# Trust Board (public) - 2 November 2022

*Wed 02 November 2022, 08:30 - 15:00*

Norfolk and Norwich University Hospitals
NHS Foundation Trust

## Agenda

### *Agenda*

00 TB Agenda Public 02.11.22.pdf (1 pages)

### *Clinical Visits (08.45 – 09.15hrs)*

### 1. Apologies and Declarations of Interest

*Information/Discussion* *Tom Spink*

#### 1.1. Chairman's Introduction

*Tom Spink*

#### 1.2. Reflections on Clinical/Departmental Visits

*All*

### 2. Experience of Care – Patient/Family Reflections- Research story

*Information* *Erika Denton*

02 Research Exp of Care Story.pdf (4 pages)

### 3. Minutes of the Board meeting held in public on 03.08.22

*Approval* *Tom Spink*

03 Unconfirmed TB Minutes 03.08.22 Public.pdf (7 pages)

### 4. Matters arising and update on actions

*Discussion* *Tom Spink*

04 Update on Actions Arising (public).pdf (2 pages)

### 5. Chief Executive's Update

*Discussion* *Sam Higginson*

# 6. Reports for Information and Assurance:

*Information, Assurance and Approval as specified*

## 6.1. People & Culture Committee (24.10.22)

*Sandra Dinneen*

06(a) Report on People and Culture Committee 24.10.22.pdf (2 pages)

## 6.2. IPR – Workforce data

*Paul Jones*

06(b) Workforce IPR Sep-2022.pdf (10 pages)

## 6.3. Staff Experience - Priority Improvement Actions

06(c) Staff Experience - Priority Improvement Actions.pdf (17 pages)

## 6.4. Quality and Safety Committee (25.10.22) (background data in Resource Centre)

*Pamela Chrispin*

06(c) Report on Quality & Safety Comm 25.10.22.pdf (3 pages)

## 6.5. IPR – Quality, Safety and Patient Experience data

*Nancy Fontaine and Erika Denton*

06(e) Quality Safety IPR report 14.10.22 with added slides_C19-Tendable_7Beds in a Bay_FINAL.pdf (29 pages)

## 6.6. Mortality data

*Erika Denton*

Information

06(f) Board_Mortality_Nov 22_FInal.pdf (10 pages)

## 6.7. Finance, Investments and Performance Committee (26.10.22)

*Tom Spink*

Information

06(g) Report on Finance Investments Performance Comm 26.10.22.pdf (3 pages)

## 6.8. IPR – Performance and Productivity data

*Chris Cobb*

06(h)(i) Performance and Activity IPR.pdf (39 pages)

## 6.9. Finance Report

*Roy Clarke*

Information

06(i)(ii) Trust Board Cover Sheet - M6 Finance Report.pdf (2 pages)
06(i)(ii)a Trust Finance Report M6 - Public Board.pdf (7 pages)

# 7. Infection Prevention and Control Annual Report 2021/22

*Information* *Nancy Fontaine*

07 IP&C TRUST BOARD REPORT 02.11.22.pdf (2 pages)
07(a) IPC Annual Report Trust Board summary.pdf (2 pages)
07(b) IPC Annual Report and programme 21-22.pdf (68 pages)

## 8. Questions from members of the public

*Tom Spink*

## 9. Any other business

*Discussion* *All*

## The next Board meeting in public will be at 9.30am on Wednesday 1 February 2023 in the Boardroom of the Norfolk and Norwich University Hospital and/or via MS Teams

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**MEETING OF THE TRUST BOARD IN PUBLIC**
**WEDNESDAY 2 NOVEMBER 2022**

A meeting of the Trust Board will take place at 9.30am on Wednesday 2 November 2022 in the Boardroom Norfolk & Norwich University Hospital and/or via MS Teams

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

## AGENDA

| | Item | Timing | Lead | Purpose |
|---|---|---|---|---|
| 0 | Clinical Visits – see separate schedule | 08.45-09.15 | | |
| 1 | - Apologies, Declarations of Interest<br>- Chairman's Introduction<br>- Reflections on Clinical/Departmental Visits | 09.30-09.40 | Chair | Information/ Discussion |
| 2 | Experience of Care – Patient/Family Reflections<br>- Hope to Outcome- Research Experience of Care | 09.40-10.00 | ED | Information |
| 3 | Minutes of the Board meeting held in public on 03.08.22 | 10.00-10.05 | Chair | Approval |
| 4 | Matters arising and update on actions | | Chair | Discussion |
| 5 | Chief Executive's Update | 10.05-10.15 | CEO | Discussion |
| 6 | **Reports for Information and Assurance:** | | | |
| | (a) People & Culture Committee (24.10.22)<br>(b) IPR – Workforce data<br>(c) Staff Experience – priority improvement actions | 10.15-10.35 | PJ | Information, Assurance & Approval as specified |
| | (d) Quality and Safety Committee (25.10.22)<br>– inc Maternity update in light of Select Cmtee report<br>(e) IPR – Quality, Safety and Patient Experience data<br>(f) Mortality data | 10.35-10.55 | PC<br>ED/NF<br>ED | |
| | (g) Finance, Investments and Performance Committee (26.10.22)<br>(h) IPR – Performance and Productivity data<br>(i) M6 Finance Report | 10.55-11.15 | TS<br>CC<br>RC | |
| 7 | Infection Prevention and Control Annual Report 2021/22 | 11.15-11.25 | NF | Information |
| 8 | Questions from members of the public | 11.25-11.30 | Chair | Discussion |
| 9 | Any other business | | | |

*** Documents uploaded to Resource Centre**

**Date and Time of next Board meeting in public**
The next Board meeting in public will be at 9.30am on Wednesday 1 February 2023 in the Boardroom of the Norfolk and Norwich University Hospital and/or via MS Teams

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| REPORT TO THE TRUST BOARD OF DIRECTORS | | | | |
|---|---|---|---|---|
| **Date** | **2 November 2022** | | | |
| **Title** | **Hope to Outcome- Research Experience of Care** | | | |
| **Author & Exec lead** | **Rosie Bloomfield, Patient Engagement and Experience Facilitator, Amrita Kulkarni, Head of Patient Experience**<br>**Professor Nancy Fontaine (Chief Nurse) & Professor Erika Denton (Medical Director)** | | | |
| **Purpose** | **For Information/Discussion** | | | |
| **Relevant Strategic Objective** | **1. We will be a provider of high quality health and care services to our local population**<br>**2. We will be a centre of excellence for research, education and innovation** | | | |
| **Are there any quality, operational, workforce or financial implications of the decision requested by this report?**<br>If so explain where these are/will be addressed. | **Quality** | **Yes✓ No☐** | | |
| | **Operational** | **Yes☐ No☐** | | |
| | **Workforce** | **Yes☐ No☐** | | |
| | **Financial** | **Yes☐ No☐** | | |

**1. Background/Context**

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

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

1.3 Today we have a patient sharing their positive experience of our Trust. David was diagnosed in 2018 with myeloma (incurable but treatable). He was offered the chance to take part in the bone marrow cancer trial. David describes his experience and outcome of the treatment has been excellent as such that his cancer is undetectable following treatment.

1.4 The story will highlight:

- The success of the MUK9 clinical trials in treating patients with high risk bone marrow cancer
- The importance of improving opportunities for patients to be involved in research
- Positive health outcomes and wider reaching health benefits for patients involved in research
- The excellent provision of treatment options via the trail for high-risk myeloma patients

- The success of the trial with NNUH recruiting the highest number of patients (39) on the nationwide research study which is taking place across 40 hospitals and involves 472 patients.

**2. Key issues, risks and actions**

2.1 Key Learning:

- The experience shared in this story has highlighted the positive outcomes for patients in research and how research active hospitals can help improve health outcomes for patients and the wider benefits of it.
- It also highlights that more work is being done in improving opportunities for patients to be involved in research and the importance of research being a valued professional activity embedded at the heart and within the culture of the NNUH

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

3.1 Research active hospitals have better outcomes for patients. The next steps are to:

- Further develop NNUH's research portfolio in line with our Research Strategy 2020-2025
- Increase the opportunities for patients to participate in research
- Provide different types of research opportunities for patients to participate in.

3.2 NNUH is an established partner in National Institute of Health and Social Care Clinical Research Network (NIHR CRN) and NNUH's accreditation in 2022 as a NIHR Norfolk Clinical Research Facility (NIHR Norfolk CRF) are a strong platform to help achieve this.

**Recommendation:**

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

| Experience of Care – Patient Story – Board Meeting |
|---|
| **Brief outline of the "story"** |
| David was diagnosed with myeloma (high risk bone marrow cancer) in June 2018. He was offered the chance to take part in the MUK9 clinical trial.<br><br>The MUK9 trial is looking at a new combination of 5 drugs to treat newly diagnosed myeloma. Doctors already use these drugs in various combinations to treat myeloma. But this is the first time people with high risk myeloma are having all 5 together.<br><br>The trial involves:<br>• treatment to get rid of the myeloma cells (induction treatment)<br>• a stem cell transplant<br>• more treatment to lower the chances of the myeloma coming back (consolidation treatment)<br>• long term treatment to keep the myeloma away (maintenance treatment)<br><br>David had some knowledge of clinical trials through his work for a scientific instrument company and had no doubts in joining the trial which is using state-of-the-art genetic profiling and a novel drug regime tailored to an individual's genetic subtype. David explains the understanding provided by the staff about his cancer and the treatment he received which both contributed to a relatively quick and marked improvement in his health. David's treatment involves taking five different drugs that have not been given in this way before. He describes feeling like he is at the forefront of new treatments for myeloma and the treatment he has received is excellent. David explains how the primary benefit of being involved in the trial was access to treatments that would not have been available to him if he had not participated. David explains feeling like he was involved in every part of the process and that it was all explained to him.<br><br>David was given a lot of information at the time of his diagnosis and at this time he was not very well so felt he was not in a good position to take it all in, his memory of the early days is a bit of a blur. Therefore his only suggestion for improvement would be that some of the details could have been drip-fed over the early stages of the treatment. However he would not change a thing about his ongoing treatment and care that he has received.<br><br>The level of control and safety is paramount, and he is monitored regularly. This level of involvement has given him the confidence in the treatment options and the decisions became easy to make.<br><br>David was quite ill when he was diagnosed, and struggled to walk even very short distances. He explains he is back to being active as he would like to be and regularly engages in activities such as walking, cycling, kayaking and fishing. |
| **What "point" it is trying to convey** |
| The story highlights:<br><br>• The success of the MUK9 clinical trials in treating patients with high risk bone marrow cancer |

| | |
|---|---|
| • Improving opportunities for patients to be involved in research<br>• Positive health outcomes and wider reaching health benefits for patients involved in research | |
| **Who will be "speaking"** | |
| **Patient** | David Anstee (attending in person) |
| **Staff** | Kristian Bowles - Consultant Haematologist<br>Jenny Longmore - Director of Research Operations<br>Victoria Licence - Clinical Trials Practitioner |
| **Time allocation for each element** | |
| **Patient story (in person)** | 5-8 minutes |
| **Staff** | Kristian Bowles, Jenny Longmore, Victoria Licence - 5 mins |
| **Questions** | 5 mins |

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# MINUTES OF TRUST BOARD MEETING IN PUBLIC

## HELD ON 3 AUGUST 2022

| | | |
|---|---|---|
| **Present:** | Mr T Spink | - Interim Chairman |
| | Dr P Chrispin | - Non-Executive Director |
| | Prof E Denton | - Medical Director |
| | Ms S Dinneen | - Non-Executive Director |
| | Prof N Fontaine | - Chief Nurse |
| | Mr J Foster | - Non-Executive Director |
| | Prof C ffrench-Constant | - Non-Executive Director |
| | Mrs J Hannam | - Non-Executive Director |
| | Mr S Higginson | - Chief Executive |
| **In attendance:** | Ms A Berry | - Director of Transformation |
| | Ms F Devine | - Director of Communications |
| | Mr J P Garside | - Board Secretary |
| | Ms S Gooch | - Director of Workforce |
| | Mr S Hackwell | - Director of Strategy & Major Projects |
| | Ms N Oliver | - Performance & Recovery Operations Director |
| | Ms V Rant | - Assistant to Board Secretary |
| | Ms L Sanford | - Director of Finance - Operations |
| | Members of the public inc | |
| | Mrs E Betts | - Governor (public) |
| | Ms N Duddleston | - Governor (public) |
| | Mr C Hind | - Governor (public) |

22/034 **APOLOGIES, DECLARATIONS OF INTEREST, CHAIRMAN'S INTRODUCTION AND REFLECTIONS ON VISITS**

Apologies were received from Mr Clarke (Ms Sanford deputising), Mr Cobb (Ms Oliver deputising), Mr Jones (Ms Gooch deputising) and Mr Prosser-Snelling. No conflicts of Interest were declared in relation to matters for consideration by the Board.

Board members reflected on the Development and Assurance visits to the Emergency Department, Chaplaincy, Main Theatres, Cley Ward and Buxton Ward. Reflections arising from the visits included the pressures on services and staff and problems with delayed discharges resulting in congestion throughout the hospital. The response of staff was impressive, evident in seeking to adapt flexibly to the needs of patients.

22/035 **EXPERIENCE OF CARE - PATIENT/FAMILY REFLECTIONS**

In attendance for this item were: Connie (patient), Sarah Higson (Associate Director for Patient Experience), Amrita Kulkarni (Head of Patient Experience) and Joel Fiddy (Divisional Governance Manager).

The Board received a report concerning Connie's experience of our care after attending the A&E Department and following surgery. Particular suggestions were made regarding noise at night and wound care following discharge.

Professor Fontaine explained that noise at night has been highlighted as an issue in patient surveys but it has been found that use of earplugs can cause falls and problems with communication. We have been working with patients to identify alternative options and to look at ways to reduce noise at night on the wards.

Connie's experience is being shared through governance and education forums. Quality improvement initiatives have been developed to improve the experience of inpatients at night and we are a developing a wound care support/information/advice education pack for launch before the end of the year. Connie has been invited to be involved with the Patient Panel and will be involved in reviewing improvements.

Non-Executives asked about the actions being taken to promote continuity of care following discharge from hospital. Professor Fontaine indicated that there is work to do across the system so that patients experience continuity across organisational boundaries when they leave our service. There may be an opportunity to establish an integrated team with upskilled nurses in the community to deliver enhanced wound care for patients.

The Board thanked Connie for sharing her experience and highlighted that the issues raised will help us to make improvements for future patients.

22/036 **MINUTES OF PREVIOUS MEETING HELD ON 8 JUNE 2022**

The minutes of the meeting held on 8 June 2022 were **agreed** as a true record and signed by the Chairman.

22/037 **MATTERS ARISING AND UPDATE ON ACTIONS**

The Board reviewed the Action Points arising from its meeting held on 8 June 2022 as follows:

22/024 – dates for Ockenden priority actions – The Quality & Safety Committee is scheduled to receive regular maternity reports to include updates on implementation and progress towards the 15 immediate and essential actions arising from the Ockenden Report into Maternity Services. Action closed.

22/029(a)(i) – mental health commissioning - The number of patients with mental health difficulties requiring support in the acute hospital environment has been highlighted again with ICS leaders. Action closed.

22/029(a)(iii) medical vacancies – Regular medical staffing reports have been scheduled for the People & Culture Committee to be updated on areas of medical vacancy, hard to fill posts and plans to address these. Action complete.

22/030 Staff Survey – Priority Improvement Actions – Carried forward. The Board was informed that an update report has been provided detailing the plan and forward trajectory for priority improvement actions. An action tracker and RAG rating was included for reporting progress against each initiative. Board members indicated that this did not entirely complete the action and requested that the action be kept open for monitoring. **Action: Mr Jones**

22/038 **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 patients without a criteria to reside in hospital has increased significantly and now stands at 227. Hospital capacity equivalent to 3 full wards is now being utilised for patients who would normally be cared for outside hospital.

This is placing very significant pressure on staff, wards and the Emergency Department. It is inevitably having a negative impact on the quality of experience for our patients and staff.

Work continues internally to ensure that we have optimised our pathways/processes and capacity on our virtual ward is increased to 40 patients. We are continuing to work with system partners to explore options to increase capacity for domiciliary community beds and to look at how additional funding and support can be leveraged.

The Trust achieved the 104-week wait target at the end of June and we are grateful to our staff for their work to ensure patients receive the care they need.

The Trust and UEA have jointly appointed 8 Clinical Academics which is a significant next step in developing our research capacity & capability.

22/039 **REPORTS FOR INFORMATION AND ASSURANCE**

**(a) Quality & Safety Committee**

The Board received a report from Dr Chrispin concerning the Quality & Safety Committee meeting on 26 July 2022.

*i) Clinical visit*

The Board was informed that the Committee had visited the Cotman Centre which accommodates the Trust's Cytology and Histopathology services. Cytology services are provided to the whole region and the number of samples has increased significantly since the pandemic. Dr Chrispin emphasised how very impressed she had been by the patient-focussed and careful way in which the team had gone about their work.

It was noted that the Histopathology Department provides a crucial element in our diagnostic pathways including 62-day cancer. There are opportunities for modernisation of labour-intensive processes, which would be in line with our People Promise.

*ii) Regular governance reports*

Safer staffing performance continues to be closely monitored by the Committee in recognition of the implications this has on staff experience and patient experience in turn.

The Committee received a report on Maternity services and reviewed maternity Serious Incidents.

*iii) Cardiology review*

A presentation was provided by the Cardiology Team regarding a review of practice relating to the use of drug coated balloons (DCBs) for management of patients with coronary artery disease. It was noted that the outcomes for interventional cardiology procedures in the Trust have been exceptionally good – some 2 standard deviations better than rest of UK.

A review had however been undertaken because clinical practice in use of DCB was outside of European guidelines at the time and there were no applicable UK guidelines. There is evidence that practice in the UK is changing but the review has made a number of recommendations with particular regard to communication with patients and obtaining consent. There were also recommendations to improve the clinical governance of new procedures or use of devices outside guidance.

Professor Denton explained that when concerns about use of DCBs were raised a review of practice was undertaken and reported to the Quality & Safety Committee. All

the recommendations have been accepted and the Cardiology team have been actively engaged in developing the associated action plan.

A decision tree has been implemented in order to ensure that there is a full documented approval process for introduction of new devices/new drugs or those falling outside of guidelines. Strengthened processes have also been put in place to ensure that patients are fully aware when treatment falls outside standard guidelines.

Non-Executives asked about the process for declaring conflicts of interest for staff who are engaged in commercially-funded research. This will be captured in line with our conflicts of interest policies and compliance checked as part of the annual consultant appraisal review.

Duty of Candour communication has been undertaken for three patients who had been found to have poor outcomes following cardiac procedures. Additional information has also been made available on the Trust's website for patients and families.

Dr Brett (Deputy Medical Director) was thanked for his work in leading this review and supporting the implementation of the recommendations. The Cardiology Team were thanked for their work with regard to a thorough and transparent review.

**(b) IPR – Quality, Safety and Patient Experience**

Professor Fontaine reported that we are seeing an increase in harm associated with the additional patients accommodated on wards at times of operational escalation. It is apparent that adding additional patients to the ward will add pressure to the workload of nurses and this is reflected in metrics on pressure ulcers and falls.

The number of deaths per month before the pandemic was 200 and this has now increased to 300. This appears to reflect a change in case mix but also delays in discharge of patients on palliative care pathways. There is a backlog of structured judgement reviews of deaths as clinical staff time has had to be prioritised to patient care. Rapid investigations continue to be undertaken on deaths where there are concerns in order to address any issues without delay if needed.

Professor Fontaine reminded the Board that the Safety Nurse role had been established in order to manage risk across the Emergency Department. This role has been a positive development in managing risk to patients and supporting work to reduce ambulance delays. Mr Spink reported that he had seen this role in practice on a recent visit to ED and it appeared to be an excellent intervention. A mortality alert has been issued in relation to the number of out of hospital cardiac arrests, originating prior to hospital admission.

**(c) Finance, Investments & Performance Committee**

The Board received a report from Mr Spink concerning the Finance, Investments & Performance Committee meeting on 27 July 2022.

The Committee was updated on key performance metrics and priorities:

- 104-week wait – achieved
- 78 weeks – ahead of trajectory
- 62-day cancer – behind trajectory
- Ambulance handovers – showing improvement but very challenging
- 110% activity – behind trajectory.

Analysis of the patient profile in the Emergency Department between 2016 and 2022 reveals an older frail population in whom the clinical complexity scores have increased. Our performance is in the top-most quartile for admission avoidance but the data

evidences an increasing workload of more complex patients and a congested hospital due to delayed discharges.

There are a number of key factors:
- higher age profile and acuity than the national average reflecting a high elderly population in this region;
- 11% rise in attendances, with a 58% increase in Majors cases;
- high rates of admission avoidance and Same Day Emergency Care, even so annual non-elective bed days increased by c.7,000;
- average length of stay increased to 8 days.

The Committee was updated with regard to major projects, notably the N&N Orthopaedic Centre and the Paediatric theatre complex. These projects remain under enhanced monitoring to drive delivery as soon as possible.

**(d) IPR – Performance and Productivity**

Ms Oliver reported that the 104-week target had been achieved and we are now focusing on delivery of 78-week and 62-day cancer targets. There is a national directive to give equal priority to both targets and achieving the requisite balance will be a challenge.

2,327 patients were converted to the Patient Initiated Follow-Up programme in June and integration of the Infinity Platform will be completed this week. This new system is working well in Rheumatology, Endocrinology and some surgical specialties.

Non-Executives reflected on underperformance in activity against plan. Board Committees have been informed of the work to recover performance. Mr Higginson confirmed the aim to achieve activity above the 110% level in specialities where possible to off-set under performance in other areas.

**(e) Finance Report (Month 3)**

The Board received a report from Ms Sanford concerning the financial position at the end of Quarter 1, which is a £1.1m surplus (£1.4m adverse to plan). We continue to forecast a breakeven position for 2022/23 but this will be at risk from cost pressures and underperformance in activity. The capital programme is £5.2m underspent due to slippage in capital schemes but the forecast outturn expenditure is an overspend of £1.1m. Action will be required to mitigate the overspend by deferral of schemes.

**(f) IPR – Workforce and Update on Staff Survey Actions**

*i) Staff Survey Priority Actions*

Ms Gooch reminded the Board that six priority actions had been identified following publication of the Staff Survey results in March. Posters have been placed across the organisation to raise awareness of the actions being taken and to show the linkage between the staff survey and commitments under our People Promise.

We have made progress in a number of areas including:
- No Excuse for Abuse campaign and posters launched;
- Development progressing for a protocol for withdrawing care due to poor behaviour;
- Leadership visits to all areas across the Trust to be completed by March 2023;
- Event on 10 August to provide staff with support on 'cost of living' challenges.

Progress on implementation of the initiatives for Schwartz Rounds and Rest and Restore Days was rated amber. Funding has now been agreed by HMB and the RAG rating will change to green.

Members of the Staff Council have been appointed from a wide range of staff across all occupations, grades and divisions. The inaugural meeting will be held on 17 August, to establish its working principles and code of practice.

Open conversations are being held with staff to raise awareness of the six priority areas and gain feedback and suggestions.

Additional data is to be provided to the People & Culture Committee meeting in October with regard to a more in-depth analysis of each priority area, to provide a better understanding of how trajectories were identified and are being addressed.

**Action: Mr Jones**

*ii) IPR – Workforce data*

Appraisal compliance is showing a downward trend but each division has a trajectory and is subject to weekly monitoring. This is expected to increase performance to achieve 90% by the end of September.

Sickness absence has increased to 5.6% (4.4% without covid-related sickness). We will be adding additional support for staff with short term absences.

The Healthcare Assistant vacancy rate has reduced to 12.1% and the aim remains to reduce this to 5% by March 2023.

Non-Executives reflected on issues of recruitment and asked about the actions we are taking to increase retention and how this will be monitored. An international recruitment drive is underway to address Registered Nursing vacancies. A report with greater detail on workforce modelling and trajectories for improvement will be provided to the People & Culture Committee. **Action: Mr Jones**

22/040 **QUESTIONS FROM MEMBERS OF THE PUBLIC**

There were no questions from members of the public.

22/041 **ANY OTHER BUSINESS**

There was no other business.

22/042 **DATE AND TIME OF NEXT MEETING**

The next meeting of the Trust Board in public will be at 9.30am on 2 November 2022 in the Boardroom of the Norfolk and Norwich University Hospital.

Signed by the Chairman: …… Date: ……
*Confirmed and approved for signature by the Board on 2 November 2022 [TBC]*

**Decisions Taken:**

| | |
|---|---|
| 22/036 Minutes of previous meeting | The minutes of the meeting held on 8 June 2022 were agreed as a true record and signed by the Chairman. |

**Action Points Arising:**

| **Actions – carried forward** | |
|---|---|
| 22/030 Staff Survey – Priority Improvement Actions | The Board was informed that an update report has been provided detailing the plan and forward trajectory for priority improvement actions. An action tracker and RAG rating was included for reporting progress against each initiative. Board members indicated that this did not entirely complete the action and requested that the action be kept open for monitoring. Carried forward. **Action: Mr Jones** |
| **New actions arising** | |
| 22/039(f)(ii) – workforce IPR – recruitment & retention | Non-Executives reflected on issues of retention and asked about the actions we are taking to increase retention and how this will be monitored. A report with greater detail on workforce modelling and trajectories for improvement will be provided to the People & Culture Committee. **Action: Mr Jones** |
| 22/039(f)(i) – staff survey priority actions | Additional data is to be provided to the People & Culture Committee meeting in October with regard to a more in-depth analysis of each priority area to provide a better understanding of how trajectories were identified and are being addressed. **Action: Mr Jones** |

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# Action Points Arising from Trust Board meeting (public)

| | | |
|---|---|---|
| **Carried forward:** | | |
| 22/030 Staff Survey – Priority Improvement Actions | The Board was informed that an update report has been provided detailing the plan and forward trajectory for priority improvement actions. An action tracker and RAG rating was included for reporting progress against each initiative. Board members indicated that this did not entirely complete the action and requested that the action be kept open and **carried forward for monitoring.** **Action: Mr Jones** | **Carried forward for monitoring**<br><br>Reviewed by P&C Committee on 24.20.22 with outcome to report to Board that "*the Committee recommends that greater focus and pace should be given to delivering these issues.*<br><br>*It is recognised that action has been taken but this needs to go further and faster to meet the expectations of staff. Our staff are our most valuable asset and more focus will need to be put on these issues*." |
| **From meeting on 3 August 2022:** | | |
| 22/039(f)(ii) – workforce IPR – recruitment & retention | Non-Executives reflected on issues of retention and asked about the actions we are taking to increase retention and how this will be monitored. A report with greater detail on workforce modelling and trajectories for improvement will be provided to the People & Culture Committee. **Action: Mr Jones** | At its meeting on 24.10.22, the P&C Committee received reports regarding medical vacancies and 'hard to fill posts', plus recruitment trajectories for nursing & HCAs.<br><br><u>Further actions agreed by Committee</u>:<br>- medical vacancies will be scheduled for regular review<br>- recruitment trajectories to be added to IPR<br>**Board action closed** |
| 22/039(f)(i) – staff survey priority actions | Additional data is to be provided to the People & Culture Committee meeting in October with regard to a more in-depth analysis of each priority area to provide a better understanding of how trajectories were identified and are being addressed. **Action: Mr Jones** | At its meeting on 24.10.22, the P&C Committee received reports<br><br>"*the Committee recommends that greater focus and pace should be given to delivering these issues.* |

| | | |
|---|---|---|
| | | *It is recognised that action has been taken but this needs to go further and faster to meet the expectations of staff. Our staff are our most valuable asset and more focus will need to be put on these issues*."<br><br><u>Further actions agreed by Committee</u>:<br>- a specific risk should be raised on the CRR with regard to the Staff Survey – so that this is given adequate weight and attention in future planning for the allocation of resources.<br><br>**?Board action closed** |

JPG 28.10.22

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# REPORT TO THE TRUST BOARD

| | |
|---|---|
| **Date** | **2 November 2022** |
| **Title** | **Chair's Key Issues from People and Culture Committee Meeting on 24.10.22** |
| **Lead** | **John Paul Garside on behalf of Sandra Dinneen (Committee Chair)** |
| **Purpose** | **For Information and assurance** |

## 1 Background/Context

The People and Culture Committee met on 24 October 2022. The meeting was quorate and papers for the meeting were made available to Board members for information via Admin Control.

## 2 Key Issues/Risks/Actions

| The Committee identified the following items to highlight to the Board: | | |
|---|---|---|
| 1 | Workforce IPR | • The Committee reviewed the IPR and it was confirmed that the requested Staff Experience Dashboard will be included from November.<br>• It was reported that a proposal to relax obligations around mandatory training and appraisal has not been agreed. Whilst recognising the operational pressures on staff and managers, there are downsides to pausing training and appraisal. Compliance deadlines have been extended and the Committee emphasised that the value of appraisals should be optimised where possible.<br>• The Committee requested a report regarding the consequences of non-compliance with mandatory training. |
| 2 | Staff Survey priorities update | The Committee discussed actions taken in response to feedback from staff through the Staff Survey and **agreed** to recommend to the Board that greater focus and pace should be given to delivering these issues. The Committee "*recognised that action has been taken but this needs to go further and faster to meet the expectations of staff. Our staff are our most valuable asset and more focus will need to be put on these issues*." The Board may wish to take this recommendation into account as it establishes the operational and financial plans for next year and the Committee requested that a specific risk should be recorded on the Risk Register regarding delayed or ineffective response to Staff Survey feedback.<br><br>The Committee discussed the approach to encouraging completion of the Staff Survey. There is no substitute for demonstrating that meaningful action has been taken in response to staff feedback however the Committee also requested learning from other organisations – for example incentivising staff to complete the Survey through entry in a prize draw. |
| 3 | Focus on recruitment and retention | • The Committee received reports regarding workforce modelling, with an intended focus on recruitment plans, retirement and attrition forecasts. This was welcomed as an important step towards addressing these fundamental issues and specific trajectories have been established with regard to registered nursing staff and HCAs. These trajectories are included in the report to the Board on Staff Survey improvement actions and |

| | | |
|---|---|---|
| | | the Committee requested that these should be added to the IPR in future to enable monitoring and possible extension of the approach to other staff groups.<br>• The Committee discussed specifically the promotion of flexible working as a means of supporting staff retention. Information from exit interviews suggests that some managers are not as open to 'flexibility' as others. It was recognised that there are practical difficulties in some cases, particularly where flexibility for some staff may result in less flexibility for others. The Committee was informed that communication with staff and managers will emphasis that flexibility is the default starting position unless there are reasonable contraindications.<br>• The Committee received a further report regarding medical vacancies and 'hard to fill' posts. Gaining visibility of these challenged positions is crucial in order to facilitate potential creative solutions, perhaps with the UEA or other system partners. |
| 4 | Education Strategy – next steps | The Committee was updated with regard to the process and timeline for developing the overarching Education Strategy, with component 'chapters' regarding education for different professional groups. This is an important point of strengthening our progress towards becoming a vibrant and mature teaching hospital and the Committee encouraged identification of measures of success as part of the Strategy development. |
| 5 | Freedom to Speak Up | The Committee received a regular report on Freedom to Speak-Up activity and requested two particular actions: i) KPIs for timely closure and ii) identification of processes for sharing of learning. |
| 6 | Talent management & business continuity planning | The Committee received a report regarding an initial assessment of business-critical roles and associated continuity plans. This is work in progress – it covers divisional/clinical roles and needs to be extended to include corporate roles that are require continuity plans. |
| 7 | Estates update & capital planning | The Committee received an update with regard to possible estates development to benefit staff. The difficulties associated with some contractual issues were recognised but progress was welcomed and the Committee encouraged continued momentum. The Committee requested a review to ensure that the CRR clearly picks-up the recognised staff issues, so that these can be considered with appropriate priority when the 5-year capital plan is re-visited. |
| 8 | Travel Planning | The Committee was updated with regard to the ongoing consultation on travel plans. Committee members questioned the premise that solutions must be cost neutral, if this is affecting staff recruitment and retention. The Trust provides significant subsidy to the Park and Ride service. Whilst that serves both staff and patients, it may be that some of that funding might be put to alternative use. |

**3 Conclusions/Outcome/Next steps**

The next formal meeting of the Committee is scheduled for 23 January 2023. The Committee has agreed to hold informal meetings interlaced with the formal cycle, to enable more detailed discussion of topics of particular importance.

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

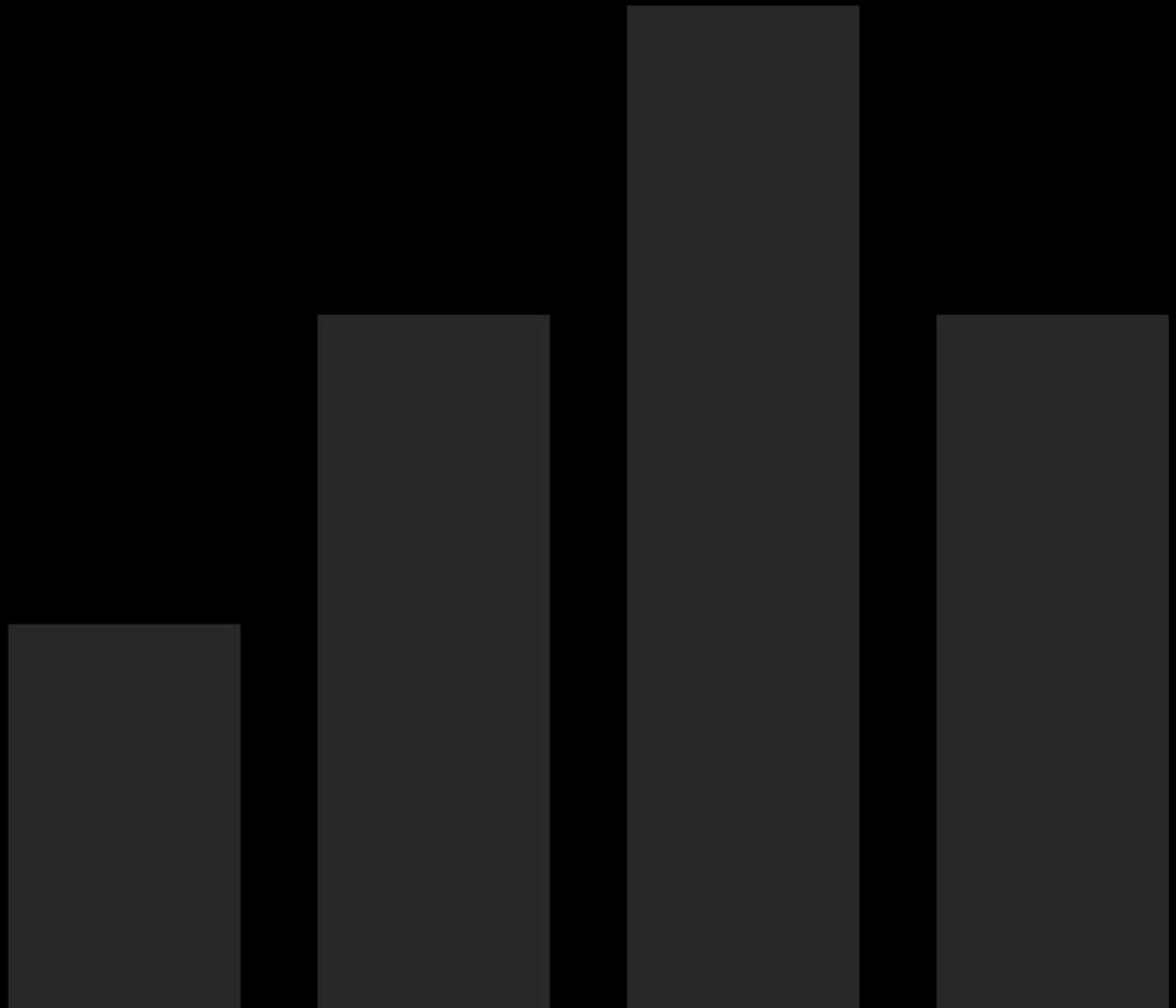
Microsoft | Power BI

# Workforce

View in Power BI

**Last data refresh:**
17/10/2022 07:30:17 UTC

**Downloaded at:**
17/10/2022 09:42:19 UTC



# Workforce Summary

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

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business intelligence

| Topic | Metric Name | Date | Result | Variation | Assurance |
|---|---|---|---|---|---|
| Staff in Post | Actual Substantive Headcount (WTE) | Sep 2022 | 8,252 | Improvement (High) | No Target |
| Vacancies | Variance: Headcount (WTE) | Sep 2022 | -976 | Concern (Low) | Not capable |

**SPC Variation Icons**

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


**SPC Assurance Icons**

Capable | Not capable | Unreliable

# Mandatory Training

NNUH Digital Health
business intelligence

## Mandatory Training

Sep 2022

Variation | Assurance

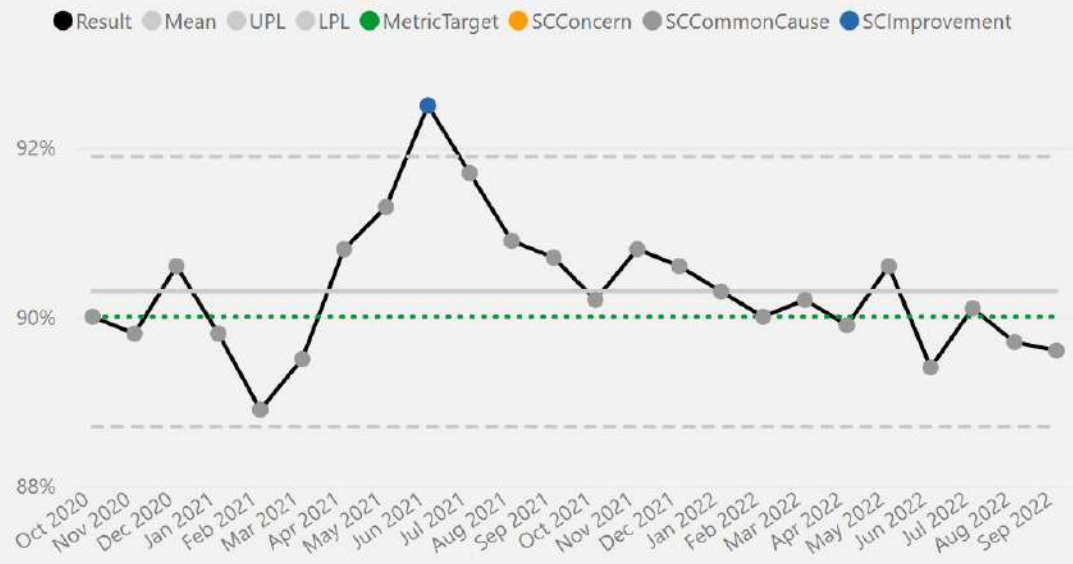
89.6% Result
90.0% Target

91.9% UPL
90.3% Mean
88.7% LPL

## Analytical Commentary

Variation is Common Cause

## Mandatory Training




## Assurance Commentary

As at the end of September, the overall compliance rate was 89.6%. For Medical staff, the compliance rate for permanent staff was 91.0% - this figure reduces to 79.9% including the fixed term rotational junior doctors.

The organisation has managed its overall compliance well given the planned switch over from level 2 Safeguarding Adults to Safeguarding level 3. The compliance on this topic has risen by a further 1.1% this month to 85.9%.

The new Resuscitation eLearning is awaiting the final practical demonstration video to be included and then we will be able to launch following final testing. This will move the current annual classroom requirement to bi-annual with an annual eLearning requirement.

## Improvement Actions

Sep 2022 - Resuscitation eLearning to have the demonstration video content added and then following testing this package can be launched.

Sep 2022 - Targeted emails were sent to staff who have fallen below on their compliance.

# Non-Medical Appraisals

NNUH Digital Health
business intelligence

## Non-Medical Appraisal

Sep 2022

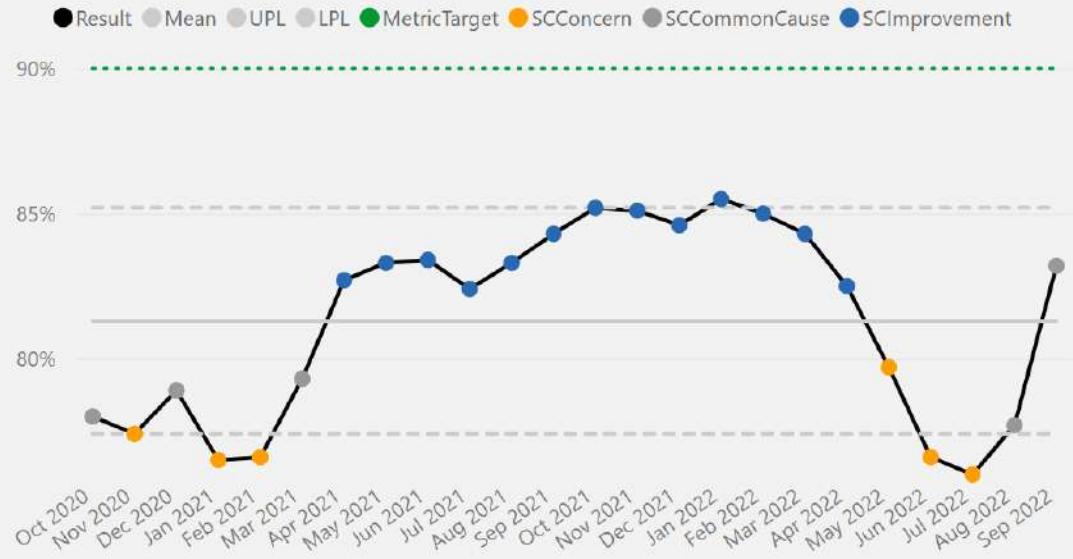
| Variation | Assurance |
|---|---|
|  |  |

| | |
|---|---|
| 83.2% Result | 85.2% UPL |
| 90.0% Target | 81.3% Mean |
| | 77.4% LPL |

## Analytical Commentary

Variation is Common Cause

## Non-Medical Appraisal




## Assurance Commentary

The Use of Resources 3.1 recommendation is that the Trust must achieve 80% compliance, with the Trust internal target of 90% of PDRs to be completed by September 2022. This target has been extended to end of November due to operational pressures.

In the 12 months to September 2022, 83.2% of eligible staff (Non-Medical appraisals) had an appraisal (inclusive of the new PDR or the previous appraisal process). This represents a 5.5% increase in performance compared to the previous month.

Training programmes have been well attended and as 30th September 2022, 571 employees had attended a workshop to understand the new approach and to ultimately improve the quality of PDR discussions and staff experience.

There is a range of evidence to support that having well-structured appraisals (where clear objectives are set, the appraisal is helpful in improving how to do the job, and the employee is left feeling valued by the employer) is particularly important for staff engagement and experience.

The 90% target by end of September via a divisional cascade approach is proving to be challenging to achieve. Divisions have revised their trajectories to achieve this by the end of November and this remains a key area of focus.

## Improvement Actions

September 2022 – Staff Survey 2022 commenced on 4/10 and includes questions regarding appraisal experience. In addition, key stakeholders have met to consider how a qualitative review of the new PDR process can be conducted via a random sample eform.

September 2022 - Ongoing provision of weekly progress reports to divisional management teams to review their performance.

September 2022 - Revised divisional compliance trajectories reviewed through the Performance Assurance Framework

# Sickness Absence

NNUH Digital Health
business intelligence

## Monthly Sickness Absence %

Sep 2022

Variation

Assurance

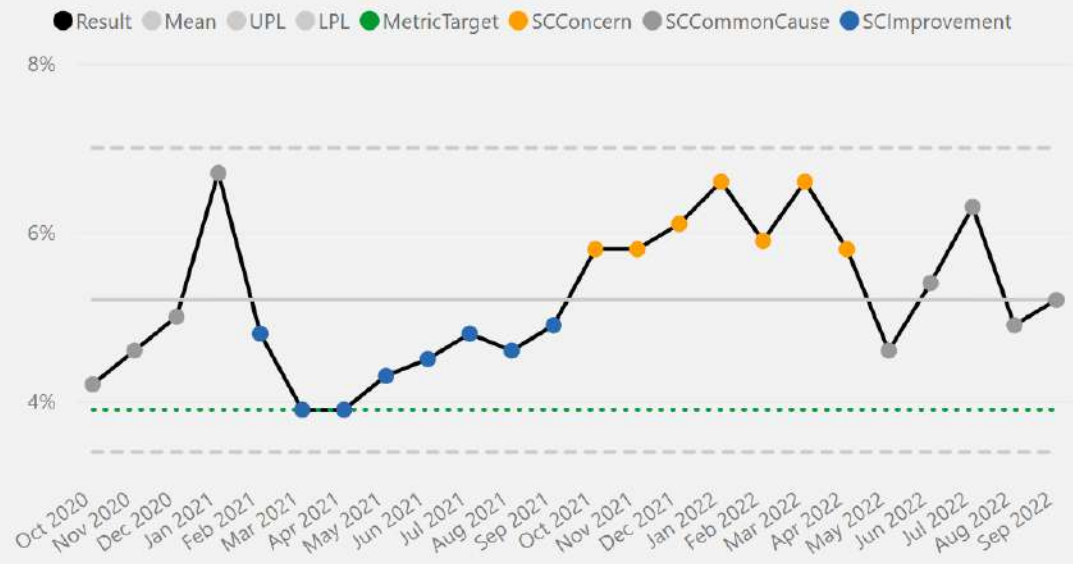
5.2% Result
3.9% Target

7.0% UPL
5.2% Mean
3.4% LPL

## Analytical Commentary

Variation is Common Cause

## Monthly Sickness Absence %




## Assurance Commentary

The Operating Plan for 2020/21 has set a 12 month rolling average target of 3.9% for sickness. As at 30 September 2022, that rate is 5.7%. The monthly absence figure for September is 5.2%. This monthly absence is higher than the 4.9% for September 2021.

Had Covid sickness been excluded the 12-month rolling average rate would be 4.4%, which could account for the increase in short and medium term absence.

Covid related sickness in September 2022 was 0.9% compared to 0.4% in September 2021. This indicates an increase in covid related sickness absence. Due to community prevalence, it is likely that this type of absence will increase which will impact on the level of staffing over the winter period.

The Trust continues to participle in an ICB wide project, developing an Attendance and Wellbeing Guidance framework in seeking to reduce absence across the system.

The work-related Occupational Health referrals have seen the continued change in reasons for psychological distress this month. 38% of the psychological work-related referrals have cited demands and shortage of staff as reasons for ill health. 80% of these cases were clinical Impact of higher number of patients per bay, inability to take breaks and workload are having significant impact on staff health. A wealth of support offerings are available to staff however organisational actions to address the root cause.

Increase seen in Musculoskeletal injuries as a result of increased demand. Moving and using faulty equipment (beds / trolleys) are key elements of MSK injury, of which 100% were clinical.

## Improvement Actions

Sep 2022 – The WHWB team are working with ED, DPU and visiting hot spot areas of absence to provide dedicated support. The WHWB team are progressing the re-launch of Schwartz Round project.

Sep 2022 – Monthly Attendance Management Training is running each month.

Sep 2022 – Managers communications promoting Top Tips for managing attendance/ absence on a fortnightly basis drafted for distribution during October.

# Staff Turnover

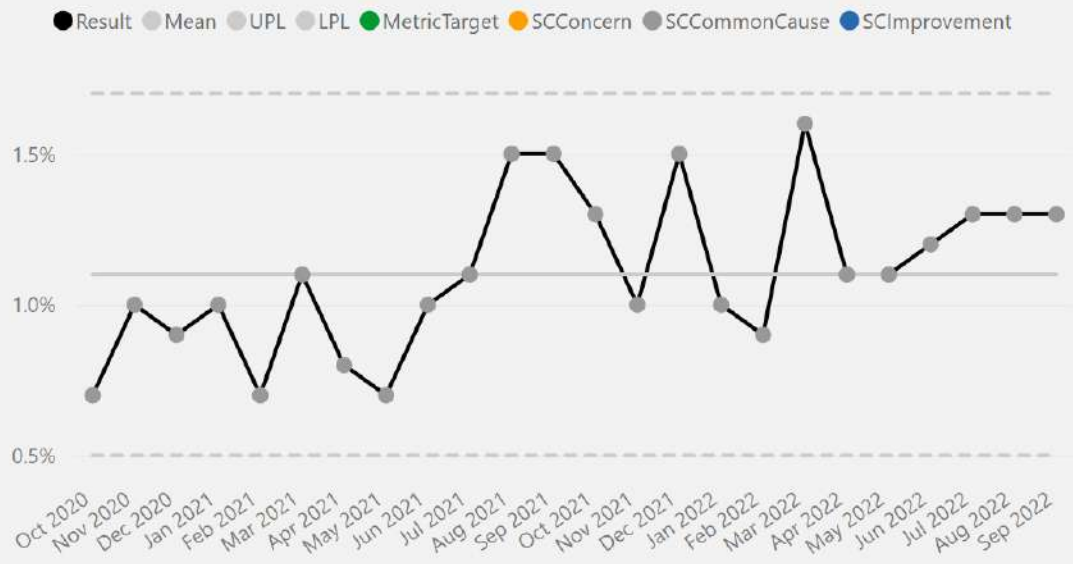
NNUH Digital Health
business intelligence

## Monthly Turnover

Sep 2022

| Variation | Assurance |
|---|---|
| 1.3% Result | 1.7% UPL |
| N/A Target | 1.1% Mean |
| | 0.5% LPL |

### Monthly Turnover




## Improvement Actions

September 2022 – Line managers play a key role in improving staff experience/retention. 2,064 managers have commenced the Licence to Lead programme (with 447 at 60% or higher completion).

September 2022 – Communications to support National Pensions week, encouraging individuals to remain in employment and work flexibly whilst taking pension benefits.

## Analytical Commentary

Variation is Common Cause

## Assurance Commentary

The monthly turnover rate for September 2022 is 1.3% which is equal to August and lower than September 2021 (1.5%). The 12-month average turnover rate is 14.7%, a decrease of 0.2% from August 2022. All divisions have decreased, but there has been an increase for corporate departments.

In order to reduce turnover to 10% per annum, a monthly turnover rate of 0.83% needs to be achieved. Processes continue to be in place to monitor turnover and deliver actions through our Retention Board.

In order to ensure a data approach is taken, a Stay/Exit Interview has been launched and a significant increase in the number of returns has been seen. Initial analysis indicates that the top reasons for leaving are promotion opportunities, and lack of flexible working. For 4 individuals, it has provided an opportunity to re-think their decision to leave as the issues a looked into to seek resolution.

The revised Flexible Working Policy has been approved and will launch in October. This introduces divisional oversight processes for increased access and equity in flexible working decisions.

# Staff in Post

NNUH Digital Health
business intelligence

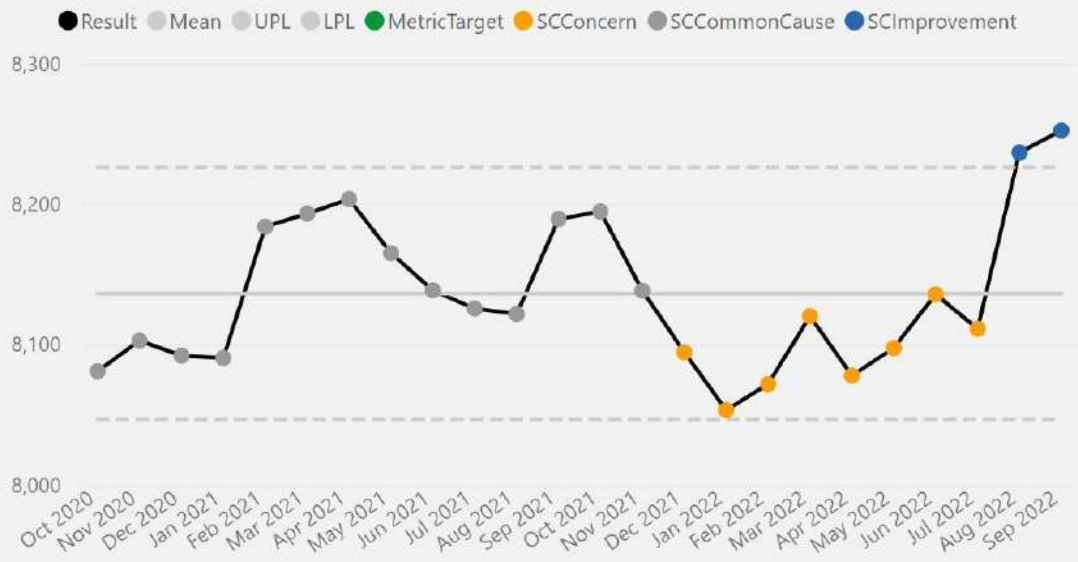
## Actual Substantive Headcount (WTE)

Sep 2022

Variation | Assurance

| | |
|---|---|
| 8,252 Result | 8,226 UPL |
| N/A Target | 8,136 Mean |
| | 8,046 LPL |

### Actual Substantive Headcount (WTE)




### Improvement Actions

September 2022 – Promotion in internal transfer policy, highlighting the streamlined processes to facilitate faster internal moves

September 2022 – Recruitment plans in place for all our 'hard to fill' medical Consultant posts to ensure the best possible service provision and to minimise premium pay costs.

September 2022 - Launch of Protocol to Withdraw Patient Care where staff are subjected to poor behaviours by patient/service users. This links to our Violence at Work policy and the No Excuse for Abuse campaign already launched.

### Analytical Commentary

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

### Assurance Commentary

Substantive staff in post is 8,252 for September 2022, an increase from August 2022 (8,237).
Improving headcount performance requires vacancy reduction and turnover reduction to be achieved.

Recruitment trajectories for nursing across Medicine, Surgery, Midwifery and Paediatrics are in place and progress is reviewed monthly through the Performance Assurance Framework.

In addition, a Trust wide trajectories is being developed for our key clinical posts that span the next 2 years inclusive of data relating to internal promotions so that robust plan can be devised in how to reduce the vacancy gap.

Timescale between individuals applying for a role and joining the Trust are also reducing.

Staff engagement is critical and the 6 priority actions for the People Promise continues. The facilities maintenance programme continues to refurbish rest areas. The travel to work options are drafted to commence consultation in October.

# Vacancies

NNUH Digital Health
business intelligence

## Variance: Headcount (WTE)

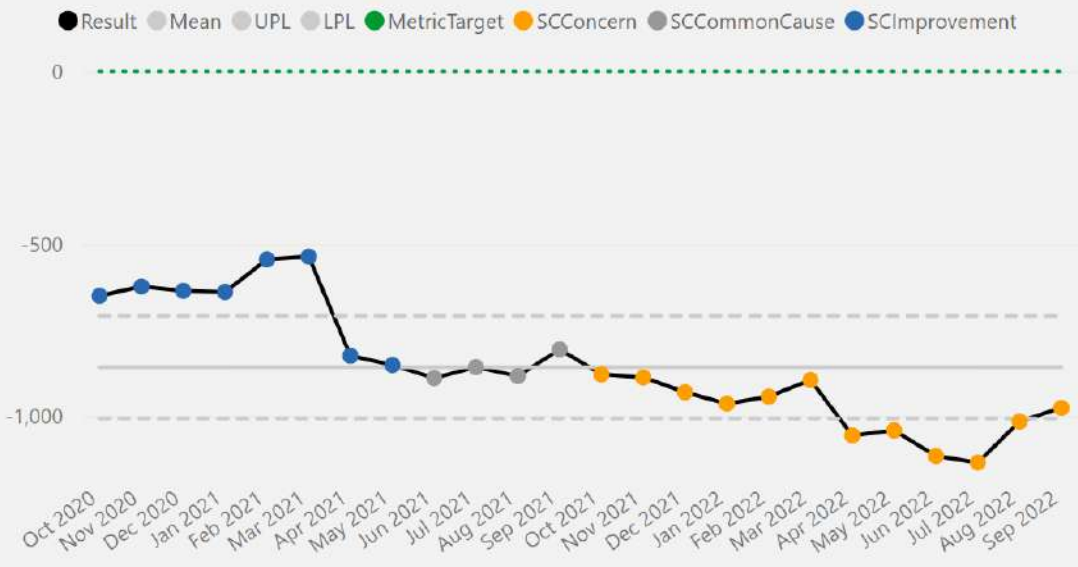
Sep 2022

| Variation | Assurance |
|---|---|
| L | F |

-976 Result
0 Target

-709 UPL
-858 Mean
-1,007 LPL

### Variance: Headcount (WTE)




### Improvement Actions

September 2022 - Recruitment action plans and trajectories continue to monitor the vacancy gap for critical nursing workforce roles for Medicine, Surgery, Midwifery and Paediatrics, and healthcare assistants across Medicine and Surgery.

September 2022 – 94 FPQ nurses and 9 ODP (Operating Department Practitioners), are due to commence employment this year.

September 2022 – 26 new HCAs started in September, a further 75 candidates are either going through pre-employment checks or have a confirmed start date.

### Analytical Commentary

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

### Assurance Commentary

Managers are encouraged to recruit to their vacancies as quickly as possible and seek ESR1 approval for all unfilled posts to allow them to advertise.

The Trust vacancy rate for September 2022 is 10.6% which is a slight reduction from 11% in August. This is the lowest vacancy level since April 2022 (reported at 11.6%), with a peaked vacancy rate of 12.3% in July. Based on the current vacancy rate, the Trust will need to recruit an additional 53.3 staff to bring the rate below 10%, provided no additional staff leave.

A business case is pending to increase international RN recruitment via the IR Hub.

Following the introduction of career conversations, 94 third year student nurses and 9 ODPs have now been offered a role at the Trust and are commencing in September and October.

A new Divisional approach to advertising for Health Care Assistants supported by events took place in September for the Divisions. This new approach limits the duplication of applicants for roles, streamlines shortlisting and interviewing time for line managers and improves the candidate journey by applying for their preferred area of work. Further events are planned for October.

Increased capacity for Corporate Induction for Health Care Assistants is being drafted in partnership with Nursing Practice Development and Education. This will enable more new starters to commence with the Trust, if the supply of candidates is available.

# Recruitment (Non-Medical)

NNUH Digital Health
business intelligence

## Time to Hire - Total

Sep 2022

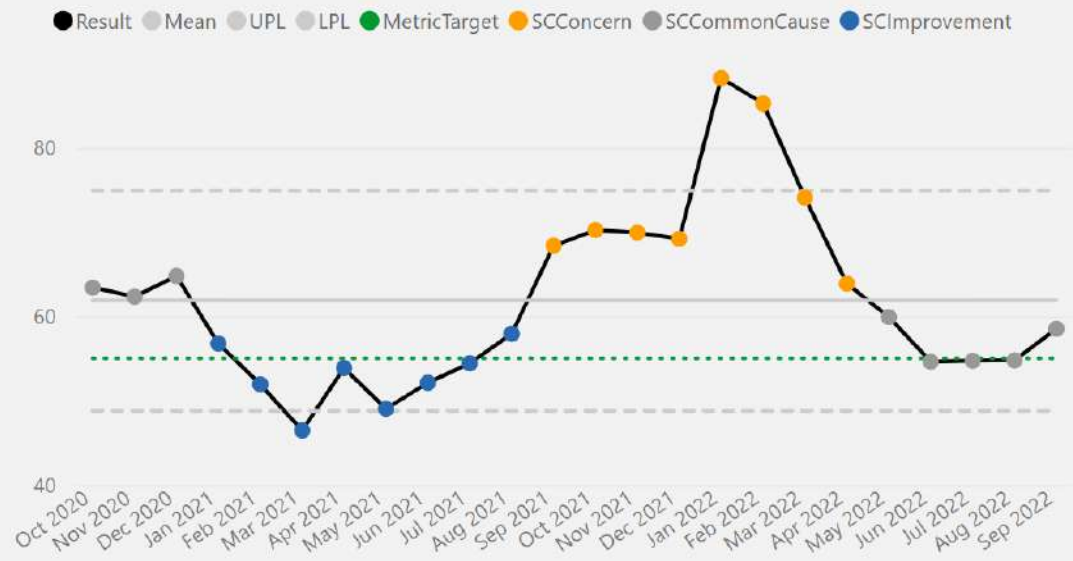
Variation | Assurance

58.5 Result
55.0 Target
74.9 UPL
61.9 Mean
48.8 LPL

## Analytical Commentary

Variation is Common Cause

## Time to Hire - Total




## Assurance Commentary

September Time to Hire was 58.5 days. This is above the Trust KPI of 55 days.

Time to advert close continues to be above the Trust KPI of 7 days at 10.3. This metric measures the advertising time. If managers chose to advertise over 7 days for roles that require longer advertising, this impacts on the metric and the overall time to hire.

Time to Offer meets the KPI of 5 days at 4.8 days.

Another element of time to hire is time to checks complete which has remained under target for each month of the past 9 months and for September is 27.3 days.

The average Time with Manager was 16.2 days. The target Time with Manager is 10 days.
For HCA large scale recruitment event the time to hire average time to hire was just over 30 days.

A new time to hire metric has been drafted, comparing with

## Improvement Actions

September 2022 – 26 HCAs commenced their induction training during September.

September 2022 – 65 First Post Qualified Nurses started work in September.

September 2022 – Business case prepared for continued international recruitment in order to continue to close our vacancy gap.

## Supplementary Metrics

| Metric Name | Date | Result | | Variation | | Assurance |
|---|---|---|---|---|---|---|
| Time to Hire - Time with Manager | Sep 2022 | 16.2 | | Common Cause | | No Target |

# Job Planning

NNUH Digital Health
business intelligence

## Job Plans Signed Off % (Within 12months)

Sep 2022

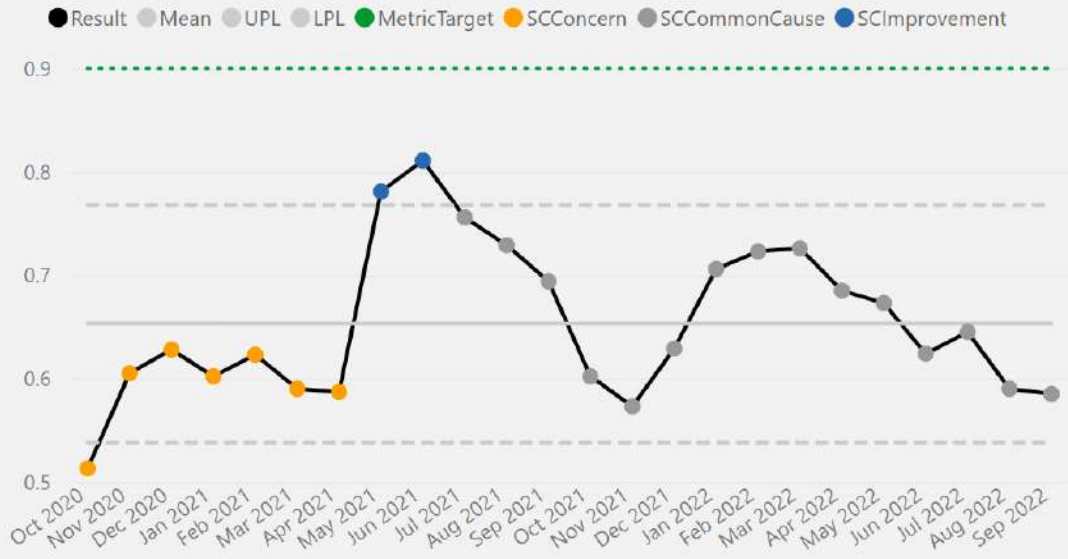
| Variation | Assurance |
|---|---|
|  |  |

| | |
|---|---|
| 58.5% Result | 76.8% UPL |
| 90.0% Target | 65.3% Mean |
| | 53.8% LPL |

## Analytical Commentary

Variation is Common Cause

## Job Plans Signed Off % (Within 12months)




## Assurance Commentary

Compliance has dropped by 0.5% compared to September, there are a variety of reasons (some of which are outside of the organisations control) for why performance is reasonably static at this moment in time. This includes:

- A series of 'bugs' in the system following an upgrade to the software
- Limited resources available (due to absence) within the eJob Planning team
- Focused months for Surgical, Critical and Emergency Care Division implementation still in implementation phase.

## Improvement Actions

- To continue to raise Service Desks calls with the software provider when system issues are identified
- To continue to support end users within the resources available
- To continue use the rollover process for job plans that have not changed following a review.

# REPORT TO TRUST BOARD

| | | | |
|---|---|---|---|
| **Date** | **Wednesday 2nd November 2022** | | |
| **Title** | **Staff Experience - Priority Improvement Actions** | | |
| **Author & Exec lead** | **Julia Buck, People Promise Manager on behalf of Paul Jones, Chief People Officer** | | |
| **Purpose** | **For discussion and information** | | |
| **Relevant Strategic Objective** | - Our NNUH Team: Together, we will support each other to be the best that we can be, to be valued and proud of our hospital for all. | | |
| **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☐** | Improved patient care, via improved staff experience |
| | **Operational** | **Yes☐ No✓** | Improved service delivery and support to address waiting time |
| | **Workforce** | **Yes✓ No☐** | Improved staff experience and morale which will lead to a reduction in vacancies and improved retention |
| | **Financial** | **Yes✓ No** | Reducing bank, agency and additional hours |

## 1. Background/Context

1.1 Following engagement with staff, six priority areas have been identified, which will make the biggest difference to them if delivered:

- Staff Shortages
- Staff Facilities
- Manager Support and Appreciation
- Staff Wellbeing
- Addressing Poor Behaviours
- Flexible Working

The six priority areas have been widely communicated to highlight to staff the actions the Trust is committed to taking and how this links to our staff survey and NNUH People Promise commitments. This can be found at Appendix A for information.

## 2. Key issues, risks and actions

2.1 The six priority areas contain twenty four actions as part of our People Promise delivery plan. Work continues to ensure these are delivered within the anticipated timescale, with remedial actions taken where any have fallen behind. A RAG rated summary can be found at Appendix B.

2.2 Notable recent achievements to report include:

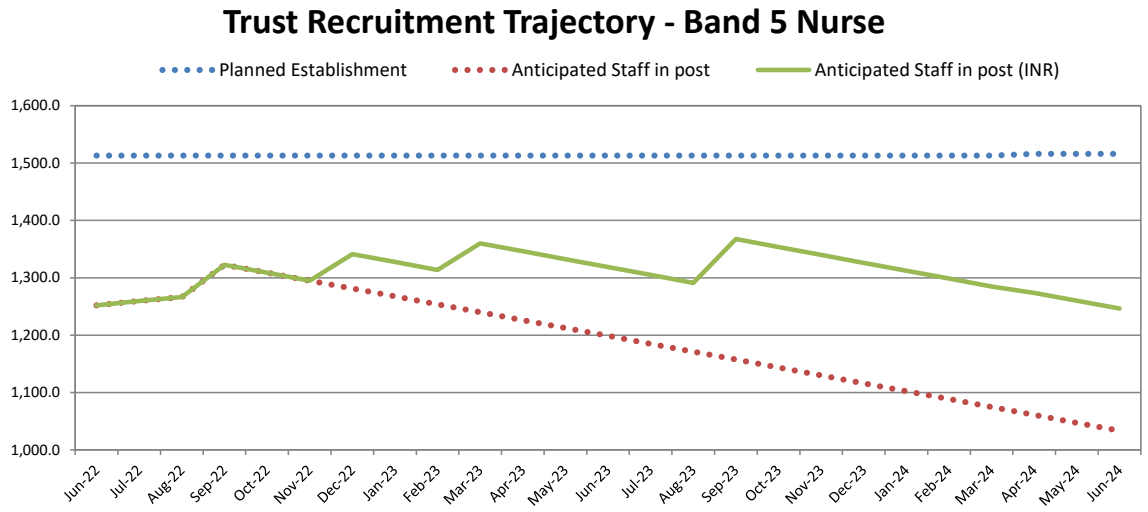
- Retention – Stay/Exit Interviews were launched to provide a better understanding of reasons for leaving and importantly, taken action that might help someone stay. In the last month 25 stay interviews were carried out. This resulted in one member of staff being retained and a further three considering a range of options and re-think their decision as the concerns are being addressed.
- Our revised Flexible Working Policy has been launched, initially as "FlexOctober" to raise awareness, supported by a series of line manager briefings, Open Conversations and posters displayed across the hospital. New flexible working agreements are now required to be recorded onto e-roster and the policy includes a divisional oversight process, supported by the HR Business Partner. This will be monitored, to evaluate our progress in implementing flexible working and supporting retention.
- Draft versions of the new NNUH Leadership Standards have been shared with trades unions and the Staff Council, and group of Leaders on development progress. Feedback will be incorporated and progressed through the Trust Governance structures.
- The consultation on Travel to Work options commenced during the first week of October to obtain feedback from staff and inform next steps of the implementation plan
- Facilitators have been trained to support the re-launch of the Schwartz Rounds, with a programme to being published
- As part of the 2022/23 NHSE funding bid, a further 60 international nurses will be recruited by December 2022, in partnership with the Norfolk and Waveney International Recruitment Hub.
- Time to Hire metric – this has been reviewed, benchmarked against Model Hospital and ICS partner data and proposals for revising the measure to achieve a further reduction is being consulted across divisions.

## 3. Key areas of focus

### 3.1 Recruitment

Registered Nursing

International nursing recruitment forms a key part of our recruitment plans. Without this intervention, due to projected leavers (inclusive of internal promotions) exceeding the projected starters, the anticipated staff (red line) decreases and the anticipated vacancy rate would increase to 31.8% by June 2024. Following the two business cases of International Nurse Recruitment being supported for December 2022 and March 2023 and Newly Qualified Staff joining in September, this would increase the staff in post number (green line) and decrease the vacancy rate to 9.6% by September 2023.

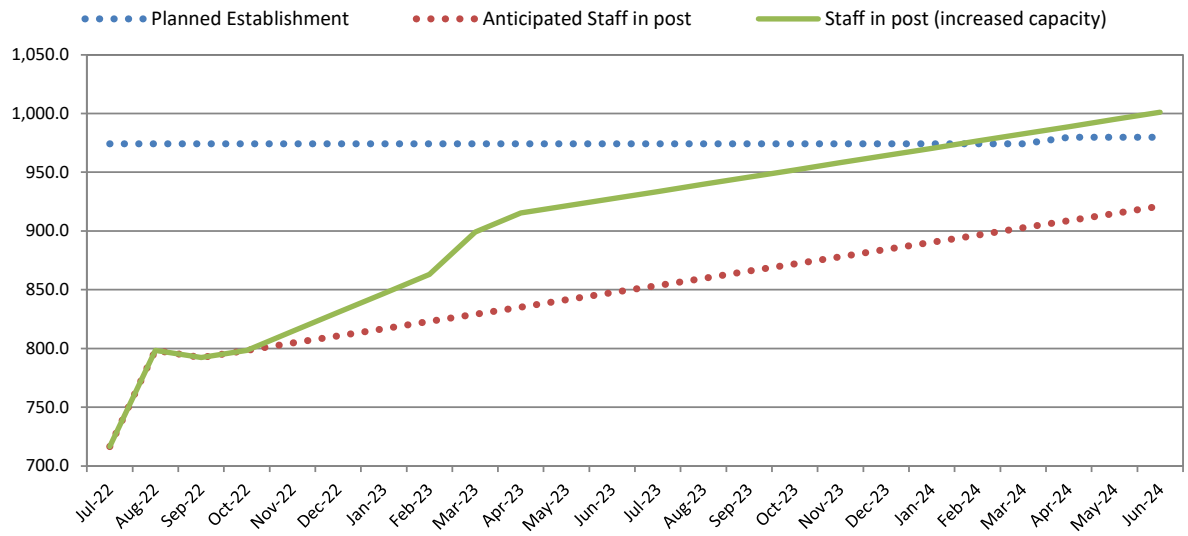



Healthcare Assistants

With the projected starters exceeding the projected leavers (7) each month, the anticipated staff (red line) gradually increases and the vacancy rate should decrease to 6.0% by June 2024. With increased corporate induction capacity from November through to May 2023, the starters would be increased further, therefore the staff in post (green line) decreases the vacancy rate to 5.4% by May 2022. This would meet the establishment by January 2024.

Action to increase retention, would accelerate this further.

**Recruitment Trajectory - Trust Band 2 Healthcare Assistant**




3.2 Retention

The vacancy position at the Trust continues to be compounded by an increase in turnover. Annualised turnover has declined consecutively in the last 2 months but remains high at 14.4% (September 2022). Annual turnover has decreased for all divisions but increased for the corporate departments.

The monthly turnover for September 2022 is 1.3%, with no change since July. The monthly turnover rate indicates an improved monthly position when compared to September 2021 which reported 1.54%. To help reach a 10% target for turnover, a monthly turnover rate of 0.83% will need to be achieved. The leavers data for Healthcare Assistants indicated the numbers of leavers may be starting to hold, with the average over the last six months being 5 WTE less than the previous six months.

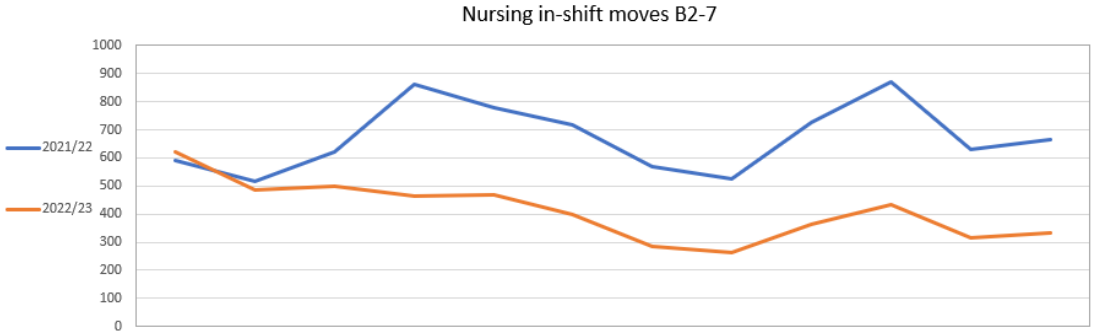
Turnover is based on all leavers, voluntary and involuntary. It can be useful to look only at attrition (leavers excluding dismissals, retirement, end of fixed term contracts), as an indicator of how our actions may be impacting. Our September performance for attrition is 1.26%, compared to 1.34% for turnover.

The average recruitment activity over the last 12 months equated to 70.75 WTE per month. To meet the 10% retention target, no more than 57 WTE leavers per month will be required. The average leaver figure over the last 12 months was 128.73WTE, so there is a gap of 57.98. This indicates staff leaving the Trust is our most significant issue in closing our vacancy gap.

Our Retention Board is structured around four pillars of retention, each with specific areas for delivery. 19 actions were reported as completed during the past month. Due to operational pressures, some actions have slowed over the past few weeks but activities to support retention of staff must remain a high priority for the Trust.

3.3 Reduction of In-shift moves

The roster "check and confirm" process and work by the Safer Staffing Team continues to make progress in reducing the number of redeployment as can be seen in the graph below.




| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2021/22 | 590 | 518 | 620 | 862 | 780 | 718 | 568 | 527 | 728 | 869 | 629 | 665 |
| 2022/23 | 620 | 484 | 497 | 464 | 467 | 397 | 284 | 264 | 364 | 435 | 315 | 333 |
| % Monthly Reduction | -5.1% | 6.6% | 19.8% | 46.2% | 40.1% | 44.7% | 50.0% | 50.0% | 50.0% | 50.0% | 50.0% | 50.0% |

Target

September 2022 is a 44.7% reduction on the same point in September 2021, and 54% down on the peak of January 2022 (869 shifts).

To further support this work Medicine division have implemented "sister wards" across specialities so wherever possible, any staff moves will be within a particular set of wards. The aim is to help reduce the number of areas colleagues are moving to, so they become familiar with the specialty as a whole and gain familiarity with colleagues to help reduce anxiety in redeployment.

3.4 PDRs and Wellbeing

The original cascade approach agreed that all PDRs would be completed between April and the end of September 2022. However, this has proven challenging to achieve due to operational pressures and a high number of managers being required to work clinically. To provide support to our managers over the winter period, it has been agreed that this will be extended to the end February 2023, to ensure they are able to conduct a meaningful PDR as a vital part of staff engagement.

Wellbeing discussions form part of the PDR process and given the extension of the PDR timetable, this may well impact on staff perceptions and delay some of the benefits sought. Workplace Health & Wellbeing (WHWB), in partnership with (Freedom to Speak Up (FTSU), hold a weekly drop-in session for staff, with further targeted support in high pressure areas. Resources have been produced for line managers to better support the mental health and wellbeing of their staff together with increasing number of Professional Nursing Advocates (PNA) to increase support. In line with our priority action, the

number of PNAs is increasing to 30 by February 2023. A training programme will also commence in January 2023 to introduce a PNA equivalent role for Allied Health Professionals.

