Our Vision
The best care for every patient

NHS
Norfolk and Norwich University Hospitals
NHS Foundation Trust

**MEETING OF THE TRUST BOARD IN PUBLIC**
**WEDNESDAY 11 SEPTEMBER 2024**

A meeting of the Trust Board will take place at 9.30am on Wednesday 11 September 2024 in the Boardroom Norfolk & Norwich University Hospital and MS Teams

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

**AGENDA**

| | Item | Timing | Lead | Purpose |
|---|---|---|---|---|
| 0 | Clinical/Departmental Visits – see separate schedule | 08.45-09.15 | | |
| 1 | Apologies & Declarations of Interest<br>- Apologies from Bernard – Michael Irvine deputising<br>Reflections on Clinical/Departmental Visits | 09.30-09.45 | Chair | Information/ Discussion |
| 2 | Minutes of the Board meeting held in public on 05.06.24 | 09.45 -09.50 | Chair | Approval |
| 3 | Matters arising and update on actions | | Chair | Discussion |
| 4 | Patient Experience of Cancer Care – Julie Speight (Patient), Bethan Phillips (Macmillan Information Manager), Jo Richardson (Lead Cancer Nurse), Rachel Casey (Macmillan Personalised Care Lead) and Sarah Higson (Associate Director for Patient Engagement and Experience) attending | 09.50 -10.10 | RC | Discussion |
| 5 | Chief Executive's Update | 10.10-10.25 | CEO | Discussion |
| 6 | Draft Green Plan<br>– Ellen Goodwin (Sustainability Manager) invited | 10.25-10.40 | SH | Approval |
| 7 | Freedom to Speak Up update<br>– Fran Dawson (Lead FTSU Guardian) invited | 10.40-10.55 | PJ | Discussion |
| 8 | CQC reports & improvement plan * | 10.55 -11.10 | LD | Discussion |
| 9 | **Reports for Information and Assurance:** | | | |
| | (a) IPR – Workforce data | 11.10-11.40 | PJ | Information, assurance & approval as specified |
| | (b) Quality and Safety Committee (30.07.24) | | PC | |
| | (c) IPR – Quality, Safety and Patient Experience data | | RC/BB | |
| | (d) Finance, Investments and Performance Committee (31.07.24) | | NG | |
| | (e) IPR – Performance and Productivity data | | CC | |
| | (f) Finance – YTD report | | LS | |
| | (g) Major Projects Assurance Committee (31.07.24) | | NG | |
| | (h) Committees in Common | | TS | |
| 10 | Questions from members of the public | | Chair | |
| 11 | Any other business | | | |

*** Background documents uploaded to Resource Centre/Website**

**Date and Time of next Board meeting in public**

The next Board meeting in public will be at 9.30am on Wednesday 06 November 2024 in the Boardroom of the Norfolk and Norwich University Hospital

# REPORT TO TRUST BOARD

| | |
|---|---|
| **Date** | **11 September 2024** |
| **Title** | **Green Plan** |
| **Author & Exec Lead** | **Ellen Goodwin, Simon Hackwell** |
| **Purpose** | **For Discussion/Agreement** |
| **Relevant Strategic Commitment** | **2 Together, we will support each other to be the best we can be, to be valued and proud of our hospital for all.**<br>**5 Together, we will use public money to maximum effect.** |

| | | | |
|---|---|---|---|
| **Are there any quality, operational, workforce and financial implications of the decision requested by this report? If so explain where these are/will be addressed.** | **Quality** | **Yes☐ No✓** | |
| | **Operational** | **Yes✓ No☐** | |
| | **Workforce** | **Yes☐ No✓** | |
| | **Financial** | **Yes☐ No✓** | |
| **Identify which Committee/Board/Group has reviewed this document:** | **Hospital Management Board**<br>**Finance Investments and Performance Committee** | | **Outcome/decision/changes made:**<br>**Approved by HMB – 16 July 2024**<br>**Approved by FIPC – 31 July 2024 – diversity considerations** |

## 1 Background/Context

The World Health Organisation considers climate change to be the biggest global health threat of the 21st century.

With around 4% of the country's carbon emissions, and over 7% of the economy, the NHS has an essential role to play in meeting the net zero targets set under the Climate Change Act,2008 and Health and Care Act, 2022.

Our new draft Green Plan takes us to within four years of NHS England's ambition to reduce direct emissions by 80% from 1990. Our current estimate suggests that our carbon footprint is still increasing although our efficiency is improving i.e. footprint increases are less than operational increases might otherwise suggest.

With climate change being the biggest global health threat of the 21st century our vision is to make sustainability a part of everything we do:

***The best care for every patient is the most sustainable care for every patient.***

**2 Key issues, risks and actions**

The Sustainability Committee has agreed the following as key areas of work as the overarching themes of the new Green Plan, plus abbreviated key objectives:

1. People Focussed leadership: NNUH will further develop communications and engagement to ensure appropriate profile is given to this plan to engender and support empowerment and transformation. NNUH will:
   - Have 500 Green Champions by the end of 2024 and ensure staff receive a level of sustainability education and objectives appropriate to their role.
   - Develop a PowerBI data dashboard and develop a green accreditation programme for wards/departments by summer 2024.
   - Have divisional green groups established and meeting bi-monthly by summer 2024. Groups will focus on sustainability streamlining.

2. Sustainable Models of Care: NNUH will embed sustainability into our divisional operations, adapting the way we work to be more informed and responsible consumers. NNUH will:
   - Review Medication usage and waste, to identify high carbon areas and alternatives identified/implemented wherever feasible.
   - Reduce non-sterile glove use by 50% by May 2026 and reduce clinical waste by 10% by 2026 (20% by 2027 aligning with Clinical Waste Strategy).
   - Work with partners to remove piped nitrous oxide from our operations by 2026 and ensure the adequate capture and destruction of Entonox.

3. Making our Infrastructure Count: NNUH will use technology to reduce its energy consumption, preparing for electrification/other decarbonisation in the future. NNUH will:
   - Ensure new permanent buildings >£15M will achieve BREEAM[1] Excellent as a minimum.
   - Reduce electrical demand by 30%, all things being equal, through lifecycle efficiency and other 'switch off'/demand projects.
   - Develop an options appraisal for decarbonising heat by 2025 and replace gas boilers with a more sustainable solution by 2030.
   - Deliver a 50% reduction in carbon emissions produced from waste by 2026 by introducing an offensive waste stream.
   - Develop plans to reduce water consumption, deliver biodiversity net gain and adapt to Climate Change, making the Trust more resilient.

4. Reducing Travel and Transport emissions: NNUH will support reducing the need to travel, encourage green forms of transport and look to provide supporting infrastructure. NNUH will:
   - Develop a net zero travel strategy by 2026: new Trust vehicles to be zero emission by 2027 and reduced staff travel emissions by 50% by 2033.
   - Use the Clean Air Hospital Framework to improve air quality across our sites.

[1] Building Research Establishment Environmental Assessment Method

5. Sustainable Procurement: NNUH will support procurement processes to limit the production of consumables where possible and ensure their responsible use and disposal. NNUH will:

    - Reduce consumables and eliminate single use plastics where practical, working to increase sterile services capacity over time.
    - Consider greener supply chain alternatives, using evidence, wherever practical.
    - Work to reduce meat consumption by 30% by 2032, deliver a new food digestor by March 2026 and deliver locally/seasonally sourced food.

6. Make it Happen: NNUH will work towards having the right funding and resources in place to support the Green Plan. This includes development of an 'invest to save' mechanism. NNUH will:

    - Develop a space utilisation strategy and subsequent masterplan by September 2025.
    - 3 to 5 sustainability schemes within our Capital Programme.

The Green Plan has now been through the following governance processes:

- Surgery, Critical and Emergency Care has endorsed the Green Plan and nominated a colleague to lead on sustainability within the division.
- Medicine has embedded sustainability into their innovation and efficiency group, adding sustainability to its title.
- Women and Children's has added sustainability to its terms of reference and are seeking a clinician to lead a divisional green group.
- Clinical Support Services are nominating triumvirate support for sustainability.
- HMB agreed the Green Plan on 16 July.
- FIPC agreed the Green Plan on 31 July.

Once agreed by the Board, we will begin a communications plan promoting the Green Plan to Staff, Patients and Visitors.

The 2023/24 annual report required an update on sustainability governance matters including detail on how climate related issues impact broader organisational plans and performance monitoring. NNUH will need to consider how sustainability is embedded within the broader organisational Strategy moving forward and seeks the Board's view on this as part of this paper.

**Issues**

Lack of budget to support this work as an area that needs consideration in the medium to longer term. Capital and Estates Committee and Finance Investments and Performance Committee will be asked to consider this in due course.

Sustainability Committee have talked about the decarbonisation of heat (i.e. moving away from gas) and off grid electricity production via solar panels on several occasions. Both can be done with support from the Public Sector Decarbonisation Scheme or indeed other investment channels that reduce our exposure to financial risk.

**Risks**

The main risk is around the Trust not having the investment available to reach net zero by 2040. This would lead to an increase in penalty fines over time and ongoing exposure to energy price volatility.

It is also critical that we begin to understand our tolerance for environmental risk and colleagues are seeking to develop a less subjective method as part of this process. The Board is asked to comment on this aspect as part of this paper.

**3 Conclusions/Outcome/Next steps**

The Board is asked to comment on and approve the Green Plan.

**Recommendations:** The Board is recommended to **COMMENT** on the contents of this paper and **APPROVE**:

- The Green Plan for communication
- Delegation to Sustainability Committee for its delivery

**APPENDIX A** – Draft Green Plan

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# Greening with PRIDE


## A more Sustainable NNUH

# Foreword

## 2023 was the hottest year on record by a large margin. It saw unprecedented levels of extreme weather events, the likes of which we'll see much more frequently as climate change progresses.

The acceleration of climate change presents a significant health challenge to our population and NNUH will see an increase in patient admissions with climate related diagnoses.

Climate change does not affect a population equally and will have a greater effect upon our vulnerable people – the elderly, the less wealthy and our children, so we must act carefully to ensure health inequalities are not widened.

As one of the largest employers, caring for hundreds of thousands of people, NNUH is one of the largest single emitters of greenhouse gases in Norfolk. Our responsibility for patient care is not just about the patient in front of us but extends to the wider community we serve and legacy we wish to leave to our successors.

The good thing is by embedding sustainability into our Trust we will not only reduce our impact on the environment, but also improve patient outcomes and staff wellbeing as well as provide financial savings – also known as the Triple Bottom Line.

Sometimes it can feel that as individuals there is not much we can do to change the world we live in. But you are not on your own. We already have over 400 Green Champions in the Trust and as a collective, simple things like being careful about waste disposal, energy use and checking whether products are sustainable, really can add up to something significant.

Acting decisively now will ensure that NNUH is in the best possible position to provide a healthy future for our whole community.

**Simon Hackwell,**
Executive Lead and Senior Responsible Officer for Sustainability

# Introduction

This Green Plan is for all NNUH staff. It highlights our commitment to improve sustainability and aims to ensure everyone's support in this journey.

The NHS has a vital role to play in the fight against climate change. It is a trusted public body and community anchor that can use its influence to drive down not only its own contribution to the national carbon footprint (~5%) but also show others how it's done. This is why on 1 July 2022, the NHS in England became the first health system to embed net zero into legislation, through the Health and Care Act 2022.

Climate change threatens the foundations of good health, with direct and immediate consequences for our patients, the public and the NHS. The World Health Organisation states that "Today, climate change is recognised as the single biggest threat to humanity. It impacts health in a myriad of ways, such as heat stress, increased infectious diseases and food production."

Sustainability in healthcare is about improving and promoting health and wellbeing for all, whilst respecting the capacity of the environment to support its delivery. At our hospitals we recognise that we have a duty to minimise the impact of our activities on the environment and ensure our resources are used efficiently.

We first adopted a Green Plan two years ago and have made some good progress in delivery to date. This plan is more streamlined and offers a more focused, two year take on more direct areas of influence. It takes us to within four years of our NHS England wide reduction target which commits to see an 80% reduction in direct emissions between 2028 and 2032.

This document serves as a vehicle for us to take an action-orientated approach towards improving sustainability, whilst ensuring our services remain fit for purpose today and in the future. It aligns NNUH with the wider NHS[1] and other relevant legislative drivers and outlines a clear road map to the sustainable operation and ongoing development of the Trust.

Our Sustainability Committee, made up of colleagues from across the organisation, monitors the delivery of this Plan and reports progress to the Board. It will review the plan in two years and amend as necessary to ensure it remains ambitious, agile and fit for purpose. Ultimately, we want to see significant progress in reducing our direct emissions ahead of this review.

# Climate change impact risks for NNUH

This Green Plan is for all NNUH staff. It highlights our commit Climate change poses a risk to hospital operations, as well as patients and staff:

- Higher temperatures combined with an ageing population, will increase service pressure, impacting patient outcomes and staff wellbeing.
- Shortages in energy, water and food could impact NNUH and our supply chain.
- Estate exposure from heat or flooding could cause damage and/or the need for unplanned works. New and emerging pests, plants and diseases would pose new health challenges and the risk of more pandemics.
- Increasing air pollution leading to a worsening of many chronic conditions would add further service pressure.

[1]NHS Long Term Plan, The NHS Standard Contract, NHS Operational Planning Guidance, Norfolk & Waveney Integrated Care System (ICS).

# Evidence

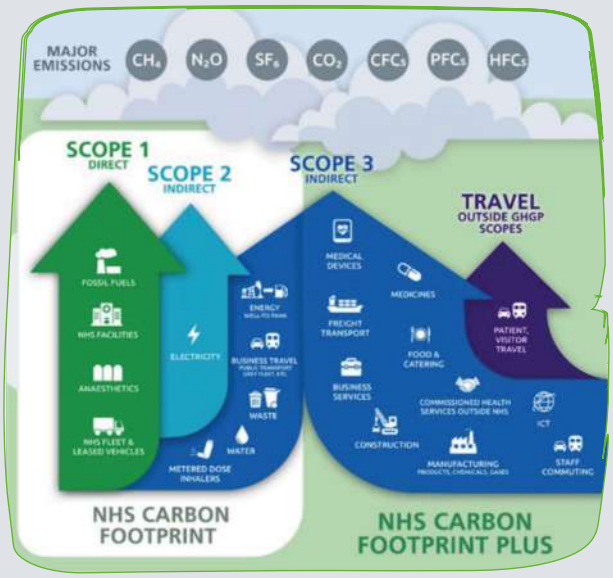



Figure 1: Emissions by scope

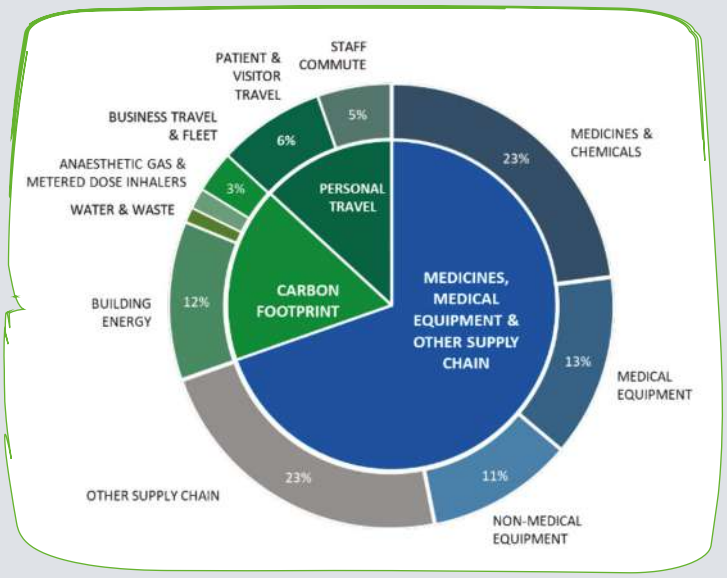



Figure 2: Sources of carbon emissions for NNUH

**NHS England estimated NNUH's core carbon footprint to be 22,320t CO2e *(equivalent impact of carbon dioxide in tonnes)* in 2019/20. Similar methodology used in 2022/23 provided an increased estimate of 25,800t CO2e. In addition, we estimate that our 'carbon footprint plus', again with differing methodologies for the original NHS England work, has increased by approximately 3% over the same period.**

**This growth has been influenced by:**

9% floorspace

**an increase in internal floor area at NNUH from 128,456m² to 140,603m²**

Staff Increase

**an increase in Whole Time Equivalent staff for the hospitals.**

9% Bed days

**an increase in bed days from 401,700 in 2018/19 to 439,600 in 2022/23**

While the increase in operational activity has contributed to an increase in our carbon footprint, our intensity *(i.e. CO2e/ patient activity)* has likely not increased by the same amount, meaning the Trust may have become more carbon 'efficient'. Given the complexity of the system, the changing methodologies, and the attribution of each element listed above, it is almost impossible to be certain, but we know that to achieve NHS net zero targets, we must consistently decrease both volume and intensity over time.

The first iteration of the Green Plan, issued in May 2022, aimed to create good baseline data to understand our current position on sustainability and carbon footprint. This goal has largely been achieved, although complex, and we now need to develop associated targets, KPIs, dashboards and a net zero pathway as laid out, in part, below.

# Our Story so far

## Green Champions

2023 saw the launch of our Green Champions campaign, which now has over 400 members. The campaign focused on a number of key areas including a 'Sustainability Week', World Environment Day, a Connected Special, Clean Air Day, Plastic Free July and some top sustainability tips to celebrate the NHS's 75th birthday. It also included Cycle to Work Day, Recycle Week, an event in Cromer, 'Switch off September', the AGM, National Tree Week and a Biodiversity Podcast.


## Green Groups

Gastroenterology has set up their own green group and has tackled projects around patient choice and staff learning. Radiology also has its own green group who meet regularly examining a number of factors, including energy use, as radiology is, unsurprisingly, a high consumer.

Our Emergency Department registered with GreenED in late 2023. It is the first evidence-based national framework specifically designed for secondary care and outlines a tiered actions framework alongside the guidelines and resources needed to achieve them. A dedicated team has been brought together with work underway to develop projects which the department can work towards.

## Electronic Patient Record

The Electronic Patient Record is not simply a digital programme; it's one of the biggest pieces of clinical and operational transformation in Norfolk and Waveney, set across three acute trusts. It will support NNUH to continue to work with system partners on future-proofing capacity and deliver significant sustainability benefits by aiding clinical decision making through remote consultations and monitoring so that care can be delivered closer to home where appropriate.

## Respiratory Virtual Ward

In February 2021 our Virtual Ward was set up with our respiratory department as an early adopter. In the first 2 years respiratory made up 23% of virtual ward referrals meaning suitable patients who need oxygen, nebulisers or intravenous antibiotics can manage their care at home. This has additional patient benefits, enabling them to stay active and mobile and reducing their deconditioning and hospital infection risk. It is estimated to have saved approximately 3,200 bed days which would have a carbon footprint of 121t $CO_2e$.

# Our Story so far

## Cardiology

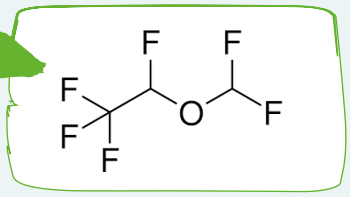
In March 2022 our Cardiology Department partnered with Vanguard Medical to collect and remanufacture our used electrophysiology catheters. Over the 18 months or so that we have been in partnership with them we have received nearly £17,000 in payments for collected devices and saved an estimated further £87,480 from using their remanufactured devices. We have also saved around 500kg CO2e by diverting devices from waste and reducing the manufacture of new devices.

## Switching from IV to oral antibiotics

Switching from IV to oral antibiotics where practicable also has sustainability benefits:
A 7-day course of ciprofloxacin has a carbon footprint almost 70 times greater via IV compared to the oral route. Swapping to oral also reduces consumables and anti-microbial resistance. Patient benefits include reduced length of stay as well as reduced infections and line-related events. The switch saves 11,000 hours of nursing time per year and £100,000.

A similar approach can be used in paediatrics by switching from liquid to tablet when appropriate.

## Volatile anaesthetic agent - Desflurane




Desflurane is used to keep patients asleep to undergo surgery and other procedures. It is the most polluting of the anaesthetic gases with use of one bottle of Desflurane being equivalent of driving over 3,000 miles in a standard petrol car.

In 2020, Dr Amy Greengrass, Consultant Anaesthetist and Clinical Lead for Sustainability presented this data to the Anaesthetic Department and immediately saw a drop in use of all volatile anaesthetic agents with virtual elimination of Desflurane. In 2020 51% of our general anaesthetics were gas based compared to 25% in 2023. In August 2023, Desflurane was removed from our formulary to pre-empt the national removal in 2024.

## Entonox cracking – working with Octagon

At NNUH we have around 4,800 deliveries per year and approximately 50% use Entonox, a greenhouse gas with a significant global warming potential. At NNUH, in conjunction with our PFI partners, we are currently in the process of procuring 3-4 individual patient mobile destruction units (MDUs) which can break down Entonox, after use, into its environmentally harmless constituents: nitrogen and oxygen. In the future we hope to move to a more centralised system.

## Pharmacy – reducing waste

The ease of ordering via EPMA can discourage use of pharmacy ward stocks, leading to additional workload and duplication of medication supplies. Pharmacy technicians now work more closely with wards to focus on earlier medicine reconciliation and patient documentation. Over a year NNUH believes it could reduce the supply of almost 50,000 medication items, saving £520,000 and 63t CO2e. Importantly a short pilot also improved morale in the pharmacy workforce by allowing greater autonomy and more time to focus on other patient care and sustainability improvements.

## Infection Prevention and Control (IP&C)

Our IP&C team has worked closely on implementing several initiatives, most notably, the Gloves Off campaign. The aim is to encourage glove use only when appropriate and discouraged otherwise. This has many benefits including reduction in single use plastic items, less contact dermatitis, a reduction in clinical waste and can actually reduce the risk of transmission. Gloves Off was introduced at NNUH as part of World Hand Hygiene week in May 2023. Quantifying reduction has been difficult due to changes in supply chain post covid, but we hope to ratify reductions shortly.

## Other projects

Diabetes and Endocrinology, in partnership with Pharmacy, have started work on a QI project looking at reducing waste from disposable insulin pens and our Radiotherapy Department has joined a European project auditing the carbon footprint of certain brachytherapy procedures.

Our Physiotherapy Department is also actively pursuing options to disinfect and re-use walking aids, a scheme which is already deployed in some other local Trusts.

## Community Diagnostic Centre (CDC)

Building Lean, Clean and Green is an approach NNUH has taken in the design for the new Community Diagnostic Centre. Early consideration of sustainability and a full lifecycle thought process led to the CDC being designed as a net zero building and one that would facilitate waste reduction and a circular economy. It aims to be classed as BREEAM (Building Research Establishment Environmental Assessment Method) “excellent” with respect to sustainability and energy.

# Our Story so far

## Sustainability checklist

For business cases over £250,000, NNUH now has a sustainability checklist.

## Theatre ventilation – working with Octagon and Serco

Theatre ventilation systems are a high user of energy and although vital to enable clean operating conditions they are often left on 24/7, albeit at a reduced rate. After careful consideration of Health Technical Memorandum 03-01 we began trialling turning ventilation off overnight. After three months we crucially saw no associated increase in surgical site infections. This will result in a cost saving of £45,000 in laminar flow theatres alone and a reduced carbon footprint of 50t CO2e annually.

## Chiller efficiencies – Octagon lifecycle betterment

Chiller replacements have and will continue to be replaced with more efficient versions; an approach regularly taken by the PFI as part of sustainable lifecycle betterment. Recently this change has led to a carbon footprint reduction of 73t CO2e annually.

## Waste segregation educational video


QI nurse for Medicine, Hiroko Spooner, commissioned a video outlining the sustainability and cost implications of mis-segregating waste. Clinical waste is typically 4x as expensive to dispose of as recyclable waste and its carbon footprint is almost 50x greater. The video can be found on NNUH's YouTube channel and has been viewed over 1,100 times since it launched in late 2023.

https://www.youtube.com/watch?v=FzdoWsH07EY

## Reusable sharps bins – delivered by Serco


Reusable sharps bins have been rolled out across the Trust. Once the project is fully up and running it will save an estimated 300t CO2e per year. The sharps bins project not only delivers sustainability benefits but health and safety benefits too. This deployment was negotiated through the Alternative Procedure process which offered the Trust financial savings too.

## Grounds Maintenance – working with Serco

We are working closely with Serco's grounds team to improve conservation within the grounds of NNUH. 2023 saw tree planting and more water bags, the first areas of wildflower matting and less frequent grass cutting. We have also extended the mulched areas around trees which helps to promote nature, water conservation and improves soil structure and aeration.

## Offsite interventions

Norse are already using more environmentally friendly cleaning products and have actively pursued LED lighting in both the Cotman Centre and Rouen Road.

## Sustainable Transport

NNUH has long worked with local bus companies to help drive modal shift through better timetabling and affordability. It's also working on improving active travel capacity and facilities and offers Beryl Bikes onsite as well as onsite bike maintenance and an affordable salary sacrifice scheme.

## What can we all do?

Every staff member is in a unique position to see which processes, consumables and equipment have room for sustainability improvement in their area. We want everyone to feel empowered to act but there are some things common to all departments:

- Always remember the mantra of refuse, reduce, re-use, repurpose and recycle *(including in pharmacy where appropriate)*:
  - Reduce unnecessary consumables, particularly single-use items including non-sterile gloves via 'Gloves Off' *(see Our Story so far)*. This could lead to a reduction in glove use of 50%.
  - Rigorous waste segregation, leading to a 20% reduction in clinical waste.
- Consider greener supply chain alternatives and greener forms of travel *(see section 4)*.
- Turn off non-essential equipment out of hours - i.e. computers and lights.
- Prescribe lower carbon footprint medication - i.e. dry power inhalers and IV to oral where available and appropriate.

# Our two-year plan

This plan takes us to within four years of NHS England's ambition to reduce direct emissions by 80%.

**Our vision is to make sustainability a part of everything we do: The best care for every patient is the most sustainable care for every patient.**

## Together, NNUH will:

**Deliver an average 10% reduction in our Core Carbon Footprint per year**

→ 2,600 tonnes

**Deliver an annual 5% reduction in our Carbon Footprint Plus with the aim of this increasing to 8% by 2030**

→ 6,250 tonnes, rising to 10,000 tonnes

"We do not inherit the earth from our ancestors, we borrow it from our children"

## 1. People Focused Leadership[2]:

**NNUH will further develop communications and engagement to ensure appropriate profile is given to this plan to engender and support empowerment and transformation.**

### Together, NNUH will:

- Have 500 Green Champions by the end of 2024.
- Develop a PowerBI data dashboard including a minimum of energy, anaesthetic gases and waste by summer 2024.
- Have divisional green groups established and meeting bi-monthly by summer 2024. Groups will be focused on undertaking a peer-review streamlining process to positively address sustainability. They will feedback, implement and monitor through Divisional Performance Committee.
- Develop a green accreditation programme for wards/departments by summer 2024.
- Ensure all staff receive a level of sustainability education appropriate to their role.
- Ensure senior leaders having sustainability actions within their annual objectives for 2025/26.
- Ensure all Trust policies and procedures undergo a sustainability accreditation as part of their update/approval process.

## 2. Sustainable Models of Care:

**NNUH will embed sustainability into our divisional operations, adapting the way we work to be more informed and responsible consumers.**

### Together, NNUH will:

- Identify specific energy/carbon hotspots and trace them to their underlying clinical activities and associated carbon reduction measures identified and implemented wherever practicable.
- Review **Medication** usage and waste, to identify high carbon areas and alternatives identified/implemented wherever feasible - i.e. IV to oral and low carbon inhalers where appropriate.
- Reduce non-sterile glove use by 50% by May 2026 to align with World Hand Hygiene Day.
- Reduce clinical waste by 10% by 2026 *(20% by 2027 to align with the Clinical Waste Strategy)*.
- Work with partners to remove piped Nitrous Oxide from our operations by 2026 and ensure the adequate capture and destruction of Entonox.
- Work to increase sterile services capacity to limit the amount of single use items needed onsite.
- Ensure the Trust's strategic research programme includes targeted sustainability research.
- Continue to work with **Digital Health** to explore new ways to reduce our carbon footprint.

[2]Aligned with ICS focus

# 3. Making our Infrastructure Count:

**NNUH will use technology to reduce its energy consumption, preparing for electrification/other decarbonisation in the future.**

Together, NNUH will work closely with **Estates and Facilities** to:

- Ensure new permanent buildings >£15M will achieve BREEAM[3] Excellent as a minimum.
- Reduce electrical demand by 30%, all things being equal, through lifecycle efficiency *(including sensored LED)* and other 'switch off' /demand projects.
- Develop an options appraisal for decarbonising heat by 2025.
- Replace gas boilers with a more sustainable solution by 2030 *(and consider back up)*.
- Deliver a 50% reduction in carbon emissions produced from waste by 2026, in line with the Clinical Waste Strategy
- Introduce an offensive waste stream as soon as possible.
- Introduce further opportunities for recycling i.e. soft plastics and certain clinical packaging.
- Develop a **Biodiversity Plan** and deliver Biodiversity Net Gain for new projects.
- Develop a Climate Change **Adaptation** *(and Resilience)* Strategy.
- Develop a plan to reduce water consumption.

# 4. Reducing Travel and Transport emissions:

**NNUH will support reducing the need to travel, encourage green forms of transport and look to provide supporting infrastructure.**

**Together, NNUH will:**

- Develop a net zero travel strategy by 2026. It will ensure all new vehicles owned and leased by the Trust will be zero emission by 2027 and aim to reduce staff travel emissions, including commuting by 50% by 2033, in line with Net Zero Travel and Transport Strategy.
- Use the Clean Air Hospital Framework to improve air quality across our sites.

[3] Building Research Establishment Environmental Assessment Method

# 5. Sustainable Procurement:

**NNUH will support procurement processes to limit the production of consumables where possible and ensure their responsible use and disposal.**

**Together NNUH will:**

- Contribute to national supply chain activities that will lead to reductions in the carbon footprint.
- Reduce consumables and eliminate single use plastics wherever practical by following the waste hierarchy: refuse, reduce, re-use, repurpose and recycle.
- Consider greener supply chain alternatives, using evidence, wherever practical.
- Work with Serco to deliver the Food and Drink Strategy and look to reduce meat consumption by 30% by 2032 through the new Alternative Procedure (2027), deliver a new food digestor by March 2026, deliver locally/seasonally sourced food onsite, ensure catering facilities are used efficiently.

# 6. Making it Happen:

**NNUH will work towards having the right funding and resources in place to support the Green Plan. This includes development of an 'invest to save' mechanism.**

**Together, NNUH will look to:**

- Recruit a Waste and Energy manager to support efficiencies in Estates and Facilities.
- Further embed sustainability into business planning.
- Retain clean renewable electricity through a new aggregation arrangement with NHS England.
- Develop a space utilisation strategy and subsequent masterplan by September 2025.
- 3 to 5 sustainability schemes within our Capital Programme.

# 1.People Focused Leadership

**This theme relates to the establishment of a point of focus for sustainability issues, on a day-to-day basis.**

## Green Champions

Engaging our workforce is vital for the delivery of this Green Plan if we are to limit risk in terms of its delivery. Shifts in behaviour and learning, driven by cultural values and embedding sustainability in everyday operations is vital. We know that engagement of a relatively small amount of people ~25% can lead to social tipping point: we aspire to achieve this through this renewed plan.


So far, we have established a Green Champions communications campaign which includes a network of Green Champions, regular blogs and staff communications as well as engagement with the Patient Panel and Governors. Through this network, NNUH will arm staff with actionable information and advice, empowering them to embed positive changes at the operational level.

**NNUH aims to deliver on this theme by:**

- Having 500 Green Champions by the end of 2024
- Developing a PowerBI data dashboard for information dissemination by summer 2024
- Having Divisional green groups established and meeting bi-monthly by summer 2024
- Developing a green accreditation programme for wards/departments by summer 2024
- Introducing a system to reward staff for their personal contributions to sustainability
- Developing a PowerBI data dashboard for information dissemination by summer 2024
- Working with Workplace Health and Wellbeing and Practice Development and Education

**NNUH will work with identified stakeholders, such as Octagon, Serco, Norse, Norwich Research Park (NRP) and Integrated Care System (ICS) partners to deliver strategic and cooperative change with shared sustainable objectives as a key driver.**

# 2. Sustainable Models of Care

This theme focuses on the clinical element of sustainability. It covers NNUH's four clinical divisions, with sustainability being synergistic with our ongoing work in providing evidence based, high quality care for our patients, something the CQC was particularly interested in during their recent visit.

Adapting models of care can reduce the environmental impact of our services. The best way to improve sustainability in healthcare is to improve human health through preventative care. Promoting healthy eating and physical exercise, both of which benefit our planet too through reduced air pollution and plant-based diets, is an example of how this can be achieved.

Similarly, moving care into the community, where appropriate, reduces the demand on high carbon acute services and gives a much better patient experience.

Digital methods of care like the virtual ward and patient-initiated care, again where appropriate, can also offer sustainability benefits. Digital care helps to reduce the need to travel as well as the volume of paper required to conduct our operations. It can also reduce the number and acuity of services through more efficient and coordinated access to care as well as earlier diagnosis. To complement this, we need to develop digital literacy.

Finally, we know that pregnant women, children and older people are more vulnerable to the climate changes we are seeing already – air pollution and extreme heat in particular. Climate change is further increasing health inequality and we must work hard to ensurethis is minimised.

**Divisions are asked to set up Green Groups. They should identify specific energy/ carbon hotspots and trace them to the clinical pathway and identify and action measures to reduce wherever practicable.**

**This should be supported by the Trust's Strategic Research Programme and by Departmental Green Groups, including Quality Improvement, where necessary or where interest/ resource dictates.**

**The Centre for Sustainable Healthcare is a valuable resource which covers most clinical specialties.**

## Surgery, Critical and Emergency Care

Demands and consumes a huge amount of energy and carbon intensive resources, many of which are single use. The carbon footprint of surgical care in the UK in 2019 was estimated as 5.7million t CO2e, equivalent to 3.2million standard petrol cars.

## Medicine

Medicine manages and influences clinical activity in a significant proportion of the hospitals. NNUH has over 60 medical specialties, all of whom have their parts to play. There are some great examples of work in our Medical Division already but there are further opportunities in other departments including water intensive renal, the Acute Medical Units (AMUs) and Older People's Medicine – a particularly vulnerable demographic, in particular.

## Women and Children's

Women and Children's is the smallest but arguably the one with the demographic most at risk from climate change so one where adaptation, as well as mitigation, are critical. It will be crucial to try and mitigate the impacts of climate change on women's health, as a demographic known to be more vulnerable to climate change and adapt to its effects on our health for our children and young people.

## Clinical Support Services

Our Clinical Support Services Division are already making great strides in sustainability *(see Our Story so far)*. The Division will continue to strive for sustainability benefits throughout their operations, including an increase in sterile service capacity and look to extend towards dietetics and sustainable food and nutrition.

## Anaesthetic gases

**Anaesthetic gases are an essential to the NHS. However, they are responsible for over 2% of all NHS emissions and an area we need to continue working on to reduce their impact. NNUH will:**

- continue to raise awareness of anaesthetic gas emissions and working with partners, remove from its operations, piped nitrous oxide (N2O), a gas which is 298 times more potent as a greenhouse gas than carbon dioxide.
- ensure the adequate capture and destruction of Entonox *(of which nitrous oxide is an active ingredient)*, which is used in many births across our Delivery Suite and Midwifery Led Birthing Unit at NNUH.

# 3. Making our Infrastructure Count

**This theme relates to energy efficiency, capital projects, heat decarbonisation, renewable energy, soft facilitates management and adaptation.**

## Capital Projects and Lifecycle Betterment

The Net Zero Building Standard *(and BREEAM Excellent for projects >£15m)*, with its whole life approach and ambition to accelerate Estate decarbonisation, should be followed as required. When looking at undertaking capital projects to relocate or expand services, the first consideration should always be whether the project can be incorporated into existing building stock rather than building new. If new building stock is required then we should think flexibly and adaptively about typology and scale at the design stage, aligning with clinical strategy. Buildings should be efficient to limit energy demand and be supported by green solutions. Energy and carbon footprint strategies and upfront limits should be set and monitored throughout the project's lifecycle and iterative learning and increased evidence-based ambition introduced as our net zero target approach. Circular economy principles *(where materials never become waste and nature is regenerated)* should be included.

## Make every kWh count

**Based on 2022-2023 data, NNUH is consuming 23.4GWh of electricity *(clean renewables: wind, solar and hydro)* and 39.6GWh of gas, equating to over 11,200t CO2e emissions per annum – a significant area for improvement.**

**Oil is still used at NNUH, but only as a back-up fuel source.**

**Through energy management alone, savings in the region of 20% could be achieved with close to zero capital expenditure, significantly reducing NNUH's energy demand.**

**We must identify and act on 'quick wins'.**

**Some key areas of focus within NNUH are:**

- Energy usage/intensity hotspots identified *(via sub-metering)* and acted on where possible.
- Upgrade to more energy efficient infrastructure *(through lifecycle replacement/condition survey output and associated lead in requirements)*, alongside other 'switch off'/demand projects:
  - Air cooling and chiller systems *(including consideration of refrigerant gases)*.
  - Heating, including recovery and re-use through a Heating Strategy.
  - Ventilation.
  - A Lighting Strategy which includes 'switch off' plans in certain areas.
- An evidence base built up to allow for more efficient building and carbon/energy management and distribution systems.
- Further smart tech/digitalisation opportunities explored and delivered where practicable.
- A space utilisation strategy and subsequent masterplan to ensure all buildings are occupied and operated to their maximum feasible capacity with energy and carbon production targets being met or exceeded.

## Prepare for electric heating, switch to non-fossil fuel heating and on-site renewables

**Some other key areas of focus within NNUH must involve:**

- Our decarbonisation of heat strategy needs to be developed into a clear roadmap for intervention. Working with the University of East Anglia (UEA) we will determine the best direction.
- Fabric first approach *(where possible)*: building upgrades to be planned and delivered.
- Efficiencies in the hot water systems planned and delivered.
- A bid to the Public Sector Decarbonisation Scheme *(PSDS)* to decommission gas boilers in a timely way.
- Increased electrical capacity in due course: onsite (likely via PSDS)/private wire renewables.
- Back up generation solution developed.
- Blending and hydrogen opportunities (for the new CHP) explored and developed.

## Water



Reuse of water is challenging in a hospital setting, however technology such as rainwater harvesting and water efficiency projects should be pursued where practicable.

# Biodiversity and green space

Healthy green spaces not only promote health and wellbeing, they also reduce the effects of climate change and improve biodiversity. There is perhaps a conflict between nature conservation and the ever-increasing demand for space on our constantly developing sites, but a growing number of patients, staff and visitors support the importance of good balance.

**NNUH will continue to work with partners, to deliver the three strands of Biodiversity Net Gain by:**

- Continuing to protect our nationally important Elm trees that pre-date Dutch Elm Disease.
- Developing our shelterbelt to improve air quality and limit surface run off during heavy rain.
- Continuing to record and understand the various species onsite, including birds, insects and fungi.
- Developing low lying planting and engaging in 'No Mow May' across our sites to continue diversification.
- Improving soil quality by adding topsoil, limiting compaction impact and surface run off.
- Eliminating pesticides and reducing the use of salt on our pathways.
- Continuing our 'Right Tree, Right Location' approach and ensuring appropriate pruning.

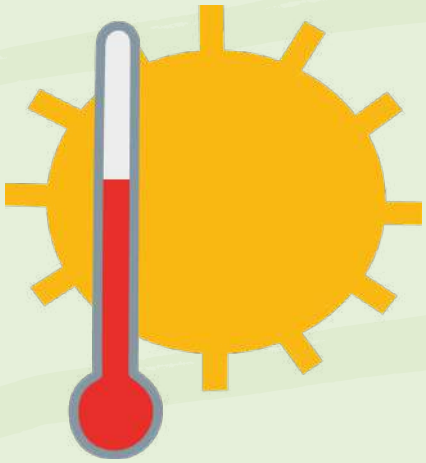
# Climate Adaptation and Resilience

It is increasingly important that we adapt to the effects of climate change. Rising temperatures and extreme weather conditions, such as flooding, droughts and heat waves, are increasing in severity and frequency and are now a visible reality that impacts the way our care is delivered.

Nature can provide shading, reduce surface temperatures and the urban heat island effect, and offer potential protection from climate change impacts such as flooding. These qualities make the existing shelterbelt and additional tree coverage particularly important at NNUH where internal overheating is an issue. Further investment in climate resilience could include increasing internal temperature controls through shading and mechanical ventilation and cooling. We could also invest in ways to reduce flooding risk.

**NNUH will:**

- Undertake a Climate Risk Assessment using NHS England's Climate Risk Assessment Tool with appropriate mitigation including work with Emergency Planning.
- Develop an Adaptation Plan for Climate Resilience *(specifically heat and flooding)* including service resilience *(Trust and suppliers)*.



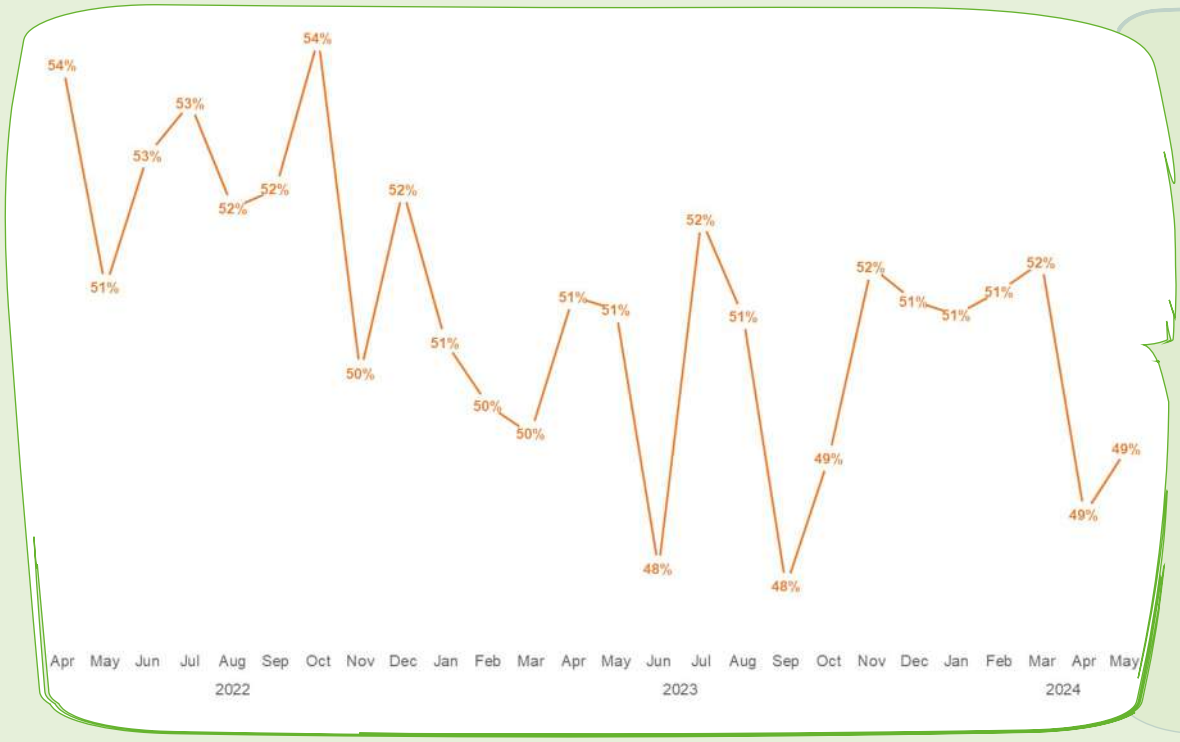
# Food and Nutrition

NNUH wants to offer healthy and nutritious catering, as well as reduce its environmental impact from both the food supplied and the catering facilities themselves. Providing more plant-based food options and locally and seasonally sourced food can help to support the aims of this Green Plan. Indeed, the National Food Strategy looks to reduce meat consumption by 30% by 2032.

NNUH will introduce initiatives to help educate people on the importance of food choices and actively encourage sustainable food choices, while working with dietetics to ensure the fundamental health and wellbeing of staff and patients is maximised. A new Food and Drink Strategy will have sustainability elements which include food re-use/waste reduction, the removal of macerators and the introduction of a further digestor and more composting where appropriate. NNUH will also work with suppliers to understand their sustainability credentials and encourage improvements where possible.

