Norfolk and Norwich University Hospitals
NHS Foundation Trust

Quality Report

2019-20

Quality Report 2019/20

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Part 1 - Chief Executive's Statement on Quality

Information about this Quality Report

Although it was only in the very last few weeks of 2019/20 that the Coronavirus pandemic began to have an impact on the services the Trust provides, it would be improper for me not to mention how hard staff have worked in preparing the hospital for dealing with the Covid-19 pandemic, and though working in extremely challenging times our staff are hugely committed in their care and support of our patients.

It was in the midst of this climate that I received the CQC report following their most recent inspection in December and January. I was delighted to welcome their recommendation that special measures are removed. I am very pleased that it recognises the sustained and significant improvements that our committed staff have made in patient care here at NNUH. Teams across the whole Trust have worked tirelessly with skill and dedication to continuously improve and develop services.

What the staff at NNUH have achieved is very impressive and the CQC has praised many aspects of care here from End of Life Care which is rated as Outstanding, Outpatients which is rated Good, and notable improvements in Urgent and Emergency Care and Surgery.

The domains of Effective and Caring are rated as Good, and the Safe, Responsive and Well-led domains are rated as Requires Improvement. This is a significant improvement from our previous report and represents a huge amount hard work, innovation and professionalism from our teams; at Requires Improvement overall, we still have more to do, but these results mark extremely good progress on our journey to outstanding.

Other highlights in the report include good examples of innovation across the Trust; the positive impact being made by the Older Persons Emergency Department, and a focus on research and development as well as the creation of a quality improvement faculty.

The most important thing to all staff at NNUH is working together to provide the best possible care and treatment for our patients, creating an environment where patients are treated with compassion, kindness and dignity, patient's individual needs are respected and families are actively involved in discussions, and that's what the CQC found here
Whilst it is important to acknowledge the pressures we have been under, we must also remember that there is a great deal to celebrate and commend.

I am delighted that NNUH is one of the top 25 Trusts in the country for patients participating in research. More than 4,000 people took part in health research at the Trust over the past year, a 21% increase on 2017/18. This rise, of over 700, puts the NNUH second in the region and 23rd nationally for total participants. We are indebted to our patients who, working in partnership with our clinicians, are taking part in more than 400 research studies here across a range of specialties, a quarter of which are focused on research projects dedicated to helping our cancer patients.

Congratulations to our team who perform robotic-assisted colorectal surgery. They won an extremely prestigious national award, the Surgical Services Initiative of the Year, at the HSJ

Value Awards. I am very proud of their achievement and very pleased that we have a robotic-assisted surgery programme at our hospital to benefit our patients.

One of the initiatives implemented as part of the Trust's Winter Plan for 2018/19 was a service under the title 'NNUH at Home' providing a link between hospital and community care, facilitating care of patients at home who would otherwise have required an inpatient bed. Our efforts in this regard have been recognised and the *NNUH at Home* service team was shortlisted for the Health Service Journal Award for partnership working. They have been congratulated accordingly.

It is always good to note that clinicians associated with the Trust have been nominated for national leadership roles. Dr Edward Morris (NNUH Consultant Obstetrician and Gynaecologist) has been elected as President of the Royal College of Obstetricians and Gynaecologists and commenced this role in December. Dr Morris has been Vice President for Clinical Quality at the RCOG since 2016 and is a former chairman of the British Menopause Society.

At the same time, Professor Amanda Howe (Professor of Primary Care at Norwich Medical School) must be congratulated for being elected as the next President of the Royal College of General Practitioners (RCGP). In addition to her role in the Norwich Medical School, Professor Howe is a GP at Bowthorpe Surgery, Norwich.

We encourage all our staff to take an active professional interest in the world outside Norfolk to bring back new ideas and both Dr Morris and Professor Howe are great examples to others.

Regarding our role as a regional university hospital and one of our four strategic objectives to be the centre for complex and specialist medicine for Norfolk and the Anglia region, we have made very significant progress on this. Our roles in running the NIHR Clinical Research Network, the Radiology Academy and the Eastern Pathology Alliance have been in place for a few years, and more recently we have been successful in our bids to run the East of England Radiotherapy Network and the East of England Cervical Screening Service. These projects and services represent a huge body of work and are a testament to the commitment and hard work of all staff involved. We have made important quality improvements over the last year, which are helping us to deliver the very best care for our patients.

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.

Sam Higginson
Chief Executive

Part 2.2 - Priorities for improvement

The table below details the Trust's Quality Priorities for 2020/21. Each of the priorities sits within one of the three domains of patient safety, clinical effectiveness, and patient experience; governance, oversight, and assurance in relation to these priorities will be gained through Evidence group reporting to the Quality Programme Board. These priorities coalesce with existing identified improvement work (Use of Resources improvements identified through NHSi assessment (UoR), Commissioning for Quality and Innovation (CQUIN)) and support the Trusts Patient Engagement and Experience and Quality Improvement Strategies. This will enable the Trust to make tangible improvement achievements.

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.

Patient Safety

Quality Domain – Safe 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.	
Quality priority	**2020-2021**
CCG1: Appropriate Antibiotic Prescribing for UTI in adults aged 16 +	Achieving 60% of all antibiotic prescriptions for UTI in patients aged 16+ years that meet NICE guidance for diagnosis and treatment. **Exclusions:** Patients prescribed antibiotic prophylaxis for the treatment of recurrent UTI; pregnant women; chronic tubulo interstitial nephritis.
CCG2: Cirrhosis and Fibrosis Tests for alcohol dependent patients	Achieving 35% of all unique inpatients (with at least one night stay) with a primary or secondary diagnosis of alcohol dependence who have an order or referral for a test to diagnose cirrhosis or advanced liver fibrosis.
CCG9: Recording of NEWS2 Score, escalation time and response times for unplanned critical care admissions	Achieving 60% of all unplanned critical care unit admissions from non critical care wards of patients aged 18+, having a NEWS2 score, time of escalation (T0) and time of clinical response (T1)
CCG10: Screening and Treatment of Iron Deficiency anaemia in patients listed for major elective blood loss surgery	Ensuring that 60% of major elective blood loss surgery patients are treated in line with NICE Guideline NG24. Total elective inpatient admissions, within the period 13 May 2020 31 March 2021, with a primary procedure in the following groups: Coronary Artery Bypass Graft , Cardiac Valve Procedures, Colorectal Resection, Cystectomy, Hysterectomy, Primary Hip Replacement, Hip Replacement Revision, Primary Knee Replacement, Knee Replacement Revision, Nephrectomy, Carotid Artery (open procedure), Other Aortic/Iliac Occlusive Disease (open procedure).
CCG13: Treatment of Community Acquired pneumonia in line with BTS Care Bundle	Achieving 70% of patients with confirmed community acquired pneumonia to be managed in concordance with relevant steps of BTS CAP Care Bundle .
CCG14: Rapid rule out protocol for ED patients with suspected acute myocardial infarction	Achieving 60% of Emergency Department (ED) admissions with suspected acute myocardial infarction for whom two high sensitivity troponin tests have been carried out in line with NICE recommendations.

Clinical Effectiveness

Quality Domain - Effective 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.	
Quality Priority	**2020-2021**
CCG15: Adherence to Evidence Based intervention Clinical Criteria	Achieving 80% of Phase 1, Category 2 procedures from the evidence based interventions (EBI) statutory guidance of November 2018 meeting the required criteria for delivery.
UoR 9.1.1: The implementation of a robust discharge to assess process and earlier more efficient discharge planning.	Reducing bed occupancy levels to a maximum of 92% through a reduction and improvements in long of stay, delayed transfers of care and avoidance of re admission in line with NHS England Operational Planning and Contracting Guidance for 2020/21. Measures include: Length of stay >21days (stranded patients Bed occupancy by week/month: DTOCs by reason; Re admission rates
UoR: 8.1.3: Same Day Emergency Care focus on frailty service	Ensuring that Same Day Emergency Care (SDEC) service is delivered for 12 hours per day 7 days a week. In addition providing an acute frailty service for at least 70 hours a week based upon NHS England Operational Planning and Contracting Guidance for 2020/21 and the NHS Long Term Plan. Suggested measures from National Guidance : https://improvement.nhs.uk/documents/2983/SDEC_guide.pdf Measures include: process/activity measure: the number of new non-elective presentations seen and treated in SDEC • impact measure: the number of new non-elective presentations of patients who convert to an admission of at least one night • balancing measure: the number of unplanned re-presentations of patients who had been managed by the SDEC unit within the previous seven days.
UoR 9.1: Reduce face to face outpatients by 20% and introduce patient initiated follow up, enabling capacity to be released back to elective activity.	Achieving a reduction of a third of face to face outpatient attendances by 2023/2024 in line with NHS England Operational Planning and Contracting Guidance for 2020/21. We are looking to make tangible progress towards this target within 2020/2021. The NNUH Transforming Outpatients Programme aims to follow the national sequential launch of speciality re-designs which includes: Ophthalmology in 2020/21 and the potential for Cardiology, MSK Orthopaedics, and Dermatology to follow. The key aims of the TOP are to improve quality and safety of services through reduced variation and improve standardisation of structures and processes and clinical

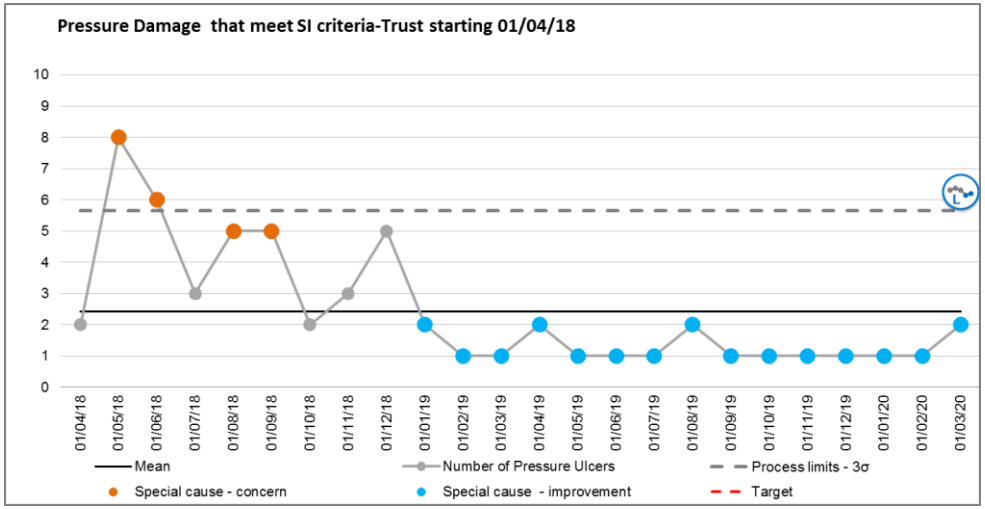
	pathways with improved efficiency to be realised through the introduction of digital technology and streamlining of back office functions. Measures **:** Reduction in face to face hospital outpatient attendances.
UoR 9.1.3: Redesign the ED footprint and patient journey processes through the department with a focus on improved triage processes and the management of ambulatory majors	Achieving an improvement in the 4 hour ED standard of patients treated, admitted or transferred with a focus on front-door clinical streaming and patient flow through the department. Focus on avoiding ambulance handover delays at hospital as per NHS England Operational Planning and Contracting Guidance for 2020/21. Measures include**:** ambulance handover times, time to triage, time to initial assessment, time to first treatment, time from DTA to move to the ward.

Care and Patient Experience

Quality domain - 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.	
Quality Priority	**2020-2021**
PSS9: Shared Decision Making	Patient satisfaction with shared decision making conversations at relating to: ablation for atrial fibrillation and aortic stenosis; cardiac surgery (CABG vs PCI);
	Patient satisfaction with shared decision making conversations at key decision points early stage lung cancer; palliative chemotherapy; localised prostate cancer; adjuvant use of chemotherapy for colorectal cancer.
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.	CYP feedback uploaded onto Meridian 'child friendly' interfaces in place on iPads in CYP areas, so the FFT is more friendly/usable for younger people. Implement a CYP Forum at NNUH, as a central point for patient engagement across CYP.
Patient experience of redesigned processes (described in effectiveness section) **UoR 9.1.1:** Discharge processes **UoR 9.1** Virtual OP appointments	Patient experience and feedback of discharge to assess and engagement with discharge planning process
	Patient experience and feedback of virtual outpatient appointments, video and telephone consultations. Patient experience and feedback of patient initiated follow up pathways.

Progress against our 2019/20 priorities

Patient Safety

1.0 Quality Domain – Safe 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**	**How did we do?** Data to end March 2020.	**Met / Not Met**
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 – new reporting therefore no baseline for 18/19. Baseline for 19/20 will become	Category 4: zero occurrence of hospital acquired pressure ulcers <40 x Category 3 HAPU per annum - demonstrating a 20% reduction Category 2 < 180 grade 2 HAPU per annum demonstrating a 20% reduction	Reported through the Clinical Safety and Effectiveness Board Cat 3 (16) and 4 (1) : (meeting SI criteria only)  	**Not Met** Decrease in number of Cat 3 but due to a change in reporting requirements in year of unstageable damage which was previously reported as Cat 3.

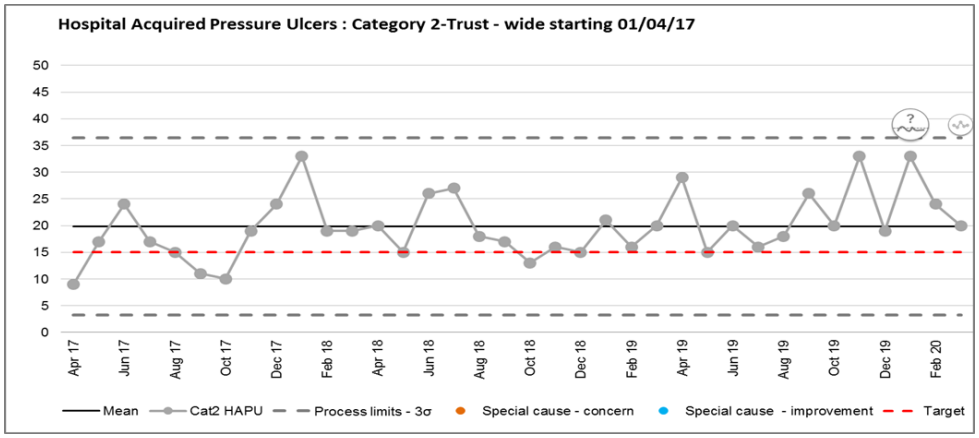
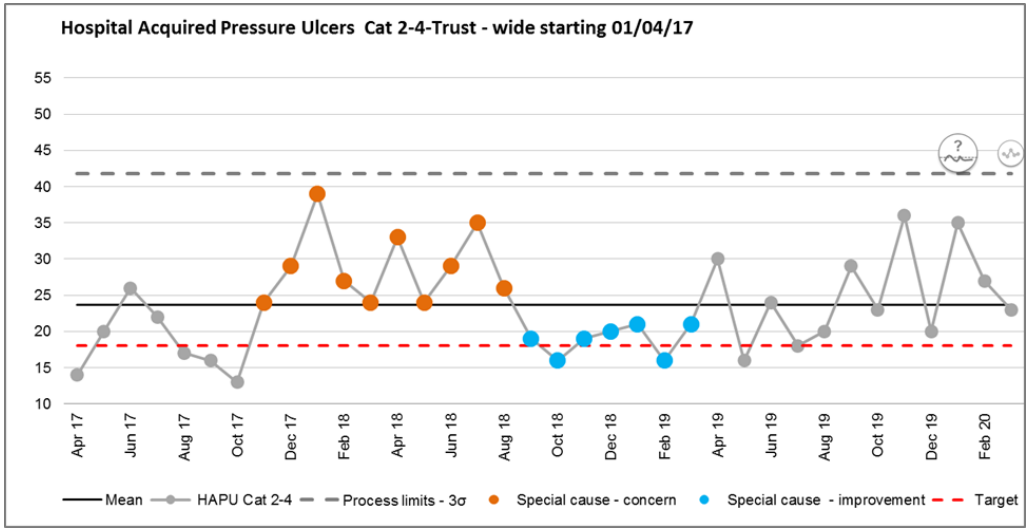
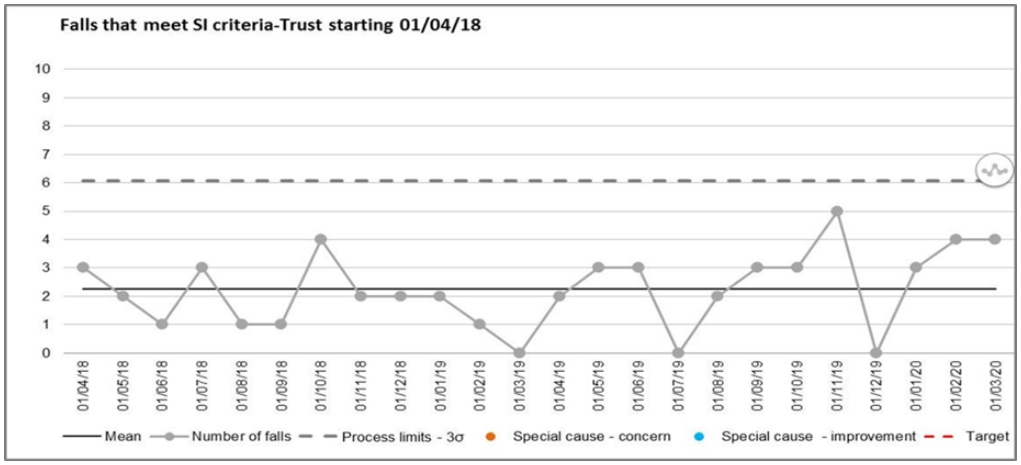
	baseline for 20/21.	% age reduction to be agreed in Q2	Cat 2: To end of March 2020 **282.**  Unstageable 34 ytd Note changing in the national reporting guidance has altered the way in which we count a Cat 3 HAPU, these would have previously included unstageable which now has a separate category.	

