NNUHFT Annual Quality Account - 2024/2025

Quality Account 2024/25 – Contents

Foreword

All providers of NHS services in England have a statutory duty to produce an annual Quality Account (QA) to the public about the quality of services they deliver. This includes the requirements of the NHS (QAs) Regulations 2010 as amended by the NHS (QAs) Amendments Regulations 2011 and the NHS (QAs) Amendments Regulations 2012. The QA aims to increase public accountability and drive quality improvement within NHS organisations. They do this by getting organisations to review their performance over the previous year, identify areas for improvement, and publish that information, along with a commitment to you about how those improvements will be made and monitored over the next year.

Quality consists of three areas that are essential to the delivery of high-quality services:

- How safe the care is (patient safety)
- How well the care provided works (clinical effectiveness)
- How patients experience the care they receive (patient experience)

Scope and Structure of the QA

This report summarises how well the Norfolk & Norwich University Hospitals NHS Foundation Trust ('NNUHFT' or 'the Trust') did against the quality priorities and goals we set ourselves in 2024/2025. It also sets out the quality priorities we have agreed for 2025/26 and how we intend to achieve them.

The report is divided into three parts:

Part One: includes statements from our Chief Executive, Chairman and Chief Nurse.

Part Two: Looks at our performance in 2024/2025 against our quality priorities we set for the year and also sets out the quality priorities for 2025/2026. Part two also includes statements of assurance relating to the quality of services and describes how we review them.

Part Three: Looks at how we identify our own priorities for improvement and gives examples of how we have improved services to patients.

The annexes towards the end of the report include comments from Healthwatch, the Integrated Care Board (ICB) and our Governors. There is also a glossary of terms used. This document is available in an Easy Read version. If you would like this document in another language, large print or braille, please email: q-s.team@nnuh.nhs.uk.

*** Please note - Text written in blue is to highlight mandatory wording as per the requirements set by NHS England.**

Lesley Dwyer

I am delighted to introduce our Quality Account for 2024 to 2025, whilst this is my second edition, it covers my first year at the organisation. This document provides an overview of activity within the Trust but with a specific focus on quality.

It is fair to say that there have been some challenges throughout the year, particularly during the winter period due to the number of patients needing admission with seasonal illnesses, such as flu, norovirus and COVID, these issues were faced across our whole region. I would like to thank our leadership teams and staff for their resilience during these times, which allowed us to treat patients safely and respectfully, plus significantly reduce the need to use escalation beds and temporary escalation spaces by the end of the year. We are very clear, that use of escalation beds is not to be normalised practice in our hospitals and is a last resort.

Urgent and emergency care

We continue to work with the Ambulance Service and other stakeholders to maintain our improvement for ambulance handover times. Over the last year we had 41,721 ambulances arrive at our hospital. 41.39% of these patients were handed over to our care within 15 minutes, 18.16% between 15-30 minutes, 15.02% between 30 minutes and 1 hour. 22.03% took longer than an hour. 162,068 patients attended our Emergency Department last year, 31,835 of these needed treatment as an inpatient. This performance has meant that we have remained one of the top performing Trusts across the country for ambulance handovers and Emergency Department waiting times.

Cancer performance

We recognise the impact on patients who have been referred to us for a suspected cancer to be diagnosed or have cancer ruled out, so it has been important to us to achieve the 28-Day Faster Diagnosis Standard, ensuring our patients are diagnosed as soon as possible and that diagnoses are confirmed for over 77% of our patients within 28 days of being referred to us.

Unfortunately, we have not been able to maintain performance to ensure that patients are not wait longer than 62 days for their treatment for the last six months of the year. This is a key priority focus for us for this coming year.

Planned care

NHS targets for patients waiting for planned care changed at the end of March 2024, with the 78-week standard being reduced to 65-weeks. To achieve this standard, we held additional clinics, and theatre lists at weekends and in the evenings.
Looking forward to 2025 – 26, we are required to reduce waiting times to no longer than 52-weeks with 60% of our patients treated within 18 weeks. All patients who have waited over 12-weeks are contacted through their preferred communication route to identify if patients still require an appointment or their priority may have changed requiring us to bring their treatment forward.

We monitor patients our longest waiting lists through our Clinical Harm Review Group.

Older Peoples Medicine

Demand for frailty services is growing, most of us are living longer. Over half of the people in England aged between 65 to 74 years have at least one long term condition. It is also expected that the number of people aged 85 years and over who will have dementia, or another long-term condition will double in the future.

Within the population we serve, 1 in 4 of our patients is 65 years or over and in the last year we have seen a 14% increase in the number of attendances in the Emergency Department and a 9% increase in admissions for patients in this age range.

To move patient care closer to our patients we, in partnership with the Integrated Care Board have established a clinic for patients with chronic respiratory disease at Dereham Community Hospital, which is led by one of our Consultants and a senior General Practitioner (GP). The clinic has helped reduce outpatient waiting lists and allows patients to be seen sooner.

At the beginning of the year, we established a new clinic for heart failure patients, based at Cromer Hospital. This enables patients in North Norfolk to be treated closer to their home. This will improve their experience of care with reduced symptoms and a better quality of life for these patients and decrease the need for admissions.

Over the last 6 months we have been reviewing the care, treatment, and length of stay for our older patients. We know that the longer a patient stays in hospital when they no longer require acute clinical care is detrimental to their longer-term wellbeing.

In December 2024, we developed a frailty model, this has changed our practice as we now triage patients to the appropriate speciality based on their clinical need instead of their age. To do this, we have trained staff in how to assess and record a Clinical Frailty Score (CFS) by using an application which incorporates an NHS recognised frailty system called ‘Rockwood.’ The quality of this model has been evaluated and been implemented across our medical inpatient areas from February 2025.

We have already seen improvements to the quality and outcomes of care for this patient group, through a reduction in their length of stay from 10.8 to 8.3 days. There has been 13% increase to the number of patients who stay between one and three days, and those that stay with us for more than 7 days has decreased by 15%. We have also been able to support an additional 10% of our patients return to their normal place of residence upon discharge, which really is a quality outcome for these individuals and their families.

In June 2024 a Falls Support Pathway was created for patients presenting at our Emergency Department (ED) and Cromer Minor Injuries Unit (MIU) post fall and who were discharged home without admission. These patients are followed up by their District Councils who will offer holistic support opportunities with a view to preventing further falls and subsequent attendances at hospital. So far 1183 onward referrals have been made supporting 403 patients. Expansion of the project is now being considered using population health and our hospital data to move to a more targeted preventative service, in line with proactive intervention projects at Norfolk County Council. Detailed data evaluation and service user focus groups are currently being worked on as part of the ongoing project.

Staff survey

We maintained the response rate of 47% for the NHS staff survey in 2024, which is slightly lower than the Acute Trust average of 49%. We are included in a group of 122 acute and community providers for national benchmarking.

Compared to the 2023 survey, four of the seven People Promise themes improved, as well as staff engagement and morale. It is great to see that the largest improvement is 'we are always learning', especially as we are a University Hospital. It is good news that we also scored above average within our group for 'we work flexibly.'

I am pleased to acknowledge improvements across 17 of the 108 questions from last year, where we scored comparable with or above within our group, compared to five questions for 2023. We had three questions comparably within the lowest scores, where we had seven previously.

Listening to our staff is especially important to me. The best way I have been able to achieve this during the last year is by committing diary time to Gemba's. A Gemba walk is derived from the Japanese word Gemba or Gembutsu, which means 'the real place.' When I undertake these walks, I spend a couple of hours in different areas to observe and understand processes first hand. It has been the most invaluable and true insight I have had of what happens in our hospital. As staff and patients have got used to me and these walks, they used these opportunities to put forward all sorts of really innovative ideas about how to improve quality across the organisation. My plan is to support staff to be able to implement these ideas and to do this we are changing our clinical structures for 2025 to return decision making and quality improvement back to those who are closest to looking after our patients.

Looking forward to the year ahead, we will see changes, starting with the commencement of our smaller Clinical Care Groups instead of bigger divisions. We have removed layers of management to ensure that decisions are made by those who are closer to service and responsible for delivering care. We have entered a Group model which will oversee all three Acute Trusts within Norfolk & Waveney.
I am delighted to announce that I have recently been appointed as the inaugural Group Chief Executive for the new Norfolk & Waveney University Hospitals Group, which means I will head up the leadership teams at all three hospitals. I truly believe that 'we're better together' and look forward to working with everyone in this role.

We will be focusing on the quality and care of our patients and their families through implementation of our operational plan for 2025 to 2026. Finally, I am immensely proud of the leadership and our staff for the work conducted throughout times which require us to work differently.

I confirm, that to the best of my knowledge the information contained within this report reflects a true, accurate and balanced picture of our performance.

Lesley Dwyer
Chief Executive

Our Chair – Tom Spink

As always, I would like to offer my sincere thanks to all our staff and volunteers who always work so hard to ensure the safe and effective care of our patients.

We continue to provide care to patients and their families across Norfolk and Waveney, and further afield for our tertiary specialities, working alongside and in partnership with a variety of other organisations. In addition, I would like to thank the many learning institution. The University of East Anglia (UEA) is one example who collaborate with us to train and develop our staff and our learners who will hopefully become our future workforce. The UEA, along with our other partners, including those on the Norwich Research Park, offer development opportunities and enhanced skills to our staff at all levels, and for our patients, it offers earlier access to new treatments, improved diagnosis, and better outcomes.

The adaptability of our staff to be able to respond to different pressures, to maintain and improve performance across a number of areas is a credit to our organisation, which is starting to be reflected in our staff survey results and continues through external recognition of some of our staff for their excellent work.

Hearing from our patients of all ages, their families and our staff is of immense importance to us. In addition to reviewing and using patient feedback via PALs, regular surveys and complaints, we also listen to patients who present their stories to Trust Board meetings, and we dedicate time prior to each meeting for our Executive Directors and Non-Executive Directors to visit areas throughout the organisation in small groups to speak with patients, families, and staff. This provides an additional perspective and provides further real time assurance to us on the quality of care our patients receive and their experience, as well as that of their families.

The Trust also benefits from having an excellent, committed, and talented Council of Governors who bring issues to the attention of Non-Executive Directors, through their interaction with members of the public, our patients, and staff.

Our Freedom to Speak up service is vital to support our staff and to protect patient safety and the quality of care. Our service followed the national trend with the largest number of matters raised in 2024. The most meaningful change for us as an organisation is that the number of anonymous matters raised to a Guardian has reduced which is a positive finding as it supports that our culture has started on the journey of where we would like it to be.

I look forward to the year ahead as we enter a Group Operating model, which will oversee all three Acute Trusts within Norfolk & Waveney.

Tom Spink
Chair

Our Chief Nurse – Rachael Cocker

This is my first Quality Account, following my substantive appointment as Chief Nurse in September 2024. It has and remains personally important to me to be able to continue to practice clinically as the nurse and midwife I initially trained to be. This keeps me connected with how nursing, midwifery, Allied Health Professionals (AHPs), healthcare scientists and administrative staff provide care to our patients and their families, at the level of quality that we would want. I have been able to fulfil this commitment throughout the year across different areas, times of the day, including a night shift and when the hospital has been at various levels of activity.

As an executive leadership team, we have had to make tough and morally challenging decisions to use escalation areas and Temporary Escalation Spaces (TES) knowing that this will provide care for our patients but not provide the level of holistic experience we would wish. When we use these spaces, it is to balance keeping the patients safe who we have seen and are in our hospitals, compared to those in the community not seen, by releasing ambulances to be able to provide that first line emergency care. We have made improvements in the last year for when we need to use escalation spaces to ensure that these patients have basics such as tables, call bells, and privacy screens. We do not accept that using escalation spaces is normal practice and as part of our daily huddles we work closely to take action to reduce the number of patients in these spaces.

An area of quality of care that often gets forgotten, is being able to see or visit someone who is important to you whilst you or they are in hospital, this can cause unnecessary worry on both sides. We have listened to our patients, their families, carers, and our staff and undertaken a review of our visiting hours in the latter part of the year. As a result, we launched our extended visiting hours which now run from 10am until 8pm to ensure that significant people for our patients can be present to provide support about their care and advocate for those who may not be able to represent themselves. We are still on a journey with this, but I would genuinely like to thank everyone who has contributed to this positive change.

My career has spanned several years, and the experience I have gained has meant I have high patient focused standards; therefore, it would be remiss of me not to say that we do not always get things right for our patients, their families, or our staff. To address these issues, we have implemented initiatives across the hospital, some of these are new, and we will take these forward further next year.

We have continued to learn from patient safety incidents, how we investigate them and learn from them by triangulating data from a variety of sources of information. Quality priorities are a specific area of focus. We have selected from these sources of information to define improvements to enhance the quality of care delivered to our patients and to support our staff who provide care through learning and training. The Accreditation of Excellence scheme is putting ownership back to our clinical areas to be proud of what they and their multidisciplinary teams do, allowing the quality of care they provide to be recognised by a rating, with ‘Platinum’ being the highest once they have evidenced, they can maintain that standard.

Looking forward into 2025 through to 2026, we have a lot of change to work through, including the introduction of the new National NHS uniforms, designed so patients and their families can recognise more easily the staff group looking after them, at any NHS hospital. My focus and that of those I lead will remain to have the interest of our patients and their families at the heart of what we do.

Finally, I would like to express my thanks to the humility and kindness I have encountered from our patients and their families, and the teamwork and commitment from our staff and volunteers to provide care to our patients.

Rachael Cocker
Chief Nurse

Our Medical Director – Bernard Brett

It has been a privilege to serve as Medical Director at the Norfolk and Norwich University Hospital following my substantive appointment in October 2024 and since then, we have made meaningful progress in improving quality and safety across several areas.

In the last six months, I have appointed two Deputy Medical Directors to support our ambitions: Tarnya Marshall, Deputy Medical Director for Quality, Safety & Clinical Transformation, and Russell Phillips, Deputy Medical Director for Workforce & Professional Standards. Their expertise and leadership are already making a positive impact across the organisation.

We continue to navigate a particularly challenging time for the NHS. The lasting effects of the pandemic on elective recovery, combined with unprecedented demand for emergency care, have placed considerable pressure on our services. In addition, the financial environment demands that we operate with ever-greater efficiency within our resources. Despite these challenges, our staff and volunteers have consistently delivered safe, compassionate, and effective care to patients and their families for which I would like to extend my heartfelt thanks to every one of you for your continued commitment and resilience. You remain our most valuable asset, and your dedication does not go unnoticed.

One area of significant progress this year is the work in our response to enhanced monitoring by the General Medical Council (GMC). You may know, the GMC imposed conditions requiring us to improve the education and training experience for resident doctors within medicine and surgery. Thanks to close collaboration between our resident doctors, medical educators, and education teams, we've made significant strides, but we know we have further to go. We continue to work with the GMC and NHS England as we pursue our ambition to become the leading centre for medical education in the East of England.

Among the GMC's conditions was a requirement to improve our organisational culture and address inappropriate behaviours. This is a cause I care deeply about, and one that is equally important to my executive colleagues. Together, our stance is that racism, misogyny, and any form of discrimination will not be tolerated. We have strengthened our mechanisms for raising concerns safely and without fear of reprisal. Thank you to those who have already stepped forward and I want to encourage others to do the same. The launch of our cultural lecture series which is open to all staff, and our new Sexual Safety at Work Policy are our latest initiatives in our cultural journey.

Clinically, we have transformed the way in which we manage frailty, triaging patients based on individual needs rather than age. This has enhanced care quality, and safely and appropriately reduced length of stay. This work also positions us to better serve the growing needs of our ageing population.

The Trust is undergoing a clinical restructure, and whilst this may be unsettling, and I know many have found this difficult, I'm excited about the opportunities this presents. The divisional structure is moving to 10 care groups which offers greater autonomy and accountability to teams closest to patient care, enabling more responsive and clinically led service delivery.

Additionally, the launch of the Norfolk and Waveney University Hospitals Group strengthens our collective ability to deliver high-quality care across the region and I look forward to working closer with the James Paget and Queen Elizabeth Hospitals within the Group model. Whilst we are addressing health inequalities within our own organisation, the group model will help reduce the impact of health inequalities on a wider population and help us develop more resilient, sustainable, safe and effective services.

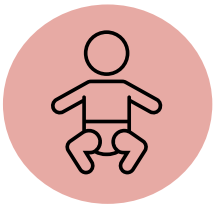
In closing, please may I thank our staff and volunteers once again for your dedication. My personal commitment is to the continued improvement of the clinical services we provide and the continued improvement in the education, training, and development of staff. Improving our workplace culture is a core component to every ting that we do – this is not only essential in improving the experience for our staff, but also a key component to enable us to continue to improve our excellent clinical care. I remain very proud to be medical director of this organisation and look forward to continuing our work together.

Bernard Brett
Medical Director

Our year on a page…

We have
1,391
hospital beds for patients

Welcomed
4,730
babies into the world



Provided
108,755
outpatient appointments

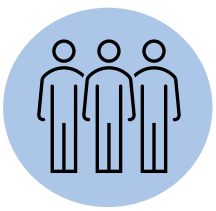
Served
1,172,388
patient meals

1,500 medical students, doctors and dentists trained

1,000 nurses, midwives and allied health professionals trained

Carried out
35,836
patient surgeries

Had a team of
9,970
brilliant staff working across the sites



Enrolled
167
staff on apprenticeships

Looked after
162,068
people within our Emergency Departments

N&N Hospitals Charity backed funding for seven research projects

An innovation fund uniting Quadram Institute scientists and our clinicians has selected seven new projects for funding

The Quadram Institute Clinical Seedcorn Fund was first established in 2021/2022 to help clinicians develop research ideas with scientists at the Quadram Institute. The fund supports secondments of NHS staff to Quadram Institute laboratories and associated research costs.

Quadram Institute Bioscience (QIB) and the N&N Hospitals Charity, have provided £150,000 each to jointly fund £300,000 of new collaborative projects.

The seven clinical research projects funded this year are:

- The role of the gut microbiome in pregnancy: Dr Antonietta Hayhoe and Prof Jonathan Lartey
- Characterising the microbiome in relation to cholestatic liver disease: Dr Naiara Beraza and Dr Simon Rushbrook
- Vitamin B12 and folate sufficiency in very pre-term babies at the time of discharge home: Prof Martin Warren and Dr Isabel Iglesias-Platas
- Bloodstream infection diagnosis using metagenomics: Dr Matthew Gilmour and Dr Ngozi Elumogo
- Establishment of an Oral Biorepository: Dr Jennifer Ahn-Jarvis and Prof John Phillips
- Use of organ-on-chip technology to address resistance to fungal infection in women:- Dr Emily Jones and Dr Paul Simpson
- Decreasing risk of urinary tract infections in Type 2 diabetes mellitus patients: Prof Alison Mather and Dr Jason Cheung.

