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 06 NOVEMBER 2024

A meeting of the Trust Board will take place at 9.30am on Wednesday 06 November 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 - Apologies - Lesley • Reflections on Clinical/Departmental Visits	09.30-09.45	Chair	Information/ Discussion
2	Minutes of the Board meeting held in public on 11.09.24		Chair	Approval
3	Matters arising and update on actions		Chair	Discussion
4	Patient Experience - Falls Prevention - https://youtu.be/bvXAm7t9LVY – Rosie Bloomfield & Anna Skipper attending	09.45 -10.05	RC	Discussion
5	Chief Executive's report	10.05-10.20	CEO	Discussion
6	IP&C annual report 2023/24 – Dr Catherine Tremlett and Dawn Cursons attending	10.20-10.35	RC	Approval
7	Committees in Common – Verbal update	10.35-10.45	TS	Discussion
8	**Reports for Information and Assurance:**			
	(a) IPR – Workforce data	10.45 -11.15	PJ	Information, Discussion & approval as indicated
	(b) Quality and Safety Committee (29.10.24)		PC	
	(c) IPR – Quality, Safety and Patient Experience data		RC/BB	
	(d) Finance, Investments and Performance Committee (30.10.24) - inc FIPC ToRs update for approval		NG	
	(e) IPR – Performance and Productivity data		CC	
	(f) Finance – YTD report		LS	
9	Questions from members of the public		Chair	
10	**In its capacity as Corporate Trustee** Report of the N&N Hospitals Charity Committee (15.10.24) inc a) approval of grant >£100k b) approval of updated SOP for Naming Trust Assets c) Charity Committee ToRs for approval	11.15-11.30	JH/JPG	Discussion & agreement

* Background documents uploaded to Resource Centre

Date and Time of next Board meeting in public
The next Board meeting in public will be at 9.30am on Wednesday 05 February 2025 in the Boardroom of the Norfolk and Norwich University Hospital

REPORT TO TRUST BOARD				
Date	**6th November 2024**			
Title	**Falls Prevention Programme and collaboration with Age UK Norwich**			
Author & Exec Lead	Anna Skipper, Falls Prevention and Management Lead in collaboration with Age UK Norwich Rosie Bloomfield, Patient Engagement & Experience Facilitator Rachael Cocker, Chief Nurse			
Purpose	**For Information and Discussion**			
Relevant Strategic Commitment	**1. We will be a provider of high quality health and care services to our local population** **2. We will be the centre for complex and specialist medicine for Norfolk and the Anglia Region** **3. We will be a centre of excellence for research, education, and innovation** **4. We will be a leader in the design and delivery of health and social care services in Norfolk** **5. To deliver our financial plan and recovery programme, supporting the Trust's return to financial sustainability**			
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:	**Board/Committee:**		**Outcome:**	

1 Background/Context

1.1 Listening to people's experiences and stories gives us the opportunity to learn about the things that we do well and consider where we can make improvements. It helps put patients at the heart of service development and improvements. This is true for hearing from patients, carers, staff and Volunteers alike.

1.2 Falls are amongst the most frequently reported patient safety incident in NHS Hospitals. No fall is harmless and there is evidence that a coordinated MDT approach can reduce their incidence. So far this year we have saved the Trust over £700k in falls associated costs and seen a year on year reduction of 10%. This is against a post pandemic frailty wave in one of the oldest populations in the UK.

1.3 The objective of the Falls Programme within NNUH is to reduce inpatient falls within NNUH through policy, documentation, education and technology. We've come to board today to provide an update on the programme alongside an experience of care video.

1.4. The experience of care video we are sharing includes retrospective experiences and raises improvement suggestions which we have worked hard to address at the Norfolk & Norwich University Hospital. The video has been co-produced by the Norfolk & Norwich University Hospital and Age UK Norwich, in collaboration with older adults who attended Age UK Norwich's falls awareness and recovery service. Some of whom experienced falls within the community and within the hospital. The video is based on real stories and events from anonymised people to highlight areas of improvement that could have reduced falls or enhanced recovery. We hope that this experience of care story can help inform falls awareness and prevention across the Norfolk & Waveney Integrated Care System as well as continue to inform our improvement programme at the NNUH.

2 Key issues, risks, and actions

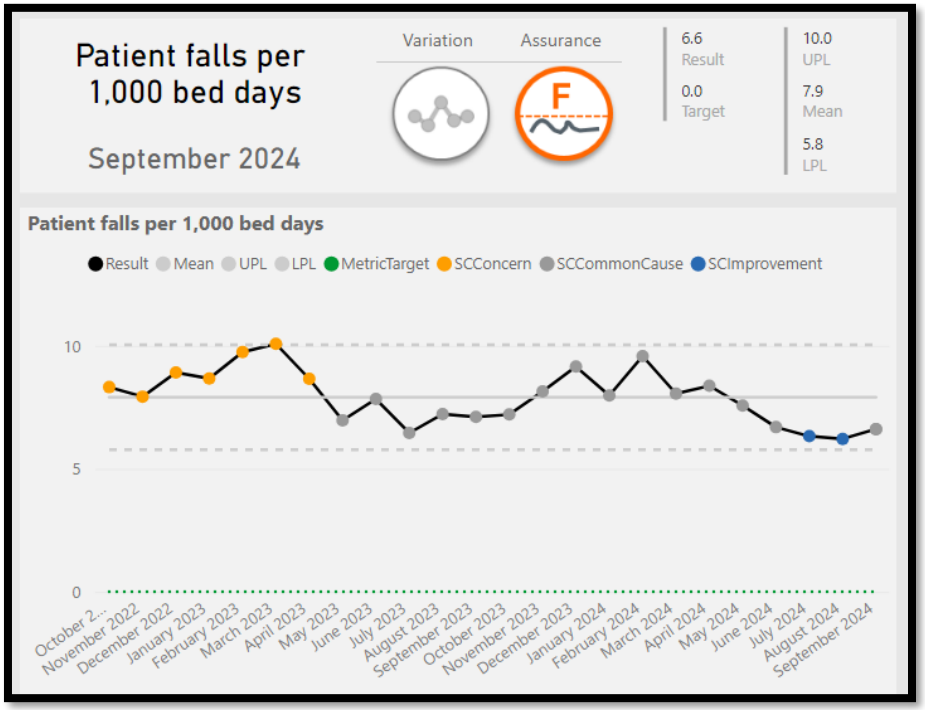
2.1 Update on progress within the Falls Programme so far:

- Increase awareness of Falls Policy and associated appendices
- Launch of NEW Multifactorial Falls Risk Assessment
- Bespoke Falls Training for MDT
- RCoP prevention of Hospital Falls
- Cross Trust collaboration through ICS Falls Groups
- Trust wide implementation of Think Yellow Initiative
- Training on Medstrom Solo Ultra-Low Bed
- Relaunch of Bay Watch Initiative
- Falls Champion Education Programme
- Lying & Standing BP enhancement on E-Obs
- Lying & Standing BP daily report
- Bed Rails Awareness Video
- Essential Care Safety Conversations twice weekly
- Creation of post falls debrief within Datix
- Relaunch of Falls Steering Group
- Assistive Technology Implementation across inpatient wards
- ICS collaboration with external stakeholders including Age UK Norwich

2.2 However we still recognise that there is work to do to join up services to ensure patients receive the multidisciplinary care needed to deliver successful cross-system falls prevention. We hope that the experience of care video will help aid this system learning. Internally we have worked hard to implement improvement but there is work to be done to influence system change.

3 Conclusions/Outcome/Next steps

3.1 Outcomes and key findings following the implementation of the Trust Wide Falls Programme:



- We have seen a consistent picture of decreasing falls rates both during summer and winter months despite lengthy periods escalation. However, summer 2024 has seen the lowest number of falls and per thousand bed days since programme began. This improvement in 2024 is likely to be attributable to improved staffing and the implementation of Falls Assistive Technology across patient wards.
- A multifactorial approach to falls risk assessment has a positive effect on the reduction of inpatient hospital falls
- A Trust wide education programme has been key in changing the process and learning around prevention of falls at NNUH
- Falls Assistive Technology does have its place in the prevention of falls when the population demographics supports a high incidence of cognitive decline

3.2 Co-production with AGE UK Norwich:

- This project looked at increasing awareness of falls prevention across the ICS and formed a strong collaboration between NNUH and Age UK Norwich which will be hugely beneficial for our patients. At NNUH we are hoping to use the video to support our staff education and further embed Age UK and other community organisations and charities to help signpost patients to support. This will help prevent falls in the community and therefore prevent further hospital admissions.

Recommendations:
The Board is asked to listen to and reflect on the stories presented, using that information to inform future strategies and improvement plans suggested.

1. Summary of Experience of Care Story

We are asking you to seriously consider frailty and the risk falls. In Norfolk, frailty affects over 115,000 people – with 4,000 community falls resulting in hospitalisation. Prevention and supporting people who fall is a critical challenge due to the impact on independence, quality of life, mortality, and the cost to the NHS. Every decision we make in healthcare has an impact on the individual and their family and shouldn't be thought about in isolation.

We've taken insight from people who attend Age UK Norwich's Falls Prevention & Recovery Class to help tell the story of Alice. It highlights multiple healthcare system opportunities which could have changed her experience and is informed by NICE Guidance in order to illustrate the steps that should have been taken. It includes retrospective experiences and raises improvement suggestions which we have worked hard to address at the Norfolk & Norwich University Hospital via our Falls Improvement Programme.

Alice is 66 years old lives alone. She has:

- A history of falls – including fractured hip.
- Type 2 Diabetes & takes insulin
- Recently prescribed a new, cheaper version
- Developed feelings of dizziness
- Pharmacy & GP didn't flag potential side effects.

There were many missed opportunities in Alice's story where different services could have supported her with Falls Prevention information and it's vital that we work together to ensure we improve experiences like this.

- Her pharmacy providing her with information about her prescription and its possible side effects
- Medical professionals looking at and considering her history of falls when changing her medication
- Providing advice and signposting on falls prevention when admitted and when discharged from hospital
- Providing falls risk assessments consistently and remembering to 'think yellow'
- GPs signposting to support with falls prevention within the community

It's vital that we work together as a system to ensure we improve experiences for patients like Alice.

What "point" it is trying to convey

Falls are traumatic and can lead to serious injury and in rare cases fatality. The effects can last for years, however there are things we can do to improve this experience:

- There are missed opportunities where health professionals from within the ICS can help prevent falls
- We need to work as a system to advocate on healthy ageing and the prevention of falls
- We need to signpost patients to services that support age healthy principles and delay the onset of frailty and fall

Who will be "speaking"

Patient	"Alice"
Staff	Anna Skipper, Falls Management and Prevention Lead, NNUH

REPORT TO TRUST BOARD				
Date	**22/10/2023 for 06/11/2024**			
Title	**Infection Prevention & Control (IP&C) Annual Report 2023-24 and Annual Plan 2024-25**			
Author & Exec Lead	**Rachael Cocker, Chief Nurse and Interim Director of Infection Prevention and Control (DIPC)** **Dawn Cursons, Deputy Director of Infection Prevention and Control (DIPC)** **Catherine Tremlett, Infection Control Doctor**			
Purpose	**For Agreement**			
Relevant Strategic Commitment [delete as appropriate]	**1. Together, we will develop services so that everyone has the best experience of care and treatment** **2. Together, we will support each other to be the best we can be, to be valued and proud of our hospital for all.** **3. Together, we will join up services to improve the health and wellbeing of our diverse communities** **4. Together, we will provide nationally recognised, clinically led services that are high quality, safe and based on evidence and research** **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 issue/document	**HICC, CSESB, HMB, Q&S**		**Outcome/decision/changes made:**	

1 Background/Context

1.1 In February 2024 the executive lead for IP&C changed, the existing DIPC of five and a half years resigned, to embark on a new leadership opportunity within the Nursing and Midwifery Council (NMC). The DIPC role is currently undertaken by the Chief Nurse with the support of the Infection Control Doctor (ICD) and IP&C team. Together the team continue to be committed to provide support and advice across the Norfolk and Norwich University Hospital (NNUH), working collaboratively with Trust staff, contracted staff and external stakeholders such as the Norfolk and Waveney Integrated Care Board (ICB).

1.2 In March 2020, the COVID-19 pandemic was declared by the World Health Organisation (WHO). Within 2023 NHS England began a transition to utilising COVID-19 testing to focus on reducing adverse outcomes and enabling individual treatment decisions, rather than identifying every individual case of COVID-19. The early risk of harm was thought to be mitigated through high immunity, high vaccination coverage and increased

access to COVID-19 therapeutics. The likelihood of being admitted to hospital for COVID-19 was thought to be lower than Influenza in the general population.
Personal Protective Equipment (PPE) requirements were also reduced, government guidance was closely followed, and adjustments made accordingly throughout the trust and across the local healthcare system (as outlined on page 46). General infection control principles remain throughout as referenced within the National infection prevention and control manual (NIPCM) (2024).

1.3 Within 2023-2024, there was an unprecedented number of laboratory confirmed cases of Measles nationally.
From the 1st of January to the 31st of December 2023 there were 362 laboratory confirmed measles cases in England. The rise in cases is thought to be attributed to a decline in Measles, Mumps, and Rubella (MMR) vaccination rates in recent years.
Whilst there have been confirmed cases of Measles within the East of England, there were nil reported cases reported at the NNUH.

1.4 In October 2023, an IP&C review was undertaken as part of the 2023-24 approved internal audit plan to allow the Trust Board to take assurance over the design and effectiveness of the processes in place to manage infections at ward level. In total two medium and two low priority actions were identified. The final opinion was, that the board can take reasonable assurance that the controls upon which the organisation relies to manage IP&C are suitably designed, consistently applied and effective. For more detailed information, please refer to pages 7 and 8 of the report.

1.5 Throughout September and October 2023, the IP&C team worked collaboratively with antimicrobial pharmacist colleagues, participating in the National Point Prevalence Survey (PPS). The survey was aimed at providing a snapshot of the burden of HCAI and describe antimicrobial use to allow meaningful comparisons between organisations. The NNUH were 1 of 78 acute trusts across England that participated. Preliminary summary results have been shared with each participating trust, there are some adjustments still to be made. The final report is pending and will be shared trust wide once available. Additional information can be found on pages 43 and 44 of the report.

1.6 The IP&C team recognise the hard work and commitment of all staff across the healthcare community who have collaboratively continued to strive for the highest quality IP&C standards, promoting patient and staff safety and reduce the risk of nosocomial transmission of infection. Recognising that this has been a challenging period with the increased demand operationally.

2 Key issues, risks and actions

2.1 The IP&C team use a commercial software system, called ICNet to manage alert organism results, suspected infections, monitor for Periods of Increased Incidence (PII) and minimise risk of outbreaks. In 2021 approval was granted to purchase the updated version 7 of ICNet, a team within the region have worked collaboratively across the Integrated Care System (ICS), to implement this. The new version of ICNet is planned to be hosted by the James Paget Hospital server, enabling local community trusts and the three acute trusts to provide pertinent IP&C patient information across the organisations and improve patient safety.

The project is currently ongoing and has taken longer than expected due to some technical obstacles which the provider is working to resolve. All IP&C teams have received training on the new system. Due to the current version 6 being unsupported and the new version unable to go clinically live at present, this remains on the Trust Risk Register (score 12).

2.2 This is the seventh year of UKHSA mandatory surveillance of Gram-negative blood stream infections including Escherichia coli, Pseudomonas aeruginosa and Klebsiella species. The objectives outlined for the 2023-24 period were reduced from 2022- 23 (as shown on pages 21- 23) and encompassed both cases pertaining to COHA (Community-Onset Healthcare-Associated) and HOHA (Hospital-Onset Healthcare-Associated). A risk remains on the register, acknowledging the reduction of the allocated threshold. Within 2023-24 Gram negative cases exceeded the thresholds set, detailed information is provided within pages 3,21,22 & 23 of the report. The IP&C team and ICD undertake weekly surveillance of all reportable hospital origin Gram-negative Blood stream infections (BSI), there were no reoccurring/common lapses in care detected.

2.3 In line with NHS England - NHS Standard Contract to minimise instances of Clostridium difficile. The United Kingdom Health Security Agency (UKHSA) mandates the reporting of both Community-Onset Healthcare-Associated (COHA) and Hospital-Onset Healthcare-Associated (HOHA) C. diff cases. The objective of 77 cases outlined for the 2023-24 period was exceeded by a total of 16 cases.

2.4 The UKHSA requires the submission of reports regarding Meticillin Resistant Staphylococcus aureus (MRSA) blood stream infections. Within the specified timeframe of 2023-2024 there was 1 case of Hospital Attributable Meticillin Resistant Staphylococcus aureus (MRSA) BSI, against an objective of zero cases. The MRSA bacteraemia was classified as healthcare associated due to collection of a blood culture over 48 hrs after admission. However, it was acknowledged upon case review with the Integrated Care Board (ICB) infection control representatives, that the bacteraemia was due to a medical condition present prior to admission and therefore truly a community acquired infection.

3 Conclusions/Outcome/Next steps

3.1 The annual programme for IP&C year 2024 – 2025 is provided outlining the objectives set by UKHSA and actions that will be followed and monitored via the Hospital Infection Control Committee (HICC) throughout the year.

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

Our Vision
The best care for every patient

NHS
Norfolk and Norwich University Hospitals
NHS Foundation Trust

Infection Prevention and Control Annual Report 2023-24

Rachael Cocker - Interim Director of Infection Prevention and Control

Dawn Cursons - Deputy Director of Infection Prevention and Control

Dr Catherine Tremlett - Infection Control Doctor

Infection Prevention and Control Team

Infection Prevention and Control Annual Report 2023-24

Table of Contents

Infection Prevention and Control Annual Report 2023-24

Executive Summary

This annual report incorporates information and data pertaining to healthcare associated infections (HCAI) during the period 1st April 2023 until 31st March 2024. It provides a summary of the Infection Prevention and Control (IP&C) work undertaken, the management and governance structures and the assurance processes.

The format follows the 10 hygiene code criteria detailed in the Health and Social Care Act 2008: code of practice on the prevention and control of infections and related guidance, updated December 2022. The annual report will be released publicly by the Director of Infection Prevention and Control (DIPC) as outlined in the code.

The Infection Prevention & Control (IP&C) team monitor alert organisms and undertake audit and surgical site surveillance programmes in partnership with the divisions.

Official alert organism government objectives were set in April 2023 and the Trust continued to monitor against objectives throughout this period:

- There were 93 total cases of *Clostridioides difficile* infection (CDI) against an objective of 77.
- There was 1 case of Hospital Attributable Meticillin Resistant *Staphylococcus aureus* (MRSA) blood stream infection (BSI), against an objective of zero cases. The MRSA bacteraemia was classified as healthcare associated due collection of blood culture over 48 hrs after admission. However, it was acknowledged upon case review with the Integrated Care Board (ICB) infection control representatives, that the bacteraemia was due to a medical condition present prior to admission and therefore truly a community acquired infection.
- There were 103 total cases of *Escherichia coli* against an objective of 91.
- There were 56 total cases of *Klebsiella species* against an objective of 24.
- There were 30 total cases of *Pseudomonas aeruginosa* against an objective of 19.

The COVID-19 pandemic was declared by the World Health Organisation (WHO) March 2020. Within 2023 NHS England began a transition to utilising COVID-19 testing to focus on reducing adverse outcomes and enabling individual treatment decisions, rather than identifying every individual case of COVID-19. The early risk of harm was thought to be mitigated through high immunity, high vaccination coverage and increased access to COVID-19 therapeutics. The likelihood of being admitted to hospital for COVID-19 was thought to be lower than Influenza in the general population. An approach was taken to move COVID-19 testing into clinical care pathways, alongside those that are routine for other respiratory infectious diseases. Personal Protective Equipment (PPE) requirements were also reduced, government guidance was closely followed, and adjustments made accordingly throughout the trust and across the local healthcare system (as outlined on page 46). General infection control principles remain throughout as referenced within the National infection prevention and control manual (NIPCM) (2024).

Within 2023-2024, there was an unprecedented number of laboratory confirmed cases of Measles nationally.

From the 1st of January to the 31st of December 2023 there were 362 laboratory confirmed measles cases in England.

Activity earlier on in the year was mainly focused on the London region. However, a rapid escalation in cases from the beginning of October was due to an outbreak in the West Midlands. Most of the cases in 2023 (62%) were in children aged 10 years and younger and 19% were in teenagers and young people aged 15 to 34 years. Between January 2024 to the end of March 2024, there were 807 laboratory confirmed cases, the majority of these continuing to be in London and the West Midlands. Confirmed cases of measles in England by month, age, region and upper tier local authority: 2024 - GOV.UK (www.gov.uk)

The rise in cases is thought to be attributed to a decline in Measles, Mumps, and Rubella (MMR) vaccination rates in recent years.

Whilst there have been confirmed cases of Measles within the East of England, there were nil reported cases reported at the NNUH.

Workplace Health and Wellbeing have communicated and contacted staff who are deemed to require vaccination. Current guidance has been made available on the trust intranet and circulated throughout the NNUH as appropriate. Workplace Health and Wellbeing (WPHWB) have reviewed in detail the government guidance for staff and developed an action plan to consider the workforce elements relating to the emerging increase in infection across the country.

The IP&C team recognise the hard work and commitment of staff across the healthcare community who have collaboratively continued to strive for the highest quality IP&C standards, promoting patient and staff safety and reduce the risk of nosocomial transmission of infection. Recognising that this has been a challenging period with changes to COVID-19 guidance, the re-emergence of disease such as Measles and the increased demand operationally.

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

- **Chief Nurse and Interim Director of Infection Prevention and Control:** Rachael Cocker
- **Deputy Director of Infection Prevention and Control:** Dawn Cursons
- **Infection Control Doctor and Consultant Microbiologist:** Catherine Tremlett

Infection Prevention and Control Annual Report 2023-24

Abbreviations

AMS	Antimicrobial Stewardship
AMU	Acute Medical Unit
BSI	Bloodstream infection
CDI	Clostridioides difficile Infection
C. difficile	Clostridioides difficile
CEO	Chief Executive Officer
COCA	Community Onset Community Associated
COHA	Community Onset Healthcare Associated
COIA	Community Onset Indeterminate Association
CPD	Continuing Professional Development
CPE	Carbapenemase-producing Enterobacteriaceae
CPO	Carbapenemase-producing organisms
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
CVC	Central Venous Catheter
DDD	Defined Daily Dose
DGSA	Dangerous Goods Safety Advisor
DH	Department of Health
DIPC	Director of Infection Prevention & Control
E. coli	Escherichia coli
EAUS	Emergency Assessment Unit Surgical
EDU	Endoscopy Decontamination Unit
ENT	Ear Nose Throat
EPA	Eastern Pathology Alliance
ESBL	Extended Spectrum Beta Lactamase
FFP3	Filtering facepiece protection
FM	Facilities Management
FR	Functional Risk
GRE	Glycopeptide Resistant Enterococcus
H&S	Health and Safety
HBN	Health Building Notes
HCAI	Health Care Associated Infection
HICC	Hospital Infection Control Committee
HII	High Impact Intervention
HMB	Hospital Management Board
HOHA	Hospital Onset Healthcare associated
HTM	Health Technical Memorandum
ICB	Integrated Care Board (previously Clinical Commissioning Group)
ICD	Infection Control Doctor
ICS	Integrated Care System
IGAS	Invasive group A Streptococcus
IHEEM	Institute of Healthcare Engineering & Estates Management
IMT	Incident Management Team
IP&C	Infection Prevention & Control
IPR	Integrated Performance Report
IS	Information Services
ITU	Intensive Care Unit
JAG	Joint Advisory Group
LFT	Lateral Flow Tests

MDR TB	Multidrug-Resistant Tuberculosis
MHRA	Medicines and Healthcare products Regulatory Agency
MMR	Measles, mumps and rubella
MRSA	Meticillin Resistant Staphylococcus aureus
MSSA	Meticillin Sensitive Staphylococcus aureus
NaNOC	The Norfolk and Norwich Orthopaedic Centre
NHS	National Health Service
NHSE/I	National Health Service England and National Health Service Improvement
NHSI	National Health Service Improvement
NICE	National Institute for Health and Care Excellence
NICU	Neonatal Intensive Care Unit
NIPCM	National Infection Prevention Control Manual
NNUH	Norfolk and Norwich University Hospital Foundation Trust
NRPIC	Norwich Research Park Innovation Centre
OPM	Older People's Medicine
OWL	Organisation Wide Learning
PAS	Patient Administration System
PCR	Polymerase chain Reaction
PEEG	Patient Engagement & Experience Governance Sub-Board
PFI	Private Finance Initiative
PICC	Peripherally Inserted Central Catheter
PII	Period of Increased Incidence
PIR	Post Infection Review
PLACE	Patient-led assessments of the care environment
PPM	Planned Preventative Maintenance
POPs	persistent organic pollutants
POU	Point of Use
PPE	Personal Protective Equipment
PPM	Pre-planned maintenance
PPS	Point Prevalence Survey
PVL	Panton-Valentine Leukocidin
QI	Quadrum Institute
RO	Reverse Osmosis
RSV	Respiratory Syncytial Virus
SARS-CoV2	Severe Acute Respiratory Syndrome - Coronavirus 2
SMART	Specific, Measurable, Achievable, Relevant, Timely
SOP	Standard Operating Procedure
SPC	Statistical Process Control
SSD	Sterile Service Department
SSI	Surgical Site Infection
TVCs	Total Viable Counts
UEA	University of East Anglia
UKAP	United Kingdom Advisory Panel
UKHSA	United Kingdom Health Security Agency
UTI	Urinary tract infection
VRE	Vancomycin Resistant Enterococcus
VZV	Varicella zoster virus
WHO	World Health Organisation
WHWB	Workplace Health and Well-Being
WSG	Water Safety Group

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

Governance and Monitoring

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

The Board of Directors collectively work within the Norfolk and Norwich University Hospital NHS Foundation Trust (NNUH) Healthcare Governance Framework to ensure that high quality and safe services are in place for patients, visitors, and staff to minimise the risk of infection.

The Hospital Infection Control Committee (HICC) is a key element of the assurance process and reports to the Clinical Safety and Effectiveness Board, see Chart 2. HICC ensures that effective systems and processes are in place to reduce the risk of hospital acquired infections and provide assurance to the board. External members from UKHSA and the ICB, along with patient representatives are invited to meetings held monthly, with exception of August and December. HICC is responsible for the strategic planning and monitoring of the Trusts IP&C programme.

The DIPC provides strategic direction and leadership to the Trust on all IP&C matters.
In February 2024 the existing DIPC of five and a half years resigned, to embark on a new leadership opportunity within the Nursing and Midwifery Council (NMC). The DIPC role is currently undertaken by the Chief Nurse with the support of the IP&C team.

IP&C Reporting Processes

The IP&C team provides a comprehensive monthly IP&C report which is widely distributed to senior managers, divisional leads, governance leads, matrons, ward managers and ICB IP&C nurses. This report provides graphical evidence of alert organism figures and trends alongside UKHSA benchmarking data, screening, antimicrobial reports and details of any outbreaks or incidents and highlights any risks.

The IP&C team report on all key aspects of IP&C at the HICC meetings with reports from internal and external representatives, see Chart 3. The Chief Nurse, who is DIPC and executive lead for IP&C, reports key performance indicators monthly to the Trust board.

The Deputy DIPC provides monthly key information within the Integrated Performance Report (IPR) in relation to mandatory reportable Health Care Associated Infections (HCAI).

The Deputy DIPC reports to the Clinical Safety and Effectiveness Sub-Board (CSESB) monthly.

Internal IP&C audit

In October 2023, an IP&C review was undertaken as part of the 2023-24 approved internal audit plan to allow the Trust Board to take assurance over the design and effectiveness of the processes in place to manage infections at ward level. The object of the review was to assess the guidance and application of the defined processes with regard to prevention and control of infections, including a review of the lessons learnt mechanisms, the identification and implementation of infection control actions, and how actions arising from clinical audit activity are being enacted.

In total, four management actions were agreed. Two actions were classified as medium priority, specifically relating to inconsistencies in completing Tendable audits and the necessity for Specific, Measurable, Achievable, Relevant and Timely (SMART) actions, as well as the need for improved action planning regarding temporary staff infection prevention and control training. Two low priority actions were identified, these included improvement of timely reporting, investigation, and closure of IP&C related incidents on Datix and the need to review the HICC terms of reference.

Upon completion of the actions, the review concluded that the Trust has well- designed controls regarding the documentation and communication of key roles and responsibilities relating to IP&C, availability of IP&C training modules for clinical and non-clinical staff, completion of IP&C training by substantive staff, and the dissemination of lessons learnt via the IP&C Organisational Wide Learning (OWL). Also commended were the consistent completion of hand hygiene and Commode audits as well as well-established and sound governance arrangements for managing IP&C issues by HICC and the CSESB.

The internal audit final opinion was, that the board can take reasonable assurance that the controls upon which the organisation relies to manage IP&C are suitably designed, consistently applied and effective. See Chart 1 for definitions of assurance.

Chart 1

Graphic	Opinion
Minimal assurance ← Partial assurance | Reasonable assurance → Substantial assurance	Taking account of the issues identified, the board can take minimal assurance that the controls upon which the organisation relies to manage this risk are suitably designed, consistently applied or effective. Urgent action is needed to strengthen the control framework to manage the identified risk(s).
Minimal assurance ← Partial assurance | Reasonable assurance → Substantial assurance	Taking account of the issues identified, the board can take partial assurance that the controls upon which the organisation relies to manage this risk are suitably designed, consistently applied or effective. Action is needed to strengthen the control framework to manage the identified risk(s).
Minimal assurance ← Partial assurance | Reasonable assurance → Substantial assurance	Taking account of the issues identified, the board can take reasonable assurance that the controls upon which the organisation relies to manage this risk are suitably designed, consistently applied and effective. However, we have identified issues that need to be addressed in order to ensure that the control framework is effective in managing the identified risk(s).
Minimal assurance ← Partial assurance | Reasonable assurance → Substantial assurance	Taking account of the issues identified, the board can take substantial assurance that the controls upon which the organisation relies to manage this risk are suitably designed, consistently applied and effective.

Infection Prevention and Control Annual Report 2023-24

Chart 2

Board of Directors and Management Board Reporting and Accountability Structure

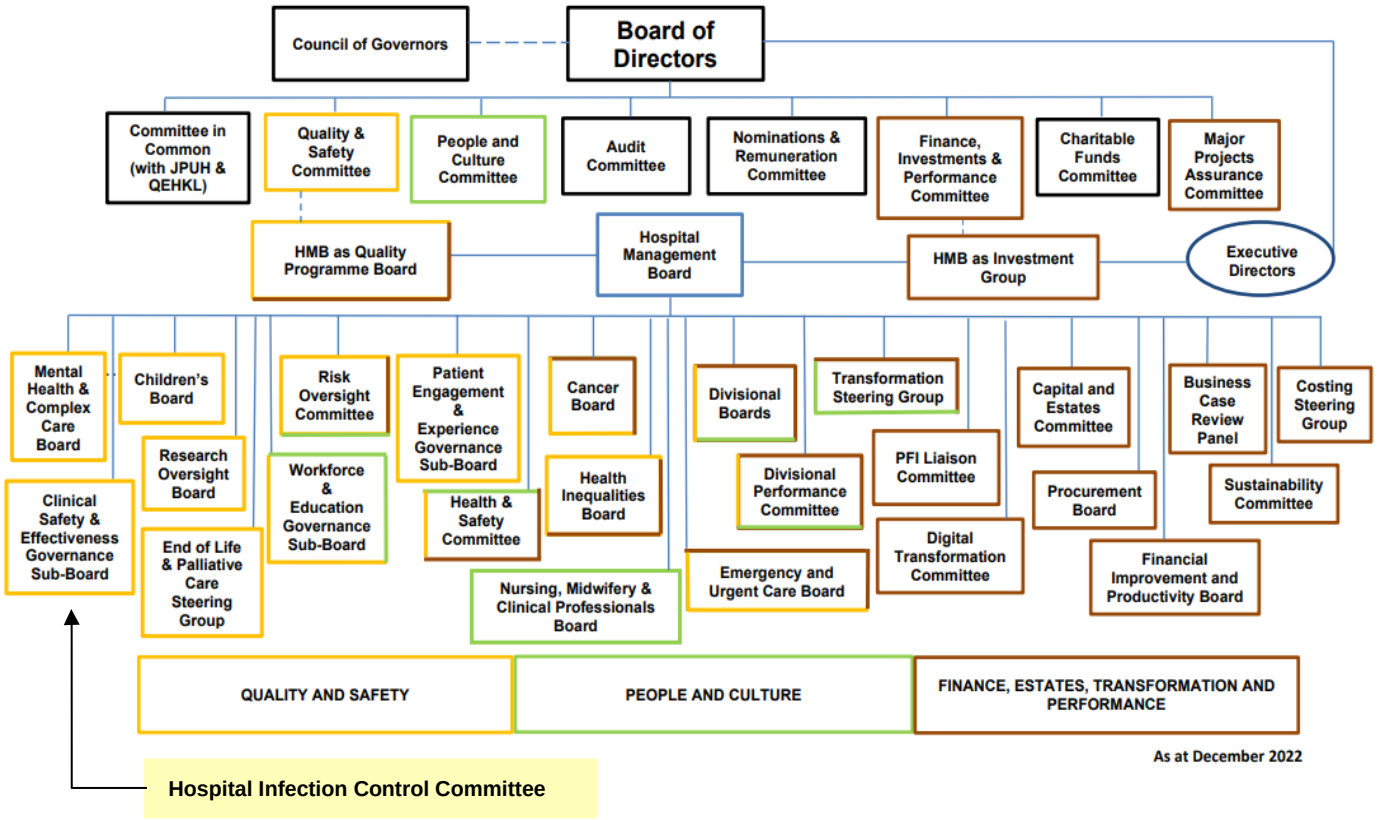


Chart 3

Infection Prevention & Control Governance Structure

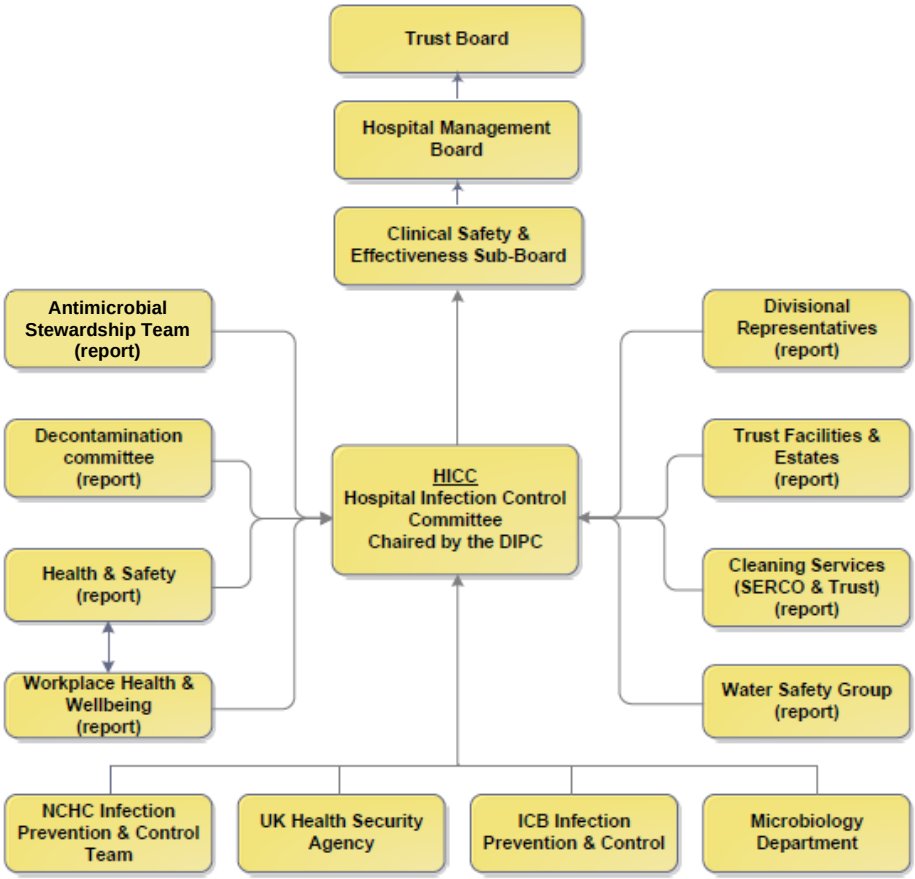
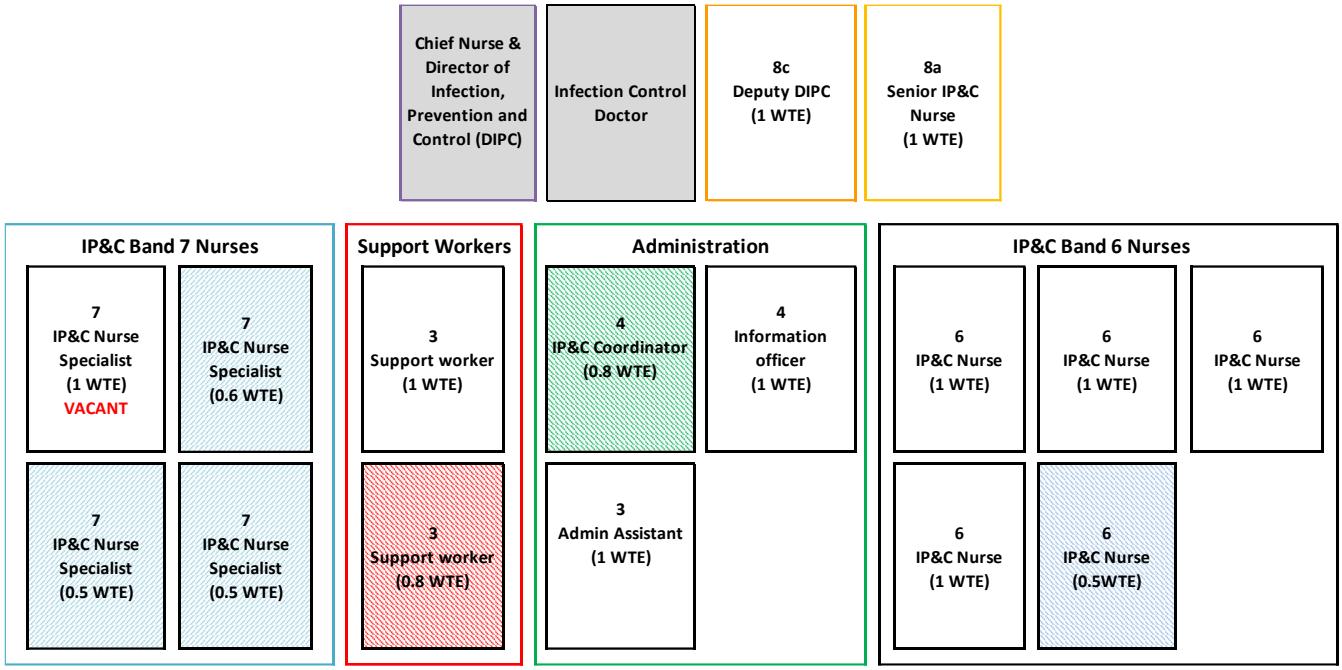


Chart 4 – Infection Prevention & Control Team Structure



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

Within the IP&C establishment there has been the opportunity to recruit two new members of staff, following two successful secondments which have progressed to substantive posts. This provides continued succession planning for the future.

Integrated Care Board (ICB)

IP&C at the NNUH is monitored by the ICB IP&C team. This involves attendance at HICC, participation in environmental inspections, contributions to Incident Management Team (IMT) meetings, conducting Post-Incident Reviews (PIRs) for all patients who develop an MRSA bacteraemia or CDI in accordance with national guidance, and attending bi-weekly Norfolk and Waveney Infection Prevention and Control (IP&C) collaborative meetings.

ICNet (IP&C Software system)

The IP&C team use a commercial software system, called ICNet to manage alert organism results, suspected infections, monitor for Periods of Increased Incidence (PII) and minimise risk of outbreaks. ICNet served notice on the existing software due to its age. Since approval was granted to purchase the newer version 7 of ICNet, a team within the region have worked collaboratively across the Integrated Care System (ICS), to implement this.

The new version of ICNet is planned to be hosted by the James Paget server, enabling local community trusts and the three acute trusts to provide pertinent IP&C patient information across the organisations and improve patient safety.

The project is currently ongoing and has taken a little longer than expected due to some technical obstacles which the provider is working to resolve. All IP&C teams have received training on the new system, it is anticipated that the project will be finalised, and all of the participating teams will go live in September 2024.

Building

The IP&C team continue to participate in a multitude of refurbishment and new developments across the different sites as the Trust reconfigures to expand and improve facilities. IP&C offer support and advice from the design stage to ensure compliance with Health Building Notes (HBN) and Heath technical memorandum (HTM). Human factor issues can also be addressed when considering new projects. The IP&C team work together with key stakeholders within the departments, facilities, project teams and contractors. When projects are near completion, IP&C join the snagging team to ensure the finished product meets requirements and safety standards.

The IP&C team regularly participates in the monthly facilities management meetings to stay informed about current and upcoming projects.

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

- NNUH Community Diagnostic Centre (CDC) approved in June 2023 and forecast to be operational by early 2025 (Image 1).
- Continuing construction of the Norfolk and Norwich Orthopaedic Centre (NaNOC), due for completion July 2024 (Image 2).
- New Paediatric theatres opened January 2024 (Image 3).
- Cooling units on level 4 required due to intolerable heat instigated as part of the Hot and Uncomfortable Working Group.

Image 1 - CDC

Image 2 - NANOC

Image 3 - Paediatric theatre

Healthcare Inspections

During the period of 2023-24 there were no IP&C external healthcare inspections undertaken.

Water Safety Group (WSG)

As part of the Trust's Governance Structure, a WSG has been established as per the Health Technical Memoranda (HTM), Safe Water in Healthcare Premises 04-01 and The Health Care Associated Infection (HCAI) Code of Practice.

Meeting quarterly, the aim of the WSG is to ensure the safety of all water used by patients, staff and visitors, and to minimise the risk of infection associated with waterborne pathogens.

NNUH has an appointed water authorising engineer who is a pivotal member of the WSG which ensures that decisions affecting the safety and integrity of the water systems and associated equipment do not go ahead without being agreed by them. This includes consultations relating to decisions on the procurement, design, installation and commissioning of water services, equipment, and associated treatment processes.

Three members of the IP&C team have completed the Legionella/water quality risk management responsible persons course, a further two members of the team have attended a study day in water safety in March 2023.

Ongoing further development of the IP&C team is anticipated, with further training on water safety planned for two members of the team in April and May 2024.

Water Safety Management Group Report provided by Chair of the Trust Water Safety Group

The Water Safety Management Group (WSG) is held on a monthly basis. Stakeholders include NNUH facilities management, NNUH Divisional representation, Norse, Serco and external facility providers and external responsible person for water compliance, who participate in meetings or send reports as required.

Under the Health and Safety at work act 1974 and control of substances hazards to health regulations 2002, actions are taken to prevent and control harmful effects of contaminated water. *Legionella* and *Pseudomonas Aeruginosa* testing is routinely conducted in order to ensure the safety of our staff, patients and visitors, this includes safe hot water, cold water and drinking water.

The WSG provides assurance that areas with abnormal test results are identified and acted upon. Where risks are identified, action plans and mitigations are put in place ensuring that IP&C procedures are maintained and monitored and approval for changes in procedure are agreed and approved.

The last water quality audit was completed in September 2023 by the Trusts water authorised engineer. The audit reviewed *Legionella* and *Pseudomonas aeruginosa* management and control, including recording all relevant Practices Programmes, ongoing operational procedures, extent of management responsibility, risk management and control, in line with the following standards:

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

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

The audit identified that improvements have been seen across the areas of the audit, however, more work is needed in the pre-planned maintenance schedules and action plans are in place across the NNUH sites to improve testing and maintenance, these include the increase in

pseudomonas testing, increasing the numbers of sentinel points that are tested across areas including the accommodation block (some of which require contractual changes) continued monitoring of hot and cold water and particularly in summer and sampling of drinking water across areas (which is currently not undertaken).

NNUH *Legionella* Testing report

A Trust wide report is completed on a monthly basis providing assurance on legionella testing and outcomes of testing. The report is shared and presented to HICC.

Pseudomonas Testing

The monthly meetings provide assurance from facility companies that water testing is carried out in appropriate areas of augmented care on a scheduled basis and actions taken where results identify cause for concern. This is in the fixture of filters and further investigation as to the cause of the concern. Once repeat results are satisfactory and after remedial action removal of filters can be considered.

Results of testing have led to an increase in the use of filters from February 24 to May 24 across the Trust. Investigations are taking place to understand if any of the causes are due to aged pipework, poor sink etiquette, the thermoplastic pipework becoming brittle or the jointing compound suitability used on the pipework. Initial works will commence within the delivery suite.

Flushing Reports

Any unused water outlets should be flushed on a regular basis to avoid water contamination from the growth of harmful bacteria that grow in stagnant water.

Unused outlets are identified to the facilities team by Divisional staff and flushing compliance monitored through Divisional Governance meetings and the WSG meeting.

Within NNUH, Serco Domestic staff flush water outlets that are in regular use during cleaning routinely. Unused water outlets within ward areas and outpatient clinical areas are identified by Trust staff and communicated to Serco to ensure they are included in the flushing schedule.

Offsite clinic areas hosted by NNUH and water safety

There are over 50 off site areas used by NNUH staff to host clinics for patients. Facility providers of offsite NNUH units present water safety updates to the Water safety meeting on a monthly basis.

Work is in progress to ensure that assurance is gained from all offsite areas.

Water Safety Risks

All water risks are monitored through the corporate risk review meeting to ensure that mitigations and actions are in place to ensure safety of water for our patients, visitors and staff.

Infection Prevention and Control Annual Report 2023-24

Table 1 – Water Risks on Register							
ID	Opened	Title	Current	Potential Cause (If)	Potential Effect (Then)	Potential Consequence (Resulting in)	Target
876	09/2019	Risk of *Pseudomonas* cross infection	4	If *Pseudomonas* is isolated in the water supply on Neonatal Intensive Care Unit (NICU)	Then there is a risk of cross contamination to babies	Resulting in significant harm	4
Controls in place		1) Enhanced frequency of water testing 2) Use of Point of Use (POU) filters on taps 3) Fixed cleanable screens fitted between sinks and incubators 4) IP&C policies and procedures - Use of Personal Protective Equipment (PPE) - Hand washing protocols - IP&C Perfect Ward Audits 5) Sinks in bays used for handwashing only (not personal cares)					
1130	05/2020	Replacement of existing taps to model able to accept POU filters for water hygiene control	5	If there is a shortage of taps within the Trust and availability is not good from suppliers	Then there could be a shortage of taps which are able to accept POU in high-risk patient areas (Augmented care)	Resulting in the risk of compromised water hygiene	5
Controls in place		1) We are currently holding enough POU in stock to serve 2 wards.					
2093	08/2022	Legionella in water outlets across the Trust	5	If Legionella is isolated in the water supply	Then there is a risk of infection to patients and staff	Resulting in significant harm to both patients and staff	5
Controls in place		1) Rolling programme of water testing and ad-hoc if deemed appropriate by IP&C team. 2) Use of POU filters on taps where appropriate (where test positive). 3) Isolation of taps where POU are not possible. 4) Markwik 21+ taps currently preferred tap for new installation or replacements. 5) Heat sanitisation where appropriate and available. 6) Temperature monitoring and control of water in place (below 20^{c} or above 60^{c} at source). 7) IP&C and facilities involved in design and commissioning of new buildings and renovations. 8) Education through mandatory training. 9) Water safety policies and procedures in place. 10) Cleaning of outlets according to HTM 04.01. 11) Flushing carried out for outlets not in use or that have been isolated.					

		12) Cleaners carry out regular draw offs from all outlets. 13) Authorised engineer appointed. 14) WSG formalised. 15) Planned maintenance of water tanks and calorifiers carried out.					
2341	05/2023	Risk of Mycobacterium abscessus infections related to water supply	5	If the water supplies within the trust become colonised with Mycobacterium abscessus	Then this could cause Mycobacterium abscessus infections in patients - of particularly concern are patients who are severely immuno-suppressed	Resulting in lung infection and in the worst case scenario, fatalities for those who are severely immuno-suppressed	5
Controls in place		1) Monitoring of new Mycobacterium abscessus to identify any concerns around hospital acquisition. 2) WSG to ensure that for all new builds, correct disinfection protocols are followed as part of the commissioning process, which includes sign off sheets in water safety plan.					
2028	06/2022	*Pseudomonas aeruginosa* in water outlets in augmented care areas	16	If *Pseudomonas* is isolated in the water supply in augmented care areas	Then there is a risk of cross contamination to patients	Resulting in significant harm	4
Controls in place		1) Regular frequency of water testing (3-6 monthly) and ad hoc if deemed appropriate by IP&C team. 2) Use of POU filters on taps where appropriate (where test positive). 3) Isolation of taps where POU are not possible. 4) Markwik 21+ taps currently preferred tap for new installation or replacements. 5) Heat sanitisation where appropriate and available. 6) Other remedial actions as appropriate. 7) 3 monthly heat sanitisation where appropriate (NICU). 8) Education through mandatory training and ad hoc re handwashing sinks. 9) Clear separation of handwashing sinks and other sinks. 10) Water safety policies and procedures in place. 11) Cleaning of outlets according to HTM 04.01. 12) Flushing carried out for outlets not in use or that have been isolated. 13) Cleaners carry out regular draw offs from all outlets. 14) Authorised engineer appointed. WSG formalised.					