			Chart for totals 2-4 ytd 	
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	25 – falls moderate harm or above Total number of falls 2154	< 20 falls 25% reduction in falls causing moderate or above harm (meeting SI criteria) Percentage reduction in falls to be agreed in Q2	YTD: **18** falls moderate harm or above that meets SI criteria 	**Not Met** Although total number falls reduced still similar number meeting SI criteria

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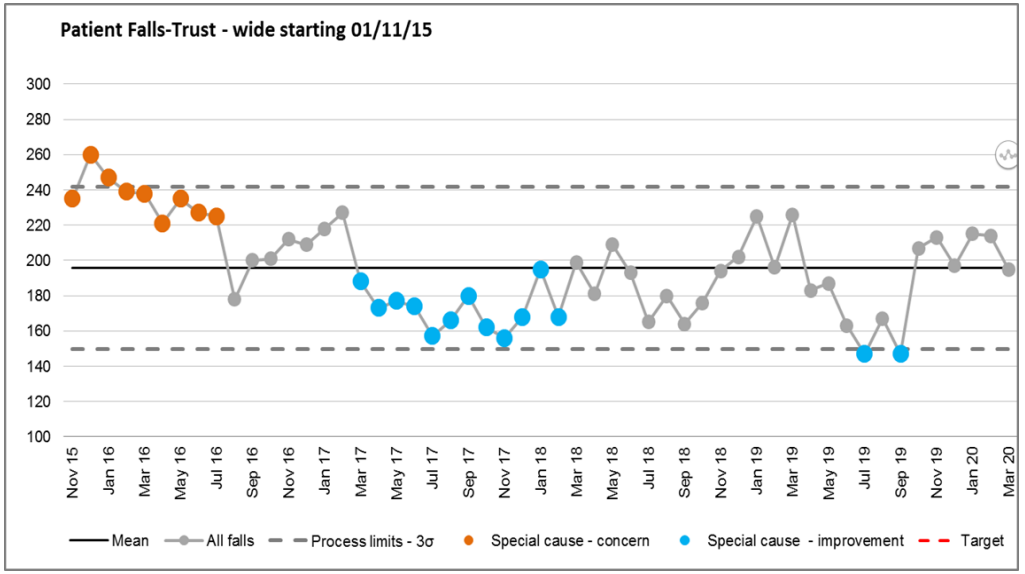
<td> 
</td>
<td></td>
</tr>
<tr>
<td>1.3 Three high impact actions to prevent Hospital Falls (CQUIN)</td>
<td>Baseline to be agreed in Q2</td>
<td>Achieving 80% of older inpatients receiving key falls prevention actions
1. Lying and standing blood pressure
2. No hypnotics or antipsychotics</td>
<td>Due to pandemic data for Q4 not analysed or submitted.
Falls CQUIN Q1 report.docx
Falls CQUIN Q2 report.docx
Falls CQUIN Q3 report final.docx
<table>
<tr><th></th><th>Q1</th><th>Q2</th><th>Q3</th><th>Q4</th></tr>
<tr><td>All elements (80%)</td><td>14%</td><td>29%</td><td>44%</td><td></td></tr>
<tr><td>1: lying standing BP</td><td>16.5%</td><td>35%</td><td>49%</td><td></td></tr>
<tr><td>2a: Number of pts with antipsychotics</td><td>7% (n6)</td><td>5% (n5)</td><td>8%(n8)</td><td></td></tr>
<tr><td>2b: Documented reasons</td><td>83% (n5)</td><td>20% (n1)</td><td>87.5%(n7)</td><td></td></tr>
<tr><td>3a: Mobility assessment within24hrs</td><td>90%</td><td>91%</td><td>95%</td><td></td></tr>
<tr><td>3b: received walking aid within 24hrs</td><td>84%</td><td>88%</td><td>95.5%</td><td></td></tr>
</table></td>
<td>Not Met

Q4 data submission paused due to COVID19</td>
</tr>
</table>

		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	7 Never events to date (1 void requested)	**Not Met**
1.5 Standardise processes to improve early detection of	Emergency Department (ED)sepsis screening 81%	95% of patients who met the criteria for sepsis	100% (data source Symphony)	**Partially met overall** Met

deterioration, and ensure timely response		screening were screened for sepsis.		
	In patient sepsis screening	95% of patients who met the criteria for sepsis screening were screened for sepsis.	We have no reliable method of collecting information from all in patients	Not Met
	Sepsis 6 compliance ED 92%	95% patients	100% Data Source Symphony. All patients who were identified as Septic had one or more of the Sepsis 6 elements completed. It is not essential that all elements of the Sepsis 6 are completed; the UK Sepsis Trust is very clear on this. The principal behind the care bundle methodology is that bundle compliance is considered as a whole rather than as individual elements i.e. it is important the whole process be completed. However, the Sepsis 6 permits and encourages variance where appropriate, clinical rationale is applied.	Met
	Sepsis 6 compliance Inpatients	95%	We have no reliable method of collecting information from all inpatients	Not Met
	NEWS 2	95% of admitted patients will have observations recorded accurately using NEWS2	96% There are 5 questions related to NEWS2 in the monthly Perfect Ward documentation audit. Question two relates to this metric: Are all patient observations complete? Guidance: This must include respiratory rate, SPO2, O2 litres per minute, blood pressure, pulse, consciousness and temperature.	Met

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	% reduction in the number of cardiac arrest calls agreed in Q1	No baseline was agreed and there is no reliable method of collecting information from all in patients due reliance on manual processes.	**Not Met**
1.7 To create and maintain a network of appropriately skilled ward based paediatric link nurses	Baseline to be agreed in Q1	%age of named children link nurses have paediatric competences	CYP competency pack approved and on trust docs Feb 2019 All areas that see children outside of Jenny Lind footprint to have a named link nurse with competency: 63% of named children link nurses that have paediatric competencies equivalent to 19.7wte across 12 areas.– new trajectory to be set for completion September 2020 • ED Nurses – x 5.4 wte required : complete 06/2019 – monitored through health roster =100% • Dermatology 2wte – complete =100% • All CYP overseas nurses x5 in total competencies completed monitored through health roster =100% • DPU 2.7 wte Nurses to run CYP theatres x 2 complete = 74% complete monitored through health roster • Recovery 5.4wte x 2 nurses completed = 50% completed monitored through health roster • Gynae clinic nurse x 2wte – complete = 100% monitored through health roster • Surgery OPD plastics x 1 nurse complete – 100% • Ortho OPD x 2 link nurses -100 % complete • Cardiology x1 required OPD 0 – on going – date for completion = September 2020 • Max fax 0 – x 1 required ongoing – date for completion = September 2020 • Maternity 0 - 5.4 wte target required individual link names requested date for completion = September 2020	**Partially Met**

Clinical Effectiveness

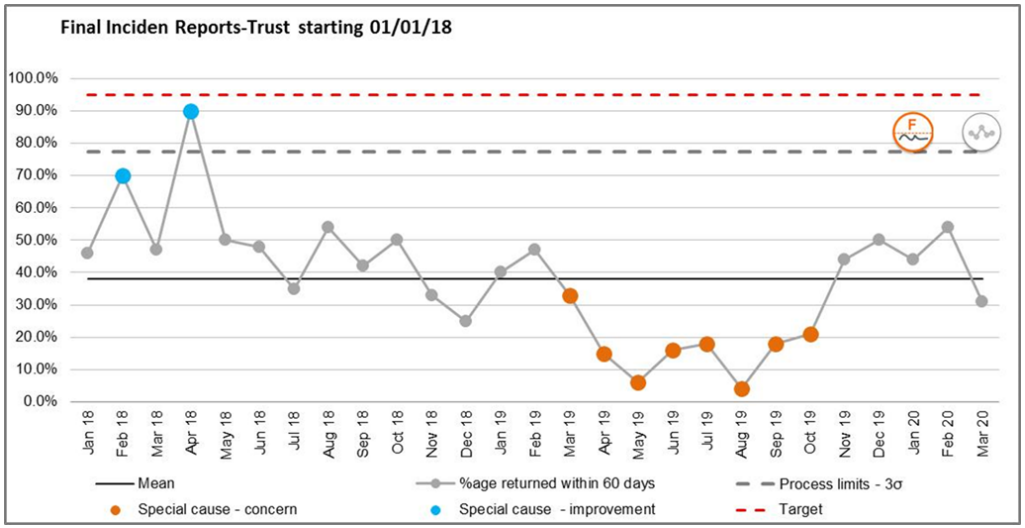
<table>
<tr><td colspan="5">2.0 Quality Domain - Effective
People’s care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence
Development and use of systems and structures that promote learning across the organisation and services.</td></tr>
<tr><th>Improvement aim</th><th>Baseline position 18/19</th><th>2019- 2020</th><th>How did we do?
Data to end March 2020.</th><th>Met/Not Met</th></tr>
<tr><td>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)</td><td>Agree baseline in Q1</td><td>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.</td><td>CQUIN - Q4 data not analysed and submitted due to pandemic
<table>
<tr><td></td><td>Q1</td><td>Q2</td><td>Q3</td><td>Q4</td></tr>
<tr><td>CCG1a

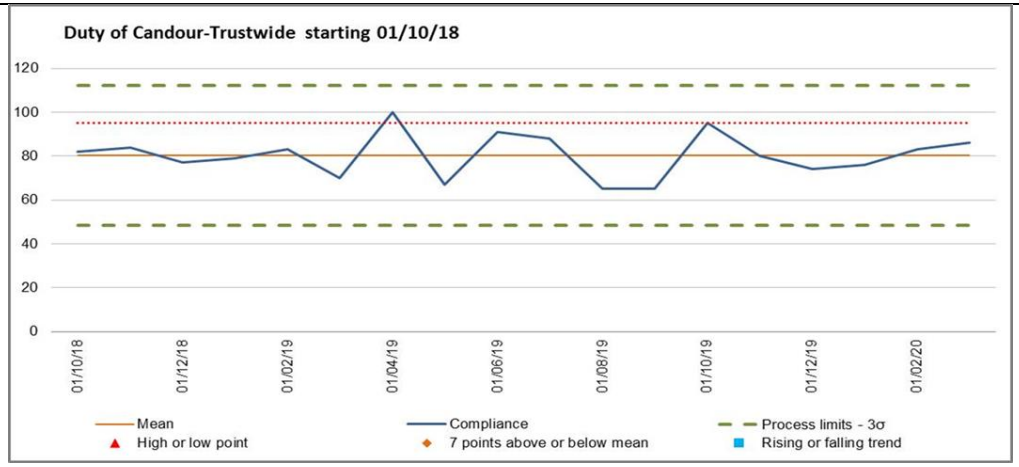
90%</td><td>20%</td><td>55%</td><td>66%</td><td></td></tr>
</table></td><td>Not Met</td></tr>
<tr><td>2.2 Reduce the number of doses used for colorectal surgery and improve compliance with antibiotic guidelines (CQUIN)</td><td>Agree baseline in Q2</td><td>Achieving 90% of antibiotic surgical prophylaxis prescriptions for elective colorectal surgery being a single dose and prescribed in accordance to local antibiotic</td><td>CQUIN - Q4 data not analysed and submitted due to pandemic
<table>
<tr><td></td><td>Q1</td><td>Q2</td><td>Q3</td><td>Q4</td></tr>
<tr><td>CCG1b

90%</td><td>87.88%</td><td>94.74%</td><td>93.75%</td><td></td></tr>
</table></td><td>Partially Met

Met in Q2 & Q3</td></tr>
</table>

		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	Monitored via the Research Board. Information from Jenny Longmore - The number of patients recruited in 2019/20 was less than previous year. This was the national trend. Final number to be confirmed	**Not Met**
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)	Measured via Trust Mortality system and reported via the mortality dashboard to CSEB For the period 1st April 2019 – 29th February 2020 there were 2,177 in-patient deaths of which 148 SJR's were escalated for in-patients. As a percentage that is: 6.8%	**Not Met**

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	Monitored via Safety report to CSEB Percentage of SIs reported within 60 day timeframe  Percentage of reports meeting the 60 day target: Jan 2018 –March 2020, Out of 286 reports submitted to the CCG, 102 met the 60 day target (36%)	**Not Met**
	To be agreed Q2	95% of action plans completed from complaints and serious incidents within agreed timescales	The actions module in Datix came live in January 2019. Not all SI actions have been inputted onto the module by the Divisional Governance teams, therefore manual monitoring and reporting processes are still relied upon. No actions from complaints are logged onto Datix yet as Divisional teams have limited access to this module. Reporting from Datix can be set up but it does depend on the module being used fully.	**Not Met**
	Duty of Candour compliance	95% of duty of candour letters	Measured via Safety report to CSEB	**Not Met**

	81%	issued within 10 days	 2019- 2020 compliance 81%	
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	Baseline taken from Thematic review for 2018/19 Q2	Reduction in recurring themes identified from baseline review Quarterly thematic reviews across SI's, complaints and SJR processes are shared Trustwide.	Due to resource constraints a thematic review was not completed for 2018/19. A thematic review is underway for the top 4 reported SI categories for 2019/20 using the Human Factors Analysis Classification System (HFACS). This will be reported to CSEB. All SI's will have a prospective thematic review for 2020/21 using HFACS. Further work is required to enable a thematic analysis of SI, complaint and SJR outputs.	**Not Met**

process are shared trust-wide				
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 Q2	Improvement trajectory agreed in Q2	Target set was 100% of all admissions requiring HDU and ITU care. CCC has had designated CYP area and Buxton has 4 commissioned HDU beds. Usage measured via Metavision, Symphony and PAS systems and is monitored by the Children's Critical Care working group reporting into the Children's Board.	**Met**

Care and Patient Experience

3.0. Quality domain : 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**	**How did we do?** Data to end Feb 2020.	**Met/Not Met**
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: 76.5% 2: 69.6% 3: 11.5% 4: 81.7% 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?	National In patient survey results from 2019 due spring 2020 We have the report in from Quality Health but that is not the final version –data is embargoed 2018 2019 1: 76.5% 73.8% 2: 69.6% 67.7% 3: 11.5% 12.1% 4: 81.7% 81.4% 5: 73.6% 75%	**Not Met**
3.2 Personalised care and support planning and compliance with Accessibility	Baseline compliance to be confirmed in Q2.	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	No baseline was confirmed. An audit undertaken by AccessAble and has been shared with the estates team to inform their planning – this links to the PLACE audit actions. Through this process experiences were captured and suggestions for improvement made. However,	**Not Met**

Information Standard		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	the site's digital immaturity has hampered progress An audit has also been conducted on hearing loops. A trial of IT system identification of AIS Reasonable Adjustments at Cromer has been planned and will be used as the pilot site. This was scheduled to start in Q4 and will run for several months. Progress is being monitored via the Accessibility standards group which feeds into Patient Engagement and Experience Group	
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	2.1 Response times (taken from PEEG board report March 2020) 2.1 Response times The investigation of all relevant complaints is undertaken with the appropriate division(s) and we aim to complete our investigations within 25 days or other agreed timeframe. Our focus is on the quality of our response, not simply meeting a timeframe, however where the investigation is going to take longer than anticipated, the complainant is updated and to arrange the extension of time.	**Partially Met** Performance improvement not agreed and data regarding overall response needs to be validated. *The current performance for July to December 2019 is projected as follows.* July 2019 85% August 2019 88% September 2019 95% October 2019 98% November 2019 87% December 2019 95%
3.4 Improvement in scores in key questions of National staff	75% Q7a 57% Q17a 66% Q17c 59% Q17d 65% Q18b	10% improvement across the range of questions Q7a: am satisfied with the quality of care I give to patients / service users	2018 2019 75.4% Q7a 74.4% -1.0 57.3% Q17a 59.6% 2.3 66.6% Q17c 68.7% 2.1 59.7% Q17d 61.4% 1.7	**Not Met**

surveys Safety Culture Responding to incidents Ability to make improvements	50% Q18c 67% Q21b 72% Q4b 48% Q4C 46% Q4d	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	65.1% Q18b 68.2% 3.1 50.3% Q18c 53.3% 3.0 67.5% Q21b 67.1% -0.4 72.8% Q4b 74.1% 1.3 48.4% Q4C 51.7% 3.3 46.8% Q4d 51.2% 4.4	

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 Q2	Increased response rate from children, young people and their families (from agreed baseline) Target set was for Tops and Pants to be rolled out across all of division.	Tops and pants agreed and in place across division by June 2019 - measured through Children's Strategy, CQC and Governance and Children's Board Work underway supported by Patient Experience and Engagement team to: • upload feedback onto meridian as currently a manual process • getting 'child friendly' interfaces in place on iPads in CYP areas, so the FFT survey used appears more friendly/usable for younger people. • develop of a CYP Forum at NNUH, as a central point for patient engagement across CYP.	**Partially Met** Feedback gained from all areas of CYP via Tops and Pants. Until reliance on manual processes ceases it is not easy to monitor and track improvements in response rates.

Part 2.2 - Board Assurance Statements

Review of services

During 2019/20 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 2019/20 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 2019/20.

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

During 2019/20, 52 Quality Account clinical audits and 3 national confidential enquires covered relevant health services that Norfolk and Norwich University Hospitals NHS Foundation Trust provides.

During that period Norfolk and Norwich University Hospitals NHS Foundation Trust participated in 100% of Quality Account clinical audits (52/55) and 100% national confidential enquires (3/3) which it was eligible to participate in. We participated in other National Audits which fall outside of the Quality Account recommended list.

During 2019/20, 98% of the clinical audits planned relating to national requirements and 95% of the audits relating to local initiatives were completed or in progress. 1 (2%) national audit was abandoned by the national programme and did not run in the 19/20 cycle.

A total of 73 additional-to-plan audits were completed in 2019/20.
Specialty Clinical Governance and Audit leads are asked to provide regular progress updates on all clinical audit activity and the actions and outcomes identified that could lead to changes and improvements in patient care, clinical outcomes and service delivery. These are reviewed and progress reported to the Clinical Safety and Effectiveness Sub-Board bi-monthly.

The Quality Account national clinical audits and national confidential enquiries that Norfolk and Norwich University Hospitals NHS Foundation Trust was eligible to participate in during 2019/20 are below in Figure 1 (on the following page). 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.

