Norfolk and Norwich University Hospitals
NHS Foundation Trust


# Quality Report 2017-18

# Quality Report 2017/18

# Chief Executive's Statement on Quality

## Information about this Quality Report

We have made significant progress this year in patient safety with our key achievement being a reduction in our mortality rate which is at an all-time low. This is an issue which is very close to my heart and when I first came to NNUH the HSMR was 115. We set ourselves a target of getting to 90, and two years later I am delighted to say that we have achieved our aim (the HSMR for the latest available 3 month period is 90.5). Our target for March 2019 is to have an HSMR of 85 and this is the right target for a big acute teaching hospital. The effort that everyone has made for the benefit of our patients is incredible.

Our track record on infection prevention and control has been impressive and the efforts of our teams have been recognised in the NHSI inspection on Infection Prevention and Control. The inspector did a thorough assessment and thanks to the hard work of the IP&C and other teams we passed the inspection with a full green rating. We are also pleased to see a year on year fall in the number of c-diff cases which follows our success in tackling hospital-attributable Methicillin Resistant Staphylococcus aureus (MRSA), where we have had only one case of hospital acquired MRSA case in the last six years.

We are working hard to keep up with the demand for care and our performance on cancer targets – the best in three years - is critical for our success as a major cancer centre. Many of our services run seven days a week and we also use temporary facilities to keep pace with demand. In the longer term, we are developing 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 an extension of the N&N building to expand facilities for interventional radiology, and cardiac catheter labs. During 2017/18, we expanded our critical care facilities adding an additional eight high dependency beds which translates into a 40% increase in capacity.

A new medical and cancer unit is also being developed at Cromer & District Hospital where one of the older buildings on site will be refurbished. There are also longer term plans to build an Ambulatory Care and Diagnostic Centre (ACAD). Building work on the Quadram Institute will be complete by the end of the summer and will house the largest endoscopy unit in Europe as well as being at the forefront of combined research into food science, gut biology and health.

Another area where we have expanding our capacity is in the Emergency Department where we have created the UK's first Older People's Emergency Department which has received national recognition. This change has been combined with a tripling of the size of our Paediatric Emergency Department and we are also creating additional facilities for mental health patients who seek help at ED.

Research and innovation are a key part of our mission and we maintain close links with the University of East Anglia. Together we are capable of leading the world in innovative techniques. A good example would be the Norfolk Diabetes Prevention Study which drew to a close in 2017 after successfully recruiting 13,000 volunteers through 135 GP practices in the three counties for five years.

Participants at highest risk of developing Type 2 Diabetes were invited to take part in a three and a half year lifestyle intervention programme run at seven centres throughout Norfolk and Suffolk. We expect the results to have a significant impact when they are published.

With rising demand and a tight fiscal situation – our deficit for 2017/18 will be £19.6m - there is no doubt that the environment in which we work will continue to be challenging. 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** **25th May 2018**

# Priorities for improvement

The 2016/17 Quality Report detailed the Trust's intention to align priorities to the Quality and Safety Improvement Strategy and to reflect the new two year NHS Standard Sub Contract by setting priorities for both 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, the Trust took into account feedback from a range of different stakeholder groups, including staff, patients, the public and commissioners. This feedback has continued to be received in a variety of forms, including survey responses, complaint letters, quality monitoring from commissioners, internal reviews of the quality of care provided across services, and staff suggestions. As part of this continuous process of review 2018/19 priorities have been updated and added to as described in Table 1 below.

Table 1

| Domain | Priority for 2018/19 | Changes from 2017/18 |
|---|---|---|
| Safety | Reduce medication errors focussing on insulin | No change |
| | Prompt recognition and treatment of deteriorating patient | Redefined from focusing solely on sepsis and will include Acute Kidney Injury (AKI) and avoidable cardiac arrest |
| | Increase safety through improved teamwork and better communication | **New priority.** |
| | Improvement in frailty provision and care | **New priority.** |
| | Keeping patients safe from hospital acquired thrombosis. | **Remove for 2018-19.** Thrombosis priority as this measure has been consistently achieved in the last year |
| | Incident reporting and management | **Remove for 2018-19.** Duty of candour compliance consistently achieved. This priority has been replaced with a more focused priority relating to human factors training and improving teamwork and communication |

| | | |
|---|---|---|
| **Effectiveness** | Improve quality of care through research | No change |
| | 7 day services - All patients admitted as an acute or emergency admission receive the same high quality of care irrespective of the time or day of the week they are admitted | Changes QP from previous year which was specific for timely review of all patients. |
| | Keeping patients safe from infection | Changes to include gram negatives and CPE |
| **Care and Patient Experience** | Improved continuity of care and experience through reduced ward moves and reduced numbers of outliers | No change |
| | Improved discharge processes and communication | Added communication to emphasise EDL as at present but also OPD communication according to required electronic format |
| | To improve our care to those at the end of their life | **New priority.** |
| | To improve the assessment and quality of care for patients in Mental Health crisis | **New priority.** |
| | Treat Patients with Dignity and Respect | **Remove for 2018-19.** This remains a high priority but the Trust has consistently achieved over 95% for patients extremely likely or likely to recommend us. This is replaced by the more specific priority in relation to improving continuity of care by reducing ward and bed moves |

## Patient Safety – No Change: Reduce medication errors focussing on insulin

**Why is this a priority for 2018/19?**

Concern in relation to harm and potential harm from errors of insulin prescriptions remains high

**How progress will be achieved, monitored and measured**

Number of insulin errors reported on DATIX– NPSA category Moderate harm or above as last year and reported via the Trusts Integrated Performance Report

## Patient Safety – Change: Prompt recognition and treatment of deteriorating patient

**Why is this a priority for 2018/19?**

Redefined from focusing solely on sepsis to reflect outcomes of Root Cause Analysis investigations and themes arising out of mortality review

**How will progress be achieved, monitored and measured**

- Sepsis CQUIN metrics
- Number of avoidable cardiac arrests
- Number of Serious Incidents/ Mortality reviews where failure to recognise and respond is identified
- Number of inpatients developing AKI (from renal registry).
- Early Warning Score audits

## Patient Safety – New Priority: Increase safety through improved teamwork and better communication

**Why is this a priority for 2018/19?**

To reflect priority for improving safe practice through the learning from Never Event (NE) investigations particularly in relation to culture change, teamwork and communication.

**How will progress be achieved, monitored and measured?**

Human Factors are the non-technical knowledge and skills that support safer ways of working. These include teamwork, situational awareness, communication and leadership. There is overwhelming evidence that the integration of Human Factors into clinical care is an important aspect of improving patient safety. By helping clinical teams to work together safely and effectively by training them about leadership, communication, situational awareness, problem solving and decision-making it will help to reduce medical error and its consequences.

- Number of staff trained in Human Factors against plan (Risk stratified roll out – priority areas where NE have occurred)
    - Q1 – devise plan and training content
    - Q2 - 4 deliver training plan
- Number of staff trained as trainers

## Patient Safety – New Priority: Improvement in frailty provision and care

**Why is this a priority for 2018/19?**

To reflect increased emphasis on older persons care and changes instituted in NNUH for older peoples medicine.

**How will progress be achieved, monitored and measured?**

Please refer to page 68 for detail on the frailty pathway development work that has been undertaken in 2017/18

The measure will be the number of comprehensive Geriatric assessments undertaken on admission.

Metrics will form part of the Trusts Quality Care Indicators for Emergency Medicine.

## Clinical Effectiveness – No change: Improve quality of care through research

**Why is this a priority for 2018/19?**

Evidence shows that research active hospitals have good quality and safety records

**How will progress be achieved, monitored and measured?**

No change to measures used last year which are detailed later in this report

## Clinical Effectiveness – Change: 7 day services

**Why is this a priority for 2018/19?**

The Trust continues to participate in the national 7 Day Services Assessment Audit and has contributed data again in March and September of 2017/18. As a result of the last audit, a robust action plan is being put in place which includes the forming of Quarterly Steering Committee services, with exec board and CCG membership, to provide additional focus on implementing the priority clinical standards for seven day hospital services.

**How progress will be achieved, monitored and measured**

Externally, The Trust submits data and assurance bi-annually to NHS England through the national 7 Day service audit process against the 4 priority clinical standards, which need to be embedded by 2020. The Trust also provides assurance through regular meetings with NHS England that the required progress is being made on the other 6 standards ensuring patients receive the same standards of care in hospitals, seven days a week.

Internally the Trust will report regular project progress to the Management board, Divisional leads and Commissioners through the newly created project Steering Committee which will meet quarterly. The Steering committee will also report into the Trusts improvement process.

## Clinical Effectiveness – Change: Keeping patients safe from infection

**Why is this a priority for 2018/19?**

1. Gram-negative blood stream infections

   NHS Improvement (NHSI) contacted all Trusts and CCGs in June 2017 sharing the ambition across the whole health sector to reduce healthcare-associated Gram-negative blood stream infections (BSI) by 50% by March 2021. The initial focus to reduce *Escherichia coli (E. coli)* was launched as a joint initiative by NHSI to promote working together.

   *E.coli* BSI figures have been published by Public Health England (PHE) since 2011. In 2017 it also became mandatory for Trusts to collect Klebsiella spp. and Pseudomonas aeruginosa BSI surveillance data for PHE.

   **How progress will be achieved, monitored and measured**

   The NNUH will collect and review surveillance data for all Gram-negative BSI with enhanced mandatory surveillance completed for any healthcare-associated Gram-negative BSI.

NHS Improvement has recognised that approximately three-quarters of *E. coli* BSIs occur before people are admitted to hospital but the sample will be taken by the hospital. Therefore the CCG IP&C lead and the Infection Prevention and Control (IPC) team at NNUH have worked together to develop a joint improvement plan. Review and evaluation of the healthcare-associated Gram-negative BSI will determine common themes that could help prioritise areas for action. Progress to achieve these priorities will be monitored and measured jointly with the CCG.

Trust Gram-negative bacteraemia figures are published monthly by PHE. NNUH Gram-negative bacteraemia figures will be reported to the Board via the Integrated Performance Report (IPR).

2. Carbapenemase-producing Enterobacteriaceae (CPE)
PHE published an acute trust toolkit for the early detection, management and control of carbapenemase-producing Enterobacteriaceae (CPE) in 2013. This provides practical advice for the management of colonisation or infection and provides risk assessment tools. In February 2014 PHE requested that this should be embedded into clinical practice within Trusts. In 2016 PHE published details of the enhanced surveillance system for CPE.

**How progress will be achieved, monitored and measured**
The NNUH will collect and review surveillance data for CPE positive cases and complete enhanced surveillance for any new cases of CPE identified.
A risk assessment tool is in place to be undertaken at patient admission. This identifies patients previously colonised or infected with CPE, those who have been a contact of a person with CPE, or have been admitted to a hospital abroad or in UK hospital with known high prevalence of CPE within the last 12 months. Those identified as “at risk” are screened and cared for in accordance with PHE guidance. The NNUH will continue to embed the risk assessment process into clinical practice.

There are currently no objectives for CPE. The enhanced surveillance form for any new cases of CPE identified will get completed and the data for England is published by PHE it is not Trust specific. CPE figures will be reported to the Board via the Integrated Performance Report (IPR).

## Care and Patient Experience – No change: Improved continuity of care and experience through reduced ward moves and reduced numbers of outliers

**Why is this a priority for 2018/19?**
Important to retain focus on this priority in the light of continuing high bed occupancy and flow challenges

**How progress will be achieved, monitored and measured**

- Number of ward moves tracked by PAS (same measures as last year)
- Clinical Utilisation Review

## Care and Patient Experience – Change: Improved discharge processes and communication

**Why is this a priority for 2018/19?**

Timely and accurate communication of discharge and out-patient letters is a specifically contracted requirement and an important duty of professionals.

**How progress will be achieved, monitored and measured**

Increased Trust communication to emphasise Electronic Discharge Letters as at present but updated to include Outpatient letters according to required electronic format.

## Care and Patient Experience – New Priority: To improve our care to those at the end of their life

**Why is this a priority for 2018/19?**

Recent inspections and external scrutiny have rightly focused upon Mental Capacity Assessment particularly in relation to DNA CPR decisions. End of Life care is a specific CQC inspection field. NNUH has invested in end of life care with increased provision in the last 4 months.

**How progress will be achieved, monitored and measured**

- DNACPR compliance
- Number of Individualised care plans in place
- Specialist palliative care coding rates
- Quarterly Local End of Life (EoL) care audit
- National EoL care audit

## Care and Patient Experience – New Priority: To improve the assessment and quality of care for patients in Mental Health crisis

**Why is this a priority for 2018/19?**

Increased national and local focus on mental health and during recent CQC inspection in ED and the expansion of the core 24 liaison service from NFST should mean that measuring the quality of this provision is a priority

**How progress will be achieved, monitored and measured**

- Number of referrals to Psychiatric liaison from:
  - ED/ assessment areas (where)
  - Wards (and where).
  - Waiting time from referral to assessment
  - standard 1hr ED, 4hrs
  - assessment areas including EAUS
  - 24hrs response for wards
- Staff training – numbers trained in year and outcome of training, confidence and competence of staff measured by outcome tool to capture baseline knowledge and confidence post training perception and focussed follow up questionnaire 6mths post training.

# Progress against our 2017/18 priorities

Table 2 describes the Trusts high level assessment of achievement against the 2017/18 priorities set within the 2016/17 Quality Report. Following this there is a more in depth review of each category.

| | Priority | Measure | Goal | Rating |
|---|---|---|---|---|
| Patient Safety | Reduction in medication errors | Number of insulin errors causing National Patient Safety Agency (NPSA) category moderate harm or above | Zero errors with harm | |
| | Prompt recognition / treatment of sepsis | % of patients screened, and % of patients treated for sepsis | CQUIN criteria | |
| | Keeping patients safe from hospital acquired thrombosis | Percentage compliance with TRA assessment as evidenced on EPMA. | 95% | |
| | Incident reporting and management | Position in relation to all acute trusts for incident reporting on NLRS.<br>Percentage compliance with Duty of Candour | Top quartile for incident reporting.<br>100% compliance Duty of Candour. | |
| Clinical Effectiveness | Keeping patients safe from infection | No. of hospital attributable C Diff cases<br>Number of hospital acquired MRSA bacteraemias | Below trajectory target for C Diff.<br><br>Zero MRSA bacteraemia | |
| | Improve quality of care through research | Numbers of patients recruited into NIHR studies | 3,300 recruitment into NIHR studies | |
| | Timely medical review of all patients | SAFER criteria for patient review:<br>**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.<br>**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<br><br>Less than 200 patients with length of stay over 14 days | |
| 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 | |

| | Priority | Measure | Goal | Rating |
|---|---|---|---|---|
| | 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 | |
| | Improved discharge processes | Estimated Date of Discharge (EDD) recorded within 24 hours of admission on WardView – SAFER criteria<br>EDL to be completed within 24 hours of discharge | 100% compliance<br><br>95% compliance | |

Rating Key

Red – Quality priority not achieved

Amber – Quality priority partially / mostly achieved or significant improvement achieved

Green – Quality priority achieved

## 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?**

Review of all reported incidents involving insulin every month undertaken by the medication incident group with a subsequent report to the Clinical Safety Sub Board, governance Leads and Dr Jeremey Turner Service Director for Endocrinology.

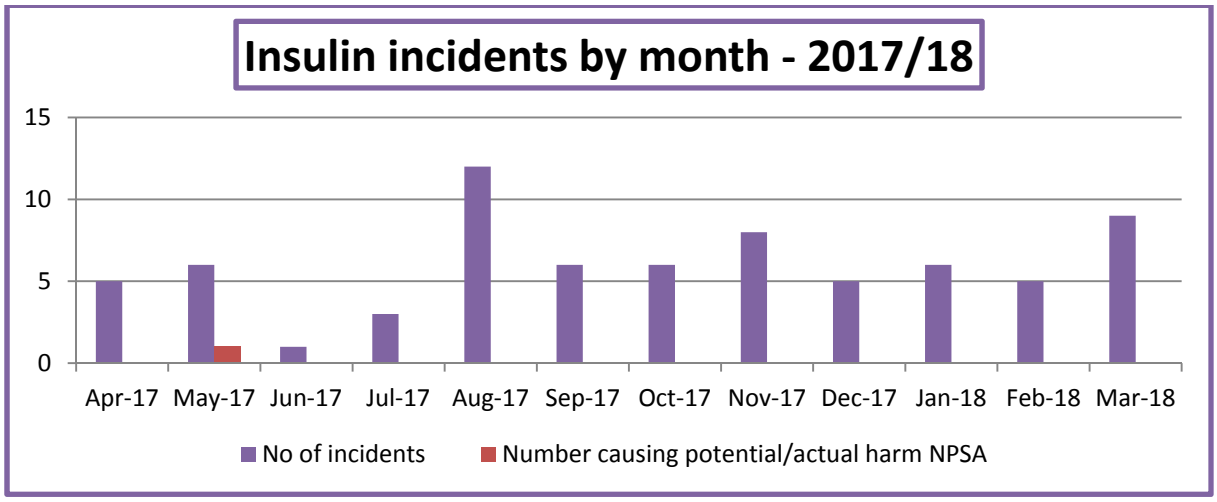
**How did we do?**

At the end of 2017/18 there had been one insulin error (moderate harm) in these NSPA categories (1 incident of moderate harm in 2016/17). The learning from the case review was the need to identify from the Electronic Prescribing and Medicines Administration system EPMA those patients prescribed high doses of insulin as soon as possible, with rapid verification of the prescription by a pharmacist. This has been achieved by commissioning a specific report from the EPMA system highlighting patients on high dose insulin to ward pharmacists on a daily basis, ensuring that all prescriptions are verified, or discontinued if a prescribing error has occurred within 24 hours.

Other initiatives aimed at the reduction of incidents involving insulin include:

- An audit of insulin prescribing assessing local performance against known local and national incidents.
- Foundation Year 1 and 2 doctor insulin prescribing session delivered as part of the prescribing education series.
- A focus group for foundation year 1 and 2 doctors to understand the barriers and issues surrounding the prescribing of insulin effectively.
- A business case approved for increased staff resources to better support in-patients who are prescribed insulin.
- A variable rate intravenous insulin quick reference guide written for the management of surgical patients, which will be an additional educational resource available to all Trust staff. This is currently being progressed through the Trust approval processes.

**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.

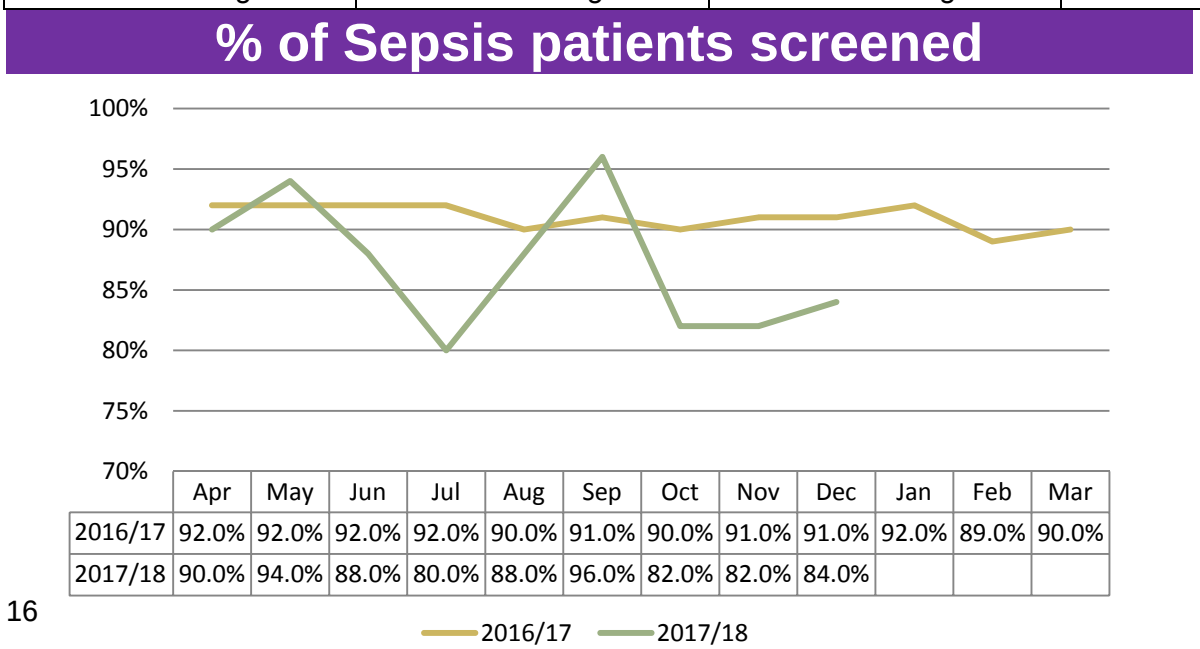
**How did we measure our performance?**

Trust performance during 2017-18 was measured using national Commissioning for Quality and Innovation (CQUIN) stipulated Key Performance Indicator (KPI) criteria

**How did we do?**

The percentage of patients who met the criteria for sepsis screening and were screened for sepsis. This indicator applies to adults and child patients arriving in hospital as emergency admissions and to all patients on acute in-patient wards. The threshold for top compliance (payment) within the CQUIN is 90% average per quarter.

