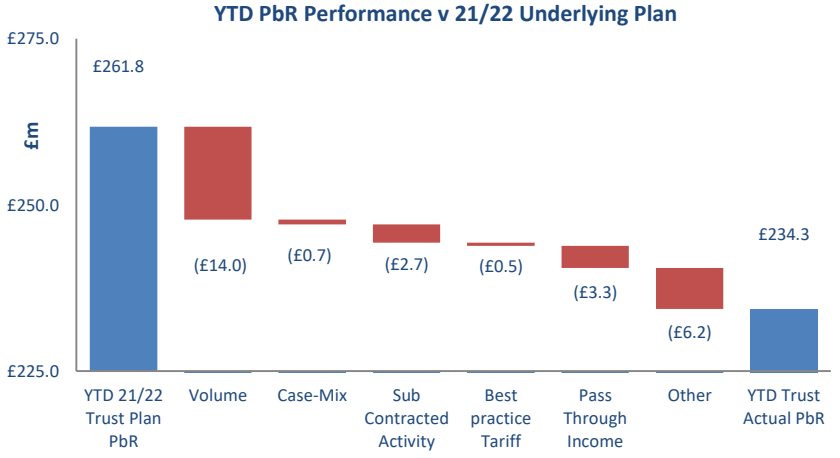
Despite being block funded, full contract monitoring processing and reporting is still being completed so that true levels of activity and income can be understood – i.e. had the Trust been paid on a Payment by Results (PbR) basis. Currently these figures are based on a mixture of the 2021/22 Consultation Tariffs and in the absence of negotiations with Commissioners, some assumptions around locally agreed pricing. A clinical income 'Base Plan' for 2021/22 has been derived from the 2020/21 draft annual plan, with some known changes reflected. A tariff inflator assumption of +1.4% has been used and demographic growth assumptions of +0.54% (based on expected population increase from ONS stats).

It must be noted the graphs opposite do not include Acute Service Integration (ASI) performance, and the activity graphs on the following slides do not include activity undertaken in the independent sector i.e. only illustrate NNUH activity. The graphs opposite shows that 'actual' performance would be below the base plan for September 2021, and 2021/22 year to date (Apr to Sep). The variance to plan remains much improved from that seen in 2020/21 to date. The case-mix variance is provided for illustrative purposes, but it is currently very difficult to forecast what actual case-mix will be with varying priorities and factors associated with recovery causing the case-mix to be different to what was seen prior to the start of the COVID pandemic. A planned change in recording of CAU from 1st July 2021 activity also reduces the calculated non-elective income, distorting the figures.

Elective Recovery Fund

Calculations have been undertaken based on NNUH performance against the NHSE requirements which indicate that there is the potential for additional funds to be received, estimates are for April, May and June are £2.4m, £2.5m and £1.1m respectively. Figures have been validated with system colleagues. It must be noted that this is subject to system wide performance and NHSE/I sign-off before figures are finalised. The change in requirement to achieve 95% of 2019 levels from 1st July 2021 mean expectations for no additional funding in July, August and September.





Norfolk and Norwich University Hospitals NHS Foundation Trust

6.2 Activity - POD

Activity in the first half of 2021/22 is to be measured against 2019/20 base-line, with expectations set by NHSE as a percentage of 2019/20 levels (adjusted for working days) Starting with 70% target in April rising by 5% each month, with 85% being highest target. The Trust has developed its own recovery plan. Actual results to be measured against both, with comparisons to 2019/20 and 2020/21 activity levels also provided for info.

Day Case & Elective Inpatient Spells

Provisional figures for September indicate that Day Case activity levels will exceed both NHSE expectations, and the Trust's recovery plan. Medical and Women & Children Divisions exceeded the NHSE activity targets, but Surgical Division fell short of the NHSE target. The graph opposite does however reflect that activity levels continue to fall short of those in 2019/20.

The number of Elective Inpatient spells however does remain much lower than that seen in 2019/20 being 77% of 2019/20, only Women & Children Division exceeded the 85% target for September.

In terms of the Trust's own activity plan, we continue to see over performance in Day Case activity, Elective Inpatient returned to exceeding the plan after under performance in August.

Outpatient Activity

Provisional figures for September indicate that outpatient activity levels will exceed the NHSE expectations (85%), including the target for attendances at which a procedure is undertaken.

Appointments with a procedure are expected to be 92% of 2019/20 levels. New attendances, without a procedure however are only expected to achieve 86% of 2019/20 levels and Follow Up 94%.

Strong performances seen in General Surgery, Urology and Cardiology. ENT did see a much improved month, particularly with New appointments. Ophthalmology is seeing mixed results with over performance expected for attendances where a procedure is undertaken, but under performance in general attendances (it should be noted Ophthalmology is also undertaking activity in the independent sector not reflected in these graphs).

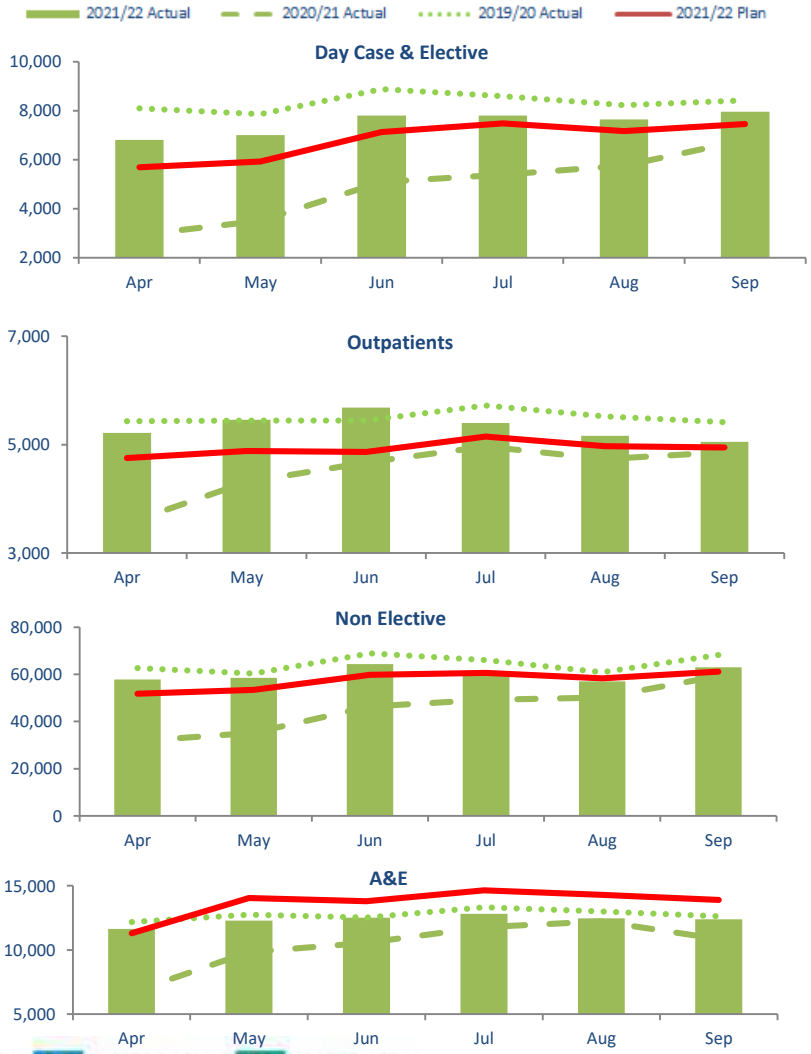
Non Elective Spells (Including Maternity)

It can be seen from the graph opposite that non elective activity has increased from that seen in 2020/21. The graph shows that activity in May and June exceeded that seen in 2019, but July, August and September have seen less activity than in 2019. Activity levels overall continue to be in line with the monthly average seen in 2019, but like-for-like comparisons are not straight forward because of recording changes.

When comparing non-elective spell count in July 2021 to that seen in 2019/20 it is noticeable that Women & Children division is seeing a significant increase on 2019/20 levels. It should be noted that figures for Women & Children Division include CAU activity now recorded as Same Day Emergency Care (SDEC) activity, previously recorded as non-elective.

A&E (Emergency Department

A&E activity levels in September 2021 actually reduced from that seen in August 2021, reducing further from the level seen in July 2021. Prior to that A&E attendances had been on an upward trend. The Trust's recovery plan for A&E shows an expected increase in activity from May onwards, with expectations of increase in attendances as COVID lockdown restrictions are eased. However, the level of activity so far in 2021/22 has not been as high as expected.



Norfolk and Norwich University Hospitals NHS Foundation Trust

7. CIP

Year to date the Trust has delivered £6.4m of CIPs against a budgeted plan of £3.5m, a positive variance of £2.9m, comprised of: a planning variance of nil; and a performance variance of £2.9m. This has arisen through accelerated delivery of additional CIP above budgeted plan offset by adverse performance in pay and discretionary spend initiatives. The risk adjusted forecast outturn CIP delivery is currently £13.4m against a CIP target of £26.4m presenting a significant risk to achievement of the target.

FY21/22 CIP Performance:

YTD the Trust has delivered £6.4m of CIPs against a budgeted plan of £3.5m, a positive variance of £2.9m, comprised of:

- A planning variance of nil; and
- A performance variance of £2.9m, see bridge below. This has arisen through:
  - £2.6m of accelerated CIP delivery above budgeted plan;
  - £0.8m of additional delivery through schemes developed since finalising budgeted plan;
  - Offset by £0.5m of adverse performance against budgeted schemes across pay and discretionary spend initiatives.

The risk adjusted forecast outturn CIP delivery for FY21/22 is currently calculated as £13.8m based on the latest forecast financial performance of Gateway 2 schemes, progress against milestone delivery and performance against quality and performance indicators.

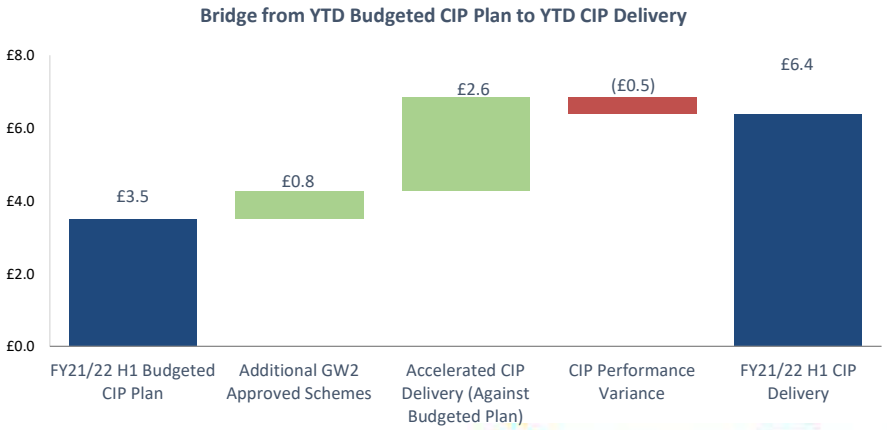
FY21/22 CIP Plan Development

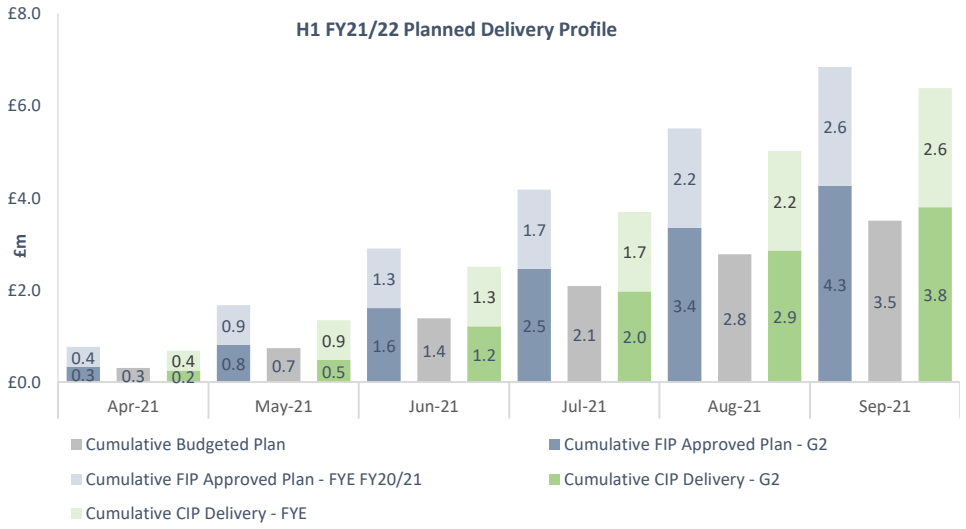
Due to the significant planning risk surrounding the efficiency programme as the Trust continues to develop plans, a CIP hedge of £13.8m has been offset against the £26.4m programme within the annual plan (Cycle 4).

As at 18 October 2021, the programme consists of £10.9m of Gateway 2 approved schemes; £5.2m of FYE of FY20/21 schemes; £2.8m of Gateway 1 approved schemes, which are being reviewed and developed to be progressed or removed from the programme; and £0.7m of schemes within the CIP development pipeline (Gateway 0).

The initiatives that comprise these values are subject to revision as a result of any revisions to planning guidance or national priorities.

FY21/22 CIP Plan - Divisional Breakdown	FY21/22 Indicative Target £m	FY21/22 FIP Board Approved £m	FYE FY20/21 £m	Gap £m	FY21/22 RAG Adj. Forecast Delivery £m	Gap £m
Medicine	7.2	6.0	2.4	1.2	7.3	0.1
Surgery	8.7	2.6	1.7	(4.4)	3.8	(4.9)
Women's & Children's	2.7	0.6	0.2	(1.9)	0.6	(2.1)
CSS	4.1	0.6	0.5	(3.0)	1.0	(3.1)
Corporate	3.7	1.2	0.3	(2.2)	1.2	(2.5)
Total	26.4	11.0	5.1	(10.3)	13.8	(12.6)





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Norfolk and Norwich University Hospitals NHS Foundation Trust

8.1 Capital

Introduction and Background

This report provides an update on the delivery of the Trust's capital programme as at 30 September 2021. Performance in this report is monitored against the latest approved internal plan, which is the plan including variations approved by the Capital and Estates Committee.

Year-to-date performance – 30 September 2021

Year-to-date as at M6, the Trust has underspent against plan by £5.5m (17%). This significant underspend is caused by an increasing number of schemes missing planned milestones that were set out in M2. This level of expenditure is £8.6m adverse to the original April 2021 plan submission.

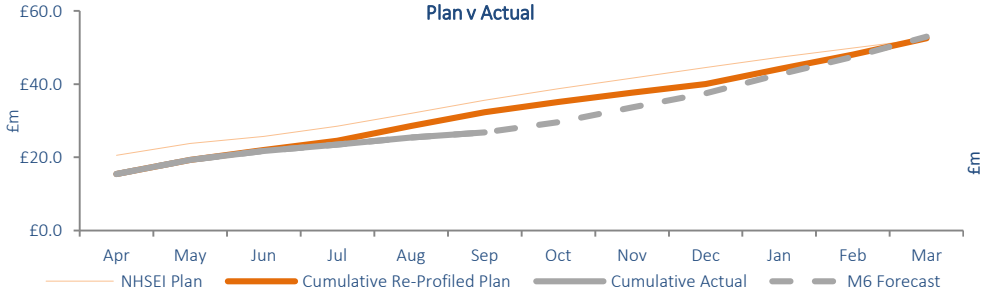
The schemes driving the YTD variance are: theatres refurbishment £1.7m, equipment replacement £1.5m, Digital Aspirant £0.5m, UEC £0.4m, Boudicca £0.4m and EDMS £0.3m.

Forecast Outturn

The significant year-to-date underspend, overall lack of reliability in forecast milestone achievement, and the increasing number of risks to delivery at scheme level places the forecast outturn at high risk. Management action is required in several areas to reduce delivery risk.

The current formal forecast outturn is to deliver an outturn of £52.931m (increased from the previous month), against the latest plan of £52.489m. The increase is for technical reasons driven by the inclusion of £0.4m of DHSC donated COVID assets, and is fully offset by additional technical funding sources.

YTD NHSEI Plan £'000	YTD Actual £'000	YTD Variance £'000	YTD Re-profiled Plan £'000	YTD Actual £'000	YTD Variance £'000	FY NHSEI Plan £'000	FY OT £'000	FY Variance £'000
35,610	26,847	(8,763)	32,314	26,847	(5,467)	52,371	52,931	560



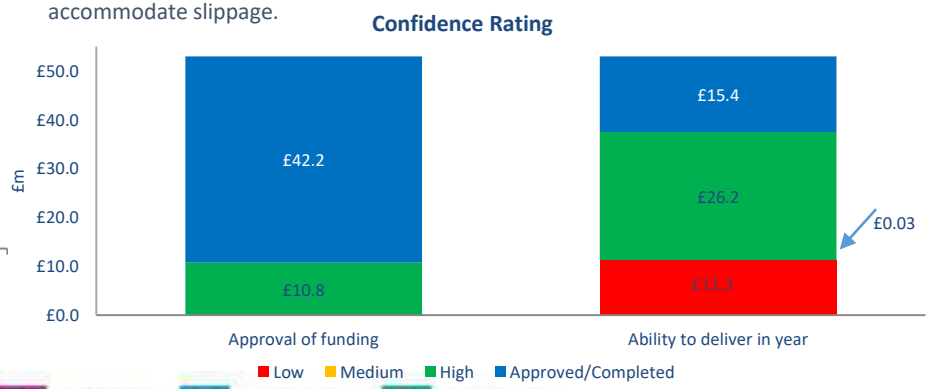
The level of risk to the programme remains high and further management action is required to mitigate these risks

While funding availability is no longer considered a significant risk to the programme, there is increased risk of not being able to deliver the programme by year end.

The chart below provides details of confidence ratings for delivery across two domains:
An assessment based on **availability of funding**:
£42.2m has been approved (increased by £0.4m from last month due to DHSC donated COVID assets), which includes internally generated funding and the distress PDC already secured. £3.8m is yet to be approved for Digital Aspirant; this is risk rated as high confidence of approval as the Trust has agreed the LOA. The remaining £7m is yet to be approved and is also risk rated a high confidence of approval. This includes £6.3m of distress funding, being £3.2m carried forward from 20/21 and £3.1m for new funding. In July, it was agreed with NHSEI that the Trust will use its existing cash reserves to fund those schemes at risk. The £7m also includes £0.6m of DAC PDC for FBC development. This is unchanged from the previous month.

An assessment based on the **internal ability to deliver:**
At present, five schemes have a low deliverability rating (four last month), and one scheme has a medium deliverability rating (two last month). The five schemes with low deliverability rating are Elective Infrastructure – Build £4.0m, Elective Infrastructure – Equipment £2.3m, Electrical Upgrade £1.0m, Digital Aspirant £3.8m and Ward Bay Doors £0.1m. The scheme risk rated medium is CBCT Enabling Works £0.03m.

Both assessments are against the risk of failing to deliver the programme by year end. For H2, given the significant distance from plan during H1, the risk assessment will be updated to assess the risk of in-year delivery as well as outturn.
Failure to deliver the planned 21/22 programme will directly impact future years' capital programmes, as investment planned in future years will need to be curtailed to accommodate slippage.



Norfolk and Norwich University Hospitals NHS Foundation Trust

9.1 Statement of Comprehensive Income

The year to date position on a control total basis as at September 2021 is a surplus of £7.1m. This is a £7.1m favourable variance to the breakeven plan. The favourable variance of £7.1m is made up of an underspend in Pay of £3.5m, clinical income of £2.9m and depreciation of £1.1m. £3.4m of out of system COVID expenditure is offset by £3.4m of income. The headline surplus which includes donated income of £2.5m and donated asset depreciation of £0.9m is £8.8m.

	In Month Month 6 - August 2022			Year to Date		
	Actual £m	Trust Plan £m	Variance £m	Actual £m	Trust Plan £m	Variance £m
Clinical Income	47.7	47.0	0.7	285.2	282.3	2.9
NT Drugs Income	1.9	0.9	1.0	9.6	5.6	4.0
Total Clinical Income	**49.6**	**48.0**	**1.7**	**294.8**	**287.8**	**6.9**
Other Income Incl. Non NHS Clinical Income	25.7	24.1	1.5	113.9	113.5	0.4
Total Operating Income	**75.3**	**72.1**	**3.2**	**408.7**	**401.4**	**7.3**
Medical Staff	(13.1)	(12.1)	(1.0)	(70.6)	(66.7)	(3.9)
Nursing	(15.6)	(16.0)	0.4	(83.5)	(85.3)	1.8
A&C	(4.9)	(5.0)	0.1	(25.5)	(26.7)	1.2
Other Staffing Groups	(7.1)	(7.4)	0.3	(37.9)	(39.4)	1.6
Other Employee Expenses	(0.3)	(0.9)	0.6	(1.5)	(4.4)	2.9
Total Employee Expenses	**(41.0)**	**(41.4)**	**0.4**	**(219.0)**	**(222.5)**	**3.5**
Drugs Costs	(8.1)	(6.9)	(1.2)	(46.7)	(41.6)	(5.1)
Clinical Supplies	(7.0)	(7.0)	(0.0)	(39.5)	(40.3)	0.9
Non Clinical Supplies	(11.1)	(9.8)	(1.3)	(54.3)	(54.3)	(0.0)
PFI	(2.6)	(2.2)	(0.4)	(13.8)	(13.4)	(0.5)
Total Expenditure Excl. Employee Expenses	**(28.8)**	**(25.9)**	**(2.9)**	**(154.4)**	**(149.6)**	**(4.8)**
Total Operating Expenditure	**(69.9)**	**(67.4)**	**(2.5)**	**(373.4)**	**(372.1)**	**(1.3)**
Total Operating Surplus/(Deficit)	**5.4**	**4.7**	**0.7**	**35.3**	**29.2**	**6.0**
Total Non Operating Expenditure	(4.7)	(5.1)	0.4	(28.1)	(29.2)	1.1
Total Surplus/(Deficit)	**0.7**	**(0.4)**	**1.1**	**7.1**	**0.0**	**7.1**
COVID (Out of System) Income	0.6	0.0	0.6	3.4	0.0	3.4
COVID (Out of System) Expenditure	(0.6)	0.0	(0.6)	(3.4)	0.0	(3.4)
Total Surplus / (Deficit)	**0.7**	**(0.4)**	**1.1**	**7.1**	**0.0**	**7.1**
Control Total Adjustments						
Donated Income & Equipment	0.6	0.1	0.5	2.5	2.7	(0.2)
Donated Assets Dep'n	(0.2)	(0.1)	(0.1)	(0.9)	(0.5)	(0.3)
Headline Surplus / (Deficit)	**1.1**	**(0.4)**	**1.5**	**8.8**	**2.2**	**6.6**
NHSEI Adjustments						
Donated Income & Equipment	(0.6)	(0.1)	(0.5)	(2.5)	(2.7)	0.2
Donated Assets Dep'n	0.2	0.1	0.1	0.9	0.5	0.3
Provider Top Up Funding	0.0	0.6	(0.6)	0.0	3.4	(3.4)
System Envelope Planning Adjustment	0.0	(3.4)	3.4	0.0	(3.4)	3.4
Adjusted Financial Performance Surplus/(Deficit) (NHSEI Reporting)	**0.7**	**(3.2)**	**3.9**	**7.1**	**0.0**	**7.1**

Norfolk and Norwich University Hospitals NHS Foundation Trust

9.2 Pay Expenditure

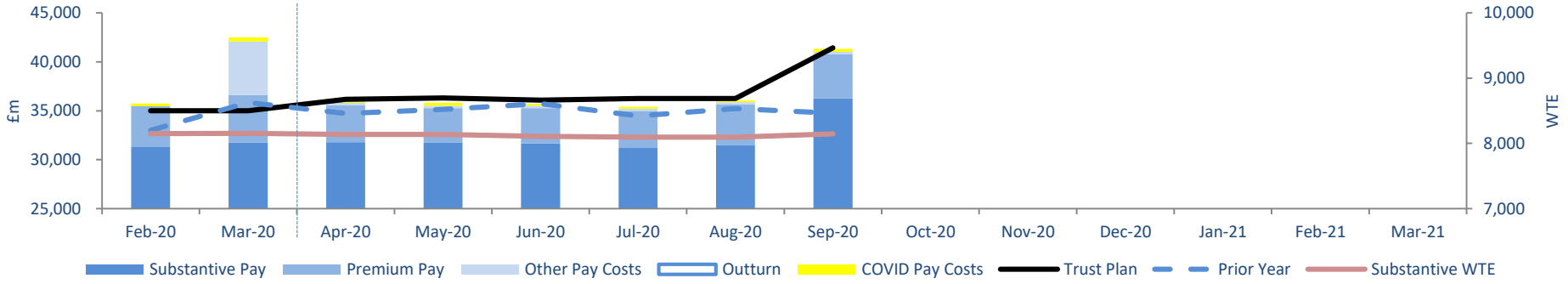
Year to date expenditure is £219.0m, a favourable position to plan of £3.5m. This is predominantly as a result of vacancies against establishment in CSS (£2.9m). £5.2m was paid in September relating to the national 3% pay award and is fully matched by additional income.