Figure 1: National clinical Audits and national confidential enquiries

National Clinical Audit (alphabetical order)	Eligible Y/N	Took part Y/N	Participation Rate Cases Submitted	Completed/ In-progress/ Ongoing
Assessing Cognitive Impairment in Older People / Care in Emergency Departments	Y	Y	150/150 (100%)	Complete
BAUS Urology Audit - Cystectomy	Y	Y	Figures not available, 100% anticipated	Completed
BAUS Urology Audit - Female Stress Urinary Incontinence	Y	Y	Figures not available, 100% anticipated	Ongoing
BAUS Urology Audit - Nephrectomy	Y	Y	Figures not available, 100% anticipated	Completed
BAUS Urology Audit - Percutaneous Nephrolithotomy	Y	Y	Figures not available, 100% anticipated	Completed
BAUS Urology Audit - Radical Prostatectomy	Y	Y	Figures not available, 100% anticipated	Completed
Care of Children in Emergency Departments	Y	Y	178/178 (100%)	Completed
Case Mix Programme (CMP)	Y	Y	886/886 (100%)	Ongoing
Child Health Clinical Outcome Review Programme	Y	Y	Long term Ventilation: 2/3 (67%) clinician forms submitted	Ongoing
Elective Surgery - National PROMs Programme	Y	Y	Hip: 405/372 (92%) Knee: 333/304 (91%)	Ongoing
Endocrine and Thyroid National Audit	Y	Y	Figures not available, 100% anticipated	Ongoing
Falls and Fragility Fractures Audit programme (FFFAP)	Y	Y	National Hip Fracture Database: 806/806 (100%) National Audit of Inpatient Falls: 7/12 (58%) anticipate 100%	Ongoing
Head and Neck Audit (HANA)	Y	N – Removed from Quality Accounts in July 2019.	Data collection has been suspended by HANA.	Removed from Quality Accounts in July 2019.
Inflammatory Bowel Disease (IBD) Registry, Biological Therapies Audit	Y	Y	100% 10/10 paediatric new starters	Ongoing

Major Trauma Audit	Y	Y	72% 465/642	Ongoing
Mandatory Surveillance of bloodstream infections and clostridium difficile infection	Y	Y	MRSA BSI (Bloodstream Infections): 0 Hospital Acquired Infection (HAI) cases in 2019/20. Gram negative HAI BSI: E.coli 39 Pseudomonas aeruginosa 13 & Klebsiella species 11 Currently no objective set. C.difficile figures signed off up until January. Trajectory 8 HOHA, Non trajectory 16 (Healthcare Onset - Healthcare Associated (HOHA) & 26 Community Onset - Healthcare Associated (COHA) pending 4 HOHA & 5 COHA. Total cases 59. 8 Trajectory cases towards objective less than 35.	Ongoing
Maternal, Newborn and Infant Clinical Outcome Review Programme	Y	Y	100% of required data submitted - Maternal death 0 Late Fetal Loss 6 Terminations 1 Stillbirth 23 Early Neonatal Death 9 Late Neonatal Death 2	Ongoing
Medical and Surgical Clinical Outcome Review Programme	Y	Y	Acute Bowel Obstruction: 5/6 clinician forms (83%) Out-of-Hospital Cardiac Arrest: 6/7 clinician forms (86%) 6/7 notes extracts (86%)	Ongoing

			Dysphagia in Parkinson's Disease: 1/4 clinician forms (25%) 4/4 notes extracts (100%)	
Mental Health - Care in Emergency Departments	Y	Y	120/120 (100%)	Completed
Mental Health Care Pathway - CYP Urgent & Emergency Mental Health Care and Intensive Community Support	N			N/A
Mental Health Clinical Outcome Review Programme	N			N/A
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP)	Y	Y	Asthma Paediatrics: 68/68 (100%) Asthma Adults: 281/281 (100%) COPD Secondary Care: 533/533 (100%)	Ongoing
National Audit of Breast Cancer in Older People (NABCOP)	Y	Y	243/243 (100%)	Ongoing
National Audit of Cardiac Rehabilitation (NACR)	Y	Y	2940/3345 (87.9%)	Ongoing
National Audit of Care at the End of Life (NACEL)	Y	Y	40/40 (100%)	Complete
National Audit of Dementia (Care in general hospitals)	Y	Y	54/54 (100%)	Complete
National Audit of Intermediate Care (NAIC)	N			N/A
National Audit of Pulmonary Hypertension (NAPH)	N			N/A
National Audit of Seizure Management in Hospitals (NASH3)	Y	Y	30/30 (100%)	
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy12)	Y	Y	58/58 (100%)	Ongoing
National Bariatric Surgery Registry (NBSR)	N			N/A
National Cardiac Arrest Audit (NCAA)	Y	Y	43/43 (100%) (01/04/19 – 30/09/19) No further figures available until April 2020	Ongoing
National Cardiac Audit Programme (NCAP)	Y	Y	Myocardial Ischaemia: 801/997 (80.3%)	Ongoing

			Percutaneous Coronary Intervention: 1428/1652 (86.4%) Heart Failure: 285/287 (99.3%) Cardiac Rhythm Management: Electro-physiology 480/493 (97.4%) Pacemakers 1160/1178 (98.5%) All expected to be 100% by end of year.	
National Clinical Audit of Anxiety and Depression	N			N/A
National Clinical Audit of Psychosis [1]	N			N/A
National Diabetes Audit – Adults	Y		Diabetes Core audit 3525/3525 (100%) National Diabetes Foot Care Audit 232/232 (100%) National Diabetes Inpatient Audit 184/184 (100%)	Complete
National Early Inflammatory Arthritis Audit (NEIAA)	Y	Y	178 new patients (% not known)	Ongoing
National Emergency Laparotomy Audit (NELA)	Y	Y	292/304 (96.0%)	Ongoing
National Gastro-intestinal Cancer Programme	Y	Y	Bowel Cancer: 464/464 (100%) Oesophageal Gastric Cancer: 184 (% unknown)	Ongoing
National Joint Registry (NJR)	Y	Y	949/949 (100%)	Ongoing
National Lung Cancer Audit (NLCA)	Y		313/313 (100%)	Ongoing
National Maternity and Perinatal Audit (NMPA)	Y	Y	All births have been registered nationally as required, data is taken directly by NHS Digital	Ongoing
National Neonatal Audit Programme - Neonatal Intensive and Special Care (NNAP)	Y	Y	All admissions to the neonatal intensive care	Ongoing

			unit are registered as required. 1110 for the audit period 01/01/19 to 31/12/19	
National Ophthalmology Audit (NOD)	Y	Y	4263/4301 (99.1%)	Ongoing
National Paediatric Diabetes Audit (NPDA)	Y	Y	297/297 (100%)	Ongoing
National Prostate Cancer Audit	Y	Y	Figures not available, 100% anticipated	Ongoing
National Smoking Cessation Audit	Y	Y	20/20 (100%)	Completed
National Vascular Registry	Y	Y	Abdominal Aortic Aneurysm 88/113 (78%) Carotid Endarterectomy 51/67 (76%) Data inputting in progress, anticipate >95% submission rate	Ongoing
Neurosurgical National Audit Programme	N			
Paediatric Intensive Care Audit Network (PICANet)	N			N/A
Perioperative Quality Improvement Programme (PQIP)	Y	Y	Figures not available, 100% anticipated	Ongoing
Prescribing Observatory for Mental Health (POMH-UK)	N			N/A
Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis)	Y	Y	Part CCG1a: Improving the management of lower UTIs in older people: Q1 50/100 (50%) Q2 65/65 (100%) Q3 70/70 (100%) Part CCG1b: Improving antibiotic prophylaxis for elective colorectal surgery: Q1 33/100 (100%) Q2 76/76 (100%) Q3 96/96 (100%)	Completed

Sentinel Stroke National Audit programme (SSNAP)	Y	Y	1021/ 1021 (100%)	N/A
Serious Hazards of Transfusion: UK National Haemovigilance Scheme	Y	Y	15/15 (100%)	Ongoing
Society for Acute Medicine's Benchmarking Audit (SAMBA)	Y	Y	75/75 (100%)	Completed
Surgical Site Infection Surveillance Service	Y	Y	Vascular SSI rates: 5.1% in Quarter 1 2019/20 (inpatient & readmission rate 2%) - 5 Infections, 4.1% in Quarter 2 (inpatient & readmission rate 1%) - 4 Infections. SSI rates following C Section: 4.2% in Quarter 1 - 10 Infections, 4.4% in Quarter 2 - 10 Infections	Ongoing
UK Cystic Fibrosis Registry	Y	Y	75/75 (100%)	Ongoing
UK Parkinson's Audit	Y	Y	Medical 30/30 (100%) Physiotherapy 11/11 (100%) Occupational Therapy 14/14 (100%)	

Review and progress of national audits and confidential enquiries in which the Trust have participated 2019/20

Directorate	Audit Name	Outcome
Cardiology	National Audit of Cardiac Rehabilitation (NACR)	This national audit was undertaken to support cardiovascular prevention and rehabilitation services to achieve the best possible outcomes for patients. The national report was published on the 20th December 2019. The results found that we are compliant with all the national standards and have achieved certification by the NACR. We continue to monitor uptake of rehabilitation at the NNUH and are working with the Heart Failure team to provide further provision.
Diabetes and Endocrinology	National Diabetes Foot Care Audit (NDFA) (Part of NDA Audit - Above)	The aim of this audit was to enable all services that treat diabetic foot ulcers to measure their performance against National Institute for Health and Care Excellence (NICE) guidance, to monitor patient outcomes and to benchmark against peer units. The data is collected on a continuous basis. The results for the NNUH found that although the outcomes were as expected, there were opportunities to improve delayed referrals. As a result an action plan was formulated this focused on providing training days for referrers.

Older People's Medicine	National Audit of Dementia (Care in general hospitals)	The National Audit of Dementia is undertaken to measure criteria relating to care delivery which are known to impact on people with dementia admitted to hospital. In response to the latest report published an improvement plan was formulated which included delivering a rolling programme of delirium awareness training.
Oncology and Haematology	National Comparative Audit of Blood Transfusion Programme	The National Comparative Audit of Blood Transfusion (NCABT) is a programme of clinical audits run by NHS Blood and Transplant (NHSBT) which looks at the use and administration of blood and blood components in NHS and independent hospitals in England and North Wales. During 2019 NCABT published a number of interim reports and one full report on their Survey of Group O D-Negative Red Cell Use (July 2019). In response to the recommendations of that report we are continuing to address packing deviations of O D-Negative Red Cells to reduce wastage.
Oncology and Haematology	Serious Hazards of Transfusion: UK National 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 published their latest annual report in July 2019 which analysed incidences reported during 2018. The report made a number of recommendations and the Trusts practice was reviewed against those. Actions resulting from the SHOT recommendations include further dissemination of the 'Blood components app' in the Trust to allow education of staff members and sharing of knowledge of guidelines and resources. Further work is being undertaken to identify ways of highlighting patients with a diagnosis of haemoglobinopathy on ICE.
Palliative Medicine	National Audit of Care at the End of Life (NACEL)	The End of Life Care Audit: Dying in Hospital is a national clinical audit commissioned by the Healthcare Quality Improvement Partnership (HQIP) and run by the Royal College of Physicians. It is designed to ensure that the priorities for care of the dying person outlined in the document One Chance to Get it Right are monitored at a national level. The results for NACEL 2 have not yet been published; an End of Life Care Audit which is on the Audit plan collects data which encompasses the National standards which when possible improvements are identified actions have been undertaken to improve patient care.
Respiratory	National Lung Cancer Audit (NLCA)	The aim of the NLCA is to assess the care delivered during referral, diagnosis, treatment and outcomes for people diagnosed with lung cancer and mesothelioma. The NLCA data helps to support our service, if we score lower than the national average we action and implement change to strive to reach these targets.
Respiratory	National Smoking Cessation Audit	The aim of the British Thoracic Society (BTS) audit programme is to drive improvements in the quality of care and services provided for patients with respiratory conditions across the United Kingdom. Smoking cessation is one of the cornerstones of the BTS strategic plan. The internal results of the audit found that 20% of current smokers offered nicotine-replacement therapy, compared to national percentage of 30%. 5% of patients had non-cigarette smoking use documented in the notes. The results were presented at Clinical Governance and an action plan was formulated which included a focus on accurate documentation in front door clerking and Inpatient ward rounds with education provided.

Rheumatology	National Early Inflammatory Arthritis Audit (NEIAA)	The aim of this audit is to improve the quality of care provided by specialist rheumatology services to people with early inflammatory arthritis (EIA). The first annual report and patient report were published on 11th October 2019. The report identified the Trust as an outlier on time taken from referral to first clinic appointment. In response the Department has designed a pathway (3 week wait) to streamline early arthritis (EA) patients but this is not used appropriately by general practitioners (GP). The department is trying to improve GP uptake of the EA referral pathway.
Anaesthetics	Audit Potential Organ Donation (National)	The Norfolk and Norwich contributes to a national audit undertaken by NHS Blood and Transplant. All 100% of the potential organ donors were included within the audit (30 patients). The report was published in October 2019 and demonstrated an improvement from the 2018-2019 data. The potential donor audit report was shared with the senior executives and the data was shared with the multidisciplinary critical care governance meeting in November 2019. No immediate actions were necessary, and the Critical Care Team remains committed to best practice in End of Life Care, in particular ensuring that when possible Organ Donation is considered.
General Surgery	National Audit of Breast Cancer in Older People (NABCOP)	This national 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 Annual Report was published on 9th May 2019. The results found that current practice was consistent with the recommendations. No further actions were required.
General Surgery	National Gastro-Intestinal Cancer Programme *(Incorporates National Bowel Cancer Audit)*	This national audit was undertaken to measure the quality and outcomes of care for patients diagnosed for the first time with bowel, oesophageal or gastric cancer. The Annual Reports were published on 13th December 2019 (Oesophageal and Gastric Cancers) and 9th January 2020 (Bowel Cancer). The results of the Bowel Cancer Report found that the rates for 90-day mortality, 18 month stomas, and unplanned readmissions were lower than national averages. Case ascertainment was achieved at 100%. Data quality and accuracy was identified as an area for improvement. As a result of the audit, the Department identified a need for a dedicated data entry clerk, which has been requested. The results of the Oesophago-Gastric Cancer Report found that the length of stay for the Trust was the lowest nationally, and the percentage of node examinations was the highest nationally. The margin positivity rate for the Trust was also among the lowest in the country. Time to treatment was identified as an issue, both locally and nationally. The Department continues to work with Trusts across the network to examine ways to improve time to treatment.

General Surgery	National Vascular Registry	This national audit was undertaken to improve the quality of care for patients with vascular disease in the UK. The Annual Report was published on 13th December 2019. The results found that the Trust had the 7th shortest time interval between assessment and surgery for Abdominal Aortic Aneurysm (AAA) repair (48 days), 4th shortest delay from index symptom to Carotid Endarterectomy (CE) surgery (within 7 days for 86% of patients, and excellent adjusted mortality rate for AAA. Key concerns were that the Trust was in the bottom quartile for documenting date of assessment (74%), pre-op Computerised Tomography (CT) / Magnetic Resonance Imaging (MRI) angiogram assessment (73%) and Multi-Disciplinary Team (MDT) discussion (74%). It was confirmed that all elective AAA patients have a CT and are discussed at Vascular MDT and this will be recorded on the National Vascular Registry.
Ophthalmology	National Ophthalmology Audit (NOD)	This national audit was undertaken to update benchmarks for standards of care for cataract surgery and help drive improvements in quality by identifying variations in access to, and outcomes of, cataract surgery. The Annual Report was published on 12th September 2019. The results found that the Trust's posterior capsular rupture complication rate was 0.5%, against a national rate of 1.2%. Capture of post-operative visual acuity data was highlighted as an area for improvement. A proforma to collect post-operative data from community Optometrists was introduced.
Trauma and Orthopaedics	National Hip Fracture Database (NHFD) *(Part of Falls and Fragility Fractures Audit Programme)*	This national audit was undertaken to improve the care pf patients with hip fractures. The Annual Report was published on 13th December 2019. The results found that the Trust was within the expected range or above national average in 4 of the 5 Key Performance Indicators. A key concern was the higher than expected mortality rate for the Trust. As a result of the audit, the pathway for patients with fractured neck of femur is being redesigned, which includes the designation of Brundall Ward as an Ortho-Medical Unit to support direct peri-operative admission under a Consultant Led Service.
Trauma and Orthopaedics	National Joint Registry (NJR)	This national audit was undertaken to improve the quality of outcomes and ensure the quality and cost effectiveness of joint replacement surgery. The Annual Report was published on 11th September 2019. The results found that practice within the Trust was consistent with the recommendations. No further actions required at the current time.
Trustwide	Elective Surgery - National Patient Related Outcomes Measures (PROMS) Programme	This national audit was undertaken to gain information on the effectiveness of care delivered to NHS patients as perceived by the patients themselves. PROMS scores are used to improve care for our patients. The results are made available via NHS Digital. The results are discussed, and any actions required to improve the effectiveness of patient's are undertaken.

Urology	National Prostate Cancer Audit (NPCA)	The National Prostate Cancer Audit (NPCA) is the national clinical audit of the care that men receive following a diagnosis of prostate cancer. It is designed to collect information about the diagnosis, management and treatment of every patient newly diagnosed with prostate cancer in England and Wales, and their outcomes. The results of the latest published results were discussed at the Urology Clinical Governance meeting on 16th January 2020. A key success was the compliance with 9 out of the 10 recommendations for prostate cancer teams (local and specialist multi-disciplinary team (MDTs)) within NHS Trusts/Health Boards. A key concern was the non-compliance with recommendation number 5: 'Investigate why men with high-risk/locally advanced disease are not considered for radical treatment (R5). The Trust reviews all high-risk cases closely and makes sure they are considered for radical treatment at multi-disciplinary team (MDT) meetings.
Obstetrics	Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK)	The Maternal, Newborn and Infant Clinical Outcome Review Programme is an ongoing audit to provide information to support the delivery of safe, equitable, high quality, patient-centred maternal, new born and infant health services. Data on all maternal and newborn deaths have been submitted as required. Two reports relating to this programme of audit were published in 2019. The reports made recommendations which have been reviewed. Key success included the introduction of prolonged rupture of membrane packs for safe outpatient care and the establishment of carbon monoxide monitoring for all women at all antenatal visits. Key concerns included difficultly with access to pre-conceptual counselling and access to the different electronic care records across the local maternity service. An action plan has been developed which includes portal access to our neighbouring units' electronic records and insistence on sharing of paper gestational related optimal weight charts in the interim. Pre-conceptual counselling clinics are being included in Consultant job plans.
Obstetrics	National Maternity and Perinatal Audit (NMPA)	The National Maternity and Perinatal Audit (NMPA) is an ongoing audit of Maternity Services across England, Scotland and Wales. All births at the Trust have been registered nationally as required and data is taken digitally by the national audit. Two reports were published in 2019 which presented 2016-17 clinical and organisational data at a national level only, these will be summarised at clinical governance in the next 3 months. As the NMPA website facilitates local reporting a comparison against the key 19 areas was made using the most recent data available. We had 4 areas that demonstrated better than expected results: Small-for-gestational-age babies born at or after 40 weeks was lower than expected, suggesting higher detection and early intervention to reduce risk of still birth; Episiotomy – lower than expected. Our 3rd/4th degree tear rate was as expected during the same timeframe; Unplanned maternal readmission within 42 days – lower than expected; Babies with encephalopathy – lower than expected. Term babies admitted to a neonatal unit was higher than expected. This has steadily reduced since we started participating in the Avoiding Term Admissions into Neonatal units (ATAIN) programme

Neonatal Intensive Care Unit	National Neonatal Audit Programme - Neonatal Intensive and Special Care (NNAP)	This national audit was undertaken to assess whether babies admitted to Neonatal Units in England received consistent care in relation to several audit questions All admissions to the neonatal intensive care unit were registered as required. A report for 2018 data was published in 2019, the data highlighted the Unit was making steady improvement in all standards. Key successes were being above the national average for magnesium sulphate, parent's attendance at ward rounds, retinopathy screening, and mother's milk at discharge. Key concerns were being below national average for temperature on admission and consultation with parents. Notable actions to drive improvements included: Implementing an evidence based hypothermia care bundle; A new entry added on the nursing admission checklist for parental consultation within 24 hours and small "1st communication complete?" reminder signs added to all incubators and cots; New facilities to improve the breast-feeding room on the Unit and education packages on breast feeding and updating the breast feeding guideline; A review of antenatal magnesium sulphate data resulting in a comprehensive education package including face-to-face sessions, posters and email distribution etc. Data continues to be submitted and reviewed on a quarterly basis and the ongoing action plan updated accordingly.
Paediatric Medicine	National Paediatric Diabetes Audit (NPDA)	This audit was undertaken to assess whether children and young people received an appropriate standard of care in accordance with national guidelines. The Paediatric Department has submitted data on all 297 cases as required. An annual report for 2017-18 cases and two spotlight audit reports were published in 2019. These reports were scheduled for discussion at the March 2020 Paediatric Clinical Governance meeting.
Trustwide	Mandatory Surveillance of Bloodstream Infections and Clostridium Difficile Infection	The Mandatory Surveillance of Bloodstream Infections and Clostridium Difficile Infection is part of National Quality Accounts. Mandatory hospital and community acquired infection surveillance outputs are used to monitor progress on controlling key health care associated infections and to provide epidemiological evidence to inform action to reduce them. The Trust submitted all data required. Any required actions were completed.
Trustwide	Surgical Site Infection Surveillance Service	This surveillance was undertaken utilising Public Health England (PHE) protocol for Surveillance of Surgical Site Infection (SSI) 2013 to provide a surveillance programme designed for the NNUH. These surveillance programmes provide quarterly reports of infection rates to the departments involved. This programme aims to promote good practice and reduce SSI rates. Vascular SSI (Surgical Site Infection) rates were 5.1% in Quarter 1 2019/20 (inpatient and readmission rate 2%) - 5 Infections and decreased to 4.1% in Quarter 2 (inpatient and readmission rate 1%) - 4 Infections. SSI rates following C Section were 4.2% in Quarter 1 - 10 Infections and were 4.4% in Quarter 2 - 10 Infections. The audit continues and actions undertaken as required.