The on-going cost of living pressures also require continued focus over the coming months to provide active support to colleagues facing financial issues.

3.5 Staff Facilities and Travel to Work

Delays in the schedule of work for improvements to staff facilities has meant that these have not received the publicity as planned. The need for improved staff facilities is recognised and an audit has been undertaken for all rest areas (NNUH and other sites) to prioritise refurbishments, with eight areas planned to be completed by the end of the 22/23 financial year.

The audit revealed poor quality, outdated furnishings across many areas. Emma Jarvis, Hospital Arts Co-ordinator, has engaged with staff to understand what they would like to see and scope the potential furniture options. Mood boards and furnishing options have been produced that reflect this feedback to provide a modern, restful environment for staff. This can be found at Appendix C and includes photographs of areas that now have this furniture (interventional radiology, delivery suite and the new ward block).

The furniture has been funded via the NNUH charity to date. Continuing funding will need to be secured to enable this programme to continue at pace.

The travel to work consultation has opened, and a further 250 temporary parking passes will be released to staff during October.

**4. Conclusions/ Next steps**

4.1 The Trust has a significant number of actions to improve staff experience. Of the 24 actions, 10 have been completed, with a further 5 due to complete shortly. All remaining actions are either longer term, to end of March 23 or have needed an adjustment to the completion date, with remedial actions in place to deliver.

3.2 It is important that communication of progress to staff is regular and consistent to provide information on what has been achieved and the continued focus on improving staff experience. This will be taken forward in partnership with colleagues from the communications team during November.

3.3 Operational pressures, meaning that managers are required to work clinically, as well as not getting engagement on Policy introductions such as flexible working should be noted as a significant risk to delivery across a number of workstreams. Divisional management teams are vital to cascade messaging and role modelling of changes.

**Recommendation:** The Board is recommended to:

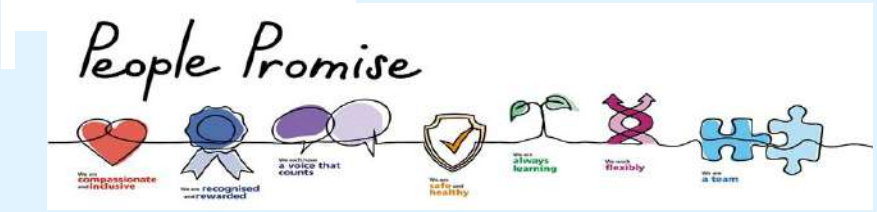
- Note the progress of the priority workstreams and risks to maintaining traction
- Provide any comment on focus for improving staff experience.

Appendix A

# NNUH People Promise - our staff survey priority actions to improve your experience at work


| Your concerns: | What we will do: | What you will see: |
|---|---|---|
| **1. Staff shortages**<br>Owner:<br>Paul Jones, Chief People Officer | • Reduce our overall vacancies<br>• Reduce the timescale between applying for a role and joining us<br>• Do more to help retain current staff<br>• Reduce short-term absences. | **More staff on our wards and at work by:**<br>• Reducing overall vacancies to 10% and key clinical roles to 5% (March 2023)<br>• Achieving an average of 55 days from placing job ad to completing employment checks (June 2022)<br>• Reducing staff turnover to under 10% (end March 2023)<br>• 20% reduction in staff absence triggers, as set out in the Attendance Policy (end March 2023). |
| **2. Staff facilities**<br>Owner:<br>Simon Hackwell, Director of Estates and Strategy | • Improve facilities<br>• Offer revised travel to work options. | **Improved and refurbished staff facilities by:**<br>• Agreed refurbishments/improvement plan (July 2022)<br>• Refurbishment programme communicated (August 2022)<br>• Revised travel to work options and parking offering published (September 2022)<br>• Implementation of the updated travel options (March 2023). |
| **3. Manager support and appreciation**<br>Owner:<br>Chris Cobb, Chief Operating Officer | • Ensure leaders are more visible across Trust<br>• Implement a new approach to Personal Development Reviews (PDRs)<br>• Ensure uptake of "Licence to Lead" by line managers. | **Greater visibility and support from management teams by:**<br>• A monthly programme of senior management visits to ward and specialty areas (from June 2022)<br>• Meaningful PDR discussion with your line manager (90% of staff by end September 2022)<br>• A minimum of 500-line managers complete "Licence to Lead" (March 2023). |
| **4. Staff Wellbeing**<br>Owner:<br>Nancy Fontaine, Chief Nurse | • Better support wellbeing at work to help address burnout<br>• Offer support and information to help with cost-of-living pressures<br>• Take action to minimise "in shift" staff moves. | **Increased support for your wellbeing by:**<br>• A wellbeing conversation as part of your PDR (90% by end September 2022)<br>• Schwartz Rounds reintroduced, increase Professional Nurse Advocate and Professional Midwifery Advocate roles and promotion of other wellbeing support (end September 2022)<br>• A monthly programme of "Rest & Restore" days (ongoing to March 2023)<br>• Practical cost-of-living support and information (June 2022)<br>• 50% reduction of "in shift" moves reported through E-Roster (October 2022). |
| **5. Addressing poor behaviours**<br>Owner:<br>Erika Denton, Medical Director | • Address poor behaviours from staff and managers<br>• Address poor behaviours from service users. | **Poor behaviours by patients and staff being addressed by:**<br>• Agreed divisional actions for areas reporting high incidence of bullying or feeling unable to speak up in the Staff Survey (June 2022)<br>• A revised Dignity at Work policy (September 2022)<br>• Implementing new NNUH Leadership Standards making the expectations of all leaders clear (July 2022)<br>• "No excuse for abuse" campaign launched (June 2022)<br>• Protocol to withdraw patient care where behaviour is unacceptable (July 2022). |
| **6. Flexible working**<br>Owner: Paul Jones, Chief People Officer and NNUH Wellbeing Guardian | • Improve access to flexible working for existing and new staff. | **Improved access to and equity of decisions about flexible working by:**<br>• At least 25% of job ads include options for flexible working (June 2022)<br>• Introducing divisional oversight for approving flexible work requests to ensure greater equity (September 2022)<br>• Organisational measures to monitor progress, with flexible working patterns recorded on E-roster (October 2022). |

Appendix B




| Task Status Key |
|---|
| Milestone or task is on schedule |
| Milestone or task is behind schedule |
| Milestone or task is overdue or unlikely to meet schedule |
| Milestone or task is complete |

## Project Plan

| No. | Key Milestone Description | Owner | Associated Actions | | Due Date | Task Status | Baseline/ Progress update |
|---|---|---|---|---|---|---|---|
| 1 | **Staff Shortages**<br>• Reduce our overall vacancies<br>• Reduce the timescale between applying for a role and joining us<br>• Do more to help retain current staff<br>• Reduce short-term absences. | Paul Jones | Actions required to complete this milestone: 4 | | | 0 | |
| | | | 1.1 | Reducing overall vacancies to 10% and key clinical roles to 5% (March 2023) | 31/03/2023 | **Milestone is on schedule** | Following business case approval for international nurse recruitment and increased HCA induction facilities, it is anticipated this may be met |
| | | | 1.2 | Achieving an average of 55 days from placing job ad to completing employment checks (June 2022) | 30/06/2022 | **Complete** | 55 days met in June, with governance in place to ensure sustainability and further improvement. |
| | | | 1.3 | Reducing staff turnover to under 10% (end March 2023) | 31/03/2023 | **Unlikely to meet schedule** | Four retention workstreams underway. Focus in supporting HCA new starters, implementation of Stay/Exit interviews and making it easier for staff to move internally should they wish to do so. |
| | | | 1.4 | 20% reduction in staff absence triggers, as set out in the Attendance Policy (end March 2023) | 31/03/2023 | **Behind Schedule** | Divisional data being shared via HRBPs to enable plans/governance to be agreed |
| 2 | **Staff Facilities**<br>• Improve facilities | Simon Hackwell | Actions required to complete this milestone: 4 | | | 0 | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | • Offer revised travel to work options. | | 2.1 | Agreed refurbishments/improvement plan (July 2022) | 31/07/2022 | **On schedule** | Prioritised schedule of areas for refurbishment has been agreed. |
| | | | 2.2 | Refurbishment programme communicated (August 2022) | 31/08/2022 | **Behind schedule** | Engagement with staff council and JSCC however delays to wider communication due to funding uncertainties |
| | | | 2.3 | Revised travel to work options and parking offering published (September 2022) | 30/09/2022 | **On schedule** | Travel to Work consultation opened October 2022 |
| | | | 2.4 | Implementation of the updated travel options (March 2023) | 31/03/2023 | **On schedule** | |
| **3** | **Manager support and appreciation**<br>• Ensure leaders are more visible across Trust<br>• Implement a new approach to Personal Development Reviews (PDRs)<br>• Ensure uptake of "Licence to Lead" by line managers. | Chris Cobb | Actions required to complete this milestone: 3 | | | 0 | |
| | | | 3.1 | A monthly programme of senior management visits to ward and specialty areas (from June 2022) | 30/06/2022 | **Complete** | Visits commenced for Surgical division, CSS. Schedule populated and diarised to cover all areas to March 2023 |
| | | | 3.2 | Meaningful PDR discussion with your line manager (90% of staff by end September 2022) | 30/09/2022 | **Unlikely to meet schedule** | Target has been amended to end Feb 23 as a supportive measure for line managers over the winter period |
| | | | 3.3 | A minimum of 500 line managers complete "Licence to Lead" (March 2023) | 31/03/2023 | **On schedule** | 60 managers completed at end of August. A further 420 have completed 60% of their Licence. |
| **4** | **Staff Wellbeing**<br>• Better support wellbeing at work to help address burnout<br>• Offer support and | Nancy Fontaine | Actions required to complete this milestone: 5 | | | 0 | |
| | | | 4.1 | A wellbeing conversation included as part of your PDR (90% by end September 2022) | 30/09/2022 | **Unlikely to meet schedule** | Reliant on the successful completion of appraisals, therefore target now end Feb 23. |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | information to help with cost-of-living pressures<br>• Take action to minimise "in shift" staff moves. | | 4.2 | Schwartz Rounds reintroduced, increase Professional Nurse Advocate and Professional Midwifery Advocate roles and promotion of other wellbeing support (September 2022) | 30/09/2022 | **On schedule** | Funding approved for Schwartz Rounds Action plan in place to train facilitators and devise programme by end Sept, ready to launch October. 11 PNAs being trained, due to complete Jan/Feb 23 which will increase numbers from 19 to 30. |
| | | | 4.3 | A monthly programme of "Rest & Restore" days (ongoing to March 2023) | 31/03/2023 | **Complete** | Funding approved for programme to end of March 23. Communicated to staff in daily bulletin |
| | | | 4.4 | Practical cost-of-living support and information (June 2022) | 30/06/2022 | **Complete** | Booklet published electronically and hard copy. Expo event held Aug 22, further event planned Jan 23. |
| | | | 4.5 | 50% reduction of "in shift" moves reported through E-Roster (October 2022) | 31/10/2022 | **Unlikely to meet schedule** | Good progress continues to be made |
| | | | | | | | |
| **5** | **Addressing Poor Behaviours**<br>• Address poor behaviours from staff and managers<br>• Address poor behaviours from service users. | Erika Denton | Actions required to complete this milestone: 5 | | | 0 | |
| | | | 5.1 | Agreed divisional actions for areas reporting high incidence of bullying or feeling unable to speak up in the Staff Survey (June 2022) | 30/06/2022 | **Complete** | Each area has identified a range of interventions appropriate to their area. HRBPs to ensure divisional governance is in place to monitor delivery. |
| | | | 5.2 | A revised Dignity at Work policy (September 2022) | 30/09/2022 | **Behind schedule** | |
| | | | 5.3 | Implementing new NNUH Leadership Standards making the expectations of all leaders clear (July 2022) | 31/07/2022 | **Behind schedule** | Report to be provided to HMB setting out proposals, with wider consultation to follow |
| | | | 5.4 | "No excuse for abuse" campaign launched (June 2022) | 30/06/2022 | **Complete** | Campaign launched and posters distributed. |
| | | | 5.5 | Protocol to withdraw patient care where behaviour is unacceptable (July 2022) | 31/07/2022 | **Complete** | Further embedding and training required |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 6 | **Flexible Working**<br>• Improve access to flexible working for existing and new staff. | Paul Jones/ Wellbeing Guardian | Actions required to complete this milestone: 3 | | | 0 | |
| | | | 6.1 | At least 25% of job ads include options for flexible working (June 2022) | 30/06/2022 | **Complete** | TRAC template now includes standard wording to encourage applications on a flexible basis, together with modifications to interview templates and recruitment request forms |
| | | | 6.2 | Introducing divisional oversight for approving flexible work requests to ensure greater equity (September 2022) | 30/09/2022 | **On schedule** | Flexible working policy approved September 2022. Launch during Flex October, with comms and line manager training |
| | | | 6.3 | Organisational measures to monitor progress, with flexible working patterns recorded on E-roster (October 2022) | 31/10/2022 | **Unlikely to meet schedule** | This is a larger piece of work than anticipated. Resource has been identified but unlikely to be completed until March 23. |

**Appendix C**

NHS
Norfolk and Norwich
University Hospitals
NHS Foundation Trust

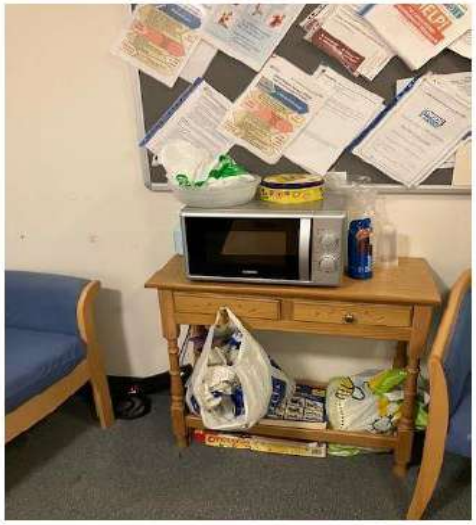
# Staff Rest Rooms Furnishings Proposal

Environmental Arts, Projects Team, Facilities Department
Emma Jarvis – August 2022

# Current Rest Rooms Examples

East Outpatients and Sterile Services

Mortuary



# Furniture Portfolio

| | |
|---|---|
| Materials: | IP&C, Fire Safety: high grade vinyl, anti microbial, in line with IP&C, metal, plastic, laminate. Vinyl either Camira or VESCOM anti microbial. Easy to clean. |
| Warranties: | 7 year warranty on manufacture |
| Design: | Similar throughout Trust to enable moves, interchangeable, smart, easy to clean, clear space underneath for cleaning and visual inspection, no crevice's for dirt to accumulate, modern, comfortable, trialled and liked. |
| Carbon Footprint: | All furniture can be re-upholstered, long warranty of 7 years, sound product base, carbon footprint on vinyl's good, long life span. |

City Chair
Comfy Lounge Diner

City Chair
Comfy Lounge Diner

College Chair
Lounge Diner

College Chair
Lounge Diner padded

Astro Chair
Lounge Modular comfy

Astro Chair Corner
Lounge Modular comfy

Cove Table
Coffee/Dining
Square or Round

Cove Table
Coffee/Dining
Square or Round

Astro Corner Table
Coffee
Square

Cove Coffee
Square or Round


NNUH Standard Clock
Square or Round

# Wall/Floor Finish/Colour Suggestion

Soft mid tone grey floor, wood look kitchen cupboard doors, wall colours white and light grey

# Furniture Colour Suggestion

Suggested VESCOM Dalma, slightly higher end, soft look finish, vinyl in line with IP&C

## Artwork suggestions

Some departments have their own artworks, where departments don't suggested modern prints, based around nature, calm and non intrusive more detailed consultation would be carried out.










## A new rest area NNUH



# A new rest area NNUH

# REPORT TO TRUST BOARD

| | |
|---|---|
| **Date** | **2 November 2022** |
| **Title** | **Chair's key Issues report from Quality and Safety Committee Meeting on 25.10.22** |
| **Author & Exec Lead** | **John Paul Garside on behalf of Dr Pam Chrispin – Non-Executive Director (Committee Chair)** |
| **Purpose** | **For Information & agreement as specified** |

The Quality and Safety Committee met on 25 October 2022. Papers for the meeting were made available to all Board members for information in the usual way via Admin Control. The meeting was quorate but, on this occasion, there were no governor observers.

In addition to consideration of the usual suite of information and reports concerning quality and safety in the Trust, the Committee received a series of reports in accordance with its Work Programme, and the following matters were identified to highlight to the Board:

| | | |
|---|---|---|
| 1 | Clinical Visits | Due to the weight of items and clinical presentations for consideration on the Agenda, the meeting was not preceded by clinical visits. |
| 2 | Divisional Presentation – Surgery Division (Emergency Care & T&O) | As part of its regular cycle of divisional reviews, the Committee met with the Surgical Division leadership & governance team – focussed on Emergency Care & Trauma and Orthopaedics.<br><br>With regard to the emergency pathway, the team confirmed that there is demonstrable improvement within the department (and knock-on benefit for ambulances) when there is flow out of the Department. It may appear self-evident but the Committee received confirmation that if the delays in admitting patients into the hospital were resolved this would resolve ambulance offload delays. |
| 3 | Focus on Research | The Committee was updated on work to implement the Research Strategy. The Committee was reminded that there is an increasing body of evidence to show that research active healthcare organisations achieve better patient outcomes. Strengthening of our research activity is therefore important for patient quality and safety. It is of particular note that:<br>• the Trust has jointly appointed 8 clinical associate professors – a significant advance in developing our research capability and infrastructure;<br>• The Trust has also been successful in attracting £1m in funding from the National Institute of Health Research (NIHR) to support development of the Clinical Research Facility (CRF). Development of the Norwich NIHR CRF is an important step towards a future successful application to be accepted as a Biomedical Research Centre (BRC). |
| 4 | Maternity (bimonthly update) | The Committee received its regular report from the Maternity Team, including the Head of Midwifery and governance facilitators. The Committee considered learning from incidents as part of the regular reporting cycle, with details available to the Board in the Resource Centre. The background to this update was the recent report into maternity services in East Kent and there was a lengthy discussion regarding the promotion of caring high-quality maternity services. To supplement previous discussions between Board members and the maternity staff, it was proposed that a broad-based discussion with a cross-section of staff would be healthy in ensuring that our services are truly patient-focussed. |

| | | |
|---|---|---|
| 5 | Corporate Risk Register | The Committee reviewed key risks relating to quality and safety, in particular:<br>*i) agency rate cap* (reported elsewhere in the papers)<br>*ii) review of Escalation processes*. The Committee was advised that the Standard Operating Procedure (SOP) for additional patients on wards is currently being rewritten to reflect creation of the new PAU pathway in ED and this will come to the Committee at its next meeting. The Committee was reminded that 10-months after introduction of these 'exceptional' measures it is consistently necessary to accommodate additional patients in ward bays. The precise number of additional patients varies daily but it is in the region of 80-100. This is not good for patient or staff experience and is a direct result of the increased number of patients in the hospital without a criteria to reside, accompanied by significant demand in the emergency pathway. Despite introduction of these escalation measures we still have prolonged ambulance waiting times and the N&W ICS is in Critical Incident status.<br>The Committee will return to this issue at its next meeting and in the meantime:<br>- **noted** the ongoing need to use escalation beds with significant numbers of additional patients on wards across the hospital, to relieve pressure on the ED and to minimise ambulance waiting times;<br>- **supported** the continued use of ringfenced surgical beds for our cancer, high-priority and longest-waiting planned-care patients – recognising that these patients also need and deserve our services;<br>- **received and accepted** the advice from senior clinical staff that the position changes regularly (influenced by operational pressures, patient case mix and staff availability). The appropriate operational response is therefore based on a dynamic risk assessment taking all these factors into account;<br>- **supported** the view that the position requires a system-response commensurate with the Critical Incident position, noting that the continued use of these exceptional escalation measures must not be 'normalised' as business as usual. |
| 6 | Q&S Integrated Performance Report (inc SSNAP & NSTEMI data) | The Committee reviewed quality & safety performance indicators. The Committee receives regular reports regarding mortality data (which is reported elsewhere on the Agenda) and has noted the exceptional impact of palliative care in the Trust's case mix (with over 50% of patients who die in the Trust having received palliative care input) together with the disruption to the mortality metrics and the calculation of 'expected deaths' caused by the pandemic.<br><br>The Committee reviewed the metrics relating to the PPCI – 'heart attack' pathway. These metrics cover 'call to balloon' and 'door to balloon'. The target performance is consistently achieved for the hospital element of the pathway, but 'call to balloon' performance is below the target level (typically reflecting delay in the pre-hospital phase) and this is another example of the importance of releasing ambulances as soon as possible back to the care of patients in the community.<br><br>Overall SSNAP performance remains challenged and below target performance, with particular difficulties in ensuring that stroke patients can be accommodated in the specialist stroke areas within a highly congested hospital. At its next meeting, the Committee is scheduled to receive a report from the neuroscience/stroke team looking particularly at actions that can be taken to support improvement. |
| 7 | Patient Safety Strategy - update for information | For information – a significant amount of work is underway with regard to the national initiative to implement priority actions under the National Patient Safety Strategy. This includes:<br>• introduction of a new framework which will replace the existing Serious Incident Framework. |

| | | |
|---|---|---|
| | | • a new National Patient Safety Training Syllabus is also being introduced. Discussions are ongoing as to whether this will become part of NHS mandatory training. Training for 30 members of Trust staff has been arranged with 8 selected to become trainers. There is also a particular focus on training of maternity staff, to support delivery of the recommendation for early review of maternity cases. |

**Conclusions/Outcome/Next steps:** The next Committee meeting is scheduled for 22 November 2022 and will review matters including:

- Divisional focus – Medical Division (inc Hip Fracture pathway review)
- Inpatient Survey Results
- Stroke/Neuroscience Strategy Implementation
- Maternity Incentive Scheme Update
- Children's Board – Annual update

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

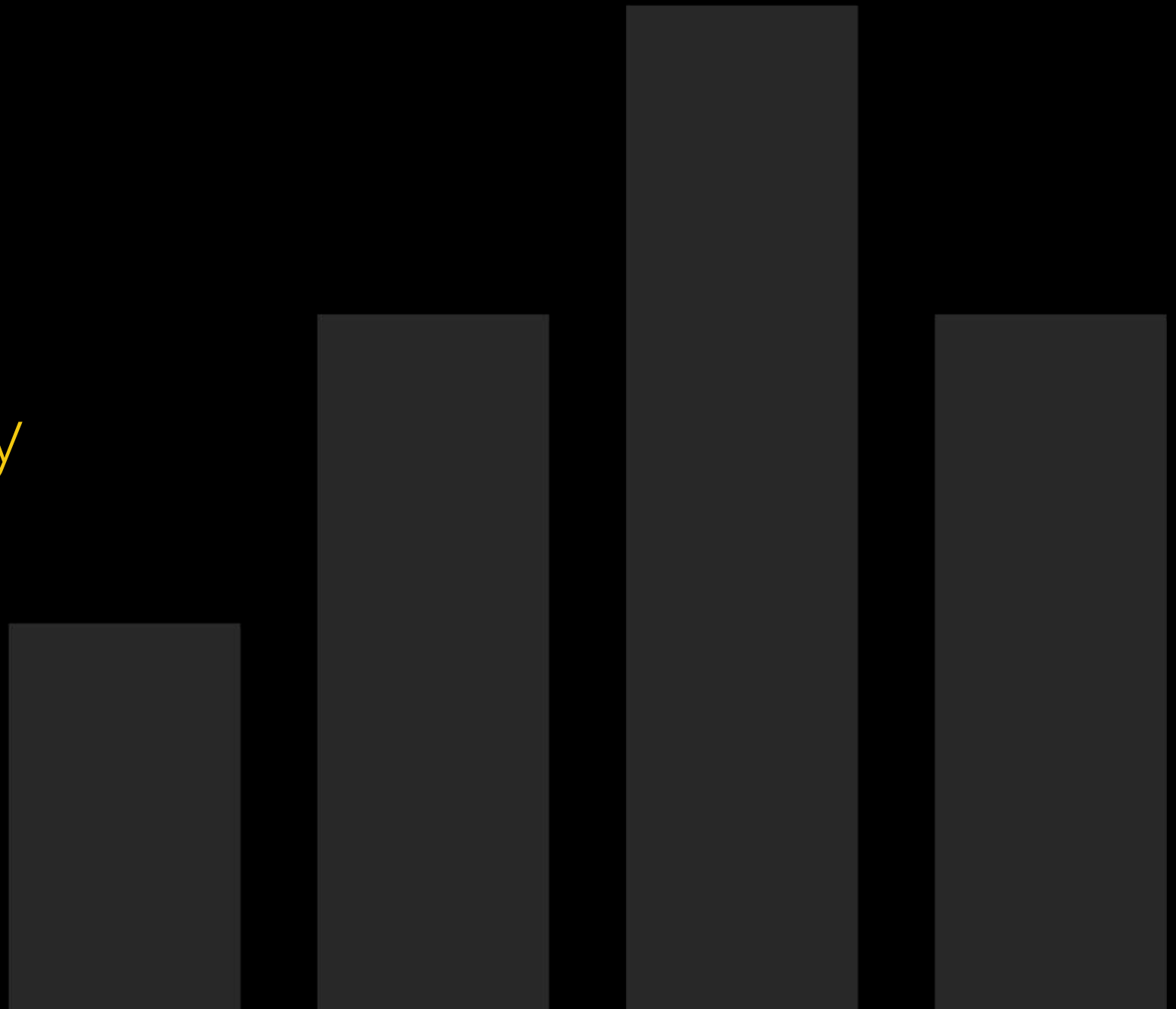
Microsoft | Power BI

# Quality & Safety

View in Power BI

**Last data refresh:**
14/10/2022 07:30:43 UTC

**Downloaded at:**
14/10/2022 14:21:45 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 |
|---|---|---|---|---|---|
| Children & Midwifery Safeguarding | Safeguarding Children | Sep 2022 | 6 | Improvement (Low) | No Target |
| Children & Midwifery Safeguarding | Safeguarding Children and Midwifery | Sep 2022 | 8 | Improvement (Low) | No Target |
| Children & Midwifery Safeguarding | Safeguarding Midwifery | Sep 2022 | 2 | Improvement (Low) | No Target |
| Maternity: Babies | Mothers Transferred Out of Unit | Aug 2022 | 1 | Improvement (Low) | No Target |
| Nutrition and Hydration (AIMS) | Nutrition and Hydration (AIMS) | Sep 2022 | 88.4% | Improvement (High) | No Target |
| Patient Concerns | PALS % Closed within 48 hours - Trust | Sep 2022 | 43.4% | Concern (Low) | No Target |
| Patient Experience | Friends & Family Score | Sep 2022 | 88.00% | Concern (Low) | Unreliable |
| Patient Observation and Escalation (AIMS) | Patient Observation and Escalation (AIMS) | Sep 2022 | 90.2% | Improvement (High) | No Target |
| Patient Safety | Incidents | Sep 2022 | 1,840 | Improvement (Low) | No Target |
| Pressure Ulcers (AIMS) | Pressure Ulcers (AIMS) | Sep 2022 | 86.9% | Improvement (High) | No Target |
| Safer Staffing | Safe Staffing Care Hours Per Patient Per Day | Sep 2022 | 6.3 | Concern (Low) | No Target |
| Safer Staffing | Safe Staffing Fill Rates | Sep 2022 | 79.80% | Concern (Low) | Not capable |
| Saving Babies Lives | CTG Training and Human factors situational awareness compliance | Sep 2022 | 76% | Concern (Low) | Not capable |
| Saving Babies Lives | SGA detected Antenatally | Sep 2022 | 131% | Improvement (High) | No Target |

**SPC Variation Icons**

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


**SPC Assurance Icons**

Capable | Not capable | Unreliable

# Patient Safety

NNUH Digital Health
business intelligence

## Serious Incidents

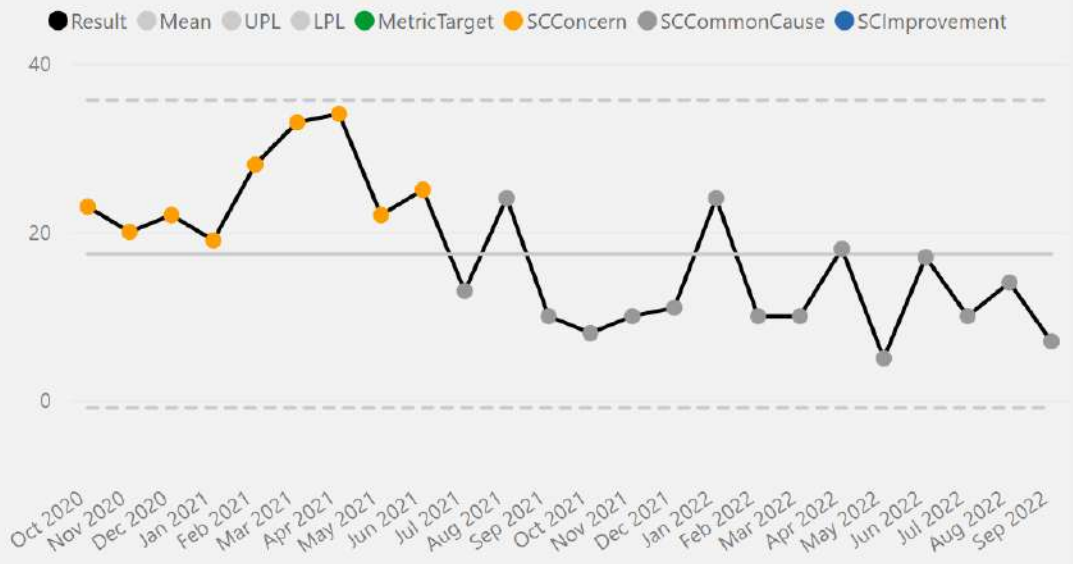
Sep 2022

| Variation | Assurance |
|---|---|
| 7 Result | 36 UPL |
| N/A Target | 17 Mean |
| | -1 LPL |

## Analytical Commentary

Variation is Common Cause

## Serious Incidents




## Assurance Commentary

Monthly Serious Incident (SIs) reporting continues to show common cause variation with no signals of concern or improvement. We can expect between 17 and 36 with a mean of 17 SIs reported each month. Duty of Candour(DoC) compliance process continues to be unreliable and is not meeting the agreed target within 10 days.

## Improvement Actions

The SI Group meets daily to discuss incidents in a supportive environment, we promote psychological safety to reinforce a just and learning culture.
The falls QI programme aims to reduce the number of falls causing serious harm which make up 22% of SIs since July 2021.
Governance teams continue to support the DoC compliance, with delays due to complex processes involving different teams.
7th patient in a 6 patient bay is being collated and the impact is shown in detail on the next slide.

## Supplementary Metrics

| Metric Name | Date | Result | | Variation | | Assurance |
|---|---|---|---|---|---|---|
| Duty of Candour Compliance | Sep 2022 | 98% | | Common Cause | | Unreliable |
| Incidents | Sep 2022 | 1,840 | | Improvement (Low) | | No Target |

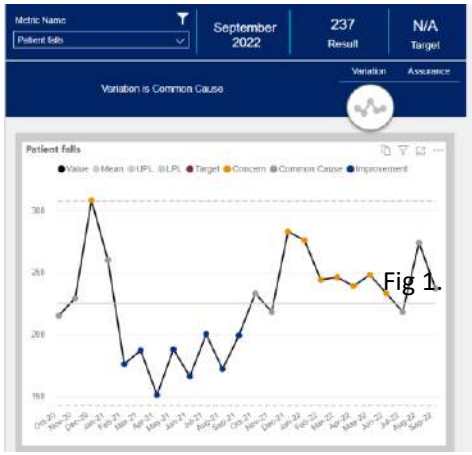



Fig 1.

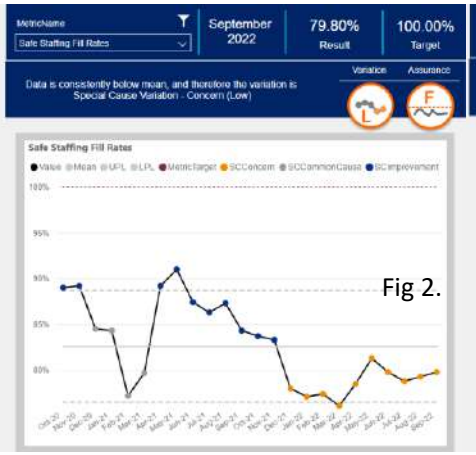



Fig 2.


Fig 3.

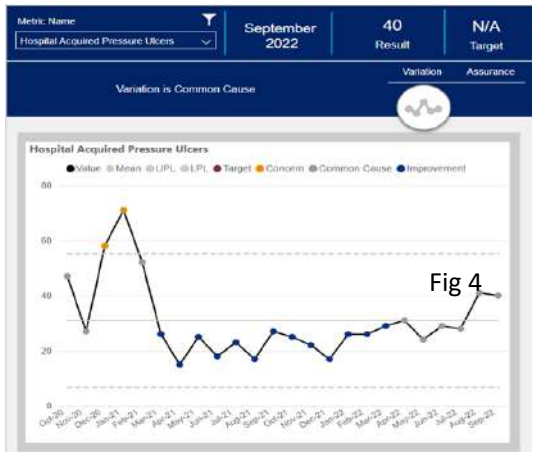



Fig 4

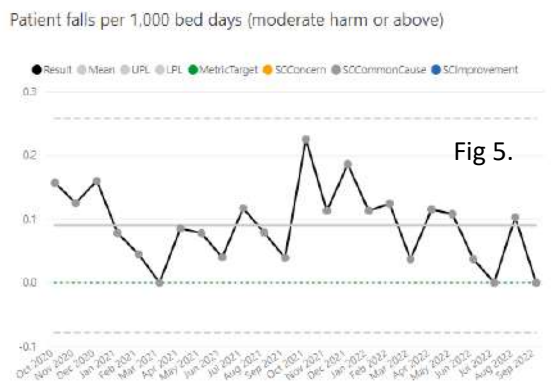



Fig 5.

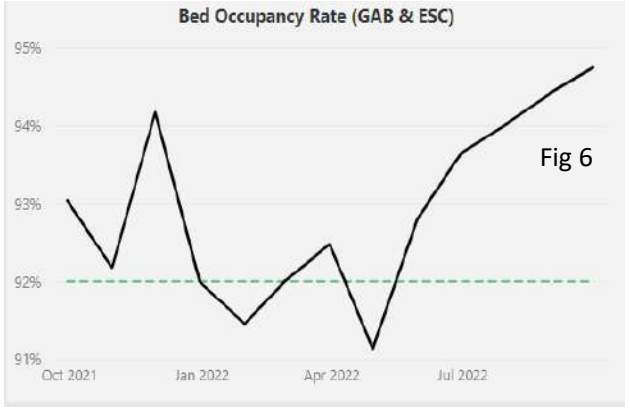



Fig 6

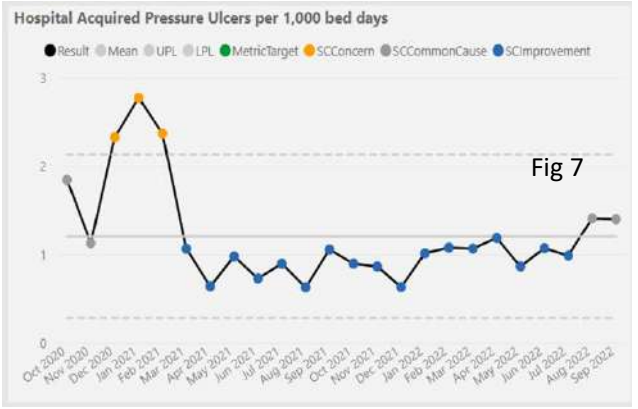



Fig 7

Fig 1 Our Trust-wide falls data is showing predictable variation between 142 and 308 falls per month, with a mean of 225. Since December 2021, the number of falls has been above the mean, this change is a signal that we call a special cause, it tells us that something in our system changed to cause an increase in the number of falls. To manage unprecedented increase in emergency admissions and in response to 3rd wave of Covid the Trust had to make the very difficult decision to increase the 6 bedded bays to take a 7th patient on 30/12/2021. You can also see from the Safe Staffing Fill Rates ( fig 2) that this date also correlates with the special cause reduction in safer staffing levels. Since September 2021 there is also a special cause of concern for Care Hours Per patient Day ( Fig 3.)

The number of HAPU was showing a sustained reduction below the mean between March 2021 and March 2022 , since April of this year the numbers are displaying common cause variation between expected limits of 7 and 55 with a mean of 31.(Fig 4.)

Staffing remains a significant challenge, coupled with the increase of our bed base to accommodate our emergency admissions are contributory factors affecting the increased number of patient falls. However, despite the staffing constraints and the increased beds and high bed occupancy (Fig 6) , the rate of falls per 1000 bed days causing moderate harm or above continue to be predictable between 0 and 0.3.(Fig 4.) Similarly the rate of HAPU per 100 bed days remains within the predicted range of between 0.3 and 2.1.(Fig 7)

# Pressure Ulcers

NNUH Digital Health
business intelligence

**Hospital Acquired Pressure Ulcers per 1,000 bed days**

Sep 2022

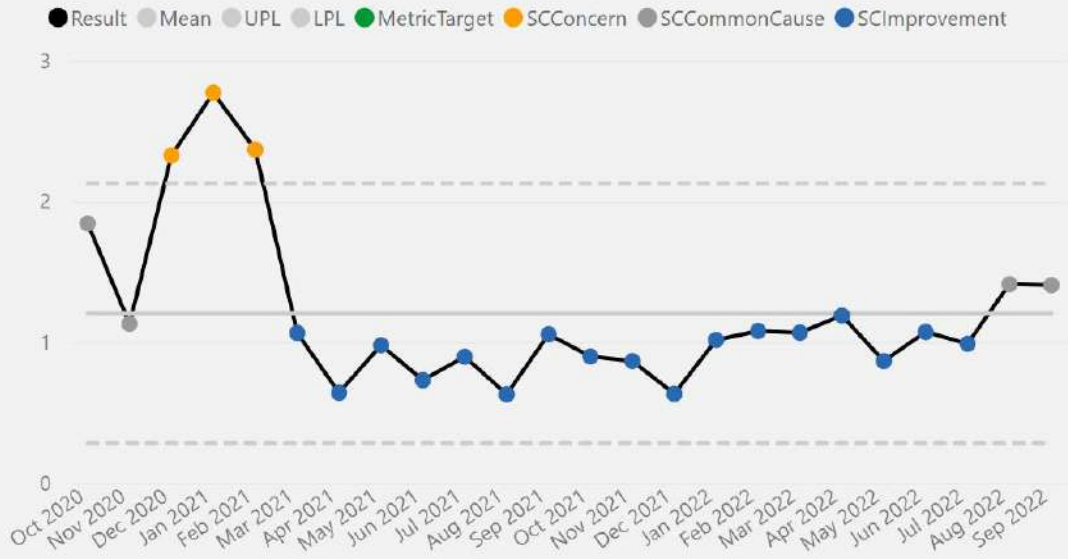
Variation | Assurance

| | |
|---|---|
| 1.4 Result | 2.1 UPL |
| N/A Target | 1.2 Mean |
| | 0.3 LPL |

## Analytical Commentary

Variation is Common Cause

**Hospital Acquired Pressure Ulcers per 1,000 bed days**




## Assurance Commentary

The rate of pressure ulcers per thousand bed days remains within predicted limits and are not showing any signals of improvement or deterioration.

## Improvement Actions

The Tissue Viability Service (TVS) assisted with new HCA training in August to support a quicker upskilling of these new staff to the wards to enable care delivery to begin to return to expected standards. Refreshed and updated mandatory E-learning for all staff has been completed along with Tissue Viability input on new staff induction days. There is to be a refreshed communication plan and education focus for embedding Purpose T across all wards

# Patient Falls

NNUH Digital Health
business intelligence

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

Sep 2022

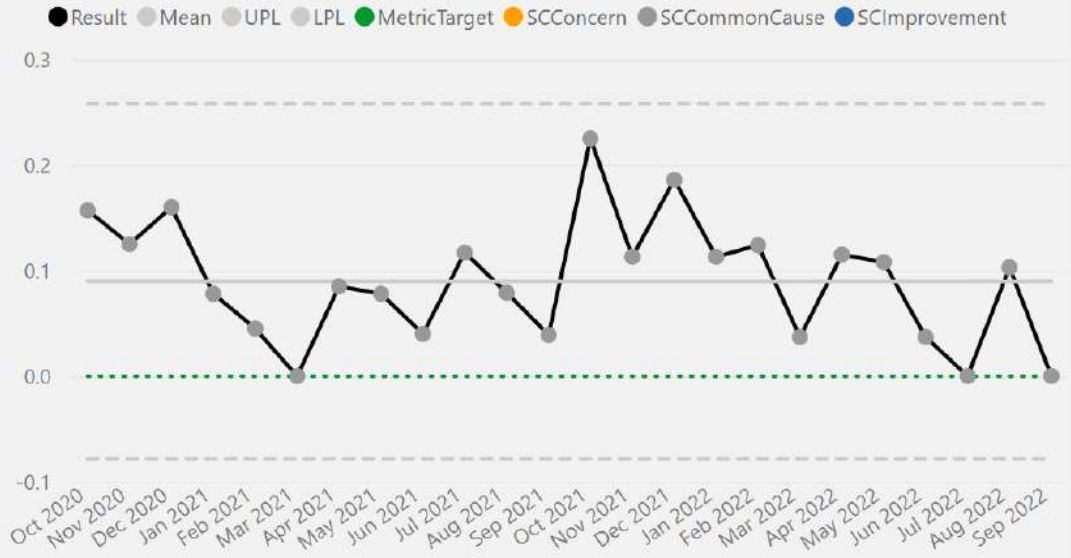
Variation | Assurance

| | |
|---|---|
| 0.0 Result | 0.3 UPL |
| 0.0 Target | 0.1 Mean |
| | -0.1 LPL |

## Analytical Commentary

Variation is Common Cause

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




## Assurance Commentary

Variation remains as common cause and showing random variation between 0 and 0.3 per thousand bed days. This is a predictable rate despite the additional ward pressures and staff challenges.

## Improvement Actions

The educational roll out of the new falls risk assessment, policy and Think Yellow initiative is embedding post training. This will now be rolled out to the multi-disciplinary and support teams such as Porters and House Keepers. The Tendable Audit now matches the new risk assessment. Ward environmental hazard walk rounds and bed audits are underway with Medstrom bed training. Falls Champion Training continues in Oct. Discussions are planned for the ED cohort area, and Critical Care for bespoke Falls Risk Assessment. Work with Serco is planned to improve distribution of Ultra Low Beds on wards.

# Patient Experience

NNUH Digital Health
business intelligence

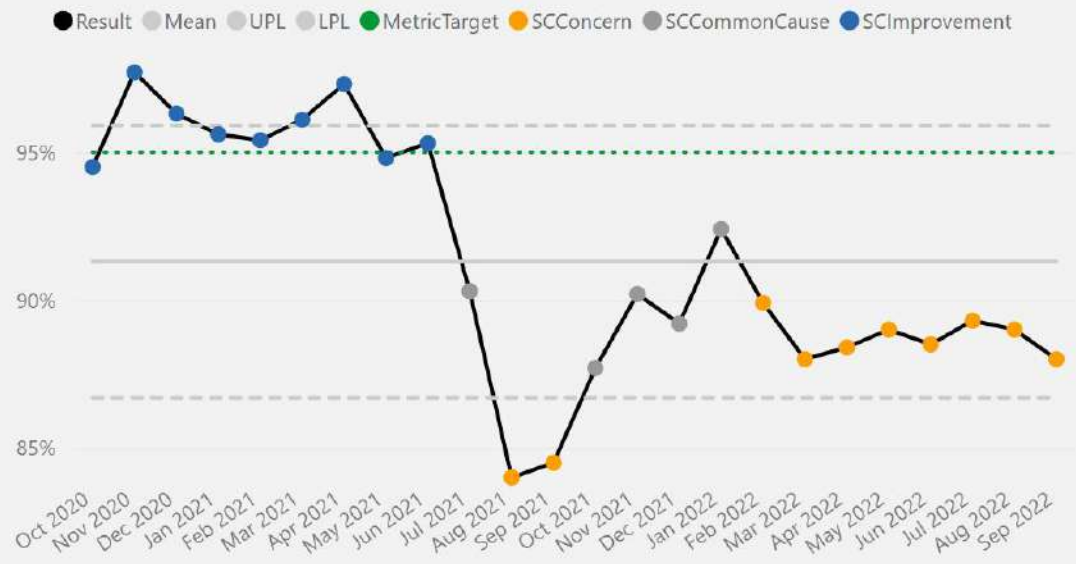
## Friends & Family Score

Sep 2022

| Variation | Assurance |
|---|---|
| L | ? |

| | |
|---|---|
| 88.00% Result | 95.90% UPL |
| 95.00% Target | 91.30% Mean |
| | 86.70% LPL |

### Friends & Family Score




### Analytical Commentary

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

### Assurance Commentary

Friends and Family Test (FFT) score has seen a slight drop to 88%, a slight drop also noticed in the number of responses received for the Trust for the month of Sep. To note the feedback shows more positive comments - top 3 positive themes emerging from FFT are staff attitude (1976), implementation of care (938) and waiting time (715) whilst top negative themes are staff attitude (260), waiting time (248) and communication (180).

### Improvement Actions

Volunteer support visiting wards to complete FFT and additional questions for 'real-time' feedback has started and plans are in place to increase resource and coverage as well as to re-start post discharge FFT calls. Posters for wards and other public areas with QR link and asking for feedback on 'quality of care' have been designed. The QR code and message will also be added to all new patient information leaflets and other communications routes

### Supplementary Metrics

| Metric Name | Date | Result | | Variation | | Assurance |
|---|---|---|---|---|---|---|
| Compliments | Sep 2022 | 408 | | Common Cause | | No Target |

# Patient Concerns

NNUH Digital Health
business intelligence

## PALS % Closed within 48 hours - Tr...

Sep 2022

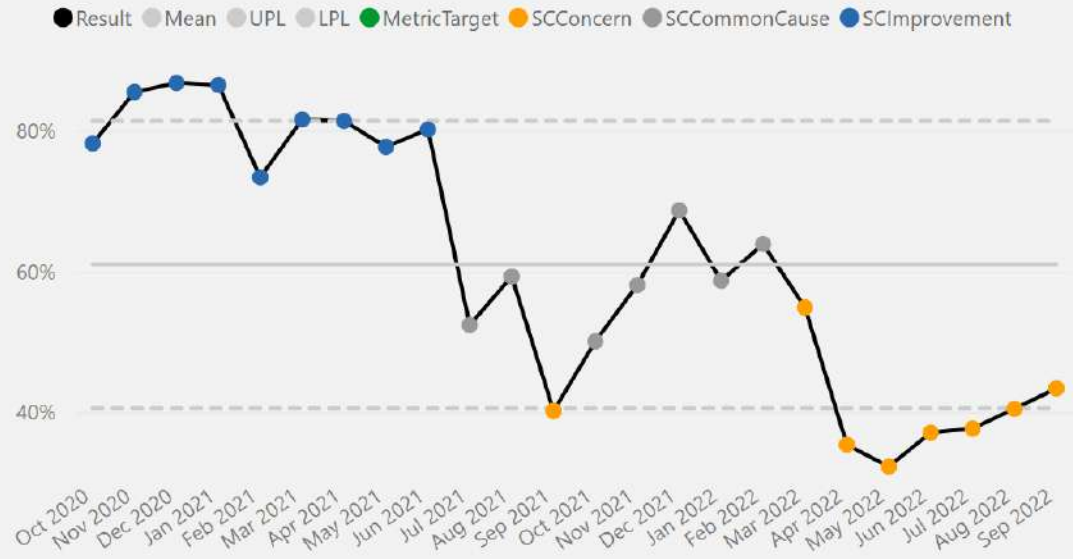
| Variation | Assurance |
|---|---|
|  | |

| | |
|---|---|
| 43.4% Result | 81.4% UPL |
| N/A Target | 61.0% Mean |
| | 40.6% LPL |

## Analytical Commentary

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

### PALS % Closed within 48 hours - Trust




## Assurance Commentary

Total PALS contacts received were 534.
Concerns= 311 Enquiry= 122 Signposting= 95 Best Wishes= 4 Suggestion= 1
Top themes remain - Communications, Appointments including delays and cancellations, Waiting Times reflecting the ongoing impact of increased activity and pressures for the trust and the system as a whole.
The data show an improvement in meeting the 48hrs KPI. The team continue to deal with higher complexity of contacts and concerns being raised as manged via PALS to facilitate early resolution.
Divisions continue to utilise feedback to inform improvements and report via Deep Dives to Patient Engagement and Experience Group.

## Improvement Actions

The team continues to be supported in improving the KPI performance, temporary admin support is currently in the recruitment stage. Ongoing support for health and wellbeing of the team continues.
Work is underway in updating Datix to align with the new triaging tool implemented within the service, matching the updated SOP and the PHSO framework. Reporting will become aligned to reflect this by the end of the year.

## Supplementary Metrics

| Metric Name | Date | Result | | Variation | | Assurance |
|---|---|---|---|---|---|---|
| PALS Contacts - Trust | Sep 2022 | 534 | | Common Cause | | No Target |

# Complaints

NNUH Digital Health
business intelligence

## Complaints (Trust)

Sep 2022

Variation | Assurance

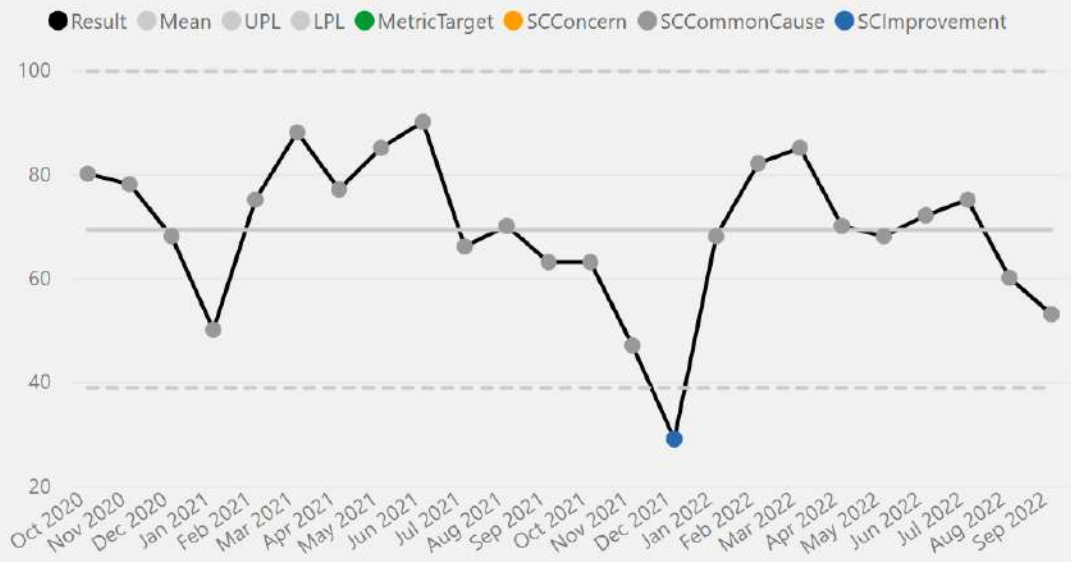
53 Result
N/A Target

100 UPL
69 Mean
39 LPL

## Analytical Commentary

Variation is Common Cause

## Complaints (Trust)




## Assurance Commentary

Total Complaints= 69
Top themes- Clinical Treatment, Access to clinical treatment and drugs and Admission discharge and transfers.
Complaints reflect the ongoing impact of increased activity and pressures for the trust and the system as a whole.
The team continue to support to divisional teams in providing timely responses and escalating where needed.
Divisions continue to utilise feedback to inform improvements and report via Deep Dives to Patient Engagement and Experience Group.

## Improvement Actions

Work is underway in updating Datix to align with the new triaging tool implemented within the service, matching the updated Standard Operating Procedure (SOP) and the Parliamentary and Health Service Ombudsman (PHSO) framework. Reporting will become aligned to reflect this by the end of the year. Temporary admin support is currently in the recruitment stage. Ongoing support for health and wellbeing of the team continues.

## Supplementary Metrics

| Metric Name | Date | Result | Variation | Assurance |
|---|---|---|---|---|
| Complaints - Acknowledgement | Sep 2022 | 98% | Common Cause | Unreliable |
| Complaints - Response Times - Trust | Sep 2022 | 90% | Common Cause | Unreliable |
| Post-investigation enquiries | Sep 2022 | 3 | Common Cause | Capable |

# Palliative Care

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business intelligence

## Palliative Care Seen Within 48 Hours

Sep 2022

Variation | Assurance

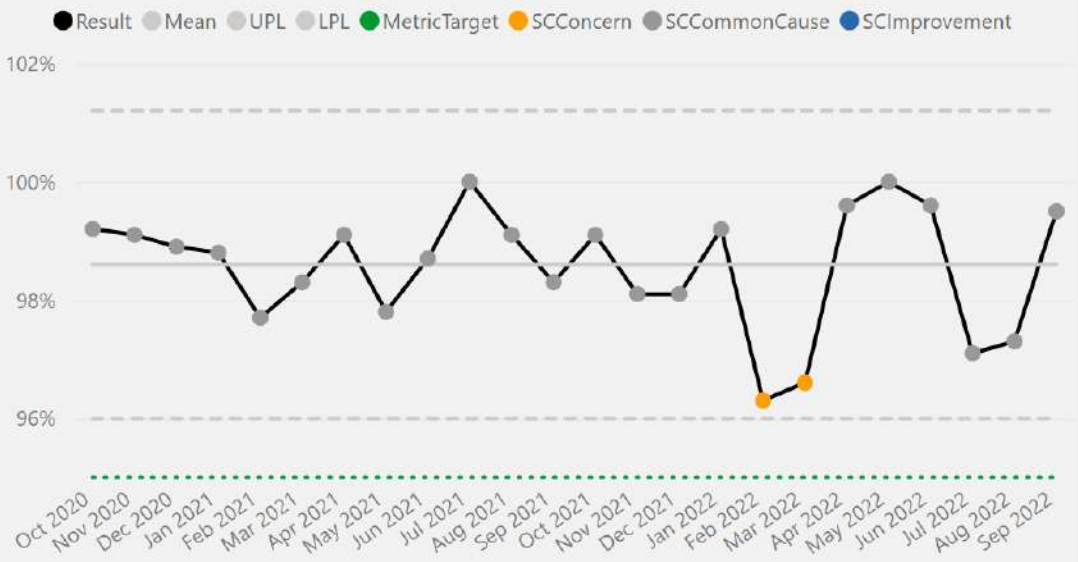
99.5% Result
95.0% Target

101.2% UPL
98.6% Mean
96.0% LPL

## Analytical Commentary

Variation is Common Cause

### Palliative Care Seen Within 48 Hours




## Assurance Commentary

The team saw 99.5 % of all new referrals within 48 hours in September.
In total there was 280 referrals:
- 18 patients were not deemed appropriate for assessment by the triaging consultant
- 19 patients died before being seen - mainly because they were referred too late
- 59 patients were discharged home
- 129 died in the hospital

6 patients were transferred to beds in Priscilla Bacon Lodge Hospice (PBL) (19 were referred to PBL in September) and one patient transferred to another hospice. 6 patients were discharged to a care home, there are 9 patients still awaiting an outcome.

## Improvement Actions

The Palliative Care Education programme continues for medical students and clinical staff.
Development of new research projects related to Palliative Care
Work to be undertaken with other specialities and care homes to provide a better service and improve the flow for this group of patients.

## Supplementary Metrics

| Metric Name | Date | Result | Variation | Assurance |
|---|---|---|---|---|
| Palliative Care Died in Trust and Seen by SPCT | Sep 2022 | 46.4% | Common Cause | No Target |
| Palliative Care IP Referrals Accepted | Sep 2022 | 204.0 | Common Cause | No Target |

# Mortality Rate

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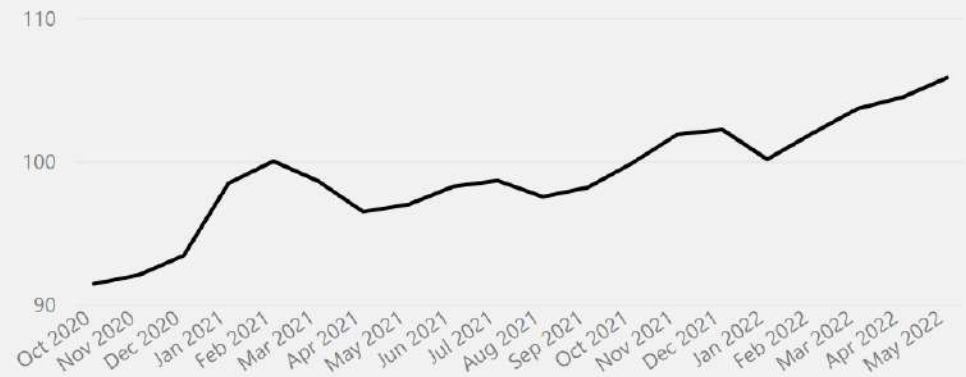
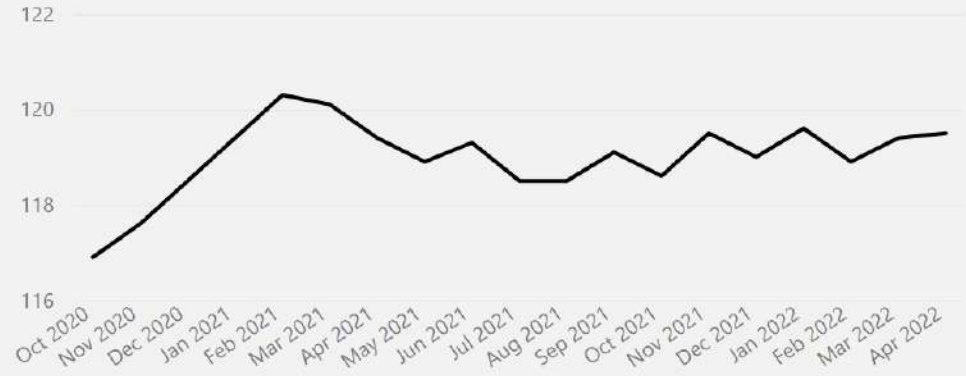
business intelligence

| MetricName | Date | Result |
|---|---|---|
| HSMR | May 2022 | 105.82 |
| SHMI | Apr 2022 | 120 |

## HSMR




## SHMI




## Assurance Commentary

The ongoing deterioration of HSMR remains of concern and is being fully investigated with details shared at Clinical Safety & Effectiveness Sub Board (CSESB) and the Quality & Safety Committee. There are, as yet, no concerns regarding patient care being identified through the Medical Examiner (ME) Service and our detailed individual case note reviews.

The ME Service reviewed 98% of inpatient deaths within NNUH in Q1 2022/23. The ME referral rate to the HM Coroner for Q4 was 21% and 16% in Q1, the national average is 21%. ME Patient Safety incident reporting for Q4 was 0.8% and 1.5% for Q1 and the national average is 1.1%. These figures indicate that NNUH is not a significant outlier.

## Improvement Actions

Working with the Palliative care team to link the two data sets to improve reporting.
PowerBI to improve the ME report to show unexpected, sudden but not unexpected, expected and individualised plan of care deaths.
Monthly SJR review group with senior clinical leaders chaired by Medical Director to continue.
To continue progressing SHMI action plan.

## Supplementary Metrics

| Metric Name | Date | Result | | Variation | | Assurance |
|---|---|---|---|---|---|---|
| Crude Mortality Rate | Aug 2022 | 5.10% | | Common Cause | | No Target |

# Safer Staffing

NNUH Digital Health
business intelligence

## Safe Staffing Fill Rates

Sep 2022

| Variation | Assurance |
|---|---|
| L | F |

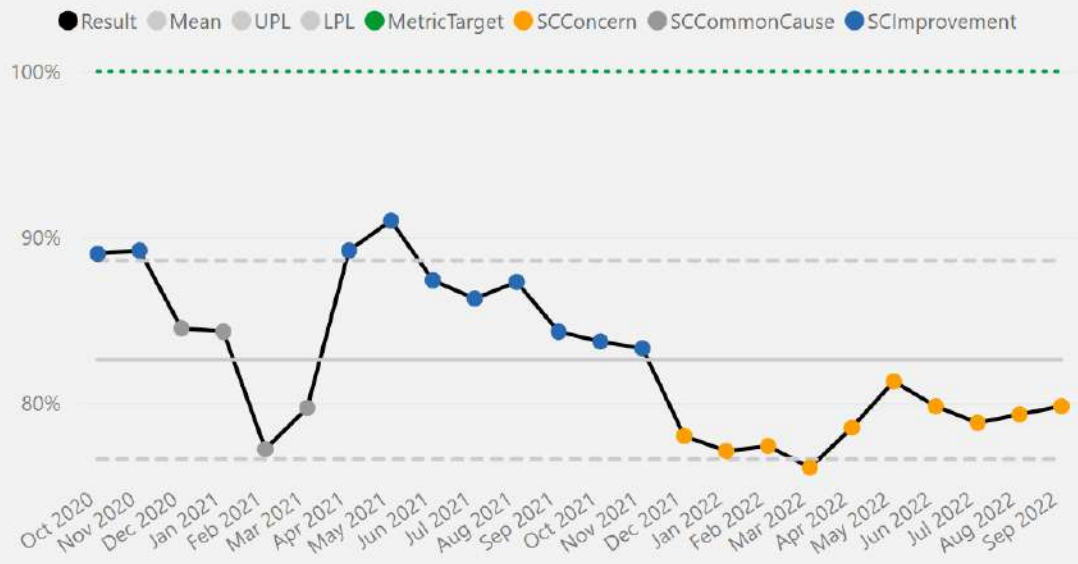
79.80% Result
100.00% Target

88.60% UPL
82.60% Mean
76.60% LPL

## Analytical Commentary

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

### Safe Staffing Fill Rates




## Assurance Commentary

The RN/M vacancy rate decreased slightly to 13.1% (n=351.5) in August, with a RN/M turnover rate of 0.8% equating to: 18.3 leavers & 22.63 new starters. Trust wide Support Worker vacancies increased by 1.7% (n=22) to 21% (n=288.6) in August; with 19 (WTE) reported leavers, (n=8.6 in Surgery, n=8.7 in Medicine) & 50.44 (WTE) new starters. Trust-wide, there were 14 inpatient areas with an RN/M vacancy rate above 20%, of which 8 are in Medicine, 4 in Surgery and 2 in Woman and Children's. The HCSW average Trust-wide fill rates have increased from 72.6% in July to 73.9% in August. The HCSW fill rate fell below 75% in 14 areas (x12 Medicine and x2 in Surgery). This is an improved position from March in which 23 areas had fill rates below 75%. Trust wide CHPPD reduced by 0.1 to 6.4 with an average of 6.9 over the past 12 months. Red flags raised increased slightly in August to 2,104 with 80% remaining open. 391 were resolved and 59 raised in error.

## Improvement Actions

The Safer Staffing policy has been circulated and will go to ratification at WESB asap. PD&E have increased business as usual to 40 HCSW inductions per month. 21 international nurses arrived in August and from the 100 FPQ ESR, 84 pre reg will join in September. Part two of the nursing establishment data collection begins in November following the first data collection in May. Check and Confirm for E-Rostering has now been handed over to the divisional leads.

## Supplementary Metrics

| Metric Name | Date | Result | | Variation | | Assurance |
|---|---|---|---|---|---|---|

# Infection Prevention & Control

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business intelligence

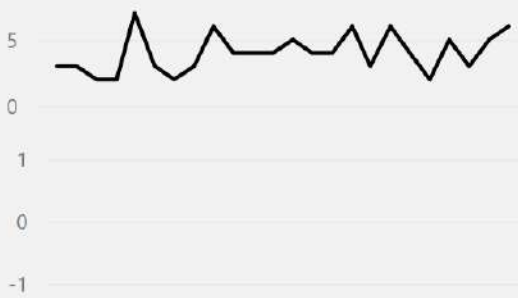
| MetricName | Date | Result | Target | Mean |
|---|---|---|---|---|
| C. difficile Cases Total | Sep 2022 | 6 | 83 | 7 |
| CPE positive screens | Sep 2022 | 1 | N/A | 1 |
| E. Coli trust apportioned | Sep 2022 | 6 | 96 | 4 |
| HOHA Trajectory C. Difficile Cases | Sep 2022 | 0 | 57 | 1 |
| Hospital Acquired MRSA bacteraemia | Sep 2022 | 0 | 0 | 0 |
| Klebsiella trust apportioned | Sep 2022 | 1 | 48 | 2 |
| MSSA HAI | Sep 2022 | 2 | N/A | 3 |
| Pseudomonas trust apportioned | Sep 2022 | 0 | 26 | 1 |

## Assurance Commentary

The 6 cases of C. difficile in September were deemed non-trajectory after Post Infection Review (PIR). At the time of reporting there were a total of 9 cases deemed trajectory following PIR with lapses of care, of 50 cases (19 COHA and 31 HOHA). 4 cases are pending review.
Gram negative bacteraemia (E. coli, klebsiella and pseudomonas): Surveillance undertaken on all Healthcare Onset Healthcare Associated (sample taken >2 days after admission) and Community Onset Healthcare Associated (sample taken < 2 days after admission, patient has been an inpatient in the last 4 weeks). To date 53 cases of E. coli towards a threshold of 96, 14 cases klebsiella towards a threshold of 48 and 8 cases of pseudomonas towards a threshold of 26.

Hospital Acquired MRSA bacteraemia


E. Coli trust apportioned




C. difficile Cases Total


MSSA HAI


Klebsiella trust apportioned


CPE positive screens


Pseudomonas trust apportioned


## Improvement Actions

Supportive measures was commenced on NICU on 23rd September, following a Period of Increased Incidence of E. coli ESBL. The 2 samples were sent for typing and this indicated they were distinct and unlikely to be related. There have been no further cases.
The IP&C team support the ward teams managing COVID outbreaks and undertake the mandatory reporting. At the time of this report there were 13 remaining areas with COVID outbreaks: Loddon, Langley, Mattishall, Elsing, Docking, Dunston, Gunthorpe, Kilverstone, Hethel, Brundall, Edgefield, Gately and Kimberley.
Following NHSE guidance, on 01/09/22 COVID-19 testing was reduced to symptomatic cases, asymptomatic screening for the immunocompromised, patients discharged to care homes and hospices and outbreak testing.

# COVID-19 Report - Timeseries

To date record of swabs taken, confirmed cases, discharges and deaths

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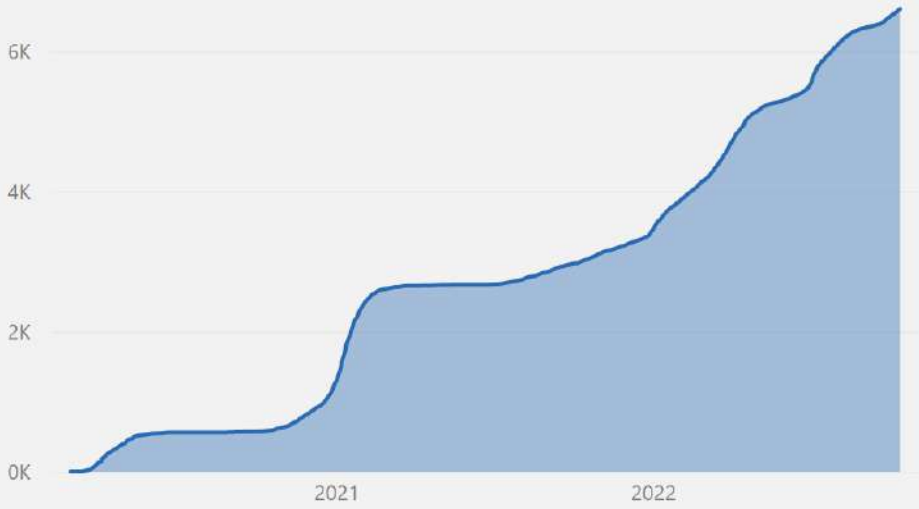
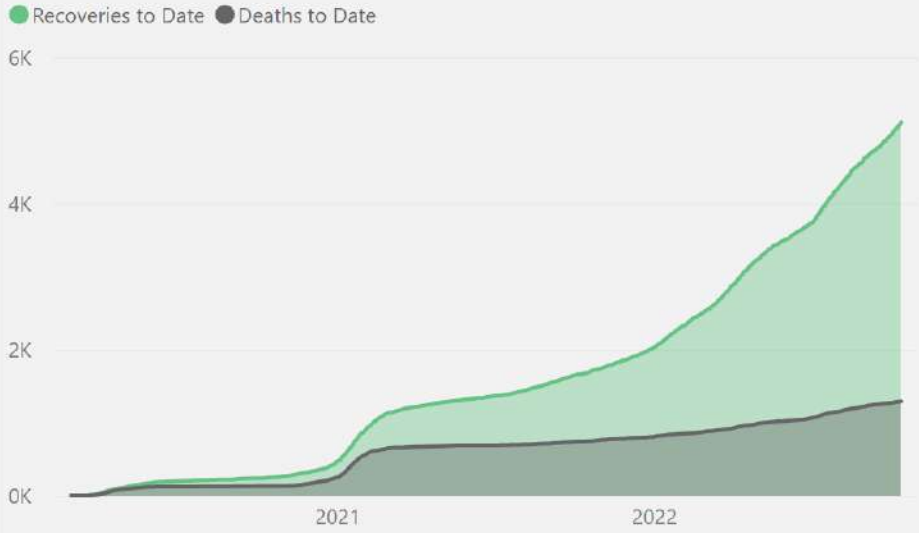
| Cumulative | Total Swabs Taken | Patients Swabbed | Confirmed Cases | Recoveries | Deaths |
|---|---|---|---|---|---|
| 01/03/20 - 13/10/22 | 255,140 | 83,793 | 6,601 | 5,113 | 1,291 |

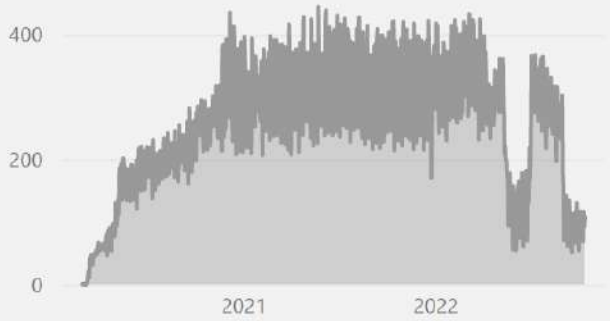
## Cumulative Confirmed at NNUH



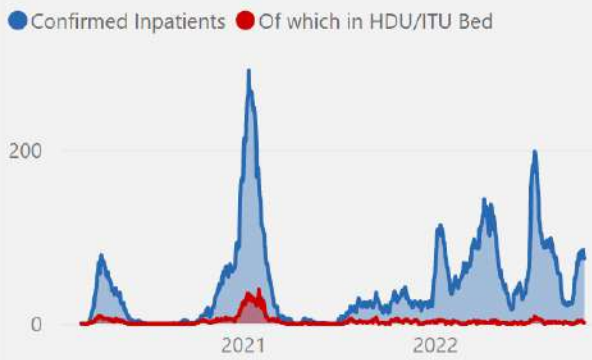

## Cumulative Recoveries & Deaths



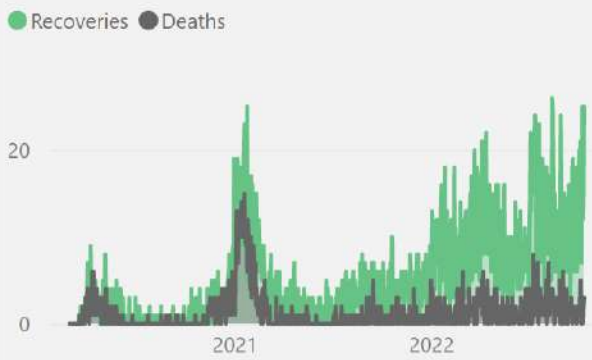

## Patients Swabbed per day




## Confirmed Inpatient per day (<=14 days)




## Recoveries & Deaths per day



# NNUH Staff COVID-19 Testing

Latest COVID test results from ICE for NNUH Staff Members, where possible staff mapped to data provided by HR.

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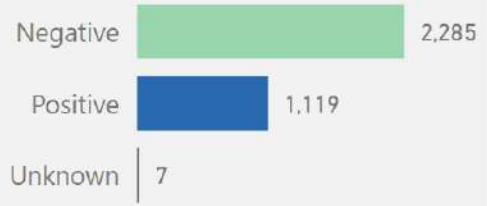
business intelligence

| NNUH Staff Tested | Results Recieved | COVID-19 Confirmed |
|---|---|---|
| 3,411 | 3,411 | 1,119 |

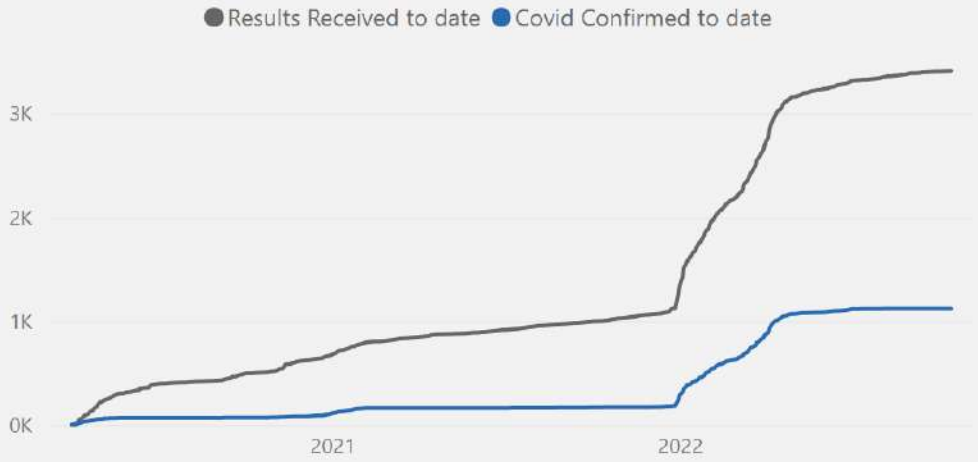
Median Hrs Test to Result: 21.5

Unmapped Staff *: 1,119

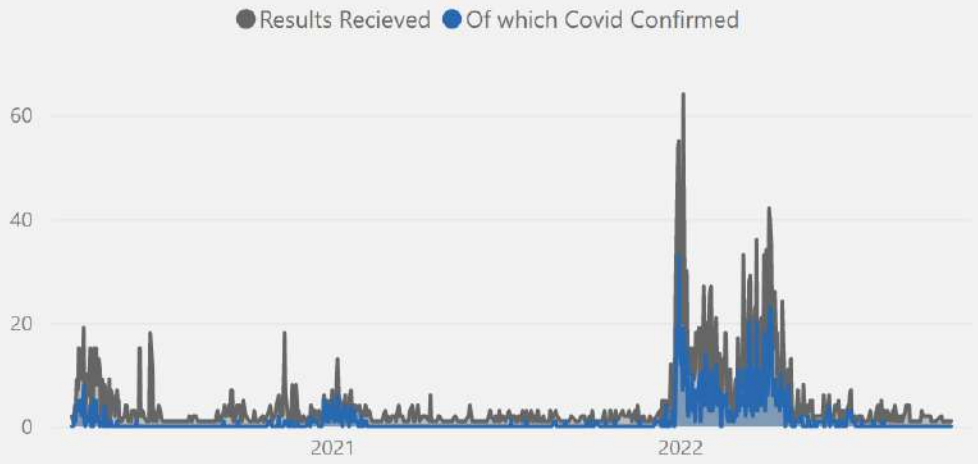
## COVID-19 Status



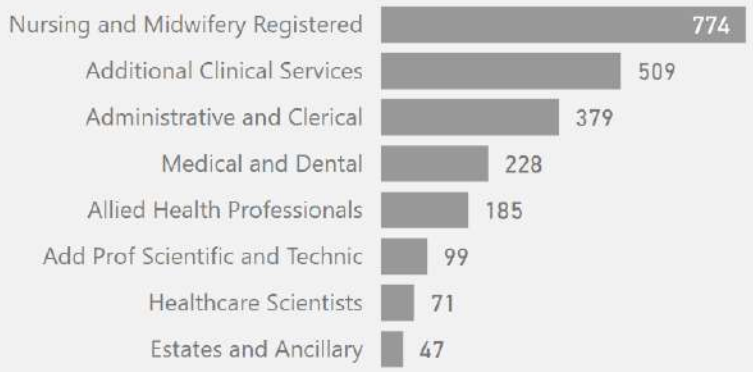

## Cumulative NNUH Staff Testing to Date



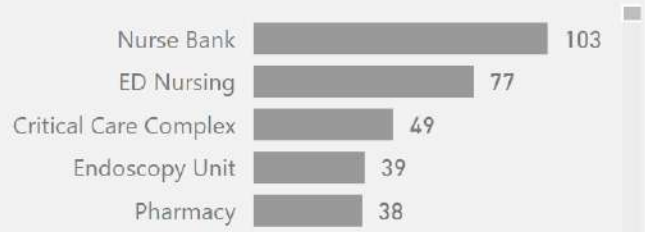

## NNUH Staff Results by date of Result




## Results Received by Staff Group




## Results Received by Organisation (10+ results)




* Of COVID-19 tests recorded on ICE as NNUH staff, a number of records were unable to be mapped back to HR data.