# Waste

Resource efficiency is an area that could help to reduce our carbon footprint. This includes considering the waste hierarchy including repair/repurposing and the appropriate segregation and disposal of waste.




Medical waste is required to be disposed of responsibly. NNUH will introduce a new offensive waste stream and alternative treatment in line with the NHS's Clinical Waste Strategy. This will help to reduce emissions from waste by 50% by 2026.

**Figure 3: Proportion of clinical waste**

There are further initiatives across the Trust that will help reduce emissions from waste including:

- Eliminating single use plastic from non-clinical areas and focus on reusable alternatives elsewhere.
- Reusing/reprocessing equipment *(such as walking aids)* until the end of their useful life.
- Introducing a 'swap shop' initiative, perhaps with other Trusts, for redundant pieces of equipment.
- Better waste segregation through continued communication and updated bin layouts, leading to:
  - Reduced clinical waste and the removal of 'covid' bins in non-clinical areas.
  - Establishing domestic as the 'go to' waste stream and the removal of office bins.
  - Increased recycling and consideration of other previously excluded items i.e. soft plastics and certain medical packaging.

# 4. Reducing Travel and Transport emissions

This theme relates to the movement of people: patients, visitors and staff which makes up 11% of our carbon footprint. The first area to focus on is reducing the initial need to travel. Digital transformation, hybrid working, and community intervention offer real opportunities in this regard. Thereafter we must endeavour to deliver modal shift by encouraging public and active travel, something we have made significant strides on in the last 18 months *(see case study)*, with further incentives yet to implement, including car sharing. Finally, the electrification of transport, and its supporting infrastructure, will help us achieve the last element of transition.

The new NHS Net Zero Travel and Transport Strategy looks to deliver a fully decarbonised fleet by 2035, with its ambulances following in 2040. Several key steps will mark the transition of NHS travel and transport:

**By 2026** **sustainable travel strategies will be developed and incorporated into Green Plans.**

**From 2027** **all new vehicles owned and leased by the NHS will be zero emission vehicles.**

**By 2033** **staff travel emissions will be reduced by 50%.**

**NNUH will:**

- Continue to be dedicated to the promotion of sustainable travel and transport and work with staff, visitors and partners to ensure ease of access and appropriate infrastructure in order to aid the transition to net zero.

**The Clean Air Hospital Framework should be used to improve air quality across our sites.**

# 5. Sustainable Procurement

This theme relates to NNUH's significant purchasing power as the sixth largest hospital in the UK. Our supply chain accounts for ~70% of our carbon footprint *(including our PFI partners)*. Analysing where more sustainable products, practices and delivery routes can be taken and considering lower carbon alternative supplies in our procurement will actively help to deliver our Green Plan. The Trust must engage with these parties and NHS Supply Chain to align our strategies and seek mutual benefit to reduce our Carbon Footprint Plus.

**The Trust has made good progress towards this theme, but this is an area where we would like to see more accelerated progress. NNUH now:**

- Requires all procurements £5m+ per year to have a Climate Reduction Plan. Expectations regarding content and value will increase over time to include all suppliers from 2027.
- Uses a 10% weighting for Social Value in all procurements including climate change on each occasion. Modern slavery requirements must be included in those tenders identified as medium/high risk.
- Uses the Evergreen Assessment Tool.
- Uses the following supply chain objectives:
  - NNUH aims to reduce its carbon footprint by 80% by 2036 and suppliers are expected to contribute 40% of this reduction.
  - NNUH aims to reduce its energy and water carbon footprint by 80% by 2030 and suppliers are expected to contribute 40% of this reduction, albeit by 2036.
  - NNUH aims to eliminate non-essential single use plastics at the earliest opportunity and reduce clinical single use plastics by half. Our supply chain is expected to facilitate this by either eliminating single use plastics from packaging, and/or follow the waste hierarchy by reducing, reusing or recycling.
  - NNUH aims to reduce transport emissions by 80% by 2036 with a 40% contribution expected from suppliers by reducing miles, consolidating deliveries and/or electrifying fleets.

**Areas of high supply chain emissions have been identified as follows: computer hardware/software, rents, imaging equipment maintenance, consulting services, medical and surgical equipment, pharmaceutical blood products and medical gases, orthotics, catering equipment maintenance, and dressings.**

## Supply chain

Many procurement decisions are made by NHS Supply Chain; it is our aim to align with these where possible as NNUH will then benefit from central efforts made to engage with suppliers to reduce their emissions. In due course, NHS Supply Chain will require product level carbon footprinting. When purchasing decisions are outside of this, we must strive to source products locally and through sustainable suppliers.

# 6. Making it Happen

## Governance, Accountability and Assurance

An Executive led Sustainability Committee is now established. Members include representatives from across the Trust and our partners including our Sustainability Manager and our Clinical Lead for Sustainability. It is tasked with embedding sustainability into our operational activity and working towards the actions set out here.

The Committee reports to Hospital Management Board as well as Finance, Investments and Performance Committee and reports to Capital and Estates Committee where necessary. Influence and reporting by exception is also established through the PFI sub-committees *(Hard FM, Soft FM and Commercials)* through into Liaison Procedure Meeting where required.

In order to further support embedment and accountability within the organisation NNUH looks to include sustainability objectives in senior leader appraisals in the first instance and seeks to work with HR further on similar initiatives. NNUH will also ensure all policies and procedures of the Trust undergo a sustainability accreditation as part of their update/approval process.

Ongoing work is taking place to engage other branches of Trust governance including each of the Clinical Divisional Boards, Procurement Board, Digital Transformation Committee and the Nursing, Midwifery and Clinicians Forum and Board.

**Divisions are asked to set up Green Groups. They should identify specific energy/carbon hotspots and trace them to the clinical pathway and identify and action measures to reduce wherever practicable.**

## Dedication to Funding, Resource and Finance

In the medium-term, a budget for feasibility/viability studies and resourcing *(including training)* will need to be allocated to enable meaningful change and to achieve the legislative targets required. This is essential to deliver actions within the Green Plan and ensure that the Trust is progressing towards its compliance requirements and reducing climate change risks.

In addition, the Capital Programme will need to include investment for both minor interventions that have invest-to-save benefits and (subject to the capital envelope) funds for major interventions, such as capital injection costs for the PFI. NNUH will actively pursue external financing for larger investments. This will include Carbon Energy Fund (CEF), Salix/ Department of Energy Security and Net Zero (DESNeZ) funding, and NHS funding. To minimise finance required, NNUH, commercial partners and Project parties, should consider:

- Minimising resource demands through staff training and facilities-based interventions.
- Increasing generation resilience on-site where possible to limit fuel price volatility.
- Working together to find whole lifecycle saving solutions, leveraging lifecycle funding.
- Ensuring all capital projects and business planning consider sustainability opportunities.
- Develop a space utilisation strategy to ensure Estate efficiency.
- Actively investing in adaptation measures for extreme events to reduce their impact.
- Ongoing reviews of emissions charge forecasts to limit risk.

**The Triple Bottom Line concept is useful for any project, be that cost or quality improvement or a business case for new investment – it combines the typical goals of cost and quality with environmental outcomes. Remember: patients, planet, profit. This concept is referenced throughout the Green Plan.**

# Key Performance Indicators

## 1. People Focused Leadership

| | |
|---|---|
| 500 Green Champions by the end of 2024 | 410 |
| 345 PowerBI data dashboard by summer 2024 | Yes/no |
| Divisional green groups established and meeting bi-monthly by summer 2024 | Yes/no |
| Green accreditation programme for wards/departments by summer 2024 | Yes/no |
| Senior leaders having sustainability actions within their annual objectives for 2025/26 | Yes/no |

## 2. Sustainable Models of Care

| | |
|---|---|
| Reduce non-sterile glove use by 50% by May 2026 to align with World Hand Hygiene Day | 406,500pw [4] |
| Reduce clinical waste by 10% by 2026 (20% by 2027). | 113.7[5] |
| Remove piped Nitrous Oxide from our operations by 2026. | Yes/no |

## 3. Making our Infrastructure Count

| | |
|---|---|
| Reduce electrical demand by 30%, all things being equal | 20.2m kWh[6] |
| Options appraisal for decarbonising heat by 2025 | Yes/no |
| 50% reduction in carbon emissions produced from waste by 2026 | 24 tonnes[7] |
| Introduce an offensive waste stream as soon as possible | Yes/no |
| Introduce further opportunities for recycling i.e. soft plastics and certain clinical packaging | Yes/no |
| Water reduction plan | Yes/no |

## 4. Reducing Travel and Transport emissions

| | |
|---|---|
| Net Zero Travel and Transport Plan. | Yes/no |

## 5. Sustainable Procurement

| | |
|---|---|
| Reduce consumables and eliminate single use plastics wherever practical | TBD |
| Consider greener supply chain alternatives, using evidence, wherever practical | TBD |
| Deliver a new food digestor by March 2026 | Yes/no |

[4] Q1 2024
[5] 12 months to Jan 2024
[6] 2023/24
[7] 2022/23


sustainability@nnuh.nhs.uk

Our Vision
The best care for every patient

NHS
Norfolk and Norwich University Hospitals
NHS Foundation Trust

# REPORT TO TRUST BOARD

| | |
|---|---|
| **Date** | **Wednesday 11th September 2024** |
| **Title** | **Freedom To Speak Up (FTSU) Report** |
| **Author & Exec Lead** | **Frances Dawson, Lead Guardian, Paul Jones Chief People Officer.** |
| **Purpose** | **For Information/Discussion** |
| **Relevant Strategic Commitment** | **1 Together, we will develop services so that everyone has the best experience of care and treatment.**<br>**2 Together, we will support each other to be the best we can be, to be valued and proud of our hospital for all.**<br>**4 Together, we will provide nationally recognised, clinically led services that are high quality, safe and based on evidence and research.** |

| | | | |
|---|---|---|---|
| **Are there any quality, operational, workforce and financial implications of the decision requested by this report? If so explain where these are/will be addressed.** | **Quality** | **Yes☐ No✓** | |
| | **Operational** | **Yes☐No✓** | |
| | **Workforce** | **Yes☐No✓** | |
| | **Financial** | **Yes☐No✓** | |
| **Identify which Committee/Board/Group has reviewed this document:** | | | **Outcome/decision/changes made:** |

**1. Background** Over 30,000 cases have been brought to NHS Freedom to Speak Up guardians throughout 2023/24 - the highest ever recorded, a 27.6% increase on the previous year. *"Culture is a patient safety issue. Every interaction – whether patient, family member, colleague or consultant – makes a difference to lives and outcomes.* Dr Jayne Chidgey-Clark, National Guardian for the NHS, National Guardians Office (NGO).

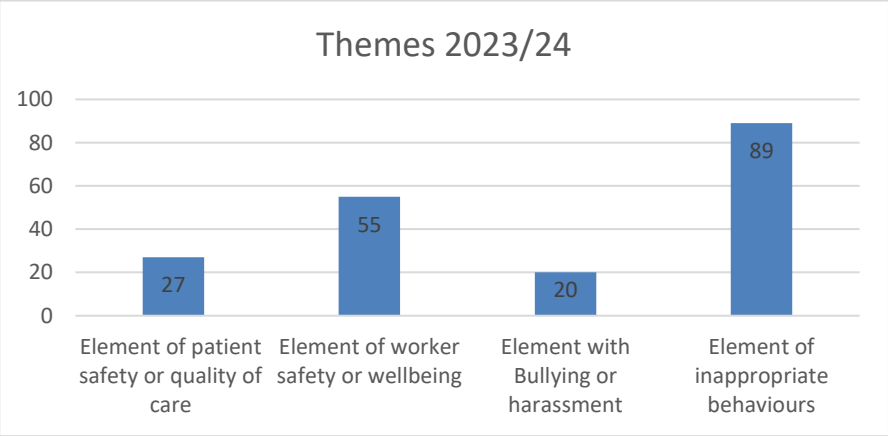
| | 2022/23 | 2023/24 |
|---|---|---|
| **Q1** | 56 | 45 |
| **Q2** | 57 | 64 |
| **Q3** | 63 | 69 |
| **Q4** | 44 | 88 |
| | **220** | **266** |

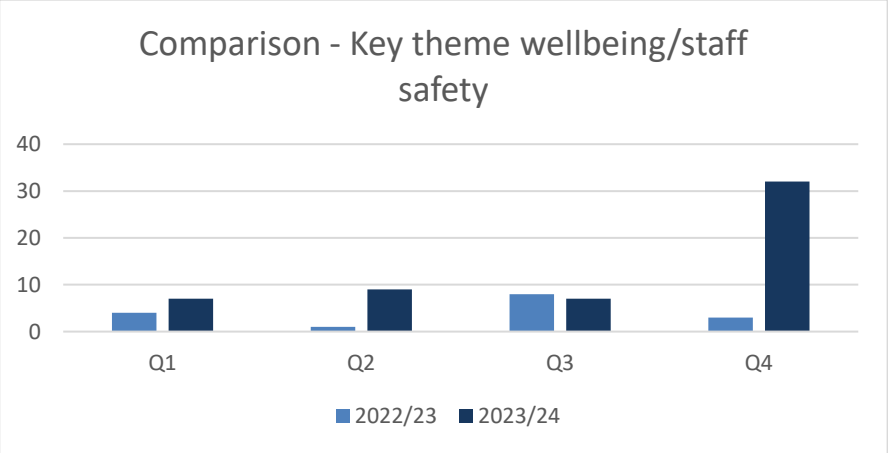
Speaking up, in safe and functional escalation systems, is part of everyone's responsibility in the NHS. The FTSU service acts as one of the routes available and aims to support the NNUH to achieve a healthy speak up culture, where matters are raised and addressed with high levels of consistency and efficiency across the organisation, resulting in learning and change where appropriate.

The NNUH saw a 21% increase in activity with anonymous matters accounting for only 7.9% of the cases compared to 11.8% the year before. A positive finding for the organisation, on the background of increased activity.

**2. Key themes**. NNUH key themes continue to follow the national picture, with behaviour of colleagues as the most cited reason for staff needing to seek support.

2.1 Wellbeing matters rose in Q4 of 2023/24. A closer look at the qualitative data we had available demonstrated that processes were often cited as part of the issue. PRIDE values or know your staff principles weren't always evident to staff when processes were being followed or conversely, processes were not followed as required.




2.2 Other wellbeing and safety matters related to workload, with staff sickness being felt in small teams, resulting in a sense of feeling that daily difficulties staff faced, were inevitable and uncontrollable.

Staff recognised the impact of pressure on their health but were less cognisant of what they could do to ensure they didn't succumb to stress. Lack of control is known to impact on morale and some staff were not comfortable raising this. They didn't believe their teams had control over what was being expected or asked of them, due to the hospital being viewed as under pressure.

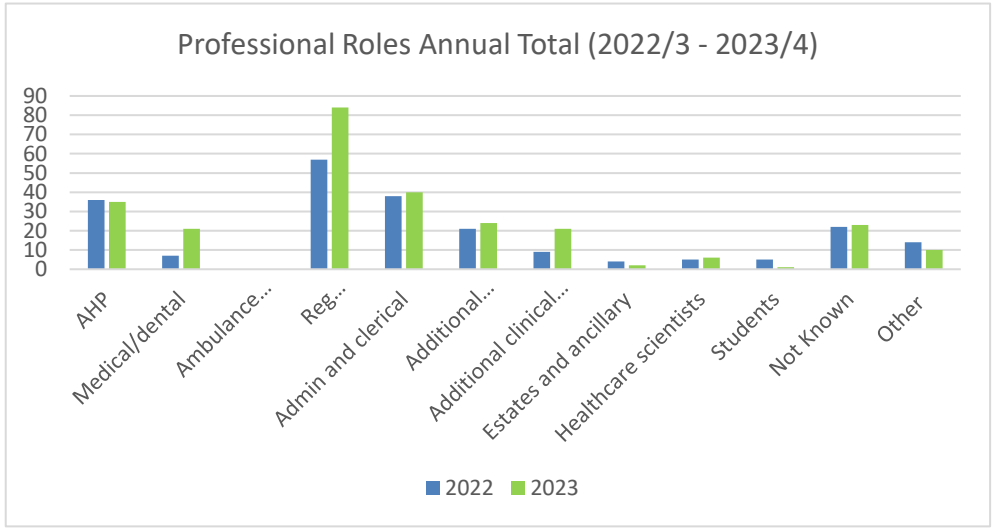
2.3 A spike in Q4 was partly due to one team raising a group concern. This was resolved and the team worked together with HR colleagues and their managers to look at what could be learnt from the matter. Colleagues had demonstrated great compassion towards a colleague who had not been well, although the statistics look concerning, the case related to a collective show of colleagues caring greatly about each other's welfare.

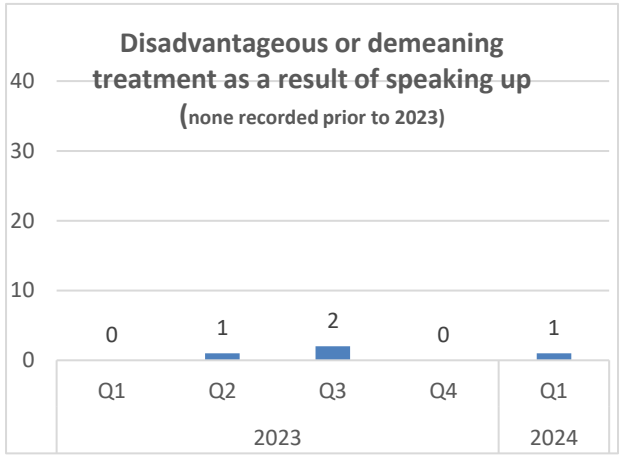
2.4 All patient safety matters are escalated as urgent matters. The majority last year related to ward situations, where extra patients had been admitted and escalation was a key feature within the NNUH. Senior staff were aware of the issues.

**3 Service user data** The FTSU service regularly monitors data on its users. We consider any local or national events that might impact patients or staff at the NNUH, such as periods of industrial action and recently national riots. We have not identified any recent significant fluctuations.

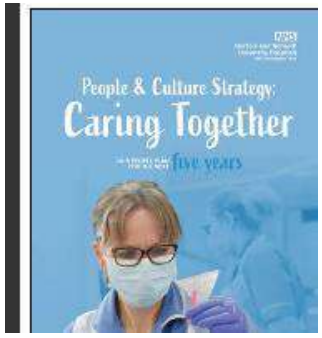
3.1 We continue to look at ways to improve access to speaking up and reducing barriers. We recognise that certain groups appear less likely to use the FTSU service and we are working collaboratively across the Trust, for example with our medical colleagues and Doctors in training, international recruitment team, and divisions through growing the speak up network. We seek to ensure that everyone at the NNUH has the know-how and feels safe to raise matters when they occur.

3.2 Recent data is provided below on staff groups and any reporting of detriment. This is helping us plan our proactive work moving forwards, including looking to improve the understanding of detriment across the Trust and how to prevent it from occurring. We are looking at ways of addressing this through policy, communication, and role modelling across the Trust, using Speak up month in October as a launch.




**4 Learning from staff speaking up and their experiences.** A key function of the FTSU service is to assist the organisation with learning from matters raised. Quarterly data, reported to the NGO is limited in its value for this. At the NNUH we have gone above what is required. We created KPI's and linked the learning to the People and Culture strategy Caring Together, which models key themes from the NHS people promise. Technical issues preventing the reporting of this data, have been resolved. This data will be useful for triangulation purposes.




**5. Next steps. NNUH FTSU Self-assessment -** It is a recommendation that Trusts undertake regular self-assessment of their organisation, using a recognised planning tool and guidance from the NGO and NHSE.

We have initiated this. The tool helps identify gaps and areas that we are performing well in. High level findings show we have a supported FTSU service with high engagement from the Trust. Areas for us to develop and improve on are how the learning is acted on, reducing known barriers for some of staff groups and measuring the effectiveness of interventions. Acting on these findings will help us address concerns related to any perception of futility in speaking up.

With improvement in numbers of staff speaking up openly, a working functional case management tool, an ability to report on KPI's and a clear focus for the Trust on next steps, we have opportunity to progress much further, addressing any futility in raising matters and learning from events.

**6. Training, leadership role modelling best practice/expertise –** as part of Speak up month, we want to ensure all senior leaders have completed speak up training, enabling them to role model and foster psychologically safety across the Trust.

Board members have three modules to complete; Speak Up, Listen Up and Follow up, available on the NNUH ESR platform. Reporting on this data will become part of our annual review and the Board is asked to undertake the training if not already completed prior to Speak up month in October.

**Recommendations:** The Board is recommended to: Support Speak Up Month, complete in full Speak up/Listen up and Follow up training.

| REPORT TO TRUST BOARD | | | | |
|---|---|---|---|---|
| **Date** | **11 September 2024** | | | |
| **Title** | **Care Quality Commission (CQC) Inspection Reports for Norfolk and Norwich University Hospitals NHS Foundation Trust** | | | |
| **Author & Exec Lead** | **Professor Lesley Dwyer, Chief Executive Officer** | | | |
| **Purpose** | **For Information** | | | |
| **Relevant Strategic Commitment** [delete as appropriate] | **1. Together, we will develop services so that everyone has the best experience of care and treatment.**<br>**2. Together, we will support each other to be the best we can be, to be valued and proud of our hospital for all.**<br>**3. Together, we will join up services to improve the health and wellbeing of our diverse communities.**<br>**4. Together, we will provide nationally recognised, clinically led services that are high quality, safe and based on evidence and research.**<br>**5. Together, we will use public money to maximum effect.** | | | |
| **Are there any quality, operational, workforce and financial implications of the decision requested by this report?**<br>**If so explain where these are/will be addressed.** | **Quality** | **Yes✓ No☐** | The overall quality rating for the organisation, requires improvement, but it should be acknowledged that services are effective and are staff are 'caring' as both domains have been rated as 'Good.' | |
| | **Operational** | **Yes✓ No☐** | At the time of the inspection the organisation had poor performance within the region of ambulance handovers, referral to treatment and cancer waiting times. | |
| | **Workforce** | **Yes✓ No☐** | The impact on our staff on reading this report due to the significant delay in it being published and the changes and improvements that have been implemented since November 2023. | |
| | **Financial** | **Yes✓ No☐** | The organisation and the wider system are in a financial recovery programme with triple lock processes in place which will have an impact on any investment required to address recommendations. | |
| **Identify which Committee/Board/Group has reviewed this document:** | **Board/Committee:**<br>Not applicable | | **Outcome:**<br>Not applicable | |

1. **Background/Context**

1.1. In September 2023, the CQC inspected Diagnostic Imaging, Outpatient Services and the Surgery, Critical and Emergency Care division. CQC returned in November 2023 to undertake a Well Led inspection regarding the overall management and leadership of the organisation. The outcomes of these inspections have collated into one report by the CQC which was published in August 2024.

1.2. In June 2024, CQC inspectors conducted an announced inspection of compliance with the Ionising Radiation (Medical Exposure) Regulations 2017 (IR(ME)R) of the diagnostics imaging department at the Norfolk and Norwich University Hospital.

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

2.1. There was a significant delay initiated within the CQC to release the draft report to the organisation to complete the normal factual accuracy process, which resulted in additional drafts of the report from the September – November 2023 inspection. There were no delays to the CQC IR(ME)R report.

2.2. The overall ratings for the main report are shown in Table 1 below, and the full details can be found in the full report (appendix 1). The overall trust quality and Well Led rating is 'Requires Improvement,' which is where the organisation had initially self-assessed itself in the autumn of 2023, through discussions with managerial teams and evidence reviews.

**Table 1: CQC ratings for Norfolk and Norwich University Hospitals NHS Foundation Trust**

| Ratings | | |
|---|---|---|
| Overall trust quality rating | Requires Improvement | ● |
| Are services safe? | Requires improvement | ● |
| Are services effective? | Good | ● |
| Are services caring? | Good | ● |
| Are services responsive? | Requires improvement | ● |
| Are services well-led? | Requires improvement | ● |

2.3. The main report contained eleven (11) 'Must Do's' and eight (8) 'Should Do's'.

**Trust wide Must do's:**

1. The trust must ensure that staff have received training in treating patients with learning disabilities and autism. (Regulation 18(2)(a))
2. The trust must ensure that the systems in place to purchase, renew and replace equipment are responsive, so service delivery is not impacted by equipment failures. (Regulation 15(1)(e))

**Diagnostic Imaging Must Do's:**

3. The service must ensure that there are processes in place to ensure there are enough suitably qualified and competent staff to make sure that the service can meet targets in respect to waiting times and reporting times. (Regulation 18(1))
4. The service must ensure that the systems in place to purchase, renew and replace equipment are responsive, so service delivery is not impacted by equipment failures. (Regulation 15(1)(e)).

**Outpatient Service Must Do's:**

5. The service must have enough staff to care for patients and keep them safe. (Regulation (18)(1))
6. The service must keep care records secure. (Regulation (17)(2)(c))
7. The service must ensure that they have safe systems for medicines management. (Regulation (17)(2)(f)(g)).

**Surgery Must Do's:**

8. The service must ensure that mental health risk assessments are completed for all surgical patients where a mental health need is indicated. (Regulation 12(2)(a))
9. The service must ensure World Health Organisation (WHO) surgical safety checklists are completed for all patients. (Regulation 12(2)(b))
10. The service must ensure that medicines are stored and recorded in line with policy. (Regulation 12(2)(g))
11. The service must ensure that records are updated and stored securely. (Regulation 17(2)(c)).

**Trust wide Should Do's:**

1. The trust should ensure people can always access care and treatment when they need it and waiting times for treatment are in line with the England average. (Regulation 12)

**Diagnostic Imaging Should Do's:**

2. The service should ensure that service users are informed of the availability of interpreter services. (Regulation 9).

**Outpatient Service Should Do's:**

3. The service should control infection risk well and provide equipment and furniture in line with national standards. (Regulation 12)
4. The service should ensure staff feel supported and valued. (18)

**Surgery Must Do's:**

5. The service should ensure that staff are aware of where ligature cutters are stored. (Regulation 12)
6. The service should ensure that equipment is properly maintained. (Regulation 12)
7. The service should ensure medical staff complete mandatory training. (Regulation 18)
8. The trust should ensure that their guidance on responding to deteriorating patients is consistently followed (Regulation 12)

2.4. The good and outstanding practice noted in the report should not be lost due to the overall rating. Some examples include:

- The radiology department had been awarded and maintained the Quality Standards in Imaging (QSI) Award since November 2012. Accreditation is the formal recognition that an imaging services provider has demonstrated that it has the organisational competence to deliver against key performance measures. These measures require the department to achieve high standards of service in relation to patient care and choice, safety, fit-for-purpose facilities, and clinical practices.
- In outpatients staff encouraged each other to be innovative and improve for the benefit of patients. Staff received certificates and vouchers for their contributions to improvements. Staff awards and nominations from patients were encouraged. We saw an example of staff innovation being awarded and inspired by an improved patient experience. Staff arranged for an anxious patient living with autism to bring their dog to attend their appointment.

- The trust had several evidence groups that worked collaboratively across the trust to provide assurance and develop ways of working across specific areas of care.

2.5. The CQC IR(ME)R report (Appendix 2) highlighted some examples of good practice, one example is that clinical leads took care to ensure that the service had set dose constraints for research participants and ethical approval for all studies.

**3. <u>Conclusions/Outcome/Next steps</u>**

3.1. The organisation has engaged fully with the CQC and completed the factual accuracy processes on each occasion including the submission of the improvement plan (due Monday 09 September 2024) within the timeframes set by the CQC.

3.2. The CQC inspections took place twelve months ago for the clinical areas and ten months ago for well led. There have been significant changes throughout the organisation of improvements made such as ambulance handover times. There have also been key changes to leadership roles at all levels within the organisation starting with a substantive Chief Executive and recruitment processes are being completed to convert the remaining interim leadership roles into substantive appointments.

3.3. The CQC improvement plan (Appendix 3) will be managed through the embedded CQC evidence group process which will be overseen by the Chief Nurse, Quality Programme Board and the Quality and Safety Committee.

3.4. The CQC IR(ME)R improvement plan (Appendix 4) submitted to the CQC IR(ME)R inspection team has been approved and a closure letter has been received for the inspection (Appendix 5).

**Recommendations:** The Board is recommended to:

- Note the summary of this report for information.
- The full reports in appendix one and two for information.
- Note the CQC IR(ME)R inspection file has been closed.
- The planned process for monitoring implementation of the improvement plan.

## Report on actions you plan to take to meet Health and Social Care Act 2008, its associated regulations, or any other relevant legislation.

Please see the covering letter for the date by when you must send your report to us and where to send it. **Failure to send a report may lead to enforcement action.**

| | |
|---|---|
| **Account number** | RM1 |
| **Our reference** | INS2-17078297001 |
| **Location name** | Norfolk and Norwich University Hospitals NHS Foundation Trust |

| **Regulated activity** | **Regulation** |
|---|---|
| **Treatment of disease, disorder or injury** | **Regulation 9**<br>**Person-centred care** |
| | **How the regulation was not being met:** |
| | The service should ensure that service users are informed of the availability of interpreter services. (Regulation 9) |

**Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve**

- Add signs within the department to reflect that interpreter services are available.
- Posters to be placed in department to inform users of the availability of hearing loops and the mini Tech-T devices for patients who are hearing impaired.

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| **Who is responsible for the action?** | Clinical Support Services |

**How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?**

- Review of availability of these posters/notices in relevant areas
- Monitor patient feedback for trend in complaints related to interpretation/signing

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| **Who is responsible?** | Clinical Support Services |

**What resources (if any) are needed to implement the change(s) and are these resources available?**

- Approach Trust supplier and Patient Engagement & Experience Team to identify if they have posters in various languages that promotes the availability of this software/service
- Medical Illustration team- option to create the posters.

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| **Date actions will be completed:** | November 2024 |

**How will people who use the service(s) be affected by you not meeting this regulation until this date?**

Regulation 9 standards not consistently being met**.**

| Regulated activity | Regulation |
|---|---|
| **Treatment of disease, disorder or injury** | **Regulation 12**<br>**Safe care and treatment** |
| | **How the regulation was not being met:** |
| | 1. The service must ensure that mental health risk assessments are completed for all surgical patients where a mental health need is indicated. (Regulation 12(2)(a))<br><br>2. The service must ensure World Health Organisation (WHO) surgical safety checklists are completed for all patients. (Regulation 12(2)(b))<br><br>3. The service must ensure that medicines are stored and recorded in line with policy. (Regulation 12(2)(g))<br><br>4. The trust should ensure people can always access care and treatment when they need it and waiting times for treatment are in line with the England average. (Regulation 12)<br><br>5. The service should ensure that staff are aware of where ligature cutters are stored. (Regulation 12)<br><br>6. The service should ensure that equipment is properly maintained. (Regulation 12)<br><br>7. The trust should ensure that their guidance on responding to deteriorating patients is consistently followed (Regulation 12)<br><br>8. The service should control infection risk well and provide equipment and furniture in line with national standards. (Regulation 12) |

| Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve | |
|---|---|
| **1** | **Action**<br>• Monthly Audit of the completion of page 11, Mental Health section of the Adult Inpatient 7 day booklet across all areas<br>• Monthly Audit of the completion of the risk review tool should one be indicated across all areas<br>• Nominate a Matron Lead to focus on leading improvements<br>• Implement a quality improvement project for completion of risk review tool and Mental Health section of the Adult Inpatient 7 day booklet<br>• Managers and Matron oversight of audit results for individual improvement<br>• Share audit results at Band 7 Sister's meeting for individual action plans<br><br>**Evidence to date**<br>• Risk review tool in place since June 2024, emailed to all SCEC ward managers and SCEC matrons |

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| | • Adult Inpatient 7 day booklet implemented since inspection with Mental Health section included<br>• Feedback on the Adult Inpatient 7 day booklet is currently being gathered to enhance the document<br><br>Action owners – SCEC Divisional Triumvirate<br><br>**Action completion date: March 2025** |
| **2** | **Action**<br>• Electronic system to record WHO surgical safety checklists are now in place in all Theatre areas other than Jenny Lind, Obstetrics, General and Trauma<br>• Roll out the electronic system to Jenny Lind w/c 02/09/24<br>• Review roll out plans for Emergency areas – Obstetrics, General and Trauma<br>• Review Power BI analytics once electronic system established and embedded<br>• Areas needing focus are Ophthalmology, Gynaecology and Trauma and Orthopaedics<br>• Theatre Matrons to lead monitoring and improving the completion of WHO surgical safety checklists<br>• Share compliance with Band 7 Theatre Leads for their individual improvement plan<br>• Increase engagement across the wider MDT to include surgeons, anaesthetists and junior medical workforce<br><br>**Evidence to date**<br>• Electronic surgical safety checklists have rolled out across all theatres, the next phase rolling out w/c 02/09/24 commences for Jenny Lind.<br>• Change in leadership (Matron and Senior Matron) within Ophthalmology focusing on improvements to the Theatre environment<br>• Clinical Audit completed each month, current compliance is 99.4%<br>• Clinical Audit team collect and share audit data every month which is shared with the Theatre leadership team.<br>• Theatre PD&E team supporting WHO surgical safety checklist compliance with the Theatre Matrons<br><br>Action owners – SCEC Divisional Triumvirate<br><br>**Action completion date: January 2025** |
| **3** | **Action**<br>• Review and share Medicine's Policy with the Band 7 Leads<br>• Check understanding of the policy and implications for practice at Band 7 Leads meeting<br>• Monthly audit using Medicine's Management, to be increased to weekly if compliance is below 90%.<br>• Feedback areas for improvement with the Band 7 Leads.<br>• Nominate a Lead Matron to oversee Medicine's Management<br><br>**Action - Storage**<br>• Fluid storage to be reviewed on EAUS and placed behind a locked door |

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| | • Medicines management and storage to be reviewed across all ward, using Tendable Medicine's Management Audit monthly<br>• Review CD cupboard size and appropriateness to store patient's own and stock CDs separately<br>• Review the locks on Medication Room cupboards and replace where required<br>• Audit the compliance of fridge checks and temperatures ranges and actions in Fundamentals 1 weekly<br>• Order replacement pod lockers for Gissing, Edgefield and Denton – 4 needed in total<br><br>**Action - Recording**<br>• Publicise the need for completion of weight and allergies on EPMA<br>• Audit EPMA fields for completion and Lead Matron to monitor improvement<br>• Audit monthly the recording CDs across wards using Medicine's Management audit<br><br>**Evidence to date**<br>• Safer practice notice issued for CDs June 2024<br>• Medicine's Management Tendable audit dashboard<br>• Daily CD checks in place now<br>• Medicine's Management Audit in place within SCEC Wards<br>• Focus within Care Assurance audits, as a current theme of interest<br>• SCEC Division Medicine's Management mandatory training currently at 89.3% compliance<br>• Spot check audit, attached to monitor presence of medication pod lockers, separate storage of patient own CDs, working order of medication trollies and lockable cupboards in the medication rooms. Areas needing attention identified and will be acted upon<br>• Bulk fluids stored behind a locked/key-pad door across all wards, with the exception of EAUS – as per storage action<br><br>Action owners – SCEC Divisional Triumvirate<br><br>**Action completion date: March 2025** |
| **4** | <u>Urgent & Emergency Care</u><br>Flow initiatives since the inspection have already made a significant difference to ambulance hand over delays, reducing the range from the reports 35-57% down to current range which is 10.1- 16.2% within the national average. The Trust has also seen reduced delays to transfers from the emergency department to wards and a reduction in the use of escalation areas including corridor care.<br><br>Examples of flow initiatives in place include:<br>• Home for lunch to create earlier discharges.<br>• Urgent clinical pathways developed, agreed and reviewed.<br>• Improved 24hour imaging turnaround for wards.<br>• Improved communication and staff training<br><br>A continued Transformation programme is in place to maintain and improve the progress to date. |

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| | Elective<br>Since the inspection several actions have been put in place to improve waiting times across several services.<br><br>Actions included:<br>• Additional clinical activity via insourcing, mutual aid and use of the independent sector. Joining the GIRFT further faster outpatient programme which reduced the overall number of long waiting outpatients across the GIRFT specialities.<br>• Validation of all waiting lists and improved communication to patients via the DRdr platform and safety net calls to patients at greatest risk.<br>• Opening of Norfolk and Norwich Orthopaedic Centre (NANOC) to deliver high volume day case activity.<br><br>Further actions include:<br>• Improvement plans for both long waiting patients and cancer pathway patients, the Trust has committed to a transformation programme that is focused on a number of strategic initiatives including elective recovery, outpatients and theatre transformation.<br>• Funding via the cancer alliance has provided targeted support which is now showing an improvement in the overall waiting times and reductions in the number patients waiting over 62 days.<br><br>It is anticipated that with improved communication and alternative options for treatment, plus a reduction in industrial action and waiting times that complaints will reduce over time. The aim is to deliver the national standard of no patients waiting longer than 65 weeks by the end of December.<br><br>We also have a trajectory agreed with NHSE tiering structure to deliver 3 consecutive months of 60% 62 day cancer performance in 24/25<br><br>Action Owner - Deputy Chief Operating Officer<br><br>**Action completion date: End of March 2025** |
| **5** | **Action**<br>• Re-share/display safety notice<br>• Manager and Matron to spot check understanding in areas<br>• Safety alert and location of ligature cutters featured in Resus training<br>• Compliant Resus trolley checklist checks<br>• Clinical Educators to cover a resus trolley check during department induction<br>• SCEC Recruitment team support understanding when visiting areas<br>• Discuss ligature cutters location in safety huddles<br><br>**Evidence already available**<br>Safety Alert Notice issued 06/10/2023 and reissued 28/08/2024<br><br>  <br>Safer Practice Notice - location of |

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| | IMPORTANT Ligature Cutters.msg<br>• Resus trolley checks – called tuff cutts<br>• Covered in Resus training, mandatory training compliance of attendance at resus session where this is covered.<br>• 85.8% Resus training compliance for SCEC – 89.4% compliance with Resus training – Nursing and 74.8% in Medical and Dental<br>• Spot checks suggest more work is needed in this area to offer assurance<br><br>Action owners – SCEC Divisional Triumvirate<br><br>**Action completion date: November 2024** |
| **6** | The SOP for the management of medical equipment has been updated to include the process for escalation of equipment that has not been made available and is detailed in a flow chart in the SOP. A clear reporting structure for oversight of the process is now in place through the Clinical Engineering governance meeting, reporting into Medical Devices Committee for any escalations.<br><br>The process for missing equipment has also been added to the SOP.<br><br>02 O7.1 Evidence Sheet V2.5.docx<br><br>Action owners – This is in place and will be monitored by Medical Devices Committee<br><br>**Action completion date: October 2024** |
| **7** | **Action**<br>• Updated NEWS 2 Standard Operating Procedure being reviewed at RRT Document Approval group<br>• Updated document for Clinical Safety Sub-Board approval<br>• 6 month re-audit reviewing NEWS 2 escalation<br>• RRT Lead Matron/Band 7 to support this work<br>• Improve the documentation of escalation of a deteriorating patient<br><br>**Evidence to date**<br>• NEWS 2 Dashboard, reviewed daily by Matron of the Day to support completion and raising awareness of high NEWS 2 scoring patients<br>• Ward Managers supporting the compliance and response to NEWS 2 reporting and escalation<br>• Oversight by DDND/DND<br>• Call for Concern and Martha's Rule launched to support improved response to concern<br>• RRT review all NEWS 2 scoring patients in the hospital and support the |

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| | deteriorating patient<br>• RRT step down from CCC reviews maintained<br>• Close monitoring of the NEWS 2 scoring across SCEC and attendance of RRT<br>• Worry and concern collaborative project completion, enclosed<br><br>QualityImprovementProjectCloseReport<br><br>Action owners – SCEC Divisional Triumvirate<br><br>**Action completion date: February 2025** |
| **8** | <u>Medicine</u><br>To ensure oncology area cleaning is maintained daily;<br>• Introduce a new daily regime<br>• Education support for housekeepers<br>This has been completed<br><br>Action owners – Medicine Divisional Triumvirate<br><br>**Action completion date: December 2024**<br><br><u>Surgery, Critical and Emergency Care</u><br>**Action**<br>• Replace the chairs in Eye Clinic<br>• Ophthalmology Matron to lead on chair replacement<br><br>**Evidence to date:**<br><br>Outpatient Areas review 082024.docx<br>• Audit of equipment in Outpatient departments completed all areas compliant with infection control standards<br>• All chairs wipeable and compliant with IP&C<br><br>Action owners – SCEC Divisional Triumvirate<br><br>**Action completion date: December 2024** |
| **Who is responsible for the action?** | See individual actions |
| **How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?** | |
| **1** | • Monthly Audit<br>• Ward manager/ Matron accountability |

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| | • Monitoring from nominated Lead Matron<br>• Senior matron oversight<br>• Escalation to DND/DDND<br>• Surgical Specialities Sub Board, Quality Improvement project for Lead Matron<br>• Sub Board reporting through service level committee.<br>• Divisional Board oversight<br>• CQC Evidence Group |
| **2** | • Review of current audit and processes<br>• Monitoring WHO surgical safety checklist compliance through IPR on Power BI<br>• Theatre Matrons accountable for monitoring and improving compliance.<br>• Senior Matron oversight<br>• Escalation to DND/DDND<br>• Electronic system and Power BI data analytics<br>• Sub Board accountability through service level committee.<br>• Divisional Board oversight<br>• CQC Evidence Group |
| **3** | • Daily CD checks<br>• Monthly medicine audits<br>• Monthly matron audits increased monitoring if concerns present<br>• Surgical Specialities Sub-Board to commence a Quality Improvement group<br>• QI project for the nominated Matron<br>• Sub Board reporting to Service Level Committee<br>• Ward manager/ Matron accountable, Senior matron oversight<br>• Escalation to DND/DDND.<br>• Divisional Board oversight<br>• CQC Evidence Group |
| **4** | • Monitoring of recovery plans daily<br>• BAU daily patient tracking meetings and weekly divisional check and challenge meetings with the divisions (to check progress against waiting list numbers in cancer, long waits and diagnostics).<br>• Within the transformation programme there will be KPIs that will be monitored and reported to the transformation board and upwards to Trust Board via the appropriate route.<br>• Continued weekly tier1 meetings with NHSE on reduction of long waiting patients and cancer performance.<br>• Monitoring of access related complaints is continued via the divisional performance reviews. |
| **5** | • Fundamentals 1 Audit compliance<br>• Check safety notice is visible in departments<br>• Spot check understanding in departments<br>• Sub Board accountability through service level committee<br>• Divisional Board oversight<br>• CQC Evidence Group |
| **6** | • Medical Devices committee monitoring<br>• Theatre Equipment Group monitoring<br>• Sub Board oversight |
| **7** | • Call for concern feedback<br>• Sub Board accountability through service level committee |

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| | • Divisional Board oversight<br>• CQC Evidence Group |
| **8** | <u>Medicine</u><br>• Cleaning audits<br>• FR1 schedules<br>• Care assurance assessments<br>• IPC audits<br>• Matron quality assurance walkarounds<br><br><u>Surgery, Critical and Emergency Care</u><br>• Matron Quality Assurance and IP&C Audit<br>• Oversight by departmental leads/ matrons.<br>• Sub Board accountability through service level committee<br>• Divisional Board oversight |
| **Who is responsible?** | See individual actions |
| **What resources (if any) are needed to implement the change(s) and are these resources available?** | |
| **1** | • Audit question to be added to Tendable to support monitoring compliance, currently not featured in Matron Quality Assurance, MCA & Dols, Fundamentals 1 and 2 or Documentation audit – when Tendable questions are reviewed. |
| **2** | • Continued support from clinical audit and improvement department.<br>• Power BI analytics report to be completed, currently in developmental stage |
| **3** | • POD lockers replacement<br>• Tendable question to be added for Patient's Own CD's and the management of discrepancy if Pharmacy will allow |
| **4** | • There is a shortfall in the number of Anaesthetists that we require to fully run all theatre sessions, this is a known issue in Norfolk.<br>• There is a shortfall of laminar flow theatre capacity in Norfolk to deliver substantial increases in some elective specialities |
| **5** | Nil |
| **6** | Nil |
| **7** | EPR expected for the organisation March 2026 |
| **8** | Furniture replacement programme required |
| **Date actions will be completed:** | Please see individual actions |
| **How will people who use the service(s) be affected by you not meeting this regulation until this date?** | |
| Regulation 12 standards not consistently being met**.** | |

| Regulated activity | Regulation |
|---|---|
| **Treatment of disease, disorder or injury** | **Regulation 15**<br>**Premises and equipment** |
| | **How the regulation was not being met:** |
| | 1. The trust must ensure that the systems in place to purchase, renew and replace equipment are responsive, so service delivery is not impacted by equipment failures. (Regulation 15(1)(e))<br><br>2. Diagnostic Imaging - The service must ensure that the systems in place to purchase, renew and replace equipment are responsive, so service delivery is not impacted by equipment failures. (Regulation 15(1)(e)) |

| **Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve** | |
|---|---|
| **1** | The Trust already operates a Clinical Equipment Replacement Programme ('CERP'). Divisions and corporate areas submit their requests using a consistent risk framework that has been developed for this purpose. This then feeds into the annual capital plan. The equipment with highest risk scores is prioritised and the amount of equipment purchased is dependent on the level of capital funding available.<br><br>However, the Trust needs to improve the link between incident reporting and CERP. A new process will be developed to ensure the Trust's Medical Device Committee ('MDC') is reviewing equipment failures and ensuring where appropriate this is cross referenced with the CERP.<br><br>Action Owner - Director of Strategy and Major Projects<br><br>**Action completion date: December 2024** |
| **2** | Equipment replacement already carried out since September 2023 CQC inspection:<br>1. G7 X-ray room replaced October 2023<br>2. G3 X-ray room replaced January 2024<br>3. CT1 scanner replaced April 2024<br>4. 2x SiteRite Ultrasound/ECG Vascular Access service machines in March 2024<br>5. Mobile mini-C-Arm Fluoroscan in March 2024<br>6. 2x MRI conditional Anaesthetic machines in March 2024<br>7. Additional investment for service expansion: 2 x SiteRite Ultrasound/ECG Vascular Access service machines in December 2023<br><br>Equipment due to be replaced (awaiting start date of works):<br>• CT3 – work expected to start Jan 2025 subject to SLA approvals. Equipment already ordered.<br><br>Equipment planned to be replaced in 25/26: |

