Norfolk and Norwich University Hospitals
NHS Foundation Trust

Quality Report

2018-19

Quality Report 2018/19

Chief Executive's Statement on Quality

Information about this Quality Report

The Care Quality Commission Inspection between October 2017 and March 2018, published in June 2018, found the Trust had some outstanding practice and care. However, it also found that there were areas of poor practice, management and leadership that resulted in an overall rating of "Inadequate". The Trust Board fully accepted the findings of the CQC report but has remained committed to working with staff, patients, carers, partners and other stakeholders to improve the care provided to patients.

The inspection ran over 5 months, during and since that time, whilst we know and fully understand we have much to do, we have made many improvements to our estate and services: Children's ED moved its location and increased its capacity from 3 to 15 spaces; and the UK's first Older People's Emergency Department – to provide specialist care to patients over 80 years of age - opened as an extension of the A&E department in December 2017

The CQC revisited the Trust between January and February 2019. Their report was published in mid-May and said there had been great improvements at the Trust since March last year, raising the overall rating from "inadequate" to "Requires Improvement", though the Chief Inspector of Hospitals has recommended that the Trust remain in special measures. Recommendations were made to continue with improvements to cultural change and openness, mandatory training, record and medicines security, leadership development, and staffing levels.

I was pleased to see that special mention was given to a number of areas of outstanding practice including robotic surgery, Quick Response bar codes (QR) in theatres and Day Procedure Unit, improvements in critical care, with the new protocol to admit patients within one hour, and high levels of support for junior doctors

Whilst it is important to acknowledge our failures and continue on our Journey to Outstanding, we must also remember that there is a great deal to celebrate and commend.

We have introduced daily Serious Incident Group meetings, where all staff members are welcome to meet and discuss incidents that have occurred in the previous 24 hours in an open and non-confrontational setting. The initial information available regarding the incident is discussed and a decision is made about whether it meets the threshold for external reporting as a serious incident and the depth of investigation. These meetings have become increasingly well attended and will regularly see 20-30 staff meeting to discuss incidents and agree a way forward for them.

The number of whistle blowing issues raised with external stakeholders has reduced significantly which is a positive indication of the success of our new systems for speaking up. The Management Board now receive monthly updates on 'speak up' issues in order to increase its oversight of issues. A fulltime Speak-Up Guardian was recently appointed and joined us in March. This is an exciting appointment and the next step on our journey towards developing a value-based organisational culture more closely aligned with staff and public.

The Gastroenterology department has moved some of its services to the state-of-the-art Quadram Institute and welcomed its first patients in December 2018. The multi-million pound facility on Norwich Research Park will be able to conduct at least 40,000

procedures a year, making it one of the largest endoscopy centres in Europe, providing world class facilities for our patients.

A major expansion of radiology and cardiology services is also being planned in 2019. The number of interventional radiology and cardiology procedure rooms (cath labs) will increase from four to eight as part of the construction project, which will add an extra level on to the East wing of the hospital.

We are proud of our links and history of working with Veterans. The Veterans Covenant Hospital Alliance has accredited the Trust as a Veteran Aware Hospital in recognition of our work identifying and sharing best practice for care of members of the armed forces. We have also received the Gold Award for our work in supporting Defence People under the Ministry of Defence Employer Recognition Scheme and invited to join the Gold Alumni Association.

In January 2019, we celebrated three years of saving and transforming cancer patients' lives through robotic surgery. Robotic surgery has helped us improve our outcomes and provide a better experience for patients with quicker recovery and a shorter length of stay in hospital. We are a busy hospital with a high volume of cases and have reached 750 cases in three years, a symbol of our highly developed level of expertise in robotic surgery.

Our Friends and Family Test score remains high at over 96% in December 2018. The number of medication errors reported has continued on an upward trend with the vast majority causing low or no harm which is a positive indication of our reporting culture and we continue to widely share learning outcomes from these incidents in order to prevent recurrence of errors in the future.

The Trust's Pressure Ulcer Collaborative Team was awarded the peer nominated award for the most innovative pressure ulcer reduction initiative, and in January this year, Earsham and Dunston Wards each achieved 100 days without a patient developing a pressure ulcer, whilst Cley Ward marked 200 days free!

Our Quality Improvement Plan is focused on the immediate priorities arising from the 2018 Care Quality Commission inspection and in setting the baseline from which to develop our longer-term objectives and priorities.

Our Quality and Safety Improvement Strategy is just as explicit. It describes a five-year forward view of quality improvement and sets out how we will define, improve and assure the quality of our services and supports our 'journey to outstanding'. It aims to give our staff a clear focus and reflects the importance and commitment the Trust Board places on the quality of care and the requirement to continually learn and improve to meet the evolving demand and expectation of our patients and staff.

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

Priorities for improvement

The table below (Table 1) details the Trust's Quality Priorities for 2019/20. 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, patient and carer feedback, quality monitoring from commissioners, internal reviews of the quality of care provided across services, and staff suggestions.

Table 1

1.0 Quality Domain – Patient Safety To eliminate avoidable harm to patients in our care as shown through a reduction in number of incidents causing moderate harm and above due to lapses in care or failure to respond by 2023.		
The achievement of the Quality Priorities will be monitored through the monthly Integrated Performance Report and relevant sub boards.		
Improvement aim	**Baseline position 18/19**	**2019- 2020**
1.1 Reduction of hospital acquired pressure ulcers (HAPU)caused by lapses in care We will reduce Hospital acquired pressure (HAPU) ulcers by at least 20% per cent in year one.	Category 4 : 0 Category 3 : 49 Category 2 : 234 Unstageable Baseline to be agreed to be agreed in Q1 (2019/20)	Category 4: zero occurrence of hospital acquired pressure ulcers <40 x grade 3 HAPU per annum - demonstrating a 20% reduction Category 2 < 180 grade 2 HAPU per annum demonstrating a 20% reduction % age reduction to be agreed in Q2
1.2 We will continue to develop strategies that reduce the number of patients who fall and reduce the number resulting in moderate harm or above whilst under our care	23 – falls moderate harm or above Total number of falls 2154	< 20 falls 25% reduction in falls causing moderate or above harm Percentage reduction in falls to be agreed in Q2
1.3 Three high impact actions to prevent Hospital Falls (CQUIN)	Baseline to be agreed in Q1 (2019/20)	Achieving 80% of older inpatients receiving key falls prevention actions 1. Lying and standing blood pressure 2. No hypnotics or antipsychotics or anxiolytics given during stay OR rationale for giving hypnotics or antipsychotics or anxiolytics documented 3. Mobility assessment documented within 24 hours of admission to inpatient unit stating walking aid not required OR walking aid provided within 24 hours of admission to inpatient unit

1.4 We will have zero 'never events'.	6 never events	zero
1.5 Standardise processes to improve early detection of deterioration, and ensure timely response	Emergency Department (ED)sepsis screening 81%	95% of patients who met the criteria for sepsis screening were screened for sepsis.
	In patient sepsis screening	95% of patients who met the criteria for sepsis screening were screened for sepsis.
	Sepsis 6 compliance ED 92%	95% patients
	Sepsis 6 compliance In patients	95%
	NEWS 2	95% of admitted patients will have observations recorded accurately using NEWS2
1.6 We will reduce the number of out of-CCC/ED cardiac arrests calls from 2018 baseline	Number of out of CCC and ED cardiac arrest calls Baseline to be agreed Q1 (2019/20)	% reduction in the number of cardiac arrest calls agreed in Q1
1.7 To create and maintain a network of appropriately skilled ward based paediatric link nurses	Baseline to be agreed in Q1 (2019/20)	%age of named children link nurses have paediatric competences

2.0 Quality Domain – Clinical Effectiveness
People's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence
Development and use of systems and structures that promote learning across the organisation and services.

Improvement aim	Baseline position 18/19	2019- 2020
2.1 Reduce inappropriate antibiotic prescribing, improve diagnosis (reducing the use of urine dip stick tests) and improve treatment and management of patients with UTI. (CQUIN)	Agree baseline in Q1 (2019/20)	Achieving 90% of antibiotic prescriptions for lower UTI in older people meeting NICE guidance for lower UTI (NG109) and PHE Diagnosis of UTI guidance in terms of diagnosis and treatment.
2.2 Reduce the number of doses used for colorectal surgery and improve compliance w ith	Agree baseline in Q1 (2019/20)	Achieving 90% of antibiotic surgical prophylaxis prescriptions for elective colorectal surgery being a single dose and prescribed in accordance to local antibiotic guidelines

antibiotic guidelines		
2.3 Improve the effectiveness of care through participation in research with a year on year increase in the number of patients recruited into research studies	TBC YTD Feb 2019 4352	10% increase from 2018 -2019 baseline
2.4 We will ensure mortality reviews are carried out using a standardised format whenever a patient dies in our care.		10% of in hospital deaths undergo Structured Judgement Review (SJR)
2.5 We will ensure Serious Incident investigations are carried out using a standardised format and improvement actions implemented to prevent recurrence	2018 SI Report submission compliance 53%	95% Serious Incident investigations are fully completed within 60 days
	To be agreed Q1 (2019/20)	95% of action plans completed from complaints and serious incidents within agreed timescales
	Duty of Candour compliance 81%	95% of duty of candour letters issued within 10 days
2.6 Evidence that themes from serious incidents, complaints and mortality reviews are utilised to prioritise our improvement programmes. Quarterly thematic reviews across SI's complaints and SJR process are shared trust-wide	Baseline taken from Thematic review for 2018/19 Q1	Reduction in recurring themes identified from baseline review Quarterly thematic reviews across SI's, complaints and SJR processes are shared Trustwide.
2.7. 100% of children and young people requiring high dependency or critical care are looked after in dedicated environment	Baseline to be agreed in Q1 (2019/20)	Improvement trajectory agreed in Q2

3.0. Quality domain : Carer & Patient Experience; Improve how we listen and respond to patients and their carers/ families going forward and use patient feedback and experience to design and improve services.		
Improvement aim	**Baseline position 18/19**	**2019- 2020**
3.1 We will improve our score in the national inpatient survey relating to responsiveness to patients' personal needs (five questions from national survey).	1: 55% 2: 52% 3: 14% 4: 82% 5: 62%	10% improvement in scores across the selected questions 1: Patients were involved as much as they wanted to be in decisions about care and treatment? 2: felt they were involved in decisions about discharge from hospital? 3: were asked to give views on the quality of their care? 4: felt care and support they expected was available when they needed it? 5: were able to get a member of staff to help within a reasonable time?
3.2 Personalised care and support planning and compliance with Accessibility Information Standard	Baseline compliance to be confirmed in Q1 (2019/20).	The Accessible Information Standard aims to make sure that people who have a disability, impairment or sensory loss get information that they can access and understand, and any communication support that they need from health and care services. Baseline survey and audit to be developed by Q3 and improvement actions agreed for Q4
3.3 We will increase our responsiveness to complaints and reduce their overall number of formal complaints	Response time 68% (December 2018) Number of formal complaints 1035	Agree performance improvement in Q2
3.4 Improvement in scores in key questions of National staff surveys Safety Culture Responding to incidents Ability to make improvements	75% Q7a 57% Q17a 66% Q17c 59% Q17d 65% Q18b 50% Q18c 67% Q21b 72% Q4b 48% Q4C 46% Q4d	10% improvement across the range of questions Q7a: am satisfied with the quality of care I give to patients / service users Q17a: My organisation treats staff who are involved in an error, near miss or incident fairly Q17c: When errors, near misses or incidents are reported, my organisation takes action to ensure that they do not happen again Q17d: We are given feedback about changes made in response to reported errors, near misses and incidents Q18b: I would feel secure raising concerns about unsafe clinical practice Q18c: I am confident that my organisation would address my concern Q21b: My organisation acts on concerns raised by patients / service users Q4b: I am able to make suggestions to improve the work of my team / department Q4C: I am involved in deciding on changes introduced that affect my work area / team / department Q4d: I am able to make improvements happen in my area of work

3.5 Age appropriate patient and family feedback mechanisms in place across the Trust to ensure that children and young people are always asked about their experience of the services they use.	Agree baseline and improvements in Q1 (2019/20)	Increased response rate from children, young people and their families (from agreed baseline)

Progress against our 2018/19 priorities

Table 2 describes the Trusts high level assessment of achievement against the 2018/19 priorities set within the 2017/18 Quality Report. Following this there is a more in depth review of each category.

Table 2

Rating Key

Red – Quality priority not achieved

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

Green – Quality priority achieved

	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	
	Change: Prompt recognition and treatment of deteriorating patient	• % of patients screened, and % of patients treated for sepsis • 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	CQUIN criteria	
	Increase safety through improved teamwork and better communication	• 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		
	Improvement in frailty provision and care	• Number of Comprehensive Geriatric Assessments completed at 'front door'. • National Audit of Dementia • Number of inpatient falls (age related) Number of avoidable pressure ulcers (age related)		

	Priority	Measure	Goal	Rating
Clinical Effectiveness	Keeping patients safe from infection	No. of hospital attributable C Diff cases Number of hospital acquired MRSA bacteraemias		
	Improve quality of care through research	Numbers of patients recruited into NIHR studies	3,300 recruitment into NIHR studies	
	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	7 day services survey	The NHS seven day services programme is designed to ensure that patients who are admitted as an emergency receive high quality consistent care whatever day they enter hospital. The Trust's five year strategy includes an objective to "Implement further measures to achieve a 24/7 acute hospital service"	
Carer and Patient Experience	To improve our care to those at the end of their life	• DNACPR compliance • Individualised care plans • Specialist palliative care coding rates • Quarterly Local EoL care audit National EoL care audit		
	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 EDL to be completed within 24 hours of discharge	100% compliance 95% compliance	
	To improve the assessment and quality of care for patients in Mental Health crisis	• Number of referrals to Psychiatric liaison from: • ED/ assessment areas (where) • Wards (and where). • Waiting time from referral to assessment • standard 1hr ED, 4hrs • 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. Patient feedback via FFT (not sure this is feasible but we should try)		

Patient Safety – Reduce medication errors focussing on insulin

What was our aim?

To have zero insulin errors causing National Patient Safety Agency (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 Incidents Review Group (subgroup of the Medicines Management Group) with a subsequent report to the Clinical Safety and Effectiveness Sub Board and Prof Jeremy Turner, Consultant Endocrinologist, who is developing an insulin strategy for the Trust.

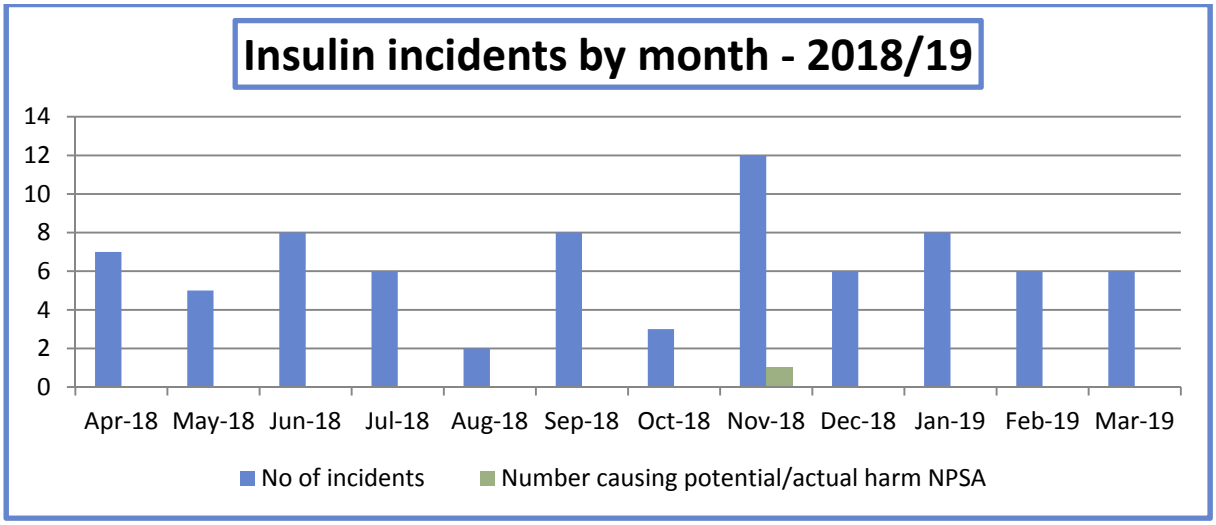
How did we do?

At the end of 2018/19 there had been one insulin error classified as causing 'moderate harm' according to NSPA category definitions. The incident involved a patient who was a newly diagnosed diabetic, who was discharged with no training or follow-up plan and subsequently re-admitted with hypoglycaemia.

Initiatives put in place aimed at the reduction of incidents involving insulin include:

- Pharmacy has appointed to the newly established role of Specialist Pharmacist for Endocrinology. The Specialist Pharmacist takes part in the newly introduced twice weekly diabetic ward rounds with a Consultant Endocrinologist to review the high risk diabetic patients in the Trust.
- A checklist for commencing Variable Rate Insulin Infusion in adult surgical patients has been developed and approved.
- A proposal to make changes to the Electronic Prescribing and Medicines Administration system (EPMA) that would minimise the risk of medication errors occurring involving insulin has been submitted to local and regional EPMA User Groups. If supported the proposal would then go to the National Group to recommend that the modifications set out in the proposal should be adopted by the provider JAC.
- A poster for display on wards and other relevant areas with pictures and information on insulins with similar-sounding names has been updated.
- The Specialist Pharmacist for Endocrinology is working with the Diabetes Team to review and improve the procedure for patients to self-administer insulin and monitor their own glucose levels whilst in hospital.

Insulin incidents by month



Patient Safety - Change: Prompt recognition and treatment of deteriorating patient

What was our aim?

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

How did we measure our performance?

- Sepsis CQUIN metrics

How did we do?

Trust performance during 2018-19 was measured using national Commissioning for Quality and Innovation (CQUIN) stipulated Key Performance Indicator (KPI) criteria

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.

The results for 2018 are as follows:

Jan 18	Feb 18	Mar 18	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sept 18	Oct 18	Nov 18	Dec 18
82%	82%	86%	82%	84%	88%	75%	74%	77%	81%	90%	82%
83.3%			84.6%			75.3%			84.3%		

The sepsis lead consultant is currently leading a working group (supported by the Chief Operating Officer and Chief Information Officer) with an aim to procure and implement an electronic observation system at NNUH during 2019/20 and with the introduction of this we would expect (in line with experience from other Trusts nationally), inpatient screening performance to improve dramatically. The Sepsis Lead has presented the case for E-Observations at the Clinical Informatics Group and this has been approved as a priority. The Sepsis Lead has also presented the case to the Hospital Management Board and priming funding has been approved to progress to the development of a full business case. In October the Outline Business Case for Electronic Observation was presented to the Hospital Management Board and approved in principle

Performance remains excellent in both the emergency and admission sepsis groups with 91% patients receiving antibiotics within an hour of diagnosis. This is in keeping with previous performance and reflects well embedded pathways for the prompt delivery of antibiotics in sepsis in both admission and inpatient areas and a continuous educational programme is in place for medical staff across the NNUH about the importance of timely sepsis management.

Jan 18	Feb 18	Mar 18	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sept 18	Oct 18	Nov 18	Dec 18
94%	92%	92%	97%	90%	92%	89%	94%	92%	91.5%	88.7%	96%
92%			92%			92%			91.3%		

The NNUH sepsis processes are included within induction for new doctors, are incorporated into the annual Foundation Year Teaching program and are taught on the Acute Life Threatening Events – Recognition and Treatment (ALERT) and Deteriorating Ward Patient (DWP) courses. Key facts training on the inpatient sepsis pathway is included within the NNUH mandatory training program having been incorporated within the mandatory annual resuscitation training for all clinical staff.

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

What was our aim?

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 did we measure our performance?

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

How did we do?

A **PROMPT** Human Factors Training programme (PROMPT = **PR**actical **O**bstetric **M**ulti-**P**rofessional **T**raining) was devised and introduced into Obstetrics and Gynaecology during 2018, with an aim to develop an understanding of what human factors are and how they influence outcomes in maternity care by exploring the vital role that nontechnical skills play in improving team working, communication and patient safety. It aimed to improve maternity outcomes and staff satisfaction through development of individual and team human factors skills.

16 staff attended a 'train the trainers' session in October 2018 – 9 Midwives and 7 Doctors from Anaesthetics and Obstetrics. Of the 300 staff invited to attend the training, 88.9% have attended in total, including 92.4% of all midwives. The course has now been opened up to other related staff groups, including Theatre staff, although capacity is limited.

Although the PROMPT programme is aimed specifically at obstetrics and gynaecology services, the Human Factors content is fairly generic and could be adapted for other departments and staff groupings.

In July 2018 the Norfolk and Norwich University Hospital initiated a human factors training project within the operating theatre surgical teams to develop their understanding and awareness of human factors in their workplace. This was achieved through half day workshops delivered to multidisciplinary staff groups and 3 day workshops delivered to key multidisciplinary staff who have since developed an in house training programme.

The human factors training programme at the Norfolk and Norwich University Hospital commenced in January 2019 after planning meetings agreed how the training was to be initiated. This included the utilisation of a human factors e-learning course available

through the NHS Electronic staff records, learning management course catalogue. This e-learning course provides the foundations of human factors training which is then explored and built on through discussion, interactive workshops and simulation training with small groups of staff on a monthly basis. Half day workshops were attended by 80 staff, 3 day workshops were attended by 15 staff who are now involved in the delivery of human factors training. The in-department workshops have supported the development of a further 51 staff.

Feedback gathered from the in-department workshops has been positive and well received. Staff have identified that human factors training has helped them to understand the importance of good communication and team work, about how seemingly small changes and events can easily add up to a significant error and that the in-department training enables them to consolidated eLearning and knowledge, good to recap for safety, good to discuss with teams, must foster better outcomes.

Patient Safety - New Priority: Improvement in frailty provision and care

What was our aim?

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

How did we measure our performance?

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.

How did we do?

Ordinary admissions discharged in month who are flagged as having frailty

MonthYear	Discharge Month	Frail Inpatient Discharges
Apr-18	30/04/2018	690
May-18	31/05/2018	760
Jun-18	30/06/2018	753
Jul-18	31/07/2018	688
Aug-18	31/08/2018	740
Sep-18	30/09/2018	649
Oct-18	31/10/2018	740
Nov-18	30/11/2018	675
Dec-18	31/12/2018	740
Jan-19	31/01/2019	793

ED Attendances that were screened for frailty

MonthYear	Discharge Month	Total Frailty Screenings in ED
Apr-18	30/04/2018	1391
May-18	31/05/2018	1554
Jun-18	30/06/2018	1325
Jul-18	31/07/2018	1388
Aug-18	31/08/2018	1552
Sep-18	30/09/2018	1550
Oct-18	31/10/2018	1413

Nov-18	30/11/2018	1470
Dec-18	31/12/2018	1502
Jan-19	31/01/2019	1709

Clinical Effectiveness - Keeping patients safe from infection

What was our aim?

- *Methicillin-resistant Staphylococcus aureus* (MRSA) blood stream infections (BSI), to have 0 cases of hospital attributable cases
- *Clostridium difficile* infection (CDI) to be under the trajectory target of 48 hospital attributable cases

1. **Reducing Gram Negative Blood Stream Infections (BSIs)**

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

E. coli BSI figures have been published by Public Health England since 2011. In 2017 it also became mandatory to submit *Klebsiella spp.* and *Pseudomonas aeruginosa* blood stream infection data to PHE.

