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

Norfolk and Norwich University Hospitals NHS Foundation Trust

Quality Report 2016-17

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Quality Report

Part 1 - Chief Executive's Statement on Quality

This was my first full year as Chief Executive at the NNUH and we have made good progress. We have a strong track record of delivering good clinical outcomes and a high standard of patient experience in both our hospitals.

It is humbling and gratifying to see the efforts made by staff for our patients. I feel enormously proud to work with such a passionate and committed team who put safety at the heart of everything they do. We are particularly pleased with the consistently high scores given to us by patients in the Friends and Family test.

Our partnership with the University of East Anglia continues to deliver a wide ranging programme of research which is aiming to improve the care we deliver to patients now and in the future. We aim to adopt best practice wherever possible, embracing innovation, and most importantly learning and improving.

Our track record on infection prevention and control has been impressive and we are pleased to say there have been no cases of hospital-attributable Methicillin Resistant Staphylococcus aureus (MRSA) in 2016/17. In fact, in the last five years there has only been one case of hospital acquired MRSA which reflects the tremendous hard work and dedication of our teams.

We are working hard to deliver and sustain rapid performance improvements including the use of temporary facilities and seven day services just to keep pace with demand. In the longer term, we will need permanent solutions to help solve the pressures on our capacity which will, in turn, help us to improve on our access targets. Our plans include building an Ambulatory Care and Diagnostic Centre (ACAD) and developing our services for interventional radiology, cardiac catheter labs and critical care. Building work has already commenced on-site on the Quadram Institute which, when complete, will house the largest endoscopy unit in Europe.

On cancer, we continue to do well on the two week waits and 31 day target despite an increase in referrals of nearly 9% which now number over 2,000 a month. There have been more challenges in delivering the 62 day target for GP referral to treatment because NNUH, like many other Trusts nationally, is continuing to see an increase in the number of referrals and requires more capacity in diagnostics, outpatient services and surgery. Ensuring that our cancer patients are treated quickly continues to be a major

Over the last year we have increased investment in the integrated discharge team to support safe and timely discharges throughout the organisation. One of the areas where extensive work has been completed is with 'stranded patients' - those patients with a hospital stay of more than 14 days – and we have seen real success with this.

Patient safety continues to be our top priority and our aim has been to reduce avoidable harm and when an incident does occur, ensure that we learn and improve. We have achieved important improvements in patient safety with the introduction of several initiatives. We have taken an innovative approach by providing emergency kit bags for wards which contain the key equipment needed to treat Sepsis fast. Suspected cases are reported with the same hospital emergency system as that used for a cardiac arrest.

The SAFER bundle has also been implemented with a significant increase in the percentage of patients that had a documented Senior Review. This early review also forms part of the Red to Green initiative which ensures every patient knows what is happening to them every day to progress their care and avoids unnecessary waiting. A simple daily assessment is carried out to identify whether each patient has a clinical and practical care plan in place which will progress their recovery (Green Day) or whether their care has not progressed or there are problems to resolve (Red Day).

In August 2016, it was announced by NHS Improvement (NHS I), our regulator, that five Trusts including NNUH were being placed in financial special measures. We set up a Programme Management Office to track and monitor financial improvement plans, with oversight from the Financial Improvement Programme Board. This approach has enabled the Trust to demonstrate financial improvement from all the actions taken by the different teams across the Trust. We were brought out of Financial Special Measures in February 2017 after working hard to bring down our deficit from £32m to £25m.

There is no doubt that in 2017/18, the environment in which we work will continue to be challenging, but I am confident that by supporting a culture of learning and improvement we will provide our patients with the safe, high quality care and experience they deserve.

The content of this report has been subject to internal review and, where appropriate, to external verification. I confirm, therefore, that to the best of my knowledge the information contained within this report reflects a true, accurate and balanced picture of our performance.

Mark Davies, Chief Executive

30th April 2017

Information about this Quality Report

We would like to thank everyone who contributed to our Quality Report.

We welcome comments and feedback on the report; these can be emailed to *communications@nnuh.nhs.uk* or sent in writing to the Communications Department, Norfolk and Norwich University Hospitals NHS Foundation Trust, Norfolk and Norwich Hospital, Colney Lane, Norwich NR4 7UY.

Further copies of the report are also available on request from the addresses above.

If the report is required in braille or alternative languages please contact us and we will do our best to help.

Part 2a - Introduction and priorities for improvement

Part Two of our report begins with a review of our performance during the past twelve months compared to the key quality targets that we set for ourselves in last year's quality report. Where possible, we have included comparative performance data from previous reporting periods, to enable readers to assess whether our performance is improving or deteriorating.

The focus then shifts to the forthcoming twelve months, and the report outlines the priorities that we have set for 2017/18, and the process that we went through to select this set of priorities.

This is followed by the mandated section of Part 2, which includes Board assurance statements and supporting information covering areas such as clinical audit, research and development, Commissioning for Quality and Innovation (CQUIN) and data quality.

Part 2 concludes with a review of our performance against a set of nationally mandated quality indicators.

Progress against our 2016/17 priorities

Our Quality priorities for 2016-17 were derived from consultation with staff through our divisions, through consultation with our CCG commissioners through the Clinical Quality Review Group, and through consultation with our public through our Council of Governors. They were ratified by our Management Board and Trust Board and have been reported through our Integrated Performance Report (IPR).

Detailed action plans and measures were developed for each of our quality priorities and, throughout the year, performance has been monitored by the appropriate Executive Sub-Boards and governance committees.

We continued to disseminate learning points for issues such as medication administration, pressure ulcer prevention, and falls avoidance through our innovative Organisation Wide Learning (OWL) bulletins.

In reviewing our progress against our targets, this report will highlight not only those areas where we have done particularly well, but also those areas where further improvement is still required.

Review of our 2016/17 Quality Priorities

	Quality Priority	Quality Aim	Rating
Patient Safety	Reduction in medication errors	Focusing on having zero insulin errors causing *NPSA* category 'moderate harm' or above	Mostly Achieved
	Prompt recognition and treatment of sepsis	Through improved screening and compliance with the Sepsis 6 care bundle	Achieved
	Keeping patients safe from hospital acquired thrombosis	Through achieving 95% compliance with thromboprophylaxis risk assessment (TRA) as evidenced on the Electronic Prescribing and Medicines Administration system (EPMA).	Achieved
	Incident reporting and management	Remain within the top 25% of acute trusts for incident reporting on NRLS, with 100% compliance with Duty of Candour	Progress Achieved
Patient Experience	Treat patients with privacy and dignity	With 100% of patients in all areas reporting through FFT that they are 'satisfied' or 'very satisfied' with the standard of care that they receive	Progress Achieved
	Improved continuity of care and experience	Reduced ward moves and reduced numbers of outliers. No more than 20 patients recorded on WardView as boarders, as measured by a monthly average report	Progress Achieved
	Improved discharge processes	EDL to be completed within 24 hours in 95% of discharges	Progress Achieved
	Dementia screening and assessment	For new admissions over 75 to be appropriately screened and assessed for dementia, in accordance with national reporting requirements	Achieved
Clinical Effectiveness	Acute Kidney Injury	Improve communication with GPs	Achieved
	Keeping patients safe from infection	C. Diff within trajectory target, 0 Hospital Acquired MRSA bacteraemia	Achieved
	Improve quality of care through research	Year on year increase in patients recruited into research studies. Aim to achieve 5000 recruitment into NIHR studies in 2016-17	Achieved
	Timely medical review of all patients	Senior review - every patient should be reviewed by a doctor every day. All new and unstable patients and all patients for potential discharge should be reviewed by an ST3 or above.	Progress Achieved

Red – Quality priority not achieved
Amber – Quality priority partially / mostly achieved or significant improvement achieved
Green – Quality priority achieved

In order to measure ourselves and report properly against our quality priorities we must be able to collect and report meaningful data. This regular measurement has proved to be difficult within a paper based records system for two of our 2016/17 specific quality priorities which we have therefore been removed for 2017/18 ("acute kidney injury" and "dementia screening and assessment").

Patient Safety – Reduction in Medication Errors

What was our aim?

To have zero insulin errors causing NPSA category 'moderate harm' or above

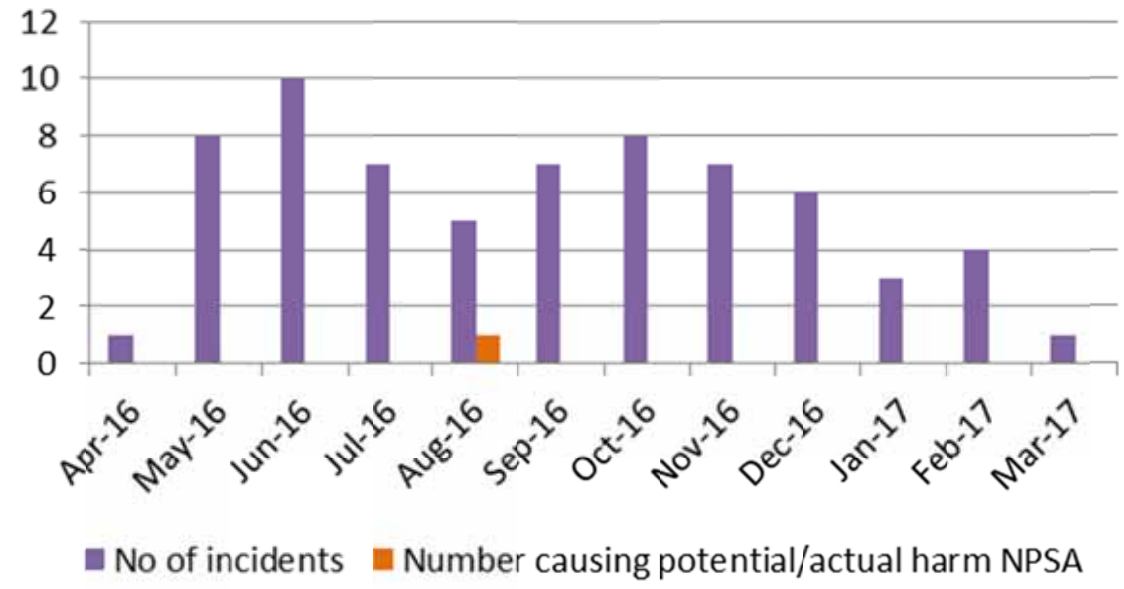
How did we measure our performance?

We monitor all reported incidents involving insulin every month via the medication incident group and send a report to the Clinical Safety Sub Board, governance Leads and Dr Jeremey Turner Service Director for Endocrinology.

How did we do?

At the end of February 2016/17 there had been one insulin error in this NSPA category (3 in 2015/16). The learning from the case review is the need to identify from the EPMA those patients at risk with diabetes and focus the resource of the diabetic team on supporting that group – e.g. patients at risk of diabetic ketoacidosis and those on variable rate insulin infusions.

Figure 1 - Insulin incidents by month



Source: NNUH data, national definition used

Patient Safety - Prompt recognition and treatment of sepsis

What was our aim?
To improve screening and compliance with the 'Sepsis 6' Care bundle, of which the single most important aspect is the administration of antibiotics within an hour of diagnosis.

How did we measure our performance?
Our performance during 2016-17 was measured using national Commissioning for Quality and Innovation (CQUIN) stipulated Key Performance Indicator (KPI) criteria as follows:

- The percentage of patients who meet the criteria for sepsis screening that were screened for sepsis.
- The percentage of patients who present with severe sepsis, red flag sepsis or septic shock that receive intravenous antibiotics (within one hour of arrival to emergency admitting areas for 'admission sepsis' and within 1 hour of diagnosis for 'sepsis developing as an inpatient') and who received an empiric review within three days of the prescribing of antibiotics.

KPIs are measured using strict auditing criteria, set nationally.

How did we do?

Figure 2 – Sepsis screening and antibiotics administration and review

Area of focus	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
ED screening	90%	92%	94%	90%	92%	94%	92%	90%	90%	92%	90%	94%
IP screening	Establishing baseline			90%	92%	90%	90%	92%	90%	90%	90%	90%
ED abx	53%	50%	63%	70%	77%	73%	83%	87%	77%	83%	80%	77%
IP abx	58%	53%	53%	63%	63%	80%	83%	79%	84%	90%	91%	93%

Source: NNUH data, national definition used

During 2015-16, our average performance for screening (adult and paediatric) patients who met the criteria for sepsis in Emergency Departments was 84.19%.

We launched a new and innovative 'Sepsis Screening and Emergency Treatment Pathway' for inpatients. This treats sepsis with the same level of priority as a cardiac arrest. If the doctor caring for the patient raises the sepsis alarm using the 2222 emergency number, a "Sepsis Emergency Treatment Kit" is delivered to the patient by our Portering staff. The kit contains all essential items needed to deliver the 'Sepsis 6' bundle. In addition, a member of the Critical Care Outreach Team or a Site Practitioner receives an emergency call and attends the patient to help the ward staff administer timely care.

This new pathway has enabled us to have a consistent method for the timely recognition and treatment of sepsis across all inpatient areas; a key improvement on previous years. We are now working with our ED and Women's and Children's colleagues to refine their existing processes, with an aim to have paperwork and processes that where possible are as generic and consistent across the organisation as possible

World Sepsis Day sees new patient safety initiative at NNUH

On World Sepsis Day (13th September 2016), new Sepsis Emergency Kit bags for treating in-patients with suspected Sepsis were launched at NNUH as part of a patient safety initiative.

Dr Michael Irvine, Consultant in Intensive Care Medicine at NNUH, said: "Timely treatment is critical when treating patients for Sepsis as survival rates are improved significantly if antibiotics can be administered within 60 minutes of diagnosis. Patients are also less likely to have serious health complications if we provide prompt treatment. However, Sepsis is more difficult to identify than conditions like heart attacks and strokes, as the symptoms are often more generalised and non-specific."

"We are taking an innovative approach and providing emergency kit bags for wards which contain the key equipment needed to treat Sepsis fast. Suspected cases will be reported with the same hospital emergency system as that used for a cardiac arrest.

Patient Safety - Keeping patients safe from hospital acquired thrombosis

What was our aim?
To achieve 95% compliance with thromboprophylaxis risk assessment (TRA), as evidenced on the Electronic Prescribing and Medicines Administration system (EPMA).

How did we measure our performance?
Data on thrombosis risk assessment (TRA) completion rates is generated electronically from the Electronic Prescribing Medicines Administration (EPMA) system. Results help to identify potential problems and inform Trust Guidelines.

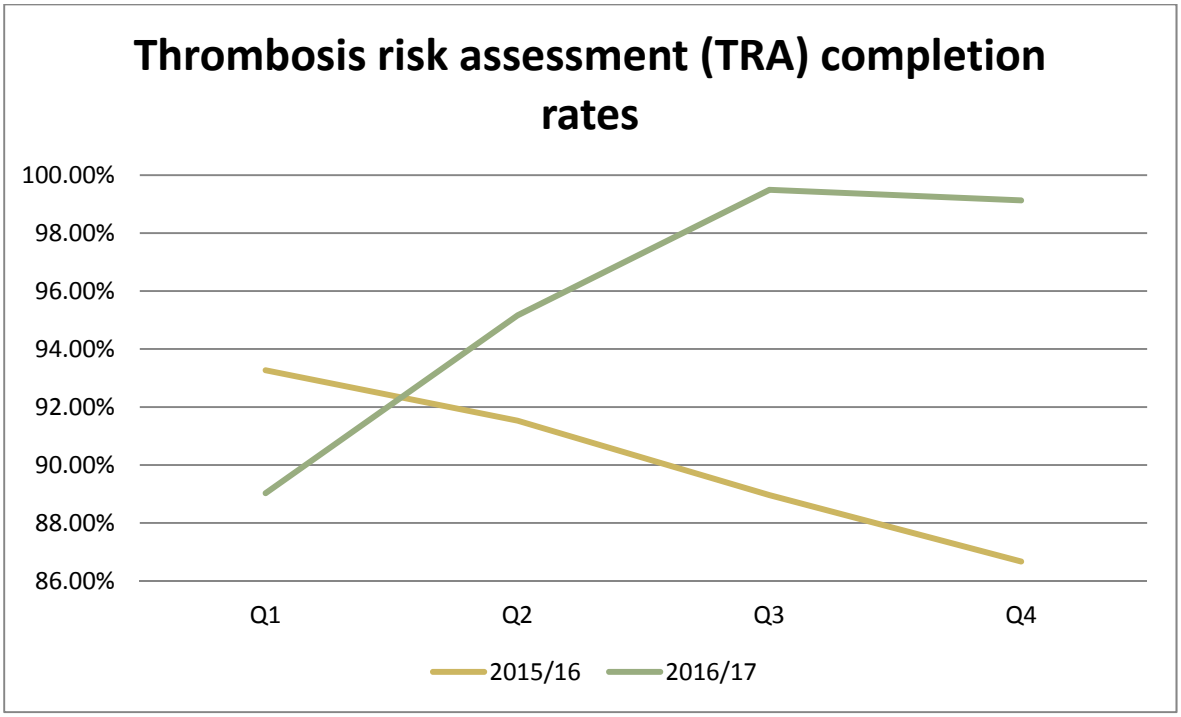
RCAs are carried out by the VTE Team on all Hospital Acquired Thrombosis (HATs) that are reported on Datix. The HATS are all initially classified as 'moderate' on Datix and then downgraded if appropriate following the RCA. The RCA target for HATs is 100%.

Two-monthly reviews of medication incidents involving anticoagulants have been introduced to identify any emerging themes or actions needed to reduce risk of similar incidents occurring in the future.

The Thrombosis and Thromboprophylaxis Committee meets on a two-monthly basis and has an active involvement in raising awareness of thrombosis issues across the Trust and in Education.

How did we do?
Figure 3 shows that 2016/17 compliance is now nearing 100%.

Figure 3 - Thrombosis risk assessment (TRA) completion rates



Source: NNUH data, national definition used

Patient Safety - Incident reporting and management

What was our aim?
To remain within the top 25% of acute trusts for incident reporting on NRLS, with 100% compliance with Duty of Candour.

How did we measure our performance?
All patient incidents, regardless of their severity, are recorded on DATIX and are submitted quarterly to the National Reporting and Learning System (NRLS).

The Risk Management Team currently maintains a Duty of Candour (DoC) Compliance database which tracks compliance regarding DoC across the Trust.

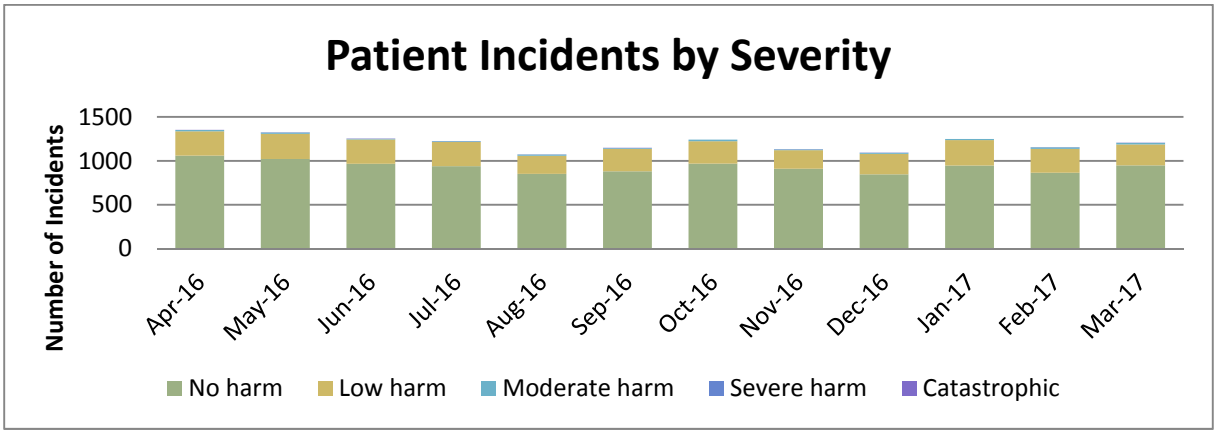
All Moderate Harm or above severity incidents which are reported an Datix are verified with the Consultant / clinical lead and a DoC "Compliance Statement" document is completed to confirm that all actions have been taken and documented.

Entries in the database between January and September 2016 were used to randomly select patient records where DoC actions had been confirmed as been fulfilled by clinical staff. A DoC audit was undertaken in October and November 2016, involving the review of twenty-seven sets of patient case notes. Each case was reviewed to establish whether the completion of all DoC actions had been fully documented in the patient records.

How did we do?
In the twelve months ending 31st March 2017, 14,464 incidents were recorded on DATIX. Of these, 14,282 (98.74%) caused either no harm or low harm to patients. In 2015/16 there were 15,283 reported incidents, of which 15,104 (98.83%) caused no harm or low harm. This indicates that the percentage of no/low harm events is reasonably static, although overall the number of reported incidents has reduced during 2016/17.

Our most recently published incident reporting rate is 41.08 incidents per 1,000 bed days (for incidents reported to NRLS between 1st April 2016 and 30th September 2016. When comparing this figure against 136 other Acute (non- specialist) organisations within our cluster, the median reporting rate for the cluster is 40.03 incidents per 1,000 bed days and the NNUH is ranked at 61st out of 136.

Figure 4 - Patient Incidents by Severity



Source: NNUH data, national definition used

Patient Experience - Treat patients with privacy and dignity

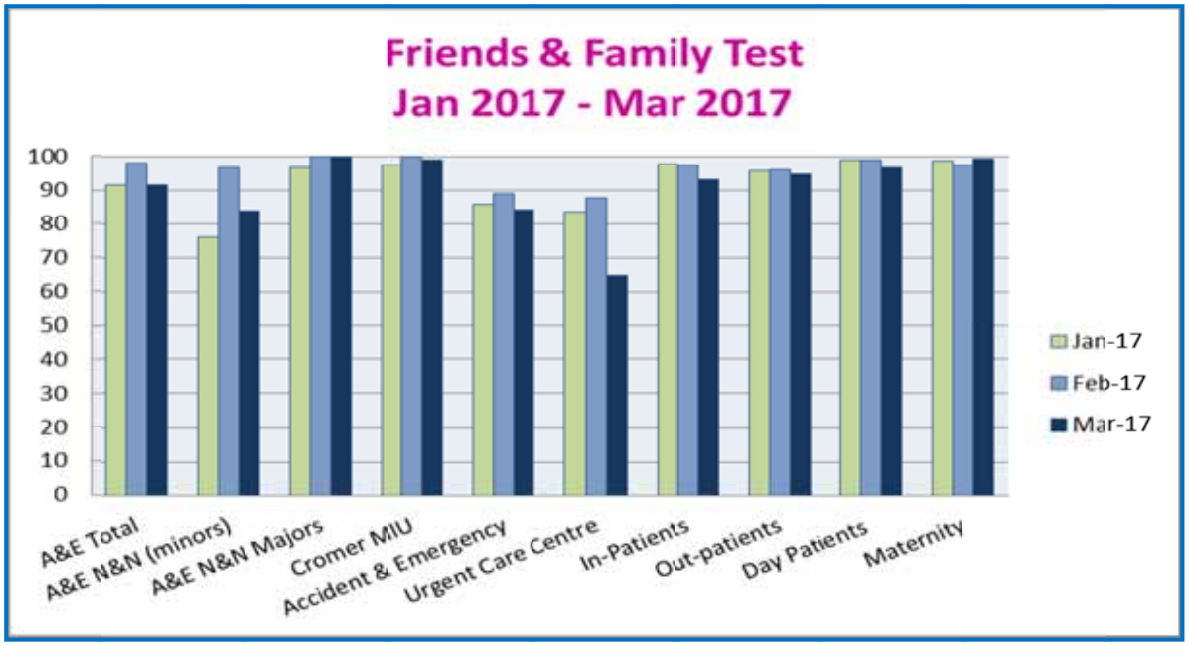
What was our aim?
For 100% of patients in all areas to report through FFT that they are 'satisfied' or 'very satisfied' with the standard of care that they receive

How did we measure our performance?
Performance by ward is monitored through the monthly performance meetings between the Director of Nursing and her senior team.

All negative free-text additional comments made during the collection of Friends and Family feedback is themed, reviewed and actioned at Directorate level and via the Patient and Experience Working Group; a group which includes external public representatives.

How did we do?
Our overall performance in Inpatients, A&E, Day Patients and Out-patients and Maternity are shown in Figure 5.

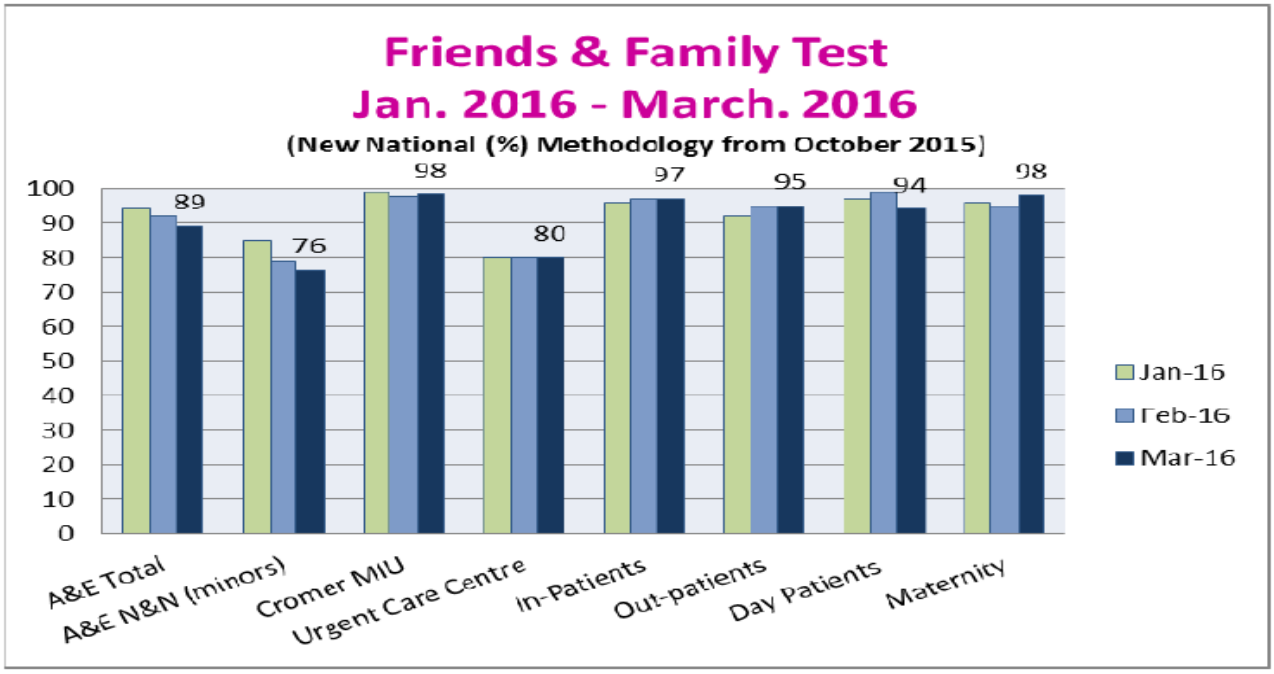
Figure 5 – Friends and Family Test Results, November 2016 – January 2017



Source: NNUH data, national definition used

Figure 5a shows the performance in the same three months of the previous year; most areas have seen a maintenance or modest improvement of their high scores compared to 2015/16.