Photo below of inside the Quadram Institute

Applications were assessed by a panel drawn from across NNUHFT, QIB and UEA and considered applications for potential patient benefit, quality, feasibility, extent of collaboration, innovation and value for money.

Bernard Brett, Medical Director, said: *"Our hospital is working with our Norwich research partners, including the Quadram Institute to strengthen our contribution to research that can positively impact on the lives or our population and patients. We're one of the four partners in the Quadram Institute and working together the partnership is serving to increase knowledge and deliver benefits for our patients. This is important work, and we are delighted that our Hospitals Charity is supporting the research and innovation of NNUHFT clinicians working alongside scientists from the Quadram Institute. Congratulations to the successful teams whose projects have been accepted for funding, I look forward to seeing the results of these studies in the future."*

Quadram Institute interim Director Prof Martin Warren said: "It's great to see NNUHFT clinicians working with scientists at the Quadram to understand more about some of the healthcare challenges they face daily, and how we can understand and then tackle them for the benefit of patients."

To find out more about the N&N Hospitals Charity or to make a donation please visit:
www.nnhospitalscharity.org.uk

Our Trust PRIDE Values

People Focused: We look after the needs of our patients, carers and colleagues to provide a safe and caring experience for all

Respect: We act with care, compassion and kindness and value others' diverse needs

Integrity: We take an honest, open and ethical approach to everything we do

Dedication: We work as one team and support each other to maintain the highest professional standards

Excellence: We continuously learn and improve to achieve the best outcomes for our patients and our hospital

Part 2 – Priorities for improvement and Board Assurance Statements…

Our paediatric theatres complex celebrated its first birthday on 9 January.

Over the past year the team has carried out a wide range of procedures including:

- Oesophageal and bowel reconstructions in newborn babies
- Major hip joint repairs in children with cerebral palsy
- Kidney drainage procedures using keyhole surgery

The Plastics team has also performed some intricate cases, such as forming thumbs out of fingers (pollicisation).

Some of the more frequent, less complex cases include:

- 190 tooth extractions
- 120 tonsillectomies

The team has also handled an extra 100 emergency cases.

The Jenny Lind Theatres Complex team has worked hard to increase use of the theatres and in December exceeded the national 85% utilisation target, with over 80% of cases achieved as day cases.

"*This is a reflection of the hard work and efforts put in by the team – it is a fantastic end to our first year*" said Clinical Lead Caroline Banson.

In feedback from patients and their families, staff have been praised for creating a relaxed atmosphere with plenty of laughter. One patient praised the staff for "*making me laugh*" and another for "*helping me feel comfortable and safe*.". Parents were equally positive, with feedback saying: "*Everyone was kind and friendly. Made myself and my child feel at ease*."

Caroline added: "*I can't believe it is already a year. We have been very busy and it is such a pleasant environment to be in. It is pleasing to see so many patients have had a positive experience with us, and it could not have been achieved without my wonderful team, so thank you team JLTC. We were not able to have a full-blown opening ceremony, so we thought it would be nice to mark our first birthday*."

- The complex consists of a twin paediatric theatre suite, a recovery unit and associated staff and patient supporting facilities. Part of a N&N Hospitals Charity grant also paid for engaging artwork by Norfolk artist Toby Rampton and Norfolk storyteller Amanda Smith, who provided a narrative to run alongside the artwork.
- Sustainability is also high on the agenda, with Consultant Paediatric Anaesthetist Amy Greengrass leading the way. The team will continue with waste segregation to reduce emissions from waste and aim to use cylinders of nitrous oxide (gas and air) to avoid leakages and waste of a potent greenhouse gas known to be associated with piped nitrous oxide.

Part 2.1 - Priorities for improvement

Introduction to Quality Priorities

Photo of the Community Diagnostic Centre (photo courtesy of Morgan Sindall)

2025/2026 Quality Priorities

Each of the 12 quality priorities established for 2024/25 involves work extending beyond a single year. Consequently, these priorities remain relevant in the current year. A detailed update on the progress achieved thus far, along with the work plan for the upcoming year, is outlined in the 'Quality Priorities Update'.

The priorities have been aligned with Chief Executive Officer's strategic commitments to support continuous improvement and to reduce some of our highest risks. In addition, they are linked to the Norfolk and Waveney Integrated Care System (ICS) quality priorities published in their Quality Strategy. The four priorities are:

1. Well-Led through a culture of compassionate leadership.
2. Focussed on improving care quality and outcomes.
3. Using insights around health inequalities and population health to achieve fair outcomes.
4. Ensuring services are safe and sustainable for now and for future generations.

Photo of the North Norfolk Macmillan Centre - Cromer

Patient Safety

QP1 – Care of patients who are frail: Develop Comprehensive Acute Frailty Services	
Rationale	Patients who are frail make up a substantial proportion of patients presenting to urgent and emergency care settings. Early, comprehensive assessment of these patients can improve outcomes by ensuring the acute care, management pathway, and future care plans are all tailored appropriately to the patient's needs. An Acute Frailty service routinely and systematically identifies and grades frailty in people who present acutely to Urgent and Emergency Care services. These services then consider the personalised needs of individuals living with frailty, considering their grade of frailty and degree of illness, supported by clear reliable pathways into and out of hospitals, aligned to the grade of frailty identified. The aim is to provide care in the right place, first time. This may be in the patient's home for a group of patients or through Same Day Emergency Care (SDEC) aiming to get the patient home with onward care as soon as initial diagnostics and treatment have been initiated. SDEC aims to reduce admissions and thus deconditioning of patients who would otherwise be admitted to hospital.
How these will be monitored and measured	• Standardised mortality rates • Patient experience • Quality Indicator 'Identification and response to frailty in emergency departments'
Executive Lead and Delivery Leads	Medical Director
Progress during 2024/2025	• Frailty app implemented change how frailty patients should be triaged • Change from age-based speciality triage to clinical needs triage. • Overall reduction in the length of stay for our Older Peoples Medicine (OPM) from 10.8 to 8.3 when compared to the same 3 Months (Jan to Mar) in 2024
Workplans for 2025/2026	• Continued use and expansion of the frailty app to identify our most frail patients

	• Working with community partners to reduce admissions from care homes. • Scoping, design and implementation of a single point of access for > 65 years old patients. Incorporating inpatient and outpatient services for our frail patients

QP2 – Reducing our standardised mortality scores through specific pathway improvement and clinical data quality improvement: Early recognition of Deterioration and Sepsis, and implementation of Martha's rule	
Rationale	Acute physical deterioration can occur in any health and care setting and is a dynamic process in which a patient becomes suddenly more ill, potentially leading to death. It can be identified by changes in standard physiological indicators. Early identification of clinical deterioration is important in preventing subsequent cardiopulmonary arrest and to reduce mortality. Sepsis is a life-threatening emergency in which timely diagnosis and emergency therapy has been shown to reduce mortality. Evidence indicates that access to a rapid review from a critical care outreach team (CCOT) or paediatric critical care outreach team is an additional and beneficial safety net in the identification, escalation and response to deterioration.
How these will be monitored and measured	• Reducing standardised mortality scores from current baseline • Patient experience 'being listened to' and achievement of key milestones for implementation of Martha's Rule. • Increase in the percentage of patients with timely repeat observations • Monitor Trust compliance of NEWS2 eLearning Package • Timely medical response to NEWS2 score trigger
Executive Lead and Delivery Leads	Medical Director Rapid Response Team Matron Consultant Lead for Acute Medical Unit (AMU)
Progress during 2024/2025	• Call for concern (Martha's rule) service available in adult & paediatrics to allow patients, relatives, carers, and staff to have 24/7 access to a dedicated team with specialised training in treating and recognising deteriorating patients • The NEWS2 standard operating procedure has launched which clearly identifies monitoring, escalation and medical attendance expectations in line with Royal College of Physicians. • An updated Recognise & Respond Team referral process has been launched with a renewed focus on 'clinical concern'. • The NEWS2 escalation sticker has been launched to provide standardised documentation within the patients notes. • Updated NEWS2 e-learning package for clinical staff.

	• Education for staff on SEPSIS now includes all staff on clinical induction.
Workplans for 2025/2026	• Launch of the Acute Admitting areas and In Patient Management of Sepsis Standard Operating Procedure • Development of Martha's rule for ED & Maternity • Continuing to work with digital health to develop a patient wellness questionnaire. • Ensuring that the Electronic Patient Record supports the early recognition of the deteriorating patient.

QP3 – Reducing our standardised mortality scores through specific pathway improvement and clinical data quality improvement: Heart Failure Pathways	
Rationale	Across Norfolk there are 8,600 patients who have been diagnosed with heart failure by their GP, but there are probably another 6,000 to 10,000 who haven't been diagnosed yet. Heart failure patients can rapidly deteriorate, leading to long hospital admissions, and this condition is the most frequent cause of hospitalisation for over 65-year-olds. Currently there are gaps in provision and many undiagnosed patients are seen in our Emergency Department. By establishing a dedicated service, we can achieve better continuity of care and a better experience for patients, their families and the clinicians. Last year there were 1,600 admissions, accounting for 17,000 hospital bed days for patients with heart failure. Hospitals admissions are expensive, they can also be harmful for patients, reducing their mobility and independence, and by intervening earlier we hope to avoid them.
How these will be monitored and measured	• Reducing our standardised mortality scores for heart failure pathways • Improve patient experience: by removing delays, provide appropriate assessment to support shared decision making about priorities of care and treatments. • Evidence of a standardised approach to the treatment of heart failure patients across all the healthcare providers in Norfolk and Waveney.
Executive Lead and Delivery Leads	Medical Director Cardiology Consultant (Heart Failure)
Progress during 2024/2025	• Gap analysis of the heart failure pathway from diagnosis, referral, treatment and management, and end of life care. • Open access cardiology multi-disciplinary team meetings have been established, allowing GPs within the system to attend, fostering greater communication and shared clinical insight. • Acute Trusts have delivered in-depth presentations, providing valuable opportunities to share best practice and promote wider learning across the system.

Workplans for 2025/2026	• Finalise the gap analysis to understand current service provision and future needs. • To explore the feasibility of establishing a joint Respiratory and Heart Failure clinic, building on the successful outcomes of the respiratory clinic pilot. • Strengthen the monitoring and analysis of heart failure-related mortality rates and mortality insight data to generate actionable intelligence and drive improvements in outcomes.

QP4 – Hospital@Night (H@N) transformation programme optimising out of hours care to deliver high quality safe care at night and supporting the wellbeing of those working at night.	
Rationale	Hospital at Night is a clinically driven and patient focused approach to managing care out of hours, which has the capacity to call in specialist expertise when necessary. It advocates supervised multi-speciality handovers; other staff taking on some of the work traditionally done by junior doctors and moving a significant proportion of non-urgent work for the night to the evening or daytime. There is an emphasis on team working and flexibility across Specialities. The existing Hospital at Night model has been in place since January 2012 when the Trust made a commitment to working towards a 24/7 approach to the deteriorating ward patient and Hospital at Night was renamed Hospital 24/7. This Quality Priority will review the current hospital 24/7 model to ensure that it encompasses all hospital wide escalation processes including but not limited to, Recognise and Respond Team, and use of Alertive to provide safe care at night.
How these will be monitored and measured	• Response times to H@N requests • Staff experience of H@N • Evidence of updated 24/7 handbook
Executive Lead and Delivery Leads	Medical Director H@N Site Matron Medicine Division Chief of Division
Progress during 2024/2025	• Hospital at night rota adjusted to increase senior medical cover • Administrator employed to monitor hospital at night rota • Reduction in the use of locum cover for Hospital at Night • Development of standard operating procedure for the Senior Physician of the night. • Handbook developed for Hospital at Night to standardise practice • Induction updated to include the role of Hospital at Night. • Formal handover meeting for medical teams, highlighting staffing position and patients requiring further review.
Workplans for 2025/2026	• Align the use of Hospital of Night within the new Care Groups • Reduce the number of inappropriate Hospital at Night requests, ensuring that time critical requests are seen within an agreed timeframe

	• Ongoing education to Care Groups to ensure that Hospital at Night processes is used by all clinical teams • Continued review of planned rosters and short-term cover requirements • Continued reduction in Locum cover for Hospital at Night rota

Clinical Effectiveness

QP5 – Reducing our standardised mortality scores through specific pathway improvement and clinical data quality improvement: Frailty and Fragility Fractures, Management of Older Major Trauma Patients	
Rationale	The care of patients with fragility fractures of the femur has long demonstrated the importance of the coordinated input of multiple specialties in improving patient outcome. Concerted and effective pathways involve nurses, doctors, therapist and allied healthcare professionals both in hospital and in the community setting. Ageing, comorbid disease, medications and frailty may all affect the expected physiological presentation of major trauma in older people. Many patients with orthopaedic trauma injuries have to be admitted to hospital, most frequently due to associated frailty, immobility or co-morbidities. Older patients have been consistently shown to have poorer outcomes following rib fractures, which may be related to: • Multiple comorbidities; • Reduced physiological reserve; • Greater difficulty in assessing and managing hemodynamics.
How these will be monitored and measured	• Reducing our standardised mortality scores for specific pathways • Improve patient experience: by removing delays, provide appropriate assessment to support shared decision making about priorities of care and treatments
Executive Lead and Delivery Leads	Medical Director Deputy Medical Director
Progress during 2024/2025	• Fragility Fractures Oversight group established • Sustained improvement in fractured neck of femur mortality and outcomes • Continued adherence to direct admission of patients to the dedicated neck of femur ward • Launch of North Norfolk Falls & Frailty Prevention Project for patients attending the Emergency Department following a fall; providing bespoke follow up social care interventions.
Workplans for 2025/2026	• Expansion of scope of current femoral fractures pathway to include distal, shaft, and peri-prosthetic.

	• To reduce mortality and variation whilst improve patient outcomes across a larger patient group by adhering to the best practice pathway for fractured neck of femur. • Embedding national GIRFT (Getting It Right First Time) NAFF (Non-Ambulatory Fragility Fractures) guidance and recommendations. Working with colleagues across the ICS and Norfolk and Waveney University Hospitals Group to implement recommendations in a consistent manner to benefit the patient. • Fragility Fractures Oversight Group to lead development and implementation of an updated rib fractures pathway at NNUHFT utilising insights, data, audit and validated clinical scores such as the BATTLE score to improve patient outcomes.

QP6 – Improving Patient Flow to improve patient and staff experience and reduce number of patients cared for in escalation areas	
Rationale	Improving patient flow is not just about resourcing and expanding urgent and emergency care capacity to keep pace with rising demand – it is also about delivering transformation in how services are delivered, expanding out-of-hospital capacity, embedding preventative approaches and realising the benefits of emerging technologies.
How these will be monitored and measured	Improvement measures to include: • Patient experience • Reduction in the number of escalation beds • Virtual ward dashboard metrics • Door to needle time (AOS)
Executive Lead and Delivery Leads	Director of Operations Medicine Division Triumvirate
Progress during 2024/2025	• Reduction in average length of stay to 6.8 days from 7.2 in 23/24 • 15% of daily discharges pre-noon • Change in Transfer of Care process to reduce intra-hospital delays
Workplans for 2025/2026	• Single front door; reviewing the current processes into specialties with the aim to create a simpler pathway • Admission avoidance; building on current pathways and focusing on Acute Chronic specialities • Discharge; working with partners to reduce patients waiting over 7 days for P1-P3 care • Frailty; Incorporating inpatient and outpatient services

QP7 – Elective care recovery and Theatre Transformation / Cancer services	
Rationale	In line with 2024-2025 operational planning guidance to support elective care, a Theatre Transformation Programme has been implemented. The aim of this programme is to first drive an increase in theatre utilisation towards 85% and second, increase the level of day case procedures to 85%. This increase in both theatre utilisation and increased levels of day case procedures will help to reduce current waiting lists, whilst ensuring patients are getting the right care in the right location.
How these will be monitored and measured	• Reduction in on-the-day cancellations • Improved theatre utilisation tracked through Data Matrix System • Theatre utilisation rates target 85% • Rate of Day case target 85% • Reduction in agency spend
Executive Lead and Delivery Leads	Director of Operations Transformation lead(s)
Progress during 2024/2025	• An 50% increase in Pre-operative Assessment capacity • The opening of the Norfolk and Norwich Orthopaedic Centre (NaNOC) to increase orthopaedic elective capacity • An increase in elective theatre utilisation to 84% in 24/25, 3% above the peer average & 1% of the national target of 85% • Reduction in last minute list cancellations.
Workplans for 2025/2026	• Productive partners supporting deep dive with selected specialities to improve theatre utilisation. • On-going work on theatre scheduling to improve productivity and reduction in last minute cancellations. • Patient empowerment to reduce on the day cancellations

QP8 – Pharmacy Transformation Programme: delivering high quality efficient, productive care.	
Rationale	Recruitment and retention challenges (national shortages, plus competition with primary care roles and band inflation at neighbouring acute trusts) Inadequate job cover and succession planning for key roles (single point of failure). Inadequate levels of pharmacy staff to be able to provide reliable services to ward / departments and train new starters / students. Low staff morale and full potential of Pharmacist and Pharmacy Technician roles not understood or utilised by wider Trust. Lack of capacity to participate in clinical and practice research, and to deliver value added pharmaceutical clinical support for in patients and outpatient clinics.
How these will be monitored and measured	• % automation, patient & staff satisfaction, error rate, medicines reconciliation (MR) rate

	• Patient satisfaction, Dispensing Turnaround time, Reduction in Missed doses • Error rates and critical incidents • % growth of clinical trials and practice research • Cost Improvement Programme (CIP) Savings
Executive Lead and Delivery Leads	Medical Director Chief Pharmacist Clinical Support Services Division Director of Operations
Progress during 2024/2025	• Retained all trainee pharmacists, commencing employment as newly qualified pharmacists in Aug/Sept 2025 • Expansion of the Education and Training Team to provide continued education of pre-registration pharmacy technicians. • Tendered for a new robot and awarded to current supplier. • Re-design of stock storage to improve efficiency in prescription assembly. • Increased pharmacy technician time on the wards to support medicines reconciliation and reduction in dispensing duplication.
Workplans for 2025/2026	• Increase in training of pre-registration pharmacy technicians and Science Manufacturing Technicians to continue the 'Grow our Own' workforce strategy. • New Robot installation; followed by space utilisation in the pharmacy footprint. • Expansion of digital top-up and goods receipting in clinical areas. • Automated Medicines reconciliation with the delivery of the electronic patient record (EPR) project.