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| | • Mobile breast screening van and mammography machine<br>• Nuclear Medicine Radiopharmacy isolators<br><br>In addition, the Fluoroscopy machine service contract review is being completed with a view to move the machine under Original Equipment Manufacturer (OEM) service maintenance cover instead of existing 3rd party, due to concerns with robustness of current service cover. This includes OEM pre contract service inspection corrective action. This should ensure more robust service cover for this machine until it is replaced.<br><br>Ongoing actions by the Radiology department:<br>• Feed into Trust Capital Equipment Replacement Programme (CERP) process by way of regular updates on risk to equipment and impact to service.<br>• Appropriately report machine downtime and impact on service on incident management system (Datix).<br>• Ensure appropriate maintenance contracts are in place. We monitor patterns within Datix and raise concerns directly with the supplier, when required, to ensure adequate service cover.<br>• Apply for external capital funding, when possible, to speed up equipment replacement.<br><br>Action Owner - Radiology Service Operations Manager<br><br>**Action completion date: December 2025** |
| **Who is responsible for the action?** | See individual actions |
| **How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?** | |
| **1** | The MDC reports to the monthly Capital and Estates Committee and in future this will include matters relating to equipment failures and CERP.<br><br>The Head of Clinical Engineering and the Trust's lead on CERP will be asked to produce the new process to ensure closer liaison and earlier identification of potential problems. |
| **2** | • Feed into Trust CERP process through regular divisional representation.<br>• Part of Eastern Diagnostic Imaging Network (EDIN) where capital funding opportunities are possible.<br>• Monitor incidents reported on Datix. |
| **Who is responsible?** | See individual actions |
| **What resources (if any) are needed to implement the change(s) and are these resources available?** | |
| **1** | The Trust continues to need additional resource to support the CERP and replace the current arrangement. |
| **2** | Sufficient capital being available by the Trust to support the CERP plan. |
| **Date actions will be completed:** | Please see individual actions |
| **How will people who use the service(s) be affected by you not meeting this regulation** | |

| until this date? |
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| Regulation 15 standards not consistently being met**.** |

| Regulated activity | Regulation |
|---|---|
| **Treatment of disease, disorder or injury** | **Regulation 17**<br>**Good Governance** |
| | **How the regulation was not being met:** |
| | 1. The service must ensure that records are updated and stored securely. (Regulation 17(2)(c))<br><br>2. The service must ensure that all policies and guidelines are up to date and reflect national guidance and recommendations. (Regulation (17)(1))<br><br>3. The service must keep care records secure. (Regulation (17)(2)(c))<br><br>4. The service must ensure that they have safe systems for medicines management. (Regulation (17)(2)(f)(g)) |

| Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve | |
|---|---|
| **1** | **Action – Updating of records**<br>• MonthlyTendable Documentation audit<br>• Raise awareness of the need updating records at Band 7 meeting<br>• Departments to implement approaches to ensure records are updated<br>• Nominate a Lead Matron to support this action<br><br>**Action – Secure storage**<br>• Daily Tendable Fundamentals 1 Audit<br>• Raise awareness of the need for safe storage of records at Band 7 meeting<br>• Review notes trolley storage<br>• Departments to implement approaches to ensure records are stored securely<br>• Nominate a Lead Matron to support this action<br><br>**Evidence to date**<br>• Respect working group, led by Jude Kivlin for the ICB<br>• Lead for Nutrition commenced in post May 2024, benchmarking compliance against national guidelines, MUST completion a focus of the audit<br>• Fall Prevention and Management Lead supporting the use of multifactorial risk assessment across the Trust.<br><br>For NEWS2 please refer to Regulation 12 point 7.<br><br>Action owners – SCEC Divisional Triumvirate<br><br>**Action completion date: March 2025** |
| **2** | **Action**<br>• All departments to review their policies with Matron ownership per speciality. |

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| | • Understand where all departments are storing their guidelines and documents and ensure approval and upload through correct processes<br>• Renew expired policies<br>• Nominated Lead Matron working to improve compliance with up to date guidance and recommendations<br>• Process in place within governance to highlight those due for renewal<br>• Personal ownership of expiring documents and a process in place to renew<br>• Adherence to policy reviews<br><br>**Evidence to date**<br>• SCEC Governance supporting compliance with updating documents, by reviewing the trust doc spreadsheet and following up completion with clinical teams<br>• DDND, DND, Clinical Educators and some Band 7 specialist nurses supporting reader panels<br><br>Action owners – Medicine and SCEC Divisional Triumvirate<br><br>**Action completion date: April 2025** |
| **3** | <u>Medicine</u><br>To ensure that medical records (paper and electronic) are consistently securely stored within the outpatient department.<br>• procure new secure notes trolleys to ensure that patient records are secured when unsupervised (designing bespoke trolleys for specific space requirements) – action complete.<br>• establish a screen lock time out for periods of inactivity (3 mins) - action complete; this has been set Trustwide.<br>• establish single sign on function across OPD action complete.<br>• progress implementation of electronic patient record provider - established through tender process and implementation plan in progress.<br><br>Action owners – Medicine Divisional Triumvirate<br><br>**Action completion date: December 2024**<br><br><u>Surgery, Critical and Emergency Care</u><br>**Action**<br>• Audit – Documentation and Outpatients Assurance Monthly<br>• Raise awareness of the need for safe storage of records shared through the Outpatients Forum<br>• Departments to implement approaches to ensure records are stored securely.<br>• Undertake “secret shopper” visits across Outpatient areas to monitor compliance.<br>• Nominate a Lead Matron to oversee this action<br><br>**Evidence to date**<br>• New trollies for storage are in use across the Divisional Outpatient areas, spot check across areas confirmed compliance, included below. |

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| | Outpatient Areas review 082024.docx<br>Action owners – SCEC Divisional Triumvirate<br><br>**Action completion date: December 2024** |
| **4** | Medicine<br>To ensure safe and secure medicines management;<br>• Replace broken locks to medication cupboards within Weybourne Day Unit - complete (No Controlled Drugs were stored within this area).<br>• Reinforced message with staff that medication cupboards remain locked at all times – complete.<br>• Replace broken locks to medicine fridges – completed at the time of inspection.<br>• Daily CD stock check in the Acute Oncology Service – added to coordinator daily check - complete<br><br>Action owners – Medicine Divisional Triumvirate<br><br>**Action completion date: December 2024**<br><br>Surgery, Critical and Emergency Care<br>**Action**<br>• Monthly Medication Audit in Outpatient areas<br>• Act on feedback from monthly medication audit.<br><br>**Evidence to date**<br>• Business as usual observed in SCEC OPDs<br>• Medicines are locked and stored appropriately across all Outpatient areas.<br>• No Controlled Drugs are kept within SCEC Outpatient areas.<br>• Spot checks indicate that outpatients do have safe systems for medicine's management – included below<br><br>Outpatient Areas review 082024.docx<br>Action owners – SCEC Divisional Triumvirate<br><br>**Action completion date: December 2024** |
| **Who is responsible for the action?** | See individual actions |
| **How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?** | |
| **1** | Surgery, Critical and Emergency Care<br>• Documentation audit and data analysis.<br>• Ward manager/ Matron accountable, Senior matron oversight |

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| | • Escalation to DND/DDND.<br>• Sub Board accountability through service level committee.<br>• Divisional Board oversight<br>• CQC Evidence Group |
| **2** | • Reduction in out of date policies<br>• Use of approved policies only<br>• Sub Board accountability through service level committee.<br>• Divisional Board oversight<br>• CQC Evidence Group |
| **3** | <u>Medicine</u><br>Quality Assurance audits conducted monthly are used to provide ongoing assurance of Information Governance compliance.<br><br>Information Governance training is mandatory each year and compliance is monitored at team/ directorate/ and divisional level.<br><br><u>Surgery, Critical and Emergency Care</u><br>• Single sign on<br>• Documentation and Outpatients Assurance audit monthly, increase to weekly if concerns present<br>• Department manager/Matron accountable<br>• Senior matron oversight.<br>• Escalation to DND/DDND.<br>• EPR coming March 2026<br>• Sub Board accountability through service level committee.<br>• Divisional Board oversight<br>• CQC Evidence Group |
| **4** | <u>Medicine</u><br>• Daily CD check in AOS is managed by the Nurse in charge with Matron oversight.<br>• Assurance is provided through Quality audits, Medicines Management Audits and Matron rounds.<br><br><u>Surgery, Critical and Emergency Care</u><br>• OPD Assurance Audit<br>• OPD Medicine management audit on Tendable- monthly<br>• Annual medicine audit by Pharmacy<br>• Sub Board accountability through service level committee.<br>• Divisional Board oversight<br>• CQC Evidence Group |
| **Who is responsible?** | See individual actions |
| **What resources (if any) are needed to implement the change(s) and are these resources available?** | |
| **1** | <u>Surgery, Critical and Emergency Care</u><br>• Availability of notes storage<br>• Access to the Respect audits and Nutrition benchmarking to support an |

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| | improvement plan<br>• EPR will eliminate the need for paper records, implementation March 2026 |
| **2** | • Access to policy renewal dates – received monthly<br>• Policy management system required Trustwide |
| **3** | Medicine<br>• Funding to support purchase of trolleys available<br>• Funding to support single sign on equipment available<br><br>Surgery, Critical and Emergency Care<br>EPR will eliminate the concern regarding storage |
| **4** | Medicine<br>Nil<br><br>Surgery, Critical and Emergency Care<br>• Outpatient Medicines Management audit – in progress |
| **Date actions will be completed:** | Please see individual action |
| **How will people who use the service(s) be affected by you not meeting this regulation until this date?** | |
| Regulation 17 standards not consistently being met**.** | |

| Regulated activity | Regulation |
|---|---|
| **Treatment of disease, disorder or injury** | **Regulation 18**<br>**Staffing** |
| | **How the regulation was not being met:** |
| | 1. The trust must ensure that staff have received training in treating patients with learning disabilities and autism. (Regulation 18(2)(a))<br><br>2. The service must have enough staff to care for patients and keep them safe. (Regulation (18)(1))<br><br>3. The service must ensure that there are processes in place to ensure there are enough suitably qualified and competent staff to make sure that the service can meet targets in respect to waiting times and reporting times. (Regulation 18(1))<br><br>4. The service should ensure medical staff complete mandatory training. (Regulation 18)<br><br>5. The service should ensure staff feel supported and valued. (18) |

| Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve | |
|---|---|
| **1** | Due to the introduction of the Health and Care Act 2022 and the requirement that regulated service providers ensure their staff receive training on learning disability and autism, with the code of practice pending, a risk, describing actions has been developed.<br><br>The Associate Director OD and Learning, the Director for Complex Health, the Associate Director of Education and the Matron from for Learning Disability and Autism worked collaboratively on the development of a proposal-presented to Hospital Management Board, in addition to participating in regional discussions regarding the roll out of the training.<br><br>The NNUH Corporation Induction includes an introduction to LD & Autism and the LD & Autism team offer bespoke training, which has been updated to extend its cover against the core capabilities frameworks, to areas as identified by their work plan.<br><br>It is understood currently (subject to the final code of practice being issued), that all staff will be required to complete a 90 mins eLearning package followed by either a 1 hr online session (Tier1) or a 1-day face to face training (Tier 2). It is estimated that 70% of staff will require Tier 2. The Trust understands that the training will be applicable to around 70% of staff. The training must include delivery by trainers with lived experience of learning disabilities and/or autism. A paper to request appropriate resources to support this large volume of training will be taken to the Hospital Management Board.<br><br>The Associate Director OD and Learning has liaised with the learning disability and autism team, presenting a subsequent report to Hospital Management Board, in addition to participating in regional discussions regarding the roll out of the training. |

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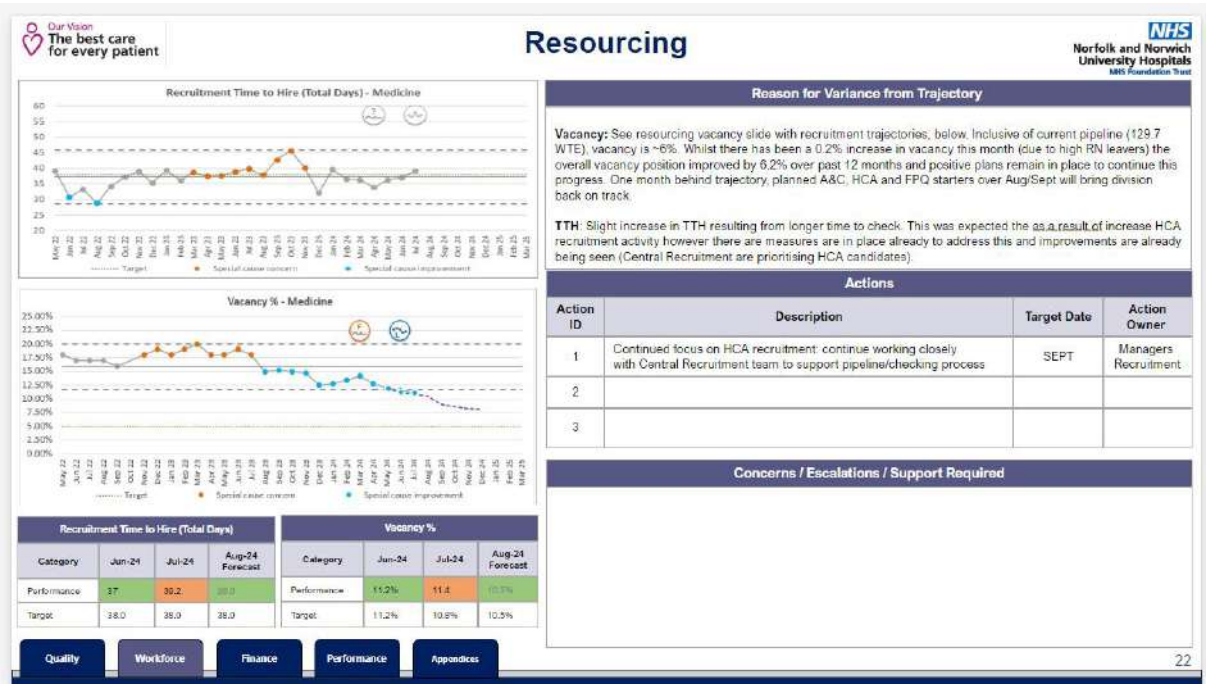
| | The ICB is currently procuring a provider to start offering this training to the System. Once available the Trust will commence the training with prioritising frontline clinical roles.<br><br>Awareness will be raised with staff around accessing the supporting eLearning package.<br><br>Action Owner - Associate Director OD and Learning along with Divisions in completing the training.<br><br>**Action completion date: For the completion of the ESR training, September 2025. For the face-to-face training, September 2027** |
| **2** | <u>Medicine</u><br>To ensure service is established as per budgeted requirements;<br>• Reviews of establishment against budget and service demand are conducted twice per year. Complete<br>• Vacancy trajectory monitored monthly via Divisional Performance reviews<br>• Ensure timely recruitment plan for each vacancy. Complete<br>• Manage retention through staff feedback and supportive "stay "conversations complete<br>• Link to health and wellbeing actions through People Promise - ongoing<br><br>  <br><br><br>Action owners – Medicine Divisional Triumvirate<br><br>**Action completion date: November 2024**<br><br><u>Surgery, Critical and Emergency Care</u><br>**Action**<br>• Vacancy for all roles reviewed regularly within the Sub Boards and service level committee |

**Evidence to date – Division wide**

**Vacancy**

- There is a greater understanding of vacancy position, turnover and leaver reasons across all departments, supported by the SCEC Recruitment and Retention team and DND.
- Current turnover for the entire Division is at 0.4% in month, with 7.8% annualised turnover
- Trustwide annualised turnover target of 10% reached in August 2023 and continues to decline, currently 7.8%.
- Non-medical time to hire rate below target of 38 days, currently 36.7 days – has been below target for 6 months.
- Total vacancy rate for the Division July 2024 is 8.6%
- Current Division wide vacancy rate for RN is 8.9% which has remained static since November 2023 reported at 8.6%.
- Current Division wide vacancy rate for HCA is 11.9% for July 2024, improved from 18.9% in November 2023 with a downward trajectory.
- Weekly review of current adverts, interviews and selection timeframes occurs with HR Recruitment Lead
- SCEC Recruitment and Retention Team supporting all Division's departments.
- Vacancy regularly reviewed within Sub Boards, Service level committee and Divisional Performance Committee – example slide included

Vacancy DPC Slide.pptx

**Evidence to date – Ophthalmology**

**Leadership**

- New nursing leadership with Matron and Eye Clinic Manager roles
- Rotation of roles within Ophthalmology, across Theatres, Nelson Day Unit and Eye Clinic to support wider skill mixing and integration of the teams.
- Expanding the Nurse Bank skills to support the Directorate.
- Clinical Educator roles embedded in the Directorate supporting training.
- Stay conversations implemented by the Matron.
- Twice daily safety huddles in place, where staffing is reviewed and reallocated if required to support safe patient care
- Re-rostering activities to support additional staff in Theatres.

**Vacancy**

- Turnover for RN is low, 4 registered staff leaving between July 24 to August 23 (April 24 1, January 24, 2 and October 23, 1)
- Turnover for HCA is low, 0 HCAs leaving between July 24 to August 23
- 1 Band 7 vacancy and less than 1 wte registered nurse combined vacancy across the whole Directorate of 23 wte registered nurses (4% vacancy rate)

**Evidence to date – Orthodontics (medical staff)**

RE_ CQC - Orthodontic Service

**Vacancy**

- No vacancies in Orthodontics at present, recent appointments to 1 wte Consultant

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| | and 1 part time consultant in post. These appointments have made a significant difference in the provision of Orthodontics.<br>• The Orthodontic workforce risk is now closed.<br><br>**Datix**<br>• A datix is raised when staffing shortfalls affect patient care<br><br>Action owners – SCEC Divisional Triumvirate<br><br>**Action completion date: November 2024** |
| **3** | **Actions completed since visit in September 2023:**<br><u>Reporting</u><br>• Additional 5wte Consultant Radiologist recruited between Sept 2023 – Jan 2024<br>• Increased collaborative working between reporting Radiographers and Registrars<br>• Backlog reduced from Sept 2023 approx 11,000 to approx. 6,500 by end Jan 2024 (since increased due to efforts with increasing acquisition)<br><br><u>Acquisition:</u><br>• Additional 7-day mobile CT van introduced Jan 2024<br>• Additional 7-day mobile MRI van in mid-August 2024<br>• Three-month funding to outsource Ultrasound (US) Musculo-Skeletal work to an Independent Sector Provider as this cohort was the longest wait on the US waiting list<br>• Funding to increase booking and Picture Archiving Communications System (PACS) staff to ensure booking volumes are managed and images produced are available for reporting in a timely manner<br>• CT and MRI Radiographer and Radiology Department Assistant (RDA) investment increased.<br><br>**Actions still to complete:**<br><u>Reporting</u><br>• Progress IT link for chosen outsourcing supplier to supplement current establishment reporting service, to enable supplier to commence reporting. This is until March 2025.<br>• Sixteen Consultants funded as part of the Community Diagnostic Centre (CDC) Full Business Case (FBC). Start dates from October 2024 through to April 2026.<br>• Request to increase Reporting Radiographer scope of practice and establishment volumes within business planning process.<br>• Continue with targeted efforts with CT cardiac backlog recovery.<br><br><u>Acquisition</u><br>• CDC staffing: onboarding earlier than CDC start date to ensure suitable training provided. Full preceptorship and exposure to relevant modalities is in place.<br>• Business as usual staffing: using NNUH and recruitment agency to improve recruitment initiatives. Recruitment incentives on offer as well.<br>• Require investment in staffing to match current acquisition levels - growth in staffing |

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| | volumes has not kept up with the growth in demand. Business planning processes will articulate volume of staff required.<br><br>Action Owner - Radiology Service Operations Manager<br><br>**Action completion date: April 2026 (supporting the work of the CDCs)** |
| **4** | **Action**<br>• COD will meet with SDs to clarify their responsibility to ensure 90% compliance within their services<br>• Division to communicate with all clinical staff to remind importance of compliance with the core mandatory training<br>• Pay progression for Consultants will be linked to compliance with mandatory training as per new Consultant pay deal<br>• COD to review mandatory training report for medical staff to follow up<br><br>**Action completion date: September 2025** |
| **5** | <u>Medicine</u><br>Between 2022 and 2023, the Medicine Division saw the greatest increase in positive scoring of all the divisions. Overall, Medicine reported a 5.7% improvement in staff engagement and experience, as measured by the annual NHS Staf Survey (50.5% to 56.2%). This included improvement across all seven People Promise factors and the Staff Engagement and Morale elements, enabled by the division's 2022 improvement actions, which have been further embedded throughout 2023/24. These successes will continue to be built on throughout 2024/25 as detailed in the attached Divisional Action Plan:<br><br>  <br>2024 Medicine Divisional Plan.pptx<br><br>The Division will continue to ensure that staff are aware of, and can access, all the wellbeing support available to them by continued close working with the HR Business Partner, HR Operations, and WHWB teams, in addition to maintaining relationships with Freedom to Speak up Guardians, Staff Networks and Trade Union partners, to enable support to be put in place for those who need it. This will be achieved and evidenced via partnership working, manager support and education, promotion via the Newsletter, and email information circulation and Board papers.<br><br>The Division will continue to encourage managers to hold Stay Conversations with staff considering/tending their resignation to understand why individuals are considering leaving. This information will be considered against recorded leaver reasons so that any themes can be identified and mitigated.<br><br>Specific focus and time will continue to be given to improving and maintaining compliance against Workforce KPIs as it is recognised that by getting these key elements right, staff experience will continue to improve.<br><br>Action owners – Medicine Divisional Triumvirate |

**Action completion date: April 2025**

Surgery, Critical and Emergency Care

**Action**

- Aim to improve staff feeling valued and supported
- Focus on the delivery of the staff survey action plan

**Evidence to date – Division wide**

**Recognition**

- Daisy/staff awards/ PRIDE awards/The Beat appreciation
- SCEC Recruitment and Retention team supporting with care certificate and work anniversary celebrations.
- SHARE document being reviewed.
- Visits from the Executive to areas, celebrating their achievements
- Tri visits across the Division, listening to concerns and offering support

**Support**

- Clinical Nurse Educators across the Division
- PD&E support with learners
- UEA Link Lecturer support with learners
- SCEC Recruitment and Retention team supporting all staff
- PNA support across the Division, 18 trained PNAs available
- Wellbeing support, Vivup platform
- External initiatives to support wellbeing, Paddleboarding, Yoga, Running Club
- Staff benefit schemes
- DND on the Work in Confidence platform
- Freedom to Speak Up presence and support by SCEC staff
- Staff survey has demonstrated an improvement in SCEC feedback from 2022 to 2023

**Education**

- Education programmes, to the value of £600K

**Vacancy/Recruitment**

- SCEC Recruitment and Retention team supporting all staff – significant reduction in turnover can be evidenced.
- Vacancy rate in outpatients continues to be low, under 2 wte RN and HCA combined across all 6 outpatient areas.
- Absence rate has reduced from 5.9% at its peak in January 2024 to 4.9% July 2024 – 0.7% higher than the trust target
- Reduction in agency spend to below 3.2% since April 2024
- Review of leavers themes across the Division by DND
- Reduction in agency spend to below NHSE threshold of 3.2% for 24/25 maintained since April 2024
- Staff survey divisional plan for improvement

2024 Surgery Divisional Plan.pptx

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| | **Evidence to date – Ophthalmology specifically, including Division/trust wide actions**<br>**Recognition**<br>• Connected leaders programme for Ophthalmology leadership team<br>• Nominations made in staff awards for the team<br>• SCEC Recruitment and Retention team supporting with care certificate and work anniversary celebrations<br><br>**Education**<br>• Matron introduced training sessions for staff<br>• Staff have been encouraged to apply for education programmes to the value of £6,000, greater investment than any other year for Ophthalmology<br><br>**Support**<br>• Matron holds a PNA qualification, encouraging the PNA role across all areas in Directorate<br>• Presence of Matron within the Directorate<br>• Clinical Educators in Ophthalmology<br>• Ophthalmology staff survey 2023 shows improvements in 6/10 sections from 2022 – recognised and rewarded, safe and healthy, always learning, work flexibly, work as a team and morale.<br><br>Action owners – SCEC Divisional Triumvirate<br><br>**Action completion date: April 2025** |
| **Who is responsible for the action?** | See individual actions |
| **How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?** | |
| **1** | Once the mandatory training programme is commenced, this will form part of the regular governance reporting of the subjects within the Trust's governance process i.e. Workforce Education Sub Board, People and Culture Committee and Trust Board.<br><br>Trajectories of when the 90% compliance will be achieved, will be drafted to enable monitoring of the achievement on a monthly basis at the relevant Trust governance meetings. |
| **2** | <u>Medicine</u><br>• Monthly directorate governance reviews, upward to Divisional Performance Review<br>• Monitoring of recruitment, retention and absence monthly via Divisional Performance Committee.<br>• Monitoring staff survey and people promise actions.<br><br><u>Surgery, Critical and Emergency Care</u><br>• Maintain recruitment and retention focus, which includes fill rate, vacancy, turnover, leavers and stay conversations<br>• MOD daily oversight to support redeployment.<br>• Reduction of agency and nurse bank in favour of substantive posts<br>• Monitoring key performance indicators in Outpatients<br>• Sub Board accountability through service level committee |

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| | • Divisional Board oversight<br>• CQC Evidence Group |
| **3** | <u>Reporting</u><br>• Monthly performance check with corrective action plans for variation<br>• Bi-weekly service review with the outsourcing company to ensure maximisation of capacity<br>• Monitor patient feedback<br><br><u>Acquisition</u><br>• Tracker reviewed regularly to ensure recruitment is meeting required turnaround times<br>• Individualised training plans as part of induction and training<br>• Service review meetings with recruitment agency to ensure timelines for recruitment are being met<br>• Career conversations with Band 5 staff to identify areas for progression to support retention and increase skills mix in areas such as CT/MRI/IR<br>• Monthly performance check with corrective action plans for variation<br>• Monitor patient feedback |
| **4** | • COD will design and implement a process for the Service Directors to actively manage individuals who fall below the 90% compliance<br>• Sub Board accountability through service level committee.<br>• Divisional Board oversight<br>• CQC Evidence Group |
| **5** | <u>Medicine</u><br>Factors that will evidence that staff feel valued and supported include:<br>• Improved and maintained staff retention: reduction in annual turnover to below 10% by end of 24/25.<br>• Improved and maintained staff attendance: reduction in annual sickness levels to 3.9% by end of 24/25.<br>• Improved response rates and 'scores' in the 2024 NHS Staff Survey: aim to achieve 60% response rate.<br>• Improved response rates to the National Quarterly Pulse Survey (153 responses achieved in July)<br>• Increased number of recorded Stay Conversations in line with Trust target: 40% of leavers to receive a Stay Conversation.<br><br><u>Surgery, Critical and Emergency Care</u><br>• Positive staff survey – for Division and Directorate<br>• Staff retention and reduced turnover<br>• Low vacancy<br>• Reduction of agency spend<br>• Low and lowering absence rate<br>• Use of well being platforms<br>• Access to PNA service<br>• Reduction in FTSU cases |

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| | • Feedback from SCEC Recruitment team support<br>• Review of leavers by DND, capturing themes<br>• Sub Board accountability through service level committee<br>• Divisional Board oversight<br>• CQC Evidence Group |
| **Who is responsible?** | See individual actions |
| **What resources (if any) are needed to implement the change(s) and are these resources available?** | |
| **1** | Provider of training currently being procured by ICB, it may be necessary to require additional resource to support the provision of the training.<br><br>Given the volume of classroom based delivery, this programme will require subject matter expert trainers, including people who are experts by experience in LD & Autism. Training room facilities and administrative support. A paper outlining these resources was previously taken to the Hospital Management Board but a decision was paused due to the absence of the signed off code of practice. |
| **2** | Nil |
| **3** | <u>Reporting</u><br>Increase scope of practice of reporting Radiographer where possible. Through business planning and network funding initiatives, seek to improve Reporting Radiographer establishment volumes. This will also help to improve staff retention and bring us in line with the reporting Radiographer services in other acute trusts of our size.<br><br><u>Acquisition</u><br>Continue recruitment efforts into funded vacancies to ensure minimal vacancy levels and backfill full time maternity cover as like-for-like. |
| **4** | • Mandatory training report covering all medical staff<br>• Medical Directors office to support highlighting mandatory training reporting and compliance for the Division to enact. |
| **5** | <u>Medicine</u><br>The Division will continue to rely on available central workforce support as follows:<br>• WHWB<br>• HR Business Partner Team<br>• HR Operations Team<br>• Training & Development / Clinical Education Team<br>• Freedom to Speak Up Guardian Team<br>• Staff Support Networks<br><br><u>Surgery, Critical and Emergency Care</u><br>• Wellbeing sessions<br>• Team Building days/events<br>• 5 – 7 day PNA service for the trust |
| **Date actions will be completed:** | See individual actions |
| **How will people who use the service(s) be affected by you not meeting this regulation until this date?** | |

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| Regulation 18 standards not consistently being met**.** |

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| **Completed by:**<br>(please print name(s) in full) | Suzanne Nurse & Gemma Lynch |
| **Position(s):** | Associate Director Quality Improvement, Nursing, Midwifery and Clinical Professionals Excellence and Regulation Governance<br><br>Governance Compliance Manager<br><br>(Approved by Chief Executive, Medical Director and Chief Nurse) |
| **Date:** | |

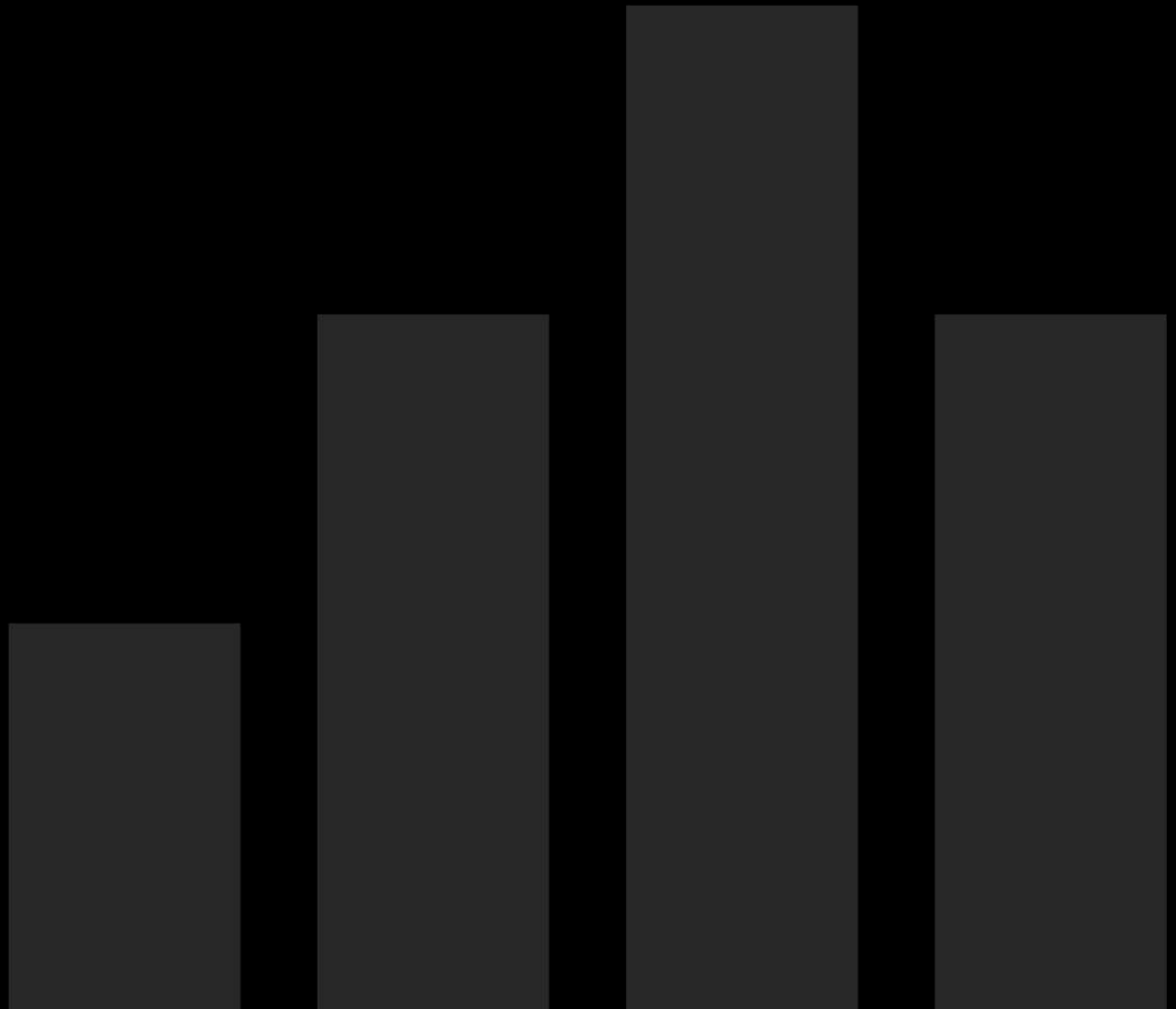
Microsoft | Power BI

# Workforce

View in Power BI

**Last data refresh:**
21/08/2024 07:31:43 UTC

**Downloaded at:**
21/08/2024 13:32:37 UTC



# Workforce Summary

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

NNUH Digital Health
business intelligence

| Topic | Metric Name | Date | Result | Variation | Assurance |
|---|---|---|---|---|---|
| Staff Turnover | Monthly Turnover | Jul 2024 | 0.6% | Improvement (Low) | Inconsistent |
| Staff in Post | Actual Substantive Headcount (WTE) | Jul 2024 | 8,648 | Improvement (High) | No Target |
| Mandatory Training | Mandatory Training | Jul 2024 | 93.0% | Improvement (High) | Capable |
| Vacancies | Variance: Headcount (WTE) | Jul 2024 | -908 | Improvement (High) | Not capable |
| Non-Medical Appraisals | Non-Medical Appraisal | Jul 2024 | 84.3% | Concern (Low) | Inconsistent |

**SPC Variation Icons**

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


**SPC Assurance Icons**

Capable | Inconsistent | Not capable

# Mandatory Training

NNUH Digital Health
business intelligence

## Mandatory Training

Jul 2024

| Variation | Assurance |
|---|---|
| H | P |

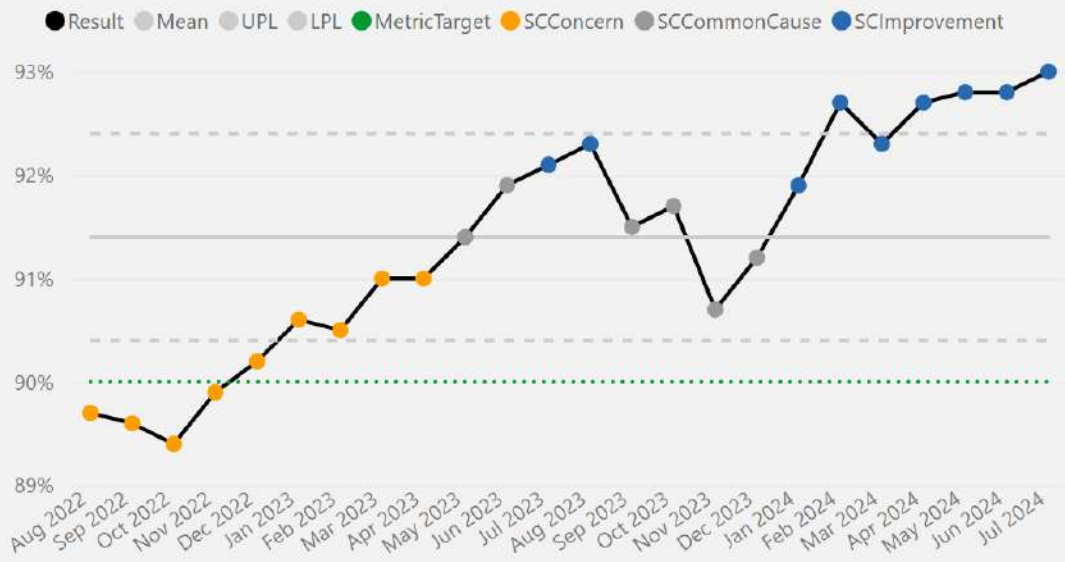
93.0% Result
90.0% Target

92.4% UPL
91.4% Mean
90.4% LPL

## Analytical Commentary

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

## Mandatory Training




## Assurance Commentary

The Trust continues to exceed the 90% target, as at the end of July the overall compliance rate was 93% which is reflected in the special cause variation of high improvement. This has been maintained since December 2022. For Medical staff, the compliance rate for permanent staff was 90.5% - this figure reduces to 85.0% including the fixed term rotational junior doctors.

For the areas of mandatory training compliance that are within the amber category, trajectories to reach 90% are in place for resuscitation and manual handling only manual handling seeing a rise in compliance this month.

## Improvement Actions

July 2024 – Reminder emails have been sent to encourage staff attendance on mandatory training.

July 2024 – Trajectories are being monitored to ensure the projected date to achieve 90% compliance for classroom based mandatory training is achieved.

# Non-Medical Appraisals

NNUH Digital Health
business intelligence

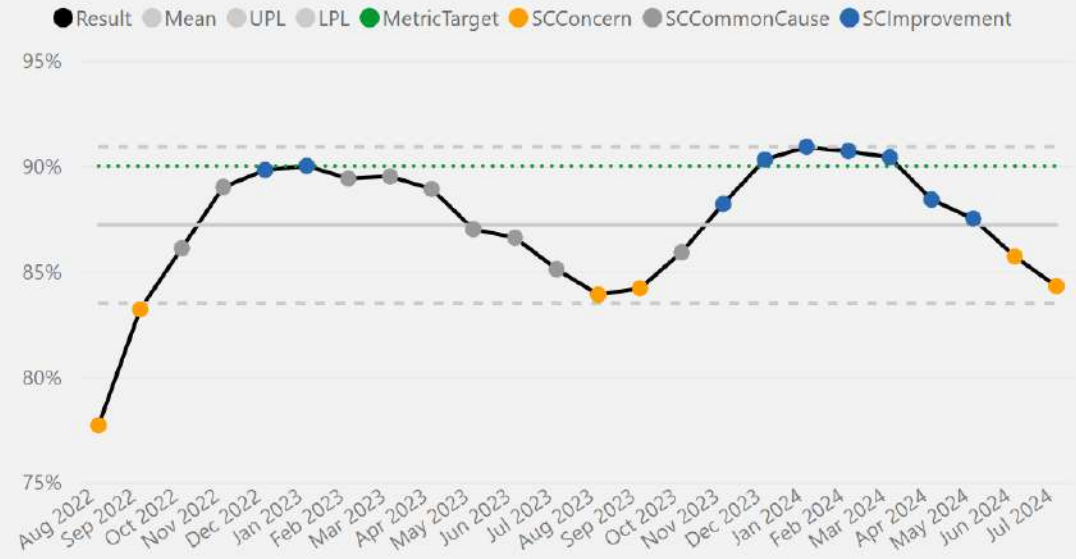
## Non-Medical Appraisal

Jul 2024

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

| | |
|---|---|
| 84.3% Result | 90.9% UPL |
| 90.0% Target | 87.2% Mean |
| | 83.5% LPL |

### Non-Medical Appraisal




## Analytical Commentary

Data point is part of a downwards trend, and therefore the variation is Special Cause Variation - Concern (Low)

## Assurance Commentary

In the 12 months to July 2024, 84.3% of eligible staff (appraisals excluding medical colleagues) had an appraisal. The downward trend is expected at this time in the cascade process.

The new appraisal cascade commenced in April, and all divisions have set a performance trajectory for this. The performance trajectories continue to be monitored via through the Performance Assurance Framework Committee (PAF) and mitigations agreed to ensure that the 90% compliance is met within the trajectory timeframe.

All divisions and corporate divisions are currently below the compliance target but the completion rates are tracking in line with the anticipated cascade trajectory with an overall completion date of September 2024 for 90%. The Medicine division has put in place interventions as their drop in compliance is greater than expected.

Regular training, both interactive classroom and online briefings, are being offered to support line managers deliver good quality PDR conversations.

## Improvement Actions

July 2024 – Where required, specific actions have been agreed through the Divisional Performance Framework to ensure the performance for the cascade model is maintained.

July 2024 – The HR Business Partner team continue to provide weekly reports to divisions to track and monitor progress against the cascade trajectory.

# Sickness Absence

NNUH Digital Health
business intelligence

## Monthly Sickness Absence %

Jul 2024

Variation

Assurance

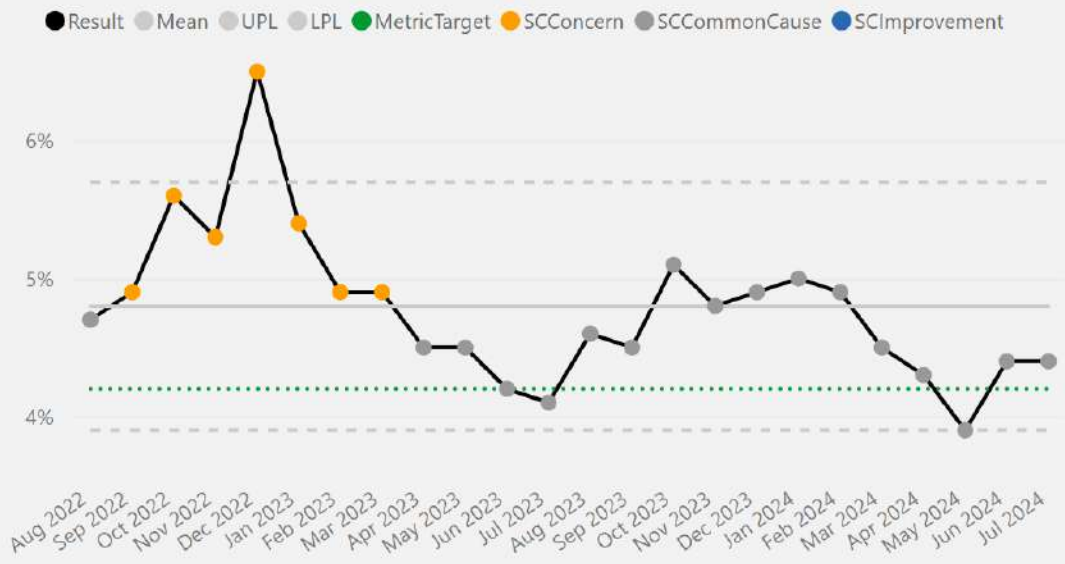
4.4% Result
4.2% Target

5.7% UPL
4.8% Mean
3.9% LPL

## Analytical Commentary

Variation is Common Cause

## Monthly Sickness Absence %




## Assurance Commentary

The current performance for the 12-month rate (4.6%) is significantly better than the same point last year (5.0%). Although there is an ongoing trend of an improving 12-monthly rate of sickness absence since August 2022 (6.5%), the current performance still remains outside the Trust target (4.2%).