Water Safety Incidents

There have been no recent water safety incidents.

Water safety training

Water safety training is crucial within the healthcare setting, all staff complete a section on Water training as part of IP&C mandatory training. Members of facilities working in areas related to water have enhanced training, as does the IP&C team, IP&C doctor and members of the WSG. The

Trust has an up-to-date Water Safety Plan approved by HICC and IP&C policies and protocols that are followed and audited re compliance to provide assurance of safety.

Emergency Response of Water safety

Responding to contamination events, such as detecting legionella have clear protocols and actions are led through the Emergency Preparedness Resilience and Response organisational framework.

Decontamination Committee

The Decontamination Committee oversee NNUH compliance with the Health and Social Care Act (2008) Code of Practice on the Prevention and Control of Infections and HTM 01-01, and 01-06.

In April 2023 a senior member of the IP&C team attended an external decontamination lead and responsibility course.

Decontamination Committee Report – provided by Chair of the Trust Decontamination Group

Audit and Governance

The 23-24 annual decontamination audit took place in December 2023 and this resulted in 3 x minor actions for correction. There were no major actions. The next audit is booked for September 2024, and this is a full reaccreditation audit which will be carried out on-site over approximately 4 days. There was a supplemental 'Extension to Scope' carried out off-site by SGS in February 2024 to incorporate 3 x replacement autoclaves and replacement Reverse Osmosis (RO) water supply into the Quality Management System.

Joint Advisory Group (JAG) accreditation audits (for flexible endoscope reprocessing) were carried out for the Endoscopy Decontamination Unit (EDU) and Quadrum Institute (QI) Decontamination Units during January 24 (IP&C) and May 24 Institute of Healthcare Engineering & Estates Management (IHEEM). Action plans for any corrective actions have been completed and forwarded to the JAG accreditation team.

The bi-monthly report on decontamination operational performance continues to be monitored by the Decontamination Committee Meeting to ensure full oversight.

Quadram Institute (QI) & EDU (N&N)

There have been no further problems with Mycobacteria but there have been occasional recent 'spikes' involving high Total Viable Counts (TVCs) and/or presumed pseudomonads on weekly water quality testing which has caused some disruption to processing. There are currently no adverse operational issues to report.

Operational highlights

The department workload has fluctuated considerably over recent weeks. The opening of the paediatric theatre development, NaNOC, additional weekend theatre working, endoscopy waiting list initiatives and additional weekend working in areas such as dermatology and Ear Nose and Throat (ENT) outpatients have created occasional backlogs. These have generally been quickly resolved.

Three replacement autoclaves were commissioned at the beginning of 2024 (see Audit and Governance above). These replaced original Getinge sterilizers which had been in place since the hospital opened and had been condemned from July 2023 during insurance inspections because of chamber cracks.

Risks

The logistics arrangements for supply and return to NaNOC are likely to become unsustainable when that unit is operating at full capacity. Various mitigating actions are currently being explored to offset the impact this could have on the Sterile Service Department (SSD) ability to keep this unit supplied effectively.

Discussions surrounding support for NaNOC2 are continuing. It will be essential to ensure that the SSD is resourced with the equipment, staffing and logistics to adequately service this area.

Remote decontamination audit awaiting completion.

Ventilation Committee Report – provided by Chair of the Trust Ventilation Group

The Trust appointed a ventilation Authorising Engineer in November 2023. They plan to conduct a ventilation audit for the trust in the summer of 2024. It can be noted that ductwork cleaning is undertaken as to planned preventative maintenance (PPM) requirement following Industry practice guidance. The cleaning of theatres and negative pressure side rooms is conducted as part of the established annual programs and in compliance with current legislation.

A condition survey which commenced two years ago, which includes ventilation. has been carried out alongside the Private Finance Initiative (PFI). The findings of this are now being worked through.

The newly established trust ventilation safety group is scheduled to meet on a quarterly basis, with the first meeting planned for April 2024.

Mandatory Surveillance of Healthcare Associated Infection to UK Health Security Agency

Clostridioides difficile infection (CDI)

In line with NHS England - NHS Standard Contract to minimise instances of *Clostridioides difficile* (*C. difficile*). Both hospital-onset healthcare associated (HOHA) and community-onset healthcare associated (COHA) *C. difficile* cases are required to be reported to UKHSA.

The C. *difficile* attribution for 2023-24 was 77 (HOHA and COHA).

Table 2 shows all C. *difficile* cases within NNUH 2023-24. Table 3 shows NNUH C. *difficile* figures (COHA & HOHA) compared to the East of England.

Hospital onset healthcare associated (HOHA): cases where specimen date is >2 days after current admission (where day of admission is 0)

Community onset healthcare associated (COHA): cases that occur in the community (or <2 days after admission) when the patient has been an inpatient in the trust reporting the case in the previous 28 days.

Infection Prevention and Control Annual Report 2023-24

Community onset indeterminate association: cases that occur in the community (or <2 days after admission) when the patient has been an inpatient in the trust reporting the case between 29 and 84 days prior to the specimen date.

Community onset community associated: cases that occur in the community (or <2 days after admission) when the patient has not been an inpatient in the trust reporting the case in the previous 84 days.

Table 2

NNUH *C. difficile* 2023-24 – number of cases

Financial Year	NNUH Objective	Community Origin (sampled before day 3)		Hospital Origin (Sampled on or after day 4)		Total
2023-24	77	COIA 16	COCA 97	HOHA 58	COHA 35	206
		113		Total 93 cases out of objective of 77. 59 cases had no lapses, leaving **34** with lapses in care.		
2022-23	83	COIA 28	COCA 103	HOHA 56	COHA 31	218
		131		Total 87 cases of which 68 had no lapses, leaving **19** with lapses in care.		
2021-22	57	COIA 31	COCA 121	HOHA 49	COHA 40	241
		152		Total 89 cases of which 66 had no lapses so not counting towards final objective, leaving **23** with lapses in care counting towards the objective.		

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

Table 3

UK Health Security Agency

Clostridium difficile

Count of healthcare associated cases per month

Trust Code	Acute Trust Name	Trajectory*	2023 April	May	June	July	August	September	October	November	December	2024 January	February	March	Total
RC9	Bedfordshire Hospitals NHS Foundation Trust	56	4	5	12	5	4	9	7	9	4	6	5	5	75
RGT	Cambridge University Hospitals NHS Foundation Trust	109	6	4	12	12	16	9	13	15	10	8	16	21	142
RWH	East & North Hertfordshire NHS Trust	58	6	10	10	7	7	5	10	6	7	12	4	7	91
RDE	East Suffolk and North Essex NHS Foundation Trust	101	5	9	11	8	14	9	18	8	7	8	11	12	120
RGP	James Paget University Hospitals NHS Foundation Trust	26	0	3	3	2	0	3	2	0	1	2	5	3	24
RAJ	Mid and South Essex NHS Foundation Trust	174	22	22	21	20	25	19	10	19	13	18	19	28	236
RD8	Milton Keynes Hospital NHS Foundation Trust	13	5	6	6	3	3	4	1	5	3	3	6	3	48
RM1	Norfolk & Norwich University Hospitals NHS Foundation Trust	77	10	8	8	8	9	8	8	5	5	8	10	6	93
RGN	North West Anglia NHS Foundation Trust	100	14	13	11	7	12	13	8	14	7	14	9	17	139
RGM	Papworth Hospital NHS Foundation Trust	7	2	2	1	2	0	1	0	2	1	1	4	3	19
RQW	Princess Alexandra Hospital NHS Trust	34	3	4	1	6	5	2	5	7	2	4	3	7	49
RCX	The Queen Elizabeth Hospital King's Lynn NHS Trust	53	5	5	5	7	8	3	5	8	4	9	6	6	71
RWG	West Hertfordshire Hospitals NHS Trust	57	7	9	9	8	4	2	3	7	1	4	3	5	62
RGR	West Suffolk Hospitals NHS Trust	49	3	6	7	11	5	11	9	7	9	7	9	10	94
	East of England Total		**92**	**106**	**117**	**106**	**112**	**98**	**99**	**112**	**74**	**104**	**110**	**133**	**1263**

A thorough PIR investigation is completed for each hospital attributable CDI (HOHA and COHA) case using a standardised PIR process, datix and including the sharing of learning and good practice at governance meetings. The investigating group includes the clinical team responsible for the patient, Antimicrobial Pharmacist, Microbiologist, NNUH IP&C and a representative from

the ICB infection control team. At the meeting the decision is made whether there have been any lapses in care and it is an opportunity to share any learning for community partners.

Following PIR meetings with the ICB IP&C team, 6 COHA and 28 HOHA cases were reviewed as trajectory (with lapses in care) against an objective of 77 cases. 29 COHA and 30 HOHA cases were deemed non-trajectory (no lapses in care), see table 4.

Table 4

NNUH lapses in care identified from 28 HOHA and 6 COHA trajectory cases of *C. difficile 2023-24*	
Lapses	**Number of times lapse occurred**
Delay in isolation (placing in single room)	15
Delay in sampling	15
Inappropriate sampling	8
Gaps in stool chart	7
Period of Increased Incidence	6
Some trajectory cases had more than one lapse. Lapses are included in the learning outcomes.	

A weekly multidisciplinary team ward round of CDI patients is undertaken by a consultant microbiologist, member of the IP&C team, antimicrobial pharmacist and consultant gastroenterologist.

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

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

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

Treatment guidelines for CDI are in accordance with National Institute for Health and Care Excellence (NICE) guidance (July, 2021) the antibiotic Fidaxomicin is available on the NNUH formulary. For second line therapy of infection after discussion with Microbiology.

Glycopeptide-resistant Enterococcus (GRE) BSI

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

Enterococci are organisms that reside in the gastrointestinal tract. GRE are resistant to the Glycopeptide antibiotics Vancomycin and sometimes Teicoplanin.

There were 12 cases of GRE/Vancomycin Resistant Enterococcus (VRE) BSI in 2023-24.

Carbapenemase-producing Enterobacteriaceae (CPE)

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

Unless action is taken and lessons are learnt from experiences elsewhere in the world, rapid spread of CPE will pose an increasing threat to public health and medical treatment pathways in the UK. These resistant bacteria can spread rapidly in healthcare settings. (Freeman, R et al, 2020 as cited in UKHSA, 2022).

Table 5 indicates the number of positive CPE cases screened within the NNUH during 2023-24.

All known CPE positive patients are alerted within ICE desktop, the patient administration system (PAS) and within the IP&C team's ICNet surveillance system. The CPE policy has been updated to reflect the most recent UKHSA guidance published, September 2022. https://assets.publishing.service.gov.uk/media/63346c44d3bf7f34f1bc882d/Framework_of_actions_to_contain_CPE.pdf

Table 5

Carbapenemase-producing Enterobacteriaceae - Cases identified		
Financial Year	**New cases tested positive on admission**	**New positive cases**
2023-24	**4**	• 1x Screened due to hospital admission in London • 3x Screened due to hospital admissions in India, Egypt, South Africa
2022-23	**0**	• 1 new case identified. (Preadmission screening due to hospital admission in Sudan)
2021-22	**4**	• 2 x clinical samples • Screened due to hospital admission in Spain • Screened due to recent exposure to Tazocin

Gram-Negative Bacteraemia/BSI

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

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

The 2023-24 objectives set were inclusive of both COHA and HOHA cases and were reduced from the previous year's objectives as shown in table 6, 8 and 10.

Escherichia coli

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

The IP&C team developed a Standard Operating Procedure (SOP) to reduce Urinary tract infections and Gram-negative blood stream infections in 2019-20 and continue to work collaboratively to promote these resources in relation to urine sampling, mid-stream urine collection, hydration, patient information and catheter prevention. The IP&C team have been working collaboratively with IP&C colleagues, across the Norfolk and Waveney ICS, participating in workstreams to reduce Gram-negative bacteraemia, initially focussing upon *E. coli* urinary catheter infections.

The NNUH objective for 2023-24 was 91 inclusive of COHA and HOHA cases. 49.5% of the 103 Hospital origin *E. coli* BSI were considered to have a urinary tract primary focus, 16.5% had an unknown focus, 17.5% were considered hepatobiliary, 12.5% gastrointestinal or intraabdominal collection, lower respiratory tract 3%, skin/soft tissue 1%.

Table 6

NNUH *Escherichia coli* BSI – number of cases

Financial Year	NNUH Objective	Community Origin	Hospital Origin	Total
2023-24	**91**	**242 COCA**	**103 (49 HOHA & 54 COHA)**	**345**
2022-23	96	214 COCA	92 (49 HOHA & 43 COHA)	306
2021-22	119	283 COCA	99 (51 HOHA & 48 COHA)	382

Table 7

UK Health Security Agency

Escherichia coli

Count of healthcare associated cases per month

Trust Code	Acute Trust Name	Trajectory*	2023 April	May	June	July	August	September	October	November	December	2024 January	February	March	Total
RC9	Bedfordshire Hospitals NHS Foundation Trust	60	6	6	6	13	6	12	7	6	4	5	6	6	**83**
RGT	Cambridge University Hospitals NHS Foundation Trust	149	19	16	12	19	10	11	18	17	17	21	9	14	**183**
RWH	East & North Hertfordshire NHS Trust	44	1	3	6	7	7	2	6	4	7	3	8	3	**57**
RDE	East Suffolk and North Essex NHS Foundation Trust	113	12	10	9	26	9	11	12	15	16	16	10	16	**162**
RGP	James Paget University Hospitals NHS Foundation Trust	52	2	2	7	6	7	7	3	7	2	2	3	8	**56**
RAJ	Mid and South Essex NHS Foundation Trust	208	24	17	17	24	15	19	21	12	17	16	23	25	**230**
RD8	Milton Keynes Hospital NHS Foundation Trust	27	7	2	1	7	6	4	6	6	6	5	5	4	**59**
RM1	Norfolk & Norwich University Hospitals NHS Foundation Trust	91	8	11	9	4	10	13	10	10	7	5	5	11	**103**
RGN	North West Anglia NHS Foundation Trust	70	5	12	9	8	4	12	8	1	8	7	7	8	**89**
RGM	Papworth Hospital NHS Foundation Trust	5	0	1	0	2	1	1	0	0	1	1	0	2	**9**
RQW	Princess Alexandra Hospital NHS Trust	33	2	5	5	7	4	4	8	1	3	4	3	7	**53**
RCX	The Queen Elizabeth Hospital King's Lynn NHS Trust	49	8	10	3	6	9	4	3	7	2	7	5	3	**67**
RWG	West Hertfordshire Hospitals NHS Trust	61	3	8	6	7	9	7	7	5	8	8	9	6	**83**
RGR	West Suffolk Hospitals NHS Trust	34	4	3	7	3	6	6	5	5	5	6	3	6	**59**
	East of England Total		**101**	**106**	**97**	**139**	**103**	**113**	**114**	**96**	**103**	**106**	**96**	**119**	**1293**

Klebsiella species

The IP&C team undertake surveillance investigation of hospital origin Gram-negative BSI. The NNUH objective for Klebsiella in 2023-24 was 24, inclusive of COHA and HOHA cases. Of the 56 Hospital origin *Klebsiella species* BSI, 25% were considered urinary tract, 34% had an unknown primary focus, 14.2% Gastrointestinal or Intraabdominal collection, 9% hepatobiliary, 7% Lower Respiratory Tract, 3.6% Bone and joint, 3.6% Skin/Soft Tissue, 3.6% Intravascular device.

Table 8

NNUH *Klebsiella species* BSI – number of cases				
Financial Year	**NNUH Objective**	**Community Origin**	**Hospital Origin**	**Total**
2023-24	**24**	**75 COCA**	**56 (41 HOHA, 15 COHA)**	**131**
2022-23	48	45 COCA	27 (21 HOHA, 6 COHA)	72
2021-22	25	73 COCA	40 (28 HOHA, 12 COHA)	113

Table 9

UK Health Security Agency

Klebsiella spp.

Count of healthcare associated cases per month

Trust Code	Acute Trust Name	Trajectory*	2023 April	May	June	July	August	September	October	November	December	2024 January	February	March	Total
RC9	Bedfordshire Hospitals NHS Foundation Trust	16	5	2	1	5	3	3	4	1	5	3	1	1	**34**
RGT	Cambridge University Hospitals NHS Foundation Trust	71	4	9	4	9	11	6	18	12	11	8	11	9	**112**
RWH	East & North Hertfordshire NHS Trust	18	0	2	3	2	2	1	4	3	0	2	2	1	**22**
RDE	East Suffolk and North Essex NHS Foundation Trust	36	4	5	6	3	3	5	4	2	10	5	6	1	**54**
RGP	James Paget University Hospitals NHS Foundation Trust	28	1	3	4	4	4	3	4	2	3	2	2	6	**38**
RAJ	Mid and South Essex NHS Foundation Trust	84	10	8	16	6	7	7	11	16	11	12	17	15	**136**
RD8	Milton Keynes Hospital NHS Foundation Trust	14	0	1	1	3	1	2	2	1	2	3	1	1	**18**
RM1	Norfolk & Norwich University Hospitals NHS Foundation Trust	24	4	2	6	10	3	5	6	5	5	4	1	5	**56**
RGN	North West Anglia NHS Foundation Trust	34	2	3	2	2	0	5	2	1	2	4	3	1	**27**
RGM	Papworth Hospital NHS Foundation Trust	10	1	2	1	0	0	1	2	1	0	1	0	0	**9**
RQW	Princess Alexandra Hospital NHS Trust	16	2	2	1	0	3	2	1	3	2	3	2	1	**22**
RCX	The Queen Elizabeth Hospital King's Lynn NHS Trust	20	1	5	0	3	4	5	2	0	0	2	4	3	**29**
RWG	West Hertfordshire Hospitals NHS Trust	32	5	8	6	1	2	2	4	4	5	3	3	5	**48**
RGR	West Suffolk Hospitals NHS Trust	10	2	1	2	1	2	2	2	1	1	3	4	2	**23**
	East of England Total		**41**	**54**	**53**	**49**	**45**	**49**	**66**	**52**	**57**	**55**	**57**	**51**	**629**

Pseudomonas aeruginosa

The NNUH objective for Pseudomonas in 2023-24 was 29, inclusive of COHA and HOHA cases.

Following investigation by the IP&C team 23% of the 30 Hospital origin *Pseudomonas* BSI, were considered to have a primary focus of urinary tract, 30% had an unknown focus, 10% were considered hepatobiliary, 14% Lower Respiratory Tract, 3% intravascular device and 20% skin/soft tissue.

Table 10

NNUH *Pseudomonas aeruginosa* BSI – number of cases				
Financial Year	**NNUH Objective**	**Community Origin**	**Hospital Origin**	**Total**
2023-24	**29**	**26 COCA**	**30 (18 HOHA & 12 COHA)**	**56**
2022-23	26	27 COCA	18 (10 HOHA & 8 COHA)	45
2021-22	24	21 COCA	29 (17 HOHA & 12 COHA)	50

Table 11

UK Health Security Agency

Pseudomonas aeruginosa

Count of healthcare associated cases per month

Trust Code	Acute Trust Name	Trajectory*	2023 April	May	June	July	August	September	October	November	December	2024 January	February	March	Total
RC9	Bedfordshire Hospitals NHS Foundation Trust	12	1	2	2	1	1	2	0	0	3	1	0	0	13
RGT	Cambridge University Hospitals NHS Foundation Trust	36	0	5	5	3	5	4	10	3	2	4	5	2	48
RWH	East & North Hertfordshire NHS Trust	10	2	2	0	0	0	1	1	1	0	1	0	4	12
RDE	East Suffolk and North Essex NHS Foundation Trust	19	3	4	4	0	0	2	6	1	1	4	4	6	35
RGP	James Paget University Hospitals NHS Foundation Trust	9	0	1	2	1	1	1	1	0	0	1	1	2	11
RAJ	Mid and South Essex NHS Foundation Trust	45	4	5	5	3	4	5	8	2	3	5	7	1	52
RD8	Milton Keynes Hospital NHS Foundation Trust	9	0	1	2	1	1	1	2	2	0	0	1	0	11
RM1	Norfolk & Norwich University Hospitals NHS Foundation Trust	19	2	1	2	5	3	4	1	3	3	2	3	1	30
RGN	North West Anglia NHS Foundation Trust	15	1	0	1	0	1	2	1	3	2	2	0	0	13
RGM	Papworth Hospital NHS Foundation Trust	3	0	0	0	0	0	0	0	0	1	0	1	0	2
RQW	Princess Alexandra Hospital NHS Trust	4	0	1	1	1	1	1	2	1	1	0	0	0	9
RCX	The Queen Elizabeth Hospital King's Lynn NHS Trust	8	2	1	1	2	1	0	2	3	0	1	3	0	16
RWG	West Hertfordshire Hospitals NHS Trust	11	2	1	2	1	5	2	2	2	3	1	3	4	28
RGR	West Suffolk Hospitals NHS Trust	3	0	1	2	1	1	2	0	0	1	0	1	1	10
	East of England Total		17	25	29	19	24	27	36	21	20	22	29	21	290

Meticillin Susceptible and Meticillin Resistant *Staphylococcus aureus*

The bacterium *Staphylococcus aureus* is commonly found colonising the skin and mucous membranes of the nose and throat. It can cause a wide range of infections from minor boils to serious wound infections; however, most people carry this organism harmlessly. In hospitals, it can cause surgical wound infections and bloodstream infections. Mandatory reporting includes all isolates, whether true infections or contaminated blood cultures and will initially be attributed to the Trust if the positive specimen is taken on or after day 2 of admission (where day of admission is 0).

Meticillin Susceptible *Staphylococcus aureus* (MSSA)

There remains no national objective currently for MSSA. Table 12 shows NNUH comparative figures years 2021-2022 until current 2023-2024. Table 13 shows NNUH count of healthcare associated cases per month comparatively to other organisations within the country.

57% of MSSA BSI were of community origin. Of the 44 hospital origin, 37% had an unknown primary focus, 32% with a skin and soft tissue primary focus, 2% urinary tract, 5% intravascular device, 11% respiratory infection, 11% bone/joint 2% aortic root abscess.

Table 12

NNUH Meticillin Susceptible Staphylococcus aureus BSI - number of cases			
Financial Year	**Community Origin**	**Hospital Origin on or after day 3**	**Total**
2023-24	**58 COCA**	**44 (38 HOHA & 6 COHA)**	**102**
2022-23	74 COCA	41 (35 HOHA & 6 COHA)	115
2021-22	73 COCA	38 (30 HOHA & 8 COHA)	111

Table 13

UK Health Security Agency

Methicillin-sensitive Staphylococcus aureus

Count of healthcare associated cases per month

Trust Code	Acute Trust Name	Trajectory*	2023 April	May	June	July	August	September	October	November	December	2024 January	February	March	Total
RC9	Bedfordshire Hospitals NHS Foundation Trust	N/A	2	3	3	7	5	3	2	5	2	1	5	0	**38**
RGT	Cambridge University Hospitals NHS Foundation Trust	N/A	3	7	1	3	2	6	5	9	4	9	7	4	**60**
RWH	East & North Hertfordshire NHS Trust	N/A	1	1	3	2	2	1	5	1	3	2	2	2	**25**
RDE	East Suffolk and North Essex NHS Foundation Trust	N/A	2	6	2	3	5	2	6	5	8	11	8	2	**60**
RGP	James Paget University Hospitals NHS Foundation Trust	N/A	3	1	2	5	1	3	1	1	0	0	2	2	**21**
RAJ	Mid and South Essex NHS Foundation Trust	N/A	9	13	9	10	12	9	11	14	10	2	3	9	**111**
RD8	Milton Keynes Hospital NHS Foundation Trust	N/A	3	0	2	2	1	3	4	2	0	1	1	2	**21**
RM1	Norfolk & Norwich University Hospitals NHS Foundation Trust	N/A	6	4	2	4	4	3	3	3	3	6	4	2	**44**
RGN	North West Anglia NHS Foundation Trust	N/A	0	3	3	3	4	5	2	2	2	2	3	3	**32**
RGM	Papworth Hospital NHS Foundation Trust	N/A	0	0	1	0	0	0	0	0	1	1	1	1	**5**
RQW	Princess Alexandra Hospital NHS Trust	N/A	3	1	0	1	1	2	0	0	2	2	0	0	**12**
RCX	The Queen Elizabeth Hospital King's Lynn NHS Trust	N/A	2	1	3	3	2	0	1	3	1	4	2	1	**23**
RWG	West Hertfordshire Hospitals NHS Trust	N/A	4	9	5	3	1	5	3	7	0	3	1	1	**42**
RGR	West Suffolk Hospitals NHS Trust	N/A	2	3	3	2	2	4	1	4	2	2	3	3	**31**
	East of England Total		**40**	**52**	**39**	**48**	**42**	**46**	**44**	**56**	**38**	**46**	**42**	**32**	**525**

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

Meticillin Resistant *Staphylococcus aureus* (MRSA)

All *Staphylococcus aureus* BSI are reported. They are categorised according to their resistance to antibiotics and are then reported separately as MSSA and MRSA. Surveillance and reporting of MRSA BSI continues with the limit set at 0 avoidable cases.

Table 14 shows NNUH comparative figures years 2021-2022 until current 2023-2024.
Table 15 shows NNUH count of healthcare associated cases per month comparatively to other organisations within the country.

There was one hospital origin MRSA BSI during 2023-24. This was classified as a healthcare associated bacteraemia by definition, due to collection of the blood culture 48 hours post admission. However, it was acknowledged upon case review with the ICB that the bacteraemia was due to a predisposing medical condition, present prior to admission and therefore truly a community acquired infection.

Table 14

NNUH MRSA BSI - number of cases				
Financial Year	**NNUH objective**	**Community Origin**	**Hospital Origin (on or after day 3)**	**Total**
2023-24	**0**	**1**	**1**	**2**
2022-23	0	0	0	0
2021-22	0	2	1	3

Table 15

UK Health Security Agency

Methicillin-resistant Staphylococcus aureus

Count of healthcare associated cases per month

Trust Code	Acute Trust Name	Trajectory*	2023 April	May	June	July	August	September	October	November	December	2024 January	February	March	Total
RC9	Bedfordshire Hospitals NHS Foundation Trust	N/A	0	0	1	0	0	0	1	0	0	0	2	0	4
RGT	Cambridge University Hospitals NHS Foundation Trust	N/A	2	0	1	1	2	0	0	0	0	1	0	1	8
RWH	East & North Hertfordshire NHS Trust	N/A	1	0	0	0	0	0	0	1	0	0	0	0	2
RDE	East Suffolk and North Essex NHS Foundation Trust	N/A	0	0	0	1	1	0	1	0	1	2	0	1	7
RGP	James Paget University Hospitals NHS Foundation Trust	N/A	0	0	0	0	0	0	0	0	0	0	0	0	0
RAJ	Mid and South Essex NHS Foundation Trust	N/A	3	1	4	1	0	2	2	3	2	6	2	1	27
RD8	Milton Keynes Hospital NHS Foundation Trust	N/A	0	0	0	0	0	0	0	0	0	0	0	0	0
RM1	Norfolk & Norwich University Hospitals NHS Foundation Trust	N/A	0	0	0	0	0	1	0	0	0	0	0	0	1
RGN	North West Anglia NHS Foundation Trust	N/A	0	0	0	0	1	1	0	1	0	0	0	0	3
RGM	Papworth Hospital NHS Foundation Trust	N/A	0	1	0	0	0	0	0	0	0	0	0	0	1
RQW	Princess Alexandra Hospital NHS Trust	N/A	0	0	1	0	0	0	0	0	0	0	0	0	1
RCX	The Queen Elizabeth Hospital King's Lynn NHS Trust	N/A	0	0	0	0	0	0	0	0	0	0	0	0	0
RWG	West Hertfordshire Hospitals NHS Trust	N/A	1	0	0	0	0	0	1	0	1	1	0	1	5
RGR	West Suffolk Hospitals NHS Trust	N/A	0	0	0	0	0	0	0	0	0	0	0	0	0
	East of England Total		**7**	**2**	**7**	**3**	**4**	**4**	**5**	**5**	**4**	**10**	**4**	**4**	**59**

Audit Programme

Throughout the year, the IP&C team provided assistance with a range of audits, including those related to hand hygiene, commodes, mattresses, environmental factors, isolation rooms, and the auditing of indwelling devices such as cannulas, urinary catheters, and central venous catheters.

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

Staff undertake monthly High Impact Intervention audits within their departments of peripheral cannula, urinary catheter, central venous catheter, and ventilator associated pneumonia care bundle practice. Peer auditing is encouraged, and results are fed back in divisional reports at HICC.

In each area staff undertake weekly Tendable IP&C audits using handheld devices. This inspection application provides an opportunity to record photographs and comments to evidence decisions made. There are also IP&C questions within the daily safety check audit; Results and reports are available on completion and provide performance comparisons and trends across individual areas, divisions, and the Trust as a whole. Staff are required to act on any learning from these audits to continually drive improvement.

Infection Prevention and Control Annual Report 2023-24

Audit results are also shared with clinical areas and at HICC and can be accessed via the intranet on the IP&C electronic dashboard where they can be viewed by individual area, division, or whole trust. See Chart 5 below. The IP&C team have worked collaboratively with the digital team and representatives from each division to compile the HICC dashboard. This means that all automated electronic data necessary for reporting at HICC is consolidated in a single location.

Chart 5

Audit results Dashboard March 2023

			YTD	Quarter				2023									2024		
		22/23	23/24	1	2	3	4	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
IP&C Audits																			
Commode	Number Pass	1772	1781	443	380	384	574	119	165	159	117	127	136	120	134	130	127	250	197
	Number Fail	175	179	25	53	40	61	7	8	10	10	26	17	7	22	11	20	24	17
	% Pass	91%	91%	95%	88%	91%	90%	94%	95%	94%	92%	83%	89%	94%	86%	92%	86%	91%	92%
Bed Pans	Number Pass	2146	2059	467	433	458	701	124	176	167	118	164	151	151	150	157	172	327	202
	Number Fail	67	48	9	19	12	8	5	3	1	2	11	6	4	4	4	1	1	6
	% Pass	97%	98%	98%	96%	97%	99%	96%	98%	99%	98%	94%	96%	97%	97%	98%	99%	100%	97%
Hand Hygiene (HH) & Dress Code (DC)	No of audits	1047	1019	263	225	267	264	74	83	106	56	65	104	91	67	109	77	101	86
	Staff Audited	9336	8676	2221	1806	2312	2337	644	735	842	484	512	810	820	630	862	674	889	774
	HH Pass %	96%	97%	98%	97%	97%	97%	98%	98%	98%	97%	97%	97%	97%	97%	98%	96%	97%	97%
	DC Pass %	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	100%	98%	99%	99%
High Impact Intervention Audits																			
HII 1 Central Venous Catheter	Insertion Obs	1260	1545	315	285	485	460	110	105	100	120	125	40	165	110	210	180	135	145
	Pass %	99%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Ongoing obs	6016	6161	1613	1624	1457	1467	501	569	543	581	527	516	422	526	509	512	388	567
	Pass %	93%	90%	89%	89%	93%	88%	86%	90%	91%	91%	89%	86%	92%	92%	93%	91%	90%	85%
HII 2 Peripheral Intravenous Cannula	Insertion Obs	13080	13924	3530	3575	3374	3445	1065	1270	1195	1175	1265	1135	1134	1080	1160	1210	1090	1145
	Pass %	98%	98%	98%	98%	97%	98%	96%	99%	97%	98%	98%	97%	97%	96%	97%	97%	98%	99%
	Ongoing obs	12167	13372	3446	3389	3296	3241	1195	1138	1113	1051	1197	1141	1145	1127	1024	1157	1022	1062
	Pass %	90%	89%	87%	89%	89%	90%	85%	89%	88%	87%	90%	88%	87%	88%	90%	91%	87%	92%
HII 5 Ventilated patients	Obs	685	747	217	180	239	111	81	67	69	81	55	44	99	72	68	65	10	36
	Pass %	98%	98%	97%	98%	99%	100%	96%	99%	97%	96%	100%	98%	98%	100%	100%	100%	100%	100%
HII 6 Urinary catheter	Insertion Obs	4004	4920	1272	1204	1200	1244	380	452	440	400	424	380	396	484	320	436	412	396
	Pass %	98%	94%	93%	93%	93%	96%	95%	91%	94%	96%	91%	92%	92%	93%	95%	95%	94%	99%
	Ongoing obs	10263	12209	3170	3116	3028	2895	1058	1073	1039	1050	1074	992	1081	1028	919	1112	917	866
	Pass %	90%	90%	89%	90%	89%	92%	90%	88%	89%	90%	91%	89%	92%	89%	86%	93%	91%	93%

Staff Training and Supervision

Whilst the mandatory e-learning package has continued to be in place, and some training remains on Teams, the IP&C team take the opportunity to deliver training face to face whenever possible and participate in regular training for healthcare assistants, volunteers, overseas colleagues, and corporate induction. The team also provide bespoke training for departments upon request and have attended divisional study days for areas such as older peoples medicine (Image 4 & 5).

The team also encourage colleagues from across the organisation to spend time with them to gain a greater understanding of the role and how increased IP&C knowledge can support daily with quality and safety of patients.

The IP&C Team continued to support clinical teams across the organisation including those wards on supportive measures for a period of increased incidence.

IP&C took part in the Junior Doctor induction which encompassed hand hygiene, infection prevention and control in practice and multi drug resistant organisms, Image 6.

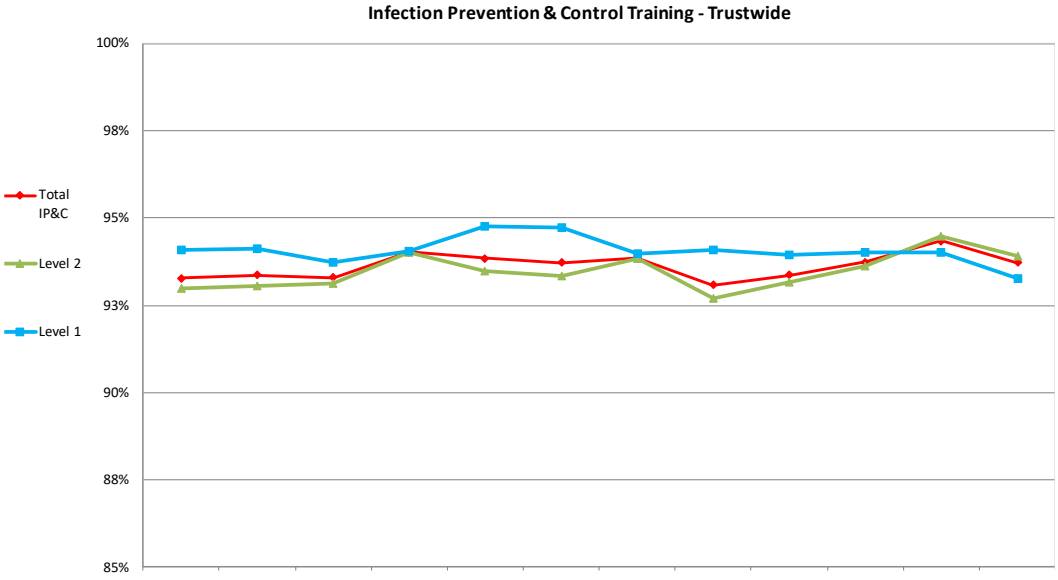
Trust overall IP&C mandatory compliance was between 93% and 95% (see Graph 1).

Image 4

Image 5

Image 6

Graph 1



IP&C Level	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Level 1	94.1%	94.1%	93.7%	94.1%	94.8%	94.7%	94.0%	94.1%	93.9%	94.0%	94.0%	93.3%
Level 2	93.0%	93.1%	93.1%	94.0%	93.5%	93.3%	93.8%	92.7%	93.2%	93.6%	94.5%	93.9%
Total IP&C	**93.3%**	**93.4%**	**93.3%**	**94.0%**	**93.9%**	**93.7%**	**93.9%**	**93.1%**	**93.4%**	**93.7%**	**94.3%**	**93.7%**

Compliance % figures exclude Honorary, Locums and Bank staff

University of East Anglia (UEA) Healthcare student training

Students are encouraged to spend time with the IP&C team. Whilst on placement nursing students joined the team to gain a greater understanding of the principles of IP&C and the diverse role of the team and how this supports the NNUH and wider healthcare systems.

IP&C team training

The IP&C team have taken advantage of numerous opportunities to engage in internal and external development opportunities, in the form of a postgraduate diploma, leadership opportunities, webinars, and conferences. These provide a great opportunity to hear from leading experts in their fields and engage with fellow IP&C colleagues from across the East of England region, and NHSE/I, enabling networking and learning.

Hand Hygiene Day

The 5th May 2023 marked the annual World Hand Hygiene Day, with both NNUH and Cromer Hospital actively participating in the event. This year's theme focused upon maintaining healthy hands along with the reduction of inappropriate glove use. The IP&C team were joined by the

Trust's sustainability manager recognising that appropriate glove use can reduce the transmission of organisms and infection whilst supporting the Net Zero National Health Service strategy. Staff and visitors alike interacted with the IP&C team.

Image 7 and 8 show the presentations provided within each hospital.

Image 7

Image 8

Image 9

SC Johnson (hand sanitiser provider) also attended, visiting various areas and reinforcing the need to use the right technique and compliance with the WHO 5 moments when decontaminating hands. https://cdn.who.int/media/docs/default-source/integrated-health-services-(ihs)/infection-prevention-and-control/your-5-moments-for-hand-hygiene-poster.pdf?sfvrsn=83e2fb0e_21

IP&C International awareness week

IP&C Awareness Week is an annual event which is typically conducted each October.

During 2023, due to participation in the national Point Prevalence Survey (PPS) of healthcare associated infections, antimicrobial use and antimicrobial stewardship in England, the team was unable to proceed with this in the usual manner. However, the IP&C team and pharmacy colleagues were visible across the NNUH at this time enabling them to offer support and education to their peers during their visits to various areas, while also gathering the necessary information for the survey.

Additional information pertaining to the PPS can be found in Criteria 3 on page 43 of the report.

IP&C link practitioners

The IP&C team continued to provide support to the IP&C link practitioners in the Trust during 2023-24.

Meetings took place throughout the year with a variety of topics covered. These were attended by IP&C link practitioners from across the organisation, who were encouraged to use these hours towards their Continuing Professional Development (CPD). Refer to Table 16 for an overview of the meeting agendas. Image 10 is an example of the meeting poster which was circulated to staff members and Image 11 is a guest speaker from 3M delivering a presentation to the IP&C link practitioners on CVC/PVD dressings, VIP scores and protecting the skin.

Infection Prevention and Control Annual Report 2023-24

Table 16	
IP&C Link Practitioner meetings 2023-24	
Date	**Agenda**
22nd June 2023	• Highlights from conference • Covid testing and isolation • General overview of TB • Catheter care and how it impacts on gram negative • CPE presentation
20th September 2023	• IP&C Interactive question and answers • Hand Hygiene • Uploading an LFT on ICE Suspected infectious diarrhoea Clinell Wipes • Cohort Isolation management • Stool charting on admission
14th December 2023	• What does the role of IP&C link practitioner mean to you? How can we improve the experience? • Keeping you up to date on national and local IP&C issues • NNUH Gloves off initiative • CVC/PVD dressings, VIP scores and protecting the skin
21st March 2024	• Norovirus – Latest increase and common themes • IP&C Support Workers • IP&C Sampling • Reusable Tourniquets • IP&C Interactive Q&A

Image 10

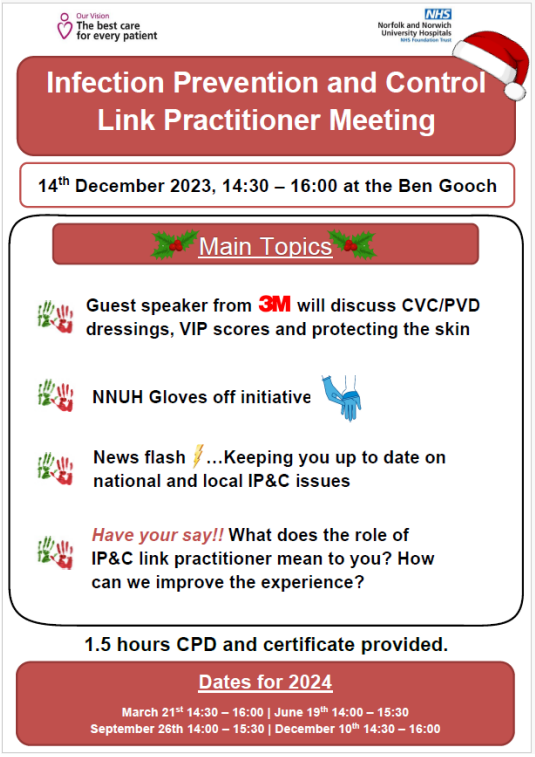
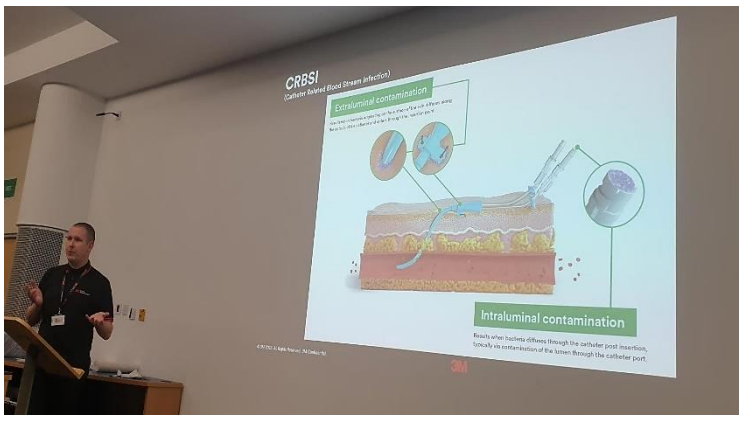


Image 11



Organisation Wide Learning (OWL)

The IP&C team continues to produce monthly organisational wide learning (OWL). The OWL is sent out in the form of a poster, sharing Trust wide IP&C information on key issues and learning such as:

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

Examples of OWLs from the year are shown in Image 12 & 13.

Image 12

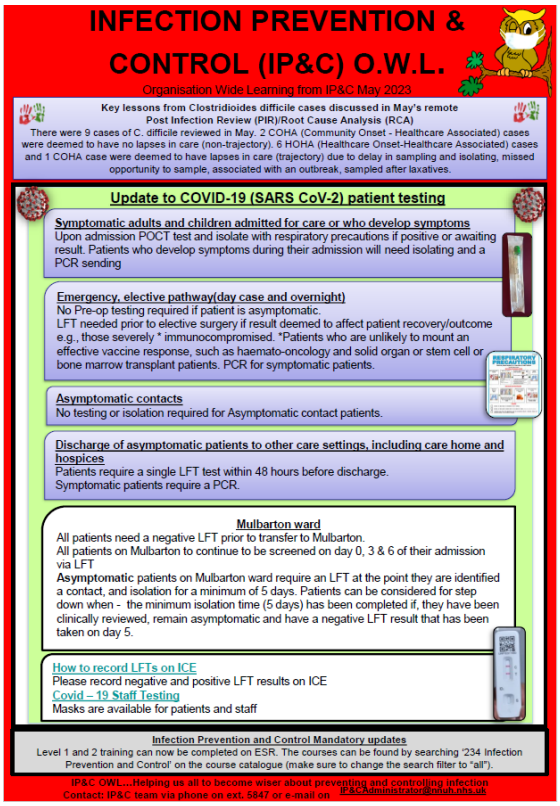
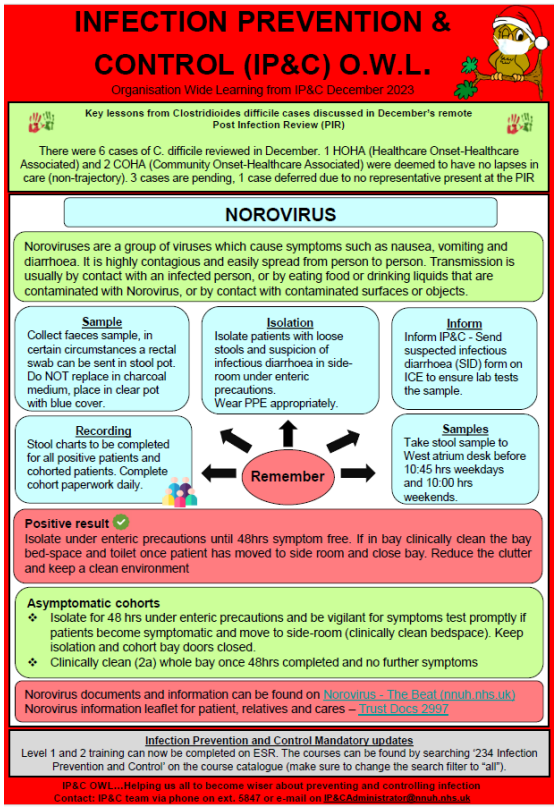


Image 13



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

Cleaning

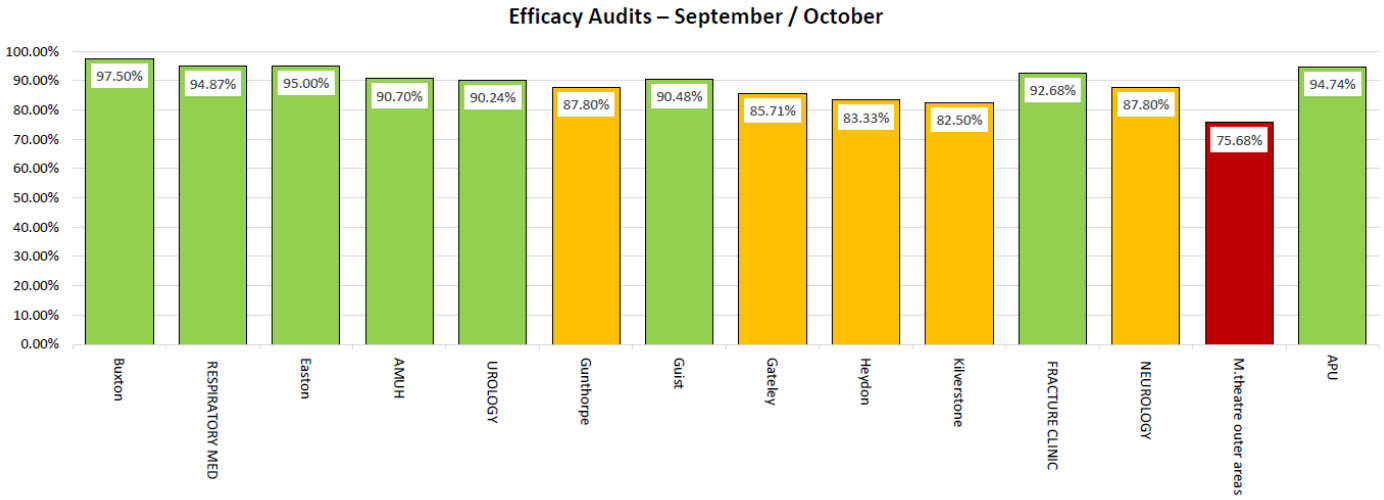
The IP&C team work in partnership to deliver a clean safe environment for patients. Cleaning schedules/charters are displayed in each area. The National Cleaning standards (2021) were implemented April 2022. All areas have been categorised in one of the 6 Functional risk categories and are reviewed according to need. A matrix of cleaning responsibilities remains in place, with commitment to the Cleanliness charter being made. Audits of all areas provide assurance and are displayed. Star ratings are in place in line with the national guidance.

Infection Prevention and Control Annual Report 2023-24

The IP&C team attend twice weekly efficacy audits undertaken at the NNUH, these are designed to assess the process of cleaning and infection control related to cleaning. The audit is carried out by a domestic manager, representatives from the facilities department, IP&C and clinical teams. Good practice is to report the findings from efficacy audits at executive level, to acknowledge good service, address poor service and drive continuous improvement. (National standards of healthcare cleanliness, 2021).

Table 17 illustrates within the NNUH how the audit is scored and results shared within the auditing group and at HICC.

Table 17



Cleaning Audits

Cleaning of the environment, equipment and estates are monitored through regular joint audits attended by both Trust and Provider staff using Facilities Management (FM) First software. See Tables 22, 23 & 24.

During the referred period, Healthcare Cleaning Services underwent a transition on several levels. The implementation of a new Computer Aided Facilities Management System along with the retirement of the Service Lead, who had a huge impact in shaping Domestic Operations on NNUH, are amongst some of the changes felt in 2023-24.

The team's knowledge, administration, deployment strategies, and resolve, were put to the test to a new extent by the pressures resulting from the volume of additional patients on the wards and the high number of clinical cleans that were necessary under Winter Pressures.

The FM specialist for Cleaning and the Operations Team on Site were inspired to design, develop, and begin delivering a new training methodology (Playbook Training) in response to the challenges presented by the new National Standards of Healthcare Cleanliness 2021 and the implementation of Efficacy Audits. This initiative will have a significant impact on the way training is delivered and the skillset that is embedded on regular operations and frequencies for years to come.

The Domestic team has also tested and put into use new cleaning equipment, that is far more effective than what was previously in place, improving cleanliness and efficiencies. As part of a larger plan, the team will also replace the outdated vacuum cleaner fleet and a reliable, albeit aging medium scrubber/dryer with the newest technology, optimizing efficiency, whilst meeting infection control regulations.

While lower than in prior years, the period saw high volumes of reactive cleaning requests that trended above the 5-year average and above pre-pandemic levels, see Graph 2.

