Norfolk and Norwich University Hospitals NHS Foundation Trust

MEETING OF THE TRUST BOARD IN PUBLIC

FRIDAY 28 SEPTEMBER 2018

A meeting of the Trust Board in public will take place at 9am on Friday 28 September 2018 in the Centrum Building, Norwich Research Park

AGENDA

	Item	Lead Director	Purpose	Page No
1	Apologies and Declarations of Interest			
2	Clinical presentation – care at the End of Life - Dr Nicola Holtom and Dr Caroline Barry (Palliative Care Consultants) to attend	NF	Information	**Presentation**
3	Minutes of the Board meeting held in public on 27.07.18	Chair	Approval	**2**
4	Matters arising	Chair	Discussion	
5	Chief Executive's Report	CEO	Discussion	**15**
6	Reports from Board Committees: (i) Audit Committee (12.09.18) (ii) Quality and Safety Committee (14.09.18) (iii) Quality Programme Board (07.08.18 & 11.09.18) (iv) Finance and Investments Committee (17.09.18)	AR SS MD TH	Information, Approval & Assurance	**23** **26** **33** **37**
7	Integrated Performance Report - Quality, Safety & Effectiveness - Caring & Patient Experience - High Risk Tracker - Performance & Productivity - Workforce - Finance	Execs	Discussion & Assurance	**39**
8	FTSU Self–Review Tool	JO	Discussion	**102**
9	Feedback from Council of Governors	Chair	Information	**Verbal**
10	Any other business			

Date and Time of next Board meeting in public
The next Board meeting in public will be at 9am on Friday 30 November 2018 in the Boardroom, Norfolk & Norwich University Hospital (TBC)

Norfolk and Norwich University Hospitals NHS Foundation Trust

MINUTES OF TRUST BOARD MEETING IN PUBLIC

HELD ON 27 JULY 2018

Present:	Mr J Fry	- Chairman
	Ms F Bolger	- Acting Chief Nurse
	Mr M Davies	- Chief Executive
	Prof E Denton	- Medical Director
	Mr J Hennessey	- Chief Finance Officer
	Mr M Jeffries	- Non-Executive Director
	Dr G O'Sullivan	- Non-Executive Director
	Mr J Over	- Director of Workforce
	Mr R Parker	- Chief Operating Officer
	Professor D Richardson	- Non-Executive Director
	Mrs A Robson	- Non-Executive Director
	Miss S Smith QC	- Non-Executive Director
In attendance:	Ms F Devine	- Director of Communications
	Prof N Fontaine	- Chief Nurse designate
	Mr J P Garside	- Board Secretary
	Mr S Hackwell	- Director of Strategy
	Mr A Lundrigan	- Chief Information Officer
	Ms V Rant	- Assistant to Board Secretary
	Ms P Slinger	- NHSI Improvement Director

18/022 **APOLOGIES AND DECLARATIONS OF INTEREST**

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

18/023 **MINUTES OF PREVIOUS MEETING HELD ON FRIDAY 25 MAY 2018**

The minutes of the meeting held on 25 May 2018 were agreed as a true record and signed by the Chairman.

18/024 **MATTERS ARISING**

The Board reviewed the Action Points arising from its meeting held on 25 May 2018 as follows:

18/017 Mrs Bolger confirmed that the QAA process has recommenced. Action closed.

18/019(d) Carried forward. Mr How noted that around 20% of cancelled operations had been due to 'equipment failure/unavailability' (IPR Additional Slide 22b) and asked if these two issues could be reported separately to assist review of issues with equipment failure in particular, given the constraints on our capital expenditure.

Action: Mr Parker

18/019(d) Carried forward. Mr How expressed concern that the number of slides within the IPR is growing and asked if this could be reviewed to determine if any can be removed to ensure that the key information remains readily accessible.

Action: Execs

18/019(e) The Cash Slide in the IPR (now Core Slide 45) has been updated to reflect approval in April 2018 to increase the borrowing limit to £100m. Action closed.

18/019(e) Additional financial information relating to divisional performance and CIPS has been added to the IPR. Action closed.

18/025 **CHIEF EXECUTIVE REPORT**

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

Mr Davies congratulated the Cellular Pathology team in their successful renewal of UKAS Accreditation. The assessors complimented the department on their professional, knowledgeable and competent staff, excellent documentation and good audits.

Professor Steve Feast (Eastern Academic Health Science Network Advisor) has been jointly appointed by NNUH, UEA and QIB to assist in development and integration of strategic priorities for research, clinical delivery, education and workforce development, maximising the joint benefits for all parties.

Professor Richardson agreed this was a very positive way forward for the organisations as it will give complicated and diverse organisations an opportunity to focus on how we will work together.

Mr Frank Sims has been appointed as Chief Officer for the North Norfolk and South Norfolk Clinical Commissioning Groups.

Mr Davies reported that he and Mr Fry had met with around 2,000 staff since the last Board meeting to update and engage staff following the publication of the CQC's inspection report. Our staff expressed a range of emotions at the meetings but there was an overwhelming sense of commitment to help and make things better.

The Board received a copy of the presentation given to the first meeting of the Oversight and Assurance Group which has been established to meet during the time that the Trust is in Special Measures. The Group consists of representatives from the regulators and multiple external stakeholders and will oversee and monitor progress in delivery of our improvement action plan. This initial meeting was successful as a set-up meeting.

The Board will also be hearing more about how our stakeholders will be working with us to deliver these improvements. Work in the last period has been focused on developing assurance systems so that the Board can be assured about progress towards delivery of the projects identified in our action plan.

We have had very positive engagement from Healthwatch and thank them for that.

We are trying to make our journey more transparent to the public and in this light, the Kings Fund Report, CQC action plan and Oversight and Assurance Group meeting presentation have been released to our staff and the public.

Our presentation to the Oversight and Assurance Group (OAG) highlighted the changes that we have made since the time of the inspection. We have significantly increased the size of the Children's Emergency Department from 3 to 15 spaces. Facilities for people with mental health problems are also being improved with creation of a 3 room suite and dedicated team of staff provided by Norfolk and Suffolk Foundation Trust. We also opened the UK's first Older People's Emergency Department to provide specialist care to patients over the age of 80.

By the end of 2018, the Emergency Department assessment/treatment areas will have tripled in number from 28 to 91 spaces.

In the last three months, there has been a 50% change in the Executive Directors with the appointment of Mr John Hennessey (Chief Finance Officer), Professor Erika Denton (Medical Director) and Professor Nancy Fontaine (Chief Nurse).

The OAG was also updated on the actions that have either been completed or were planned around culture and leadership.

Three of the actions are focused around senior leadership. A Board development programme will commence in the Autumn. Development programmes for the Management Board and Executive Team have already commenced and the Exec Team is having a further away day at the end of this month. A leadership and development programme for middle management is also due to start in the Autumn.

The visit from the National Freedom to Speak-Up Guardian Office was extremely helpful and we are now looking to appoint a full-time Freedom to Speak-Up Guardian and there has been a lot of interest in this post. We are also considering how we can develop roles for departmental Speak-Up Champions.

Mr Davies is introducing regular 'drop-in surgeries' to provide staff with an opportunity to come and discuss any concerns. Staff have been keen to get involved in influencing the future of our organisation and we are planning to introduce 'clinical senates'. These meetings will provide a forum for debate about our clinical strategy and how we can continue to develop our academic mission. We are also looking to extend these senates to include our non-clinical staff. Professor Denton indicated that she envisages a forum dealing with issues crossing over governance and management structures, with membership determined according to topic but there is further work to identify a formula that will be most effective and will sit alongside our Leadership Forum. It may also be possible to open the forum to external clinicians in due course.

Miss Smith asked how we will measure the impact of the senate and FTSU guardian role to demonstrate efficacy. Mr Davies explained that some interventions will show in the 'macro' data, such as the staff survey results. In others, we will be able to evaluate our progress by monitoring Key Performance Indicators. Professor Denton suggested that it should be possible for staff to recognise a personal impact across the organisation.

Dr O'Sullivan welcomed the appointment of a full-time Speak-Up Guardian and asked how we will be evaluating their effectiveness. Mr Over explained that this was a new model and a full time dedicated role. Regional and national networks are available for the guardians to link with and the full-time guardian will attend the Board regularly to keep the Board appraised of relevant issues.

Dr O'Sullivan asked if there was a risk that they would be seen as part of the Board and not independent if they were attending regularly. Mr Over explained that introduction of the Guardian for Safe Working Hours had been successful for the junior doctors and no negative impact had been perceived by their regular attendance at the Management Board.

Dr O'Sullivan asked about the recruitment process and whether this will be open to provide confidence that they are independent and selected fairly. Mr Over confirmed that it will be and will include representatives from a range of stakeholders.

Professor Denton commented that we are all speak up guardians and should be encouraging staff at every level to speak up. We need everyone to feel comfortable to be able to speak up.

Mr Davies reported that the Quality Improvement Plan (QIP) had been submitted to the CQC on 6 July. The QIP has been developed to address the CQC's 'must' and 'should' dos and work to deliver those actions is underway. We will also be working with staff patients and partners to develop a Quality Improvement Strategy which will focus on delivering sustainable quality improvement. This work will need to be driven through a robust governance structure in order to drive the required scale and breadth of improvement.

In line with national best practice, we have established a Quality Programme Board (QPB). The QPB will meet monthly to obtain assurance for the Trust Board on implementation of the QIP.

It will be helpful to have a Non-Executive Director member of the Quality Programme Board and Mr Fry has volunteered to undertake this, with other NEDS welcome to attend as well or as alternates.

The QPB will be reporting to the Board and also provide reports to the Oversight and Assurance Group (OAG).

Alongside the OAG's role to hold us to account, the OAG is also required to work with us on system-wide initiatives. A number of areas were highlighted at the first meeting where our partners could help us:

- close whole system working with robust plans to manage demand for emergency care over the winter;
- support in development of our speak up initiatives/approach;
- help in designing/establishing the way to ensure the patient's voice is heard in decision making across the Trust;
- support with assurance visits/checks to test QIP progress;
- capital support to expand capacity and improve safety;
- develop a joint communication plan.

Mrs Robson reflected that the IRU had been one of the STP's priority schemes for funding but this had not been forthcoming and asked if there would be any other way to leverage the required funding for this scheme.

Mr Hackwell reported that the STP had submitted its next wave of capital bids on 15 July and the outcome will be known in due course. Our loan application for Department of Health funding is still awaiting decision. Mrs Robson highlighted that it may be helpful to receive feedback about why funding bids have not been successful as this may help to inform for future bids. Mr Davies assured the Board that we have been doing all we can to let our regulators know why this funding is so important. It has been a sense of great worry and frustration that we have not been able to do this to reduce the clinical risk for our patients.

Mrs Robson reflected that there had been an extensive delay between the CQC's inspection visit and issue of their report. Work to address concerns had started before the report had been published and Mrs Robson asked if it was possible to indicate how much progress had been made so far. Mr Davies indicated that it was difficult to determine an exact percentage figure at this stage but the Board will be aware that work is underway and our staff are fully engaged in this improvement work. We will be undertaking audits along this journey to determine how we are doing but it will

ultimately be the CQC's next review that will judge how far we have been able to improve.

Ms Bolger explained that the next piece of work is focusing on collection of the evidence from audits that will show what progress has or has not been made. Mr Fry emphasised that the Board should be provided with a monthly update on progress and to ensure that actions are being taken in those areas falling behind.

Miss Smith asked if there would be any feedback from the CQC following submission of the QIP on 6 July. Mr Davies explained that the CQC representatives form part of the OAG and will be attending every month to monitor the progress. Professor Fontaine indicated that the view of our staff will also be important and the CQC will speak to a focus group of staff to gauge progress. Consistent data over six months will give the CQC a positive indication of change.

Mr Fry asked how we should be assessing our progress. Professor Fontaine indicated that that Trust should undertake an externally commissioned review of those areas that had been performing poorly, ideally twice before the next CQC inspection. Mr Davies agreed that visits from members of the OAG and their colleagues will be important.

18/026 **WINTER PLANNING 2018/19**

The Board received a report from Mr Parker concerning 2018/19 winter planning.

Mr Parker informed the Board that the NNUH schemes to prepare for the winter are a component part of a much larger system-wide winter plan.

An 8 point plan has been developed for NNUH based around three main themes (capacity; leadership; and process). Bed capacity has been modelled using the NHSI tool with very prudent assumptions: 6% growth in emergency demand, no improvements in length of stay and 92% occupancy rate. The tool forecasts that we will require an additional 22 to 40 beds for the winter.

We have deliberately planned to over-provide capacity, to mitigate risks to delivery. The wisdom of this approach is supported by the high occupancy rate and high non-elective demand in Q1, suggesting that demand may again be very high this winter.

Mr Parker highlighted key aspects of the Plan:

i) We have already brought the refurbishment decant ward back into regular use and have halted the ward refurbishment programme.

ii) We are looking to establish a temporary modular ward to provide escalation space. Recruitment for staffing has commenced.

iii) Creation of a Discharge Lounge. A Task and Finish Group has been established to identify suitable accommodation, which may be a modular building. Mr Parker indicated that it may be possible to refurbish and repurpose the existing 'Pod' café for patients awaiting transport on discharge. Miss Smith asked for assurance that these patients would be appropriately segregated. Mr Parker explained that the design is still in development but we will obviously have to ensure that all appropriate measures are in place with regard to privacy and dignity.

Use of overnight escalation has been driven by the number of discharges that take place in the afternoon and bringing this forward by two hours (so that 30% of

discharges take place by midday) will provide an opportunity to reduce the discrepancy between admissions and demand by around 23 beds.

iv) Rapid Assessment (RATS) capacity in ED has been the main barrier to off load ambulances in a timely way. We currently have 3-4 spaces which can process 4 patients per hour. The range of ambulance attendances varies from 105 to 182 patients per day. RATS capacity is to be increased to 8 spaces which will allow assessment of 32 patients per hour. The cost of this scheme is expected to be around £1.2m and staff costs are being assessed in a review of ED establishment.

v) We are working with a third party provider to establish a 30 bed virtual ward for patients within a 15 mile radius of the hospital. This would allow patients requiring long term antibiotic therapy or multiple insulin dose administration or with complex wound dressings to remain under our care but to receive treatment in their homes. This model of care is relatively common in the NHS and the service would be funded through tariff payment. There is a 12 week mobilisation timescale and will be implemented initially as a trial.

Miss Smith asked how responsibility for patients would be addressed. Mr Parker explained that patients would remain under the care of NNUH but formal arrangements will be put in place for when treatment plans are adjusted. Mr Hennessey agreed that it will be essential to put in place formal contractual arrangements and asked if we should consider developing our own staff to manage a virtual ward in the future. Mr Parker informed the Board that the third party provider had confirmed that they would be open to working with us on different arrangements, so there would be potential to develop our own team in future. Professor Fontaine reported that she had had experience of different systems but essentially the ward would be an extension of the hospital and staff would be bound to NNUH governance processes.

Miss Smith asked if the Consultants were in support of this scheme and this was confirmed by Professor Denton who indicated by way of example that beds utilised by patients on IV antibiotics will be released for orthopaedic patients. Mr Davies emphasised that the plan has the unanimous support of the Management Board.

vi) Fewer patients over the age of 80 were admitted over the winter due to the work of the OPED. Given the proven effectiveness of this service, the unit will be extending its operating hours to 7 days per week until 8pm. The scheme is supported by the Commissioners and additional staff/revenue costs are being negotiated in the commissioning contract. In future it is hoped to increase the service to all patients from care homes.

Mr Jeffries asked what additional nursing staff will be needed to meet additional capacity. Ms Bolger confirmed that an overseas recruitment exercise had been undertaken and 19 nurses will be joining the Trust in September. Mr Parker indicated that the number of porters will also need to increase in order to minimise delay in moving patients around the site.

Mr Jeffries asked if the additional staffing costs had been included in the financial plan and Mr Hennessey confirmed that the overall costings are still being refined. Mr Parker informed the Board that the Commissioners have been asked to allocate funding towards winter pressures and extended operational hours of the OPED. Mr Hennessey noted that the budget provides a contingency of £2m for CQC-related improvement actions and £5m on income risk. This contingency is being viewed ‘in

the round' and will need to support the winter plan, given the increase in non-elective demand in Q1, which is well above the contract plan. It will be necessary to keep costs closely under review but the imperative of taking action is clear, given our reflections on last year and the pressures already apparent this year.

Mr Parker reported that the Management Board had discussed the need to act quickly with a need to establish the winter team and to generate good staff engagement in projects. Junior doctors have put forward some good suggestions for schemes that they could be involved in.

Professor Richardson asked how progress towards implementation of the plan was going to be monitored. Mr Parker confirmed that one of the next steps would be to develop the systems for monitoring and reporting progress, with regular updates to the Finance and Investments Committee and Board.

Mr Fry noted that we need discharge lounge space, escalation space and decant space for the refurbishment programme. This equates to approximately 3 wards. Would it not be better to build a permanent new ward block of 4 wards, rather than this expensive temporary space? The difficulty with this approach however is one of both timing and availability of capital. The new capacity is needed by the winter and our ability to invest is very limited.

Mr Fry expressed concern that car access for patients and disabled people may be restricted by the alterations required to the hospital plaza and asked for this to be taken into consideration. Feedback currently is that patients and visitors are finding this a problem and we need to include it as part of our ongoing planning.

The Board **approved** the Winter Plan so that the Executives could progress work on schemes outlined in the Plan without delay and in anticipation of increased demand in Winter.

18/027 **KINGS FUND REVIEW OF ORGANISATIONAL DEVELOPMENT**

The Board received a report from Mr Over concerning the Kings Fund review of organisational development (OD).

Mr Over reported that the Kings Fund report had been widely shared with our staff and the public, in line with one of the Kings Fund recommendations around increasing transparency.

Mr Over reminded the Board that the Kings Fund had been commissioned to undertake a review following release of the Staff Survey results in March. The action plan has been developed to address the 15 recommendations identified from the review undertaken by the Kings Fund.

Progress is being made:

- the Trust has commenced a recruitment programme to appoint a full time Speak-Up Guardian;
- a high profile leadership/management development programme is under preparation to commence in September with a focus on developing positive team cultures and reducing bullying within teams.

Implementation of the action plan will be overseen by the Quality Improvement Board.

Mr Jeffries asked if the recommendations will be addressing fundamental issues such as establishing Job Descriptions that staff can be performance managed against. Mr Over explained that the Kings Fund had talked to around 300 staff during their review.

It had been identified that there was a need to review middle management and nursing structures in order to improve reporting lines which should make it easier to performance manage staff.

18/028 **INTEGRATED PERFORMANCE REPORT**

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

(a) Quality, Safety and Effectiveness

Ms Bolger reported that the Trust indicator score in the most recent CQC Insight Report for Never Events and Whistle Blowing alerts was worse than the national average. An indicator showing as better than the national average is sick days for medical and dental staff.

Professor Denton informed the Board that mortality rates are continuing to show an improvement. It is anticipated that the HSMR may plateau. The SHMI is within the expected range. We are reviewing practice around coding relating to Priscilla Bacon Lodge and sepsis patients and this is expected to reduce the crude mortality rate.

Ms Bolger reported that 13 Serious Incidents had been reported in June. One Never Event was reported and concerned misplacement of an NG tube and the Procedure Oversight Committee is reviewing processes to identify actions for improvement. Professor Denton informed the Board that a review is being undertaken to ensure we have robust processes for reviewing incidents and identifying learning from them.

Ms Bolger indicated that the Surgical Division had implemented Human Factors training this month and a survey is being developed in order to monitor improvements. A pilot project '10,000 feet' has been introduced in T&O which gives staff a trigger word to use when challenging a colleague's actions and to speak out about their concerns.

As part of our participation in the pressure ulcer collaboration, we are undertaking an in depth review of Tissue Viability Team processes/documentation and action plans to ensure that adequate learning is being gained from Root Cause Analysis reviews.

We are looking to reduce use of catheters and UTIs by 5% in line with national requirements. Urine testing and sampling processes are being updated in line with national guidance and the process will be introduced on two wards that have a high use of catheters. The team at Queen Elizabeth Hospital in Kings Lynn have also requested to work with us to learn about what we are doing to make improvements.

Two babies have been tested positive for MRSA bacteraemias on the Neonatal Intensive Care Unit. Enhanced cleaning and hand hygiene has been implemented as a precautionary measure

Professor Denton informed the Board that she had chaired her first Mortality Committee meeting yesterday and highlighted a need to ensure that processes are not being duplicated.

Dr O'Sullivan noted that the number of PALS enquiries in the year to date was showing an increase (335) compared to the position last year (282) and asked what actions were being taken to address the themes identified. Ms Bolger explained that most concerns had related to appointments or waiting times and work is ongoing in outpatients and ITT to address issues. We are also trying to embed systems to use information from complaints in governance review processes in order to make improvements.

Miss Smith noted that a new system was to be introduced for review of Never Events and asked if that was to be focused on individual events or around identified themes. Professor Denton confirmed that it would look at both individual events and themes. The framework is still under development but it recognised that it needs to be a robust process at Executive level and with fixed times for the reviews. This will look at individual cases and themes.

Professor Denton explained that these meetings will be held at the conclusion of the RCA process. Professor Fontaine indicated that this would provide executives with an opportunity to question processes and teams but consideration could be given to inviting an observer from outside of the division to attend. The process is expected to strengthen our governance processes.

(b) Caring and Patient Experience

The Board received an update report from the CAPE governance sub-board.

(c) High Risk Tracker

The Board received the High Risk tracker in its usual format.

(d) Performance and Productivity

Mr Parker informed the Board that a spike in referrals for urology cancer has had an impact on our ability to achieve the 62 day cancer target. The level of referrals has now plateaued but at a higher level than previously seen and actions have been put in place to adjust capacity to cope with the additional demand. A trial of undertaking biopsies under local anaesthetic is being undertaken. We are working to recover performance against the target by September and we are working with our regulators on the actions to achieve this.

Mr Fry asked if our current capacity would be able to meet the new level of demand. Mr Parker explained that it has been necessary to divert capacity from the RTT 18 week elective work. There is an urgent need to work more closely with other providers in order to access capacity for patients to receive timely treatment.

A&E performance was better than trajectory in June at 87.5% but demand remains 4% higher than the previous year and there is a 4.9% increase in emergency admissions. The Emergency Department leadership team is now fully embedded and we are also starting to see the benefits of the overseas recruitment drive. The large proportion of major patients appears to be driving the emergency admission rate and performance is not showing the usual decline that is seen during the summer months.

The internal Sentinel Stroke Audit Programme (SSNAP) rating in June was B (74%). Each domain has been challenged with achieving an A rating but significant challenges remain at the front door. Monthly RCA meetings are being held to focus work on those pathway domains that rely on the front door.

Concerning the 18 Week RTT, we have been working with commissioners to create a demand management plan as previous schemes for demand management have not been successful.

Dr O'Sullivan expressed concern that stoke performance is showing a decline. Mr Parker explained that we are focusing our efforts on the two worst performing areas in order to address issues. We now have a dedicated neurosciences team in place but stroke performance is impacted by other capacity constraints. A focus group is working to identify ways to protect stroke capacity.

Dr O'Sullivan highlighted that our performance has been below the stroke indicator targets in a number of areas for some time now and asked how the Board could be assured that this was going to improve. Mr Parker indicated that the areas reported are chosen as these are the most challenging for the Trust. Our overall rating is good but it is recognised that these areas need to be addressed. Mr Davies assured the Board that the Management Board is closely monitoring actions being taken to improve performance, highlighting that overall performance has in fact improved. We are however pressing on to achieve a SSNAP rating of A rather than B.

Improvement in stroke services is also a major drive of the STP and our plans to provide a thrombectomy service is an integral part of stroke services improvement. Mr Parker asked if the Quality and Safety Committee would find it helpful to invite the stroke team to present an update at a future meeting to provide assurance on their work. Mr Garside explained that the stroke team had attended the Quality and Safety Committee on two previous occasions. A recent update from the stroke team to the Management Board had given a more rounded picture and the team had been proud of what they have achieved so far. There is rightly a particular focus on 'door to needle' time and 'time to scanning' – both of these are in part subject to capacity constraints outside the control of the stroke team.

The Board will receive regular updates on progress through the IPR.

(e) Workforce

Mr Over informed the Board that appraisal compliance is currently 71.2%. A trajectory for the Divisions to achieve compliance has been developed and performance is being monitored weekly.

Mandatory training compliance has also increased to 82% against the target of 90%. At its next meeting, the Management Board will be looking at recommendations for achieving further improvement.

The results of the 2018 GMC Junior Doctor Survey have been published and NNUH remains 3rd out of 17 Trusts in the East of England for overall satisfaction. This is a very good result. The results are being analysed and Professor Denton indicated that the Execs will be meeting with the teams who had scored poorly in order to provide support towards improvement. Mr Davies noted that this was a positive achievement, indicating that junior doctors see NNUH as a good place to learn and congratulated those areas that had done well.

(f) Finance

Mr Hennessey reported that the Month 3 financial position is £0.5m ahead of plan and clinical income is ahead of plan by £0.27m. The deficit in the year to date is £15.1m against the re-profiled plan of £15.2m.

CIP performance in the year to date has delivered £5.2m against the FIP Board approved plan of £4.2m. Performance is weighted towards the second half of the year and we have done well on delivery in the year to date. However, progress appears to have slowed recently and we recognise that we need to ensure that momentum continues as the year progresses. Performance by Division is showing that surgery is behind plan and medicine significantly ahead of plan currently. There was a focus on Surgery at the Finance and Investments Committee last month.

There is risk relating to the delivery of the clinical income plan which is 5.5% higher than 2017/18 outturn. There is no provision in the Annual Plan for non-achievement of CQUINs but a provision in the year to date has been made of £450k.

There is an expectation that our exposure to fines will be capped and reinvested in the Trust but this remains the subject of negotiation. Fines from cancer, cancelled operations and mixed sex accommodation are £0.24m to date.

A second risk relates to CIP schemes. Schemes worth £20.2m have been fully worked up but we need to develop further schemes to achieve the £30m target.

Deficit support is assumed at £48m for the year and capital borrowings at £22.7m. Confirmation of borrowings is being confirmed/declined on a monthly basis.

The financial risk arising from implementation of the CQC, Kings Fund and winter pressure action plans has yet to be fully defined. There is a contingency allocation of £2m for this in the plan but the actual amount needed is anticipated to be greater and may need to utilise some of the £5m income contingency.

Mr Hennessey informed the Board that there is an estimated financial risk of £400k arising from the 1% pay awards which may not be centrally funded. This is in addition to a potential liability associated with reimbursement of Serco pay costs, which is subject to ongoing assessment.

Mr Hennessey explained that although we have been discussing options for a block contract with the CCGs, negotiations have not yet progressed to a point at which we can make any recommendation.

18/029 **QUALITY PROGRAMME BOARD TERMS OF REFERENCE**

The Board received a report from Mr Garside concerning the Terms of Reference for the Quality Programme Board (QPB).

The QPB is being established with the core purpose being to oversee and to gain assurance with regard to implementation of our Quality Improvement Plan and associated action plans. Its Terms of Reference have been developed in line with our standard format.

Membership comprises Management Board members, a Non-Executive Director and the meeting will be chaired by the Chief Executive.

Meetings will be held monthly whilst the Trust is in Special Measures and it is intended that ongoing oversight and scrutiny arrangements for quality improvement will be reviewed again once the Trust has exited Special Measures.

A report will be prepared for the Trust Board following each meeting of the QPB.

The Management Board has agreed to vacate one of its meeting slots every month to enable a time for the QPB to meet, in order to avoid increasing the number of scheduled meetings in the Trust further. The first meeting will be taking place on 7 August and the QPB will have met twice by the time the Trust Board meets again in September.

The relationship between the Quality and Safety Committee and QPB will need to be considered to avoid overlap and this is something that the Quality and Safety Committee will be considering at its next meeting. The Quality and Safety Committee's Terms of Reference will need to be revised to reflect any agreed changes but any reduction in the work load of the Quality and Safety Committee will free-up time for increased interaction with clinical and divisional teams.

Miss Smith and Dr O'Sullivan expressed concern that potential overlap of duties of the Quality and Safety Committee and the QPB will need further consideration. Mr Davies highlighted that this structure reflected national best practice and the advice of our regulators. Professor Fontaine suggested that the role of the Quality Programme Board is to provide assurance to the Board on the QIP whereas the Quality and Safety Committee forms part of quality and safety assurance as 'business as usual'. Mr Garside noted that at least four members of the QPB are also members of the Quality & Safety Committee (CEO, COO, MD & CN), so duplication should be easily recognised. The QPB papers will be circulated to all Board members in the usual way.

The Board **approved** the Quality Programme Board Terms of Reference and **agreed** to receive monthly reports on its work. The Board also **agreed** that the Terms of Reference of the Quality and Safety Committee should reviewed with careful consideration to avoid gaps or duplication between the duties/functions of the two committees.

18/030 **ANY OTHER BUSINESS**

There was no other business.

18/031 **BOARD IN ITS CAPACITY AS CORPORATE TRUSTEE**

(a) Charitable Fund Expenditure Requests

In its capacity as Corporate Trustee the Board received a number of requests for expenditure of charitable funds, in excess of £10k and totalling £126k. These were for:

- replacement resus trolleys;
- operating chair for Central Norwich Eye Clinic;
- acute Ischaemic Stroke Intervention (Thrombectomy) module for the Interventional Radiology Simulator;
- reception desk for Colney Centre;
- ultrasound machine for Rheumatology Department;
- off-line elective management modules for community midwives;
- ultrasound machine.

The proposed expenditure was confirmed to be consistent with the objects of the relevant charitable funds and in its capacity as Corporate Trustee, the Board **approved** expenditure of charitable funds as requested.

18/032 **DATE AND TIME OF NEXT MEETING**

The next meeting of the Trust Board in public will be at 9am on Friday 28 September 2018 in the Boardroom of the Norfolk and Norwich University Hospital.

Signed by the Chairman: …… Date: ……

Action Points Arising:

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

18/024	Carried forward. Mr How expressed concern that the number of slides within the IPR is growing and asked if this could be reviewed to determine if any can be removed to ensure that the key information remains readily accessible. Action: Execs

Norfolk and Norwich University Hospitals NHS Foundation Trust

REPORT TO THE TRUST BOARD (in public)

Date	**28 September 2018**
Title	**Chief Executive's Report**
Purpose	**To update the Board on matters relating to the Trust that are not covered elsewhere in the papers**

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

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

(i) Core messages communicated with our staff (as summarised in the **attached** Viewpoint letter)
   a) Quality improvement
   b) Winter Planning
   c) Capacity Expansion
(ii) Employer Recognition Scheme – Gold Award
(iii) Our successful NNUH Apprenticeships Programme
(iv) Leading with PRIDE
(v) Norfolk Acute Hospitals Group and STP partnership working

The next Viewpoint open session for all staff, will be held on 24 September, to include Trust-wide updates and a presentation on the programme of mental health transformation work ongoing in the Trust.

Recommendation
The Board is recommended to note recent matters relating to the Trust as highlighted and to be updated at its meeting.

CHIEF EXECUTIVE'S REPORT TO TRUST BOARD 28 September 2018

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

1 FOCUS ON QUALITY & SAFETY

1.1 Quality Improvement and the Special Measures process

As Board members will be aware, a huge amount of work has been ongoing across the Trust to develop and implement our Quality Improvement Plan. The structure through the Special Measures process of a Quality Programme Board and an Oversight and Assurance Group is well established and is working well. There is much to do but good progress is being made.

1.2 Clinical Support for East Coast Hospice

The Trust has been invited to provide clinical support for the East Coast Hospice at Margaret Chadd House once its construction is completed. Dr Nicola Holtom (Palliative Care Consultant) leads the team providing these services and at its meeting the Board will hear directly from Dr Holtom on the improvements that we have been making to End of Life care in the Trust.

2 STAFF MATTERS

2.1 Leading with PRIDE

As part of our response to the Staff Survey and King's Fund Report, we have launched a leadership development programme for line managers across the Trust. This includes senior doctors, nurses and staff from across the multi-disciplinary spectrum that comprises the Trust workforce.

These staff have been taking part in leadership masterclasses during September, to support our 'journey to outstanding' and respond to the opportunities identified in the King's Fund and CQC reports. The purpose is to equip all line managers at all levels, to create the right team cultures – addressing bullying and 'speak up' concerns and making sure we demonstrate values-led leadership to all staff and teams. It represents a swift and high profile response to the issues we are concerned about and provides capacity for all line managers to benefit from a leadership development intervention that gives them the skills to 'lead with values'. The programme was piloted by the Hospital Management Board first, earlier in the month, both to help shape the course content but also to demonstrate commitment from the top of the organisation to getting our organisational culture 'right'.

The fortnight of events (17-28 September) will involve launching a new set of tools and guidance for all of us – staff, managers, colleagues – who might be experiencing, handling or witnessing inappropriate behaviour at work (including bullying), how to get support and deal with it. These materials were designed in collaboration with staff and staff representatives during August.

Further feedback and next steps will be shared with the Board in October, once the masterclasses have concluded and been evaluated. Initial feedback from staff at the events and via social media has been very positive.

2.2 Employer Recognition Scheme – Gold Award

The Trust has been selected for a Gold Award under the Ministry of Defence Employer Recognition Scheme and was recognised as an exemplar employer supporting Defence People. (**Attachment** – letter from Secretary of State for Defence – Rt Hon Gavin Williamson MP).

2.3 Our successful NNUH Apprenticeships Programme

NNUH has an excellent track record of being a trailblazer in the field of Apprenticeships, helping to build a healthcare workforce for today and for the future, supporting career

journeys and changing lives in the process. It has proven to be a valuable pathway for apprentices and the organisation alike, in terms of developing and retaining talent. This continues to be recognised externally and most recently two prestigious awards have been won by NNUH for its work to promote apprenticeships at the Trust as part of the National Apprenticeship Awards for the East of England.

NNUH was awarded regional 'Macro Employer of the Year' 2018 and Regional 'Recruitment Excellence Award' 2018. We have now been entered into the National Apprenticeship Awards for these categories which will take place in November. We are thrilled that our apprenticeship programme has received this recognition which is attributable to our amazing apprentices, managers and teams across the organisation championing personal and professional development at work.

98% of our apprentices go on to employment, of which 92% stay at the Trust and continue their career here. Many apprentices have subsequently entered Higher Education to do Nursing, Midwifery, Biomedical Science, Audiology, Finance, Business, and Management & Leadership, demonstrating that apprenticeships form the start of long and exciting careers in the NHS.

3 OPERATIONAL PERFORMANCE AND SERVICE DEVELOPMENTS

3.1 Winter Planning

Our plans to strengthen and expand our services ready for the coming Winter continue apace as summarised in the Viewpoint letter. The Board will be updated at its meeting.

3.2 Capacity Expansion

It was with great pleasure that we were able to announce to staff and public that we had been successful in our loan application to fund the creation of our new Interventional Radiology facility. This is something that we have been working towards for such a long period and it will be of benefit for vascular, stroke, renal, and cardiology patients and those of other specialities too.

The project timetable is established and we await arrival of the builders.

4 SYSTEM AND PARTNERSHIP WORKING

4.1 STP acute services transformation.

The STP partners continue to work together to enhance the consistency, quality and cost-effectiveness of the services for patients across Norfolk and Waveney. Clinical teams are working together across an increasing number of specialties and the Board will be updated on the position at its meeting.

4.2 Creation of the new Clinical Research Facility

On 18 September we were delighted to take occupation of the new Clinical Research Facility (CRF) in the Quadram Institute. The move proceeded without incident and the staff involved are to be congratulated. The first patients/volunteers were seen in the CRF the following day.

This is a real step forwards for the Trust towards realisation of our third Strategic Objective (*"to be a centre of excellence for research, education and innovation"*), working in partnership with colleagues in Quadram Institute Bioscience and University of East Anglia.

Final works will be completed in the QI building before the staggered occupation of the QIB area and of our endoscopy unit, with a formal opening of the building in 2019.

4.3 Anglia Innovation Partnership LLP – 'Bringing the Norwich Research Park Vision to Life'

The organisations comprising Norwich Research Partners LLP have announced that it will be changing its name to 'Anglia Innovation Partnership LLP'. The change of name is intended to avoid confusion with the Norwich Research Park.

5 RECOMMENDATION

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

From: Davies, Mark (NNUHFT)
Sent: 20 August 2018 16:51
To: NNUH Staff
Subject: Viewpoint - August 2018

Dear Colleagues,

I am pleased to write to you today in the August Viewpoint letter where we look at our approach to quality improvement, preparations for Winter and news on IRU and the Cath Lab expansion.

Update on quality improvement

From now on we will talk about our Quality Improvement Plan (QIP), rather than our CQC action plan, because we will be moving into a new approach with quality improvement. Completing all the actions promptly for the CQC are really important of course and we will want to think about a much broader view of the quality improvement work we want to do. We will create something that is long-lasting and not a series of quick fixes. So we already have the **Quality Improvement plan (the CQC must do's and should do's)** and during the next few months we will be developing a Quality Improvement Strategy that takes a much longer view and covers our approach to quality and safety improvement as a whole. Our new Chief Nurse Nancy Fontaine is the Executive Officer leading on the plan's delivery.

We have now established a Quality Programme Board which met for the first time on 7th August 2018. It is the membership of the Management Board, plus John Fry, our Chairman and other colleagues who are supporting this work. The job of this board is to assure the Trust Board and all our external stakeholders that all the necessary actions are being taken, monitored and completed in the appropriate timeframe and that our hospital becomes a better, safer place for our patients.

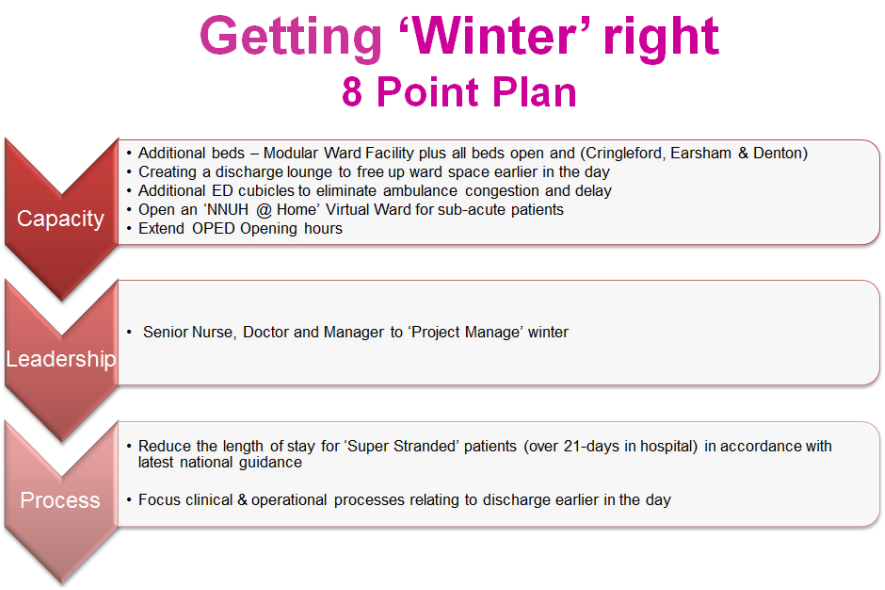
This work is also about broader, long-term issues, for example, how we improve people's ability to speak up, how to continue our journey to improve the culture here and how we improve our approach to leadership development. We are taking the opportunity that the CQC has given us to embed a long-lasting strategic quality improvement approach so that we get better and better. On the way to outstanding, some of the actions that we will be taking are as a result of recommendations in the King's Fund **report.** We are already getting on with this. For example, we are in the process of appointing a full-time Speak-Up guardian. I have asked our new Medical Director, Professor Erika Denton and our new Chief Nurse Professor Nancy Fontaine to look at setting up a Clinical Senate and I am starting drop-in surgeries away from my office, in the style of MPs' surgeries where any member of staff can drop in to talk through an issue or have a chat. I will circulate the locations, dates and times for these when the first of these are set up.

