Our Vision
The best care for every patient

NHS
Norfolk and Norwich University Hospitals
NHS Foundation Trust

Schedule of Development and Assurance Visits

02 April 2025

NB: formal Board meeting starts at 9.30am – please ensure you arrive at the Boardroom in time for a prompt start

There will be a pre meet in the boardroom at 08:30am,Mr Nigel Roberts will meet everyone at the boardroom and walk you down to East Block Level 1

This Months visits are all linked to pathology.

Not on Visits: Dr Sarkar

Pathology Clinical	Pathology Administration	Pathology Biochemistry
Alex Chris Nikki Julian	Janice Rachael Jo Sarah Claire	Bernard Sandra Phil Tom
Meeting who: Dr Lyall Clinical Chief of Service	**Meeting who:** Mr Roberts Service Operations Manager	**Meeting who:** Dr Chipchase Clinical Lead

Development & Assurance

- This programme of visits is intended to support Board Development – to provide insight into the reality of life in the Trust. They are not supposed to be too 'staged' and visits are deliberately quite short, to avoid causing too much operational interruption.
- The Board has recognised that one of the valuable outputs from these visits is that it provides an opportunity for executive and non-executive directors to do something together – and to be seen doing so – as part of a unitary board.
- Whilst these visits are an opportunity to cross-reference and gain first-hand assurance, they are not intended as 'inspections'. They are an opportunity to offer support and say 'thankyou'.

Prompts or questions:

It may be helpful to ask:

- What are you most proud of about this area/your team and service?
- Can you give a recent example of something that has changed and improved in response to patient or staff experience (feedback, incident or complaint)?
- What is good about the Trust and what can be improved?
- Other factors to be mindful of – first impressions, does the area appear clean, well-organised and welcoming?

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NHS Foundation Trust

Meeting of the Trust Board in Public
04 June 2025

To be held: 09.30 to 12.00 on **04 June 2025**
Venue: NNUH boardroom and Microsoft Teams

Agenda

	Item	Timing	Lead	Purpose
0	Clinical/Departmental Visits –attend boardroom for brief, Visit will be to pharmacy and pathology	08:40-09.15		
0	Patient Experience Story	09.30- 10.00	SH	Information
1.	• Apologies & Declarations of Interest – • Reflections on Clinical/Departmental Visits	10.00-10.15	Chair	Information/ Discussion
2.	Minutes of the Board meetings held in public on 06.11.2025 02.04.2025		Chair	Approval
3.	Matters arising and update on actions		Chair	Discussion
4.	Group Chair Update - Verbal	10.15-10.25	MF	Information
5.	Group Chief Executive's report	10.25-10.35	LD	Information
6.	Interim Executive Managing Directors Report	10.35-10.45	TB	Information
7.	Corporate Risk Register and presentation	10.45-11.00	PD	Information
8.	Finance Finance report YTD Business cases for approval; Robotics OBC	11.00-11.20	MT	Information Approval
9.	Performance Report including IPR	11.20-11.30	CC	Information
10.	IPR – Workforce data	11.30-11.40	SG	Information
11.	IPR – Quality, Safety and Patient Experience data	11.40- 11.50	RC/BB	Information
12.	**Reports for Information and Assurance from Sub Committees:**			
	(a) Quality and Safety Committee	11.50-12.00	CF	Discussion
	(b) Finance, Investments and Performance Committee - Verbal update with formal paper to follow.		NG	
13.	Questions from members of the public		Chair	

* 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 11 September 2025 in the Boardroom of the Norfolk and Norwich University Hospital

REPORT TO TRUST BOARD				
Date	**Wed 4 June 2025**			
Title	**Valuing Volunteering - experiences of volunteering and patient care**			
Author & Exec Lead	Sally Dyson, Voluntary Services Manager, Louise Willimott, Inpatient Volunteer Project Coordinator, Sarah Higson, Associate Director of Patient Engagement and Experience for Rachael Cocker, Chief Nurse			
Purpose	**For Information and Discussion**			
Relevant Strategic Commitment	**1. Together, we will develop services so that everyone has the best experience of care and treatment**			
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, Cares, staff – and Volunteers.

1.2 02-08 June is Volunteers' Week and the stories shared this month focus on the experiences of one of our patients alongside our ward-based volunteers. The story looks at the journey into volunteering through ill health and how volunteers support others through lived experience with the same or similar conditions. Volunteering demonstrates there is 'something for everyone' and peoples lived and life experiences are a driving force behind their motivation to volunteer and give their time freely to the NNUH.

1.3 Andy is one of our three 'Expert by Experience' volunteers on Kilverstone Ward. Andy's story demonstrates how his volunteer role in Cardiology draws upon his lived experience from when he had triple bypass surgery at Papworth back in 2020, having first spent four weeks on Kilverstone ward that January. He in turn has visited a gentleman (Stephen) who is currently an inpatient on Kilverstone following a heart attack, taking the first steps on his recovery journey as he waits for a date for surgery at Papworth Hospital.

2 Key issues, risks and actions

2.1 Key learning/actions:

- Volunteering can bring a holistic offering to the care of our patients, utilising life skills and own experiences to support our patients and staff.

- Volunteering can be beneficial in so many ways.

- **Volunteering (Andy's story) illustrates the following benefits:**
  - Opportunity to give back following care received
  - Enriches the diversity of our organisation
  - Provides sense of purpose and value to the retiree
  - Aids social participation
  - Provides cognitive benefits

  Stephen's (the patient) story illustrates the following benefits:
  - Holistic offering is of huge benefit to patients and gives peace of mind where lived experience reflects their own journey
  - Brings personalised knowledge and experience to the organisation which cannot be replicated by staff
  - Demonstrates to the patient that there is life after their procedure and support available, with opportunities to utilise their experience for the good of others.

- Recruitment for Trust volunteers rightly focuses on ensuring our voluntary services can continue to provide roles that meet the requirements of all prospective volunteer recruits and enhance patient, carer, staff and volunteer experiences by best and most productive match of lived experience and transferable skills.

3 Conclusions/Outcome/Next steps

3.1 The experiences shared in this story have provided valuable learning.
3.2 Demonstrates the need to continue to invest and support our voluntary services who provide vital support to our Trust.
3.3 Demonstrates the need to develop innovate voluntary roles to support the services our Trust provides and the needs of our patients and carers.
3.4 People's lived experiences can be hugely beneficial across Volunteer roles and for patients with similar conditions.

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.

Brief outline of the "story"

<u>Andy's story</u> – Volunteer with lived experience

Andy spent four weeks on Kilverstone ward in January 2020 before being transferred to Papworth to undergo triple bypass surgery, and after this experience wanted to give back something back as a thank you for the excellent care he received.

Andy fully retired from employment in 2024 and after a chance meeting with a staff member at the NNUH, decided to apply to be a volunteer. After attending the induction and looking at the various roles available, he felt that offering his experience to patients who were preparing themselves to go on a similar journey would be a great fit.

He has now been visiting Kilverstone ward for a year, and with the support of the staff is finding it very fulfilling- speaking to patients pre their Papworth operation and hopefully allaying any fears or apprehensions they might have. During his time as an inpatient, he realised firsthand the importance of keeping up morale. Fortunately, he has a great sense of humour and often utilises this on the ward, engaging with people easily and helping to improve their mood, reducing anxiety and offering a brief respite from the boredom that waiting for a confirmed Papworth date can bring!

<u>Stephen's story</u> – Patient perspective

Stephen is currently an inpatient on Kilverstone ward. He was admitted after a heart attack and has been in the hospital for just over three weeks.
During his time on the ward, he has had the opportunity to chat with two of three our 'Expert by Experience' volunteers on Kilverstone ward, Andy and Bernie, about their own cardiology journeys and reflects on the difference this has made to his experience.

What "point" it is trying to convey

The benefits to patients, carers, volunteers and the wider Trust from volunteering.

- **Volunteering (Andy's story) illustrates the following benefits:**
  - Opportunity to give back following care received
  - Enriches the diversity of our organisation
  - Provides sense of purpose and value to the retiree
  - Aids social participation
  - Provides cognitive benefits

Stephen's story illustrates the following benefits: - Holistic offering is of huge benefit to patients and gives peace of mind where lived experience reflects their own journey - Brings personalised knowledge and experience to the organisation which cannot be replicated by staff - Demonstrates to the patient that there is life after their procedure and support available, with opportunities to utilise their experience for the good of others.	
Who will be "speaking"	
Patient	Stephen
Staff	Andy (volunteer), Louise Willimott, Volunteer Coordinator
Time allocation for each element	
Lou's intro to volunteers' week & volunteers	5 minutes
Andy's story (Volunteer)	7 minutes
Stephen's story (Inpatient)	3 minutes
Questions	5 mins

REPORT TO TRUST BOARD	
Date	**04 June 2025**
Title	**Chief Executive Monthly Report to Public Board**
Author & Exec Lead	**Professor Lesley Dwyer, Chief Executive**
Purpose	**For Information**
Relevant Strategic Commitment	**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.**

Background/Context

The purpose of this report is to briefly cover matters that are not addressed elsewhere within the Board papers of additional activities being undertaken by the organisation.

1. Introduction
2. National Picture
3. Local Picture
4. Communication Reset
5. Group Transition Arrangements
6. Group Appointments
7. Major Projects Review and Reset
8.

Recommendations: The Board is recommended to note the content of this report for information

1. Introduction

I have been in the role just over 4 weeks and have managed to visit each site – whilst providing leave cover here at the NNUH. During this period with minimal executive appointments, we have been undertaking our own due diligence at each Trust and at a Group level as well as determining the next 90-day priorities.

I would normally cover in this report items that do not form part of the agenda but rather give an update as to the priorities of the Group, update on progress against priorities as well as to provide a contextual report that framed the discussions at the first Special Purposes Joint Committee held on the 29th of May 2025.

2. National picture

Ten Year Plan

We still await publication of the Ten-Year Plan, with the current estimated date to be June 2025. It is anticipated that the plan will set out more detail the wider system architecture and clarify the role and accountabilities of trusts, systems and the centre. Currently it is still unclear how functions will change, especially those held by neighbourhood teams, place-based partnerships, primary care at scale, trusts and integrated care partnerships (ICPs). However, some interesting work is underway to define a 'model region' which should help bring this to life.

NHS England has confirmed that the plan will set out a new operating model that is "rules-based, provides earned autonomy and incentivises good financial and operational performance".

It seems likely that the changes are likely to require primary legislation and therefore will probably being to impact from 26/27 onwards.

VSM Pay framework

NHSE has now published this which is designed to help trusts manage the salaries of their most senior roles. The stated aim is to ensure fairness, consistency and transparency across very senior pay. A report on this and the potential implications for our Group will be taken to a meeting of the Remuneration Committees in Common in June. However, key points include:

- The framework applies to chief executives, directors that report to chief executives, and all other designated VSMs in ICBs, NHS trusts and NHS foundation trusts and aims to standardise remuneration for VSMs within and across these organisations. For VSMs in provider trusts, remuneration is based on turnover.
- The framework is effective from 1 April 2025 but is not expected to be applied retrospectively. VSMs already in post, who earn above the revised pay band, are not expected to have their salaries reduced to meet the framework's parameters.
- Compliance with the framework is not mandatory, but all organisations are expected to comply or explain why not in their annual reports. All salaries above £170,000 will require central approval from NHSE and in some cases this may also involve DHSC.

- A pay premium of up to 10% of one's base salary may be awarded if a VSM takes on additional responsibilities, works across multiple organisations, or performs exceptionally well.
- The annual pay award may be withheld for a VSM if they are subject to internal performance management processes (conduct or capability) and/or fail to meet appraisal objectives.
- Annual pay awards will be withheld for all VSMs of organisations in segment 5 (see below) and the recovery support programme under the NPAF, unless they have been in role for less than two years. There will be a 15% salary incentive for a period of up to 24 months for VSMs moving to challenged organisations.

The framework should be taken into account in setting VSM pay, but it is important to remember that Remuneration Committees remain responsible for setting the pay of VSMs. For our Group this will continue to be the Remuneration Committees in Common.

NHS Performance Assessment Framework (NPAF)

This framework is currently out for consultation. It aims to assess each organisation against an agreed set of performance metrics. Each ICB and provider is placed in a segment from 1 to 4 based on its performance against short- and medium-term NHS priorities. It is proposed that there will be an additional segment 5 for those in most need of support.

At the end of Month 1, all three Trusts were behind in the delivery of their Operational Plans and following Month 2 we will meet with the Regional Team to determine what support we require to deliver.

All 3 Trusts are currently supported by Hunter Health as part of the Investigation and Intervention regime. More detail for the NNUH will be provided in the Finance agenda item at the meeting.

3. Local picture

The first iteration of the Model ICB Blueprint is an important first step towards greater clarity of system working. It reiterates the system leadership role ICBs have as strategic commissioners, working to improve population health, reduce inequalities and improve access to more consistently high-quality care. It also introduces new 'neighbourhood health providers', which will sit between ICBs and neighbourhoods in driving delivery of a neighbourhood health service. This latter point is likely to feature heavily in the ten year plan which will hopefully provide more detail on this matter.

In the meantime, ICBs are required to reduce their running costs by approximately 50% by December 2025. Locally, the East of England ICBs see a strategic opportunity for improving outcomes by aligning ICB boundaries with Local Authority boundaries, particularly the new Mayoral Authority boundaries. They also recognise that they may not be viable as stand-alone organisations. As a result in our part of the region, we will be working towards creating a Norfolk and Suffolk ICB and a Greater Essex ICB. National direction is to cluster ICBs in the first instance ahead of mergers by 1 April 2026 (or by 1 April 2027 if more time is needed).

The Committee will be aware that as a first step the Norfolk and Suffolk ICBs have already 'clustered' and are implementing a (interim) single senior management structure as part of this. It is important that the new hospital group has early engagement with the ICBs during this transition phase and plays a major role in shaping the future arrangements. The new interim Chief Executive of the Norfolk / Suffolk ICB has already reached out to us to start this conversation.

Finally, I hope the NNUH Board will have seen the news that the ICB has just announced to keep the Norwich Walk In Centre open. This is important as potentially its closure could have led to a significant increase in activity at NNUH.

4. Communications reset

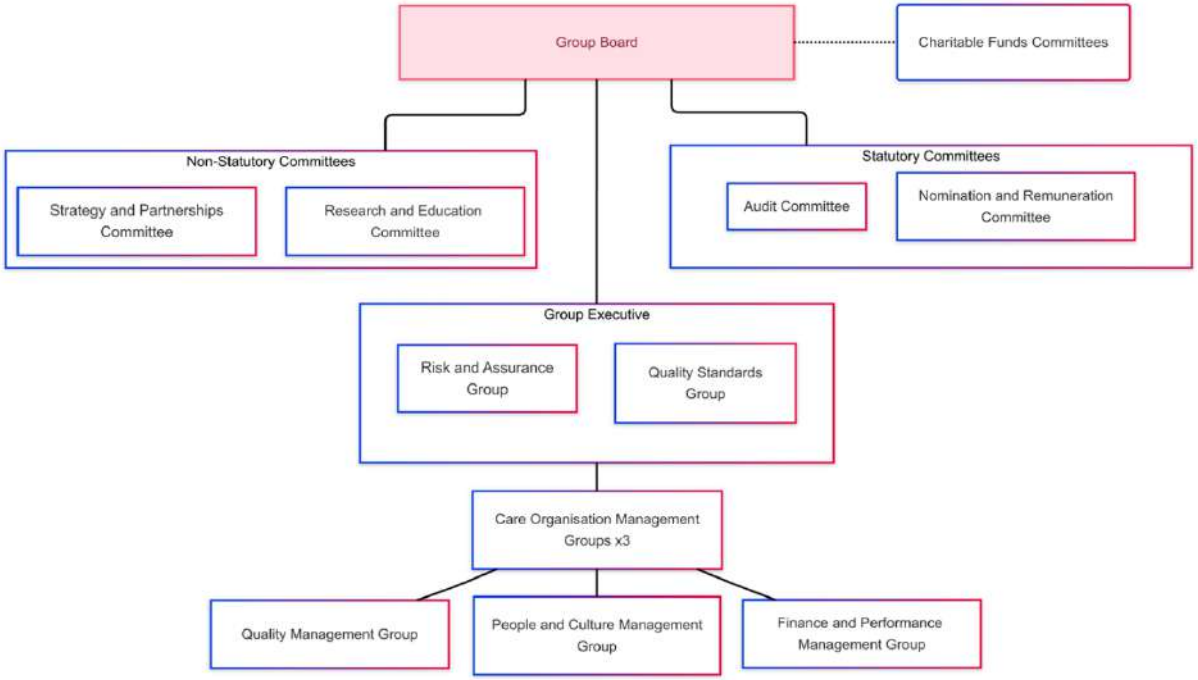
Following the decisions around establishing the hospital group and the initial appointments, it is now time for a reset of our communications activity. I recognise that to date this has largely been a transactional and "on transmit" approach to provide information about the changes. However, it is now time for a more pro-active and two-way communications plan. We are getting some specialist support to help us develop this plan over the next few weeks and as part of this we will look to set out the broad aims and vision of our group and the individual hospitals.

In addition to this the Interim Group Chair and myself will be undertaking another round of stakeholder engagement, which includes attending the Health and Oversight Scrutiny Committee on 3rd July.

5. Group transition arrangements

One the key roles of the SPJC is to oversee the transition to 'full group' working. Currently this is anticipated to be achieved by no later than October 2025. There are many components to this, and the initial work programme is set out in the 90 day plan.

One of the key elements is the development of a more mature risk management system to underpin the assurance function. The initial thoughts on this were set out in the Group Operating Model which the Trust Boards have considered over recent months. The team have done some further work on this and the proposed arrangements for October onwards are set out below:



Central to the new ways of working is the move away from assurance committees to an enhanced Audit Committee – which could probably be more accurately described as an Audit and Risk Assurance Committee. This will be where Non-Executive Directors are able to undertake an assessment of risks and the effectiveness of their controls and where appropriate undertake deep dives against any of these.

To achieve this change, the Executive Directors and their senior management teams need to have the capability of moving into more of an assurance role to satisfy themselves that their particular risks are being managed effectively and where necessary there is appropriate escalation to the Group level. This is new territory for many of us and it will be important that sufficient development time is given for this change to take place. As part of this it is proposed that in the September cycle of assurance committees at each hospital, the relevant executive director chairs the meeting. They will need some help to do this, and we will be asking the respective committee chairs to mentor the executives prior to and after the meeting.

I have also sought advice as to support from external parties in shifting the current Trust committees of the Executive to those that will enable a risk-based assurance approach by which to report to the SPJC and post October to the Group Board.

The Interim Chair has already begun to undertake discussions around a corresponding development plan for non-executive directors. There is also a Governor development group which the NNUH Chair is leading.

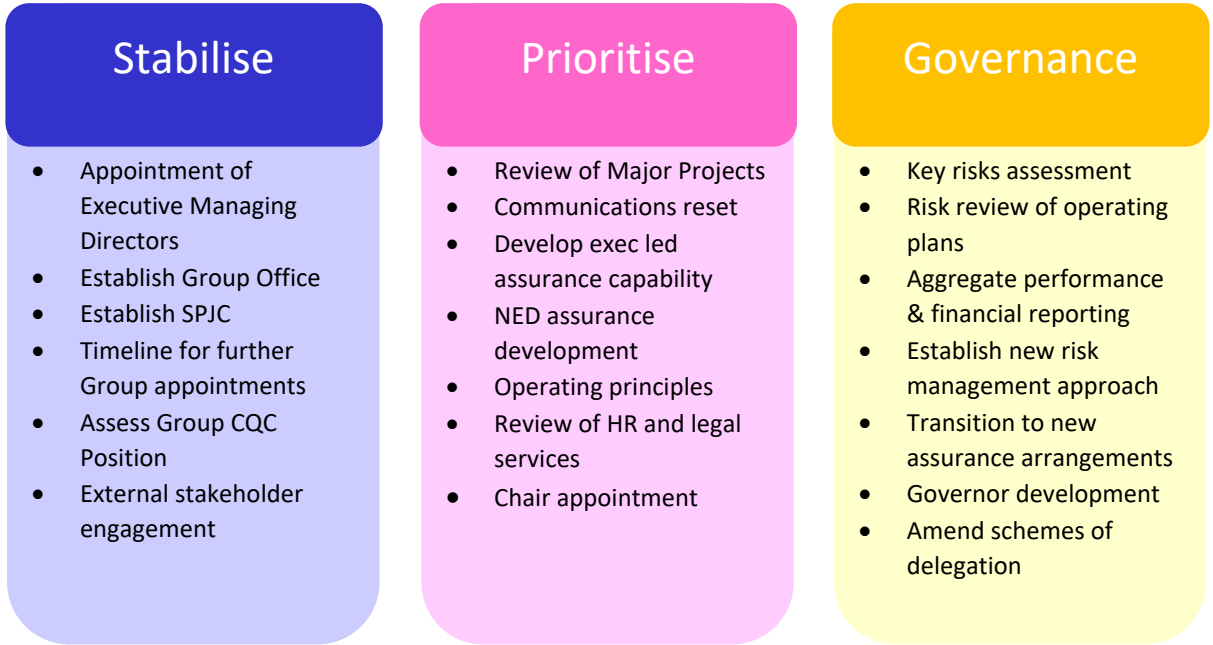
As we develop these plans for this transition, we will have further discussion at both the SPJC and the Trust Boards. For the avoidance of doubt, the individual Trust Boards and their assurance committees will continue to meet as normal over June and July, with transition to the executive committees over August and September – supported by the NEDs and reporting to individual Trusts then from October to the Group Board.

90 Day Plan

I have been consistent in my view that this first 3 – 6 months is to support the operational delivery of each of the Trust's plans and not distract from delivery of the key priorities we have.

However, there is still much that needs to be done in transitioning to the changed governance as a Group. We have developed a 90-day plan to help focus priorities for the Group. We do not have the bandwidth to do everything at once, and it is appreciated at Group level, that each Trust and the teams at each site need to deliver care to patients and improve performance.

The Group Executive team have agreed 3 objectives:



6. Group appointments

I was able to confirm the appointment of the Interim Executive Hospital Managing Director for the Queen Elizabeth Hospital- Chris Bown. This will complete the appointment of the interim Managing Directors at all the hospitals and together represents a significant injection of new senior leadership talent into the group.

There now needs to be a short period of stabilisation and we will need to prioritise the substantive Managing Directors, Group Chief Medical Officer and Group Chief Nurse during this period.

I am pleased to say that the triumvirates of current executives have worked well to select representatives to join this Committee in the meantime.

7. Major projects Review and reset

The Group Executive undertook an initial stocktake of the key major projects currently being delivered across the group. These are the two New Hospital Programmes, the Electronic Patent Record, Acute Clinical Strategy and a proposal to consolidate the three digital teams (known as the 'Digital Target Operating Model').

I will be able to provide further information in the Private Board as to our next steps following this review.

REPORT TO THE BOARD				
Date	**04th June 2025**			
Title	**Corporate Risk Register and Risk Management Training Refinement**			
Author & Exec Lead	**Perry Djahit – Head of Risk Management**			
Purpose	**For Information**			
Relevant Strategic Commitment	**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 document:			**Outcome/decision/changes made:**	

1 Background/Context

This report provides an overview of the corporate risk register, as well as a condensed version of a training package, designed for senior leadership within the organisation.

2 Key issues, risks and actions

There are currently 41 high scoring risks (risk scoring 15+) which are regularly reviewed by relevant management teams across the organisation. The organisation is currently transitioning from our existing Risk Management Information System (Datix) to InPhase. As part of this process, a robust reviewing, moderation and consolidation of risks is taking place.

The slides included in the pack are a selection taken from an updated package being produced, aimed at senior leaders within the organisation. The slides set out the purpose of the risk management function and its role as a 2nd line of defence, as well as an approach to control effectiveness ratings which will support the understanding of risk, assurance and reporting within and up outside of the site.

3 Conclusions/Outcome/Next steps

The report provides an overview of the CRR as it currently stands. This will change significantly as we transition from Datix to InPhase and as the CG Leadership Teams embed.

The training package will further enhance the understanding of risk, risk management and our maturing approach to control and assurance.

Recommendations: The Committee is recommended to:

- Note the content of the paper, taking into account the transition from one digital system to another
- Review the training slides and take assurance that this package of training will support improved risk management

Perry Djahit
Head of Risk Management (NNUH)
2025

Risk Management for Senior Managers

Why Risk Management Matters in the NHS

Risk management **creates** and **protects value**. It contributes to the **achievement of objectives** and the improvement of performance. It also encourages innovation (ISO31000:2018).

Promotes safer, better care for patients

Supports CQC and regulatory compliance

Protects staff, reputation, and resources

Enables confident, risk-informed Decisions

Strengthens organisational resilience by preparing for disruption, anticipating and adapting to change

Risk Management Teams' Purpose

The purpose of the Risk Management function is to:

- Provide support to management in their identification and management of risk
- Ensure the Risk Management Policy is embedded
- Serve as a second line of defence (figure one below)

Risk Management Team Activities

A Risk Management Team undertakes the following activities amongst other things:

- Facilitation of scheduled risk profile reviews (e.g. workshops with Care Groups and specialist / corporate areas)
- Routine reporting of current and emerging risks to Assurance Committees and The Board
- Routinely facilitate risk assessments with Management and Executives
- Undertake control testing and reporting of critical risks
- Conduct regular evaluation of the risk framework, maturity, culture and appetite
- Deliver a risk awareness programme and training
- Maintain and enhance the Risk Management Information System

Risk Management Documents

There are 2 core documents for which the Risk Management Team are responsible and contain detail of our risk management approach:

Risk Management Strategy

Outlines the structure, approach and organisational direction toward risk management, as well as the continual improvement plan.

Risk Management Policy

Outlines the overall process for risk management, includes key principles of the framework, responsibilities of staff and step by step guidance or risk management.

Leadership Commitment

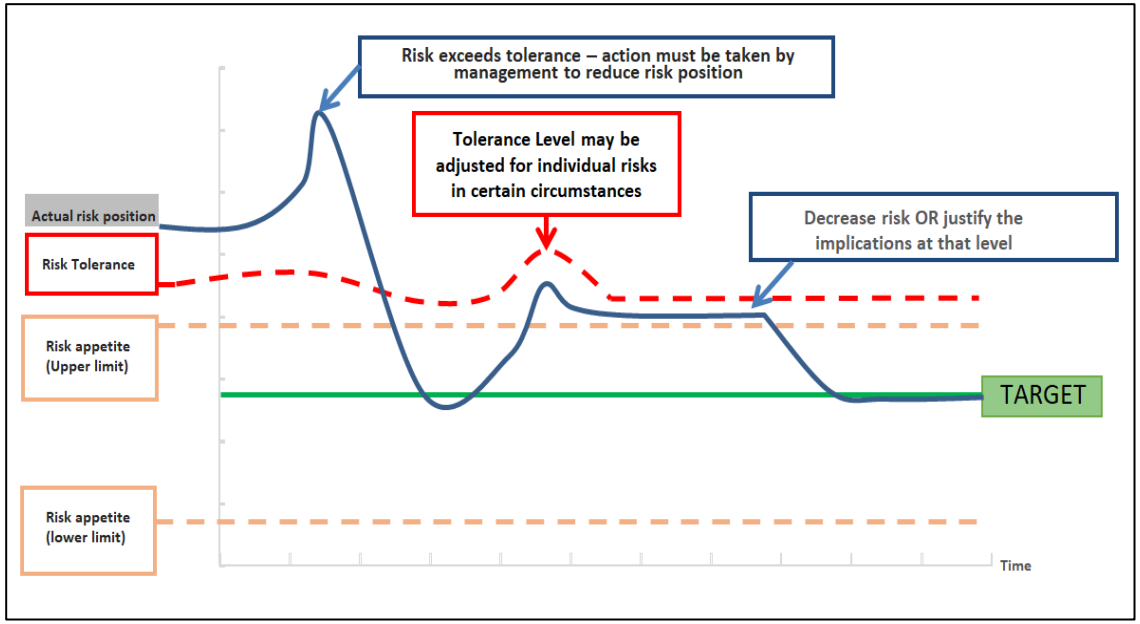
The Senior Leadership Team are committed to maintaining effective risk management, and to reinforcing the behaviours of a positive risk culture.

The Team recognises that effective risk management is essential to achieving the organisation's strategic and operational objectives. Beyond supporting objective delivery, robust risk management protects and enhances organisational value by enabling the identification and pursuit of opportunities, while safeguarding our staff, patients, assets, reputation, and long-term financial sustainability.

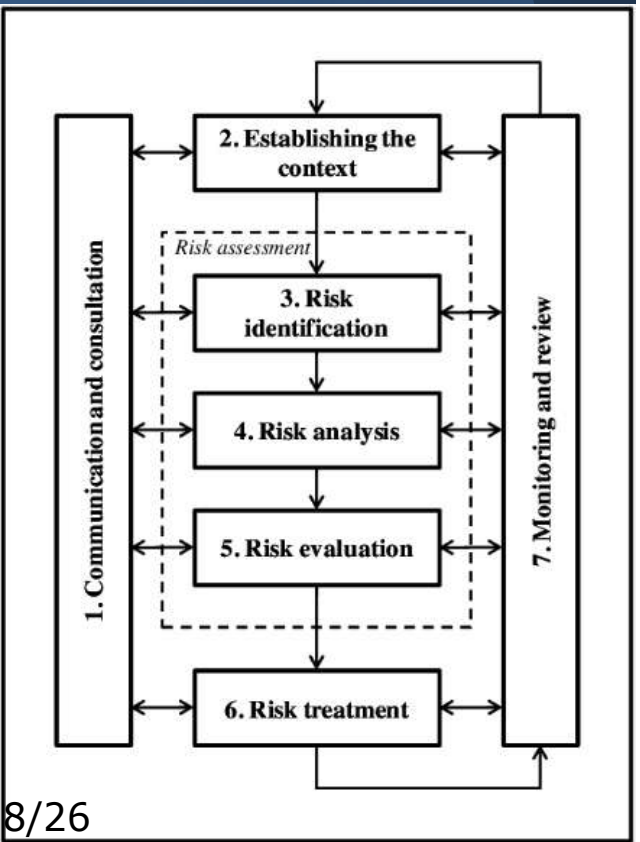
In order to deliver these ambitions, a proactive, holistic approach to risk management both clinical and non-clinical is required from management and staff all staff across the organisation.

Risk Appetite

The organisation has a clear risk appetite statement that sets out the level of risk in certain domains that the organisation is willing to accept, and how much tolerance there is for risks that exceed that threshold.



Risk Management Process



Risk Management is the "…coordinated activities to direct and control an organisation with regard to risk"– ISO 31000

Components:

Establish Context – Define what we do and what our objectives are

Risk identification – What might happen to affect the achievement of those objectives?

Risk analysis – Understand consequence and likelihood.

Risk evaluation – Compare against criteria to determine significance.

Risk treatment – Choose and implement options to reduce, accept, transfer, or avoid.

Monitoring and review – Track performance, detect change, and reassess risks.

Communication and Consultation – Document decisions, rationale, and actions.

What is a Risk?

"The effect of uncertainty on objectives" – ISO 31000

or,

"An uncertain event or set of events, which should it occur, will have an effect upon (i.e. threaten) the achievement of objectives"

Components:

- Cause: Why it might happen

- Event: What might happen

- Consequence: The impact if it does

Risk needs all 3 components

Strategic vs Operational

Strategic Risk

- Risks that **could** impact the organisation's ability to achieve its long-term **goals** and strategic **objectives**.
- Often linked to decisions at Board or executive level.

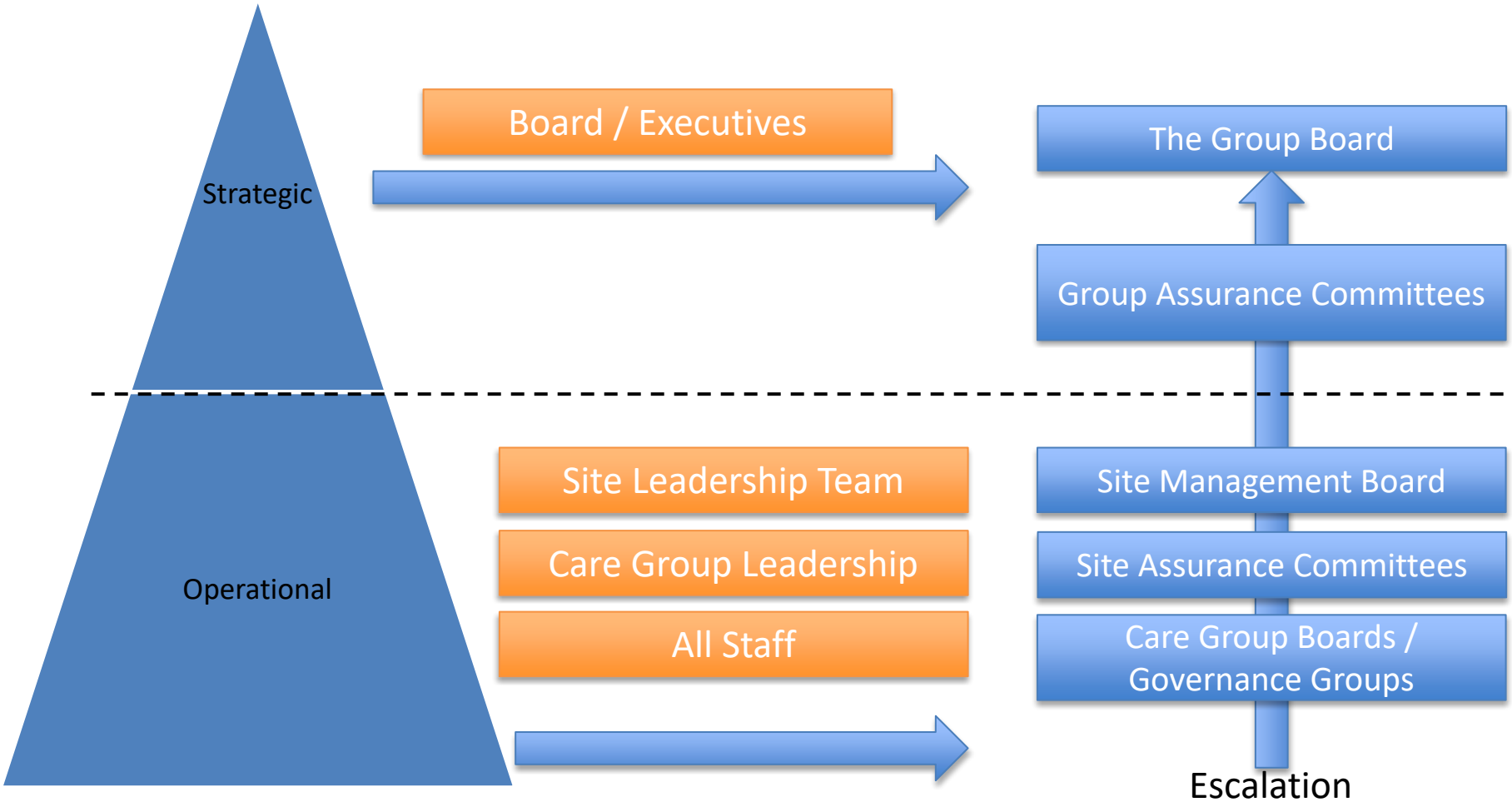
Examples: shifts in policy, major investment, strategic partnerships, market changes, damage to reputation.

Operational Risk

- Risks that **may** affect the **day-to-day operations** of the organisation.
- Typically arise from processes, people, infrastructure or external events.

Examples: IT system failures, staff shortages, non-compliance with procedures, supply chain disruption.

Strategic vs Operational Risk Ownership



Chronic Vs Acute Risk

Chronic Risk - Strategic in nature:

A long-term, persistent risk that develops gradually and can erode an organisation's performance, resilience, or ability to meet objectives, e.g.:

- Persistent staff shortages, ageing infrastructure, rising demand.
- Often scored highly due to sustained impact.
- Managed strategically (e.g. via long-term planning / strategy).
- Needs sustained action, not emergency / incident response.

Evidence of risk seen in persistent vacancies, poor performance, backlog maintenance, aging infrastructure and digital assets

Chronic Vs Acute Risk

Acute Risk – Operational in nature:

A sudden, high-impact event that requires immediate response to protect safety, operations, or reputation, e.g.:

- Cyberattack, major IT outage, disease outbreak, industrial action.
- Often triggers incident response or business continuity plans.
- Short proximity, immediate impact.
- Focused on urgent mitigation and recovery.

Evidence of risk seen in incident reports, audits, complaints and other event records.

Risk vs Issue

Risk:

- - **May** happen
- - **Could** happen
- - Uncertain
- - Can plan for
- - Managed via risk register

Issue:

- - Something that **is** (happening)
- - **Certain**
- - Must act now
- - Managed via issue log or response plan if an ongoing incident

How to Assess a Risk

Consider:

- Potential Impact

- Frequency or likelihood of occurrence

- Exposure

How to Assess a Risk

Exposure & Proximity

Proximity relates to the **expected timeframe** in which the risk is **likely to materialise**. The shorter the proximity, the more immediate the need for action.

Close Proximity Example

Risk: Industrial action by junior doctors scheduled next week
Why it's close proximity: The event is imminent, with a confirmed date (timebound).
Impact: Immediate disruption to elective care, outpatient clinics, and rota coverage.
Action needed: Activate business continuity plans, communicate with patients, reallocate staff.
Exposure: High if cover is not in place, especially in emergency and maternity services.

How to Assess a Risk

Exposure & Proximity

Longer-Term Risk Example

Risk: *Aging medical equipment across radiology services*
- **Why it's longer-term:** Equipment is still functioning, but there's a clear trajectory of deterioration and increasing repair frequency.
- **Impact:** Delays in diagnostics, increased maintenance costs, potential safety incidents.
- **Action needed:** Strategic capital investment plan, inclusion in risk register, potential bid for national funding.
- **Exposure:** Medium to high, growing over time — depends on contingency and maintenance strategy.

What is a Control?

ISO 31000:2018 defines a control as:

"A measure that modifies risk."

This includes any process, policy, device, practice, or other actions which are designed to alter risk, typically by reducing the likelihood or consequence of a risk event.

Controls do not eliminate risk entirely but modify it. i.e. the risk will typically still exist but to a lesser extent with the control applied.

They may be **preventive**, **detective**, or **corrective** in nature.

Examples include training, access restrictions, alarms, audits, and engineering controls.

How much control?

The standard also notes that:

"Controls may not always exert the intended or assumed modifying effect."

This underscores the importance of evaluating **control effectiveness**, which is also a key principle in ISO 31000 aligned risk management framework ISO 31010:2019 – Risk Assessment Techniques .

Assessing Control Effectiveness

ISO 31010 notes that when assessing controls, organisations should consider:

Existence – Is the control actually in place?

Design effectiveness – Is it well designed to manage the specific risk?

Operating effectiveness – Is it implemented correctly and working as intended?

Documentation and communication – Is the control documented and understood?

Monitoring – Is it subject to review or audit?

Ask:

- - Are controls clearly defined?
- - Are they being followed?
- - Do they work in practice?
- Document gaps and residual risk

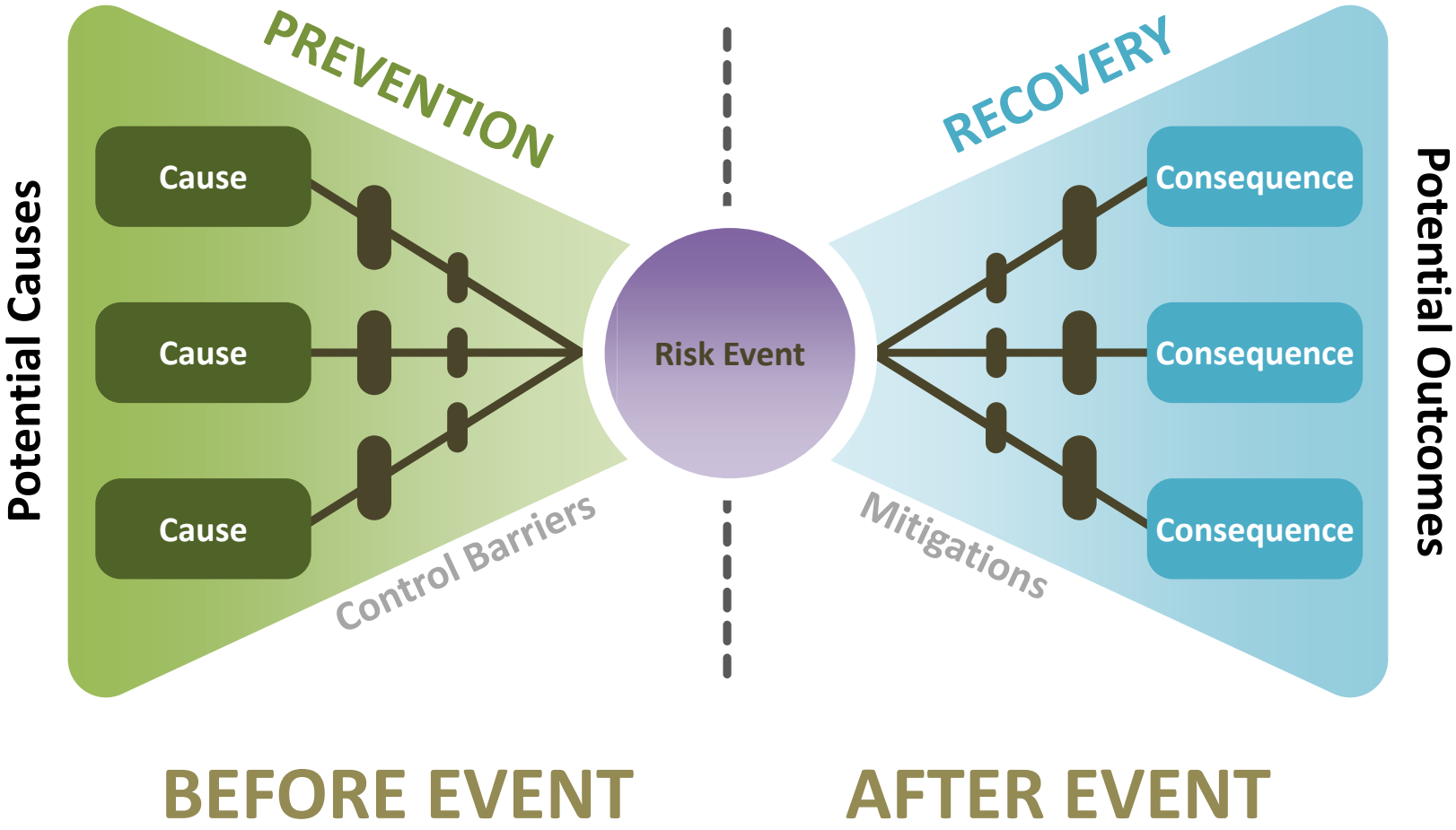
Assessing Control Effectiveness - Rating

Each control should then be assessed and given a 'Control Effectiveness Rating'. A 3 – 5 tier is typically utilised for this:

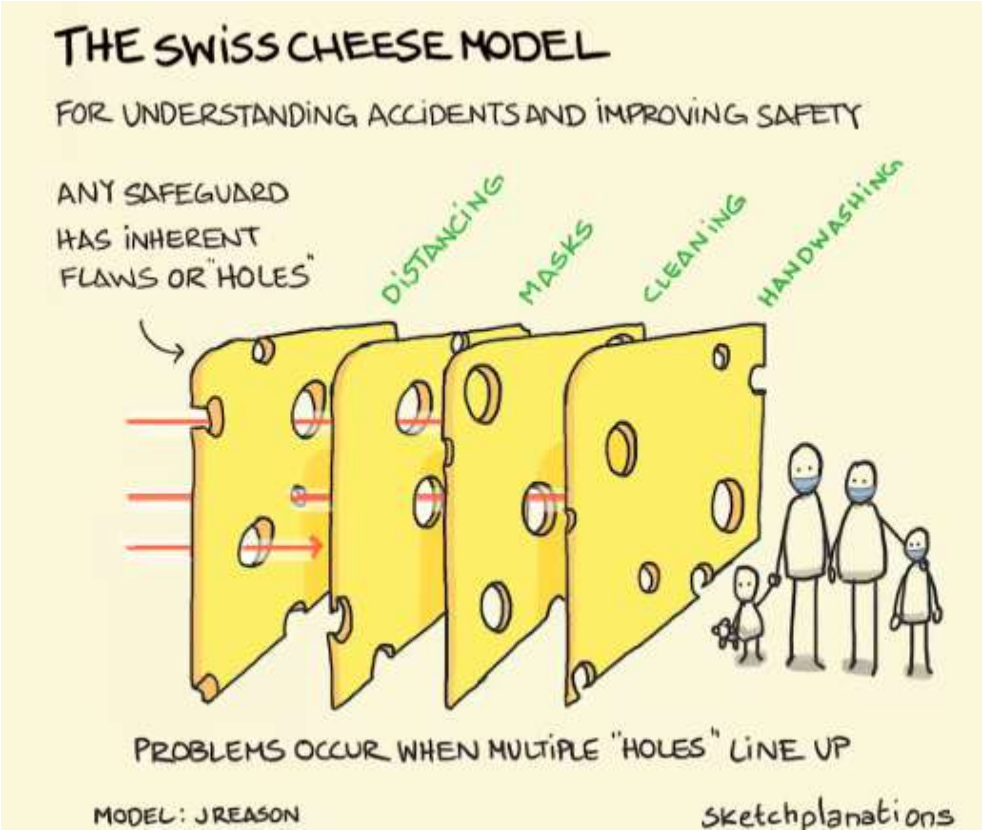
Rating	Score	Definition
Substantial Control / Substantially Effective	1	Control is well-designed and consistently implemented; no significant gaps.
Reasonable Control / Reasonably Effective	2	Control is generally reliable; minor improvements may be needed.
Partial Control / Partially Effective	3	Some components work, but there are material weaknesses in either design or execution.
Minimal Control / Minimally Effective	4	Major weaknesses exist; the control provides minimal assurance.
Zero Control	5	No control exists or it is wholly unfit for purpose.

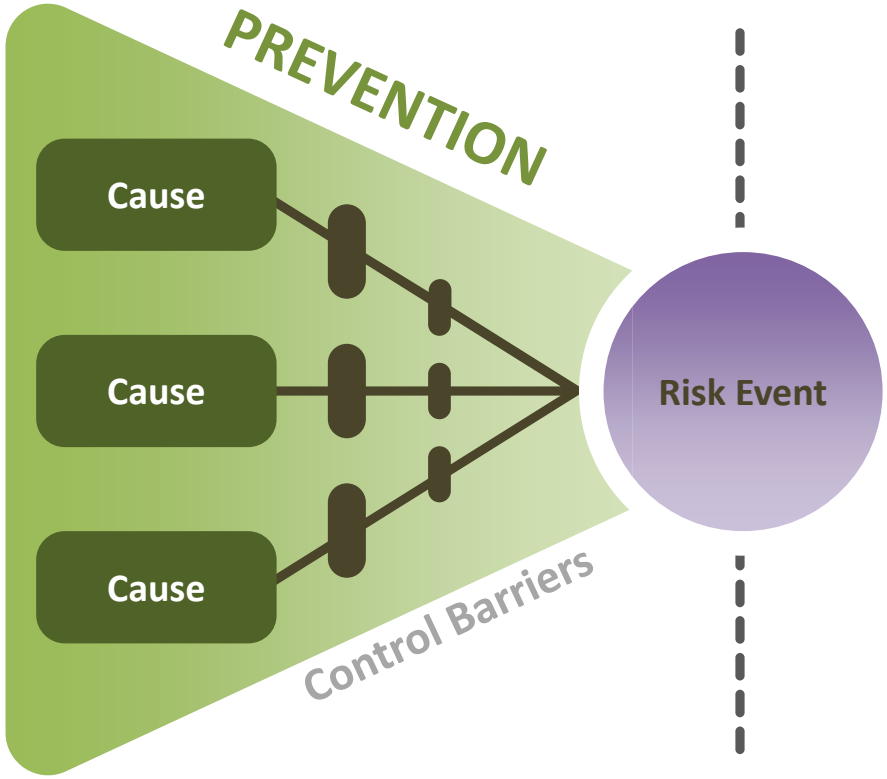
The individual ratings for each control should then be used to provide an aggregated 'Control Effectiveness Rating' for the risk.

Bowtie Diagram – Example



The Swiss Cheese and the Bowtie





BEFORE EVENT

Action Planning

Action plans should:

- Address Control Gaps and Residual Risk

- Be SMART (Specific, Measurable, Achievable, Relevant, Time-bound)

- Be Monitor through: Risk Registers, Committee Oversight and Regular Risk Reviews

Summary – What You Need to Know

- Risk is uncertainty that can impact objectives
- Good controls are layered and tested
- Risks are assessed, not guessed
- Action planning must be purposeful and SMART
- Know the difference between risks and issues
- Know the difference between Strategic and Operational risks

Questions & Discussion

- Thank you, Any Questions?

REPORT TO TRUST BOARD

Date	**4 June 2025**
Title	**Month 1 IPR – Finance**
Author & Exec Lead	**Marcus Thorman (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 FY25/26 as outlined in Cycle 3 of the 25/26 planning process is breakeven. Performance is measured against this.

2 Key issues, risks and actions

2.1 Summary of Performance

April position is a £3.4m deficit on a control total basis, £1.5m adverse to the planned £1.9m deficit.

CIP Under delivery is £1.9m and Divisional pay is overspent of £0.3m, of which £0.1m relates to staffing escalation areas. Divisional non pay spend incl. drugs is overspent by £1.3m and activity of £0.2m adverse to plan. This is partially offset by £0.3m of interest income due to higher than planned cash balances and £1.9m of non recurrent risk mitigations and unutilised reserves.

Activity: Value-based activity performance for April was £0.2m adverse to plan equating to 99% of planned levels. The elective elements were on plan equating to 100%, and other chargeable API (Chemotherapy Delivery and Diagnostic Imaging) activity was £0.2m adverse to plan equating to 87%.
CIP: Year to date CIP delivery is £0.2m against a budgeted plan of £2.1m, an adverse variance of £1.9m, comprised of an adverse planning variance of £1.9m. As at 13th May 2025, the programme consists of £10.6m of Gateway 2 approved schemes. This is £33.1m adverse to the planned £43.7m full year CIP requirement.