Pay Expenditure (Excl. Out of System COVID)	Feb-21 £m	Mar-21 £m	Apr-21 £m	May-21 £m	Jun-21 £m	Jul-21 £m	Aug-21 £m	Sep-21 £m	FY £m
Substantive staff	**31.3**	**31.8**	**31.8**	**31.7**	**31.7**	**31.2**	**31.5**	**36.3**	**194.2**
Medical Internal Locum Staff	1.2	1.6	1.0	1.0	0.6	0.8	0.8	0.9	5.1
Medical External Locum Staff	0.2	0.2	0.1	0.1	0.2	0.2	0.2	0.2	1.0
Additional Medical Sessions	0.5	0.4	0.3	0.5	0.5	0.6	0.7	0.8	3.3
Nursing Bank Staff	1.2	1.5	1.3	0.0	0.0	0.0	0.0	0.0	1.3
Nursing Agency Staff	0.1	0.1	0.1	0.0	0.0	0.0	0.0	0.0	0.1
Nursing Overtime	0.3	0.2	0.4	0.2	0.3	0.3	0.4	0.4	
Other Bank (AHPs/A&C)	0.2	0.3	0.2	1.4	1.4	1.5	1.6	1.7	7.7
Other Agency (AHPs/A&C)	0.2	0.5	0.2	0.3	0.4	0.4	0.3	0.4	2.0
Other Overtime (AHPs/A&C)	0.2	0.2	0.1	0.1	0.2	0.1	0.2	0.2	0.9
Premium Pay	**4.2**	**4.8**	**3.8**	**3.5**	**3.6**	**3.8**	**4.1**	**4.5**	**23.3**
Total Direct Pay Costs	**35.5**	**36.6**	**35.6**	**35.3**	**35.3**	**35.0**	**35.6**	**40.8**	**217.5**
Redundancy	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Apprenticeship Levy	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.2	0.9
Local CEA	(0.2)	0.4	0.1	0.1	0.1	0.1	0.1	0.1	0.6
Annual Leave, Flowers & Other	0.0	4.8	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total Other Pay Costs	**(0.1)**	**5.3**	**0.2**	**0.3**	**0.3**	**0.2**	**0.2**	**0.3**	**1.5**
Total Pay Costs - Actual	**35.4**	**41.9**	**35.8**	**35.5**	**35.5**	**35.2**	**35.9**	**41.0**	**218.9**
Total Pay Costs - Plan	**35.9**	**35.9**	**36.2**	**36.3**	**36.1**	**36.3**	**36.3**	**41.4**	**222.5**
Favourable / (Adverse) v Plan	**0.5**	**(6.0)**	**0.3**	**0.8**	**0.6**	**1.0**	**0.4**	**0.4**	**3.5**

Substantive WTE	Feb-21 WTE	Mar-21 WTE	Apr-21 WTE	May-21 WTE	Jun-21 WTE	Jul-21 WTE	Aug-21 WTE	Sep-21 WTE	Mar-22 WTE
A&C	1,566	1,566	1,563	1,564	1,569	1,568	1,577	1,583	
Medical	1,175	1,169	1,181	1,173	1,170	1,166	1,168	1,195	
Nursing	3,703	3,711	3,691	3,693	3,678	3,686	3,666	3,666	
Other	1,707	1,706	1,702	1,706	1,691	1,678	1,683	1,703	
Total	**8,151**	**8,152**	**8,136**	**8,136**	**8,109**	**8,097**	**8,095**	**8,147**	

Premium Source (Excl. Out of System COVID) YTD			Total Trust Total £m	Premium Cost* £m
Medical	**Source**	Internal Locum	5.1	*1.0*
		External Locum	1.0	*0.5*
		WLI/NAG	3.3	*1.6*
		Total	**9.4**	***3.2***
Nursing	**Source**	Bank	7.6	*0.0*
		Overtime	1.9	*0.6*
		Agency	0.7	*0.2*
		Total	**10.2**	***0.8***
A&C & Other	**Source**	Bank	1.4	*0.0*
		Overtime	0.9	*0.3*
		Agency	1.4	*0.3*
		Total	**3.7**	***0.6***
Total	**Source**	Bank/Internal Locum	14.1	*1.0*
		Overtime	2.8	*0.9*
		Agency/External Locum	3.2	*1.0*
		WLI/NAG	3.3	*1.6*
		Total	**23.3**	***4.6***

** Incremental cost of premium staff over substantive staff*



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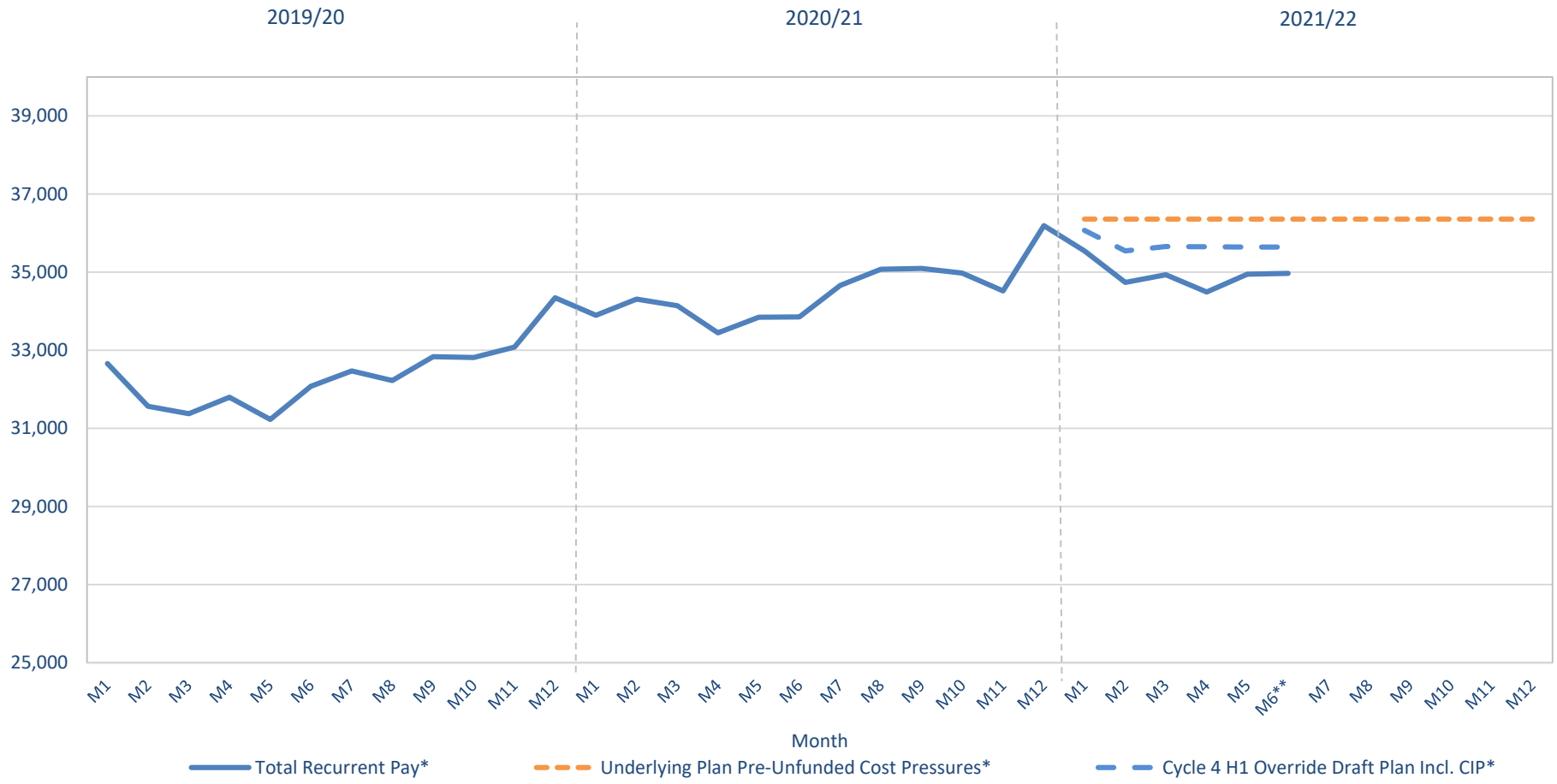
9.3 Pay Expenditure Run Rate

Pay expenditure run rate is favourable to both the Underlying Plan and Cycle 4 H1 plan for H1. Since May pay has returned to similar levels seen through H2 2020/21 after slight increases in March 2021 and April 2021.

Pay Expenditure Actual Run Rate FY19/20 to date Compared To Underlying Plan FY21/22 and Cycle 4 H1 Draft Budget*



*Excludes all COVID expenditure
**Excludes £5.2m for H1 3% Pay Increase

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9.4 Statement of Financial Position

The Statement of Financial Position at the end of September has increased by £12.9m compared to the opening balance, this reflects the £7.1m surplus to date on a control total basis, in addition to £1.7m of donated asset additions & depreciation, together with £4.1m of capital funding via PDC.

Property, plant and equipment
This balance is £16.5m higher than the opening balance. The key items are capital expenditure of £12.2m offset in part by depreciation of £10.3m, together with a £14.7m transfer from trade and other receivables relating to the capitalisation of a lifecycle maintenance prepayment.

Trade and Other Receivables – non current
This balance is £15.4m lower than the opening balance, with the key item being a transfer of £14.7m to PPE for the capitalisation of a lifecycle maintenance prepayment.

Trade and Other Receivables - current
This balance is £8.9m higher than the opening balance. The key items are £1.4m of prepayments for CNST and £3.4m of IT prepayments.

Cash
This is £4.3m lower than the opening balance. The key reasons are a reduction in capital creditors and capital accruals of £5.0m, together with other working capital movements - in particular a reduction in trade payables of £17.4m offset in part by an increase in accruals of £15.1m.

Trade and other payables
This is £5.7m lower than the opening balance. The key reason is the settlement of 2 credit notes (totalling £15.3m) raised to N&W CCG relating to repatriation of COVID unspent funds and a regional true-up of resources. This is offset in part by a reduction in capital creditors and accruals of £5.0m.

Provisions
This balance is £2.8m higher than the opening balance. The key reason is a reclassification of £3.2m relating to VAT reclaims offset in part by a £1.5m reduction in the provision required relating to the Clinicians Pension Tax Scheme from 2019/20.

Borrowings
The £2.3m decrease in non-current borrowings relates to capital repayment for the PFI contract.

Deferred Income
This balance is £0.9m lower than the opening balance. This is due to a reclassification of £3.2m relating to VAT reclaims, offset by £1.1m of cancer transformation funding, £0.2m relating to research posts, and £0.3m of funding relating to the Ockenden maternity report and £0.8m of devices.

September 2021	Actual Mar-21 £m	Actual Sep-21 £m	Movement £m	Prior Month £m
Property, plant and equipment	349.0	365.5	16.5	365.9
Trade and other receivables	62.5	47.1	(15.4)	48.5
Total non-current assets	**411.5**	**412.6**	**1.1**	**414.4**
Inventories	13.1	14.2	1.1	13.6
Trade and other receivables	31.3	40.2	8.9	37.3
Cash and cash equivalents	68.9	64.6	(4.3)	66.6
Total Current assets	**113.3**	**119.0**	**5.7**	**117.5**
Trade and other payables	(114.3)	(108.6)	5.7	(105.8)
Borrowings - PFI & Finance Lease	(5.0)	(5.0)	0.0	(5.0)
Provisions	(0.5)	(0.3)	0.2	(4.1)
Deferred Income	(15.8)	(18.9)	(3.1)	(21.5)
Total current liabilities	**(135.6)**	**(132.8)**	**2.8**	**(136.4)**
Total assets less current liabilities	**389.2**	**398.8**	**9.6**	**395.5**
Borrowings - PFI & Finance Lease	(182.4)	(180.1)	2.3	(180.5)
Borrowings - Revenue Support	0.0	0.0	0.0	0.0
Provisions	(4.8)	(7.8)	(3.0)	(5.3)
Deferred Income	(5.3)	(1.3)	4.0	(1.2)
Total non-current liabilities	**(192.5)**	**(189.2)**	**3.3**	**(187.0)**
Total assets employed	**196.7**	**209.6**	**12.9**	**208.5**
Financed by				
Public dividend capital	290.7	294.8	4.1	294.8
Retained Earnings (Accumulated Losses)	(121.1)	(112.0)	9.1	(113.2)
Revaluation reserve	27.1	26.8	(0.3)	26.8
Total Taxpayers' and others' equity	**196.7**	**209.6**	**12.9**	**208.4**

Norfolk and Norwich University Hospitals NHS Foundation Trust

Appendix

Appendix A – System Financial Position

Year to Date (M6) N&WHCP is reporting a surplus of £3.4m against a planned surplus of £0.1m, £3.3m favourable to plan.

	Year to Date			Forecast Outturn April 2021 - September 2021		
	Actual £m	Plan £m	Variance £m	Actual £m	Plan £m	Variance £m
JPUH	0.8	0.0	0.8	0.8	0.0	0.8
NNUH	7.1	0.0	7.1	7.1	0.0	7.1
NSFT	0.6	0.0	0.6	0.6	0.0	0.6
NCHC	0.7	0.1	0.7	0.7	0.1	0.7
QEHKL	0.1	0.0	0.1	0.1	0.0	0.1
Sub Total - Providers	**9.3**	**0.1**	**9.2**	**9.3**	**0.1**	**9.2**
N&W CCG	(13.3)	0.0	(13.3)	(13.3)	0.0	(13.3)
Reimbursement Due - HDP	6.8	0.0	6.8	6.8	0.0	6.8
Adjustments - Other	0.6	0.0	0.6	0.6	0.0	0.6
Sub Total - CCG	**(5.9)**	**0.0**	**(5.9)**	**(5.9)**	**0.0**	**(5.9)**
Total N&WHCP	**3.4**	**0.1**	**3.3**	**3.4**	**0.1**	**3.3**

Appendix B – Corporate Reserve

The H1 plan included £0.5m of corporate reserves of which £0.4m has been assigned leaving £0.1m unallocated. The underlying position included £1.0m of corporate reserves of which £0.8m has been assigned recurrently leaving £0.2m unallocated.

	Receiving Division / Department	H1 Plan £k	Underlying Position £k
Opening Plan		**0.50**	**1.00**
Nurse Roster Rebasing	ALL / Nursing	(0.22)	(0.45)
HR Resourcing - Priorities	Corporate / HR	(0.08)	(0.16)
Sustainability Plan	Corporate / Trust Management	(0.04)	0.00
Intranet	Corporate / Communications	(0.06)	(0.06)
Anti-racism strategy	Corporate / Trust Management	(0.01)	0.00
Hard FM Costs	Corporate / Facilities	(0.06)	(0.13)
Latest Plan / Remaining Budget		**0.03**	**0.21**

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

REPORT TO THE TRUST BOARD			
Date	**3 November 2021**		
Title	**Use of Resources Update**		
Author & Exec lead	**Rob Marshall (Associate Director of Finance) and Roy Clarke (Chief Finance Officer)**		
Purpose	**For Information**		
Relevant Strategic Objective	**5. To deliver our financial plan and recovery programme, supporting the Trust's return to financial sustainability**		
Are there any quality, operational, workforce or financial implications of the decision requested by this report? If so explain where these are/will be addressed.	**Quality**	**Yes☐ No✓**	
	Operational	**Yes☐ No✓**	
	Workforce	**Yes☐ No✓**	
	Financial	**Yes☐ No✓**	

1. Background/Context

The Use of Resources Response paper acknowledged the outcome of the CQC Use of Resources review and provided an overview of the Trust's planned response both in relation to the recommendations raised and the wider, more strategic actions to be delivered.

2. Financial Governance Review (FGR)

The independent Financial Governance Review was completed in October 2020, following a detailed factual accuracy review.

The Trust has developed an action plan in response to the recommendations raised within the Financial Governance Review, comprising of 68 individual actions. As at the 30 September 2021, 66 actions have been completed, 27 of which are 'Must Do'; the remaining 2 actions are currently overdue. These actions are being monitored through Hospital Management Board and Finance, Investments & Performance Committee.

A formal review of the progress against the action plan is due to be performed by Internal Audit in mid-October 2021. The revised implementation dates for the two outstanding actions suggest that these will remain overdue at the time of the audit.

3. Financial Strategy

The Trust's Financial Strategy was approved by the Trust Board on 6 October 2021. The strategy provides a clear diagnosis of our current financial position and the historic factors that have driven this and sets out a Trust framework for delivering sustainable financial improvement across three horizons. Board approval of our

Trust's financial strategy is an important milestone in the improvement of our financial performance, providing a roadmap for improving our productivity, efficiency, sustainability and reducing our deficit over the short, medium and long-term.

Board approval of our Trust's financial strategy is an important milestone in the improvement of our financial performance, providing a roadmap for improving our productivity, efficiency, sustainability and reducing our deficit over the short, medium and long-term. The Trust will now work with system partners to create a wider system financial strategy, ahead of approval of the strategy by both the ICS and NHSE/I. Alongside this the Trust can move into more detailed planning for delivery, which will involve all areas of the organisation as well as our system partners.

4. UoR Annual Assessment

The Trust has undertaken an annual review of its Use of Resources against the national framework (KLOEs), including a review of the latest Model Hospital data. This was presented to HMB on 1st June 2021. The review identified two key recommendations:

- Targeted change programmes around identified opportunity themes should be developed and incorporated into the Financial Strategy, with delivery overseen by the Transformation Steering Group; and
- The Use of Resources Tactical Action Plan should be refreshed to reflect the findings and reset delivery expectations.

Following the approval of the Trust's Financial Strategy by the Board, the Use of Resources Tactical Action Plan will be refreshed to incorporate the strategic initiatives and other opportunity themes. This will be completed by 31 November 2021.

5. Tactical Action Plan Update

The next Evidence Group Deep Dive will be held on the 15th October 2021. The meeting will aim to continue to provide support and challenge to delivery leads and monitor progress against the individual recommendations that comprise the Tactical Action Plan. Three recommendations, in relation to workforce, UoR 12, UoR 14 and UoR 15 remain within formal SRO Intervention. There is now a plan for all three of the recommendations to be removed from SRO Intervention by October 2021.

As at 30 September 2021, the position shows that of the 303 individual actions within the Tactical Action Plan 252 have been completed; 36 are currently on track; 1 action is overdue by less than 30 days and 14 have become overdue by greater than 30 days. **The overdue actions have been followed up with the responsible officers and the current status understood, see *Section 4.***

6. Getting It Right First Time (GIRFT)

The only planned GIRFT visit is the Deep Dive with Cardiothoracic taking place in December 2021. The Baseline assessment against GIRFT toolkit has now been completed.

Recommendation:

The Board is recommended to NOTE the contents of the report.

Norfolk and Norwich University Hospitals NHS Foundation Trust

Use of Resources Update

Report to Trust Board

3 November 2021

Norfolk and Norwich University Hospitals NHS Foundation Trust

1. Executive Summary

This paper provides an update on the progress against the strategic enablers and an updated position for the Tactical Action Plan, including an update on the performance against GIRFT recommendations.

Financial Governance Review (FGR)

The independent Financial Governance Review was completed in October 2020, following a detailed factual accuracy review.

The Trust has developed an action plan in response to the recommendations raised within the Financial Governance Review, comprising of 68 individual actions. As at the 30 September 2021, 66 actions have been completed, 27 of which are 'Must Do'; the remaining 2 actions are currently overdue. These actions are being monitored through Hospital Management Board and Finance, Investments & Performance Committee.

A formal review of the progress against the action plan is due to be performed by Internal Audit in mid-October 2021. The revised implementation dates for the two outstanding actions suggest that these will remain overdue at the time of the audit.

Financial Strategy

The Trust's Financial Strategy was approved by the Trust Board on 6 October 2021. The strategy provides a clear diagnosis of our current financial position and the historic factors that have driven this and sets out a Trust framework for delivering sustainable financial improvement across three horizons. Board approval of our Trust's financial strategy is an important milestone in the improvement of our financial performance, providing a roadmap for improving our productivity, efficiency, sustainability and reducing our deficit over the short, medium and long-term.

Board approval of our Trust's financial strategy is an important milestone in the improvement of our financial performance, providing a roadmap for improving our productivity, efficiency, sustainability and reducing our deficit over the short, medium and long-term.

The Trust will now work with system partners to create a wider system financial strategy, ahead of approval of the strategy by both the ICS and NHSE/I. Alongside this the Trust can move into more detailed planning for delivery, which will involve all areas of the organisation as well as our system partners.

Annual Review of Use of Resources

The Trust has undertaken an annual review of its Use of Resources against the national framework (KLOEs), including a review of the latest Model Hospital data.

The review identified two key recommendations:

1. **Targeted change programmes around identified opportunity themes should be developed and incorporated into the Financial Strategy, with delivery overseen by the Transformation Steering Group; and**
2. **The Use of Resources Tactical Action Plan should be refreshed to reflect the findings and reset delivery expectations.**

Following the approval of the Trust's Financial Strategy by the Board, the Use of Resources Tactical Action Plan will be refreshed to incorporate the strategic initiatives and other opportunity themes. This will be completed by 31 November 2021.

Tactical Action Plan Update

The next Evidence Group Deep Dive will be held on the 15th October 2021. The meeting will aim to continue to provide support and challenge to delivery leads and monitor progress against the individual recommendations that comprise the Tactical Action Plan. Three recommendations, in relation to workforce, UoR 12, UoR 14 and UoR 15 remain within formal SRO Intervention.

Two Change Control Requests (UoR 13 and UoR 15) are due to be presented at the Evidence Group. These will be embedded into the programme ahead of the next report, where applicable.

As at 30 September 2021, the position shows that of the 303 individual actions within the Tactical Action Plan: 252 have been completed; 36 are currently on track; 1 action is overdue by less than 30 days and 14 have become overdue by greater than 30 days. **The overdue actions have been followed up with the responsible officers and the current status understood, see *Section 4.***

Getting It Right First Time (GIRFT)

The only planned GIRFT visit is the Deep Dive with Cardiothoracic taking place in December 2021. The Baseline assessment against GIRFT toolkit has now been completed.

To improve performance the following action has been identified:

- Add new recommendations from 18 national reports to Master spreadsheet; and
- Provide additional support to divisions on Future NHS Workspace.

Norfolk and Norwich University Hospitals NHS Foundation Trust

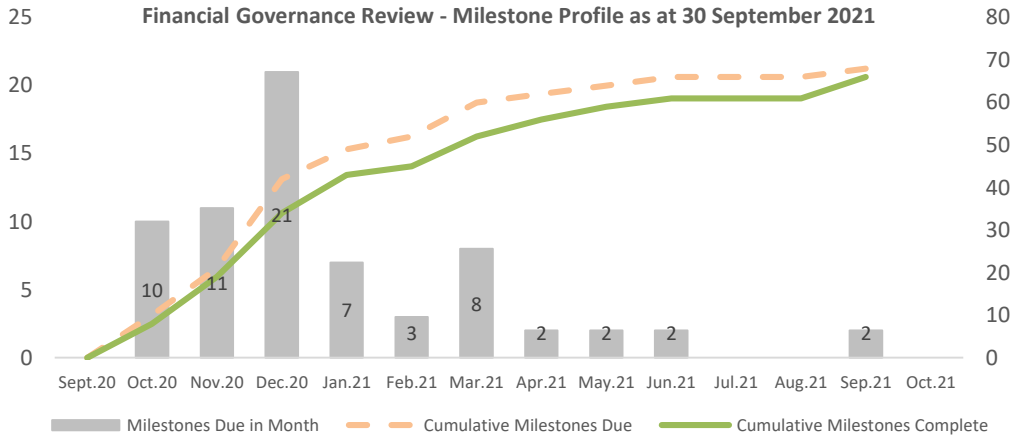
2. Financial Governance Review – Action Plan Progress

The Trust has developed an action plan in response to the recommendations raised within the Financial Governance Review, comprising of 68 individual actions. As at the 30 September 2021, 66 actions have been completed, 27 of which are 'Must Do'; the remaining 2 actions are currently overdue. These actions are being monitored through Hospital Management Board and Finance, Investments & Performance Committee.

The independent Financial Governance Review was completed in October 2020, following a detailed factual accuracy review. The FGR identified 53 recommendations, 23 of which were designated as 'Must Do' and 30 as 'Should Do'. This has led to the development of an FGR action plan consisting of 65 actions for completion (now 68 due to Change Control).

As at 30 September 2021, 66 actions have been completed, two are on track and the remaining 2 remain overdue (see table in Section 2a). The overdue actions continue to be monitored through Hospital Management Board.

A formal review of the progress against the action plan is due to be performed by Internal Audit in mid October 2021. The revised implementation dates for the two outstanding actions suggest that these will remain overdue at the time of the audit.