Table 18 - NNUH audit scores

Functional risk	2022-2023		2023-2024		Target
	Number of audits	Average score	Number of audits	Average score	
FR 1	1920	98.98%	2106	98.97%	98%
FR 2	635	97.56%	673	96.97%	95%
FR 3	7	98.31%	6	96.23%	90%
FR 4	236	95.57%	218	94.95%	85%
FR 5	63	95.43%	43	93.40%	80%

Table 19 - Cromer Hospital audit scores

Functional risk	2022-2023		2023-2024		Target
	Number of audits	Average score	Number of audits	Average score	
FR 1	175	96.64%	220	98.01%	98%
FR 2	109	95.25%	84	92.28%	95%
FR 3	0	N/A	0	N/A	90%
FR 4	21	96.03%	46	87.08%	85%
FR 5	1	98%	2	100%	80%

Table 20 - Offsite areas audit scores
20 Rouen Road, Cotman Centre, Eye Clinic, Francis Medical Records

Functional risk	2022-2023		2023-2024		Target
	Number of audits	Average score	Number of audits	Average score	
FR 1	12	99.73%	84	99.79%	98%
FR 2	180	99.07%	84	98.74%	95%

Graph 2

Patient led, focus on the environment (PLACE)

The national PLACE Assessment results have been published. 1,106 assessments were undertaken nationally in 2023 compared to 1,046 in 2022. 37 assessments were excluded due to patient assessor numbers or ratio to staff assessors not meeting the minimum criteria. National findings are based on the 1069 remaining assessments and results are not comparable with previous years due to changes in methodology.

National averages for each domain are listed below:

- Cleanliness (acutes) – 98.1%
- Condition, appearance and maintenance (acutes) – 96.0%
- Dementia (acutes) – 81.5%
- Disability (acutes) – 83.4%
- Combined food (acutes) – 90.8%
- Organisation food (acutes) – 91.3%
- Ward food (acutes) – 90.8%
- Privacy, dignity and wellbeing (acutes) – 86.3%

The NNUH's results for each domain are listed below:

- Cleanliness – 96.04% (94.96% in 2022)
- Condition, appearance and maintenance – 92.68% (94.02% in 2022)
- Dementia – 71.97% (75.40% in 2022)
- Disability – 73.10% (76.67% in 2022)
- Combined food – 85.42% (79.87% in 2022)
- Organisational food – 98.96%
- Ward food – 82.41%
- Privacy, dignity and wellbeing – 71.82% (72.67% in 2022)

NHS England have advised that the results are not comparable with previous years. However, we have used the same data collection methods in 2022 and 2023 so as we continue to collect more data, we can start to compare scores going forward.

This year has seen an increase in our scores in cleanliness and ward food. However, we have seen a decrease in our scores for condition, appearance and maintenance, dementia, disability and privacy/dignity/wellbeing.

Our performance in comparison to the national scores is also lower than the median in all domains and in terms of the picture across the East of England our scores have fallen below the averages for the East of England in all domains except organisational food. For Norfolk & Waveney, our neighbouring Trusts scores scored higher than us except in organisation food scores.

We have lower scores across all domains apart from organisation food than other Trusts in Norfolk & Waveney, although data for other Trusts may not have been completely submitted at time of assessment.

The Patient Engagement & Experience Team, Estates and Facilities Team, Serco and Quality Improvement have been working together to look at the corrective action plans. The Estates & Facilities Team have shared the cleanliness and catering actions with wards to update on progress and help review the food actions. The Patient Engagement & Experience Team, Estates and Facilities Team and the Quality Improvement team have reviewed all corrective actions to identify trust wide themes which may require further support.

Report and Action Plans to be shared and monitored via Patient Engagement & Experience Governance Sub-Board (PEEG) and Estate/Facilities Governance and contract management routes. Overall results and updates will feed through to Hospital Management Board (HMB) and the Trust Board.

Commode and Bedpan Cleanliness

The IP&C support workers maintain a continuous programme of commode and bedpan audits Trust wide with practical training provided. See Table 21.

Table 21

Number of commodes audited and average percentage pass across NNUH sites		
Financial Year	**Total No. of Commodes audited**	**Percentage Pass**
2023-24	**1781**	**91%**
2022-23	1772	91%
2021-22	1837	87%
Scores of 0-49% result in a re-audit within 1 week, 50-74% within 2 weeks, and 75-99% within 3 weeks.		

Environmental Authority

The Environment Agency attended the NNUH to complete a Healthcare Waste Audit on the 8th of November 2023. The three inspectors were hosted by Trust Estates, Health and Safety Lead Advisor and a contingent from the soft FM provider.

The following actions were identified from the audit which centre around ensuring waste segregation, offensive waste, policy and checks on waste collectors and consignment notes.

Action 1

- Take measures to prevent and minimise paper hand towels being deposited into green bins for recycling by both colleagues and the public if they aren't able to be currently routed into that waste stream.
- Take measures to ensure paper hand towels are correctly coded depending on the source and use of the towels.
- Take measures to ensure paper hand towels are routed to waste facilities that can accept the relevant coded waste.
- Update Trust Waste Management Policy to remove hand towels from the recycling waste stream if they aren't able to be currently routed into that waste stream.

Action 2

- Review Trust waste management policy to consider the strategy target in the HTM 07-01 to introduce arrangements for the management of offensive waste streams.

Action 3

- Ensure the Trust use the correct consignment note format in line with the guidance provided on GOV.UK.

Action 4

- Review guidance on GOV.UK on persistent organic pollutants (POPs). Consider how the Trust can ensure waste containing POPs is managed in accordance with the guidelines provided.

Action 5

- Carry out duty of care checks to ensure mixed municipal waste is taken to a site that can accept this waste type. Ensure the place of disposal provided on your transfer notes correctly reflect this disposal/recovery site and contains the correct legal entity.

The findings are being managed via the Soft FM Group which consists of PFI Landlord, Trust Estates, Health and Safety as well as the soft FM provider. Details of the audit and findings were discussed during the January 2024 Health and Safety Committee for awareness.
Visit completed and report received back from the Environment Agency on the 11th December. This is being managed through the Soft FM meeting which has attendees from PFI, Serco and Trust.

Face Fit Testing

To ensure Business Continuity for future pandemics, potential high consequence infectious diseases or exposure to other respiratory infections, Face Fit Testing continues to meet the requirements of the 5 key resilience principles per the Department of Health and Social Care, Filtering facepiece protection (FFP3) Resilience in the Acute Setting correspondence received in June 2021.

The Trust has assigned the management of Fit Testing back to the divisional fit testers (in place pre Covid-19) for the mandatory areas. The Trust has 229 colleagues (fit testers) that have undertaken Train the Trainer for Fit Testing. Details on compliance is provided via the Health and Safety Committee as part of the Health and Safety Quarterly report.

Currently two forms of fit testing can be completed:

- Quantative by Portacount
- Qualitative by Hood/Solution

As of the 31/03/24 the Trust was at 79.2% compliance for mandatory areas.

Waste Policy

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

The policy was recently reviewed in January 2024 after the findings from the Healthcare Waste Audit and amendments made to align with HTM 07-01 update on Offensive Waste as well as Persistent Organic Pollutants. During the review stage the following areas were involved in the consultation process Dangerous Goods Safety Advisor, Infection Prevention and Control, Trust Estates, Serco Waste Management Team, Radiation Safety/QA Lead – Radiology and Health and Safety Committee Membership.

The document is due its biannual review in January 2026, but this can be completed earlier where there is a change of legislation, process etc.

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

- Trust Facilities department manage the contracts via facilities management (FM) providers. All clinical waste is currently collected by an appointed external service provider.
- Trust H&S team leads on waste policy and participate in monitoring with Facilities team. The policy is based on the document HTM 07-01 Safe Management of Healthcare Waste.
- During period 2023-24 the Safety Team continued with the services of the external contractor Independent Safety Services Ltd to act in the role of Dangerous Goods Safety Advisor on behalf of the Trust.
- Nuclear Medicine department oversee the management process of radioactive waste.

The Trust has an appointed a Sustainability Manager in post with a focus on sustainability within our waste processes.

Waste Monitoring and Measurement

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

- The Dangerous Goods Safety Advisor (DGSA) has a provision of 6 days over the 12-month period which includes report writing.
- Clinical waste is monitored on a daily basis by the FM companies to ensure it has been placed in the correct stream before leaving site. This involves a visual check of bin and content and observation of items entering the compactors. Waste bags are never decanted or opened unless there is any suspicion of them containing incorrect waste.
- On site monitoring of correct clinical waste segregation via pre-acceptance audits (annually) this was completed in November 2023 by Stericycle.
- Security of clinical waste is monitored by the FM contractor and Trust PFI Contract manager.

Duty of Care Visits

Unfortunately, Duty of Care visits for Clinical and Non-Clinical waste had not been completed during the period and this was identified in the Healthcare Waste Audit Action 5. This has been taken forward within the Soft FM group as action ref 0712/123.

Dangerous Goods Safety Advisor (DGSA)

The DGSA has completed site visits and audits in the following areas.

Table 22			
27/06/2023	**26/09/2023**	**05/12/2023**	**25/03/2024**
Stericycle Vehicle Audit	Medical Gases	Nuclear Medicine/ Radiopharmacy	Sterile Services
Main waste compound	Microbiology	Theatres – Radiation Protection	Disposal holds in Outpatient Areas
Battery Storage	The Cotman Centre (Cytology & Histopathology)	Brachytherapy	
Chemical Waste and Storage - Serco	Pathology	Pharmacy	
CSSD and Endoscopy Chemicals	Endoscopy	Internal waste storage areas.	

During the visits in 2023 there were a total of 22 issues identified which were incorporated into an action plan and monitored by the Health and Safety Lead Advisor. All 22 issues have been closed. At the time of report the details for the March visit have not been received.

Sharps

The safe handling and disposal of sharps is covered by policy Trust Doc ID 585 Prevention and Management of Needlestick (inoculation), Sharps Injuries, and Blood exposure incidents which also sit within the Health & Safety Team remit. This was reviewed in January 2024 with the next full review scheduled for January 2026.

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

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

Minimising blood splashes is also a main focus of the Inoculation group members. The purpose of the group still continues to change the culture and that PPE is not just for COVID-19 and that eye protection is to be worn where a blood/bodily fluid splash could occur.

The HMB is fully supportive of ensuring staff safety, protection from blood or bodily fluid splashes. Management at all levels should be promoting to colleagues that eye protection should be worn where there is a potential for a blood/body exposure to occur.

Currently sharps bins used within the Trust are the disposable type and these will continue in small quantities in regard to those being provided to patients when they are discharged. During the latter part of 2023 a trial was undertaken utilising reusable sharps bins which are more robust, solid in construction improving colleague safety. This trial has proved popular and a roll out with the main hospital site is planned for 2024.

Laundry

Trust PFI Contract Performance Manager informed that the Estates Team have completed a Duty of Care visit on the provider in November 2023. From the visit no issues were highlighted, and it was observed all linen was washed, stored and transported appropriately.

In terms of monitoring, the monthly inspections continue with on average 340 items being reviewed at the time with contractor, Soft FM provider and a member of the Trust monitoring team in attendance. Additionally, the service elements are all monitored throughout the course of the month, which includes HTM 01-04 Decontamination of linen for health and social care, https://www.england.nhs.uk/publication/decontamination-of-linen-for-health-and-social-care-htm-01-04/.

Hygiene Code Compliance Criteria 3:
Appropriate antimicrobial use and stewardship to optimise outcomes and to reduce the risk of adverse events and antimicrobial resistance.

Prudent Use of Antibiotics (information provided by Specialist Antimicrobial Pharmacist)

Antimicrobial Consumption Surveillance

For the purposes of surveillance and monitoring, antimicrobial consumption is reported in units of Defined Daily Dose per 1000 total admissions (including day case). Defined Daily Dose (DDD) is the WHO standard unit and is based on the average daily dose of a medicine used for its main indication in adults. Standardisation in this manner enables comparison between Trusts of different size and range of specialties and against the average for the East of England region. Data for surveillance is obtained from RxInfo Define as this is the source used by UKHSA for monitoring antibiotic consumption within the NHS Standard Contract.

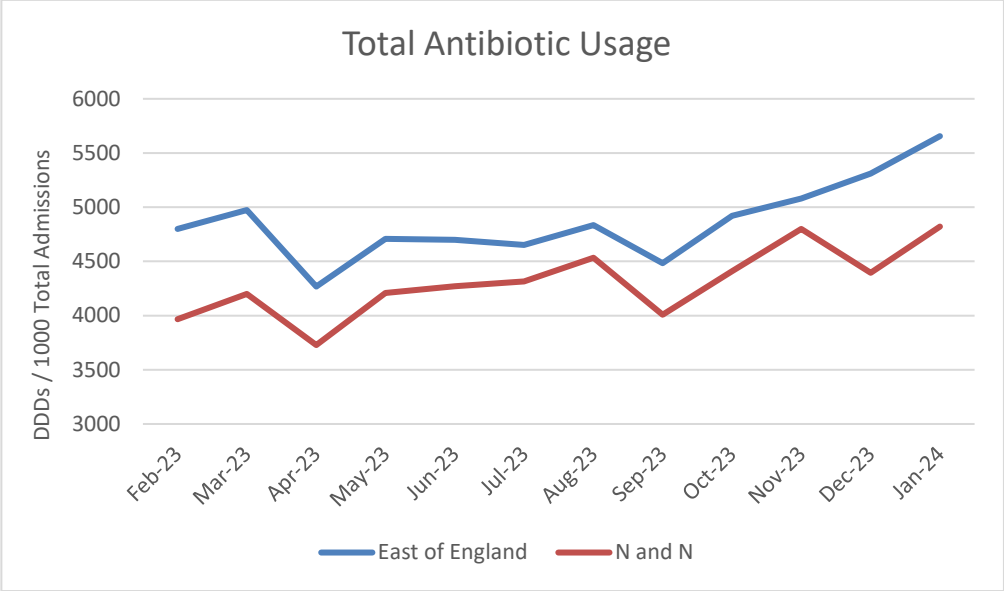
The figures below show the 12-month rolling trend of antimicrobial usage within the Trust compared with the NHS East of England average.

Total Antibiotic Consumption

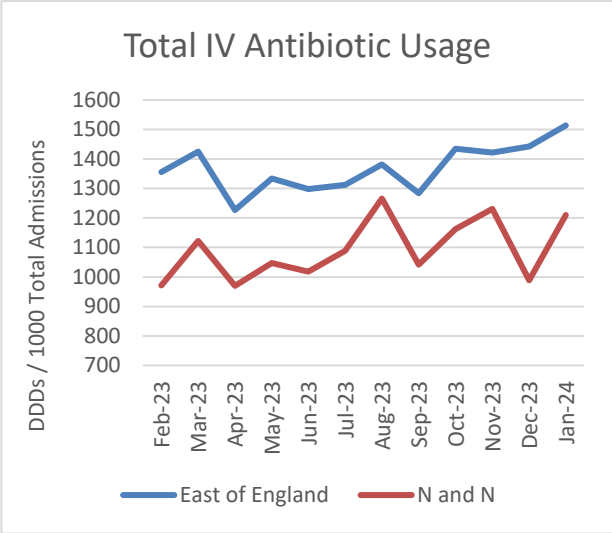
Total antibiotic consumption over the most recent period appears to be consistent with use from previous months and is broadly in-line with the trend of the region. NNUH continues to use considerably fewer antibiotics when compared to the rest of the region. We should continue to focus our efforts on minimising broad-spectrum antibiotic use and on timely IV to oral switching refer to Table 27.

Following the Medicines and Healthcare products Regulatory Agency (MHRA) warning in January 2024 regarding the use of Ciprofloxacin we have seen a dramatic fall in use. Of particular note is our recent increase in Carbapenem consumption since January 2024. This can partly be explained due to the decrease in use of Ciprofloxacin. We will now be focussing our efforts to reducing Carbapenem use by monitoring appropriate use on a daily basis and re-instating Meropenem ward rounds.

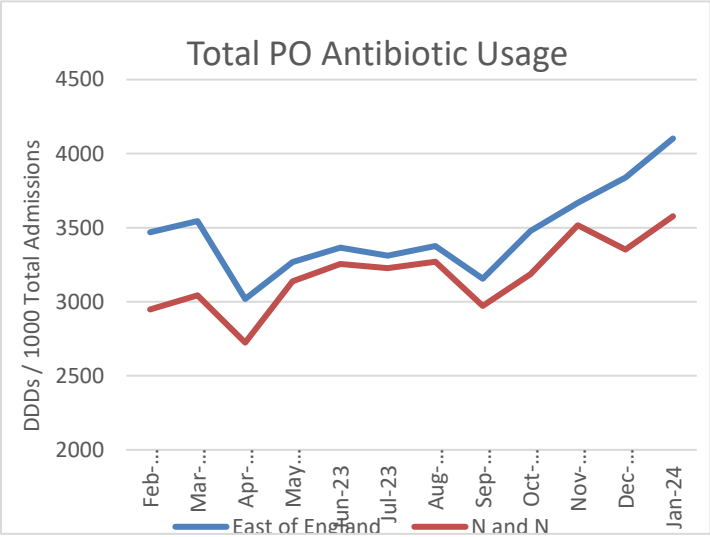
Graph 3



Graph 4



Graph 5



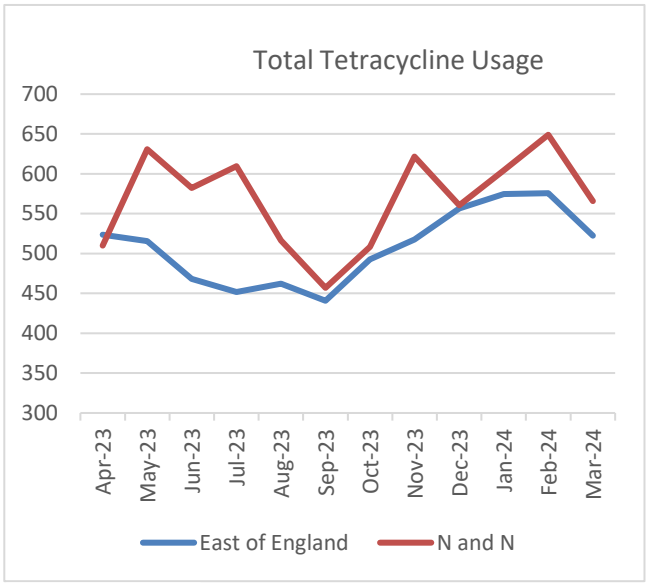
Broad-Spectrum Antibiotic Consumption

The Trust continues to use significantly fewer broad-spectrum antibiotics than the regional average except for doxycycline and cephalosporins. These figures will be monitored to ensure that any increase in prescribing is appropriate, and that action is taken to reduce unnecessary use of broad-spectrum agents.

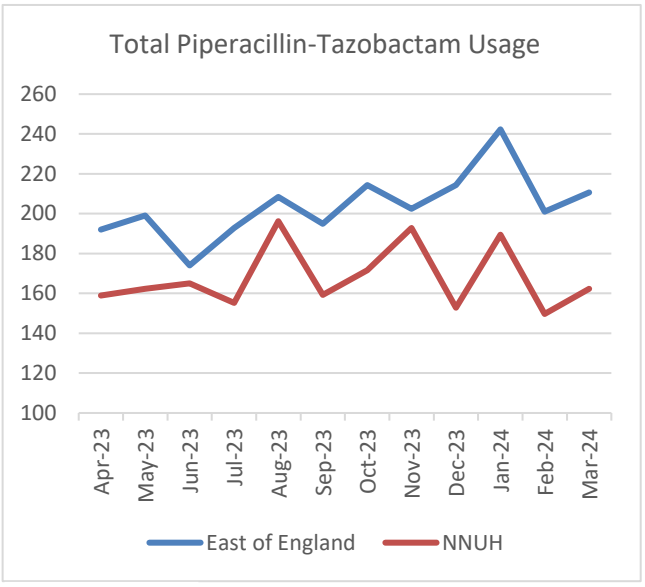
Doxycycline use is higher as we recommend this in the Antibiotic policy in place of Co-amoxiclav (which has a higher likelihood of causing C. *difficile* infection).

Infection Prevention and Control Annual Report 2023-24

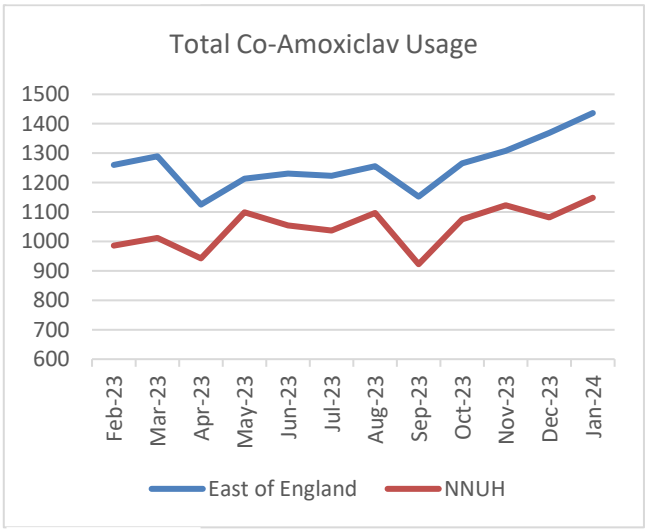
Graph 6



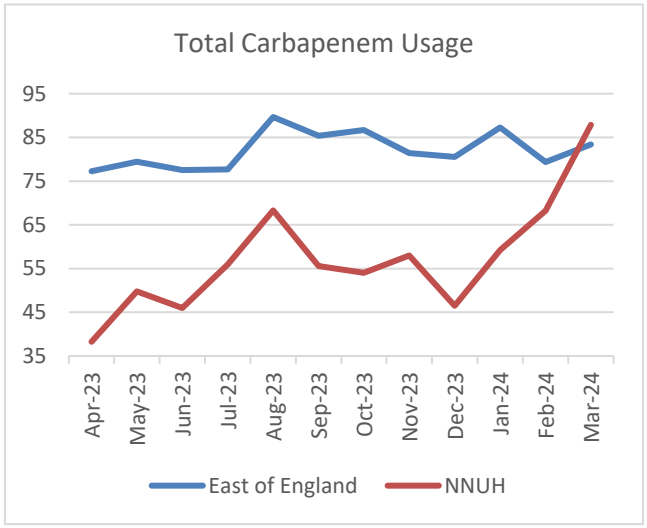
Graph 7



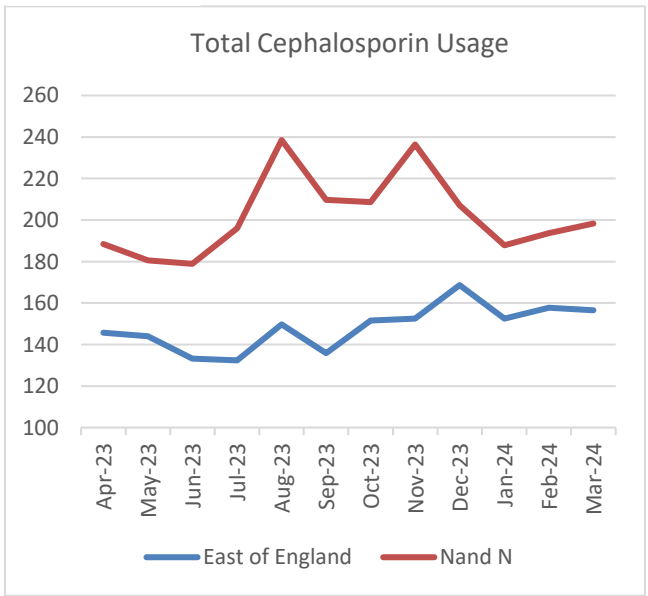
Graph 8



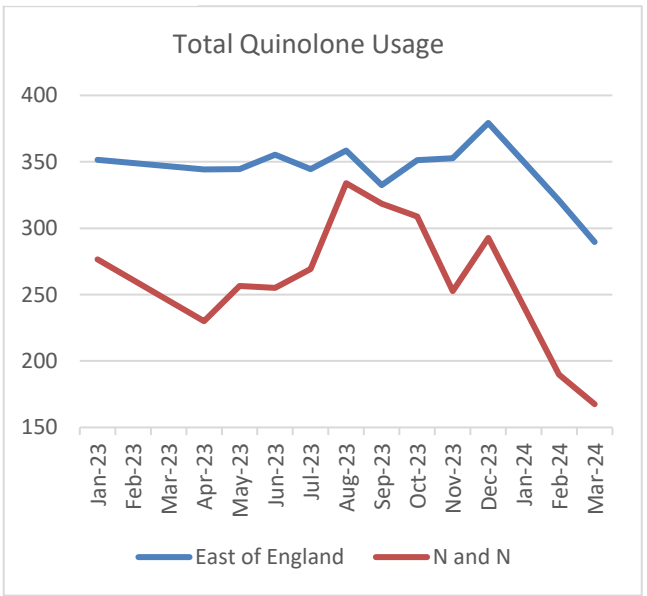
Graph 9



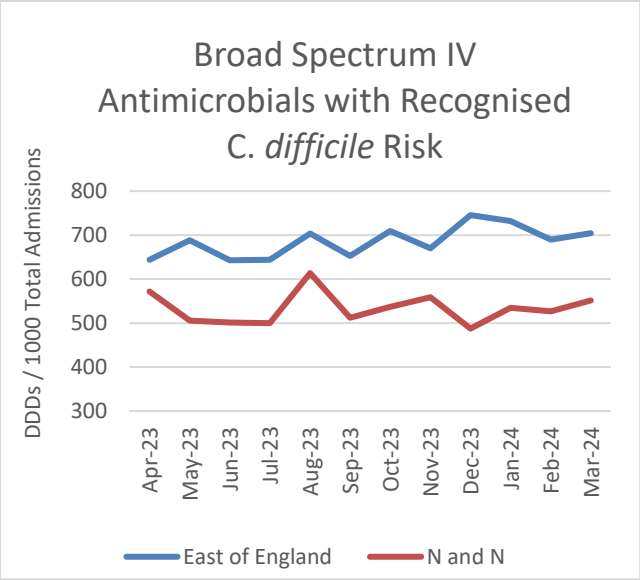
Graph 10



Graph 11



Graph 12



Antibiotic Audits

Point Prevalence Survey

The last point prevalence audit was carried out in March 2024. The next audit is scheduled for June 2024.

Table 23 - Trust Wide Data					
Date	**% of patients on Antibiotics**	**% given by oral route**	**% given by IV route**	**Tazocin use as % of Ab use**	**Co-amoxiclav use as % of Ab use**
Sept 2023	41	46	54	8	7
Dec 2023	43	51	49	12	23
March 2024	43	48	52	15	24

Table 24 - Surgery Data				
Date	**Number of Antibiotics prescribed**	**% given by oral route**	**% given by IV route**	**Tazocin use as % of Ab use**
Sep 2023	174	42	58	17
Dec 2023	171	42	58	11
March 2024	176	43	57	12

Table 25 – Older Peoples Medicine Data			
Date	**Number of Antibiotics prescribed**	**% given by oral route**	**% given by IV route**
Sept 2023	77	59	41
Dec 2023	68	57	43
March 2024	70	64	36

Table 26 - Medicine Data			
Date	**Number of Antibiotics prescribed**	**% given by oral route**	**% given by IV route**
Sept 2023	177	54	46
Dec 2023	180	61	39
March 2024	187	47	53

Other Audits

We have recently audited antibiotic use in the Older People Medicine department and are in the process of feeding the results back to the department.

Antimicrobial Stewardship (AMS) Commissioning for Quality and Innovation (CQUIN)

CQUIN 2023-24

AMS CQUIN for 2023-24: Data collection ran from April 2023 to March 2024. Data for 100 patients per quarter were collected across varying specialities.

Table 27

CQUIN04: Prompt switching of intravenous (IV) antimicrobial treatment to the oral route of administration as soon as patients meet switch criteria	
Applicability: Acute **CQUIN goal:** 60% to 40% (NB lower % = more compliant) **Supporting ref:** NICE NG15[4]	There are significant benefits to IVOS interventions demonstrated in research literature including: increasing hospital bed capacity to support recovery from the COVID-19 pandemic; reducing exposure to broad-spectrum antibiotics; increasing nursing workforce capacity; reducing drug expenditure; reducing carbon footprint of medicines; and reducing healthcare-associated bloodstream infections. This CQUIN aligns with a commitment in NHS England's 2022-23 Priorities and Operational Planning Guidance to support reduced lengths of hospital stays by ensuring that intravenous antibiotics are only used for as long as clinically necessary.

The aim was that patients would be switched to oral antibiotics sooner, and/or have reduced course lengths. This coincides with multiple benefits including reduced lengths of hospital stay, improved patient experience, fewer line-related adverse events, reduced carbon footprint, and reduced expenditure.

Results

The CQUIN was achieved for all four quarters.

Table 28

1: CQUIN Compliance **Minimum 60%** **Maximum 40%** **Lower = better performance**	**Q1**	**Q2**	**Q3**	**Q4**
	27%	29%	19%	23%

There is no mandatory CQUIN for the year 2024-25.

Guidelines and Policies

Updates

Following the MHRA warning regarding the use of ciprofloxacin the Trust Empirical Antibiotic guideline has been reviewed and amended where necessary, removing ciprofloxacin as the empirical choice where appropriate. The Antifungal guideline is up for review and is in the process of being updated. The Paediatric Antibiotic guideline and Sepsis guideline are also in the process of being updated.

MicroGuide

Funding for Microguide has been continued for another 3 years as of February 2023.

Formulary Updates

Applications

New formulary applications for Cefiderocol for the treatment of severe drug-resistant Gram-negative bacterial infections have been discussed and approved at D&TC.

Supply Chain

Nil to report currently.

Antimicrobial Stewardship Ward Rounds

Ward Round Update

Weekly ward rounds continued on surgical wards, including Vascular and General Surgery, all Older People's Medicine (OPM) wards and Gastroenterology. These are in addition to a number of other well established clinical rounds that include antimicrobial review – e.g. NICU, Critical Care Units and Haematology and Oncology ward.

National Point prevalence Survey on healthcare associated infections, antimicrobial use and antimicrobial stewardship in England, 2023.

National Point Prevalence Surveys (PPS) for HCAIs and/or antimicrobial use have been conducted in England for the past 40 years.

Throughout the survey period of September, the 18th to October the 27th 2023, the IP&C team worked alongside antimicrobial pharmacist colleagues to gather the required inpatient data for submission to the UKHSA.

Information was gathered across acute, community and mental health NHS trusts and independent acute-care hospitals. 124 trusts and independent sector organisations participated.

The NNUH were 1 of 78 acute trusts across England that participated.

The survey was aimed at providing a snapshot of the burden of HCAI and describe antimicrobial use to allow meaningful comparisons between organisations.

Preliminary summary results have been shared with each participating trust, there are some adjustments still to be made. The final report is pending and will be shared trust wide once available.

The results of the survey will:

- Support development of local and national policies and procedures to reduce HCAIs and inappropriate antimicrobial use.
- Facilitate comparisons of HCAI and antimicrobial use across organisations in England and in an international context.
- Contribute to efforts to address antimicrobial resistance nationally and internationally through National and Global Action Plans.
- Allow benchmarking with peer group hospitals in England to identify opportunities for improvement.

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

Information for Service Users, Visitors and Carers

The IP&C team regularly update the information and have continued to work closely with the communications department updating information in line with current IP&C guidance. IP&C information is shared in several ways including:

- Face to face discussion
- Via IP&C link practitioners
- Awareness campaigns
- Information leaflets
- Posters
- Noticeboards
- Switchboard answer phone messages
- Press statements via the NNUH website
- NNUH website

Hygiene Code Compliance Criteria 5:
That there is a policy for ensuring that people who have or at risk of developing an infection are identified promptly and receive the appropriate treatment and care to reduce the risk of transmission of infection to other people.

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

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

Screening is undertaken on emergency and elective admissions for MRSA. This enables any patients found to be positive whilst in the Trust to have topical decolonisation and if required antimicrobial treatment, see Table 29. Compliance with screening is monitored divisionally and reported to HICC monthly.

Table 29

MRSA Screening for Emergency and Elective Patients - numbers of Patient Screened		
Financial Year	**Emergency Screened Patients**	**Elective Screened Patients**
2023-24	**92.1%**	**92.4%**
2022-23	89.2%	92.2%
2021-22	96.1%	94.8%

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

A winter dashboard created by collaborative working between the IP&C team and digital health team, is accessible to Trust staff and provides a live overview of inpatients with Influenza, COVID-19, Norovirus & Respiratory Syncytial Virus (RSV).

There is also a screening process in place for patients that may be at risk of colonisation with CPE or are a previously known case, see Table 30. CPE risk assessment updated in May 2022, to reflect isolation requirements.

Table 30

Carbapenemase-Producing Enterobacteriaceae - numbers of Patient Screened				
Financial Year	**Admission in UK high risk hospital in last year**	**Hospital admission abroad in last year**	**Screened for other reasons (e.g., Holiday for Renal Dialysis patients)**	**Total**
2023-24	**530**	**96**	**1019**	**1645**
2022-23	431	73	1541	2045
2021-22	459	36	541	1036

Period of Increased Incidence (PII) and Supportive Measures

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

Audit results are monitored weekly by the IP&C team and additional interventions planned with the ward management team to provide an action plan.

Table 31

Number of new episodes of supportive measures due to a PII				
Financial Year	**MRSA**	***C. difficile***	**ESBL**	**VRE**
2023-24	2	4	1	1
2022-23	0	3	1	0
2021-22	1	4	1	0

During this reporting year there were 4 PIIs for *C. difficile* which triggered supportive measures, see Table 32. These were on Mulbarton, (2 patients) Heydon (3 patients), Ingham (3 patients) and Dilham (2 patients) wards. Further PIIs for MRSA were triggered on Home First Unit (formerly Gunthorpe ward, 2 patients) & NICU (2 patients). Supportive measures were initiated on Mulbarton for 2 patients with VRE. Two babies presented with ESBL on NICU activating a PII.

The IP&C team supported the staff throughout this period, supportive measures were continued until there had been 28 days with no further cases and IP&C Tendable, Hand Hygiene, Environmental and isolation room audits were all in acceptable range. The team established strong engagement at all levels, as the clinical teams actively participated in the enhanced interventions, training, auditing, and improvement initiatives.

COVID-19

On the 12th of January 2020 the World Health Organisation (WHO) announced that a novel coronavirus had been identified in samples obtained from Wuhan City, Hubei Province, China. This virus is now regularly referred to as COVID-19. WHO declared a pandemic on the 11th of March 2020.

Throughout this reportable year 2023- 2024, Government guidance and prevalence of disease dictated the process and type of testing required by patients.

In April 2023 the UKHSA published revised guidance on testing during low prevalence. Throughout the COVID-19 pandemic, the government prioritised protecting the most vulnerable and those in high-risk settings. Government-funded testing continued to focus on these groups, with new guidance coming into effect in England from 1 April 2023.

The ongoing success of the vaccination programme, increased access to treatments and high immunity amongst the population, allowed the government to scale back testing in England. Symptomatic adults and children admitted for care or developing symptoms within hospitals could be tested by a lateral flow device at local discretion. The need for polymerase chain reaction (PCR) testing was no longer a requirement for all scenarios.

The NNUH released new guidance to reflect this change at the beginning of May 2023, having had executive approval at the Hospital Management Board (HMB). It was agreed that all symptomatic patients would continue to receive a PCR test. Asymptomatic patients on the oncology and haematology ward would continue to screen upon day 0, 3 & 6 as a precautionary measure.

Asymptomatic contacts were no longer required to be tested or isolated, unless on Mulbarton ward. Known contacts would only be tested (by PCR) if they became symptomatic.

Infection Prevention and Control Annual Report 2023-24

A Norfolk and Waveney system approach was undertaken when aligning the reduction of wearing surgical masks for sessional use in April 2023 to align with government guidance, with the exception of Mulbarton ward, which serves exceptionally vulnerable patients. This area minimised mask usage in June 2023, returning to transmission-based infection prevention and control precautions as per the NIPCM and other areas across the trust.

In August 2023 a review of testing and screening for COVID-19 on Mulbarton ward was undertaken, the decision was made supported by HMB, that testing and isolation procedures would align with all other inpatient areas.

Throughout the year, the IP&C team continued to advise staff on updated UKHSA guidance and digital systems were adjusted according to new regimes.

The COVID-19 situation continues to be monitored, regular IP&C ICS meetings and regular information from colleagues at NHS England provide information upon regional and national prevalence and updates.

Graph 13 provides NNUH COVID-19 by attribution April 2023-March 2024. Image 14 provides attribution definitions.

Graph 13

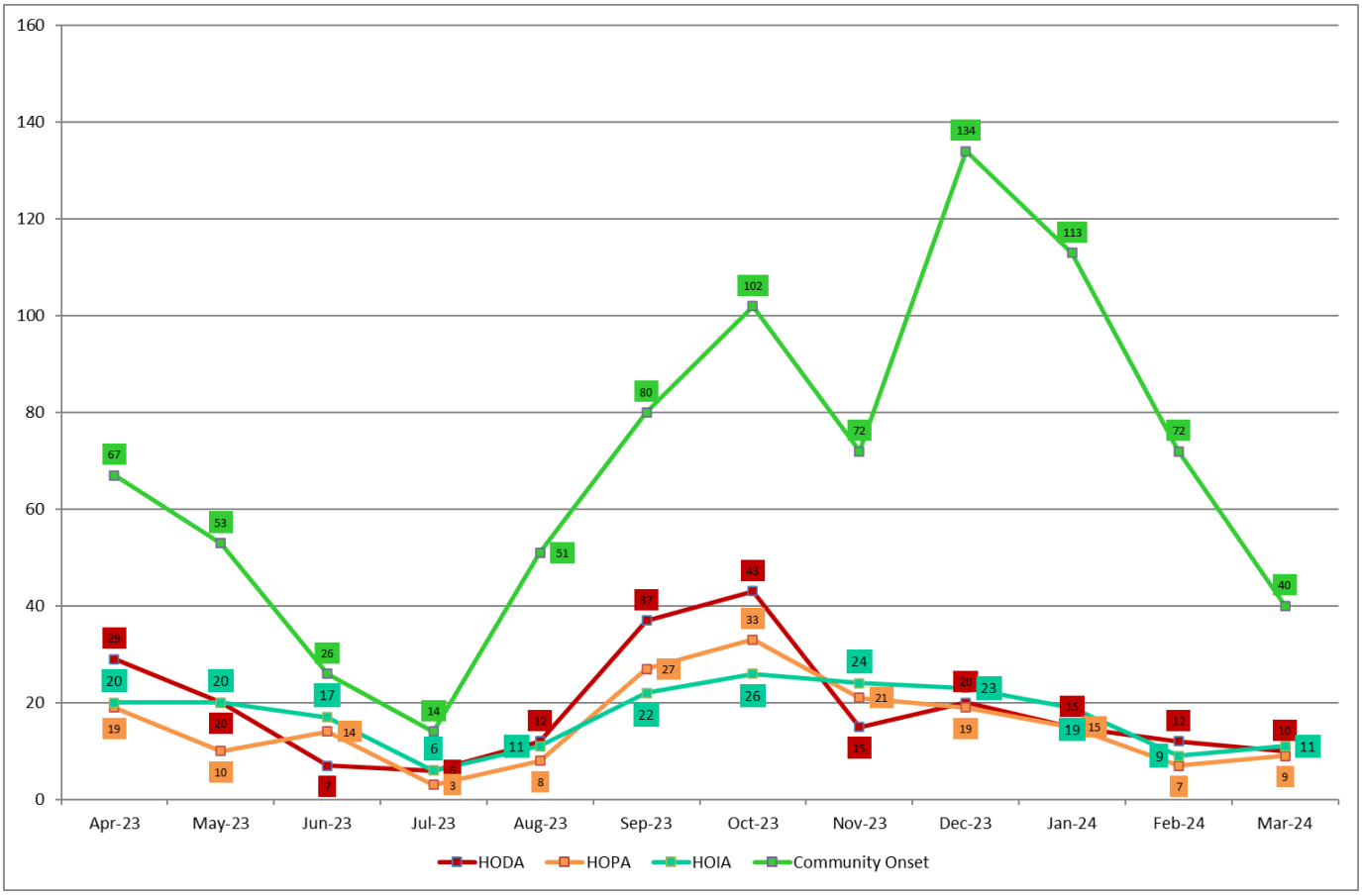
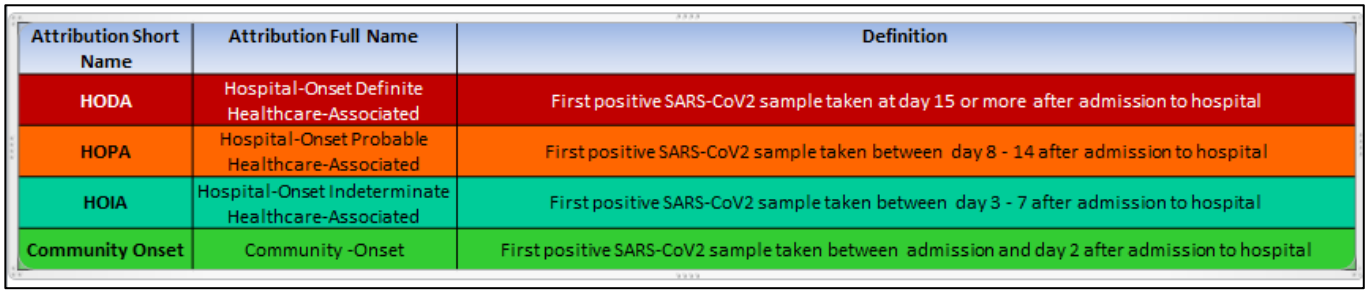


Image 14



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

During 2023–2024 there were 2886 positive cases of COVID-19 within the organisation. 7.8% of these were Hospital Onset Definite Healthcare-Associated and 6.4% were Probable Healthcare-Associated.

Outbreaks and Serious Incidents

Table 32

Number of episodes of outbreak or serious incident					
Financial Year	**MRSA**	***C. difficile***	**Influenza Ward closure**	**Norovirus Ward closure**	**COVID-19 Outbreaks**
2023-24	**1**	**3**	**2**	**6**	**49**
2022-23	0	0	1	4	111
2021-22	0	0	0	8	46

Between April 2023 and March 2024, according to NHSE COVID-19 outbreak definition there were 49 COVID-19 outbreaks at NNUH. These outbreaks continued to be reported centrally as a requirement from NHS England. Outbreaks involved between 2 and 49 patients. The duration of these lasted 28 days. As from March 2024, the closure of an outbreak was signified by no test-confirmed cases with illness onset dates in the previous 5 days in the outbreak setting as per UKHSA guidance. Prior to this, the requirement had been 28 days.

The IP&C team offered assistance to the affected areas during each outbreak by providing educational support and conducting audits. They also held regular meetings with ICB IP&C colleagues to discuss outbreak management to minimise nosocomial transmission.

PPE continued to be accessible through the procurement team, who designated a specific collection point for PPE. The H&S team has coordinated fit testing for staff members. Furthermore, regular audits were conducted to ensure compliance with PPE requirements in our wards via Tendable, thereby maintaining a safe and secure working environment.

In March 2023, UKHSA revised the information regarding next steps and the wearing of facemasks. A system wide IP&C review was undertaken, to align with the UKHSA “next steps” and the transition to reduce the wearing of face masks sessionally in all areas, across all three acute trusts was agreed. From April the 3rd 2023, staff were no longer required to wear Type IIR SFM masks in offices, social settings or when travelling around the hospital. Those working in clinical areas continued to wear the appropriate facemask as part of Personal Protective Equipment (PPE) and transmission-based precautions i.e. universal type IIR SFM or FFP3 when required.

Indwelling device audit

The High Impact Intervention (HII) care bundles are designed to highlight critical elements of each procedure or care process and the key actions required, providing a way of demonstrating reliability through the audit process. The care bundles at the NNUH are available to access electronically on the IP&C department page. The IP&C team support auditors in each area with training and advice. All areas are expected to achieve a compliance of 80% or above.

Table 33

High Impact Intervention Audit Scores			
High Impact Intervention care bundle audit	2021-22	2022-23	**2023-24**
Central venous catheter care	95%	93%	**90%**
Peripheral intravenous cannula	93%	90%	**89%**
Ventilated patients	97%	98%	**98%**
Urinary catheter	93%	90%	**90%**

Audit of Compliance with Isolation Guidelines and Single Room Use

An annual audit of compliance with the Isolation guidelines was undertaken by the IP&C team supported by a group of Trust Volunteers in October 2023 (see Image 15). This audit aimed to ensure that practices are consistent with the guidance outlined in the Health and Social Care Act, 2008, and that clinical practices adhere to the Trust's Isolation guidelines.

Image 15

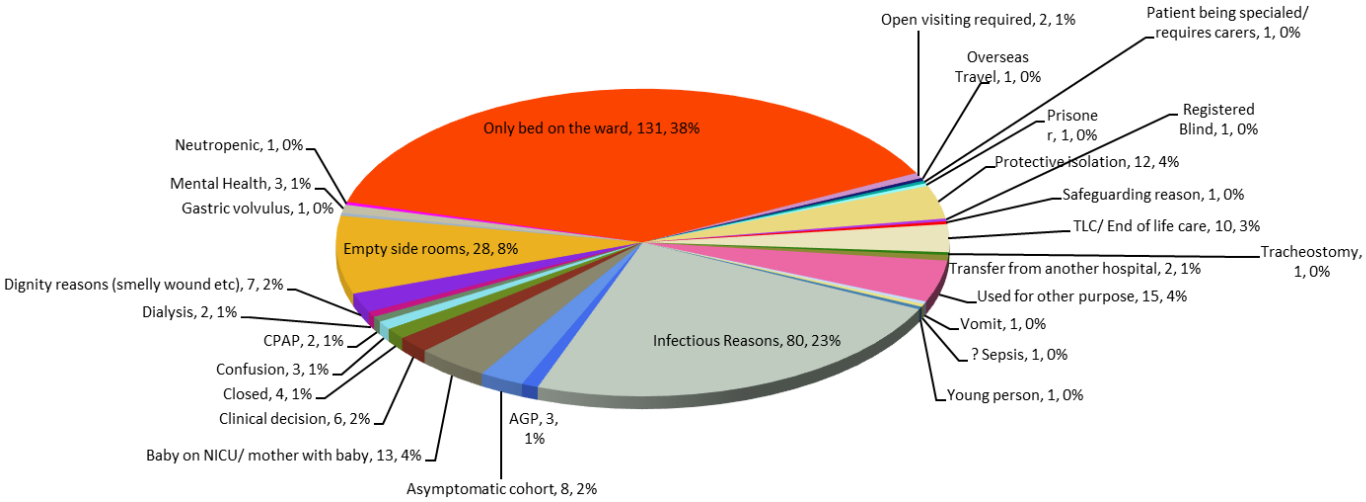
All patients with confirmed or suspected infection require isolation. At the time of audit 23% of single rooms were being used for IP&C reasons in comparison to 38% in 2022. 100% of patients requiring isolation for IP&C reasons were provided with a single room, no patients at the time of audit were risk assessed as unsafe to isolate for any reason. The electronic ward view system highlights those requiring isolation for IP&C reasons facilitating correct placement of these patients.

Overall compliance with the audit of single isolation rooms was 81% compared to 83% in 2022.

Table 34	
NNUH - Isolation and Single Room Use Audits	
Financial Year	**Overall Compliance %**
2023-24	**81%**
2022-23	83%
2021-22	80%

The top three issues were single room doors being open with lack of documentation to support this, dedicated observation equipment and colour coded cleaning equipment available in side-rooms. The results were shared Trust wide along with actions for continuing to facilitate improvement, see Table 34 & Chart 6.

Chart 6 – Single room isolation audit reasons



Central Venous Catheter (CVC) Surveillance

A continuous surveillance programme monitors the CVC infection rates in adults. The overall infection rate remains below the Matching Michigan reference point of 1.4 per 1000 line days. During 2023-24 haematology line infection rates were reported as 2.70 per 1000 line days. Recently the number of haematology central lines included within the surveillance has decreased, with a total of 21 lines being included throughout 2023/24. it is difficult to compare data to previous years when the denominator data have changed substantially. This is due to the increase usage of PICC lines throughout the Trust. The IP&C team will investigate introducing PICC surveillance in the future. Of the 21 haematology central lines included within the surveillance 3 were reported to have infections.

Quarterly results are shared with Trust staff and in the IP&C monthly report, see Table 35.

Table 35			
NNUH CVC related infections			
CVC infections are measured by rate per 1000 line days	**2021-22**	**2022-23**	**2023-24**
Renal	0.24	0.37	**0.27**
Haematology	2.55	0.93	**2.70**
Other areas	Nil	Nil	**Nil**
Overall	0.40	0.41	**0.33**

Surgical Site Surveillance (SSI) Committee

A SSI surveillance committee was initiated to help structure and promote the Surgical Site Infection Surveillance within the Trust, in line with recommendations Government guidance Protocol for the Surveillance of Surgical Site Infection commencing January 2023. The committee meet every quarter with the objective of aiding in the development and supervision of a well-structured surveillance program. Additionally, the committee strive to encourage the adoption of surveillance practices throughout the organisation, identify and address any training gaps, assist in the formulation and monitoring of action plans to improve practices whenever necessary based on surveillance findings, and review, analyse, and consider the implementation of new guidance and recommendations as they become available.

The last meeting took place in July 2023. Subsequent meetings have been postponed due to operational constraints and challenges in achieving quorum. Surgical site surveillance has continued, and the results were reviewed in divisional and specialty governance meetings as well as during the Health Infection Control Committee (HICC) discussions. As the organisation transitions to business as usual these meetings will be reinstated.