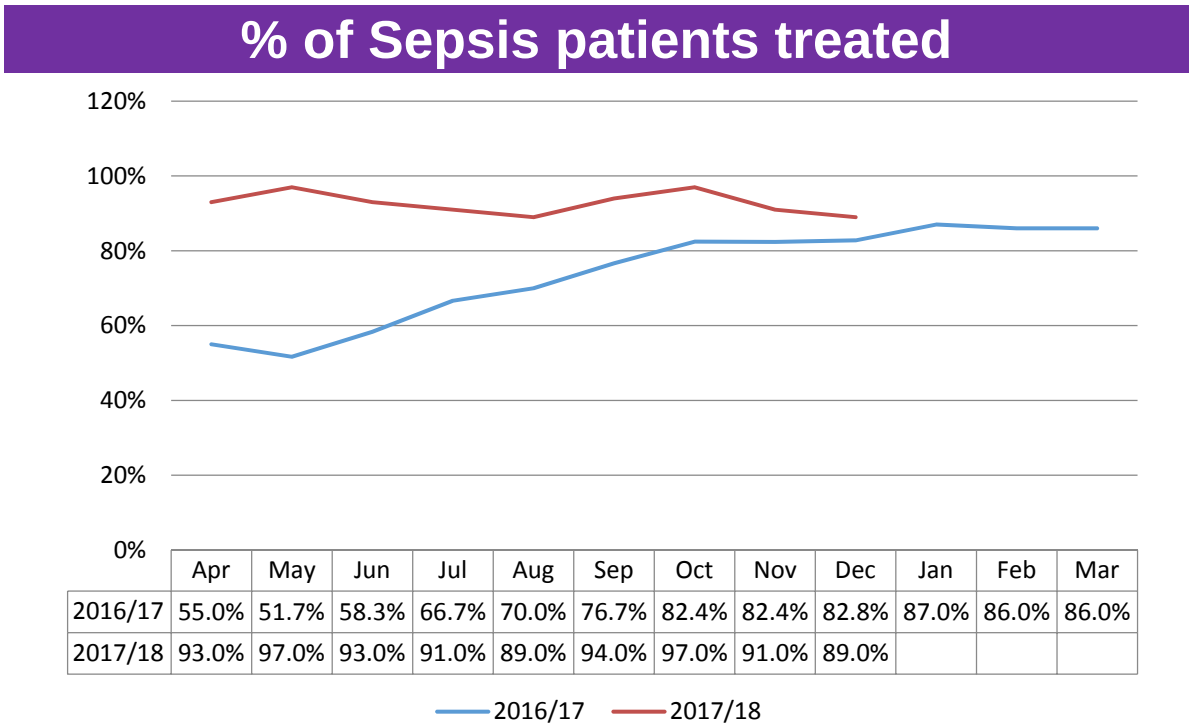
| Apr-17 | May-17 | Jun-17 | Jul-17 | Aug-17 | Sep-17 | Oct-17 | Nov-17 | Dec-17 | Jan-18 | Feb-18 | Mar-18 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 90% | 94% | 88% | 90% | 94% | 88% | 82% | 82% | 84% | Data not yet available | | |
| 91% Average | | | 91% Average | | | 83% Average | | | | | |




| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2016/17 | 92.0% | 92.0% | 92.0% | 92.0% | 90.0% | 91.0% | 90.0% | 91.0% | 91.0% | 92.0% | 89.0% | 90.0% |
| 2017/18 | 90.0% | 94.0% | 88.0% | 80.0% | 88.0% | 96.0% | 82.0% | 82.0% | 84.0% | | | |

The percentage of patients who were found to have sepsis and received IV antibiotics within 1 hour of diagnosis. The indicator applies to adults and child patients arriving in hospital as emergency admissions and to all patients on acute in-patient wards. The threshold for top compliance (payment) within the CQUIN is 90% average per quarter.

| Apr-17 | May-17 | Jun-17 | Jul-17 | Aug-17 | Sep-17 | Oct-17 | Nov-17 | Dec-17 | Jan-18 | Feb-18 | Mar-18 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 93% | 97% | 93% | 93% | 97% | 93% | 97% | 91% | 88% | Data not yet available | | |
| 94% Average | | | 94% Average | | | 92% Average | | | | | |




| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2016/17 | 55.0% | 51.7% | 58.3% | 66.7% | 70.0% | 76.7% | 82.4% | 82.4% | 82.8% | 87.0% | 86.0% | 86.0% |
| 2017/18 | 93.0% | 97.0% | 93.0% | 91.0% | 89.0% | 94.0% | 97.0% | 91.0% | 89.0% | | | |

The percentage of antibiotic prescriptions documented and reviewed by a competent clinician (E.g. Infection control senior doctor; Infection control pharmacist; or a senior member of the clinical team) within 72 hours. The threshold for top compliance (payment) within the CQUIN is 90% average per quarter.

| Apr-17 | May-17 | Jun-17 | Jul-17 | Aug-17 | Sep-17 | Oct-17 | Nov-17 | Dec-17 | Jan-18 | Feb-18 | Mar-18 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 77% | 83% | 90% | 77% | 83% | 90% | 93% | 97% | 87% | Data not yet available | | |
| 83% Average | | | 83% Average | | | 92% Average | | | | | |

Some of the actions that have helped us to achieve performance:

- The Sepsis lead consultant has worked with the Symphony Emergency Department IT system administrator to develop an electronic sepsis screening tool that will be automatically triggered when a patient attends with an elevated Early Warning Score. This process went live in July 2017 and has improved Emergency Admissions Sepsis Screening through the Emergency Department to near 100%. It has also reduced the auditing burden significantly from a by hand paper based search to an electronic report that can be generated much more rapidly.
- The Sepsis Lead consultant has delivered Sepsis Training Sessions to new medical staff and on the local FY1 and FY2 teaching program to further improve the awareness and utilisation of the '2222 Inpatient Emergency Sepsis Pathway'.
- The Critical Care Outreach Team (CCOT) and Hospital at Night team (H@N) are working with the Sepsis Lead to improve utilisation of the Inpatient Sepsis

Screening Tool by requesting the inpatient ward nursing staff to use the tool as a necessary component of a referral to both the CCOT and H&N teams.

- A new obstetric sepsis screening pathway unified with the other sepsis pathways across the Trust has been introduced in July.
- A Sepsis Lead Nurse has been seconded to help develop sepsis care, improve pathways and deliver ward level sepsis education.
- The Sepsis Lead consultant has delivered Sepsis Training Sessions to Emergency Department medical staff from the eastern region, presented a sepsis update at the Eastern Region Anaesthesia Conference and has attended the inaugural Regional Sepsis meeting where the Sepsis Leads from most Trusts in the Eastern region have met to discuss practice and disseminate learning from across the area. This group have agreed to meet quarterly with an aim to standardise some sepsis pathways and processes across hospitals in the region.
- The Sepsis Lead clinician has visited Nottingham University Hospitals NHS Foundation Trust with the E-Observations Working Group (which he leads) to evaluate the Nerve-Centre E-Obs system. This system incorporates Automated Sepsis Screening and Alerting and has the potential to revolutionise the care of sick and deteriorating patients across the NNUH. A business case is being prepared to support the introduction of an E-observation system at the NNUH.
- Reliable Inpatient screening for sepsis has remained a challenge as sepsis is much less common on inpatient wards compared with admission areas and reducing the variation in practice across over 25 wards has proven difficult. The Sepsis Lead Nurse and Lead Consultant are developing a revised inpatient sepsis screening pathway whereby the sepsis screening tool is incorporated into the standard ward observation chart rather than on a separate sticker. It is intended that this will remind ward nursing staff of the sepsis screening pathway whenever they take a set of observations and the screening tool for sepsis will be on the patient observation charts making it easier for them to be completed.

## 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.

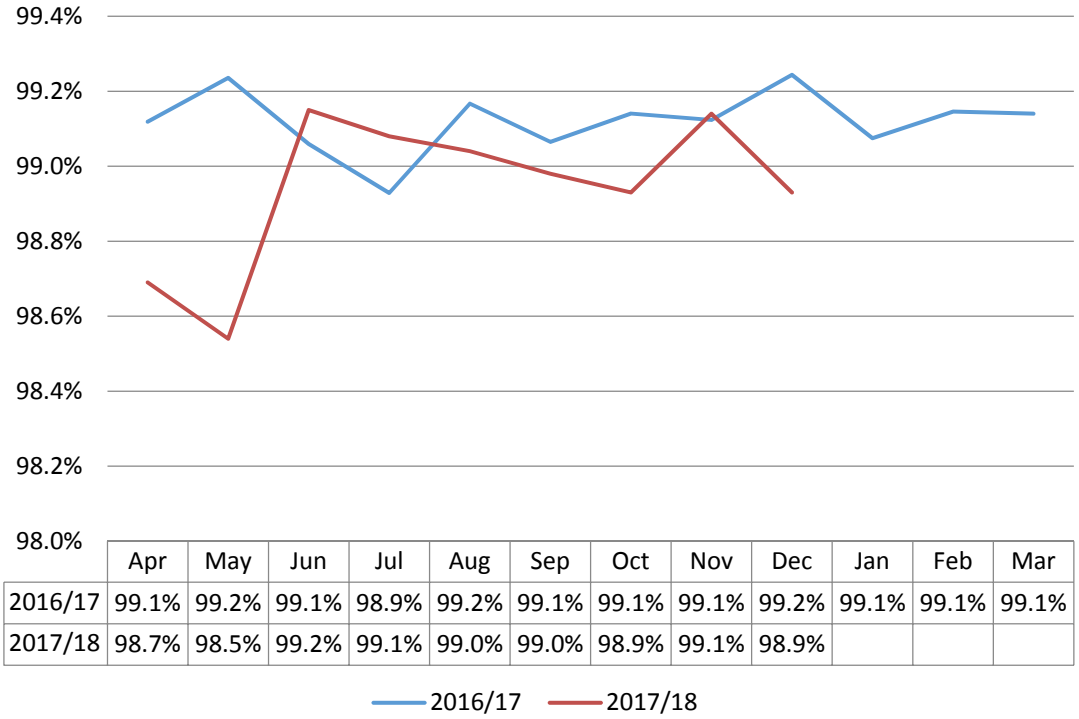
RCAs are carried out by the VTE Team on all Hospital Acquired Thrombosis (HATs) that are reported on Datix. The HATS are all initially classified as ‘moderate’ on Datix and then downgraded if appropriate following the RCA. The RCA target for HATs is 100%.

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?**

# % compliance with TRA assessment as evidenced on EPMA




| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2016/17 | 99.1% | 99.2% | 99.1% | 98.9% | 99.2% | 99.1% | 99.1% | 99.1% | 99.2% | 99.1% | 99.1% | 99.1% |
| 2017/18 | 98.7% | 98.5% | 99.2% | 99.1% | 99.0% | 99.0% | 98.9% | 99.1% | 98.9% | | | |

Ward-level VTE Screening Compliance
TRA compliance report for 2017/18

| Division | Total Not Complete | Total Eligible | Compliance |
|---|---|---|---|
| **Women & Children Division** | 736 | 14401 | 94.89% |
| **Surgical Division** | 902 | 35377 | 97.45% |
| **Not recorded** | 29 | 21397 | 99.86% |
| **Medical Division** | 3 | 112215 | 100.0% |
| **Clinical Support Services Division** | 0 | 35 | 100.0% |

| Year | Month | Screening Not Complete | Total Eligible Population | Compliance |
|---|---|---|---|---|
| 2017 | April | 131 | 15167 | 99.136% |
| | May | 126 | 16792 | 99.250% |
| | June | 141 | 16547 | 99.148% |
| | July | 149 | 16393 | 99.091% |
| | August | 158 | 16474 | 99.041% |
| | September | 165 | 16144 | 98.978% |
| | October | 177 | 16501 | 98.927% |
| | November | 143 | 16689 | 99.143% |
| | December | 169 | 15723 | 98.925% |
| 2018 | January | 156 | 16505 | 99.055% |
| | February | 174 | 14689 | 98.815% |
| | March | 13 | 5801 | 99.776% |

## Patient Safety - Incident reporting and management

**What was our aim?**

To remain within the top quartile of acute trusts for incident reporting on NRLS and to achieve 100% Duty of Candour compliance.

**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 and Patient Safety Team maintain a Duty of Candour Compliance database which tracks compliance regarding Duty of Candour across the Trust. Duty of Candour is a Health and Social Care Act (2008) regulation that ensures that providers are open and transparent with people who use services and other 'relevant persons' (people acting lawfully on their behalf) in general in relation to care and treatment. It also sets out some specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong.

All Moderate Harm or above severity incidents which are reported an Datix are verified with the Consultant / clinical lead and a Duty of Candour 'Compliance Statement' is completed to confirm that all actions have been taken and documented in the patient notes. In addition, the team requests confirmation that a letter has been provided confirming the details of the Duty of Candour conversation, and that a copy of this letter is kept within the patient's medical records.

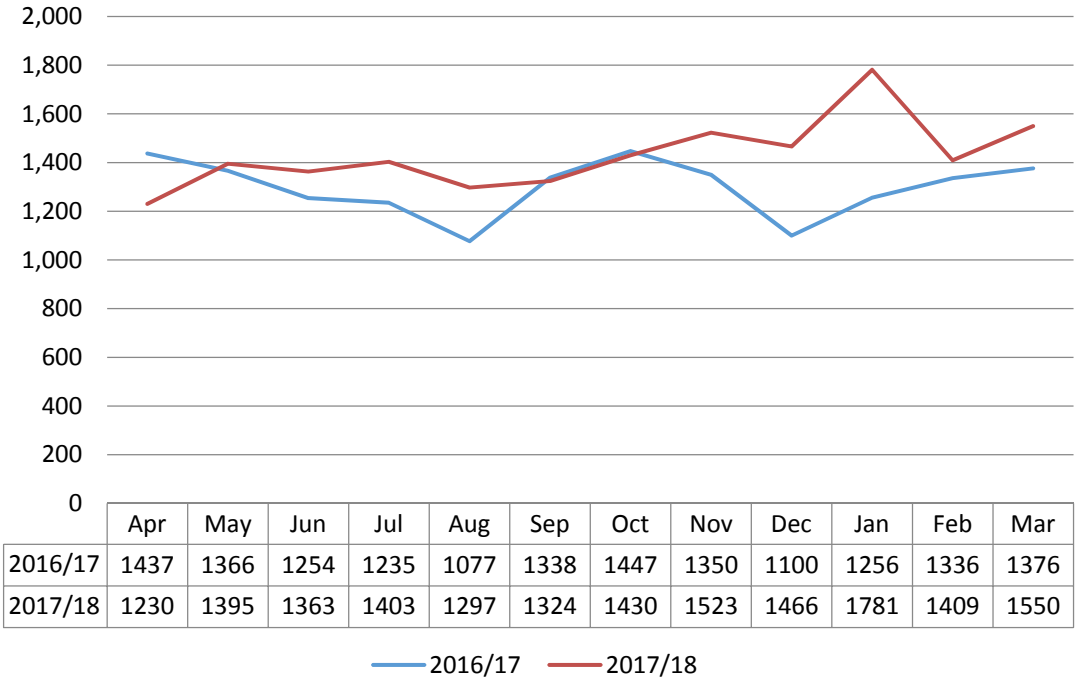
Compliance with the Duty of Candour process is audited and reported on the IPR and in the Clinical Safety & Effectiveness Sub-Board Report every month. Any predicted breaches (these may be on compassionate grounds) in meeting Duty of Candour are reported to the CCG by the Medical Director. From April 2017 to the date of this report there were five such occasions that were reported.

**How did we do?**

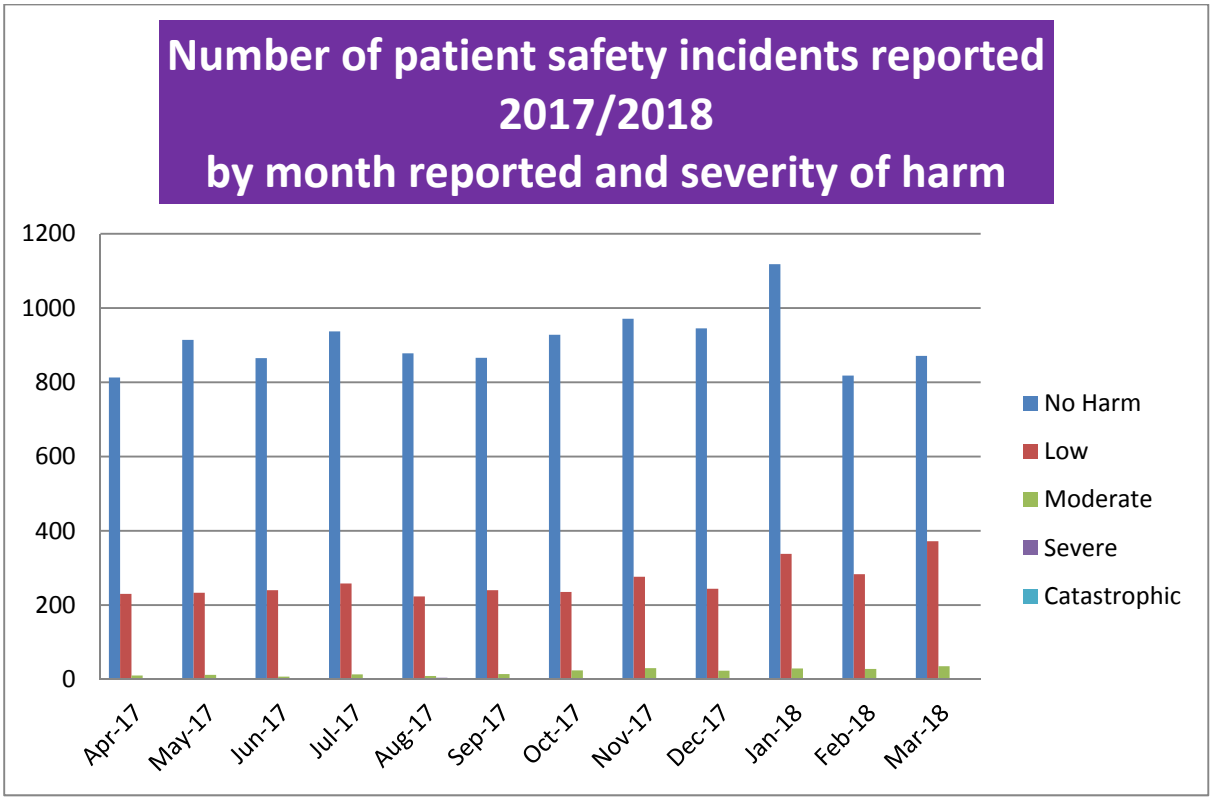
In the twelve months ending 31st March 2018, **14,356 incidents** were recorded on DATIX. Of these, **14,096 (98.19%)** caused either no harm or low harm to patients. In 2016/17 there were 14,469 reported incidents, of which 14,309 (98.89%) caused no harm or low harm. This indicates that the percentage of no/low harm events is reasonably static, although overall the number of reported incidents has marginally reduced during 2017/18.

Our most recently published incident reporting rate is 42.14 incidents per 1,000 bed days (for incidents reported to NRLS between 1st October 2016 and 31st March 2017). When comparing this figure against 136 other Acute (non- specialist) organisations within our cluster, the median reporting rate for the cluster is 40.14 incidents per 1,000 bed days and the NNUH is ranked at 57th out of 136.

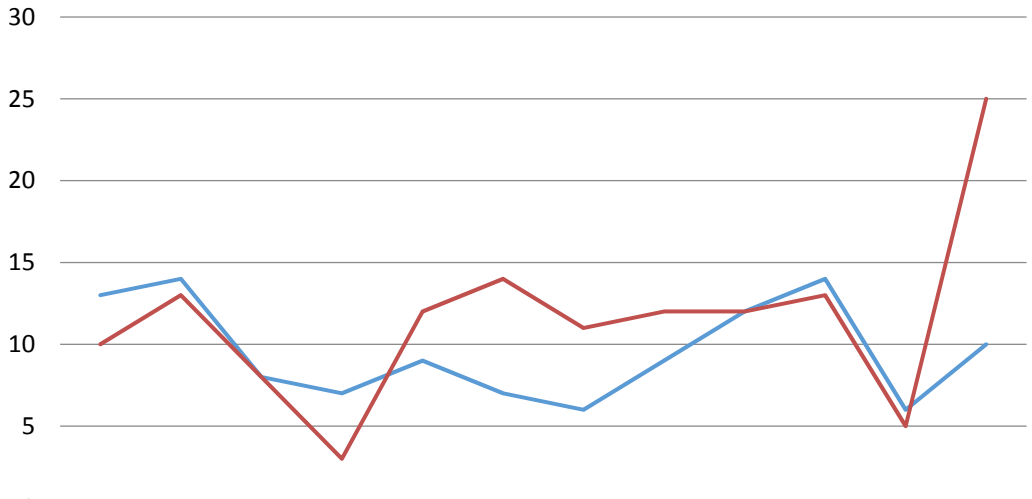
## Incident Reporting




| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2016/17 | 1437 | 1366 | 1254 | 1235 | 1077 | 1338 | 1447 | 1350 | 1100 | 1256 | 1336 | 1376 |
| 2017/18 | 1230 | 1395 | 1363 | 1403 | 1297 | 1324 | 1430 | 1523 | 1466 | 1781 | 1409 | 1550 |




## Serious Incidents




| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2016/17 | 13 | 14 | 8 | 7 | 9 | 7 | 6 | 9 | 12 | 14 | 6 | 10 |
| 2017/18 | 10 | 13 | 8 | 3 | 12 | 14 | 11 | 12 | 12 | 13 | 5 | 25 |

All incidents reported provide an opportunity for learning and continuous improvement in care delivery. As such the Trust supports a culture of reporting and in Quarter 4 of 2017/18 governance structures within Divisions were strengthened providing greater oversight of incidents. This is reflected in the number of incidents declared in March, although it should be noted that four of these occurred in February but were unable to be recorded in the National reporting system as it was being transferred to another platform.

As in previous years, pressure ulcers *(PUs)* and falls have together accounted for the majority of the recorded *Serious Incidents* (SI) during the period covered by this report. In respect of *PUs,* the figure only includes hospital-acquired tissue damage that following specialist peer review is concluded as avoidable harm. 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 and Effectiveness Sub-Board, and learning points are disseminated.

## Clinical Effectiveness - Keeping patients safe from infection

**What was our aim?**

*Clostridium difficile* 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 *Clostridium difficile* (*C. difficile*) infection (CDI) was originally introduced in 2004 for patients aged 65 years and over. From April 2007 this was then extended to include all cases in patients aged 2 years and over.

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) monthly report continued to be distributed with surveillance and alert organism graphs and tables data updated monthly. Local *C. difficile* and MRSA data by ward is available to staff on the IP&C dashboard as part of on-going surveillance.