How progress will be achieved, monitored and measured

The NNUHFT Infection Prevention and Control Team (IPCT) will continue to collect and review surveillance data for all Gram negative BSIs and complete enhanced mandatory surveillance for any healthcare-associated Gram-negative BSI.

NNUHFT IPCT and the Antimicrobial Stewardship Team will enforce the following measures to reduce healthcare associated Gram negative BSIs in 2019/20 :-

- Update the Trust guidelines for the use and care of urethral and suprapubic catheters and the urinary catheter monitoring chart.
- Provide guidance on when it is appropriate to dipstick urine and why.
- Provide guidance on collecting urine samples and provide a patient information leaflet on Urinary Tract Infection (UTI).
- Implement the Antibiotic CQUIN 2019/20 Diagnosing and Treating UTIs in the over 65's.
- Enforce principles of good antimicrobial stewardship through education, dedicated antimicrobial stewardship ward rounds and audits, and use of supportive national guidance such as Start Smart Then Focus
- Continue collaboration with other Norfolk acute, community and CCG infection Control teams who are participating in the Norfolk Urinary Tract Infection Collaborative project (NUTIC) to improve the quality of urine sampling across the county, and decrease unnecessary sampling and antimicrobial treatment.
- Review the safety thermometer data for the Trust: number of catheters and catheter associated urinary tract infections (CAUTI).

2. Carbapenemase-producing Enterobacteriaceae (CPE)

Public Health England (PHE) has said "*the spread of **Carbapenemase-producing Enterobacteriaceae** (CPE) is a matter of national and international concern as they are an emerging cause of healthcare-associated infections, which represent a major challenge to health systems. CPE remains a significant concern because the trend in detections is increasing on a year-on-year basis. Infections caused by CPE are*

associated with an increase in morbidity, attributable mortality, and healthcare costs".
PHE publications gateway 2019

How progress will be achieved, monitored and measured
The PHE acute trust toolkit for the early detection, management and control of carbapenemase-producing Enterobacteriaceae (CPE) 2013 is embedded in the Trust guidance for staff to follow. It provides practical advice for the management of colonisation or infection, risk assessment tools and patient information leaflets. The toolkit has been reviewed and during 2019 a Framework of Actions to contain CPE will be published. The IP&CT will update the Trust guidance accordingly.

The IP&CT will continue to collect and review surveillance data for CPE positive cases and complete enhanced surveillance for any new cases of CPE identified.

CPE figures will be reported to the Board via the Integrated Performance Report (IPR).

3. IP&C Improvement Programme

In February 2019 the Trust was risk rated as red for IP&C following an IP&C inspection by NHSI. An IP&C rapid recovery plan was put in place and will continue into 2019/20.

How progress will be achieved, monitored and measured
IP&C and Quality Improvement Teams are working with the clinical teams to support the improvement programme ahead of the NHSI return visit in July 2019. IP&C recovery action plans are in place with measures for improvement e.g. cleaning and IP&C audit results. Monitoring will be via oversight meetings and as part of the QIP programme.

A series of Matrons and Ward manager master classes and education will commence. The IP&C link practitioner programme has been reviewed and the divisions have made a commitment pledge to increase the number of link practitioners so that there is at least one in each of the clinical areas.

A communication strategy has commenced to ensure that audit results, changes made and outcomes reach all staff within teams and that learning is shared.

How did we measure our performance?
Since April 2004 it has been mandatory for NHS acute Trusts to report all cases of MRSA BSI. Also CDI for patients aged 65 years and over. For CDI in April 2007 this was then extended to include all cases in patients aged 2 years and over.

Public Health England uses the surveillance data we send to produce spread sheets and graphs that we used to measure our performance against other acute Trusts.

Internally the Infection Prevention and Control (IP&C) monthly report continues to be distributed with surveillance and alert organism data in graphs and tables updated monthly. Local CDI and MRSA BSI data by ward is available to staff on the IP&C dashboard as part of on-going surveillance. Results are monitored via the hospital infection control committee.

For any hospital attributable cases of MRSA BSI and CDI the clinical teams from the hospital and IP&C nurses from the clinical Commissioning Group (CCG) and the hospital review every case.

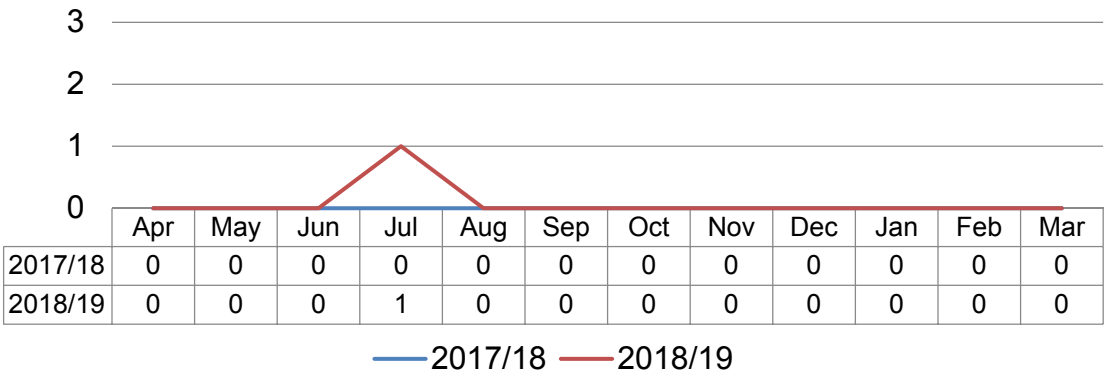
The post-infection review process establishes whether there have been any lapses in care that can be learnt from. Learning is then shared throughout the Trust via the monthly

IP&CT organisational wide learning [OWL] and as part of the divisional governance meetings.

How did we do? MRSA BSI

The Trust 2018-19 MRSA BSI objective was 0 hospital acquired cases and the Trust had **1** case. A post infection review meeting was undertaken and the overall impression was that the positive blood culture was unlikely to represent a genuine MRSA infection.

MRSA HAI BSI Cases

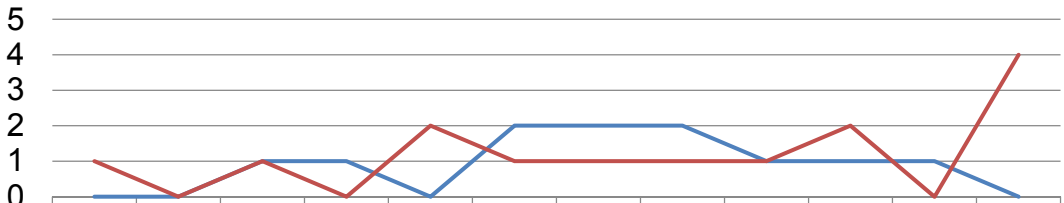


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2017/18	0	0	0	0	0	0	0	0	0	0	0	0
2018/19	0	0	0	1	0	0	0	0	0	0	0	0

How did we do? CDI The CDI objective was to stay below 48 hospital attributable cases which we have achieved, along with an improvement on the 2017/18 figures, see table 1. The final total was **31** CDI cases deemed to be hospital acquired. We successfully appealed **17** cases resulting in a final trajectory target total for the year of **14**.

Table 1 CDI summary all cases	Non-Trajectory	Trajector	Pending	Total
Quarter 4	**2**	**6**	**0**	**8**
Quarter 3	**1**	**3**	**0**	**4**
Quarter 2	**8**	**3**	**0**	**11**
Quarter 1	**6**	**2**	**0**	**8**
April 18 to March 19	**17**	**14**	**0**	**31**
April 17 to March 18	***24***	***11***	***0***	***35***

HAI CDI Cases (excluding non-trajectory)



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2017/18	0	0	1	1	0	2	2	2	1	1	1	0
2018/19	1	0	1	0	2	1	1	1	1	2	0	4

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 increased recruitment into NIHR studies in 2019-20.

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 2018/19, our total recruitment was 4112 compared against 2017/18 recruitment of 3884.

The chart below shows that at the end of February we achieved our stated goal of recruiting 3300 participants into National Institute of Health Research (NIHR) studies in 2018/19.

Recruitment into Research Studies

Recruitment for 18/19	Number	Percent
Portfolio recruitment target	3300	
Total Recruitment	4122	
NIHR Portfolio	3702	90%
Non Portfolio	420	10%
Commercial Studies	163	4%
Non Commercial Studies	3959	96%

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 375 clinical research studies (335 in 2017/18) in a wide range of medical specialities during 2018/19. 112 new studies were opened in 2018/2019 (104 in 2017/18). There were around 150 clinical staff (Consultants) participating in research approved by a research ethics committee during 2018/19; 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 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 2018/19 building work has finished on the Quadram Institute (QI). The Clinical Research Facility (CRF) in QI, which is committed to becoming the leading facility for undertaking human health and nutrition research trials in the UK, opened its doors to research participants in September 2018. 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.

Clinical Effectiveness – 7 Day Services

What was our aim?

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 executive 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.

How did we do?

Standard		Mar 2018	Mar 2020	NNUH Assessment of compliance by March 2020
2	Time to first consultant review within 14 hours of admission	Target = 50% **Actual = 69%**	Target = 100%	To achieve compliance, investment in resources will be required. All specialties are reassessing rotas and capability. Any requirements to deliver will be signed off by divisions.
5	Part a - Availability – scheduled seven-day access to diagnostic services: Part b - Performance - Consultant-directed diagnostic tests and completed reporting will be available seven days a week: 1 hour for critical patients; 12 hours for urgent patients and 24 hours for non-urgent patients	Availability Target = 50% **Actual = 94%** Performance Target = 50% **Actual = N/A**	Target = 90%	NNUH are currently assessed on availability of scheduled access to diagnostic tests and not the performance targets. 100% compliance to scheduled availability will be achieved in summer 2019 with a new seven day echocardiography service. To achieve compliance against the performance targets investment in resources is likely to be required. NNUH are currently aligning Diagnostic Imaging requesting and reporting to the seven day services performance standards through the Norfolk Imaging Alliance (NNUH, James Paget University Hospital and Queen Elizabeth Hospital) and developing an internal workforce gap analysis to be signed off by the Clinical Support Services division.
6	Access to consultant-directed interventions	Target = 50% **Actual = 100%**	Target = 100%	NNUH intends to maintain 100% compliance to this standard
8	Ongoing review by consultant, twice daily for high dependency patients, daily for others	Target = 50% **Actual = 97%**	Target = 95%	March 2020 targets are being achieved with current processes

Key results / themes of the internal autumn 2018 audit:

- 72% of patients received a consultant review within 14hrs.
- Compliance is lower if a patient is admitted in the afternoon (between 13:00-18:00) than in the morning / evening - 55% in the afternoon compared to 80% at other times – see table 1.
- There was no marked difference in weekend (75%) v weekday (71%) performance.
- 89% of patients received a senior review from an ST3+ within 14 hrs.

	Autumn 2016	Spring 2017	Autumn 2017	Spring 2018	Autumn 2018
Clinical Standard 2: Time to first consultant review	76%	61%	60%	69%	72%

Clinical Standard 5: Access to consultant directed diagnostics	N/A	94%	N/A	94%	N/A
Clinical Standard 6: Access to consultant directed interventions	N/A	94%	N/A	100%	N/A
Clinical Standard 8: Ongoing daily consultant review	Once daily: 98% Twice daily 96%	94%	N/A	97%	N/A

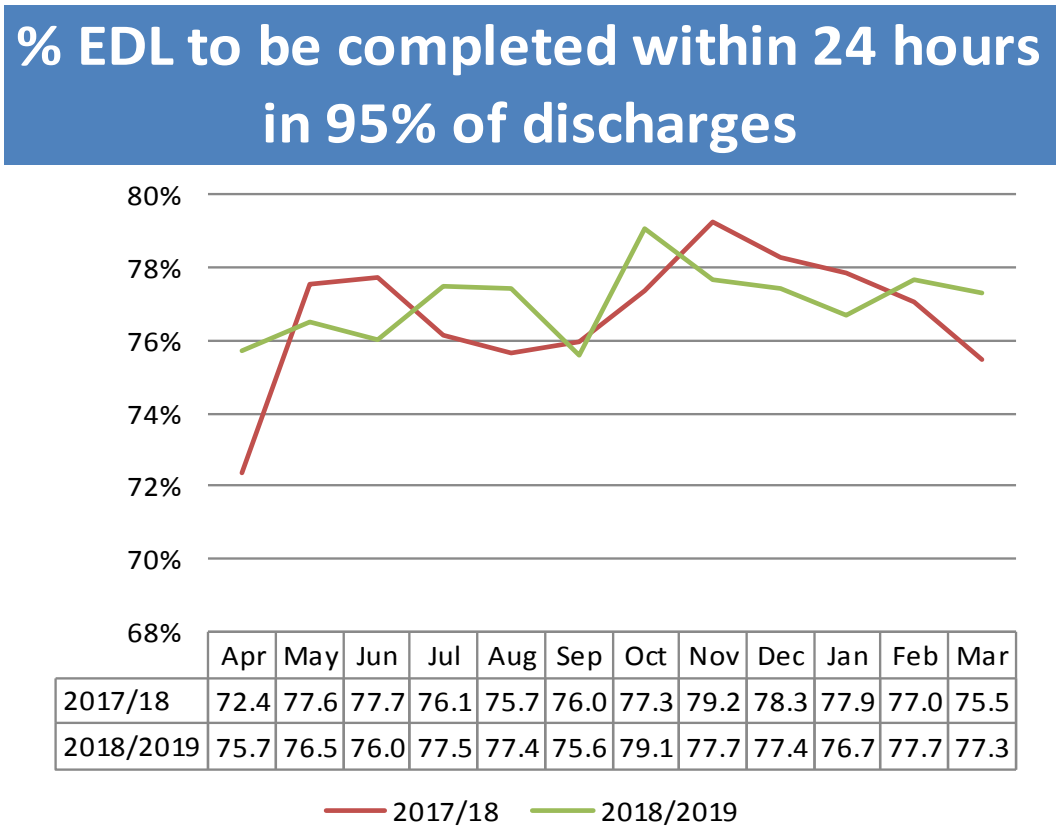
The next internal audit is due in March 2019 and will be reported in June 2019.

Carer and Patient Experience - Change: Improved discharge processes and communication

What was our aim?
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 (EDL) as at present but updated to include Outpatient letters according to required electronic format.

How did we do?



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
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
2018/2019	75.7	76.5	76.0	77.5	77.4	75.6	79.1	77.7	77.4	76.7	77.7	77.3

As the chart above demonstrates, we have now started reviewing the Estimated Date of Discharge (EDD) for the majority of our patients on admission. There is further work needed to fully embed this and the SAFER Flow bundle is being re-launched to support this, which will complement the STP transformation plan.

EDL performance is significantly improved compared to the previous year but it continues to be a challenge. What has been identified is that the cause of this is multifaceted; this

means that we can now continue to address issues such as IT hardware availability, process clarification and inclusion definitions during 2019/20 to further improve performance.

Carer and Patient Experience - Improved continuity of care and experience through reduced ward moves and reduced numbers of outliers

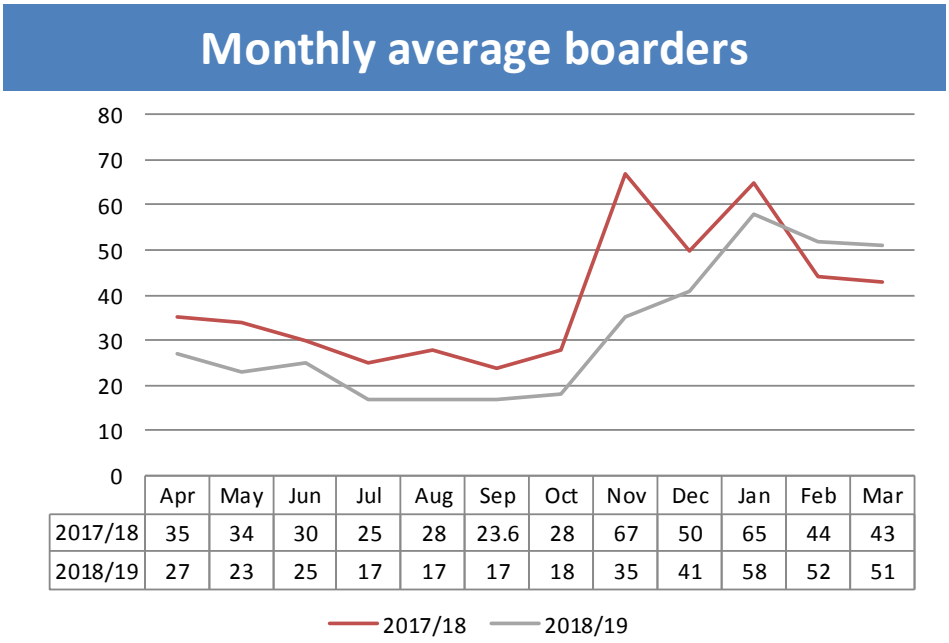
What was our aim?

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

How did we do?



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2017/18	35	34	30	25	28	23.6	28	67	50	65	44	43
2018/19	27	23	25	17	17	17	18	35	41	58	52	51

Carer and Patient Experience - New Priority: To improve our care to those at the end of their life

What was our aim?

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

How did we do?

DNACPR compliance – Local audits demonstrate these forms have been completed. 85% of patients who died (Nov/Dec) have had this decision discussed with their next of kin. 50% of patients at end of life had this discussed with them (many too poorly or lacked capacity to have this discussion).

No of Individualised care plans in place – see No 4 this is audited here and No 5. Local Audit November/December 2018 45% patients audited were on an Ind. Care Plan (this is not just the text of the notes but on the specific care plan).

Weekly audits of 5 patients who have died are now being undertaken. Results discussed at bi-monthly end of life steering group (undertaken and report written by education team). Item to be added as standing agenda item.

End of Life audit: undertaken on 80+ sets of notes – results have been received and are very promising. Once approved by Trust board, an action plan will be written and disseminated through the end of life steering group and CaPE board.

Carer and Patient Experience - New Priority: To improve the assessment and quality of care for patients in Mental Health crisis

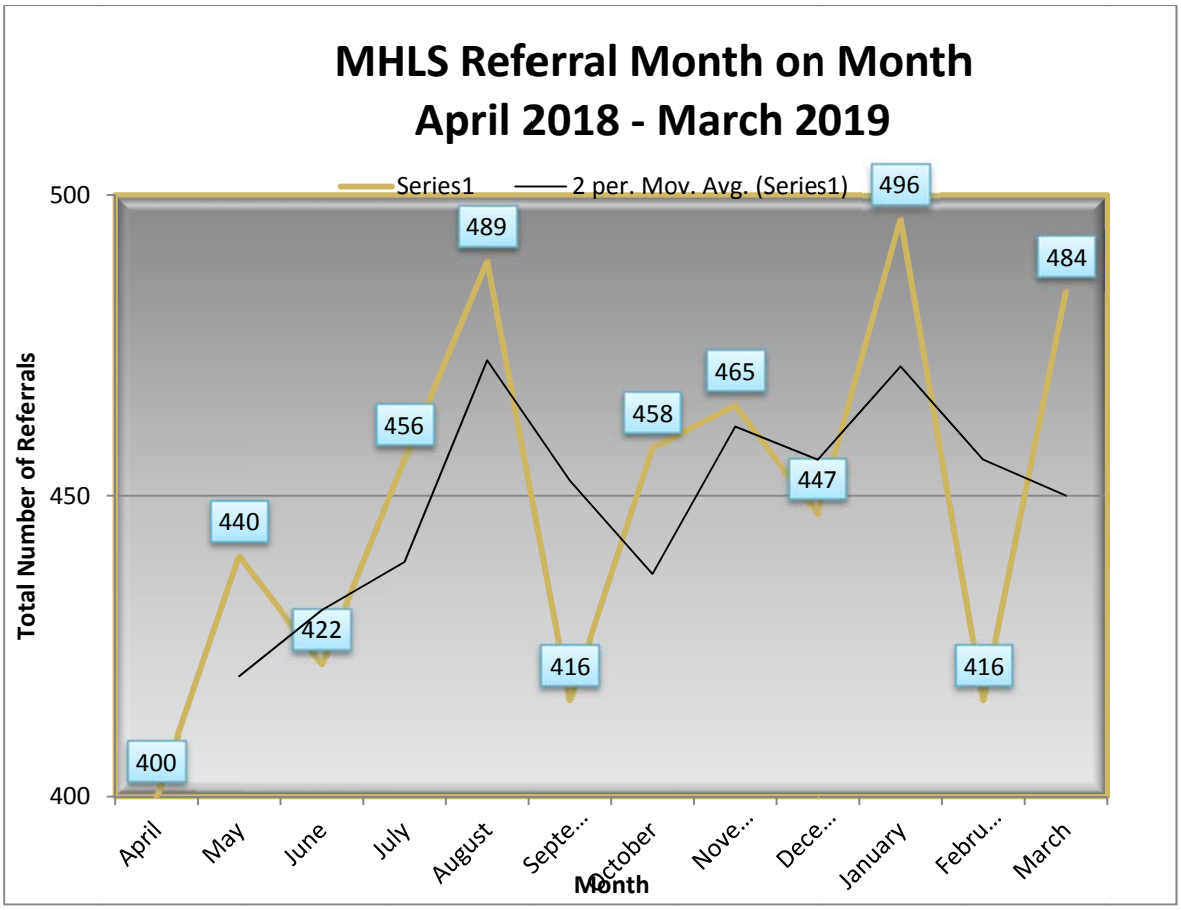
What was our aim?

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

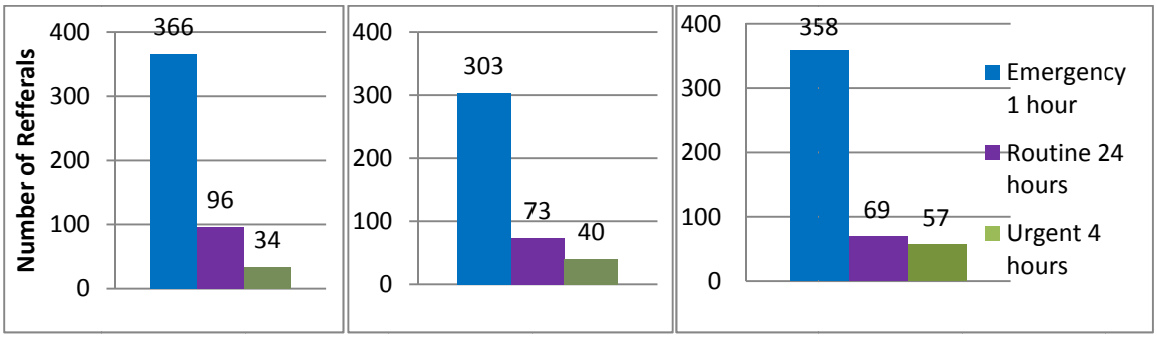
- Number of referrals to Psychiatric liaison from:
  - ED/ assessment areas (where)
  - Wards (and where).
  - Waiting time from referral to assessment
  - standard 1hr ED, 4hrs
  - assessment areas including EAUS
  - 24hrs response for wards
- Staff training – numbers trained in year and outcome of 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.

How did we do?