QP9 – Health Inequalities: Equality, Diversity and Inclusion (EDI) and Diversity, Inclusion and Belonging (DIB) including developing and delivering a Core20PLUS5 plan	
Rationale	For some people there are still unfair and avoidable inequalities in their health as well as their access to and experiences of NHS services. Health inequalities are the preventable, unfair and unjust differences in health status between groups, populations or individuals that arise from the unequal distribution of social, environmental, and economic conditions within societies. They can determine the risk of people getting ill, their ability to prevent sickness, or their opportunities to take action and access treatment when ill health occurs. The approach defines a target population cohort – the 'Core20PLUS' – and identifies '5' focus clinical areas requiring accelerated improvement.
How these will be monitored and measured	• Completed self-assessment. • Approved improvement plan based on self- assessment. • Evidence of ongoing progress against improvement plans for each workstream.

Executive Lead and Delivery Leads	Medical Director Associate Medical Director Primary Care and Integration Named workstream leads
Progress during 2024/2025	• 6 NNUHFT staff members supported as Core20PLUS5 Ambassadors; supported from a national level to form local, regional and national networks to improve healthcare inequalities. • NNUHFT Health inequalities board in place, chaired by the deputy medical director
Workplans for 2025/2026	• Review of Health Inequalities will continue via the new Board. • Review of the ICS PowerBI Report to identify any potential areas of review • Review of current work taking place in the Trust on Health Inequalities to identify areas of good practice, to look for opportunities for organisational roll out • Benchmarking within the Norfolk & Waveney University Hospitals Group to standardise and transfer organisational knowledge

Patient and Staff Experience

QP10 – Transition Pathways for young people	
Rationale	The transfer of health care for children and young people into adult services can often be difficult. In many cases, the health needs of young people will have been met by the same people who have looked after them for as long as the child or young person can remember. As they reach adulthood, they 'transition' to an adult healthcare environment and may be faced with having to consult with several different health teams, therapy teams and adult social care services. This Quality Priority will ensure that no child or young person will become lost in the gaps between children and adult services, and their experience of moving between services will be safe, well planned and prepared for. They will feel supported and empowered to make decisions about their health and social care needs.
How these will be monitored and measured	• Evidence that Quality Standards (QS140) have been met • Patient experience
Executive Lead and Delivery Leads	Chief Nurse Lead Transition Nurse
Progress during 2024/2025	• Epilepsy pathway in development with the ICB • Diabetes Pathway – Electronic data on number of patients on diabetes transition, allowing a link with consultant and location of appointments • Quality Improvement (QI) project underway on young people's inpatient/ emergency experience post transition

Workplans for 2025/2026	• Identification of numbers of patients who require transition for 2025/26 • Review transition data and identify specialities and pathways to ensure that they are smooth transition to adult services in primary, secondary and tertiary care. Identifying those specialities to target in Q2-4 in 2025/26 • Ready, steady, go paperwork to reviewed and built into the Electronic Patient Record

QP11 – Improving Communication around End-of-Life Care	
Rationale	Poor communication with patients as they approach the end of their life is a recurring theme in complaints, feedback from the Medical Examiner reviews, Structured Judgement Reviews and in the results of the National Audit of Care at the End of Life (NACEL). NNUFT has around 3000 deaths per year during admission or in the 30 days after discharge, and it is estimated that 30% of inpatients in acute hospitals are likely to be in their final year of life. As stated in the "Ambitions for Palliative and End of Life Care National Framework", end of life care "has to be considered as everybody's business". This is because the majority of end-of-life care will be carried out by generalists working in all specialties across the hospital. Good communication, advance care planning and individualisation of care are recognised to be essential components of good end-of-life care in the National End of Life Care Strategy (2008), Ambitions for Palliative and End of Life Care National Framework 2021-2026, and National Institute for Health and Clinical Excellence (NICE) Quality Standard QS144 (2017). The Integrated Care Board has recently carried out a review which identified the actions that are urgently required to ensure that it delivers its statutory duty in the provision of palliative and end-of-life Care for Norfolk and Waveney, in accordance with the National Delivery Plan. The delivery of personalised care and to support planning was one of those urgent priorities. Improving the timing, quality and effectiveness of communication with patients and their loved ones offers an opportunity to greatly enhance the quality of the care experienced by our patients. By identifying and clarifying patient's wishes and preferences as they approach the end of their life, good communication has the potential to not only enhance patient autonomy but can also reduce unwanted attendances at the Emergency Department, reduce admission to hospital, and shorten length of stay in hospital.
How these will be monitored and measured	• Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) audit • Individualised Plan of Care (IPOC) audit • Reduction in complaints related to communication at End of Life (EOL) • Improvement in communication identified through Structured Judgement Review (SJR) • Increase in numbers of patients with a documented Advanced Care Plan (ACP) • EOL care lead appointed

	• Increase in patients achieving preferred place of death (via Inter Deanery Transfer (IDT) data)
Executive Lead and Delivery Leads	Chief Nurse Palliative Care Consultant and Specialty leads
Progress during 2024/2025	• Accreditation of Excellence program focused on Palliative and End of Life Care (PEOLC) to establish our baseline metrics. • The launch of 3 tiers of ReSPECT training for all staff • A finalised ICB Norfolk & Waveney ReSPECT policy • A standardised Fast Track Discharge checklist and information booklet across all 3 acutes. • An approved Community Support and Information Hub at the NNUHFT, which will host support services clinics from across the Norfolk & Waveney system. • The launch of a one-day advance care planning clinic in Cromer.
Measures for 2025/2026	• Ensuring that the electronic patient record can record a primary and secondary preferred place of death for patients • Increased number of patients dying in their preferred place of death • Standardise the recording of ReSPECT training to allow organisational overview • 90% compliance of Tier 3 ReSPECT training

QP12 – Improving learner experience	
Rationale	To meet requirement of education contract, and obligation as a University Teaching Hospital, ensure we are supporting our future workforce and meet our responsibility to be an exporter of excellence. To satisfy the General Medical Council standards and exit enhanced monitoring for Curriculum coverage, Staff behaviour; Supportive environment and Time for training
How these will be monitored and measured	• Data from the various surveys of learner and trainee experience: • National Education and Training Survey (NETS) • GMC and Staff Survey questions • Health Education England (HEE) Quality Assurance Framework
Executive Lead and Delivery Leads	Medical Director Director of Medical and Dental Education Associate Director for Education
Progress during 2024/2025	• A significantly improved NETS response rate. • Appointment to the Guardian of Safe Working Hours (GoSWH) administrator to commence completion of GoSWH exception reporting • Continued positive engagement with the GMC and NHS England. • Trust wide communications and Consultant engagement following notification of enhanced conditions from the GMC.

	• Relaunch of the Resident Doctors Forum (RDF – previously Junior Doctors forum) • Launch of Medical Director Blog

Measures for 2025/2026	• Use the Learner Quality Assurance meetings to review
	  • Numbers attending meeting (and their staff/professional group)
	  • Numbers of concerns/compliments/issues raised
	  • Actions taken (% investigated, % action plan put in place, % professional conversation undertaken, % no issues identified that required resolution)
	  • Number of policies reviewed by the learners and % where suggestions are made
	• Consider novel ways of collating learner feedback
	• Continued support for staff to complete national learner surveys

Using Artificial Intelligence (AI) to identify patients more at risk of developing skin cancer

Zoe, Consultant Dermatologist and Clinical Associate Professor (CAP), has received a British Skin Foundation Young Investigator Award to develop her research which will analyse the anonymised prescription data of more than a million patient records.

The national study, which she's leading, supported by Wenjia Wang, Professor of AI at the School of Computer Sciences and Dr Kathryn Richardson, Senior Statistician at University of East Anglia (UEA), aims to use AI to investigate possible links between certain prescription medications and rising rates of skin cancer.

Zoe said: "*We know that some medications increase photosensitivity which makes it more likely to get sun burnt and in turn this could lead to an increase in the likelihood of skin cancer. There is good evidence to suggest that a blood pressure medication that increases the risk of sun burn and in turn skin cancer risk and there are many other drugs that cause photosensitivity. However, it is difficult to give a definitive answer and this project will help to provide a more informed discussion with patients as to whether certain medicines may pose an increased risk.*"

Our ageing population, changing sun exposure behaviours and improvements to cancer registration are believed to be the reasons why there has been a 26% increase in skin cancer cases over a six-year period.

Zoe will use AI to help analyse the prescriptions of over a million patients to see if there's any connection with certain drugs and skin cancer.

It is not the only use of AI in the field of dermatology – other research projects are also using the technology to spot cancer risks from images of people's moles.

Zoe said: "*AI is a fantastic tool to use with big datasets and this work could help us identify future studies that are focused on specific drugs. This is the first time we have done something like this and the results could help us to inform patients about the risks and to take extra precautions in the sun or switch to medications that are less risky. Additionally, we may find a medication that helps protect against skin cancer that we didn't know about.*"

Zoe is one of eight CAPs to receive joint funding from NNUHFT and UEA to develop medical research with partners across Norwich Research Park. A second cohort of the CAP programme is due to run this year.

Zoe has published 22 papers since October 2022, including publications on skin cancer epidemiology and development of a skin cancer risk calculator, and has been successful with seven funding applications to progress her research.

Part 2.2 - Board Assurance Statements

Photo of the entrance way to the Emergency Department at the NNUHFT

Review of services

During 2024/2025 the Norfolk and Norwich University Hospitals NHS Foundation Trust provided and/or sub-contracted 82 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 82 of these relevant health services.

The Trust remains mostly funded in 2024/2025 by block/fixed funding, with a variable element for elective activity. The elective activity is paid on a unit price basis, with the Trust's performance included within the clinical income total. The clinical income total represents 88% of the Trust's overall income for the 2024/2025 financial year.

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

During 2024/2025, 66 of the Quality Account national clinical audits and 5 Quality Account national confidential enquiries covered relevant health services that Norfolk and Norwich University Hospitals NHS Foundation Trust provides.

During that period Norfolk & Norwich University Hospitals NHS Foundation Trust participated in 85% national clinical audits and 100% national confidential enquiries of the Quality Account national clinical audits and national confidential enquiries that it was mandated to participate in.

The reasons for Trust non-participation in Quality Account national audits is given below:

- **Quality and Outcomes in Oral and Maxillofacial Surgery** (QOMS) audits (N4) due to lack of clinical engagement. Escalated through Divisional

Governance and Divisional Governance Management routes, as well as the Clinical Effectiveness Operational Group (CEOG).

- **Audit of Blood Transfusion** against NICE Quality Standard 138 (2023) (Part of National Comparative Audit of Blood Transfusion Programme). This audit was repeated in October 2024. It was discussed at the Trust Blood Transfusion Committee. The committee decided that as the actions from the 2023 audit had not been implemented it was agreed that repeating the audit without the implementation of these was not appropriate.
- **Pulmonary Rehabilitation-Organisational and Clinical Audit**. Service no longer being offered in the Trust.
- **Adolescent Mental Health (part of the Emergency Medicine Quality Improvement Programme).** This Quality Improvement Programme was deferred by the Royal College of Emergency Medicine, to commence from January 2026.
- **Fracture Liaison Service Database (FLS-DB)** (part of the Falls and Fragility Fracture Audit Programme). Trust does not have a Fracture Liaison Service and therefore was not eligible to participate in the audit.
- **British Hernia Society Registry**. The British Hernia Society (BHS) Registry became available for national participation in November 2024. The General Surgery Department applied to participate but could not commence data submission due to Information Governance concerns relating to the patient information and consent form provided by the BHS. These concerns are being actively pursued with the BHS by the Clinical Audit and Improvement Department, to enable participation to commence as soon as possible.
- **National Obesity Audit (NOA) NHS Digital**. Audit requires the use of the Community Services Data Set, which the Trust does not use and is not mandated to use, which was confirmed to Commissioning by NHS England. Data from complications for excess weight (CEW) clinics is exempt from the National Obesity Audit (NOA).

We participated in other National Audits which fall outside of the Quality Account recommended list.

The national Quality Account clinical audits and national confidential enquiries that Norfolk and Norwich University Hospitals NHS Foundation participated in during 2024/2025 are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

[NB. The data collection period for some of these audits is still in progress. Final figures are not yet available for all audits and these participation rates may increase or decrease.]

Table 1 National Clinical Audits in Alphabetical Order

Quality Account Participation 24-25

National Clinical Audit		Eligible Y/N	Took Part Y/N	Participation Rate Cases Submitted Figures and percentage	Completed/ In-progress/ Ongoing
British Association of Urological Surgeons (BAUS) Audit Programme	a) BAUS Penile Fracture Audit	Y	Y	4/4 (100%)	In-progress
	b) BAUS I-DUNC (Impact of Diagnostic Ureteroscopy on Radical Nephroureterectomy and Compliance with Standard of Care Practices)	Y	Y	35/35 (100%)	Completed
	c) Environmental Lessons Learned and Applied to the bladder cancer care pathway audit (ELLA)	Y	Y	56/56 (100%)	Completed
Breast and Cosmetic Implant Registry		Y	Y	33/33 (100%)	Ongoing
British Hernia Society Registry		Y	N	Non-participation in new Quality Account audit due to Information Governance concerns relating to patient information and consent. Concerns raised with British Hernia Society, and are under consideration	Not on Quality Accounts 25-26
Case Mix Programme (CMP)		Y	Y	1610/1610 (100%)	Ongoing
Child Health Clinical Outcome Review Programme		Y	Y	Emergency (non-elective) Procedures in Children and Young People: 13/13 (100%)	Ongoing
Cleft Registry and Audit Network (CRANE) Database		N	N	Not applicable (N/A)	N/A
Emergency Medicine Quality Improvement Programmes (QIPs):	a) Adolescent Mental Health	Y	N	Royal College of Emergency Medicine deferred the start date to January 2026.	N/A
	b) Care of Older People	Y	Y	203/203 (100%)	Ongoing
	c) Time Critical Medications	Y	Y	255/255 (100%)	Ongoing
Epilepsy12: National Clinical Audit of Seizures and Epilepsies for Children and Young People		Y	Y	7/50-70 (Around 10%)	Ongoing
Falls and Fragility Fracture Audit Programme (FFFAP)	a) Fracture Liaison Service Database (FLS-DB)	N	N/A	Not commissioned	N/A
	b) National Audit of Inpatient Falls (NAIF)	Y	Y	15/15 (100%)	Ongoing
	c) National Hip Fracture Database (NHFD)	Y	Y	822/822 (100%)	Ongoing

National Clinical Audit		Eligible Y/N	Took Part Y/N	Participation Rate Cases Submitted Figures and percentage	Completed/ In-progress/ Ongoing
Learning from lives and deaths – People with a learning disability and autistic people (LeDeR)		Y	Y	21/21 (100%)	Ongoing
Maternal, Newborn and Infant Clinical Outcome Review Programme		Y	Y	41/41 (100%)	Ongoing
Medical and Surgical Clinical Outcome Review Programme		Y	Y	End of Life Care: 3/4 (75%) Rehabilitation Following Critical Illness: 4/5 (80%) Blood Sodium: 7/9 (78%) Acute Limb Ischaemia: 3/3 (100%)	Ongoing
Mental Health Clinical Outcome Review Programme		N	N/A	N/A	N/A
National Adult Diabetes Audit (NDA):	a) National Diabetes Core Audit. Includes: - Care Processes and Treatment Targets - Complications & Mortality - Type 1 Diabetes - Learning Disability and Mental Health - Structured Education - Prisons and Secure Mental Health Settings	Y	Y	652/652 (100%)	Ongoing
	b) Diabetes Prevention Programme (DPP) Audit	N	N	Primary Care	N/A
	c) National Diabetes Footcare Audit (NDFA)	Y	Y	198/198 (100%)	Ongoing
	d) National Diabetes Inpatient Safety Audit (NDISA)	Y	Y	3/3 (100%)	Ongoing
	e) National Pregnancy in Diabetes Audit (NPID)	Y	Y	42/42 (100%)	Ongoing
	f) Transition (Adolescents and Young Adults) and Young Type 2 Audit	Y	Y	n/a – This audit draws data from 2 other audits we participate in, the National Diabetes Audit and the National Paediatric Diabetes Audit. Submission numbers will be based on those.	Ongoing
	g) Gestational Diabetes Audit	Y	Y	100% (Taken automatically from Maternity Services Data Set)	Ongoing

National Clinical Audit		Eligible Y/N	Took Part Y/N	Participation Rate Cases Submitted Figures and percentage	Completed/ In-progress/ Ongoing
National Audit of Cardiac Rehabilitation		Y	Y	1985/3165 (62.7%) 3165 patients started cardiac rehab over 24-25 but cannot be downloaded until completed.	Ongoing
National Audit of Cardiovascular Disease Prevention in Primary Care		N	N/A	N/A	N/A
National Audit of Care at the End of Life (NACEL)		Y	Y	81/81 (100%)	Complete
National Audit of Dementia (NAD)		Y	Y	41/41 (100%)	Complete
National Bariatric Surgery Registry		N	N/A	N/A	N/A
National Cancer Audit Collaborating Centre (NATCAN)	National Audit of Metastatic Breast Cancer (NAoMe)	Y	Y	31/31 (100%)	Ongoing
	National Audit of Primary Breast Cancer (NAoPri)	Y	Y	657/657 (100%)	Ongoing
	National Bowel Cancer Audit (NBOCA)	Y	Y	408/408 (100%)	Ongoing
	National Kidney Cancer Audit (NKCA)	Y	Y	76/76 (100%)	Ongoing
	National Lung Cancer Audit (NLCA)	Y	Y	1393/1393 (100%)	Ongoing
	National Non-Hodgkin Lymphoma Audit (NNHLA)	Y	Y	204/204 (100%)	Ongoing
	National Oesophago-Gastric Cancer Audit (NOGCA)	Y	Y	132/132 (100%)	Ongoing
	National Ovarian Cancer Audit (NOCA)	Y	Y	95/95 (100%)	Ongoing
	National Pancreatic Cancer Audit (NPaCA)	Y	Y	108/108 (100%)	Ongoing
	National Prostate Cancer Audit (NPCA)	Y	Y	504/504 (100%)	Ongoing
National Cardiac Arrest Audit (NCAA)		Y	Y	33 team visit records have been submitted during 01/08/2024 – 30/11/2024.	Ongoing
National Cardiac Audit Programme	a) National Adult Cardiac Surgery Audit (NACSA)	N	N/A	N/A	N/A
	b) National Congenital Heart Disease Audit (NCHDA)	N	N/A	N/A	N/A