The clinical teams from the hospital and an IP&C nurse from the clinical Commissioning Group (CCG) jointly review every case of hospital-acquired case *C. difficile*. The post-infection review process establishes whether there have been any lapses in care that can be learnt from. Learning was shared throughout the Trust via the monthly IP&C organisational wide learning [OWL].

**How did we do?**

Our 2017-18 *C. difficile* objective remained the same as the previous year to stay below 49 hospital acquired cases. The objective was achieved and there was an improvement on the 2016/17 figures with a total of **35** *C. difficile* cases deemed to be hospital acquired. We successfully appealed **24** cases resulting in a final total for the year of **11**.

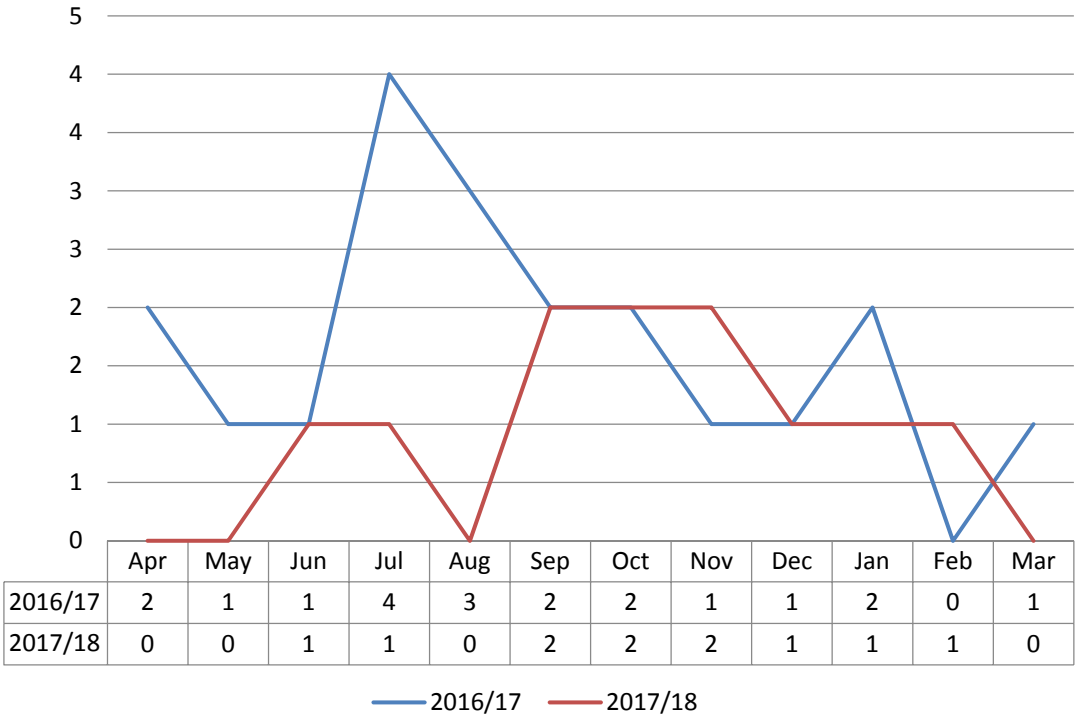
**C. difficile Performance**

| Summary Table | | Non-Trajectory | Trajectory | Pending | Total |
|---|---|---|---|---|---|
| Quarter | 4 | 5 | 2 | 0 | 7 |
| | 3 | 5 | 5 | 0 | 10 |
| | 2 | 6 | 3 | 0 | 9 |
| | 1 | 8 | 1 | 0 | 9 |
| April 17 to March 18 | | 24 | 11 | 0 | 35 |
| | | | | | |
| April 16 to March 17 | | *22* | *20* | *0* | *42* |

*Source: NNUH data, national definition used*

The Trust 2017-18 MRSA bacteraemia (blood stream infections) objective was zero hospital acquired cases and again the objective was achieved with 0 hospital attributable MRSA blood stream infections.

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




| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2016/17 | 2 | 1 | 1 | 4 | 3 | 2 | 2 | 1 | 1 | 2 | 0 | 1 |
| 2017/18 | 0 | 0 | 1 | 1 | 0 | 2 | 2 | 2 | 1 | 1 | 1 | 0 |

## NNUH is first hospital in region to offer new option for pain relief in labour

The Norfolk and Norwich University Hospital will be the first in the region to offer a new choice of pain relief for women in labour.

Remifentanil is a potent, very short-acting drug which can be used as an alternative to Pethidine. With Remifentanil Patient Controlled Analgesia (PCA) women in labour can control when and how much pain relief they receive, by pressing a button. The button is connected to a specifically designed pump which will deliver a small dose of pain relief. Unlike Pethidine, Remifentanil does not accumulate in mother or baby and breastfeeding is not affected.

Remifentanil PCA will be available to women giving birth within the hospital's Delivery Suite.

The hospital took part in the national RESPITE trial between December 2014 and September 2016, recruiting 16 patients to participate. The trial sought to investigate the proportion of women, who having had either Remifentanil PCA or Pethidine during their labour, went on to require an epidural.

This research was published last month and showed that 50% less people who have Remifentanil go on to have an epidural than those who have had Pethidine. There was also a significant reduction in the number of women who needed an instrumental delivery (Forceps or Ventouse). Research has shown that pain scores are lower and maternal satisfaction is higher with Remifentanil when compared with Pethidine.

## 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 3300 recruitment into NIHR studies in 2017-18.

**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 2017/18, our total recruitment was 3,228 compared against 2016/17 recruitment of 5,438.

Figure 9 shows that at the end of February we are close to achieving our stated goal of recruiting 3300 participants into NIHR studies in 2017/18.

**Figure 9: Recruitment into research studies**

| Recruitment for 17/18 | Number | Percent |
|---|---|---|
| Portfolio recruitment target | 3300 | |
| Total Recruitment | 3228 | |
| NIHR Portfolio | 3137 | 97% |
| Non Portfolio | 91 | 3% |
| Commercial Studies | 165 | 5% |
| Non Commercial Studies | 3063 | 95% |

*Source: NNUH data, national definition used*

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 335 clinical research studies (369 in 2016/17) in a wide range of medical specialities during 2017/18. 104 new studies were opened in 2017/2018 (130 in 2016/17). There were around 150 clinical staff (consultants) participating in research approved by a research ethics committee during 2017/18; supported by approximately 150 research nurses, research administrators/managers and research specialists in our support departments (e.g. Pharmacy, Radiology, Pathology).

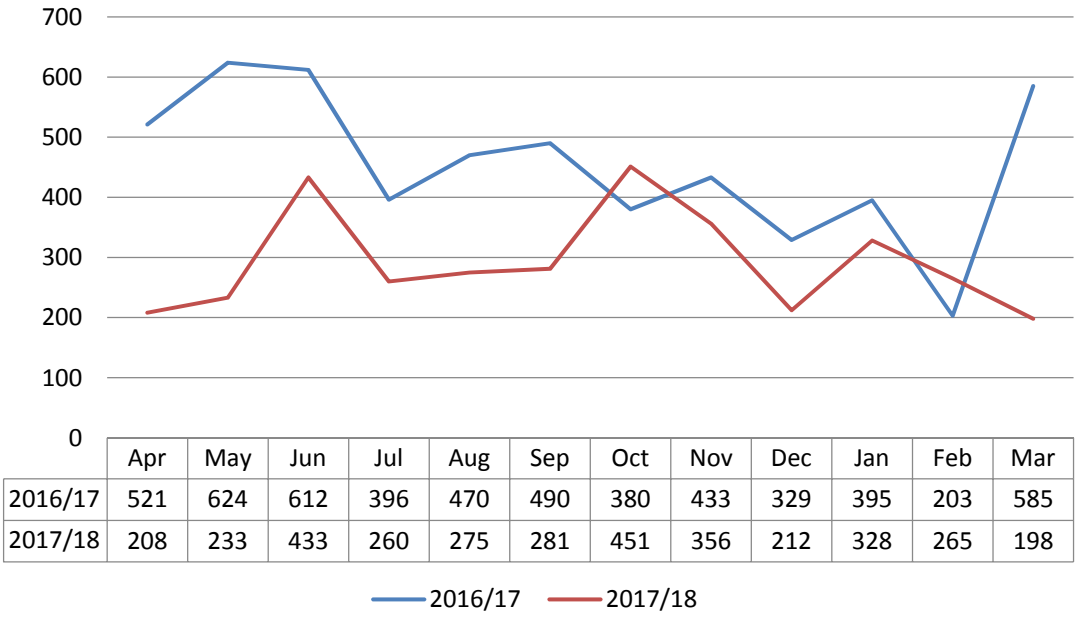
To facilitate consistent local research management, and to greatly improve performance, we participate in the National institute of Health Research (NIHR) Research Support services. We have publicly available Standard Operating Procedures (SOPs) for research.

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/

### Overview of research activities

During 2017/18 building work has continued on the Quadram Institute (QI) and is due for completion later this year. QI will house a Clinical Research Facility (CRF) which is committed to becoming the leading facility for undertaking human health and nutrition research trials in the UK. The CRF will host both academic and commercial studies undertaken by researchers from across the Norwich Research Park (NRP) and beyond. There are several dedicated NHS clinical trial facilities throughout the UK, but the CRF will become the only purpose-built trials facility in Norfolk. The co-location of the CRF, endoscopy suites and research labs within QI will resolve geographical issues associated with the coordination of clinical and academic expertise and availability of human tissue. The unique stability and demographics of the Norfolk population provide additional advantages for the recruitment of study participants for long-term studies.

## Patients recruited into research studies




| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2016/17 | 521 | 624 | 612 | 396 | 470 | 490 | 380 | 433 | 329 | 395 | 203 | 585 |
| 2017/18 | 208 | 233 | 433 | 260 | 275 | 281 | 451 | 356 | 212 | 328 | 265 | 198 |

# Clinical Effectiveness - Timely medical review of all patients

**What was our aim?**

The SAFER patient flow bundle blends five elements of best practice. It's important to implement all five together for cumulative benefits. SAFER stands for **S**enior review, **A**ll patients, **F**low, **E**arly discharge, and **R**eview; the criteria for patient review are:

**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 (senior medical trainee) 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.

**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)
- A multidisciplinary team review (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 Doe CON)
- A ward round or board round which included a senior decision maker.

**How did we do?**

**Senior Review**

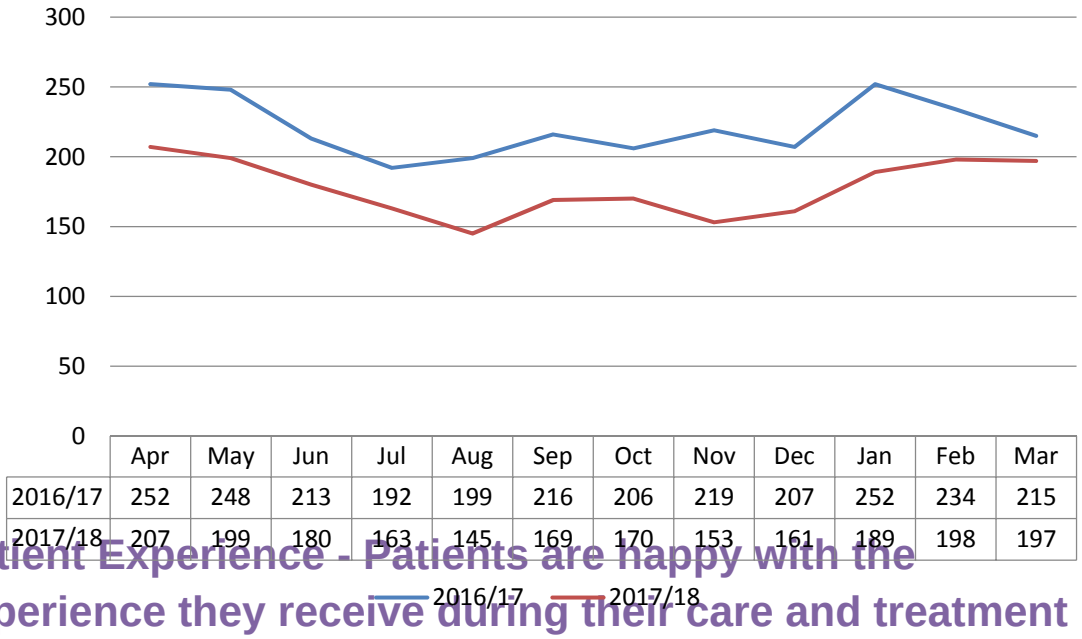
Since the 2016/17 report, the Trust now has a mechanism in place to electronically record whether each patient has had a senior review every day. A report has been designed within Information Services to pull this data weekly and distribute to all Ward managers, Matrons, Divisional Nursing Directors. Red to Green and SAFER are led by a named Matron within the Improvement Team who is currently re-launching on each ward to embed process and improve compliance.

## % Senior Review Complete


| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2017/18 | | | | | 78.9% | 79.6% | 77.9% | 81.2% | 84.8% | 85.1% | 85.3% | 85.4% |

**Patients staying in Excess of 14 days**

## Average number of patients with LoS >14 days




| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2016/17 | 252 | 248 | 213 | 192 | 199 | 216 | 206 | 219 | 207 | 252 | 234 | 215 |
| 2017/18 | 207 | 199 | 180 | 163 | 145 | 169 | 170 | 153 | 161 | 189 | 198 | 197 |

## Patient Experience - Patients are happy with the experience they receive during their care and treatment

**What was our aim?**

95% or more of patients in all areas report through the Friends and Family Test that they are extremely likely or likely to recommend our services to their friends and family

**How did we measure our performance?**

Performance is monitored by ward through monthly performance meetings between the Director of Nursing and her senior team and the measure is reported through the Trust Integrated Performance Report.

Any negative free-text comments made during the collection of Friends and Family feedback is themed, reviewed and actioned at Directorate level.

**How did we do?**

At the time of writing the snapshot view of February 2018 was that 2137 responses were received. January responses totalled 3392 once all final submissions were included. The overall Trust wide score remains high in February at 97%.

Individually A & E - (96%), In-patients (97%), Maternity (98%) and Day Patients (97%) continue to be amongst those receiving strong positive scores.

Patients were asked additional questions to assist us with the monitoring of the care on our wards. Of the 683 patients who responded when asked if they had been involved in their care, 98% responded they had been. 98.6% of patients felt they had been treated with dignity and respect.

In terms of the overall year a total of 38,380 responses were recorded with 96.52% of participants saying that they would recommend the Trust, 1.46% stating that they would not, and the remaining 3.48% stating that they would neither be likely or unlikely or do not know whether they would recommend the Trust.

# NNUH team carries out the first robotic colorectal cancer surgery in East Anglia

A team at the Norfolk and Norwich University Hospital (NNUH) has become the first in East Anglia to carry out robotic colorectal cancer surgery.

Last month, Consultant colorectal surgeon Irshad Shaikh led the team on the first surgery of its kind at the Trust.

The surgery was carried out in collaboration with Colorectal Surgeon Professor Amjad Parvaiz, one of the country's leading robotic surgeons.

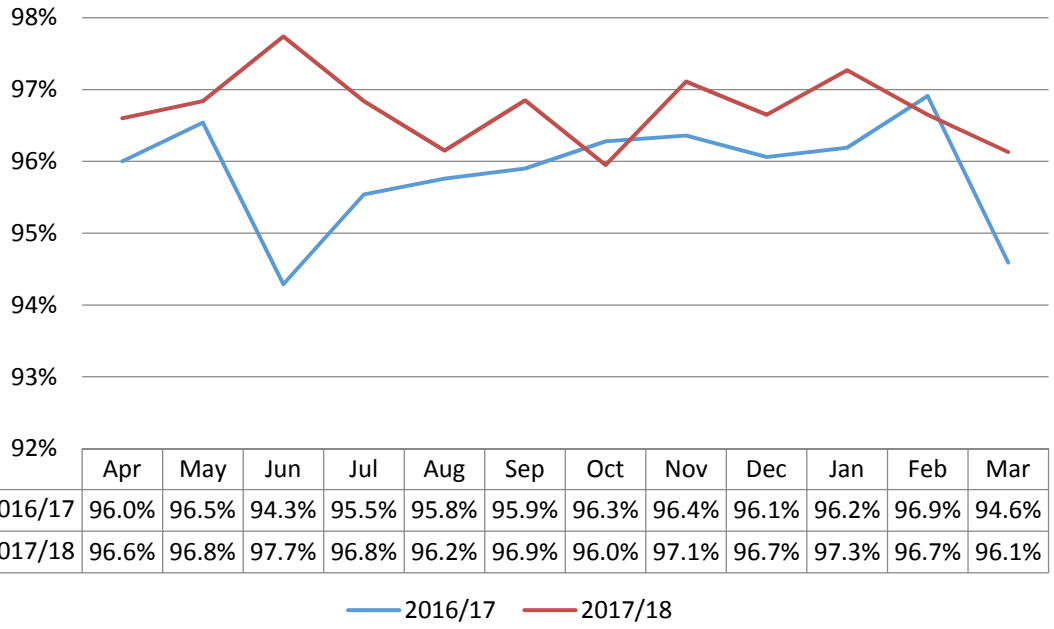
The team has carried out more than 1,100 colorectal operations over the past five years – among the highest of any Trust in the country.

Mr Shaikh said robotic surgery offered a minimal invasive approach and dissection was more precise because the method offered a three-dimensional view and full freedom of movement.

He said: "The robot was first used by the urology team at NNUH and, building on their excellent work, we now have the option of using it for colorectal cancer removal."

Surgery for such cancer removal can be carried out via a number of ways: open, where the surgeon makes a cut in the abdomen, keyhole (laparoscopic) surgery or robotic surgery which may improve functional outcomes for patients as it allows better dissection around pelvic nerves needed for bowel, bladder and sexual function.

# %FFT Trust Scores




| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2016/17 | 96.0% | 96.5% | 94.3% | 95.5% | 95.8% | 95.9% | 96.3% | 96.4% | 96.1% | 96.2% | 96.9% | 94.6% |
| 2017/18 | 96.6% | 96.8% | 97.7% | 96.8% | 96.2% | 96.9% | 96.0% | 97.1% | 96.7% | 97.3% | 96.7% | 96.1% |

## Patient Experience - Improved continuity of care and experience

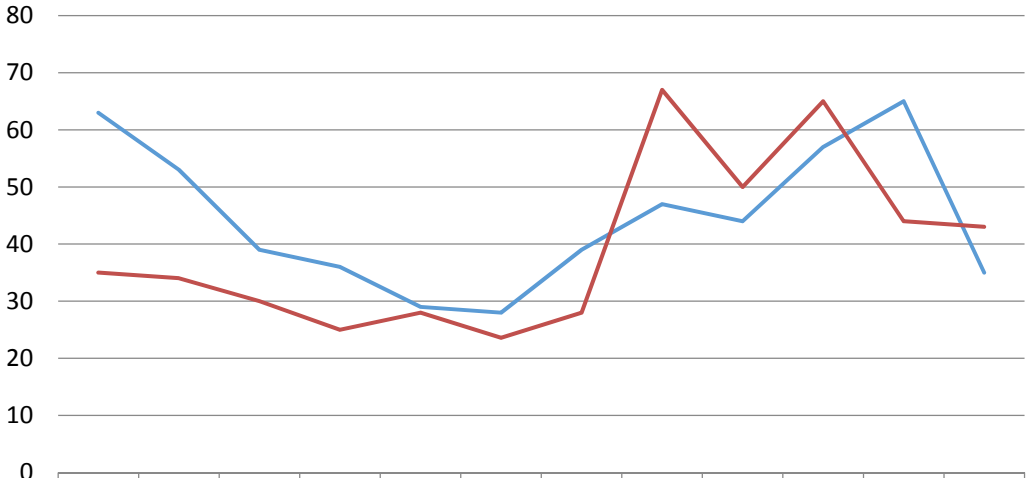
**What was our aim?**

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?**

The Trust's 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).

# Monthly average boarders




| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2016/17 | 63 | 53 | 39 | 36 | 29 | 28 | 39 | 47 | 44 | 57 | 65 | 35 |
| 2017/18 | 35 | 34 | 30 | 25 | 28 | 24 | 28 | 67 | 50 | 65 | 44 | 43 |

## Patient Experience - Improved discharge processes

**What was our aim?**

100% of Estimated Date of Discharges (EDD) recorded within 24 hours of admission on WardView – SAFER criteria;

95% Electronic Discharge Letters (EDL) to be completed within 24 hours of discharge

### How did we measure our performance?

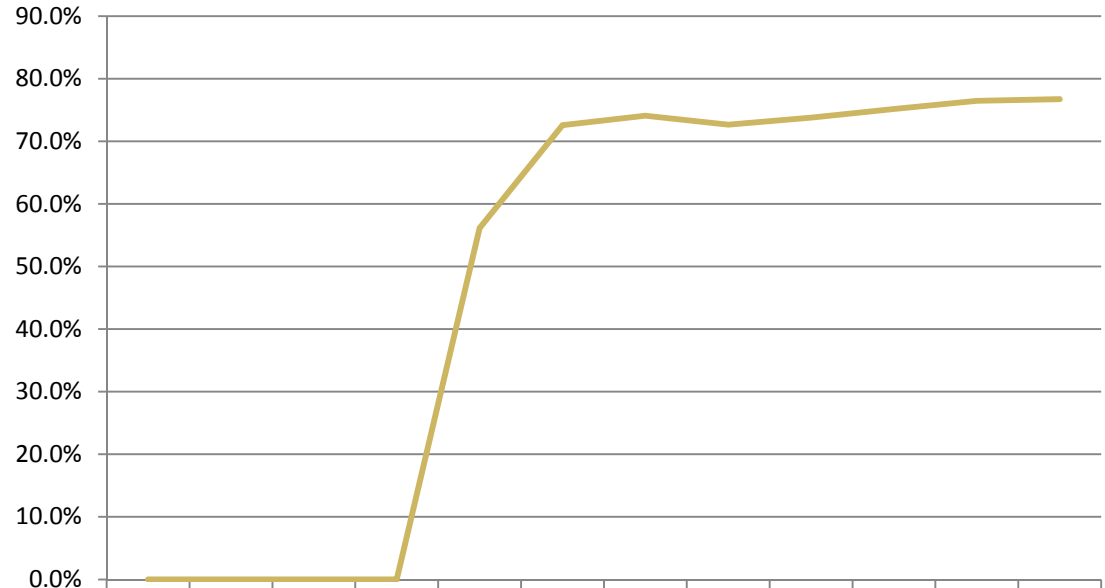
With regards to EDD, WardView no longer exists and has been replaced by the National Medworxx Clinical Utilisation Review (CUR) system. EDD continues to be documented on the Trusts Patient Administration Service which is then data mined by Medworxx CUR. Wards are required to record EDD's and this is enforced via Board Rounds. Reports can be pulled from CUR to demonstrate compliance of completion of EDD.