# Maternity: Mothers

NNUH Digital Health
business intelligence

## Mothers Delivered

Sep 2022

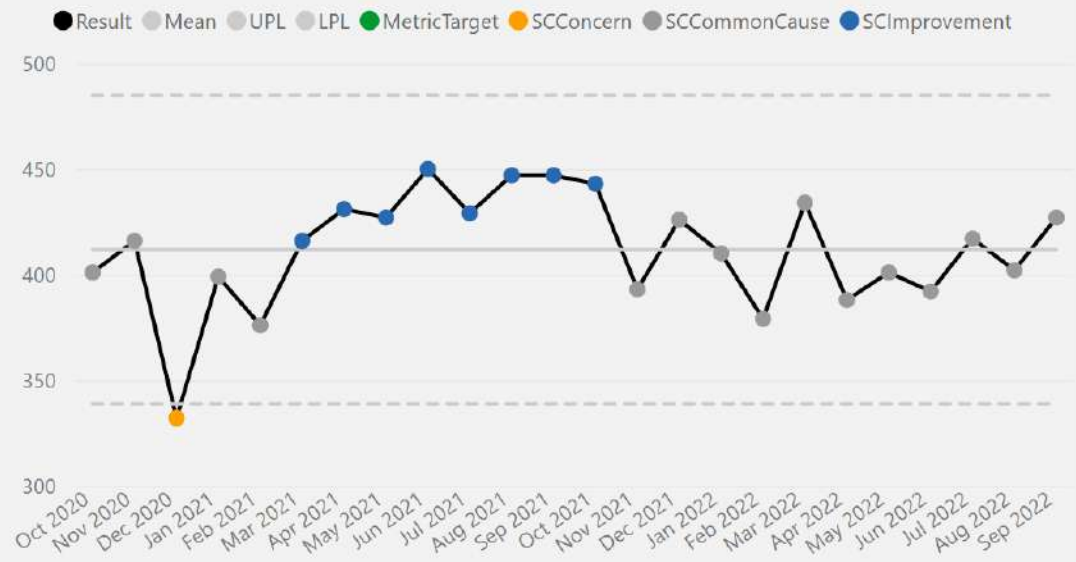
Variation | Assurance

427 Result
N/A Target
485 UPL
412 Mean
339 LPL

## Analytical Commentary

Variation is Common Cause

## Mothers Delivered




## Assurance Commentary

Full service / establishment review this week identifying staffing challenges across the department. Senior leadership meeting supportive of Divisional Midwifery Director action plan for resolution. Caesarean Section and Induction of Labour lists being monitored and reviewed daily to ensure optimal care provided with minimal delay.

## Improvement Actions

Continue to share learning with the teams.
Rolling recruitment and trajectory in place. Continual monitoring of the clinical appropriateness of Caesareans via weekly Cardiotocography (CTG) meetings chaired by the Intrapartum Lead Consultant. Still awaiting the outcome of a funding bid for a fetal monitoring lead clinician.

## Supplementary Metrics

| Metric Name | Date | Result | | Variation | | Assurance |
|---|---|---|---|---|---|---|
| 1:1 Care in Labour | Sep 2022 | 97.8% | | Common Cause | | No Target |
| 3rd & 4th Degree Tears | Sep 2022 | 1.2% | | Common Cause | | Unreliable |
| Births Before Arrival | Sep 2022 | 1 | | Common Cause | | No Target |
| Post Partum Haemorrhage ≥1500mls | Sep 2022 | 3.3% | | Common Cause | | No Target |

Mothers Delivered

427

Babies Delivered

437

# Maternity: Babies

NNUH Digital Health
business intelligence

## Unplanned NICU ≥37 week Admissions (E3)

Sep 2022

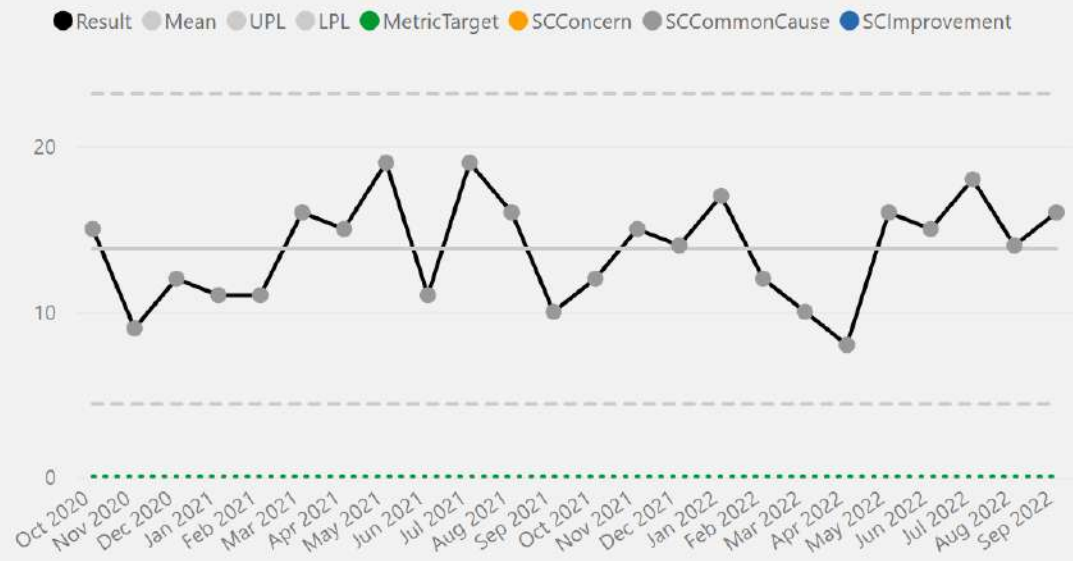
Variation

Assurance

16 Result
0 Target

23 UPL
14 Mean
4 LPL

### Unplanned NICU ≥37 week Admissions (E3)




## Analytical Commentary

Variation is Common Cause

## Assurance Commentary

Work continues across service to ensure optimisation of neonatal wellbeing at point of delivery.

## Improvement Actions

A Cross divisional working group has been set up to evaluate preterm deliveries transferred to NICU.
Safer practice notices circulated.
NICU are leading on a project Maintaining Normothermia in Neonates.

## Supplementary Metrics

| Metric Name | Date | Result | | Variation | | Assurance |
|---|---|---|---|---|---|---|
| Adjusted Still Births | Sep 2022 | 0 | | Not Applicable | | No Target |
| Apgar score <7 @5, ≥37 weeks | Sep 2022 | 5 | | Common Cause | | No Target |
| Early Neonatal Death | Sep 2022 | 0 | | Not Applicable | | No Target |
| Mothers Transferred Out of Unit | Aug 2022 | 1 | | Improvement (Low) | | No Target |

# Saving Babies Lives

NNUH Digital Health
business intelligence

| Topic | Metric Name | Date | Result | | Variation | | Assurance |
|---|---|---|---|---|---|---|---|
| Smoking Awareness | Smoking Status at Delivery | Sep 2022 | 10.3% | | Common Cause | | Unreliable |
| Fetal Growth Restriction | Less Than 3rd centile born > 37+6 weeks | Sep 2022 | 3% | | Common Cause | | Not capable |
| Fetal Growth Restriction | SGA detected Antenatally | Sep 2022 | 131% | | Improvement (High) | | No Target |
| Reducing Preterm Birth | Singleton Births Preterm | Sep 2022 | 5% | | Common Cause | | Unreliable |
| Reducing Preterm Birth | Singleton live births < 34 wks (AN corticosteroids within 7 days PN) | Sep 2022 | 67% | | Common Cause | | Unreliable |
| Effective Fetal Monitoring | CTG Training and Human factors situational awareness compliance | Sep 2022 | 76% | | Concern (Low) | | Not capable |

## Assurance Commentary

Digital Health (DH) and DH midwife reviewing CO2 monitoring recording information and data collection, identified some inaccuracy in data pull from E3. These issues and the systems are being reviewed. Manual tracking identified that the service is on track for CO2 monitoring for booking for 36 weeks women.

## Improvement Actions

To increase compliance with carbon monoxide monitoring we created a set of actions, which have now been completed:
Recruited inpatient and outpatient champions to work closely with the LMNS Public Health Midwife in driving up compliance at booking and 36 weeks.
Established regular meetings with champions, Public Health Midwife and Deputy Director Midwifery.
Shared communications with all staff explaining the importance of CO monitoring compliance.
Trained all MCA's in performing CO monitoring.
The maternity department are developing a training compliance policy for all statutory and mandatory training. There will be stricter rules around staff who DNA or are not up to date with training compliance.
New fetal monitoring lead midwife and Practice Development Midwives have an action plan to improve Growth Assessment Protocol (GAP) training compliance.
Reviewing data feed for <30week deliveries by Digital Maternity team, to confirm correct details are being pulled across.

# Adult Safeguarding

NNUH Digital Health
business intelligence

Safeguarding Adults

Sep 2022

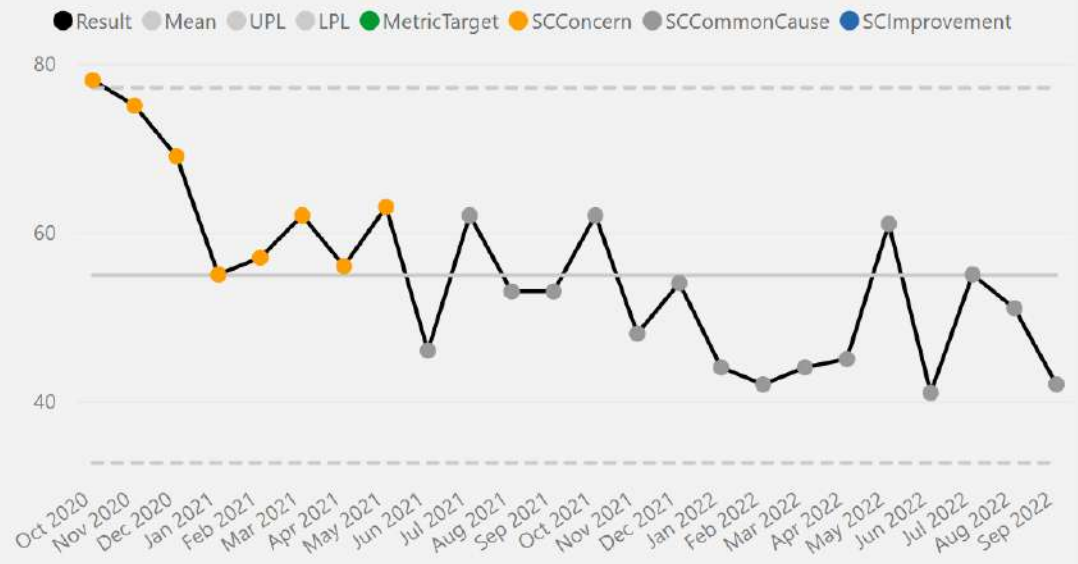
| Variation | Assurance |
|---|---|

42 Result
N/A Target
77 UPL
55 Mean
33 LPL

## Analytical Commentary

Variation is Common Cause

## Safeguarding Adults




## Assurance Commentary

The Safeguarding Team and Hospital Social Work Team are in the process of developing relationships to work collaboratively to safeguard vulnerable adults. We continue to work with the Local Authority to streamline processes for raising section 42s.

## Improvement Actions

The Norfolk Safeguarding Adults Board (NSAB) is yet to publish the new threshold guidance and initially NHS providers will trial it. If successful, it will be rolled out to other providers. The Integrated Care Board (ICB) has reinstated the Safeguarding Adults Health Action Forum (SAHAF) which provides peer support for leads, and NNUH will participate in this. The first meeting will be held on 20th October.

# Children & Midwifery Safeguarding

NNUH Digital Health
business intelligence

## Safeguarding Children and Midwife...

Sep 2022

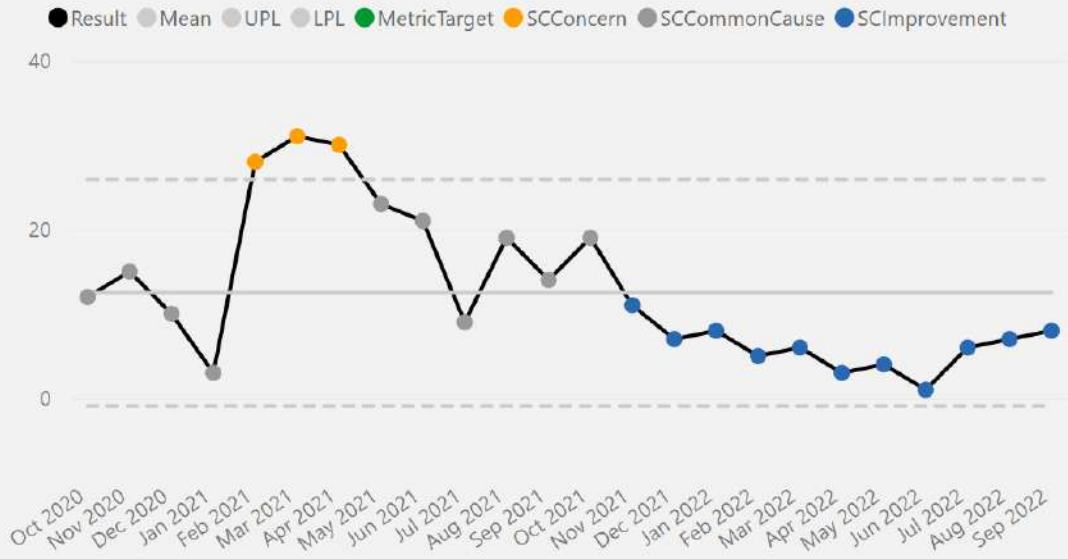
| Variation | Assurance |
|---|---|
|  | |

| | |
|---|---|
| 8 Result | 26 UPL |
| N/A Target | 13 Mean |
| | -1 LPL |

## Analytical Commentary

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

## Safeguarding Children and Midwifery




## Assurance Commentary

The supervision model that was launched by the Named Midwife for Safeguarding has been positively received by staff. So far 77 midwives have received this since August this year. Apart from providing support and building resilience to staff, it will reduce the risks to babies while identifying their needs. As a Think Family Approach, it will also identify needs in older children and their families. The Safeguarding Team continue to work collaboratively within a multi-agency context to ensure we are up to date with processes and reduce the risks to children and young people.

## Improvement Actions

There is ongoing collaboration within the Complex Health Hub (CHH) to promote a trauma informed approach to working throughout the organisation. Discussions are ongoing to develop the service specifications and pathways of care for Children's Mental Health. Staff are being supported through supervision to manage complex cases. Moving the CHH to one office has been beneficial in promoting more joined up working.

## Supplementary Metrics

| Metric Name | Date | Result | | Variation | | Assurance |
|---|---|---|---|---|---|---|
| Safeguarding Children | Sep 2022 | 6 | | Improvement (Low) | | No Target |
| Safeguarding Midwifery | Sep 2022 | 2 | | Improvement (Low) | | No Target |

# Audit Overview

Monthly scores by audit, question and overtime.

**Sep-2022**

NHS
Norfolk and Norwich University Hospitals

## Filters

*Select 'All' on division and area for trust view*

Division: All

Area: All

Audit: Multiple selections

Question: All

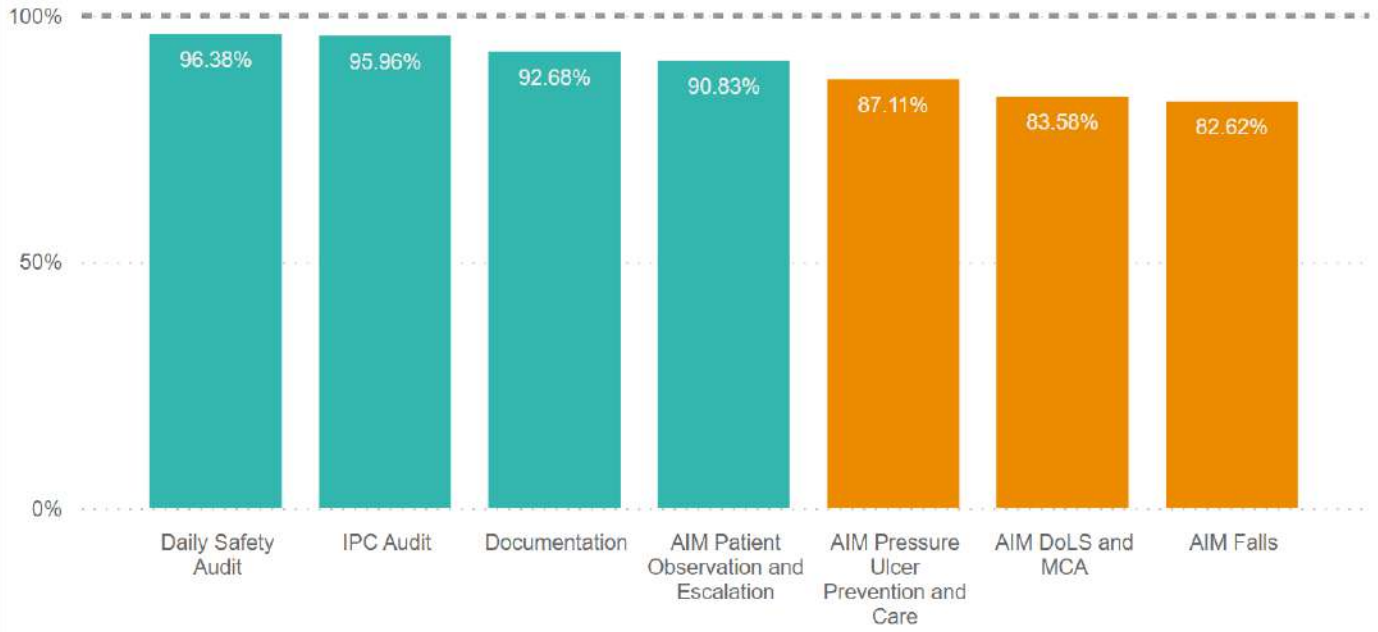
Month: Sep-2022

**7**
Total Audit Types

**105**
Total Areas

**240**
Total Questions

### Score by Audit Type




*Filter by Audit to return overtime chart. Switch date period view using buttons.*

Daily | Weekly | **Monthly**

### Score by Date Period

Score %

| Question | Score |
|---|---|
| 3. Is there documented evidence that the patient had a fall during this admission? | 25.0% |
| Has the cardiac arrest block been checked and the drugs in date? | 28.6% |
| For all patients with a diagnosis of Dementia is there a complete 'This is me booklet'? | 51.2% |
| For all patients with a diagnosis of Dementia is the completed 'This is me booklet' in view of patient's bed? | 58.7% |
| 2. If required, has Part 2 of the Multifactorial Falls Risk Assessment been completed in full and is dated and signed by the assessing staff member. | 59.0% |
| Is the fridge clean, food labelled and in date? | 61.9% |
| 3c. Has the Multi-Disciplinary Team Standard Assessment and Falls Prevention Actions for all Adult Inpatients been reassessed and updated following the fall? | 64.5% |
| 6. Is there evidence that the Sepsis 6 Treatment Tool has been completed as appropriate? | 64.9% |
| Are there any drugs prepared over 12 hours that haven't vee used? | 65.0% |
| 4c. Has the patient's lying and standing blood pressure been recorded? | 67.6% |
| 2c. Is there documented evidence that the patient had a referral to a Physiotherapist and/or Occupational Therapist for assessment? | 69.3% |
| 2h. Is there documented evidence that the patient has been asked about their | 71.2% |

# Area Overview by Audit

Monthly area overview for audit compliance. An audit must be selected on the filter on this page.

**Sep-2022**

NHS
Norfolk and Norwich University Hospitals

## Filters

*Select 'All' on division and area for trust view*

Division: All

Area: All

Audit: AIM DoLS and MCA

Month: Sep-2022

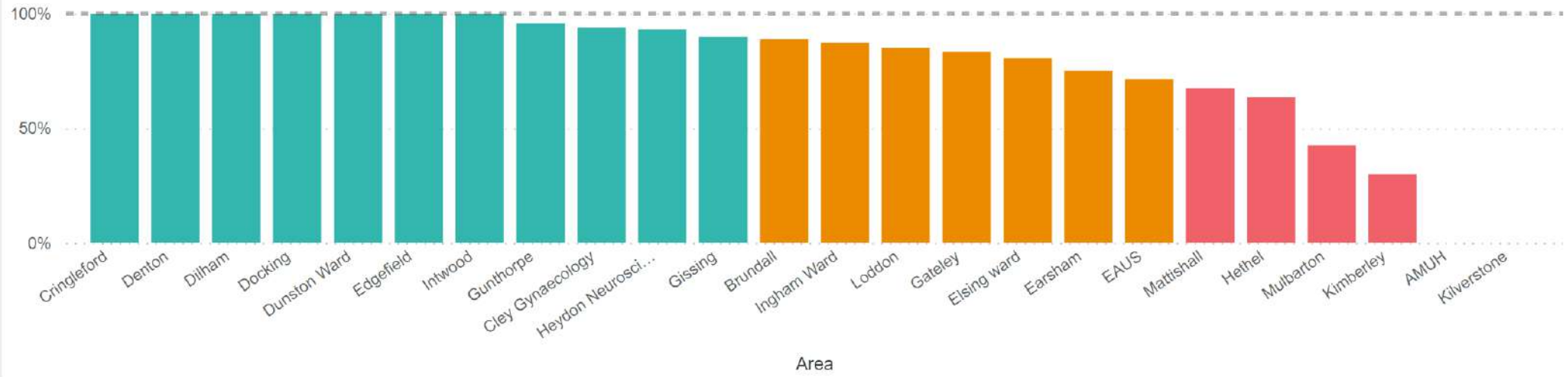
## Summary

**1** of **28** areas have completed all **AIM DoLS and MCA** audits in **Sep-2022**. These audits are to be completed **Monthly**.

The score for **AIM DoLS and MCA** is **83.58%.**

## Audit selected: **AIM DoLS and MCA**

Score by Area




Audits Completed

*No. for month is based on when that area is open*

| Area | No. For Month | No. Completed | % Completed | No. Missing |
|---|---|---|---|---|
| Heydon Neuroscience | 20 | 20 | 100% | 0 |
| Ingham Ward | 20 | 17 | 85% | -3 |
| Denton | 20 | 15 | 75% | -5 |
| Elsing ward | 20 | 15 | 75% | -5 |
| Gateley | 20 | 12 | 60% | -8 |
| Gissing | 20 | 10 | 50% | -10 |
| Loddon | 20 | 10 | 50% | -10 |
| Mattishall | 20 | 10 | 50% | -10 |
| Cley Gynaecology | 20 | 8 | 40% | -12 |
| Hethel | 20 | 8 | 40% | -12 |

5 Lowest Scoring Questions

| Question | Score |
|---|---|
| Is there documented evidence of regular capacity assessments within the Patient's Care Record by medical staff? | 75.5% |
| Is there documented evidence of regular capacity assessments within the Patient's Care Record by nursing staff? | 81.3% |
| Has a Mental Capacity Assessment for the decision to be accommodated at NNUH been completed by nursing staff? | 81.9% |
| Has the mental capacity assessment on RESPECT been completed? | 86.7% |
| Is there a copy of the DOLS application in the patient care record? | 97.8% |

# Area Overview by Audit

Monthly area overview for audit compliance. An audit must be selected on the filter on this page.

**Sep-2022**

NHS
Norfolk and Norwich University Hospitals

## Filters

*Select 'All' on division and area for trust view*

Division: All

Area: All

Audit: AIM Falls

Month: Sep-2022

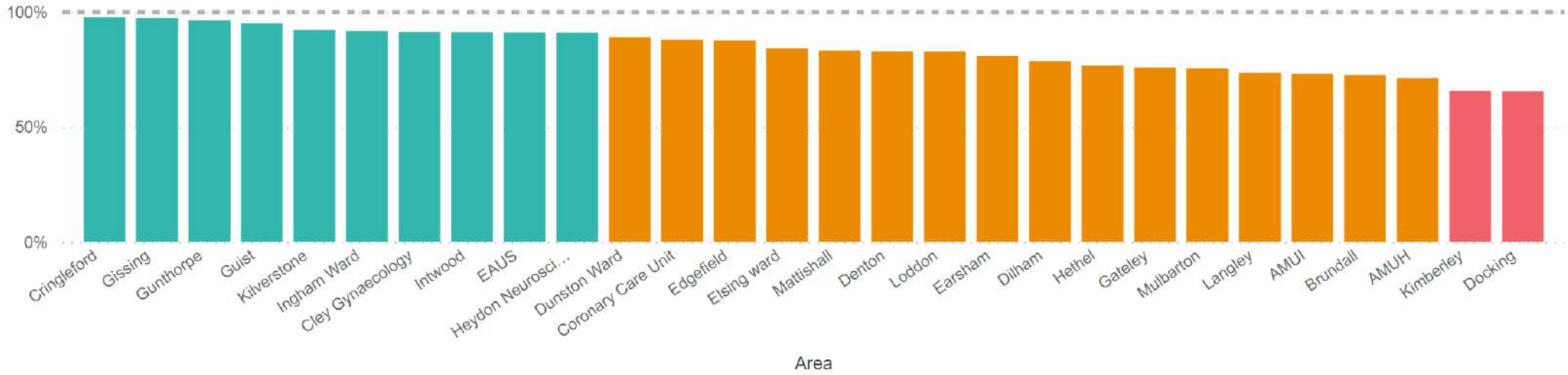
## Summary

**19** of **28** areas have completed all **AIM Falls** audits in **Sep-2022**. These audits are to be completed **Monthly**.

The score for **AIM Falls** is **82.62%.**

## Audit selected: **AIM Falls**

Score by Area




Audits Completed

*No. for month is based on when that area is open*

| Area | No. For Month | No. Completed | % Completed | No. Missing |
|---|---|---|---|---|
| Brundall | 20 | 36 | 180% | 0 |
| Elsing ward | 20 | 32 | 160% | 0 |
| Hethel | 20 | 31 | 155% | 0 |
| Cringleford | 20 | 29 | 145% | 0 |
| Docking | 20 | 29 | 145% | 0 |
| Heydon Neuroscience | 20 | 29 | 145% | 0 |
| AMUH | 20 | 28 | 140% | 0 |
| Dilham | 20 | 28 | 140% | 0 |
| Gateley | 20 | 27 | 135% | 0 |
| Ingham Ward | 20 | 27 | 135% | 0 |

5 Lowest Scoring Questions

| Question | Score |
|---|---|
| 3. Is there documented evidence that the patient had a fall during this admission? | 25.0% |
| 2. If required, has Part 2 of the Multifactorial Falls Risk Assessment been completed in full and is dated and signed by the assessing staff member. | 59.0% |
| 3c. Has the Multi-Disciplinary Team Standard Assessment and Falls Prevention Actions for all Adult Inpatients been reassessed and updated following the fall? | 64.5% |
| 4c. Has the patient's lying and standing blood pressure been recorded? | 67.6% |
| 2c. Is there documented evidence that the patient had a referral to a Physiotherapist and/or Occupational Therapist for assessment? | 69.3% |

# Area Overview by Audit

Monthly area overview for audit compliance. An audit must be selected on the filter on this page.

**Sep-2022**

NHS
Norfolk and Norwich University Hospitals

## Filters

*Select 'All' on division and area for trust view*

Division: All

Area: All

Audit: AIM Nutrition and Hydr…

Month: Sep-2022

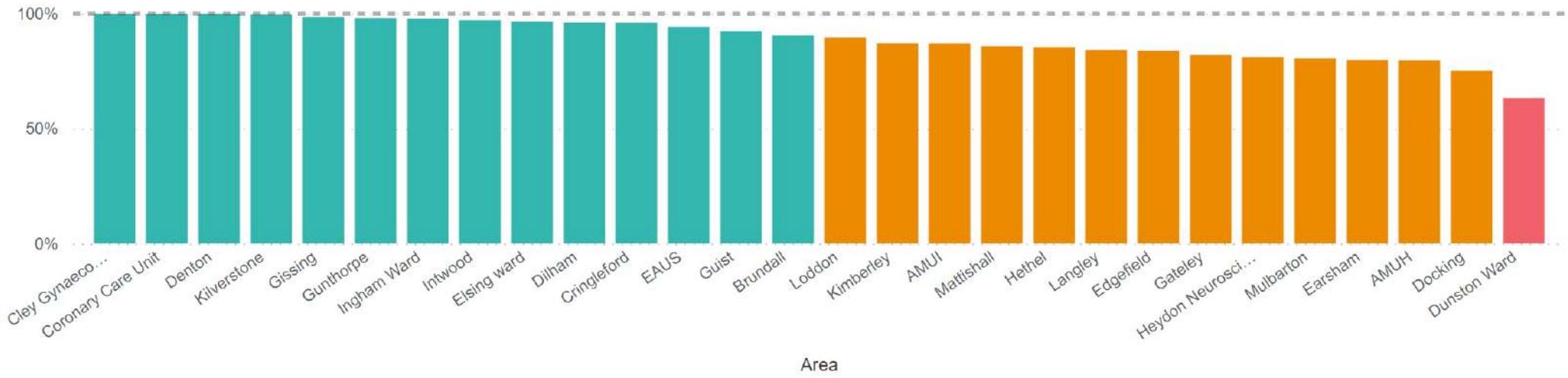
## Summary

**15** of **28** areas have completed all **AIM Nutrition and Hydration** audits in **Sep-2022**. These audits are to be completed **Monthly**.

The score for **AIM Nutrition and Hydration** is **90.55%.**

## Audit selected: **AIM Nutrition and Hydration**

Score by Area




Audits Completed

*No. for month is based on when that area is open*

| Area | No. For Month | No. Completed | % Completed | No. Missing |
|---|---|---|---|---|
| Brundall | 20 | 35 | 175% | 0 |
| Kilverstone | 20 | 29 | 145% | 0 |
| Dilham | 20 | 27 | 135% | 0 |
| Ingham Ward | 20 | 27 | 135% | 0 |
| Cringleford | 20 | 26 | 130% | 0 |
| AMUI | 20 | 24 | 120% | 0 |
| Loddon | 20 | 24 | 120% | 0 |
| AMUH | 20 | 23 | 115% | 0 |
| Coronary Care Unit | 20 | 23 | 115% | 0 |
| Mulbarton | 20 | 22 | 110% | 0 |

5 Lowest Scoring Questions

| Question | Score |
|---|---|
| 2.1. If unable to calculate the patient's BMI using current height and weight, has a MUAC been measured? | 53.3% |
| 4.1. Has a food record chart been commenced and fully completed? | 57.6% |
| 4.2. Is there documented evidence that shakes/soups have been offered? | 60.0% |
| 5.2. Is there documented evidence that shakes/soups have been offered? | 62.0% |
| 5.5.1. Has a dietician reviewed the patient as per the standards in the Dietetic prioritisation guideline? | 63.4% |

# Area Overview by Audit

Monthly area overview for audit compliance. An audit must be selected on the filter on this page.

**Sep-2022**

NHS
Norfolk and Norwich University Hospitals

## Filters

*Select 'All' on division and area for trust view*

Division: All

Area: All

Audit: AIM Patient Observatio…

Month: Sep-2022

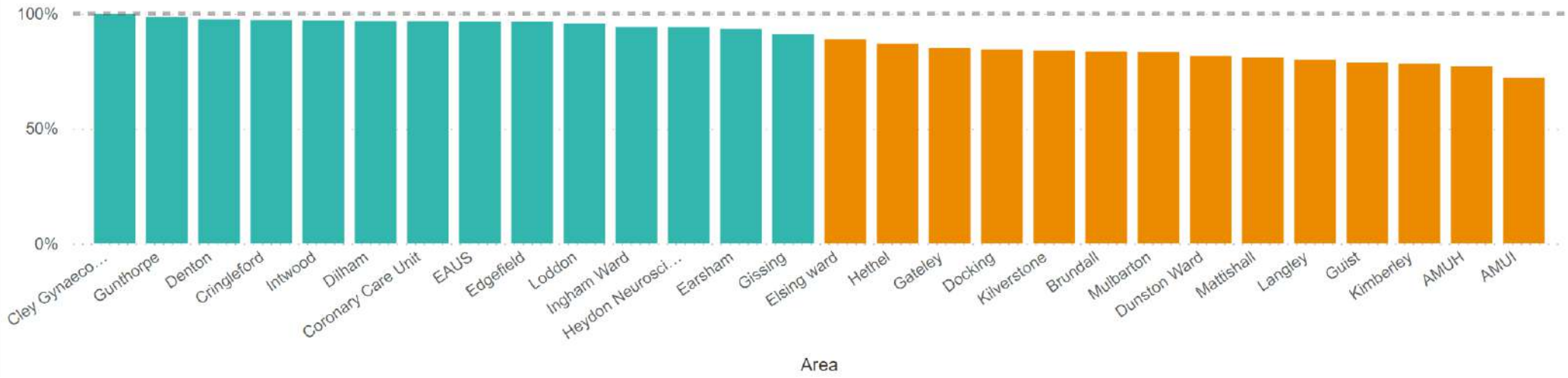
## Summary

**10** of **28** areas have completed all **AIM Patient Observation and Escalation** audits in **Sep-2022**. These audits are to be completed **Monthly**.

The score for **AIM Patient Observation and Escalation** is **90.83%.**

## Audit selected: **AIM Patient Observation and Escalation**

Score by Area




Audits Completed

*No. for month is based on when that area is open*

| Area | No. For Month | No. Completed | % Completed | No. Missing |
|---|---|---|---|---|
| Ingham Ward | 20 | 29 | 145% | 0 |
| Heydon Neuroscience | 20 | 28 | 140% | 0 |
| Cringleford | 20 | 27 | 135% | 0 |
| Dilham | 20 | 26 | 130% | 0 |
| Intwood | 20 | 21 | 105% | 0 |
| Mattishall | 20 | 21 | 105% | 0 |
| Denton | 20 | 20 | 100% | 0 |
| EAUS | 20 | 20 | 100% | 0 |
| Gissing | 20 | 20 | 100% | 0 |
| Hethel | 20 | 20 | 100% | 0 |

5 Lowest Scoring Questions

| Question | Score |
|---|---|
| 6. Is there evidence that the Sepsis 6 Treatment Tool has been completed as appropriate? | 64.9% |
| 7. Has the patients pain score been documented on WebV? | 73.9% |
| 5.1. Is there documented evidence of escalation in the notes ? | 78.9% |
| 4 Has the corresponding oxygen target saturation range been prescribed on EPMA? | 84.6% |
| 2. Have the patient's physiological observations and NEWS2 score been reassessed and recorded at the required frequency? | 97.4% |

# Area Overview by Audit

Monthly area overview for audit compliance. An audit must be selected on the filter on this page.

**Sep-2022**

NHS
Norfolk and Norwich University Hospitals

## Filters

*Select 'All' on division and area for trust view*

Division: All

Area: All

Audit: AIM Pressure Ulcer Pre…

Month: Sep-2022

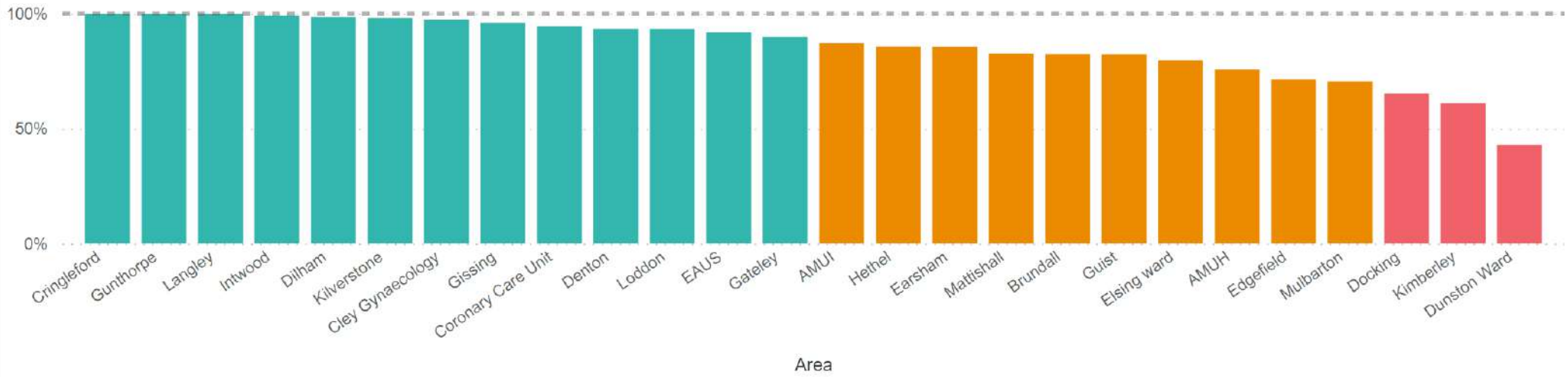
## Summary

**8** of **28** areas have completed all **AIM Pressure Ulcer Prevention and Care** audits in **Sep-2022**. These audits are to be completed **Monthly**.

The score for **AIM Pressure Ulcer Prevention and Care** is **87.11%.**

## Audit selected: **AIM Pressure Ulcer Prevention and Care**

Score by Area




Audits Completed

*No. for month is based on when that area is open*

| Area | No. For Month | No. Completed | % Completed | No. Missing |
|---|---|---|---|---|
| Brundall | 20 | 35 | 175% | 0 |
| Cringleford | 20 | 27 | 135% | 0 |
| Dilham | 20 | 27 | 135% | 0 |
| Loddon | 20 | 25 | 125% | 0 |
| Elsing ward | 20 | 21 | 105% | 0 |
| Denton | 20 | 20 | 100% | 0 |
| EAUS | 20 | 20 | 100% | 0 |
| Gissing | 20 | 20 | 100% | 0 |
| Mattishall | 20 | 19 | 95% | -1 |
| Intwood | 20 | 18 | 90% | -2 |

5 Lowest Scoring Questions

| Question | Score |
|---|---|
| Is there a completed corresponding care plan for the patients identified level of risk? | 78.9% |
| Is there documented evidence that the patient's Purpose T risk assessment has been correctly re-assessed, according to NNUH policy? | 81.6% |
| Is there documented evidence that relevant equipment / preventative methods has been considered, or is in use, for at risk areas on the Individualised Care Plan ? | 84.5% |
| Is there documented evidence that a daily skin inspection has been completed for the patient as per NNUH policy? | 89.3% |
| Has the Patient had a Purpose T pressure ulcer risk assessment tool completed within six hours of admission to the inpatient area, dated, timed and signed by the assessing staff member? | 91.3% |

# Area Overview by Audit

Monthly area overview for audit compliance. An audit must be selected on the filter on this page.

**Sep-2022**

NHS
Norfolk and Norwich University Hospitals

## Filters

*Select 'All' on division and area for trust view*

Division: All

Area: All

Audit: Daily Safety Audit

Month: Sep-2022

## Summary

**14** of **105** areas have completed all **Daily Safety Audit** audits in **Sep-2022**. These audits are to be completed **Daily**.

The score for **Daily Safety Audit** is **96.38%.**

## Audit selected: **Daily Safety Audit**

Score by Area


### Audits Completed

*No. for month is based on when that area is open*

| Area | No. For Month | No. Completed | % Completed | No. Missing |
|---|---|---|---|---|
| Respiratory Medicine Outpatients | 21 | 26 | 124% | 0 |
| Cromer Renal Unit | 21 | 25 | 119% | 0 |
| Norfolk and Norwich Kidney Centre | 21 | 24 | 114% | 0 |
| Surgical AEC | 21 | 24 | 114% | 0 |
| Cardiology Cath Labs | 21 | 22 | 105% | 0 |
| Cardiology Outpatients Clinics | 21 | 22 | 105% | 0 |
| Endoscopy NNUH | 21 | 22 | 105% | 0 |
| Endoscopy QI | 21 | 22 | 105% | 0 |

### 5 Lowest Scoring Questions

| Question | Score |
|---|---|
| Has the cardiac arrest block been checked and the drugs in date? | 28.6% |
| For all patients with a diagnosis of Dementia is there a complete 'This is me booklet'? | 51.2% |
| For all patients with a diagnosis of Dementia is the completed 'This is me booklet' in view of patient's bed? | 58.7% |
| Is the fridge clean, food labelled and in date? | 61.9% |
| Are there any drugs prepared over 12 hours that haven't vee used? | 65.0% |

# Area Overview by Audit

Monthly area overview for audit compliance. An audit must be selected on the filter on this page.

**Sep-2022**

NHS
Norfolk and Norwich University Hospitals

## Filters

*Select 'All' on division and area for trust view*

Division: All

Area: All

Audit: Documentation

Month: Sep-2022

## Summary

**33** of **88** areas have completed all **Documentation** audits in **Sep-2022**. These audits are to be completed **Weekly**.

The score for **Documentation** is **92.68%.**

## Audit selected: **Documentation**

Score by Area


Audits Completed

*No. for month is based on when that area is open*

| Area | No. For Month | No. Completed | % Completed | No. Missing |
|---|---|---|---|---|
| AMUI | 4 | 5 | 125% | 0 |
| Coronary Care Unit | 4 | 5 | 125% | 0 |
| Cromer Hospital - Day Procedures | 4 | 5 | 125% | 0 |
| Cromer Renal Unit | 4 | 5 | 125% | 0 |
| Ear Nose Throat Outpatients | 4 | 5 | 125% | 0 |
| Earsham | 4 | 5 | 125% | 0 |
| Gunthorpe | 4 | 5 | 125% | 0 |
| Hethel | 4 | 5 | 125% | 0 |

5 Lowest Scoring Questions

| Question | Score |
|---|---|
| Do all entries in the notes, include name, signature & designation? | 78.8% |
| Do all entry in the notes, include a name and designation? | 81.7% |
| Are any errors in the record, removed with a single line strike through, and dated, timed, signed, with full name, signature and designation. | 83.5% |
| Are the patients demographic details on all documentation? | 88.6% |
| Are all entries dated and timed | 90.7% |

# Area Overview by Audit

Monthly area overview for audit compliance. An audit must be selected on the filter on this page.

**Sep-2022**

NHS
Norfolk and Norwich University Hospitals

## Filters

*Select 'All' on division and area for trust view*

Division: All

Area: All

Audit: IPC Audit

Month: Sep-2022

## Summary

**60** of **104** areas have completed all **IPC Audit** audits in **Sep-2022**. These audits are to be completed **Weekly**.

The score for **IPC Audit** is **95.96%.**

## Audit selected: IPC Audit

Score by Area


Audits Completed

*No. for month is based on when that area is open*

| Area | No. For Month | No. Completed | % Completed | No. Missing |
|---|---|---|---|---|
| Cardiology Outpatients Clinics | 4 | 5 | 125% | 0 |
| Cringleford | 4 | 5 | 125% | 0 |
| Cromer Hospital - Day Procedures | 4 | 5 | 125% | 0 |
| Cromer Hospital - Outpatients | 4 | 5 | 125% | 0 |
| Cromer Renal Unit | 4 | 5 | 125% | 0 |
| Docking | 4 | 5 | 125% | 0 |
| ED - Navigation, Triage and Waiting Rooms | 4 | 5 | 125% | 0 |

5 Lowest Scoring Questions

| Question | Score |
|---|---|
| Are the Monitors and Lantroniz box visibly clean and free of dust? | 75.0% |
| Has the MRSA whiteboard been updated in the last 24 hours? | 84.2% |
| Is separate colour coded cleaning equipment in us in the isolation rooms? | 85.9% |
| Is there dedicated observation equipment available? eg. A minimum of stethoscope, BP cuff and thermometer for those patients isolated in a side room with IP&C precautions. | 86.8% |
| Are there any used bottles of Octenisan in ward bathrooms? | 87.8% |

Our Vision
The best care for every patient

NHS
Norfolk and Norwich University Hospitals
NHS Foundation Trust

# Mortality Data

## Trust Board Update

Professor Erika Denton, Medical Director

2nd November 2022

Our Values People focused Respect Integrity Dedication Excellence

# Ways to monitor mortality

***Crude Mortality***

Looks at the number of discharges from the hospital over 12 months and divides this figure by the number of patients who have died in hospital.

*This basic method does not facilitate us knowing whether our mortality rate is higher or lower than other hospitals, or provide assurance we provide safe care to our patients.*

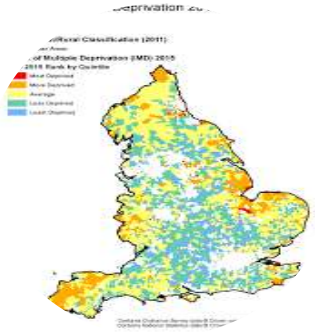
# *Standardised Mortality Ratios (SMRs)*

Calculations which make allowances for factors that may be outside a hospital's control which include:

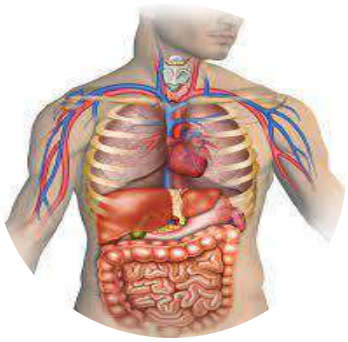
Population

Gender

Admitting Condition

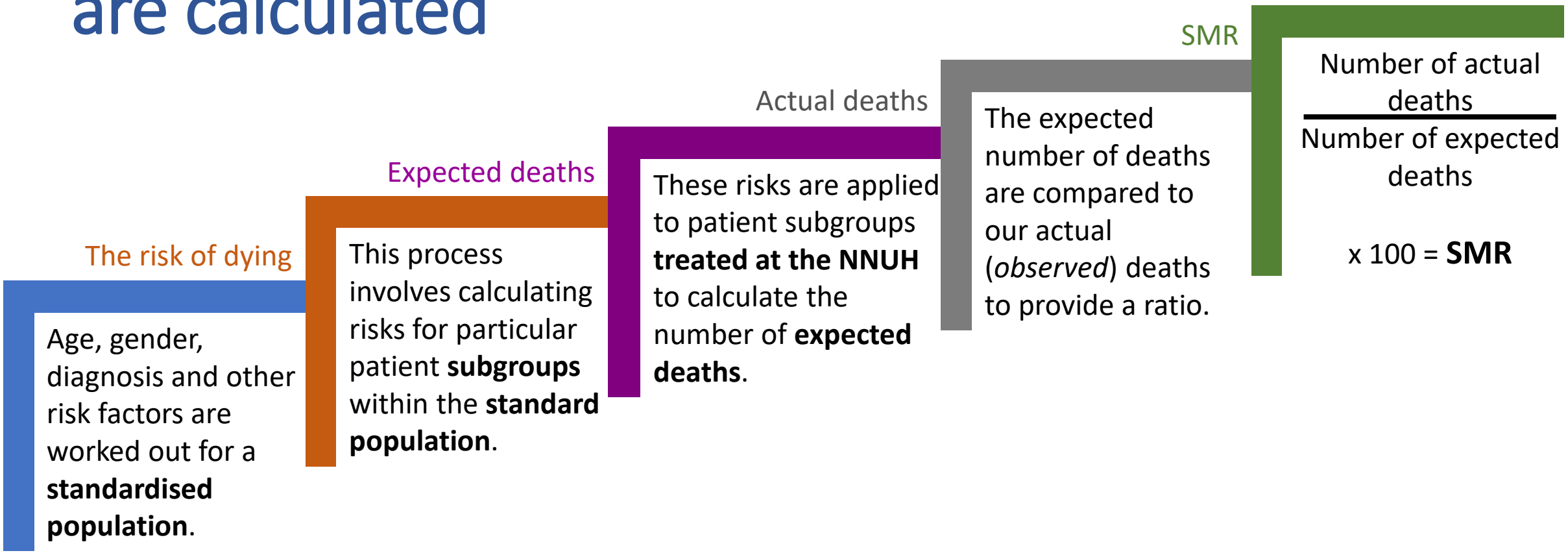


Level of Deprivation



Coexisting conditions

# How Standardised Mortality Ratios (SMRs) are calculated



# Excess Deaths

The difference between the expected and actual death numbers is termed '**excess**' deaths.

It does not mean these deaths were avoidable, unexpected or due to failings in care. **This can not be inferred from SMRs/'Excess deaths'**.

However a 'higher than expected' SMR is a 'smoke signal' highlighting the need for further investigation. The investigation is completed locally through our learning from deaths processes.

# National SMRs used and their differences

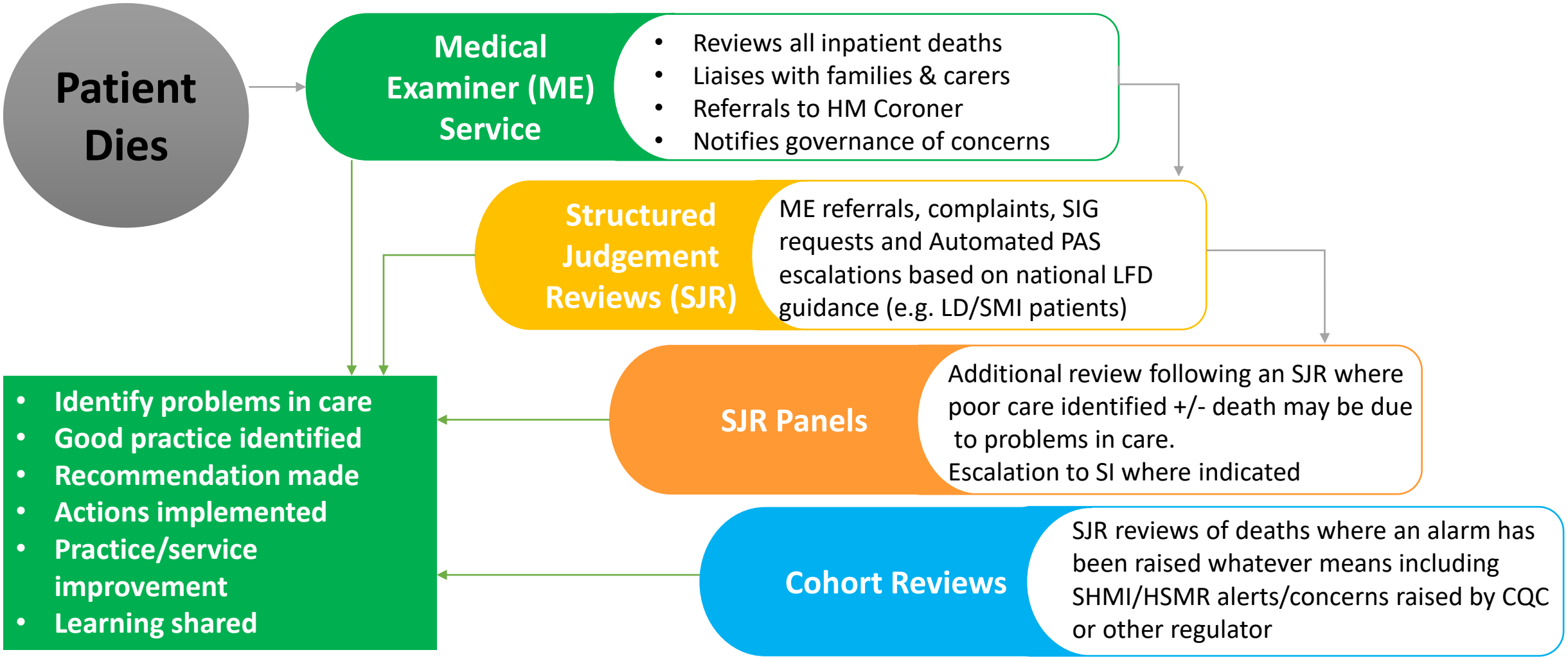
**Hospital Standardised Mortality Ratio (HSMR)**

- In Hospital deaths
- 56 specified diagnosis groups
- Factors in palliative care status

**Summary Hospital Mortality Indicator (SHMI)**

- In Hospital deaths
- ***And*** deaths of NNUH patients who died within 30 days of discharge
- Palliative care status ***not*** included

# How we review our deaths



# Factors affecting NNUH SMRs



| | | |
|---|---|---|
| **Our Population** | Large number of elderly & frail | • ≥ 1 long term medical condition (co-morbidities)<br>• Multiple admissions due to multiple medical conditions<br>• Limited nursing/care home beds<br>• **SMRs do not factor in frailty as a risk factor for death** |
| | Pockets impacted by all 7 domains of deprivation & 2 supplementary indices. | • Linked to poor health<br>• Linked to premature death |
| **Data** | How we record data/quality of data. Variances against other organisations | • Paper records, how episodes are captured on PAS<br>• Importance of timely/accurate EDL/EDN completion<br>• Multiple fragmented clinical IT systems<br>• Clinical Coding resources |
| **Palliative Care** | The service we provide to our patients which includes an acute oncology unit | • **Palliative care not included in SHMI but impacts it**<br>• Limited hospice beds in Norfolk<br>• Insufficient palliative care services in the community<br>• Limited community care packages for patients to die in their preferred place of death |
| **Activity** | Increased patient acuity | • **SMRs do not factor in patient acuity**<br>• Increase in admission avoidance schemes at NNUH |

# Actions required to improve our SMRs

1. Ability for clinical staff to record data required including comorbidities per admission to ensure that the complexity of patient is accurately represented in our data, very hard given ongoing and immense operational pressures. EPR implementation improves SMRs.
2. Appropriate clinical coding resources including clinical coding consultant leads to identify and implement education, training and coding improvement programmes
3. Review of data capture for patient pathways where differences compared to other organisations have been identified.
4. Digital Health resources to provide a dedicated system administrator for the mortality governance system and Information Services resources to review, maintain and develop PowerBI Reports
5. Engagement and availability of clinical staff to complete SJRs, SJR Panels and Cohort reviews
6. Availability of casenotes (hard copy or mediviewer) for coding and learning from death reviews
7. Completion of system wide quality improvement programmes linked to outlier alerts such as Congestive Cardiac Failure (CCF)
8. Ring fencing beds identified in specialist pathways, for example fractured neck of femur
9. More beds/services in the community to support patients to be looked after outside an acute hospital setting at the end of life

**Recommendation**
Further dedicated board session to analyse NNUH HSMR and SHMI data in detail.

# Any Questions?

Our Vision
The best care for every patient

NHS
Norfolk and Norwich University Hospitals
NHS Foundation Trust

# REPORT TO TRUST BOARD

| | |
|---|---|
| **Date** | **2 November 2022** |
| **Title** | **Chair's key Issues report from Finance, Investments and Performance Committee meeting on 26.10.22** |
| **Author & Exec Lead** | **Mr Tom Spink (Committee Chair)** |
| **Purpose** | **For Information** |

The Finance, Investments and Performance Committee met on 26 October 2022. Papers for the meeting were made available to Board members for information in the usual way via Admin Control. The meeting was quorate. On this occasion no governor observers were present.

The Committee endeavoured to conduct its meeting as discussed at the Board development day – to spend less time looking backward and more forward looking, seeking the right KPIs for assurance, with only 'not assured' or cross-cutting issues escalated to the Board.

The Committee reviewed reports in accordance with its Terms of Reference, including updates on the current financial and operational position and updates to the Finance Strategy as reported to the Board elsewhere. The following issues were identified to highlight to the Board:

| | | |
|---|---|---|
| 1 | Clinical Visits | The meeting commenced with visits to the Delivery Suite and Midwifery Led Birthing Unit (MLBU) on Blakeney Ward. Committee members took the opportunity to gain insight into the work of the Maternity Department and to hear directly from staff about its practice and culture. |
| 2 | Performance & Productivity IPR | The Committee was updated with regard to Key 2022/23 operational performance priorities:<br>• 78 week planned care – **better than trajectory**<br>• 62 day cancer – **off track**<br>• Ambulance handovers – **off track**<br>• 110% activity – **off track**<br><br>The ongoing impact of operational congestion in the hospital is evident – with discharge delays impeding flow through the hospital and having impact which tracks back to cause congestion in the ED and delayed ambulance handovers. The Committee was advised that when there is flow out of the ED the delays are significantly reduced – the fundamental issue is the excessive number of patients in the hospital without a 'criteria to reside' who are awaiting discharge elsewhere. |

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|---|---|---|
| | | The Committee was updated on some of the key workforce risks and the potential impact on the elective recovery plans.<br><br>The Committee discussed the performance with regard to 62-day cancer pathways alongside the 78-week planned care pathway. The two are intended to be of equal priority but 62-day performance is falling behind. It was recognised that there are a multitude of factors that impact on the scheduling of workload and the components of the 62-day and 78-week pathways are not equivalent but the Committee requested that further consideration should be given to ensuring that the 62-day KPI is given adequate priority.<br><br>The Committee noted that virtual outpatient, PIFU and virtual ward utilisation had not expanded as far as hoped and requested a follow-up report particularly with regard to utilisation of the virtual ward. |
| 3 | Clinical Systems risk review (Action 22/071 May '22) | The Committee received a report summarising those digital systems currently used in the Trust and which will require updating or replacement in advance of or as part of introducing a comprehensive EPR system.<br><br>Work has been undertaken with 75 suppliers to identify the relevant position with each of the 113 systems requiring review, to identify the level of risk and the extent of work required to upgrade or change existing systems in parallel with implementing the EPR.<br><br>The Committee supported the suggested approach that the risks relating to those systems that are to be subsumed into or replaced by the EPR should be overseen by the EPR Board. Those systems that will require replacement or upgrade in advance of the EPR should remain directly managed by the Trust.<br><br>The Committee recognised this summary as a helpful and important piece of work and encouraged further horizon-scanning and forward-looking in our approach to identification and management of risk. |
| 4 | Strategic initiatives | The Committee received a summary update with regard to the development of a programme for delivery of strategic initiatives aimed at enhancing operational and financial sustainability, service transformation and efficient use of resources. A refreshed governance and transformation approach is being established and the Committee welcomed the consolidated approach to planning, oversight and reporting on the progress and delivery of these initiatives which include length of stay, outpatients, diagnostics, business admin processes and theatres.<br><br>The Committee supported the approach of remaining focussed on delivery of the financial targets this year whilst at the same time ensuring that robust plans are in place for next year. The Committee requested where possible the plans should be accelerated, but recognised the competing pressure on key resources. The sooner we can implement efficiency improvements the better the position will be for patients and staff going forwards. |
| 5 | Estates management | The Committee noted the lack of updates on key Estate Projects including the NANOC and DAC. The Executives were asked to make a quick recommendation about how the governance at committee level should operate for the strategic programmes. |

| | | |
|---|---|---|
| | | The Committee approved the Play Book for the management of PFI contracts and congratulated the team for an excellent piece of work. |
| 6 | Digital security | The Committee noted the work done on ensuring Cyber security but also recognised the work still to be done. In response to a question, the Committee was informed that phising tests would feature as part of the next phase of improved cyber security. |

**3 Conclusions/Outcome/Next steps**

The next Committee meeting is scheduled for 23 November 2022.

**Recommendation:** The Board is recommended to **note** the work of its Finance, Investments & Performance Committee.

# Integrated Performance Report:

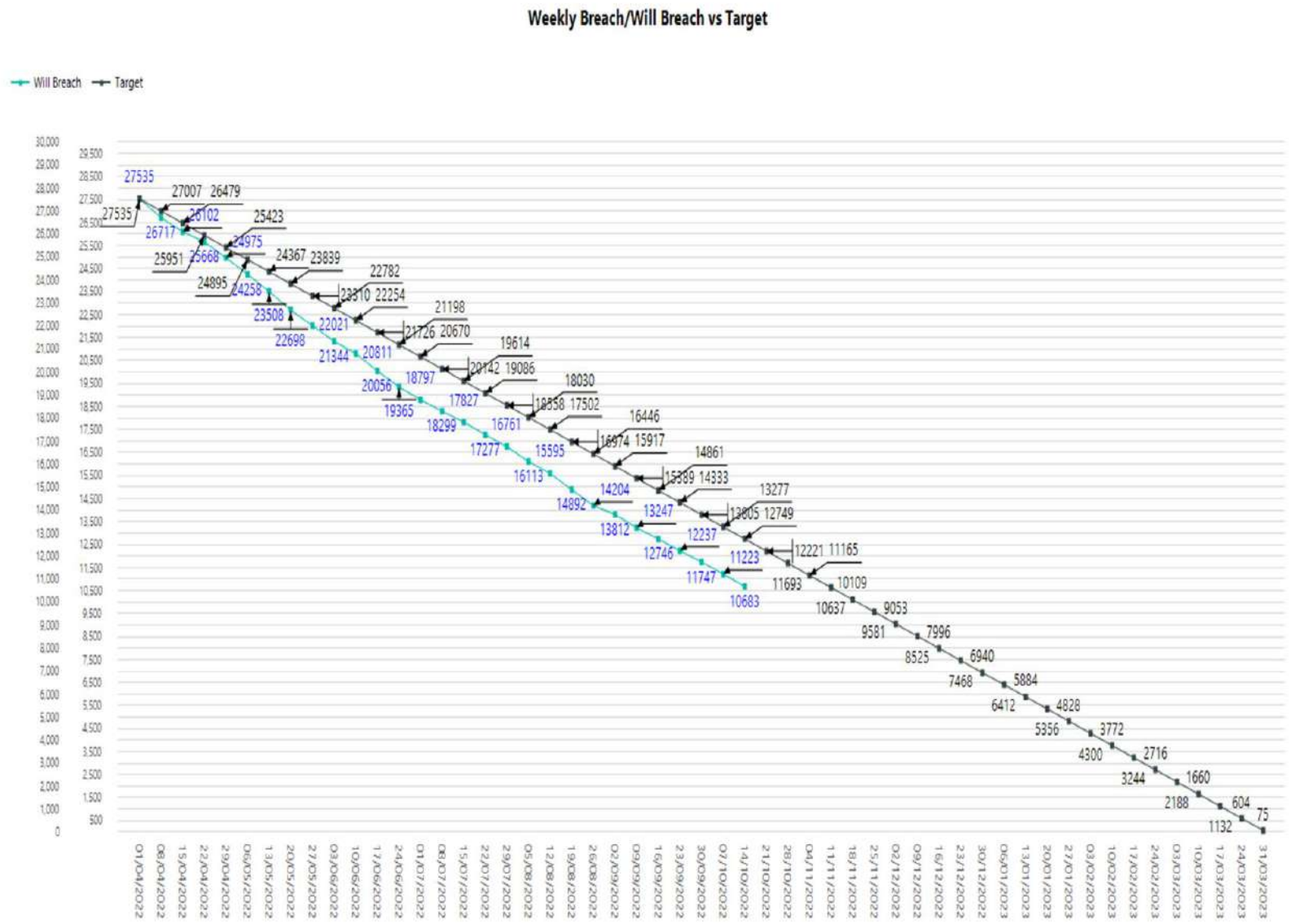
## Performance & Activity Domains


September 2022

# Key 2022-23 Operational Priorities

- **78-Week Breaches:** Better Than Trajectory
- **62-Day Cancer:** Off Track
- **Ambulance Handovers:** Off Track
- **110% Activity:** Off Track (Provisional Data)

# Performance – RTT 78-Week Breaches




## Commentary

**September 2022 Performance**

The end of September position had 11,794 patients needing to be treated by the end of March 2023 to avoid any patients being over 78 weeks wait for treatment. 7,902 patients or 67.4% of this patient group are in 4 specialities, these are:

| Speciality | Admitted | | Non-Admitted | | Total | |
|---|---|---|---|---|---|---|
| | Aug | Sept | Aug | Sept | Aug | Sept |
| T&O | 1,886 | 1,691 | 616 | 512 | 2,502 | 2,203 |
| Dermatology | 493 | 446 | 1,993 | 1,911 | 2,486 | 2,357 |
| Gynaecology | 517 | 433 | 1,517 | 1,305 | 1,960 | 1,738 |
| ENT | 223 | 175 | 1,629 | 1.533 | 1,852 | 1,604 |

There continues to be an increased focus on the non-admitted patients over the coming months to ensure that the teams have sufficient capacity to deliver the conversions to the admitted waiting list.

**Improvement Actions**

A set of 5 strategic capacity and sustainability interventions will help support and reduce the volumes of long waits, including:

1. Protection of ringfenced surgical beds.
2. Construction of NANOC.
3. Construction of Paediatric theatres.
4. Backfill of Paediatric theatres (main – conversion to adult) – business case required.
5. Participation in National POP pilot.

**Risk To Delivery** AMBER

Currently Amber, however this could potentially move to Red if the Medical and Nursing staff undertake strike action. There is also a national shortage of blood which could impact on Elective Surgery provision.

# Performance – NNUH 78-Week Recovery Forecast (Specialty Level)

NNUH Digital Health
business intelligence

| Specialty | | Weekly Averages | 09/09/2022 | 16/09/2022 | 23/09/2022 | 30/09/2022 | 07/10/2022 | 14/10/2022 | 21/10/2022 | 28/10/2022 | 04/11/2022 | 11/11/2022 | 18/11/2022 | 25/11/2022 | 02/12/2022 | 09/12/2022 | 16/12/2022 | 23/12/2022 | 30/12/2022 | 06/01/2023 | 13/01/2023 | 20/01/2023 | 27/01/2023 | 03/02/2023 | 10/02/2023 | 17/02/2023 | 24/02/2023 | 03/03/2023 | 10/03/2023 | 17/03/2023 | 24/03/2023 | 31/03/2023 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Total | Starting Cohort | - | 27,535 | 27,535 | 27,535 | 27,535 | 27,535 | 27,535 | 27,535 | 27,535 | 27,535 | 27,535 | 27,535 | 27,535 | 27,535 | 27,535 | 27,535 | 27,535 | 27,535 | 27,535 | 27,535 | 27,535 | 27,535 | 27,535 | 27,535 | 27,535 | 27,535 | 27,535 | 27,535 | 27,535 | 27,535 |
| | Will Breach | - | 13,247 | 12,746 | 12,237 | 11,747 | 11,223 | 10,683 | | | | | | | | | | | | | | | | | | | | | | | |
| | Weekly Removals | 602 | 565 | 501 | 509 | 490 | 524 | 540 | | | | | | | | | | | | | | | | | | | | | | | |
| | Target | 528 | 15,389 | 14,861 | 14,333 | 13,805 | 13,277 | 12,749 | 12,221 | 11,693 | 11,165 | 10,637 | 10,109 | 9,581 | 9,053 | 8,525 | 7,996 | 7,468 | 6,940 | 6,412 | 5,884 | 5,356 | 4,828 | 4,300 | 3,772 | 3,244 | 2,716 | 2,188 | 1,660 | 1,132 | 604 | 75 |
| | Difference | - | -2,142 | -2,115 | -2,095 | -2,057 | -2,053 | -2,065 | | | | | | | | | | | | | | | | | | | | | | | |
| | Future TCIs | 2066 | | | | | | | 651 | 396 | 346 | 204 | 107 | 96 | 78 | 36 | 49 | 27 | 6 | 19 | 22 | 14 | 9 | 3 | | 1 | | 1 | | 1 | | |
| | Provisional TCIs | 381 | | | | | | | 57 | 62 | 56 | 46 | 45 | 43 | 22 | 15 | 16 | 9 | 0 | 4 | 4 | 2 | 0 | 0 | | 0 | | 0 | | 0 | | |
| 330 - Dermatology | Starting Cohort | - | 3,599 | 3,599 | 3,599 | 3,599 | 3,599 | 3,599 | 3,599 | 3,599 | 3,599 | 3,599 | 3,599 | 3,599 | 3,599 | 3,599 | 3,599 | 3,599 | 3,599 | 3,599 | 3,599 | 3,599 | 3,599 | 3,599 | 3,599 | 3,599 | 3,599 | 3,599 | 3,599 | 3,599 | 3,599 |
| | Will Breach | - | 2,481 | 2,439 | 2,403 | 2,360 | 2,307 | 2,211 | 2,163 | 2,115 | 2,067 | 2,019 | 1,971 | 1,923 | 1,875 | 1,827 | 1,779 | 1,731 | 1,683 | 1,635 | 1,587 | 1,539 | 1,491 | 1,443 | 1,395 | 1,347 | 1,299 | 1,251 | 1,203 | 1,155 | 1,107 | 1,059 |
| | Weekly Removals | 48 | 19 | 42 | 36 | 43 | 53 | 96 | 48 | 48 | 48 | 48 | 48 | 48 | 48 | 48 | 48 | 48 | 48 | 48 | 48 | 48 | 48 | 48 | 48 | 48 | 48 | 48 | 48 | 48 | 48 | 48 |
| | Target | 69 | 2,011 | 1,942 | 1,873 | 1,804 | 1,735 | 1,666 | 1,597 | 1,528 | 1,459 | 1,390 | 1,321 | 1,252 | 1,183 | 1,114 | 1,045 | 976 | 907 | 838 | 769 | 700 | 631 | 562 | 493 | 424 | 355 | 286 | 217 | 148 | 79 | 10 |
| | Difference | - | 470 | 497 | 530 | 556 | 572 | 545 | | | | | | | | | | | | | | | | | | | | | | | |
| | Future TCIs | 195 | | | | | | | 77 | 63 | 31 | 18 | 2 | 1 | 2 | | | | | | 1 | | | | | | | | | | |
| | Provisional TCIs | 17 | | | | | | | 1 | 3 | 4 | 1 | 7 | 0 | 1 | | | | | | 0 | | | | | | | | | | |
| 502 - Gynaecology | Starting Cohort | - | 3,406 | 3,406 | 3,406 | 3,406 | 3,406 | 3,406 | 3,406 | 3,406 | 3,406 | 3,406 | 3,406 | 3,406 | 3,406 | 3,406 | 3,406 | 3,406 | 3,406 | 3,406 | 3,406 | 3,406 | 3,406 | 3,406 | 3,406 | 3,406 | 3,406 | 3,406 | 3,406 | 3,406 | 3,406 |
| | Will Breach | - | 1,949 | 1,887 | 1,809 | 1,742 | 1,670 | 1,604 | 1,539 | 1,473 | 1,408 | 1,343 | 1,277 | 1,212 | 1,147 | 1,081 | 1,016 | 951 | 885 | 820 | 755 | 690 | 624 | 559 | 494 | 428 | 363 | 298 | 232 | 167 | 102 | 36 |
| | Weekly Removals | 64 | 58 | 62 | 78 | 67 | 72 | 66 | 65 | 65 | 65 | 65 | 65 | 65 | 65 | 65 | 65 | 65 | 65 | 65 | 65 | 65 | 65 | 65 | 65 | 65 | 65 | 65 | 65 | 65 | 65 | 65 |
| | Target | 65 | 1,904 | 1,838 | 1,773 | 1,708 | 1,642 | 1,577 | 1,512 | 1,446 | 1,381 | 1,316 | 1,250 | 1,185 | 1,120 | 1,054 | 989 | 924 | 858 | 793 | 728 | 663 | 597 | 532 | 467 | 401 | 336 | 271 | 205 | 140 | 75 | 9 |
| | Difference | - | 45 | 49 | 36 | 34 | 28 | 27 | | | | | | | | | | | | | | | | | | | | | | | |
| | Future TCIs | 244 | | | | | | | 95 | 60 | 25 | 14 | 16 | 10 | 4 | 6 | 5 | 3 | 1 | 0 | 1 | 1 | | 2 | | | | | | 1 | |
| | Provisional TCIs | 104 | | | | | | | 17 | 23 | 17 | 4 | 11 | 11 | 6 | 8 | 4 | 2 | 0 | 1 | 0 | 0 | | 0 | | | | | | 0 | |
| 171 - Paediatric Surgery | Starting Cohort | - | 324 | 324 | 324 | 324 | 324 | 324 | 324 | 324 | 324 | 324 | 324 | 324 | 324 | 324 | 324 | 324 | 324 | 324 | 324 | 324 | 324 | 324 | 324 | 324 | 324 | 324 | 324 | 324 | 324 |
| | Will Breach | - | 178 | 170 | 165 | 163 | 160 | 155 | 151 | 147 | 143 | 139 | 135 | 131 | 127 | 123 | 119 | 115 | 111 | 107 | 103 | 99 | 95 | 91 | 87 | 83 | 79 | 75 | 71 | 67 | 63 | 59 |
| | Weekly Removals | 4 | 3 | 8 | 5 | 2 | 3 | 5 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 |
| | Target | 6 | 181 | 175 | 169 | 162 | 156 | 150 | 144 | 138 | 131 | 125 | 119 | 113 | 107 | 100 | 94 | 88 | 82 | 75 | 69 | 63 | 57 | 51 | 44 | 38 | 32 | 26 | 20 | 13 | 7 | 1 |
| | Difference | - | -3 | -5 | -4 | 1 | 4 | 5 | | | | | | | | | | | | | | | | | | | | | | | |
| | Future TCIs | 21 | | | | | | | 13 | 2 | 3 | 2 | 0 | 0 | | | 0 | | | 1 | | | | | | | | | | | |
| | Provisional TCIs | 24 | | | | | | | 10 | 2 | 4 | 4 | 1 | 2 | | | 1 | | | 0 | | | | | | | | | | | |
| 840 - Audiology | Starting Cohort | - | 85 | 85 | 85 | 85 | 85 | 85 | 85 | 85 | 85 | 85 | 85 | 85 | 85 | 85 | 85 | 85 | 85 | 85 | 85 | 85 | 85 | 85 | 85 | 85 | 85 | 85 | 85 | 85 | 85 | 85 |
| | Will Breach | - | 37 | 33 | 42 | 35 | 36 | 34 | 33 | 32 | 31 | 30 | 29 | 28 | 27 | 26 | 25 | 24 | 23 | 22 | 21 | 20 | 19 | 18 | 17 | 16 | 15 | 14 | 13 | 12 | 11 | 10 |
| | Weekly Removals | 1 | -5 | 4 | -9 | 7 | -1 | 2 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| | Target | 2 | 48 | 46 | 44 | 43 | 41 | 39 | 38 | 36 | 34 | 33 | 31 | 30 | 28 | 26 | 25 | 23 | 21 | 20 | 18 | 17 | 15 | 13 | 12 | 10 | 8 | 7 | 5 | 3 | 2 | 0 |
| | Difference | - | -11 | -13 | -2 | -8 | -5 | -5 | | | | | | | | | | | | | | | | | | | | | | | |
| | Future TCIs | 31 | | | | | | | 6 | 10 | 4 | 2 | 1 | 3 | 2 | | 2 | | | 1 | | | | | | | | | | | |
| | Provisional TCIs | 0 | | | | | | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | 0 | | | 0 | | | | | | | | | | | |
| 214 - Paediatric Trauma and Orthopaedic | Starting Cohort | - | 205 | 205 | 205 | 205 | 205 | 205 | 205 | 205 | 205 | 205 | 205 | 205 | 205 | 205 | 205 | 205 | 205 | 205 | 205 | 205 | 205 | 205 | 205 | 205 | 205 | 205 | 205 | 205 | 205 |
| | Will Breach | - | 89 | 87 | 85 | 81 | 79 | 76 | 74 | 72 | 70 | 68 | 66 | 64 | 62 | 60 | 58 | 56 | 54 | 52 | 50 | 48 | 46 | 44 | 42 | 40 | 38 | 36 | 34 | 32 | 30 | 28 |
| | Weekly Removals | 2 | 1 | 2 | 2 | 4 | 2 | 3 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 |
| | Target | 4 | 115 | 111 | 107 | 103 | 99 | 95 | 91 | 87 | 83 | 79 | 75 | 71 | 67 | 63 | 60 | 56 | 52 | 48 | 44 | 40 | 36 | 32 | 28 | 24 | 20 | 16 | 12 | 8 | 4 | 1 |
| | Difference | - | -26 | -24 | -22 | -22 | -20 | -19 | | | | | | | | | | | | | | | | | | | | | | | |
| | Future TCIs | 12 | | | | | | | 3 | 2 | 4 | | 2 | | | | | | | | | | 1 | | | | | | | | |
| | Provisional TCIs | 0 | | | | | | | 0 | 0 | 0 | | 0 | | | | | | | | | | 0 | | | | | | | | |
| 160 - Plastic Surgery | Starting Cohort | - | 760 | 760 | 760 | 760 | 760 | 760 | 760 | 760 | 760 | 760 | 760 | 760 | 760 | 760 | 760 | 760 | 760 | 760 | 760 | 760 | 760 | 760 | 760 | 760 | 760 | 760 | 760 | 760 | 760 |
| | Will Breach | - | 390 | 373 | 361 | 349 | 340 | 328 | 316 | 304 | 292 | 280 | 268 | 256 | 244 | 232 | 220 | 208 | 196 | 184 | 172 | 160 | 148 | 136 | 124 | 112 | 100 | 88 | 76 | 64 | 52 | 40 |
| | Weekly Removals | 12 | 10 | 17 | 12 | 12 | 9 | 12 | 12 | 12 | 12 | 12 | 12 | 12 | 12 | 12 | 12 | 12 | 12 | 12 | 12 | 12 | 12 | 12 | 12 | 12 | 12 | 12 | 12 | 12 | 12 | 12 |
| | Target | 15 | 425 | 410 | 396 | 381 | 366 | 352 | 337 | 323 | 308 | 294 | 279 | 264 | 250 | 235 | 221 | 206 | 192 | 177 | 162 | 148 | 133 | 119 | 104 | 90 | 75 | 60 | 46 | 31 | 17 | 2 |
| | Difference | - | -35 | -37 | -35 | -32 | -26 | -24 | | | | | | | | | | | | | | | | | | | | | | | |
| | Future TCIs | 45 | | | | | | | 15 | 8 | 8 | 5 | 2 | 1 | | 1 | 0 | 2 | 1 | 1 | | 1 | | | | | | | | | |
| | Provisional TCIs | 40 | | | | | | | 7 | 3 | 5 | 7 | 1 | 2 | | 6 | 1 | 3 | 0 | 3 | | 2 | | | | | | | | | |
| 217 - Paediatric Oral and Maxillofacial Surgery | Starting Cohort | - | 40 | 40 | 40 | 40 | 40 | 40 | 40 | 40 | 40 | 40 | 40 | 40 | 40 | 40 | 40 | 40 | 40 | 40 | 40 | 40 | 40 | 40 | 40 | 40 | 40 | 40 | 40 | 40 | 40 |
| | Will Breach | - | 37 | 37 | 33 | 33 | 30 | 30 | 30 | 29 | 28 | 27 | 26 | 25 | 24 | 23 | 22 | 21 | 20 | 19 | 18 | 17 | 16 | 15 | 14 | 13 | 12 | 11 | 10 | 9 | 8 | 7 |
| | Weekly Removals | 0 | 8 | 0 | 4 | 0 | 3 | 0 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| | Target | 1 | 22 | 22 | 21 | 20 | 19 | 19 | 18 | 17 | 16 | 15 | 15 | 14 | 13 | 12 | 12 | 11 | 10 | 9 | 9 | 8 | 7 | 6 | 5 | 5 | 4 | 3 | 2 | 2 | 1 | 0 |
| | Difference | - | 15 | 15 | 12 | 13 | 11 | 11 | | | | | | | | | | | | | | | | | | | | | | | |
| | Future TCIs | 1 | | | | | | | | | | 1 | | 0 | | | | | | | | | | | | | | | | | |
| | Provisional TCIs | 2 | | | | | | | | | | 1 | | 1 | | | | | | | | | | | | | | | | | |

## Commentary

For the overarching requirement of 78 week delivery by the end of March, delivery is ahead of trajectory at a Trust level, with 10,274 patients remaining in the cohort against a target of 12,359. There are 6 specialities behind plan and 1 specialty (Dermatology) that is forecast not to deliver against the requirement. All other specialities remain on track if current levels of removal sustain. System mutual aid is being progressed for 750 new outpatients in Dermatology to be taken on by other provider(s).