National Clinical Audit		Eligible Y/N	Took Part Y/N	Participation Rate Cases Submitted Figures and percentage	Completed/ In-progress/ Ongoing
	c) National Heart Failure Audit (NHFA)	Y	Y	785/785 (100%)	Ongoing
	d) National Audit of Cardiac Rhythm Management (CRM)	Y	Y	Electrophysiology 670/720 (96.8%) Pacemakers 1667/1667 (100%)	Ongoing
	e) Myocardial Ischaemia National Audit Project (MINAP)	Y	Y	851/907 (93.8%)	Ongoing
	f) National Audit of Percutaneous Coronary Intervention (NAPCI)	Y	Y	1564/1586 (98.6%)	Ongoing
	g) National Audit of Mitral Valve Leaflet Repairs (MVLR)	N	N/A	N/A	N/A
	h) UK Transcatheter Aortic Valve Implantation (TAVI) Registry	N	N/A	N/A	N/A
	i) Left Atrial Appendage Occlusion (LAAO) Registry	N	N/A	N/A	NA
	j) Patent Foramen Ovale Closure (PFOC) Registry	N	N/A	N/A	N/A
	k) Transcatheter Mitral and Tricuspid Valve (TMTV) Registry	N	N/A	N/A	N/A
National Child Mortality Database (NCMD)		Y	Y	100% - All child deaths are registered as required via the Child Deaths Overview Panel (CDOP) and the national database takes its data direct from the CDOPs.	Ongoing
National Clinical Audit of Psychosis (NCAP)		N	N/A	N/A	N/A
National Comparative Audit of Blood Transfusion	a) National Comparative Audit of NICE Quality Standard QS138	Y	N	This was a re-audit but the NNUHFT did not take part. It was discussed at the September Trust Blood Transfusion Committee and as actions from the 2023 audit had not yet been implemented the committee decided that repeating the audit without changing practices was not appropriate.	Complete
	b) National Comparative Audit of Bedside Transfusion Practice	Y	Y	19/19 (100%)	Complete

National Clinical Audit		Eligible Y/N	Took Part Y/N	Participation Rate Cases Submitted Figures and percentage	Completed/ In-progress/ Ongoing
National Early Inflammatory Arthritis Audit (NEIAA)		Y	Y	9/9 (100%)	Ongoing
National Emergency Laparotomy Audit (NELA)		Y	Y	284/184 (100%)	Ongoing
National Joint Registry		Y	Y	447/447 (100%)	Ongoing
National Major Trauma Registry [Note: Previously Trauma audit Research Network (TARN)]		Y	Y	599/1000 (59.9%)	Ongoing
National Maternity and Perinatal Audit (NMPA)		Y	Y	100% - Submission data is taken automatically by NHS Digital, so submission numbers expected to be 100%	Ongoing
National Neonatal Audit Programme (NNAP)		Y	Y	866/866 (100%)	Ongoing
National Obesity Audit (NOA)		Y (Paeds)	N	Audit relies on the use of the Community Services Data Set, which the Trust does not use and is not mandated to use, which was confirmed to Commissioning by NHS England.	Ongoing
National Ophthalmology Database (NOD)	a) Age-related Macular Degeneration Audit	Y	Y	New Quality Account audit that the Trust has successfully applied to participate in. First data extract not due until July 2025	Ongoing
	b) Cataract Audit	Y	Y	2058/2058 (100%)	Ongoing
National Paediatric Diabetes Audit (NPDA)		Y	Y	363/363 (100%)	Ongoing
National Perinatal Mortality Review Tool		Y	Y	32/32 (100%)	Ongoing
National Pulmonary Hypertension Audit		N	N/A	N/A	N/A
National Respiratory Audit Programme (NRAP): [Note: previously named National Asthma and Chronic Obstructive Pulmonary Disease Audit Programme (NACAP)]	a) COPD Secondary Care	Y	Y	489/489 (100%)	Ongoing
	b) Pulmonary Rehabilitation	Y	N	Not commissioned	N/A
	c) Adult Asthma Secondary Care	Y	Y	475/475 (100%)	Ongoing
	d) Children and Young People's Asthma Secondary Care	Y	Y	40/40 (100%)	Ongoing
National Vascular Registry (NVR)		Y	Y	511/511 (100%)	Ongoing

National Clinical Audit		Eligible Y/N	Took Part Y/N	Participation Rate Cases Submitted Figures and percentage	Completed/ In-progress/ Ongoing
Out-of-Hospital Cardiac Arrest Outcomes (OHCAO)		N	N/A	OHCAO is a prospective study, collecting information on all out-of-hospital cardiac arrests in the UK. Data is provided by the Ambulance Services.	N/A
Paediatric Intensive Care Audit Network		N	N/A	N/A	N/A
Perioperative Quality Improvement Programme		Y	Y	41 Although on Quality Accounts, this is a research project. The NNUHFT recruits patients undergoing elective thoracic surgery. The study sponsor agreed this methodology.	Ongoing
Prescribing Observatory for Mental Health (POMH)	a) Rapid tranquillisation in the context of the pharmacological management of acutely disturbed behaviour	N	N/A	N/A	N/A
	b) The use of melatonin	N	N/A	N/A	N/A
	c) The use of opioids in mental health services	N	N/A	N/A	N/A
Quality and Outcomes in Oral and Maxillofacial Surgery (QOMS)	a) Oncology & Reconstruction	Y	N	0% Non-participation in new Quality Account audit due to lack of clinical engagement. Escalated through Divisional Governance and Divisional Governance Management routes, as well as the Clinical Effectiveness Operational Group (CEOG).	Completed
	b) Trauma	Y	N	0% Non-participation in new Quality Account audit due to lack of clinical engagement. Escalated through Divisional Governance and Divisional Governance Management routes, as well as CEOG.	Completed

National Clinical Audit		Eligible Y/N	Took Part Y/N	Participation Rate Cases Submitted Figures and percentage	Completed/ In-progress/ Ongoing
	c) Orthognathic Surgery	Y	N	0% Non-participation in new Quality Account audit due to lack of clinical engagement. Escalated through Divisional Governance and Divisional Governance Management routes, as well as the CEOG.	Completed
	d) Non-melanoma skin cancers	Y	Y	200/200 (100%)	Completed
	e) Oral and Dentoalveolar Surgery	Y	N	0% Non-participation in new Quality Account audit due to lack of clinical engagement. Escalated through Divisional Governance and Divisional Governance Management routes, as well as the CEOG.	Completed
Sentinel Stroke National Audit Programme (SSNAP)		Y	Y	1036/1035 (100%)	Ongoing
Serious Hazards of Transfusion (SHOT): UK National Haemovigilance Scheme		Y	Y	22/22 (100%)	Ongoing
Society for Acute Medicine Benchmarking Audit (SAMBA)		Y	Y	92/92 (100%)	Complete
UK Cystic Fibrosis Registry		Y	Y	Paeds – 66/66 (100%) Adults – 99/100 (100%)	Ongoing
UK Renal Registry Chronic Kidney Disease Audit		Y	Y	Quarter 117 (Jan- Mar 2024) created on 05/03/2025 and contains 871 patients	Ongoing
UK Renal Registry National Acute Kidney Injury Audit		Y	Y	7,072/7,072 (100%)	Ongoing

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 2024/2025 that were recruited during that period to participate in research approved by a research ethics committee was 3,139.

Commissioning for Quality and Innovation (CQUIN)

Please note the mandatory CQUIN scheme has been paused. A set of non-mandatory quality indicators which systems may choose to use can be found on the FutureNHS Collaboration Platform (a FutureNHS account is required to access this content).

Our Breast Clinic teams

Breast Screening team wins EDI Award

Our Breast Screening Promotion team have won a Quality Improvement in Equality, Diversity and Belonging award at the Equality, Diversity & Inclusive (EDI) Awards.

The team which is comprised of radiographers, associate practitioners, breast care nurses and admin and clerical staff were presented with the award at the Norfolk and Waveney Allied Health Professions conference in October 2024.

They were praised for their dedication and commitment to reaching more patients to promote the service. The team regularly attends community events such as Women Institute groups, participates in Norwich PRIDE, establishes new community contacts, and posts monthly 'check your chest' reminders on their Facebook page. Team members volunteer in their own time because they passionately believe in promoting the importance of breast screening.

Rebecca Bond, Deputy Breast Imaging Manager, said: "*I would like to say a huge thank you to everyone who gives up their own time to attend community events; reaches out to seek new areas we can promote in; to everyone who speaks so passionately to the general public and screening clients on a day-to-day basis about our wonderful service and being breast aware. It's lovely to have the recognition for the hard work we have been doing to reach more people and encourage them to attend their screening appointments.*"

DNA 'barcoding' project to transform breast cancer care

A groundbreaking breast cancer treatment programme that could save thousands of lives has opened at our hospital.

Patients who join the Personalised Breast Cancer Programme (PBCP) will have their DNA read like a barcode, with the whole genome of their tumour sequenced and the results returned to inform treatment planning.

This means more people in the East are set to benefit from personalised treatment, as the ground-breaking breast cancer study is expanded. Our hospital is the fourth site in the East and the fifth site to be opened nationally following on from the implementation of the programme in Cambridge, Ipswich, Colchester and Oxford.

The first patient was seen at NNUHFT on 25 September 2024. So far over 1,500 patients have been enrolled in the study. Results are returned within six to 12 weeks, enabling patients to have a more precise and personalised cancer treatment. For many, results have confirmed they were receiving the best treatment available for their disease, whilst over a third have had a change in clinical management. Dr Clare Hannon and Dr David Maskell are overseeing the study our hospital.

Dr Hannon said: "*It is very exciting to be able to bring the programme to NNUHFT as part of a national drive for better cancer treatments and personalised medicine. Recruiting started at the end of September. For the patients on the programme, DNA and Ribonucleic Acid readouts from their tumour cells are compared with those of their healthy cells to study which genetic mistakes are causing the disease, and which weaknesses could be targeted with cancer drugs. The results also identify whether the patient has any inherited genetic faults that increase the risk of breast cancer or could cause toxic side effects to chemotherapy.*

"In a small subset of patients, the DNA will be analysed from additional biopsy and blood samples taken at the time of other routine appointments, meaning that there are no more appointments than usual and no delays in starting treatment. Longer term, this study will help us to predict which patients will or won't benefit from a particular treatment. It leads us to much more effective and personalised care which increases survival rates and reduces the side effects of treatments."

Cancer Research UK's Professor Jean Abraham, who leads the PBCP from Cambridge University Hospitals NHS Foundation Trust, said that for every patient on the programme DNA and Ribonucleic Acid readouts from their tumour cells are compared with those of their healthy cells to study which genetic mistakes are causing the disease, and which weaknesses could be targeted with cancer drugs.

She said: *"The beauty of this sequencing project is we get the data faster and can act on it. The benefits are various and depend on the stage of the cancer. If it's at an advanced stage, the genetic information we get from the whole genome might push us towards a different treatment or you might find a specific mutation that means the patient could take part in a certain clinical trial. Ultimately, these findings can help direct clinicians to using more novel and targeted drugs that have the best chance of helping individual patients."*

Every year, around 5,700 women - as well as a small number of men- are diagnosed with breast cancer in the East of England, whilst around 1,100 women in the region die from the disease.

Professor Abraham added: *"A lot of patients won't see their treatment plan change, but it might offer hope and faster access to the most appropriate treatment if there's a relapse. Having the genetic information of the tumour will give us a better idea of what to do should a patient relapse. It becomes an armoury of knowledge, and it could reveal weakness we can target. That can be very reassuring to patients. In addition, establishing an individual doesn't carry any high-risk hereditary genes is a relief to both the patient and their family."*

Care Quality Commission (CQC) reviews

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

The Care Quality Commission has not taken enforcement action against Norfolk & Norwich University Hospitals NHS Foundation Trust during 2024/2025.

Norfolk and Norwich University Hospitals NHS Foundation Trust has participated in special reviews or investigations by the Care Quality Commission relating to the following areas during 2024/2025:

- In August 2024 the Norfolk and Norwich University Hospitals NHS Foundation Trust received the inspection report for the inspection of Surgery, Diagnostic Imaging, Outpatients and Well-led which was conducted on the 27th – 28th September 2023 and 28th – 30th November 2023.
- An announced inspection of compliance with the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) 2017, of the Diagnostic Imaging department. This inspection does not provide a rating.

Table 2: CQC Ratings of the August 2024 inspection report

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Requires Improvement	Not rated	Good	Requires Improvement	Requires Improvement	Requires Improvement
Diagnostic Imaging	Good	Not rated	Good	Requires Improvement	Requires Improvement	Requires Improvement
Outpatients	Requires Improvement	Not rated	Good	Requires Improvement	Requires Improvement	Requires Improvement
Overall	Requires Improvement	Good	Good	Requires Improvement	Requires Improvement	Requires Improvement

Norfolk and Norwich University Hospitals NHS Foundation Trust intends to take the following action to address the conclusions or requirements reports by the CQC.

Table 3: CQC 'Must Do' and 'Should Do' Recommendations for the August 2024 inspection report.

Ref	Must Do / Should Do	Area	Area for Improvement
TW 2024.a	Must Do	Trust Wide	The trust must ensure that staff have received training in treating patients with learning disabilities and autism. (Regulation 18(2)(a))
TW 2024.b	Must Do	Trust Wide	The trust must ensure that the systems in place to purchase, renew and replace equipment are responsive, so service delivery is not impacted by equipment failures. (Regulation 15(1)(e))
Surgery, Critical and Emergency Care (SCEC) 2024.a	Must Do	Surgery	Surgery: The service must ensure that mental health risk assessments are completed for all surgical patients where a mental health need is indicated. (Regulation 12(2)(a))

Ref	Must Do / Should Do	Area	Area for Improvement
SCEC 2024.b	Must Do	Surgery	The service must ensure World Health Organisation (WHO) surgical safety checklists are completed for all patients. (Regulation 12(2)(b))
SCEC 2024.c Med 2024.c W&C 2024.c	Must Do	Surgery	The service must ensure that medicines are stored and recorded in line with policy. (Regulation 12(2)(g))
SCEC 2024.d (i) and (ii)	Must Do	Surgery	The service must ensure that records are updated and stored securely. (Regulation 17(2)(c))
OP 2024.a	Must Do	Outpatients	The service must ensure that all policies and guidelines are up to date and reflect national guidance and recommendations. (Regulation (17)(1))
OP 2024.b	Must Do	Outpatients	The service must have enough staff to care for patients and keep them safe. (Regulation (18)(1))
OP 2024.c (i) and (ii)	Must Do	Outpatients	The service must keep care records secure. (Regulation (17)(2)(c))
OP 2024.d (i), (ii), and (iii)	Must Do	Outpatients	The service must ensure that they have safe systems for medicines management. (Regulation (17)(2)(f)(g))
CSS 2024.a	Must Do	Diagnostic Imaging	The service must ensure that there are processes in place to ensure there are enough suitably qualified and competent staff to make sure that the service can meet targets in respect to waiting times and reporting times. (Regulation 18(1))
CSS 2024.b	Must Do	Diagnostic Imaging	The service must ensure that the systems in place to purchase, renew and replace equipment are responsive, so service delivery is not impacted by equipment failures. (Regulation 15(1)(e))
TW 2024.c	Should Do	Trust Wide	The trust should ensure people can always access care and treatment when they need it and waiting times for treatment are in line with the England average. (Regulation 12)
SCEC 2024.e	Should Do	Surgery	The service should ensure that staff are aware of where ligature cutters are stored. (Regulation 12)
SCEC 2024.f	Should Do	Surgery	The service should ensure that equipment is properly maintained. (Regulation 12)
SCEC 2024.g Med 2024.g W&C 2024.g CSS 2024.g	Should Do	Surgery	The service should ensure medical staff complete mandatory training. (Regulation 18)
TW 2024.h (previously SCEC 2024.h)	Should Do	Surgery	The trust should ensure that their guidance on responding to deteriorating patients is consistently followed (Regulation 12)

Ref	Must Do / Should Do	Area	Area for Improvement
OP 2024.e	Should Do	Outpatients	The service should ensure staff feel supported and valued. (18)
OP 2024.f	Should Do	Outpatients	The service should control infection risk well and provide equipment and furniture in line with national standards. (Regulation 12)
CSS 2024.c	Should Do	Diagnostic Imaging	The service should ensure that service users are informed of the availability of interpreter services. (Regulation 9)

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

Table 4: CQC Areas of Improvement from IR(ME)r inspection report.

Ref	Area for Improvement
IR01	The employer must ensure written procedures in place for those matters described in schedule 2 are reflective of current practice, reference up to date guidance from professional bodies and contain sufficient information to enable duty holders to comply with regulation.
IR02	The employer must ensure all duty holders understand the relevance of the written procedures in order to ensure compliance.
IR03	The employer must establish an effective quality assurance programme for written procedures and written protocols that is reflective of current practice.

Norfolk and Norwich University Hospitals NHS Foundation Trust has made the following progress by 31st March 2025 in taking such action:

The actions required to address the must-do and should-do recommendations are reviewed by the NNUHFT CQC Evidence Group, where a RAG status is applied to monitor progress and ensure accountability:

Green – On track to meet outcome date.
Amber – At risk of not meeting outcome date.
Red - Will not meet the outcome date or has already passed outcome date.
Blue – Recommendation is complete but requires further monitoring from Quality Programme Board (QPB).

Once a recommendation has been agreed as complete it is turned **Black** and is archived. Since April 2024, 11 of the recommendations have been turned black.

Table 5: Progress on CQC ‘Must Do’ and ‘Should Do’ Recommendations as identified in the August 2024 Report.