Figure 5a – Friends and Family Test Results, January 2016 – March 2017



Source: NNUH data, national definition used

Patient Experience - Improved continuity of care and experience

What was our aim?

To reduce ward moves and reduce numbers of outliers, so that no more than 20 patients at any one time are recorded as boarders, as measured by a monthly average report. The term 'boarder' is a patient who is not cared for on the speciality ward which would be most appropriate for their condition.

How did we measure our performance?

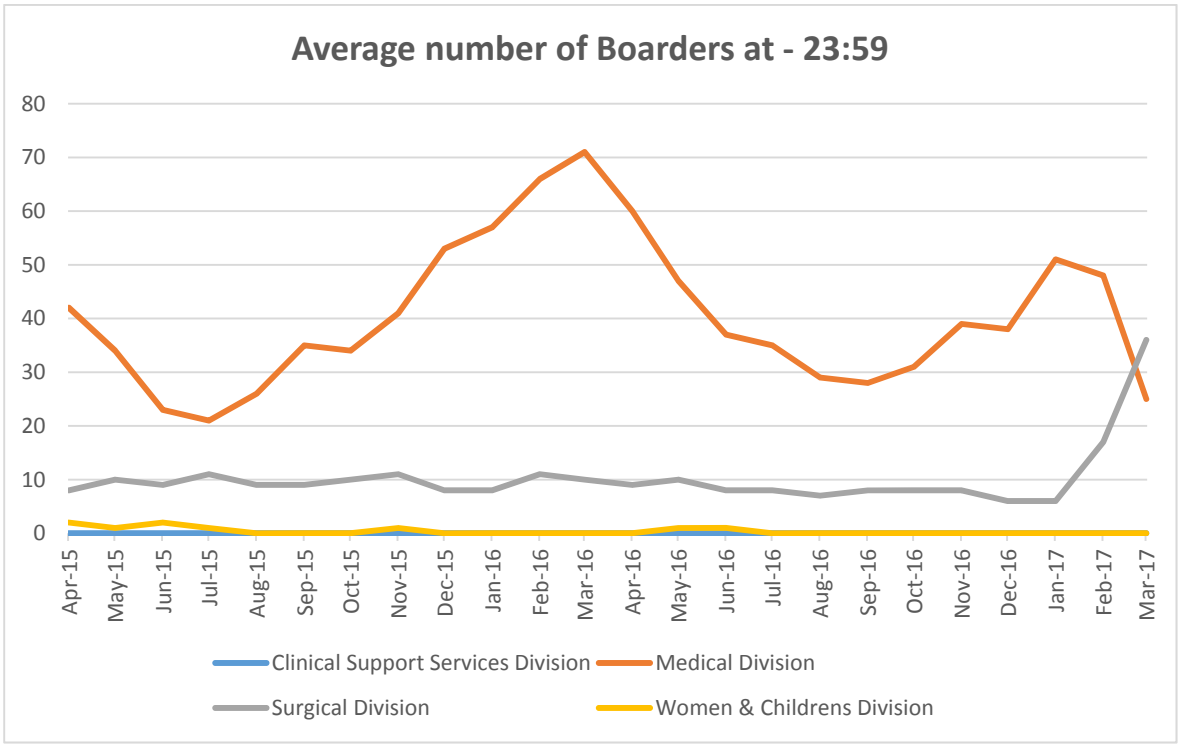
Our Information Services (IS) team produces a monthly automated report which monitors the amount of transfers in each inpatient area (i.e. the number of times that patients have been transferred once, twice etc. during the course of their inpatient stay).

How did we do?

During February 2017 a sample review of notes was carried out of patients who were recorded as having had multiple transfers during their stay. No significant concerns were identified in relation to inappropriate multiple transfers once appropriate exclusions had been applied (i.e. to exclude patients whose nominated consultant had changed or patients who had simply been moved from one bed space to another in the same ward or moved to an out-patient setting for a necessary procedure).

Figure 6 shows that boarders from the Surgical Division and Women and Children Division have remained relatively static, and boarders from the Medical Division have decreased sharply since February 2017. The Medical Division accounts for by far the largest numbers of boarders, and their figure of 25 boarders in March 2017 is a significant improvement on the March 2016 position, when there were 71 medical boarders.

Figure 6 - Average number of boarders at 23:59 hours



Source: NNUH data, national definition used

Patient Experience - Improved discharge processes

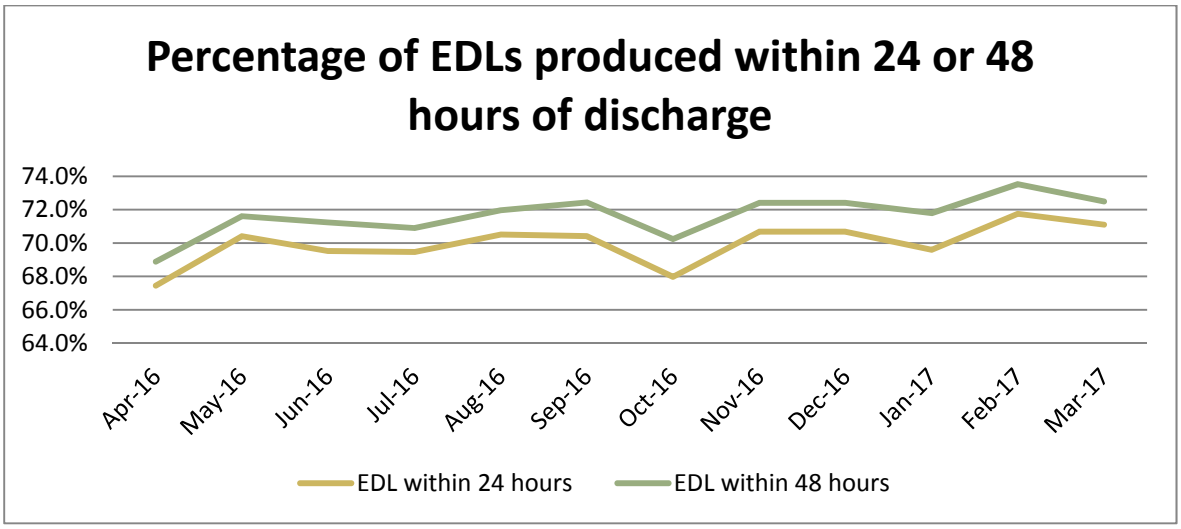
What were our aims?
Electronic discharge letter (eDL) to be completed within 24 hours in 95% of discharges

How did we measure our performance?
Our Information Services department records this data, which is then published in the monthly Integrated Performance Review.

How did we do?

In regard to the production of EDLs within 24 or 48 hours of discharge, Figure 7 shows that our performance has improved marginally over the course of the year, but there is still considerable room for improvement. This issue is being addressed internally, and compliance is monitored closely by our commissioners.

Figure 7 - Percentage of EDLs produced within 24 or 48 hours of discharge



Source: NNUH data, local definition used

Patient Experience - Dementia screening & assessment

What was our aim?
For new admissions over 75 to be appropriately screened and assessed for dementia, in accordance with national reporting requirements

How did we measure our performance?
A daily report identifies the current inpatients that require a memory assessment test and those who, following assessment, require further dementia assessment.

Memory assessment screens are carried out by our fully trained administrative staff and are recorded on our Patient Administration System (PAS). If, as a result of that memory assessment screen, a patient is identified who needs further dementia assessment, this assessment is carried out by our clinical staff and the results are recorded on the Integrated Clinical Environment (ICE) system and shared with the patient's GP and dementia assessors working in Norfolk and Suffolk Foundation Trust. This in turn facilitates tertiary referral to specialist mental health services if required.

How did we do?
Since launching dementia screening and assessment in November 2012, we have achieved compliance of at least 90% for each separate element of the pathway (screening, assessment and referral) in every single month except for February 2017 when – due to a major system change in reporting – our performance in respect of the assessment element only dropped sharply. This was a one-off 'blip' that was corrected the following month and has not reoccurred. We are proud of having maintained throughout 2016/17 the level of compliance that we achieved during the three previous years, when compliance was a requirement of the national dementia screening and assessment CQUIN.

NNUH help shape future new-born care

NNUH has introduced screening for all babies for congenital heart defects upon birth, after the successful completion of a national pilot program.

The East Anglian hospital was one of seven to be invited to join the first phase of the Department of Health national screening pilot to test pulse oximetry screening (POS) on new born babies as part of the newborn discharge process.

The new pilot proposed screening all babies upon birth for congenital heart defects not detected during pregnancy by routine ultrasound scans and newborn examination.

Clinical Effectiveness - Acute Kidney Injury

What was our aim?
To improve communication with GPs for patients who have experienced an episode of acute kidney injury (AKI) during the course of their admission.

How did we measure our performance?
We developed a bespoke report on the Integrated Clinical Environment (ICE) system which enables us to interrogate all electronic discharge letters (eDLs) to identify if appropriate AKI information was included in the discharge reporting to GPs. Appropriate information includes, but is not limited to:

- the stage of AKI alert,
- any medication review that was carried out during the admission, and
- the timing/frequency of follow-on tests that should be carried out in primary care.

How did we do?
In the ten month period 1st April 2016 – 31st January 2017, the inclusion of appropriate AKI information in eDLs improved by 83% when compared against the baseline period (the whole of the twelve months ending 31st March 2016).

This confirms that communication to GPs is improving, although further improvement is still both possible and desirable.

To further improve communication, two information leaflets were produced for GPs by the Eastern Pathology Alliance to help GPs to manage the care of patients who have experienced an episode of AKI.

The first of these leaflets is called 'AKI Information for Primary Care'. It educates GPs on the risk factors for community-acquired AKI and the steps that GPs can take to help reduce the risk of AKI developing or worsening in the primary care setting. The leaflet includes an algorithm that GPs can follow to ensure that they are following best practice guidelines in the care of patients with elevated serum creatinine.

The second information leaflet - called 'Post-AKI care: what to do when a patient has been discharged after an episode of AKI' - includes guidelines for the ongoing care and treatment of patients who have been discharged from secondary care after an episode of AKI. This guidance leaflet supplements the information that is included in the eDL.

Clinical Effectiveness - Keeping patients safe from infection

What was our aim?
C. Diff within trajectory target, 0 cases of Hospital Acquired MRSA bacteraemia

How did we measure our performance?
It has been mandatory for NHS acute Trusts to report all cases of Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia since April 2004. Surveillance of C. difficile infection (CDI) was originally introduced in 2004 for patients aged 65 years and over. This was then extended to include all cases in patients aged 2 years and over in April 2007. Public Health England uses the surveillance data to produce spreadsheets and graphs that we used to measure our performance against other acute Trusts.

Internally the Infection Prevention and Control (IP&C) report continued to be sent out to staff throughout the year, with surveillance and alert organism graphs and tables data updated monthly. Local C. diff and MRSA data by ward is presented monthly to matrons and ward managers as part of on-going surveillance.

The post-infection review process continues following every case of hospital-acquired case of C. diff. This brings together the clinical teams from the hospital and the clinical Commissioning Group (CCG) who jointly review the evidence in order to establish whether there were any lapses in care.

How did we do?
Our 2016-17 Clostridium difficile objective was to stay below 49 hospital acquired cases. The objective was achieved and there was an improvement on the 2015-16 figures with a total of 42 C. diff cases deemed to be hospital acquired. We successfully appealed 22 cases resulting in a final total for the year of 20.

Figure 8: CDiff Performance

Summary Table		Non-Trajectory	Trajectory	Pending	Total
Quarter	4 (to date)	2	0	4	6
	3	3	4	0	7
	2	5	9	0	14
	1	6	4	0	10
April 16 to March 17		16	17	4	37
April 15 to March 16		*24*	*32*	*0*	*56*

Source: NNUH data, national definition used

Our 2016-17 MRSA bacteraemia (blood stream infections) objective was zero hospital acquired cases. The objective was achieved and there was an improvement on 2015-16 with 0 hospital acquired MRSA blood stream infections.

Clinical Effectiveness - Improve quality of care through research

What was our aim?

Year on year increase in patients recruited into research studies. Aim to achieve 5000 recruitment into NIHR studies in 2016-17

How did we measure our performance?

Data on research and development (R&D) is collected by our R&D team and is included in each month's Integrated Performance Report. All studies not achieving 40 day (3/6) and 70 day (0/4) targets are reviewed and the causes of the delay are identified, understood and fed back to research teams.

How did we do?

During 2016/17, our total recruitment was 5,438 for 2016/17, compared against 2015/16 recruitment of 5,008. Fifteen new studies were approved in February, of which fourteen were portfolio studies and six were commercially sponsored.

Figure 9 shows that at the end of February we had exceeded our stated goal of recruiting 5000 participants into NIHR studies in 2016/17. We had also exceeded our CRN portfolio recruitment target (3000).

Figure 9: Recruitment into research studies

Recruitment for 16/17	Number	Percent
Portfolio recruitment target	3000	
Total Recruitment	5438	
NIHR Portfolio	4492	83%
Non Portfolio	946	17%
Commercial Studies	339	6%
Non Commercial Studies	5099	94%

Source: NNUH data, national definition used

Clinical Effectiveness - Timely medical review of all patients

What was our aim?

All new and unstable patients and all patients potentially ready for discharge to be reviewed daily by an ST3 or above.

How did we measure our performance?

The 'S' of SAFER stands for 'Senior Review', which means every patient should be reviewed by a decision maker before 1100hrs each day. A Senior Review is defined as a documented reference in the patient's notes by 1100hrs of one of the following:

- A review by a senior decision maker (ST3 or above)
- An MDT which included a senior decision maker
- A note from a junior doctor that they discussed the patient with a senior decision maker (e.g. plan d/w Dr Bloggs CON)
- A ward round or board round which included a senior decision maker.

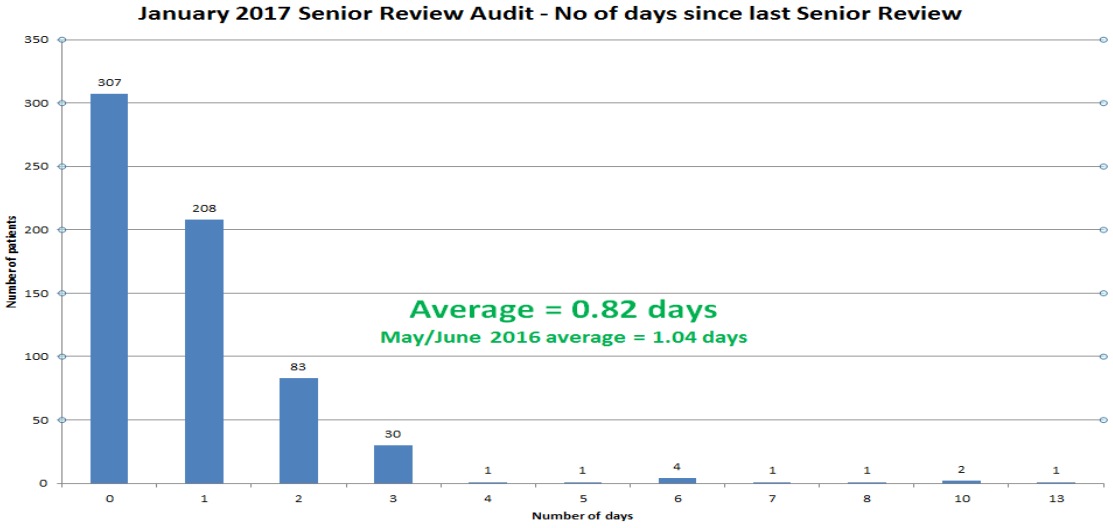
Currently, the only method of measuring whether the above take place is to conduct an audit of patient notes. The baseline audit took place in June 2016 and comprised a comprehensive 7 day audit of over 1000 patient records.

A one day re-audit took place on Thursday 26 January to assess performance against this baseline. A total of 27 wards and 653 patient notes were audited.

How did we do?

The audit evidenced that the percentage of patients that had a documented Senior Review increased from 33% in June 2016 to 53% in January 2017. The average time since the last senior review was 0.82 days, as shown in figure 10.

Figure 10: Number of days since last senior review



Source: NNUH data, local definition used

Monthly audits are planned going forwards to enable continued performance monitoring of this important SAFER element.

NNUH Stroke Patients First in County for Speedy Results

Dr Kneale Metcalf and a patient on the new monitor

Stroke patients in NNUH are the first in the country to benefit from a new monitoring system which will help prevent a second stroke occurring.

With information received from the new system the consultants can prescribe medication within two days, preventing further strokes. Previously this process could take several weeks.

"This is an exciting new use of technology to benefit patient care," said NNUH Stroke Consultant Dr Kneale Metcalf.

Looking Forwards - Our 2017/18 priorities for improvement

To align to our Quality and Safety Improvement Strategy, we have decided to set our quality priorities for the next two years – i.e. for 2017/18 and 2018/19. Each of the priorities sits within one of the three domains of patient safety, clinical effectiveness, and patient experience; assurance in relation to these priorities is provided by the relevant assurance sub-board reporting to the Management Board.

In selecting the priorities, we took into account feedback on the things that are most important to them from many different stakeholder groups, including staff, patients, the public and our commissioners. This feedback was received in many forms, including survey responses, complaints letters, quality monitoring from commissioners, internal reviews of the quality of care provided across our services, and staff suggestions. The shortlist of priorities was then discussed at Management Board, and the final selection agreed and ratified by the Council of Governors.

	Priority	Measure	Goal	Lead
Patient Safety	Reduction in medication errors	Number of insulin errors causing NPSA category moderate harm or above	Zero errors with harm	Medical Director
	Prompt recognition and treatment of sepsis	% of patients screened, and % of patients treated for sepsis	CQUIN criteria	Medical Director
	Keeping patients safe from hospital acquired thrombosis	Percentage compliance with TRA assessment as evidenced on EPMA.	95%	Medical Director
	Incident reporting and management	Position in relation to all acute trusts for incident reporting on NLRS. Percentage compliance with Duty of Candour	Top quartile of all trusts for incident reporting. 100% compliance Duty of Candour.	Director of Nursing
Clinical Effectiveness	Keeping patients safe from infection	Numbers of hospital attributable C Diff cases Number of hospital acquired MRSA bacteraemias	Below trajectory target for C Diff. Zero MRSA bacteraemia	Director of Nursing
	Improve quality of care through research	Numbers of patients recruited into NIHR studies	5000	Medical Director

	Priority	Measure	Goal	Lead
	Timely medical review of all patients	SAFER criteria for patient review: **Senior review** - every patient should be reviewed by a doctor every day. All new and unstable patients and all patients for potential discharge should be reviewed by an ST3 or above. **Review** – there will be a weekly systematic review of patients with extended lengths of stay (>14days) to identify the actions required to facilitate discharge.	100% patients have recorded senior review daily on board round Less than 200 patients with length of stay over 14 days	Chief Operating Officer
Patient Experience	Patients are happy with the experience they receive during their care and treatment	Percentage of patients in all areas report through FFT that they extremely likely or likely to recommend our services to their friends and family	95% or more	Director of Nursing
	Improved continuity of care and experience through reduced ward moves and reduced numbers of outliers	Number of patients recorded on WardView as boarders. Monthly average report	No more than 20	Chief Operating Officer
	Improved discharge processes	Estimated Date of Discharge (EDD) recorded within 24 hours of admission on WardView – SAFER criteria EDL to be completed within 24 hours of discharge	100% compliance 95% compliance	Chief Operating Officer

These priorities have been discussed by and will be agreed through our Council of Governors, Management Board, Quality and Safety Committee, and Trust Board. Each of these quality priorities has an executive lead and a defined measure which we will track and report through the Integrated Performance Report (IPR). The IPR is a public document which is shared with our commissioners.

Designated committees, Boards and Sub-Boards within our corporate and clinical governance reporting structure will have responsibility for the on-going monitoring of the components of our quality and safety improvement strategy, objectives and delivery plans.

Part 2b

Board Assurance Statements

All providers of NHS services are required to produce a Quality Report, and elements within that report are mandatory. This section contains that mandatory information, enabling readers of the report to make comparisons between other Trusts.

Review of services

During 2016/17 the Norfolk and Norwich University Hospitals NHS Foundation Trust provided and/or sub-contracted 43 relevant health services.

The Norfolk and Norwich University Hospitals NHS Foundation Trust has reviewed all the data available to them on the quality of care in 43 of these relevant health services through its performance management framework and its internal assurance processes.

The income generated by the relevant health services reviewed in 2016/17 represents 85.7% of the total income generated from the provision of relevant health services by the Norfolk and Norwich University Hospitals NHS Foundation Trust for 2016/17.

Information on participation in national clinical audits (NCA) and national confidential enquiries (NCE)

The purpose of clinical audits is to assess and continually improve patient care by carrying out review of services and processes and making any necessary changes indicated following the reviews.

National Confidential Enquiries are nationally conducted investigations into a particular area of healthcare, which seek to identify and disseminate best practice.

During 2016/17 39 national clinical audits and 4 national confidential enquires covered relevant health services that Norfolk and Norwich University Hospitals NHS Foundation Trust provides.

During that period Norfolk and Norwich University Hospitals NHS Foundation Trust participated in 100% national clinical audits (38/38) and 100% national confidential enquires (4/4) which it was eligible to participate in. We also participated in other national audits which fall outside of the Quality Account recommended list.

The national clinical audits and national confidential enquiries that Norfolk and Norwich University Hospitals NHS Foundation Trust was eligible to participate in during 2016/17 are as follows (see Figure 11). The national clinical audits and national confidential enquiries that Norfolk and Norwich University Hospitals NHS Foundation Trust participated in during 2016/17 are as follows: (see Figure 11). Norfolk and Norwich University Hospitals NHS Foundation Trust participated in 100% of the NCAs and NCEs in which it was eligible to participate.