Latest national NHS sickness data (March 2024) reports the NHS England monthly average as 4.7%. The East of England average as 4.5% and Norfolk and Waveney reports as 5.1%. The Trust continues reports the lowest monthly sickness absence rate for Trusts in Norfolk and Waveney, 4.5% for the same period.

The Trust has rewritten its Attendance Policy, gained Trust feedback before it is to be ratified at PACS later in August with a view to launching in October alongside a rigorous communications plan.

In this reporting period there has been an increase in reported work-related stress referrals to Workplace Health & Wellbeing from 20% to 46%. The main issues cited are linking to demands and relationships. All relationship cases occurred in the Women & Childrens Division in this reporting period. Demands were across clinical and administrative job roles.

From a muscular skeletal perspective, 8% were considered as caused by work this month. A wide spread of reasons were cited – Workplace posture, inanimate object handling as well as an injury sustained at work from a slip, trip, fall.

## Improvement Actions

Jul-24 – Ongoing engagement of Staff Support hub, in line with current operational pressures and colleague relationships. HWB 1-2-1 support sessions have re-commenced. Peer support group for administration workers commencing. A new sleep workshop is being delivered by the WHWB team commencing in August.

Jul-24 – Very encouraging response to paddle boarding sessions supported by the Charity both in numbers and feedback on wellbeing impact supporting physical and mental health for staff.

Jul-24 – Discussions commenced of re-introducing Schwartz rounds. Round in September being

# Staff Turnover

NNUH Digital Health
business intelligence

## Monthly Turnover

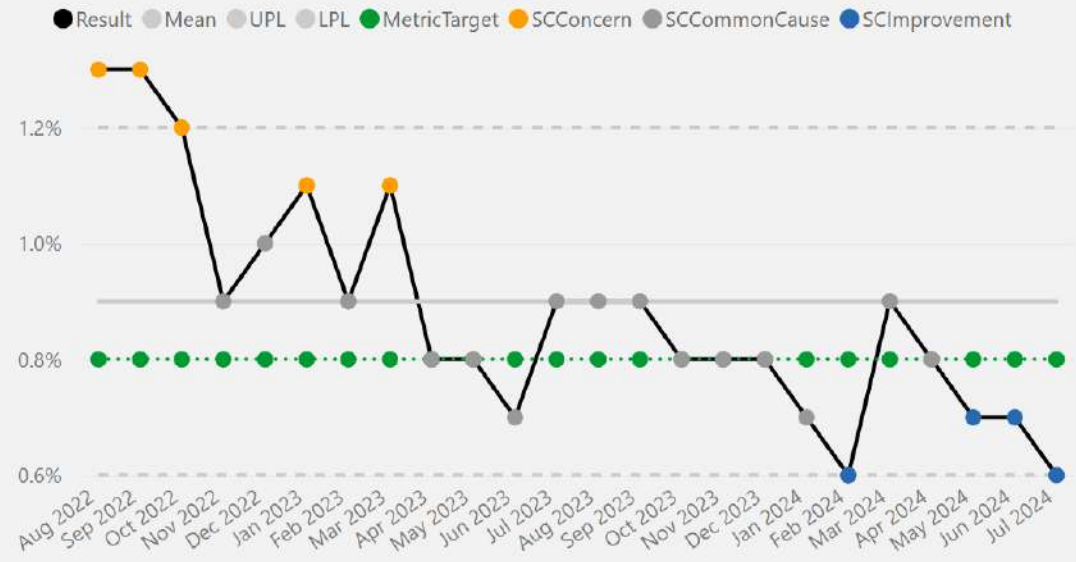
Jul 2024

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

0.6% Result
0.8% Target

1.2% UPL
0.9% Mean
0.6% LPL

### Monthly Turnover




## Improvement Actions

July 2024 – Medicine and Surgery focusing specifically on recruitment and retention of HCAs – this includes prioritisation of resource to assist the central recruitment team with administrative processes.

July 2024 – Actions drafted following analysis of stay conversations/leavers data have been agreed at the Workforce and Education Sub Board meeting.

## Analytical Commentary

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

## Assurance Commentary

The monthly turnover rate for July 2024 is 0.6% a reduction of 0.1% from June 2024 and July 2023 (0.9%). The turnover rate continues to be within 0.8% and 0.6% which is reflected in the special cause variation of low improvement after two months at 0.6%.

The 12-month average turnover rate has reduced further to 9.2%, which shows sustained improvement.

Of the 46.2 (FTE) leavers that left in the month of July, which compares to 56.2 in June 2024; 41.1 were from three main staffing groups. These are: registered nursing and midwifery, additional clinical services (e.g Healthcare Assistants and other support workers) and administration and clerical.

The number of Stay Conversations is currently averaging 23% for the last 12 months (195 surveys from 845 leavers) against the target of 40%. Completion in July was 29%. This is reported and monitored through the divisional performance committees.

Retention is highlighted as a key focus for the NHS Operational Plan 2024/25 and each division is proactively focusing on initiatives, in line with the staff survey results, reasons for leaving and the stay conversations data.

# Staff in Post

NNUH Digital Health
business intelligence

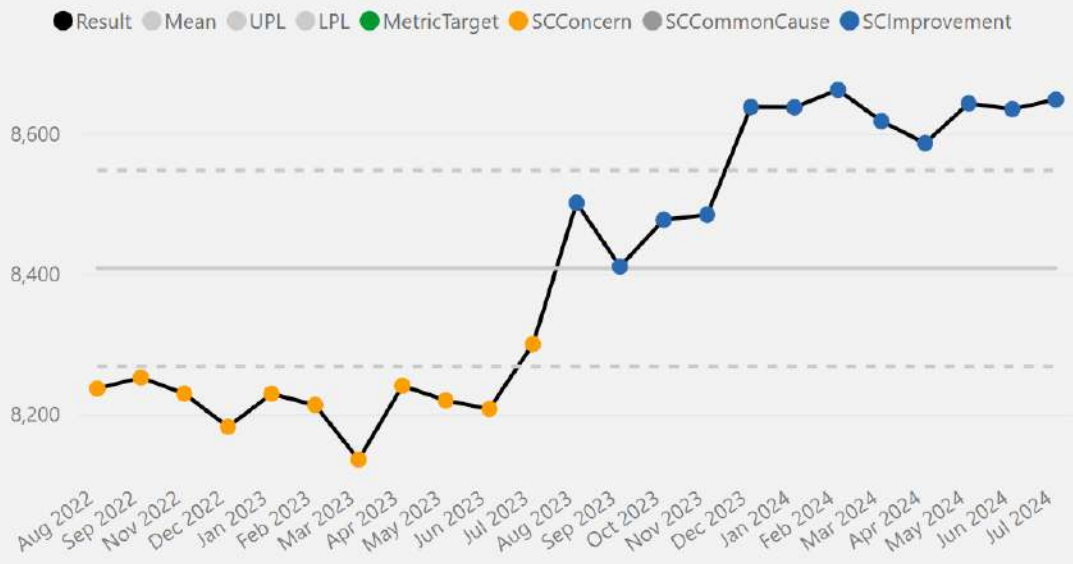
## Actual Substantive Headcount (WTE)

Jul 2024

Variation | Assurance

| | |
|---|---|
| 8,648 Result | 8,548 UPL |
| N/A Target | 8,408 Mean |
| | 8,268 LPL |

### Actual Substantive Headcount (WTE)




### Improvement Actions

June 2024 – The People Promise programme plan is being reviewed to provide delivery leads for each of the actions

July 2024 – Progress is being made on a number of the People Promise actions

### Analytical Commentary

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

### Assurance Commentary

The substantive staff workforce (8,648 wte) remains stable with only a marginal increase from the 8,634 wte reported in June (increase of 13.6 wte). When comparing to the same point last year (8,300), the current staffing numbers represent an increase of 4.2%.

Following approval of the 2024/25 People Promise plan by the Trust Board, a project plan has been set-up to identify delivery leads and to define the activity which sits behind delivering the key actions.

Progress has already been made towards improving staff experience in these areas, such as;

- The new infant feeding room has been completed and a launch event took place in world breastfeeding week. Positive feedback has already been received from colleagues using the new space.
- A sexual safety trust protocol has been drafted and is out for consultation
- A review of the misconduct policy is underway
- Recruitment trajectories have been finalised for clinical posts
- A space utilisation survey has been completed and a consultant has been hired to review space data for Rouen Rd.
- Solar film requests have been completed and temporary air conditioning units have been provided in drugs cupboards
- The working on the parking permits review is progressing well with 3,037 invites sent with 2,543 colleagues being eligible. 72 cases have been reviewed by the special circumstances panels and there are 8 appeals.

People and Culture Committee agreed to remove the staff in post metric and replace with a stability metric. It is aimed that this will be reported from September.

# Vacancies

NNUH Digital Health
business intelligence

## Variance: Headcount (WTE)

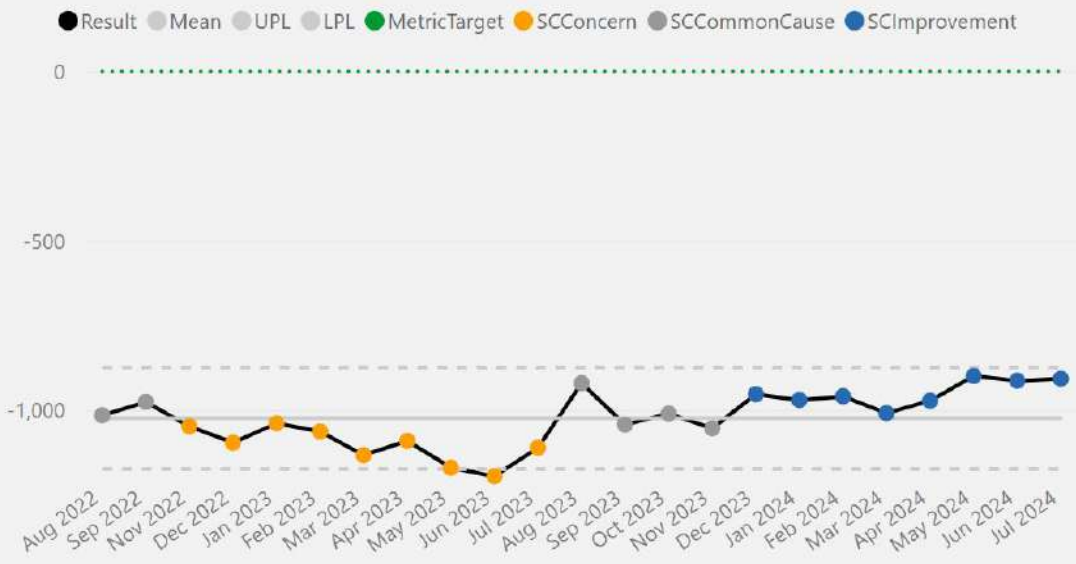
Jul 2024

| Variation | Assurance |
|---|---|
| H | F |

-908 Result
0 Target

-874 UPL
-1,025 Mean
-1,175 LPL

### Variance: Headcount (WTE)




## Improvement Actions

July 2024 – All Trust roles (Clinical roles now included) to be approved by the Executive Recruitment Panel, with non-clinical also requiring ICB approval.

## Analytical Commentary

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

## Assurance Commentary

The Trust vacancy rate for July 2024 is 9.5% which is a marginal reduction from 9.6% in June. The current rate is lower than the average vacancy rate for the past 12-months (10.1%), and is significantly lower than the same point last year (11.8%).

The Trust is part of the 'Triple Lock' ICS wide process which is required to deliver enhanced financial control in the Norfolk NHS system. All Trust roles now have to be approved for recruitment by the Executive Recruitment Panel. Due to the heightened financial constraints, it is predicted that the new process will add some delays in recruitment and potentially hold vacancies open for longer periods of time. This will be monitored and any impact will be reported.

Ongoing active recruitment to Healthcare Assistant vacancies continues with 53 having pre booked start dates and a further 86 currently moving through the recruitment process.

# Recruitment (Non-Medical)

NNUH Digital Health
business intelligence

## Time to Hire - Total

Jul 2024

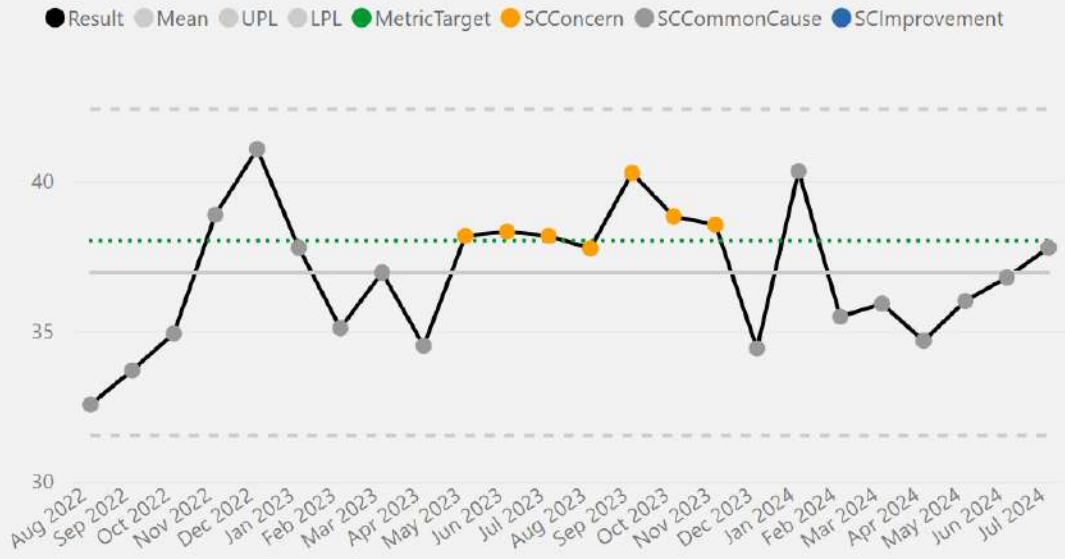
| Variation | Assurance |
|---|---|
|  |  |

| | |
|---|---|
| 37.8 Result | 42.4 UPL |
| 38.0 Target | 36.9 Mean |
| | 31.5 LPL |

## Analytical Commentary

Variation is Common Cause

## Time to Hire - Total




## Assurance Commentary

Time to hire for July was 37.8 working days, a marginal decrease on June's rate (36.8 days). The Trust continues to perform ahead of its target (38.0 days). In addition, the current rate of performance is ahead of the same point last year (38.2 days).

HR has completed the first process mapping exercise to allows commencement of the first robotic automation process to be designed by Digital Health. HR has identified 6 processes for which robots will be designed and implemented by Mar'25

The recruitment team is holding training sessions with divisional ward managers to improve the quality of the recruitment input and reduce any unnecessary delays in recruiting.

The Healthcare Assistant pipeline remains healthy with 139 candidates currently in process, 53 of which have start dates booked from August onwards.

## Improvement Actions

July 2024 – Process map created to start design of first Robotic Process in recruitment.

July 2024 – Feedback being gained on proposed critical job roles list, to allow these to be recruited without further approvals being needed.

## Supplementary Metrics

| Metric Name | Date | Result | | Variation | | Assurance |
|---|---|---|---|---|---|---|
| Time to Hire - Time To Select | Jul 2024 | 10.0 | | Common Cause | | No Target |

# Job Planning

NNUH Digital Health
business intelligence

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

Jul 2024

Variation

Assurance

F

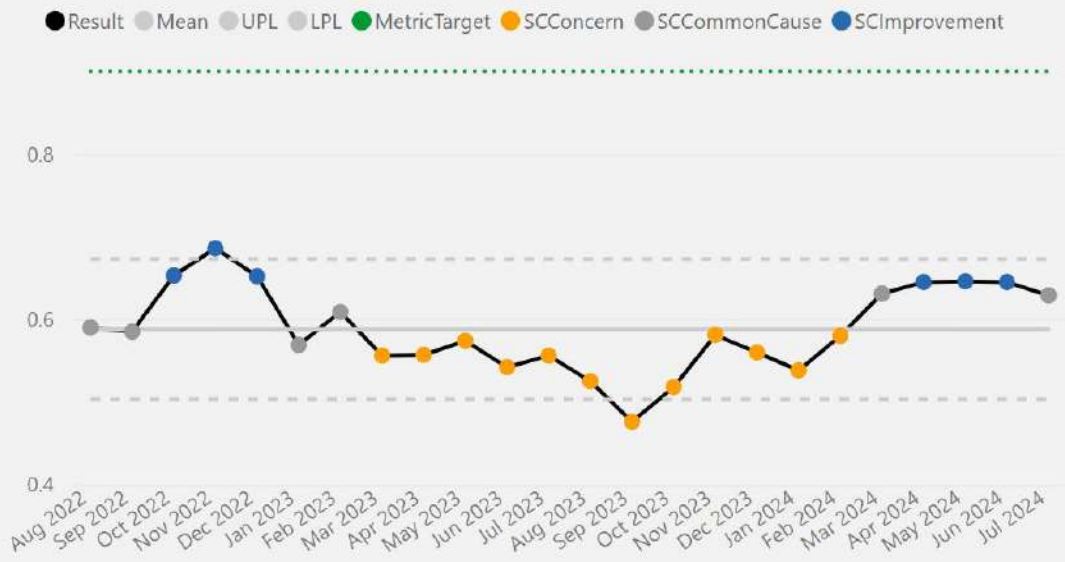
62.9% Result
90.0% Target

67.3% UPL
58.8% Mean
50.3% LPL

## Analytical Commentary

Variation is Common Cause

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




## Assurance Commentary

Unadjusted performance has dipped slightly (1.6%) in July which is likely to be attributed to summer leave absences.

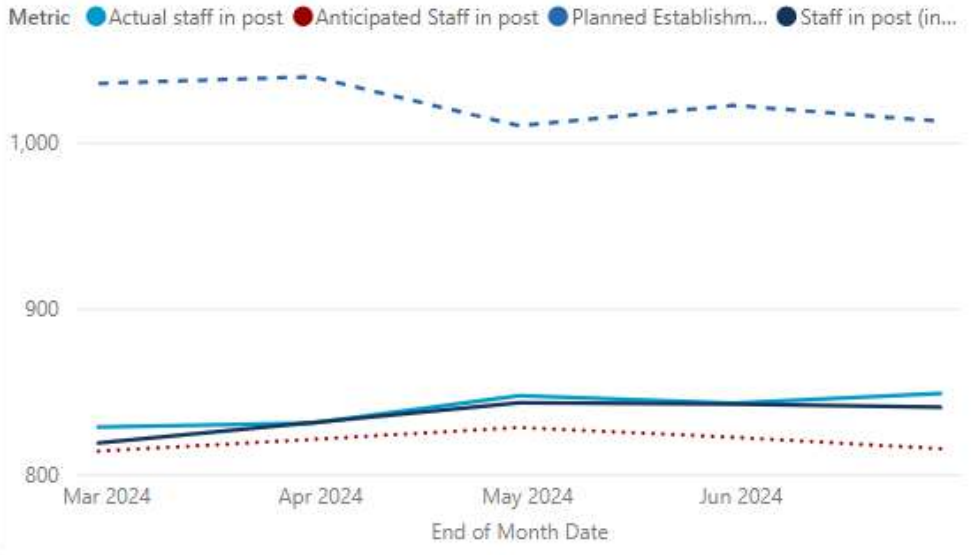
## Improvement Actions

For divisions to continue to focus on the start date of job plans to ensure that these are all within the last 12 months to address data quality issues.

# Recruitment Trajectories

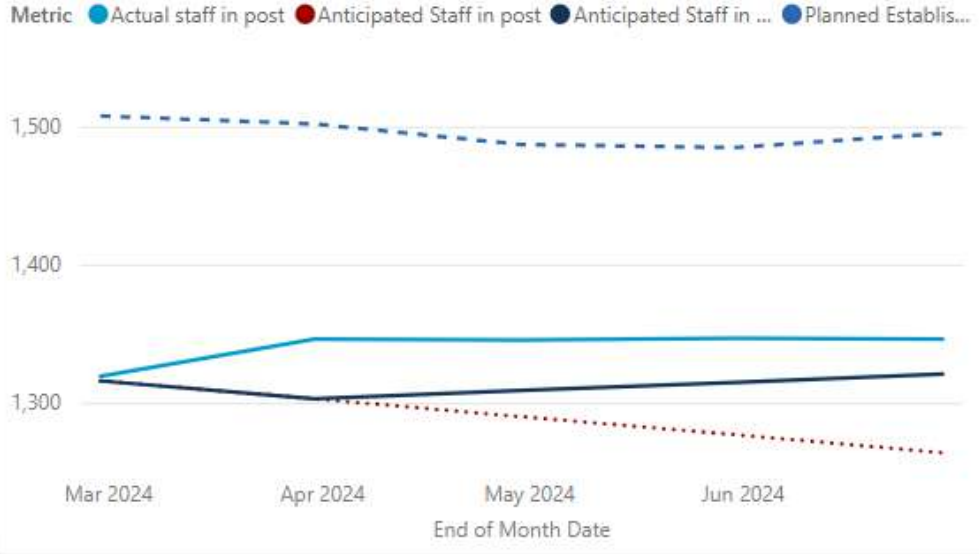
NNUH Digital Health
business intelligence

## Recruitment Trajectory - Trust Band 2 Healthcare Assistant




| Metric | Apr-24 | May-24 | Jun-24 | Jul-24 |
|---|---|---|---|---|
| Actual staff in post | 847.34 | 842.73 | 848.53 | |
| Anticipated Staff in post | 827.98 | 822.11 | 815.24 | |
| Anticipated Vacancy % | 18.0% | 19.6% | 19.5% | |
| Anticipated Vacancy % (increased capacity) | 16.5% | 17.6% | 17.0% | |
| Increased Capacity | 5.00 | 5.00 | 5.00 | |
| Internal Promotions | 0.87 | 0.87 | 0.87 | |
| Other Leavers | 16.00 | 29.00 | 30.00 | |
| Planned Establishment | ,010.09 | 1,022.43 | 1,012.80 | |
| Recruitment Activity | 24.00 | 24.00 | 24.00 | |
| Staff in post (increased capacity) | 842.98 | 842.11 | 840.24 | |

## Recruitment Trajectory - Trust Band 5 Nurse




| Metric | Apr-24 | May-24 | Jun-24 | Jul-24 |
|---|---|---|---|---|
| Vacancy % (INR) | % 12.0% | 11.4% | 11.7% | |
| Recruitment Activity | 0 6.00 | 6.00 | 6.00 | |
| Promotions | 0 7.00 | 7.00 | 7.00 | |
| Planned Establishment | 3 1,486.91 | 1,484.76 | 1,494.99 | |
| Leavers | 0 12.00 | 12.00 | 12.00 | |
| Increased Capacity | 19.00 | 19.00 | 19.00 | |
| Anticipated Vacancy FTE (INR) | 7 178.15 | 170.00 | 174.23 | |
| Anticipated Vacancy FTE | 7 197.15 | 208.00 | 231.23 | |
| Anticipated Vacancy % | % 13.3% | 14.0% | 15.5% | |
| Anticipated Staff in post (INR) | 6 1,308.76 | 1,314.76 | 1,320.76 | |
| Anticipated Staff in post | 6 1,289.76 | 1,276.76 | 1,263.76 | |
| Actual staff in post | 7 1,345.39 | 1,346.68 | 1,346.00 | |

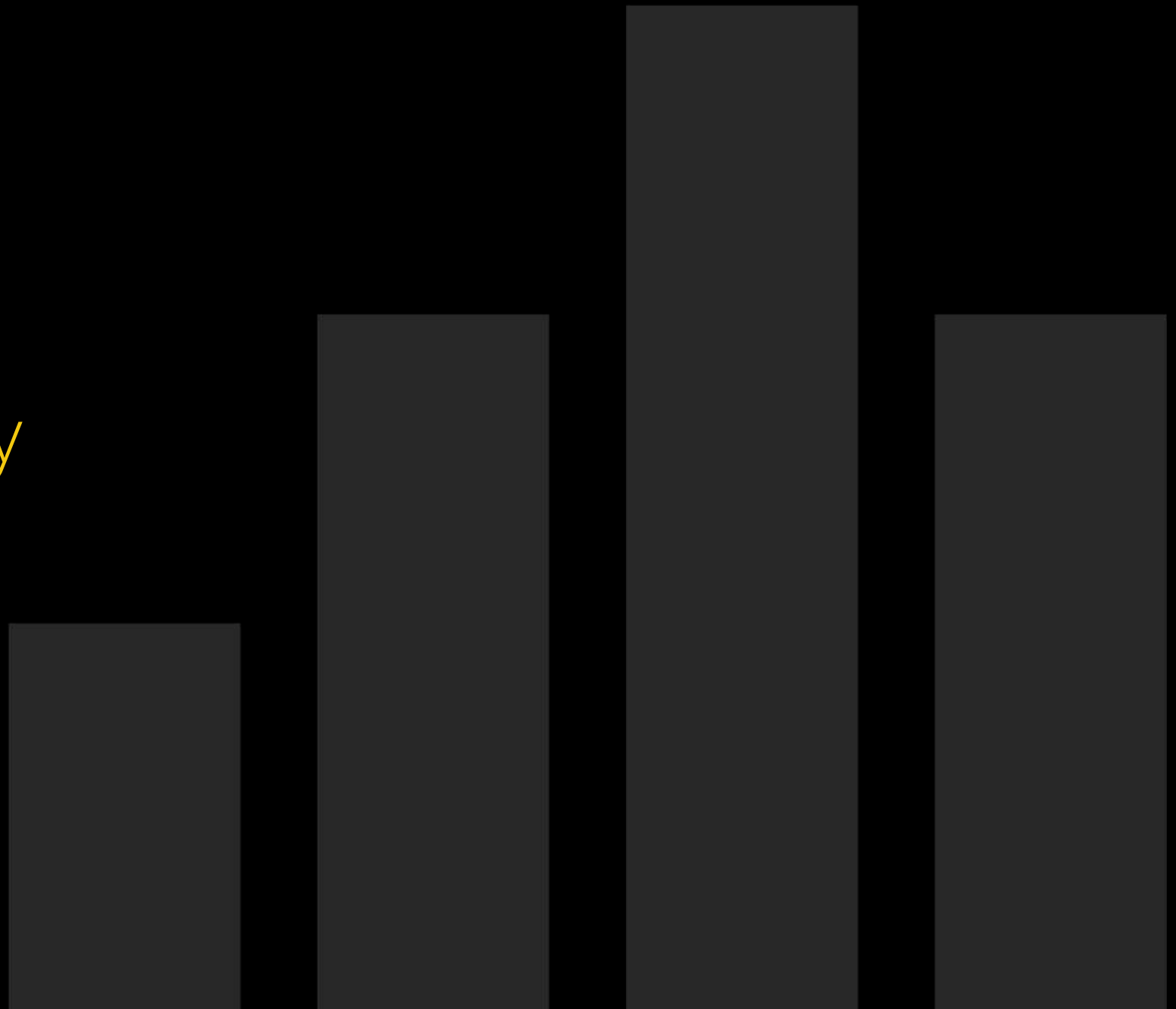
Microsoft | Power BI

# Quality & Safety

View in Power BI

**Last data refresh:**
12/07/2024 07:30:50 UTC

**Downloaded at:**
12/07/2024 10:59:46 UTC



# Quality Summary

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

NNUH Digital Health
business intelligence

| Topic | Metric Name | Date | Result | Variation | Assurance |
|---|---|---|---|---|---|
| Maternity Activity | Emergency Caesarean Deliveries | June 2024 | 21.5% | Improvement (low) | No Target |
| Palliative Care | Palliative Care IP Referrals Accepted | June 2024 | 168.0 | Concern (low) | No Target |
| Safer Staffing | Safe Staffing Care Hours Per Patient Per Day | June 2024 | 7.8 | Improvement (High) | No Target |
| Safer Staffing | Safer Staffing Fill Rates | June 2024 | 94.40% | Improvement (High) | Not Capable |
| Children & Midwifery Safeguarding | Safeguarding Children & Midwifery Referrals | June 2024 | 27 | Concern (High) | No Target |
| Children & Midwifery Safeguarding | Safeguarding Midwifery Referrals | June 2024 | 12 | Concern (High) | No Target |
| Saving Babies Lives | SGA Detected Antenatally | June 2024 | 98% | Concern (low) | No Target |

**SPC Variation Icons**

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


**SPC Assurance Icons**

Capable | Inconsistent | Not capable

# Patient Safety

NNUH Digital Health
business intelligence

| | Incident Type | Last Month | YTD |
|---|---|---|---|
| National Priorities | Maternity & Neonatal incidents which meet the 'Each Baby Counts' criteria referred to MNSI | 1 | 2 |
| | Maternal deaths referred to Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRRACE) | 0 | 0 |
| | Neonatal Deaths Referred To PMRT | 3 | 8 |
| | Child Death referred to local Child Death Overview Panel (CDOP) | 2 | 6 |
| | Death involving patient with Learning Disability referred to local LeDeR reviewer | 0 | 0 |
| | Safeguarding Adults Referrals | 54 | 180 |
| | Information Governance incidents referred to Information Commissioner's Office (ICO) | 1 | 1 |
| | Incidents related to National Screening Programmes referred to local Screening Quality Assurance Team | 0 | 0 |
| | Deaths of patients in custody, in prison or on probation referred to Prison and Probation Ombudsman | 0 | 0 |
| | Incidents meeting Never Event Criteria to undergo PSII | 0 | 2 |
| | Incidents resulting in death, assessed as more likely than not due to problems in care following Structured Judgement Review to undergo PSII | 1 | 1 |
| Trust PSII Priorities | Missed / Delay in Diagnosis to undergo PSII | 2 | 3 |
| | Sub-optimal care to undergo PSII | 0 | 0 |
| Local Level PSR | Incidents to undergo another Patient Safety Review (PSR) to provide a proportionate learning response | 68 | 198 |

| | Supplementary Metrics | Last Month | YTD |
|---|---|---|---|
| Other | Duty of Candour Compliance | 86% | 94% |
| | Incidents | 1,884 | 6,236 |

## Assurance Commentary

There were 1884 incidents reported in June, of these 1398 were patient safety incidents.
There were 71 patient safety incidents causing moderate harm and above, that is 5.08 % of all incidents.
63 incidents causing moderate harm, this includes 35 emergency admission of patient on waiting list: 3 patient falls, 4 Safeguarding (2 Section 42 enquiries)
3 patient deaths caused by safety incidents were reported in this period: 1 patient death whilst on an ENT waiting list (MDT review): 1 self-harm ligature: (PSII) 1 unexpected cardiac arrest.
5 patients reported to have suffered severe harm: 2 Neck of Femur, in patient falls, 1 self-harm (AAR) 1 missed or delay in diagnosis (PSII); 1 injury of unknown origin (MDT review).

## Improvement Actions

Divisional Governance teams to continue daily incident triage of incidents to allocate them to the proportionate learning response.
The Patient Safety Team and Business Intelligence Team have refreshed the data and reporting requirements in the Integrated Performance Report and the Performance Assurance Framework to reflect the Patient Safety Incident Response Plan (PSIRP).
To agree the governance process for developing actions for areas of improvement identified through PSII.

# Pressure Ulcers

NNUH Digital Health
business intelligence

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

Jun 2024

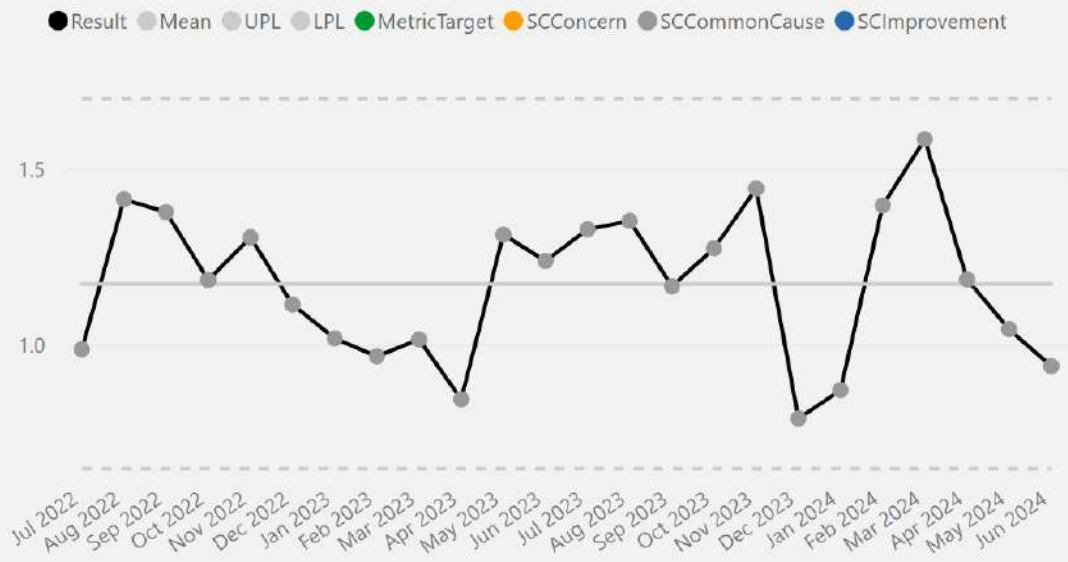
Variation | Assurance

| | |
|---|---|
| 0.9 Result | 1.7 UPL |
| N/A Target | 1.2 Mean |
| | 0.6 LPL |

## Analytical Commentary

Variation is Common Cause

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




## Assurance Commentary

June continues a downward trend in Hospital acquired pressure ulcers with 20 Category 2 pressure ulcers and 5 Category 3 pressure uclers. One Category 3 was linked to end of life skin changes and 2 Category 2 pressure ulcers were related to the use of medical devices on acutely unwell patients. Overall reduction in numbers is a reflection of the ongoing focused effort across medicine division.

## Improvement Actions

Health Care Support Worker (HCSW) inductions and newly qualified nurses have access to pressure care awareness sessions across the rest of the year to support knowledge and confidence. June and July will see training and roll out of clinical photography of pressure ulcers for patient records and verification purposes.
Training and education focus remains a key element to support focussed effort. Feedback from auditing Risk Assessments and care plans continues to support wider Trust staff learning.

# Patient Falls

NNUH Digital Health
business intelligence

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

Jun 2024

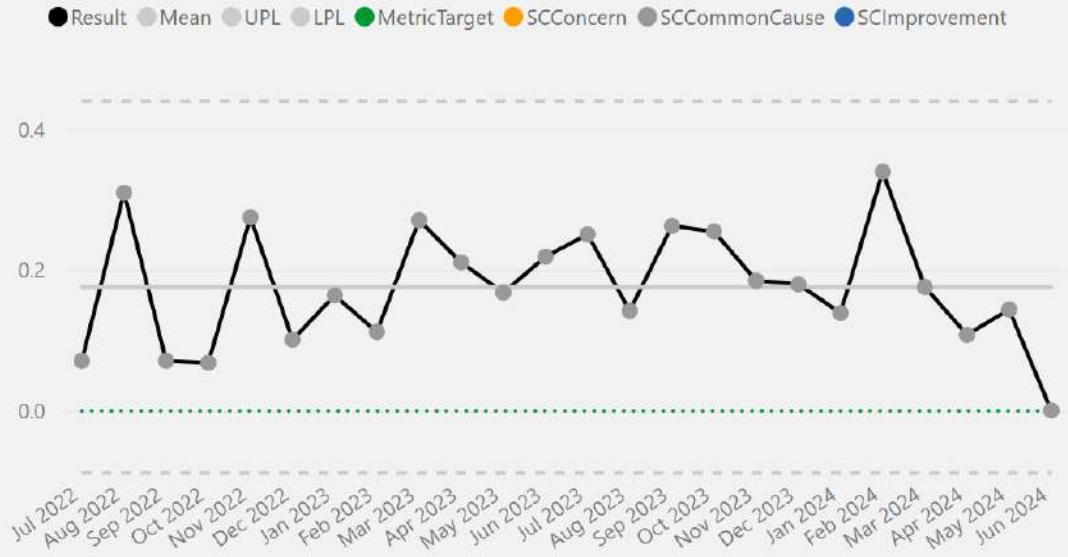
Variation | Assurance

| | |
|---|---|
| 0.0 Result | 0.4 UPL |
| 0.0 Target | 0.2 Mean |
| | -0.1 LPL |

## Analytical Commentary

Variation is Common Cause

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




## Assurance Commentary

Variation remains common cause for all Falls metrics currently, however, falls per thousand bed days reduction continues for the second consecutive month with a further drop to 6.7 for June. Gross Falls numbers has also reduced to 178 in June which is a considerable reduction compared to June 2023, also against a higher level of escalation beds in use when compared to June 2023.

## Improvement Actions

Assistive Technology implementation completed and embedding, additional units purchased as required, training ongoing. Pilot documentation of alarm testing has been provided and guidance being written. Ramblegard have created a patient fall alarm leaflet which will be distributed in July. Compliance with investigations on Datix monitored through governance. Moderate harm and above falls to be supported with a SWARM or After-Action Review locally on wards as the new PSIRF approach embeds across the Trust. We are supporting a Year 2 UEA Physio Student placement for 8 weeks for in July/August.

# Patient Experience

NNUH Digital Health
business intelligence

## Friends & Family Score

Jun 2024

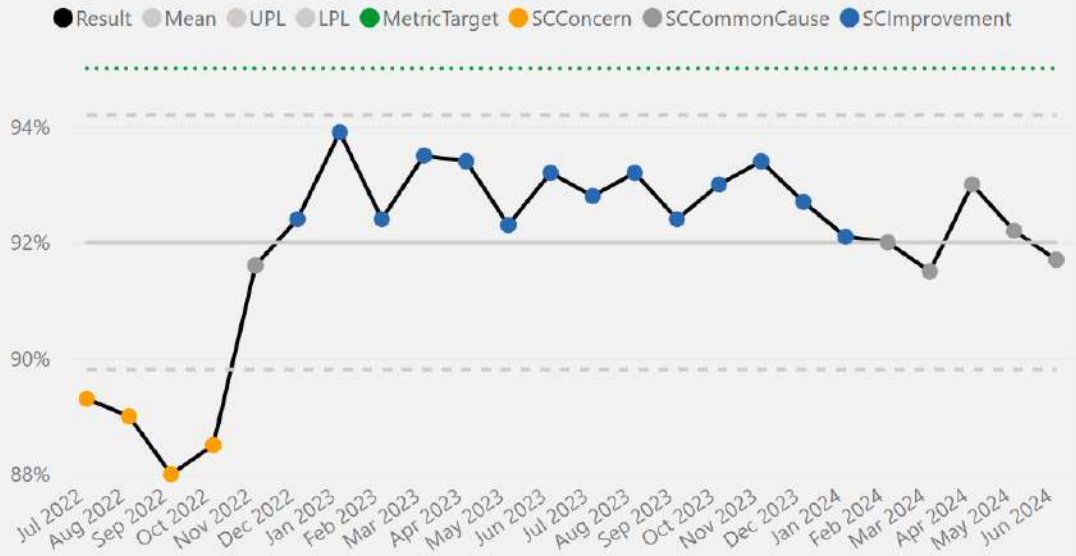
| Variation | Assurance |
|---|---|
|  |  |

| | |
|---|---|
| 91.70% Result | 94.20% UPL |
| 95.00% Target | 92.00% Mean |
| | 89.80% LPL |

## Analytical Commentary

Variation is Common Cause

### Friends & Family Score




## Assurance Commentary

3366 Friends and Family Test (FFT) responses were received in June, both the score and responses remain within our usual limits.
Top feedback themes remain staff attitude, implementation of care, waiting times and communication for both positive and negative. Admission featured in the top five positive themes this month. 565 positive and 83 negative around this topic.
Overall, just under 92% of feedback received is positive.

## Improvement Actions

Awareness raising of FFT continues across the Trust. Suggestions for improving the volunteer survey process will be taken forward in July.
The test site for SMS on inpatient wards was successfully rolled out on Kilverstone ward, just over 10% response rate for this area. A change to how frequently outpatient surveys are sent out has been implemented to free up budget to support inpatient rollout. We will continue to review the impact this has.

## Supplementary Metrics

| Metric Name | Date | Result | | Variation | | Assurance |
|---|---|---|---|---|---|---|
| Compliments | Jun 2024 | 122 | | Common Cause | | No Target |

# Patient Concerns

NNUH Digital Health
business intelligence

## PALS % Closed within 5 days - Trust

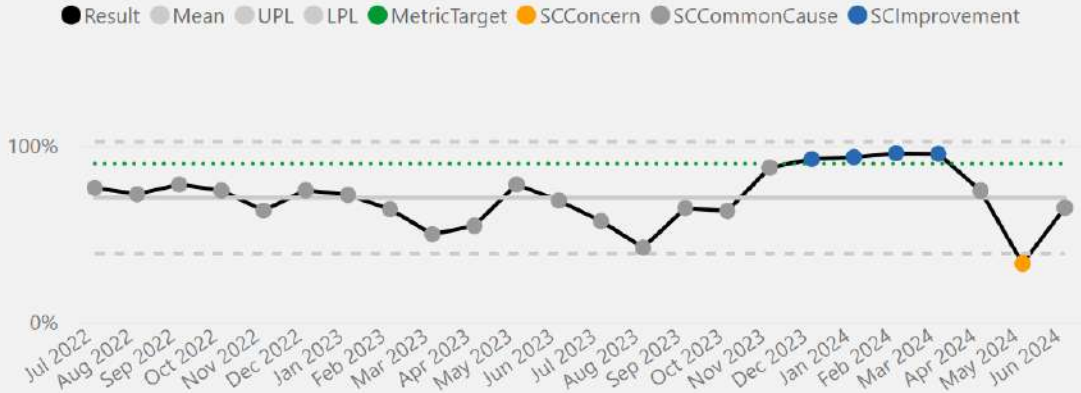
Jun 2024

Variation | Assurance

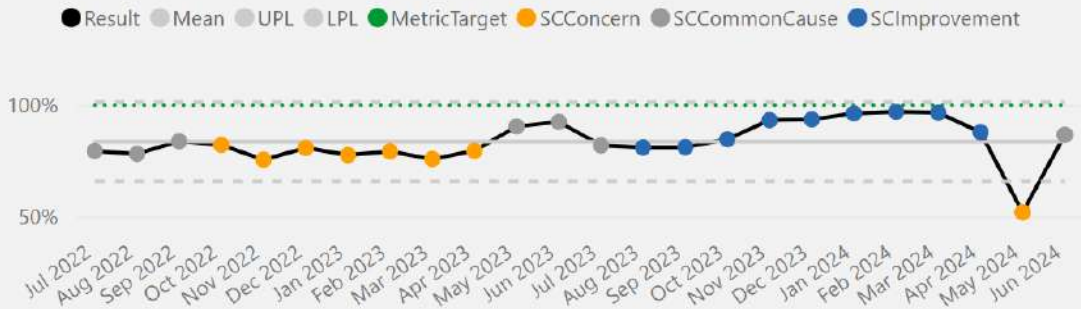
65.0% Result
90.0% Target

102.4% UPL
70.6% Mean
38.8% LPL

### PALS % Closed within 5 days - Trust




### PALS % Closed within 7 days - Trust




### Supplementary Metrics

| Metric Name | Date | Result | | Variation | | Assurance |
|---|---|---|---|---|---|---|
| PALS Contacts - Trust | Jun 2024 | 351 | | Common Cause | | No Target |

### Analytical Commentary

Variation is Common Cause

### Assurance Commentary

350 PALS matters raised this month. Of those 205 were categorised as enquiries, 143 signposting, 1 suggestion and 1 best wishes message for an inpatient.
The KPIs for the team continue to be impacted by staff absence and increased workload. An improvement is seen this month however, linked to a review of how the team manage administration and their workload. Further improvement is expected once long term sickness absence ends.
PALS KPI 65.1% of contacts were closed within 5 days from first received, target being 90%
PALS KPI 86.9% of contacts were closed within 7 days from first received, target of 100%
Appointments including delays and cancellations (70) and waiting times (42) continue to be the most common subject matter.

### Improvement Actions

Bank support now in place to support administration in the team whilst the recruitment for the fixed term admin post is live.
Members of the team continue to do extra hours whilst there is absence and annual leave in the team.
The service manager and Quality Improvement team have been working on improvements including this month focussing on clearer communications via updating the answerphone message.