Financial Domain		Position as at 30 September 2021					Position as at 31 August 2021				
		Blue	Green	Amber	Red	Total	Blue	Green	Amber	Red	Total
Financial Planning & Budgeting	Must Do	9	0	0	1	**10**	7	1	0	2	**10**
	Should Do	9	0	0	0	**9**	8	1	0	0	**9**
Culture of Financial Sustainability	Must Do	3	0	0	0	**3**	3	0	0	0	**3**
	Should Do	9	0	0	0	**9**	9	0	0	0	**9**
Financial Reporting	Must Do	0	0	0	0	**0**	0	0	0	0	**0**
	Should Do	9	0	0	0	**9**	9	0	0	0	**9**
Framework of Financial Control	Must Do	9	0	0	1	**10**	8	0	0	2	**10**
	Should Do	9	0	0	0	**9**	9	0	0	0	**9**
Investment Decision Making	Must Do	6	0	0	0	**6**	6	0	0	0	**6**
	Should Do	3	0	0	0	**3**	3	0	0	0	**3**
Total		**66**	**0**	**0**	**2**	**68**	**62**	**2**	**0**	**4**	**68**

Norfolk and Norwich University Hospitals NHS Foundation Trust

2a. Financial Governance Review – Overdue Actions

The Trust has developed an action plan in response to the recommendations raised within the Financial Governance Review, comprising of 68 individual actions. As at the 30 September 2021, 66 actions have been completed, 27 of which are 'Must Do'; the remaining 2 actions are currently overdue. These actions are being monitored through Hospital Management Board and Finance, Investments & Performance Committee.

The table below provides an update on the current overdue actions (three as at 30 September 2021) and the identified actions to ensure that these are completed.

Overdue Action	Due Date	Days Overdue	Executive Sponsor	Explanation and Next Steps
4.1 A triangulation exercise will be performed to ensure that agreed establishments are reflected within both ESR and e-Roster. Once completed, the outputs from this exercise will be used in the Trust's annual planning process.	31/10/2020	342	Chief Nurse & Chief People Officer	**Ongoing** – Following the approval of the nursing and midwifery roster rebasing by HMB, the first rosters have now been uploaded to the HealthRoster system and are going through a rigorous quality assurance process. Finance, nursing and rostering teams are working together to ensure that the uploaded roster templates agree to the whole time equivalent resource and the budget agreed for the 2021/22 financial year. Where wards have been reconfigured or adjustments requested to the agreed rosters, papers will be prepared for relevant Boards and individuals to ensure that strong governance is maintained. The remaining rosters will be uploaded upon completion of the quality assurance process and approval of requested amendments. **Proposed Revised Implementation Date:** 30 November 2021
42.3 The outcomes of the workforce management work will be reported through HMB, FI&P Committee and Trust Board	28/02/2021	185	Chief People Officer	**Delayed** – HMB paper was presented regarding Theatre Recruitment Strategy in July. The Divisional Workforce plans were discussed at RRIG in August 2021 and progress monitored in September 2021. These will be presented at People and Culture Committee and HMB in October 2021. **Proposed Revised Implementation Date:** 31 October 2021

Norfolk and Norwich University Hospitals NHS Foundation Trust

3. Financial Strategy

The Trust's Financial Strategy was approved by the Trust Board on 6 October 2021. The strategy provides a clear diagnosis of our current financial position and the historic factors that have driven this and sets out a Trust framework for delivering sustainable financial improvement across three horizons. Board approval of our Trust's financial strategy is an important milestone in the improvement of our financial performance, providing a roadmap for improving our productivity, efficiency, sustainability and reducing our deficit over the short, medium and long-term.

Financial Strategy

After a period of internal development and engagement, the Trust's financial strategy was approved by the Trust Board on 6th October 2021.

The draft financial strategy was considered by HMB, FI&PC and the Trust Board in January 2021. Since the draft was issued, there has been further analysis of financial improvement opportunities and engagement over several months with divisional management and their teams, as well as the Executive Team.

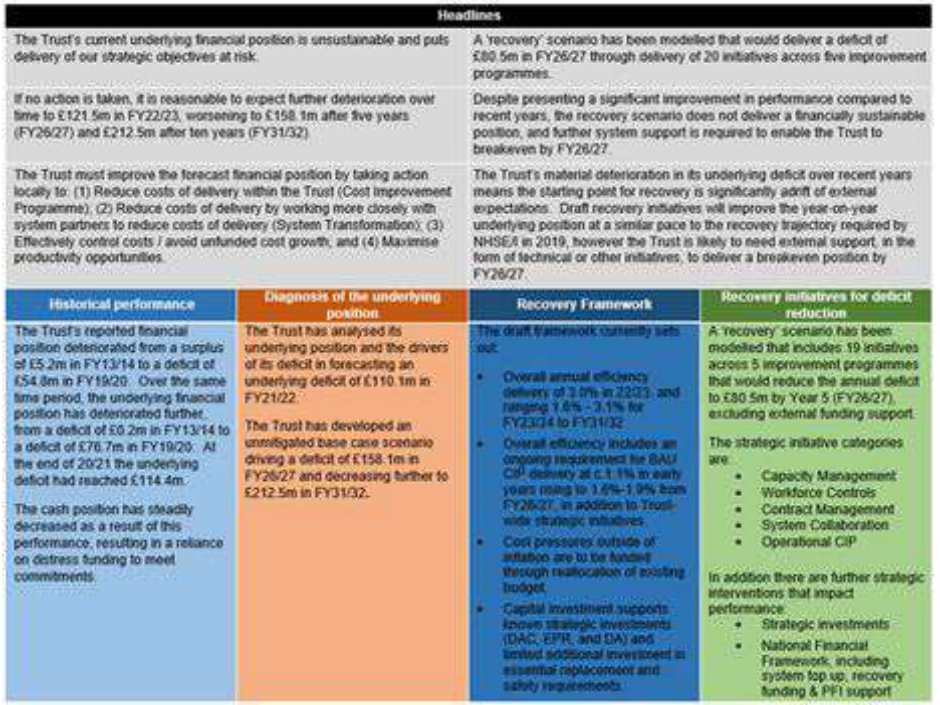
Key themes for improvement were identified through the UoR self-assessment performed in June 2021, and approval was given at this stage to progress with modelling improvement initiatives in accordance with these themes.

The financial strategy provides a clear diagnosis of our current financial position and the historic factors that have driven this. Most importantly, it sets out a Trust framework for delivering a sustainable financial improvement over the short, medium and long term.

The Strategy has been developed using the 7 step methodology set out in NHSE/I's Seven Stage Framework of Strategy Development for Foundation Trusts. The Trust's final Financial Strategy has:

1. Set out the significant financial challenge facing the Trust over the short and medium term (next 1-10 years), as well as a very long term view to coincide with the end of the PFI contract in FY37/38;
2. Identified a strategic framework that the Trust will pursue in response to this challenge, to move it to a position of financial sustainability;
3. Highlight the risks to successful delivery of the proposed strategic initiatives, and the related financial impact; and
4. Set out the financial framework and governance arrangements that will be required to support and monitor delivery of the strategy.

Board approval of our Trust's financial strategy is an important milestone in the improvement of our financial performance, providing a roadmap for improving our productivity, efficiency, sustainability and reducing our deficit over the short, medium and long-term.



Headlines	
The Trust's current underlying financial position is unsustainable and puts delivery of our strategic objectives at risk.	A 'recovery' scenario has been modelled that would deliver a deficit of £80.5m in FY26/27 through delivery of 20 initiatives across five improvement programmes.
If no action is taken, it is reasonable to expect further deterioration over time to £121.5m in FY22/23, worsening to £158.1m after five years (FY26/27) and £212.5m after ten years (FY31/32).	Despite presenting a significant improvement in performance compared to recent years, the recovery scenario does not deliver a financially sustainable position, and further system support is required to enable the Trust to breakeven by FY26/27.
The Trust must improve the forecast financial position by taking action locally to: (1) Reduce costs of delivery within the Trust (Cost Improvement Programme); (2) Reduce costs of delivery by working more closely with system partners to reduce costs of delivery (System Transformation); (3) Effectively control costs / avoid unfunded cost growth; and (4) Maximise productivity opportunities.	The Trust's material deterioration in its underlying deficit over recent years means the starting point for recovery is significantly adrift of external expectations. Draft recovery initiatives will improve the year-on-year underlying position at a similar pace to the recovery trajectory required by NHSE/I in 2019, however the Trust is likely to need external support, in the form of technical or other initiatives, to deliver a breakeven position by FY26/27.

Historical performance	Diagnosis of the underlying position	Recovery Framework	Recovery initiatives for deficit reduction
The Trust's reported financial position deteriorated from a surplus of £5.2m in FY13/14 to a deficit of £54.8m in FY19/20. Over the same time period, the underlying financial position has deteriorated further, from a deficit of £0.2m in FY13/14 to a deficit of £76.7m in FY19/20. At the end of 20/21 the underlying deficit had reached £114.4m. The cash position has steadily decreased as a result of this performance, resulting in a reliance on distress funding to meet commitments.	The Trust has analysed its underlying position and the drivers of its deficit in forecasting an underlying deficit of £110.1m in FY21/22. The Trust has developed an unmitigated base case scenario driving a deficit of £158.1m in FY26/27 and decreasing further to £212.5m in FY31/32.	The draft framework currently sets out: • Overall annual efficiency delivery of 3.9% in 22/23, and ranging 1.6% - 3.1% for FY23/24 to FY31/32 • Overall efficiency includes an ongoing requirement for BAU CIP delivery at c.1.1% in early years rising to 1.6%-1.9% from FY26/27, in addition to Trust-wide strategic initiatives • Cost pressures outside of inflation are to be funded through reallocation of existing budget • Capital investment supports known strategic investments (DAC, EPR, and DA) and limited additional investment in essential replacement and safety requirements	A 'recovery' scenario has been modelled that includes 19 initiatives across 5 improvement programmes that would reduce the annual deficit to £80.5m by Year 5 (FY26/27), excluding external funding support. The strategic initiative categories are: • Capacity Management • Workforce Controls • Contract Management • System Collaboration • Operational CIP In addition there are further strategic interventions that impact performance: • Strategic investments • National Financial Framework, including system top up, recovery funding & PFI support

The Trust's current capacity and capability to deliver the scale of improvement set out within the strategy poses a significant risk which requires further work to mitigate. Detailed delivery plans will be required to underpin the framework set out in the strategy.

The Trust will now work with system partners to create a wider system financial strategy, ahead of approval of the strategy by both the ICS and NHSE/I. Alongside this the Trust can move into more detailed planning for delivery, which will involve all areas of the organisation as well as our system partners.

Norfolk and Norwich University Hospitals NHS Foundation Trust

4. Tactical Action Plan – Evidence Groups

The latest Evidence Group Deep Dive will be held on the 15th October 2021. The meeting will aim to continue to provide support and challenge to delivery leads and monitor progress against the individual recommendations that comprise the Tactical Action Plan. Three recommendations, in relation to workforce, UoR 12, UoR 14 and UoR 15 remain within formal SRO Intervention. There is now a plan for all three of the recommendations to be removed from SRO Intervention by the end of October 2021.

Quality Programme Board

The progress against the individual Use of Resources recommendations continues to be monitored and scrutinised through the use of Quality Improvement Evidence Groups, feeding in to Quality Programme Board.

A formal, rolling programme for a deep dive across each recommendation has been developed to ensure that each recommendation is reviewed and challenged at least once every three months, alongside ensuring that any recommendation in SRO intervention is reviewed monthly.

Annual Review of Use of Resources

The Trust has undertaken an annual review of its Use of Resources against the national framework (KLOEs), including a review of the latest Model Hospital data. This was presented to HMB on 1st June 2021.

The review identified two key recommendations:

1. **Targeted change programmes around identified opportunity themes should be developed and incorporated into the Financial Strategy, with delivery overseen by the Transformation Steering Group; and**
2. **The Use of Resources Tactical Action Plan should be refreshed to reflect the findings and reset delivery expectations.**

Following the approval of the Trust's Financial Strategy by the Board, the Use of Resources Tactical Action Plan will be refreshed to incorporate the strategic initiatives and other opportunity themes. This will be completed by 31 November 2021.

Evidence Groups

The next UoR Deep Dive Evidence Group will be held on Friday 15th October 2021 to review progress against the granular action plans.

- There will be a spotlight on UoR 12.1 - Effective Use of e-Rostering and the implementation of the nursing rosters;
- There will be a spotlight on UoR 11.1 - Reduced Reliance on Temporary Capacity and how best to take the recommendation forward;
- Two of the schemes, UoR 4.1 - Non-High cost drugs and UoR 16.1 - Procurement Collaboration are to presented to the Group for discussion as completed;
- A Change Control Request will be presented to change the action plan for UoR 13.1 – Ensure the revised job planning process translates into optimisation of consultant workforce; and
- A Change Request will be presented to amend what good looks like for UoR 15.1 - HR Operations Improvements.

Recommendation	Current Status	Proposed Decision at Evidence Group	Review Date
UoR 4.1			15/10/2021
UoR 11.1			15/10/2021
UoR 12.1			15/10/2021
UoR 13.1			15/10/2021
UoR 14.1			15/10/2021
UoR 15.1			15/10/2021
UoR 16.1			15/10/2021
UoR 17.1			15/10/2021

The progress of each individual recommendation, alongside the dates of Change Controls raised, can be seen within Appendix 1.

Norfolk and Norwich University Hospitals NHS Foundation Trust

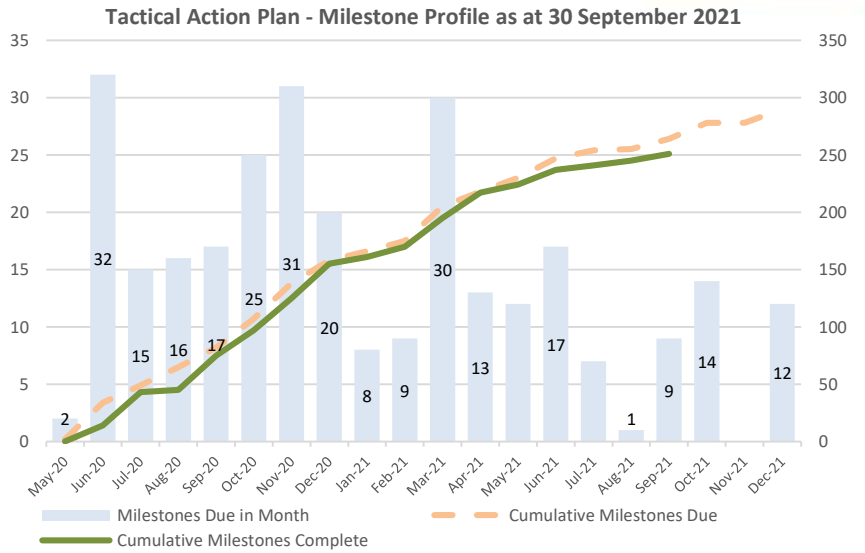
4. Tactical Action Plan - Performance

The Trust has completed 252 individual actions, with a further 15 showing as overdue. These have been followed up with the responsible officers and the current status understood. These must be completed or subject to Change Control ahead of the next Evidence Group.

As at 30 September 2021, the position shows that of the 303 individual actions within the Tactical Action Plan (see table below): 252 have been completed; 36 are currently on track; 1 is overdue by less than 30 days and 14 have become overdue by greater than 30 days.

The overdue actions are outlined on the following pages, alongside the proposed route to resolution.

Following an approved Change Control in May 2021, 20 additional actions have been included within UoR 9.1 *Improved National Standard Performance* to reflect the agreed trajectories for the Trust's performance improvement against the revised national standards for elective and non-elective care.



Strategic Enabler/Recommendation	Evidence Group RAG	Position as at 30 September 2021					Position as at 31 August 2021				
		Blue	Green	Amber	Red	Total	Blue	Green	Amber	Red	Total
Financial Governance Review		5	0	0	0	5	5	0	0	0	5
Financial Strategy		5	0	0	0	5	5	0	0	0	5
Alignment of Improvement Functions		1	0	0	0	1	1	0	0	0	1
GIRFT Governance		8	0	0	0	8	8	0	0	0	8
UoR 3 - Consideration should be given to regular use of service line reporting	BLACK	10	0	0	0	10	10	0	0	0	10
UoR 4 - Investigate and address the drivers of the high spend on non-high cost drugs	BLUE	1	0	0	0	1	1	0	0	0	1
UoR 8 - Deliver expected reductions in long length of stay and better utilisation of non-elective beds	RED	16	0	0	0	16	16	0	0	0	16
UoR 9 - Improve performance against constitutional operational standards	AMBER	40	20	0	0	60	38	0	0	0	38
UoR 10 - Improve internal capacity and capability to drive CIPs	RED	14	0	0	4	18	14	0	0	4	18
UoR 11 - Review operational and business planning processes to reduce reliance on temporary capacity	RED	24	0	0	0	24	24	0	0	0	24
UoR 12 - Continue working to embed effective use of e-Rostering	GREEN	48	0	0	4	52	47	0	0	5	52
UoR 13* - Ensure that revised job planning processess translates into optimisation of consultant workforce	RED	22	0	0	1	23	22	0	0	1	23
UoR 14 - Consider use of modern systems in payroll to ensure faster and traceable transactions	GREEN	14	4	0	0	18	14	4	0	0	18
UoR 15 - Progress implementation of improvements in HR operations	AMBER	17	6	1	0	24	13	11	0	0	24
UoR 16 - Continue working to develop procurement collaboration with NHS partners	GREEN	9	6	0	1	16	9	6	0	1	16
UoR 17 - Implement identified actions to reduce the cost of its PFI	GREEN	5	0	0	4	9	5	0	0	4	9
UoR 18 - Review the workforce model and recruitment strategies	BLACK	13	0	0	0	13	13	0	0	0	13
Total		**252**	**36**	**1**	**14**	**303**	**245**	**21**	**0**	**15**	**281**

Blue Action is signed off as completed. **Green** Action is on track to deliver in line with its due date. **Amber** Action is overdue, but by less than 30 days. **Red** Action is overdue by greater than 30 days.

***13.1- CR submitted for that will change the status to Green**

Our Values People focused Respect Integrity Dedication Excellence

Norfolk and Norwich University Hospitals NHS Foundation Trust

4. Tactical Action Plan – Overdue Actions

The Trust has completed 252 individual actions, with a further 15 showing as overdue. These have been followed up and the current status understood. These must be completed or subject to Change Control ahead of the next Evidence Group.

The table below provides an update on the current overdue milestones (15 as at 30 September 2021) and the identified actions to ensure that these are completed.

Overdue Action	Due Date	Days Overdue	Executive Sponsor	Explanation and Next Steps
10.1.6 Perform a formal review of the resource profile and remit of the Programme Management Office to ensure that the function is adequately resourced to deliver transformational CIP.	30/06/2021	93	Chief Operating Officer	**Ongoing** - ' Discussions with PMO team members have been conducted to explore existing skillsets and areas of individual interest. Further similar conversations combined with a view of capacity will help inform how resources are aligned for future projects. Fortnightly meetings have been setup with fellow Associate Directors under the Improvement umbrella to explore areas of potential collaboration. A paper was presented to HMB followed by further discussions at the Exec Strategy Away Day on Monday 20th September 2021.
10.1.6a Perform analysis of requirements	30/06/2021	93	Chief Operating Officer	
10.1.6b Review alignment with Improvement Team and other Transformational Functions	30/06/2021	93	Chief Operating Officer	
10.1.6c Provide report on recommendations to Hospital Management Board	30/06/2021	93	Chief Operating Officer	
12.1.4 Develop divisional-level KPI dashboard by November 2020	31/07/2021	62	Chief People Officer	**Ongoing** - RAG ratings agreed and Toby Lewis to provide copy to exec team. Meeting with Digital Health - IS is being arranged by Operations to confirm the PAF metrics.
12.12.04 Creation of KPI Dashboard reporting to IPR replacing current roster indicator dashboard. KPI Reporting via BI	31/07/2021	69	Chief People Officer	**Ongoing** - Meeting being arranged by Toby Lewis with Digital Health - IS team to progress PAF metric setup. Date of meeting to be confirmed .
12.23.05 Annual leave management for Medical staff via Healthroster	26/03/2021	196	Chief People Officer	**Ongoing** - This has to be implemented in line with the overall Medical Rostering project. The delivery date will be in line with the medical rostering rollout plan.

Norfolk and Norwich University Hospitals NHS Foundation Trust

4. Tactical Action Plan – Overdue Actions (Cont.)

The Trust has completed 252 individual actions, with a further 15 showing as overdue. These have been followed up and the current status understood. These must be completed or subject to Change Control ahead of the next Evidence Group.

The table below provides an update on the current overdue milestones (15 as at 30 September 2021) and the identified actions to ensure that these are completed.

Overdue Action	Due Date	Days Overdue	Executive Sponsor	Explanation and Next Steps
12.23.06 Study leave management for Medical staff via Healthroster	26/03/2021	152	Chief People Officer	**Ongoing** - Following discussions with the management team which supports the PAF (Performance Assurance Framework) reporting, a request will be progressed with IS to develop the BI dashboard to enable the identified metrics to be included within the PAF.
13.1.1 To complete outstanding actions in the medical staffing work plan.	30/06/2021	56	Chief People Officer	**Ongoing** - Job planning in IPR for July about to be released but will not have reached the 90%. Forecasted report for August will reduce compliance figures to 76.6% due a large number of job plans due to expire in August. Risk of not being signed off to minimal staff numbers due annual leave, C19 isolation and hospital pressures. A CR will be submitted with a new completion date.
15.1.3.6 Identify and develop additional actions which will be required to deliver the agreed HR service offering	30/09/201	1	Chief People Officer	**Ongoing -** The substantive post of HR Business Partner for Women and Children's has been filled. The post of Medical Workforce Manager was not recruited to following two recruitment rounds. However, an interview is being set up in the next couple of weeks for one candidate.
16.1.1.2 Seek approval from STP Committees in common for Strategic Outline Case (SOC)	30/06/2021	63	Chief People Officer	**Ongoing** - The SOC case has been written and is with ICS committees. Currently waiting for a comparison report from NHS SBS then both documents will be presented to the to the ICS exec group.
17.1.2 Complete market testing of FM marketplace and mobilisation of refreshed service standards	01/06/2021	31	Chief Finance Officer	**Ongoing -** AP- Accepted by Trust and waiting for Octagon Funder Consent agreement. Planned revised completion is 31/10/21. Funder Technical Adviser report review due this week & then two meetings set up to agree changes if required to complete AP in October 21
17.1.2b Trust to decide to accept Alternative Procedure offer or commence Market Testing	01/06/2021	92	Chief Finance Officer	**Ongoing -** Market testing progressing in line with above on the A/P. If AP gets completed in October 21, then Market testing falls away
17.1.3 Dilapidations Survey	21/05/2021	103	Chief Finance Officer	**Delayed** - Standstill agreement remains outstanding which is holding up the start date, raised every 2 weeks & at monthly Liaison procedure Meetings
17.1.3b Commence Dilapidations Survey	21/06/2021	72	Chief Finance Officer	**Delayed** - Survey held up due to legal process, CFO kept informed every two weeks and new start date will now be 01 12/21 & completion 31/05/22

Norfolk and Norwich University Hospitals NHS Foundation Trust

5. Getting It Right First Time – Performance Update

The only planned GIRFT visit is the Deep Dive with Cardiothoracic taking place in December 2021. The Baseline assessment against GIRFT toolkit has been completed.

Delivering the GIRFT programme is integral to the Trust achieving improved Use of Resources and to drive the development of the efficiency programme.

Adam Wright, Business Support Manager has completed a baseline assessment against the national GIRFT toolkit. Gap analysis on findings to be reported to the Clinical Effectiveness Operational Group.

Central GIRFT email address created to aid engagement, including circulation of service specialty GIRFT webinars.

Meetings have taken place with 3 of the 4 Divisional Governance leads to get an update on their GIRFT actions, obtain feedback on the existing GIRFT process and possible future improvements.

Items for Escalation

Limited progress made against GIRFT actions within divisions as identified in the table.

The table shown outlines the performance against the GIRFT recommendations for the month of September 2021:

- 249 completed actions (+3);
- 28 actions are on track (-10);
- 8 actions are overdue by less than 30 days (+8);
- 197 actions are overdue by greater than 30 days (+14), which are all in relation to the GIRFT programme and will be subject to revision and
- 156 actions do not yet have an agreement status or delivery date, of which 80 actions have been proposed to be marked as not accepted due to the service not being provided by the Trust.

Next Steps

- Meet monthly to support divisions progress against actions
- Add new recommendations from 18 national reports to Master spreadsheet
- Provide additional support to divisions on Future NHS Workspace.