The national clinical audits and national confidential enquiries that Norfolk and Norwich University Hospitals NHS Foundation Trust participated in, and for which data collection was completed during 2016/17, are listed below (see Figure 11 – detail on the data collection status of each NCA/NCE is shown in the final column) alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

Figure 11: National clinical audits and national confidential enquiries

Key		
National Clinical Audit	National Confidential Enquiry	Not applicable to NNUH

National Clinical Audit (alphabetical order)	Eligible	Took part	Participation Rate Cases Submitted	Completed / In-progress/ Ongoing
Acute coronary syndrome or Acute myocardial infarction (MINAP)	Y	Y	905/1004 (90%)	On-going
Adult Asthma	Y	Y	43/20 (215%)	Completed
Adult Cardiac Surgery	N	N/A	N/A	
Asthma (paediatric and adult) care in emergency departments	Y	Y	42/42 (100%)	Completed
Bowel Cancer (NBOCAP)	Y	Y	435/435 100% (April to Jan 2017)	On-going
Cardiac Rhythm Management (CRM)	Y	Y	Pace 1066/1072 (99%) Electrophysiology 134/134 (100%)	On-going
Case Mix Programme (CMP)	Y	Y	883/883 (100%) (April to September 2016)	On-going
Child Health Clinical Outcome Review Programme	Y	Y	Chronic Neurodisability Study: Clinician 5/10 (50%) Notes 5/10 (50%0 (Data collection still underway) Young People's Mental Health study: Clinician 1/5 (20%) Notes 4/5 (80%) Data collection still underway	In progress In progress
Chronic kidney disease in primary care	N	N/A	N/A	
Congenital Heart Disease (CHD)	N	N/A	N/A	
Coronary angioplasty/National Audit of Percutaneous Coronary Intervention (PCI)	Y	Y	1077/1455 (74.0%)	On-going
Diabetes (Paediatric) (NPDA)	Y	Y	311/311 (100%)	Complete
Elective Surgery (National PROMs Programme)	Y	Y	Hip 746/655 (88%) Knee	On-going On-going

National Clinical Audit (alphabetical order)	Eligible	Took part	Participation Rate Cases Submitted	Completed / In-progress/ Ongoing
			648/580 (90%) Hernia 777/572 (74%) Varicose Veins 228/191 (84%)	 On-going On-going
Endocrine and Thyroid National Audit	Y	Y	21	On-going
Falls and Fragility Fractures Audit Programme (FFFAP)	Y	Y	National Hip Fracture Database – 806/806 (100%) (2016) Fracture Liaison Service – Not required to submit data National Inpatient Falls Audit – Postponed to 2017	On-going Ongoing Planned
Head and Neck Cancer audit	Y	N/A	The organising body did not finalise the dataset and submission method so participation was not possible	On-going
Inflammatory Bowel Disease (IBD) Programme	Y	Y	3/3 (100%) Paediatrics Adults did not participate	On-going
Learning disability Mortality Review Programme (LeDeR Programme)	Y	N/A	Audit still being established – Not yet running in our region	On-going
Major Trauma: The Trauma Audit and Research Network	Y	Y	603/683 (88.2%)	On-going
Maternal, Newborn and Infant Clinical Outcome Review Programme	Y	Y	Maternal deaths: 2/2 (100%) Perinatal deaths: 9/26 (35%)	On-going On-going
Medical and Surgical programme: National Confidential Enquiry into Patient Outcome and Death	Y	Y	Non-invasive Ventilation study: Clinician 1/3 (33%) Notes 3/3 (100%) Cancer in Children, Teens and Young Adults study: Data collection in progress	In progress In progress
Mental Health Clinical Outcome Review	N	N/A	N/A	
National Audit of Dementia	Y	Y	50/50 (100%)	Completed
National Audit of Pulmonary Hypertension	N	N/A	N/A	
National Cardiac Arrest Audit (NCAA)	Y	Y	83/83 (100%) (April to Sept 2016)	On-going
National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme	Y	Y	Pulmonary Rehab Audit in progress data being submitted Continuous Secondary Care Audit opened for data collection 3rd Feb 2017	In progress Ongoing

National Clinical Audit (alphabetical order)	Eligible	Took part	Participation Rate Cases Submitted	Completed / In-progress/ Ongoing
National Comparative Audit of Blood Transfusion	Y	Y	Audit of Patient Blood Management in Scheduled Surgery 22/45 (49%) Management of patients at risk of Transfusion Associated Circulatory Overload (TACO) Audit started March 2017	Completed In-progress
National Diabetes Audit - Adults	Y	Y	National Pregnancy in Diabetes (NPiD) Audit: 47/57 (82%) (April –Dec 2016) National diabetes Adult (NDA) 462/462 (100%)	On-going Completed
National Emergency Laparotomy Audit (NELA)	Y	Y	345/345 (100%) (Year 3 ran from 1st Dec 2015 to 30th Nov 2016)	On-going
National Heart Failure Audit	Y	Y	179/826 (21%)	On-going
National Joint Registry	Y	Y	1116/1116 (100%) (Jan to Dec 2016)	On-going
National Lung Cancer Audit (NLCA)	Y	Y	545/545 (100%)	Ongoing
National Neurosurgery Audit Programme	N	N/A	N/A	
National Ophthalmology Audit	Y	Y	2473/2473 (100%) Data collection still in progress	In progress
National Prostate Cancer Audit	Y	Y	417/417 (100%) (April to Dec 2016)	On-going
National Vascular Registry	Y	Y	Acute Aortic Aneurysms 69/120 (58%) Carotid Endarterectomy 45/100 (45%) Bypasses 17/80 (estimated) (currently 21%) Major Amputations 43/100 (43%)	On-going On-going On-going On-going
Neonatal Intensive & Special Care (NNAP)	Y	Y	1294/1294 (100%)	On-going
Nephrectomy Audit	Y	Y	Figures not yet available anticipated 100%.	On-going
Oesophago-gastric Cancer (NAOGC)	Y	Y	163/163 (100%) (April 2016 to Jan 2017)	On-going
Paediatric Intensive Care (PICANet)	N	N/A	N/A	
Paediatric Pneumonia	Y	Y	In progress data entry period ends April 2017 Anticipated	In-progress

National Clinical Audit (alphabetical order)	Eligible	Took part	Participation Rate Cases Submitted	Completed / In-progress/ Ongoing
			90-100%	
Percutaneous Nephrolithotomy (PCNL)	Y	Y	Figures not yet available anticipated 100%	On-going
Prescribing Observatory for Mental Health (POMH-UK)	N	N/A	N/A	
Radical Prostatectomy Audit	Y	Y	Figures not yet available anticipated 100%	On-going
Renal replacement therapy (Renal Registry)	Y	Y	800/800 (100%)	On-going
Rheumatoid and Early Inflammatory Arthritis	Y	Y	Not able to submit data during 2016-17 audit halted until new provider identified	To be reinitiated
Sentinel Stroke National Audit Programme (SSNAP)	Y	Y	971/1024 (95%)	Ongoing
Severe Sepsis and Septic Shock – care in emergency departments	Y	Y	50/50 (100%)	Completed
Specialist rehabilitation for patients with complex needs	N	N/A	N/A	
Stress Urinary Incontinence Audit	Y	Y	Figures not yet available anticipated 100%	On-going
United Kingdom Cystic Fibrosis Registry	Y	Y	Adult 79/79 (100%) Paediatrics 65/65 (100%)	On-going On-going

The reports of 18 national clinical audits were reviewed by the provider in 2016/17 and Norfolk and Norwich University Hospitals NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided (see Appendix A).

The reports of 135 local clinical audits were reviewed by the provider in 2016/17 and Norfolk and Norwich University Hospitals NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided (See Appendix B).

Participation in research and development

The number of patients receiving relevant health services provided or sub-contracted by Norfolk and Norwich University Hospitals NHS Foundation Trust in 2016/17 that were recruited during that period to participate in research approved by a research ethics committee was 5,438 (5,008 in 2015/16).

Commissioning for Quality and Innovation (CQUIN)

A proportion of Norfolk and Norwich University Hospitals NHS Foundation Trust's income in 2016/17 was conditional on achieving quality improvement and innovation goals agreed between the Norfolk and Norwich University Hospitals NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.

Further details of the agreed goals for 2016/17 and for the following 12 month period are available electronically at http://www.nnuh.nhs.uk/TrustDoc.asp?ID=605&q=cquins.

The amount of Trust income in 2016/17 that was conditional upon achieving quality improvement and innovation goals was approximately £9.2m, and the Trust is expecting to receive approximately £8.3m. The amount of Trust income in 2015/16 that was conditional upon achieving quality improvement and innovation goals was £9.25m, and the Trust received £8.0m.

We took part in three of the national CQUINs in 2016/17 (Workplace Health and Wellbeing, Sepsis and Antimicrobial Stewardship), and we also agreed eight CQUINs with specialist commissioners and a further six local CQUINs with our CCG commissioners. The local CQUINs focused on strategically important areas including:

- Introducing a pathway for frail patients,
- improving our discharge processes
- improving diabetes care
- increasing the number of people who die in their preferred place of care

Care Quality Commission (CQC) reviews

Norfolk and Norwich University Hospitals NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is unconditional.

Norfolk and Norwich University Hospitals NHS Foundation Trust has no conditions on registration. The Care Quality Commission has not taken enforcement action against Norfolk and Norwich University Hospitals NHS Foundation Trust during 2016/17.

Norfolk and Norwich University Hospitals NHS Foundation Trust has not participated in any special reviews or investigations by the Care Quality Commission during the reporting period.

Data Quality

Norfolk and Norwich University Hospitals NHS Foundation Trust submitted records during 2016/17 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

Figure 12: Data Quality

The % of records in the published data which included:	the patient's valid NHS number was:		the patient's valid General Medical Practice Code was:	
	NNUH	Nat Avg.	NNUH	Nat Avg.
Admitted patient care	99.9%	99.2%	100.0%	99.9%
Outpatient care	99.9%	99.5%	100.0%	99.8%
Accident & emergency care	99.0%	96.6%	100.0%	98.9%

Information Governance Toolkit Attainment Levels

Norfolk and Norwich University Hospitals NHS Foundation Trust's Information Governance Assessment Report overall score for 2016/17 was 82%, and was graded RED (not satisfactory). We did not achieve Level 2 in one of 45 Requirements. Requirement 112 mandates that 95% of staff members should have completed the IG training by end of March; this was not achieved. Thus, we our status/grading dropped from 'Green' to 'Red'. We have an action plan to address this.

Left to right David Willis, Nicola Wilson, Yasmin Tate and Dr Jenny Nobes

New advanced technology at the NNUH to treat skin cancer

Patients with certain skin cancers are being treated with a new piece of specialist radiotherapy equipment with advanced technology for cancers on and close to the surface of the skin.

The Xstrahl radiotherapy unit adds to the comprehensive range of treatment techniques on offer to patients with Cancer in Norfolk. NNUH is at the forefront of treating those with cancer and is the only centre in Norfolk to offer this type of treatment. .

The new specialist equipment offers a dedicated treatment environment for the vast majority of skin cancer patients who require radiotherapy. It has the benefit of being able to treat patients with superficial X-Rays, which only penetrate a few millimetres into the skin, and is very suitable for early skin cancers. It is particularly useful for treating skin tumours around the eyes and nose, because it avoids causing any unnecessary damage to normal tissues by treating a very small area.

Clinical Coding error rate

Norfolk and Norwich University Hospitals NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2016/17 by the Audit Commission. Norfolk and Norwich University Hospitals NHS Foundation Trust will be taking the following actions to improve data quality (DQ):

- We plan to set up a monthly meetings for the new Departmental Validators to enhance communication and share best practice
- We hold quarterly meetings with Ward Clerks to enhance communication and share best practice
- We continue to work collaboratively on PAS Enhancements to support staff in meeting policy, to support 18 weeks and to enhance patient experience
- 18 week training is on-going and monitored on a monthly basis; eLearning compliance performance has improved. 23 out of 26 specialties have enhanced performance for 2016/17
- The 18 Week Audit Programme 2016/17 included:
  - 26 x Audits Completed
  - 18 x Specialties improved performance, 2 specialties achieved the 90% target
  - 7 x Specialties have decreased in performance
  - 1 x Specialties performance remained the same as 2015/16

All information within the Norfolk and Norwich University Hospitals NHS Foundation Trust is derived from individual data items, collected from numerous sources, which must comply with local and national data standards. It is essential to have measures and processes in place to ensure data are accurate, valid, reliable, relevant, timely and complete. We aim to have 100% accurate and timely data, compliant with NHS standards and Trust Policies.

Performance against the national quality indicators

For each of the following mandated indicators, our current performance is reported alongside the national average performance and the performance of the best and worst performing acute foundation trusts. Wherever possible, comparative data are also shown for the previous two reporting periods, to enable readers to assess our performance trends.

No data for 2016/17 (and little data for 2015/16) is yet available on the NHS Digital website (from where Trusts are instructed to obtain the data in the published Quality Report guidance). The absence of this data in the public domain has been escalated to our external auditors for national advice.

Figure 13: Table of mandated national quality indicators

SHMI value and banding						
Indicator	2016/17				NNUH 15/16	NNUH 14/15
	NNUHFT	National Average	Best performer	Worst performer		
SHMI value and banding	No data yet published	No data yet published	No data yet published	No data yet published	1.056 Band 2	1.035 Band 2

No data published for 2016/17
Location: https://indicators.hscic.gov.uk/webview/ > SHMI indicator > Download September 2016 publication > SHMI data at trust level, select from value and banding columns
Current version uploaded: Mar-17 (contains only data for Oct16 – Sep16). // Next version due: Jun-17

% of patient deaths with palliative care						
Indicator	2016/17				NNUH 15/16	NNUH 14/15
	NNUHFT	National Average	Best performer	Worst performer		
% of patient deaths with palliative care coded at either diagnosis or specialty level for the reporting period	No data yet published	No data yet published	No data yet published	No data yet published	19.5%	17.4%

No data published for 2016/17
Location: https://indicators.hscic.gov.uk/webview/ > SHMI indicator > Download September 2016 publication > SHMI contextual indicators > Palliative care coding > Percentage of deaths with palliative care coding
Current version uploaded: Mar-17 (contains only data for Oct16 – Sep16). // Next version due: Jun-17

The Norfolk and Norwich University Hospitals NHS Foundation Trust considers that this data is as described for the following reasons: The data sets are nationally mandated and internal data validation processes are in place prior to submission.
The Norfolk and Norwich University Hospitals NHS Foundation Trust intends to take the following actions to improve the indicator and percentage in (a) and (b), and so the quality of its services. By increasing the amount of analysis on the factors underpinning SHMI, the Trust is confident that it will be able to improve its performance.

PROMS						
Indicator	2016/17				NNUH 15/16	NNUH 14/15
	NNUHFT	National Average	Best performer	Worst performer		
Patient reported outcome scores for groin hernia surgery	No Trust data yet published	No Trust data yet published	No Trust data yet published	No Trust data yet published	0.095 (Apr-Sep)	0.098

Patient reported outcome scores for varicose vein surgery	No Trust data yet published	No Trust data yet published	No Trust data yet published	No Trust data yet published	0.088 (Apr-Sep)	0.142
Patient reported outcome scores for hip replacement surgery	No Trust data yet published	No Trust data yet published	No Trust data yet published	No Trust data yet published	0.421 (Apr-Sep)	0.376
Patient reported outcome scores for knee replacement surgery	No Trust data yet published	No Trust data yet published	No Trust data yet published	No Trust data yet published	0.293 (Apr-Sep)	0.272

Data is only available at CCG level and last reporting period is 2014/15 as of 6/04/2017
Location: 3.3 Patient reported outcome measures (PROMs) for elective procedures
Current version uploaded: Sep-16 // Next version due: Sep-17

The Norfolk and Norwich University Hospitals NHS Foundation Trust considers that the outcome scores are as described for the following reasons: The number of patients eligible to participate in PROMs survey is monitored each month. Results are monitored and reviewed within the surgical division.
The Norfolk and Norwich University Hospitals NHS Foundation Trust intends to take the following actions to improve these outcome scores, and so the quality of its services: Our primary goal over the forthcoming months is to focus on improving the patient experience for patients that undergo primary knee replacement surgery.

28 day readmission rates

Indicator	2016/17				NNUH 15/16	NNUH 14/15
	NNUHFT	National Average	Best performer	Worst performer		
28 day readmission rates for patients aged 0-15	No data yet published	No data yet published	No data yet published	No data yet published	No public data	12.47 %
28 day readmission rates for patients aged 16 or over	No data yet published	No data yet published	No data yet published	No data yet published	No public data	12.6%

There is no data published for 2012/13, 2013/14, 2014/15 and 2015/16 as of 6/04/2017.
Current version uploaded: Dec-13 // Next version due: TBC

The Norfolk and Norwich University Hospitals NHS Foundation Trust considers that these percentages are as described for the following reasons: This is based upon clinical coding and we are audited annually.
The Norfolk and Norwich University Hospitals NHS Foundation Trust has taken the following actions to improve these percentages, and so the quality of its services: We have continued to review readmission data on a monthly basis to identify emergent trends, e.g. the rate rising in a particular specialty or for a particular procedure.

Trust responsiveness

Indicator	2016/17				NNUH 15/16	NNUH 14/15
	NNUHFT	National Average	Best performer	Worst performer		
Trust's responsiveness to the personal needs of its patients during the reporting period.	No Trust data yet published	No Trust data yet published	No Trust data yet published	No Trust data yet published	No public data	68.3

Data only available at CCG level, reporting period 2015/16 (provisional) as of 6/04/2017
Location: https://indicators.hscic.gov.uk/webview/ > 4.5 Responsiveness to Inpatients' personal needs > CCG OIS - Indicator 4.5
Current version uploaded: Sep-16 // Next version due: Sep-17
The Norfolk and Norwich University Hospitals NHS Foundation Trust considers that this data is as described for the following reasons: The data source is produced by the Care Quality Commission.
The Norfolk and Norwich University Hospitals NHS Foundation Trust has taken the following actions to improve this data, and so the quality of its services: By increasing the amount of feedback we gather from patients in real time through the Friends and Family test and our inpatient feedback project, we are able to identify emergent issues very quickly and to swiftly take any appropriate corrective action to address the cause of the problem.

% Staff employed who would recommend the trust						
Indicator	2016/17				NNUH 15/16	NNUH 14/15
	NNUHFT	National Average	Best performer	Worst performer		
Percentage of staff employed by, or under contract to, the Trust during the reporting period who would recommend the Trust as a provider of care to their family or friends.	No data yet published	No data yet published	No data yet published	No data yet published	71.5%	68.3%

No data found in the portal

The Norfolk and Norwich University Hospitals NHS Foundation Trust considers that this score is as described for the following reasons: The data have been sourced from the Health & Social Care Information Centre and compared to published survey results.
The Norfolk and Norwich University Hospitals NHS Foundation Trust has taken the following actions to improve this percentage, and so the quality of its services: We now send out the survey to 100% of staff, which gives us a broader range of responses and a clearer picture of where we can target our improvement.

% of patients assessed for VTE						
Indicator	2016/17				NNUH 15/16	NNUH 14/15
	NNUHFT	National Average	Best performer	Worst performer		
Percentage of patients who were admitted to the hospital and who were risk assessed for VTE during the reporting period	No data yet published	No data yet published	No data yet published	No data yet published	91.2% (Apr-Dec)	97.9%

No data available in NHS indicator portal

The Norfolk and Norwich University Hospitals NHS Foundation Trust considers that this percentage is as described for the following reason: The data have been sourced from the Health & Social Care Information Centre and compared to internal trust data.
The Norfolk and Norwich University Hospitals NHS Foundation Trust has taken the following actions to improve this percentage, and so the quality of its services: Reporting is now possible via the Electronic Medicines Administration System. Monthly reports are issued to managers detailing VTE performance by area, to enable prompt corrective measures to be implemented if compliance appears to be deteriorating, and monthly data is also provided to our commissioners. Overall performance is monitored monthly by ward or department.

C difficile						
Indicator	2016/17				NNUH 15/16	NNUH 14/15
	NNUHFT	National Average	Best performer	Worst performer		
Rate per 100,000 bed days of cases of C.difficile infection reported within the Trust amongst patients aged 2 or over during the reporting period	No data yet published	No data yet published	No data yet published	No data yet published	54.75	55.43

Rates found for financial years of 2014/15 and 2015/16. No data for 2016/17
Location: https://indicators.hscic.gov.uk/webview/ > NHS Outcomes Framework - Indicator **5.2.ii**
Current version uploaded: Aug-16 / / Next version due: Aug-17
The Norfolk and Norwich University Hospitals NHS Foundation Trust considers that this rate is as described for the following reasons: The data have been sourced from the Health & Social Care Information Centre, compared to internal Trust data and data hosted by the Health Protection Agency

The Norfolk and Norwich University Hospitals NHS Foundation Trust has taken the following actions to improve this rate, and so the quality of its services: Measures are in place to isolate and cohort-nurse patients with suspected and confirmed C.Diff, in order to contain the spread of infection, and our Infection Control team works in a targeted way to quickly contain any emergent outbreaks. Rapid response deep cleaning processes are in place to contain any suspected infections, and these are complemented by an established and effective programme of preventative deep cleaning, aimed at avoiding an outbreak entirely if at all possible.

Patient Safety Incidents per 100 admissions

Indicator	2016/17				NNUH 15/16	NNUH 14/15
	NNUHFT	National Average	Best performer	Worst performer		
Number and rate of patient safety incidents per 100 admissions	No data yet published	No data yet published	No data yet published	No data yet published	21.3 rate No:7,297 (Apr-Sept)	42.8 rate No:14,843
Number and percentage of patient safety incidents per 100 admissions resulting in severe harm or death	No data yet published	No data yet published	No data yet published	No data yet published	0.12% No: 9 (Apr-Sept)	0.09% No: 14

Most recent period available in indicator portal is Oct 2013 – Mar 2014, with 6,630 safety incidents; rate of 8.1. // Notes further down indicate that a more up to date version might be available in S:\Corporate Departments\Trust Management\Quality Report\2015-16 Quality Report\Mandated Indicators\Patient Safety Incidents

Location: 5.6 Patient safety incidents reported (formerly indicators 5a, 5b and 5.4) > NHS Outcomes Framework

Current version uploaded: Nov-16 / / Next version due – May-17

The Norfolk and Norwich University Hospitals NHS Foundation Trust considers that this number and rate are as described for the following reasons: All internal data were thoroughly re-checked and validated, in collaboration with our external auditors. This review has given us the necessary assurance that the revised data reflect our true position.

The Norfolk and Norwich University Hospitals NHS Foundation Trust has taken the following actions to improve this number and rate, and so the quality of its services: Through the improvements we have made to our incident reporting protocols, and as a consequence of having constantly promoted the message that each and every incident must be reported, we are confident that we will continue to improve the quality of our data, and increase our understanding of the factors that lead to incidents occurring.

Part 3

Other Information

Performance of Trust against Selected Metrics

This section of the report sets out our performance against a range of important indicators, covering the three dimensions of quality:

- **Patient safety**
- **Clinical effectiveness**
- **Patient experience**

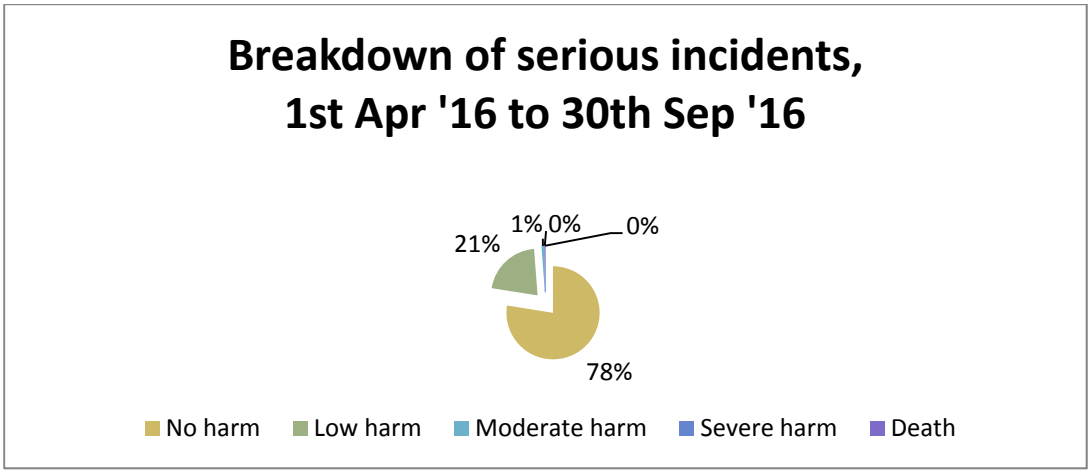
The information is presented wherever possible to allow comparison with previous reporting periods and with the performance of other Foundation Trusts. Many indicators were also included within previous reports, reflecting their continuing importance as determinants and markers of the quality of patient care. Where indicators were included in previous reports but have been excluded from the current report, readers can access the latest performance data by reading the public Trust Board papers, which are accessible at the following web address:

http://www.nnuh.nhs.uk/about-us/the-trust/trust-board-papers/

Patient Safety – Serious Incidents (SIs)

As in previous years, pressure ulcers (PUs) and falls have together accounted for the majority of the recorded SIs during the period covered by this report. In respect of PUs, the figure includes hospital-acquired and community-acquired ulcers. Hospital-acquired PUs are monitored closely to identify trends by ward and department and to highlight opportunities for improvements in clinical care. Full RCA is carried out on all Grade 2 and 3 hospital-acquired PU cases, with the learning outcomes shared with the clinical teams. SI figures are reported monthly to the Trust Board via the Clinical Safety Sub-Board, and learning points are disseminated to all staff groups.

Figure 14: Serious Incidents



(Source: NRLS*:* *https://improvement.nhs.uk/resources/organisation-patient-safety-incident-reports-22-march-2017/)*

Patient Safety – Duty of Candour

The Duty of Candour (DoC) is a legal duty on hospital, community and mental health trusts to inform and apologise to patients if there have been mistakes in their care that have led to significant harm. DoC aims to help patients receive accurate, truthful information from health providers.

Our 'Being Open and The Duty of Candour' policy has been widely publicised internally and cascaded to all teams. As a further means of raising awareness and understanding among staff of the DoC, we held staff briefing sessions and produced a Briefing Note for clinical staff which was emailed to all clinical staff and provided as a handout to staff undergoing mandatory training.

In respect of DoC, the Risk Management Team currently maintains a DoC Compliance database which tracks compliance regarding DoC in respect of patient incidents across the Trust.

All incidents that are categorised as 'Moderate Harm or above' and reported an Datix are verified with the Consultant / clinical lead; a DoC "Compliance Statement" document is completed and returned to confirm that all actions have been taken and documented. A letter template is also provided for clinicians to use to formulate the required letter.

Patient Safety – Never events

'Never Events' are a sub-set of Serious Incidents and are defined as 'serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers.

In our hospitals there were four never events during the period covered by this Quality Report (five in 2015/16).

- Retained guidewire following femoral central line insertion
- Incorrect localisation and excision of breast cancer
- Incorrect skin biopsy
- Insertion of wrong sided knee replacement
- Removal of incorrect side of Thyroid gland

Thorough RCA was carried out on all events, and the learning points were disseminated to the teams through Organisation Wide Learning (OWL) bulletins and a Surgical Safety Summit that was held in November 2016. These learning points included the following:

- CXRs after central venous access must always be reviewed by the radiographer.
- The induction programme of all junior doctors who undertake Seldinger catheterisation will advise doctors to check that guidewires are outside the patient at the end of any Seldinger technique.
- Staff who perform skin biopsies must ensure the correct site is identified for biopsy with the patient prior to the procedure commencing.
- The pre-op checklist procedure for skin biopsy must be improved to eradicate the risk of wrong site biopsy

- There is a need to standardise the procedure for confirming implant sizes and implant selection for all Orthopaedic joint replacement surgery.
- Operating theatre practitioners must recognise and minimise the risks associated with repeated interruptions to the surgical team during crucial procedural steps.
- Radiological images (where available) must be checked during the consent process and in the operating theatre as part of the WHO checklist at the time of the surgery and the site of surgery verified.
- The consent process should include a clear confirmation that the site of surgery on the consent form is correct by reference to notes and available images

Actions agreed at the November 2016 Surgical Safety Summit included:

- A working group was convened to review the current WHO Safety Checklist in Theatres in order to make recommendations for changes to this.
- A Theatre Charter is being developed to help improve the safety culture within the operating theatres.
- A Human factors training programme will be developed and delivered involving clinical teams in Theatres and Anaesthetics.
- WHO safety checklist audits which are carried out in theatre will be reviewed
- A working group has been set up to coordinate the implementation of LOCsips (Local Safety Standards for Invasive Procedures) to non-theatre areas as well as in the operating theatres where procedures are carried out.