# Performance – NNUH 78-Week Recovery Forecast (Specialty Level)

NNUH Digital Health
business intelligence

| Specialty | | Weekly Averages | 09/09/2022 | 16/09/2022 | 23/09/2022 | 30/09/2022 | 07/10/2022 | 14/10/2022 | 21/10/2022 | 28/10/2022 | 04/11/2022 | 11/11/2022 | 18/11/2022 | 25/11/2022 | 02/12/2022 | 09/12/2022 | 16/12/2022 | 23/12/2022 | 30/12/2022 | 06/01/2023 | 13/01/2023 | 20/01/2023 | 27/01/2023 | 03/02/2023 | 10/02/2023 | 17/02/2023 | 24/02/2023 | 03/03/2023 | 10/03/2023 | 17/03/2023 | 24/03/2023 | 31/03/2023 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 191 - Pain Management | Starting Cohort | - | 411 | 411 | 411 | 411 | 411 | 411 | 411 | 411 | 411 | 411 | 411 | 411 | 411 | 411 | 411 | 411 | 411 | 411 | 411 | 411 | 411 | 411 | 411 | 411 | 411 | 411 | 411 | 411 | 411 |
| | Will Breach | - | 108 | 102 | 102 | 98 | 95 | 87 | 83 | 79 | 75 | 71 | 67 | 63 | 59 | 55 | 51 | 47 | 43 | 39 | 35 | 31 | 27 | 23 | 19 | 15 | 11 | 7 | 3 | 0 | 0 | 0 |
| | Weekly Removals | 4 | 4 | 6 | 0 | 4 | 3 | 8 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | | |
| | Target | 8 | 230 | 222 | 214 | 206 | 198 | 190 | 182 | 175 | 167 | 159 | 151 | 143 | 135 | 127 | 119 | 111 | 104 | 96 | 88 | 80 | 72 | 64 | 56 | 48 | 41 | 33 | 25 | 17 | 9 | 1 |
| | Difference | - | -122 | -120 | -112 | -106 | -103 | -103 | | | | | | | | | | | | | | | | | | | | | | | | |
| | Future TCIs | 25 | | | | | | | 10 | 4 | 5 | 2 | 2 | 2 | | | | | | | | | | | | | | | | | | |
| | Provisional TCIs | 4 | | | | | | | 1 | 0 | 2 | 1 | 0 | 0 | | | | | | | | | | | | | | | | | | |
| 110 - Trauma and Orthopaedic | Starting Cohort | - | 4,978 | 4,978 | 4,978 | 4,978 | 4,978 | 4,978 | 4,978 | 4,978 | 4,978 | 4,978 | 4,978 | 4,978 | 4,978 | 4,978 | 4,978 | 4,978 | 4,978 | 4,978 | 4,978 | 4,978 | 4,978 | 4,978 | 4,978 | 4,978 | 4,978 | 4,978 | 4,978 | 4,978 | 4,978 | 4,978 |
| | Will Breach | - | 2,480 | 2,382 | 2,298 | 2,205 | 2,122 | 2,028 | 1,935 | 1,842 | 1,749 | 1,656 | 1,563 | 1,470 | 1,377 | 1,284 | 1,191 | 1,098 | 1,005 | 912 | 819 | 726 | 633 | 540 | 447 | 354 | 261 | 168 | 75 | 0 | 0 | 0 |
| | Weekly Removals | 93 | 105 | 98 | 84 | 93 | 83 | 94 | 93 | 93 | 93 | 93 | 93 | 93 | 93 | 93 | 93 | 93 | 93 | 93 | 93 | 93 | 93 | 93 | 93 | 93 | 93 | 93 | 93 | 93 | | |
| | Target | 95 | 2,782 | 2,687 | 2,591 | 2,496 | 2,400 | 2,305 | 2,209 | 2,114 | 2,018 | 1,923 | 1,828 | 1,732 | 1,637 | 1,541 | 1,446 | 1,350 | 1,255 | 1,159 | 1,064 | 968 | 873 | 777 | 682 | 586 | 491 | 396 | 300 | 205 | 109 | 14 |
| | Difference | - | -302 | -305 | -293 | -291 | -278 | -277 | | | | | | | | | | | | | | | | | | | | | | | | |
| | Future TCIs | 627 | | | | | | | 95 | 85 | 102 | 79 | 38 | 36 | 56 | 21 | 35 | 21 | 4 | 15 | 19 | 11 | 8 | 1 | | | 1 | | | | | |
| | Provisional TCIs | 53 | | | | | | | 6 | 4 | 7 | 7 | 7 | 5 | 4 | 1 | 9 | 3 | 0 | 0 | 0 | 0 | 0 | 0 | | | 0 | | | | | |
| 257 - Paediatric Dermatology | Starting Cohort | - | 242 | 242 | 242 | 242 | 242 | 242 | 242 | 242 | 242 | 242 | 242 | 242 | 242 | 242 | 242 | 242 | 242 | 242 | 242 | 242 | 242 | 242 | 242 | 242 | 242 | 242 | 242 | 242 | 242 | 242 |
| | Will Breach | - | 158 | 151 | 142 | 139 | 126 | 123 | 117 | 111 | 105 | 99 | 93 | 87 | 81 | 75 | 69 | 63 | 57 | 51 | 45 | 39 | 33 | 27 | 21 | 15 | 9 | 3 | 0 | 0 | 0 | 0 |
| | Weekly Removals | 6 | 2 | 7 | 9 | 3 | 13 | 3 | 6 | 6 | 6 | 6 | 6 | 6 | 6 | 6 | 6 | 6 | 6 | 6 | 6 | 6 | 6 | 6 | 6 | 6 | 6 | 6 | | | | |
| | Target | 5 | 135 | 131 | 126 | 121 | 117 | 112 | 107 | 103 | 98 | 93 | 89 | 84 | 80 | 75 | 70 | 66 | 61 | 56 | 52 | 47 | 42 | 38 | 33 | 29 | 24 | 19 | 15 | 10 | 5 | 1 |
| | Difference | - | 23 | 20 | 16 | 18 | 9 | 11 | | | | | | | | | | | | | | | | | | | | | | | | |
| | Future TCIs | 26 | | | | | | | 12 | 6 | 2 | 3 | 2 | | 1 | | | | | | | | | | | | | | | | | |
| | Provisional TCIs | 0 | | | | | | | 0 | 0 | 0 | 0 | 0 | | 0 | | | | | | | | | | | | | | | | | |
| 108 - Spinal Surgery | Starting Cohort | - | 591 | 591 | 591 | 591 | 591 | 591 | 591 | 591 | 591 | 591 | 591 | 591 | 591 | 591 | 591 | 591 | 591 | 591 | 591 | 591 | 591 | 591 | 591 | 591 | 591 | 591 | 591 | 591 | 591 | 591 |
| | Will Breach | - | 337 | 326 | 313 | 301 | 281 | 272 | 258 | 244 | 230 | 216 | 202 | 188 | 174 | 160 | 146 | 132 | 118 | 104 | 90 | 76 | 62 | 48 | 34 | 20 | 6 | 0 | 0 | 0 | 0 | 0 |
| | Weekly Removals | 14 | 19 | 11 | 13 | 12 | 20 | 9 | 14 | 14 | 14 | 14 | 14 | 14 | 14 | 14 | 14 | 14 | 14 | 14 | 14 | 14 | 14 | 14 | 14 | 14 | 14 | 14 | 14 | 14 | | |
| | Target | 11 | 330 | 319 | 308 | 296 | 285 | 274 | 262 | 251 | 240 | 228 | 217 | 206 | 194 | 183 | 172 | 160 | 149 | 138 | 126 | 115 | 104 | 92 | 81 | 70 | 58 | 47 | 36 | 24 | 13 | 2 |
| | Difference | - | 7 | 7 | 5 | 5 | -4 | -2 | | | | | | | | | | | | | | | | | | | | | | | | |
| | Future TCIs | 69 | | | | | | | 25 | 11 | 10 | 5 | 6 | 5 | 1 | 4 | 1 | | | | 1 | | | | | | | | | | | |
| | Provisional TCIs | 9 | | | | | | | 1 | 4 | 0 | 0 | 1 | 2 | 1 | 0 | 0 | | | | 0 | | | | | | | | | | | |
| 320 - Cardiology | Starting Cohort | - | 571 | 571 | 571 | 571 | 571 | 571 | 571 | 571 | 571 | 571 | 571 | 571 | 571 | 571 | 571 | 571 | 571 | 571 | 571 | 571 | 571 | 571 | 571 | 571 | 571 | 571 | 571 | 571 | 571 | 571 |
| | Will Breach | - | 105 | 89 | 80 | 108 | 100 | 91 | 86 | 81 | 76 | 71 | 66 | 61 | 56 | 51 | 46 | 41 | 36 | 31 | 26 | 21 | 16 | 11 | 6 | 1 | 0 | 0 | 0 | 0 | 0 | 0 |
| | Weekly Removals | 5 | 16 | 16 | 9 | -28 | 8 | 9 | 5 | 5 | 5 | 5 | 5 | 5 | 5 | 5 | 5 | 5 | 5 | 5 | 5 | 5 | 5 | 5 | 5 | 5 | | | | | | |
| | Target | 11 | 319 | 308 | 297 | 286 | 275 | 264 | 253 | 242 | 232 | 221 | 210 | 199 | 188 | 177 | 166 | 155 | 144 | 133 | 122 | 111 | 100 | 89 | 78 | 67 | 56 | 45 | 34 | 23 | 13 | 2 |
| | Difference | - | -214 | -219 | -217 | -178 | -175 | -173 | | | | | | | | | | | | | | | | | | | | | | | | |
| | Future TCIs | 48 | | | | | | | 17 | 9 | 5 | 7 | 4 | 1 | 3 | 1 | 1 | | | | | | | | | | | | | | | |
| | Provisional TCIs | 0 | | | | | | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | | | | | | | | | | | | | | |
| 101 - Urology | Starting Cohort | - | 1,030 | 1,030 | 1,030 | 1,030 | 1,030 | 1,030 | 1,030 | 1,030 | 1,030 | 1,030 | 1,030 | 1,030 | 1,030 | 1,030 | 1,030 | 1,030 | 1,030 | 1,030 | 1,030 | 1,030 | 1,030 | 1,030 | 1,030 | 1,030 | 1,030 | 1,030 | 1,030 | 1,030 | 1,030 | 1,030 |
| | Will Breach | - | 517 | 492 | 470 | 444 | 428 | 407 | 385 | 363 | 340 | 318 | 296 | 274 | 251 | 229 | 207 | 185 | 162 | 140 | 118 | 96 | 73 | 51 | 29 | 7 | 0 | 0 | 0 | 0 | 0 | 0 |
| | Weekly Removals | 22 | 23 | 25 | 22 | 26 | 16 | 21 | 22 | 22 | 22 | 22 | 22 | 22 | 22 | 22 | 22 | 22 | 22 | 22 | 22 | 22 | 22 | 22 | 22 | 22 | | | | | | |
| | Target | 20 | 576 | 556 | 536 | 516 | 497 | 477 | 457 | 437 | 418 | 398 | 378 | 358 | 339 | 319 | 299 | 279 | 260 | 240 | 220 | 200 | 181 | 161 | 141 | 121 | 102 | 82 | 62 | 42 | 23 | 3 |
| | Difference | - | -59 | -64 | -66 | -72 | -69 | -70 | | | | | | | | | | | | | | | | | | | | | | | | |
| | Future TCIs | 83 | | | | | | | 30 | 12 | 15 | 11 | 3 | 11 | 0 | | 1 | | | | | | | | | | | | | | | |
| | Provisional TCIs | 42 | | | | | | | 6 | 7 | 5 | 8 | 6 | 8 | 2 | | 0 | | | | | | | | | | | | | | | |
| 120 - Ear Nose and Throat | Starting Cohort | - | 4,001 | 4,001 | 4,001 | 4,001 | 4,001 | 4,001 | 4,001 | 4,001 | 4,001 | 4,001 | 4,001 | 4,001 | 4,001 | 4,001 | 4,001 | 4,001 | 4,001 | 4,001 | 4,001 | 4,001 | 4,001 | 4,001 | 4,001 | 4,001 | 4,001 | 4,001 | 4,001 | 4,001 | 4,001 | 4,001 |
| | Will Breach | - | 1,846 | 1,817 | 1,691 | 1,630 | 1,545 | 1,482 | 1,395 | 1,308 | 1,221 | 1,134 | 1,047 | 960 | 873 | 786 | 699 | 612 | 525 | 438 | 351 | 264 | 177 | 90 | 3 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | Weekly Removals | 87 | 159 | 29 | 126 | 61 | 85 | 63 | 87 | 87 | 87 | 87 | 87 | 87 | 87 | 87 | 87 | 87 | 87 | 87 | 87 | 87 | 87 | 87 | 87 | | | | | | | |
| | Target | 77 | 2,236 | 2,159 | 2,083 | 2,006 | 1,929 | 1,853 | 1,776 | 1,699 | 1,622 | 1,546 | 1,469 | 1,392 | 1,315 | 1,239 | 1,162 | 1,085 | 1,008 | 932 | 855 | 778 | 702 | 625 | 548 | 471 | 395 | 318 | 241 | 164 | 88 | 11 |
| | Difference | - | -393 | -342 | -392 | -376 | -384 | -371 | | | | | | | | | | | | | | | | | | | | | | | | |
| | Future TCIs | 251 | | | | | | | 134 | 37 | 50 | 13 | 5 | 5 | 3 | 2 | 2 | | | | 0 | | | | | | | | | | | |
| | Provisional TCIs | 18 | | | | | | | 6 | 2 | 3 | 2 | 1 | 2 | 1 | 0 | 0 | | | | 1 | | | | | | | | | | | |
| 219 - Paediatric Plastic Surgery | Starting Cohort | - | 142 | 142 | 142 | 142 | 142 | 142 | 142 | 142 | 142 | 142 | 142 | 142 | 142 | 142 | 142 | 142 | 142 | 142 | 142 | 142 | 142 | 142 | 142 | 142 | 142 | 142 | 142 | 142 | 142 | 142 |
| | Will Breach | - | 72 | 64 | 65 | 59 | 59 | 53 | 50 | 47 | 43 | 40 | 37 | 34 | 31 | 28 | 24 | 21 | 18 | 15 | 12 | 8 | 5 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | Weekly Removals | 3 | 0 | 8 | -1 | 6 | 0 | 6 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | | | | | | | | |
| | Target | 3 | 79 | 77 | 74 | 71 | 68 | 66 | 63 | 60 | 58 | 55 | 52 | 49 | 47 | 44 | 41 | 39 | 36 | 33 | 30 | 28 | 25 | 22 | 19 | 17 | 14 | 11 | 9 | 6 | 3 | 0 |
| | Difference | - | -7 | -13 | -9 | -12 | -9 | -13 | | | | | | | | | | | | | | | | | | | | | | | | |
| | Future TCIs | 3 | | | | | | | 2 | | 0 | 0 | | | 1 | | 0 | 0 | | | 0 | | | | | | | | | | | |
| | Provisional TCIs | 13 | | | | | | | 1 | | 1 | 3 | | | 3 | | 1 | 1 | | | 3 | | | | | | | | | | | |
| 100 - General Surgery | Starting Cohort | - | 1,830 | 1,830 | 1,830 | 1,830 | 1,830 | 1,830 | 1,830 | 1,830 | 1,830 | 1,830 | 1,830 | 1,830 | 1,830 | 1,830 | 1,830 | 1,830 | 1,830 | 1,830 | 1,830 | 1,830 | 1,830 | 1,830 | 1,830 | 1,830 | 1,830 | 1,830 | 1,830 | 1,830 | 1,830 | 1,830 |
| | Will Breach | - | 809 | 781 | 756 | 701 | 653 | 614 | 574 | 534 | 494 | 454 | 414 | 374 | 334 | 294 | 254 | 214 | 174 | 134 | 94 | 54 | 14 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | Weekly Removals | 40 | 45 | 28 | 25 | 55 | 48 | 39 | 40 | 40 | 40 | 40 | 40 | 40 | 40 | 40 | 40 | 40 | 40 | 40 | 40 | 40 | 40 | | | | | | | | | |
| | Target | 35 | 1,023 | 988 | 953 | 918 | 882 | 847 | 812 | 777 | 742 | 707 | 672 | 637 | 602 | 567 | 531 | 496 | 461 | 426 | 391 | 356 | 321 | 286 | 251 | 216 | 180 | 145 | 110 | 75 | 40 | 5 |
| | Difference | - | -214 | -207 | -197 | -217 | -229 | -233 | | | | | | | | | | | | | | | | | | | | | | | | |
| | Future TCIs | 70 | | | | | | | 15 | 17 | 14 | 5 | 4 | 11 | 2 | | 1 | | | | | | | | 1 | | | | | | | |
| | Provisional TCIs | 20 | | | | | | | 0 | 3 | 5 | 3 | 4 | 5 | 0 | | 0 | | | | | | | | 0 | | | | | | | |

## Commentary

For the overarching requirement of 78 week delivery by the end of March, delivery is ahead of trajectory at a Trust level, with 10,274 patients remaining in the cohort against a target of 12,359. There are 6 specialities behind plan and 1 specialty (Dermatology) that is forecast not to deliver against the requirement. All other specialities remain on track if current levels of removal sustain. System mutual aid is being progressed for 750 new outpatients in Dermatology to be taken on by other provider(s).

# Performance – NNUH 78-Week Recovery Forecast (Specialty Level)

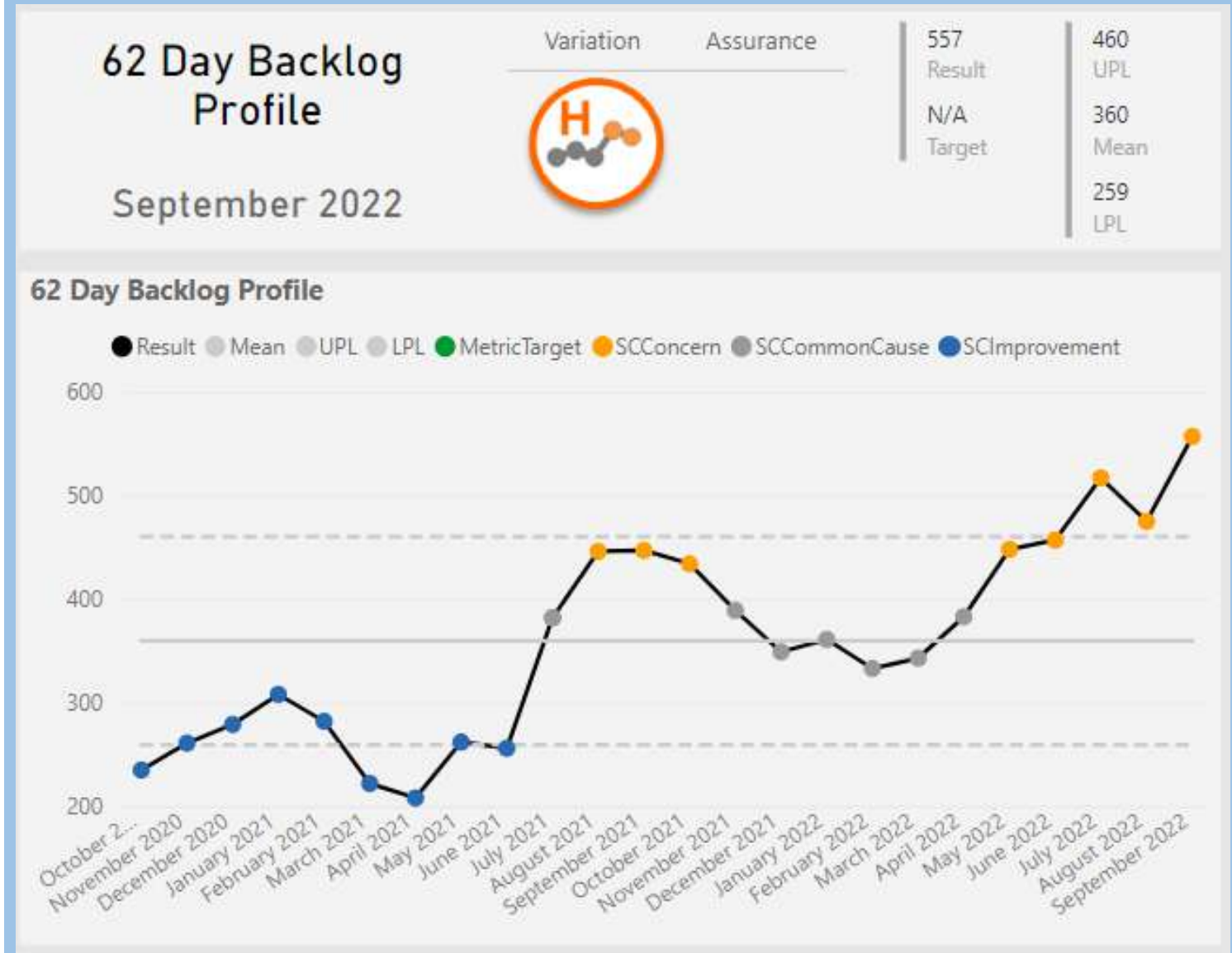
NNUH Digital Health business intelligence

| Specialty | | Weekly Averages | 09/09/2022 | 16/09/2022 | 23/09/2022 | 30/09/2022 | 07/10/2022 | 14/10/2022 | 21/10/2022 | 28/10/2022 | 04/11/2022 | 11/11/2022 | 18/11/2022 | 25/11/2022 | 02/12/2022 | 09/12/2022 | 16/12/2022 | 23/12/2022 | 30/12/2022 | 06/01/2023 | 13/01/2023 | 20/01/2023 | 27/01/2023 | 03/02/2023 | 10/02/2023 | 17/02/2023 | 24/02/2023 | 03/03/2023 | 10/03/2023 | 17/03/2023 | 24/03/2023 | 31/03/2023 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 130 - Ophthalmology | Starting Cohort | - | 1,960 | 1,960 | 1,960 | 1,960 | 1,960 | 1,960 | 1,960 | 1,960 | 1,960 | 1,960 | 1,960 | 1,960 | 1,960 | 1,960 | 1,960 | 1,960 | 1,960 | 1,960 | 1,960 | 1,960 | 1,960 | 1,960 | 1,960 | 1,960 | 1,960 | 1,960 | 1,960 | 1,960 | 1,960 |
| | Will Breach | - | 837 | 796 | 766 | 712 | 653 | 594 | 546 | 498 | 450 | 402 | 354 | 306 | 258 | 210 | 162 | 114 | 66 | 18 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | Weekly Removals | 48 | 45 | 41 | 30 | 54 | 59 | 59 | 48 | 48 | 48 | 48 | 48 | 48 | 48 | 48 | 48 | 48 | 48 | 48 | | | | | | | | | | | |
| | Target | 38 | 1,095 | 1,058 | 1,020 | 983 | 945 | 908 | 870 | 832 | 795 | 757 | 720 | 682 | 644 | 607 | 569 | 532 | 494 | 456 | 419 | 381 | 344 | 306 | 268 | 231 | 193 | 156 | 118 | 81 | 43 | 5 |
| | Difference | - | -258 | -262 | -254 | -271 | -292 | -314 | | | | | | | | | | | | | | | | | | | | | | | |
| | Future TCIs | 150 | | | | | | | 49 | 29 | 38 | 22 | 8 | 4 | | | | | | | | | | | | | | | | | |
| | Provisional TCIs | 11 | | | | | | | 0 | 8 | 0 | 2 | 1 | 0 | | | | | | | | | | | | | | | | | |
| 400 - Neurology | Starting Cohort | - | 127 | 127 | 127 | 127 | 127 | 127 | 127 | 127 | 127 | 127 | 127 | 127 | 127 | 127 | 127 | 127 | 127 | 127 | 127 | 127 | 127 | 127 | 127 | 127 | 127 | 127 | 127 | 127 | 127 |
| | Will Breach | - | 17 | 15 | 15 | 16 | 15 | 12 | 11 | 10 | 9 | 8 | 7 | 6 | 5 | 4 | 3 | 2 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | Weekly Removals | 1 | 1 | 2 | 0 | -1 | 1 | 3 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | | | | | | | | | | | | |
| | Target | 2 | 71 | 69 | 66 | 64 | 61 | 59 | 56 | 54 | 51 | 49 | 47 | 44 | 42 | 39 | 37 | 34 | 32 | 30 | 27 | 25 | 22 | 20 | 17 | 15 | 13 | 10 | 8 | 5 | 3 | 0 |
| | Difference | - | -54 | -54 | -51 | -48 | -46 | -47 | | | | | | | | | | | | | | | | | | | | | | | |
| | Future TCIs | 2 | | | | | | | | | 1 | | | 1 | | | | | | | | | | | | | | | | | |
| | Provisional TCIs | 0 | | | | | | | | | 0 | | | 0 | | | | | | | | | | | | | | | | | |
| 215 - Paediatric Ear Nose and Throat | Starting Cohort | - | 582 | 582 | 582 | 582 | 582 | 582 | 582 | 582 | 582 | 582 | 582 | 582 | 582 | 582 | 582 | 582 | 582 | 582 | 582 | 582 | 582 | 582 | 582 | 582 | 582 | 582 | 582 | 582 | 582 |
| | Will Breach | - | 310 | 275 | 242 | 219 | 210 | 201 | 180 | 159 | 138 | 117 | 96 | 75 | 54 | 33 | 12 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | Weekly Removals | 21 | 16 | 35 | 33 | 23 | 9 | 9 | 21 | 21 | 21 | 21 | 21 | 21 | 21 | 21 | 21 | | | | | | | | | | | | | | |
| | Target | 11 | 325 | 314 | 303 | 292 | 281 | 269 | 258 | 247 | 236 | 225 | 214 | 203 | 191 | 180 | 169 | 158 | 147 | 136 | 124 | 113 | 102 | 91 | 80 | 69 | 57 | 46 | 35 | 24 | 13 | 2 |
| | Difference | - | -15 | -39 | -61 | -73 | -71 | -68 | | | | | | | | | | | | | | | | | | | | | | | |
| | Future TCIs | 26 | | | | | | | 11 | 10 | 2 | | 3 | | | | | | | | | | | | | | | | | | |
| | Provisional TCIs | 0 | | | | | | | 0 | 0 | 0 | | 0 | | | | | | | | | | | | | | | | | | |
| 107 - Vascular Surgery | Starting Cohort | - | 283 | 283 | 283 | 283 | 283 | 283 | 283 | 283 | 283 | 283 | 283 | 283 | 283 | 283 | 283 | 283 | 283 | 283 | 283 | 283 | 283 | 283 | 283 | 283 | 283 | 283 | 283 | 283 | 283 |
| | Will Breach | - | 79 | 72 | 65 | 57 | 51 | 43 | 37 | 31 | 25 | 19 | 13 | 7 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | Weekly Removals | 6 | 2 | 7 | 7 | 8 | 6 | 8 | 6 | 6 | 6 | 6 | 6 | 6 | 6 | | | | | | | | | | | | | | | | |
| | Target | 5 | 158 | 153 | 147 | 142 | 136 | 131 | 126 | 120 | 115 | 109 | 104 | 98 | 93 | 88 | 82 | 77 | 71 | 66 | 60 | 55 | 50 | 44 | 39 | 33 | 28 | 22 | 17 | 12 | 6 | 1 |
| | Difference | - | -79 | -81 | -82 | -85 | -85 | -88 | | | | | | | | | | | | | | | | | | | | | | | |
| | Future TCIs | 17 | | | | | | | 10 | | 4 | 1 | 2 | | | | | | | | | | | | | | | | | | |
| | Provisional TCIs | 2 | | | | | | | 0 | | 1 | 1 | 0 | | | | | | | | | | | | | | | | | | |
| 310 - Audio Vestibular Medicine | Starting Cohort | - | 50 | 50 | 50 | 50 | 50 | 50 | 50 | 50 | 50 | 50 | 50 | 50 | 50 | 50 | 50 | 50 | 50 | 50 | 50 | 50 | 50 | 50 | 50 | 50 | 50 | 50 | 50 | 50 | 50 |
| | Will Breach | - | 19 | 17 | 18 | 10 | 11 | 11 | 10 | 8 | 7 | 5 | 4 | 3 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | Weekly Removals | 1 | 3 | 2 | -1 | 8 | -1 | 0 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | | | | | | | | | | | | | | | | |
| | Target | 1 | 28 | 27 | 26 | 25 | 24 | 23 | 22 | 21 | 20 | 19 | 18 | 17 | 16 | 15 | 15 | 14 | 13 | 12 | 11 | 10 | 9 | 8 | 7 | 6 | 5 | 4 | 3 | 2 | 1 | 0 |
| | Difference | - | -9 | -10 | -8 | -15 | -13 | -12 | | | | | | | | | | | | | | | | | | | | | | | |
| | Future TCIs | 7 | | | | | | | 2 | 1 | 1 | 3 | | | | | | | | | | | | | | | | | | | |
| | Provisional TCIs | 0 | | | | | | | 0 | 0 | 0 | 0 | | | | | | | | | | | | | | | | | | | |
| 140 - Oral Surgery | Starting Cohort | - | 1,002 | 1,002 | 1,002 | 1,002 | 1,002 | 1,002 | 1,002 | 1,002 | 1,002 | 1,002 | 1,002 | 1,002 | 1,002 | 1,002 | 1,002 | 1,002 | 1,002 | 1,002 | 1,002 | 1,002 | 1,002 | 1,002 | 1,002 | 1,002 | 1,002 | 1,002 | 1,002 | 1,002 | 1,002 |
| | Will Breach | - | 207 | 179 | 164 | 145 | 127 | 117 | 102 | 87 | 72 | 57 | 42 | 27 | 12 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | Weekly Removals | 15 | 2 | 28 | 15 | 19 | 18 | 10 | 15 | 15 | 15 | 15 | 15 | 15 | 15 | | | | | | | | | | | | | | | | |
| | Target | 19 | 560 | 541 | 522 | 502 | 483 | 464 | 445 | 426 | 406 | 387 | 368 | 349 | 329 | 310 | 291 | 272 | 253 | 233 | 214 | 195 | 176 | 156 | 137 | 118 | 99 | 80 | 60 | 41 | 22 | 3 |
| | Difference | - | -353 | -362 | -358 | -357 | -356 | -347 | | | | | | | | | | | | | | | | | | | | | | | |
| | Future TCIs | 59 | | | | | | | 14 | 18 | 13 | 5 | 5 | 4 | 0 | | | | | | | | | | | | | | | | |
| | Provisional TCIs | 21 | | | | | | | 1 | 2 | 2 | 2 | 5 | 5 | 4 | | | | | | | | | | | | | | | | |
| 143 - Orthodontic | Starting Cohort | - | 111 | 111 | 111 | 111 | 111 | 111 | 111 | 111 | 111 | 111 | 111 | 111 | 111 | 111 | 111 | 111 | 111 | 111 | 111 | 111 | 111 | 111 | 111 | 111 | 111 | 111 | 111 | 111 | 111 |
| | Will Breach | - | 20 | 18 | 18 | 16 | 15 | 12 | 10 | 8 | 6 | 4 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | Weekly Removals | 2 | 3 | 2 | 0 | 2 | 1 | 3 | 2 | 2 | 2 | 2 | 2 | | | | | | | | | | | | | | | | | | |
| | Target | 2 | 62 | 60 | 58 | 56 | 54 | 51 | 49 | 47 | 45 | 43 | 41 | 39 | 36 | 34 | 32 | 30 | 28 | 26 | 24 | 22 | 19 | 17 | 15 | 13 | 11 | 9 | 7 | 5 | 2 | 0 |
| | Difference | - | -42 | -42 | -40 | -40 | -39 | -39 | | | | | | | | | | | | | | | | | | | | | | | |
| | Future TCIs | 8 | | | | | | | 3 | 1 | | | | 1 | 1 | | 1 | | | | | 1 | | | | | | | | | |
| | Provisional TCIs | 0 | | | | | | | 0 | 0 | | | | 0 | 0 | | 0 | | | | | 0 | | | | | | | | | |
| 340 - Respiratory Medicine | Starting Cohort | - | 314 | 314 | 314 | 314 | 314 | 314 | 314 | 314 | 314 | 314 | 314 | 314 | 314 | 314 | 314 | 314 | 314 | 314 | 314 | 314 | 314 | 314 | 314 | 314 | 314 | 314 | 314 | 314 | 314 |
| | Will Breach | - | 35 | 29 | 29 | 23 | 21 | 18 | 15 | 12 | 9 | 6 | 3 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | Weekly Removals | 3 | 3 | 6 | 0 | 6 | 2 | 3 | 3 | 3 | 3 | 3 | 3 | | | | | | | | | | | | | | | | | | |
| | Target | 6 | 175 | 169 | 163 | 157 | 151 | 145 | 139 | 133 | 127 | 121 | 115 | 109 | 103 | 97 | 91 | 85 | 79 | 73 | 67 | 61 | 55 | 49 | 43 | 37 | 31 | 25 | 19 | 13 | 7 | 1 |
| | Difference | - | -140 | -140 | -134 | -134 | -130 | -127 | | | | | | | | | | | | | | | | | | | | | | | |
| | Future TCIs | 10 | | | | | | | 4 | 2 | 3 | | | | | | | | | 1 | | | | | | | | | | | |
| | Provisional TCIs | 0 | | | | | | | 0 | 0 | 0 | | | | | | | | | 0 | | | | | | | | | | | |
| 301 - Gastroenterology | Starting Cohort | - | 505 | 505 | 505 | 505 | 505 | 505 | 505 | 505 | 505 | 505 | 505 | 505 | 505 | 505 | 505 | 505 | 505 | 505 | 505 | 505 | 505 | 505 | 505 | 505 | 505 | 505 | 505 | 505 | 505 |
| | Will Breach | - | 67 | 54 | 48 | 41 | 39 | 36 | 28 | 20 | 12 | 4 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | Weekly Removals | 8 | 17 | 13 | 6 | 7 | 2 | 3 | 8 | 8 | 8 | 8 | | | | | | | | | | | | | | | | | | | |
| | Target | 10 | 282 | 273 | 263 | 253 | 244 | 234 | 224 | 214 | 205 | 195 | 185 | 176 | 166 | 156 | 147 | 137 | 127 | 118 | 108 | 98 | 89 | 79 | 69 | 59 | 50 | 40 | 30 | 21 | 11 | 1 |
| | Difference | - | -215 | -219 | -215 | -212 | -205 | -198 | | | | | | | | | | | | | | | | | | | | | | | |
| | Future TCIs | 17 | | | | | | | 4 | 5 | 3 | 2 | 1 | | 2 | | | | | | | | | | | | | | | | |
| | Provisional TCIs | 0 | | | | | | | 0 | 0 | 0 | 0 | 0 | | 0 | | | | | | | | | | | | | | | | |

## Commentary

For the overarching requirement of 78 week delivery by the end of March, delivery is ahead of trajectory at a Trust level, with 10,274 patients remaining in the cohort against a target of 12,359. There are 6 specialities behind plan and 1 specialty (Dermatology) that is forecast not to deliver against the requirement. All other specialities remain on track if current levels of removal sustain. System mutual aid is being progressed for 750 new outpatients in Dermatology to be taken on by other provider(s).

# Performance – Cancer 62-Day Backlog Profile




## Commentary

**September 2022 Performance**

The Trust's competing priorities in relation to the reduction of the 78 week routine position is still contributing to a slowed reduction in patients over 62 days. Backlogs appear to be rising however there is some level of administrative delay in removal from the pathway due to administrative vacancy, leave and sickness. New guidance distributed by NHS England in relation to removal of patients that are treated awaiting Histological Diagnosis is to be implemented week commencing 17th October. Implementation of this guidance and administrative catch up would result in a backlog reduction of approximately 150 patients.

**Improvement Actions**

1. Daily recovery tracker developed and launched in September 2022.
2. Implementation of new guidance to commence week commencing 17th October with Skin.
3. Oncology business case progressed to HMB investment group for discussion within October, however business case rejected as no funding stream identified.
4. Gynaecology business case progressed to full business case from business case review panel in October.

**Risk To Delivery**

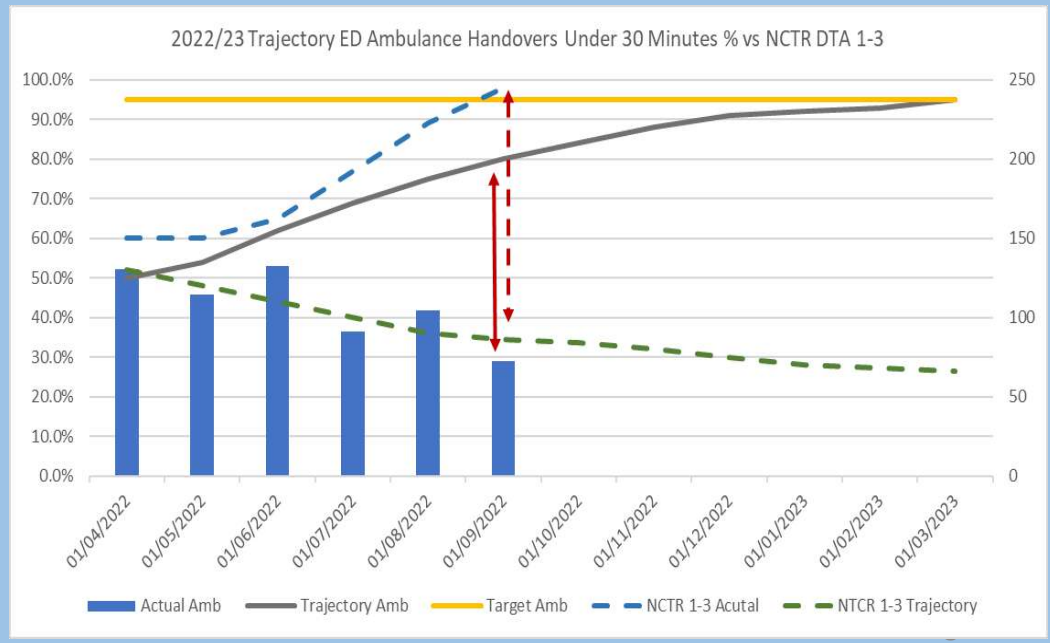
**RED**

# Performance – Ambulance Performance < 30 Minutes

NNUH Digital Health business intelligence

| Hospital Name | Oct-21 | Nov-21 | Dec-21 | Jan-22 | Feb-22 | Mar-22 | Apr-22 | May-22 | Jun-22 | Jul-22 | Aug-22 | Sep-22 | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Addenbrookes Hospital | 68.20% | 81.17% | 82.11% | 77.44% | 78.25% | 70.00% | 71.65% | 80.84% | 73.26% | 64.89% | 81.48% | 79.01% | 75.20% |
| Basildon & Thurrock Hospital | 83.33% | 76.09% | 82.67% | 89.63% | 80.36% | 64.68% | 60.36% | 59.42% | 59.60% | 54.01% | 54.86% | 47.10% | 70.53% |
| Bedford Hospital South Wing | 86.91% | 80.14% | 84.71% | 83.54% | 83.30% | 87.48% | 81.10% | 89.32% | 90.66% | 86.60% | 89.77% | 85.42% | 86.02% |
| Broomfield Hospital | 72.20% | 65.59% | 71.65% | 72.52% | 62.17% | 49.42% | 55.58% | 69.47% | 73.36% | 58.62% | 63.22% | 59.28% | 65.65% |
| Colchester General Hospital | 84.08% | 79.11% | 80.89% | 88.00% | 84.08% | 74.02% | 76.50% | 82.78% | 73.29% | 69.63% | 74.90% | 68.85% | 78.78% |
| Hinchingbrooke Hospital | 52.79% | 55.30% | 49.10% | 56.88% | 53.43% | 42.14% | 51.95% | 54.02% | 52.43% | 37.95% | 57.84% | 78.10% | 53.72% |
| Ipswich Hospital | 75.25% | 77.71% | 74.77% | 72.01% | 71.90% | 67.17% | 72.71% | 79.81% | 73.40% | 68.78% | 75.63% | 71.34% | 74.05% |
| James Paget Hospital | 57.13% | 72.69% | 65.83% | 67.87% | 55.03% | 54.23% | 57.76% | 67.12% | 51.08% | 35.67% | 33.38% | 32.98% | 56.29% |
| Lister Hospital | 45.81% | 51.58% | 55.14% | 49.45% | 50.75% | 41.01% | 31.25% | 38.72% | 39.14% | 24.19% | 34.01% | 23.62% | 41.94% |
| Luton And Dunstable Hospital | 85.09% | 80.29% | 81.42% | 80.95% | 78.10% | 79.12% | 78.61% | 82.02% | 76.43% | 73.65% | 77.58% | 73.31% | 79.65% |
| Norfolk & Norwich University Hospital | **57.90%** | **57.45%** | **60.03%** | **54.91%** | **46.49%** | **43.24%** | **51.25%** | **45.42%** | **52.14%** | **35.44%** | **40.47%** | **28.24%** | **50.61%** |
| Peterborough City Hospital | 48.27% | 38.10% | 39.20% | 36.91% | 37.48% | 28.28% | 33.89% | 36.06% | 35.89% | 29.19% | 40.22% | 46.09% | 38.09% |
| Princess Alexandra Hospital | 41.76% | 45.70% | 47.16% | 50.78% | 43.81% | 40.62% | 50.69% | 50.00% | 54.43% | 36.74% | 41.97% | 36.58% | 45.74% |
| Queen Elizabeth Hospital | 56.37% | 59.53% | 59.28% | 72.84% | 61.41% | 43.66% | 62.47% | 58.09% | 45.48% | 52.59% | 47.63% | 42.15% | 56.57% |
| Southend University Hospital | 68.41% | 57.38% | 64.61% | 56.70% | 49.09% | 40.76% | 45.92% | 47.08% | 52.02% | 52.54% | 46.57% | 41.49% | 54.79% |
| Watford General Hospital | 72.30% | 69.32% | 57.35% | 55.64% | 50.89% | 52.36% | 54.01% | 46.35% | 33.72% | 40.27% | 45.91% | 48.18% | 57.37% |
| West Suffolk Hospital | 84.66% | 87.54% | 88.38% | 88.57% | 91.07% | 85.17% | 89.28% | 90.58% | 79.92% | 83.68% | 82.17% | 86.85% | 86.80% |
| Total | 68.73% | 67.93% | 69.04% | 69.49% | 65.37% | 58.63% | 61.75% | 65.44% | 61.75% | 55.35% | 59.81% | 57.64% | 64.51% |

| KPI | 2. Ambulance Handover < 30 min | | |
|---|---|---|---|
| Target | 95% | | |
| | Actual | Trajectory | Latest Update |
| Apr-22 | 52.18% | 50.0% | Performance: Ranking 16th in region with significantly deteriorated performance and behind trajectory.<br><br>Root Cause: Continued issues, relating to the overall ED capacity and flow – exit block continues to be the main challenge with increasing high D2A 1 – 3 delays. Significant number of patients with no C2R.<br><br>Actions for the Next Period: Continued restructure of emergency flow process around PAU with revised metrics for ED, PAU, AMU and discharge to the community. Restructure of front door real estate to relocate cohort and dismantling of bed bays to support OPED. Implement internal IMT model of support from 20th October. Extend to System IMT from week commencing 31st October. |
| May-22 | 45.82% | 54.0% | |
| Jun-22 | 52.94% | 62.0% | |
| Jul-22 | 36.37% | 69.0% | |
| Aug-22 | 41.88% | 75.0% | |
| Sep-22 | 28.89% | 80.0% | |
| Oct-22 | | 84.0% | |
| Nov-22 | | 88.0% | |
| Dec-22 | | 91.0% | |
| Jan-23 | | 92.0% | |
| Feb-23 | | 93.0% | |
| Mar-23 | | 95.0% | |



# 110% Activity – September 2022 Forecast vs Plan Electives

| | | | | | | % Achievement of Plan | | |
|---|---|---|---|---|---|---|---|---|
| Plan - Elective IP | Plan - Elective DC | Plan - Total | Actual Delivery - Elective IP | Actual Delivery - Elective DC | Actual Delivery - Total | Total | Elective IP | Elective DC |
| 1,192 | 9,081 | 10,273 | 870 | 7,895 | 8,765 | 85.3% | 73.0% | 86.9% |

## Medicine

| Specialty | | Plan - Elective IP | Plan - Elective DC | Plan - Total | Actual Delivery - Elective IP | Actual Delivery - Elective DC | Actual Delivery - Total | % Achievement of Plan Total | Elective IP | Elective DC |
|---|---|---|---|---|---|---|---|---|---|---|
| 300 | General Internal Medicine | 0 | 0 | 0 | 0 | 0 | 0 | 0.0% | 0.0% | 0.0% |
| 301 | Gastroenterology | 24 | 2,143 | 2,167 | 10 | 1,885 | 1,895 | 87.5% | 43.2% | 87.9% |
| 302 | Endocrinology | 1 | 11 | 12 | 1 | 7 | 8 | 64.7% | 84.9% | 62.6% |
| 303 | Clinical Haematology | 33 | 956 | 988 | 25 | 928 | 953 | 96.4% | 76.5% | 97.1% |
| 308 | Blood and Marrow Transplantation | 1 | 7 | 8 | 0 | 2 | 2 | 23.8% | 0.0% | 27.7% |
| 315 | Palliative Medicine | 0 | 0 | 0 | 0 | 0 | 0 | 0.0% | 0.0% | 0.0% |
| 320 | Cardiology | 29 | 309 | 338 | 13 | 314 | 327 | 96.9% | 45.8% | 101.7% |
| 340 | Respiratory Medicine | 16 | 93 | 110 | 10 | 92 | 102 | 92.7% | 58.5% | 98.7% |
| 341 | Respiratory Physiology | 5 | 0 | 5 | 0 | 0 | 0 | 0.0% | 0.0% | 0.0% |
| 343 | Adult Cystic Fibrosis | 3 | 0 | 4 | 0 | 0 | 0 | 0.0% | 0.0% | 0.0% |
| 361 | Renal Medicine | 35 | 33 | 68 | 36 | 28 | 64 | 94.1% | 104.0% | 83.7% |
| 400 | Neurology | 1 | 54 | 55 | 1 | 130 | 131 | 239.5% | 113.5% | 241.6% |
| 410 | Rheumatology | 1 | 203 | 204 | 0 | 201 | 201 | 98.3% | 0.0% | 99.0% |
| 430 | Elderly Medicine | 0 | 8 | 8 | 0 | 5 | 5 | 61.7% | 0.0% | 64.8% |
| 800 | Clinical Oncology | 39 | 1,819 | 1,858 | 16 | 1,789 | 1,805 | 97.2% | 41.4% | 98.4% |
| 1 | Medicine | 189 | 5,637 | 5,826 | 112 | 5,381 | 5,493 | 94.3% | 59.5% | 95.5% |

## CSS

| Specialty | | Plan - Elective IP | Plan - Elective DC | Plan - Total | Actual Delivery - Elective IP | Actual Delivery - Elective DC | Actual Delivery - Total | % Acheivement of Plan Total | Elective IP | Elective DC |
|---|---|---|---|---|---|---|---|---|---|---|
| 811 | Interventional Radiology | 0 | 3 | 3 | 0 | 3 | 3 | 90.4% | 0.0% | 90.4% |
| 4 | CSS | 0 | 3 | 3 | 0 | 3 | 3 | 90.4% | 0.0% | 90.4% |

## Commentary

The focus on the delivery of the 104-week breaches impacted the volumes of activity through theatres due to complexity/case mix. % against 19/20 activity levels provide an indicative comparator as some technical adjustments have not been included in the calculations.

# 110% Activity – September 2022 Forecast vs Plan Electives

NNUH Digital Health business intelligence

## Surgery

| Specialty | | Plan - Elective IP | Plan - Elective DC | Plan - Total | Actual Delivery - Elective IP | Actual Delivery - Elective DC | Actual Delivery - Total | % Acheivement of Plan Total | % Acheivement of Plan Elective IP | % Acheivement of Plan Elective DC |
|---|---|---|---|---|---|---|---|---|---|---|
| 100 | General Surgery | 100 | 167 | 268 | 76 | 136 | 212 | 79.3% | 76.0% | 81.2% |
| 101 | Urology | 225 | 818 | 1,043 | 175 | 663 | 837 | 80.3% | 77.5% | 81.0% |
| 107 | Vascular Surgery | 50 | 76 | 126 | 38 | 62 | 100 | 79.3% | 76.4% | 81.1% |
| 108 | Spinal Surgery | 32 | 10 | 42 | 22 | 15 | 37 | 89.5% | 70.1% | 151.9% |
| 110 | Trauma and Orthopaedic | 221 | 222 | 442 | 149 | 126 | 275 | 62.3% | 67.5% | 57.0% |
| 120 | Ear Nose and Throat | 83 | 198 | 281 | 45 | 111 | 156 | 55.6% | 54.4% | 56.1% |
| 130 | Ophthalmology | 4 | 592 | 595 | 6 | 273 | 279 | 46.9% | 168.9% | 46.1% |
| 140 | Oral Surgery | 22 | 274 | 296 | 11 | 202 | 213 | 72.0% | 50.5% | 73.7% |
| 141 | Restorative Dentistry | 0 | 1 | 1 | 0 | 0 | 0 | 0.0% | 0.0% | 0.0% |
| 160 | Plastic Surgery | 54 | 223 | 277 | 37 | 122 | 159 | 57.4% | 68.4% | 54.7% |
| 173 | Thoracic Surgery | 39 | 6 | 45 | 36 | 2 | 38 | 83.5% | 92.1% | 31.5% |
| 191 | Pain Management | 0 | 210 | 210 | 0 | 97 | 97 | 46.2% | 0.0% | 46.3% |
| 192 | Intensive Care Medicine | 1 | 0 | 1 | 1 | 0 | 1 | 120.6% | 120.6% | 0.0% |
| 211 | Paediatric Urology | 0 | 0 | 0 | 0 | 9 | 9 | 0.0% | 0.0% | 0.0% |
| 214 | Paediatric Trauma and Orthopaedic | 12 | 20 | 33 | 15 | 18 | 33 | 100.4% | 121.5% | 87.9% |
| 215 | Paediatric Ear Nose and Throat | 8 | 18 | 26 | 12 | 24 | 36 | 138.2% | 151.5% | 132.3% |
| 216 | Paediatric Ophthalmology | 0 | 2 | 2 | 0 | 5 | 5 | 320.9% | 0.0% | 320.9% |
| 217 | Paediatric Oral and Maxillofacial Surgery | 0 | 3 | 3 | 1 | 10 | 11 | 424.7% | 1150.6% | 399.5% |
| 219 | Paediatric Plastic Surgery | 1 | 3 | 4 | 0 | 14 | 14 | 315.5% | 0.0% | 401.3% |
| 254 | Paediatric Audio Vestibular Medicine | 0 | 1 | 1 | 0 | 0 | 0 | 0.0% | 0.0% | 0.0% |
| 330 | Dermatology | 4 | 343 | 347 | 2 | 375 | 377 | 108.7% | 46.0% | 109.5% |
| 2 | Surgery | 856 | 3,187 | 4,043 | 626 | 2,264 | 2,890 | 71.5% | 73.1% | 71.1% |

## Women & Children

| Specialty | | Plan - Elective IP | Plan - Elective DC | Plan - Total | Actual Delivery - Elective IP | Actual Delivery - Elective DC | Actual Delivery - Total | % Acheivement of Plan Total | % Acheivement of Plan Elective IP | % Acheivement of Plan Elective DC |
|---|---|---|---|---|---|---|---|---|---|---|
| 171 | Paediatric Surgery | 30 | 30 | 61 | 9 | 34 | 43 | 70.7% | 29.6% | 111.9% |
| 251 | Paediatric Gastroenterology | 1 | 12 | 13 | 0 | 17 | 17 | 137.3% | 0.0% | 149.0% |
| 252 | Paediatric Endocrinology | 0 | 15 | 16 | 0 | 21 | 21 | 135.5% | 0.0% | 138.7% |
| 258 | Paediatric Respiratory Medicine | 1 | 37 | 37 | 0 | 1 | 1 | 2.7% | 0.0% | 2.7% |
| 260 | Paediatric Medical Oncology | 0 | 1 | 1 | 0 | 23 | 23 | 3598.1% | 0.0% | 3598.1% |
| 262 | Paediatric Rheumatology | 1 | 7 | 8 | 0 | 15 | 15 | 197.4% | 0.0% | 212.7% |
| 420 | Paediatrics | 2 | 58 | 60 | 0 | 47 | 47 | 78.1% | 0.0% | 81.0% |
| 421 | Paediatric Neurology | 0 | 0 | 0 | 0 | 0 | 0 | 0.0% | 0.0% | 0.0% |
| 502 | Gynaecology | 111 | 94 | 205 | 123 | 89 | 212 | 103.3% | 110.9% | 94.5% |
| 3 | W&C | 147 | 254 | 401 | 132 | 247 | 379 | 94.5% | 89.6% | 97.4% |

# 110% Activity – September 2022 Forecast vs Plan Outpatients

NNUH Digital Health business intelligence

| | Plan - New | New - Face to Face | New with Procedure - Face to Face | New - Telephone | New - Video | % Achievement of Plan New |
|---|---|---|---|---|---|---|
| Trust Total | 25,279 | 16,923 | 3,765 | 2,504 | 385 | 78.4% |

## Medicine

| | Plan - New | New - Face to Face | New with Procedure - Face to Face | New - Telephone | New - Video | % of Plan New |
|---|---|---|---|---|---|---|
| General Internal Medicine | 479 | 351 | 0 | 7 | 0 | 74.7% |
| Gastroenterology | 641 | 145 | 0 | 184 | 0 | 51.3% |
| Endocrinology | 191 | 168 | 0 | 0 | 0 | 87.7% |
| Clinical Haematology | 544 | 476 | 0 | 15 | 3 | 90.9% |
| Hepatology | 142 | 99 | 0 | 17 | 0 | 81.5% |
| Diabetes | 351 | 158 | 0 | 123 | 7 | 82.1% |
| Blood and Marrow Transplantation | 1 | 1 | 0 | 0 | 0 | 113.9% |
| Palliative Medicine | 243 | 204 | 0 | 2 | 0 | 84.9% |
| Cardiology | 804 | 685 | 72 | 117 | 0 | 99.8% |
| Transient Ischaemic Attack | 115 | 99 | 18 | 12 | 0 | 96.4% |
| Congenital Heart Disease | 16 | 8 | 0 | 2 | 0 | 59.8% |
| Respiratory Medicine | 269 | 246 | 1 | 15 | 1 | 97.1% |
| Respiratory Physiology | 136 | 18 | 0 | 92 | 0 | 81.0% |
| Infectious Diseases | 0 | 0 | 0 | 236 | 0 | 0.0% |
| Renal Medicine | 104 | 71 | 0 | 58 | 0 | 123.8% |
| Neurology | 584 | 386 | 1 | 15 | 0 | 68.6% |
| Clinical Neurophysiology | 414 | 297 | 252 | 0 | 0 | 71.7% |
| Rheumatology | 455 | 352 | 5 | 7 | 0 | 78.8% |
| Elderly Medicine | 135 | 106 | 0 | 2 | 0 | 79.8% |
| Podiatry | 141 | 97 | 0 | 0 | 0 | 68.6% |
| Clinical Oncology | 1,076 | 284 | 0 | 145 | 0 | 39.9% |
| Medicine | 6,843 | 4,250 | 350 | 1,048 | 11 | 77.6% |

## W&C

| | Plan - New | New - Face to Face | New with Procedure - Face to Face | New - Telephone | New - Video | % of Plan New |
|---|---|---|---|---|---|---|
| Paediatric Surgery | 267 | 237 | 117 | 11 | 12 | 97.4% |
| Paediatric Gastroenterology | 39 | 15 | 0 | 0 | 0 | 38.8% |
| Paediatric Endocrinology | 28 | 32 | 0 | 1 | 1 | 120.2% |
| Paediatric Clinical Haematology | 3 | 2 | 0 | 0 | 0 | 65.0% |
| Paediatric Respiratory Medicine | 38 | 26 | 0 | 11 | 0 | 96.0% |
| Paediatric Medical Oncology | 2 | 2 | 0 | 0 | 0 | 131.7% |
| Paediatric Rheumatology | 25 | 18 | 0 | 0 | 0 | 72.9% |
| Paediatric Diabetes | 5 | 7 | 0 | 0 | 0 | 151.2% |
| Paediatric Cystic Fibrosis | 1 | 0 | 0 | 0 | 0 | 0.0% |
| Paediatric Cardiology | 0 | 38 | 0 | 0 | 0 | 0.0% |
| Paediatrics | 478 | 265 | 0 | 194 | 0 | 96.0% |
| Paediatric Neurology | 58 | 62 | 0 | 0 | 0 | 105.8% |
| Obstetrics | 628 | 305 | 0 | 0 | 212 | 82.4% |
| Gynaecology | 1,242 | 1,071 | 463 | 16 | 0 | 87.4% |
| Gynaecological Oncology | 76 | 48 | 5 | 0 | 0 | 63.5% |
| Fetal Medicine Service | 0 | 61 | 0 | 0 | 0 | 0.0% |
| **W&C** | **2,890** | **2,188** | **584** | **233** | **225** | **91.6%** |

**Commentary**

% against 19/20 activity levels provide an indicative comparator as some technical adjustments have not been included in the calculations.

# 110% Activity – September 2022 Forecast vs Plan Outpatients

NNUH Digital Health business intelligence

| Surgery | Plan - New | New - Face to Face | New with Procedure - Face to Face | New - Telephone | New - Video | % of Plan New |
|---|---|---|---|---|---|---|
| General Surgery | 1,407 | 1,336 | 48 | 288 | 0 | 115.4% |
| Urology | 1,743 | 1,276 | 178 | 176 | 0 | 83.3% |
| Vascular Surgery | 213 | 174 | 12 | 14 | 0 | 88.3% |
| Spinal Surgery | 202 | 91 | 1 | 4 | 0 | 46.8% |
| Trauma and Orthopaedic | 1,585 | 1,282 | 4 | 66 | 0 | 85.1% |
| Ear Nose and Throat | 1,928 | 1,169 | 618 | 36 | 0 | 62.5% |
| Ophthalmology | 2,089 | 1,345 | 507 | 1 | 4 | 64.6% |
| Oral Surgery | 451 | 237 | 0 | 3 | 0 | 53.2% |
| Restorative Dentistry | 4 | 2 | 0 | 0 | 0 | 47.8% |
| Orthodontic | 26 | 17 | 1 | 0 | 0 | 65.6% |
| Maxillofacial Surgery | 29 | 18 | 0 | 0 | 0 | 62.3% |
| Plastic Surgery | 391 | 290 | 13 | 12 | 3 | 78.1% |
| Thoracic Surgery | 34 | 16 | 0 | 0 | 0 | 47.3% |
| Emergency Medicine | 15 | 8 | 0 | 0 | 0 | 52.5% |
| Anaesthetic | 12 | 0 | 0 | 0 | 0 | 0.0% |
| Pain Management | 246 | 124 | 0 | 55 | 0 | 72.8% |
| Paediatric Urology | 17 | 20 | 0 | 0 | 0 | 116.5% |
| Paediatric Trauma and Orthopaedic | 301 | 101 | 0 | 151 | 0 | 83.7% |
| Paediatric Ear Nose and Throat | 240 | 81 | 17 | 3 | 0 | 35.3% |
| Paediatric Ophthalmology | 206 | 131 | 10 | 0 | 0 | 63.6% |
| Paediatric Plastic Surgery | 21 | 20 | 2 | 0 | 0 | 94.4% |
| Paediatric Audio Vestibular Medicine | 270 | 235 | 126 | 0 | 0 | 87.1% |
| Paediatric Dermatology | 61 | 48 | 20 | 0 | 0 | 78.5% |
| Clinical Physiology | 200 | 111 | 89 | 0 | 0 | 55.6% |
| Audio Vestibular Medicine | 176 | 75 | 55 | 6 | 7 | 49.9% |
| Allergy | 5 | 3 | 1 | 0 | 0 | 60.1% |
| Dermatology | 1,249 | 1,109 | 912 | 58 | 0 | 93.4% |
| Orthotics | 169 | 108 | 0 | 0 | 0 | 63.9% |
| Audiology | 605 | 344 | 180 | 0 | 0 | 56.9% |
| Surgery | 13,896 | 9,772 | 2,791 | 874 | 14 | 76.7% |

| CSS | Plan - New | New - Face to Face | New with Procedure - Face to Face | New - Telephone | New - Video | % of Plan New |
|---|---|---|---|---|---|---|
| Clinical Genetics | 12 | 0 | 0 | 0 | 0 | 0.0% |
| Physiotherapy | 849 | 427 | 8 | 155 | 78 | 77.8% |
| Occupational Therapy | 377 | 193 | 31 | 46 | 6 | 65.0% |
| Speech and Language Therapy | 53 | 18 | 0 | 10 | 2 | 57.7% |
| Dietetics | 340 | 55 | 0 | 132 | 46 | 68.3% |
| Child and Adolescent Psychiatry | 12 | 11 | 0 | 1 | 2 | 114.1% |
| Interventional Radiology | 6 | 8 | 0 | 5 | 0 | 200.3% |
| CSS | 1,651 | 712 | 39 | 349 | 135 | 72.4% |

# Activity – Non-Theatre Activity 120% – Medicine

NNUH Digital Health business intelligence

| Speciality | Values | April | May | June | July | August | Septemt | October | Novembe | Decembe | January | February | March | YTD |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 308 - Blood and Marrow Transplantation | | | | | | | | | | | | | | |
| | 22/23Actual | | | 2 | 1 | | 4 | | | | | | | 7 |
| | 19/20 - 120% | 19 | 8 | 5 | 4 | 5 | 12 | 7 | 4 | 11 | 7 | 6 | 4 | 53 |
| | % of 19/20 | | | 50% | 33% | | 40% | | | | | | | 16% |
| | **Variance to 120%** | | | **-3** | **-3** | | **-8** | | | | | | | **-46** |
| 302 - Endocrinology | | | | | | | | | | | | | | |
| | 22/23Actual | 6 | 10 | 13 | 9 | 10 | 8 | | | | | | | 56 |
| | 19/20 - 120% | 5 | 18 | 8 | 19 | 13 | 10 | 17 | 16 | 7 | 13 | 14 | 7 | 73 |
| | % of 19/20 | 150% | 67% | 186% | 56% | 91% | 100% | | | | | | | 92% |
| | **Variance to 120** | **1** | **-8** | **5** | **-10** | **-3** | **-2** | | | | | | | **-17** |
| 301 - Gastroenterology | | | | | | | | | | | | | | |
| | 22/23Actual | 1,811 | 2,037 | 1,851 | 1,703 | 2,086 | 1,886 | | | | | | | 11,374 |
| | 19/20 - 120% | 2,147 | 2,317 | 2,202 | 2,552 | 2,099 | 2,161 | 2,369 | 2,198 | 2,258 | 2,405 | 2,251 | 1,368 | 13,478 |
| | % of 19/20 | 101% | 105% | 101% | 80% | 119% | 105% | | | | | | | 101% |
| | **Variance to 120** | **-336** | **-280** | **-351** | **-849** | **-13** | **-275** | | | | | | | **-2,104** |
| 303 - Clinical Haematology | | | | | | | | | | | | | | |
| | 22/23Actual | 824 | 968 | 883 | 892 | 982 | 933 | | | | | | | 5,482 |
| | 19/20 - 120% | 944 | 1,100 | 978 | 1,024 | 1,046 | 966 | 1,058 | 1,051 | 1,006 | 1,093 | 1,028 | 887 | 6,059 |
| | % of 19/20 | 105% | 106% | 108% | 105% | 113% | 116% | | | | | | | 109% |
| | **Variance to 120** | **-120** | **-132** | **-95** | **-132** | **-64** | **-33** | | | | | | | **-577** |
| 320 - Cardiology | | | | | | | | | | | | | | |
| | 22/23Actual | 276 | 270 | 327 | 310 | 325 | 332 | | | | | | | 1,840 |
| | 19/20 - 120% | 313 | 328 | 260 | 304 | 300 | 304 | 330 | 344 | 334 | 402 | 412 | 419 | 1,808 |
| | % of 19/20 | 106% | 99% | 151% | 123% | 130% | 131% | | | | | | | 122% |
| | **Variance to 120** | **-37** | **-58** | **67** | **6** | **25** | **28** | | | | | | | **32** |
| 800 - Clinical Oncology | | | | | | | | | | | | | | |
| | 22/23Actual | 1,777 | 1,817 | 1,791 | 1,678 | 1,905 | 1,798 | | | | | | | 10,766 |
| | 19/20 - 120% | 1,975 | 2,116 | 1,843 | 2,176 | 2,045 | 1,964 | 2,134 | 1,888 | 1,812 | 1,966 | 1,760 | 1,914 | 12,119 |
| | % of 19/20 | 108% | 103% | 117% | 93% | 112% | 110% | | | | | | | 107% |
| | **Variance to 120** | **-198** | **-299** | **-52** | **-498** | **-140** | **-166** | | | | | | | **-1,353** |
| 340 - Respiratory Medicine | | | | | | | | | | | | | | |
| | 22/23Actual | 86 | 115 | 108 | 114 | 89 | 92 | | | | | | | 604 |
| | 19/20 - 120% | 97 | 90 | 94 | 106 | 98 | 91 | 96 | 96 | 97 | 115 | 110 | 74 | 576 |
| | % of 19/20 | 106% | 153% | 138% | 130% | 109% | 121% | | | | | | | 126% |
| | **Variance to 120** | **-11** | **25** | **14** | **8** | **-9** | **1** | | | | | | | **28** |
| 410 - Rheumatology | | | | | | | | | | | | | | |
| | 22/23Actual | 203 | 223 | 233 | 253 | 237 | 201 | | | | | | | 1,350 |
| | 19/20 - 120% | 202 | 217 | 216 | 224 | 218 | 174 | 220 | 260 | 205 | 240 | 222 | 113 | 1,252 |
| | % of 19/20 | 121% | 123% | 129% | 135% | 130% | 139% | | | | | | | 129% |
| | **Variance to 120** | **1** | **6** | **17** | **29** | **19** | **27** | | | | | | | **98** |
| 361 - Renal Medicine | | | | | | | | | | | | | | |
| | 22/23Actual | 51 | 48 | 48 | 23 | 45 | 28 | | | | | | | 243 |
| | 19/20 - 120% | 29 | 36 | 30 | 43 | 24 | 36 | 34 | 31 | 28 | 35 | 35 | 26 | 198 |
| | % of 19/20 | 213% | 160% | 192% | 64% | 225% | 93% | | | | | | | 147% |
| | **Variance to 120** | **22** | **12** | **18** | **-20** | **21** | **-8** | | | | | | | **45** |
| 400 - Neurology | | | | | | | | | | | | | | |
| | 22/23Actual | 124 | 115 | 116 | 136 | 146 | 130 | | | | | | | 767 |
| | 19/20 - 120% | 62 | 65 | 44 | 49 | 58 | 47 | 67 | 44 | 47 | 68 | 72 | 52 | 325 |
| | % of 19/20 | 238% | 213% | 314% | 332% | 304% | 333% | | | | | | | 283% |
| | **Variance to 120** | **62** | **50** | **72** | **87** | **88** | **83** | | | | | | | **442** |
| **Total 22/23Actual** | | **5,158** | **5,603** | **5,372** | **5,119** | **5,825** | **5,412** | | | | | | | **32,489** |
| **Total 19/20 - 120%** | | **5,794** | **6,295** | **5,681** | **6,500** | **5,906** | **5,765** | **6,331** | **5,933** | **5,804** | **6,344** | **5,911** | **4,864** | **35,941** |
| **Total % of 19/20** | | **107%** | **107%** | **113%** | **94%** | **118%** | **113%** | | | | | | | **108%** |
| **Total Variance to 120%** | | **-636** | **-692** | **-309** | **-1,381** | **-81** | **-353** | | | | | | | **-3,452** |

## Commentary

To compensate for the reduced throughput in Main Theatres to match the demands of 104 and 78 weeks and the cancer priorities, the non-theatre day cases will aim to deliver at 120% of 19/20 levels.

This process and tracking commenced in July and will be managed as part of the 104-week elective process, established in October.