# Complaints

NNUH Digital Health
business intelligence

## Complaints (Trust)

Jun 2024

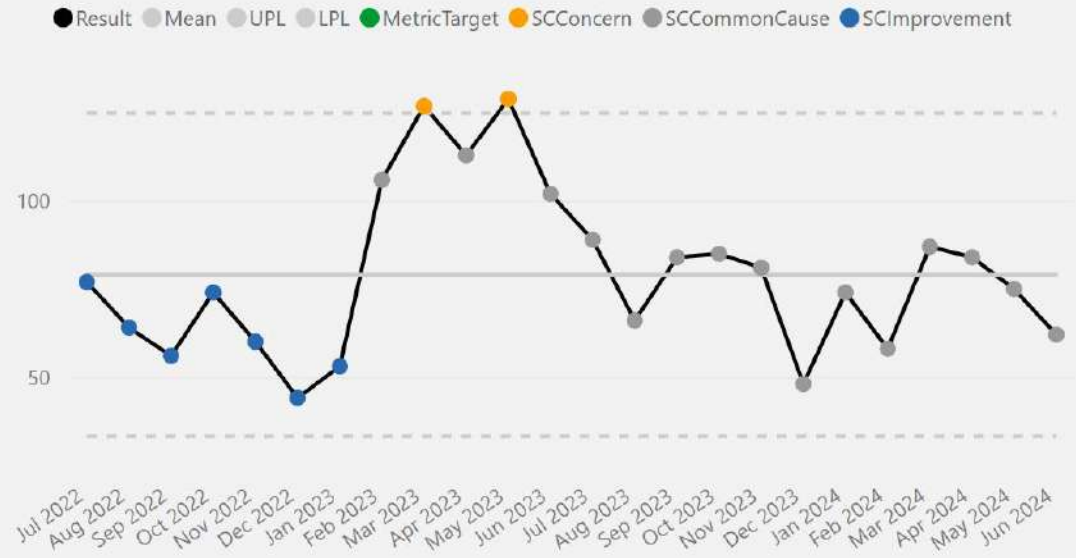
| Variation | Assurance |
|---|---|
|  | |

| | |
|---|---|
| 62 Result | 125 UPL |
| N/A Target | 79 Mean |
| | 33 LPL |

## Analytical Commentary

Variation is Common Cause

## Complaints (Trust)




## Assurance Commentary

61 formal complaints were received this month. Predominant themes are:
Clinical treatment (24), Values and Behaviours of staff (13), Patient Care (10), Access to treatment or drugs (10) were the highest subject areas.
6 complaints were reopened following rebounded complaints.

## Improvement Actions

A Quality Improvement process is underway to improve processes. A workshop was held, and change ideas generated. 125 cases have been closed since the start of the Close the Gap project focussing on prioritising cases approaching 5 months.
At the end of June, 38 cases reached the 5-month trigger; 186 cases open at 5-month milestone. The service manager continues to support in the absence of the project lead. Unable to recruit to additional posts/Bank due to triple lock restriction.

## Supplementary Metrics

| Metric Name | Date | Result | Variation | Assurance |
|---|---|---|---|---|
| Complaints - Acknowledgement | Jun 2024 | 100% | Common Cause | Inconsistent |
| Complaints - Response Times - Trust | Jun 2024 | 92% | Common Cause | Inconsistent |
| Post-investigation enquiries | Jun 2024 | 6 | Common Cause | Capable |

# Palliative Care

NNUH Digital Health
business intelligence

## Palliative Care Seen Within 48 Hours

Jun 2024

Variation | Assurance

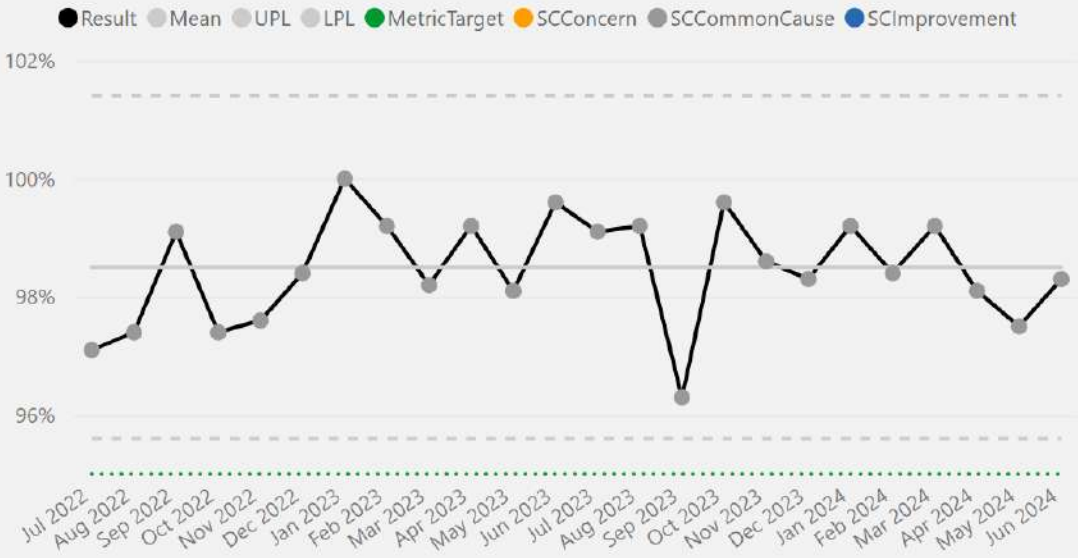
98.3% Result
95.0% Target

101.4% UPL
98.5% Mean
95.6% LPL

## Analytical Commentary

Variation is Common Cause

### Palliative Care Seen Within 48 Hours




## Assurance Commentary

Priscilla Bacon beds on hold in May, now open.
Discharge Clinical Educator driving improvements for patients who are fast tracked for discharge, but die in hospital through a formal QI project following last month's deep dive.
Appointment of new Matron Lead for Palliative and End of Life Care.

## Improvement Actions

Gap analysis in progress for NNUH against National Ambitions for Palliative and End of Life Care.
New metrics in development aligned to the National Ambitions to articulate wider breadth of care quality and performance domains.
New metrics to be discussed and agreed through the End of Life Steering Committee for IPR inclusion.

## Supplementary Metrics

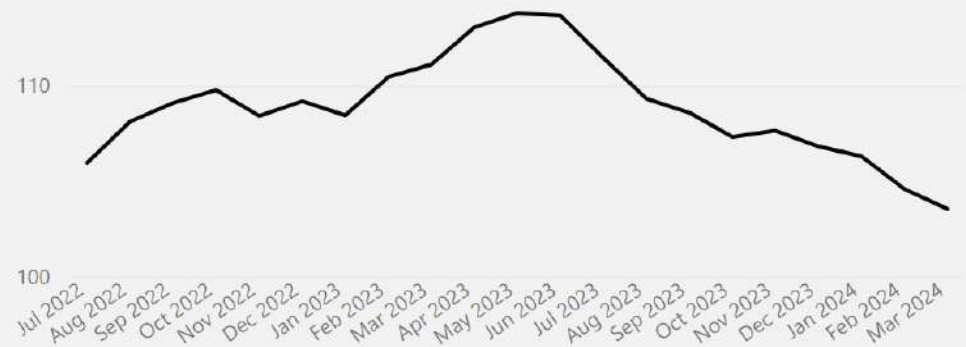
| Metric Name | Date | Result | Variation | Assurance |
|---|---|---|---|---|
| Palliative Care Died in Trust and Seen by SPCT | Jun 2024 | 48.4% | Common Cause | No Target |
| Palliative Care IP Referrals Accepted | Jun 2024 | 177.0 | Concern (Low) | No Target |

# Mortality Rate

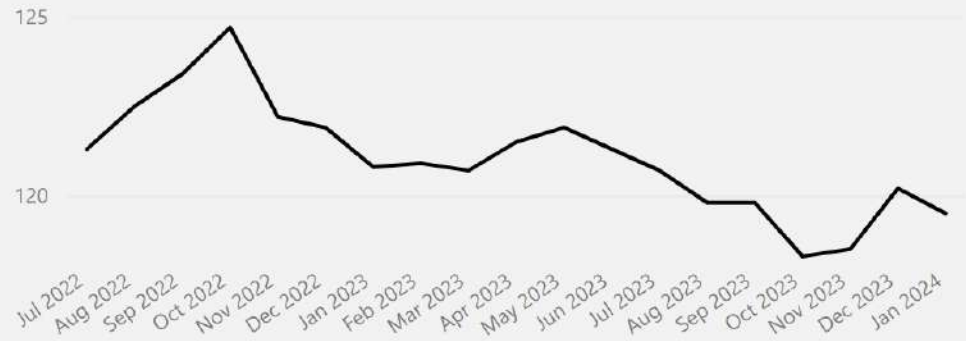
NNUH Digital Health
business intelligence

| MetricName | Date | Result |
|---|---|---|
| HSMR | Mar 2024 | 103.52 |
| SHMI | Jan 2024 | 120 |

## HSMR




## SHMI




## Supplementary Metrics

| Metric Name | Date | Result | | Variation | | Assurance |
|---|---|---|---|---|---|---|
| Crude Mortality Rate | May 2024 | 4.80% | | Common Cause | | No Target |

## Assurance Commentary

HSMR: Recent HES data integrity issues which delayed data release have been resolved. HSMR is 103.5 for reporting period April 2023 - March 2024, remaining 'within expected' levels. There are 2 diagnosis groups with relative risks statistically higher than expected: 'Septicaemia -except in labour' and 'Senility and organic mental disorders'. There are 2 new relative risk outlier alerts: Peri, endo and myocarditis cardiomyopathy and gastrointestinal haemorrhage. There is 1 new CUSUM alert; cancer of the bladder.
SHMI: remains statistically higher than expected at 119.0 for March 2023 - February 2024 reporting period. 3 diagnosis groups banded higher then expected: Septicaemia, fracture neck of femur and a new alert gastrointestinal haemorrhage.
HSMR methodology is being updated (HMSR+) to address baises reported in the model allowing improved benchmarking and to reflect new coding and data practices. Implementation planned for late Autumn. NHS Digital SHMI will continue to incorporate the Charlson Index.

## Improvement Actions

To continue work to develop an overarching action plan to address the recommendations for the completed clinical coding review and to incorporate any recommendations made by the RCP once available.
To continue with the various workstreams reviewing morality alerts, escalating safety concerns and improving documentation.
To work with Telestra Health to understand the impact of changes to the HSMR methodology.

# Safer Staffing

NNUH Digital Health
business intelligence

## Safe Staffing Fill Rates

Jun 2024

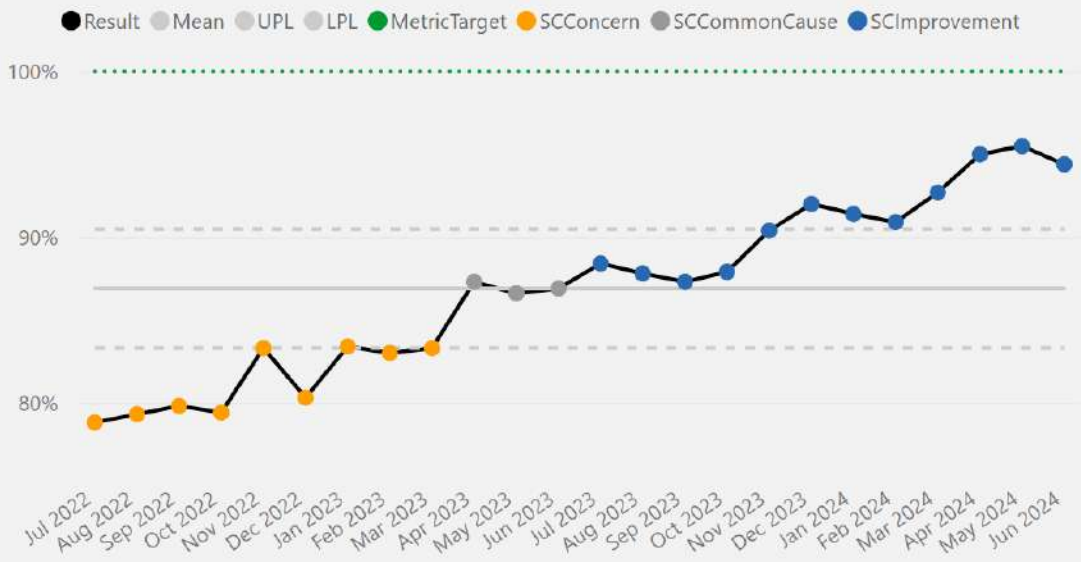
| Variation | Assurance |
|---|---|
| H | F |

| | |
|---|---|
| 94.40% Result | 90.50% UPL |
| 100.00% Target | 86.90% Mean |
| | 83.30% LPL |

## Analytical Commentary

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

### Safe Staffing Fill Rates




## Assurance Commentary

Fill rates for registered nurses and midwives (RN/M) was 96.5% and 91.5% for Health Care Support Workers (HCSW) resulting in 94.2% overall.
Overall CHPPD was 7.8 in June, a slight increase from 7.7 in May. A positive increase of 0.7 from June 2023. However, remains lower than the national value reported at 8.5 (April 24). CHPPD reported for RN/N was 4.4 in June which is below the national value of 5.0 for RN/M. Furthermore, the CHPPD for HCSW was reported at 3.5 for HCSW which is slightly higher than the national value of 3.4.
Red flags reduced slightly to 1,346 with 70.5% remaining open. 320 were resolved, 65 reviewed & 74 raised in error. Kimberley (56/72), Hethel (53/83) and EAUS (53/64) were the top 3 areas with the highest open red flags.

## Improvement Actions

Continue work to improve safer staffing metrics & roster compliance across Midwifery & AHPs by August.
To complete Safe Staffing and Escalation Policy review by August.
Work continues to reduce Agency Spend to less than 3.2% which is monitored at Divisional Performance Committee. Current spend across Nursing, AHP's & Midwifery is 3.9% of overall spend. Finance have developed a central reduction in spend trajectory which will be mapped against divisional spend to visualise trends.

## Supplementary Metrics

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

# Infection Prevention & Control

NNUH Digital Health
business intelligence

| MetricName | Date | Result | Target | Mean |
|---|---|---|---|---|
| C. difficile Cases Total | Jun 2024 | 7 | 77 | 7 |
| CPE positive screens | Jun 2024 | 3 | N/A | 1 |
| E. Coli trust apportioned | Jun 2024 | 3 | 91 | 4 |
| HOHA Trajectory C. Difficile Cases | Jun 2024 | 1 | 0 | 2 |
| Hospital Acquired MRSA bacteraemia | Jun 2024 | 0 | 0 | 0 |
| Klebsiella trust apportioned | Jun 2024 | 1 | 24 | 3 |
| MSSA HAI | Jun 2024 | 3 | N/A | 3 |
| Pseudomonas trust apportioned | Jun 2024 | 1 | 19 | 1 |

## Assurance Commentary

Threshold figures for Organisms subject to monthly mandatory reporting to UK Health Security Agency have yet to be published (Date not known).
Five Wards (Brundall, Ingham, Mulbarton, Elsing & Hethel) have had Covid outbreaks. There have been no (0) ward closures for IP&C reasons in June.
Three Ward (Kimberley, Guist and NICU) received support for increased incidences, NICU's incident closed in June (17).

Hospital Acquired MRSA bacteraemia


E. Coli trust apportioned


C. difficile Cases Total


HOHA Trajectory C. Difficile Cases


MSSA HAI


Klebsiella trust apportioned


CPE positive screens


Pseudomonas trust apportioned


## Improvement Actions

C. difficile Post Infection Review (PIR) meetings held monthly with clinical staff and Norfolk & Waveney ICB to establish lapses in care. Learning is disseminated in the monthly OWL and is now integrated within Datix. Providing access to divisional governance teams, ensuring actions and learning is discussed and disseminated appropriately.
Surveillance undertaken on each Healthcare Associated Gram-negative Blood Stream Infection to ascertain the potential sources.
All periods of increased incidence have had an IMT completed and supportive measures appropriately put in place.

# Covid-19 Timeseries

Inpatient deaths and discharges recorded on PAS for Covid-19 positive patients

NNUH Digital Health
business intelligence

Discharge Date
01/04/2024 11/07/2024

Gender
All

Age Band
All

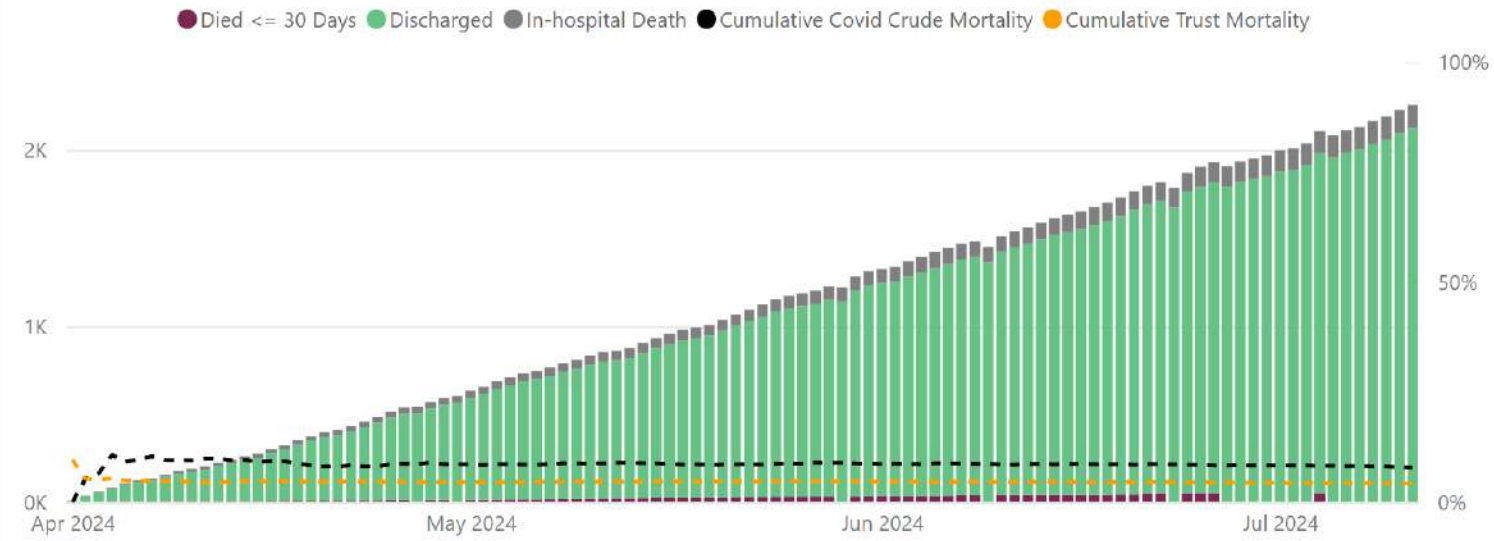
Ethnic Group
All

NNUH Risk Group
All

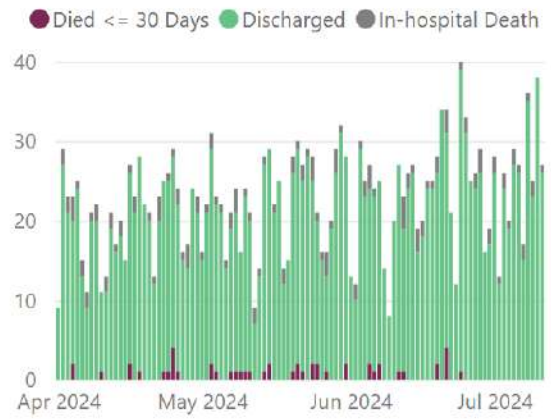
Critical Care
All

| Total Covid-19 Discharges | C19 In-hospital Deaths | C19 Died <= 30 Days Discharge | Covid-19 Discharged | Covid-19 Crude Mortality | Overall Trust Crude Mortality | C19 Discharges to Code | Suspected Covid-19 Deaths |
|---|---|---|---|---|---|---|---|
| 2304 | 133 | 49 | 2122 | 7.9% | 4.2% | 503 | 1 |

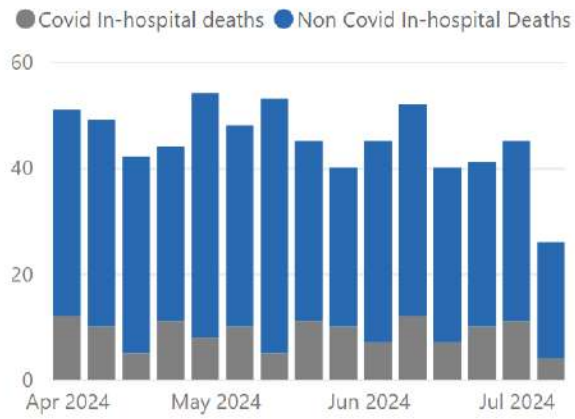
Cumulative Covid-19 Discharges, Deaths and Crude Mortality



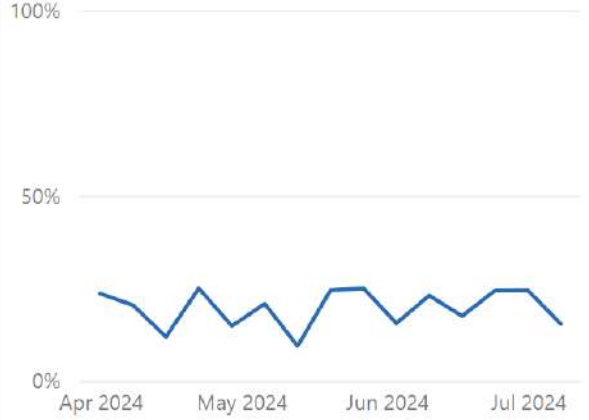

Covid-19 Discharges and Deaths by Day




In-hospital Deaths by Week




% Covid-19 Positive In-hospital Deaths



# Maternity: Mothers

NNUH Digital Health
business intelligence

## Mothers Delivered

Jun 2024

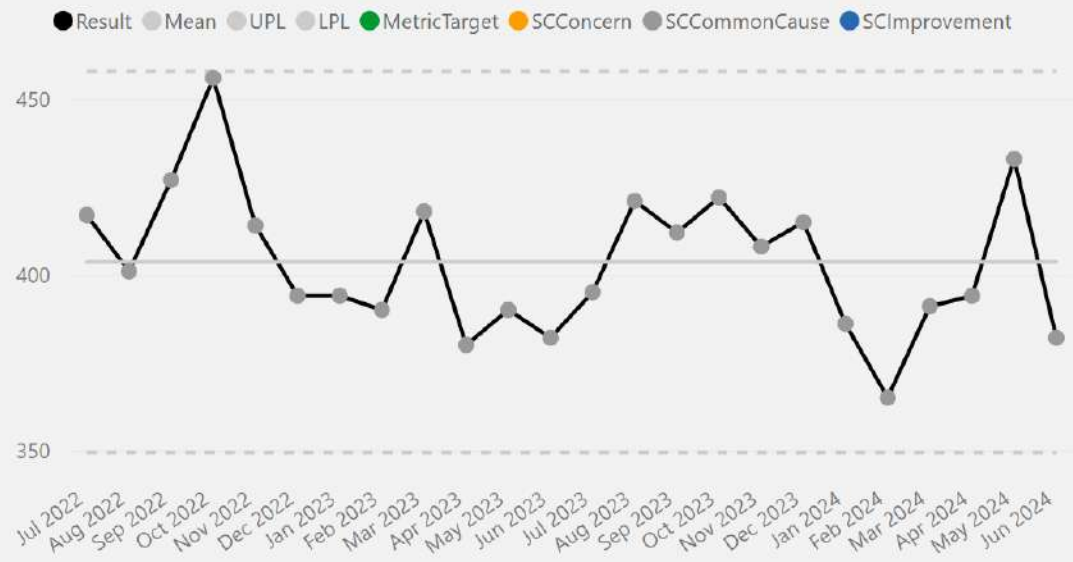
Variation | Assurance

382 Result
N/A Target
458 UPL
404 Mean
349 LPL

## Analytical Commentary

Variation is Common Cause

## Mothers Delivered




## Assurance Commentary

In June 382 mothers delivered- 312 on delivery suite, 50 in MLBU, 19 at home and 1 in transit. There were 9 BBA's compared to 5 in May - each case is reviewed and lessons shared with teams. There were 151 cesarian sections - 82 emergencies and 69 elective. There were 47 instrumental deliveries. 92.2% pregnant population were booked pre 13/52. There was a 0.9% 3/4th degree tear rate which was a significant drop from 3% in May. The PPH rate was 4.7% in June compared with 3.9% in May. There were 2 readmissions in June - both mothers had feeding problems/challenges. There were 2 admissions to Critical Care - these were due to post delivery haemorrhage. 2 transfers to other units occured due to acuity on delivery suite.

## Improvement Actions

## Supplementary Metrics

| Metric Name | Date | Result | | Variation | | Assurance |
|---|---|---|---|---|---|---|
| 1:1 Care in Labour | Jun 2024 | 98.2% | | Common Cause | | No Target |
| 3rd & 4th Degree Tears | Jun 2024 | 0.9% | | Common Cause | | Inconsistent |
| Births Before Arrival | Jun 2024 | 9 | | Common Cause | | No Target |
| Post Partum Haemorrhage ≥1500mls | Jun 2024 | 4.7% | | Common Cause | | No Target |

Mothers Delivered

382

Babies Delivered

387

# Maternity: Babies

NNUH Digital Health
business intelligence

## Unplanned NICU ≥37 week Admissions (E3)

Jun 2024

Variation

Assurance

F

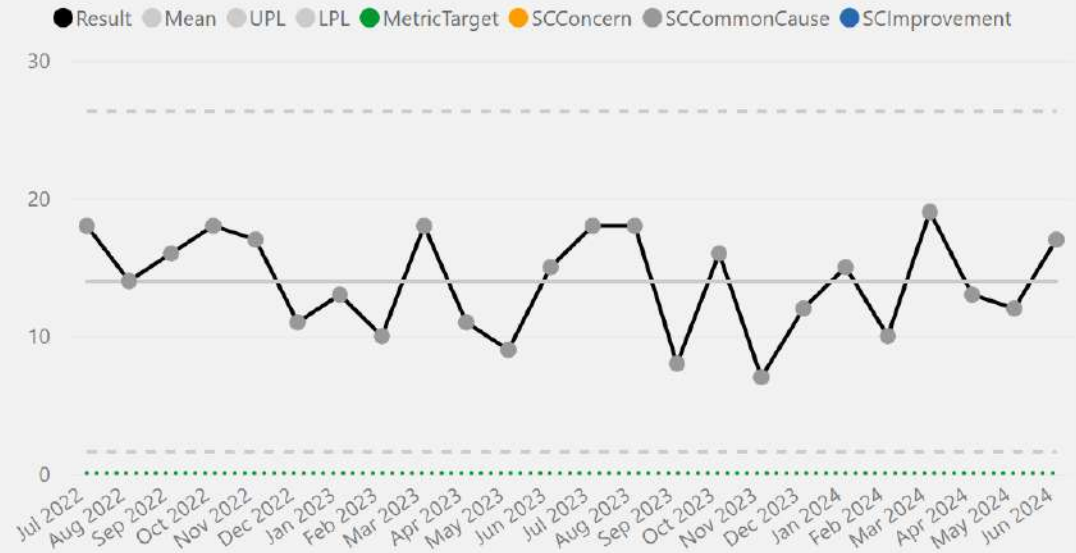
17 Result
0 Target

26 UPL
14 Mean
2 LPL

## Analytical Commentary

Variation is Common Cause

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




## Assurance Commentary

387 babies were delivered. There were no stillbirths, 1 Neonatal death compared to 6 in May.
17 unexpected term admissions to NICU compared with 12 in May, which have been reviewed through the Avoiding Term Admissions Admission into Neonatal Units (ATAIN) meetings with lessons learnt shared.
75% babies initially received breast milk and 60% on leaving hospital.
The preterm delivery rate was 6.1% with 100% of mothers receiving magnesium sulphate. 54% mothers received steroids.
A baby was cooled in line with the Hypoxic-Ischemic Encephalopathy (HIE) guidelines which will be reviewed by Maternity & Neonatal Safety Incidents (MNSI).

## Improvement Actions

## Supplementary Metrics

| Metric Name | Date | Result | | Variation | | Assurance |
|---|---|---|---|---|---|---|
| Adjusted Still Births | Jun 2024 | 0 | | Not Applicable | | No Target |
| Apgar score <7 @5, ≥37 weeks | Jun 2024 | 7 | | Common Cause | | No Target |
| Early Neonatal Death | Jun 2024 | 1 | | Not Applicable | | No Target |
| Mothers Transferred Out of Unit | Jun 2024 | 2 | | Common Cause | | No Target |

# Caesarean section births in Robson groups

Improving lives together
Norfolk and Waveney Integrated Care System

Organisation

NNUH

Date Range

01/05/2023 31/05/2024

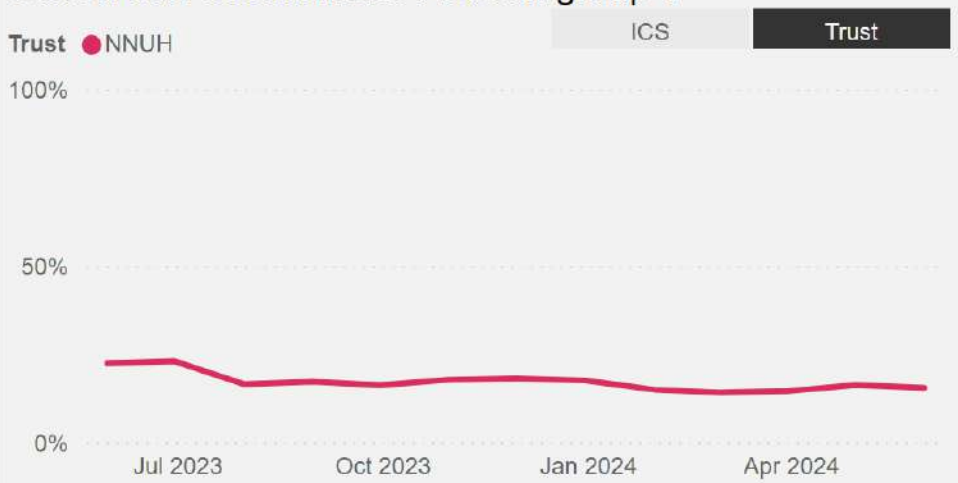
May 2024

Robson group 1
15.5%

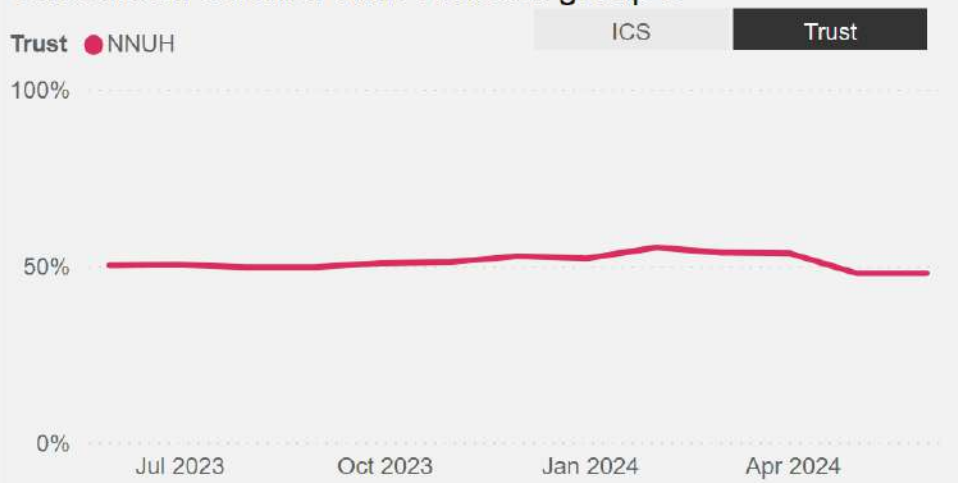
Robson group 2
47.9%

Robson group 5
83.1%

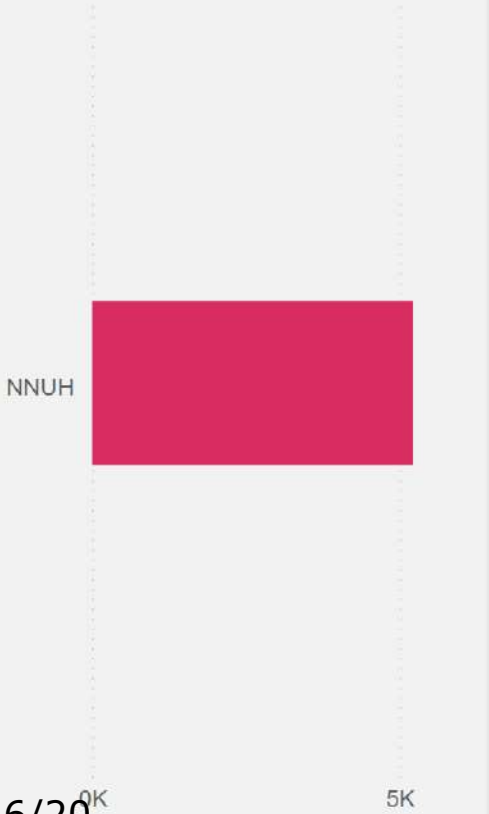
Caesarean Section Rate Robson group 1



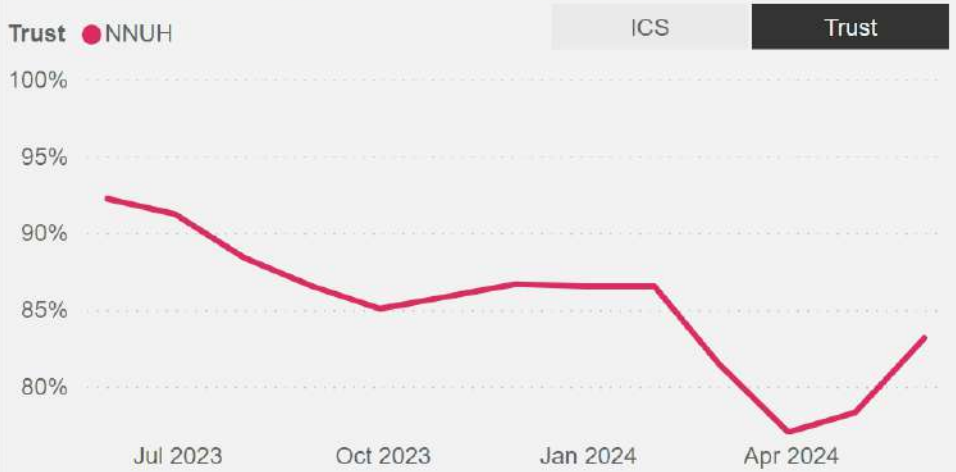

Caesarean Section Rate Robson group 2




Number of Women Birthed




Caesarean Section Rate Robson group 5



# Caesarean section births in Robson groups

Improving lives together
Norfolk and Waveney Integrated Care System

Organisation
Multiple selections

Date Range
01/05/2023 31/05/2024

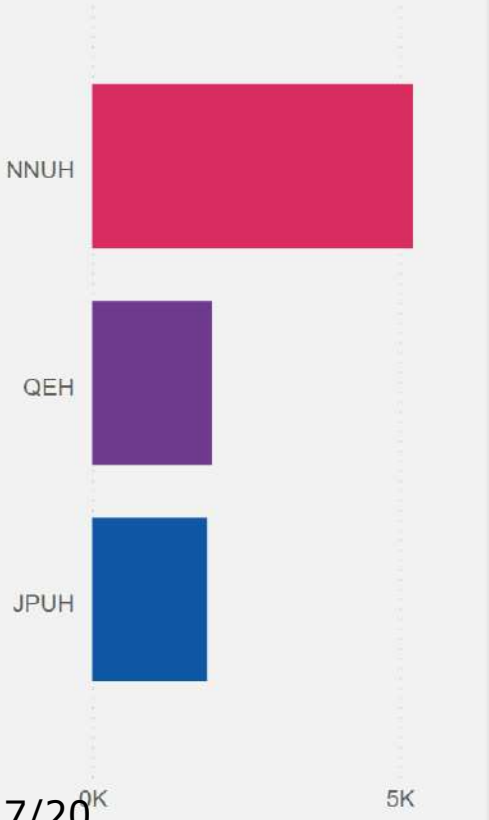
May 2024

Robson group 1
17.7%

Robson group 2
48.1%

Robson group 5
82.4%

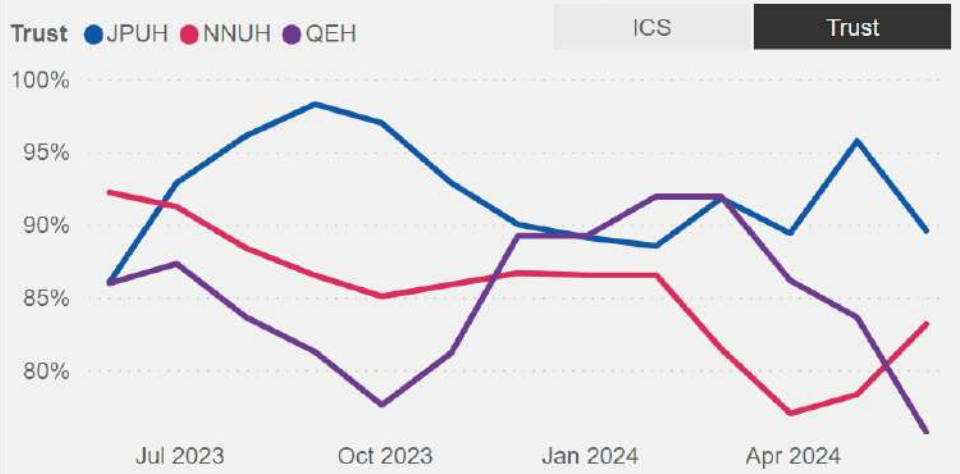
Number of Women Birthed




Caesarean Section Rate Robson group 1


Caesarean Section Rate Robson group 2


Caesarean Section Rate Robson group 5



# Saving Babies Lives

NNUH Digital Health
business intelligence

| Topic | Metric Name | Date | Result | | Variation | | Assurance |
|---|---|---|---|---|---|---|---|
| Smoking Awareness | Smoking Status at Delivery | Jun 2024 | 5.5% | | Common Cause | | Inconsistent |
| Fetal Growth Restriction | Less Than 3rd centile born > 37+6 weeks | Jun 2024 | 3% | | Common Cause | | Not capable |
| Fetal Growth Restriction | SGA detected Antenatally | Jun 2024 | 98% | | Concern (Low) | | No Target |
| Reducing Preterm Birth | Singleton Births Preterm | Jun 2024 | 6% | | Common Cause | | Inconsistent |
| Reducing Preterm Birth | Singleton live births < 34 wks (AN corticosteroids within 7 days PN) | Jun 2024 | 55% | | Common Cause | | Inconsistent |

## Assurance Commentary

We continue to monitor our SBLCB performance. 6.8% mothers smoking at time of booking and 5.5% at delivery. CO2 monitoring 96.4% at booking. 13.3% referral rate to smoking cessation services. Our work continues to support the developmetn of systemwide smoking cessation services. 98.4% women received leaflet/informaiton about reduced fetal movements. Mandatory training performance is monitored by our PDM and Mandatory training administrator. 96.5% staff have completed their fetal monitoring training and 99.6% intelligent intermittent ausucalation training completed. 89.2% have completed their SBLCB training.

## Improvement Actions

For the diabetes midwifery and consultant team to complete the compliance review of Element 6 (management of pre-existing diabetes) of Version 3 of the Saving Babies Lives Care Bundle (SBLCB).
To complete the series of audits related to pregnancies at risk of fetal growth restriction.
To continue partnership working with the Local Maternity and Neonatal System (LMNS) workstream for smoking cessation (Element 1) supporting the new advisors within each Trust.

# Adult Safeguarding

NNUH Digital Health
business intelligence

## Safeguarding Adults Referrals

Jun 2024

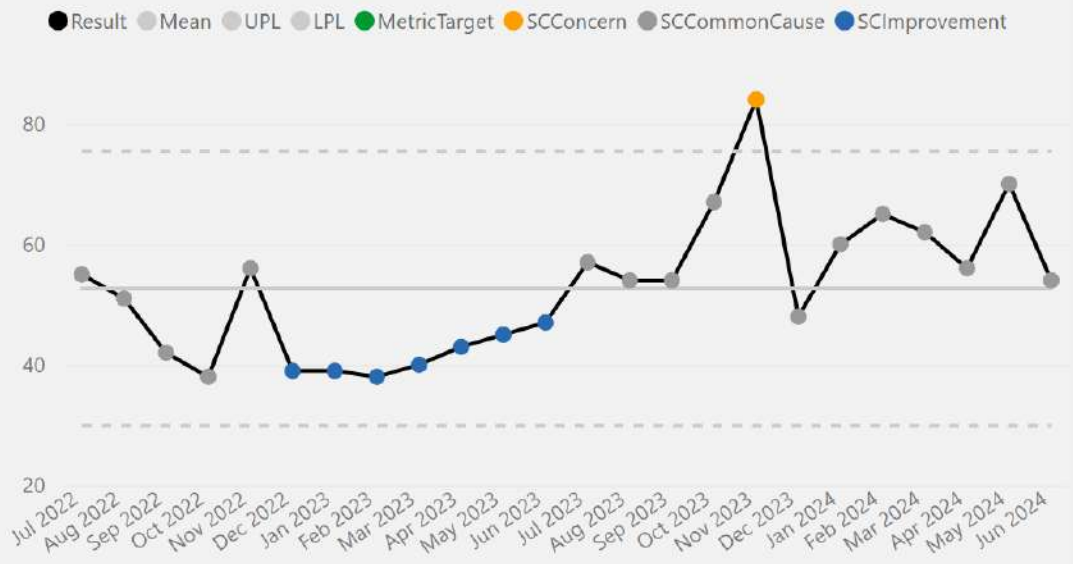
Variation | Assurance

54 Result
N/A Target
75 UPL
53 Mean
30 LPL

## Analytical Commentary

Variation is Common Cause

## Safeguarding Adults Referrals




## Assurance Commentary

A Norfolk Safeguarding Adults Board (NSAB) Data review has identified that approximately 77% of safeguarding referrals made in relation to NNUH are converted to full s.42 enquiries. Further analysis of this data will provide an insight into the potential reasons for this as it is higher than the county-wide average. NNUH continues to actively contribute to both Safeguarding Adult and Domestic Homicide Review panels and the safeguarding team are proactive in sharing the learning across the Trust.

## Improvement Actions

Proposed Local Authority and Health Framework pilot: The pilot is scheduled to start on the 1st of July. The safeguarding team will launch this on the OPM wards. It has been identified that data will be collated via a pre and post survey due to the fact that relying on data from the 3 Acutes is a challenge, owing to collecting different types of data. The safeguarding lead has made contact with Medicine`s Deputy Divisional Nursing Directors and senior Matron for the OPM wards to go through the proposed framework and pilot. The pilot is expected to last for 6 months.

# Children & Midwifery Safeguarding

NNUH Digital Health
business intelligence

## Safeguarding Children and Midwife...

Jun 2024

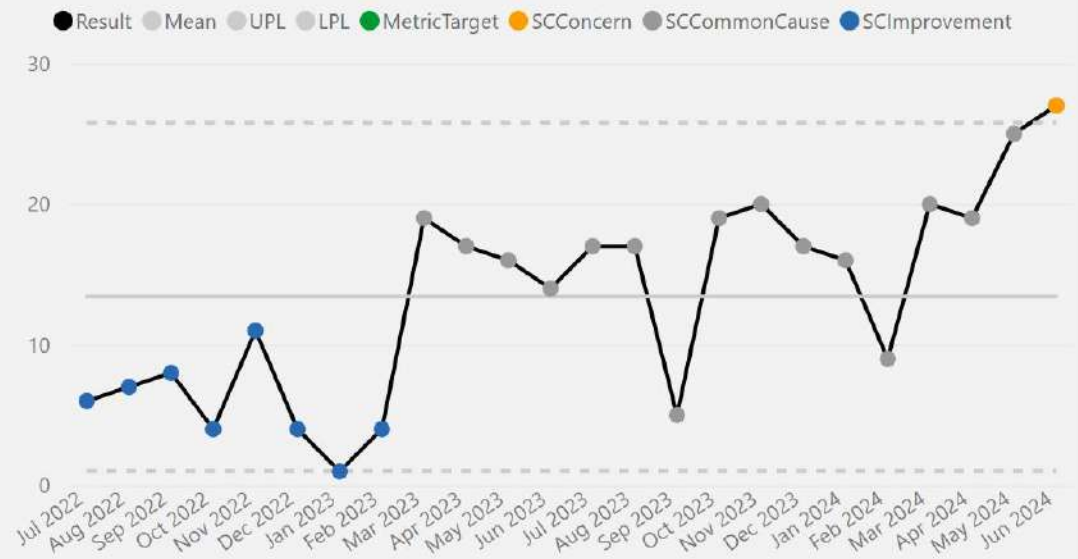
| Variation | Assurance |
|---|---|
| H | |

| | |
|---|---|
| 27 Result | 26 UPL |
| N/A Target | 13 Mean |
| | 1 LPL |

## Analytical Commentary

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

### Safeguarding Children and Midwifery Referrals




## Assurance Commentary

Safeguarding Training continues to be above 90% trust wide with both nursing and medical colleagues recording good compliance. Following a review of the safeguarding training packages there is consideration of offering the training to external agencies.