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

Hip, Knee and Fracture Neck of Femur: mandatory submission

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

Mandatory UKHSA data are now submitted each quarter for one of the categories.

Surgical teams are adapting to new upgraded theatres, with excellent outcomes.

The validated rates of infection (identified prior to discharge and on readmission) for Orthopaedic categories were: See Table 36.

The rates of infection above UKHSA standards within hip and knee surgery have been discussed within governance meetings and reported to HICC. Upon investigation the increased infection rate was thought to have been linked to the unavailability of an elective orthopaedic ward. Consequently, provisions have been made to reinstate the elective orthopaedic ward which is currently situated on Cringleford ward.

Table 36			
Orthopaedic Surgical Site Surveillance - Percentage of SSI detected post op (mandatory submission)			
Calendar Year	**Hip – UKHSA 0.5%**	**Knee – UKHSA 0.4%**	**Repair # Neck of Femur – UKHSA 0.9%**
2023 SSI %	**1.17%**	**0.62%**	**0.42%**
2022 SSI %	0.19%	0.34%	0.43%
2021 SSI %	0.48%	0.53%	0.71%

Spinal Surgery: Voluntary submission

UKHSA data submission for Spinal SSI was undertaken for April-December 2023. See Table 37.

Table 37		
Spinal Surgical Site Surveillance - Percentage of SSI detected post op (voluntary submission)		
Calendar Year	**Spinal SSI %**	**UKHSA SSI %**
2023 SSI %	**1.55%**	**1.4%**
2022 SSI%	0%	1.4%
2021 SSI %	0.32%	1.3%

Other Surgical Site Surveillance

Vascular surgery surveillance

There has been continuous voluntary systematic SSI surveillance in vascular surgery since 2009. During 2022-23 the SSI rates have been between 6.0% and 8.5%. UKHSA inpatient and readmission benchmark is 2.3%. Results are shared for discussion and action at Vascular governance and HICC. See Table 38.

Table 38				
Post vascular surgery surgical site infection rates				
Year	**April-June SSI %**	**July-Sept SSI %**	**Oct-Dec SSI %**	**Jan-March SSI %**
2023-24	**6.0%**	**6.1%**	**7.6%**	**8.5%**
2022-23	5.9%	5.5%	3.9%	3.9%
2021-22	6.7%	3.4%	4.0%	4.4%

Caesarean section surgery

There has been continuous systematic voluntary SSI surveillance following C-section since 2010. Collaborative working between the obstetric department and IP&C provides an on-going cycle of feedback and review at clinical governance meetings.

During 2023-24 the SSI rates have been between 1.2% - 2.4%. No UKHSA benchmark is available. See Table 39.

Table 39				
Post caesarean section surgical site infection rates				
Year	**April-June SSI %**	**July-Sept SSI %**	**Oct-Dec SSI %**	**Jan-March SSI %**
2023-24	**1.3%**	**2.4%**	**1.2%**	**1.6%**
2022-23	0.8%	1.7%	1.2%	0.8%
2021-22	2.5%	2.2%	2.0%	1.8%

Audit Programme

Hand Hygiene and Dress Code Audits

The IP&C undertake a continuous programme of Hand Hygiene and Dress Code audits across the Trust.

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

All IP&C mandatory training includes Hand Hygiene guidance. Staff are encouraged to strive for 100% compliance and act as role models, challenging and educating others in best practice. See Table 40.

Table 40			
Number of hand hygiene and related dress code audits and average percentage pass in NNUH			
Financial Year	**Number of Audits**	**Percentage Pass**	
		Hand Hygiene	**Dress code**
2023-24	**1019**	**97%**	**99%**
2022-23	1051	96%	99%
2021-22	758	96%	99%
Scores <95% lead to a re-audit within 1 week.			

The IP&C team has engaged in discussions with staff and reviewed national guidance regarding workwear and the implementation of reasonable adjustments that will fulfil appropriate hand hygiene practices, particularly in scenarios where exposure of forearms may not be appropriate. This has since been included within the latest dress code and uniform policy (Trust Docs ID 22782).

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

All staff including volunteers joining the Trust are required to attend an IP&C induction session and thereafter mandatory IP&C training. Compliance with IP&C training is monitored by the training department.

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

The Trust official visitors and contractors' procedure document (Trust Docs ID 587), along with all policies and guidelines, are available to staff via the Beat. There are also IP&C specific documents available on the Beat, IP&C department page. IP&C have worked together with SERCO, providing information to complement existing IP&C training provided.

Hygiene Code Compliance Criteria 7:
The provision or ability to secure adequate isolation facilities. The provision or ability to secure adequate isolation facilities.

The IP&C team undertake an annual isolation room audit to assess why patients are in the single rooms across the Trust, how many patients who require isolation facilities are in single rooms and how those in isolation are managed. See Table 34 (page 50) and Chart 6 (page 50).

Most of the single room accommodation on each ward is en-suite and can be used for isolation of infectious and suspected infectious patients. In addition, the respiratory ward has two single en-suite rooms that have negative pressure ventilation for severe respiratory disease e.g. multi-drug resistant Tuberculosis (these rooms do not have lobbies so are limited for use as an isolation facility). Areas such as Paediatrics where there is a recognised lack of side rooms for isolation have added this as a risk to the Trust risk register. The Hoveton unit has 9 isolation rooms with the capacity to be used as negative pressure, each has an area for donning and doffing. This facility was opened on March 31, 2021, and has not yet been required to be utilised as an isolation unit.

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

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

Laboratory, information contributed by Microbiology Network Manager and Chief Biomedical Scientists

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

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

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

Laboratory Operational Hours

Monday – Friday:	08:00 – 20:00
Saturday, Sunday & Bank Holidays:	08:00 – 16:00

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

Following recent audits, we can confirm that we remain compliant with the 4-hour bleed to load time target for blood cultures.

We have several service improvement plans in place as well as verifications of new tests and repatriated tests in order to provide a higher quality service to the users.

We continue to evaluate and act on as appropriate, new clinical guidance to remain as up to date as possible with recommendations and developments.

Over the past year we have continued to see a 10% increase in work in all areas of the department.

A number of IP&C staff have been to the laboratory for tours, which has made us feel closer together and helped to open communication lines to enable us to work more effectively together. We hope to continue doing this.

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

IP&C Policies

NNUH has a robust process for keeping guidelines and policies up to date. The IP&C team share new and reviewed documents via the weekly communications bulletins. They widely consult when developing new documents and they are signed off by the HICC.
All IP&C and associated policies and guidelines are easily accessible to staff via several electronic routes.

Hygiene Code Compliance Criteria 10:
Providers have a system or process in place to manage staff health and wellbeing, and organisational obligation to manage infection, prevention and control.

Workplace Health and Wellbeing (WHWB) Report provided by Head of WHWB

All staff have access via self-referral route to gain appropriate occupational health (OH) advice. Ordinarily this is available Monday – Friday between 08:30–17:00hrs. Out of hours infection related OH advice continues to be available via the intranet (now named The Beat) with a dedicated section 'Contact with Infectious diseases.

WHWB have maintained their full suite of in-house procedures and Trust guidelines in relation to prevention and management of communicable infections. Easily accessible advice for staff as detailed above on The Beat. Policies created by the IP&C team are reviewed by WHWB to consider the staff implications.

Immunisation Services

Immunisations for staff are available and provided in line with Green Book.

All staff who have patient contact (clinical & non-clinical) are required to have an immunisation review. This commences with their pre-placement health questionnaire. If immunisations for their specific role are not complete, then they are required to attend WHWB for an immunisation assessment. Their immunisations are recorded on their individual record on the dedicated occupational health system. At the time of the assessment the relevant immunisations are offered whilst advising the worker the importance of complying with UKHSA guidance.

The WHWB team keep up to date with new guidance and review both Trust guidelines and WHWB procedures accordingly. If any new guidance requires to review the immunisation status of existing staff, then this is undertaken. Due to the pandemic, a significant backlog of staff are outstanding in various immunisation requirements. Whilst WHWB are attempting to resolve this, without significant additional resource being allocated to the team, this will remain for several years.

Covid Autumn Boosters/Influenza Vaccinations

The Head of Health & Wellbeing once again mobilised a team to provide a seasonal vaccination programme which included both Covid and Influenza boosters. A programme of co-delivery was designed but also allowed staff to have these undertaken separately if that was their preference.

The team used a dedicated software system to allow online booking and were provided with a clinical space to create a dedicated vaccine hub. For financial resourcing constraints, our programme ran for a 2-month period rather than 3 (& beyond) as per previous campaigns. A separate programme was made available to those staff based at Cromer to prevent travelling to Norwich and the vaccination team made visits to offsite locations as well as using the flu trolley on the main site to increase participation.

Whilst our uptake was not as high as previous years, our results reflected the national picture of vaccine fatigue amongst NHS staff. NNUH was the 2nd highest Acute Trust uptake in our region for flu and highest nationally for Covid, with 55% of our staff receiving a Covid vaccine & 67% of staff receiving a flu vaccine. Our success within this programme, was undoubtedly because of strong medical and nursing leadership together with the support of a dedicated software programme and prominent communications plan.

Figures at close of January 2024:

Table 41				
All staff number	**Covid Booster**	**Covid %**	**Flu**	**Flu %**
All staff (without bank)	4806	50	5730	61
All staff (with bank)	5239	52	6289	63
All Staff (with Bank & Contractors)	5960	55	6791	65

Table 42		
Division %	**Covid %**	**Flu %**
Medicine	46	56
Surgery & Emergency Services	48	59
Women & Children	44	57
Clinical Support Services	56	65
Corporate Services	57	72

Table 43				
Staff Groups	**Covid**	**%**	**Flu**	**%**
Add prof & Scientific	252	55	284	62
Add Clinical Support	880	45	1252	61
Administrative	1315	59	1491	66
Allied Health Professional	347	60	393	68
Estates & Ancillary	98	44	108	49
Healthcare Scientist	147	52	154	54
Medical	787	55	890	61
Nursing / Midwives	1355	47	1708	58

Infection Prevention and Control Annual Report 2023-24

Contact Tracing undertaken 2023-24

Below is a summary of the various contact tracing activities that WHWB have undertaken in the last year.

Tuberculosis

WHWB have undertaken contact tracing for Tuberculosis on 5 separate occasions:

- **May 2023:** DPU theatres whereby bronchial washings were being undertaken and staff were not wearing FFP3' masks. As a result of the contact tracing 9 staff required follow up and attended for IGRA blood tests 6 weeks post exposure in line with Trust policy. A datix report was submitted in this case. TB was subsequently excluded.
- **May - June 2023**: Dilham & Guist ward. Whilst the patient was orginally admited in April 2023, WHWB were not advised that suspected TB until 2nd June 2023. WHWB were advised no staff met definition of close contact and were wearing appropriate PPE.
- **June 2023**: Matishall Ward confirmation from ward manager no staff met definition of close contact.
- **July 2023:** Emergency Department & Buxton ward. No staff met definition of close contact.
- **January 2024:** PAU pre-assessment. No staff met definition of close contact.

IGAS

15 areas were contact traced during the reporting period for IGAS infection – HDU, AMU (x3), EAUS (x3), PAU, ICU, Easton ward, Gissing ward (x2), Buxton ward, Colitishall ward, Loddon ward, Docking ward, Emergency Department (x2), CCC, OPED, and Elsing ward.

VZV

VZV contact tracing has been implemented for 9 cases following notification from IP&C of confirmed cases:

- **April 2023:** Buxton and Coltishall ward
- **May 2023**: PAU, AMUI and Cringleford ward
- **June 2023:** Guist Ward
- **June 2023**: Endoscopy Unit including administrative staff
- **July 2023:** Buxton & CAU
- **October 2023:** Buxton, CAU, Jenny Lind Unit
- **November 2023**: Langley, MRI scanning
- **November 2023**: Opthamology
- **January 2024:** PAU, Gastro & Guist ward. This patient was a 'corridor patient' which had significant impact on number of staff exposed to the virus. No staff needed to be excluded due to VZV history but masks had not been routinely worn.

VZV – Shingles

- **January 2024:** Langley, EAUS & Gately ward
- **Janury 2024:** Nelson Day unit

- **February 2024:** Nelson Day unit

Meningitis

- **April 2023:** AMU - Notification from IP&C regarding postive Meningitis case. Patient was isolated and nursed with appropriate PPE so no staff contact trace action required.
- **October 2023**: Eye casualty & Coltishall ward – No staff level of contact required prophylaxis.
- **November 2023:** Buxton & Jenny Lind - No staff level of contact required prophylaxis.

Monkey Pox

- **January 2024:** WHWB were alerted to a case who had been admitted on EAUS via SDEC. This case requried significant OH Nurse and doctor input. It was estimated as 5 days OHA time, 2 days band 8a & 1 day OHP due to the level of details needed from staff, the difficulties encountered in gaining information from UKHSA, the changes to the vaccination availability for post exposure prophylaxis and the requirement for NNUH to provide this service to a staff member at short notice (which included writing of written instruction, engagement with pharmacy to obtain the vaccine etc.).

  At the conclusion of the case, the totals were as follows:

  - Category 1 – 1 staff member
  - Category 2 - 4 staff members
  - Category 3 - 6 staff member
  - 1 staff member was offered the vaccination however, refused following private reading

- **January 2024**: suspected case Oncology/Dermatology.

PVL (panton valentine leukocidin) staphylococcus aureus

- **February 2024:** WHWB were alerted by IP&C of a postive patient on NICU – did not meet the criteria for contact tracing as not respiratory.

Measles

- **March 2024:** Coltishall / Buxton

Mumps

- **March 2024**: Coltishall / Buxton

Summary

The relaxation of PPE wearing by staff has significantly increased the level of contact tracing required by WHWB during this year. Upon investigation staff are often found not to be following the transmission based precautions. Compliance with this would reduce the level of contact tracing being undertaken.

Measles

Following release of NHSE document 'Guidance for risk assessment and infection prevention and control measures for measles in healthcare settings' and updated UKHSA 'National Measles Guidance' in January 2024, WHWB have reviewed in detail the documents and developed an action plan to consider the workforce elements relating to the emerging increase in infection across the country.

Key areas of work involve:

- Checking immunity of staff in high-risk areas.
- Developing a risk assessment for immunosuppressed staff and pregnant staff.
- Developing contact tracing and exclusion guidance in the event of exposure as well as promoting Fit testing compliance.

All information has been updated on The Beat as well as communicated via email to Ward leaders, Matrons, Service Directors.

A task and finish group was created to consider both Workforce and patient aspects in relation to this subject area of which WHWB is undertaking many of the workforce actions. With Hospital Management Board (HMB) support, additional resources have been provided to check through records of staff in high-risk areas and this work is progressing. To date the entry points in the hospital have been reviewed as well as areas with vulnerable patients. Commencement of the rest of the medical division has now commenced. Where we have not got confirmed evidence on the occupational health file, invites to book a vaccine are being sent. We have seen a significant increase in the uptake of MMR vaccinations and some measles serology testing since this work has commenced. In Oct – Dec 2023, 259 MMR vaccinations were given. In this reporting period 723 have been undertaken. As a result, additional vaccination clinics have been provided.

In addition, to ensure new starters have the necessary protection, with HMB approval, WHWB will not provide clearance to start in employment until evidence of MMR has been seen or undertaken by WHWB for all clinical areas. WHWB have also ensured that missed MMR appointments from workers are being chased and encouraged to re-book.

Blood Borne Virus

In line with UKHSA guidance, all staff can access a test for Hep B/C or HIV if requested. Those staff who are Exposure Prone procedure workers will have the appropriate tests prior to undertaking this activity in line with the 'Integrated guidance on health clearance of healthcare workers and the management of healthcare workers infected with bloodborne viruses (Hepatitis B, Hepatitis C & HIV)'. Any staff member found to be positive will have a consultation with the Consultant Occupational Health Physician who will advise on fitness for work and further monitoring and refer to Hepatologist or Sexual health services if required for further monitoring and treatment. For those 'Exposure Prone Procedure' workers who have a blood borne virus strict monitoring is undertaken by the occupational health department and monitoring recorded via United Kingdom Advisory Panel (UKAP) – Occupational Health Register. Currently we have 3 individuals who are being monitored in this way.

Blood exposure incidents

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

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

157 needlestick incidents were reported in this last year and occurred at the following stages of the activity.

- During procedure - 72
- During disposal - 61
- Incorrect disposal – 24

Key theme resulting in injury were:

- Lapse of concentration (63)
- Safety device not being implemented correctly/Not adhering to safety of sharp (29)
- Unexpected movement of patient (17)
- Incorrect disposal by colleague (14) patient (4)
- Sharps bin too full (5)

29 Blood exposure incidents (splash were also reported of which 9 could have been avoided if correct PPE was worn). It is vitial that all practitioners wear appropriate PPE including eye wear when performing tasks where a blood splash may occur

Infection Prevention and Control Annual Report 2023-24

References and further reading

Department of Health (2007) Saving Lives: reducing infection, delivering clean and safe care, available at: http://webarchive.nationalarchives.gov.uk/+/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_078134 Last accessed 02/09/24

Department of Health and Social Care (2022), The Health and Social Care Act 2008. Available at: https://www.gov.uk/government/publications/the-health-and-social-care-act-2008-code-of-practice-on-the-prevention-and-control-of-infections-and-related-guidance/health-and-social-care-act-2008-code-of-practice-on-the-prevention-and-control-of-infections-and-related-guidance Last accessed 02/09/2024.

Department of Health and Social Care (2022) Code of Practice on the prevention and control of infections and related guidance, available at: https://www.gov.uk/government/publications/the-health-and-social-care-act-2008-code-of-practice-on-the-prevention-and-control-of-infections-and-related-guidance/health-and-social-care-act-2008-code-of-practice-on-the-prevention-and-control-of-infections-and-related-guidance Last accessed 02/09/24

Department of Health (2021) Health Technical Memorandum 01-01 Decontamination of surgical instruments. Available from: https://www.england.nhs.uk/publication/decontamination-of-surgical-instruments-htm-01-01/ Last accessed 02/09/24.

Department of Health (2021) Health Technical Memorandum 01-06 Management and decontamination of flexible endoscopes. Available from: https://www.england.nhs.uk/publication/management-and-decontamination-of-flexible-endoscopes-htm-01-06/ Last accessed 02/09/24.

Department of Health (2016) Health Technical Memorandum 04-01 Safe Water in Healthcare Premises: Parts A, B, C & Supplement. Available at: https://www.england.nhs.uk/publication/safe-water-in-healthcare-premises-htm-04-01/ Last accessed 02/09/24.

Department of Health (2014) - Health Technical Memorandum 00 Policies and principles of healthcare engineering. Available at: https://www.england.nhs.uk/wp-content/uploads/2021/05/HTM_00.pdf Last accessed 02/09/24.

Department of Health (2016) Health Technical Memorandum 01-04 Decontamination of linen for health and social care. Available from: https://www.england.nhs.uk/wp-content/uploads/2021/05/BS_EN14065.pdf Last accessed 02/09/24.

GOV.UK (2020) Collection Staphylococcus aureus: guidance data and analysis. available at: https://www.gov.uk/government/collections/staphylococcus-aureus-guidance-data-and-analysis Last accessed 02/09/24

Health and Safety Executive (2013) Health and Safety Guidance 274 Parts 1-3. Available from: https://legionellacontrol.com/wp-content/uploads/2018/08/hsg274-part-1-control-of-legionella-in-evaporative-cooling-systems.pdf Last accessed 02/09/24.

Health and Safety Executive (2013) Legionnaires' disease - The Control of Legionella bacteria in water systems Approved Code of Practice and guidance on regulations L8 (Fourth Edition). Available from: https://www.hse.gov.uk/pubns/priced/l8.pdf Last accessed 02/09/24.

Infection Prevention Society (2019) One Together Infection Assessment Toolkit. available at: https://www.ips.uk.net/professional-practice/onetogether-infection-control-assessment-toolkit/ Last accessed 02/09/24

NHS England (2023) Health Technical Memorandum 07-01 Management and disposal of healthcare waste
Available from: https://www.england.nhs.uk/publication/management-and-disposal-of-healthcare-waste-htm-07-01/ Last accessed 02/09/24.

NHS England (2023) Minimising Clostridiodes difficile and Gram-negative Bloodstream infections, available at:
https://www.england.nhs.uk/publication/minimising-clostridioides-difficile-and-gram-negative-bloodstream-infections/ Last accessed 24/07/23.

NHS England (2023), National infection prevention and control manual for England. available at:
https://www.england.nhs.uk/publication/national-infection-prevention-and-control/
Last accessed 02/09/24.

NHS England (2021) NHS National Standards of Healthcare Cleanliness, available at:
https://www.england.nhs.uk/publication/national-standards-of-healthcare-cleanliness-2021/ Last accessed 02.09.24

RCN (2021) The role of the link nurse in infection prevention and control (IPC): developing a link nurse framework.
https://www.rcn.org.uk/professional-development/publications/rcn-role-of-the-link-nurse-in-infection-prevention-and-control-uk-pub-009595 Last accessed 02/09/24

UKHSA (2022) Actions to contain carbapenemase-producing Enterobacterales. Available at
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1107705/Framework_of_actions_to_contain_CPE.pdf Last accessed 02/09/24

UKHSA (2013) Protocol for the surveillance of surgical site infection, available at:
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1048707/Protocol_for_the_Surveillance_of_Surgical_Site_Infection.pdf Last accessed 02/09/24.

UKHSA (2024) Confirmed cases of measles in England by month, age, region and upper tier local authority: 2024 – Available at:
https://www.gov.uk/government/publications/measles-epidemiology-2023/confirmed-cases-of-measles-in-england-by-month-age-region-and-upper-tier-local-authority-2024 Last accessed 02/09/24

Our Vision
The best care for every patient

NHS
Norfolk and Norwich University Hospitals
NHS Foundation Trust

REPORT TO THE TRUST BOARD

Date	06.11.2024
Title	Chair's Key Issues Report from Quality and Safety Committee
Lead	Dr Pam Chrispin – Non-Executive Committee Chair
Purpose	**For Information**

1 Background/Context

The Quality and Safety Committee met on 29 October 2024 and discussed matters in accordance with its Terms of Reference. Papers for the meeting have been made available to all Board members for information in the usual way via Admin Control. The meeting was quorate and was attended by Mrs E Betts as a Governor Observer.

Key Issues/Risks/Actions

In addition to reviewing standard reports in accordance with its Terms of Reference, the Committee identified the following matters of note to bring to the attention of the Board:

	Issues considered	Outcomes/decisions/actions
1	Patient Experience Story	The Committee did not undertake a clinical visit this month but instead heard from a mother whose son had died after self-discharging. Her son had ASD and was unable to cope with the ward environment and so did not receive care which may have saved his life. The committee heard that some changes had been made to assist people with ASD and train staff in supporting them, however it was disappointing to hear that the investigation process had been extremely slow with the mother having to chase at every stage to get information. Implementation of changes had also been very slow. This poor experience of care and communication had prompted the mother to join the Patient Panel, and the Committee thanked her for her powerful advocacy for this group of patients and their families.
2	Annual IP&C Report	The Committee discussed the report in some detail. The template is mandated but key local issues were drawn out of the report in relation to rising rates of notifiable infections, which is a national concern. Microbial stewardship was discussed and also water safety. The Committee noted the progress since last year, however the control measures had stopped the use of the baths on MLBU. Monitoring is regular and ongoing. A concern was raised about water coolers being outside the scope of management, however there was assurance that

		this was a known issue and being dealt with. The Committee commends the Annual Report to the Board for approval and wishes to thank the team for their ongoing concerted efforts.
3	Medical Staffing	The Committee received a report on medical staffing and noted two primary risks relating to the uncertainty around ongoing enhanced monitoring by the GP and the pause in implementing the new rostering system. The Committee noted the appointment of Dr Bernard Brett as Medical Director and congratulated him and his refreshed team, especially welcoming Dr Tarnya Marshall who was deputising at the meeting. The Nursing / AHP report was not received this month, however Mrs Emma Chapman gave a verbal update and no new concerns were identified.
4	Stroke Pathway and Hip Fracture Pathway	The Committee received updates on the Stroke and Hip Fracture Pathways. Whilst it was pleasing to see real progress being made in areas that have been a concern for some time the committee were disappointed in the speed of implementation.
5	Chronic Conditions Pathways	The Committee was pleased to see real progress being made on various chronic condition pathways
6	Escalation SOP	The Committee was made aware that the redraft escalation SOP is not yet finalised but that there are plans in place with a opportunity to review the full SOP
7	Clinical Quality Impact Assessment (CQIA)	The Committee received a refreshed paper on CQIA and was assured that the safety/ quality elements of any Cost Improvement Plans (CIP) were discussed in detail and repeatedly reviewed during the process.

3 Conclusions/Outcome/Next steps

The Committee is scheduled to meet again on 26 November 2024, at which meeting the Committee is due to consider:

- Review of the Mortality Report
- Waiting List Harm Review Group
- Quality Programme Board Report
- Mental Health and Complex Care Board report

Recommendation:

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

The Board is recommended to **approve** the annual IP&C report

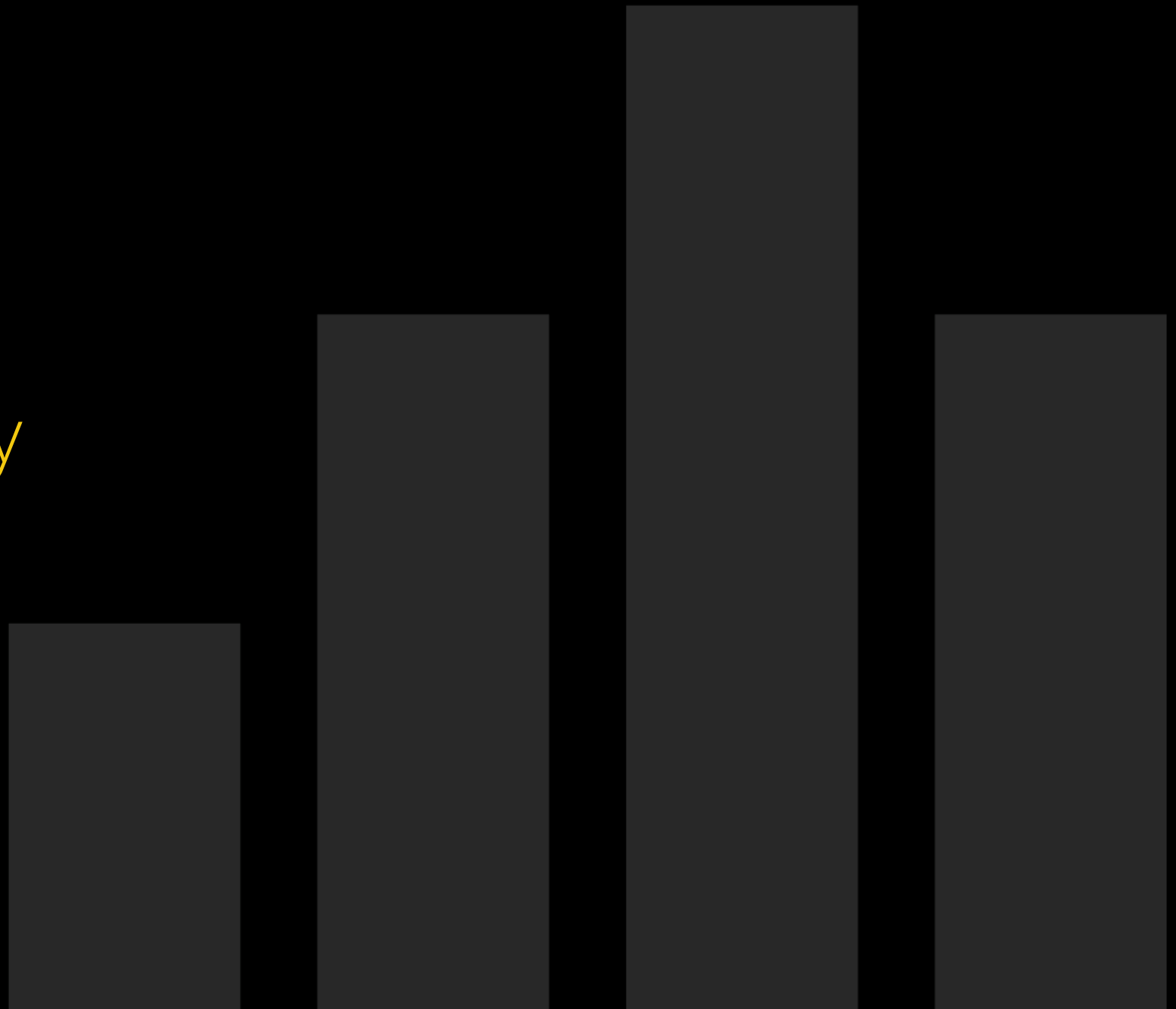
Microsoft | Power BI

Quality & Safety

View in Power BI

Last data refresh:
18/10/2024 09:48:09 UTC

Downloaded at:
18/10/2024 09:54:03 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
Mortality Rate	Crude Mortality Rate	Aug 2024	4.00%	Improvement (Low)	No Target
Palliative Care	Palliative Care IP Referrals Accepted	Aug 2024	6.0	Concern (Low)	No Target
Maternity Activity	Emergency Caesarean Deliveries	Sep 2024	17.5%	Improvement (Low)	No Target
Pressure Ulcers	Hospital Acquired Pressure Ulcers per 1,000 bed days	Sep 2024	0.7	Improvement (Low)	No Target
Palliative Care	Palliative Care Died in Trust and Seen by SPCT	Sep 2024	2.3%	Concern (Low)	No Target
Patient Safety	Percentage Green Incidents Closed Within 20 Working Days	Sep 2024	58%	Improvement (High)	No Target
Safer Staffing	Safe Staffing Care Hours Per Patient Per Day	Sep 2024	7.7	Improvement (High)	No Target
Safer Staffing	Safe Staffing Fill Rates	Sep 2024	94.40%	Improvement (High)	Not capable

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	0	2
	Maternal deaths referred to Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRRACE)	0	0
	Neonatal Deaths Referred To PMRT	1	17
	Child Death referred to local Child Death Overview Panel (CDOP)	4	15
	Death involving patient with Learning Disability referred to local LeDeR reviewer	1	11
	Safeguarding Adults Referrals	53	343
	Information Governance incidents referred to Information Commissioner's Office (ICO)	0	2
	Incidents related to National Screening Programmes referred to local Screening Quality Assurance Team	1	2
	Deaths of patients in custody, in prison or on probation referred to Prison and Probation Ombudsman	0	1
	Incidents meeting Never Event Criteria to undergo PSII	0	4
	Incidents resulting in death, assessed as more likely than not due to problems in care following Structured Judgement Review to undergo PSII	0	2
Trust PSII Priorities	Missed / Delay in Diagnosis to undergo PSII	0	5
	Sub-optimal care to undergo PSII	1	1
Local Level PSR	Incidents to undergo another Patient Safety Review (PSR) to provide a proportionate learning response	71	417

	Supplementary Metrics	Last Month	YTD
Other	Duty of Candour Compliance	100%	97%
	Incidents	1,875	11,960

Assurance Commentary

Total number of patient safety incidents reported on Datix in September was 1250, with 97.2% of all incidents reported as causing no or low harm. There were 53 patient safety incidents causing moderate harm and above, that is 2.8 % of all incidents. 45 incidents caused moderate harm, this includes 17 emergency admission of patient on waiting list: 2 patient falls, 3 patients who were returned to theatre.
4 fatal outcomes were reported in this period, I delay in diagnosis (PSII suboptimal care) 2 unexpected cardiac arrests, I intrapartum stillbirth. (external investigation) 4 patients reported to have suffered severe harm: 1 treatment delay, 1 IP fall, 1 unexpected cardiac arrest, 1 nutrition incident. There was 1 incident escalated for a full Patient Safety Incident Investigation (PSII) 1 Sub optimal care and 2 cases referred for Structured Judgment Reviews (SJR) There are 8 ongoing PSIIs. Since June 2024 the number of incidents reported is below the mean of 2015.

Improvement Actions

Divisional Governance teams continue daily incident triage of incidents to allocate them to a proportionate learning response. 1156 safety events were triaged during September. 1064 of which were triaged for validation of facts and logged on Datix. 67 learning responses were for a case note review.
The governance process for developing safety action to address areas of improvement identified through PSII is still work in progress.

Pressure Ulcers

NNUH Digital Health
business intelligence

Hospital Acquired Pressure Ulcers per 1,000 bed days

Sep 2024

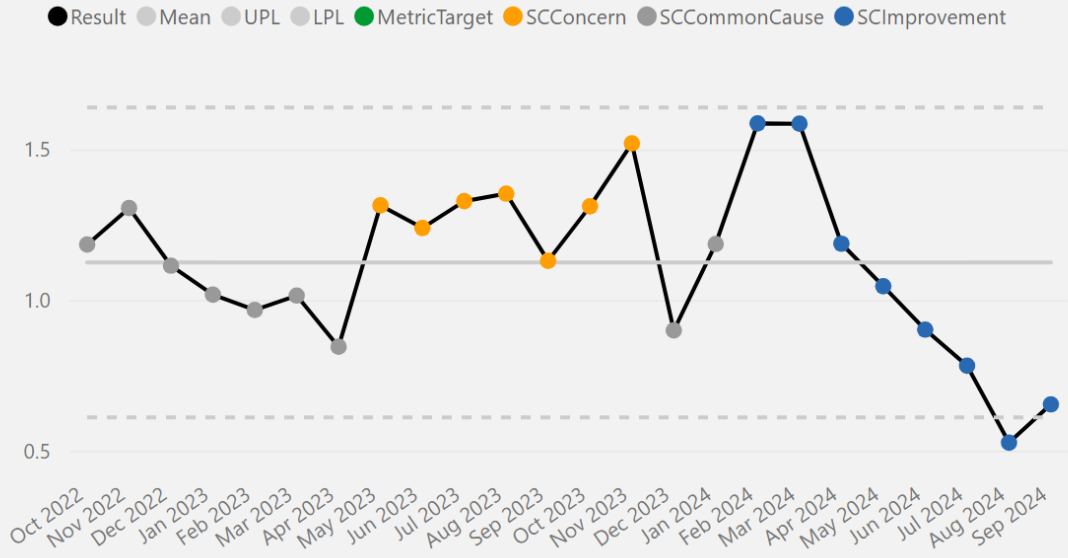
Variation | Assurance

0.7 Result	1.6 UPL
N/A Target	1.1 Mean
	0.6 LPL

Analytical Commentary

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

Hospital Acquired Pressure Ulcers per 1,000 bed days



Assurance Commentary

Despite a slight increase in Hospital Acquired Pressure Ulcers this month compared to last month, our average continues to improve in comparison to previous years. Risk assessment tools appear to be being completed within a suitable timeframe.

Improvement Actions

Healthcare Support Worker induction days continue to be supported by Tissue Viability in which we cover Pressure Ulcer prevention and management.
The trial for clinical photography of Pressure Ulcers will commence soon once staff in the pilot area are signed up to the PhotoWare system. If successful, the roll out of training across the trust will take place so that we may meet the new national guidelines/requirements.

Patient Falls

NNUH Digital Health
business intelligence

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

Sep 2024

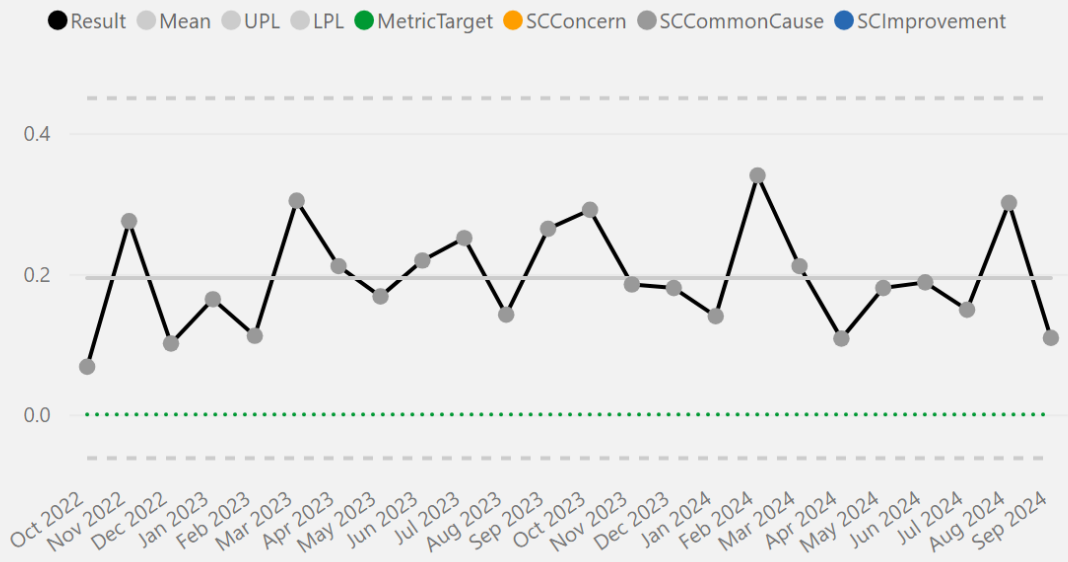
Variation | Assurance

0.1 Result
0.0 Target
0.5 UPL
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

Falls per thousand bed days for September is at 6.6 showing a variation which is common cause. The seasonal increase in falls has already started in correlation with an increase in bed occupancy, however remains lower than 2023. Falls per thousand bed days moderate harm and above are 0.3 within the upper process limit following 7 falls which caused moderate harm or above.

Improvement Actions

ICS falls & frailty data sharing project between CMIU / NNUH ED & North Norfolk District Council progressing well, data will be included in the Falls Joint Strategic Needs Assessment for Norfolk & Waveney. Falls Datix questions to be exported to Power Bi to generate falls KPI dashboard to monitor internal compliance. Electronic NNUH specific falls training to be discussed with PD&E. Patient stories project with Age UK Norwich animation to be completed by November. Reframing of Falls Prevention Assessment to Safe Activity Assessment to be adopted in line with National Audit of Inpatient Falls.

Patient Experience

NNUH Digital Health
business intelligence

Friends & Family Score

Sep 2024

Variation	Assurance
	

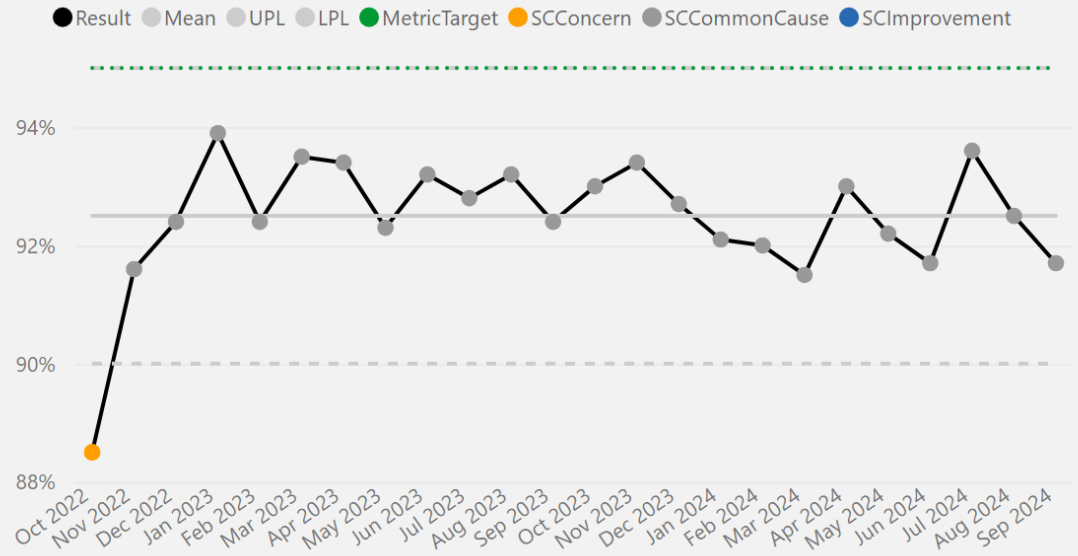
91.70% Result
95.00% Target

95.00% UPL
92.50% Mean
90.00% LPL

Analytical Commentary

Variation is Common Cause

Friends & Family Score



Assurance Commentary

3512 Friends and Family Test (FFT) responses were received in September, responses remain within our usual limits.
Top feedback themes remain staff attitude, implementation of care, waiting time, communication, and environment for both positive and negative.
Overall, 91.3% of feedback received was positive.

Improvement Actions

Staff engagement with the friends and family test (FFT) and the system we use to report on it has increased. Patient Experience Facilitators aligning with divisions to support patient feedback/involvement within quality improvement work.
SMS use across the Trust being reviewed to ensure it is being used in the most efficient way now we have a more robust and flexible mechanism for managing it. System upgrade to improve demographic reporting is underway with the supplier.

Supplementary Metrics

Metric Name	Date	Result		Variation		Assurance
Compliments	Sep 2024	101		Common Cause		No Target

Patient Concerns

NNUH Digital Health
business intelligence

PALS % Closed within 5 days - Trust

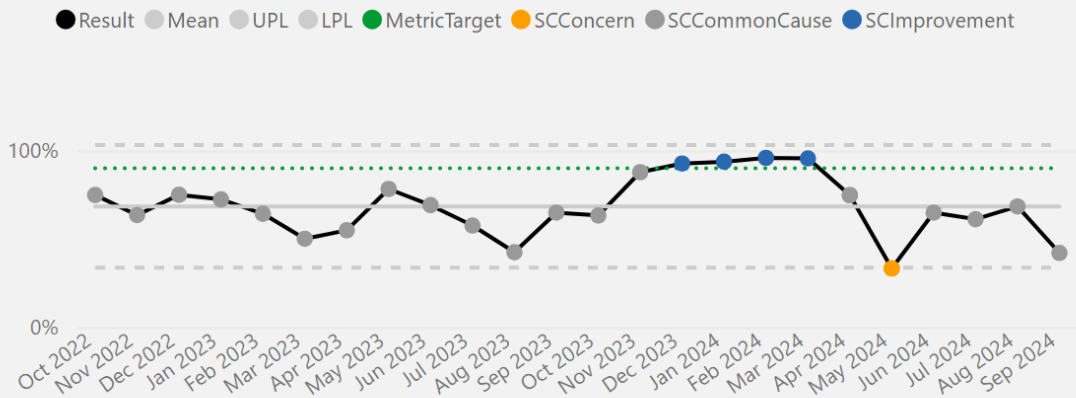
Sep 2024

Variation | Assurance

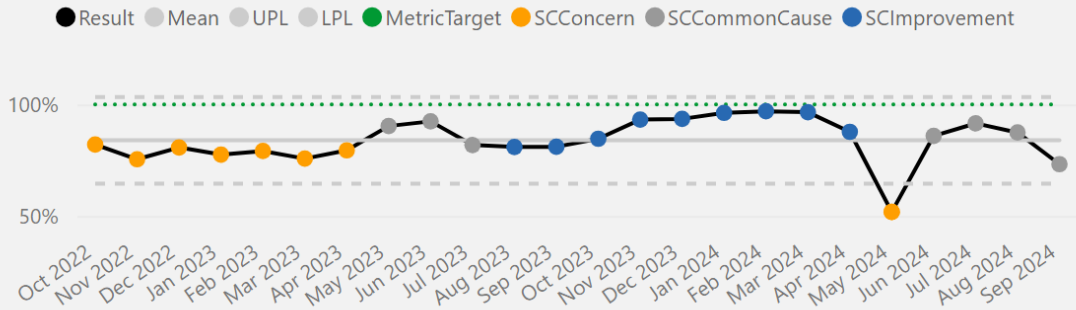
42.0% Result
90.0% Target

103.0% UPL
68.3% Mean
33.6% LPL

PALS % Closed within 5 days - Trust



PALS % Closed within 7 days - Trust



Supplementary Metrics

Metric Name	Date	Result		Variation		Assurance
PALS Contacts - Trust	Sep 2024	441		Common Cause		No Target

Analytical Commentary

Variation is Common Cause

Assurance Commentary

An increase to 440 PALS matters raised this month. Of those 177 were categorised as Enquiries, 259 signposting, 2 best wishes and 2 suggestions. Appointments including delays and cancelations (70), waiting times (24) and communications (22) continue to be the most common subject matter. PALS KPI 38.5% of contacts were closed within 5 days from first received, target being 90%. PALS KPI 68.3% of contacts were closed within 7 days from first received, target of 100% Achieving the KPIs has been very challenged this month due to the vacancy in the team, no Bank support and higher volume of contacts in September.

Improvement Actions

Substantive post going through recruitment process.
Additional interim Bank replacement support now being sourced to support vacancy recruitment gap. When PALS have full establishment the KPI should improve.
Early analysis of the answerphone changed message (to reduce repeat callers) shows decrease from 41 in July to 23 in August and September. This will continue to be monitored.

Complaints

NNUH Digital Health
business intelligence

Complaints (Trust)

Sep 2024

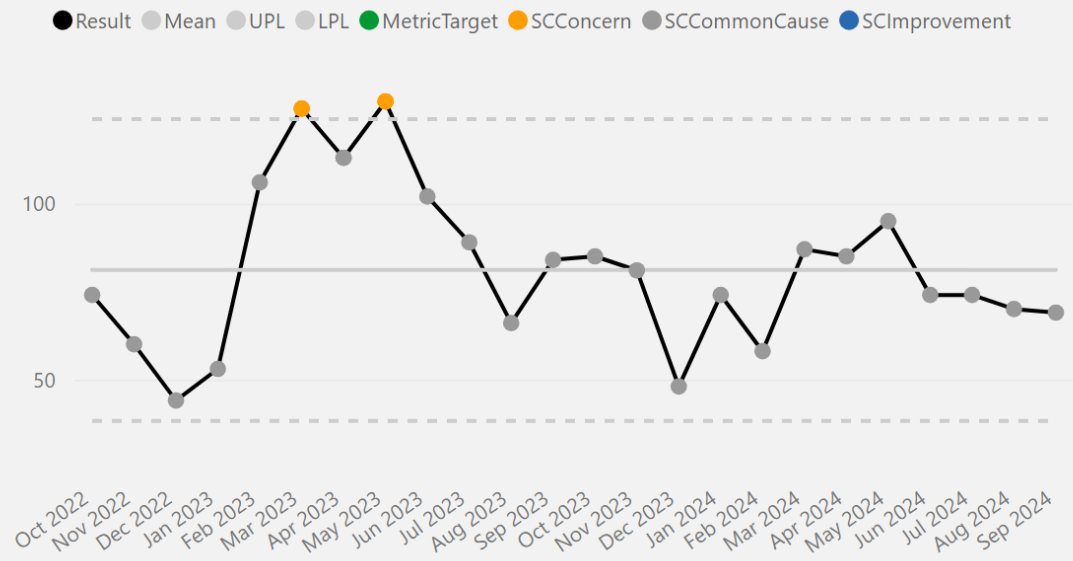
Variation | Assurance

69 Result
N/A Target
124 UPL
81 Mean
38 LPL

Analytical Commentary

Variation is Common Cause

Complaints (Trust)



Assurance Commentary

65 formal complaints were received this month, with a further 28 pending consent and 11 potential complaints.
Clinical treatment (35), Patient care including nutrition and hydration (19) and values and behaviours of staff (14) were the top subject areas.
Closing the Gap is still active, currently there are 155 cases 5 months or older awaiting a first Trust response, a reduction of 29 from the previous month.

Improvement Actions

Improvement work continues with the addition of Women and Children Division into new fielding process. All divisions now aligned. Extra phoneline for open complaints working well, improving communication with case managers. A dedicated email is to be trailed to further enhance this. Website information being updated.
Vacant Band 6 post is currently filled by someone on a redeployment trial period. Bank staff continue to support Closing the Gap and long term sickness.

Supplementary Metrics

Metric Name	Date	Result		Variation		Assurance
Complaints - Acknowledgement	Sep 2024	98%		Common Cause		Inconsistent
Complaints - Response Times - Trust	Sep 2024	83%		Common Cause		Inconsistent
Post-investigation enquiries	Sep 2024	12		Common Cause		Capable

Palliative Care

NNUH Digital Health
business intelligence

Palliative Care Seen Within 48 Hours

Aug 2024

Variation | Assurance

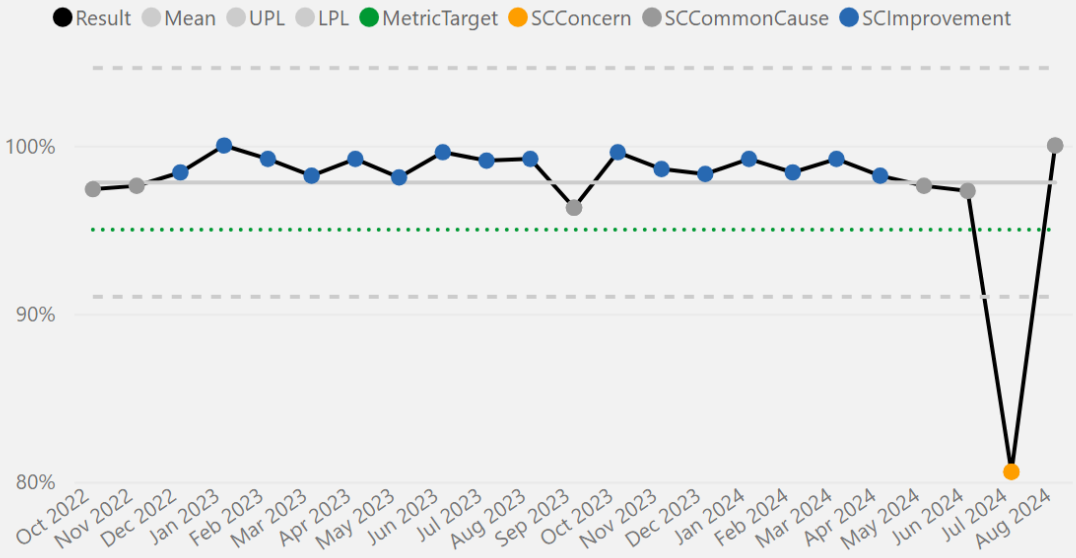
100.0% Result
95.0% Target

104.6% UPL
97.8% Mean
91.0% LPL

Analytical Commentary

Variation is Common Cause

Palliative Care Seen Within 48 Hours



Assurance Commentary

The team continue to see patients within the 48 hours KPI, and have been consistently above the 95% target, this month 99.3%, with the number of referrals within typical activity for the team. The percentage of patients who died in hospital who had been seen by the Specialist Palliative Care Team remains higher at 40.6% than the national average of 30%.
National Ambitions presented to the hospital board, who were very positive and supportive.
Metrics agreed with Chief Nurse and Divisional Nursing Director.