In both the Trust Board and Management Boards we are looking at team development and what improvements we can make. We take development programmes very seriously which is why we have organised a series of one day "Leading with PRIDE" masterclasses to help build a culture we can all be proud of.

We have commissioned 700 places and the masterclasses are running over a two week period every weekday starting on 17th September to enable all line managers, including the management board, to attend. You can book your place **here.** Please have a look at this and put your name down. If we have a great response we will do more.

Winter

We are doing as much as possible to prepare better for Winter. Initiatives we are looking at include additional escalation beds and a new discharge lounge so that we can free up beds earlier in the day. We want to do everything we can to avoid the escalation issues that we had last Winter. We are increasing the number of assessment cubicles in ED and we are creating a virtual NNUH@ home capability where the appropriate patients will be treated at home under the care of our consultants. This could cover treatments like wound dressings or antibiotic therapy or those who need physiotherapy or occupational therapy support. We are also extending the OPED service into seven days per week and lengthening the opening hours. Of course the increase of our capacity also needs the appropriate staffing. We will also have a "Winter room" which will be a triumvirate of clinicians and managers to ensure our approach to Winter is co-ordinated in the best way possible. (The Winter room approach is also happening regionally and nationally). We are determined that we put in the right facilities and the right staffing for the benefit of patients.



IRU and Cath Lab Expansion

We now have the go ahead for the IRU and Cath Lab Expansion which is fantastic news. It has been long-awaited but now the loan has been approved so that we can get this project off the ground. It will be an additional floor on top of the East Wing ; the design is nearly finalised and the project will now begin to progress at pace with the construction of the unit happening off site which will then be craned on to the roof. We expect the builders to be on site just after Christmas and hopefully the extended service will be starting in just over a year's time. This is wonderful news for patients and a big boost for us.

Patient letter

I would like to share a patient letter with you and it is the first time I have received a letter like this, it starts: "Dear Administrator, I apologise for not being able to address you by name and also for the quality of the notepaper as it is all I have. I am writing to you to express my very great appreciation for the excellent treatment and the respect and

politeness shown to me on the many occasions that I have attended hospital for various health conditions. I am a prisoner at HMP Bure where I have been incarcerated for three years and during this time I have attended the Norfolk and Norwich Hospital on six occasions for consultations and investigations. Sadly on all outside visits I have to be handcuffed to an officer. On one such visit I was led around the hospital on a long steel chain on a visit to Dermatology. A member of the public took a photograph of me which needless to say only served to intensify my humiliation. Attending hospital under such conditions is for me a very painful emotional experience. I have met prisoners who will not report any health condition which might result in a hospital visit so that they can avoid the mortifying experience and humiliation, particularly those who like me, insist we were wrongly convicted. I have only mentioned the public's response to my situation so that you can then better appreciate the contrast between that and the warm and caring reception I have received from all the staff I have met on my many visits to the hospital. I was feeling very embarrassed and upset because of the photograph and I would have left there and then to return to prison had I been able to. However I was quite overcome with the non-judgemental treatment and attention I received where I had my procedure carried out. The staff's polite, relaxed and friendly manner restored my faith in human nature and I felt so much better in myself after I had left that morning. In fact they helped me more than I can adequately express. I would be grateful if you could pass on to the staff my enormous appreciation of their kindness and courtesy which I have received from all of them. I shall be 80 years old on my next Birthday, and I shall be released later this year and my wife and I are looking forward to celebrating together. My wife of 53 years would also like to thank you for the care and treatment I have received and we believe I could not have been in more caring hands than those who work at the Norfolk and Norwich Hospital."

I look forward to seeing you at the next Viewpoint event on 24th September at 1pm.

Best wishes,

Mark Davies
Chief Executive

C&O 19466

Ministry of Defence

SECRETARY OF STATE
MINISTRY OF DEFENCE
FLOOR 5 ZONE D MAIN BUILDING
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Telephone: 020 721 82111/2/3
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E-mail: defencesecretary-group@mod.gov.uk

4.4.2.4

30 July 2018

Dear Mark,

It gives me great pleasure to write to inform you that Norfolk & Norwich University Hospitals NHS Foundation Trust has been selected for a Gold Award under the Defence Employer Recognition Scheme.

Through the Employer Recognition Scheme, the Ministry of Defence publicly recognises the commitment that organisations such as Norfolk & Norwich University Hospitals NHS Foundation Trust are making by acting as advocates for Defence People. We are grateful for your positive attitude and policies towards the Armed Forces community and see you as an exemplar employer supporting Defence.

You will shortly receive a personal invitation to an awards ceremony which will be held in a suitable location in London later this year. Defence Relationship Management will be in contact very soon to discuss the next steps in more detail, including communications around the announcement of your award.

I would like to take this opportunity both to congratulate Norfolk & Norwich University Hospitals NHS Foundation Trust on receiving this Gold Award and to thank you for the considerable support you are giving to our Servicemen and women. I very much hope to be able to see you at the awards event.

THE RT HON GAVIN WILLIAMSON MP

Mr Mark Davies
Chief Executive
Norfolk & Norwich University Hospitals NHS Foundation Trust
Colney Lane
Norwich
Norfolk
NR4 7UY

REPORT TO THE TRUST BOARD

Date	**28 September 2018**
Title	**Audit Committee meeting – 12 September 2018**
Author & Exec lead	**John Paul Garside Board Secretary on behalf of Mrs Angela Robson – Chair of the Audit Committee**
Purpose	**For Information**

1 Background/Context

The Audit Committee met on 12 September 2018 and discussed matters in accordance with its Terms of Reference. The Agenda for the meeting is **attached**.

2 Key Issues/Risks/Actions

In addition to reviewing standard items of Committee business, items of note considered at the meeting included:

	Issues considered	Outcomes/decisions/actions
1	Implementation of Internal Audit recommendations	As previously noted and reported, follow-up of IA recommendations remains inconsistent and too slow. It was agreed at the meeting in May that RSM will be asked to include this follow-up work in its service to the Trust to bring about the required improvement.
2	Internal Audit Progress Report	Good progress was reported towards the Internal Audit Plan for 2018/19 with 45% of audits completed in the year to date. Two audit assignments have been completed since the last meeting: Data Quality – 4 hour waits (Reasonable Assurance); Data Quality – Cancer Waits (Reasonable Assurance). The Committee noted that there was a delay in conclusion of the Management of the PFI Contract audit assignment. Further work needs to be done to provide assurance on management of the PFI contract and an external specialist review has been commissioned. The advisory report from the Theatre Productivity Review was highlighted as being very useful. RSM viewed our systems and processes for theatre organisation (booking lists etc) as being some of the best they had seen. However, compliance with those processes by some staff was inconsistent. This suggests financial/productivity opportunities. There is also a need to ensure that this is not linked with other aspects of non-compliance leading to quality or safety incidents.
3	Local Counter Fraud Service	RSM's new LCFS team is getting established and have been meeting with the Executives.
4	Fraud Risk Assessment	An assessment has been undertaken. The Committee requested assurance on cyber security penetration testing to be provided at its next meeting.
5	Emergency Preparedness, Resilience, Response and Business Continuity – assessment against national	The Committee received a report concerning a self-assessment of EPRRBC compliance against national standards. One rea of non-compliance is identified - outside Trust control and subject to nationwide mitigation. A peer review at regional level has been undertaken to assess the accuracy of our self-assessment {outcome awaited].

	Core Standards	
6	Review of audited Charitable Funds Annual Report of the Trustee, financial statements and commentary	The Committee reviewed the Charitable Funds Annual Report of the Trustee and Financial Statements for 2017/18 and **agreed** to recommend the Charitable Fund Accounts for approval by the Board in its capacity as Corporate Trustee.
7	Report to Management / ISA 260 Report	As External Auditors, KPMG confirmed that an unqualified audit opinion had been issued on the financial statements. No issues were identified in relation to accounting policies adopted by management. There is a recommendation to formalise allocation of donations to funds in a policy and the Committee will be updated at its next meeting.
8	Review of Letter of Representation	The draft Letter of Representation to the auditors with respect to the Charitable Funds Audit was **agreed** for recommendation to the Corporate Trustee for approval.
9	Risk management	The Committee is due to receive an update on steps being taken to improve Risk Maturity in the Trust, to improve the Risk Register and associated procedures and staff knowledge.

3 Conclusions/Outcome/Next steps

The Committee is scheduled to meet again at 9am on 12 December 2018, at which meeting the Committee is due to consider:

- Agreement of External Audit Plan and Fees (Trust and Charitable Funds)
- Risk Maturity assessment and action plan
- Speak Up Procedures – Annual Report
- Updated FRC Code of Governance Review
- Charity Policies review update

Recommendation:

The Board is recommended to note the work of its Audit Committee.

Norfolk and Norwich University Hospitals NHS Foundation Trust

MEETING OF THE AUDIT COMMITTEE
12 SEPTEMBER 2018

A meeting of the Audit Committee will take place at 9am on 12 September 2018 in the Brancaster Room of the Norfolk and Norwich University Hospital

AGENDA

	Item	Lead	Purpose	Page No
1	Apologies and Declarations of Interest			
2	Minutes of meeting held on 25 May 2018		Approval	**2**
3	Matters arising			
4 Internal Audit				
4.1	Implementation of Internal Audit recommendations	JH	Information	**9**
4.2	Internal Audit Progress Report	RSM	Information	**13**
5 External Audit				
5.1	Review of non-audit work undertaken by External Auditors	JPG	Information	**40**
6 Local Counter Fraud Service				
6.1	LCFS Progress Report *(Associate Director Andrea Deegan Attending from RSM)*	RSM	Information	**41**
6.2	Fraud Risk Assessment	RSM	Discussion	**58**
7 Risk Management & Governance				
7.1	Emergency Preparedness, Resilience, Response and Business Continuity – assessment against Core Standards Assurance 2018/19 *– Debbie Laws (Trust Lead – EPRRBC)*	DL	Discussion	**86**
7.2	Board Assurance Framework – periodic review	JPG	Discussion	**97**
7.3	Use of the Trust Seal	JPG	Information	**125**
7.4	FRC Code of Governance update	JPG	Agreement	**126**
7.5	Risk Management Strategy and Structures - update	KK	Discussion	*verbal*
8 Charitable Funds				
8.1	Review of audited Charitable Funds Annual Report of the Trustee, financial statements and commentary	JH	Approval	**129**
8.2	Report to Management / ISA 260 Report	KPMG	Information	**168**
8.3	Review of Letter of Representation – charitable funds	JH	Approval	**191**
9 Committee Business				
9.1	Agenda for next meeting	JPG	Agreement	**195**
9.2	Any other business			

Date and Time of next meeting
The next meeting of the Audit Committee will be at 9am on 12 December 2018 in the Brancaster Room of the Norfolk and Norwich University Hospital

REPORT TO THE TRUST BOARD

Date	**28 September 2018**
Title	**Quality and Safety Committee Meeting (14.09.18)**
Author & Exec lead	**John Paul Garside (Board Secretary) on behalf of Sally Smith QC (as chair of the Committee)**
Purpose	**For Information and approval**

1 Background/Context

The Quality and Safety Committee met on 14 September 2018 and discussed matters in accordance with its Terms of Reference. The Agenda for the meeting is **attached**.

2 Key Issues/Risks/Actions

Items of particular note considered at the meeting included:

	Issues considered	Outcomes/decisions/actions
1	Mental Health Update - visit to new ED facility	A cohort from the Committee visited the new area in ED – built in the vacated Children's area, in response to criticisms made by CQC. This facility has been designed with specialist advice from NSFT Estates team – to ensure that it meets best practice standards for safety of MH patients and staff caring for them.
2	Divisional Focus – Clinical Support Services – visit to Radiology/IRU	The remainder of the Committee visited the Radiology Department and in particular the area in CT about which the CQC commented. Refurbishment work in this area is due to start on 10 October. A future visit will be to the Interventional Radiology Unit.
3	Clinical Quality Impact Assessment	The Committee continues to receive regular reports regarding the operation of the CQIA process, as a means of gaining assurance that we are appropriately monitoring and mitigating risks associated with our financial improvement plans.
4	Risk Register – High Risk Tracker	Risks relating to equipment failure have been added to the HRT, whilst the improvements to ED (observed on the clinical visit) are recognised in a reduced risk rating). External expertise is being commissioned to assist in the work to cleanse the Risk Register, assist in staff training and review policies and procedures.
5	Serious Incidents & Organisation-wide Learning (inc Selected SI RCA Report)	• The Committee was informed that a new structure of daily meetings has been introduced (at 13.00hrs in the Ops Centre) to discuss incidents, completed Si investigations and shared learning opportunities. This has been well received by staff. • At its next meeting the Committee will review an RCA report concerning >12hr stay in A&E for a patient with mental health difficulties – as this seems to be something of a theme in Serious Incidents and may reflect a deficit in service provision
6	Escalation and Winter Planning to safeguard quality & safety	The Committee received an update on our plans to avoid the risks inherent in the severe operational pressures experienced last Winter. Recruitment is ongoing to secure staff for the additional capacity in development (Discharge Lounge etc).

7	Speak Up/Whistleblowing Cases	There was discussion of a number of further cases of 'whistleblowing' to the CQC, concerning a variety of themes including nurse staffing. The daily meeting at 13.00 hrs was reported to be a helpful introduction, providing an additional regular and reliable forum for raising issues or concerns and sharing feedback/learning.
8	Safe Staffing update	The latest update on our maturing system for monitoring, mitigating and reporting risks to appropriate staffing levels was received. This has remained on the Q&S agenda to maintain focus on development of regular reporting but it may fall within the remit of a People Committee in due course.
9	Review of Q&S TORs in light of QPB creation	The Committee reviewed and discussed its Terms of Reference (as **attached** with tracked changes) in light of creation of the QPB. It was noted that the ToRs for the QPB are explicit that its role is to *"obtain assurance on behalf of the Board with regard to implementation of the Quality Improvement Plan (QIP) and relevant action plans*". The QPB reports directly to the Board. To avoid duplication or possible confusion, the Committee therefore **agreed** with the proposal that receiving reports relating to the QIP should be removed from the duties of the Q&S Cmtee. This should be reviewed in due course, when the Board reviews the role of the QPB when we leave Special Measures.

3 Conclusions/Outcome/Next steps

The Committee is scheduled to meet again on 15 November 2018 although this may need to be rearranged if the OAG is going ahead that day. Committee members are hoping to attend one of the lunchtime incident review meetings.

As of the next Committee meeting, Dr O'Sullivan will take the role of Chair of the Committee.

Recommendation:

The Board is recommended to:

- **note** the work of its Quality and Safety Committee
- **approve** the revised Terms of Reference for the Committee, to reflect the creation of the Quality Programme Board. These should be subject to review once the Trust is no longer in Special Measures.

MEETING OF THE QUALITY AND SAFETY COMMITTEE

FRIDAY 14 SEPTEMBER 2018

A meeting of the Quality and Safety Committee will take place from 1pm to 4pm on 14 September 2018 in the Chief Executive's Office of the Norfolk and Norwich University Hospital

AGENDA

	Item	Lead	Purpose	Page
1	Apologies and Declarations of Interest			
2	Minutes of meeting held on 21 June 2018 & matters arising		Approval & Discussion	2
3a	Divisional Focus – Clinical Support Services – visit to Radiology/IRU		Discussion	
3b	Mental Health Update - visit to new ED MH suite		Discussion	
4	Quality & Safety current position - extract from IPR	ED/DW	Discussion	10
5	Clinical Quality Impact Assessment – update from PMO	RM	Information	22
6	CQC Insight Report – composite core indicator	DW	Information	35
7	Risk Register and High Risk Tracker	KK	Information	37
8	Serious Incidents & Organisation-wide Learning (inc Selected SI RCA Report)	KK	Discussion	38
9	Escalation and Winter Planning to safeguard quality & safety	DW/RP	Discussion	Verbal
10	Speak Up/Whistleblowing Cases – if any	DW	Discussion	Verbal
11	Safe Staffing update	DW	Discussion	81
12	Extracts from BAF (Sections 1 & 2)	JPG	Discussion	95
13	Review of Q&S TORs in light of QPB creation	JPG	Agreement	108
14	Draft Agenda for next meeting	JPG	Discussion	113
15	Any other business			

Date and Time of next meeting:
The next meeting will be on Thursday 15 November 2018 at 1pm at the Norfolk and Norwich University Hospital

Norfolk and Norwich University Hospitals NHS Foundation Trust

QUALITY AND SAFETY COMMITTEE

TERMS OF REFERENCE

1 CONSTITUTION AND PURPOSE

As part of the Trust's Governance Structure, the Board of Directors has established a committee of the Board to be known as the Quality and Safety Committee.

The Purpose of the Committee is to provide scrutiny and challenge with regard to all aspects of quality and clinical safety, including strategy, delivery, clinical governance and audit, in order to provide assurance and make appropriate reports or recommendations to the Board.

2 AUTHORITY

The Committee has no delegated powers other than those specified in these Terms of Reference. The Committee is authorised to investigate any activity within its Terms of Reference and all Trust employees are directed to co-operate with any request made by the Committee.

The Committee is authorised to obtain independent professional advice as it considers necessary in accordance with these Terms of Reference.

3 MEMBERSHIP

Membership of the Committee shall comprise:

- No fewer than two Non-Executive Directors
- Medical Director
- Director of Nursing
- Chief Operating Officer
- Chief Executive

The Board of Directors will review membership of the Committee annually to ensure that it meets the evolving needs of the Trust.

The Committee may invite non-members to attend all or part of its meetings as it considers necessary and appropriate, at the discretion of the Committee Chair. The Chairman, Chief Executive or other executive director may be invited to attend any meeting of the Committee, particularly when the Committee is discussing areas of the Trust's operation that are the responsibility of that director.

4 MEETINGS AND QUORUM

Meetings of the Committee shall be chaired by one of the Non-Executive Director members, with the other acting as deputy in his/her absence.

Meetings of the Committee shall take place at a frequency and timing necessary to enable discharge of its responsibilities and the Committee will routinely meet at least five times in each financial year. Responsibility for calling meetings of the Committee shall rest with the Committee Chair.

To be quorate at least 3 members of the Committee must be present including at least one non-executive director. Attendance at the meeting may be by teleconference or videoconferencing at the discretion of the Committee Chair.

In accordance with Standing Orders, if it is necessary to resolve an issue at a meeting of the Committee by way of a vote, this shall be determined by a majority of the votes of the Members present and voting and, in the case of any equality of votes, the person presiding shall have a second or casting vote.

5 SUPPORT ARRANGEMENTS

The Board Secretary will be responsible for providing secretarial support to the Committee. Agendas for forthcoming meetings will be agreed with the Committee Chair and papers distributed to members in advance of the meeting as agreed. Meeting papers will also be available to other members of the Board for information.

The Committee will establish an annual Work Programme, summarising those items that it expects to consider at forthcoming meetings.

6 DECLARATION OF INTERESTS

All members must declare any actual or potential conflicts of interest relevant to the work of the Committee, which shall be recorded in the Minutes accordingly. Members should exclude themselves from any part of a meeting in which they have a material conflict of interest. The Chair will decide whether a declared interest represents a material conflict.

7 DUTIES

In furtherance of achievement of its Purpose, particular duties of the Committee are to receive and review reports concerning:

7.1 the development and implementation of the Trust's Quality Strategy and Priorities ~~and Quality Improvement Plan~~;

7.2 data and trends in patient safety, experience and outcomes to provide assurance to the Board on performance and undertake 'deep dives' as appropriate at the discretion of the Committee;

7.3 operation of the Trust's clinical governance systems and processes at a corporate and Divisional level to :

(a) promote safety and excellence in patient care;
(b) identify, prioritise and manage risk arising from clinical care on a continuing basis;
(c) ensure the effective and efficient use of resources through evidence-based clinical practice;

7.4 compliance with relevant national standards and regulatory requirements;

7.5 progress against actions to mitigate quality and safety risks on the Risk Register in line with the Board's risk appetite;

7.6 promotion within the Trust of a culture of open and honest reporting of any situation that may threaten the quality of patient care and compliance with the requirements of the Duty of Candour;

7.7 the processes within the Trust to ensure that appropriate action is taken in response to adverse clinical incidents, complaints and litigation and that learning is disseminated within the Trust and beyond if appropriate;

7.8 ~~quality and safety related national enquiries or reviews and regulatory inspections, such as those by the CQC, including assurance with regard to the preparation and implementation of associated action plans~~.

8 RELATIONSHIP WITH OTHER BOARD COMMITTEES ~~AUDIT AND FINANCE AND INVESTMENT COMMITTEES~~

In practice, issues of finance, quality, safety and performance are inextricably linked. Through careful communication and alignment of the relevant Work Programmes for each of the Board Committees overlap or gaps in their collective assurance function will be avoided.

For the avoidance of doubt, it is noted that the following items remain within the area of responsibility of the Audit Committee (as specified in its Terms of Reference):

- Internal and External Audit
- Local Counter Fraud Specialist work
- Approval of Financial Statements and Quality Accounts
- Oversight of the structures and systems for risk management and the processes in place for identifying and managing key risks including the Risk Register.

The Board has also established a Quality Programme Board with specific responsibility to obtain assurance on behalf of the Board with regard to the development and implementation of the Trust's Quality Improvement Plan and other associated action plans.

9 REPORTING

To facilitate oversight by the Board of Directors of matters relating to Quality and Safety, papers for meetings of the Committee will be circulated for information to those members of the Board who are not members of the Committee. Thereafter, following each meeting of the Committee, the Chair of the Committee shall make a report to the next meeting of the Board of Directors and draw to its attention any issues that require its particular attention, or require it to take action.

10 REPORTING COMMITTEES

There are no standing sub-committees which report to the Quality and Safety Committee.

11 PROCESS FOR MONITORING EFFECTIVENESS OF THE COMMITTEE

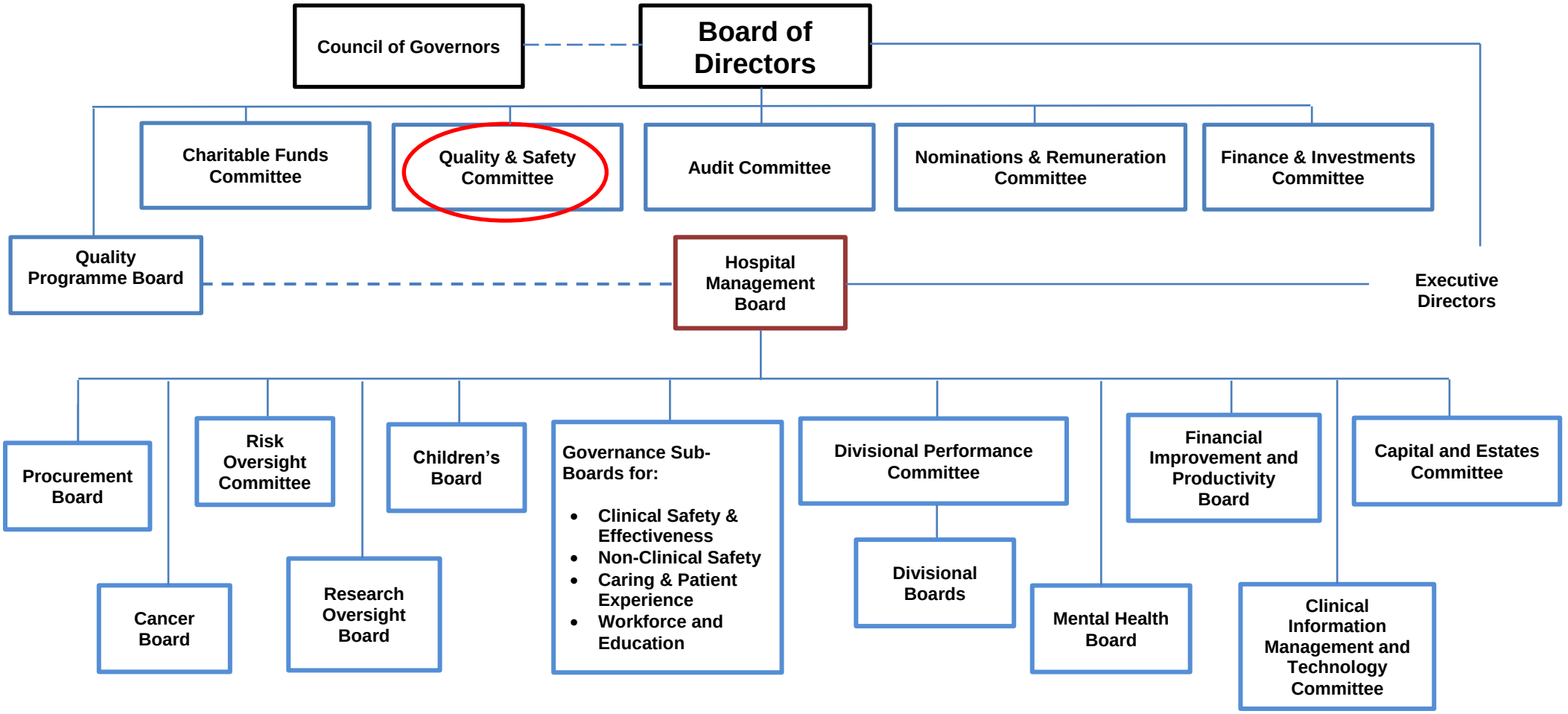
The Committee will carry out an annual review of its performance and function in satisfaction of these Terms of Reference and report to the Board on any consequent recommendations for change.

Approved by the Trust Board of Directors in September ~~February~~ 2018

Date for next review: March 2019

Norfolk and Norwich University Hospitals NHS Foundation Trust

Board of Directors and Management Board Reporting and Accountability Structure



S:\Corporate Departments\Complaints & Legal Services\Foundation Trust Board\Organisational Structure Chart

Sept 2018

REPORT TO THE TRUST BOARD

Date	**21 September 2018**
Title	**Quality Programme Board meetings 07.08.18 and 11.09.18**
Author & Exec lead	**Stacy Hartshorn (Improvement Manager)** **Nancy Fontaine (Chief Nurse)**
Purpose	**For Information**

1 Background/Context

The Quality Programme Board has now met on two occasions 7 August and 11 September 2018. The Agendas for the meeting are **attached**. The QPB discussed matters in accordance with its Terms of Reference which was updated to include new membership at the meeting.

2 Key Issues/Risks/Actions

Items of note considered at the meetings included:

	Issues considered	Outcomes/decisions/actions
1	PowerBI as the reporting tool for CQC actions	Agreed to use this tool going forward.
2	Highlight reports from exec and functional areas	- It was agreed that to guarantee assurance further actions will need to be added to the plans. - All areas of red assurance were discussed in detail and improvement actions agreed.
3	Quality Improvement Strategy	A five year QI strategy slide was presented and agreed by the group.
4	Deep dive planning	A copy of the deep dive schedule for forthcoming meetings is **attached**.
5	OAG papers	It was agreed to circulate these to QPB and also to be placed on the Trust intranet.

3 Conclusions/Outcome/Next steps

The Committee is scheduled to meet again on 9 October 2018, at which meeting the Committee is due to consider:

- The first live version of PowerBI
- Highlight reports from exec and functional areas for September.

Recommendation:

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

OAG Deep Dive Schedule
(as at 11/09/2018)

September 2018	**Leadership and Culture** **End of Life**
October 2018	Freedom to Speak Up Interventional Radiology Unit
November 2018	ED – Safety and Leadership Immediate Action & Early Outcomes – Surgery & Diagnostics.
December 2018	Medicine Older People's Medicine Patient Voice
January 2019	Capacity review – outcomes and plan STP Appraisals and Mandatory Training
February 2019	Maternity Safeguarding , Mental Capacity Act & DoLs
March 2019	Medical engagement scale – outcomes and plans for ongoing improvement. DNACPR
April 2019	Complaints Information Governance

QUALITY PROGRAMME BOARD AGENDA

Tuesday 7th August 2018 Boardroom 0900-1200 Hours

	Item	Lead	Purpose	Page No
1	Apologies and Declaration of Interests			
2	Role and purpose of meeting	CEO	Discussion	
3	Terms of Reference	CEO	For approval	
4	Membership	CEO	For approval	
5	The QIP	Nancy/Frances	To note and discuss	
6	Executive Highlight Reports	All Exec Directors	To note and discuss	
7	QIP Governance & delivery – how the Board fits in with the Trust Governance and the Oversight group, and how we are going to deliver the plan and gain the necessary assurance	Nancy/Frances	Discussion	
8	QIP workstream discussion (i.e. agreement of which actions should be allocated to which workstream/Exec Director)	Nancy/Frances	Discussion	
9	Risks and Issues	CEO	Discussion and approval	
10	Resources needed to deliver the plan		Discussion and decision	
11	QIP Communication Plan	CEO	Discussion (verbal)	
12	Quality Improvement Strategy	Nancy/Frances	Discussion	
13	Any other business			

Date and Time of next meeting: 11th September 2018, 0900 hours, Boardroom

QUALITY PROGRAMME BOARD AGENDA

Tuesday 11th September 2018 Boardroom 0900-12:00 Hours

	Item	Lead	Purpose	Format
1.	Apologies and declarations of interest	CEO		Verbal
2.	Review of minutes and matters arising	Exec Directors and CODs	To note and discuss	Document
3.	Demonstration of the PowerBI reporting dashboard	Pete Best	Demonstration for information	Visual presentation
4.	Highlight reports from Execs and functional areas, focusing on: - Red recommendations (Off track) - Blue recommendations (complete) - Any successes or concerns that SROs wish to particularly highlight	Exec Directors and CODs	To note and discuss	Slide presentation
BREAK				
5.	Quality Improvement Strategy	Chief Nurse		Slide presentation
6.	Deep dive planning	CEO	Discussion	Verbal
7.	Risks and issues	CEO	Discussion	Document
8.	AOB			

Date and Time of next meeting: Tuesday 9th October 2018, 09:00 hours, Boardroom

REPORT TO THE TRUST BOARD

Date	**28 September 2018**
Title	**Finance and Investments Committee – 17 September 2018**
Author	**John Paul Garside (Board Secretary) on behalf of Mr Tim How (Committee Chair)**
Purpose	**For Information**

1 Background/Context

The Finance and Investments Committee met on 17 September 2018 and discussed matters in accordance with its Terms of Reference. The Agenda for the meeting is **attached**.

It was planned to try to start the meeting this month with a clinical visit to the Nuclear Medicine Department, which has a particular vested interest in the equipment replacement programme. The date of the meeting however had to be rearranged to accommodate the NHSI Board to Board meeting and the visit therefore has been postponed to another occasion.

2 Key Issues/Risks/Actions

Particular items of note considered at the meeting included:

	Issues considered	Outcomes/decisions/actions
1	Divisional focus – Division of Medicine	Presentation from Division of Medicine, represented by Chris Cobb (Divisional Operations Director), with regard to finance and activity within the Division.
2	- Financial performance YTD - CIP update - reserve utilisation	The Committee was updated on the financial position YTD, stalled progress in developing the CIP and pressure to utilise 'contingency' to support both winter planning and quality improvement. The need to maximise CIP delivery is self-evident.
4	Financial Recovery & Governance Plan	The Committee received a report on steps being taken to further financial recovery. The Executive was encouraged to ensure that the full range of opportunities have been explored, to think creatively and ensure that this process is inclusive – to gather all ideas.
5	Capital investments & capacity expansion - IRU update - Diagnostic and Assessment Centre Scheme	• The Committee received a project update on the IRU development. A project timeline has been established with a view to commencement of service in the new facility by the end of 2019. • The Committee was updated on a bid made via the STP for capital to create additional radiology capacity across the STP. The outcome of the bid is awaited as part of a national allocation of capital.
6	Briefing on procurement of Pathology equipment	The Committee was undated regarding procurement of a managed equipment service for laboratory analysers. We are changing suppliers and there has been a perceived risk regarding continuity of service in light of the need for NHSI approval given the value of the contract. An interim solution has been identified but this case is an illustration of our need to develop a much more rigorous and structured approach to equipment replacement than has been in place in the past.

3 Conclusions/Outcome/Next steps

The Committee is scheduled to meet again on 6 December 2018, at which meeting it is due to consider matters including:

- Divisional focus – Division of Clinical Support Services
- Operational & financial planning - 2019/20
- Clinical Information developments
- Service Line Reporting
- PFI contract monitoring

Recommendation:

The Board is recommended to note the work of its Finance and Investments Committee.

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

Norfolk and Norwich University Hospitals NHS
NHS Foundation Trust

MEETING OF THE FINANCE AND INVESTMENTS COMMITTEE

17 SEPTEMBER 2018

A meeting of the Finance and Investments Committee will take place at 12pm on 17 September 2018 in the Chief Executive's Office of the Norfolk and Norwich University Hospital

AGENDA

	Item	Lead	Purpose	Page
1	Apologies and Declarations of Interest			
2	Divisional focus – Division of Medicine	RP/SH	Discussion	
3	Minutes of meeting held on 25 June 2018 & Matters Arising		Approval	2
4	4.1 Financial Performance YTD 4.2 CIP Update	JH	Discussion	9 18
5	Reserve Utilisation	JH	Information	25
6	Financial Recovery & Governance Plan **(BAF 1.4)**	JH	Discussion	32
7	CQUIN plans & progress	RP	Information	42
8	Update on 'winter' capital schemes 8.1 ED RATS 8.2 Discharge Lounge	RP	Information	To follow
9	Capital investments & capacity expansion **(BAF 1.2 & 2.3)** 9.1 IRU update 9.2 Diagnostic and Assessment Centre Scheme	SH	Discussion	 49 53
10	Briefing on Pathology procurement	SH	Discussion	61
11	Service Line Reporting **(BAF 1.5)**	JH	Discussion	Verbal
12	Timetable/plans for operational & financial planning 2019/20	SH/RP	Discussion	Verbal
13	Review of F&I related BAF Strategic Threats (1.2, 1.4, 1.5, 2.3, 3.1 & 4.3)	JPG	Discussion	66
14	Draft Agenda for next meeting	JPG	Agreement	73
15	Any other business			

Date and Time of next meeting:
The next meeting will be at 2pm on 6 December 2018 at the Norfolk and Norwich University Hospital

Integrated Performance Report

September 2018 (August 2018 data)

CQC Insight Report – the August and September versions have not been issued due to technical issues.

Core Slide 2
"*Remain within top quartile of acute trusts for incident reporting on NLRS*" metric removed as no longer measured.

Performance section :
The following slides have been removed:

Core Slide 18c - 62 Day GP Benchmarking (July)
Additional Slide 22b – Cancelled Operations (Reasons graphs)
Core slides 23a to 23f – Stroke Slides
Core slide 26 – Emergency Admissions
Additional Slide 27f – Theatre productivity: theatre dashboard instructions.

The following have been combined:

Additional slide 22c with Additional Slide 22d: Cancelled operations
Core Slide 24 with Core Slide 24a: Cardiology

There are some changes to the core slide numbering to reflect these changes.

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

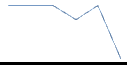
Quality & Safety		Target	Jan 2017 to Dec 2017	Jan 2016 to Dec 2016
Mortality	Core Slide 4			
1 SHMI*		N/A	106.47	108.97

Quality & Safety		Outturn 2017/18	Monthly Target	Aug-18	6 month trend	YTD 2017/18	YTD 2018/19
Mortality	Core Slide 4						
1 HSMR**			100	96.8			
2 Crude Mortality Rate***		5.07	0	3.09		5.07	3.87
Incidents	Core Slide 5-6						
3 Serious Incidents		138	n/a	6		46	60
4 Incident Reporting		17171	n/a	1666		6688	8107
5 Insulin errors causing NPSA category moderate harm or above		1	0	0		1	0
6 Medication Errors		1204	n/a	137		484	603
7 Patient Falls causing moderate harm or above		33	n/a	1		16	9
8 Never Events		7	0	0		2	2
Pressure Ulcers	Core Slide 7						
9 Grade 2 hospital acquired pressure ulcers		217	n/a	18		82	107
10 Grade 3 hospital acquired pressure ulcers		56	n/a	7		14	33
11 Grade 4 hospital acquired pressure ulcers		2	0	0		1	0
Infection Control	Core Slide 8						
12 HAI C. difficile Cases (excluding non-trajectory and pending cases)		11	0	0		2	2
13 Hospital Acquired MRSA bacteraemia		0	0	0		0	1
14 CPE screens taken		n/a	n/a	44		n/a	268
15 CPE positive screens		n/a	n/a	0		n/a	0
16 CPE screens of patients positive from other hospitals		n/a	n/a	1		n/a	1
17 E.coli trust apportioned		n/a	n/a	2		20	21
18 E. Coli community apportioned		n/a	n/a	25		125	134
19 Klebsiella trust apportioned		n/a	n/a	2		n/a	4
20 Klebsiella community apportioned		n/a	n/a	5		n/a	23
21 Pseudomonas trust apportioned		n/a	n/a	1		n/a	7
22 Pseudomonas community apportioned		n/a	n/a	4		n/a	17
Other							
23 EDL to be completed within 24 hours in 95% of discharges		76.72%	95.00%	77.43%		75.89%	76.64%
24 Harm Free Care		90.95%	n/a	86.00%		93.84%	85.29%
25 Patients 'extremely likely' or 'likely' to recommend our service to friends and family		96.73%	100.00%	96.50%		96.83%	96.18%
26 Complaints		890	n/a	90		345	439

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

Core Slide 2

Quality Priorities – Patient Safety

	Quality Priorities - Patient Safety	Measure	Lead	Outturn 2017/18	Monthly Target	Aug-18	6 month trend	YTD 2017/18	YTD 2018/19
1	Reduction in medication errors	Insulin errors causing NPSA category moderate harm or above	Erika Denton	1	0	0		1	0
2	Prompt recognition and treatment of sepsis**	% of Sepsis patients screened	Erika Denton	86.17%	90.00%	88.00%		88.00%	84.67%
		% of Sepsis patients treated	Erika Denton	92.61%	90.00%	91.89%		92.60%	93.08%
3	Keeping patients safe from hospital acquired thrombosis	95% compliance with TRA assessment as evidenced on EPMA. (and audit of appropriate actions)	Erika Denton	98.93%	95.00%	99.13%		98.90%	98.94%
4	Incident reporting and management	NNUH duty of candour compliance	Erika Denton	99.48%	100.00%	0.95%		100.00%	74.79%

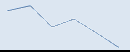
*The most recently published incident reporting rate for the Trust is 42.57 incidents per 1,000 bed days (for incidents reported between 01 April 2017 and 30 September 2017), which is marginally higher than the median reporting rate for our cluster (Acute non- specialist hospitals) of 41.68 incidents per 1,000 bed days. The NNUH is currently ranked 63rd out of the 135 Trusts in our cluster, which is 29 places outside of the highest 25% of reporters.