Capital Expenditure: Year to date total capital spend is £1.5m, a £3.1m underspend against the planned £4.6m. This is as a result of delivery of scheme milestones running behind plan assumptions across the central, core and IFRS16 lease programme.

Cash: Cash held on 30th April 2025 was £100.3m, £9.5m higher than the FY25/26 submitted forecast due to working capital movements.

3 Conclusions/Outcome/Next steps

Year to date, the Trust has delivered a £3.4m deficit against the planned £1.9m deficit, £1.5m adverse to plan. Forecast Outturn remains Breakeven. The Trust underspent Capital Expenditure by £3.1m for the month. Forecast Outturn for the total capital plan is £78.5m, a £0.6m overspend against the Trust's CDEL allocation of £93.2m.

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

Norfolk and Norwich University Hospitals NHS Foundation Trust

Finance Report
April 2025

04 June 2025

Marcus Thorman, Chief Finance Officer

Norfolk and Norwich University Hospitals NHS Foundation Trust

1. Executive Dashboard

The Trust operational plan for FY25/26 as outlined in Cycle 3 of the 2025/26 planning process is breakeven. Performance is measured against this.

April position is a £3.4m deficit on a control total basis, £1.5m adverse to the planned £1.9m deficit.

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Cash held on 30th April 2025 was £100.3m, £9.5m higher than the FY25/26 submitted forecast due to working capital movements.

	In Month			Year To Date		
	Actual	Plan	Variance	Actual	Plan	Variance
SOCI	£m	£m	£m	£m	£m	£m
Clinical Income	67.8	68.0	(0.2)	67.8	68.0	(0.2)
Other Income	10.9	10.4	0.5	10.9	10.4	0.5
TOTAL INCOME	**78.7**	**78.4**	**0.3**	**78.8**	**78.4**	**0.3**
Pay	(49.9)	(50.0)	0.1	(49.9)	(50.0)	0.1
Non Pay	(22.0)	(20.5)	(1.5)	(22.0)	(20.6)	(1.5)
Drugs (Net Expenditure)	(3.6)	(3.1)	(0.6)	(3.6)	(3.1)	(0.6)
TOTAL EXPENDITURE	**(75.5)**	**(73.6)**	**(1.9)**	**(75.5)**	**(73.6)**	**(2.0)**
Non Opex	(6.6)	(6.8)	0.2	(6.6)	(6.8)	0.2
Control Total Surplus / (Deficit)	(3.4)	(1.9)	(1.5)	(3.4)	(1.9)	(1.5)
Statutory Surplus / (Deficit)	(2.9)	(1.4)	(1.5)	(2.9)	(1.4)	(1.5)
Other Financial Metrics	£m	£m	£m	£m	£m	£m
Cash at Bank (before support funding)	100.3	90.8	9.5	100.3	90.8	9.5
Capital Programme Expenditure	1.5	4.6	3.1	4.6	1.5	3.1
CIP Delivery	0.2	2.1	(1.9)	0.2	2.1	(1.9)
Activity Metrics	£m	£m	£m	£m	£m	£m
Day Case	5.6	5.7	(0.1)	5.6	5.7	(0.1)
Elective Inpatient	4.4	4.7	(0.3)	4.4	4.7	(0.3)
Outpatients - New & Procedures	5.7	5.4	0.4	5.7	5.4	0.4
Other Chargeable activity included within API	1.3	1.5	(0.2)	1.3	1.5	(0.2)
TOTAL	17.1	17.3	(0.2)	17.1	17.3	(0.2)

Norfolk and Norwich University Hospitals NHS Foundation Trust

2. Statement of Comprehensive Income

April is £1.5m adverse on a control total basis. The statutory position, which includes peppercorn lease/donated asset depreciation of £0.2m and an adjustment to PFI revenue costs of £0.7m, is a £2.9m deficit, £1.5m adverse to plan. Trust Performance is measured against the Control Total.

	In Month Month 01 - April 2025			Forecast outturn FY 2025/26		
	Actual £m	Trust Plan £m	Variance £m	FOT £m	Trust Plan £m	Variance £m
Clinical Income	67.8	68.0	(0.2)	824.1	824.1	0.0
NT Drugs Income	6.2	6.6	(0.4)	78.6	78.6	0.0
Total Clinical Income	**74.00**	**74.6**	**(0.6)**	**902.7**	**902.7**	**0.0**
Other Income Incl. Non NHS Clinical Income	10.9	10.4	0.5	119.1	119.1	0.0
Total Operating Income	**84.9**	**85.0**	**(0.0)**	**1,021.8**	**1,021.8**	**0.0**
Medical Staff	(15.9)	(16.0)	0.1	(190.7)	(190.7)	0.0
Nursing	(18.8)	(18.2)	(0.6)	(218.6)	(218.6)	0.0
A&C	(7.1)	(7.4)	0.3	(88.6)	(88.6)	0.0
Other Staffing Groups	(6.5)	(7.0)	0.5	(85.2)	(85.2)	0.0
Other Employee Expenses	(1.6)	(1.4)	(0.2)	(2.6)	(2.6)	0.0
Total Employee Expenses	**(49.9)**	**(50.0)**	**0.1**	**(585.8)**	**(585.8)**	**0.0**
Drugs Costs	(9.8)	(9.6)	(0.2)	(115.3)	(115.3)	0.0
Clinical Supplies	(8.5)	(8.9)	0.4	(108.1)	(108.1)	0.0
Non Clinical Supplies	(10.4)	(8.6)	(1.8)	(93.5)	(93.5)	0.0
PFI	(3.0)	(3.0)	(0.0)	(36.6)	(36.6)	0.0
Total Expenditure Excl. Employee Expenses	**(31.8)**	**(30.2)**	**(1.6)**	**(353.4)**	**(353.4)**	**0.0**
Total Operating Expenditure	**(81.7)**	**(80.1)**	**(1.6)**	**(939.2)**	**(939.2)**	**0.0**
Total Operating Surplus/(Deficit)	**3.3**	**4.8**	**(1.6)**	**82.6**	**82.6**	**0.0**
Total Non Operating Expenditure	(5.9)	(6.2)	0.3	(75.2)	(75.2)	0.0
Adjust PFI revenue costs to UK GAAP basis	(0.7)	(0.6)	(0.1)	(7.4)	(7.4)	0.0
Control Total Surplus/(Deficit)	**(3.4)**	**(1.9)**	**(1.5)**	**(0.0)**	**(0.0)**	**0.0**
Control Total Adjustments						
Donated/Peppercorn lease Income & Equipment	0.0	0.0	0.0	0.0	0.0	0.0
Donated/ Peppercorn lease Assets Dep'n	(0.2)	(0.1)	(0.1)	(2.4)	(2.4)	0.0
Adjust PFI revenue costs to UK GAAP basis	0.7	0.6	0.1	7.4	7.4	0.0
Statutory Surplus / (Deficit)	**(2.9)**	**(1.4)**	**(1.5)**	**5.1**	**5.1**	**0.0**

** Note: calculations are done unrounded – only one decimal place displayed.*

Norfolk and Norwich University Hospitals NHS Foundation Trust

3. Statement of Financial Position

The Statement of Financial Position at the end of April has decreased by £3.6m compared to the opening balance. This is as a result of the in-month deficit.

Property, plant and equipment: This balance is £0.2m lower than the opening balance. The key items are capital expenditure of £1.4m offset by depreciation of £1.6m.

Right of use assets – leased assets: This balance is £0.9m lower than the opening balance. The is as a result of £0.9m depreciation.

Receivables: due from DHSC group bodies: This balance is £5.6m lower than the opening balance. The key items are the release of income accruals relating to Digital Aspirant of £4.0m and EPA of £1.5m.

Receivables: due from non-DHSC group bodies: This balance is £1.8m higher than the opening balance. The key items are higher levels of prepayments: PFI lifecycle maintenance of £0.5m, CNST of £0.4m and HR £0.4m.

Cash: This is £4.3m lower than the opening balance. The key reasons are working capital movements.

Trade and other payables: capital: This has decreased by £5.7m mainly as a result of high capital spend at the end of 2024/25 with a much reduced level of spend in M01 2025/26. The key item was the year end accrual for EPR reducing by £3.7m.

Trade and other payables: non-capital: This is £4.6m higher than the opening balance. Aged creditors have increased by £0.8m, and accrued expenditure has increased by £4.7m predominantly due to clinical trial commitments of £1.7m and pharmacy invoices in transit £2.5m. PAYE & NI accruals are £1.3m higher as a result of increases in employer's NI of £1.0m.

Borrowings: leases: The current and non-current element is a total of £0.8m lower than the opening balance. The key item is £0.8m of repayments.

Borrowings: PFI: The £0.4m decrease in non-current PFI borrowings relates to capital repayment of £1.5m, offset in part by an increase in liability of £1.0m for in year indexation.

Deferred Income: This balance is £5.4m higher than the opening balance. The key items are LDA, CPD and other education income increasing by £6.1m.

April 2025	Actual Mar-25 £m	Actual Apr-25 £m	Movement £m
Property, plant and equipment	413.9	413.7	(0.2)
Right of use assets - leased assets	43.7	42.8	(0.9)
Receivables: due from DHSC group bodies	3.2	3.3	0.1
Receivables: due from non-DHSC bodies	60.5	54.8	(5.7)
Total non-current assets	**521.2**	**514.6**	**(6.7)**
Inventories	15.8	15.9	0.1
Receivables: due from DHSC group bodies	23.6	17.9	(5.7)
Receivables: due from non-DHSC group bodies	25.1	32.6	7.5
Cash and cash equivalents	93.4	97.7	4.3
Total Current assets	**157.9**	**164.1**	**6.2**
Trade and other payables: capital	(16.6)	(10.9)	5.7
Trade and other payables: non-capital	(126.6)	(131.2)	(4.6)
Borrowings - PFI	(18.0)	(18.0)	0.0
Borrowings: leases current	(8.5)	(8.3)	0.2
Current provisions	(1.5)	(1.5)	0.0
Deferred Income	(23.3)	(28.9)	(5.6)
Total current liabilities	**(194.6)**	**(198.8)**	**(4.3)**
Total assets less current liabilities	**484.5**	**479.9**	**(4.8)**
Borrowings - PFI	(351.0)	(350.6)	0.4
Borrowings: leases non-current	(31.9)	(31.3)	0.6
Provisions	(6.5)	(6.5)	0.0
Deferred Income	(1.2)	(1.1)	0.1
Total non-current liabilities	**(390.6)**	**(389.5)**	**1.1**
Total assets employed	**93.9**	**90.4**	**(3.7)**
Financed by			
Public dividend capital	390.8	390.8	0.0
Retained Earnings (Accumulated Losses)	(323.1)	(326.7)	(3.6)
Revaluation reserve	26.3	26.3	0.0
Total Taxpayers' and others' equity	**94.0**	**90.4**	**(3.6)**

REPORT TO TRUST BOARD

Date	Wednesday 4th June 2025			
Title	Outline Business Case – Institute of Robotic Surgery			
Authors	James Hernon, Associate Clinical Director Toby Lewis, Senior Business Manager			
Purpose	For Approval			
Relevant Strategic Commitment	Together, we will develop services so that everyone has the best experience of care and treatment 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☐**	As outlined within case – Significant patient benefits, outcomes, readmission, complications and length of stay improvements
		Operational	**Yes✓** **No☐**	As outlined within case – Conversion of laparoscopic activity to robotic surgery, supportive of Cancer pathways
		Workforce	**Yes✓** **No☐**	<1 WTE in Digital Health support included in the case for integration. No other pay or workforce implications of the case.
		Financial	**Yes✓** **No☐**	As outlined within case – Capital & Revenue investment required
Identify which Committee/Board/Group has reviewed this issue/document	Business Case Review Pannel – 8th May 2025 Capital & Estates Committee – 15th May 2025 Hospital Management Board Investment Group – 16th May 2025 Finance, Investments and Performance Committee – 3rd June 2025			

1. Background/Context

This business case aims to evaluate the introduction of the robotic-assisted surgery (RAS) programme, and in doing so, provide evidence of a required need for expansion. The business case also explores the future vision for the robotic-assisted surgery programme at NNUH.

As defined in the original case for investment in robotic surgery, the consolidation and expansion of the programme aims to deliver the following:

- Demonstrate development and use of leading-edge science, research and technology: The robot will help us push the boundaries, innovate, and further improve the potential for research within the region and at NNUH.
- Value, support, and develop all our staff: further training and utilisation of surgeons in robotic technique
- Become a centre of choice for cancer education and training.
- Continue to improve our patient outcomes and robotic offer to the population the Trust serves.

Summarised key developments between SOC and OBC have been included for ease of reference. Of note, during OBC circulation the first comprehensive national guidance from GIRFT on the introduction of robotic-assisted surgery systems was published. This set out clear expectations for Trusts and ICSs on the equitable, cost-effective, and clinically safe rollout of robotic platforms. Recommendations include aligning system procurement with regional service design, ensuring high surgical volumes per platform, embedding robust training and governance arrangements, and adopting national data standards to enable outcome tracking and evaluation.

A rapid review against the delivery checklist provided by GIRFT indicates that the business case aligns well with these recommendations. However, in certain areas such as regional collaboration require further development, which is likely to be supported through the Norfolk and Waveney University Hospitals Group model.

2. 5 Case Model Overview

The strategic case details the progress made today in the evolution of the robotic programme at NNUH. The case for change describes the robotic capacity shortfalls and the growing demand for RAS. The Trust Board has adopted a high tolerance for innovation with strategy underpinning the ambitions to "Be recognised as a leading NHS Trust in applying research and adopting innovation to deliver the best patient care and to benefit the wider NHS". This case aligns with the Trust's ambition to become a **flagship centre for robotic surgery** and maintain technological advancements as an **education and teaching centre.**

The economic case explores the long list of options available to the NNUH for the future of robotic assisted surgery. It assessed four shortlisted options to be carried forward to outline business case and details indicative value for money assessments across the four options. The preferred option based upon evaluation against critical success factors and capital availability is **Option 2: Expansion of 2 Surgical Robotic Systems.** This option has economic CRB of £428k per annum.

The commercial case explores the viable routes to market, both by way of the procurement of the additional investment, and the ongoing revenue costs in terms of maintenance and consumables. The case pays consideration to all procurement options in terms of purchase / leasing etc. with regards to the assets themselves.

The financial case details the financial case at SOC stage provides a high-level analysis of the proposed shortlisted options in terms of both capital and revenue affordability and impact on the Trust's underlying position.

The **capital** costs for the PWF have been estimated based upon quotes from suppliers. The estimated costs, including appropriate contingencies, are £3,179k. The charity is required to provide assurances that they will undertake fundraising activities for the capital elements of the robotic business case. There is no internal capital funding available without charitable contributions. This case only has Capital Affordability with charitable funding.

The **revenue** implications outlined in the Statement of Comprehensive Income have a positive impact on the Trust's Income and Expenditure position of £530k over a ten-year period. A prudent approach has been taken in the financial modelling, including a contingency of 5% on revenue costs over the 10-year period. On this basis, this case does have Revenue Affordability at current. This however is based upon a number of key assumptions which require additional scrutiny as the finalised deal is negotiated (FBC stage):

- An average tariff uplift of 10% compared converted laparoscopic approaches to surgery*

- 60 Private Patient cases to be completed per annum
- Non-Pay Theatre costs for Paediatric and ENT Surgery assumed 18% and 40% respectively, of laparoscopic costs due to absence of PLCs data for applicable procedures, this may be higher as is seen in other specialities.

The management the governance that will be put in place to deliver the project. It sets out the clear parameters in which the project will be delivered, and the measures of success to determine if the investment delivered on its objectives. The Project is intended to deliver the project by March 2026. The milestones for the programme are set out within the case and include the key dates for approvals of the business case within a period to Summer 2025.

3. Key issues, risks and actions

A project risk log has been developed within the management case and highlights three key strategic risks for the board to consider:

1. The likely revenue impact of the increased cost of consumables compared with laparoscopic instruments
2. The additional NHS income assumed may not be affordable to the system in 25/26 within the current financial framework
3. The lack of re-procurement/replacement strategy following the useful life of the system, inherently linked to the charitable funding source of capital.

Mitigations against each of these have been included in the risk register but broadly include:

1. For the consumables costs, additional analysis, validation and sensitivity checks on non-pay theatre costs using the PLC methodology have been undertaken and will be subject to additional analysis in lieu of the final deal being procured.
2. For the income assumptions, limited activity is proposed in 25/26 giving some leniency in the level of risk this carries. Further to this, engagement at with commissioners and finance colleagues will be undertaken to confirm assumptions made from 26/27 onwards in the absence of guidance.
3. For the re-procurement implications, there are potential opportunities arising from both contracting and transition to the group model to explore alternative funding methodologies for acquiring new or replacement systems following the end of the useful life of the systems.

4. Conclusions/Outcome/Next steps

The Board is recommended to approve the Strategic Outline Case for the Institute of Robotic Surgery proceeds to Full Business Case (FBC) stage for finalising the deal.

Recommendations: The Board is recommended to **Approve** the OBC: Institute of Robotic Surgery proceeds to tender and FBC stage to confirm the negotiated deal and implications.

Norfolk and Norwich University Hospitals
NHS Foundation Trust

Institute of Robotic Surgery
(OBC)

May 2025

Table of Contents

Change Control

Quality Assurance		
Document:	Institute of Robotic Surgery – Outline Business Case	
Version:	1	
Status:	Draft	
	Name	**Date**
Prepared by:	James Hernon, Consultant General Surgeon Toby Lewis, Senior Business Manager	May 2025
Finance Edits by:	Mark Shearing, Finance Business Partner	May 2025
Approved by:		

Key Developments from SOC to OBC

Following feedback received at SOC stage, the following areas have been updated and reflective of iterative development for the business case:

- **Strategic Case:** Moved Sections of Clinical Case for Change to Appendix. Utilisation comparison to non-robotic theatres included to demonstrate benefit and throughput.
- **Commercial Case:** Updated detail on procurement approach through tender exercise preparations and leveraging of commercial benefits.
- **Financial Case:** Inclusion of indicative digital health costs reflected in SOCI, NPV and SOFP.
- **Management Case:** Implications for Estates, Digital Health and CSSD developed with relevant stakeholders and detailed included within project plan. Impact of training and utilisation also included.

GIRFT & NICE Guidance May 2025

In May 2025, during the circulation of the OBC, NHS England, GIRFT, and NICE simultaneously published the first comprehensive national guidance on the introduction of robotic-assisted surgery systems. These documents set out clear expectations for Trusts and ICSs on the equitable, cost-effective, and clinically safe rollout of robotic platforms. Recommendations include aligning system procurement with regional service design, ensuring high surgical volumes per platform, embedding robust training and governance arrangements, and adopting national data standards to enable outcome tracking and evaluation. The NICE Early Value Assessment further identified 11 robotic systems suitable for NHS adoption during an evidence generation period.

Broadly, the guidance recommends/translated into the following considerations for the business case:

- **Strategic Case**: Demonstrate alignment with ICS-level service models and equity of access, with a focus on high-volume, multi-specialty use.
- **Commercial Case and Procurement**: Use the national procurement framework to access approved systems and support compliant, value-based purchasing.
- **Economic Case**: Evidence efficiency gains through reduced LOS, revision rates, or downstream costs, and reference published GIRFT productivity benchmarks.
- **Management Case**: Establish a Trust-level RAS Steering Committee, proctoring strategy, and workforce plan, with assurance of training, evaluation, and long-term sustainability.

The procurement of systems via the Robotic Medical Equipment and Associated Accessories Framework aligns to these recommendations, and NICE-approved systems are included within the current framework supplier list.

The GIRFT guidance further includes a **Delivery Checklist,** this is currently being completed and will be appended to the business case to demonstrate the Trusts alignment with the guidance

and steps to be undertaken during the procurement, FBC and delivery phases reflecting best practice.

1. Executive Summary

1.1 Introduction

This business case aims to evaluate the introduction of the robotic-assisted surgery (RAS) programme, and in doing so, provide evidence of a required need for expansion. The business case also explores the future vision for the robotic-assisted surgery programme at Norfolk and Norwich University Hospitals NHS Foundation Trust (NNUH).

Robotic-assisted surgery has been in use within the NHS since the early 2000s, and despite being a late adopter, NNUH has led innovation in the field. The addition of the second system at NNUH created additional capacity, allowing us to expand the number of specialties that have access. There are, however, still limitations to the number of specialities that can benefit from the robotic system, including the number of surgeons that can be trained within each speciality.

The NNUH currently has two Da Vinci robots, which have helped deliver the Trust's vision to advance surgical practice and to be a lead trust in cancer treatment, technology adoption and robotic surgery. The requirement for additional robots to support surgery is evidenced throughout this business case, as well as the ambition to become a Centre of Robotics at NNUH. Additional robotic capacity would increase availability of robots for existing specialities utilising RAS, as well as enabling new specialities to access the benefits of robotic-assisted surgery.

As defined in the original business case for the investment in robots, the consolidation and expansion of the NNUH robotic surgery programme aimed to deliver the following:

- Demonstrate development and use of leading-edge science, research and technology: The robot will help us push the boundaries, innovate, and further improve the potential for research within the region and at NNUH.
- Value, support, and develop all our staff: further training and utilisation of surgeons in robotic technique
- Become a centre of choice for cancer education and training.
- Continue to improve our patient outcomes and robotic offer to the population the Trust serves.

To evaluate the effectiveness of the robotic-assisted surgery programme against these objectives, the following areas have been measured: clinical outcomes compared to traditional approaches (pre-robot), robot platform utilisation, and financial return on investment. In addition, summarising the key strategic benefits of the robotic programme for NNUH, i.e. reputational, workforce or service enhancements as a direct result of robotic-assisted surgery.

Finally, the case will evaluate the future vision and opportunities for expansion of the robotic-assisted surgery programme and define the infrastructure required to deliver these aims.

1.2 Strategic Case

The strategic case details the progress made today in the evolution of the robotic programme at NNUH. Within this, it explores the benefit seen in clinical outcomes to date. The case for change describes the robotic capacity shortfalls and the growing demand for RAS. It highlights that robotic theatres at NNUH consistently achieve 90% capped utilisation, markedly above non-robotic theatres. The Trust Board has adopted a high tolerance for innovation with strategy underpinning

the ambitions to “Be recognised as a leading NHS Trust in applying research and adopting innovation to deliver the best patient care and to benefit the wider NHS”.

This OBC proposes a further investment in the robotic programme, based on the continued levels of demand exceeding the capacity demonstrated within the strategic case.

From the analysis presented in the strategic case, this OBC presents five Investment Objectives for this investment. These are detailed in the figure below:

Table 1 - Investment Objectives

Ref	Area	Description	Measures
1	Patient Experience	Achieve an improvement in patient outcome measures (recovery time, complications, readmission rates, blood loss) compared to baselines for open or laparoscopic procedures within the first two operational years.	1. Reduced Recovery Time (Mins) 2. Reduced Complication % 3. Reduced Readmission Rate % 4. Reduced Blood Loss (mL)
2	Operational and Financial Efficiency	Ensure that the Trust’s infrastructure and equipment are responsive to advancements in surgical activity, whilst allowing for integration with existing systems and optimising workforce / patient pathways.	1. Two additional robots introduced to the NNUH robotic programme 2. Loss of activity during system deployment
3	Operational and Financial Efficiency	By end 2025, provide a robotic suite that is capable of increasing robotic throughput, delivering long term operational and clinical efficiencies.	1. Activity assumption 2. Length of stay reduction / bed capacity gain 3. Non-cash releasing cost avoidance through improved outcomes
4	Long Term Sustainability	Further investment in robotic assisted surgery will provide the Trust with a competitive advantage in the healthcare market and help maintain the reputation NNUH has as a leader in this field.	1. Recognised as an Institute of Robotic Assisted Surgery
5	Staff Experience	Significant improvement in training and development opportunities linked to robotic assisted surgery, supporting recruitment and retention. Reduced surgeon fatigue and ergonomic improvement during surgery.	1. Number of surgeons performing robotic assisted surgery. 2. Increased Numbers of Proctorship Offers 3. Reduced workplace related injury from performing open / lap cases.

1.3 Economic Case

The economic case explores the long list of options available to the NNUH for the future of robotic assisted surgery. It assessed four shortlisted options to be carried forward to outline business case.

1.4 Commercial Case

The commercial case explores the viable routes to market, both by way of the procurement of the additional investment, and the ongoing revenue costs in terms of maintenance and consumables.

The case pays consideration to all procurement options in terms of purchase / leasing etc. with regards to the assets themselves.

1.5 Financial Case

The financial case provides analysis of the proposed shortlisted options in terms of both capital and revenue affordability and impact on the Trust's underlying position.

Capital

The capital costs for the PWF have been estimated based upon quotes from suppliers. The estimated costs, including appropriate contingencies, are £3,179k. The charity is required to provide assurances that they will undertake fundraising activities for the capital elements of the robotic business case. There is no internal capital funding available without charitable contributions.

This case only has Capital Affordability with charitable funding.

Revenue

Within the Statement of Comprehensive Income perspective, the proposed operational model has a positive impact on the Trust's Income and Expenditure position of £530k over a ten-year period. A prudent approach has been taken in the financial modelling, including a contingency of 5% on revenue costs over the 10-year period.

On this basis, this case does have Revenue Affordability at current.

This however is based upon a number of key assumptions which require scrutiny and exploration at FBC stage:

- An average tariff uplift of 10% compared converted laparoscopic approaches to surgery*
- 60 Private Patient cases to be completed per annum
- Non-Pay Theatre costs for Paediatric and ENT Surgery assumed 18% and 40% respectively, of laparoscopic costs due to absence of PLCs data for applicable procedures, this may be higher as is seen in other specialities.

Given these assumptions additional analysis pre-procurement, analysis will be refreshed during the FBC stage to validate non-pay theatre costs using the PLC methodology, with the goal of determining if cost neutrality can be achieved with confidence. Additionally, key benefits, such as reduced complication rates, will be re-evaluated and quantified to demonstrate the broader holistic advantages of RAS.

*Additional NHS income may not be affordable to the system in 25/26, however limited activity is proposed in 25/26 giving some leniency to confirm financial framework from 26/26 onwards but is considered at risk.

1.6 Management Case

The management case details the governance that will be put in place to deliver the outline business case, full business case, and beyond in terms of programme delivery. It sets out the clear parameters in which the project will be delivered, and the measures of success to determine if the investment delivered on its objectives.

The Project Programme is intended to deliver the project by March 2026. The milestones for the programme are set out within the case and include the key dates for approvals of the OBC and FBC within a short period to Summer 2025.

1.7 Recommendations

This case recommends that an Outline Business Case is developed to further explore the options and benefits of expanding the robotic assisted surgery programme at NNUH and becoming an Institute for Robotic Surgery. The initial assumptions of the future development of this business case include:

- The purchase of two robotic surgical systems, likely via charitable donation. The outline business case will detail the various options available, both in terms of robotic solutions and procurement options.
- The use of DPU 3 & 4 for robotic assisted surgery.
- The potential rebrand of DPU1 - 4 to the Norfolk and Norwich Hospitals Charity Centre for Robotic Surgery.

2. Strategic Case

2.1 Introduction

The strategic case for the proposed expansion of robotic-assisted surgery (RAS) at Norfolk and Norwich University Hospitals (NNUH) is rooted in the recognition of the transformative potential that RAS holds for patient care, clinical outcomes, and operational efficiency within the NHS. This proposal outlines the strategic context in which the expansion is considered, emphasising the need to align with the latest technological advancements and to maintain the hospital's competitiveness in providing high quality healthcare. The analysis highlights the significant benefits RAS offers not only to patients and clinical staff but also to the wider health economy by reducing hospital stays, enhancing precision in surgical procedures, and optimising resource utilisation, evidence by current data.

RAS represents a cutting-edge, minimally invasive approach where surgeons operate through robotic systems that provide unparalleled precision, flexibility, and control. The surgeon, operating from a console within the theatre, manipulates robotic arms that perform the surgery with a level of accuracy unattainable through conventional techniques. This advanced technology facilitates complex procedures with greater ease, reduces recovery times, and minimises the risk of complications, ultimately leading to better patient outcomes. As healthcare continues to evolve, the integration of such innovative technologies has become a critical element in delivering high-quality, efficient care and is fast becoming the future of surgical practice.

Over the past decade, RAS has experienced rapid advancements, with successive generations of technology enhancing the capabilities of these systems. The pace of innovation presents a challenge for NHS Trusts to keep their RAS capabilities up to date. However, many Trusts have recently invested in expanding their RAS services to stay abreast of these technological developments and to fully realise the benefits offered by the latest systems. The proposed expansion at NNUH is, therefore, a strategic imperative to ensure that the hospital not only remains competitive but also continues to provide the highest standard of care in a rapidly advancing medical technology landscape.

2.2 Rationale

In 2015/16, the Trust made its first commitment to robotic assisted surgery introducing the Da Vinci RAS system supplied by Intuitive Surgical. Since this time NNUH has been at the forefront of robotic surgery. In 2019/20 the one 2nd generation system in place was replaced by two 4th generation systems, following the approval of a business case. This provided double the robotic capacity compared to previously, but since this time the demand has continued to increase – both in terms of patients who would benefit from robotic surgery, and surgeons being trained / waiting to train, and those expressing an interest in performing robotic surgery. At present, there are several surgeons waiting to be trained. The Trust is also not able to offer robotic sessions to newly appointed surgeons due to the limited robot availability. Having been at the forefront of this surgery, potential candidates are interested in roles at NNUH due to our robotic offer. Without being able to offer robotic sessions to newly appointed surgeons or potential candidates, there is a risk that the Trust will not be able to attract and / or retain high calibre surgeons.

Since the purchase of the two systems in 2019/20, uptake of robotic surgery in the NHS has increased with many Trusts investing in multiple systems. Without continuing to do so NNUH will no longer be able to maintain its reputation in this field.

It is also important to note that at present many patients who would benefit from robotic assisted surgery are not receiving this due to lack of access. This is partly due to the increasing volume of evidence for more procedures, but also due to patient volume increase. This is driving an inequity of care amongst our patient cohort.

Table 2 - Robotic Development Phases

Phase	Milestone	Key Documents	Timeline
Phase 1	First 2nd Generation Da Vinci System installed	Business Case	2015/16
Phase 2	Upgrade to existing Da Vinci System – replaced with 2 x 4th Generation platforms	Business Case	2019/20
Phase 3	Expansion of Robotic Service	Institute of Robotics at NNUH: Strategic Outline Case (SOC) Outline Business Case (OBC) Full Business Case (FBC)	2024/25 - 2025/26
Phase 4	Institute of Robotic Assisted Surgery	Post Implementation Review (PIR) Post Project Evaluation (PPE)	2025/26

2.3 Strategic Context

This section outlines the context of the case in terms of national, regional and local policies/strategies relevant to this investment, and how the proposal aligns to existing literature.

Robotic Assisted Surgery at NNUH aligns with the strategic context by delivering:

- Improved quality and effectiveness of **clinical service** incorporating best practice care models.
- Improved **patient experience**, including equity of access to specialised services, improved clinical outcomes and quality of life.
- Improved **recruitment** and **retention** of high calibre surgeons attracted to NNUH by its robotic assisted surgery offer.
- Excellent positioning at the forefront of rapidly developing robotic assisted surgery, supporting the Trust's reputation as a **Centre of Excellence.**
- Significant benefits of proximity with UEA campus for healthcare **education, research** and workforce development.
- Increased patient participation and opportunities for expanding **research** in collaboration with the NHIR Norfolk Clinical Research Facility (CRF) on the Norwich Research Park
- Tackling **health inequalities** as **one high quality resilient service** aligned to the Norfolk and Waveney Clinical Strategy

Overview of NNUH Clinical Services

NNUH carries out nearly one million outpatient appointments, day case procedures and inpatient admissions annually. It predominantly serves the Norfolk and north Suffolk population, although

many patients are referred from further afield especially to access specialist services available at this Trust.

The Trust operates more than 60 specialist services as a tertiary centre, including more than a dozen specialist cancer and radiotherapy treatments, and is one of the biggest cancer centres in the country. The specialist services delivered at NNUH which are linked to robotic assisted surgery include:

- Thoracic Surgery
- Head & Neck Regional Centre
- Urology Cancer services
- Upper GI Surgery
- Gynaecology

Overview of NNUH Research
Research carried out at our NNUH is focused on the healthcare needs of people living across Norfolk and Waveney. This is achieved through research active staff testing research concepts in a clinical setting not just in a laboratory and by making research patient centred. This approach enables delivery of important healthcare benefits and supports evidence-based service improvement. The Trust's research strategy focuses on four key goals:

1. Embed a culture of research throughout NNUH creating an inspirational environment that is recognised nationally and internationally, which inspires future leaders of clinical research
2. Consolidate and deepen the special partnership with the University of East Anglia and Quadram Institute Bioscience
3. Develop sustainable strategic partnerships critical to the region and wider NHS
4. Be recognised as a leading NHS Trust in applying research and adopting innovation to deliver the best patient care and to benefit the wider NHS

This programme on robotic assisted surgery will be reflective of these goals and the Trust's research strategy with RAS giving rise to opportunities for non-commercial and commercial purposes.

Clinical Strategy
Working with the James Paget University Hospitals and The Queen Elizabeth Hospital King's Lynn, the Trust has been collaborating on a Joint Acute Clinical Strategy (ACS). The strategy is linked with the work on a shared Electronic Patient Record (EPR) and aims to maximise the benefits of integrated pathways and adopt common procedures and practices. The strategy is due to be published in 2024/25. Elective surgery including robotics care is expected to form an significant part of the ACS reflecting the collaborative work on patient transfers and optimising the services across the three sites. It should also be noted that James Paget University Hospitals are in the process of fundraising for the purchase of a robot as of September 2024.

2.3.1 Strategy and Policy Alignment
The figure below provides an overview of the key national, regional and local strategic context.

Table 3 - Strategy and Policy Alignment

Level	Document	Relevance
National	Independent Investigation of the NHS in England (2024), Lord Darzi	Lord Darzi's 2024 NHS report emphasises the importance of integrating advanced technologies, to enhance healthcare productivity. Although the report does not specifically reference RAS, it highlights a pressing need to leverage innovations across the board to address productivity shortfalls and improve patient flow, reflecting a broader encouragement for technology adoption in clinical practices. The focus is on using cutting-edge solutions to increase efficiency and improve outcomes, aligning well with the potential benefits of expanding RAS in surgery.
National	NHS Long Term Plan	The NHS Long Term Plan outlines the strategic priorities for the National Health Service (NHS) in England, including the adoption of innovative technologies to improve patient care. Robotic surgery aligns with this strategy by offering advanced treatment options for patients with complex medical conditions.
National	Innovation and Technology Payment (ITP) Program	The ITP programme aims to accelerate the adoption of proven innovations and technologies within the NHS. Hospitals implementing robotic surgery may be eligible for funding and support through this programme to facilitate the adoption and integration of robotic systems into clinical practice. For this business case, it is assumed that no additional funding will be made available.
National	National Institute for Health and Care Excellence (NICE) Guidelines Prostate Cancer Colorectal Cancer Gynecological Conditions Cardiothoracic Surgery Urological Conditions	NICE provides evidence-based guidance and recommendations to support healthcare professionals in delivering high-quality care. All the procedures taking place currently and those proposed as part of this development, are recognised by NICE or specialty associations. In April 2025, NICE provided formal recommendation of 11 robotic systems for use within the NHS, underpinned by comments from the NHS Medical Director “This is fantastic news for patients and shows that the NHS continues to find new ways to utilise the latest technological innovations to improve care. This will be a vital element of the 10 Year Health Plan which will be published in the coming months”.
National	Surgical Innovation Collaboratives	The NHS has established Surgical Innovation Collaboratives (SICs) to facilitate the adoption of innovative surgical technologies, including robotics, across NHS trusts. This provides a platform to share best practices, exchange knowledge, and access training and support for robotic surgery implementation.
National	Digital Health and Technology Strategy	The UK government's Digital Health and Technology Strategy aims to harness the power of digital technology to improve healthcare outcomes and patient experiences. Robotic surgery aligns with this strategy by leveraging digital technologies to enhance surgical precision, efficiency, and patient outcomes.

Local	NNUH Caring with Pride: Our Plan for the Next 5 Years	In 2022, NNUH published its 5-year strategic plan, Caring with PRIDE. The plan outlines a number of key commitments for staff, patients, partners, and other stakeholders including: • Increased equity in service provision, better engagement from diverse people/communities in service improvements and redesign. • Improved health experience and outcomes of those who experience health inequalities. • Enhance staff psychological training and support services. • People will benefit from better quality and access to hospital services for a range of health conditions. • Joined up research & development capabilities could mean larger, more comprehensive studies in Norfolk and Waveney and offer more patients access to cutting edge treatments. • A population health approach to service planning and development • Collaboration to maximise equitable and efficient and use of all hospital sites in Norfolk and Waveney • We will increase the amount of research activity year-on-year as measured by research funding. • We will increase the number of patients enrolled in trials each year to double the baseline by 2025. The investment in robotic surgery aligns to these commitments focusing on a cross-organizational approach to improving surgical care for patients, upgrading facilities and capacity to improve population health outcomes. The Trusts literature further reinforced a high tolerance with an ambition to "Be recognised as a leading NHS Trust in applying research and adopting innovation to deliver the best patient care and to benefit the wider NHS."
Local	People & Culture Strategy: Our People Plan for the Next 5 Years	NNUH's people and culture strategy underlines a commitment to developing and growing a diverse workforce. Included within the strategy are core commitments on: Compassion & Inclusivity; Recognition & Reward; A Voice That Counts; Safety & Health; Continuous Learning; Flexible Working and Team Working. The development of robotic assisted surgery provides a unique opportunity to improve the working lives of the teams involved, as well as attracting and retaining high caliber surgical expertise in the future.
Local	Norfolk and Waveney ICB Clinical Strategy	The strategy focuses on what patients should expect from their NHS, with six core objectives to deliver on as an integrated system. Tackling Health Inequalities is one of these objectives ensuring resources are prioritised to groups that experience the greatest health inequalities and worse health and wellbeing outcomes to deliver on the national Core 20 Plus 5 plans. Additionally, the strategy aims to establish 'One, High-Quality Resilient Service,' promoting efficient information flow throughout the region, optimising the use of our estates and

		equipment for effective care delivery. The strategy further focuses on the system providing a reliable service, seeking to reduce travel times for patients and fostering collaboration across organisations both in and out of the system. The Clinical Strategy aligns closely with the development of robotic assisted surgery as a specialised service, as this investment would offer a fantastic opportunity to ensure availability and equitable access across the system for this service when needed most by patients. Simultaneously, the strategy aims to enhance health outcomes for patients and contribute to the long-term organisation of new hospitals and healthcare infrastructure.
Local	NNUH Research Strategy 2020 – 2025	This strategy focuses on strengthening the high quality, high value research undertaken at NNUH aligning the wider Trust vision. The strategy emphasises the importance of collaboration with key partners to create a research-oriented organisation, applying best practice to patient pathways.

2.3.2 Clinical Indicators

Surgery delivered robotically is guided by various clinical standards and guidelines from organisations including, but not limited to:

Table 4 - Clinical Standards Groups

Organisations	
American College of Surgeons	Getting It Right First Time
International Society of Robotic Surgery (ISRS)	Royal College of Surgeons of England (RCSEng)
Society of Robotic Surgery (SRS)	NHS Clinical Advisory Groups
European Association for Endoscopic Surgery (EAES)	National Institute for Health and Care Excellence (NICE)
Society of American Gastrointestinal and Endoscopic Surgeons (SAGES)	Royal College of Obstetricians and Gynecologists (RCOG)
The Robotics and Automation Society (IEEE RAS)	Royal College of Anesthetists (RCoA)
European Urological Society	Association of Surgeons in Training (ASiT)
British Association of Urological Surgeons (BAUS)	Society for Cardiothoracic Surgery (SCTS)

2.3.3 Population Need

With advancements in robotic-assisted surgery (RAS), an increasing number of procedures, and therefore patients, are becoming suitable for robotic intervention compared to traditional open or laparoscopic methods. The continuous evolution of RAS technology has expanded its application across a broader range of surgical specialties, offering enhanced precision, reduced recovery times, and fewer complications. This trend is driving a growing demand for robotic surgery, as more procedures are deemed appropriate for this advanced technique. This is recognised in the latest GIRFT guidance which references the need to improve equity of access to robotic surgery.

RAS in Norfolk and Waveney

Within Norfolk and Waveney, RAS provision is improving but must keep pace with the wider national picture. At NNUH x2 DaVinci Systems are in situ for General Surgery, Urology, Gynaecology, Thoracics and ENT procedures. At JPUH x1 DaVinci System is currently undergoing commissioning for Urology procedures. At QEH x1 Versius System is used for

General Surgical Procedures. The formation of the Norfolk and Waveney University Hospitals Group (NWUHG) provides a unique opportunity to improve equity of access, expand RAS provision and embed innovation across clinical pathways. Increasing the number of robotic systems will enable more patient, particularly those currently outside existing referral networks to benefit from minimally invasive surgery. With rising cancer incidence and sustained elective pressures, this expansion directly supports the delivery of a regionally aligned, population-wide RAS service. The following sections detail the specific population need, including cancer demand and elective backlog.

Cancer

The incidence of cancers in the UK is increasing and is projected to rise further, with Macmillan projecting an increase of up to 5.3m people living with cancer cases by 2040. As a tertiary centre for cancer bodysites and the largest by volume in the East of England, it is pivotal that the Trust remains at the forefront of surgical technologies to treat cancer patients and improve outcomes.

As cancer incidence is more prevalent in the elderly population and the East of England having one of the highest proportions of over 65s the region is likely to see disproportionately high demand for cancer treatments. Analysing this specifically in Norfolk and Waveney, the age-standardised incidence of cancer is higher than the national average in England. In turn, the overall demand for RAS and surgical input into cancer treatment is only set to increase, highlighting the critical need for the Trust to expand its RAS capabilities to keep pace with the growing patient demand and ensure optimal treatment outcomes.

Table 5 - Age-Standardised Cancer Rates per 100,000 population (2021)

	Females	Males	Total
Norfolk & Waveney ICB	29.6	34.1	32.0
England	27.6	34.6	31.2

Locally, several urology pathways for bladder and prostate cancer are now almost entirely dependent on RAS. However limited system capacity has created delays with some surgeries unable to be scheduled for 6 weeks.

Waiting List Review:

In collaboration with surgical teams from ENT, General Surgery, Urology, Paediatrics, Thoracics, and Gynaecology, an analysis was conducted to identify the potential next 'cohorts' of procedures that could be performed robotically at NNUH. This indicative assessment revealed that there are currently 1,100 patients on the waiting list for these identified procedures, representing **21% of the total admitted waiting list** within these specialties. This data highlights a significant patient population that could benefit from the precision and efficiency of robotic surgery, reducing their time on waiting lists and improving their overall surgical outcomes, as well as post operative complications and length of stay. At present, the Trust cannot accommodate delivering this activity robotically due to insufficient capacity.

Table 6 - RAS Waiting List Analysis

Specialty	RAS Applicable Procedures - Waiting List	Total Waiting List (September 24)	% of Admitted Waiting List
ENT	165	701	24%
General Surgery	83	1196	7%

Gynaecology	392	1295	30%
Paediatrics	40	474	8%
Thoracics	31	40	78%
Urology	402	1498	27%
Total	**1113**	**5204**	**21%**

The combined waiting list review has identified an unmet need due to a lack of robotic capacity. The final stage of this exercise was to establish length of time in theatre for the current unmet need.

Table 7 - Indicative RAS Demands

Spec	Anticipated Case Time	Anticipated Volumes*	Annual Mins Required	Theatre Sessions Required	Theatres
Urology	235	799	187565	782	1.6
General Surgery	279	343	95628	398	0.8
Thoracics	215	227	48862	204	0.4
Gynaecology	156	536	83616	348	0.7
ENT	196	418	81719	340	0.7
Total		2654	497390	2072	**4.3**

*23-24 Theatre Activity under procedure codes previously identified as robotic-applicable

This identified a requirement for a minimum of two additional robots on top of the current two existing robots.

As RAS technology continues to advance, there is a gradual expansion in the range of elective procedures that can be performed using robotic systems. The initial review data underscores the substantial proportion of the Trust's elective waiting list that could benefit from robotic surgery, not only improving patient outcomes but also contributing to broader positive externalities, such as decreased hospital stays / length of stay, and enhanced resource allocation. This growing need underscores the importance of expanding RAS capabilities at NNUH to meet the evolving demands of the patient population and to ensure the Trust remains at the forefront of surgical innovation.

2.3.4 Scope

Current Patient Demographics and Target Population

Although significant advancements have been made to the number of procedures able to be completed robotically, only a proportion of patients appropriate for robotic procedures are able to have these undertaken – a theme explored in Section 2.2.3. Procedures currently undertake using the two robots are within the specialties of General Surgery, Urology, Thoracics, Gynaecology and ENT.

The primary goal of this case is to extend these services to patients identified based on surgical need and suitability for procedures where robotic assistance is applicable and beneficial. This includes patients who are undergoing surgeries approved by the National Institute for Health and Care Excellence (NICE) for robotic assistance.

Clinical and Operational Scope

The business case aims to directly replace non-robotic surgical activities with robotic-assisted procedures where appropriate. This transition is expected to enhance surgical precision, reduce

complications, and improve patient outcomes. As will be explored in Proposed Model, several delivery models are available either with ‘replacement’ of activity or ‘displacement’ of activity, mitigated by additional elective capacity.

2.4 Existing Arrangements and Business Need

2.4.1 Evolution of Robotic Assisted Surgery at NNUH

The first da Vinci system, an Si, was installed into NNUH in December 2015. At the time, the Si was a third-generation surgical platform that offered the surgeon three-dimensional vision with a high-definition camera. The enhanced vision combined with wristed instrumentation allowed greater precision and control compared to laparoscopy and open surgery. The platform was initially used to treat urological conditions. In July 2020, NNUH traded the Si system for two da Vinci X surgical robots, the latest fourth-generation system which allowed NNUH to expand the programme into Colorectal, Gynaecology, Head and Neck and Thoracic surgery and to date the Trust has surpassed 5,000 procedures. The robots are currently based in DPU 1 and 2.

Since the programme expansion in 2020 and due to the introduction of the two 4th Generation da Vinci systems, there has been significant growth in robotic assisted surgery (RAS) activity in NNUH. In 2023, eight hundred da Vinci procedures were completed, compared to 781 procedures in 2022 (4% growth in 2023 Vs 2022). Data provided by the supplier for Oct-Dec 2023 showed the average utilisation of a da Vinci X system within the UK and Ireland to be 63 cases, compared to DPU 1 (SL0625) and DPU 2 (SL0623) systems, which achieved 118 and 103 procedures during the same period (see figure 1).

To evaluate the utilisation of our systems, an analysis was carried out by Intuitive Surgical Ltd., which found that the two da Vinci systems at Norfolk and Norwich are 6th and 16th in the UK for the number of procedures per system [96th and 90th percentile, including all (NHS & private) private hospitals] 95th and 85th percentile in Europe. The two da Vinci systems at NNUH are among the country's highest volume/utilised systems.

Figure 1 - Bar chart shows programme evolution since introducing the 4th Generation da Vinci X systems in Q3 2020.