Area	Position as at 30 Sept 2021						
	Awaiting Agreement	Blue	Green	Amber	Red	Total	Grand Total
Surgery	91	166	0	0	133	299	390
Breast Surgery	1	8	0	0	13	21	22
Dermatology	2	9	0	0	6	15	17
General Surgery	2	20	0	0	8	28	30
Hospital Dentistry	9	0	0	0		0	9
Intensive and Critical Care	0	6	0	0	2	8	8
Ophthalmology	7	28	0	0	16	44	51
Oral and Maxillofacial	10	14	0	0	10	24	34
Orthopaedic Surgery	6	27	0	0	5	32	38
Paediatric Surgery	0	9	0	0		9	9
Spinal Surgery	10	6	0	0	22	28	38
Urology	0	17	0	0	12	29	29
Vascular	3	19	0	0	26	45	48
Ear, Nose and Throat	24	1	0	0	9	10	34
Paediatric T&O	6	0	0	0	1	1	7
Plastic Surgery and Burns	7	0	0	0		0	7
T&O (Trauma)	4	2	0	0	3	5	9
Medicine	45	50	25	0	48	123	168
Cardiology	3	3	0	0	3	6	9
Diabetes	0	10	5	0	6	21	21
Endocrinology	1	7	0	0	5	12	13
Neurology	0	5	0	0	4	9	9
Renal	2	6	0	0	8	14	16
Respiratory	5	1	0	0		1	6
Rheumatology	10	1	0	0	3	4	14
Stroke	9	1	17	0	8	26	35
Gastroenterology	10	12	3	0	2	17	27
Lung	5	4	0	0	9	13	18
W&C	11	15	0	0	3	18	29
Obstetrics and Gynaecology	0	15	0	0	3	18	18
Neonatology	11	0	0	0		0	11
CSS	22	12	3	0	4	19	41
Imaging and Radiology	11	4	3	0	4	11	22
Pathology	9	10	0	0	0	10	19
E&UC	1	4	0	1	4	9	10
Emergency Medicine	1	4	0	1	4	9	10
Grand Total	170	**247**	**28**	1	192	**468**	**638**

Norfolk and Norwich University Hospitals NHS Foundation Trust

Appendix 1 – Evidence Group RAG Ratings

The January 2020 Use of Resources report identified 11 recommendations, which were reviewed and formed the basis of a tactical, detailed action plan. Two further actions which had not been fully actioned from the previous inspection were also added.

These recommendations formed the immediate programme of work within the Trust's Use of Resources Programme, with the progress being monitored and scrutinised through the use of Quality Improvement Evidence Groups, feeding in to Quality Programme Board.

A formal rolling programme for deep dive across each recommendation has been developed to ensure that each recommendation is reviewed and challenged at least once every three months, alongside ensuring that any recommendation in SRO intervention is reviewed monthly.

The table below outlines the progress and Evidence Group RAG rating for each recommendation, alongside any revised completion dates via QPB approved change control documents.

Recommendation	Evidence Group RAG Rating (incl. Change Control Revised Outcome Dates)									Current Outcome Delivery Date	Aspirational Rating for Next Evidence Group
	11/01/2021	22/02/2021	22/03/2021	12/04/2021	07/05/2021	04/06/2021	09/07/2021	07/08/2021	07/09/2021		
UoR 3 - Consideration should be given to regular use of service line reporting											
UoR 4 - Investigate and address the drivers of the high spend on non-high cost drugs										07/08/2021	
UoR 8 - Deliver expected reductions in long length of stay and better utilisation of non-elective beds					31/09/2021					31/09/2021	
UoR 9 - Improve performance against constitutional operational standards					31/03/2022					31/03/2022	
UoR 10 - Improve internal capacity and capability to drive CIPs					30/06/2021					30/06/2021	
UoR 11 - Review operational and business planning processes to reduce reliance on temporary capacity										31/03/2021	
UoR 12 - Continue working to embed effective use of e-Rostering				31/07/2021				30/09/2021		30/09/2021	
UoR 13 - Ensure that revised job planning processes translates into optimisation of consultant workforce				30/06/2021						30/06/2021	
UoR 14 - Consider use of modern systems in payroll to ensure faster and traceable transactions							31/10/2021			31/10/2021	
UoR 15 - Progress implementation of improvements in HR operations				31/10/2021						31/10/2021	
UoR 16 - Continue working to develop procurement collaboration with NHS partners				31/03/2022						31/03/2022	
UoR 17 - Implement identified actions to reduce the cost of its PFI									Deferred	31/07/2021	
UoR 18 - Review the workforce model and recruitment strategies				31/05/2021							


Microsoft | Power BI
Workforce
View in Power BI
Last data refresh:
20/10/2021 07:30:21 UTC
Downloaded at:
20/10/2021 14:43:18 UTC

Workforce Summary

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

NNUH Digital Health
business intelligence

Topic	Metric Name	Date	Result	Variation	Assurance
Recruitment (Non-Medical)	Time to Hire - Time with Manager	Sep 2021	16.9	Improvement (Low)	No Target
Staff in Post	Actual Substantive Headcount (WTE)	Sep 2021	8,189	Improvement (High)	No Target
Non-Medical Appraisals	Non-Medical Appraisal	Sep 2021	84.3%	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 2021

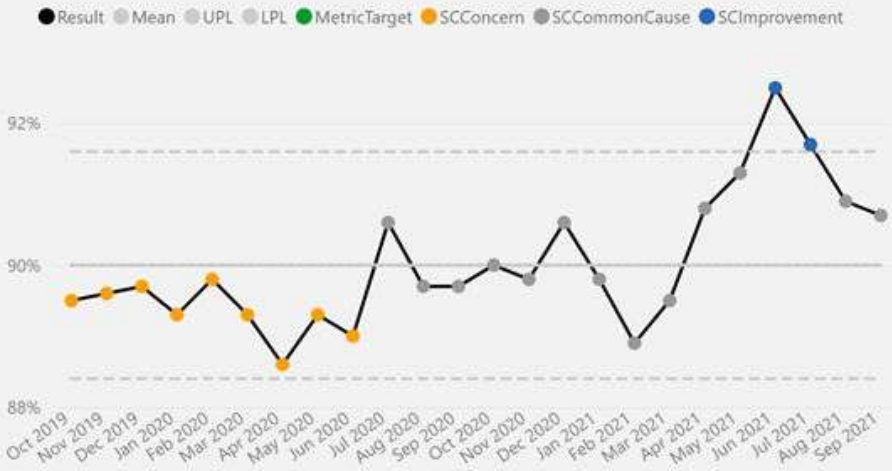
90.7% Result
90.0% Target

91.6% UPL
90.0% Mean
88.4% LPL

Analytical Commentary

Variation is Common Cause

Mandatory Training



Assurance Commentary

As at the end of September, the compliance rate was 90.7%. This has now been consistently above 90% for a six month period.

For Medical staff, the compliance rate for permanent staff was 90.7% - this figure reduces to 82.0% including the fixed term rotational junior doctors.

There is a notable number of do not attends for face to face mandatory training. This was escalated to the Workforce and Education Sub Board (WESB) where actions are being agreed to ensure these are limited and in line with the current agreed policy for non-attendance.

Improvement Actions

A series of improvements and interventions are in place to support mandatory training compliance. The majority of mandatory training is now delivered via eLearning with a limited number remaining face to face where it has been deemed necessary for this to continue to be delivered in this way. 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 2021

Variation	Assurance
H	F

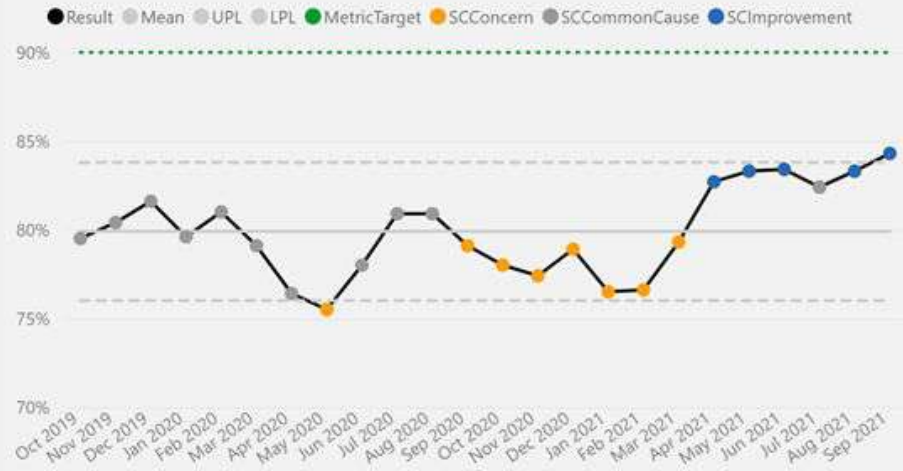
84.3% Result
90.0% Target

83.8% UPL
79.9% Mean
76.0% LPL

Analytical Commentary

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

Non-Medical Appraisal



Assurance Commentary

The Operating Plan for 2020/21 reflects an aspiration for 90% compliance. For the Use of Resources 3.1 recommendation, it has been agreed to achieve the 90% consistently by August 2022.

84.3% of eligible staff (Non-Medical appraisals) had an appraisal during the last 12 months which is an increase in the last three months.

The quality review with a stakeholder panel commenced in August and we will meet on a monthly basis to form improvements for the appraisal process.

For Divisions who are not currently at 90% compliance, appraisal trajectories have been developed to provide assurance of achieving 90% by January 2022 and consistently by August 2022.
A bespoke improvement plan has been developed for Corporate to improve compliance rates, with the initial action being taken place in September 21.

Improvement Actions

August 2021 – HR are leading a quality review for appraisals, with key stakeholders in Divisions and Corporate areas. The first stakeholder panel has met and development for improvements in the appraisal process will commence to support the target of achieving 90% compliance by August 2022.

October 2021 – Analysis is currently being undertaken as a result of an appraisal survey that was distributed to all staff to feed into the qualitative review.

Sickness Absence

NNUH Digital Health
business intelligence

Monthly Sickness Absence %

Sep 2021

Variation | Assurance

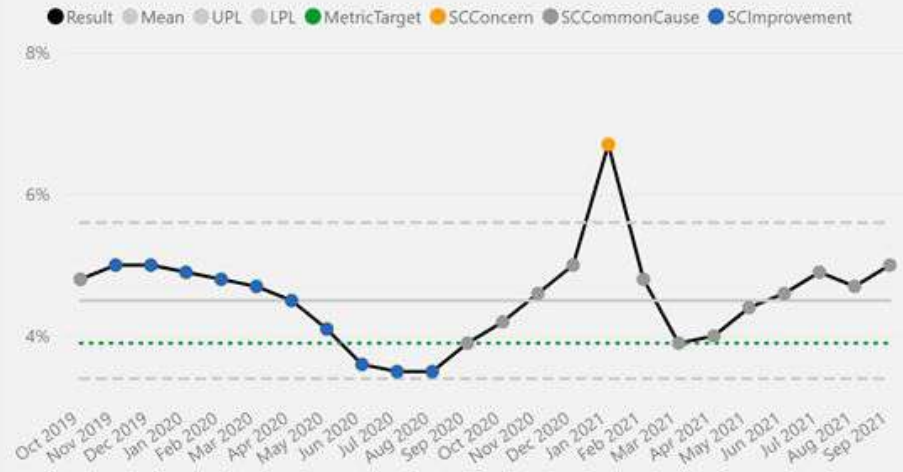
5.0% Result
3.9% Target

5.6% UPL
4.5% Mean
3.4% LPL

Analytical Commentary

Variation is Common Cause

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 30 September 2021, that rate is 4.71%. The monthly absence figure for September is 4.95%.

All figures since March 2019 include Covid related sickness absence. Had Covid sickness been excluded the 12-month rolling average rate would be 4.0%.

A new 'Red to Green' initiative has been developed for Divisions for short-term and long-term absences. This initiative will ensure action plans are completed for long term and short term absences. The Red to Green process will enable the identification of those needing additional support to assist the individuals in returning to work in a supported manner.

The Attendance Improvement Group will also undertake several tasks to develop actions plans for resolution. This will include a deep dive review into the top 2 reasons to see if there are any hotspots that could potential be tackled with Just and Learning culture principals, review the gender split of short term absences, review all long Covid and continue to work with our system partners on the appropriate next steps concerning pay and review whether 'Unknown Reason' can be removed from ESR as a reason to give richer data on the reasons for absence. A multi professional case conference with the manager, HR and Health and Wellbeing will be implemented to ensure a holistic supportive approach is developed. A review of the ability for staff to have access to fast track treatment will also be undertaken.

Improvement Actions

October 2020 – A refresh of the attendance policy and toolkits were approved at PACS on 15/10/2020

May 2021 – The revisions to the attendance policy and supporting toolkits have been launched to all staff with follow up manager led training to be provided in future months.

October 2021 - Both the Covid sickness absence rate and the sickness absence rate are increasing and this will be discussed at the Attendance Improvement Group (AIG) in October to establish appropriate action plans for intervention and improvement.

Staff Turnover

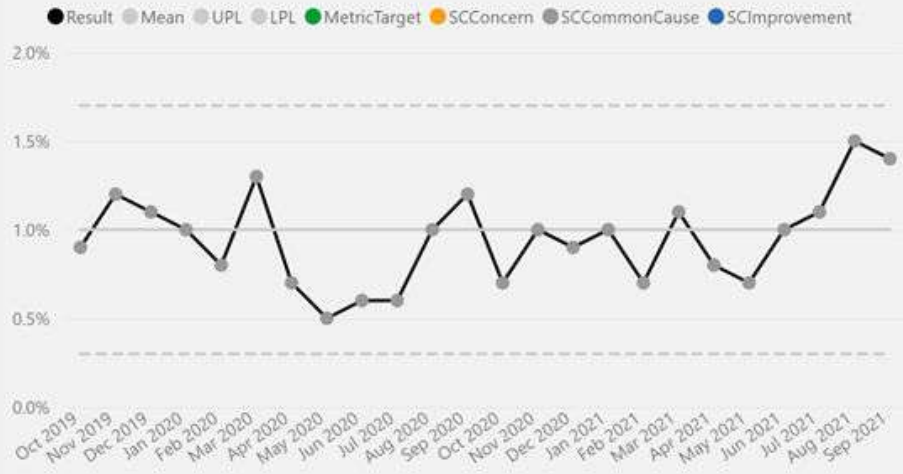
NNUH Digital Health
business intelligence

Monthly Turnover

Sep 2021

Variation	Assurance
1.4% Result	1.7% UPL
N/A Target	1.0% Mean
	0.3% LPL

Monthly Turnover



Improvement Actions

May 21 - The Trust's turnover, vacancy, recruitment trajectories and retention plans will be developed for the Trust and will be actioned and monitored at the Recruitment and Resourcing Improvement Group.

August 21 – the Recruitment and Resourcing Improvement Group have agreed actions for retention and this was reported to Hospital Management Board on the 17th August.

September 21 - A task and finish group has been developed to ensure actions are implemented and tracked. This will be reported to the Recruitment and Resourcing Improvement Group on a

Analytical Commentary

Variation is Common Cause

Assurance Commentary

The monthly turnover rate for September 2021 is 1.44% - a decrease from August (1.49%) and higher than September 2020 (1.16%). The actual number of leavers for September 2021 is 101.9 WTE compared to 105.6 WTE for August 2021.

The 12-month average turnover rate is 12.0%, an increase of 0.3% from August 2021. This increase will be reviewed and actions agreed. In comparison to the Acute Hospitals in the N&W area (for the 12 months to 31st May), JPUH is at 12.3% and QEH is at 9.7%.

The Trust is the Lead Provider for an STP Retention and Improvement Group which has focused review on three key areas: legacy nurses, exit interviews and career conversations. Specific Trust retention initiatives have been agreed and confirmed at the Recruitment and Resourcing Improvement Group and will monitored by this group.

Each Division has developed recruitment trajectories for focused resolutions for key identified areas.

Staff in Post

NNUH Digital Health
business intelligence

Actual Substantive Headcount (WTE)

Sep 2021

Variation | Assurance

H

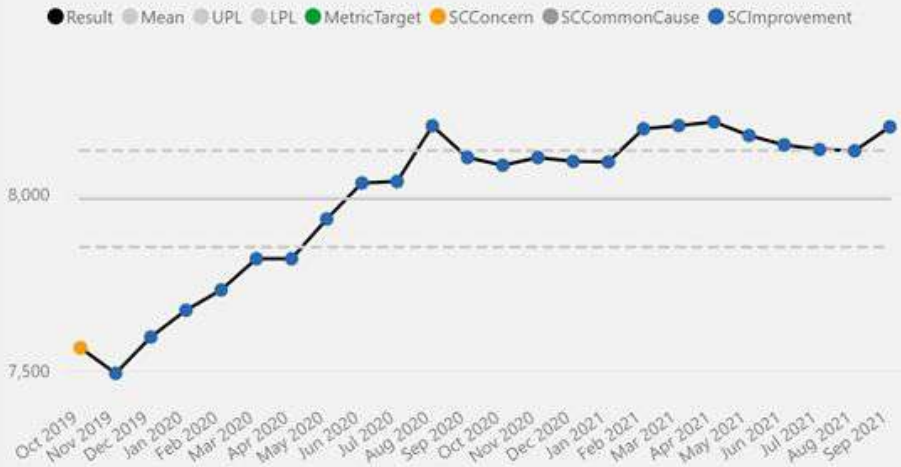
8,189 Result
N/A Target

8,122 UPL
7,986 Mean
7,849 LPL

Analytical Commentary

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

Actual Substantive Headcount (WTE)



Assurance Commentary

Since April 2020 there has been an increase of 4.3%, 333.0 WTE (7,730.2 staff in post 31-Mar-20)

Since April 2019 there has been an increase of 12.3%, 885.6 WTE (7,177.5 staff in post 31-Mar-19)

Since April 2018 there has been an increase of 18.8%, 1,276.1 WTE (6,787.1 staff in post 31-Mar-18)

Since April 2017 there has been an increase of 25.1%, 1,615.6 WTE (6,447.6 staff in post 31-Mar-17)

Improvement Actions

Sept/ Oct 2020 - end of fixed term contracts, including for temporary Covid support workers – leading to staffing reduction.

May 21 - Due to the establishment review which has led to an increase in vacancies, it is expected that the substantive headcount will increase throughout this year.

Vacancies

NNUH Digital Health
business intelligence

Variance: Headcount (WTE)

Sep 2021

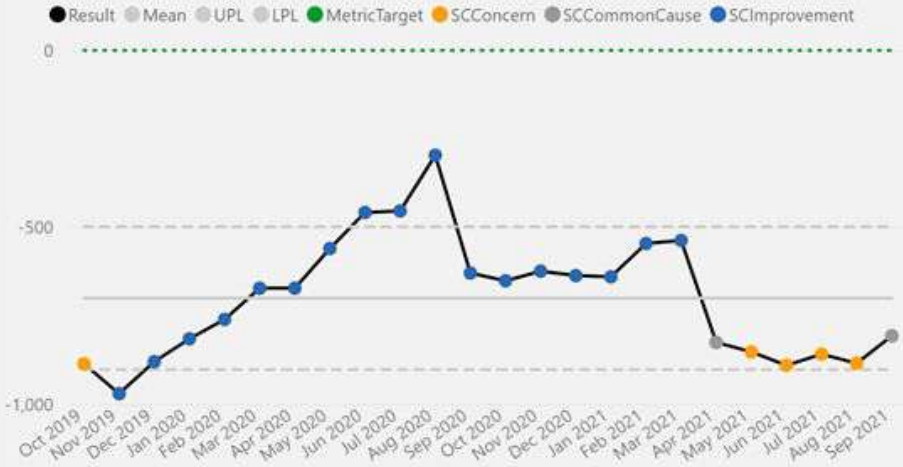
Variation | Assurance

-807 Result
0 Target
-498 UPL
-700 Mean
-902 LPL

Analytical Commentary

Variation is Common Cause

Variance: Headcount (WTE)



Assurance Commentary

Due to the Nursing & Midwifery Establishment Triangulation and Rebasing exercise, there is an increased vacancy position for Registered Nursing with an additional 55 FTE and Unregistered with an additional 76 FTE. This has been made effective in May's Divisional budget.

Recruitment trajectories have been developed for key vacancies within Divisions and these will be monitored on a monthly basis.

A review is being undertaken to ensure all budgeted vacancies are being actively recruited to. A 'recruit at risk' pathway is also being established to ensure recruitment is undertaken is quick and efficient way.

Initiatives for the temporary staffing workforce have also commenced with the STP collaborative bank commencing by the end of September, a 'new deal' for the temporary staff is in progress and will include dedicated on-boarding, recognition initiatives and so on, will commence over the next few months, along with campaigns for skills gaps on the Temporary staffing Bank.

Improvement Actions

Sept/Oct 2020 - Finance establishment for September has been revised to 8,732.1, an increase of 243.2 (which includes 111 posts for the new ward block).

Sept/ Oct 2020 - End of fixed term contracts, including for temporary Covid support workers – leading to staffing reduction and vacancy increase.

May 2021 – Due to varying recruitment and retention strategies reduced figure, only 33.6% of the identified hard to fill posts are now required to be actively recruited to.

Recruitment (Non-Medical)

NNUH Digital Health
business intelligence

Time to Hire - Total

Sep 2021

Variation | Assurance

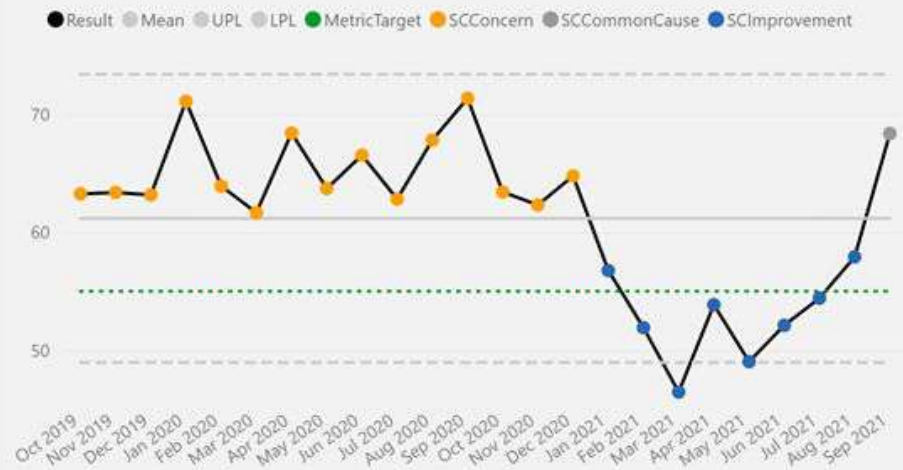
68.4 Result
55.0 Target

73.4 UPL
61.2 Mean
49.0 LPL

Analytical Commentary

Variation is Common Cause

Time to Hire - Total



Assurance Commentary

The 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 September 21 the time to hire figure was 68.4 days, an increase from August (57.9 days). All Divisions are above the 55 day target with all areas over 70 days. Due to the increase in time to hire, a review of the current workload, processes, resources are being reviewed on the 20th October 2021 of which an outcome will be reported to Hospital Management Board.

The increase in the time to hire figures have been impacted by a significant increase in recruitment over the last two months and this has been at a time of vacancies within the Recruitment Team. These vacancies will be resolved and filled by October. Interventions have been put in place to internally escalate time to hire concerns to the HR Business Partner Team for time to hire, this includes notification of short listing timescales and checking processes above 30 days.

Improvement Actions

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

October 2021 – Actions to be agreed to reduce time to hire figures

Supplementary Metrics

Metric Name	Date	Result	Variation	Assurance
Time to Hire - Time with Manager	Sep 2021	16.9	Improvement (Low)	No Target

Norfolk & Norwich Hospitals Charity

Norfolk and Norwich University Hospitals NHS Foundation Trust

REPORT TO CORPORATE TRUSTEE	
Date	**03 November 2021**
Title	**N&N Hospitals Charity – Annual Report and Accounts 2020/21**
Author & Exec Lead	**John Paul Garside, Executive Lead for Charity.**
Purpose	**For approval**

1. Background/Context

- The N&N Hospitals Charity is registered with the Charity Commission (reg no: 1048170), under the corporate trustee model, whereby the Board of Directors acts on behalf of the Foundation Trust as Corporate Trustee.
- The Charity's Annual Report & Accounts 2020/21 have now been subject to External Audit by KPMG. They were reviewed by the Audit Committee at its meeting on 20 September 2021 and by the Charitable Funds Committee on 27 October 2021 – both committees agreed to recommend the Report and Accounts to the Board for approval.

2. Key Issues, risks and actions

- Preparation of the Charity's Annual Report and Accounts has been led by Julie Cooper, the Charity Accountant & Head of Grants, with input from other members of the Charity Team and review by Finance Department; Following their Audit, KPMG have confirmed to the Audit Committee that:
  - they intend to issue an unqualified audit opinion;
  - no significant accounting issues have arisen during the audit;
  - there have been no adjusted or unadjusted audit differences; and
  - they have made no control recommendations.