Improvement Actions

To present proposed new metrics aligned to the National Ambitions to End of Life Steering Group. This was cancelled this month due to hospital pressures.
To continue with ongoing programme of training and education for all staff for End of Life.
To continue ongoing planning aligned with the 6 National Ambitions of End of Life care.

Supplementary Metrics

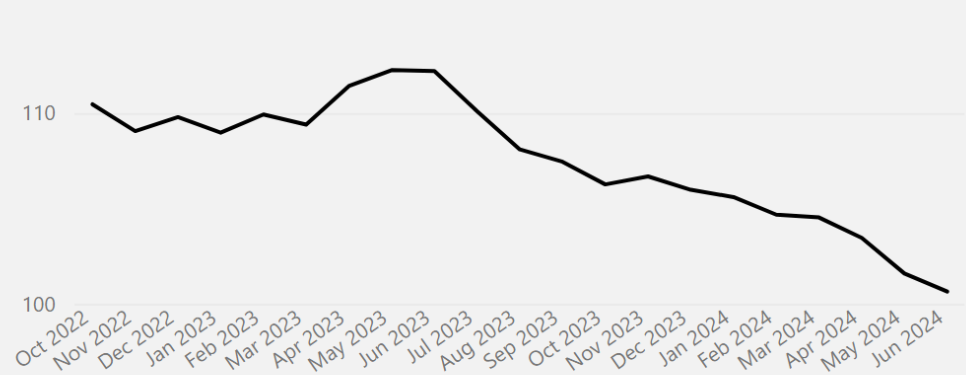
Metric Name	Date	Result		Variation		Assurance
Palliative Care Died in Trust and Seen by SPCT	Sep 2024	2.3%		Concern (Low)		No Target
Palliative Care IP Referrals Accepted	Aug 2024	6.0		Concern (Low)		No Target

Mortality Rate

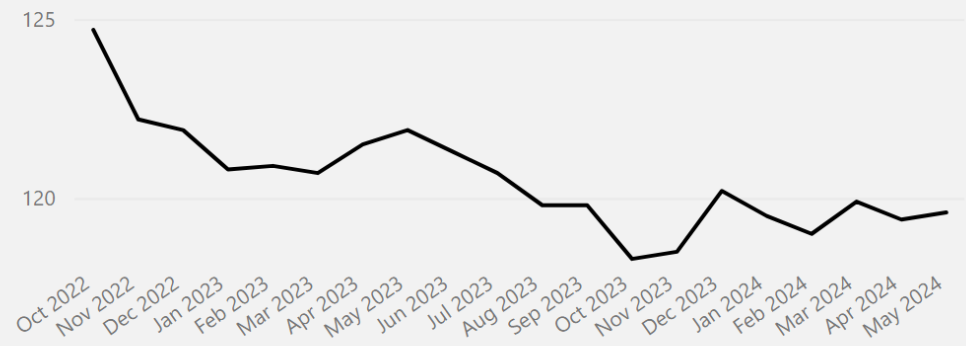
NNUH Digital Health
business intelligence

MetricName	Date	Result
HSMR	Jun 2024	100.64
SHMI	May 2024	120

HSMR



SHMI



Supplementary Metrics

Metric Name	Date	Result		Variation		Assurance
Crude Mortality Rate	Aug 2024	4.00%		Improvement		No Target

Assurance Commentary

HSMR is on downward trajectory, however palliative care adjustment will cease under HSMR+, and the HSMR+ may potentially more closely match SHMI.
SMR remains "higher than expected", in part due to the use of "Residual Codes, unclassified" where the final hospital spell has not been coded. These hospital spells are allocated a low risk of death though this may be incorrect.
One new SMR alert: "Other congenital anomalies", which is being reviewed with the other known eight alerts.

Improvement Actions

For the Medical Director, supported by the Deputy Medical Director for Quality, Safety and Clinical Transformation to review the improvement programme for Mortality & Morbidity and the implementation management of these improvements as the Associate Medical Director of Quality & Safety has stepped down from the end of September.

Safer Staffing

NNUH Digital Health
business intelligence

Safe Staffing Fill Rates

Sep 2024

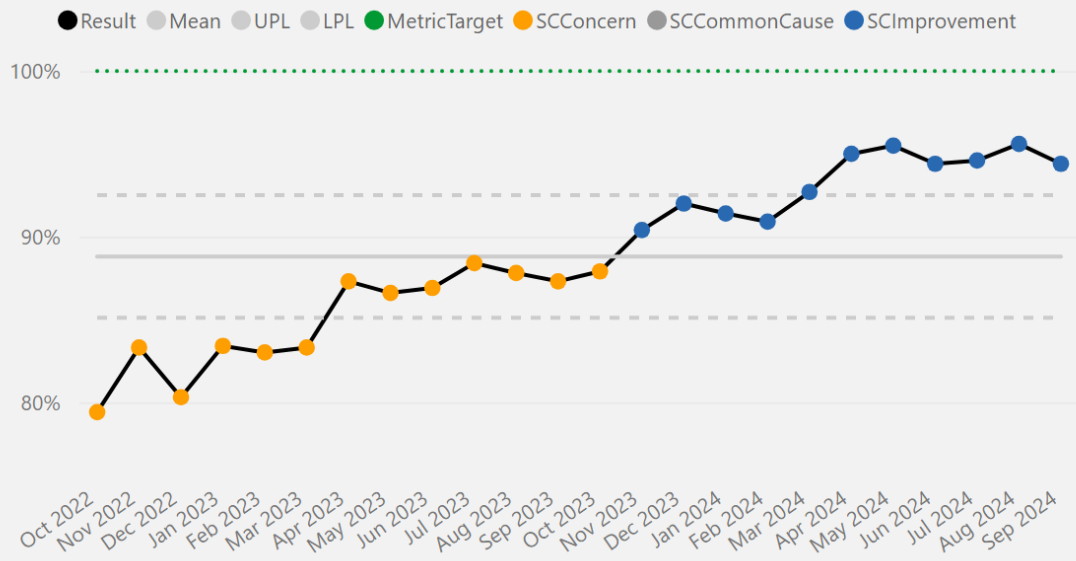
Variation	Assurance
H	F

94.40% Result	92.50% UPL
100.00% Target	88.80% Mean
	85.10% 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

Trust-wide vacancy rate for registered staff has increased to 8.8% (241.9 WTE) and continues to slowly decrease to 14.0% (n=202.9) from 14.9% (n=215.3) in July with a reported turnover rate of 1.5% (21.6 new starters / 16.6 WTE leavers) for HCSWs. RN/M fill rate & remained static at 95.3%.
Trust wide fill rates for September RN/M fill rate fell below 80%. The HCSW fill rate fell below 80% in September in escalation, & Cley Ward. CHPPD was 8.1 September 2024, placing us in the lowest 25% (quartile 1), though this is above the 12-month average of 7.5. Despite the absence of a nationally set CHPPD figure, our numbers fall below both our recommended peer average of 8.2 and the provider median of 8.5 for total nursing and midwifery.
Red flags decreased to 1,139 in August with 66% remaining open (in total, 339 were resolved, 36 reviewed and 52 raised in error). 603 of these were raised for a shortfall in RN time and 498 for shortfall of HCA.

Improvement Actions

Work continues to reduce and sustain Agency Spend to less than 3.2% which is monitored at Divisional Performance Committee.
To continue to monitor incidents reported, 183 incidents reported in July as causing harm relating to Nursing and Midwifery indicators, a decrease from 209 in July. Of these, 7 were reported as moderate harm, 5 slips/falls reported as moderate and 3 severe reports of slips/falls.

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	Sep 2024	7	90	7
CPE positive screens	Sep 2024	2	N/A	1
E. Coli trust apportioned	Sep 2024	8	100	4
HOHA Trajectory C. Difficile Cases	Sep 2024	0	0	2
Hospital Acquired MRSA bacteraemia	Sep 2024	0	0	0
Klebsiella trust apportioned	Sep 2024	2	55	3
MSSA HAI	Sep 2024	1	N/A	3
Pseudomonas trust apportioned	Sep 2024	1	29	1

Assurance Commentary

Heydon has had a COVID-19 outbreak.
Guist and NICU received support for increased incidences.
Regular NICU IMT meetings held, latest 04.09.2024. No further cases. Guist period of increased incident closed 13.09.24.
One case of Candida Auris transferred from a London hospital, managed appropriately. Hydrogen Peroxide Vapour (HPV) utilised to clean the environment.

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 via monthly OWL and is integrated within Datix. Providing access to divisional governance teams, ensuring actions and learning is discussed and disseminated appropriately.

C. difficile Post Infection Review (PIR) meetings held monthly with clinical staff and Norfolk & Waveney ICB to establish lapses in care. Learning is disseminated via 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.
Local Candida Auris screening policy undergoing review. SERCO arranging training of their staff on the use of the HPV machine.

Covid-19 Timeseries

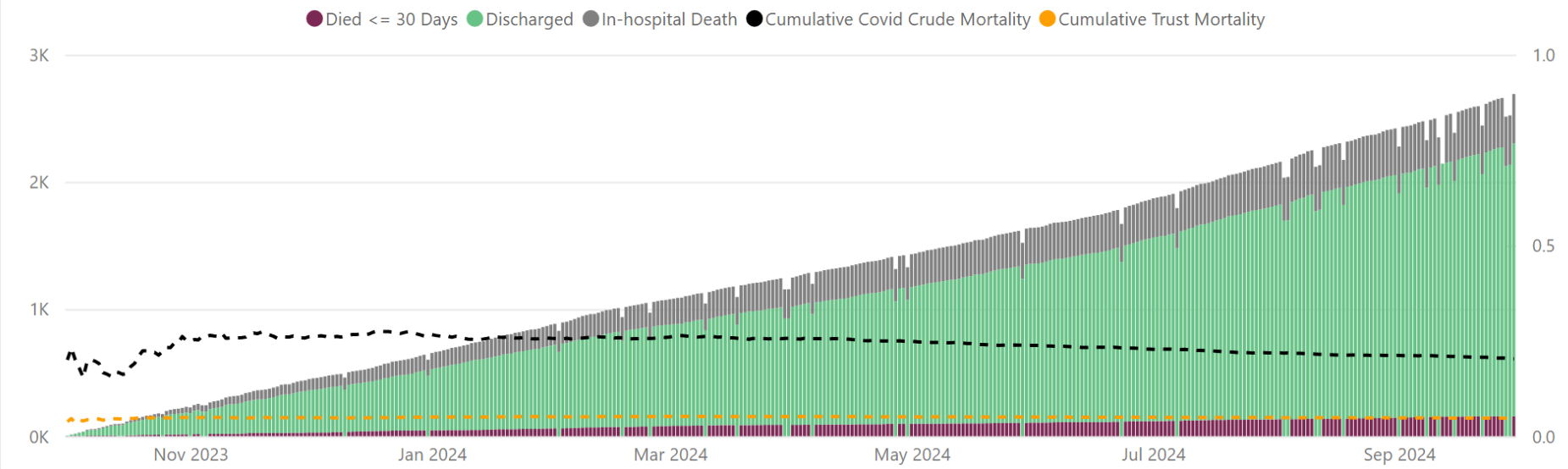
Inpatient deaths and discharges recorded on PAS for Covid-19 positive patients

NNUH Digital Health
business intelligence

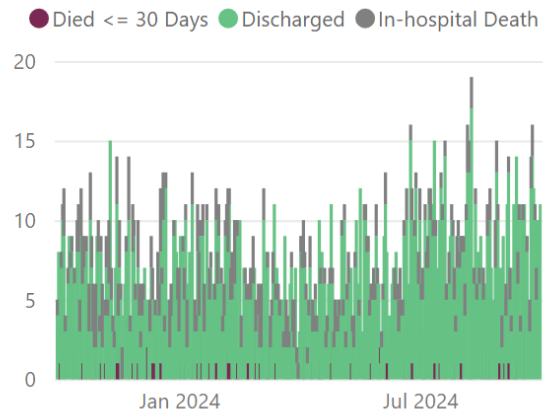
Discharge Date: 01/10/2023 – 30/09/2024

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
2690	388	157	2145	0.20	0.05	19	5

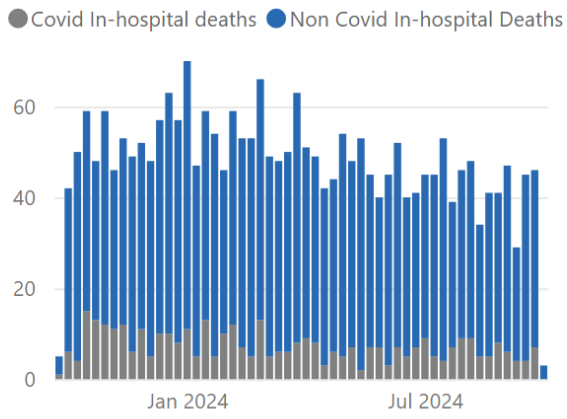
Cumulative Covid-19 Discharges, Deaths and Crude Mortality



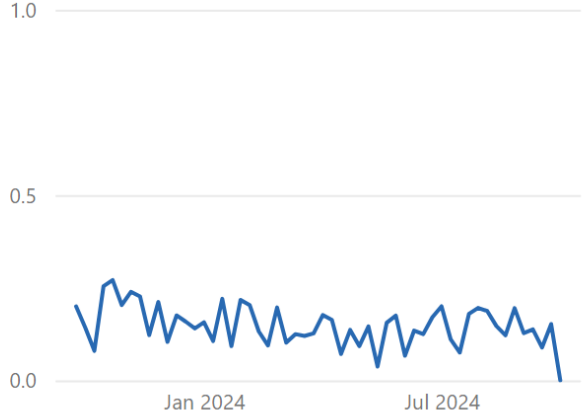
Covid-19 Discharges and Deaths by Day



In-hospital Deaths by Week



% Covid-19 Positive In-hospital Deaths



Maternity: Mothers

NNUH Digital Health
business intelligence

Mothers Delivered

Sep 2024

Variation | Assurance

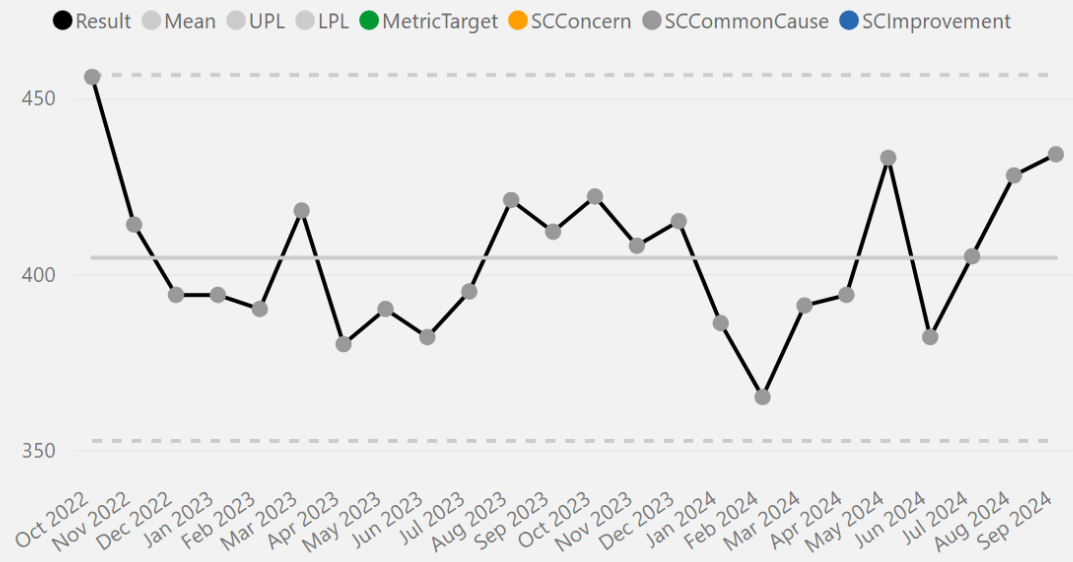
434 Result
N/A Target

457 UPL
405 Mean
352 LPL

Analytical Commentary

Variation is Common Cause

Mothers Delivered



Assurance Commentary

In September we had 434 mothers delivered with 435 babies. We had 369 babies birthed on delivery suite, 52 on Midwifery Led Birthing Unit, 13 home births and 3 born before arrival. 91.1% of our women were booked before 13 weeks. 33.2% of pregnant women were induced - 0.7% of those were for reduced fetal movements. We had 158 c/s - 82 elective cases and 76 emergency cases. We had 72 instrumental deliveries and 204 cephalic deliveries. We had 1 admission to critical care - as a planned event following AIP c/s. We had 6 maternal readmissions back to the hospital - these cases have been reviewed and 3 were due to sepsis, 1 hypertension, 1 secondary post-partum haemorrhage and 1 for Trial Without Catheter (TWOC). We had 2.9% 3/4th degree tear and 2.1% PPH rate - both within the benchmark parameters.

Improvement Actions

To monitor readmissions. To monitor Born Before Arrival's. To review admissions to Critical Care and to monitor and consider impact of transfers of women due to NICU activity.

Supplementary Metrics

Metric Name	Date	Result		Variation		Assurance
1:1 Care in Labour	Sep 2024	97.8%		Common Cause		No Target
3rd & 4th Degree Tears	Sep 2024	2.9%		Common Cause		Inconsistent
Births Before Arrival	Sep 2024	3		Common Cause		No Target
Post Partum Haemorrhage ≥1500mls	Sep 2024	2.1%		Common Cause		No Target

Mothers Delivered

434

Babies Delivered

435

Maternity: Babies

NNUH Digital Health
business intelligence

Unplanned NICU ≥37 week Admissions (E3)

Sep 2024

Variation	Assurance
	

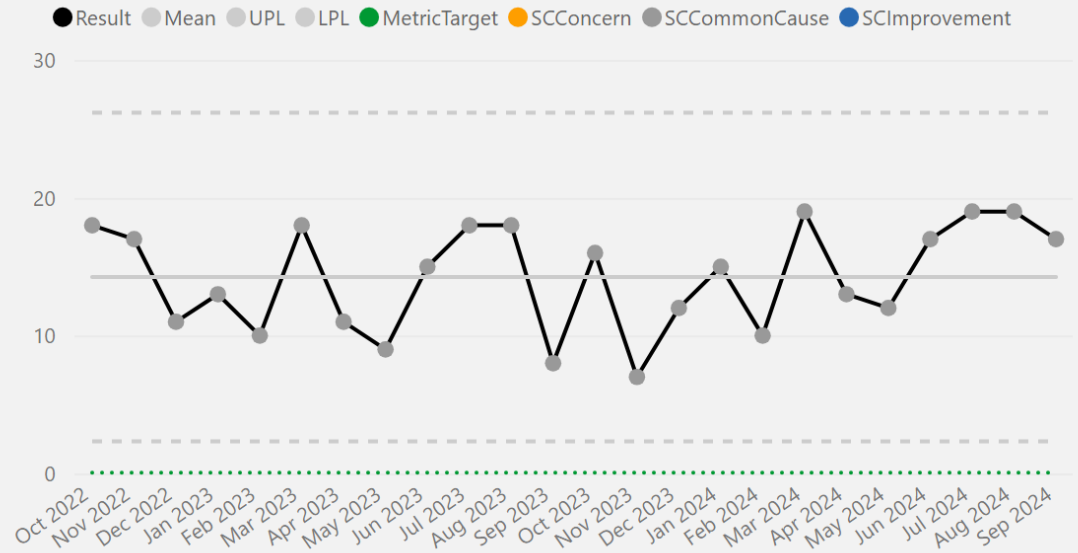
17 Result
0 Target

26 UPL
14 Mean
2 LPL

Analytical Commentary

Variation is Common Cause

Unplanned NICU ≥37 week Admissions (E3)



Assurance Commentary

In September we had 435 babies delivered. We had 4 stillbirths and 0 Neonatal deaths. We had 1 Hypoxic Ischaemic Encephalopathy (HIE) 111/cooled baby - this case is being reviewed.
6.4% of babies delivered in this period were preterm, with 100% of these babies that were born before 30/40 gestational age, the woman receiving magnesium sulphate.

Improvement Actions

NICU admissions to be reviewed via the daily triage process and deep dive by Avoiding Term Admissions into Neonatal Units (ATAIN) team. Monitor infant feeding statistics.

Supplementary Metrics

Metric Name	Date	Result		Variation		Assurance
Adjusted Still Births	Sep 2024	3		Not Applicable		No Target
Apgar score <7 @5, ≥37 weeks	Sep 2024	9		Common Cause		No Target
Early Neonatal Death	Sep 2024	0		Not Applicable		No Target
Mothers Transferred Out of Unit	Sep 2024	3		Common Cause		No Target

Saving Babies Lives

NNUH Digital Health
business intelligence

Topic	Metric Name	Date	Result		Variation		Assurance
Smoking Awareness	Smoking Status at Delivery	Sep 2024	5.8%		Common Cause		Inconsistent
Fetal Growth Restriction	Less Than 3rd centile born > 37+6 weeks	Sep 2024	2%		Common Cause		Not capable
Fetal Growth Restriction	SGA detected Antenatally	Sep 2024	94%		Common Cause		No Target
Reducing Preterm Birth	Singleton Births Preterm	Sep 2024	6%		Common Cause		Inconsistent
Reducing Preterm Birth	Singleton live births < 34 wks (AN corticosteroids within 7 days PN)	Sep 2024	20%		Common Cause		Not capable

Assurance Commentary

In September we had 6.2% of women smoking at booking, we had 5.8% smoking at delivery. We referred 11.4% of women to smoking cessation services. We performed CO2 monitoring on 98.4% of our booking appointments. 99.3% of our women were given the reduced fetal movement information at 28/40. We had 1 referral for HIE 111, and 4 stillbirths. 6.4% of our September deliveries were preterm. 100% of preterm 30/40 mothers received the magnesium sulphate. We were compliant with our mandatory training for Fetal Monitoring - 96%, IAA 99.2%, and 89.8% for Saving Babies Lives Care Bundle.

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.

Caesarean section births in Robson groups

Improving lives together
Norfolk and Waveney Integrated Care System

Organisation

NNUH

Date Range

01/06/2023 31/08/2024

August 2024

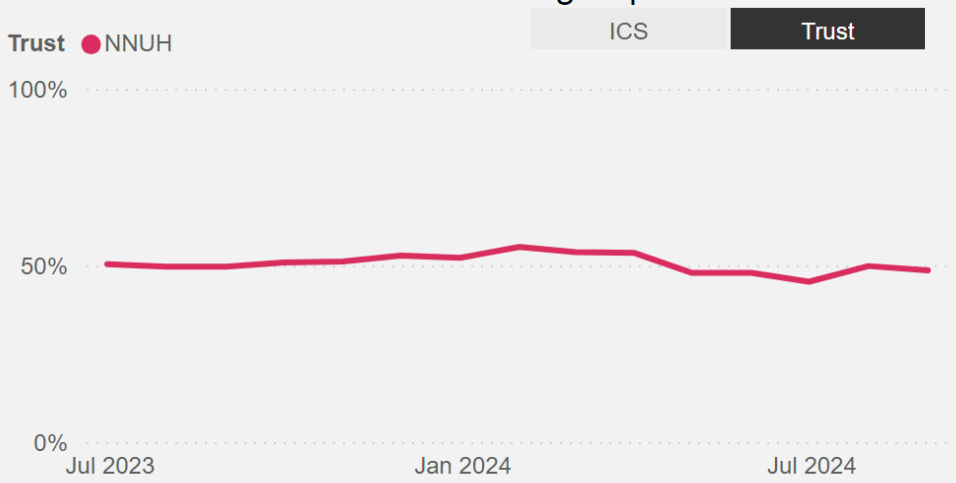
Robson group 1
13.0%

Robson group 2
48.6%

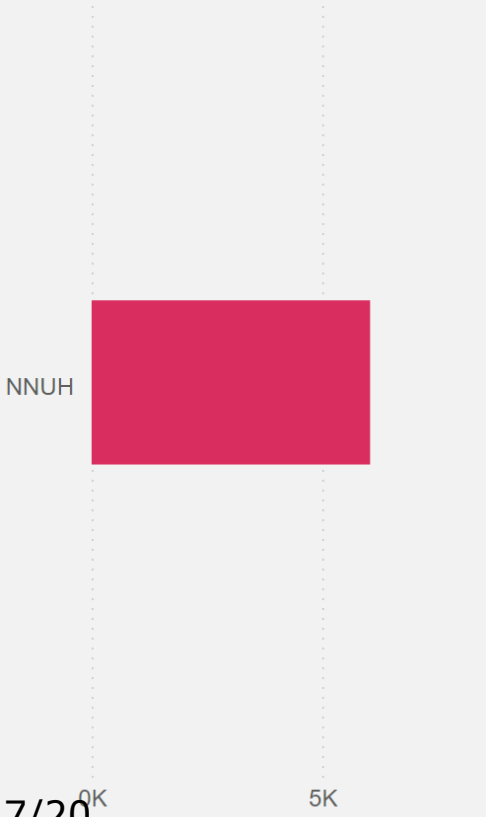
Robson group 5
86.0%

Caesarean Section Rate Robson group 1

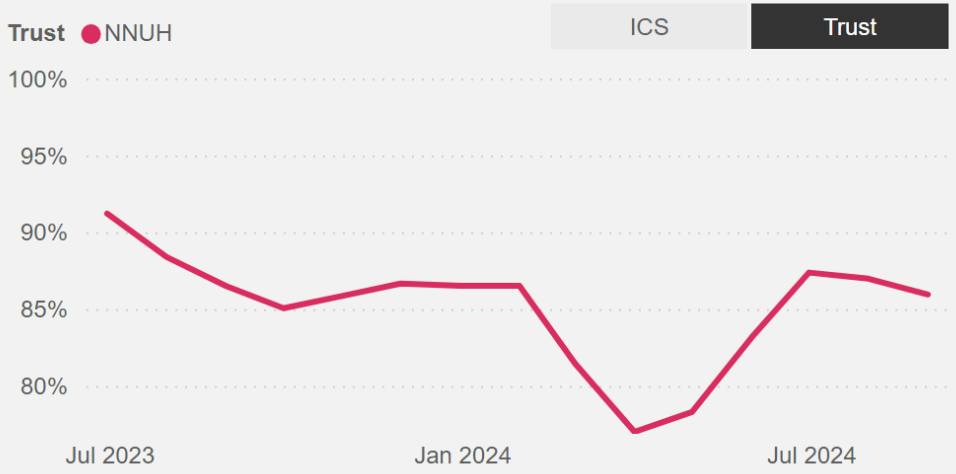
Caesarean Section Rate Robson group 2



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

01/06/2023 31/08/2024

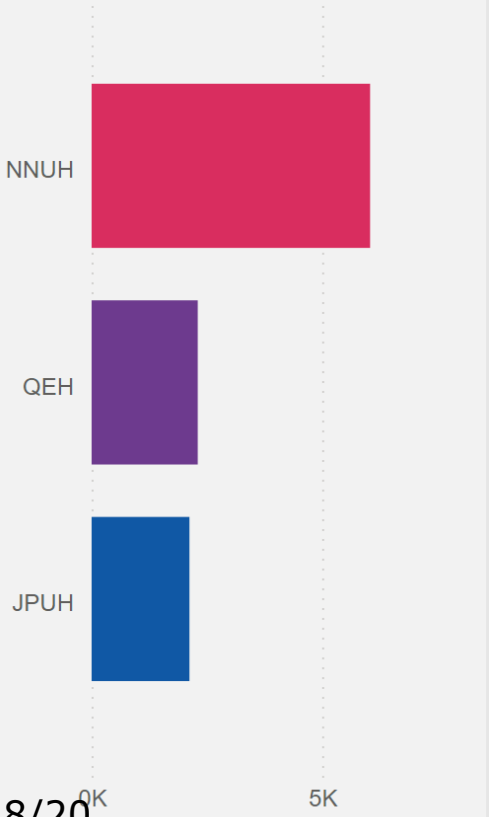
August 2024

Robson group 1
19.2%

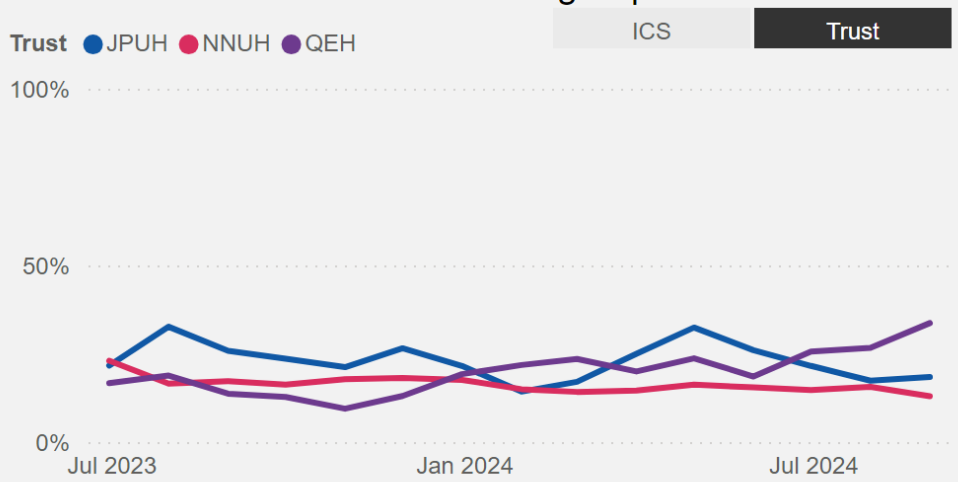
Robson group 2
51.8%

Robson group 5
83.8%

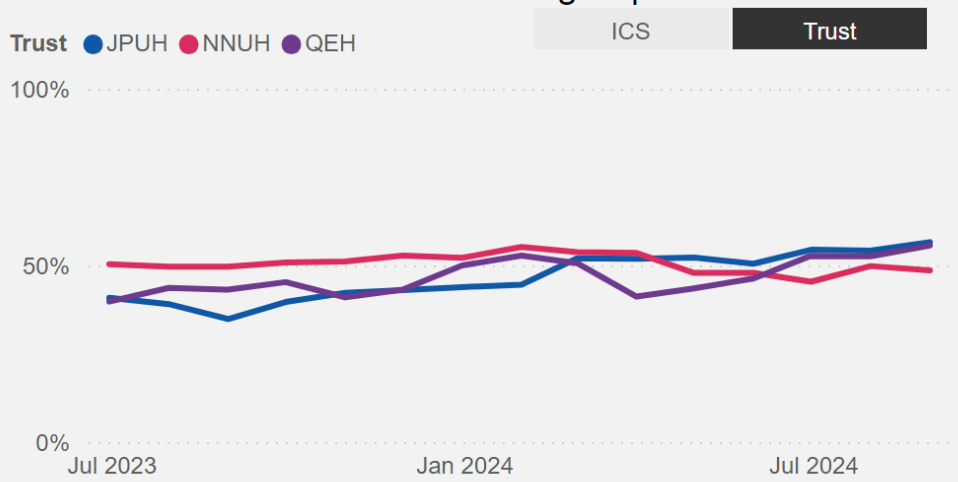
Number of Women Birthed



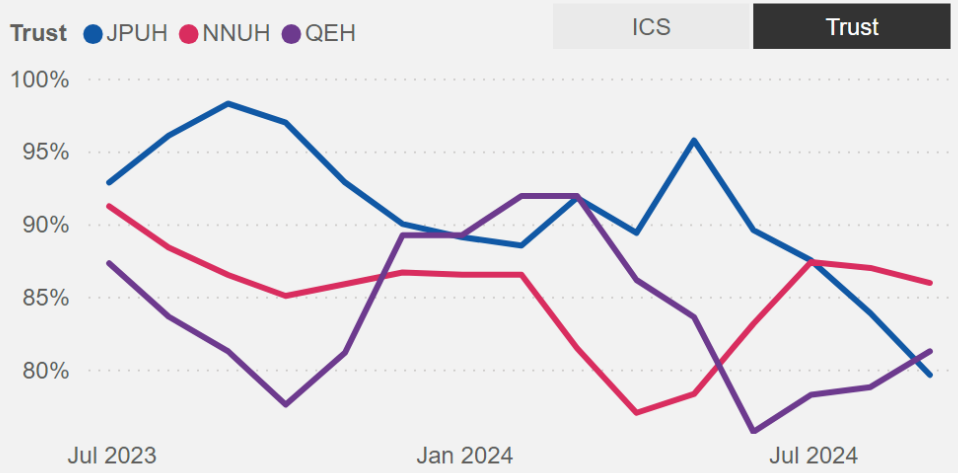
Caesarean Section Rate Robson group 1



Caesarean Section Rate Robson group 2



Caesarean Section Rate Robson group 5



Adult Safeguarding

NNUH Digital Health
business intelligence

Safeguarding Adults Referrals

Sep 2024

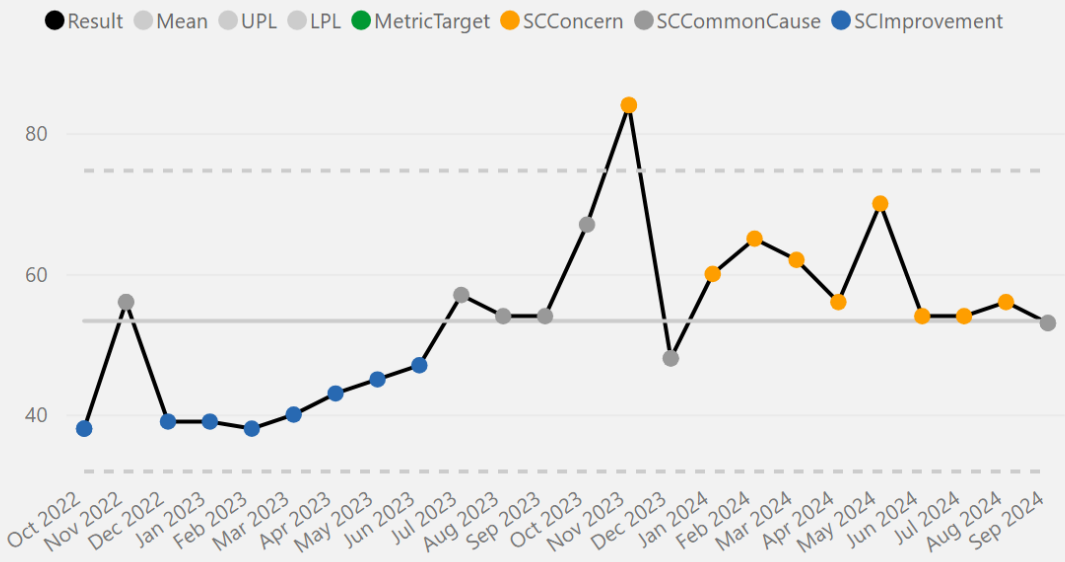
Variation | Assurance

53 Result
N/A Target
75 UPL
53 Mean
32 LPL

Analytical Commentary

Variation is Common Cause

Safeguarding Adults Referrals



Assurance Commentary

The Norfolk Safeguarding Adults Board (NSAB) Framework pilot is at the mid-way point. The OPM wards are still engaging and contributing to the work. NNUH are meeting with QEH, JPH, alongside Adult Social Services colleagues to identify gaps and effective ways of working when investigating enquiries raised by Norfolk County Council (NCC). This will be chaired by The Head of Service for Safeguarding at NCC and will be scheduled for end of November/early December. The objective is to support NCC to streamline how they make enquiries but also for the acutes to try and establish if there are practices, we can emulate from each other despite the different ways in which each Acute Hospital operates or the systems they use.

Improvement Actions

The safeguarding team have so far been invited to participate in 2 Accreditation of Excellence visits led by the Quality Improvement Team. The team has identified some gaps in knowledge in ward areas and are building supportive procedures to help increase staff confidence in safeguarding and MCA matters. NNUH Safeguarding Team continues to represent the Trust at multi-agency forums involving specific cases but also in collaboration to improve processes as a system. Legislation surrounding safeguarding adults has updated in some areas, this has been reflected in our Trust guidance.

Children & Midwifery Safeguarding

NNUH Digital Health
business intelligence

Safeguarding Children and Midwife...

Sep 2024

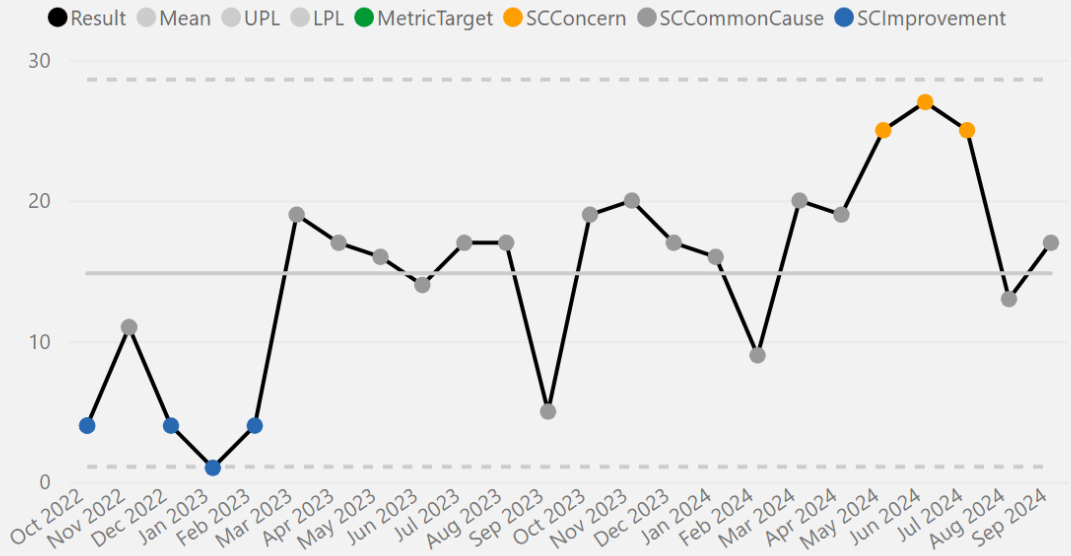
Variation	Assurance
	

17 Result	29 UPL
N/A Target	15 Mean
	1 LPL

Analytical Commentary

Variation is Common Cause

Safeguarding Children and Midwifery Referrals



Assurance Commentary

The Norfolk Graded Care Profile (NGCP) is fully embedded within midwifery practice. This tool consistently standardises the language used surrounding neglect and the grading across the multi-agency. It supports staff to manage challenging conversations that are likely to ensue with families but it also positively reflects some family dynamics which sometimes get missed owing to concentrating on the safeguarding aspects. NNUH Safeguarding Team is committed to raising the profile of neglect and the use of the tool as part of the response to it being one of the Norfolk Safeguarding Children`s Partnership priorities. There are plans to roll out the tool within Paediatrics Specialist areas.

Improvement Actions

The Child Protection Information Sharing System (CP-IS) is up and running in CHED. NHSE Digital is promoting CP-IS and mandating it`s use in healthcare settings. Next phase at NNUH will be promoting it in CAU and maternity departments. The section 11 for 2024 has been completed by the Safeguarding Lead and Named Midwife for Safeguarding. The draft will be shared with the Safeguarding Assurance Committee at the next Board on 16th October for feedback. Final sign off will be provided by the Chief Nurse and Director for Complex Health, Safeguarding and Professional Standards.

Supplementary Metrics

Metric Name	Date	Result		Variation		Assurance
Safeguarding Children Referrals	Sep 2024	9		Common Cause		No Target
Safeguarding Midwifery Referrals	Sep 2024	8		Common Cause		No Target

REPORT TO THE TRUST BOARD

Date	30 October 2024
Title	Chair's Key Issues Report from Finance, Investments & Performance Committee
Lead	Mrs N Gray – NED Committee Chair
Purpose	**For Information & approval as specified**

1 Background/Context

The Finance, Investment and Performance Committee met on 30 October 2024 and discussed matters in accordance with its Terms of Reference. Papers for the meeting have been made available to all Board members for information in the usual way via Admin Control. The meeting was quorate and was attended by Dr Bruce Fleming as Governor Observer.

2 Key Issues/Risks/Actions

In addition to reviewing standard reports in accordance with its Terms of Reference, the Committee identified the following matters to highlight to the Board:

	Issues considered	Outcomes/decisions/actions
1	Cyber Security	The Committee received a report regarding the progress being made in implementing recommendations arising from experience of cyber attacks by the NHS. The Committee further discussed the need for the profile of cyber security to be heightened at Board level and culturally across the wider organisation and what associated investments would be required to support this need. The Committee **took partial assurance** that investment will be considered in the 24/25 planning cycle, however, would be subject to the usual prioritisation challenges.
2	Digital Oversight	The Committee **discussed the need** for greater oversight of the Trust's digital agenda, strategy and roadmap and considered the need for an additional Board Committee to be set-up accordingly. Mr Prosser-Snelling will compile a recommendation for FIPC consideration.
3	Insourcing and Indemnification	The Committee received an update report following Board discussion of indemnity arrangements for insourced clinical services. The Committee **sought and gained assurance** that any risk is understood, recorded on the risk register and largely mitigated.
4	Treatment of Elective Patients at distant providers	Mr Cobb explained a significant risk to meeting the elective waiting time targets is limitations on the use of distant providers for elective surgery, due to complications associated with prolonged transport times in the peri-operative period. The transportation issue is exacerbated as the use of unfamiliar implants may require patients to travel to the surgical provider for post-operative follow-up. The Committee **noted the work** and involvement of the national team to further understand and remediate this issue. Mr Cobb will provide a further update at both the Q&S and FIP Committees to assure the Board that any risk to patient safety and further impact on elective targets is understood and mitigated.

5	Pay Overspend	The Committee **expressed concern** regarding the continuing overspend against the pay budget as presented in the Finance YTD report. Ms Sanford agreed to provide further analysis of this issue at the next Recovery Plan Progress meeting, scheduled for 7 Nov.
6	Decant Options	The Committee noted the findings from the ongoing Condition Survey and the increasingly urgent requirement for decant options to enable refurbishment and remedial works to be undertaken. The Committee **supported the recommendation** to proceed to developing an Outline Business Case at pace.
7	Health & Safety Report	The Committee **gained no assurance** from the H&S report as presented, which was out of date and of poor quality. The Committee further noted that this report had been to Committee on previous occasions with little or no improvements seen. Mr Cobb offered to provide support to the development of an improved report which the Committee gratefully acknowledged.
8	Operational Planning Framework & CIP Delivery	The Committee noted the inclusion of significant CIP targets in the developing 25/26 Operational Plan and the Trust's under-delivery of planned CIP in 24/25. The Committee requested that the methodology and approach to identifying and delivering CIP needs to change, which was acknowledged by the COO and CFO, who will consider what change is required. The Board will receive a separate paper regarding the process for developing the Plan for 2025/26 and the Committee **recommends that the Operational Planning Framework be approved by the Board** and that **authority is delegated to the Executive** to update the Financial Strategy.
9	Shoulder Orthotic Consumables	The Board will receive a separate paper regarding a renewed agreement for products used in shoulder surgery. The Committee was assured that a compliant procurement process has been followed, noting the annual savings of £120k. The Committee **recommends that the Board** approves this agreement.
10	Pharmacy Automated Dispensing System	The Board will receive a separate paper regarding replacement of the Pharmacy Automated Dispensing System. The Committee was assured from the high quality OBC that this investment has been appropriately analysed and evaluated and accordingly, **recommends that the Board approves** the preferred option.
11	Committee Terms of Reference	Following the decision of the Board to close the Major Projects Assurance Committee (MPAC), the FIP Committee's Terms of Reference have been updated to reintroduce those duties that were previously within the remit of MPAC and are **attached.** The wording is essentially the same as that previously approved by the Board and the Board is **requested to approve** the updated FIP ToRs.

3 Conclusions/Outcome/Next steps

The Committee is scheduled to meet again on 27 November 2024, at which meeting the Committee is due to consider:

- updates from the Transformation Steering Group;
- financial recovery actions;
- operational and financial planning for remainder of 2024/25 and 2025/26.

Recommendation:

The Board is recommended to:

- **note** the work of its Finance, Investment and Performance Committee;
- **receive** the recommendations as specified; and
- **approve** the updated Terms of Reference.

FINANCE, INVESTMENTS AND PERFORMANCE COMMITTEE

TERMS OF REFERENCE

1 CONSTITUTION AND PURPOSE

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

The **Purpose** of the Committee is to provide scrutiny and challenge with regard to:

- the Trust's financial and operational planning and performance;
- its achievement of business and operational objectives;
- planning and delivery of capital investments and major projects;
- estates, facilities and digital strategy and implementation;
- Emergency Preparedness, Resilience and Response & Business Continuity;
- strategic service transformation and system & process optimisation;

in order to provide assurance and make appropriate reports or recommendations to the Board.

2 AUTHORITY

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

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

3 MEMBERSHIP

Membership of the Committee shall comprise:

- Three Non-Executive Directors
- Chief Finance Officer
- Chief Operating Officer
- Chief Executive
- Director of Strategy and Major Projects
- Chief People Officer
- Clinical Executive (Medical Director or Chief Nurse)
- Chief Digital Information Officer
- Director of Transformation

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

4 MEETINGS, ATTENDANCE AND QUORUM

The Committee may invite non-members to attend all or part of its meetings as it considers necessary and appropriate, at the discretion of the Committee Chair. If not already members, the Chairman, Chief Executive or other Board director may be invited to attend any meeting of the Committee, particularly when the Committee is discussing areas of the Trust's operation that are the responsibility of that director.

The Committee may ask any or all of those who normally attend Committee meetings but who are not members to withdraw to facilitate discussion of any particular matters at the discretion of the Chair.

In exceptional circumstances when an executive member cannot attend Committee meetings, they must arrange for a fully briefed deputy of sufficient seniority to attend on their behalf.

Meetings of the Committee shall be Chaired by one of the Non-executive Director members, with another acting as deputy in his/her absence.

Responsibility for calling meetings of the Committee shall rest with the Committee Chair.

To be quorate at least 3 members of the Committee must be present including at least one non-executive director. Attendance at the meeting may be by teleconference or videoconferencing at the discretion of the Committee Chair. A duly convened meeting of the Committee at which a quorum is present shall be competent to exercise all or any of the authorities, powers and discretions invested in, or exercised by the Committee.

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

5 SUPPORT ARRANGEMENTS

The Board Secretary will be responsible for ensuring provision of secretarial and administrative support to the Committee.

The Committee shall operate as follows:

- The Committee will routinely meet monthly unless agreed otherwise;
- The Committee will establish an annual Work Programme, summarising those items that it expects to consider at forthcoming meetings;
- Agendas for forthcoming meetings will be based on the Work Programme, reviewed by the Committee and agreed with the Committee Chair;
- Unless otherwise agreed, papers for the meeting should be submitted to the Committee secretary a minimum of 6 working days prior to the meeting. Papers on other matters will be put on the agenda only at the request of or with the prior agreement of the Chair;
- Papers will be sent out by the Committee secretary at least 4 days before each meeting unless otherwise agreed;
- To facilitate oversight by the Board of Directors of matters relating to finance, investments and performance, papers for meetings of the Committee will be circulated for information to those members of the Board who are not members of the Committee;
- Minutes will be prepared after each meeting of this Committee within 14 days and circulated to members of the Committee and others as necessary once confirmed by the Chair of the Committee. A record of action points arising from meetings of the Committee shall be made and circulated to its members with the minutes ;
- Following each meeting of the Committee, the Chair of the Committee shall make a report to the next meeting of the Board of Directors highlighting any issues that require its particular attention, or require it to take action;
- The Terms of Reference of the Committee will be reviewed annually and will only be changed with the approval of the Trust Board.

6 DECLARATION OF INTERESTS

All members must declare any actual or potential conflicts of interest relevant to the work of the Committee, which shall be recorded in the Minutes accordingly. Members should

exclude themselves from any part of a meeting in which they have a material conflict of interest. The Chair will decide whether a declared interest represents a material conflict.

7 DUTIES

In furtherance of achievement of its Purpose, particular duties of the Committee shall be to provide assurance to the Board in relation to:

Financial Planning & Performance

7.1 the Trust's financial strategy and plans, financial planning framework, budgets, cost improvement and income generation programmes and capital investment plans;

7.2 delivery of financial performance with respect to the programmes, plans and budgets (as per 7.1 above) as reported in the monthly Integrated Performance Report (IPR) to the Trust Board, noting any trends, exceptions and variances against plans on a Trust-wide and divisional basis and reviewing in detail any major performance variations as appropriate;

7.3 monitoring the rolling capital programme, including scrutiny of the prioritisation process and its delivery;

Operational Planning and Performance

7.4 delivery of operational performance targets as reported in the Integrated Performance Report (IPR) to the Trust Board, noting any trends, exceptions and variances against plans on a Trust-wide and divisional basis and reviewing in detail any major performance variations as appropriate;

7.5 performance within the Trust and Divisions with particular regard to:

- achievement of key standards and contractual obligations;
- activity, income, costs and contractual penalties;
- quality, innovation, productivity and cost improvement plans;
- commissioning for quality and innovation plans (CQUIN);
- effective and efficient use of resources.