Within CUR there is also a PDD (planned date of discharge) to further improve discharge planning processes which is completed following an informed decision agreed at ward or board rounds.

Electronic discharge summaries (EDL) must be sent by either secure email or direct electronic transmission. This generates a time stamped record from which performance is recorded and monitored via the relevant hospital Divisional management process.

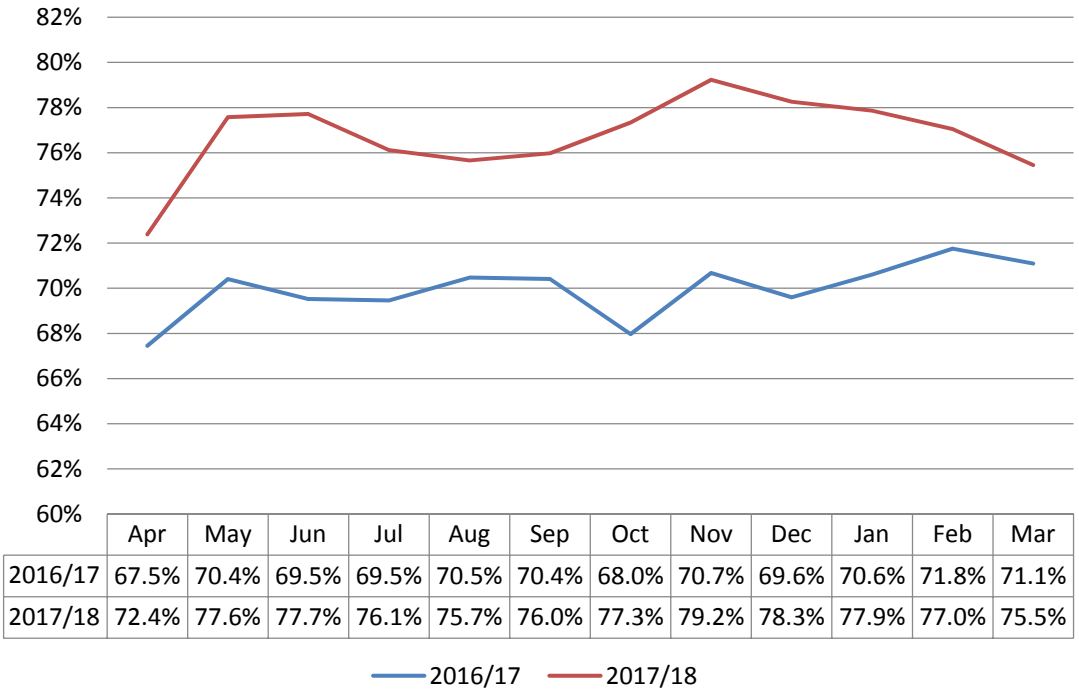
**How did we do?**

## % EDD Reviewed




| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2017/18 | 0.0% | 0.0% | 0.0% | 0.0% | 56.1% | 72.6% | 74.1% | 72.6% | 73.8% | 75.2% | 76.5% | 76.7% |

## % EDL to be completed within 24 hours in 95% of discharges




| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2016/17 | 67.5% | 70.4% | 69.5% | 69.5% | 70.5% | 70.4% | 68.0% | 70.7% | 69.6% | 70.6% | 71.8% | 71.1% |
| 2017/18 | 72.4% | 77.6% | 77.7% | 76.1% | 75.7% | 76.0% | 77.3% | 79.2% | 78.3% | 77.9% | 77.0% | 75.5% |

## Expansion plan announced for Cromer Hospital

Cromer & District Hospital is due to be expanded as part of the future plans by the Norfolk and Norwich University Hospitals NHS Foundation Trust which runs the hospital. NNUH has agreed to redevelop one of the original buildings on the Cromer & District Hospital site and bring it up to modern standards.

Part of this building has been modernised already and contains the renal dialysis unit. An existing building on the hospital site will be redeveloped to create the new medical unit which will provide services such as chemotherapy, blood transfusion and rheumatology treatments. It will also free up space in the main Cromer Hospital building to deliver surgical treatments in dermatology, urology, vascular surgery and pain management.

Due to the previous generosity of local individuals and the community we are able to use our existing charitable funds to fund much of the scheme. The NHS pays for the staffing and running costs of Cromer & District Hospital and this will include the new unit. A new fundraising campaign will be launched later in the year to help achieve the full amount required for the building and the equipment.

An exhibition event for the public is being held on Wednesday 25th October, from 4pm to 8pm, at Cromer & District Hospital, where people will be able to find out more about the plans and get involved.

Simon Hackwell, Director of Strategy at NNUH, said: “We will be redeveloping one of the original buildings on the site, bringing it up to modern standards and using it for medical treatments. This will benefit local people who can be treated without travelling to Norwich”.

Iain Young, Operational Manager for Cromer & District Hospital, said: “We are delighted to be in a position to offer more services to patients in North Norfolk and further afield. Cromer & District Hospital offers a high quality service in a modern setting.”

# Board Assurance Statements

## Review of services

During 2017/18 the Norfolk and Norwich University Hospitals NHS Foundation Trust provided and/or sub-contracted 79 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 79 of these relevant health services.

The income generated by the relevant health services reviewed in 2017/18 represents 83.8% of the total income generated from the provision of relevant health services by the Norfolk and Norwich University Hospitals NHS Foundation Trust for 2017/18.

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

During 2017/18 49 national clinical audits and 4 national confidential enquiries covered relevant health services that the 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 and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.
The national clinical audits and national confidential enquiries that the Norfolk and Norwich University Hospitals NHS Foundation Trust was eligible to participate in during 2017/18 are as follows:

| Key | | |
|---|---|---|
| National Clinical Audit | National Confidential Enquiry | Not applicable to NNUH |

| National Clinical Audit (alphabetical order) | Eligible y/n | Took part y/n | Participation Rate Cases Submitted | Completed/ In-progress/ Ongoing |
|---|---|---|---|---|
| Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP) | Y | Y | 849/948 (89%) | Ongoing |
| Adult Cardiac Surgery | N | N/A | | |
| Adult Community Acquired Pneumonia | Y | N/A | Audit listed in Quality Accounts but did not take place in 2017/18 | n/a |
| BAUS Urology Audits: Cystectomy | Y | Y | Figures not available until June 2018 | Ongoing |
| BAUS Urology Audits: Nephrectomy | Y | Y | Figures not available until June 2018 | Ongoing |

| | | | | |
|---|---|---|---|---|
| BAUS Urology Audits: Percutaneous nephrolithotomy | Y | Y | Figures for 17/18 not available but will be 100% | Ongoing |
| BAUS Urology Audits: Radical prostatectomy | Y | Y | Figures for 17/18 not available but will be 100% | Ongoing |
| BAUS Urology Audits: Urethroplasty | Y | Y | Figures for 17/18 not yet available | Ongoing |
| BAUS Urology Audits: Female stress urinary incontinence | Y | Y | Figures for 17/18 not yet available | Ongoing |
| Bowel Cancer (NBOCAP) | Y | Y | 533/533 (100%) | Ongoing |
| Cardiac Rhythm Management (CRM) | Y | Y | Electrophysiology (EP) 164/164 (100%) Pacemakers 1073/1073 (100%) | Ongoing |
| Case Mix Programme (CMP) | Y | Y | 445 (01/04/2017-01/06/2017) No further figures or percentage available from Clinicians | Ongoing |
| Child Health Clinical Outcome Review Programme | Y | Y | Young People's Mental Health, Clinical Forms 1/5 (20%) Clinical Notes 5/5 (100%)<br><br>Chronic Neurodisability, Lead Clinician forms 6/6 (100%) Admission Clinical Form 6/9 (66%) Clinical Notes 15/15 (100%) | Ongoing |
| Congenital Heart Disease (CHD) | N | N/A | | |
| Coronary Angioplasty/National Audit of Percutaneous Coronary Interventions (PCI) | Y | Y | 1569/1645 (95.4%) | Ongoing |

| | | | | |
|---|---|---|---|---|
| Diabetes (Paediatrics) (NPDA) | Y | Y | 302/302 (100%) | Completed |
| Elective Surgery (National PROMs Programme) | Y | Y | Hip<br>736/658 (89%)<br>Knee<br>665/607 (91%)<br>Hernia<br>551/417 (76%)<br>Varicose Veins<br>122/104 (85%) | Ongoing |
| Endocrine and Thyroid National Audit | Y | Y | Throidectomy<br>38/38 (100%)<br>Parathryoidectomy 10/10 (100%) | Ongoing |
| Falls and Fragility Fractures Audit Programme (FFFAP) | Y | Y | 30/30 (100%) | Completed |
| National Hip Fracture Database | Y | Y | 696/696 (100%) | Ongoing |
| Fractured Neck of Femur | Y | Y | 50/50 (100%) | Completed |
| Head and Neck Cancer Audit (HANA) (TBC) | Y | Y | Data collected on 740 patients will be submitted April 2018. Will be 100% | Ongoing |
| Inflammatory Bowel Disease (IBD) Programme | Y | Y | 7/7 (100%) | Ongoing |
| Learning Disability Mortality Review Programme (LeDeR Programme) | Y | Y | 9/9 (100%) | Ongoing |
| Major Trauma Audit | Y | Y | 584/683 (86%) | Ongoing |

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| Maternal, Newborn and Infant Clinical Outcome Review Programme | Y | Y | Maternal 1/1 (100%)<br><br>Late Fetal Loss 2/2 (100%)<br><br>Terminations 2/2 (100%)<br><br>Stillbirths 29/29 (100%)<br><br>Early Neonatal Deaths 6/6 (100%)<br><br>Late Neonatal Deaths 2/2 (100%) | Ongoing |
| Medical and Surgical Clinical Outcome Review Programme | Y | Y | Acute Heart Failure Clinician Forms 6/6 (100%) Clinical Notes 6/6 (100%)<br><br>Perioperative Management of Diabetes Clinician Forms 9/12 (75%) Clinical Notes 6/6 (100%) | Ongoing |
| Mental Health Clinical Outcome Review Programme | N | N/A | | |
| National Audit of Anxiety and Depression | N | N/A | | |
| National Audit of Breast Cancer in Older Patients (NABCOP) | Y | Y | Submission numbers are unavailable until report published | Ongoing |
| National Audit of Dementia | Y | Y | 20/20 (100%) | Completed |
| National Audit of Intermediate Care (NAIC) | N | N/A | | |
| National Audit of Psychosis | N | N/A | | |

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| National Audit of Rheumatoid and Early Inflammatory Arthritis | Y | N/A | Does not start until March 2018 | Ongoing |
| National Audit of Seizures and Epilepsies in Children and Young People | Y | Y | 1/1 Only requirement this year was for an organisational data set. Clinical data collection will not commence until April 2018 | Ongoing |
| National Bariatric Surgery Registry (NBSR) | N | N/A | | |
| National Cardiac Arrest Audit (NCAA) | Y | Y | April 2017-June 2017 22/22 (100%) No further figures available from clinicians | Ongoing |
| National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme | Y | Y | 530/530 (100%) | Ongoing |
| National Clinical Audit of Specialist Rehabilitation for Patients with Complex Needs following Major Injury (NCASRI) | N | N/A | | |
| National Comparative Audit of Blood Transfusion Programme | Y | Y | 57/80 72% | Completed |
| National Diabetes Audit - Adults | Y | Y | National Diabetes audit 2177/2177 (100%)<br><br>National Diabetes Inpatient Audit 132/132 (100%)<br><br>National Diabetes Foot care Audit 242/242 (100%) | Completed |
| National Emergency Laparotomy Audit (NELA) | Y | Y | 227/227 (100%) | Ongoing |
| National End of Life Care Audit | Y | N/A | Did not run 2017/18 Data collection to commence Autumn 2018 | Ongoing |

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| National Heart Failure Audit | Y | Y | 192/886 (22%) | Ongoing |
| National Joint registry (NJR) | Y | Y | 1089 (100%) | Ongoing |
| National Lung Cancer Audit (NLCA) | Y | Y | Invasive Lung 288/288 (100%) Mesothelioma 15/15 (100%) | Ongoing |
| National Maternity and Perinatal Audit | Y | Y | 5803/5803 (100%) April 17 to March 2018 | Ongoing |
| National Neonatal Audit Programme (NNAP) (Neonatal Intensive and Special Care) | Y | Y | 1208/1208 (100%) | Ongoing |
| National Ophthalmology Audit | Y | Y | 4409/4409 (100%) | Completed |
| National Vascular Registry | Y | Y | Clinicians did not give data | Ongoing |
| Neurosurgical National Audit Programme | N | N/A | | |
| Non-Invasive Ventilation - Adults | Y | N/A | Audit listed in Quality Accounts but did not take place in 2017/18 | n/a |
| Oesophago-gastric cancer (NAOGC) | Y | Y | 238/238 (100%) | Ongoing |
| Paediatric Asthma | Y | N/A | Audit listed in Quality Accounts but did not take place in 2017/18 | n/a |
| Paediatric Intensive Care (PICANet) | N | N/A | | |
| Paediatric Pneumonia | Y | N/A | Audit listed in Quality Accounts but did not take place in 2017/18 | n/a |
| Pain in Children | Y | Y | 50/50 (100%) | Completed |
| Pleural Procedures | Y | N/A | Audit listed in Quality Accounts but did not take place in 2017/18 | n/a |
| Prescribing Observatory for Mental Health(POMH-UK) | | | | |
| Procedural Sedation in Adults (care in emergency departments) | Y | Y | 50/50 (100%) | Completed |

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| Prostate Cancer | Y | Y | Figures for 17/18 not available but will be 100% | Ongoing |
| Sentinel Stroke National Audit Programme (SSNAP) | Y | Y | April-June2017: 346/346 (100%)<br><br>Aug –Nov 2017: 387/387 (100%) | Ongoing |
| Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme | Y | Y | 11/11 (100%) | Ongoing |
| Smoking Cessation | Y | N/A | Audit listed in Quality Accounts but did not take place in 2017/18 | n/a |
| UK Parkinson's Audit | Y | Y | 40/40 (100%) | Y |

The reports of 14 national clinical audits were reviewed by the provider in 2017/18 and the Norfolk and Norwich University Hospitals NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided

| Audit and Survey Title | Results/Actions Taken / Planned |
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| Acute Coronary Syndrome or Acute Myocardial Infarction National Audit Project (MINAP) | The Myocardial Ischaemia National Audit Project (MINAP) is a national clinical audit of the management of heart attack. MINAP provides comparative data to help clinicians and managers to monitor and improve the quality and outcomes of their local services. MINAP published its annual report in June 2017 and it was discussed at the July 2017 Governance meeting. The report demonstrated that Norfolk and Norwich University Hospital (NNUH) data is consistent with national data. NNUH performance is at or above national averages with no evidence of significant variance. |
| Coronary Angioplasty/ National Audit of Percutaneous Coronary Interventions (PCI) | The aim of this national audit is to describe the quality and patterns of care, the process of care and outcomes for patients receiving a percutaneous coronary intervention (PCI). The annual report for January to December 2015 was published in September 2017. The report demonstrated that the Cardiology Department practice pattern is consistent with national data. This is the only hospital with high rates of using drug coated balloons rather than drug-eluting stents with emerging evidence that they give a similar or better outcome. |
| National Heart Failure Audit | The aim of this national audit is to improve the quality of heart failure services and achieve better outcomes for patients. The National Heart Failure annual report for 2014-15 was published in August 2017. The report demonstrated that the Norfolk and Norwich University (NNUH) care is at or above national average. A new Heart Failure Nurse was appointed earlier this year to help improve outcomes further. |
| United Kingdom Renal Registry (UKRR) Audit | The results of the United Kingdom Renal Registry (UKRR) Audit were published 29th September 2017. The report was reviewed at the Renal Governance meeting in November 2017. The Renal Department is examining in greater detail any patients who are being prepared for renal transplant and the management of anaemia in patients. |

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| Audit of Potential Organ Donation | An audit report is published every six months detailing the performance of each Trust in relation to organ donation. This includes the rate of referral, approach rate, approaches with Specialist Nurse for Organ Donation (SN-OD) presence, consent rate and number of proceeding donors. NNUHFT is one of the busiest Trusts in the whole of the eastern region in relation to its donation activity. The Trust currently performs above that of the national average. Since April 2017, 29 families out of 36 approached have said 'yes' to donation. 20 of those patients have gone on to be actual organ donors - saving the lives of 59 others. Each case of missed opportunity is scrutinised by the SN-OD team, discussed with the Trust's clinical lead for organ donation and further discussed with all members of the Multi-Disciplinary Team directly involved. Outcomes of the investigations are then shared throughout various channels and specific related objectives then added to any local/regional educational programmes whilst feedback may also be constructively given to those colleagues involved. |
| National Audit of Breast Cancer in Older Patients (NABCOP) | The aim of this national audit was to evaluate quality of care provided to women aged 70 years or older by Breast Cancer Services in England and Wales. The annual report was published in July 2017. This audit found regional variations in the way women were treated. The Breast Surgery Department reviewed the report and follows all the recommendations, no further action was required. |
| National Audit of Oesophago-Gastric Cancer (NAOGC) | The aim of this National Oesophago-Gastric Cancer Audit (NOGCA) is to examine the overall care received by patients from the time they are diagnosed with cancer or high-grade dysplasia to the end of their primary treatment. The NOGCA annual report covering April 2014 to March 2016 was published in December 2017. The Norfolk and Norwich University Hospital (NNUH) continues to be rated as top in the country for its Oesophago-Gastric Cancer Centre. Nationally the centre has the shortest length of stay at 7 days and the lowest mortality at 0.7%. This is down to continuous team effort and the successful implementation of Minimally Invasive oesophagectomy, and enhanced recovery program at NNUH over the last 8 years. |
| National Vascular Registry | The 2017 Annual Report for the National Vascular Registry (NVR) was published in November 2017. This national audit is undertaken to support improvement in vascular services by comparing units on outcomes for the major vascular interventions. This audit found that the NNUH undertook the 2nd highest number ruptured acute abdominal aneurysm repairs in the United Kingdom with a mortality rate well below national average. The recommendations made by NVR in the report were thoroughly reviewed some areas for improvement were identified as well as areas where the Trust is doing exceptionally well. |
| National Joint Registry | The National Joint Registry (NJR) collects data on all hip, knee, ankle, elbow and shoulder replacement operations and monitors performance of joint replacement implants. The NJR published their 14th annual report in September 2017. This report outlined outcomes and activity up to December 2016. The audit found that the hip replacement and shoulder replacement revision rates at the Norfolk and Norwich University Hospital (NNUH) were below national average and that the knee replacement revision rate at NNUH was in line with national averages. The NJR 13-year results do suggest that whilst the cemented cup used at NNUH has excellent (10A*) results, there may be a comparable cup with slightly superior survival. In response to this audit the Orthopaedic Department is reviewing a possible change to hip replacement constructs in line with evidence presented in the national report. |

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| National Hip Fracture Audit | The aim of this national audit is to improve the care and secondary prevention of hip fracture. The National Hip Fracture Database (NFHD) published their annual report in September 2017. The report covered patients presenting in 2016. The report identified several areas of improvement for the Trust. Over the past 12 months the Orthopaedic, Anaesthetic and Older Persons Medicine (OPM) Departments have been involved in a number of initiatives to improve the management of hip fracture patients. These include the prioritisation of hip fracture patients on trauma lists to ensure more are operated on within the 36 hour target, introduction of anaesthetic standard operating procedure to help with mobilisation, and the appointment of another Ortho-Geriatric Consultant. |
| Major Trauma Audit - Trauma Audit and Research Network (TARN) | The Trauma Audit and Research Network (TARN) is a national database of trauma care. The audit was undertaken to benchmark national survival figures and trauma care against nationally accepted standards. Submissions to the audit are continuous. The National Clinical Report for the Trauma Audit and Research Network (TARN) was published on 24th November 2017. Findings were 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 outcome 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 published a report on Non-Invasive Ventilation (NIV) in July 2017. A gap analysis was carried out against NCEPOD recommendations and an action plan put in place. These included ensuring Acute NIV beds are protected to allow quick patient transfer and a database of all staff who are trained to prescribe or make changes to NIV treatment. The report on 'Each and Every Need' a review of the care received by patients aged 0-25 with a cerebral palsy on 8th March 2018. This is currently under review by the Trust and a gap analysis and action plan will be undertaken in relation to the recommendations. |
| Elective Surgery National Patient Reported Outcome Measures (PROMS) Programme 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 the Clinical Safety and Effectiveness Sub-Board monthly. The results are discussed and any actions required to improve the effectiveness of patient's are undertaken. PROMS scores are used to improve care for our patients. |
| 7 Day Services Assessment Audit | The Trust contributed data in March and September 2017. As a result of the last audit, a robust action plan is being put in place. This includes the formation of a quarterly Steering Committee, with Executive Board and Clinical Commissioning Group membership. This will provide additional focus on implementing the priority clinical standards for seven day hospital service. |