## Medicine – Non Theatre Daycase Activity September

**Achieved 113% of 19/20**

# Activity – Non-Theatre Activity 120% – Surgery & Women and Children's

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| Speciality | Values | April | May | June | July | August | Septem | October | Novemb | Decemb | January | Februar | March | YTD |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **130 – Ophthalmology** | | | | | | | | | | | | | | |
| | 22/23 Actual | 204 | 224 | 294 | 221 | 249 | 274 | | | | | | | 1466 |
| | 19/20 - 120% | 612 | 714 | 642 | 743 | 670 | 679 | 642 | 716 | 544 | 670 | 557 | 410 | 4,060 |
| | % of 19/20 | 40% | 38% | 55% | 36% | 45% | 48% | | | | | | | 43% |
| | **Variance to 12** | **-408** | **-490** | **-348** | **-522** | **-421** | **-405** | | | | | | | **-2,594** |
| **191 – Pain Management** | | | | | | | | | | | | | | |
| | 22/23 Actual | 38 | 42 | 43 | 68 | 36 | 44 | | | | | | | 271 |
| | 19/20 - 120% | 102 | 108 | 109 | 108 | 90 | 121 | 112 | 120 | 91 | 95 | 114 | 67 | 638 |
| | % of 19/20 | 45% | 47% | 47% | 76% | 48% | 44% | | | | | | | 51% |
| | **Variance to 12** | **-64** | **-66** | **-66** | **-40** | **-54** | **-77** | | | | | | | **-367** |
| **100 – General Surgery** | | | | | | | | | | | | | | |
| | 22/23 Actual | 12 | 20 | 24 | 24 | 18 | 10 | | | | | | | 108 |
| | 19/20 - 120% | 31 | 28 | 31 | 50 | 20 | 38 | 32 | 35 | 30 | 20 | 37 | 35 | 199 |
| | % of 19/20 | 46% | 87% | 92% | 57% | 106% | 31% | | | | | | | 65% |
| | **Variance to 12** | **-19** | **-8** | **-7** | **-26** | **-2** | **-28** | | | | | | | **-91** |
| **120 – Ear Nose and Throat** | | | | | | | | | | | | | | |
| | 22/23 Actual | 23 | 27 | 24 | 27 | 32 | 27 | | | | | | | 160 |
| | 19/20 - 120% | 40 | 30 | 50 | 43 | 54 | 36 | 55 | 48 | 44 | 41 | 40 | 37 | 253 |
| | % of 19/20 | 70% | 108% | 57% | 75% | 71% | 90% | | | | | | | 76% |
| | **Variance to 12** | **-17** | **-3** | **-26** | **-16** | **-22** | **-9** | | | | | | | **-93** |
| **107 – Vascular Surgery** | | | | | | | | | | | | | | |
| | 22/23 Actual | 23 | 18 | 21 | 33 | 22 | 39 | | | | | | | 156 |
| | 19/20 - 120% | 41 | 44 | 52 | 47 | 40 | 50 | 31 | 40 | 38 | 41 | 31 | 46 | 274 |
| | % of 19/20 | 68% | 49% | 49% | 85% | 67% | 93% | | | | | | | 68% |
| | **Variance to 12** | **-18** | **-26** | **-31** | **-14** | **-18** | **-11** | | | | | | | **-118** |
| **140 – Oral Surgery** | | | | | | | | | | | | | | |
| | 22/23 Actual | 100 | 214 | 184 | 160 | 179 | 158 | | | | | | | 995 |
| | 19/20 - 120% | 293 | 245 | 210 | 227 | 216 | 162 | 251 | 221 | 149 | 202 | 191 | 146 | 1,352 |
| | % of 19/20 | 41% | 105% | 105% | 85% | 99% | 117% | | | | | | | 88% |
| | **Variance to 12** | **-193** | **-31** | **-26** | **-67** | **-37** | **-4** | | | | | | | **-357** |
| **330 – Dermatology** | | | | | | | | | | | | | | |
| | 22/23 Actual | 301 | 255 | 261 | 268 | 355 | 375 | | | | | | | 1815 |
| | 19/20 - 120% | 374 | 390 | 342 | 379 | 408 | 325 | 420 | 385 | 349 | 347 | 348 | 289 | 2,219 |
| | % of 19/20 | 96% | 78% | 92% | 85% | 104% | 138% | | | | | | | 98% |
| | **Variance to 12** | **-73** | **-135** | **-81** | **-111** | **-53** | **50** | | | | | | | **-404** |
| **101 – Urology** | | | | | | | | | | | | | | |
| | 22/23 Actual | 125 | 114 | 117 | 117 | 109 | 143 | | | | | | | 725 |
| | 19/20 - 120% | 72 | 71 | 110 | 126 | 106 | 110 | 154 | 139 | 109 | 108 | 102 | 107 | 595 |
| | % of 19/20 | 208% | 193% | 127% | 111% | 124% | 155% | | | | | | | 146% |
| | **Variance to 12** | **53** | **43** | **7** | **-9** | **3** | **33** | | | | | | | **130** |
| **214 – Paediatric Trauma and Orthopaedic** | | | | | | | | | | | | | | |
| | 22/23 Actual | 4 | 4 | 3 | | 3 | 6 | | | | | | | 20 |
| | 19/20 - 120% | 2 | 1 | 2 | 2 | 5 | 4 | 5 | 2 | 2 | 1 | 4 | 1 | 17 |
| | % of 19/20 | 200% | 400% | 150% | | 75% | 200% | | | | | | | 143% |
| | **Variance to 12** | **2** | **3** | **1** | | **-2** | **2** | | | | | | | **3** |
| **160 – Plastic Surgery** | | | | | | | | | | | | | | |
| | 22/23 Actual | 96 | 69 | 93 | 75 | 60 | 65 | | | | | | | 458 |
| | 19/20 - 120% | 37 | 48 | 54 | 59 | 55 | 52 | 55 | 54 | 26 | 56 | 38 | 29 | 305 |
| | % of 19/20 | 310% | 173% | 207% | 153% | 130% | 151% | | | | | | | 180% |
| | **Variance to 12** | **59** | **21** | **39** | **16** | **5** | **13** | | | | | | | **153** |
| **110 – Trauma and Orthopaedic** | | | | | | | | | | | | | | |
| | 22/23 Actual | 38 | 57 | 53 | 48 | 61 | 60 | | | | | | | 317 |
| | 19/20 - 120% | 17 | 23 | 16 | 25 | 25 | 23 | 13 | 31 | 6 | 29 | 10 | 18 | 128 |
| | % of 19/20 | 271% | 300% | 408% | 229% | 290% | 316% | | | | | | | 296% |
| | **Variance to 12** | **21** | **34** | **37** | **23** | **36** | **37** | | | | | | | **189** |
| **Total 22/23 Actual** | | **964** | **1044** | **1117** | **1041** | **1124** | **1201** | | | | | | | **6491** |
| **Total 19/20 – 120%** | | **1,621** | **1,702** | **1,619** | **1,810** | **1,688** | **1,601** | **1,770** | **1,792** | **1,390** | **1,609** | **1,471** | **1,186** | **10,040** |
| **Total % of 19/20** | | **71%** | **74%** | **83%** | **69%** | **80%** | **90%** | | | | | | | **78%** |
| **Total Variance to 120%** | | **-657** | **-658** | **-502** | **-769** | **-564** | **-400** | | | | | | | **-3,549** |

| Speciality | Values | April | May | June | July | August | Septemt | October | Novembi | Decembi | January | Februar | March | YTD |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **258 – Paediatric Respiratory Medicine** | | | | | | | | | | | | | | |
| | 22/23 Actual | | | 2 | 2 | 2 | 1 | | | | | | | 7 |
| | 19/20 - 120% | 40 | 44 | 42 | 52 | 41 | 31 | 40 | 36 | 23 | 55 | 36 | 28 | 250 |
| | % of 19/20 | | | 6% | 5% | 6% | 4% | | | | | | | 3% |
| | **Variance to 120%** | | | **-40** | **-50** | **-39** | **-30** | | | | | | | **-243** |
| **171 – Paediatric Surgery** | | | | | | | | | | | | | | |
| | 22/23 Actual | 2 | 4 | 1 | 1 | 3 | | | | | | | | 11 |
| | 19/20 - 120% | 5 | 5 | 2 | 2 | 4 | 1 | 2 | 4 | 1 | 1 | 4 | 8 | 19 |
| | % of 19/20 | 50% | 100% | 50% | 50% | 100% | | | | | | | | 69% |
| | **Variance to 120** | **-3** | **-1** | **-1** | **-1** | **-1** | | | | | | | | **-8** |
| **420 – Paediatric** | | | | | | | | | | | | | | |
| | 22/23 Actual | 29 | 20 | 37 | 34 | 46 | 47 | | | | | | | 213 |
| | 19/20 - 120% | 48 | 43 | 41 | 61 | 50 | 61 | 73 | 88 | 73 | 84 | 71 | 25 | 305 |
| | % of 19/20 | 73% | 56% | 109% | 67% | 110% | 92% | | | | | | | 84% |
| | **Variance to 120** | **-19** | **-23** | **-4** | **-27** | **-4** | **-14** | | | | | | | **-92** |
| **502 – Gynaecology** | | | | | | | | | | | | | | |
| | 22/23 Actual | 23 | 18 | 19 | 10 | 20 | 9 | | | | | | | 99 |
| | 19/20 - 120% | 13 | 18 | 25 | 32 | 11 | 18 | 22 | 14 | 31 | 23 | 24 | 28 | 118 |
| | % of 19/20 | 209% | 120% | 90% | 37% | 222% | 60% | | | | | | | 101% |
| | **Variance to 120** | **10** | **0** | **-6** | **-22** | **9** | **-9** | | | | | | | **-19** |
| **252 – Paediatric Endocrinology** | | | | | | | | | | | | | | |
| | 22/23 Actual | 19 | 15 | 11 | 14 | 14 | 21 | | | | | | | 94 |
| | 19/20 - 120% | 11 | 12 | 12 | 14 | 11 | 24 | 13 | 12 | 14 | 29 | 20 | 13 | 84 |
| | % of 19/20 | 211% | 150% | 110% | 117% | 156% | 105% | | | | | | | 134% |
| | **Variance to 120** | **8** | **3** | **-1** | **-0** | **3** | **-3** | | | | | | | **10** |
| **262 – Paediatric Rheumatology** | | | | | | | | | | | | | | |
| | 22/23 Actual | 20 | 15 | 14 | 20 | 14 | 15 | | | | | | | 98 |
| | 19/20 - 120% | 6 | 2 | 6 | 7 | 4 | 8 | 7 | 11 | 6 | 10 | 5 | 10 | 34 |
| | % of 19/20 | 400% | 750% | 280% | 333% | 467% | 214% | | | | | | | 350% |
| | **Variance to 120** | **14** | **13** | **8** | **13** | **10** | **7** | | | | | | | **64** |
| **251 – Paediatric Gastroenterology** | | | | | | | | | | | | | | |
| | 22/23 Actual | 3 | 7 | 11 | 3 | 7 | 10 | | | | | | | 41 |
| | 19/20 - 120% | 6 | | 1 | 4 | 1 | 5 | 1 | 1 | 1 | | 2 | 1 | 17 |
| | % of 19/20 | 60% | | 1100% | 100% | 700% | 250% | | | | | | | 293% |
| | **Variance to 120** | **-3** | | **10** | **-1** | **6** | **5** | | | | | | | **24** |
| **260 – Paediatric Medical Oncology** | | | | | | | | | | | | | | |
| | 22/23 Actual | 18 | 33 | 37 | 34 | 31 | 23 | | | | | | | 176 |
| | 19/20 - 120% | | 2 | 2 | 1 | | 1 | 2 | 1 | 1 | 2 | | 1 | 7 |
| | % of 19/20 | | 1650% | 1850% | 3400% | | 2300% | | | | | | | 2933% |
| | **Variance to 120%** | | **31** | **35** | **33** | | **22** | | | | | | | **169** |
| **Total 22/23 Actual** | | **114** | **112** | **132** | **118** | **137** | **126** | | | | | | | **739** |
| **Total 19/20 – 120%** | | **128** | **127** | **132** | **174** | **121** | **150** | **161** | **167** | **151** | **204** | **162** | **114** | **833** |
| **Total % of 19/20** | | **107%** | **106%** | **120%** | **81%** | **136%** | **101%** | | | | | | | **106%** |
| **Total Variance to 120%** | | **-14** | **-15** | **0** | **-56** | **16** | **-24** | | | | | | | **-94** |

**Women & Children's – Non Theatre Daycase Activity September**

**Achieved 101% of 19/20**

# Supplementary Report

# Non-Elective Care

# Non-Elective Summary Overview

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## NNUH Non-Elective Recovery & Improvement Plan 2022/23

### Core Clinical Review Standards

| KPI | 1. Ambulance Handover < 15 min | | | 2. Ambulance Handover < 30 min | | | 3. Ambulance Handover > 60 min | | | 4. Initial Assessment < 15 mins | | | 5. Admitted within 1 hour of clinically ready to proceed | | | 6. Total Time in ED < 12 hours | | | 7. Average Time in ED (Non-Adm) | | | 8. 4hr Standard | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Target | 65% | | | 95% | | | 5% | | | 100% | | | 100% | | | 98% | | | 220 | | | 95% | | |
| | Actual | Trajectory | Latest Update | Actual | Trajectory | Latest Update | Actual | Trajectory | Latest Update | Actual | Trajectory | Latest Update | Actual | Trajectory | Latest Update | Actual | Trajectory | Latest Update | Actual | Trajectory | Latest Update | Actual | Trajectory | Latest Update |
| Apr-22 | 24.93% | 25.0% | Behind trajectory. Critical incident level actions deployed. Standing up AMU's. | 52.18% | 50.0% | Significantly adrift from trajectory and prior months performance. Challenges finding suitable patients to cohort and large volumes of DTAs in ED affecting offloads. No criteria to reside hindering flow. | 30.37% | 32.0% | Higher than forecast due to exit block from ED and acuity - rapid release launched to mitigate risk with support from NHSEI. Looking at expediting reverse cohort options as part of recovery plan | 43.52% | 31.7% | Behind trajectory, high acuity walk in. | 23.39% | 19.2% | Flow on to wards limited, congestion with 7 in a 6 bed bay. | 88.58% | 88.4% | Slightly below trajectory with a surge in walk in activity and the department being OPEL 4 with very high volumes of patients. Tracker Team being re-trained to focus on unblocking delays and imaging diagnostic action plan in progress. | 272 | 293 | Adrift by 23 minutes - linked to higher activity volumes especially in the evenings. Admission avoidance for ICT25 and WiC. | 70.27% | 63.9% | Slightly behind trajectory. |
| May-22 | 20.59% | 28.0% | | 45.82% | 54.0% | | 31.71% | 28.0% | | 37.22% | 40.0% | | 16.46% | 24.0% | | 88.73% | 89.0% | | 275 | 290 | | 68.42% | 64.0% | |
| Jun-22 | 25.12% | 35.0% | | 52.94% | 62.0% | | 25.77% | 25.0% | | 40.23% | 49.0% | | 15.30% | 30.0% | | 88.68% | 90.0% | | 282 | 286 | | 68.11% | 66.0% | |
| Jul-22 | 14.33% | 40.0% | | 36.37% | 69.0% | | 43.54% | 20.0% | | 37.57% | 62.0% | | 15.05% | 38.0% | | 86.50% | 90.5% | | 294 | 280 | | 66.85% | 68.0% | |
| Aug-22 | 16.30% | 45.0% | | 41.88% | 75.0% | | 37.38% | 16.0% | | 43.95% | 68.0% | | 11.53% | 49.0% | | 86.43% | 91.0% | | 278 | 275 | | 70.45% | 70.0% | |
| Sep-22 | 10.24% | 50.0% | | 28.89% | 80.0% | | 52.05% | 12.0% | | 40.60% | 76.0% | | 13.05% | 57.0% | | 85.17% | 92.0% | | 293 | 270 | | 68.64% | 72.0% | |
| Oct-22 | | 55.0% | | | 84.0% | | | 10.0% | | | 80.0% | | | 70.0% | | | 94.0% | | | 261 | | | 76.0% | |
| Nov-22 | | 60.0% | | | 88.0% | | | 9.0% | | | 86.0% | | | 78.0% | | | 95.0% | | | 250 | | | 78.0% | |
| Dec-22 | | 61.0% | | | 91.0% | | | 8.0% | | | 89.0% | | | 87.0% | | | 96.0% | | | 240 | | | 85.0% | |
| Jan-23 | | 62.0% | | | 92.0% | | | 8.0% | | | 95.0% | | | 94.0% | | | 97.0% | | | 232 | | | 89.0% | |
| Feb-23 | | 63.0% | | | 93.0% | | | 7.0% | | | 98.0% | | | 98.0% | | | 97.5% | | | 228 | | | 91.0% | |
| Mar-23 | | 65.0% | | | 95.0% | | | 5.0% | | | 100.0% | | | 100.0% | | | 98.0% | | | 220 | | | 95.0% | |

### Non-elective Improvement Additional Internal KPIs

| KPI | 9. SDEC Activity as total of emergency presentations excl. ED | | | 10. Average Time in ED (Adm) | | | 11. Virtual Ward Activity | | | 12. Average LOS | | | 13. D2A 0 Patients NC2R | | | 14. GP Streaming | | | 15. D2A 1 - 3 Patients NC2R (now <6.5% of bed base, was 2.5%) | | | 16. Discharges Before 12 Noon | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Target | 60% | | | 220 | | | Avg. 60 Patients | | | 4.5 | | | 50 | | | 28% | | | 60 | | | 25% | | |
| | Actual | Trajectory | Latest Update | Actual | Trajectory | Latest Update | Actual | Trajectory | Latest Update | Actual | Trajectory | Latest Update | Actual | Trajectory | Latest Update | Actual | Trajectory | Latest Update | Actual | Trajectory | Latest Update | Actual | Trajectory | Latest Update |
| Apr-22 | 51.53% | 53.1% | Slightly lower than forecast but still significantly above national average. Promoting SDEC front door to EEAST. | 669 | 635 | Significant rise in length of delay for admission and several extensive MH waits in ED has driven average up. System to support with radical reduction of the D2A 1 - 3 backlog. | 16 | 20 | Generally acuity has risen and it has proven challenging to find more patients ready to be transferred onto virtual ward. Team expanding criteria to front door and admission avoidance; being embedded in R2G reviews and walking the wards. | 5.2 | 5.4 | Improvement mainly due to drive on more effective R2G and divisional focus on C2R and increasing pathway zero discharges. | 55 | 68 | Ahead of trajectory with improvement plans on CLD, transport, ward view. | 19.8% | 15.0% | Working with ICS to continue to expand. | 150 | 130 | Significant deterioration in this figure. System looking at critical actions. | 15.7% | 14.0% | Slightly behind trajectory. Wards taking ownership further and CLD. |
| May-22 | 52.79% | 53.0% | | 666 | 625 | | 18 | 25 | | 5.1 | 5.4 | | 49 | 67 | | 16.3% | 16.0% | | 150 | 120 | | 15.8% | 15.0% | |
| Jun-22 | 53.10% | 54.0% | | 659 | 620 | | 25 | 30 | | 5.0 | 5.3 | | 43 | 66 | | 16.1% | 17.0% | | 162 | 110 | | 15.9% | 16.0% | |
| Jul-22 | 53.51% | 54.5% | | 734 | 613 | | 28 | 32 | | 5.0 | 5.2 | | 58 | 65 | | 17.7% | 18.0% | | 192 | 100 | | 16.3% | 17.0% | |
| Aug-22 | 54.55% | 55.0% | | 820 | 599 | | 28 | 35 | | 5.4 | 5.1 | | 66 | 64 | | 17.3% | 19.0% | | 223 | 90 | | 15.4% | 18.0% | |
| Sep-22 | 53.94% | 56.0% | | 859 | 580 | | 24 | 41 | | 5.2 | 5 | | 58 | 63 | | 17.2% | 20.0% | | 245 | 86 | | 15.7% | 19.0% | |
| Oct-22 | | 56.5% | | | 542 | | | 46 | | | 4.9 | | | 62 | | | 22.0% | | | 84 | | | 20.0% | |
| Nov-22 | | 57.0% | | | 500 | | | 49 | | | 4.8 | | | 61 | | | 24.0% | | | 80 | | | 21.0% | |
| Dec-22 | | 57.5% | | | 402 | | | 54 | | | 4.8 | | | 60 | | | 25.0% | | | 75 | | | 22.0% | |
| Jan-23 | | 58.0% | | | 300 | | | 56 | | | 4.7 | | | 58 | | | 26.0% | | | 70 | | | 23.0% | |
| Feb-23 | | 59.0% | | | 240 | | | 58 | | | 4.6 | | | 55 | | | 27.0% | | | 68 | | | 24.0% | |
| Mar-23 | | 60.0% | | | 220 | | | 60 | | | 4.5 | | | 50 | | | 28.0% | | | 66 | | | 25.0% | |

# Performance – Ambulance Performance < 15 Minutes

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| Hospital Name | Oct-21 | Nov-21 | Dec-21 | Jan-22 | Feb-22 | Mar-22 | Apr-22 | May-22 | Jun-22 | Jul-22 | Aug-22 | Sep-22 | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Addenbrookes Hospital | 25.13% | 35.36% | 34.48% | 32.55% | 31.87% | 29.27% | 25.57% | 30.90% | 27.10% | 18.72% | 31.23% | 35.80% | 29.50% |
| Basildon & Thurrock Hospital | 39.47% | 35.69% | 40.19% | 45.17% | 40.35% | 26.01% | 19.98% | 21.80% | 23.34% | 18.83% | 21.33% | 17.66% | 31.55% |
| Bedford Hospital South Wing | 47.45% | 43.45% | 43.26% | 43.32% | 42.32% | 44.60% | 38.31% | 43.34% | 42.63% | 43.12% | 49.22% | 48.37% | 44.47% |
| Broomfield Hospital | 29.57% | 26.95% | 30.39% | 33.15% | 22.51% | 16.46% | 19.85% | 27.52% | 29.61% | 21.22% | 22.77% | 22.53% | 26.46% |
| Colchester General Hospital | 15.13% | 14.57% | 16.46% | 19.49% | 16.94% | 13.16% | 11.53% | 17.10% | 14.29% | 14.86% | 14.92% | 13.20% | 15.22% |
| Hinchingbrooke Hospital | 12.56% | 15.41% | 12.23% | 13.69% | 16.04% | 11.00% | 11.67% | 12.74% | 13.58% | 10.38% | 20.16% | 36.35% | 15.50% |
| Ipswich Hospital | 31.20% | 30.38% | 27.00% | 31.30% | 30.32% | 22.62% | 21.95% | 27.14% | 25.97% | 21.18% | 26.58% | 26.01% | 27.33% |
| James Paget Hospital | 17.55% | 20.92% | 17.57% | 22.75% | 18.81% | 17.34% | 19.95% | 23.35% | 16.08% | 11.80% | 9.64% | 8.53% | 17.82% |
| Lister Hospital | 7.33% | 7.96% | 9.21% | 8.32% | 8.20% | 5.44% | 4.95% | 5.68% | 3.78% | 3.55% | 4.70% | 3.38% | 6.20% |
| Luton And Dunstable Hospital | 44.07% | 38.85% | 41.51% | 39.37% | 38.05% | 36.51% | 34.81% | 35.09% | 31.95% | 29.95% | 31.90% | 26.43% | 36.86% |
| Norfolk & Norwich University Hospital | **25.87%** | **27.10%** | **29.32%** | **26.28%** | **21.97%** | **19.51%** | **24.53%** | **19.95%** | **24.24%** | **13.50%** | **16.02%** | **9.79%** | **23.42%** |
| Peterborough City Hospital | 7.45% | 5.38% | 5.27% | 4.22% | 4.55% | 2.44% | 4.01% | 5.29% | 3.79% | 4.09% | 5.69% | 7.66% | 5.12% |
| Princess Alexandra Hospital | 12.45% | 12.78% | 14.75% | 17.29% | 15.50% | 11.99% | 15.90% | 15.34% | 16.72% | 9.34% | 10.03% | 10.64% | 14.13% |
| Queen Elizabeth Hospital | 29.28% | 32.39% | 31.04% | 41.41% | 29.90% | 20.49% | 32.30% | 29.85% | 20.46% | 26.29% | 23.78% | 18.72% | 29.15% |
| Southend University Hospital | 13.93% | 10.21% | 13.20% | 12.40% | 9.79% | 10.01% | 13.66% | 10.96% | 10.30% | 11.60% | 9.48% | 11.67% | 11.92% |
| Watford General Hospital | 26.54% | 25.17% | 5.63% | 6.69% | 6.69% | 6.70% | 7.61% | 5.93% | 4.64% | 5.85% | 5.88% | 9.56% | 13.67% |
| West Suffolk Hospital | 38.41% | 40.06% | 36.41% | 37.36% | 41.34% | 34.29% | 36.39% | 38.72% | 29.42% | 31.17% | 35.40% | 37.88% | 36.83% |
| Total | 25.58% | 25.53% | 25.27% | 26.72% | 24.45% | 20.53% | 20.95% | 22.99% | 20.91% | 18.18% | 20.47% | 20.94% | 23.40% |

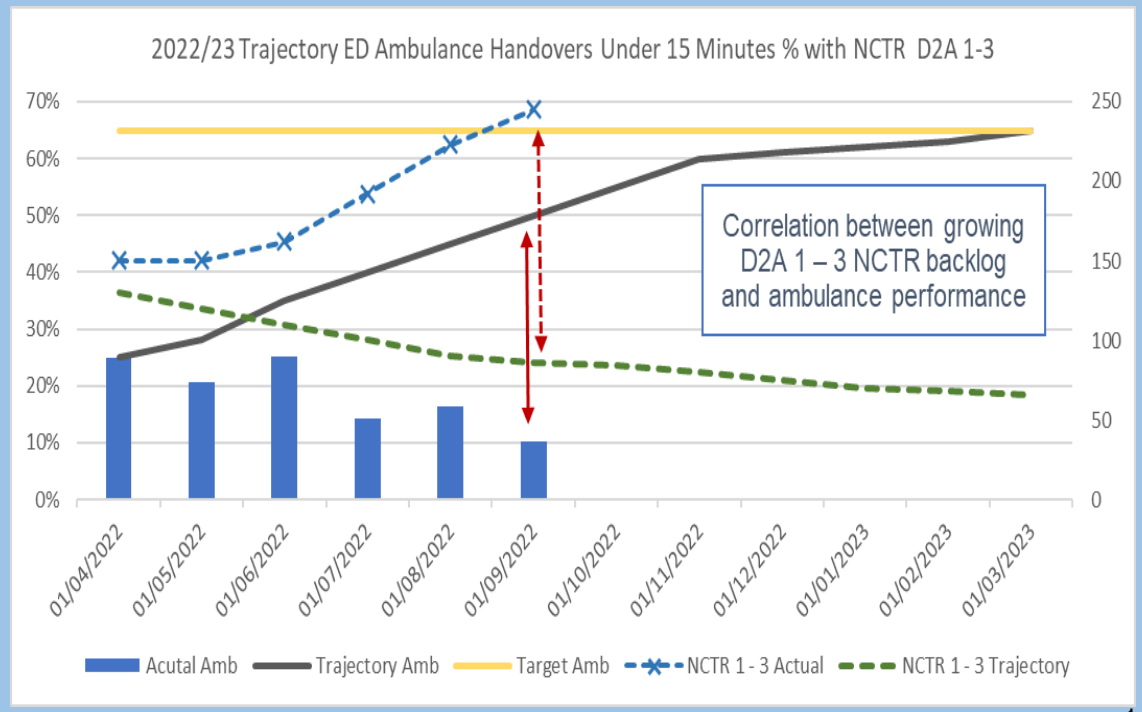
| KPI | 1. Ambulance Handover < 15 min | |
|---|---|---|
| Target | 65% | |
| | Actual | Trajectory |
| Apr-22 | 24.93% | 25.0% |
| May-22 | 20.59% | 28.0% |
| Jun-22 | 25.12% | 35.0% |
| Jul-22 | 14.33% | 40.0% |
| Aug-22 | 16.30% | 45.0% |
| Sep-22 | 10.24% | 50.0% |
| Oct-22 | | 55.0% |
| Nov-22 | | 60.0% |
| Dec-22 | | 61.0% |
| Jan-23 | | 62.0% |
| Feb-23 | | 63.0% |
| Mar-23 | | 65.0% |

**Latest Update**

Performance: Performance for September is below trajectory with NNUH ranking 13th in the EoE but 9th at an annualised view.

Root Cause: Ability to decompress was restricted to a very limited period from some surge beds but continued reliance on full escalation protocols throughout the Trust. Large number of patients with no criteria to reside. Staffing has been challenged across the Trust – hindering discharge. Multiple aborted journeys based on numerous issues – impacting flow.

Actions for the Next Period: Continued restructure of emergency flow process around PAU with revised metrics for ED, PAU, AMU and discharge to the community. Restructure of front door real estate to relocate cohort and dismantling of bed bays to support OPED. Implement internal IMT model of support from 20th October. Extend to System IMT from week commencing 31st October.



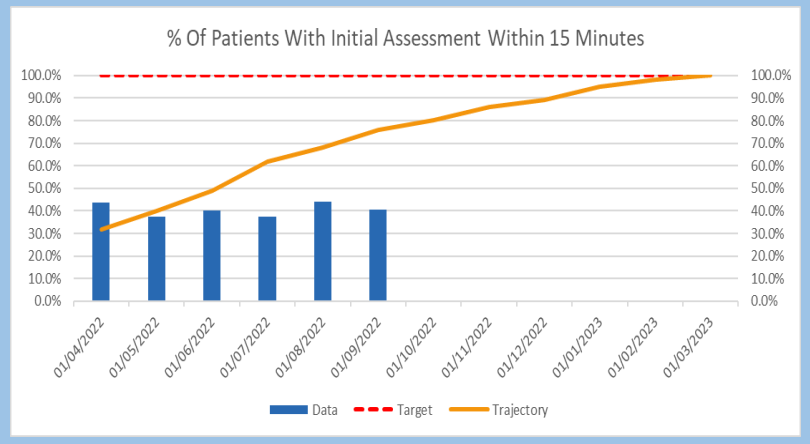
# Performance – Ambulance Performance > 60 Minutes

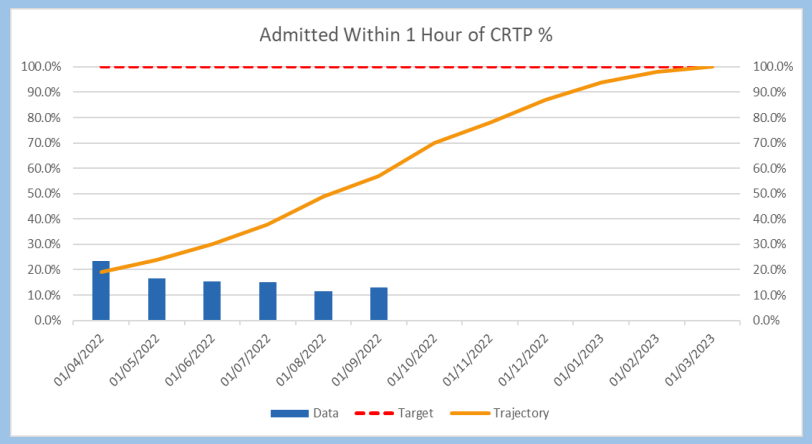
NNUH Digital Health business intelligence

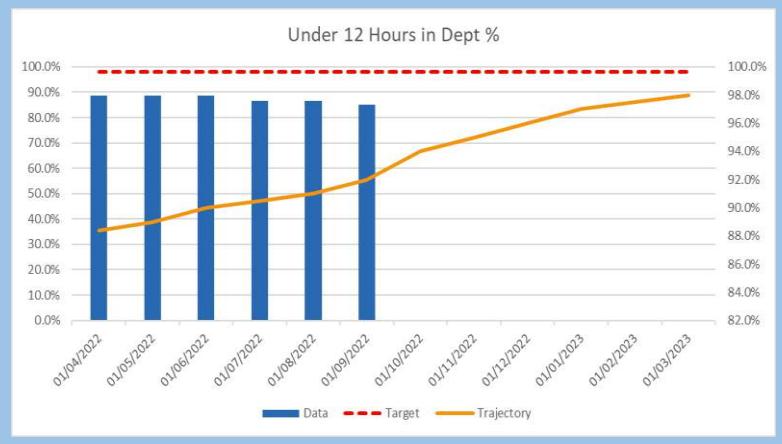
| Hospital Name | Oct-21 | Nov-21 | Dec-21 | Jan-22 | Feb-22 | Mar-22 | Apr-22 | May-22 | Jun-22 | Jul-22 | Aug-22 | Sep-22 | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Addenbrookes Hospital | 12.52% | 6.19% | 4.74% | 7.66% | 6.73% | 13.06% | 11.98% | 4.53% | 9.29% | 15.19% | 4.46% | 8.09% | 9.06% |
| Basildon & Thurrock Hospital | 4.51% | 8.05% | 5.47% | 2.10% | 6.77% | 16.13% | 18.68% | 21.03% | 19.79% | 26.79% | 23.34% | 32.00% | 13.47% |
| Bedford Hospital South Wing | 5.17% | 9.03% | 6.28% | 7.38% | 5.62% | 4.38% | 7.97% | 2.59% | 2.60% | 5.49% | 3.10% | 6.74% | 5.49% |
| Broomfield Hospital | 12.41% | 15.42% | 11.82% | 13.79% | 20.74% | 27.16% | 24.47% | 13.83% | 10.91% | 20.90% | 16.93% | 21.05% | 16.67% |
| Colchester General Hospital | 4.95% | 6.09% | 5.64% | 2.26% | 4.01% | 8.60% | 6.62% | 5.86% | 10.47% | 13.94% | 10.48% | 14.08% | 7.50% |
| Hinchingbrooke Hospital | 18.04% | 18.97% | 22.39% | 15.75% | 20.10% | 30.65% | 19.94% | 19.42% | 20.69% | 38.06% | 19.38% | 8.07% | 20.39% |
| Ipswich Hospital | 10.87% | 9.15% | 10.57% | 14.49% | 11.15% | 14.91% | 12.41% | 6.65% | 10.70% | 13.87% | 11.71% | 14.30% | 11.34% |
| James Paget Hospital | 25.99% | 13.72% | 17.78% | 16.97% | 27.88% | 29.66% | 23.97% | 18.22% | 31.79% | 47.54% | 49.63% | 46.15% | 27.44% |
| Lister Hospital | 25.64% | 21.45% | 17.96% | 21.64% | 17.65% | 23.72% | 36.20% | 27.19% | 29.72% | 46.79% | 35.28% | 47.23% | 27.89% |
| Luton And Dunstable Hospital | 3.76% | 7.28% | 6.49% | 6.95% | 8.38% | 9.21% | 8.50% | 5.13% | 8.38% | 13.01% | 7.18% | 10.43% | 7.45% |
| Norfolk & Norwich University Hospital | **23.18%** | **23.89%** | **22.29%** | **27.70%** | **36.78%** | **38.70%** | **31.59%** | **32.17%** | **27.25%** | **45.10%** | **39.67%** | **53.18%** | 30.87% |
| Peterborough City Hospital | 21.58% | 32.66% | 28.78% | 31.54% | 33.01% | 38.57% | 36.52% | 27.61% | 31.25% | 37.86% | 23.14% | 20.52% | 29.81% |
| Princess Alexandra Hospital | 30.33% | 29.07% | 26.88% | 25.12% | 31.26% | 34.62% | 20.87% | 21.22% | 19.13% | 33.68% | 27.26% | 35.15% | 27.39% |
| Queen Elizabeth Hospital | 26.85% | 26.30% | 27.87% | 13.96% | 21.74% | 44.30% | 25.14% | 27.45% | 38.75% | 32.97% | 36.19% | 42.77% | 28.94% |
| Southend University Hospital | 13.31% | 17.18% | 15.96% | 23.74% | 29.70% | 35.01% | 33.10% | 31.62% | 23.96% | 26.08% | 33.70% | 38.05% | 24.05% |
| Watford General Hospital | 10.68% | 10.68% | 11.97% | 10.57% | 12.85% | 12.36% | 11.07% | 18.54% | 32.95% | 28.01% | 24.98% | 23.50% | 15.44% |
| West Suffolk Hospital | 5.34% | 4.33% | 3.43% | 3.12% | 2.65% | 4.98% | 2.40% | 1.58% | 5.70% | 6.15% | 6.46% | 4.66% | 4.11% |
| Total | 14.09% | 14.59% | 13.61% | 13.83% | 16.60% | 21.60% | 19.02% | 15.93% | 18.46% | 25.26% | 20.89% | 23.77% | 17.33% |

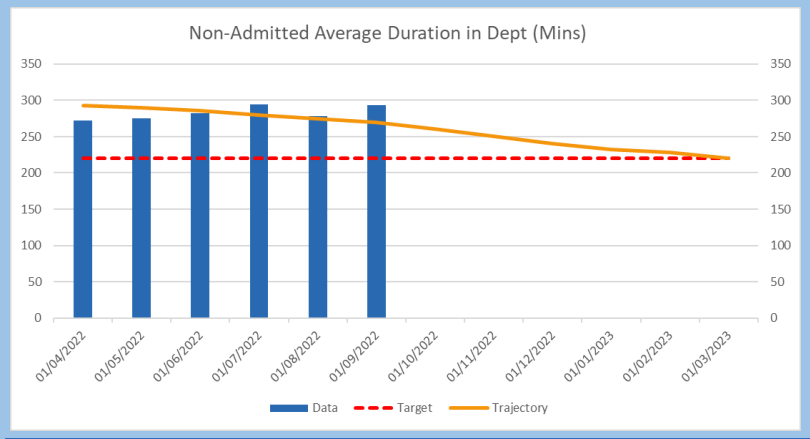
| KPI | 3. Ambulance Handover > 60 min | | |
|---|---|---|---|
| Target | 5% | | |
| | Actual | Trajectory | Latest Update |
| Apr-22 | 30.37% | 32.0% | Performance: Ranking 17th in region, significantly adrift from trajectory.<br><br>Root Cause: Significant congestion and overcrowding in ED with high numbers of patients in the department throughout the last week – this compounded the ability to receive and offload. Surge and waves continued to be enacted to support flow. Significant number of patients with no criteria to reside on pathways 1-3, compounding ability to admit patients in line with CRTP due to lack of capacity and continued use of escalation and surge.<br><br>Actions for the Next Period: Continued restructure of emergency flow process around PAU with revised metrics for ED, PAU, AMU and discharge to the community. Restructure of front door real estate to relocate cohort and dismantling of bed bays to support OPED. Implement internal IMT model of support from 20th October. Extend to System IMT from week commencing 31st October. |
| May-22 | 31.71% | 28.0% | |
| Jun-22 | 25.77% | 25.0% | |
| Jul-22 | 43.54% | 20.0% | |
| Aug-22 | 37.38% | 16.0% | |
| Sep-22 | 52.05% | 12.0% | |
| Oct-22 | | 10.0% | |
| Nov-22 | | 9.0% | |
| Dec-22 | | 8.0% | |
| Jan-23 | | 8.0% | |
| Feb-23 | | 7.0% | |
| Mar-23 | | 5.0% | |

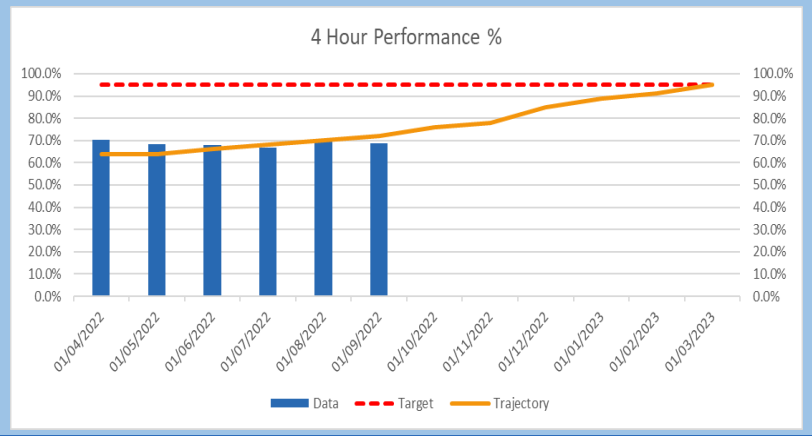
# Performance – ED Performance

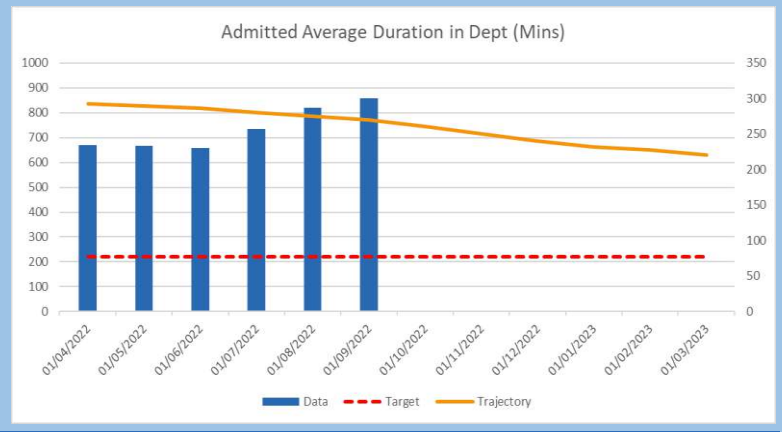


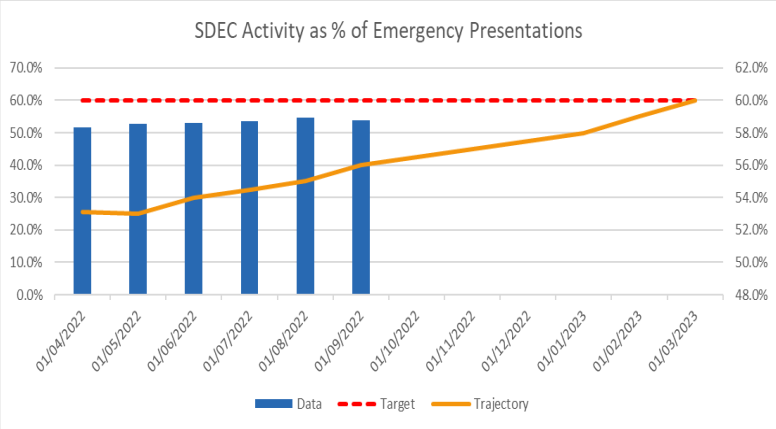

## Commentary

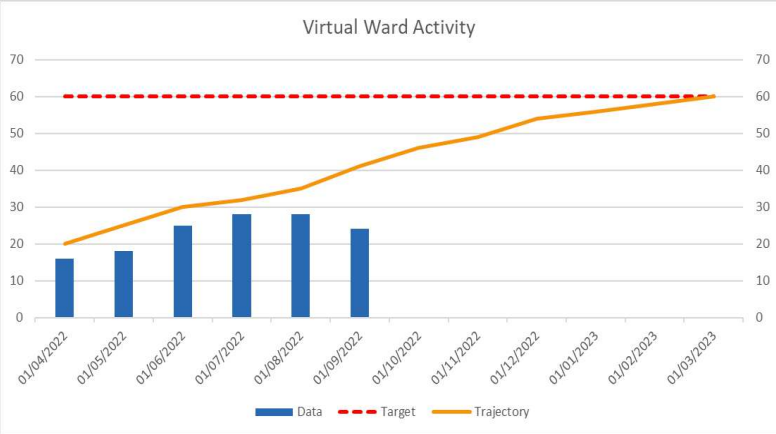
**Performance**: The overall position reflects the extremely challenging situation and the Trust being in a constant state of business continuity and OPEL 4 status. The CRTP poor performance is the most adrift, and corresponds to the poor discharge profile.

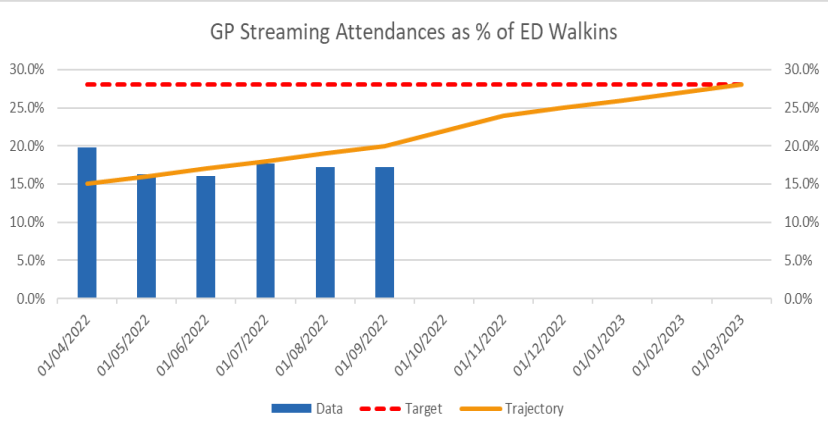
**Root Cause:** Significant congestion and overcrowding in ED with high numbers of patients in the department with exit block due to the numbers of patients with NCTR not discharged. Still in surge.

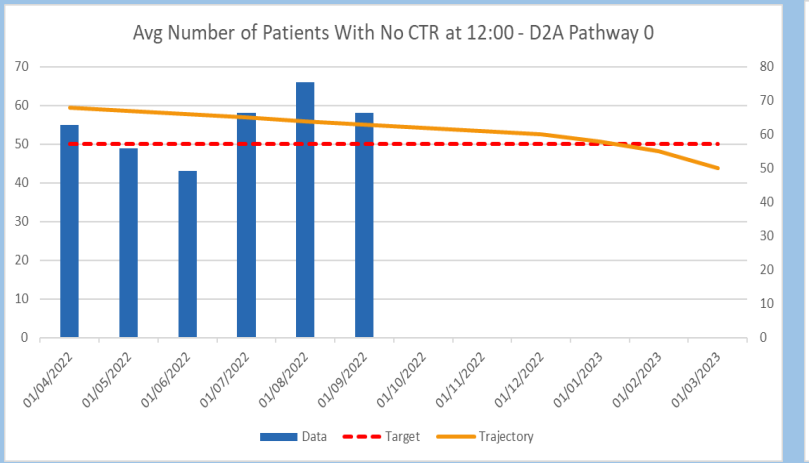
**Actions for the Next Period:** The NNUH system has a plan to open 140 additional beds in October 2022. Internal processes will focus on the creation of PAU and ECIST supported work on the discharge process. Awaiting outcome of NHSE/I visit and missed opportunities audits to form part of UEC / Ambulance improvements and action plan.

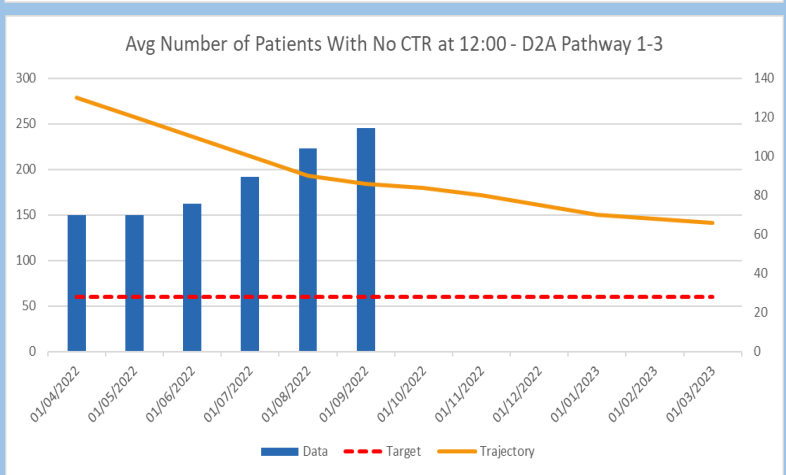
# Performance – Through & Out: Alternative Pathways & Discharge

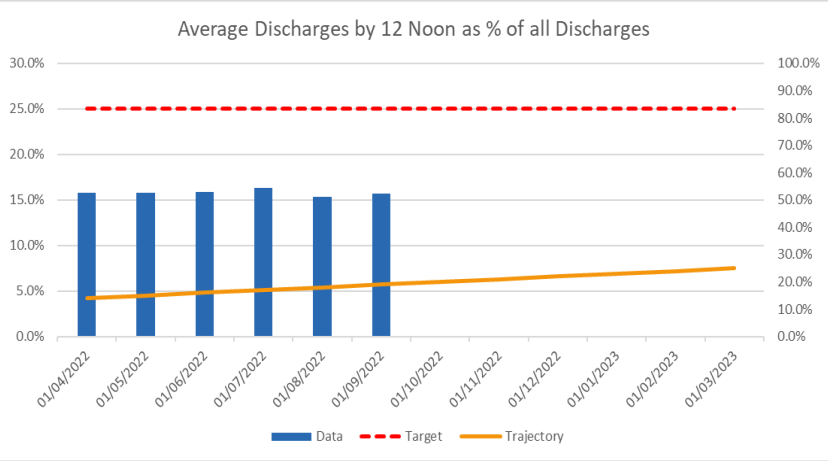



## Commentary

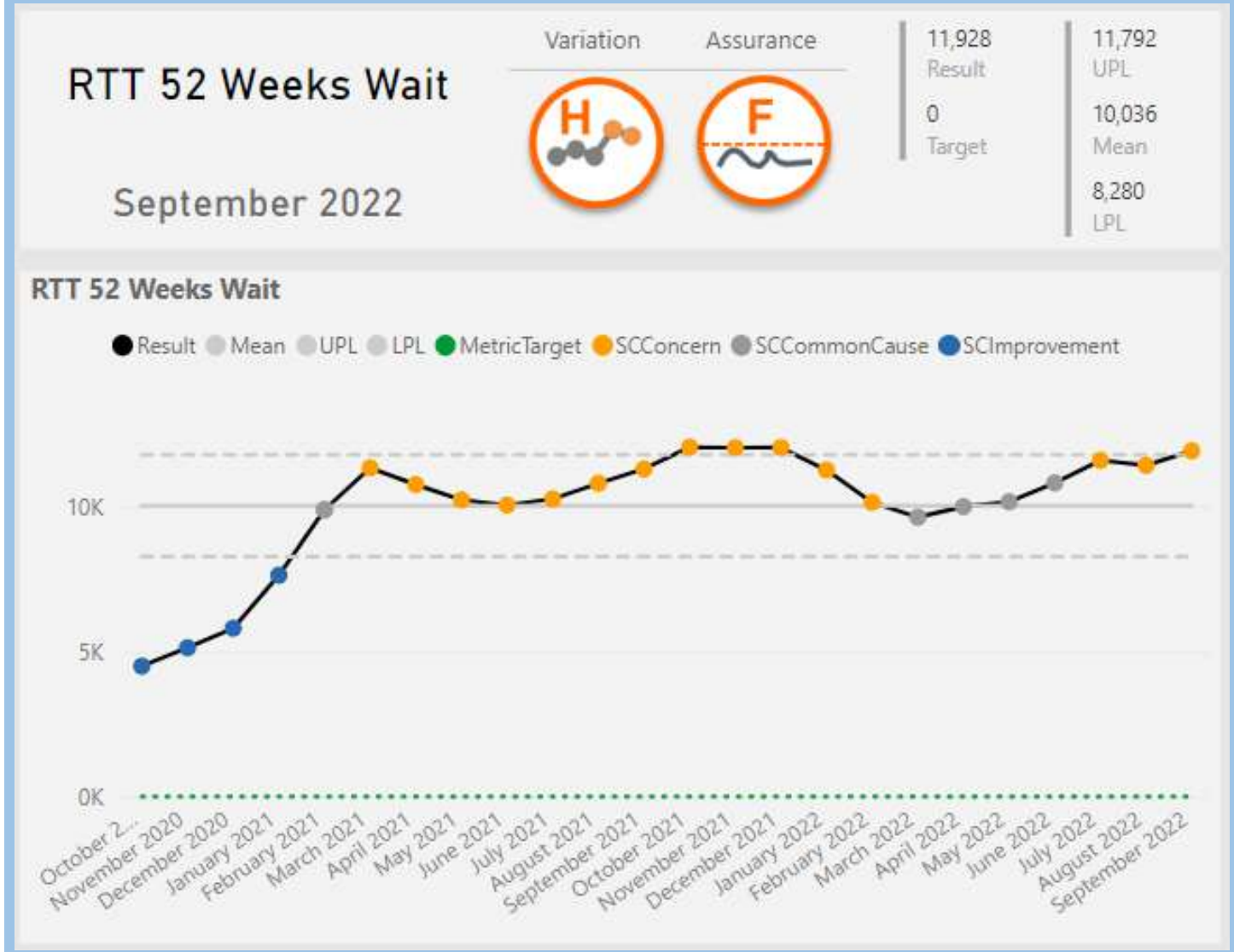
**Performance**: All standards are behind trajectory, except SDEC activity and discharges by 12 noon. D2A 0 has also seen improvement.

**Root Cause:** Extraordinary number of patients with no criteria to reside on Pathways 1-3 effectively blocked over 200 beds in September. Additionally, there were up to 138 patients in super surge beds to help offload ambulances. Despite this, the ability to decompress was restricted to a very limited period and the Trust relied on implementation of an internal critical incident and the full escalation protocol to manage demand.

**Actions for the Next Period:** Working with internal teams to identify earlier discharges. Work with System partners to progress D2A recovery plans; internally drive pathway zero discharges and use of alternative pathways, like SDEC and the virtual ward. Work with EEAST and ED teams to ensure safety reviews and clinical prioritisation takes place. Progress outputs of System intervention actions and continue focus on the pathway zero discharge processes.

# Elective Care

# Performance – RTT 52-Week Breaches




## Commentary

**September 2022 Performance**

There has been a slight increase in the number of 52-week breaches going from 11,426 in August to 11,928 in September.

**Divisional Breakdown:**

Medicine – 202
Surgery – 9,807
W&C – 1,911
CSS – 8.

Of the 11,928 patients, the majority remain in 4 specialties: which have risen by 1,083 patients in month. Ophthalmology has also had a significant rise of 90 patients.

| Speciality | August | September | Trend |
|---|---|---|---|
| T&O | 2,263 | 2,590 | ↑ |
| ENT | 1,696 | 1.949 | ↑ |
| Dermatology | 2,041 | 2,501 | ↑ |
| Gynaecology | 1,698 | 1,741 | ↑ |
| Ophthalmology | 625 | 715 | ↑ |

The Trust continues to receive assistance from Medacs for 6 specialities. Outsourcing to Spire will also continue.

**Improvement Actions**

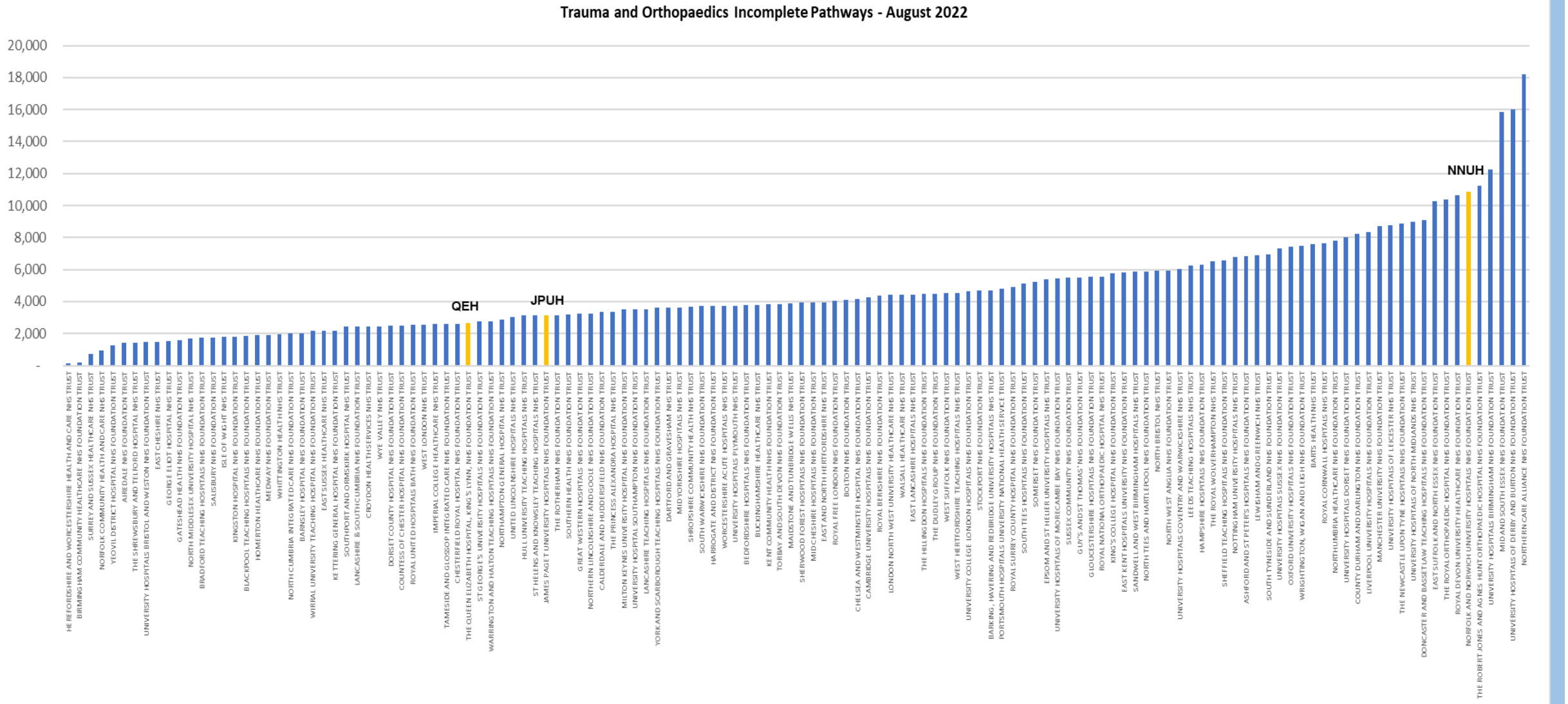
1. Continued focus on creating additional capacity (WLI at weekends) to treat the most urgent patients to then focus on longer waiting patients.
2. Insourcing and Independent Sector solutions are continuing.
3. Development of 5 interventions to increase theatre capacity is ongoing.

**Risk To Delivery**

**GREEN**

# Performance – T&O Waiting List Benchmarking

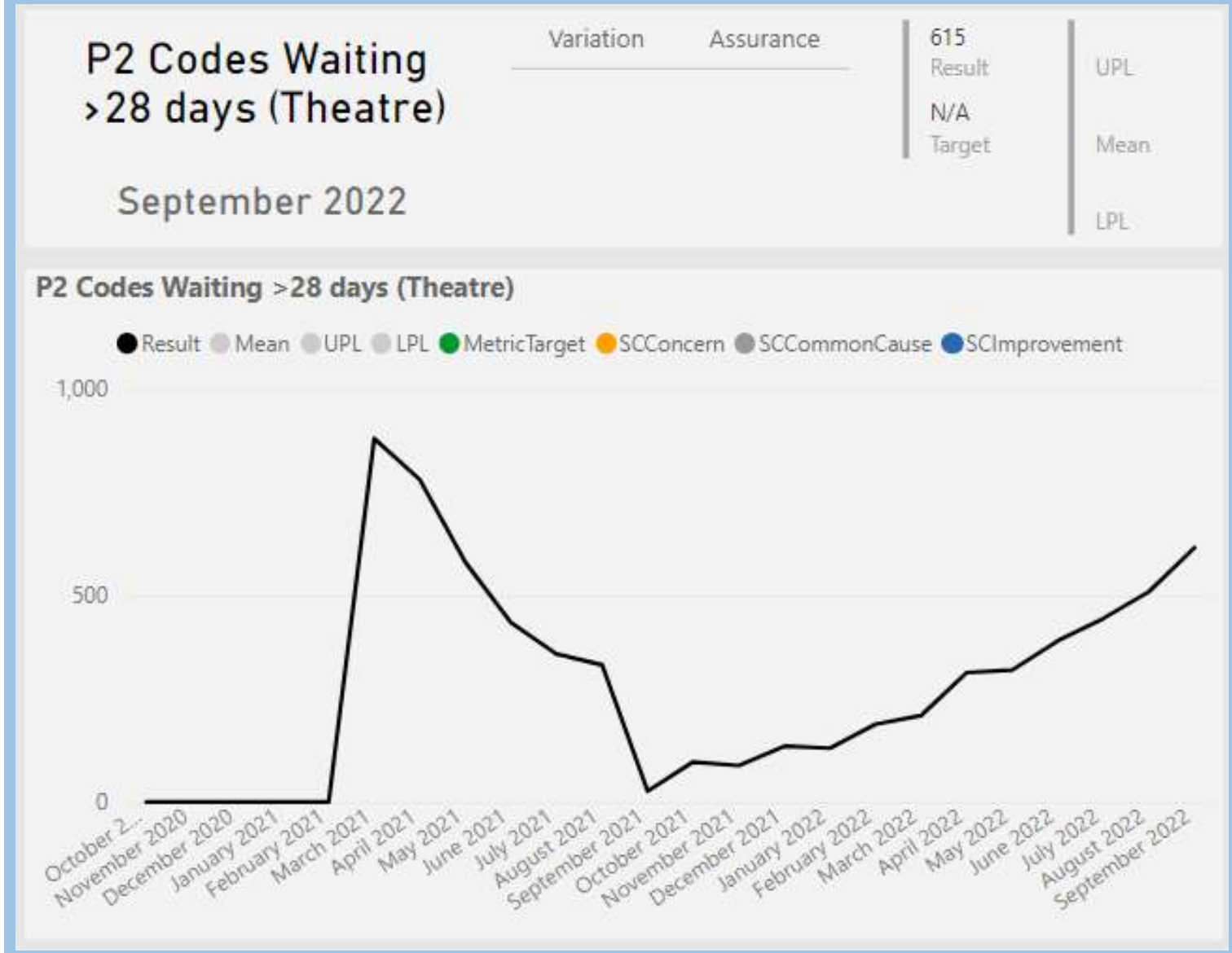
NNUH Digital Health
business intelligence




## Comments

NNUH had the 6th largest Orthopaedics Waiting List in England as of August 2022 with 10,885 patients.

# Performance – P2 Patients Waiting > 28 Days for Theatre




## Commentary

**September 2022 Performance**

The P2 position saw further increase in month with the number of patients waiting > 28 days reaching 615. The level of patients with a TCI booked maintained at 43%. The ongoing campaign of clearing our longest waiting patients continues to have an impact.

**Improvement Actions**

1. Review theatre plans with specialities with the biggest backlogs: Urology, General Surgery, Plastics & Orthopaedics.

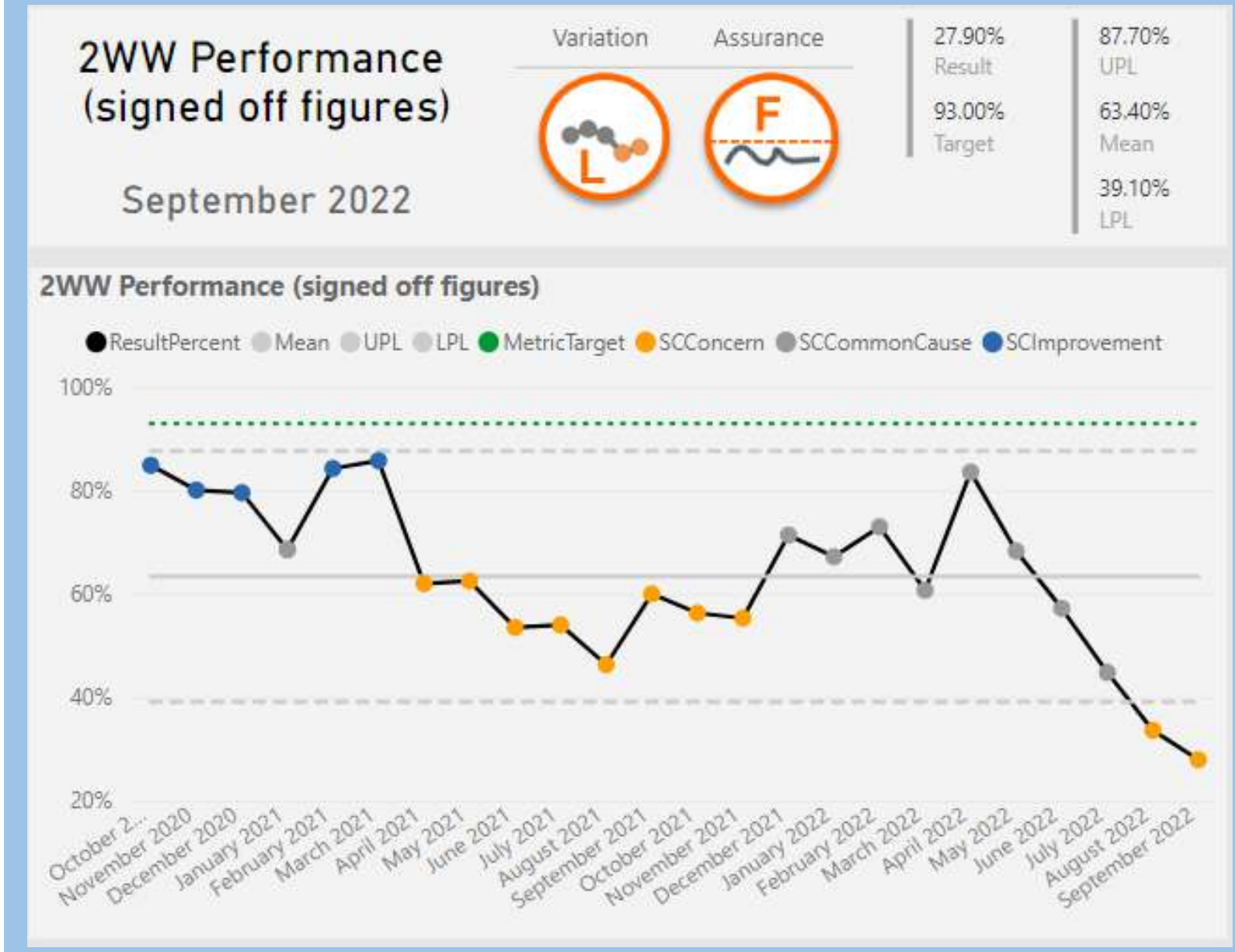
2. Validation of patients to ensure P2 prioritisation is appropriate.

3. Clinical review of remaining backlog being completed.

**Risk To Delivery**

**RED**

# Performance – Cancer 2WW Performance




## Commentary

**September 2022 Performance (Provisional)**

Backlog improvements within Skin and Gynae have caused a downturn in performance in August and September. Breast performance has reduced in month due to leave across consultant and radiographer teams causing lost activity. Improvement to position expected in November 2022.

**Improvement Actions**

1. Dermatology Team planning to increase Telederm throughput for Routine patients only. It is proposed that this will discharge a high number of patients pre appointment to free up first OPA capacity for SCC and Melanoma patients that need to be seen.

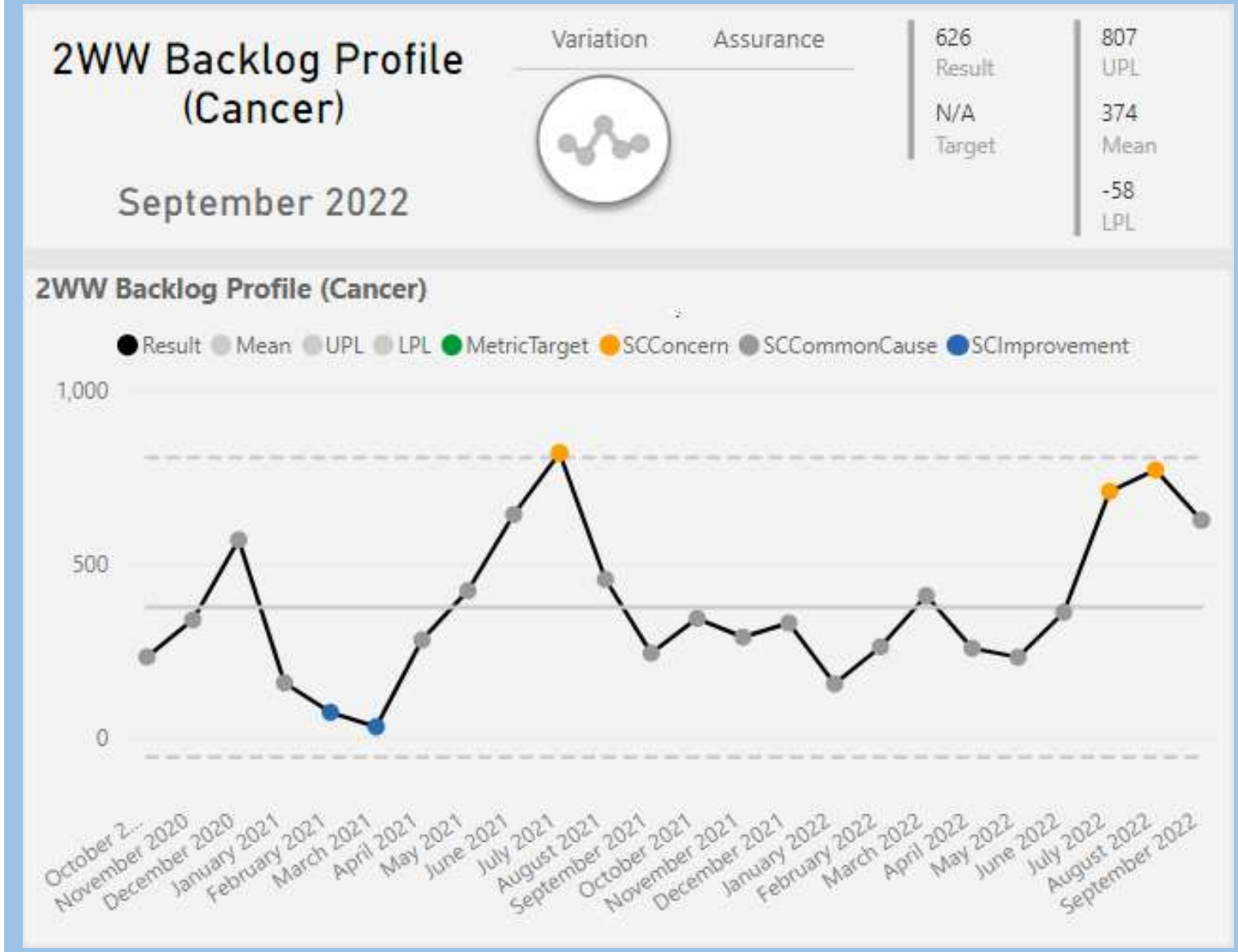
2. Two Week Wait capacity issues due to increases in referrals into the suspected Gynaecological Cancer pathway that do not appear to meet NG12 criteria, additional clinics provided in October to reduce this backlog.

3. GP Webinar for education on referral completeness planned for Skin in November 2022.

**Risk To Delivery**

**RED**

# Performance – Cancer 2WW Backlog




## Commentary

**September 2022 Performance**

Mirroring performance, backlogs have increased primarily in Gynaecology and Skin in August and planned recovery in September has now seen a downturn in the number of patients over 14 days. YTD referrals are up 37% on 19/20 in skin. Gynaecology continue to have capacity issues with increase in referrals received but not appearing to meet NG12 criteria. Additionally, Breast and Lower GI have seen an increase in breaches as the median days wait has been pushed out towards 14 days.

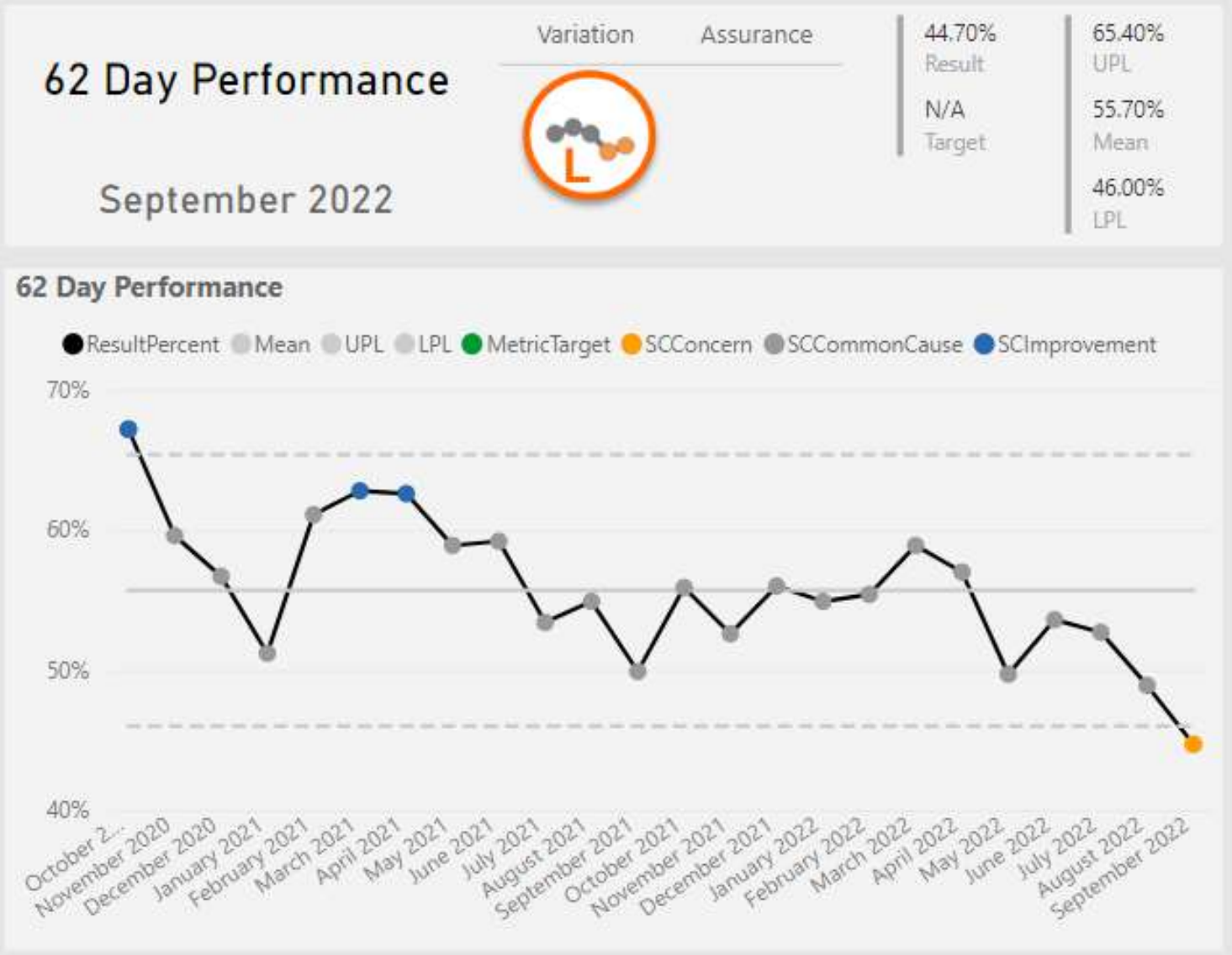
**Improvement Actions**

1. GP Webinar to improve referral quality in Lower GI took place on 12th October.
2. All two week wait proformas are being reviewed in conjunction with our ICB partners.
3. As part of the rapid improvement week for Lower GI, referral guidance to be issued to GPs to ensure patients that do not meet NG12 criteria are referred on an appropriate non-cancer pathway.

**Risk To Delivery**

**RED**

# Performance – Cancer 62-Day Performance




## Commentary

**September 2022 Performance (Provisional)**

As the Trust still has a large volume of patients in the 62 day backlog, performance against the 62 day standard will still be low as we recover our position. Renewed focus and equal priority given to Cancer recovery and 78 week recovery will show improvements to the backlog, however, this is expected to take some time to reflect in 62 Day Performance.

**Improvement Actions**

1. Rapid improvement week for Lower GI undertaken on week commencing 12th September was successful. Additional SOPs to be created to ensure timely removal or progression of patients on their pathway. CT staging within 72 hours of positive CTC now in place and plans to extend to positive Colonoscopy.

2. The planned 'Firebreak Week' has pushed additional patients through for Histological diagnosis. Additional Cancer Alliance funding has been provided to Histopathology to outsource an additional 100 cases per week for 10 weeks.

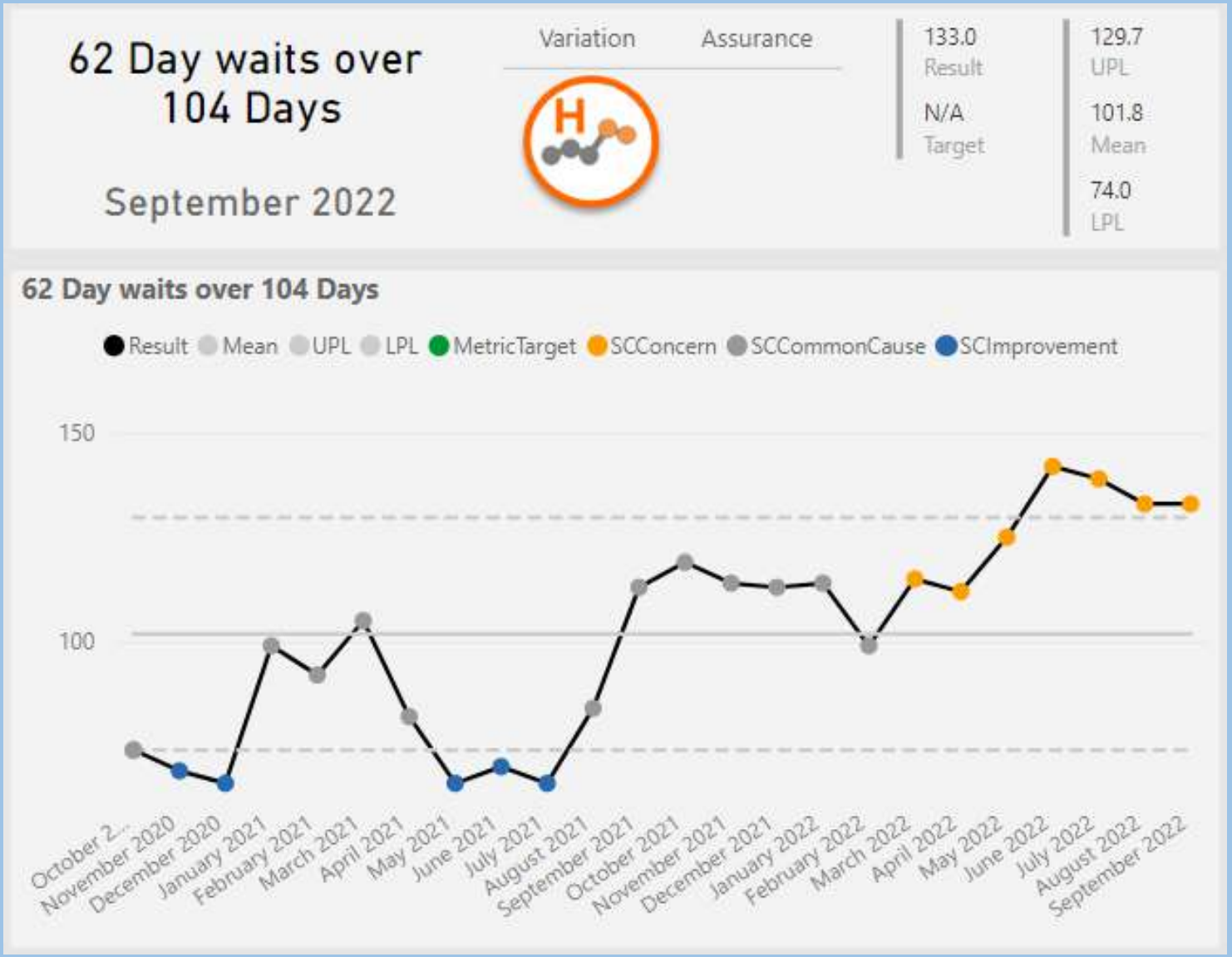
3. 'Move it by Movember' initiative in place for additional sessions and CNS clinics to reduce all Prostate Biopsy delays by end of November.

4. Implementation of Artificial Intelligence for Prostate Biopsy Histopathology Reporting is underway. Reducing the need for dual reporting to free up consultant time. Implementation expected to be completed by Q4 22/23.

**Risk To Delivery**

**RED**

# Performance – Cancer 62-Day Waits over 104 Days




## Commentary

**September 2022 Performance**

The Trust's focus on improvement to the 104-week position in Q1 2022/23 contributed to an increase in 104 day cancer backlogs. A renewed focus and equal priority given to cancer recovery and 78 week recovery has shown initial improvements to the backlog, particularly to those waiting the longest.

**Improvement Actions**

1. Progression of the Oncology and Haematology business case to HMB Investment Group to support sustainable capacity for Oncology, request from HMB investment group to explore Cancer Alliance funding, however no funding stream available.