7.6 the structures, processes and responsibilities within the Trust with regard to Emergency Preparedness, Resilience and Response & Business Continuity, and the associated assessment of risk, effectiveness and internal control.

Contracts & Business Cases

7.7 major contracts, procurement and investment projects and business cases, including the investment appraisal of business cases in accordance with the Trust's Business Case process and thresholds stated within and wider business development opportunities, under direction from the Trust Board;

7.8 areas of substantial business collaboration with other organisations (e.g. the Eastern Pathology Alliance; Acute Services Integration);

Estates Planning & Management

7.9 development and implementation of the Trust's Estates Strategy, in order to optimise efficiency, facilitate operational performance and achievement of the Trust's Strategic Objectives;

7.10 oversight of the Trust's PFI contract at NNUH, including performance monitoring arrangements, significant contractual issues and lifecycle programme;

7.11 delivery of the Facilities Management contracts across the Trust's Estate, including oversight of monitoring arrangements and performance against contract;

7.12 oversight of procurement and market testing processes for the Facilities Management contracts, including recommendations to the Board for contract renewal / award.

7.13 relevant areas of Trust activity such as estates management, including fire safety and compliance with the NHS Premises Assurance Model,

Digital Infrastructure & Maturity

7.14 development and implementation of the Trust's Digital Strategies and Plans, to include cyber security, information governance and data quality

Use of Resources, Productivity, Efficiency, and Regulatory Compliance

7.15 advising the Board on the Trust's disclosure statement confirming compliance with national guidance relating to the National Cost Collection and the underlying process;

7.16 compliance with the Trust's obligations and ambitions concerning energy efficiency, sustainability and the commitment to a Net Zero-Carbon NHS;

7.17 service transformation and system & process optimisation to enhance productivity, cost-effectiveness and patient experience;

7.18 risks and mitigations related to the Trust's financial and operational performance and to review reports or extracts from the Board Assurance Framework and Corporate Risk Register as relevant to the remit of the Committee and in line with the Board's Risk Appetite;

Delivery of Major Projects

7.19 arrangements to ensure adequate and robust programme and project arrangements for the effective management of major projects including:

a) that projects are underpinned by strong monitoring and governance

b) compliance with any conditions relating to relevant business cases, regulatory or Board approvals

c) achievement of major delivery milestones

d) compliance with agreed budgets

e) review and management of risks and mitigations

f) adequate and appropriate corrective action to rectify escalated issues

g) completion of post-project reviews and benefits realisation assessment

Strategic Transformation Programme

7.20 to achieve implementation of the Trust's Strategic Transformation Programme:

a) service transformation and system & process optimisation to enhance productivity, cost-effectiveness and patient experience

b) progress towards delivery of the Trust's Strategic Commitments

c) appropriate response to risks and opportunities associated with Transformation Workstreams, including interdependencies and connection with wider system working

d) significant financial savings or income benefits

e) greater understanding of the organisational capacity and cultural readiness for ongoing transformation and change

8 RELATIONSHIP WITH OTHER BOARD COMMITTEES

In practice, issues of finance, quality, safety and performance are inextricably linked. Through alignment of the relevant Work Programmes for each of the Board Committees overlap or gaps in their collective assurance function will be avoided. For the avoidance of doubt, it is noted that the following items remain within the area of responsibility of the:

a) Audit Committee:
- Internal and External Audit;
- Local Counter Fraud Specialist work;
- approval of Financial Statements and Accounts;
- oversight of the structures and systems for risk management and the processes in place for identifying and managing key risks including the Risk Register.

b) Quality & Safety Committee:
- clinical quality impact assessment of cost improvement plans

c) People & Culture Committee:
- workforce strategy and planning

9 PROCESS FOR MONITORING COMMITTEE EFFECTIVENESS

The Committee shall submit an Annual Report to the Trust Board, reporting on the work of the Committee, member attendance and the results of its annual review of performance and function.

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

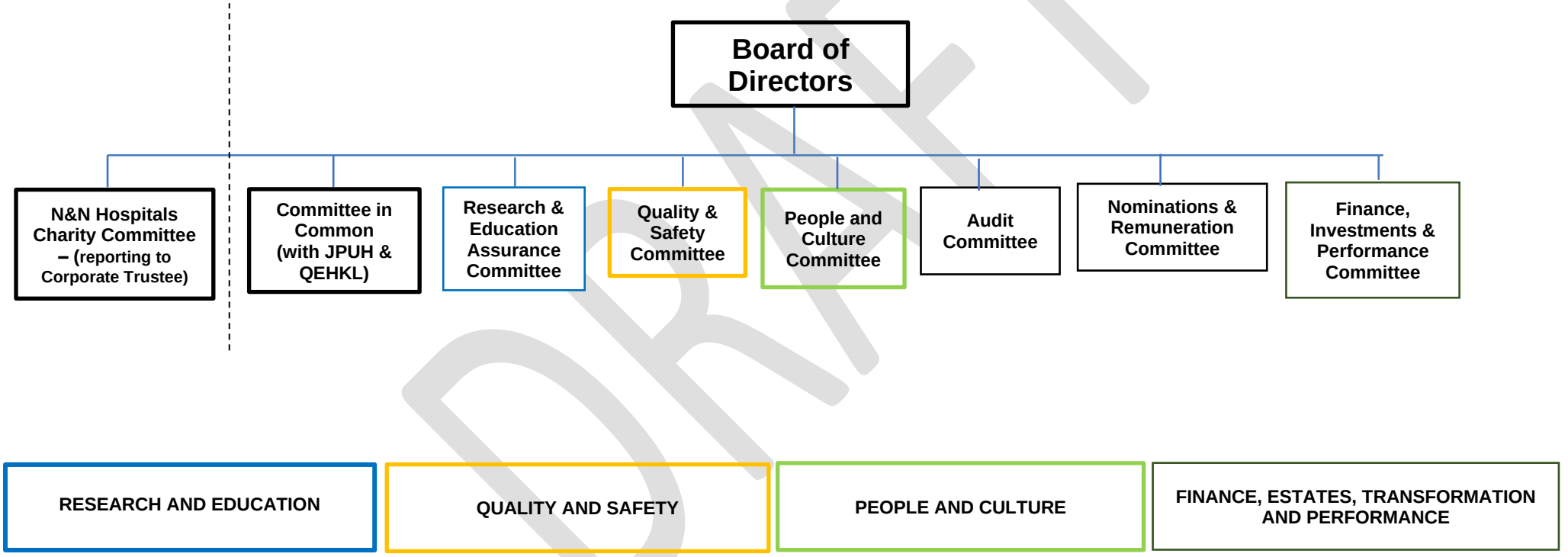
10 REPORTING COMMITTEES

There are no standing sub-committees which report to the Finance, Investments and Performance Committee. In order to obtain assurance with regard to the operation of the Trust's financial, business planning and operational performance processes, however, the Committee will receive regular reports from the Capital and Estates Committee, Investment Committee, Divisional Performance Committee, Financial Improvement and Productivity Board and otherwise in accordance with the Board-approved Organisational Governance Framework.

Approved by the Trust Board on: 6 November 2024 [TBC]
Annual Review date: December 2025

Foundation Trust Board Reporting Structure

- Leadership of the Foundation Trust is provided by its Board of Directors (a unitary Board with a majority of Non-Executive Directors (8) and 6 Executive Directors).
- The Board has established a structure of Board Committees with responsibility to seek assurance on behalf of the Board and/or to exercise specific delegated authority.
- That Committee structure is detailed below:



As at October 2024

REPORT TO FINANCE, INVESTMENTS AND PERFORMANCE COMMITTEE

Date	**30th October 2024**		
Title	**Performance and Activity IPR**		
Author & Exec Lead	**Chris Cobb – Chief Operating Officer**		
Purpose	**For Information**		
Relevant Strategic Objective	**BAF 1.2 and BAF 1.3**		
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✓**	

Background/Context

The attached report provides an update on compliance 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 (79.4% for September) – The NNUH continues to perform in the top decile against this standard.

Elective Care:

- 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)':* On Track – Achieved September planning submission target of less than 1,643 patient breaches. Currently forecasting 793 patient breaches on 31st October if all interventions go ahead.

- Theatre Utilisation – '*Meet the 85% theatre utilisation expectations, using GIRFT and moving procedures to the most appropriate settings*': Off Track – Total Theatre Utilisation was 77.2% in September. This is an improved position compared to June, July and August but reduced from April and May.

- 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 August and September performance currently indicates a reduced performance compared to July.

Cancer:

- 28-Day Faster Diagnosis Standard – '*Improve performance against the 28-day Faster Diagnosis Standard to 77% by March 2025':* Off Track – Closed August performance was 59.1%, a reduction from the previous 2 months and behind trajectory, predominantly driven by the high volumes of patients within the Skin pathway.

- 62-Day Performance – '*Improve performance against the headline 62-day standard to 70% by March 2025'*: Off Track – Closed August performance was 61.1% - this is the highest in-month performance for over 2 years and is above trajectory for the first time 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 – improved performance compared to the previous 2 months but remaining below planning trajectory to achieve 95% target by 31st March 2025.

Recommendations:
The Finance, Investments and Performance Committee 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

September 2024

Key 2024-25 Operational Priorities

Operational Priorities	Description	Target	Deadline	September 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	79.4%	The NNUH continues to perform above target.	
Elective Care						
65 Week Waits	Eliminate waits of over 65 weeks for elective care	0	December 2024	1,091 patient breaches on 30th September	Achieved September 2024 planning submission target of less than 1,643 patient breaches. Currently forecasting 793 patient breaches on 31st October if all interventions go ahead.	
Theatre Utilisation	Capped theatre touch time utilisation	85%	March 2025	77.2%	Improved position compared to June, July and August 2024 but reduced from April and May. Remains below 85% target.	
Day Case	Elective surgery delivered as either a day case or outpatient procedure (BADS)	85%	March 2025	86.2%	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	45.1% (provisional)	Confirmed July performance (45.6%) was higher than the first 3 months of 24/25. Provisional August and September performance currently show a slightly reduced performance compared to July.	

Key 2024-25 Operational Priorities

Operational Priorities	Description	Target	Deadline	September 2024 Position	Commentary	RAG Rating
Cancer						
28-Day Faster Diagnosis Standard	Improve performance against the 28-day Faster Diagnosis Standard	77%	March 2025	August 2024 = 59.1% (closed performance)	Closed August performance was 59.1% - a reduction from the previous 2 months and behind trajectory, predominantly driven by the high volumes of patients within the Skin pathway.	
62-Day Performance	Improve performance against the headline 62-day standard	70%	March 2025	August 2024 = 61.1% (closed performance)	Closed August performance was 61.1% - this is the highest in-month performance for over 2 years and is above trajectory for the first time in 2024/25. This is the result of work undertaken to address the long waits.	
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	85.9%	Consistently delivered.	
Diagnostics						
Diagnostic Test Within 6 Weeks	Increase the percentage of patients that receive a diagnostic test within 6 weeks	95%	March 2025	62.9%	Improved performance compared to the previous 2 months but remaining below trajectory to achieve 95% target by 31st March 2025.	

Emergency Care Improvement Support Team (ECIST) – Progress Review and Conclusion of Intensive Support [1 of 2]

Emergency Care Improvement Support Team
Safer, faster, better care for patients

NHS England

Chris Cobb
Chief Operating Officer
Norfolk and Norwich University Hospital

Dear Chris,

Emergency Care Improvement Support Team – progress review and conclusion of intensive support

I am writing formally to confirm that from 29 July 2024, the Emergency Care Improvement Support Team (ECIST) has concluded its intensive support work with the Norfolk and Norwich University Hospital (NNUH), as part of the nationally defined urgent and emergency care tiering support. This comes as a result of both of the system being stepped down to tier two (and therefore a lower level of support), and the aims of the agreed support program being met, the impact of which is now being seen.

Following the commencement of our engagement with the system in September 2023, I am pleased to provide you with a review of progress against the agreed areas of support from ECIST, as well as a set of next steps based on achievements to date.

The content of this review has been co-developed with the clinical and operational teams from the site who we have been working alongside through this engagement. Numerical data included in the progress review has been provided by ECIST unless stated otherwise. A full supporting data pack is provided in Appendix A.

Summary of progress against agreed support

1. Significant progress has been made across the system in improving ambulance handover times and emergency department (ED) processes. There is more clarity on improvement opportunities, ownership, and buy-in from local teams.
2. Work is firmly underway to improve ward and discharge processes, with stronger governance and system working in place.
3. The integrated care coordination hub is established with appropriate leadership and is evolving through a continuous improvement approach, with learning being shared nationally.

In addition, the system-wide frailty focus has led to some improvements in service provision for those living with frailty. There are further opportunities to continue and progress improvement in this priority area.

Summary of site progress against agreed support

Thank you to all the staff who have provided their time, energy and insight into supporting this engagement. In summary:

1. A clearer focus has been achieved in the understanding, structure and measurement of improvement priorities areas outlined below.

Emergency Care Improvement Support Team
Safer, faster, better care for patients

NHS England

2. Progress has been made with ambulance handover, 14 day + length of stay and reduction in 12-hour patient stays in the emergency department and other measures outlined below.

The progress report provides full details of workstream progress and the next steps we have agreed on with you and the executive team, namely:

1. Continue to use progress and momentum achieved to date to move forward with all patient flow improvement plans.
2. Continue work to develop the medical model with clinical teams to best meet patient and organisational needs.

Feedback on our approach and next steps

As a team that strives to continuously improve our offer, we would appreciate feedback from you and your teams, to continue to develop our approach to best meet our clients' needs. I am therefore seeking your permission to reach out to your teams for feedback in the form of surveys and a small number of in-depth interviews (the findings of which will be anonymised and used for our internal development processes). All feedback is gratefully received - the survey link can be found at the end of this letter.

Furthermore, I would be pleased to return in six months to visit the teams and reflect on the sustainability of interventions.

I want to take this opportunity to thank you and your colleagues again for engaging so constructively with ECIST. It has been a pleasure to work with you and your colleagues and I wish you success with your continuing improvement journey. Please do not hesitate to contact me if you require any further ECIST support or input.

Yours sincerely

Richard Brownhill
Head of Improvement, ECIST

Copies to:
Helen Bennett, Director of Improvement, ECIST
Batsi Katsande Regional Director of UEC

Click here to send your feedback, or scan the QR code:

Emergency Care Improvement Support Team (ECIST) – Progress Review and Conclusion of Intensive Support [2 of 2]

Emergency Care Improvement Support Team
Safer, faster, better care for patients

NHS England

Norfolk and Norwich University Hospital: workstream review

Workstream	Aims and objectives of ECIST intervention	What has been delivered by ECIST	Impact of ECIST support	Next steps (ECIST and site colleagues)
Front door processes	• Facilitate the ED team in identifying and prioritising ambulance handover improvement opportunities. • Support ED teams and site leadership to understand the patient journey from arrival. • Demonstrate optimised nurse staffing for emergency medicine, to enable the alignment of capacity and demand. • Support the site develop an efficient and sustainable acute medical model.	• Front door observation and facilitated 10 patient mapping exercise (using QI swim lane methodology) to identify opportunities in ambulance handover and pathways. • Delivered two workshops with clinical and operational leads, and NHSE regional colleagues, to design a test for change for the new acute medical model. • Support from ECIST clinical leads for peer discussion	• Ambulance handover improvement opportunities have influenced redesign across the UEC pathway. • Joint vision for and commitment to redefined acute medical model. • Sharing of acute medicine models from other areas/sites/models	• The site to agree on measures/dates for tests of change.
Same day emergency care (SDEC)	• Support site to improve internal referral processes to SDEC and enable GP and ambulance direct access.	• In conjunction with EEAST, Norfolk and Waveney ICB - SDEC lead, ECIST supported the weekly improvement work on direct SDEC referral. (now ceased). • Advisory support on the development of the SDEC capacity and demand profile (in conjunction with medical model design).	• Joint vision for and commitment to redefined acute medical model. • Sharing of acute medicine models from other areas, sites and models	• The medicine team to continue to develop a dashboard and measurements to aid operational processes and improvements
Frailty	• Support the site to understand the ED frailty demand. • Support the site to develop strategic objectives of the future frailty offer.	• Supported frailty demand modelling (derived from ED frailty scoring) to aid service design. • Advisory support to clinical and executive teams on potential frailty	• Frailty scores are now completed in ED. • Now able to determine hourly/daily frailty demand.	• Older persons medicine (OPM)/Older persons emergency department (OPED) team to conduct a test of change on the 9th of September to

Emergency Care Improvement Support Team
Safer, faster, better care for patients

NHS England

		offers (as part of changes to the medical model).	• Frailty has become a strategic priority.	extend consultant reviews until 20:00 • Continue with the GIRFT frailty report recommendations and collaborate the work with ICB plans.
Building improvement capability	• Support the site in the use of improvement principles, tools and techniques to support the success of transformation efforts.	• Working with leadership and transformation team on readiness assessments, and to augment the improvement strategy and workstreams to ensure executive sponsorship. • Advisory support at the weekly task force, to support readiness, direction and the programme's rigour.	• Senior responsible officers at an executive level now supporting the task force. • Increased use of improvement tools including ten patient mapping, readiness assessments and Plan Do Study Act (PDSA)	• Continue to develop further rigour and discipline around formal testing. To adopt a continuous improvement approach, building on previous learning from tests of change.
Wards and discharge	• Support the trust in understanding the variation in applying red-to-green principles. • Promote the principles of effective board and ward processes within clinical teams. • Support the transformation team in improving the variation in ward and discharge processes.	• Review of red-to-green practices to understand opportunities. • Led a five-ward observation exercise. • Patient mapping for pathway zero to understand processes and opportunities (highlighting issues associated with tablets to take out (TTOs), transport and the home first approach). • Advisory support to clinical teams and transformation team in designing improvement approaches. • Specific advisory support aimed at increasing weekend discharge.	• Teams have a greater insight into the variation in the application of the red-to-green principles. Action learning is now in place. • Weekend discharge planning programme underway. • Developed an understanding of length of stay/discharge opportunities in pathway 0 and pathway 1 patients using swim lanes methodology.	• ECIST have agreed to facilitate swim lane mapping of pathway 2 patients with community and therapies input in September - date to be confirmed

NNUH Paediatric Orthopaedic – GIRFT Case Study

GIRFT GETTING IT RIGHT FIRST TIME
NHS IMPACT Improving Patient Care Together

Norfolk and Norwich Paediatric Super Clinics

NHS England

Norfolk and Norwich University Hospitals NHS Foundation Trust

Summary

Norfolk and Norwich University Hospitals (NNUH) have held two 'Super Saturdays', where 3 consultants and one assistant saw 75 patients. Over the two Saturday mornings, 150 patients were seen. This was successful in reducing the non-admitted waiting list by 30%.

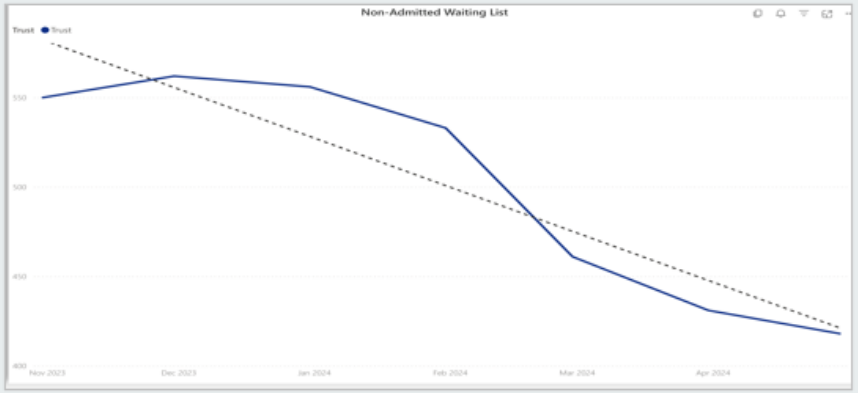
Contextual challenges

- At the end of 2023, NNUH Paediatric orthopaedic department had 560 patients on their non-admitted waiting list
- 70 of these patients had been waiting over 52 weeks from GP referral

Approach

- The department wanted to safely see as many of these patients as they could
- Additional staffing costs were to be kept to a minimum:
  - 3 consultants on a Saturday
  - All imaging was performed in advance during normal working hours
  - Administration cover for typing was provided by the clinic receptionist
  - One clinic assistant supported the 3 consultants

Performance change



Achievements and results

- The Saturday clinics reduced the overall non-admitted waiting list by 30%
- The number of patients waiting over 52 weeks was reduced by almost 70%
- The rate of increase of long waiters was slowed

Resource links

- Further Faster Orthopaedics
- Further Faster Children & Young People

Chris Cobb
Chief Operating Officer,
NNUH

"The commitment shown by our Paediatric Orthopaedic team in bringing down waiting times for children under our care has been exemplary. It has had such a positive impact on patient experience, waiting times and team morale! We are really proud of what they have – and continue – to achieve.""

30% decrease in non-admitted waiting list numbers

70% decrease in number of patients on 52-week non-admitted waiting list

Next steps

- Additional clinics being offered as mutual aid to other providers

Contacts for further information

Mr Sanghrajka, Consultant surgeon, Norfolk & Norwich University Hospitals
Anish.sanghrajka@nnuh.nhs.uk

Urgent and Emergency Care

Performance – ED 4 Hour Performance

Commentary

September 2024 Performance

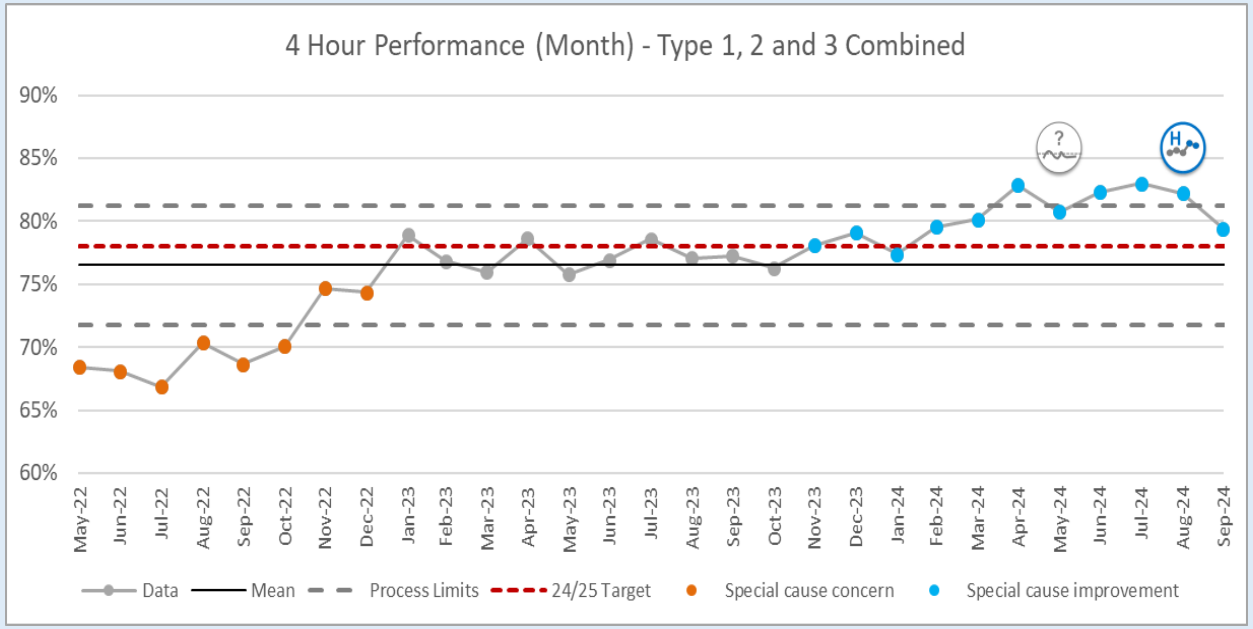
Combined 4-hour performance for September 2024 = **79.4% -** a reduction compared to the first 5 months of 24/25 but higher than 10 of the 12 months in 2023/24 and above the 2024/25 target of 78%.

Year-to-date (24/25) 4-hour performance at **81.8%.**

Type 1 4-hour performance for September 2024 = 66% - reduced compared to the first 5 months of 24/25 but higher than any month in 2023/24.

Risk To Delivery

GREEN

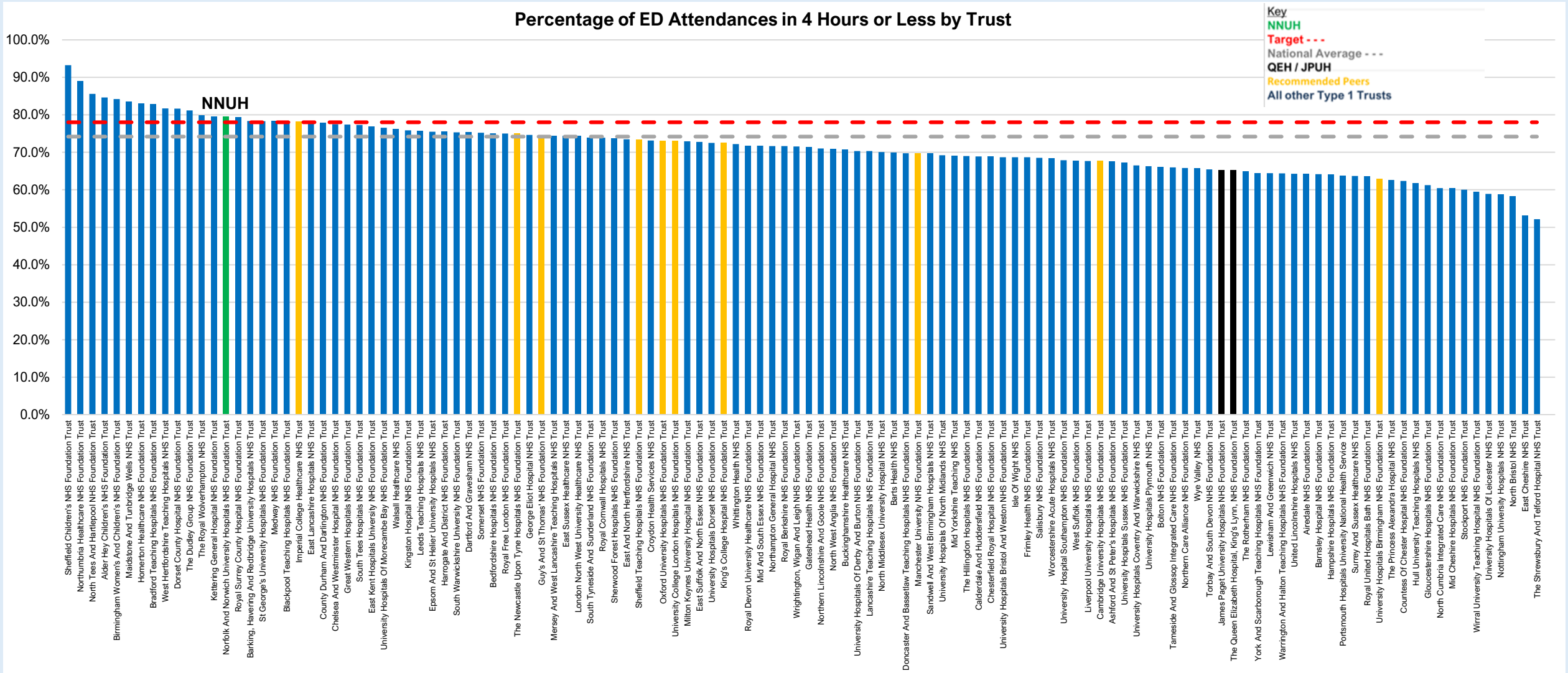


4 Hour Performance - Rolling September 2024: 79.4%

Category	Type	Sun Sep 01	Mon Sep 02	Tue Sep 03	Wed Sep 04	Thu Sep 05	Fri Sep 06	Sat Sep 07	Sun Sep 08	Mon Sep 09	Tue Sep 10	Wed Sep 11	Thu Sep 12	Fri Sep 13	Sat Sep 14	Sun Sep 15	Mon Sep 16	Tue Sep 17	Wed Sep 18	Thu Sep 19	Fri Sep 20	Sat Sep 21	Sun Sep 22	Mon Sep 23	Tue Sep 24	Wed Sep 25	Thu Sep 26	Fri Sep 27	Sat Sep 28	Sun Sep 29	Mon Sep 30	Sept Avg.
Type 1 Breaches	ED Admitted	72	53	85	74	64	54	63	73	69	75	66	47	64	58	50	65	74	56	67	87	75	68	64	68	72	67	74	70	58	54	66
	ED Non-Admitted	53	91	101	76	90	103	49	60	66	85	38	48	70	76	58	60	76	59	61	93	82	62	84	63	109	97	86	61	57	68	73
	Type 1 Breaches	**125**	**144**	**186**	**150**	**154**	**157**	**112**	**133**	**135**	**160**	**104**	**95**	**134**	**134**	**108**	**125**	**150**	**115**	**128**	**180**	**157**	**130**	**148**	**131**	**181**	**164**	**160**	**131**	**115**	**122**	**139**
Type 1 Attendances	ED Admitted	90	69	106	86	82	82	96	110	89	99	84	84	86	88	76	81	104	78	88	105	100	94	82	88	100	89	91	90	81	75	89
	ED Non-Admitted	314	368	307	331	282	335	281	330	338	282	259	310	286	319	315	339	323	314	307	302	310	354	388	309	336	318	308	300	270	338	316
	Type 1 Attendances	**404**	**437**	**413**	**417**	**364**	**417**	**377**	**440**	**427**	**381**	**343**	**394**	**372**	**407**	**391**	**420**	**427**	**392**	**395**	**407**	**410**	**448**	**470**	**397**	**436**	**407**	**399**	**390**	**351**	**413**	**405**
Type 1 (ED) Admitted		20.0%	23.2%	19.8%	14.0%	22.0%	34.1%	34.4%	33.6%	22.5%	24.2%	21.4%	44.0%	25.6%	34.1%	34.2%	19.8%	28.8%	28.2%	23.9%	17.1%	25.0%	27.7%	22.0%	22.7%	28.0%	24.7%	18.7%	22.2%	28.4%	28.0%	**25.7%**
Type 1 (ED) Non-Admitted		83.1%	75.3%	67.1%	77.0%	68.1%	69.3%	82.6%	81.8%	80.5%	69.9%	85.3%	84.5%	75.5%	76.2%	81.6%	82.3%	76.5%	81.2%	80.1%	69.2%	73.5%	82.5%	78.4%	79.6%	67.6%	69.5%	72.1%	79.7%	78.9%	79.9%	**77.0%**
Type 1 (ED) Combined		69.1%	67.0%	55.0%	64.0%	57.7%	62.4%	70.3%	69.8%	68.4%	58.0%	69.7%	75.9%	64.0%	67.1%	72.4%	70.2%	64.9%	70.7%	67.6%	55.8%	61.7%	71.0%	68.5%	67.0%	58.5%	59.7%	59.9%	66.4%	67.2%	70.5%	**65.7%**
Type 1, 2 and 3 Combined		81.8%	80.7%	72.5%	76.9%	75.1%	77.7%	83.8%	82.3%	80.9%	75.8%	81.2%	83.4%	78.1%	80.6%	83.6%	82.1%	78.1%	82.4%	80.8%	73.3%	77.2%	82.5%	81.3%	79.9%	73.3%	74.7%	75.6%	81.2%	81.9%	82.5%	**79.4%**

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 (September 2024)



Commentary

In September, NNUH were ranked 14th across all Type 1 NHS Trusts and the best performing amongst our Shelford Group peers with 79.5% of ED patients either admitted, transferred or discharged within 4 hours of arrival. This was also ahead of the national target of 78% and the September national average of 74.2%.

Elective Care

Our Vision
The best care for every patient

65 Weeks – Specialty Level Forecast to 31st October 2024

NHS
Norfolk and Norwich University Hospitals
NHS Foundation Trust

																Current Breaches			Interventions						
																Admitted Breaches	Non-Admitted Breaches	Total (excl. OP TCI) No Interv.	NNUH Capacity	Spire / N2S	Medacs	Bromsgrove / MSE / RNOH	Other	Total Interventions	Total Breaches
Specialty	Action	Weekly Averages	16/08/2024	23/08/2024	30/08/2024	06/09/2024	13/09/2024	20/09/2024	27/09/2024	04/10/2024	Snapshot 09/10/2024	11/10/2024	18/10/2024	25/10/2024	31/10/2024	668	739	1,407	279	36	46	39	214	614	793
Total	Breach (excl. OP TCI)	-	6,183	5,744	5,313	4,608	3,906	3,312	2,660	2,110	1,796	1,743	1,591	1,480	1,407										
	Will Breach IP	-									1,057	1,004	852	741	668										
	Will Breach OP	-									739	739	739	739	739										
	Weekly Removals	554	360	439	433	705	702	594	652	550															
	Target	898																							
	Future TCIs											107	262	175	119										
	Future TCIs IP											53	152	111	73										
	Future TCIs OP											54	110	64	46										
110 - Trauma and Orthopaedic	Breach (excl. OP TCI)	-	1,808	1,730	1,630	1,439	1,177	1,022	804	613	515	501	472	442	416			416	55	28		21	40	144	272
	Will Breach IP	-									317	303	274	244	218	218									
	Will Breach OP	-									198	198	198	198	198		198								
	Weekly Removals	158	70	78	100	191	262	155	218	191															
	Target	258																							
	Future TCIs											29	60	51	51										
	Future TCIs IP											14	29	30	26										
	Future TCIs OP											15	31	21	25										
502 - Gynaecology	Breach (excl. OP TCI)	-	884	836	798	726	690	601	536	441	400	396	373	357	347			347	25		20	18	62	125	222
	Will Breach IP	-									217	213	190	174	164	164									
	Will Breach OP	-									183	183	183	183	183		183								
	Weekly Removals	60	35	48	38	72	36	89	65	95															
	Target	200																							
	Future TCIs											22	49	24	13										
	Future TCIs IP											4	23	16	10										
	Future TCIs OP											18	26	8	3										
120 - Ear Nose and Throat	Breach (excl. OP TCI)	-	449	413	379	317	274	231	188	146	124	118	111	108	105			105	35		6		14	55	50
	Will Breach IP	-									73	67	60	57	54	54									
	Will Breach OP	-									51	51	51	51	51		51								
	Weekly Removals	40	15	36	34	62	43	43	43	42															
	Target	62																							
	Future TCIs											8	15	10	5										
	Future TCIs IP											6	7	3	3										
	Future TCIs OP											2	8	7	2										
108 - Spinal Surgery	Breach (excl. OP TCI)	-	239	230	213	203	181	165	150	135	113	107	99	96	95			95	10	8			14	32	63
	Will Breach IP	-									67	61	53	50	49	49									
	Will Breach OP	-									46	46	46	46	46		46								
	Weekly Removals	13	3	9	17	10	22	16	15	15															
	Target	57																							
	Future TCIs											8	11	5	4										
	Future TCIs IP											6	8	3	1										
	Future TCIs OP											2	3	2	3										
100 - General Surgery	Breach (excl. OP TCI)	-	484	440	399	316	244	191	151	130	105	102	94	92	90			90	19		20		20	59	31
	Will Breach IP	-									44	41	33	31	29	29									
	Will Breach OP	-									61	61	61	61	61		61								
	Weekly Removals	49	38	44	41	83	72	53	40	21															
	Target	53																							
	Future TCIs											5	9	4	4										
	Future TCIs IP											3	8	2	2										
	Future TCIs OP											2	1	2	2										

Commentary

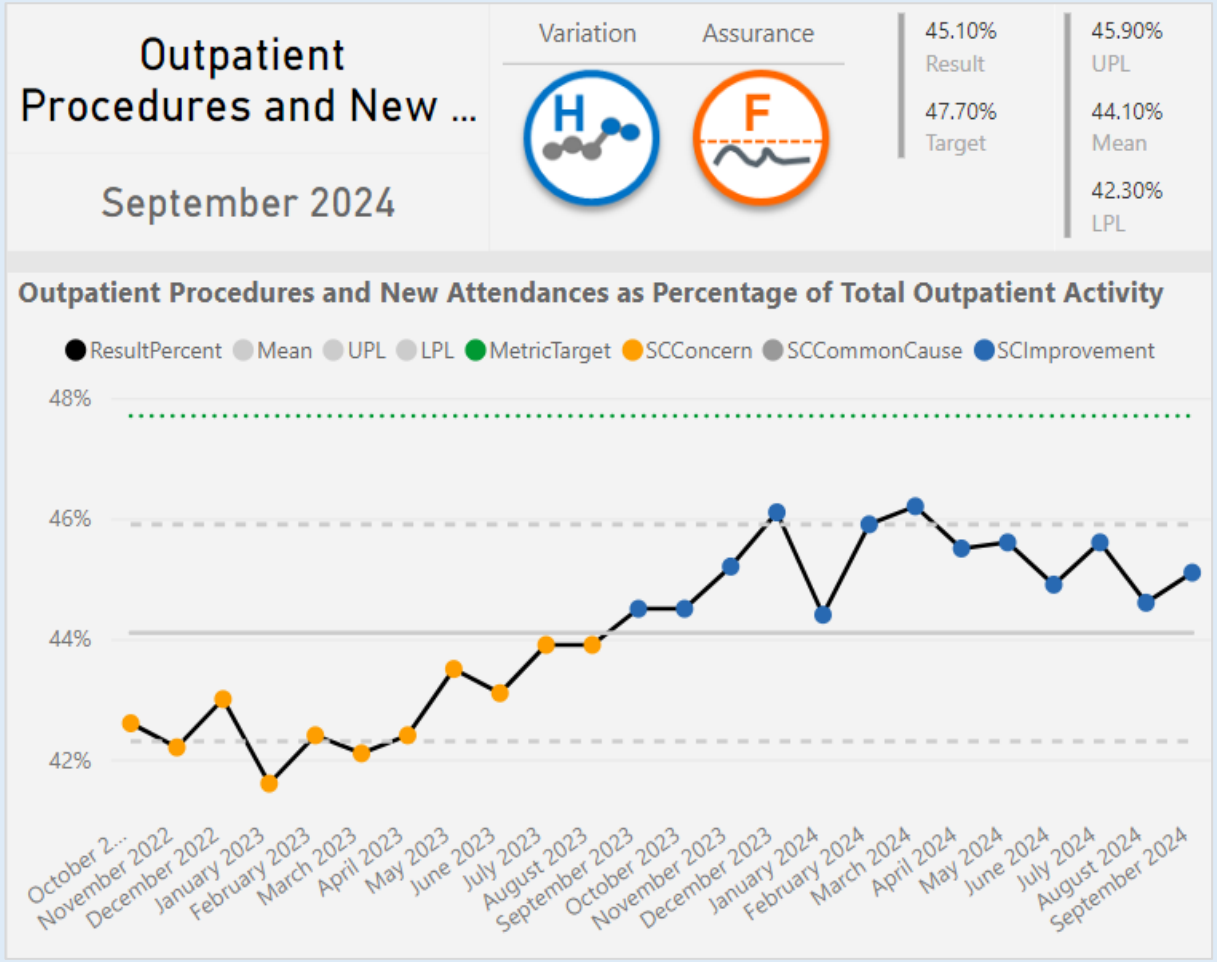
Performance Update

The 65-week breach position to end of October 2024 is **793** patients, with identified interventions taking place.
The breach position prior to interventions is 1,407 with 614 interventions identified to reach the month end position.

Risk To Delivery

AMBER

Performance – Percentage of News / Procedures of Total Outpatients



Commentary

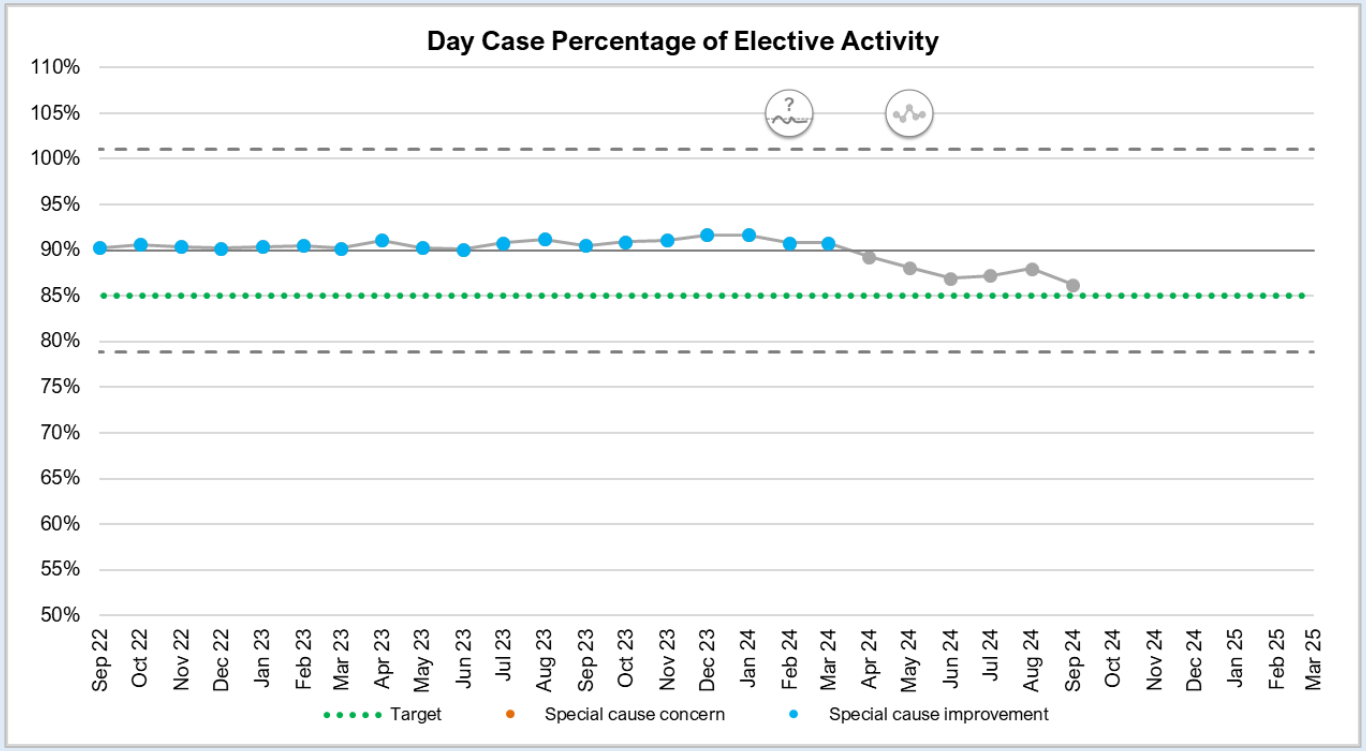
September 2024 Performance (Provisional)

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 July was 45.6%, with provisional performance for August at 44.6% and September at 45.1%.

Risk To Delivery

RED

Performance – 85% Day Case



Commentary

September 2024 Performance

In September, NNUH delivered 86.2% of elective activity as day cases. This is a reduction from previous months but remains above the 85% target.

Risk To Delivery

GREEN

Performance – Theatre Utilisation

Commentary

September 2024 Performance

Touch time delivery across all Theatres in September increased to 77.2% - the 3rd consecutive month-on-month improvement but remaining below target.

Utilisation levels for Level 2 Theatres increased in September to 75.9% from 75.7% in August. Level 3 Theatre utilisation also increased in month at 81.0%, compared to 78.6% in August.

Across all Theatres, a total of 1,186 elective sessions ran in month – this is the highest number of sessions ran in month for at least the last 12 months. The number of on the day cancellations was 189, increased from 142 in August.

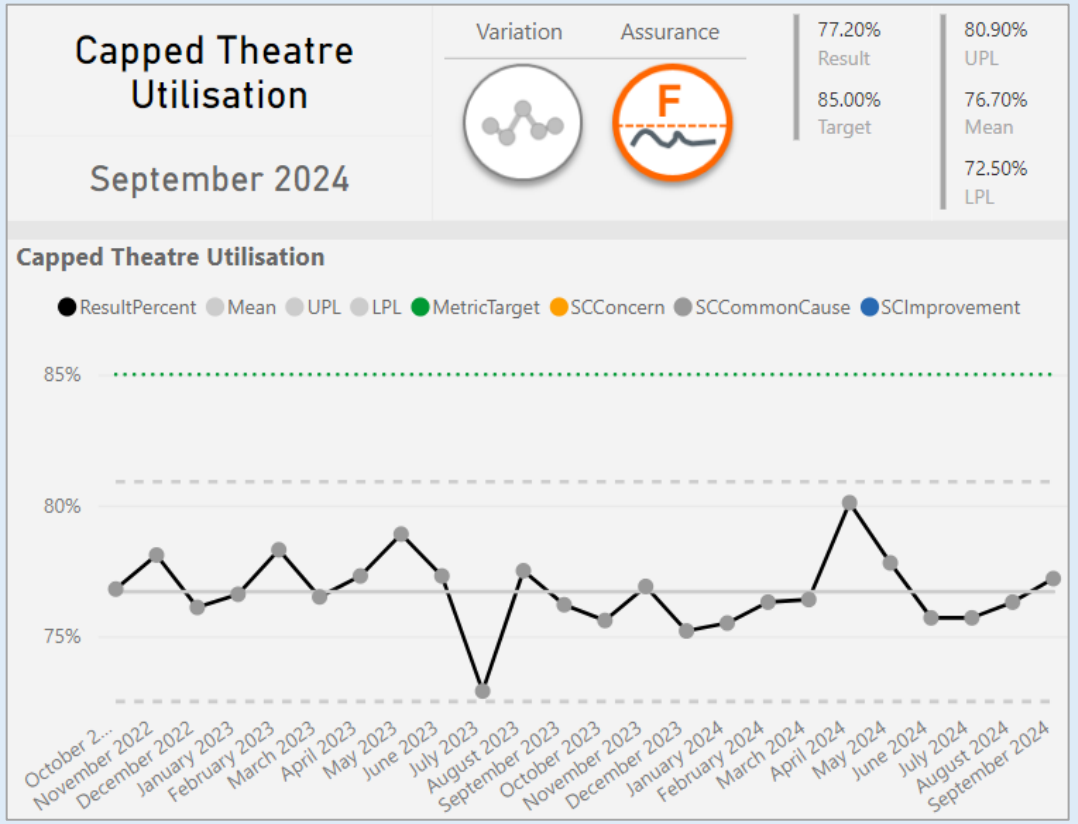
78 (41%) of the cancellations were for clinical reasons, such as the treatment being deferred (46), or the procedure no longer being required (14). 65 (34%) were for non-clinical reasons primarily due to emergency admissions (24) and lists overrunning (23). 46 (24%) were due to patient reasons, including the patient was unfit for their procedure (15), did not attend (14), or procedure was not wanted (10).

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. Delays with digital health enabling work for next steps now resolved and work in progress.
2. Improvement action plan in place, supported by transformation team, across domains of DQ, POA, late start and early finish, anaesthetic cover.
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. Trajectories to be monitored through productivity board and reported through service level performance committee for senior divisional oversight of progress.
4. Engagement event in October facilitated by NHSE to support constructive work between theatres and specialties.

Risk To Delivery

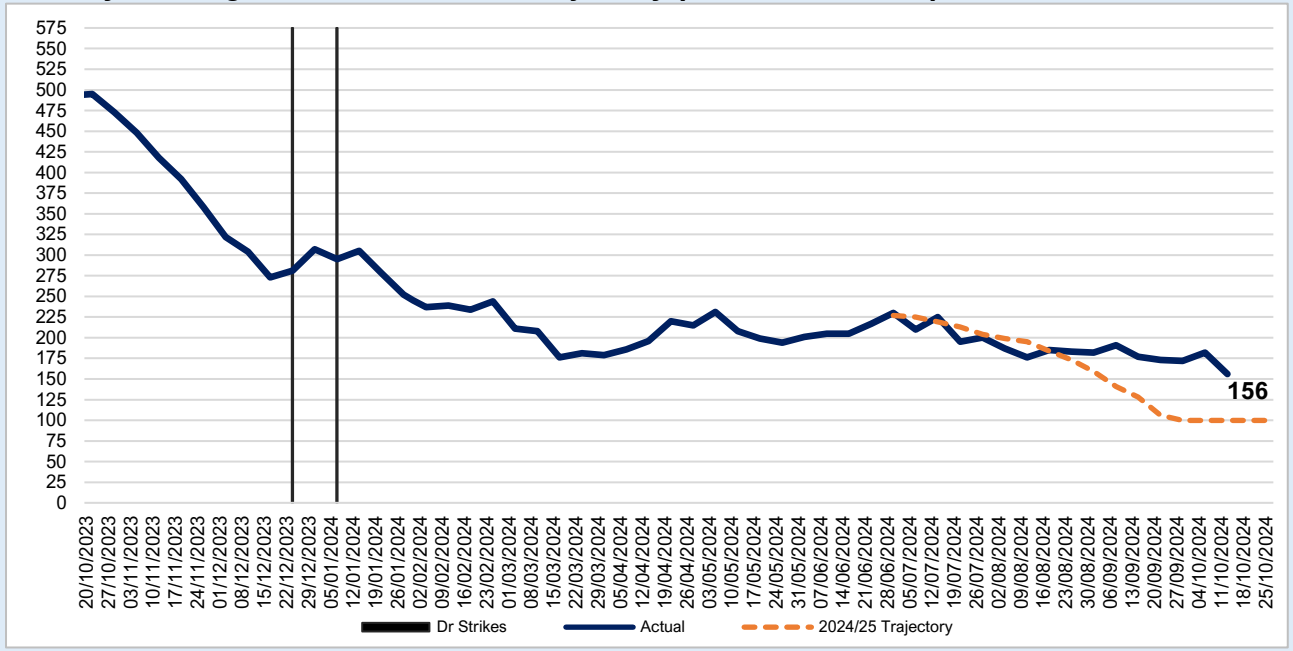
AMBER



Cancer

Cancer – 62-Day Backlog Profile

62 Day Backlog – NNUH Actuals Vs Trajectory (13th October 2024)



Suspected Tumour Type	Past day 62	Change in last week	Change in 4 weeks	Change in 12 weeks
Brain	0	0	0	0
Breast	5	0	+1	-5
Children's	0	0	-1	0
Gynaecological	25	-9	-5	-12
Haematological	7	-2	+1	-1
Head & Neck	12	-5	-7	-5
Lower Gastrointestinal	37	+2	-8	+2
Lung	7	-2	-3	-8
Sarcoma	4	-1	+1	-1
Skin	32	-6	+6	+15
Upper Gastrointestinal	9	-3	+2	-3
Urological	18	0	-8	-21
Other	0	0	0	0
All Suspected Cancers	**156**	**-26**	**-21**	**-39**

Commentary

Performance Update

Up to 13th October the 62-day backlog saw a net reduction of 26 patients waiting over 62 days compared to the previous week and a net reduction of 21 patients compared to the prior 4-week period.