## Improvement Actions

The section 11 return for 2024 has been published. This year`s priorities are Family Community Networking, with a focus on inclusion of fathers, Neglect and Child Exploitation. The Lead for Safeguarding and Named Midwife for Safeguarding will respond on behalf of NNUH. The deadline for completion of the report is October. Supervision within paediatrics and midwifery continues to be offered and is well received. The health IDVA is fully embedded within the safeguarding team and departments are becoming more and more aware of her role and are accessing support with Domestic Abuse.

## Supplementary Metrics

| Metric Name | Date | Result | Variation | Assurance |
|---|---|---|---|---|
| Safeguarding Children Referrals | Jun 2024 | 15 | Common Cause | No Target |
| Safeguarding Midwifery Referrals | Jun 2024 | 12 | Concern (High) | No Target |

# REPORT TO TRUST BOARD

| | |
|---|---|
| **Date** | **11th September 2024** |
| **Title** | **Performance and Activity IPR** |
| **Author & Exec Lead** | **Chris Cobb – Chief Operating Officer** |
| **Purpose** | **For Information** |
| **Relevant Strategic Commitment** | **2 Together, we will support each other to be the best we can be, to be valued and proud of our hospital for all.**<br>**3 Together, we will join up services to improve the health and wellbeing of our diverse communities** |

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

**1 Background/Context**

The attached report provides an update on compliance in July 2024 against the Operational Priorities 2024-25:

Urgent and Emergency Care:

- A&E Waiting Times – '*Improve A&E waiting times compared to 2023/24, with a minimum of 78% of patients seen within 4 hours'*: On Track (83.0% for July) – The NNUH continues to perform in the top decile against this standard.

Elective Care:

- 78 Week Waits – '*Eliminate waits of over 78 weeks for elective care*': Off Track – The 78-week position on 31st July was 202 patient breaches. The forecasted number of patient breaches on 31st August is 258 patients. The Trust remains reliant on support from the Independent Sector as demand in Theatres exceeds capacity.
- 65 Week Waits – '*Eliminate waits of over 65 weeks for elective care by September 2024 (except where patients choose to wait longer or in specific specialties)':* Off Track – The current forecast identifies 1,450 patient breaches on 30th September. The Trust remains reliant on support from the Independent Sector as demand in Theatres exceeds capacity.

- Theatre Utilisation – '*Meet the 85% theatre utilisation expectations, using GIRFT and moving procedures to the most appropriate settings*': Off Track – Total Theatre Utilisation was 76.3% in July. This is a reduction in performance compared to April, May and June 2024.

- Day Case – '*Meet the 85%-day case expectations using GIRFT and moving procedures to the most appropriate setting*': On Track – Consistent delivery.

- Outpatients – '*Increase the proportion of all outpatient attendances that are for first appointments or follow up appointments attracting a procedure tariff'*: Off Track – Provisional performance is behind target.

Cancer:

- 28-Day Faster Diagnosis Standard – '*Improve performance against the 28-day Faster Diagnosis Standard to 77% by March 2025':* Off Track – Provisional unvalidated July performance shows an improvement to 67.0% - the highest performance so far in 2024/25. Increases in Breast, Brain, Urology, Gynaecology, Paediatrics and Haematology are the predominant drivers of this.

- 62-Day Performance – '*Improve performance against the headline 62-day standard to 70% by March 2025'*: Off Track – Provisional unvalidated July performance shows an improvement to 51.6% - the highest performance so far in 2024/25.

- Lower GI Referrals with a FIT Test – '*Implement and maintain priority pathway changes for lower GI (at least 80% of FDS lower GI referrals are accompanied by a FIT result), Skin (Teledermatology) and Prostate Cancer (best practice timed pathway)':* On Track – Consistently delivered target in 2023/24 and 2024/25 so far.

Diagnostics:

- Diagnostic Test Within 6 Weeks – '*Increase the percentage of patients that receive a diagnostic test within 6 weeks in line with the March 2025 ambition of 95%':* Off Track – reduced performance compared to the first 3 months of 2024/25 and below trajectory to achieve 95% target by 31st March 2025.

**Recommendations:** The Board is recommended to: **Acknowledge** the paper and latest position for information.

Our Vision
The best care for every patient

Norfolk and Norwich University Hospitals
NHS Foundation Trust

# Integrated Performance Report:

## Performance & Activity Domains

**July 2024**

# Key 2024-25 Operational Priorities

| Operational Priorities | Description | Target | Deadline | July 2024 Position | Commentary | RAG Rating |
|---|---|---|---|---|---|---|
| **Urgent and Emergency Care** | | | | | | |
| A&E Waiting Times | Improve A&E waiting times compared to 2023/24, with a minimum of 78% of patients seen within 4 hours | 78% | March 2025 | 83.0% | The NNUH continues to perform above target and in the top decile against this standard. Improved performance compared to May 2024. | |
| **Elective Care** | | | | | | |
| 78 Week Waits | Eliminate waits of over 78 weeks for elective care | 0 | July 2024 | 202 patient breaches on 31st July. | Currently forecasting 258 patient breaches on 31st August. | |
| 65 Week Waits | Eliminate waits of over 65 weeks for elective care | 0 | September 2024 | 1,975 patient breaches on 31st July. | Currently forecasting 1,450 patient breaches on 30th September. | |
| Theatre Utilisation | Capped theatre touch time utilisation | 85% | March 2025 | 76.3% | Reduced position compared to the first 3 months of 2024/25 and remains below target. | |
| Day Case | Elective surgery delivered as either a day case or outpatient procedure (BADS) | 85% | March 2025 | 87.0% | Consistently delivered. | |
| Outpatients | Increase the proportion of all outpatient attendances that are for first appointments or follow up appointments attracting a procedure tariff | 47.7% | March 2025 | 45.9% (provisional). | Action taken on 15th April to increase percentage of Outpatients with procedures as part of activity stretch. | |

# Key 2024-25 Operational Priorities

| Operational Priorities | Description | Target | Deadline | July 2024 Position | Commentary | RAG Rating |
|---|---|---|---|---|---|---|
| **Cancer** | | | | | | |
| 28-Day Faster Diagnosis Standard | Improve performance against the 28-day Faster Diagnosis Standard | 77% | March 2025 | June 2024 = 61.1% (closed performance)<br><br>July 2024 = 67.0% (unvalidated performance) | Closed June 2024 performance was 61.1% - an improvement from April and May but remaining behind trajectory. Provisional unvalidated July performance shows a further improvement to 67.0%. Increases in Breast, Brain, Urology, Gynaecology, Paediatrics and Haematology are the predominant drivers of this. | |
| 62-Day Performance | Improve performance against the headline 62-day standard | 70% | March 2025 | June 2024 = 45.9% (closed performance)<br><br>July 2024 = 51.6% (unvalidated performance) | Closed June 2024 performance was 45.9% - improved from April and May but remains behind trajectory. Provisional unvalidated July performance is 51.6%. Increased backlog position caused performance to be below trajectory in May and June, through addressing long-waits in month. Additional activity provided by regional funding will support continual improvements through to December. | |
| Lower GI Referrals with a FIT Test | Implement and maintain priority pathway changes for Lower GI (at least 80% of FDS Lower GI referrals are accompanied by a FIT result), Skin (Teledermatology) and Prostate Cancer (best practice timed pathway) | 80% | March 2025 | 89.8% | Consistently delivered. | |
| **Diagnostics** | | | | | | |
| Diagnostic Test Within 6 Weeks | Increase the percentage of patients that receive a diagnostic test within 6 weeks | 95% | March 2025 | 62.3% | Reduced performance compared to the first 3 months of 2024/25 and below trajectory to achieve 95% target by 31st March 2025. | |

# Urgent and Emergency Care

# NHS England Letter – UEC Tiering and Improvement Support



Classification: Official-Sensitive

NHS England

To:
- ICB:
  - Chief Executive
  - Chair

CC:
- NHS England Regional Director

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

**5 August 2024**

Dear colleagues,

**RE: UEC Tiering and Improvement Support - Tier 2**

Following the publication of the delivery plan for recovering urgent and emergency care published in January 2023, we wrote to you in May 2023, identifying that all ICBs had been allocated into one of three tiers, determining the level of improvement and oversight. Allocation of systems into tiers was regionally led, based on local insight and performance, and evidenced by data. Based on this methodology and discussions with regions, your system was initially allocated to Tier 1.

Within the Urgent and emergency care recovery plan year 2: building on learning from 2023/24, two key targets have been set for 2024/25:

- Patients being seen more quickly in emergency departments: with the ambition to improve to 78% of patients being admitted, transferred or discharged within four hours by March 2025
- Ambulances getting to patients quicker: with improved ambulance response times for Category 2 incidents to 30 minutes on average over 2024/25

In July 2024 a review was undertaken of the progress systems have made in delivering these key targets and enabling metrics. As before, allocation of systems into tiers has been regionally led, informed by both performance data and local insight. Based on this methodology and discussions with the East of England region, your system, Norfolk & Waveney ICB, **has been de-escalated to Tier 2.**

This reflects the sustained improvement in performance and the progress towards achieving the above targets, your collaborative approach with system partners, together with your clear commitment to culture change and empowering your frontline clinical and operational leaders. As a Tier 2 system, you will continue to receive regionally led support to help achieve the ambitions of the UEC Recovery Plan, but this will be much lighter touch to that which you would have experienced in Tier 1. National ECIST support will also be maintained in James Paget University Hospitals to ensure their continued improvement journey.

We would like to arrange a visit to the system in October to thank your frontline staff for their impressive improvement work and celebrate the dedication of all colleagues for their efforts to meet our shared ambitions by embedding sustainable actions to improve patient care and experience.

We recognise that there is still more to on delivering the ambitions outlined in the delivery plan for recovering urgent and emergency care and encourage you to continue your journey of improvement, of which you should be rightly proud.

Yours sincerely,

**Sarah-Jane Marsh,**

**National Director for iUEC and Deputy Chief Operating Officer**

# Performance – ED 4 Hour Performance

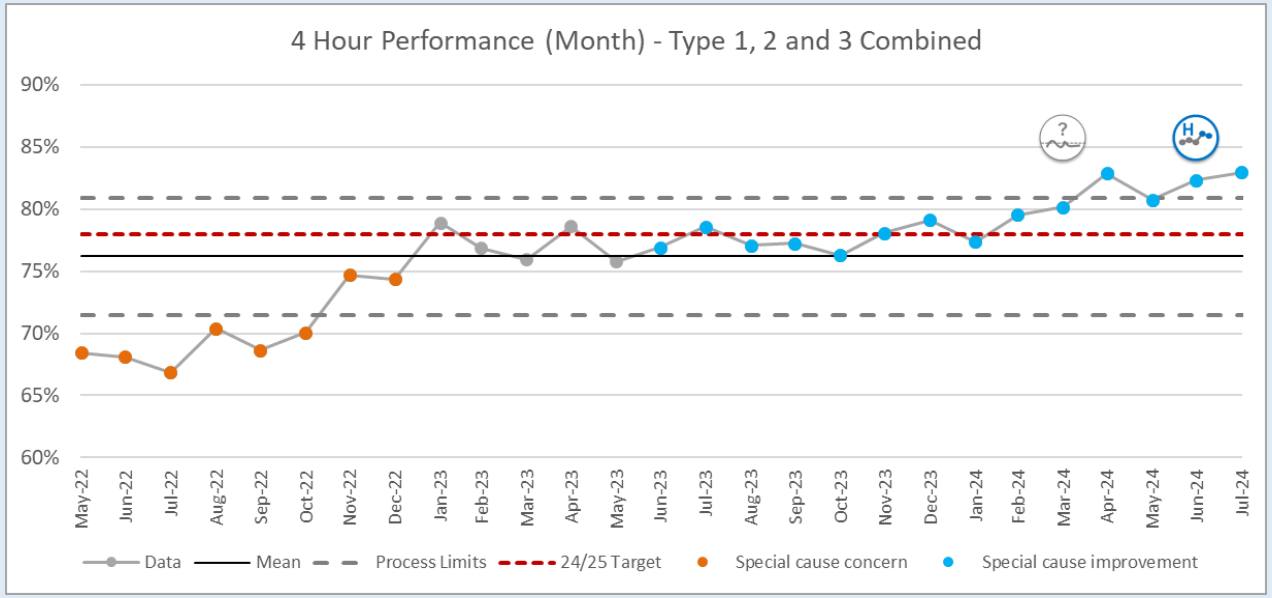


## Commentary

Combined 4-hour performance for July 2024 = **83.0% -** this was the highest combined (Type 1, 2 and 3) monthly performance since November 2018 and above the 78% target.

Rolling August performance is currently **82.2%,** with year-to-date (24/25) 4-hour performance also at 82.2%.

Type 1 4-hour performance for July 2024 = 71.0% - this was the highest Type 1 monthly performance since June 2020.




**4 Hour Performance - Rolling July 2024: 83.0%**

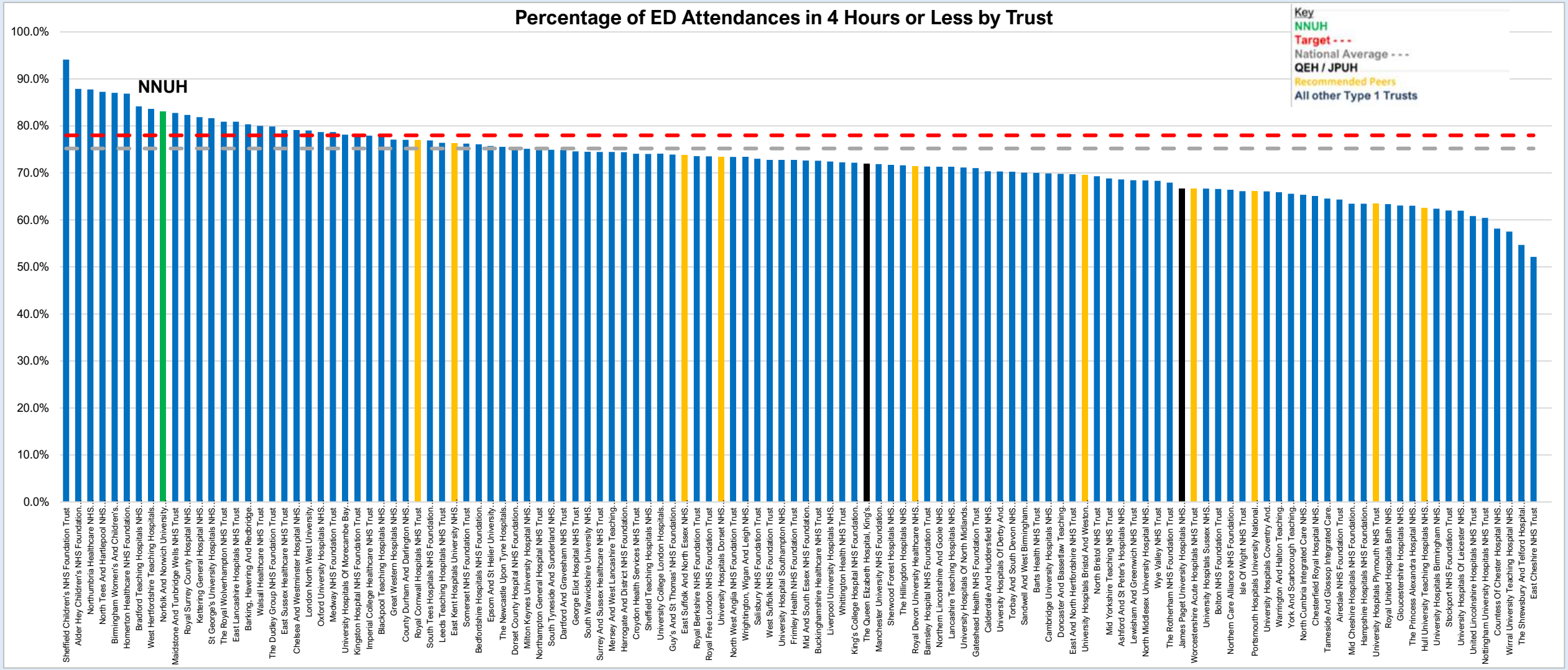
| Category | Type | Mon Jul 01 | Tue Jul 02 | Wed Jul 03 | Thu Jul 04 | Fri Jul 05 | Sat Jul 06 | Sun Jul 07 | Mon Jul 08 | Tue Jul 09 | Wed Jul 10 | Thu Jul 11 | Fri Jul 12 | Sat Jul 13 | Sun Jul 14 | Mon Jul 15 | Tue Jul 16 | Wed Jul 17 | Thu Jul 18 | Fri Jul 19 | Sat Jul 20 | Sun Jul 21 | Mon Jul 22 | Tue Jul 23 | Wed Jul 24 | Thu Jul 25 | Fri Jul 26 | Sat Jul 27 | Sun Jul 28 | Mon Jul 29 | Tue Jul 30 | Wed Jul 31 | July Avg. |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Type 1 Breaches | ED Admitted | 52 | 52 | 61 | 64 | 57 | 44 | 55 | 61 | 61 | 58 | 72 | 68 | 58 | 57 | 59 | 63 | 54 | 51 | 61 | 88 | 45 | 52 | 57 | 72 | 63 | 71 | 57 | 49 | 58 | 77 | 45 | 59 |
| | ED Non-Admitted | 37 | 45 | 56 | 32 | 51 | 49 | 29 | 65 | 69 | 53 | 56 | 90 | 42 | 35 | 66 | 44 | 47 | 57 | 63 | 72 | 43 | 65 | 53 | 46 | 32 | 66 | 50 | 76 | 87 | 87 | 64 | 56 |
| | **Type 1 Breaches** | **89** | **97** | **117** | **96** | **108** | **93** | **84** | **126** | **130** | **111** | **128** | **158** | **100** | **92** | **125** | **107** | **101** | **108** | **124** | **160** | **88** | **117** | **110** | **118** | **95** | **137** | **107** | **125** | **145** | **164** | **109** | **115** |
| Type 1 Attendances | ED Admitted | 87 | 83 | 86 | 84 | 85 | 81 | 79 | 77 | 80 | 75 | 94 | 77 | 77 | 82 | 82 | 91 | 92 | 88 | 88 | 114 | 84 | 84 | 83 | 97 | 91 | 85 | 81 | 66 | 81 | 99 | 79 | 85 |
| | ED Non-Admitted | 342 | 310 | 303 | 284 | 303 | 284 | 249 | 335 | 340 | 310 | 325 | 323 | 274 | 269 | 355 | 301 | 290 | 314 | 281 | 321 | 318 | 348 | 334 | 298 | 292 | 325 | 320 | 310 | 363 | 318 | 324 | 312 |
| | **Type 1 Attendances** | **429** | **393** | **389** | **368** | **388** | **365** | **328** | **412** | **420** | **385** | **419** | **400** | **351** | **351** | **437** | **392** | **382** | **402** | **369** | **435** | **402** | **432** | **417** | **395** | **383** | **410** | **401** | **376** | **444** | **417** | **403** | **397** |
| **Type 1 (ED) Admitted** | | 40.2% | 37.3% | 29.1% | 23.8% | 32.9% | 45.7% | 30.4% | 20.8% | 23.8% | 22.7% | 23.4% | 11.7% | 24.7% | 30.5% | 28.0% | 30.8% | 41.3% | 42.0% | 30.7% | 22.8% | 46.4% | 38.1% | 31.3% | 25.8% | 30.8% | 16.5% | 29.6% | 25.8% | 28.4% | 22.2% | 43.0% | **30.0%** |
| **Type 1 (ED) Non-Admitted** | | 89.2% | 85.5% | 81.5% | 88.7% | 83.2% | 82.7% | 88.4% | 80.6% | 79.7% | 82.9% | 82.8% | 72.1% | 84.7% | 87.0% | 81.4% | 85.4% | 83.8% | 81.8% | 77.6% | 77.6% | 86.5% | 81.3% | 84.1% | 84.6% | 89.0% | 79.7% | 84.4% | 75.5% | 76.0% | 72.6% | 80.2% | **82.1%** |
| **Type 1 (ED) Combined** | | 79.3% | 75.3% | 69.9% | 73.9% | 72.2% | 74.5% | 74.4% | 69.4% | 69.0% | 71.2% | 69.5% | 60.5% | 71.5% | 73.8% | 71.4% | 72.7% | 73.6% | 73.1% | 66.4% | 63.2% | 78.1% | 72.9% | 73.6% | 70.1% | 75.2% | 66.6% | 73.3% | 66.8% | 67.3% | 60.7% | 73.0% | **71.0%** |
| **Type 1, 2 and 3 Combined** | | 86.8% | 85.8% | 82.1% | 84.3% | 84.1% | 84.8% | 85.7% | 82.5% | 81.4% | 83.3% | 81.1% | 75.4% | 84.8% | 85.5% | 83.2% | 83.6% | 84.8% | 84.0% | 80.4% | 77.5% | 87.2% | 84.3% | 84.2% | 82.7% | 86.1% | 80.0% | 84.5% | 81.5% | 80.3% | 76.9% | 83.9% | **83.0%** |

*NHSE 24/25 Target: 78%*

The NNUH 4 Hour Target includes attendances for ED, Cromer MIU, GP Streaming and the Walk in Centre.

# ED Waiting Times <4 hours – National Position (July 2024)






## Commentary

In July, NNUH were ranked 9th across all Type 1 NHS Trusts and the best performing amongst our recommended peers (for most similar attributes) with 83.0% of ED patients either admitted, transferred or discharged within 4 hours of arrival. This was ahead of the national target of 78% and the July national average of 75.2%.

# Elective Care

# 78 Weeks – Specialty Level Forecast to 31st August 2024



| Specialty | | Weekly Averages | 21/06/2024 | 28/06/2024 (IA) | 05/07/2024 (IA) | 12/07/2024 | 19/07/2024 | 26/07/2024 | 02/08/2024 | 09/08/2024 | 16/08/2024 | 23/08/2024 | 30/08/2024 (Public Holiday) | 31/08/2024 | Breaches 258 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 110 - Trauma and Orthopaedic | Will Breach | - | 479 | 432 | 392 | 344 | 307 | 272 | 254 | 231 | 211 | 186 | 171 | 167 | 167 |
| | Weekly Removals | 37 | 53 | 47 | 40 | 48 | 37 | 35 | 18 | 23 | 17 | 25 | 15 | 4 | |
| | Future TCIs | 54 | | | | | | | | | 17 | 23 | 14 | 4 | |
| 130 - Ophthalmology | Will Breach | - | 114 | 102 | 87 | 67 | 54 | 47 | 42 | 37 | 31 | 26 | 21 | 21 | 21 |
| | Weekly Removals | 10 | 6 | 12 | 15 | 20 | 13 | 7 | 5 | 5 | 5 | 5 | 5 | 0 | |
| | Future TCIs | 6 | | | | | | | | | 3 | 0 | 3 | 0 | |
| 502 - Gynaecology | Will Breach | - | 246 | 207 | 177 | 146 | 121 | 94 | 74 | 63 | 46 | 31 | 16 | 16 | 16 |
| | Weekly Removals | 25 | 22 | 39 | 30 | 31 | 25 | 27 | 20 | 11 | 15 | 15 | 15 | 0 | |
| | Future TCIs | 33 | | | | | | | | | 15 | 11 | 7 | 0 | |
| 160 - Plastic Surgery | Will Breach | - | 81 | 76 | 66 | 56 | 47 | 37 | 34 | 32 | 30 | 24 | 18 | 18 | 18 |
| | Weekly Removals | 6 | 4 | 5 | 10 | 10 | 9 | 10 | 3 | 2 | 2 | 6 | 6 | 0 | |
| | Future TCIs | 7 | | | | | | | | | 1 | 3 | 3 | 0 | |
| 108 - Spinal Surgery | Will Breach | - | 59 | 49 | 45 | 40 | 33 | 29 | 26 | 22 | 20 | 15 | 10 | 10 | 10 |
| | Weekly Removals | 5 | 7 | 10 | 4 | 5 | 7 | 4 | 3 | 4 | 2 | 5 | 5 | 0 | |
| | Future TCIs | 7 | | | | | | | | | 1 | 4 | 2 | 0 | |
| 100 - General Surgery | Will Breach | - | 126 | 105 | 85 | 62 | 53 | 37 | 30 | 24 | 20 | 14 | 8 | 8 | 8 |
| | Weekly Removals | 14 | 12 | 21 | 20 | 23 | 9 | 16 | 7 | 6 | 2 | 6 | 6 | 0 | |
| | Future TCIs | 6 | | | | | | | | | | 4 | 2 | 0 | |
| 216 - Paediatric Ophthalmology | Will Breach | - | 16 | 17 | 17 | 14 | 10 | 9 | 9 | 8 | 8 | 7 | 6 | 6 | 6 |
| | Weekly Removals | 1 | 0 | -1 | 0 | 3 | 4 | 1 | 0 | 1 | 0 | 1 | 1 | 0 | |
| | Future TCIs | | | | | | | | | | | | | | |
| 120 - Ear Nose and Throat | Will Breach | - | 90 | 79 | 61 | 46 | 38 | 27 | 19 | 16 | 14 | 9 | 4 | 4 | 4 |
| | Weekly Removals | 9 | 5 | 11 | 18 | 15 | 8 | 11 | 8 | 3 | 2 | 5 | 5 | 0 | |
| | Future TCIs | 6 | | | | | | | | | 2 | 2 | 2 | 0 | |
| 101 - Urology | Will Breach | - | 89 | 72 | 58 | 40 | 27 | 19 | 10 | 8 | 6 | 5 | 3 | 3 | 3 |
| | Weekly Removals | 11 | 8 | 17 | 14 | 18 | 13 | 8 | 9 | 2 | 2 | 1 | 2 | 0 | |
| | Future TCIs | 2 | | | | | | | | | 1 | | 1 | 0 | |
| 330 - Dermatology | Will Breach | - | 33 | 24 | 18 | 14 | 13 | 9 | 8 | 7 | 5 | 3 | 1 | 1 | 1 |
| | Weekly Removals | 3 | 5 | 9 | 6 | 4 | 1 | 4 | 1 | 1 | 1 | 2 | 2 | 0 | |
| | Future TCIs | 1 | | | | | | | | | 1 | | | 0 | |
| 140 - Oral Surgery | Will Breach | - | 3 | 3 | 3 | 4 | 4 | 4 | 4 | 4 | 3 | 2 | 1 | 1 | 1 |
| | Weekly Removals | (0) | 0 | 0 | 0 | -1 | 0 | 0 | 0 | 0 | 0 | 1 | 1 | 0 | |
| | Future TCIs | | | | | | | | | | | | | | |
| 219 - Paediatric Plastic Surgery | Will Breach | - | 6 | 6 | 6 | 6 | 3 | 3 | 3 | 3 | 3 | 2 | 1 | 1 | 1 |
| | Weekly Removals | 1 | 3 | 0 | 0 | 0 | 3 | 0 | 0 | 0 | 0 | 1 | 1 | 0 | |
| | Future TCIs | 1 | | | | | | | | | | | 1 | | |
| 302 - Endocrinology | Will Breach | - | 7 | 5 | 4 | 4 | 2 | 2 | 2 | 2 | 2 | 2 | 1 | 1 | 1 |
| | Weekly Removals | 1 | 1 | 2 | 1 | 0 | 2 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | |
| | Future TCIs | | | | | | | | | | | | | | |
| 840 - Audiology | Will Breach | - | 2 | 2 | 3 | 1 | 0 | 0 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| | Weekly Removals | 0 | 0 | 0 | -1 | 2 | 1 | 0 | -1 | 0 | 0 | 0 | 0 | 0 | |
| | Future TCIs | | | | | | | | | | | | | | |

## Commentary

The Trust has forecasted a net position of 258 patients breaching 78-weeks on 31st August 2024. Loss of Anaesthetic cover due to x3 long term sickness cases and x1 short notice leave has led to a reallocation of theatre lists, prioritising emergency trauma, cancer and long waits. 2 new anaesthetists start in September. Position expected to recover in September as a result.

# 65 Weeks – Specialty Level Forecast to 30th September 2024



| Specialty | | Weekly Averages | 21/06/2024 | 28/06/2024 (IA) | 05/07/2024 (IA) | 12/07/2024 | 19/07/2024 | 26/07/2024 | 02/08/2024 | 09/08/2024 | 16/08/2024 | 23/08/2024 | 30/08/2024 (Public Holiday) | 06/09/2024 | 13/09/2024 | 20/09/2024 | 27/09/2024 | 30/09/2024 | Total Breaches - No Additional Funding |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | | | | | | | | | | 1,450 |
| 110 - Trauma and Orthopaedic | Will Breach | - | 2,027 | 1,929 | 1,834 | 1,721 | 1,627 | 1,529 | 1,453 | 1,360 | 1266 | 1197 | 1139 | 1026 | 913 | 800 | 687 | 637 | 637 |
| | Weekly Removals | 97 | 115 | 98 | 95 | 113 | 94 | 98 | 76 | 93 | 82 | 69 | 58 | 113 | 113 | 113 | 113 | 50 | |
| | Future TCIs | 391 | | | | | | | | | 82 | 62 | 50 | 77 | 47 | 34 | 39 | | |
| 502 - Gynaecology | Will Breach | - | 960 | 902 | 860 | 822 | 776 | 734 | 699 | 680 | 646 | 602 | 552 | 496 | 440 | 384 | 328 | 309 | 309 |
| | Weekly Removals | 39 | 36 | 58 | 42 | 38 | 46 | 42 | 35 | 19 | 30 | 44 | 50 | 56 | 56 | 56 | 56 | 19 | |
| | Future TCIs | 131 | | | | | | | | | 30 | 28 | 10 | 16 | 18 | 12 | 17 | | |
| 120 - Ear Nose and Throat | Will Breach | - | 473 | 445 | 418 | 401 | 390 | 359 | 325 | 308 | 296 | 270 | 244 | 218 | 192 | 166 | 140 | 131 | 131 |
| | Weekly Removals | 22 | 12 | 28 | 27 | 17 | 11 | 31 | 34 | 17 | 11 | 26 | 26 | 26 | 26 | 26 | 26 | 9 | |
| | Future TCIs | 40 | | | | | | | | | 11 | 4 | 12 | 5 | 2 | 3 | 3 | | |
| 100 - General Surgery | Will Breach | - | 665 | 591 | 543 | 491 | 437 | 397 | 359 | 342 | 322 | 284 | 254 | 216 | 178 | 140 | 102 | 86 | 86 |
| | Weekly Removals | 53 | 101 | 74 | 48 | 52 | 54 | 40 | 38 | 17 | 6 | 38 | 30 | 38 | 38 | 38 | 38 | 16 | |
| | Future TCIs | 61 | | | | | | | | | 6 | 24 | 6 | 8 | 5 | 8 | 4 | | |
| 130 - Ophthalmology | Will Breach | - | 435 | 401 | 364 | 311 | 279 | 263 | 251 | 233 | 223 | 197 | 178 | 152 | 126 | 100 | 74 | 60 | 60 |
| | Weekly Removals | 27 | 19 | 34 | 37 | 53 | 32 | 16 | 12 | 18 | 8 | 26 | 19 | 26 | 26 | 26 | 26 | 14 | |
| | Future TCIs | 60 | | | | | | | | | 8 | 14 | 12 | 13 | 4 | 5 | 4 | | |
| 108 - Spinal Surgery | Will Breach | - | 258 | 242 | 227 | 208 | 193 | 182 | 174 | 164 | 156 | 142 | 132 | 118 | 104 | 90 | 76 | 69 | 69 |
| | Weekly Removals | 14 | 19 | 16 | 15 | 19 | 15 | 11 | 8 | 10 | 8 | 14 | 10 | 14 | 14 | 14 | 14 | 7 | |
| | Future TCIs | 47 | | | | | | | | | 8 | 10 | 13 | 2 | 9 | 2 | 3 | | |
| 215 - Paediatric Ear Nose and Throat | Will Breach | - | 218 | 210 | 198 | 182 | 171 | 157 | 143 | 132 | 121 | 109 | 100 | 88 | 76 | 64 | 52 | 47 | 47 |
| | Weekly Removals | 11 | 4 | 8 | 12 | 16 | 11 | 14 | 14 | 11 | 7 | 12 | 9 | 12 | 12 | 12 | 12 | 5 | |
| | Future TCIs | 38 | | | | | | | | | 7 | 4 | 9 | 5 | 1 | 5 | 7 | | |
| 160 - Plastic Surgery | Will Breach | - | 323 | 311 | 292 | 263 | 245 | 219 | 204 | 193 | 168 | 151 | 139 | 117 | 95 | 73 | 51 | 42 | 42 |
| | Weekly Removals | 19 | 26 | 12 | 19 | 29 | 18 | 26 | 15 | 11 | 18 | 17 | 12 | 22 | 22 | 22 | 22 | 9 | |
| | Future TCIs | 76 | | | | | | | | | 18 | 17 | 12 | 12 | 9 | 7 | 1 | | |
| 216 - Paediatric Ophthalmology | Will Breach | - | 27 | 30 | 30 | 28 | 25 | 24 | 24 | 22 | 23 | 23 | 23 | 22 | 22 | 21 | 21 | 21 | 21 |
| | Weekly Removals | 1 | 1 | -3 | 0 | 2 | 3 | 1 | 0 | 2 | 0 | 0 | 0 | 1 | 0 | 1 | 0 | 0 | |
| | Future TCIs | | | | | | | | | | | | | | | | | | |
| 101 - Urology | Will Breach | - | 384 | 346 | 317 | 280 | 257 | 231 | 208 | 183 | 169 | 139 | 118 | 97 | 76 | 55 | 34 | 23 | 23 |
| | Weekly Removals | 26 | 12 | 38 | 29 | 37 | 23 | 26 | 23 | 25 | 7 | 30 | 21 | 21 | 21 | 21 | 21 | 11 | |
| | Future TCIs | 47 | | | | | | | | | 7 | 10 | 13 | 8 | 5 | 3 | 1 | | |
| 107 - Vascular Surgery | Will Breach | - | 63 | 60 | 57 | 51 | 52 | 50 | 45 | 45 | 43 | 37 | 31 | 27 | 23 | 19 | 15 | 14 | 14 |
| | Weekly Removals | 2 | 1 | 3 | 3 | 6 | -1 | 2 | 5 | 0 | 1 | 6 | 6 | 4 | 4 | 4 | 4 | 1 | |
| | Future TCIs | 16 | | | | | | | | | 1 | 6 | 6 | 3 | | | | | |
| 140 - Oral Surgery | Will Breach | - | 145 | 138 | 135 | 125 | 110 | 100 | 94 | 86 | 79 | 69 | 59 | 48 | 38 | 28 | 18 | 11 | 11 |
| | Weekly Removals | 8 | 6 | 7 | 3 | 10 | 15 | 10 | 6 | 8 | 5 | 10 | 10 | 11 | 10 | 10 | 10 | 7 | |
| | Future TCIs | 36 | | | | | | | | | 5 | 10 | 6 | 11 | 3 | 1 | 0 | | |

## Commentary

The Trust has forecasted 1,450 patients to be breaching 65-weeks at the end of September 2024. A significant number of theatre sessions have been lost in August and are forecast to be lost in September due to a shortfall in anaesthetic cover.

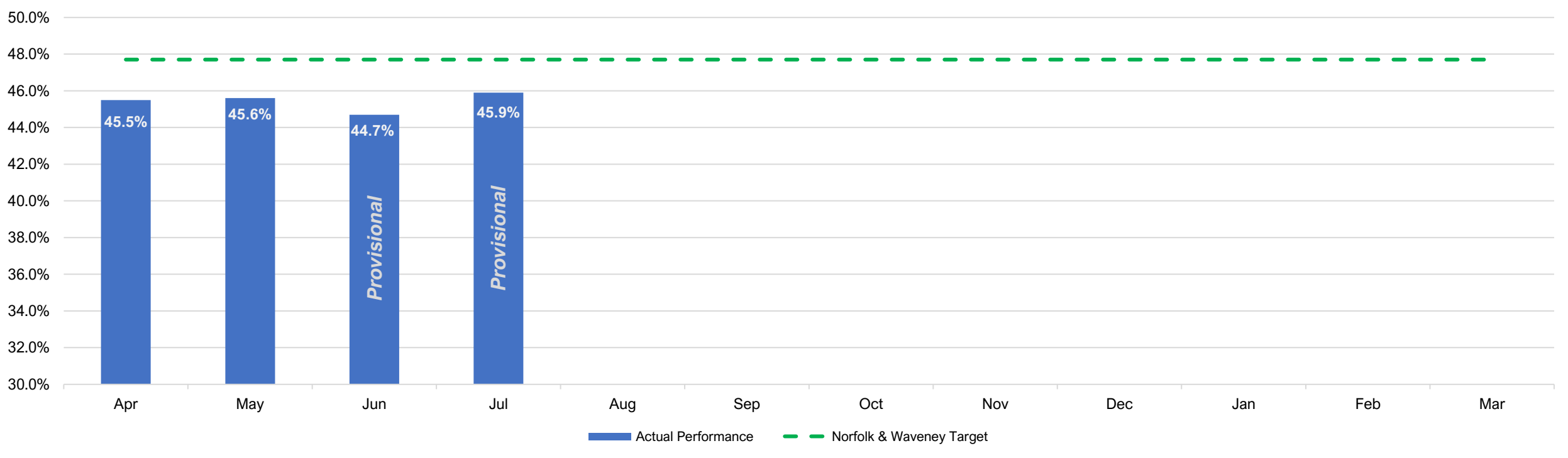
We are in the worst 9 Trusts nationally in terms of risk of delivery of the national ask of zero patients waiting over 65-weeks by 30th September.

In our April 2024 planning submission, we forecast 1,643 breaches of 65-week patients and a resolution date of end of December.

We are in the process of developing a recovery plan to improve the forecast.

# Performance – Percentage of News / Procedures of Total Outpatients






## Commentary

**July 2024 Performance (Provisional)**

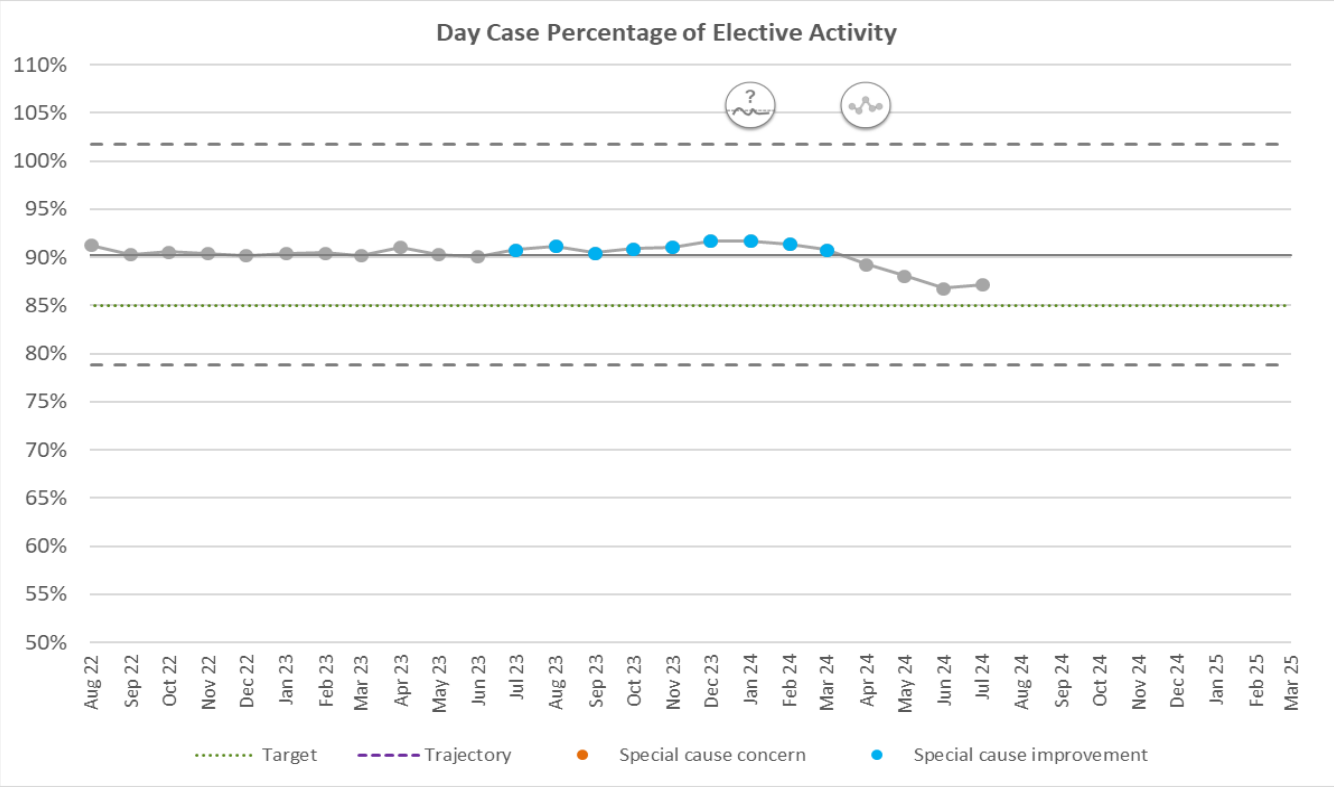
The 2024/25 priorities and operational planning guidance includes a new metric measuring the proportion of all outpatient attendances that are for first or follow-up appointments attracting a procedure tariff (the proportion of activity that is pathway completing). The target for Norfolk and Waveney to achieve by March 2025 is 47.7%. The confirmed Trust wide performance for May was 45.6%, with provisional performance for June at 44.7% and July at 45.9%.

**Risk To Delivery**

**AMBER**

# Performance – 85% Day Case






## Commentary

**July 2024 Performance**

In July, NNUH delivered 87.2% of elective activity as day cases. This is an increase from June and remains above the 85% target.

**Risk To Delivery**

**GREEN**

# Performance – Theatre Utilisation



## Commentary

**July 2024 Performance**

Touch time delivery across all Theatres in July reduced to 76.3% compared to 76.8% in June and 78.7% in May.

Utilisation levels for Level 2 Theatres reduced in July to 75.3% from 76.6% in June. Level 3 Theatre utilisation also reduced in month at 76.3% compared to 77.1% in June.

Across all Theatres, a total of 1,148 sessions ran in month – this higher than any of the last 12 months. The number of on the day cancellations was 194 in July – higher than any of the last 12 months.