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

Quality Priorities – Patient Experience

	Quality Priorities - Patient Experience	Measure	Lead	Outturn 2017/18	Monthly Target	Aug-18	6 month trend	YTD 2017/18	YTD 2018/19
1	Treat Patients with privacy and dignity	Patients 'extremely likely' or 'likely' to recommend our service to friends and family	Frances Bolger	96.73%	100.00%	96.50%		96.83%	96.18%
2	Improved continuity of care and experience through reduced ward moves and reduced numbers of outliers	No more than 20 patients recorded as boarders. Monthly average	Richard Parker	42.65	20.00	17.00		42.65	21.72
3	Improved discharge processes	EDL to be completed within 24 hours in 95% of discharges	Richard Parker	76.72%	95.00%	77.43%		75.89%	76.64%

Quality Priorities – Clinical Effectiveness

	Quality Priorities - Clinical Effectiveness	Measure	Lead	Outturn 2017/18	Monthly Target	Aug-18	6 month trend	YTD 2017/18	YTD 2018/19
1	Keeping patients safe from infection	HAI C. difficile Cases (excluding non-trajectory and pending cases)	Frances Bolger	11	0	0		2	2
2	Keeping patients safe from infection	Hospital Acquired MRSA bacteraemia	Frances Bolger	0	0	0		0	1
3	Improve quality of care through research	Year on year increase in patients recruited into research studies. Aim to recruit 5000 into research studies in 2016-17.	Erika Denton	3500	417	325		1409	2262
4	Timely medical review of all patients	Average number of patients with LoS >14 days	Richard Parker	196.6	200	175		196.6	187.5

Core Slide 3

Mortality Dashboard - Inpatient Monitoring

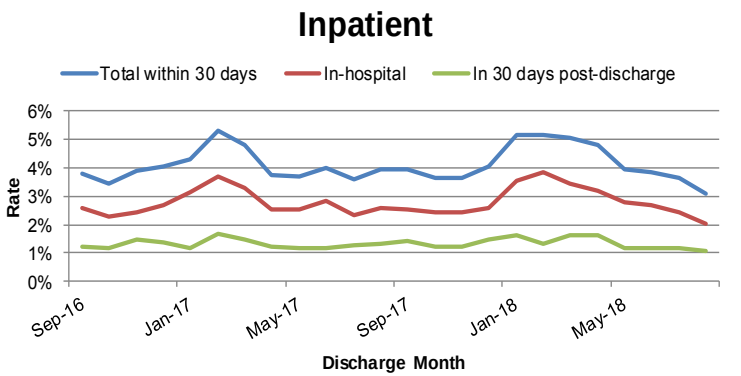
Crude Mortality	
Month	Rate
Mar-18	5.08%
Apr-18	4.83%
May-18	3.95%
Jun-18	3.84%
Jul-18	3.63%
Aug-18	3.09%

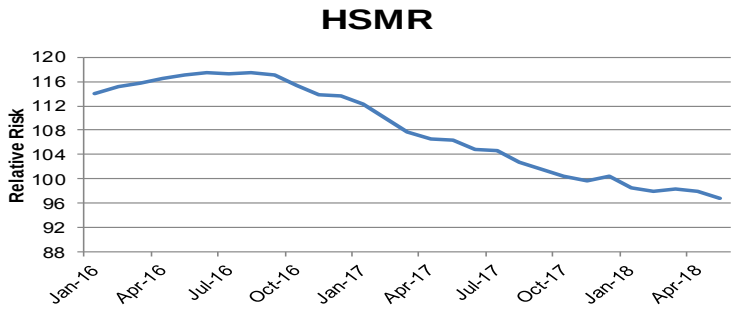
(Crude Mortality is reported one month in arrears)

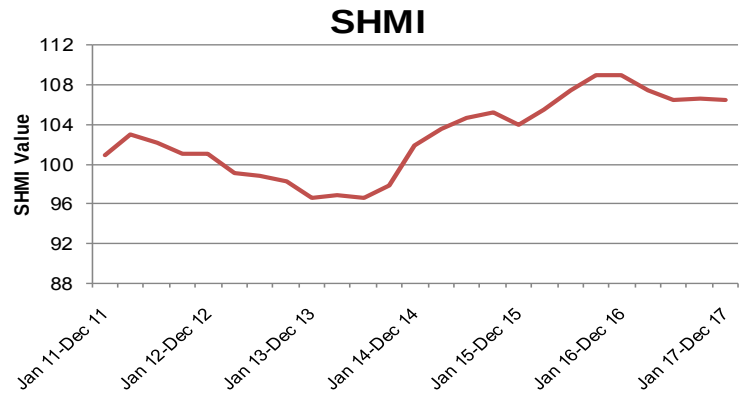
HSMR	
Mar-18	98.38
Apr-18	98.05
May-18	96.85

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

SHMI	
Jan 17-Dec 17	106.47

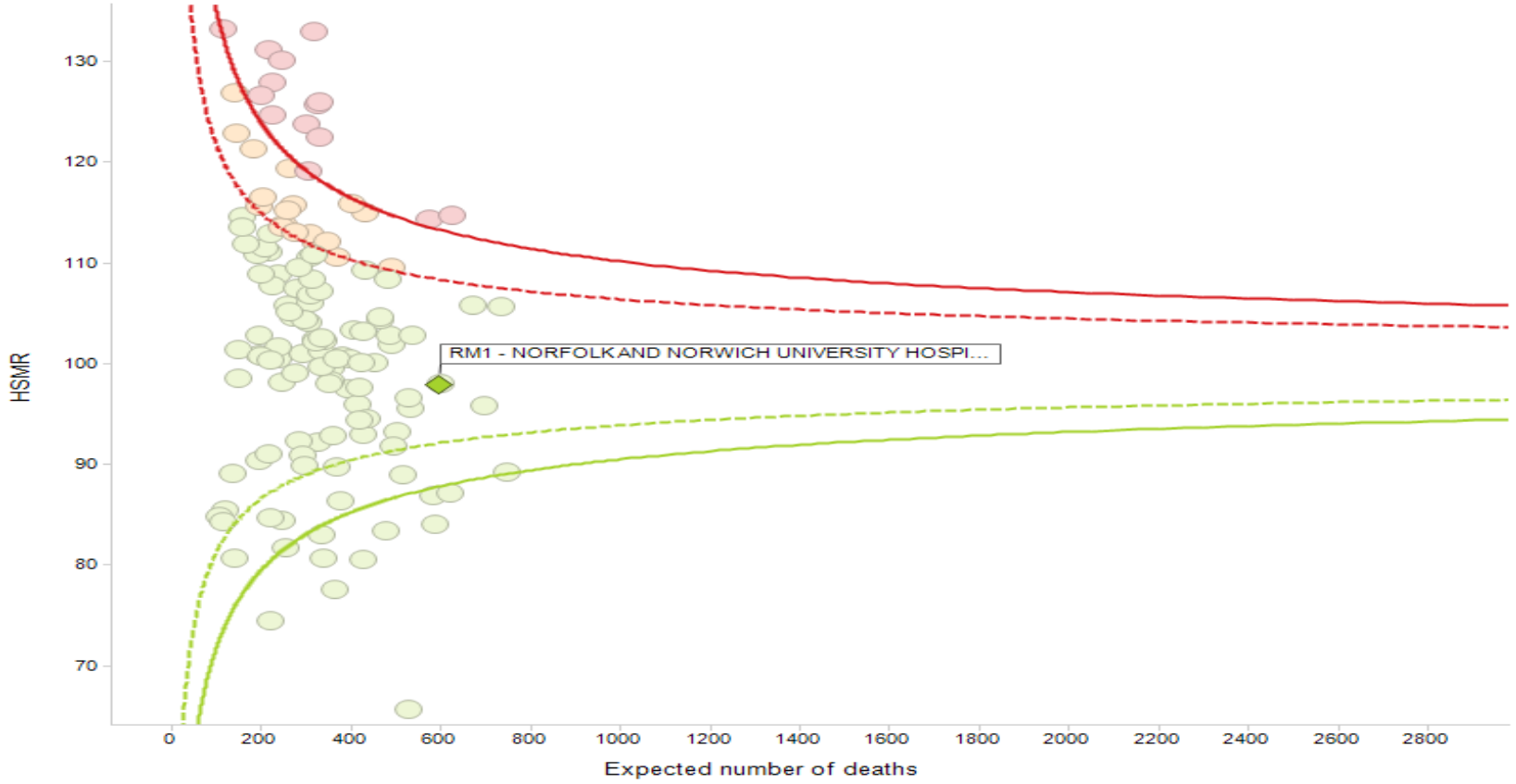






	2017/18		2018/19	
	Q3	Q4	Q1	Q2
Total deaths excluding ED	974	1082	856	460
Total deaths for ED	43	62	28	29
Number of in-hospital deaths	646	752	591	319
Number of deaths within 30 days of discharge	328	330	265	142
Number of reviews completed	569	393	339	88
Number of deaths on review considered potentially preventable	2	2	4	0
Percentage of deaths considered as potentially preventable	0.35%	0.51%	1.18%	0.00%
Numbers of deaths considered under SI process	3	3	6	2
Maternity deaths reviewed	0	0	0	0
Deaths in Learning disability reviewed (LeDeR)	3	3	0	0
Paediatric deaths reviewed	0	0	0	0
Mental Health deaths reviewed	0	0	0	0
Themes identified from mortality reviews and investigations	A need has been identified for strengthened mortality surveillance processes for improved accuracy of information form all sources so we can identify themes and trends in a consistent way.			
Actions taken	Work with Karen Kemp, Berenice Lopez and Angela Adams to establish assurance processes.			

Core Slide 4 HED - HSMR Overview – March 2018 to May 2018



Organisation (provider): RM1 - NORFOLK AND NORWICH UNIVERSITY HOSPITALS NHS FOUNDATION TRUST
Trust Group: 1. My Trust
Alert Level: Green
HSMR: 97.87
HSMR 95% CI: (90.08,106.16)
Number of super-spells: 17345.00
Number of observed deaths: 582.00
Expected number of deaths: 594.64

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

Thrombosis & Thromboprophylaxis Committee
A report on key issues being addressed by the Thrombosis and Thromboprophylaxis Committee (T&T) has been received and was noted.

The Terms of Reference for this committee have been reviewed, updated and submitted for ratification.

The MD advised that completion of the TRA is a significant action in the CQC inspection report. An initial meeting had taken place and work has begun to work up an action plan against this CQC recommendation.

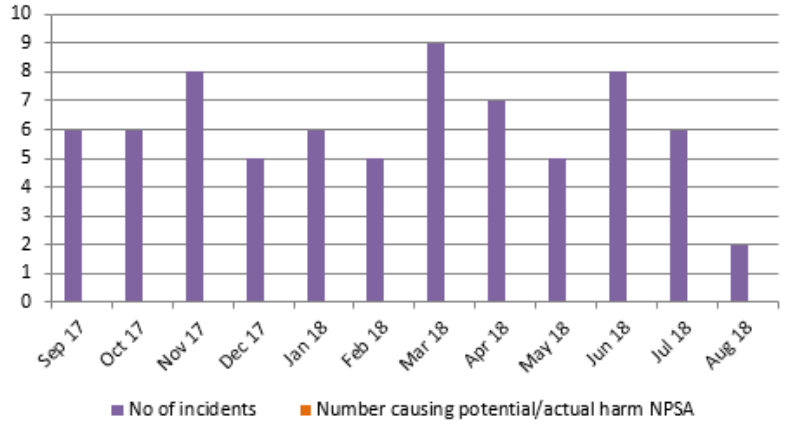
Clinical Review Group
This Group will be co-chaired by the Medical Director and the Chief Nurse is being renamed to better reflect the terms of reference. The main remit is to carry out a review of clinical harm experienced by patients on the waiting lists to provide assurance to NHSI that such harm is being managed. Currently retrospective reviews of people coming to harm while on the waiting list are being carried out but the focus will be changed to current and 'live' harm management rather than retrospective.

Detention Under the Mental Health Act
Under the mental health act sections 2 & 3, certain patients may be detained in hospital in the interests of their health or in the protection of others. Under section 5 (2) doctors have the power to 'hold' a patient up to 72 hours to that the patient may be assessed by approved MH professionals. A register of all detained patients is maintained in accordance of statutory requirements. The table below demonstrates the increase of numbers of patients being treated under the MH act at NNUH.

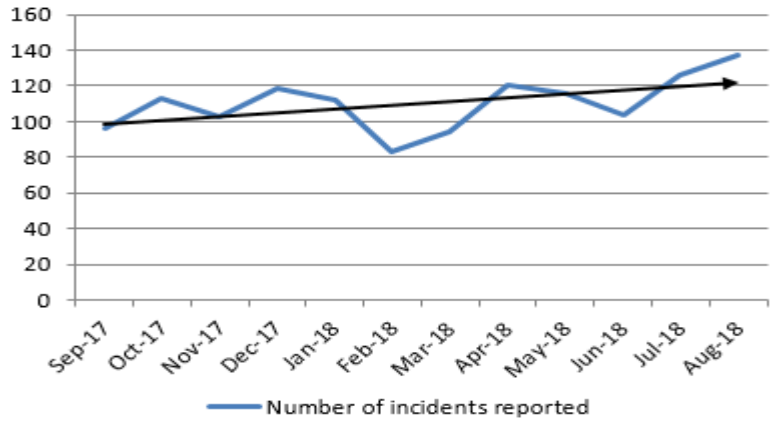
Patients treated in the Trust whilst detained under the Mental Health Act	
2014/15	48
2015/16	39
2016/17	73
2017/18	90
2018/19 YTD	31

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

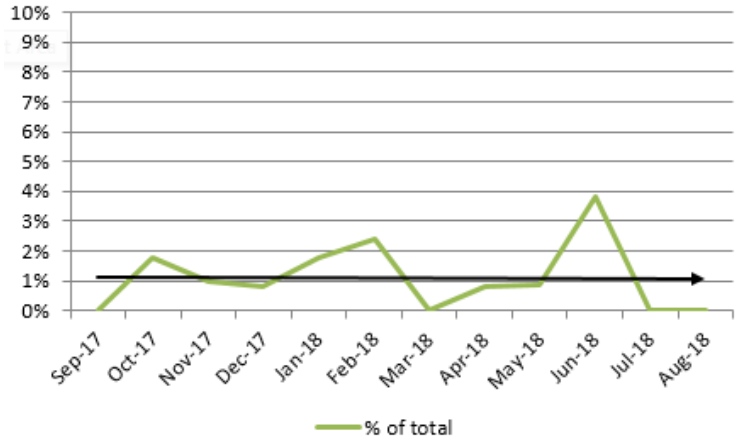
Insulin incidents past 12 months NPSA severity categories



Medication Incidents



Medication Incidents causing potential/actual harm



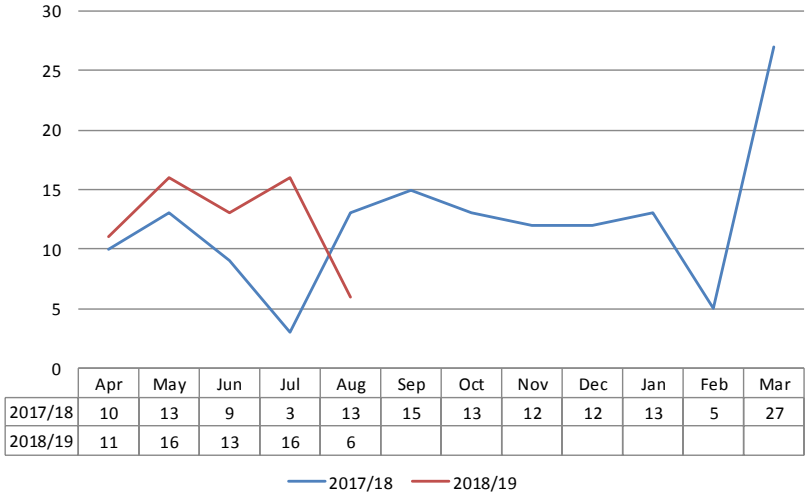
There were 126 medication incidents reported in July, a slight increase from June (104). None of these incidents had caused harm to the patient.

There are global drug shortages including aztreonam, coamoxiclav, Diamorphine, gentamicin, meropenem and also issues with piperacillin with tazobactam. At times the Trust runs perilously close to having no stock.

Core Slide 7

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

Serious Incidents and Never Events (reported onto STEIS)



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

New Serious Incident Group commenced in September. Chaired by Chief Nurse/ Chief Medical Director, the group meets daily and reviews all moderate harm incidents and medication errors from across the Trust.

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

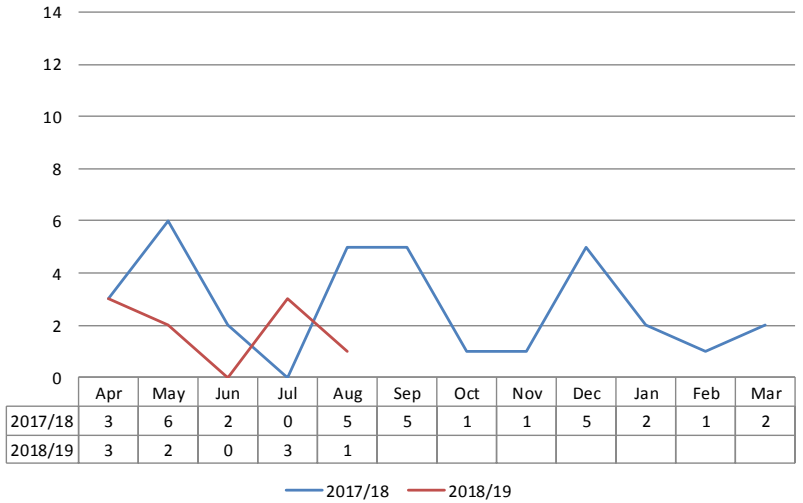
- 5 patients acquired G3 pressure ulcers (concluded as potentially avoidable at RCA).
- 1 Newborn blood spot screening incident.
- 1 Patient Fall where patient sustained a hip fracture.
- 2 x Treatment Delay (1 x patient drain retained in error requiring readmission for antibiotic therapy; 1 x equipment failure in IRU resulting in delay and increased complexity of treatment options)
- 1 patient received an overdose of Haloperidol.

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

- 3 12hr breach in ED for patients awaiting Mental Health bed allocation outside of the Trust

Compliance with the Duty of Candour has breached in 1 case – 1 x Surg
RCA investigations are in progress for all relevant incidents.

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



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

In August 2018 there were 167 inpatient falls reported. This is the same number as the previous month - the overall trend over the previous 12 months is static. 1 patient fall was reported which resulted in moderate harm or above in August 2018. The trend for Moderate Harm or greater falls continues on a downward trajectory.

The Royal College of Physicians reports national average of **6.63** falls per 1000 bed days and **0.19** result in moderate harm or greater.

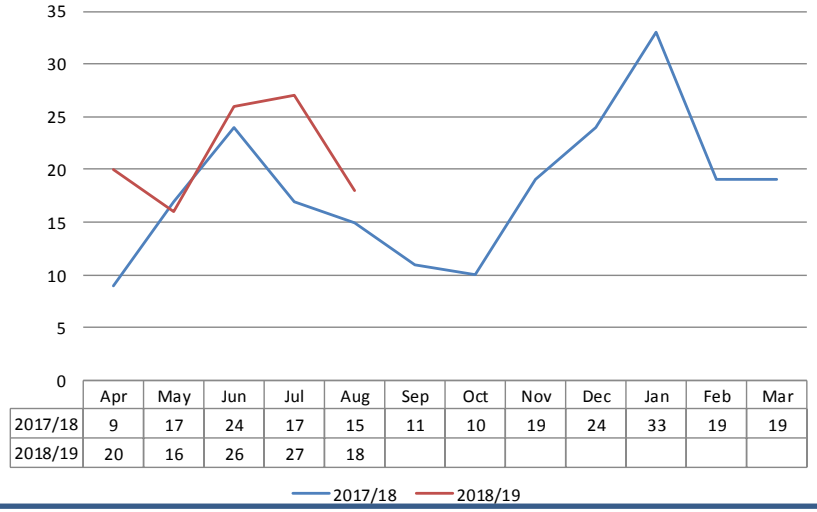
The Trust data for June 2018 (July bed day data is not yet available) indicates that the NNUH inpatient falls rate is **5.81** falls per 1000 patient bed days which is lower than the national average .

Mod harm falls for June 2018 were recorded as **0.12** which is below the average recorded nationally.

Core Slide 8

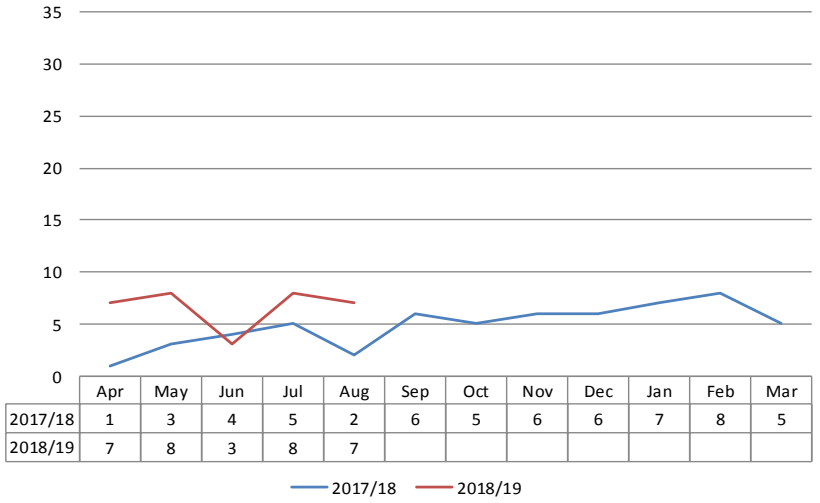
Quality & Safety (Pressure Ulcers) – Lead Director Nancy Fontaine

Grade 2 hospital acquired pressure ulcers



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

Grade 3/4 hospital acquired pressure ulcers



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

Category 2 PU

- A total of 26 patients developed a Grade 2 PU whilst in our care in July 2018.
- 8 cases were found to be potentially avoidable following RCA investigation and peer review.
- 15 cases were found to be unavoidable when peer reviewed following RCA investigation.
- 3 cases are still pending RCA investigation and peer review.
- **Grade 3 & 4 HAPU**
- A total of 8 patients developed a Grade 3 pressure ulcer whilst in our care in July 2018.
- Following peer review and root cause analysis investigation, 4 cases were concluded as potentially unavoidable and 3 cases potentially avoidable. .

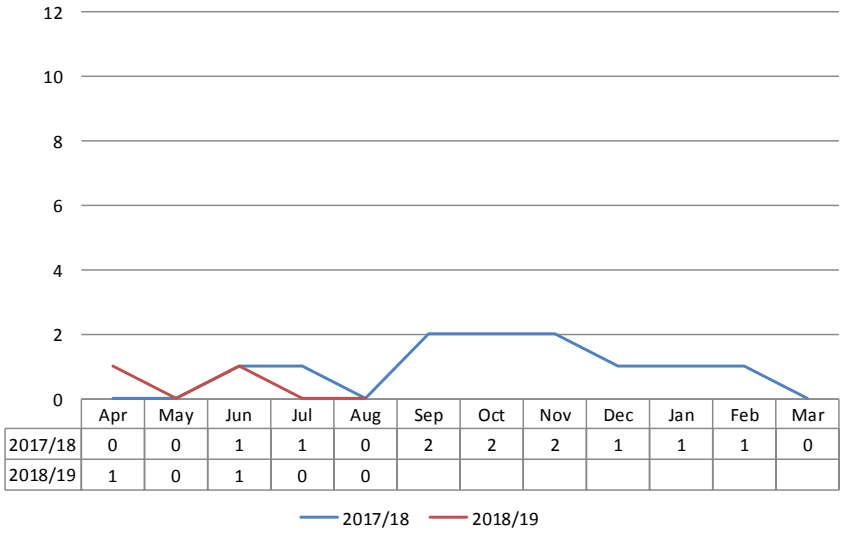
Learning from recently completed RCA's

The learning from the RCA's is reviewed by the TVN's:

- An accurate history is required on admission of falls history
- Accuracy of Waterlow assessments and documentation of skin inspections continue to recur as a theme in RCA's
- Further evidence of ongoing learning and improvements in care - Critical Care are part of the pressure ulcer collaborative and have recently managed a 28 day period without a pressure ulcer which has been the longest period achieved in some time. Poster presentation prepared by team to share learning

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

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



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

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

MSSA Hospital Attributable Bacteraemia 2018/19 No objective
- Year to date 7

Gram Negative Hospital Attributable Bacteraemia 2018 (YTD)
- E. coli 21
  Pseudomonas aeruginosa 7
- Klebsiella sp. 4

NICU – 1 Pseudomonas aeruginosa meningitis
- *Pseudomonas aeruginosa* isolated in water sample from sink near baby, point of use filters placed on all hand washing sinks in rooms with babies.
- Full testing undertaken with *Pseudomonas aeruginosa* isolated in water samples from 5 outlets, filters in place.

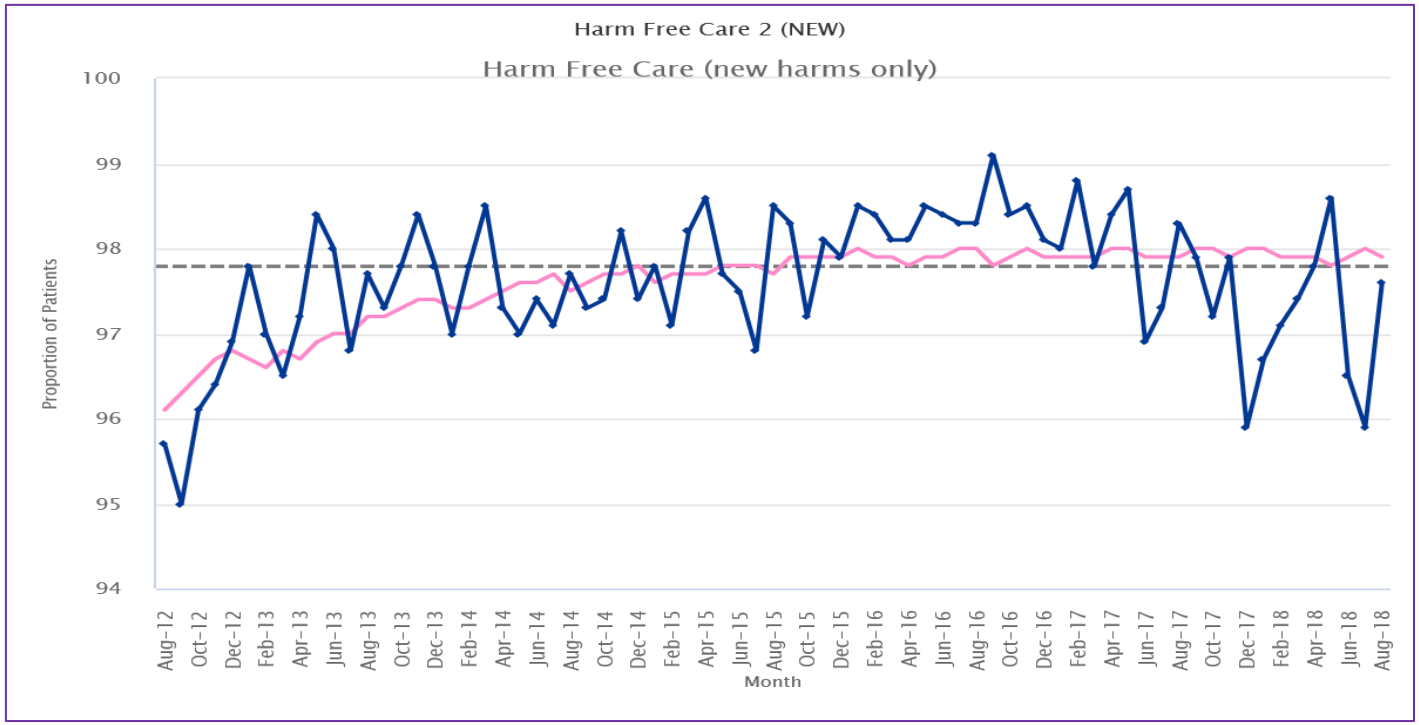
Following the post infection review [PIR] meeting with Trust and CCG's representatives each hospital acquired case of C. difficile is:-	
Trajectory	deemed to have lapses in care
Non-Trajectory	Deemed to have no lapses in care

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

Summary Table		Non-Trajectory	Trajectory	Pending	Total
Quarter	4				
	3				
	2	4	0	5	9
	1	6	2	0	8
Year to date 18/19		10	2	5	17
Previous year 2017/18 Total		*24*	*11*	*0*	*35*

Core Slide 10

Safety Thermometer – Lead Director Nancy Fontaine



The Patient Safety Thermometer Data published on the website contains information that relates to all data collection until May 2018. The above data compares “Harm Free Care – New Harms” since data collection began. The graph above has been taken from the PST website and demonstrate NNUH NHSFT Harm Free Care (All new harms) of 97.6% for August 2018 against a national average reported of 97.9%. The graph provides data since Safety Thermometer collection commenced in 2012.
. “New harms” are harms that are recorded in the 72hrs prior to data collection as opposed to “all harms” which include community acquired pressure ulcers for example.

Core Slide 11

Maternity Safety Dashboard – Lead Director Nancy Fontaine

		NNUH Maternity 2018/19	April	May	June	July	Aug	Total
Activity	Mothers Delivered	Mothers delivered	438	479	460	475	470	2322
	Babies Delivered	Total Births	443	488	466	479	479	2355
		Live Births	439	483	463	478	477	2340
		Total Stillbirths	4	4	3	1	1	13
	Early NND	NNUH born alive & die ≤ 7days	0	1	0	0	1	2
	Bookings	Total number of Bookings	481	513	489	482	448	2413
		% Bookings ≤12+6 Weeks	92.7%	92.0%	90.6%	88.4%	89.3%	90.6%
	Inductions of labour	% Total IOLs	37.0%	35.3%	36.7%	35.2%	30.6%	34.9%
	Normal Vaginal Deliveries	% Total Cephalic & Other Cephalic & Breech	61.4%	65.8%	60.7%	57.7%	59.4%	61.0%
	Instrumental Deliveries	% Total Ventouse / Forceps	9.8%	10.0%	12.0%	11.4%	11.7%	11.0%
		% Forceps	7.5%	6.3%	8.3%	8.2%	7.2%	7.5%
		% Ventouse	2.3%	3.8%	3.7%	3.2%	4.5%	3.5%
	Caesarean Sections	% Total CS (Elective & Emergency)	29.2%	26.5%	28.5%	31.8%	30.9%	29.4%
		% Emergency (CS1, CS2, CS3)	16.9%	12.3%	15.9%	17.1%	13.2%	15.0%
		% Elective (CS4)	12.3%	14.2%	12.6%	14.7%	17.7%	14.3%
		% Robson 1: Primip single cephalic ≥37 wks spont. onset	1.6%	2.5%	2.4%	1.5%	2.1%	2.0%
		% Robson 2: Primip single cephalic ≥ 37 wks IOL / ELCS	9.8%	8.8%	12.4%	14.7%	10.4%	11.2%
		% Robson 5: Multip Prev CS, single cephalic ≥37 wks	8.0%	5.0%	5.7%	5.9%	5.5%	6.0%
Place	MLBU Births	MLBU Births	18.9%	18.4%	16.7%	18.1%	17.4%	17.9%
	Homebirths	Home births (Planned & Unplanned & Intransit)	2.1%	2.5%	2.0%	1.7%	1.7%	2.0%
Professionals	Care in Labour	Number BBA's (No MW or Obstetrician in attendance)	5	8	3	2	2	20
		% 1:1 Care in Labour	91.9%	92.2%	92.5%	93.1%	93.8%	92.7%
	Lead professional	% MW Led at birth	41.6%	39.9%	34.8%	38.5%	34.0%	37.7%
		% Cons Led at birth	58.7%	0.6033403	65.2%	61.5%	66.2%	62.4%
	Cons Hrs	Wkly dedicated Cons hrs on Labour ward	60	60	60	60	60	60
	MW Hrs	Midwife : Birth Ratio excl. band 3 MCA	1:30	1:30	1:30	1:30	1:30	1:30
		Midwife : Birth Ratio inc. band 3 MCA's	1:28	1:28	1:28	1:28	1:28	1:28
Wellbeing	Smoking status	% Mothers smoking at Booking	10.5%	11.5%	12.8%	11.4%	10.0%	11.2%
		% Mothers smoking at Delivery	10.7%	10.6%	10.2%	9.9%	8.7%	10.0%
	Breastfeeding	% Initiation: Breast milk < 48hrs	83.1%	80.4%	79.3%	78.5%	78.9%	80.0%
		% Exclusive BF @ transfer to community	62.3%	63.7%	62.2%	61.3%	64.0%	62.7%
		% Breast + Mixed feeding @ transfer to community	72.6%	71.6%	70.9%	69.5%	72.3%	71.4%
Risk Management	Maternal	% 3rd & 4th degree tears (per vaginal births)	2.2%	3.9%	4.2%	3.7%	4.2%	3.7%
		% PPH ≥1500mls	3.7%	2.9%	3.3%	3.8%	2.3%	3.2%
		Number Unplanned Admission To Critical Care Complex	0	0	0	0	1	1
		Number Emerg readmissions ≤30 days of delivery	6	10	4	12	4	36
		Number Maternal Death	0	0	0	0	0	0
	Neonatal	Number of Hypoxic Encephalopathy (Grades 2 & 3)	0	0	0	0	0	0
		Number Unplanned NICU ≥37wk Admissions (E3)	19	19	13	18	17	86
		Number Apgar score <7 @5, ≥37wk	3	7	5	0	8	23
	Serious Incidents	Number Number of SI's	0	0	0	1	1	2
	Closures & Diverts	Number Unit closures	0	0	0	0	0	0
		Number Mothers transferred out of unit	2	0	0	0	3	5

HoM Comments:

SI = NNST Screening incident
Improvements in BBA rate Aug 17 to Aug 18 & Smoking reduced by 3% over the year
SB's causing concern increased by 3 from similar period last year – PMRT introduced to look for themes.

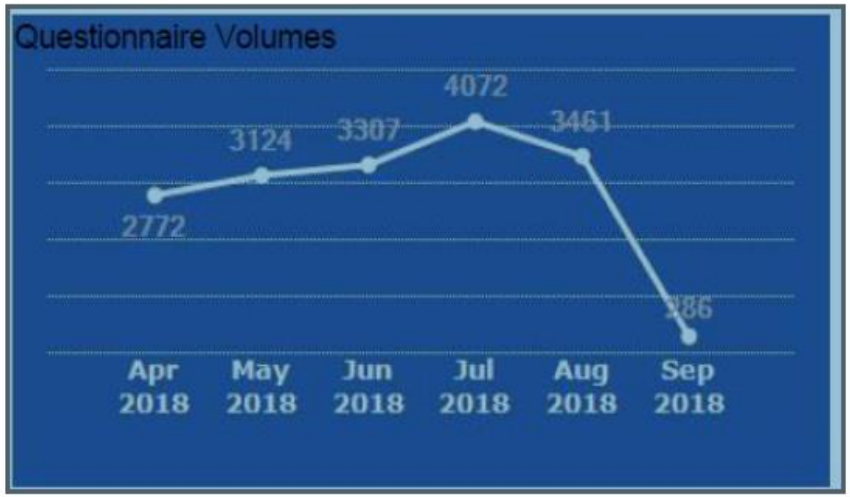
Core Slide 12

Quality and Safety Dashboard – Lead Director Nancy Fontaine

		Outrun 2017/18	Monthly Target	Aug-18	6 Month Trend	YTD 2017/18*	YTD 2018/19
Caring and Patient Experience							
1	Same Sex Breach	62	0	12		8	32
Infection Prevention and Control							
2	C Diff cases (hospital acquired)	35	N/A	5		15	17
3	MRSA bacteraemias (hospital acquired)	0	0	0		0	1
4	Norovirus (confirmed cases)	88	N/A	0		54	27
5	Elective MRSA Screening compliance	95.7%	>=95.0%	97.5%		93.3%	95.7%
6	Emergency MRSA Screening compliance	96.5%	>=95.0%	96.9%		96.7%	96.5%
7	Hand Hygiene Compliance	95.5%	>98.0%	96.4%		96.2%	95.5%
8	Dress Code Compliance	98.4%	>98.0%	98.3%		98.4%	98.4%
9	Commode Audits	94.8%	>98.0%	96.8%		95.7%	94.8%
Health & Safety							
10	Needlestick Incidents	114	N/A	7		50	39
Incident Reporting							
11	Total Number of Datix Incidents in month	12368	N/A	1214		4899	5596
12	Datix Incidents (reported in month) Finally Approved	6089	N/A	629		2627	2904
13	Number of Datix Incidents reported in month not closed	6270	0	585		2263	2693
Cleaning							
14	Cleaning Audit Results	96.1%	>=95.0%	96%		96.3%	96.1%
15	Cleaning Audit Results if Re-Audited	96.7%	>=95.0%	96%		95.8%	96.7%
Call Bell Waits							
16	Day Call Bell: Patient Call	02 min 03 sec	02 min 30 sec	02 min 01 sec		02 min 02 sec	02 min 03 sec
17	Day Call Bell: Bathroom Call	01 min 23 sec	02 min 00 sec	01 min 24 sec		01 min 18 sec	01 min 23 sec
18	Night Call Bell: Patient Call	01 min 20 sec	02 min 30 sec	01 min 17 sec		01 min 19 sec	01 min 20 sec
19	Night Call Bell: Bathroom Call	00 min 53 sec	02 min 00 sec	01 min 04 sec		00 min 58 sec	00 min 53 sec
Staffing							
20	Number of red flags for the month	12342	N/A	610		5691	2668

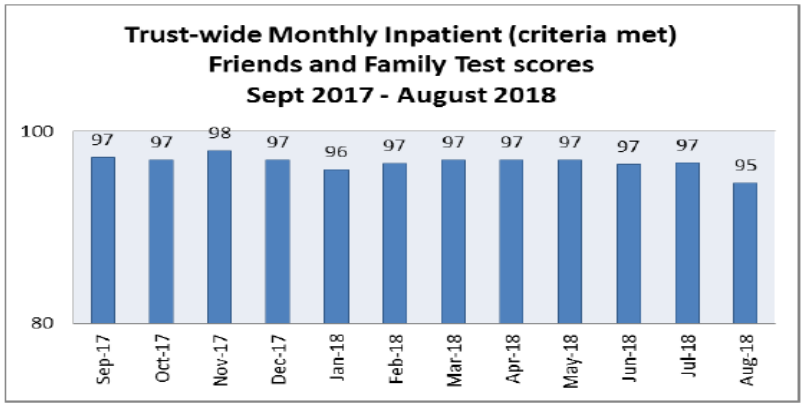
**YTD 2017/18 refers to the YTD figure at this point last year*

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



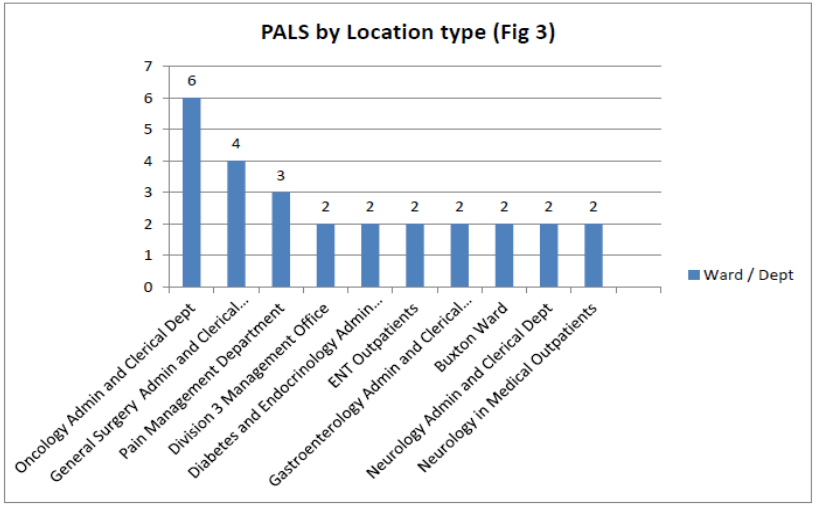
Patient Feedback

- During August2018, 3461 responses were received from our patients. Graph above demonstrates clearly the improvements made in the number of FFT received.