- Key highlights for the year 2020/21 are summarised in the first four pages of the Annual Report (notably the Year at a Glance):
  - as detailed on pages 19 & 20 of the Annual Report, income for the year totalled £1.8m, whilst total expenditure was also £1.8m;
  - 93p in every £1 of expenditure was spent on charitable activities. This is very favourable relative to peers (the benchmarking average in our aspirational comparator peer group was 80p/£1(as reported to the Board in Oct 2020);
  - significant additional expenditure commitments have been made but a number of projects in the Trust have inevitably been subject to delay due to the pandemic;
  - as at 31 March 2021, the Charity held expenditure commitments of £4.6m against a Funds Balance of £11.7m . Board members will be aware that a further Grant of £2m was made by the Corporate Trustee on 6 September.

- The Charity's Investment Policy and performance is overseen by the Charitable Funds Committee and the Charity has engaged external independent investment services through Barratt & Cooke stockbrokers regulated through the Finance Conduct Authority.

3. Next steps

Once approved by the Corporate Trustee, the Report and Accounts will be submitted to the Charity Commission and made available on the Charity's website. As in previous years, a short summary 'Year at a Glance' document will also be produced and also a separate Impact Report – highlighting the benefits achieved through grants made by the Charity.

Recommendations:

In its capacity as Corporate Trustee, the Board is recommended to:

- **approve** the audited report and accounts of the N&N Hospitals Charity for the year ended 31 March 2021;
- **approve** the associated Letter of Representation to KPMG.

N&N

Norfolk & Norwich Hospitals Charity

Annual Report & Accounts 2020/21

Registered Charity no: 1048170

Annual Report 2020/21

Norfolk & Norwich Hospitals Charity

Contents

Annual Report 2020/21

Norfolk & Norwich Hospitals Charity

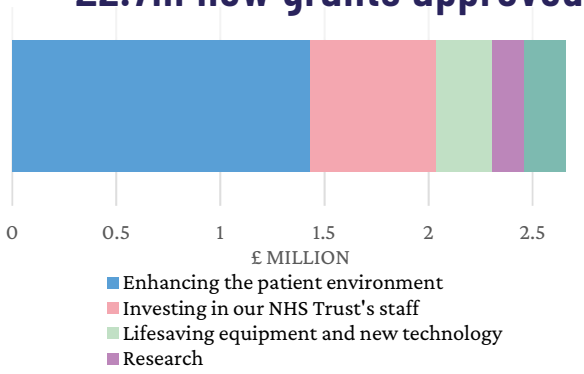
2020/21 - Our year at a glance

We have supported NHS staff and patients through the covid pandemic:

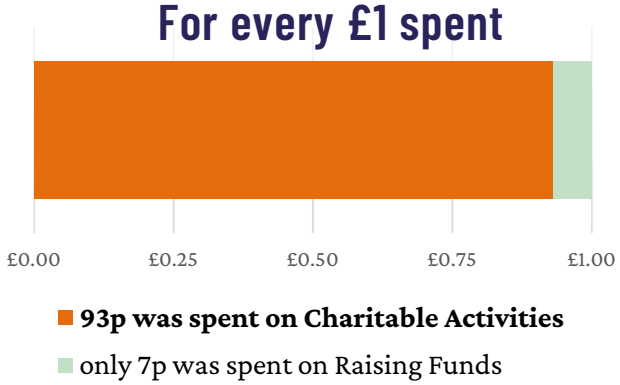
Distributing flowers & meals & toiletries & fridges & coffee & biscuits & toilet roll & kettles & masks & ipads & books & much, much more. All given by our incredible local community.

Thank you to everyone for your support

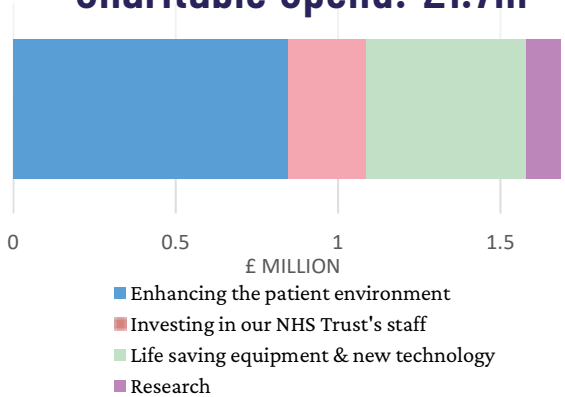
£2.7m new grants approved



For every £1 spent



Charitable Spend: £1.7m



Worked in partnership with:

NHS CHARITIES TOGETHER

Norfolk Community Foundation
Together, Norfolk shines brighter

Hope for Tomorrow
Bringing cancer treatment closer to home

Norfolk's Cancer Charity

MACMILLAN CANCER SUPPORT

Annual Report 2020/21

Norfolk & Norwich Hospitals Charity

Our year at a glance. In 2020/21 we:

raised a total of £1.8m, thanks to our generous supporters

spent £1.7m to benefit patients

funded £185k of equipment for the new Norfolk Centre for Interventional Radiology

used Covid grants to support staff and patients

funded development of the Boudicca Breast Unit

approved £87k to support additional training for over 200 staff members

N&N Norfolk & Norwich Hospitals Charity LOTTERY

launched our first ever lottery

lit up the N&N for Christmas with the help of local businesses

agreed over £170k for staff rest areas

helped our local community provide support for our amazing NHS staff

awarded grants of £151k for new research projects

saw the Charity-funded Mobile Cancer Care Unit, in use in the community

Our support for our local hospitals is only possible thanks to our incredibly generous supporters.
To everyone who has helped us, we say a huge 'THANK YOU' – from the charity and from our NHS Trust.

Annual Report 2020/21

Foreword from the Corporate Trustee

Welcome to the 2020/21 Annual Report and Accounts for the N&N Hospitals Charity.

We are absolutely delighted that, despite the circumstances that have made this past year so exceptionally difficult for everyone, the Norfolk & Norwich Hospitals Charity has been able to continue making a positive difference for our hospitals' patients and staff. Throughout this report you will see inspirational examples of the use of charitable funds and the positive impact that they have made.

This past year has seen the Charity allocate £2.7m of grant funding to support better care and services for patients, including:

- £400,000 for the next phase in development of the Boudicca Breast Unit
- Over £170,000 for new and improved staff rest areas
- £340,000 to provide a new café building at Cromer Hospital, alongside development of the North Norfolk Macmillan Cancer Centre.

Despite the challenging times, due to the generosity of our donors and supporters, in total we were able to provide:

- £1.4million to enhance the environment and facilities for patients
- £600,000 as an investment in the development and wellbeing of our NHS Trust's staff
- £300,000 for equipment and new technology for the treatment and care of patients
- £151,000 on new research projects

This is a very significant achievement and we thank everyone who has supported us and who continues to do so. Throughout the pandemic and national lockdowns we have seen and felt real support from our local community, businesses, patients and public. It has been very much appreciated.

The Covid challenges have meant that our small charity team has had to work very differently. Unable to carry out face-to-face fundraising events or meet supporters at our hospitals, the past year saw them switch to receiving and distributing the incredible influx of gifts in kind. Flowers, food, toiletries and fridges are just some tangible examples of the generosity and care shown to the staff and patients of our hospitals. It has been humbling to witness and experience. Thank you to everyone who has donated and offered support.

We are continuing to nurture and grow our Charity, so that we can achieve more to benefit our patients. The Trust is now planning for celebrations in 2022 to mark the 250th anniversary of the opening of the original Norfolk & Norwich Hospital. We look forward to strengthening relationships with our local communities whose determined predecessors made the hospital a reality in 1772.

Thank you once again for supporting the extras that we provide for our NHS hospitals.

John-Paul Garside
Charity Director

Joanna Hannam
Chair of the Charitable Funds Committee

About the N&N Hospitals Charity

The Norfolk and Norwich Hospitals Charity (referred to in this report as "the Charity") is registered with the Charity Commission (registration number 1048170). By securing donations, legacies and sponsorship, the Charity provides support for additional equipment and projects above and beyond what is available through normal NHS funding. In this way we make a real difference for patients, families and staff and support the Trust to achieve its vision of providing every patient with the care we want for those we love the most.

Our charitable objectives

The Objects of the Charity specify:

'The trustees shall hold the trust fund upon trust to apply the income, and at their discretion, so far as may be permissible, the capital, for any charitable purpose or purposes relating to the National Health Service'

In accordance with these Objects the Charity:

- funds new and additional services where the NHS has no obligation to do so;
- enhances services above the level provided by statutory funds; and
- supports innovative services and research, pump-priming new initiatives and supplementing other funding sources.

Our mission

By raising new funds, and with careful management of our existing assets, the Charity provides a public benefit by making grants to support relevant research, staff education and enhanced services to patients.

Grants are made in accordance with charity law. In making grants, we endeavour to reflect the wishes of patients and staff by directing funds towards areas they tell us are most in need. When considering where to focus our support, our corporate trustee's board and, the members of the Charitable Funds Committee have regard to the Charity Commission's guidance on public benefit. During the year 2020/21, 428 grant applications totalling £2.7m were approved by the Charity, and grant expenditure totalling £1.7m was made. As a consequence of the Covid-19 pandemic £4.6m of existing funding commitments have been rolled forward to future years. These will be completed as services return to 'normal'.

Our hospitals

The **Norfolk & Norwich University Hospital** (N&N) is a 1200 bed teaching hospital offering a range of specialist and tertiary services and state-of-the-art facilities. It works closely with the University of East Anglia to train health professionals and undertake clinical research. On its original city-centre site, the Hospital was opened in 1772, funded through charitable subscription. In 2022 the Hospital will therefore celebrate its 250th anniversary.

The **Jenny Lind Children's Hospital** is part of the Norfolk & Norwich University Hospital and is focussed on services for children and young people. First established in 1854, the Jenny Lind is one of the longest established children's hospitals in the country. Its creation was funded by the proceeds of fundraising concerts held in Norwich by the international soprano Jenny Lind.

The **Cromer and District Hospital** serves the population of North Norfolk and beyond, with many outreach services provided from Norwich-based clinical teams. The Hospital provides a Minor Injuries Unit and a wide range of outpatient and day-case services, including surgery and chemotherapy. The Hospital was rebuilt in 2012 using charitable funds including extremely generous legacy donations. An extension to the Hospital is currently under construction, again funded by charitable funds.

Key Priorities

2020/21 saw the Charity team change from their usual plans and priorities of raising funds and administering grants, to co-ordinating an overwhelming level of gift-in-kind donations and ensuring their distribution appropriately across the Trust, so that NHS staff were receiving the maximum support available.

Creation of additional and improved staff rest areas has become a priority over the last year, and having created some successful schemes already, the Charity is continuing to work with the Trust's Estates Team to develop further areas outside on the N&N site.

Work is continuing on raising the profile of the Charity, both within the Trust and in the wider community. There is now a dedicated Charity Hub, situated in the East Atrium at the Norfolk and Norwich Hospital. The Charity has put in place strategic plans for communications and for legacies, and the work carried out so far has included the creation of a quarterly newsletter which is sent out to our supporters, as well as updates to our website.

Cromer Hospital has seen the completion of the North Norfolk Macmillan Centre, partly funded by our £1.8m grant. To provide additional relaxation space for the increase in staff, patients and visitors resulting from the new service, the Charity is adding a new café building at the front of the hospital. The café will be run on behalf of the Charity, and we expect to see it open by January 2022, with an exciting menu of food on offer.

The Charity will also be putting in place additional catering provision at the Norfolk and Norwich Hospital site, with a mobile, takeaway catering unit, that we hope will provide an income stream for the Charity, as well as more flexible catering for staff and patients, which we believe will be important as we move on from the pandemic.

The Charity has committed to raising £2m towards a new elective Orthopaedic Surgical Centre for the Norfolk and Norwich Hospital, and with £1m already in place, has launched an appeal for the remaining £1m funding. This will form part of the N&N's 250th anniversary in 2022, and provide a lasting legacy from the celebrations. Further appeals are in development and will be announced soon.

If you would like to help us by raising funds for the Charity, then please visit nnhospitalscharity.org.uk or contact our fundraising team at fundraising@nnuh.nhs.uk, or on 01603 287107.



Support for NHS Staff during Covid-19 pandemic

During 2020/21, with the ongoing Covid-19 pandemic, the Charity Team have focussed on maximising support for the Trust's staff. Our Norfolk community has shown overwhelming support for their local hospitals and NHS staff, and the Trust has received an unprecedented level of gift-in-kind donations – from toiletries to flowers to meals to visits from farm shops.

With no possibility of carrying out face-to-face fundraising, the Charity Team stepped into action to ensure that all donated items were distributed across the Trust. The Charity's Fundraising Team, based at the Norfolk & Norwich Hospital site, focused on distributing the donated items to staff, while the Grants Team, based at Rouen Road dealt with the steady in-flow of parcels for purchases from our Amazon wishlist and donations dropped off in the City Centre.

Once the immediate support of Trust staff had been put in place, the Charity considered how it could use available funding to provide longer-term support. The most appropriate way was agreed to be improved and additional rest areas for staff.

Using Covid grants from NHS Charities Together, alongside funds donated by the local community, the Charity has been able to work with the Trust's Capital and Estates Team to create a new staff rest area in one of the courtyards leading from the N&N Hospital's 'Main Street'. It has also provided a much-improved space outside the Benjamin Gooch Lecture Theatre, along with a dedicated staff kitchen area. Additional picnic benches to provide external seating for staff have been installed, and the Charity's Grants Team is working on a further project with the Hospital's Environmental Arts Co-ordinator to provide more space for staff to sit and take a break outside.

There has been incredible support shown to our Trust staff by the local community. On behalf of us all, we would like to say:

THANK YOU

The Boudicca Breast Unit

Thanks to a huge number of supporters, the Boudicca Breast Cancer Appeal has already funded the equipment needed to enable patients to receive clinical consultation, diagnostic tests and imaging assessment all on the same day at their initial clinic appointment.

The next phase – creation of a dedicated waiting area is already in progress, with building work underway, artwork commissioned, and furniture on order. We hope that the unit, shown in the architect's impression below, will provide a more calming, comforting environment than the typical hospital waiting room.

The Boudicca Appeal continues, with the next phase to take place consisting of creation and upgrade to counselling and consultation rooms. Once all of the room upgrades are completed, we will be continuing with the Boudicca Appeal on a permanent basis, to enable medical staff to provide state-of-the art care for local breast unit patients on an ongoing basis.

This development has been made possible by the incredible fundraising efforts of local businesses, community groups and individuals, and we thank each and every person who has supported this Appeal. Your continued support will help us to complete work on the Unit and help with ongoing care for patients.

Please visit our website for further information on our plans for the unit, and to help us do more for patients: **www.nnhospitalscharity.org.uk**

Our Grants

This year our charitable expenditure of £1.7m has supported many projects designed to enhance patient care. The following pages highlight some of the new projects we have agreed to fund, as well as examples of the various ways in which charitable grants have already improved the hospital experience for patients, funded new and better equipment, and supported research, and staff education. Some of our grants are for millions of pounds, whereas others are for much smaller sums – donations of all sizes can make a real difference:

Supporting cutting-edge surgical procedures

£1,000,000 **Life-saving equipment & new technology** **2020**

In 2020 the Charity agreed to provide £1m funding towards a new surgical robot at the Norfolk and Norwich University Hospital,helping to deliver more cutting-edge treatments to improve patient care. More patients are now able to receive minimally invasive surgery, with improved recovery times.

Consultant Tim Duncan and the Gynaecology Cancer team have the new robot to perform laparoscopic (key-hole) surgery. In order to perform the first surgery, the team were assisted by nurses from Urology, who already have significant experience of robotic surgery.

Tim Duncan said: ***"With improved post-operative outcomes. Robotic surgery represents advancement in this form of surgery, allowing increasingly complex procedures to be performed. Thanks to the robot, operating times can be reduced from five to three hours and patients will be in less pain when they are recovering.***

"There are plans to extend the number of surgeons in our department who are trained to use the robot. This will mean we can deliver the advantages of robotic surgery to a wider group of patients, in particular those with endometrial cancer."

Supporting healthcare research to make improvements for NHS patients

£150,000 **Research** **2020/21**

During 2020/21 the Charity has agreed funding for a range of research projects, that it is hoped will make improvements for NHS patients. These include:

- £10,000 for a research project on the treatment of retinal detachment;
- £50,000 to fund a research fellow for Cardiology;
- £80,000 to fund research capability relating to infectious diseases;
- £10,000 to fund a melanoma database;

Annual Report 2020/21

Norfolk & Norwich Hospitals Charity

Supporting patients during the pandemic

£115,000 **Patients and their families** **2019**

The Volunteer Driver Scheme completed its first full year of operation in February 2021. Despite a series of disruptions and challenges posed by the global pandemic, the scheme has delivered on its original objective to help patients without alternative methods of transport get home from hospital safely and securely. It has also demonstrated innovation and flexibility in developing additional services during times of lockdown, providing the hospital with cost-effective support for key activities.

286 referrals were received and assessed, and 227 patients were transported home – 60 to North Norfolk, 32 to East Norfolk, 55 to South Norfolk, 33 to West Norfolk and 104 across Norwich. As you can see, the Volunteer Driver team have travelled the length and the breadth of the region, helping patients get home from hospital.

In March 2020, when the first national lockdown commenced, the Volunteer Driver Scheme was approached to support the delivery of pharmacy medications to patients shielding across Norfolk and Waveney. This support is still ongoing and so far 2474 pharmacy medications have been delivered across the region.

During the first lockdown the Weybourne Day Unit moved their chemotherapy service to the Norwich Spire Hospital so that patient treatments could continue. The Pharmacy team approached the Volunteer Driver Scheme for their help to transport chemotherapy treatments. The Charity was offered the use of a Mini by Chatsbrook Finance Ltd, and this vehicle was used by the volunteer team to transport the treatments between the two hospitals. Between 14 April and 28 August 2020 597 deliveries were made from the Norfolk & Norwich University Hospital to Weybourne @ Spire Hospital, covering 2169 miles, and ensuring that 60 patients per day were able to continue their treatment.

We congratulate the Voluntary Services Team for the difference this scheme has made for patients, and extend our sincere thanks to the Chatsbrook Finance team for their generosity in allowing us to use their car during the pandemic.

If you are interested in volunteering for the Norfolk & Norwich University Hospitals NHS Foundation Trust please visit the Trust's website at **www.nnuh.nhs.uk/getting-involved/volunteer-with-us**

Improving the life-chances for babies

£171,000 **Life-saving equipment & new technology** **2020**

In 2020/21 funding in the amount of £171,108 was agreed from NICU charitable funds, and from the Charity's general funds to purchase equipment for the Neonatal Intensive Care Unit (NICU), the Delivery Suite and for the Community Midwifery team, to help improve outcomes for babies.

Remote monitoring devices were purchased for the Delivery Suite, to allow women in labour freedom of movement while monitoring continues.

Portable ultrasound scanners were purchased for the community midwifery team, to enable confirmation of fetal presentation at home, avoiding the need to travel to hospital.

The NICU team have reported that our grant funding allowed them to purchase highly accurate monitoring equipment to be used on post-natal and transitional care babies. This allows prompt and accurate assessment of vital observations without the need to separate mums and babies. This promotes bonding and attachment and reduces parental anxiety. Having the equipment has reduced the number of babies needing transfer to NICU and has promoted early identification of subtle or developing issues .

Improving the environment in the Emergency Department for families coping with loss

£7,000 **Patients and their families** **2019**

The Charity aims to make improvements to the hospital environment where it will have the most impact for patients and their families.

The Emergency Department team and the Hospital's Environmental Arts Co-ordinator approached the Charity in 2019, to see whether we could help improve the bereaved relatives room, which had been described as 'gloomy' and 'dim'.

We were able to provide £7,000 in funding from our General Funds, and while we know that nothing can make receiving bad news 'better', we hope that the new room provides a kinder and more supportive environment for anyone dealing with loss, while in the N&N Emergency Department.

Improving the hospital environment

£33,000 **Patients and their families** **2019**

The Charity was asked to provide funding for better furniture for the Trust's Pain Management Clinic, based at Adelaide Street Health Centre. A budget of £33k was agreed and working with the Hospital Environmental Arts Team a consultation exercise with staff and patients resulted in a comprehensive scheme.

It was delightful to receive this feedback on the impact of the grant:

"On behalf of the Pain Management Service, based at Adelaide Street Health Centre, please can I extend a huge thank you to the NNUH Charities Fund, for our new furniture which has been delivered today.

Pain Management has been based off site since it was established upwards of 25 years ago; firstly at the Old West Norwich, latterly at Norwich Community Hospital and more recently at Adelaide Street.

The new furniture has given the whole team a real sense of pride, and we are really looking forward to welcoming patients back into the clinic once the situation allows."

Did you know....

that nearly 1 in 2 of our grants for improving patient care are thanks to gifts in wills?

Providing additional facilities at Cromer Hospital

£340k **Patients and their families** **2021**

We are very pleased to report that we have agreed funding to provide a new charity café facility at Cromer Hospital. The café will be situated in a new extension to the front of the main building, and will offer a larger space to accommodate the increased number of patients, visitors and staff expected as a result of the new North Norfolk Macmillan Centre.

The new café is expected to be built by the end of Autumn 2021, and will be open by the middle of December. It will be run on behalf of the Norfolk & Norwich Hospitals Charity, and we hope that it will help us to provide additional funds to enable further improvements at Cromer Hospital.

Weddings made possible for patients facing end-of-life care

£160 **Patients and their families** **2021**

The chaplaincy team at the Norfolk and Norwich University Hospital has used grant funding to fill boxes with items to support a wedding at the hospital at short notice for patients who are receiving end-of-life treatment who wish to marry their partners but are unable to attend a registry office.

The items include decorations to transform the patient's room, flowers, confetti, bunting, tea lights and keepsakes for the patient and new spouse.

Adrian Woodbridge, Head of Spiritual Care said of the services in hospital:

"It is a real mixture of joy and celebration and a reflection of what the occasion symbolises. It's a celebration of the couple's love and commitment to each other and the staff really help lift the spirits, decorating the patient's room and making a huge effort to create special memories. Due to the nature of the weddings, they are often at short notice. We support around four each year and these boxes make it easier for teams to create something special when time is limited."

What our supporters have achieved

The support for our Charity continues to grow with patients, friends, family, staff, and the local community making donations and organising and taking part in events. Here are just some of the highlights of the year but we know there are many more unsung heroes, and we thank you all for your support.

James Barham raises almost £30,000 during leukaemia treatment

James Barham faced both the happiest and hardest of times in the space of a few weeks last year.

On April 2 his first child, Charlie, was born but just four weeks later, James blacked out and was taken to the N&N for blood tests and a bone marrow biopsy. Within minutes of leaving the hospital, James received a call from medical staff with the news he had aggressive blood cancer, acute myeloid leukaemia, and was to return the next day to start chemotherapy.

Despite the gruelling treatment, James spent his time on Mulbarton ward leading a fundraising campaign to thank staff for their amazing care and support. His campaign proved to be an inspiration to almost 1,000 people across the world who made a donation, raising almost £30,000 for the cancer teams at the N&N.

One year on, James returned to meet Mulbarton Ward Sister Kirsty Lewis and Head of Radiotherapy Mark Gilham to plan where the money will be spent.

James said: ***"I couldn't be happier with the decision that we've made and look forward to seeing the results."***

We are so grateful to everything James has done to raise money for the cancer teams here at the N&N and we know the money he has raised will directly benefit patients for many years to come.

TikTok videos are sweet gift to charity

Reece Durrant, Cytology Biomedical Support Worker raised £210 for the hospital charity following the sales of festive fudge sold to colleagues and friends and the community.

The former assistant manager at a bakery, used his previous baking knowledge to raise the money, with the support of Pure Gym in Aylsham Road, ASDA Hellesdon, Tesco in Aylsham Road, Morrisons in Dereham, who all donated ingredients.

Simon's fundraising walk for hospital charity in exoskeleton suit

A Norfolk man, who became the first paralysed man to walk the London Marathon, took part in a new challenge in February this year, raising almost £14,000 for our charity.

Simon Kindleysides, 35, from Blofield, set himself a goal to walk four miles every day of February wearing a specially-made exoskeleton suit.

The batteries in his suit will allow Simon to travel four miles before they need recharging and each four-mile leg will take him three-and-a-half hours to complete.

He said at the time: ***"I was sitting at home doing nothing and I just wanted to do something to support the NHS and in particular, the teams at the NNUH, and I will be walking various four-mile routes through Norwich during the month.***

"This lockdown is driving everyone crazy, mentally and physically so I wanted to push myself again."

During wet weather, Simon called on members of his bubble to accompany him with an umbrella.

Simon was a dancer and a restaurant manager but in 2013 was diagnosed with a brain tumour and functional neurological disorder that left him paralysed from the waist down.