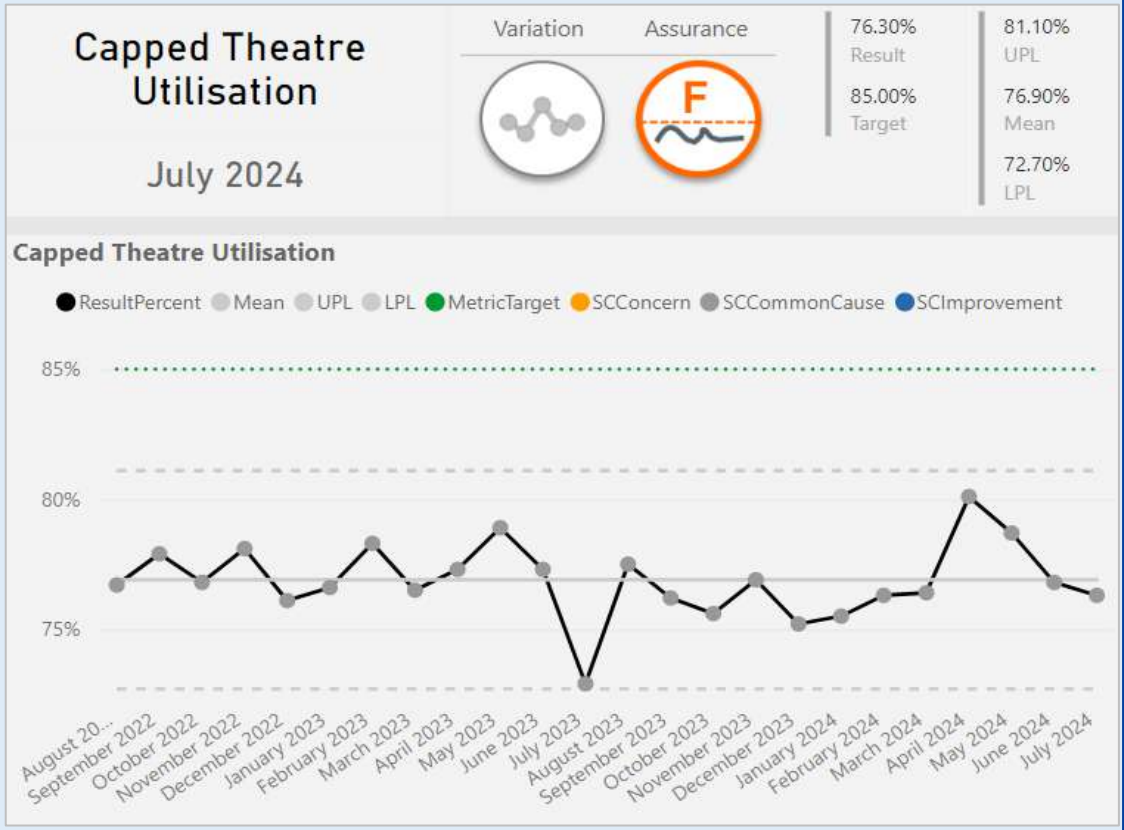
75 (39%) of the cancellations were for clinical reasons, such as the treatment being deferred (51), or the procedure no longer being required (18). 68 (35%) were for non-clinical reasons primarily due to clinical staff being unavailable (27), lists overrunning (16) or emergency admissions (12) and 51 (26%) due to patient reasons, including did not attend (21), the patient being unfit for procedure (10), or procedure was not wanted (9).

**Improvement Actions**

1. Over 3,000 patients have been added to the Digital POA system across all specialties; these are all long waiting patients that hadn't been POA'd. More work required in terms of configuration of Digital POA system before it can be rolled out to be used in specialty clinics.
2. Draft report received following NHSE visit to support theatre utilisation, including actions regarding support with data quality and increased alignment with model hospital, separation of Orthopaedics and Spinal Surgery in utilisation reporting due to impact of spinal trauma and distorting impact on Orthopaedics for example.
3. Trajectories for each specialty to achieve 85% utilisation target have been completed and are used in weekly specialty reviews when looking at utilisation and assigning actions for improvement. Plan to hold specialty specific meetings with specialty triumvirates across Q2 to inform actions. Trajectories to be monitored through productivity board and reported through service level performance committee for senior divisional oversight of progress.

**Risk To Delivery**

**AMBER**

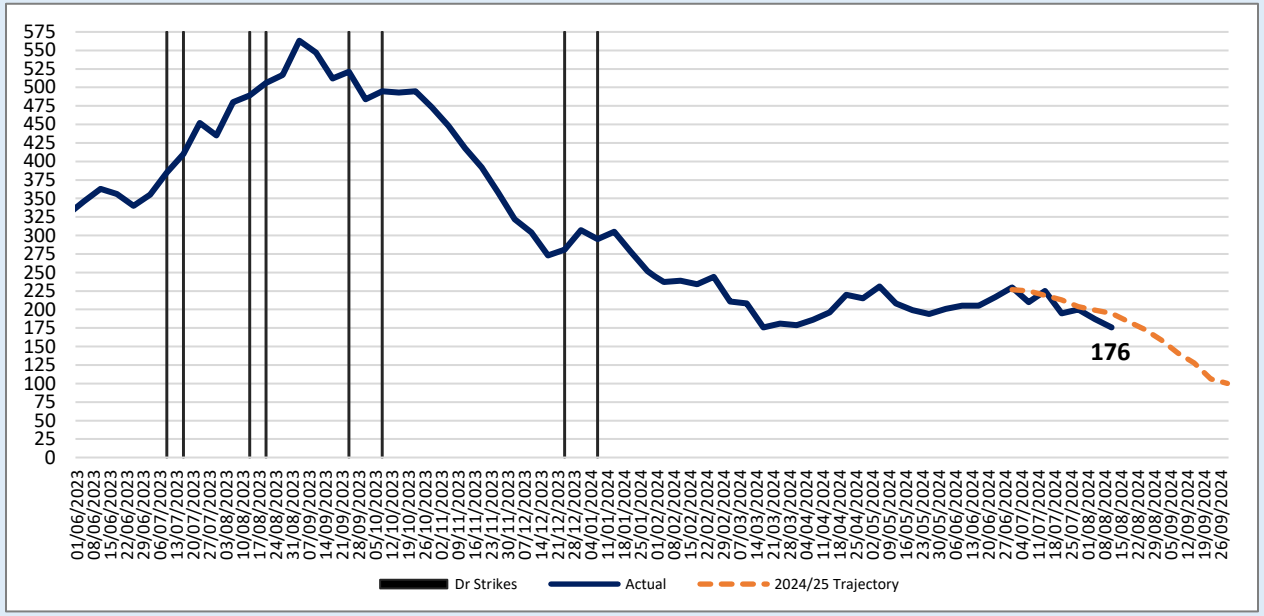


# Cancer

# Cancer – 62-Day Backlog Profile



## 62 Day Backlog – NNUH Actuals Vs Trajectory (11th August 2024)




| Suspected Tumour Type | Past day 62 | Change in last week | Change in 4 weeks |
|---|---|---|---|
| Brain | 0 | 0 | 0 |
| Breast | 7 | -3 | -3 |
| Children's | 0 | 0 | 0 |
| Gynaecological | 34 | 0 | -13 |
| Haematological | 7 | 0 | 1 |
| Head & Neck | 21 | 0 | -2 |
| Lower Gastrointestinal | 31 | -2 | -16 |
| Lung | 13 | -1 | -1 |
| Sarcoma | 3 | -1 | -3 |
| Skin | 17 | 0 | 0 |
| Upper Gastrointestinal | 9 | 1 | -1 |
| Urological | 34 | -5 | -11 |
| Other | 0 | 0 | 0 |
| **All Suspected Cancers** | **176** | **-11** | **-49** |

## Commentary

**Performance Update**

The 62-day backlog saw a net reduction of 11 patients waiting over 62 days up to 11th August compared to the previous week and a net reduction of 49 patients compared to the prior 4-week period (below left) on 14th July.

Across all body sites, Urology, Gynaecology and Lower GI have seen the largest reductions in backlog over the last 4 weeks (-40), resulting from:

- Urology – additional template biopsy sessions and associated improvement in Histology turnaround. The number of patients between day 29 and 62 is vastly reduced.
- Gynaecology – high volumes of histology has been outsourced.
- Lower GI – additional Endoscopy capacity for diagnostic and therapeutic procedures in place following successful regional bid. Additional Locum recruited to reduce delays to Lower GI Oncology OPAs and improve treatment times post MDT.

**Recovery Plan Key Treatment Phase Actions**

1. Increased EMR / Polypectomy capacity utilising regional recovery funding to support Lower GI recovery.
2. Increased Prostatectomy Capacity from August to support continued Urological Improvement
3. Skin excisional capacity increased in line with additional clinic capacity to ensure adequate capacity for short notice bookings.

**Risk To Delivery**

**GREEN**

# Cancer – 62-Day Backlog Recovery



| 62 Day Trajectory | | 30/06/2024 | 07/07/2024 | 14/07/2024 | 21/07/2024 | 28/07/2024 | 04/08/2024 | 11/08/2024 | 18/08/2024 | 25/08/2024 | 01/09/2024 | 08/09/2024 | 15/09/2024 | 22/09/2024 | 29/09/2024 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Total | Target Backlog | 227 | 225 | 219 | 213 | 204 | 199 | 195 | 184 | 173 | 159 | 141 | 128 | 106 | 100 |
| | Actual Backlog | 230 | 210 | 225 | 195 | 200 | 187 | 176 | | | | | | | |
| Urology | Target Backlog | 60 | 55 | 55 | 55 | 48 | 48 | 48 | 44 | 44 | 44 | 40 | 40 | 40 | 34 |
| | Actual Backlog | 55 | 45 | 45 | 39 | 41 | 39 | 34 | | | | | | | |
| Skin | Target Backlog | 35 | 33 | 31 | 29 | 27 | 25 | 23 | 21 | 19 | 17 | 15 | 13 | 11 | 10 |
| | Actual Backlog | 28 | 20 | 17 | 17 | 15 | 17 | 17 | | | | | | | |
| Lower GI | Target Backlog | 53 | 57 | 56 | 54 | 58 | 56 | 56 | 55 | 52 | 49 | 47 | 43 | 45 | 47 |
| | Actual Backlog | 48 | 42 | 47 | 35 | 41 | 33 | 31 | | | | | | | |
| Gynaecology | Target Backlog | 37 | 36 | 36 | 36 | 34 | 34 | 34 | 30 | 30 | 30 | 28 | 28 | 28 | 28 |
| | Actual Backlog | 34 | 36 | 47 | 37 | 40 | 34 | 34 | | | | | | | |

# Cancer – 28-Day Faster Diagnosis Standard



## Commentary

**July 2024 Performance**

Closed June 2024 performance was 61% - an improvement from the previous 2 months.

Provisional unvalidated July performance shows a further improvement to 67%. Increases in Breast, Gynaecology, Haematology and Urology are the predominant drivers of this.

However, Industrial Action resulted in delays to MDTs, Outpatient appointments and Diagnostic testing will impact on July FDS performance.

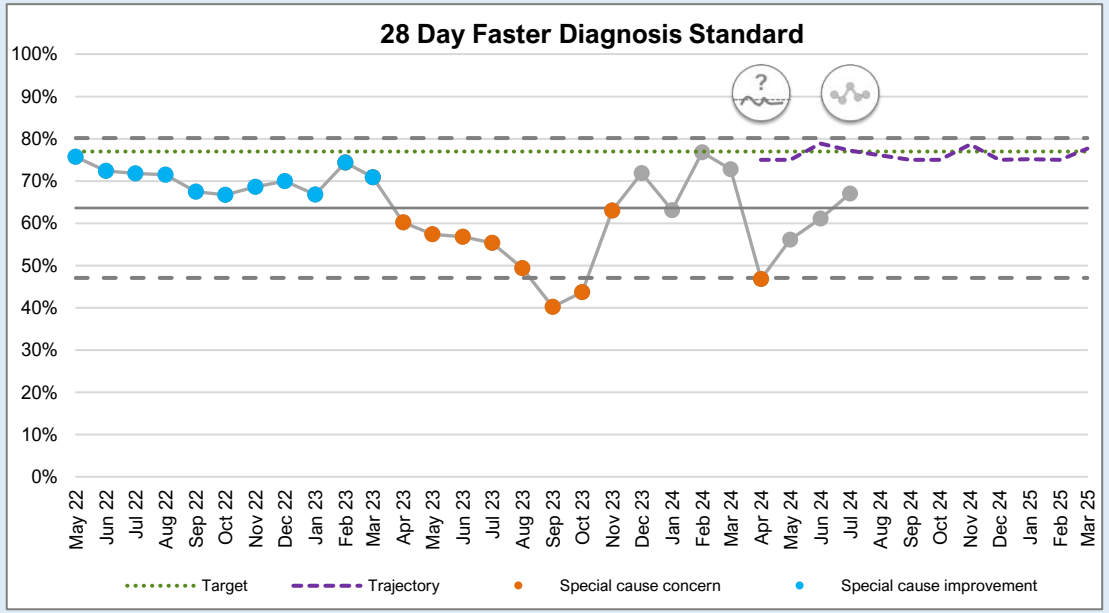
**Improvement Actions**

1. Skin recovery plan has embedded additional activity through to October 2024 to mitigate the increased demands, supporting forecast increases in performance for June and July.
2. Addressing capacity constraints within Breast through additional weekday and weekend clinics, with improvement demonstrated in July.

**Risk To Delivery**

**AMBER**

| Body Site | Jul-24 (Provisional) |
|---|---|
| Brain | 57.1% |
| Breast | 96.1% |
| Gynaecology | 52.0% |
| Haematology | 70.8% |
| Head and Neck | 77.1% |
| Lower GI | 50.5% |
| Lung | 83.9% |
| Paediatric | 80.0% |
| Sarcoma | 43.3% |
| Skin | 45.7% |
| Testicular | 96.2% |
| Upper GI | 87.0% |
| Urology | 61.1% |
| **Grand Total** | **67.0%** |




| Key | |
|---|---|
| | Above trajectory |
| | Within 5% below trajectory |
| | More than 5% below trajectory |

# Cancer – 62-Day Performance



## Commentary

**July 2024 Performance**

Closed performance in June was 46% - improved from April and May. Provisional unvalidated July performance is 51.6%. Increased backlog position caused performance to be below trajectory in May and June, through addressing long-waits in month. Additional activity provided by regional funding will support continual improvements through to December.

Recovery plans for each body-site have been completed and actions agreed to support improvement against trajectory.

**Recovery Plan Key Treatment Phase Actions**

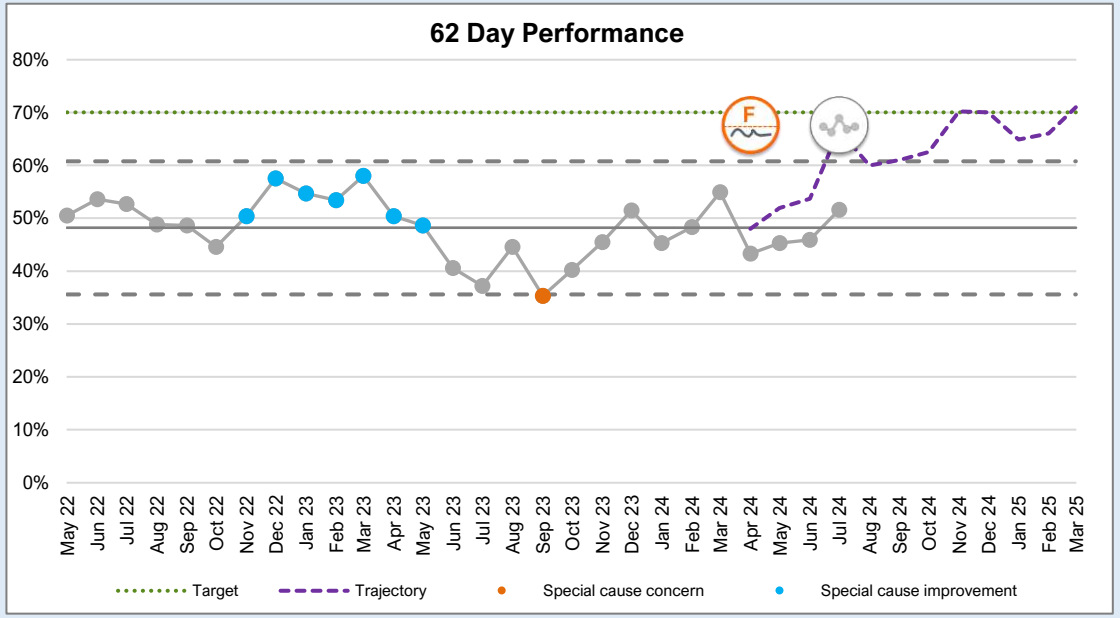
- Increased EMR / Polypectomy capacity utilising regional recovery funding.
- Reduced RALP capacity mid-July due to unexpected leave overlapping planned leave. Capacity planned in August to ensure continued improvements.
- Upper GI shown reduction in month due to higher than usual number of complex patients requiring extensive planning in month. Performance expected to improve in August.

**Risk To Delivery**

**AMBER**

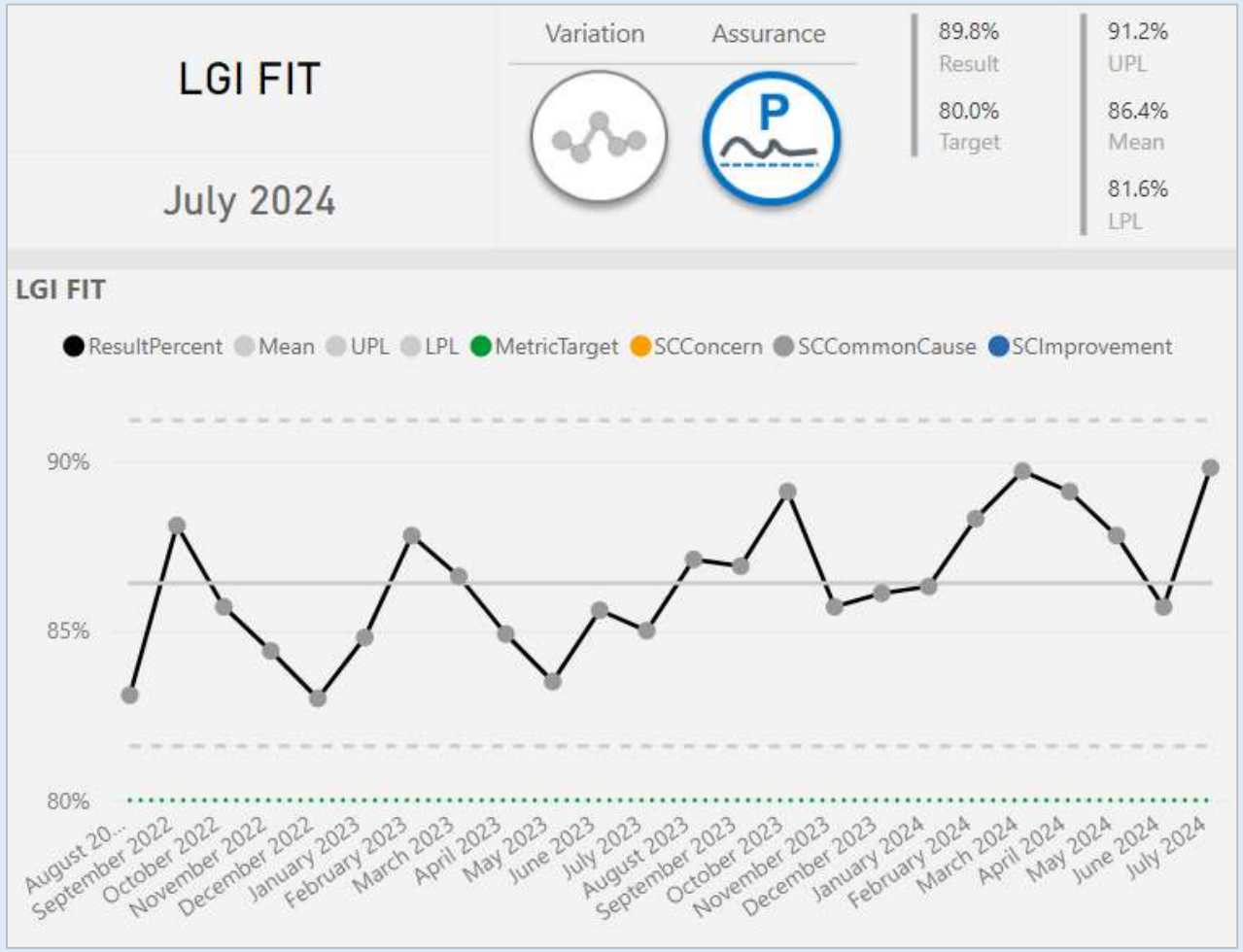
| Body Site | Jul-24 (Provisional) |
|---|---|
| Breast | 75.0% |
| Gynaecology | 51.9% |
| Haematology | 45.5% |
| Head and Neck | 28.1% |
| Lower GI | 30.4% |
| Lung | 29.0% |
| Skin | 83.3% |
| Upper GI | 28.6% |
| Urology | 47.4% |
| **Grand Total** | **51.6%** |

| Key | |
|---|---|
| | Above trajectory |
| | Within 5% below trajectory |
| | More than 5% below trajectory |



# Cancer – Lower GI Referrals with a FIT Test






## Commentary

**July 2024 Performance**

Performance improved to 89.8% in July – the highest performance since pre-August 2022 and remains ahead of target for all LGI referrals having an accompanying FIT result, enabling effective triage and straight to test investigations where criteria met.

**Improvement Actions**

1. FIT negative service led in Primary Care ceased due to funding.
2. Process in place to ensure FIT negative patients are safety netted in Primary Care.

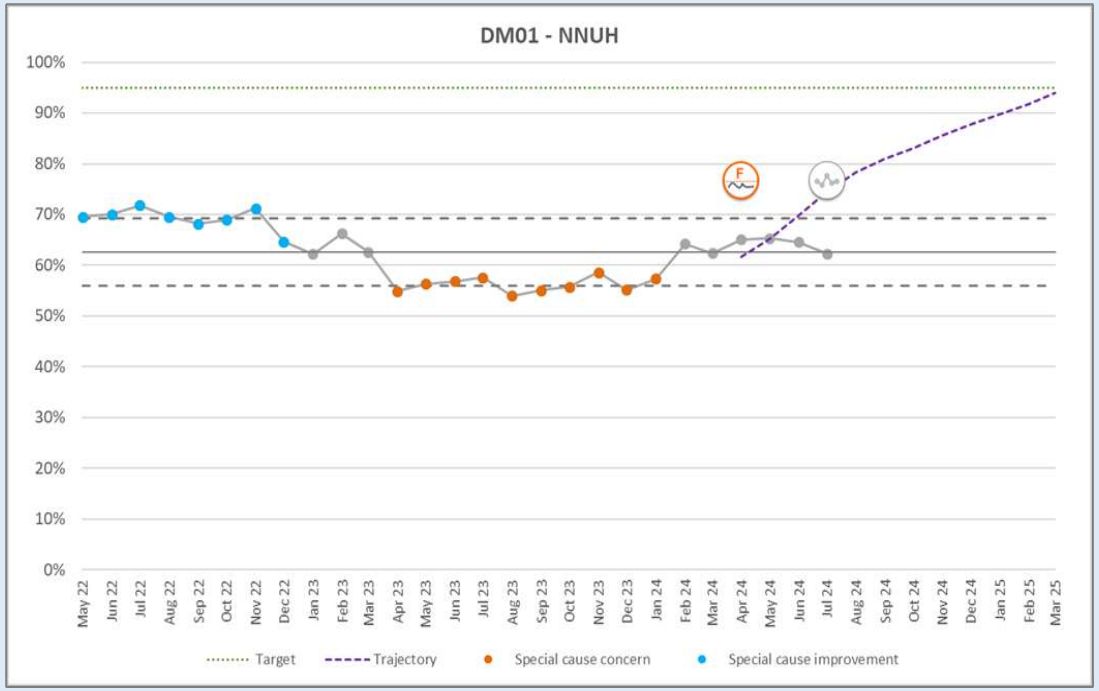
**Risk To Delivery**

GREEN

# Diagnostics

# Diagnostic Test Within 6 Weeks (DM01)






| Exam | Jul-24 |
|---|---|
| Magnetic Resonance Imaging | 45.73% |
| Computed Tomography | 83.75% |
| Non-Obstetric Ultrasound | 81.66% |
| DEXA Scan | 99.69% |
| Cardiology - echocardiography | 46.44% |
| Colonoscopy | 56.60% |
| Flexi sigmoidoscopy | 79.34% |
| Gastroscopy | 84.60% |
| **Grand Total** | **62.30%** |

| Key | |
|---|---|
| | Above trajectory |
| | Within 5% below trajectory |
| | More than 5% below trajectory |

## Commentary

**July 2024 Performance**

Performance reduced to 62.3% in July from 64.6% in June and is behind trajectory.
Although there continues to be performance improvements in CT and Non-Obstetric Ultrasound, as projected for July there has been a further reduction in MRI and Echocardiography performance, with improvements expected in September, as described below.

**Improvement Actions**

Echo deterioration resulting from the discontinuation of Independent Sector and the impact of Industrial Action due to the proportion of Junior Doctors involved in Echocardiograms. Immediate action taken to use Locum in August and reinstate the use of Independent Sector from September.

MRI deterioration due to staff long term sickness and continued increase in Inpatient and emergency demand for MRI. Immediate actions include agreed replacement of additional MRI in situ 19th August. Expected improvement in MRI performance in September as a result.

Endoscopy department seeing an additional 50 patients a month through August, September and October.

**Risk To Delivery**

**AMBER**

# Supplementary Information

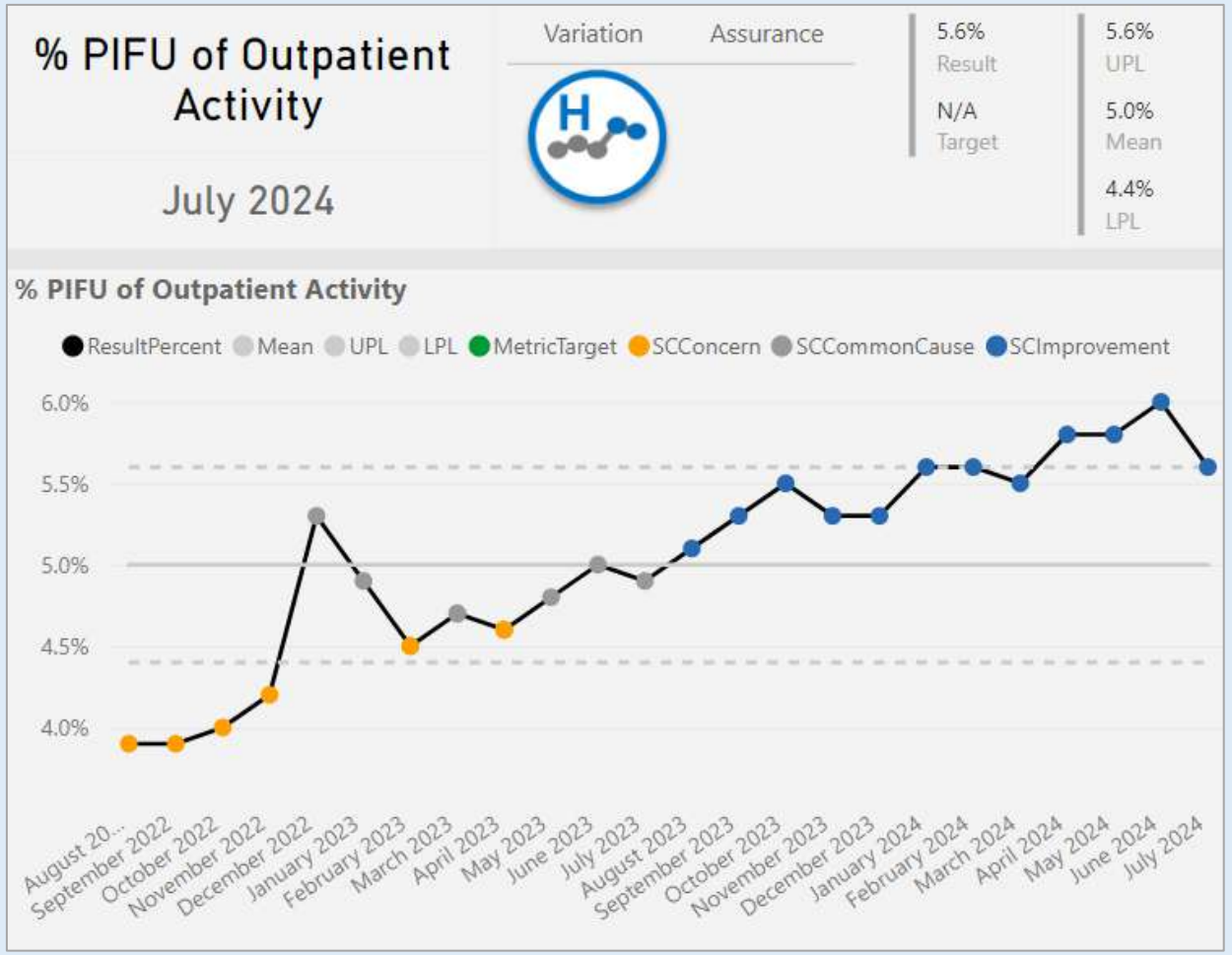
# Patient Initiated Follow Up



## Commentary

**July 2024 Performance**

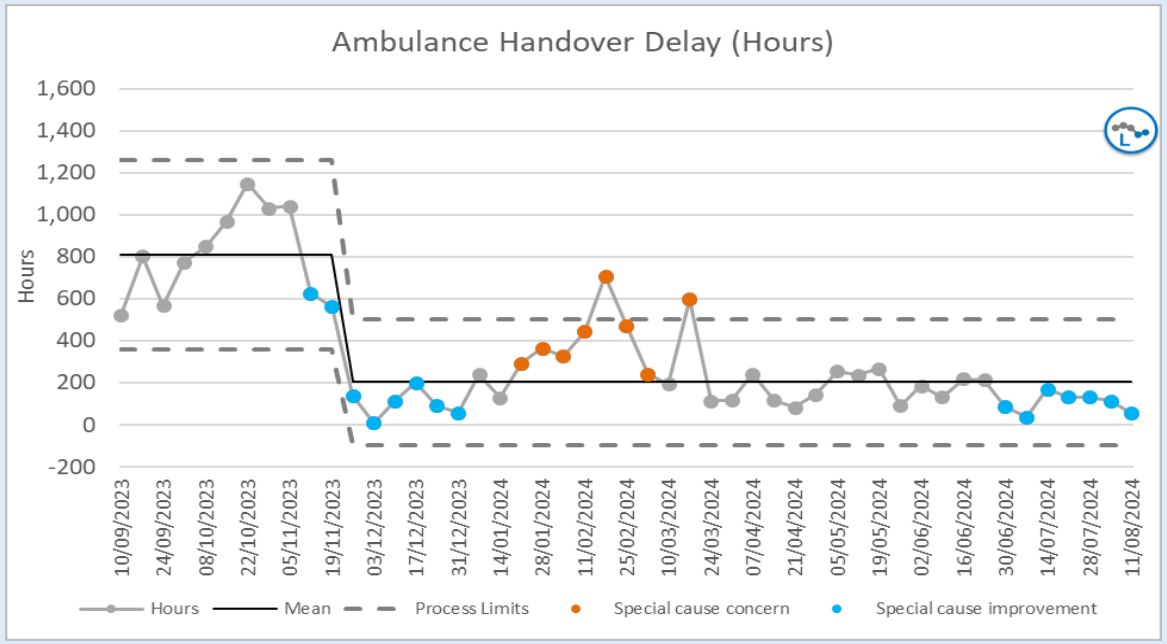
The number of patients added to a PIFU list as a percentage of the monthly outpatient activity reduced in July to 5.6%.

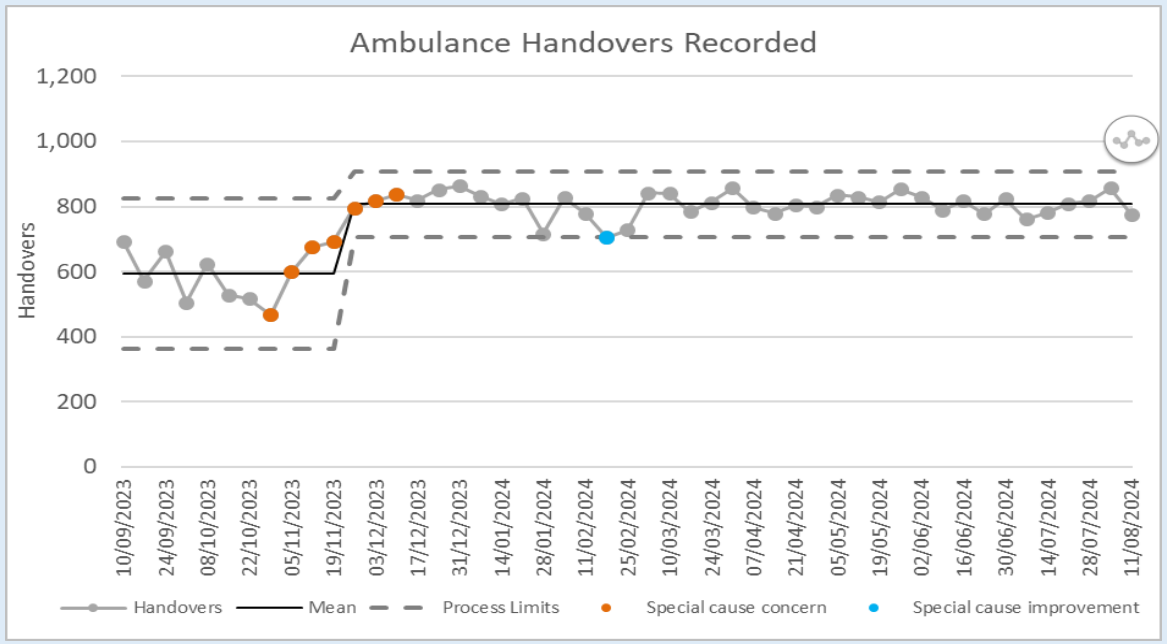


# Performance – Ambulance Handovers



| Week Ending | 23-Jun | 30-Jun | 07-Jul | 14-Jul | 21-Jul | 28-Jul | 04-Aug | 11-Aug |
|---|---|---|---|---|---|---|---|---|
| **Ambulance handover delays (hours)** | **213** | **87** | **38** | **170** | **133** | **133** | **115** | **54** |
| Ambulance handovers recorded | 778 | 824 | 761 | 781 | 810 | 817 | 857 | 777 |
| Average handover delay duration (mins) | 16 | 6 | 3 | 13 | 10 | 10 | 8 | 4 |
| Difference from baseline of 505 handovers | 65% | 61% | 66% | 65% | 62% | 62% | 59% | 65% |




## Commentary

**July 2024 Performance**

The total number of ambulance handover delays (hours) in July was 560. This was a reduction of 167 hours compared to June (727), despite there being an additional day in July and 70 more ambulance handovers recorded in July compared to June. The charts above illustrate the increase in the number of ambulance handovers since November 2023 but the reduction in handover delays over the same period.

# Activity Planning Run Rate



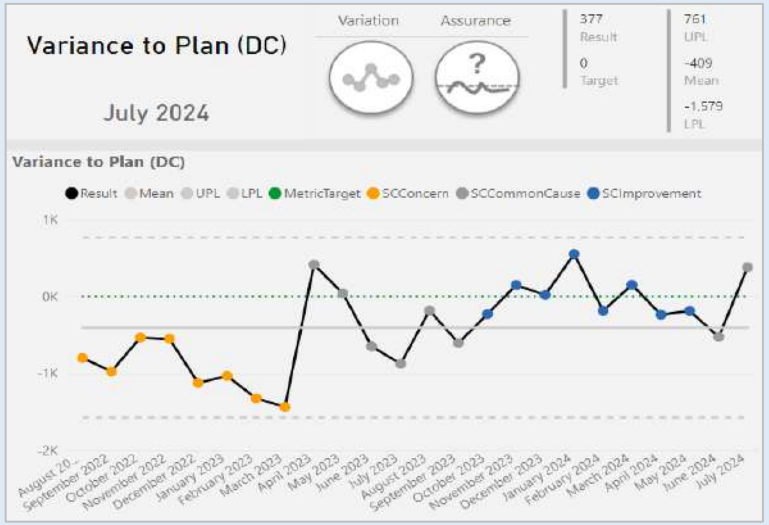
## Commentary

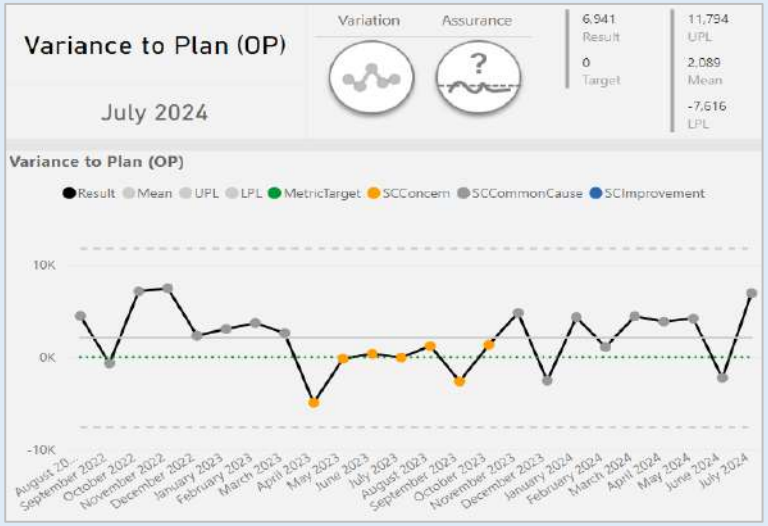
**July 2024 Performance (provisional)**

The graphs below summarise the activity variance to plan for Day Case, Outpatients, Non-Elective and Inpatients. Provisional performance shows a positive variance to plan across all 4 pathways. The top 3 contributing specialties to the positive variance are included in the tables beside each graph.

**Day Case Variance to Plan – Top 3 Specialties**

| Specialty | Positive Variance |
|---|---|
| Gastroenterology | 303 |
| Dermatology | 154 |
| Cardiology | 78 |



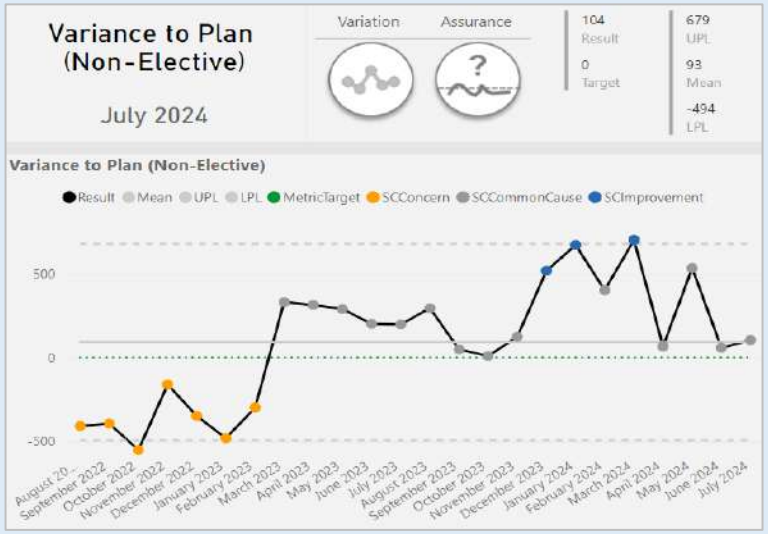



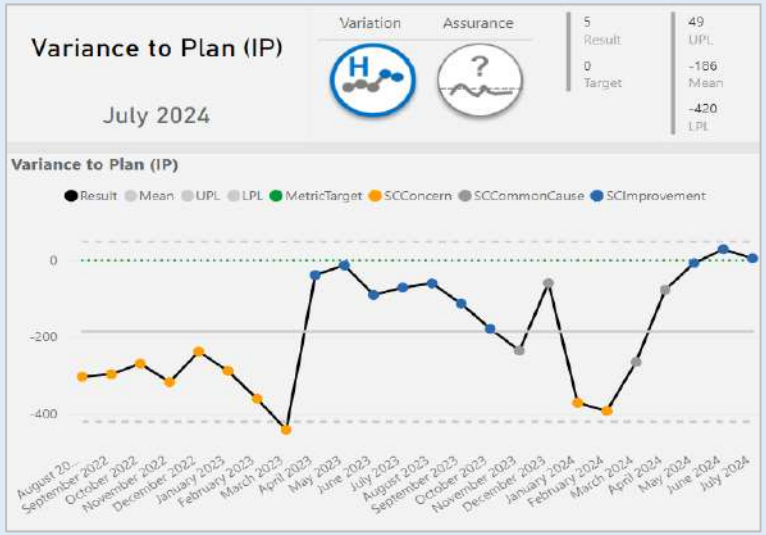

**Outpatient Variance to Plan – Top 3 Specialties**

| Specialty | Positive Variance |
|---|---|
| Ophthalmology | 693 |
| Cardiology | 540 |
| General Surgery | 412 |

**Non-Elective Variance to Plan – Top 3 Specialties**

| Specialty | Positive Variance |
|---|---|
| Gastroenterology | 83 |
| Respiratory Medicine | 65 |
| Cardiology | 47 |




**Inpatient Variance to Plan – Top 3 Specialties**

| Specialty | Positive Variance |
|---|---|
| Urology | 58 |
| Gynaecology | 26 |
| ENT | 14 |

Our Vision
The best care for every patient

# Activity Forecast

NHS
Norfolk and Norwich University Hospitals
NHS Foundation Trust

**Activity Forecast: July 2024 Full Month Estimate vs 2024/25 Business Plan**
**As at: 06/08/2024**
**% 2024/25 Business Plan Achieved**

Business Plan Achieved
Business Plan Not Achieved

| | Med | Surg&EM | W&C | CSS | Total |
|---|---|---|---|---|---|
| APC – Daycase | 109% | 101% | 93% | 88% | **106%** |
| APC – Elective | 87% | 98% | 119% | | **100%** |
| OP – Procedures | 111% | 112% | 92% | 85% | **108%** |
| OP - New (exc procedures) | 113% | 103% | 86% | 112% | **104%** |
| **Subtotal – ERF** | **111%** | **107%** | **89%** | **102%** | **106%** |
| APC - Non Elective | 106% | 104% | 95% | | **102%** |
| OP - Follow Up (exc Procedures) | 114% | 114% | 112% | 107% | **113%** |
| **Subtotal - Non ERF** | **113%** | **113%** | **107%** | **107%** | **112%** |
| **Overall** | **112%** | **109%** | **100%** | **105%** | **109%** |

**Note:** Plan for July now includes additional activity added to the plan in respect of Medacs in-Sourcing, summary as follows

| | Day Case | Elective |
|---|---|---|
| Trauma & Orthopaedics | 12 | 35 |
| General Surgery | 32 | 5 |
| Urology | 50 | 13 |
| **Medacs Total (July)** | **94** | **53** |

## Commentary

**1st + 2nd July Industrial Action Impact:**

Cancelled Activity:
2 Electives
30 Day Cases
183 Outpatients

Lost Activity:
433 Total Not booked
201 New
198 Follow up
16 Elective
18 Day Cases

**NNUH**

| | Medicine | | | Surgery & Emergency | | | Women & Children | | | Cinical Support | | | TOTAL | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Forecast | Plan | Variance | Forecast | Plan | Variance | Forecast | Plan | Variance | Forecast | Plan | Variance | Forecast | Plan | Variance |
| APC – Daycase | 4,381 | 4,009 | 372 | 2,535 | 2,501 | 34 | 266 | 287 | (21) | 7 | 8 | (1) | **7,189** | **6,805** | **385** |
| APC – Elective | 108 | 124 | (16) | 648 | 674 | (26) | 214 | 179 | 35 | 0 | 0 | 0 | **970** | **977** | **(7)** |
| APC - Non Elective | 2,765 | 2,601 | 164 | 1,125 | 1,084 | 41 | 1,878 | 1,979 | (101) | 0 | 0 | 0 | **5,768** | **5,664** | **104** |
| **Admitted – Total** | **7,254** | **6,734** | **520** | **4,308** | **4,258** | **50** | **2,358** | **2,445** | **(87)** | **7** | **8** | **(1)** | **13,927** | **13,446** | **482** |
| OP – Procedures | 2,562 | 2,311 | 251 | 11,321 | 10,142 | 1,180 | 1,126 | 1,229 | (103) | 587 | 696 | (109) | **15,596** | **14,378** | **1,218** |
| OP - New (exc procedures) | 6,301 | 5,556 | 745 | 8,658 | 8,338 | 320 | 2,029 | 2,371 | (341) | 1,421 | 1,272 | 149 | **18,409** | **17,537** | **872** |
| OP - Follow Up (exc Procedures) | 18,457 | 16,147 | 2,309 | 15,235 | 13,365 | 1,870 | 4,624 | 4,110 | 514 | 3,132 | 3,159 | (27) | **41,448** | **36,782** | **4,665** |
| **Non Admitted – Total** | **27,320** | **24,015** | **3,305** | **35,214** | **31,845** | **3,369** | **7,779** | **7,710** | **69** | **5,139** | **5,127** | **12** | **75,453** | **68,697** | **6,756** |
| **Total – NNUH** | **34,574** | **30,749** | **3,825** | **39,522** | **36,103** | **3,419** | **10,137** | **10,155** | **(18)** | **5,146** | **5,135** | **11** | **89,381** | **82,143** | **7,238** |

**Spire**

| | Medicine | | | Surgery & Emergency | | | Women & Children | | | Cinical Support | | | TOTAL | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Forecast | Plan | Variance | Forecast | Plan | Variance | Forecast | Plan | Variance | Forecast | Plan | Variance | Forecast | Plan | Variance |
| APC – Daycase | 0 | 0 | 0 | 31 | 39 | (8) | 0 | 0 | 0 | 0 | 0 | 0 | **31** | **39** | **(8)** |
| APC – Elective | 0 | 0 | 0 | 53 | 41 | 12 | 0 | 0 | 0 | 0 | 0 | 0 | **53** | **41** | **12** |
| APC - Non Elective | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **0** | **0** | **0** |
| **Admitted – Total** | **0** | **0** | **0** | **84** | **80** | **4** | **0** | **0** | **0** | **0** | **0** | **0** | **84** | **80** | **4** |
| OP – Procedures | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2 | 0 | 2 | **2** | **0** | **2** |
| OP - New (exc procedures) | 0 | 0 | 0 | 0 | 80 | (80) | 0 | 0 | 0 | 0 | 0 | 0 | **0** | **80** | **(80)** |
| OP - Follow Up (exc Procedures) | 0 | 0 | 0 | 110 | 80 | 30 | 0 | 0 | 0 | 233 | 0 | 233 | **343** | **80** | **263** |
| **Non Admitted – Total** | **0** | **0** | **0** | **110** | **160** | **(50)** | **0** | **0** | **0** | **235** | **0** | **235** | **345** | **160** | **185** |
| **Total – Spire** | **0** | **0** | **0** | **194** | **240** | **(46)** | **0** | **0** | **0** | **235** | **0** | **235** | **429** | **240** | **189** |

**All Providers**

| | Medicine | | | Surgery & Emergency | | | Women & Children | | | Cinical Support | | | TOTAL | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Forecast | Plan | Variance | Forecast | Plan | Variance | Forecast | Plan | Variance | Forecast | Plan | Variance | Forecast | Plan | Variance |
| APC - Daycase | 4,381 | 4,009 | 372 | 2,566 | 2,540 | 26 | 266 | 287 | (21) | 7 | 8 | (1) | **7,220** | **6,844** | **377** |
| APC - Elective | 108 | 124 | (16) | 701 | 715 | (14) | 214 | 179 | 35 | 0 | 0 | 0 | **1,023** | **1,018** | **5** |
| APC - Non Elective | 2,765 | 2,601 | 164 | 1,125 | 1,084 | 41 | 1,878 | 1,979 | (101) | 0 | 0 | 0 | **5,768** | **5,664** | **104** |
| **Admitted - Total** | **7,254** | **6,734** | **520** | **4,392** | **4,338** | **54** | **2,358** | **2,445** | **(87)** | **7** | **8** | **(1)** | **14,011** | **13,526** | **486** |
| OP - Procedures | 2,562 | 2,311 | 251 | 11,321 | 10,142 | 1,180 | 1,126 | 1,229 | (103) | 589 | 696 | (107) | **15,598** | **14,378** | **1,220** |
| OP - New (exc procedures) | 6,301 | 5,556 | 745 | 8,658 | 8,418 | 240 | 2,029 | 2,371 | (341) | 1,421 | 1,272 | 149 | **18,409** | **17,617** | **792** |
| OP - Follow Up (exc Procedures) | 18,457 | 16,147 | 2,309 | 15,345 | 13,445 | 1,900 | 4,624 | 4,110 | 514 | 3,365 | 3,159 | 206 | **41,791** | **36,862** | **4,928** |
| **Non Admitted - Total** | **27,320** | **24,015** | **3,305** | **35,324** | **32,005** | **3,319** | **7,779** | **7,710** | **69** | **5,374** | **5,127** | **247** | **75,798** | **68,857** | **6,941** |
| **Grand Total (NNUH + ASI + Spire)** | **34,574** | **30,749** | **3,825** | **39,716** | **36,343** | **3,373** | **10,137** | **10,155** | **(18)** | **5,381** | **5,135** | **246** | **89,809** | **82,383** | **7,426** |

| REPORT TO TRUST BOARD | | | | |
|---|---|---|---|---|
| **Date** | **11 September 2024** | | | |
| **Title** | **Month 4 IPR – Finance** | | | |
| **Author & Exec Lead** | **Liz Sanford (Interim Chief Finance Officer)** | | | |
| **Purpose** | **For Information** | | | |
| **Relevant Strategic Commitment** | **1 Together, we will develop services so that everyone has the best experience of care and treatment**<br>**5 Together, we will use public money to maximum effect.** | | | |
| **Are there any quality, operational, workforce and financial implications of the decision requested by this report?**<br>**If so explain where these are/will be addressed.** | **Quality** | **Yes✓ No☐** | **Delivery of the financial plan supports the delivery of operational, quality and workforce plans** | |
| | **Operational** | **Yes✓ No☐** | **Delivery of the financial plan supports the delivery of operational, quality and workforce plans** | |
| | **Workforce** | **Yes✓ No☐** | **Delivery of the financial plan supports the delivery of operational, quality and workforce plans** | |
| | **Financial** | **Yes✓ No☐** | **Delivery of the financial plan supports the delivery of operational, quality and workforce plans** | |
| **Identify which Committee/Board/Group has reviewed this document:** | **Board/Committee: HMB** | | **Outcome: Report for information only, no decisions required.** | |

## 1 Background/Context

The Trust operational plan for FY24/25 as outlined in Cycle 4 of the 2024/25 planning process is breakeven. The transition to accounting for PFI under IFRS16 and being required to report our performance under UK GAAP result in a net deficit of £5.5m. A technical income adjustment of £5.5m has been received resulting in a breakeven plan on a control total basis. Therefore, Trust performance is measured against a Breakeven plan.