Number of referrals to Psychiatric liaison by NNUH Locations

	16/17	17/18	18/19
Number of referrals	3900	5224	5432



NNUH Referrals to MHLS by priority Jan-March 2019

Staff Training

In 2018, the Trust commenced a Mental Health (MH) Training workstream as part of the Mental Health Improvement Plan. However, due to operational pressures and a need to prioritise elements of work within the Improvement Plan, this workstream did not progress at the intended pace. Consequently, the Training Workstream is scheduled to recommence in April 2019.

The purpose of the training workstream is to pull together all elements of mental health training provision across the Trust, to ensure that there is a joined up strategy for delivery.

Going forward, it is intended that the NNUH will hold a full one day Mental Health Induction course, which will be applicable to all new employees (clinical and non-clinical). The training plan will be pragmatic so as to include details regarding how this new induction will also be rolled out to existing employees.

The induction will consist of the following four topic areas (to become known as Tier 1, Core Mental Health Training):

- Mental Health Awareness – Introduction to Common MH Presentations in Acute Hospital Population: Recognising Signs and Symptoms.
- Cognitive Impairment: Introduction to Delirium, Dementia and Mental Capacity.
- Trauma-Informed Care.
- Communicating Positively in Challenging Circumstances: An Introduction to Non-Violent Communication.

In addition to the Tier 1 Core Training, there will also be area specific (Tier 2) training available, which will provide more in depth specialist knowledge into key areas, for example delivery of Eating Disorders training for Gastroenterology wards, delivery of Dementia training for Older People's Medicine wards, and so forth.

More specialist knowledge, or specific individual topics, will be covered on a case by case basis (Tier 3 training) and will include topics such as:

- Understanding Self-Harm
- Understanding Personality Disorder
- Introduction to Medically-Unexplained Symptoms.

In addition to the development and delivery of the planned Mental Health Induction programme, the training workstream will naturally incorporate those elements of future training developments that have already been mentioned above (specifically but not exclusive to Restrictive Interventions, Learning Disabilities and Dementia).

Board Assurance Statements

Review of services

During 2018/19 the Norfolk and Norwich University Hospitals NHS Foundation Trust provided and/or sub-contracted 83 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 83 of these relevant health services.

The income generated by the relevant health services reviewed in 2018/19 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 2018/19.

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

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

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

During 2018/19 52 national clinical audits and 4 national confidential enquires covered relevant health services that Norfolk and Norwich University Hospitals NHS Foundation Trust provides.

During that period Norfolk and Norwich University Hospitals NHS Foundation Trust participated in 98% national clinical audits (51/52) and 100% national confidential enquires (4/4) which it was eligible to participate in. We also participated in other National Audits which fall outside of the Quality Account recommended list.

The national clinical audits and national confidential enquiries that Norfolk and Norwich University Hospitals NHS Foundation Trust was eligible to participate in during 2018/19 are below. The number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry is given.

National Clinical Audit (alphabetical order)	Eligible y/n	Took part y/n	Participation Rate Cases Submitted	Completed/ In-progress/ Ongoing
Adult Cardiac Surgery	N	N/A	N/A	N/A
Adult Community Acquired Pneumonia	Y	Y	Data currently being entered 100% anticipated	Ongoing
British Association of Urological Surgeons (BAUS) Urology Audit – Cystectomy	Y	Y	Figures not yet available, 100% anticipated	Ongoing
British Association of Urological Surgeons (BAUS) Urology Audit – Female Stress UrinaryIncontinence (SUI)	Y	Y	Figures for 2018/19 not yet available, 100% anticipated	Ongoing
British Association of Urological Surgeons (BAUS) Urology Audit – Nephrectomy	Y	Y	Figures not yet available, 100% anticipated	Ongoing
British Association of Urological Surgeons (BAUS) Urology Audit - Percutaneous Nephrolithotomy (PCNL)	Y	Y	Figures for 2018/19 not yet available, 100% anticipated	

				Ongoing
British Association of Urological Surgeons (BAUS) Urology Audit – Radical Prostatectomy	Y	Y	83/83 (100%) (01/04/18 – 31/12/18)	Ongoing
Cardiac Rhythm Management (CRM)	Y	Y	Electro-Physiology 319/320 (99.7%) Pacemakers 1101/1102 (99.9%)	Ongoing
Case Mix Programme (CMP)	Y	Y	1456/1456 (100%) (01/04/18 – 31/12/18)	Ongoing
Child Health Clinical Outcome Review Programme	Y	Y	No data required to be submitted in 2018	Ongoing
Elective Surgery (National PROMs Programme)	Y	Y	Hip 547/483 (88%) Knee 462/129 (93%)	Ongoing
Falls and Fragility Fractures Audit Programme (FFFAP)*	Y	Y	Data currently being entered 100% anticipated	Ongoing
Feverish Children (care in Emergency Departments)	Y	Y	128/128 (100%)	Complete
Inflammatory Bowel Disease programme / IBD Registry	Y	Y	5/5 100%	Ongoing
Learning Disability Mortality Review Programme (LeDeR)	Y	Y	15 cases submitted to LeDeR (100%) LeDeR allocated 8 for review by NNUH 6 of those completed (75%)	Ongoing
Major Trauma Audit	Y	Y	342/647 (53%) for the period April to December 2018, anticipated final submission for year 80%	Ongoing

Mandatory Surveillance of Bloodstream Infections and Clostridium Difficile Infection	Y	Y	MRSA Blood Stream Infection: 1 Hospital Acquired Infection (HAI) MSSA Blood Stream Infection: 10 HAI 73 Community Acquired Infection (CAI) 83 Total C. difficile: 25 HAI, 15 Non-Trajectory, 8 Trajectory, 2 Pending Cases, (NHS England Target <48) E. coli: 48 HAI 247 CAI, 295 Total Klebsiella Species – 12 HAI 46 CAI, 56 Total Pseudomonas aeruginosa – 14 HAI 26 CAI, 40 Total	Ongoing
Maternal, Newborn and Infant Clinical Outcome Review Programme	Y	Y	100% of required data submitted Maternal death 1 Late Fetal Loss 6 Terminations 1 Stillbirth 26 Early Neonatal Death 5 Late Neonatal Death 2	Ongoing
Medical and Surgical Clinical Outcome Review Programme	Y	Y	Pulmonary Embolism Study: 5/6 clinician forms (83%) 6/6 notes extracts for review (100%)	Ongoing
Mental Health Clinical Outcome Review Programme	N	N/A	N/A	N/A
Myocardial Ischaemia National Audit Project (MINAP)	Y	Y	937/1027 (91.2%)	Ongoing
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme*	Y	Y	Asthma Audit data currently being entered 100% anticipated COPD 279/279 (100%)	Ongoing

National Audit of Anxiety and Depression	N	N/A	N/A	N/A
National Audit of Breast Cancer in Older People	Y	Y	259/259 (100%)	Ongoing
National Audit of Cardiac Rehabilitation	Y	Y	3180/3325 (95.6%)	Ongoing
National Audit of Care at the End of Life (NACEL)	Y	Y	150/150 (100%)	Complete
National Audit of Dementia	Y	Y	50/50 (100%)	Complete
National Audit of Intermediate Care	N	N/A	N/A	N/A
National Audit of Percutaneous Coronary Interventions (PCI)	Y	Y	1490/1657 (89.9%)	Ongoing
National Audit of Pulmonary Hypertension	N	N/A	N/A	N/A
National Audit of Seizures and Epilepsies in Children and Young People	Y	Y	137/137 100%	Ongoing
National Bariatric Surgery Registry (NBSR)	N	N/A	N/A	N/A
National Bowel Cancer Audit (NBOCA)	Y	Y	337/337 (100%)	Ongoing
National Cardiac Arrest Audit (NCAA)	Y	Y	38/38 (100%) (01/04/18 - 30/09/18) No further figures available until April 2019	Ongoing
National Clinical Audit for Rheumatoid and Early Inflammatory Arthritis (NCAREIA)	Y	Y	162 (Unable to determine percentage)	In progress (2 years)
National Clinical Audit of Psychosis	N	N/A	N/A	N/A
National Clinical Audit of Specialist Rehabilitation for Patients with Complex Needs following Major Injury (NCASRI)	N	N/A	N/A	N/A
National Comparative Audit of Blood Transfusion programme*	Y	Y	Management of major haemorrhage 10/10 (100%) Audit of use of Fresh Frozen Plasma, Cryoprecipitate and of Transfusions for Bleeding in neonates and children 5/5 (100%)	In progress
National Congenital Heart Disease (CHD)	N	N/A	N/A	N/A

National Diabetes Audit – Adults*	Y	Y	National Diabetes Audit 3611/3611 (100%) Adult Foot Inpatient Audit 246/246 (100%) Diabetes in Pregnancy Audit 39/39 (100%)	Ongoing
National Emergency Laparotomy Audit (NELA)	Y	Y	242/242 (100%) April 2018 to End of Jan 2019	Ongoing
National Heart Failure Audit	Y	Y	185/686 (27%)	Ongoing
National Joint Registry (NJR)	Y	Y	1099/1099 (100%) over 2018, figures only available per calendar year	Ongoing
National Lung Cancer Audit (NLCA)	Y	Y	Data taken by the Royal College of Physicians 2018/19 figures not yet available 100% anticipated	Ongoing
National Maternity and Perinatal Audit (NMPA)	Y	Y	All births have been registered nationally, data is taken directly by NHS Digital	Ongoing
National Mortality Case Record Review Programme	Y	N	0	Did not participate as recommended methodology not in place will participate in future
National Neonatal Audit Programme (NNAP)	Y	Y	All discharges from Neonatal Intensive Care Unit (NICU) registered on the BadgerNet data-base 1206 cases 100%	Ongoing
National Audit of Oesophago-gastric Cancer (NAOGC)	Y	Y	Data currently being inputted Anticipated to be 200 (100%)	Ongoing
National Ophthalmology Audit	Y	Y	4407/4407 (100%)	Ongoing
National Paediatric Diabetes Audit (NPDA)	Y	Y	All data has been submitted as required. Actual numbers currently unavailable until publication of report	Complete
National Prostate Cancer Audit	Y	Y	431/431 (100%) (01/04/18 – 31/12/18)	Ongoing
National Vascular Registry	Y	Y	Acute Aortic Aneurysms – 104/104 (100%) Carotid Endarterectomy – 54/65 (83%)	Ongoing

			Lower Limb Angioplasty – 4/255 (2%) Infra-inguinal Bypass – 43/88 (49%) Lower Limb Amputation – 66/66 (100%)	
Neurosurgical National Audit Programme	N	N/A	N/A	N/A
Non-Invasive Ventilation – Adults	Y	y	Data currently being entered 100% anticipated	Ongoing
Paediatric Intensive Care (PICANet)	N	N/A	N/A	N/A
Prescribing Observatory for Mental Health (POMH-UK)*	N	N/A	N/A	N/A
Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis)*	Y	Y	Timely identification of sepsis 900/900 (100%) Timely treatment for sepsis 641/641 (100%) Antibiotic Review 191/191 (100%) Reduction in antibiotic consumption per 1,000 admissions and proportion of antibiotic usage 100%	Ongoing
Sentinel Stroke National Audit programme (SSNAP)	Y	y	1047/1047 (100%)	Ongoing
Serious Hazards of Transfusion (SHOT): UK National Haemovigilance	Y	Y	16/16 (100%)	Ongoing
Seven Day Hospital Services	Y	Y	April 2018 245/245 (100%) October 245/245 (100%)	Completed
Surgical Site Infection (SSI) Surveillance Service	Y	Y	Vascular SSI 209 Quarters 1 and 2 (percentage not available) Lower Segment Caesarean Section 787 Quarters 1 and 2 (percentage not available) Further data not yet available	On –going
UK Cystic Fibrosis Registry	Y	y	77/77 (100%)	ongoing
		Y	120/120	Complete

Vital Signs in Adults (care in emergency departments)			(100%)	
VTE risk in lower limb immobilisation (care in emergency departments)	Y	Y	132/132 (100%)	Complete

The reports of 18 national clinical audits were reviewed by the provider in 2018/19 and Norfolk and Norwich University Hospitals NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided (see Table A).

Examples of 43 local clinical audits reviewed by the provider in 2018/19 and Norfolk and Norwich University Hospitals NHS Foundation Trust are given below (See Table B, page 37).

Table A

Audit and Survey Title	Results/Actions Taken / Planned
National Audit of Cardiac Rehabilitation (NACR)	This audit was undertaken to determine if the Norfolk and Norwich cardiac rehabilitation services are fulfilling national standards. The audit for a partial year found that we are exceeding the minimum standards for 5 of the 7 standards. Following the audit we are in discussion with the National Audit of Cardiac Rehabilitation for the acceptance of our 42 day programme, which is slightly shorter than their standard of 56 days to help improve patient care.
Audit to British Society of Gastroenterology (BSG) quality and safety indicators for endoscopic ultrasound (EUS)	This audit was undertaken to assess standards of clinical quality in endoscopic ultrasound (EUS) against those set by the Joint Advisory Group (JAG) on gastrointestinal endoscopy. This audit found that over the year of 2017 the department achieved high compliance with the JAG standards. Results were fed back to the department and no further action needed.
Serious Hazards of Transfusion (SHOT): United Kingdom National Audit and Haemovigilance Scheme	The aim of this national audit was to collate and identify themes from all incidents reported through the Serious Hazards of Transfusion (SHOT) scheme and where risks and problems are identified produce recommendations to improve patient safety. SHOT produced an annual report in July 2018 covering incidents which had taken place during 2017 and made three key recommendations. We are meeting recommendations about training in blood groups and use of information technology. We do not have a formal pre-transfusion risk assessment for transfusion associated circulatory overload (TACO). We reduce risk of TACO with single unit transfusions and mandatory training.
United Kingdom Renal Registry (UKRR) Audit	This national audit was undertaken to compare quality of care indicators from renal centres across the United Kingdom. The annual report was published in July 2018. The report was presented and discussed at the Renal Governance meeting. Further work into transplantation, anaemia and vascular access is being undertaken to improve patient care.
Case Mix Programme (CMP) Audit	The aim of this on-going audit was to collect data on all patients admitted to the Critical Care Unit. The annual quality report for 2017/8 was reviewed. Data completion was close to 100% in all domains. On reviewing the quality dashboard the Trust was consistent with United Kingdom data. We have a large unit with high through put. Overall our Standardised Mortality Ratio (SMR) was below 1. Following review of the report, no actions were necessary.

National Cardiac Arrest Audit (NCAA)	This audit was undertaken to identify patients who had a cardiac arrest at the NNUH; to see if the arrest could have been prevented or if a Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) order should have been made; and to disseminate these findings to improve care. The National Cardiac Arrest Audit Report was published 20th November 2018 and was circulated to the Resuscitation Officer. The audit found a low incidence of cardiac arrests per 100 admissions compared to other hospitals. Initial survival was 52.3% and survival to discharge was 15.8%. The report was discussed at the Recognise and Respond Committee meeting. A Development of Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) Implementation Group was initiated to improve education of staff and patient care.
Audit of Potential Organ Donation	The Potential for Organ Donation National Audit is a summary of the number of potential donors, actual donors, patients transplanted, average number of organs donated per donor and organs donated, obtained from the UK Transplant Registry. The Report of Actual and Potential Deceased Organ Donation (1 April 2018 to 30 September 2018) was published in November 2018. The Trust referred 27 potential organ donors during the first six months of 2018/19. From 13 consented donors the Trust facilitated 8 actual solid organ donors resulting in 22 patients receiving a life-saving or life-changing transplant. There was 1 occasion where a potential organ donor was not referred. The results of the report were discussed at the Trust Organ Donation Committee. The missed opportunity rates were reviewed at the Critical Care Governance Meeting and actions discussed.
National Audit of Breast Cancer in Older People (NABCOP)	This audit was undertaken to evaluate the quality of care provided to women aged 70 years and older by breast cancer services in England and Wales. The national annual report was published in June 2018, and reviewed at the Breast Surgery Departmental meeting where it was determined that all recommendations in the report are followed and no further action was required.
National Emergency Laparotomy Audit (NELA)	This audit was undertaken to assess the delivery of key processes of care for patients undergoing emergency laparotomy, and to report outcomes at hospital level for patients undergoing emergency laparotomy in England and Wales. The annual report was published on 8th November 2018 and reviewed by the Specialty Audit Lead. The Trust achieved a 100% risk assessment rate, had a lower length of stay (9 days against national median 11 days) and better mortality rate (10.3% against national mean of 10%). Areas of concern were the rate of admissions to critical care (70% against national rate 88%), and Consultant presence in theatres (58% against national rate 83%). Work is ongoing in respect of these and Surgical Consultant input in theatre has improved to 100% and Anaesthetic Consultant input to above 80%.
National Vascular Registry (NVR)	The National Vascular Registry (NVR) purpose is to provide comparative figures on the performance of vascular services in NHS hospitals and support vascular specialists with local benchmarking and quality improvement. The annual report was published on28th November 2019 and was shared with the Specialty Audit Lead for review. Elective Abdominal Aortic Aneurysm (AAA) and Carotid Endarterectomy (CE), case ascertainment above the national standard of 90% was achieved (100% for AAA and 98% for CE). The Trust was the 6th busiest Aortic Centre in the United Kingdom, with excellent adjusted mortality rate for AAA, despite performing a larger proportion of open AAA repairs than the national average. The Trust achieved 98.2% risk adjusted 30 day stroke free survival rate in relation CE, and had one of the shortest symptom to surgery times; median 8 [5-10] days, lower than the National Institute for Health and Care Excellence (NICE) guidelines recommendations and NVR aspiration standard of 14 days.

National Hip Fracture Database (NHFD) *(Part of Falls and Fragility Fractures Audit Programme)*	The National Hip Fracture Database (NHFD) was established as part of the Falls and Fragility Fractures Audit Programme, and aims to improve the care and secondary prevention of hip fracture. The annual report was published on 15th November 2018. The Trust had a reduction in crude and adjusted 30 day mortality rates; the Trust is no longer an outlier for mortality. Acute length of stay was reduced. There was a low rate of 120 day follow up, admission to an orthopaedic ward within 4 hours, physiotherapy review on day 1 post-procedure. Improvements have been made since the data was submitted and almost all patients are seen by a physiotherapist on day 1 post-procedure.
National Joint Registry (NJR)	The National Joint Registry (NJR) was established to collect data relating to joint replacement surgery in order to provide an early warning of patient safety issues, and continuously drive improvements in the quality of patient outcomes. The annual report was published on 25th September 2018. The outcomes and recommendations in the annual report were reviewed within the specialty. The new Minimum Data Set (MDS7) has been introduced into the Bluespier system and coordinated with the perioperative theatre management system to ensure ongoing data compliance. A review of local level surgeon data was undertaken and no actions were required.
British Association of Urological Surgeons (BAUS) Urology Audits: Radical Prostatectomy Audit	This audit was undertaken to determine standards across the UK. The data for 2017 was published on 23rd July 2018. 100% of the 83 cases were reported to the national British Association of Urological Surgeons (BAUS) data base. The outcome data in comparison with the national figures for 2017 was excellent. There were no transfusions; median length of stay was 1 day in line with national figures. No further actions were required.
National Neonatal Audit programme (NNAP)	This national audit was undertaken to assess whether babies admitted to Neonatal Units in England receive consistent care in relation to several audit questions. Data on all discharges from the Neonatal Intensive Care Unit (NICU) are entered onto the NICU data capture system BadgerNet NICU was highlighted as an outlier for documented consultation with parents within 24 hours of admission. The proportion of admitted babies having measurement of temperature within 1 hour of birth and being given antenatal steroids was lower than the national average. Actions implemented include; adding a new entry on the nursing admission checklist to confirm the admission time with the admitting doctor; new reminder signs on notes trolleys and to all clean incubators and cots and Review of BadgerNet entries for accuracy. Modification of the care bundle and a "warm chain" audit has been implemented.
Learning Disability Mortality Review Programme (LeDeR Programme) Audit	This national project is aimed at identifying, through structured mortality reviews of all deaths of people aged 4+ with a learning disability, learning points, areas for improvement, themes, mortality trends, and good practice. The audit has helped us to commence collaborative working relationships as well as identifying key areas for improvement and action to improve patient care. A combined Speech and Language Therapy and Learning Disability (LD) Liaison structured judgement review on risk-feeding pathway and mortality has taken place. LD Liaison staff now participate in the Restrictive Intervention Group and the Mental Health Operational Board.
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. Following publication of benchmarking data, case selection processes have been revised to enable more timely submissions, a review of time to definitive airway in patients with Glasgow Coma Scale less than 9 and formal peer review of unexpected deaths is being undertaken.

Elective Surgery National Patient Reported Outcome Measures (PROMS) Programme	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.
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 reports on Heart Failure, Cancer in Children, Teens and Young Adults, and on Perioperative Diabetes. The self-assessment document for the Heart Failure Study is still in progress. Actions implemented following review of compliance to recommendations from the Perioperative and Cancer studies included; ensuring all systemic anti-cancer therapy prescriptions available on the Trust Information Technology systems and education of staff to ensure the safe handover of patients with diabetes from theatre recovery to the ward.

Table B Local Audits

Audit and Survey Title	Results / Actions Taken / Planned
Re-Audit of World Health Organisation (WHO) checklist in Cardiology Catheter Labs	This audit was undertaken to ensure that all components of the WHO checklist and handover signatures are completed for patients undergoing a procedure in the Cardiology Catheter Laboratory. This audit found improvement since the previous audit in completeness of documents such as the safe surgery checklist and handovers signatures. There are still some areas requiring improvement. The results were communicated to staff and posters created. Regular spot checks of documentation are undertaken and a re-audit completed. The re-audit demonstrated a marked improvement in completion of the documents. The audit is on-going.
Re-Audit of World Health Organisation (WHO) surgical checklist	This audit was undertaken to monitor the use of the WHO checklist for procedures carried out in the Endoscopy Unit. A sample of procedures was audited each month. The use of the WHO checklist has remained high over the audit period. No further action needed.
Audit of Compliance to local Safety Standards for Invasive Procedures (LocSSIP) for Botulinum Toxin Injections	This audit was undertaken to determine compliance with the Local Safety Standards for Invasive Procedures (LocSSIP) for Botulinum Toxin Injections. The results found that 100% of patients had documented consent prior to the first injection, however only 25% of patients had full documentation completed. As a result, documentation has been streamlined by updating the LoCSSIPs form and a re-audit will be undertaken to monitor compliance.
Audit of World Health Organisation (WHO) checklist	The aim of this audit was to ensure that all components of the World Health Organisation (WHO) checklist and handover signatures are completed for patients undergoing a procedure in the Respiratory Investigations Unit (RIU) The results found that there was an overall good compliance achieving on average 99-100% in Bronchoscopy and Pleural Procedures, however post procedure checks accounted for 1% of incomplete checks. As a result, observational audits have been introduced auditing 10% of weekly procedures carried out in RIU and the audit is ongoing to monitor compliance.