Simon's challenge, which involved 8,000 steps each day and a total of 224,000 across the month, received national and international media coverage. In June he was named Volunteer Fundraiser of the Year at the Chartered Institute of Fundraising (East Anglia) Awards.

Paige bakes up a charity treat

Talented young baker Paige has been raising money for the Jenny Lind Children's Hospital by baking and selling her fantastic cakes.

The eight-year-old has already raised more than £400 for the hospital where she has been treated for the past two years for Juvenile Idiopathic Arthritis.

We think Paige is wonderful and her cakes are amazing. Her fundraising is delicious practice before she applies to enter the Junior Great British Bake Off next year, when she turns nine. The money she is raising will make a huge difference for our youngest patients in the hospital where work is continuing to create a £6.5m dedicated theatre complex.

Head shave raises £3,000 for Boudicca Appeal

Senior Operating Department Practitioner Kate Didwell and Operating Department Practitioner Hannah Hembry-Pearson took part in an April Fool's Day head shave, raising £3,000 for the Boudicca Breast Cancer Appeal.

Kate and Hannah work in the plastic reconstructive theatres where their work supports reconstructive procedures for patients following breast cancer.

Hannah said: "We wanted to recognise our patients' bravery and recovery by fundraising and doing something for the greater good – it is not only inspiring ourselves but also those we work with."

Tribute to fundraiser Brian Garrad

This year we sadly lost one of our oldest fundraisers, Brian Garrad, who raised almost £4,000 during the first national Covid lockdown, back in Spring 2020.

The 97-year-old Army veteran, who served with the 120th Light Anti-Aircraft Regiment during the Second World Ward, had been due to take part in VE Day celebrations at Buckingham Palace before they were cancelled as a result of the Covid-19 pandemic.

The three-day celebration should have seen a parade through the capital, a flyover, afternoon tea at the Palace, followed by dinner with the Queen and other members of the Royal Family.

However, instead, Mr Garrad took on his own challenge, walking around his garden in a bid to cover 10 miles in a month – 70 laps. Despite, having COPD, Mr Garrad celebrated VE Day doing more laps with his family and taking part in their own mini-parade.

The Charity Team were deeply saddened to hear that Mr Garrad had passed away, saying that "He was a true inspiration to us all and we have such lovely memories of his fundraising efforts and his fantastic VE Day celebrations at home. The money he raised is making a huge difference to our hospital and our thoughts are with all his family and friends."

THANK YOU

for all the support you have given to us and to our Trust's NHS staff

Gifts in Wills

Legacy gifts can have a huge impact, funding the latest medical equipment, providing staff development opportunities, creating welcoming environments and funding pioneering research.

Projects funded by legacies recently include:

- staffing costs for three years for a mobile cancer care unit taking cancer treatment closer to home for patients across the region;
- developing the cancer centre at Cromer Hospital;
- providing £1m for a new surgical robot;
- creation of the Boudicca Breast Unit at the Norfolk & Norwich Hospital

Our legacies in 2020-21 ranged from £250 to more than £100,000 and allowed us to provide funding where it is needed most. Some were cash gifts while others were a portion of the remaining estate, after family and friends had been taken care of.

Every gift, large or small, makes a real, lasting difference for local patients.

A recent legacy came from Florence Bradley (known as Babs), who moved to Norfolk in 1986 and grew to love the county.

Florence's nephew told us she was an ***'amazing lady'***, who had done many jobs, from being a nanny at 14 to working in a sewing factory, working in a Co-op and managing a hairdressers. She loved people and would talk to anyone. At 91 Florence was still catching the bus into Great Yarmouth, until she fell and broke her hip. Sadly, she passed away in April 2020.

Florence's decision to leave the residue of her estate to two hospitals in the county she loved has made her family very proud. In their words, ***'It could not have been a better choice'***.

Did you know....

over the past four years, one in two of the projects funded by the N&N Hospitals Charity were made possible by a gift in a will?

Breast Cancer legacy

We were also fortunate to receive notification of a legacy gift from Bernice Clarke, and were privileged to be told her story by her friend Christine.

Bernice and her husband, Stan, moved to Norfolk and ran the village post office in Horning for many years. Bernice was diagnosed with breast cancer around the same time that her husband Stan was diagnosed with Alzheimer's, and despite the cancer and its treatment, she was able to look after him at home until he died in 2000.

Christine has described Bernice as a ***'very independent lady with a wicked sense of humour'***, who looked after people's dogs, cats and even parrots, as she was lovely with animals. She did meals on wheels and offered lifts to anyone wanting to get to medical appointments etc., until she had to give up driving due to her health.

Bernice passed away in December 2020, and asked for her legacy to go to the Breast Unit at the Norfolk & Norwich Hospital. It will be used to complete the works being undertaken as part of our Boudicca Breast Cancer Appeal, so that Bernice's legacy provides improvements for other patients for many years into the future.

A family decision to leave gifts in wills

We recently had the privilege to receive a legacy gift from Nicholas Fuller, known to family and friends as Nick.

Nick was diagnosed with muscular dystrophy at a very young age, and his condition developed as he got older. Nick's parents were initially told that his lifespan would be around 35 years. He was 54 when he passed away, and had enjoyed his life to the full, making visits around the world with his parents, and making friends wherever he went.

Nick's father, George, describes him as an **'amazing young man, in that he never let his disability affect his approach to life. Always with a smile on his face, loved and respected by everyone who knew him.'** Nick became wheelchair dependant at the age of 38, but continued with his passionate support for Manchester United Football Club, travelling to Manchester for 12 home games each season.

Nick worked for the Ministry of Defence, after leaving school at 16, and served in Germany at the same time as his father George was there serving in the Royal Air Force. On their return to the UK Nick was stationed at an RAF base in Cambridgeshire until he passed away in 2020.

When the family moved to Norfolk in 2003, the Norfolk & Norwich University Hospital was where Nick was monitored by consultants from various departments. Nick's father cannot speak highly enough of those consultants, with one in particular forming a special bond with the family.

George was diagnosed with a form of cancer in 2017, and when the family decided to update their wills in 2019, they asked for legacy gifts to the Norfolk & Norwich Hospitals Charity to be included, as a way of saying thank you for the treatment they have received.

Nick's family are very proud of their son, and we are privileged to have heard his story, and to be able to help create a lasting legacy from the gift he has given in his will. We thank the family for their generosity.

For more information about leaving a legacy to your local hospitals, to benefit your friends, neighbours and the local community please contact legacy@nnuh.nhs.uk.

Financial Review

The following key figures are taken from the 2020/21 Accounts, which carry an 'unqualified audit' report:

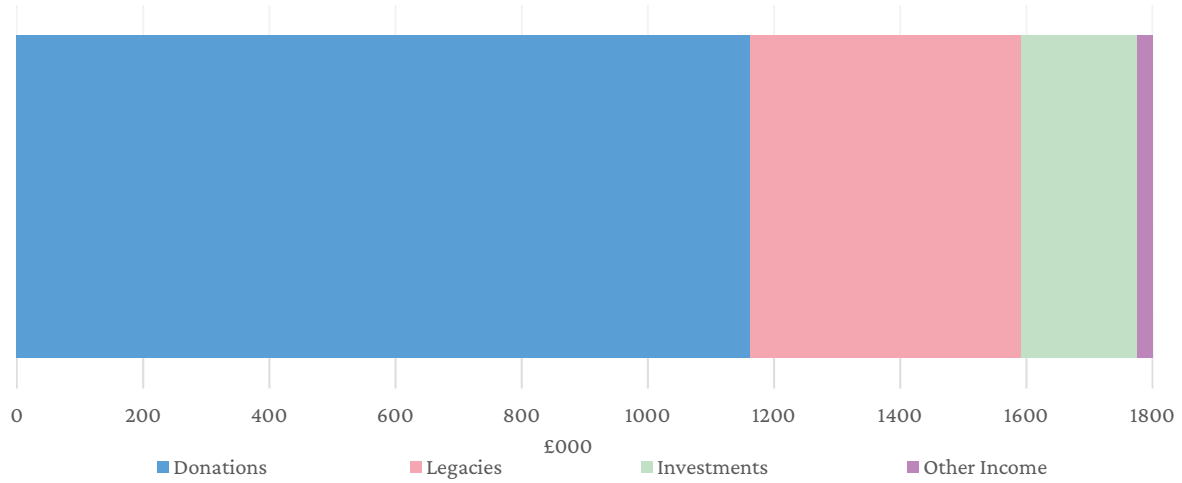
Funds received in the year (£1.8m)

Donations received (£1,162k)

The Charity was privileged to benefit from the huge outpouring of support for the NHS, with donated income totalling £1,162k (£796k in the previous year). This includes £421k received in grant funding, primarily from the NHS Charities Together Covid Emergency Appeal, and £695k from donations made by our local community, including gifts of meals, flowers, toiletries, white goods, etc for our NHS Trust staff.

Legacy donations (£430k)

A gift in a will really is an investment in the future of our charity, and we are fortunate to be supported in this way by so many people each year. Income from legacies is expected to vary from year to year but it continues to make an important contribution to the Charity with £430k received in 2020/21 (£292k in 2019/20).



Investment income (£185k)

Through application of a formal Investment Policy, this year the Charity used its funds to generate a further £185k of investment income (£243k in 2019/20). This was achieved in the form of dividends and bank interest. The Investment Policy and performance are regularly monitored by the Corporate Trustee through its Charitable Funds Committee.

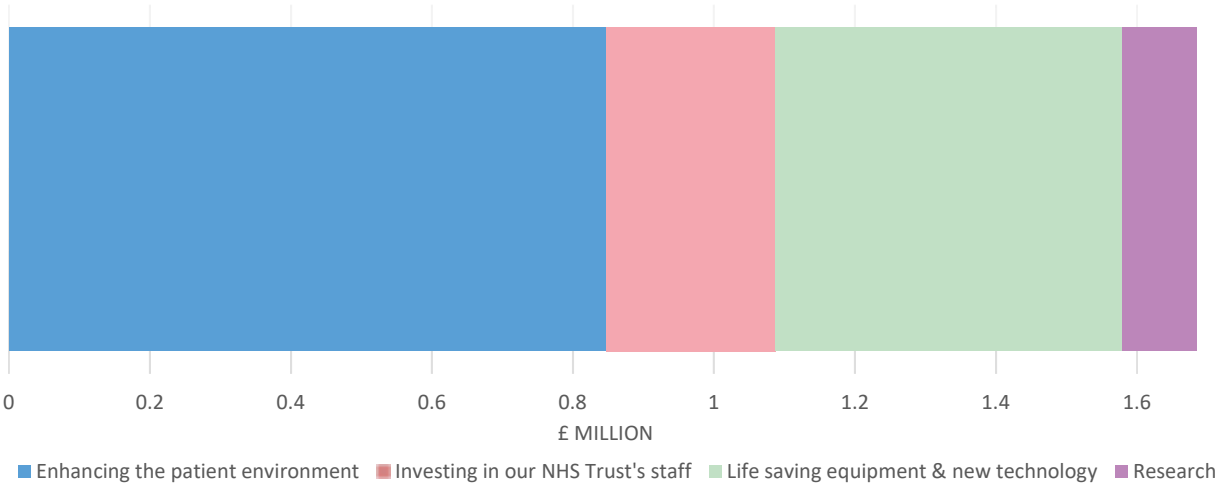
Other income (Total £24k)

Departments within the Trust were not able to run the many courses and conferences they usually would, due to the pandemic. Additionally, the Charity was not able to hold face to face fundraising events (2019/20: £132k)

Money spent in the year (£1.8m)

Expenditure on Charitable Activities (£1.7m)

The expenditure for the year on charitable activities was £1.7m (£3.2m in the previous year). The breakdown of expenditure on the Charity's four key areas of focus in 2020/21 is shown below:



Examples of expenditure and funding committed for expenditure include:

- £50k to fund 1 year's salary for a Cardiology Research Fellow;
- £2k to purchase a bariatric reclining chair for the Weybourne Day Unit;
- £8k to fund an upgrade to an existing cardiac ultrasound machine
- £35k to fund an Augmented Reality system for use in 3D modelling for research, training and treatment;
- £68k to purchase additional remote CTG monitoring devices for the Delivery Suite;
- £100k to purchase additional ultrasound scanners for the community midwifery team.

Expenditure on Raising Funds (£127k)

Expenditure on raising funds includes the cost of fundraising staff as well as promotional material, the purchase of leaflets, donation boxes and envelopes. The Charity's aim is to keep fundraising costs as low as possible whilst appropriately promoting the Charity and its work. In this way our supporters can be confident that the maximum possible portion of their donation is being spent on charitable activities. For 2020/21 expenditure on raising funds equated to 7p for each £1 spent, compared to 93p on charitable activities. Whilst the amount spent on fundraising is expected to increase over the next few years, as the Charity grows, our intention is to keep it as low as possible, maximising funds available for supporting the Trust.

Fund balance (£11.7m) and reserves

The Corporate Trustee has set a minimum reserve level of £0.5m in unrestricted funds, to ensure that ongoing costs for running the Charity can be met, as well as providing a buffer for fluctuations in the value of investments.

At 31 March 2021, the total funds of the Charity amounted to £11.7m (£10.0m at the end of 2019/20). Of these:

- £0.5m was held in restricted funds for use in the Jenny Lind Children's Hospital, at Cromer Hospital and to support NHS staff. £0.4m has been committed for expenditure from these funds;
- £9.0m was held in unrestricted (designated) funds where money has been donated for particular purposes, but no binding trust has been created. We aim to follow donor's wishes on the focus of expenditure when it is practicable to do so. £3.8m has been committed for expenditure from these funds;
- £2.1m in unrestricted general funds. (£0.6m in 2019/20). £0.4m has been committed for expenditure from these funds.

The Charity's Head of Grants works with individual fund advisers to plan expenditure of funds. In addition, the Charity has established a series of strategic plans for expenditure of the Charity's funds in the years ahead, aimed at maximising beneficial impact and promoting sustainability of the charity. The timing of major expenditure is under the control of the Corporate Trustee (and Charitable Funds Committee under delegated authority).

At the end of 2020/21, £0.4m of unrestricted funds had been agreed for future projects. The total amount of funding agreed for future expenditure from all funds is £4.6m.

As a result of the recovery of investment values during 2020/21, the Charity had free reserves of £1.7m at the end of March 2021.

Investment policy and performance

The Charity has a formal Investment Policy and Investment Mandate, approved and overseen by its Charitable Funds Committee. The objective of this Policy is to ensure that there is a diversified portfolio of investments (thereby spreading exposure to risk) with an intention to maximise financial return to the Charity within a 'medium risk' investment profile.

At the end of 2020/21, £9.6m of the Charity's funds were invested in the diversified portfolio of investments, managed by Barratt & Cooke stockbrokers regulated by the Financial Conduct Authority. In 2020/21, the administration charge for management of the Charity's investments was £876 (2019/20: £900).

During the year, there was a net gain of £1.7m on investments (£0.6m loss in 2019/20). This was made up of a realised gain of £44k from disposal of investments (loss of £31k in 2019/20), and an unrealised gain of £1,678k on the investment portfolio held at the year-end (loss of £608k in 2019/20).

The Charity uses professional and regulated investment services to manage its investment portfolio. Investment performance is kept under review by the Charity Team and Charitable Funds Committee, and the Investment Manager meets with the Committee on an annual basis to discuss performance and strategy. Barratt and Cooke were reappointed in 2019/20 to provide Investment Manager services to the Charity for the period to 2022.

Trustee arrangements

The Norfolk and Norwich University Hospitals NHS Foundation Trust (the Trust) is the sole corporate trustee of the Charity and the Trust's Board of Directors is tasked with exercising all powers and duties of the Trust, including the responsibility of corporate trustee. Membership of the Board of Directors is detailed in the Trust's Annual Report and Accounts and on its website (www.nnuh.nhs.uk).

The Trust Audit Committee and Trust Board have considered whether the Charity accounts should be consolidated with those of the Trust. Whilst the Charity may be considered to be 'under the control' of the Trust Board, it is not considered to be financially material to the Trust and the accounts are therefore not consolidated.

The Board has established a Charitable Funds Committee with formal Terms of Reference which are reviewed and updated on a regular basis. The purpose of the Committee is to:

- provide assurance oversight of the management of the Charity;
- oversee investment of the Charity's assets;
- assist the Board in meeting its responsibilities as Corporate Trustee;
- support the Corporate Trustee in strategic overview of the Charity.

During 2020/21, the members of the Charitable Funds Committee were:

Joanna Hallam	Non-Executive Director and Chair of Committee
John Paul Garside	Board Secretary - Executive Lead for the Charity
Sam Higginson	NNUHFT Chief Executive
Roy Clarke	NNUHFT Chief Finance Officer
Simon Hackwell	NNUHFT Director of Strategy
Julian Foster	Non-Executive Director
Tom Spinks	Non-Executive Director

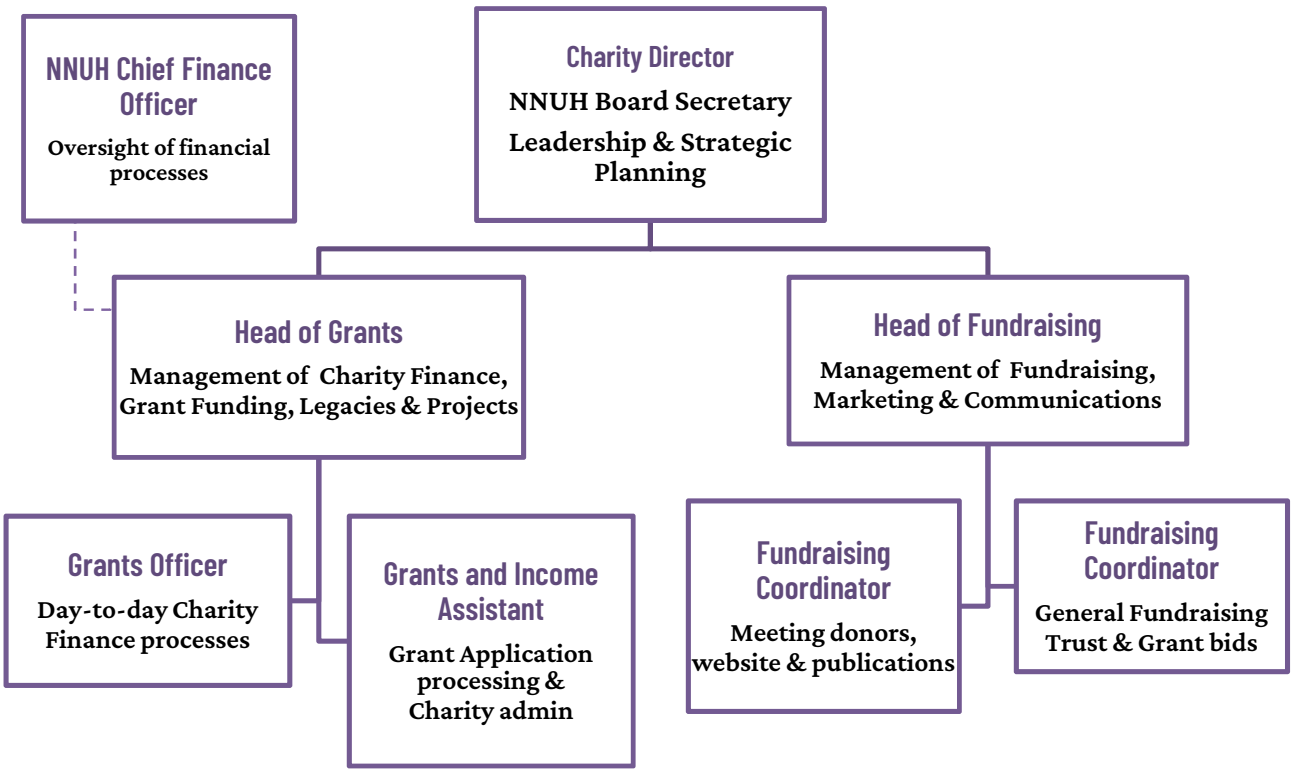
The Charitable Funds Committee has been active on behalf of the Corporate Trustee in overseeing and encouraging development of the Charity during 2020/21. This has involved strengthening the governance and management arrangements for the Charity and enhancing its forward planning. Work undertaken by the Committee during the year has included:

- reviewing and approving the Charity Investment Policy to ensure that there is appropriate diversification of investments and balance between investment return, ethical considerations and mitigation of investment risks;
- overseeing development of plans for major projects such as provision of a new café building and service at Cromer Hospital;
- developing and implementing the charity's Communication and Legacy strategies;
- establishing additional income streams, including the launch of the charity's fundraising lottery;
- working with clinical and managerial teams to identify funding priorities and expenditure plans including funding for staff rest areas and additional clinical equipment and facilities for the Jenny Lind Children's Hospital

In accordance with the scheme of delegation and standing financial instructions, the Trust Board delegates responsibility for the day to day management of the N&N Hospitals Charity to the Trust's Chief Executive and Executive lead for Charitable Funds.

Our staff and advisors

Executive oversight of the Charity is undertaken by John Paul Garside, Board Secretary and General Counsel for the Trust. Management and operation of the Charity is carried out by:



Professional Advisers

Investment managers:

Messrs. Barratt & Cooke
5/6 Opie Street
Norwich
NR1 3DW

External auditors:

KPMG LLP (UK)
Dragonfly House
2 Gilders Way
NR3 1UB

Bankers:

Barclays Corporate Services
Po Box 729
1 Capability Green
Luton
Bedfordshire
LU1 3US

Risk Management

As part of the business planning process for the Charity, the Charitable Funds Committee has considered the major risks to which the Charity is exposed. The risk areas particularly assessed were governance and management, operational risk, financial risk, reputational risk, environmental and external factors, and compliance risk. The highest risks were determined as:

- **Strategic uncertainty and failure to achieve the Charity's full potential**

- Uncertainty over NHS strategy and finances, particularly as a result of the Covid pandemic, blights planning for the Charity with respect to both expenditure and fundraising risk. Mitigation includes the setting of annual plans, with an objective to increase expenditure. The plan for 2020/21 was the most ambitious annual plan; however, this was impacted by the pandemic. Systematic construction of the foundations for future success and sustainability has taken place, with agreement of Communications, Legacy and Investment strategies; improved governance processes; and establishment of connections with fund advisers to agree clinically relevant appeals and projects. Further work is required on Fundraising and Financial strategies, with an overarching Charity strategy to be developed once the Trust's own strategy is in place.

- Strategic focus and ambition for Charity is inevitably limited due to primary focus of Corporate Trustee on the Trust. The NHS is going through a period of unprecedented challenge and change, and the Charity seeks to develop a strategy that recognises future uncertainty, and prioritises projects that will enhance sustainable income streams. Opportunities for sources of income other than investment or donation will be explored, alongside opportunities for partnerships and match funding. There is a need to strike a balance between the certainty required to fundraise, whilst enabling flexibility as the Trust's strategy develops. Work will take place to draw on the Charity's 'core' audiences and support base in North Norfolk, Paediatrics and chronic conditions.

- Inadequate historical resourcing of Charity Team inhibits delivery of challenging agenda. A lot of work has been done in recent years to develop the Charity's capacity to deliver projects, including reforming and refocussing the Charitable Funds Committee, creation of a single Charity Team, establishment of a governance structure and policy portfolio and appointment of the Trust's Company Secretary as Charity Director. Development of the Charity Team will continue apace, to enable delivery of large fundraising appeals, and matching expenditure resulting from the Norfolk and Norwich Hospital's 250th anniversary in 2022.

- **Financial risks in a Post-Covid economic downturn**

- There is a possibility that the Charity will encounter 'fallow ground' for fundraising and communication messaging due to an economic downturn. This could be as a result of a failure to adequately promote the Charity. To mitigate this issue, an expanded and targeted expenditure programme demonstrates the value of giving to the Charity, alongside enhanced impact reporting. Our Communications and Legacy strategies, approved in October 2020, promote giving to the Charity, and publicises the value of doing so. Further steps will be taken to enhance the profile and presence of the Charity, including establishment of a Charity Hub on the N&N and Cromer Hospital sites. The Charity needs the support of the Trust with respect to the presence of other charities on Trust property, and their ability to fundraise at the Trust's linked NHS Charity's expense.

- Pressure to expend charity assets inappropriately increases at times of financial distress in the NHS. This is mitigated by the guidance from the Charity Commission on maintaining independence in the management of charitable funds,

which was provided to the Charitable Funds Committee, and a reminder on every Committee agenda. There is demarcation in Board agendas to distinguish when acting as Corporate Trustee, with duties only to the Charity, and the Scheme of Delegation incorporates proportionate controls to prevent executive misapplication of fund for non-charitable purposes.

- **Financial risk through reliance on voluntary income and 'at risk' investments**

-Overreliance on voluntary income, with no endowments or reliable sources of future income. This results in uncertainty over future donations, and is mitigated by a Legacy strategy to increase our legacy income stream in future years, and approval to set up a Charity Lottery and a Charity Café at Cromer Hospital. In addition, there is exploration for additional ways to create diversified income streams that are not dependent on individual acts of benevolence.