The reports of 85 local clinical audits were reviewed by the provider in 2017/18 and the Norfolk and Norwich University Hospitals NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided

| Audit and Survey Title | Results/Actions Taken / Planned |
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| Laboratory Service User - Feedback Audit | This audit was undertaken to ensure user satisfaction with the Laboratory Service for both Hospital and General Practitioner Users within the Eastern Pathology Alliance (EPA). The results highlighted some areas for improvement and as a result, an action plan was formulated to improve information sharing between all of the EPA sites. |
| Audit of Point of Care Testing (POCT) | This audit was undertaken to ensure that the results documented in the notes are accurate with those recorded using glucose meters. The results of the audit showed positive levels of compliance with how the Glucose results were recorded in the Patient notes and as a, it was felt that no immediate actions are required. |
| Audit of percutaneous transabdominal superior hypogastric plexus block prior to uterine artery embolization (new therapy) | This audit was undertaken as part of the process to introduce a New Therapy into the Trust for percutaneous transabdominal superior hypogastric plexus block prior to uterine artery embolization. The results demonstrated that the treatment did not raise any concerns and was signed off for use within the Trust. |
| Audit of Non-Medical Led Peripherally Inserted Central Catheter (PICC) Service. Using BARD Sherlock 3CG system provided at the bedside | This audit was undertaken as part of the process to introduce a New Therapy into the Trust for Non-Medical Led Peripherally Inserted Central Catheter (PICC) Service using BARD Sherlock 3CG system provided at the bedside. The results demonstrated that the treatment did not raise any concerns and was signed off for use within the Trust. |
| Audit of Weight Management Psychology Service | This audit was undertaken to ensure patient satisfaction with the Weight Management Psychology Service. The audit demonstrated that most patients attending the service found it worthwhile. Following the audit a drive to develop service provision was actioned. This included increasing the group capacity, development of psychoeducational groups and improving the sharing of information. |
| Audit of Trust Carers Passport | This audit was undertaken to assess the impact of the introduction of the Trust Carers Passport. The results demonstrated that the passport has had a very positive impact for carer experience. The audit did highlight some awareness issues by staff but these have since been addressed. |
| 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 identified that samples were not always repeated at the appropriate time interval. As a result of this audit, posters/ flow charts have been introduced to highlight current guidelines in Acute Medical Units (AMU) with further education for junior medical staff being undertaken. |

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| Audit to British Society of Gastroenterolgy (BSG) quality and safety indicators for endoscopic retrograde cholangio-pancreatography (ERCP) | This audit was undertaken to determine if the endoscopic retrograde cholangio-pancreatography (ERCP) service and provision at Norfolk and Norwich University Hospital (NNUH) reaches the standards set out in the British Society of Gastroenterology's document 'ERCP – The way forward, a standards framework'. The audit found that the service met all the standards set out in the framework. A re-audit will be carried out once the Gastroenterology Department has relocated to the new Quadram. |
| Older People's Medicine (OPM) Regional Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Audit | The audit was undertaken to determine if resuscitation was being appropriately discussed in patients admitted under Older People's Medicine and that resuscitation decisions were being communicated to patients' General Practitioners (GPs). The audit found if patients had potentially life limiting illnesses then appropriate decisions would take place. Since the audit, changes have been made to the electronic discharge letter template to aid the documentation of DNACPR decisions and communicating the decisions to GPs. |
| Do Not Attempt Cardiopulmonary Resuscitation Electronic Discharge Letter Documentation Audit | The audit was undertaken to identify if all resuscitation decisions were documented on electronic discharge letters (EDLs). The audit demonstrated an improvement from previous results, with 90% of patients having their resuscitation decisions documented. Following the audit it was agreed to send the 'Gold Standard EDL' lesson of the week at the start of every junior doctor rotation and to re-audit on an annual basis. |
| Haemodialysis vascular access audit | This audit was undertaken to ensure 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 was very close to national target of 80% long-term patients on correct vascular access. However the Trust fell short of the 60% target for new patients getting dialysis via a functioning arteriovenous fistula or arteriovenous graft. A Service Improvement Programme is in place in the Renal Department which should address the issues found in this audit. |
| Adequacy of Haemodialysis Audit | This audit was undertaken to ensure that all patients have an adequate level of haemodialysis. This audit found a small number of patients were not having enough dialysis. Following this audit individual plans were created for each patient. |
| Audit of adherence to national protocols; clinical reviews of staff in Newborn Hearing Screening Programme (NHSP) | This audit was undertaken to assess the clinical practice by Newborn Hearing Screeners and to ensure adherence to national and local protocols. The results found all screens were conducted according to protocols and in line with national guidelines and as a result of the audit no actions were required. |
| Documentation audit of adult hearing aid reassessment service | This audit was undertaken to ensure documentation had been completed for patients attending the hearing aid reassessment service. The results found a good adherence, with 84% of medical questions being completed. The ear conditions question was left blank and as a result of this audit the history form has been adapted to include prompts. |

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| Audit of Periorbital Cellulitis | The aim of this audit was to ensure that children presenting with Periorbital Cellulitis were managed according to the current guidelines. The results of the audit found that there was a good compliance against the current guidelines and a re-audit will be undertaken to ensure continued compliance. |
| Audit of robotic assisted colorectal resection using Da Vinci | This audit was undertaken to examine outcomes of using the new procedure, the Da Vinci Robot Assisted Bowel Resection. The audit collected outcome data from the first eight patients who underwent this procedure. The outcomes were reviewed by the Clinical Standards Group. The treatment did not raise any concerns and was signed off for use within the Trust. |
| Delay to discharge post major limb amputation Audit | The aim of this audit was to determine whether the pathway for patients with lower limb amputations followed recommendations by the Vascular Society. The audit found some areas for improvement. Following the audit a proforma has been produced to improve documentation. The pain team are involved on day one post operation, and antibiotic education is given to staff. |
| Re-audit of Infant Feeding | This audit was undertaken to ensure minimum standards in infant feeding and relationship building practices were achieved to protect maternal and infant physical and emotional health. The results found that of the 34 United Nations Children's Fund (UNICEF) Baby Friendly Initiative standards which were assessed, 26 were met. As a result of the audit, the Maternity Team at the Norfolk and Norwich University Hospital were re-accredited. |
| Audit of management of infants at risk of Hepatitis B | This audit was undertaken to evaluate if all babies at risk of Hepatitis B virus (HBV) were given the first vaccination dose as per Trust guidance. The findings demonstrated that all standards were complied with. |
| Audit of adherence to guidelines of postnatal management of antenatally detected hydronephrosis | This audit was undertaken to evaluate compliance to the Trust guideline on post-natal management of antenatal hydronephrosis (ANH). The findings confirmed the majority of babies were managed appropriately, however for babies born outside of the Trust data was limited so full assessment could not be made. As a result the guideline has been updated and a database of ANH will be instigated and maintained. |
| Audit of compliance to NICE Policy | 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 and appointment of Governance Managers for each Division is anticipated to improve compliance. A re-audit will be undertaken in 18/19. |
| Audit of compliance to Audit Policy | This re-audit of compliance to the Trust Clinical Audit Policy reviewed a random selection of 25 audit evidence folders from the 16/17 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 18/19. |

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| Head and Neck Cancer - Multidisciplinary Team Audit | This audit aimed to ensure good clinical practice and documentation around the treatment of Head and Neck patients. The results of this audit supported the development of an integrated care plan which was introduced into practice. |
| Audit of the Adherence to the Mental Capacity Act 2005 when working with People with Learning Disabilities<br><br>And<br><br>Audit of Reasonable Adjustments and Use of Learning Disability Resources | Results from these monthly audits were presented to the Caring and Patient Experience (CaPE) Sub-Board, as a part of the Learning Disability and Autism report. The frequency of audit enabled dynamic assessment of results and quick response to areas of change. Changes were made to both the strategic direction and operational processes of the Learning Disability Liaison Team as a result of the dynamic identification of trends |
| Audit of Patient Satisfaction in Adult Rehabilitation | The aim of this audit was to determine if service users were satisfied with the Adult Rehabilitation Service. The results demonstrated a high level of satisfaction with 100% of patients being very satisfied. No actions were required but a re-audit will be undertaken to ensure that patients remain satisfied with the service provided. |
| Audit of Patient Satisfaction in Paediatric Audiology | The aim of this audit was to determine if service users are satisfied with the Paediatric Audiology Service. The results demonstrated a high level of satisfaction. No actions were required but a re-audit will be undertaken in 12 months. |
| Audit of Patient Satisfaction in Vestibular Service | The aim of this audit was to determine if service users are satisfied with the Vestibular Service. The results of the audit demonstrated that 100% of patients were very satisfied with the overall service and as a result no actions were required. |
| Audit of Patient satisfaction in Bone Conduction Hearing Systems Service | The audit was undertaken to evaluate patient experience and satisfaction with the bone conduction hearing systems service. The results found that over 95% of patients were very satisfied with the service. A re-audit is planned for the following year to continue surveillance of the service. |
| Audit of Patient satisfaction of Vascular Access Practitioners-led Peripherally Inserted Central Catheter (PICC) line insertion | This audit was undertaken to ensure patient satisfaction when undergoing Peripherally Inserted Central Catheter (PICC) line insertion. The feedback was of a very high standard with 100% satisfaction throughout. |

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| Audit of Chaplaincy Provision for Patients in an In-Patient setting from Staff Perspective | This audit was undertaken to evaluate staff understanding of the role of the chaplains. The audit demonstrated that staff members felt very positive about the Chaplaincy Service and understood the role which it plays throughout the Trust. An action plan was put into place to maintain and enhance this understanding. |
| Audit of Patient Experience of Psychology Treatment within the Pain Centre | This audit was undertaken to ensure patient satisfaction with the Pain Management Psychology Service. The feedback was generally positive. As a result of the audit, patient information was improved with amendments being made to the clinical psychology leaflets in the clinic. Psychology expansion within the Pain Clinic is now also being explored. |
| Audit of Patient Feedback in Nuclear Medicine | The aim of this audit was to assess the patient experience of the Nuclear Medicine Department. The feedback was very positive with 97% of answers given rating each element of practice as either good or very good. It was felt that patient information could be improved so a review of information letters was undertaken to improve patient experience. |
| Audit of Patient Satisfaction of Speech and Language Therapy (SLT) Surgical Voice Restoration Service | The aim of this audit was to assess patient experience of the Specialist Voice Prosthesis Clinic, provided by the Specialist Head and Neck Speech and Language Therapy Team. The results were positive with high levels of satisfaction demonstrated. An action plan was formulated which included an investigation of outpatient parking facilities |
| Audit of Gastroenterology Unit Patient Experience 2017 | This audit of patient experience was undertaken as part of the requirements of the Global Rating Scale for Endoscopy. The findings demonstrated the service was in accordance with recommendations although keeping patients informed of delays was not always achieved. Patient views were very positive. The survey has led to the Unit Coordinator checklist being amended to include regular feedback of delays to patients. Chairs and coat hooks have been placed in changing areas. |
| Dementia Person Centred Care Audit | The audit was undertaken to establish the use of the 'This is Me' tool and dementia approved identifications for patients with dementia across the Trust. The audit demonstrated largely improved results compared to 2016/17. As a result of the audit, an Associate Physician in training is completing a service improvement project to assist improved use of the identification flower wristband and This is me. A Dementia Support Nurse is also now in post and applying extra vigilance of these elements. |
| Audit of satisfaction with the Big C centre information day | This audit was undertaken to evaluate patient and relative/carer satisfaction with the November 2017 Big C Centre information day. The findings from the evaluation suggest the day continues to be well received. The majority of visitors find the day useful and said it helped them understand and manage issues around cancer more effectively. 98% would recommend the day to others, which supports the continuation of the events. |

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| End of Life Care Audit | The audit was undertaken to assess the care of patients who were identified as dying, with regard to the appropriate and accurate prescribing of anticipatory medication and the use of the Palliative Care Rounding. The audit found there was a need to continue end of life education for all clinical staff, including communication skills training pertaining to end of life situations to support complex discussions. Specialist Palliative Care (SPC) Educators will continue supporting end of life care on wards and referrals to the SPC team will be promoted throughout the Trust alongside individualised patient care plans. |
| Audit of use of Cystic Fibrosis Identification Wristbands | This audit was undertaken to identify the opinion of service users with cystic fibrosis in regard to wearing coloured identification wristbands to aid the prevention of cross infection when in public areas. The results demonstrated that patients were keen on the idea. The department have purchased the wristbands and put them into use. |
| Stroke Carer's Audit | The aim of this audit was to determine if carers had all the information they needed to care for stroke patients when stroke patients were discharged from hospital. The results of the audit found that overall the carer's feedback was excellent. All stroke carers would have recommended the Early Supported Discharge (ESD) Team to friends and family. A re-audit will be undertaken to ensure standards are being maintained. |
| Audit of Nurse-led Breast Screening Patient Experience | The aim of this audit was to collect information about patient experiences following attendance at the Breast Screening Assessment Clinic at the Norfolk and Norwich University Hospital. The response rate was high at 65%. The survey had very positive feedback from the patients about the Breast Care Nurses, valuing the time they spent with the nurses when being given the results of their investigations and the support they provided. Some patients commented that they felt unprepared for further investigations such as biopsy. All assessment patients are now sent a more detailed biopsy leaflet before their appointment. |
| Grove Road Patient Experience Audit | This audit was undertaken to review patient satisfaction with regards to their experience of attending the Central Norwich Eye Clinic at Grove Road. The feedback demonstrated high levels of patient satisfaction. An action plan was put in place to improve the signage and the parking at the clinic. |
| Diabetes Eye Screening - Patient Satisfaction Audit | This audit was undertaken to review patient satisfaction with regards to their experience of attending Diabetes Eye Screening. The results were positive and demonstrated a high level of patient satisfaction and therefore no immediate actions were required. |
| Colposcopy Clinic Re-audit | This audit was undertaken in response the Colposcopy Quality Assurance Team Visit on the 28th September 2016, which recommended yearly audit. The audit reviewed the quality of the colposcopy service and patients' level of satisfaction with the clinic. Results highlighted that overall satisfaction was high although provision of verbal and written communication could be improved. As a result the NNUH Colposcopy Booklet is sent with every new colposcopy appointment and written information is available in the clinic for colposcopists to give following any discussions with patients. |

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| Audit of Out of Hours Discharges | The Out of Hours Discharge Audit reviewed the discharges of all patients discharged between the hours of 2300 and 0559 from 1st April 2017 to 31st May 2017 to their usual place of residence. 18 sets of notes were reviewed for in depth analysis. The results were reported to the Caring and Patient Experience Sub-Board. As result of the audit it will be ensured that Ensure that PAS is updated in 'real time' and accurately reflects the time the patient discharged from the ward and a review of the inclusion/exclusion for the audit amended. This audit will be part of the on-going audit programme in the future. |
| 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 |
| Quality Assurance Audits of Care Quality Commission Fundamental Standards | These audits were undertaken to evidence that the Trust is achieving the Care Quality Commission Fundamental Standards. Results have demonstrated that overall the percentage of 'Good' or 'Outstanding' standards remains high across the Trust at 90.2%. Local action plans have been put in place to address the few standards rated as requiring improvement. The audit programme will continue for 2018/19 |
| Audit of Red to Green Days | The aim of the audit was to demonstrate as part of the Red2Green initiative that the patient experience was enhanced due to an increased understanding of the identified four questions. The audit ran for one cycle which did demonstrate an increase in the patients understanding of the four questions compared to baseline data. All medical and surgical inpatients wards are now supporting the Red2Green initiative which will enable more sites for data to be collected in the future. An audit will now completed every three months and the results will be shared with the Patient Flow and Site Operations Group and appropriate actions 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. |
| Cardiology Local Safety Standards for Invasive Procedures (LocSSIPs) Audit | This audit was undertaken to determine if that all components of the Cardiology Local Safety Standards for Invasive Procedure (LocSSIP) and handover signatures are completed for patients undergoing a procedure in the Cardiology Catheter Laboratories. The audit found that not all checklists were fully completed. The results were fed back to staff in emails and posters. Spot checks of documents and a re- audit are planned. |
| Audit of compliance to LocSSIP (Local Safety Standards for Invasive Procedures) for Botulinum Toxin injections | This audit was undertaken to evaluate compliance to the completion of the local safety standard for botulinum injections. A pilot audit was undertaken which revealed the form was not in routine use. This has now been addressed and all clinicians have started to use the form. A re-audit will be undertaken in 2018/19. |

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| Medical Documentation Audit - Older People's Medicine | The audit was undertaken to ensure basic standards as set out in the Health Records Keeping Policy were being met. The audit found that improvements could be made. As a result a lesson of the week was sent and DNACPR decisions have become part of 'Red-to-Green' discussions. |
| Urology Documentation Audit | This audit reviewed several touch points on the patient journey including transfers between care areas. The majority of overall compliance for audited documentation was greater than 60% and key metrics within sections were greater than 80% compliant. The audit findings were presented at the Clinical Governance Meeting and circulated to clinicians to enable improvement. A re-audit will be undertaken in the future. |
| Audit of Ongoing Surveillance of Modified Early Obstetric Warning Score (MEOWS) | This audit was undertaken to evaluate compliance to recording and acting on the modified early obstetric warning score (MEOWS). The findings demonstrated compliance on completion and accuracy was stable but had dipped below 90% in quarter 3. Actions taken in response include revision of the MEOWS observation chart to include sepsis prompts and the introduction of sepsis stickers. "Champions" have been identified in each area to promote the use of MEOWS and collect the data. Education continues and a report has been submitted to the Clinical Safety and Effectiveness Sub Board. This is an ongoing audit. |
| Audit on children's early warning scores (CEWS) | This audit was undertaken to evaluate compliance to recording and acting on children's early warning scores (CEWS). The results demonstrated consistently good compliance to completeness and accuracy of CEWS, some areas for improvement were identified. Early warning scoring systems for children are complex and results have been discussed in Operational Meetings and the adoption of new national guidance to improve compliance is being discussed. |
| 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 5.2% did not have an EDL and 5.2% of EDLs did not mention C. *difficile* of these 3.4% 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. The audit will continue. |
| Audit of Manual Handling | A total of 278 Nursing and Patient Care Records were audited in June 2017. The audit demonstrated 88% 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. The Health and Safety Lead Advisor and Manual Handling Co-ordinator will be to continue to impress upon staff at Induction and update training the importance of completing this documentation for compliance and safety reasons. A re-audit will be undertaken in 2018/19. |
| Audit of Compliance to Discharge Policy | An audit of compliance with the completion of the Home Circumstances and Discharge documentation was undertaken in July 2017.The audit identified that our acute Trust processes to support discharges to long term environments could be improved. As a result, key actions have been identified and implemented. A re-audit again in 2018/19. |

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| Falls Documentation Audit | This audit was undertaken to ensure good clinical practice with regards to the completion of paperwork for patients at risk of falling as part of the Falls Steering Group review of the Falls Policy. An action plan was formulated which included changes to the Falls Policy. |
| 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 has been an overall improvement across all aspects. Annual audits will continue to be undertaken to review and ensure compliance. |
| Audit of Oxygen and Suction Equipment | The audit was undertaken to determine the process for checking emergency oxygen and suction equipment and to review the compliance of checks. The results found that there has been an overall improvement across all aspects. Annual audits will continue to be undertaken to review and ensure compliance. |
| Audit of Hypo Box Equipment | The audit was undertaken to determine the process for checking emergency glucose monitoring equipment and to review the compliance of checks. The results found that there has been an overall improvement across all aspects. Annual audits will continue to be undertaken to review and ensure compliance. |
| 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. Newer versions of the consent forms are being used across the Trust. Compliance of completion had improved but the audit identified improvement was still required for some specific elements of the documentation .An action plan was introduced which included a clinically-led review of the current Consent Policy. A re-audit will be undertaken. |
| Early Warning Score Observation Documentation, and Early Warning Score Response Audit | Quarterly audits of a small sample of triggering episodes were undertaken by the Clinical Care Outreach Team (CCOT), to review the response to Early Warning Score (EWS) triggers ≥4, by adult wards. Real time feedback was given to ward staff by the CCOT when undertaking these audits to ensure any omissions were reviewed by senior nursing staff. The results are reported to the Recognise and Respond Committee, Clinical Safety and Effectiveness Sub-Board and the Matrons dashboard for discussion and any actions recommended are implemented. An amendment to the current auditing process is being undertaken. |
| Handover of Care Audit | This audit was undertaken to ensure that patients being transferred in to Radiology have appropriate documentation and assessments completed. The audit highlighted that compliance with these could improve. An action plan included improving awareness of requirements amongst staff and the introduction of incident reporting for cases not meeting the criteria. A re-audit will be undertaken on a monthly basis in the 2018/19 cycle. A larger annual audit will also be completed. |

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| Audit of Sepsis Commissioning for Quality and Innovation (CQUIN) element | This audit is undertaken to determine compliance with the National Sepsis CQUIN. On-going actions undertaken to continue to improve compliance include; the implementation of an electronic sepsis screening tool that will be automatically triggered when a patient in the Emergency Department with a high Early Warning Score presents. This process went live at the beginning of Quarter 2 and has improved Emergency Admissions Sepsis Screening through the ED to near 100%. The Sepsis Lead Consultant has delivered Sepsis Training Sessions to new medical staff and on both the FY1 and FY2 education program in August and September 2017. The Critical Care Outreach Team (CCOT) and Hospital @ Night (H&N) team are continuing to work with the Sepsis Lead to improve utilisation of the Inpatient Sepsis Screening Tool by requesting the inpatient ward nursing staff to use the tool as a necessary component of a referral to both the CCOT and H&N teams. The NNUH sepsis processes are now routinely covered during the NNUH ALERT (Acute Life-Threatening Event Recognition and Treatment) courses which run for NNUH staff and medical students throughout the year. A business case has been approved for a 'Sepsis Audit and Improvement Officer to assist the Sepsis Lead with regular ward level audit and early feedback, ward level sepsis education and sepsis pathway development. The Inpatient Sepsis Emergency 2222 Pathway has seen increased reflecting improved awareness of sepsis at ward level. The Sepsis Lead clinician has established a working group to evaluate current electronic patient observation systems with an aim to gain approval for procurement and implementation across all inpatient areas at the NNUH during 2018. The audit will continue. |
| Re-audit of unplanned admissions from Day Procedure Unit | This audit was undertaken to identify unplanned patient admission rates following day surgery. The results found that the unplanned admission rate during this re-audit period improved to 1.1% (from 1.5% in 2012) This remains within expected Royal College of Anaesthetists (RCoA) standard. As a result of the audit no improvements were required. The audit will be repeated in a year's time to continue to monitor unplanned admission rate from day surgery. |
| Audit of stress ulcer prophylaxis in adult critically ill patient | This audit was undertaken to determine if the Trust Guideline for Stress Ulcer Prophylaxis in Critically Ill Patients was followed. The results found that 100% of patients on intermittent positive pressure ventilation (IPPV), without established enteral feed, received stress ulcer prophylaxis. 95% of patients with specific indications received stress ulcer prophylaxis. The results were presented at the Critical Care Complex (CCC) Clinical Governance meeting. As a result of the audit the guidelines have been amended and dual antiplatelet as an indication for stress ulcer prophylaxis has been added. |
| Audit of the quality of the undertaking of World Health Organisation checklist within theatres | This audit is undertaken to assess the level of compliance and involvement in carrying out the World Health Organisations surgical safety checklist in theatres. The audit collects information on teams' involvement with each stage of the checklist process. Reports of the audit are distributed to Senior Theatre Staff for action on a monthly basis. |
| Re-audit of child safeguarding training | This audit was undertaken to identify if safeguarding children training increases participants knowledge in recognising and appropriately acting upon safeguarding issues. All course participants rated their knowledge on specific criteria pre and post workshop. The results demonstrated participants felt their knowledge and understanding post workshop had increased. The majority of participants scored 8-10 for most categories (a score of equal to or greater than 8 is considered ideal for confirming the workshop's positive impact). The mean score for usefulness of the workshop was 9.1 out of 10. No improvements to the training programme were recommended. A re-audit will be undertaken. |