Patient Advice and Liaison Service (PALS)

- 295 PALS enquiries were received in August 2018 v 302 received in August 2017
- 19 comments were posted on the Care Opinion website. 15 of these were compliments
- In August, the percentage of PALS enquiries closed within 48 hours of receipt was 83%. Any enquiries not closed within 48 hours will be because we are awaiting a response from staff or the enquiry is ongoing. .

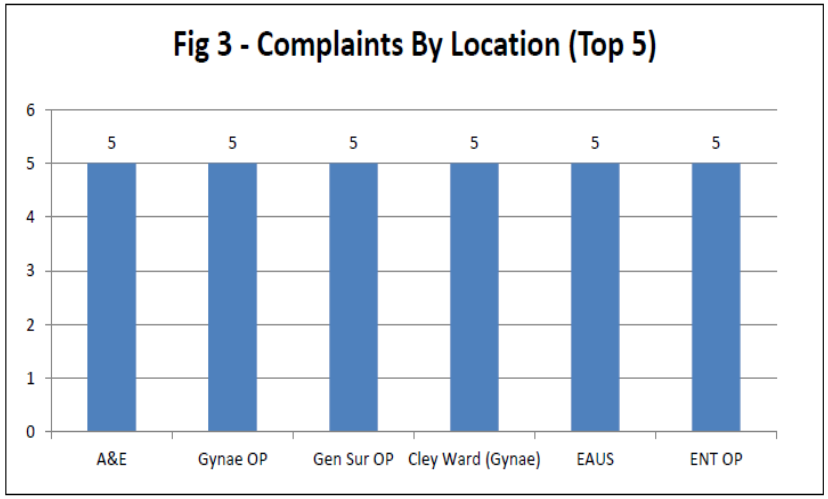


2. Learning
ID 38753 Patient emails to ask what time blood tests are available at Cromer.
Outcome: This information does not appear to be available on the Trust's website. PALS checked the opening times and this information was given to the patient. PAL informed staff that this information was not available and the website has now been updated with the opening times now included.

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

Complaints Summary

90 complaints were received in August 2018, compared with 78 complaints received in August 2017 and 93 in 2016. The NHS Complaints Regulations 2009, suggest that all complaints should be made within 1 year of the date of knowledge of the relevant event or issue arising. Where appropriate, we apply discretion over application of this limitation and 5 complaints are being investigated this month which fall outside the 1 year timeframe.



Many complaints relate to a series of events or a course of treatment over a period of time rather than a specific 'incident' and in that situation we record the earliest incident date. 65% of complaints received this month relate to care provided in June and July 2018

A review has been undertaken of complaints relating to the care of patients who are deceased. As a 'benchmark' it was anticipated this to be around 8% of all complaints received.

In the year to date there have been 30 complaints relating to deceased patients, which is 7% of all complaints received. This is in line with the 2017/18 figure, but is a fall compared to 2016/17 and 2015/16.

Issue	2018/19 (YTD)	2017/18
Unhappy with Treatment/Diagnosis	7	28
Delays with death certificate process	1	1
Poor communication	7	8
Discharge (either wrong place; inappropriate; or, delayed)	5	8
Deceased's lost property	2	6
Unhappy with Nursing care	5	10
Other	1	2
DNAR	1	1
Questions appropriateness of palliative care	1	0

Dementia Support Team (DST)

The Dementia Support Team are now funded substantively by CSS Division following 5 year funding by a charitable board of trustees

The success of the DST on Langley ward offers a model which can be replicated across the Trust. It is based on early assessment and daily intervention which provides cognitive and physical stimulation, carer engagement and nursing dementia care advice. The approach facilitates care needs being met and prevents deterioration and escalation of behaviour which challenges

Core Slide 15 High Risk Tracker Lead Director Nancy Fontaine

Risk Register HIGH RISK Tracker 15+ Risks **Date of Update** **17/09/2018**

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

Ref	Risk Name	Current Risk score			3 month risk trend			Date Risk added	Executive Lead	Date of Last review	Latest Status report	Anticipated Date for reduction or resolution
		Cons.	Freq.	Risk Score	1mth ago	2mth ago	3mth ago					
ID 604	Sustainability of Cardiology catheterisation laboratory services due to equipment failure	4	4	16	16	16	16	03/05/2018	R.Parker	03/08/2018	Mitigation plan being worked up for additional cath lab. IRU expansion has been given consent from DH	Jun-18
ID 572	Financial sustainabilty	4	5	20	20	20	20	13/10/2015	J. Hennessey	24/07/2018	The Trust re-profiled the annual plan to reflect updated components and timing of CIPs and a number of other changes; this was submitted to NHSI in June. NHSI will be monitoring performance against this Plan. There remains some risk relating to getting approval to borrow the necessary funds to support the deficit Plan. A Financial Recovery Group for the STP is being established, which should support improving the NNUH financial position and reducing this risk. The Trust has written to NHS England regarding MFF and PFI support and is awaiting a response.	Jul-18
ID 576	Nuclear Medicine - loss/disruption of service and regulatory compliance due to equipment failure, design of facilites and access to medical physics resource.	4	4	16	16	16	16	18/01/2018	R.Parker	03/08/2018	Business case progressing	Jun-18
ID 571	Failure to achieve key local and national operational performance targets	4	4	16	16	16	16	13/10/2015	R.Parker	25/07/2018	52wk RTT plans meet the 18/19 NHS Planning Guidance. ED 4 hour target remains challenging, and achievement of this fluctuates, however improving against NHSE plan.	Oct-18
ID 387	IRU capacity	4	4	16	16	16	16	03/06/2014	R.Parker	03/08/2018	Clinical mitigation plan in place lead by MD. IRU expansion has been given consent from DH	Apr-19
ID 404	Cardiology pacing waiting lists	4	4	16	16	16	16	10/11/2017	R.Parker	03/08/2018	Mitigation plan being worked up for additional cath lab. IRU expansion has been given consent by DH.	Jul-18
ID 568	Non -compliance with mandatory training	3	5	15	10	10	10	02/09/2015	J.Over	25/07/2018	Oversight rests with WESB with data and analysis provided to HMB and Board via IPR. This has been expanded recently in the light of CQC Must do's. Activities and interventions in place to increase have included: bespoke training days, non clinical mandatory compliance 1 day sessions, introduction of ESR portal and ESR app for remote distance learning, bank staff paid for training time, review of capacity of certain topics eg Resus. Score amended - current to 15 to reflect the impact on non compliance	Oct-18
ID 610	Ageing IT infrastructure	5	4	20	20	New	New	02/08/2018	A. Lundigran	02/08/2018	Existing controls will cease to have effect after December 2018. Mandate to proceed to Procurement. Business case for investment in IT infrastructure being developed. Move to virtual servers with failover functionality	Dec-18
ID 611	Ageing Sterile Services Equipment	4	4	16	16	New	New	14/08/2018	R.Parker	14/08/2018	Replacement programme to commence immediately with two replacement machines Old machines to be decommissioned and used for spares to maintain the remaining machines pending replacement Replacement programme to continue with two machines per year until all 7 have been replaced Cost approximately £70k per machine	Dec-19

Core Slide 16

Performance – Monitor KPI's - Lead Director Richard Parker

Performance		Outturn 2017/18	Monthly Target	Aug-18	6 month trend	YTD 2017/18	YTD 2018/19
Cancer	Core Slide 18-20						
1 Cancer 62 day target for referral to treatment - GP Referral * +		81.52%	85.00%	73.67%		80.03%	72.60%
2 Reallocated Cancer 62 day target for referral to treatment (Previous Month) - GP Referral *		83.04%	85.00%	76.46%		80.44%	75.40%
3 Cancer 2 week wait - all cancers *		94.29%	93.00%	81.17%		92.32%	83.54%
4 Cancer - 62 day screening *		87.41%	90.00%	93.33%		86.43%	85.24%
6 Cancer 31 day target compliance		98.59%	96.00%	95.59%		98.43%	96.56%
7 Cancer 31 day target for subsequent treatments - Surgery *		95.33%	94.00%	82.42%		96.93%	88.25%
8 Cancer 31 day target for subsequent treatments - Anti Cancer Drugs *		99.77%	98.00%	98.84%		100.00%	99.41%
9 Cancer 31 day target for subsequent treatments - Radiotherapy *		98.32%	94.00%	95.77%		97.96%	97.24%
A&E	Core Slide 21						
10 A&E 4 hour target compliance		80.67%	85.00%	82.09%		90.02%	83.21%
11 A&E 4 hour target compliance combined (inc WiC)***		n/a	85.00%	87.70%			88.47%
12 Number of 30 minute handover breaches		6196	0	879		1237	3291
13 Number of 60 minute handover breaches		3698	0	420		443	1192
14 Arrival to Handover time (>15 minutes)		48.9%		66.2%		25.3%	62.7%
RTT	Core Slide 22						
15 18 week RTT target - Patients on an incomplete pathway		83.91%	92.00%	84.28%		84.84%	85.04%
16 Admitted Backlog		3995.0	n/a	3806		3995	3819
17 Incomplete Non Admitted Backlog		2423	n/a	2821		2423	2307
Stroke	Core Slide 23-24						
18 Stroke internal overall SSNAP rating		B	B	B	ABBBAB	C	A
Patient Flow							
19 Diagnostics		99.14%	99.00%	99.08%		99.12%	99.24%
20 Cancelled Operations		1354	n/a	76		471	444
21 Number of 28 day breaches		231	0	11		81	74
22 Average Delayed Transfers of Care		36	n/a	39		36	37
23 30 Day Readmission Rates**		7.22%	n/a	0.12%		12.30%	0.13%
24 Length of Stay (Elective)		3.10	n/a	3.74		3.10	3.27
25 Length of Stay (Non-Elective)		4.23	n/a	3.97		4.23	4.08
26 Average number of patients with LoS >14 days		197	200	175		197	188
*Please note these figures are provisional							
** Reporting one months in arrears							

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

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

Core Slide 17

Performance Summary - Lead Director Richard Parker

Performance – key issues

1. **Cancer** – Sustained increase in 2WW referrals has continued which impacted on all pathways and exacerbated bottlenecks, especially Urology. Backlog reduction planned to complete August however lower than forecast activity has deferred this to September, slight increase in month but overall PTL size decreasing.

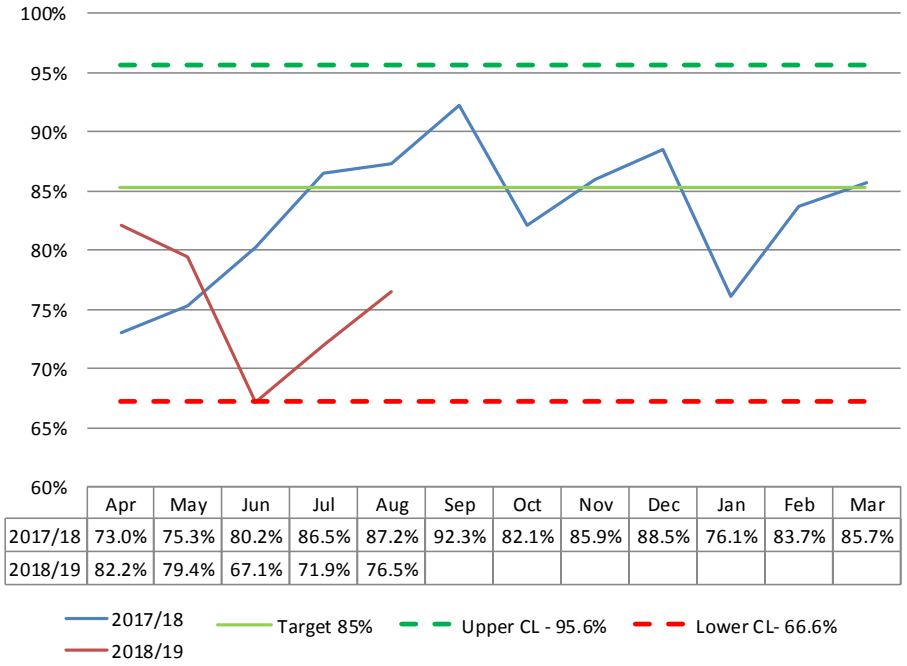
2. **ED**. System performance for August was below the recovery trajectory at 87.7%. ED demand increased by 7% on July 17, with a corresponding 5.3% increase in ambulance arrivals. Bed pressures, variability in process and human factors contributed to the under delivery of the trajectory.

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

2. **Stroke** Hyper Acute Stroke standards have been sustained with focus on flow management and escalation plans. Overall SSNAP rating of “B” for August is an improvement on same period of 2017.

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

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



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

Issues

- Significant increase in 2ww referrals impacting on capacity and recovery. Backlog reduction seen in consecutive months although slowed in August.
- Capacity constraints in template biopsies, increased waiting times for surgery impacting on urology pathway.
- Capacity constraints for CT guided Lung biopsies, surgical capacity and late tertiary referrals impacting on lung pathway.
- Capacity constraints in Oncology (OPA and RT/Chemo) impacting on colorectal pathway

Actions

- Micromanagement of cancer PTL continues with second weekly escalation PTL meeting in place for Urology and Colorectal
- Increased treatment capacity in Urology in place for September
- Trial of template biopsies under LA commenced.
- Switch of Theatre capacity from General surgery to Thoracic surgery baselined from July
- STP focus on lung and urology pathways with additional posts for Urology pathway approved.
- Cancer transformation funding allocated for projects to commence and recruitment now underway. Capital funding allocation still outstanding.

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

Core Slide 18a

Performance (Cancer) - Lead Director Richard Parker

62 Day GP Breaches – July (Open)

	Breast	Gynaecology	Haematology	Head and Neck	Lower GI	Lung	Sarcoma	Skin	Upper GI	Urology	Grand Total
Administrative delay (e.g. failed to be rebooked after Did Not Attend, lost referral)		0.5	1	0.5	1	1.5				9.5	14
Complex diagnostic pathway (many or complex diagnostic tests required)		2	1	1			1		1	1	7
Elective cancellation (for non-medical reasons)								1			1
Elective capacity inadequate (Patient unable to be scheduled for treatment within standard time)	2	1			3	2				10.5	18.5
Health care provider initiated delay to diagnostic test or treatment planning				2	1	1			1	2	7
Out-patient capacity inadequate (i.e. no cancelled clinic, but not enough slots for this patient)	1			1	1					1	4
Patient choice (patient declined or cancelled an offered appointment date for treatment)		0									0
Patient initiated (choice) delay to diagnostic test or treatment planning, advance notice given			1	2						1	4
Treatment delayed for medical reasons (Patient unfit for treatment episode, excluding planned recovery period following diagnostic test)	1										1
Other reason										0	0
Clinic cancellation										1	1
(blank)									0	0.5	0.5
Patient choice delay relating to first outpatient appointment										1	1
Grand Total	**4**	**3.5**	**3**	**6.5**	**6**	**4.5**	**1**	**1**	**2**	**27.5**	**59**

	Cancer Waiting Times	East of England Reallocation
Activity	193	193
Breaches	58.5	53
Performance	69.69%	72.54%

Urology contributes highest number of breaches, Prostate pathway remains an area of focus to reduce number of breaches.
Colorectal represent backlog reduction with less breaches forecast in future months
Focus on head and neck pathway underway improve performance

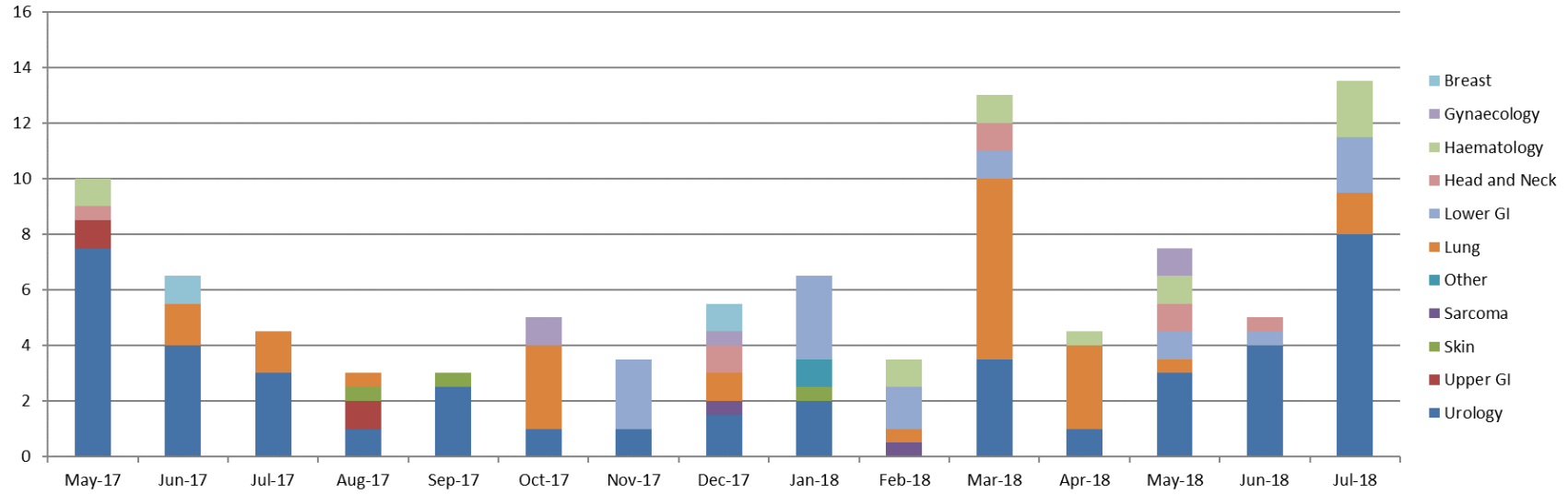
Core Slide 18b

Performance (Cancer) - Lead Director Richard Parker

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

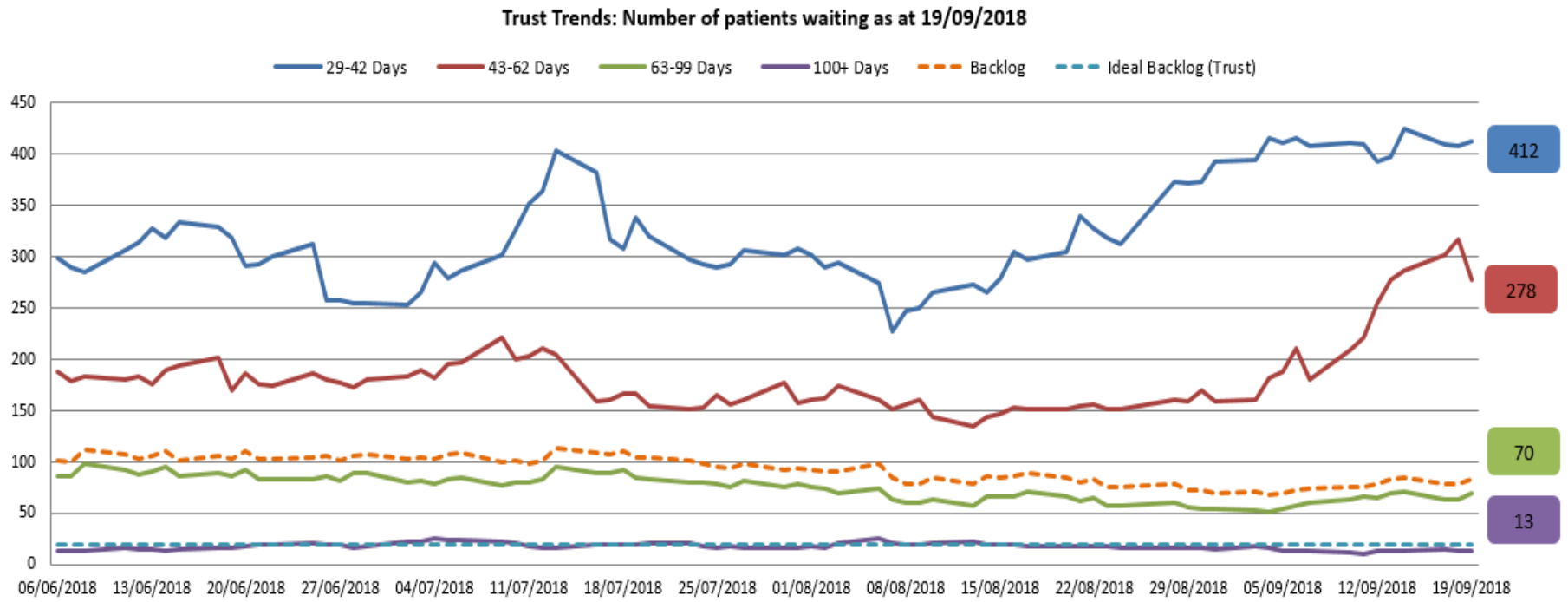
	Gynaecology	Haematology	Lower GI	Lung	Urology	Grand Total
Administrative delay (e.g. failed to be rebooked after Did Not Attend, lost referral)		1		0.5	2	3.5
Complex diagnostic pathway (many or complex diagnostic tests required)	0	1			1	2
Elective capacity inadequate (Patient unable to be scheduled for treatment within standard time)			1		3.5	4.5
Health care provider initiated delay to diagnostic test or treatment planning			1	1	1	3
(blank)					0.5	0.5
Grand Total	**0**	**2**	**2**	**1.5**	**8**	**13.5**

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



Core Slide 19

Performance (Cancer) - Lead Director Richard Parker



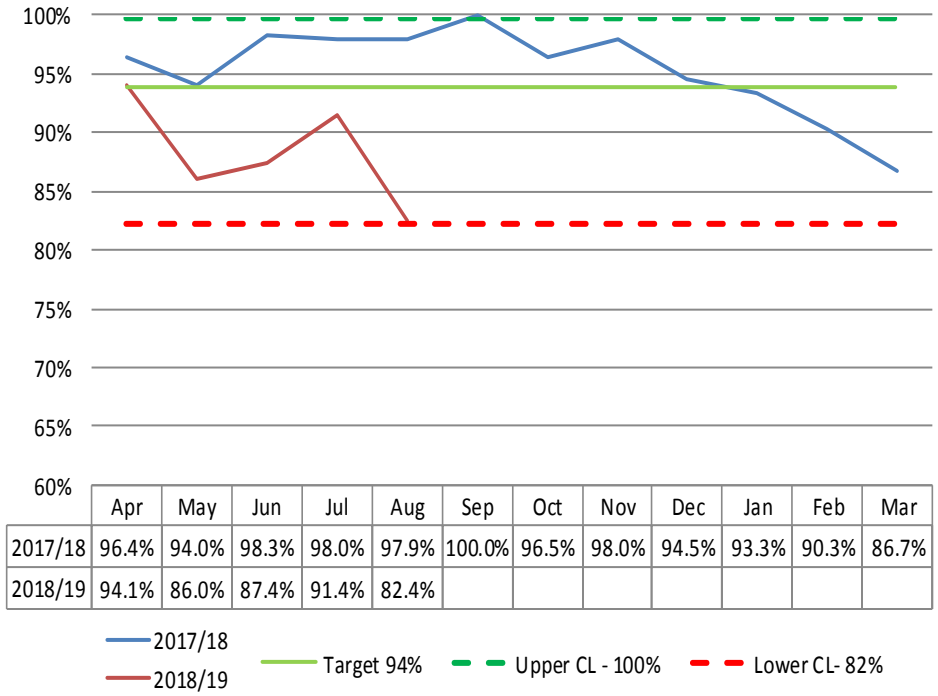
TOTAL	0-14 Days	15-28 Days	29-42 Days	43-62 Days	63-99 Days	100+ Days	Backlog	Rollovers*
2,295	1,002	520	412	278	70	13	83	26

Increasing numbers of patients on the PTL for a number of specialities, additional focus to reduce in place

Core Slide 20

Performance (Cancer) – Lead Director Richard Parker

Cancer 31 day target for subsequent treatments - Surgery *



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

Issues

- Competing targets and pressures in Urology and Plastic Surgery continue to depress performance.
- Actions in place to increase capacity in plastics

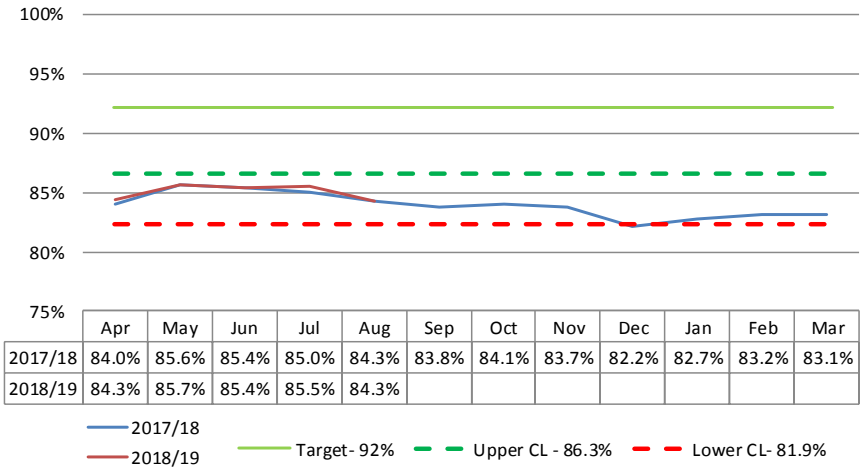
Actions

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

Core Slide 21

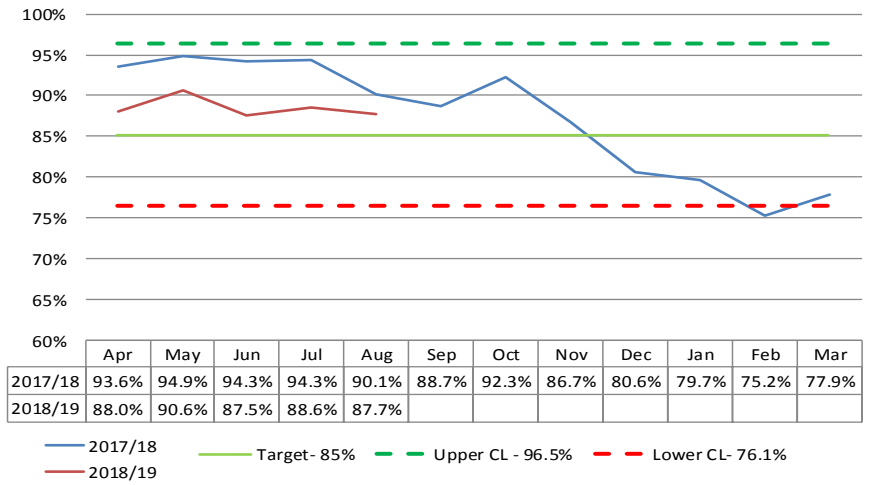
Performance (RTT and A&E) – Lead Director Richard Parker

18 week RTT target - Patients on an incomplete pathway



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

System Performance



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

Issues

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

Actions

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

Issues

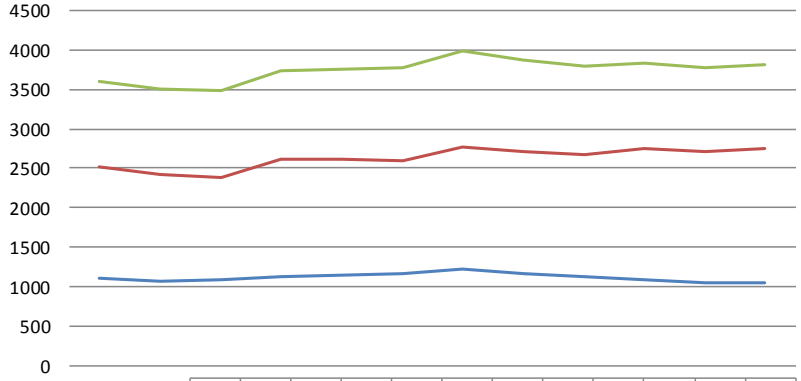
- System trajectory was not delivered
- 7% increase in A&E demand
- 5.3% increase in ambulance arrivals on August 17

Actions

- Winter Plan developed
- Winter Room Ops Director appointed
- Series of pre-winter Improving Care Events (ICE) planned

Core Slide 22 Performance (RTT) – Lead Director Richard Parker

Admitted Backlog

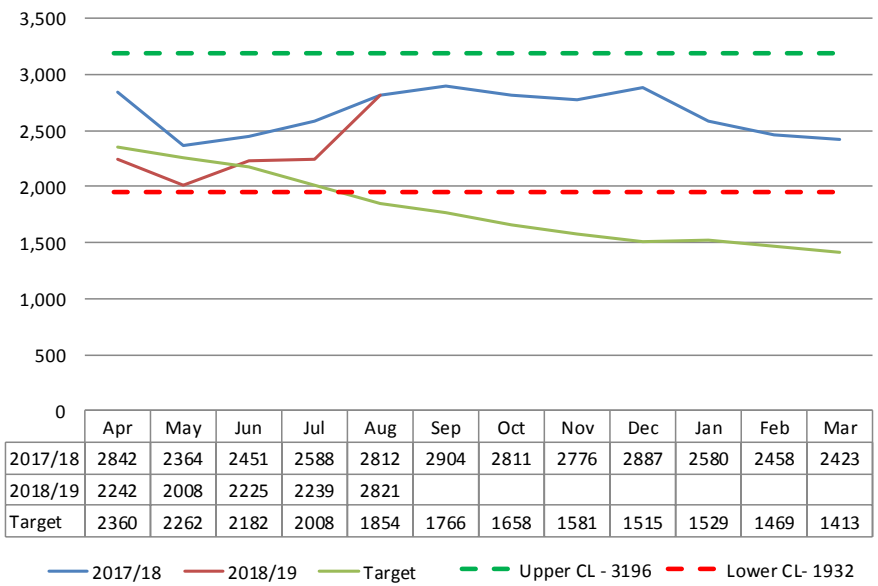


	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18
Admitted IP Backlog	1115	1076	1088	1133	1139	1174	1224	1172	1126	1095	1059	1055
Admitted DC Backlog	2522	2425	2392	2611	2608	2596	2771	2707	2667	2744	2720	2751
Admitted Backlog	3600	3501	3481	3747	3748	3770	3995	3879	3793	3839	3779	3806

Issues
- Backlog increased over winter and subsequent cancer demand impacting on recovery back to pre winter levels.
- Theatre refurb programme delayed by two weeks, will impact on activity during September

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

Incomplete Non Admitted Backlog



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

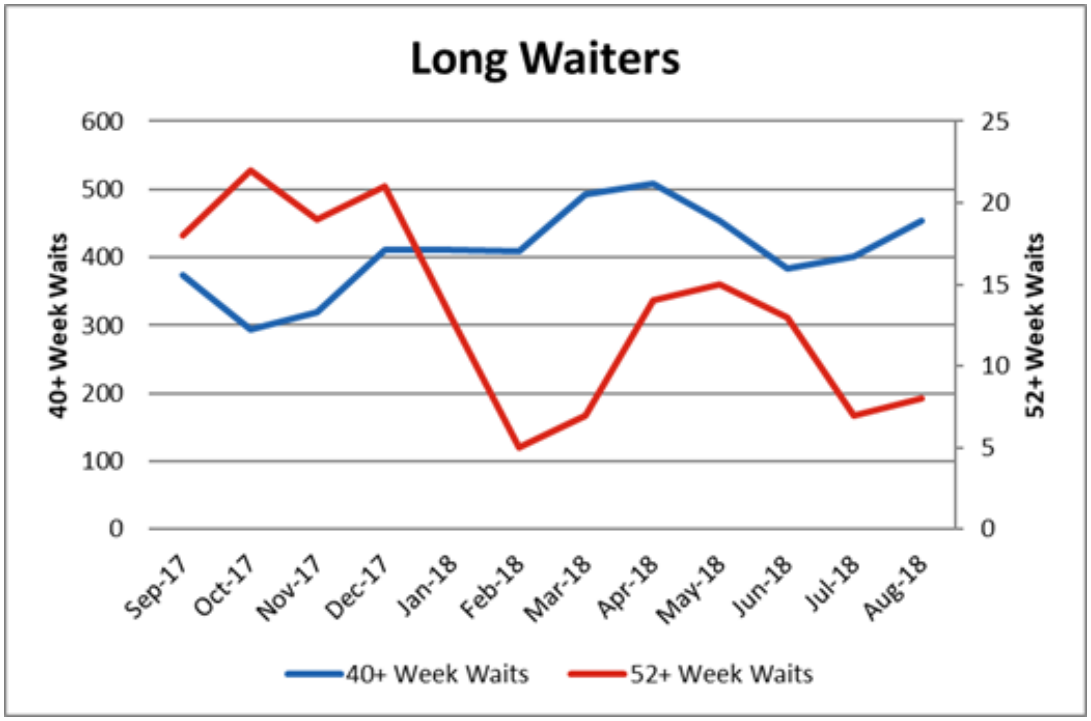
Issues
- Increase in non admitted waiting list continues, driven by increase demand and 2ww referrals
- Increase in 2ww referrals impacting on overall waiting list size and will continue to impact on backlog in future months

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

Additional Slide 22a

Performance (RTT) – Lead Director Richard Parker

Long Waiters - Over 40 and 52 weeks



Comments

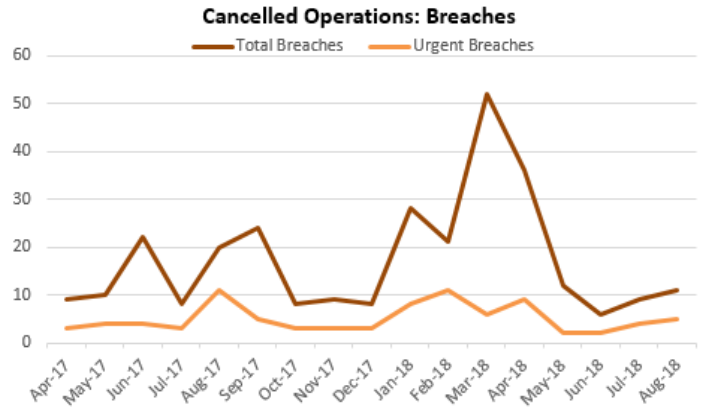
- Slight increase in 52wk patient numbers and 40wks waits have slightly increased due to current A/l period
- Rigorous monitoring of clinical harm in place
- Proactive management of long-waiting patients continues but with an increasing spread across several specialities.
- Reduced flexibility/capacity across theatre complex during theatre refurbishment programme

Additional Slide 22b

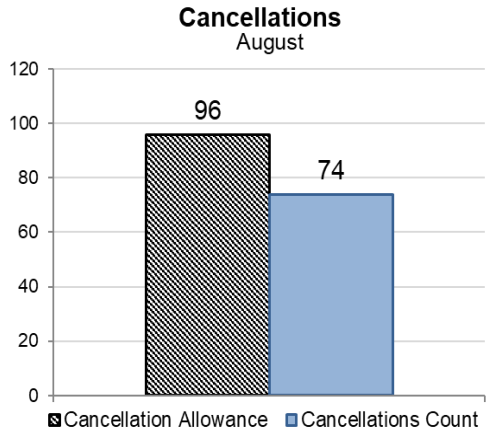
Performance (RTT) – Lead Director Richard Parker

Cancelled Operations

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

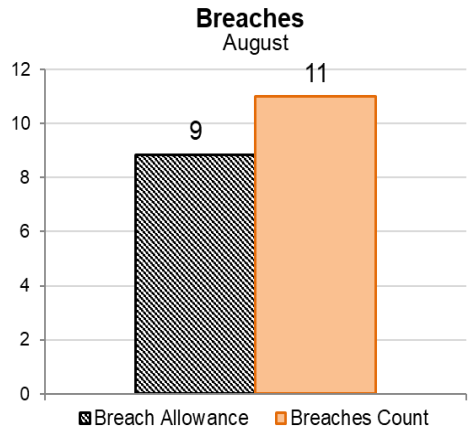


Month	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18
Total Breaches	9	10	22	8	20	24	8	9	8	28	21	52	36	12	6	9	11
Urgent Breaches	3	4	4	3	11	5	3	3	3	8	11	6	9	2	2	4	5



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

- Based on August's elective activity this would equate to **96** cancellations.
- NNUH saw **74** cancellations.
- This represented **0.8%** of elective activity.



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

- Based on August's last minute cancellations this would equate to **9** breaches.
- NNUH saw **11** breaches.
- This represented **14.9%** of cancellations.

Core Slide 23

Internal Sentinel Stroke Audit Programme (SSNAP) Dashboard

PERIOD	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18
OVERALL SSNAP SCORE	77.0	77.0	77.0	77.0	74.5	72.0	66.0	84.0	74.0	72.0	74.0	82.0	76.0
OVERALL SSNAP RATING	B	B	B	B	B	B	C	A	B	B	B	A	B
POTENTIAL STROKES	322	334	288	297	309	297	296	310	310	311	283	281	299
DIAGNOSED STROKES	104	108	99	91	97	98	107	112	106	93	80	103	91

DOMAIN 1 score	CT Scanning	86.6	86.6	86.6	86.6	85.3	84.0	73.5	96.7	87.7	93.3	82.5	96.7	93
DOMAIN 1 rating		B	B	B	B	B	C	C	A	B	B	C	A	A
DOMAIN 2 score	Stroke Unit	65.9	65.9	65.9	65.9	60.9	55.9	49.7	60.8	69.5	69	67	74.5	74.9
DOMAIN 2 rating		D	D	D	D	D	E	E	D	D	D	D	C	C
DOMAIN 3 score	Thrombolysis	71.6	71.6	71.6	71.6	70.6	69.6	63.4	71	55.3	66.4	65.7	75.8	75.4
DOMAIN 3 rating		B	B	B	B	B	C	D	B	D	C	C	B	B
DOMAIN 4 Score	Specialist Assessments	90	90	90	90	90.5	91	83.3	89.3	86.7	88	85.1	88	91
DOMAIN 4 Rating		A	A	A	A	A	A	B	B	B	B	B	B	A
DOMAIN 5 Score	Occupational Therapy	73.7	73.7	73.7	73.7	77.1	80.4	74.5	82.5	76.2	67	75.9	77.2	74.7
DOMAIN 5 Rating		C	C	C	C	B	A	C	A	B	C	B	B	C
DOMAIN 6 Score	Physiotherapy	79.5	79.5	79.5	79.5	74.7	69.8	76.3	80.2	78.6	73.2	75	76	75.1
DOMAIN 6 Rating		B	B	B	B	C	C	B	B	B	C	B	B	C
DOMAIN 7 Score	SALT	60.2	60.2	60.2	60.2	58.8	57.3	63.6	70.5	65.7	62.8	62.5	59.5	53.6
DOMAIN 7 Rating		C	C	C	C	C	C	C	B	B	C	C	C	D
DOMAIN 8 Score	MDT Working	80	80	80	80	78.8	77.6	78.2	82	79.5	75.8	80.9	81.9	79.2
DOMAIN 8 Rating		B	B	B	B	C	C	C	B	C	C	B	B	C
DOMAIN 9 Score	Standards by Discharge	93.5	93.5	93.5	93.5	95.8	98.0	97.7	97.9	98.7	95.7	97.9	98.3	92
DOMAIN 9 Rating		A	A	A	A	A	A	A	A	A	A	A	A	B
DOMAIN 10 Score	Discharge Process	99	99	99	99	99.5	100.0	100	100	100	100	100	100	98.3
DOMAIN 10 Rating		A	A	A	A	A	A	A	A	A	A	A	A	A

Internal overall SSNAP Rating for August 2018

B 76%

Overall Summary:

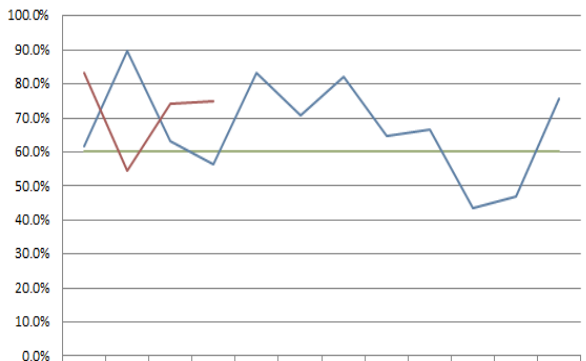
- Have held the performance across the Hyper-acute domains
- Therapy Domain performance have all dropped resulting in our drop to B rating
- The SSNAP QUIP team has been developing targeted interventions to improve SSNAP ratings consistently.