Trustwide	Child Health Clinical Outcome Review Programme	The Child Health Programme 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 making available the results of these activities. Two reports were published this year; the report on Mental Healthcare in Young People and Young Adults in September 2019, and the report on Long-term Ventilation (Child) in February 2020. The self-assessment document for the Mental Health study has been completed. Actions implemented following the review of the recommendations include developing closer links and working relationship with the local Mental Health Trust and developing a standard operating procedure to detail the process of triage and risk assessment in the Emergency Department. The Long-term Ventilation study self-assessment is currently being reviewed.
Trustwide	Major Trauma Audit (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. A quarter 1 report was published on 11/10/2019, key successes included administration of Tranexamic Acid; delivering consultant led trauma teams within 30 minutes; patients being transferred to a Major Trauma Centre within 12 hours of request and patients with a Glasgow Coma Score <9 having definitive airway management within 30 minutes. Key concerns included delivering CT scans within 60 minutes; delivering Specialty Trainee Registrar grade 3 led trauma teams on arrival and providing rehabilitation prescriptions for patients with an injury severity score of more than 8. The Emergency Department are identifying sources of delay in time to CT and the establishment of a regional working party is in progress.
Trustwide	Medical and Surgical Clinical Outcome Review Programme (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 making available the results of these activities. During this year NCEPOD have published reports on Pulmonary Embolism and Acute Bowel Obstruction. The Trust self-assessment document was completed for the Pulmonary Embolism (PE) study and listed actions such as providing education to areas including Ambulatory Emergency Care (AEC) and the Respiratory Department on severity scoring, and documentation, and developing a Standard Operating Procedure for management of patients with a suspected PE in AEC. The self-assessment document for Acute Bowel Obstruction is still under review. During this year the Trust also submitted data to the Out-of-hospital Cardiac Arrest study and the Dysphagia in Parkinson's Disease study.

Trustwide	Learning Disability Mortality Review Programme (LeDeR Programme) Audit (National)	This national project is aimed at identifying, through structured mortality reviews of all deaths of people aged above 4 years old with a learning disability; learning points, areas for improvement, themes, mortality trends and good practice. Audit findings were reported to the mortality committee regularly. The audit demonstrated a decrease in the number of in-hospital deaths of people with learning disabilities but demonstrated that 45% of in-hospital deaths were related to pneumonia. This was slightly higher than LeDeR figures for combined aspiration/pneumonia figures (41%). An action plan was agreed which included ongoing cross-agency working around dysphagia and swallowing difficulties This included the implementation of a Learning Disabilities Dysphagia pathway. Action groups were established for sepsis and dysphagia, with clear plans and objectives based on the reports. There is now Learning Disability representation at the Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) committee.

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 2019/20 that were recruited during that period to participate in research approved by a research ethics committee was 2653 (as at Jan 2020) (4629 in 2018/19).

What was our aim?
Year on year increase in patients recruited into research studies.

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 2019/20, our total recruitment was 2653 compared against 2018/19 recruitment of 4629.

Recruitment into Research Studies

Recruitment for 19/20	Number	Percent
Portfolio recruitment target	3325	
Total Recruitment	2653	
NIHR Portfolio	2480	94%
Non Portfolio	173	6%
Commercial Studies	276	10%
Non Commercial Studies	2377	90%

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 2018/19) in a wide range of medical specialities during 2019/20. 112 new studies were opened in 2019/20 (104 in 2018/19). There were around 150 clinical staff (Consultants) participating in research approved by a research ethics committee during 2019/20; 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

This year has seen significant change in Research and Development with the appointment of senior posts to strengthen research within the Trust. Dr Jenny Longmore joined in July 2019 as Director of Research Operations and Professor Kris Bowles as associate Medical Director for Research. A Business Development Manager and Senior Finance Business Partner will be joining the team in the coming months.

A new 5 year research strategy has recently been launched alongside an implementation plan. This will involve regular reporting to the Hospital Management Board and Trust Board. Research governance has been improved with the formation of the Research Oversight Board and there is now research representation on UEA / NNUH Executive Committee, Digital Transformation Committee, Bio-Repository Science Strategy Group and Norwich Research Park Science Development Group.

Relationships on the Norwich Research Park continue to develop. Joint posts with Quadram Institute of Bioscience and University of East Anglia have been advertised.

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.

Currently the Trust participates in a number of hospital wide CQUIN schemes. CQUIN is a national framework which is underpinned by a number of schemes aimed at raising patient quality standards or improving the working environment for our staff. From 1 April 2019 – schemes were valued at 1.25% of our NHS Standard Contract Value (c.£5.1m). This additional money is available to the Trust for participation and delivery of pre-defined targets within CQUIN schemes.

2019/20 Schemes - CCG

For 2019/20 – our Norfolk Clinical Commissioning Groups (CCG) required the Trust to participate within the following 5 key schemes:

1. Anti-Microbial Resistance (for Lower UTI Infections in Older People and Surgical prophylaxis prescriptions for elective colorectal surgery)
2. Staff Flu Vaccinations (achieving 80% uptake)
3. Alcohol & Tobacco Screening (achieving 80% of inpatients admitted for at least one night to be screened)
4. Alcohol & Tobacco Advice (90% of identified patients to be given advice or offered a specialist referral)
5. Three High Impacts to prevent hospital falls (achieve 80% of older inpatient of the following:
    i. Lying and standing blood pressure to be recorded
    ii. No hypnotics or anxiolytics to be given during stay OR rationale documented
    iii. Mobility assessment and walking aid to be provided if required
6. Same Day Emergency Care (SDEC) – achieve 75% of patients to be managed in same day setting where clinically appropriate for Pulmonary Embolus; Tachycardia with Atrial Fibrillation and Community Acquired Pneumonia.

Further details of the agreed goals for 2019/20 are available electronically at https://www.england.nhs.uk/nhs-standard-contract/cquin/cquin-19-20/.

2019/20 Schemes – NHSE Specialised

There are further schemes available with our non-CCG commissioned clinical work across a number of broad areas:

- Medicines Optimisation
- Cystic Fibrosis Self – Care
- Trauma
- Thrombectomy training programmes
- Dental Dashboard
- Breast & AAA Screening
- Armed Forces Champion

Further details of the agreed goals for 2019/20 are available electronically at https://www.england.nhs.uk/nhs-standard-contract/cquin/cquin-19-20/.

The monetary value of CQUIN available to the Norfolk and Norwich University Hospitals NHS Foundation Trust in 2019/20 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 2018/19 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.

CQC Ratings Grid April 2020

Ratings for Norfolk and Norwich Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement ➔➔ Apr 2020	Good ↑ Apr 2020	Good ➔➔ Apr 2020	Requires improvement ➔➔ Apr 2020	Requires improvement ➔➔ Apr 2020	Requires improvement ➔➔ Apr 2020
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 2020	Good ➔➔ Apr 2020	Good ➔➔ Apr 2020	Requires improvement ➔➔ Apr 2020	Requires improvement ➔➔ Apr 2020	Requires improvement ➔➔ Apr 2020
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	Good ↑ Apr 2020	Good ↑ Apr 2020	Outstanding ↑ Apr 2020	Good ↑ Apr 2020	Outstanding ↑↑ Apr 2020	Outstanding ↑↑ Apr 2020
Outpatients	Requires improvement ➔➔ Apr 2020	N/A	Good ➔➔ Apr 2020	Good ↑ Apr 2020	Good ↑ Apr 2020	Good ↑ Apr 2020
Diagnostic imaging	Requires improvement Jun 2018	N/A	Good Jun 2018	Requires improvement Jun 2018	Requires improvement Jun 2018	Requires improvement Jun 2018
Overall*	Requires improvement ➔➔ Apr 2020	Good ↑ Apr 2020	Good ➔➔ Apr 2020	Requires improvement ➔➔ Apr 2020	Requires improvement ➔➔ Apr 2020	Requires improvement ➔➔ Apr 2020

*Overall ratings for this hospital are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

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

The Care Quality Commission carried out an inspection of the NNUH between 10th December 2019 and 15th January 2020, and issued its report on 17th April 2020.

The rating of the trust remained the same, being rated it as requires improvement, but the Chief Inspector of Hospitals made a recommendation that the trust was removed from special measures which was confirmed by receipt of a letter dated 13th May 2020.

The report went on to say: *We rated safe, responsive and well led as requires improvement and caring as good. Effective went up from requires improvement to good. Ratings for four key questions, safe, caring, responsive and well led remained the same whilst effective improved. The rating for the well led question at trust level remained the same as requires improvement.*

We rated two of the trust's four acute core services as requires improvement (urgent and emergency care and surgery), one as good (outpatients) and one as outstanding (end of life care). Overall ratings for urgent and emergency care and surgery remained the same, and outpatients and end of life care had improved. In rating the trust, we took into account the current ratings of the four services not inspected this time.

The Trust's Chief Executive said the Trust had received and welcomed the CQC report and were very pleased that it recognises the sustained and significant improvements that our fantastic staff have made in patient care here at NNUH. Teams across the whole Trust have worked tirelessly with skill and dedication to continuously improve and develop services. Also welcome was the CQC's recommendation that special measures are removed and the Trust looks forward to receiving NHS England and Improvement's decision.

"What the staff at NNUH have achieved is very impressive and the CQC has praised many aspects of care here from End of Life Care which is rated as Outstanding, Outpatients which is rated Good and notable improvements in Urgent and Emergency Care and Surgery.

"The domains of Effective and Caring are rated as Good, and the Safe, Responsive and Well-led domains are rated as Requires Improvement. This is a significant improvement from our previous report and represents a huge amount hard work, innovation and professionalism from our teams; at Requires Improvement overall, we still have improvements to make, but these results mark extremely good progress on our journey to outstanding.

"Other highlights in the report include good examples of innovation across the Trust; the positive impact being made by the Older Persons Emergency Department, and a focus on research and development as well as the creation of a quality improvement faculty.
"The most important thing to all staff at NNUH is working together to provide the best possible care and treatment for our patients, creating an environment where patients are treated with compassion, kindness and dignity, patient's individual needs are respected and families are actively involved in discussions, and that's what the CQC found here."

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.

The Norfolk and Norwich University Hospitals NHS Foundation Trust Information Governance Assessment Report overall score for 2019/20 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 2019/20 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 2019/20:

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 2019/20 results

26 Audits were completed

11 Specialties improved on 2018/19 results
04 Specialities achieved the Trust target of 90%
03 Specialties achieved the same results as 2018/19
12 Specialties decreased in performance

The Trust reviewed the results and patterns of errors from the 2019/20 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.

2020 Training Programme

The Data Quality team rolled out an ongoing 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

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.

<u>7 audits have been completed to date:</u>
Somerset Cancer Register
RIS
ORSOS
Symphony
eMEDRenal
Cystic Fibrosis
CaptureStroke

<u>3 Key Systems Audits are currently in progress</u>:
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/

Table 1: Summary of In-Hospital deaths and deaths within 30 days of discharge for the financial year 2019/2020.

	Total Discharges	Deaths within 30 days of Discharge	In-hospital deaths	Total Deaths	Deaths with Learning Difficulties (1)	Deaths with Severe Mental Illness (2)	Still births (3)	Neonatal Deaths (4)
Q1	22,081	303	594	897	4	8	4	3
Q2	22,493	316	545	861	4	11	3	6
Q3	22,608	344	627	971	4	6	5	3
Q4	20,036	302	644	946	9	7	2	3
Total	87,218	1,265	2,410	3,675	21	32	14	15

(1) As notified to LeDeR mortality review process.

(2) The diagnostic codes for SMI included for 2019/2020 are:

a) F20 to F29 inclusive (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) F33.3 Recurrent depressive disorder, current episode severe with psychotic symptoms)
g) F50.0 Anorexia nervosa
h) F50.1 Atypical anorexia nervosa
i) F50.2 Bulimia nervosa
j) F50.3 Atypical bulimia nervosa
k) F50.4 Overeating associated with other psychological disturbances
l) F50.5 Vomiting associated with other psychological disturbances
m) F50.8 Other eating disorders
n) F50.9 Eating disorder, unspecified
o) X60 to X84 inclusive (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

By April 1st 2020, **3,675** Norfolk and Norwich University Hospital patients died. Of which **21** were patients with Learning Difficulties, **32** patients had a Severe Mental Illness, **14** were Still Births and **15** were Neonatal Deaths.

This comprised the following number of deaths which occurred in each quarter of the reporting period:

897 in the first quarter, of which **4** were patients with Learning Difficulties, **8** had a Severe Mental Illness, **4** were Still Births and **3** were Neonatal Deaths.

861 in the second quarter, **4** were patients with Learning Difficulties, **11** had a Severe Mental Illness, **3** were Still Births and **6** were Neonatal Deaths.

971 in the third quarter, **4** were patients with Learning Difficulties, **6** had a Severe Mental Illness, **5** were Still Births and **3** were Neonatal Deaths.

946 in the fourth quarter, **9** were patients with Learning Difficulties, **7** had a Severe Mental Illness, **2** were Still Births and **3** were Neonatal Deaths.

Medical Examiner Reviews and Specialty Level Mortality Reviews

In April 2019, the Medical Examiner Service was introduced to:

- provide greater safeguards for the public by ensuring proper scrutiny of all non-coronial deaths
- ensure the appropriate direction of deaths to the coroner
- provide a better service for the bereaved and an opportunity for them to raise any concerns to a doctor not involved in the care of the deceased
- improve the quality of death certification
- improve the quality of mortality data

The Medical Examiner office will be expanded during 2020/21, to enable scrutiny of all in-patient deaths, informing the selection of cases for further review and replacing the current system of Specialty Level Mortality Reviews. The service will be expanded to cover deaths in the NHS and independent settings as well as deaths in the community in the future.

During 2019/2020, the Medical Examiners reviewed a total of **1,558** deaths. Of those, **56** were escalated to the Structured Judgment Review (SJR) process and **29** were referred to the specialties for discussion at their local mortality meetings. Table 2 displays these figures by quarters.

Table 2: Medical Examiner reviews and escalations

	Total Number of Deaths Reviewed by the Medical Examiner Service	Total Number of Deaths Escalated to SJR by the Medical Examiner Service	Total Number of Deaths Escalated to Local Mortality Meetings by the Medical Examiner Service
Q1	346	1	1
Q2	436	22	13
Q3	377	19	9
Q4	399	14	6
Total	1,558	56	29

Whilst Specialty Level Mortality Reviews are still taking place, during the reporting period **1,400** deaths were reviewed. Of those, **53** deaths were escalated to the Structured Judgement Review process. Table 3 displays these figures broken down by quarters.

Table 3: Specialty level reviews and escalations

	Total Number of Specialty Level Mortality Review's Completed	Total Number of Deaths Escalated to SJR following Specialty Level Mortality Reviews

Q1	379	11
Q2	376	23
Q3	334	13
Q4	311	6
Total	1,400	53

Case Record Reviews: Structured Judgement Review Method

After a period of building capacity and capability, the Structured Judgement Review (SJR) process was implemented across the Trust in May 2019. The process is still embedding. Trained SJR reviewers independently undertake case note reviews outside of their own specialty and make explicit judgements around the quality and safety relating to the patients last admission. Criteria for SJR are aligned to those set out in the National Quality Board 2017 Learning From Deaths guidance and are as follows:

- Learning Disabilities
- Severe Mental Illness
- Homeless
- Significant concerns raised by family/carers about quality of care
- Significant concerns raised by staff about quality of care
- Death within 30 days of discharge (where concern is raised)
- All expected Child deaths
- Elective Procedures
- Alarm raised: audits, SHMI/HSMR/SMR alerts, concerns raised by CQC/other external regulator
- Coroners Regulations 28
- Aligned to Trust QI priorities
- Additional random selection

A weekly SJR scrutiny panel has also been set up where SJRs flagging poor or very poor overall care are reviewed with relevant expert input, allowing key learning and areas of focus for improvement work to be identified and the appropriate governance response agreed. A monthly slot is reserved for all SJRs conducted (including those where overall care was judged adequate, good or excellent) in children and patients with complex care needs (LD, severe mental illness and homeless patients). This approach allows relevant specialist support teams e.g. LD liaison to input into the review and inform the governance response. It also enables sight of a proportion of all SJRs scoring overall care as adequate, good or excellent across the hospital. Advantages include the positive impact on culture of recognising notable practice and being able to thank teams as well as the targeting of Safety II approaches (i.e. learning from care that goes well not just care that does not as promoted in the National Patient Safety Strategy July 2019) to cohort of patients where care is often hardest to get right and where we are most likely to identify opportunities for learning and improvement which may ultimately help all patients.

By April 2020, **146** Structured Judgement Reviews were completed. Of those, **6** were patients with Learning Difficulties, **7** had a Severe Mental Illness and **1** patient was Homeless.

Table 4 displays these figures broken down into quarters. *Please note that these figures are based on completed reviews only and do not take into account SJR's which are still in progress.*

Table 4: SJRs completed and breakdown by vulnerable group

	Total Number of SJR's Completed (1)	Number of SJR's Completed for patients with Learning Difficulties (2)	Number of SJR's Completed for patients with Severe Mental Illness (3)	Number of SJR's Completed for patients who were Homeless [4]
Q1	26	0	0	0
Q2	31	4	4	0
Q3	60	1	0	0
Q4	29	1	3	1
Total	146	6	7	1

Case Record Investigations: Serious Incidents

A total of 27deaths were reported in 2019/20 via the Strategic Executive Information System (StEIS) as they met the criteria for reporting as a Serious Incidents. These deaths are investigated using Root Cause Analysis methodology as required by the National Serious Incident Framework, rather than by Structured Judgement Review.

Thematic analysis of 22 of these deaths was conducted using the Human Factors Analysis and Classification System (HFACS). This is a coding framework adapted for the NHS Acute Care setting by Shale, S and Woodier, N, (2017) and enables contributory factors identified from investigations to be themed to highlight areas for improvement; 5 deaths are still under active investigation and therefore excluded in this analysis.

Whilst some investigations are still ongoing, to date there are **18** Serious Incidents where the death was considered potentially preventable. As an overall percentage, this represents **0.49%** of the total number of patient deaths during the reporting period. This is displayed in Table 5.

Table 5: Potentially preventable deaths (or deaths judged more likely than not to have been due to problems in care)

	Number of Deaths reported on stEIS as a Serious Incident	Number of Deaths Reported to SI judged more likely than not to have been due to problems in care.	% of Total Number of Deaths Considered Potentially Preventable during the reporting period
Total	27	18	0.49%

Perinatal Mortality Reviews (PMRT)

During 2019/2020, **12** Neonatal/Post Neonatal deaths and **12** Still Births were reviewed using the Perinatal Mortality Review Tool. It is important to note that not all deaths are reviewed using the Perinatal Mortality Review Tool.

Child Death Overview Panel Reviews (CDOP)

During 2019/2020 **5** deaths were reviewed at the Child Death Overview Panel Review.

Learning from Case Record Reviews and Investigations

Below are areas where improvement work is required.

Methods and tools to share the learning include; Grand Rounds, SJR panel meetings, Local Mortality and Morbidity meetings, Governance Meetings and Trust wide OWLS (Organisation Wide Learning).