Audit of Transnasal Oesophagostomy (TNO) Local Safety Standards for Invasive Procedures (LocSSIP)	This audit was undertaken to determine compliance with the Local Safety Standards for Invasive Procedures (LocSSIP) in the Ears, Nose and Throat (ENT) Department. The Trust demonstrated an overall compliance rate of 85%. As a result of the audit, nursing staff check all notes and place LocSSIP's and consent forms inside the notes prior to the day of the procedure. Following the actions there has been an increase in awareness of utilizing LocSSIPs and the importance of ensuring they are completed by the medical staff. Compliance has risen to 100%. A re-audit has been planned in 19/20.
Re-Audit of compliance to LocSSIP (Local Safety Standards for Invasive Procedures) for Lumbar Puncture	This audit was undertaken to determine compliance to the use and completion of the local safety standard for invasive procedures for lumbar punctures on the Neonatal Intensive Care Unit (NICU). The results demonstrated good compliance to both audit standards and no specific actions were required.
Audit of compliance to LocSSIP (Local Safety Standards for Invasive Procedures) for Chest Drain	This audit was undertaken to determine compliance to the use and completion of the local safety standard for invasive procedures (LocSSIP) for chest drains in NICU. The findings highlighted documentation of the procedure could be improved along with completion of the LocSSIP form. As a consequence the LocSSIP has been incorporated into a condensed sticker format to be placed in the notes. A re-audit will be undertaken.
Audit of checklist completion for Local Safety Standards for Invasive Procedures (LocSSIP): Removal and Replacement of Surgical Voice Prosthesis (SVR)	This audit was undertaken to ensure that the Removal and Replacement of Surgical Voice Prosthesis LoCSSIP was being appropriately completed prior to patients undergoing this treatment. The audit demonstrated that the LocSSIPs were being fully completed in 100% of cases and due to high compliance, no immediate actions were required. A re-audit is planned for 2019/20.
Infection Control Alerts Transcription Audit	This audit was undertaken to monitor compliance of transcription of Infection Control alerts onto Casualty Cards by reception staff. The results of the audit found the trend line is positive overall with an 80% compliance frequently achieved however high staff turnover and new intake can have a significant negative impact on compliance. As a result, Patient Administration System alerts should be automatically transferred to symphony. This has been added to the symphony project team agenda and is currently with the software suppliers to look at feasibility. Audits will continue on a monthly basis until the process is automated.
Emergency Department Mental Capacity Documentation Audit	The aim of this audit was to ensure Mental Health (MH) risk assessment documentation is being completed and to identify actions to improve accuracy and consistency of information recording for patients with mental health aspects to their attendance. The results found that there was a poor compliance in general with inconsistent use of documentation. As a result the MH triage form has been re-designed and all clinical staff instructed how to use the form. Monthly audits will continue.
Re-Audit of Removal of Epidural Catheter Risk Assessment Tool (RAT) – compliance with use	This audit was undertaken to measure compliance with completion of the risk assessment tool for epidural catheter removal in areas that support epidural analgesia. A key success showed that at least one Registered Nurse per shift with epidural / patient controlled analgesia (PCA) enhanced practice training was on duty. Key concerns included the discharge Patient Care Record (PCR) document and risk assessment tool was not completed on all occasions; Key actions included feeding back to individual Ward Managers, including pain team members to highlight potential safety risks. A re-audit will be undertaken.

Re-Audit of epidural observations compliance	This audit was undertaken to measure compliance with Trust guidelines for the safe management of epidural analgesia for adults and children. Key successes demonstrated that Buxton Ward, Critical Care Unit (CCU) and Cringleford Ward were 100% compliant with the audit standards. No key concerns were identified. Key actions included discussing results with individual ward areas and the Pain Service. A re-audit has also been planned.
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) in the Paediatric and Emergency Departments. Overall compliance with the documentation aspects of this audit remained poor although Quarter 3 results demonstrated an improvement in the frequency of observations matching the clinical guideline and consistency in the documented evidence of a medical review. The findings have continued to highlight the complexity of early warning scoring systems. A study morning in December was held to discuss possible alternative methods to address different requirements across the Emergency and Ward environments. A national survey regarding the use of CEWS by NHS England was completed by the Trust. The CEWS audits will continue for 2019-20.
Do Not Attempt Cardio Pulmonary Resuscitation Documentation Audit	This audit was undertaken to ensure that Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) orders are appropriately completed in the patient notes. The results identified that compliance with all audit standards were not achieved, particularly in relation to documentation of assessment of capacity. As a result of the audit, an action plan implemented which included ongoing monitoring of the DNACPR orders by the Matrons as well as the introduction of ReSPECT to help integrate the DNACPR decision making with overall advance care planning.
Audit of the Adherence to Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards - Emergency Department	This audit was undertaken to identify if compliance to the MCA was undertaken in the Emergency Department (ED). The audit identified that the Trust assessment of capacity form is not always being used. As a result, electronic documentation within ED went live on 22nd January 2019. The MCA 'pop up' is active for all patients over 16 and both questions "Is there an impairment in the mind or brain?" and Type of impairment/disturbance" are now mandatory fields. A re-audit will be undertaken in 19/20.
Audit of Resus Equipment	This audit was undertaken to determine the compliance with the completion of the resuscitation trolley checklist and to ensure that the correct checklist was used. The results found that 74% of trollies used the correct checklists, 67% of trollies had been checked daily and 99% of sealed contents of trolleys checked once weekly on a Monday. As a result of the audit, Matrons have now incorporated audits of compliance into their regular checks.
Audit of Folfirinox Chemotherapy	The audit was undertaken to ascertain if Folfirinox was being administered as per Trust Protocol and to compare outcomes with clinical trials. This audit found high compliance with the Protocol and patient outcomes were better than those quoted in published trials. The results were discussed by clinicians. No further actions needed.

Audit of Sepsis Commissioning for Quality and Innovation (CQUIN) element	This audit was undertaken to determine compliance with the National Sepsis Commissioning for Quality and Innovation (CQUIN). Key successes included 100% of eligible patients were screened in the Emergency Department (ED) due to the electronic screening process. There was a full achievement of patients with a confirmed diagnosis of sepsis receiving antibiotics within 1 hour of diagnosis, and of patients receiving an empiric antibiotic review within 72 hours. Key concerns identified the lack of an electronic observation and patient recorded system which meant that the audit burden for sepsis screening in inpatient areas remains high, and patients with learning disabilities and autism have been identified with an increased mortality from sepsis. Key actions included the Sepsis Team liaising with the Learning Disabilities and Autism Team. The Sepsis Audit and Improvement Nurse has implemented a rotational education programme in the ED where all staff will have received training by the end of March 2019.
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 determine 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.
Audit Weight Loss in Orthognathic Patients	This re-audit was undertaken to identify if the introduction of improved diet advice given to patients undergoing orthognathic surgery. The re-audit demonstrated a lower average weight loss than the last audit cycle, suggesting successful implementation of a diet advice sheet. Following the audit, protein shakes have been included on the diet advice sheet and a re-audit will be undertaken.
Re-Audit of infant feeding standards	This audit was undertaken to identify if minimum standards in infant feeding and relationship building practices were achieved. The results found that the United Nations Children's Fund (UNICEF) Baby Friendly Initiative standards were met for Staff Knowledge and Neonatal Unit Audits. A small proportion of standards in the Mothers Audit achieved less than the 80% target compliance. As a result; antenatal breastfeeding workshops in the community will be piloted, supplementation rates will be subject to spot check audits, staff will be asked to emphasise in I training the importance of responsive feeding and the findings shared via the Infant Feeding Team newsletter. A re-audit will be undertaken.
Parkinson’s Disease missed dose audit	This audit was undertaken to ensure that patients with Parkinson’s Disease do not miss a dose of a medication and that medication is given in timely in terms of the patient’s personal drug regimen. The results of the audit demonstrated that our outcomes were better than the national average. The Specialist Nurses are now involved in training of general ward staff to improve practice further.
Audit of physiotherapy rehabilitation following hip fracture against national standards	This audit was undertaken to establish a baseline performance level measured against the new national standard for Physiotherapy provision following hip fracture. The audit found some standards met completely. Some areas required improvement to achieve compliance. An action plan included; development of local Physiotherapy management guidelines to reflect core elements of the national standard; the introduction of an education and training package to support the guideline implementation and induction of new staff and ongoing training for the physiotherapy team.

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 96% 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% for 2 consecutive audits, a follow up is sent to the sister/charge nurse to action learning outcomes. Results are available on the Nursing Dashboard. The audits will continue.
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 0.69 per 1000 line days and in quarter 2 it was 0.28 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 Infection Prevention and Control 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 2019/20 audit cycle.
Audit of compliance to Clinical Audit Policy	This re-audit of compliance to the Trust Clinical Audit Policy reviewed a random selection of 32 audit evidence folders from the 17/18 Trust Audit Plan. Following the audit a number of actions were implemented. These included; Audit Policy and Staff Guidance for Staff under taking clinical audit at NNUH updated to include reporting flow chart for completed audits. Divisional Governance Managers will ensure Bi-monthly Clinical Standards Group and Annual Audit Report are submitted to Divisional Board. Audit Learning Forum 29th January 2018. Audit OWL created and sent out to staff twice a year. A re-audit will be undertaken in 19/20.
Pressure Ulcers Audit	An on-going surveillance audit reviews all pressure ulcers in the Trust. Various methods are utilised for the audit including: daily 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, sent by the Tissue viability service, which includes all community acquired pressure ulcers and hospital acquired category 2 and above, is circulated to Senior Staff. A Root Cause Analysis (RCA) is undertaken by ward staff, deputy director of nursing and the Divisional Matron for any reported category 2 or above pressure ulcers. A weekly meeting, which has recently been changed to an Essential Care Scrutiny Panel, is held to discuss the category 2 and above pressure ulcers and falls that have occurred in hospital. It is chaired by the Deputy Director of Nursing and attended by the ward staff concerned in the pressure ulcer or fall, Tissue Viability Specialist, Senior Matron and now includes members of the multidisciplinary team. An action plan is formulated following each RCA and learning is disseminated within the Divisions to determine learning is shared across the organisation. In January 2019 NHSI identified some major changes to the way pressure ulcers were categorised and documented. These changes have had a big impact on the Tissue Viability eservice and teaching is ongoing across the trust to ensure compliance with the new guidelines is undertaken by all areas.
Diabetes Department Patient Satisfaction Audit	This audit was undertaken to evaluate patient experience and satisfaction of the Diabetes Centre. The results of the audit were positive and demonstrated a good level of satisfaction with the service provided. Patients did express concerns in relation to the appointments system and the appearance of the waiting area. As a result there is a plan for refurbishment to be undertaken to the waiting area and to update the appointment system.

Audit of Patient Experience of the Headache Clinic	The aim of the audit was to evaluate patient experience and satisfaction of the Headache Clinic. The results found that 100% of patients felt that staff were friendly and supportive, they were treated with dignity, listened to and were offered adequate psychological support. 3 patients commented they found the lights too bright in clinic rooms. A re-audit will be undertaken over a longer period to include a larger percentage of patients and a request has been made for minor works in order to improve the blinds and lighting in 2 of the clinic rooms.
Nurse Led Assessment and Treatment Delivery Clinics Audit	This audit was undertaken to determine if patients are satisfied with Nurse-led Oncology Clinics. Results were positive. Patients felt well informed, not rushed, able to ask questions, respected and good relations with clinical staff. Patients do not like the parking at the hospital, and some commented about the waiting area being dark, or crowded. Results were shared with clinical team and the waiting area has recently been refurbished.
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 results found that; there was good documentation that it is recognised the patient is dying and the patient and their next of kin have been communicated with in most cases. Bereavement booklets were not being given out regularly. As a result the department have raised the profile of the bereavement booklet and introduced bite size education on wards where compliance was lower.
Renal Replacement Therapy Education and Information Audit	This audit was to determine patient views of the information available for stage 5 Chronic Kidney Disease (CKD) patients and if they felt supported in their decisions around the type of Renal Replacement Therapy (RRT) used. Questionnaires were given out to patients who had attended the Renal Replacement Therapy Education Clinics. The audit demonstrated a high level of satisfaction with the information and with the support of the staff. No further action currently needed.
Audit of Critical Care Follow up Clinic Feedback	This audit was undertaken to ascertain patient satisfaction of the Critical Care Follow up Clinic (CCFuC). Key successes showed that 100% of surveyed patients found the CCFuC a positive aid to recovery long term, and 100% of patients thanked the staff for the care and compassion they (and their families) received during their stay. Key concerns included poor patient attendance as well as insufficient information specific to the CCFuC on the clinic invitation letter. Key actions included telephoning patients 48 hrs prior to appointment as a reminder and confirm, and re-drafting the invite letter.
Audit of Patient Information about Anaesthesia	This audit was undertaken to check that information about venous thromboembolism (VTE) and risks of anaesthesia and surgery were being given to patients. Key successes demonstrated that VTE information and admission paperwork scored highly and 100% of patients were able to describe in their own words what their procedure entailed. Key concerns showed that information relating to local and spinal anaesthetic was weaker and the Surgical Information Leaflet was recalled by only 32% of patients. Key actions included ensuing leaflets on local and spinal anaesthetics are available on the Intranet and given to patients. Paperwork will be mailed to patients if they cannot attend Pre-operative Assessment, or it will be flagged up so that on arrival they receive the paperwork. The new anaesthetic chart has a specific section to document risks.
Audit of Patient Satisfaction in Paediatric Audiology	The aim of this audit was to determine if service users were satisfied with the Paediatric Audiology Service. The results were positive and demonstrated a high level of satisfaction with the service provided. 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 Bone Conduction Hearing Systems Service	The aim of this audit was to determine if service users were satisfied with the Bone Conduction Hearing Systems Service. The results of the audit were positive and found a high level of satisfaction with the service. No actions were required but a re-audit will be undertaken to ensure that patients remain satisfied with the service provided.
Audit of Dietetic Services - Patient Feedback	This audit was undertaken to assess patient feedback with the Dietetic Renal Service. This audit demonstrated that patients were satisfied with the nutritional support they were given (96%). All patients said they would recommend the service. Patients were less satisfied with the timeliness of the input (Cromer 18% dissatisfied). An action plan was implemented which included; a review of Cromer provision of Dietitians; a standard of care for all patients from pre dialysis through the initial period for managing on dialysis and a review of diet sheets with regards to content.
Audit of Medical Illustration Patient Satisfaction	This audit was undertaken to find the level of service user satisfaction whilst being in Medical Illustration. The results of this audit demonstrated high levels of user satisfaction and as a result, no immediate actions were required
Audit of Pet Therapy - Patient Feedback	This Audit was undertaken to ascertain patient and staff feedback with regard to Pets as Therapy (PAT) dog visits. The results of the audit demonstrated high levels of satisfaction with the use of PAT dogs with patients. No immediate actions were required. As the service is now established, amendments were made to the feedback forms to allow further monitoring.
Audit of in-patient and out-patient quality standards	These series of audits were undertaken to offer continuous quality assurance against standards derived from the Care Quality Commission's Fundamental Standards. Monthly quality rounds and weekly spot check audits were undertaken as routine across the Trust's inpatient and outpatient settings throughout the year. All findings were shared with the Matrons and other Senior Ward/Department staff of the areas audited and where required, actions implemented. The audit programme will continue for 2019/20.
Audit of Patient Advice and Liaison Service (PALS) - 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. PALS now have a twitter account to allow more flexibility for patients and carers wishing to contact them.
Audit of Ionising Radiation (Medical Exposure) Regulations (IRMER) Operator and Practitioner Training	This audit was undertaken to determine if Practitioners and Operators were compliant with national training requirements. Audit results demonstrated a high percentage of Practitioners and Operators had theoretical training in radiation protection. The audit demonstrated a need for improved compliance with IRR (Ionising Radiation Regulations) 2017 regulation 15 as Practitioners and Operators are required to have theoretical training in radiation protection in the last 3 years. As a result of the audit, Radiation Protection modules were made an annual mandatory training requirement to Norfolk and Norwich University Hospital workers. Annual self-competency documents were introduced for Medical Physician Operators and Practitioners such as Cardiologists, Radiologists, Urologists and Consultant Anaesthetists (Pain Relief).

Audit of the Adherence to Mental Capacity Act 2005 and Deprivation of Liberty Safeguards - Staff Survey	This audit was undertaken to help understand staff attitudes and thoughts around Mental Capacity. Staff appeared to lack confidence in applying for a Deprivation of Liberty Safeguards (DoLS). As a result of this audit, bespoke training for all staff via Clinical Governance Meetings, Ward training and Staff Study Days was introduced

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 2018/19 that were recruited during that period to participate in research approved by a research ethics committee was 4122 (as at Jan 2019) (3,228 in 2017/18).

Commissioning for Quality and Innovation (CQUIN)

A proportion of the Norfolk and Norwich University Hospitals NHS Foundation Trust's income in 2018/19 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. Preventing ill health by risky behaviours – alcohol and tobacco (2018/19 only)
6. Reinforcing the critical role Providers have in developing and implementing local STPs
7. Clinical Utilisation Review (NHS England Commissioning)
8. Hospital Pharmacy Transformation and Medicines Optimisation (NHS England Commissioning)
9. Nationally standardised Dose banding for Adult Intravenous Anticancer Therapy (SACT) (NHS England Commissioning)
10. Development of the Breast Screening Network within the STP footprint for Norfolk.

Further details of the agreed goals for 2018/19 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 2018/19 is £9.53 million conditional on achieving goals.

The monetary value of CQUIN available to the Norfolk and Norwich University Hospitals NHS Foundation Trust in 2017/18 was £7.3 million, plus £1.5 million CCG Risk Reserve.

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.

The Care Quality Commission Inspection between October 2017 and March 2018, published in June 2018, found the Trust had some outstanding practice and care. However, it also found that there were areas of poor practice, management and leadership that resulted in an overall rating of “Inadequate”.

CQC Ratings Grid June 2018

Ratings for Norfolk and Norwich hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Inadequate ↓ Jun 2018	Requires improvement ↓↓ Jun 2018	Good ↓ Jun 2018	Requires improvement ↓ Jun 2018	Inadequate ↓↓ Jun 2018	Inadequate ↓↓ Jun 2018
Medical care (including older people’s care)	Requires improvement Aug 2017	Good Mar 2016	Good Mar 2016	Requires improvement Aug 2017	Requires improvement Aug 2017	Requires improvement Aug 2017
Surgery	Inadequate ↓ Jun 2018	Good →← Jun 2018	Good →← Jun 2018	Requires improvement →← Jun 2018	Inadequate ↓ Jun 2018	Inadequate ↓ Jun 2018
Critical care	Requires improvement Mar 2016	Good Mar 2016	Good Mar 2016	Good Mar 2016	Good Mar 2016	Good Mar 2016
Maternity	Requires improvement Aug 2017	Requires improvement Aug 2017	Good Aug 2017	Good Aug 2017	Good Aug 2017	Requires improvement Aug 2017
Services for children and young people	Requires improvement Aug 2017	Good Mar 2016	Good Mar 2016	Good Aug 2017	Good Aug 2017	Good Aug 2017
End of life care	Requires improvement →← Jun 2018	Requires improvement →← Jun 2018	Good →← Jun 2018	Requires improvement →← Jun 2018	Requires improvement →← Jun 2018	Requires improvement →← Jun 2018
Outpatients	Requires improvement Jun 2018	Not rated	Good Jun 2018	Requires improvement Jun 2018	Requires improvement Jun 2018	Requires improvement Jun 2018
Diagnostic imaging	Requires improvement Jun 2018	Not rated	Good Jun 2018	Requires improvement Jun 2018	Requires improvement Jun 2018	Requires improvement Jun 2018
Overall*	Inadequate ↓ Jun 2018	Requires improvement →← Jun 2018	Good →← Jun 2018	Requires improvement →← Jun 2018	Inadequate ↓ Jun 2018	Inadequate ↓ Jun 2018

For full details of the recommendations contained in the Report and the action plan, please see Appendix 1.

The CQC revisited the Trust between January and February 2019. Their report was published in mid-May and said there had been great improvements at the Trust since March last year, raising the overall rating from “inadequate” to “Requires Improvement”, though the Chief Inspector of Hospitals has recommended that the trust remain in special measures. Recommendations were made to continue with improvements to cultural change and openness, mandatory training, record and medicines security, leadership development, and staffing levels.

Special mention was given to a number of areas of outstanding practice including robotic surgery, Quick Response bar codes (QR) in theatres and Day Procedure Unit, improvements in critical care, with the new protocol to admit patients within one hour, and high levels of support for junior doctors

CQC Ratings Grid May 2019

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement ↑ Apr 2019	Requires improvement →← Apr 2019	Good →← Apr 2019	Requires improvement →← Apr 2019	Requires improvement ↑ Apr 2019	Requires improvement ↑ Apr 2019
Medical care (including older people's care)	Requires improvement →← Apr 2019	Requires improvement ↓ Apr 2019	Good →← Apr 2019	Good ↑ Apr 2019	Requires improvement →← Apr 2019	Requires improvement →← Apr 2019
Surgery	Requires improvement ↑ Apr 2019	Good →← Apr 2019	Good →← Apr 2019	Requires improvement →← Apr 2019	Requires improvement ↑ Apr 2019	Requires improvement ↑ Apr 2019
Critical care	Requires improvement →← Apr 2019	Good →← Apr 2019	Good →← Apr 2019	Good →← Apr 2019	Requires improvement ↓ Apr 2019	Requires improvement ↓ Apr 2019
Maternity	Requires improvement Apr 2019	Good Apr 2019	Good Apr 2019	Good Apr 2019	Requires improvement Apr 2019	Requires improvement Apr 2019
Services for children and young people	Requires improvement →← Apr 2019	Good →← Apr 2019	Good →← Apr 2019	Requires improvement ↓ Apr 2019	Requires improvement ↓ Apr 2019	Requires improvement ↓ Apr 2019
End of life care	Requires improvement Jun 2018	Requires improvement Jun 2018	Good Jun 2018	Requires improvement Jun 2018	Requires improvement Jun 2018	Requires improvement Jun 2018
Outpatients	Requires improvement →← Apr 2019	Not rated	Good →← Apr 2019	Requires improvement →← Apr 2019	Requires improvement →← Apr 2019	Requires improvement →← Apr 2019
Diagnostic imaging	Requires improvement Jun 2018	Not rated	Good Jun 2018	Requires improvement Jun 2018	Requires improvement Jun 2018	Requires improvement Jun 2018
Overall*	Requires improvement ↑ Apr 2019	Requires improvement →← Apr 2019	Good →← Apr 2019	Requires improvement →← Apr 2019	Requires improvement ↑ Apr 2019	Requires improvement ↑ Apr 2019

The full CQC report can be viewed here: http://www.cqc.org.uk/provider/RM1

Data Quality

The Norfolk and Norwich University Hospitals NHS Foundation Trust submitted records during 2018/19 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%	99.4%	100.0%	99.9%
Outpatient care	99.9%	99.6%	100.0%	99.8%
Accident & emergency care	99.0%	97.5%	100.0%	99.3%

Information Governance Toolkit Attainment Levels

Information governance (IG) training is mandatory for all staff members and is renewed on an annual basis. The Trust continued to raise awareness of Information Governance and the importance of protecting personal information with its staff members through a comprehensive training programme. To complement this learning, a wealth of policies, guidance and best practice are made available to staff members via the Trust's intranet. The Trust did not attain Level 2 in Requirement 112 of the IG Toolkit (IG Training) and an action plan is in place to resolve this anomaly.

IG Toolkit Assessment Summary Report
NORFOLK AND NORWICH UNIVERSITY HOSPITALS NHS FOUNDATION TRUST
(Acute Trust)
Prepared on 20/02/2019

Assessment	Stage	Overall Score	Self-assessed Grade	Reviewed Grade
Version 14.1 (2017-2018)	Published	76%	Not Satisfactory	Satisfactory

Grade Key

Not Satisfactory	Not evidenced Attainment Level 2 or above on all requirements (Version 8 or after)
Satisfactory with Improvement Plan	Not evidenced Attainment Level 2 or above on all requirements but improvement actions provided (Version 8 or after)
Satisfactory	Evidenced Attainment Level 2 or above on all requirements (Version 8 or after)

The Norfolk and Norwich University Hospitals NHS Foundation Trust Information Governance Assessment Report overall score for 2018/19 was 76% and was graded: Green – 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 2018/19 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 2018/19:

18 Weeks Referral to Treatment (RTT)

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 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 2018/19 results

26 Audits were completed

11 Specialties improved on 2017/18 results
04 Specialities achieved the Trust target of 90%
03 Specialties achieved the same results as 2017/18
12 Specialties decreased in performance

The Trust reviewed the results and patterns of errors from the 2018/19 audit programme and have 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.