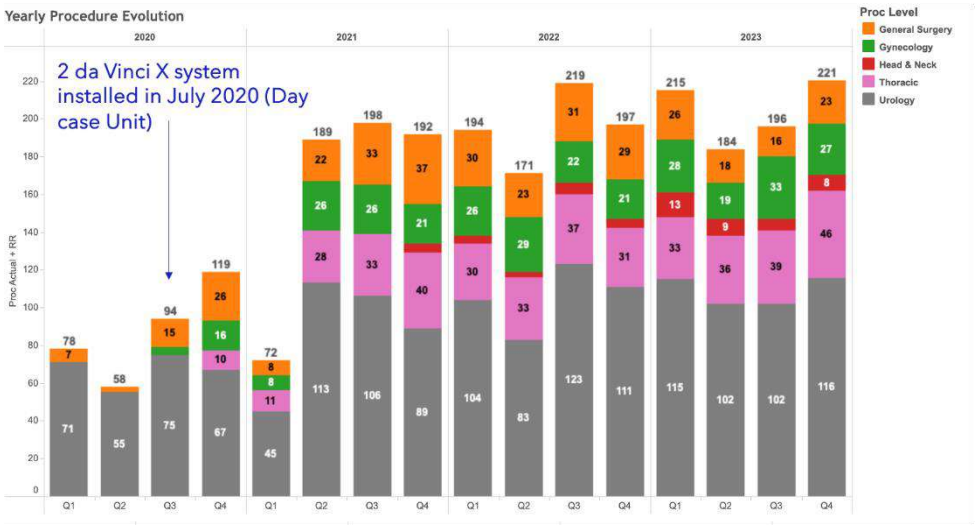
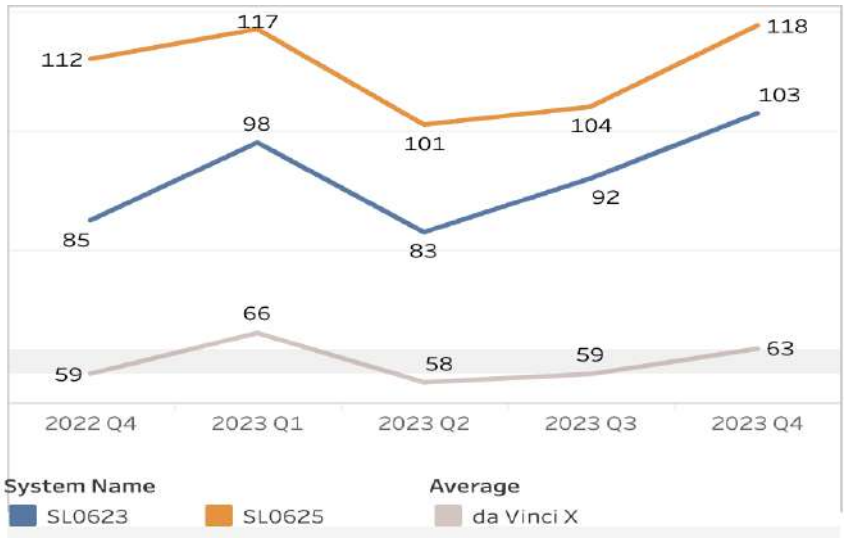
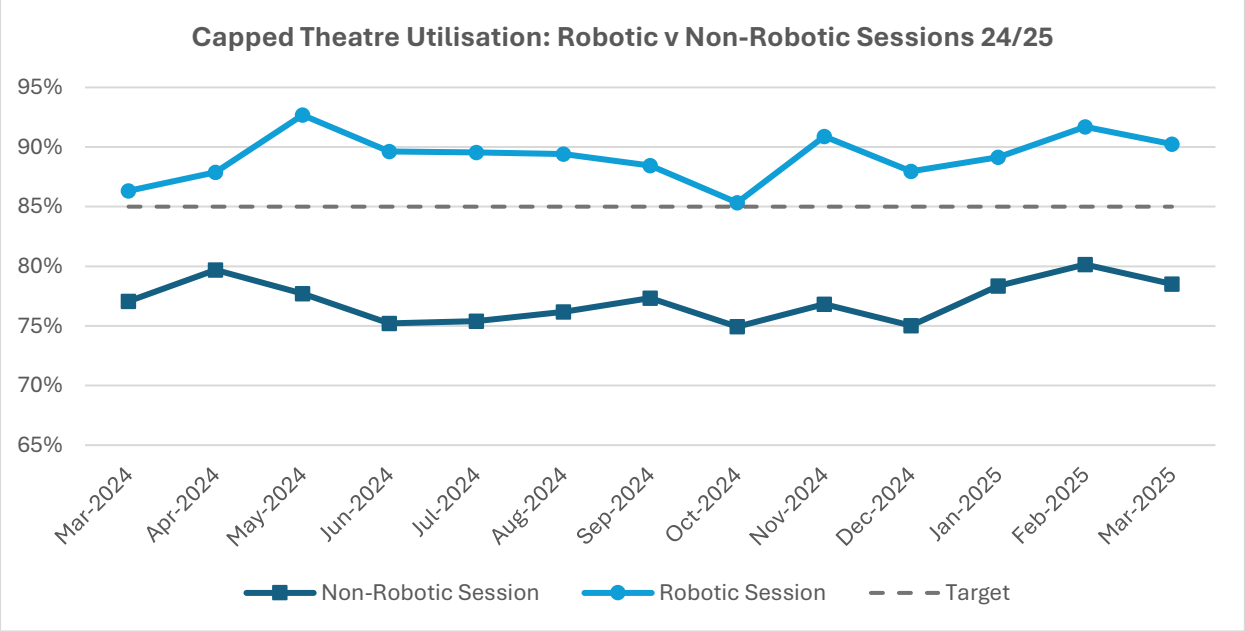


Figure 2 - Average Utilisation October - December 2023



Utilisation of robotic theatres at NNUH, when benchmarked against non-robotic theatres, shows consistently higher performance, reflecting the high throughput achieved. As shown in Figure 3, utilisation has remained above the 85% target in every month of 2024/25, a level rarely sustained and a clear testament to the effectiveness of the existing robotic programme. Further detail on the operational rigour and management approach underpinning this performance is provided in the Management Case.

Figure 3 - Capped Theatre Utilisation Robotic v Non-Robotic Sessions 24/25



2.4.2 Current Arrangements

Currently NNUH operates with two robotic systems. This is insufficient capacity for the number of patients requiring robotic surgery, and the number of surgeons who are seeking access to the existing robots as demonstrated in Section 2.3. Despite the success of the existing programme,

there is a growing demand for robotic surgery services, partly driven by increased awareness among patients and referring physicians about the benefits of this advanced surgical technology, and the increasing evidence of its benefits. However, our current capacity is insufficient to meet this demand effectively, resulting in missed opportunities to provide patients with this enhanced technique and missing out on opportunities to improve outcomes, reduce length of stay and post operative cancellations.

The two existing robots are based in DPU 1 and 2, and are utilised by Urology, Gynaecology, Head and Neck, General Surgery, and Thoracics. An indicative timetable for access by specialty is below:

Figure 4 - Robotic Timetable by Specialty - Current

Robot	Monday	Tuesday	Wednesday	Thursday	Friday
DPU1	Urology	Urology	Urology	Urology	Urology
DPU2	General Surgery	Gynaecology	General Surgery	Head & Neck	Thoracic

Existing Workforce

The Trust has 18 fully trained consultants who have performed cases on one of the two da Vinci surgical robots. The current specialities plan to expand into new indications and further training for surgeons and fellows once further capacity is available. The Trust is also employing robotically trained surgeons, or those who wish to train, who do not have access to the robot. Employing these individuals is important to ensure a high calibre of surgeons are in post but is not easy when other Trusts can offer robot availability.

Figure 5 - Da Vinci Surgeons by Specialty (those who have completed at least one case)

Robotic Surgeons	2022-23 FY	2023-24 FY
Total	**14**	**18**
Colorectal	3	3
Urology	6	6
Gynecology	2	2
Thoracic	2	3
Head and Neck	1	2
Upper GI	0	1

Surgeon Fatigue and Ergonomics

It should also be noted that robotic assisted surgery offers notable benefits for surgeon welfare. Complex surgical procedures performed open or laparoscopic can lead to longer operative times and a greater risk of musculoskeletal strain and injury for surgeons. Studies have identified that surgeons' self-reported physical workload and objective muscle activity are lower when performing robotic-assisted surgery than conventional laparoscopy. Further studies have supported these findings by comparing ergonomic measurements to perform tasks in simulated obese vs healthy weight range BMI models, where robotic-assisted surgical tasks have significantly lower muscle activity and movements than conventional laparoscopy. Work related injury is therefore considered as a measure for the investment objectives of this case.

2.4.3 Education and Research

NNUH is one of the few sites in the UK providing proctoring and case observation expertise across the UK and EU in several specialties, including Urology, Colorectal, Thoracic, and Gynaecological surgery. It is also one of the few da Vinci programs in the UK that has received robotic fellowship accreditation and grant funding to support post-CCT trainees' fellowships in robotic-assisted surgery. Our robotics programme also attracts visitors from the UK and EU to further afield and is recognised internationally as one of the best.

The use of robotic surgery outside of more established specialities such as Urology offers the possibility of a training centre of excellence and adds to Trust's Reputation.

Training for trainees:

- Robotic fellowship for peri-CCT trainees
- Development of curriculum
- Positive impact on departmental recruitment and retention
- Training centre for national and international courses
- Robotic training courses at a regional, national, and international level
- Establishing a proctoring centre: As early as 18 months into the programme, some staff may take up proctoring. This generates revenue from industry for the organisation, including our simulation centre.

This business case is therefore centred around becoming a Robotic Centre of Excellence, supporting both education and training as well as research in this area.

2.5 Clinical Outcomes by Specialty

The introduction of the da Vinci robotic surgical platform has been the most significant change to providing minimally invasive surgical care at NNUH. It has placed the Trust at the very forefront of advancing this area of surgical innovation nationally. The clinical benefits have been evaluated across all the da Vinci surgical system users at NNUH. The highlights of the current programme have been included in the appendix for reference.

2.6 Case for Change – Proposed Model

NNUH has been at the forefront of healthcare innovation with regards to developments in surgical technique, consistently striving to provide the highest quality care to our patients through the introduction of the NNUH robotic programme. To maintain this position this case proposes the introduction of two additional robots for robotic surgery. Robotic-assisted surgery offers numerous benefits over traditional surgical methods, including increased precision, faster recovery times, and reduced complication rates. By expanding our robotic surgery programme, the Trust aims to enhance patient outcomes, improve operational efficiency, and maintain our position as a leader in surgical innovation.

2.6.1 Institute of Robotic Surgery

NNUH is one of the few sites in the UK providing proctoring and case observation expertise across the UK and EU in several specialties, including Urology, Colorectal, Thoracic, and Gynaecological surgery. The programme has been recognised for its clinical and operational excellence, with NNUH's delivery being showcased at the 2022 and 2023 Intuitive Surgical Ltd. innovation and executive peer-to-peer events. As a robotic-assisted surgery centre of reference,

NNUH has demonstrated excellence across clinical, operational, and economic outcomes. Additional robot capacity would further elevate the Trust's reputation as a Centre of Excellence for research, innovation, education, and specialist services. These achievements align with the overall NNUH strategy, aiming to deliver on key objectives such as being patient-centred, fair, collaborative, accountable, and empowered. This presents a unique opportunity for the Trust to leverage its position to create an "Institute of Robotic Surgery," which will serve as a central hub for the development and dissemination of robotic surgical techniques, fostering a culture of continuous improvement and collaboration across multiple organizations.

The following initiatives will drive innovation through our robotic programme, solidifying the Institute's role as a leader in robotic surgery:

Clinical Outcomes: The Institute will focus on improving key clinical metrics, including reduced length of stay, enhanced rehabilitation, minimized blood loss, and advancements in minimally invasive surgery (MIS). These improvements will lead to better patient outcomes and elevate the overall standard of care.

Workforce and Education: Expanding nursing and medical roles, including surgical first assistants and robotic coordinators. The Institute will also serve as a case observation site, offering national and international surgeons the opportunity to learn from our expertise, thereby positioning our staff as leaders in robotic-assisted surgery.

Research: The Institute will leverage its position to drive research excellence by integrating fellowship programs, producing high-impact publications, and leading groundbreaking studies. This commitment to research will ensure the continuous advancement of robotic surgery techniques and contribute significantly to the global medical community.

Reputation and Commercial: The Institute's reputation will enable the Trust to establish itself as a leading centre for robotic surgery, opening branding opportunities, commercial ventures, and attracting charitable support. This, in turn, will secure the necessary resources to sustain and grow the programme.

Efficiency and Utilisation: Through the robotics steering group, the Institute will monitor and maximise the efficiency and utilisation of robotic systems, ensuring equitable access across specialties and optimising resource use to achieve the best possible outcomes.

2.6.2 Proposed Additional Robotic Specialties

In line with the proposed Institute of Robotic Surgery, it is crucial to consider the inclusion of additional specialties that currently lack dedicated robotic capacity. Clinical evidence increasingly supports the use of robotic-assisted surgery in these areas, where it can offer significant advantages over traditional methods. Expanding robotic access to these specialties will not only enhance patient outcomes but also strengthen the Trust's position as a comprehensive centre of excellence in robotic surgery. The specialties identified for potential expansion include:

- **Upper GI**: Robotic surgery for oesophageal cancer offers enhanced precision, 3D vision, and articulation, improving mediastinal dissection, reducing complications, and providing superior access to hard-to-reach areas for better oncological results.
- **Paediatrics**: Robotic-assisted surgery in paediatrics would improve precision, reduce complications, and enable more complex procedures, especially in urology, with benefits like smaller incisions, faster recovery, and the potential to attract patients from nearby hospitals.
- **General Gynaecology and Endometriosis**: Robotic surgery in gynaecology enhances precision, reduces operative times, and enables better treatment of complex cases like endometriosis and fibroids, improving patient outcomes and hospital efficiency, with potential for expansion into uro-gynaecology.
- **Complex Abdominal Wall Surgery**: Robotic surgery in abdominal wall procedures offers significant advantages in managing high-risk cases, reducing pain and complications, optimizing theatre time, and increasing throughput, thus reducing waiting times and improving patient outcomes.
- **Plastic Surgery**: Adding robotic surgery to plastic surgery would enhance precision in microsurgery and breast surgery, positioning the hospital as a leader in innovative surgical care and improving overall surgical outcomes.

Further detail for potential scope of expansion and potential benefits for each of these specialities is included within the Appendix.

Proposed Model – Timetables & Activity

Within the Economic Case, several options for delivering an expansion to robotic surgery will be explored. The evidence presented demonstrates a clear need for investment and early expansion in robotic resources to meet rising demand and position the Trust as a leader in surgical innovation, enhancing patient care and driving positive organisational outcomes.

With the proposed expansion in mind, several options will be evaluated as part of the Economic Appraisal. To identify a do-moderate option, the proposed model and analysis below consider the expansion by adding two additional surgical robots, bringing the total to four. This option balances the need to increase capacity with financial feasibility, ensuring that the expansion supports the Trust's strategic goals and will be explored further in the economic appraisal.

An indicative timetable for this option is provided below, aligned with the demand identified in section 2.3.3. This plan involves operating within the Day Procedure Unit (DPU) environment to maximise co-efficiencies by sharing resources and streamlining processes in a single location.

Figure 6 - Indicative Robotic Timetable by Specialty – Future*

Theatre	Mon	Tue	Wed	Thu	Fri	Sessions P.A
DPU 1	General Surgery	General Surgery	General Surgery	General Surgery	Paediatric Surgery	480
DPU 2	Urology	Urology	Urology	Urology	Urology	480
DPU 3	Urology	General Surgery	Gynaecology	Gynaecology	Gynaecology	480
DPU 4	Thoracics	Thoracics	Thoracics	ENT	ENT	480

***For indicative analysis only: Plastic Surgery and Paediatric Sessions to be added into final timetable.**

While the procedural-level data does not show an immediate, significant reduction in case time, however small marginal efficiencies have been accounted for, contributing to overall improvements in the programme's operational effectiveness. These are outlined further within the economic analysis.

Table 8 - Indicative Timetable Impact on Elective Activity

Specialty	TFC	Current Sessions PA	Proposed Sessions PA	Converted Sessions	CPS non-robotic	CPS Robotic	Pre-Robot Activity	Post-Robot Activity
General Surgery	100	275	500	225	0.8	0.85	180	191
Urology	101	500	600	100	0.95	1	95	100
ENT	120	25	200	175	1.5	1.5	263	263
Paeds	171	0	100	100	2	2	200	200
Thoracics	173	100	300	200	1	1.05	200	210
Gynaecology	502	100	300	200	1.1	1.2	220	240
Total		**1000**	**2000**	**1000**			**1158**	**1204**

This case assumes that all activity delivered in DPU 3 and 4 is laparoscopic currently and will instead be delivered robotically if two additional robots are made available. Operationally this may result in ‘swaps’ of theatre timetabled sessions with other specialities but result in a ‘neutral’ position. The activity projections also present a static annualised figure and a phased increase to this level of activity would be expected over Years 1-5 from install due to training requirements, particularly for new procedures and specialities.

2.6.3 Future of the Robotic Workforce

Expanding access to robotic surgical systems is critical if NNUH wishes to attract and retain top talent within the hospital. Surgeons who are trained on the system are more likely to stay with a hospital that offers access to the latest technology, which can help to improve the hospital's reputation and attract more patients. In addition, a number of the NNUH surgeons are waiting to be trained on robotic systems with potential surgeon candidates are requesting access to training / robotic sessions when considering NNUH for their future employment. The Trust is at risk of losing potential candidates if this cannot be offered. Robotic-assisted surgery will therefore increase our attractiveness as an employer and is in keeping with the Trust’s strategies of high-quality specialist care and driving health innovation. This will directly impact the recruitment of high-calibre staff, staff retention, and service sustainability.

2.6.4 Charitable Donation

It is unlikely that the Trust’s capital programme will be able to fund investment in additional robot capacity within the next few years. Therefore, the Trust is looking to the Charity Committee to support this investment and early indications of support are positive. This would require significant fundraising effort but result in notable reputational benefits for the NNUH Charity. Given this is likely to be the funding source, this business case proposes a potential rename of DPU1-4 to the Norfolk and Norwich Hospitals Charity Centre for Robotic Surgery.

2.6.5 Summary of Requirements

To provide the additional anticipated activity outlined, the following enhancements in estate and workforce are required at NNUH:

- Procurement of two additional robotic systems. The outline and full business case will conduct a complete exercise on the preferred supplier and procurement option, which will be supported by a full tendering exercise.
- Alignment of existing estate to support the introduction of the two robotic systems, including proposed utilisation of DPU 3&4 and consideration of CSSD requirement.
- Investment in the relevant annual maintenance contracting for the robotic systems.
- Investment in the non-pay budget to support the increased usage of robotic consumables.

This business case does not require or consider any workforce investment requirement.

2.7 Investment Objectives and Benefits

2.7.1 Investment Objectives

The Investment Objectives for this case investment set out clearly the targeted outcomes to be achieved:

Table 9 - Investment Objectives

Ref	Area	Description	Measures
1	Patient Experience	Achieve an improvement in patient outcome measures (recovery time, complications, readmission rates, blood loss) compared to baselines for open or laparoscopic procedures within the first two operational years.	5. Reduced Recovery Time (Mins) 6. Reduced Complication % 7. Reduced Readmission Rate % 8. Reduced Blood Loss (mL)
2	Operational and Financial Efficiency	Ensure that the Trust's infrastructure and equipment are responsive to advancements in surgical activity, whilst allowing for integration with existing systems and optimising workforce / patient pathways.	3. Two additional robots introduced to the NNUH robotic programme 4. Loss of activity during system deployment
3	Operational and Financial Efficiency	By end 2025, provide a robotic suite that can increase robotic throughput, delivering long term operational and clinical efficiencies.	4. Activity assumption 5. Length of stay reduction / bed capacity gain 6. Non-cash releasing cost avoidance through improved outcomes
4	Long Term Sustainability	Further investment in robotic assisted surgery will provide the Trust with a competitive advantage in the healthcare market and help maintain the reputation NNUH has as a leader in this field.	2. Recognised as an Institute of Robotic Assisted Surgery

5	Staff Experience	Significant improvement in training and development opportunities linked to robotic assisted surgery, supporting recruitment and retention. Reduced surgeon fatigue and ergonomic improvement during surgery.	4. Number of surgeons performing robotic assisted surgery. 5. Increased Numbers of Proctorship Offers 6. Reduced workplace related injury from performing open / lap cases.

2.7.2 Strategic Benefits

The strategic benefits anticipated from this investment are:

Table 10 - Strategic Benefits

Area	Benefits
Clinical Quality	• Improvement in average operative times vs traditional laparoscopic surgery • Reduction in post operative complication rates vs traditional laparoscopic surgery • Reduction in overall elective length of stay vs traditional laparoscopic surgery • Greater visualisation, dexterity and precision of operative methods
Recruitment and Retention	• Modern, attractive, amenities • Improved programmes for surgical trainees • Reputation and renowned educational programme • Purpose build-facilities will attract staff and academics to practice in the new facilities • With rising demand for elective care– it has been proven that modern practices are needed to adapt, upskilling and preparing the next generation of ophthalmic specialists is needed, non-medical staff, AHPs, nurses and optometrists can be upskilled and equip to deliver exceptional patient care in these new ways of working.
Staff Experience & Satisfaction	• Current facilities and working areas are not the most favourable • Well-designed and engagement in the design process will contribute to staff satisfaction with • Need to retain talent and skills basis • Grow and recruit a highly skilled workforce with experience and skills with robotic surgery for the next generation
Clinical Education	• Development of robotic surgery education and presence at UEA/NNUH • Leading to more positive externalities – students putting learning into best practice, encouraging them to develop the service themselves. • Becoming advocates for the taught course • Strengthening links with the UEA links and medical partnership • Opportunities to develop new roles or offer posts such as Robotic Fellowships
Research & Development	• Links to better clinical outcomes for patients • Improved recruitment to studies and trials • Opportunities for clinical trials needs close collaboration and integration to facilitate this in a faster timeframe

	• Global research and research goals – elevate the presence of NNUH and NHS EoE, NRP to look at new innovations in surgical technologies.
Use of Technology	• Forefront of robotic surgery equipment and technology available • Improving data collection and capture on outcomes, pre, intra and post operative measures • Improved surgical planning tools to estimate procedure times and scheduling
Encouraging MDT work	• New models of care introduced • Improved collaboration and partnerships with suppliers, other NHS partners

A full benefits register has been developed and is available within the Management Case.

2.8 Constraints, Dependencies and Strategic Risk

The constraints and dependencies of the proposed investment are detailed below:

2.8.1 Constraints

- The availability of funding both capital and revenue.
- The ability to secure relevant approvals for the case through internal and external governance arrangements
- Lead times and ability to procedure the capital options will potentially delay milestones in the proposed activity timetable.
- Impacts upon existing elective services.

2.8.2 Dependencies

- Existing Trust Business Case Programme including:
  - The Trust's Theatre Capacity Strategy – provides additional theatre capacity through the introduction of Paediatric Theatres, the backfill of the vacated lists, and the Norfolk and Norwich Orthopaedic Centre.
- Confirmation of revenue to support the preferred option.
- Confirmation of capital to support the preferred option.
- Technology infrastructure can support the introduction of additional robotic surgery.
- Sufficient trained workforce is in place to utilise additional robotic capacity.

2.8.3 Strategic Risk

The strategic risks associated with the planned investment, plus the management actions to assist in their mitigation, are detailed below:

Table 11 - Project Strategic Risks

Risk	Description and Consequence	Management Action
Approvals		
Failure to present compelling case	Failure to present compelling clinical case to consider for investment.	• Ongoing engagement with key stakeholders, from internal finance colleagues, surgical teams, to external commissioning colleagues.
Failure to mitigate key risks prior to	Given the overwhelming support this case has from all clinical and operational colleagues, most risks can	• Early engagement with finance colleagues • Early engagement with Estates colleagues regarding minor works requirement

FBC approval	be mitigated by the teams involved. The most significant risk to this case is financial affordability, which will need to be resolved to present the FBC.	• Potential for multi trust consumable deals to reduce non pay spend. • Negotiation with supplier regarding annual maintenance cost.
Financial / Activity		
Potential revenue unaffordability	Cost overrun meaning that the programme becomes unaffordable	• Appropriate calculation of optimism bias and planning contingency • Non-Pay consumables analysis conducted with theatre and costing analysts.
Capital availability	Full capital requirement is not available via charitable funds.	• Early engagement with Charities Committee • Early fundraising appeal launch with diverse range of fundraising ideas.
PFI		
Delays to required changes to estates infrastructure	An underestimate of the timescale / costs involved in reaching agreements.	• Formal engagement with Serco via Estates team at earliest opportunity.
Workforce		
Staff Availability	Insufficient surgical expertise to utilise the two additional robots.	• Continued roll out of training at earliest possibility. • Realignment of job plans to ensure robotic utilisation, without losing any alternative activity.
Operational		
Unable to enact the underlying operational plan	Negative impact of additional robots on underlying activity plan.	• Business case will need to be signed off on the basis that the robots will result in an incremental activity increase. • Any negative impact to be offset.

2.9 Conclusion

This strategic case has set out context for the establishment of an Institute of Robotic Surgery and demonstrated the need for additional robotic systems and benefits realised from the current programme.

3. Economic Case

3.1 Introduction

Several potential options have been developed through identifying the scope, delivery, timeframe and funding routes available for robotic expansion. From this long-list, options were considered against the Investment Objectives and an agreed set of Critical Success Factors to develop a short-list.

3.2 Critical Success Factors

The Critical Success Factors (CSFs) that have been developed for this Case are based on those suggested by the HM Treasury guidance. In line with HM Treasury guidance, the CSFs must be '*crucial, not merely desirable, and not set at a level that could exclude important options at an early stage of identification and appraisal*'. Based on the case for change and the agreed programme objectives the CSFs for the project are shown below. The options considered in this case are considered against these CSFs.

The Critical Success Factors for the proposed investment are:

Table 12 - Critical Success Factors

Key Critical Success Factors	Description
CS1: Strategic Fit	The scheme must align with the Trust's key priorities and long-term vision, with a particular focus on supporting **elective and cancer recovery** and future-proofing surgical services.
CS2: Patient Experience	Options must enhance patient experience by **improving clinical outcomes, reducing length of stay, minimising complications, and lowering readmission** rates for patients undergoing robotic-assisted surgery.
CS3: Capacity	The option **must deliver the required increase in robotic surgical capacit**y, ensuring resilience and long-term sustainability of the programme across the Trust and the ICS.
CS4: Deliverability	The option must be realistic and achievable within infrastructure constraints and supplier capabilities while ensuring the **smooth integration of robotic surgery into existing surgical pathways**.
CS5: Affordability	The options **must be financially viable** within available capital and revenue envelopes, with a clear and sustainable funding model.
CS6: Innovation	The scheme, should support the growth of robotic surgery, **enabling research collaboration with UEA and the CRF, enhancing surgical education**, and fostering technological advancements to improve efficiency and patient outcomes.

3.3 Option Development

Longlisting

The longlisted options were identified by the Robotic Steering Group in April 2024, and measured against scope, solution, delivery, implementation, and funding. Additionally, a

further service solution of displacing activity into a 'Vanguard' or temporary theatre solution was put forward via the Trust's Big Ideas Group (BIG) and has been explored as part of the options development. The outcome of this exercise is visualised in the table below:

Table 13 - Options Longlisting

Dimension	Longlisted Options					
Scope (What)	1.1 Do Nothing	1.2 Expand by 1 Robot	1.3 Expand by 2 Robot	1.4 Expand by 4 Robots		
Solution (How)	2.1 Conversion of Non-RAS Lists to RAS	2.2 Addition of RAS Lists displacing non-RAS activity	2.3 Addition of RAS Lists displacing non-RAS activity (into a rental theatre unit)	2.4 Addition of RAS Lists displacing non-RAS activity (into a new build theatre unit)		
Delivery (Who)	3.1 In House	3.2 Managed Service Contract	3.3 Insourcing	3.4 Outsourcing		
Implementation (When)	4.1 Phased	4.2 Big Bang				
Funding	5.1 NNUH CDEL & Revenue	5.2 Charitable Funds	5.3 Operating Lease	5.4 Activity Managed Programme (PPP)	5.5 Commercial Partnerships	5.6 Hybrid Funding

These options were subjected to a review by stakeholders including the RAG rating, culminating in the shortlisting of four choices for further in-depth analysis and costings as part of the OBC. This process ensures that only the most viable and impactful options are advanced, paving the way for informed decision-making and successful project implementation. Detail of shortlisting against IO's and CFS including a summary of the shortlisting has been included in the table below:

Dimension	Stakeholder Analysis
Scope (What)	1.1 (Red) Fails to address capacity (CS3) or patient experience (CS2), misaligning with all CSFs. 1.2 & 1.3 (Amber) Expands robotic capacity partially but do not fully meet long-term demand (CS3), limiting strategic fit (CS1). 1.4 (Green) Aligns well with CS1 and CS3, ensuring sufficient capacity and long-term sustainability and innovation in surgical technologies.
Solution (How)	2.1 (Green) Supports CS3 (Capacity) and CS2 (Patient Experience) by expanding robotic surgery lists within existing resources and is likely deliverable (CS4). 2.2 (Amber) Improves efficiency and aligns but displaces non-RAS activity likely to a detrimental service provision impact. 2.3 & 2.4 (Red) Introduce operational risks (CS4) and may be unaffordable and unlikely deliverable (CS5), despite potential capacity gains.
Delivery (Who)	3.1 (Green) Best aligns with CS1 (Strategic Fit) and CS4 (Deliverability), ensuring in-house expertise and service integration. 3.2 Managed Service (Amber) is viable but is not available through the Robotic Framework at the moment, so contingent on future flexibility with NHSCC (CS4). 3.3 & 3.4 (Red) Risk workforce reliance and integration issues, reducing long-term sustainability (CS3).
Implementation (When)	4.1 (Green) Phased implementation ensures smooth transition (CS4) and aligns with funding constraints (CS5). 4.2 (Amber) Risks operational disruption but could expedite benefits if executed well.
Funding	5.1 (Red) Over-reliance on internal capital risks affordability and no identified route in 25/26 or 5 year plan (CS5). 5.2 (Amber) Charitable funds align well to patient benefit but is unlikely to provide a long-term revenue solution (CS3). 5.3 (Amber) Operating lease enables access but may not be cost-effective (CS5).

	5.4 (Green) Managed Programme (PPP) provides structured investment, aligning well with CS5 and CS6 (Innovation). 5.5 (Green) Commercial partnerships could enhance sustainability (CS3) and innovation (CS6). 5.6 (Green) Hybrid funding balances financial risk (CS5) and strategic growth (CS1).

Four options have subsequently been shortlisted below including a BAU scenario. These identified options will be taken forwards for economic analysis:

Table 14 - Options Shortlist

	Shortlisted Options			
Option // Dimension	**Option 0**	**Option 1**	**Option 2**	**Option 3**
Scope	BAU	1.2 Expand by 1 Robot	1.3 Expand by 2 Robot	1.4 Expand by 4 Robots
Solution		2.1 Conversion of Non-RAS Lists to RAS	2.1 Conversion of Non-RAS Lists to RAS	2.1 Conversion of Non-RAS Lists to RAS
Delivery		3.1 In House	3.1 In House	3.1 In House
Implementation		4.2 Big Bang	4.1 Phased	4.1 Phased
Funding		5.6 Hybrid Funding	5.6 Hybrid Funding	5.6 Hybrid Funding

3.5 Economic Appraisal

This modelling follows the HM Treasury Green Book approach to estimated costs and assumptions, insofar as is relevant to this decision as described in the section below.

3.5.1 VFM Analysis

As part of VfM analysis, a method of comparison between the shortlisted options is to perform a net present value (NPV) calculation which considers the time value of money, which discounts the annual payments back to the 'today's money'. Costs in a years' time will not have the same value of money as today. The net present value (NPV) calculation excludes VAT, interest, depreciation and loan interest in line with the requirements of the HMT Green Book.

The following calculations use a discount rate of 3.5% which is the Trust's current borrowing rate and cost of capital. The table below compares by option the NPV over 10 years and the years to delivering a positive NPV. The following assumptions have been made in developing the economic appraisal:

- Any capital purchases will be charitably funded,
- Start date within 25/26
- No workforce requirements,
- No estates requirements,

- Zero downtime in theatres,
- 10% tariff uplift is expected for transitioning activity to robotic cases (4% for Gynae),
- Surgeons will capture robotic procedures information on patient notes for Coding
- Income and costs assume a loss of non-robotic associate activity
- Private patient activity performed at weekends, evenings.
- Robotic surgery on new equipment would be phased to commence 1st October (robot 1), 1st March (robot 2),
- Surgeons would be working at full capacity immediately from commencement dates,
- No additional overheads would be incurred as the theatres are already operational,
- No impact on ward staffing or non-pay costs
- Reductions in length of stay and readmissions through less invasive robotic surgery will have cash releasing benefits

Table 15 - NPV and SOCI Summary for Shortlisted Options

	Option 0	Option 1	Option 2	Option 3
Scope	**BAU**	**1.2 Expand by 1 Robot**	**1.3 Expand by 2 Robot**	**1.4 Expand by 4 Robots**
SOCI over 10 years	-26	265	530	1,171
NPV over 10 years	-21	255	510	1,126
Total Capital	0	1,589	3,179	6,358

BAU has minimal impact on the Trust. The existing Service Maintenance Contracts (SMC) on current robots would increase with indexation.

The increased cost of robotic consumables compared with laparoscopic a non-pay cost pressure with private patient contributions and income indicatively mitigating some of this increase. However, assumptions have been made in the absence of PLCs or reference data for ENT and Paediatric Surgery robotic procedures. This should be considered carefully and within the context of wider economic benefits assessed in 3.5.2.

The addition of two new robots, generates a positive annual NPV of £510k over a 10-year period using a discount value of 3.5%. This increases as the number of assets is increased as per the above table.

A brief exploration into the financial viability of the BIG idea of adding 4 robotic assets, and then a Vanguard unit, further deteriorates the return on investment with a rental unit, at c.£6m per annum, with similar levels of additional medical staff WLI makes this unfeasible.

The NPV for the PWF, the addition of two robots is below:

Table 16 - NPV - Option 2

Net Present Value Calculation	Indexation	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	2033/34	2034/35
Clinical Income - robotic	0.8%	0	1,879	6,492	6,492	6,492	6,492	6,492	6,492	6,492	6,492	6,492
Clinical Income - private patients	0.8%	0	321	1,110	1,110	1,110	1,110	1,110	1,110	1,110	1,110	1,110
Clinical Income - non-robotic	0.8%	0	-1,648	-5,696	-5,696	-5,696	-5,696	-5,696	-5,696	-5,696	-5,696	-5,696
Total income		**0**	**551**	**1,906**	**1,906**	**1,906**	**1,906**	**1,906**	**1,906**	**1,906**	**1,906**	**1,906**
Revenue costs												
Pay costs	2.1%	0	-12	-4	-4	-4	-4	-4	-4	-4	-4	-4
Clinical Supplies - robotic	0.8%	0	-1,242	-4,291	-4,291	-4,291	-4,291	-4,291	-4,291	-4,291	-4,291	-4,291
Clinical Supplies - non-robotic	0.8%	0	931	3,218	3,218	3,218	3,218	3,218	3,218	3,218	3,218	3,218
Clinical Supplies - private patients	0.8%	0	-68	-236	-236	-236	-236	-236	-236	-236	-236	-236
Non-Clinical Supplies - robotic	0.8%	0	-10	-36	-36	-36	-36	-36	-36	-36	-36	-36
Non-Clinical Supplies - robotic pp	0.8%	0	0	0	0	0	0	0	0	0	0	0
Non-Clinical Supplies - non-robotic	0.8%	0	0	0	0	0	0	0	0	0	0	0
Service maintenance costs	0.8%	0	-119	-412	-412	-412	-412	-412	-412	-412	-412	-412
Ward Non-Pay	0.8%	0	0	0	0	0	0	0	0	0	0	0
Total revenue costs		**0**	**-520**	**-1,761**	**-1,761**	**-1,761**	**-1,761**	**-1,761**	**-1,761**	**-1,761**	**-1,761**	**-1,761**
PDC - 3.5%												
Depreciation												
Total capital charges		**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Overheads	2.5%											
Contingency	5%	0	-26	-88	-88	-88	-88	-88	-88	-88	-88	-88
Incremental impact on SOCI		**0**	**5**	**56**	**56**	**56**	**56**	**56**	**56**	**56**	**56**	**56**
Discounted NPV		**0**	**5**	**56**	**56**	**56**	**56**	**56**	**56**	**56**	**56**	**56**
NPV over 10 years		**510**										

3.5.2 Economic & Cash Releasing Benefits

A comprehensive review of the economic benefits beyond those captured in the SOCI and NPV calculations is essential to inform investment decisions regarding robotic surgery expansion. While many benefits are cash-releasing, a significant proportion are challenging to quantify in financial terms or attribute directly to specific departments or cost centres. Therefore, these benefits should be assessed separately and has been discussed with the Senior Finance Management Team (SMT).

The table below summarises key economic benefits associated with robotic surgery, along with their sources and potential financial impact. The three primary benefits: length of Stay reduction, reduced complication rates, and lower readmission rates—were prioritised based on the availability of internal benchmarking data and their broad applicability across the proposed procedures.

Table 17 - RAS Economic Benefits

Benefit	Source	£	Benefit Category
Length of Stay	NHS HES Data	400	CRB
Complications	Abdo Surgery Paper	6024	CRB
Readmissions	NICE Paper	2400	CRB
Theatre Time	Per TH Min	16	CRB
Anastomotic Leak Rate	Anterior Resection	7137	CRB
Transfusions	Per Unit Blood	170	CRB
Conversions	LoS + Equipment (DC - EL)	2200	CRB
Reduced Surgeon Recruitment Cost	Avg Incentives + Campaign Costs per surgeon, 10 recruitments per annum	£1,500	

To ensure methodological robustness, internal data was used to compare pre-robotic surgery outcomes with those from the 2023/24 financial year for 10 key procedures. These procedures were selected based on their robotic surgery volumes (at least 10 cases per year), ensuring a reliable basis for comparison. While external benchmarking studies could be referenced, this analysis prioritised internal data to maintain consistency and credibility.

The procedures included in this analysis are:

- **M611** Total excision of prostate and capsule of prostate
- **H333** Anterior resection of rectum and anastomosis of colon to rectum using staples
- **E543** Lobectomy of lung
- **F341** Bilateral dissection tonsillectomy
- **M341** Cystoprostatectomy
- **E544** Excision of segment of lung
- **H072** Right hemicolectomy and side-to-side anastomosis of ileum to transverse colon
- **Q074** Total abdominal hysterectomy NEC
- **M039** Unspecified partial excision of kidney
- **M021** Nephrectomy and excision of perirenal tissue

Table 18 - RAS Economic Benefits: Costed for Options

Benefit	Non-Robotics	Robotics	Improvement	Option 1: Expand By 1	Option 2: Expand By 2	Option 3: Expand By 4
Length of Stay	3.7	3.0	-0.7	£176,050	£337,050	£645,050
Complications	8.6%	8.1%	-0.5%	£18,938	£36,257	£69,389
Readmissions	8.0%	6.1%	-1.9%	£28,671	£54,891	£105,051
Total				**£223,659**	**£428,198**	**£819,490**

The analysis demonstrates that the expansion of robotic surgery, even with the addition of a single robot, has the potential to generate a minimum of **£200k per annum in economic benefits per robot**. This figure is expected to scale with further expansion, albeit with a natural limit due to constraints on the number of trained surgeons and the feasible volume of Robotic-Assisted Surgery (RAS) procedures.

Further economic analysis will be undertaken at the FBC stage, incorporating improved data sources and refined methodologies to support a more detailed and accurate assessment of benefits.

3.5.3 Capital Purchase Options

As highlighted in Section 2.6.4 and the wider economic options development in 3.3, there is identified capital from the Norfolk & Norwich Hospitals Charity to support the purchase of additional robotic surgical systems. This said, an appraisal of various delivery models for the systems has taken place to support VFM analysis.

The table below summarises the gross cost comparisons and relevant lease costs of these models at an indicative level. This highlights the relative flexibility and VFM of an outright purchase if capital availability is supportive of this.

Table 19 - VfM Comparisons of Operating Models

Option	Cost (£'000k)	+1 robot	+2 robots	+4 robots
Outright purchase	Gross Cost	1,582	3,164	6,328
	Annual depreciation	158	316	633
7-year operating lease	Gross Cost	3,780	7,560	15,120
	Annual lease cost	540	1,080	2,160
2-year rental	Gross Cost	1,080	2,160	4,320
	Annual lease cost	540	1,080	2,160
AMP/Pay per procedure	Gross Cost	3,830	7,661	15,322
	Annual cost	547	1,094	2,189

3.6 Preferred Option

Based on consideration of both qualitative and quantitative analysis undertaken as part of the economic appraisal, **Option Two: Expand by Two Surgical Robots** demonstrates the following characteristics, which draw it out as the Preferred Way Forward:

- Adherence to the Investment Objectives and Critical Success Factors
- Strategically aligned to the relevant documentation sited within this strategic case
- Provides significant economic benefits to the Trust
- Deliverable – represents feasible options developed through clinical engagement that will meet both patient and staff need.

The preferred option will be assessed in the following section to ensure it is commercially deliverable, is affordable and is capable of successful delivery.

4. Commercial Case

4.1 Introduction

The commercial case summarises the process by which the projects components will be procured and the processes that will be put in place to ensure the Trust procures a legally compliant solution with assurance for value for money. It sets out:

- The proposed procurement strategy
- Service scope and outputs
- Risk allocation and approach
- Payment structure considerations
- Contractual and accountancy considerations

Further detail will be added within the FBC, including the agreed commercial deal and draft contract.

4.2 Procurement Strategy

Given the value and complexity of the proposal, all procurement activity will align with public procurement regulations and Trust Standing Financial Instructions (SFIs). **The Trust intends to utilise the NHS Supply Chain Robotic Medical Equipment and Associated Accessories Framework (2024/S 000-004668) to access the market**. A full tender exercise, supported by Procurement colleagues, will evaluate lifetime costs including equipment, maintenance, training, and accessories.

The procurement strategy has been informed by:

- Early market engagement in September 2024 with key suppliers
- Clinical feedback from conferences, supplier site visits and peer observations
- Evaluation of funding routes including the confirmed use of charitable funds

The procurement timeline is provided in the Management Case, with an expected 30-day duration from OBC approval.

While collaborative procurement with other Trusts (including the newly formed Norfolk and Waveney University Hospitals Group) was considered, it was not pursued for this capital procurement due to funding source constraints and framework scope. Future arrangements for consumables and supplies may be aligned across the group via the ICB's integrated procurement team.

It is also recognised from that there may be added value both clinically and commercially in procuring robots from different suppliers, as opposed to only utilising one supplier. Therefore, procurement will not restrict to a single supplier if value and service quality can be improved by multiple supplier contracts.

Given that multiple theatres would be operating robotic equipment, consideration has been made as to the introduction of a Managed Service Contract (MSC) and if this would prove advantageous to the procurement of the additional robotic consoles. Given there is currently no framework applicable for Robotic Surgery MSCs, an open competition would need to be

run and coordinated by the Trust procurement team. This would be a significant undertaken and require additional resource to complete. Given the complexities of this and the current contractual arrangements (Section 4.4). There is also a risk that the overarching VAT benefits which can be provided by a MSC remain at risk. Given that charitable funding for the preferred option available, an MSC would not improve the commercial implications of this. Future consideration may be made during equipment replacement and contract reviews to this.

4.3 Service Requirements

The commercial needs of this business case are as follows:

- A value-for-money solution to procuring additional robotic capacity
- A maintenance contract to support the additional robotic capacity that meets the needs of the service and organisation
- A consumable arrangement that delivers to the level of anticipated activity and meets the needs of all departments involved, including CSSD

The procurement will cover the robotic systems, associated accessories, training, maintenance and digital integration. A schedule of requirements has been developed using the NHS Supply Chain template and informed by examples of best practice from recent NHS procurements. This schedule is included in the appendix for illustrative purposes.

Consumables will be considered as part of the evaluation process to understand the overall lifetime cost and supply model for each system. However, they will be procured on a transactional basis outside of the main tender process, using existing NHS Supply Chain arrangements. This approach provides flexibility while ensuring value for money.

In addition, the required enhancements to the Central Sterile Services Department (CSSD) to accommodate additional robotic capacity will be procured through the relevant NHS Supply Chain framework. While these enhancements are not part of the same tender, they are considered essential to the delivery of the expanded service and form part of the overall commercial planning.

4.4 Contractual Arrangements

It should be noted that the Trust is already in contract with Intuitive Surgical Ltd for the provision of the current two Da Vinci robots on site. Procurement colleagues are supporting clinical and operational team members in ensuring discussions taking place with this incumbent supplier do not compromise the integrity of any future commercial decisions.

From a commissioning perspective, the only robotic tariff currently available is radical prostatectomy. However, small uplifts on a limited number of existing HRGs are available when a robotic procedure is recorded. (further detailed in Section 5.6) This case assumes this robotic tariff will continue. It also assumes no other direct robotic tariffs will be introduced, although there has been discussion at national level regarding the payment of robotic activity given the increasing trend towards this. The activity assumed within this case is therefore a continuation of the current tariff received for all procedures aside from radical prostatectomy.

4.5 Risk Allocation

A high-level risk allocation has been considered based on the complexity and scale of the procurement. As the Trust is procuring via a pre-approved framework for a defined capital purchase, most risks are either retained by the Trust or shared with the supplier where performance delivery is involved. The most material risks for this case are:

- Implementation and transition: managed through shared planning and supplier onboarding
- Availability and performance of the robotic system: managed via service specifications and escalation procedures
- Operating and revenue: retained by the Trust
- Technology obsolescence: partially mitigated through supplier track record and framework alignment

A full commercial risk register will be developed as part of the FBC with mitigation and contingency planning.

4.6 Payment Mechanism

The preferred payment structure is an outright capital purchase, supported by charitable funds. This allows VAT recovery and simplifies long-term financial commitments.

Performance-related incentives are not currently proposed as part of the contract. Supplier evaluation during procurement will focus on proven delivery, support, and service quality rather than financial KPIs.

Market benchmarking and value-for-money checks will be embedded in the tender evaluation criteria to ensure competitive pricing.

4.7 Summary of Commercial Case

The preferred procurement route is via a competitive tender process under the NHS Supply Chain framework, with full details of the schedule of requirements included in the appendix. While all procurement options remain available, the initial acquisition is expected to be a capital purchase funded through charitable contributions.

5. Financial Case

5.1 Introduction

The purpose of the Financial Case is to provide an overview of the financial arrangements for the successful delivery of the project.

The financial case demonstrates the impact of the Preferred Option compared to Business as Usual on the Trust's financial position and provides a high-level assessment of revenue and capital affordability based on the information available.

5.2 Income Model

Activity Assumptions:

- Costed using 23/24 National Tariff, inclusive of MFF
- Admission Spells: Income has been calculated using the average tariff linked to the historic data for, each body area split by ISS score. Multiplying the average tariff by the expected activity.
- Best Practice Tariff: Assumption that best practice tariff is not relevant for this patient cohort.
- Critical Care Stays: Assumption that a majority of critical care spells will be HRG XC06Z - Adult Critical Care - 1 Organs Supported - this has been based on critical care activity linked to the historic data
- The only relevant robotic tariff in use is for radical prostatectomy, this business case assumes this tariff will continue as is.
- Robotic OPCS codes to inform HRGs including Y721, Y753, Y765 and Y452 will be used to capture robotic procedures.

5.2.1 Proposed Activity and Income

For the preferred option the below income and activity has been assumed.

Specality	TFC	Converted Sessions	CPS Robotic	Post-Robot Activity	DC	EL
General Surgery	100	225	0.85	191	£21,417	£1,216,372
Urology	101	100	1	100	£6,191	£523,472
ENT	120	175	1.5	263	£0	£850,000
Paeds	171	100	2	200	£0	£836,533
Thoracics	173	200	1.05	210	£0	£1,977,455
Gynaecology	502	200	1.2	240	£0	£1,009,134
Total		**1000**		**1204**	**£27,608**	**£6,412,966**

5.2.2 Patient Level Costing

22/23 Patient Level Costings (PLCs) data has been used to support the financial assessments. The methodology utilised to support the costings involved analysing non-pay costs such as theatre and consumables and length of stay metrics. Two distinct datasets were created to capture admission-level costs, one using core procedure codes and the other using full OPCS codes, ensuring comprehensive coverage of relevant procedures.

However, a level of pragmatism has been applied to refine comparisons across different procedures, given the complexities of surgical coding and evolving practice patterns. For instance, procedures such as prostatectomy are now exclusively performed robotically,

meaning PLC data would need to be adjusted retrospectively, inflating figures back to pre-robotic adoption in 17/18 to establish a meaningful comparison. Similarly, OPCS codes alone can be insufficient when evaluating procedures such as tonsillectomy, which is typically straightforward when performed laparoscopically but can also form part of a more complex robotic head and neck cancer case. In paediatric and plastics surgery, where robotic-assisted procedures have not been implemented there are no reference costs locally or nationally. These factors underscore the importance of a more detailed evaluation at FBC where known non-pay costs can be applied to ensure financial modelling accounts for procedural complexity, historical baselines, and potential future shifts in surgical practice.

5.3 Research

The proposed expansion of robotic surgery presents significant opportunities for future research income, particularly through commercial research partnerships and NHIR-led initiatives. By leveraging the Trust's surgical population and the range of complex surgeries planned, the Robotic Centre will be well-positioned to attract high-value research collaborations. However, given the non-recurrent nature of these funding opportunities, no additional research income has been factored into the financial projections.

5.4 Cost Effectiveness of Robotic Assisted Surgery

Initial analysis of RAS costings involved collaboration with various suppliers to explore different costing methodologies available in the literature and through NHS frameworks, such as pay-per-case models, which provides transparent pricing structures. However, while the costs of surgical instruments used in RAS were initially found to be cost-neutral or on occasion more favourable compared to laparoscopic surgery, an internal analysis by Theatre Teams revealed that the overall expenses associated with RAS, including robotic ports and additional consumables, tended to be higher due to the lack of economies of scale currently achievable with laparoscopic procedures in the NHS.

This insight validates the PLCs methodology for non-pay theatre costs, which have informed the financial assessments for the business case. However, the PLCs methodologies require refinement as previously highlighted; the absence of a standardised inventory management system across all NNUH theatres means that the associated costs are primarily indicative and based on algorithms. Moving forward, at FBC and delivery stages, there is an ambition to iterate the PLCs data available for RAS costings. This with the expectation that this will ultimately provide evidence of reduced costs and cost neutrality over time, a sentiment highlighted in GIRFT guidance on the implementation of RAS.

5.5 Capital Requirements

The PWF includes the requirement to purchase two additional robotic units at a total cost of c.£3,179k. This includes two robotic systems, associated equipment and a 5% contingency.

Assurances have been received from Norfolk & Norwich Hospitals Charity that the capital purchase of the robots would be charitably funded. No depreciation will be payable through the Trust SOCI. A reserves transfer is made to account for the depreciation on charitably funded assets. This does not impact the Trust's control total.

No VAT is payable on charitable purchases.

5.6 Revenue Requirements

Commissioning have reviewed the opportunity to enhance robotic coding for elective procedures. When reviewed, this offers the potential to increase the average tariff received per elective procedure by c.10% for Urology, General Surgery, Thoracics and ENT. The increase to Gynaecology procedures is estimated to be c.4%. There is a significant risk that theatres do not record sufficient data to enable the clinical coding team to capture the increased tariffs. The initial review of the tariff uplift suggested that a 15% uplift was possible. This has been reduced to 10% to reflect the risk of recording the additional data. The assumed tariff uplift equates to £802k pa. within the PWF.

The PWF assumes theatres will cease purchasing consumable kit for non-robotic procedures but will commence procuring robotic instrumentation. There is a net £1,082k pa cost pressure created through this switch for NHS cases.

Annual Service Plans have been assumed at a cost £142.5k per annum (+ VAT). Digital Health server licensing fees have been included at £30k per annum (+VAT), reflected under the as an indicative guide for local storage on procedure data including capture capabilities.

A small amount of costs associated with pay for digital health integration have been included for 3 months in 25/26 with ongoing support from 26/27 onwards.

These costs are subject to change following the tender exercise.

The Trust's experience with its existing robotic equipment evidences clear patient benefits including a reduced length of stay for patients as evidenced in Sections 3.5.2 and 2.5.

The PWF assumes a level of private patient working. 60 patients are expected to be treated over the course of a year, charged at £18.5k per procedure.

5.7 Financial Assessment

5.7.1 Statement of Comprehensive Income

The table below shows the incremental impact of purchasing two additional robots to the Trust's Statement of Comprehensive Income over a ten-year period. The total cumulative impact is a positive £530k.