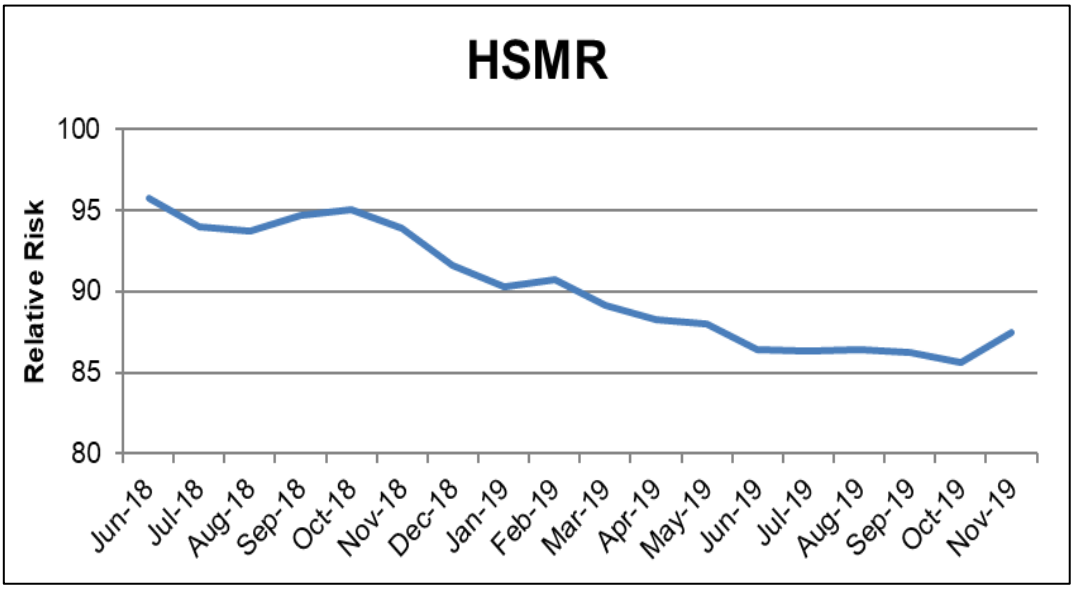
Table 6: Learning from Case Record Reviews

	Themes identified through reviews – Suboptimal Care	Actions
1.	Fractured neck of femur (#NOF) pathway -	This relates to the findings of an SJR cohort review of 55 deaths in response to a National Hip Fracture Database mortality outlier alert. Whilst surgery is often timely, not all patients are admitted to an orthogeriatric ward from the outset which is associated with fragmentation of and more variable care. A working group is in place to optimise the #NOF pathway with the support of the Trust Improvement Team.
2.	Monitoring - ability to recognise and respond to changing clinical status	The most common issues are failure to recognise/adequately respond to acute deterioration, insufficient frequency/seniority of review and vital signs monitoring. The Trust will be implementing electronic observations (e-obs) shortly. This will facilitate earlier identification of potential deterioration, accurate calculations and fewer errors and as well as support clinical best practice and protocols. In addition, e-obs will allow central oversight of all acutely unwell patients across the Trust.
3.	Diagnosis – problems relating to timely and accurate diagnosis	The most common issues are failure/delay in acquiring senior/specialist review, delayed action to a clinically significant reported result and failure/delay in performing an indicated test. In response to this, the Trust is taking the following actions: For critical laboratory results: Implementation of an automated communication pathway to improve critical test result management For all diagnostic test results: New processes are being developed to improve the rate of clinician acknowledgment including an escalation process for those results not acknowledged within an agreed time-frame The Trust is working towards the implementation of an electronic patient record which will improve these processes.

Below are the main themes identified through the Serious Incident Investigations. This learning will be used to inform focussed future quality improvement work to minimise recurrence.

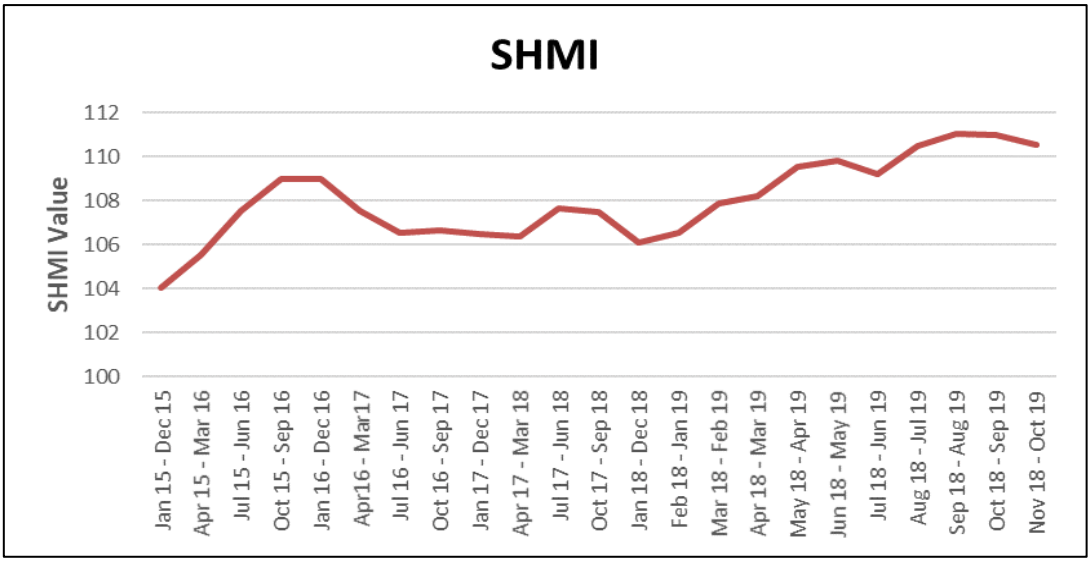
Table 7: Learning from investigations

	Themes identified through investigations	Comments
1.	Risks not identified	This relates to risks/benefits associated with a task, procedure, decision or plan not being identified. The most common error in this category is risk assessments that have not been carried out or that are incomplete.
2.	Risks not acted on	This relates to risks associated with a task, procedure, decision or plan that is not acted on. The risk has been identified but there was an error at the point of decision making around the actions to take to minimise the risk.
3.	Frailty or multiple comorbidities	This relates to patient associated pre-existing health conditions and underlying functional state which can affect treatment.
4.	Information transfer ineffective within in between teams.	This relates to information which is omitted or misinterpreted when a patients' care is transferred to the next shift, department or team etc. which can affect the quality of care received.
5.	Coordination between organisations ineffective.	This relates to information omitted or misinterpreted associated with referrals, booking of follow-up, community discharge and the transfer of information between care providers.



HSMR (*Hospital standardised mortality ratio)*

This is a methodology developed by Dr Foster Intelligence to calculate the risk of death for hospital patients on the basis of clinical and hospital characteristic data It is a ratio of the acute deaths to expected deaths and focuses on the diagnosis groups that account for the majority of in hospital deaths.



SHMI *(Summary Hospital-level Mortality Indicator)*

SHMI 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.

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 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 18/19	NNUH 17/18
	NNUH Jan-19-Dec-19 Published by NHSI	National Average	Best performer	Worst performer		
SHMI value and banding	1.1338 Band 2	No data yet published	No data yet published	No data yet published	1.0748 Band 2	1.0639 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 Jan-Dec 2019, published May 2020**						
% 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 18/19	NNUH 17/18
	NNUHFT	National Average	Best performer	Worst performer		
Trust's responsiveness to the personal needs of its patients during the reporting period.	68.1	67.2	85.0	60.5	68.8	68.8

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-19 // Next version due: Aug-20

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	2019 NHS Staff Survey Results				NNUH 17/18	NNUH 16/17
	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.	62%	62.6%	81%	39.2%	61.9%	60.7%

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
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 Venous Thromboembolism (VTE)						
Indicator	2019/20 (Trust Reported)				NNUH 18/19	NNUH 17/18
	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 2019/20	95.65% Q2 2019/20	100% Q2 2019/20	68.67% Q2 2019/20	98.94	98.94

Location: https://improvement.nhs.uk/resources/vte-risk-assessment-data-q2-201920/
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	2018/19 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 2018/19

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

Current version uploaded: July-19 // Next version due: July-20

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	2018/19 NHS Digital				NNUH 17/18	NNUH 16/17
	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	No data published	No data published	No data published	Q1/2 Rate 41.1 (n7276) Q3/4 Rate 42.1	21.3 rate No:7,297 (Apr-Sept)

	34.5 (n5564)				(7076)	
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-19** **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

Background/Context

In partnership with NHS England, NHS Improvement have introduced a new way of measuring seven day hospital services for all providers of acute services, replacing the previous survey with a self-assessed Board Assurance Framework.

All providers of acute services were required to submit a board assured self-assessment return in November 2019 showing current compliance against the 4 priority seven day service clinical standards as well as progress against the other 6. This is the second NNUH self–assessed Board Assurance Framework paper following the successful submission in June 2019.

Following the June 2019 submission we received positive feedback for our response, with a few recommendations to enhance future submissions.

NNUH was also visited by the NHS England, regional lead facilitator for seven day services, Erika Ottley, in September 2019. This visit included a meeting, attended by our 7 day services clinical leads, who showcased their plans to ensure we will be compliant in delivery of compliance to the priority standards by March 2020.

Key issues, risks and actions

Of the four priority clinical standards, Clinical Standard 2, ***14 hrs to first consultant review from admission*** is at risk of not achieving the target of 90% compliance by March 2020, despite continual improvement being evidenced from each bi-annual audit that is undertaken.

For the Autumn 2019 submission compliance is 82% (up from 78% in Spring 19 and 72% in Autumn 2018) and there is minimal variation in compliance from a weekday to a weekend, however some key issues still remain:

- Specialty compliance is variable (see table 8)

- Compliance for patients admitted in the afternoon is significantly lower than those admitted in the morning / evenings (see table 9)

The mitigating actions taken to address the compliance issues are:

- Non-compliant specialties are required to create individual action plans and participate in a further audit once plans are implemented.
- Clinical standard 2 is now reflected in the internal professional standards and within the patient flow and escalation policy which feeds into the Emergency and Urgent Care board.

Table 8: Percentage compliance to patients receiving a consultant review within 14 hours of admission by specialty / division

Table 9: Percentage compliance to patients receiving a consultant review within 14 hours of admission by specialty / division

Compliance based on time of admission

Survey*	morning 0800-1259	afternoon 1300-1759	evening 1800-0759
Spring 18	79%	47%	78%
Autumn 18	80%	55%	79%
Spring 19	85%	65%	84%
Autumn 19	92%	65%	89%

*Note - breakdown by admission time not possible in Autumn 17

Conclusions/Outcome/Next steps

The following specialties required to work on individual action plans for achieving 90% compliance to the 14 hr consultant review target by March 2020.

- **Medicine –** Diabetes, General Medicine*, Haematology, Neurology, Oncology.
- **Surgery –** ENT*, General Surgery, Plastic Surgery, Urology
- **Women and Children –** Paediatric Medicine.

** These specialties already have plans in place that were implemented in September 2019 – an additional audit in Winter 19 should confirm improved compliance*

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 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 as examples– 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 Freedom to Speak Up Guardians.

Finally it identifies that if these escalation routes are not responsive staff can contact the Trust's Chief Executive or Chairman, and if necessary, outside bodies such as NHS England, HEE, NHSCFA or the CQC.

The Policy outlines confidentiality and anonymous reporting of concerns and gives advice on support available for those raising concerns and explains how the Speak Up process works. It reassures staff that detriment to speaking up is not acceptable and how this would be taken seriously and investigated by the organisation.

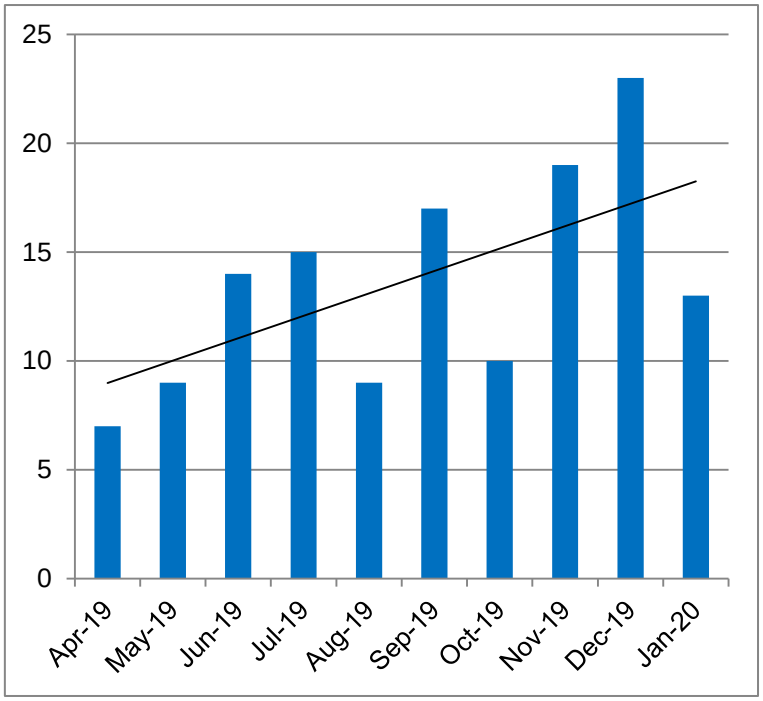
Freedom to Speak Up (FTSU) Guardian Service

- Staff have access to a team of six Freedom To Speak Up Guardians and a fulltime Lead Guardian. Champion roles are being developed which will improve direct

access for staff in Cromer and FTSU is working with the Equality, Diversity and Inclusion (EDI) team to ensure staff networks groups have improved representation.

- Staff meet the Lead Guardian at corporate induction and Speak Up training is delivered as part of induction in line with NGO (National Guardians Office) guidance on training, ensuring all staff feel confident they know what speaking up is, why it is important and how to do it.
- Management Board receive a bi-monthly FTSU report with monthly updates on 'speak up' issues in order to increase its oversight of issues.
- All staff using the FTSU service are asked to provide feedback which includes questions regarding whether any detriment was experienced due to speaking up and whether they would recommend the service to others. Any incidents of detriment would be investigated (None at date of this report).
- Posters signposting staff to the FTSU service are visible throughout the organisation, pages are accessible on the intranet and the FTSU service features regularly in NNUH communications to staff.
- Lessons from cases brought to the FTSU service are being linked into the organisations Sharing the Learning forum with quarterly publications which is accessed throughout the organisation.
- If data collected shows "hotspots" in an area or department, this will be considered with wider triangulation of information available and can trigger the service to provide a wider "speak up event" in the area. This helps to ensure areas are supported in fully raising their concerns and can work collaboratively to address the issue raised.
- Quarterly data is submitted to the NGO on all cases accessing the Guardian FTSU service.

Figure 2: Staff using the FTSU Guardian Service April 2019 to January 2020



Other Information

Patient Safety – Serious Incidents (SIs)

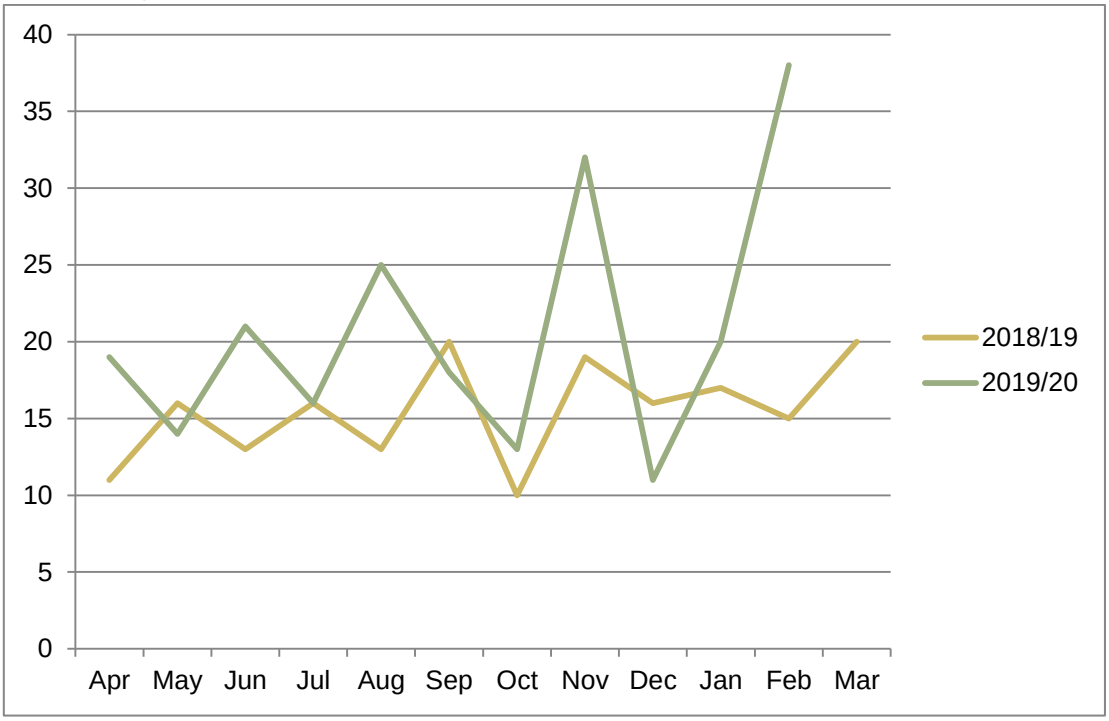
All patient incidents, regardless of their severity, are recorded on DATIX and are submitted quarterly to the National Reporting and Learning System (NRLS).

In the twelve months ending 31st March 2019, 19,609 incidents were recorded on DATIX. Of these, 96.5% were deemed to have caused either no harm or low harm to patients and 3% was classed as Moderate Harm. Of the Moderate incidents, 194 relate to VTEs which have yet to be fully investigated – it is expected that most of these will be reclassified as low harm incidents.

The number of reported incidents has continued to rise over the last few years due to an increased awareness of safety issues and an improved quality and safety culture.

In 2018/19 there were 17,222 reported incidents, of which 96.85 were classed as low or no harm to patients, and in 2017/18, there were 14,358 reported incidents, of these 98.2% caused no harm or low harm.

Figure 3: Serious Incidents and Never Events reported on StEIS *(Strategic Executive Information System)*



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2018/19	11	16	13	16	13	20	10	19	16	17	15	20
2019/20	19	14	21	16	25	18	13	32	11	20	38	

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 Root Cause Analysis (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 seven never events during the period covered by this Quality Report (six in 2018/19).

Jun-19	Wrong route drug administration
Jul-19	Misconnection of patient to air
Nov-19	Incorrect patient midline insertion
Nov-19	Misconnection of patient to air
Nov-19	Misconnection of patient to air
Jan-20	Misconnection of patient to air
Feb-20	Retention of guidewire

Since January 2019 the Trust has adopted a new approach to the governance of Never Events and selected Serious Incidents through a 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 identified by the Chief Nurse or Medical Director and 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 recurrence. The whole purpose is to closely examine the facts of an incident, in order to learn from it.