Across all body sites, Urology, Lower GI, Gynaecology, Lung and Children's have seen a net reduction in backlog over the last 4 weeks, with Breast, Head and Neck, Upper GI, Haematology and Sarcoma further contributing to a net reduction of 39 patients from the backlog over the last 12 weeks.

- Urology backlog has decreased by 8 patients compared to 4 weeks ago due to additional robotic surgery, template biopsy sessions and associated improvement in Histology turnaround and is now 10 below the target backlog.
- Skin backlog has reduced in week (-6) but increased over the last 4 weeks (+6). Additional activity and associated excision capacity in October will support improvements. Histopathology continuing to outsource.
- Lower GI improved by 8 over the last 4 weeks and below the target backlog. Continued focus on timely Endoscopy, CTC and associated administrative processes supporting increased turnaround.
- Gynaecology activity reduced by 9 over the last week and by 5 patients compared to the prior 4 weeks and is now below the target backlog.

Cancer – 28-Day Faster Diagnosis Standard

Commentary

August 2024 Performance

Closed August 2024 performance was 59.1% - a reduction from the previous 2 months and behind trajectory. This is primarily driven by the high volume of patients within the Skin pathway. Skin recovery plan has stalled due to sickness and 2x resignations within the department. As a result, performance is not expected to increase in September.

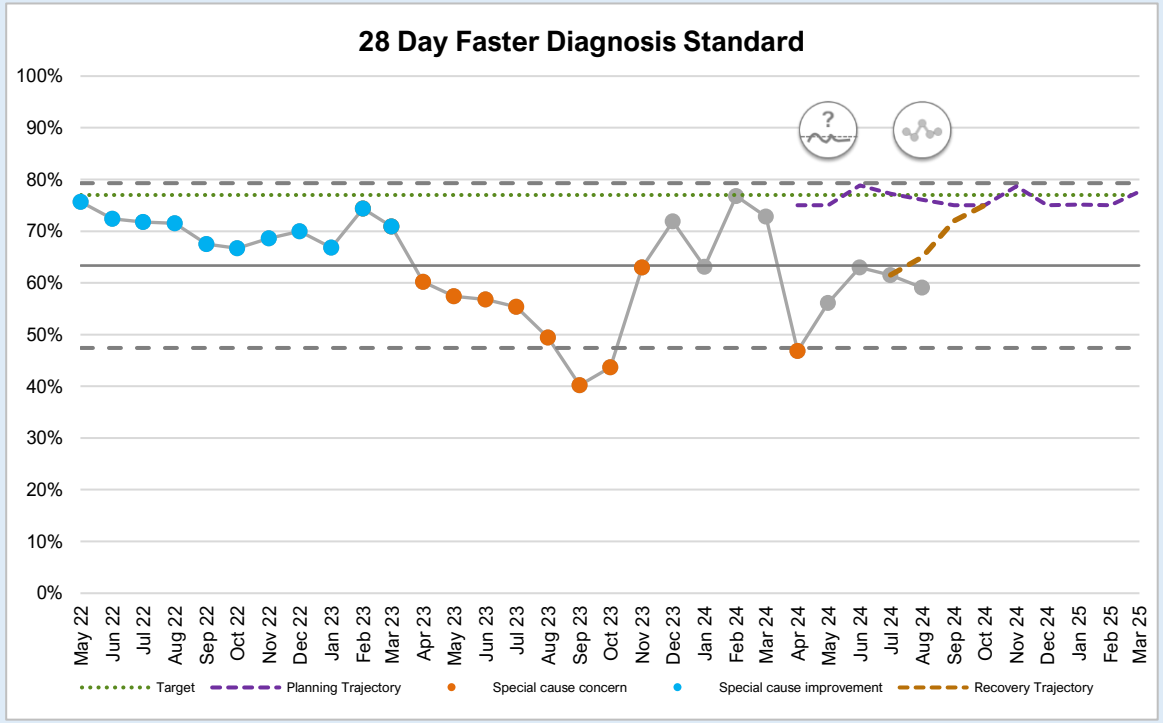
Improvement Actions

1. Additional Skin clinic room capacity through movement of our private service clinic rooms and additional locums commencing week commencing 7th October.
2. Cancer Alliance funding is being utilised to support improvements to Radiology and Endoscopy through September in Lower GI. Overall backlog and total PTL size is reducing which will pull through to FDS performance in coming months.

Risk To Delivery

RED

Body Site	Aug-24 (Closed)
Brain	77.8%
Breast	97.0%
Gynaecology	51.5%
Haematology	50.0%
Head and Neck	69.4%
Lower GI	46.1%
Lung	55.6%
Paediatric	94.4%
Sarcoma	41.2%
Skin	29.8%
Testicular	100.0%
Upper GI	94.2%
Urology	66.0%
Grand Total	**59.1%**



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

Cancer – 62-Day Performance

Commentary

August 2024 Performance

Closed performance in August was above trajectory at 61.1% - the 4th consecutive month of improvement and the highest performance since pre-May 2022. Month-on-month improvement predominantly resulting from the work undertaken to address long waits.

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

Recovery Plan Key Treatment Phase Actions

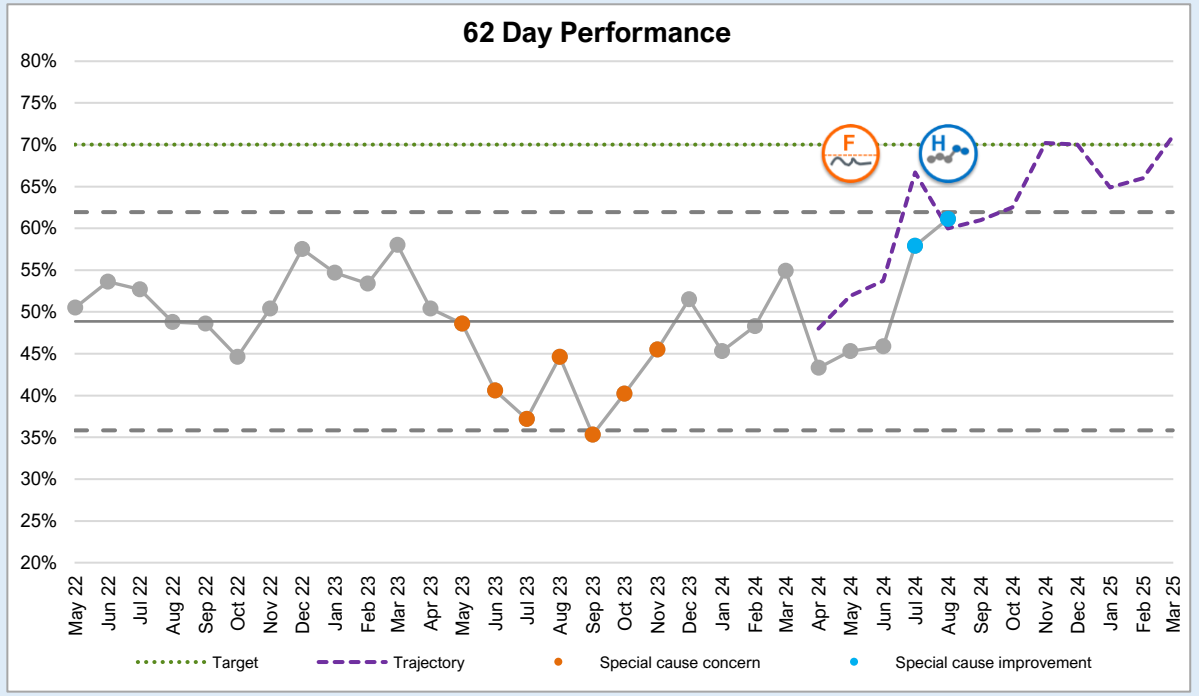
- Robotic Surgery extra lists planned through additional funding in September and October.
- Additional Chemotherapy agency staff commence in September and additional substantive staff to deliver treatment from October onwards to support increased chair capacity and improvements in time to SACT delivery.

Risk To Delivery

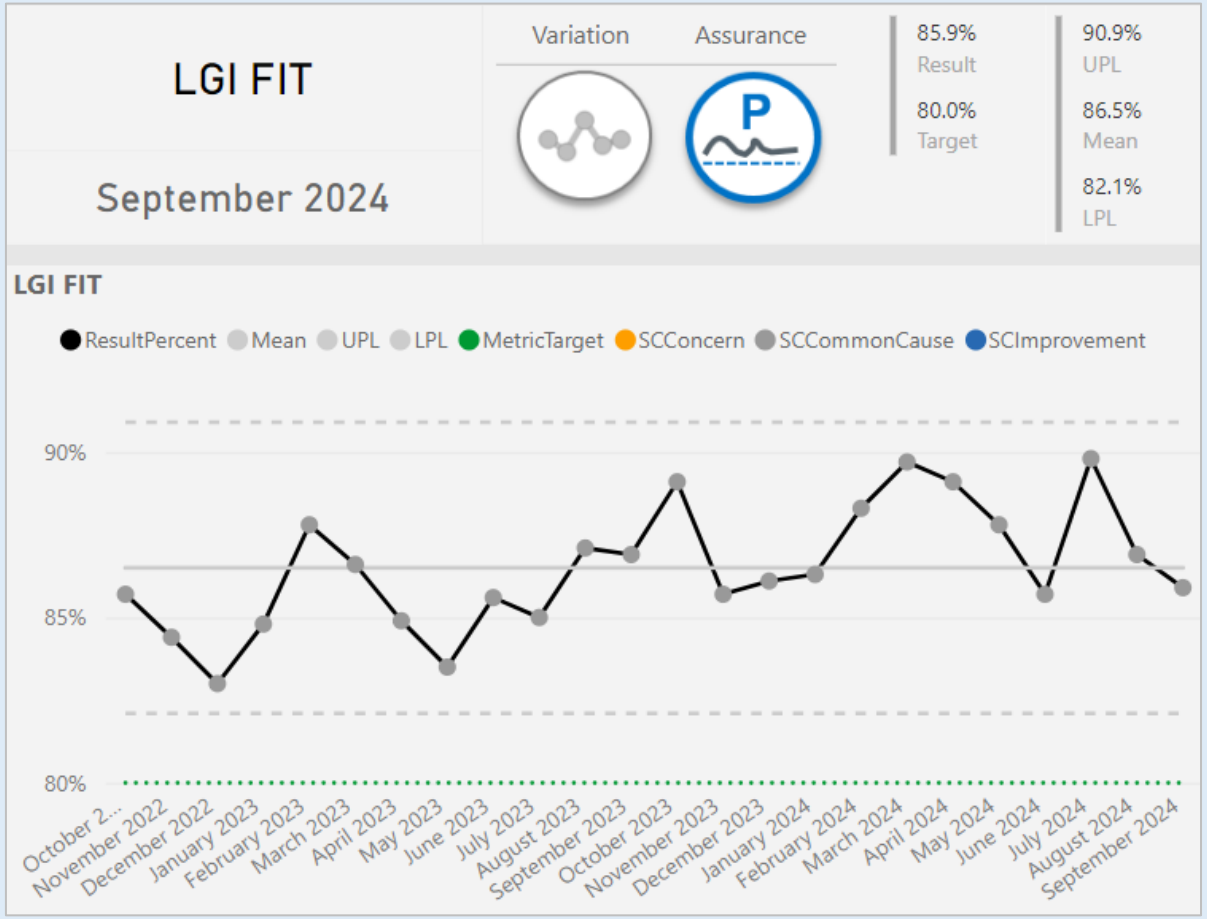
GREEN

Body Site	Aug-24 (Closed)
Breast	78.6%
Gynaecology	50.0%
Haematology	45.0%
Head and Neck	51.1%
Lower GI	48.4%
Lung	37.3%
Skin	81.0%
Upper GI	36.4%
Urology	55.8%
Grand Total	**61.1%**

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



Cancer – Lower GI Referrals with a FIT Test



Commentary

September 2024 Performance

Performance was 85.9% in September – this is reduced from July and August but 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

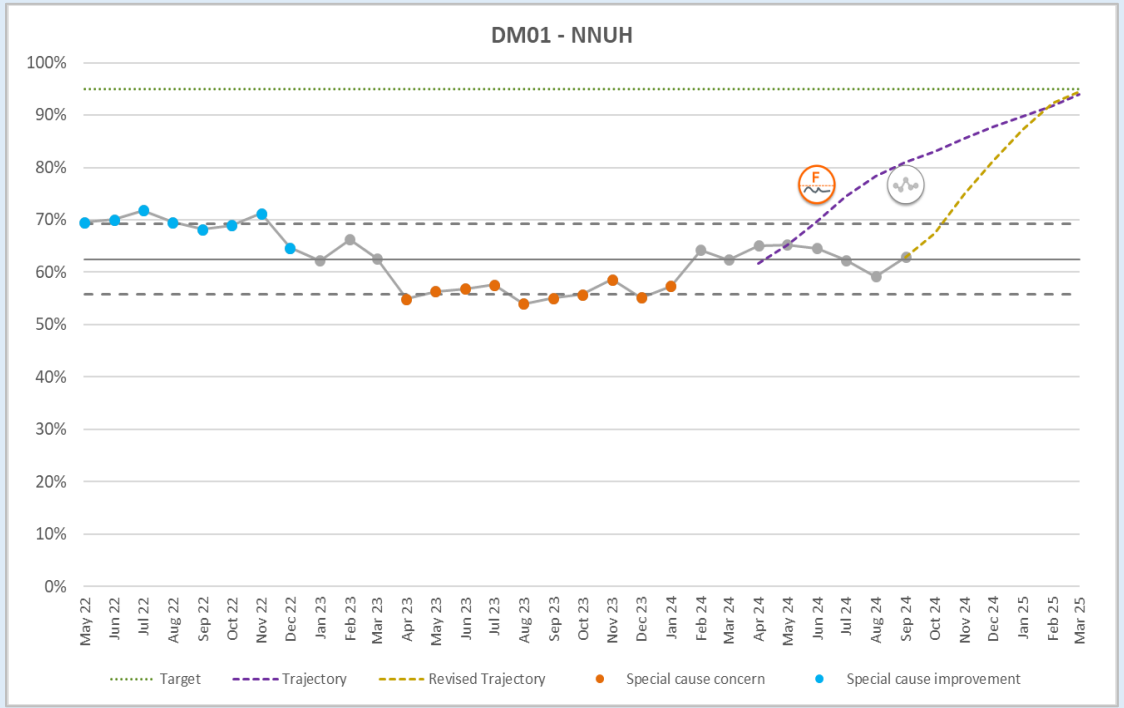
GREEN

Diagnostics

Our Vision
The best care for every patient

Diagnostic Test Within 6 Weeks (DM01)

NHS
Norfolk and Norwich University Hospitals
NHS Foundation Trust



Exam	Aug-24	Sep-24
Magnetic Resonance Imaging	46.4%	47.7%
Computed Tomography	80.4%	91.7%
Non-Obstetric Ultrasound	79.1%	89.0%
DEXA Scan	99.3%	98.9%
Cardiology - echocardiography	38.5%	39.5%
Colonoscopy	53.6%	55.4%
Flexi sigmoidoscopy	72.9%	78.5%
Gastroscopy	86.1%	80.1%
Grand Total	**59.2%**	**62.9%**

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

Commentary

September 2024 Performance

Performance increased to 62.9% in September from 59.2% in August and 62.3% in July but remains behind the original NHSE planning submission trajectory. However, performance for September was in line with revised recovery trajectory to achieve target by March 2025.

Improvements seen in most exam types. The largest of these was seen in CT (80.4% in August to 91.7% in September) and NOUS (79.1% in August to 89.0% in September).

Despite a further improvement in MRI in September, this did not achieve the performance levels forecasted in-month due to the prioritisation of 65 week wait elective cases, including those waiting less than 6 weeks from their diagnostic referral to diagnostic appointment.

Improvement Actions

Echocardiology – Improvement from August to September lower than forecasted due to delay in reinstatement of Insourcing. Insourcing commenced the first weekend in October and will result in further improvement in October DM01 performance.

Colonoscopy – Continued Cancer Alliance funding enabling for appropriate Cancer appointments to be booked during the weekend and providing additional weekday capacity for DM01 activity.

Risk To Delivery

AMBER

Supplementary Information

UEC Performance Overview - SBF Dashboard - FY 2024/25

Monthly performance of the core 16 SBF UEC metrics against targets and trajectories over the 2024/25 Financial Year.

NHS
Norfolk and Norwich University Hospitals

SBF UEC Metric Targets - FY 2024/25

24/25 SBF Metric	Target
01. Ambulance Handover < 30 min	80.0%
02. Ambulance Handover > 60 min	8.0%
03. Sum Ambulance Handover Delays	500.00
04. Initial Assessment < 15 mins	95.0%
05. Admitted within 1hr CRTP	60.0%
06. Total Time in ED < 12hrs	98.0%
07. Average Time in ED (Non-Adm)	195.0
08. 4hr Standard	78.0%
09. SDEC Activity	55.0%
10. Average Time in ED (Adm)	400.0
11. Mean Virtual Ward Activity	60
12. Average LoS (Exc 0 LoS)	6.0
13. D2A 0 Patients NC2R	50.0
14. GP Streaming	25.0%
15. D2A 1 - 3 Patients NC2R	80.0
16. Discharges Before 12 Noon	25.0%

No data is available for 'D2A 0 Patients NC2R' and 'D2A 0 Patients NC2R' April - June 24 due to unreliable reporting of data during the system migration from Medworxx to Optica.

● More than 10% away from trajectory ● Within 10% of trajectory ● Target or trajectory hit ● Target and trajectory hit

	01. Ambulance Handover < 30 min		02. Ambulance Handover > 60 min		03. Sum Ambulance Handover Delays		04. Initial Assessment < 15 mins		05. Admitted within 1hr CRTP		06. Total Time in ED < 12hrs		07. Average Time in ED (Non-Adm)		08. 4hr Standard	
Month Year	Result	Trajectory	Result	Trajectory	Result	Trajectory	Result	Trajectory	Result	Trajectory	Result	Trajectory	Result	Trajectory	Result	Trajectory
April 24	73.5%	65.0%	13.9%	20.0%	684.00	800.00	79.5%	72.0%	56.8%	60.0%	96.5%	96.0%	194.1	205.0	82.9%	78.0%
May 24	68.8%	66.5%	16.2%	19.0%	864.00	775.00	73.7%	74.5%	53.6%	60.0%	96.6%	96.5%	201.9	205.0	80.7%	78.0%
June 24	72.0%	68.0%	13.6%	18.0%	727.00	750.00	77.8%	77.0%	55.5%	60.0%	97.1%	97.0%	191.3	205.0	82.3%	78.0%
July 24	76.9%	70.0%	10.1%	17.0%	560.00	725.00	78.6%	79.5%	52.8%	60.0%	97.0%	97.5%	187.4	205.0	83.0%	78.0%
August 24	76.9%	70.0%	11.3%	16.0%	609.00	700.00	78.1%	82.0%	60.8%	60.0%	97.3%	98.0%	199.1	205.0	82.2%	78.0%
September 24	64.0%	70.0%	19.7%	15.0%	1,309.00	675.00	70.5%	84.5%	49.1%	60.0%	95.3%	98.0%	200.9	205.0	79.4%	78.0%
October 24		71.5%		14.0%		650.00		87.0%		60.0%		98.0%		200.0		78.0%
November 24		73.0%		13.0%		625.00		89.5%		60.0%		98.0%		200.0		78.0%
December 24		75.0%		12.0%		600.00		92.0%		60.0%		98.0%		200.0		78.0%
January 25		77.0%		11.0%		575.00		94.0%		60.0%		98.0%		195.0		78.0%
February 25		79.0%		10.0%		550.00		95.0%		60.0%		98.0%		195.0		78.0%
March 25		80.0%		8.0%		500.00		95.0%		60.0%		98.0%		195.0		78.0%

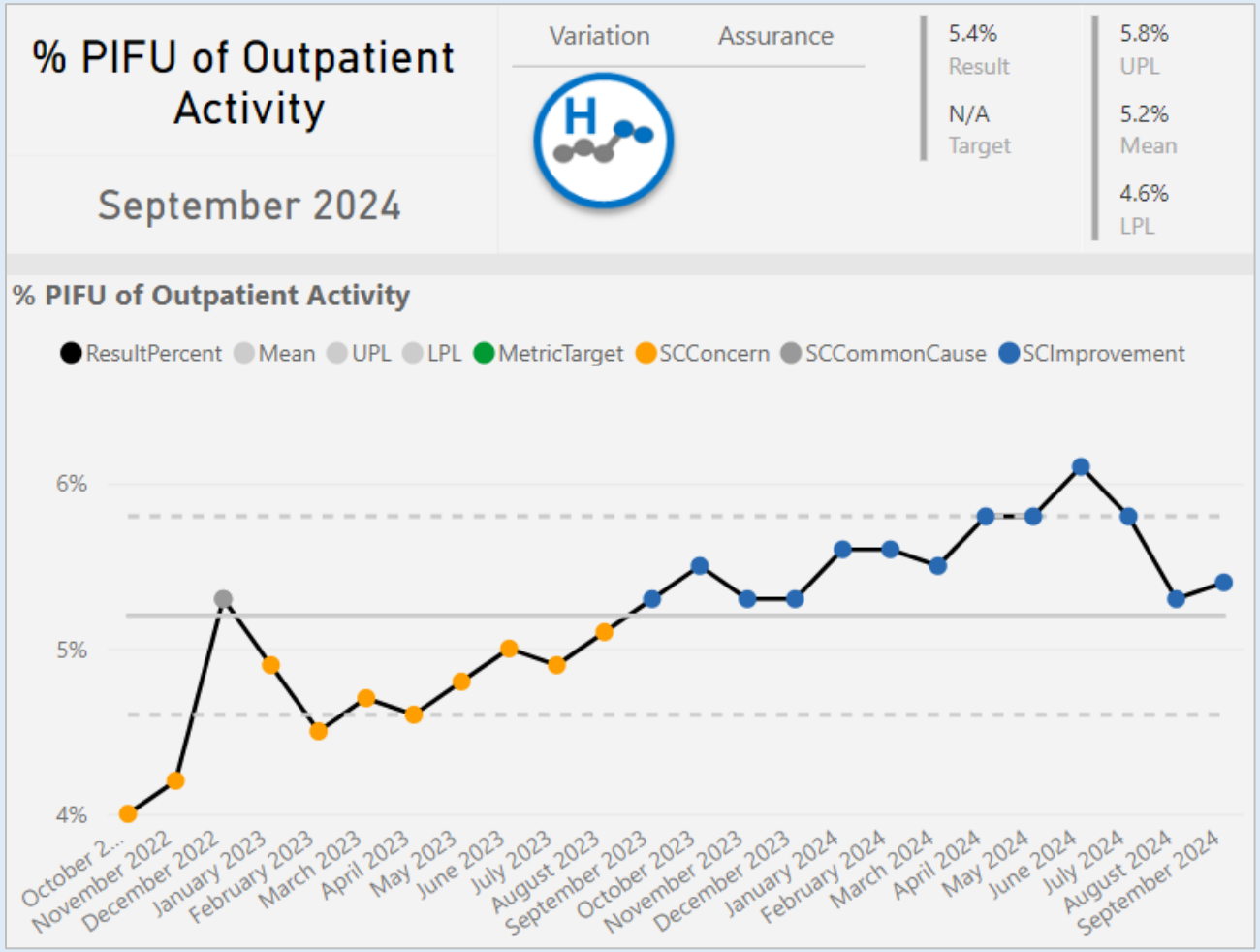
	09. SDEC Activity		10. Average Time in ED (Adm)		11. Mean Virtual Ward Activity		12. Average LoS (Exc 0 LoS)		13. D2A 0 Patients NC2R		14. GP Streaming		15. D2A 1 - 3 Patients NC2R		16. Discharges Before 12 Noon	
Month Year	Result	Trajectory	Result	Trajectory	Result	Trajectory	Result	Trajectory	Result	Trajectory	Result	Trajectory	Result	Trajectory	Result	Trajectory
April 24	47.0%	47.0%	390.2	440.0	54	60	7.2	6.5		68.0	19.4%	22.0%		120.0	15.7%	19.0%
May 24	48.8%	48.0%	406.6	437.0	44	60	6.7	6.5		66.0	17.7%	22.1%		115.0	15.5%	19.5%
June 24	48.4%	49.0%	391.7	433.0	56	60	6.5	6.4		64.0	18.4%	22.1%		110.0	16.1%	20.0%
July 24	48.3%	50.0%	393.6	429.0	55	60	6.8	6.4	103.6	61.0	18.4%	22.2%	99.2	105.0	14.9%	20.5%
August 24	46.1%	51.0%	357.4	425.0	46	60	6.4	6.3	90.9	59.0	19.7%	22.2%	98.0	100.0	15.3%	21.0%
September 24	47.3%	51.5%	451.6	421.0	49	60	6.3	6.3	97.4	56.0	17.7%	22.3%	95.3	95.0	16.0%	21.5%
October 24		52.0%		417.0		60		6.2		55.0		22.3%		90.0		22.0%
November 24		52.5%		413.0		60		6.2		54.0		22.4%		85.0		22.5%
December 24		53.0%		409.0		60		6.1		53.0		22.4%		80.0		23.0%
January 25		53.5%		405.0		60		6.1		52.0		22.5%		80.0		25.0%
February 25		54.0%		401.0		60		6.0		51.0		22.5%		80.0		25.0%
March 25		55.0%		400.0		60		6.0		50.0		25.0%		80.0		25.0%

Patient Initiated Follow Up

Commentary

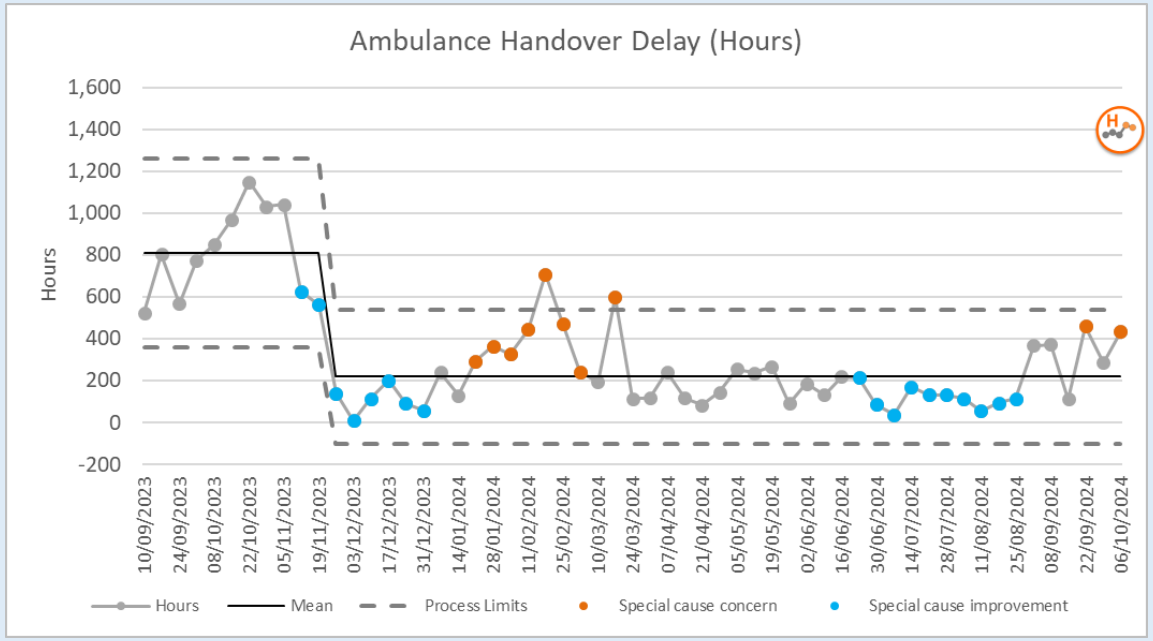
September 2024 Performance

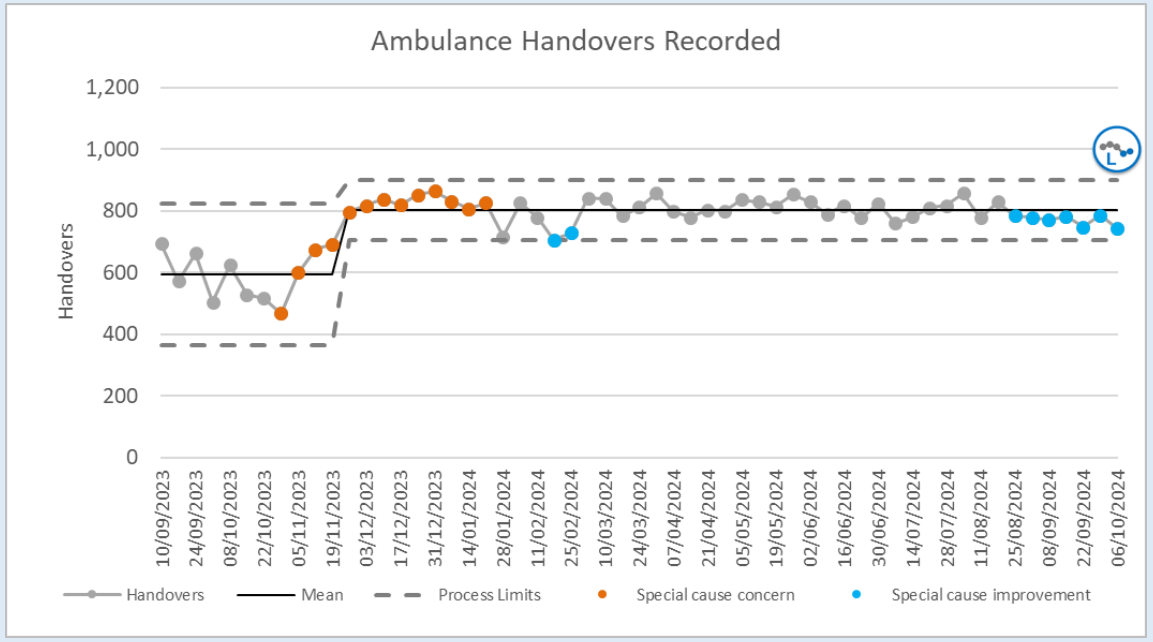
The number of patients added to a PIFU list as a percentage of the monthly outpatient activity increased to 5.4% in September compared to 5.3% in August.



Performance – Ambulance Handovers

Week Ending	04-Aug	11-Aug	18-Aug	25-Aug	01-Sep	08-Sep	15-Sep	22-Sep	29-Sep	06-Oct
Ambulance handover delays (hours)	**115**	**54**	**94**	**115**	**369**	**374**	**112**	**461**	**286**	**434**
Ambulance handovers recorded	857	777	830	785	779	770	783	748	787	742
Average handover delay duration (mins)	8	4	7	9	28	29	9	37	22	35
Difference from baseline of 505 handovers	59%	65%	61%	64%	65%	66%	65%	68%	64%	68%





Commentary

September 2024 Performance

The total number of ambulance handover delays (hours) in September was 1,309. This was an increase of 700 hours compared to August (609), with 254 less ambulance handovers recorded in September compared to August.

Activity Planning Run Rate

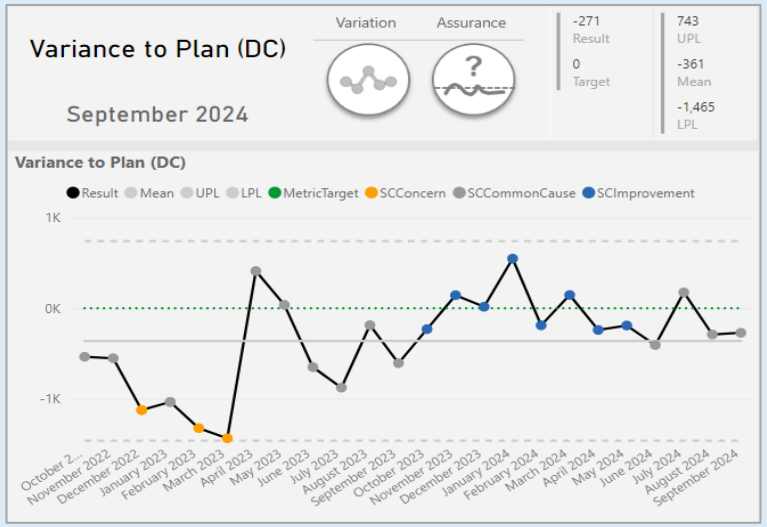
Commentary

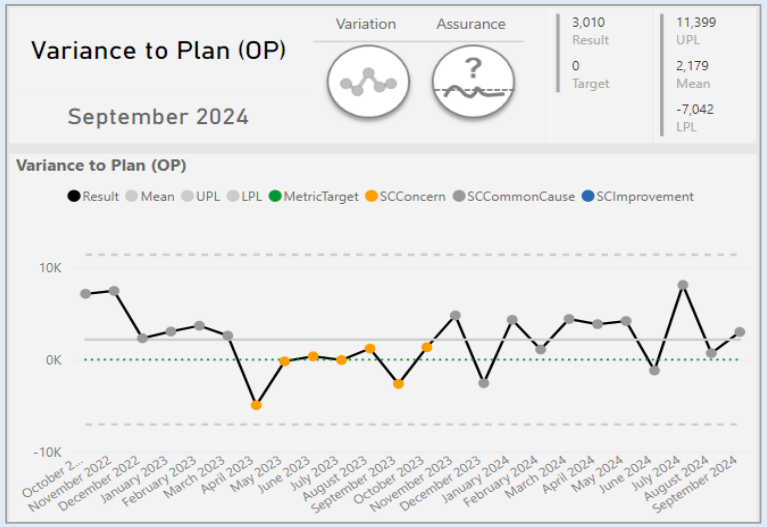
September 2024 Performance (provisional)

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 / negative variance are included in the tables beside each graph.

Day Case Variance to Plan – Top 3 Specialties

Specialty	Negative Variance
Urology	-126
Ophthalmology	-110
Clinical Oncology	-101



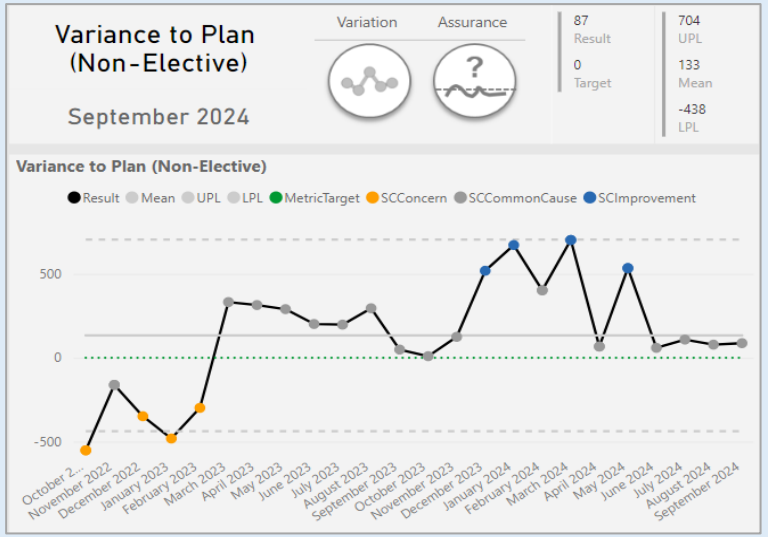


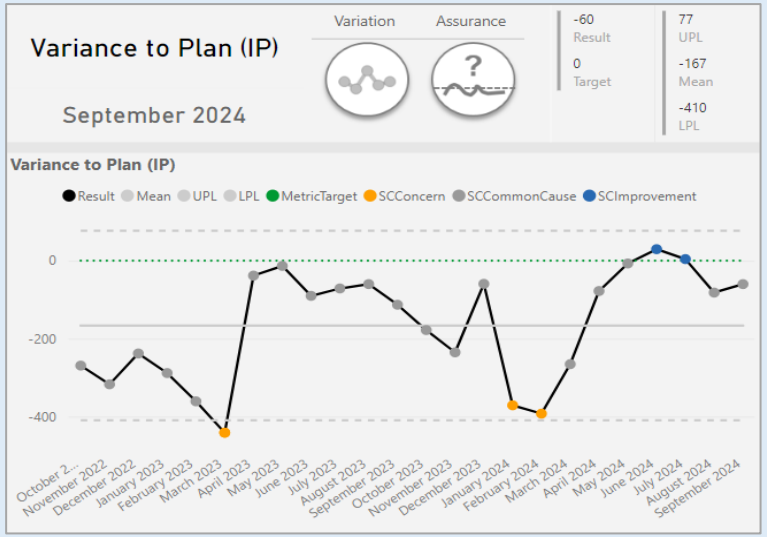
Outpatient Variance to Plan – Top 3 Specialties

Specialty	Positive Variance
Cardiology	196
Paediatric ENT	179
Trauma and Orthopaedics	173

Non-Elective Variance to Plan – Top 3 Specialties

Specialty	Positive Variance
Acute Internal Medicine	71
Trauma and Orthopaedic	46
Obstetrics	43





Inpatient Variance to Plan – Top 3 Specialties

Specialty	Negative Variance
Trauma and Orthopaedic	-75
ENT	-19
Plastic Surgery	-13

Activity Forecast

Activity Forecast: September 2024 Full Month Estimate vs 2024/25 Business Plan

% 2024/25 Business Plan Achieved

Business Plan Achieved
Business Plan Not Achieved

	Med	Surg&EM	W&C	CSS	Total
APC - Daycase	100%	91%	96%	63%	**96%**
APC - Elective	89%	89%	117%		**94%**
OP - Procedures	101%	95%	91%	81%	**95%**
OP - New (exc procedures)	105%	100%	85%	89%	**99%**
Subtotal - ERF	**102%**	**96%**	**89%**	**86%**	**97%**
APC - Non Elective	100%	110%	100%		**102%**
OP - Follow Up (exc Procedures)	116%	110%	108%	94%	**111%**
Subtotal - Non ERF	**114%**	**110%**	**105%**	**94%**	**110%**
Overall	**109%**	**102%**	**99%**	**91%**	**103%**

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	4,088	4,105	(17)	2,314	2,555	(241)	267	277	(10)	5	8	(3)	**6,673**	**6,945**	**(271)**
APC - Elective	97	109	(12)	669	740	(71)	226	192	34	0	0	0	**992**	**1,041**	**(49)**
APC - Non Elective	2,656	2,667	(11)	1,131	1,031	100	1,949	1,952	(3)	0	0	0	**5,737**	**5,650**	**87**
Admitted - Total	**6,841**	**6,881**	**(40)**	**4,114**	**4,326**	**(212)**	**2,442**	**2,421**	**21**	**5**	**8**	**(3)**	**13,402**	**13,636**	**(234)**
OP - Procedures	2,231	2,199	32	10,064	10,575	(511)	1,082	1,191	(109)	549	679	(130)	**13,926**	**14,644**	**(718)**
OP - New (exc procedures)	5,725	5,433	292	8,220	8,112	108	2,020	2,385	(365)	1,102	1,238	(136)	**17,067**	**17,168**	**(102)**
OP - Follow Up (exc Procedures)	17,724	15,258	2,466	14,056	12,778	1,278	4,381	4,058	323	2,690	3,074	(384)	**38,851**	**35,168**	**3,683**
Non Admitted - Total	**25,680**	**22,890**	**2,790**	**32,339**	**31,465**	**875**	**7,483**	**7,634**	**(151)**	**4,341**	**4,991**	**(650)**	**69,844**	**66,980**	**2,863**
Total - NNUH	**32,521**	**29,771**	**2,750**	**36,454**	**35,791**	**663**	**9,925**	**10,055**	**(130)**	**4,346**	**4,999**	**(653)**	**83,246**	**80,617**	**2,629**

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	39	39	0	0	0	0	0	0	0	**39**	**39**	**0**
APC - Elective	0	0	0	30	41	(11)	0	0	0	0	0	0	**30**	**41**	**(11)**
APC - Non Elective	0	0	0	0	0	0	0	0	0	0	0	0	**0**	**0**	**0**
Admitted - Total	**0**	**0**	**0**	**69**	**80**	**(11)**	**0**	**0**	**0**	**0**	**0**	**0**	**69**	**80**	**(11)**
OP - Procedures	0	0	0	0	0	0	0	0	0	1	0	1	**1**	**0**	**1**
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	94	80	14	0	0	0	212	0	212	**306**	**80**	**226**
Non Admitted - Total	**0**	**0**	**0**	**94**	**160**	**(66)**	**0**	**0**	**0**	**213**	**0**	**213**	**307**	**160**	**147**
Total - Spire	**0**	**0**	**0**	**163**	**240**	**(77)**	**0**	**0**	**0**	**213**	**0**	**213**	**376**	**240**	**136**

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	4,088	4,105	(17)	2,353	2,594	(241)	267	277	(10)	5	8	(3)	**6,712**	**6,984**	**(271)**
APC - Elective	97	109	(12)	699	781	(82)	226	192	34	0	0	0	**1,022**	**1,082**	**(60)**
APC - Non Elective	2,656	2,667	(11)	1,131	1,031	100	1,949	1,952	(3)	0	0	0	**5,737**	**5,650**	**87**
Admitted - Total	**6,841**	**6,881**	**(40)**	**4,183**	**4,406**	**(223)**	**2,442**	**2,421**	**21**	**5**	**8**	**(3)**	**13,471**	**13,716**	**(245)**
OP - Procedures	2,231	2,199	32	10,064	10,575	(511)	1,082	1,191	(109)	550	679	(129)	**13,927**	**14,644**	**(717)**
OP - New (exc procedures)	5,725	5,433	292	8,220	8,192	28	2,020	2,385	(365)	1,102	1,238	(136)	**17,067**	**17,248**	**(182)**
OP - Follow Up (exc Procedures)	17,724	15,258	2,466	14,150	12,858	1,292	4,381	4,058	323	2,903	3,074	(171)	**39,158**	**35,248**	**3,910**
Non Admitted - Total	**25,680**	**22,890**	**2,790**	**32,433**	**31,625**	**809**	**7,483**	**7,634**	**(151)**	**4,554**	**4,991**	**(437)**	**70,151**	**67,140**	**3,010**
Grand Total (NNUH + ASI + Spire)	**32,521**	**29,771**	**2,750**	**36,617**	**36,031**	**586**	**9,925**	**10,055**	**(130)**	**4,559**	**4,999**	**(440)**	**83,622**	**80,857**	**2,765**

REPORT TO TRUST BOARD

Date	**6 November 2024**
Title	**Month 6 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** **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☐**	**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 and FI&P Committee**		**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

September position is a £3.0m deficit on a control total basis, £3.6m adverse to the planned £0.6m surplus. Recurrent performance is a £3.8m deficit, £4.4m adverse to plan.

Recurrent underperformance is due to CIP under-delivery of £2.4m (of which £1.6m relates to the budgeted CIP stretch target), divisional overspends of £1.0m, of which pay is £1.5m overspent offset by savings in drugs & clinical supplies, and activity under performance of £1.2m offset by £0.2m of additional interest income. Recurrent underperformance is offset by non-recurrent net mitigations totalling £0.8m of which the Financial Recovery Plan is £0.3m.

YTD position is a £13.1m deficit on a control total basis, £9.5m adverse to the planned £3.6m deficit. Recurrent performance is a £21.5m deficit, £17.9m adverse to plan.

Recurrent performance is driven by CIP under delivery of £9.1m (of which £4.9m relates to the budgeted CIP stretch target), divisional pay expenditure is £6.6m adverse, and activity is £3.9m adverse, offset by favourable net drugs expenditure of £0.3m and interest income of £1.2m. Recurrent underperformance is offset by non-recurrent net mitigations totalling £8.4m, of which the Financial Recovery Plan is £1.0m with balance being due to delayed investments and reserve utilisation.

Financial Recovery Plan (FRP): Year to date the FRB has delivered £0.95m of non-recurrent savings, an adverse variance of £0.03m against the planned £0.98m

Pay: The year to date pay overspend is £9.4m, £8.6m excluding the £0.8m of direct costs relating to Industrial Action in June. A further £2.2m relates to the under delivery of CIP. Of the remaining £6.4m overspend £4.5m relates to medical staff across the four operational divisions, medical locum spend remains a concern running at c £1.9m per month (inc. WLI) increasing to £2.1m in Aug and then back to £1.9m in Sep. Whilst nursing agency has reduced on a monthly basis from £0.7m in April to £0.3m in August, and bank spend has remained static at c. £1.9m substantive staffing increased from August by c £0.4m without any reduction in premium staffing from August to September. **Focus is required to minimise all areas of temporary staffing to ensure minimum premium is paid and additional shifts are not worked over the agreed rosters.** This will require scrutiny of the substantive workforce to ensure we are utilising staff productively and reducing the need for temporary staffing.

Forecast Outturn: Year to date £22.3m of crystalised risk offset by £12.8m of crystallised mitigations (£9.5m Adverse YTD). The further crystallisation of risk is forecast to be £30.1m offset by agreed mitigations in run rate totalling £17.8m. Additional mitigations totalling £8.6m 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.

Run Rate: To achieve the forecast outturn of a £13.2m deficit monthly performance needs to move from an average of £2.9m deficit in Aug & Sep to an average monthly deficit of £0.1m, a c £3.0m monthly improvement in performance. To achieve the breakeven plan the favourable swing needs to be c. £5.0m

Activity: Value-based activity performance for September was £1.0m adverse to plan (£4.4m adverse YTD) equating to 95% of planned levels (96% YTD). The elective elements were £1.1m adverse (£5.1m YTD) equating to 94% (95% YTD), and other chargeable API (Chemotherapy Delivery and Diagnostic Imaging) activity was £0.1m favourable to plan (106%) (£0.7m favourable YTD, 107%).

Cash: Cash held on 30th September 2024 was £82.6m, £17.2m lower than the FY24/25 submitted forecast as result of the underlying deficit performance.

Capital Expenditure: Year to date total capital spend is £17.1m, a £8.2m underspend against the planned £25.2m. **Forecast Outturn** for the total capital plan is £90.7m, an £8.1m overspend against the Trust's CDEL allocation of £82.6m 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 £13.1m deficit against the planned £3.6m deficit, £9.5.m adverse to plan. Forecast Outturn remains Breakeven. Trust has underspent Capital Expenditure by £11.1m year to date. Forecast Outturn for the total capital plan is £78.8m, an £8.1m overspend against the Trust's CDEL allocation of £70.7m.

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

Norfolk and Norwich University Hospitals NHS Foundation Trust

Finance Report September 2024

6 November 2024

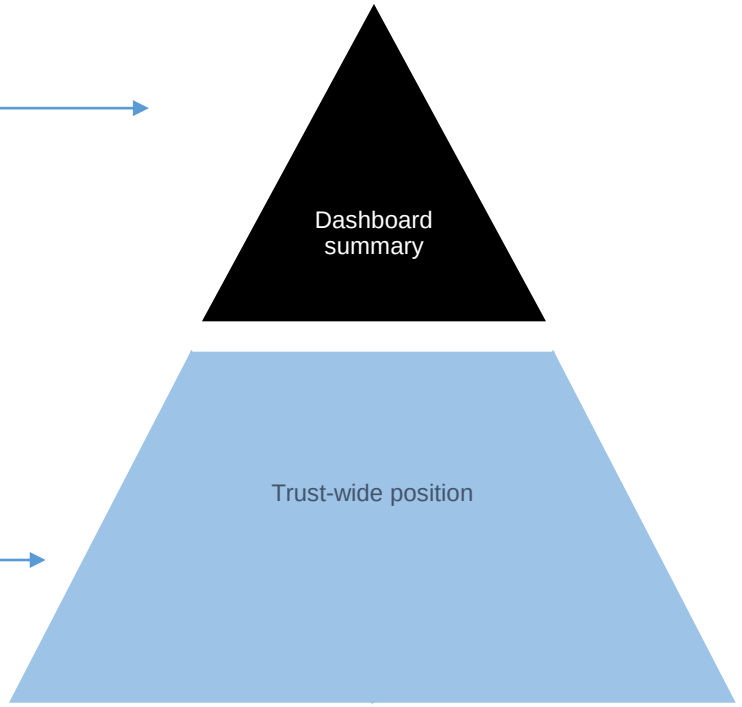
Liz Sanford, Interim Chief Finance Officer

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.