Ref	Status	Action
TW 2024.a	Amber	• Require trajectories and timelines around the completion of e-learning and the number of staff who are required to complete the tier one and tier two training. • E-learning has a target date of September 2025 to achieve the required 90% compliance. Divisions need to demonstrate a plan to achieve this. • The learning and disability and autism team review patient feedback, Datix incidents, PALs and complaints etc. this will provide data as to whether the training is having an impact.
TW 2024.b	Red	• There is a draft Standard Operating Procedure (SOP) in place, once approved the SOP along with a summary update will be added to the evidence.
SCEC 2024.a	Red	• This recommendation has been added to a QI project which will be tracked and can support the recommendation. • Current work and monitoring to be continued whilst the booklet is being developed and approved.
SCEC 2024.b	Blue	• An electronic solution for emergency cases is being worked on and should be complete by the end of March 2025. • Compliance is monitored at theatre management group and at performance meetings, a report is completed weekly of misses which are followed up as business as usual • Continued data to evidence that compliance remains high to be added.
SCEC 2024.c	Red	• Incidents to be triangulated with non-compliance of checks to determine if there is an impact on non-compliance of checks with incidents. • Trajectories to address and improve results for any non-compliant areas need to be added to the evidence. • A sustained improvement for areas which are already compliant needs to be demonstrated.
Med 2024.c	Red	• Tether points are a challenge, Temporary Escalation Space (TES) patients and meal services are impacting on staff being able to access the tether points. • There has been some feedback that drug ward rounds take a long time to complete – this need to be reviewed. It could be due to the complexity / acuity of the patients. It could also be due to the mix of oral and IV medications which requires staff to go back and forth from the trolley to the medicine room. • An action plan to address this recommendation in place, with accountable staff for delivery of the actions.
W&C 2024.c	Red	• Tendable Audits are performed monthly. Require some additional data points around compliance for assurance of continued improvements. • There needs to be some narrative around work which is being completed to address any actions. • Peer review is required to ensure the audit results are accurate.
SCEC 2024.d (i)	**Black**	• Matrons’ quality assurance audit completed monthly provides further support of compliance. • Tendable audits are discussed as part of dashboard meeting and actions taken. • Matrons discuss Tendable audits in weekly meetings. Also have discussions with band 7s monthly. • This is monitored as business as usual with data points to support this. It was agreed this can be closed.

Ref	Status	Action
SCEC 2024.d (ii)	Red	• Some areas are completing spot checks around key issues identified. • Updating documents is a key issue for surgery. All areas have completed an action plan which are cross referenced into a divisional action plan. • Respect forms and respect training for writers shows an overall maintained compliance of above 90%, with some areas at 100% • Require peer review or expert review over a six-month period for assurance that improvements are being delivered.
OP 2024.a	Red	• A Trust Document Review Group has been formed to tackle the oldest overdue documentation • A paper has been submitted proposing an extension for overdue documents while the Trust is in a state of transition. This would allow for an initial review of a document to ensure patient safety then the ability to apply for an extension to the expiry date, where applicable.
OP 2024.b	**Black**	Medicine: • No Datix forms raised specifically in relation to this. • There has been a review of roster and budget to ensure where should be, nothing flagging. • Sickness and turnover rates in line with Trust targets. Surgery: • Data demonstrates that vacancy and headcount is in a good position. • Plaster room risk is closed. • No vacancies in nursing and admin and clerical in oral health, but there is a low vacancy in medical. • There is monitoring of all vacancies as business as usual. • Risk have been addressed with clear processes in place.
OP 2024.c (i)	**Black**	• Lockable notes trolleys for all surgical outpatient (OP) areas are in place. • There is a screen time lock for computer systems in place. • This is monitored within the care assurance audits and the Tendable audits, results are discussed at Divisional Performance Committee (DPC) and matron's performance meetings as business as usual • Six data points of compliance was demonstrated within the Tendable audits and the care assurance audits from January 2024 for records security has been 100%. It was agreed that this recommendation can be closed.
OP 2024.c (ii)	Red	• An action plan is in place with accountable individuals against each action. • A replacement strategy for notes trolleys will need to be agreed by divisional board. • It was noted that the matron's assurance audit is very inpatient (IP) focused, there needs to be an OP matron's assurance audit.
OP 2024.d (i)	Blue	• The data shows that checks are happening, but independent spot check shows much lower compliance. • It was agreed that the individual areas with low compliance are to be monitored and supported to demonstrate whether these were one off incidents and to show an improvement in compliance. • Further data to be included to demonstrate sustained compliance for those areas which are already compliant.
OP 2024.d (ii)	Red	• There will be a fortnightly OP quality meeting to discuss CQC recommendations involving all teams for collaboration and shared learning. • There are individual action plans for all areas, these are Specific, Measurable, Achievable, Relevant, and Time-bound (SMART) actions with time frames included so that action owners can be held to account.
OP 2024.d (iii)	Red	• Individual issues have been picked up as part of the analysis of the audit data for some OP areas. • Further audit data to be provided for assurance against improvements / compliance.

Ref	Status	Action
		• Action plan in place to be updated.
CSS 2024.a	**Black**	• Power Bi reports can evidence the impact which additional posts have had on reporting and waiting times. • Reported monthly as part of DPC slides. • The process is business as usual and is reviewed in other forums in detail with any issues escalated. • It was agreed this recommendation could be closed.
CSS 2024.b	**Black**	• All equipment has regular monitoring through clinical engineering. The team has processes in place to ensure any equipment is flagged if it has broken. • There is a Clinical Expert Review Panel (CERP) process Trust wide which Clinical Support Services (CSS) follows. • CSS has a process in place to monitor its equipment as business as usual and escalate as required. • It was agreed this recommendation could be closed.
TW 2024.c	**Black**	• New guidance has been released since this recommendation was set. • This is monitored as business as usual in other forums. • It was agreed this recommendation can be closed.
SCEC 2024.e	Blue	• The ligature cutters are located on the resus trolley. It will be checked whether this is included in the online resus training which staff must complete and if it is not then a request for this to be added will be made. • Six data points from Tendable to show audits continue to demonstrate compliance are required.
SCEC 2024.f	**Black**	• This recommendation relates to O7.1, which was turned black in July 2024. • Medical Device Committee (MDC) is used as a point of escalation. • A freshdesk form has been introduced to be used for any issues / help required with tracking and requests. • This recommendation is business as usual and can be closed.
SCEC 2024.g	Green	• Data to demonstrate continued monitoring and improved compliance to be included.
Med 2024.g	Green	• Data to demonstrate continued monitoring and improved compliance to be included.
W&C 2024.g	Red	• Data to demonstrate monitoring and improved compliance to be included.
CSS 2024.g	Red	• Data to demonstrate monitoring and improved compliance to be included.
TW 2024.h (previously SCEC 2024.h)	Red	• All ward areas have action plans in place to address compliance. These individual action plans will be pulled together into one divisional overarching plan. • Additional audit data needs to be gathered to determine if the action plans are having an impact on compliance with documentation. • The live dashboard shows in real time any patients who have a score which should trigger escalation.
OP 2024.e	**Black**	• The CQC report focused on staff turnover, vacancy rates and sickness levels. These are all monitored as business as usual through DPC. The divisions are actively monitoring these trends and have processes in place. • It was agreed this recommendation could be closed.

Ref	Status	Action
OP 2024.f	Red	Medicine: • Gap analysis of what requires replacing to be completed with an action plan developed in response. • Need to review the number of Housekeepers and any education required. • FM First compliance needs to be reviewed as this remains a challenge. Surgery: • Charitable funds committee will discuss funding approval for replacement chairs.
CSS 2024.c	Blue	Six months Tendable data is required to provide assurance of continual monitoring outside of the two snapshot audits. • Review of complaints etc. for any stating there was no access to an interpreter to be included in the evidence for triangulation. • Data around the number of times the interpreter has been utilised to be included for cross reference and assurance.

Table 6: Progress on CQC IR(ME)R's Areas of Improvement

Ref	Status	Action against areas of improvement
IR01	**Black**	Review and amend Diagnostic imaging Employers procedures to address points identified specifically. **Completed**
IR02	**Black**	Presentation to all staff at next Radiology Governance session on the Employers Procedures document and its accessibility. Presentation to be recorded and made available through radiation safety teams channel to those not in attendance. **Completed**
IR03	**Black**	Review and document current practices for QA of written policies and procedures within Employers Procedures. **Completed**

Data Quality

The Norfolk and Norwich University Hospitals NHS Foundation Trust submitted records during 2024/2025 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

Table 7: Records of published Month 10 2025

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:	
	NNUHFT	Nat Avg.	NNUHFT	Nat Avg.
Admitted patient care	99.9%	99.7%	100%	99.4%
Outpatient care	100%	99.7%	100%	99.3%
Accident & emergency care	99.5%	98.9%	100%	99.8%

The following are actions taken to improve the data in the above table:

- Completed Referral to Treatment (RTT) Audit Programme for 2024/25 and action plans completed.

- Commissioning Assurance Programme evolving, the above dashboard confirms compliance in key areas and ad hoc audits have been completed as required
- The Clinical Threshold and Individual Funding Requests (IFR) audit programmes have been reviewed and updated to capture patients added to a waiting list in real time, records are audited to ensure the patient meets the clinical criteria to be listed. If they do not meet the criteria, the patient is removed from the waiting list as the Trust is not funded to carry out the procedure in this instance
- Referral to Treatment and Data Quality web pages reviewed and updated, providing guidance documents and SOPs to further support staff with policy, process and progressing patient pathways.
- Staff are completing the Trust Induction Programme to support continuity with education
- Policies reviewed and updated to provide further clarity and understanding.
- Continue to use benchmarking tools such as the Secondary Users Service (SUS) dashboard and Data Quality Maturity Index (DQMI) Dashboards to ensure the NNUHFT are meeting national averages and proactively work with stakeholders to ensure resolution in areas of weakness if identified. If there is a change to the contract Data Set, this can reflect in the scores on the SUS dashboard, An example being, historically the Trust used clinics set up under generic 'Combined' codes for operational reasons such as capacity management and rota cover. This included clinics set up under 'Combined Consultant' (C9999998), 'Combined Nurse' (N9999998), 'Combined Midwife' (M9999998) and 'Combined Other Health Professional' (H9999998).
- Due to the change made by NHS England to the Commissioning Data Set (CDS), these codes are no longer valid and should not be used. This caused the Trust to flag as an outlier on the CDS as we were extensively using these codes. Work has started towards correcting this issue as new clinic requests must now include a named practitioner before the sign off, and current combined clinics are being changed to a named consultant diary owner. This is a huge task so are working through the specialties.
- There are now 46 Data Quality Metrics which identify incorrect or incomplete data on the patient administration system (PAS). Completing the metrics will ensure patient pathways are correct and patients are progressed through their pathways in a timely manner. There is a dashboard to give an overview of performance immediately and the metrics have been prioritised, so the most important ones linked to care are completed first.
- Supported with multiple validation objectives to support recovery and NHSE directives, used findings to deliver learning and coaching via the Referral to Treatment Operational Management Group Meetings (RTTOMG) about to take part in another validation programme called sprint which starts on the 7th April 2025 up to the 30th June 2025.

Information Governance Data Security & Protection Toolkit Attainment Levels

Norfolk and Norwich University Hospital Foundation Trust's Data Security & Protection Toolkit overall score for 2024 was of a "standards met" assurance status.

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 2024/2025 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:

- Monthly Data Quality Referral to Treatment Operational Management Group Meetings (RTTOMG) to discuss RTT performance by Specialty, discussing RTT issues / concerns, this is a forum to share best practice. Minutes are provided and can be used as a reference tool.
- Continue to review data recording issues raised via Data Quality SUS dashboards, Commissioning issues and ad-hoc audits and review anomalies as they arise
- Continue to provide RTT training and coaching to Operational Managers, Admin Managers and RTT Validators to support as part of their induction programme.
- Manage the Information Standard Notice Data Base to ensure the Trust works towards compliance by the implementation date, escalate when necessary and ensure risks are highlighted and recorded if the Trust is non-compliant.
- Complete ad-hoc commissioning audits to support business need
- Complete ad-hoc Patient Administration system (PAS) audits to support Electronic Patient Record (EPR) and System working
- Support the Trust with the new structure as follows
    - Group Model
    - Hospital Leadership Team
    - Care Group
    - Clinical Services
    - Our Patients
- Support PAS data cleansing in preparation for the new EPR including duplicate records on the Master Patient Index (MPI), this will ensure we have one patient data base between the 3 Acute Trusts (Group)
- Review current practices to see how we can work differently/smarter, simplify and ensure continuity of practice.
- Work with the Group to ensure the 3 Acute Trusts are recording data/activity with continuity, this includes the management of RTT pathways.

Our new Norfolk and Norwich Orthopeadic Centre (NaNOC)

Staff outside of the NaNOC

Our new state-of-the-art Norfolk and Norwich Orthopaedic Centre (NaNOC) welcomed its first patients in July 2024.

The 50-strong Trauma and Orthopaedics team began treating their first patients this morning (23 July) and the centre is in direct response to the profound impact the Covid-19 pandemic had on patients waiting for treatment.

Very much a patient-centred unit, it has been developed with its own facilities including a same-day admissions unit, treatment rooms, two laminar flow theatres, post anaesthetics care unit, a 21-bedded ward, called Ashill, physiotherapy rooms and a pharmacy and dispensing room for the embedded Pharmacy team.

Some of the most up to date surgical equipment has been provided by the N&N Hospitals Charity, which supported the build with a £2m grant – the biggest single grant in its history.

A theatre inside of the NaNOC

NaNOC will carry out procedures three days a week, with an ambition of running six days a week later in the year. Once it is running at full capacity, the team will carry out around 2,500 orthopaedic cases a year for patients who need ankle, foot, hip, knee or shoulder operations. To help with this work four new consultants - experts in hip, knee, shoulder and hand surgery, have been employed to bring the most innovative techniques to the team.

All staff are receiving training in the Trust's Advanced Recovery Programme, which focuses on sending patients home as early and as safely as possible.

Consultant Surgeon James Wimhurst said: "*The main ethos of the unit is for 'enhanced recovery' ie getting patients up and about after surgery with a combination of surgical, anaesthetic techniques, tailored analgesia regimes and targeted physiotherapy. Our current length of stay is three days. The idea is to get patients home after a day for hip and knee replacement and some even home on the day of surgery. The unit is slightly removed from the main hospital and suitable for patients without complex medical needs. By moving those patients to NaNOC frees up space on the in-patient orthopaedic ward (Cringleford) for patients with more complex medical needs or more complex surgery. This has been incredibly challenging at times as we have had to convert an existing clinical unit with a purpose-built unit on the side to create a brand-new orthopaedic centre. We have learned a lot, and it is really exciting that we are now ready. We have been supported amazingly by the N&N Hospitals Charity, which has helped us with buying some of the most up-to-date equipment currently available. I'd like to say a huge thank you to them.*"

Julie Cooper, Head of Charity for N&N Hospitals Charity, said: *"It has been lovely to hear how pleased the Elective Orthopaedics team are with their new facility. We look forward to continuing our support for the unit, having seen how our £2m grant is being put to good use to improve the patient experience."*

To find out more about the N&N Hospitals Charity or to make a donation please visit: www.nnhospitalscharity.org.uk

Above - Lord-Lieutenant of Norfolk Lady Philippa Dannatt MBE (Member of the Most Excellent Order of the British Empire) officially opening the centre, alongside Lesley Dwyer (CEO at NNUHFT), Tom Spink (Chairman at NNUHFT) and Consultant Orthopaedic Surgeon James Wimhurst (NNUHFT)

Photo of the outside of the Norfolk and Norwich Orthopaedic Centre

Learning from Deaths

Learning from the deaths of patients in the care of NNUHFT is a key priority for the organisation. Behind every inpatient death is a person who was deeply loved. It is our responsibility to honour their lives by reflecting on the care and treatment they received, ensuring that we identify meaningful opportunities to enhance the quality of care for others. By learning from these patient journeys, we strive to implement improvements that make a real difference, providing the best possible care with dignity, respect, and compassion.

During the financial year 2024/2025 2,269 of the Norfolk & Norwich University Hospital NHS Foundation Trust in-patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:

604 in the first quarter, of which 10 were patients with Learning Difficulties, 9 had a Severe Mental Illness, 1 was Still Born and 3 were Neonatal Deaths.

562 in the second quarter, 9 were patients with Learning Difficulties, 7 had a Severe Mental Illness, 8 were Still Births and 1 was a Neonatal Death.

642 in the third quarter, 2 were patients with Learning Difficulties, 11 had a Severe Mental Illness, 6 were Still Births and 1 was a Neonatal Death.

708 in the fourth quarter, 10 were patients with Learning Difficulties, 1 had a Severe Mental Illness, 5 were Still Births and 1 was a Neonatal Death.

Table 8: Summary of In-Hospital deaths and deaths within 30 days of discharge for the financial year 2024/2025 (as of 22nd April 2025)

Financial Year 2024/2025	Total Discharges	Deaths within 30 days of Discharge	In-hospital deaths	Total Deaths	In-hospital Deaths with Learning Difficulties	In-hospital Deaths with Severe Mental Illness	In-hospital Still births	In-hospital Neonatal Deaths
Q1	53,475	338	604	942	10	9	1	3
Q2	54,425	311	562	873	9	7	8	1
Q3	53,512	327	642	969	2	11	6	1
Q4	52,955	309	708	1,017	10	1	5	1
Total	196,312	1,285	2,516	3,801	31	28	20	6

Medical Examiner Reviews

Table 9: Medical Examiner reviews and escalations

Financial Year 2024/2025	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
	Inpatient deaths	Community deaths	Total		
Q1	639	252	891	8	34
Q2	588	463	1,051	3	20
Q3	713	1,014	1,727	7	37
Q4	797	809	1,606	4	25
Total	2,737	2,538	5,275	21	116

There were no escalations to Structured Judgement Review (SJR)/ Morbidity and Mortality (M&M) of deaths within 30 days of discharge by the Medical Examiner Service.

Learning Disabilities

The Trust takes seriously the learning gained from LeDeR (Learning from Lives and Deaths - people with a learning disability and autistic people (external reviewers)) and other mortality-related projects. It is well-evidenced that people with learning disabilities die younger than a 'general population', and often due to potentially preventable reasons, with a higher proportion dying in hospital.

The Norfolk and Waveney Integrated Care Board, with whom the learning disability team works closely, approached the Trust to share positive feedback about its 'learning from deaths' programme, with a view to expanding the Trust's model to other local acute hospital Trusts.

The Trust's model for learning from deaths for learning disabilities (and other Complex Health focuses) incorporates several key approaches:

- SJR
- Parallel internal learning disability specialist mortality review (exploring issues of health inequality, diagnostic overshadowing, bias and discrimination)
- Escalation to SJR Scrutiny Panel for patients with learning disabilities where concerns have been identified
- Transparent process inviting external LeDeR reviewers to Panel to encourage cross-agency learning
- Engagement with regional LeDeR steering group, and associated working groups
- Regular learning disability report summarising internal and external mortality-related learning to the Trust's Learning from Deaths committee

The learning disability team is currently engaged in several working groups associated with LeDeR learning, including respiratory care, end of life care, acute

care, and will continue this work in the coming year, also aiming to turn its focus on to other key areas as identified via the LeDeR process.