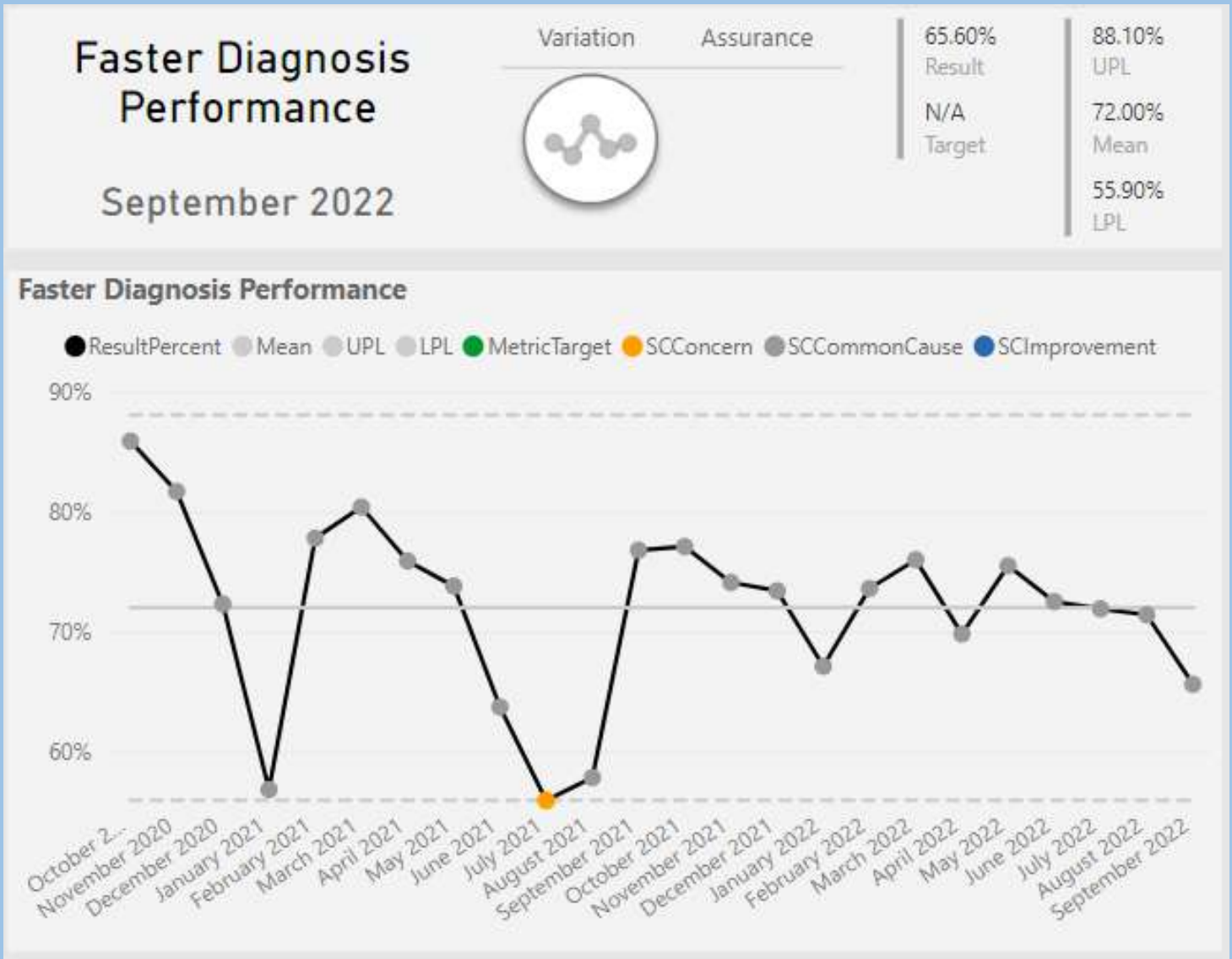
2. Guide in conjunction with clinical colleagues in Lower GI to ensure patients are removed from the cancer pathway at the correct time awaiting clinical sign off.

3. Approval from HMB to progress the Digital Histopathology Artificial Intelligence system. This will remove the need for a second reporter for prostate biopsies, freeing clinical time. Implementation within 6 months.

**Risk To Delivery**

**RED**

# Performance – Faster Diagnosis Standard




## Commentary

**September 2022 Performance (Provisional)**

September FDS performance not complete. Performance expected to increase to circa. 70% once final validation completed prior to NHS Digital upload on 1st November.

**Improvement Actions**

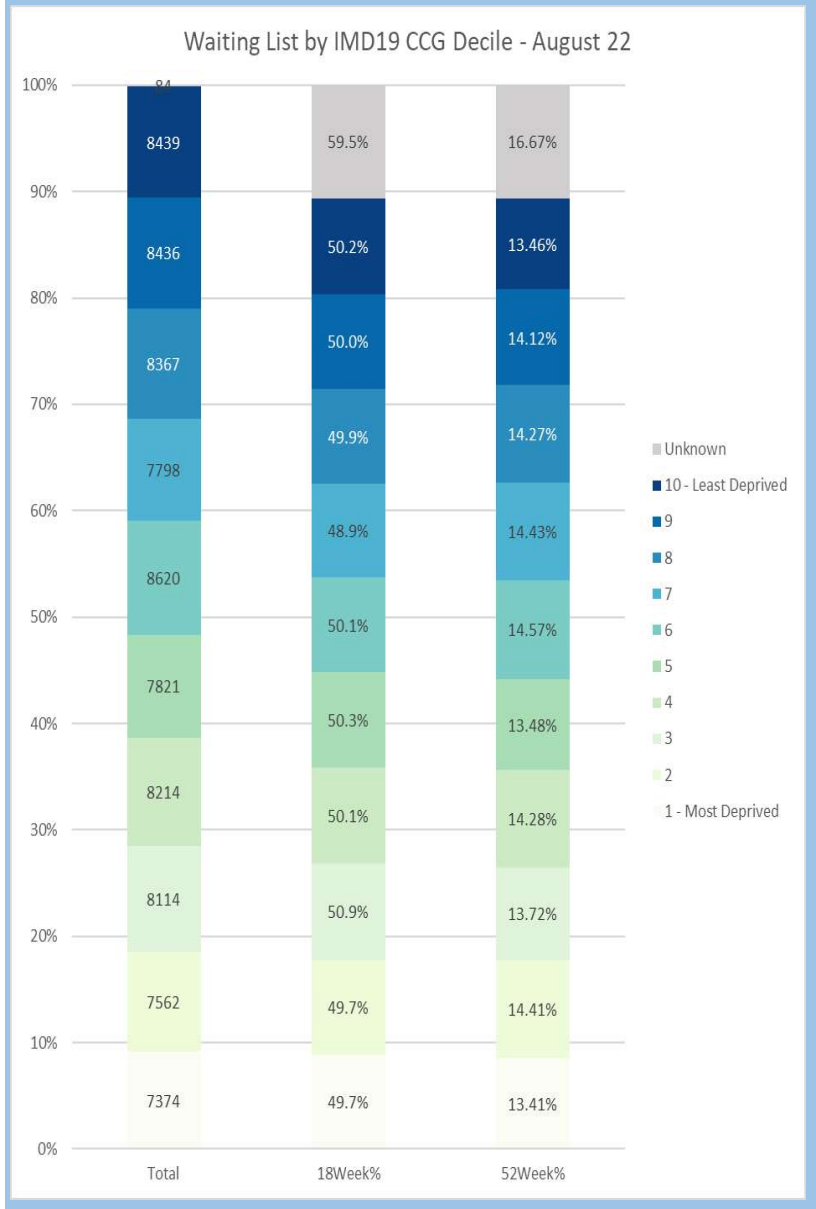
Continued data quality review to ensure completeness of information for submission to NHS digital is key to ensuring we meet the standard.

Additional FTC staff recruited to aid in timely data collection to support new metrics required by the NHS England Cancer Programme.

**Risk To Delivery**

**RED**

# Performance – Waiting List Health Inequalities




## Commentary

### Trust Waiting List: Deprivation

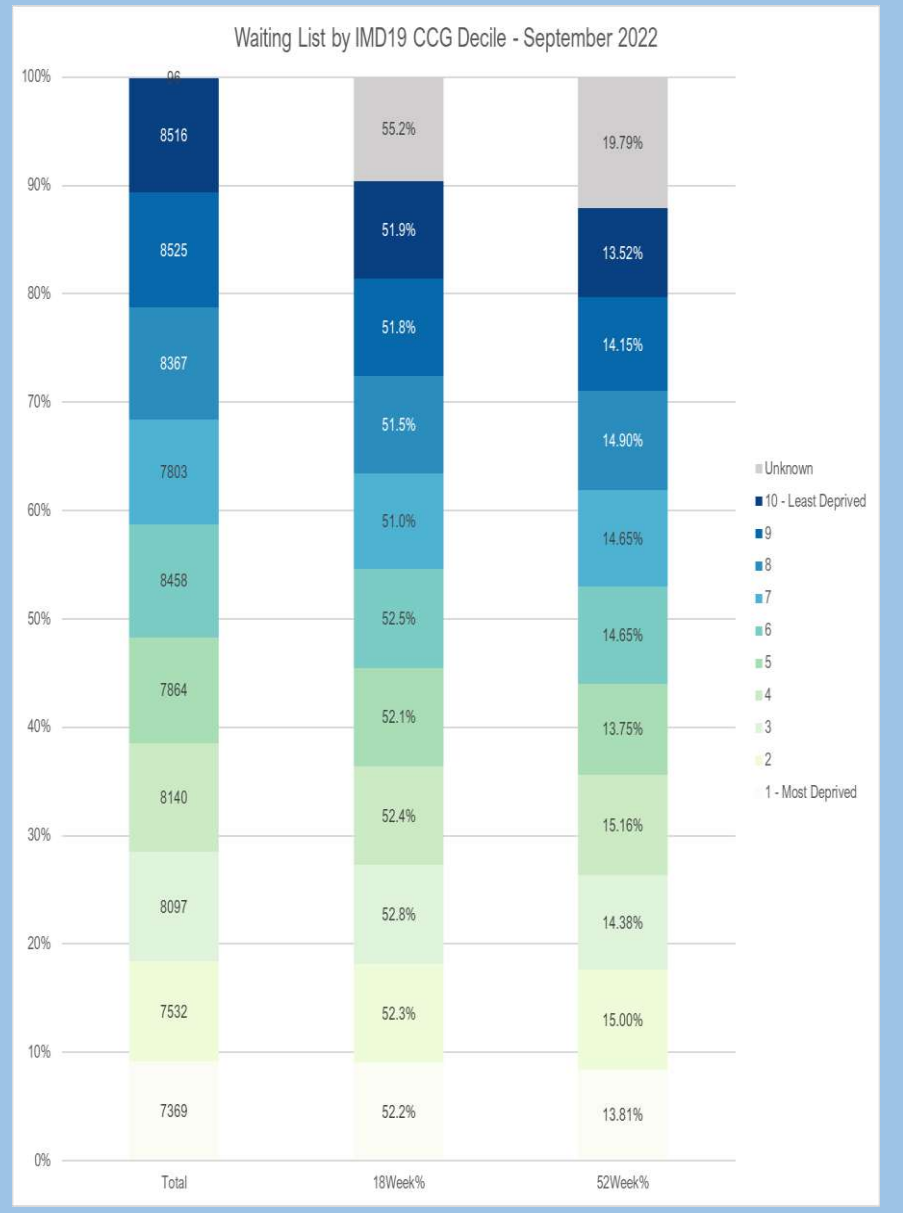
As part of the monitoring of health inequalities, the Trust's waiting list is monitored for variation in demographics.

<u>The Index of Multiple Deprivation (IMD)</u>
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%).

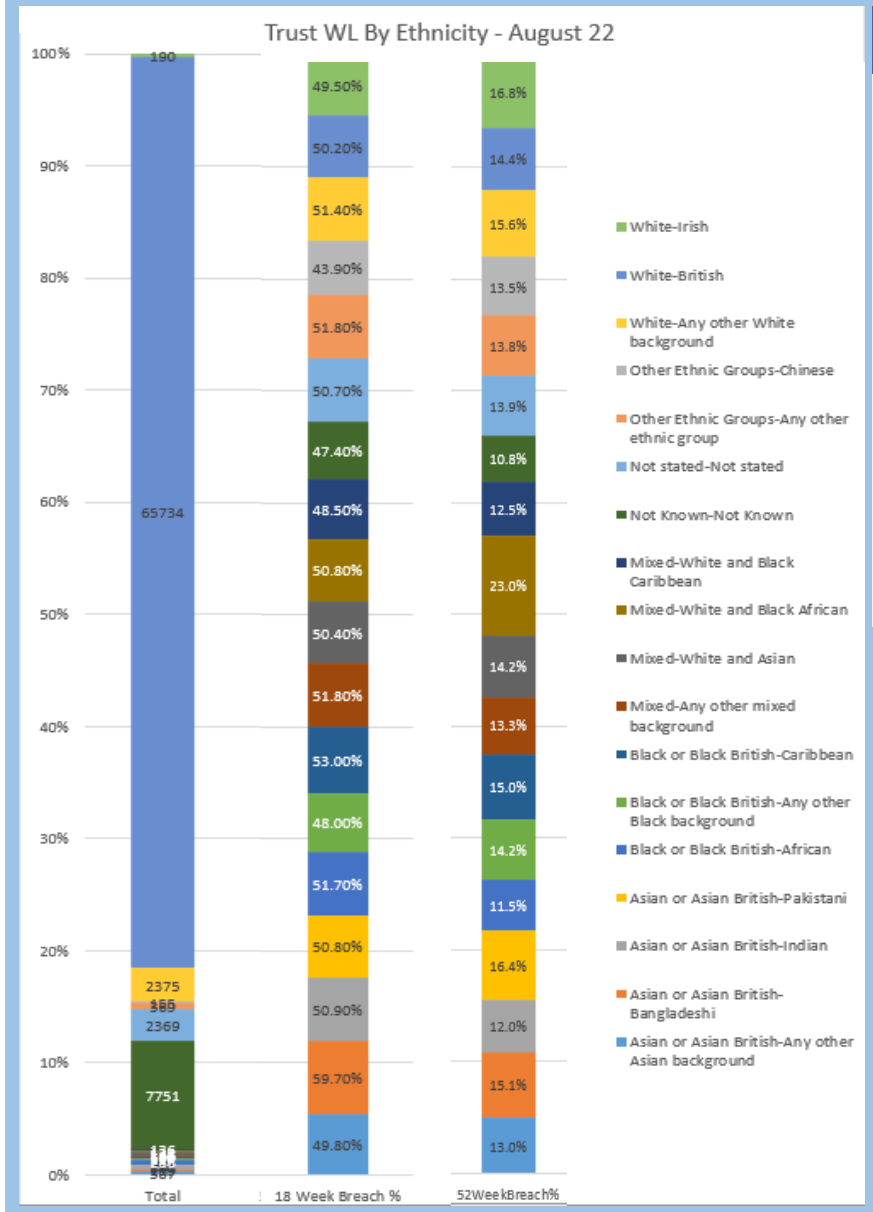
<u>Update</u>
Broadly just over 50% of each indices group are waiting over 18 weeks and nearly 15% of each group – over 52 weeks.

From August to September the changes in the waiting list composition included a rise of 1.1% of patients in decile 9 compared to an average rise of 4% over the previous 3 months. In decile 4 there was a 5% increase in patients breaching 52 weeks, which is the largest increase in month compared to other deciles.

There were 178 additional patients (4.9% increase) breaching 18 weeks for decile 1 – the highest rise of any group.



# Performance – Waiting List Health Inequalities



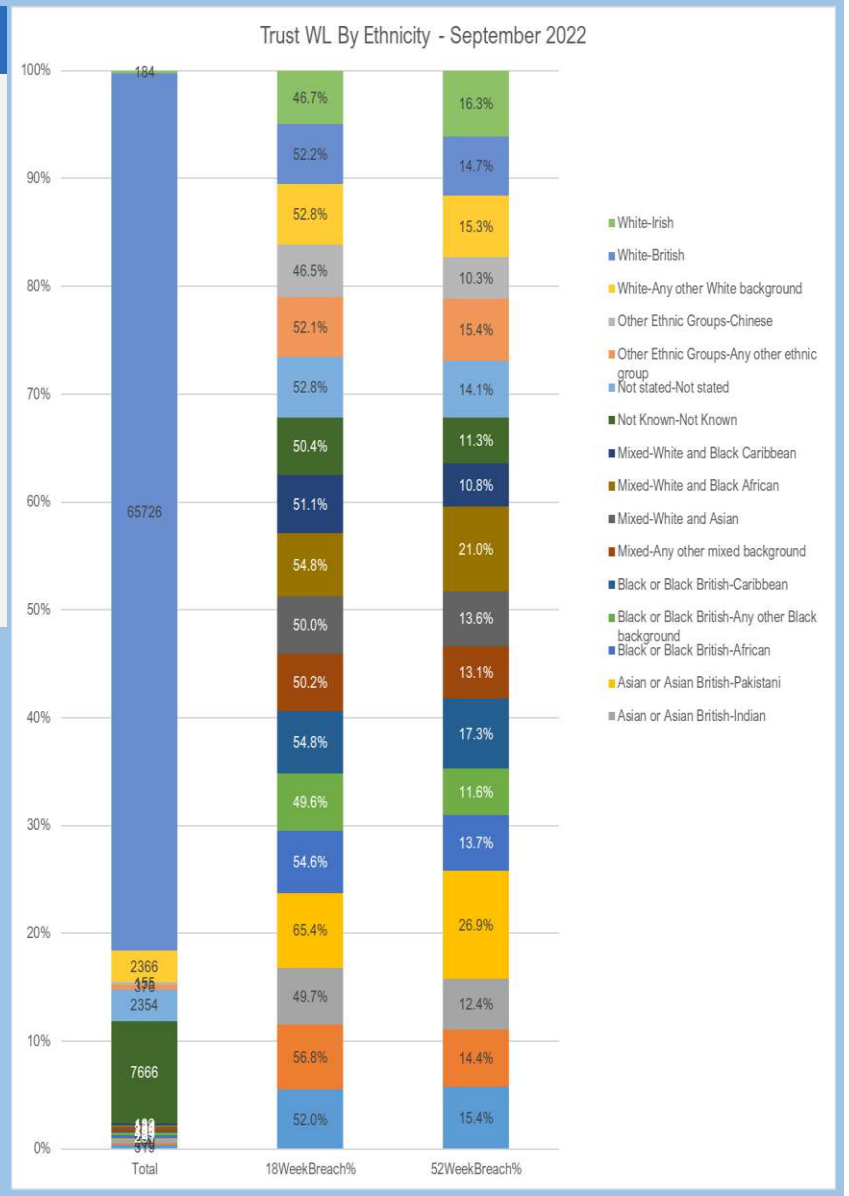

## Commentary

### Trust Waiting List: Ethnicity

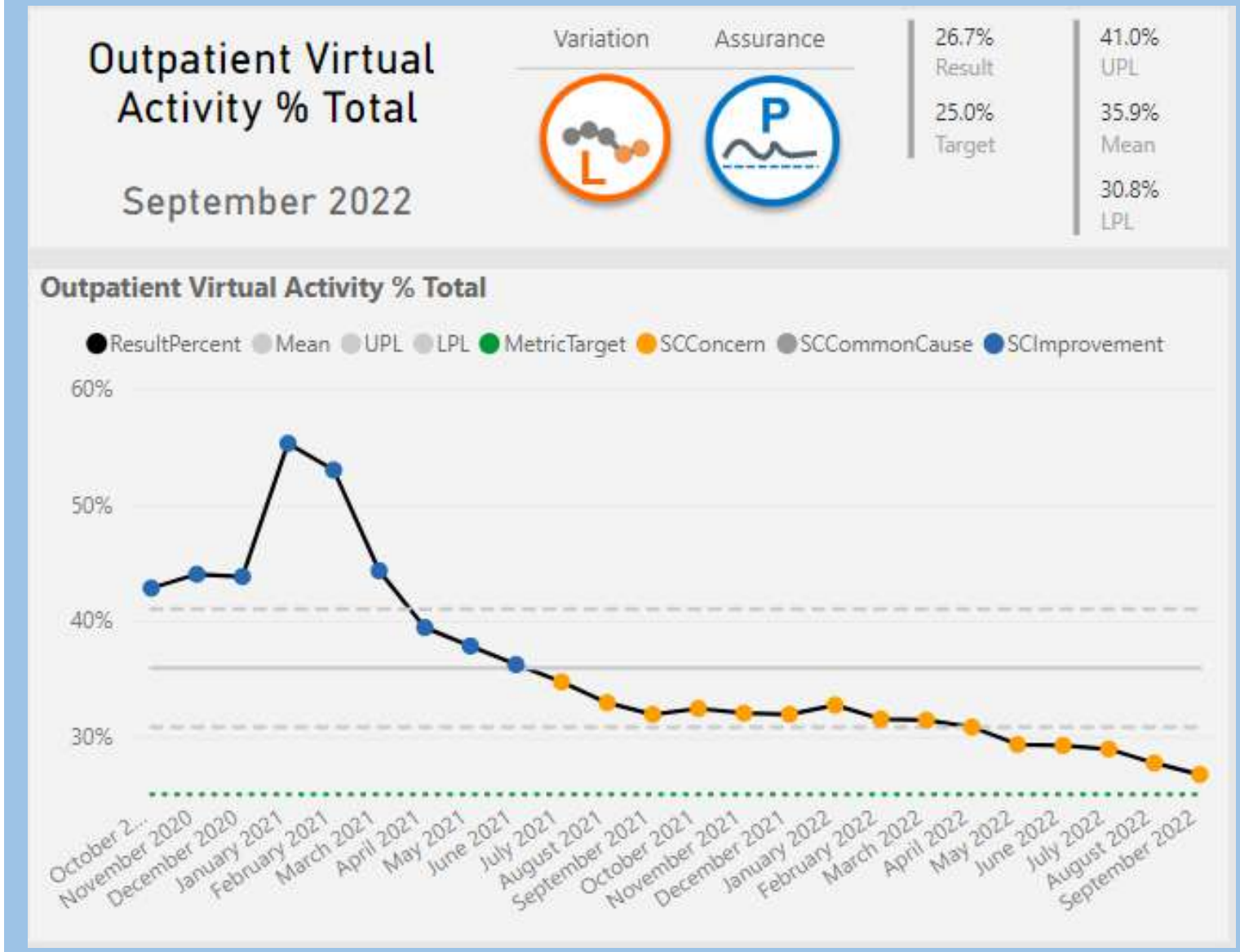
As part of the monitoring of health inequalities, the Trusts waiting list is monitored for variation in demographics.

48 (92.3%) of the 52 patients on the waiting list with an ethnicity recorded as Asian or Asian British-Pakistani have breached 18 or 52 weeks – a 17% increase from August. For comparison, the average percentage of patients breaching 18 or 52 weeks across all other ethnicities was 66%.

There were no other significant variation or concern in September 2022.



# Performance – Remote Outpatients




## Commentary

**September 2022 Performance**

The Trust delivered 26.7% of its outpatient appointments remotely during September, which is a slight drop from August (27.4%), however, we are still ahead of the 25% national target.

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

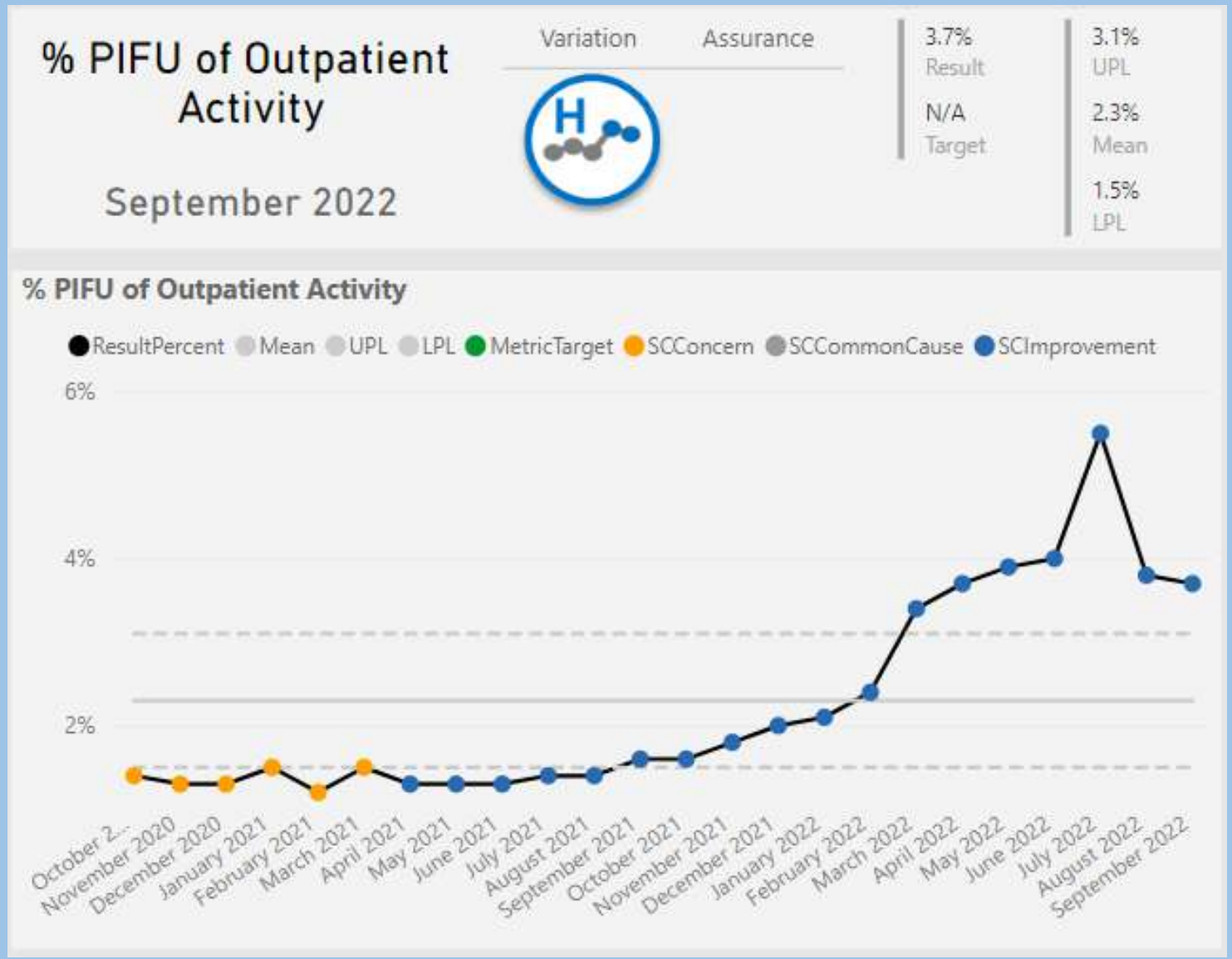
**Improvement Actions**

1. Scoping out the possibility of implementing the use of Virtual Fracture Clinics.
2. Work alongside Personalised Outpatients Programme to encourage alternative means of delivering outpatient care i.e virtual.

**Risk To Delivery**

**GREEN**

# Performance – Patient Initiated Follow Up (PIFU)




## Commentary

**September 2022 Performance**

There was a slight dip in performance in September for the % PIFU of outpatient activity, with the numbers of patients added to a list increased to 2,408 in the month.

This position is expected to improve in the following months with the expansion of XPIFU, which will contribute to maintaining or increasing % in following months. This will focus on a number of additional pathways and increase the cohort of patient that may be suitable to be managed via XPIFU.

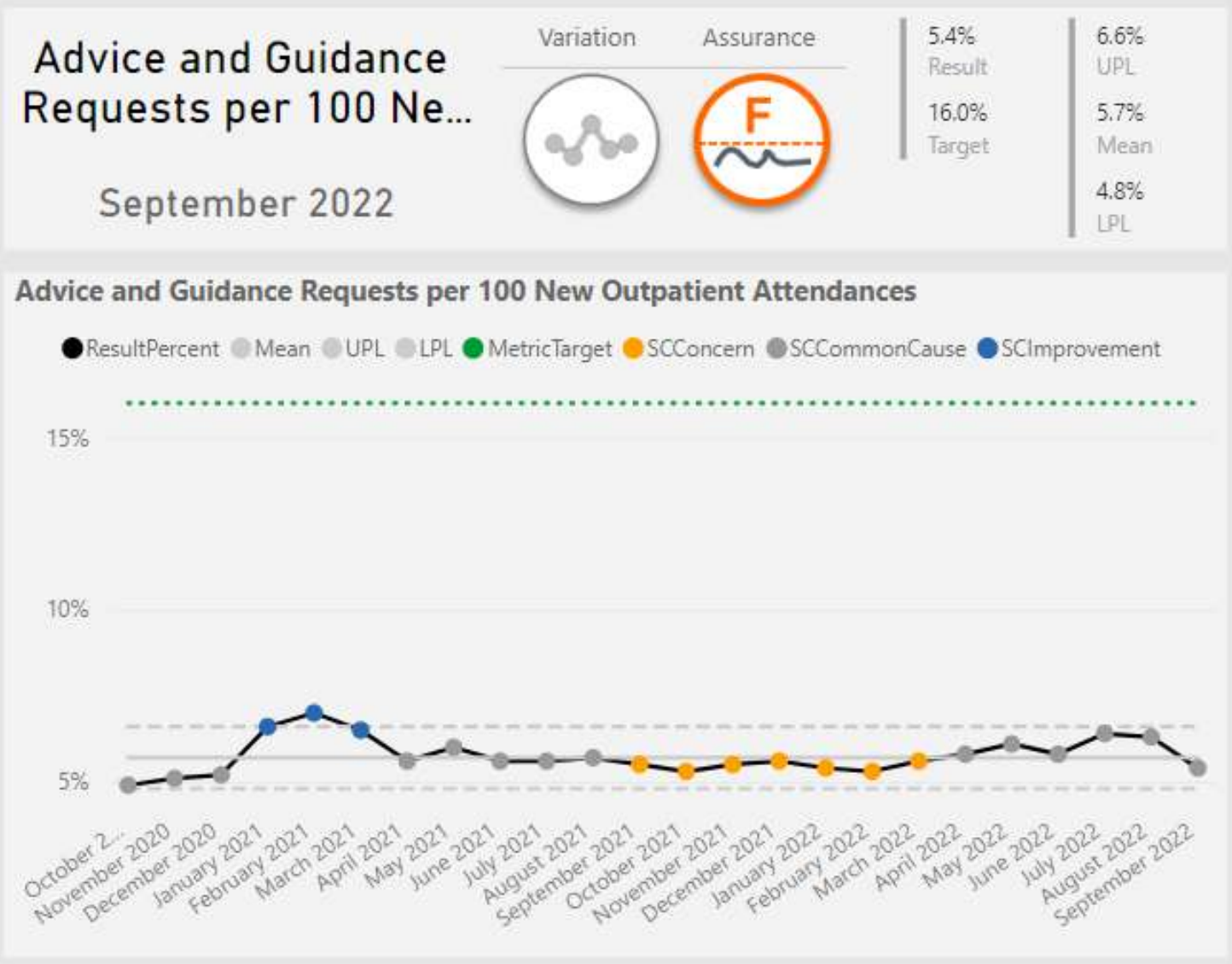
**Improvement Actions**

1. Departmental sign off for SALT (Laryngectomy), Pediatric (Haematology), Gastro (IBD), Rheumatology (Osteoporosis), Oral Health, Pediatric Occupational Therapy and Pediatric Physiotherapy.
2. Progress additional pathways for Gynae (cancer pathways), Physio, Cardiology, Urology, Oral Health, Dermatology, Plastics, Dietetics (Allergy), Psychology and T&O.
3. Enhanced post go live support plan to encourage adoption.
4. POP/PIFU live events led by Consultants in the clinical design authority and the platforms.

**Risk To Delivery**

**GREEN**

# Performance – Advice & Guidance




## Commentary

**September 2022 Performance**

In relation to the newly introduced target of 12 A&G requests per 100 new outpatient appointments, we continue to sit below the target, with reduced performance in September.

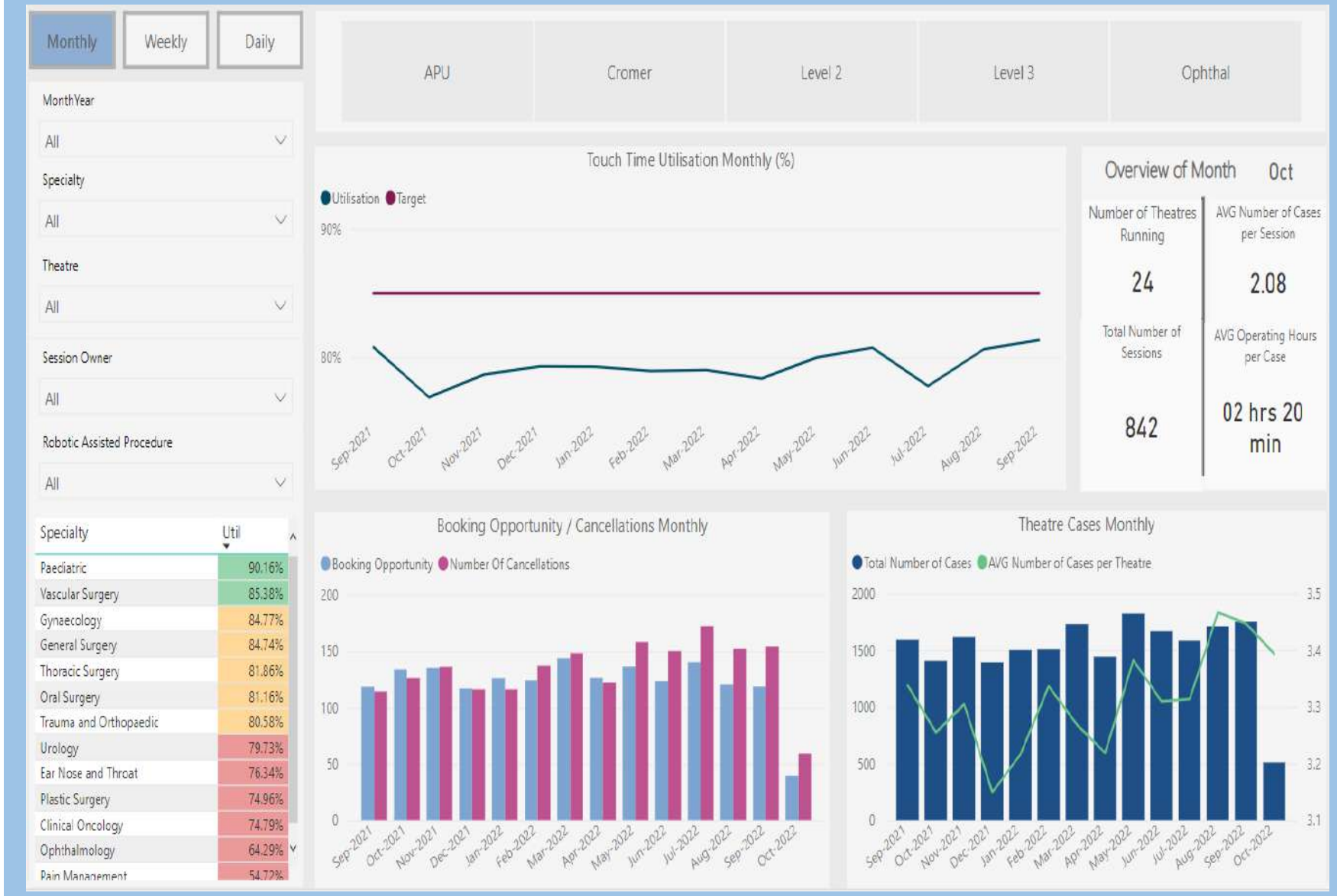
**Improvement Actions**

1. RITS request submitted to look into the possibility of A&G being provided as a triage option on the Outpatient Referral Console.
2. Work on job plans to ensure clinicians have allotted A&G time in their day.

**Risk To Delivery**

**RED**

# Performance – Theatre Dashboard: Utilisation




## Commentary

**September 2022 Performance**

The touch time delivery across all theatres showed a slight increase to 81% in September. Level 3 theatres delivered 84%, while Level 2 utilisation was 79% for the month. Thoracis and General Surgery delivered the most significant improvements in utilisation during the month.

Booking position remained at 71% across all theatres, however level 2 theatres (DPU) showed a 2% improvement at 78%.

**Improvement Actions**

1. Work around the development of POA pathways has continued, with a full process mapping completed. NHSI to present findings in October.

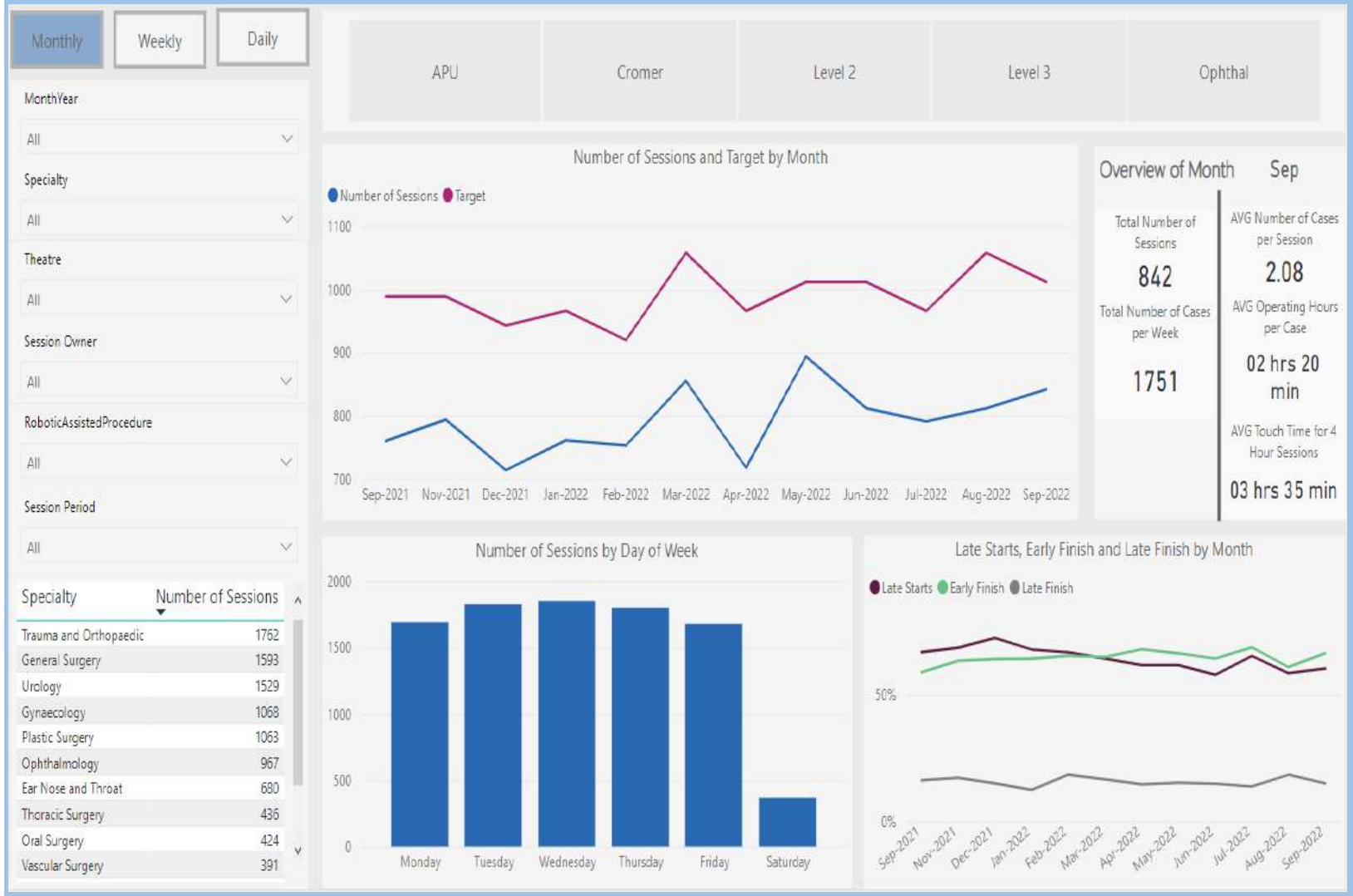
2. Theatre data to be reviewed at the end of each session to ensure proactive closure of sessions reduced by last minute cancellations.

3. Finalise development of 10 step utilisation plan and work as part of refreshed Use of Resources Assessment in September.

**Risk To Delivery**

**AMBER**

# Performance – Theatre Dashboard: Sessions




## Commentary

**September 2022 Performance**

The number of sessions in month increased slightly. A total of 842 sessions were delivered in September.

Theatre staffing levels improved in September as a number of learners completed their supernumerary period of training. Additional capacity continued across weekends via the Medacs Healthcare insourcing campaign, providing up to x 11 all day sessions per week.

The level of on the day cancellations continues to be the significant factor in early finishes, as the cancellations are too late to refill the theatre slots, however late starts remained static.

**Improvement Actions**

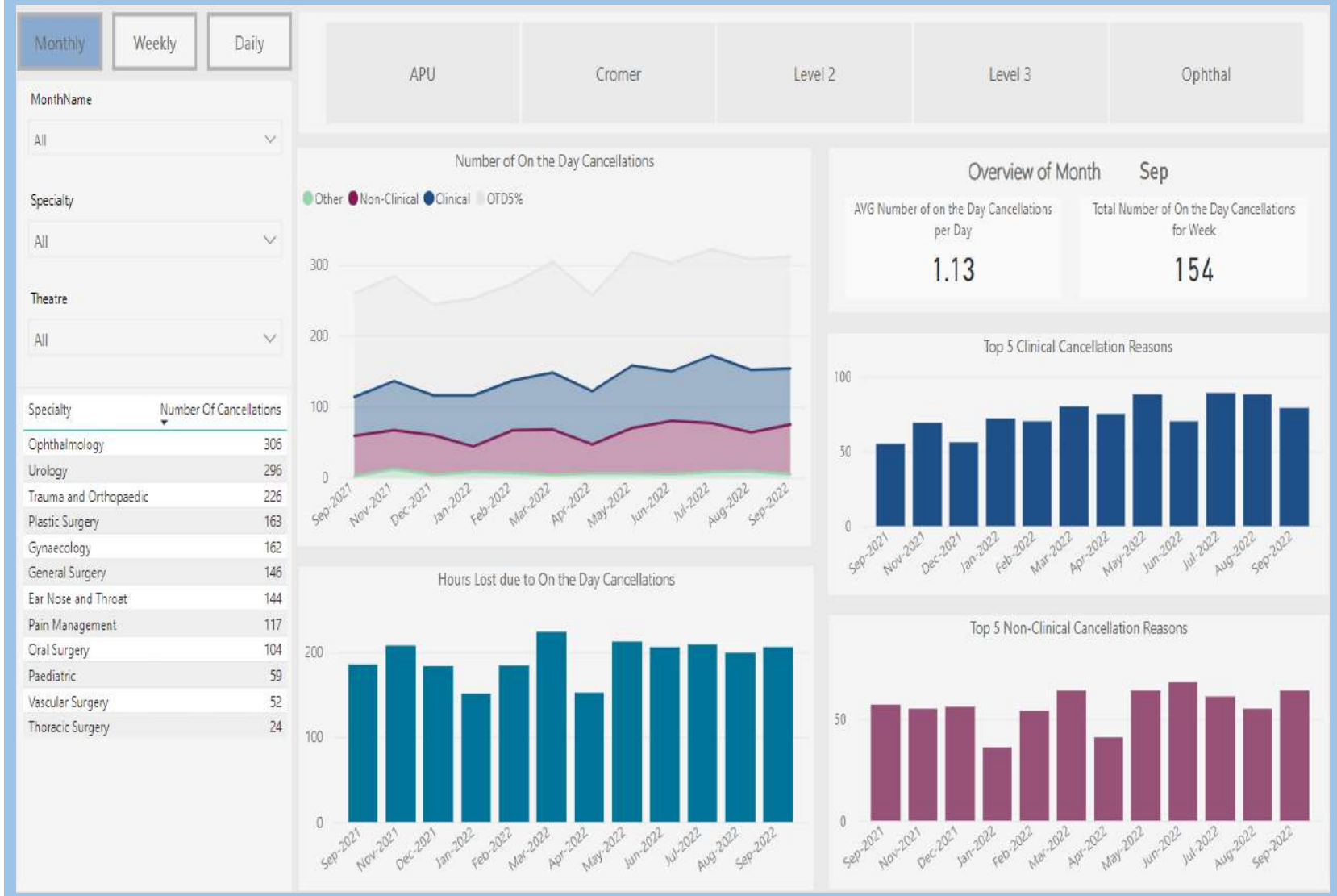
1. Early look at Anaesthetic rota to be carried out to avoid last minute closure of sessions where possible as we move into October.

2. Formal locking of theatre sessions to be introduced to avoid start delays through list order changes being known. Implementation date Monday 8th October.

**Risk To Delivery**

**Amber**

# Performance – Theatre Dashboard: Cancellations




## Commentary

**September 2022 Performance**

The on the day cancellation rate dropped slightly in September with a total of 154 cancellations in month (152 in August).

There were 79 clinical cancellations, attributable to patients being unfit (34), and a further 19 patients cancelled due to the operation no longer being required. The level of cancellations due to COVID reduced to just 7 cases (19 in August).

Levels of non-clinical cancellations increased in month from 55 to 70, with 17 due to a lack of theatre time on the day, 16 were through patients not attending and 6 administrative errors.

**Improvement Actions**

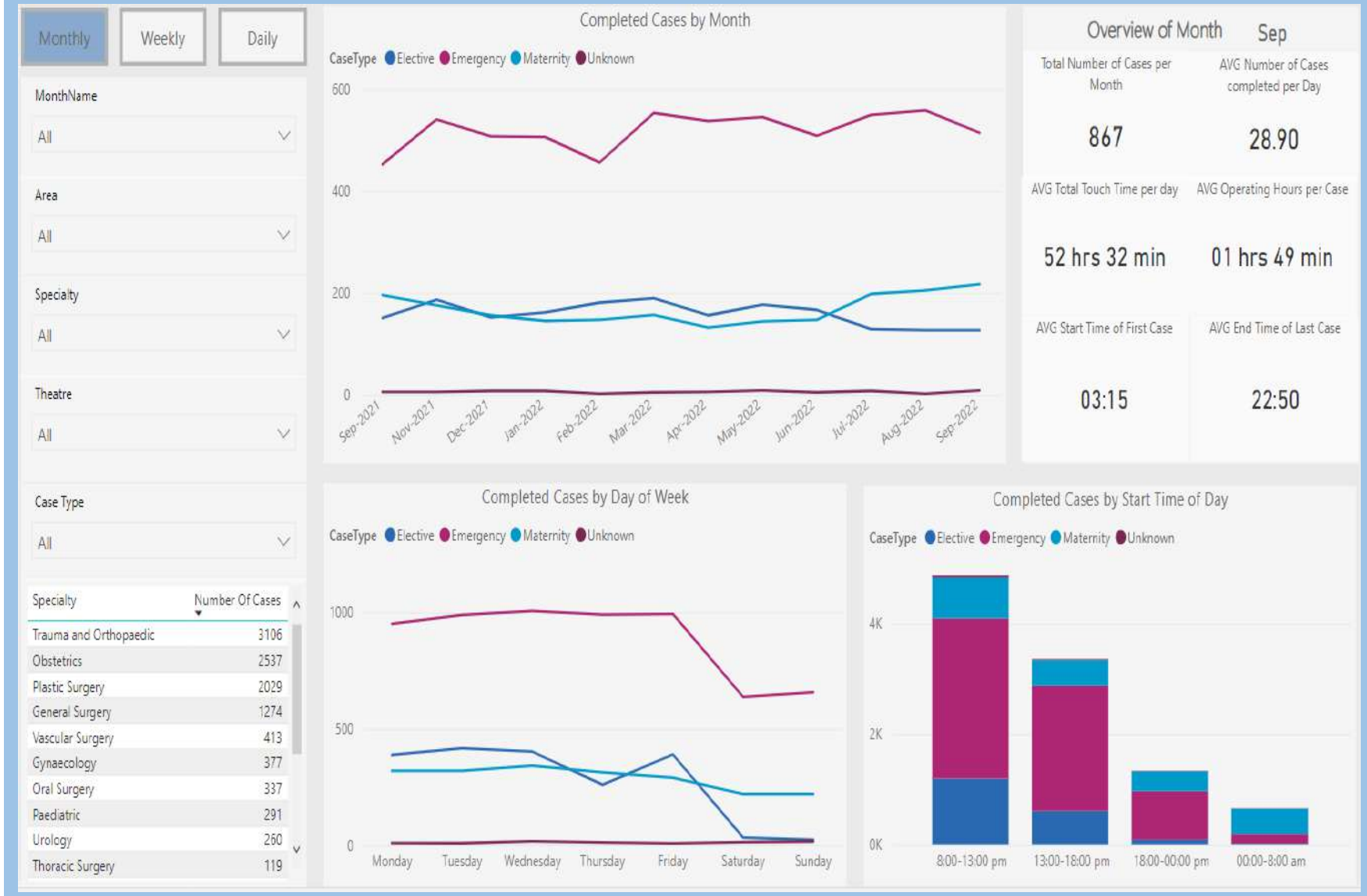
1. Specialities to conduct RCAs for patients cancelled due to the operation no longer being indicated to identify themes and inform action plan.

2. Review of administration support to facilitate pre-admission cancellation prevent role being reinstated.

**Risk To Delivery**

**RED**

# Performance – Theatre Dashboard: Emergency Theatres




## Commentary

**September 2022 Performance**

Non-elective demand decreased during September, with a total of 867 cases in month (892 in August).

Demand for elective obstetric capacity continued to outstrip baseline capacity which was managed through overtime.

**Improvement Actions**

1. Cross divisional meetings to be held in order that elective obstetric demand is understood and plans to mitigate put in place.

2. APU to be prioritised for Trauma.

**Risk To Delivery**

**AMBER**

# REPORT TO THE TRUST BOARD

| | | | |
|---|---|---|---|
| **Date** | **2 November 2022** | | |
| **Title** | **Month 6 IPR – Finance** | | |
| **Author & Exec lead** | **Roy Clarke (Chief Finance Officer)** | | |
| **Purpose** | **For Information** | | |
| **Relevant Strategic Objective [delete as appropriate]** | - Our Patients: Together, we will develop services so that everyone has the best experience of care and treatment.<br>- Our Resources: Together, we will use public money to maximum effect. | | |
| **Are there any quality, operational, workforce or financial implications of the decision requested by this report?** If so explain where these are/will be addressed. | **Quality** | **Yes✓ No☐** | **Delivery of the financial plan supports the delivery of operational, quality and workforce plans** |
| | **Operational** | **Yes✓ No☐** | **Delivery of the financial plan supports the delivery of operational, quality and workforce plans** |
| | **Workforce** | **Yes✓ No☐** | **Delivery of the financial plan supports the delivery of operational, quality and workforce plans** |
| | **Financial** | **Yes✓ No☐** | **Delivery of the financial plan supports the delivery of operational, quality and workforce plans** |

## 1. Background/Context

The Trust operational plan for FY22/23 (as submitted on 20th June 2022) is breakeven.

## 2. Key issues, risks and actions

**For the month of September 2022, the Trust delivered a breakeven position, which on a control total basis is £0.4m favourable to plan.** The position includes the fully funded Pay Award relating to months 1 to 6 and a further provision for income claw-back of £1.4m due to the Trust's activity performance falling below the required baseline offset by reduced expenditure.

**Year to date as at September 2022 is breakeven on a control total basis.** This is £1.4m adverse to plan. The position includes a provision for income claw-back of £4.8m due to the Trust's activity performance falling below the baseline offset by reduced expenditure. Pay is overspent by £1.1m driven by a £5.1m adverse variance in medical staffing offset by savings across nursing and professional & technical staff.

**Activity**: September elective activity was significantly behind plan, with estimated performance at 83% of plan for all elective activity. As a result year to date (YTD) performance is currently 89%. Value based activity performance for September was 82%, 88% YTD.

**Forecast outturn is breakeven, unchanged from the FY22/23 breakeven plan submitted on 20th June.** There is identified delivery risk to the breakeven plan of £39.6m which would result in a downside deficit of £39.6m. This is offset by mitigations totalling £39.6m resulting in the breakeven Forecast Outturn.

**Cash: Cash held at 30 September 2022 is £85.0m.** The closing balance is £18.6m above the FY22/23 submitted forecast as result of the continued delay to the capital programme and other working capital movements. Cash balances are forecast to reduce by c.£19.8m however, remain positive in March 2023 thus no revenue support would be required. Short term cash balances have stabilised in September following the requirement to switch off the Trust's finance system following a national cyber-attack in August.

**110% of 2019/20 Baseline:** The Activity Metrics show the proportion of delivery against the 2022/23 plan, which is an activity baseline of 110% of 2019/20 delivery, which equates to 104% of weighted value in financial terms.

**Capital: Year-to-date as at 30 September, the Trust underspent against the latest plan by £2.6m (£1.3m in month).** The latest plan was approved in September and a further variation has been approved at IG in October. The significant underspend is caused by a number of schemes missing planned milestones. The forecast outturn expenditure is £26.0m, excluding the impact of IFRS16, and is line with the latest plan.

## 3. Conclusions/Outcome/Next steps

The Trust delivered a breakeven position against the planned £0.4m deficit with the Trust now £1.4m adverse to the Trust Control Total. The Trusts delivery of the Capital Expenditure again fell behind that expected.

**Recommendation:**
The Board is recommended to:

- **Note** the contents of the report

Norfolk and Norwich University Hospitals NHS Foundation Trust

# Finance Report September 2022

## 25 October 2022

## Roy Clarke, Chief Finance Officer

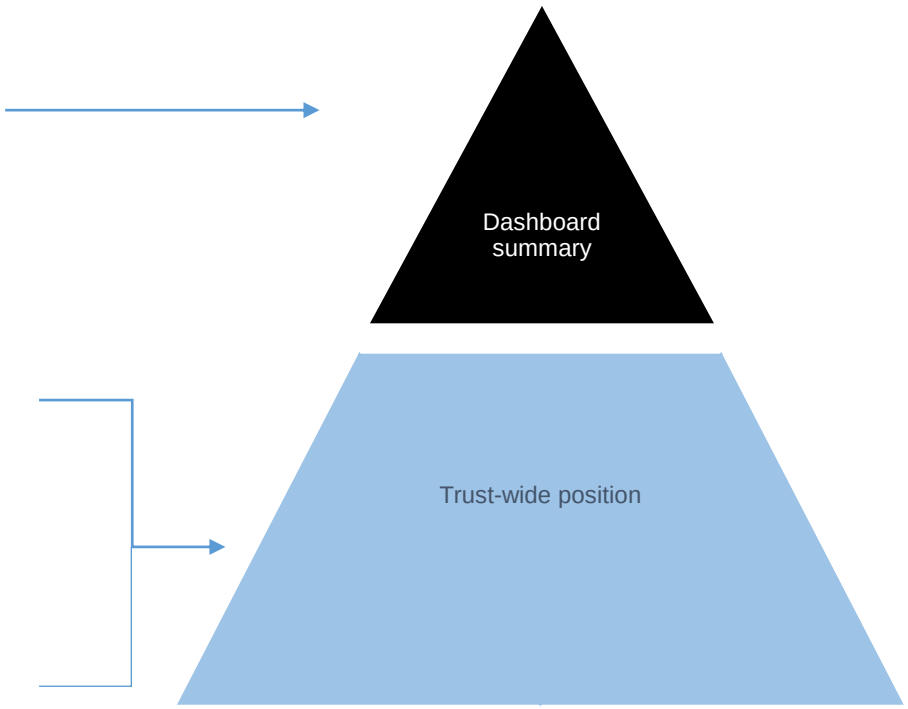
Norfolk and Norwich University Hospitals NHS Foundation Trust

# 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.





# 1.1 Executive Dashboard

Norfolk and Norwich University Hospitals NHS Foundation Trust

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| | In Month | | | Year to Date | | |
|---|---|---|---|---|---|---|
| | Actual | Plan | Variance | Actual | Plan | Variance |
| **SOCI** | £m | £m | £m | £m | £m | £m |
| Clinical Income | 62.3 | 63.6 | (1.3) | 348.4 | 352.0 | (3.6) |
| Other Income | 9.2 | 7.4 | 1.8 | 47.4 | 43.8 | 3.6 |
| **TOTAL INCOME** | **71.5** | **71.0** | **0.5** | **395.9** | **395.8** | **0.0** |
| Pay | (43.8) | (44.3) | 0.5 | (236.7) | (235.6) | (1.1) |
| Non Pay | (18.6) | (18.3) | (0.2) | (106.4) | (107.0) | 0.6 |
| Drugs (Net Expenditure) | (2.8) | (2.7) | (0.1) | (16.9) | (15.8) | (1.1) |
| **TOTAL EXPENDITURE** | **(65.2)** | **(65.3)** | **0.2** | **(360.0)** | **(358.5)** | **(1.6)** |
| Non Opex | (6.3) | (6.0) | (0.3) | (35.8) | (35.9) | 0.1 |
| COVID (Out of System) Net Expenditure | (0.0) | (0.0) | 0.0 | (0.0) | (0.0) | 0.0 |
| Reported Surplus / (Deficit) | 0.0 | (0.4) | 0.4 | 0.0 | 1.4 | (1.4) |
| **Other Financial Metrics** | £m | £m | £m | £m | £m | £m |
| Cash at Bank (before support funding) | 85.0 | 66.4 | 18.6 | 85.0 | 66.4 | 18.6 |
| Capital Programme Expenditure | 1.7 | 3.0 | (1.3) | 12.8 | 15.4 | (2.6) |
| CIP Delivery | 1.2 | 1.6 | (0.4) | 5.6 | 9.1 | (3.4) |
| **Activity Metrics*** | % | % | % | % | % | % |
| Day Case* | 87% | | (13%) | 92% | | (8%) |
| Elective Inpatient* | 73% | | (27%) | 81% | | (19%) |
| Outpatients - New & Procedures* | 82% | | (18%) | 89% | | (11%) |
| Activity performance v baseline* | 83% | | (17%) | 89% | | (11%) |
| Value based Activity performance v baseline | 82% | | (18%) | 88% | | (12%) |

** Activity count as a % of 22/23 Planned Delivery*

Norfolk and Norwich University Hospitals NHS Foundation Trust

# 1.2 Executive Dashboard

## Risk

**The Trust's overall risk profile remains stable, with no changes in risk scoring this month.**

As part of FY22/23 annual planning there were 13 key strategic and operational risks identified with an initial score of ≥ 12, as part of the monthly review process a 14th risk with a score ≥ 12 was identified in May. The Finance Directorate continues to formally review the Financial Risk Register on a monthly basis, reviewing the risks and adding new risks which have been identified across the finance portfolio.

**There are ten risks rated as 'Extreme' on the risk register which have a potential risk assessed financial impact of £39.6m, of which £11.4m has crystalised YTD.**

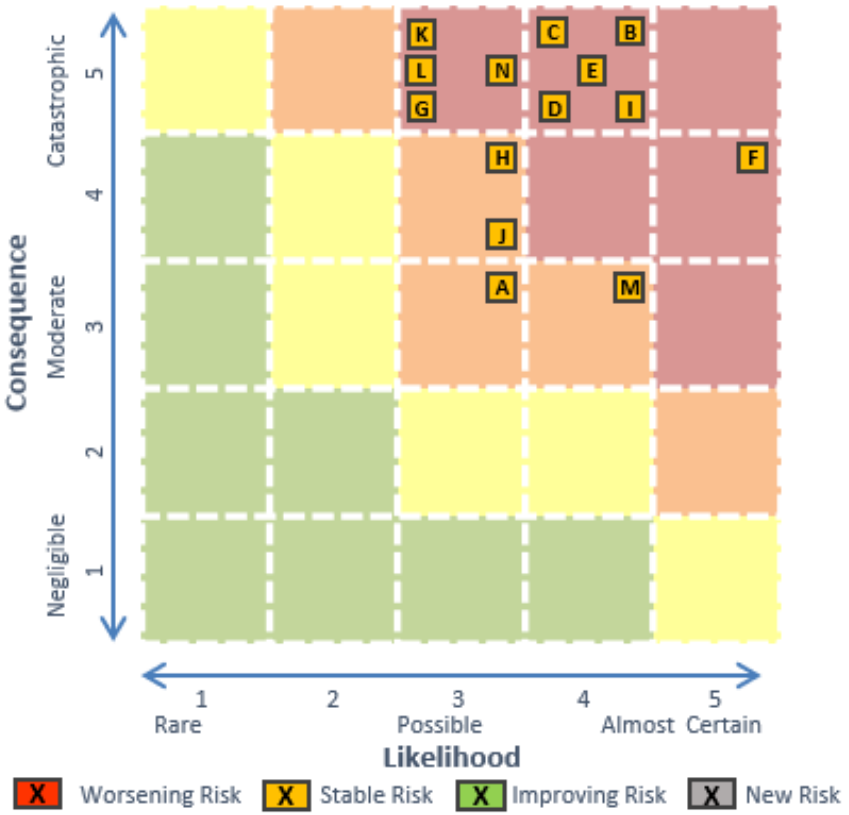
The YTD crystalized risks are:

**Risk F:** Income claw-back as a result of failure to deliver weighted elective activity in line with plan (Risk F) has a crystalised impact of £4.8m YTD at September as a result of value based activity being c. 88%.
**Risk B:** Year to date, CIP Delivery is £5.6m, £3.4m adverse to the budgeted plan of £9.3m, comprising of a planning variance of £3.0m and a performance variance of £0.4m. Gateway 2 approved CIP is currently £16.6m, £6.5m adverse to the Trust efficiency target of £23.1m.
**Risk E:** Year to date ED staff expenditure is £2.4m overspent as a result of increased rostering of medical staff. Escalation ward continues to be open in Q2 despite budget being allocated in Q1 only (£0.2m).
**Risk D:** Home First Unit remains open in Q2 despite budget being allocated in Q1 only (£0.5m).

**Management Actions Complete:**
- **Capital variation approved at IG**
- **Divisional recovery plans completed and reviewed**

**Management Actions Outstanding:**
- **Identify remaining CIPs to meet Trust's efficiency target**
- **Deliver on existing CQIA approved CIP, including YTD shortfall**
- **Deliver Trust activity plan including YTD shortfall**
- **Mitigate pay expenditure overspends and enact required controls**

| Risk Rating | | Risks | Financial Impact FY22/23 £m | Risk Assessed Impact £m | YTD Crystallised Impact £m |
|---|---|---|---|---|---|
| Extreme | 15+ | B, C, D, E, F, G, I, K, L, N | 76.4 | 39.6 | 11.4 |
| High | 9-14 | A, H, J, M | 6.0 | 0.0 | 0.0 |
| Moderate | 5-8 | - | 0.0 | 0.0 | 0.0 |
| Low | 1-4 | - | 0.0 | 0.0 | 0.0 |
| Total | | | 82.4 | 39.6 | 11.4 |
| Risk mitigated through Non Recurrent YTD underspends & Release of Expenditure Reserves | | | | | (10.0) |
| Total | | | 88.4 | 39.6 | 1.4 |



Norfolk and Norwich University Hospitals NHS Foundation Trust

# 2.1 Financial Performance – September 2022

**For the month of September 2022, the Trust delivered a breakeven position, which on a control total basis is £0.4m favourable to plan The position includes the fully funded Pay Award relating to months 1 to 6 and a further provision for income claw-back of £1.4m due to the Trust's activity performance falling below the required baseline offset by reduced expenditure.**

**Income:**
Income is reporting a favourable variance of £0.6m in September. This favourable variance is due to £0.3m private patient income, £0.1m of devices income, £0.3m of R&D Income, £0.4m of income backed cancer alliance expenditure and £0.4m of other income backed expenditure, including Reservists staffing, EPA Outflow, Digital Aspirant, Personalised Outpatients, international nurse recruitment and virtual ward offset by a provision for income claw-back of £1.4m due to the Trust's activity performance falling below the required baseline.

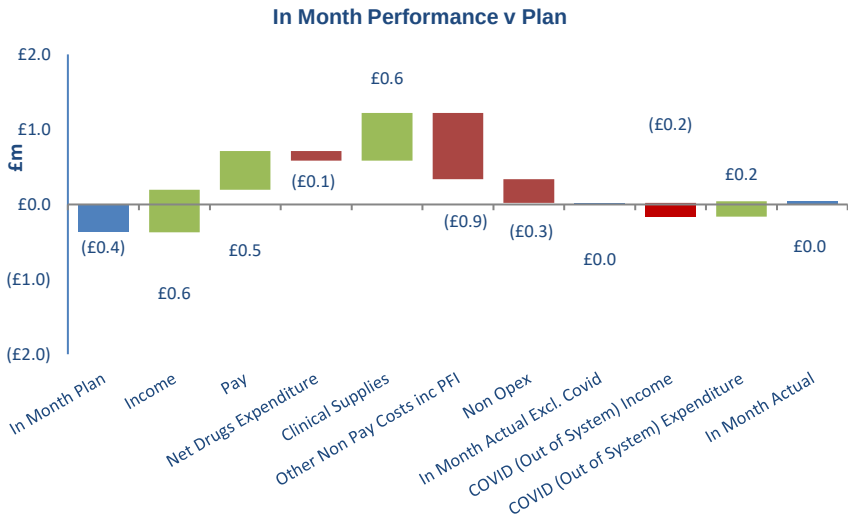
**Pay:**
Pay for September is £0.5m favourable to plan. This is due to £0.9m overspend in Medical staffing and £0.3m of unidentified CIP in month offset by delays in service development expenditure (£0.6m), and net underspends across nursing (£0.7m), A&C (£0.2) and AHP/Technical (£0.2m). Expenditure control particularly in relation to medical pay requires further management action.

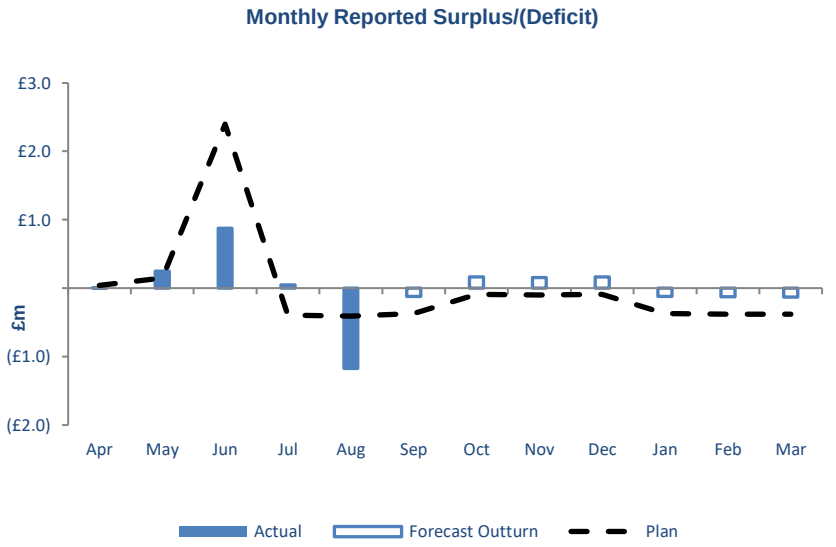
**Net Drugs Cost:**
The net drugs position for September is £0.1m adverse.

**Non Pay:**
There is a £0.3m adverse variance in September. This is due to a £1.1m favourable performance as a result of Growth and Prices reserves which were not required in month, offset by £1.0m of unidentified CIP and £0.4m additional expenditure on devices and other pass through (offset by matching income).

**Non Operating Expenditure:**
There is a £0.3m adverse variance in September as a result of the restatement of a lease under IFRS16

**Out of System COVID 19 Expenditure:**
The COVID-19 expenditure in month is £0.1m, with offsetting income of £0.1m and therefore an in month breakeven position.



Norfolk and Norwich University Hospitals NHS Foundation Trust

# 2.2 Financial Performance – Year to Date

**Year to date as at September 2022 is breakeven on a control total basis. This is £1.4m adverse to plan. The position includes a provision for income claw-back of £4.8m due to the Trust's activity performance falling below the required baseline offset by reduced expenditure.**

**Income:**
Income is reporting a favourable variance of £0.1m year to date. This adverse variance is due to a provision for income claw-back of £4.8m due to the Trust's activity performance falling below the required baseline, offset by favourable variances in Devices income (£1.2m), R&D Income (£1.7m) and £1.9m of other income backed expenditure, including Digital Aspirant, Personalised Outpatients, international nurse recruitment and virtual ward.

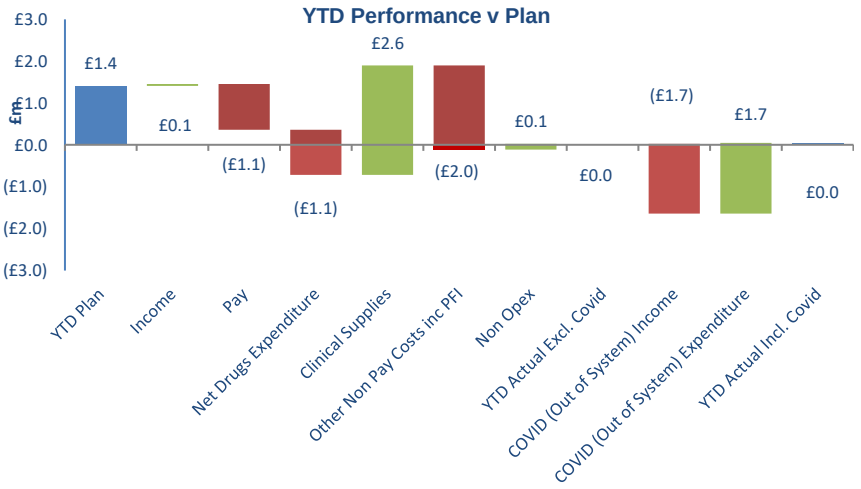
**Pay:**
Medical pay is £4.9m adverse to plan and unidentified CIP is driving a £1.7m adverse variance, this is offset by delays in service development expenditure (£1.1m), and net underspends across nursing (£2.7m), A&C (£1.4) and AHP/Technical (£0.3m) resulting in a £1.1m adverse net pay position. Surgery pay spend is £3.0m adverse to plan including £1.2m due to the unidentified CIP.

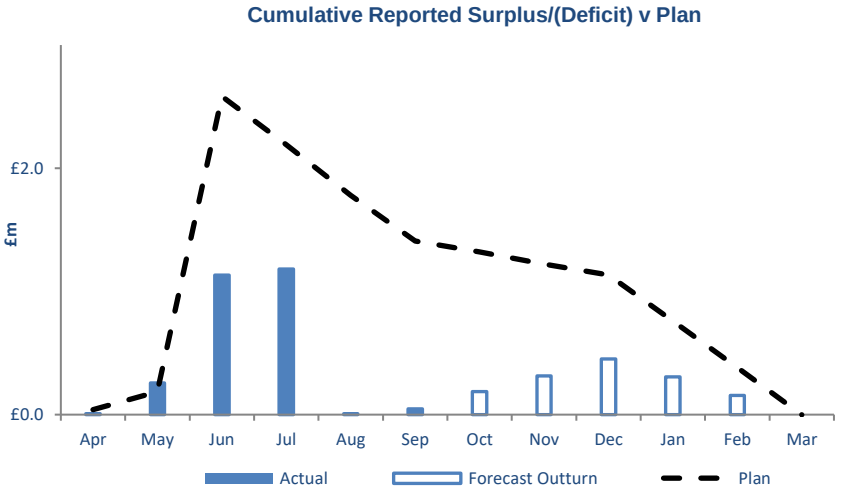
**Net Drugs Cost:**
Year to date net drugs position is £1.1m adverse. This is predominantly as a result of increased expenditure on drugs included within block agreements and the transfer of two specific drugs from cost and volume to block.

**Non Pay:**
Year to date non pay is £0.6m favourable to plan. This is due to a £3.5m favourable performance as a result un utilised Growth and Prices reserves, £1.9m reduced spend as a result of lower than planned activity levels offset by £4.8m additional expenditure on devices and other pass through expenditure (offset by matching income as noted above).

**Non Operating Expenditure:**
Year to date non operating expenditure is showing a £0.1m favourable variance.

**Out of System COVID 19 Expenditure:**
The COVID-19 expenditure year to date is £0.9m, with offsetting income of £0.9m and therefore a YTD breakeven position. The main area of expenditure remains testing. Expenditure is £1.7m favourable to plan due to the reduced prevalence of COVID and step down in COVID restrictions.




**All divisions are struggling to deliver their financial plans, with the surgical division having the greatest gap due to pay spend in ED (£1.9m), reduced activity and CIP shortfall (£1.6m).**

Norfolk and Norwich University Hospitals NHS Foundation Trust

# 2.3 22/23 FOT

**Forecast outturn is breakeven, unchanged from the FY22/23 breakeven plan submitted on 20th June. There is identified delivery risk to the breakeven plan of £39.6m which would result in a downside deficit of £39.6m. This is offset by mitigations totalling £39.6m resulting in the breakeven FOT.**

❶ **Risk:** Risk of income deduction for Trust's failure to deliver weighted activity in line with the plan. **Total Risk: £10.9m**
**Mitigation:** Suspension of Income Claw Back scheme in H1 and increased activity delivery in H2. **Total Mitigation: £10.9m.**
**Net Risk £0.0m**

❷ **Risk:** Risk of overspends due to failure to identify and deliver Trust's efficiency programme. **Total Risk: £9.3m**
**Mitigation:** Full identification and delivery of Efficiency Programme, through non recurrent schemes if necessary. **Total Mitigation: £9.3m**
**Net Risk £0.0m**

❸ **Risk:** Risk of overspends if inflation rates increase beyond levels allowed for within the plan. **Total Risk: £3.0m**
**Mitigation:** Inflation rates remain within levels allowed for within the plan due to continued payment holiday's as a result of fixed contracts. **Total Mitigation: £3.0m**
**Net Risk £0.0m**

❹ **Risk:** Risk of requirement to add additional capacity at an additional cost. **Total Risk: £9.8m**

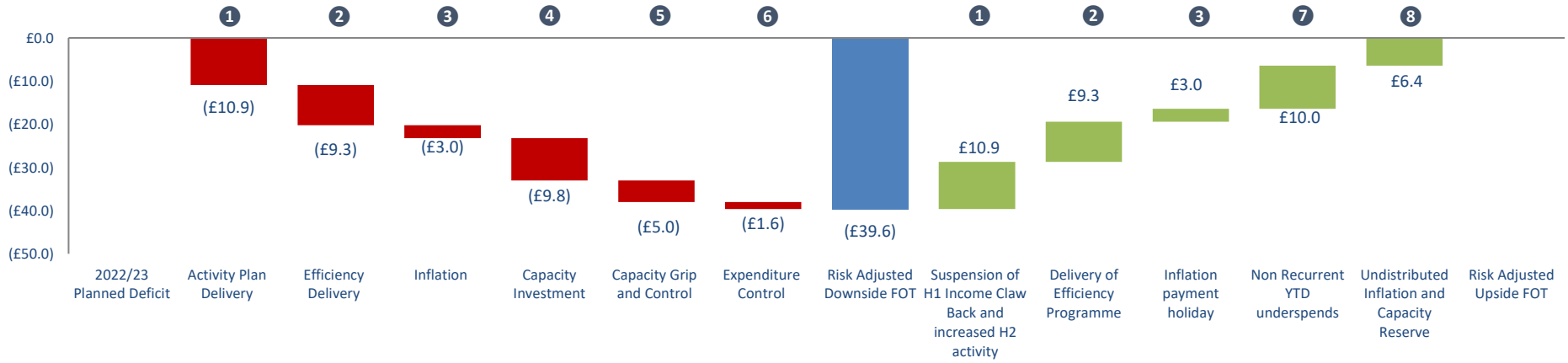
❺ **Risk:** Risk of the Trust's capacity plan not reflecting available clinical space and workforce effective hours. **Total Risk: £5.0m**

❻ **Risk:** Risk of overspends due to failure to control in expenditure in line with plan. **Total Risk: £1.6m**

❼ **Non Recurrent YTD underspends:** Reduced expenditure as a result of lower activity levels seen year to date. **Total Mitigation: £10.0m**

❽ **Undistributed Reserve:** Grip and control of expenditure plan including ensuring the use of the capacity available is optimised and contracts are managed so that the relative reserves are not drawn down. **Total Mitigation: £6.4m**

**This results in a risk adjusted upside forecast outturn breakeven, unchanged from the FY22/23 breakeven plan submitted on 20th June.**



# REPORT TO TRUST BOARD

| | |
|---|---|
| **Date** | **2 November 2022** |
| **Title** | **Infection Prevention & Control (IP&C) Annual Report 2021-22 and Annual Plan 2022-23** |
| **Author & Exec Lead** | **Professor Nancy Fontaine, Director of Infection Prevention and Control (DIPC) and Chief Nurse**<br>**Elizabeth Morrison, Deputy Director of Infection Prevention and Control (DDIPC)** |
| **Purpose** | **For Agreement** |
| **Relevant Strategic Commitment** | **1. Together, we will develop services so that everyone has the best experience of care and treatment**<br>**2. Together, we will support each other to be the best we can be, to be valued and proud of our hospital for all**<br>**3. Together, we will join up services to improve the health and wellbeing of our diverse communities** |

| | | | |
|---|---|---|---|
| **Are there any quality, operational, workforce and financial implications of the decision requested by this report?**<br>**If so explain where these are/will be addressed.** | **Quality** | **Yes☐ No✓** | |
| | **Operational** | **Yes☐ No✓** | |
| | **Workforce** | **Yes☐ No✓** | |
| | **Financial** | **Yes☐ No✓** | |

| | | |
|---|---|---|
| **Identify which Committee/Board/Group has reviewed this document:** | • **Hospital Management Board 20/09/22**<br>• **Hospital Infection Control Committee 26/09/22**<br>• **Quality and Safety Committee 27/09/22**<br>• **Council of Governors 06/10/22** | **Outcome: Approved** |

## 1 Background/Context

1.1 The IP&C team provide the Annual report on behalf of the DIPC as a requirement of the Trust Board 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 report provides assurance of Infection Prevention and Control activity during the financial year 2021-2022.