Patient Safety – Duty of Candour

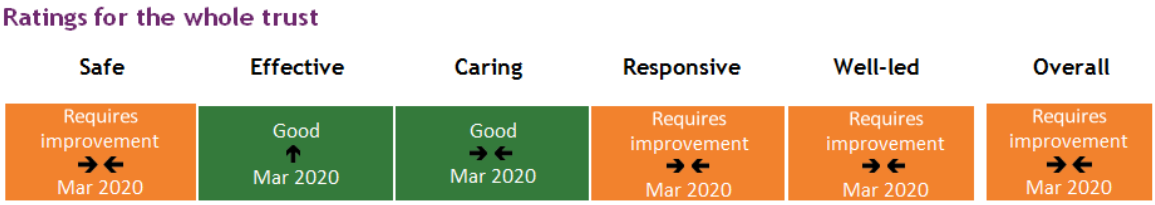
The Risk and Patient Safety Team maintain a Duty of Candour Compliance database which tracks compliance regarding Duty of Candour across the Trust. Duty of Candour is a Health and Social Care Act (2008) regulation that ensures that providers are open and transparent with people who use services and other '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 Intgrated Performance Report (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



The rating for well-led is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions are from combining ratings for services and using our professional judgement.

Full details of CQC report can be found on page 44

Clinical Effectiveness – NHS Improvement Governance Indicators

Performance against the relevant indicators and performance thresholds set out in the oversight documents issued by NHS Improvement. For 2019/20 these are:

Indicator		Threshold 2019/20	NNUH 2019/20
Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate – patients on an incomplete pathway		92%	March 2020 71.9%
A&E: maximum waiting time of four hours from arrival to admission/ transfer/discharge		95%	NNUH Only 66.26% Combined Trust & CCG 76.18%
All cancers: 62 day wait for first treatment from:	urgent GP referral for suspected cancer	85%	69.1%
	NHS Cancer Screening Service referral	90%	80.5%
Maximum 6-week wait for diagnostic procedures		1%	March 2020 4.5%
C difficile: variance from plan* * Please interpret the figures with extreme caution due to the changes in attribution of cases, from 19/20 the total case figure includes both Hospital onset healthcare associated cases (HOHA) and Community onset healthcare associated cases (COHA). This is in line with NHSI Guidance. Clostridium difficile is now known as Clostridioides difficile.		<35 cases for the year and 11.3 rate by bed day.	66 cases total and 22.14 rate by bed day.

Summary Hospital-level Mortality Indicator (also included in quality accounts regulations)	100	Dec 18-Nov 19 112.37
Venous thromboembolism (VTE) risk assessment	97%	99.34%

Clinical Effectiveness – Achieving cancer referral and treatment times

	National Standard	Q1 1920	Q2 1920	Q3 1920	Q4 1920
GP 2WW	93%	87.70%	74.09%	75.07%	75.49%
Breast Sympt 2WW	93%	95.67%	95.96%	55.36%	84.08%
31 Day First Treat	96%	96.90%	96.56%	96.11%	94.39%
31 Day Subs ACD	98%	100.00%	99.76%	99.50%	96.68%
31 Day Subs RT	94%	98.66%	97.99%	97.81%	95.41%
31 Day Subs Surgery	94%	90.68%	84.50%	83.52%	72.86%
62 Day GP	85%	73.72%	71.72%	71.85%	
Reallocated 62 Day GP**	85%	76.50%	74.15%	72.23%	64.30%
62 Day Upgrade		53.90%	44.88%	40.78%	55.46%
62 Day Screening	90%	85.71%	84.93%	78.29%	74.70%
62 Day Breast Sympt	85%	80.00%	80.00%	0.00%	83.33%

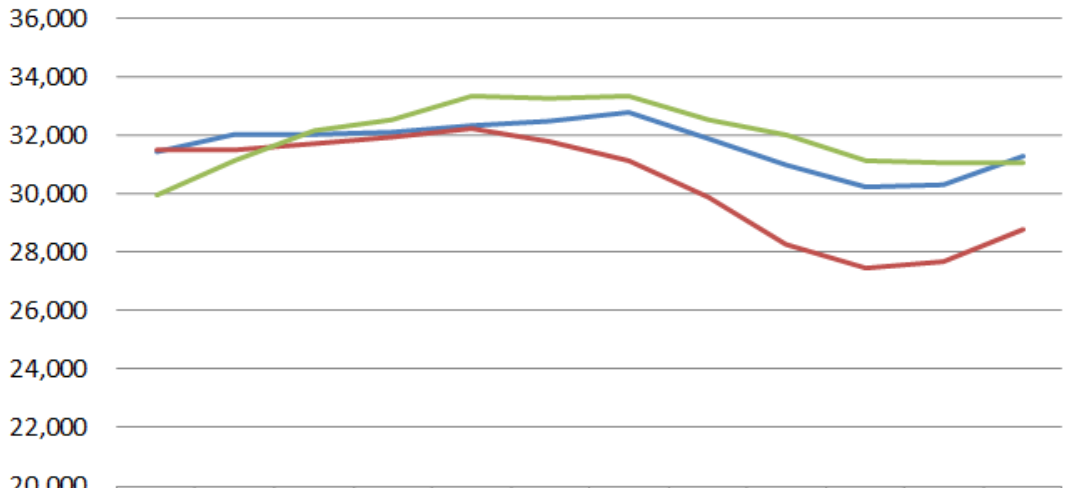
***Please note that the Reallocated 62 Day GP figures are calculated internally by Cancer Management and not done on a quarterly basis, as such this is the aggregated value of each month within the quarter.*

Clinical Effectiveness – 18 week RTT waiting times

In line with National reporting, 2019/20 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.

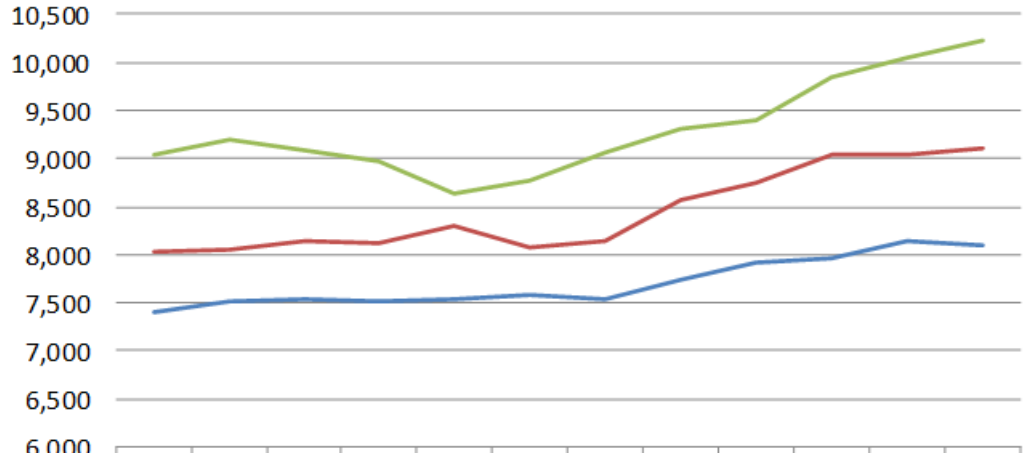
These factors have impacted on the Trusts 18 week referral to treatment performance, however recovery trajectories have been remodelled to take into account revised operational plan and impact of outpatient/day case/inpatient procedures cancelled during adverse weather.

Non-Admitted Waiting List



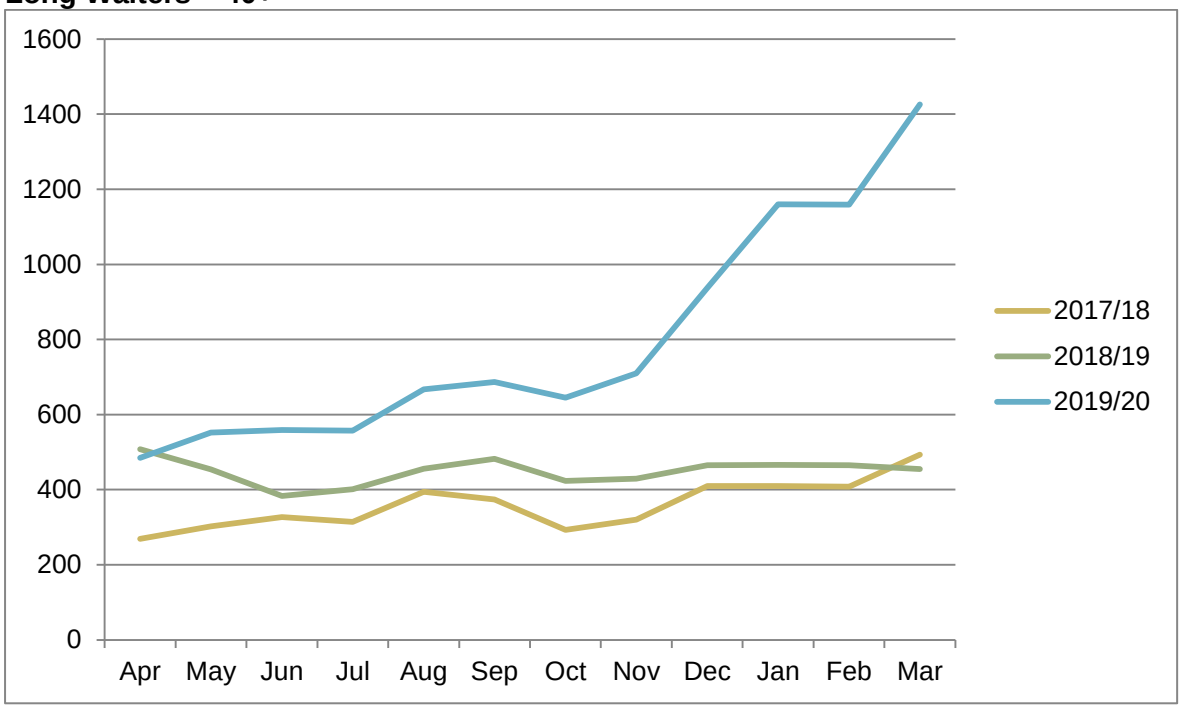
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2017/18	31475	32068	32046	32105	32326	32483	32782	31888	31019	30284	30371	31280
2018/19	31559	31495	31770	31933	32240	31804	31177	29885	28255	27459	27683	28773
2019/20	29951	31176	32201	32567	33367	33284	33406	32562	32053	31129	31082	31096

Admitted Waiting List



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2016/17	7411	7515	7541	7516	7532	7588	7538	7744	7915	7964	8143	8104
2017/18	8024	8059	8146	8129	8300	8077	8138	8577	8742	9039	9030	9109
2018/19	9038	9189	9073	8965	8639	8768	9057	9306	9391	9851	10041	10236

Long Waiters – 40+

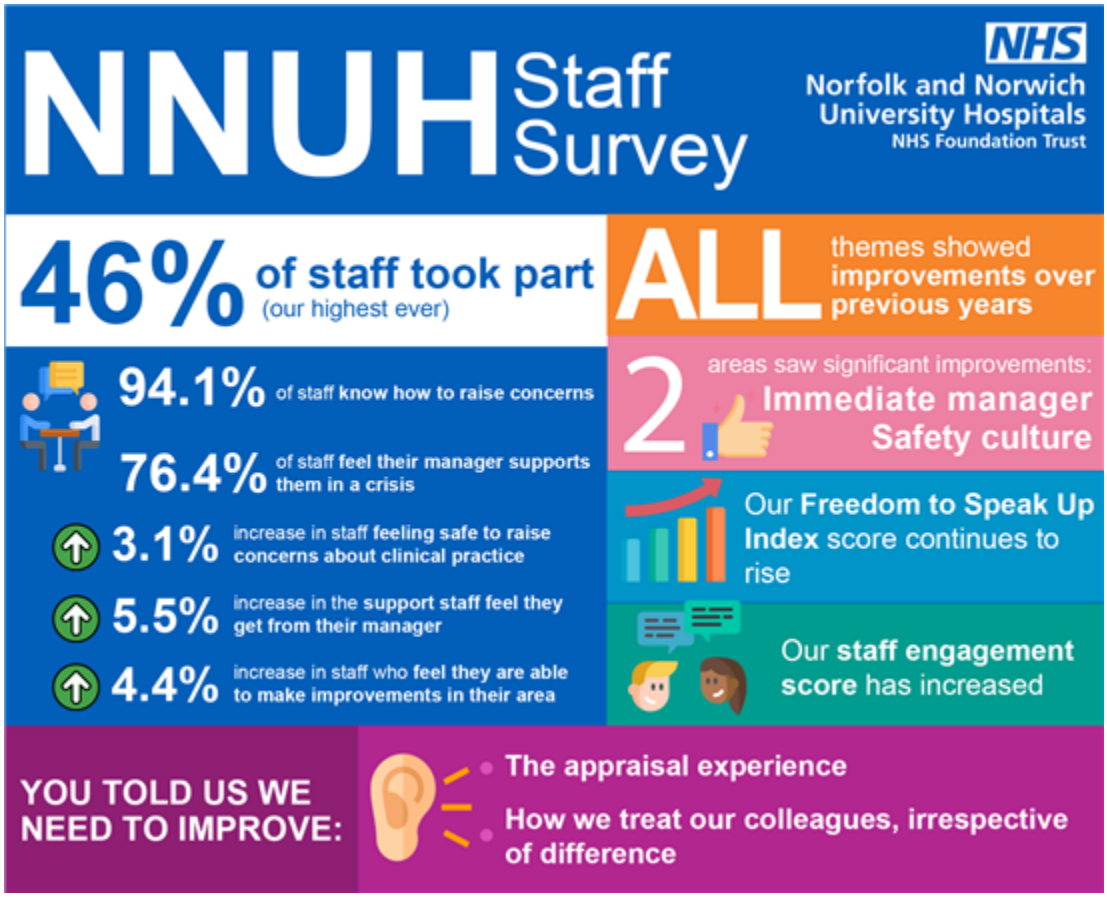


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2017/18	269	302	327	314	394	374	293	320	410	410	408	493
2018/19	508	454	383	401	456	482	423	429	465	466	465	455
2019/20	485	552	559	557	667	687	645	710	937	1160	1159	1426

Clinical Effectiveness – Clinical research and development

See page 41

Staff Experience – NHS Staff Survey



More people than ever – 3,776 - responded to the 2019 Staff Survey.
The survey groups responses into 11 themes, and all showed an improvement on the previous year's survey.

In fact, two of these themes – "Immediate Manager" and "Safety Culture" have improved significantly. The barometer measure of "Staff Engagement" has also improved, as has the "Freedom to Speak Up" index.

All six questions relating to **immediate managers** are improved on the past two years, with a 5.5% increase in people saying they are supported by their line manager, 4.9% more saying they receive clear feedback, 3.8% more saying their opinion is sought before their manager takes decisions that affect their work, and 3.3% more staff said that their manager takes a positive interest in their health and wellbeing. In addition, 72.5% of staff are satisfied with the opportunities to use their skills, and 75.4% are content with the amount of responsibility they're given.

Five out of the six questions relating to **safety culture** showed an improved response on 2018, with 3.1% more people saying they would feel safe raising concerns about unsafe clinical practice, 3% more are confident that their concerns would be addressed, and 2.1% more people believe that errors, near misses and incidents are acted on to ensure that they don't happen again.

The key theme of **staff engagement** has improved on last year, with an increase of 4.4% people saying they are able to make improvements happen in their area, 2.1% more saying

that there are frequent opportunities for them to show initiative and 1.3% indicating that they are able to make suggestions for improvement.

The survey also takes a range of questions regarding openness, culture and safety to create what is known as a **Freedom to Speak Up** index. This index has increased by 2.2% since 2018 and 4% since 2015.

“We’re delighted to see such improvement in these themes, because they’re key indicators of how are staff ‘feel’ and we want all of our staff to have the best possible experience at work,” said Paul Jones, Chief People Officer.

There are some questions which also show progress on our journey to outstanding:

- **Openness:** 94.1% of staff know how to raise concerns and 89.3% are positive about the Trust encouraging them to report errors and near misses.
- **Quality:** 58% of staff are positive about the Trust using patient feedback to improve services and 67.9% receive regular updates about patient experience.
- **Bullying:** The positive trend for experience of bullying from managers or colleagues continues, with a 4.8% improvement since 2015.
- **Health and wellbeing:** 92% of staff believe that the Trust takes health and wellbeing seriously.

Areas for improvement

Despite the positive improvements across the staff survey’s themes, there remain areas where our staff are saying that there is room for improvement:

- **Perspective of organisation:** Fewer staff (71%) believe that care of patients is the Trust’s top priority (down 2% on the previous survey) and 72% would be happy with the standard of care if a friend or relative needed treatment – although this is down 4% on the previous survey this figure is 3% higher than the average for acute trusts.
- **Appraisals:** While all four questions comprising the “quality of appraisals” theme have improved, just 18.4% of staff said that their appraisal helps them improve how they do their job and only 31.7% said they make them feel valued by the organisation.
- **Workforce equality standards:** The survey results highlighted the need for continued improvement with equality, diversity and inclusion. 35.1% of Black, Asian and Minority Ethnic (BAME) staff said they experienced bullying from staff. In addition, 21% of BAME staff said they experienced discrimination from their manager or colleagues, which is more than three times higher than for white staff.
  20.8% of staff with a disability also reported bullying from their line manager – twice that for non-disabled staff. A further 32.9% reported bullying from colleagues - 74% higher than non-disabled staff.

Next steps

Staff Survey Steering Group: A new Steering Group will be convened to deliver the improvement plan resulting from the staff survey. It will comprise representatives from each of the Divisions, Emergency and Urgent Care and corporate departments as well as others including trade union representation and our diverse staff networks.

Communication of results: Divisional results will be communicated locally and leaders across the Trust will seek opportunities to listen to views and suggestions for improvements.

Communications: There will be regular communications on the improvement plan and progress on its delivery. A dedicated intranet page is being populated with all information relating to the staff survey.

Figure 4: NNUH 2019 Staff Survey Results against other organisations

	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of appraisals	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement	Team working
Best	9.4	6.7	7.4	6.7	6.6	8.1	8.5	9.6	7.2	7.5	7.2
Your org	9.1	6.0	6.7	6.1	5.5	7.1	7.8	9.5	6.5	6.9	6.5
Average	9.0	5.9	6.8	6.1	5.6	7.5	7.9	9.4	6.7	7.0	6.6
Worst	8.3	5.3	6.0	5.5	4.8	6.7	7.3	9.2	5.7	6.1	5.9
Responses	3,744	3,757	3,741	3,699	3,215	3,324	3,731	3,739	3,745	3,754	3,730

Patient Experience – Encouraging Patient Flow

The SAFER patient flow bundle blends five elements of best practice. It is 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 2019/20 the Trust has delivered a range of inpatient and outpatient service developments to improve provision and care for frail patients.

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

OPAS (Older People's Assessment Service)

The Trust has made significant improvements to the way in which the outpatient service functions, by reducing the wait for an appointment and moving to an ambulatory approach to care which supports patient independence and admission avoidance. This service provides a rapid assessment of needs including all appropriate elements of a Comprehensive Geriatric Assessment.

GPs fill in an electronic referral and access the service via a confidential email account. Once the referral is received, the patient is contacted and invited for assessment. Results of the assessment and changes / recommendations for future care and management are made available to GPs via the same email system, usually on the same day.

The service has seen a reduction in patients requiring a follow-up appointment and long waits for an assessment significantly reduced from an average of 6 weeks to 2 days.