Staff Training

The 18 week eLearning package 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.

2019 Training Programme

The Data Quality team plan to roll out a 12 month training programme starting April 2019. The team will be taking a back to basics approach. Policy, process and RTT validation coaching/workshops will be scheduled with all Admin Managers, Deputy Admin Managers and RTT Validators. Knowledge and skills can then be shared to all team members within Specialty.

The training time is protected and allows the data quality team to schedule training around busy operational requirements.

Key System Audit Programme 2018/19

The Key Systems rolling audit programme aims to ensure the Trust maintains accurate data, is able to report correctly attracting the correct level of income for work undertaken and to ensure information used in the service line reporting is accurate, valid, reliable, timely, relevant and complete. The Data Quality Team maintains an audit program of Key Systems and databases within the Trust. The audit programme will be made up of the following components which will provide data quality assurance to the Trust as well as providing vital evidence required under Information Governance:

- A rolling Key System audit work plan.
- A Data Quality Key Systems Questionnaire to ensure compliance of NHS standard definitions and values.
- Cost & Volume (C&V) data criteria as provided by Commissioning Information Department, which forms the basis for the sample of data selected to be analysed. The C&V criteria will be updated by Commissioning Department on an annual basis.
- Comprehensive audit report listing all findings and recommendations.

The audit progression and outcomes are reported to the Information Governance Steering Group (IGSG) which feeds into the Trust Access Group chaired by the COO.

7 audits have been completed to date:

Somerset Cancer Register
RIS
ORSOS
Symphony
eMEDRenal
Cystic Fibrosis
CaptureStroke

3 Key Systems Audits are currently in progress:

ARIA (Training of new Auditor)
Intellect
Direct Access Orthotics

Status of Audit Actions to date

STATUS	HIGH	MODERATE	LOW	VERY LOW	TOTAL
Escalation 1	0	0	0	0	**0**
Escalation 4	0	0	0	0	**0**
Active	18	20	0	5	**43**
In Progress	7	3	2	4	**16**
New Action	4	5	2	1	**12**
Re-Opened	1	5	0	0	**6**
Closed	3	6	0	0	**9**
Resolved	39	28	3	4	**74**
TOTAL	**72**	**67**	**7**	**14**	**160**

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 (APC), Outpatient Care(OPC) and A&E (the only exception is Data Item – Patient pathway ID on APC & OPC)

Data Quality Maturity Index (DQMI)

The roll out of the Data Quality Maturity Index (DQMI) provides healthcare data submitters with timely and transparent information about their data.
Moving forward the NNUH will be using this tool to benchmark performance as the DQMI will highlight any data issues or in fact give assurance we have no issues.

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/

Summary of In-Hospital deaths and deaths within 30 days of discharge for 2018/19

	Total discharge	In-hospital deaths	Deaths within 30 days of Discharge	Total Deaths	Deaths with Learning Difficulties (1)	Deaths with Severe Mental Illness (2)	Still births (3)	Neonatal Deaths (4)
Q1	22484	602	273	875	8	9	11	2
Q2	22420	525	280	805	3	6	5	3
Q3	22476	547	298	845	7	12	4	3
Q4	21995	679	329	1008	2	13	1	5

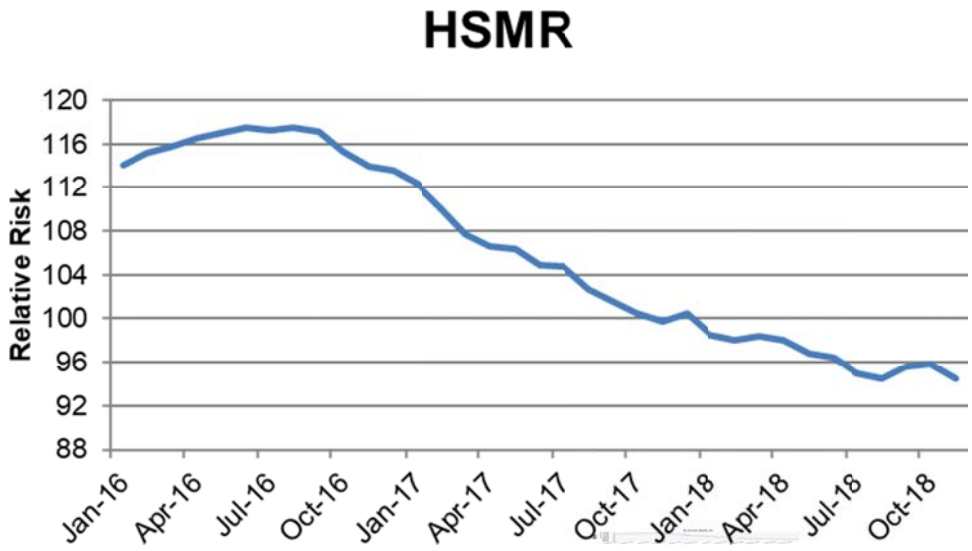
(1) As notified to LeDeR mortality review process
(2) Please note that the diagnostic criteria for SMI are currently under review for 2019/20
The diagnosis codes included for 2018/19 are:
a. F20 to F29 schizophrenia, schizotypal and delusional disorders
b. F30.2 mania with psychotic symptoms
c. F31.2 bipolar, current episode with psychotic symptoms
d. F31.5 bipolar, current episode severe depression with psychotic symptoms
e. F32.3 severe depressive episode with psychotic symptoms
f. F32.3 recurrent depressive disorder, current episode severe with psychotic symptoms
g. X60 to X84 intentional self-harm
(3) Stillbirths delivered from 24 weeks notified to MBRRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries in the UK)
(4) Neonatal deaths from 22 weeks notified to MBRRACE-UK

During 2018/19, 3533 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: 875 in the first quarter; 805 in the second quarter; 845 in the third quarter; 1008 in the fourth quarter.

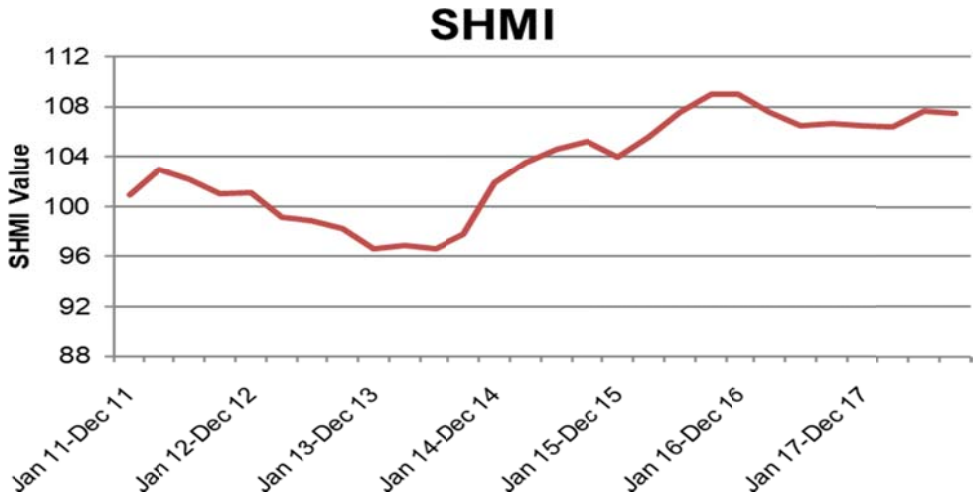
By 1st April 2019, there were1256 case record reviews carried out and 10 deaths, on review, were considered potentially preventable.

The number of deaths in each quarter for which a case record review or an investigation was carried out was: 403 in the first quarter; 409 in the second quarter; 309 in the third quarter; 135 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.

The 10 cases where a death was considered potentially preventable, represents 0.28% of the patient deaths during the reporting period. In relation to each quarter, this consisted of: 4 representing 0.46% for the first quarter; 2 representing 0.25% for the second quarter; 3 representing 0.36% for the third quarter; 1 representing 0.10% for the fourth quarter.



HSMR (hospital standardised mortality ratio) is an indicator of healthcare quality that measures whether the number of deaths in hospital is higher or lower than you would expect



SHMI (Summary Hospital-level Mortality Indicator) reports on mortality at trust level across the NHS in England using a standard and transparent methodology. It is produced and published monthly as a National Statistic by NHS Digital. The SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there.

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; the Quality and Safety team has been redesigned and now has an increased focus on family liaison; a Medical Examiner business case is being developed.

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 2018/19. 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, 2017/18 and 2016/17, are as published by NHS Digital.

SHMI value and banding						
Indicator	2017/18 NHS Digital not available				NNUH 17/18	NNUH 16/17
	NNUH Oct-17-Sep-18 Published by NHSI	National Average	Best performer	Worst performer		
SHMI value and banding	1.0748 Band 2	No data yet published	No data yet published	No data yet published	1.0639 Band 2	1.056 Band 2
Location: https://digital.nhs.uk/data-and-information/publications/clinical-indicators/shmi > Download Feb-18 publication > SHMI data at trust level, select from value and banding columns **Latest version available covers Oct-17- Sep-18, published Feb-19**						

% of patient deaths with palliative care						
Indicator	2017/18 NHS Digital not available				NNUH 17/18	NNUH 16/17
	NNUH Oct-17-Sep-18 Published by NHSI	National Average	Best performer – Lowest %	Worst performer – highest %		
% of patient deaths with palliative care coded at either diagnosis or specialty level for the reporting period	43.1%	33.6%	14.3%	59.5%	34.3%	22.1%
Location: https://digital.nhs.uk/data-and-information/publications/clinical-indicators/shmi > Download Feb-18 publication > SHMI data at trust level, select from value and banding columns **Latest version available covers Oct-17- Sep-18, published Feb-19** **National Average- https://app.powerbi.com/view?r=eyJrIjoiZDA0NzE1NjYtMGYyNC00ZTJkLTljYTQtYzYzMzFlMjNmZjUxIiwidCI6IjUwZjYwNzFmLWJiZmUtNDAxYS04ODAzLTY3Mzc0OGU2MjllMiIsImMiOjh9**						

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	0.069 (Apr-Sep 2017)	0.089 (Apr-Sep 2017)	0.137 (Apr-Sep 2017)	0.029 (Apr-Sep 2017)	0.099	0.095 (Apr-Sep)
Patient reported outcome scores for varicose vein surgery	(Apr-Sep 2017)	0.096 (Apr-Sep 2017)	0.134 (Apr-Sep 2017)	0.035 (Apr-Sep 2017)	0.099	0.088 (Apr-Sep)
Patient reported outcome scores for hip replacement surgery	0.456 2017/18	0.458 2017/18	No data published	No data published	0.495	0.421 (Apr-Sep)
Patient reported outcome scores for knee replacement surgery	0.342 2017/18	0.337 2017/18	No data published	No data published	0.259	0.293 (Apr-Sep)

Location: https://digital.nhs.uk/data-and-information/publications/statistical/patient-reported-outcome-measures-proms/hip-and-knee-replacement-procedures---april-2017-to-march-2018

Current version uploaded: Apr-17 – March-18 Published Feb 2019
Adjusted average health gain 'EQ-5D Index' scores

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	12.74 Apr-18 – Jan-19	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

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	2017/18 NHS Digital				NNUH 17/18	NNUH 16/17
	NNUHFT	National Average	Best performer	Worst performer		
Trust's responsiveness to the personal needs of its patients during the reporting period.	68.8	68.6	85.0	60.5	68.8	68.2

Location: https://digital.nhs.uk/data-and-information/publications/clinical-indicators/nhs-outcomes-framework/current > 4.2 Responsiveness to Inpatients' personal needs
Current version uploaded: Aug-18 // Next version due: Aug-19

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	2018 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.	61.9%	62.6%	81%	39.2%	60.7%	56.3%

Reporting and analysis of the NHS Staff Survey has been changed this year, with the 32 key findings now presented as 10 high level themes, benchmarked against other hospital trusts (see page 61 for full details)
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	2018/19 (Trust Reported)				NNUH 17/18 (Trust reported)	NNUH 16/17
	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	98.89% Q2 2018/19	95.49% Q2 2018/19	100% Q2 2018/19	68.67% Q2 2018/19	98.94	99.31 (Oct-Mar)

Location: https://improvement.nhs.uk/resources/vte-risk-assessment-data-q2-201819/
Data published quarterly
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	2017/18 NHS Digital				NNUH 17/18	NNUH 16/17
	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	11.10	13.65	91.00	1.44	11.10	11.97

Latest data available for 2017/18

Location: https://www.gov.uk/government/statistics/clostridium-difficile-infection-annual-data#history > use Table_8

Current version uploaded: July-18 // Next version due: July-19

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	2017/18 NHS Digital				NNUH 16/17	NNUH 15/16
	NNUHFT	National Average	Highest	Lowest		
Number and rate of patient safety incidents per 100 admissions	38.55 Q1/2 Rate 42.6 (n6623) Q3/4 Rate 34.5 (n5564)	No data published	No data published	No data published	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	Q1/2 Rate 0.06 (n9) Q3/4 Rate 0.06 (n10)	No data published	No data published	No data published	Q1/2 Rate 0.07 (n12) Q3/4 Rate 0.06 (n10)	0.12 No: 9 (Apr-Sept)

Location: https://digital.nhs.uk/data-and-information/publications/clinical-indicators/nhs-outcomes-framework/current/domain-5-treating-and-caring-for-people-in-a-safe-environment-and-protecting-them-from-avoidable-harm-nof/5-6-patient-safety-incidents-reported-formerly-indicators-5a-5b-and-5-4
Current version uploaded: Nov-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.

Review of Implementation of 7 Day Services

Please see page 21.

Review of Speak Up Policy

The Freedom to Speak Up: Raising Concerns (Whistleblowing) Policy (formally the Speak Up Policy) was introduced in August 2018 and carefully explains the four step process to raise and escalate a concern. The Freedom to Speak Up Policy is explained to new staff as part of their Corporate Induction and posters detailing the names and contact details of the Freedom to Speak Up Guardians are displayed across the Trust's premises.

The Policy details the various concerns that should be raised - unsafe patient care, unsafe working conditions, inadequate induction or training for staff, lack of, or poor, response to a reported patient safety incident, suspicions of fraud, or a bullying culture (across a team or organisation rather than individual instances of bullying) – then outlines the process of reporting to a line manager or tutor, or, if unable to raise it with them, details of others who can be approached: Chief Nurse, Medical Director, Chief Operating Officer, etc., and the aforementioned Freedom to Speak Up Guardians. Finally it speaks of contacting the Trust's Chief Executive or Chairman, and if necessary, outside bodies such as NHS England or the CQC.

The Policy talks about confidentiality, and advice and support available for those raising concerns, and then explains how the Speak Up process works. It also addresses the subject of detriment and stresses that if a staff members raises a genuine concern under this policy, they will not be at risk of losing their job or suffering any form of reprisal as a result and that the Trust will not tolerate the harassment or victimisation of anyone raising a concern. Nor will the Trust tolerate any attempt to bully the staff member into not raising any such concern. Any such behaviour is a breach of the Trust's values as an organisation and, if upheld following investigation, could result in disciplinary action. It also says that provided the staff member is acting honestly, it does not matter if they are mistaken or if there is an innocent explanation for their concerns.

A fulltime Speak-Up Guardian, who was recently appointed and joined the Trust in March, supplies the Management Board with monthly updates on 'speak up' issues in order to increase its oversight of issues.

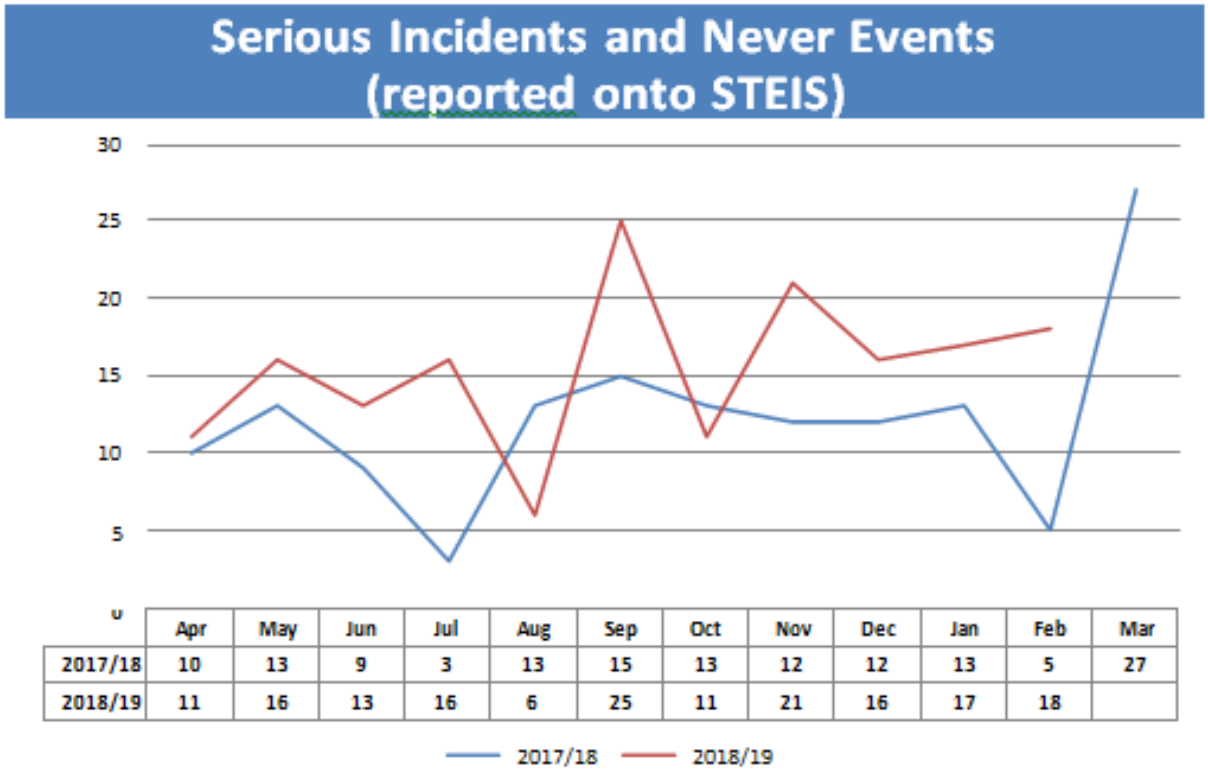
Other Information

Patient Safety – Serious Incidents (SIs)

All patient incidents, regardless of their severity, are recorded on DATIX and are submitted quarterly to the National Reporting and Learning System (NRLS).

In the twelve months ending 31st March 2019, 17,222 incidents were recorded on DATIX. Of these, 96.85% caused either no harm or low harm to patients. In 2017/18 there were 14,358 reported incidents, of which 98.2% caused no harm or low harm.

The number of reported incidents has increased dramatically in 2018/19 due to an increased awareness of safety issues and an improved quality and safety culture.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2017/18	10	13	9	3	13	15	13	12	12	13	5	27
2018/19	11	16	13	16	6	25	11	21	16	17	18	

All incidents reported provide an opportunity for learning and continuous improvement in care delivery. The Trust has continued to support a culture of reporting and in 2018/19 governance structures within Divisions were strengthened providing greater oversight of incidents.

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.

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 (six in 2017/18).

- Insertion of wrong implant (April)
- Retained guidewire (May)
- 'Misplaced' NG Tube (June)
- Retained drain (September)
- Wrong side nerve injection (November)
- Wrong side hip aspiration (January)

Since January 2019 the Trust has adopted a new approach to the governance of Never Events and Serious Incidents – the CEO Assurance Panel. This is an Assurance Panel which is the highest form of governance for the organisation and held only for the most serious of incidents. Incidents are presented to the panel and immediate learning opportunities identified and disseminated with the clinical teams invited to present their updates on the action plan 3 months later. The Panel does not replace the full Root Cause Analysis (RCA) process but will seek to understand what went wrong, what can be done to put things right and most importantly what action needs to be taken to minimise a risk of re-occurrence. The whole purpose is to closely examine the facts of an incident, in order to learn from it.

Patient Safety – Duty of Candour

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.

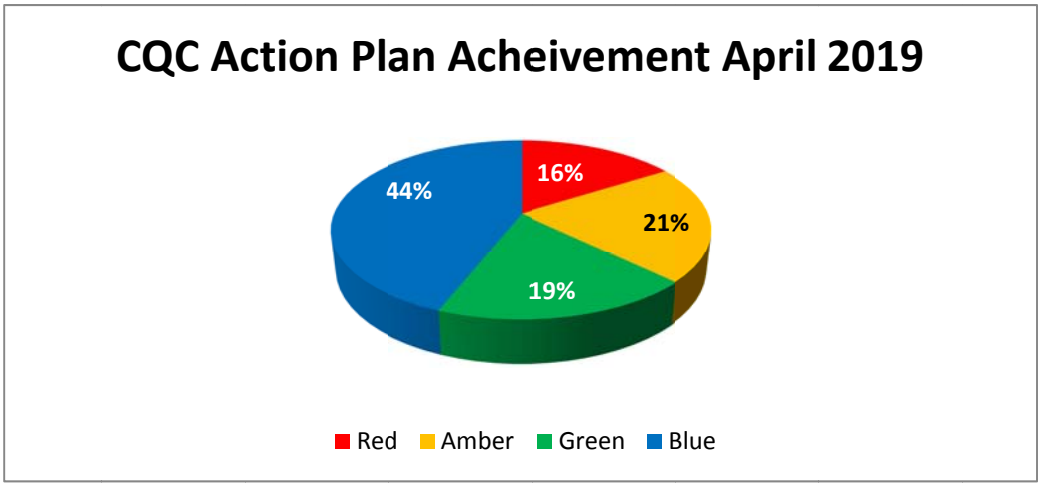
All Moderate Harm or above severity incidents which are reported on Datix are verified at the Trust daily Serious Incident Group Meeting – if moderate Harm or greater is confirmed, Duty of Candour is requested to be met by the relevant clinician within the statutory time frame. Evidence of the completed letter is kept with the Datix investigation report and forms a formal part of the patient 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.

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

The Care Quality Commission Inspection between October 2017 and March 2018, published in June 2018, found the Trust had some outstanding practice and care. However, it also found that there were areas of poor practice, management and leadership that resulted in an overall rating of "Inadequate".

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 the recommendations within the June 2018 inspection report.



Overdue or not on track	At risk of delivery	On Track	Complete & evidenced

Full details of CQC Action Plan can be found in Appendix 1.