Child Death Overview Panel (CDOP) Reviews

By the end of quarter 4, there have been 16 paediatric deaths, 2 of which were in young people aged 16+ who were managed entirely under adult teams. Of the 14 children with paediatric involvement, 12 have been discussed in M&M, with the remaining 2 arranged for next month. Of these cases, 5 have so far already been discussed in the Norfolk CDOP panel, alongside cases from previous years.

Case Record Reviews:

Structured Judgement Review (SJR) Method

An SJR is a review conducted by an independent, senior health professional/s using an evidence based methodology for reviewing case notes. It is based on the principle that health professionals trained in SJR use explicit statements to comment on the quality of healthcare in a way that allows a judgement to be made that is reproducible.

Following the implementation of the SJR process across the Trust in May 2019, trained SJR reviewers independently undertake case record reviews outside of their own specialty and make explicit judgements around the quality and safety relating to the patients last admission.

Whilst every inpatient death is independently reviewed by the Medical Examiner Service, they may not require an SJR. The criteria for an 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, Summary Hospital-level Mortality Indicator (SHMI)/ Hospital Standardised Mortality Ratio (HSMR)/ Structured Medication Reviews (SMR) alerts, concerns raised by CQC/ other external regulators
- Coroners Regulation 28 Report (actions which NNUHFT should take to prevent further deaths)
- Aligned to Trust QI priorities
- Patient death from an incident, reported through PSIRF

Following the completion of the SJR, a scrutiny panel may be held with input from relevant expert and specialist teams and, where appropriate, external stakeholders. They will assess the SJR findings to identify key learning and areas of focus for improvement which may ultimately help all patients. The panel will also agree any appropriate governance response. The scrutiny panel chair will thank teams for any notable practise highlighted in the review.

An SJR scrutiny panel will be held when any of the following criteria are met:

- Overall care score is Poor or Very Poor
- Quality of care score indicates Avoidability
- Regulation 28 from the Coroner
- Patient was homeless
- Paediatric patients who have an SJR completed
- Escalation of concerns following a local Learning Disabilities or Severe Mental Illness review
- Escalation of outstanding practice identified through the SJR or following a local Learning Disabilities/Severe Mental Illness review

Table 10: All SJR's completed during the 2024/2025 reporting period, including a breakdown by vulnerable group.

Financial Year 2024/2025	Total Number of SJR's completed during the reporting period	Number of SJR's completed for patients with Learning Disabilities	Number of SJR's completed for patients with Severe Mental Illness	Number of SJR's completed for patients who were Homeless
Q1	39	8	11	1
Q2	40	8	8	2
Q3	56	11	16	0
Q4	37	6	11	0
Total	172	33	46	3

Note: these are total SJR's completed in the 2024/25 period regardless of the date of death.

Table 11: SJR's reviews completed in relation to the deaths which occurred during the 2024/2025 reporting period, including a breakdown by vulnerable group.

Financial Year 2024/2025	Total Number of SJR's completed during the reporting period	Number of SJR's completed for patients with Learning Disabilities	Number of SJR's completed for patients with Severe Mental Illness	Number of SJR's completed for patients who were Homeless
Q1	4	1	0	0
Q2	13	4	3	2
Q3	43	8	12	0
Q4	30	5	11	0
Total	90	18	26	2

Perinatal Mortality Review Tool
A collaboration led by National Maternal and Newborn Infant Clinical Outcome Review Programme (MBRRACE-UK) developed and established a national standardised Perinatal Mortality Review Tool (PMRT) building on the work of the Department of Health/Sands Perinatal Mortality Review 'Task and Finish Group'.

The PMRT was released in January 2018, used by all NHS maternity, and neonatal units in England, Wales and Scotland, as well as being wholly integrated within the MBRRACE-UK programme of work.

The PMRT tool is used on all Stillbirths delivered from 24 weeks, and Neonatal deaths from 22 weeks.
The tool supports:

- Systematic, multidisciplinary, high-quality reviews of the circumstances and care leading up to and surrounding each stillbirth and neonatal death, and the deaths of babies who die in the post-neonatal period having received neonatal care.
- Active communication with parents to ensure they are told that a review of their care and that of their baby will be carried out and how they can contribute to the process.
- A structured process of review, learning, reporting and actions to improve future care.
- Coming to a clear understanding of why each baby died, accepting that this may not always be possible even when full clinical investigations have been undertaken; this will involve a grading of the care provided.
- Production of a clinical report for inclusion in the medical notes.
- Production of a report for parents which includes a meaningful, plain English explanation of why their baby died and whether, with different actions, the death of their baby might have been prevented.
- Other reports from the tool which will enable organisations providing and commissioning care to identify emerging themes across a number of deaths to support learning and changes in the delivery and commissioning of care to improve future care and prevent the future deaths which are avoidable.
- Other reports for use by the Child Death Review process and the PMRT will link with the soon to be commissioned National Child Mortality Database.
- Production of national reports of the themes and trends associated with perinatal deaths to enable national lessons to be learned from the nation-wide system of reviews.
- Parents whose baby has died have the greatest interest of all in the review of their baby's death. Alongside the national annual reports, a lay summary of the main technical report will be written specifically for families and the wider public. This will help local NHS services and baby loss charities to engage patients with the local review process and improvements in care.

Table 12: Case Record Review - Perinatal Mortality Review Tool (PMRT) –

Financial Year 2024/2025	Total Number of PMRTs completed during the reporting period on Neonatal/Post Neonatal deaths	Total Number of PMRTs completed during the reporting period on Still Births
Q1	5	3
Q2	6	4
Q3	2	4
Q4	5	7
Total	18	18

Note: these are total PMRT's completed in the 2024/25 period regardless of the date of death.

Patient Safety Incident Investigations

From the 1st September 2023, the Trust implemented PSIRF and conducts Patient Safety Incident Investigations (PSII) where patient safety incidents meets one of the following criteria:

- Patient safety incident is a Never Event (NE)
- Deaths more likely than not due to problems in care. This can be identified through an incident and/or the learning from deaths process.
- Missed/ Delay in Diagnosis (Patients under the care of the Emergency Department or Medical Specialties where a missed or delay in diagnosis leads to a significant delay in the initiation of essential treatment.)
- Sub Optimal Care (Incidents affecting patients where care is being managed between more than 1 clinical specialty, where management resulted in the patient being transferred to multiple wards and there was a failure or delay in acting on an escalation of a deteriorating clinical situation.)

Within our safety governance processes, all patient safety incidents that have been reported as fatal are discussed at a weekly multidisciplinary Complex Case Review Group (CCRG). The initial facts gathered about the case are presented and reviewed. If the death is judged to be more likely than not due to problems in healthcare a PSII is commissioned. For those where it is not clear, a case record review is undertaken using the SJR methodology to determine if any gaps in care have potentially contributed towards the death. The review is presented at CCRG and if the death is judged more likely than not due to problems in care a PSII is undertaken, if not the review is completed at this point.

Table 13: Patient Safety Incident Investigations reported, and investigations completed in relation to the deaths which occurred during the 2024/2025 reporting period:

Financial Year 2024/2025	Total Number of PSIIs reported in relation to the deaths which occurred during the report period	Total Number of PSIIs completed
Q1	2	2
Q2	2	2
Q3	2	1
Q4	2	0
Total	8	5

Total number of case record reviews and investigations in 2024/2025

By the end of Quarter 4, 118 case record reviews and 5 investigations have been carried out in relation to the 2,269 in-patient deaths reported during the 2024/2025 financial year.

In 0 cases a death was subject to both a case record review and investigation.

The number of deaths in each quarter for which a case record review or investigation was carried out was: 7 in the first quarter; 24 in the second quarter; 50 in the third quarter; 42 in the fourth quarter.

Of the 118 deaths reviewed, 13 representing 0.6% of patient deaths during 2024/2025 (2,269) are judged to be more likely than not to have been due to problems in the care provided to the patient.

In relation to each quarter, this consisted of:
Quarter 1: 2 representing 0.3% of patient deaths during 2024/2025 (604)
Quarter 2: 4 representing 0.7% of patient deaths during 2024/2025 (562)
Quarter 3: 7 representing 1% of patient deaths during 2024/2025 (642)
Quarter 4: 0 representing 0% of patient deaths during 2024/2025 (461)

This number has been estimated using the following:

1. Case record reviews:

Table 14: SJR Case record reviews completed in relation to deaths which occurred during the 2024/2025 reporting period, where the death was judged to be more likely than not due to problems in care

Financial Year 2024/2025	Total Number of SJR's completed relating to deaths during the reporting period	Number of deaths judged at SJR to be more likely than not due to problems in care.	% of Total Number
Q1	4	0	0%
Q2	13	2	15%
Q3	43	6	14%
Q4	30	0	0%
Total	90	8	9%

These numbers have been estimated using the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) grading which it has been mapped to Royal College of Physicians (RCP) 'Avoidability' scores and PSIRF.

Note: Of the 8 deaths judged at SJR to be more likely than not due to problems in care all 8 are awaiting validation at an SJR scrutiny panel.

Table 15: PMRT Case record reviews completed in relation to Neonatal/Post Neonatal deaths which occurred during the 2024/2025 reporting period, where the death was judged to be more likely than not due to problems in care

Financial Year 2024/2025	Total Number of PMRT's completed relating to Neonatal/Post Neonatal deaths during the reporting period	Number of deaths judged to be more likely than not due to problems in care	% of Total Number
Q1	1	0	0%
Q2	6	1(QEHKL care only)	0% for NNUHFT
Q3	2	0	0%
Q4	5	0	0%
Total	14	1	7.14%

Table 16: PMRT Case record reviews completed in relation to Still Births which occurred during the 2024/2025 reporting period, where the death was judged to be more likely than not due to problems in care

Financial Year 2024/2025	Total Number of PMRT's completed relating to Still Births during the reporting period	Number of deaths judged to be more likely than not due to problems in care	% of Total Number
Q1	0	0	0%
Q2	3	0	0%
Q3	4	0	0%
Q4	7	0	0%
Total	14	0	0%

2. Investigations:

Table 17: Patient Safety Incident Investigations completed in relation to patients who have died during the 2024/2025 reporting period where the death was judged to be more likely than not due to problems in care

Financial Year 2024/2025	Total Number of PSII's completed	Number of deaths judged to be more likely than not due to problems in care following investigation	% of Total Number
Q1	2	2	100%
Q2	2	2	100%
Q3	1	1	100%
Q4	0	0	n/a
Total	5	5	100%

Thematic analysis of the death was conducted using Systems Engineering Initiative for Patient Safety (SEIPS) model. SEIPS is a framework for understanding outcomes with complex socio-technical systems.

Learning from Case Record Reviews and Investigations

Methods and tools to share the learning include:

- Dedicated pages on the Trust Intranet the Beat,
- Grand Rounds,
- SJR panel meetings,
- Speciality Mortality and Morbidity meetings,
- Speciality/Divisional Governance Meetings,
- Trust wide OWLS (Organisation Wide Learning)
- Patient Safety Bulletin
- Speciality/Divisional safety newsletters

Below are areas where improvement work is required.

Table 18: Learning from Case Record Reviews – SJRs

	Themes identified through case record review	Update/ Action
1	**Monitoring**	Monitoring is the top theme from the SJR process this year. The main sub-themes include: - Failure to recognise/adequately respond to acute deterioration - Monitoring of oxygenation - Vital Signs/Early Warning Score monitoring This patient safety insight may also triangulate with the PSII criteria 'Missed or delayed diagnosis' which had 7 PSIIs commissioned within the reporting period. Areas for improvement from the PSIIs are monitored through the Learning from Insights and Outcomes Group (LIOG). The Trust continues to implement and extend the 'call for concern' initiative to enable patients, as well as their families, carers, and advocates to contact the Rapid Response team if they are worried about their/the patient's condition. The Trust Recognise and Respond Team (RRT) have recently published changes within the WebV (electronic observation) system and the escalation proforma of increased NEWS scores which bringing us into line with the Royal College of Physicians recommendations in managing patients with escalated NEWS scores. This change will

		help to ensure timely, proportionate reviews are undertaken as per national guidance to help safeguard our patients.
2	**Documentation**	The main sub-themes within the documentation category are gaps in nursing and medical documentation. The Trust continues to use paper case records so there is a higher risk of poor legibility, misfiling, mishandling, loss, or damage. Sub-optimal clinical information data quality is also a theme from work undertaken as part of mortality surveillance and clinical coding A shared EPR across 3 acute trusts in Norfolk and Waveney is currently in the development phase and implementation on track for March 2026. The implementation of the EPR is expected to support a vast improvement in the clinical data quality captured. Furthermore, local audits conducted via Tendable are completed to provide assurance and support improvements at a departmental level regarding the quality of documentation.
3	**Communication and Coordination**	The main sub-themes within the communication and coordination category includes sub-optimal communication between teams and sub-optimal communication with patients/families. Interestingly, communication with patient/family/key workers is the number 1 notable practice across SJRs within the reporting period. The implementation of an EPR (planned March 2026) to provide accurate, up to date and complete information about patients at the point of care, enable quick access to patient records for more coordinated, efficient care and securely share electronic information with patients and other clinicians will also help improve communication between teams. The Trust continues work to improve communication with patients and families via measures such as relative liaison staff, and has recently extended visiting hours on the ward supporting increased engagement between families/visitors and healthcare staff. Furthermore, in collaboration with our community and system partners, the Trust has improved the Transfer of Care form to help communicate care

		needs with any member of the multidisciplinary team across the patients care pathway.

Table 19: Learning from Case Record Reviews – PMRT

	Themes identified through investigations	Update/ Action
1	**Extreme prematurity**	Update following last submission, the employment of a preterm birth/multiple birth specialist midwife to support the service
2	**Social barriers to accessing care**	Childcare, mental health and finances present regularly as reasons why care opportunities are missed. Active listening approach taken and did not attends pursued to identify barriers and personalised approach to overcoming those barriers. Providing taxis for some very vulnerable families has ensured care can be accessed.
3	**Administration of clinic and triage environments**	Actions taken include Birmingham Symptom Specific Obstetric Triage System triage process embedded and new phoneline service in place. Ongoing challenge to ensure there is always administrative support in all maternity areas and that antenatal clinic has administrators to answer the phone for appointment queries.

Table 20: Learning from investigations

	Themes identified through investigations	Comments
1	Deficiencies in verbal and written communication within and between teams within NNUHFT	A large organisational improvement / transformation programme is currently being scoped to address identified deficiencies with communication which will be commenced in 2025/26.
2	Deficiencies in verbal and written communication between NNUHFT and other care providers	
3	Interoperability of clinical systems within NNUHFT and across partner acute hospital providers within Norfolk & Waveney ICS	A new digital patient record system is planned to launch in 2026, will transform acute hospital healthcare within Norfolk & Waveney ICS ensuring that patients receive the right care at the right time by: • Ending the use of paper-based records and disjointed systems • Storing patient information electronically • Streamlining communication between patients and staff

		• Improving and co-ordinating the flow of information between services, making it easier to provide care • Enabling clinicians' instant access to real time health and care information in one place.

Reporting
A comprehensive report on mortality and learning from death data and information including themes, areas for improvement, risks and key actions is compiled and presented to our Clinical Safety and Effectiveness Sub-Board, Quality and Safety Committee (committee of the Board) and through to the Trust Board.

Update on Case Record Reviews and Investigations for 2023/2024

78 case record reviews and 7 investigations were completed after 1st April 2024 which related to in-patient deaths which took place before the start of the reporting period.

Of the 85 deaths reviewed, 14 representing 0.5% of in-patient deaths before the reporting period (2,668) are judged to be more likely than not to have been due to problems in the care provided to the patient.

This number has been estimated using the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) grading which has been mapped to Royal College of Physicians (RCP) 'Avoidability' scores (case record reviews), thematic analysis of the deaths investigations conducted using the Human Factors Analysis and Classification System (HFACS); a coding framework adapted for the NHS Acute Care setting by Shale, S and Woodier, N, (2017) as well as the SEIPS model, and the Perinatal Mortality Review Tool.

24 representing 0.8% of the in-patient deaths (2,668) during 2023/2024 are judged to be more likely than not to have been due to problems in the care provided to the patient.

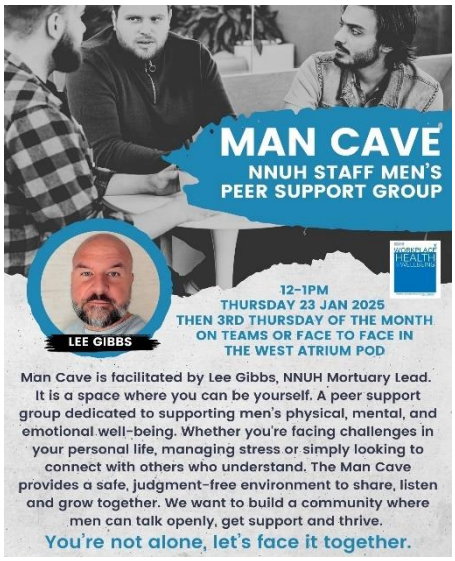
Please note: 16 of the 24 have received confirmation through an full investigation, case review or SJR scrutiny panel to validate the if the death was more likely than not due to care problems in care. The remaining 8 are to be validated through the SJR scrutiny panel process.

Mental Health Matters

One in four adults and one in 10 children experience mental illness, and many more of us know and care for people who do.

Mental disorder is defined, for the purposes of the Mental Health Act, as "any disorder or disability of the mind". With this in mind, it has been so important for the NNUHFT to offer support groups for staff, to enable staff to talk openly and share their thoughts and feelings, within a safe space.

Men's peer support group launched – the 'Man Cave'



The Workplace Health & Wellbeing group will be facilitated by Lee Gibbs, Mortuary Lead, to offer male colleagues a safe space to help deal with personal challenges and stress, build connections and somewhere to share, listen and grow.

Lee said, "*Men's health and wellbeing have been important to me for many years. Over my 20-year tenure here, I've dealt with far too many suicides, especially among men, and think it's very important for them to have a safe place to discuss and explore their feelings as well as receive support and signposting to suitable groups should they wish."*

"I am keen to help because men's wellbeing and support are severely lacking in mental health services. There's a year-on-year national increase in male suicide in the UK, with men aged 45 to 49 most likely to take their own lives—some four times higher than women in a similar age group. Suicide is the biggest killer of men under 50 across all causes of death. I was keen to see if a conversation, listening ear and supportive shoulder in a safe, non-judgemental way could go some way to helping, even in a small way.