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| Audit Monitoring of Compliance to Trust Hand Hygiene Standards | 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 97%, doctors 95% and others 97%. Following the audits, results were 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. Results are also published on the Nursing Dashboard. Audits will continue. |
| Audit and Surveillance of compliance to High Impact Interventions | 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 86%, Urinary Catheters 91%, Central Venous Catheters 92%, prevention of Ventilator Associated Pneumonia 99%, Renal Dialysis catheters 100% and prevention of Surgical Site Infection 79%. 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 ongoing to encourage ownership and make changes in practice particularly in relation to consistent documentation. These audits will continue in the 2018/19 audit cycle. |
| Audit Surveillance of Central Lines Infection Rate | 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 the rate was 0.41 per 1000 line days and in quarter 2 it was 0.19 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. These audits will continue in the 2018/19 audit cycle. |
| Surveillance Audit of Surgical Site Infection (SSI) | 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 were 7.1% in quarter 1 2017/18 and 10.8% in quarter 2. SSI rates following C section have decreased from 5.5% in quarter 1 to 2.4% over this period. These audits will continue in the 2018/19 audit cycle. |
| Audit of meticillin-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 93% and the emergency screening average is 97% for the Trust. These audits will continue in the 2018/19 audit cycle. |
| 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 34% of the side rooms were used for Infection Prevention and Control reasons. A priority table for isolation is available in the Isolation policy. A re-audit will be undertaken in the 2018/19 audit cycle. |

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| 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 and signature in line with the Trust guideline for Cleaning and Disinfection in the hospital. The audit found an average of 95% compliance. 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 reported on the Nursing Dashboard. These audits will continue in the 2018/19 audit cycle. |
| 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. A weekly meeting is held to discuss the grade 2 pressure ulcers that have occurred in hospital. It is attended by the ward staff concerned in the pressure ulcer, Lead Tissue Viability Specialist and Senior Matron. The grade 3 pressure ulcer, Root Cause Analysis are discussed at ward level with the ward teams, Divisional Matron, Matron of the area and Lead Tissue Viability Specialist. 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 Clinical Incidents, Complaints and Claims | Clinical incidents, complaints and claims have been reviewed alongside each other throughout the year in order to identify themes. Information resulting from these reviews has been disseminated to staff via a specific Organisation-Wide Learning publication and within reports to the Clinical Safety and Effectiveness Sub-Board. Opportunities to improve communication with our patients have been a consistent theme from reviews of complaints. There have been no significant themes between clinical incidents, complaints and claims identified. |
| Audit of Duty of Candour | This audit is undertaken to assess Trust compliance with Duty of Candour (DoC) statutory obligations. A monthly report is submitted to the Clinical Safety and Effectiveness Sub-Board. The audit found that specialities were not routinely following up conversations held with patients in writing. As a result of the audit clinicians are requested to add all Duty of Candour letters to the electronic template, if a copy is not to be filed in the patient notes. The electronic template is a formal repository for patient notes and should be seen as an additional resource when clinical notes are reviewed. |
| Audit of Trust Quality Priorities | 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 consequently data collection for some elements has been incomplete. Some extremely aspirational targets have also not been achieved. Quality Priorities for 2018-19 will be set in line with some of our challenges and will be reviewed and agreed through consultation with Governors and the Trust Board. |

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| Health Records Management | 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. For the ward bed state audits, compliance was much improved. Often the delay in receipting case notes to the ward seemed to occur on overnights and weekends when ward clerk cover is limited. 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 external safety alerts, recalls, inquiries, investigations or reviews | A monthly report is submitted to the Clinical Safety and Effectiveness Sub-Board, to provide assurance on the assessment of and action taken in respect of safety alerts and recall notices received via the Department of Health's Central Alert System. Through these monthly reports, the Trust has been assured that all appropriate action is taken where the alert is assessed as being relevant to the organisation |
| Audit of Transfer Guidelines and Clinical Handover of Care | The process for auditing clinical handover within the Trust was changed from an annual audit to a more focused 3 monthly review of incident reports for issues related to transfers. This is themed to allow for targeted further actions and auditing if required. Datix incidents were reviewed on a quarterly basis and were then reported quarterly to the Clinical Safety and Effectiveness Sub-Board for discussion and any actions recommended implemented. |
| 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 the Workforce Sub Board and quarterly to Health and Safety Committee. It has been noted that the reasons for work related stress have broadened this year. There have continued to be concerns from staff surrounding the relationship elements although this has seen an increase in colleague to colleague relationships rather than line manager to colleague issues. Concerns regarding the demands of people's roles have been raised in this last year as concerning and a trend identified within the specialist nurse role. As far as peoples role is concerned, a new area of concern is the impact on staff dealing with a 'difficult shift' has been cited, continued concerns regarding change, future changes to role or the impact of ward closures. The Trust has supported the Health and Wellbeing Department in the recruitment of some preventative resource. A Health and Well Being Assistant Practitioner commenced in post in January 2018 and this individual will be working with departments and training staff in preventative mental health initiatives. |

## Participation in research and development

The number of patients receiving relevant health services provided or sub-contracted by the Norfolk and Norwich University Hospitals NHS Foundation Trust in 2017/18 that were recruited during that period to participate in research approved by a research ethics committee was 3,228 (5,438 in 2016/17).

## Commissioning for Quality and Innovation (CQUIN)

A proportion of the Norfolk and Norwich University Hospitals NHS Foundation Trust's income in 2017/18 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.

The agreed measures for the Trust are as follows:

1. Improving staff health and wellbeing
2. Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis)
3. Improving services for people with mental health needs who present to A&E
4. Offering advice and guidance
5. NHS e-Referrals (2017/18 only)
6. Preventing ill health by risky behaviours – alcohol and tobacco (2018/19 only)
7. Supporting proactive and safe discharge
8. Reinforcing the critical role Providers have in developing and implementing local STPs
9. Clinical Utilisation Review (NHS England Commissioning)
10. Hospital Pharmacy Transformation and Medicines Optimisation (NHS England Commissioning)
11. Nationally standardised Dose banding for Adult Intravenous Anticancer Therapy (SACT) (NHS England Commissioning)

Further details of the agreed goals for 2017/18 and for the following 12-month period are available electronically at https://www.england.nhs.uk/nhs-standard-contract/cquin/cquin-17-19/.

The monetary value of CQUIN available to the Norfolk and Norwich University Hospitals NHS Foundation Trust in 2017/18 is £9.581 million conditional on achieving goals.

The monetary value of CQUIN available to the Norfolk and Norwich University Hospitals NHS Foundation Trust in 2016/17 was c£9.2 million as reported in the 2016/17 Quality Report

## 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 2017/18.

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.

## NNUH Oesophago-gastric Cancer Unit named as one of the best in UK in recent national audit

The Oesophago-gastric Cancer Centre at the Norfolk and Norwich University Hospital is celebrating results from the recent National Oesophago-gastric Cancer Audit (NOGCA), which show the Trust to have maintained an ‘excellent profile’ for their services offered to patients.

Most notably, NNUH reported a 30 day mortality percentage of 0% and the shortest length of stay for patients after major complex operations for cancer of the oesophagus compared with every major cancer centre in the country. This means we have one of the quickest recovery rates following this type of surgery for our patients in the country.

In addition, the Trust continues to perform the highest percentage of Minimally Invasive Oesophagectomy (MIO) in the UK, a procedure to remove part of the oesophagus (gullet). The national average for minimally invasive approaches to oesophagectomies is 38%. NNUH performs at around 95%.

Mr Edward Cheong, Upper GI Cancer Lead and Consultant Oesophago-Gastric Surgeon said: “The results from this recent audit reflect the enormous dedication and commitment from the entire Oesophago-gastric Cancer team at the hospital. We are extremely proud of the work we do and it is fantastic to be independently recognised for the quality of our service.”

NNUH is rated as one of the top units in the country for treating Oesophago-Gastric Cancer and one of the few units in Europe to perform totally minimally invasive oesophagectomy whereby the entire operation is done by keyhole surgery (laparoscopic and thoracoscopic oesophagectomy). The keyhole or laparoscopic surgery is less traumatic to the body allowing the patient to recover significantly faster.

## Data Quality

The Norfolk and Norwich University Hospitals NHS Foundation Trust submitted records during 2017/18 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

| 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

The Norfolk and Norwich University Hospitals NHS Foundation Trust Information Governance Assessment Report overall score for 2017/18 was 76% and was graded Red – Not satisfactory.

## Clinical Coding error rate

The Norfolk and Norwich University Hospitals NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2017/18 by the Audit Commission.

## Improving Data Quality

The Norfolk and Norwich University Hospitals NHS Foundation Trust will be taking the following actions to improve data quality 2017/18

**18 Weeks Referral to Treatment**

As part of the Trust's internal data quality spot check audit programme the Data Quality team will undertake a rolling programme of 18 week RTT Spot Checks. The audit will include all specialities with a view to ensure data is accurate, valid, reliable, timely, relevant and complete on the Patient Administration System (PAS). The audit's main focus will be on the data accuracy of those patients on an 18 Week Referral to Treatment (RTT) pathway in compliance with the Trust's, Patient Access Policy, Information Governance & National Guidance for 18wk RTT Rule Suite.

The 18 week RTT pathway is about improving patient's experience of the NHS – ensuring all patients receive high quality elective care without any *unnecessary* delay. Managing a patient through their pathway involves accurate data capture at each step along the way thus providing: the clinicians with an accurate 18 week status for their patients and administrative staff with potential evidence of any bottlenecks in the pathway which may be due to process delay.

**18 Week Audit Programme 2017/18 results**

- 26 Audits were completed
- 17 Specialties improved on 2016/17 results
- 4 Specialities achieved the Trust target of 90%
- 2 Specialties achieved the same results as 2016/17
- 6 Specialties decreased in performance

The Trust reviewed the results and patterns of errors from the 2017/18 audit programme and has used the information to plan coaching and robust communication over the next 12 months.

The Trusts holds monthly Referral to Treatment Operational meetings (RTTOMG) attended by Admin Leads. At this forum best practice is shared and issues raised throughout the previous month are discussed, audit results are shared to date and advice and guidance is provided as required on multiple subject matters.

The 18 week eLearning forms part of core competency for staff who manage 18 week patient pathways, noncompliance is flagged via a report. This process ensures we keep ourselves updated and informed.

**Secondary Uses Service (SUS) Dashboard**
SUS is the single, comprehensive repository for healthcare data in England which enables a range of reporting and analyses to support the ***NHS*** in the delivery of healthcare services.
The SUS+ Data Quality Dashboards (DQDs) monitor and drive improvements in the quality and completeness of SUS+ data. They allow organisations to assess their own data in SUS+ to ensure that it is comprehensive and compliant with data standards. They also show a comparison to National and Region level data.
The NNUH reviews the data and will work collaboratively to enhance performance in multiple areas – please see example below of on-going work to ensure NHS numbers are recorded and used on PAS and Key Systems.

**NHS Number**
The NNUH works collaboratively to ensure the patients NHS number is recorded on PAS and other Key Systems used within the Trust.
The General Principles as summarised on NHD Digital are:
Find it, Use it, Share it
The NNUH has its own NHS Number Policy to assist staff with the robust management of NHS numbers.
The SUS Dashboard is used as a bench marking tool.
We use some of the data items included within the SUS Dashboard to form part of the Key System Audit criteria and again we can work together to enhance performance.
The NNUH's performance is above the national average for Admitted Patient Care, Outpatient Care and A&E (the only exception is Data Item – Patient pathway ID on APC & OPC)

## Learning From Deaths

In support of this section the Trust draws the reader's attention to the our public Corporate and Clinical Governance web page, which details the Trust's Responding to Patient Deaths Policy and supporting information: http://www.nnuh.nhs.uk/about-us/healthcare-and-governance/

During 2017/18 3177 of Norfolk and Norwich University Hospitals NHS Foundation Trust patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period: 933 in the first quarter; 995 in the second quarter; 1189 in the third quarter; 1188 in the fourth quarter.

By 1st April 2018 1545 case record reviews and 13 investigations have been carried out in relation to 4365 of the deaths included above.

In 13 cases a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was:

532 in the first quarter; 479 in the second quarter; 358 in the third quarter; 176 in the fourth quarter. For Q4 and to a lesser extent for Q3 there will be more reviews coming through as the teams catch up in April, May and June. These latter two quarter figures therefore are not complete.

13 representing 0.41% of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient.

In relation to each quarter, this consisted of: 5 representing 0.5% for the first quarter; 5 representing 0.5% for the second quarter; 2 representing 0.17% for the third quarter; 1 representing 0.08% for the fourth quarter.

These numbers have been estimated using the Trust Potentially Preventable death review process. The Structured Judgment Review Method as recommended by the National Mortality Case Record Review programme is currently being implemented as the methodology for this process.

Learning from case record reviews has highlighted appropriate response to acute deterioration or to clinically significant results; Early Warning Score monitoring; Fluid balance and electrolytes management; lack of senior review; resuscitation status documentation and inappropriate resuscitation team calls; and medication issues – anticoagulants.

As a consequence of the learning gained from record reviews and investigations, the Trust has made the following actions: Clinical Governance focus on Early Warning Score and response on Sepsis 6; Acute Kidney Injury (AKI) group formed with an associated business case for AKI services in development; focus on senior review through SAFER and the 7 day survey; a business case is being developed for emergency observation services; the overall redesign of the Quality and Safety team to increase family liaison; a Medical Examiner business case is being developed; Neck of Femur Fracture Excellence Together working group

With respect to the impact these actions are having, regarding the Neck of Femur Fracture Excellence Together working group, from Nov 16- April 17 the average time to theatre for neck of femur (NOF) patients was 32 hours, this has progressively decreased every month to 28 hours for Feb 2018 (National Hip Fracture database data)

Overall from February to July 2017, 30 day mortality averaged 9%, significantly above the national average of 7% which led to the NNUH being identified as a national outlier. This has now decreased to 5.9 % for the month of Feb 2018.

364 case record reviews and 9 investigations completed after 1st of April 2017 which related to deaths which took place before the start of the reporting period.

9 representing 0.2% of the patient deaths before the reporting period, are judged to be more likely than not to have been due to problems in the care provided to the patient. This number has been estimated using the Potentially Preventable death review as per local Trust process. The Structured Judgment Review Method as recommended by the National Mortality Case Record Review programme is currently being implemented as the methodology for this process.

22 representing 0.5% of the patient deaths during 2016/17 are judged to be more likely than not to have been due to problems in the care provided to the patient.

# Reporting against core indicators

Please note that the guidance 'Detailed requirements for quality reports 2017/18' published by NHS Improvement instructs that 'since 2012/13 NHS foundation trusts have been required to report performance against a core set of indicators using data made available to the trust by NHS Digital' (p15). Currently no such data is available to Trusts through NHS Digital for the year 2017/18. However, so as to offer as detailed and transparent a picture of Trust performance as possible, what follows is the best information available at the time of writing. Please note that previous reporting years, 2016/17 and 2015/16, are as published by NHS Digital.

**SHMI value and banding**

| Indicator | 2017/18 NHS Digital not available | | | | NNUH 16/17 | NNUH 15/16 |
|---|---|---|---|---|---|---|
| | NNUHFT (Self-reported Oct 2016-Sept 2017) | National Average | Best performer | Worst performer | | |
| SHMI value and banding | 1.066 Band 2 | No data yet published | No data yet published | No data yet published | 1.065 Band 2 | 1.056 Band 2 |

No data published for 2017/18
Location: https://indicators.hscic.gov.uk/webview/ > SHMI indicator > Download September 2017 publication > SHMI data at trust level, select from value and banding columns
**Current version uploaded: Mar-18 (contains only data for Oct16 – Sep17). // Next version due: Jun-18**

**% of patient deaths with palliative care**

| Indicator | 2017/18 NHS Digital not available | | | | NNUH 16/17 | NNUH 15/16 |
|---|---|---|---|---|---|---|
| | NNUHFT (Self-reported July 2016-June2017) | National Average | Best performer | Worst performer | | |
| % of patient deaths with palliative care coded at either diagnosis or specialty level for the reporting period | 22.3% | No data yet published | No data yet published | No data yet published | 22.1% | 19.5% |

No data published for 2017/18
Location: https://indicators.hscic.gov.uk/webview/ > SHMI indicator > Download September 2017 publication > SHMI contextual indicators > Palliative care coding > Percentage of deaths with palliative care coding
**Current version uploaded: Mar-18 (contains only data for Oct16 – Sep17). // Next version due: Jun-18**

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 | 2017/18 NHS Digital not available | | | | NNUH 16/17 | NNUH 15/16 |
|---|---|---|---|---|---|---|
| | 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 | 0.099 | 0.095 (Apr-Sep) |
| Patient reported | No Trust | No Trust | No Trust | No Trust | 0.099 | 0.088 |

| | | | | | | |
|---|---|---|---|---|---|---|
| outcome scores for varicose vein surgery | data yet published | data yet published | data yet published | data yet published | | (Apr-Sep) |
| 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 | 0.495 | 0.421 (Apr-Sep) |
| 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 | 0.259 | 0.293 (Apr-Sep) |

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-17 // Next version due: Sep-18**

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 | 2017/18 (NNUH reported based on the NHS Outcomes Framework Specification) | | | | NNUH 16/17 (NNUH Reported) |
|---|---|---|---|---|---|
| | NNUHFT | National Average | Best performer | Worst performer | |
| 28 day readmission rates for patients aged 0-15 | 12.43 | No data published | No data published | No data published | 12.58 |
| 28 day readmission rates for patients aged 16 or over | | No data published | No data published | No data published | |

Please note that this indicator was last updated in December 2013 and future releases have been temporarily suspended pending a methodology review.
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 NHS Digital | | | | NNUH 16/17 | NNUH 15/16 |
|---|---|---|---|---|---|---|
| | NNUHFT | National Average | Best performer | Worst performer | | |
| Trust's responsiveness to the personal needs of its patients during the reporting period. | 68.2 | 68.1 | 85.2 | 60 | 68.2 | 68.7 |

Location: https://indicators.hscic.gov.uk/webview/ > 4.5 Responsiveness to Inpatients' personal needs > CCG OIS - Indicator 4.5
**Current version uploaded: Sep-17 // Next version due: Sep-18**

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 | 2017 NHS Staff Survey Results | | | | NNUH 16/17 | NNUH 15/16 |
|---|---|---|---|---|---|---|
| | 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. | 76% | 70% | 86% | 47% | 76% | 71.5% |

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 | 2017/18 (Trust Reported) | | | | NNUH 16/17 | NNUH 15/16 |
|---|---|---|---|---|---|---|
| | 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 | 98.94 | No data yet published | No data yet published | No data yet published | 99.31 (Oct-Mar) | 91.2% (Apr-Dec) |

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 NHS Digital | | | | NNUH 16/17 | NNUH 15/16 |
|---|---|---|---|---|---|---|
| | NNUHFT | National Average | Highest | Lowest | | |
| 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 | 11.97 | 13.19 | 82.72 | 1.17 | 11.97 | 16.11 |

Rates found for financial years of 2015/16 and 2016/17. No data for 2017/18
Location: https://indicators.hscic.gov.uk/webview/ > NHS Outcomes Framework - Indicator **5.2.ii**
**Current version uploaded: Aug-17 // Next version due: Aug-18**

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 NHS Digital | | | | NNUH 16/17 | NNUH 15/16 |
|---|---|---|---|---|---|---|
| | NNUHFT | National Average | Highest | Lowest | | |
| Number and rate of patient safety incidents per 100 admissions | 41.6 | 40.95 | 70.4 | 22.1 | Q1/2 Rate 41.1 (n7276) Q3/4 Rate 42.1 (7076) | 21.3 rate No:7,297 (Apr-Sept) |
| Number and percentage of patient safety incidents per 1000 admissions resulting in severe harm or death | 0.065 | 0.16 | 0.565 | 0.01 | Q1/2 Rate 0.07 (n12) Q3/4 Rate 0.06 (n10) | 0.12 No: 9 (Apr-Sept) |

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

**Current version uploaded: Nov-17 // Next version due – May-18**

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.

# Other Information

## Patient Safety – Serious Incidents (SIs)

Please refer to pages 20

## 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 six never events during the period covered by this Quality Report (four in 2016/17).

- Insertion of wrong implant – stent
- Retained Swab post surgery
- Retained Swab post delivery
- Wrong site surgery
- Transfusion of incompatible blood product (Declared in March 2018. Still under investigation)
- Insertion of wrong tunnelled line

Thorough *Root Cause Analysis (RCA)* was carried out on all events, and the learning points were disseminated to the teams through Organisation Wide Learning (OWL) bulletins. These learning points included the following:

- A standardised procedure for identifying and checking correct prosthesis / implant for interventional procedures in a non-theatre setting
- Distractions during swab checks must be limited to enable the team to fully focus; a 'silent cockpit' principle should be embedded. (This was a feature in 2 cases).
- Unnecessary swabs removed from the sterile packs used in delivery
- Environment in Delivery suite modified to minimise unnecessary distractions
- Doctors' bleeps should be held by another member of the team whilst theatre cases in progress.
- Checking procedures to identify surgical site identification reviewed and strengthened
- Environment in Interventional Radiology no longer sufficient to meet demand. Business case for new unit with the most advanced level equipment in progress.