Clinical Effectiveness – Achieving cancer referral and treatment times

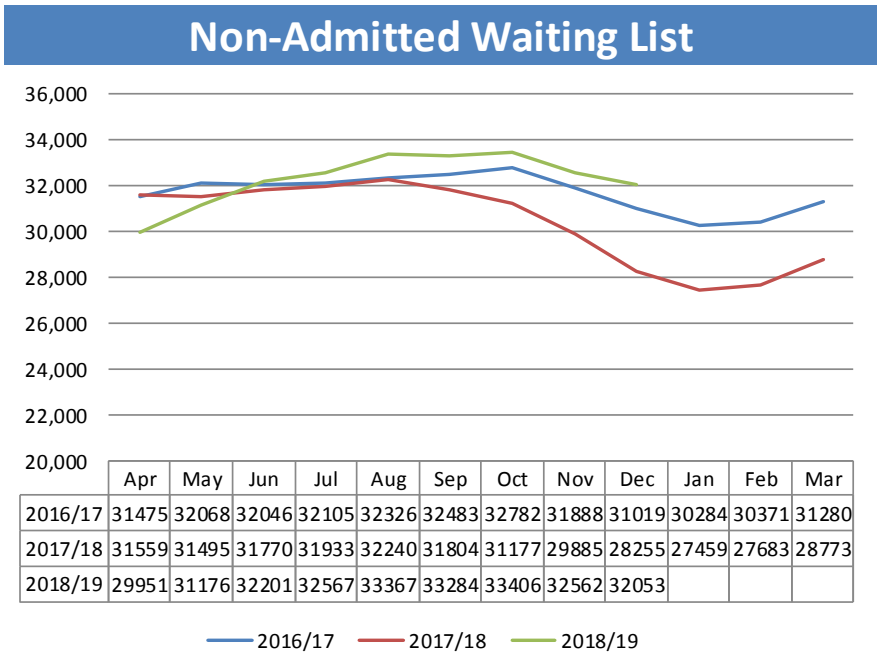
	National Standard	Q1 1819	Q2 1819	Q3 1819
GP 2WW	93%	87.70%	74.09%	75.07%
Breast Sympt 2WW	93%	95.67%	95.96%	55.36%
31 Day First Treat	96%	96.90%	96.56%	96.11%
31 Day Subs ACD	98%	100.00%	99.76%	99.50%
31 Day Subs RT	94%	98.66%	97.99%	97.81%
31 Day Subs Surgery	94%	90.68%	84.50%	83.52%
62 Day GP	85%	73.72%	71.72%	71.85%
Reallocated 62 Day GP**	85%	76.50%	74.15%	72.23%
62 Day Upgrade		53.90%	44.88%	40.78%
62 Day Screening	90%	85.71%	84.93%	78.29%
62 Day Breast Sympt	85%	80.00%	80.00%	0.00%

***Please note that the Reallocated 62 Day GP figures are calculated internally by Cancer Management and not done on a quarterly basis, as such this is the aggregated value of each month within the quarter.*

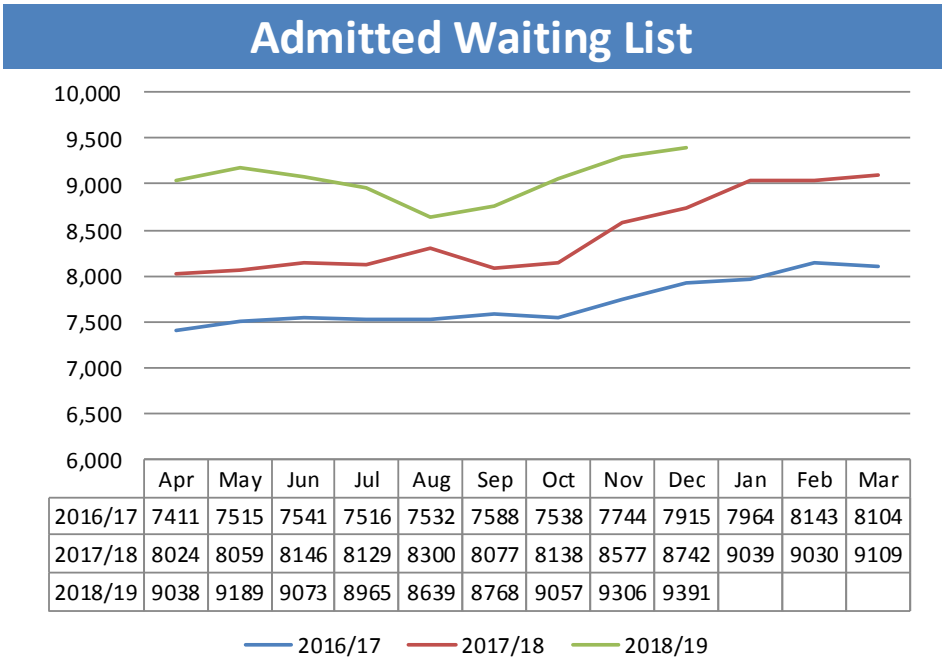
Clinical Effectiveness – 18 week RTT waiting times

In line with National reporting, 2018/19 has seen congestion from increased non elective admissions, particularly over the severe winter period, 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.

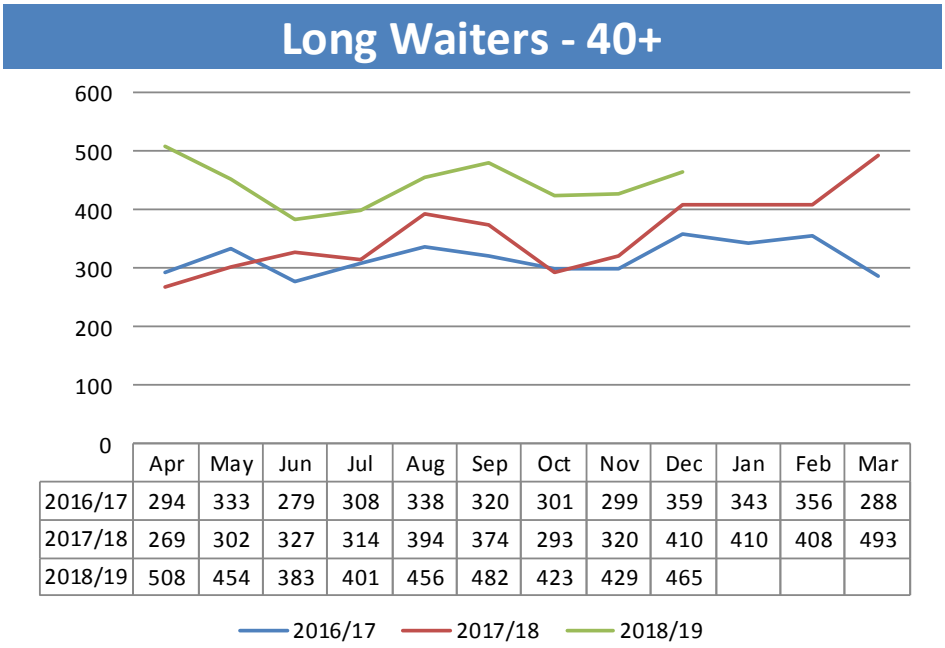
These factors have impacted on the Trusts 18 week referral to treatment performance, however recovery trajectories have been remodelled to take into account revised operational plan and impact of outpatient/daycase/inpatient procedures cancelled during adverse weather.



	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
2018/19	29951	31176	32201	32567	33367	33284	33406	32562	32053			



	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
2018/19	9038	9189	9073	8965	8639	8768	9057	9306	9391			



	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
2018/19	508	454	383	401	456	482	423	429	465			

Clinical Effectiveness – Clinical research and development

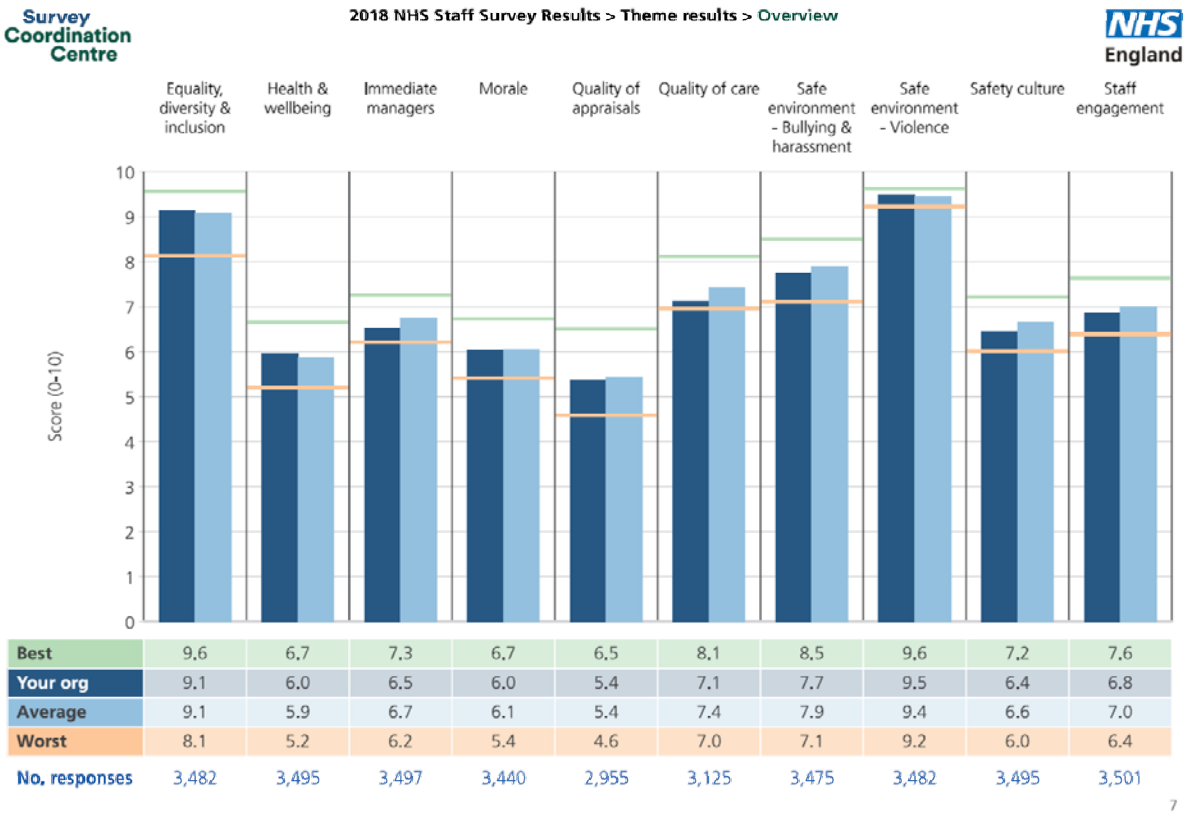
Please refer to page 45.

Staff Experience – NHS Staff Survey

All hospitals' staff survey reports are published online at:
http://nhsstaffsurveys2018.com/files/NHS_staff_survey_2018_RM1_full.pdf

3,517 Trust Staff returned the survey form. The report shows a slight decline in overall involvement of 46% (as opposed to 47% in 2017) but still higher than the national average of 44%.

Reporting and analysis of the survey has been changed this year, with the 32 key findings now presented as 10 high level themes, benchmarked against other hospital trusts.



The Significance Testing section of the report, which details the Trust's theme scores for 2017 and 2018 and the number of responses each of these are based on, shows just two of the ten as being 'significantly' lower – Health & Wellbeing: 6.0, with 3495 responses, in 2018 as opposed to 6.2 and 3517 responses in 2017; and Quality of Care: 7.1, with 3125 responses, in 2018 as opposed to 7.3 and 3121 responses in 2017.

Staff engagement with the Trust remains positive, with 61.9% of respondents saying, "I would recommend my organisation as a place to work", up from 60.7% in 2017; and over 75% agreeing "If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation".

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

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.

Patient Experience – Frailty Strategy

During 2018/19 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.

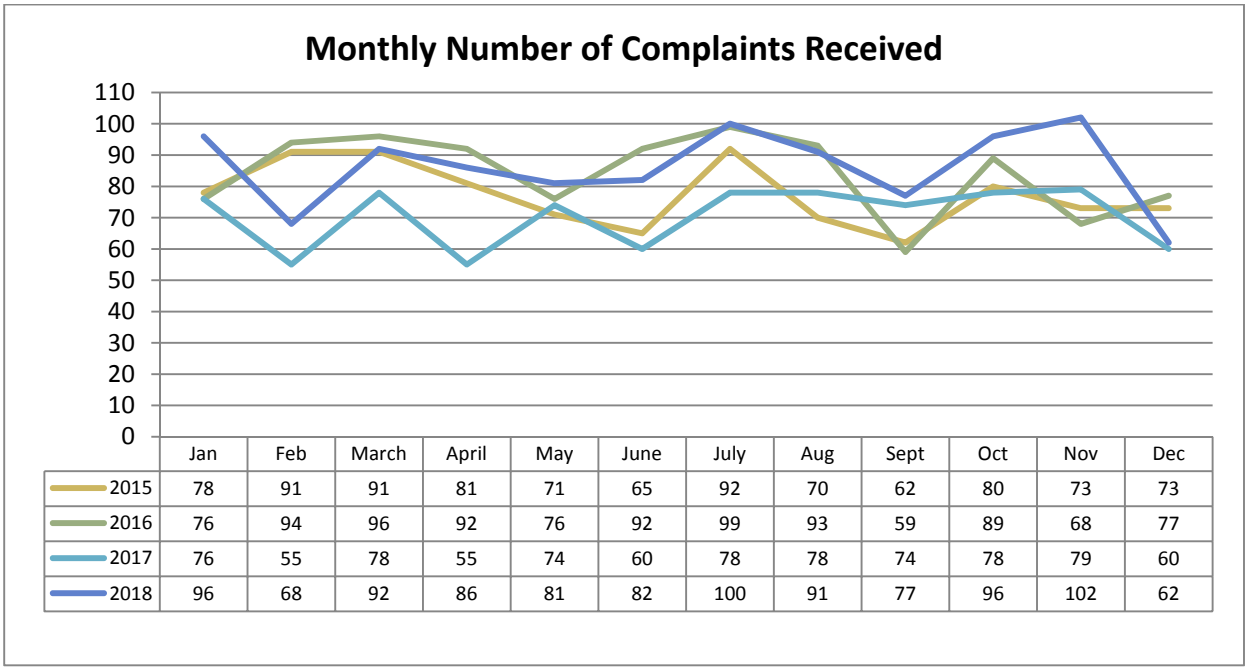
Details of comprehensive Geriatric assessments undertaken on admission during 2018/19 is detailed on page 16.

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



	Jan	Feb	March	April	May	June	July	Aug	Sept	Oct	Nov	Dec
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
2018	96	68	92	86	81	82	100	91	77	96	102	62

To ensure that our complaints processes are 'patient-focussed', every year we welcome a team from Healthwatch Norfolk to carry out an independent review of complaints files, most recently in July 2018. We are grateful to Healthwatch for their work with us to provide an additional means of independent assurance with regards to our approach to handling complaints. The Healthwatch Team has been consistently complimentary of our approach to managing complaints and we have been pleased to implement a number of recommendations made by the Healthwatch team.

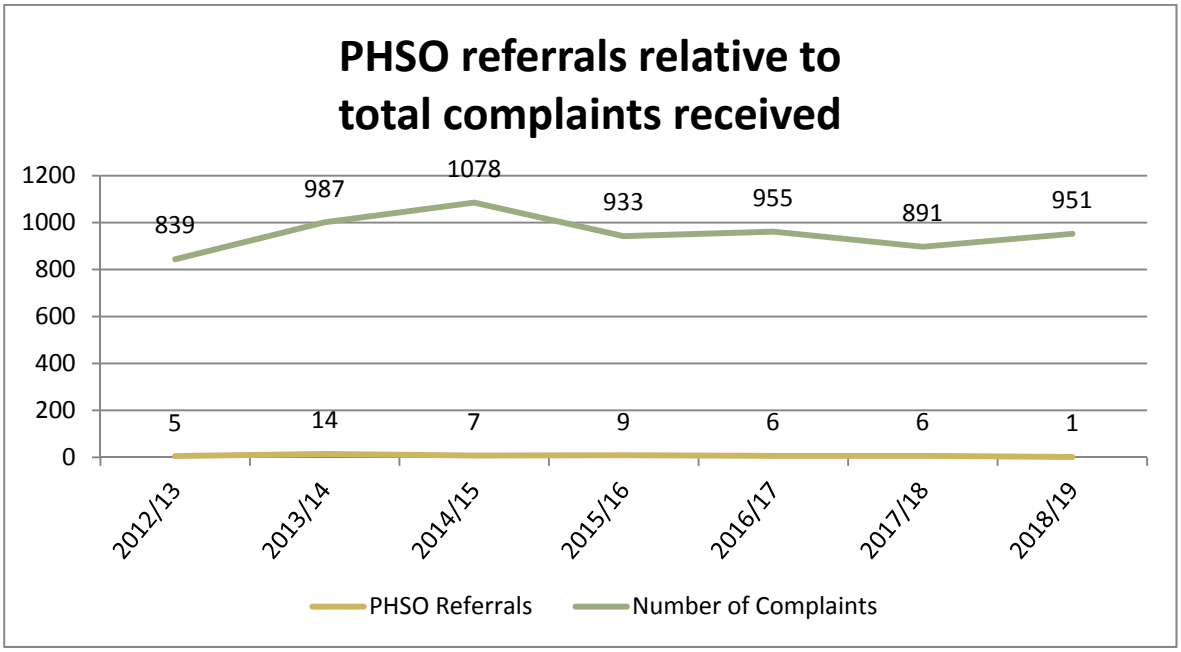
Each month, based on feedback from senior matrons and clinical teams, as well as using data collected from the QAA process and Friends and Family Test, the CaPE Governance Sub-Board is provided with a 'deep dive' report focusing on a particular theme. In the last year, themes have included reviews of: infection control, premises, medicines management, communication, car parking, end of life care, and clinical treatment in various specialities. This data is used alongside other sources to improve learning across the organisation.

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.

PHSO referrals

The role of the Parliamentary and Health Service Ombudsman (PHSO) in the NHS Complaints Procedure relates particularly to complaints that remain unresolved even once efforts at 'Local Resolution' by the individual Trust are completed. To ensure that the option to appeal to the PHSO is known to our complainants, we provide every complainant with information about how to contact the PHSO if they remain dissatisfied following our complaints investigation.

During the period covered by this report, the number of complaints 'appealed' to the PHSO was as shown below. The number of PHSO referrals from this Trust is low, suggesting success in resolving matters at the first stage of the complaints procedure. The number of appeals to the PHSO in 2018/19 represents approximately 0.1% of complaints received by the Trust:



Plans for year ahead

In 2019/20 responsibility for dealing with formal complaints received by the Trust will transfer to our Patient Experience Team, so that this is integrated with the broader work of improving the experience of our patients across the Trust.

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 the Norfolk and Norwich University Hospital Foundation Trust (NNUHFT) on behalf of the Norfolk and Waveney CCGs (Norwich, North Norfolk, South Norfolk, West Norfolk and Great Yarmouth & Waveney), supports the Trust in its publication of the 2018/19 Quality Account.

Having reviewed the mandatory detail of the report, the CCGs are partially assured that the Quality Account incorporates the mandated elements that are required.

The CCG recognises that NNUHFT has developed and delivered a significant number of quality improvement initiatives during 2018/19. This has included plans to successfully expand the children's and adult's emergency department including the provision of a high dependency unit for children outside of the resuscitation department. The CCG also recognises the ongoing work to ensure that incidents are reported and investigated in a timely way by trained investigators and the more transparent and collaborative working relationship with external agencies to better understand any identified issues and to ensure shared learning.

The CCGs recognise the challenges experienced by the Trust and the impact that this has had on the organisation as a whole, not least on its frontline staff, including feedback from the two Section 29a letters submitted by the CQC and the outcome of the CQC inspection undertaken in March 2018. SNCCG is assured that the Trust has taken ownership of the issues identified in both letters and that good progress is being made towards successful resolution of these. The CCGs also recognise the investment being made into improving leadership and culture across the organisation.

There are two areas that have not been identified by the Trust as priorities for 2019/20 that the CCGs feel would be of benefit and as such should be considered for continued inclusion; Infection Prevention and Control and Electronic Discharge Letters.

The CCGs recognise that while keeping patients safe from infection was achieved based on the number of hospital attributable *Clostridium Difficile* cases and the number of hospital acquired MRSA bacteraemia cases during 2018/19, the NHS Improvement Infection Prevention (IP) visit on 11 February 2019 identified a significant number of concerns, therefore we would expect to see this as a continued quality priority for 2019/20.

The CCG also wishes to receive assurance as to how the NNUHFT will continue to monitor the delivery of seven-day services. We note that this has been rated as 'green' despite Quarter Four data not yet being available.

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 via the Clinical Quality Review Group meetings (CQRG) and the Oversight and Assurance Group. We have also welcomed the opportunity to work with the Trust at Evidence Review Meetings and to be involved in the new Executive level oversight of serious incidents.

Quality Priorities 2018/19

Patient Safety

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

   The CCGs confirm that NNUHFT only had one incident where a patient had sustained moderate harm or above arising from an insulin error at the end of 2018/19 and welcomes the continued inclusion unchanged in the Trust's quality priorities for 2019/20. The CCGs would encourage the Trust to demonstrate any learning from the investigation into this incident both internally and externally with system colleagues

2) Focus on sepsis to reflect outcomes of Root Cause Analysis (RCA) investigations and themes arising out of mortality review.

   The Trust has included narrative derived from 2018/19 CQUIN submissions which demonstrates an average compliance of 81.4% for sepsis screening and 91.7% for antibiotic administration during quarters one to three. However, no narrative has been included to demonstrate reflection on the outcomes of RCA investigations and themes arising from mortality review. The CCGs request that this continues to be included in the Trust's quality priorities for 2019/20.

3) Improving safe practice through the learning from Never Event (NE) investigations particularly in relation to culture change, teamwork and communication.

   The CCGs recognise the excellent work undertaken with Human Factors training within Obstetrics and Gynaecology and looks forward to seeing this adopted in other areas and staff groups. The Trust should consider how it will report and evidence improvements in clinical practice following training in the forthcoming year.

4) To reflect increased emphasis on older persons care and changes instituted in the NNUHFT for older peoples medicine.

The Trust identified the following as indicators of success:

- Number of Comprehensive Geriatric Assessments undertaken on admission.
- National Audit of Dementia.
- Number of inpatient falls (age related).
- Number of avoidable pressure ulcers (age related).

From the data presented it is only possible to assess how many frailty screening were completed therefore it is not possible to determine if the ambition was achieved.

Clinical Effectiveness.

1) Infection Prevention and Control
   - Methicillin-Resistant Staphylococcus Aureus (MRSA) blood stream infections (BSI), to have 0 hospital attributable cases.
   - *Clostridium Difficile* infection (CDI) to be under the trajectory target of 48 hospital attributable cases.

   The CCG recognises that while keeping patients safe from infection was achieved based on the number of hospital attributable C Difficile cases and the number of hospital acquired MRSA bacteraemia for 2018/19,

following the NHS Improvement Infection Prevention (IP) visit post CQC on 11th February 2019 whereby a significant number of issues were identified the CCG would recommend that this is a continued area of priority for 2019/20.

The evidence presented appears to conflate last year's ambition and the newly defined priority for 2019/20. The CCG also notes that CPE and IP&C Improvement Programme quality priorities are not included.

2) Seven Day Services

The Trust have rated this priority as Green for the year in the absence of quarter four data. It has not been identified as a priority area for 2019/20 as such the CCG would look to the Trust for further detail as to how they will monitor delivery and provide assurance going forward.