OPAC (Older People's Ambulatory Care)

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

OPED (Older People's Emergency Department)

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

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

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

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

Patient Experience – Complaints

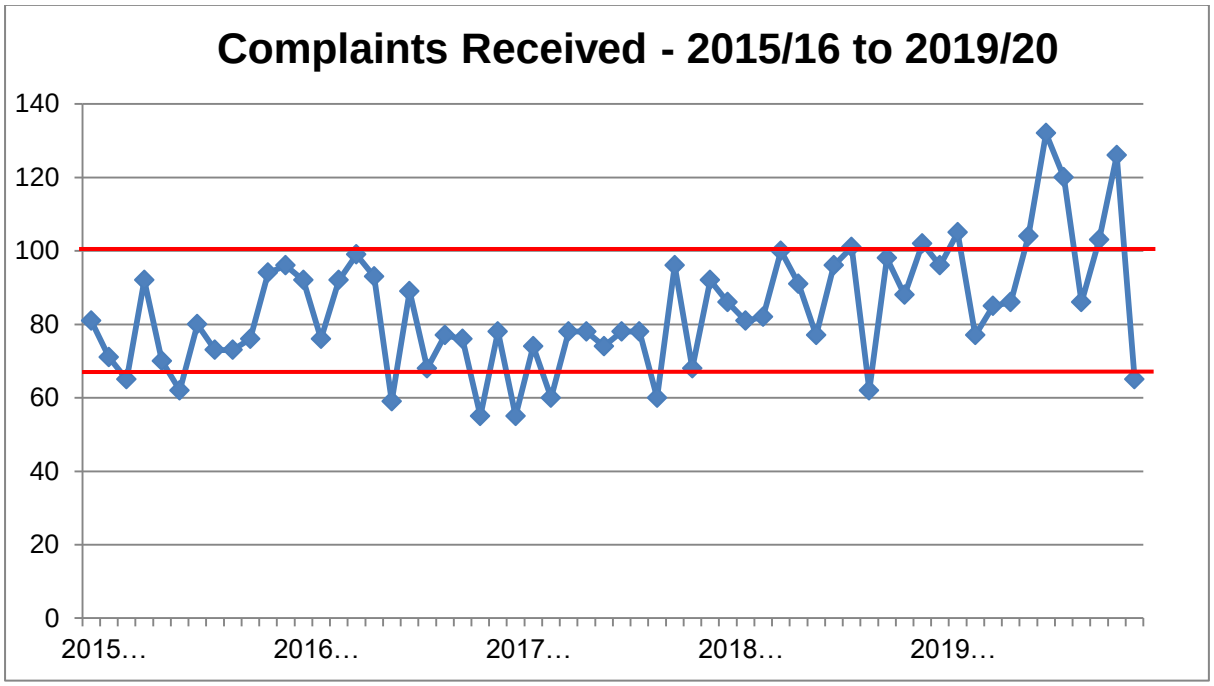
We have an established process for investigating, managing and learning from formal complaints about our services.

Learning from complaints

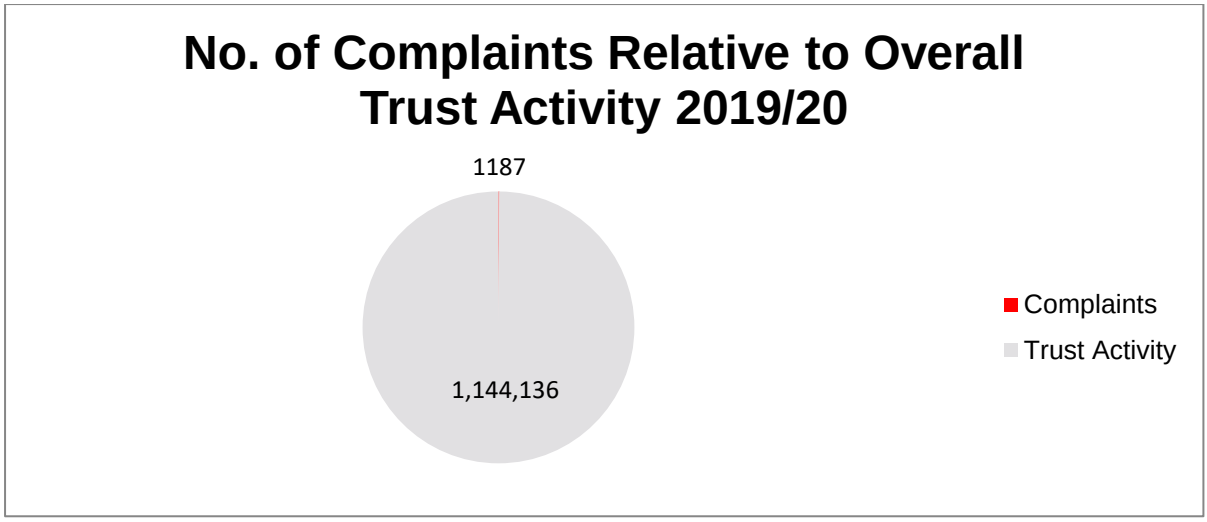
In order to ensure that complaints are used to learn lessons and to prompt service improvements for patients, every complaint is reported to the relevant divisional/departmental manager and service clinical leaders so that any necessary actions can be taken. We recognise the importance of learning from feedback from our patients and this process of learning from complaints is overseen by our Patient Experience and Engagement Governance Sub-Board (PEEG), under the executive leadership of the Chief Nurse. All our divisions are represented on PEEG and monthly reports on complaints are provided to PEEG with summary information provided to the Management Board and Board of Directors.

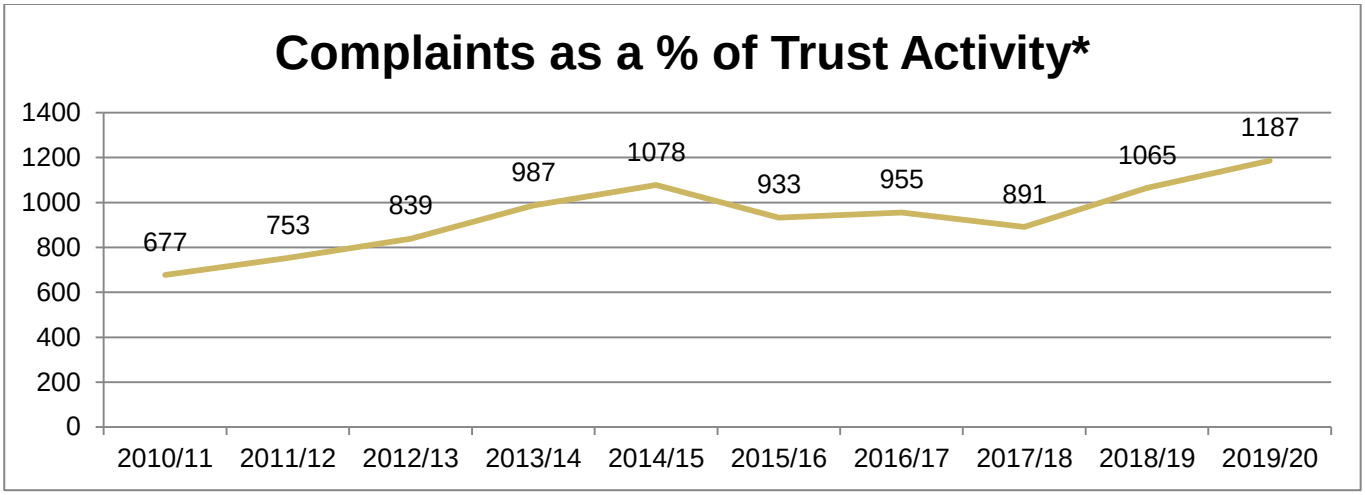
The number of complaints

The profile of complaints in 2019/20 was unusual. A relatively high number of complaints in the early part of the year was followed by low numbers as the Covid-19 pandemic struck. Overall, the Trust received 1187 complaints in 2019/20, compared with 1065 complaints received in 2018/19.



The graphs below show the number of complaints relative to the Trust's activity. The number of complaints is consistently in the range of 0.08 and 0.1% of all Trust activity.



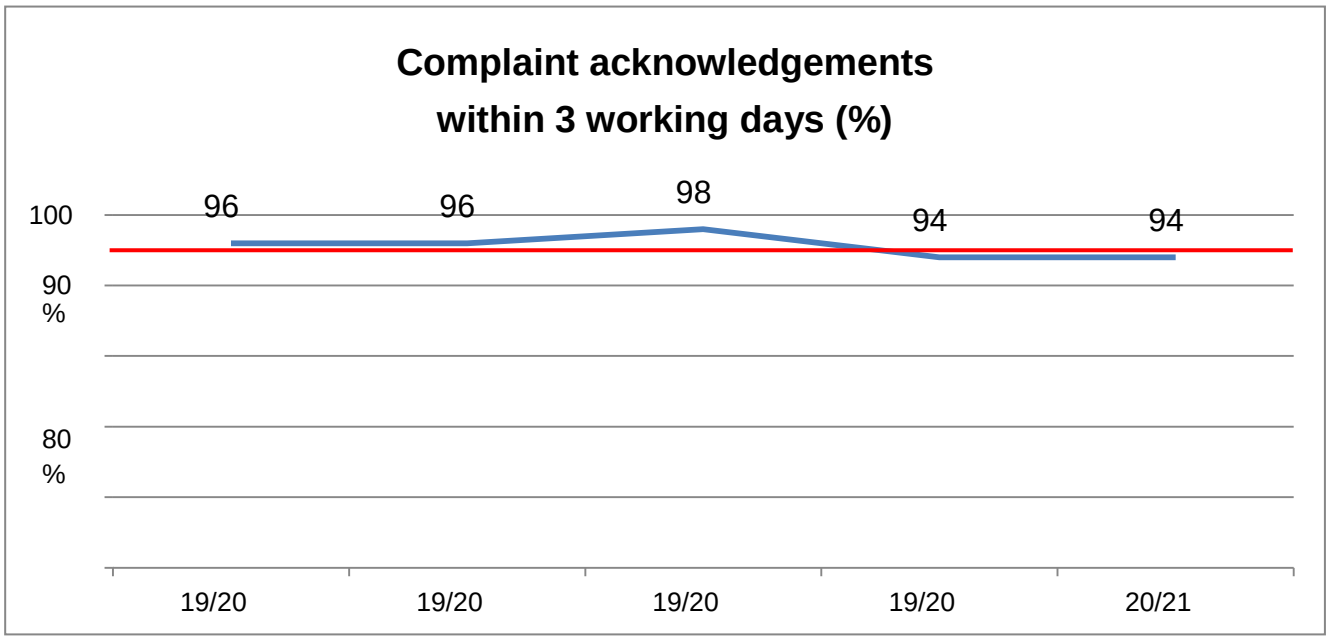


Activity	812,824	857,022	867,882	916,293	939,354	978,060	1,050,376	1,049,130	1,110,453	1,144,136
%	0.08	0.09	0.09	0.10	0.10	0.09	0.09	0.08	0.10	0.10

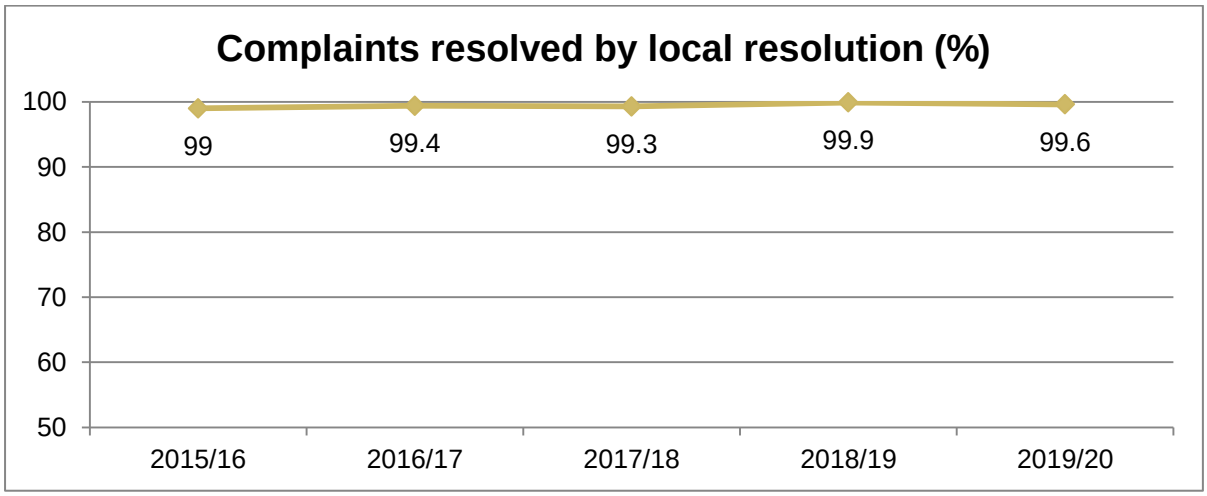
* Figures provided by Information Services Department to include: inpatient both elective and non-elective; day cases; outpatients, new and follow up appointments; and, A&E attendances

Resolution of disputes

One of the aims of the NHS Complaints procedure is to achieve resolution of disputes. The first step to achieving this is a timely acknowledgement (within 3 working days) and our performance in achieving this in 2019/20 is shown below. .

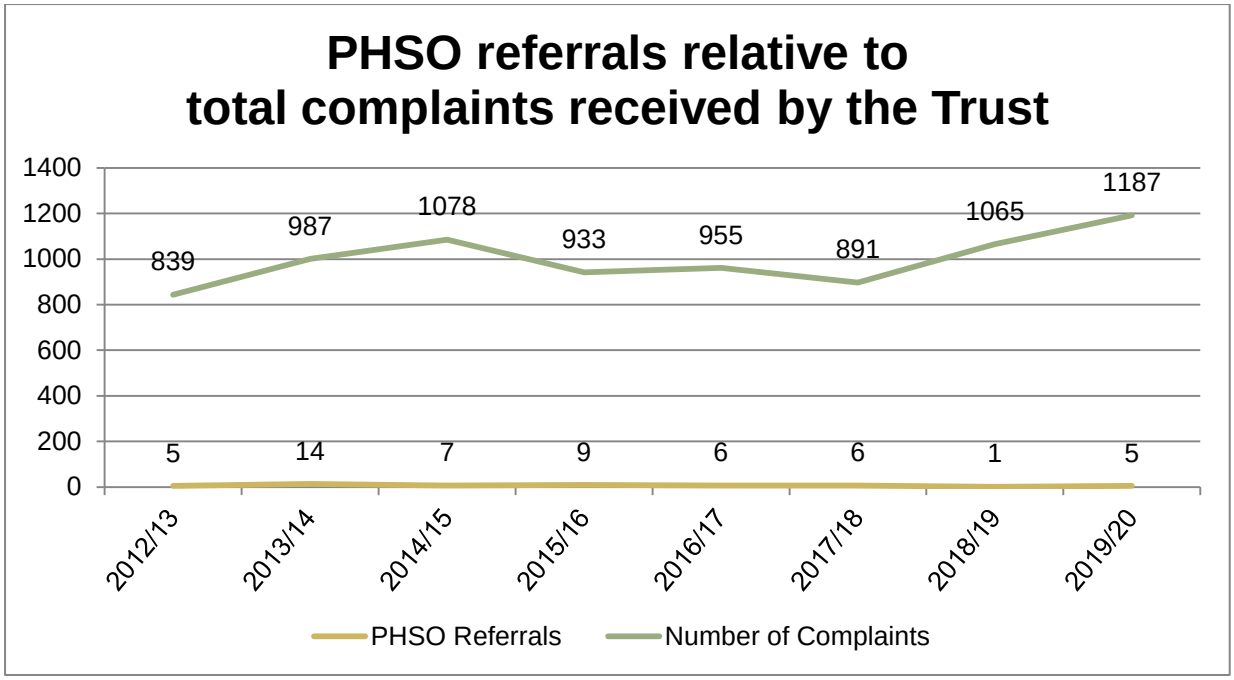


Efforts are made to achieve resolution of complaints through a process known as 'local resolution' – involving direct contact between Trust and complainant and typically a report from the Chief Executive summarising the outcome of our investigation. During 2019/20. 99.6% of complaints were resolved through this local resolution process as below. This performance was maintained despite the impact of the Covid pandemic.



The role of the Parliamentary & Health Service Ombudsman (PHSO) in the NHS Complaints Procedure relates particularly to complaints that remain unresolved 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 2019/20, 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.



Are complaints well-founded?

Hearing first-hand accounts of the care and services the Trust provides has a real resonance and poignancy for staff and all complaints offer an opportunity for review and reflection, and provide a valuable opportunity to gather feedback from patients. All complaints may be considered "well founded" in that a misunderstanding or misinterpretation of events may, for example, indicate a breakdown in communication leading to dissatisfaction.

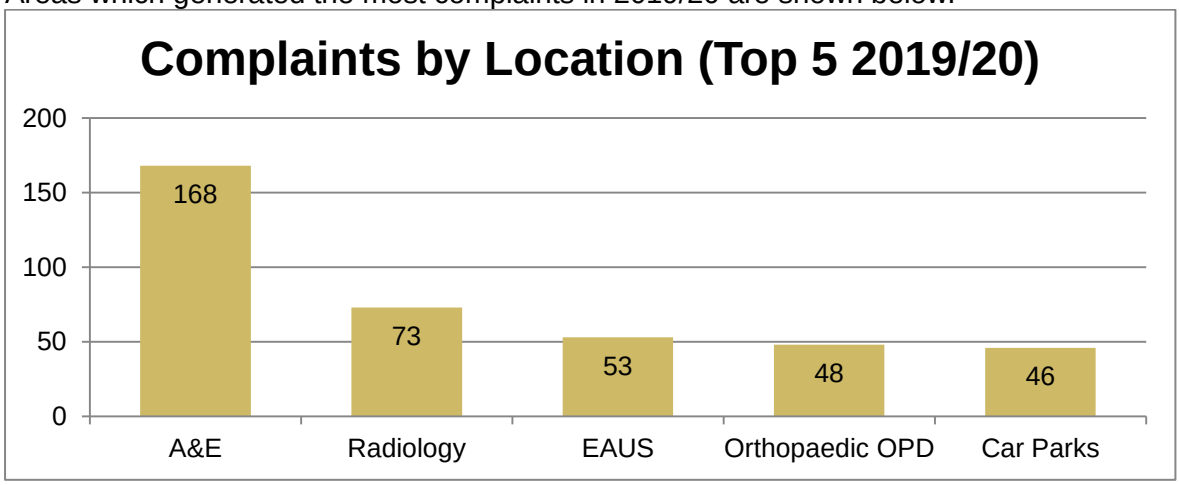
The table below shows that 98% of complaints resolved in 2019/20 were considered "well founded". The small minority which are not investigated, e.g. because they relate to historical care, account for those which are "not well-founded".