Review of IT systems within Blood Transfusion to introduce a system where it is not possible to issue ABO incompatible products.

## Patient Safety – Duty of Candour

Please refer to page 20

## Patient Safety – Care Quality Commission (CQC) ratings and action plan

The Care Quality Commission (CQC) last inspected our Trust in April 2017 and published their report in August 2017. 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 August 2017 inspection report

| Warning Notice Item | Overall Task Status | Update |
|---|---|---|
| The Children's emergency department was not suitable for the service provided, the area was not large enough to accommodate the potential number of service users using the department at any one time, and there was no High Dependency care service outside of the department | **Completed** | • Revised footprint designed by Paediatric ED Lead Consultant and ED Paed Team.<br>• Children's ED created in accordance with expanded specification to up to 14 cubicles and HDU facilities.<br>• A dedicated children's HDU environment has been created within new ED environment.<br>• Final touches of furniture and artwork being signed off W/B 12th March |
| The Emergency department premises were not fit for purpose; the layout was widely spread, the area was not large enough to accommodate the potential number of service users using the department at any one time, and multiple areas within the department were not being used as intended or safely | **Ongoing** | • OPED launched in December 2017 and Children's ED relocated to expanded footprint.<br>• CDU fully operational in temporary location, with design for permanent solution signed off by ED Senior Leaders team. Construction phase provisionally planned to start April 2018.<br>• Call Bell system installation complete, commissioning completed 8th March 2018 . New panic alarm strips in ED quiet room now all functional.<br>• Revised SOPs have been produced, ratified and made available to all staff.<br>• Tannoy / PA system to be installed across all ED areas end of March 2018 to improve communication and emergency response. |
| There was a lack of safe, and secure where necessary, environments for those living with serious mental health concerns including those that were detained under the mental health act (1983) | **Ongoing** | • Specification for works to address safety and security concerns have been agreed and completed across most areas. MH cubicle, and quiet rooms in ED and Children's ED completed Feb 2018<br>• Mental Health Board, chaired by Medical Director, set up and initial meetings held.<br>• Interim Mental Health Risk Assessment completed on 01/02/2018, whilst awaiting completion of all estate works.<br>• Works commenced on new MH spec isolation unit in old Paeds ED area due for completion 30th March 2018 |
| The healthcare records of service users were not always accurate and complete in relation to care | **Completed** | • Reminders have been circulated to all ED staff in relation to the importance of the accuracy of patient documentation. Process for audit of documentation standards has been agreed and audits have |

| | | |
|---|---|---|
| and treatment provided to the service user, and of decisions taken in relation to the care and treatment provided | | commenced.<br>• Bespoke training sessions have been provided by the Trust DOLS/MCA matron on completion of documentation including new mental health triage tool and capacity assessments.<br>• Re-Audit of MH documentation to be completed 13th March after educational work and further training |
| Staff were not able to demonstrate a sufficient understanding of the mental capacity act (2005) nor that they were working within the requirements of this act | **Completed** | • Training has been provided by the Trust Mental Capacity Act (MCA) lead within the Emergency Department. Training ongoing with rotation of Junior ED staff into the department. Investigating mandatory training requirements of junior Drs who will rotate through ED to increase compliance.<br>• Compliance is being measured and this is now a standing item on the ED Governance Meeting agenda (recent reduction in compliance with junior Dr changeover – most do not have have MCA/DOLS as training requirement on ESR – being investigated). |
| Systems & Processes were neither properly established nor operating effectively to ensure preventing and controlling the spread of infections, including those that are healthcare associated | **Completed** | • Weekly IP&C meetings set up with ED Managers and Sarah Morter to review progress against agreed plans. Standard infection control notices have been updated to specify cubicle use and have been put up within ED.<br>• SOP for IP&C/Cleaning processes has been revised, ratified and uploaded to Trust central documentation.<br>• Seating is constructed from intervene fabric that is waterproof, washable and anti-microbial.<br>• Cleaning logs are being audited to ensure the regimented cleaning schedule is being adhered to.<br>• Recent audits of compliance with transcribing IP&C PAS alerts onto ED patient documentation has demonstrated continued improvement. Audited monthly<br>• Minor works request outstanding to replace 1 sink in ED which is not standard handwashing sink (risk assessment complete)<br>• Minor works in place to add wall brackets for sharps bins, and increase number of alcohol gel dispensers in ED escalation corridor after recent external IP&C inspection highlighted areas for improvement. |

| CQC Must Do Action | Associated QIP SMART Action |
|---|---|
| The Trust must ensure that medication is stored in line with Trust policy & staff record medication refrigeration temperatures. | Review and enforce requirements and processes for the safe storage of medicines, including an options appraisal regarding technical solutions in relation to monitoring of temperatures. |
| The Trust must ensure that resuscitation equipment in wards, theatres and other areas is checked in accordance with Trust policy. | Review and enforce requirements and processes for resuscitation equipment checks. |
| The Trust must ensure that patient records are stored securely. | Review and enforce requirements and processes for the safe storage of medical records. |
| The provider must ensure staff complete appropriate mandatory training including safeguarding training to the required level for their job role. | Review and amalgamate existing policies regarding mandatory training, to provide explicit expectations regarding obligations for each staff group and the most effective method of achieving this. |

## Clinical Effectiveness – Achieving cancer referral and treatment times

| | National Standard | Q1 1718 | Q2 1718 | Q3 1718 | Q4 1718* |
|---|---|---|---|---|---|
| **GP 2WW** | 93% | 92.99% | 92.27% | 96.11% | 95.52% |
| **Breast Sympt 2WW** | 93% | 97.66% | 98.30% | 98.27% | 90.32% |
| **31 Day First Treat** | 96% | 97.91% | 99.49% | 99.19% | 97.91% |
| **31 Day Subs ACD** | 98% | 100.00% | 100.00% | 100.00% | 99.29% |
| **31 Day Subs RT** | 94% | 97.93% | 98.18% | 98.99% | 98.00% |
| **31 Day Subs Surgery** | 94% | 96.29% | 98.70% | 96.38% | 89.76% |
| **62 Day GP** | 85% | 76.54% | 87.57% | 84.25% | 77.93% |
| **Reallocated 62 Day GP** | 85% | 76.54% | 88.89% | 85.36% | 80.49% |
| **62 Day Upgrade** | | 62.93% | 61.29% | 65.04% | 53.95% |
| **62 Day Screening** | 90% | 86.11% | 88.62% | 86.82% | 90.51% |
| **62 Day Breast Sympt** | 85% | 100.00% | 100.00% | 100.00% | 50.00% |

*Source: NNUH data, national definitions used*

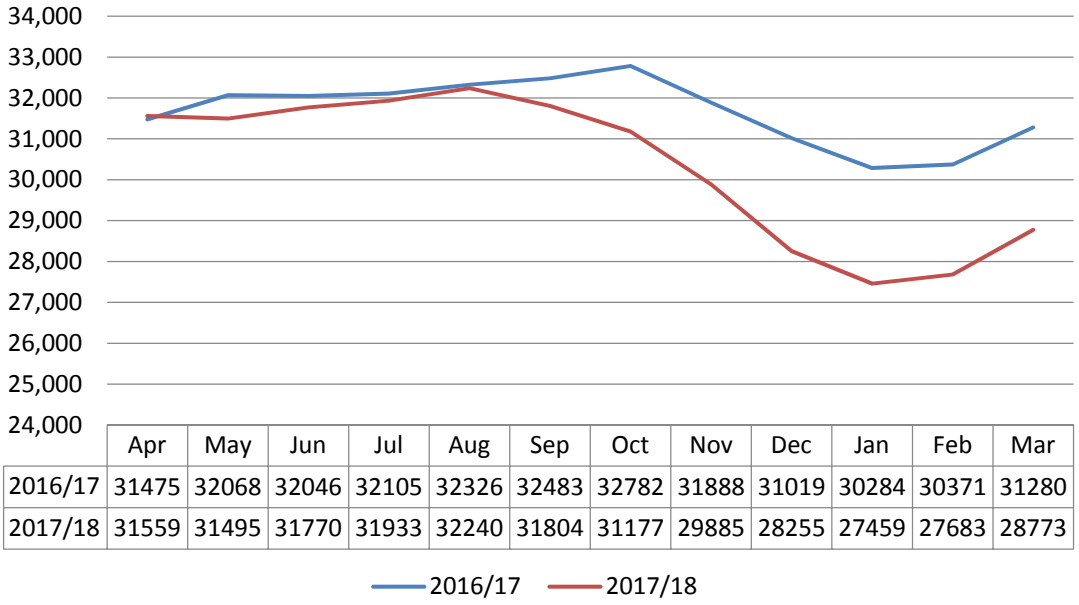
**Quarter 4 2017/18 data is currently provisional*
*Please note that reallocations have been applied in line with the East of England Cancer Alliance policy, and are only available from August 2017 onwards*

## Clinical Effectiveness – 18 week RTT waiting times

In line with National reporting, 2017/18 has seen congestion from increased non elective admissions, particularly over the severe Winter period and complexity of presentation and conversion rates have increased. There has been a significant acuity and rise in admissions for Respiratory and attendees in the age group 70-79.

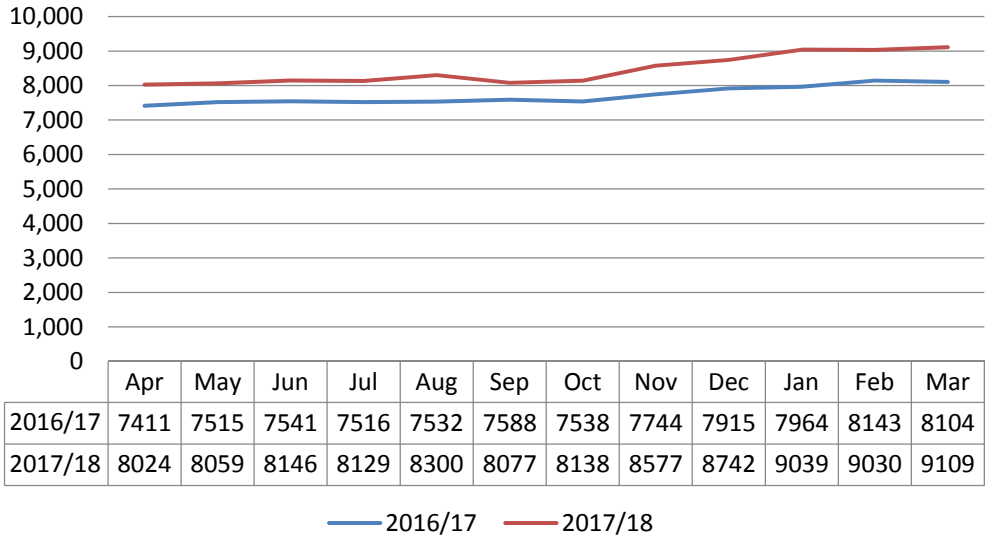
These factors have impacted on the Trusts 18 week referral to treatment performance, however recovery trajectories have been remodelled to take into account revised operational plan and impact of outpatient/daycase/inpatient procedures cancelled during adverse weather.

# Non-Admitted Waiting List



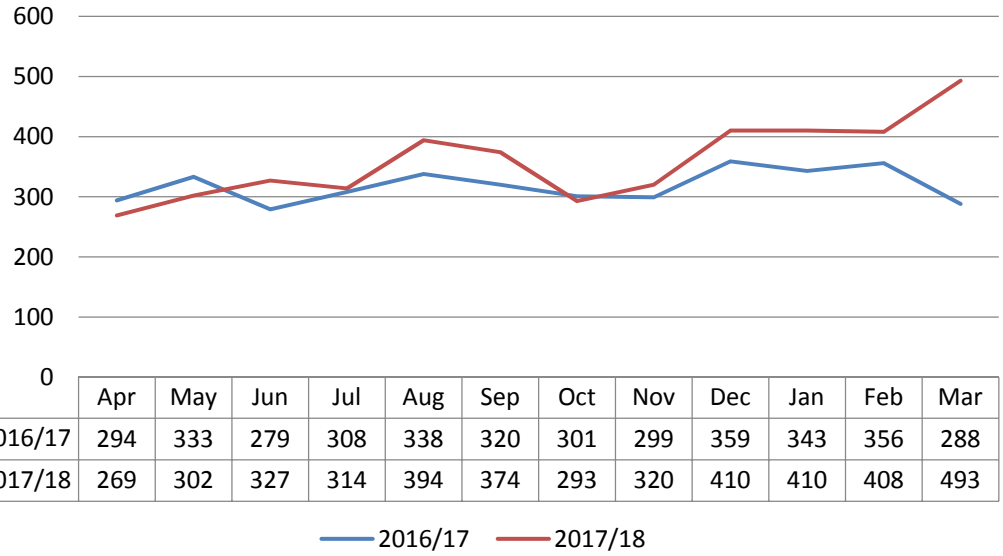

| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2016/17 | 31475 | 32068 | 32046 | 32105 | 32326 | 32483 | 32782 | 31888 | 31019 | 30284 | 30371 | 31280 |
| 2017/18 | 31559 | 31495 | 31770 | 31933 | 32240 | 31804 | 31177 | 29885 | 28255 | 27459 | 27683 | 28773 |

# Admitted Waiting List



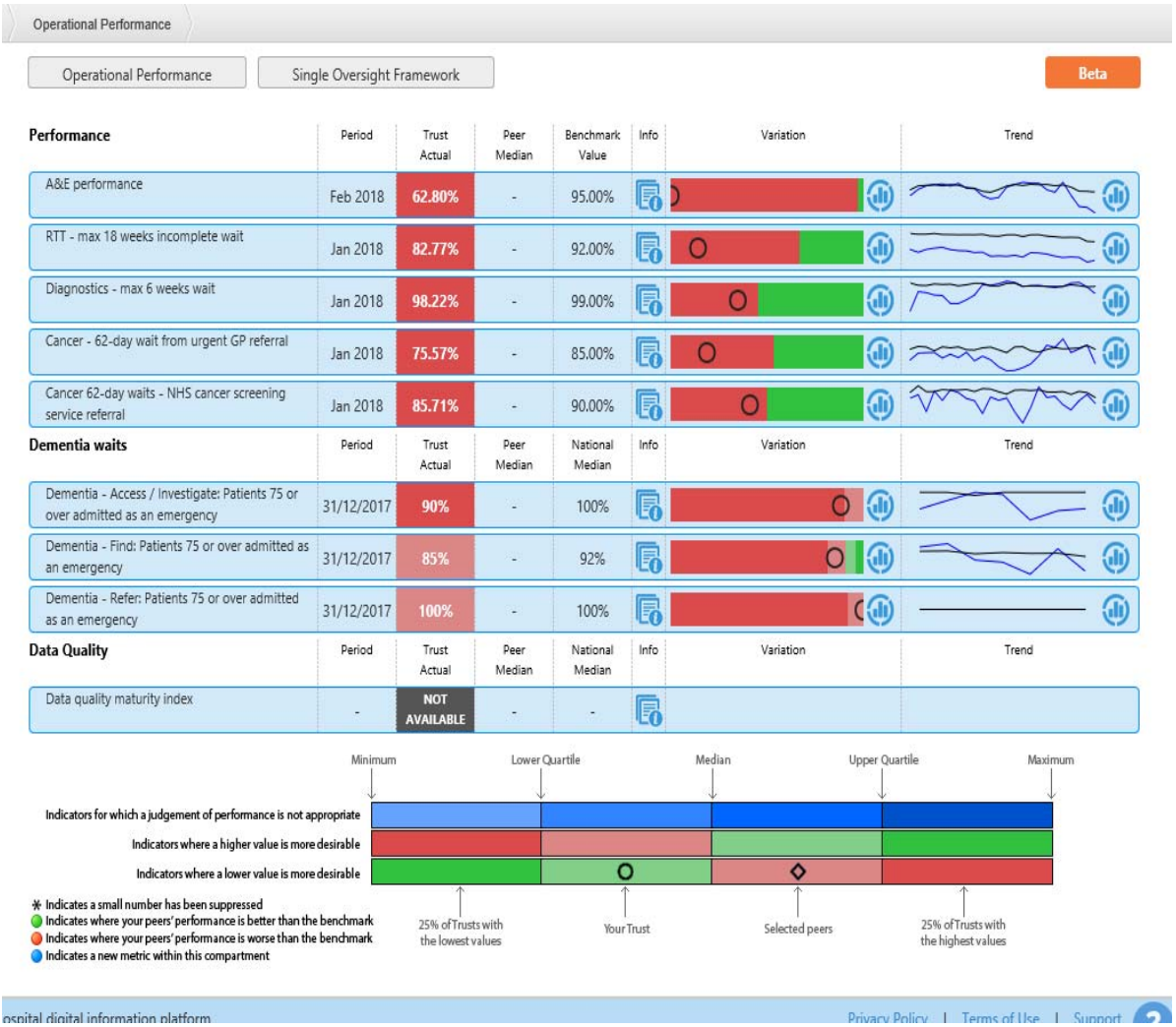

| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2016/17 | 7411 | 7515 | 7541 | 7516 | 7532 | 7588 | 7538 | 7744 | 7915 | 7964 | 8143 | 8104 |
| 2017/18 | 8024 | 8059 | 8146 | 8129 | 8300 | 8077 | 8138 | 8577 | 8742 | 9039 | 9030 | 9109 |

# Long Waiters - 40+




| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2016/17 | 294 | 333 | 279 | 308 | 338 | 320 | 301 | 299 | 359 | 343 | 356 | 288 |
| 2017/18 | 269 | 302 | 327 | 314 | 394 | 374 | 293 | 320 | 410 | 410 | 408 | 493 |

## Clinical Effectiveness - NHSi's Compliance Framework (limited to those metrics that were included in both RAF and SOF for 2017/18)



## Clinical Effectiveness – Clinical research and development

Please refer to page 26

## Staff Experience – NHS Staff Survey

All hospitals' staff survey reports are published online at www.nhsstaffsurveys.com

Over 3,500 of Trust Staff returned the survey form. The report shows that 18 of the 32 categories demonstrated significant improvement over the last 2 years, and none of the key findings worsened in the rankings.

There were 10 key findings in the bottom category compared with all trusts in the country (reduced from 20 last year) and this shows us where we need to focus our attention to improve things for you and colleagues.

Results are shared within clinical divisions and corporate departments, and through other groups like the council of governors, joint committee with trade union reps and the staff experience working group, in order to plan actions for continuing further improvements.

## Patient Experience – Encouraging Patient Flow

Please refer to page 28

## Patient Experience – Frailty Strategy

During 2017/18 the Trust has delivered a range of inpatient and outpatient service developments to improve provision and care for frail patients.
The ultimate aim of these developments is to ensure that all patients receive the "gold standard" of care as quickly as possible. Identifying potentially Frail patients and completing a Comprehensive Geriatric Assessment (CGA) of their medical conditions, cognitive state, level of independence and social circumstances, is accepted as the most effective way in which to ensure that older people avoid unnecessary hospital stays while having their care needs met, maintaining their independence for as long as possible and spending no longer in hospital than is absolutely necessary.

OPAS (Older People's Assessment Service)
The Trust has made significant improvements to the way in which the outpatient service functions, by reducing the wait for an appointment and moving to an ambulatory approach to care which supports patient independence and admission avoidance. This service provides a rapid assessment of needs including all appropriate elements of a Comprehensive Geriatric Assessment.
GPs fill in an electronic referral and access the service via a confidential email account. Once the referral is received, the patient is contacted and invited for assessment. Results of the assessment and changes / recommendations for future care and management are made available to GPs via the same email system, usually on the same day.
The service has seen a reduction in patients requiring a follow-up appointment and long waits for an assessment significantly reduced from an average of 6 weeks to 2 days.

OPAC (Older People's Ambulatory Care)
OPAC provides care for patients arriving from the Emergency Department (ED). OPAC is a more conducive environment for older patients who may require further investigations, a period of recovery and a Comprehensive Geriatric Assessment. The aim of OPAC is to safely discharge the patient to their usual place of residence within a day.

OPED (Older People's Emergency Department)

OPED is the UK's first Emergency Department that is entirely dedicated to older patients. The department opened in December 2017. It has a designated Older People's team consisting of Emergency Department Consultants and a senior geriatrician, junior medical staff and advanced Nurse Practitioners who work in conjugation with the Early Intervention team identifying and assessing potentially frail older patients. OPEDs working hours are 9-5pm Monday to Friday with the ambition to extend these hours to 8pm Monday to Friday and eventually 7 days a week.

There are already fast track pathways in existence for patients with stroke, fractured neck of femur and heart attack. OPED is for those patients that do not fit the established pathways already in place. When a patient of 80 years or over arrives at the emergency department (ED), they are triaged and if suitable go straight to OPED. Patients who require admission will be admitted directly to one of the specialist older people's wards or to another specialty ward if appropriate.

Working closely with clinical teams in the Emergency Department to identify and pull these patients through to OPED has resulted in a continued reduction in the Emergency Department's conversion rate and better outcomes as regards length of stay if admitted.