Patient Safety – Sign Up To Safety and patient safety improvement

We signed up to the 'Sign Up To Safety' campaign, and we are progressing well with all of our goals, which included the following:

- Reducing medication prescription errors through a programme of education, audit and feedback
- Developing Organisation Wide Learning (OWL) tools to allow sharing of lessons learned and highlighting needs for change in practices, systems and processes
- Monitoring and reporting compliance with the requirements under the Duty of Candour to the Trust Board.
- Leading on the development of electronic prescribing across the intra-hospital sites involved.
- Providing regular updates to all staff on clinical performance indicators.

In respect of reducing medication prescription errors, our successful implementation of the Electronic Prescribing and Medicines Administration system (EPMA) has been pivotal in identifying and mitigating the risk of prescribing errors.

We have produced OWLs for EPMA, Medication, Falls and Pressure Ulcers, Information Governance, Incident Reporting and Infection Prevention & Control, Never Events and Risk Management.

Our compliance with Duty of Candour is being monitored and reported monthly via our Clinical Safety Executive sub-boards and the Integrated Performance Report (IPR).

We led on the development of electronic prescribing across the relevant intra-hospital sites, and achieved a smooth and successful implementation.

We provide regular updates to all staff on clinical performance indicators via the Clinical Safety Sub Board, the Divisional Performance and Nursing Quality Dashboards and by making the IPR available to all staff each month.

Patient Safety – CQC ratings and action plan

The Care Quality Commission (CQC) last inspected our Trust in November 2015 and published their report in March 2016. The report highlighted the caring nature of the service provided by our staff. No part of our service was judged to be inadequate and the overall rating of 'requires improvement' was in line with our own self-assessment.

We continue to review and evaluate our compliance with all CQC regulations on an on-going basis and maintain an action plan developed to specifically address recommendations within our March 2016 inspection report. See Figure 15.

Figure 15: CQC Action Plan

Actions to address our 'requires improvement' rating include:	
SAFE	• Formalised the documentation of our processes for assessing and actioning patient acuity assessments • Provided enhanced training for those who undertake investigations • Enhanced the processes that support staff in managing cohorting of patients in relation to infection, prevention and control measures • Enhanced access control within some areas of our hospital • Audited our clinical documentation standards to drive improvements • Re-designed our clinical documentation in relation to 'do not attempt cardio-pulmonary resuscitation' and mental capacity assessment • Enhanced our on-going auditing methods in relation to the storage of medicines • Mitigated some of the constraints of our paediatric environment in the Emergency Department • Standardised the processes for checking certain generic types of emergency equipment • Enhanced the paediatric nursing expertise within our Emergency Department • Audited our discharge paperwork in relation to safeguarding elements • Reviewed options to expand our physical capacity
EFFECTIVE	• Enhanced discharge processes and discharge teams, and communication with our patients, so that daily reviews of all patients, and actions to progress their discharge from our hospital, take place in a timely manner • Reviewed our mandatory training components and enhanced the methods of access to such training • Sourced additional funding to enhance our Specialist Palliative Care Team • Worked to enhance access to IT for some of our off-site services
RESPONSIVE	• Reviewed our bed-base to optimise our ability to improve performance against national access targets for elective care • Reviewed and enhanced our bed managing processes • Made mental capacity training a mandatory component of our staff training and re-designed our processes for documenting these assessments • Reviewed our ambulatory care pathways in our Acute Medical Units • Enhanced the processes for regular patient reviews including the assessment of the need for pain relief in the Emergency Department
WELL LED	• Introduced a clinically led Divisional organisational structure • Undertook a Trust-wide organisational values initiative and developed an associated action plan for embedding the learning from this • Enhanced our staff appraisal systems to reflect our values work • Enhanced clinical leadership in key areas within our Trust

Our ratings grid from the formal inspection is shown in Figure 16.

Figure 16 – CQC Ratings grid

	Safe	Effective	Caring	Responsive	Well-led		Service Overall
Urgent and emergency services	Requires Improvement	Outstanding	Outstanding	Good	Good		Good
Medical care (including older people's care)	Requires Improvement	Good	Good	Requires Improvement	Requires Improvement		Requires Improvement
Surgery	Requires Improvement	Good	Good	Requires Improvement	Requires Improvement		Requires Improvement
Critical care	Requires Improvement	Good	Good	Good	Good		Good
Maternity and gynaecology	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement		Requires Improvement
Services for children and young people	Requires Improvement	Good	Good	Requires Improvement	Requires Improvement		Requires Improvement
End of life care	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement		Requires Improvement
Outpatients and diagnostic imaging	Requires Improvement	N/A	Good	Requires Improvement	Good		Requires Improvement
	Safe	**Effective**	**Caring**	**Responsive**	**Well-led**		**Overall**
Trust Overall:	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement		Requires Improvement

Clinical Effectiveness – Achieving cancer referral and treatment times

Our performance against the national cancer targets is shown in Figure 17.

Figure 17 – Cancer performance against the national operational standards

	National Standard	Q4 1516	Q1 1617	Q2 1617	Q3 1617	Q4 1617 *
GP 2WW	93%	98.57%	98.91%	98.28%	97.10%	93.54%
Breast Sympt 2WW	93%	97.81%	96.58%	98.91%	98.68%	97.90%
31 Day First Treat	96%	97.47%	97.17%	97.65%	97.04%	96.93%
31 Day Subs ACD	98%	99.27%	99.73%	100.00%	99.74%	99.50%
31 Day Subs RT	94%	97.64%	97.80%	97.09%	98.44%	98.68%
31 Day Subs Surgery	94%	92.54%	91.80%	96.04%	91.30%	93.42%
62 Day GP	85%	78.91%	81.11%	80.49%	78.38%	72.17%
62 Day Upgrade		66.96%	67.02%	61.54%	60.00%	76.32%
62 Day Screening	90%	91.86%	85.99%	92.25%	85.00%	85.71%
62 Day Breast Sympt	85%	100.00%	100.00%	100.00%	66.67%	91.67%

Source: NNUH data, national definitions used

**Quarter 4 2016/17 data is currently provisional*

We have a 'Cancer First' policy, which ensures that cancer is prioritised over and above RTT. Our performance against our recovery trajectory is closely monitored by NHSi and our commissioners, and 62-day GP referral performance remains a priority for recovery.

Work to set a trajectory for cancer recovery has been undertaken with system partners and our cancer remedial action plan (RAP) has been submitted to our commissioners. The trajectory is for recovery in May 2017. This is despite overarching demand side pressures for cancer referrals (circa 10% annual growth), which present a significant challenge to performance.

A robust monitoring process is enforced to trigger escalation if a patient is at risk of breaching the treatment target; this has been successful in improving performance over the course of the year. Progress is monitored by commissioners at a weekly review meeting, and internal governance is also in place, with a fortnightly meeting chaired by the Divisional Director of Surgery. Daily management of the cancer patient target list continues to be led by the cancer manager, with input from operational managers and patient pathway coordinators. Escalation protocols are in place to encourage rapid removal of obstacles if required.

Clinical Effectiveness – 18 week RTT waiting times

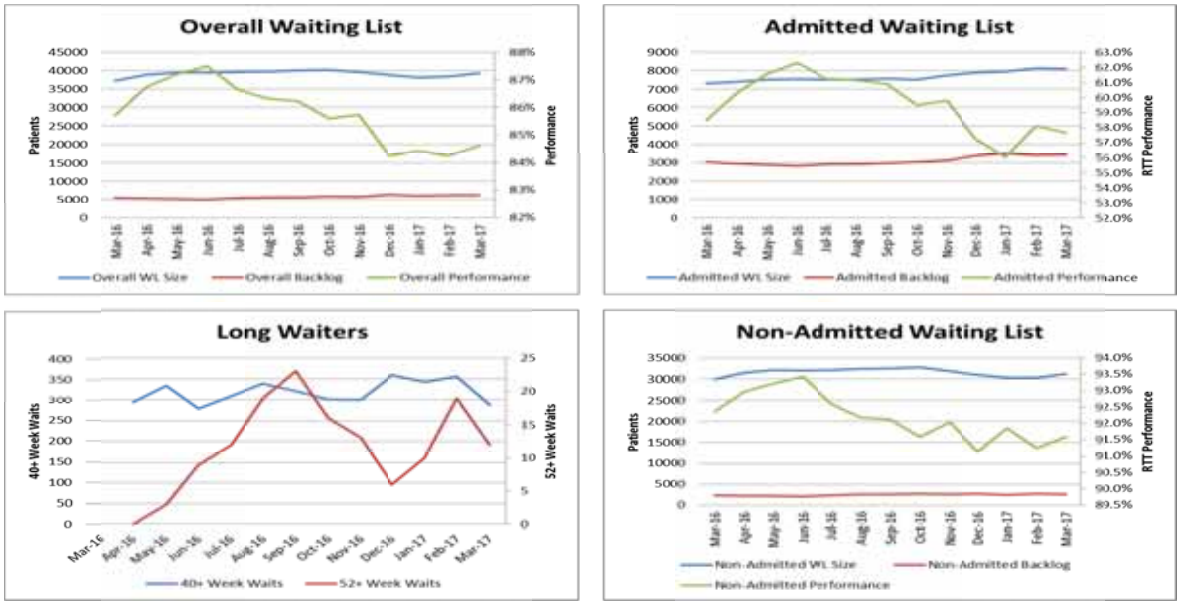
The admitted waiting list has increased from 7,325 patients at the end of March 2016 to 8,143 as at the end of February 2017, as shown in figure 18. Cancer patients continue to be prioritised, followed by the clinically most urgent and longest waiting patients.

Figure 18 – RTT waiting list and backlog

	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Overall WL Size	37275	38886	39583	39587	39621	39858	40071	40320	39632	38934	38248	38514	39384
Overall Backlog	5324	5154	5063	4949	5288	5452	5520	5803	5647	6132	5964	6066	6061
Overall Performance	85.7%	86.7%	87.2%	87.5%	86.7%	86.3%	86.2%	85.6%	85.8%	84.3%	84.4%	84.2%	84.6%
40+ Week Waits		294	333	279	308	338	320	301	299	359	343	356	288
52+ Week Waits		0	3	9	12	19	23	16	13	6	10	19	12
Admitted WL Size	7325	7411	7515	7541	7516	7532	7588	7538	7744	7915	7964	8143	8104
Admitted Backlog	3039	2940	2887	2843	2912	2926	2965	3051	3112	3383	3501	3410	3433
Admitted Performance	58.5%	60.3%	61.6%	62.3%	61.3%	61.2%	60.9%	59.5%	59.8%	57.3%	56.0%	58.1%	57.6%
Non-Admitted WL Size	29950	31475	32068	32046	32105	32326	32483	32782	31888	31019	30284	30371	31280
Non-Admitted Backlog	2285	2214	2176	2106	2376	2526	2555	2752	2535	2749	2463	2656	2628
Non-Admitted Performance	92.4%	93.0%	93.2%	93.4%	92.6%	92.2%	92.1%	91.6%	92.1%	91.1%	91.9%	91.3%	91.6%

Source: NNUH data, national definitions used

Figure 19: RTT Performance



Source: NNUH data, national definitions used

Our recovery trajectory is closely monitored by NHSi and significant partnership work has been completed to establish a recovery action plan with our commissioners. Current recovery trajectories set a return to compliance by October 2018

Detailed system wide recovery planning is being taken forward through system RTT Delivery Board. We are working hard to match capacity with demand, but the NHSi ECIST review has confirmed that our current elective capacity is unable to meet demand to achieve steady state 18 week compliance. To address this issue, we have developed an Outline Business Case for a new Ambulatory Care and Diagnostic Centre, which will provide the much-needed additional capacity. Work has now recommenced on this business case and we are currently examining fast track construction solutions on a site adjacent to the main hospital.

Clinical Effectiveness - NHSi's Compliance Framework (limited to those metrics that were included in both RAF and SOF for 2016/17)

Figure 20 – NHSi compliance framework

Indicator	2016/17		2015/16	
	Goal	Actual	Goal	Actual
C. difficile – meeting the C. difficile objective	49	22	50	32
Max time of 18 weeks from point of referral to treatment (RTT) in aggregate – patients on an incomplete pathway**	92%	84.6% *	92%	81.05%
All cancers: 62-day wait for first treatment from urgent GP referral for suspected cancer	85%	72.12% *		77.24%
All cancers: 62-day wait for first treatment from NHS Cancer Screening Service referral	90%	85.71% *		92.86%
A&E: maximum waiting time of four hours from arrival to admission/ transfer/ discharge**	95%	85.9%	95%	85.4%
Certification against compliance with requirements regarding access to healthcare for people with a learning disability	N/A	All met	N/A	All met

Source NNUH data, national definitions used.

The standard national definitions for many of these indicators are included within the Technical Guidance for the 2012/13 Operating Framework: http://www.gpcwm.org.uk/wp-content/uploads/file/A-Z%20DOWNLOADS/T%20DOWNLOADS/Technical_guidance_for_the_2012_13_operating_framework_22_dec_11.pdf

**denotes a metric that has been subject to external audit.*

The overall table forms part of the performance dashboard, which is submitted monthly to commissioners and quarterly to Monitor. The green shading indicates that performance was within agreed tolerance levels, whereas the red shading indicates where performance exceeded the agreed tolerance levels. Comparative performance data is available for all

other Foundation Trusts on the Foundation Trust Directory (*https://www.gov.uk/government/publications/nhs-foundation-trust-directory/nhs-foundation-trust-directory*)

Clinical Effectiveness – Clinical research and development

Participation in clinical research demonstrates our commitment to both improving the quality of care we offer to our patients and to contributing to wider health improvement. Involvement in research enables our clinicians to remain in the vanguard of the latest available treatment options, and there is strong evidence that active participation in research leads to improved patient outcomes. We have an active programme to engage health professionals and other staff in research through our research seminars and email updates on relevant research issues.

The Norfolk and Norwich University Hospitals NHS Foundation Trust was involved in conducting 369 clinical research studies (416 in 2015/16) in 37 medical specialities during 2016/17 (38 in 2015/16). 130 new studies were opened in 2016/2017 (111 in 2015/16). There were 150 clinical staff (consultants) (170 in 2015/16) participating in research approved by our research ethics committee during 2016/17; supported by approximately 150 research nurses, research administrators/managers and research specialists in our support departments (e.g. Pharmacy, Radiology, Pathology).

Overview of research activities

2016/17 has been a period of change both locally and nationally. Professor Alastair Forbes was appointed as our Chief of Research and Innovation, a post jointly funded by the University of East Anglia. As part of our continuing relationship with the University of East Anglia as its academic partner and our commitment to developing excellence in research, a further ten jointly funded, Senior Clinical Academic posts will be advertised shortly.

April 2016 saw the implementation of Health Research Authority (HRA) approval, the aim of which is to simplify the approvals process for research in England.

To facilitate consistent local research management, and to greatly improve performance, we participate in the National institute of Health Research (NIHR) Research Support services. We have publicly available Standard Operating Procedures (SOPs) for research.

We are also assessed by NIHR on our ability to deliver the first patient with 70 days from registration of a new study and have reached 86.4% compliance (national average 76.8%) with a steady improvement since 2014; this ranks us 21/170 Trusts providing this information to NIHR. We are also 58.8% compliant in the national research metric for enrolment "to time and target" for commercially supported clinical trials compared to the national average of 52.9%.

Readers wishing to learn more about the participation of acute Trusts in clinical research and development can access the library of reports on the website of the National Institute for Health Research, at the following address: http://www.nihr.ac.uk/Pages/default.aspx and the Trust website http://www.nnuh.nhs.uk/research-and-innovation/research-outcomes-patient-benefits/

The 100,000 Genomes Project

In 2015 Norfolk and Norwich University Hospitals NHS Foundation Trust was successful in a joint bid with NHS Trusts in Cambridge, Nottingham and Leicester to participate in the 100,000 Genomes Project.

The aim of the project is to create a new genomic medicine service for the NHS – transforming the way people are cared for. Patients may be offered a diagnosis where there wasn't one before. In time, there is the potential of new and more effective treatments.

The project will sequence 100,000 genomes from around 70,000 people. Recruitment at the Trust commenced in July 2016 and 37 patients have been recruited. The project will continue until the end of 2018. To date over 20,000 whole genomes have been sequenced nationally.

National research study to revolutionise cancer treatments gets underway in Norfolk

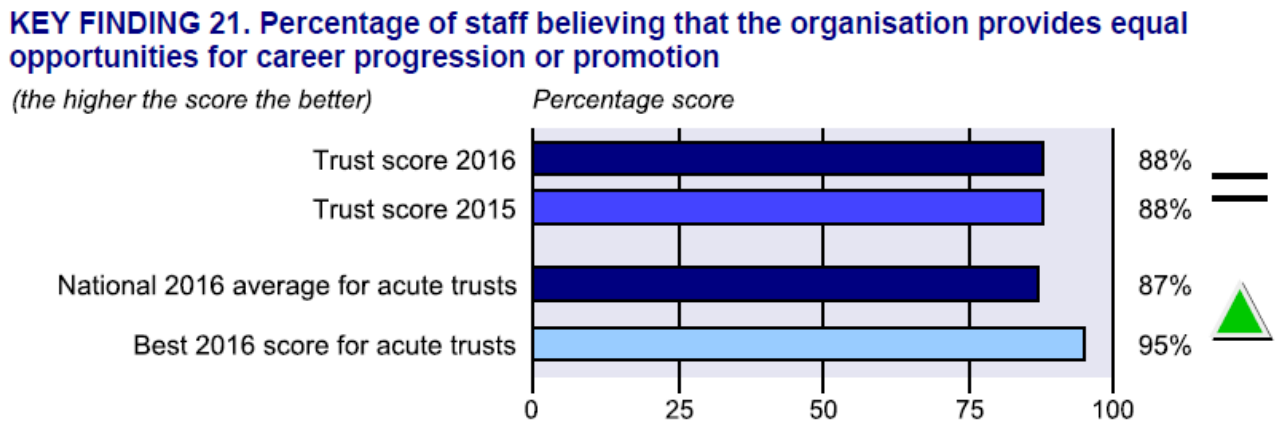
Patient Catherine Harris who was the first patient to take part in the 100,000 genomes research programme

The Norfolk and Norwich University Hospital (NNUH) is one of the hospitals in the UK which is taking part in the 100,000 Genomes Project, a world-leading DNA project which aims to sequence 100,000 complete sets of DNA from around 70,000 NHS patients.

Staff Experience – NHS Staff Survey

Figures 21 and 22 below show the outcomes in respect of Key Findings 21 and 26 in the 2016 Staff Survey. Positive findings are indicated with a green arrow (i.e. where the score has significantly improved since 2015 or compares favourably with other acute hospital trusts in England). Negative findings are highlighted with a red arrow (i.e. where the score has significantly deteriorated since 2015 or does not compare favourably with other acute hospital trusts in England). An 'equals' sign indicates that there has been no change.

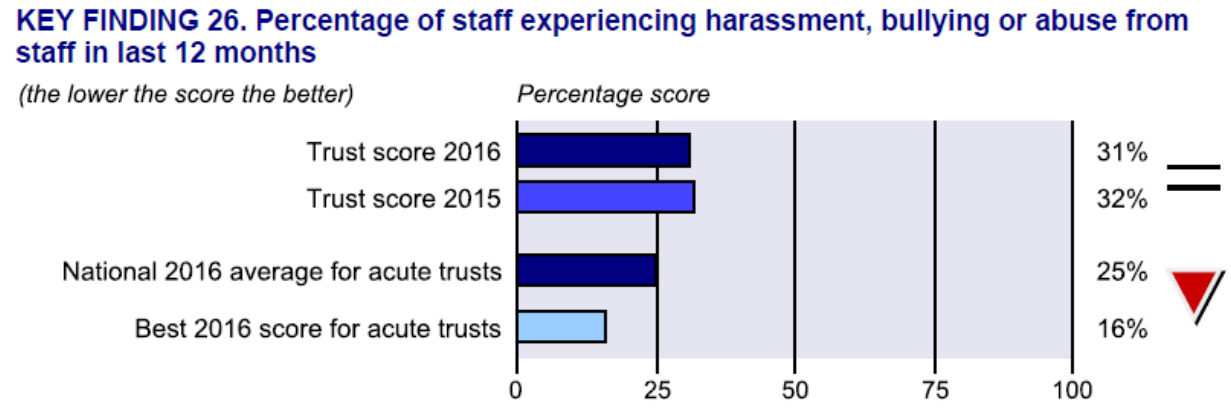
Figure 21 – Performance against KF21



Source: National data, national definition applied

Key Finding 21 shows that 88% of staff believe NNUH provides equal opportunities for career progression or promotion, which is 1 percentage better than the national average for acute hospital trusts in England. This falls in the 'above average' categorisation as stated in the published national staff survey report for 2016.

Figure 22 – Performance against KF26



Source: National data, national definition applied

In respect of key finding KF26, which measures the percentage of staff reporting that they have experienced harassment, bullying or abuse from colleagues in the last 12 month, the score has improved by one percentage point compared to 2015. This however is still six percentage points worse than the average for acute hospital trusts in England, and places us in the highest (worst) 20% of comparator hospitals.

Our PRIDE Values in Action programme, launched in the autumn of 2016, will improve the experience of staff by identifying and addressing the issues at work that can cause dissatisfaction and disengagement, most notably setting standards of behaviour that are congruent with our values, based on the feedback of 2,000 staff and patients that took part in an organisation-wide listening exercise.

NNUH first NHS hospital to introduce revolutionary treatment for Prostate problems

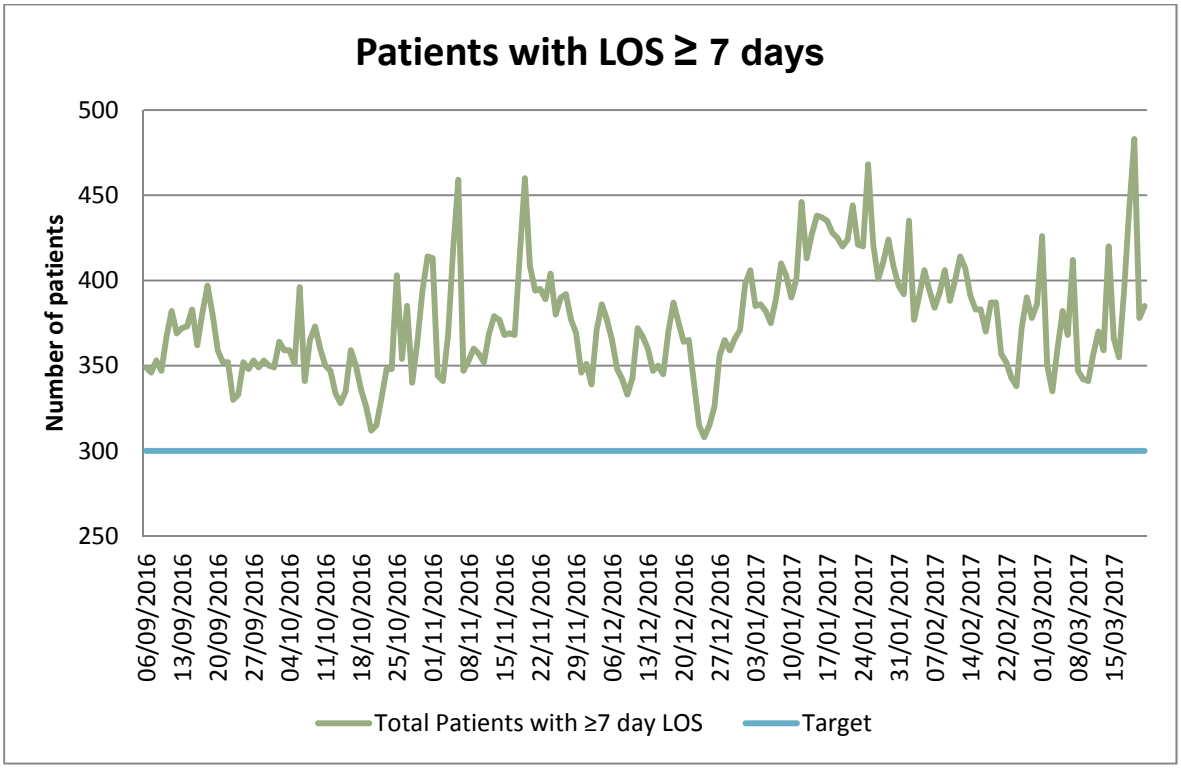
NNUH is the first NHS hospital in the Eastern region to carry out newly approved NICE procedure, UroLift, a permanent implant that has been shown to relieve symptoms of an enlarged prostate in men.

The new medical device is a minimally invasive alternative to operations where the prostate is cut away, such as Transurethral resection of the prostate (TURP) or Holmium Laser Enucleation of the prostate (HoLEP) to treat symptoms caused by an enlarged prostate.

Mark Rochester NNUH Consultant Urological Surgeon explained: “Urolift implants hold back obstructing prostate tissue to open up the urethra and reduce obstruction. I travelled to Copenhagen last year to learn this procedure and to get this started at NNUH. The benefit to patients is huge from being able to get home quicker and reduced side effects and we’re able to carry out more procedures in a day.”

Patient Experience – Encouraging Patient Flow

Figure 23 – Stranded patients



We have expanded our definition of 'stranded patients' to include all patients with a length of stay over 7 days. This will ensure that we maintain an optimal focus on this challenging cohort of patients.

Overall acute Trust DTOCs have reduced from 4.5% to 2.8% (27 patients). DTOCs related to external agencies have remained static at 15 per day against a target of 24 a day to provide backlog reduction.