Table 20 - SOCI for PWF

Statement of Comprehensive Income	Indexation	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	2033/34	2034/35
Clinical Income - robotic	0.8%	0	1,894	6,544	6,596	6,649	6,702	6,756	6,810	6,864	6,919	6,975
Clinical Income - non-robotic	0.8%	0	-1,661	-5,742	-5,788	-5,834	-5,881	-5,928	-5,975	-6,023	-6,071	-6,120
Clinical Income - robotic - considered at Risk			232	802	808	815	821	828	835	841	848	855
Clinical Income - private patients	0.8%	0	324	1,119	1,128	1,137	1,146	1,155	1,164	1,174	1,183	1,193
Total income		**0**	**556**	**1,921**	**1,936**	**1,952**	**1,967**	**1,983**	**1,999**	**2,015**	**2,031**	**2,047**
Revenue costs												
Pay costs	2.1%	0	-12	-4	-4	-4	-4	-5	-5	-5	-5	-5
Clinical Supplies - robotic	0.8%	0	-1,252	-4,326	-4,360	-4,395	-4,430	-4,466	-4,501	-4,537	-4,574	-4,610
Clinical Supplies - non-robotic	0.8%	0	939	3,244	3,270	3,296	3,323	3,349	3,376	3,403	3,430	3,458
Clinical Supplies - private patients	0.8%	0	-69	-238	-240	-241	-243	-245	-247	-249	-251	-253
Non-Clinical Supplies - robotic	0.8%	0	-11	-36	-37	-37	-37	-37	-38	-38	-38	-39
Non-Clinical Supplies - robotic pp	0.8%	0	0	0	0	0	0	0	0	0	0	0
Non-Clinical Supplies - non-robotic	0.8%	0	0	0	0	0	0	0	0	0	0	0
Service maintenance costs	0.8%	0	-120	-416	-419	-422	-426	-429	-433	-436	-440	-443
Ward Non-Pay	0.8%	0	0	0	0	0	0	0	0	0	0	0
Total revenue costs		**0**	**-524**	**-1,776**	**-1,790**	**-1,804**	**-1,819**	**-1,833**	**-1,848**	**-1,863**	**-1,877**	**-1,892**
PDC - 3.5%		0	0	0	0	0	0	0	0	0	0	0
Depreciation		0	0	0	0	0	0	0	0	0	0	0
Total capital charges		**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Overheads	2.5%											
Contingency	5%	0	-26	-89	-89	-90	-91	-92	-92	-93	-94	-95
Incremental impact on SOCI		**0**	**5**	**56**	**57**	**57**	**58**	**58**	**59**	**59**	**60**	**60**
Incremental impact on SOCI - 10 years	**530**											

The depreciation on the Charity's £3,179k investment has been included for disclosure only. The impact on the Trust's financial position is highlighted.

5.7.2 Statement of Financial Position

The incremental impact on the Trust's Statement of Financial Position is shown below:

Table 21 - SoFP for PWF

Statement of Financial Position	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	2033/34	2034/35
Fixed assets	0	0	0	0	0	0	0	0	0	0	0
Cash	0	5	62	119	176	234	292	351	410	470	530
Reserves	0	5	62	119	176	234	292	351	410	470	530
PDC reserve	0	0	0	0	0	0	0	0	0	0	0
Donated asset reserve	0	0	0	0	0	0	0	0	0	0	0

The 10-year impact being a £530k positive impact.

5.7.3 Cash Flow Statement

The Cash Flow Statement indicates that the investment in two robots as the PWF would have a positive impact on the Trust's cash flow.

Table 22 - Statement of Cash Flows for PWF

Statement of cash flows	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	2033/34	2034/35
Cash flows from operating activities		5	56	57	57	58	58	59	59	60	60
Less: depreciation	0	0	0	0	0	0	0	0	0	0	0
Cash flows from investing activities											
Trust asset purchase	0	0	0	0	0	0	0	0	0	0	0
Charitable funds asset purchase	0	-3,305	0	0	0	0	0	0	0	0	0
Cash flows from financing activities											
PDC borrowed for Trust asset purchase	0	0	0	0	0	0	0	0	0	0	0
Donated income	0	3,305	0	0	0	0	0	0	0	0	0
Incremental impact	**0**	**5**	**56**	**57**	**57**	**58**	**58**	**59**	**59**	**60**	**60**
Cumulative impact	**0**	**5**	**62**	**119**	**176**	**234**	**292**	**351**	**410**	**470**	**530**

5.8 Overall Affordability Assessment

The capital costs for the PWF have been estimated based upon quotes from suppliers. The estimated costs, including appropriate contingencies, are £3,179k. The charity is required to provide assurances that they will undertake fundraising activities for the capital elements of the robotic business case. There is no internal capital funding available without charitable contributions.

This case only has Capital Affordability with charitable funding.

Within the Statement of Comprehensive Income perspective, the proposed operational model has a positive impact on the Trust's Income and Expenditure position of £530k over a ten-year period. A prudent approach has been taken in the financial modelling, including a contingency of 5% on revenue costs over the 10-year period.

On this basis, this case does have Revenue Affordability currently within assumptions made.

6. Management Case

6.1 Introduction

The management case details the project management and governance arrangements that the Trust has put in place to support the delivery of this project. It sets out the following arrangements:

- Project Plan
- Project Management
- Operational Management
- Project Reporting & Monitoring
- Benefits Management
- Risk Management
- Contract and Change Management
- Project Evaluation & Close
- Contingency Plan

The project shows an operational date of December 2025, contingent on development of subsequent stages of the business case and approvals of the case, noting previously identified constraints and dependencies.

6.2 Project Plan

The Project Programme is intended to deliver the project by May 2026. The milestones for the programme are set out below and include the key milestones for approvals. Given the tight timeframe linked to the milestones indicated below, which indicate orders in August 2025, two months flex has been scheduled to allow for any delay.

Table 23 - Project Milestones

Strategic Outline Case	
Divisional Board Approval	March 2025
Business Case Review Panel	
Capital and Estates Committee	
Hospital Management Board Investment Group	
Finance, Investment and Performance Committee	
Charity Committee	
Trust Board	April 2025
Outline Business Case	
Business Case Review Panel	May/June 2025
Capital and Estates Committee	
Hospital Management Board Investment Group	
Finance, Investment and Performance Committee	
Charity Committee	
Trust Board	June 2025
Tender Exercise Initiated	June 2025
Full Business Case	

Tender Exercise Concludes	July 2025
Business Case Review Panel	August 2025
Capital and Estates Committee	
Hospital Management Board Investment Group	
Finance, Investment and Performance Committee	
Charity Committee	
Trust Board	
Triple Lock Pannel	
Implementation	
Medical Devices Committee Review	August 2025
Orders placed	August 2025
1st Robot Delivery (6–8-week lead in time)	October 2025
Commissioning / IT Integration / Training	October 2025
Full Utilisation	December 2025
2nd Robot Delivery (6–8-week lead in time)	March 2026
Commissioning / IT Integration	March 2026
Full Utilisation	May 2026

6.2.1 Digital Health Integration

Within the tender exercise, systems requirements linked to Digital Health integration will be outlined to suppliers and close engagement will take place. During the OBC production a Request for IT Support (RITS) has been raised to prioritise and support the project with any digital requirements. Membership of the project group is inclusive of colleagues in Digital Health in order to anticipate and calculate additional resource requirements for the project which have been included within the revenue and capital costings.

6.2.2 Estates Requirements

Following SOC approval, an estates support request was submitted to assess integration requirements for the preferred option in DPU to accommodate the robotic systems. The appraisal confirmed no additional estates enabling works are required within theatres. Supplier readiness guides will be reviewed post-tender to ensure compatibility.

Outside of theatres, a new plasma steriliser will be installed in CSSD to improve resilience. A suitable area has been identified, and a request for a new three-phase power socket will be submitted. No other utility changes or interdependencies with other schemes have been identified.

6.2.3 Training and Integration Impact

The project plan includes dedicated time for commissioning and integration of each robotic system into the theatre suite, ensuring all necessary safety checks and functionality tests are completed. For the first robot, a shorter one-month lead-in time is planned before reaching full utilisation. This reflects existing demand pressures, a pool of trained surgeons already exceeding available robotic sessions, and proactive planning by the project group.

In contrast, the second robot will have a slightly longer lead time between commissioning and full utilisation. This is due to the introduction of newer specialties, such as paediatrics, where surgical cycles over 4–8 weeks may initially result in lower utilisation. However, this lead time

is minimised by early training efforts. During the first phase of the third robot's implementation, additional surgeons will undergo training via simulation, cadaveric courses, and comprehensive supplier-led programmes. These training provisions are a core component of the procurement and tender evaluation process. Based on previous integration experience, activity during the first quarter of use typically reaches around 80% of target utilisation before stabilising. This is captured in the project risk registers and will be actively monitored by the project group.

6.3 Project Management

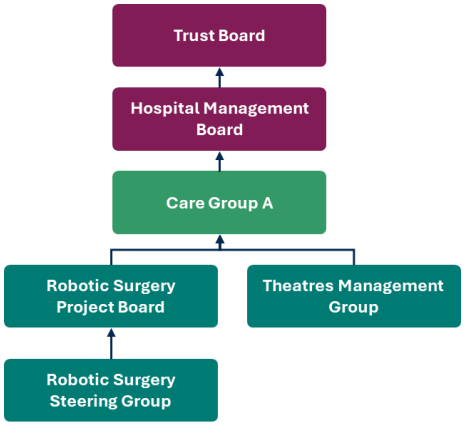
The project will be led by the Robotic Surgery Project Board, which is accountable to Care Group A, and onwards to Hospital Management Board. Additionally, updates will be issued to the Charity Committee given the nature of the investment expected.

The role of the Project Board will be to ensure the aims outlined and success factors detailed within this case are delivered, activity is coordinated, to ensure all stakeholders are engaged in development plans and to ensure the programme aligns with overarching policies and strategies. The board will also discuss risks and put in place plans for mitigation where possible or escalate where required. The primary objectives of the project organisation are to ensure:

- Ensure the delivery of the project on time, in accordance with the clinical brief
- The delivery of new patient-centred service models and associated pathways
- Effective engagement from both internal and external stakeholders

The project governance and reporting structure has been outlined below.

Figure 7 - Project Governance & Reporting



6.4 Project Reporting and Monitoring

The Project will report to the Trust's Capital and Estates Committee during the delivery phase and to the Trust's HMB Investment Group during business case development (with appropriate approvals via the Trust's Finance, Investments and Performance Committee and Trust Board).

The development of the programme requires frequent planned and ad hoc meetings to ensure appropriate information dissemination and feedback amongst key stakeholders.

Table 24 - Project Group Governance

Group	How	When
Robotic Surgery Project Board	Will meet via Microsoft team or in person were appropriate to review progress	1 hour fortnightly
Robotic Steering Group	Will meet ad hoc as required via Microsoft team or in person were appropriate	1 hour fortnightly

The Project Senior Responsible Officer (SRO) will be the Chief Operating Officer. The Divisional Operations Director for SCEC is the Projects Sponsor. A Project Manager will be in place to support the development of the business case.

Throughout the development of the proposals regular briefings and communications have been scrutinised and reported to the Trust Hospital Management Board Investment Group (HMB-IG), Business Case Review Panel (BCRP), Capital Committee and ultimately the Trust Board. Engagement with the Norfolk and Waveney ICB and new Norfolk and Waveney University Hospitals Group (NWUHG) governance is proposed but not yet defined.

Membership of the NNUH project board and sub-groups are outlined in the appendix. Terms of reference are in place for Robotic Steering Group and the relevant sub-boards and beyond.

6.5 Workforce Strategy

This business case does not include any pay costs, and thus there is no requirement for a workforce strategy from a staff recruitment, training and retention perspective.

This business case however will require the training of additional robotic surgeons and supporting theatre teams. The Trust has sufficient robotic trained surgeons to commence utilisation of two additional robots from commencement, and therefore the training of further surgeons is not imperative to the delivery of this case. However, providing training to others is an important factor in delivering some of the key benefits. The chosen supplier will support the Trust in the development and implementation of a thorough training plan for both surgeons and theatre teams, which will be put into place ahead of presentation of the full business case.

6.6 Risks and Benefits

The project group will regularly review the project Risk Register during the fortnightly meetings addressing risks in both the clinical and infrastructure workstreams. Management of the project risks will be managed through the dynamic risk register (extract below). A comprehensive report and update on these risks will be issued as part of wider project reporting to the Project Board. The highest rated risks are escalated to Divisional Board and Trust Capital & Estates Committee and as appropriate.

Table 25 - Project Risk Log

Reference	Area	Risk	Cause	Effect	Controls	Owner
IoR-01	Business Objectives/Projects	Additional robots impact on other elective Pathways	If the Trust invests in additional robots	Then there may be unintended adverse impacts on existing elective patient demand	1. Robust Capacity Planning - review of additional activity and impact across specialities 2. Introduction of additional infrastructure/capacity rather than shifts 3. Non robot activity being displaced is factored into theatre timetable elsewhere	Project Board
IoR-02	Clinical Quality	Infrastructure	If the Trust does not have adequate infrastructure available for this investment	Then there may be delays to treatment using the robots	1. Infrastructure assessment undertaken / gap analysis vs service specification 2. Early and wide engagement with departmental leads to conduct local review of requirements and benchmarking against peer sites 3. Project management structure in place to ensure oversight and timeline in place	Project Board
IoR -03	Clinical Quality	Impact on CCC Demand	If there is insufficient CCC capacity to manage additional robot patients	Then there would be significant clinical consequences and delays to patients being received at NNUH	1. CCC pathway to form part of clinical reference group 2. Demand & Capacity Models undertaken peer reviewed by project group and local leads	Project Board
IoR-04	Clinical Quality	Poor engagement	If there is poor engagement from stakeholders	Then the clinical case for change and operating model may not work effectively	1. Project group established 2. Communication and engagement strategy in place 3. Protected time from clinical teams at NNUH to partake in project groups, modelling in place	Project Board
IoR-05	Clinical Quality	Speciality Based Risks	If there is insufficient workforce and infrastructure allocated to key specialities involved in post op care	Then there may be adverse patient outcomes and delays to post op care	1-Early engagement undertaken with all local specialty / ward leads 2-Assessment and gap analysis undertaken at speciality level built into wider project plan	Project Board
IoR-06	Compliance	Compliance with NICE guidance	If the Trust is unable to meet the required standards set in specific NICE guidance	Then the Trust will be unable receive and manage robotic patients and may not fully utilise additional robots	1. Robust governance structure in place with a dedicated Robotic Steering Group 2. Clinical Trust robotic Lead in place 3. Quarterly KPI reviews undertaken 4. Audit plan in place for robotics 5. Speciality robot leads in place 6. Dedicated infrastructure in place for robotic surgery	Project Board
IoR-07	Financial	Failure to deliver planned activity	If the Trust is unable to meet the planned level of activity set out in the business case	There will be an adverse impact on the income position within the case	1. Phased increase in activity assumed within income model 2. Capacity and demand modelling completed with conservative view taken towards improvements in case volumes	Project Board
IoR-08	Business Objectives/Projects	Delay in obtaining necessary approvals or committee signoffs	If key approvals are not obtained within the project milestones	Then this could result in delayed orders, missed timeline targets, and lost commercial opportunities	1. Engage with approval committees early to pre-empt requirements	Project Board
IoR-09	Financial	Inability to close non-pay deficit gaps (unaffordability of preferred option)	If a route to closing existing gaps in non-pay cost pressures are not identified	Then the project will likely be unaffordable in current financial envelopes or/and worsen the trusts underlying financial position	1. Engagement with PLC and Theatre teams to explore cost-neutral solutions and validate current consumables assumptions 2. Regular financial reassessments	Project Board

IoR-10	Financial	Income unaffordability to system	If additional income is assumed above current baseline levels of activity	Then this may not be affordable/reimbursed within the ICB financial envelope due to caps on income set out in the financial framework for FY25-26	1. Engagement with finance senior management team 2. Engagement with ICB and contractual colleagues 3. Limited activity proposed in FY25/26 for which the framework is applicable to, mitigating impact of potentially lost income above baseline laparoscopic tariffs	Project Board
IoR-11	Financial	Inability to replace robotic systems at end of life.	If future capital is not available due to initial charitable funding and lack of alignment with replacement planning.	Then clinical services may be disrupted or forced to rely on outdated or unsupported equipment.	1. Engage procurement early on long-term strategies (e.g. leasing, managed service contracts) 2. Align with capital planning and equipment lifecycle.	Project Board & Procurement

Table 26 - Benefits Register

Benefit Details								Benefit Monitoring					
Reference	**Benefit Name**	**Benefit Description**	**Category**	**Associated Investment Objective**	**QALY**	**Feature (Activities Required)**	**Benefit Owner**	**KPI / Calculation of Benefit**	**Assumptions Made in Calculation**	**Data Sources Used to Calculate Benefit**	**Baseline**	**Target**	**Risk RAG**
IoR-01	Reduction in Surgical Complications	Decreased post operative complications due to enhanced surgical precession of robots	QB	IO1	QALY	Robots in place Protocols for Robotic Procedures	Project Board	% Complications Rate % Re-Admissions Rate	Value adjusted calculations of a patient with minor complication vs without complications c. £6,000 for applicable procedures*	https://pubmed.ncbi.nlm.nih.gov/25791798	2.58% Readmission Rate 2023 (BI)	0.2% Readmission Rate	
IoR-02	Reduced Length of Stay	Reduced elective length of stay due to minimally invasive procedures and improved recovery times	QB	IO3	QALY	Training staff, Robots in place	Project Board	Average Length of Stay for Elective Patients a) Robotic b) Non-Robotic	Value adjusted cost of a G&A bed day at c. £400 *for applicable procedures	NHS National Schedule of Reference Costs 2017-18	4.2 Days 2022/23	3.3 Days	
IoR-03	Reduced Procedure Time	Reduction in operative minutes of procedures compared with open or laparoscopic surgical methods	QB	IO1 IO3	Non- QALY	Robots in Place Scheduling Procedures	Project Board	Average Procedure Time for a) Robotic b) Non-Robotic	£32 per min as per NNUH Patient Level Costings methodology *for applicable procedures	Patient Level Costings data 2019-2023	266 mins 2022/23	231 mins	
IoR-04	Enhanced Reputation	Improved hospital reputation to attract skilled workforce and improved patient trust	Non-QB	IO4 IO5	Non- QALY	Marketing / Branding Recruitment Programmes	Project Board		N/A	N/A	N/A	N/A	
IoR-05	Enhanced Patient Experience	Higher patient satisfaction due to less pain, quicker recovery, and minimally invasive procedures.	QB	IO1	QALY	Bespoke Patient Feedback Collections/Follow-Ups	Project Board	FFT Feedback	Gradual improvement from baseline over 12 months from introduction of x2 robots. For Surgical Division, DC/Inpatients	Friends and Family Test Scores (Envoy)	94.4% August 2024	95.5%	
IoR-06	Compliance with Best Practice Recommendations (% Daycase Rates)	Increased ability to perform more procedures as day cases, reducing the need for overnight stays.	QB	IO1	Non- QALY	Appropriate Data Feed to GIRFT/Model Hospital	Project Board	GIRFT % Daycase Rate by Specialty		Model Hospital – Organisational level daycase rates for British Association of Day Surgery (*3 months to month end)	80.4% May 2024	83.5%	

IoR-07	Enhanced Workforce Development	Collaboration with suppliers to provide courses, fellowships and improved training experience for surgical trainees	QB	IO5	QALY	Robots in Place Training Programmes Developed Supplier Engagement	Project Board	GMC Survey Scores	N/A	N/A	N/A	N/A	
IoR-08	Delivery of Activity Plans	Delivery of surgical elective activity plans for daycase and elective with improved scheduling (IoR3) and reduced complications (IoR1) allowing for additional cases to be completed.	QB	IO2 IO3	QALY	Robots in Place Scheduling Procedures	Project Board	Variance to Elective Activity Plan	Activity delivered in line with timetable	Commissioning Data Sets			
IoR-09	Reduction in Blood Loss	Smaller incisions and improved visualisation, dexterity result in reduced blood loss and transfusion requirements during operative procedures	QB	IO1	QALY	Robots in Place Training		Average Blood Loss a) Robotic b) Non-Robotic					

6.7 Projects Tolerances

Table 27 - Project Tolerances

Area	Proposed Tolerance Level
Cost	There is **LOW** cost tolerance.
Time	There is a **LOW** tolerance for delay of contract negotiation and procurement.
Scope	There is a **LOW** tolerance for changes in scope.
Risk	There is a **LOW** tolerance for risk impacting services.
Benefits	The work stream **CAN** tolerate increased benefits.
Quality	The work stream **CAN** tolerate increased quality.

6.8 Post Implementation Review

The Trust has a well-developed and documented guide to follow for all Business Cases.

The Robotic Steering Group will host a workshop at an agreed time following implementation with multi-disciplinary stakeholders involved. This will be in accordance with the Trust's Post Project Review (PPR) procedure. The workshop will allow a thorough review of all the project specific outcomes and analyse project success against the original objectives. The evaluation is a team effort, where each member of the team can put forward their point of view, identifies good practice, advises on lessons learnt and makes suggestions to benefit future projects. It is recognised that a successful aspect of the project for one party, may have been perceived as detrimental by another.

The workshop will:

- Allow data collection
- Review the project baseline against the proposal/ brief
- Review the actual outcome against the baseline
- Review project approach/processes, including project organisation, governance & controls
- Review contributor's performance including external suppliers
- Analyse success against the objectives
- Allow documentation of the review and learning for future projects.

Each of these will be considered through the various stages of the project from inception to completion of the construction contract and rectification of snagging.

A Pre-Workshop Survey will be conducted as part of the PPR workshop preparation. The questionnaire will be issued as a separate document prior to the workshop. The PPR guide details topics for evaluation with section headings including, start-up and design, procurement and construction, handover, operations, and user perspective and follows a comprehensive set list of questions for each section. Further to this the PPR will include pre and post occupancy valuation with patients and staff members which is described in the section below titled Pre and Post Occupancy Evaluation.

Following the completion of the workshop the Facilitator will produce a project close report addressing:

- Completion against schedule.
- Achievement of forecast budget.
- Rationale for any variations, and mitigating action taken.
- Recommendations for future projects.
- Functional suitability and patient outcomes.
- Review against critical success factors and investment objectives
- Review of working relations between suppliers.
- Lesson Learned.

The report will be used to complete the Trust's post implementation review documentation and ensure compliance with Trust governance process.

7. Recommendation

Norfolk and Norwich University Hospitals are committed to a vision of achieving excellence in surgical innovation and for the associated development of specialist services to the East of England population.

It is therefore recommended that the **Strategic Outline Case for the Institute of Robotic Surgery proceeds to tender for the preferred option, will a Full Business Case developed following this exercise.**

8. Appendices

8.1 Table of Figures

8.2 Strategic Case for Change: Clinical Outcomes to Date

8.2.1 Urology

Urology is a speciality with an established experience base in this field of surgery, having used such technology for the previous ten years. The procedures currently undertaken by Urology at NNUH include Prostate, Kidney (partial nephrectomy), and Bladder (Cystectomy) surgery.

Cystectomy outcomes
The research presented by Catto et al. (2022) demonstrates the positive perioperative benefits of robotic surgery in Robotic Radical Cystoprostatectomy and Cystectomy patients.

- Reduced thromboembolic complications (1.9% vs 8.3%); decreased wound complications (5.6% vs 16.0%) and post-op blood transfusion rate (7% vs 12%)
- Readmission after discharge: 21.8% for iRARC and 32.2% for Open Radical Cystectomy (ORC)
- Intraoperative blood transfusion: 2.6% for iRARC and 6% for ORC
- The patient health-related outcomes for general health, disability, stamina and cancer are all improved on individual measures for these areas.

Partial Nephrectomy outcomes
A retrospective outcomes analysis was completed with Mr Rochester comparing 674 da Vinci, 70 laparoscopic and 183 open partial nephrectomies completed between August 2010 and 2023. Da Vinci robotic-assisted partial nephrectomy offers several benefits, including:

- The average length of stay for da Vinci was one day. Compared to 3 days for laparoscopic and five days for open partial nephrectomy
- Lower complication rate for da Vinci (0.29%) compared to open partial nephrectomy (1.6%)
- The conversion rate for laparoscopic partial nephrectomy is 1.5% compared to 0.29% for da Vinci.
- Shorter operative time for da Vinci (80 minutes) compared to 112 minutes lap and 95 minutes open approach.

Other improved outcomes include:

Reduction in the length of stay for robotic-assisted laparoscopic prostatectomy (RALPs) from 4 days to 2 days
- Reduction in the transfusion rate for RALP from 45% to less than 0.2% for patients in theatre
- There was a considerable reduction in the length of stay for cystectomies from 14 days to an average of 7
- The readmission rate was 20% with an open procedure, and this has been reduced to 10%
- ICU admissions for cystectomies have reduced from 100% to 75% and will continue to fall with changes in the clinical understanding of risk following an audit of outcomes.
- Reduced cancer waiting times for diagnosis.
- Reduced cancer waiting times to be treated.

Mark Rochester case observation, proctor. NNUH Urology Centre of Reference for da Vinci robotic-assisted Surgery.

8.2.2 Gynaecology

Gynaecological Oncology at NNUH is performing the current indications: Hysterectomy, Para-aortic lymphadenectomy, Total hysterectomy and pelvic lymphadenectomy, hysterectomy in patients with severe obesity.

Mr Duncan completed a retrospective analysis of 50 Malignant Hysterectomy via laparoscopy and da Vinci at NNUH, and the outcomes showed the following improvements:

- The length of stay was reduced from 1.4 days (Lap) to 1.1 days (da Vinci)
- There were no 30-day post-operative complications for the da Vinci patients, compared to 8% (lap)
- There were no 30-day readmissions for the da Vinci patients, compared to 9.1% (lap)
- Lymph nodal upstaging improved from 16.4% lap compared to 3.4% da Vinci.

Other improved outcomes include:

- Increased rate of MIS for high BMI, complex patients (previously treated via an open approach)
- Reduced rate of open surgery
- The sentinel lymph node programme started with Firefly (fluorescence imaging available on the da Vinci)
- Sentinel lymph node accuracy (bilateral detection) has increased from 69% with laparoscopic to 91% with robotic approach
- 0% conversion rate for robotic cases
- Reduced operating pressures, allowing easier ventilation with obese patients, has allowed
- greater numbers of these challenging patients access to surgery

Tim Duncan case observation, proctor. NNUH Gynaecology Centre of Reference for da Vinci robotic-assisted Surgery.

8.2.3 Colorectal

The colorectal team have benefited from many improved clinical outcomes through robotic-assisted surgery. The team has developed and led innovative techniques such as complete mesocolic excision for right colon cancer and intracorporeal anastomosis, which have been proven to reduce recovery times and hernia rates. A retrospective analysis of 110 laparoscopic compared to 74 da Vinci colorectal resections was completed on a cohort of patients treated by Prof Irshad Sheikh. The study showed the following improved outcomes:

- The conversion rate for the laparoscopic patients reduced from 16% to 0% for the da Vinci cohort.
- The anastomotic leak rate was reduced from 5.5% lap to 4% for the da Vinci patients.
- Overall complications were reduced from 20% lap to 12.2% for da Vinci.
- The median length of stay reduced from 5 days (lap) to 3 days for da Vinci.
- Prof Irshad Sheikh case observation, proctor. NNUH Colorectal Centre of Reference for da Vinci robotic-assisted Surgery

Other improved outcomes include:

- Right hemicolectomy laparoscopic complication rate from 28% down to 13% for robotics
- Length of stay for right hemicolectomy from 6 days down to 5
- Right colon Anastomotic leak rate from 8% to 0% for robotics.
- A series of 10+ patients (the first in the country) were discharged on the same day.

Prof Irshad Sheikh case observation, proctor and centre of reference Achievement. Proctor for robotic-assisted surgery across the UK and EU

8.2.4 Thoracics

Thoracic data from NNUH shows that the surgery volume has almost doubled from less than 100 cases in 2012 to 180+ since the start of the da Vinci programme in 2020. In FY 2023-24, it's expected that the number of robotic-assisted thoracoscopic (RATS) lung resections at NNUH will be over 150 cases, with a small number of cases being performed open (thoracotomy) and by video-assisted thoracoscopic surgery (VATS). This is based on lung cancer resections of circa 250 per annum. The initiated NHS screening programme will significantly increase workload by 20-30% in next 2-3 years with more sublobar sections. The increase in RATS has led to several significant improvements in outcomes, as shown in a recent retrospective of 55 RATS patients compared to 85 VATS lung resections by Mr Vasilious Kouritas's. The retrospective analysis showed the following improved outcomes:

- The length of stay was reduced from 5 days (VATS) to 3 days RATS.
- There were no unplanned critical care admissions for RATS, compared to 15% VATS.
- There were no 30-day readmissions for RATS compared to 9% for VATS.
- Operative time was reduced from 215 minutes for VATS to 198 minutes for RATS.

Mr Bartosik robotic data with 123 cases showed similar outcome improvement. Average lobectomy time was 111 mins with a higher number of resected lymph nodes.

Mr Vasilious Kouritas / Mr Waldemar Bartosik case observation, proctor. NNUH Thoracic Center of Reference for da Vinci robotic-assisted Surgery.

8.2.5 Head and Neck

An NNUH retrospective analysis of 44 patients undergoing Transoral robotic surgery (n23 TORS) and transoral laser microsurgery (n21 TLM) was completed between 01/01/20 and 30/06/23.

The analysis suggests that TORS is better than TLM at identifying the primary site in head and neck squamous cell carcinoma of unknown primary HNSCCUP and reduces the chance of patients receiving adjuvant therapy. These findings support the possibility of TORS as a treatment de-escalation for cases of HNSCCUP.

- Managing head and neck squamous cell carcinomas of unknown primary (HNSCCUP) is challenging due to the difficulties in finding the primary site.
- The oropharynx is a complex area to assess and operate in without causing significant morbidity – the invention of transoral surgical techniques has made operating easier.
- Transoral robotic surgery (TORS) and transoral laser microsurgery (TLM) are two popular transoral surgical techniques - relatively few studies have compared their ability to identify the primary site in cases of HNSCCUP.
- More primary sites were identified in patients who underwent TORS than those who underwent TLM, resulting in TORS patients receiving less adjuvant therapy.

8.3 Strategic Case for Change: Proposed Robotic Specialties

Upper GI

Currently, most Oesophageal cancer patients are treated with an open technique nationally. The robotic approach offers several benefits over conventional open and laparoscopic approaches. For example, the robotic approach allows 3D Vision and wristed articulation to perform an accurate mediastinal dissection of the Oesophagus en bloc, with surrounding lymphatic tissue and mediastinal fat, often harbouring metastatic disease. Dissection of the greater curvature of the stomach is often difficult with MIS/Open techniques due to the lack of vision and access due to a lack of articulation. This can lead to damage to the gastroepiploic vessels that supply the future gastric tube. The robotic platform with ten times magnification would reduce this risk and could lead to lower complications post-operatively. Tumours in the upper mediastinum and paratracheal lymph node metastases are often very close to or in contact with the mediastinal blood vessels. These are often very difficult to access with open and laparoscopic approaches. With the robot, this region can be accessed accurately without compromise leading to a superior oncological result. Access to additional robotic-assisted surgery at NNUH will improve our minimal access surgery rate and reduce this procedure's technical complexity.

Paediatrics

NNUH paediatric surgery has been at the forefront of paediatric laparoscopic surgery since its inception in 1997. Following this, the Trust was one of the only two centres in UK successfully starting urological reconstructive surgery in 2004. Most other units are now on par with NNUH in laparoscopic surgery. Despite the early adoption of laparoscopic surgery, paediatrics have not been able to develop their robotic assisted surgery offer. This is despite one surgeon completing a fellowship for training in paediatric robotic urology.

Robotic-assisted surgery offers several benefits for paediatric patients. Firstly, it allows for more precise and accurate surgical procedures, minimizing the risk of complications. The robotic system provides enhanced visualization and magnification, enabling surgeons to perform delicate procedures with greater precision. Secondly, the minimally invasive nature of robotic-assisted surgery results in smaller incisions, reducing post-operative pain and scarring. Paediatric patients often experience faster recovery times and shorter hospital stays compared to traditional open and laparoscopic surgery.

The robotic system's advanced technology also allows for improved dexterity and range of motion, enabling surgeons to navigate complex anatomical structures more effectively. This can be particularly advantageous in paediatric cases where the organs and tissues are smaller and more delicate.

The paediatric team are keen to commence advanced reconstructive urological procedures robotically, including bladder augmentations, Mitrofenoff, pyeloplasties, reimplantations and pelvic procedures. As well as the well documented improvement to patient outcomes, this would result in fewer patients being transferred to London and have the potential to attract work from neighbouring hospitals such as ESNEFT should the Trust wish to pursue this. The introduction of robotic paediatric activity would also significantly boost the reputation of the NNUH paediatric service.

General Gynaecology and Endometriosis

Implementing robotic-assisted surgery for gynaecology and endometriosis at NNUH will increase surgical capacity by reducing operative times while enhancing precision compared to traditional laparoscopy. The integration of robotic surgery will facilitate cross-specialty collaboration with urology, colorectal, and thoracic teams, who are increasingly preferring robotic approaches for complex cases. The enhanced 3D visualization provided by robotic systems will improve the identification and excision of endometriotic lesions, allowing more complete surgeries. This approach is especially beneficial for complex benign cases, such as fibroid uteri, patients with high BMI, multiple C-sections, or those with large fibroids or adhesions. By transitioning from open surgery to robotic surgery, the hospital can expect shorter hospital stays and higher rates of same-day discharge. In the long term, expanding robotic-assisted procedures to uro-gynaecology will further bolster the NNUH's reputation as a leader in innovative surgical care.

Complex Abdominal Wall Surgery

The potential expansion of RAS into the sub-speciality of abdominal wall addresses the complexities associated with these procedures, which often involve higher-risk patients requiring extensive and physically demanding open surgeries that can last up to six hours. Currently, only a limited number of surgeons are equipped to handle these cases at NNUH, and there are no viable alternatives for patient transfer to other units. As the demand for these surgeries continues to grow, transitioning to a robotic approach could significantly enhance surgical capacity, allowing for a potential increase in case throughput, reducing waiting times and improving patient outcomes.

While laparoscopic techniques have been attempted, they often result in longer operating times, prompting the surgical team to seek robotic solutions. The integration of RAS not only promises improved patient outcomes through reduced pain and complications but also

addresses operational efficiencies by optimising theatre time, thereby positively impacting waiting lists without the need for external transfers or decommissioning services. Additionally, any future robotic platforms will be evaluated for their training and proctoring opportunities, with capabilities compatible with existing mesh used in abdominal wall surgeries considered a core requirement.

Plastic Surgery

Exploring the use of additional robotic capacity in plastic surgery presents a unique opportunity to enhance precision and outcomes in various procedures and become one of the first centres in the UK to introduce RAS into this area. Initial focus will be on collaborating with the plastic surgery department and suppliers to identify procedures where robotic assistance could provide the most benefit, drawing from emerging literature in microsurgery and breast surgery highlighting improved outcomes.

8.5 Commercial Case: Procurement SOR Document

SOR Template - Robotics - RM1 NNL

8.6 Management Case: Project and Steering Group Membership

Table 28 - Robotic Steering Group

Steering Group Role	Name	Job Title
Chair	James Hernon	General Surgery Consultant
Clinical Lead - Theatres Robot User	Mark Rochester	Urology Consultant
Clinical Director – Planned Care	Michael Irvine	Clinical Director – Planned Care
Robot User	Bhaskar Kumar	General Surgery Consultant
Robot User	Cristina Viola	Thoracic Consultant
Robot User	Gautam Raje	Obstetrician & Gynaecologist Consultant
Robot User	Irshad Shaikh	General Surgery Consultant
Robot User	Medha Sule	Obstetrician & Gynaecologist Consultant
Robot User	Michael Lewis	General Surgery Consultant
Robot User	Nassif Ramez	ENT Consultant
Robot User	Nicholas Penney	General Surgery Consultant

Robot User	Nikolaos Burbos	Gynaecological Oncologist Consultant
Robot User	Simon Wemyss-Holden	General Surgery Consultant
Robot User	Sreedharan Loveena	General Surgery Consultant
Robot User	Timothy Duncan	Consultant Gynaecological Oncologist
Robot User	Vasileios Kouritas	Thoracic Consultant
Robot User	Vivekanandan Kumar	Urology Consultant
Robot User	Waldemar Bartosik	Thoracic Consultant
Theatres Nursing Lead	Charlotte Ellis-Brown	Non-Elective Theatres Matron
Theatres Nursing Lead	James Noble	Interim Senior Matron - Surgical Support
Theatres Support	Nadine Barford	Clinical Practitioner - Main Theatres
SCP Lead	Dolly Dowsett	Surgical Care Practitioner
Operational Lead - ENT	Wajia Abbas	ENT Operational Manager
Operational Lead - Theatres	Fiona Cotterill	Operations Manager
Operational Lead - Theatres	Mollie Snelling	Operational Manager
CSSD Lead	TBC	Operational Manager
Administrative Support	Andrea Plumstead	Administrator

Table 29 - Robotic Surgery Project Board

Steering Group Role	Name	Job Title
Chair	James Hernon	General Surgery Consultant
Project Management	Toby Lewis	Senior Business Manager
Operational Lead	Ed Aldus	Associate Operations Director
Operational Lead - Theatres	Mollie Snelling	Theatres Operational Manager
CSSD Lead	TBC	CSSD Operational Manager
Estates Lead	Dale Smith	Programme Manager
Procurement Lead	Jonathan Wade	Procurement Business Partner

Digital Health Lead	TBC	TBC
Charitable Funds Lead	TBC	TBC
Project Officer	Andrea Plumstead	Administrator

Table 30 - Project Communication

Interested Party	Information Requirements	Frequency of Comms	Method of Communication
HMB / Charity Committee	Highlight Report Summary	Monthly	FI&P Committee during business case development. Then the Major Projects Assurance Committee during delivery.
	Programme Risks	Monthly	
Care Group Board	Highlight Report Summary	Monthly	Board Meeting
	Risks Report	Monthly	Board Meeting
Robotic Surgery Project Board	Highlight Report Summary Risks Report	Fortnightly	Governance Meeting
	General communications	Ad Hoc	Email
	Exception Report	Ad Hoc	Email
Robotic Steering Group	Direction	Fortnightly	Email/ One-to-one basis / telephone
	Highlight report	Fortnightly	Email
	General communications	Ad Hoc	Email/ One-to-one basis / telephone
Programme Sponsor	Highlight report	Monthly	Email
Project Manager	Direction	Weekly	Board meeting (face-to-face)
	Progress updates	Weekly	One-to-one basis / telephone
	Project Issues	Ad Hoc	Email
	Project Risks	Ad Hoc	Email
	Project plan	At Initiation	Hard Copy

8.7 ICB Letters of Support

[To Be Sought in May 2025]

8.8 Charitable Funds Letter of Support

[To Be Sought at CFC 5th June 2025]

8.9 GIRFT RAS Delivery Checklist

[To Be Completed During OBC]

Integrated Performance Report

April 2025

Key Operational Priorities

Our Vision
The best care for every patient

2025-26 Headline Operational Priorities

NHS
Norfolk and Norwich University Hospitals
NHS Foundation Trust

Operational Priorities	Description	2025-26 Plan	Apr-25 Plan	Apr-25 Actual	Variance to Month Plan	Commentary	RAG
Urgent and Emergency Care							
Improve A&E Waiting Times	The proportion of patients that were admitted, discharged or transferred from ED within 4 hours	80.9%	80.7%	80.2%	-0.5%	3rd consecutive month above 80% but below the April plan. Ranked 19th across all Type 1 NHS Trusts in April.	
	The proportion of patients that were admitted, discharged or transferred from ED within 12 hours	96.0%	96.5%	94.8%	-1.7%	Performance was below the April 2025 plan but higher than 3 of the last 4 months.	
Elective Care							
18 Weeks	Improve the percentage of patients waiting no longer than 18 weeks for treatment	60.1%	52.8%	51.9%	-0.9%	Performance was below April plan – predominantly due to the overall waiting list reduction in April, aided by the validation sprint, where the majority of removals took place at the front end of the pathway. Current May performance is correcting the April variation and returning to trajectory.	
	Improve the percentage of patients waiting no longer than 18 weeks for a first appointment	67.0%	57.9%	57.9%	0.0%	In line with April plan.	
52 Weeks	Reduce the proportion of people waiting over 52 weeks for treatment to less than 1% of the total waiting list	2.2%	4.6%	4.8%	+0.2%	Performance was above April plan – predominantly due to the overall waiting list reduction in April, aided by the validation sprint, where the majority of removals took place at the front end of the pathway.	
Cancer							
28-Day Faster Diagnosis Standard	Improve performance against the 28-day Cancer Faster Diagnosis Standard	80.0%	68.5%	*79.7%* (provisional)	+11.2%	Closed March performance was above target at 82.9%. Provisional April performance has reduced to 79.7% but is above the April plan.	
62-Day Performance	Improve performance against the headline 62-day Cancer standard	65.0%	60.1%	*52.2%* (provisional)	-7.9%	Closed March performance was below target at 51.8%. Provisional April performance has increased to 52.2% but is below the April plan.	

Urgent and Emergency Care

Our Vision
The best care for every patient

Improve A&E Waiting Times – ED 4 Hour Performance

NHS
Norfolk and Norwich University Hospitals
NHS Foundation Trust

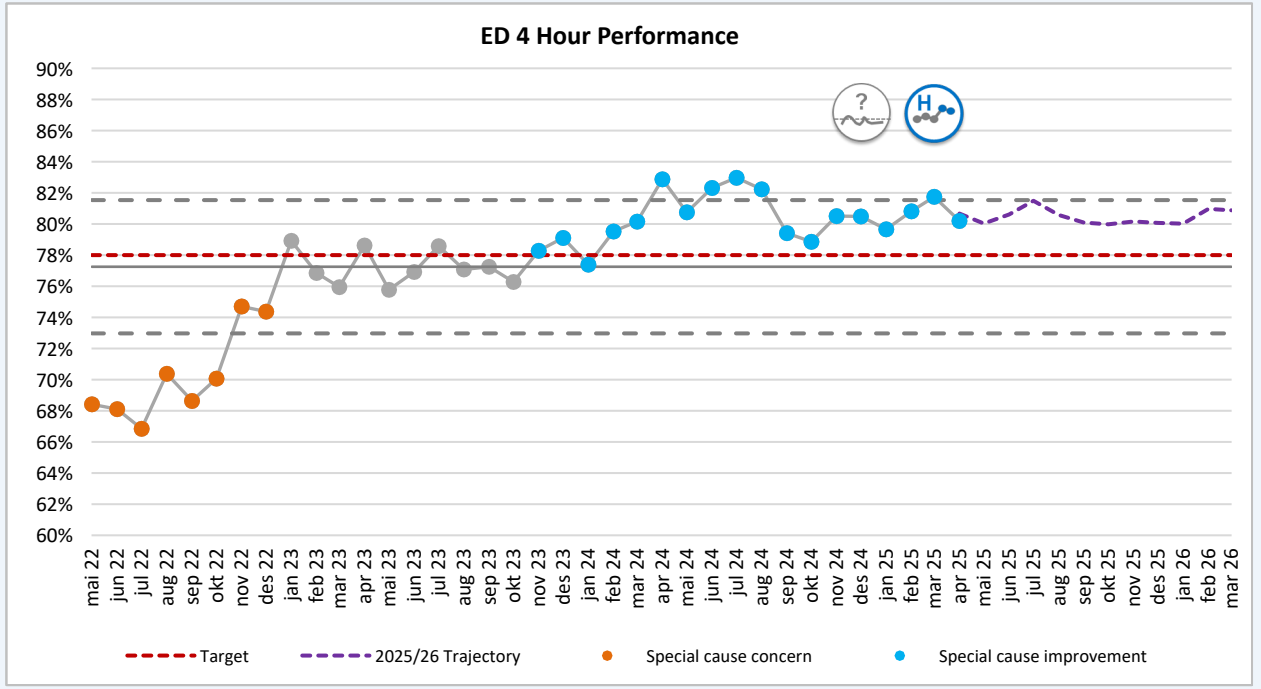
Commentary

April 2025 Performance
Combined 4-hour performance for April 2025 = **80.2%** - this is below the April plan (80.7%) but above the March 2026 national target of 78.0%.

Type 1 4-hour performance for April 2025 = 67.2%

Risk To Delivery

GREEN

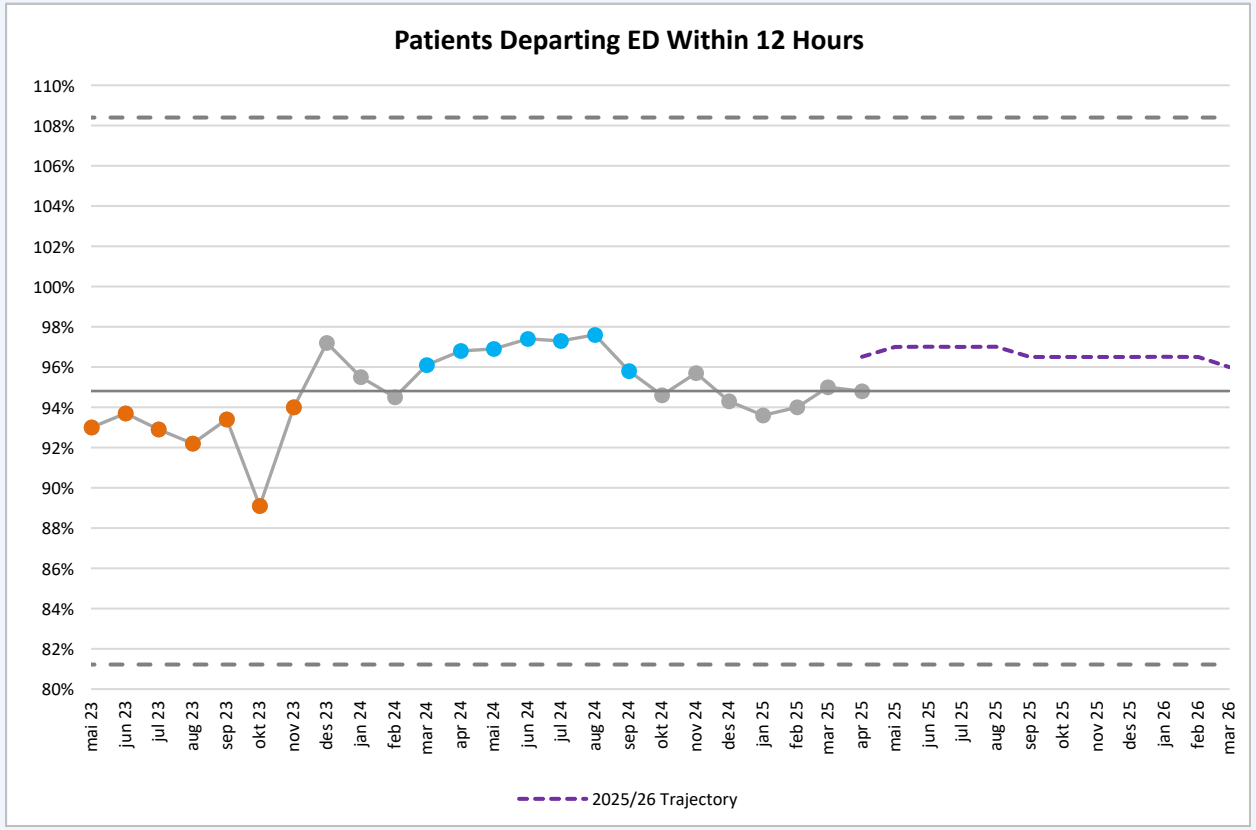


4 Hour Performance - April 2025: 80.2%

Category	Type	Tue Apr 01	Wed Apr 02	Thu Apr 03	Fri Apr 04	Sat Apr 05	Sun Apr 06	Mon Apr 07	Tue Apr 08	Wed Apr 09	Thu Apr 10	Fri Apr 11	Sat Apr 12	Sun Apr 13	Mon Apr 14	Tue Apr 15	Wed Apr 16	Thu Apr 17	Fri Apr 18	Sat Apr 19	Sun Apr 20	Mon Apr 21	Tue Apr 22	Wed Apr 23	Thu Apr 24	Fri Apr 25	Sat Apr 26	Sun Apr 27	Mon Apr 28	Tue Apr 29	Wed Apr 30	April Avg.
Type 1 Breaches	ED Admitted	70	65	67	77	74	50	64	70	73	64	73	71	68	60	71	78	74	69	60	43	60	61	72	75	79	68	64	62	79	64	68
	ED Non-Admitted	62	54	37	95	64	59	66	65	63	74	99	53	84	59	51	72	58	59	59	36	59	80	81	83	77	56	70	90	67	61	66
	Type 1 Breaches	**132**	**119**	**104**	**172**	**138**	**109**	**130**	**135**	**136**	**138**	**172**	**124**	**152**	**119**	**122**	**150**	**132**	**128**	**119**	**79**	**119**	**141**	**153**	**158**	**156**	**124**	**134**	**152**	**146**	**125**	**134**
Type 1 Attendances	ED Admitted	93	77	87	99	92	74	87	79	90	87	83	85	77	73	92	86	86	93	95	79	77	83	88	88	101	85	79	78	94	80	86
	ED Non-Admitted	311	312	283	345	309	319	349	309	330	300	327	281	334	347	297	335	302	307	321	308	321	351	336	353	319	296	306	410	333	341	323
	Type 1 Attendances	**404**	**389**	**370**	**444**	**401**	**393**	**436**	**388**	**420**	**387**	**410**	**366**	**411**	**420**	**389**	**421**	**388**	**400**	**416**	**387**	**398**	**434**	**424**	**441**	**420**	**381**	**385**	**488**	**427**	**421**	**409**
Type 1 (ED) Admitted		24.7%	15.6%	23.0%	22.2%	19.6%	32.4%	26.4%	11.4%	18.9%	26.4%	12.0%	16.5%	11.7%	17.8%	22.8%	9.3%	14.0%	25.8%	36.8%	45.6%	22.1%	26.5%	18.2%	14.8%	21.8%	20.0%	19.0%	20.5%	16.0%	20.0%	**21.1%**
Type 1 (ED) Non-Admitted		80.1%	82.7%	86.9%	72.5%	79.3%	81.5%	81.1%	79.0%	80.9%	75.3%	69.7%	81.1%	74.9%	83.0%	82.8%	78.5%	80.8%	80.8%	81.6%	88.3%	81.6%	77.2%	75.9%	76.5%	75.9%	81.1%	77.1%	78.0%	79.9%	82.1%	**79.4%**
Type 1 (ED) Combined		67.3%	69.4%	71.9%	61.3%	65.6%	72.3%	70.2%	65.2%	67.6%	64.3%	58.0%	66.1%	63.0%	71.7%	68.6%	64.4%	66.0%	68.0%	71.4%	79.6%	70.1%	67.5%	63.9%	64.2%	62.9%	67.5%	65.2%	68.9%	65.8%	70.3%	**67.2%**
Type 1, 2 and 3 Combined		81.0%	81.6%	83.9%	76.3%	80.6%	83.9%	82.1%	79.3%	79.7%	78.7%	73.9%	81.2%	77.2%	83.2%	81.4%	77.7%	79.9%	80.8%	82.8%	87.5%	83.0%	80.4%	77.8%	77.4%	76.4%	81.4%	78.8%	79.5%	77.7%	81.2%	**80.2%**

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

Improve A&E Waiting Times – ED 12 Hour Performance



Commentary

April 2025 Performance

The percentage of patients that were admitted, discharged or transferred from ED within 12 hours in April 2025 was 94.8% - this is below the April 2025 plan (96.5%) but above 3 of the last 4 months.