September position is a £3.0m deficit on a control total basis, £3.6m adverse to the planned £0.6m surplus. Recurrent performance is a £3.8m deficit, £4.4m adverse to plan.

Recurrent underperformance is due to CIP under-delivery of £2.4m (of which £1.6m relates to the budgeted CIP stretch target), divisional overspends of £1.0m, and activity under performance of £1.2m offset by £0.2m of additional interest income. Recurrent underperformance is offset by non-recurrent net mitigations totalling £0.8m of which the Financial Recovery Plan is £0.3m.

YTD position is a £13.1m deficit on a control total basis, £9.5m adverse to the planned £3.6m deficit. Recurrent performance is a £21.5m deficit, £17.9m adverse to plan.

Recurrent performance is driven by CIP under delivery of £9.1m (of which £4.9m relates to the budgeted CIP stretch target), divisional pay expenditure is £6.6m adverse, and activity is £3.9m adverse, offset by favourable net drugs expenditure of £0.3m and interest income of £1.2m. Recurrent underperformance is offset by non-recurrent net mitigations totalling £8.4m, of which the Financial Recovery Plan is £1.0m with balance being due to delayed investments and reserve utilisation.

Forecast Outturn: Year to date £22.3m of crystalised risk offset by £12.8m of crystallised mitigations (£9.5m Adverse YTD). The further crystallisation of risk is forecast to be £30.1m offset by agreed mitigations in run rate totalling £17.8m. Additional mitigations totalling £8.6m 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 September was £1.0m adverse to plan (£4.4m adverse YTD) equating to 95% of planned levels (96% YTD). The elective elements were £1.1m adverse (£5.1m YTD) equating to 94% (95% YTD), and other chargeable API (Chemotherapy Delivery and Diagnostic Imaging) activity was £0.1m favourable to plan (106%) (£0.7m favourable YTD, 107%).

Capital Expenditure: Year to date total capital spend is £20.5m, an £11.1m underspend against the planned £31.6m. **Forecast Outturn** for the total capital plan is £78.8m, an £8.1m overspend against the Trust's CDEL allocation of £70.7m 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 £25.7m on NANOC 2.

Cash held on 30th September 2024 was £82.6m, £17.2m lower than the FY24/25 submitted forecast as result of the underlying deficit performance.

	In Month			Year to Date		
	Actual	Plan	Variance	Actual	Plan	Variance
SOCI	£m	£m	£m	£m	£m	£m
Clinical Income	65.0	66.2	(1.2)	388.0	392.7	(4.7)
Other Income	10.5	8.4	2.1	62.3	49.6	12.7
TOTAL INCOME	**75.5**	**74.6**	**0.9**	**450.3**	**442.3**	**8.0**
Pay	(46.7)	(45.2)	(1.5)	(276.4)	(267.0)	(9.4)
Non Pay	(22.7)	(18.8)	(3.9)	(129.3)	(118.7)	(10.6)
Drugs (Net Expenditure)	(2.5)	(3.1)	0.6	(18.4)	(18.5)	0.1
TOTAL EXPENDITURE	**(71.9)**	**(67.1)**	**(4.9)**	**(424.0)**	**(404.2)**	**(19.8)**
Non Opex	(6.6)	(7.0)	0.3	(39.3)	(41.6)	2.3
Control Total Surplus / (Deficit)	(3.0)	0.6	(3.6)	(13.1)	(3.6)	(9.5)
Statutory Surplus / (Deficit)	(1.7)	0.9	(2.6)	(6.0)	(1.6)	(4.4)
Other Financial Metrics	£m	£m	£m	£m	£m	£m
Cash at Bank (before support funding)	82.6	99.8	(17.2)	82.6	99.8	(17.2)
Capital Programme Expenditure	3.4	6.3	2.9	20.5	31.6	11.1
CIP Delivery	0.8	3.1	(2.4)	2.6	11.7	(9.1)
Activity Metrics	£m	£m	£m	£m	£m	£m
Day Case	6.1	6.2	(0.1)	35.2	36.5	(1.3)
Elective Inpatient	4.7	5.3	(0.7)	25.9	28.9	(3.0)
Outpatients - New & Procedures	5.5	5.8	(0.3)	34.2	34.9	(0.8)
Other Chargeable activity included within API	1.7	1.6	0.1	10.7	10.0	0.7
TOTAL	18.0	19.0	(1.0)	106.0	110.4	(4.4)

Norfolk and Norwich University Hospitals NHS Foundation Trust

1.2 Executive Dashboard

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 took place in August 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 the latest 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 is unchanged at Month 6, of which £22.3m has crystalised year to date.

The Month 6 crystalised risks are:

CIP Under Delivery (Risk A) is £9.1m adverse year to date - £2.6m delivered against the budgeted plan of £11.7m, comprising of a planning variance of £8.7m and an adverse performance variance of £0.4m, which equates to an underperformance of c. 78%.

Failure to control expenditure in line with plan (Risk B) has a crystalised impact of £6.8m year to date, due to a Divisional Pay overspend of £6.3m and £0.8m of spend to cover Industrial Action, offset by £0.3m underspend on drugs.

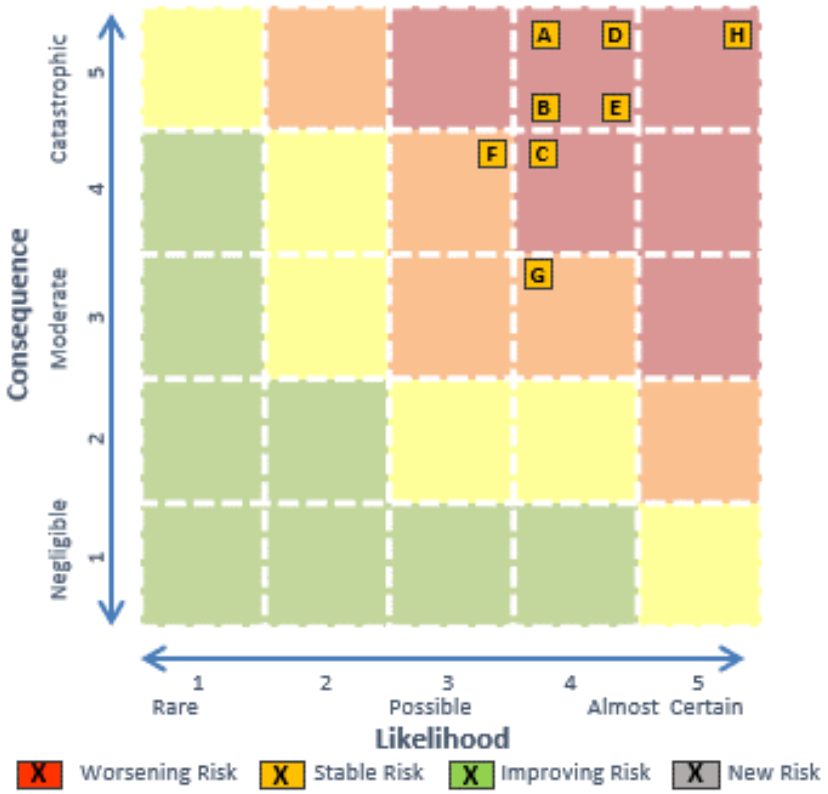
Failure to increase income contracts for service development (Risk C) has a crystalised impact of £0.2m year to date.

Failure to utilise Clinical Space / Workforce in line with the plan (Risk D) has a crystalised impact of £6.1m year to date, due to an under performance in the Elective Elements of £5.1m (Industrial action had an estimated adverse impact of £0.5m), offset by overperformance in Chemo & Radiology of £0.7m. Increased use of the Independent Sector to support the Elective activity plan was an additional £0.7m and continued opening of the Discharge Suite and Escalation £1.0m.

Risk G: The risk of the NANOC 2 project being cancelled resulting in a £2.6m revenue impact in 24/25 has been included, however is shown as fully mitigated through receipt of external funding (ongoing discussions).

Financial Recovery Plan: As a result of the forecast adverse variance to plan a Financial Recovery Plan has been implemented and is detailed in Appendix E. Year to date delivery is £0.95m, £0.03m behind plan.

Risk Rating		Risks	Financial Impact FY24/25 £m	YTD Crystallised Impact £m	Forecast Further Crystalisation £m	Financial Impact FY24/25 (Revised) £m
Extreme	15+	A, B, C, D, E, H	77.5	22.3	55.2	77.5
High	12-14	F, G	0.0	0.0	2.6	2.6
Moderate	5-11	-		0.0	0.0	0.0
Low	1-4	-		0.0	0.0	0.0
Total			77.5	22.3	57.8	80.1
Mitigation of risk prior to full value crystalising				0.0	(27.8)	(27.8)
Net Total Risk Assessed Impact				22.3	30.1	52.3
Risk mitigated through Non Recurrent YTD underspends & Release of Expenditure Reserves				(11.8)	(17.8)	(29.6)
Risk mitigated through Delivery of Financial Recovery Plan (FRP)				(1.0)	(8.6)	(9.6)
Total Risk Assessed Impact				9.5	3.7	13.2



2.1 Financial Performance – September 2024

Norfolk and Norwich University Hospitals NHS Foundation Trust

September position is a £3.0m deficit on a control total basis, £3.6m adverse to the planned £0.6m surplus. Recurrent performance is a £3.8m deficit, £4.4m adverse to plan. Recurrent underperformance is due to CIP under-delivery of £2.4m (of which £1.6m relates to the budgeted CIP stretch target), divisional overspends of £1.0m, and activity under performance of £1.2m offset by £0.2m of additional interest income. Recurrent underperformance is offset by non-recurrent net mitigations totalling £0.8m of which the Financial Recovery Plan is £0.3m.

Income: Income is reporting a favourable variance of £0.9m in September. However, variable activity performance was adverse to plan by £1.2m. Other income includes favourable pass-through income for Cancer Alliance of £0.6m, Digital Aspirant £0.4m, R&D of £0.6m and EPA of £0.2m, along with other pass-through income and staff secondments (which are offset by expenditure) of £0.2m. Private Patients income is £0.1m favourable.

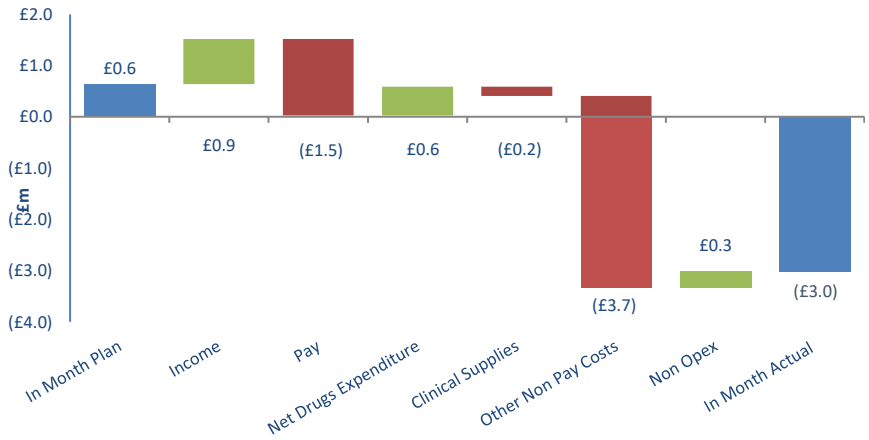
Pay: Pay is overspent by £1.5m in September. This is due to £1.9m divisional pay overspends, of which £0.4m is due to unidentified CIP, £0.6m overspend of divisional nursing spend (£0.3m in Medicine), and £1.0m overspend of divisional medical spend (£0.7m in Surgery, £0.3m in Medicine), offset by £0.1m underspends in A&C and AHPs. The offsetting £0.4m underspend relates to delayed investments.

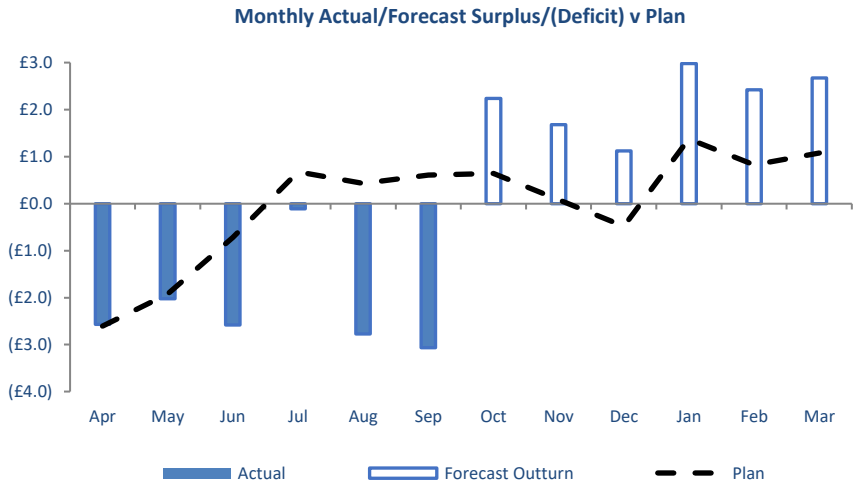
Agency spend in September is 2.2%, 1.0% lower than the NHS threshold of 3.2%, and 0.5% lower than the Trust plan of 2.7%. Medical is the largest user of agency spend in September, being 2.6% of total medical spend, a decrease of 0.5% from August.

Net Drugs Cost: In month drugs are favourable to plan by £0.6m.

Non-Pay: Non pay is adverse by £3.9m. This is due to under delivery of CIP of £2.1m (of which £1.6m relates to the budgeted CIP stretch target). The remainder relates to pass-through expenditure on R&D, Cancer Alliance and Digital Aspirant of £1.8m.

Non-Operating Expenditure: September non-operating expenditure is showing a £0.3m favourable variance. This is due to £0.2m of interest income received due to continued high interest rates and £0.1m due to lower depreciation and PFI indexation charges in month.





2.2 Financial Performance – Year to Date

Norfolk and Norwich University Hospitals NHS Foundation Trust

YTD position is a £13.1m deficit on a control total basis, £9.5m adverse to the planned £3.6m deficit. Recurrent performance is a £21.5m deficit, £17.9m adverse to plan. Recurrent performance is driven by CIP under delivery of £9.1m (of which £4.9m relates to the budgeted CIP stretch target), divisional pay expenditure is £6.6m adverse, and activity is £3.9m adverse, offset by favourable net drugs expenditure of £0.3m and interest income of £1.2m. Recurrent underperformance is offset non-recurrent net mitigations totalling £8.4m, of which the Financial Recovery Plan is £1.0m with balance being due to delayed investments and reserve utilisation.

Income: Income is reporting a favourable variance of £8.0m year to date. Variable activity performance is adverse to plan by £4.4m (of which £0.5m is due to cancelled activity due to industrial action that took place in June and July). Other income includes favourable pass-through income for Cancer Alliance of £4.3m and £2.6m of R&D, the remainder includes other pass-through expenditure of £2.0m, and staff secondments of £1.9m, which are all offset with expenditure, and £0.6m workplace health and well-being, and Private Patients income which is £1.0m favourable.

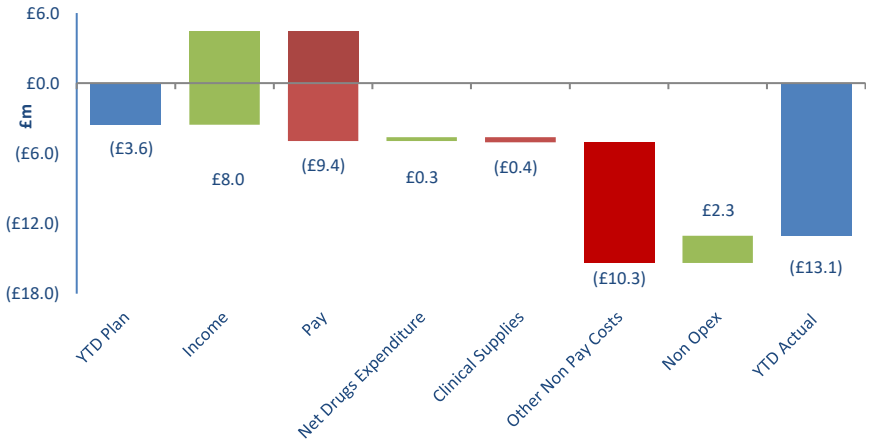
Pay: Pay is overspent by £9.4m year to date of which £0.8m is due to industrial action that took place in June and July. The remaining £8.6m is due to £1.9m of unidentified CIP, £3.2m overspend in nursing (£2.0m of this is in Medicine), and £3.7m overspend in medical (£3.0m of this is in Surgery). Offset by £0.9m underspends on A&C and AHPs. The remaining £0.7m relates to pass through expenditure for staff secondments and R&D.

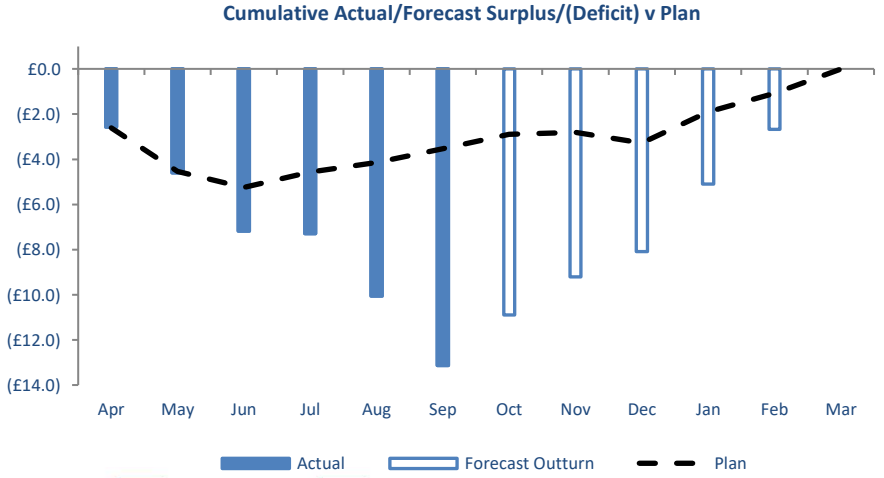
Agency spend year to date is 2.4%, 0.8% lower than the NHS threshold of 3.2%. Registered Nursing is the largest user of agency spend, being 3.2% of total nursing spend.

Net Drugs Cost: Year to date net drugs position is £0.3m favourable.

Non-Pay: Non pay is adverse by £10.7m. This includes under delivery of CIP of £7.2m (of which £4.9m relates to the budgeted CIP stretch target), pass-through expenditure of £2.5m (which is income backed) and additional expenditure on the independent capacity sector support of £0.8m.

Non-Operating Expenditure: Non-operating expenditure has a £2.3m favourable variance. This is due to £1.3m of interest income received due to continued high interest rates and £0.7m due to lower depreciation charges year to date, and favourable PFI indexation of £0.3m.



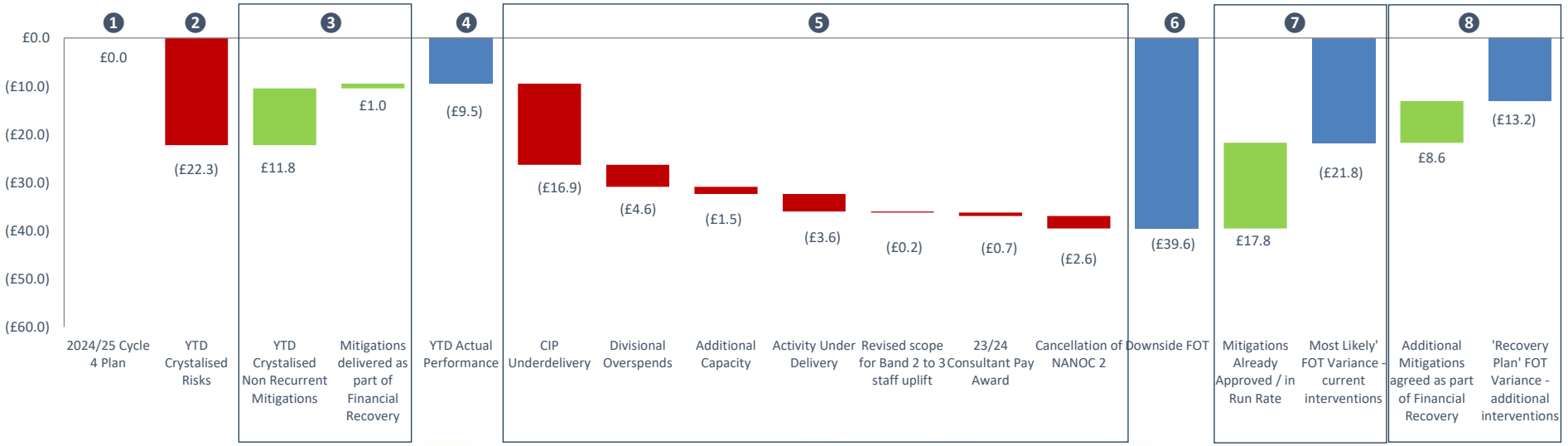


2.3 Forecast Outturn

Norfolk and Norwich University Hospitals NHS Foundation Trust

Year-to-date, £22.3m of risks and £12.8m of mitigations have crystalised, resulting in a £9.5m adverse variance to plan at Month 6. For the remainder of the year, further risk crystallisation is forecast at £30.1m, resulting in a downside forecast outturn of a £39.6m deficit, £39.6m adverse to the planned breakeven position. Agreed mitigations / mitigations in run rate totalling £17.8m have been identified resulting in a 'Most Likely' forecast outturn of £21.8m deficit. Additional mitigations totalling £8.6m 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 £22.3m, of which £6.3m relates to divisional pay overspends, £9.1m relates to under delivery of CIP, £4.4m 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 £12.8m, of which £6.1m relates to non-recurrent risk mitigation, £4.5m unutilised reserves, £1.2m of interest income and £1.0m from delivery of the Financial Recovery Plan.
4. YTD actual performance of a £9.5m deficit, £9.5m adverse to plan
5. Further run rate risk of £30.1m forecast to crystallise through remainder of the year based on current run rates
6. Downside Forecast Outturn of a £39.6m, £39.6m adverse to the breakeven plan
7. Agreed mitigations / mitigations in run rate totalling £17.8m, of which divisional recovery plans total £3.0m, £6.2m of central mitigations, £2.3m of activity recovery, and forecast conversion of CIP pipeline into delivery of £2.5m, resulting in a 'Most Likely' Forecast Outturn of a £21.8m, £21.8m adverse to the breakeven plan
8. Additional mitigations totalling £8.6m, 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. Breakdown of the Financial Recovery Plan is included in Appendix E.

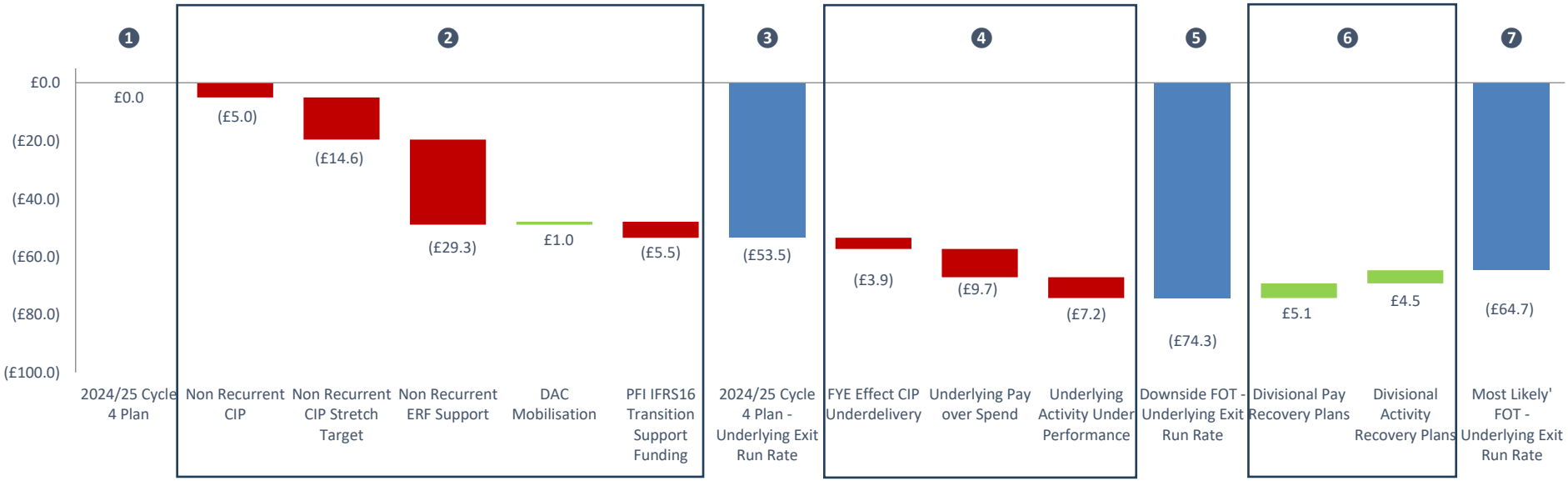


2.4 Underlying Exit Run Rate

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 in year recurrent underperformance the downside underlying exit run rate is now a £74.3m deficit, £21.8m adverse to the planned underlying exit run rate of £53.5m. The 'Most Likely' underlying exit run rate is a £64.7m deficit, £12.2m adverse to plan.

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 planned exit run rate at Month 6 is £20.8m adverse. This is a result of £3.9m 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 £74.3m deficit, £20.8m 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 £64.7m deficit, £11.2m adverse to planned Underlying Exit Run Rate of £53.5m



A Standard Operating Procedure for Naming Trust Assets
(typically individual departments or parts of Trust estate)

Name & job title of document author:	John Paul Garside (Board Secretary)
Division responsible for document:	Corporate
Date document written:	2022
Approving committee & date: NB: Under the Scheme of Delegation, Naming of Trust assets is a matter reserved to the Board of Directors	Hospital Management Board 16 Aug 2022 Board of Directors on 05 October 2022 & 6 Nov 2024 Charitable Funds Committee on 18 May '22 & 15 Oct '24
Next due for review:	December 2026
For use in:	All Trust Departments
For use by:	All staff – especially Estates, Communications, Executive Directors and Divisional leaders
Key words:	Naming, Sponsorship

Executive Summary

In accordance with the Scheme of Delegation and Schedule of Matters Reserved, naming Trust assets is one of the items reserved for decision of the Trust Board.

This SOP sets out the principles, criteria and processes that govern how the Trust decides on naming its assets. This is in recognition that:

- there is potential value in the profile and publicity of such names;
- once made, decisions can be difficult to reverse;
- it is important to have a process that is consistent, avoids unconscious bias or inappropriate influences and follows appropriate rules
- this process provides an opportunity for the Board to demonstrate its support for the N&N Hospitals Charity as the principal Charity associated with the Trust.
-

Ultimately each case will be considered by the Board on its own merits, in its particular circumstances and in the best interests of the Trust.

The process is simple and is summarised in a step-by-step Decision Tree (at Appendix 1)

Version	Updated By	When	Description of Changes
2	JPG	Oct '24	Updating with reference to Board's commitment to N&N Hospitals Charity as the principal charity associated with the Trust

Standard Operating Procedure for Naming Trust Assets

1. Objectives*

The Objective of this Procedure is to document the approach of the Trust to Naming assets of the Trust. Such assets are typically individual departments or parts of Trust estate.

This SOP is intended to mitigate associated risks – to ensure that there is a consistent and robust approach and 'due diligence' to avoid association with inappropriate individuals or organisations.

2. Rationale*

2.1 Naming areas of the Trust may serve a number of purposes:

	Purpose	Examples
(i)	Facilitate practical wayfinding – to aid navigation around the Hospital.	Factual descriptors (East Outpatients, Centre Block) or naming Wards in alphabetical order.
(ii)	Fit with the Trust's Strategic Commitments e.g. emphasising our role in providing specialist care, or our association with research or education.	Sir Thomas Browne Academic Colorectal Unit, Norfolk & Norwich Orthopaedic Centre, Norfolk Centre for Interventional Radiology.
(iii)	Celebrate a notable individual that we would like to honour and with whom we would like to be associated.	Edith Cavell School of Nursing, Benjamin Gooch Lecture Theatre, Jenny Lind Children's Hospital.
(iv)	As a 'thank you' to prominent staff or individual Charity supporters.	Jack Pryor Renal Unit, Bernstein Minor Injuries Unit; Elsie Bertram Diabetes Centre, McKee House, Alan Birt meeting room.
(v)	Recognise and 'cement' a relationship with a commercial sponsor or grant-giving body.	Wolfson Research Wing, Snelling Lecture Theatre, NIHR Clinical Research Facility.
(vi)	Fostering 'community' links and engagement.	Naming all our wards after Norfolk villages and places reflects that the Hospital is rooted in the community it serves.

2.2 There are a number of risks associated with Naming:

- association with well-known and apparently respected individuals may tarnish over time – Rolf Harris, Jimmy Saville, Edward Colston;
- linkage to a particular person or clinical speciality may inhibit flexibility in the future use of the estate;
- the rationale for some connections may become increasingly less obvious with the passage of time;
- there can be a tendency to favour some groups of staff more than others;
- there are hazards associated with unfortunate acronyms that should be avoided and names that appear a 'good idea' at the time but subsequently lose their appeal.

2.3 In accordance with the Scheme of Delegation and Schedule of Matters Reserved, award of 'naming rights' is reserved for decision of the Trust Board. This helps to maintain consistency of approach, avoids short-term 'idiosyncratic' decisions and ensures that there is 'due diligence' to avoid association with inappropriate individuals or organisations.

3. Scope

There are a number of principles underlying the Trust's approach:

3.1 the Board retains to itself the final authority to decide on naming, based on its assessment of the best interests of the Trust and in accordance with its Values;

3.2 the Board will take into account the views of staff and other stakeholders but ultimately it is responsible for agreeing the approach – this mitigates against undue influence or lobbying from any individual or group;

3.3 ours is a hospital for all - the Board will seek to avoid names that are party-political;

3.4 the Board is willing to consider commercial opportunities associated with naming. Each case must be considered in its own circumstances but the Board will apply the exclusions specified in its Ethical Fundraising & Donations Policy – e.g. to avoid association with producers of tobacco, pornography or armaments;

3.5 standard principles and SFIs regarding conflicts of interest must apply in applying this process;

3.6 there is a presumption toward time-limited names – so that they are subject to review at appropriate intervals;

3.7 the Board recognises the potential value to the Charity of celebrating our donors though naming ~~–~~ this is a particular means by which the Board can demonstrate its support for the N&N Hospitals Charity as the principal Charity associated with the Trust;

3.8 there is a presumption against naming that promotes any charity other than the official N&N Hospitals Charity;

3.9 the use of Norfolk place names in alphabetical order should be maintained, unless otherwise agreed by the Board, to assist patients, visitors and new staff to navigate around the NNUH site;

3.10 the process of naming should actively mitigate against the effect of unconscious bias;

3.11 naming has 'pros and cons' – there are alternative ways of celebrating and thanking key donors, staff or public figures. It is often appropriate to use one of these alternatives and this is not an indication of disrespect or lack of value.

4. Processes to be followed*

The process to be followed is summarised in the Decision Tree (at Appendix 1)~~below~~.

This should ensure and include:

- consideration of 'Why?, Why not? and Alternatives;
- relevant 'due diligence' to avoid inappropriate association or misunderstandings;
- staff/patient engagement;
- potential future leverage of the name;
- duration of naming & appropriate review period;
- active consideration of opportunities to promote the N&N Hospitals Charity as the principal Charity associated with the Trust.

5. Potential commercial exploitation or sponsorship:
The Board has demonstrated a willingness to use naming rights in association with commercial opportunities or to recognise particular grants or donations. The Board is however obliged to take into account standard Procurement principles and SFIs regarding conflicts of interest.

Local experience is that there can be limited appetite on behalf of institutional donors for association with some capital developments. Each case must be considered on its own merits and in its own circumstances including:

- the prominence and profile of the asset concerned,
- the timing and duration, and
- the nature of the relationship.

There cannot therefore be a 'going rate' for naming sponsorship, but the Board Secretary may be able to advise regarding arrangements made previously in the Trust or elsewhere on the Norwich Research Park~~RP~~.

6. Practicalities & planning for the future
Consideration should be given to the practical implementation of a name if adopted, in particular:

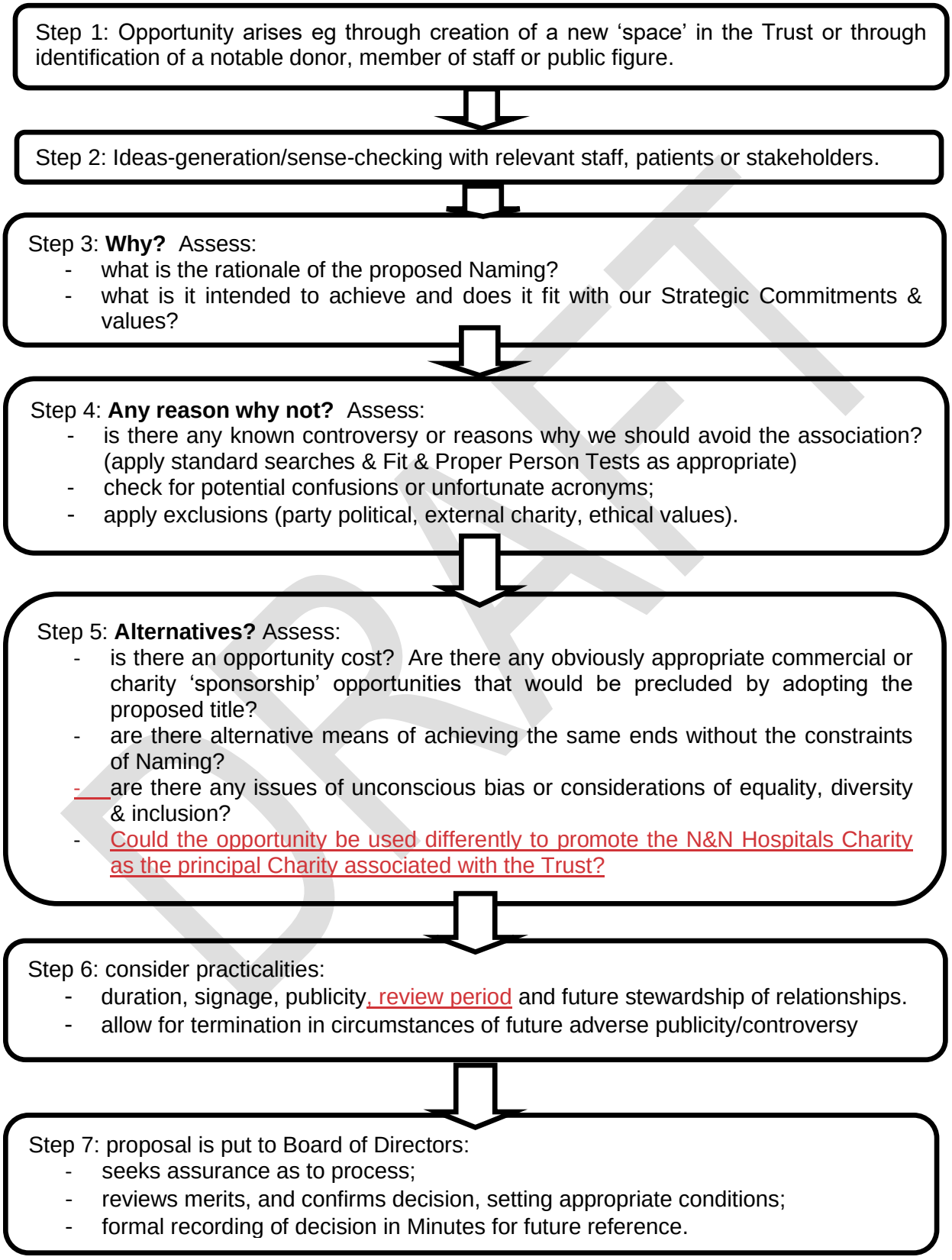
- its use on signage and letterheads,
- consistency with NHS brand guidelines
- opt-out/termination provisions to apply in circumstances of future adverse publicity/controversy
- it should be clearly considered and documented whether the naming is open-ended or for a limited period, with a timetable for review at intervals of, say, 5 -10 years;
- consideration should also be given to erecting an appropriate information board or explanation providing background to the naming.

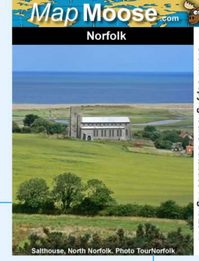
7. Associated Documentation*

- Standing Financial Instructions – (section 19 - Inducements, Declaration of Interests - Acceptance of Gifts and Hospitality) (Trust Docs – 1016)
- Conflicts of Interest and Business Conduct Policy (Trust Docs – 979)
- N&N Hospitals Charity Ethical Fundraising & Donations Policy (Trust Docs – 16429)
- NHS Brand Guidelines - https://www.england.nhs.uk/nhsidentity/
- Scheme of Delegation & Schedule of Matters Reserved

8. Appendices
Appendix 1 – summary Decision Tree
Appendix 2 - map indicating the current Norfolk villages/towns ~~places~~ recognised in the Trust.

Appendix 1: Decision Tree





~~CHARITABLE FUNDS~~N&N HOSPITALS CHARITY COMMITTEE

TERMS OF REFERENCE

1 CONSTITUTION AND PURPOSE

By resolution of the Trust Board of Directors, acting in its capacity as Corporate Trustee, a Committee of the Trust is established, to be known as the ~~Charitable Funds~~N&N Hospitals Charity Committee ("the Committee" or "the Charity Committee").

The Purpose of the Committee is to:

- provide assurance oversight of the management of the Norfolk and Norwich ~~University~~ Hospitals ~~NHS Foundation Trust Charitable Fund~~Charity (registered charity number 1048170) ~~and its subsidiary funds~~ ("the ~~Fund~~Charity");
- oversee investment of the ~~Fund~~ Charity's assets;
- assist the Board in meeting its responsibilities as the Corporate Trustee of the ~~Fund~~Charity;
- support the Corporate Trustee in strategic overview and development of the ~~Fund~~Charity.

2 AUTHORITY

The Committee has no executive powers other than those specified in these Terms of Reference. The Committee is authorised to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

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

The Committee has delegated authority to approve expenditure of charitable funds in accordance with the Scheme of Delegation approved by the Corporate Trustee.

3 MEMBERSHIP

Membership of the Committee shall comprise:

- ❖ at least two Non-Executive Directors;
- ❖ at least two executive directors;
- ❖ the Trust executive with assigned responsibility for ~~Charitable Funds~~the Charity (if not one of the above);
- ❖ no more than two independent members (who shall not be current members of Trust staff).

The Corporate Trustee will review the membership of the Committee annually to ensure that it meets the requirements of the ~~Fund~~ Charity and Corporate Trustee.

Only members of the Committee are entitled to be present at its meetings. The Committee may however invite non-members, including external advisors, to attend part or all of its meetings as it considers necessary and appropriate. If not a member of the Committee, the Chairman of the Trust shall have the right of attendance at meetings of the Committee.

4 MEETINGS AND QUORUM

The Committee shall be chaired by one of the non-executive directors of the Trust.

Meetings of the Committee shall take place at a frequency and timing necessary to enable discharge of its Purpose and Duties and the Committee will routinely meet once every quarter. Additional meetings of the Committee may be called at the discretion of the Committee Chair or otherwise at the request of at least 2 Committee Members.

To be quorate, at least one executive director member and one non-executive director member of the Committee must be present.

Attendance at the meeting may be by teleconference or videoconference at the discretion of the Committee Chair.

Arrangements for administrative support for the Committee shall be established in consultation with the Committee Chair. Agendas for forthcoming meetings will be agreed with the Committee Chair and papers distributed to members in advance of the meeting as agreed. Meeting papers will also be available to other members of the Board for information.

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

5 DUTIES

In furtherance of achievement of its Purpose, particular duties of the Committee are to act on behalf of the Corporate Trustee to:

Management and Expenditure of the ~~Fund~~ Charity's funds

5.1 receive reports concerning the ~~Fund~~ Charity which should include the following information[1]:

- i) number and value of charitable and endowment funds;
- ii) spend in period;
- iii) total spent to date*;
- iv) comparative figures for the previous financial year*;
- v) budget for year*;
- vi) list of large or unusual transactions;
- vii) list of significant donations;
- viii) use of chairman's (or other officers') discretionary and delegated authority;
- ix) summary investment report;
- x) report on slow moving or overdrawn funds; and
- xi) compliance with any restrictions on use of funds.

* broken down to fund or budget heading

5.2 receive such reports from individual fund ~~holders~~ advisers as it considers appropriate, which may include fundraising or spending plans;

Investment of the ~~Fund~~Charity's funds

5.3 engage and take such advice from professional ~~fund~~ investment managers as the Committee thinks fit and:

- i) agree an investment strategy for the ~~Fund~~Charity, including the appointment and monitoring of investment managers;
- ii) oversee and approve investment transactions of the ~~Fund~~Charity; and
- iii) consider and monitor the risk profile of the ~~Fund's~~ Charity's investments such that any necessary and appropriate recommendations may be made to the Corporate Trustee;

5.4 ensure that, where the Committee delegates discretionary powers in respect of investments:

- i) the investment policy and scope of the power delegated is clearly set out in writing, communicated to the person or persons who will exercise it and kept under review;
- ii) adequate internal controls and procedures are in place to ensure that the delegated power is being exercised properly and prudently; and
- iii) the person(s) exercising the delegated power are subject to appropriate regulation and their performance is regularly reviewed.

Strategic Overview and Development of the ~~Fund~~Charity

5.5 review and agree as appropriate:

- i) relevant strategy, policies and procedures relating to the ~~Fund~~Charity;
- ii) major fundraising and expenditure plans;
- iii) publicity material and literature relating to the ~~Fund~~ Charity for potential donors;

[1] As recommended by the National Audit Office (Charitable Funds Associated with NHS bodies -June 2000).

iv) guidance for individual fund ~~holders~~advisers;
v) relevant reports of the internal and external auditors; ~~and~~
vi) the annual accounts and Report of the Trustee; and
vii) the Charity's Annual Plan and Budget.

5.6 review grant applications and approve expenditure of funds in accordance with delegated authority (<£100k), making recommendations to the Corporate Trustee as appropriate;

5.7 promote a clear and effective approach to supporting equality, diversity and inclusion in the Charity's policies and practice.

5.8 carry out an annual review of its satisfaction of these Terms of Reference.

6 REPORTING

After each meeting of the Committee, the Chair of the Committee shall make a report to the next meeting of Trust Board and draw to its attention any issues that require its particular attention or require it to take action.

Minutes of meetings of the Committee are to be presented to the Trust Board in its capacity as Corporate Trustee.

7 RELATIONSHIP WITH AUDIT AND FINANCE AND INVESTMENT COMMITTEES

Through alignment of the relevant Work Programmes for each of the Board Committees overlap or gaps in their collective assurance function will be avoided. For the avoidance of doubt, it is noted that the following items remain within the area of responsibility of the Audit Committee (as specified in its Terms of Reference):

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

8 DECLARATIONS OF INTEREST

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

9 REPORTING COMMITTEES

There are no standing sub-committees which report to the Charit~~able Funds~~y Committee.

10 PROCESS FOR MONITORING EFFECTIVENESS OF THE COMMITTEE

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

11 OTHER MATTERS

Guidance or documents associated with these Terms of Reference include:

- NNUH Standing Financial Instructions and Scheme of Delegation;
- Charity Commission document NHS charities guidance (October 2022) NHS charities guidance - GOV.UK (www.gov.uk)
- National Audit Office – Charitable Funds Associated with NHS bodies (June 2000).
- Charity Commission - Charities and investment matters: a guide for trustees (August 2023) https://www.gov.uk/government/publications/charities-and-investment-matters-a-guide-for-trustees-cc14/charities-and-investment-matters-a-guide-for-trustees
- Charity Commission Guidance for trustees Charity Commission guidance - GOV.UK (www.gov.uk)
- Guidance for charities associated with a non-charity Guidance for charities with a connection to a non-charity - GOV.UK (www.gov.uk)
- NHS Charitable Funds – HFMA Practical Guide 5th ed (2020) https://www.hfma.org.uk

Approved by the Board of Directors as Corporate Trustee on: 06 Nov 2024 [TBC]

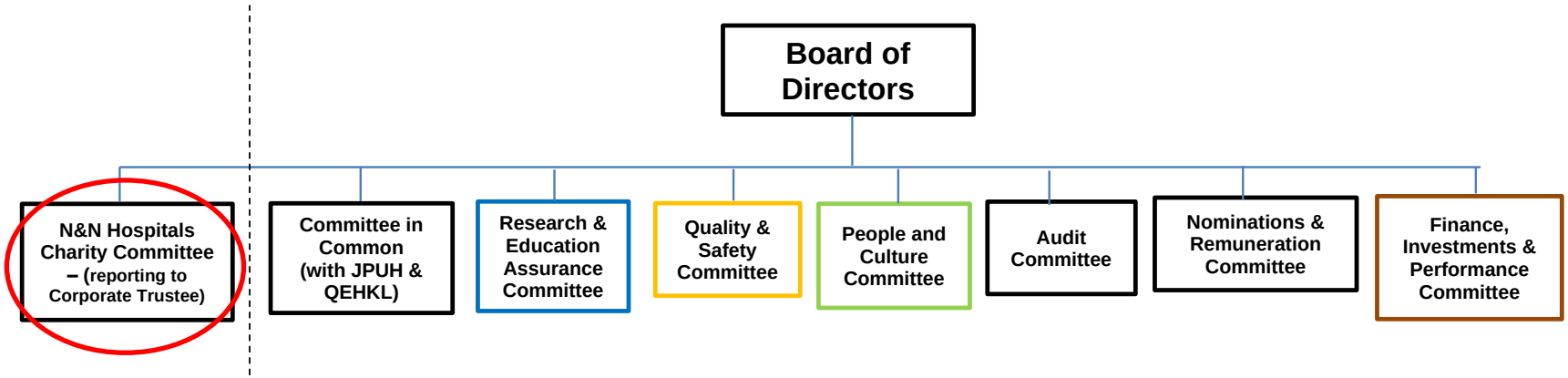
Date for next review: July 2025

Board of Directors and Management Board Reporting and Accountability Structure

Norfolk and Norwich University Hospitals NHS Foundation Trust

Foundation Trust Board Reporting Structure

i. Leadership of the Foundation Trust is provided by its Board of Directors (a unitary Board with a majority of Non-Executive Directors (8) and 6 Executive Directors).
ii. The Board has established a structure of Board Committees with responsibility to seek assurance on behalf of the Board and/or to exercise specific delegated authority.
iii. That Committee structure is detailed below:



As at October 2024

Section 4 - Charity Governance

- Executive Lead: Company Secretary

The Norfolk and Norwich Hospitals Charity is registered with the Charity Commission (registration number 1048170). By securi ng donations, legacies and sponsorship, the Charity is able to provides support for additional equipment and projects above and beyond what is available through normal NHS funding. Ultimately the Charity is overseen by the Board of Directors, acting on behalf of the Foundation Trust as a **Corporate Trustee.**

The Charity Commission has issued guidance which is relevant to charities associated with third parties such as NHS bodies https://www.gov.uk/guidance/guidance-for-charities-with-a-connection-to-a-non-charity.

The guidance sets out six principles:

i. Recognise the risks – relationships with non-charities can benefit charities, but the risks of any particular relationship must be assessed and appropriate steps taken to manage risks.

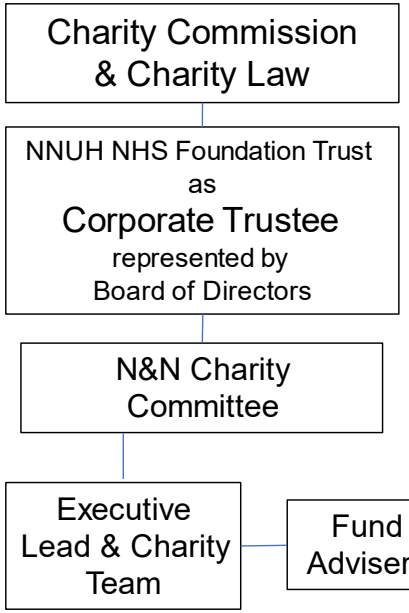
ii. Do not further non-charitable purposes – for a charity to be charitable **all charitable funds must be applied exclusively for charitable purposes**.

iii. Operate independently – a charity must remain independent of any non-charitable organisation with which it has a close connection. **The trustees must act in the best interests of the charity alone**.

iv. Avoid unauthorised personal benefit and address conflicts of interest – The guidance notes that any personal benefit from a charity must be appropriately authorised in advance and any conflict of interest must be appropriately managed.

v. Maintain your charity's separate identity – The guidance states that **charity trustees have a legal obligation "to keep it [*the charity*] distinct from any connected organisation".** The guidance is particularly concerned with the extent to which a charity might share its identity with a non-charitable organisation, and the potential risks of sharing an identity.

vi. Protect your charity - A key duty of charity trustees is to safeguard the assets of their charity (including its reputation).



It is therefore crucial that there should be clear segregation and distinction between the funds and interests of the Charity and those of its host Foundation Trust. The Charity has separate accounts and governance from the Foundation Trust, with separate lines of decision-making and reporting. An established N&N Charity Committee oversees the Charity's – investments policy, budget setting and long-term plans., in accordance with the Charity's Strategy (2023-27) - ***Supporting Better Care*** **.**