Action:

- Education and monitoring of the stroke escalation policy implementation
- Therapy workforce plan being developed

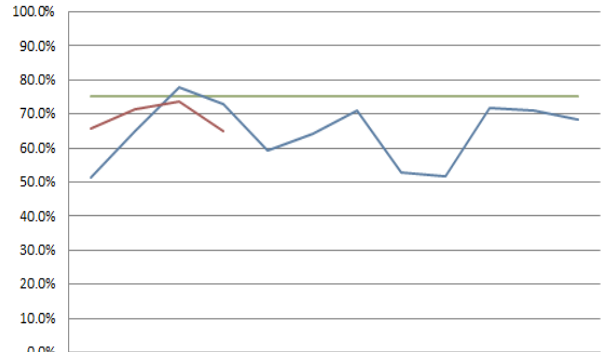
Core Slide 24 Performance (Cardiology) - Lead Director Richard Parker

% NSTEMI Time to Procedure < 72 Hours



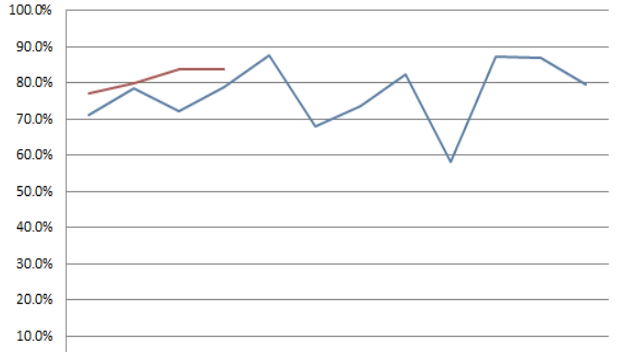
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Target	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%
2017-18	61.5%	89.7%	63.3%	56.5%	83.3%	70.6%	82.1%	64.9%	66.7%	43.5%	46.9%	75.8%
2018-19	83.3%	54.5%	74.4%	75.0%								

% PPCI Call to Balloon < 150 Minutes



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Target	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%
2017-18	51.4%	64.9%	77.8%	73.0%	59.4%	64.3%	71.1%	52.9%	51.6%	71.8%	71.1%	68.4%
2018-19	65.7%	71.4%	73.8%	64.9%								

% PPCI Door to Balloon < 60 Minutes



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2017-18	71.1%	78.4%	72.2%	78.9%	87.5%	67.9%	73.7%	82.4%	58.1%	87.2%	86.8%	79.5%
2018-19	77.1%	80.0%	83.7%	83.8%								

Standard Delivered

Breach reasons:
Our of area transfer
Delay in A&E
Pt already on the table
Journey >60 minutes
Self presented to non international hospital, delay in referral
Cardiac Arrest pre admission, further medical assessment required, emergency treatment required pre PPCI, another Pt already on the table.
Long on scene time, journey >60 minutes, difficult procedure

Standard delivered

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

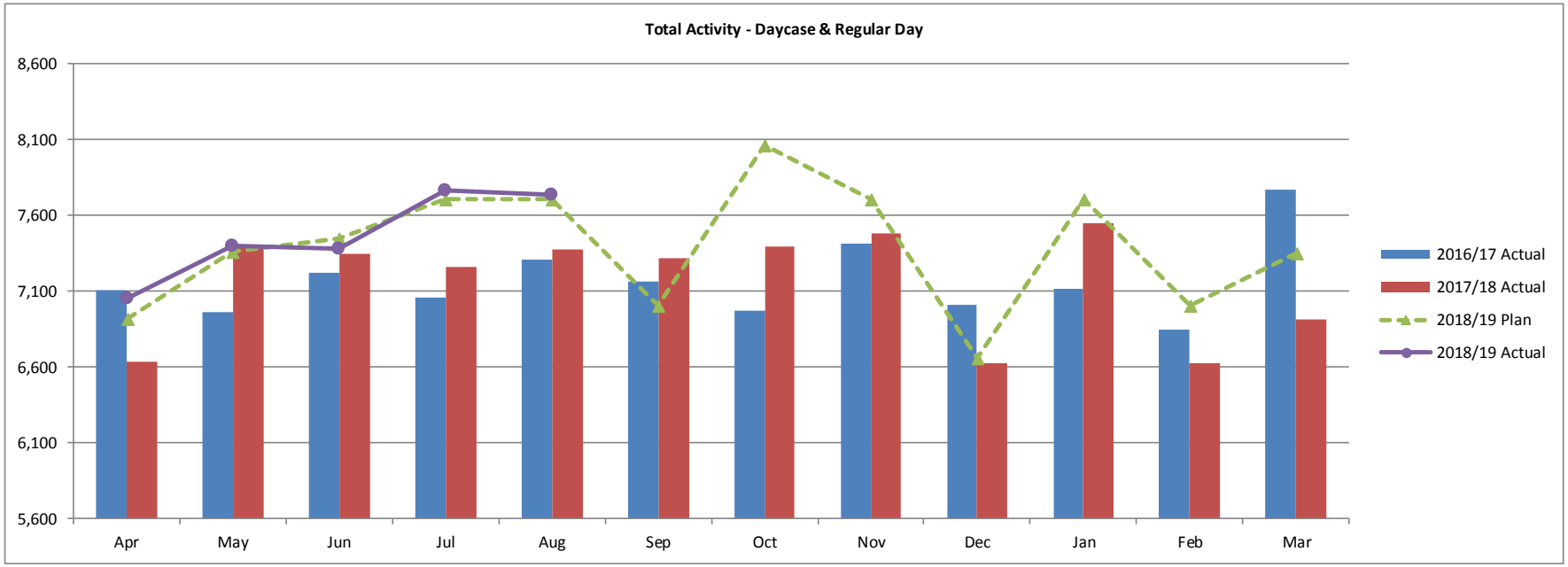
Productivity		Outturn 2017/18	Monthly Target	Aug-18	6 month trend	YTD 2017/18	YTD 2018/19
A&E Activity (attendances)		131235	11534	12260		56271	60213
Emergency Admissions	Core Slide 27	56018	4341	4902		22824	24284
Outpatient Activity (consultant led & non-consultant led)	Core Slide 27	725710	62229	61979		297911	317974
Elective Activity - Elective inpatient spells	Core Slide 28	13330	1198	1028		5681	5511
Elective Activity - Day case spells	Core Slide 28	85923	7709	7735		36019	37341

Core Slide 26

Performance (Productivity) – Lead Director Richard Parker

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

Activity	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Full Year
2016/17 Actual	7,111	6,959	7,219	7,063	7,311	7,161	6,970	7,419	7,013	7,113	6,846	7,774	35,663	85,959
2017/18 Actual	6,636	7,402	7,346	7,263	7,372	7,316	7,400	7,481	6,627	7,546	6,623	6,912	36,019	85,924
2018/19 Plan	6,920	7,360	7,449	7,709	7,709	7,006	8,064	7,707	6,656	7,708	7,010	7,356	37,147	88,654
2018/19 Actual	7,053	7,398	7,385	7,770	7,735								37,341	37,341
Variance to 2017/18	417	(4)	39	507	363								1,322	1,322
Variance to 2017/18 %	6.3%	-0.1%	0.5%	7.0%	4.9%								3.67%	
Variance to Plan	133	38	(64)	61	26								194	194
Variance to Plan %	1.9%	0.5%	-0.9%	0.8%	0.3%								0.52%	



Issues and Comment

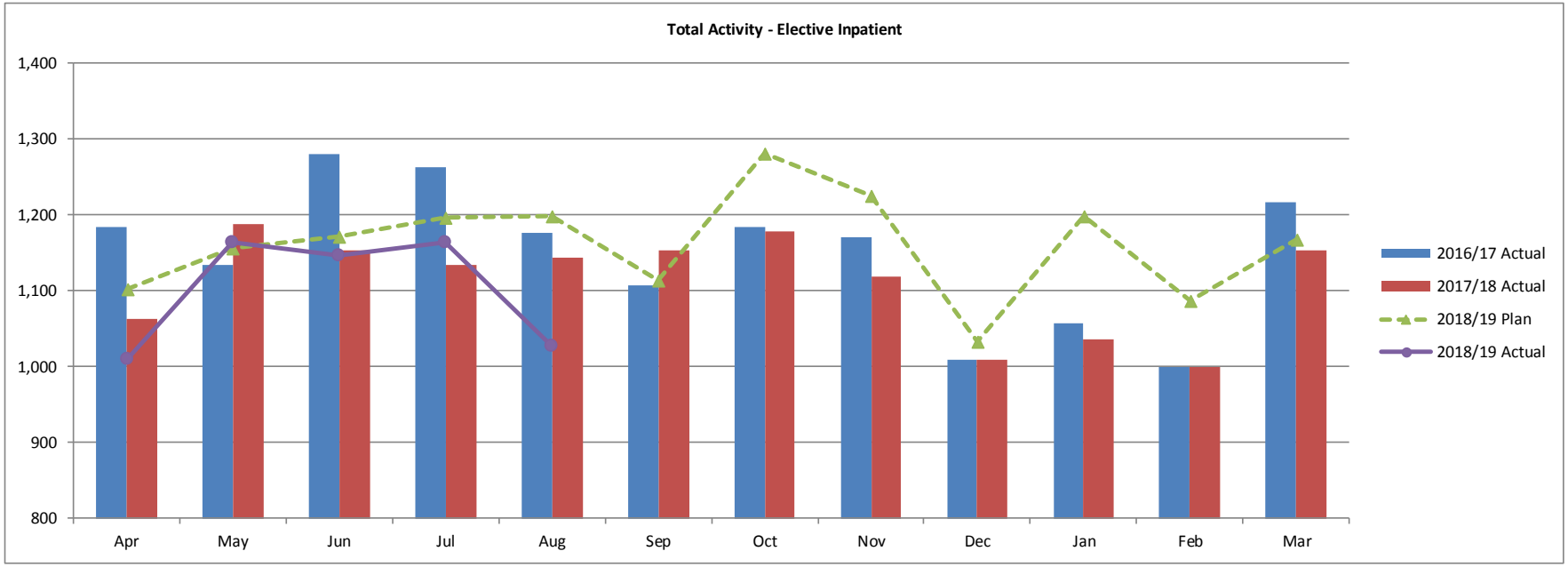
- Overall daycase performance was ahead of plan by 26 cases (0.3%) and 363 cases (4.9%) ahead of August 17 levels.
- This performance was again a mixed picture with +105 medicine over performance (principally gastro) & cardiology and surgery -277 cases down from plan (mainly dermatology). Dermatology have an ongoing challenge with capacity and demand, new outpatients prioritised to manage 2ww referrals, full compliment of Junior doctors from September will see an improving picture. Dermatology accounted for 209 cases behind the plan.
- Case mix shift in Surgery work with a high level of non-elective activity particularly in general surgery, plastics and urology, limiting over performance in day cases and electives as a result of theatre productivity programme

Additional Slide 26a

Performance (Productivity) – Lead Director Richard Parker

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

Activity	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Full Year
2016/17 Actual	1,184	1,134	1,280	1,263	1,177	1,107	1,184	1,171	1,009	1,057	999	1,217	**6,038**	**13,782**
2017/18 Actual	1,063	1,188	1,153	1,134	1,143	1,154	1,179	1,118	1,009	1,036	1,000	1,153	**5,681**	**13,330**
2018/19 Plan	1,101	1,156	1,172	1,197	1,198	1,114	1,282	1,225	1,033	1,199	1,087	1,167	**5,825**	**13,933**
2018/19 Actual	1,010	1,163	1,147	1,163	1,028								**5,511**	**5,511**
Variance to 2017/18	(53)	(25)	(6)	29	(115)								**(170)**	**(170)**
Variance to 2017/18 %	-5.0%	-2.1%	-0.5%	2.6%	-10.1%								**-2.99%**	
Variance to Plan	(91)	7	(25)	(34)	(170)								**(314)**	**(314)**
Variance to Plan %	-8.3%	0.6%	-2.2%	-2.8%	-14.2%								**-5.39%**	



Issues and Comment

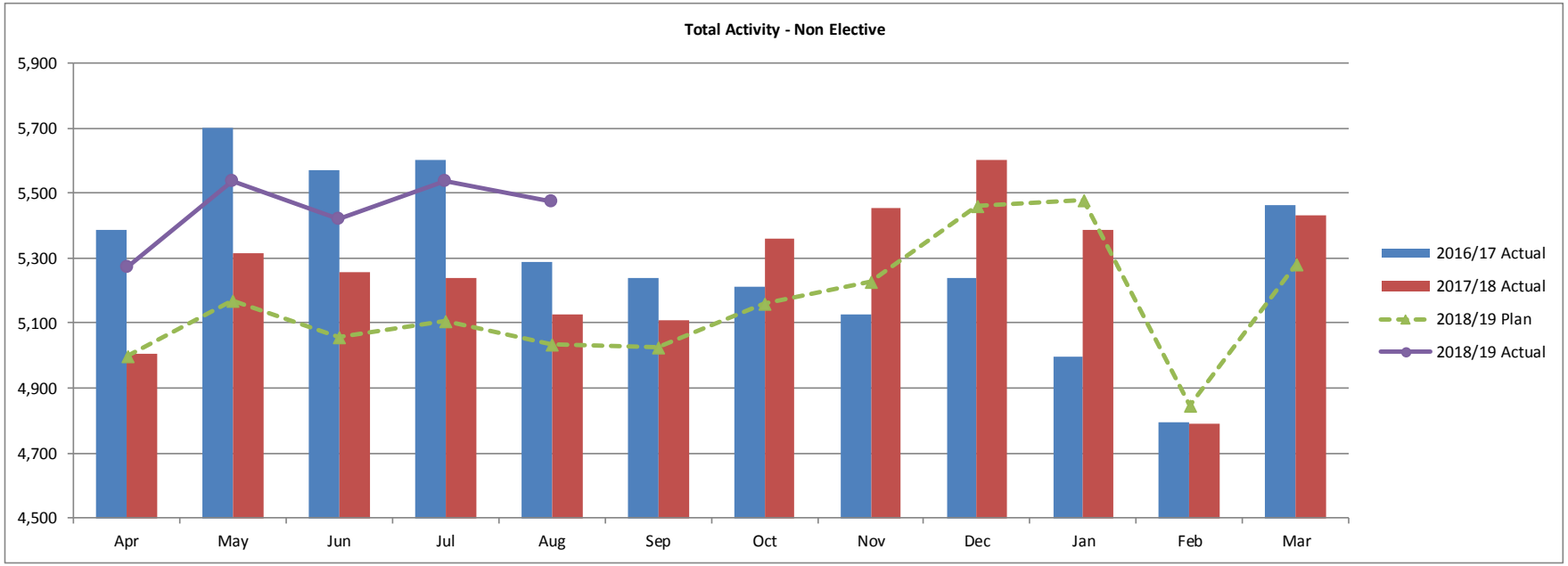
- Elective activity was 170 cases behind plan (-14.2%) and 115 cases (-10.1%) behind August 2017 levels.
- Surgery were 203 cases behind plan in month (due to T&O, general surgery and urology). Cardiology were also 74 cases behind plan. High levels of non-elective activity within the hospital and surgical specialities has had a knock on impact on electives. Significant over performance in thoracic surgery as a result of increase demand capacity switched from general surgery to thoracic surgery resulting in change in case mix and overall activity.
- Theatre productivity programme focusses on d/c electives. This is not reflected in current reporting therefore the plan will be corrected for future months i.e. the elective plan reduces and the day-case plan increases

Additional Slide 26b

Performance (Productivity) – Lead Director Richard Parker

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

Activity	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Full Year
2016/17 Actual	5,385	5,703	5,572	5,602	5,289	5,240	5,212	5,128	5,240	4,998	4,794	5,464	27,551	63,627
2017/18 Actual	5,006	5,314	5,255	5,239	5,127	5,111	5,359	5,453	5,601	5,388	4,788	5,432	25,941	63,073
2018/19 Plan	5,000	5,169	5,057	5,107	5,034	5,025	5,162	5,229	5,460	5,478	4,845	5,280	25,367	61,847
2018/19 Actual	5,274	5,539	5,421	5,539	5,474								27,247	27,247
Variance to 2017/18	268	225	166	300	347								1,306	1,306
Variance to 2017/18 %	5.4%	4.2%	3.2%	5.7%	6.8%								5.03%	
Variance to Plan	274	370	364	432	440								1,880	1,880
Variance to Plan %	5.5%	7.2%	7.2%	8.5%	8.7%								7.41%	



Issues and Comment

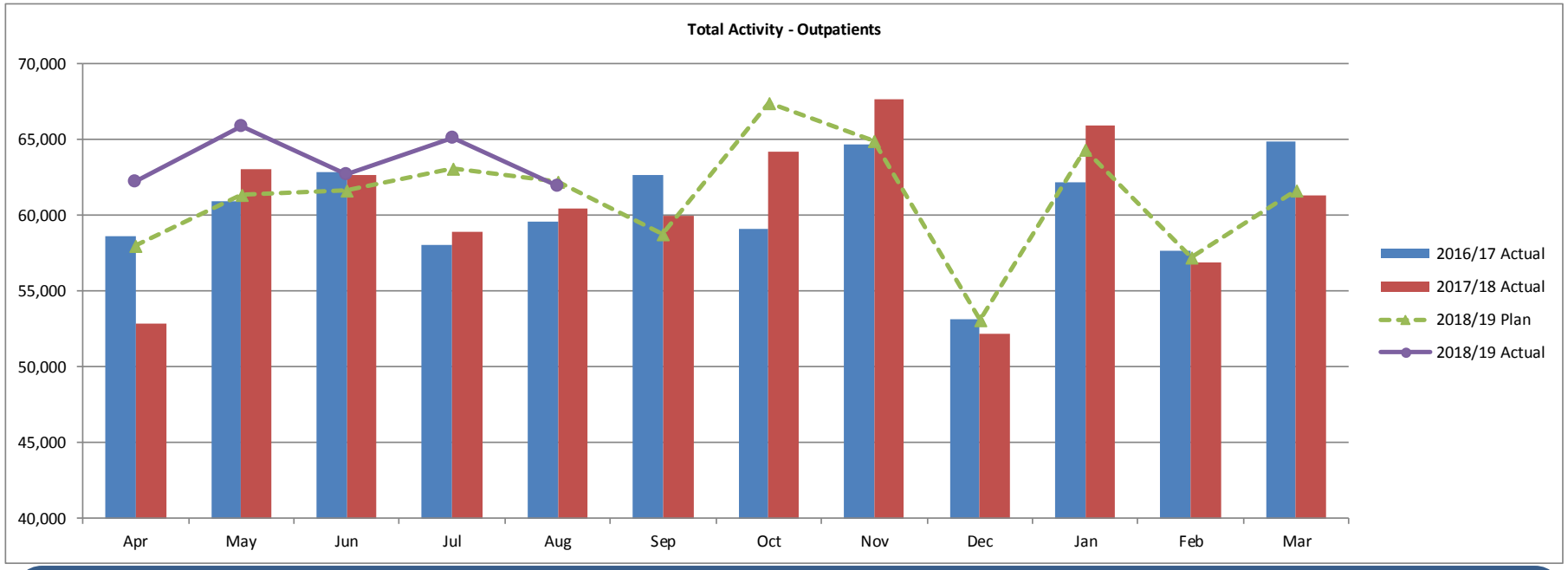
- Non-electives were 8.7% (440 cases) above business plan and 6.8% (347 cases) above prior year levels. The levels of non-elective admissions remain a cause for concern re the impact on elective capacity.
- An early warning contract notice has been issued to commissioners to highlight concern around growing levels of non-elective demand.
- The main areas of over performance were across surgery (+213 cases) as well as women & children (+46 cases) – with the worst hit specialities being general surgery / plastics / urology and paediatrics.

Additional Slide 26c

Performance (Productivity) – Lead Director Richard Parker

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

Activity	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Full Year
2016/17 Actual	58,647	60,971	62,885	58,054	59,595	62,622	59,078	64,679	53,131	62,166	57,652	64,853	300,152	724,333
2017/18 Actual	52,854	63,012	62,641	58,913	60,491	60,005	64,170	67,685	52,135	65,980	56,915	61,313	297,911	726,114
2018/19 Plan	58,005	61,327	61,643	63,068	62,229	58,746	67,457	64,977	53,084	64,342	57,259	61,639	306,272	733,777
2018/19 Actual	62,223	65,871	62,750	65,151	61,979								317,974	317,974
Variance to 2017/18	9,369	2,859	109	6,238	1,488								20,063	20,063
Variance to 2017/18 %	17.7%	4.5%	0.2%	10.6%	2.5%								6.73%	
Variance to Plan	4,218	4,544	1,107	2,083	(250)								11,702	11,702
Variance to Plan %	7.3%	7.4%	1.8%	3.3%	-0.4%								3.82%	

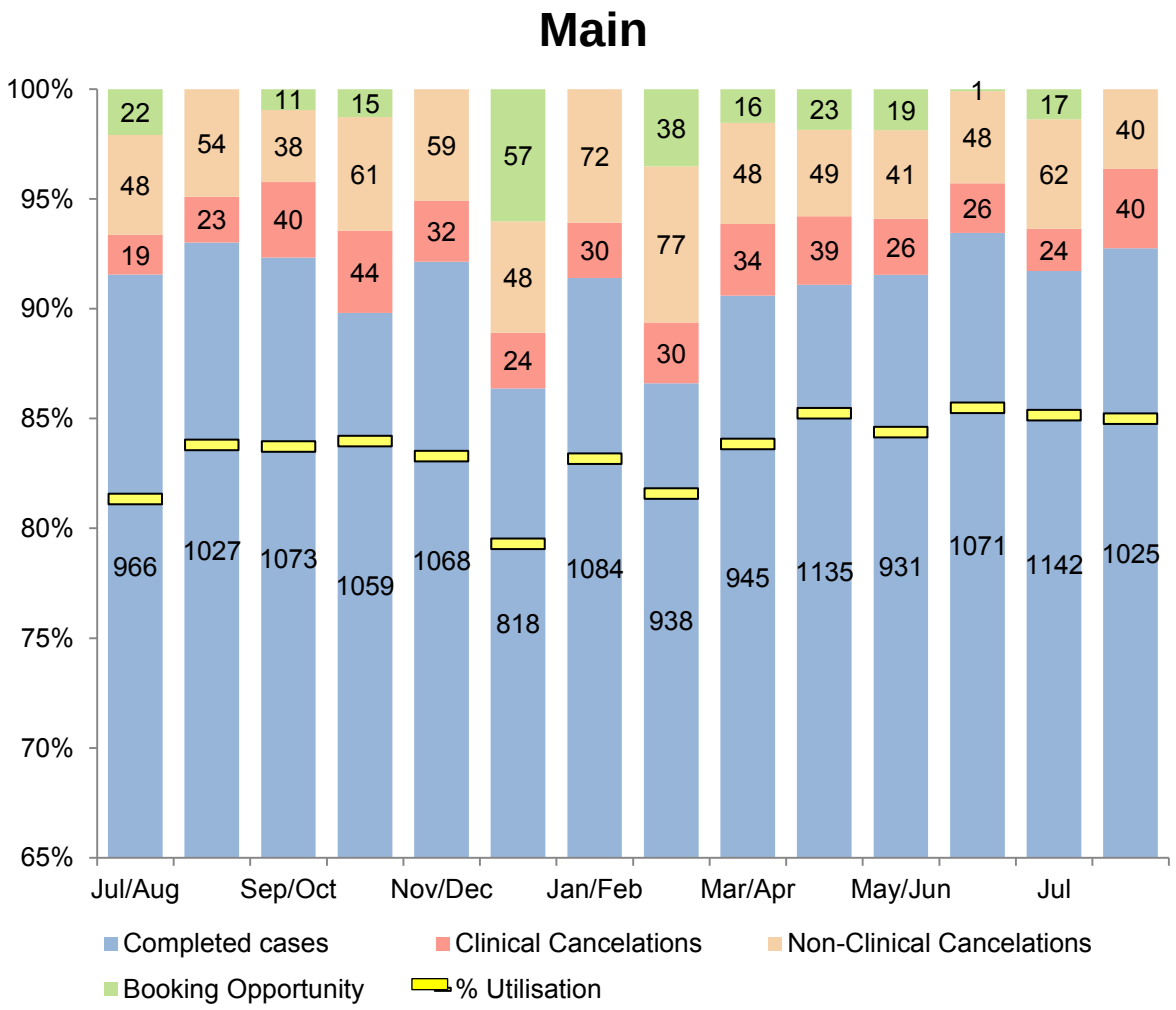


Issues and Comment

- OP activity performance for August was .04% behind plan and 2.5% ahead of 2017/18.
- Overall consultant OP news were behind plan (-2,682) – driven by shortfalls in surgery (-1,810) (particularly Ophthalmology, T&O and Dermatology) and Gynaecology (-181 cases). Staffing gaps in surgical specialities the main driver for the shortfall. Recovery expected in dermatology and T&O over October/November.
- Overall consultant follow-ups were also behind plan (-669) with gains in medicine (+877) being offset by surgery (-1,417).

Additional Slide 26d

Theatre Productivity (Main) – Lead Director Richard Parker



Issues

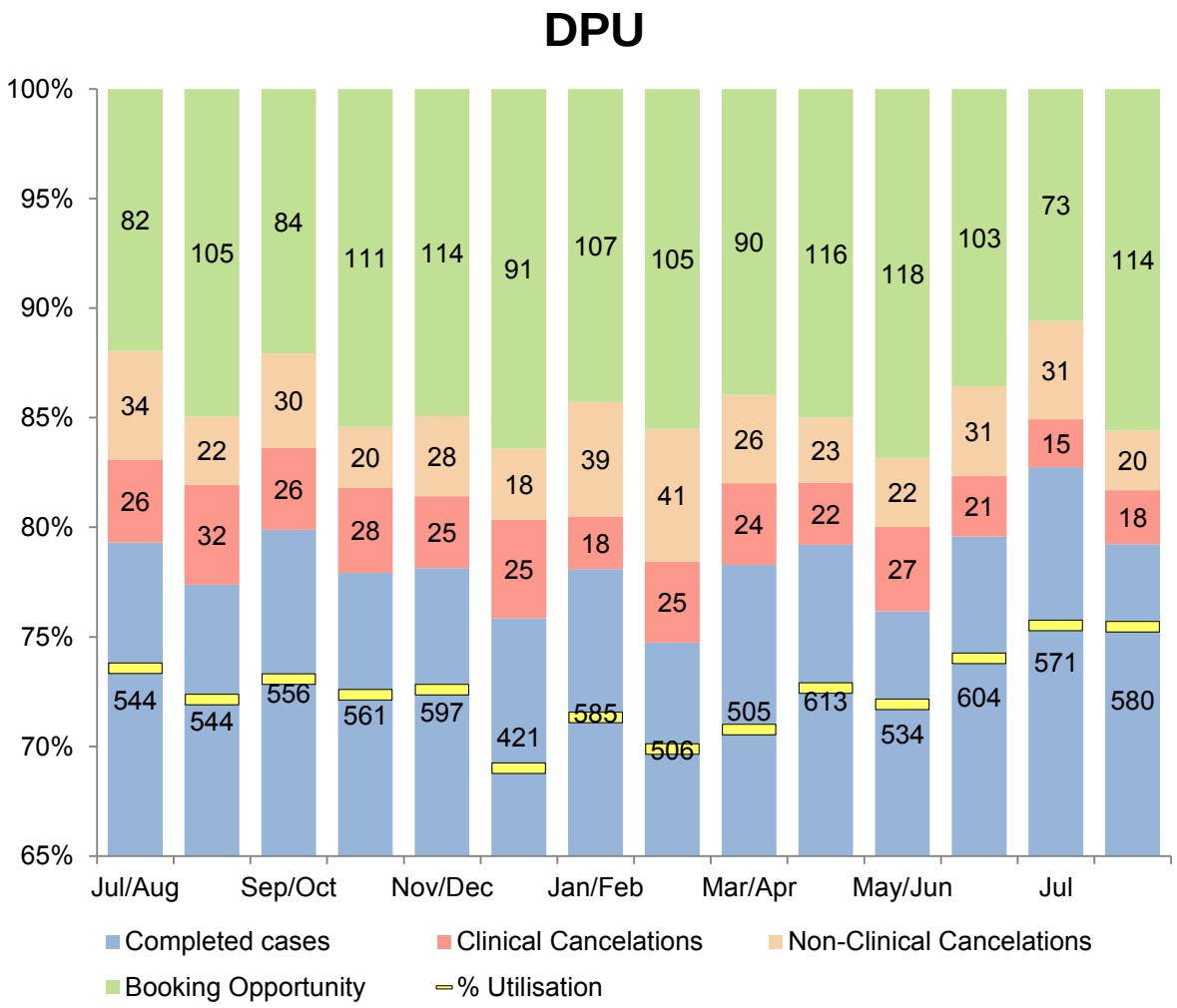
- Main theatre continue to see improvements in last four week cycle with no booking opportunity identified.
- Non elective demand in surgery impacting on patient flow.
-

Actions

-lock down of lists at 4 weeks for surgeon and 2 weeks for patients top priority
-Surgical bed model reviewed and plans to increase capacity under way.

Additional Slide 26e

Theatre Productivity (DPU) – Lead Director Richard Parker



Issues

- Signs of recovery from winter period with % opportunity realised and % utilisation both climbing over the last 4 four week periods.

Booking opportunity still remains in DPU

Actions

- Prioritise lock down of lists at 4 weeks and patients booked by 2 weeks
- Clinical cancellations under review in urology and processes changes planned.
- POA review and reallocation under review to standardise processes and increase flexibility between Day cases and inpatients.

Core Slide 27

Workforce Summary – Lead Director Jeremy Over

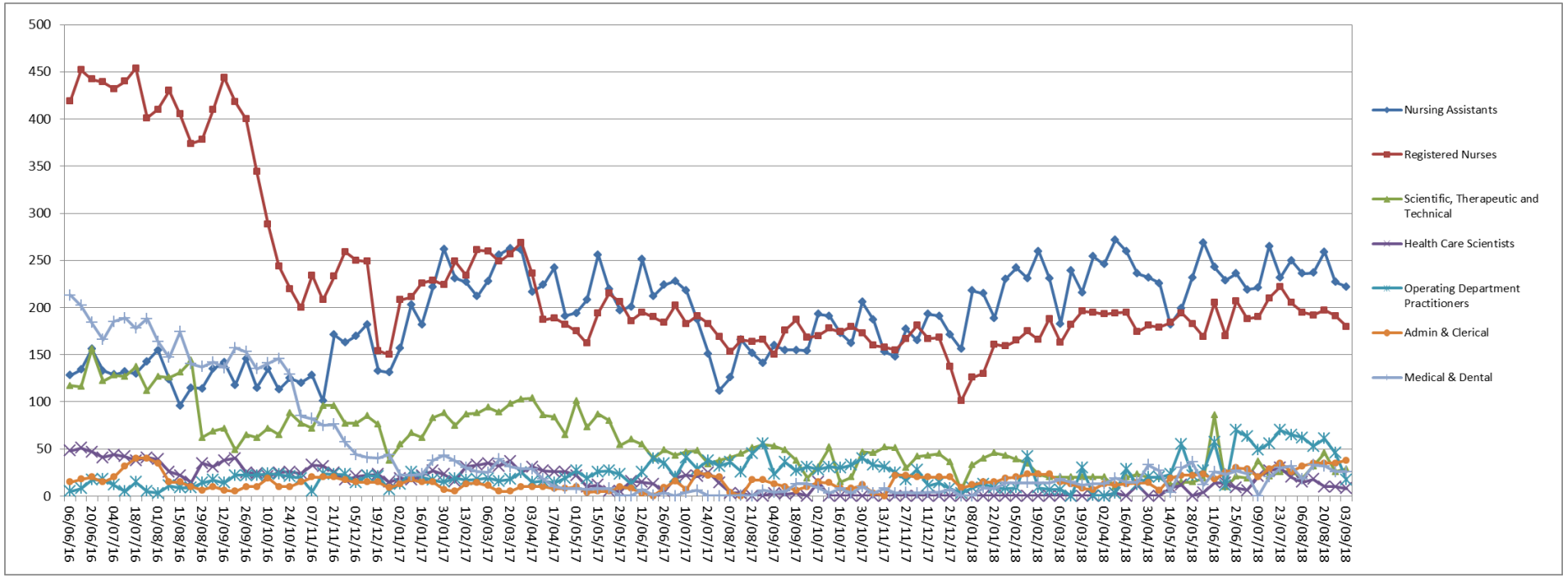
Workforce		Outturn 2017/18	Monthly Target	Aug-18	6 month trend	YTD 2017/18	YTD 2018/19
Payroll							
1 Budgeted WTE*		7360	n/a	TBC		7360	TBC
2 Actual WTE*		6830	n/a	TBC		6830	TBC
3 Vacancy maximum (%)		7.20%	10.00%			7.20%	
Pay Spend							
4 Pay spend - % employed (%)*		90.13%	n/a	88.88%		89.94%	89.46%
5 Pay spend - % bank (%)*		3.29%	n/a	4.31%		3.30%	3.66%
6 Pay spend - % agency (%)*		2.56%	n/a	2.62%		2.56%	2.64%
7 Pay Spend - % Medical Locum (%)*		2.38%	n/a	2.35%		2.48%	2.50%
Staffing Numbers	Core Slide 36						
8 % of registered nurse day hours filled as planned		92.30%	n/a	85.80%		92.94%	89.50%
9 % of unregistered care staff day hours filled as planned		123.25%	n/a	111.69%		128.39%	111.42%
10 % of registered nurse night hours filled as planned		93.85%	n/a	89.66%		93.47%	92.62%
11 % of unregistered care staff night hours filled as planned		138.08%	n/a	144.99%		139.50%	143.51%
12 RGN % Actual to planned		92.96%	n/a	87.41%		93.17%	90.80%
13 HCA % Actual to planned		129.30%	n/a	124.43%		133.02%	123.61%
14 Care hours per patient day (registered)		3.9	n/a	4.0		3.9	4.1
15 Care hours per patient day (Non-registered)		3.3	n/a	3.6		3.3	3.6
16 Care hours per patient day (Total)		7.3	n/a	7.7		7.3	7.7
Other							
17 Appraisals completed	Core Slide 32	65.80%	80.00%	77.05%		67.06%	71.03%
18 Staff Turnover rate	Core Slide 33	10.43%	10.00%	10.53%		10.79%	10.35%
16 Mandatory Training	Core Slide 34	83.13%	90.00%	83.74%		82.45%	82.49%
17 Sickness levels**	Core Slide 35	4.03%	3.50%	3.90%		3.53%	3.74%
18 Time to Hire (All)		68.5	n/a	77.8		68.5	72.7
Staff Survey							
19 Staff FFT – recommendation of NNUH as a place to receive care		72%	n/a	76%		TBC	TBC
20 Staff FFT – recommendation of NNUH as a place to work		56%	n/a	61%		TBC	TBC

* Please note these figures are provisional

** Reported one month in arrears

Core Slide 28 — Workforce - Lead Director Jeremy Over

Agency and Locum Shifts Booked

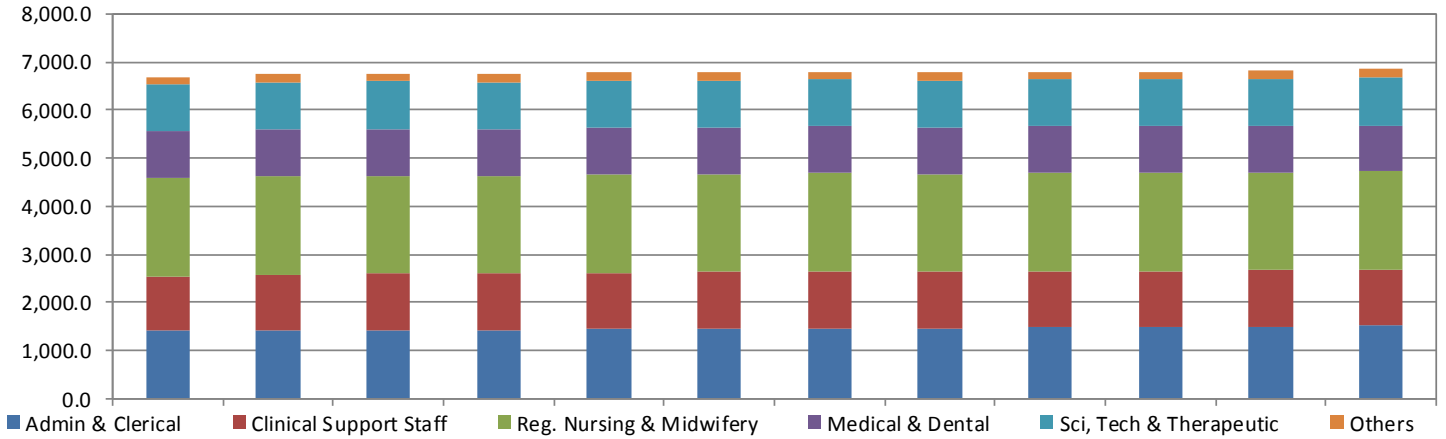


Commentary

- Month 5 agency expenditure is detailed in the Finance IPR section
- Controls continue to be effective and responsive to situations where temporary workers are absolutely required based on clinical need and safety grounds.
- The Finance section of the IPR details the expenditure for the month.
- Weekly price cap compliance consistently above 75% (compared to c.0% in September 2016).
- Break glass arrangements only for exceptional safety grounds (with executive level sign off).
- Pre-authorisation checklist and daily scrutiny by Medical Director for all locum requests has been very effective.
- Recruitment Oversight Group is in operation and applies controls to avoid cost pressures and assists with speedy recruitment.
- Bank incentives have had an impact on RN 'bank hours worked'.