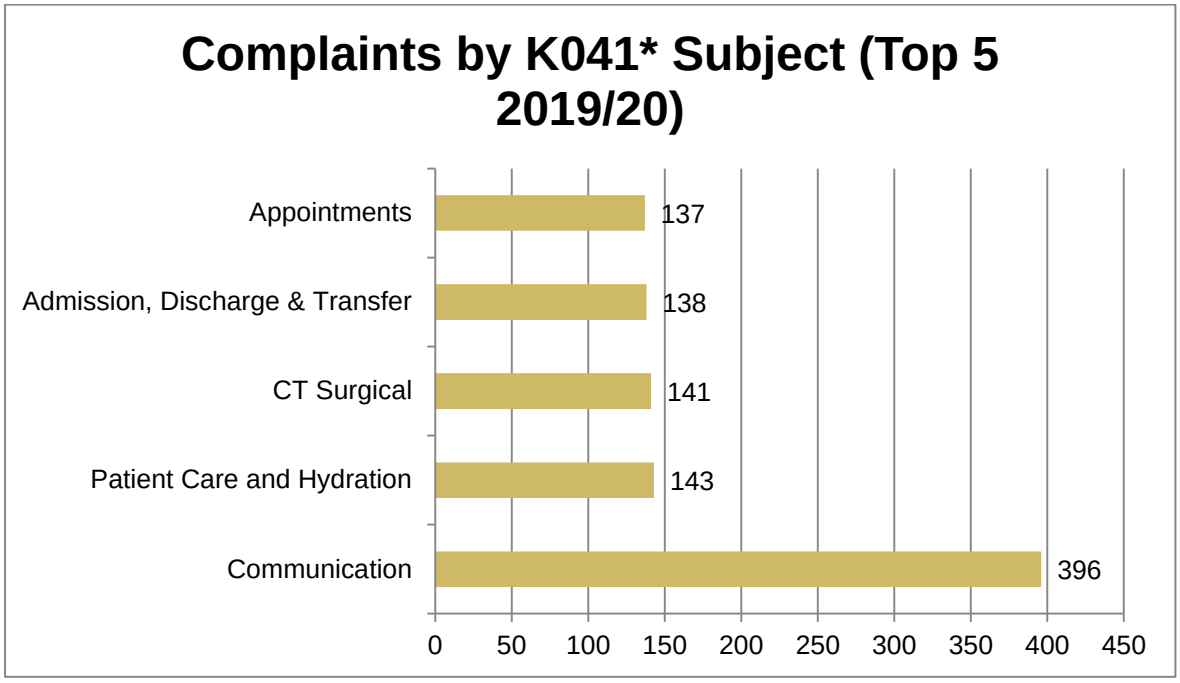
Quarter – 2019/20	Well-founded	Not well-founded	Total Resolved*
Q1	223	9	232
Q2	333	4	337
Q3	277	6	283
Q4	227	7	234
Total	**1060 (98%)**	**26 (2%)**	**1086**

* The total resolved figure is different to the total received figure, as a number of investigations will still be ongoing at the end of the financial year and will thus carry forward to next year's figure

Subject Matter

Areas which generated the most complaints in 2019/20 are shown below.





*K041 is the national system for collecting data with regard to complaints in the NHS.

Drawing on feedback from senior matrons and clinical teams, as well as using data collected from patient feedback and the quality governance process, the PEEG regularly reviews 'deep dive' reports focusing on a particular theme arising from complaints. In 2019/20 those thematic reviews have included: General Medicine, Endoscopy, fractures, Car Parking, Appointments, Emergency Department, Gynaecology and Radiology. This data is used alongside other sources to improve learning across the organisation.

The annual Clinical Audit Plan 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 and this area of action planning and follow-up to ensure learning from complaints is one that we will continue to develop in the year ahead.

Quality Improvement Update

We were pleased to present our Quality and Safety Improvement Strategy for 2019 to 2023. It supports our 'journey to outstanding' and the achievement of our vision ***"to provide every patient with the care we want for those we love the most"*** and is underpinned by our core values.

We have set out our quality priorities for the next five years, to improve patient safety, clinical effectiveness and the experience of those who use our services. These are the areas where we know we can make the greatest difference.

Just as importantly, however, we will equip our staff with the tools, techniques, training and support needed to deliver quality improvements in all areas, day in day out. In particular, we will develop a QI Faculty and widen access to quality improvement training for all our staff.

The Board is committed to making both the care we provide, and the experience of the staff who work in our hospitals and community services outstanding. We will engender a culture in which our staff can make quality their priority, and will support and empower them to make changes; we will remove barriers to quality improvement and maintain an open and honest dialogue on where we need to go further for our patients.

We want this strategy to become the compass that guides us towards being an outstanding hospital where staff are valued and patients feel safe in our care. We will plan, manage and measure the improvements we make, and we will hold ourselves to account for delivering planned improvements and for facilitating a focus on quality at all levels.

We know we have challenges in the light of recent Care Quality Commission reports and we need to strengthen our safety culture, to support the Trust moving from Requires Improvement towards being an outstanding hospital.

We know that when we work together, great things happen, and with the greater focus on quality and safety improvement outlined above, we are confident that we can deliver measurable improvements for our patients in the next five years.

This strategy will evolve over the coming years and we will ensure that as many people as possible, particularly our staff and patients, can share their views and shape our quality plans going forward.

Patient & Staff Experience Listening and responding to patients and their carers/ families going forward and using patient feedback and experience to design and improve services.	**Safe Systems** We aim to give every patient consistently safe, high quality and compassionate care. Reduce avoidable harm from failures in care and failure to rescue	**Effectiveness** Adhering to evidence, guidelines and standards to identify and implement best practice Development and use of systems and structures that promote learning across the organisation and services.
As measured by:- • Friends and family test • Improved scores in key questions national patient surveys • 10% improvement in scores in key questions of national staff surveys • Improving response rate and feedback real-time patient and carers surveys • Increased response rate from children, young people and their families (from agreed baseline) • Increase from baseline (in the handling and responding to complaints and concerns raised at the point of care.	As measured by:- • 95% patients screened for sepsis according to Trust policy • 95% of admitted patients will have observations recorded accurately using NEWS2 • 20% reduction in hospital acquired pressure ulcers • 10% reduction in falls with harm • 80% of older in patients receive key falls prevention actions • 100% of named children link nurses have paediatric competences	As measured by:- • 100% Duty of Candour compliance • 95% Serious Incident investigations are fully completed within 60 days • 95% of action plans completed from complaints and serious incidents within agreed timescales • Evidence that themes from serious incidents and complaints and mortality reviews and utilised to prioritise our improvement programme. • 95% of cases requiring SJR completed in line with policy • 100% of children and young people requiring high dependency or critical care are looked after in dedicated environment • Antimicrobial Resistance – Lower Urinary Tract Infections in Older People & Antibiotic Prophylaxis in Colorectal Surgery

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

Healthwatch Norfolk Statement –NNUH Quality Report 2019/20

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

Introduction
The introduction from the Chief Executive has many positive issues to emphasize – coming out of special measures, an outstanding rating for End of Life Care and a good rating for Outpatients for example. Good news is very welcome in the current climate, and it is, of course, very appropriate that the Report opens with a tribute to how the staff have been working in a hugely committed way in their care and support of patients, particularly in response to Covid-19.

There are many other causes for celebration in the Chief Executive's Statement, notably that NNUH is one of the top 25 Trusts in the country for patients participating in research, and robot-assisted colorectal surgery winning an award in Surgical Services Initiative of the Year. Healthwatch Norfolk is particularly impressed by the fact that the NNUH at Home Service Team was shortlisted by the Health Service Journal for partnership working – at a time when Social Care has been under great pressure.

Priorities for Improvement
It is worth noting, and to some extent, very understandable, that the majority of 2019/20 priorities for improvement were not met given the unexpected impact of Covid-19. However it looks as though many of the priorities were not achieved in the first 9 months of the year. Hopefully they can be met this year.
The priorities for 2020/21 have been identified, but without timescales.

Patient safety
There has been an increase in the reporting of serious incidents in 2019/20 – 19,609 recorded on Datix, (compared with 17,222 in 2018/19 and 14,358 in 2017/18). 3% were classed as causing moderate harm, compared with 3.2% 2018/19, with higher than average spikes occurring in August, November and January/February. There were seven never events in 2019/20, compared with six the previous year.
In common with many other Trusts in England the NHS improvement Governance Indicators were not met: e.g 18 weeks from point of referral to treatment 71.9% against 92% threshold; A & E maximum of 4 hours waiting time from arrival to admission/transfer/discharge 66.26% against 95% threshold; maximum 6 week wait for diagnostic procedures 4.5% against 1% threshold; and C Difficile 66 cases total for the year and 22.14 by bed day against thresholds of 35 cases for the year and 11.3 rate by bed day.

Patient Experience – Frailty Strategy
Healthwatch Norfolk is very pleased to note that the Trust has identified a "gold standard" of care for frail patients, which includes a Comprehensive Geriatric Service. We also welcome

Older People's Assessment Service, Older People's Ambulatory Care and an Older People's Emergency Department – the first in the UK entirely dedicated to older patients.

Patient Experience – Friends and Family Test
We were not able to locate the most recent Friends and Family Test, relevant to 2019/20.

Complaints
The pattern of complaints in 2019/20 was unusual. A high number of complaints were received in the early part of the year, followed by low numbers as the Covid-19 pandemic struck. Overall the Trust received 1187 complaints in 2019/20, compared with 1065 complaints the previous year. The number of complaints has consistently, over the last nine years been in the range of 0.1% of overall Trust activity – in plain English 1 in a 1,000 patients of all kinds. It is good to note that over the last five years between 99% and 99.9% have been resolved by local resolution, particularly as 98% of complaints were considered to be well founded (2019/20).

CQC Report
The CQC inspected NNUH between December 2019 and January 2020. The rating still states Requires Improvement, but "the Chief Inspector of Hospitals made a recommendation that the Trust was removed from special measures." The Report went on to say "We rated safe, responsive and well led as requires improvement and caring as good. Effective went up from requires improvement to good."

Workforce
46% of staff took part in the staff survey (the highest ever at NNUH). 94.1% know how to raise concerns, 76.4% feel their Manager supports them in a crisis. Staff engagement has improved by 4.4% and the Freedom to Speak Up Index has also improved by 2.2% since 2018.

72% of staff agreed that "If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation." However this is 3% below the previous year's figure.

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 and definition of acronyms are very helpful to the lay reader. 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
August 2020

Statement from NHS North Norfolk CCG

NHS
Norfolk and Waveney
Clinical Commissioning Group

Re: Commissioner Response to Norfolk & Norwich University Hospitals Foundation Trust Quality Account 2019-2020.

I am writing to confirm that NHS Norfolk and Waveney Clinical Commissioning Group (CCG) supports the Trust in its publication of a Quality Account 2019-2020. Having reviewed the report, we are satisfied that the Quality Account incorporates the mandated elements required, based on information available.

We would like to thank the Trust staff for their strong leadership and hard work underpinning the continuous improvement in the quality of care delivered to the local population. The CCG recognises the challenges experienced by the Trust over the last contractual year and the impact that this has had on the organisation.

We would like to highlight the Trust's continued development and delivery of quality improvement initiatives during 2019/20, which led to the recommendation from the Care Quality Commission (CQC) that Special Measures be removed from the Trust. The Trust has an overall CQC rating of Requires Improvement, with end of life care rated as Outstanding and Outpatients rated as Good. Improvement is noted throughout the CQC report published in April 2020 and the CCG recognises the commitment and passion of staff at every level of the Trust, to improving the quality of care for patients.

Additionally, the CCG recognises the challenges the Trust has faced more recently due to the current COVID-19 pandemic. The challenge of delivering safe care at this unprecedented time has been met proactively and dynamically and we commend the skill and commitment of staff, some of whom we know to have made personal sacrifice to continue to deliver care to our communities.

The Trust has continued to work in a collaborative and integrated way with system partners and stakeholders across the Norfolk and Waveney Sustainability Transformation Partnership (STP), to strengthen and enhance integrated working practice in order to focus resources where our patients need them most and provide the best possible outcome for patients. The CCG is pleased to note the Trust's Quality and Safety Improvement strategy for 2019-2023, which further supports the Trusts journey and ambition to becoming a CQC 'Outstanding' rated hospital. It sets out clear areas for a planned focus to ensure that there is continued improvement.

This Quality Account documents the Trust plans around the creation of a Quality Improvement Faculty and acknowledges the work that has progressed this work so far. This will provide a cohesive mechanism and platform to support all staff; clinical and non-clinical, in bringing about continuous changes to deliver person centred care that is better, safer, more effective and more efficient.

NHS Norfolk and Waveney CCG looks forward to working collaboratively with the Trust during 2020-2021 to continue the development of quality improvements within the organisation, local community and across Norfolk and Waveney STP.
We recognise the significant challenge ahead and the value the work of all staff in the Trust's ongoing focus on improving patient, relative and carer engagement and experience of patients, relatives and carers, ensuring the learning from national improvement reports and independent enquiries are embedded into practice.

On behalf of NHS Norfolk and Waveney CCG, I would like to thank you personally, for your continued hard work and we look forward to working with you throughout the 2020-2021 contracting year.

Karen Watts
Associate Director of Nursing and Quality
NHS Norfolk and Waveney Clinical Commissioning Group
October 2020

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.

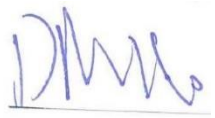
NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality 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 2019/20 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 2019 to March 2020
    - papers relating to quality reported to the board cover the period April 2019 to March 2020
    - feedback from commissioners
    - feedback from governors
    - feedback from local Healthwatch organisations
    - feedback from Overview and Scrutiny Committee
    - the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated June 2020
    - the 2019 national patient survey
    - the 2020 national staff survey
    - the Head of Internal Audit's annual opinion of the trust's control environment
    - CQC inspection report of January 2020
- 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:



David White
Chairman 22/10/2020

Sam Higginson
Chief Executive 22/10/2020

Annex 3 – Independent Auditor Report

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

As part of the Quality report requirements the Trust it is required that an external auditor is commissioned to provide independent assurance engagement review in respect of Norfolk & Norwich University Hospitals NHS Foundation Trust's Quality Report for the year ended 31 March 2020 (the 'Quality Report') and certain performance indicators contained therein.

However, in line with guidance issued on 23 March 2020 from NHSi:
In light of expected amendments to quality accounts arrangements, NHS foundation trusts are no longer required to include a quality report in their annual report for 2019/20. The FT ARM will be updated in due course. NHS foundation trusts are encouraged to include the additional quality report content in their quality account when prepared.

Assurance work on quality accounts and quality reports should cease, and no limited assurance opinions are expected to be issued in 2019/20. Where auditors have completed interim work or early testing on indicators, auditors should consider whether value can be derived from work already completed, such as a narrative report being provided to the trust, or governors at a NHS foundation trust. For NHS foundation trusts, there is no formal requirement for a limited assurance opinion or governors' report.

Annex 4 - 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 or 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	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

Annex 5 - Acronyms A-Z

A&E	Accident and Emergency Department (See ED)
ACU	Acute Cardiac Unit
BPT	Best Practice Tariff
C.difficile (C.diff)	Clostridium difficile
CAM	Confusion Assessment Method
CAPE	Carer and Patient Experience Committee
CDI	*Clostridium difficile* infection
CG NICE	Clinical Guideline
CHD	Congenital Heart Disease
CHKS	Caspe Healthcare Knowledge Systems
CLAW	Collaborative Learning Action Workshops
CMP	Case Mix Programme
CMT	Core Medical Trainee
CPR	Cardiopulmonary Resuscitation
CQC	Care Quality Commission
CQUIN	Commissioning for Quality Improvement and Innovation
CRM	Cardiac Rhythm Management
CT	Computerised Tomography
CYP	Children and Young Persons
DNACPR	Do not attempt Cardiopulmonary Resuscitation
DVT	Deep Vein Thrombosis
EADU	Emergency Admission and Discharge Unit
EAHSN	Eastern Academic Health Science Network
ECG	Electrocardiogram
ED	Emergency Department (See A&E)
EEAST	East of England Ambulance Service NHS Trust
ENT	Ear, nose and throat
EPLS	European Paediatric Advanced Life Support
EPMA	E-Prescribing and Medicines Administration
FFFAP	Falls and Fragility Fractures Audit Programme
FFT	Friends and Family Test
FY	Foundation Year
GCP	Good Clinical Practice
GIRFT	Getting it right first time
HALO	Hospital Ambulance Liaison Officer
HANA	Head and Neck Cancer Audit
HAT	Hospital Acquired Thrombosis
HES	Hospital Episode Statistics
HMCI	Her Majesty's Chief Inspector of Education, Children's Services and Skills
HSCIC	Health and Social Care Information Centre
HTA	Human Tissue Authority
IBD	Inflammatory Bowel Disease
IG	Information Governance

IGT	Information Governance Toolkit
IS	Information Services
IT	Information Technology
JAG	Joint Advisory Group
JPUH	James Paget University Hospitals NHS Foundation Trust
KF	Key Finding
KLOE	Key Lines of Enquiry
MASH	Multi-Agency Safeguarding Hub
MINAP	Myocardial Ischaemia National Audit Project
MRI	Magnetic Resonance Imaging
MTPJ	Metatarsophalangeal Joint
N/A	Not applicable
NAD	National Audit of Dementia
NAOGC	National Oesophago-Gastric Cancer Audit
NBOCAP	National Bowel Cancer Audit
NCA	National Comparative Audit
NCEPOD	National Confidential Enquiry into Patient Outcome and Death
NDA	National Diabetes Audit
NDFA	National Diabetes Footcare Audit
NED	National Endoscopy Database
NELA	National Emergency Laparotomy Audit
NG	NICE Guidance
NHFD	National Hip Fracture Database
NHS	National Health Service
NHSLA	National Health Service Litigation Authority
NICE	National Institute for Health and Care Excellence
NIHR	National Institute for Health Research
NJR	National Joint Registry
NLCA	National Lung Cancer Audit
NNAP	National Neonatal Audit Programme
NNUH	Norfolk and Norwich University Hospital NHS Foundation Trust
NOFERP	Neck of Femur Enhanced Recovery Programme
NPDA	National Paediatric Diabetes Audit
NPSA	National Patient Safety Agency
NRLS	National Reporting and Learning Service
PALS	Patient Advice and Liaison Service
PbR	Payment by Results
PCNL	Percutaneous nephrolithotomy
PE	Pulmonary Embolism
PICA	Net Paediatric Intensive Care Audit Network
PLACE	Patient-Led Assessments of the Care Environment
PODs	Patients' own drugs
PROMs	Patient Reported Outcome Measures
PSEC	Patient Safety and Effectiveness Committee
PSI	Patient Safety Incident

QI	Quality Improvement
QIR	Quality Incident Report
QS	NICE Quality Standard
RAG	Red/Amber/Green
RCA	Root Cause Analysis
ROP	Retinopathy of prematurity
SACT	Systemic Anti-Cancer Therapy
SAFER	Senior review, All patients, Flow, Early discharge, Review
SEND	Special Educational Needs and Disability
SHMI	Summary hospital level mortality indicator
SHOT	Serious Hazards of Transfusion
SI	Serious Incident
SSNAP	Sentinel Stroke National Audit Programme
STP	Sustainability and Transformation Plan
StR	Specialty Registrar
T&O	Trauma and Orthopaedic
TACO	Transfusion Associated Circulatory Overload
TARN	Trauma Audit and Research Network
UKRETS	UK Registry of Endocrine and Thyroid Surgery
VC	Virtual Clinic
VTE	Venous Thromboembolism
WTE	Whole Time Equivalent

Annex 6 - 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
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

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_131880

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).

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]

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

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

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 2019/20 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. This means that objectives have been set according to performance in this period.

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

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

Indicator construction
Numerator: The number of patient safety incidents recorded as causing severe harm /death as described above.
The ‘degree of harm’ for PSIs is defined as follows;
‘severe’ – the patient has been permanently harmed as a result of the PSI, and
‘death’ – the PSI has resulted in the death of the patient.

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

Indicator format:
Standard percentage

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

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