During 2016, our visibility of the issues impacting flow was improved by the introduction of two complementary initiatives.

The first initiative was the purchase and implementation of a clinical decision support system called 'Clinical Utilisation Review' (CUR). The CUR system is designed to identify the best care setting for patients. Used correctly in admission areas, it identify those patients who would benefit from being signposted to a more appropriate care setting even before they have been inappropriately admitted to the acute care setting. Used correctly in inpatient settings, it identifies those patients who are now fit for discharge to a less acute setting.

To complement CUR, we also launched the Red To Green (R2G) initiative at the end of January 2017 on 5 exemplar wards in the acute Trust and 3 wards in the Community Trust

R2G is a visual way of identifying wasted time in a patient's journey. It focuses on care for patients, and encourages a shift in mind-set, where care is only delivered in an acute hospital bed if that is the *only way* the care can be delivered.

R2G encourages supportive peer challenge of the causes of delay in the patient's care pathway.

A RED day is a day of no value for a patient. Nothing happens to progress the patient's pathway of care through to discharge. Planned treatments, diagnostics or therapies are not undertaken and, if seen in outpatients, the patient's status would not warrant emergency admission.

A GREEN day is a day of value for a patient. Something happens to support the patient's pathway of care through to discharge. All that is planned or requested happens on the day it is requested, diagnostics tests are undertaken and/or reviewed and a clear plan is formulated. If seen in outpatients, the patient's status would warrant acute hospital admission.

R2G is currently being piloted on 6 wards in the hospital, and solutions to mitigate the top causes of delay are currently being explored. The R2G data is collected on the CUR system, enabling the benefits of both systems to be linked.

We are planning to measure median LOS and median time of day of discharge as part of our System ECIP Concordat. Expert advice is being provided from the Emergency Care Intensive Support Team (ECIST) and Dr Ian Sturgess.

Patient Experience – Frailty Strategy

Why focus on frailty?

The British Geriatrics Society describes frailty as a distinctive health state related to the aging process that causes patients to lose their in-built reserves. For many patients living with frailty a seemingly minor episode such as an infection or a new medication can result in significant deterioration in their health.

During 2016/17 we have delivered a range of service developments and system work to support our commitment to deliver excellent care to patients identified as living with frailty. This local focus on frailty is viewed as an essential part of the system response to the challenge of caring for an increasing population of older people with complex health needs over the next 10 years.

The motivation for this work was driven by a range of factors including:

- A national focus on shaping the Urgent Care response to managing frail patients
- Local challenges facing the Acute Trust resulting in complicated pathways and increased length of stay for frail patients
- Mandated Commissioning for Quality and Innovation (CQUIN) requirements
- A focus on patient and carer experience to ensure the best outcomes for patients by only admitting frail patients if absolutely necessary.

At the core of all the initiatives is the mission statement developed by the Acute Frailty team. This supports the aim to move from a small number of geriatricians identifying and managing frailty at the front end of the hospital to an integrated Trust-wide pathway approach, with all departments and teams taking responsibility for delivering care to frail patients.

Frailty Mission Statement

Patients with frailty should be 'known' to all and safety nets should be in place to prevent crisis. If an acute admission is unavoidable, it should be as short as possible and the patient should be discharged safely to their usual place of residence.

Where did we start?

We joined the Acute Frailty Network in September 2015. We have benefited from a 'collaborative improvement' model that encouraged both Acute and Community teams to improve services locally, supported by clinical and improvement experts sharing their experiences through national networking events and site visits.

The Acute Frailty team was able to build on the existing model of service delivery in Older Person's Medicine (OPM). They introduced a screening tool and a highly visible Trust-wide frailty icon (a yellow flower). This icon alerts ward teams to the presence of a frail patient and reminds them of the need to deliver the appropriate elements of a Comprehensive Geriatric Assessment, to initiate appropriate discharge planning and to communicate comprehensive information to community teams.

Next steps included the implementation of an easy to use frailty screening tool and the delivery of Trust wide training and updates to a wide range of staff groups.

Who did we talk to?

The Acute Frailty team initiated collaborative work with a wide range of staff and teams. This partnership work resulted in a wide range of frailty initiatives, examples of which are listed below.

- Multiple ward-based and department-based multidisciplinary teams received frailty training; MDT input ensures that the Acute Frailty pathway is based on a truly holistic approach. Ward-based medical and nursing leads champion the priorities of care for frail patients at daily board rounds and support the delivery of the Comprehensive Geriatric Assessment.

- Increased liaison with clinical teams in the Emergency Department resulted in the earlier identification of frail patients. There is a proactive approach to referring frail patients who are discharged home from the department to the OPM team for follow up appointments or telephone consultation.

- Engagement with Pharmacy teams has ensured that robust medication reviews now commence in ED; we have also introduced a Medication Review tool based on the nationally recognised STOPP/START tool. This screening tool is designed to alert clinicians and pharmacists to potentially inappropriate prescriptions that may lead to medication-related hospital admissions in patients with frailty.

- Increased engagement and collaboration with Community teams resulted in a joint understanding of priorities for frail patients and identified opportunities to develop better system working and improved discharge information through the use of a revised Electronic Discharge Letter.

- Discussions with the East of England Ambulance Service (EEAST) led to a greater understanding of pre-hospital screening for frailty and led to the introduction of a Consultant advice line which is accessible to paramedic crews attending calls in Care Home settings. We hope that this will enable paramedic crews to identify patients who are able to remain in their Care Home setting following specialist OPM advice and potential signposting to other services. In addition to other work with Care Home teams, this should contribute to a reduction in the number of frail patients admitted unnecessarily to hospital from a Care Home.

- Ward based Discharge Coordinators work closely with clinical teams to identify frail patients who are ready for discharge; they provide additional support to patients and carers during the discharge process.

Focus on Patient Experience

Various Trust-wide initiatives helped to raise awareness of frailty. The Acute Frailty team are encouraged by the number of different work areas that now promote an understanding of the care priorities for patients living with frailty. The well-known 'Mrs Andrews' video on YouTube has been used to highlight the patient experience element of the patient journey from admission to discharge. The video describes the factors that may occur during the clinical pathway for frail patients and has been used to ensure that staff working in all settings understand how to manage frail patients.

The focus on the early identification of frailty has resulted in an increase in the number of patients being discharged directly from the Emergency Department; this potentially reduces unnecessary admissions and avoids the complications associated with an acute inpatient stay. We have also seen a steady improvement in the number of frail patients who are discharged back to their usual place of residence; this promotes independence and supports patient choice.

Joint work with the Care Homes Network

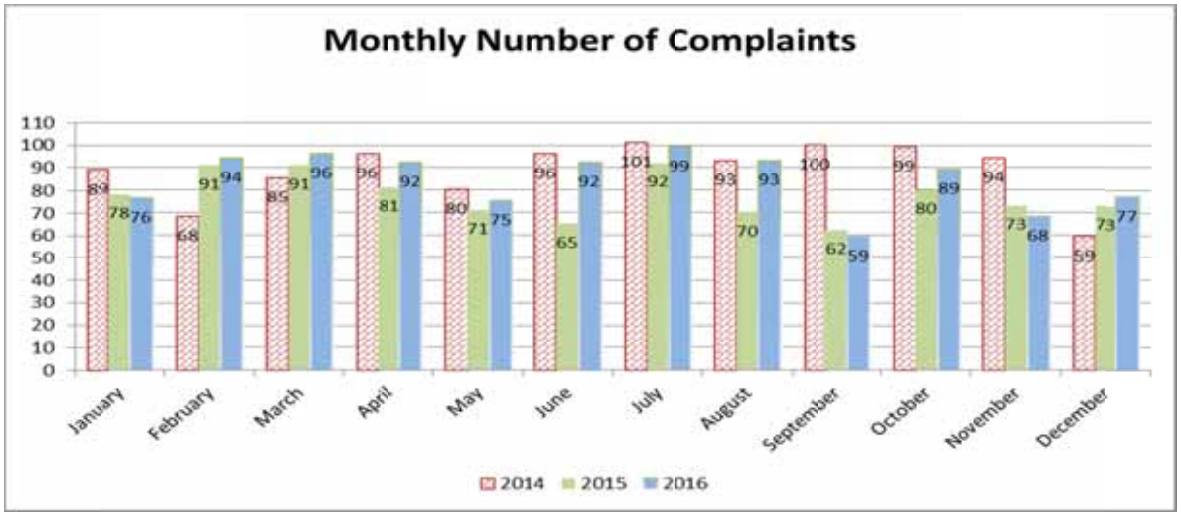
The Acute Frailty team continues to meet with Care Home leads to explore mechanisms that could be developed to increase trust and promote collaborative working; this should allow patients to be discharged back to their usual Care Home without the need for further review.

Patient Experience – Complaints

We have a long-established process for investigating, managing and learning from formal complaints about our services.

In order to ensure that complaints are used to learn lessons and to prompt service improvements for patients, every complaint is reported to the relevant divisional/departmental manager and clinical director so that any necessary actions can be taken. Monthly reports are then reviewed by our Caring and Patient Experience Governance Sub-Board, with summaries provided to the Management Board and Board of Directors.

Figure 24 - Complaints

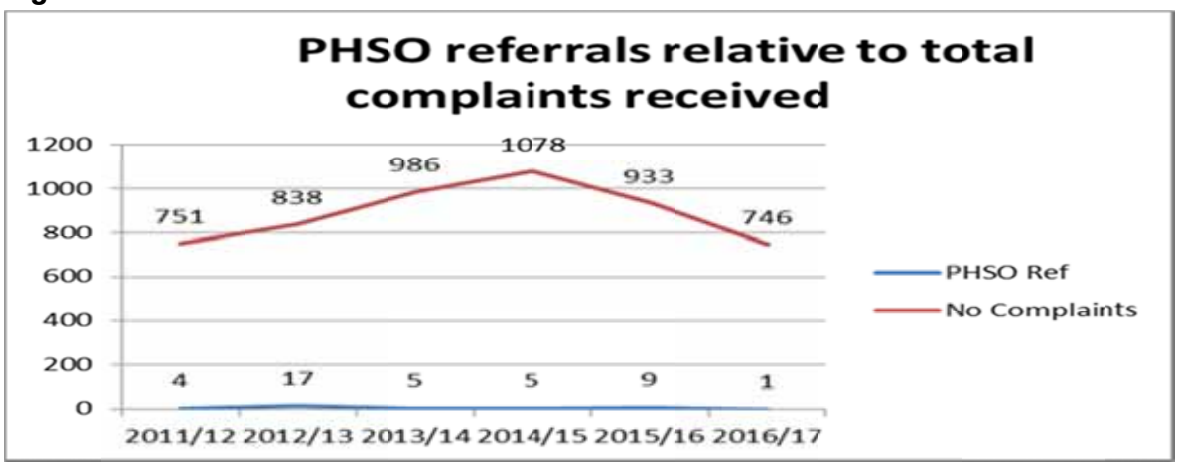


Source: NNUH data, local definition

To ensure that our complaints processes are 'fit for purpose' and are being followed, they are regularly reviewed by our Internal Audit service. They were last reviewed in 2015 and no recommendations for change were made.

During the period covered by this report, an analysis of complaints 'appealed' to the Parliamentary and Health Service Ombudsman (PHSO) was carried out (Figure 25)

Figure 25 – PHSO referrals



Source: NNUH data, local definition

The PHSO has the power to investigate a complaint once local resolution has been completed. A few years ago the PHSO announced that it intended to increase ten-fold the number of complaints it investigates. Figure 25 shows the number of complaints referred to the PHSO from this Trust over the last 5 years. These are single figures each year, except for a spike in 2012/13; this appears to be associated with a change in PHSO threshold relative to the total number of complaints. The number of appeals represents 0.5-2%. The number of referrals from this Trust is low relative to other Trusts, indicating relative success in resolving matters at the first stage.

This conclusion is supported by the periodic review of complaints files conducted by the Healthwatch Norfolk Team which has been consistently complimentary of our approach to managing complaints.

The outcome of PHSO investigations is not always straightforward. For example, sometimes complainants raise new matters with the PHSO which had not been previously notified to us. Nevertheless, all recommendations made by the PHSO are referred to specialties in the usual way to process through the established clinical governance processes.

The annual Clinical Audit Plan now includes reference to those areas that are being audited in response to changes resulting from complaints. This ensures that there is clear follow-up of the implementation of actions agreed.

NNUH recruits first patient to global research study

The Cardiology research team at the NNUH has enrolled the first ever patient to a global cardiology study to look at potentially life-saving treatment.

This new study is a recent addition to the National Institute of Health Research's (NIHR) Portfolio of studies and investigates the impact of a treatment in heart failure patients who experience a sudden worsening of their symptoms. The treatment is called LCZ696 (Sacubitril/Valsartan).

The treatment was previously examined in an international study and was indicated by some to be the future cornerstone of chronic-heart failure therapy. It is now licensed in the UK for adult patients displaying symptoms of a type of chronic heart failure.

Appendix A - Local Clinical Audit – Actions to improve quality

Audit and Survey Title	Results/Actions Taken / Planned
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	The Myocardial Ischaemia National Audit Project (MINAP) is a national clinical audit of the management of heart attack. It supplies participating hospitals and ambulance services in England, Wales and Northern Ireland with a record of their management and compares this with nationally and internationally agreed standards. MINAP published their 2014/15 data on January 30th 2017. The audit demonstrates continuous improvement in a number of aspects of the quality of care for patients following heart attack. Immediate (primary) percutaneous coronary intervention (PCI) is now established as the preferred way to reopen a blocked artery (reperfusion) in ST-elevation myocardial infarction (STEMI). Clinicians have not identified any changes required to local practice.
Cardiac Rhythm Management (CRM)	The aim of the Cardiac Rhythm Management (CRM) audit is to examine the implant rates and outcomes of all patients who undergo pacemaker, implantable cardioverter defibrillators (ICD) and cardiac resynchronization therapy (CRT) implantation procedures in the United Kingdom. The latest report from the CRM audit was published in January 2017. It covered the period from April 2015 to March 2016. Nationally the report found the UK use of ICDs and pacemakers falls short of its use elsewhere in Europe. However the use of CRT implants continues to rise in the UK and is now above the European average. Clinicians have not identified any changes required to local practice.
Coronary Angioplasty/National Audit of Percutaneous Coronary Interventions (PCI)	The aim of this national audit is to monitor the clinical care and outcomes of patients receiving percutaneous coronary interventions. Data is collected at each participating hospital continuously. The data covering the period of January to December 2014 was published in April 2017. The PCI procedure, which involves inserting a tube or catheter into the patient's arterial system to reach the locked artery in order to improve blood flow, is associated with fewer complications if carried out through the radial artery rather than the femoral artery. The latest report demonstrates an increase from 26.9% to 75.3% in the use of a safer method of PCI (angioplasty) between 2007 and 2014. Clinicians have not identified any changes required to local practice.
National Heart Failure Audit (HF)	The aim of the Heart Failure national audit is to capture data on clinical indicators which have a proven link to improved outcomes, and to encourage the increased use of clinically recommended diagnostic tools, disease modifying treatments and referral pathways. The latest report on the Heart Failure audit was published in July 2016 and covered the year from April 2014 to March 2015. Nationally the report found that just fewer than 50% of patients with heart failure were managed on specialist cardiac wards. Those that were managed on specialist cardiac wards were more likely to survive to discharge, more likely to receive key disease modifying drugs, more likely to have timely specialist follow up and likely to be alive at follow up.
Audit of Intraoperative Neuromonitoring of Spinal Cord During Corrective Spinal Deformity Surgery.	Neurophysiological monitoring of spinal cord function is an increasingly commonly performed procedure to improve surgical outcomes from corrective spinal deformity surgery. To determine quality, national standards were produced in 2013. This audit was designed to assess how strictly departments around the UK adhere to these Standards. The findings for this Trust demonstrated 100% compliance in all areas. Results have been shared with the clinical team.
Smoking Cessation Audit	This national audit was undertaken to examine whether a properly led and staffed smoking cessation service existed within the Trust and create an environment more supportive of smoking cessation efforts. The results of the audit found that less than half of patients had a formal smoking status recorded, and that of those who were found to be smokers, none had evidence of being offered any smoking cessation advice or service. As a result, a hospital wide education program will be conducted, beginning with foundation trainees as these are the most common front line doctor responsible for the initial clerking.

National Audit for Rheumatoid and Early Inflammatory Arthritis	The aim of this audit was to compare the early management of patients with suspected early rheumatoid or inflammatory arthritis against NICE standards. Data collection for the National Audit did not take place in 2016-17 while a new provider is sought. However the second annual report was published in July 2016 reporting on data collected from February 2015 to January 2016. This report demonstrated that locally GPs refer 14% of patients to the rheumatology unit within 3 days of presentation (nationally 20%); 14% are seen in the rheumatology unit within 3 weeks (nationally 37%); 72% of patients are commenced on appropriate treatment within 6 weeks of referral (nationally 72%); 95% of the patients had an agreed target set at the outset (nationally 92%); 97% of patients had the means to contact the rheumatology unit for advice within 1 working day (nationally 92%. We were 2 of 16 units in East of England which did not have an annual review clinic; our patients felt a greater disease impact on their life compared to the rest of the country however they reported a greater improvement than the rest of the country with treatment.
Sentinal Stroke National Audit Programme (SSNAP)	The audit was undertaken to look at all aspects of the stroke care pathway from admission to recovery against national benchmarks to help identify problem areas. Up until November last year (the most recent report) it has shown a steady improvement in stroke care within the Trust. As a result of the audit, thrombolysis delays and admission delays have all been assessed so further improvements can continue to be made.
Case Mix Programme (CMP) Audit	The aim of this on-going audit was to collect data on all patients admitted to the Critical Care Unit. The annual quality report for 2015/6 was reviewed and data completeness was close to 100% in all fields. All quality indices were comparable with similar units and within the normal range. Unit acquired infection was above the mean but not statistically. This figure relies heavily on reporting and is thus subjective. As a result of the report, no actions were necessary.
National Cardiac Arrest Audit (NCAA)	This audit was undertaken to identify patients who had a cardiac arrest at the Norfolk and Norwich University Hospitals NHS Foundation Trust (NNUH); to see if the arrest could have been prevented or if a Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) order should have been made; and to disseminate these findings to improve care. The audit found an initial survival rate of 40% with 20% of patients surviving to discharge. The report was reviewed at the Recognise and Respond Committee meeting in January 2017. It was recommended that monitoring of outcome following cardiac arrest and participation in the National Cardiac Arrest Audit (NCAA) data collection is continued to enable review and improve practice where required.
Audit of Potential Organ Donation	This audit was undertaken to establish the number of patients meeting organ donation referral criteria. The report NHS Blood and Transplant Executive Summary: Actual and Potential Organ Donors for 1 April 2016 - 30 September 2016 was published in November 2016. The audit found that 94% of potential organ donors were identified and referred. 100% of appropriate patients were referred to the organ donation team. Following the audit no changes in practice were required, however regular teaching sessions continue in order to keep all staff up to date with notification criteria for potential organ donors.
National Emergency Laparotomy Audit (NELA)	The National Emergency Laparotomy Audit (NELA) aims to audit the key processes of care for patients undergoing emergency laparotomy and report processes and outcomes for these patients at hospital level. The Second Patient Report of the National Emergency Laparotomy Audit was published in July 2016. This report covered patients submitted to the audit from December 2014 to November 2015. Nationally this report demonstrated that a lack of consistent care for patients undergoing high-risk emergency bowel surgery may be negatively affecting patient outcomes and placing a major strain on NHS resources. During the second year of the audit the cases submitted by the Norfolk and Norwich University Hospital was below 50%. During 2016 processes have been improved and the submission rate to year three of the audit is close to 100%.
National Vascular Registry (NVR) Audit	The National Vascular Registry (NVR) reports on the quality and outcomes for all patients who undergo major vascular surgery in NHS hospitals in England and Wales. The latest annual report was published in November 2016. The Vascular Surgery department at the Norfolk and Norwich is the 5th busiest vascular unit in the UK and has treated more ruptured acute aortic aneurysms than any other hospital. This report demonstrates that this unit compares very favourably with national figures. Mortality rates are lower than average. The unit is in the top third in the UK for symptom to speed of operation for carotid endarterectomy.

National Joint Registry (NJR) Audit	The National Joint Registry collects data on all hip, knee, ankle, elbow and shoulder replacement operations and monitors performance of joint replacement implants. The NJR published their 13th Annual Report in September 2016. This report outlines activity and outcomes up to December 2015. The orthopaedic department at the Norfolk and Norwich Hospital continues to be one of the busiest centres for joint replacements in the country, performing the most primary and revision hip replacements in the Eastern Region. Nationally the outcomes in hip and knee replacement surgery continue to be positive with revision rates at twelve years remaining low at 5% for the majority of procedures and extremely low at 2% for some. After a review of the data it was concluded that there is no compelling evidence to switch the type of implants that we use at NNUH. The outcomes are as good as the best on the NJR database.
National Hip Fracture Database (NHFD) Audit	The aim of the National Hip Fracture Database (NHFD) is to improve the care and secondary prevention of hip fracture – the most common serious injury of older people. The National Hip Fracture Database published their annual report in September 2016. This report covered patients presenting with a hip fracture during 2015.The Orthopaedic Department at the Norfolk and Norwich University Hospital is the third largest hip fracture unit in the country. We have a 30 day mortality of 8.2% adjusted, which is within national limits and is an improvement from the previous year's data where we were identified as an outlier. Two thirds of patients achieve 'Best Practice Tariff' care and efforts are being made to introduce additional operating capacity and also to provide a more consistent holistic approach to care.
Patient Reported Outcome Measures (PROMS) on going National Audit	This audit was undertaken to gain information on the effectiveness of care delivered to NHS patients as perceived by the patients themselves. The results are made available via NHS Digital and are disseminated via our Effectiveness Sub-Board monthly. The results are discussed and any actions required are undertaken. PROMS scores are used to improve care for our patients.
Trauma Audit Research Network (TARN) Audit on Trauma Care	The Trauma Audit and Research Network (TARN) is a national database of trauma care. The audit benchmarks national survival figures and trauma care against nationally accepted standards. Submissions to the audit are continuous. As of January 2017 submission numbers for 2016 were 603/683 (88.2%), which exceeded the minimum requirement of 80%. Findings are discussed at the Trauma Committee and actions to improve practice are actively discussed and implemented.
Medical and Surgical Clinical Outcome Review Programme: National Confidential Enquiry into Patient Outcomes and Death (NCEPOD)	The National Confidential Enquiry of Patient Outcomes and Death (NCEPOD) aims to improve standards of clinical and medical practice by reviewing the management of patients, by undertaking confidential surveys and research, and by maintaining and improving the quality of patient care by publishing and generally making available the results of these activities. During this year NCEPOD has published two reports; Acute Pancreatitis Study in July 2016 and Mental Health Care in Acute Hospitals in January 2017. Both of these reports have been reviewed by an identified Trust lead and a gap analysis undertaken to identify required actions for improvement.

Appendix B - Local Clinical Audit – Actions to improve quality

Audit and Survey Title	Results/Actions Taken / Planned
Audit of the Use of Second Troponins after an Initial Negative Troponin in Accident & Emergency (A&E) and Acute Medical Unit (AMU)	This audit was undertaken to assess practice around the trust policy for troponins. The results demonstrated that samples were not always repeated at the appropriate time interval and that in certain cases, a troponin was unnecessarily requested. As a result of this audit, crib sheets to guide blood test requesting and senior-led triaging were instigated by A&E with further education for junior medical staff being undertaken.
Prescribing Audit	This audit was undertaken to assess the practice of antibiotic prescription on the Acute Medical Unit against Trust Policy and Guidelines. Results were positive with 100% being scored for prescriptions having review dates or durations recorded. The lowest compliance score (94% compliance) related to the indication for prescription being recorded on EPMA (Electronic Prescribing and Medicines Administration) interface. As a result of the audit the EPMA interface was recommended to include both the indication and duration together in the same link which will be reviewed.
East of England (EoE) Audit of Primary Percutaneous Coronary (PPCI) Intervention	The aim of this audit was to evaluate treatment times and outcomes of Primary Percutaneous Coronary Intervention (PPCI) in the East of England. The details of every PPCI activation and all PPCI cases carried out at the Norfolk and Norwich University Hospital (NNUH) in 2015 was downloaded from the Cardiology database and collated. This audit found that the level of activity, treatment times and outcomes at the NNUH were comparable with other centres in the region.
Audit of Phototherapy Local PUVA (Psoralen combined with ultraviolet A) Burns	The audit was undertaken to determine the success rate of treatment and to identify episodes of burning and patients having local Psoralen combined with ultraviolet (PUVA). The results demonstrated a good response rate, 62% of patients improved with local PUVA with psoriasis treatment and although burns occur they do not appear above expected. As a result of this audit no actions were required.
Audit of Psoriasis Area and Severity Index (PASI)	This audit was undertaken to determine that phototherapy treatment is improving patients' skin conditions, and to determine that the Psoriasis Area and Severity Index (PASI) scores are being performed. The results of the audit found that PASI scores were not being completed regularly before or after treatment. 6/6 PASI scores were performed pre-treatment but none afterwards. As a result nurses are now being taught how to do perform PASI scores and a re-audit will be undertaken.
Audit of Dermatology Life Quality Index (DLQI)	The audit was undertaken to determine that phototherapy treatment is improving patients' skin conditions, and to determine that the Dermatology of Life Quality Index (DLQI) scores were being performed. The results of the audit found that 10/13 had pre DLQIs performed and no post treatment DLQI scores had been undertaken. The findings have been presented at the phototherapy meeting with minutes distributed to all staff doing the post assessments and a re-audit will be undertaken.
Audit of Documentation of Key Diagnostic Details From Patients With Alopecia Areata Against British Association of Dermatologists (BAD) guidelines.	The aim of this audit was to determine compliance with the British Association of Dermatologists (BAD) guidelines. The results found that although there was good compliance with some of the documentation, some areas were lower and as a result a proforma will be created to aid documentation and a re-audit will be undertaken.
Audit of Glucagon Like Peptide 1 (GLP1)	This audit was undertaken to determine whether the use of Glucagon-like peptide-1 (GLP-1) was in accordance with national and local guidelines. The results demonstrated a compliance of 95.3% and 90.5% in keeping with The National Institute for Health and Care Excellence (NICE) guidelines. As a result of the audit the department are continuing to use GLP-1 in line with NICE guidance and will re-audit in a years' time.