Reason for Variation

- Intentional overnight stays in OPED 4 bed bay
- Medical bed availability.

Actions

- Remove OPED from 4-hour clock.

Risk To Delivery

AMBER

Elective Care

65 Weeks – Specialty Level Forecast to 31st May 2025

Specialty		Weekly Removal Averages / Total Future TCIs	11/04/2025	18/04/2025	25/04/2025	02/05/2025	09/05/2025	12/05/2025	16/05/2025	23/05/2025	30/05/2025	31/05/2025	Breaches 149
502 - Gynaecology	Will Breach	-	480	375	337	253	196	163	141	96	51	50	50
	Weekly Removals	71	51	105	38	84	57	33	22	45	45	1	
110 - Trauma and Orthopaedic	Will Breach	-	259	206	162	116	91	84	57	36	24	21	21
	Weekly Removals	54	55	53	44	46	25	7	27	21	12	3	
140 - Oral Surgery	Will Breach	-	88	84	73	66	60	60	47	35	20	18	18
	Weekly Removals	9	12	4	11	7	6	0	13	12	15	2	
120 - Ear Nose and Throat	Will Breach	-	166	150	141	90	80	75	61	36	18	15	15
	Weekly Removals	21	36	16	9	51	10	5	14	25	18	3	
100 - General Surgery	Will Breach	-	114	100	86	62	52	43	37	25	13	10	10
	Weekly Removals	24	28	14	14	24	10	9	6	12	12	3	
101 - Urology	Will Breach	-	92	73	61	52	47	46	34	24	13	9	9
	Weekly Removals	12	14	19	12	9	5	1	12	10	11	4	
108 - Spinal Surgery	Will Breach	-	43	34	32	23	18	17	16	11	9	9	9
	Weekly Removals	10	5	9	2	9	5	1	1	5	2	0	
130 - Ophthalmology	Will Breach	-	44	30	27	16	13	13	10	9	7	7	7
	Weekly Removals	11	8	14	3	11	3	0	3	1	2	0	
215 - Paediatric Ear Nose and Throat	Will Breach	-	50	43	42	33	32	31	21	15	6	5	5
	Weekly Removals	6	5	7	1	9	1	1	10	6	9	1	
160 - Plastic Surgery	Will Breach	-	42	36	33	24	22	21	17	10	4	3	3
	Weekly Removals	5	10	6	3	9	2	1	4	7	6	1	
340 - Respiratory Medicine	Will Breach	-	77	56	48	34	26	19	15	9	4	2	2
	Weekly Removals	14	17	21	8	14	8	7	4	6	5	2	

Commentary

Current Position

The end of April 65-week breach position was 157. Current end of May forecast is 120-149.

Forecast position for June:

Currently 80 at risk. Specialty summit planned for week of 26th May to reduce further. Aim remains zero position for 30th June.

Actions

1. Specialty summit week commencing 26th May.
2. Continue to validate waiting list to ensure all patients have been contacted / are clinically fit and ready to proceed.
3. Maximise theatre utilisation – Productive Partners
4. Daily PTL oversight to continue to ensure grip and control over booking processes.
5. Continued use of mutual aid.

Risk To Delivery

- Ongoing theatre capacity constraints
- Trust restructure
- Vacancies in ENT and Gynae

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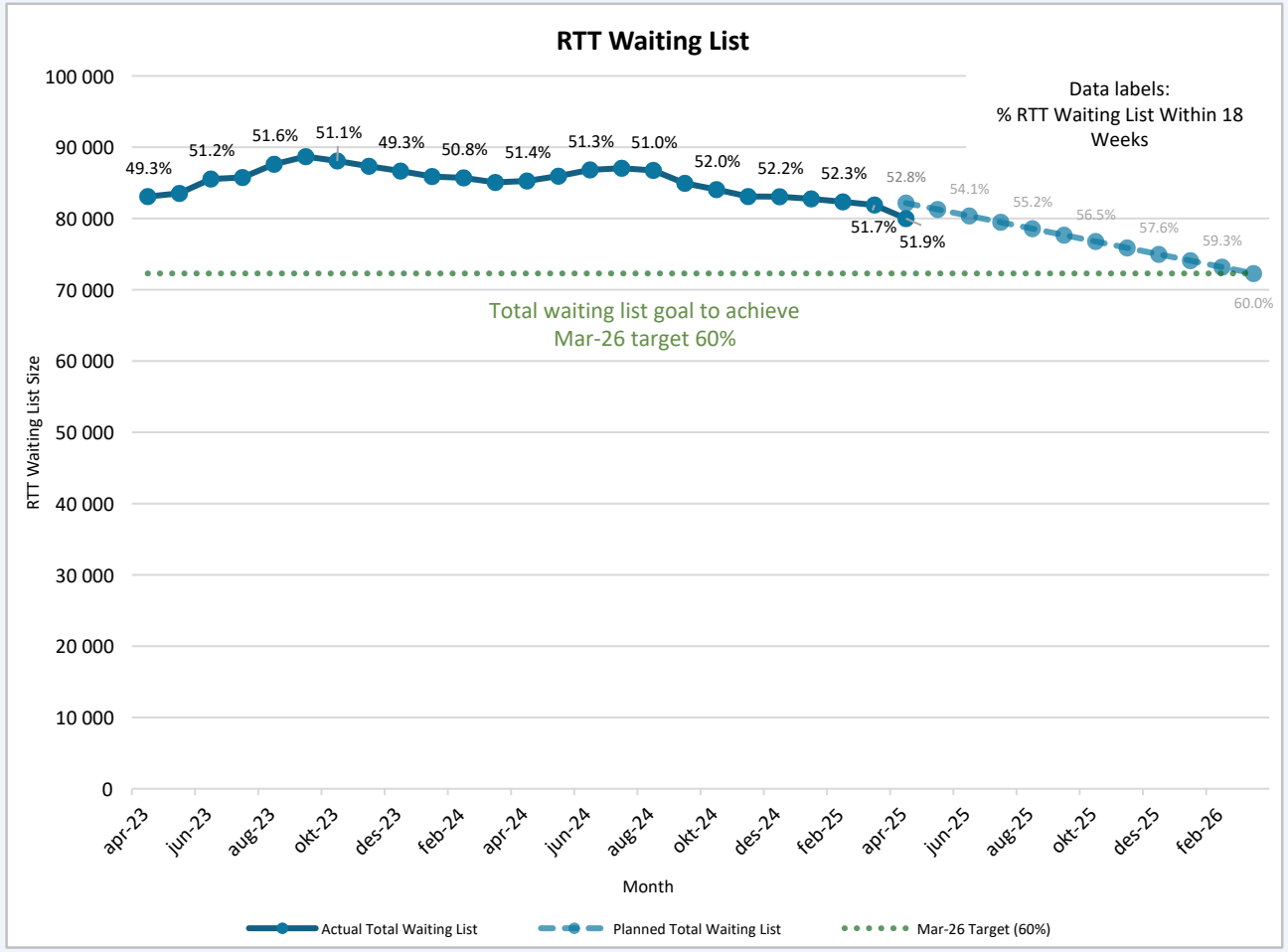
Our Vision
The best care for every patient

Percentage of Patients Waiting Less than 18 Weeks for Elective Treatment

NHS
Norfolk and Norwich University Hospitals
NHS Foundation Trust



RTT 18 Week Performance – April 2025	
April Performance	51.9%
April Plan	52.8%
Variation	-0.9%
RAG	
Reason	Validation

RTT 18 Week Performance – May 2025	
May Performance (Current)	53.9%
May Plan	53.8%
Variation	0.0%
RAG	
Reason	Forecasted return to plan in May

The chart above illustrates the RTT waiting list size with 18-week performance annotated, displayed as actuals (dark blue) and planned (light blue).

Our Vision
The best care for every patient

Percentage of Patients Waiting Less than 18 Weeks for Elective Treatment (Specialty Level)

NHS
Norfolk and Norwich University Hospitals
NHS Foundation Trust

		Delivery	Apr-25	May-25 (current)	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Trust	RTT waiting list	Actual	79,987	*79,534*										
		Trajectory	82,163	81,265	80,367	79,470	78,572	77,674	76,776	75,878	74,980	74,082	73,185	72,287
	RTT 18-week performance	Actual	51.9%	*53.8%*										
		Trajectory	52.8%	53.8%	54.1%	54.6%	55.2%	55.8%	56.5%	57.1%	57.6%	58.6%	59.3%	60.0%
110 - Trauma and Orthopaedic	RTT waiting list	Actual	9,333											
		Trajectory	9,253	9,110	8,994	8,873	8,748	8,623	8,495	8,371	8,252	8,115	7,988	7,863
	RTT 18-week performance	Actual	40.0%	*41.8%*										
		Trajectory	41.1%	42.0%	42.3%	42.8%	43.4%	44.0%	44.7%	45.3%	45.8%	46.8%	47.6%	48.3%
101 - Urology	RTT waiting list	Actual	4,854											
		Trajectory	4,734	4,698	4,651	4,608	4,565	4,522	4,481	4,438	4,393	4,355	4,313	4,271
	RTT 18-week performance	Actual	60.1%	*61.6%*										
		Trajectory	61.6%	62.5%	62.8%	63.3%	63.9%	64.4%	65.1%	65.6%	66.1%	67.0%	67.6%	68.3%
502 - Gynaecology	RTT waiting list	Actual	7,179											
		Trajectory	7,301	7,190	7,099	7,005	6,906	6,809	6,709	6,613	6,520	6,413	6,315	6,216
	RTT 18-week performance	Actual	41.3%	*43.0%*										
		Trajectory	41.7%	42.6%	43.0%	43.5%	44.1%	44.7%	45.4%	46.0%	46.5%	47.5%	48.2%	49.0%
120 - Ear Nose and Throat	RTT waiting list	Actual	8,628											
		Trajectory	8,646	8,520	8,414	8,305	8,192	8,079	7,965	7,853	7,745	7,624	7,510	7,396
	RTT 18-week performance	Actual	40.1%	*41.8%*										
		Trajectory	43.3%	44.2%	44.6%	45.1%	45.7%	46.3%	47.0%	47.6%	48.1%	49.1%	49.9%	50.6%
130 - Ophthalmology	RTT waiting list	Actual	4,689											
		Trajectory	4,786	4,754	4,709	4,667	4,626	4,585	4,546	4,506	4,462	4,427	4,388	4,347
	RTT 18-week performance	Actual	65.7%	*65.8%*										
		Trajectory	64.0%	64.9%	65.2%	65.7%	66.2%	66.8%	67.4%	67.9%	68.4%	69.2%	69.9%	70.5%
340 - Respiratory Medicine	RTT waiting list	Actual	2,108											
		Trajectory	2,127	2,100	2,076	2,050	2,024	1,999	1,973	1,948	1,923	1,896	1,871	1,845
	RTT 18-week performance	Actual	41.4%	*48.9%*										
		Trajectory	47.9%	48.9%	49.2%	49.7%	50.3%	50.9%	51.6%	52.2%	52.7%	53.7%	54.5%	55.2%
341 - Respiratory Physiology	RTT waiting list	Actual	1,759											
		Trajectory	1,911	1,877	1,852	1,824	1,796	1,767	1,738	1,710	1,683	1,651	1,622	1,593
	RTT 18-week performance	Actual	33.5%	*34.9%*										
		Trajectory	34.9%	35.8%	36.1%	36.6%	37.1%	37.7%	38.4%	38.9%	39.5%	40.4%	41.1%	41.9%
330 - Dermatology	RTT waiting list	Actual	4,929											
		Trajectory	4,831	4,782	4,730	4,679	4,627	4,576	4,525	4,474	4,423	4,372	4,322	4,270
	RTT 18-week performance	Actual	58.3%	*61.3%*										
		Trajectory	54.4%	55.4%	55.7%	56.2%	56.8%	57.4%	58.1%	58.7%	59.2%	60.1%	60.9%	61.6%
320 - Cardiology	RTT waiting list	Actual	3,847											
		Trajectory	4,072	4,041	4,001	3,963	3,926	3,889	3,853	3,816	3,777	3,745	3,708	3,672
	RTT 18-week performance	Actual	56.0%	*57.5%*										
		Trajectory	61.4%	62.3%	62.6%	63.1%	63.7%	64.2%	64.9%	65.4%	65.9%	66.8%	67.4%	68.1%
100 – General Surgery	RTT waiting list	Actual	5,535											
		Trajectory	6,529	6,466	6,398	6,330	6,265	6,198	6,133	6,065	5,998	5,934	5,868	5,803
	RTT 18-week performance	Actual	61.8%	*62.8%*										
		Trajectory	56.3%	57.3%	57.6%	58.1%	58.7%	59.3%	60.0%	60.6%	61.0%	62.0%	62.7%	63.4%

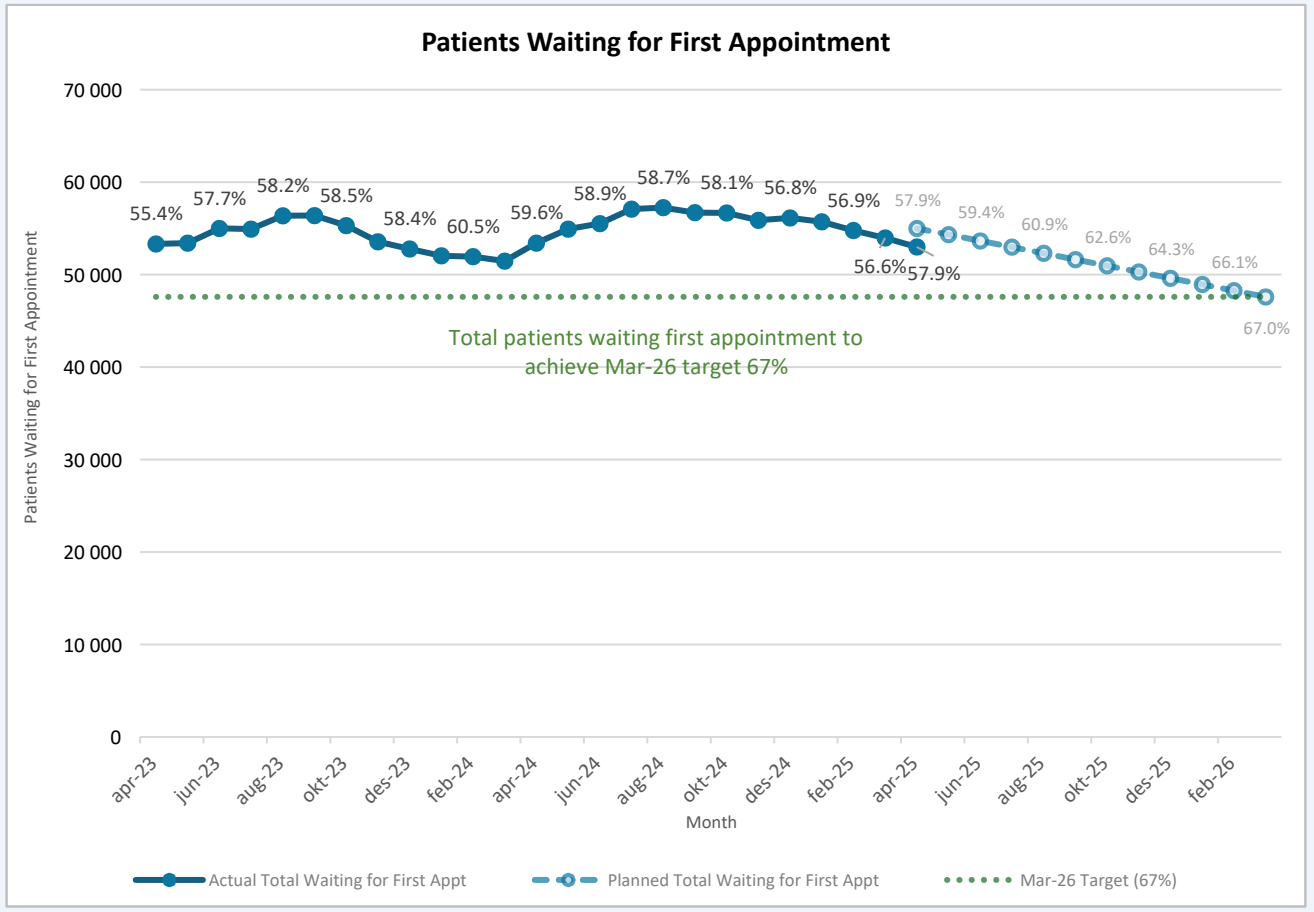
Performance Update

18-week performance was 51.9% in April 2025 against a plan of 52.8%.

Validation Sprint: total validated pathways = 18,192 (+18% above baseline expectations). This included 4,429 removals from the waiting list in April – the majority of these were under 18 weeks wait and therefore this negatively affected 18-week RTT percentage performance.

May is currently (up to 16th May) correcting the April variation and returning to trajectory (currently 53.8% against the May plan of 53.8%).

Percentage of Patients Waiting Less than 18 Weeks for First Appointment

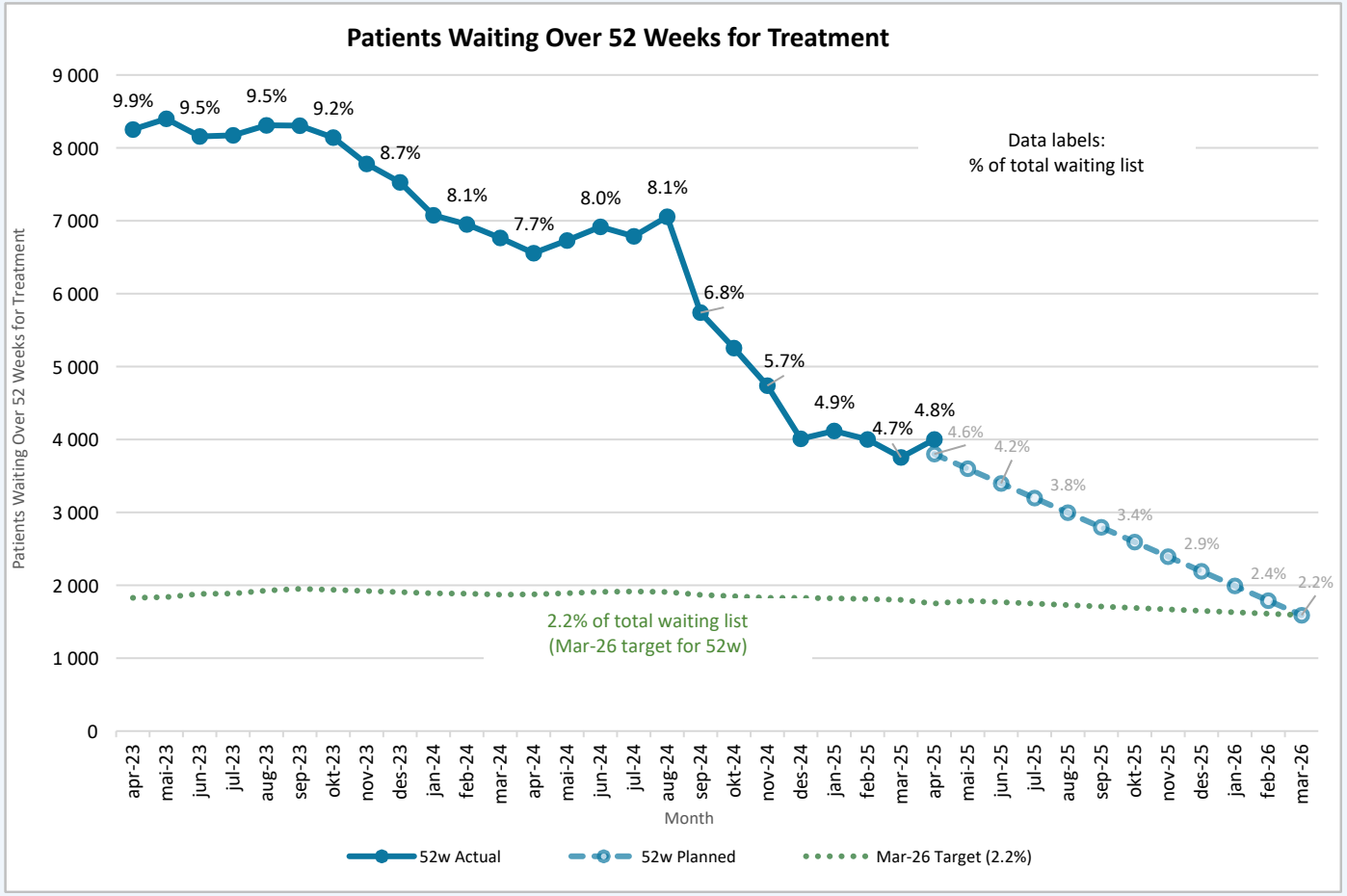


Patients Waiting for First Appointment <18 Weeks – April 2025	
April Performance	57.9%
April Plan	57.9%
Variation	0.0%
RAG	

Patients Waiting for First Appointment <18 Weeks – May 2025	
May Performance (Current)	59.5%
May Plan	58.7%
Variation	+0.8%
RAG	

The chart above illustrates the number of RTT patients waiting for their first appointment, with performance annotated, displayed as actuals (dark blue) and planned (light blue).

Proportion of Patients Waiting Over 52 Weeks for Treatment



RTT 52 Week Performance – April 2025	
April Performance	4.8%
April Plan	4.6%
Variation	0.2%
RAG	
Reason	Validation

RTT 52 Week Performance – May 2025	
May Performance (Current)	4.6%
May Plan	4.4%
Variation	0.2%
RAG	
Reason	Validation

The chart above illustrates the number of RTT patients waiting over 52 weeks for treatment, with performance annotated, displayed as actuals (dark blue) and planned (light blue).

Elective Care – Actions and Risks Summary

Specialty	Actions (May 2025)	Risks for Current / Future Months
Trauma and Orthopaedics	• Continued use of mutual aid to reduce long waits and reduce time to first OPA • Prioritisation of theatre and clinic's for longer waiting patients • Maximise theatre utilisation (Productive Partners) • Expand pre-assessment clinics to avoid late cancellations	• Trust restructure • WLI risk
Ear, Nose and Throat	• Review pathway delays in diagnostic stages • Prioritise all >40-week waiters for pooled new OPA • "42 Week" dashboard under development	• Vacancies within consultant staff group • Diagnostic dependencies (Audiology, MRI) causing delay
Gynaecology	• Continued use for local mutual aid, in first OPA • Targeted validation • Prioritise Histology reporting in May and June • Increase OPH clinics over weekends during May and June • Confirm mutual aid slots by mid-May and book all >50w patients	• Late referrals and inconsistent triage • High vacancy factor across the speciality
Urology	• Explore mutual aid • Productive Partners – 42 Weeks / Theatre Utilisation	• Very high volume of referrals into the service impacting RTT and Cancer (public VIP)

Cardiology	• Increase uptake of community diagnostics (CDC) for Echo/ECG
	  ○ Offer virtual follow-ups where appropriate
	  ○ Prioritise longest waiters weekly
	• Complete full PTL review of >40w patients
		• CDC reporting delays impacting decision to treat
		• Workforce constraints for face-to-face OPAs

Respiratory Medicine	• Run dedicated validation sprint for long waiters
	  ○ Deliver targeted "wait list cleanse" clinics
	  ○ Explore digital respiratory triage solutions
		• Limited clinic capacity for diagnostics + follow-ups
		• High DNA risk in chronic patients without digital engagement

Respiratory Physiology	• Changes to pathway underway – virtual review of results without the need to bring in patients where appropriate	• Diagnostic result delays impact onward treatment • Workforce shortages in physiology staff

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Diagnostic Test Within 6 Weeks (DM01)

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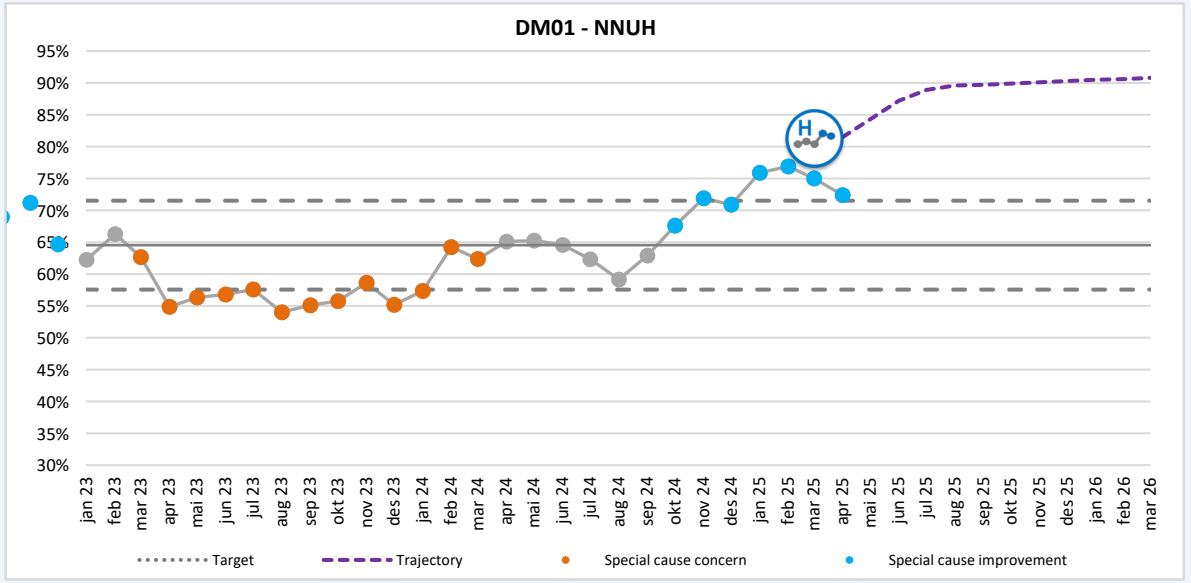
NHS Foundation Trust



Commentary

April 2025 Performance

Overall, Trust DM01 performance in April was 72.4% compared to the April plan of 81.5%. Reduced from March performance of 75.0%.

Risk To Delivery

RED

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

Exam Type	Apr-25	Variance to Exam Type Plan	Reasons for Variation in Performance	Actions	Risks for Current Month
MRI	70.0%	-12.0%	20% sickness rate in April	• Additional 9 lists managed to be added for May through skill mix review. • Review of staffing structure for consideration of on call impact. • Focused efforts on case mix booking in accordance with staffing skill mix with the introduction of 6:4:2 GIRFT processes to allow for booking changes in time, while sickness is still high. • Morning huddles for IP/ED case mix review	Staffing sickness levels and increasing on call and subsequent impact of compensatory rest on staff unavailability.
CT	76.2%	-5.8%	Sickness and vacancies and focus on reducing breaches / long waits for April. Improved DM01 performance due to staff skill mix review and ensuring sufficient capacity for all elective streams: 2ww, long waits, DM01, interventional, despite variance in activity plan	• Continue with cardiac training and a revision of cardiac service. • Focused efforts on case mix booking in accordance with staffing skill mix with the introduction of 6:4:2 GIRFT processes to allow for booking changes in time, while sickness is still high. • Morning huddles for IP/ED case mix review	AMDU bed availability for elective work. Cardiac service – review of acquisition and reporting options to be tabled in May.
NOUS	91.5%	-1.5%	Minimal change but primarily impacted by bed availability.	Use of NCIR recovery space where possible. Seeking alternative recovery space.	If ED/IP pressures continue, Trust bed availability for elective work compromised.
DEXA	99.8%	+0.8%	No concerns		
Echo	88.0%	+6.5%	Continuation of insourcing is seeing the positive variation in performance	Insourcing extension to commence April-June 2025	Physiologists not in post until 29th September 2025 (approx. 6 month wait for Physiologists to be in post)
Colonoscopy	45.8%	-15.9%	Endoscopist sickness and vacancy has impacted recovery trajectory, back fill cover for lists has been limited to single modality trained staff due to skill mix	Executive Summit – May Review of complex procedures cases (dye spray) and surveillance guidance, extra weekend lists for backlog clearance.	Workforce gaps
Flexi Sig	57.7%	-10.3%			
Gastroscopy	64.8%	-11.2%	Backlog of complex GA procedures, as well as staff sickness and vacancy.	Executive Summit – May Additional 3 lists for GA procedures, clinical review of remaining procedures to be completed	Workforce gaps
Grand Total	**72.4%**	**-2.6%**			

Activity

Commentary

April 2025 – Provisional Activity and May 2025 – Activity Forecast

As at 1st May, the provisional April position (below left) indicates that Activity was above plan (104%), predominantly due to Outpatient Follow Ups – excluding procedures (107%) and Outpatient News – excluding procedures (106%). Day Case (99%) and Electives (92%) were both below plan in April, with Outpatient Procedures (100%) in line with plan.

The bottom table provides further detail on the Activity, Plan and Variance to Plan by Care Group and Point of Delivery for April.

As at 15th May, the May forecast position shows booked activity at 106% of plan (below right).

AMBER

Commentary

April 2025 – Provisional Elective Variance Performance

£42k above plan in April (Summary by Point of Delivery provided across).

	Actual		Plan		Variance	
	Apr-25	Total	Apr-25	Total	Apr-25	Total
New Procedure	£840,432	**£840,432**	£785,899	**£882,394**	£54,533	**£54,533**
Follow Up Procedure	£1,695,394	**£1,695,394**	£1,700,759	**£2,290,215**	(£5,365)	**(£5,365)**
New Attendances	£3,378,839	**£3,378,839**	£3,035,953	**£3,660,884**	£342,887	**£342,887**
Daycase	£5,693,869	**£5,693,869**	£5,753,131	**£7,263,302**	(£59,262)	**(£59,262)**
Elective	£4,530,836	**£4,530,836**	£4,821,015	**£7,970,438**	(£290,179)	**(£290,179)**
Total	**£16,139,370**	**£16,139,370**	**£16,096,756**	**£16,096,756**	**£42,614**	**£42,614**

Business Plan Achieved
Business Plan Not Achieved

April 2025 – Provisional Activity

	A	B	C	D	E	F	G	H	I	J	Total
APC - Daycase	102%	85%	98%	99%	38%		120%	108%	105%		**99%**
APC - Elective	157%	76%	95%	98%			97%	49%	100%		**92%**
OP - Procedures	98%	98%	114%	111%		99%	95%	108%	89%		**100%**
OP - New (exc procedures)	114%	96%	108%	90%	210%	92%	122%	103%	103%	172%	**106%**
Subtotal - Variable	**108%**	**96%**	**106%**	**92%**	**160%**	**94%**	**109%**	**103%**	**101%**	**172%**	**102%**
APC - Non Elective	108%	106%	98%	103%			97%	92%	108%	90%	**99%**
OP - Follow Up (exc Procedures)	33%	98%	122%	114%	149%	101%	104%	128%	113%	115%	**107%**
Subtotal - Non Variable	**35%**	**98%**	**118%**	**110%**	**149%**	**101%**	**102%**	**127%**	**113%**	**98%**	**106%**
Overall	**45%**	**97%**	**111%**	**105%**	**152%**	**98%**	**105%**	**121%**	**109%**	**129%**	**104%**

May 2025 – Activity Forecast

	A	B	C	D	E	F	G	H	I	J	Total
APC - Daycase	65%	90%	106%	69%	111%		104%	104%	110%		**101%**
APC - Elective	77%	88%	102%	106%			133%	160%	98%		**101%**
OP - Procedures	89%	94%	122%	99%		84%	100%	97%	47%		**97%**
OP - New (exc procedures)	74%	99%	108%	98%	210%	96%	132%	116%	98%	182%	**110%**
Subtotal - Variable	**71%**	**94%**	**110%**	**96%**	**182%**	**92%**	**115%**	**114%**	**92%**	**182%**	**103%**
APC - Non Elective	110%	90%	101%	103%			90%	86%	94%	93%	**96%**
OP - Follow Up (exc Procedures)	35%	97%	130%	110%	91%	121%	106%	121%	113%	150%	**110%**
Subtotal - Non Variable	**36%**	**97%**	**126%**	**108%**	**91%**	**121%**	**101%**	**120%**	**112%**	**112%**	**108%**
Overall	**41%**	**95%**	**117%**	**104%**	**116%**	**110%**	**108%**	**119%**	**105%**	**141%**	**106%**

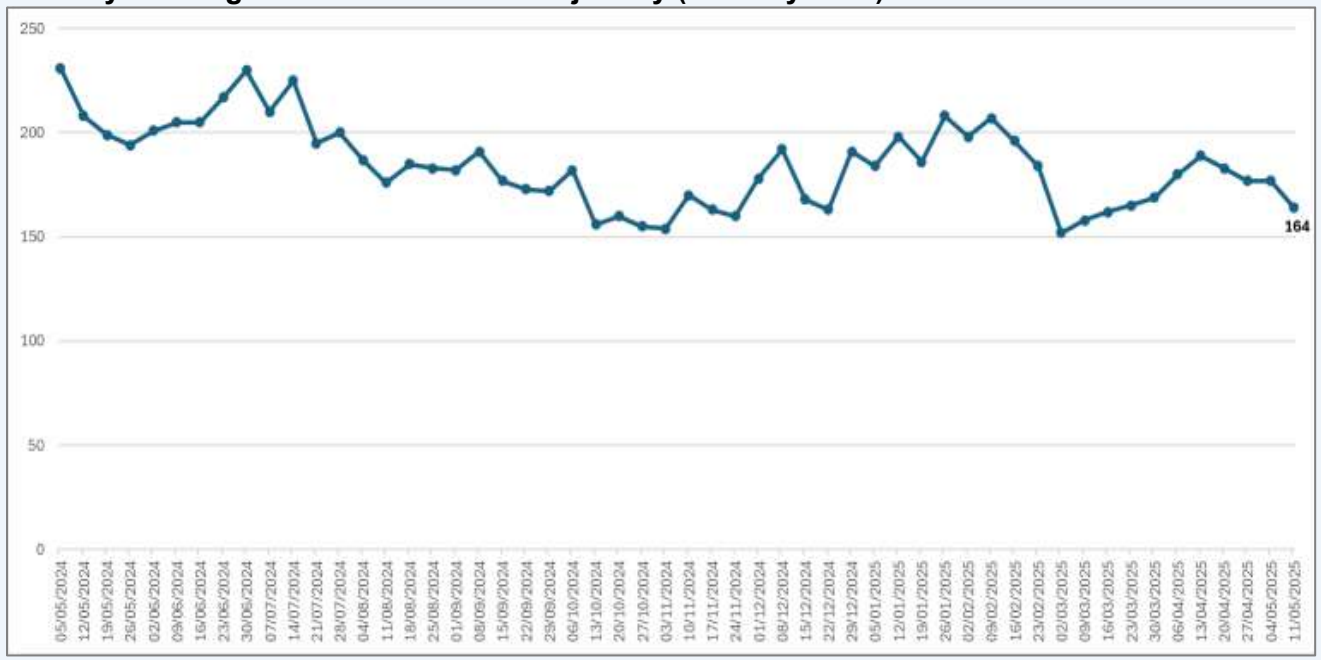
April 2025 – Provisional Activity (Care Group Detail)

NNUH	A - Surgical Support			B - Head & Neck			C - Gen Surg & Ortho			D - Maternity & Paediatrics			E - Radiology & Labs			F - Therapies			G - Medicine 1			H - Medicine 2			I - Cancer Services			J - Emergency & Acute			TOTAL		
	Activity	Plan	Var	Activity	Plan	Var	Activity	Plan	Var	Activity	Plan	Var	Activity	Plan	Var	Activity	Plan	Var	Activity	Plan	Var	Activity	Plan	Var	Activity	Plan	Var	Activity	Plan	Var	Activity	Plan	Var
APC - Daycase	175	171	4	1,137	1,334	(197)	2,675	2,740	(64)	152	153	(1)	3	8	(5)	0	0	0	623	519	104	301	279	22	1,112	1,058	54	0	0	0	**6,178**	**6,261**	**(83)**
APC - Elective	2	1	1	89	116	(27)	664	702	(37)	79	83	(4)	0	0	0	0	0	0	23	24	(1)	10	20	(10)	42	42	0	0	0	0	**908**	**987**	**(79)**
APC - Non Elective	45	42	3	307	291	16	1,250	1,277	(28)	1,598	1,555	43	0	0	0	0	0	0	1,560	1,606	(46)	182	199	(17)	249	230	19	378	421	(44)	**5,570**	**5,622**	**(52)**
Admitted - Total	**222**	**214**	**8**	**1,533**	**1,741**	**(208)**	**4,589**	**4,719**	**(129)**	**1,829**	**1,791**	**38**	**3**	**8**	**(5)**	**0**	**0**	**0**	**2,206**	**2,148**	**57**	**493**	**497**	**(4)**	**1,403**	**1,330**	**73**	**378**	**421**	**(44)**	**12,656**	**12,870**	**(214)**
OP - Procedures	27	27	(0)	8,851	8,989	(138)	2,799	2,460	339	117	105	11	0	0	0	545	552	(7)	2,017	2,126	(109)	55	51	4	535	600	(65)	0	0	0	**14,945**	**14,910**	**35**
OP - New (exc procedures)	253	222	31	2,510	2,605	(96)	6,449	5,956	493	1,358	1,514	(156)	42	20	22	1,195	1,301	(106)	2,582	2,122	460	1,183	1,148	35	1,078	1,046	33	789	458	331	**17,439**	**16,392**	**1,046**
OP - Follow Up (exc Procedures)	832	2,500	(1,668)	4,731	4,833	(102)	9,268	7,610	1,658	3,174	2,783	390	112	75	37	2,909	2,873	36	3,867	3,725	142	6,090	4,742	1,348	5,710	5,041	669	250	217	32	**36,942**	**34,399**	**2,543**
Non Admitted - Total	**1,111**	**2,749**	**(1,638)**	**16,092**	**16,428**	**(336)**	**18,515**	**16,026**	**2,489**	**4,649**	**4,403**	**246**	**154**	**95**	**59**	**4,649**	**4,726**	**(77)**	**8,467**	**7,973**	**493**	**7,328**	**5,940**	**1,387**	**7,322**	**6,686**	**636**	**1,039**	**675**	**364**	**69,325**	**65,701**	**3,624**
Total - NNUH	**1,333**	**2,963**	**(1,630)**	**17,625**	**18,169**	**(544)**	**23,104**	**20,744**	**2,360**	**6,478**	**6,194**	**284**	**157**	**103**	**54**	**4,649**	**4,726**	**(77)**	**10,672**	**10,122**	**551**	**7,821**	**6,438**	**1,383**	**8,726**	**8,016**	**709**	**1,417**	**1,097**	**320**	**81,981**	**78,572**	**3,409**

Cancer

62-Day Backlog Profile

62 Day Backlog – NNUH Actuals Vs Trajectory (11th May 2025)



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	+2	+1	+1
Children's	0	0	0	0
Gynaecological	26	-10	-2	-4
Haematological	3	-2	-3	0
Head & Neck	14	-2	+3	+6
Lower Gastrointestinal	31	0	+9	-13
Lung	6	-3	-5	-14
Sarcoma	3	0	0	-1
Skin	16	-4	-9	+7
Upper Gastrointestinal	2	-1	-3	-1
Urological	58	+7	-16	-13
Other	0	0	0	0
All Suspected Cancers	**164**	**-13**	**-25**	**-32**

Commentary

Current Position

Up to 11th May, the 62-day backlog saw a net decrease of 13 patients waiting over 62 days compared to the previous week, a reduction of 25 patients compared to 4 weeks ago and 32 patients compared to 12 weeks ago.

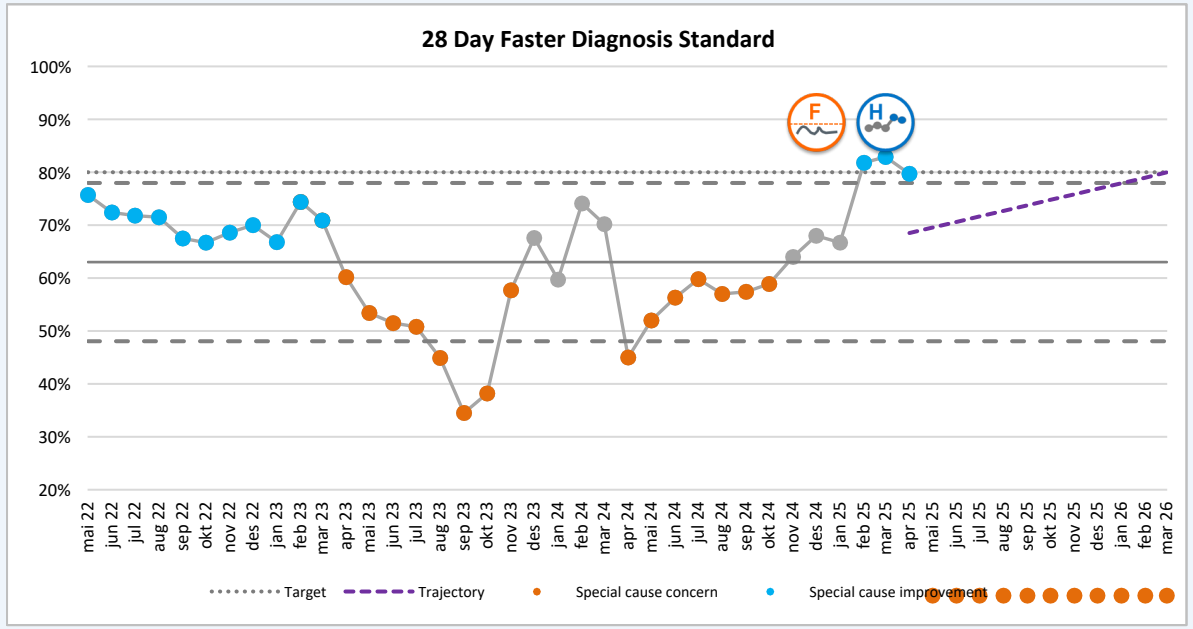
Reason for Variation

- Increase in Urology backlog as the service manages the high volume of treatments now exceeding tip overs.
- Reduction in Lung backlog due to the impact of CNS triage and pathway efficiency.
- Skin reduction due to an earlier increase in referrals.

Actions

- PMB clinics starting May 14th and then straight to OHP will ease the flow through the Gynaecology pathway.
- Skin – planning additional capacity to manage increased seasonal referrals – further capacity still to be identified.
- Urology – additional robotic lists utilised for April and May.

28-Day Faster Diagnosis Standard



Body Site	Mar-25 (Confirmed)	Apr-25 (Provisional)
Brain	85.7%	73.7%
Breast	93.0%	90.2%
Gynaecology	64.8%	59.9%
Haematology	21.4%	53.3%
Head and Neck	82.0%	82.6%
Lower GI	73.3%	70.7%
Lung	71.1%	63.6%
Paediatric	66.7%	62.5%
Sarcoma	50.0%	56.5%
Skin	83.5%	75.1%
Testicular	100.0%	100.0%
Upper GI	91.2%	93.6%
Urology	92.3%	93.7%
Grand Total	**82.9%**	**79.7%**

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

Commentary

Current Position

Closed performance in March was above the 2024/25 target at 82.9%. Provisional April performance is 79.7% - ahead of the April 2025 plan of 68.5%.

Reason for Variation

- Breast – strong performance with additional 1-stop capacity and Upper GI with CNS triage.
- Gynaecology – decline driven by rising PMB referrals, outpacing current triage and diagnostic capacity.
- Lower GI – remains above 70% following implementation of CNS led triage.
- Upper GI – CNS led triage embedded.
- Head & Neck – CNS led triage planned to commence in June to maintain performance.
- Urology – increased utilisation of CNS and middle grades in diagnostic phase. Improvement from 47.8% in January to ~90% in March and April, amongst the highest in the country.
- Skin – slight reduction in performance due to out of season increase in referrals volumes.

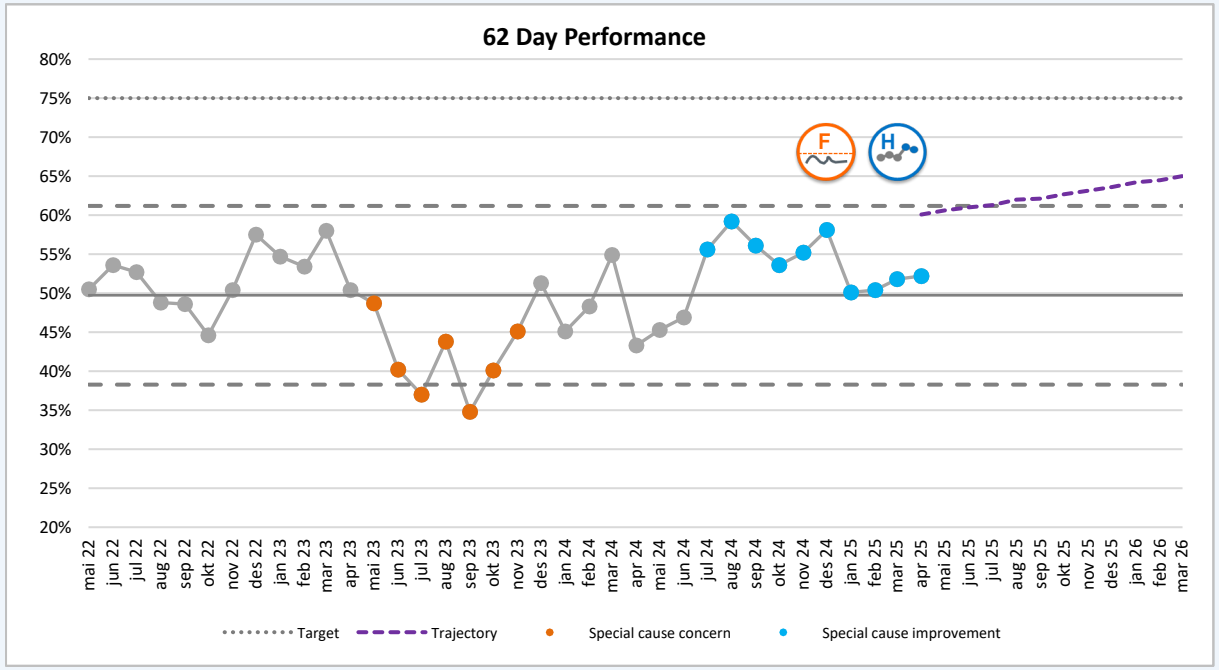
Actions

- Gynaecology – PMB CNS triage commencing May 14th, fully implemented June 2nd (48 slots per week). Reviewing outpatient and one-stop clinic capacity. May flex clinic templates or use insourcing / weekend sessions if demand remains high. Impact will be seen in June / July.
- Skin to identify and implement sufficient capacity to manage seasonal demand plus expansion of Telederm, flexing job plans, recruiting short term-locums.
- Lung – CNS team to triage referrals to expedite investigations, improvement seen in FDS by July.

Risk to Delivery

GREEN

62-Day Performance



Commentary

Current Position

Closed performance in March was 51.8% - below trajectory. Provisional April performance is at 52.2% - below April 2025 plan.

Reason for Variation

- Gynaecology – reduction in performance due to staff sickness and consultant leave.
- Head and Neck – robotic capacity for ENT patients.
- Skin – pathways still to be closed for April, including several complex histology cases requiring second opinions.
- Lower GI – performance remains low due to theatre capacity.
- Urology – performance improved from March but remains low due to treatment capacity vs recent high volume of referrals for prostate and bladder, alongside late tertiary referrals.
- Upper GI – performance reduced due to low volume treated in March, with tip overs into April due to complex cases requiring review at other hospitals. Body site performance remains in line with national average.

Actions

- Gynaecology – PMB clinics will facilitate the front end of the pathway for all patients. Additional OPH clinics planned for May and June. Majority of patients in backlog have TCIs for May.
- Head and Neck – additional theatre lists obtained for May and June to ensure that patients can be booked within target.
- Lower GI – team working to maximise theatre utilisation, with assistance from Productive Partners.
- Skin – progression of vacancies through triple lock process, with supporting detail behind PA sessions in relation to increases in USC clinics, surgery and Teledermatology activity for FDS and 62-day performance improvement.
- Upper GI – building on improved FDS performance to ensure timely transfer to surgery for treatment in time.
- Urology – additional robotic lists with increased pooling. Building on FDS performance for AS and hormones, plus surgery.