- Vulnerability through lack of sustainable income streams or diversification in modes of investment. Large swings in the value of the Charity's investments in the stock market can create extreme differences in the Charity's fund value at any time. This is mitigated by the utilisation of a professional Funds Manager, with performance subject to regular review and targets against industry benchmarks. The Charity has a formal investment policy, with a 'Medium Risk' investment mandate, subject to regular review. An expenditure programme for active utilisation of funds reduces exposure to fluctuations of the stock market. The Charity aims to develop projects to diversify investments, including purchasing property for staff accommodation and other mixed-motive investments.

- **Competing Operational Priorities**

- Trust and corporate departments are preoccupied with other demands and their 'core' operational priorities, resulting in limited support for Charity. Demands on Trust corporate functions have increased during the Covid pandemic, and the related distortion of the Trust's capital programme. It has therefore been impossible to implement the Charity's 2020/21 expenditure programme, and future programmes may need to be selected based on a lower reliance on Trust functions where possible, and on the use of external project management and turnkey solutions.

- **Lack of adequate Charity presence or promotion**

- lack of facilities dedicated to the Charity results in inadequate presence and profile. SWOT analysis confirms the need to develop communication and messaging around the Charity, resulting in the approval of a Communications strategy in October 2020, to be implemented over three years. Further measures include the need to enhance the Charity's presence through installation of an Interim Charity Hub at the N&N site, creation of a new Charity Café at Cromer Hospital, followed by creation of a Charity Hub in the current café location. Ultimately, the charity seeks to establish a firm presence at the N&N site, with creation of a permanent Hub giving room for the team to grow, with provision of additional café facilities, staff rest areas and training/seminar rooms for use by the Trust.

- inadequate differentiation between identity of Charity and that of the Trust. This is mitigated by the Communication strategy, with actions to enhance and promote identity of the Charity as distinct from that of the Trust.

Fundraising Report

Donors to the Norfolk and Norwich Hospitals Charity can be assured that we comply with the regulatory standards for fundraising. We are registered with the Fundraising Regulator and are committed to the Fundraising Promise and adherence to the Code of Fundraising Practice. This report covers the requirements charities must follow as set out in the Charities Act 2016.

Like every charity in 2020/21, we faced a year of obstacles and challenges. Much of the year's activity has been supporting virtual events organised by members of the public and the community. Planned events were cancelled, in keeping with Covid guidance at the time. Support was provided to our wonderful by phone, email and social media.

In early 2021 it was agreed to use Unity Community Lottery platform (run by external service provider Sterling Lotteries) to launch a N&N Hospitals Charity Lottery open to staff and public to raise monies for the charity. The first draw was in April 2021.

We are registered with the Fundraising Regulator and comply with all the relevant standards set out in the Code of Fundraising Practice. Two out of three members of our fundraising team are members of the Chartered Institute of Fundraising. Complaints are dealt with in line with the Norfolk & Norwich University Hospitals NHS Foundation Trust complaints policy, which can be found on their website. We received one complaint in the 2020/21 financial year. In the previous year, we received two complaints. All complaints are investigated and responses made.

The Charity follows the Trust's Safeguarding Policy, which is in place to protect people in vulnerable circumstances. We also adhere to industry guidelines and regulations and are here to talk to individuals about our work, or to answer any questions. Contact can be made via our website, social media, emails, phone or by post.

Related parties

The Norfolk and Norwich University Hospitals NHS Foundation Trust is the corporate trustee of the N&N Hospitals Charity and is therefore a related party.

Our relationship with the wider community

The ability of the N&N Hospitals Charity to continue its work is dependent on its ability to maintain donations from the general public. The N&N Hospitals Charity continues to forge strong relationships with members of staff of the hospital without whose co-operation the ability to make an effective contribution would be much diminished.

Volunteers

The Charity pays tribute to:

- our volunteers for their time, support, and commitment;
- the members of staff who give of their time out of hours in support of the work of the N&N Hospitals Charity;
- our fundraisers who do so much to enrich lives through donations and fundraising activities;
- the many external organisations, companies, trusts, and foundations that have supported our work.

Signed on behalf of the trustee:

Statement of the Trustee's responsibilities in respect of the Trustee's annual report and the financial statements

Under the trust deed of the charity and charity law, the trustee is responsible for preparing the Trustee's Annual Report and the financial statements in accordance with applicable law and regulations. The trustee has elected to prepare the financial statements in accordance with UK Accounting Standards, including FRS 102 *The Financial Reporting Standard applicable in the UK and Republic of Ireland.*

The financial statements are required by law to give a true and fair view of the state of affairs of the charity and of the incoming resources and application of resources for that period.

In preparing these financial statements, generally accepted accounting practice entails that the trustee:

- select suitable accounting policies and then apply them consistently;
- make judgements and estimates that are reasonable and prudent;
- state whether applicable UK Accounting Standards and the Statement of Recommended Practice have been followed, subject to any material departures disclosed and explained in the financial statements;
- state whether the financial statements comply with the trust deed, subject to any material departures disclosed and explained in the financial statements;
- assess the charity's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and
- use the going concern basis of accounting unless they either intend to liquidate the charity or to cease operations or have no realistic alternative but to do so.

The trustee is required to act in accordance with the trust deed of the charity, within the framework of trust law. They are responsible for keeping accounting records which are sufficient to show and explain the charity's transactions and disclose at any time, with reasonable accuracy, the financial position of the charity at that time, and to enable the trustee to ensure that, where any statements of accounts are prepared by them under section 132(1) of the Charities Act 2011, those statements of accounts comply with the requirements of regulations under that provision. They are responsible for such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error, and have general responsibility for taking such steps as are reasonably open to them to safeguard the assets of the charity and to prevent and detect fraud and other irregularities.

The trustee is responsible for the maintenance and integrity of the financial and other information included on the charity's website. Legislation in the UK governing the preparation and dissemination of financial statements may differ from legislation in other jurisdictions.

These financial statements were approved on 3 November 2021 and signed on behalf of the trustee by:

Board member: ..... Name: .....

Date: .....

Independent auditor's report to the Trustee of Norfolk and Norwich Hospitals Charity

Opinion

We have audited the financial statements of Norfolk and Norwich Hospitals Charity ("the charity") for the year ended 31 March 2021 which comprise the Statement of Financial Activities, Balance Sheet, Statement of Cash Flows and related notes, including the accounting policies in note 1.

In our opinion the financial statements:

- give a true and fair view of the state of the charity's affairs as at 31 March 2021 and of its incoming resources and application of resources for the year then ended;
- have been properly prepared in accordance with UK accounting standards, including FRS 102 *The Financial Reporting Standard applicable in the UK and Republic of Ireland*; and
- have been prepared in accordance with the requirements of the Charities Act 2011.

Basis for opinion

We have been appointed as auditor under section 144 of the Charities Act 2011 (or its predecessors) and report in accordance with regulations made under section 154 of that Act.

We conducted our audit in accordance with International Standards on Auditing (UK) ("ISAs (UK)") and applicable law. Our responsibilities are described below. We have fulfilled our ethical responsibilities under, and are independent of the charity in accordance with, UK ethical requirements including the FRC Ethical Standard. We believe that the audit evidence we have obtained is a sufficient and appropriate basis for our opinion.

Going concern

The trustee has prepared the financial statements on the going concern basis as they do not intend to liquidate the charity or to cease its operations, and as they have concluded that the charity's financial position means that this is realistic. They have also concluded that there are no material uncertainties that could have cast significant doubt over its ability to continue as a going concern for at least a year from the date of approval of the financial statements ("the going concern period").

In our evaluation of the trustee's conclusions, we considered the inherent risks to the charity's business model and analysed how those risks might affect the charity's financial resources or ability to continue operations over the going concern period.

Our conclusions based on this work:

- we consider that the trustee's use of the going concern basis of accounting in the preparation of the financial statements is appropriate;
- we have not identified, and concur with the trustee's assessment that there is not, a material uncertainty related to events or conditions that, individually or collectively, may cast significant doubt on the charity's ability to continue as a going concern for the going concern period.

However, as we cannot predict all future events or conditions and as subsequent events may result in outcomes that are inconsistent with judgements that were reasonable at the time they were made, the above conclusions are not a guarantee that the charity will continue in operation.

Fraud and breaches of laws and regulations – ability to detect

Identifying and responding to risks of material misstatement due to fraud

To identify risks of material misstatement due to fraud ("fraud risks"), we assessed events or conditions that could indicate an incentive or pressure to commit fraud or provide an opportunity to commit fraud. Our risk assessment procedures included:

- Enquiring of management and inspection of documentation as to the entity's high-level policies and procedures to prevent and detect fraud.
- Reading Board meeting minutes.
- Using analytical procedures to identify any unusual or unexpected relationships.

We communicated identified fraud risks throughout the audit team and remained alert to any indications of fraud throughout the audit.

As required by auditing standards, we perform procedures to address the risk of management override of controls and the risk of fraudulent revenue recognition. However, due to the nature of the income received by the charity we have rebutted the fraud risk in relation to revenue recognition.

Within the Charities sector, auditors also consider the risk that material misstatements due to fraudulent financial reporting may arise from the manipulation of expenditure recognition and therefore an additional risk has been identified in relation to this. Due to the nature of the expenditure recognised by the Charity, this risk has been limited to expenses which do not relate to transfers to the Norfolk and Norwich University Hospitals NHS Foundation Trust.

We performed procedures including:

- Identifying journal entries to test based on risk criteria and comparing the identified entries to supporting documentation. These included those posted to unusual accounts combinations;
- Agreeing a sample of expense transactions back to relevant invoices and supporting documentation.

Identifying and responding to risks of material misstatement due to non-compliance with laws and regulations

We identified areas of laws and regulations that could reasonably be expected to have a material effect on the financial statements from our general commercial and sector experience and through discussion with the Trustee and other management (as required by auditing standards). We discussed with the Trustee and other management the policies and procedures regarding compliance with laws and regulations.

We communicated identified laws and regulations throughout our team and remained alert to any indications of non-compliance throughout the audit.

The potential effect of these laws and regulations on the financial statements varies considerably.

Firstly, the Charity is subject to laws and regulations that directly affect the financial statements including financial reporting legislation (including the Charities SORP) and taxation legislation and we assessed the extent of compliance with these laws and regulations as part of our procedures on the related financial statement items.

Secondly, the Group is subject to many other laws and regulations where the consequences of non-compliance could have a material effect on amounts or disclosures in the financial statements, for instance through the imposition of

fines or litigation. We identified the following areas as those most likely to have such an effect: health and safety, anti-bribery, and certain aspects of charity legislation, recognising the nature of the Charity's activities and its legal form. Auditing standards limit the required audit procedures to identify non-compliance with these laws and regulations to enquiry of the Trustee and other management and inspection of regulatory and legal correspondence, if any. Therefore, if a breach of operational regulations is not disclosed to us or evident from relevant correspondence, an audit will not detect that breach.

Context of the ability of the audit to detect fraud or breaches of law or regulation

Owing to the inherent limitations of an audit, there is an unavoidable risk that we may not have detected some material misstatements in the financial statements, even though we have properly planned and performed our audit in accordance with auditing standards. For example, the further removed non-compliance with laws and regulations is from the events and transactions reflected in the financial statements, the less likely the inherently limited procedures required by auditing standards would identify it.

In addition, as with any audit, there remains a higher risk of non-detection of fraud, as these may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal controls. Our audit procedures are designed to detect material misstatement. We are not responsible for preventing non-compliance or fraud and cannot be expected to detect non-compliance with all laws and regulations.

Other information

The trustee is responsible for the other information, which comprises Statement of Trustee's responsibilities in respect of the Trustee's annual report and the financial statements. Our opinion on the financial statements does not cover the other information and, accordingly, we do not express an audit opinion or, except as explicitly stated below, any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether, based on our financial statements audit work, the information therein is materially misstated or inconsistent with the financial statements or our audit knowledge. We are required to report to you if:

- based solely on that work, we have identified material misstatements in the other information; or
- in our opinion, the information given in the Trustee' Annual Report is inconsistent in any material respect with the financial statements.

We have nothing to report in these respects.

Matters on which we are required to report by exception

Under the Charities Act 2011 we are required to report to you if, in our opinion:

- the charity has not kept sufficient accounting records; or
- the financial statements are not in agreement with the accounting records; or
- we have not received all the information and explanations we require for our audit.

We have nothing to report in these respects.

Trustee's responsibilities

As explained more fully in their statement set out on page 27, the trustee is responsible for: the preparation of financial statements which give a true and fair view; such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; assessing the charity's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and using the going concern basis of accounting unless they either intend to liquidate the charity or to cease operations, or have no realistic alternative but to do so.

Auditor's responsibilities

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue our opinion in an auditor's report. Reasonable assurance is a high level of assurance, but does not guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements.

A fuller description of our responsibilities is provided on the FRC's website at www.frc.org.uk/auditorsresponsibilities.

The purpose of our audit work and to whom we owe our responsibilities

This report is made solely to the charity's trustee as a body, in accordance with section 144 of the Charities Act 2011 (or its predecessors) and regulations made under section 154 of that Act. Our audit work has been undertaken so that we might state to the charity's trustee those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the charity and its trustee as a body, for our audit work, for this report, or for the opinions we have formed.

Stephanie Beavis
for and on behalf of KPMG LLP, Statutory Auditor
Chartered Accountants
Dragonfly House
2 Gilders Way
Norwich
NR3 1UB

3 November 2021

KPMG LLP is eligible to act as an auditor in terms of section 1212 of the Companies Act 2006

How to contact us

Further information about the Charity is available via our website at www.nnhospitalscharity.org.uk

The charity office and working address of the N&N Hospitals Charity is:

c/o The Head of Grants

N&N Hospitals Charity

East Atrium

Norfolk & Norwich University Hospital

Norwich

NR4 7UY

01603 287495

Email - charity@nnuh.nhs.uk

For fundraising queries please contact:

The Head of Fundraising

N&N Hospitals Charity

East Atrium

Norfolk & Norwich University Hospital

Norwich

NR4 7UY

01603 287107

Email – fundraising@nnuh.nhs.uk

The corporate trustee, Norfolk and Norwich University Hospitals NHS Foundation Trust, principal address is:

The Chief Executive

Norfolk and Norwich University Hospital

Norwich Research Park

Norwich

NR4 7UY

01603 286286

Statement of Financial Activities

The Statement of Financial Activities is a financial report detailing the change in the charity's net assets during the financial year.

It provides an analysis of the income received and expenditure by the charity on its activities and presents a reconciliation of the movements in a charity's funds for the reporting period, which runs from 1 April 2020 to 31 March 2021.

		2020/21			2019/20		
		Unrestricted Funds	Restricted Funds	Total Funds	Unrestricted Funds	Restricted Funds	Total Funds
	Note	£000s	£000s	£000s	£000s	£000s	£000s
Income from:							
Donations and Legacies	3	1,198	394	1,592	967	121	1,088
Investments	4	185	0	185	243	0	243
Charitable Activities		11	0	11	43	0	43
Other Trading Activities	5	0	0	0	15	0	15
Other Income		13	0	13	74	0	74
Total Income		**1,407**	**394**	**1,801**	**1,342**	**121**	**1,463**
Expenditure On:							
Charitable Activities	7&8	1,444	241	1,685	2,998	225	3,223
Raising Funds	9	127	0	127	110	0	110
Total Expenditure		**1,571**	**241**	**1,812**	**3,108**	**225**	**3,333**
Net Gains/(Losses) on Investments	15	1,722	0	1,722	(639)	0	(639)
Transfers between funds		0	0	0	18	(18)	0
Net Movement in Funds		**1,558**	**153**	**1,711**	**(2,387)**	**(122)**	**(2,509)**
Reconciliation of funds							
Total Funds Brought Forward	21	9,632	342	9,974	12,019	464	12,483
Total Funds Carried Forward		**11,190**	**495**	**11,685**	**9,632**	**342**	**9,974**

The notes on pages 36 to 46 form part of these financial statements.

Balance Sheet

The balance sheet provides a view of the charity's assets and liabilities and how these are represented by the different classes of funds held by the charity. The objective of the balance sheet is to show the resources available to the charity and whether these are available for all purposes of the charity or must be used for specific purposes because of legal restrictions placed on their use.

		2020/21			2019/20		
		Unrestricted Funds	Restricted Funds	Total Funds	Unrestricted Funds	Restricted Funds	Total Funds
	Note	£000s	£000s	£000s	£000s	£000s	£000s
Fixed Assets							
Intangible Assets	13	9	0	9	13	0	13
Non-Current Assets (WIP)	14	0	0	0	10	0	10
Investments	16	9,630	0	9,630	8,013	0	8,013
Total Fixed Assets		**9,639**	**0**	**9,639**	**8,036**	**0**	**8,036**
Current Assets							
Stocks	17	14	0	14	0	0	0
Debtors	18	14	0	14	11	0	11
Short Term Investments And Deposits	19	0	0	0	25	0	25
Cash At Bank And In Hand		1,808	541	2,349	2,327	594	2,921
Total Current Assets		**1,836**	**541**	**2,377**	**2,363**	**594**	**2,957**
Creditors							
Creditors: Amounts Falling Due Within One Year	20	(285)	(46)	(331)	(767)	(252)	(1,019)
Net Current Assets		**1,551**	**495**	**2,046**	**1,596**	**342**	**1,938**
Total Net Assets		**11,190**	**495**	**11,685**	**9,632**	**342**	**9,974**
Total Funds							
Restricted		0	495	495	0	342	342
Unrestricted	21	2,101	0	2,101	619	0	619
Unrestricted (designated)		9,089	0	9,089	9,013	0	9,013
Total Funds		**11,190**	**495**	**11,685**	**9,632**	**342**	**9,974**

The financial statements on pages 33 to 46 were approved by the Board of the Trustee on 3 November 2021 and signed on its behalf by:

Signed:

Name:

Date:

Statement of Cash Flows

The Statement of Cash Flows aims to show how changes in balance sheet accounts and income affect cash and cash equivalents, and breaks the analysis down to operating, investing, and financing activities. The cash flow statement is concerned with the flow of cash in and out of the charity during the financial year, which runs from 1 April 2020 to 31 March 2021.

	Note	2020/21 £000s	2019/20 £000s
Cash flows from operating activities			
Net cash (used in)/ provided by operating activities		**(887)**	**49**
Cash flows from investing activities			
Dividends and interest from investment	4	185	243
Purchase of investments	16	(1,403)	(1,351)
Purchase of non-current assets	14	0	(10)
Proceeds on disposal of investments		1,508	1,338
Net cash provided/(used in) by investing activities		**290**	**220**
Change in cash and cash equivalents in the reporting period		**(597)**	**269**
Cash and cash equivalents at the beginning of the reporting period		2,946	2,677
Cash and cash equivalents at the end of the reporting period	19	**2,349**	**2,946**

Reconciliation of net movement in funds to net cash flow from operating activities			
Net movement in funds (statement of financial activities)		1,711	(2,509)
(Gains)/Losses on investments	15	(1,722)	639
Income from investments	4	(185)	(243)
Amortisation of intangible assets	13	4	5
Non-current assets WIP balance written down to SOFA	14	10	0
(Increase)/Decrease in stocks	17	(14)	0
(Increase)/ Decrease in debtors	18	(3)	1,552
(Decrease)/ Increase in creditors	20	(688)	605
Cash (outflow)/ inflow from operating activities		**(887)**	**49**

The notes on pages 36 to 46 form part of these financial statements.

Notes to the Accounts

1. Accounting Policies

(a) Basis of preparation

The financial statements have been prepared under the historic cost convention except for investments, which are included at fair value.

The accounts (financial statements) have been prepared in accordance with the Statement of Recommended Practice: Accounting and Reporting by Charities preparing their accounts in accordance with the Financial Reporting Standard applicable in the UK and Republic of Ireland (FRS 102) issued in October 2019 and the Financial Reporting Standard applicable in the United Kingdom and Republic of Ireland (FRS 102) and the Charities Act 2011 and UK Generally Accepted Practice as it applies from 1 January 2019.

The charity is a public benefit entity as defined by FRS 102.

The trustee considers that there are no material uncertainties about the Norfolk and Norwich Hospitals Charity's ability to continue as a going concern. While the Covid-19 pandemic has had an impact on the Charity it is not such a significant impact as to affect the charity's ability to continue as a going concern.

(b) Funds structure

Where there is a legal restriction on the purpose to which a fund may be put, the fund is classified either as a restricted fund or an endowment fund.

Restricted funds are those where the donor has provided for the donation to be spent in furtherance of a specified charitable purpose. N&N Hospitals Charity's restricted funds typically result from legacies.

Endowment funds arise when the donor has expressly provided that the gift is to be invested and only the income of the fund may be spent. The N&N Hospitals Charity currently has no endowment funds.

Those funds which are neither endowment nor restricted funds, are unrestricted funds which are sub analysed between designated (earmarked) funds where the trustee has set aside amounts to be used for specific purposes or which reflect the non-binding wishes of donors, and unrestricted funds which are at the trustee's discretion. Unrestricted funds include the general fund, and represent the charity's reserves. The major funds held in each of these categories are disclosed in note 20.

(c) Incoming resources

All incoming resources are recognised once the charity has entitlement to the resources, it is probable (more likely than not) that the resources will be received, and the monetary value of incoming resources can be measured with sufficient reliability.

Where there are terms or conditions attached to incoming resources, particularly grants, then these terms or conditions must be met before the income is recognised, as the entitlement condition will not be satisfied until that point. Where terms or conditions have not been met or uncertainty exists as to whether they can be met then the relevant income is not recognised in the year but deferred and shown on the balance sheet as deferred income.

(d) Incoming resources from legacies

Legacies are accounted for as incoming resources either upon receipt or where the receipt of the legacy is probable. Receipt is probable when:

- confirmation has been received from the representatives of the estate(s) that probate has been granted;
- the executors have established that there are sufficient assets in the estate to pay the legacy; and
- all conditions attached to the legacy have been fulfilled or are within the charity's control.

If there is uncertainty as to the amount of the legacy, and it cannot be reliably estimated, then the legacy is shown as a contingent asset until all the conditions for income recognition are met.

(e) Resources expended and irrecoverable VAT

All expenditure is accounted for on an accruals basis and is recognised when the following criteria are met:

- there is a present legal or constructive obligation resulting from a past event
- it is more likely than not that a transfer of benefits (usually a cash payment) will be required in settlement
- the amount of the obligation can be measured or estimated reliably.

Irrecoverable VAT is charged against the category of resources expended for which it was incurred.

(f) Recognition of expenditure and associated liabilities because of grant

Grants payable are payments made to linked, related party, or third-party NHS bodies and non-NHS bodies, in furtherance of the charitable objectives of the funds held on trust, primarily relief of those who are ill.

Grant payments are recognised as expenditure when the conditions for their payment have been met or where there is a constructive obligation to make a payment.

A constructive obligation arises when:

- We have communicated our intention to award a grant to a recipient who then has a reasonable expectation that they will receive a grant; or
- We have made a public announcement about a commitment which is specific enough for the recipient to have a reasonable expectation that they will receive a grant;

The trustee has control over the amount and timing of grant payments and consequently where approval has been given by the trustee and any of the above criteria have been met then a liability is recognised. Grants are awarded on condition that the Charity is acknowledged as the funder, and a report on the impact of expenditure is provided within six months of payment being made. If a grant has been offered but there is uncertainty as to whether it will be accepted or whether conditions will be met, then no liability is recognised.

(g) Support and governance costs

Support costs are those costs which do not relate directly to a single charitable activity. These include some staff costs, costs of administration and IT support. Governance costs include audit, and any other regulatory fees. The analysis of support and governance costs are shown in note 8.

(h) Fundraising costs

The costs of generating funds are those costs attributable to generating income for the charity, other than those costs incurred in undertaking charitable activities or the costs incurred in undertaking trading activities in furtherance of the charity's objects. The costs of generating funds represent fundraising costs together with the salaries for the charity's fundraising team and are shown in note 9.

(i) Charitable activities

Costs of charitable activities comprise all costs incurred in the pursuit of the charitable objects of the charity. These costs, where not wholly attributable, are apportioned between the categories of charitable expenditure in addition to the direct costs. The total costs of each category of charitable expenditure include an apportionment of support costs as shown in note 7.

(i) Intangible assets

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the charity's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to the charity, and where

the cost of the asset can be measured reliably. Intangible fixed assets are amortised at rates calculated to write them down to estimated residual values on a straight-line basis over their estimated useful lives. Computer software is expected to have a useful life of 5 years.

(j) Fixed asset investments

Investments are a form of basic financial instrument. Fixed asset investments are initially recognised at their transaction value and are subsequently measured at their fair value (market value) as at the balance sheet date. The Statement of Financial Activities includes the net gains and losses arising on revaluation and disposals throughout the year. Quoted stocks and shares are included in the Balance Sheet at the current market value quoted by the investment analyst, excluding dividend. Other investments are included at the trustee's best estimate of market value.