Patient and Carer Experience

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

The CCG is not assured from the data presented that the performance has improved significantly as stated and would ask the Trust to confirm that this is the correct data set or if it is incomplete. The CCG would encourage the Trust to continue with this quality priority in 2019/20.

2) Improved continuity of care and experience through reduced ward moves and reduced numbers of patients being nursed in areas that are not primarily focused on the speciality their condition requires.

The Trust has rated this as Green against an ambition of a monthly average of no more than 20. From the evidence presented it would appear that there were only four months where there were less than 20 outliers, with numbers increasing from November 2018. The data for February and March 2019 is incomplete. As such the CCG feels this should be rated Amber and continued as a quality priority going forwards.

3) To improve our care to those at the end of their life.

The Trust has rated this Green but goes on to state that only 45% of patients audited were on an end of life care plan. The CCG would like to receive assurance regarding the remaining 55% of patients.

It is also reported that 50% of patients at end of life had this discussed with them. The CCGs would like to receive assurance regarding the remaining 50% and to better understand the learning behind the information shared and what plans are in place to improve the patient / carer experience.

Quality Priorities 2019/20

The CCGs support the key quality priorities identified for 2019/20. The CCGs do however recommend that the Trust ensures that those quality priorities that were not realised in 2018/19 are continued. NNUHFT 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. NNUHFT should also ensure that improvements are measureable and demonstrable by designing comprehensive measures and patient outcomes against each quality priority identified for 2019/20, especially in those areas where data is incomplete.

The CCGs 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:

- Improvement in frailty provision and care – the CCGs previously stated that they would like to understand in more detail what this priority wanted to achieve and do not feel that the evidence presented demonstrates success or improved outcomes for patients. The CCG recommends and welcomes the continued focus on falls prevention, reducing urinary tract infections and reducing the number of Grade Two and Grade Three Pressure Ulcers.
- Infection Prevention and Control – the Trust should ensure this is a continued priority for 2019/20.
- Serious Incident Investigations – the CCG welcomes the addition of this priority however would encourage the Trust to have an ambition of 100% compliance with national standard with agreed exceptions as opposed to 95% compliance.
- To improve the score in the national inpatient survey relating to responsiveness – The CCG welcomes the addition of this priority, not least as the response rate is currently lower than we would like, as such we recommend that the Trust also include an ambition to increase the overall response rate as well as the score.
- To improve the assessment and quality of care for patients in Mental Health crisis – the CCG is very pleased to see this new priority and commend you on its ambition. The CCG would ask that this includes those patients with a Learning Disability in crisis also.

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. We particularly value the inclusion of children and young people. 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 as noted above. The Trust should continue to explore different ways of increasing and improving feedback and patient / family / carer engagement.

Finally the CCGs recognise, that while the recent staff survey has shown some improvement there are areas that continue to be of concern. The CCG does welcome however NNUH's commitment to improve staff satisfaction through the implementation of a robust Workforce and Organisational Plan.

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

Alison Leather
Chief Quality Officer (SNCCG & NNCCG)
1st May 2019

Statement from Norfolk Health Overview and Scrutiny Committee

No return at the time of publication

Statement from Healthwatch Suffolk

No return at the time of publication

Statement from Healthwatch Norfolk

Healthwatch Norfolk Statement –NNUH Quality Report 2018/19

Healthwatch Norfolk appreciates the opportunity to make comments on the NNUH Quality Report.

The introduction from the Chief Executive quite rightly initially focusses on the critical findings of the CQC report, but also emphasizes positive developments – more specialised emergency department provision for children and people over 80 for example. The introduction of a daily serious incident meeting for all staff, the appointment of a full time Right to Speak Up Guardian and the arrival of patients in the new Quadram Institute, in December 2018, are all very welcome developments. Healthwatch Norfolk is also delighted to read that the Trust is accredited as a Veteran Aware hospital.

Current Pressures

Healthwatch Norfolk is aware that the NHS is under pressure for many reasons – for example, 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 the Trust scores 96% on the Friends and family Test. It is also good to note that MRSA (one case) was very low and that CDI reduced slightly by comparison to 2017/18. However, in common with many other hospitals cancer referral and treatment times did not reach the national standard nor did performance in ED.

Format of the Report

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. The provision of a glossary is 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 priorities for improvement for 2018/9 are clearly stated, as objectives, but at this point a large number are only defined as “to be established in quarter 1”.

Incidents

The number of reported incidents at the Trust has increased dramatically in 2018/19 – 17,222 compared with 14,358 the previous year. However the Trust states that 96.85% caused either no harm or low harm to patients and attributes the increase to an “increased awareness of safety issues and an improved quality and safety culture”. Pressure ulcers

and falls have together accounted for the majority of the recorded serious incidents, which have been recorded as averaging 17 per month. There were six never events, the same as the previous year.

Complaints

The number of complaints has increased in 2018, as reported, and Healthwatch are very pleased to have participated in an independent review of complaints files in July 2018, following which recommendations have been implemented by the Trust. It is not possible to say whether an increase in complaints reflects a more open culture or an increase in actual problems.

The Trust has participated in 51/52 national clinical audits and 4/4 national confidential enquiries, which it was eligible to take part in. Details are provided in the Report.

CQC Report

Although the Trust was able to respond to many of the August 2017 CQC report recommendations, unfortunately the follow up June 2018 CQC report put the Trust in special measures, with a finding of inadequate on Safe and Well Led ratings. The Quality report provides a CQC Action Plan, which gives the situation at April 2019, Blue for complete, Amber for Risk to Delivery and Red – Not on Track to Deliver, thereby demonstrating that measures of improvement have been defined, but are currently ongoing.

Workforce

Staff engagement with the Trust remains fairly positive, with 61.9% saying ”I would recommend my organisation as a place to work” up from 60.7% the previous year and over 75% agreeing that “If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation”.

Healthwatch Norfolk remains 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 recommendations for change, where appropriate.

Alex Stewart

Chief Executive

May 2019

Statements from Governors

From: Nina Duddleston
Sent: 29 April 2019
Subject: Quality Report NNUH

Good morning
I have now completed reading through the 114 pages of the report.
My comments are:
As much as the glossary is appreciated a list of Acronyms would also be very useful.
I am aware that when information is first written the Acronym is detailed but when used further in the text it takes time to trawl back through the pages if you need to remind yourself of its meaning.

The tables that are displayed are not very user friendly to those that are not medically trained, a written summary of the contents of these tables would very useful.
Other than these two comments an excellent piece of work. Any other queries I have can hopefully be discussed at future governors meetings.

Kind regards
Nina Duddleston
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 2018/19 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 2018 to March 2019
    - papers relating to quality reported to the board cover the period April 2018 to March 2019
    - feedback from commissioners dated May2019
    - feedback from governors dated April 2019
    - feedback from local Healthwatch organisations dated May 2019
    - feedback from Overview and Scrutiny Committee dated May 2019
    - the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated May 2019
    - the 2018 national patient survey
    - the 2019 national staff survey
    - the Head of Internal Audit's annual opinion of the trust's control environment dated May 2019
    - CQC inspection report dated 19/06/2018
- 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 **29 May 2019**

Mark Davies
Chief Executive **29 May 2019**

Glossary of terms

Acute Medical Unit (AMU) Rapid assessment and diagnosis unit for emergency patients

Bacteraemia An infection resulting from presence of bacteria in the blood

BCIS British Cardiovascular Intervention Society

Clinical Audit The process of reviewing clinical processes to improve them

Clinical Governance Processes that maintain and improve quality of patient care

Clostridium difficile, C difficile or C.diff A bacterium that can cause infection

Coding or clinical coding An internationally agreed system of analysing clinical notes and assigning clinical classification codes

CQC, or Care Quality Commission The independent regulator of all health and social care services in England.

CQUIN Commissioning for Quality and Innovation. Schemes to deliver quality improvements which carry financial rewards in the NHS.

CT scan Computed Tomography scanning, a technique which combines special x-ray equipment with computers to produce images of the inside of the body.

DAHNO Data for Head and Neck Oncology, a database of information on head and neck cancer patients

Data Quality The process of assessing how accurately the information and data we gather is held

Datix Datix is a patient safety web-based incident reporting and risk management software for healthcare and social care organizations.

Decile A statistical term, meaning one tenth of the whole.

Delayed Transfers of Care, or DToCs Term for patients who are medically fit to leave a hospital but are waiting for social care or primary care services to facilitate transfer

Dementia The loss of cognitive ability (memory, language, problem-solving) in a previously unimpaired person, beyond that expected of normal aging

Dr Foster A company that has developed a Hospital Standardised Mortality Rate and other data comparisons across the NHS

Drugs, Therapeutics and Medicines Management Committee (DTMM) An internal committee that considers all drug related issues

Early Warning Score (EWS) A clinical checklist process used to identify rapidly deteriorating patients

East of England Ambulance Service (EEAST) The Ambulance Service which covers Bedfordshire, Cambridgeshire, Essex, Hertfordshire, Norfolk and Suffolk.

Escherichia coli or E.coli Part of the normal intestinal microflora in humans and warm-blooded animals. Some strains can cause disease in humans, ranging from mild to severe.

GPs General Practitioners i.e. family doctors

Health Protection Agency (HPA) An independent body that protects the health and well-being of the population.

HPV Human papillomavirus – a DNA virus from the papillomavirus family that is capable of infecting humans.

Hospital Standardised Mortality Ratio (HSMR) An indicator of healthcare quality that measures whether the death rate at a hospital is higher or lower than should be expected.

ICNARC CMP Intensive Care National Audit and Research Centre Case Mix Programme

LoS Length of stay

MDT Multi-disciplinary Team, composed of doctors, nurses, therapists and other health professionals

MI or Myocardial Infarction A heart attack, usually caused by a blood clot, which stops the blood flowing to a part of the heart muscle

MINAP Myocardial Infarction Audit Project

MRSA Methicillin Resistant Staphylococcus aureus, a strain of bacterium that is resistant to one type of antibiotic

MSSA Methicillin-sensitive Staphylococcus aureus, a strain of bacteria that is sensitive to one type of antibiotic

NBOCAP National Bowel Cancer Audit Programme

NCAA National Cardiac Arrest Audit, the national, clinical audit for in-hospital cardiac arrest

NCE – National Confidential Enquiries A system of national confidential audits which carry out research into patient care in order to identify ways of improving its quality.

Neonates Medical term for babies born prematurely in the first 28 days of life

NHFD National Hip Fracture Database

NICE National Institute for Health and Clinical Excellence

NICU – Neonatal Intensive Care Unit The unit in the hospital which cares for very sick or very premature babies

NIHR National Institute for Health Research

NLCA National Lung Cancer Audit

Norovirus Sometimes known as the winter vomiting bug, the most common stomach bug in the UK, affecting people of all ages

NNAP National Neonatal Audit Programme

NRLS National Reporting and Learning System – A database of patient safety information

Palliative Care Form of medical care that concentrates on reducing the severity of disease symptoms to prevent and relieve suffering

Paediatrics The branch of medicine for the care of infants, children and young people up to the age of 16.

Perinatal Defines the period occurring around the time of birth (five months before and one month after)

PHSO Parliamentary and Health Service Ombudsman

PLACE – Patient Led Assessment of Clinical Environment A national programme that replaced PEAT from April 2013.

PPCI – Primary Percutaneous Coronary Intervention A treatment for heart attack patients which unblocks an artery by opening a small balloon, or stent, in the artery

Prescribing The process of deciding which drugs a patient should receive and writing those instructions down on a patient's drug chart or prescription

Pressure Ulcer Pressure ulcers are a type of injury that breaks down the skin and underlying tissue. They are caused when an area of skin is placed under pressure. They are also sometimes known as "bedsores" or "pressure sores".

PROM - Patient Reported Outcome Measures A national programme whereby patients having particular operations fill in questionnaires before and after their treatment to report on the quality of care

Quartile A statistical term, referring to one quarter of the whole

RCA or Root Cause Analysis A method of problem solving that tries to identify the root causes of faults or problems

Screening Assessing patients who are not showing symptoms of a particular disease or condition to see if they have that disease or condition

Sepsis Sometimes called blood poisoning, sepsis is the systemic illness caused by microbial invasion of normally sterile parts of the body

Serco The company that provides support services like catering, cleaning and engineering to the Norfolk and Norwich University Hospital

STEMI - ST segment elevation myocardial infarction A heart attack which occurs when a coronary artery is blocked by a blood clot.

Stent A small mesh tube used to treat narrow or weak arteries. Arteries are blood vessels that carry blood away from your heart to other parts of your body.

Streptococcus A type of infection caused by a type of bacteria called streptococcal or 'strep' for short. Strep infections can vary in severity from mild throat infections to pneumonia, and most can be treated with antibiotics.

Stroke The rapidly developing loss of brain function due to a blocked or burst blood vessel in the brain.

Surgical Site Infection (SSI) Occurs when microorganisms enter the part of the body that has been operated on and multiply in the tissues.

TARN Trauma Audit and Research Network

Thrombolysis or thrombolysed The breakdown of blood clots through use of clot busting drugs

Thromboprophylaxis Any measure taken to prevent coronary thrombosis

Thrombosis The process of a clot forming in veins or arteries

Thrombus A clot which forms in a vein or an artery

TIA or Transient Ischaemic Attack This happens when blood flow to a part of the brain stops for a brief period of time. A person will have stroke-like symptoms for up to 24 hours, but in most cases for 1 – 2 hours. A TIA is felt to be a warning sign that a true stroke may happen in the future if something is not done to prevent it.

Tissue Viability (TV) The medical specialism concerned with all aspects of skin and soft tissue wounds including acute surgical wounds, pressure ulcers and leg ulcers

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

We have been engaged by the Council of Governors of Norfolk and Norwich University Hospitals NHS Foundation Trust to perform an independent assurance engagement in respect of Norfolk and Norwich University Hospitals NHS Foundation Trust's Quality Report for the year ended 31 March 2019 (the 'Quality Report') and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2019 subject to limited assurance consist of the following two national priority indicators:

- A&E: maximum waiting time of four hours from arrival to admission, transfer or discharge;
- maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers;

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 2018/19* ('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 Guidance.

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 2018 to May 2019;
- papers relating to quality reported to the board over the period April 2018 to May 2019;
- feedback from commissioners, dated 22 May 2019;
- feedback from governors, dated 22 May 2019;
- feedback from local Healthwatch organisations, dated 22 May 2019;
- feedback from Overview and Scrutiny Committee, not received at time of publishing.
- the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009;
- the 2018 national patient survey, dated February 2019;

- the 2017 national staff survey, dated June 2018;
- Care Quality Commission Inspection, dated 15 May 2019;
- the 2018/19 Head of Internal Audit's annual opinion over the trust's control environment, dated 29 May 2019; and
- any other information included in our review.

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

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

This report, including the conclusion, has been prepared solely for the Council of Governors of Norfolk and Norwich University Hospitals NHS Foundation Trust as a body, to assist the Council of Governors in reporting the NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2019, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicator. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and Norfolk and Norwich University Hospitals NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

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

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

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

Limitations

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

The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable measurement techniques which can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may

change over time. It is important to read the quality report in the context of the criteria set out in the *NHS Foundation Trust Annual Reporting Manual* and supporting guidance.

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

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2019:

- 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 indicators in the Quality Report subject to limited assurance have 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

KPMG LLP
Chartered Accountants
Botanic House
100 Hills Road
Cambridge
CB2 1AR
22 May 2019

29 May 2019

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

A&E Waiting Times – Total time in the A&E department

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 (two-week 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.

---

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

APPENDIX 1 – CQC ACTION PLAN APRIL 2019

CQC Domain	Recommendation	Desired Outcome ('What does good look like?)	Recommended Completion Date	Estimated OUTCOME delivery date	Status
Caring	The trust must ensure that patients are treated with dignity and respect at all times.	QAA evidence and collection of feedback which reflects patients are treated with dignity and respect and in accordance with guidance and policy; Patients involved as core members of all quality committees; Formal Patient Panel has been implemented	01/04/2019	01/04/2019	**AMBER - Risk to delivery**
Caring	The trust should review its communication aids available to assist staff to communicate with patients living with a sensory loss, such as hearing loss.	We self-assess against national accessible information standards & action plan in place Patients and carers involvement Identify pilot site for next phase to test	01/04/2019	01/04/2019	**BLUE - Complete & evidenced**
Effective	The trust must review the knowledge, competency and skills of staff in relation to the Mental Capacity Act and Deprivation of Liberty safeguards.	i) QAA evidence that staff have appropriate understanding of MCA/DOLs, know when, how and why to invoke the guidance and can talk with confidence about a positive MH culture ii) > 90% of appropriate staff are compliant with MCA & DOLs training iii) Audit - 100% compliance with accurate recording of MCA/DOLs decision in patient notes iv) Reduction in	02/01/2019	31/03/2019	**BLUE - Complete & evidenced**

		complaints related to contravention of MCA/DOLs guidance			
Effective	The Trust must ensure that staff annual appraisal completion improves	Trust appraisal completion for AfC staff should be at or above 80%.; There will also be an associated improvement noted within the staff survey questionnaire	01/02/2019	01/02/2019	**BLUE - Complete & evidenced**
Effective	The trust must ensure that local audit findings are utilised to identify actions for improvement and that these are monitored, and reviewed.	i) QAA evidence that staff have appropriate understanding of audits local to their area, and can talk with confidence about audit action plans and outcomes ii) Documentary evidence (meeting minutes, action logs etc.) to show that audit outcomes are discussed widely (Divisional, Directorate, Departmental, Clinical Governance and Team meetings), that action plans are drawn up, and that the learning/feedback loop is closed, and learning disseminated through a regular Audit OWL	01/04/2019	31/01/2019	**BLUE - Complete & evidenced**

Effective	The trust must ensure that the healthcare records for patients' subject to restraint are complete and in line with the trust's policy and procedure.	Named lead for Reduction of Restrictive Intervention (RRI) in place; RRI strategy and protocol signed off and in place; Clear reporting and performance monitoring measures available; Staff training plan in place and trajectory agreed; Scenario based training sessions carried out in high risk areas to embed learning	01/10/2018	30/06/2019	**AMBER - Risk to delivery**
Effective	The trust must review 'do not attempt cardio-pulmonary resuscitation' (DNACPR) forms to ensure they are completed fully and in line with trust policy and national guidance.	i) QAA evidence that staff have appropriate understanding of DNACPR, feel confident of their ability to initiate and record conversations and can talk with confidence about a positive culture around care of the dying ii) Audit - Improved recording of DNACPR conversations in patient notes iii) Reduction in complaints related to contravention of DNACRP documented conversations iv) Evidence of shared approach with partner agencies	01/03/2019	01/04/2019	**GREEN - On track to deliver**

Responsive	The trust should ensure effective processes are in place for the timely completion of diagnostic reports.	Diagnostic reports are available to clinicians within a time period that is appropriate for clinical risk.	01/12/2018	31/03/2020	**AMBER - Risk to delivery**
Responsive	The trust should ensure that diagnostic imaging services are provided on a seven-day basis, in line with national guidance.	Scheduled seven-day access to diagnostic imaging services is available to inpatients	01/06/2019	31/03/2020	**AMBER - Risk to delivery**
Responsive	The trust must review the bed management and site management processes within the organisation to increase capacity and flow and ensure effective formalised processes are in place to ensure patient safety in all escalation areas.	Increased capacity and flow resulting in improved performance in key flow metrics (e.g. 4 hour target, stranded patients and median time of discharge)	External review August 2018. Discharge Lounge open by 1 November 2018	01/12/2019	**BLUE - Complete & evidenced**
Responsive	The trust must embed the recently formalised processes for review and assessment of escalation areas to reduce the risk to patient safety	Increased capacity and flow resulting in improved performance in key flow metrics (e.g. 4 hour target, stranded patients and median time of discharge)	External review August 2018. Discharge Lounge open by 1 November 2018	01/12/2019	**GREEN - On track to deliver**
Responsive	The trust must ensure that lessons learnt from concerns and complaints are used to improve the quality of care.	Divisions have easy access to their complaint and PALS enquiries via Datix system A monthly complaints synopsis is discussed at Monthly Governance meetings Documentary evidence of dissemination of	01/02/2019	30/04/2018	**AMBER - Risk to delivery**

		learning and closing the loop (e.g. OWLs)			
Responsive	The trust should ensure that the management of referrals into the organisation reflects national guidance in order that the backlog of patients on an 18-week pathway are seen.	Patients complete their first definitive treatment or are discharged within the standards set out in the NHS Constitution (Achievement of RTT targets and standards) Patients that sit outside of 18W criteria have clinical review	01/10/2018	31/10/2019	**BLUE - Complete & evidenced**
Responsive	Ensure complaints are responded to in line with the complaints policy deadline of 25 working days.	Complaints response time within 25 days reported through monthly complaints report, received by CaPE	01/09/2018	30/11/2018	**RED - Not on track to deliver**
Responsive	The trust must improve its performance times in relation to national time of arrival to receiving treatment (which is no more than one hour), four-hour target and monthly median total time in A&E.	ED is meeting all access targets that are either contractual or recommended by the College of Emergency Physicians including: Percentage of Patients admitted, transferred or discharged within four hours. Percentage of patients waiting between four and 12 hours from the decision to admit until being admitted. Number of patients	01/08/2018	01/08/2019	**AMBER - Risk to delivery**

		waiting more than 12 hours from decision to admit until being admitted. Percentage of patients that left the trust's urgent and emergency care services before being seen for treatment. Median total time in A&E per patient			
Safe	The trust must ensure that observational audits of the quality of the World Health Organisation (WHO) and five steps to safer surgery checklists are undertaken.	The WHO and five steps to safer surgery checklists are correctly completed and recorded for every procedure for which they are required. Learning from checklist completion is disseminated across the organisation.	01/10/2018	31/12/2018	**BLUE - Complete & evidenced**
Safe	The trust must ensure that specialist personal protective equipment, such as the integrity of lead aprons, is checked on a regular basis.		01/09/2018	31/12/2018	**BLUE - Complete & evidenced**
Safe	The trust must ensure that the call bell system within nuclear medicine is fit for purpose.	Patients in nuclear medicine are able to alert staff for their need for help in an emergency.	01/12/2018	31/12/2019	**BLUE - Complete & evidenced**

Safe	The trust must ensure that the environment, equipment storage, medicines management and infection control procedures are appropriate in the interventional radiology unit. (S)	(NB - this recommendation actually refers to the CT/MRI anaesthetic area). An appropriate environment is maintained in the CT/MRI anaesthetic area.	01/12/2018	01/12/2018	**BLUE - Complete & evidenced**
Safe	The trust should ensure that diagnostic imaging equipment remains fit for use through the implementation of a capital replacement programme.	All diagnostic imaging equipment is fit for purpose, correctly maintained and replaced when necessary.	01/03/2019	31/03/2020	**BLUE - Complete & evidenced**
Safe	The trust must ensure that there is effective governance, safety and quality assurance processes within the theatre department that are structured, consistent, and monitored to improve practice and reduce risk to patients.	Theatre governance meetings and theatre governance lead role established. Theatre OWL (per Specialty) highlighting risk - disseminated monthly by Theatre Governance Facilitator Consistent approach across all directorates is evident at Directorate Governance Leads Meetings Identified risks acted on appropriately or in a timely manner with supporting actions in place	01/03/2019	01/03/2019	**RED - Not on track to deliver**
Safe	The trust must ensure that the World Health Organisation (WHO) and five steps to	Audit data and learning outcomes displayed in department and discussed in	01/03/2019	01/03/2019	**BLUE - Complete & evidenced**

	safer surgery checklist is completed appropriately, and that learning from incidents and regular monitoring processes become embedded to empower staff to challenge and report any poor practice.	Theatre management group Observational and compliance audit programme in place Regular reporting of output from both compliance and observational audits provided All specialties / departments and divisions review learning from incidents and other forms of intelligence in their governance meetings and this is clearly documented in the minutes template and action log			
Safe	The trust should ensure that theatre staff adhere to the dress code policy.	Theatre dress code policy reviewed and updated, where appropriate. All theatre staff aware and adhere to policy Regular audit of compliance of dress code in theatres and feedback process in place	01/10/2018	30/03/2019	**GREEN - On track to deliver**
Safe	The trust must ensure that mandatory training attendance improves to ensure that all staff are aware of current practices. (TW)	Trust Mandatory Training compliance is above 90% with no significant pockets of low achievement either by department or course, and all staff complete the appropriate level associated with their roles.	02/01/2019	31/03/2019	**AMBER - Risk to delivery**