## 2 Key issues, risks and actions

**July position is a £0.3m deficit on a control total basis, £0.9m adverse to the planned £0.6m deficit. Recurrent performance is a £2.2m deficit, £2.8m adverse to plan.**

The recurrent underperformance is due to CIP under-delivery of £2.4m (of which £1.6m relates to the budgeted CIP stretch target), and divisional overspends of £0.9m, offset by £0.2m of additional interest income and £0.2m of activity over performance. This has been offset by non-recurrent net

mitigations of £2.0m; reserve utilisation of £1.2m partly offset by £0.1m of costs relating to additional capacity, divisional non-pay underspends of £0.6m and Financial Recovery Plan actions of £0.3m.

**Year to date position is a £7.3m deficit on a control total basis, £2.8m adverse to the planned £4.5m deficit. Recurrent performance is a £12.9m deficit, £8.4m adverse to plan.**

CIP under delivery is £4.2m adverse (of which £1.6m relates to the budgeted CIP stretch target), divisional pay expenditure is £3.4m adverse, activity is £1.3m adverse and net drugs expenditure is adverse by £0.3m, offset by favourable interest income of £0.9m. This has been offset by non-recurrent net mitigations of £5.6m, of which £1.7m is non pay divisional underspends, £0.3m from Financial Recovery Plan actions. and £6.4m reserve utilisation offset by £1.5m additional expenditure required for independent capacity support and discharge suite / escalation and £1.3m for Industrial Action costs/reduction in activity.

**Activity:** Value-based activity performance for June was £0.2m favourable (£1.8m adverse YTD) to plan equating to 101% (97% YTD) of planned levels. The elective elements were £0.2m favourable (£2.2m adverse YTD) equating to 101% (97% YTD) of planned levels and delivery of other chargeable API (Chemotherapy Delivery and Diagnostic Imaging) activity was on plan (£0.4m favourable YTD).

**Forecast Outturn:** Year to date £12.1m of crystalised risk offset by £9.3m of crystallised mitigations. The further crystallisation of risk is forecast to be £38.4m offset by agreed mitigations in run rate totalling £18.6m resulting in a 'Most Likely' forecast outturn of £22.5m deficit. Additional mitigations totalling £9.3m have been agreed as a part of the Financial Recovery Plan, resulting in a forecast outturn of £13.2m deficit, £13.2m adverse to the planned breakeven position.

**Cash:** Cash held on 31st July 2024 was £94.7m, £10.5m lower than the FY24/25 submitted forecast as result of working capital movements.

**Capital Expenditure**: Year to date total capital spend is £14.7m, a £3.2m underspend against the planned £17.9m. **Forecast Outturn for the total capital plan** is £90.6m, an £8.1m overspend against the Trust's CDEL allocation of £82.5m overspend and is attributable to the IFRS16 impact of leases. **Forecast Outturn for central programmes** is underspent against plan as a result of significant slippage of £13.8m on NANOC 2.

## 3 Conclusions/Outcome/Next steps

Year to date, the Trust has delivered a £7.3m deficit against the planned £4.5m deficit, £2.8m adverse to plan. Forecast Outturn remains Breakeven. The Trust has underspent Capital Expenditure by £3.2m year to date. Forecast Outturn for the total capital plan is £90.6m, an £8.1m overspend against the Trust's CDEL allocation of £82.5m.

**Recommendations:** The Board is recommended to **note** the contents of the report.

Norfolk and Norwich University Hospitals NHS Foundation Trust

# Finance Report
# July 2024

## 11 September 2024

## Liz Sanford, Interim Chief Finance Officer

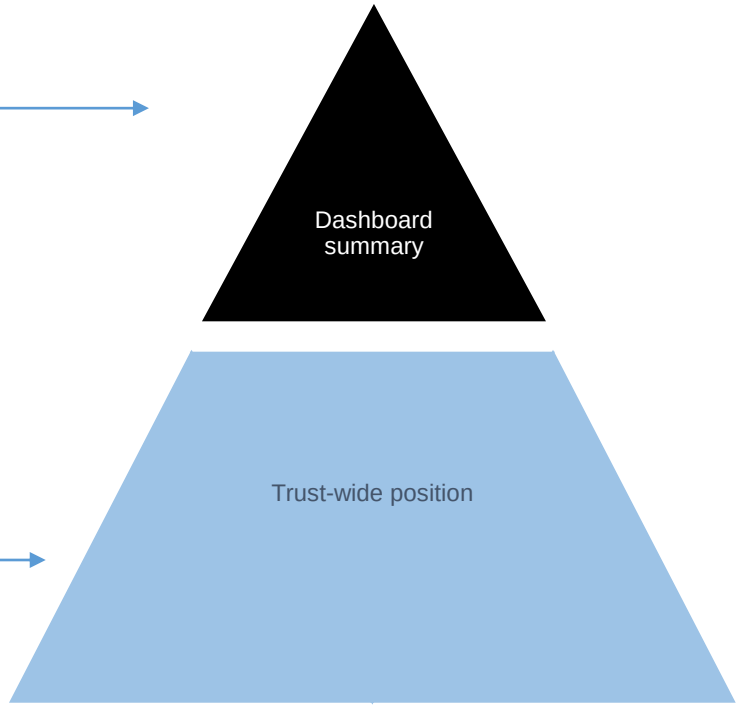
Norfolk and Norwich University Hospitals NHS Foundation Trust

# Contents

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

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





# 1.1 Executive Dashboard

Norfolk and Norwich University Hospitals NHS Foundation Trust

The Trust operational plan for FY24/25 as outlined in Cycle 4 of the 2024/25 planning process is breakeven, performance is measured against this.

**July position is a £0.3m deficit on a control total basis, £0.9m adverse to the planned £0.6m surplus. Recurrent performance is a £2.2m deficit, £2.8m adverse to plan.**

CIP under delivery is £2.4m (of which £1.6m relates to the budgeted CIP stretch target), and divisional overspends are £0.9m, offset by £0.2m of additional interest income and £0.2m of activity over performance. This has been offset by net non-recurrent mitigations of £2.0m, reserve utilisation of £1.2m partly offset by £0.1m of costs relating to additional capacity, divisional non-pay underspends of £0.6m and Financial Recovery Plan actions of £0.3m.

**YTD position is a £7.3m deficit on a control total basis, £2.8m adverse to the planned £4.5m deficit. Recurrent performance is a £12.9m deficit, £8.4m adverse to plan.**

CIP under delivery is £4.2m adverse (of which £1.6m relates to the budgeted CIP stretch target), divisional pay expenditure is £3.4m adverse, activity is £1.3m adverse and net drugs expenditure is adverse by £0.3m, offset by favourable interest income of £0.9m. This has been offset by non-recurrent net mitigations of £5.6m, of which £1.7m is non pay divisional underspends, £0.3m from Financial Recovery Plan actions, and £6.4m reserve utilisation offset by £1.5m additional expenditure required for independent capacity support and discharge suite / escalation and £1.3m for Industrial Action.

**Forecast Outturn: Year to date £12.1m of crystalised risk offset by £9.3m of crystallised mitigations. The further crystallisation of risk is forecast to be £38.4m offset by agreed mitigations in run rate totalling £18.6m. Additional mitigations totalling £9.3m have been agreed as a part of the Financial Recovery Plan resulting in a forecast outturn of £13.2m deficit, £13.2m adverse to the planned breakeven position.**

**Activity:** Value-based activity performance for July was £0.2m favourable to plan (£1.8m adverse YTD) equating to 101% (97% YTD) of planned activity levels. The elective elements were £0.2m favourable (£2.2m adverse YTD) equating to 101% (97% YTD) of planned activity levels and delivery of other chargeable API activity was on plan (£0.4m favourable YTD).

**Capital Expenditure:** Year to date total capital spend is £14.7m, a £3.2m underspend against the planned £17.9m. **Forecast Outturn** for the total capital plan is £90.6m, an £8.1m overspend against the Trust's CDEL allocation of £82.5m overspend and is attributable to the IFRS16 impact of leases. **Forecast Outturn** for central programmes is underspent against plan as a result of significant slippage of £13.8m on NANOC 2.

**Cash** held on 31st July 2024 was £94.7m, £10.5m lower than the FY24/25 submitted forecast as result of working capital movements.

| | In Month | | | Year to Date | | |
|---|---|---|---|---|---|---|
| | Actual | Plan | Variance | Actual | Plan | Variance |
| **SOCI** | £m | £m | £m | £m | £m | £m |
| Clinical Income | 65.8 | 65.8 | 0.0 | 259.0 | 261.0 | (2.0) |
| Other Income | 11.6 | 8.6 | 3.0 | 41.2 | 33.3 | 7.9 |
| **TOTAL INCOME** | **77.5** | **74.4** | **3.0** | **300.2** | **294.3** | **5.9** |
| Pay | (44.6) | (44.3) | (0.3) | (183.6) | (177.6) | (6.0) |
| Non Pay | (23.2) | (19.5) | (3.7) | (85.0) | (81.0) | (4.0) |
| Drugs (Net Expenditure) | (3.4) | (3.1) | (0.3) | (12.8) | (12.4) | (0.4) |
| **TOTAL EXPENDITURE** | **(71.2)** | **(66.9)** | **(4.3)** | **(281.4)** | **(271.0)** | **(10.4)** |
| Non Opex | (6.5) | (7.0) | 0.4 | (26.0) | (27.8) | 1.7 |
| Control Total Surplus / (Deficit) | (0.3) | 0.6 | (0.9) | (7.3) | (4.5) | (2.8) |
| Statutory Surplus / (Deficit) | 0.6 | 0.8 | (0.2) | (2.5) | (2.8) | 0.3 |
| **Other Financial Metrics** | £m | £m | £m | £m | £m | £m |
| Cash at Bank (before support funding) | 94.7 | 105.2 | (10.5) | 94.7 | 105.2 | (10.5) |
| Capital Programme Expenditure | 5.0 | 5.9 | 0.9 | 14.7 | 17.9 | 3.2 |
| CIP Delivery | 0.5 | 2.9 | (2.4) | 1.3 | 5.5 | (4.2) |
| **Activity Metrics** | 000 | 000 | 000 | 000 | 000 | 000 |
| Day Case | 6.1 | 6.0 | 0.0 | 22.2 | 23.5 | (1.3) |
| Elective Inpatient | 4.6 | 4.9 | (0.3) | 17.5 | 18.2 | (0.6) |
| Outpatients - New & Procedures | 6.1 | 5.7 | 0.4 | 22.3 | 22.6 | (0.3) |
| Other Chargeable activity included within API | 1.7 | 1.7 | 0.0 | 6.9 | 6.5 | 0.4 |
| TOTAL | 18.5 | 18.3 | 0.2 | 68.9 | 70.7 | (1.8) |

# 1.2 Executive Dashboard

Norfolk and Norwich University Hospitals NHS Foundation Trust

## Risk

**The strategic financial risks remain the same in nature as at Cycle 4 of the Business Planning Process.**

As part of FY24/25 annual planning there were 15 key strategic and operational risks identified with an initial score of ≥ 12. A review of the risks has taken place in July consolidating the number of risks with a score of ≥ 12 to eight. The Finance Directorate continues to formally review the Financial Risk Register on a monthly basis, following this review the Forecast Financial Impact has been increased from £77.5m to £80.1m

**There are six risks rated as 'Extreme' on the risk register which had a potential risk assessed financial impact of £77.5m at Cycle 4 of the Business Planning. This remains as £77.5m at Month 4, of which £12.1m has crystalised year to date.**

The Month 4 crystalised risks are:

**CIP Under Delivery (Risk A) is £4.22m adverse year to date - £1.32m delivered against the budgeted plan of £5.54m**, comprising of a planning variance of £3.95m and an adverse performance variance of £0.27m, which equates to an underperformance of c. 76%.

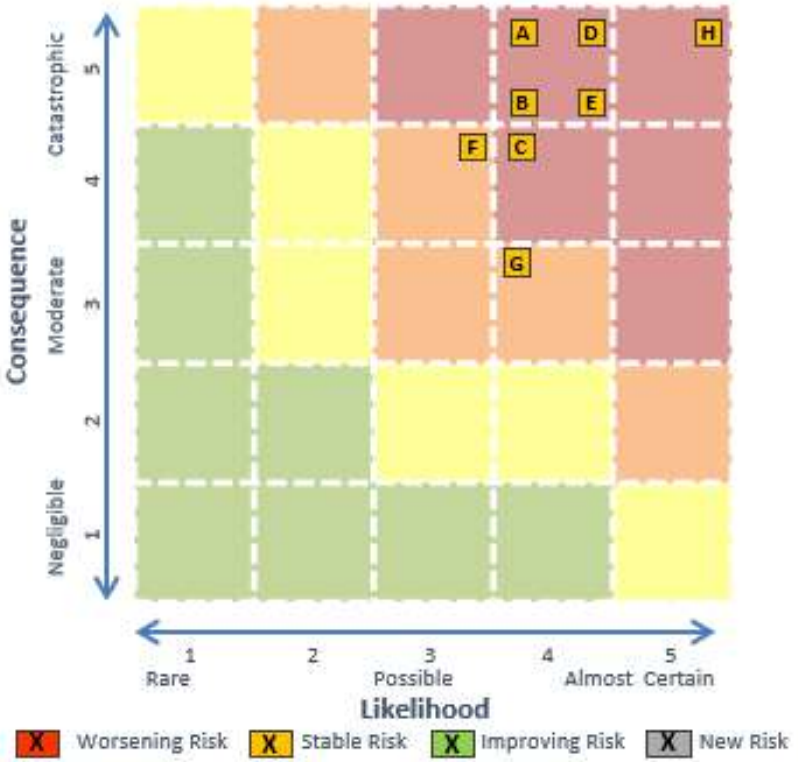
**Failure to control expenditure in line with plan (Risk B) has a crystalised impact of £4.4m year to date,** comprising of overspends in Divisional Pay (£3.2m), £0.8m of spend to cover Industrial Action, Drugs (£0.3m) and an additional provision of £0.1m for the Band 2 to 3 staff re-banding.

**Failure to increase income contracts for service development (Risk C) has a crystalised impact of £0.2m year to date.**

**Failure to utilise Clinical Space / Workforce in line with the plan (Risk D) has a crystalised impact of £3.3m year to date,** due to an under performance in the Elective Elements of £2.2m (Industrial action had an estimated adverse impact of £0.5m), offset by overperformance in Chemo & Radiology of £0.4m. Increased use of the Independent Sector to support the Elective activity plan was an additional £0.6m and continued opening of the Discharge Suite and Escalation £0.9m.

**Financial Recovery Plan: As a result of the forecasted adverse variance to plan a Financial Recovery Plan has been implemented.**

| Risk Rating | | Risks | Financial Impact FY24/25 £m | Financial Impact FY24/25 (Revised) £m | YTD Crystallised Impact £m |
|---|---|---|---|---|---|
| me | 15+ | A, B, C, D, E, H | 77.5 | 77.5 | 12.1 |
| | 12-14 | F, G | 0.0 | 2.6 | 0.0 |
| rate | 5-11 | - | | 0.0 | 0.0 |
| | 1-4 | - | | 0.0 | 0.0 |
| | | | 77.5 | 80.1 | 12.1 |
| Mitigation of risk prior to full value crystalising | | | | (29.6) | 0.0 |
| Net Total Risk Assessed Impact | | | | 50.5 | 12.1 |
| Risk mitigated through Non Recurrent YTD underspends & Release of Expenditure Reserves | | | | (27.7) | (9.0) |
| Risk mitigated through Delivery of Financial Recovery Plan (FRP) | | | | (9.6) | (0.3) |
| Risk Assessed Impact | | | | 13.2 | 2.8 |



# 2.1 Financial Performance – July 2024

Norfolk and Norwich University Hospitals NHS Foundation Trust

**July position is a £0.3m deficit on a control total basis, £0.9m adverse to the planned £0.6m surplus. Recurrent performance is a £2.2m deficit, £2.8m adverse to plan. The recurrent underperformance is due to CIP under-delivery of £2.4m (of which £1.6m relates to the budgeted CIP stretch target), and divisional overspends of £0.9m, offset by £0.2m of additional interest income and £0.2m of activity over performance. This has been offset by non-recurrent net mitigations of £2.0m; reserve utilisation of £1.2m partly offset by £0.1m of costs relating to additional capacity, divisional non-pay underspends of £0.6m and Financial Recovery Plan actions of £0.3m.**

**Income:** Income is reporting a favourable variance of £3.0m in July. Variable activity performance was favourable to plan by £0.2m. Other income includes favourable pass-through income for Cancer Alliance of £1.1m, R&D of £0.1m and devices of £0.3m, along with other pass-through income and staff secondments which are offset by expenditure of £1.1m. Private Patients income is £0.2m favourable.

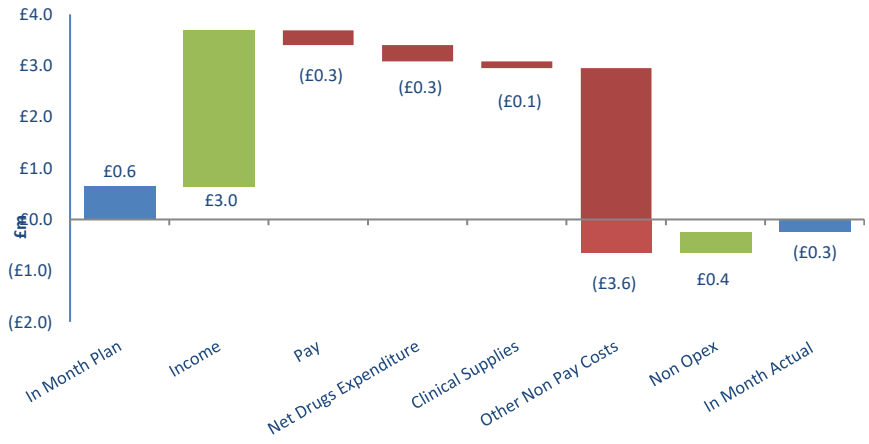
**Pay:** Pay is overspent by £0.3m in July. Year to date Cancer Alliance costs have been recoded to non-pay in month totalling £0.7m. This partly offsets the £1.1m divisional pay overspends, of which £0.4m is due to unidentified CIP, £0.3m overspend of divisional nursing spend (of which £0.2m is in Medicine), and £0.4m overspend of divisional medical spend (all in Surgery).

Agency spend in July is 2.3%, 0.9% lower than the NHS threshold of 3.2%, and 0.5% lower than the Trust plan of 2.8%. Registered Nursing is the largest user of agency spend, being 2.3% of total nursing spend, a reduction from 2.8% in June.

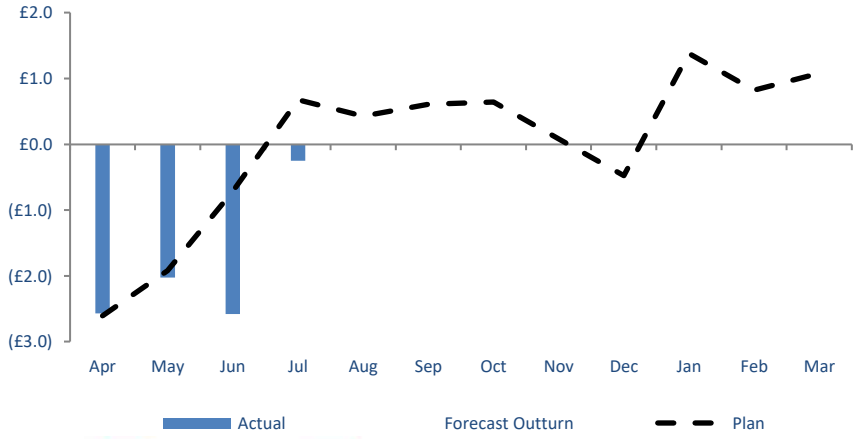
**Net Drugs Cost:** In month drugs position is £0.3m adverse to plan, due to an adverse variance in Oncology and Haematology.

**Non-Pay:** Non pay is adverse by £3.7m. This is due to under delivery of CIP of £2.4m (of which £1.6m relates to the budgeted CIP stretch target) and £0.7m due to recoding of year to date Cancer Alliance costs. The remainder relates to pass-through expenditure on R&D (£0.2m) and Cancer Alliance (£0.4m).

**Non-Operating Expenditure:** July non-operating expenditure is showing a £0.4m favourable variance. This is due to £0.2m of interest income received due to continued high interest rates and £0.2m due to lower depreciation and PFI indexation charges in month.




**Monthly Actual/Forecast Surplus/(Deficit) v Plan**



# 2.2 Financial Performance – Year to Date

Norfolk and Norwich University Hospitals NHS Foundation Trust

**Year to date position is a £7.3m deficit on a control total basis, £2.8m adverse to the planned £4.5m deficit. Recurrent performance is a £12.9m deficit, £8.4m adverse to plan. CIP under delivery is £4.2m adverse (of which £1.6m relates to the budgeted CIP stretch target), divisional pay expenditure is £3.4m adverse, activity is £1.3m adverse and net drugs expenditure is adverse by £0.3m, offset by favourable interest income of £0.9m. This has been offset by non-recurrent net mitigations of £5.6m, of which £1.7m is non pay divisional underspends, £0.3m from Financial Recovery Plan actions. and £6.4m reserve utilisation offset by £1.5m additional expenditure required for independent capacity support and discharge suite / escalation and £1.3m for Industrial Action costs/reduction in activity.**

**Income:** Income is reporting a favourable variance of £5.9m year to date. Variable activity performance is adverse to plan by £1.8m (of which £0.5m is this due to cancelled activity due to Industrial Action that took place in July). Other income includes favourable pass-through income for Cancer Alliance of £2.9m and £4.1m of R&D, devices and staff secondments which are all offset with expenditure, and Private Patients income which is £0.7m favourable.

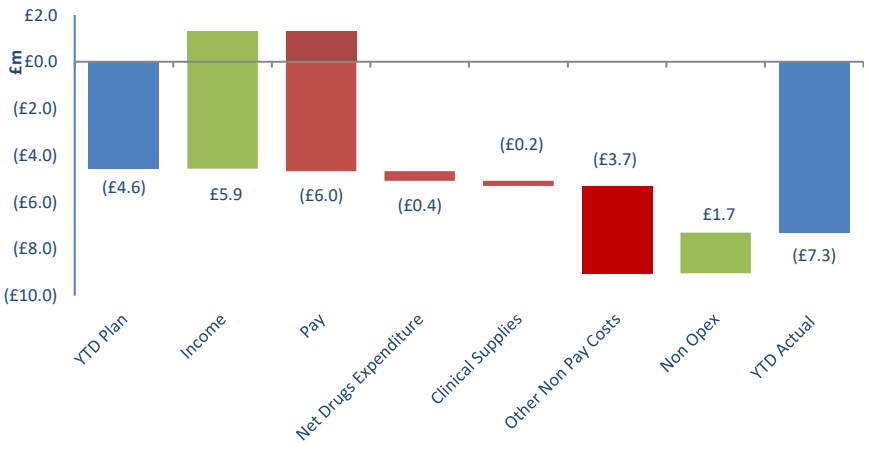
**Pay:** Pay is overspent by £6.0m year to date of which £0.8m is due to Industrial Action that took place in July. The remaining £5.2m is due to £1.4m of unidentified CIP, £2.3m overspend in nursing (£1.5m of this is in Medicine), and £2.2m overspend in medical (£1.7m of this is in Surgery). Offset by £0.5m underspends on A&C and AHP's.

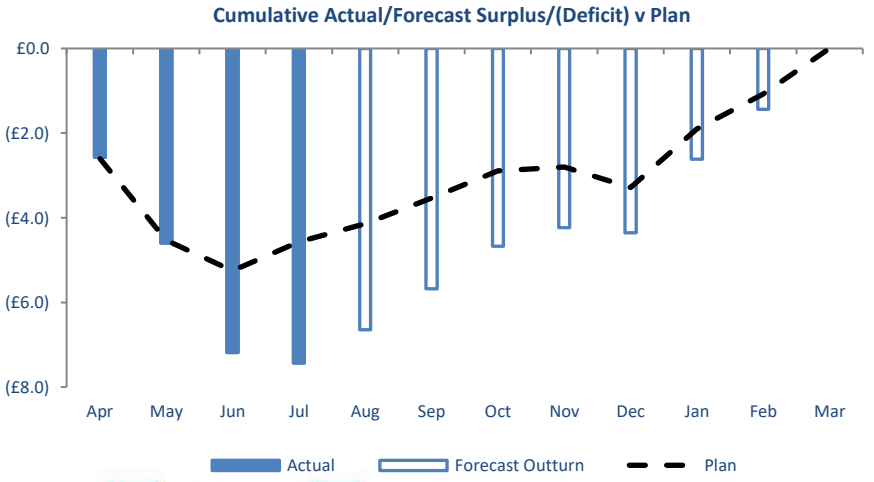
Agency spend year to date is 2.5%, 0.7% lower than the NHS threshold of 3.2%. Registered Nursing is the largest user of agency spend, being 3.6% of total nursing spend.

**Net Drugs Cost:** Year to date net drugs position is £0.4m adverse, due to an adverse variance in Oncology and Haematology.

**Non-Pay:** Non pay is adverse by £3.9m. This is due to under delivery of CIP of £4.2m (of which £1.6m relates to the budgeted CIP stretch target), pass-through expenditure of £1.9m (which is income backed), and additional expenditure on the independent capacity sector support of £0.7m, offset by £2.9m of unutilised reserves.

**Non-Operating Expenditure:** Non-operating expenditure is showing a £1.7m favourable variance. This is due to £0.9m of interest income received due to continued high interest rates and £0.6m due to lower depreciation charges year to date, and favourable PFI indexation of £0.2m.



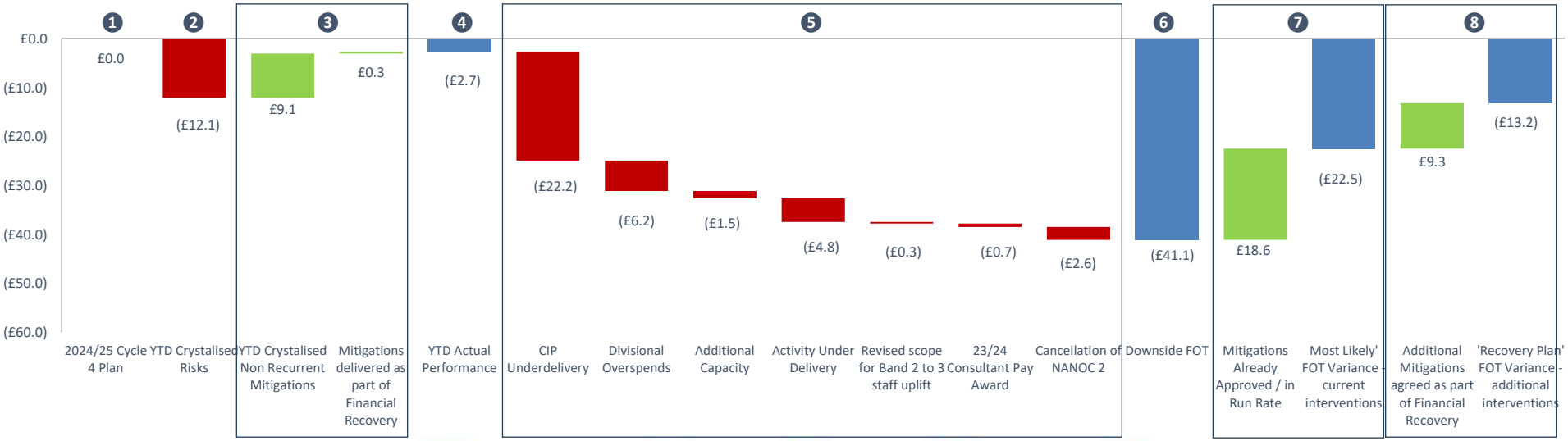



# 2.3 Forecast Outturn

Norfolk and Norwich University Hospitals NHS Foundation Trust

**Year-to-date, £12.1m of risks and £9.3m of mitigations have crystalised, resulting in a £2.8m adverse variance to plan at Month 4. For the remainder of the year, further risk crystallisation is forecast at £38.4m, resulting in a downside forecast outturn of a £41.1m deficit, £41.1m adverse to the planned breakeven position. Agreed mitigations / mitigations in run rate totalling £18.6m have been identified resulting in a 'Most Likely' forecast outturn of £22.5m deficit. Additional mitigations totalling £9.3m have been agreed as a part of the Financial Recovery Plan, resulting in a forecast outturn of £13.2m deficit, £13.2m adverse to the planned breakeven position.**

1. The Trust operational plan including the technical impact of PFI remeasurement for FY24/25 as outlined in Cycle 4 of the 2024/25 planning process is breakeven
2. Year to date crystalised risks of £12.1m, of which £3.6m relates to divisional pay overspends, £4.2m relates to under delivery of CIP, £1.8m relates to under delivery of activity and £0.8m relates to direct pay as a result of Industrial Action
3. Year to date crystalised mitigations of £9.4m, of which £4.8m relates to non-recurrent risk mitigation, £3.4m unutilised reserves, £0.9m of interest income and £0.3m from delivery of the Financial Recovery Plan.
4. YTD actual performance of a £2.7m deficit, £2.7m adverse to plan
5. Further run rate risk of £38.4m forecast to crystallise through remainder of the year based on current run rates
6. Downside Forecast Outturn of a £41.1m, £41.1m adverse to the breakeven plan
7. Agreed mitigations / mitigations in run rate totalling £18.6m, of which divisional recovery plans total £4.9m, £6.4m of central mitigations, £3.0m of activity recovery and forecast conversion of CIP pipeline into delivery of £2.5m resulting in a 'Most Likely' Forecast Outturn of a £22.5m, £22.5m adverse to the breakeven plan
8. Additional mitigations totalling £9.3m, agreed as part of the Financial Recovery Plan resulting in a forecast outturn of £13.2m deficit, £13.2m adverse to the planned breakeven position.

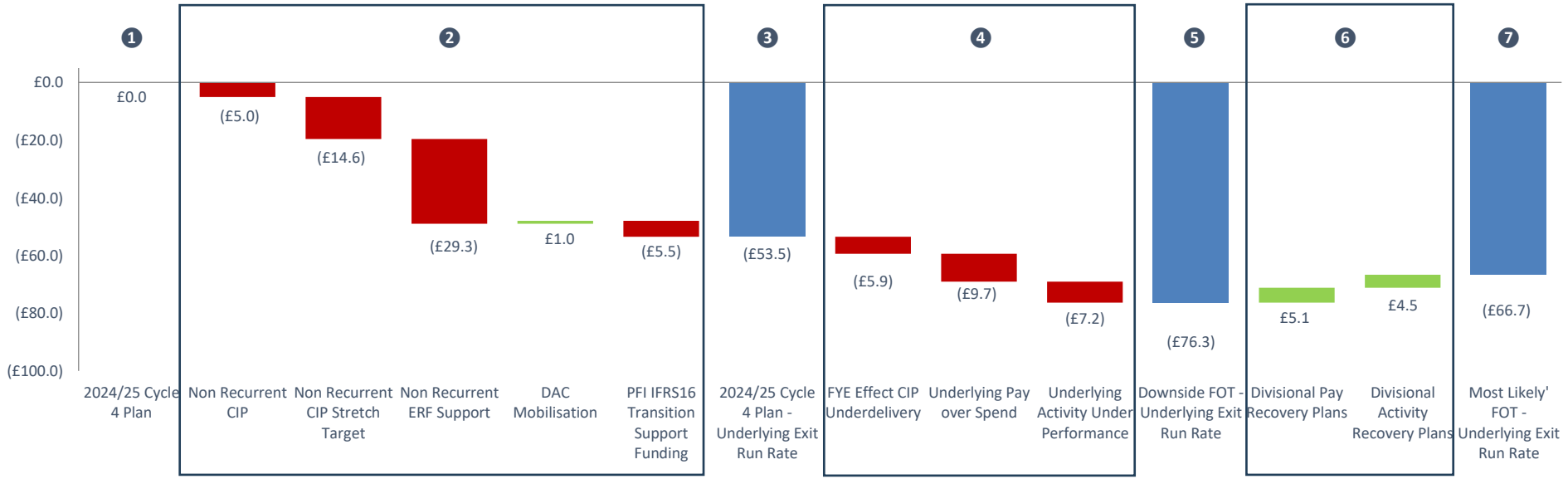


# 2.4 Underlying Exit Run Rate

Norfolk and Norwich University Hospitals NHS Foundation Trust

**The Trust operational plan, including the technical impact of PFI remeasurement for FY24/25, as outlined in Cycle 4 of the 2024/25 plan had an underlying exit run rate of £53.5m after adjusting for non-recurrent items. As a result of recurrent underperformance in 24/25 the downside underlying exit run rate is a £76.3m deficit, £22.9m adverse to the planned underlying exit run rate of £53.5m. The 'Most Likely' underlying exit run rate is a £66.7m deficit, £13.2m adverse to planned underlying exit run rate of £53.5m**

1. The Trust operational plan including the technical impact of PFI remeasurement for FY24/25 as outlined in Cycle 4 of the 2024/25 planning process is breakeven
2. FY24/25 Cycle 4 plan was supported by £53.5m of non-recurrent income / reduced expenditure:
   - Non-Recurrent CIP totalling £19.6m
   - ERF Support of £29.3m
   - DAC net mobilisation expenditure of £1.0m
   - PFI IFRS16 Transition Support Funding of £5.5m
3. 2024/25 Cycle 4 Plan - Underlying Exit Run Rate of a £53.5m deficit.
4. Recurrent variance to underlying plan at Month 4 is £22.9m adverse. This is a result of £5.9m full year effect (FYE) of CIP under delivery, full year effect of recurrent pay overspend totalling £9.7m and full year effect of under delivery of activity plan of £7.2m
5. Downside FOT – Underlying Exit Run rate of a £76.3m deficit, £22.9m adverse to planned Underlying Exit Run Rate of £53.5m
6. Recurrent divisional recovery plans of £9.6m, of which £5.1m relates to reduced pay expenditure and £4.5m relates to increased activity
7. Most Likely FOT – Underlying Exit Run rate of a £66.7m deficit, £13.2m adverse to planned Underlying Exit Run Rate of £53.5m



| Report in Common to the Trust Boards | |
|---|---|
| **Report Title:** | Development of the Norfolk and Waveney Acute Hospital Collaborative (NWAHC)<br>Update - Boards of Directors in Public (August 2024) |
| **Prepared/Presented by:** | Jon Barber – Deputy CEO, JPUH<br>Simon Hackwell – Director of Strategy and Major Projects, NNUH<br>Carly West-Burnham – Director of Strategy and Integration, QEH |
| **Date:** | August 2024 |
| **Issues for escalation/ decision(s) required:**<br>The Boards of Directors are asked to note the outcomes from the August Committees in Common and the key areas of focus for the Norfolk and Waveney Acute Hospital Collaborative (NWAHC) moving forward. | |
| | |

## Progress Update

The NWAHC Committees in Common recognised that the governance arrangements across the provider collaborative are in transition and as such future meetings may well change both in structure and content. The meeting was joined by Simon Wood, NHSE Regional Director of Strategy and Integration.

## Risks

N/A

## Update on the Development of the Norfolk and Waveney Acute Hospital Collaborative

**Acute Collaborative development**

N&WAHC governance review

As has previously been reported, detailed discussions are ongoing between the three providers around future governance arrangements. These are being supported by the ICB and NHS Regional colleagues. To assist in this work, the Trust have agreed to work with some experienced external advisors. This will work will intensify over the forthcoming weeks to establish a preferred model and thereafter supportive work in helping make any transition.

The meeting emphasised the importance of patients' interests being at the heart of any changes, as well as a clear narrative on the case for making a change and the anticipated benefits.

Should there be agreement around a new governance model it may be necessary to seek NHS England support for this.

Finally the need for any changes to be supported by a clear implementation plan with milestones was agreed.

Tri Board meeting

An update was given on actions from the last meeting.
All agreed that the recent ICB Systems Leaders event had been a useful and positive meeting.

**Implementation of a Shared Electronic Patient Record (EPR)**
It was reported that the Programme is currently going through a transition as it moves into delivery mode and as such a review of programme management arrangements (including risks and reporting lines) was being undertaken.

It was agreed that the Programme should check the supplier's capacity for the critical implementation period.

There was a discussion which highlighted the difference between Day One deliverables of the EPR and the subsequent work on optimisation of the new capabilities. As part of this it as agreed to circulate to the CiC a summary of the Benefits Optimisation as per the FBC.

Finally, it was agreed to seek clarification from the Programme on the dependencies n other programmes that EPR is reliant upon and the contractual dependencies the Trusts have with the supplier.

**Acute Clinical Strategy**
Development of the Specialty Clinical Networks continues and it was reported that there is mixed progress across the different specialties. The position would be considered by the next Tri Divisional Leadership Summit in October which would identify any corrective action required and also consider the launch of Module 3 of the SCN toolkit.

The Macro Model of Care work with Grant Thornton has concluded, although the final report has not yet been received. A common report to all three Trust Boards will be submitted in September (a report will also be prepared for the ICB Board). It was recognised that addressing the findings from the GT work is potentially a large piece of work which will need strong leadership and sufficient resource to support it. It was suggested that an overarching programme management approach across the Provider Collaborative might be the best way forward.

**N&W ICB Financial Recovery Board**
It was reported that the work was focussed around three 'sprint' areas: reducing length of stay; practical workforce actions and clinical standardisation. Colleagues across the ICB were now being identified to undertake a more formal role in supporting this important system work.

**CDC (DAC) Programme**
The meeting formally received the Gateway 4 report ('Readiness for service') from the Infrastructure and Projects Authority. The meeting noted the recommendations in the report and the acknowledgement of strong collaborative working on this programme.

**New Hospital Programme Update**
It was noted that HMG had announced a review of the New Hospitals Programme and terms of reference for this (including the position of RAAC hospitals) were awaited. Meanwhile work was continuing on the SOCs at both QEH and JPUH and the feasibility of appointing a joint SRO was being considered.

**Community Services Review**
The NNUH Director of Transformation gave an update on the PLACE Boards and development of neighbourhood teams. The meeting felt that a closer link to Trust Boards would be helpful and learning from other systems about effective integrated care models.

**Primary Care**
A briefing was provided about the work being undertaken at JPUH with primary care together with the possible developments at Cromer Hospital including primary care involvement

**Dentistry**
The current position in relation to the establishment of a dental school was discussed and the possible collaboration between the UEA and other institutions in support of a bid for a Dental School facility.

**Aligned approach to transformation**
The meeting noted that the three provider transformation functions are continuing to work together to develop a more collaborative approach and this included opportunities around a common PMO approach around CIPs, continuous improvement and development of the transformation network.

The meeting was keen to understand the interdependencies between the different transformation programme and the main risks to delivery. This will help understanding of whether resources needed to be rebalanced and what the delivery pipeline should look like.

Trust Boards are asked to note and approve the key outcomes from the June Committees in Common meeting.