"I've been used to having difficult conversations in my role - if I can put that skill set to use in helping those who might be struggling, it would be my pleasure and honour."

Pets As Therapy (PAT) Dogs – Staff Wellbeing Sessions

Since 2018, we have partnered with Pets As Therapy (PAT), a charity founded in 1983, where dedicated volunteers and their calm, friendly pets visit people in various settings to provide animal-assisted therapy (AAT).

The therapeutic benefits of animal-assisted activity are well recognised with research validating the emotional and physical benefits for anyone feeling isolated and withdrawn.

The hospital has a team of well-behaved therapy dogs who make visits to our hospital to spend time with our patients and staff who can interact with them and their owners.

The staff have enjoyed having the opportunity to spend time with the PAT dogs, as well as their human. Staff are able to spend time with the PAT dogs on the last Tuesday of every month.

If you or anyone you know needs help, please contact Mind on: 0300 123 3393 or: https://www.mind.org.uk/need-urgent-help/ but please remember that it is okay to not be okay, and to reach out for help – you are not alone.

Part 2.3 - Reporting against core indicators

Photo of the outside of the Norfolk and Norwich Kidney Centre

Please note that the guidance 'Detailed requirements for quality reports 2020/21 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' (p17).

Summary Hospital Level Mortality Indicator (SHMI) value and banding						
Indicator	NNUHFT Nov 23 – Oct 24 Published by NHS Digital	National Average	Best performer	Worst performer	NNUHFT Sep 22 – Aug 23	NNUHFT Oct 21 – Sep 22
SHMI value and banding	1.1831	1.0036	0.6967	1.2985	1.1979 Band 1	1.2340 Band 1

Location: Summary Hospital-level Mortality Indicator (SHMI) - Deaths associated with hospitalisation, England, November 2023 - October 2024 - NHS England Digital

Latest version available covers: November 2023 to October 2024, published 13th March 2025

The Norfolk and Norwich University Hospitals NHS Foundation Trust considers that this rate is as described for the following reasons:

The 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. The Trust has an opportunity to review and carry out additional quality assurance on some of the indicators produced by NHS England prior to publication.

The 'higher than expected' SHMI is considered to reflect a number of factors which have been identified within an external invited review conducted by the RCP, these include:

- Clinical Data Quality to support Depth of Coding
- Community healthcare provision including limited community palliative care provisions
- Functionality of specific pathways of care –these include Fractured neck of femur, heart failure and septicaemia
- Hospital capacity and utilisation
- Impact of Same Day Emergency Care (SDEC) areas reducing the denominator

The Norfolk and Norwich University Hospitals NHS Foundation Trust has taken and will take the following actions to improve this rate, and the quality of its services:

Following receipt of the external invited review conducted by the RCP, the Trust has updated its mortality action plan which is monitored for oversight through the Mortality Action and Review group. Key improvements already underway include:

- Fragility fractures oversight group. Following introduction of an improved neck of femur pathway for patients at the NNUHFT, the fractured neck of femur SHMI banding has improved from higher than expected to within normal range.
- A Clinical Data Quality improvement workstream including 'probable month' on AMU to improve ability for coders to code probable diagnoses.
- Inclusion of Heart failure, Sepsis, and Falls and Fragility management within the Trust Quality Priorities framework.
- Improved recognition and triaging of frailty to appropriate clinical teams.
- Implementation of call for concern by the Trust RRT

Further opportunities to improve our SHMI level include:

- Introduction and implementation of the EPR to further improve Clinical Data Quality.
- Closer working opportunities with the JPUH and QEHKL within the University Hospitals Group Model.
- Transition to inPhase for mortality data to increase ability triangulation against other areas of insight (incidents and complaints) to improve opportunities to learn from deaths.

% of patient deaths with palliative care						
Indicator	NNUHFT Nov 23 – Oct 24 Published by NHS Digital	National Average	Lowest %	Highest %	NNUHFT Sep 22 – Aug 23	NNUHFT Nov 21 – Oct 22
% of patient deaths with palliative care coded at either diagnosis or specialty level for the reporting period	52%	44%	17%	66%	55%	55%

Location: Summary Hospital-level Mortality Indicator (SHMI) - Deaths associated with hospitalisation, England, November 2023 - October 2024 - NHS England Digital https://digital.nhs.uk/data-and-information/publications/statistical/shmi/2023-03> interactive data visualisation > page 7 (contextual indicators: Palliative Care)

Latest version available November 2023 to October 2024, published 13th March 2025

The Norfolk and Norwich University Hospitals NHS Foundation Trust considers that this rate is as described for the following reasons:

The SHMI methodology does not make any adjustment for patients who are recorded as receiving palliative care. This is because there is considerable variation between Trusts in the way that palliative care is recorded.

SHMI contextual metrics show that more deaths occur in the NNUHFT than the national average and fewer outside hospital within 30 days of discharge. In addition, more deaths have specialist palliative care recorded at either treatment or speciality level than the national average.

The high percentage of patient deaths with palliative care coding is considered to reflect:

- Insufficient community social care provision resulting in more patients dying in hospital. Norfolk has an older population than average. While the proportion (count per 1000 resident population) of people in both North and South Norfolk living in all care homes is close to the national average, the total supply of nursing home beds (as opposed to care) in Norfolk is very low at 2.5 per 100 residents aged 75 years and above. There are also

proportionately less deaths in a hospice than for other parts of the country as a result of inadequate number of hospice beds in the region, leading to more patients being admitted to hospital at the end of their life than receiving hospice care.

- Work by the Trust palliative care team to ensure that patients recognised as end of life have access to specialist palliative care provision in a timely manner and robust systems for capturing this activity.

The Norfolk and Norwich University Hospitals NHS Foundation Trust has taken and will take the following actions to improve this rate, and the quality of its services:
The Trust's has introduced an integrated end-of-life support team in the specialist palliative care team which is providing enhanced support to the wards in managing end of life patients.

PROMS					
Indicator	2023/2024				NNUHFT 22/23
	NNUHFT	National Average	Best performer	Worst performer	
Patient reported outcome scores for groin hernia surgery	No longer measured	No longer measured	No longer measured	No longer measured	No longer measured
Patient reported outcome scores for varicose vein surgery	No longer measured	No longer measured	No longer measured	No longer measured	No longer measured
Patient reported outcome scores for hip replacement surgery	20.932	22.303	No data available	No data available	22.062
Patient reported outcome scores for knee replacement surgery	16.174	16.815	No data available	No data available	15.068

Location: Patient Reported Outcome Measures (PROMs) in England, Final 2023/24 data - NHS England Digital > Adjusted Average Health Gain from Oxford hip and Oxford knee score

Latest version available: April 2023 – March 2024, published 13th February 2025

The Norfolk and Norwich University Hospitals NHS Foundation Trust considers that this rate is as described for the following reasons: the number of patients eligible to participate in PROMs survey is monitored each month.

The Norfolk and Norwich University Hospitals NHS Foundation Trust will take the following actions to improve this rate, and the quality of its services: we have now launched NaNOC, featuring a dedicated physiotherapist and regular wound and telephone follow-up clinics. This initiative has successfully reduced patient length of stay. Additionally, by repatriating patients from private providers back to NNUHFT, we anticipate improvements in our QE-5D and Oxford hip and knee scores, as this patient cohort tends to be in better overall health, leading to more favourable joint replacement outcomes.

28-day readmission rates						
Indicator	2024/2025 (NNUHFT reported based on the NHS Outcomes Framework Specification)				NNUHFT (Apr 23 – Mar 24)	NNUHFT 22/23
	NNUHFT (Apr 24 – Mar 25)	National Average	Best performer	Worst performer		
28-day readmission rates for patients aged 0-15	2.89%	No data published	No data published	No data published	Average Rate 5.6%	Average rate 7.09%
28-day readmission rates for patients aged 16 or over	14.97%	No data published	No data published	No data published	Average Rate 10.8%	Average rate 9.27%
There is no data published since 2012/13. Data above has been based upon clinical coding within Norfolk & Norwich University Hospitals NHS Foundation Trust. **The Norfolk and Norwich University Hospitals NHS Foundation Trust has taken the following actions to improve this rate, and the quality of its services:** Please see our initiatives on virtual ward (page 89), Patient Initiated Follow-Up (PIFU) (page 92) and Executive Length of Stay (page 95).						

Trust responsiveness				
Indicator	CQC Adult Inpatient Survey 2023		NNUHFT 2022	NNUHFT 21/22
	NNUHFT	National Average		
Trust's responsiveness to the personal needs of its patients during the reporting period.	2023 Data has not been published on the CQC website at the time of compiling this account.		7.8 'About the same as others'	No data available
Location: This data has been obtained from the CQC Adult Inpatient Survey – overall view of Inpatient Services. https://www.cqc.org.uk/provider/RM1/surveys/34 **Latest version available:** 2022, published September 2023. **The Norfolk and Norwich University Hospitals NHS Foundation Trust have taken and will take the following actions to improve this rate, and the quality of its services:** The Trust has continued to implement its patient engagement and experience strategy successfully engaging with a number of communities which are the less well heard. The NNUHFT strategy contains experience of care as a key component with continued emphasis on equality, diversity and inclusion. The Patient Engagement & Experience Group (PEEG) continues to oversee divisional reporting against actions arising from all forms of feedback, including the Friends and Family Test (FFT), complaints and PALS and engagement with community groups including Healthwatch Norfolk.				

% Staff employed who would recommend the trust						
Indicator	2024 NHS Staff Survey Results				NNUHFT 2023	NNUHFT 2022
	NNUHFT	National Average	Best performer	Worst performer		
NHS Staff Survey *Q25d If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation.*	54.80%	61.54%	89.59%	39.72%	53.96%	47.09%
The Norfolk and Norwich University Hospitals NHS Foundation Trust considers that this score is as described for the following reasons: This is nationally published results. **The Norfolk and Norwich University Hospitals NHS Foundation Trust will take the following actions to improve this rate, and the quality of its services:** In comparison to 2023, four of the seven People Promise themes (We are Recognised and Rewarded, We are Safe and Healthy, We						

Are Always Learning, We Work Flexibly) and the two additional themes of staff engagement and morale have improved. The People Promise themes of We Are Compassionate and Inclusive, We Each Have a Voice That Counts, We Are a Team have decreased. All improvements and decreases are marginal and not considered statistically significant and therefore NNUHFT have maintained their position in 2024 when compared with 2023. The NNUHFT results score below the Acute Trusts average on themes apart from We Work Flexibly which scored above the Acute Trust average.

When comparing the NNUHFT 2024 question to 2023 results, out of 108 questions 51 questions improved, 4 stayed the same, 1 was new, (so no comparison to previous year) and 52 declined. Progress has been made with the actions in the People Promise programme which has contributed to the improvements experienced by the NNUHFT in the last year.

In summary, we have achieved:

- Reduction in turnover throughout the year, from 8.4% in February 2025 to 6.7% in February 2025
- Continued to support eligible colleagues to retire and return, with 59% of colleagues doing so in 2024
- Time to hire remains good at 34 days
- Car parking project has seen a reduction in those on the waiting list from over 2000 to 840
- Preference rostering was introduced in 2023 and continues to support colleagues with their work life balance, with almost 80% of requests being approved
- Out of the 108 questions, 51 questions improved, and 74 only changed by 1% or less, which indicates the NNUHFT maintained our position in 2024
    - The NNUHFT scored above average for all acute trust for “We work flexibly”

NNUHFT compared with the National Acute Trust Average

When comparing the 108 NNUHFT question scores to the national Acute Trust average, 17 score comparable with or above average, 91 are below average, with 3 questions being equal to the lowest scoring Trust.

We need to make transformational, sustained improvement into how our staff feels about working at NNUHFT. A 3-year Improvement Plan, aligned to the 7 elements of the NHS People Promise, will be updated to reflect the 2024 results, and identify priority actions which will have the greatest impact. Significant improvement over multiple years is required to continue the improvement.

% of patients assessed for Venous Thromboembolism (VTE)

Indicator	2024/2025 (Trust data)				NNUHFT 23/24	NNUHFT 22/23
	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.	99.42%	No data available	No data available	No data available	99.52%	99.35%

Location: The data has been provided by our Digital Health – Business Intelligence Team at NNUHFT and is Submitted as part of the NHSE ‘VTE Risk Assessment Quarterly Data Collection’

The Norfolk and Norwich University Hospitals NHS Foundation Trust considers that this rate is as described for the following reasons: The data has been provided by our Digital Health – Business Intelligence Team at NNUHFT and is Submitted as part of the NHSE ‘VTE Risk Assessment Quarterly Data Collection’

The Norfolk and Norwich University Hospitals NHS Foundation Trust has taken the following actions to improve this rate, and the quality of its services: The target level previously was above 99% and our current level of 99.42%, which is above the standard, this is comparable to the previous year. There will be continued communication and education of staff of risk assessing patients for VTE.

Clostridium difficile						
Indicator	2023/2024 NHS Digital				NNUHFT 22/23	NNUHFT 21/22
	NNUHFT FT 23/24	National Average	Best performer	Worst performer		
Rate per 100,000 bed days of cases of C. difficile infection reported within the Trust amongst patients aged 2 or over during the reporting period	13.2	18.8	0	56.6	15.4	13.68

Note: Data is always a year behind due to the publishing of data after the quality report deadline dates.

Latest data available for 2023/2024
Location: https://www.gov.uk/government/statistics/clostridium-difficile-infection-annual-data#history (drop down selection of rate and hospital onset)

The Norfolk and Norwich University Hospitals NHS Foundation Trust considers that this rate is as described for the following reasons:
The data has been sourced from the UK Health Security Agency's Data Capture System and compared to internal Trust data.

Norfolk and Norwich University Hospitals NHS Foundation Trust has taken the following actions to improve this rate, and the quality of its services:
Measures are in place to isolate and cohort-nurse patients with suspected and confirmed C. difficile, in order to contain the spread of infection, and our Infection Prevention & Control (IP&C) team works in a targeted way to quickly contain any 'Periods of Increased Incidence'. Clinical cleaning processes are in place to contain any suspected infections. National Standards of Healthcare Cleanliness 2021 are in place.

The IP&C team at the NNUHFT work closely together with the ICB and IP&C colleagues throughout the healthcare system to contribute to the C. difficile infection workstream.

Patient Safety Incidents	
Indicator	These indicators are part of the NHS Outcomes Framework, developed by the Department of Health and Social Care to monitor health outcomes and provide an overview of NHS performance. A wide-ranging consultation on the NHS Outcomes Framework was conducted from December 2023 to March 2024, and the results are currently in the final stages of approval. During this period, only five indicators were formally published under the framework, excluding patient safety incidents. Links to other relevant data sources were provided. Since September 2023, the publication of national and organisational patient safety incident reports has been paused. This pause allows NHS England to consider future publication strategies in alignment with the introduction of the Learn from Patient Safety Events (LFPSE) system, which has replaced the National Reporting and Learning System (NRLS). As a result, we are unable to provide data for this indicator at this time. However, further details on our work related to the Patient Safety Incident Response Framework can be found on page 78.
Number and rate of patient safety incidents per 1,000 bed days	
Number and percentage of patient safety incidents per 1,000 bed days resulting in severe harm or death	

Review of Implementation of 7 Day Services

The ten national standards are used to underpin our internal clinical standards of care for our patients and are aligned with our Caring with Pride strategy which reflects our continual commitment to improve the care and experience our patients receive no matter what day of the week they require our care and support.

Seven Day standards performance is evidenced through a number of data sources across the organisation, and compliance has been reported to the Quality Programme Board which meets the reporting standards as required by NHS Improvements. The Trust has evidenced compliance in Standards 1, 3, 4, 6, 9, and 10. Evidence available demonstrates standards 2, 5, 7, and 8 as partially compliant however there is limited data available to demonstrate Trust compliance. Implementation of the Electronic Patient Record (EPR) will enhance data availability to evidence compliance against all standards.

Review of Speak Up Policy

The policy is practical for the user, gives clear guidance and support and underpins safety, transparency, and learning, the key factors for healthy speak up culture.

It directs staff into safety teams and governance channels in divisions. The policy ensures correct channels for escalation are clear, and that emphasis is on the “normality” of speaking up.

Should someone feel they have suffered detriment, guidance to raise this with their manager or a Freedom to Speak Up (FTSU) Guardian is now given. Previously any clarity around this was missing and vague. Statistics around this are reported externally to the National Guardians Office, by FTSU Guardians.

How matters are reported is included, making staff aware of what happens and the Trust more accountable to that process. This policy can now help educate its users on what best practice is and therefore what to expect.

Speak up training is now categorised as essential for staff.

Freedom to Speak Up (FTSU) Guardian Service

The Freedom to Speak Up Service has both vertical and horizontal representation across the NNUHFT, with established senior oversight, seven trained Guardians and a network of Champions from a variety of roles including resident Doctors, administrative and clerical colleagues and nursing staff.

- Designated Non-Executive Director – Sandra Dineen
- Executive Lead – Sarah Gooch
- Lead of Service – Frances Dawson
- Guardians – Aligned to each division (7)
- Champions – Aligned to departments (25+)

The service presents to the Trust Board bi-annually, reporting on key themes such as patient and staff safety, bullying, harassment, sexual misconduct and detriment. Learning from matters raised and the trends presented, is a shared responsibility across the Trust. The FTSU service also presents to Workforce Education Sub-Board (WESB), the Patient Experience and Engagement Group (PEEG) and People and Culture committee. Each of these opportunities brings discussion around what can be improved on or challenged further if necessary.

Service users have an improved experience, an automated booking system is now in place, enabling staff access to a Guardian usually within two working days. The service has a refurbished office, opening in mid April 2025, enabling fast access to a confidential space for discussion and early interventions.

Barriers to staff using the service, are continually considered. Profiles of service users is now collected through anonymous feedback, giving us the insight needed to establish what barriers may still exist for some staff groups.

Proactive work continues with the NHS staff survey findings acting as a guide for the service to support areas where speak up culture is highlighted. Engagement work around detriment continues for example, Resident Doctors forum work and Grand Round meetings have engaged senior colleagues across the Trust to broaden the understanding and knowledge of how to prevent detriment from occurring and support staff speaking up safely.

We continue to be active in the National and East Regional FTSU networks and Communities of practice (COP's). This provides opportunity for sharing practice and learning from other NHS organisations, without boundaries.