Risk To Delivery

RED

Body Site	Mar-25 (Confirmed)	Apr-25 (Provisional)
Breast	78.7%	84.3%
Gynaecology	51.2%	24.1%
Haematology	60.0%	57.1%
Head and Neck	46.2%	40.7%
Lower GI	22.2%	32.2%
Lung	33.3%	54.3%
Skin	90.5%	60.9%
Upper GI	93.3%	64.3%
Urology	32.7%	34.2%
Grand Total	**51.8%**	**52.2%**

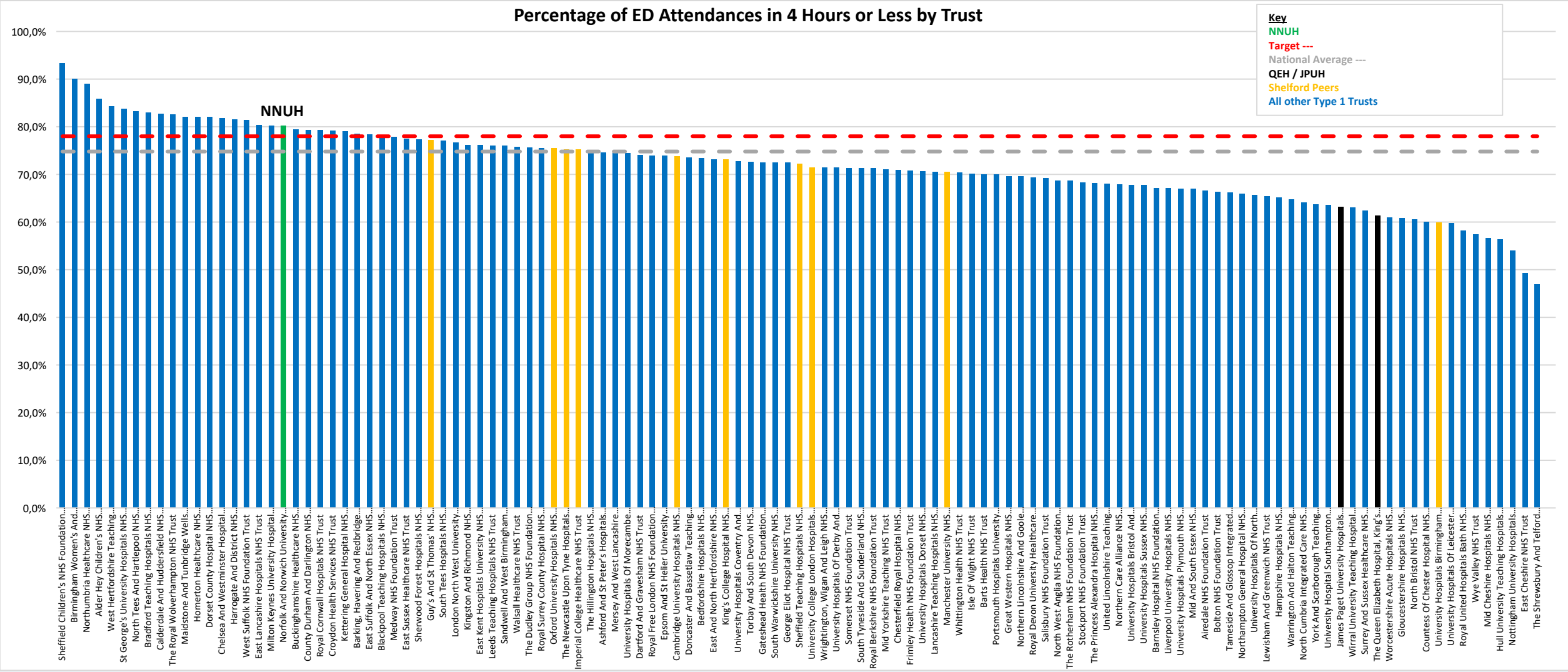
Key	
	Above trajectory
	Within 5% below trajectory
	More than 5% below trajectory

Regional / National Benchmarking

Our Vision
The best care for every patient

UEC: ED 4 Hour Performance – National Position (April 2025)

NHS
Norfolk and Norwich University Hospitals
NHS Foundation Trust



Commentary

In April, NNUH were ranked 19th across all Type 1 NHS Trusts and the best performing amongst our Shelford Group peers with 80.2% 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 April national average of 74.8%.

Elective: System and Provider Level Total Waiting Trend (East of England)

Commentary

The table below details the total elective waiting list trend by East of England Systems and Providers over the last 6 weeks (up to 11th May).
The NNUH average reduction of 694 patients per week from the waiting list (based on the last 4 weeks of data) was the 3rd largest average across the East of England providers.

Org code	Org Name	w-e 06 Apr 25	w-e 13 Apr 25	w-e 20 Apr 25	w-e 27 Apr 25	w-e 04 May 25	w-e 11 May 25	Change from previous week	Average volume change per week (based on latest 4 weeks)	Difference from weekly change to 4 week average
Y61	EAST OF ENGLAND	885,014	882,850	882,505	878,847	876,478	872,315	-4,163	-2,634	-1,529
QHG	NHS BEDFORDSHIRE, LUTON AND MILTON KEYNES INTEGRATED CARE	134,790	132,962	133,860	133,151	131,885	129,963	-1,922	-750	-1,172
QUE	NHS CAMBRIDGESHIRE AND PETERBOROUGH INTEGRATED CARE BOA	153,165	152,692	152,362	151,527	151,114	150,522	-592	-543	-50
QM7	NHS HERTFORDSHIRE AND WEST ESSEX INTEGRATED CARE BOARD	161,962	161,329	159,983	158,237	157,105	155,898	-1,207	-1,358	151
QH8	NHS MID AND SOUTH ESSEX INTEGRATED CARE BOARD	169,718	170,542	171,165	171,364	171,973	172,410	437	467	-30
QMM	NHS NORFOLK AND WAVENEY INTEGRATED CARE BOARD	141,780	142,202	142,071	141,592	141,676	141,191	-485	-253	-232
QJG	NHS SUFFOLK AND NORTH EAST ESSEX INTEGRATED CARE BOARD	123,599	123,123	123,064	122,976	122,725	122,331	-394	-198	-196
RC9	BEDFORDSHIRE HOSPITALS NHS FOUNDATION TRUST	103,237	101,593	102,085	101,346	100,035	98,097	-1,938	-874	-1,064
RGT	CAMBRIDGE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	67,670	67,158	67,132	66,873	66,949	66,579	-370	-145	-225
RWH	EAST AND NORTH HERTFORDSHIRE NHS TRUST	57,742	57,364	57,042	56,298	55,705	55,350	-355	-504	149
RDE	EAST SUFFOLK AND NORTH ESSEX NHS FOUNDATION TRUST	87,640	87,549	87,405	87,253	86,862	86,468	-394	-270	-124
RGP	JAMES PAGET UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	33,590	34,008	34,276	34,608	34,983	35,040	57	258	-201
RAJ	MID AND SOUTH ESSEX NHS FOUNDATION TRUST	169,718	170,542	171,165	171,364	171,973	172,410	437	467	-30
RD8	MILTON KEYNES UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	31,553	31,369	31,775	31,805	31,850	31,866	16	124	-108
RM1	NORFOLK AND NORWICH UNIVERSITY HOSPITALS NHS FOUNDATION	82,296	81,758	81,278	80,295	79,900	78,981	-919	-694	-225
RGN	NORTH WEST ANGLIA NHS FOUNDATION TRUST	78,154	78,161	77,887	77,363	77,047	76,926	-121	-309	188
RGM	ROYAL PAPWORTH HOSPITAL NHS FOUNDATION TRUST	7,341	7,373	7,343	7,291	7,118	7,017	-101	-89	-12
RQW	THE PRINCESS ALEXANDRA HOSPITAL NHS TRUST	55,846	55,736	55,113	54,344	53,339	52,328	-1,011	-852	-159
RCX	THE QUEEN ELIZABETH HOSPITAL, KING'S LYNN, NHS FOUNDATION TI	25,894	26,436	26,517	26,689	26,793	27,170	377	184	194
RWG	WEST HERTFORDSHIRE HOSPITALS NHS TRUST	48,374	48,229	47,828	47,595	48,061	48,220	159	-2	161
RGR	WEST SUFFOLK NHS FOUNDATION TRUST	35,959	35,574	35,659	35,723	35,863	35,863	0	72	-72

Elective: Validation Sprint (East of England Providers)

Commentary

The table below details the Validation Sprint performance by East of England providers, including a breakdown of the actual clock stops, the cumulative performance against baseline, the total waiting list, and the full 12-week validation sprint performance.
NNUH has validated 27,724 pathways (+19% above baseline expectations) since the commencement of the Validation Sprint, with a 4-week average of 4,612 actual clock stops.

*Clock stops as per validation methodology of comparing open pathways each week	Actual Clock Stops*					w-e 11 May 25		Cumulative Performance against baseline						Total WL (Latest Week)								
	04/05/2025	11/05/2025	4 Week Average	Variance from last week	Variance against 4 wk average	Baseline	Actual	Baseline	Actuals	Variance	% Variance	% Variance against Baseline (Last Week)	% point change from last week	Total WL at 30/03/25	11/05/2025	Change from previous week	Average volume change per week (based on latest 4 weeks)	Difference from weekly change to 4 week average	Change from 30/03/25	% Change	Full 12 week sprint baseline	12 week validation Performance
BEDFORDSHIRE HOSPITALS NHS FOUNDATION TRUST	8,383	8,192	7,279	-191	913	5,589	8,192	30,626	45,468	14,842	48%	49%	0%	103,307	98,097	-1,938	-874	-1,064	-5,210	-5.0%	65,236	88.5%
CAMBRIDGE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	4,520	3,839	3,901	-681	-62	3,668	3,839	22,832	24,814	1,982	9%	9%	-1%	67,661	66,579	-370	-145	-225	-1,082	-1.6%	47,405	88.2%
EAST AND NORTH HERTFORDSHIRE NHS TRUST	4,548	3,640	3,861	-908	-221	2,873	3,640	19,364	23,336	3,972	21%	19%	1%	57,840	55,350	-355	-504	149	-2,490	-4.3%	41,261	72.8%
EAST SUFFOLK AND NORTH ESSEX NHS FOUNDATION TRUST	5,659	4,867	4,816	-792	51	4,150	4,867	27,644	29,609	1,965	7%	5%	2%	87,187	86,468	-394	-270	-124	-719	-0.8%	56,623	0.0%
JAMES PAGET UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	2,047	2,189	1,918	142	271	2,154	2,189	12,955	11,947	-1,008	-8%	-10%	2%	32,992	35,040	57	258	-201	2,048	6.2%	27,158	23.5%
MID AND SOUTH ESSEX NHS FOUNDATION TRUST	12,705	10,912	10,857	-1,793	55	9,853	10,912	66,535	67,675	1,140	2%	0%	2%	169,718	172,410	437	467	-30	2,692	1.6%	136,855	61.7%
MILTON KEYNES UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	2,143	2,173	1,918	30	255	2,094	2,173	11,631	11,464	-167	-1%	-3%	1%	31,422	31,866	16	124	-108	444	1.4%	25,705	59.5%
NORFOLK AND NORWICH UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	4,758	4,774	4,612	16	162	3,663	4,774	23,312	27,724	4,412	19%	17%	2%	81,738	78,981	-919	-694	-225	-2,757	-3.4%	48,093	67.5%
NORTH WEST ANGLIA NHS FOUNDATION TRUST	5,103	3,956	4,422	-1,147	-466	4,549	3,956	27,237	26,978	-259	-1%	1%	-2%	77,788	76,926	-121	-309	188	-862	-1.1%	58,896	72.2%
ROYAL PAPWORTH HOSPITAL NHS FOUNDATION TRUST	503	489	448	-14	42	316	489	2,380	2,647	267	11%	5%	7%	7,363	7,017	-101	-89	-12	-346	-4.7%	4,907	29.3%
THE PRINCESS ALEXANDRA HOSPITAL NHS TRUST	3,473	2,776	2,745	-697	31	1,663	2,776	10,542	15,745	5,203	49%	46%	3%	55,297	52,328	-1,011	-852	-159	-2,969	-5.4%	23,273	84.4%
THE QUEEN ELIZABETH HOSPITAL, KING'S LYNN, NHS FOUNDATION TRUST	2,255	1,731	1,927	-524	-196	2,136	1,731	13,579	12,074	-1,505	-11%	-10%	-1%	25,348	27,170	377	184	194	1,822	7.2%	28,018	100.0%
WEST HERTFORDSHIRE HOSPITALS NHS TRUST	2,830	2,448	2,681	-382	-233	2,780	2,448	17,167	17,003	-164	-1%	1%	-2%	47,866	48,220	159	-2	161	354	0.7%	36,576	58.1%
WEST SUFFOLK NHS FOUNDATION TRUST	2,046	null	1,643			1,834	null	11,242	11,085	-157	-1%	-1%	0%	35,843	35,863	0	72	-72	20	0.1%	23,820	-

Our Vision
The best care for every patient

Cancer: National Rankings – 28-Day Faster Diagnosis Standard (Feb 2025)

NHS
Norfolk and Norwich University Hospitals
NHS Foundation Trust

Positioned 43rd nationally in February – an increase of 59 places from January, due to a 15% improvement in performance and a 6.7% improvement compared to the same month last year.

Ranking	Region	Trust Name	Cases	Breaches	% in target	Change in last month	Change compared to same month last year
1	NW	BOLTON NHS FOUNDATION TRUST	1687	165	90.2%	3.5%	1.4%
2	L	KINGSTON HOSPITAL NHS FOUNDATION TRUST	1780	178	90.0%	5.6%	8.7%
3	NEY	NORTHUMBRIA HEALTHCARE NHS FOUNDATION TRUST	1662	169	89.8%	9.6%	9.5%
4	NEY	COUNTY DURHAM AND DARLINGTON NHS FOUNDATION TRUST	1843	188	89.8%	4.9%	-0.2%
5	M	NORTHAMPTON GENERAL HOSPITAL NHS TRUST	1777	203	88.6%	5.3%	3.5%
6	M	WALSALL HEALTHCARE NHS TRUST	721	91	87.4%	3.7%	0.3%
7	M	THE DUDLEY GROUP NHS FOUNDATION TRUST	1634	210	87.1%	5.6%	-0.4%
8	EoE	WEST HERTFORDSHIRE HOSPITALS NHS TRUST	1736	224	87.1%	8.7%	7.3%
9	L	CROYDON HEALTH SERVICES NHS TRUST	1561	202	87.1%	11.4%	-0.7%
10	L	IMPERIAL COLLEGE HEALTHCARE NHS TRUST	2471	322	87.0%	6.8%	-0.5%
11	SE	EAST SUSSEX HEALTHCARE NHS TRUST	2496	336	86.5%	7.6%	4.0%
12	L	ST GEORGE'S UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	1768	238	86.5%	6.4%	14.8%
13	SE	ROYAL SURREY COUNTY HOSPITAL NHS FOUNDATION TRUST	1057	143	86.5%	5.5%	-1.5%
14	SW	PLYMOUTH HOSPITALS NHS TRUST	2782	381	86.3%	8.8%	7.8%
15	SW	GREAT WESTERN HOSPITALS NHS FOUNDATION TRUST	1592	220	86.2%	6.0%	15.8%
16	EoE	CAMBRIDGE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	2407	335	86.1%	2.5%	1.2%
17	SE	FRIMLEY HEALTH NHS FOUNDATION TRUST	2891	412	85.7%	9.9%	2.6%
18	M	KETTERING GENERAL HOSPITAL NHS FOUNDATION TRUST	1235	177	85.7%	5.5%	0.9%
19	SE	QUEEN VICTORIA HOSPITAL NHS FOUNDATION TRUST	487	72	85.2%	6.6%	-4.6%
20	SE	SURREY AND SUSSEX HEALTHCARE NHS TRUST	2015	301	85.1%	3.3%	4.9%
21	NEy	THE ROTHERHAM NHS FOUNDATION TRUST	1045	159	84.8%	8.2%	6.9%
22	L	CHELSEA AND WESTMINSTER HOSPITAL NHS FOUNDATION TRUST	2323	361	84.5%	7.5%	4.3%
23	SE	UNIVERSITY HOSPITAL SOUTHAMPTON NHS FOUNDATION TRUST	2399	374	84.4%	3.8%	-4.6%
24	NEy	CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST	2041	323	84.2%	5.9%	-3.3%
25	SW	ROYAL CORNWALL HOSPITALS NHS TRUST	2309	366	84.1%	8.4%	2.3%
26	SE	ASHFORD AND ST PETER'S HOSPITALS NHS FOUNDATION TRUST	1936	310	84.0%	7.4%	-1.9%
27	NW	UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST	1719	276	83.9%	3.8%	0.0%
28	NW	TAMESIDE HOSPITAL NHS FOUNDATION TRUST	1158	186	83.9%	2.7%	7.5%
29	SE	ROYAL BERKSHIRE NHS FOUNDATION TRUST	1956	320	83.6%	3.6%	7.2%
30	NEY	MID YORKSHIRE HOSPITALS NHS TRUST	2281	376	83.5%	2.5%	0.0%
31	NEY	AIREDALE NHS FOUNDATION TRUST	693	115	83.4%	3.3%	-1.1%
32	M	UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST	4132	686	83.4%	7.6%	0.5%
33	NEy	THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST	2317	385	83.4%	12.7%	0.2%
34	L	UNIVERSITY COLLEGE LONDON HOSPITALS NHS FOUNDATION TRUST	1931	321	83.4%	6.1%	3.0%
35	L	GUY'S AND ST THOMAS' NHS FOUNDATION TRUST	2321	389	83.2%	6.9%	9.7%
36	SW	TORBAY AND SOUTH DEVON NHS FOUNDATION TRUST	1758	296	83.2%	7.7%	2.9%
37	NW	LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST	2001	340	83.0%	4.7%	4.1%
38	NEY	LEEDS TEACHING HOSPITALS NHS TRUST	3860	656	83.0%	7.5%	8.3%
39	SW	ROYAL DEVON AND EXETER NHS FOUNDATION TRUST	3371	573	83.0%	6.1%	5.1%
40	EoE	NORTH WEST ANGLIA NHS FOUNDATION TRUST	1969	337	82.9%	7.5%	12.3%

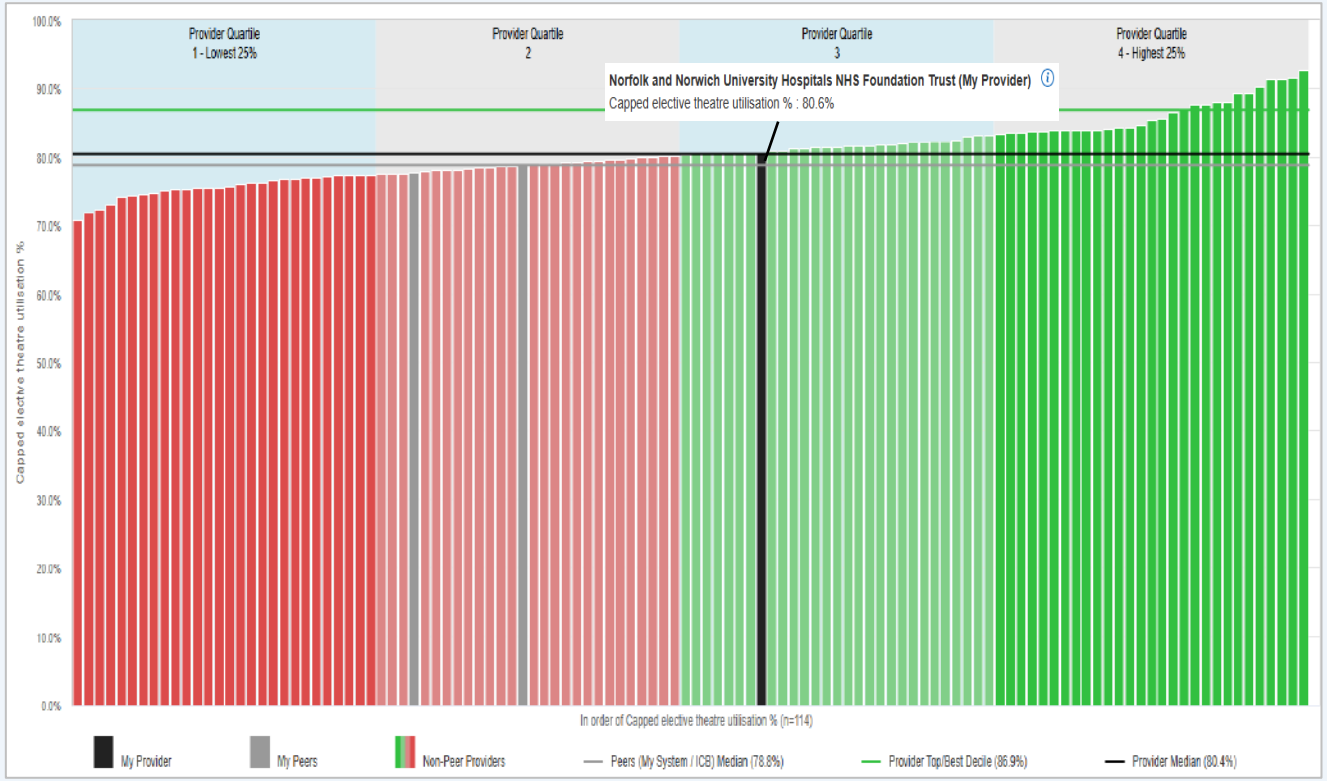
Ranking	Region	Trust Name	Cases	Breaches	% in target	Change in last month	Change compared to same month last year
41	M	WYE VALLEY NHS TRUST	974	167	82.9%	10.5%	3.8%
42	NW	COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST	1231	213	82.7%	2.6%	2.2%
43	EoE	NORFOLK AND NORWICH UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	3537	616	82.6%	15.0%	6.7%
44	SW	NORTH BRISTOL NHS TRUST	2917	513	82.4%	6.2%	7.7%
45	L	EPSOM AND ST HELIER UNIVERSITY HOSPITALS NHS TRUST	1177	208	82.3%	-0.6%	-3.6%
46	SE	HAMPSHIRE HOSPITALS NHS FOUNDATION TRUST	1944	344	82.3%	9.2%	8.9%
47	NW	WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST	1643	291	82.3%	3.6%	-2.1%
48	SE	DARTFORD AND GRAVESHAM NHS TRUST	970	172	82.3%	10.6%	-0.2%
49	NEY	BARNSLEY HOSPITAL NHS FOUNDATION TRUST	969	172	82.2%	3.1%	-4.9%
50	M	THE ROYAL WOLVERHAMPTON NHS TRUST	1882	342	81.8%	4.3%	0.7%
51	SE	UNIVERSITY HOSPITALS OF SUSSEX NHS FOUNDATION TRUST	5490	1016	81.5%	10.3%	8.4%
52	NEY	DONCASTER AND BASSETLAW TEACHING HOSPITALS NHS FOUNDATION TRUST	1713	318	81.4%	2.2%	-1.5%
53	NEY	BRADFORD TEACHING HOSPITALS NHS TRUST	1598	303	81.0%	2.7%	-3.7%
54	M	SOUTH WARWICKSHIRE NHS FOUNDATION TRUST	1410	269	80.9%	5.4%	5.4%
55	SE	MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST	1991	380	80.9%	5.7%	0.8%
56	L	BARKING, HAVERING AND REDBRIDGE UNIVERSITY HOSPITALS NHS TRUST	2400	461	80.8%	3.2%	4.2%
57	NW	STOCKPORT NHS FOUNDATION TRUST	1096	211	80.7%	5.6%	-1.2%
58	NEy	GATESHEAD HEALTH NHS FOUNDATION TRUST	1288	249	80.7%	2.9%	-2.9%
59	NW	EAST LANCASHIRE HOSPITALS NHS TRUST	2089	404	80.7%	6.2%	-2.6%
60	L	LONDON NORTH WEST UNIVERSITY HEALTHCARE NHS TRUST	2975	579	80.5%	10.0%	1.9%
61	L	HOMERTON UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	1360	266	80.4%	5.1%	-0.2%
62	M	SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST	1549	303	80.4%	8.1%	5.1%
63	L	BARTS HEALTH NHS TRUST	3274	642	80.4%	7.8%	2.8%
64	NEy	NORTH TEES AND HARTLEPOOL NHS FOUNDATION TRUST	1522	300	80.3%	4.9%	-1.3%
65	M	UNITED LINCOLNSHIRE HOSPITALS NHS TRUST	2692	531	80.3%	5.1%	5.7%
66	SE	PORTSMOUTH HOSPITALS UNIVERSITY NATIONAL HEALTH SERVICE TRUST	2394	476	80.1%	7.7%	0.0%
67	SW	GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST	2612	520	80.1%	9.7%	-0.5%
68	NEY	SOUTH TYNESIDE AND SUNDERLAND NHS FOUNDATION TRUST	1330	267	79.9%	3.7%	-1.8%
69	M	WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST	2444	491	79.9%	2.9%	10.4%
70	M	SHERWOOD FOREST HOSPITALS NHS FOUNDATION TRUST	1662	338	79.7%	8.1%	-3.3%
71	SW	UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST	2738	558	79.6%	4.6%	1.8%
72	SE	BUCKINGHAMSHIRE HEALTHCARE NHS TRUST	2084	425	79.6%	12.1%	5.7%
73	NW	NORTHERN CARE ALLIANCE NHS FOUNDATION TRUST	3790	775	79.6%	7.0%	1.1%
74	SE	OXFORD UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	2903	603	79.2%	4.0%	-2.0%
75	L	KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST	3153	655	79.2%	8.9%	5.1%
76	EoE	EAST AND NORTH HERTFORDSHIRE NHS TRUST	1473	307	79.2%	7.0%	-4.3%
77	L	THE HILLINGDON HOSPITALS NHS FOUNDATION TRUST	1130	236	79.1%	5.9%	1.5%
78	EoE	MILTON KEYNES UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	1512	316	79.1%	11.8%	4.9%
79	M	UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST	4143	875	78.9%	8.6%	2.5%
80	SW	SOMERSET NHS FOUNDATION TRUST	2193	469	78.6%	6.6%	-6.1%

Theatres – Capped Theatre Utilisation %

Total capped touch time within valid elective sessions as a proportion of total planned theatre session duration.

National / System Benchmarking

System Providers	Value
Norfolk and Norwich University Hospitals NHS Foundation Trust	80.6%
Queen Elizabeth Hospital King's Lynn NHS Foundation Trust	78.8%
James Paget University Hospitals NHS Foundation Trust	77.7%

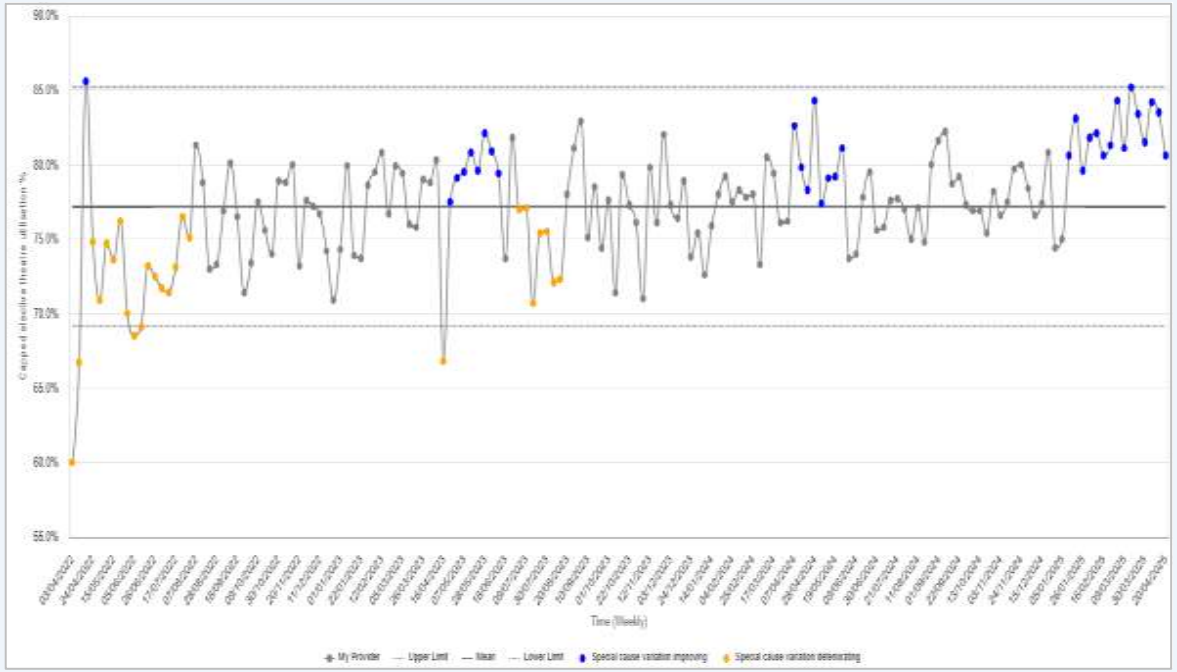


Commentary

NNUH achieved 80.6% theatre utilisation for the 2 weeks up to 20th April, above both JPUH and QEH and the national median (80.4%).

The rolling NNUH performance (below) highlights weekly special cause variation improving since January 2025 compared to the last 3 years.

NNUH Performance (03/04/2022 – 20/04/2025)



Theatres – % of Valid Elective Sessions with an Unplanned Extension

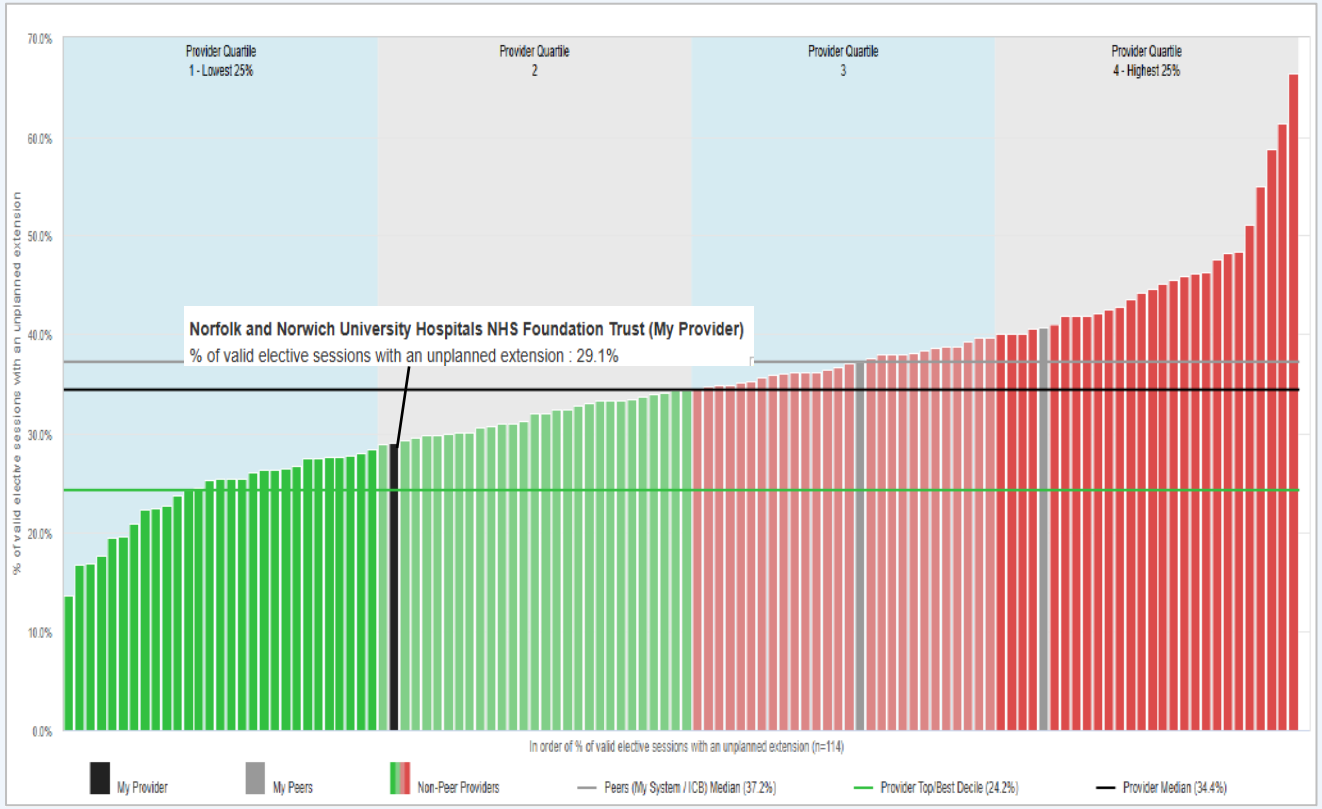
The percentage of valid elective sessions where the last case in the session finished after the planned session finish time

National / System Benchmarking

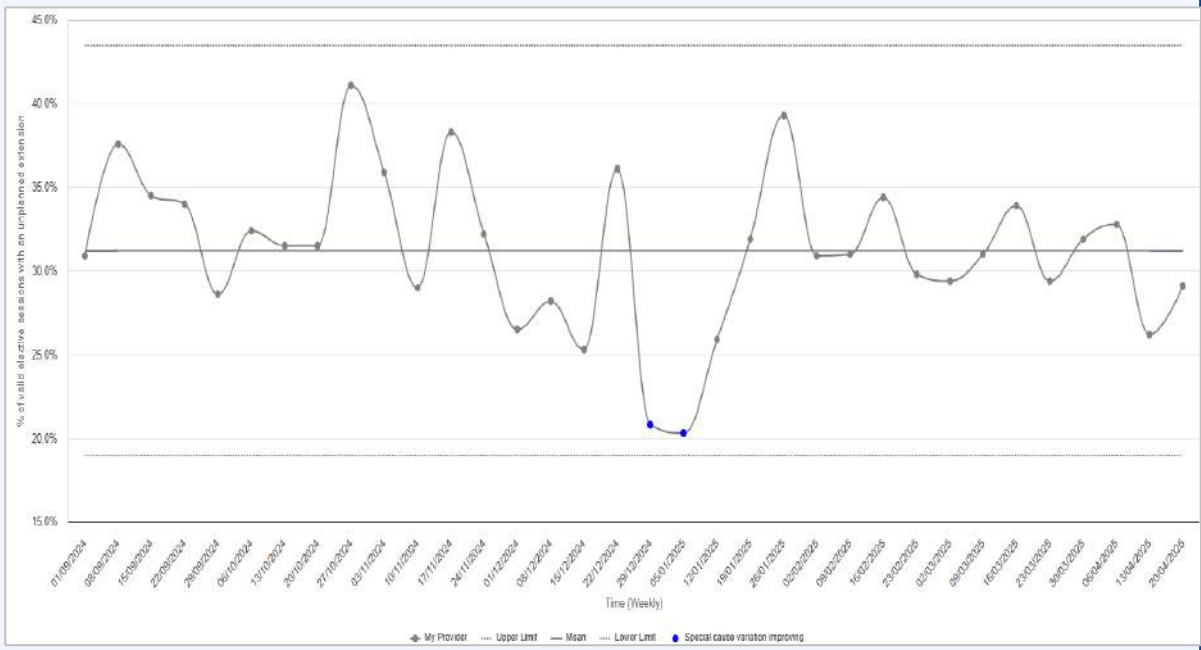
System Providers	Value
Norfolk and Norwich University Hospitals NHS Foundation Trust	29.1%
Queen Elizabeth Hospital King's Lynn NHS Foundation Trust	37.2%
James Paget University Hospitals NHS Foundation Trust	40.7%

Commentary

29.1% of NNUH's elective sessions had an unplanned extension for the 2 weeks up to 20th April, lower than both JPUH and QEH and the national median (34.4%).



NNUH Performance (01/09/2024 – 20/04/2025)

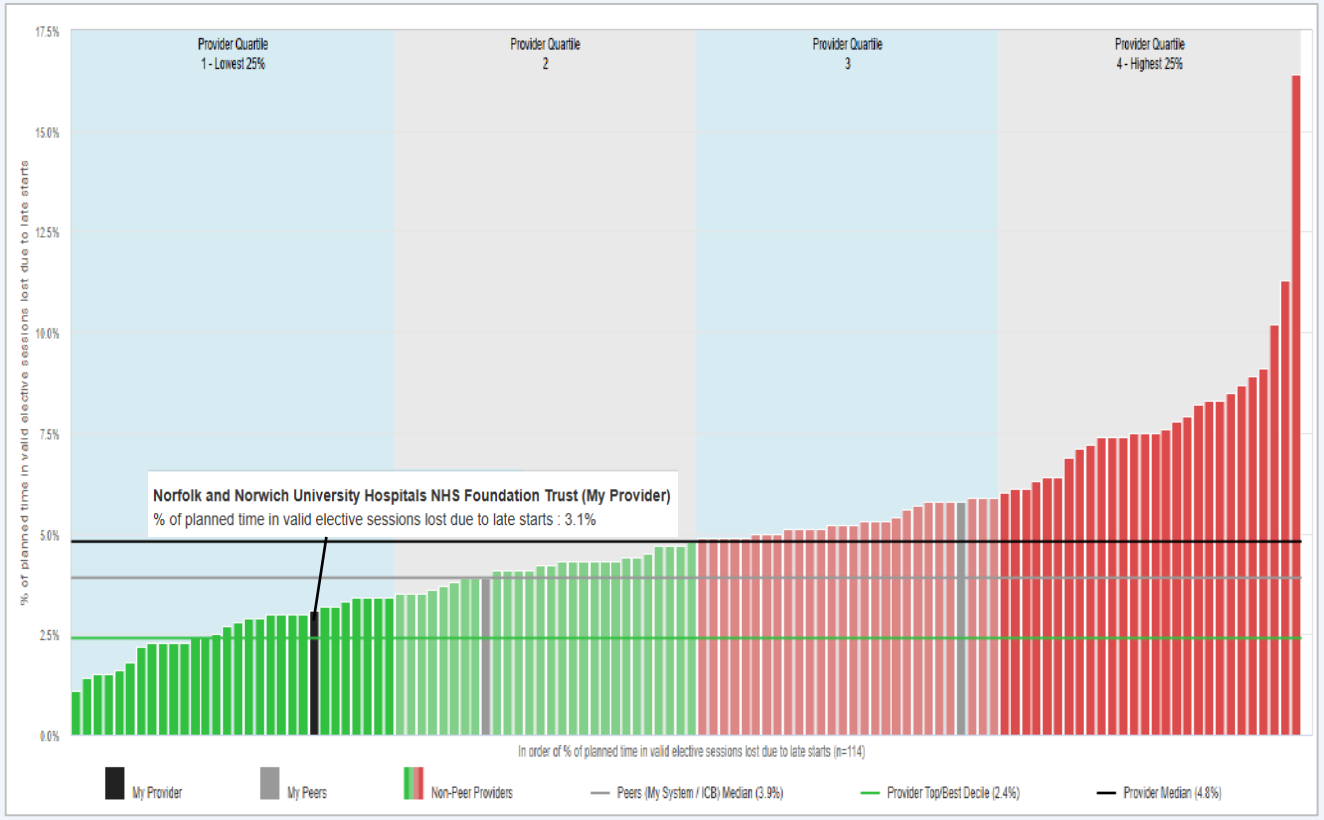


Theatres – % of Planned Session Time Lost Due to Late Starts

The percentage of planned elective operating time in valid elective sessions that was lost due to sessions starting after the planned session start time.

National / System Benchmarking

System Providers	Value
Norfolk and Norwich University Hospitals NHS Foundation Trust	3.1%
James Paget University Hospitals NHS Foundation Trust	3.9%
Queen Elizabeth Hospital King's Lynn NHS Foundation Trust	5.8%

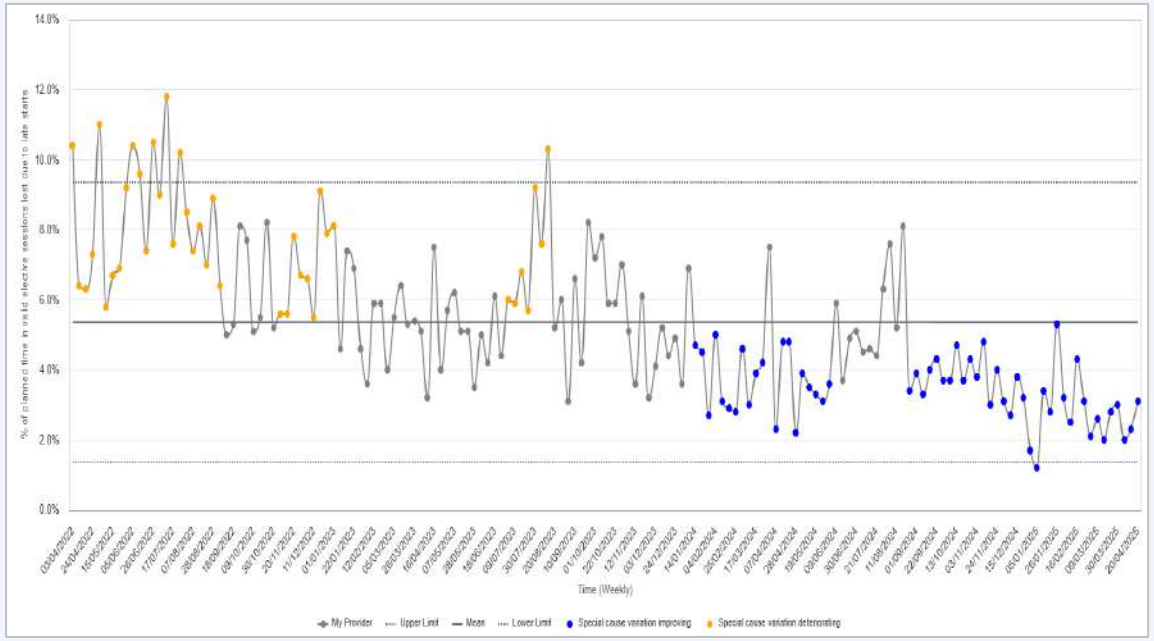


Commentary

NNUH lost 3.1% of planned session time due to late starts for the 2 weeks up to 20th April, lower than both JPUH and QEH and the national median (4.8%).

The rolling NNUH performance (below) highlights weekly special cause variation improving since September 2024 compared to the last 3 years.

NNUH Performance (03/04/2022 – 20/04/2025)

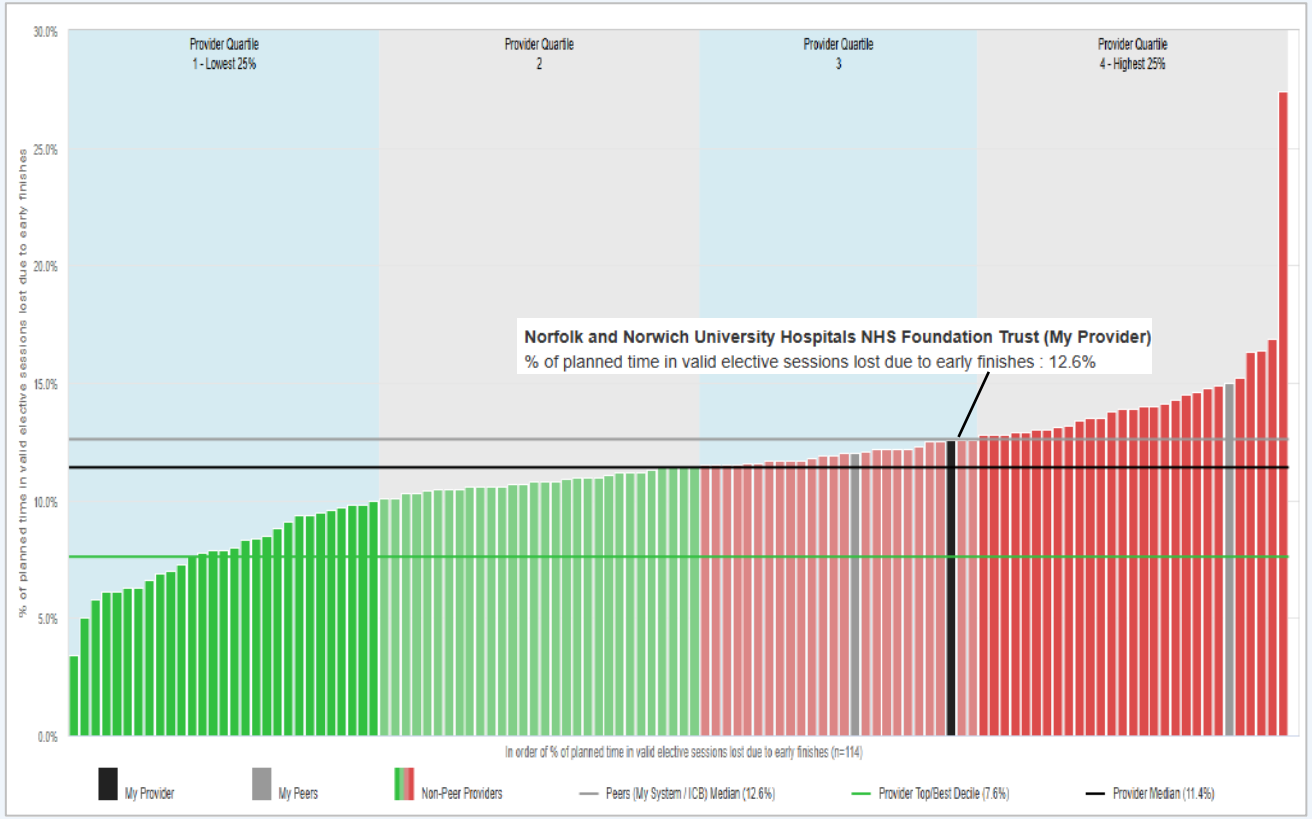


Theatres – % of Planned Session Time Lost Due to Early Finishes

The percentage of planned elective operating time in valid elective sessions that was lost due to sessions finishing earlier than the planned session finish time.

National / System Benchmarking

System Providers	Value
Queen Elizabeth Hospital King's Lynn NHS Foundation Trust	12.0%
Norfolk and Norwich University Hospitals NHS Foundation Trust	12.6%
James Paget University Hospitals NHS Foundation Trust	15.0%

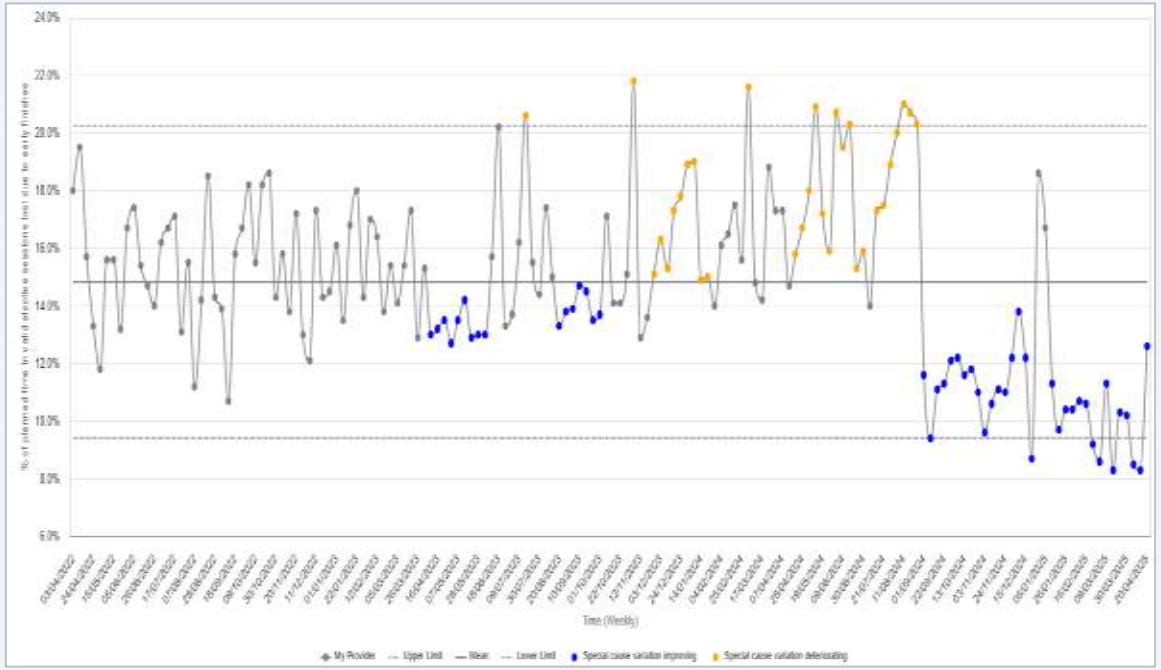


Commentary

NNUH lost 12.6% of planned session time due to early finishes for the 2 weeks up to 20th April, lower than JPUH but higher than QEH and the national median (11.4%).

The rolling NNUH performance (below) highlights weekly special cause variation improving since January 2025 compared to the last 3 years.