Re-Audit of Parathyroidism	This audit was to determine the management of primary hyperparathyroidism at the Norfolk and Norwich University Hospital (NNUH). The results of the audit found that referral rates from endocrine clinic to surgeons had dropped from 49% to 43% and time to surgery had increased despite reduced referrals. As a result the department will aim to reduce time between endocrine clinic and referral to surgeons. Clinicians are being encouraged to refer to surgeons as the same time as requested imaging rather than waiting for results.
Audit of Insulin Omission and Insulin Errors	The audit was undertaken to determine the number of insulin omissions across the trust inpatient areas and where possible to identify the cause. The results of the audit found more insulin omission errors at the Norfolk and Norwich University Hospital (NNUH) than expected, and these were Trust wide rather than in specific ward area. It was identified that some reported omissions were not real but a facet of the Electronic Prescribing and Medicines Administration (EPMA) reporting system. As a result of the audit further insulin education is required across the Trust and the Diabetes team will work with the EPMA team to determine robust, accurate reporting.
Audit of Hypoglycaemic Episodes from existing data	This audit was undertaken to determine compliance with the documentation of episodes of hypoglycaemia. The audit results found poor adherence to the Trust guidelines for the management of hypoglycaemia both in terms of documenting the treatment that was given and ensuring that the treatment is appropriate. As a result of the audit a sticker is has been developed to determine documentation is correctly completed and to give treatment guidance and a re-audit will be undertaken.
Senior Review Prior to Discharge	The audit was undertaken to determine a senior review has been undertaken prior to discharge or admitted for any child presenting to the Emergency Department (ED). The results found that 91% of children audited had a senior review as per guidance in the Emergency Department. As a result the department will continue to audit and feedback to clinicians who are not maintaining the standard.
Audit of The Use of Non Invasive Positive Pressure Ventilation in Type 2 Respiratory Patients	This aim of this audit was to assess the speed of referral to the respiratory team and the provision of Non Invasive Positive Pressure Ventilation (NIPPV) for patients in type 2 respiratory failure. The results found that 62% of patients were referred to the respiratory team. As a result the respiratory department are hiring a Bilevel positive airway pressure (BiPAP) machine which is likely to improve initiation of treatment.
Audit of Accuracy of Data Input to Symphony	The audit was undertaken to determine whether Integrated Clinical Environment (ICE) requests are correctly made within Symphony and if diagnostic tests are correctly input in correspondence with Central Alerting System (CAS) cards. The audit identified that Symphony does not accurately reflect information on the CAS card in all instances. As a result the department are hoping to disable the two way button for ICE within Symphony which should resolve the issue and will conduct regular monthly audits for discrepancies between CAS cards and Symphony. Training will be provided to all staff on checking all information has been entered correctly.
Audit to Endoscopy Start and Finish Times	This audit was undertaken to evaluate avoidable delays in the start of clinic lists. The results demonstrated that 83% of lists commenced on time or were early and 17% had avoidable delays. Reasons for the delays included the overrun of previous lists and endoscopists undertaking other clinical priorities. Staff have been requested not to overbook lists.
Audit of Lumber Puncture Documentation	This audit was undertaken to evaluate the documentation of elective lumbar punctures and the use of a lumbar puncture checklist. The results highlighted a number of documentation issues such as infrequent recording of the indication, documentation of requested investigations and presence/absence of complications. Infrequent use of the lumbar puncture safety checklist was noted. As a consequence the lumbar puncture checklist pro-forma will be amended to include sections covering the areas or poor documentation and the use of the form will be encouraged via the doctor's induction handbook.
Re-Audit on Secondary Prevention in Osteoporotic Fragility Fracture	The audit was undertaken to see if improvements had been made in bone health assessments of patients with non-hip fragility fractures. The results found that although this remains poor, there had been progress. The NNUH now assesses at a rate higher than the national average. To improve further, informal teaching sessions have been put in place for Orthopaedic Specialist Nurses and a section on Bone Health Assessments has been added to the Older People's Medicine Induction Handbook for junior doctors.

Audit of Anticholinergic Cognitive Burden (ACB) Scoring	The audit was undertaken to determine whether patient's ACB scores are recorded and to determine action is taken for any drugs currently prescribed that have been shown to be associated with falls (and dementia). The audit found of the 10 patients identified with high ACB score a decision was made to omit a drug for one patient, and it was suggested the GP/specialist to do so in 40%. As a result of the audit a modified ACB score has been included in the STOP/START frailty advice for pharmacists/clinicians. Further education will also be continued.
Audit of Medicine Administration Record (MAR) Charts on Henderson Unit	The re-audit was undertaken to identify how effective the coloured stickers on the front of MAR charts are at aiding the recording of allergies. The audit found that the introduction of stickers resulted in an increase from 10% to 92% of patients with allergies recorded on the chart. No further actions could take place following this audit as the unit has now been permanently closed.
Dementia Person Centred Care Audit	This audit was undertaken to establish the use of dementia approved identifications and the 'This is Me' tool for patients across the Trust with dementia. After the summer the results improved significantly after ensuring that blue wristbands were available, addressing issues around wristbands breaking, ensuring all wards have stock of the' This is Me' tool and involving Dementia Link staff in these processes.
Dementia Carer's Audit	This audit was undertaken to determine a good level of clinical care and support is received by carers of patients with dementia. The audit found an overall satisfaction with clinical care and the support received as carers. As a result of the audit there is now a recliner chair available to enable relatives to stay with patients overnight. The audit has seen individual issues raised and addressed by reporting directly to ward managers and the Patient Advice and Liaison Service. These issues may not otherwise have been reported.
Re-audit of Ipsilateral Radiotherapy in Tonsillar Cancers	This re-audit was undertaken to evaluate the contralateral neck recurrence (CNR) rate in patients with tonsillar squamous cell carcinoma after changing from ipsilateral to bilateral neck Intensity Modulated Radiotherapy (IMRT). In total 23 patients with N2b disease were treated with bilateral neck IMRT of which 20 patients had p16 positive carcinomas. The median follow-up was 21 months and the CNR rate was 0% (compared to 7.4% in the first audit) and the 5-year contralateral neck recurrence-free survival (CNRFS) was 100% (compared to 82.9% in the first audit). The results have shown that by changing our practice to bilateral neck radiotherapy we have managed to improve our patient outcomes.
Audit of Vismodegib Use Against Cancer Drug Fund (CDF) Criteria	This audit was undertaken to evaluate the use of Vismodegib against the Cancer Drug Fund criteria. The results demonstrated that Vismodegib was prescribed in accordance with recommendations, although approval by relevant specialist skin cancer multidisciplinary team was not always evident. This was discussed at the Specialist Skin Multidisciplinary meeting educational session as a route to improve compliance.
Vascular Access Audit	This audit was undertaken to determine that new end-stage kidney disease patients planning to start haemodialysis and patients on long-term dialysis are given the type of vascular access as recommended by the United Kingdom Renal Association. The audit also counted the number of 'line infection days'. Data was collected on all suitable patients and reported at quarterly Vascular Access meetings. Over the year the Trust has been very close to the national targets for vascular access of 60% for new patients and reached the national target of 80% for long-term patients. There was one line infection day this year. The renal team are looking at capturing all potential line infections with more 'real time' data.
Acute Kidney Injury (AKI) E-alert Audit	This audit examined the management of patients with Acute Kidney Injury, ensuring that they follow local guidelines and CQUIN goals. A sample was selected from the AKI database stratified by stage of AKI. It was found that there was good compliance with early AKI assessment and management, but improvement was required with discharge summaries and instructions for primary care, although follow-up bloods in primary care is good.
Oxygen Prescribing Audit	The audit was undertaken to determine the Trust emergency oxygen policy is implemented correctly and support safe practice around oxygen management. The Electronic Prescribing and Medicines Administration System (EPMA) has complicated the audit process. Results appear to be worse due to the disconnect that exists between the electronic prescription and the administration/adjustment part of the process. Without more reliable data it is difficult to report a definite change in performance. The audit is to be redesigned to determine it captures the data required. Auditing will recommence on Hethel and Mattishall wards before once again looking at the Trust performance as a whole.

Audit of Outcome Monitoring of Patients on Biologic Therapy	This audit was undertaken to monitor the outcomes of patients currently treated with biologics medicines. Patients on these medicines run an increased risk of infection. Every quarter a report is generated of all mortality and all hospital emergency admissions of patients being treated with biologics. This report is analysed for trends, then presented and discussed at the Rheumatology Governance meeting. Actions included rewriting the Trust's guideline on interruptions in biologic treatments.
Re-audit of Epidural Observations Compliance	This audit was undertaken to measure compliance with epidural analgesia observations required in Trust guidance. The results have improved from last year and a re-audit has been planned for 2017/18.
Re-audit of Removal of Epidural Catheter Risk Assessment Tool (RAT) – compliance with use	This audit was undertaken to measure compliance with completion of the risk assessment tool for epidural catheter removal in areas that support epidural analgesia. The results have improved from last year but the use of risk assessments required improvement. A re-audit has been planned for 2017/18.
Audit of Paediatric Anaesthetic Pre-assessment – a review of quality and effectiveness	This audit was undertaken to clarify that parents and children/young people found the paediatric pre-assessment clinic beneficial; and to identify areas for improvement in the service. The results found that 100% of respondents either strongly agreed or agreed that seeing the Anaesthetist was useful. As a result of the audit the Pre-Operative Assessment (POA) letter will be amended to advise all parents in advance that they will have the opportunity to see an anaesthetist when they come in for surgical/nurse POA.
Handover of Care Audit	This audit was undertaken to determine the safe handover of patients. The results demonstrated 100% of patients had an appropriate member of staff available for the handover and 80% of patients were documented on the handover sheet. As a result junior doctors are being educated about the importance of documentation during their induction and a re-audit will be undertaken.
Audit of Polydioxanone Foil (PDS foil) and Microporous High-Density Polyethylene Implant (MEDPOR)	The audit was undertaken to determine the use of Medpor nasal implants in augmentation septorhinoplasty. The results of the audit found that 17 patients had Medpor implants inserted from 2008-2015. The majority (14) had dorsal nasal implants which were stable. When Medpor was used as a columellar strut (8 cases) it was less stable with one being extruded. As a result of this audit, dorsal Medpor implants will continue to be used in appropriate patients. However, caution is advised when inserting a Medpor columellar grafts and an autologous "shield" graft will always be used in these instances.
Audit on the Surgical Management of Patients Presenting with Unresolved Pneumothorax	The aim of this audit was to determine whether patients with persistent air leak or failed lung re-expansion are referred to thoracic surgery within 5 days of admission. The audit found 11 out of 21 (52%) patients were referred within 5 days. The referral pattern does not comply with the British Thoracic Society guidelines. The plan following this audit is to inform respiratory medicine about the outcome and implement strategies to speed up referrals, within 24 hours of admission, to Thoracic Surgery.
Orthognathic Consent Audit	This audit was undertaken to assess the current consent process and to improve the thoroughness of consent within the department. The results of the audit were generally good. However, the audit demonstrated a lack of documentation in key areas – most notably alternative treatments and frequent risks. As a result of the audit, a proforma was introduced to assist with the consent process. In addition to the above, training for taking consent is now included as part of the formal induction period for senior staff.
Audit of Endometriosis Centre Rolling Patient Outcomes - British Society for Gynaecological Endoscopy (BSGE)	This audit was undertaken to fulfil the Trust's responsibilities as a British Society for Gynaecological Endoscopy (BSGE) Endometriosis Centre and contribute to the national database for the purposes of endometriosis research. The audit found that the Trust completed 30 cases that involved surgery in the pararectal space. Following the audit no changes were required as the Trust has fulfilled the appropriate criteria to maintain their status as a BSGE Endometriosis Centre.
Audit of Staff Knowledge of Diabetes and Pregnancy	This audit was undertaken to determine staff knowledge of current issues and care management for pregnant women with diabetes. The audit results found that knowledge regarding insulin could be improved. Midwives must continue to access electronic training in the safe use of insulin annually.
Audit of Infant Feeding	This audit was undertaken to determine minimum standards in infant feeding were being achieved. The audit results indicated that staff competence level was of the correct standard. A re-audit has been planned for 2017/18.

Audit on Donor Breast Milk (DBM) in the Neonatal Intensive Care Unit (NICU)	The aim of this audit was to evaluate compliance with the Trust guideline on the use of donor breast milk (DBM) on the neonatal unit. The findings demonstrated that all babies receiving DBM met the eligibility criteria; however written consent was not always evident in the notes. In addition Consultant decision to continue DBM once full enteral feeds was established was not always documented clearly. Consent forms have been made more readily available in the Neonatal Unit. A checklist for introduction of DBM has been introduced.
Audit to Recommendations of the Bliss Family Friendly Accreditation Scheme	This audit was undertaken to compare local delivery of neonatal care against the Bliss baby charter standards 2011. The neonatal unit's compliance to the 7 principles. Assessment to the standards was assessed through a range of methods including patient feedback and observational audit. The findings highlighted 16 standards where the unit was unable to fully comply and therefore rated "amber". An action plan has been developed, which includes updating the unit's protocol around lighting and sound.
Audit of Children's Early Warning Scores	This audit was undertaken to evaluate compliance to recording and acting on children's early warning scores (CEWS). The results demonstrated a drop in compliance compared to the previous audit percentages in all three standards. As the audit methodology had changed slightly from previously it was recommended the methodology reverts back and data collection continues. If the same trend continues frequent weekly audits and nurse training will be undertaken. The need to document clinician reviews will also be discussed in the junior doctor training sessions. This will be an on-going audit
Paediatric Oncology Audit	This audit was undertaken to determine if all children with life limiting conditions (LLC) have assessment of palliative care needs and planning of the delivery of care as per national standards, and to establish local guidelines and a management framework. The results demonstrated that standards were not fully achieved and that documentation and advance planning were sub-optimal. This was particularly the case for children with non-cancer LLC. Actions taken and planned include raising awareness of palliative care needs of children with non-cancer LLC through study days and communication skills workshops, the development of a Trust guideline and contribution to a gap-analysis report to commissioners, urging them to commission a dedicated palliative-care service for children. A care pathway has been written and disseminated and will be incorporated into routine care.
Fine Needle Aspiration (FNA) Thyroid Audit	This audit was undertaken to measure the measure the Thy1 rate at the NNUH for Ultrasound-Fine Needle Aspiration. The standard was a diagnostic yield of above 80% and the results demonstrated that we had marginally failed to meet this standard for the past 2 years. As a result of the audit, discussions regarding the technique were held with the operators to determine that improvements can be made by learning from those with lower rates.
Audit of General Practitioner (GP) Minor Injury Assessment (MIA) Pathway	This audit was undertaken to assess the practice around report times for General Practitioners (GP) Direct Access Patients and the appropriateness of GP requests. The audit highlighted that 68% were requesting in accordance with the protocol which was less than previous audits had demonstrated. The report turnaround had greatly improved. As a result of the audit, a link to the protocol was introduced and a patient information leaflet placed on the knowledge Norfolk website; which allows both patients and G.P.'s direct access to the policy.
Handover of Care Audit (Radiology)	This audit was undertaken to determine that patients were being transferred to Radiology appropriately, e.g. having been risk assessed, escorted where appropriate and appropriate documentation available. The results demonstrated that improvements were required and as a result of the audit, a training and education programme for all registered nurses was implemented across the Trust in order to increase awareness of the Risk Assessment Tool documentation and the Trust Policy for Intra Hospital transfers. In addition, plans to raise awareness of the Trust policy in the weekly Team Brief Communications circular were put in place. Where unsafe transfers to radiology occur, Datix forms will now be completed to highlight issues and a re-audit is planned with information to be shared with the Critical Outreach team.
Dietetic Department Documentation Audit	This audit was undertaken to determine that dietetic documentation in patient notes was compliant with standard record keeping protocol. The audit demonstrated high compliance but demonstrated a need to improve documentation of the timing of entries in dietetic notes. As a result of the audit, a more in depth audit will take place in 2017/18 to also encompass the content of dietetic assessments.

Audit of Ophthalmology Photography - Quality of photography	This was a re-audit undertaken to measure patient satisfaction with the current service and to compare this with previous cycles. The results were very positive showing that practice and compliance had stayed at a high level and had even improved since the last project. As a result, no immediate actions were necessary.
Audit of Medical Illustration - Patient Experience	This audit was undertaken to measure patient satisfaction with the current service to compare this with previous cycles. The results were very positive showing that practice and compliance had stayed at a high level. As a result, no immediate actions were necessary.
Audit of the Quality of Life Outcomes for Pregnant Women	This audit was undertaken to assess the effectiveness of physiotherapy in treating antenatal / postnatal low back pain and/or pelvic girdle pain. The results demonstrated that physiotherapy during pregnancy had a positive impact on a patient's condition and should be considered to be an effective and positive treatment for women with pregnancy related pelvic girdle pain and/or lower back pain. Due to positive feedback, it was felt that no immediate actions were required. Further refinement of the audit process for this group of women may yield a higher response rate in future. This may include use of online questionnaires if appropriate. A re-audit is planned in two years' time.
Speech and Language Therapy Bedside Chart / Catering Audit	This audit was undertaken to assess the practice around patient meal times to determine patients were given choice, appropriate support and that they received the appropriate meals. The results of the demonstrated that; patients were not always given the full choices for meals; compliance with speech and language therapy recommendations had improved since the previous audit (with nearly 100% compliance rate); patients requiring red tray support at meal time were not always receiving this promptly; policy on placing thickener behind beds was not always adhered to. As a result of the audit, training of the meal time ordering system was introduced for catering staff, general staff training was introduced on the risks of placement of thickener on the wards and healthcare assistant training was amended to include info around meal time support via red tray system.
Implementation of National Institute of Health Excellence Policy Monitoring of Compliance Audit	This re-audit of compliance to the Trust Implementation of National Institute of Health and Care Excellence Policy reviewed a random selection of the central evidence folders and the central NICE Spread sheet. The audit found that limited evidence was available from Divisional Boards when formal risk assessments relating to NICE were presented. The implementation of the new clinically led divisional structure is anticipated to improve compliance. A re-audit will be undertaken in 17/18.
Implementation of Best Practice National Confidential Enquiries Policy compliance audit	This was a re-audit of compliance to the National Confidential Enquiries Policy. The audit found that compliance to the Policy was good. A re-audit will be undertaken in 17/18.
Audit of Compliance to Policy on Procedural documents	This re-audit of compliance to the Trust Policy on Procedural documents reviewed 30 procedural documents on Trustdocs. The audit demonstrated satisfactory compliance to the policy in regards to Standard Operating Procedures and Non Clinical Policies, however although compliance was higher in relation to last year's audit compliance was poor overall in regard to documents labelled as Procedure. Gate keepers will continue to monitor compliance and a re-audit will be undertaken in 2017/18.
Pressure Ulcers Audit	This on-going surveillance audit reviews all pressure ulcers in the Trust. Various methods are utilised for the audit including: review of Datix Incident Reports, review of ward documentation during Quality Assurance Audits and ward staff reviews of their documentation during matron's rounds. A weekly pressure ulcer report which includes all community acquired pressure ulcers and hospital acquired grade 2 and above is circulated to Senior Staff. A Route Cause Analysis (RCA) is undertaken by ward staff and the Divisional Matron for any reported Grade 2 or above pressure ulcer. An action plan is formulated following each RCA and learning is disseminated within the Divisions to determine learning is shared across the organisation.

Audit of Transfer Guidelines and Clinical Handover of Care	This audit was undertaken to determine that there was documented evidence of patients having been risk assessed prior to intra hospital transfer from ward areas and that the appropriate actions had been taken as per policy. A new Risk Assessment Booklet had been introduced and this audit was to assess compliance with this new method of documentation. This large Trust wide audit was undertaken for several different locations of transfers; ward transfers, theatre transfers and transfers to radiology. The overall compliance with the documentation of the risk assessment process over all these areas was poor. An action plan has been put into place with the support of the Divisional Nurse Directors and Clinical Governance Leads Group. This is to embed the correct practice, make improvements to the transfer process and generally raise the awareness of patient safety on intra hospital transfer.
Audit of Reasonable Adjustments	This audit was undertaken to determine the use of Learning Disabilities resources throughout the Trust. The audit highlighted a range of areas of strength within the Trust, as well as some areas in which improvement is required. As a result of the audit, the following actions were implemented: on-going plan of monitoring of areas to determine good/improved results; amendments to Learning Disabilities referral process to determine on-going appropriate referrals and a focus on the use of care bundles in learning disabilities liaison work with clinical areas. The communication library - 'Everybody Communicates' programme was developed further to determine higher use of Adapted Augmented Communication by staff.
Audit of the Use of Learning Disability Resources	This audit was undertaken to determine the use of Learning Disabilities resources throughout the Trust. The audit highlighted areas of strength within the Trust, as well as some areas in which improvement is required. As a result of the audit, the following actions were implemented: on-going plan of monitoring of areas to determine good/improved results; amendments to Learning Disabilities referral process to determine on-going appropriate referrals and a focus on the use of care bundles in learning disabilities liaison work with clinical areas.
Audit of the Adherence to the Mental Capacity Act 2005 when working with People with Learning Disabilities	This audit was undertaken to assess practice to enable more focused action planning, tailored support and strategic management where necessary. The audit demonstrated good identification by clinical teams of potential needs relating to mental capacity and the need for further mental capacity assessment. There was also evidence of multidisciplinary-working in best interest decision-making. The results demonstrated that implementation of the Mental Capacity Act (MCA)recommendations to meet those identified needs required improvement; including maximisation of capacity, use of supportive resources, documentation of rationale and assessment. The following actions were implemented to determine improvement in practice; comprehensive review of Mental Capacity Act documentation to determine supportive measures more prominently considered; Consideration of more formal reporting and investigation of instances in which Mental Capacity Act not adhered to and review of consent aspects of Quality Assurance Audits documentation and the implementation of a standardised Best Interest template. MCA training is now mandatory.
Tracheostomy Box & Label audit	This audit was undertaken to determine correct equipment availability and accurate label completion with regards to the Tracheostomy Box and bedside labels. The audit results demonstrated that compliance was generally good with only minimal areas requiring improvements.
Audit of Manual handling	A total of 446 Nursing and Patient Care Records were audited in September 2016. The audit demonstrated 90% of manual handling risk assessments were documented on admission. The results were disseminated to all relevant leads and clinical staff for review and action in their areas if required. A re-audit will be undertaken in 2017/18 to continue to assess compliance.
Audit of compliance to Clinical Audit Policy	This re-audit of compliance to the Trust Clinical Audit Policy reviewed a random selection of 24 audit evidence folders from the 15/16 Trust Audit Plan. The audit demonstrated a high level of compliance and no changes to the current policy were recommended. A re-audit will be undertaken in 17/18.

Audit of Critical Care Outreach Team Observation Tool	Quarterly audits looked at the standard of observation recording, documentation in all adult ward areas and of patient's observation charts, when moved from Critical Care Complex (CCC) and Accident and Emergency (A&E) Department to ward areas. Key targets were set for 'Observation Completeness' and 'EWS Allocation Accuracy'. CCC and A&E Dept. had specific targets related to their areas. The results maintained high standards for ward areas achieving 95-97% compliance with 'Observation Completeness' and 98-99% for Early Warning Score (EWS) Allocation Accuracy. Both Critical Care Complex and A&E Department implemented action plans to drive improvement from within their department with key EWS champions leading. Improvement work was assisted and maintained by the EWS Links (health care assistants and registered nurses) and Critical Care Outreach Team (CCOT) nurses. These results were reported to the Clinical Safety Sub Board and appeared on the Matrons dashboard.
Audit of Trust Quality Priorities 2016/17	Our Quality Priorities and the work streams underpinning them have been monitored via our governance committees and reported monthly via the Integrated Performance Reports to the Trust Board. Sepsis screening is among our safety priorities where improvement is demonstrated, whilst some patient experience elements have proved challenging due to a combination of the on-going operational pressures and some extremely aspirational targets. Collection of required reporting information has sometimes been challenging and in some areas not possible. Quality Priorities for 2017-18 will be modified in the light of this experience through consultation with Governors and the Trust Board.
Audit of Transfers of Care	This audit was undertaken to help identify the reasons behind delays in discharge with a view to preventing delays in discharges during peak times. However, the audit highlighted limitations with the information available and the need to have an alternative reporting system to allow better access to the Delayed Transfer of Care (DTOC) information. As a result, the Medworxx CUR system is being introduced to help with patient flow as well as the availability of discharge information.
Audit of Section 5 notices	This audit was carried out to determine the practice associated with discharge notices was effective to help reduce delays, support local authority referrals, improve/expedite discharges and improve patient experience. The audit did however highlight inconsistencies with the information recorded on the discharge notices. As a result, the discharge notice was redesigned to improve the quality and consistency of Discharge Notice completion. In addition to this, Discharge notices will be made available electronically on ICE, ensuring that the progress of discharge notices can be tracked through this system allowing for easier access to information and an improved management process.
Electrophysiology and Ablation Satisfaction Audit	This audit examined whether the electrophysiology service is meeting patients expectations. Questionnaires were sent out to attenders from November 2015 to May 2016. There was a response rate of 79%. Patients were extremely positive about the service. All patients felt it had met their expectations and would recommend it. Comments made by patients also praised the aftercare service. In response to the audit the written material is to be reviewed and reinstating the arrhythmia nurse in the catheter laboratory on procedure days is being considered.
Audit of Nurse-led Patch Test Clinic Patient Satisfaction	The audit was undertaken to assess the patient satisfaction of the Nurse Led Patch Test Clinic. The results found that the majority of patients felt the clinic from referral, consultation and overall dealing with the department was very good. One issued raised was that we could improve on the information supplied about the appointment. The information leaflet has now been updated and a re-audit will take place in 2017/18.
Audit of Gastroenterology Unit Patient Experience 2016	This audit was undertaken as part of the requirements of the Global Rating Scale for endoscopy (GRS) to demonstrate compliance to a range of service measures. The findings demonstrated the service was in accordance with all recommendations and that patient's views on the service remained positive. No actions were considered necessary.
Audit of Satisfaction With the Big C Centre Information Day	This audit was undertaken to evaluate patient and relative/carer satisfaction with the May Big C Centre information day. The day was well attended and the results demonstrate attendees viewed the day very positively and thought it of value. Results have been shared with the Big C who have recommended an additional route for promotion to raise its profile.