Core Slide 29 — Workforce - Lead Director Jeremy Over

Workforce Staff in Post - WTE



Staff Group	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Difference	*% change*
Admin & Clerical	1,400.0	1,424.2	1,429.9	1,429.8	1,444.1	1,452.0	1,458.5	1,461.7	1,478.8	1,481.3	1,490.1	1,505.8	105.8	*7.6*
Clinical Support Staff	1,148.1	1,151.8	1,159.9	1,160.7	1,168.7	1,170.4	1,171.0	1,167.3	1,169.3	1,171.8	1,173.5	1,171.9	23.8	*2.1*
Reg. Nursing & Midwifery	2,034.0	2,052.5	2,045.5	2,021.3	2,055.1	2,043.7	2,048.1	2,045.0	2,035.7	2,031.2	2,040.1	2,036.6	2.6	*0.1*
Medical & Dental	967.3	978.6	978.1	975.9	967.5	966.1	973.5	965.3	970.7	968.8	955.3	971.2	3.9	*0.4*
Sci, Tech & Therapeutic	971.2	977.8	982.9	980.9	984.8	983.3	978.9	973.8	977.3	978.1	983.9	997.6	26.5	*2.7*
Others	167.9	166.5	171.0	168.3	166.8	164.9	164.9	161.0	161.6	163.4	162.0	160.0	-7.9	*-4.7*
Grand Total	**6,688.5**	**6,751.2**	**6,767.2**	**6,736.9**	**6,787.0**	**6,780.4**	**6,794.9**	**6,774.0**	**6,793.4**	**6,794.5**	**6,804.9**	**6,843.2**	**154.7**	***2.3***

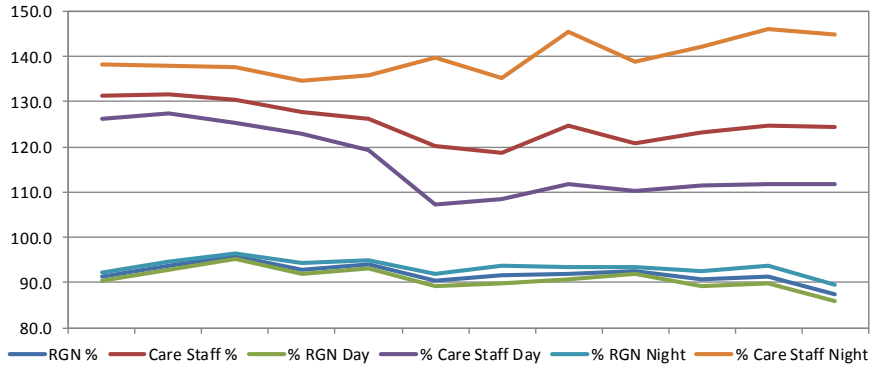
Commentary

- This slide / graph details the numbers of staff in post (WTE) at month end.
- The graph stacks the staff in post by staff group.
- Overall, in the last twelve months, there are 154 additional staff, an increase of 2.3% across NNUH as a result of service developments and capacity and quality investments.

Core Slide 30

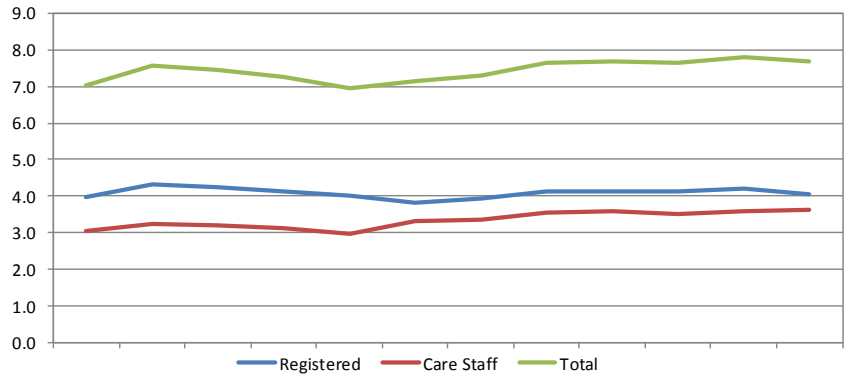
Workforce - Lead Director Jeremy Over

Ward Nursing fill-rate Analysis



	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
RGN %	91.3	93.6	95.8	92.9	94.0	90.5	91.6	91.9	92.7	90.7	91.4	87.4
Care Staff %	131.4	131.8	130.4	127.7	126.2	120.1	118.8	124.7	120.8	123.3	124.8	124.4
% RGN Day	90.4	92.9	95.3	91.8	93.3	89.3	89.9	90.6	92.1	89.3	89.7	85.8
% Care Staff Day	126.4	127.3	125.4	122.9	119.3	107.4	108.4	111.9	110.2	111.5	111.7	111.7
% RGN Night	92.3	94.6	96.6	94.4	95.0	92.1	93.9	93.6	93.5	92.7	93.7	89.7
% Care Staff Night	138.4	138.0	137.6	134.6	135.9	139.9	135.1	145.3	138.9	142.2	146.1	145.0

Care Hours per Patient Day - CHPPD



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

Escalations

<80% RN fill rate for August:

Ward	RN Fill Rate %
Denton	79.0
GMDU	63.9
MLBU	76.3

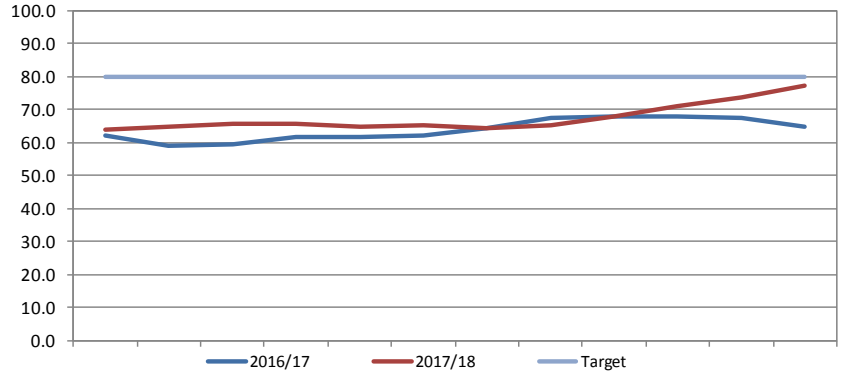
Commentary

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

Core Slide 31

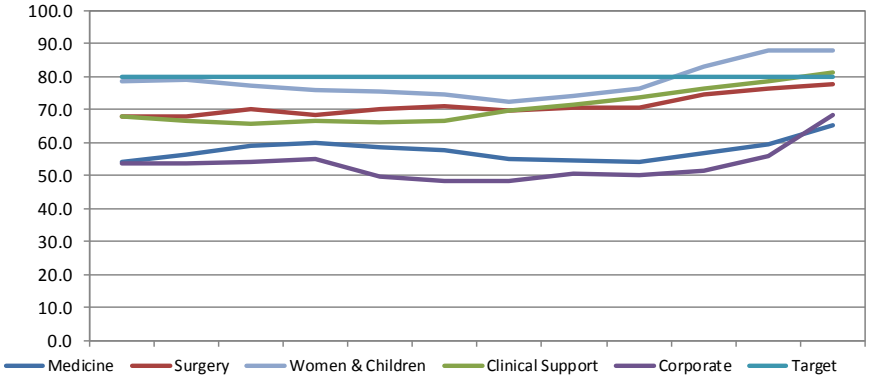
Workforce - Lead Director Jeremy Over

Appraisals completed - Trust



Division	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
2016/17	62.1	59.1	59.6	61.6	61.8	62.1	64.4	67.3	67.8	67.8	67.5	64.9
2017/18	64.0	64.6	65.6	65.5	65.0	65.1	64.5	65.3	68.0	71.2	73.6	77.0
Target	80.0	80.0	80.0	80.0	80.0	80.0	80.0	80.0	80.0	80.0	80.0	80.0

Appraisals completed - Divisions



Division	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
Medicine	54.10	56.47	59.21	59.81	58.69	57.55	55.04	54.50	54.33	56.89	59.50	65.09
Surgery	67.95	68.06	69.94	68.44	70.04	70.85	69.90	70.57	70.76	74.66	76.50	77.55
Women & Children	78.78	78.97	77.24	75.72	75.45	74.51	72.46	74.10	76.48	83.14	88.04	88.02
Clinical Support	67.81	66.62	65.76	66.49	66.25	66.74	69.69	71.63	73.64	76.56	78.38	81.30
Corporate	53.73	53.57	54.03	54.81	49.82	48.21	48.21	50.54	50.27	51.52	55.69	68.15
Target	80.00	80.00	80.00	80.00	80.00	80.00	80.00	80.00	80.00	80.00	80.00	80.00

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

Commentary

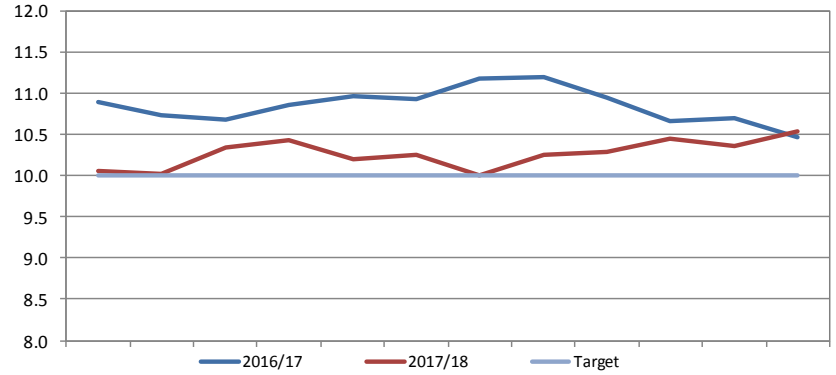
- Improvement of the annual appraisal completion rate is a must do from the CQC inspection.
- As part of the QPB update, regular updates on divisional and corporate departments are being circulated with an expectation that all staff with an outstanding appraisal have a date scheduled in the coming weeks and months.
- 77.0% of eligible staff (Non medical and Medical Staff) have had an appraisal during the last 12 months. Furthermore the rate of non-medical appraisals has increased from 65% to 74.9% in the past 2 months
- The NHS Staff Survey results suggest that 83% of our staff have responded that they have been appraised in the last 12 months (up from 82% in 2016). Also, the survey reports an increase in the quality of appraisals from 2016 to 2017 (the 'rating' increasing from 2.90 to 3.03 of a scale of 1-5).
- A review of the non-medical appraisals confirms a consistency of 75% of staff have had an appraisal in the last 15 months and 80% in the last 18 months. This at least provides re-assurance that the majority of our staff are experiencing an appraisal, and aligns itself more closely to the Staff Survey response.
- Efforts continue to be focused on maximising compliance.

Corporate Breakdown	Eligible	Current	Compliance %
Communications	4	4	100.0%
Improvement Team	7	7	100.0%
Clinical Effectiveness & Audit	9	9	100.0%
Workplace Health & Wellbeing	34	33	97.1%
Commisioning, Data Quality, Coding	53	51	96.2%
Human Resources	61	53	86.9%
Training, Learning & Development	25	21	84.0%
Information Technology	58	48	82.8%
Practice Development	20	16	80.0%
Complaints & Legal	13	10	76.9%
Ops Centre	23	16	69.6%
Infection Control	14	9	64.3%
Finance	35	22	62.9%
Integrated Discharge	43	23	53.5%
Research*	90	46	51.1%
Safeguarding	8	4	50.0%
Estates & Facilities	35	13	37.1%
Other**	40	12	30.0%
Risk Mgt & Incident Reporting	7	1	14.3%
PMO	5	0	0.0%

Core Slide 32

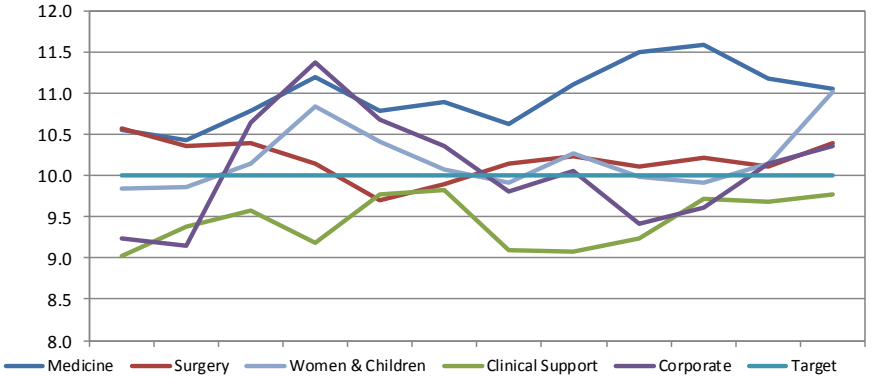
Workforce - Lead Director Jeremy Over

Annualised Staff Turnover rate - Trust



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

Annualised Staff Turnover rate - Divisions



Division	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
Medicine	10.55	10.44	10.79	11.19	10.79	10.89	10.63	11.11	11.50	11.58	11.19	11.06
Surgery	10.58	10.36	10.40	10.15	9.70	9.90	10.14	10.23	10.10	10.21	10.10	10.40
Women & Children	9.85	9.87	10.15	10.84	10.42	10.08	9.91	10.27	9.99	9.91	10.15	11.03
Clinical Support	9.02	9.39	9.57	9.18	9.77	9.82	9.10	9.07	9.24	9.72	9.69	9.78
Corporate	9.23	9.16	10.64	11.38	10.68	10.35	9.81	10.05	9.42	9.61	10.15	10.36
Target	10.00	10.00	10.00	10.00	10.00	10.00	10.00	10.00	10.00	10.00	10.00	10.00

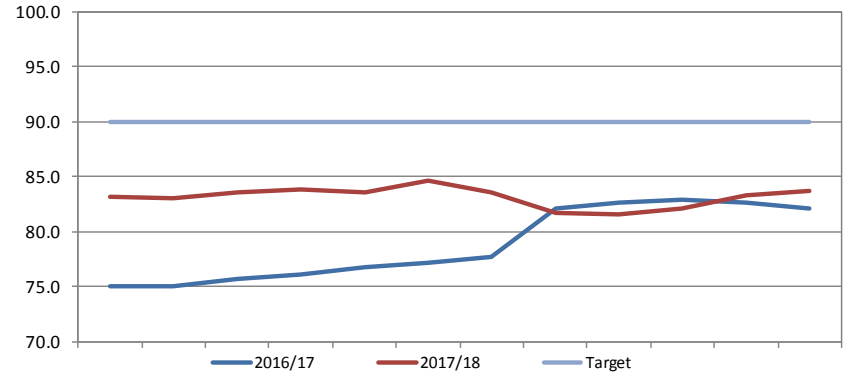
Commentary

- The Turnover rate is the percentage of the workforce that has left NNUH over the past twelve months. It is a 12-month rolling figure.
- The calculation excludes fixed-term contracts, (for instance junior doctors on rotational training programmes).
- The 12-month Turnover rate continues to be low and is the same as August 2017.
- For each month since June 2017 the annual turnover rate has been lower than in the corresponding monthly figure from 12 months previously.
- Reduced turnover means greater retention of knowledge and skill in our teams, and reduced volume of replacement recruitment activity and induction / on-boarding.

Core Slide 33

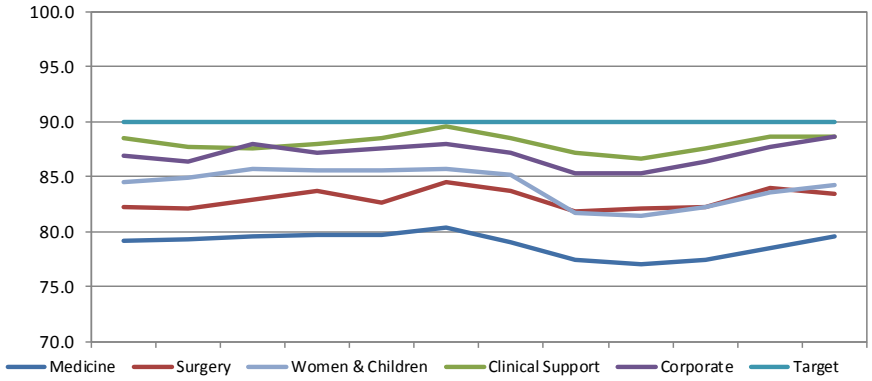
Workforce - Lead Director Jeremy Over

Mandatory Training - Trust



Division	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
2016/17	75.0	75.0	75.7	76.1	76.8	77.1	77.6	82.0	82.6	82.9	82.6	82.1
2017/18	83.2	83.0	83.5	83.8	83.6	84.6	83.6	81.7	81.6	82.1	83.3	83.7
Target	90.0	90.0	90.0	90.0	90.0	90.0	90.0	90.0	90.0	90.0	90.0	90.0

Mandatory Training - Divisions



Division	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
Medicine	79.22	79.31	79.60	79.73	79.67	80.38	79.00	77.46	77.06	77.45	78.50	79.60
Surgery	82.28	82.04	82.85	83.70	82.67	84.54	83.72	81.81	82.15	82.21	83.90	83.40
Women & Children	84.45	84.93	85.68	85.51	85.55	85.73	85.20	81.71	81.40	82.20	83.60	84.27
Clinical Support	88.51	87.68	87.63	88.00	88.50	89.57	88.52	87.12	86.66	87.56	88.57	88.68
Corporate	86.90	86.39	87.95	87.16	87.61	88.02	87.17	85.27	85.27	86.41	87.69	88.70
Target	90.00	90.00	90.00	90.00	90.00	90.00	90.00	90.00	90.00	90.00	90.00	90.00

Commentary

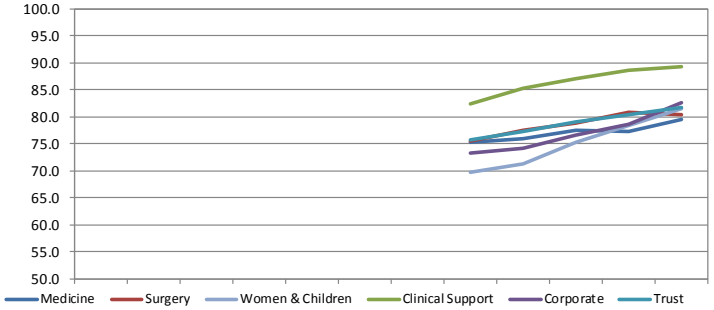
- Improvement of mandatory training attendance is a must do from the CQC inspection.
- A paper was presented to HMB in August, suggesting further activity to improve compliance. A further update to HMB will be presented in September.
- The overall compliance rate has remained above 80% since April 2017.
- New Mandatory Training topics have had a marginal impact on compliance rates, with targeted work taking place to encourage completion.
- A series of improvements and interventions are in place to support enhanced compliance. These include training days/events where support is available to maximise mandatory training and a range of support options for staff accessing eLearning.
- Divisional level mandatory training rates are discussed at divisional performance committee.
- The Head of OD & Learning is leading on a project to address the capacity and system constraints that need to be overcome in order to enable greater take-up of mandatory training which is resulting in ongoing improvements.
- The 'one-stop-shop' training events for staff to receive updates on a number of training topics in one sitting has been running since September and has been well received by our staff.

Additional Slide 33a

Workforce - Lead Director Jeremy Over

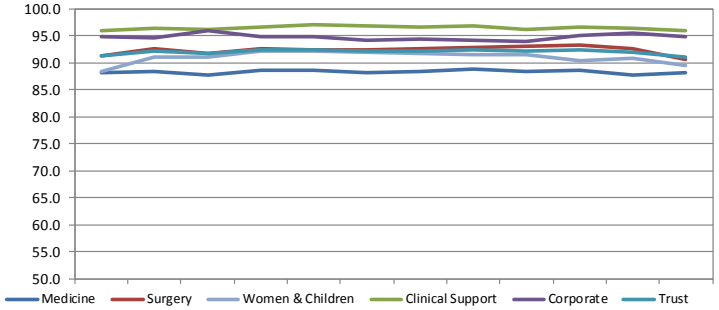
Mandatory Training – CQC 'must do'

MCA/DoLS Training - Divisions



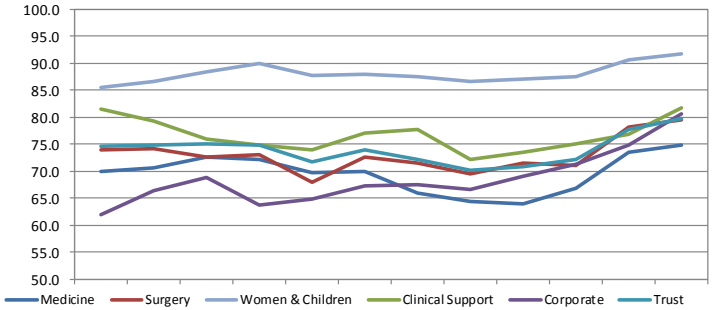
Division	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
Medicine								75.37	76.01	77.45	77.36	79.56
Surgery								75.44	77.50	78.84	80.87	80.44
Women & Children								69.81	71.33	75.17	78.29	81.41
Clinical Support								82.46	85.29	86.97	88.53	89.27
Corporate								73.33	74.07	76.69	78.68	82.61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

Safeguarding Children Training - Divisions



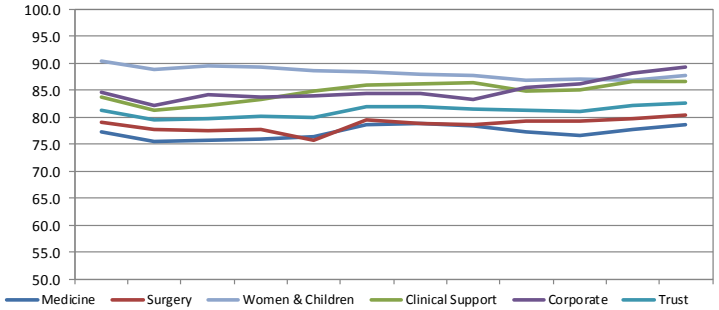
Division	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
Medicine	88.22	88.38	87.84	88.53	88.56	88.17	88.38	88.91	88.50	88.55	87.72	88.13
Surgery	91.40	92.61	91.85	92.72	92.38	92.39	92.57	92.79	93.08	93.22	92.67	90.55
Women & Children	88.42	91.06	91.16	92.22	92.22	92.04	91.66	91.60	91.53	90.41	90.92	89.44
Clinical Support	95.88	96.44	96.29	96.62	97.09	96.96	96.73	96.89	96.11	96.71	96.50	95.88
Corporate	94.96	94.59	95.96	94.84	94.92	94.22	94.45	94.15	94.04	95.02	95.56	94.89
Trust	91.33	92.08	91.79	92.36	92.38	92.15	92.19	92.42	92.19	92.33	91.96	91.16

Resus (Adult) Training - Divisions



Division	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
Medicine	69.99	70.54	72.66	72.15	69.60	69.97	66.00	64.43	63.97	66.90	73.53	74.85
Surgery	74.03	74.25	72.56	72.99	67.93	72.55	71.53	69.45	71.44	70.98	78.16	79.39
Women & Children	85.60	86.65	88.50	89.88	87.69	88.00	87.60	86.72	87.17	87.52	90.65	91.71
Clinical Support	81.59	79.23	75.97	74.79	74.01	77.02	77.71	72.22	73.40	75.04	76.89	81.83
Corporate	61.83	66.31	68.85	63.64	64.92	67.37	67.57	66.49	68.95	71.28	74.87	80.61
Trust	74.56	74.81	74.96	74.75	71.82	74.02	72.26	70.09	70.87	72.16	77.72	79.64

Infection Control Training - Divisions



Division	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
Medicine	77.26	75.57	75.73	75.96	76.47	78.71	78.76	78.31	77.24	76.52	77.81	78.70
Surgery	79.07	77.83	77.45	77.66	75.71	79.57	78.94	78.66	79.27	79.34	79.74	80.37
Women & Children	90.32	88.83	89.45	89.19	88.67	88.37	88.06	87.73	86.88	87.12	86.81	87.70
Clinical Support	83.71	81.30	82.22	83.30	84.88	85.98	86.13	86.34	84.81	84.98	86.57	86.52
Corporate	84.70	82.20	84.11	83.75	83.93	84.50	84.44	83.23	85.60	86.25	88.13	89.18
Trust	81.17	79.41	79.77	80.11	80.00	82.04	81.86	81.55	81.19	81.11	82.07	82.72

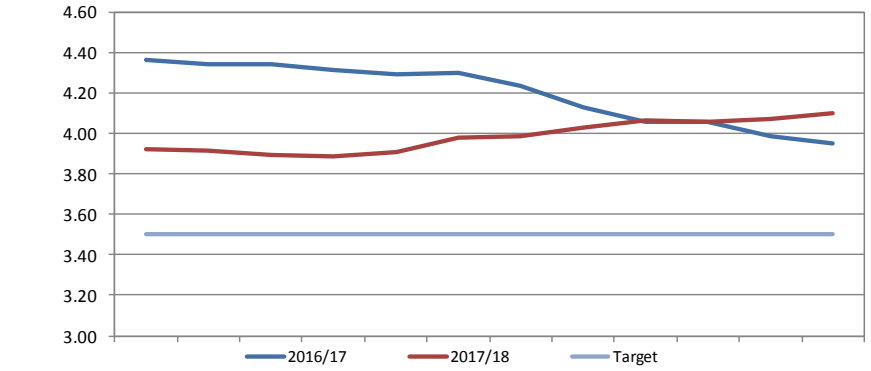
Commentary

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

Core Slide 34

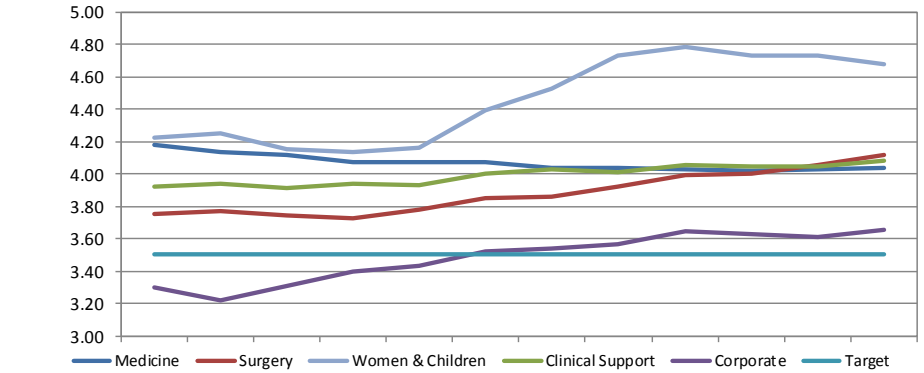
Workforce - Lead Director Jeremy Over

Sickness levels (12 month rolling average)



Division	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul
2016/17	4.36	4.34	4.34	4.32	4.30	4.30	4.23	4.13	4.06	4.06	3.99	3.95
2017/18	3.93	3.92	3.90	3.89	3.91	3.98	3.99	4.03	4.07	4.06	4.07	4.10
Target	3.50	3.50	3.50	3.50	3.50	3.50	3.50	3.50	3.50	3.50	3.50	3.50

Sickness levels (12 month rolling average)



Division	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul
Medicine	4.18	4.13	4.12	4.07	4.08	4.07	4.04	4.04	4.03	4.02	4.03	4.04
Surgery	3.76	3.77	3.75	3.73	3.78	3.85	3.86	3.92	3.99	4.00	4.06	4.12
Women & Children	4.22	4.25	4.15	4.13	4.16	4.39	4.53	4.73	4.79	4.74	4.73	4.68
Clinical Support	3.93	3.94	3.92	3.94	3.93	4.00	4.03	4.01	4.05	4.05	4.04	4.08
Corporate	3.30	3.22	3.31	3.39	3.43	3.52	3.54	3.57	3.65	3.63	3.61	3.65
Target	3.50	3.50	3.50	3.50	3.50	3.50	3.50	3.50	3.50	3.50	3.50	3.50

** Reported one month in arrears

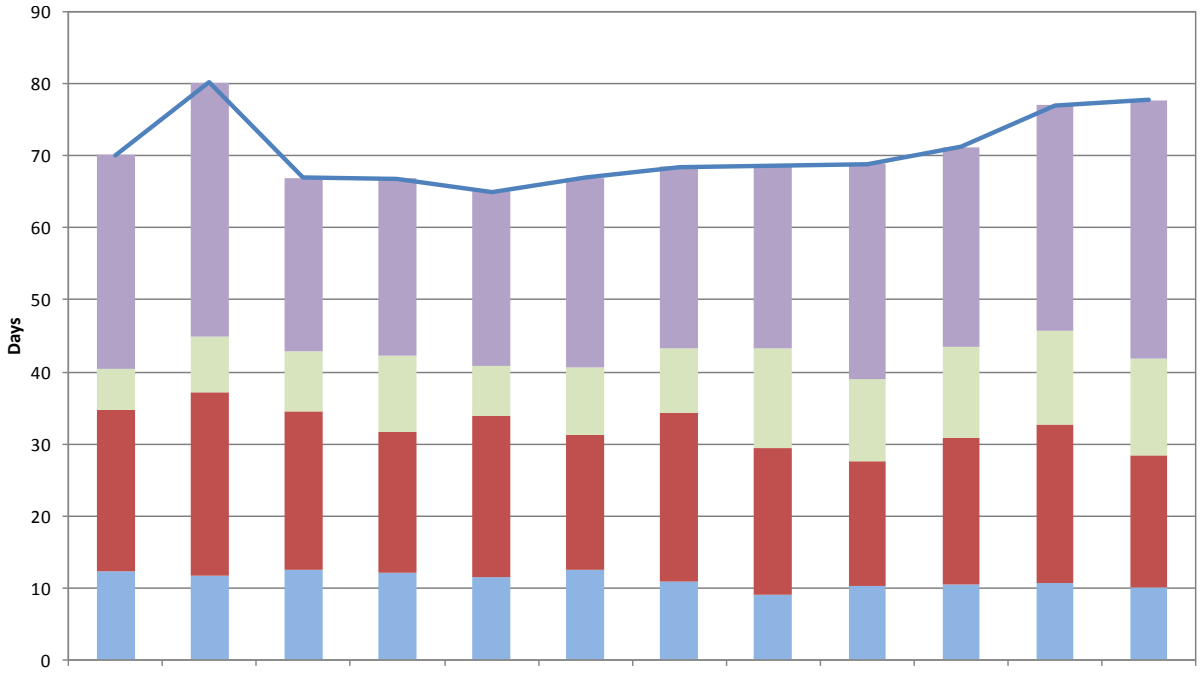
Commentary

- The most significant indicator is the rolling 12-month average sickness rate.
- As at 31 July 2018, the rate is 4.1% and this represents a significant reduction of 7% on the peak from August 2016 and equates to the equivalent of approximately 25 additional staff (headcount) being available every day.
- Despite the impact of flu/gastro in December to March, sickness levels are returning to lower rates with the forecast being a reduction the 12 month rolling average during 2018/19. Expectations are that the seasonally adjusted rate will be at 3.9% (or lower), by the end of the year.
- Data recently published by the Department of Health for the calendar year of 2017 indicates that on average there were 9.1 lost working days per staff member.
- This 'ranks' NNUH as 83rd out of 224 Trusts. For comparison, QEH has 11.2 days, NCHC has 10.9 days, JPH has 9.3 days and Cambridge 7.3 days.
- NB. For data accuracy and reliability purposes, sickness figures are reported one-month in arrears.

Core Slide 35

Workforce - Lead Director Jeremy Over

Recruitment Time to Hire



Recruitment Stage	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18
Total Time to Hire	70.2	80.2	67.0	66.9	65.1	67.0	68.5	68.6	68.9	71.2	77.0	77.8
Checks Complete	29.7	35.2	24.2	24.7	24.2	26.4	25.2	25.3	29.9	27.8	31.3	35.9
Time to Offer	5.7	7.9	8.4	10.5	6.8	9.2	9.1	13.9	11.4	12.5	13.0	13.5
Time with Manager	22.5	25.3	21.9	19.7	22.5	18.8	23.3	20.3	17.4	20.5	22.2	18.2
Time to advert close	12.2	11.7	12.5	12.0	11.5	12.6	10.9	9.1	10.3	10.5	10.6	10.1
Number at checks complete	129	137	151	107	134	112	109	105	130	140	122	114

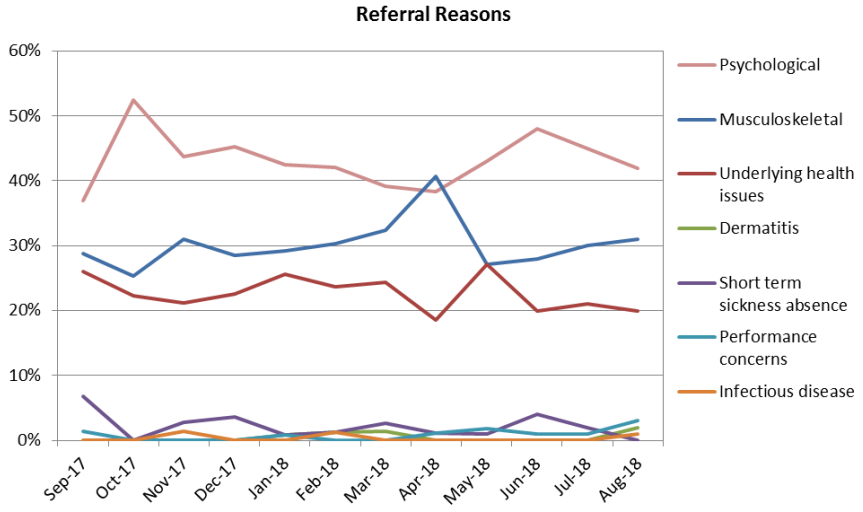
Commentary

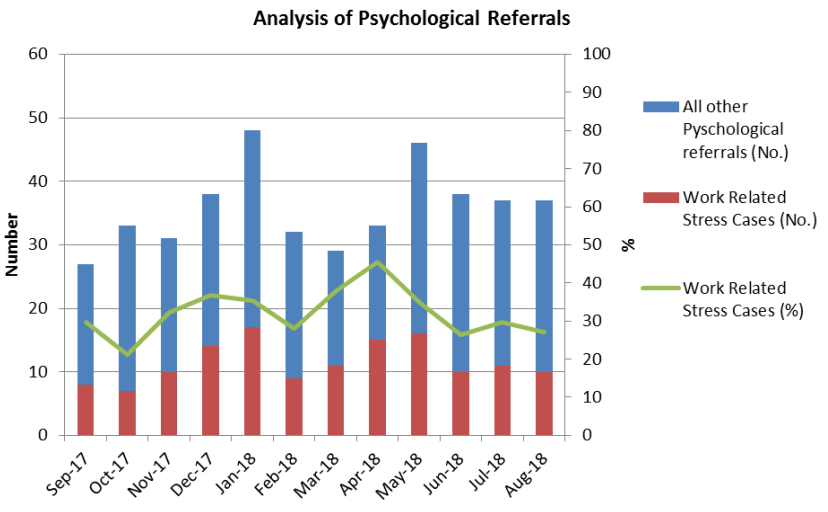
- This data reflects all substantive recruitment through our Trac system.
- It now reflects all the recruitment which has been centralised to the central recruitment team at Rouen Road.
- The HR team continue to work with Managers in order to avoid unnecessary recruitment delays.
- Our like for like Time to Hire figure reflects positively with other Trusts.

Core Slide 36

Workforce - Lead Director Jeremy Over

Staff Health, Safety and Wellbeing





Commentary

- The first graph reflects the trend in respect of all referrals (by managers, or self-referral) to Workplace, Health and Wellbeing.
- There were 89 referrals in August 2018 which was a similar level to July 2018 and 14% increase since August 2017. There remains a continued trend of the highest % of referrals being related to psychological referrals.
- The second graph reflects the trend for psychological referrals (by managers, or self-referral) received by Workplace, Health and Wellbeing.
- Of the new psychological referrals seen in this month 10 were considered to be work caused which is a similar level in comparison to July 2018 (11) and June 2018 (10)

Additional Slide 36a

Workforce - Lead Director Jeremy Over

Consultant Job Plans

Stage	Trust	Medicine	Surgery	Women & Children	Clinical Support	Other
Total Consultants	470	157	185	58	68	1
Job plans signed off	155	52	38	14	51	0
	33.0%	33.1%	20.5%	24.1%	75.0%	0.0%
In discussion stage/ draft stage	132	47	40	35	8	1
	28.1%	29.9%	21.6%	60.3%	11.8%	100.0%
Awaiting sign off	183	58	107	9	9	0
	38.9%	36.9%	57.8%	15.5%	13.2%	0.0%

Commentary

- The above chart reflects progress in respect of the introduction of Electronic Job Planning for Consultants as at 9 September 2018
- E-job planning was introduced from April 2017 with extensive engagement and consultation with Consultants.
- Oversight of e-job planning sits with an E-job Planning Advisory Panel which reports into the Medical Workforce Group, chaired by the Director of Workforce, and attended by senior clinicians from each Division.
- There is a need to accelerate the sign off of the first round of e-job plans.

Core Slide 37 – Workforce – supplementary briefing

Leadership and Culture

Leading with PRIDE
The first of the Leading with PRIDE masterclasses took place in September, with the Hospital Management Board pilot. A further 700 line managers are scheduled to attend the development programme during the two weeks commencing 17 September. These one day masterclasses will help build a culture we can be proud of, promoting positive team cultures that care for colleagues and supports the safest and highest quality care for our patients.

New resources have been produced in collaboration with staff under the umbrella, 'Communicating with PRIDE' which represents a new framework for promoting 'Dignity at Work' – supporting staff, managers and colleagues who have either experienced, are handling or witnesses inappropriate behaviour at work, including bullying.

Freedom to Speak Up
The recruitment of a dedicated Lead Freedom to Speak Up Guardian attracted 50 applications. Further to shortlisting, the selection process will conclude shortly. A range of staff will be involved in the assessment day.

Staff Survey 2018

Preparations are underway for the 2018 national staff survey; survey forms will be sent to all staff during the first week of October. During September we have brought together all of the various improvements from the last 12 months into a '*You said, we did*' document to highlight the progress made.

Misconduct Policy

The new Misconduct Policy (replacing the disciplinary policy) went live on 3 September 2018 and has been well received by Managers. The policy was produced in partnership with our Trade Union colleagues.

Apprenticeships success

Our Apprenticeships team have received two regional awards recognising their success in recruiting and developing apprentices at NNUH, as detailed in the Chief Executive's report to the Board. This highlights the role the team play in developing the future workforce of NNUH, with many apprentices moving into substantive employment and further education, retaining talented individuals within the Norfolk healthcare system.

Core Slide 38

Finance - Lead Director John Hennessey

Executive Summary

- The actual deficit for the year to date is £23.3m, being £0.1m better than budget.
- The in-month position, before mitigation is £1m worse than budget, mainly due to clinical income being £1m worse than budget. This has been mitigated by releasing £0.9m of the 'risk' accrued in months 1-4.
- The remaining risk accrued at end M5 is £0.97m. Thus we could have reported an improved cumulative position by this amount.
- Opex at end M5, net of drugs income is £1.68m better than budget (0.7% small fav variance) comprising:, Pay of £0.6m (0.4%), Drugs-net of £0.18m, Clinical Supplies of £0.5m (1.8%) and Non Clinical Supplies of £0.4m (1.1%).
- The CIP target is £30m (5% of opex). The YTD CIP budget is £7.9m with actual YTD being £8.7m. The profile of CIPs is £10m in the first half year and £20m in the second half year.

Key Risks

- Delivering the £30m cost improvement programme – currently £6.4m yet to reach Gateway 2
- No specific provision for any of the unbudgeted risks which include CQUIN (£1.4m), AfC reform underfunding of Serco staff (£0.5m), and any penalties arising in 2018/19.
- Securing cash loan support from DHSC for the 2018/19 revenue and capital plans.