The main form of financial risk faced by the charity is that of volatility in equity markets and investment markets due to wider economic conditions, the attitude of investors to investment risk, and changes in sentiment concerning equities and within particular sectors or sub sectors. Further information on the N&N Hospitals Charity's investments can be found in note 15.

(k) Non-Current assets (WIP)

Non-Current assets (WIP) refer to Work-in-Progress on non-current assets for the Charity. In 2020/21 the creation of an external Charity Hub was placed on long term hold. Consequently, the costs recorded in 2019/20 have been written down as expenditure to the SOFA in 2020/21.

(l) Stock

Stock held for resale is valued at the lower of cost and net realisable value. Stocks of non-perishable gift in kind items held at the year end are recorded at fair value.

(m) Debtors

Debtors are amounts owed to the charity. They are measured based on their recoverable amount.

(n) Cash and cash equivalents

Cash at bank and in hand is held to meet the day to day running costs of the charity as they fall due. Cash equivalents are short term, highly liquid investments, usually in 90-day notice interest bearing savings accounts.

(o) Creditors

Creditors are amounts owed by the charity. They are measured at the amount that the charity expects to have to pay to settle the debt. The Charity has no amounts which are owed in more than a year.

(p) Realised gains and losses

All gains and losses are taken to the Statement of Financial Activities as they arise. Realised gains and losses on investments are calculated as the difference between sales proceeds and carrying value in the previous month (or purchase date). Unrealised gains and losses are calculated as the difference between the market value at the year end and opening carrying value (or purchase date if later).

(q) Staff costs and pensions

Norfolk and Norwich University Hospitals NHS Foundation Trust (the Trust) fully re-charged the N&N Hospitals Charity for the members of staff who work for the charity.

Staff members belong to the NHS Pension Scheme which is an unfunded defined benefit scheme accounted for as a defined contribution scheme. The recharge from the Trust includes the employee contributions to that scheme. For more information on the NHS Pension Scheme refer to the Trust's annual report and accounts.

Notes to the Accounts

2. Related party transactions

The Charity has a related party relationship with the Norfolk and Norwich University Hospitals NHS Foundation Trust. The Trust holds the employment contracts for all Charity staff, provides the Charity with office accommodation, legal services, financial oversight and is the responsible Corporate Trustee for the Charity.

Transactions between the Charity and the Trust during the year were in relation to salary payments for its staff, income invoiced by the Trust for the Charity, payment of Charity supplier invoices that were processed through the Trust's procurement and payment systems and refunded by the Charity, and for administrative and management costs.

The Trust recharged £247,381 to the Charity (2019/20 £170,464) for its staffing and administration costs. The increase is due to the growth of the Charity team.

The services of the Norfolk and Norwich University Hospitals NHS Foundation Trust have benefited from payments of £1,302,956 (2019/20 £1,209,334) from the Charity for enhancement of the patient environment, investment in staff, additional equipment and research.

During 2020/21 capital assets to the value of £236,984 (2019/20 £1,907,956) were purchased by the Charity and donated to the Trust.

None of the members of the Trust board or parties related to them have undertaken any transactions with the N&N Hospitals Charity or received any benefit from the charity in payment or kind. Board members received no honoraria, emoluments, or expenses in the year.

At the end of the financial year, £226,008 was owed by the Charity to the Trust. (2019/20 £850,442)

3. Income from donations and legacies

	2020/21			2019/20
	Unrestricted Funds	Restricted Funds	Total Funds	Total Funds
	£000s	£000s	£000s	£000s
Voluntary Income				
General donations	685	0	685	551
Corporate donations	56	0	56	240
Legacies	430	0	430	292
Grants	27	394	421	5
Total Voluntary Income	**1,198**	**394**	**1,592**	**1,088**

Notes to the Accounts

4. Income from investments

	2020/21			2019/20
	Unrestricted Funds	Restricted Funds	Total Funds	Total Funds
	£000s	£000s	£000s	£000s
Investment Income				
Interest on deposits	2	0	2	11
Fixed asset equity investments	183	0	183	232
Total Investment Income	**185**	**0**	**185**	**243**

5. Analysis of other income

	2020/21			2019/20
	Unrestricted Funds	Restricted Funds	Total Funds	Total Funds
	£000s	£000s	£000s	£000s
Incoming Resources from Charitable Activities				
Training Income	11	0	11	43
Total Incoming Resources from Charitable Activities	**11**	**0**	**11**	**43**
Activities for Generating Funds				
Fundraising events	0	0	0	14
Lotteries and raffles	0	0	0	1
Total Activities for Generating Funds	**0**	**0**	**0**	**15**
Other Incoming Resources				
Other Income	13	0	13	74
Total Other Incoming Resources	**13**	**0**	**13**	**74**

6. Role of volunteers

Like all charities, the N&N Hospitals Charity is reliant on a team of volunteers for our smooth running. Our volunteers perform two roles:

- Fund advisors – there are about 400 Trust staff who support the charitable funds committee when deciding how the charity's designated funds should be spent. These funds are designated (or earmarked) by the charitable funds committee to be spent for a particular purpose or in a ward or department. Each fund advisor submits funding requests and monitors the financial status of their fund.
- Fundraisers – there are many local volunteers who actively fundraise for the N&N Hospitals Charity by running events.

In accordance with the SORP, due to the absence of any reliable measurement basis, the contribution of these volunteers is not recognised in the accounts.

Notes to the Accounts

7. Analysis of charitable expenditure

The charity did not undertake any direct charitable activities on its own account during the year. Charitable expenditure was in the form of grant funding to the Trust to carry out activities or to purchase equipment that will benefit NHS patients and their families.

	2020/21			2019/20
	Support Costs	Grant funded activity	Total	Total
	£000s	£000s	£000s	£000s
Charitable Activities				
Enhancing the patient environment	73	774	847	632
Investing in NHS staff	21	219	240	403
Life saving equipment & new technology	42	450	492	2,105
Research	9	97	106	83
Total Charitable Activities	**145**	**1,540**	**1,685**	**3,223**

8. Analysis of support costs and governance costs

Support costs are back-office costs related to the day-to-day running of the charity. Governance costs are those support costs which relate to the strategic management of the charity.

	2020/21			2019/20
	Unrestricted Funds	Restricted Funds	Total Funds	Total Funds
	£000s	£000s	£000s	£000s
Support costs included in Charitable Activities				
Charity Staff Costs	79	0	79	61
Management and Administration Costs	16	0	16	19
Total Support Costs	**95**	**0**	**95**	**80**
Governance Costs included in Charitable Activities				
Audit	9	0	9	6
Staff costs	40	0	40	4
Other Governance Costs	1	0	1	6
Total Governance Costs	**50**	**0**	**50**	**16**
Total Support and Governance Costs	**145**	**0**	**145**	**96**

Notes to the Accounts

9. Analysis of expenditure on raising funds

	2020/21			2019/20
	Unrestricted Funds	Restricted Funds	Total Funds	Total Funds
	£000s	£000s	£000s	£000s
Cost of Raising Funds				
Fundraising staff costs	83	0	83	76
Fundraising expenditure	44	0	44	33
Total Costs of Generating Funds	**127**	**0**	**127**	**109**

10. Trustee remuneration, benefits, and expenses

Members of the Trust board give their time freely and receive no remuneration for the work that they undertake in relation to the N&N Hospitals Charity. They can claim expenses, however, to reimburse them for costs that they incur in fulfilling their duties relating to N&N Hospitals Charity – these include travelling specifically for charitable funds committee meetings and charity specific training events.

No expenses were claimed from the Charity by committee members (2019/20 nil)

11. Analysis of staff costs

The average number of full-time equivalent employees during the year was 5.60 (2019/20 4.89).

Staff Costs	2020/21	2019/20
	£000s	£000s
Salaries and Wages	164	131
Social Security Costs	14	12
Other Pension Costs	24	19
Total	**202**	**162**

A further recharge of time spent by Finance Department Managers was made by the Trust. This related to time spent authorising payments, reviewing reconciliations, and checking the annual accounts. The amount recharged was £4k (2019/20 £4k).

The N&N Hospitals Charity considers its key management personnel to be the Charity Director, who is the Board Secretary for the Norfolk and Norwich University Hospitals NHS Foundation Trust. A recharge of time spent by the Charity Director and his administrative support was made by the Trust. The amount recharged was £36k (2019/20 nil).

No employees had emoluments in excess of £60,000 (2019/20 nil)

12. Auditor's remuneration

The auditor's remuneration of £9,000 (2019/20: £4,820) related solely to the audit with no other additional work being undertaken (2019/20 nil). These figures are exclusive of VAT, however because the Charity is not able to reclaim VAT it is included in Note 8 figures.

Notes to the Accounts

13. Intangible assets

This relates to the donor database and accounting software which will be amortised over five years.

	2020/21	2019/20
Intangible Fixed Assets	**£000s**	**£000s**
Opening balance	13	18
Additions	0	0
Amortisation	(4)	(5)
Closing balance	**9**	**13**

14. Non-Current assets (WIP)

In 2019/20 this related to costs incurred for creation of a Charity Hub, a separate building to be located at the Norfolk & Norwich Hospital site. During 2020/21 this project has been placed on hold indefinitely, so the costs have been cleared down.

	2020/21	2019/20
Non-Current Assets (WIP)	**£000s**	**£000s**
Opening balance	10	10
(Disposals)/Additions	(10)	0
Closing balance	0	10

15. Analysis of gains/losses on investments

	2020/21	2019/20
	£000s	**£000s**
Realised gains/(losses)	44	(31)
Unrealised gains/(losses)	1,678	(608)
Total gains/(losses) on investments	**1,722**	**(639)**

16. Fixed asset investments

All investments are carried at their fair value and are managed by expert advisors. Cash held by our asset managers is available on request, and is included in the investment split for comparison, but is included in the cash and cash equivalents figure on the balance sheet.

Movement in Fixed Asset Investments	2020/21	2019/20
	£000s	**£000s**
Market Value at Start of Financial year	8,013	8,639
Less: Disposals at Carrying Value	(1,465)	(1,369)
Add: Acquisitions at Cost	1,403	1,351
Net Gain/(Loss) on Revaluation	1,678	(608)
Market Value at End of Financial Year	**9,630**	**8,013**

Fixed Asset Investment Split	2020/21	2019/20
Cash	5.00%	4.84%
Gilts/Fixed Interest	15.00%	15.92%
Investment/Unit Trusts	16.50%	13.03%
Equities	63.50%	66.21%
	100%	**100%**

Notes to the Accounts

17. Stock

	2020/21	2019/20
Stock	**£000s**	**£000s**
Online shop stock	5	0
Gifts in Kind stock	9	0
Total stock	**14**	**0**

18. Analysis of current debtors

	2020/21	2019/20
Amounts Falling Due Within One Year	**£000s**	**£000s**
Prepayments	9	9
Accrued Income	4	1
Other Debtors	1	1
Total Debtors Falling Due Within One Year	**14**	**11**

19. Analysis of cash and cash equivalents

	2020/21	2019/20
Cash & Cash Equivalents	**£000s**	**£000s**
Cash in hand & at bank	2,349	2,921
Short term investment	0	25
Total	**2,349**	**2,921**

The short-term investment was closed in April 2020, due to the low rate of interest available.

20. Analysis of liabilities

	2020/21	2019/20
Amounts Falling Due Within One Year	**£000s**	**£000s**
Trade Creditors	96	135
Amounts Due to NNUH NHS Foundation Trust	226	851
Accruals	9	33
Total	**331**	**1019**

Notes to the Accounts

21. Analysis of charitable funds

Unrestricted	Balance Apr 2020	Incoming resources	Resources expended	Gains and losses	Transfers	**Balance Mar 2021**
	£000s	£000s	£000s	£000s	£000s	£000s
N&N General Fund	82	434	585	1,722	0	**1,653**
Cromer General Fund	445	9	10	0	(3)	**441**
Others (2 funds)	92	15	42	0	(58)	**7**
Total	**619**	**458**	**637**	**1,722**	**(61)**	**2,101**

Name of fund	**Description of the purpose of each fund**
Norfolk and Norwich General	For the benefit of staff and patients
Cromer General	For the benefit of staff and patients at the Cromer site

Restricted Funds:	Balance Apr 2020	Incoming resources	Resources expended	Transfers	**Balance Mar 2021**
	£000s	£000s	£000s	£000s	£000s
NHS Charities Together Stage 3 Fund	0	198	46	0	**152**
Cromer Equipment Fund	102	0	0	0	**102**
Cromer Building Fund	108	0	9	0	**99**
Friends Fund	114	0	51	0	**63**
NHS Charities Together Stage 1 Fund	0	196	135	0	**61**
The Macleod Fund	18	0	0	0	**18**
Total	**342**	**394**	**241**	**0**	**495**

Name of fund	**Description of the purpose of each fund**
NHS Charities Together Stage 3 Fund	For Covid recovery and wellbeing projects for NHS staff and patients
Cromer Equipment Fund	For medical and surgical equipment at Cromer Hospital
Cromer Building Fund	For building related work at Cromer Hospital
Friends Fund	For the benefit of patients and staff within the Trust
NHS Charities Together Stage 1 Fund	For Covid support projects for NHS staff and patients
The Macleod Fund	For the benefit of paediatric patients within the Trust

The NHS Charities Together Stage 3 Fund has been fully committed for the provision of additional psychological support for NHS staff at NNUH over the next 12 months.

The Cromer Building and Equipment Funds have been committed in full towards the cost of the North Norfolk Macmillan Centre development.

The NHS Charities Together Stage 1 Fund has been fully committed for the provision of additional staff rest areas at the NNUH site.

Notes to the Accounts

Designated Funds	Balance Apr 2020	Incoming resources	Resources expended	Transfers	**Balance Mar 2021**
	£000s	**£000s**	**£000s**	**£000s**	**£000s**
Cromer Legacy Fund	1,079	29	0	0	**1,108**
Earmarked Grant Fund	1,005	90	323	101	**873**
Radiotherapy & Oncology Fund	496	71	46	(4)	**517**
Marjorie Ann Lockett Fund	569	0	103	0	**466**
Andrew Leslie Kemp Fund	422	0	0	0	**422**
Renal Fund	398	3	17	(4)	**380**
Orthopaedics Fund	300	1	3	0	**298**
Cromer Building & Equipment Fund	282	0	5	0	**277**
AOS Legacy Fund	242	2	0	0	**244**
Leukemia Childrens Cancer Fund	206	0	0	0	**206**
Charity Accomodation Fund	95	0	0	105	**200**
Kidney Research Fund	197	0	0	0	**197**
Eye Department Fund	168	0	0	(13)	**155**
Critical Care Fund	97	42	2	0	**137**
Neurosciences Fund	124	2	2	7	**131**
Haematology Fund	122	9	1	0	**130**
Respiratory Medicine Fund	133	0	0	(7)	**126**
Ear, Nose & Throat Fund	125	0	0	0	**125**
NICU Fund	87	45	30	0	**102**
Others (260 funds)	2,866	655	402	(124)	**2,995**
Total	**9,013**	**949**	**934**	**61**	**9,089**

Name of fund	**Description of the purpose of each fund**
Cromer Legacy Fund	For the benefit of patients at the Cromer Hospital
Earmarked Grant Fund	General funds designated for planned grant expenditure
Radiotherapy & Oncology Fund	Cause, prevention, treatment, cure & defeat of cancer
Marjorie Ann Lockett Fund	Cause, prevention, treatment, cure & defeat of cancer
Andrew Leslie Kemp Fund	For the provision of dialysis equipment, otherwise for general use
Renal Fund	For the benefit of renal patients
Orthopaedics Fund	For the benefit of orthopaedic patients
Cromer Building & Equipment Fund	For building or equipment at Cromer Hospital
AOS Legacy Fund	Cause, prevention, treatment, cure & defeat of cancer
Leukemia Childrens Cancer Fund	Cause, prevention, treatment, cure & defeat of cancer in children
Charity Accomodation Fund	To establish a Charity Hub at the N&N site
Kidney Research Fund	Cause, prevention, treatment, and cure of renal illness
Eye Department Fund	For the benefit of ophthalmology patients
Critical Care Fund	For the benefit of critical care patients
Neurosciences Fund	For the benefit of neurology patients
Haematology Fund	For the benefit of haematology patients
Respiratory Medicine Fund	For the benefit of respiratory medicine patients
Ear, Nose & Throat Fund	For the benefit of ENT patients
NICU Fund	For the benefit of patients in the Neonatal Intensive Care Unit

Norfolk & Norwich Hospitals Charity

KPMG LLP
Dragonfly House
2 Gilders Way
Norwich
NR3 1UB

3 November 2021

Dear Stephanie,

This representation letter is provided in connection with your audit of the financial statements of Norfolk and Norwich Hospitals Charity ("the Charity"), for the year ended 31 March 2021, for the purpose of expressing an opinion:

i. as to whether these financial statements give a true and fair view of the state of the Charity's affairs as at year end and of its surplus or deficit for the financial year then ended;

ii. whether the financial statements have been properly prepared in accordance with UK Generally Accepted Accounting Practice (including Charities SORP FRS 102: Statement of Recommended Practice applicable to charities preparing their accounts in accordance with the Financial Reporting Standard applicable in the UK and Republic of Ireland (FRS 102)); and

iii. whether the financial statements have been prepared in accordance with the Charities Act 2011.

These financial statements comprise the Balance Sheet, the Statement of Financial Activities, the Cash Flow Statement, and notes, comprising a summary of significant accounting policies and other explanatory notes.

The Trustee confirms that the Charity is exempt from the requirement to also prepare consolidated financial statements.

The Trustee confirms that the representations they make in this letter are in accordance with the definitions set out in the Appendix to this letter.

The Trustee confirms that, to the best of their knowledge and belief, having made such inquiries as it considered necessary for the purpose of appropriately informing themself:

Norfolk & Norwich Hospitals Charity

Financial statements

1. The Trustee has fulfilled their responsibilities, as set out in the terms of the audit engagement dated 13 May 2021, for the preparation of financial statements that:

   i. give a true and fair view of the state of the Charity's affairs as at the end of its financial year and of its surplus or deficit for that financial year;

   ii. have been properly prepared in accordance with UK Generally Accepted Accounting Practice ("UK GAAP") (including Charities SORP FRS 102: Statement of Recommended Practice applicable to charities preparing their accounts in accordance with the Financial Reporting Standard applicable in the UK and Republic of Ireland (FRS 102)); and

   iii. have been prepared in accordance with the Charities Act 2011.

The financial statements have been prepared on a going concern basis.

2. The methods, the data and the significant assumptions used in making accounting estimates and their related disclosures are appropriate to achieve recognition, measurement or disclosure that is reasonable in the context of the applicable financial reporting framework.

3. All events subsequent to the date of the financial statements and for which section 32 of FRS 102 requires adjustment or disclosure have been adjusted or disclosed.

Information provided

4. The Trustee has provided you with:

   - access to all information of which they are aware, that is relevant to the preparation of the financial statements, such as records, documentation and other matters;
   - additional information that you have requested from the Trustee for the purpose of the audit; and
   - unrestricted access to persons within the Charity from whom you determined it necessary to obtain audit evidence.

5. All transactions have been recorded in the accounting records and are reflected in the financial statements.

6. The Trustee confirms the following:

   i) The Trustee has disclosed to you the results of their assessment of the risk that the financial statements may be materially misstated as a result of fraud.

Included in the Appendix to this letter are the definitions of fraud, including misstatements arising from fraudulent financial reporting and from misappropriation of assets.

   ii) The Trustee has disclosed to you all information in relation to:

   a) Fraud or suspected fraud that it is aware of and that affects the Charity and involves:

      - management;

Norfolk & Norwich Hospitals Charity

- employees who have significant roles in internal control; or
- others where the fraud could have a material effect on the financial statements; and

b) allegations of fraud, or suspected fraud, affecting the Charity's financial statements communicated by employees, former employees, analysts, regulators or others.

In respect of the above, the Trustee acknowledges their responsibility for such internal control as they determine necessary for the preparation of financial statements that are free from material misstatement, whether due to fraud or error. In particular, the Trustee acknowledges their responsibility for the design, implementation and maintenance of internal control to prevent and detect fraud and error.

7. The Trustee has disclosed to you all known instances of non-compliance or suspected non-compliance with laws and regulations whose effects should be considered when preparing the financial statements.

8. The Trustee has disclosed to you and has appropriately accounted for and/or disclosed in the financial statements, in accordance with section 21 of FRS 102 all known actual or possible litigation and claims whose effects should be considered when preparing the financial statements.

9. The Trustee has disclosed to you the identity of the Charity's related parties and all the related party relationships and transactions of which it is aware. All related party relationships and transactions have been appropriately accounted for and disclosed in accordance with section 33 of FRS 102.

Included in the Appendix to this letter are the definitions of both a related party and a related party transaction as we understand them and as defined in FRS 102.

10. The Trustee confirms that:

a) The financial statements disclose all of the key risk factors, assumptions made and uncertainties surrounding the charity's ability to continue as a going concern as required to provide a true and fair view and to comply with FRS 102.

b) No events or circumstances exist that may cast significant doubt on the ability of the Charity to continue as a going concern.

This letter was tabled and agreed at the meeting of the Trustee on 3 November 2021.

Yours faithfully,

David White
Chairman

Appendix to the Trustee' Representation Letter of Norfolk and Norwich Hospitals Charity: Definitions

Criteria for applying the disclosure exemptions within Financial Reporting Standard 102 for the Charity's Financial Statements

- The Charity discloses in the notes to its financial statements:
  - A brief narrative summary of the disclosure exemptions adopted; and
  - The name of the parent of the group in whose consolidated financial statements its financial statements are consolidated, and from where those financial statements may be obtained

Financial Statements
A complete set of financial statements (before taking advantage of any of the FRS 102 exemptions) comprises:

- a Balance Sheet as at the end of the period;
- a Statement of Financial Activities for the period;
- a Cash Flow Statement for the period; and
- notes, comprising a summary of significant accounting policies and other explanatory information.

Material Matters
Certain representations in this letter are described as being limited to matters that are material.

FRS 102 states that:

Omissions or misstatements of items are material if they could, individually or collectively, influence the economic decisions of users taken on the basis of the financial statements. Materiality depends on the size and nature of the omission or misstatement judged in the surrounding circumstances. The size or nature of the item, or combination of both, could be the determining factor.

Fraud
Fraudulent financial reporting involves intentional misstatements including omissions of amounts or disclosures in financial statements to deceive financial statement users.

Misappropriation of assets involves the theft of an entity's assets. It is often accompanied by false or misleading records or documents in order to conceal the fact that the assets are missing or have been pledged without proper authorisation.

Error
An error is an unintentional misstatement in financial statements, including the omission of an amount or a disclosure.

Prior period errors are omissions from, and misstatements in, the entity's financial statements for one or more prior periods arising from a failure to use, or misuse of, reliable information that:

a) was available when financial statements for those periods were authorised for issue; and

b) could reasonably be expected to have been obtained and taken into account in the preparation and presentation of those financial statements.

Such errors include the effects of mathematical mistakes, mistakes in applying accounting policies, oversights or misinterpretations of facts, and fraud.

Management

For the purposes of this letter, references to “management” should be read as “management and, where appropriate, those charged with governance”.

Qualifying Entity

A member of a group where the parent of that group prepares publicly available consolidated financial statements which are intended to give a true and fair view (of the assets, liabilities, financial position and profit or loss) and that member is included in the consolidation by means of full consolidation.

Related Party and Related Party Transaction

Related party:

A related party is a person or entity that is related to the entity that is preparing its financial statements (referred to in FRS 102 as the “reporting entity”).

a) A person or a close member of that person’s family is related to a reporting entity if that person:
    i. has control or joint control over the reporting entity;
    ii. has significant influence over the reporting entity; or
    iii. is a member of the key management personnel of the reporting entity or of a parent of the reporting entity.

b) An entity is related to a reporting entity if any of the following conditions apply:
    i. The entity and the reporting entity are members of the same group (which means that each parent, subsidiary and fellow subsidiary is related to the others).
    ii. One entity is an associate or joint venture of the other entity (or an associate or joint venture of a member of a group of which the other entity is a member). iii. Both entities are joint ventures of the same third party.
    iv. One entity is a joint venture of a third entity and the other entity is an associate of the third entity.
    v. The entity is a post-employment benefit plan for the benefit of employees of either the reporting entity or an entity related to the reporting entity. If the reporting entity is itself such a plan, the sponsoring employers are also related to the reporting entity.
    vi. The entity is controlled, or jointly controlled by a person identified in (a).
    vii. A person identified in (a)(i) has significant influence over the entity or is a member of the key management personnel of the entity (or of a parent of the entity).
    viii. The entity, or any member of a group of which it is a part, provides key management personnel services to the reporting entity or to the parent of the reporting entity.

Related party transaction:

A transfer of resources, services or obligations between a reporting entity and a related party, regardless of whether a price is charged.