1.2 This report has been submitted to the Hospital Management Board, Hospital Infection Control Committee and the Quality and Safety Committee prior to this submission.

## 2 Key issues, risks and actions

2.1 The SARS CoV2 pandemic was ongoing during this period and this report includes the third wave. The IP&C team commend the hard work and dedication of staff across the healthcare community who worked collaboratively and continued to strive for high IP&C standards. Despite challenging times, they continued to promote patient and staff safety whilst endeavouring to reduce the risk of nosocomial transmission.

2.2 In June 2021 the DIPC, IP&C and clinical teams were able to demonstrate to NHSE/I and CCG colleagues their pride in the partnership working with Divisions and Facilities management, the systems to manage infection and promote patient safety along, with the cleanliness of the environment.

2.3 In 2021 a business case was successful for an upgrade of the IP&C software system ICNet to work together across the region. Work is ongoing to achieve this and therefore it remains on the Trust Risk Register.

**3 Conclusions/Outcome/Next steps**

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

**Recommendations:** The Board is recommended to **Approve** this report as an assurance of IP&C practice within the Trust.

# Infection Prevention & Control Annual Report 2021-22

Norfolk and Norwich University Hospitals NHS Foundation Trust

| NNUH *C. difficile* 2021-22 – number of cases | | | | | | |
|---|---|---|---|---|---|---|
| Financial Year | NNUH Objective | Community Origin (sampled before day 3) | | Hospital Origin (Sampled on or after day 4) | | Total |
| | | COIA 31 | COCA 121 | HOHA 49 | COHA 40 | |
| 2021-22 | 57 | 152 | | Total 89 cases of which 66 had no lapses so not counting towards final objective, leaving **23** with lapses in care counting towards the objective. | | 241 |

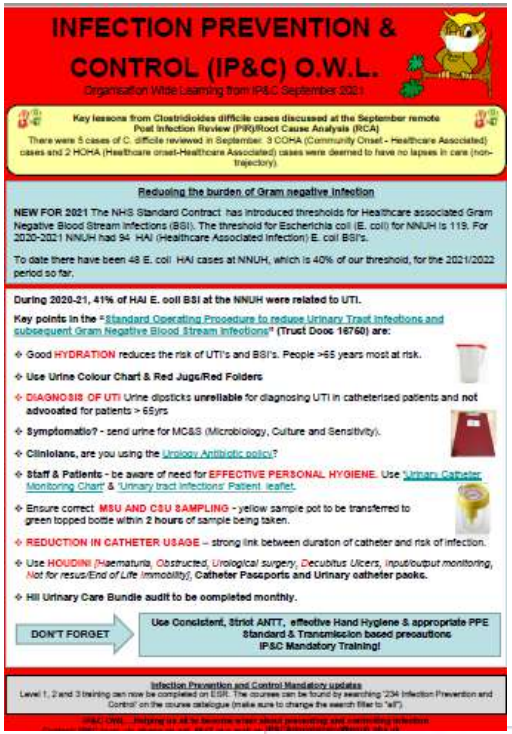
- C.difficile 28.32 per 100,000 bed days (East of England 31.07)
- Post infection review
- Learning is shared Divisionally and via Organisational Wide Learning (OWL)

- 1 case MRSA blood stream infection >3 days deemed unavoidable with notable practice
- MRSA 0.64 per 100,000 bed days (East of England 1.48)

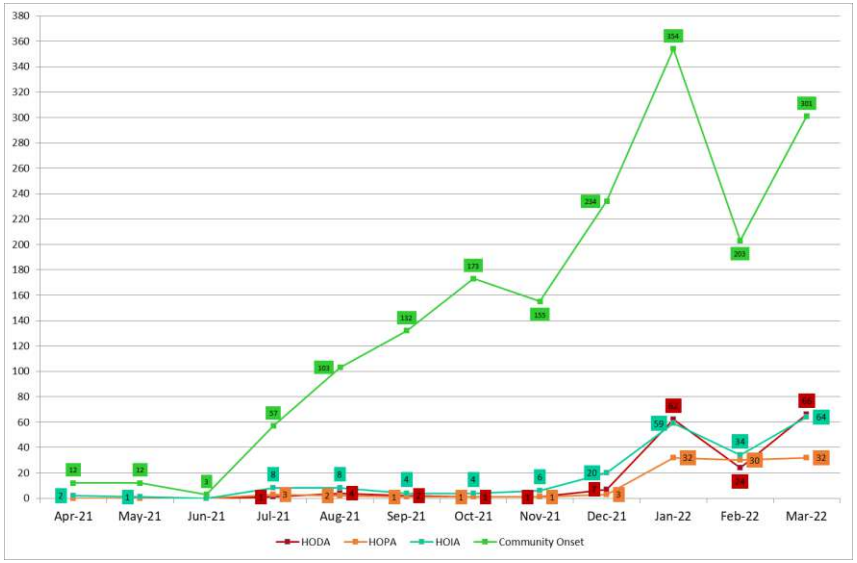
- 30 cases MSSA blood stream infection > 3 days
- MSSA 12.09 per 100,000 bed days (East of England 13.64)

| NNUH *Escherichia coli* BSI – number of cases | | | |
|---|---|---|---|
| **Financial Year** | **Community Origin** | **Hospital Origin** | **Total** |
| 2021-22 | 283 COCA | 51 HOHA, 48 COHA | 382 |

- 99 (26%) of cases of hospital origin (objective119)
- E.coli 31.50 per 100,000 bed days (East of England 33.56)




- Wave 3 of the SARS CoV2 pandemic
- Staff advice on UKHSA guidance
- Support Trust IMT
- Advise on mitigations at times of extreme pressure




| 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 |

Our Vision
The best care for every patient

NHS
Norfolk and Norwich University Hospitals
NHS Foundation Trust

# Infection Prevention and Control Annual Report 2021-22 and Annual Plan 2022-23


**Director of Infection Prevention and Control: - Professor Nancy Fontaine**

**Deputy Director of Infection Prevention and Control: - Liz Morrison**

**Infection Control Doctor: - Dr Catherine Tremlett**

**Infection Prevention and Control Team**


# Infection Prevention and Control Annual Report 2021-22

# Infection Prevention and Control Annual Report 2021-22

## Executive Summary

This annual report incorporates information and data pertaining to healthcare associated infections during the period 1st April 2021 until 31st March 2022. 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.

Official alert organism government objectives were set in August 2021 and the Trust continued to monitor against objectives throughout this period.

- There were 89 total cases of *Clostridioides difficile* infection (CDI) of which after the post infection reviews 23 had lapses in care and therefore counted towards this set objective of 57.
- There was 1 case of Hospital Attributable Meticillin Resistant *Staphylococcus aureus* (MRSA) blood stream infection (BSI) deemed unavoidable, 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 third wave of this pandemic.

In June 2021 NHSE/I undertook a planned supportive visit with CCG colleagues which enabled the DIPC, IP&C team and clinical teams to demonstrate their partnership working with divisions and Facilities management. They shared the effective systems to manage infection, promote safety for patients, staff and visitors and demonstrated cleanliness in the environment, prompt identification of risk and learning from Post Infection Review (PIR) during the COVID-19 pandemic. Colleagues from our Emergency Department (ED) and Renal Department shared their experiences during this challenging time. All involved were proud of the partnership working, innovation and supportive approach.

In February 2022 there were unannounced external CQC inspections to the Cromer Minor Injuries Unit (MIU), Cromer medical services and to older people's care at the NNUH. This was during the height of the third wave. Whilst these inspections were not rated it was noted that infection was controlled well, equipment and control measures were used to protect patients, themselves and others, and the environment was visibly clean at both sites. Staff followed infection control principles and were observed wearing correct Personal Protective Equipment (PPE).

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.

# Infection Prevention and Control Annual Report 2021-22

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

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

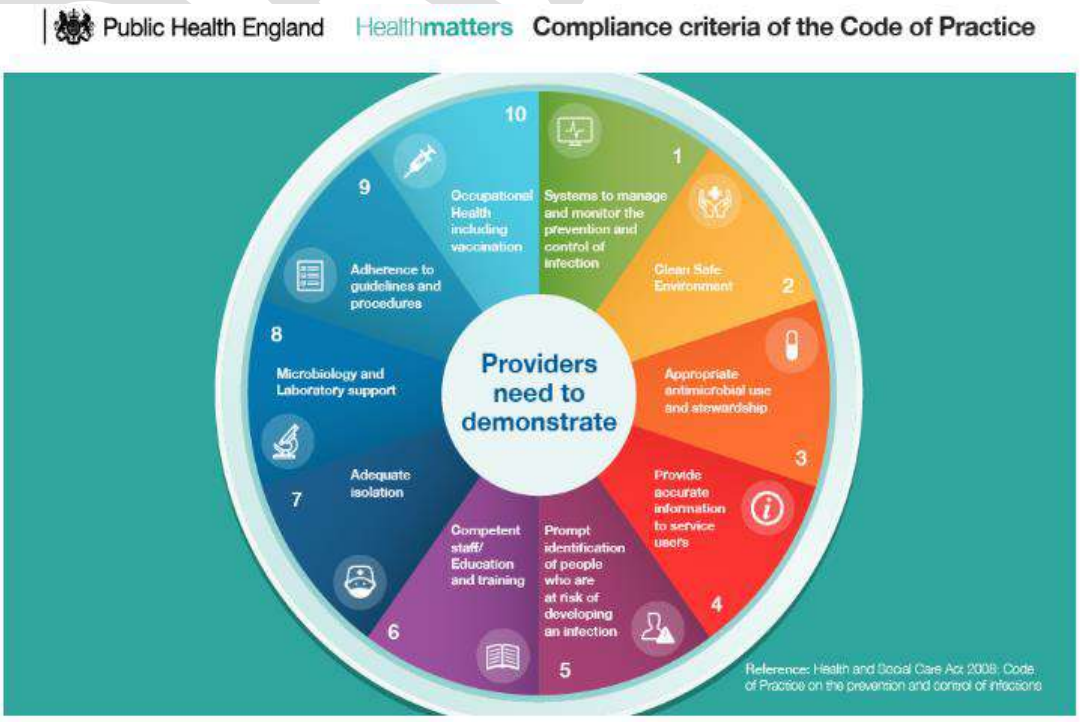
## Abbreviations

| | |
|---|---|
| **AMR** | Antimicrobial Resistance |
| **BSI** | Bloodstream infection |
| **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 Definite 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) |
| **HICC** | Hospital Infection Control Committee |
| **ICD** | Infection Control Doctor |
| **ICB** | Integrated Care Board (previously CCG) |
| **ICN** | Infection Control Nurse |
| **IP&C** | Infection Prevention & Control |
| **MHRA** | Medicines and Healthcare Products Regulatory Agency |

# Infection Prevention and Control Annual Report 2021-22

| | |
|---|---|
| **MRSA** | Meticillin Resistant *Staphylococcus aureus* |
| **MSSA** | Meticillin 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 |
| **OPAT** | Outpatient parenteral antimicrobial therapy |
| **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 |
| **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 |
| **UKHSA** | United Kingdom Health Security Agency |
| **VRE** | Vancomycin Resistant Enterococcus |
| **WHWB** | Workplace Health and Well-Being |

**Image 1**



# Infection Prevention and Control Annual Report 2021-22

**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 UKHSA/PHE and CCG, along with patient representatives are invited to meetings held monthly, with exception of July, August, December, and March 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. During this period the Senior IP&C nurse was seconded into the role of Head of Infection Prevention & Control as the deputy DIPC was seconded to the Queen Elizabeth hospital in Kings Lynn. This also enabled a band 7 IP&C nurse to second into the Senior Nurse role providing opportunity for leadership development. 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 UKHSA/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/Head of IP&C reports to the clinical safety sub-board monthly.

# Infection Prevention and Control Annual Report 2021-22

**Chart 1**

Norfolk and Norwich University Hospitals NHS Foundation Trust

## Board of Directors and Management Board Reporting and Accountability Structure

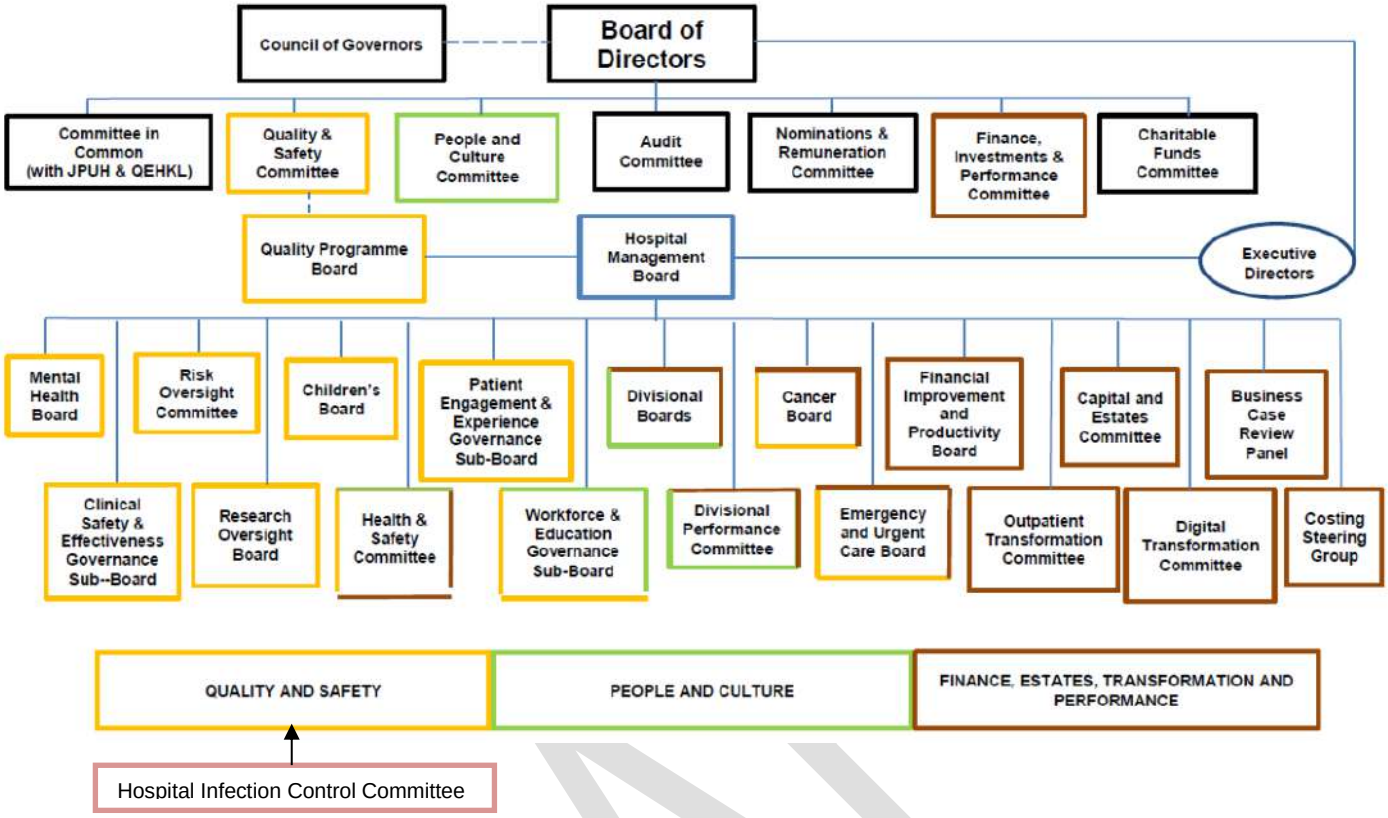
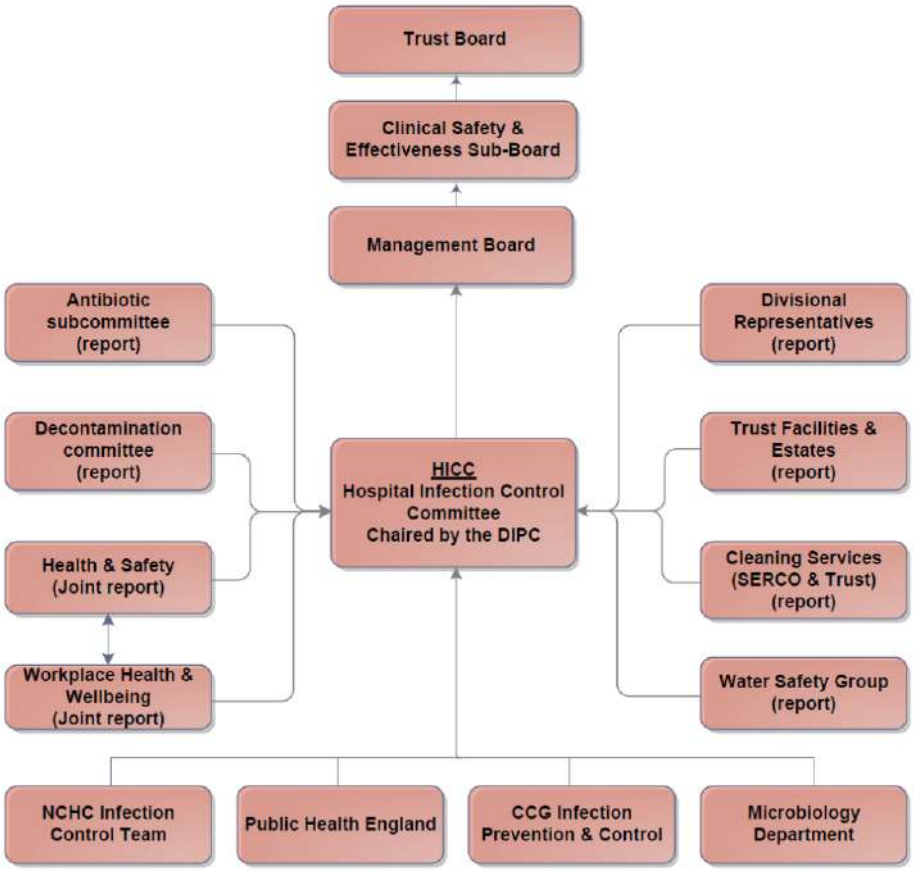



**Chart 2**

## Infection Prevention & Control Governance Structure

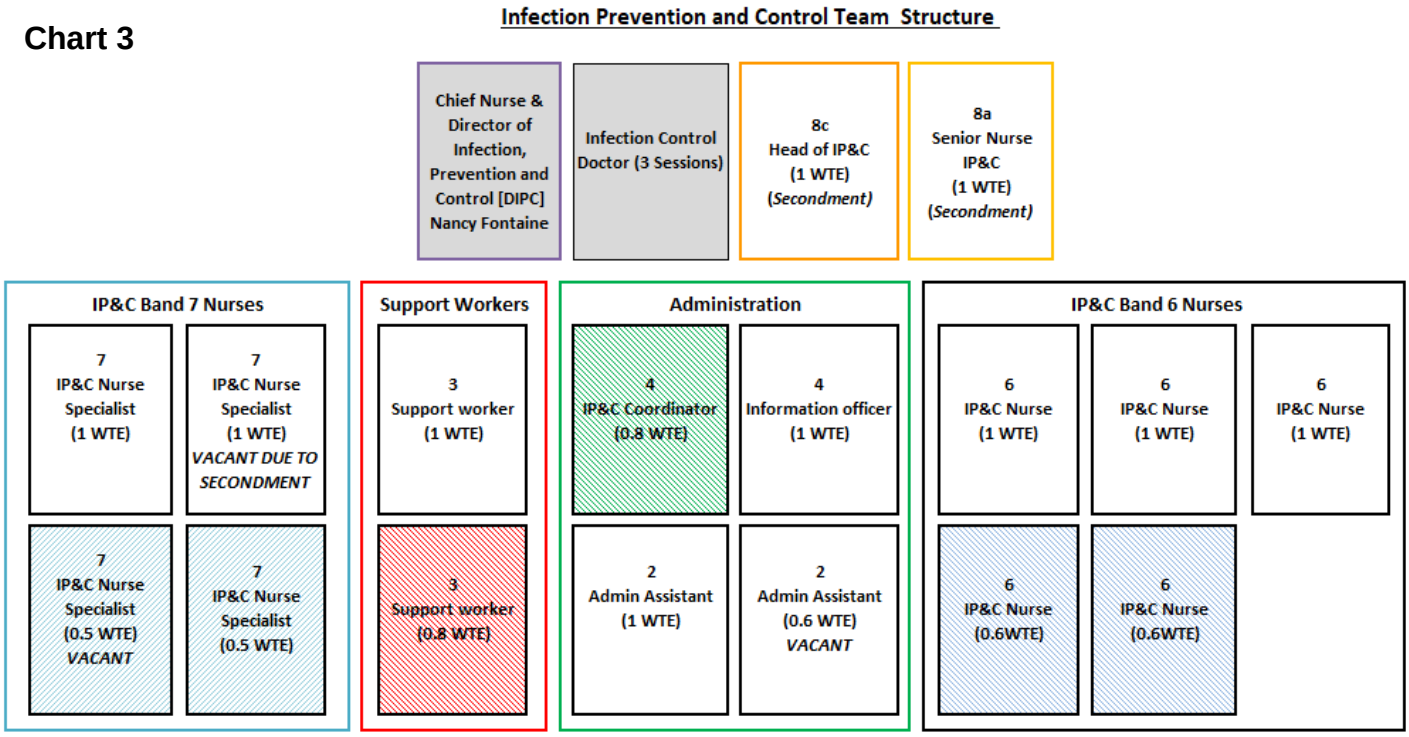


# Infection Prevention and Control Annual Report 2021-22

## The IP&C 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 to incident management meetings and the Post Infection Review (PIR) for all patients who develop an MRSA bacteraemia or *Clostridioides difficile* Infection (CDI) in line with national guidance.

## Decontamination and Water Safety Groups

This report provides a highlight summary of the Trust Decontamination Group's activities over the financial year 2021-22.

### Audit and Governance

The 21-22 annual audit took place in July; this resulted in 2 minor actions for correction. There were no major actions. This continued the year-on-year improvements we have seen; 20-21 audit saw 1 major (due to a previous minor not being closed to the auditors' satisfaction); 19-20 saw 0 major and 7 minor, whilst 18-19 saw 6 major and 11 minor actions.

The bi-monthly report on decontamination operational performance continues to be monitored by the Theatre Management Group but has also been introduced to the Decontamination Committee Meeting to ensure full oversight.

### Quadram Institute (QI)

There have been no further problems with Mycobacteria since the issues previously reported to HICC. There was a leak of kitchen drain water in the ceiling above the endoscope drying/storage cabinets in January which required 6 machines to be removed from service.

All affected machines were repaired (where necessary), fully decontaminated and decommissioned and there have been no further issues to date.

**Operational highlights**
Decontamination activity saw a steady increase as elective activity began its recovery; weekend theatre sessions were introduced in January, but the department has been able to facilitate the increased demands across the (7-day) week.

A project has commenced to install 4 Belimed washer disinfectors and 1 MMM autoclave; the project is primarily in response to the expansion of the elective theatre footprint with the construction of the Norwich Orthopaedic complex (NaNOC) which is scheduled to open later this year. Some building works and facilitates upgrades are required which are being carefully orchestrated to ensure minimal disruption to business as usual.

**Risks**
Unfortunately, the reduced availability of capital funds meant that there has not been any further progress on the 3 replacement washer disinfectors in line with the rolling capital replacement program. This has been risk assessed and is currently scored as a 16. There is an intention to replace a minimum of 2 machines in the financial year 22/23.

## Water Safety Management Group Report

The Water Safety Management Group is held on a monthly basis and stakeholders include NNUH facilities management, NNUH Divisional representation, Norse, Serco and external facility providers and external responsible person for water compliance are opted into meetings or send reports as required.

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 sp.* and *Pseudomonas aeruginosa*, 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 with abnormal test results are identified and acted upon, 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 water quality audit was completed in September 2021 by Samuel Rollins, water expert and Authorised Engineer from Hydrop. The audit reviewed *Legionella sp.* and *Pseudomonas aeruginosa* management and control, including recording all relevant Practices Programmes, ongoing operational procedures, extent of management responsibility, risk management and control, in line with the following standards:

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

The outcome of the audit provided a clear action plan to review and update records and processes.

# Infection Prevention and Control Annual Report 2021-22

## Assessed level of overall Governance Assurance

### Image 2

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

### Image 3

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

The Comprehensive action plan now in place following the audit covers the following areas:

- Management responsibilities, appointments, water safety group membership, training programme for all staff.
- Water safety plan review update.
- Reporting structure from Norse / Serco to the Water Safety Group and assurance from external facility providers.
- Review of operational procedures including remedial works.

# Infection Prevention and Control Annual Report 2021-22

- Review of *Pseudomonas* sampling and mitigation for repeated fails.
- Flushing and recording review.
- Sampling review of water coolers and drinking water points across sites.
- Governance reporting and escalation, including incident reporting and risk management / risk register compliance.

| | |
|---|---|
| Updated water safety policy | September 2022 |
| Water safety training for all staff | December 2022 |
| Completion of all actions on action plan | December 2022 |
| Action plan assurance report presented to HICC | November 2022 |

A Trustwide report is completed on a monthly basis providing assurance on *legionella* sp. testing and *Pseudomonas* testing and outcomes of testing, the report is shared and presented to HICC. (see table 1)

**Table 1**

Bringing service to life

serco

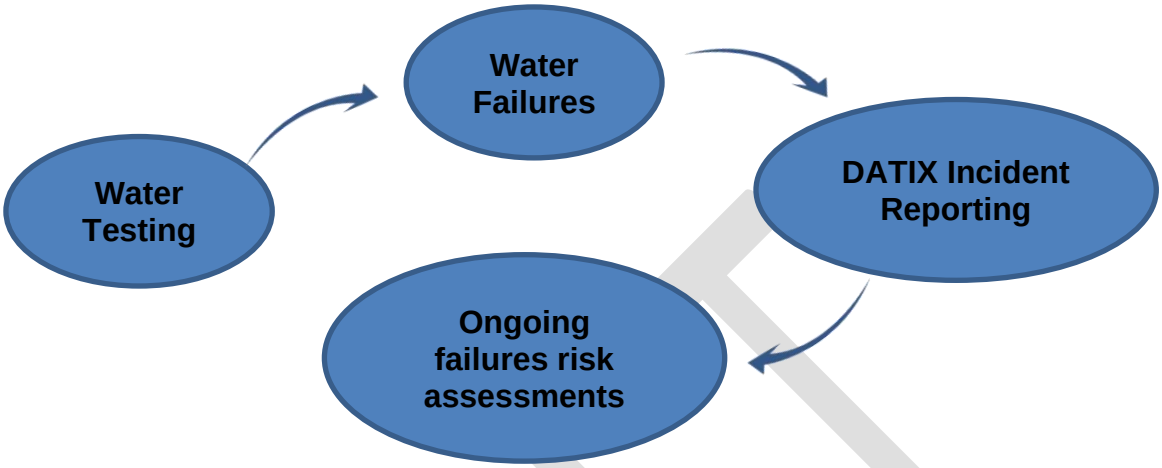
**Legionella Testing Schedule 2021 / 2022**

| Jun 01/06/2021 | Aug 03/07/2021 | Nov 02/11/2021 | Jan 25/01/2022 |
|---|---|---|---|
| Main water tanks | Main water tanks | Main water tanks | Main water tanks |
| Mortuary Clorifier | Mortuary Clorifier | Mortuary Clorifier | Mortuary Clorifier |
| Furthest cut up table | Furthest cut up table | Furthest cut up table | Furthest cut up table |
| Plantroom 1 Clorifier A (B under maitanance) | Plantroom 1 Clorifier A | Plantroom 1 Clorifier B | Plantroom 1 Clorifier A |
| Dental 30.2.138 | Dental 30.2.138 | Dental 30.2.138 | Dental 30.2.138 |
| Plantroom 4 Clorifier B | Plantroom 4 Clorifier A | Plantroom 4 Clorifier B | Plantroom 4 Clorifier A |
| CSSD 11.1.029 | CSSD 11.1.029 | CSSD 11.1.029 | CSSD 11.1.029 |
| Plantroom 6 Clorifier B | Plantroom 6 Clorifier A | Plantroom 6 Clorifier B | Plantroom 6 Clorifier A |
| Physio 31.2.081 | Physio 31.2.081 | Physio 31.2.081 | Physio 31.2.081 |
| Pathology Clorifier | Pathology Clorifier | Pathology Clorifier | Pathology Clorifier |
| Pathology 12.1.070 | Pathology 12.1.070 | Pathology 12.1.070 | Pathology 12.1.070 |
| Plantroom 13 Clorifier B | Plantroom 13 Clorifier A | Plantroom 13 Clorifier B | Plantroom 13 Clorifier A |
| Brundall 20.1.054 | Brundall 20.1.054 | Brundall 20.1.054 | Brundall 20.1.054 |
| Plantroom 15 Clorifier B | Plantroom 15 Clorifier A | Plantroom 15 Clorifier B | Plantroom 15 Clorifier A |
| Gunthorpe 24.1.054 | Gunthorpe 24.1.054 | Gunthorpe 24.1.054 | Gunthorpe 24.1.054 |
| Plantroom 18 Clorifier B | Plantroom 18 Clorifier A | Plantroom 18 Clorifier B | Plantroom 18 Clorifier A |
| Knapton 26.1.021 | Knapton 26.1.021 | Knapton 26.1.021 | Knapton 26.1.021 |
| Plantroom 20 Clorifier B | Plantroom 20 Clorifier A | Plantroom 20 Clorifier B | Plantroom 20 Clorifier A |
| Winterton 45.1.019 | Winterton 45.1.019 | Winterton 45.1.019 | Winterton 45.1.019 |
| Big C Kitchen | Big C Kitchen | Big C Kitchen | Big C Kitchen |
| Alysham suite room 4 shower | Alysham suite room 4 shower | Alysham suite room 4 shower | Alysham suite room 4 shower |
| Alysham suite room 31 WHB | Alysham suite room 31 WHB | Alysham suite room 31 WHB | Alysham suite room 31 WHB |
| | | | |
| Indicates clear result | | | |
| Indicates borderline result | Retests show clear results for 24.1.054 | | |

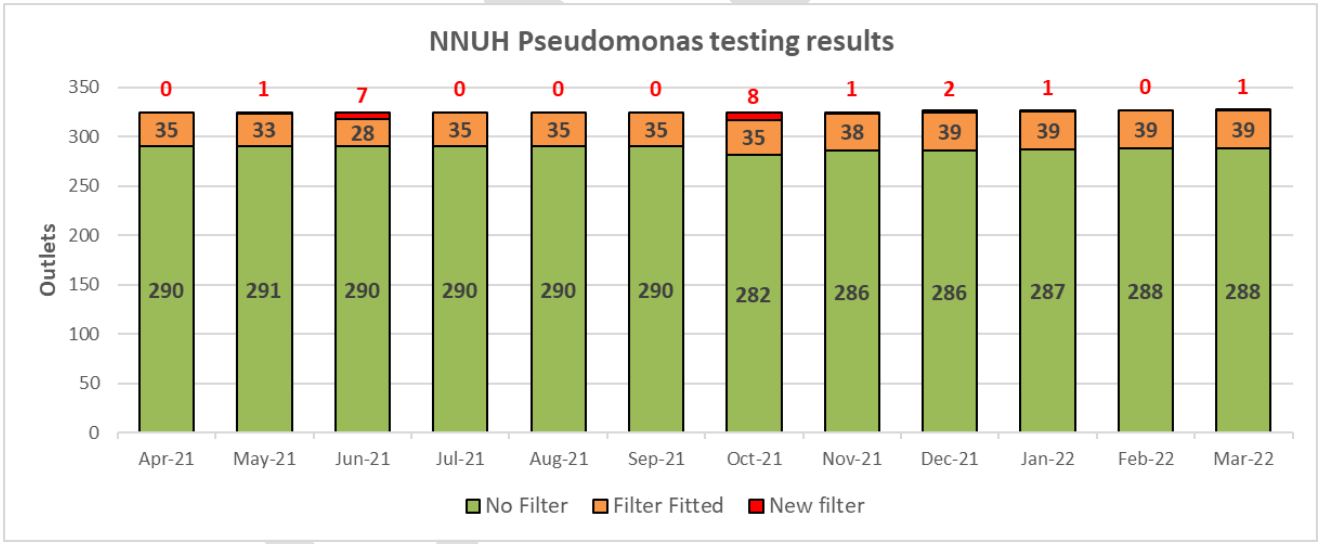
Gunthorpe now indicates clear results since report was completed

Divisional water safety reports are now provided monthly, shared with water safety representatives and Governance leads from each Division and at the Water Safety meeting. The reports clearly identify unused water outlets on flushing schedule and usage of filters. The Divisional reports provide Divisional specific information that will drive ownership and collaborative work with Serco, Norse and Facilities to provide water safety assurance.

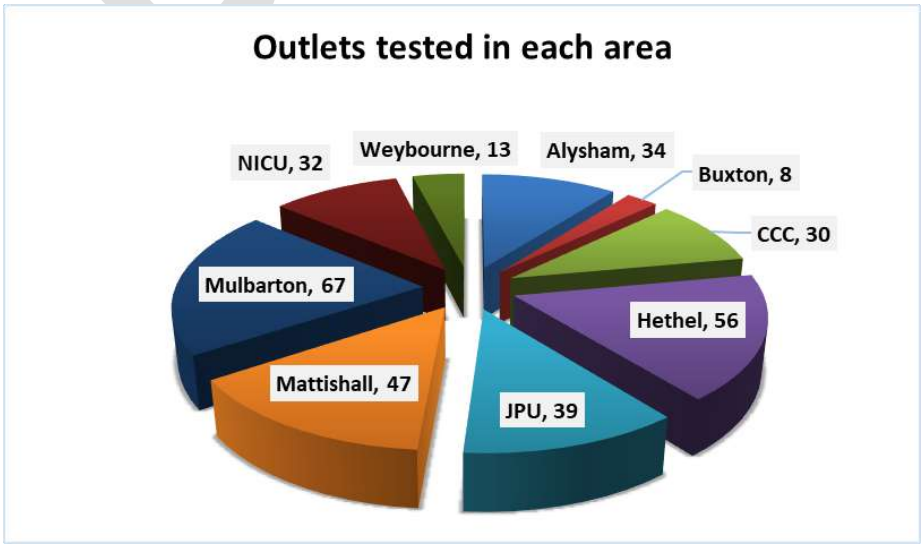
**Chart 4**



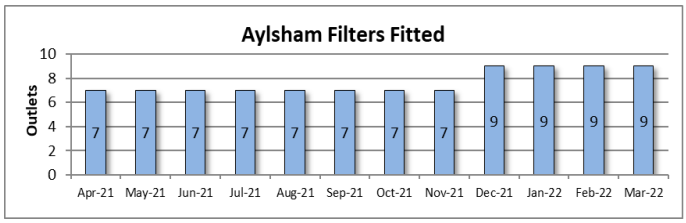

**Graph 1**

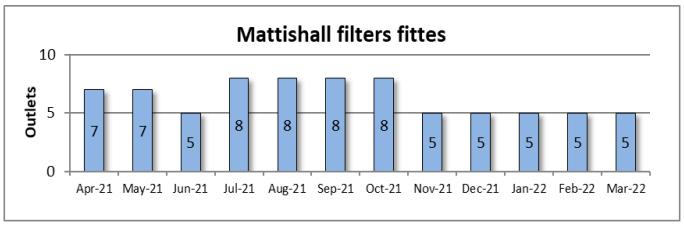


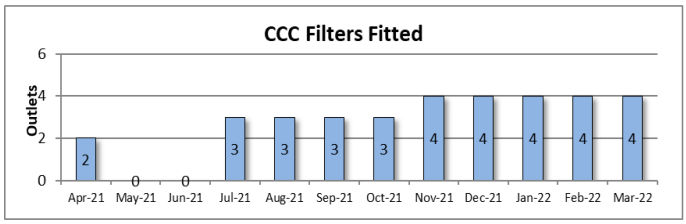

**Graph 2**

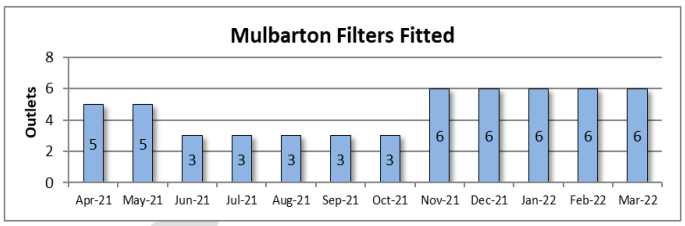


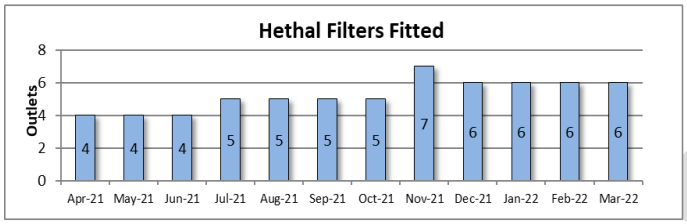
## Graph 3

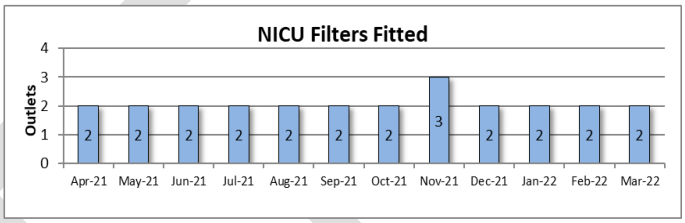


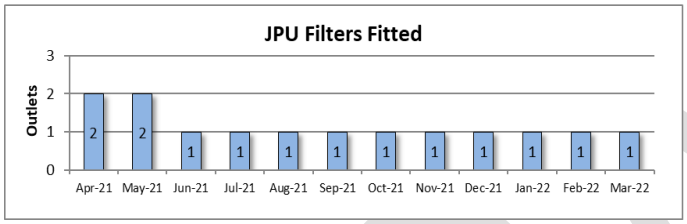



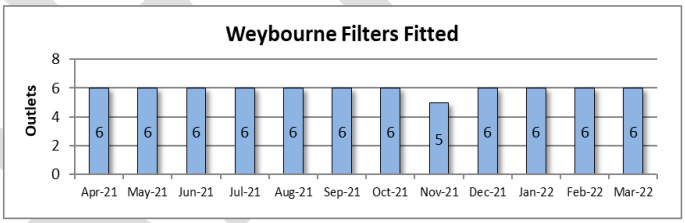




**Offsite clinic areas hosted by NNUH and water safety.**

Over 50 off site areas are used by NNUH staff to host clinics for patients.

All facility managers of external organisations are to be recontacted to provide assurance of testing and provide assurance that NNUH facilities managers will be contacted regarding 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 and remedial work planned where required.
- Incident/risk recording is clarified and implemented.
- Water safety action plan completed and reported to HICC.

## Ventilation

Full ventilation cleans were undertaken in Theatres according to schedule including the Day Procedure Unit 3, 4, 5, Main kitchen, Block 30 level 2 ,3 and 4, Block 31 level 2, 3 and 4, pharmacy production and MRI 3.

The air ducts in blocks 30 and 31 were cleaned during this period.

## ICNet (IP&C Software system)

The IP&C team use a commercial software system, called ICNet to manage alert organism results, suspected infections, monitor for Periods of Increased Incidence (PII) and minimise risk of outbreaks. ICNet served notice on the existing software due to its age. A Sustainability Transformation Partnership (STP) bid for a system wide ICNet upgrade was unsuccessful. Initially we worked 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. However, we had concerns that we would be operating from a system different to other Trusts in the region which would not promote continuity of care. Our Divisional Operational manager worked with IP&C to develop a business case for upgrading to the new ICNet system which was approved and the team across the region are working to implement this during 2022.

## Building

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

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

### The Norfolk and Norwich Orthopaedic Centre (NANOC)

This development will create a stand-alone, COVID-secure, elective surgical facility, containing 2 new laminar flow theatres. The theatres will be a modular construction, meaning the bulk of construction is carried out off site and once built the units will be craned into position. When fitted together, and connected to services, internal fixtures and fittings and clinical equipment will be installed. The attached 21 bedded ward section will be a refurbishment of the existing Aylsham suite. During this period the IP&C team supported and advised at the design stage. The site compound and groundworks began on 5th of February 2022 to prepare for the delivery of the modular unit. (see image 4 & 5)

**Image 4**


**Image 5**

**Theatres, Day Procedure Unit and Ambulatory Procedure Unit**

The IP&C team undertook an advisory role in relation to building work undertaken in Theatre Recovery during April 2021, Main Theatre 11 during October and November 2021 and Ophthalmic theatres 1 and 2 in January and February 2022. The Day Procedure Unit (DPU) were supported to undergo building work between August and September 2021 and the Ambulatory Procedure Unit (APU) between April and August 2021.

**Addition of bay doors in Paediatric ward areas**

Doors were added to bays on both Buxton and Colitshall ward by the Serco construction team in August 2021 this will assist with preventing the spread of infection by providing the ability to isolate a bay if required. IP&C supported the paediatric teams with the Aspergillosis risk assessment process and monitored the conversion regarding the Aspergillosis risk mitigations.

**Image 6**

The IP&C team have been advising at the design stages of the proposed Diagnostic Assessment Centre with a plan to open in 2024.

## The Cromer Macmillan Centre

The IP&C team provided advice and support with the creation of the new Macmillan centre with five treatment chairs, providing space for chemotherapy and acute Oncology, three new clinic rooms and two minor procedure rooms facilitating an additional 10,000 outpatient appointments each year. This unit opened in October 2021, and this freed up space in the main Cromer building to deliver extra surgical procedures in dermatology, urology, vascular surgery and pain management. (see image 7)

**Image 7**


## Refurbishment of Nuclear medicine

Final snagging and décor completed following redesign and refurbishment supported by the IP&C team. (see image 8)

**Image 8**

# Infection Prevention and Control Annual Report 2021-22

## Healthcare Inspections

In June 2021 NHSE/I undertook a planned supportive visit with CCG colleagues which enabled the DIPC, IP&C team and clinical teams to demonstrate their partnership working with Divisions and Facilities management. They shared the effective systems to manage infection, promote safety for patients, staff and visitors and demonstrated cleanliness in the environment, prompt identification of risk and learning from Post Infection Review (PIR) during the COVID-19 pandemic. Colleagues from our Emergency Department (ED) and Renal Department shared their experiences during this challenging time. All involved were proud of the partnership working, innovation and supportive approach.

**Image 9**

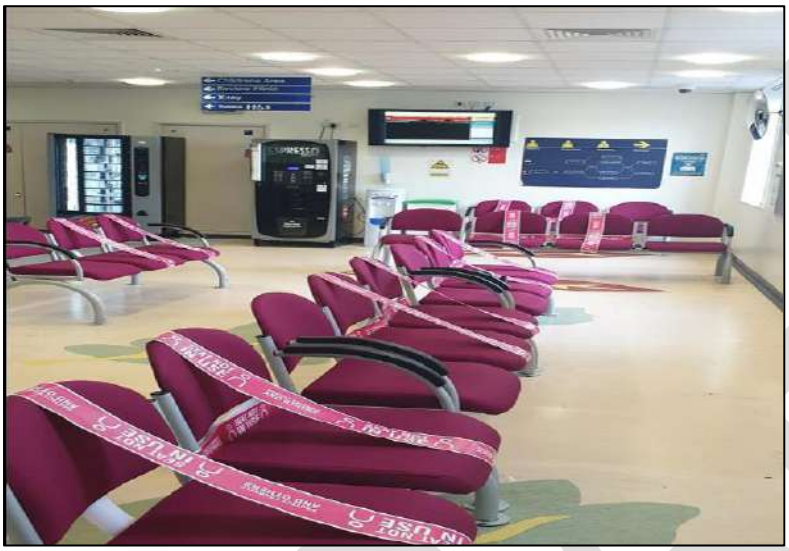


**Image 10**


**Image 11**

**Image 12**


In February 2022 there were unannounced external CQC inspections to the Cromer Minor Injuries Unit (MIU), Cromer medical services and to older people's care at the NNUH. This was during the height of the third wave. Whilst these inspections were not rated it was noted that infection was controlled well, equipment and control measures were used to protect patients, themselves and others, and the environment was visibly clean at both sites. Staff followed infection control principles and were observed wearing correct Personal Protective Equipment (PPE). On the 13th of May 2022 CQC published a report rating the NNUH as overall good.

# Infection Prevention and Control Annual Report 2021-22

## Mandatory Surveillance of Healthcare Associated Infection to Public Health England/ UK Health Security Agency (from October 2021).

### *Clostridioides difficile* infection (CDI)

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

C. *difficile* attribution for 2021-22 is as follows:

**Acute providers:**
**Hospital onset healthcare associated (HOHA):** cases where specimen date is >3 days after current admission (where day of admission is 1)

**Community onset healthcare associated (COHA):** cases that occur in the community (or < 3 days after admission) when the patient has been an inpatient in the trust reporting the case in the previous 28 days.

**Community:**
**Community onset indeterminate association:** cases that occur in the community (or <3 days after admission) when the patient has been an inpatient in the trust reporting the case between 29 and 84 days prior to the specimen date.

**Community onset community associated:** cases that occur in the community (or < 3 days after admission) when the patient has not been an inpatient in the trust reporting the case in the previous 84 days.

**Table 2**

**NNUH *C. difficile* 2021-22 – number of cases**

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

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

**Table 3**

UK Health Security Agency

## Clostridium difficile

Count of healthcare associated cases per month

| Trust Code | Acute Trust Name | Trajectory* | 2021 April | May | June | July | August | September | October | November | December | 2022 January | February | March | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| RC9 | Bedfordshire Hospitals NHS Foundation Trust | 42 | 6 | 4 | 4 | 4 | 8 | 2 | 5 | 9 | 5 | 8 | 7 | 3 | 65 |
| RGT | Cambridge University Hospitals NHS Foundation Trust | 99 | 7 | 11 | 11 | 12 | 11 | 6 | 10 | 14 | 11 | 5 | 10 | 14 | 122 |
| RWH | East & North Hertfordshire NHS Trust | 52 | 5 | 3 | 8 | 9 | 5 | 3 | 6 | 8 | 5 | 4 | 4 | 5 | 65 |
| RDE | East Suffolk and North Essex NHS Foundation Trust | 99 | 8 | 4 | 12 | 14 | 10 | 8 | 6 | 7 | 6 | 9 | 12 | 9 | 105 |
| RGP | James Paget University Hospitals NHS Foundation Trust | 23 | 1 | 7 | 1 | 3 | 5 | 2 | 4 | 3 | 5 | 2 | 2 | 0 | 35 |
| RAJ | Mid and South Essex NHS Foundation Trust | 177 | 19 | 11 | 20 | 19 | 19 | 19 | 23 | 10 | 19 | 18 | 18 | 24 | 219 |
| RD8 | Milton Keynes Hospital NHS Foundation Trust | 14 | 2 | 0 | 2 | 2 | 1 | 2 | 0 | 0 | 1 | 5 | 4 | 4 | 23 |
| RM1 | Norfolk & Norwich University Hospitals NHS Foundation Trust | 57 | 9 | 6 | 6 | 11 | 8 | 7 | 11 | 8 | 7 | 7 | 4 | 5 | 89 |
| RGN | North West Anglia NHS Foundation Trust | 113 | 8 | 7 | 16 | 7 | 15 | 10 | 10 | 13 | 7 | 9 | 2 | 5 | 109 |
| RGM | Papworth Hospital NHS Foundation Trust | 10 | 1 | 2 | 2 | 2 | 1 | 1 | 0 | 1 | 0 | 0 | 1 | 1 | 12 |
| RQW | Princess Alexandra Hospital NHS Trust | 23 | 4 | 6 | 1 | 2 | 7 | 4 | 2 | 2 | 0 | 2 | 0 | 5 | 35 |
| RCX | The Queen Elizabeth Hospital King's Lynn NHS Trust | 40 | 4 | 6 | 6 | 2 | 5 | 7 | 5 | 6 | 1 | 3 | 5 | 5 | 55 |
| RWG | West Hertfordshire Hospitals NHS Trust | 41 | 2 | 4 | 5 | 6 | 5 | 10 | 5 | 3 | 6 | 5 | 3 | 6 | 60 |
| RGR | West Suffolk Hospitals NHS Trust | 36 | 4 | 4 | 2 | 5 | 3 | 3 | 6 | 9 | 3 | 8 | 5 | 4 | 56 |
| | **East of England Total** | | **80** | **75** | **96** | **98** | **103** | **84** | **93** | **93** | **76** | **85** | **77** | **90** | **1050** |

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 share any learning for community partners.

Following PIR meetings with the CCG IP&C team, 3 COHA and 20 HOHA cases were reviewed as trajectory (with lapses in care) against an objective of 57 cases. 37 COHA and 29 HOHA cases were deemed non-trajectory (no lapses in care), see table 4.

NNUH has consistently met its national CDI objectives since 2011.

**Table 4**

| **NNUH lapses in care identified from 23 HOHA and 3 COHA trajectory cases of *C. difficile* 2021-22** | |
|---|---|
| Lapses | Number of times lapse occurred |
| Delay in isolation (placing in single room) | 12 |
| Delay in sampling | 9 |
| Gaps in stool chart | 8 |
| Inappropriate sampling | 7 |
| Hand hygiene audit fails | 3 |
| Documentation issues | 1 |
| Delay in commencing antibiotics | 1 |
| **Some trajectory cases had more than one lapse. Lapses are included in the learning outcomes.** | |

A weekly multidisciplinary team ward round of CDI patients is led by a consultant microbiologist. *Clostridioides difficile* can be carried asymptomatically and may be present prior to admission becoming apparent when toxin production is triggered by administration of antibiotics after admission. Possible sources are asymptomatic colonisation prior to admission or via cross infection in a healthcare setting e.g. from contaminated equipment or hands of staff. It is notable

that some patients who are colonised with *Clostridioides difficile* may excrete the bacteria and spores without showing symptoms of infection.

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

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

Treatment guidelines for CDI have been reviewed in 2021 alongside NICE guidance to introduce the new antibiotic Fidaxomicin to the NNUHFT formulary.

## Glycopeptide-resistant Enterococcus (GRE) BSI

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

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

There were 7 cases of GRE/VRE BSI in 2021-22.

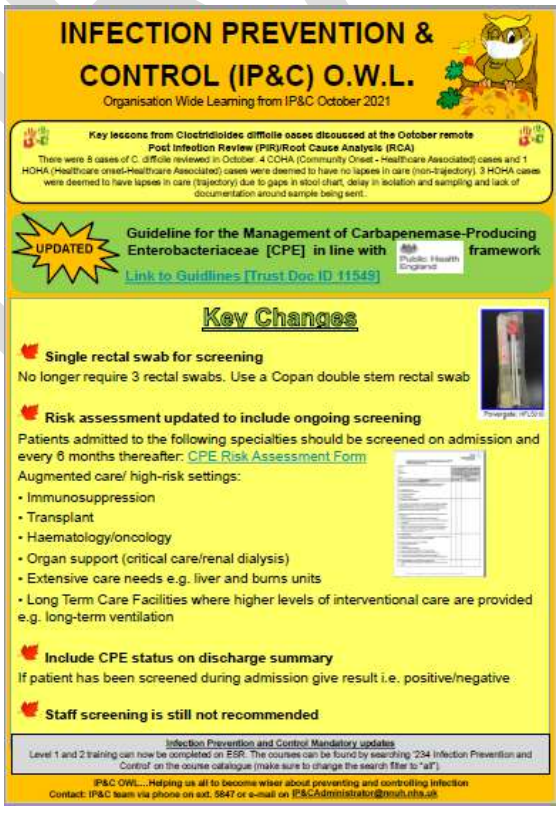
## Carbapenemase-producing Enterobacteriaceae (CPE)

In the UK, over the few years there has been a rapid rise in the incidence of infection and colonisation by multi-drug resistant carbapenemase-producing organisms (CPO) with an increase in the number of clusters and outbreaks reported in England. An OWL was communicated to staff in October 2021 updating on the changes in National screening guidance (image 13).

**Table 5**

| Carbapenemase-producing Enterobacteriaceae - Cases identified | | | |
|---|---|---|---|
| **Financial Year** | New cases tested positive on admission | New positive cases | Previously positive patients tested negative on admission |
| **2021-22** | **4** | • 2x clinical samples<br>• Screened due to hospital admission in Spain<br>• Screened due to recent exposure to Tazocin | **3** |
| **2020-21** | **3** | • Previous positive from Addenbrookes Hospital,<br>• Previous positive from NCH&C<br>• Previous CPO now CPE | **5** |
| 2019- 20 | 5 | 3 Screened due to hospital admissions in Greece, London and South Africa<br>2 x clinical samples | 3 |
| **4 new cases identified 2021-22** | | | |

**Image 13**



## Gram-Negative Bacteraemia/BSI

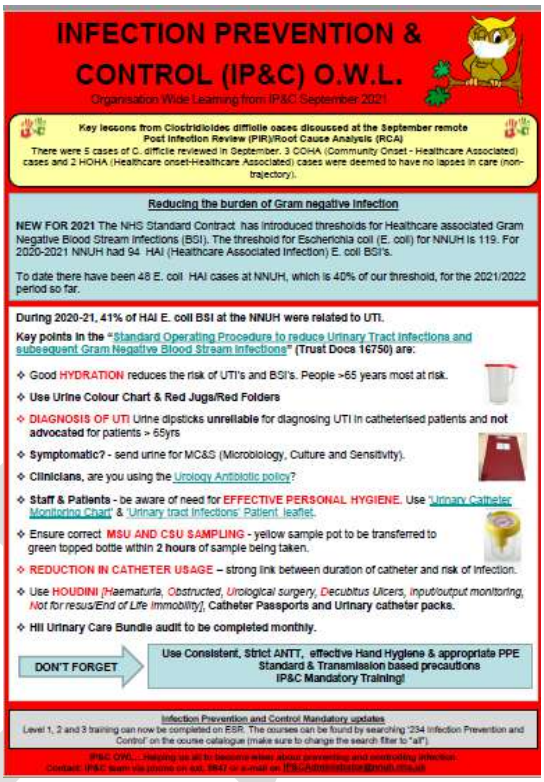
In 2016, the Department of Health and Social Care set an ambition for England to halve the number of healthcare associated Gram-negative Blood Stream Infections (BSI) by March 2021.

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.

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

This is the fourth year of UKHSA/PHE reporting for *Klebsiella spp. and Pseudomonas aeruginosa* and therefore we now have comparative figures for *E. coli, Klebsiella spp.* and *Pseudomonas aeruginosa*. See tables 6, 7, 8, 9, 10 & 11.

**Image 14**




In 2021-2022 the objectives set related to COHA cases in addition to HOHA cases for the first time. An OWL was circulated to staff in September 2021 to inform of good practice with the aim to reduce Gram-negative blood stream infections.

### *Escherichia coli*

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

The IP&C team developed a Standard Operating Procedure (SOP) to reduce Urinary tract infections and Gram-negative blood stream infections in 2019-20 and continue to work collaboratively to promote these resources in relation to urine sampling, mid-stream urine collection, hydration, patient information and catheter prevention. The IP&C team have become part of further collaborative work to bid for a pilot hydration programme in the community with a view if successful that the intervention could be scaled up across the healthcare economy to help prevent Gram-negative bacteraemia.

37% of the 99 Hospital origin *E. coli* BSI were considered to have a lower urinary tract primary focus, 18% had an unknown focus and 14% were considered hepatobiliary.

**Table 6**

| NNUH *Escherichia coli* BSI – number of cases | | | |
|---|---|---|---|
| **Financial Year** | **Community Origin** | **Hospital Origin** | **Total** |
| **2021-22** | **283 COCA** | **51 HOHA, 48 COHA** | **382** |
| 2020-21 | 335 (87.92%) | 46 (12.08%) | 381 |
| 2019- 20 | 293 (87.21%) | 43 (12.79%) | 336 |

**Table 7**

UK Health Security Agency

**Escherichia coli**

Count of healthcare associated cases per month

| Trust Code | Acute Trust Name | Trajectory* | 2021 April | May | June | July | August | September | October | November | December | 2022 January | February | March | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| RC9 | Bedfordshire Hospitals NHS Foundation Trust | 98 | 11 | 3 | 2 | 7 | 5 | 7 | 12 | 3 | 8 | 7 | 4 | 6 | **75** |
| RGT | Cambridge University Hospitals NHS Foundation Trust | 189 | 11 | 14 | 15 | 13 | 19 | 12 | 21 | 13 | 14 | 16 | 10 | 19 | **177** |
| RWH | East & North Hertfordshire NHS Trust | 120 | 2 | 1 | 3 | 4 | 6 | 7 | 8 | 5 | 2 | 5 | 5 | 3 | **51** |
| RDE | East Suffolk and North Essex NHS Foundation Trust | 190 | 15 | 8 | 10 | 8 | 10 | 6 | 14 | 13 | 8 | 18 | 7 | 8 | **125** |
| RGP | James Paget University Hospitals NHS Foundation Trust | 64 | 5 | 4 | 7 | 4 | 8 | 1 | 3 | 5 | 4 | 7 | 4 | 8 | **60** |
| RAJ | Mid and South Essex NHS Foundation Trust | 308 | 8 | 21 | 38 | 12 | 26 | 13 | 20 | 21 | 14 | 18 | 23 | 12 | **226** |
| RD8 | Milton Keynes Hospital NHS Foundation Trust | 77 | 2 | 2 | 5 | 2 | 2 | 2 | 3 | 2 | 4 | 4 | 5 | 6 | **39** |
| RM1 | Norfolk & Norwich University Hospitals NHS Foundation Trust | 119 | 4 | 9 | 9 | 9 | 11 | 6 | 10 | 8 | 7 | 8 | 7 | 11 | **99** |
| RGN | North West Anglia NHS Foundation Trust | 108 | 9 | 6 | 5 | 6 | 8 | 4 | 14 | 6 | 4 | 4 | 6 | 5 | **77** |
| RGM | Papworth Hospital NHS Foundation Trust | 8 | 0 | 1 | 1 | 1 | 2 | 1 | 0 | 1 | 1 | 0 | 0 | 0 | **8** |
| RQW | Princess Alexandra Hospital NHS Trust | 38 | 5 | 3 | 1 | 4 | 6 | 5 | 2 | 5 | 2 | 4 | 3 | 5 | **45** |
| RCX | The Queen Elizabeth Hospital King's Lynn NHS Trust | 68 | 7 | 5 | 8 | 7 | 2 | 7 | 4 | 3 | 1 | 4 | 4 | 4 | **56** |
| RWG | West Hertfordshire Hospitals NHS Trust | 105 | 3 | 5 | 4 | 7 | 8 | 8 | 7 | 4 | 4 | 6 | 3 | 5 | **64** |
| RGR | West Suffolk Hospitals NHS Trust | 64 | 3 | 5 | 1 | 2 | 5 | 4 | 3 | 2 | 1 | 3 | 1 | 2 | **32** |
| | **East of England Total** | | **85** | **87** | **109** | **86** | **118** | **83** | **121** | **91** | **74** | **104** | **82** | **94** | **1134** |

### *Klebsiella species*

The IP&C team undertake surveillance investigation of hospital origin Gram-negative BSI. Of the 40 Hospital origin *Klebsiella spp.* BSI, 27.5% had an unknown primary focus, 20% were considered lower urinary tract and 20% hepatobiliary. Any learning is shared with clinical teams.

**Table 8**

| NNUH *Klebsiella spp.* BSI – number of cases | | | |
|---|---|---|---|
| **Financial Year** | **Community Origin** | **Hospital Origin** | **Total** |
| **2021-22** | **73 COCA** | **28 HOHA, 12 COHA** | **113** |
| 2020-21 | 79 (73.1%) | 29 (26.9%) | 108 |
| 2019- 20 | 68 (83%) | 14 (17%) | 82 |

# Infection Prevention and Control Annual Report 2021-22

## Table 9

UK Health Security Agency

### Klebsiella spp.

Count of healthcare associated cases per month

| Trust Code | Acute Trust Name | Trajectory* | 2021 April | May | June | July | August | September | October | November | December | 2022 January | February | March | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| RC9 | Bedfordshire Hospitals NHS Foundation Trust | 36 | 2 | 1 | 1 | 1 | 1 | 0 | 4 | 1 | 2 | 5 | 3 | 4 | 25 |
| RGT | Cambridge University Hospitals NHS Foundation Trust | 76 | 3 | 1 | 10 | 8 | 9 | 15 | 13 | 13 | 10 | 5 | 7 | 4 | 98 |
| RWH | East & North Hertfordshire NHS Trust | 34 | 1 | 1 | 5 | 2 | 1 | 3 | 2 | 3 | 2 | 2 | 0 | 0 | 22 |
| RDE | East Suffolk and North Essex NHS Foundation Trust | 50 | 3 | 3 | 3 | 3 | 2 | 3 | 7 | 5 | 8 | 1 | 4 | 1 | 43 |
| RGP | James Paget University Hospitals NHS Foundation Trust | 26 | 4 | 4 | 4 | 5 | 2 | 1 | 4 | 2 | 1 | 2 | 1 | 5 | 35 |
| RAJ | Mid and South Essex NHS Foundation Trust | 114 | 2 | 5 | 4 | 12 | 11 | 7 | 4 | 8 | 10 | 9 | 3 | 4 | 79 |
| RD8 | Milton Keynes Hospital NHS Foundation Trust | 14 | 0 | 1 | 1 | 1 | 4 | 4 | 0 | 1 | 1 | 1 | 2 | 1 | 17 |
| RM1 | Norfolk & Norwich University Hospitals NHS Foundation Trust | 25 | 3 | 1 | 6 | 5 | 5 | 3 | 1 | 7 | 2 | 4 | 1 | 2 | 40 |
| RGN | North West Anglia NHS Foundation Trust | 22 | 4 | 3 | 4 | 3 | 6 | 1 | 4 | 4 | 2 | 3 | 4 | 4 | 42 |
| RGM | Papworth Hospital NHS Foundation Trust | 14 | 3 | 1 | 0 | 2 | 1 | 0 | 0 | 0 | 0 | 1 | 1 | 1 | 10 |
| RQW | Princess Alexandra Hospital NHS Trust | 10 | 1 | 3 | 1 | 4 | 0 | 2 | 1 | 1 | 1 | 2 | 1 | 1 | 18 |
| RCX | The Queen Elizabeth Hospital King's Lynn NHS Trust | 21 | 4 | 2 | 3 | 1 | 0 | 3 | 5 | 2 | 5 | 4 | 0 | 2 | 31 |
| RWG | West Hertfordshire Hospitals NHS Trust | 24 | 1 | 3 | 4 | 2 | 2 | 6 | 1 | 2 | 0 | 2 | 1 | 2 | 26 |
| RGR | West Suffolk Hospitals NHS Trust | 15 | 0 | 1 | 2 | 0 | 0 | 0 | 1 | 2 | 0 | 0 | 0 | 0 | 6 |
| | East of England Total | | 31 | 30 | 48 | 49 | 44 | 48 | 47 | 51 | 44 | 41 | 28 | 31 | 492 |

## *Pseudomonas*

Following investigation by the IP&C team 21% of the 29 Hospital origin *Pseudomonas* BSI, 21% were considered to have a primary focus of skin/ soft tissue, 21% had an unknown focus and 17% were considered lower urinary tract. Any learning is shared with clinical teams

## Table 10

**NNUH *Pseudomonas aeruginosa* BSI – number of cases**

| Financial Year | Community Origin | Hospital Origin | Total |
|---|---|---|---|
| **2021-22** | **21 COCA** | **17 HOHA, 12 COHA** | **50** |
| 2020-21 | 40 (75.5%) | 13 (24.5%) | 53 |
| 2019- 20 | 35 (71.5%) | 14 (28.5%) | 49 |

## Table 11

UK Health Security Agency

### Pseudomonas aeruginosa

Count of healthcare associated cases per month

| Trust Code | Acute Trust Name | Trajectory* | 2021 April | May | June | July | August | September | October | November | December | 2022 January | February | March | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| RC9 | Bedfordshire Hospitals NHS Foundation Trust | 16 | 0 | 1 | 1 | 3 | 2 | 2 | 1 | 1 | 0 | 0 | 1 | 2 | 14 |
| RGT | Cambridge University Hospitals NHS Foundation Trust | 29 | 6 | 1 | 2 | 3 | 4 | 2 | 4 | 3 | 6 | 5 | 6 | 1 | 43 |
| RWH | East & North Hertfordshire NHS Trust | 15 | 1 | 0 | 0 | 1 | 3 | 4 | 1 | 1 | 2 | 0 | 0 | 1 | 14 |
| RDE | East Suffolk and North Essex NHS Foundation Trust | 28 | 1 | 3 | 0 | 3 | 3 | 3 | 4 | 0 | 2 | 1 | 1 | 1 | 22 |
| RGP | James Paget University Hospitals NHS Foundation Trust | 12 | 0 | 2 | 1 | 0 | 2 | 1 | 0 | 2 | 0 | 0 | 0 | 1 | 9 |
| RAJ | Mid and South Essex NHS Foundation Trust | 60 | 4 | 1 | 4 | 6 | 7 | 7 | 7 | 4 | 8 | 3 | 3 | 2 | 56 |
| RD8 | Milton Keynes Hospital NHS Foundation Trust | 10 | 0 | 1 | 0 | 3 | 3 | 1 | 0 | 0 | 2 | 1 | 1 | 1 | 13 |
| RM1 | Norfolk & Norwich University Hospitals NHS Foundation Trust | 24 | 5 | 1 | 3 | 3 | 3 | 3 | 1 | 3 | 1 | 2 | 3 | 1 | 29 |
| RGN | North West Anglia NHS Foundation Trust | 17 | 2 | 1 | 2 | 1 | 0 | 2 | 1 | 3 | 2 | 2 | 2 | 1 | 19 |
| RGM | Papworth Hospital NHS Foundation Trust | 1 | 0 | 1 | 0 | 1 | 1 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 4 |
| RQW | Princess Alexandra Hospital NHS Trust | 9 | 1 | 1 | 1 | 1 | 3 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 8 |
| RCX | The Queen Elizabeth Hospital King's Lynn NHS Trust | 19 | 1 | 1 | 0 | 2 | 0 | 2 | 1 | 2 | 1 | 0 | 1 | 2 | 13 |
| RWG | West Hertfordshire Hospitals NHS Trust | 11 | 0 | 2 | 0 | 0 | 4 | 1 | 2 | 1 | 1 | 3 | 1 | 1 | 16 |
| RGR | West Suffolk Hospitals NHS Trust | 8 | 1 | 0 | 1 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 4 |
| | East of England Total | | 22 | 16 | 15 | 27 | 36 | 28 | 23 | 20 | 25 | 18 | 19 | 15 | 264 |

## Meticillin Susceptible and Meticillin Resistant *Staphylococcus aureus*

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

## MSSA BSI

There remains no national objective currently for MSSA. See table 12 & 13.

73% of MSSA BSI were of community origin. Of the 30-hospital origin 47% had an unknown primary focus, followed by 27% with a skin and soft tissue primary focus. An Organisational Wide Learning (OWL) (image 15) circulated in August 2021, reminded staff of good practice to minimise MSSA blood stream infections.

**Table 12**

| NNUH MSSA BSI - number of cases | | | |
|---|---|---|---|
| ***Financial Year*** | **Community Origin** | **Hospital Origin on or after day 3** | **Total** |
| **2021-22** | **81 (72.9%)** | **30 (27.1%)** | **111** |
| 2020-21 | 94 (71.8%) | 37 (28.2%) | 131 |
| 2019-20 | 74 (77.9%) | 21 (22.1%) | 95 |

**Table 13**

UK Health Security Agency

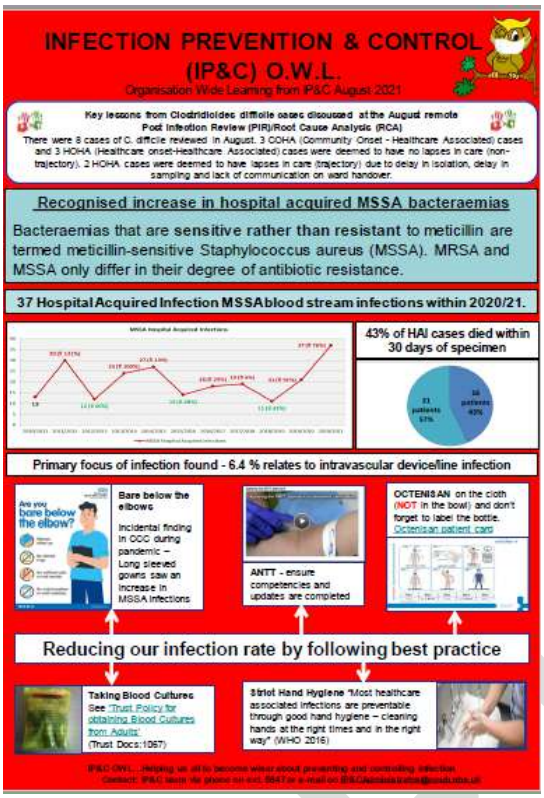
**Methicillin-sensitive Staphylococcus aureus**

Count of healthcare associated cases per month

| Trust Code | Acute Trust Name | Trajectory* | 2021 April | May | June | July | August | September | October | November | December | 2022 January | February | March | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| RC9 | Bedfordshire Hospitals NHS Foundation Trust | N/A | 1 | 2 | 1 | 3 | 3 | 4 | 3 | 6 | 1 | 1 | 2 | 1 | **28** |
| RGT | Cambridge University Hospitals NHS Foundation Trust | N/A | 3 | 4 | 5 | 5 | 6 | 6 | 6 | 3 | 2 | 6 | 3 | 4 | **53** |
| RWH | East & North Hertfordshire NHS Trust | N/A | 2 | 0 | 2 | 3 | 1 | 1 | 2 | 4 | 0 | 1 | 0 | 3 | **19** |
| RDE | East Suffolk and North Essex NHS Foundation Trust | N/A | 8 | 7 | 4 | 5 | 8 | 2 | 5 | 4 | 3 | 11 | 4 | 2 | **63** |
| RGP | James Paget University Hospitals NHS Foundation Trust | N/A | 2 | 2 | 0 | 3 | 1 | 1 | 1 | 1 | 4 | 1 | 2 | 1 | **19** |
| RAJ | Mid and South Essex NHS Foundation Trust | N/A | 4 | 4 | 8 | 5 | 8 | 10 | 10 | 5 | 13 | 11 | 5 | 7 | **90** |
| RD8 | Milton Keynes Hospital NHS Foundation Trust | N/A | 0 | 1 | 0 | 3 | 1 | 0 | 2 | 0 | 1 | 6 | 0 | 1 | **15** |
| RM1 | Norfolk & Norwich University Hospitals NHS Foundation Trust | N/A | 5 | 5 | 2 | 5 | 4 | 1 | 3 | 1 | 1 | 1 | 5 | 5 | **38** |
| RGN | North West Anglia NHS Foundation Trust | N/A | 2 | 3 | 4 | 1 | 1 | 0 | 4 | 0 | 4 | 1 | 8 | 5 | **33** |
| RGM | Papworth Hospital NHS Foundation Trust | N/A | 1 | 0 | 1 | 2 | 0 | 2 | 1 | 2 | 0 | 0 | 2 | 1 | **12** |
| RQW | Princess Alexandra Hospital NHS Trust | N/A | 2 | 4 | 1 | 4 | 2 | 0 | 1 | 1 | 1 | 2 | 2 | 0 | **20** |
| RCX | The Queen Elizabeth Hospital King's Lynn NHS Trust | N/A | 2 | 4 | 2 | 1 | 6 | 4 | 4 | 1 | 0 | 4 | 1 | 1 | **30** |
| RWG | West Hertfordshire Hospitals NHS Trust | N/A | 5 | 1 | 0 | 0 | 1 | 1 | 2 | 3 | 2 | 2 | 3 | 0 | **20** |
| RGR | West Suffolk Hospitals NHS Trust | N/A | 3 | 1 | 2 | 0 | 2 | 3 | 3 | 3 | 0 | 0 | 3 | 1 | **21** |
| | **East of England Total** | | **40** | **38** | **32** | **40** | **44** | **35** | **47** | **34** | **32** | **47** | **40** | **32** | **461** |

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

**Image 15**




## MRSA BSI

All *Staphylococcus aureus* BSI are reported. They are categorised according to their resistance to antibiotics and are then reported separately as Meticillin Sensitive *Staphylococcus aureus* (MSSA) and Meticillin Resistant *Staphylococcus aureus* (MRSA). Surveillance and reporting of MRSA BSI continues with the limit set at 0 avoidable cases. See tables 14 & 15.

There was 1 hospital origin MRSA BSI during 2021-22. A Post Infection Review was undertaken with the clinical team, CCG, DIPC, IP&C team, ICD, Microbiologist and Governance manager to promptly identify any learning from the case, improving practice in the future. It was clear that this case was unavoidable due to the condition of the patient and there was notable practice by the ward.

**Table 14**

| NNUH MRSA BSI - number of cases | | | |
|---|---|---|---|
| **Financial Year** | **Community Origin** | **Hospital Origin (on or after day 3)** | **Total** |
| **2021-22** | **2** | **1** | **3** |
| 2020-21 | 4 | 0 | 4 |
| 2019- 20 | 2 | 0 | 2 |
| | | | |

UK Health Security Agency

## Methicillin-resistant Staphylococcus aureus

Count of healthcare associated cases per month

| Trust Code | Acute Trust Name | Trajectory* | 2021 April | May | June | July | August | September | October | November | December | 2022 January | February | March | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| RC9 | Bedfordshire Hospitals NHS Foundation Trust | N/A | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 1 | 0 | 0 | 2 |
| RGT | Cambridge University Hospitals NHS Foundation Trust | N/A | 0 | 1 | 1 | 1 | 0 | 0 | 0 | 1 | 1 | 0 | 0 | 0 | 5 |
| RWH | East & North Hertfordshire NHS Trust | N/A | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| RDE | East Suffolk and North Essex NHS Foundation Trust | N/A | 1 | 0 | 0 | 2 | 2 | 0 | 0 | 0 | 1 | 0 | 1 | 1 | 8 |
| RGP | James Paget University Hospitals NHS Foundation Trust | N/A | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| RAJ | Mid and South Essex NHS Foundation Trust | N/A | 0 | 2 | 4 | 3 | 0 | 3 | 2 | 2 | 0 | 2 | 0 | 2 | 20 |
| RD8 | Milton Keynes Hospital NHS Foundation Trust | N/A | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 1 | 0 | 0 | 0 | 0 | 2 |
| RM1 | Norfolk & Norwich University Hospitals NHS Foundation Trust | N/A | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 1 | 0 | 2 |
| RGN | North West Anglia NHS Foundation Trust | N/A | 0 | 0 | 0 | 0 | 2 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 3 |
| RGM | Papworth Hospital NHS Foundation Trust | N/A | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| RQW | Princess Alexandra Hospital NHS Trust | N/A | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 1 | 1 | 0 | 0 | 0 | 3 |
| RCX | The Queen Elizabeth Hospital King's Lynn NHS Trust | N/A | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 1 |
| RWG | West Hertfordshire Hospitals NHS Trust | N/A | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 2 |
| RGR | West Suffolk Hospitals NHS Trust | N/A | 0 | 0 | 0 | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2 |
| | **East of England Total** | | **1** | **4** | **5** | **7** | **6** | **4** | **4** | **5** | **4** | **4** | **2** | **4** | **50** |

## Audit Programme

Throughout the year the IP&C team supported a programme of audits ranging from hand hygiene, commodes, mattresses, environmental, isolation rooms and support with audits of indwelling devices – cannulas, urinary catheters, and central venous catheters.