Financial Summary

I&E Performance YTD	£23.3m	Deficit
I&E Variance against budget YTD	£0.1m	Favourable
Movement in month against budget	£-0.1m	Adverse
Cash at Bank	£7.6m	Favourable
Borrowings	£74.9m	Favourable
Net cash / borrowings	£2.8m	Favourable
CIP Variance against budget YTD	£0.8m	Favourable
Note:		
Risk - put away	*£1m*	*Favourable*
£7m Reserve - Accrued to Date	*£1.1m*	*Nil variance*
Clinical Income against budget YTD	*£-1.4m*	*Adverse*

SUMMARY INCOME AND EXPENDITURE ACCOUNT	In Month			Year to Date			Full Year Budget		
	Actual £m	Budget £m	Variance (adv)/fav £m	Actual £m	Budget £m	Variance (adv)/fav £m	Forecast £m	Budget £m	Variance (adv)/fav £m
Clinical Income excluding NT Drugs	37.4	38.4	(1.0)	186.0	187.4	(1.4)	454.9	454.9	0.0
NT Drugs	5.9	5.8	0.1	28.0	28.8	(0.8)	69.2	69.2	0.0
Other Income	8.3	7.6	0.7	32.4	33.1	(0.7)	76.3	76.3	0.0
TOTAL OPERATING INCOME	51.6	51.8	(0.2)	246.4	249.3	(2.9)	600.4	600.4	0.0
Pay Costs	(30.7)	(30.4)	(0.3)	(146.1)	(146.7)	0.6	(351.0)	(351.0)	0.0
Drugs	(6.9)	(6.9)	0.0	(33.4)	(34.4)	1.0	(82.3)	(82.3)	0.0
Other Non Pay Costs	(14.7)	(14.9)	0.2	(72.9)	(73.8)	0.9	(177.7)	(177.7)	0.0
TOTAL OPERATING EXPENSES	(52.3)	(52.2)	(0.1)	(252.4)	(254.9)	2.5	(611.0)	(611.0)	0.0
EBITDA	(0.7)	(0.4)	(0.3)	(6.0)	(5.6)	(0.4)	(10.6)	(10.6)	0.0
Depreciation	(0.8)	(0.9)	0.1	(4.3)	(4.4)	0.1	(11.0)	(11.0)	0.0
Finance Costs	(2.6)	(2.7)	0.1	(13.1)	(13.4)	0.3	(33.4)	(33.4)	0.0
Other - PDC, Disposals & Interest Income	0.0	0.0	0.0	0.1	0.0	0.1	0.0	0.0	0.0
(Deficit)/surplus after tax excluding Donated Additions	(4.1)	(4.0)	(0.1)	(23.3)	(23.4)	0.1	(55.0)	(55.0)	0.0

Core Slide 39

Finance - Lead Director John Hennessey

Income and Expenditure Summary as at August 2018

The reported I&E position for August is a deficit of £4.1m, against a planned deficit of £4.0m. This results in an adverse variance of £0.1m in month (favourable variance of £0.1m YTD). The reported position is after recognising £0.9m of 'risk accrual' release. Without this the in-month position would have been £1m worse than budget.

Clinical Income, is £1m worse than budget in month, being the main driver of the adverse in-month position, before mitigation.

The mitigation is a release from the total amount of 'risk' accrued at the end of M4 which was £1.84m. We have released £0.86m to leave £0.97m still accrued at the end of M5. The accrual and movements to it is reported within non clinical income.

Summary of I&E Indicators

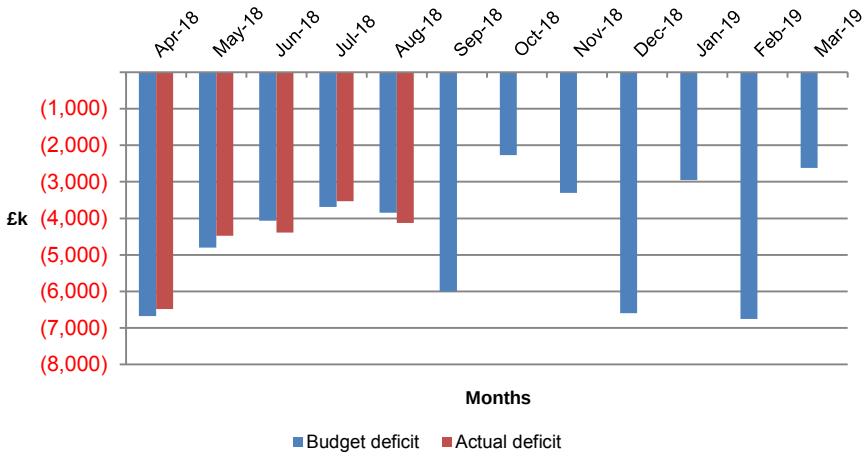
Income and Expenditure	Actual / Forecast £'000	Budget / Target £'000	Variance to Budget (adv) / fav £'000	Direction of travel (variance)	RAG
In month (deficit) / surplus	(4,131)	(3,986)	(145)	↓	Amber
YTD (deficit) / surplus	(23,381)	(23,446)	65	↓	Green
Forecast (deficit) / surplus	(55,000)	(55,000)	0	↔	Green
Clinical Income YTD	215,179	217,534	(2,355)	↓	Red
Non Clinical Income YTD	31,184	31,784	(600)	↑	Red
Pay YTD	(146,138)	(146,739)	601	↓	Green
Non Pay YTD	(106,245)	(108,175)	1,930	↑	Green
Non Opex YTD	(17,419)	(17,846)	427	↑	Green
CIP Target YTD	8,699	7,890	809	↓	Green

Criteria:

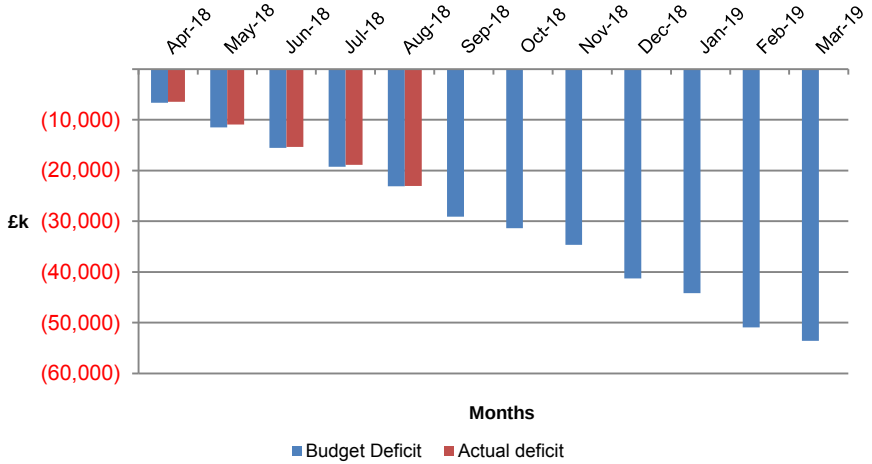
Green	Favourable or nil variance
Amber	Adverse Variance less than £200k
Red	Adverse Variance more than £201k

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

Monthly I&E deficit against budget for 2018/19



Cumulative I&E deficit against budget for 2018/19

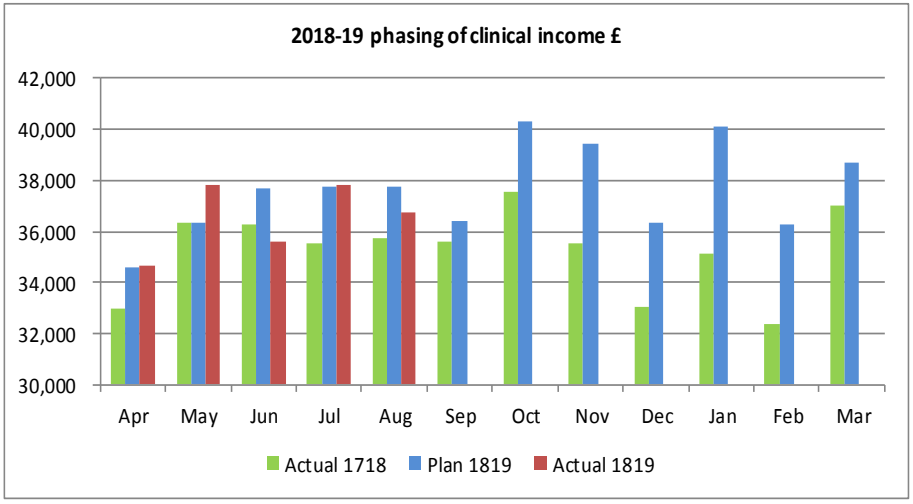


Core Slide 40

Finance - Lead Director John Hennessey

Income Analysis

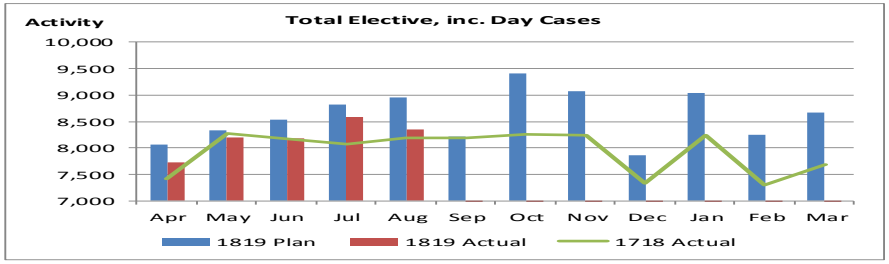
The chart below sets out the monthly phasing of the clinical income plan (exc Spire to aid prior yr comparison) for 2018 / 19. This phasing is in line with activity phasing which is how the income is recognised. The phasing is responsive to actual days and working days, hence the monthly variation.

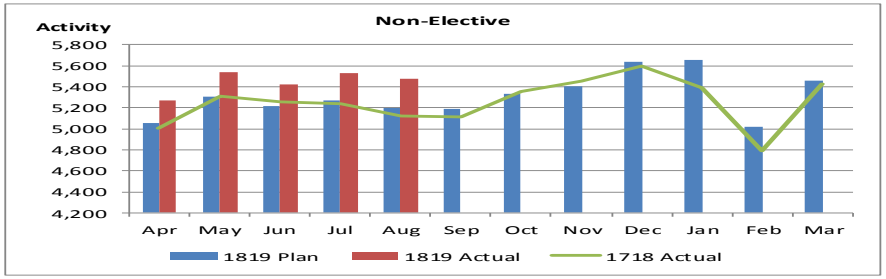


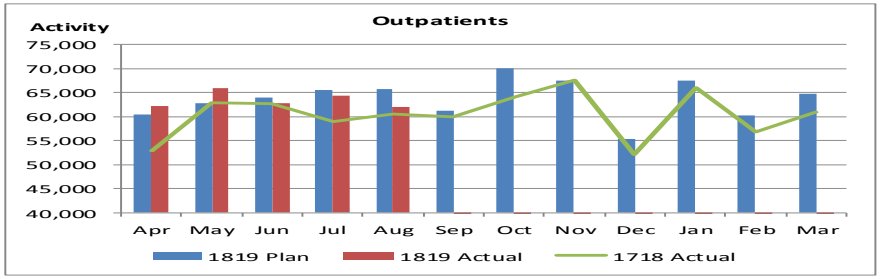
The income position was behind plan for August, with the under-performance mainly within Surgery - £1.26m. Overall Electives have under-performed by £596k, OP by £461k.

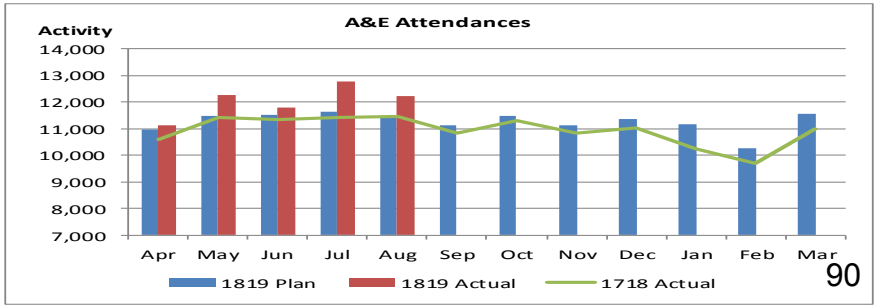
	Current month			Year to date		
Income (£'000s)	**Plan**	**Actual**	**Variance**	**Plan**	**Actual**	**Variance**
Daycase	4,431	4,364	-68	21,462	21,015	-448
Elective	4,164	3,569	-596	19,890	18,763	-1,127
Non Elective	11,570	12,413	843	57,785	61,047	3,262
Marginal Rate Reduction	-720	-904	-184	-3,526	-4,394	-868
Accident & Emergency	1,431	1,481	50	7,121	7,296	175
Outpatients	6,747	6,287	-461	32,815	32,366	-449
CQUIN	824	820	-4	4,024	4,118	95
C&V	6,131	5,835	-296	29,619	29,375	-245
Other*	3,816	3,500	-316	18,167	16,390	-1,776
Total	**38,387**	**37,364**	**-1,023**	**187,357**	**185,976**	**-1,381**

* includes M5 actuals of; EPA (£1.2m), Spire (£1.4m), Block (£0.8m).









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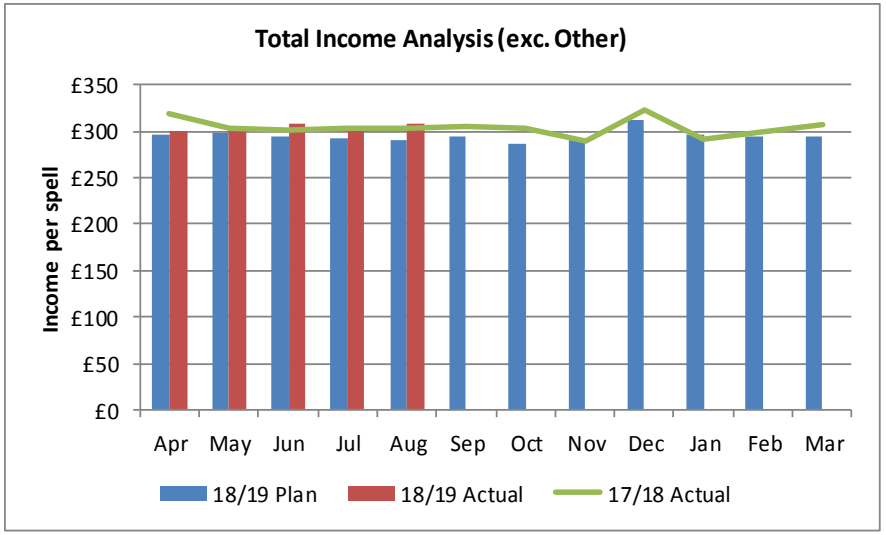
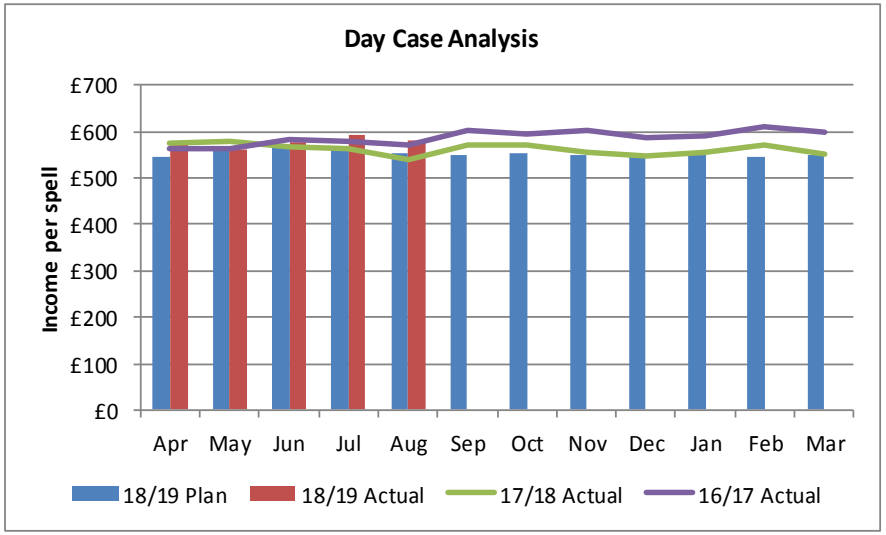
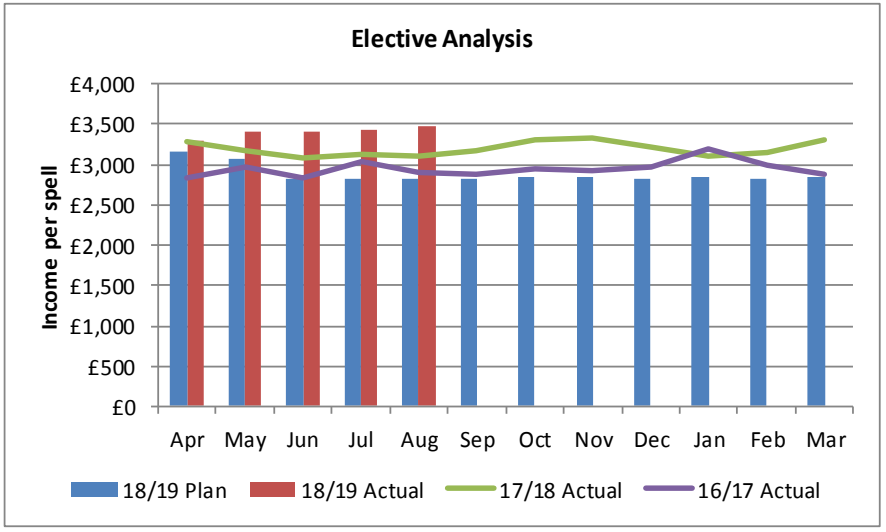
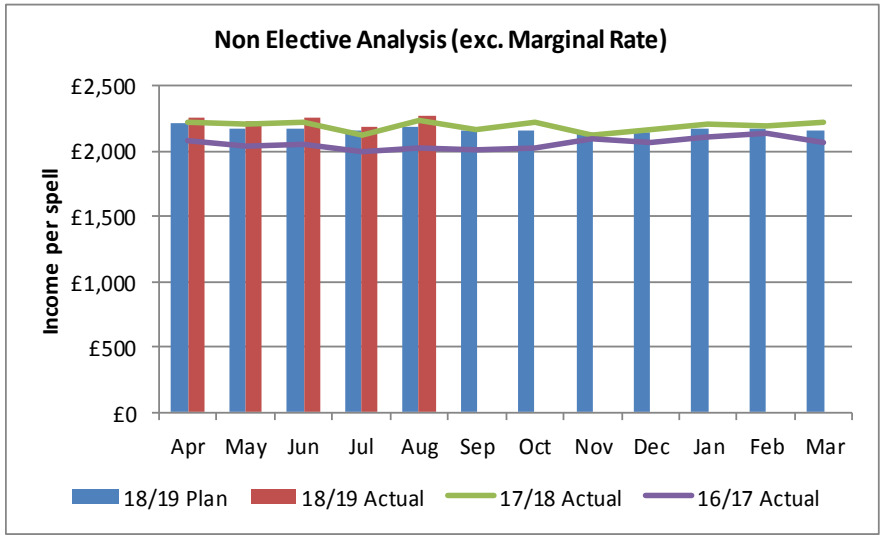
Finance - Lead Director John Hennessey









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Finance - Lead Director John Hennessey

Pay cost by 'type'

Monthly Expenditure (£)				
As at August 2018	Aug-18	Jul-18	Aug-17	YTD 2018-19
	£'000	£'000	£'000	£'000
Budgeted costs in month	**30,430**	**29,281**	**27,403**	**146,739**
Actuals:				
Substantive staff	**26,544**	**25,609**	**24,395**	**127,124**
Medical External Locum Staff*	296	221	94	1,119
Medical Internal Locum Staff	537	597	598	2,829
Additional Medical Sessions	450	490	529	2,241
Nursing Agency Staff*	561	433	462	2,779
Nursing Bank Staff	1,166	940	806	4,634
Other Agency Staff (AHPs/A&C)*	243	217	181	1,078
Other Bank Staff (AHPs/A&C)	156	147	163	716
Overtime	512	472	-	2,671
On Call	188	185	176	948
Total temporary expenditure	**4,110**	**3,701**	**3,008**	**19,014**
Total Pay costs	**30,654**	**29,310**	**27,403**	**146,138**
Variance Fav / (Adv)	(224)	(29)	-	601
Temp Staff costs % of Total Pay	**12.8%**	**12.0%**	**10.3%**	**12.4%**
Memo: Total agency spend in month*	**1,101**	**871**	**737**	**4,975**

Headcount

Monthly Whole Time Equivalents (WTE)			
As at August 2018	Aug-18	Jul-18	Aug-17
	WTE	WTE	WTE
Budgeted WTE in month	**7,984**	**7,980**	**7,273**
Employed substantive WTE in month	**6,866**	**6,821**	**6,550**
Medical External Locum Staff*	16	12	5
Medical Internal Locum Staff	79	85	87
Additional Sessions	13	12	12
Nursing Agency*	71	41	61
Nursing Bank	63	61	47
Other Agency (AHPs/A&C)*	124	113	79
Other Bank (AHPs/A&C)	353	338	210
Overtime	142	152	181
On Call Worked	36	36	35
Total equivalent temporary WTE	**897**	**850**	**716**
Total equivalent employed WTE	**7,763**	**7,670**	**7,266**
Variance Fav / (Adv)	221	310	7
Temp Staff WTE % of Total Pay	**12%**	**11%**	**10%**
Memo: Total agency WTE in month*	**211.15**	**166.11**	**144.92**
Sickness Rates	**3.90%**	**3.61%**	**3.90%**
Mat Leave	**2.32%**	**2.40%**	**2.25%**

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

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

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

Additional sessions, overtime & on call sourced from payroll.

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

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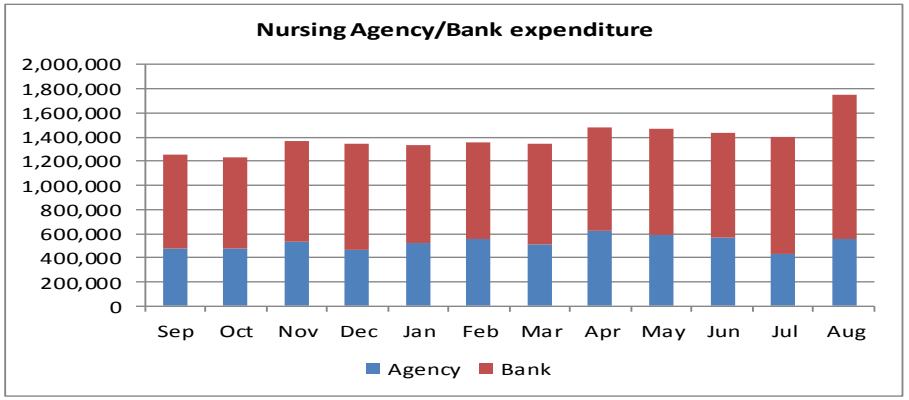
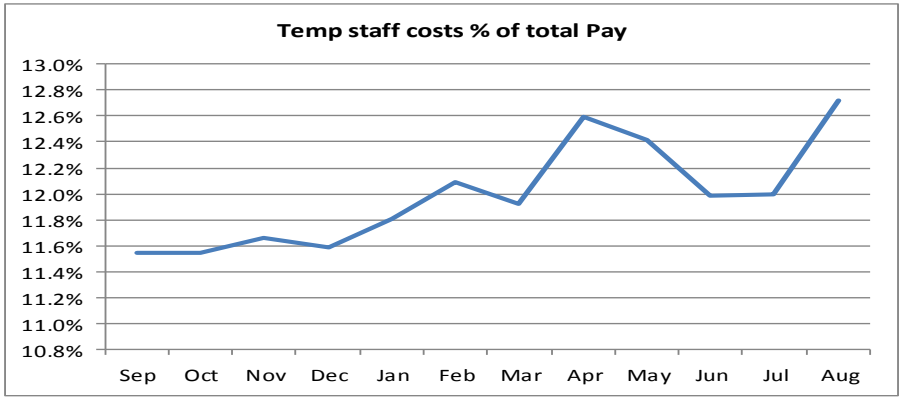
Finance - Lead Director John Hennessey

Pay Trends & Analysis

Medical staff premium Pay YTD (source: budget statements)	WLI	Internal Locum	External Locum & NAG	Total
Emergency	0	1,210,908	399,635	**1,610,543**
Surgical Support	392,308	54,398	354,275	**800,982**
General Surgery	177,525	140,580	68,397	**386,502**
Older Peoples Medicine	27,403	303,029	4,973	**335,404**
Imaging	300,373	2,389	0	**302,761**
Oral Surgery	11,587	158,061	77,193	**246,840**
Plastic Surgery	67,828	144,917	33,524	**246,269**
Ophthalmology	167,177	76,253	0	**243,430**
Urology	200,702	23,405	9,372	**233,478**
Cellular Pathology	81,813	76	96,472	**178,361**
Obs & Gynae	77,967	92,558	5,608	**176,133**
Dermatology	142,956	26,738	0	**169,694**
Paediatrics	41,427	116,390	6,131	**163,948**
Gastroenterology	148,087	11,634	0	**159,721**
T&O	105,198	39,000	0	**144,198**
Service	0	113,896	15,833	**129,729**
Respiratory Medicine	70,138	52,844	0	**122,982**
Neurosciences	71,365	51,230	0	**122,595**
Ear Nose And Throat	67,216	35,118	15,288	**117,622**
Cardiology	78,560	14,817	11,507	**104,884**
Oncology & Haematology	7,785	86,532	3,264	**97,581**
Endocrinology	2,310	23,133	3,456	**28,898**
Laboratory Medicine	0	14,624	13,607	**28,231**
Palliative Care	0	24,695	0	**24,695**
Therapies & Support Services	0	9,104	0	**9,104**
Renal	0	2,014	0	**2,014**
Rheumatology	1,182	565	0	**1,746**
Total	**2,240,904**	**2,828,907**	**1,118,534**	**6,188,345**





- The Pay budget YTD is £146.7m v £146.1m actual cost delivering an underspend of £601k.
- Emergency has overspent in the YTD by £871k through additional Locum spend, additional floor coordinators & doctor cover in the evening of circa two doctors. The locum overspend is being reviewed within the division.
- Premium pay (all temp costs exc on-call) is currently running at circa £3.6m per month (£3.9m in M5), £18m YTD. Key areas of focus is control on overtime payments (£2.7m YTD, £0.53m per month), Agency (£3.8m YTD; £0.76m pm) & Locum incl NAG spend (£3.9m YTD; £0.8m pm).

Core Slide 44 CIP Performance

CIP Plan Development

- To date £23.6m of cost improvement initiatives have been approved through Gateway 2 and into delivery against the £30.0m CIP target with further schemes continuing to be developed through the governance process, with £3.8m through 'Gateway 1' and £0.5m sitting within the Trust's CIP pipeline.
- A concerted effort is required to convert Pipeline Panel approved schemes into 'In Delivery' workbooks as soon as practical to provide further assurance over the deliverability of the CIP plan. Weekly meetings are being held between the PMO and divisional representatives to ensure these schemes continue to be developed to address the shortfall in CIP identification.

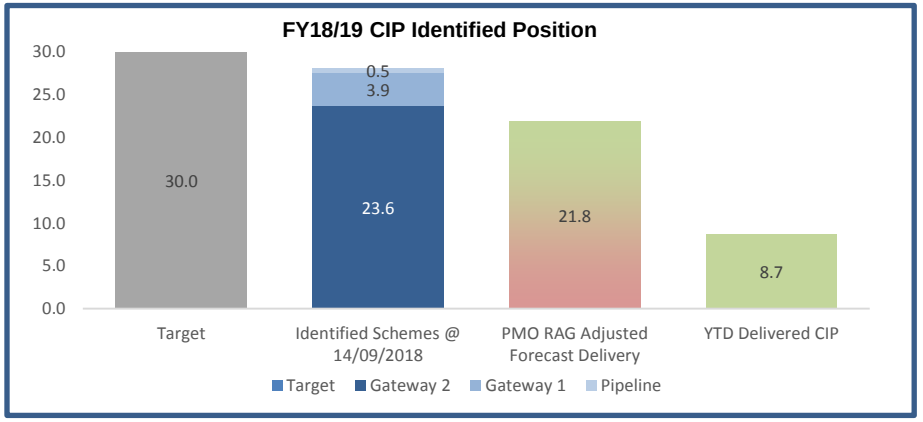
CIP Performance

- YTD the Trust has delivered £8.70m of CIPs against a FIP Board approved YTD plan of £7.74m (YTD plan per annual plan is £7.88m), an over-performance of £0.96m arising due to significant additional delivery in day case and outpatient productivity schemes within Medicine, offset by underachievement in elective income generation initiatives in surgery.
- The risk adjusted forecast delivery for Gateway 2 schemes is currently £21.8m based on the YTD financial performance of 'in delivery' CIPs, progress against milestone delivery and performance against quality and performance indicators. This presents a significant risk to achievement of the £30.0m target.

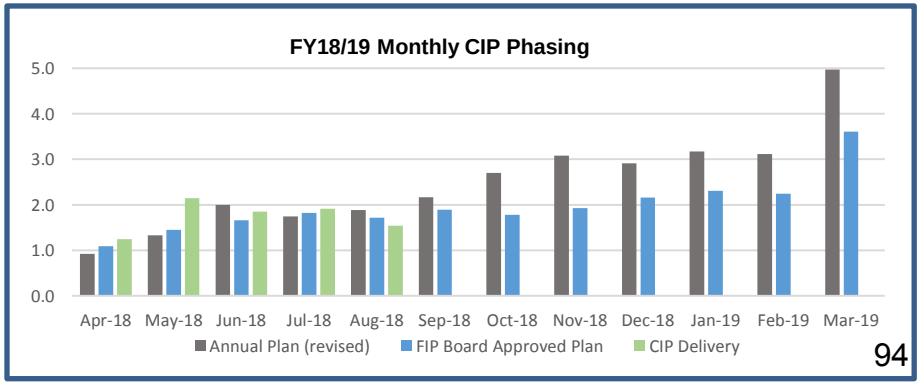
FY18/19 Performance by Division

Division	Number of schemes 'In Delivery'	CIP Delivery		
		YTD FIP Board Approved Plan £'000	YTD Actual £'000	YTD Variance £'000
Medicine	32	2,766.5	4,082.9	1,316.4
Surgery	24	2,612.3	2,219.2	(393.1)
Women & Children's	15	877.8	1,042.2	164.4
Clinical Support Services	17	1,003.9	836.9	(167.0)
Corporate	13	476.9	517.9	40.9
Cross-Divisional*	2	-	-	-
	103	**7,737.4**	**8,699.1**	**961.6**
YTD per Annual Plan		7,878.2		
Variance to Annual Plan		**(140.8)**		

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



Category	Plan YTD £'000	Actual YTD £'000	Variance £'000
Clinical Income	5,175.1	6,187.6	1,012.5
Pay (net)	2,288.1	2,150.0	(138.1)
Non-pay (net)	117.1	141.5	24.4
Other Income (net)	(5.7)	57.2	62.9
Non-Opex	162.8	162.8	-
	7,737.4	**8,699.1**	**961.7**



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Finance - Lead Director John Hennessey

Summary by Directorate

DIRECTORATES INCOME & EXPENDITURE	Aug-18 Budget £k	Aug-18 Actual £k	Aug-18 Variance F/(A) £k	Year to date Budget £k	Year to date Actual £k	Year to date Variance F/(A) £k
MEDICINE						
Total Income	19,415	19,801	387	95,594	98,684	3,090
Pay Costs	-9,830	-10,204	-374	-47,173	-47,903	-730
Non-Pay Costs	-7,277	-7,817	-540	-35,590	-37,074	-1,483
Total Expenditure	-17,107	-18,021	-914	-82,763	-84,977	-2,214
SURPLUS/(DEFICIT)	**2,308**	**1,780**	**-527**	**12,831**	**13,707**	**876**
SURGERY						
Total Income	15,372	13,902	-1,470	72,986	70,409	-2,578
Pay Costs	-8,956	-9,155	-199	-43,316	-43,086	230
Non-Pay Costs	-4,391	-4,036	355	-20,756	-20,238	517
Total Expenditure	-13,347	-13,192	155	-64,072	-63,324	748
SURPLUS/(DEFICIT)	**2,026**	**710**	**-1,315**	**8,914**	**7,084**	**-1,830**
WOMENS & CHILDREN						
Total Income	5,410	5,082	-328	26,897	26,463	-434
Pay Costs	-3,392	-3,352	40	-16,180	-16,103	78
Non-Pay Costs	-580	-545	35	-3,031	-2,741	290
Total Expenditure	-3,972	-3,897	75	-19,211	-18,844	367
SURPLUS/(DEFICIT)	**1,438**	**1,185**	**-253**	**7,686**	**7,619**	**-67**
CLINICAL SUPPORT						
Total Income	4,146	4,230	84	20,201	20,831	630
Pay Costs	-5,566	-5,516	49	-26,609	-26,054	555
Non-Pay Costs	-2,382	-2,533	-151	-12,330	-13,307	-977
Total Expenditure	-7,948	-8,050	-102	-38,939	-39,361	-422
SURPLUS/(DEFICIT)	**-3,801**	**-3,820**	**-18**	**-18,738**	**-18,530**	**208**
SERVICES						
Total Income	601	643	42	3,080	3,176	96
Pay Costs	-2,415	-2,396	20	-11,570	-11,187	384
Non-Pay Costs	-4,963	-5,183	-220	-24,945	-25,184	-238
Total Expenditure	-7,378	-7,578	-201	-36,516	-36,370	145
SURPLUS/(DEFICIT)	**-6,777**	**-6,936**	**-158**	**-33,435**	**-33,195**	**241**
OTHER						
Total Income	6,886	7,986	1,100	30,559	26,801	-3,758
Pay Costs	-271	-30	241	-1,891	-1,807	84
Non-Pay Costs	-5,794	-5,006	788	-29,373	-25,062	4,311
Total Expenditure	-6,065	-5,036	1,029	-31,264	-26,869	4,395
SURPLUS/(DEFICIT)	**821**	**2,950**	**2,129**	**-704**	**-68**	**637**
TOTAL						
Total Income	51,830	51,643	-186	249,317	246,362	-2,955
Pay Costs	-30,430	-30,654	-224	-146,739	-146,138	601
Non-Pay Costs	-25,386	-25,120	266	-126,025	-123,606	2,419
Total Expenditure	-55,816	-55,774	42	-272,765	-269,745	3,020
SURPLUS/(DEFICIT)	**-3,986**	**-4,130**	**-144**	**-23,448**	**-23,382**	**65**

Medicine

Performance YTD the Medicine and Emergency division remains strong; ahead of plan by £876k . Total Income is £3.1m ahead of plan YTD of which clinical income is £1.9m ahead, which is driving the division over performance. A&E activity is ahead of plan by £177k with increased number of attendances YTD of over 3,000. Non elective activity is up, £1.5m YTD and outpatients the remaining over achievement.

Pay remains a concern in the Emergency division with over spend YTD of £807k; off set minimally with underspend elsewhere. Increased activity has driven spend, and a subset of this is an additional 2 junior doctors to ensure the trust meets the NHSI targets. The on boarding of Doctors from the overseas recruitment is behind plan, so the conversion of premium pay into substantive has been delayed.

Surgery

Performance YTD for the surgical division is behind plan by £1.8m. Total Income is £2.6m behind plan YTD of which clinical income has driven the YTD variance, as it is circa £2.7m behind plan.

General surgery non elective income is up through the increase A&E activity; this is impacting on the elective activity which is a higher income generating area. Vacancies and long term sickness in Plastics, Dermatology and T&O has resulted in a reduction in performance against plan.

The impact of the underperformance against Clinical income has been offset through a reduction in spend in Pay and non-pay expenditure.

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Finance - Lead Director John Hennessey

Summary by Directorate (cont.)

Women's and Children's
Performance YTD is slightly behind plan by £67k. Total Income is £434k behind plan YTD this is all variance in clinical income. Outpatients are the significant driver of the deterioration.

Pay and Non pay expenditure is behind budget YTD, with vacancies in administration and student midwives behind plan spend on SHS and Medinet lower than plan.

Clinical Support
Divisional performance for CSSC remains strong, with an over performance against plan of £208k YTD.

Total Income is ahead of plan by £630k, with increased activity seen in the radiology department and an increase in the EPA alliance income, and drugs income.

Pay remains behind plan YTD by £555k, with underspend across the directorates expect Cellular pathology which is overspent, relating to an increased demand and clearance of backlog.

Non pay remains a concern, as this is over spent against budget by £977k, however netted off against income generation in drugs and non-clinical income is £541k. Overspend has been seen in a number of maintenance contracts relating to the imaging equipment, specifically the ageing CT equipment. The underachievement of CIPs YTD relating to the Abbotts contract has contributed £225k of the variance.

Services
YTD services are ahead of plan by £241k. Pay is £384k underspent against budget YTD. Non pay however is overspent YTD against budget, overspend in relation to Electricity and the provision for bad debt.

Other
Clinical Income is £993k worse than budget being:
£629k penalties and challenges worse than budget - Canx ops £200k, Challenges £350k and £520k specialised block adjustment – done more activity than block. Other small.

Drugs income is £1.99m adverse which contra's with a favourable drugs expense variance within non-pay of £2.2m.

Other Income £722k adverse, being:
R&D £0.5m contra with non-pay costs below, and 'risk' accrual of £350k shown as negative income to maintain integrity of all other income and expenditure categories.

Non pay is £3.8m better than budget being:
Drugs cost favourable £2.2m – contra drugs income above, general inflation £900k – not allocated, R&D £0.5m contras with R&D income.

Non-opex is £489k better than budget being:
Depreciation £126k, Interest on borrowings £200k both timing which will not reverse. Contingent Rent, RPI less than assumed £99k. Other small.

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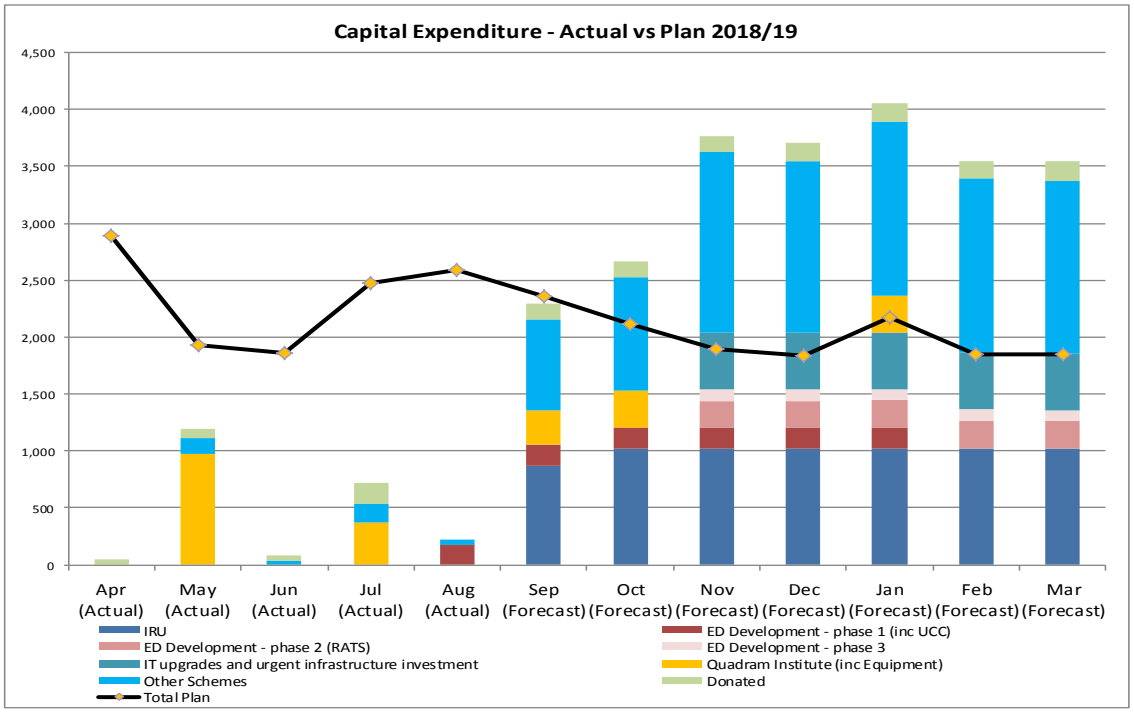
Finance - Lead Director John Hennessey

Capital Progress Report



The capital programme for the year and monthly phasing is shown in the graph to the left.