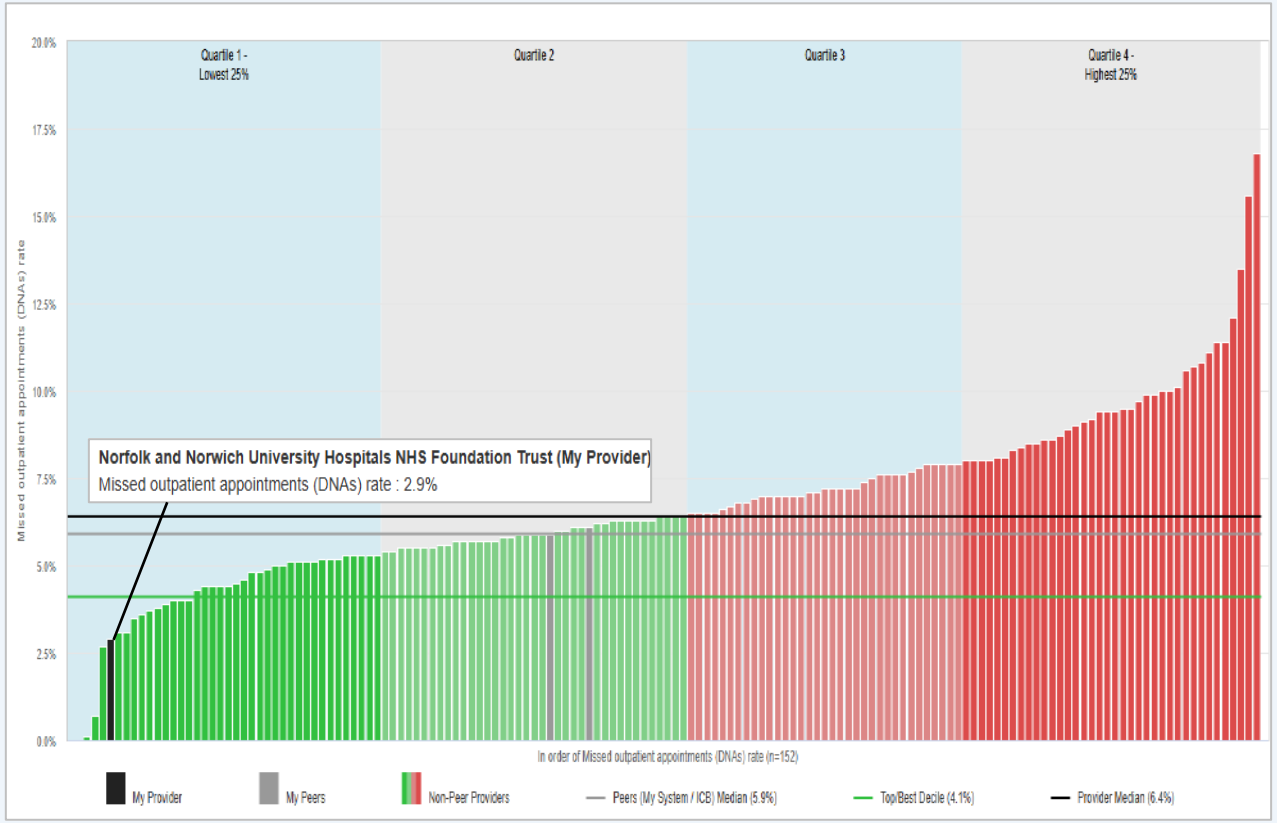
NNUH Performance (03/04/2022 – 20/04/2025)



Missed Outpatient Appointments (DNAs) – Mar 2025

National / System Benchmarking

System Providers	Value
Norfolk and Norwich University Hospitals NHS Foundation Trust	2.9%
James Paget University Hospitals NHS Foundation Trust	5.9%
Queen Elizabeth Hospital King's Lynn NHS Foundation Trust	6.1%

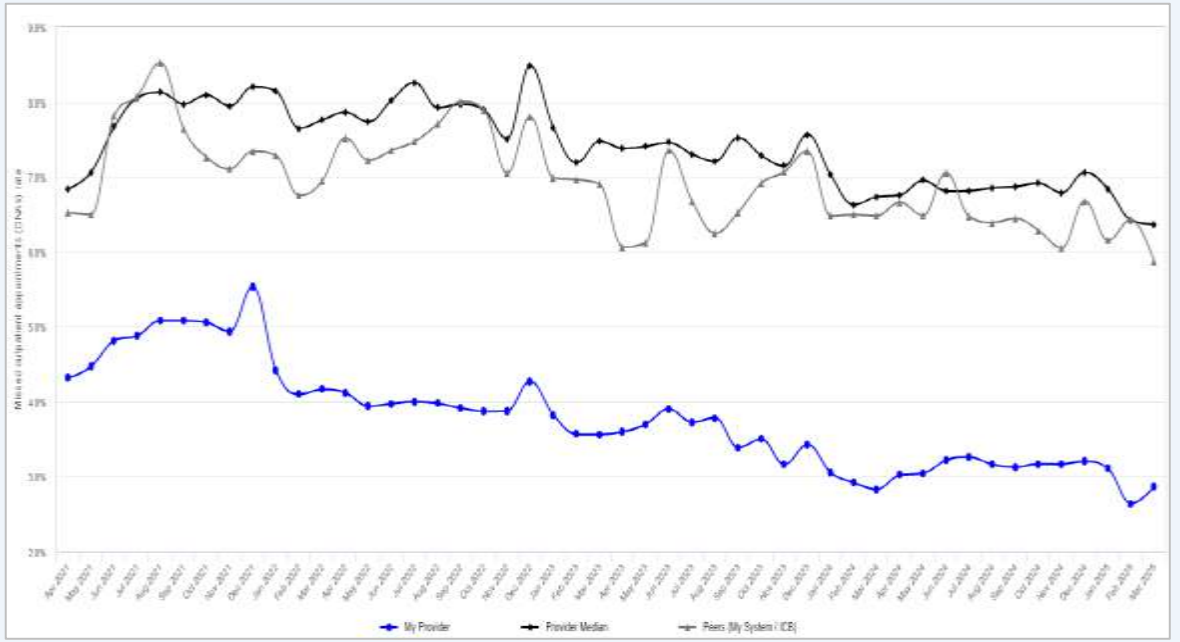


Commentary

The percentage of missed outpatient appointments by patients at NNUH in March was 2.9%, lower than JPUH and QEH and the national median (6.4%).

The rolling NNUH performance (below) shows performance consistently ahead of the national median and JPUH and QEH performance.

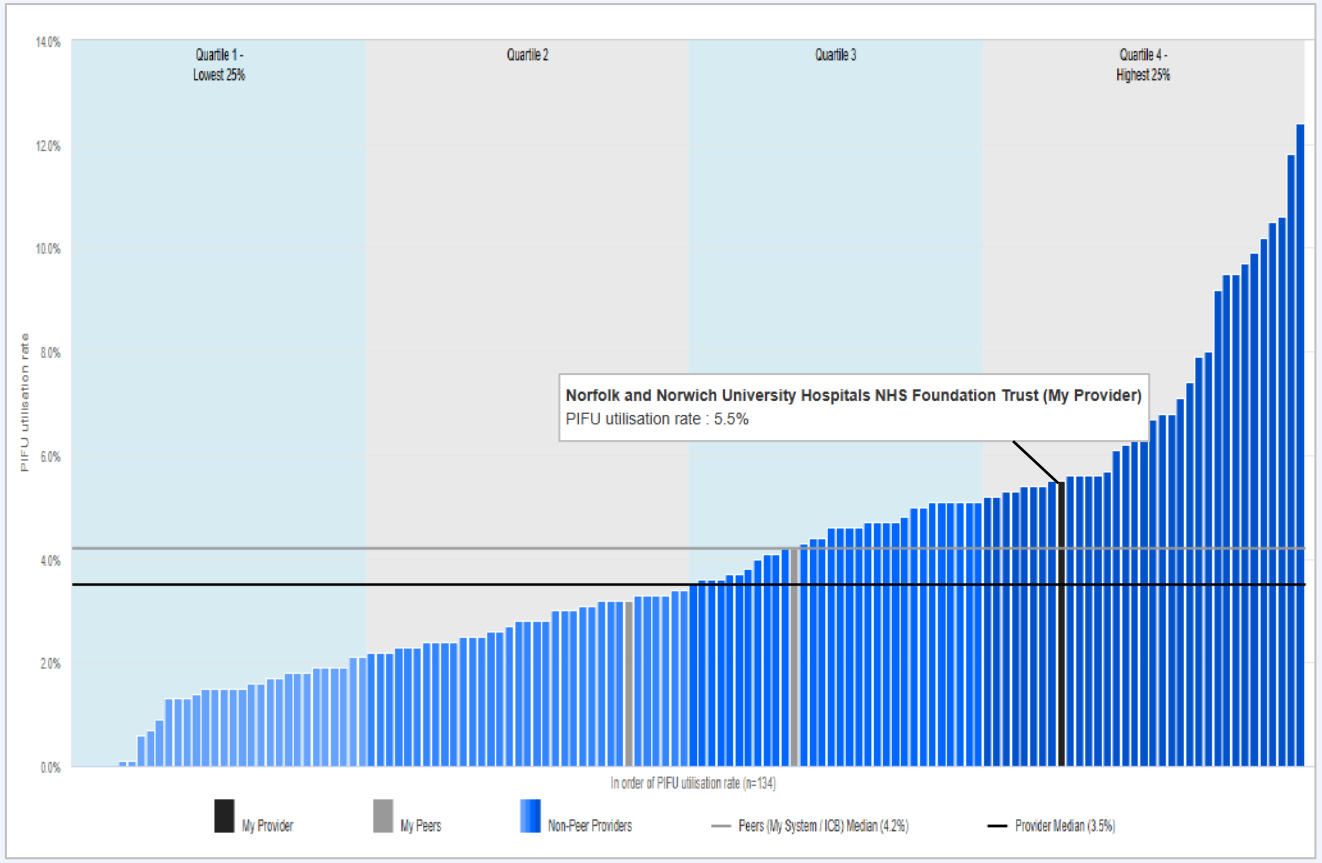
NNUH Performance (April 2021 – March 2025)



PIFU Utilisation Rate – Mar 2025

National / System Benchmarking

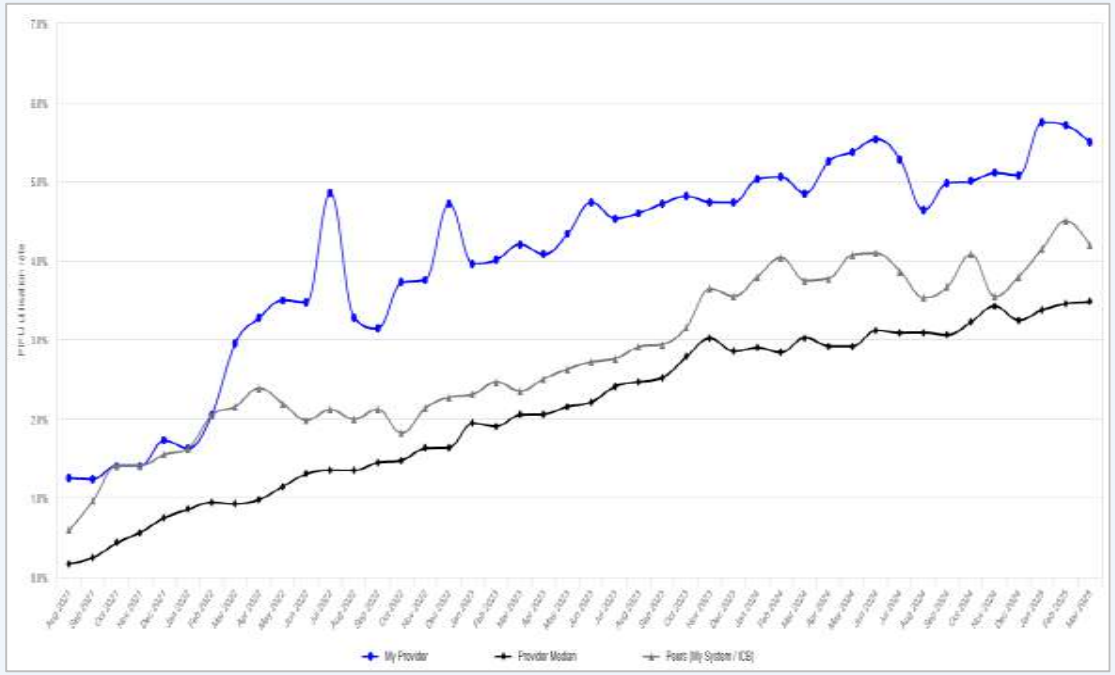
System Providers	Value
Norfolk and Norwich University Hospitals NHS Foundation Trust	5.5%
James Paget University Hospitals NHS Foundation Trust	4.2%
Queen Elizabeth Hospital King's Lynn NHS Foundation Trust	3.2%



Commentary

NNUH remain ahead of System Providers and the national median for its PIFU Utilisation Rate in March 2025, with rolling NNUH performance (below) consistently above System Providers and the national median for the past 3 years.

NNUH Performance (August 2021 – March 2025)



Microsoft | Power BI

Workforce

View in Power BI

Last data refresh:
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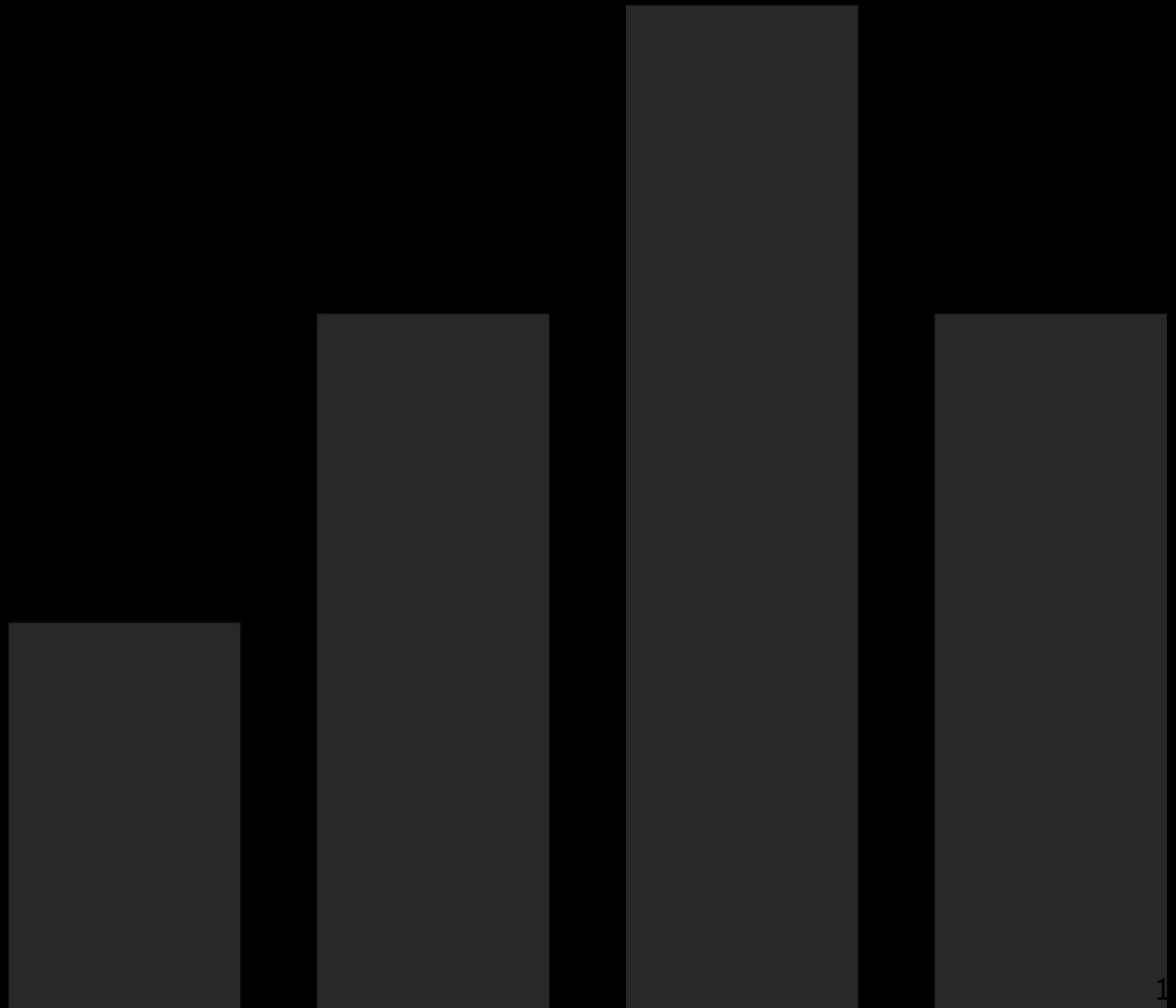

Workforce Summary

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

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Topic	Metric Name	Date	Result	Variation	Assurance
Recruitment (Non-Medical)	Time to Hire - Total	Apr 2025	27.4	Improvement (Low)	Inconsistent
Vacancies	Vacancy Maximum (%)	Apr 2025	10.0%	Improvement (Low)	Not capable
Staff in Post	Actual Substantive Headcount (WTE)	Apr 2025	8,862	Improvement (High)	No Target
Staff in Post	Stability Index	Apr 2025	89.90%	Improvement (High)	No Target

SPC Variation Icons

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

SPC Assurance Icons

Capable | Inconsistent | Not capable

Mandatory Training

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business intelligence

Mandatory Training

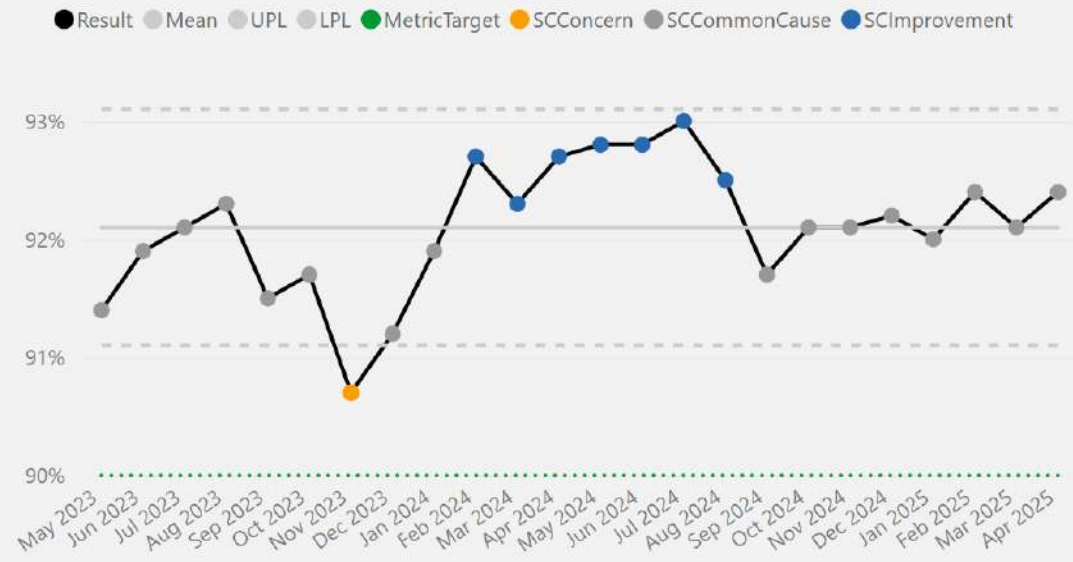
Apr 2025

Variation | Assurance

92.4% Result
90.0% Target

93.1% UPL
92.1% Mean
91.1% LPL

Mandatory Training



Improvement Actions

April 2025 – Promotion of the new Oliver McGowan and Fire Safety training being undertaken.

Analytical Commentary

Variation is Common Cause

Assurance Commentary

The Trust continues to exceed the 90% target with the overall compliance rate for April being 92.4%. Compliance has now been maintained for over 2 years (since December 2022).

Specifically for Medical staff, the compliance rate for permanent staff was 90.3%, which reduces to 83.3% when the fixed term rotational resident doctors are included.

The topics which remain below the 90% target are Fire Safety (88.2%), Moving and Handling Level 2 (87.1%), Resus Adults (87.7%) and Resus Paediatrics (89.6%) have all seen incremental improvements for the latest reporting period. The focus remains in this area and reminder emails are being sent to non-compliant staff to encourage attendance.
The new structure for Fire Safety training is underway with the team delivering level 2 and 3 units for colleagues to support patients who would require support to exit in the event of a fire.

Since the launch of the new Oliver McGowan training, the eLearning (part 1) compliance continues to rise which now sits at 68%. The part 2 face to face training delivery has started.

The national review of Statutory and Mandatory training continues with a full update being provided to Workforce & Education Sub Board. All actions requested have been completed by the NNUH to date.

Non-Medical Appraisals

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Non-Medical Appraisal

Apr 2025

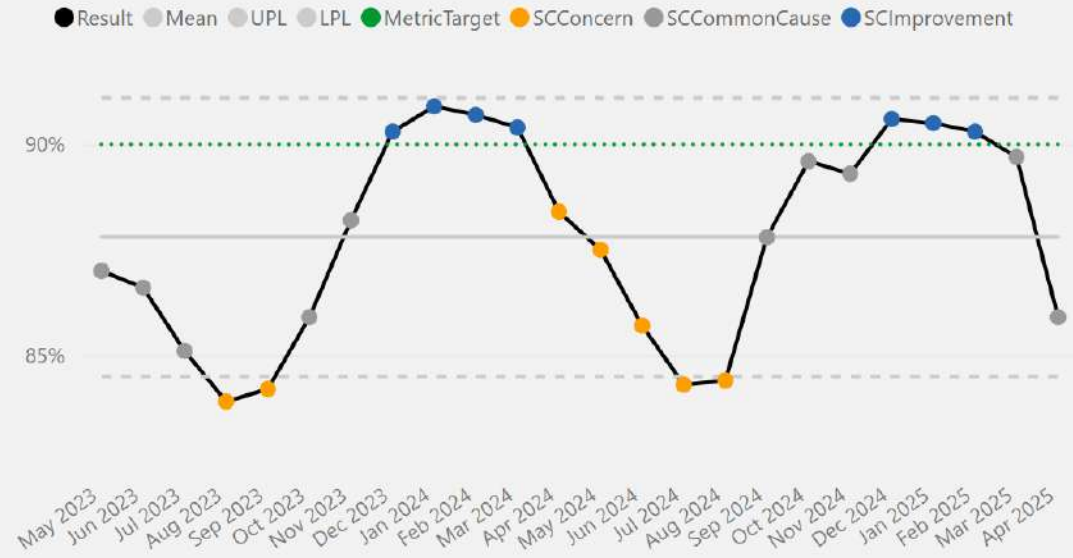
Variation | Assurance

85.9% Result	91.1% UPL
90.0% Target	87.8% Mean
	84.5% LPL

Analytical Commentary

Variation is Common Cause

Non-Medical Appraisal



Assurance Commentary

In the 12 months to April 2025, 85.9% of eligible staff (excluding medical colleagues) had an appraisal. This is below the 90% target.

The PDR form has been updated to encourage line managers to check with staff whether their objectives are clear and whether their appraisal has helped them to improve how they do their job, which reflect the staff survey questions.

Care Groups encouraged to make decisions on the best way to undertake PDR's given the current change.
Training continues to be offered to support line managers deliver good quality PDR conversations.

Improvement Actions

April 2025 – As we transition to Care Groups, implementation plans are in place to ensure the compliance data is updated and available to the new Care Group Leadership Teams.

Sickness Absence

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business intelligence

Monthly Sickness Absence %

Apr 2025

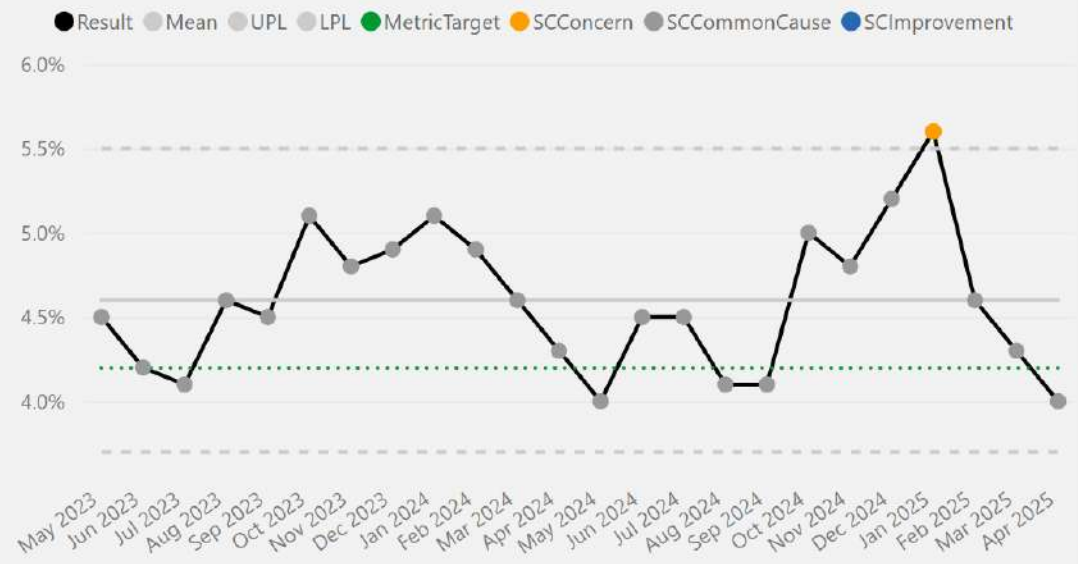
Variation | Assurance

4.0% Result	5.5% UPL
4.2% Target	4.6% Mean
	3.7% LPL

Analytical Commentary

Variation is Common Cause

Monthly Sickness Absence %



Assurance Commentary

The current performance for the 12-month rate (4.6%) mirrors the same point last year but remains outside the Trust target (4.2%).

The top 2 reasons for sickness absence (number of days) is currently stress/anxiety/depression (22.3%) and other known causes (11.8%), compared to the same point last year when it was stress/anxiety/depression, at 22.6% and other known reasons at 11.0%.

In this reporting period work-related stress referrals to Workplace Health & Wellbeing have remained at a significant level of 43%. The main issues reported in this quarter relate to Demands and Relationships and MSK referrals at 13%. No trends identified in the MSK work related cases.

Sickness absence management is a high priority HR workstream as part of the Financial Recovery programme. Analysis is being undertaken to understand where the most effective interventions and supportive measures can be introduced to lower the overall absence rates for the Trust, and ensure correct and timely management action is being used.

Workforce representative continues to attend the Wellbeing Hub allowing 'drop in' support to managers/staff as well as online support resources continue to be available for managers and staff to access, complimented by our Wellbeing Service and support phone line. A further Schwartz Round was undertaken in April 2025.

Improvement Actions

April 2025 – Ongoing promotion of the Wellbeing café and staff support hub. The wellbeing team continue to support the 'Start Well, End Well' initiative being introduced in teams as a further mechanism to support staff wellbeing

April 2025 – Promotion of wellbeing support to staff impacted by the organisational changes and restricting.

April 2025 – Actions created as part of the Workforce Financial Recovery Programme that has focus on trigger points, short term and long term sickness absence

Staff Turnover

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business intelligence

Monthly Turnover

Apr 2025

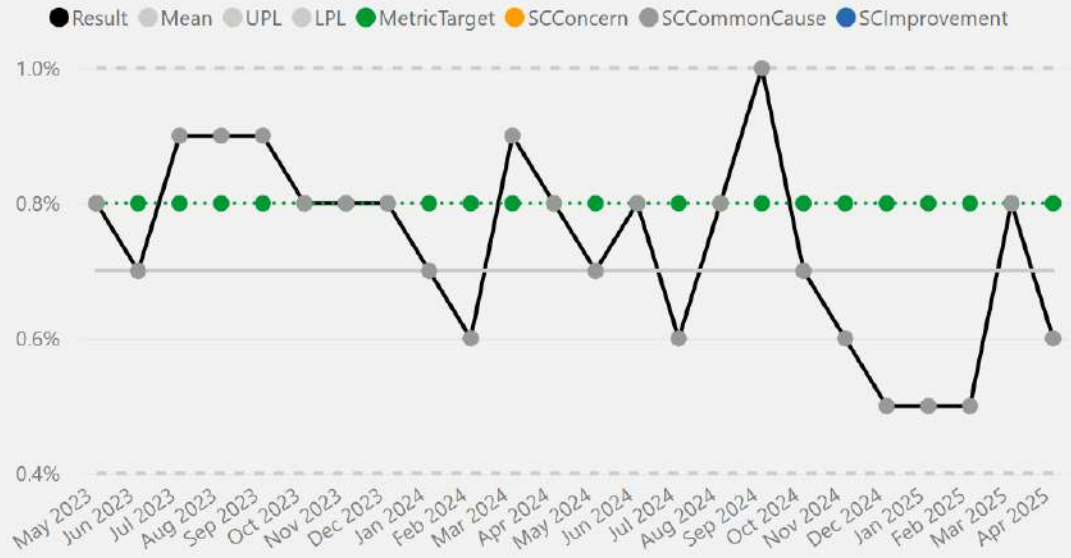
Variation | Assurance

0.6% Result	1.0% UPL
0.8% Target	0.7% Mean
	0.4% LPL

Analytical Commentary

Variation is Common Cause

Monthly Turnover



Assurance Commentary

The monthly turnover rate for April 2025 is 0.6%

The 12-month average turnover rate continues to reduce, currently to 8.0%.

Of the 44.4 (FTE) leavers that left in the month of April (which compares to 62.4 in March 2025); 34.4 were from three main staffing groups: additional clinical services (e.g. Healthcare Assistants and other support workers); administration and clerical; and registered nursing and midwifery. The main reasons for leaving in April are work life balance, 24.4% and other reasons, 17.0% of leavers in month.

The annualised turnover rate for Registered Nursing & Midwifery is 6.0% reduced from a peak of 13.2% in July 2022. The annualised turnover rate for clinical support workers is 12.1% reduced from a peak of 24% in July 2022.

Support for our workforce in the current changing environment is being enhanced with the development of a new Careers Hub which includes application and CV writing, interview skills and other resources. Further Trust benefits include the wellbeing portal (Vivup) which has many resources of support including access to 24/7 confidential, impartial, telephone support, financial support and guidance for staff, to mention a few in addition to the local staff support hub available Monday – Friday.

Improvement Actions

April 2025 – Support provided to staff impacted by the implementation of the clinical leadership structure, including minimising redundancies where possible.

April 2025 – Development and launch of a Trust wide voluntary redundancy programme, including detailed FAQs, calculators and guidance to enable colleagues to access a range of information to inform if they wish to apply.

Stability Index

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business intelligence

Stability Index

Apr 2025

Variation | Assurance

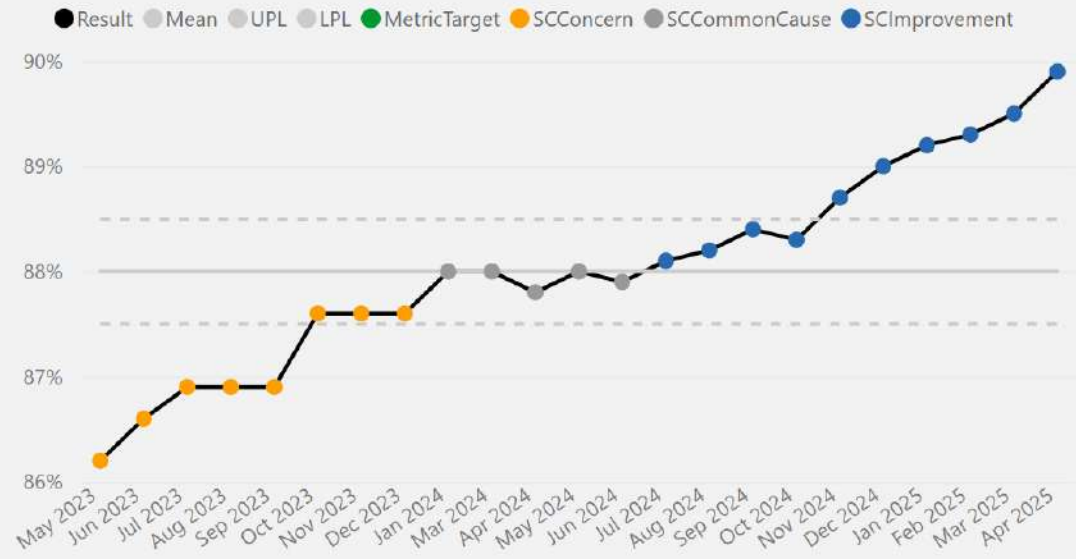
89.90% Result
N/A Target

88.50% UPL
88.00% Mean
87.50% LPL

Analytical Commentary

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

Stability Index



Assurance Commentary

The stability index measures the headcount of staff that are in post 12 months ago that remain in post. The stability index for April is 89.9% - where 7,754 staff remain from 8,625 in post 12 months ago. This has seen a gradual improvement over the last 24 months.

The following progress has been made on the People Promise programme during this reporting period:
- Annualised Staff turnover remains low at 6.2% in April 2025
- Infant feeding room has shown an increase in booking from 30 in March to 46 in April
- Car Parking self-assessment process is still underway
- Rouen Rd Space survey has been completed, with the proposals under review.
- Start Well End Well trial
- Schwartz round on being new to the NNUH took place on 29th April
- Sexual Safety at Work policy launched on 29 April
- 17 managers have fully completed their Licence to Lead in April

Resident Doctor survey around detriment completed, results to be shared with Medical Director with detriment risk assessment guidance for distribution to leaders.

Dedicated private FTSU office space opened. Reduction in time required to arrange for meetings and follow ups. Improved access for staff to anonymous reporting has led to an increase of users. A Speak up Champion for AMU has been recruited.

The Workforce Financial Recovery Programme has supported the completion of phase one of the Clinical Structure and preparing for phase two and the launch of a voluntary redundancy programme. Further recommendations being

Improvement Actions

April 2025 – Dedicated private FTSU office space opened.

April 2025 – The outcomes of the staff engagement events to review and make recommendations on the Staff Survey feedback have been collated in preparation for prioritising and finalising the People Promise plan for 2025/26.

Vacancies

NNUH Digital Health
business intelligence

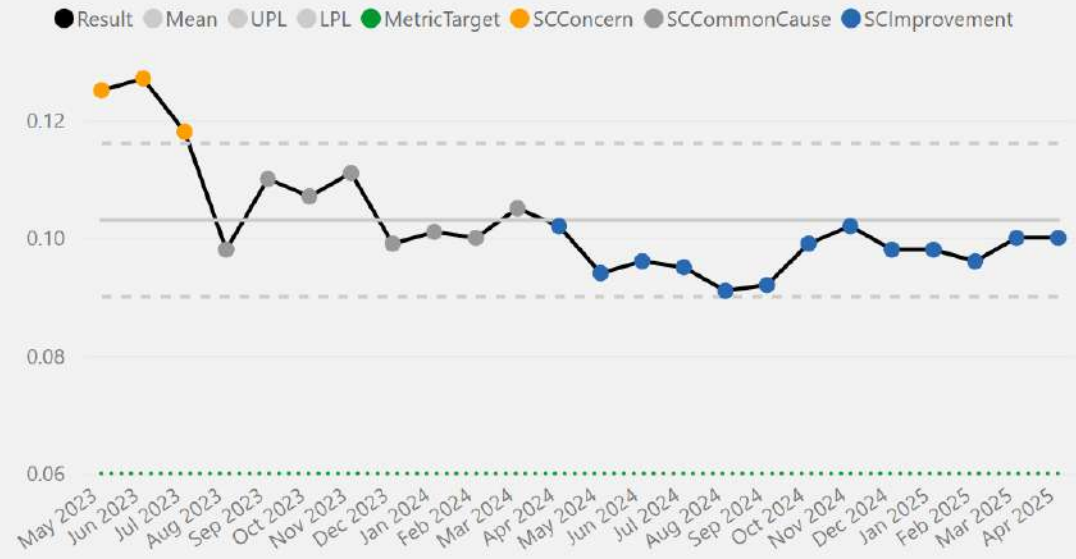
Vacancy Maximum (%)

Apr 2025

Variation	Assurance
L	F

10.0% Result	11.6% UPL
6.0% Target	10.3% Mean
	9.0% LPL

Vacancy Maximum (%)



Improvement Actions

April 2025 – Vacancy control panels continue. FAQs updated to reflect the decision that roles are advertised internally only first, unless an exception is agreed.

Analytical Commentary

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

Assurance Commentary

The Trust vacancy rate for April 2025 is 10.0% which is equal to the previous month, although lower than the same period last year (10.2%). The average vacancy rate for the past 12-months is (9.7%).

The staff group with the highest rate of vacancies (13.7%) is the staff group of Administration and Clerical. The rate has been increasing since July 2024 (9.6%) and is connected to enhanced vacancy control requirements.

Enhanced vacancy controls remain in place with additional requirements introduced that requires a default position of 'internal only' advertising for vacancies unless the role is a Band 2 role which will then go out for external fill.

The Healthcare Assistant pipeline is ongoing with 43 candidates currently in the selection process and in addition, a further 25 which have start dates booked from April onwards.

As part of the Workforce Financial Recovery Programme, a 'red pen' exercise will be undertaken to review vacancies that have been held for longer than three months as to whether these can be deleted from the establishment permanently. This will aid the workforce reduction.

Recruitment (Non-Medical)

NNUH Digital Health
business intelligence

Time to Hire - Total

Apr 2025

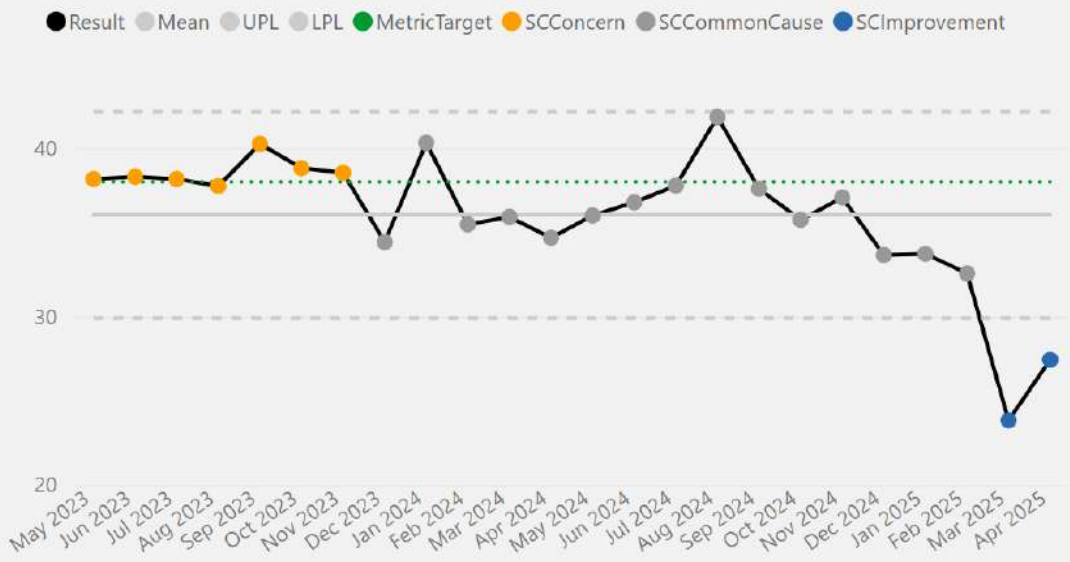
Variation	Assurance
L	?

27.4 Result	42.2 UPL
38.0 Target	36.0 Mean
	29.9 LPL

Analytical Commentary

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

Time to Hire - Total



Assurance Commentary

Time to hire for April was 27.4 working days and although an increase on last month (23.8 days), performance remains well ahead of the Trust target of 38 days.

The ongoing improved performance is directly related to the reduction in recruitment associated with enhanced vacancy controls. In line with trends in previous years, the speed of recruitment slows from April and is usually attributed to an increase in annual leave in March (end of annual leave year) impacting on time to recruit of recruiting managers and recruitment team.

While recruitment KPI data suggests the speed of recruitment is performing very well, the data does not incorporate the additional time that has been introduced to obtain approval to start recruitment through internal vacancy control measures, as well as delays experienced through gaining the wider ICB and NHS England approvals.

Work is currently underway in advance of next month end cycle that will see recruitment data reflected into the Care Groups

Improvement Actions

April 2025 – Realignment of Trac in to Care Groups model for all current and future recruitment episodes.

Supplementary Metrics

Metric Name	Date	Result	Variation	Assurance
Time to Hire - Time To Select	Apr 2025	11.6	Common Cause	No Target

Job Planning

NNUH Digital Health
business intelligence

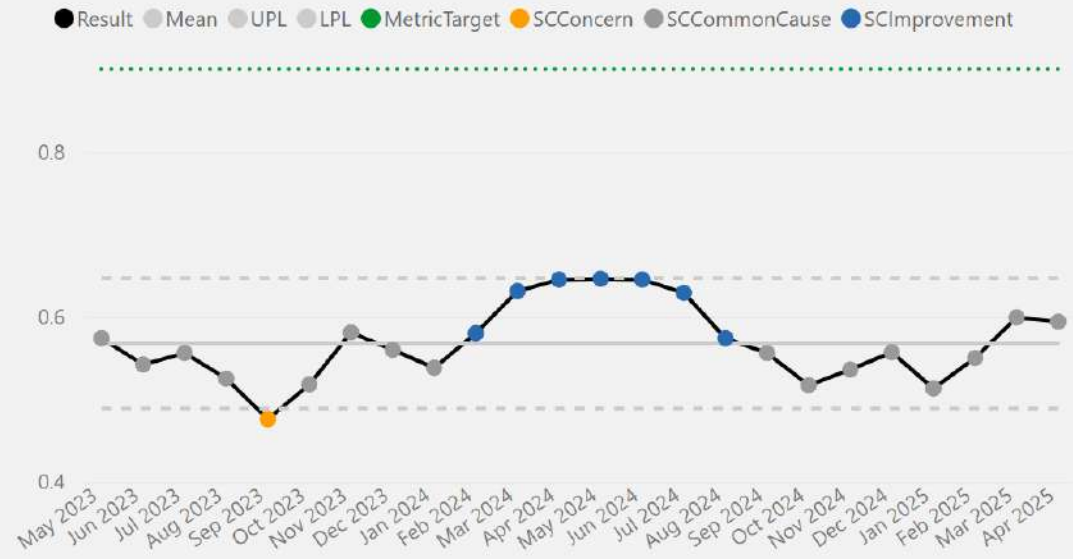
Job Plans Signed Off % (Within 12months)

Apr 2025

Variation	Assurance
	

59.4% Result	64.7% UPL
90.0% Target	56.8% Mean
	48.9% LPL

Job Plans Signed Off % (Within 12months)



Analytical Commentary

Variation is Common Cause

Assurance Commentary

The monthly unadjusted figure has decreased from 59.9% to 59.4%. The adjusted figure has increased from 68.5% to 74.2%. Performance remains behind the target of 90%. The target has not been achieved since May 2021. A range of barriers exist, primarily around the capacity of clinical colleagues.

A new reporting metric is being developed to provide clarity on the compliance, in line with NHS E revised guidance and the adjusted compliance figure of 95%.

Accountability for job planning compliance is expected to improve with the transition to care groups. All Associate Clinical Directors will be invited to be part of the Job Planning Assurance group.

Improvement Actions

April 2025 – Review of reporting methodology subject to final decision, to ensure this is compliant with NHS E revised guidance and the adjusted compliance figure of 95%.

April 2025 – Work has commenced to create a single job plan policy across the group.

April 2025 - RSM external audit actions from job plan audit last year have all been closed.

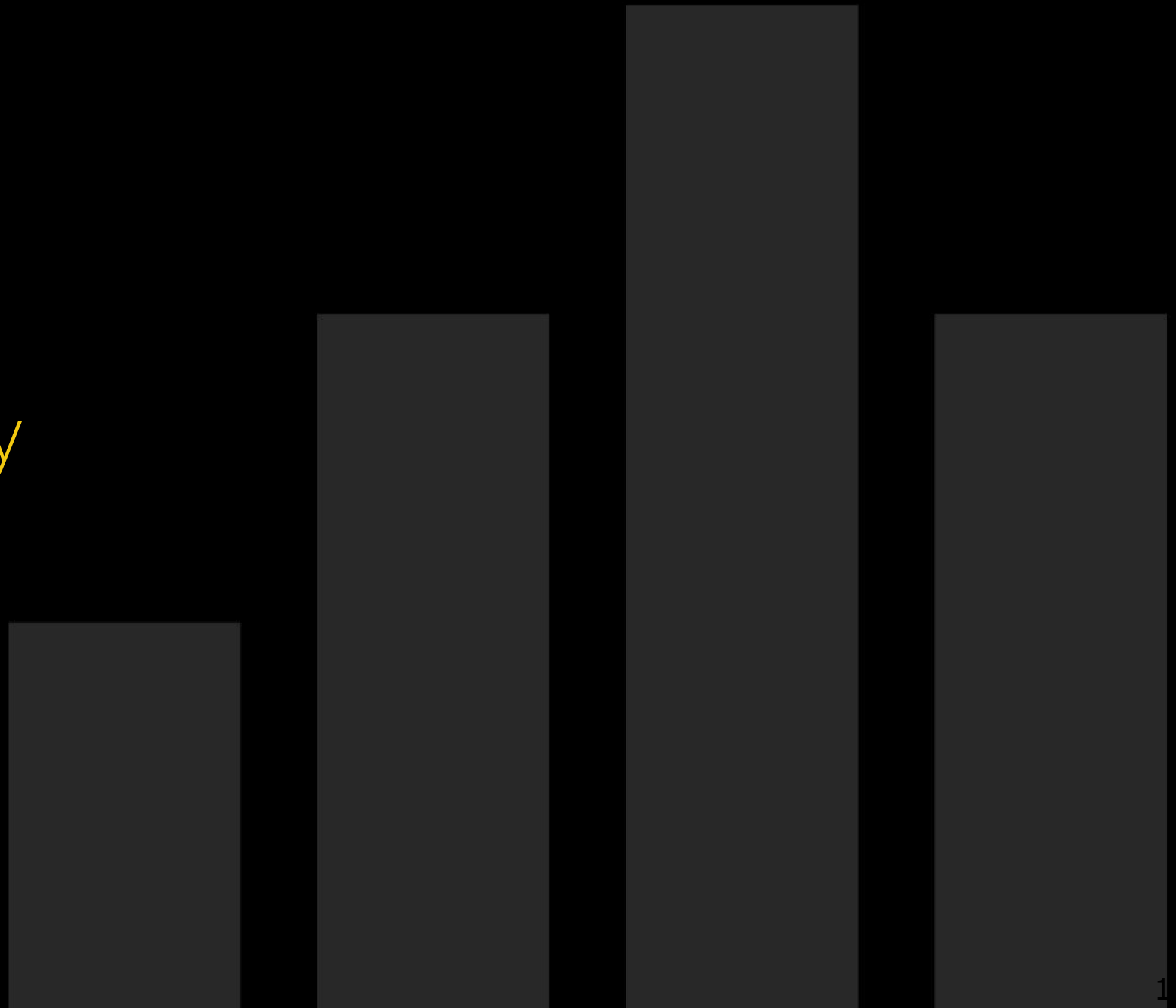
Microsoft | Power BI

Quality & Safety

View in Power BI

Last data refresh:
15/05/2025 10:53:28 UTC

Downloaded at:
15/05/2025 12:53:44 UTC



Quality Summary

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

NNUH Digital Health
business intelligence

Topic	Metric Name	Date	Result	Variation	Assurance
Maternity: Mothers	Babies Delivered	Apr 2025	375	Concern (Low)	No Target
Complaints	Complaints - Response Times - Trust	Apr 2025	28%	Concern (Low)	Inconsistent
Maternity: Mothers	Mothers Delivered	Apr 2025	370	Concern (Low)	No Target
Safer Staffing	Safe Staffing Care Hours Per Patient Per Day	Apr 2025	8.1	Improvement (High)	No Target
Safer Staffing	Safe Staffing Fill Rates	Apr 2025	96.20%	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	0
	Maternal deaths referred to Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRRACE)	0	0
	Child Death referred to local Child Death Overview Panel (CDOP)	0	0
	Information Governance incidents referred to Information Commissioner's Office (ICO)	0	0
	Deaths of patients in custody, in prison or on probation referred to Prison and Probation Ombudsman	0	0
	Incidents meeting Never Event Criteria to undergo PSII	0	0
	Incidents resulting in death, assessed as more likely than not due to problems in care following Structured Judgement Review to undergo PSII	0	0
	Missed / Delay in Diagnosis to undergo PSII	0	0
	Sub-optimal care to undergo PSII	0	0
	Incidents related to National Screening Programmes referred to local Screening Quality Assurance Team	1	1
	Neonatal Deaths Referred To PMRT	2	2
Trust PSII Priorities	Death involving patient with Learning Disability referred to local LeDeR reviewer	2	2
	Incidents to undergo another Patient Safety Review (PSR) to provide a proportionate learning response	54	54
Local Level PSR	Safeguarding Adults Referrals	81	81

	Supplementary Metrics	Last Month	YTD
Other	Duty of Candour Compliance	100%	100%
	Incidents	1,907	1,907

Assurance Commentary

There were no patient safety incidents allocated for Patient Safety Incident Investigation during April 2025. There were no PSII's signed off during April. There are currently 6 active Patient Safety Incident Investigations There were 54 incidents identified as requiring another Patient Safety Review to provide a proportionate response. Duty of candour compliance was 100% during April.

Improvement Actions

The learning from incidents and outcomes group (LIOG) continues to meet monthly to monitor oversight of actions arising from patient safety insights including 22 patient safety incident investigations (PSII). This month will see the transition from Datix to InPhase with the incident management module the first to transition to the new system. Support and guidance has been communicated and is on offer from the patient safety team.

Pressure Ulcers

NNUH Digital Health
business intelligence

Hospital Acquired Pressure Ulcers per 1,000 bed days

Apr 2025

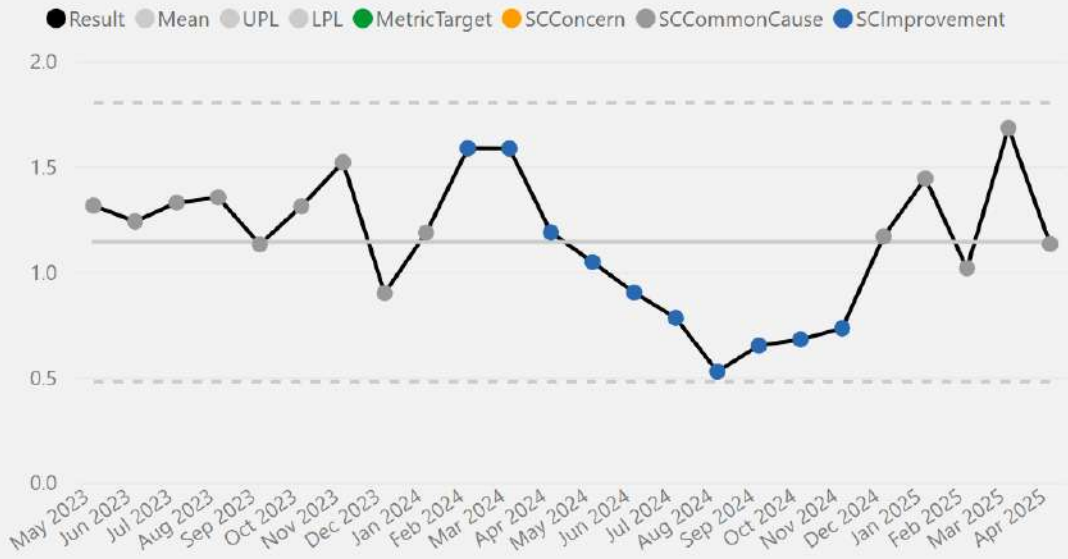
Variation | Assurance

1.1 Result
N/A Target
1.8 UPL
1.1 Mean
0.5 LPL

Analytical Commentary

Variation is Common Cause

Hospital Acquired Pressure Ulcers per 1,000 bed days



Assurance Commentary

April saw an average pressure ulcer incidence of 1.1 per 1000 bed days. This equates to a total of 31 hospital acquired reportable pressure ulcer incidents and in a reduction on the April 2024 (1.2 per 1000 bed days). The trend continues to be under previous 12 months average. Medical areas continue to have the higher incidence, as expected as they hold the higher proportion of vulnerable patients. It is noted that there has been a reduction in heel pressure ulcers this month and 4 device related pressure ulcers that could not be avoided due to clinical need of the patients. Staff continue to remain focused on essential care elements and monthly training for new staff continues to support this.