		QAA evidence to show that staff are also able to exhibit knowledge gained from these courses. Any new mandatory courses will be expected to....			
Safe	The trust must ensure that there is an effective process for quality improvement and risk management in all departments	We have a Trust Wide QI Strategy with an implementation plan in place, communicated to staff	Strategy completed and agreed by 1 October 2018 - other dates to be set against the implementation plan that will be within the strategy	31/01/2019	**BLUE - Complete & evidenced**
Safe	The trust must ensure that there is an effective process for quality improvement and risk management in all departments.	An informed understanding of high operational risks, reflected through a revised risk register and managed through an effective risk management group Risk management systems that are fit for a high performing health organisation Risk information that flows from specialities through Divisions to the board and aligned to the Board Assurance Framework Board members that provide strong leadership in a risk-based approach embedded within the quality governance framework and set	External Governance review completed by 1 November 2019. Risk Registers reviewed and refreshed by 2 January 2019. Revised Governance structure in place together with Risk management procedures by 1 March 2019	01/03/2019	**RED - Not on track to deliver**

		a clear expectation to all staff regarding the management of risk Wider teams and individual staff are equipped to use a risk-based approach for the challenge of delivering revised expectations and are prepared for an environment where continual improvement and management of risk is the norm			
Safe	The trust must ensure that resuscitation equipment is checked in accordance with trust policy.	Policy reviewed, updated and available on the intranet Trollies replaced and meet current standards Compliance audit of checking equipment completed Process for ongoing monitoring agreed (included real time dashboard visibility to identify check status) and communicated by Divisional Nursing Directors following audit analysis	01/10/2018	31/12/2018	**RED - Not on track to deliver**

Safe	The trust must ensure that action plans are monitored and that action is taken following the investigation of serious incidents	i) QAA evidence that staff have appropriate awareness of incidents and know when, how and why to log incidents and 'great catches' on DATIX and can talk with confidence about a positive safety culture ii) Increased recording of incidents and 'great catchs' on DATIX iii) Minuted evidence of incident reviews & RCAs, eg. a SI OWL iv) Evidence that SIs are being discussed at Departmental Clinical Governance meetings v) Documentary evidence of dissemination of learning and closing the loop across divisions	01/10/2018	31/03/2019	**BLUE - Complete & evidenced**
Safe	The trust must ensure that there are effective systems and processes in place to ensure assessing the risk of, and preventing, detecting and controlling the spread of infections, including those that are healthcare associated.	QAA evidence that staff, patients and visitors have appropriate awareness of IP&C guidance, act in accordance with guidance and policy, and can talk with confidence about a positive IP&C culture Metric: Remain within the NHSI objectives for MRSA and C. diff. Documentary evidence of dissemination of learning and closing the loop (e.g. IP&C OWLs) Improved IP&C	01/08/2018	31/12/2018	**BLUE - Complete & evidenced**

		audit outcomes, in particular the HII audits which should attain a minimum of 80% Reduction in complaints related to IP&C			
Safe	The trust must ensure staff compliance improves for major incident training	90% or more of all staff members that need major incident training have received the required training. Staff members are able to articulate the nature of a major incident, their individual actions and escalation processes.	01/12/2018	31/12/2018	**RED - Not on track to deliver**
Safe	The trust must ensure that oxygen cylinders are stored safely, that oxygen is readily available in all patient areas, and that this equipment is properly maintained.	Oxygen cylinders are stored in accordance with Health and Safety Executive (HSE) guidance, specifically to keep cylinders chained or clamped to prevent them from falling over. Piped oxygen equipment is checked at the required frequency with records kept of checks made. All oxygen equipment is maintained according to the required schedule.	01/10/2018	31/12/2018	**BLUE - Complete & evidenced**

Safe	The trust must ensure that patient venous thromboembolism (VTE) risk assessments are completed.	i) QAA evidence that junior doctors and nursing staff have appropriate awareness of the importance of TRA and can explain how to carry out & record a TRA and how to administer appropriate thromboprophylaxis ii) Metric: XX% reduction in preventable PEs and DVTs iii) Documentary evidence of dissemination of learning and closing the loop (e.g. RCAs and incident reporting)	01/12/2018	31/03/2019	**BLUE - Complete & evidenced**
Safe	The trust must ensure that necessary risk assessments and healthcare records are complete for mental health patients.	i) QAA evidence that staff have appropriate understanding of MH risk assessments, know when, how and why to conduct & record them, and can talk with confidence about a positive MH culture ii) >90% of appropriate staff are compliant with MH risk assessment training iii) Audit - >90% compliance with accurate recording of MH risk assessments in patient notes iv) Reduction in complaints related to contravention of MH policies	01/11/2018	01/05/2018	**GREEN - On track to deliver**

Safe	The trust must ensure that computers are locked and that patient healthcare records are stored securely.	Patient records and trust computer equipment are secure and protected at all times.	01/12/2018	31/03/2019	**AMBER - Risk to delivery**
Safe	The trust must ensure that incidents are reported and investigated in a timely way by trained investigators	A robust system of incident review is in place with an agreed response time target for incident review and ongoing monitoring of compliance levels The Trust have a Serious Incident Group (SIG) in place Reporting and incident investigation training available to staff and guidance material provided	01/03/2019	01/03/2019	**BLUE - Complete & evidenced**
Safe	The trust must ensure that medicines and contrast media are stored securely and in line with national guidance	i) QAA evidence that staff have appropriate understanding of the storage of medicines and contrast media, and are compliant with SOPS ii) Audit - Improved audit outcomes	02/01/2019	28/02/2019	**BLUE - Complete & evidenced**
Safe	The trust must ensure temperature charts for blood and medicine fridges are appropriately completed and records held in line with national requirements.	Audit process in place. Reported via Medicine Management Committee and feedback provided to areas. Part of the Perfect Ward suite of metrics included as part of the performance dashboard. QAA evidence that staff have appropriate awareness of	01/11/2018	31/12/2018	**RED - Not on track to deliver**

		national requirements when completing records concerning temperature charts for blood and medicine fridges			
Safe	The trust should ensure that effective processes are in place for correct handling and disposal of clinical waste, including sharps bins, and that storage of chemicals is secure in line with the Control of Substances Hazardous to Health (COSSH) guidelines.	Clinical waste is handled and disposed of appropriately and risks to staff safety are minimised	01/11/2018	01/11/2018	**BLUE - Complete & evidenced**
Safe	The trust should ensure morbidity and mortality meeting minutes include sufficient detail of background information, discussions and those in attendance.	i) Evidence to show that Morbidity and Mortality meetings are multi-disciplinary, attended by the appropriate people, minuted, and the outcomes/learning are disseminated appropriately ii) Improved HSMR	01/09/2018	30/06/2019	**AMBER - Risk to delivery**
Safe	The trust should ensure that specialist personal protective equipment is checked on a regular basis and worn appropriately by staff.	Processes are in place to ensure staff receive sufficient protection effectively from radiation and hazardous materials: 1) Policies and processes are in place that cover the logging, checking and maintenance of specialist PPE 2) Functioning specialist PPE is available to staff at the point of need 3) Staff are trained on the appropriate	01/09/2018	31/12/2018	**RED - Not on track to deliver**

		use of specialist PPE			
Safe	The trust should continue to monitor and actively recruit to ensure that there is an adequate number of nursing staff with the appropriate skill mix to care for patients in line with national guidance.	Comprehensive staffing review to include the exploration of different roles to support frontline care delivery and against national recommendation carried out; e-rostering policy in place and communicated to staff; Staffing establishment agreed that is fit for purpose and supports a flexible acuity demand with recruitment plan agreed and in place; Three times a day cross divisional staffing meetings and review of red flag events in place	01/04/2019	01/04/2019	**AMBER - Risk to delivery**
Safe	The trust should ensure that staff carrying out Root Cause Analysis (RCA) investigations for serious incidents receive appropriate RCA training.	Rolling programme of RCA training with sufficient capacity to meet demand established; Protected time for staff to undertake training in place; Target number of staff trained in each specialty; Uptake and compliance monitored .	01/12/2018	01/12/2018	**BLUE - Complete & evidenced**
Safe	The Trust must ensure that the premises for urgent and emergency services protect patients from potential harm and used for the intended purpose.	The ED department will have: - Suitable Handwashing sinks throughout the department - A sluice within Children's ED - A HDU for	01/10/2018	01/11/2018	**BLUE - Complete & evidenced**

	This includes all areas of the service for both children & adults.	Children and Young people outside of Resus. - Children and young people ED area is large enough to accommodate all children and young people. - Waiting facilities for Children and Young people large enough to accommodate all children and young people separate from adult waiting space. - Secured access to Children's ED for both entry and exit. - Piped oxygen and suction available in all ED patient areas. - Suitable areas for mental health patients that can be isolated from environmental and ligature risks if required following patient environmental risk assessments.			
Safe	The trust must ensure that there is a system in place, which is adequately resourced, to ensure that patients are assessed, treated and managed in a time frame to suit their individual needs. (The trust should review its use of the Rapid Assessment and Treatment (RAT) system and ensure this is embedded into practice.)	The RAT column on symphony is used consistently or replaced with another system of identifying RATs patients and their outcomes. That all appropriate patients go through the RATs process in its operational hours or staff member working.	01/11/2018	01/10/2019	**GREEN - On track to deliver**

Safe	The trust must action its plans to expand the children's and adults emergency department, including the provision of a high dependency unit for children outside of the resuscitation department.	The Emergency Department will have: Additional space in adult and paediatric areas compared to November 2017 as outline in plans submitted to the CQC. A HDU area for children outside of the resuscitation area	01/09/2018	01/11/2018	**BLUE - Complete & evidenced**
Safe	The trust must review its nursing and medical staffing numbers for the urgent and emergency services and plan staffing acuity accordingly	The medical and nursing numbers within ED reflect the acuity and volume of patients. Allowing all shifts to be equally busy and the ability for 95% of patients to be discharged, transferred or admitted within 4 hours when all policies and procedures are followed. Follow policy on weekend and night shifts	01/10/2018	01/10/2019	**GREEN - On track to deliver**
Safe	The trust must review its nursing and medical staffing numbers for the urgent and emergency services and plan staffing acuity accordingly	The medical and nursing numbers within ED reflect the acuity and volume of patients. Allowing all shifts to be equally busy and the ability for 95% of patients to be discharged, transferred or admitted within 4 hours when all policies and procedures are followed.	01/10/2018	01/10/2019	**GREEN - On track to deliver**

Safe	The trust must ensure that there is one registered children's nurse at all times within the children's emergency department and take necessary action to increase the number of registered children's nurses employed.	A children's nurse is available 24/7 within Children's ED in a sustainable manner. This will be noted on roster and also in QAA a paediatric nurse will also be available.	01/10/2018	01/10/2019	**GREEN - On track to deliver**
Safe	The trust must ensure a good skill mix within the children's ED nursing workforce.	There is a nursing establishment that reflects the Children's ED SOP recommended levels. With shifts rostered to ensure appropriate seniority of staff on shifts.	01/12/2018	01/10/2019	**GREEN - On track to deliver**
Safe	The trust must ensure audio and visual separation between adults and children being assessed and waiting within the emergency department and minor injuries unit.	There must be suitable sized facilities for Children to ensure that they can always wait and be treated in a paediatric only environment other than those requiring resuscitation. Children should not have to walk through adult treatment areas to access paediatric areas.	31/03/2019	31/03/2019	**AMBER - Risk to delivery**
Safe	The trust must ensure emergency equipment, including ligature cutters and children's resuscitation equipment is readily available.	The ED department will have: - Suitable Handwashing sinks throughout the department - A sluice within Children's ED - A HDU for Children and Young people outside of Resus. - Children and young people ED area is large	01/10/2018	01/11/2018	**BLUE - Complete & evidenced**

		enough to accommodate all children and young people. - Waiting facilities for Children and Young people large enough to accommodate all children and young people separate from adult waiting space. - Secured access to Children's ED for both entry and exit. - Piped oxygen and suction available in all ED patient areas. - Suitable areas for mental health patients that can be isolated from environmental and ligature risks if required following patient environmental risk assessments.			
Safe	The trust must ensure that there is a medical lead appointed for the service.	A medical lead is in post and working as part of the departmental triumph ate. The staff within ED can identify their medical lead in QAA.	01/08/2018	01/08/2018	**BLUE - Complete & evidenced**
Safe	The trust must ensure that there is a local audit programme in place for the service, that action plans are in place and necessary improvements are made to practice following audit.	All audit plans are complete including the dates. That audit samples are appropriate and not too low and that all audits have associated action plans. All audits with action plans should have a date of repeat audit planned.	01/09/2018	31/03/2019	**AMBER - Risk to delivery**

Safe	The trust should ensure that regular and minuted mortality and morbidity meetings take place for urgent and emergency services.	Morbidity and mortality are discussed in a meeting either within another meeting or a separate meeting. This meeting must be fully minuted. The learning and lessons from these are reported to the divisional and trust wide meetings to share practice.	01/09/2018	01/11/2018	**BLUE - Complete & evidenced**
Safe	The trust should ensure that a safety thermometer is implemented for children's and adult urgent and emergency services.	A method of showing the prevalence patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in harm free care. It is suggested this is via the safety thermometer and national paediatric safety thermometer. N.B. the CQC are aware that this information is reported in the nursing dashboard and still requested the safety thermometer implementation.	01/10/2018	31/03/2019	**BLUE - Complete & evidenced**
Safe	The trust should ensure that sepsis training is available to all staff providing urgent and emergency care.	All staff have a record of receiving Sepsis training and a standard programme of training is available to deliver the training. QAA all staff are able to discuss how to identify and treat a patient with suspected sepsis	01/12/2018	01/12/2018	**RED - Not on track to deliver**

Safe	The trust must ensure there are effective governance processes in place to ensure timely and appropriate capacity and risk assessments for mental health patients are undertaken	The service has a robust process to monitor the quality of medical documentation, including a programme of weekly audits to evaluate compliance with use of: • The deliberate self-harm proforma • Mental capacity assessment, including second stage assessments • Risk assessments for patients with MH concerns to ensure steps are taken to keep patients safe. • The ED Adult Mental Health Triage Form with the results presented at clinical governance meetings and the mental health board, and disseminated monthly through the ED newsletter			**RED - Not on track to deliver**
Safe	The trust must review and monitor the use of the Clinical Decisions Unit for patients who present with mental health requirements, to ensure that patients are protected from potential harm	• The CDU SOP and CDU Deliberate Self Harm Protocol have been revised to ensure that the circumstances under which patients can be transferred is made explicit • CDU pathways for patients who present with mental health requirements have been reviewed to ensure patients are not admitted to CDU with solely a mental health requirement.			**RED - Not on track to deliver**

		• Patients at high risk of deliberate self-harm have a further risk assessment prior to their transfer from ED to CDU, to facilitate the documentation of changes in risk. • An audit programme is in place to monitor compliance with the policies, with the audit results presented at clinical governance meetings and the mental health board, and disseminated through the ED newsletter			
Safe	The trust should continue to monitor and actively recruit to ensure that there is an adequate number of nursing and medical staff with the appropriate skill mix to care for patients in urgent and emergency services	Nursing vacancies have been filled, to enable the three new MH treatment rooms to open appropriately to meet need			**GREEN - On track to deliver**

Safe	The trust must ensure that effective governance and quality assurance processes are in place to measure service improvement. Including escalation of concerns and monitoring of actions arising from meetings, local audits, recommendations from regulators and external reviews.	A documentation audit programme and associated action plan is in place, with the audit results presented at clinical governance meetings and disseminated through the ED newsletter. The audit to cover: • cannula insertion and documentation • IP&C e.g. commode and bed pan cleaning, cleaning log audits • deliberate self-harm risk assessment completion • use of PPE • MH documentation (including MH triage form and safeguarding referrals) ED Clinical Governance meetings take place monthly, with multi-disciplinary attendance, and are fully and comprehensively minuted to evidence that all agenda items are discussed and that audit outcomes and action plans are reviewed.			**GREEN - On track to deliver**

Safe	The trust must ensure that effective processes are in place, and monitored, to ensure clinical policies and guidelines are regularly reviewed and updated in line with national guidance	• The Deliberate Self Harm and Shared Decision Making Policies have been reviewed, and updated versions are available to all staff on Trust Docs and ED notice boards • Compliance with the ED SOP for ambulant patients is monitored at monthly clinical governance meeting, as evidenced by Agendas and meeting minutes • Compliance with the ED Protocol for the Management of Patients with a Mental Health Need within the ED Interview Room is monitored at monthly clinical governance meeting, as evidenced by Agendas and meeting minutes • An up to date risk assessments is in place for all areas used for the assessment and treatment of patients with MH concerns • The Consent working group has completed all the actions on its Action Plan, and the plan has been signed off at a Clinical Governance meeting.			**AMBER - Risk to delivery**

Safe	The staff must improve staff understanding of isolation procedures and ensure that compliance is regularly monitored	♦Compliance with Isolation procedures is monitored through the Clinical Governance meeting, as evidenced by Agendas and meeting minutes ♦There is a programme of regular audit for IP&C, cannula insertion etc. and results are monitored and acted upon through the Clinical Governance meeting, as evidenced by Agendas, meeting minutes and action plans ♦The consistent use of Infection Risk cards is used in areas where patients are being isolated, and compliance is monitored through the Clinical Governance meeting, as evidenced by Agendas, meeting minutes			**GREEN - On track to deliver**
Safe	The trust should ensure that the emergency department strategy is regularly reviewed	There is an agreed and published ED strategy available to all staff on Trust Docs and ED notice boards, and review dates are set to ensure that the strategy remains current.			**GREEN - On track to deliver**

Safe	The trust should ensure that all relevant information is gathered and reviewed during incident investigations, including input from all relevant staff, external stakeholders and specialist providers	• Staff carrying out incident investigations are fully trained in RCA • The MH Liaison Team is fully involved in all incident investigations relating to patients whom they have reviewed • A review has been carried out on the effectiveness of joint working and communication between the trust and the mental health liaison team, and changes have been implemented as a result of the review • The quality of Serious Incident RCA is monitored through the Clinical Governance meetings, as evidenced by meeting minutes and agendas.			**BLUE - Complete & evidenced**
Safe	The trust should ensure that information is gathered to monitor whether areas within the urgent and emergency service are being utilised as intended	• There is a process in place to collect and analyse data showing where patients have been treated in inappropriate environments such as the Review Clinic room and CDU. • This data is reviewed, monitored and acted upon at monthly Clinical Governance meetings, as evidenced by Agendas, minutes and action logs.			**RED - Not on track to deliver**

Safe	The trust should review the level of scrutiny and oversight that the mental health board provides	• The Mental Health Board agenda allots sufficient time in each meeting for a full discussion of learning from incidents, risk register review and review of local audit findings and action plans • Agenda and meeting minutes evidence that these items have been fully discussed at each meeting			**AMBER - Risk to delivery**
Well-Led	The trust should ensure that there is ongoing monitoring of the outpatient service, including the re-development of an outpatient dashboard.	Improved outpatient services as evidenced by achievement of key performance targets in the Outpatient Dashboard.	01/10/2018	31/12/2019	**AMBER - Risk to delivery**
Well-Led	The trust must ensure that leadership, culture and behaviours within the operating theatre department are actively addressed.	Standard operating procedures in place to support consistent approach and accountability from the senior leads across the theatre specialities Appropriate leadership structure in place with additional leadership roles of Senior Matron and Operational Manager for Anaesthetics and Theatres within Surgical Division Theatre OWL (per Specialty) - disseminated monthly by Theatre Governance	01/05/2019	01/05/2019	**GREEN - On track to deliver**

		Facilitator Speak Up Guardian role promoted in theatres Theatre Safety Huddle in place Surgical teams have participated in Human Factors training to improve communication/team work			
Well-Led	The trust must improve the relationship and culture between the site management team and the Senior Nursing and Clinical teams to ensure open dialogue where patient safety is equally weighted to operational pressure to reduce risks to patients and staff.	The operational meetings and decision making takes place within Trust policy, which is well known by staff and ensures the best Trust wide safety. QAA evidence that staff can challenge and raise safety issues within the operational meetings and with the site operational team. Where decisions are made against standard Trust policy they are recorded as to why policy was breached and the mitigating action to return to normal service ASAP.	31/12/2018	31/03/2019	**RED - Not on track to deliver**

Well-Led	The trust must review process for whistleblowing and take definitive steps to improve the culture, openness and transparency throughout the organisation.	An updated whistleblowing policy. Evidence that whistle blows and speak up reports are reviewed and actioned as appropriate. QAA evidence that all staff know how to whistle blow and raise concerns and would feel they could do so without negative consequence.	Clarity regarding approach to staff engagement by 1 September with expected start of implementation of a Trust wide programme by 2 January 2019	02/01/2019	**BLUE - Complete & evidenced**
Well-Led	The trust must improve the functionality of the board and ensure formalised processes are in place for the development and support of both current and new executive directors. The trust must improve the level of oversight, scrutiny and challenge from the chair and non-executive directors (NEDS). (The trust should ensure that regular review of the executive portfolio takes place to ensure capacity and capability to deliver requirements.)	Development plans being in place for members of the board. Evidence ? Board minutes highlighting the challenges from NEDs.	01/03/2019	01/03/2019	**BLUE - Complete & evidenced**

Well-Led	The Trust must ensure consistency processes are in place for recruitment, fit and proper persons regulation and line management at executive level.	Review of Fit and Proper Persons regulation and ensuring all executives are compliant. 80% of Executives having current appraisals in line with the Trust target. All Executives have a current Personal Development Plan.	01/08/2018	30/11/2018	**BLUE - Complete & evidenced**
Well-Led	The Trust should review the support managers provide to support staff in times of increased demand	Structured Management programme for all line managers. A reasonable maximum number of staff to report to each member of management to allow us to "know our staff". Clear lines of operational, medical and nursing management in all areas 24/7.	01/08/2018	31/03/2019	**AMBER - Risk to delivery**
Well-Led	The trust should ensure that staff carrying out Duty of Candour applications receive appropriate training.	Training provision reviewed, alternative approaches utilised and clear guidance for staff on their responsibilities provided Divisional Governance Managers trained to ensure that there is a local 'expert' to support staff All COS / Ward and Department leads trained in DoC	02/01/2019	02/01/2019	**BLUE - Complete & evidenced**

Norfolk and Norwich University Hospitals NHS Foundation Trust

Colney Lane

Norwich

NR4 7UY

Website: http://www.nnuh.nhs.uk

Email: communications@nnuh.nhs.uk