Expenditure is behind plan, thus the phasing / cash flow of the schemes will be revised to reflect likely spend over the remainder of the year.

Year to date the overall expenditure of £2,245k is behind the plan of £11,758k. A variance of £9,513k.

This is primarily due to the delay of the £11.6m capital support loan requested from DHSC. Of that £8,488k of capital support was assumed in the YTD.

The forecast assumes all projects planned for this financial year will continue to be completed in year and will recover the slippage to date. This will be reassessed .

Internally generated funding for capital is £5,800k, comprising, depreciation net of balance sheet cash items of £1,296k and STF of £4,504k.

	Apr Actual £'000	May Actual £'000	Jun Actual £'000	Jul Actual £'000	Aug Actual £'000	Sep Forecast £'000	Oct Forecast £'000	Nov Forecast £'000	Dec Forecast £'000	Jan Forecast £'000	Feb Forecast £'000	Mar Forecast £'000	TOTAL Forecast £'000
IRU - Separate Funding	0	0	0	0	0	875	1,021	1,021	1,021	1,021	1,021	1,019	**7,000**
ED Development - phase 1 (inc UCC)	0	0	0	0	175	185	180	180	180	185	0	0	**1,085**
ED Development - phase 2 (RATS) - Separate Fundir	0	0	0	0	0	0	0	239	239	239	242	242	**1,200**
ED Development - phase 3	0	0	0	0	0	0	0	100	100	100	100	100	**500**
IT upgrades and urgent infrastructure investment	0	0	0	0	0	0	0	498	497	497	497	498	**2,487**
Quadram Institute (£2m Build & £0.3m Equipment)	0	975	0	375	0	300	325	0	0	325	0	0	**2,300**
Other Schemes	0	133	30	158	44	791	996	1,593	1,512	1,528	1,530	1,513	**9,829**
Donated	42	86	50	188	0	139	139	139	159	159	155	169	**1,425**
Total Actual to Date / Forecast	42	1,194	80	721	220	2,290	2,661	3,770	3,708	4,054	3,545	3,541	25,826
Cumulative Actual to Date	42	1,236	1,317	2,038	2,258								
Total Plan	2,896	1,933	1,858	2,479	2,592	2,356	2,118	1,894	1,832	2,173	1,849	1,846	25,826

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Finance - Lead Director John Hennessey

Statement of Financial Position at 31st August 2018

	Opening Balance as at 1 April 2018 £'000	Plan 31 March 2019 £'000	Plan YTD 31 August 2018 £'000	Actual YTD 31 August 2018 £'000	Variance YTD 31 August 2018 £'000
Property, plant and equipment	234,749	249,516	242,089	232,743	(9,346)
Trade and other receivables	71,245	77,940	74,017	74,045	28
Other financial assets	0	0	0	0	0
Total non-current assets	305,994	327,456	316,106	306,788	(9,318)
Inventories	9,369	9,369	9,369	9,276	(93)
Trade and other receivables	28,621	24,040	26,188	29,716	3,528
Non-current assets for sale	0	0	0	0	0
cash and cash equivalents	5,733	1,681	1,817	7,566	5,749
Total Current assets	43,723	35,090	37,374	46,558	9,184
Trade and other payables	(61,085)	(61,256)	(61,011)	(62,651)	(1,640)
Borrowing repayable within 1 year	0	0	0	0	0
Current provisions	(308)	(307)	(307)	(308)	(1)
Deferred Income	(5,138)	(4,764)	(4,764)	(9,144)	(4,380)
Total current liabilities	(66,531)	(66,327)	(66,082)	(72,103)	(6,021)
Total assets less current liabilities	283,186	296,219	287,398	281,243	(6,155)
Borrowings	(246,249)	(312,855)	(273,323)	(267,600)	5,723
Provisions	(2,159)	(1,892)	(2,048)	(2,097)	(49)
Deferred Income	(4,606)	(4,875)	(4,936)	(4,389)	547
Total non-current liabilities	(253,014)	(319,622)	(280,307)	(274,086)	6,221
Total assets employed	30,172	(23,403)	7,091	7,157	66
Financed by					
Public dividend capital	28,408	28,408	28,408	28,408	0
Retained Earnings (Accumulated Losses)	(13,239)	(66,814)	(36,320)	(36,245)	75
Revaluation reserve	15,003	15,003	15,003	14,994	(9)
Total Taxpayers' and others' equity	30,172	(23,403)	7,091	7,157	66

Non-Current Assets

There is some slippage on the capital programme primarily due to a delay in receiving capital support from DHSC of £8.5m YTD.

Trade and Other Receivables

This balance is £3.5m higher than plan YTD. Key driver is timing, eg

£0.4m relates to a Medipass prepayment for radiotherapy.

£0.3m PDC receivable that is due to be received in Sept.

Cash

Cash is £5.7m higher than plan at the end of August due to short term timing differences. Loan drawdowns continue to be delayed as long as possible.

Trade and other payables

This is £1.6m higher than plan YTD. The key driver is the backdated AfC pay increase and consequential increase in N.I. and income tax liability.

Deferred Income

This balance is £3.8m higher than plan YTD. £1.8m relates to H.E.E. and is a short term timing difference. £0.6m relates to risk on assumed VAT recovery relating to the QI. The remainder are small timing differences.

Borrowings

Total overall borrowings are £5.7m lower than plan.

In year revenue borrowings are £22.5m against a YTD plan of £19.7m. Being £2.8m higher than plan.

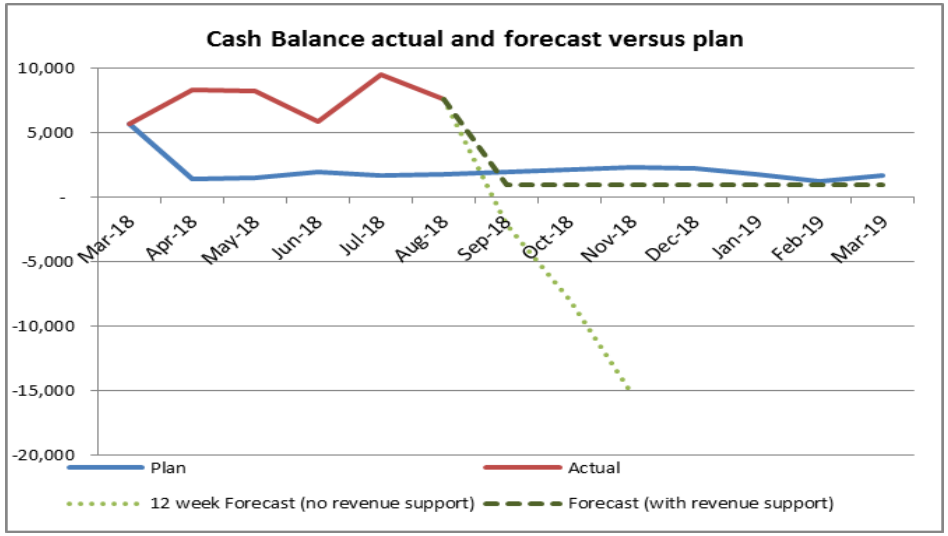
In year capital borrowings are £0m against a YTD plan of £8.5m. Being £8.5m lower than plan. This is primarily due to the lengthy DHSC process of approving the capital loan applications of £18.6m and the funding being released.

Note: the £7m capital borrowing request for the IRU has been approved as has £1.2m for RATS. Thus the balance unapproved is £10.4m and this is being reviewed and progressed with NHSI.

Core Slide 49

Finance - Lead Director John Hennessey

Cash Balance Forecast for the Year



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

- The graph shows the cash levels since the end of March 2018. Short term timing differences drive the difference between actual and plan.
- The Trust is required to keep a minimum balance of £1 million, hence the closing cash plan every month is @ £1m .
- The future cash loan requirements on current projections are - £1.5m in September, £6.1m in October, and £7.5m in November.
- The borrowings of £74.9m at the end of M5 comprise: £16m in 2016/17, £36.4m in 2017/18 & £22.5m in 2018/19.
- The interest rates are: 3.5% on £31.0m. 1.5% on the remainder of £43.9m.
- The plan for 2018/19 assumes additional borrowings of £51.1m for revenue.
- The Trust Board approved borrowing 'limit' is £100m revenue and £25m capital. This was confirmed at the April 2018 Trust Board meeting.
- The need for the funds is driven by our operational performance.

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

Income Statement Comparison - for the Month of August

	For the month			Variances Fav / (Adv)			
	Actual	Budget	Prior year	To Budget		To prior year	
	£'000	£'000	£'000	£'000	%	£'000	%
INCOME							
NHS clinical income							
Clinical Income	36,757	37,756	35,749	(999)	(3%)	1,008	3%
Clinical Income - Spire Contract	607	631		(24)	(4%)	607	
NT Drugs	5,923	5,768	4,688	155	3%	1,235	26%
Total NHS clinical income	**43,287**	**44,155**	**40,437**	**(868)**	**(2%)**	**2,850**	**7%**
Non NHS clinical income							
Private patients	169	158	95	11	7%	74	78%
Other - RTA	233	110	46	123	112%	187	407%
Total Non NHS clinical income	**402**	**268**	**141**	**134**	**50%**	**261**	**185%**
Other Income							
R&D	1,633	1,810	1,527	(177)	(10%)	106	7%
Education & Training	1,928	1,929	1,815	(1)	(0%)	113	6%
STF Income			886			(886)	(100%)
Other non patient care income	4,393	3,668	4,543	725	20%	(150)	(3%)
Total other Income	**7,954**	**7,407**	**8,771**	**547**	**7%**	**(817)**	**(9%)**
TOTAL OPERATING INCOME	**51,643**	**51,830**	**49,349**	**(187)**	**(0%)**	**2,294**	**5%**
EXPENDITURE							
Employee benefit expenses	(30,654)	(30,430)	(27,403)	(224)	(1%)	(3,251)	(12%)
Drugs	(6,936)	(6,867)	(5,633)	(69)	(1%)	(1,303)	(23%)
Clinical supplies	(5,285)	(5,453)	(5,365)	168	3%	80	1%
Non clinical supplies	(7,598)	(7,615)	(5,610)	17	0%	(1,988)	(35%)
- Fixed	*(1,775)*	*(1,775)*	*(1,435)*		*0%*	*(340)*	*(24%)*
- Capacity	*(535)*	*(589)*	*(318)*	*54*	*9%*	*(217)*	*(68%)*
- Income Backed including Spire	*(2,338)*	*(2,475)*	*(1,582)*	*137*	*6%*	*(756)*	*(48%)*
- £2m Contingency Reserve	*(180)*	*(180)*				*(180)*	
- Variable	*(2,770)*	*(2,596)*	*(2,275)*	*(174)*	*(7%)*	*(495)*	*(22%)*
PFI operating expenses	(1,802)	(1,809)	(1,720)	7	0%	(82)	(5%)
TOTAL OPERATING EXPENSES	**(52,275)**	**(52,174)**	**(45,731)**	**(101)**	**(0%)**	**(6,544)**	**(14%)**
Profit/(loss) from operations	**(632)**	**(344)**	**3,618**	**(288)**	**84%**	**(4,250)**	**(117%)**
Non-operating income							
Interest	9	2	2	7	(350%)	7	350%
Profit/(loss) on asset disposals		(4)	4	4	100%	(4)	(100%)
Total non-operating income	**9**	**(2)**	**6**	**11**	**(550%)**	**3**	**50%**
Non-operating expenses							
Interest on PFI and Finance leases	(1,428)	(1,429)	(1,454)	1	0%	26	(2%)
Interest on Non Commercial Borrowing	(147)	(208)	(70)	61	29%	(77)	110%
Depreciation	(855)	(905)	(910)	50	6%	55	(6%)
PDC			(59)			59	(100%)
Other - Contingent Rent	(1,078)	(1,098)	(969)	20	2%	(109)	11%
Total non operating expenses	**(3,508)**	**(3,640)**	**(3,462)**	**132**	**4%**	**(46)**	1%
Surplus (deficit) after tax from continuing operations	**(4,131)**	**(3,986)**	**162**	**(145)**	**(4%)**	**(4,293)**	**2650%**
Memo:							
Donated Asset Additions		139	279	(139)	(100%)	(279)	(100%)
Surplus (deficit) after tax and Donated Asset Additions	**(4,131)**	**(3,847)**	**441**	**(284)**	**(7%)**	**(4,572)**	**1037%**

Notes:

Calendar Days	31	31	31
Working Days	22	22	22

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

Income Statement Comparison - Year to 31 August 2018

	FULL YEAR BUDGET	Year to date			Variances Fav / (Adv)			
		Actual	Budget	Prior year	To Budget		To prior year	
	£'000	£'000	£'000	£'000	£'000	%	£'000	%
INCOME								
NHS clinical income								
Clinical Income	*447,320*	182,672	184,200	176,889	(1,528)	(1%)	5,783	3%
Clinical Income - Spire Contract	*7,578*	3,304	3,157		147	5%	3,304	
NT Drugs	*69,230*	27,992	28,837	26,252	(845)	(3%)	1,740	7%
Total NHS clinical income	***524,128***	**213,968**	**216,194**	**203,141**	**(2,226)**	**(1%)**	**10,827**	**5%**
Non NHS clinical income								
Private patients	*1,899*	543	791	738	(248)	(31%)	(195)	(26%)
Other - RTA	*1,318*	668	549	540	119	22%	128	24%
Total Non NHS clinical income	***3,217***	**1,211**	**1,340**	**1,278**	**(129)**	**(10%)**	**(67)**	**(5%)**
Other Income								
R&D	*21,644*	8,489	8,976	8,627	(487)	(5%)	(138)	(2%)
Education & Training	*23,267*	9,730	9,767	9,186	(37)	(0%)	544	6%
STF Income				3,765			(3,765)	(100%)
Other non patient care income	*28,176*	12,965	13,041	20,383	(76)	(1%)	(7,418)	(36%)
Total other Income	***73,087***	**31,184**	**31,784**	**41,961**	**(600)**	**(2%)**	**(10,777)**	**(26%)**
TOTAL OPERATING INCOME	***600,432***	**246,363**	**249,318**	**246,380**	**(2,955)**	**(1%)**	**(17)**	**(0%)**
EXPENDITURE								
Employee benefit expenses	*(351,045)*	(146,138)	(146,739)	(134,920)	601	0%	(11,218)	(8%)
Drugs	*(82,270)*	(33,368)	(34,395)	(31,323)	1,027	3%	(2,045)	(7%)
Clinical supplies	*(65,909)*	(26,822)	(27,325)	(26,929)	503	2%	107	0%
Non clinical supplies	*(90,707)*	(37,114)	(37,546)	(30,101)	432	1%	(7,013)	(23%)
- Fixed	*(21,366)*	*(8,875)*	*(8,875)*	*(7,177)*		*0%*	*(1,698)*	*(24%)*
- Capacity	*(6,213)*	*(2,802)*	*(2,438)*	*(2,727)*	*(364)*	*(15%)*	*(75)*	*(3%)*
- Income Backed including Spire	*(29,720)*	*(12,053)*	*(12,384)*	*(8,750)*	*331*	*3%*	*(3,303)*	*(38%)*
- £2m Contingency Reserve	*(2,000)*	*(640)*	*(640)*				*(640)*	
- Variable	*(31,408)*	*(12,744)*	*(13,209)*	*(11,447)*	*465*	*4%*	*(1,297)*	*(11%)*
PFI operating expenses	*(21,091)*	(8,941)	(8,909)	(8,647)	(32)	(0%)	(294)	(3%)
TOTAL OPERATING EXPENSES	***(611,022)***	**(252,383)**	**(254,914)**	**(231,920)**	**2,531**	**1%**	**(20,463)**	**(9%)**
Profit/(loss) from operations	***(10,590)***	**(6,020)**	**(5,596)**	**14,460**	**(424)**	**8%**	**(20,480)**	**(142%)**
Non-operating income								
Interest	*32*	49	13	13	36	(277%)	36	277%
Profit/(loss) on asset disposals	*(40)*	9	(17)	4	26	153%	5	125%
Total non-operating income	***(8)***	**58**	**(4)**	**17**	**62**	**(1550%)**	**41**	**241%**
Non-operating expenses								
Interest on PFI and Finance leases	*(17,085)*	(7,142)	(7,144)	(7,267)	2	0%	125	(2%)
Interest on Non Commercial Borrowing	*(2,799)*	(607)	(807)	(313)	200	25%	(294)	94%
Depreciation	*(11,021)*	(4,279)	(4,405)	(4,346)	126	3%	67	(2%)
PDC				(295)			295	(100%)
Other - Contingent Rent	*(13,497)*	(5,391)	(5,490)	(4,927)	99	2%	(464)	9%
Total non operating expenses	***(44,402)***	**(17,419)**	**(17,846)**	**(17,148)**	**427**	**2%**	**(271)**	2%
Surplus (deficit) after tax from continuing operations	***(55,000)***	**(23,381)**	**(23,446)**	**(2,671)**	**65**	**0%**	**(20,710)**	**(775%)**
Memo:								
Donated Asset Additions	*1,425*	366	365	1,051	1	0%	(685)	(65%)
Surplus (deficit) after tax and Donated Asset Additions	***(53,575)***	**(23,015)**	**(23,081)**	**(1,620)**	**66**	**0%**	**(21,395)**	**(1321%)**

The table below shows the position on a control total basis. Although the control total has not been accepted, the Trust is obliged to report against this on a monthly basis to NHSI.

Deficit on a control total basis - reportable to NHSI:								
Surplus (deficit) after tax and Donated Asset Additions	*(53,575)*	(23,015)	(23,081)	(1,620)	66	0%	(21,395)	1321%
Remove: Donated Asset Additions	*(1,425)*	(366)	(365)	(1,051)	(1)	0%	685	(65%)
Add back: Donated Depreciation	*807*	349	334	303	15	4%	46	15%
Adjusted financial performance surplus/(deficit)	***(54,193)***	**(23,032)**	**(23,112)**	**(2,368)**	**80**	**0%**	**(20,664)**	**873%**
CONTROL TOTAL	***10,683***	**3,915**	**3,915**	**(1,287)**		**0%**	**5,202**	**(404%)**
Performance against control total	***(64,876)***	**(26,947)**	**(27,027)**	**(1,081)**	**80**	**0%**	**(25,866)**	**2393%**

Notes:

Calendar Days	153	153	153
Working Days	106	106	104

REPORT TO BOARD of DIRECTORS

Date	28 September 2018
Title	Freedom to Speak Up self-review tool for NHS trusts and foundation trusts
Author(s)	Amy Knights, Senior HR Manager for Jeremy Over, Director of Workforce
Purpose	To facilitate a Board discussion regarding the improvements we are making to embed a Speak Up culture at NNUH, supported by best practice guidance developed by the National Guardian's office.

Introduction

The Board has overarching responsibility for organisational culture at NNUH. We want all members of staff to feel that they work within a culture where they can raise concerns knowing their feedback is welcomed with no repercussions. We are committed to this through our Speak Up policy and are seeking continuous improvements to ensure that this is achieved.

Our staff survey results show we are making gradual improvements in this domain over recent years although the proportion of staff who say they feel safe to raise a concern at work is worse than the average score for acute hospitals in England. One of the actions the Board has taken in response to this has been to commission the diagnostic review by the King's Fund and an associated agreed action plan is currently being delivered following Board discussion at its meeting in June 2018.

Self-review tool

The attached self-review tool has been published this year to enable NHS trusts to assess their current position against best practice guidance produced by the National Freedom to Speak Up Guardian's Office.

A draft assessment has been undertaken for review. It sets out the organisational arrangements that are currently established at NNUH and the actions that are either being taken forward or are pending in order to provide positive assurance against the self-review criteria.

The Board is requested to review the draft self-assessment and agree any additional identified actions to further improve the position statement as described.

Next steps

The appointment of a full-time Lead Freedom to Speak Up Guardian (in addition to our current staff governor speak up guardians) is a crucial step to further promoting a speak up culture at NNUH. Interviews are scheduled for 09 October 2018 and the appointee will be responsible for a range of improvement actions, in addition to the responsibilities held by members of the Board.

Given the importance of this domain to quality, safety and staff experience it is recommended that the Board request an updated assessment against the tool in 4-6 month's time.

Action Required (✓)	FOR INFORMATION FOR DISCUSSION ✓ FOR APPROVAL ✓

National Guardian
Freedom to Speak Up

NHS
Improvement

Freedom to Speak Up self-review tool for NHS trusts and foundation trusts

May 2018

Draft for Board Review on 28 September 2018

Completed by Norfolk & Norwich University Hospitals NHS Foundation Trust

August 2018

How to use this tool

Effective speaking up arrangements help to protect patients and improve the experience of NHS workers. Having a healthy speaking up culture is evidence of a well-led trust.

NHS Improvement and the National Guardian's Office have published a guide setting out expectations of boards in relation to Freedom to Speak Up (FTSU) to help boards create a culture that is responsive to feedback and focused on learning and continual improvement.

This self-review tool accompanying the guide will enable boards to carry out in-depth reviews of leadership and governance arrangements in relation to FTSU and identify areas to develop and improve.

The Care Quality Commission (CQC) assesses a trust's speaking up culture during inspections under key line of enquiry (KLOE) 3 as part of the well-led question. This guide is aligned with the good practice set out in the well-led framework, which contains references to speaking up in KLOE 3 and will be shared with Inspectors as part of the CQC's assessment framework for well-led.

Completing the self-review tool and developing an improvement action plan will help trusts to evidence their commitment to embedding speaking up and help oversight bodies to evaluate how healthy a trust's speaking up culture is.

Self review indicator (Aligned to well-led KLOEs)	To what extent is this expectation being met?	What are the principal actions required for development?	How is the board assured it is meeting the expectation? Evidence
Our expectations			
Leaders are knowledgeable about FTSU			
Senior leaders are knowledgeable and up to date about FTSU and the executive and non-executive leads are aware of guidance from the National Guardian's Office.	Meeting expectation		Representatives from the National Guardian's Office visited NNUH and presented best practice guidance to the Trust Board on 29.6.18.
Senior leaders can readily articulate the trust's FTSU vision and key learning from issues that workers have spoken up about and regularly communicate the value of speaking up.	In development	Improved capture of key learning so that this can be shared across the organisation more visibly.	The FTSU vision is included in our Speak Up Policy and Speak Up intranet hub page pages.
They can provide evidence that they have a leadership strategy and development programme that emphasises the importance of learning from issues raised by people who speak up.	In development	Embed and spread the learning from Leading with PRIDE to ensure a sustainable, positive impact on culture is	'Leading with PRIDE' masterclasses delivered to 700 line managers in Sept 2018 which promoted importance of

		secured.	speak up culture within teams and includes tools to achieve this.
Senior leaders can describe the part they played in creating and launching the trust's FTSU vision and strategy.	Meeting expectation		Workforce & Education Strategy, approved by the Board in Dec 2017, embeds Speak Up within the vision and objectives for workforce leadership and development at NNUH.
Leaders have a structured approach to FTSU			
There is a clear FTSU vision, translated into a robust and realistic strategy that links speaking up with patient safety, staff experience and continuous improvement.	In development	Formalise the triangulation of reporting and learning across patient safety, staff experience and quality improvement.	Vision in place described in Workforce & Education Strategy and Speak Up Policy.
There is an up-to-date speaking up policy that reflects the minimum standards set out by NHS Improvement.	Meeting expectation		Speak Up Policy is up to date with key contact details and reflects the minimum NHS Improvement standards. The policy is available to all staff on the trust

			intranet site and dedicated Speak Up hub pages.
The FTSU strategy has been developed using a structured approach in collaboration with a range of stakeholders (including the FTSU Guardian) and it aligns with existing guidance from the National Guardian.	Meeting expectation	Trust's strategic intention, exemplified in Speak Up Policy, Workforce strategy and other sources to be set out in designated stand-alone strategy statement.	Staff representatives and staff governor guardians consulted in development of existing Speak Up policy and Workforce strategy.
Progress against the strategy and compliance with the policy are regularly reviewed using a range of qualitative and quantitative measures.	In development	Direct, regular, formalised reporting from the Lead FTSUG to Board to be implemented.	The Policy is regularly reviewed and feedback is reported to board via the Audit Committee.
Leaders actively shape the speaking up culture			
All senior leaders take an interest in the trust's speaking up culture and are proactive in developing ideas and initiatives to support speaking up.	Meeting expectation		In accordance with our organisational PRIDE values and 'Know your Staff' people management, managers are actively encouraged to engage with staff in seeking to provide the

			best possible services for our patients. Managers value staff feedback and seek this in a variety of ways.
They can evidence that they robustly challenge themselves to improve patient safety, and develop a culture of continuous improvement, openness and honesty.	Meeting expectation	Embedding of new SIG approach to organisation learning in respect of incidents and near misses.	Implementation of a safety-focused culture led by the Chief Nurse and Medical Director through daily SIG meetings and promotion of learning.
Senior leaders are visible, approachable and use a variety of methods to seek and act on feedback from workers.	In development	Implement King's Fund review action plan including approaches to regular visibility and engagement	Visibility and approachability established as a core responsibility of senior leaders
Senior leaders prioritise speaking up and work in partnership with their FTSU Guardian.	In development	Partnership working with senior leaders across the trust will be established once Lead FTSU Guardian appointed.	Monthly engagement between staff governor guardians and executive director colleagues is currently active.
Senior leaders model speaking up by acknowledging mistakes and making improvements.	Meeting expectation		Honest dialogue with staff through regular

			forums such as CEO Viewpoint.
The board can state with confidence that workers know how to speak up; do so with confidence and are treated fairly.	In development	Implement King's Fund review action plan	Staff Survey demonstrates that 94% of staff know how to speak up; however only 65% feel safe and confident to do so.
Leaders are clear about their role and responsibilities			
The trust has a named executive and a named non-executive director responsible for speaking up and both are clear about their role and responsibility.	Meeting expectation		The named individuals are aware of their roles and are named within the trust's Speak Up Policy.
They, along with the chief executive and chair, meet regularly with the FTSU Guardian and provide appropriate advice and support.	In development	Regular engagement with Lead FTSU Guardian to be formalised following appointment.	The chief executive, chair and director of workforce meet with the staff governor guardians on a regular basis to seek feedback and provide advice and guidance.

Other senior leaders support the FTSU Guardian as required.	Meeting expectation		The staff governor guardians have access to any trust senior leader as and when required.
Leaders are confident that wider concerns are identified and managed			
Senior leaders have ensured that the FTSU Guardian has ready access to applicable sources of data to enable them to triangulate speaking up issues to proactively identify potential concerns.	In development	For the Lead FTSUG to work with senior leaders and identify and agree routes for sharing data to improve triangulation.	
The FTSU Guardian has ready access to senior leaders and others to enable them to escalate patient safety issues rapidly, preserving confidence as appropriate.	Meeting expectation	Establishing collaborative relationships between senior leaders and the Lead FTSU Guardian will be a priority following their appointment and commencement.	Staff governor guardians can make contact or raise an issue with any trust senior leader as and when required. If they are unsure as to who to go to then the Director of Workforce is able to signpost them to an appropriate leader.
Leaders receive assurance in a variety of forms			

Workers in all areas know, understand and support the FTSU vision, are aware of the policy and have confidence in the speaking up process.	Partly met, part in development	To improve staff confidence in the speak up process by improving communication and awareness of speak up processes.	All staff have access to the NNUH Speak Up intranet pages which reiterates our Speak Up vision and provides access to Speak Up contacts and resources.
Steps are taken to identify and remove barriers to speaking up for those in more vulnerable groups, such as Black, Asian or minority ethnic (BAME), workers and agency workers	In development	To engage BAME staff and identify and remove any barriers to speaking up. We are currently seeking staff from BAME backgrounds to be involved in a working group to make a positive difference to working at NNUH. This is being promoted via trust communications.	
Speak up issues that raise immediate patient safety concerns are quickly escalated	Meeting expectation		The process for managers to respond to concerns is detailed in the Speak Up Policy. Assessing the risk and considering escalation is integral to this process.

Action is taken to address evidence that workers have been victimised as a result of speaking up, regardless of seniority	Meeting expectation		Any allegations would be thoroughly investigated and addressed appropriately in accordance with trust polices.
Lessons learnt are shared widely both within relevant service areas and across the trust	In development	For the Lead FTSUG to implement improvements for communicating and learning across services and the trust.	Is likely to take place within services but not consistently across the trust.
The handling of speaking up issues is routinely audited to ensure that the FTSU policy is being implemented	In development	For the Lead FTSUG to consider introducing routine audits to ensure the FTSUG policy is being implemented.	The Speak Up policy is reviewed currently in accordance with national guidance.
FTSU policies and procedures are reviewed and improved using feedback from workers	In development	For the Lead FTSUG to consider ways to receive speak up policy feedback specifically from workers.	The Speak Up policy and procedures are reviewed currently in accordance with national guidance.
The board receives a report, at least every six months, from the FTSU Guardian.	In development	Direct, regular, formalised reporting from the Lead FTSUG	Formal reporting via the Audit Committee is currently annual

		to Board to be implemented.	
Leaders engage with all relevant stakeholders			
A diverse range of workers' views are sought, heard and acted upon to shape the culture of the organisation in relation to speaking up; these are reflected in the FTSU vision and plan.	In development	For the Lead FTSUG to consider ways to obtain workers views in shaping the FTSU vision and plan.	Views from workers have recently been sought via the Kings Fund review and recommendations are being acted upon.
Issues raised via speaking up are part of the performance data discussed openly with commissioners, CQC and NHS Improvement.	Meeting expectation		Information is shared accordingly on a 2-way basis.
Discussion of FTSU matters regularly takes place in the public section of the board meetings (while respecting the confidentiality of individuals).	In development	Direct, regular, formalised reporting from the Lead FTSUG to Board to be implemented.	Discussion will take place in the public section of board meetings, when matters are raised.
The trust's annual report contains high level, anonymised data relating to speaking up as well as information on actions the trust is taking to support a positive speaking up culture.	In development	Identified as an action for the Lead FTSUG to include data in future annual report publications.	The trust's approach to managing and responding to speak up issues is included in our annual report.

Reviews and audits are shared externally to support improvement elsewhere.	In development	Identified as an action for the Lead FTSUG.	
Senior leaders work openly and positively with regional FTSU Guardians and the National Guardian to continually improve the trust's speaking up culture	In development	For the Lead FTSUG to work with senior leaders and inform them of regional and National FTSUG contacts.	Within the trust's guidance for managers when responding to speak up concerns there is signposting to the National Guardian Office if required.
Senior leaders encourage their FTSU Guardians to develop bilateral relationships with regulators, inspectors and other local FTSU Guardians	Meeting expectation	Lead FTSU Guardian appointment is pending, who will develop relationships with stakeholders	The staff governor guardians are part of the regional FTSUG network and link with the National Office training, annual conference and events. They are also involved in regulator reviews/ visits.
Senior leaders request external improvement support when required.	Meeting expectation		Where a need is identified, senior managers are responsible for ensuring the appropriate support is available.

Leaders are focused on learning and continual improvement			
Senior leaders use speaking up as an opportunity for learning that can be embedded in future practice to deliver better quality care and improve workers' experience.	In development	Implement associated actions arising from King's Fund review to further evidence how learning is embedded and spread	Evidence of regular contact from staff with senior leaders whose views and opinions are welcomed and responded to
Senior leaders and the FTSU Guardian engage with other trusts to identify best practice.	Meeting expectation		Staff Governor guardians regularly meet with FTSUGs from other trusts across the region to share best practice and discuss national guidance.
Executive and non-executive leads, and the FTSU Guardian, review all guidance and case review reports from the National Guardian to identify improvement possibilities.	In development	The lead FTSUG to facilitate case review reports and relevant national guidance within the regular meetings with the chief executive, chair, non-exec lead and director or workforce.	

Senior leaders regularly reflect on how they respond to feedback, learn and continually improve and encourage the same throughout the organisation.	In development	Implement King's Fund review action plan	King's Fund review commissioned to garner feedback from staff on this area of organisational culture
The executive lead responsible for FTSU reviews the FTSU strategy annually, using a range of qualitative and quantitative measures, to assess what has been achieved and what hasn't; what the barriers have been and how they can be overcome; and whether the right indicators are being used to measure success.	In development	Lead FTSUG to formalise FTSU strategy to include qualitative and quantities measures	Director of Workforce reviews FTSUG indicators and reports to Board via the Audit Committee at least annually.
The FTSU policy and process is reviewed annually to check they are fit for purpose and realistic; up to date; and takes account of feedback from workers who have used them.	Meeting expectation	Lead FTSUG to ensure staff feedback is incorporated into future reviews.	The policy and process is reviewed in accordance with national guidance. Specific staff contacts are updated when there are any changes to named individuals within the policy as required,
A sample of cases is quality assured to ensure: • the investigation process is of high quality; that outcomes and recommendations are reasonable	In development	Lead FTSUG to introduce quality assurance of FTSU processes.	Policy in place which details the investigation process to ensure they are independent, fair and objective and staff

and that the impact of change is being measured • workers are thanked for speaking up, are kept up to date though out the investigation and are told of the outcome • Investigations are independent, fair and objective; recommendations are designed to promote patient safety and learning; and change will be monitored			are kept up to date of progress and outcome.
Positive outcomes from speaking up cases are promoted and as a result workers are more confident to speak up.	In development	Lead FTSUG to consider communication options to promote results and action taken in response to staff speaking up within the trust.	
Individual responsibilities			
Chief executive and chair			
The chief executive is responsible for appointing the FTSU Guardian.	Meeting expectation		The chief executive, supported by the Director of Workforce,

			has ensured that appointments to guardian roles has taken place.
The chief executive is accountable for ensuring that FTSU arrangements meet the needs of the workers in their trust.	Meeting expectation		The chief executive takes accountability for FTSU arrangements across the trust.
The chief executive and chair are responsible for ensuring the annual report contains information about FTSU.	Meeting expectation		The chief executive and chair ensures that the annual report contains FTSU and FTSUG information.
The chief executive and chair are responsible for ensuring the trust is engaged with both the regional Guardian network and the National Guardian's Office.	Meeting expectation		The chief executive and chair ensure that our staff governor guardians are involved in regional FTSU networks and facilitated the National Guardian's Office to present to the board of directors in June 2018.
Both the chief executive and chair are key sources of advice and support for their FTSU Guardian and meet	Meeting expectation		The chief executive and chair have regular meetings arranged with

with them regularly.			the staff governor guardians and are both accessible to them outside of these meetings to provide advice and support.
Executive lead for FTSU			

Ensuring they are aware of latest guidance from National Guardian's Office.	Meeting expectation		The Director of Workforce is informed of the latest guidance from the National Guardian's Office.
Overseeing the creation of the FTSU vision and strategy.	Meeting expectation		Responding to feedback from the commissioned King's Fund review, the Director of Workforce informed the Board of recommendations and is acting on them i.e. the appointment of a Lead FTSUG and strengthening the speak up culture across NNUH.
Ensuring the FTSU Guardian role has been implemented, using a fair recruitment process in accordance with the example job description and other guidance published by the National Guardian.	Meeting expectation		The Director of Workforce agreed the FTSUG and Lead FTSUG appointments with the Trust Board. The appointments were made using the National Guardian's Office job description and

			guidance.
Ensuring that the FTSU Guardian has a suitable amount of ring fenced time and other resources and there is cover for planned and unplanned absence.	Meeting expectation		The Director of Workforce led the appointments of six staff governors to act as FTSUGs. The structure is currently being strengthened by appointing a dedicated Lead FTSUG on a full time basis.

Ensuring that a sample of speaking up cases have been quality assured.	In development	To work with the Lead FTSUG to consider mechanisms for quality assurance.	
Conducting an annual review of the strategy, policy and process.	Meeting expectation		Overseen by the Director of Workforce.
Operationalising the learning derived from speaking up issues.	In development	To work with the Lead FTSUG to agree and consider ways to share learning across the organisation.	
Ensuring allegations of detriment are promptly and fairly investigated and acted on.	Meeting expectation		Any allegation would be managed promptly and fairly investigated in accordance with the appropriate trust policies.
Providing the board with a variety of assurance about the effectiveness of the trusts strategy, policy and process.	Meeting expectation		Annual reporting in place via the Audit Committee.
Non-executive lead for FTSU			

Ensuring they are aware of latest guidance from National Guardian's Office.	In development	Executive lead to ensure designated NED is briefed on National Guardian guidance and training / conferences	
Holding the chief executive, executive FTSU lead and the board to account for implementing the speaking up strategy.	Meeting expectation		Discussion at meetings of the Board of Directors
Robustly challenge the board to reflect on whether it could do more to create a culture responsive to feedback and focused on learning and continual improvement.	Meeting expectation		Discussion at meetings of the Board of Directors
Role-modelling high standards of conduct around FTSU.	Meeting expectation		Discussion at meetings of the Board of Directors
Acting as an alternative source of advice and support for the FTSU Guardian.	Meeting expectation		Designated NED contact details highlighted in Speak Up Policy
Overseeing speaking up concerns regarding board members.	Meeting expectation		Oversight role established
Human resource and organisational development directors			

Ensuring that the FTSU Guardian has the support of HR staff and appropriate access to information to enable them to triangulate intelligence from speaking up issues with other information that may be used as measures of FTSU culture or indicators of barriers to speaking up.	Meeting expectation		The staff governor guardians meet with the Director or Workforce and a dedicated HR Manager on a monthly basis to access information and seek advice accordingly. They are both also contactable outside of the regular monthly meeting.
Ensuring that HR culture and practice encourage and support speaking up and that learning in relation to workers' experience is disseminated across the trust.	Meeting expectation	Learning from speak up issues to be included in future organisation wide communications.	HR practice supports encouraging staff to speak up and learn from workers experiences. HR policies are reviewed and agreed with staff side representatives to ensure workers experiences are considered,
Ensuring that workers have the right knowledge, skills and capability to speak up and that managers listen well	Meeting expectation		All staff have access to a range of speak up materials and support via the intranet Speak

and respond to issues raised effectively.			Up hub page. HR advise managers to listen and respond to issues in accordance with trust policies and specifically the managers checklist for responding to concerns which is contained within the Speak Up Policy.
Medical director and director of nursing			
Ensuring that the FTSU Guardian has appropriate support and advice on patient safety and safeguarding issues.	In development	To be established once Lead FTSU Guardian is appointed.	
Ensuring that effective and, as appropriate, immediate action is taken when potential patient safety issues are highlighted by speaking up.	Meeting expectation		Staff governor guardians and staff are able to escalate matters directly to the Medical Director and Chief Nurse who can take immediate action as required, in response to any speak up issue.

Ensuring learning is operationalised within the teams and departments that they oversee.	Meeting expectation	Embedding of new SIG approach to organisation learning in respect of incidents and near misses.	Current learning is shared through clinical governance routes and could be enhanced as per the identified action.