Improvement Actions

TVS and Research Teams are planning to join a national trial for heel pressure damage and NOFs in those over 65 in early June; the outcomes are anticipated to help shape local pressure care delivery. Brundall are looking to trial a different heel pressure distribution device on their patients to see if we can increase our equipment types without increasing current spend, particularly in OPM areas. This started in May and runs separately to the national trial. Dressing dispenser trial is due ot start in June. Clinical photography trial for pressure ulcers commences on Docking in May.

Patient Falls

NNUH Digital Health
business intelligence

Patient falls per 1,000 bed days

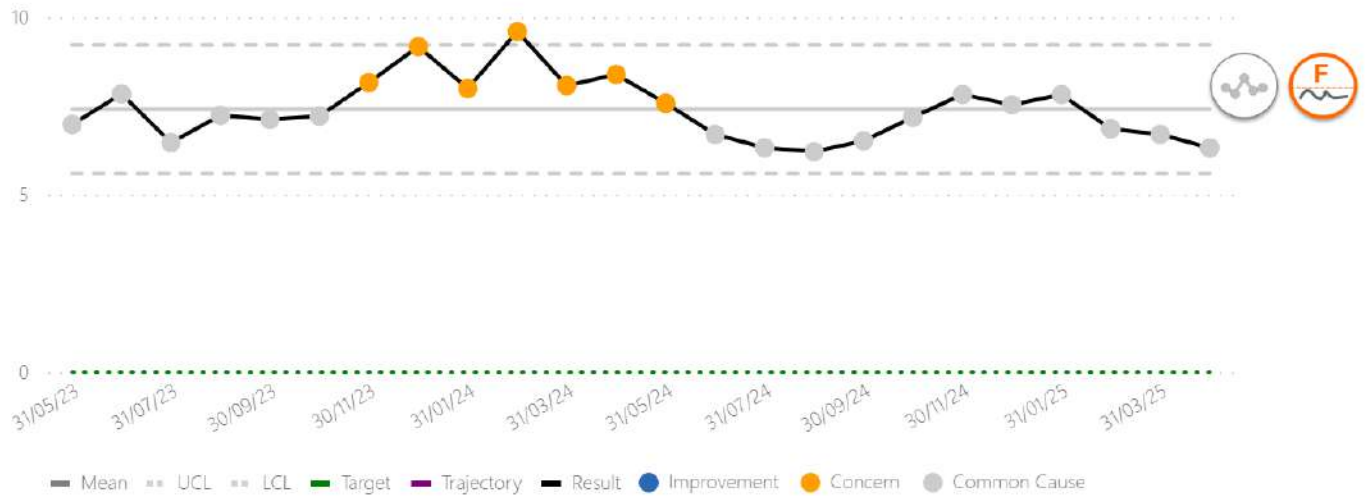
Apr 2025

6.32
Result

0.00
Target

Falls Setting

ALL SETTING



Assurance Commentary

Total falls for April 2025 173 and falls per 1000 bed days 6.3. This is a reduction of 17.5% for gross falls numbers and 18.8% for falls per 1000 bed days when compared to this point in the year in 2024 and appears related to new frailty triage model to OPM. Falls moderate harm and above 2 for April.

Improvement Actions

Falls Retrieval & Delirium simulation training continues to be used as a training tool and have been extremely well received and retrieval from the floor is now built into Trust Induction through the Manual Handling Team training.
Side room safety poster and leaflet being developed to be launched Trust Wide in May. Trust wide falls e-learning to be launched in May and initially hosted on the 'Beat'. External facing Trust Falls Programme page now live and updated NICE guidance for falls is being implemented and or planned for EPR implementation as part of the tri Trusts falls working group.

Patient Experience

NNUH Digital Health
business intelligence

Friends & Family Score

Apr 2025

Variation | Assurance

F

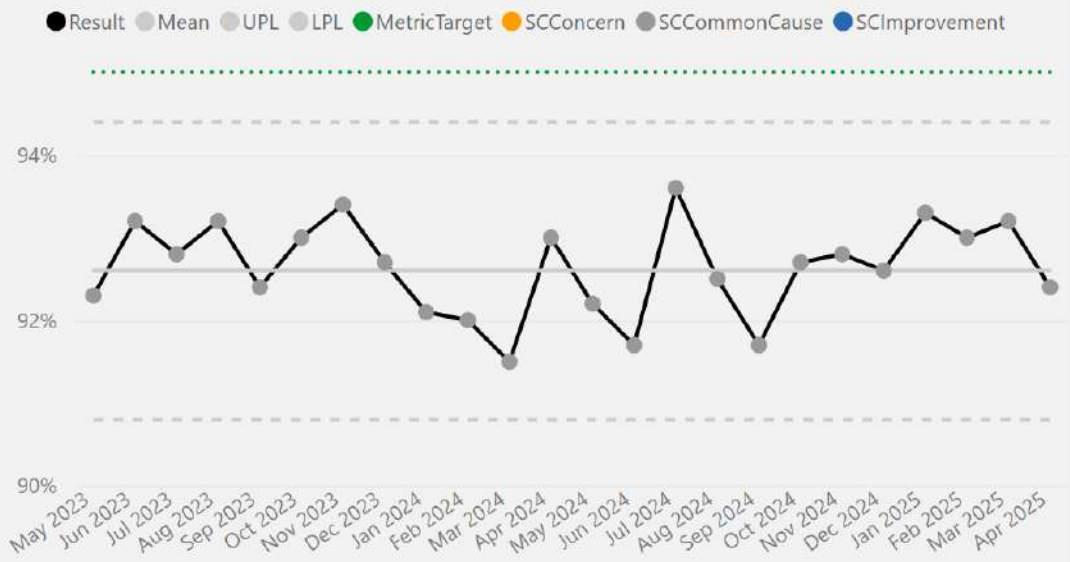
92.40% Result
95.00% Target

94.40% UPL
92.60% Mean
90.80% LPL

Analytical Commentary

Variation is Common Cause

Friends & Family Score



Assurance Commentary

3588 Friends and Family Test (FFT) responses were received in April, responses remain within our usual limits.
Top feedback themes remain staff attitude, waiting time, communication, implementation of care, and environment for both positive and negative. Overall, 92.53% of feedback received was positive.

Improvement Actions

We are still experiencing delays with new supplier implementation due to cyber and Information Governance sign off at NNUH. Everything else is ready for implementation.

Admin training has commenced. Plans for SMS testing to commence after 14th May update with supplier. PowerBI team are supporting with in house changes to hierarchy.

Supplementary Metrics

Metric Name	Date	Result		Variation		Assurance
Compliments	Apr 2025	114		Common Cause		No Target

Patient Concerns

NNUH Digital Health
business intelligence

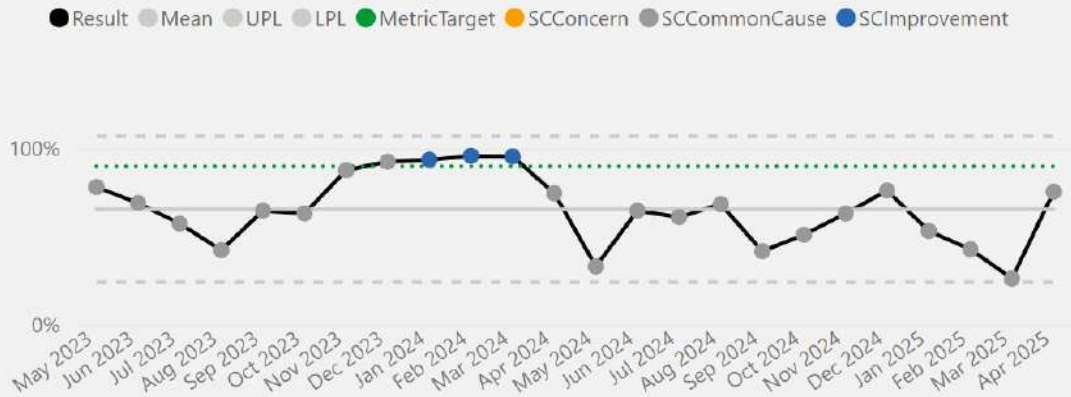
PALS % Closed within 5 days - Trust

Apr 2025

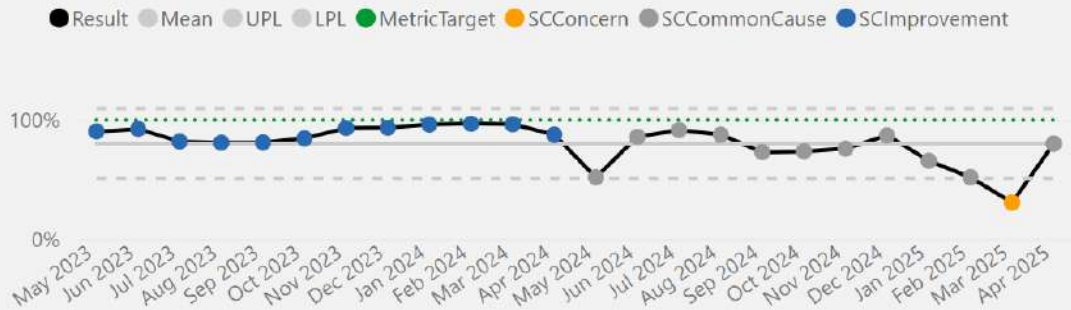
Variation	Assurance
	

75.5% Result	106.9% UPL
90.0% Target	65.5% Mean
	24.1% LPL

PALS % Closed within 5 days - Trust



PALS % Closed within 7 days - Trust



Supplementary Metrics

Metric Name	Date	Result		Variation		Assurance
PALS Contacts - Trust	Apr 2025	290		Common Cause		No Target

Analytical Commentary

Variation is Common Cause

Assurance Commentary

At the time of reporting data is incomplete for April and therefore KPIs are not an accurate reflection of performance. Despite this, the data does show some positive impact of the changes introduced for managing new cases. 275 cases have been recorded. Of those, 173 were enquiries and 101 signposting and 1 suggestion. Waiting times (52), Appointments including delays and cancellations (41) and Communications (35) are the most common subjects this month.

Improvement Actions

Data input remained a challenge during April due to ongoing sickness and vacancy affecting available resources alongside an increase in contacts in month.

The refreshed process for managing new cases into PALS has seen a significant increase in issues and concerns being dealt with in a timely way with ongoing support to clear older records. A review of establishment will be completed to ensure effective deployment of resource to meet volume via PALS.

Complaints

NNUH Digital Health
business intelligence

Complaints (Trust)

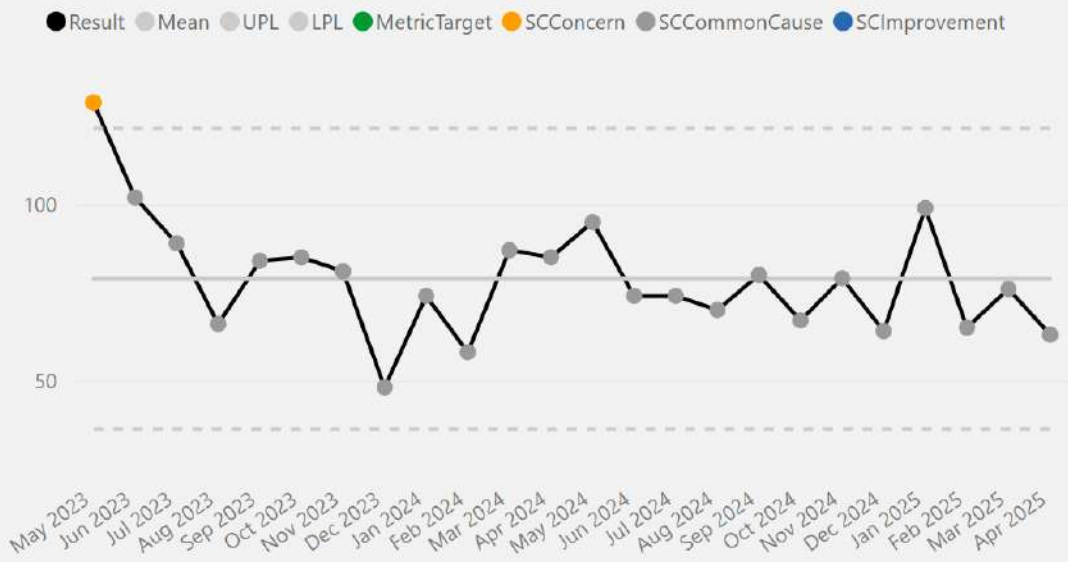
Apr 2025

Variation	Assurance
63 Result	122 UPL
N/A Target	79 Mean
	36 LPL

Analytical Commentary

Variation is Common Cause

Complaints (Trust)



Assurance Commentary

59 formal complaints were received this month with a further 27 potential complaints and 37 awaiting consent.
31 complaints were closed this month, 13 of which were older complaints.

The most common subject matter of complaints were: Clinical treatment (30), Communications (11) and Access to treatment or Drugs (9).

122 cases are 5 months or older, including additional 32 first received November 2024. An increase of 23 in total in this cohort.

Improvement Actions

Vacancies increased in month with additional sickness impacting resource available for case management. Service Manager providing additional support to clear oldest cases and intensive support for current case management with further review of processes and Officer roles and establishment. Officers will be aligned to the new Care Groups. Discussions to take place to establish a replacement for current divisional meetings. The team will work flexibly across the Care Groups to ensure continuity.

Supplementary Metrics

Metric Name	Date	Result	Variation	Assurance
Complaints - Acknowledgement	Apr 2025	95%	Common Cause	Inconsistent
Complaints - Response Times - Trust	Apr 2025	28%	Concern (Low)	Inconsistent
Post-investigation enquiries	Apr 2025	0	Common Cause	Capable

Mortality Rate

NNUH Digital Health
business intelligence

Crude Mortality Rate

Mar 2025

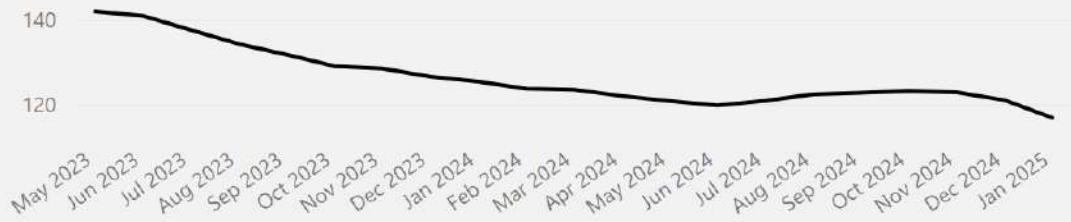
Variation | Assurance

2.00% Result
N/A Target

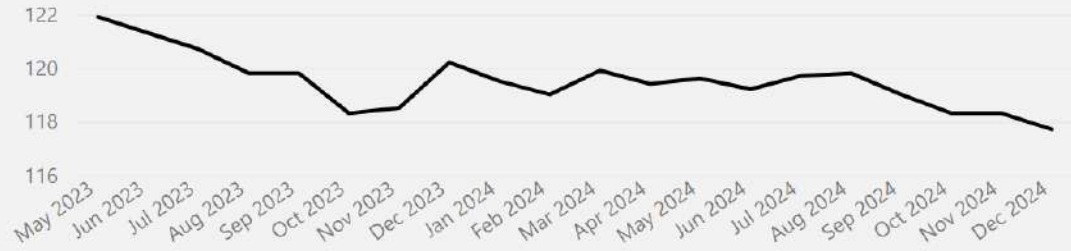
2.10% UPL
1.80% Mean
1.50% LPL

Crude Mortality Rate

HSMR



SHMI



Analytical Commentary

Variation is Common Cause

Assurance Commentary

SHMI for the rolling year period ending Dec 2024 is 118 (statistically higher than expected) but continues on an improvement trajectory. HSMR+ is 116.7 (statistically higher than expected) but also demonstrates an improvement from 120.89 in the previous reporting month. Crude mortality is reported as 2.0% within March 2025 which is slightly up from 1.8% in Feb 25 but remains within statistical control limits.

Improvement Actions

The mortality improvement action plan continues monitoring through the mortality action and review group. In addition, the transformation team are supporting improvements in clinical data quality which will support an increased depth of coding, in-directly supporting the mortality data improvements.

Metric Name	Date	Result
HSMR	Jan 2025	116.70
SHMI	Dec 2024	118

Safer Staffing

NNUH Digital Health
business intelligence

Safe Staffing Fill Rates

Apr 2025

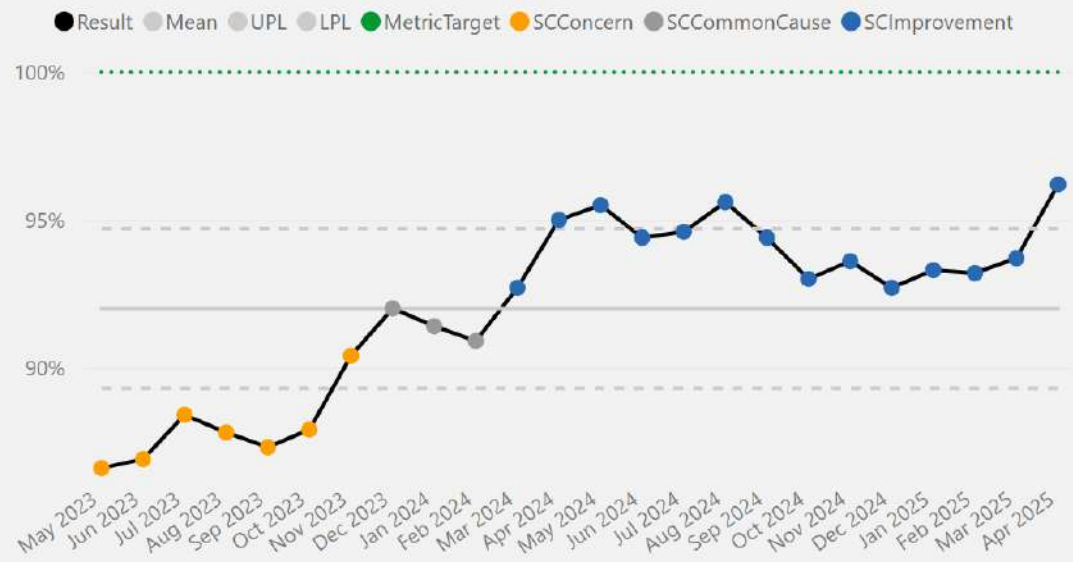
Variation	Assurance
H	F

96.20% Result	94.70% UPL
100.00% Target	92.00% Mean
	89.30% LPL

Analytical Commentary

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

Safe Staffing Fill Rates



Assurance Commentary

In April 2025, fill rates for Registered Nursing and Midwifery (RN/M) staff stood at 94.7% and 98.0% for Healthcare Support Workers (HCSW). Medicine achieved an RN fill rate of 100.9% and HCSW rate of 97.7% (overall 99.1%), while SCEC reported 92.9% for RN and 103.3% for HCSW (96.8% overall). The Women & Children's division had lower staffing levels, with RN/M at 86.1% and HCSW at 90.3% (87.2% overall). The overall Care Hours Per Patient Day (CHPPD) was 8.1 (RN/M: 4.4, HCSW: 3.7), with variations across divisions: Medicine (7.3), SCEC (8.0), and Women & Children's (12.8). A total of 136 incidents resulting in patient harm were reported, including one severe fall under review, and several moderate harm events in medicine and surgery. Seven TES-related incidents were logged with no or low harm; all but one have been closed.

Improvement Actions

Chief Nurse's Office Check & Confirm audit tool shared with Hunter Healthcare group to allow additional scrutiny and identify any further learning or efficencies to ensure a consistent approach to roster planning, creation and management across the hospital.

Exemption panels are in place to ensure safer staffing is maintained during increased vacancy control.

Supplementary Metrics

Metric Name	Date	Result		Variation		Assurance

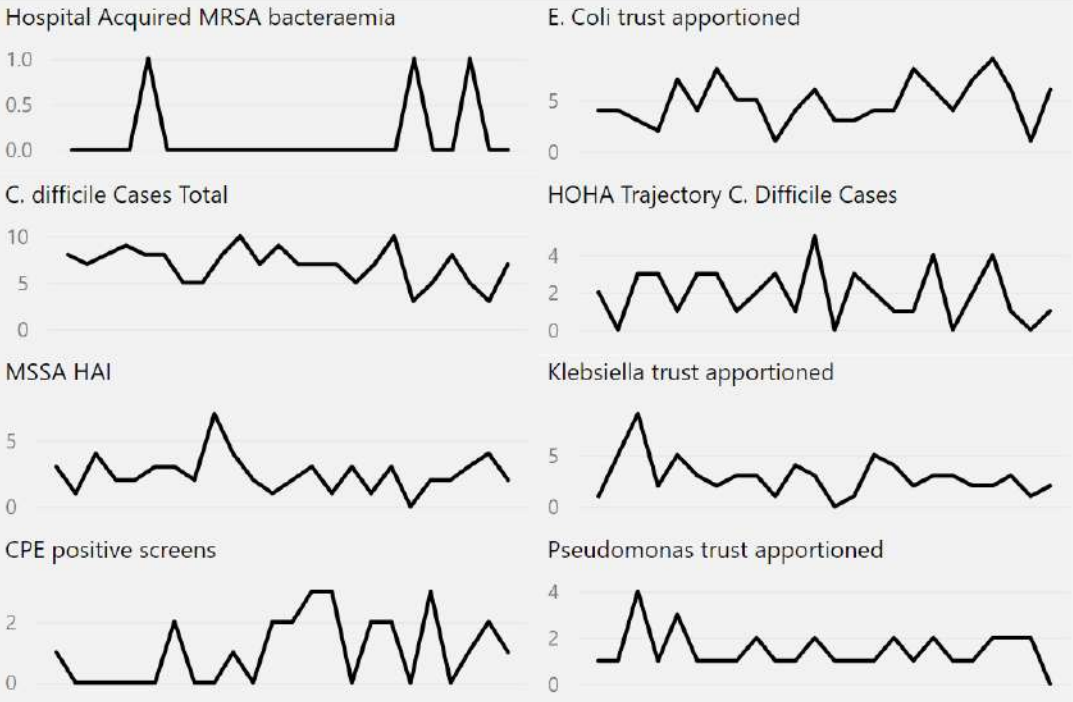
Infection Prevention & Control

NNUH Digital Health
business intelligence

MetricName	Date	Result	Target	Mean
C. difficile Cases Total	Apr 2025	7	90	7
CPE positive screens	Apr 2025	1	N/A	1
E. Coli trust apportioned	Apr 2025	6	100	5
HOHA Trajectory C. Difficile Cases	Apr 2025	1	0	2
Hospital Acquired MRSA bacteraemia	Apr 2025	0	0	0
Klebsiella trust apportioned	Apr 2025	2	55	3
MSSA HAI	Apr 2025	2	N/A	3
Pseudomonas trust apportioned	Apr 2025	0	29	1

Assurance Commentary

1 COVID-19 outbreak – Jack Pryor escalation – 3 patients.
1 Influenza outbreak – Mattishall – 2 patients.
CCC commenced supportive measures on 01.04.2025 – 08.05.2025 due to 2 cases of ESBL Klebsiella.
Guist commenced supportive measures on 29.04.2025 - ongoing due to 2 cases of HCAI C. diff.
3 ward closures for Norovirus – Elsing, Dunston & Elsing.
Reportable Healthcare Associated Infection (HCAI) figures April 2024 – March 2025
Clostridioides difficile - total of 82 HOHA & COHA cases within the annual threshold of 90.
E. Coli – total of 111 HOHA & COHA cases exceeding the annual threshold of 100.
Klebsiella – total of 43 HOHA & COHA cases within the annual threshold of 55.
Pseudomonas – total of 28 HOHA & COHA cases within the annual threshold of 29



Improvement Actions

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

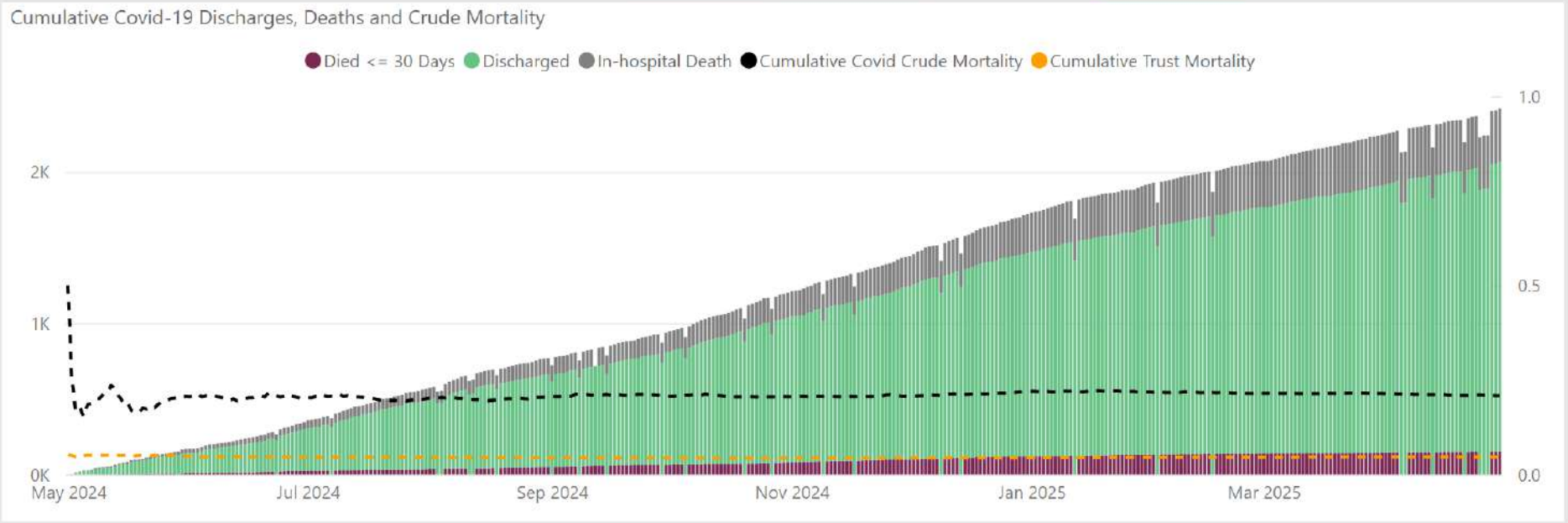
Covid-19 Timeseries

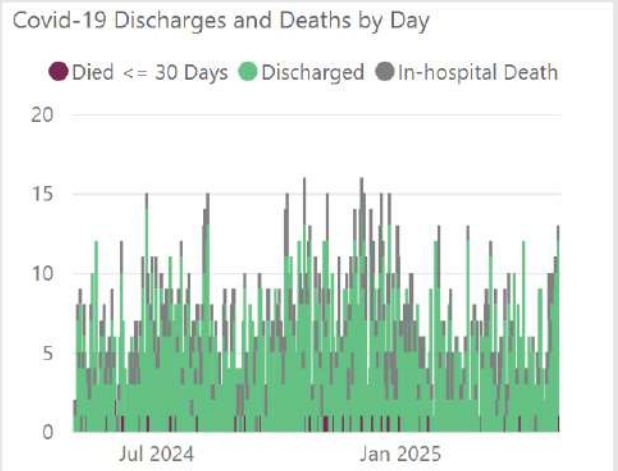
Inpatient deaths and discharges recorded on PAS for Covid-19 positive patients

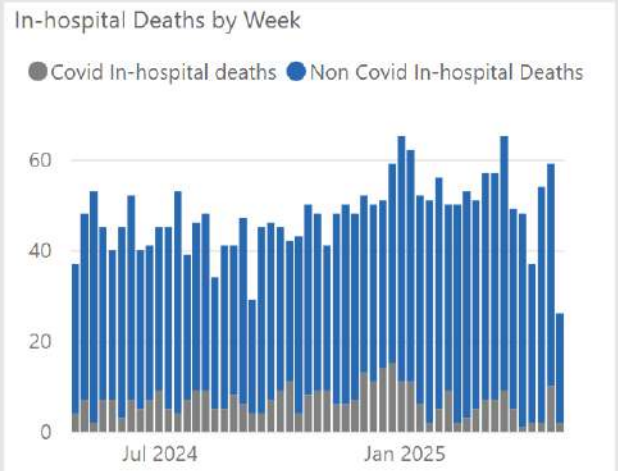
NNUH Digital Health
business intelligence

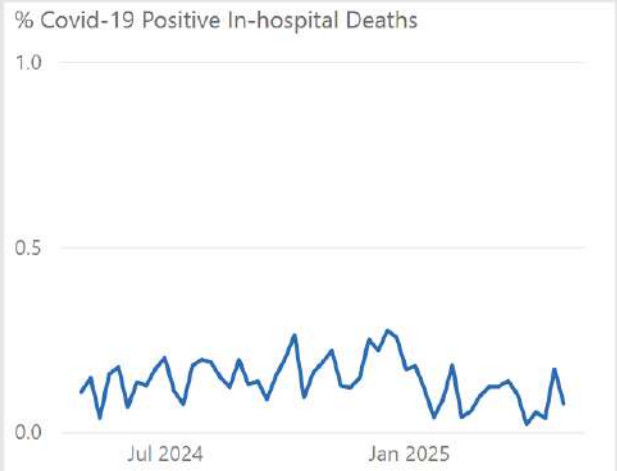
Discharge Date: 01/05/2024 – 30/04/2025

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
2420	352	152	1916	0.21	0.05	45	4









System IPR: SPC Summary

Maternity - Caesarean births in Robson group 1 - Provider

Metric Description

The percentage of women in Robson Group 1 who birthed by caesarean section in the given month. *Figure reported is 3 month rolling average

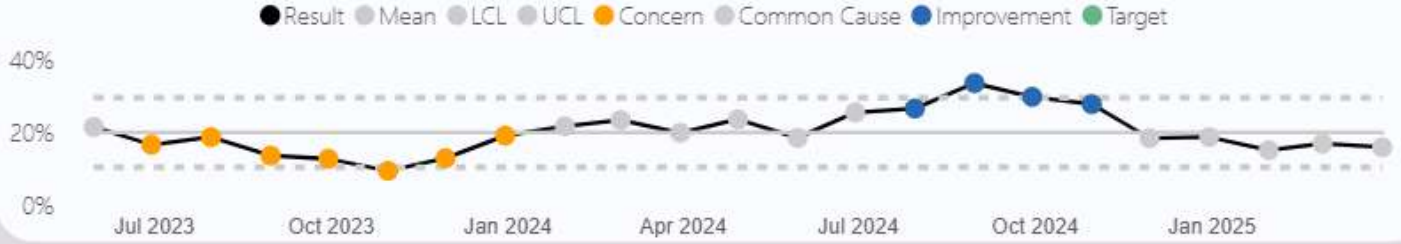
Level	Latest Date	Metric Data Source	Result	Target	Variation	Assurance
All Acutes	Mar 25	Provider Submission	21.80 %			
JPUH	Mar 25	Provider Submission	24.50 %			
NNUH	Mar 25	Provider Submission	22.60 %			
QEH	Mar 25	Provider Submission	16.00 %			

All Acutes

JPUH

NNUH

QEH



System IPR: SPC Summary

Maternity - Caesarean births in Robson group 2 - Provider

Metric Description

The percentage of women in Robson Group 2 who birthed by caesarean section in the given month. *Figure reported is 3 month rolling average

Level	Latest Date	Metric Data Source	Result	Target	Variation	Assurance
All Acutes	Mar 25	Provider Submission	51.40 %			
JPUH	Mar 25	Provider Submission	44.00 %			
NNUH	Mar 25	Provider Submission	53.30 %			
QEH	Mar 25	Provider Submission	52.90 %			

All Acutes

JPUH

NNUH

QEH

System IPR: SPC Summary

Maternity - Caesarean births in Robson group 5 - Provider

Metric Description

The percentage of women in Robson Group 5 who birthed by caesarean section in the given month. *Figure reported is 3 month rolling average

Level	Latest Date	Metric Data Source	Result	Target	Variation	Assurance
All Acutes	Mar 25	Provider Submission	11.00 %			
JPUH	Mar 25	Provider Submission	11.40 %			
NNUH	Mar 25	Provider Submission	11.00 %			
QEH	Mar 25	Provider Submission	10.80 %			

All Acutes

JPUH

NNUH

QEH

Maternity: Mothers

NNUH Digital Health
business intelligence

Mothers Delivered

Apr 2025

Variation | Assurance

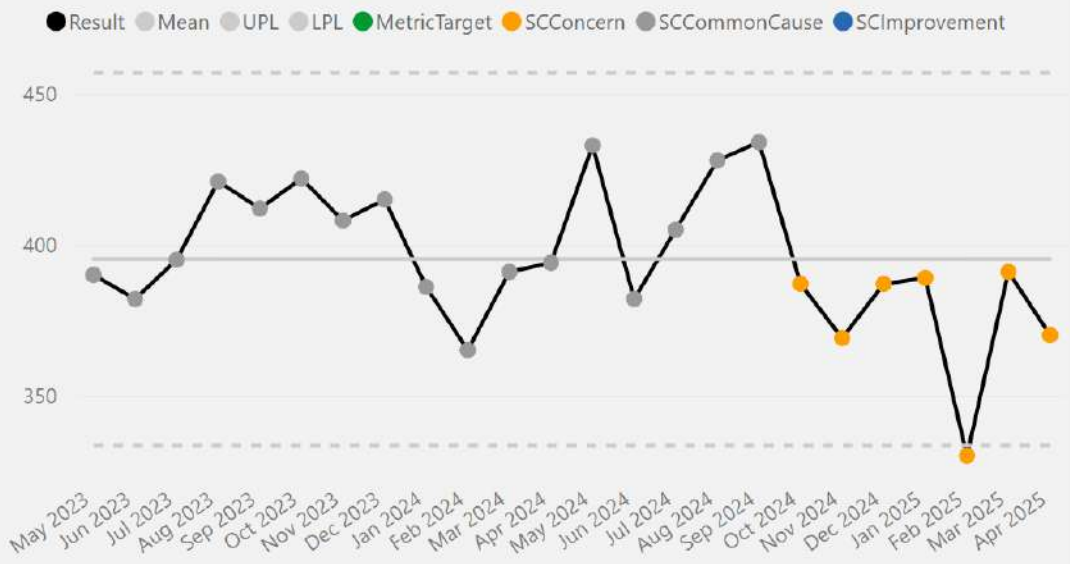
370 Result
N/A Target

457 UPL
395 Mean
333 LPL

Analytical Commentary

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

Mothers Delivered



Assurance Commentary

In April we deliverd 370 mothers with 375 babies. We had 1 stillbirth. WE delivered 332 mothers on delivery suite, 33 on MLBU and 4 at home. We had 1 BBA - This will be reviewed by the community team leaders. We had 183 cephalic deliveries - 49.5%, - 150 c/s 40.5% - 83 emergency cases / 67 elective cases, and 35 instrumental deliveries 9.5% - 19 forceps and 16 ventouse deliveries. We had 37.6% of women induced - 0.3% of those for reduced fetal movements. We had 2.3% - 3/4th degree tears and 3.8% of PPH. We had 3 readmissions - 2 sepsis/wound infections and 1 post dural headache. We had 2 transfers out due to acuity. We booked 91.1% of women before 13 weeks.

Improvement Actions

To monitor readmissions, Born Before Arrivals (BBAs) and consider impact of transfers of women due to NICU activity.

Supplementary Metrics

Metric Name	Date	Result		Variation		Assurance
1:1 Care in Labour	Apr 2025	99.3%		Common Cause		No Target
3rd & 4th Degree Tears	Apr 2025	2.3%		Common Cause		Inconsistent
Births Before Arrival	Apr 2025	1		Common Cause		No Target
Post Partum Haemorrhage ≥1500mls	Apr 2025	3.8%		Common Cause		No Target

Mothers Delivered

370

Babies Delivered

375

Maternity: Babies

NNUH Digital Health
business intelligence

Unplanned NICU ≥37 week Admissions (E3)

Apr 2025

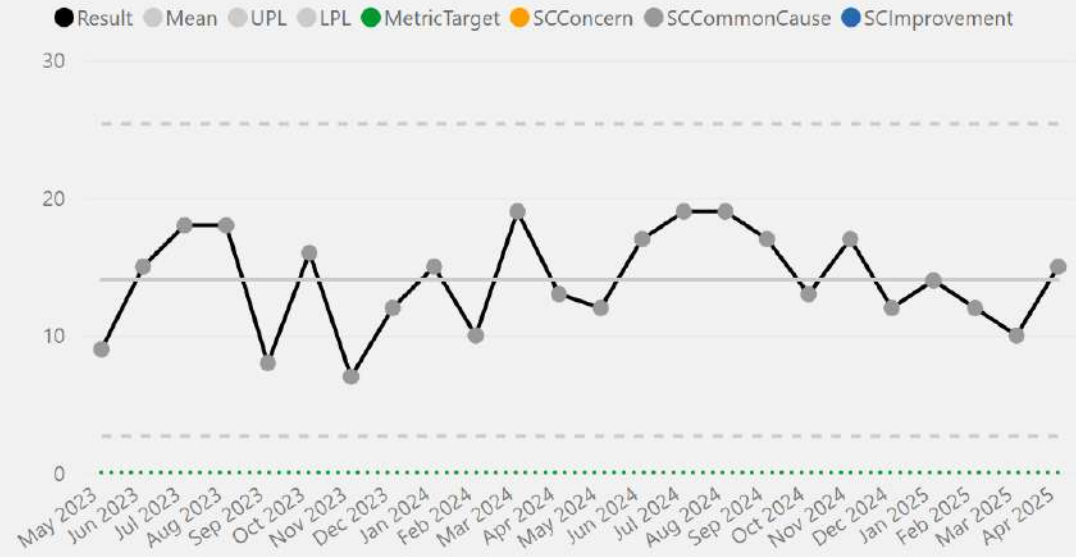
Variation	Assurance
	

15 Result	25 UPL
0 Target	14 Mean
	3 LPL

Analytical Commentary

Variation is Common Cause

Unplanned NICU ≥37 week Admissions (E3)



Assurance Commentary

In April we support 370 mothers to deliver 375 babies. We had 1 stillbirth and 1 neonatal death - these incidents are reviewed at our daily triage meeting and discussed at the weekly joint MIRE meeting. There was 15 unexpected admissions to NICU - these will be reviewed at the triage meeting and investigated by the ATAIN group for themes and trends. No Hypoxic-Ischemic Encephalopathy (HIE) cases were identified. 81% of babies breast fed at delivery and 61.6% on transfer to the community. 77% were mixed feeding on transfer. 7.7% of babies delivered pre-term.

Improvement Actions

NICU admissions are reviewed via the daily triage process with deep dive by the ATAIN team.
Infant feeding statistics continue to be monitored.

Supplementary Metrics

Metric Name	Date	Result		Variation		Assurance
Adjusted Still Births	Apr 2025	1		Not Applicable		No Target
Apgar score <7 @5, ≥37 weeks	Apr 2025	9		Common Cause		No Target
Early Neonatal Death	Apr 2025	1		Not Applicable		No Target
Mothers Transferred Out of Unit	Apr 2025	2		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	Apr 2025	6.8%		Common Cause		Inconsistent
Fetal Growth Restriction	Less Than 3rd centile born > 37+6 weeks	Apr 2025	1%		Common Cause		Not capable
Fetal Growth Restriction	SGA detected Antenatally	Apr 2025	51%		Common Cause		No Target
Reducing Preterm Birth	Singleton Births Preterm	Apr 2025	8%		Common Cause		Inconsistent
Reducing Preterm Birth	Singleton live births < 34 wks (AN corticosteroids within 7 days PN)	Apr 2025	33%		Common Cause		Inconsistent

Assurance Commentary

The Saving Babies' Lives Care Bundle (SBLCB) V3.2 has been launched - the team will review its contents / changes and act accordingly. The team will work with the LMNS/Regional team to facilitate the compliance required.

Improvement Actions

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

Adult Safeguarding

NNUH Digital Health
business intelligence

Safeguarding Adults Referrals

Apr 2025

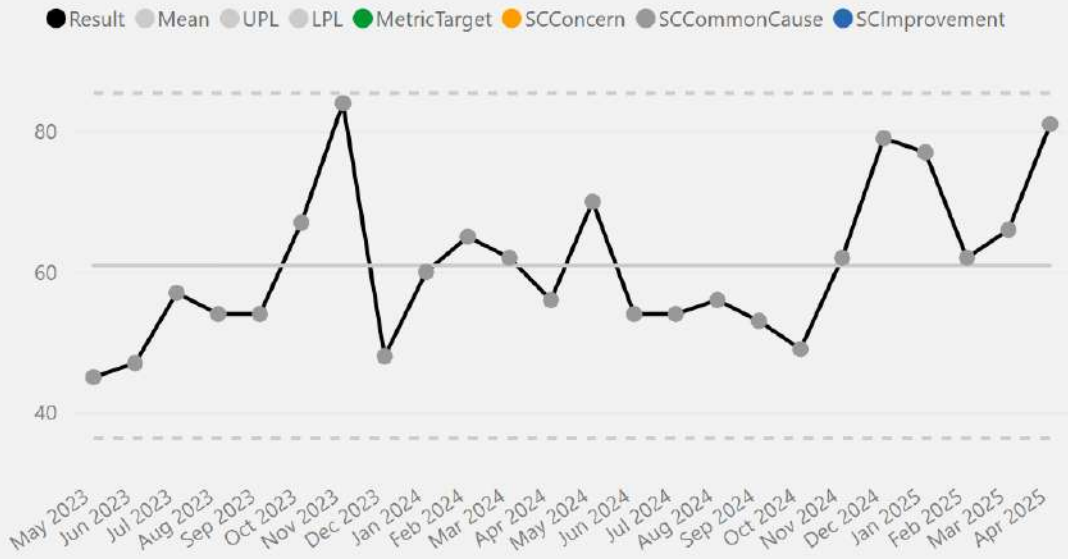
Variation	Assurance
	

81 Result	85 UPL
N/A Target	61 Mean
	36 LPL

Analytical Commentary

Variation is Common Cause

Safeguarding Adults Referrals



Assurance Commentary

There were six section 42s raised against NNUH in April, five relating to pressure ulcers, and one an allegation of neglect. The three acute hospitals safeguarding leads have had a discussion with regards to managing pressure ulcers and ascertaining when it's appropriate to make a safeguarding referral and subsequent to this, on 14/04/25 the leads delivered an action to the three Tissue Viability Nurses in each of the acutes to collaborate on a single pathway relating to safeguarding referrals of pressure ulcers so that the Group can follow the same process. This is work ongoing.

Improvement Actions

The Norfolk Safeguarding Adults Board (NSAB) Framework pilot completed end of January 2025. The Safeguarding Leads met with the ICB Designated Safeguarding Team to review the recommendations of the pilot. It was observed that the sample used was not big enough to represent the demographics of the organisations involved in this evaluation. This will be fed back to NSAB by the ICB to make a final analysis on whether the framework should be endorsed. Separate to this, NNUH safeguarding adults pathways are undergoing an audit facilitated by RSM. Initial feedback is expected 23/05/25.

Children & Midwifery Safeguarding

NNUH Digital Health
business intelligence

Safeguarding Children and Midwife...

Apr 2025

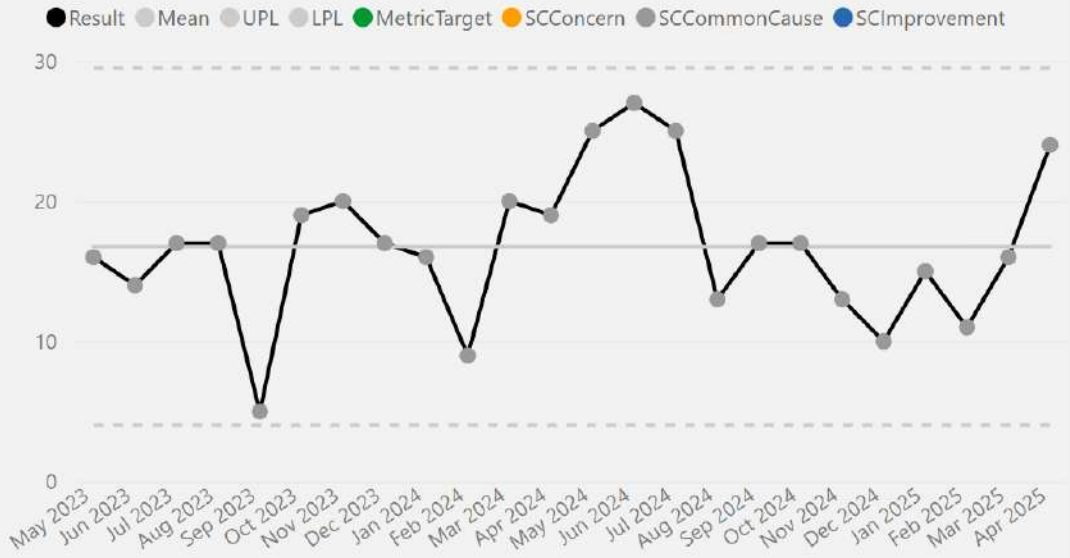
Variation	Assurance
	

24 Result	29 UPL
N/A Target	17 Mean
	4 LPL

Analytical Commentary

Variation is Common Cause

Safeguarding Children and Midwifery Referrals



Assurance Commentary

There was a real push from the safeguarding team to staff in paediatrics and midwifery to complete ICE notifications when a referral for a child or unborn baby is made to Children's Services. Referrals into the Local Authority are still telephone only and staff are being encouraged to complete the process by notifying the internal safeguarding team to be able to support with any follow up required. We did see a slight increase in the number of ICE notifications made in April, totalling 24. Outside of this, staff still feel confident in identifying concerns of families that require external input. Supervision continues to be offered adhoc.

Improvement Actions

The safeguarding team is undergoing an audit facilitated by RSM looking at our safeguarding children, safeguarding adults and MCA/DoLS processes. An initial meeting was held on 22/04/25 with the Audit Consultants to better understand our procedures. Since then, the safeguarding team has been providing the evidence requested to offer a better analysis of our governance and reporting structures, as well as an assessment of our legislative responses. RSM will attend NNUH on 16/05/25 for audit testing and then a meeting has been scheduled for 23/05/25 to receive initial feedback of the audit.

Supplementary Metrics

Metric Name	Date	Result	Variation	Assurance
Safeguarding Children Referrals	Apr 2025	15	Common Cause	No Target
Safeguarding Midwifery Referrals	Apr 2025	9	Common Cause	No Target

REPORT TO THE TRUST BOARD	
Date	04 June 2025
Title	Chair's Key Issues Report from the Quality and Safety Committee
Lead	Dr C Fernandez Committee Chair
Purpose	**For Information**

1. Background/Context

The Quality and Safety Committee met on 20 May 2025 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 Ms Abdulkareem and Mrs Moore as Patient Safety Partners.

2. 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:

- The Committee spent time reviewing and agreeing the work programme of agenda items to be reported for the remainder of the fiscal year.
- It was agreed clinical visits are important and that these should be aligned to the agenda topics as much as possible
- The level of assurance of the Committee suffered due to the lateness of some papers and the level of content within the papers. It is felt that the content of the papers goes into too much operational detail, without highlighting key areas for concern or improvement, and provide reassurance rather than assurance to the Committee. The Committee noted the level of change within the Trust and transition to the Group Model, and highlighted the need to ensure that during this time assurance provided on the quality, safety and experience of care provided is not affected.

Key Matters for the Attention of the Board

Assurance Levels	
• Quality Account for 2024-2025, the draft document was shared with the Committee for comment. The Committee expressed a view that the document required improvement and the images did not reflect our workforce or meet our values relating to equality, diversity, and inclusion. The level of detail contained within the document was variable and there were	Not Assured

inconsistencies in terms of grammar and language. The Committee agreed a series of remedial actions to address these issues, and it was agreed to circulate an updated version of the document via email to the Committee for approval.	
• Safer Staffing report nursing, midwifery and AHPs, the report was detailed and addressed the concerns previously raised by the Committee concerning Care Hours Per Patient Day (CHPPD), vacancies and the triple lock process. The process of recording the acuity three times a day and allows staff with appropriate skills to be moved to mitigate any potential risks and red flags was described. The Chief Nurse also provided detail on how information is being triangulated in relation to the rosters, budgets, head count review and reduction in the use of agency and bank staff.	Assured
• Chronic Condition Pathways and hot clinics. More detailed analysis to be brought back in June due a slight delay in progress due to the implementation of Care Groups. These clinics are all available to Paramedics and will be rolled out to the Community Hospital shortly. Looking to co locate community team alongside Loddon to create a Frailty AMU. A further report is scheduled for the June meeting to address the issues raised by the Committee.	Partially Assured
• IPR. Good performance noted in Staffing with Mortality, Maternity Cardiology and Safeguarding metrics to include a more focussed and informative narrative on the key areas of concern, actions to address and impact on patient outcomes	Partially assured
• ICCNA. Good assurance on the embedding of PSIRF framework within the organisation and participation in local and national audits. Limited assurance on the timely response to historical SI action plans and the impact of actions from PSIRF. Limited assurance on the timely response to PALS and complaints and that these are being effectively used to drive improvements. Request that audit data is presented to provide assurance that good performance and areas for improvement are clearly identified.	Partially assured
• PLACE Assessment. Improvements noted across all domains and support from largest patient assessors to date with an action plan in place to drive further improvements and operational oversight by PEEG.	Assured
Alerts to Board	
• All papers need to be uploaded to Admin Control in a timely manner (Thursday ahead of the Q&S), otherwise the Committee cannot undertake the appropriate level of review and scrutiny. A timetable has been put in place to address this.	
Advice to Board	
• Non-Executives need to be better when saying a paper for a Committee or to Board provides good assurance and provide constructive feedback on areas where papers can be improved, so that colleagues can learn from what provides assurance and reassurance. • An education programme needs to be provided to the Care Groups to support with drafting papers accordingly. • Note the valuable discussion about the work plan for the Committee and to continue to dedicate time to this as it will be important during the transition to Group governance.	

3 Conclusions/Outcome/Next steps

The Committee is scheduled to meet again on 24 June 2025.

Recommendation:

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