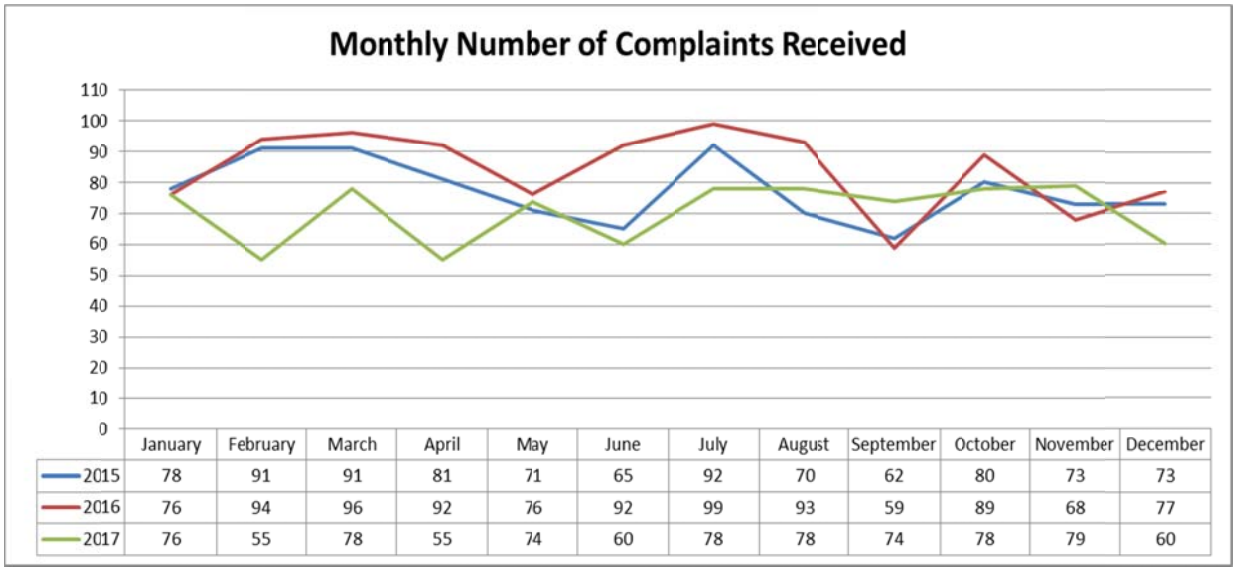
Feedback from patients, relatives and GPs has been positive so far. Patients find the environment quieter than the main ED. Families find it helpful to talk to an expert doctor or nurse on the day of admission very helpful. It also gives our staff the opportunity to gain very useful information to help with planning for discharge and / on-going care needs

## 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 summary information provided to the Management Board and Board of Directors.

**Complaints received by month**




| | January | February | March | April | May | June | July | August | September | October | November | December |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2015 | 78 | 91 | 91 | 81 | 71 | 65 | 92 | 70 | 62 | 80 | 73 | 73 |
| 2016 | 76 | 94 | 96 | 92 | 76 | 92 | 99 | 93 | 59 | 89 | 68 | 77 |
| 2017 | 76 | 55 | 78 | 55 | 74 | 60 | 78 | 78 | 74 | 78 | 79 | 60 |

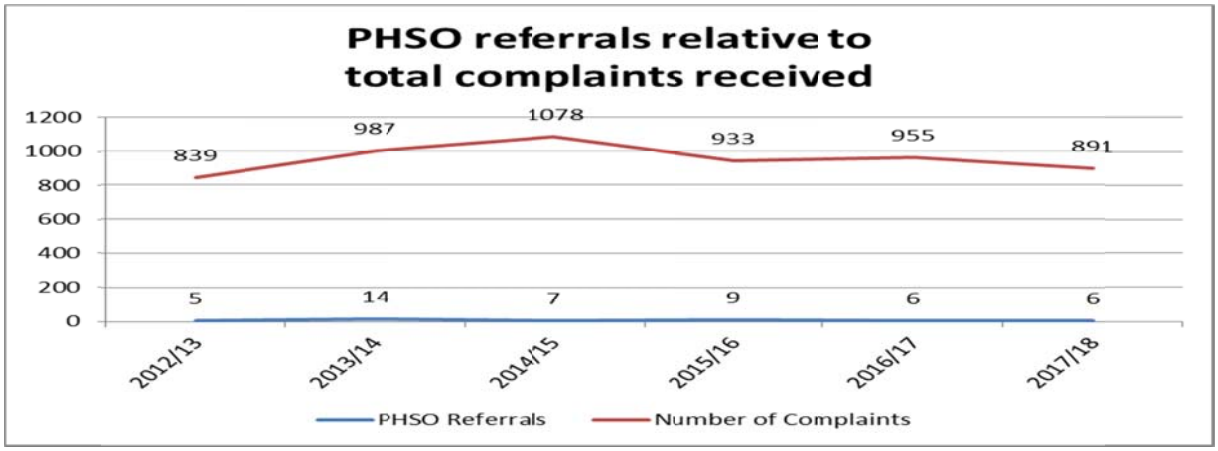
*Source: NNUH data, local definition*

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.

A periodic review of complaints files is also conducted by the Healthwatch Norfolk Team, which has been consistently complimentary of our approach to managing complaints. We are grateful to Healthwatch for their work with us to provide an additional means of independent assurance with regards to our approach to complaints. We have been pleased to implement a number of recommendations made by the Healthwatch team.

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

**PHSO referrals**




*Source: NNUH data, local definition*

The PHSO has the power to investigate a complaint once local resolution has been completed. The number of appeals to the PHSO represents 0.5-2% of complaints. The number of referrals from this Trust is low relative to other Trusts, indicating relative success in resolving matters at the first stage.

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 receives recognition for fantastic Friends and Family Test rate

“The trust is a real example to others, demonstrating how to ensure that patients get the care that they deserve” said Jeremy Hunt Secretary of State for Health in a letter to the Norfolk and Norwich University Hospital in regards to the trust’s Friends and Family Test recent recommendation rate.

NNUH achieved 97% in the Friend and Family Test recommendation rate in June this year following feedback from outpatients. The test allows patients who have visited one of our outpatient departments to provide their comments on the care they have received.

Mr Hunt added: “From visiting organisations throughout the country, I know that the immense amount of work that will have been behind this outcome cannot be underestimated. This is a testament to the hard work and dedication of the trust’s staff.”

The feedback taken from the survey allows the Trust to look at how and where improvements can be made to enhance patient experience at NNUH.

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

## Statement from NHS North Norfolk CCG

NHS North Norfolk Clinical Commissioning Group (NNCCG), as the coordinating commissioner for Norfolk and Norwich University Hospital (NNUH FT) for the Norfolk and Waveney CCG's (Norwich, North Norfolk, South Norfolk, West Norfolk and Great Yarmouth & Waveney), supports the Trust in its publication of the 2017/18 Quality Account.

Having reviewed the mandatory detail of the report, the CCG's are satisfied that the Quality Account incorporates the mandated elements that are required. The CCG recognises that NNUH have undertaken to develop and deliver a significant number of quality improvement initiatives including a significant reduction in your mortality rate. The success in delivery of key metrics associated with infection prevention and control in 2017/8 is also recognised.

The CCG's recognise the challenges experienced by the Trust and the impact that this has had on the organisation as a whole not least its frontline staff. NNUH is currently awaiting feedback from the Section 29a letter submitted to the CQC in January 2018 and the outcome of the CQC Inspection undertaken in March 2018.

The Trust continues to work collaboratively with a range of stakeholders and has received external support from both NHS I and NHS E during the year. The CCG has and will continue to support the Trust through Clinical Quality Review Meetings (CQRM).

Quality Priorities 2017/18

1) Reduction in medication errors: zero insulin errors causing moderate harm or above.

   The CCG's confirms that NNUH only had one incident of moderate harm at the end of 2017/8 however overall the number of incidents did not decline and we welcome the continued inclusion unchanged in the priorities for 2018/9.

2) 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.

   The CCG's recognise that progress was made across the domains however there is still further work to be done. The CCG welcomes the proposal to continue to focus on sepsis as part of the redefined priority for 2018/9. Data remains incomplete for the year.

3) To ensure that 95% compliance with thromboprophylaxis risk assessment (TRA), as evidenced on the Electronic Prescribing and Medicines Administration system (EPMA).

   NNCCG note that this measure has been consistently achieved throughout the year.

4) To remain within the top quartile of acute trusts for incident reporting on NRLS and to achieve 100% Duty of Candour compliance.

   NNUH have consistently delivered its ambition to achieve 100% Duty of Candour compliance.

The Trust has also achieved its ambition to be in the top quartile of acute trusts for incident reporting on NRLS. NNUH is a good reporter of incidents generally NNCCG would however recommend that further work is required to ensure the Trust maintains and improves on this ambition. The CCG welcomes the addition of a new priority focusing on human factors and improving teamwork and communication. The CCG also noted that in March this year there were 25 SIs reported which was a marked increase on the monthly incidents previously reported. The CCG requests that NNUH also continue to focus on decreasing potential SI's notably those that cause moderate harm or above and the improving the quality of the investigations. NNUH should also ensure that the lessons learnt are fully embedded and that this is demonstrable.

5) Clostridium difficile within trajectory target, 0 cases of Hospital Acquired MRSA bacteraemia.

   NNUH have achieved this ambition and improved on the previous year's position.

6) Year on year increase in patients recruited into research studies. Aim to achieve 3300 recruitment into NIHR studies in 2017-18.

   The CCG whilst recognising there are pockets of excellence note that NNUH continue to experience problems recruiting patients to take part in research and as such recommend that this remain a priority for 2018/9. The CCG would like to better understand where the challenges have been and what actions are being taken to improve this.

7) Timely medical review of all patients - 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 (senior medical trainee) or above.

   Compliance against this ambition has not been achieved and data is only reported for part of the year. A number of SI's during the year have also indicated that timely review of patients has not always been achieved and has in part contributed to delays in treatment. The CCG's welcome the implementation of a new reporting tool and will continue to monitor this at CQRG. NNCCG recommend that this remains a Quality Priority for 2018/9.

8) 95% or more of patients in all areas report through the Friends and Family Test that they are extremely likely or likely to recommend our services to their friends and family.

   The CCG's recognise that NNUH have consistently achieved this ambition with 96.52% of participants saying that they would recommend the Trust. This is an excellent reflection of the value patients place on the care received at NNUH. Whilst not distracting from this achievement it is important to note that overall numbers of responses is low in some areas and NNUH should explore new ways to improve on this.

9) Improved continuity of care and experience through reduced ward moves and reduced numbers of outliers.

   During the year NNUH has experienced unprecedented demand for beds this has subsequently had an impact on the ability to deliver this priority. It is important that NNUH do not lose sight of this ambition due to the impact on patient care and outcomes. Likewise NNUH need to ensure that escalation policies reflect the need to repatriate patients back to the appropriate clinical area as soon as possible.

10) Improved discharge process 100% of Estimated Date of Discharges (EDD) recorded within 24 hours of admission on WardView – SAFER criteria (now Medworxx).

    95% Electronic Discharge Letters (EDL) to be completed within 24 hours of discharge.

NNUH have failed to achieve this ambition and this continues to be discussed on a regular basis at CQRG and SPRG. The CCG have requested an action plan to provide assurance that this ambition is being addressed across the Trust. The CCG recommends that this remains a Quality Priority for 2018/9.

Quality Priorities 2018/19

The CCG's are in support the key quality priorities for 2018/19. The CCG's do however recommend that the Trust ensures that those Quality Priorities that were not realised in 2017/8 are continued. NNUH should ensure that there are SMART Action plans put in place against all priorities so that assurance can be provided to Regulators and Commissioners that the level of ambition can be realistically achieved. NNUH should also ensure that improvements are measureable and demonstrable by designing comprehensive measures and patient outcomes against each quality priority identified for 2018/19.

The CCG's will continue to work with the Trust to monitor and review progress on the areas identified and have made the following additional recommendations on specific priorities:

***Patient Safety***

- Prompt recognition and treatment of deteriorating patient – the CCG welcomes this as a priority and the links to investigations and the mortality review process. Further understanding is required as to what the key lessons and recommendations that have resulted from investigations are and how these will inform the actions that demonstrate how this priority will be achieved.
- Improvement in frailty provision and care – the CCG's would like to understand in more detail what this priority will achieve. Similarly more detail would be welcomed as to the actions that will be undertaken to deliver this ambition and how success will be demonstrated. The document suggests further detail is provided later specifically at page 68. This could not be found. The CCG recommends that NNUH include a focus on falls prevention, reducing urinary tract infections and reducing the number of Grade Two and Grade Three Pressure Ulcers.

***Clinical Effectiveness***

- Seven day services – the CCG welcomes this ambition however more assurance is required about delivery including detail of the action plan that is referred to, key performance measures and improved quality outcomes to demonstrate how it will be realised.
- Keeping Patients Free form Infection - we fully support the step change included within the 'Keeping patients safe from infection priority' which now includes Gram–negative blood stream infections and Carbapenemase-producing Enterobacteriaceae (CPE) which are aligned with the national agenda.

***Patient Experience***

- Improved discharge processes and communication' – The CCG notes that contractual requirement regarding timely and accurate discharge communication and outpatient letters are not included in the key outcome measures. The CCG would like assurance that these will be monitored and that any trends and themes identified result in embedded learning and action plans.

- Care and Patient Experience – To improve our care to those at the end of their life -
  The CCG's welcome and support the inclusion of improving care to those at the end of their life and would suggest this could be strengthened by including the review of all audit results and the development of actions according to

recommendations from each. The CCG would also recommend that particular attention is paid to advanced care planning for patients with dementia.

- Care and Patient Experience – To improve the assessment and quality of care for patients in Mental Health crisis – the CCG's are pleased to see this as a priority area for 2018/9. NNCCG as coordinating commissioner would recommend that NNUH consider how the organisation will gather the views and experience of patients in mental health crisis in the delivery of this ambition, for example could patient stories be used?

  Additional quality measures that demonstrate how outcomes for patients are improved should be included as should measures that demonstrate engagement and co-production with service users and NSFT who will need to work in partnership with NNUH in the delivery of this ambition.

Overall we recognise that the Trust is using a range of national and local audits, national and local key performance indicators (KPIs), surveys and other forms of feedback such as the Friends and Family Test (FFT) to gain feedback from service users and their families and to improve services. Whilst outcomes from some of these measures (for example, FFT response rates) are positive there is further work to be done to increase the number of responses. The Trust should continue to explore different ways of increasing and improving feedback and patient engagement. The CCGs' also note that only four specialities achieved the Trust target of 90% for the 18 week audit programme (ref p57) and would like to understand how this will be improved upon in 2018/9.

The CCG's welcome the detailed quantitative analysis related to the learning from deaths but are mindful that this could be difficult for the reader to interpret and as such a narrative to support the analysis would further enhance the findings.

Finally the CCG's recognise, that while the recent staff survey has shown some improvement there are areas that continue to be of concern. NNUH should therefore be working hard to improve staff satisfaction through a robust Workforce and Organisational Plan where it is clear there is more to do.

The CCG looks forward to continuing to working in a positive and collaborative manner with the Trust to continue improvements in patient care during the coming year.

**Alison Leather**
**Chief Quality Officer (SNCCG & NNCCG)**

## Statement from Norfolk Health Overview and Scrutiny Committee

The Norfolk Health Overview and Scrutiny Committee has decided not to comment on any of the Norfolk provider Trusts' Quality Accounts and would like to stress that this should in no way be taken as a negative comment. The Committee has taken the view that it is appropriate for Healthwatch Norfolk to consider the Quality Accounts and comment accordingly.

## Statement from Healthwatch Suffolk

No return at the time of publications

## Statement from Healthwatch Norfolk

**Healthwatch Norfolk Statement –NNUH Quality Account**

Healthwatch Norfolk appreciates the opportunity to make comments on the NNUH Quality Account for 2017/18.

In terms of the format of the document we were not able to locate any details about how to obtain the document in large print, Braille or another language. However we presume this will be added in Part 1 “Information about this report”. There is currently no glossary, which would be very helpful to the lay reader. At the time of writing this statement we note that there is significant data to be added to the draft report prior to publication and we assume that the wording attached to the graphs and tables will be amended appropriately once all data is included.

The introduction from the Chief Executive is very good in the way it summarises a range of mainly positive information, particularly improved infection prevention and control, better performance on cancer targets and an all time low on mortality rate. The development of critical care facilities at the N & N, a new medical and cancer unit at Cromer hospital, and the new Quadram Institute are all very welcome developments.

In general , the report presents very detailed Quality information, some of which is not easy for members of the public to understand. This could perhaps be addressed by providing an Executive Summary in plain English – or this could be done by expanding the statement from the Chief Executive.

Healthwatch Norfolk is aware that the NHS is under pressure for many reasons, increased numbers attending hospitals, especially older people, an expanding number of opportunities for intervention and treatment, and a reduction in budgets. All this places a strain on health and social care staff, and makes the achievement of targets harder and harder. In this context it is good that 95% of patients are happy with their experience of care and treatment at the NNUH.

The priorities for improvement appear to be more systematic and show greater improvements, when compared to last year.

It is perhaps worthy of note that patient safety incidents were highest in January 2018 and there was a significantly higher number of serious incidents in March 2018, more than double the average for the rest of the year.

The report gives considerable detail on national clinical audits (49) and national confidential enquiries (4), and 3228 patients have participated in research (down from the 5438 figure of 2016/17).

**Key Targets**

From the information provided in the report it would appear that whilst 17 out of 26 specialties improved their performance on the 18 week referral to treatment pathway, only 4 achieved the Trust target of 90%.

Although the Chief Executive recorded improved performance on cancer treatment, there some significant shortfalls in the 4th quarter, notably 62 day GP (77.9%) and 62 day breast symptoms. (50%).

**CQC Report**

The most recent CQC report was published in August 2017, with a rating of requires improvement. There does seem to have been a detailed and rapid response to the most significant warnings; notably hat the Children's emergency department was not suitable for the service provided, that the area was not large enough and there was no high dependency care outside the department. Similarly that the Emergency department premises were deemed not fit for purpose. There were 4 other warning notices and 4 must do actions, all of which have been addressed. It will be interesting to see whether the CQC are happy on their next visit.

**Staff Survey**

It is well worth reading the 2017 national NHS staff survey for the Norfolk and Norwich hospital in detail at www.nhsstaffsurveys.com For example, the following two questions:

| | 2017 | 2016 |
|---|---|---|
| I would recommend my organisation as a place to work: | 61% | 56% |
| If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation | 76% | 71% |

We remain totally committed to work with the Trust to ensure that the views of patients, their families and carers are taken into account and to make recommendation for change, where appropriate.

**Alex Stewart**

**Chief Executive**

May 2017

## Statements from Governors

From: Nina Duddleston
Sent: 13 May 2018 14:19
Subject: Quality report 2017/18

Hi Janice
Comments after reading the extremely detailed and informative report.
Noted that the use of Acronyms is necessary and most are explained when used in the report for the first time, but I feel it would be very useful to have a glossary to refer back to when advancing through the document.
Kind regards
Nina

**From:** Boyce, Robert (NNUHFT)
**Sent:** 16 May 2018 12:10
**Subject:** Quality Report 17/18 Statement

Hi Janice

My statement for inclusion in the Quality Report 17/18:

Despite the adverse environment in which the NHS is currently operating, this report demonstrates that the NNUH staff are striving, with determination, to deliver a safe & clinically effective experience for each and every patient that they care for, whilst delivering ground breaking innovation that will continue to improve the quality of the region's health services.

Regards,

Rob

**Rob Boyce**

Radiotherapy Practice Educator (Wed & Thurs) / Lead Radiographer

Norfolk and Norwich University Hospital NHS Foundation Trust

**Clinical Support Staff Governor**

**From:** Erica Betts [mailto:the.betts32@btinternet.com]
**Sent:** 25 May 2018 16:31
**To:** Bradfield, Janice (NNUHFT)
**Subject:** Statement for 2017/18 Quality Report

Dear Janice,

Please see below my statement:

I have read the Quality Report for 2017/18 and commend those responsible for completing this huge piece of work. This year's version seems to be clearer and easier to understand.

It would be interesting to know why 2000 fewer patients were involved in research trials in 2017/18? Also while Pressure Ulcers and Falls account for the majority of serious incidents, there seem to be far more protocols for PUs than falls. The Falls & Fragility

Fractures Audit was completed and the Falls Policy has been reviewed and changes recommended but no results have been shared in the report to show what exactly is being recommended and done to try to reduce falls.

It is good to see improvements in many areas such as the mortality rate, increased space in ED for Paediatrics plus the addition of an Older Persons ED, which makes so much sense in a county like Norfolk with a high population of older people. The introduction of an E-observation system to detect sepsis seems an excellent idea to help catch cases as early as possible. It is also good that there is a new priority to improve care to patients at the end of their life.

Erica Betts

Public Governor (Breckland)

## 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 2017/18 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 2017 to 25/05/2018
    - papers relating to quality reported to the board cover the period April 2017 to 25/05/2018
    - feedback from commissioners dated 23/05/2018
    - feedback from governors dated May 2018
    - feedback from local Healthwatch organisations dated 21/05/2018
    - feedback from Overview and Scrutiny Committee dated 01/05/2018
    - the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 03/05/2018
    - the 2016 national patient survey
    - the 2017 national staff survey
    - the Head of Internal Audit's annual opinion of the trust's control environment dated 25/05/2018
    - CQC inspection report dated 10/08/2017

- 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:

**John Fry**
**Chairman** **25th May 2018**

**Mark Davies**
**Chief Executive** **25th May 2018**

# Annex 3 – Independent Auditor Report

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

We have been engaged by the Council of Governors of Norfolk & Norwich University Hospitals NHS Foundation Trust to perform an independent assurance engagement in respect of Norfolk & Norwich University Hospitals NHS Foundation Trust's Quality Report for the year ended 31 March 2018 (the 'Quality Report') and certain performance indicators contained therein.

**Scope and subject matter**

The indicators for the year ended 31 March 2018 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;
- 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 2017/18* ('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 2017/18.*

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 2017 to 25 May 2018;
- papers relating to quality reported to the board over the period April 2017 to 25 May 2018;
- feedback from commissioners, dated 23 May 2018;
- feedback from governors, dated May 2018;
- feedback from local Healthwatch organisations, dated 21 May 2018
- feedback from Overview and Scrutiny Committee, dated 1 May 2018;

- the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 3 May 2018;
- the 2016 national inpatient survey;
- the 2017 national staff survey;
- Care Quality Commission Inspection report, dated 10 August 2017;
- the Head of Internal Audit's annual opinion over the trust's control environment, dated 25 May 2018; 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 & 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 2018, 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 & 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 & 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 2018:

- 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**
**Botanic House, 100 Hills Road, Cambridge, CB2 1AR**

**25 May 2018**

# 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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