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

**Image 16**


Within the departments staff undertake monthly audits of peripheral cannula, urinary catheter, central venous catheter, and ventilator associated pneumonia care bundle practice. Peer auditing is encouraged, and results are fed back in divisional reports at HICC (image 16).

In each area staff undertake weekly Tendable IP&C audits using handheld devices. This inspection app provides opportunity to record photographs and comments to evidence decisions made. There are also IP&C questions within the daily safety check audit and bespoke COVID-19 audits were in place during this period. Validation audits are undertaken to monitor quality and provide assurance. Results and reports are available on completion and provide performance comparisons and trends across individual areas, divisions, and the Trust as a whole. Staff are required to act on any learning from these audits to continually drive improvement.

**Image 17**

# Infection Prevention and Control Annual Report 2021-22

**Image 18**

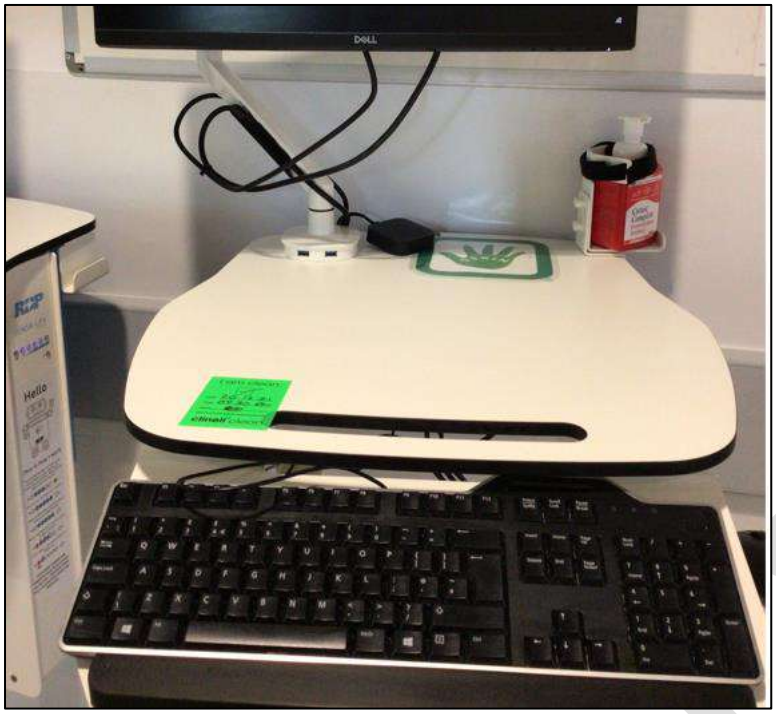


**Image 19**

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

**Chart 4**

**Infection Control Dashboard**

Go to Front Sheet

Go to Alert Organisms

Go to Audit Results

Key:
- 100%
- 80% to 99%
- 50% to 79%
- 0 to 49%

Obs: *Observations*

*Audit results Dashboard (May 2022)*

| | | 20/21 | YTD 21/22 | Quarter 1 | 2 | 3 | 4 | 2021 Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | 2022 Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **IP&C Audits** | | | | | | | | | | | | | | | | | | | |
| Commode | Number Pass | 1401 | 1837 | 424 | 468 | 404 | 541 | 133 | 149 | 142 | 140 | 207 | 121 | 139 | 136 | 129 | 194 | 158 | 189 |
| | Number Fail | 179 | 274 | 64 | 78 | 73 | 59 | 18 | 20 | 26 | 21 | 43 | 14 | 24 | 28 | 21 | 13 | 16 | 30 |
| | % Pass | 89% | 87% | 87% | 86% | 85% | 90% | 88% | 88% | 85% | 87% | 83% | 90% | 85% | 83% | 86% | 94% | 91% | 86% |
| Bed Pans | Number Pass | 1607 | 2450 | 578 | 579 | 565 | 728 | 173 | 204 | 201 | 184 | 249 | 146 | 157 | 212 | 196 | 238 | 215 | 275 |
| | Number Fail | 45 | 59 | 6 | 14 | 15 | 24 | 2 | 0 | 4 | 5 | 6 | 3 | 7 | 4 | 4 | 1 | 10 | 13 |
| | % Pass | 97% | 98% | 99% | 98% | 97% | 97% | 99% | 100% | 98% | 97% | 98% | 98% | 96% | 98% | 98% | 100% | 96% | 95% |
| Hand Hygiene (HH) & Dress Code (DC) | No of audits | 736 | 758 | 193 | 169 | 182 | 214 | 65 | 60 | 68 | 63 | 46 | 60 | 49 | 62 | 71 | 64 | 44 | 106 |
| | Staff Audited | 6429 | 6766 | 1702 | 1545 | 1579 | 1940 | 561 | 541 | 600 | 580 | 405 | 560 | 435 | 572 | 572 | 551 | 376 | 1013 |
| | HH Pass % | 97% | 96% | 95% | 95% | 96% | 97% | 96% | 96% | 93% | 95% | 95% | 94% | 96% | 96% | 97% | 98% | 96% | 97% |
| | DC Pass % | 99% | 99% | 98% | 98% | 99% | 99% | 99% | 99% | 98% | 98% | 99% | 98% | 99% | 99% | 99% | 99% | 99% | 99% |
| **High Impact Intervention Audits** | | | | | | | | | | | | | | | | | | | |
| HII 1 Central Venous Catheter | Insertion Obs | 1505 | 1155 | 265 | 285 | 275 | 330 | 90 | 85 | 90 | 105 | 100 | 80 | 40 | 130 | 105 | 105 | 120 | 105 |
| | Pass % | 97% | 100% | 99% | 100% | 99% | 100% | 100% | 100% | 98% | 100% | 100% | 100% | 100% | 99% | 99% | 100% | 100% | 100% |
| | Ongoing obs | 5196 | 5437 | 1408 | 1276 | 1554 | 1199 | 478 | 485 | 445 | 419 | 485 | 372 | 538 | 551 | 465 | 480 | 368 | 351 |
| | Pass % | 96% | 95% | 97% | 97% | 93% | 94% | 97% | 96% | 96% | 97% | 97% | 96% | 92% | 93% | 93% | 93% | 93% | 95% |
| HII 2 Peripheral Intravenous Cannula | Insertion Obs | 11658 | 13297 | 3510 | 3356 | 3516 | 2915 | 1185 | 1100 | 1225 | 1121 | 1185 | 1050 | 1225 | 1151 | 1140 | 1060 | 915 | 940 |
| | Pass % | 98% | 98% | 98% | 98% | 99% | 99% | 98% | 99% | 98% | 97% | 98% | 97% | 99% | 99% | 99% | 99% | 98% | 99% |
| | Ongoing obs | 10670 | 11659 | 3193 | 2727 | 3065 | 2674 | 1044 | 1079 | 1070 | 896 | 978 | 853 | 1079 | 998 | 988 | 976 | 909 | 789 |
| | Pass % | 94% | 93% | 93% | 94% | 92% | 92% | 93% | 94% | 93% | 94% | 94% | 95% | 92% | 91% | 92% | 93% | 92% | 91% |
| HII 5 Ventilated patients | Obs | 720 | 818 | 239 | 166 | 228 | 185 | 80 | 76 | 83 | 70 | 60 | 36 | 76 | 72 | 80 | 76 | 71 | 38 |
| | Pass % | 98% | 97% | 97% | 98% | 97% | 98% | 93% | 97% | 100% | 99% | 97% | 100% | 97% | 96% | 98% | 96% | 99% | 100% |
| HII 6 Urinary catheter | Insertion Obs | 3173 | 3585 | 924 | 901 | 1036 | 724 | 332 | 296 | 296 | 329 | 280 | 292 | 436 | 308 | 292 | 260 | 256 | 208 |
| | Pass % | 97% | 98% | 98% | 96% | 100% | 99% | 99% | 98% | 98% | 93% | 95% | 98% | 99% | 100% | 99% | 100% | 98% | 100% |
| | Ongoing obs | 8350 | 9470 | 2519 | 2305 | 2576 | 2070 | 825 | 847 | 847 | 797 | 829 | 679 | 929 | 840 | 807 | 727 | 766 | 577 |
| | Pass % | 94% | 93% | 94% | 92% | 93% | 93% | 93% | 94% | 94% | 93% | 93% | 90% | 94% | 93% | 94% | 95% | 93% | 92% |

# Infection Prevention and Control Annual Report 2021-22

## Staff Training and Supervision

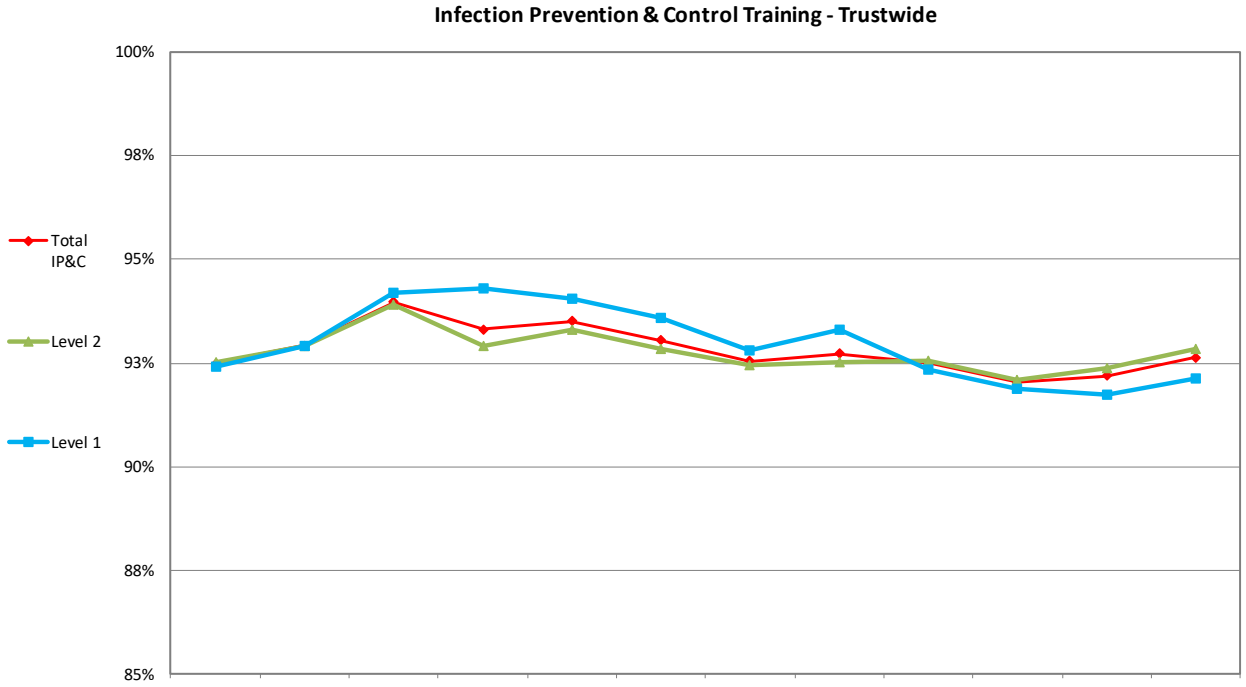
During this last year most of our attention has continued to have been focussed on COVID-19. We stopped large scale in person mandatory training sessions in 2021 delivering our training via Microsoft Teams and making the national IP&C e-learning package available as an option for staff. Both delivery methods had advantages and challenges, but certainly allowed staff the flexibility to maintain their IP&C training compliance. Trust overall compliance was between 92% and 94%.

The IP&C Team continued to support clinical teams across the organisation in their response to COVID-19, including those wards on supportive measures for a period of increased incidence. Healthcare Assistants (HCAs) continued to receive COVID-19 secure face to face training from the IP&C Support Worker. IP&C supported the Housekeeper and IP&C Link Practitioner meetings on Teams.

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

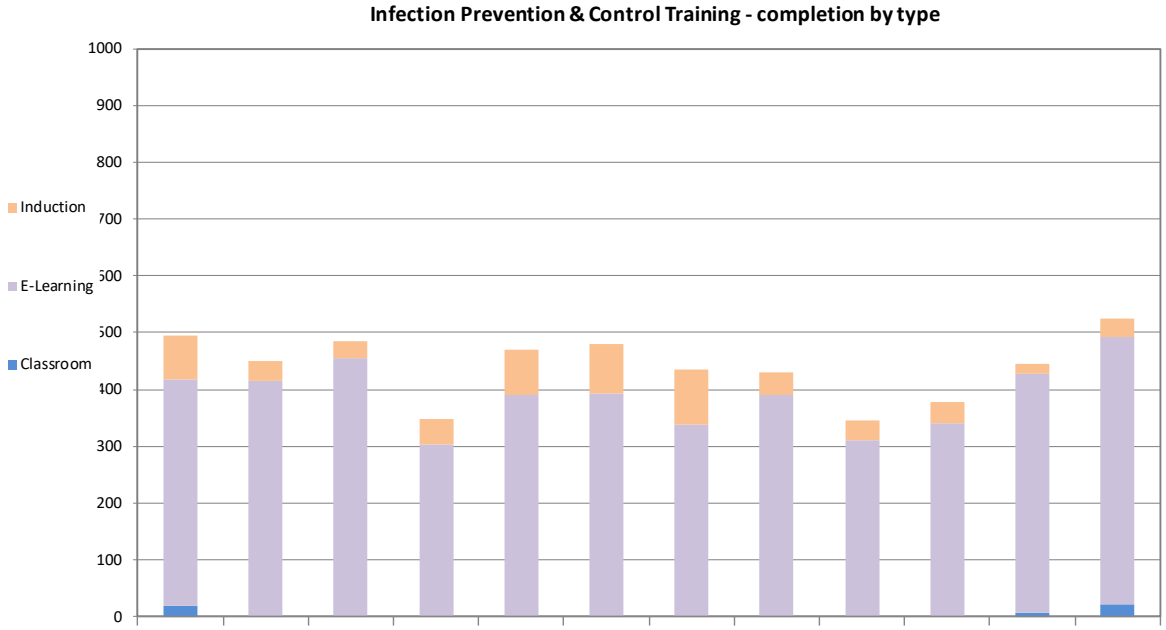
IP&C took part in the Junior Doctor induction which encompassed hand hygiene, infection prevention and control in practice and multi drug resistant organisms.

**Graph 4**




| IP&C Level | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Nov-21 | Dec-21 | Jan-22 | Feb-22 | Mar-22 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Total IP&C | 92.5% | 92.9% | 94.0% | 93.3% | 93.5% | 93.0% | 92.5% | 92.7% | 92.5% | 92.0% | 92.2% | 92.6% |
| Level 1 | 92.4% | 92.9% | 94.2% | 94.3% | 94.1% | 93.6% | 92.8% | 93.3% | 92.3% | 91.9% | 91.7% | 92.1% |
| Level 2 | 92.5% | 92.9% | 93.9% | 92.9% | 93.3% | 92.8% | 92.4% | 92.5% | 92.6% | 92.1% | 92.4% | 92.8% |

## Graph 5




| Training Type | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Nov-21 | Dec-21 | Jan-22 | Feb-22 | Mar-22 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Classroom | 18 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 7 | 22 |
| E-Learning | 399 | 416 | 455 | 302 | 391 | 392 | 338 | 390 | 310 | 341 | 421 | 470 |
| Induction | 79 | 35 | 30 | 47 | 80 | 87 | 96 | 40 | 35 | 36 | 16 | 33 |
| % Classroom | 3.6% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 1.6% | 4.2% |
| % E-Learning | 80.4% | 92.2% | 93.8% | 86.5% | 83.0% | 81.8% | 77.9% | 90.7% | 89.9% | 90.5% | 94.8% | 89.5% |
| % Induction | 15.9% | 7.8% | 6.2% | 13.5% | 17.0% | 18.2% | 22.1% | 9.3% | 10.1% | 9.5% | 3.6% | 6.3% |
| Total Trained | 496 | 451 | 485 | 349 | 471 | 479 | 434 | 430 | 345 | 377 | 444 | 525 |

*Attendance figures may double count staff who have attended multiple sessions or where staff have completed e-learning plus a classroom session*

## University of East Anglia (UEA) Healthcare student training

Although not directly in partnership with the UEA during this period, IP&C were invited to present a face-to-face session with 42 pre-registration student Nurses and Apprentice APs at the invitation of the Clinical Educator - Pre-registration Education & Placements on 10/03/2022

## IP&C team training

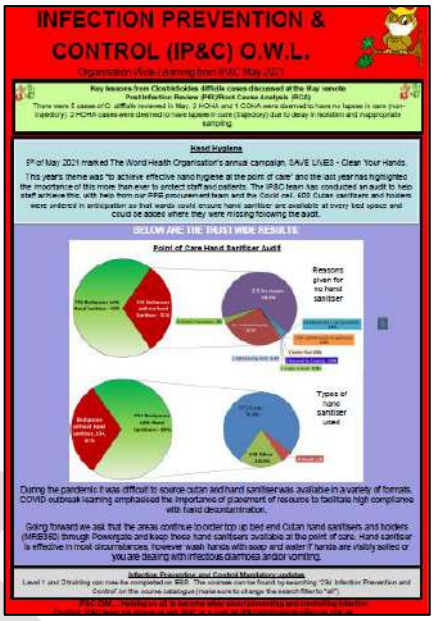
The IP&C team have taken advantage of numerous opportunities to engage with training and development opportunities in the form of postgraduate diplomas, leadership opportunities, webinars, and e-conferences. These have been more accessible; many have been free and a great opportunity to hear from leading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

## Hand Hygiene Day

The 5th of May was World Hand Hygiene Day. This year we focused on achieving hand hygiene at the point of care. Staff were reminded that good hand hygiene practice is vital in preventing the transmission of harmful micro-organisms, hand sanitiser is effective in most circumstances, but they must wash hands with soap and water if visibly soiled or dealing with infectious diarrhoea and/or vomiting bugs. Hand hygiene should be performed at five specific moments and by using the right technique at the point of care. This can be achieved by using the WHO multimodal hand hygiene improvement strategy.

**Image 18**


**Image 19**




The IP&C team conducted an audit to see where bed-end hand sanitisers and holders were missing, and Procurement ordered supplies that could be collected from the Personal Protective Equipment (PPE) store as advised. Staff were reminded how to continue to order replacement bed-end hand sanitisers.

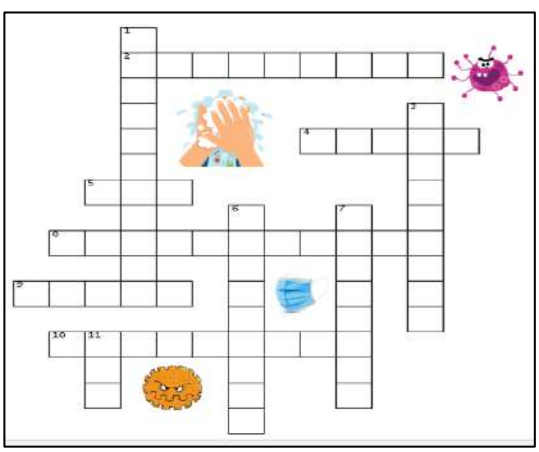
## IP&C International awareness week

Each year the 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 2021. Despite the challenge posed by the ongoing pandemic, the wards and link staff engaged with the challenge of undertaking an IP&C quality improvement project. Congratulations to Edgefield ward who won a coffee machine for their outstanding contribution to infection prevention and control improvement (see image 20). The team put improvements in place following two cases of *C. difficile* on the ward, which included introduction of regular dirty utility and commode checking. The staff took ownership of this simple measure, which has had significant impact on patient safety. The staff also took part in refresher training to update their knowledge of diarrhoea assessment and management.

The IP&C team created a crossword competition (see image 21) for staff to enter and this was won by a Pre-Registered Nurse in AMUK who was presented with a Serco meal voucher.

**Image 20**


**Image 21**



## IP&C link practitioners

The IP&C Team continued to provide support to the IP&C link practitioners in the Trust during 2021-22.

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 16.

**Table 16**

| IP&C Link Practitioner meetings 2021-22 | | | |
|---|---|---|---|
| **23/06/2021** | **19/10//2021** | **08/12/2021** | **23/03/22** |
| **Agenda**<br>• ANTT Presentation<br>• Antibiotic Resistance<br>• Mattresses<br>• Isolation Audit | **Agenda**<br>• Talk by Sarah Morter on her career in IP&C<br>• Trust responsibilities for isolation room cleaning prior to clinical clean<br>• Gama Representative | **Agenda**<br>• New CPE guidance<br>• New PPE poster<br>• Respiratory screen requesting on ICE<br>• Winter viruses/ avian flu<br>• SC Johnson rep to talk about sanitiser audit and hand hygiene | **Agenda**<br>• Back to Basics: standard precautions<br>• Outbreak Management<br>• Medstrom Mattress Cleaning |
| | | | |

## Organisation Wide Learning (OWL)

The IP&C team continues to produce a monthly organisational wide learning (OWL). March 2022 was the only month an OWL was not produced due to the organisational and team pressures 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

**Image 22**

Examples of the OWL from the year are shown throughout the annual report (image 23 & 24).

**Image 23**

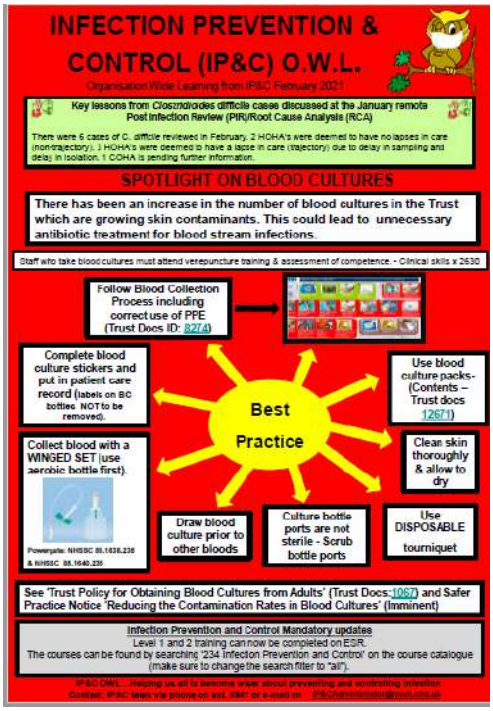
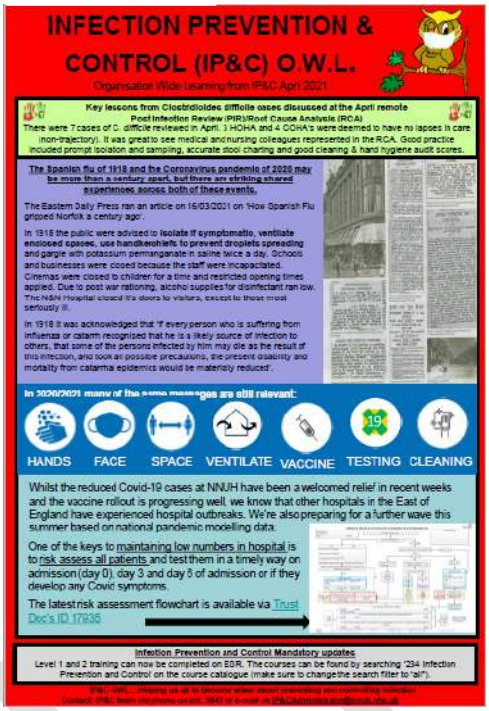



**Image 24**




## Movement of Service Users

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

During the COVID-19 pandemic the IP&C team worked closely with Information Services (IS) and the Incident Management Team (IMT) to ensure that suitable reports were available to identify contacts and isolate and cohort patients safely. This partnership working continued 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 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 Incident Management Team (IMT) to utilise the reports provided to manage the patient pathways as safely as possible. The IP&C team provide an on-call service and attend daily operational meetings to support and provide advice.

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

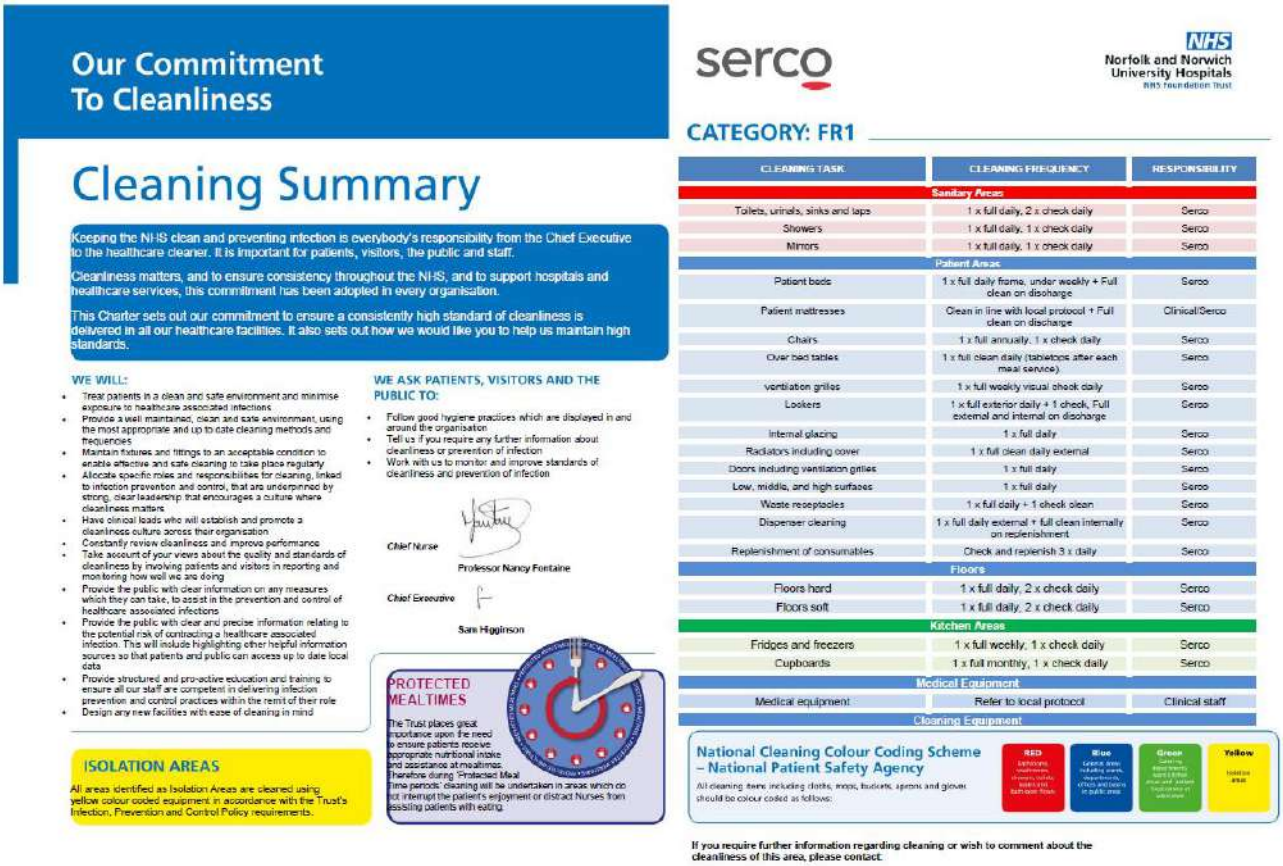
**Hygiene Code Compliance Criteria 2:**
**Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.**

## Cleaning

The IP&C team work in partnership to deliver a clean safe environment for patients. Cleaning schedules/ charters are displayed in each area. Work began to plan for alignment with the National Cleaning standards (2021). All areas were assessed and categorised in one of the 6

Functional risk categories. Elements, frequencies and performance parameters were agreed. A matrix of cleaning responsibilities remains in place. A commitment to the Cleanliness charter was made. Audits of all areas provide assurance and will be displayed. Star ratings will be in place in line with the guidance in the next report period.

**Image 25**



Our Commitment To Cleanliness

Cleaning Summary

Keeping the NHS clean and preventing infection is everybody's responsibility from the Chief Executive to the healthcare cleaner. It is important for patients, visitors, the public and staff.

Cleanliness matters, and to ensure consistency throughout the NHS, and to support hospitals and healthcare services, this commitment has been adopted in every organisation.

This Charter sets out our commitment to ensure a consistently high standard of cleanliness is delivered in all our healthcare facilities. It also sets out how we would like you to help us maintain high standards.

WE WILL:

- Treat patients in a clean and safe environment and minimise exposure to healthcare associated infections
- Provide a well maintained, clean and safe environment, using the most appropriate and up to date cleaning methods and frequencies
- Maintain fixtures and fittings to an acceptable condition to enable effective and safe cleaning to take place regularly
- Allocate specific roles and responsibilities for cleaning, linked to infection prevention and control, that are underpinned by strong, clear leadership that encourages a culture where cleanliness matters
- Have clinical leads who will establish and promote a cleanliness culture across their organisation
- Constantly review cleanliness and improve performance
- Take account of your views about the quality and standards of cleanliness by involving patients and visitors in reporting and monitoring how well we are doing
- Provide the public with clear information on any measures which they can take, to assist in the prevention and control of healthcare associated infections
- Provide the public with clear and precise information relating to the potential risk of contracting a healthcare associated infection. This will include highlighting other helpful information sources so that patients and public can access up to date local data
- Provide structured and pro-active education and training to ensure all our staff are competent in delivering infection prevention and control practices within the remit of their role
- Design any new facilities with ease of cleaning in mind

WE ASK PATIENTS, VISITORS AND THE PUBLIC TO:

- Follow good hygiene practices which are displayed in and around the organisation
- Tell us if you require any further information about cleanliness or prevention of infection
- Work with us to monitor and improve standards of cleanliness and prevention of infection

Chief Nurse

Professor Nancy Fontaine

Chief Executive

Sam Higginson

ISOLATION AREAS

All areas identified as Isolation Areas are cleaned using yellow colour coded equipment in accordance with the Trust's Infection, Prevention and Control Policy requirements.

PROTECTED MEALTIMES

The Trust places great importance upon the need to ensure patients receive appropriate nutritional intake and assistance at mealtimes. Therefore during 'Protected Meal Time periods' cleaning will be undertaken in areas which do not interrupt the patient's enjoyment or distract Nurses from assisting patients with eating.

serco

NHS Norfolk and Norwich University Hospitals NHS Foundation Trust

CATEGORY: FR1

| CLEANING TASK | CLEANING FREQUENCY | RESPONSIBILITY |
|---|---|---|
| **Sanitary Areas** | | |
| Toilets, urinals, sinks and taps | 1 x full daily, 2 x check daily | Serco |
| Showers | 1 x full daily, 1 x check daily | Serco |
| Mirrors | 1 x full daily, 1 x check daily | Serco |
| **Patient Areas** | | |
| Patient beds | 1 x full daily frame, under weekly + Full clean on discharge | Serco |
| Patient mattresses | Clean in line with local protocol + Full clean on discharge | Clinical/Serco |
| Chairs | 1 x full annually, 1 x check daily | Serco |
| Over bed tables | 1 x full clean daily (tabletops after each meal service) | Serco |
| ventilation grilles | 1 x full weekly visual check daily | Serco |
| Lockers | 1 x full exterior daily + 1 check, Full external and internal on discharge | Serco |
| Internal glazing | 1 x full daily | Serco |
| Radiators including cover | 1 x full clean daily external | Serco |
| Doors including ventilation grilles | 1 x full daily | Serco |
| Low, middle, and high surfaces | 1 x full daily | Serco |
| Waste receptacles | 1 x full daily + 1 check clean | Serco |
| Dispenser cleaning | 1 x full daily external + full clean internally on replenishment | Serco |
| Replenishment of consumables | Check and replenish 3 x daily | Serco |
| **Floors** | | |
| Floors hard | 1 x full daily, 2 x check daily | Serco |
| Floors soft | 1 x full daily, 2 x check daily | Serco |
| **Kitchen Areas** | | |
| Fridges and freezers | 1 x full weekly, 1 x check daily | Serco |
| Cupboards | 1 x full monthly, 1 x check daily | Serco |
| **Medical Equipment** | | |
| Medical equipment | Refer to local protocol | Clinical staff |
| **Cleaning Equipment** | | |

National Cleaning Colour Coding Scheme – National Patient Safety Agency

All cleaning items including cloths, mops, buckets, aprons and gloves should be colour coded as follows:

RED | Blue | Green | Yellow

If you require further information regarding cleaning or wish to comment about the cleanliness of this area, please contact:

## 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 17, 18 & 19.

**Table 17**

| NNUH Cromer Hospital site - cleaning audit scores | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Area** | **Number of Audits** | | | **Average Score** | | | **Target Range** |
| | 2019-20 | 2020-21 | **2021-22** | 2019-20 | 2020-21 | **2021-22** | |
| Wards | 24 | 26 | **24** | 97% | 95% | **97%** | 95-100% |
| A&E (MIU) | 15 | 14 | **13** | 94% | 96% | **98%** | 95-100% |
| Theatres | 12 | 12 | **13** | 98% | 95% | **99%** | 95-100% |
| Clinics/Admin | 60 | 60 | **68** | 98% | 97% | **97%** | 95-100% |

**Table 18**

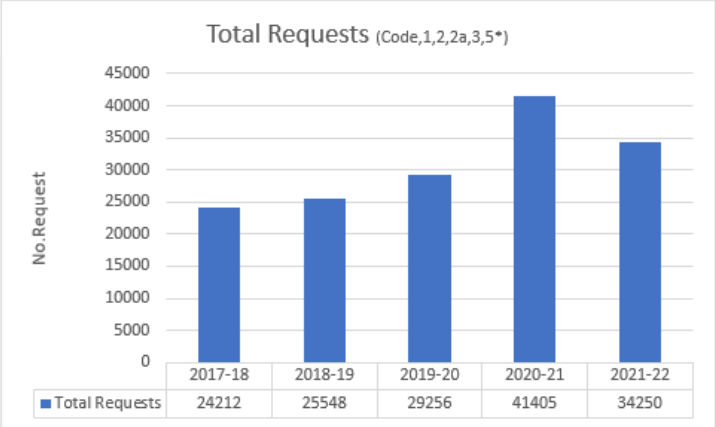
| NNUH remote sites - cleaning audit scores | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Area** | **Number of Audits** | | | **Average Score** | | | **Target Range** |
| | 2019-20 | 2020-21 | **2021-22** | 2019-20 | 2020-21 | **2021-22** | |
| Cotman Centre admin | 72 | 72 | **72** | 98% | 99% | **97.88%** | 95-100% |
| Francis Centre admin | 12 | 12 | **12** | 93% | 93% | **95.50%** | 75% (Low risk) |
| Eye Clinic Grove Road* | 12 | 11 | **12** | 99% | 99% | **99.50%** | 95-100% |
| Rouen Road | 72 | 72 | **72** | 97% | 98% | **98.15%** | 95-100% |
| Kidney Centre** | 0 | 32 | **48** | 0 | 97% | **97.00%** | 98-100% |
| * Eye clinic – closed April 2020.<br>** The kidney centre was not operational between January 2020 – July 2020 | | | | | | | |

Cleaning Services throughout the period continued to respond to the organisational pressure in combatting the pandemic whilst maintaining core service delivery. During the period additional investment of equipment included replacement clinical clean trolleys, heavy equipment such as scrubber dryers, steam and carpet cleaning machines, I-mop machines for very high risk areas, and commencement of full ward cleaning trolley replacements at the end of the period which will continue through to April 2022. A new dry mop system was also introduced in March which reduces general waste and improves efficiency of floor cleaning. The cleaning department also continued investment in the supervisory support for the frontline staff during the year. The period noted high volumes of reactive requests for cleaning trending above the 5-year average with Quarter 1 2022 trending c.12% above forecast.

**Table 19**

| NNUH Colney Site - Cleaning audit scores | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Area** | **Number of Audits** | | | **Average Score** | | | **Target Range** |
| | 2019-20 | 2020-21 | **2021-22** | 2019-20 | 2020-21 | **2021-22** | |
| Wards | 408 | 405 | **562** | 96% | 97% | **96%** | 90%-95% |
| A&E | 72 | 96 | **104** | 96% | 97% | **97%** | 90%-95% |
| Theatres | 228 | 154 | **183** | 98% | 98% | **98%** | 90%-95% |
| Clinics/Admin &Public Areas | 1084 | 1228 | **1211** | 97% | 97% | **97%** | 90%-95% |
| | | | | | | | |

**Graph 6**




## 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-19 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 20.

**Table 20**

| Number of commodes audited and average percentage pass across NNUH sites | | |
|---|---|---|
| **Financial Year** | **Total No. of Commodes audited** | **Percentage Pass** |
| **2021-22** | **1837** | **87%** |
| 2020-21 | 1401 | 89% |
| 2019- 20 | 1853 | 91% |
| | | |

## Environmental Authority

No visits to the hospital were conducted by the authority during 2021-22.

## Face Mask Fit Testing

Face fit testing continues to be the focus of the organisation as the COVID-19 Pandemic continues. Clinics have been managed by the team and utilised a selection of our in-house team of fit testers within the trust to provide competent fit testing to colleagues who would need to wear enhanced Personal Protective Equipment such as FFP3, Respirator.

During June 2021 the Department of Health and Social Care released correspondence in respect of FFP3 Resilience in the Acute Setting. The letter informed of 5 key resilience principles that Trusts are asked to consider and implement:

- Item 1: All FFP3 users should be fit tested and using at least two different masks (ideally three):
- Item 2: FFP3 users should interchangeably wear the masks they are fit tested to.

- Item 3: Trusts should ensure that a range of FFP3 masks are available to users on the frontline and overall should not exceed 25% usage on any one type of FFP3.
- Item 4: Frontline stocks will be managed at no more than 7-10 days per SKU.
- Item 5: Trusts will register FFP3 users and fit test results in ESR and review individual usage every quarter.

From 28/06/21 the Trust have been able to acquire the use of the Free Fit Testing resource to ensure staff receive a suitable fit test where required on more than one type of mask.

## Waste Management

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 with the next full review scheduled for January 2023. A minor change was completed in February 2022 due to the UN Number for Category A Waste changing to UN3549.

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 Health & Safety (H&S) team leads on waste policy and participate in monitoring with Facilities team. The policy is based on the document HTM 07-01 Safe Management of Healthcare Waste.
- During period 2021-22 the Safety Team continued with the services of the external contractor Independent Safety Services Ltd to act in the role of Dangerous Goods Safety Advisor on behalf of the Trust.
- Nuclear Medicine department oversee the management process of radioactive waste.

## 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 daily 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 17th of August 2021 by Stericycle (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 has not taken place during 20-21 & 21-22. As a temporary

measure a desk top audit was completed in May 2021 from a Duty of Care documentation pack which was provided from SRCL. A full site visit is to be arranged for 22/23.

## Dangerous Goods Safety Advisor (DGSA)

### Year 1 2020-21

During year 1 the DGSA visited the Trust on 4 occasions, 12th of August, 24th of November 2020, 30th of March and the 28th of April 2021 and observed the following departments/areas.

**Table 21**

| 12/08/20 | 24/11/20 | 30/03/21 | 28/03/21 |
|---|---|---|---|
| Main waste compound | Pharmacy | Mortuary | Main waste compound |
| Internal and external waste stores | Endoscopy | Community Nurses | Internal and external waste stores |
| Battery Storage | Sterile Services | Theatres – Radiation Supervisor | Battery Storage |
| Chemical Storage | Medical Gases | Nuclear Medicine - Radiation | Chemical Storage |
| Transport Documentation | Service Corridor Waste Storage. | Radiotherapy (Brachytherapy Suite) – Verbal | Medical Gases |
| | | Hazardous Waste Documentation | Pathology |

All actions identified in Year 1 (August 2020 to August 2021) have been completed and signed off by the DGSA.

### Year 2 2021-22

During year 2 the DGSA has visited the Trust on 1st of September, 27th of October 2021 and 31st of January 2022. A further visit is scheduled for the 17th of May 2022.

**Table 22**

| 01/09/21 | 27/10/21 | 31/01/22 |
|---|---|---|
| Main waste compound | Microbiology | Main waste compound |
| Battery Storage | The Cotman Centre | Internal waste storage areas |
| Chemical Storage | Mortuary | Battery Storage |
| Pharmacy | Pathology | Chemical Storage |
| Endoscopy | Medical Gases | |
| CSSD | Chemical Storage | |

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.

## Sharps Management

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. This was reviewed in January 2022 with the next full review scheduled for January 2024.

Compliance with the policy is monitored on a frequent basis by the following routes:

Collaborative approach by the Health & Wellbeing and Health & Safety Teams via incidents raised by the electronic reporting system Datix.

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

During 2022 the Inoculation Group concentrated on a mini campaign focusing on Sharp Prevention – safe ways of working. From this campaign the following Organisation Wide Learning (OWL) were released by the central communications daily update for all staff.

- SHARPS Acronym OWL, Trust Doc ID: 18688
- Minimising Sharps and Blood Exposure Incidents OWL, Trust Doc ID: 18733

Minimising blood splashes was also a focus of the team to change the culture that PPE is not just for COVID-19, and that eye protection is to be worn to where a blood splash could occur. All divisional governance leads are to raise in their local governance meetings. Senior and Local Management should be promoting to colleagues that eye protection should be worn where there is a potential for a blood/body exposure to occur.

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. Going forwards it is envisaged that all duty of care visits will be arranged during this time frame.

Other measures that the team have continued are as follows but going forwards may change with new monitoring elements that are under discussion.

- 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-19 this was restricted to be conducted only in the 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)

The Antimicrobial Subgroup Committee meets quarterly to review antimicrobial prescribing issues and reports to the Drugs, Therapeutics and Medicines Management Committee. The Antimicrobial team comprises of a Consultant Microbiologist, Lead Antimicrobial Pharmacist and Specialist Antimicrobial Pharmacist. The Consultant Microbiologist role has been vacant since December 2021. However, stewardship ward rounds are still taking place, shared between 3 Consultant Microbiologists. Dr Tremlett is taking overall lead until a new Consultant Microbiologist is appointed into the post.

### Antimicrobial Ward Rounds

As previously weekly ward rounds included Vascular and General Surgery ward, Surgical wards, all Older People's Medicine (OPM) wards and Gastroenterology. These are in addition to a number of other well established clinical rounds that include antimicrobial review – e.g., NICU, Critical Care Units and Haematology and Oncology. These are now being done in person. During COVID-19 these had switched to remote reviews.

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.

### Audit

Trust wide antibiotic audits to monitor and improve antimicrobial prescribing and use were carried out in April 2021, November 2021 and March 2022 and results circulated via HICC, Monthly Infection control report and AMSC.

An audit looking at appropriate antimicrobial prescribing on the respiratory wards was carried out in February 2022 and the results will be discussed with the appropriate consultants.

### 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. The CQUIN will be reinstated during April 2022 and will concentrate on improving the management of lower urinary tract infections in all patients over 16 years old

**Other Work**:

- Yearly teaching sessions to Fy1 and Fy2 doctors.
- Formulary applications; most recently dalbavancin and Fidaxomicin
- Antimicrobial Pharmacist attendance at the OPAT clinic (alongside a Consultant Microbiologist and OPAT nurse).
- Policy review; currently reviewing the Surgical Prophylaxis guidelines.
- Antimicrobial Pharmacist input into the *C. difficile* PIRs
- Attendance at Clinical Governance meetings, for example to discuss the CQUIN at the AMU clinical governance meeting.

**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 2022-23 include:

- Continuation and development of antimicrobial ward rounds
- Working towards achieving the 2022/2023 AMR CQUIN
- Trust wide audits
- Further work on the IV to Oral switch as directed by the regional Antimicrobial Pharmacist lead.
- Policy development and review in line with national recommendations
- Supporting development of dedicated microbiology ward rounds in Orthopaedics.

**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

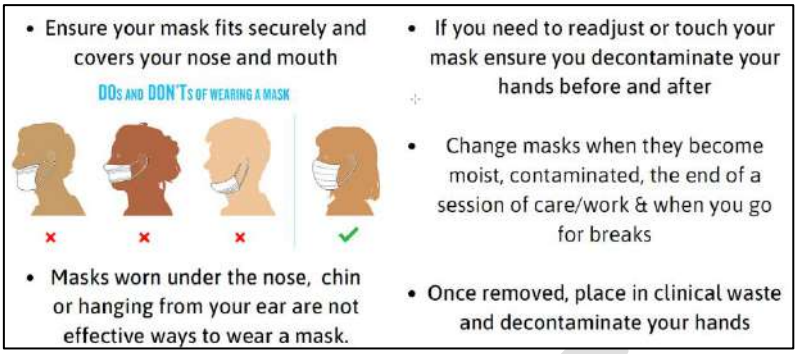
The IP&C team regularly update the information and have worked closely with the communications department throughout the pandemic. IP&C information is shared in several ways including:

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

# Infection Prevention and Control Annual Report 2021-22

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

**Image 26**




The Trust has had a robust visiting SOP in place throughout the pandemic. It has reflected the national picture and the local COVID-19 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.

**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 and IP&C team.

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 23.

**Table 23**

| MRSA Screening for Emergency and Elective Patients - numbers of Patient Screened | | |
|---|---|---|
| **Financial Year** | **Emergency Screened Patients** | **Elective Screened Patients** |
| **2021-22** | **96.1%** | **94.8%** |
| 2020-21 | 96.8% | 90.1% |
| 2019- 20 | 95.6% | 95.4% |

## Infection Prevention and Control Annual Report 2021-22

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.

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 24. Screening was increased in 2021-22 in line with new National Guidance.

**Table 24**

| Carbapenemase-Producing Enterobacteriaceae - numbers of Patient Screened | | | | |
|---|---|---|---|---|
| **Financial Year** | Admission in UK high risk hospital in last year | Hospital admission abroad in last year | Screened for other reasons (e.g., Holiday for Renal Dialysis patients) | Total |
| **2021-22** | **459** | **36** | **541** | **1036** |
| 2020-21 | 162 | 28 | 119 | 309 |
| 2019-20 | 146 | 143 | 6 | 295 |

### Period of Increased Incidence (PII) and Supportive Measures

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

These audit results are monitored weekly by the IP&C team and additional interventions planned with the ward management team to provide an action plan, see table 25 & 26.

**Table 25**

| Number of new episodes of supportive measures due to a PII | | | | |
|---|---|---|---|---|
| **Financial Year** | **MRSA** | ***C. difficile*** | **Influenza** | **ESBL** |
| **2021-22** | **1** | **4** | **0** | **1** |
| 2020-21 | 0 | 2 | 0 | 0 |
| 2019- 20 | 1 | 2 | 0 | 0 |

During this reporting year we had 4 PII's for *Clostridioides difficile* which triggered supportive measures. These were on Ingham, Mattishall, Docking and Edgefield wards. There was also a PII for Guist ward following 2 cases of MRSA. The clinical teams were all engaged with the

increased interventions, training, auditing and improvement work. On all occasions there were 2 patients involved triggering the PII, but no further cases were linked subsequently.

On each occasion the ward underwent enhanced cleaning as one of the key interventions.

Supportive measures were instigated on NICU between December and March with 11 patients with ESBL. The IP&C team supported the staff throughout this period promoting individual equipment availability in each cot space, reducing clutter, and instigating extra cleaning of the whole area. The Supportive measures were continued until there had been 28 days with no further cases and IP&C Tendable, Hand Hygiene, Environmental and isolation room audits were all in acceptable range. The team had great engagement at all levels and were pro-active and open to suggestions, working with new parents, helping them to understand access to the milk kitchen and essential good hand hygiene practice.

## 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-19 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-19 state levels.

The Pandemic Infectious Respiratory Disease plan provides IP&C guidance and action cards for each of the 6 local COVID-19 states. Clear pathways to manage patients in line with PHE/UKHSA guidance have been in place throughout the pandemic.

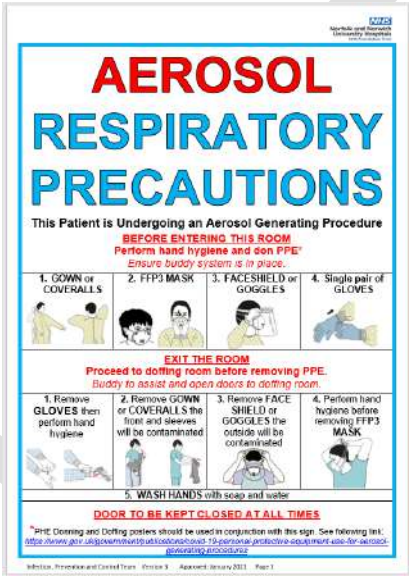
Patients are risk assessed on admission to ensure that they are placed in the correct area. During this period, the third wave; COVID-19 screening was undertaken on admission, day 3, day 6 and prior to discharge to care homes as there was significant asymptomatic carriage of COVID-19. Patients who had tested positive with COVID-19 in the previous 90 days did not require rescreening.

**Image 27**

# Infection Prevention and Control Annual Report 2021-22

The financial year 2021-22 began with the National COVID-19 incident level reduced to level 3 and the local COVID-19 state downgraded to 1. In May 2021 the WHO recommended a naming system for SARS CoV2 variants that uses the Greek alphabet. In June 2021 the first Delta variant was reported at the Trust, and this would go on to be superseded by the Omicron variant. In July 2021 restrictions were lifted in England and the public were asked to be responsible and choose to protect each other. In October 2021 UKHSA recommended a reduction of physical distancing from 2 metres to 1 metre with appropriate mitigations, such as continued use of facemasks, in clinical areas where patient admission was planned/ scheduled (for example elective surgery or procedures). This only applied to areas where patients were asymptomatic, not a contact of COVID-19 and have a negative SARS-CoV2 test. Throughout the year the IP&C team continued to advise staff on the UKHSA guidance. Support was provided to the Trust IMT, advising on mitigations during times of extreme pressure despite increasing capacity of the Virtual ward and working across the wider system to discharge patients to all available facilities when medically fit.

**Image 28**




Graph 7 below provides NNUH SARS CoV2 by attribution April 2021- March 2022.

**Graph 7**

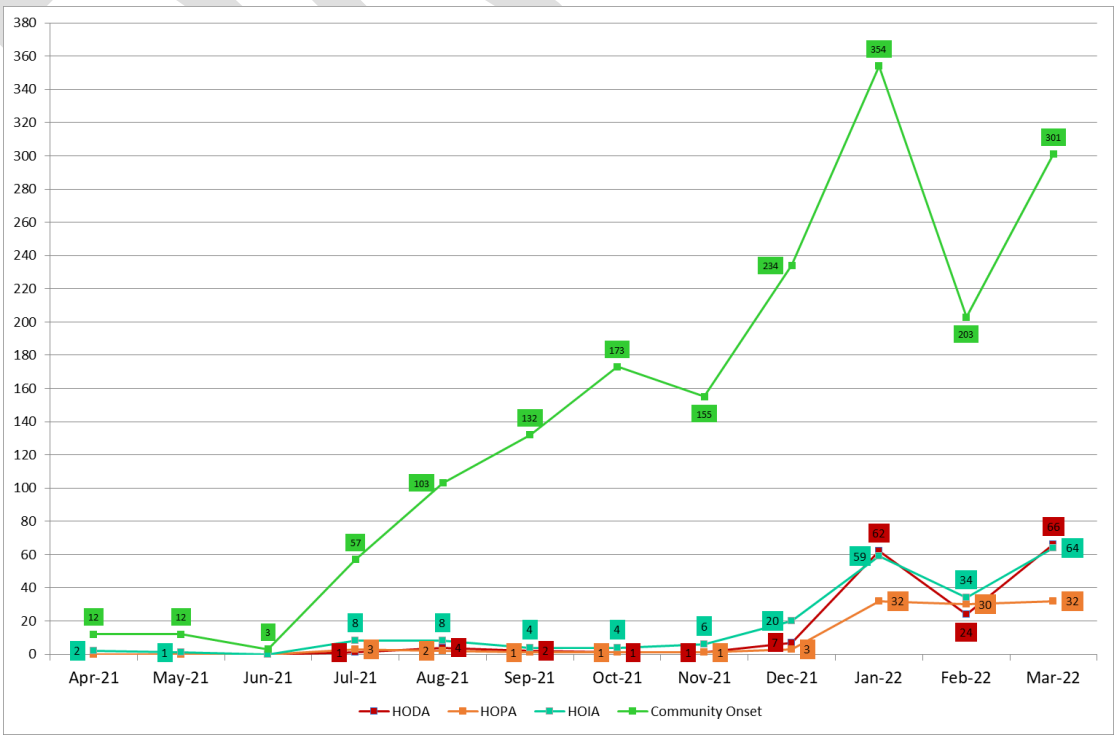


**Image 16**

| 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 |

During wave 3, Omicron quickly became the dominant virus in NNUH, taking over from Delta. At the height of the third wave in January we had 507 new cases of SARS-CoV2. 6.3% of these were Hospital Onset Definite Healthcare-Associated and 12.2% were Probable Healthcare-Associated.

## Outbreaks and Serious Incidents

**Table 26**

| Number of episodes of outbreak or serious incident | | | | | | |
|---|---|---|---|---|---|---|
| **Financial Year** | **MRSA** | ***C. difficile*** | **Influenza** | ***Pseudomonas aeruginosa*** | **Norovirus Ward closure** | **COVID-19** |
| **2021-22** | **0** | **0** | **0** | **0** | **8** | **46** |
| 2020-21 | 0 | 0 | 0 | 0 | 0 | 22 |
| 2019-20 | 0 | 1 | 1 | 0 | 7 | N/A |

In June 2020 NHSE provided guidance on COVID-19 outbreak process. According to this definition at the NNUH there were 46 COVID-19 outbreaks between 3rd July 2021 and 31st March 2022. Outbreaks involved between 2 and 27 patients. They lasted between 28 and 56 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 third wave the IP&C team provided the outbreak areas with support through education and audit and met weekly with the IP&C CCG and NHSE/I to discuss outbreak management to minimise nosocomial transmission.

Staff tested weekly with LAMP testing and then moved to twice weekly using Lateral Flow Tests. Patients were screened at day 0, 3 and 6. Ward view icons and email reminders were sent to highlight those requiring screening.

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

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 arranged to promote social distancing and posters detailed numbers allowed in each room.

**Image 29**

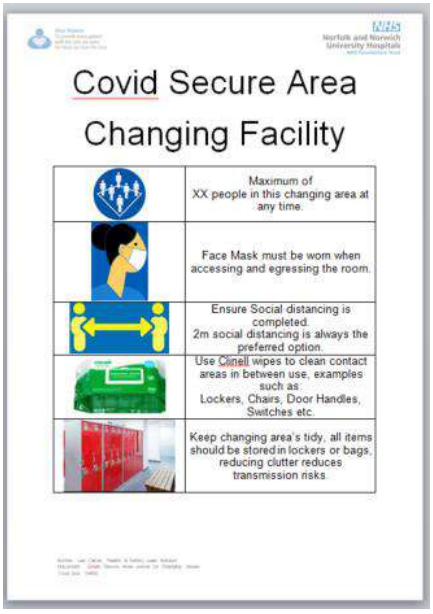



**Image 30**


## Indwelling device audit

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

**Table 27**

| High Impact Intervention Audit Scores | | | |
|---|---|---|---|
| High Impact Intervention care bundle audit | 2019- 20 | 2020-21 | **2021-22** |
| Central venous catheter care | 97% | 96% | **95%** |
| Peripheral intravenous cannula | 94% | 94% | **93%** |
| Ventilated patients | 99% | 98% | **97%** |
| Urinary catheter | 94% | 94% | **93%** |
| | | | |

## Audit of Compliance with Isolation Guidelines and Single Room Use

An annual audit of compliance with the Isolation guidelines was undertaken in October 2021 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.

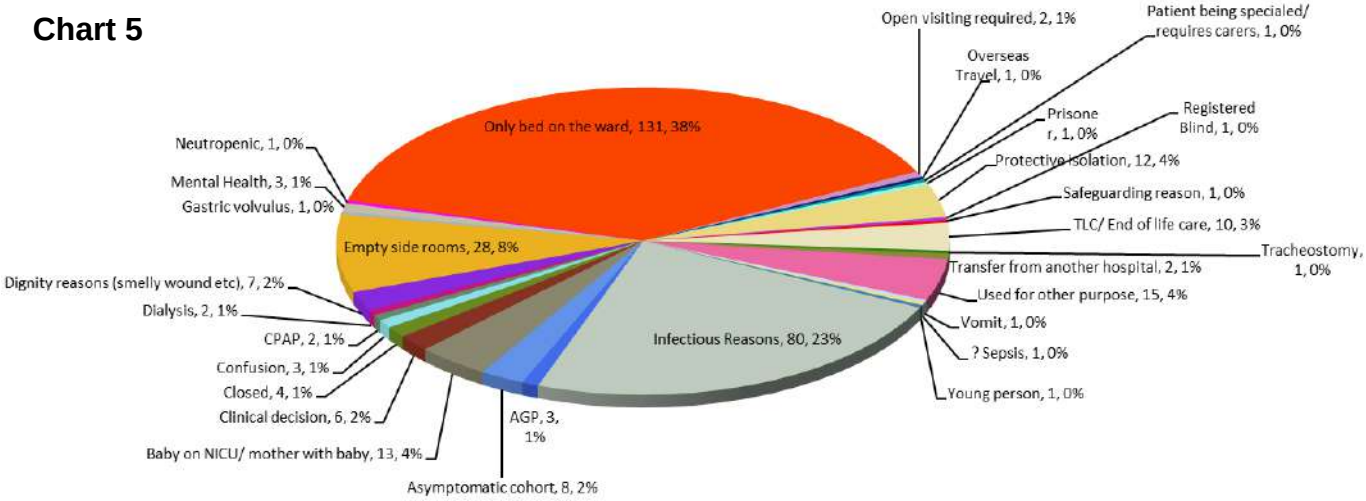
All patients with confirmed or suspected infection require isolation. At the time of audit 23% of patients were in a single room for IP&C reasons in comparison to 24% in 2020. 91% of patients requiring isolation for IP&C reasons were provided with a single room, however some patients are risk assessed 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 80% compared to 81% in 2020. The main issue was insufficient dedicated observation equipment although this had improved from 32.5% to 53.4% from last year. The results were shared Trust wide along with actions for continuing to facilitate improvement, see table 28 & chart 5.

**Table 28**

| NNUH - Isolation and Single Room Use Audits | |
|---|---|
| **Financial Year** | **Overall Compliance %** |
| **2021-22** | **80%** |
| 2020-21 | 81% |
| 2019-20 | 81% |

**Chart 5**




## Central Venous Catheter (CVC) Surveillance

A continuous surveillance programme monitors the CVC infection rates in adults. The overall infection rate remains below the Matching Michigan reference point of 1.4 per 1000 line days. Quarterly results are shared with Trust staff and in the IP&C monthly report, see table 29.

**Table 29**

| NNUH CVC related infections | | | |
|---|---|---|---|
| CVC infections are measured by rate per 1000 line days | 2019-20 | 2020-21 | **2021-22** |
| Renal | 0.44 | 0.5 | **0.24** |
| Haematology | 2.21 | 2.53 | **2.55** |
| Other areas | 2.29 | 0.14 | **Data not complete** |
| Overall | 0.79 | 0.6 | ***Not available as other areas not included** |

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

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

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

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

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

The validated rates of infection (identified prior to discharge and on readmission) for Orthopaedic categories were: See table 30.

**Table 30**

| Orthopaedic Surgical Site Surveillance | | | |
|---|---|---|---|
| **Calendar Year** | **Hip – PHE/UKHSA 0.5%** | **Knee – PHE/UKHSA 0.5%** | **Repair # Neck of Femur – PHE/UKHSA 1.0%** |
| **2021 SSI %** | **0.48%** | **0.53%** | **0.71%** |
| 2020 SSI % | 0.7%* | 0.0% | 0.47% |
| 2019 SSI % | 0.6%* | 1.8% | 0.34% |
| | | | |

**Spinal Surgery: Voluntary submission**

PHE/UKHSA Continuous data submission was undertaken this year. * Spinal consultant team engagement and practice changes by whole surgical care team, continue to support service improvement(s). See table 31.

**Table 31**

| Spinal Surgical Site Surveillance: Voluntary submission | | |
|---|---|---|
| **Calendar Year** | **Spinal SSI %** | **PHE/UKHSA SSI %** |
| **2021 SSI %** | **0.32%** | **1.3%** |
| 2020 SSI % | 1.14% | 1.5% |
| 2019 SSI % | 1.66% | 1.5% |
| | | |

## Other Surgical Site Surveillance

### Vascular surgery surveillance

There has been continuous systematic SSI surveillance in vascular surgery since 2009. So far during 2021-22 the SSI rates have been between 6.7% and 4%. See table 32.

**Table 32**

| Post vascular surgery surgical site infection rates | | | | |
|---|---|---|---|---|
| **Year** | **April-June SSI %** | **July-Sept SSI %** | **Oct-Dec SSI %** | **Jan-March SSI %** |
| **2021-22** | **6.7%** | **3.4%** | **4.0%** | **Awaited** |
| 2020-21 | 1.8% | 7.5% | 3.9% | 8.1% |
| 2019- 20 | 5.1% | 4.1% | 2.7% | 3.1% |

### Caesarean section surgery

There has been continuous systematic SSI surveillance following C section since 2010. Collaborative working between the obstetric department and IP&C has reduced SSI rates from 19.1% to 2%.

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 33.

**Table 33**

| Post caesarean section surgical site infection rates | | | | |
|---|---|---|---|---|
| **Year** | **April-June SSI %** | **July-Sept SSI %** | **Oct-Dec SSI %** | **Jan-March SSI %** |
| **2021-22** | **2.5%** | **2.2%** | **2.0%** | **1.8%** |
| 2020-21 | 2.3% | 3.1% | 1.0% | 1.5% |
| 2019- 20 | 4.2% | 4.4% | 3.1% | 2.2% |

## 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 guidance. Staff are encouraged to strive for 100% compliance and act as role models, challenging and educating others in best practice. See table 34.

**Table 34**

| 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 |
| **2021-22** | **758** | **96%** | **99%** |
| 2020-21 | 736 | 97% | 98% |
| 2019-20 | 697 | 96% | 98% |
| **Scores <95% lead to a re-audit within 1 week.** | | | |

**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 practitioner meetings, ad hoc education and teaching and planned study and awareness raising days.

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

**Image 31**


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

We undertake an annual isolation room audit to assess why patients are in the single rooms across the Trust, how many patients who require isolation facilities are in single rooms and how those in isolation are managed. See Table 28 and Chart 5.

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

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

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

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

## Laboratory, information contributed by Chief Bio-medical Scientist

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

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

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

| **Laboratory Operational Hours** | |
|---|---|
| Monday – Friday | 08:00 – 21:00 |
| 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.

In line with National Guidance, we have expanded our programme for screening patients for carriage of multi-resistant bacteria in the gut and also expanded our screening programme for carriage of potentially pathogenic bacteria during pregnancy.

We have introduced a new system for processing blood cultures that leads to faster diagnosis of sepsis and faster access to negative results, which assists antimicrobial stewardship and bed management.

We are currently modifying our processes for investigating prosthetic joint infection to improve diagnostic ability.

The CPE screening programme supports changes to National guidance.

**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 new documents and they are signed off by the HICC.

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

**Hygiene Code Compliance Criteria 10:**
**Providers have a system 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. Of course, 2021-22 has seen the continued 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 Occupational Health (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 last two years 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. Over 1700 contact tracing events have been undertaken in the last year. At each stage when new guidance was released, WHWB have ensured the Trust guidance has been updated. This has also included the development of an Isolation exemption policy and risk assessment template.

### 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

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

In addition, the Workplace risk assessments for clinical areas have been updated in line with guidance so that managers can assess and implement COVID-19 risk mitigation measures for individuals in their work areas to support the documentation provided by the Health & Safety team on general office/area COVID-19 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. Easily 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 & nonclinical) are required to have an immunisation review. This commences with their pre-placement health questionnaire. If immunisations for their specific role are not complete, then they are required to attend WHWB for an immunisation assessment. Their immunisations are recorded on their individual record on the dedicated occupational health system. At the time of the assessment the relevant immunisations are offered whilst advising the worker the importance of complying with UKHSA/PHE 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.

## COVID-19 Autumn Boosters / Influenza Vaccinations

The launch of the COVID-19 autumn booster and Annual Influenza Vaccination commenced in September. This year due to the co-administration of the COVID-19 booster and Influenza vaccination. NNUH secured a portakabin from NHSE/I for this vaccination programme. Therefore, the departmental peer vaccinator model was not utilised and all staff had the opportunity to receive their Influenza & COVID-19 booster via the new vaccine hub. A separate Influenza programme has been available for those staff based at Cromer in case they wish to access Influenza and COVID-19 separately (& prevent two journeys to Norwich), and the vaccination team have been making visits to offsite locations as well as using the Influenza trolley on the main site to increase participation.

# Infection Prevention and Control Annual Report 2021-22

**Figures at close of January 2022:**

| Table 35 | | | | |
|---|---|---|---|---|
| All staff number 9389 | COVID-19 Booster | COVID-19% | Influenza | Influenza% |
| All staff (without bank) | 7869 | 83.81 | 7304 | 77.79 |
| All staff (with bank) | 8603 | 84.98 | 7997 | 79.32 |
| All Staff (with Bank & Contractors) | 9967 | 86.77 | 9284 | 81.67 |

| Table 36 | | |
|---|---|---|
| Division % | COVID-19% | Influenza% |
| Medicine | 79.97 | 74.80 |
| Surgery & Emergency Services | 83.42 | 77.12 |
| Women & Children | 81.041 | 76.23 |
| Clinical Support Services | 86.97 | 80.79 |
| Corporate Services | 83.61 | 75.82 |

| Table 37 | | |
|---|---|---|
| Staff Groups | COVID-19 | % |
| Add prof & Scientific | 404 | 90.99 |
| Add Clinical Support | 1726 | 77.58 |
| Administrative | 1910 | 89.00 |
| Allied Health Professional | 532 | 92.36 |
| Estates & Ancillary | 186 | 83.03 |
| Healthcare Scientist | 236 | 85.82 |
| Medical | 1180 | 81.89 |
| Nursing / Midwives | 2429 | 84.46 |

| Table 38 | | |
|---|---|---|
| Staff Groups | Influenza | % |
| Add prof & Scientific | 368 | 82.88 |
| Add Clinical Support | 1644 | 77.58 |
| Administrative | 1746 | 81.63 |
| Allied Health Professional | 503 | 87.48 |
| Estates & Ancillary | 160 | 71.11 |
| Healthcare Scientist | 211 | 77.29 |
| Medical | 1094 | 76.18 |
| Nursing / Midwives | 2271 | 78.28 |

NNUH vaccine team supported the national booster response 'ramp up' programme in December vaccinating 500-600 members of the public a day in addition to the maternity walk-in and staff programme. A vaccine team was set up at Cromer Hospital by Cromer Hospital staff to support the national initiative.

**Contact Tracing**

In addition to COVID-19 contact tracing, WHWB have also undertaken contact tracing in the last year due to exposure to

**PVL MSSA**

WHWB undertook contact tracing following confirmation of a positive PVL patient and provided advice to individuals and the organisation

**Meningitis**

WHWB undertook contact tracing following confirmation of exposure to *Neisseria meningitidis* culture in bacteriology. Prophylactic antibiotics was provided on the advice / recommendation of the Consultant microbiologist

**Blood Borne Virus**

In line with UKHSA/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.

## References and further reading

Collection Staphylococcus aureus: guidance data and analysis July 2014 updated 22 January 2020, available at:
Staphylococcus aureus: guidance, data and analysis - GOV.UK (www.gov.uk)
Lat accessed 24.06.22

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
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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 Last accessed 24/06/22

Infection Prevention and Control Commissioning Toolkit Guidance and information for nursing and commissioning staff in England, RCN and IPS, January 2016, available at:
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NHS England Minimising Clostridiodes difficile and Gram-negative Bloodstream infections, August 2021 available at:
NHS England » Minimising Clostridioides difficile and Gram-negative Bloodstream Infections Last accessed 24/06/22

NHS National Standards of Healthcare Cleanliness 2021, available at:
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# Infection Prevention & Control

## Annual Programme

## April 2022 – March 2023

## Written & compiled by:

## Infection Prevention & Control Team

## April 2022

Norfolk and Norwich University Hospitals NHS Foundation Trust

# Infection Prevention and Control Annual Programme 2022-23

| Drivers | Actions | Evidence or Anticipated Outcome | Lead | By when/ Frequency | RAG Comments |
|---|---|---|---|---|---|
| **DH - The Health and Social Care Act 2008** Code of Practice on the prevention and control of infections and related guidance, July 2015 | Review and update NNUH compliance with the Code of Practice on the prevention and control of infections and related guidance, July 2015 | • To monitor elements via HICC quarterly<br>• Board minutes<br>• HICC minutes | IP&C team/DND's and Governance leads | Quarterly | |
| **Contract with ICB** | Required to send the board approved IP&C plan and annual report to Integrated Care Board (ICB) IP&C team.<br><br>Electronic version of both documents to be sent to ICB once ratified by board | • Board minutes<br>• HICC minutes<br>• Acknowledgement of receipt from ICB | DIPC | Annually | |
| **Contract with ICB** | IP&C monthly report - to include:<br>Antibiotic policy Trust audit results or similar antibiotic review process<br>HII Audit programme compliance results and Hand Hygiene/Dress Code audit results dashboard | • Email evidence of sending report to ICB | DIPC | Monthly | |
| **Contract with ICB** | The provider will be required to send any copies of all external IP&C focus visits/inspections that are not publicly available to ICB IP&C team. | • Email evidence of sending to ICB<br>• 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].<br>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**<br>***C. difficile* objective**<br><br>New attribution of cases according to 2019-20 guidelines (HOHA and COHA attributable to the Trust). | *C. difficile* case threshold 83 cases<br><br>Continue work proven to result in low rates of *C. difficile* infection (CDI) as described in *C. difficile* policy and annual report. | **Less than 21 HAI *C. difficile* cases per quarter**<br>**Q1 = 25**<br>**Q2 =**<br>**Q3 =**<br>**Q4 =**<br><br>• Published by UKHSA (government national statistics)<br>• HICC minutes<br>• Monthly IPR board minutes<br>• Monthly IP&C report<br>• IP&C dashboard for Trust staff<br>• Learning disseminated by OWL | IP&C Team | Throughout | |
| **Contract with ICB**<br>Complete a Root Cause Analysis/PIR for all cases of HOHA and COHA *Clostridioides difficile* | Joint PIR undertaken monthly with ICB and NNUH staff for each CDI diagnosed by toxin EIA identified on or after day 3 of admission or toxin positive cases who have been an inpatient within the last 4 weeks. ICB to agree those that are non-trajectory (no lapses in care). | ***C. difficile* trajectory cases per quarter**<br>**Q1 = 7 Q2 = Q3 = Q4 =**<br><br>• HICC minutes<br>• Monthly IPR board minutes<br>• Monthly IP&C report<br>• Email to ICB showing summary of PIR meeting showing outcome | Admin co-ordinator | Monthly | |
| | Lessons learnt and any action plans will be monitored by relevant divisional governance groups with updates on progress to HICC quarterly by division | • HICC minutes<br>• Divisional Governance minutes | Matrons and divisional governance leads | Quarterly | |

# Infection Prevention and Control Annual Programme 2022-23

| MRSA specific Drivers | Actions | Evidence or Anticipated Outcome | Lead | By when/ Frequency | RAG Comments |
|---|---|---|---|---|---|
| **NHS England and NHS Improvement MRSA objective** | No avoidable MRSA bacteraemia<br><br>Maintain a 'zero tolerance' approach to hospital attributable MRSA bacteraemia<br><br>Continue work proven to result in low rates of MRSA bacteraemia described in MRSA guidelines and annual report. | **NNUH attributable MRSA bacteraemia cases per quarter**<br>**Q1 = 0 Q2 = Q3 = Q4 =**<br><br>• Published by UKHSA (government national statistics)<br>• Quarterly HICC meeting minutes<br>• Monthly IPR board minutes<br>• Monthly IP&C report<br>• IP&C dashboard for Trust staff<br>• Divisional Governance minutes | IP&C Team<br><br>If a case occurs actions and any learning shared by Divisional Triumvirates | Throughout | |
| **Contract with ICB**<br>Assist in the supply of information for MRSA bacteraemia Post-infection Review (PIR) process where the patient has had healthcare contact with the Provider | ICB informed of an MRSA bacteraemia within 3 working days from result<br><br>PIR undertaken for any cases identified on or after day 3 of admission.<br><br>Assist in completing PIR with ICB for cases identified on pre day 3 of admission or had recent hospital contact. | • Email of draft copy of completed PIR form sent to ICB<br>• MRSA bacteraemia meeting minutes. | DIPC/Lead IP&C Nurse<br><br>IP&C nurses | Within 3 working days from a positive result | |
| **Contract with ICB**<br>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<br>• Monthly IPR board minutes<br>• Monthly IP&C report<br>• IP&C dashboard for Trust staff<br>• Divisional 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**<br>**Q1 = 7 Q2 = Q3 = Q4 =**<br>• Published by UKHSA [government national statistics]<br>• Quarterly HICC meeting minutes<br>• Monthly IPR to board<br>• Monthly IP&C report<br>• IP&C dashboard for Trust staff | IP&C Team<br>If a case occurs actions and any learning shared with Divisions | Monthly | |
| | PIR currently undertaken by IP&C team for any MSSA bacteraemia cases identified on or after day 3 of admission.<br>Determine whether there were any associated lapses in care. | • Quarterly HICC meeting minutes<br>• IP&C dashboard for Trust staff<br>• Divisional Governance reports | IP&C Team | | |

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| Other alert organism Drivers | Actions | Evidence or Anticipated Outcome | Lead | By when/ Frequency | RAG Comments |
|---|---|---|---|---|---|
| **UKHSA** reporting<br><br>• *E. coli* bacteraemias<br>• *Klebsiella* spp. bacteraemias<br>• *Pseudomonas* aeruginosa bacteraemia's | *E. coli* case threshold 96 cases<br>*Klebsiella* spp. case threshold 48 cases<br>*Pseudomonas* case threshold 26 cases<br><br>Minimise the number of cases of Gram-negative bacteraemia cases identified on or after day 3 of admission | **No more than 24 HAI *E. coli* bacteraemia cases per quarter**<br>**Q1 = 23**<br>**Q2 =**<br>**Q3 =**<br>**Q4 =** | IP&C Team | Monthly | |
| | Any significant themes will be identified, and improvement measures will be planned with clinical teams. | **No more than 12 HAI *Klebsiella spp*. bacteriemia cases per quarter**<br>**Q1 = 3**<br>**Q2 =**<br>**Q3 =**<br>**Q4 =** | IP&C Team | Monthly | |
| | Lessons learnt and any action plans will be monitored by relevant divisional governance groups with updates on progress to HICC quarterly by division | **Less than 7 HAI *Pseudomonas aeruginosa* bacteraemia cases per quarter**<br>**Q1 = 3**<br>**Q2 =**<br>**Q3 =**<br>**Q4 =** | IP&C Team | Monthly | |
| | Plan to promote appropriate UTI diagnosis, along with correct antimicrobial prescribing and reminder of guidance for urine sampling:<br>ICD to work with ICS AMS group.<br>Participation in 2022-23 CQUIN on diagnosis and management of UTI in patients >16 years led by AMS pharmacist<br>IP&C team to work with Reduction of Gram-negative ICS group. | • Rates published by UKHSA (government national statistics)<br>• HICC meeting minutes<br>• Monthly IPR to board<br>• Monthly IP&C report<br>• IP&C dashboard | IP&C Team | Ongoing | |

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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 UKHSA protocol | • HICC meeting minutes<br>• Divisional Governance minutes | IP&C | Ongoing | |
| | C section surgical site infection voluntary surveillance scheme | • HICC meeting minutes<br>• Divisional Governance minutes | IP&C | Ongoing | |
| Mandatory to report 1 quarter a year | Continuous surveillance of hip and knee replacement and spinal surgical site infection through participation in the UKHSA national mandatory surveillance scheme | • Rates published by UKHSA<br>• HICC meeting minutes<br>• Divisional Governance minutes | Orthopaedic SSIS lead | Ongoing | |
| | Advice and support the Dermatology division with Dermatology Surgical Site Surveillance at Cromer and NNUH | • HICC meeting minutes<br>• Divisional Governance minutes | Surgery | Ongoing | |
| MRSA Bacteraemia reduction | Continuous surveillance of Central line related blood stream and exit site infections in adults outside the Critical Care Complex | • HICC meeting minutes<br>• Divisional Governance minutes | IP&C | Ongoing | |

# Infection Prevention and Control Annual Programme 2022-23

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

# Infection Prevention and Control Annual Programme 2022-23

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

# Infection Prevention and Control Annual Programme 2022-23

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