End of Life Care Audit (Including Preferred Place of Dying CQUIN)	The audit was undertaken to determine the use of the palliative care rounding tool to optimise nursing care and prescribe appropriate and accurate anticipatory medication for palliative patients. The audit demonstrated around half of appropriate patients anticipated to die were commenced on the palliative care rounding tool. Anticipatory prescribing for Buscopan had improved from 67% to 75%. Documentation of patients' preferred place of death increased from 48% to 80%, and action taken to achieve the preferred place had increased from 38 to 45%. As a result of the audit more education has been arranged for staff all around the Trust. The audit will continue to be undertaken on a quarterly basis.
Syringe Driver Audit 2016/17	The audit was undertaken to monitor the standard of clinical care regarding the care and use of syringe drivers in the Trust. The results indicated that clinical practice appears to be safe and effective. However, the pressure on doctors and nurses may be leading to a delay in re-prescribing and changing syringe drivers. As a result all wards are to undertaken competency completion in use of syringe drivers. Awareness of the syringe driver tracking system will continue and disposable devices have been introduced for patients that are discharged with a syringe driver.
Diabetes Eye Screening - Patient Satisfaction Audit	This was a re-audit to assess patient satisfaction with the service and compare with previous results to determine patient satisfaction was maintained. The results demonstrated that patient satisfaction continued at a high level. As a result, no changes to practice were required.
Patient Satisfaction Survey - Grove Road Clinic	This audit was undertaken to assess the level of patient satisfaction with the new Central Norwich Eye Clinic. Two rounds of data collection have taken place and both sets of results demonstrated a high level of satisfaction with the new service. The feedback did highlight that patients felt that there was a lack of dedicated parking. As a result, Norwich City Council have agreed to provide 3 on road car parking permits which allow parking for 2 hours. A re-audit is planned for 2017/18.
Re-audit of Patient Satisfaction with the One Stop Clinic	The aim of this audit was to obtain feedback from patients attending the Urology One Stop Clinic. The audit results found that there had been no change to the service from the patient's perspective but patient satisfaction had improved since the 2015 audit. As a result of the audit no actions were necessary but the Trust will continue to monitor the time that patients stay in clinic.
Audit of Induction of Labour after Fetal Death	This audit was carried out to review departmental compliance with the Trust Guideline for The Management of Late Intrauterine Fetal Death and Stillbirth. The audit results found that improvements were required. In other areas good compliance was demonstrated. As a result of the audit, families offered SANDS information will be documented in the bereavement documentation destination checklist and clinic follow-up letters. Discussions about fertility and contraception, and the offer of lactation suppression will be included in "Midwives checklist for miscarriage over 12 weeks, Medical terminations, neonatal deaths and stillbirths".
Audit of Information Received Prior to Interventional Procedure - Patient Feedback	This audit was undertaken to determine patients received the appropriate information. The results were positive demonstrating that practice was compliant for the vast majority of standards. Information in patient letters is being reviewed to aid communication.
Audit of Patient Feedback to the General Radiology Department	This audit was undertaken to determine patient satisfaction with the various modalities within the Radiology Department. Results demonstrated that patient satisfaction was high with most patients rating their experience as good or very good. However, some areas for improvement were highlighted. A training resource was emailed to staff to determine improvement in staff communication in areas such as confidentiality and education in radiation protection. Staff were also reminded to offer 2 gowns to all patients to maintain patient dignity.
Audit of Patient Satisfaction of Service Provided on Henderson Ward	This audit was undertaken to assess patient satisfaction from patients seeing a chaplain on Henderson Ward. Henderson Ward was permanently closed during the data collection period so this audit was not able to run as planned. However, the feedback which was received was positive. As this audit focused on practice around the Henderson Unit, no actions can be put in place as a result.
Audit of Paediatric Clinical Psychology - Patient Experience	This audit was undertaken to assess patient satisfaction with the Paediatric Clinical Psychology Service. The results demonstrated that the service was highly valued by families but that the service needed to expand to offer more timely appointments and to cover other specialist areas. As a result of the audit, therapy will be offered in other modalities, i.e. starting with trialling a therapy group for parents as well as running a parents group for newly diagnosed families with Type 1 Diabetes. Plans were also put in place to recruit to the vacant Paediatric Rheumatology post to determine continuity of service.

Audit of Patient Satisfaction Survey of the Dietetic Paediatric Obesity Service	This audit was undertaken to determine service user satisfaction in terms of time spent, quality of the information given and effective communication. As a result of the audit, a review of timescales of follow up and duration of appointments was undertaken to allow for improved practice. Dietary written information was also reviewed with liaison with regional dietetic/weight management teams to combine/agree information. A re-audit was planned once changes have been fully implemented.
Henderson Unit - Patient Satisfaction Audit	This audit was undertaken to identify the level of patient satisfaction on the Henderson Unit. The results demonstrated that there was a high level of patient satisfaction with the Unit as all patients audited stated that they were overall either Very satisfied or satisfied with their stay on the unit. Results were analysed and shared but no action plans could be implemented due to the permanent closure of the Henderson Unit as part of the Trust re-structuring undertaken in 2016
Audit of Patient Experience in Outpatient Rheumatology	This audit was undertaken to identify if patient needs are met and to ascertain any areas for improvement. The results were limited due to a small sample size. The results did show positive patient feedback with regards to satisfaction, but did highlight the potential need for a review of patient information. As a result of the audit, a review of patient information took place to enable the generation of Occupational Therapy Service Information Leaflets for patients to be provided at the point of referral.
Audit of Patient Experience in Hand Therapy Outpatient Clinic	This audit was undertaken to determine patient satisfaction in the Hand Therapy Outpatient Clinic. The results were very positive and demonstrated that patient satisfaction remains at a high standard. Therefore, no immediate actions were required to the service.
Physiotherapy Musculoskeletal Outpatients - Patient Satisfaction Survey	This audit was undertaken to assess patient satisfaction with the Physiotherapy Musculoskeletal Outpatients Service. The results were in keeping with previous cycles of the audit, demonstrating that the confidence patients have with their physiotherapists remaining high with there being many positive comments to support this. Various points of consideration were raised around making the appointment, the reception / waiting room, physiotherapy treatment and overall privacy of the appointment. Following the audit a review the booking of appointments for an agreement of priorities was undertaken.
Voice - Patient Satisfaction Audit	This audit was undertaken to determine patient satisfaction across the nine different clinics provided within the Specialist Voice Service. The results demonstrated high levels of patient satisfaction with the only significant concern being the Outpatient parking facilities. The results were disseminated accordingly with no immediate actions required to practice.
Audit of Patient Experience with the Volunteer Settle in Service	This audit was being undertaken to determine that patients being discharged under the volunteer settle in service, are satisfied and supported appropriately. Initial results demonstrated high levels of satisfaction with the service. However, the settle in service is no longer in place - therefore no actions could be implemented.
Audit of Patient Advice and Liaison Service Activities and Trends	This audit is undertaken to determine activity and trends of patient requests to the Patient Advice and Liaison Service. The audit reviews all requests received by the Patient Advice and Liaison Service. The results are reported monthly to the Caring and Patient Experience Sub-Board for discussion and any actions recommended implemented.
Audit of Patient Advice and Liaison Service - Patient Feedback	This audit was undertaken to monitor whether PALS was providing a good service to its clients and is meeting clients' needs. This audit relates to Key Lines of Enquiry relating to Caring and Patient Experiences and Responsiveness. The audit demonstrated that patients were very positive about the service received. The results were reported to the Caring and Patient Experience Sub-Board for discussion and any actions recommended implemented.
Quality Assurance Audit of Care Quality Commission Fundamental Standards Audit	These audits are based on enhanced Care Quality Commission Outcome standards. Each area now receives two visits annually led by the Clinical Matrons and supported by sisters, charge nurses and allied professional colleagues, alongside our team of external auditor volunteer patient representatives. The annual programme also involves self-assessment, Quality Rounds, Quality Safety Visits and a formal structure for review should any standard be deemed non-compliant. Results are shared with all relevant clinical and managerial teams and are reported monthly to the Trust Board. Feedback from patients is actively sought, especially by our external audit team members and is used to help inform on-going improvements in the services we provide.

Audit of Wandsworth Call Bell	This audit was undertaken to demonstrate compliance with agreed response times for patient and bathroom Calls. Any wards whose call bell audits fall outside of the accepted range of answering Patient and Bathroom calls are discussed at the Matrons Monthly Performance Meetings with the Director of Nursing and appropriate actions are implemented.
Audit of the Management of Diabetes Ketoacidosis (DKA)	This audit was undertaken to assess the management of patients being referred to Acute Medicine with DKA (Diabetic Ketoacidosis). The audit demonstrated that compliance in terms of documenting information is generally good. The audit did identify the need for a better format to document and monitor parameters. Therefore an amended document was produced which will be discussed with the Diabetes team.
Case Notes Audit (Dermatology)	This is was undertaken to determine whether patient's notes are complete for appointments in the outpatient clinics as very often the notes are partial or not available at all. The results found that 92% of patient's notes were complete; however on 2 occasions case notes were unable to be located. As a result of the audit interventions will be designed to improve record-keeping in Dermatology clinics and a re-audit will be undertaken in 2017/18.
Re-Audit: Use of Ciclosporin in Dermatological Patients – Are We Meeting The Standards?	This audit was undertaken to determine the health and safety of the patients commenced on ciclosporin and to determine compliance with the British Association of Dermatologists (BAD) guidance. The results found improved outcomes at re-audit: 100% of patients had their blood pressure checked at baseline and 86.7% at further follow-ups. Improvement is still required with documentation and as s a result a checklist is being designed and a re-audit will be undertaken in a years' time.
Re-Audit of the Documentation of Medication Reviews by Older Peoples Medicine Doctors	This audit was undertaken to monitor the documentation of medication reviews on three OPM wards to determine levels were satisfactory. The re-audit demonstrated there had been improvement, but compliance was still low. 28% of medication reviews were correctly documented. As a result the NO TEARS medication review tool will be taught and a routine weekly medical review will be introduced to help minimise errors.
Audit of Venous Thromboembolism (VTE)	This audit was undertaken to evaluate Trust-wide compliance to completion of thromboprophylaxis risk assessments (TRA). Screening figures for adult inpatients (excluding maternity, surgical day case admissions and other agreed reporting exclusions) were obtained from the hospital patient administration system, main theatre system and the electronic prescribing and medicine administration system. The findings demonstrated that Trust-wide a thrombosis risk assessment was completed for 99.5% of patients during July to December 2016; this is an increase from the 92% for April to January 2015. Monitoring of TRAs will continue for 2017.
World Health Organisation (WHO) Checklist Re-audit	This audit was undertaken to determine compliance with practice surrounding the WHO checklist for both the preparation of the patient as well as documentation in ophthalmology. The results demonstrated that practice is of a high standard with the observational elements providing evidence. However, the documentation did not always reflect this. Therefore, the results were disseminated and discussed as necessary with the department to highlight the importance of ensuring that all aspects of the WHO checklist are followed and documented accordingly.
Audit of Termination of Pregnancies (TOP)	The aim of this audit was to measure compliance with Trust protocols for the medical termination of pregnancies. The results found the audited areas of the service have proven to be excellent in the majority of cases. Documentation of sensitive disposal of pregnancy tissue, supply of antibiotics post procedure and the checking of Anti-D requirements prior to discharge required improvement. As a result of the audit discussions have taken place with ward staff regarding Anti-D requirements and the supply of antibiotics. Discussions were also held with the mortuary and theatre staff about documenting sensitive disposal.
Audit of Hand Held Ultrasound Scanning to Prevent Undiagnosed Breech (Sign Up to Safety Campaign)	This audit was undertaken to determine if all women who attended in labour had a portable ultrasound scan of fetal presentation. The audit demonstrated that documentation could be improved. There is a proposal to amend the documentation in the antenatal record. It has also been recommended that the hand-held ultrasound (HHUS) equipment is relocated to community so that community midwives can undertake the scans prior to induction or labour.
Re-audit of Child Safeguarding Training	This audit was undertaken to evaluate the effectiveness of safeguarding training. All course participants between April 2015 and March 2016 rated their knowledge on specific criteria pre and post workshop. The results clearly demonstrated an increase in knowledge and understanding post workshop with between 61-69% of participants scoring 8-10 for most categories. The mean score for usefulness was 9.1 out of 10. Knowledge on which to contact in the wider National Health Service and Norfolk County Council Children's Services if concerns exist did not score as well and therefore the training module will be reviewed to identify potential improvements in delivery of key points.

Serial Monthly Audits in Blood Transfusion	A number of audits were undertaken to determine compliance with the Blood Safety and Quality Regulations 2005 (as amended) as monitored by the Medical and Healthcare Products Regulatory Agency (MHRA), compliance with ISO 15189:2012 as assessed by the United Kingdom Accreditation Service (UKAS), and compliance with Trust procedure. Improvements identified/implemented were in the areas of reporting of external blood product recalls, documentation of Quality Control procedures, instituting regular IT Quality Control checks, supplier records, maintenance of external blood banks, assessment of Information Technology server room and revising Information Technology permissions.
Serial Monthly Audits in Clinical Biochemistry and Immunology	A number of audits were undertaken to determine compliance with ISO 15189:2012 as assessed by the United Kingdom Accreditation Service (UKAS), and compliance with Trust procedure. Improvements implemented related to pre-examination, examination and post-examination processes.
Serial Monthly Audits in Cytogenetics	A number of audits were undertaken to determine compliance with ISO 15189:2012 as assessed by the United Kingdom Accreditation Service (UKAS), and compliance with Trust procedure. Improvements implemented were in the area of documentation, records, equipment and health and safety.
Serial Monthly Audits in Haematology (including Andrology and Phlebotomy)	A number of audits were undertaken to determine compliance with ISO 15189:2012 as assessed by the United Kingdom Accreditation Service (UKAS), and compliance with Trust procedure. Improvements implemented related to pre-examination, examination and post-examination processes.
Serial Monthly Audits in Microbiology	A number of audits were undertaken to determine compliance with ISO 15189:2012 as assessed by the United Kingdom Accreditation Service (UKAS), and compliance with Trust procedure. Improvements implemented related to pre-examination, examination and post-examination processes.
Programme of Horizontal Quality Management System Audits across Eastern Pathology Alliance	A number of audits were undertaken to determine compliance with ISO 15189:2012 as assessed by the United Kingdom Accreditation Service (UKAS), and compliance with Trust procedure. Improvements implemented related to aspects of the Quality Management System.
Missed Doses Audit	With the advent of EPMA, missed doses are now being regularly "audited" in terms of a report is run regularly. The EPMA team are extracting this data and are working on a method of reporting this on a regular basis which will go to the Medicines Management subgroup of the DTMM.
World Health Organisation (WHO) Checklist Audit	This audit was undertaken to assess compliance with the World Health Organisation (WHO) checklist for interventional procedures undertaken under Computed Tomography (CT) and Ultrasound (US) guidance. The results were positive but the audit did highlight a lack of information being documented with regards to allergies for the CT cases. As a result of the audit, emails were distributed to all staff to highlight importance of the checklist and to remind staff around practice with regards to Soliton. In addition to this, posters are now displayed in the CT control room and ultrasound room respectively to raise awareness.
Audit of Malnutrition Universal Screening Tool (MUST)/Trust Nutritional Standards (Using the British Association For Parenteral And Enteral Nutrition (BAPEN) Nutritional Care Tool)	This audit was undertaken to determine that Malnutrition Universal Screening Tool (MUST) was appropriately completed in a timely and accurate manner. The results demonstrated that further MUST Training is required for the nursing staff. As a result of the audit, ward-based MUST training and focussed MUST training sessions on implementation of MUST Care Plan Actions was introduced. MUST training with Healthcare Assistants Clinical Induction Programme was re-instigated.
Audit of Screening Tool for the Assessment of Malnutrition in Paediatrics (STAMP) on the Paediatric ward	This audit was undertaken to determine appropriate and accurate completion of STAMP assessment on the Paediatric ward. The results demonstrated that STAMP was not completed on admission for 18 of the 21 patients audited and that it was not always repeated as advised by care plan. Therefore a training programme was devised for ward Nursing Staff regarding STAMP completion on admission, which will be conducted over the next year. Plans for re-audit were also put in place.
Falls Management within Occupational Therapy - Re-Audit	This audit was a re-audit to measure practice in relation to patients at risk of falls (in relation to NICE and College of Occupational Therapists Guidance). This audit demonstrated that overall compliance had improved following implementation of previous recommended actions. However, there was room for further improvement and as a result of the audit, a review of the OT Falls Risk Assessment was undertaken and OT paperwork amended. Tutorials on the preceptorship programme and laminated cue cards were introduced.

Health Records Management Audit	This audit was undertaken to demonstrate users' compliance with tracking plus timely and appropriate handling of case notes. The audit found a significant high proportion of users not complying with this standard, particularly when receipting case notes on PAS. Health Records are investigating the possibility for all newly trained PAS users to visit the Health Records Library and thereby understand the issues arising from poorly tracked case notes.
Audit of Hand Hygiene	This audit was undertaken to demonstrate compliance with parts of the hand hygiene policy. The audit found an average of 97% compliance. The nurse average was 97%, HCA 96%, doctors 98% and others 98%. Results are fed back monthly and the importance of good hand hygiene was emphasised throughout all training. If results are below 95% a follow up is sent to the sister/charge nurse to action learning outcomes, requesting return of the completed plan to Infection Prevention and Control (IP&C). Results are also available on the Nursing Dashboard.
Audit of High Impact Intervention Care Bundles	This audit was undertaken to demonstrate compliance with the High Impact Intervention care bundles for Peripheral Cannulas, Urinary Catheters, Central Venous Catheters, prevention of Ventilator Associated Pneumonia, Renal Dialysis catheters and prevention of Surgical Site Infection using the electronic audit system. Average results for this period for Peripheral Cannulas 82%, Urinary Catheters 90%, Central Venous Catheters 88%, prevention of Ventilator Associated Pneumonia 91%, Renal Dialysis catheters 100% and prevention of Surgical Site Infection 72%. Audit results were fed back monthly. Action plans were sent to sisters/ charge nurses in areas with scores below 80%, to action learning outcomes and return the completed plan to IP&C. Work is on-going to encourage ownership and make changes in practice particularly in relation to consistent documentation.
Audit of Electronic Discharge Letters of Patients who had C-Diff	This audit was undertaken to demonstrate whether a patient with confirmed C. difficile infection has this on their Electronic Discharge Letter (EDL) / death notification. The audit found that 2.6% did not have an EDL and 7.9% of EDLs did not mention C. difficile of these 6.9% were death notifications. A letter is sent to the consultant in charge of the patient asking for the EDL to be updated where required following the audit checks.
Infection Prevention and Control: Surveillance Audit of Central Venous Catheter Infection rates in adults outside Critical Care Complex	This surveillance was undertaken to determine the blood stream and exit site infection rates for adults with central lines in place for 48 hours or more (excluding the Critical Care Complex). In quarter 1 there were no infections and in quarter 2 the rate was 0.55 per 1000 line days, well below the Matching Michigan bench mark of 1.4 per 1000 line days. Results are fed back quarterly on the IP&C monthly report and at training sessions as part of a session for trained nurses that aims to prevent complications with central venous catheters.
Infection Prevention and Control: Surgical Site Infection Surveillance Audit (Vascular and Caesarean Section)	This surveillance was undertaken utilising Public Health England (PHE) protocol for Surveillance of Surgical Site Infection (SSI) 2013 to provide a surveillance programme designed for the NNUH. These surveillance programmes provide quarterly reports of infection rates to the departments involved. This programme aims to promote good practice and reduce SSI rates. Vascular SSI rates to date have reduced from 7.3% at the beginning of 2016/17 to 2.9%. SSI rates following C section have remained between 3.4% and 4.8% over this period.
Audit of methicillin-resistant staphylococcus aureus (MRSA) (hospital acquired) infections and screening for MRSA	This audit was undertaken to demonstrate the timely identification of patients found to be MRSA positive. It also aims to determine the number of hospital acquired cases of MRSA and the number of patients screened correctly. It is in line with the Trust guideline for MRSA screening. The audit demonstrates that the elective screening average is 98% and the emergency screening average is 95% for the Trust.
Audit of Compliance to Trust Isolation Policy	This annual audit was undertaken to determine whether patients are isolated in accordance with the isolation policy. It also provides information on the reasons for side room use. It demonstrated that 33.3% of the side rooms were used for IP&C reasons. There were 6 patients requiring isolation that were placed in a bay. A priority table for isolation is available in the Isolation Policy.

Infection Prevention and Control: Audit of Trust Commodes	This audit was undertaken to demonstrate that all surfaces of the commode are visibly clean with no blood or body substances, dust, dirt, debris, adhesive tape or spillages. It also monitors evidence of cleaning with time, date & signature in line with the Trust Guideline for Cleaning and Disinfection in the hospital. The audit found an average of 93% compliance. AMUM and JPU results have been 100% for over 3 years. Following the audit, results are fed back and ward sisters/charge nurses are asked to action learning outcomes. Training is provided if required. Results are also available on the Nursing Dashboard.
Audit of Compliance to Consent Policy	This audit was undertaken to establish the level of compliance with the completion of the consent forms and to ascertain the types of information being recorded. The results demonstrated that there has been an overall improvement in the completion of the Consent forms. There is some additional work on-going to determine that all consent forms are in the new approved template. As a result of the audit, support is offered to transcribe procedure specific consent forms onto the new template as identified. Further review of the new consent template and compliance with completion will be monitored during on-going annual audits.
Audit of Health Record-Keeping Standards	This was a detailed re-audit of compliance with the Nursing and Patient Care Record (PCR) documentation undertaken in September 2016. During this audit 446 PCRs, Discharge Checklists and Nursing Assessments and Plans of Care were reviewed and a very 'literal' assessment made of compliance with documentation was undertaken by the Clinical Audit & Improvement Department team. Overall compliance remains within a 5% variance from 2015 on each of the standards. The results of the audit were disseminated to senior clinical staff within the Trust and the Clinical Safety Sub-Board. Each clinical area is expected to undertake an audit in relation to their documentation in the 17/18 audit cycle.
Audit of Compliance to Discharge Policy	An audit of compliance with the completion of the Home Circumstances and Discharge documentation demonstrated little improvement from that undertaken the previous year. The results have been collated and presented by individual ward area as a means of effecting improved performance. The results have been disseminated to all clinical leads. Next year each area will undertake their specific audit of documentation.
Audit of Slips, Trips and Falls (Patients)	A total of 446 Nursing and Patient Care Records were audited in September 2015. The audit demonstrated that overall performance has improved from 74% to 91% in relation to documentation of falls risk assessments in nursing documentation. The results were disseminated to all relevant leads and clinical staff for review and action in their areas if required. A re-audit will be undertaken in 2017/18 to continue to assess compliance.
Clinical Incidents, Complaints and Claims	Clinical incidents, complaints and claims have been regularly reported via our established governance assurance committees and reviewed in order to identify themes. Lessons learned have been disseminated to staff as per our relevant policies. An opportunity to improve communication with our patients has been a predominant theme and has helped inform a number of improvement projects.
Re-Audit of Inoculation Incidents	An audit was carried out during February 2016 to establish compliance with two elements of an action plan arising from a Health and Safety Executive visit in September 2015. At this time the Trust was issued with a Notice of Contravention of Health and Safety (Sharps Instruments in Healthcare) Regulations 2013. The audit found that compliance with the investigation process was good. There was only one anomaly which had occurred when an incident was reclassified. Compliance with the insulin safety devices was poor. The audit was repeated in May 2016 and this demonstrated greater availability of devices (compliance increased from 52% to 69%) and more awareness of their usage. As some wards still did not have the safety syringe this was followed up and rechecked in June when 100% compliance was achieved. There continue to be injuries whilst using insulin pen devices and these are monitored by H&S Lead Advisor and the Incident inoculation group and investigated accordingly.
Audit of Duty of Candour	This audit was undertaken to assess compliance with Duty of Candour (DoC) statutory obligations. The audit found that Duty of Candour actions were reported by clinicians and nursing staff to be fulfilled; however copies of letters to patients/ relatives were not placed in patient notes in all cases. Following the audit the process for tracking and escalating Duty of Candour has been reviewed and enhanced. A re-audit of compliance is planned for 17/18.
Qualitative Audit of Patient Transfers	The aim of this audit was to establish reasons for multiple patient moves as indicated from our Patient Administration System. Ward to ward transfers were deemed to be for clinical reasons (to appropriate specialty), with step-downs prior to discharges and transfers for dialysis a theme within those with multiple transfers.

Audit of Resus Equipment	The audit was undertaken to determine the process for checking emergency resuscitation equipment and to review the compliance of checks. The results found that there was no standard checklist and that bespoke checklists had been developed without formal ratification. As a result of this audit, a standard equipment checklist template has been developed along with a Standard Operating Procedure for the checking of emergency equipment, these were approved by the Recognise and Respond Committee and are now being used.
Audit of Oxygen and Suction	The audit was undertaken to determine the process for checking oxygen and suction equipment and to review the compliance of checks. The results found that there was no standard checklist and that bespoke checklists had been developed without formal ratification. As a result of this audit, a standard equipment checklist template has been developed along with a Standard Operating Procedure for the checking of emergency equipment, these were approved by the Recognise and Respond Committee and are now being used.
Audit of Glucose Monitoring	The audit was undertaken to determine the process for checking hypoglycaemia boxes and to review the compliance of checks. The results found that there was no standard checklist and that bespoke checklists had been developed without formal ratification. As a result of this audit, a standard equipment checklist template has been developed along with a Standard Operating Procedure for the checking of emergency equipment, these were approved by the Recognise and Respond Committee and are now being used.
Early Warning Score Observation Documentation, and Early Warning Score Response Audit	Quarterly audits of a small sample triggering episodes continue to be undertaken by the Critical Care Outreach Team (CCOT), to look at the response to Early Warning Score triggers ≥4, by adult wards. Real time feedback was given to ward staff by the CCOT when undertaking audits to determine omissions were dealt with by senior nursing staff. Results reported to the Clinical Safety Sub Board and appeared on the Matrons dashboard. Main area requiring improvement was the initial repeating of observations within 60 minutes timeframe. Improvements implemented, assisted and maintained by the EWS Links (health care assistants and registered nurses) and CCOT nurses.
Do Not Attempt Cardio Pulmonary Resuscitation Documentation Audit	This audit was undertaken to monitor compliance with Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) processes at the NNUH. The results demonstrated that there was an overall improvement in compliance with respect to – consultant countersignature within 24 hours (51%), non-cognitive patients with documented discussion with relatives (83%), decision discussed with cognitive patients (94%). As a result of the audit it was decided to separate the DNACPR Policy from the overall resuscitation policy and to revise our Patient Care record (PCR) to specifically record whether the patient had capacity to be involved in making the DNACPR decision. This aspect of our PCR had been criticised in the CQC report. The revised policy and PCR were implemented in January 2017.
Audit of Local Induction of Temporary Staff	This audit is an on-going audit and is undertaken to determine that induction of all temporary staff is completed and recorded. The results are reported to the Workforce Sub-Board monthly. The results are discussed and any actions required to improve compliance are undertaken. A new Workplace Induction checklist has now been developed to help improve the experience for new starters and to increase completion rates.
Audit of Mental Capacity Act - Staff Feedback	This audit was undertaken to collect staff feedback in relation to their views of the treatment provided to patients with Learning Disabilities in the Trust. The small number of results received was insufficient to be considered representative of the Trust. Therefore, alternative methods to increase the response rate and to increase the profile and awareness of the subject matter were explored with further data collection planned for 2017/18.
Audit of Local Induction of Permanent Staff	This audit is an on-going audit and is undertaken to determine all new permanent staff complete local induction within 8 weeks of starting and that this is recorded. The results are reported to the Workforce Sub-Board monthly. The results are discussed and any actions required to improve compliance are undertaken. A new Workplace Induction checklist has now been developed to help improve the experience for new starters and to increase completion rates.

Audit of Stress	This audit was undertaken to demonstrate how workplace stressors are identified within the organisation. The audit found that these are being identified in line with the stress at work policy. Trends are reported monthly to workforce sub board and quarterly to Health and Safety committee – it has been noted that the reasons for work related stress have altered in this last year. Predominantly relationship issues in the workplace and change have been cited. Change is a new area of concern for our organisation and reflects the impact of ward changes that occurred in the autumn months. The relationship issues are often linked to the relationship with managers. Line manager training is being introduced. The previous audit identified that Workplace Health and Well Being do not always receive copies of the individual stress risk assessment when requested following a referral. A system to chase these from managers has been instigated – this has improved over the last year. To date we are 75% compliant.

Annex 1 - Statements from Clinical Commissioning Boards, Local Healthwatch organisations and Overview and Scrutinty

Statement from NHS North Norfolk CCG

Commissioner response to: The Norfolk and Norwich University Hospital Trust Quality report 2016/17

North Norfolk Clinical Commissioning Group (The CCG) as the coordinating commissioning organisation for The Norfolk and Norwich University Trust (The Trust) on behalf of Norfolk CCG's confirm that the NNUHFT have consulted and invited comment on their Quality Report for 2016/17.

The CCG have reviewed the report and agree that it meets the required mandated elements and to the best of our knowledge confirm that this provides an accurate representation of the data, information, challenges and achievements experienced by the Trust within the past year.

Performance

As for most acute Hospital around the country 2016/17 has proved a challenging year for The Trust. Capacity and activity has continued to impact upon a number of constitutional performance targets. Focus upon recovery importantly remains upon achieving a minimum 4 hour wait within the Accident and Emergency department for 95% of patients, the delivery of 18 week referral to treatment time pathway and Cancer 62 day GP referral to treatment time targets.

In order to assure the safety of patients who are experiencing delays for treatment The Trust team alongside Norfolk CCG's have developed processes that support robust clinical review in order to monitor these areas of performance and safeguard patients who are or might become vulnerable while they wait for their treatment.

It is disappointing that breaches to these important targets continue. However it is recognised that The Trust undertakes to maintain clear clinical priority wherever necessary to ensure that patients with the greatest need, such as those with Cancer diagnosis, are prioritised for admission and treatment. However while clinical prioritisation is essential this does have further impact upon delays within the 18 week pathway and so throughout this coming year The CCG will increase their focus and support of The Trust in its work to meet and sustain these targets.

Quality of Care

The Trust has undertaken a range of quality initiatives throughout the year. Staff have shown great motivation to innovate and improve the services they offer to patients and receive a high-level of satisfaction from patients experience. Where this is not the case The Trust takes every opportunity to learn from complaints and patient feedback, striving to ensure that patient experience is a fundamental priority to care delivery.

Workforce
Recruitment remains an area of challenge for the Trust, this problem is reflected across other healthcare providers within Norfolk and indeed the country, however The Trust have looked at innovative ways to consider skill-mix of vacancies and improve and speed up recruitment processes.

The annual staff survey identified some areas of staff experience which still requires improvement. The Trust have developed an excellent programme of Wellbeing initiatives for staff in the coming year which will aim to recognise the hard work and commitment of the team while improving work/life balance opportunities for individuals. It is hoped that these improvements will be well reflected within the Staff Survey for 17/18.

The CCG will continue to work with clinicians and managers within The Trust and alongside patients who use the service in order to improve the quality, safety and effectiveness of care wherever possible. This quality report demonstrates the commitment of The Trust to ensure that quality and patient safety remains its key priority over the coming year.

Mark Burgis
Chief Operating Officer
NHS North Norfolk CCG
5th May 2017

Statement from Norfolk Health Overview and Scrutiny Committee

None received.

Statement from Healthwatch Suffolk

None received.

Statement from Healthwatch Norfolk

None received.

Statements from Governors

Hi Mark

I am responding to your request for comments re. the 2016/2017 Quality report, and have a few observations to make as follows:-

Your introductory statement is dated 31 April, and there is a mistake in the third paragraph which I think should read .....now (the) and in the future.

On page 10 the heading for the next section is included at the bottom of the page.

No doubt these small errors would have been picked up in final checks, but wanted to mention as proof that I've had a "good read".

Grateful for the opportunity to read and comment, and commend those contributing to such a comprehensive document for their hard work and diligence.

Kind Regards

Brian Cushion, 08 April 2017

This report has been read by Nina Duddleston and apart from a typing error in the introduction from Mark Davies (on the start of the third line under the photograph of Mark) a few other spelling mistakes already underlined in red in the main report and the need to enter figures in graphs I have no further comment to make on this excellent detailed report.

Nina Duddleston, 11 April 2017

Dear Mark,

Apologies for my tardiness. I have read the report which is a huge piece of work for you all but essential in order to monitor the work of the NNUH going forward.

These are my comments:

There are several figures/diagrams missing from the document and certain sums of money appear as XXs in the version we have which I assume are being sorted out.

In the section, page 16, on Dementia Screening - how did we do - there is a sentence which reads "we have been achieved 90%" which needs changing. In the section on dementia it mentions Admin Staff doing the initial Dementia screen. Are these staff fully trained to do this? As only as a result of the initial screening will a full assessment be offered. To miss someone in the early stages of dementia who could be helped would be very disappointing.

EDLs - we are told the level of letters sent out is disappointing.

Then page 17, under AKIs we are told that there will be leaflets included with the EDLs for GPs. As not enough EDLs are being sent out is this the best way to get information to the GPs?

Page 18 Paragraph before fig 8 lots of ??s.

Page 25, Figure 11. There is the number 21 printed in red against Endocrine & Thyroid. Not sure if it should be in red? Is correct?

Page 34, Patient Safety - Duty of Candour. 3rd paragraph, 1st sentence does not make sense " All moderate harm or above severity incidents which are reported an Datix are"

Page 34, Never Events. These are obviously scary but human error is so hard to control. Silly comment possibly but are not all sites for surgery marked with a pen on the patient?

Page 34, Figure 18 Elective Capacity - waiting list backlog. It is suggested that there will be a return to compliance by Oct 2018. Are we really confident this is possible given the situation and demand going forward?

Page 43. Stranded Patients. Having spent a day shadowing the Discharge Matron Danny, I can only applaud the results that have been achieved in this area by the introduction of the Discharge Hub and Ward Co-ordinators. I know there is further work planned.

Page 62, Audit of Wandsworth Call Bell. The comments against this seem woolly in the extreme. The audit was done but what the results were is not clear. We all know this can be an issue on certain wards and this appears to be glossed over.

I don't know if these comments are what you need. Use or not as you see fit.

Best Wishes

Erica Betts, 9th May 2017

Annex 2 - Statement of Directors' responsibilities in respect of the Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- the content of the Quality Report meets the requirements set out in the NHS foundation trust annual reporting manual 2016/17 and supporting guidance
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
    - board minutes and papers for the period April 2016 to March 2017
    - papers relating to quality reported to the board over the period April 2016 to March 2017
    - feedback from commissioners dated 05/05/2017
    - feedback from governors dated 08/04/2017, 11/04/17 and 09/05/2017
    - feedback from local Healthwatch organisations – none received
    - feedback from Overview and Scrutiny Committee – none received
    - the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 29/07/2016, 27/20/2016 and 27/04/2017
    - the 2016 national patient survey, published May 2016
    - the 2016 national staff survey, published February 2017
    - the Head of Internal Audit's annual opinion of the trust's control environment dated 15/03/2017
    - CQC inspection report dated 16/03/2016
- the Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered
- the performance information reported in the Quality Report is reliable and accurate
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice

- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review and
- the Quality Report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the board

Chairman

Date: 26/5/2017

Chief Executive

Date: 26/5/2017

Annex 3 - Independent Auditor Report

INDEPENDENT AUDITOR'S REPORT TO THE COUNCIL OF GOVERNORS OF NORFOLK AND NORWICH UNIVERSITY HOSPITALS NHS FOUNDATION TRUST ON THE QUALITY REPORT

We have been engaged by the Council of Governors of Norfolk and Norwich University Hospitals NHS Foundation Trust to perform an independent assurance engagement in respect of Norfolk and Norwich University Hospitals NHS Foundation Trust's Quality Report for the year ended 31 March 2017 (the 'Quality Report') and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2017 subject to limited assurance consist of the following two national priority indicators (the indicators):

- percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period; and
- A&E: maximum waiting time of four hours from arrival to admission, transfer or discharge.

We refer to these national priority indicators collectively as the 'indicators'.

Respective responsibilities of the directors and auditors

The directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual* issued by NHS Improvement.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual* and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in the *Detailed requirements for quality reports for foundation trusts 2016/17* ('the Guidance'); and
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the *Detailed Requirements for external assurance for quality reports for foundation trusts 2016/17.*

We read the Quality Report and consider whether it addresses the content requirements of the NHS Foundation Trust Annual Reporting Manual and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Report and consider whether it is materially inconsistent with:

- Board minutes and papers for the period April 2016 to May 2017;
- papers relating to quality reported to the board over the period April 2016 to May 2017;
- feedback from commissioners;
- feedback from governors;
- feedback from local Healthwatch organisations;

- the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009;
- the national patient survey;
- the national staff survey;
- Care Quality Commission Inspection, dated 16 March 2016;
- the 2016/17 Head of Internal Audit's annual opinion over the trust's control environment; and
- any other information included in our review.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively, the 'documents'). Our responsibilities do not extend to any other information.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

This report, including the conclusion, has been prepared solely for the Council of Governors of Norfolk and Norwich University Hospitals NHS Foundation Trust as a body, to assist the Council of Governors in reporting the NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2017, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicator. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and Norfolk and Norwich University Hospitals NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) – 'Assurance Engagements other than Audits or Reviews of Historical Financial Information', issued by the International Auditing and Assurance Standards Board ('ISAE 3000'). Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicator;
- making enquiries of management;
- testing key management controls;
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- comparing the content requirements of the NHS Foundation Trust Annual Reporting Manual to the categories reported in the Quality Report; and
- reading the documents.

A limited assurance engagement is smaller in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable measurement techniques which can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time. It is important to read the quality report in the context of the criteria set out in the *NHS Foundation Trust Annual Reporting Manual* and supporting guidance.

The scope of our assurance work has not included governance over quality or the non-mandated indicator, which was determined locally by Norfolk and Norwich University Hospitals NHS Foundation Trust.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2017:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in the Guidance; and
- the indicator in the Quality Report subject to limited assurance has not been reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the Guidance.

KPMG LLP
Chartered Accountants
Dragonfly House, 2 Guilders Way, Norwich, Norfolk NR3 1UB

26 May 2017

Annex 4 - Mandatory performance indicator definitions

The following indicator definitions are based on Department of Health guidance, including the 'NHS Outcomes Framework 2016/17 Technical Appendix' (https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/385751/NHS_Outcomes_Tech_Appendix.pdf)

Where the HSCIC Indicator Portal does not provide a detailed definition of the indicator this document continues to use older sources of indicator definitions.

Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways

Source of indicator definition and detailed guidance
The indicator is defined in the technical definitions that accompany Everyone counts: planning for patients 2014/15-2018/19 at www.england.nhs.uk/wpcontent/uploads/2014/01/ec-tech-def-1415-1819.pdf

Detailed rules and guidance for measuring referral to treatment (RTT) standards are at www.england.nhs.uk/statistics/statistical-work-areas/rtt-waiting-times/rtt-guidance/

Detailed descriptor
EB3: The percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the period

Numerator
The number of patients on an incomplete pathway at the end of the reporting period who have been waiting no more than 18 weeks

Denominator
The total number of patients on an incomplete pathway at the end of the reporting period

Accountability Performance is to be sustained at or above the published operational standard. Details of current operational standards are available at: www.england.nhs.uk/wpcontent/uploads/2013/12/5yr-strat-plann-guid-wa.pdf (see Annex B: NHS Constitution Measures).

Indicator format
Reported as a percentage

Source of indicator definition and detailed guidance

Source of indicator definition and detailed guidance
The indicator is defined in the technical definitions that accompany Everyone counts: planning for patients 2014/15 - 2018/19 at www.england.nhs.uk/wpcontent/uploads/2014/01/ec-tech-def-1415-1819.pdf

Detailed rules and guidance for measuring A&E attendances and emergency admissions are at www.england.nhs.uk/statistics/wpcontent/uploads/sites/2/2013/03/AE-Attendances-Emergency-Definitions-v2.0- Final.pdf

Additional information
Paragraph 6.8 of the NHS England guidance referred to above gives further guidance on inclusion of a type 3 unit in reported performance.

Numerator
The total number of patients who have a total time in A&E of four hours or less from arrival to admission, transfer or discharge.

Calculated as: (Total number of unplanned A&E attendances) – (Total number of patients who have a total time in A&E over 4 hours from arrival to admission, transfer or discharge)

Denominator
The total number of unplanned A&E attendances

Accountability
Performance is to be sustained at or above the published operational standard. Details of current operational standards are available at:
www.england.nhs.uk/wpcontent/uploads/2013/12/5yr-strat-plann-guid-wa.pdf
(see Annex B: NHS Constitution Measures).

Indicator format
Reported as a percentage

Referral to Treatment Pathways

Source of indicator definition and detailed guidance
The indicator is defined within the document 'Technical Definitions for Commissioners' https://www.england.nhs.uk/wp-content/uploads/2015/02/6-tech-defi-comms-0215.pdf.

Detailed Descriptor:
The percentage of Referral to Treatment (RTT) pathways within 18 weeks for completed admitted pathways, completed non-admitted pathways and incomplete pathways.

Lines Within Indicator (Units):
E.B.1: The percentage of admitted pathways within 18 weeks for admitted patients whose clocks stopped during the period, on an adjusted basis.
E.B.2: The percentage of non-admitted pathways within 18 weeks for non-admitted patients whose clocks stopped during the period.
E.B.3: The percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the period.

Data Definition:
A calculation of the percentage within 18 weeks for completed adjusted admitted RTT pathways, completed non-admitted RTT pathways and incomplete RTT pathways based on referral to treatment data provided by NHS and independent sector organisations and signed off by NHS commissioners.
The definitions that apply for RTT waiting times are set out in the RTT Clock Rules Suite found here: https://www.gov.uk/government/publications/right-to-start-consultant-led-treatment-within-18-weeks.
Guidance on recording and reporting RTT data can be found here: http://www.england.nhs.uk/statistics/statistical-work-areas/rtt-waiting-times/rtt-guidance/

Monitoring Frequency: Monthly

Monitoring Data Source: Consultant-led RTT Waiting Times data collection (National Statistics)

What success looks like, Direction, Milestones:
Performance will be judged against the following waiting time standards:-
· Admitted operational standard of 90% – the percentage of admitted pathways (on an adjusted basis) within 18 weeks should equal or exceed 90%
· Non-admitted operational standard of 95% – the percentage of non-admitted pathways within 18 weeks should equal or exceed 95%
· Incomplete operational standard of 92% – the percentage of incomplete pathways within 18 weeks should equal or exceed 92%

Timeframe/Baseline: Ongoing

Rationale:
The operational standards that:
- 90% of admitted patients and 95% of non-admitted patients should start treatment within a maximum of 18 weeks from referral; and,
- 92% of patients on incomplete pathways should have been waiting no more than 18 weeks from referral.

These RTT waiting time standards leave an operational tolerance to allow for patients who wait longer than 18 weeks to start their treatment because of choice or clinical exception. These circumstances can be categorised as:
- Patient choice - patients choose not to accept earliest offered reasonable appointments along their pathway or choose to delay treatments for personal or social reasons
- Co-operation - patients who do not attend appointments that they have agreed along their pathways
- Clinical exceptions - where it is not clinically appropriate to start a patient's treatment within 18 weeks

Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers

Detailed descriptor[1]
PHQ03: Percentage of patients receiving first definitive treatment for cancer within 62 days of an urgent GP referral for suspected cancer

Data definition
All cancer two-month urgent referral to treatment wait

Numerator
Number of patients receiving first definitive treatment for cancer within 62 days following an urgent GP (GDP or GMP) referral for suspected cancer within a given period for all cancers (ICD-10 C00 to C97 and D05)

Denominator
Total number of patients receiving first definitive treatment for cancer following an urgent GP (GDP or GMP) referral for suspected cancer within a given period for all cancers (ICD-10 C00 to C97 and D05)

Accountability
Performance is to be sustained at or above the published operational standard. Details of current operational standards are available at:
www.england.nhs.uk/wpcontent/uploads/2013/12/5yr-strat-plann-guid-wa.pdf
(see Annex B: NHS Constitution Measures).

1 Cancer referral to treatment period start date is the date the acute provider receives an urgent (twoweek wait priority) referral for suspected cancer from a GP and treatment start date is the date first definitive treatment starts if the patient is subsequently diagnosed. For further detail refer to technical guidance at www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_131 880

Emergency re-admissions within 28 days of discharge from hospital[2]

Indicator description
Emergency re-admissions within 28 days of discharge from hospital

Indicator construction
Percentage of emergency admissions to a hospital that forms part of the trust occurring within 28 days of the last, previous discharge from a hospital that forms part of the trust

Numerator
The number of finished and unfinished continuous inpatient spells that are emergency admissions within 0 to 27 days (inclusive) of the last, previous discharge from hospital (see denominator), including those where the patient dies, but excluding the following: those with a main speciality upon re-admission coded under obstetric; and those where the re-admitting spell has a diagnosis of cancer (other than benign or in situ) or chemotherapy for cancer coded anywhere in the spell.

Denominator
The number of finished continuous inpatient spells within selected medical and surgical specialities, with a discharge date up to 31 March within the year of analysis. Day cases, spells with a discharge coded as death, maternity spells (based on specialty, episode type, diagnosis), and those with mention of a diagnosis of cancer or chemotherapy for cancer anywhere in the spell are excluded. Patients with mention of a diagnosis of cancer or chemotherapy for cancer anywhere in the 365 days before admission are excluded.

Indicator format
Standard percentage

More information
Further information and data can be found as part of the HSCIC indicator portal.

2 This definition is adapted from the definition for the 30 days re-admissions indicator in the NHS Outcomes Framework 2013/14: Technical Appendix. We require trusts to report 28-day emergency re-admissions rather than 30 days to be consistent with the mandated indicator requirements of the NHS (Quality Accounts) Amendment Regulations 2012 (S.I. 2012/3081).

Minimising delayed transfer of care

Detailed descriptor
The number of delayed transfers of care per 100,000 population (all adults, aged 18 plus).

Data definition
Commissioner numerator_01: Number of Delayed Transfers of Care of acute and non-acute adult patients (aged 18+ years)
Commissioner denominator _02: Current Office for National Statistics resident population projection for the relevant year, aged 18 years or more
Provider numerator_03: Number of patients (acute and non-acute, aged 18 and over) whose transfer of care was delayed, averaged over the quarter. The average of the three monthly SitRep figures is used as the numerator.
Provider denominator_04: Average number of occupied beds[3]

Details of the indicator
A delayed transfer of care occurs when a patient is ready for transfer from a hospital bed, but is still occupying such a bed.
A patient is ready for transfer when:
[a] a clinical decision has been made that the patient is ready for transfer AND
[b] a multidisciplinary team decision has been made that the patient is ready for transfer AND
[c] the patient is safe to discharge/transfer.
To be effective, the measure must apply to acute beds, and to non-acute and mental health beds. If one category of beds is excluded, the risk is that patients will be relocated to one of the 'excluded' beds rather than be discharged.

Accountability
The ambition is to maintain the lowest possible rate of delayed transfers of care.
Good performance is demonstrated by a consistently low rate over time, and/or by a decreasing rate. Poor performance is characterised by a high rate, and/or by an increase in rate.

Detailed guidance and data
Further guidance and the reported SitRep data on the monthly delayed transfers of care can be found on the NHS England website.[4]

3 In the quarter open overnight.
4 /www.england.nhs.uk/statistics/statistical-work-areas/delayed-transfers-of-care/

C. difficile[5]

Detailed descriptor
Number of Clostridium difficile (C. difficile) infections, as defined below, for patients aged two or over on the date the specimen was taken.

Data definition
A C. difficile infection is defined as a case where the patient shows clinical symptoms of C. difficile infection, and using the local trust C. difficile infections diagnostic algorithm (in line with Department of Health guidance), is assessed as a positive case. Positive diagnosis on the same patient more than 28 days apart should be reported as separate infections, irrespective of the number of specimens taken in the intervening period, or where they were taken. In constructing the C. difficile objectives, use was made of rates based both on population sizes and numbers of occupied bed days. Sources and definitions used are:
For acute trusts: The sum of episode durations for episodes finishing in 2010/11 where the patient was aged two or over at the end of the episode from Hospital Episode Statistics (HES).

Basis for accountability
Acute provider trusts are accountable for all C. difficile infection cases for which the trust is deemed responsible. This is defined as a case where the sample was taken on the fourth day or later of an admission to that trust (where the day of admission is day one). To illustrate:
• admission day; • admission day + 1; • admission day + 2; and
• admission day + 3 – specimens taken on this day or later are trust apportioned.

Accountability
The approach used to calculate the C. difficile objectives requires organisations with higher baseline rates (acute trusts and primary care organisations) to make the greatest improvements in order to reduce variation in performance between organisations. It also seeks to maintain standards in the best performing organisations. Appropriate objective figures have been calculated centrally for each primary care organisation and each acute trust based on a formula which, if the objectives are met, will collectively result in a further national reduction in cases of 26% for acute trusts and 18% for primary care organisations, whilst also reducing the variation in population and bed day rates between organisations.

Timeframe/baseline
The baseline period is the 12 months, from October 2010 to September 2011. This means that objectives have been set according to performance in this period.

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5 The QA Regulations requires the C. difficile indicator to be expressed as a rate per 100,000 bed days. If C. difficile is selected as one of the mandated indicators to be subject to a limited assurance report, the NHS foundation trust must also disclose the number of cases in the quality report, as it is only this element of the indicator that we intend auditors to subject to testing.

Percentage of patient safety incidents resulting in severe harm or death[6]

Indicator description

Patient safety incidents (PSIs) reported to the *National Reporting and Learning Service (NRLS),* where degree of harm is recorded as 'severe harm' or 'death', as a percentage of all patient safety incidents reported.

Indicator construction

Numerator: The number of patient safety incidents recorded as causing severe harm /death as described above.

The 'degree of harm' for PSIs is defined as follows;

'severe' – the patient has been permanently harmed as a result of the PSI, and

'death' – the PSI has resulted in the death of the patient.

Denominator: The number of patient safety incidents reported to the *National Reporting and Learning Service (NRLS).*

Indicator format:

Standard percentage.

6 This definition is adapted from the definition for the 30days readmissions indicator in the NHS Outcomes Framework 2012/13: Technical Appendix

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