Rota Gaps

Each year, approximately 450 resident doctors and dentists join our Trust as part of foundation and specialty training programmes coordinated through Health Education East of England (HEEoE), the regional Deanery.

Ensuring these doctors receive high-quality educational and employment experience remains a central priority to the NNUHFT. While we continue to make progress, we acknowledge that there is more to do.

Our ongoing efforts are collaborative, engaging stakeholders, system partners, and resident doctors themselves in shaping a sustainable, supportive training and working environment.

To drive improvements in rota coverage and the overall experience of our resident doctor workforce, we have focused on the following initiatives:

- **Strengthened Partnership with HEEoE**: We maintain proactive communication to secure timely allocations and data through the Training Information System (TIS), supporting smooth induction and rota planning.
- **Rota and Work Schedule Development**: Our rotas and work schedules are designed in full alignment with national terms and conditions, ensuring

compliance while supporting wellbeing and service needs. Working with departmental rota leads to draft rota patterns ensuring service need is aligned.

- **Supplementing the Workforce**: We continue to address gaps through recruitment of locally employed doctors, Advanced Nurse Practitioners (ANPs), and Physician Associates, improving consistency in care and reducing pressure on training posts.
- **Listening to Feedback**: Insights from the General Medical Council's (GMC) National Training Survey and the National Education and Training Survey (NETS) inform targeted improvements across departments. We will continue to work closely with partners to demonstrate improvements.
- **Empowering Resident Doctors**: Our Resident Doctors Forum provides a structured platform for colleagues to raise any concerns, share ideas, and influence change.
- **Championing Safe Working**: Our newly appointed Guardian of Safe Working Hours ensures safe staffing principles are upheld and responds to concerns raised by resident doctors regarding work hours or conditions. Proactively reviewing exception reporting data to ensure challenges with rota design are highlighted and addressed.
- **Technology-Driven Solutions**: The implementation of Optima, our electronic rostering system for resident doctors, has brought increased visibility, flexibility, and operational efficiency which we will continue to embed within NNUHFT to ensure benefits are realised.

These efforts reflect our commitment to cultivating a positive and sustainable training environment that not only meets the expectations of our resident doctors but also supports the delivery of safe, high-quality patient care.

Cromer Hospital

Background

Cromer Hospital dates to 1866 and the Cromer and District Hospital opened in 1932. Our current hospital was built in 2012, replacing the 1930's founded hospital, and its creation was the result of a legacy left by local resident Segal Bernstein in recognition of treatment received at the hospital for her sister Muriel Thoms (whom our theatre procedure unit is named after). Although stand-alone we are very much part of the NNUHFT and rely on the support of visiting clinicians who help provide the services we deliver.

Picture of outside of Cromer Hospital

Service delivery-what do we offer?

Cromer Hospital is a nurse led community hospital but offers a consultant led outpatient service and procedures unit. We provide over 25 speciality services and have a bespoke North Norfolk Macmillan Unit (NNMC) for cancer treatment and support. We also provide a Minor Injuries Unit (MIU), a Renal dialysis unit and a range of diagnostic services including X-ray, ultrasound, mammography, magnetic resonance imaging (MRI), and bone density (DEXA) scanner. We also have the Cromer 'Allies' eye clinic which forms a significant Ophthalmology service, supporting our main site at NNUHFT. Visiting consultants and nurses provide a range of services covering cataract, retinal and glaucoma services. This includes procedures and a busy outpatient service.

Charitable Support and Community links

Recognition for the support we receive from the Cromer Community and Hospital Friends Charity and the N&N Hospitals Charity cannot be highlighted enough. Without their support we wouldn't have the building and equipment that we have and it's the consistent support from the community and regular donations that provide the ability to develop. In the last 5 years, Cromer Hospital has benefited from grants in excess of £3m from the N&N Hospitals Charity. Donations happen on a weekly basis and that is very motivational for the team at Cromer to feel so valued and strive to offer a range of services that the community needs.

North Norfolk Macmillan Centre

We are immensely proud of our NNMC and were recently awarded the Macmillan Environment Quality Mark for the creation of a service that provides a calm, welcoming environment that will have a positive impact on the care we provide. Our focus at NNMC is on supporting patients on a cancer pathway-through diagnosis to treatment, particularly chemotherapy. Our Information Centre is open to all, every day with no appointment necessary and provides a safe space for people to share their concerns and be supported. We also offer several regular help groups and therapies to support those with cancer and their friends and family. We are working with the team at NNUHFT to offer the option to all patients to receive their chemotherapy at Cromer, where safe and appropriate to do so. This is important as we must maximise capacity at Cromer to enable patients to benefit from a shorter wait time for chemotherapy at our Weybourne Day Unit

Picture above and left of inside the North Norfolk Macmillan Centre

Minor Injuries Unit (MIU)
The MIU at Cromer opens between 8am and 8pm every day of the year and sees an average of 14,000 patients per year. The service is linked to the NNUHFT ED who provide regular advice, support, and guidance.

Renal
The Cromer Renal Dialysis Unit opens 6 days a week and treats over 900 patients a month. The centre cares for patients requiring haemodialysis and hemodiafiltration from North Norfolk and works closely with the Norfolk and Norwich Kidney Centre and NNUHFT. It's a nurse led service and a consultant visit weekly to provide medical management of patients in a supportive environment.

Our Future Ambition

- Palliative care clinics and Breathlessness clinics
- Increased prostrate biopsy procedures.
- Head & Neck cancer outpatients' clinic.
- Movement Disorder clinic (Parkinson's disease)
- New General Surgery clinics
- A research hub capturing the North Norfolk demographic.
- Increasing chemotherapy to support NNUHFT.
- Increase outpatient clinics for Trauma & Orthopaedics.
- Community Midwife support
- Enhanced pain management
- Mental Health support
- A Rheumatology Infusion Service
- A future cataract hub
- Heart Failure Clinic and increased cardiology services; including a new Echocardiogram (ECHO) scanning service

Picture of inside of Cromer Hospital – a reception area

Family & Friends feedback confirms the value that Cromer Hospital adds to the North Norfolk community and it's important that we keep moving forward and can maximise what we can offer. We still have gaps in capacity and missed opportunities when we could be supporting patients and colleagues with extra clinics. However, we are working to close that gap and constantly assessing the environment to ensure we are efficient, caring, and safe.

Part 3 - Overview of the Quality of Care…

Photo of the Cotman Centre

Patient Safety

Patient Safety Incident Response Framework (PSIRF)

The Patient Safety Incident Response Framework (PSIRF) focusses on learning and improvement which supports the development and maintenance of an effective patient safety incident response system that integrates four key aims:

COMPASSIONATE ENGAGEMENT & INVOLVEMENT OF THOSE AFFECTED BY PATIENT SAFETY INCIDENTS

APPLICATION OF A RANGE OF SYSTEM BASED APPROACHES TO LEARNING FROM PATIENT SAFETY INCIDENTS

CONSIDERED AND PROPORTIONATE RESPONSES TO PATIENT SAFETY INCIDENTS

SUPPORTIVE OVERSIGHT FOCUSED ON STRENGTHENING RESPONSE SYSTEM FUNCTIONING AND IMPROVEMENT

One of the underpinning principles of PSIRF is to do fewer “investigations” but to do them better in a small number of areas of highest patient safety risk.

Better means taking the time to conduct a systems-based investigations by people that have been trained to do them.

Our Patient Safety Incident Response Plan (PSIRP)

Our first PSIRP was published in September 2023 and set out how we intended to respond to safety incidents under the PSIRF.

There are only 2 mandated patient safety incidents that must be investigated under PSIRF

- Patient safety incident is a Never Event
- Deaths more likely than not due to problems in care. This can be identified through an incident and/or the learning from deaths process.

Through analysis of our patient safety insights, we identified 2 local patient safety priorities that would undergo an in-depth Patient Safety Incident Investigation (PSII). These were:

Table 21: Local Priorities 2023-25

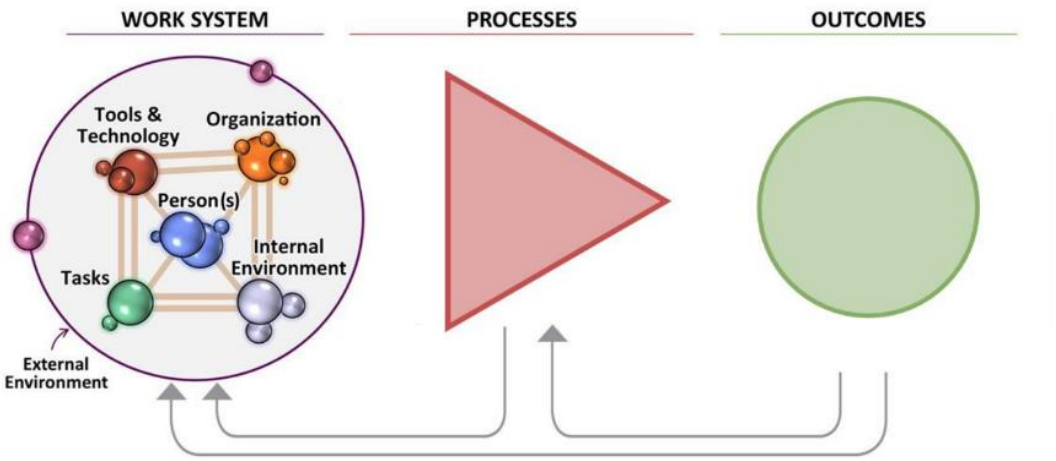
Key Theme	Key Risks from Activity
Missed/ Delay in Diagnosis	Patients under the care of the Emergency Department or Medical Specialties where a missed or delay in diagnosis leads to a significant delay in the initiation of essential treatment.
Sub Optimal Care	Incidents affecting patients where care is being managed between >1 clinical specialty, where management resulted in the patient being transferred to multiple wards and there was a failure or delay in acting on an escalation of a deteriorating clinical situation.

Patient Safety Incident Investigation

We have 3.8 whole time equivalent (WTE) Patient Safety Incident Investigators who carry out Patient Safety Investigations. They are trained in the use of the Systems Engineering Initiative for Patient Safety (SEIPS) model and are equipped with knowledge and tools to support high quality, system-based investigations to identify learning from patient safety incidents.

SEIPS is a framework for understanding outcomes with complex socio-technical systems.

Figure 2 below describes how a **work system** (or socio-technical system, left) can influence **processes** (the work done middle) which in turn shapes **outcomes** (right).



The SEIPS framework acknowledges that work systems and processes constantly adapt and that multiple interactions between the work system factors help us to look at complex system issues rather than simple linear cause and effect relationships.

Table 22: April 2024 – March 2025 PSIIs

Incidents meeting Never Event Criteria to undergo PSII	5
Incidents resulting in death, assessed as more likely than not due to problems in care following Structured Judgement Review to undergo PSII	6
Missed / Delay in Diagnosis to undergo PSII	7
Sub – optimal care to undergo PSII	1
Exceptional PSII due to it being an unexpected incident which signifies an extreme level of risk and where the potential for learning and improvement is great.	1

Patient Safety Learning Responses

Incidents not meeting the criteria for an in depth PSII, but where there is potential for significant learning to be identified, will have a Patient Safety Review using a proportionate learning response to review what has not gone as expected. Divisional Governance teams review all incidents and triage them to the most appropriate learning response as set out in our PSIRF policy. There are a range of system-based approaches which we use to ensure we have a considered and proportionate response which are focussed on learning and improvement following a patient safety incident.

Figure 1. Learning Response Approaches

After Action Review (AAR)	AAR is a structured facilitated discussion of an event, which gives individuals involved in the event understanding of why the outcome differed from that expected and the learning to assist improvement. AAR generates insight from the various perspectives of the Multi-Disciplinary Team (MDT) and can be used to discuss both positive outcomes as well as incidents.
SWARM Huddle	Immediately after an incident, staff 'swarm' to the site to quickly analyse what happened, how it happened and decide what needs to be done to reduce risk.
MDT Review	An MDT meets to identify learning from multiple patient safety incidents; agree the key contributory factors and system gaps; explore a safety theme, pathway, or process; and gain insight into 'work as done' in a health and social care system.
Case note review	A method used to determine whether there were any problems in the care provided to a patient within a particular service.
Structured Judgement Review	A case note review methodology that blends traditional, clinical-judgement based review methods with a standard format. This approach requires trained reviewers to make safety and quality judgements over phases of care, to make explicit written comments about care for each phase. It used to review the last episode of care prior to an inpatient death.
Thematic Review	An in-depth analysis of a specific topic or theme, often used to identify patterns, issues, and good practices across a number of patient safety incidents, using qualitative and sometimes quantitative data.

Table 23: April 2024 – March 2025 Incidents selected for a PSIRF Learning Response

Learning Response	Total
AAR	34
SWARM	1
MDT Review	32
Case Note Review (including SJR)	630
Thematic Review	8
Total	705

Next Steps

We have undertaken data analysis from multiple sources of insight to inform the Trust's local PSII priorities for the next iteration of our Patient Safety Incident Response Plan. There will also be a Norfolk and Waveney system priority for PSII which all providers within the ICS will commit and contribute to. The refreshed version of our PSIRP will be signed off by the Trust Board and will set out how we intend to respond to Patient Safety Incidents in from April 2025 and into 2026.

Never Events (NEs)

'Never Events' are a sub-set of Incidents and are defined nationally as 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 five never events during the period covered by this Quality Account

May 2024	Misplaced NG Tube
May 2024	Wrong site surgery
July 2024	Wrong site surgery
August 2024	Wrong site surgery
March 2025	Wrong site surgery

Never Events remain a national priority that requires a full Patient Safety Incident Investigation under the PSIRF.

MCA wins award for saving baby's life

The Mama Academy Awards 2024 celebrate the unwavering dedication and hard work of all healthcare professionals in the maternity industry who tirelessly support expectant parents and their babies. The Healthcare Professional of the Year award goes to someone who has gone above and beyond to deliver exceptional care. Sarah Arnold, Maternity Care Assistant (MCA) was nominated for her lifesaving work she carried out during a routine shift on our postnatal ward.

Whilst checking a baby's observations she heard an abnormal heart rate and escalated this to her midwife and the Neonatal Intensive Care Unit (NICU) team. A later Electrocardiogram (ECG) confirmed an abnormality, and the patient has since been referred to Great Ormand Street Hospital for further investigation.

Director of Midwifery Stephanie Pease congratulated Sarah on her award: *"Sarah is a credit to the women and children of Norfolk and beyond and to the NHS. Her skills and knowledge helped changed the direction of the babies care and her escalation undoubtedly saved this baby's life. We are incredibly proud of her. Her award recognises the vital work of our MCA team and how this role can be pivotal in the lives of mothers and babies."*

Sarah said: *"I would like to thank whoever nominated me for this award. I work with a great team of people and love my job. It is a privilege to be part of a great team of people including midwives, MCAs and the neonatal team. We all do a great job caring for mums and babies."*

Martha's Rule

The implementation of patient and family-initiated escalation has been a key focus for the NNUHFT since 2021. During this time, the Trust applied to join the NHS England Worry and Concern Collaborative and participated in two projects exploring the role of patients and families in managing deteriorating patients. As a result, with the release of the Martha's Rule guidance in early 2024, we were well-positioned to move forward with its implementation within NNUHFT.

Martha's Rule Component 1:
Patients will be asked, at least daily, about how they are feeling, and whether they are getting better or worse. This information will be acted on in a structured manner.

To date, we have trialled this initiative on two wards, where patients are regularly asked whether they feel their condition is improving or deteriorating. Initially, this was implemented on paper, but we are now working to develop digital processes to expand and streamline the initiative. During the trial period, we assessed how confident patient's felt in raising concerns about their condition to determine whether the implementation was having a positive benefit.

Key successes from the pilot include exceptional engagement from the trial wards, where staff demonstrated enthusiasm for elevating the patient's voice within their care journey. There is growing recognition that a patient's perception of their condition plays a crucial role in assessing their health. We have also received positive feedback from patients, with many reporting that being asked regularly about their condition would encourage them to escalate concerns if they felt their condition was worsening. This demonstrates the broader impact this initiative can have on patient engagement.

The key challenge remains developing effective methods for collecting and escalating this information. Our goal is to make the process streamlined and integrated with existing systems. As such, we have been collaborating closely with our digital partners to explore how this system can be developed and effectively integrated with our current processes. Following this we have developed an 'App' which we are hoping will be the digital solution we are seeking. Ultimately this process will be embedded within our Electronic Patient Record which is due to launch in 2026 across the ICS.

Martha's Rule Components 2 & 3:
All staff will have the ability to request a review from a different team if they are concerned a patient is deteriorating and not receiving a timely response. This escalation route will also be available to patients, their families, and carers, and will be clearly advertised across the hospital.

In response to this component of Martha's Rule, NNUHFT developed the *Call for Concern* service. This service was initially trialled with patients who had been stepped down from Critical Care, allowing us to refine its processes. Following the release of Martha's Rule guidance, we were ready to roll out the service to all adult

inpatients by July 2024. We then worked collaboratively with the paediatric team, launching the service for paediatric inpatients in January 2025.

So far, we have received 123 calls. We have tried to gain feedback from individuals who have used the service, to determine whether their concern has been resolved, in order to measure the impact of the service. The key successes include embedding the service within the wider Recognise and Respond service for deteriorating patients, ensuring calls are triaged by the appropriate practitioner for a timely response. Additionally, the partnership between adult and paediatric services has been essential in meeting the specific needs of these patient groups.

The primary challenge remains the complexity and nature of some calls received. Communication challenges are a recurring theme in the Call for Concern data, often requiring in-depth reviews to fully understand the concerns raised. This presents challenges in managing the service alongside other workloads and ensuring staff have the necessary communication skills to address complex issues effectively. Ongoing analysis of call data will help us identify areas for improvement and refinement.

Looking ahead, our goal over the next 12 months is to collaborate with colleagues in the Emergency Department, Maternity, and Outpatients to understand how the service could be adapted for these areas. Ultimately, we aim to make the service available in all areas of NNUHFT ensuring equal opportunities and access to this imperative healthcare initiative.

Mortality

Baseline: what increased the focus for the Mortality work you have been doing?

In 2023, the NNUHFT commissioned an invited external review by the Royal College of Physicians (RCP) due to an upward trend in both the Hospital Standardised Mortality Ratio (HSMR) and the Summary Hospital-level Mortality Indicator (SHMI) values. Both mortality metrics showed an increase and were higher than expected from 2020 to 2023. The external RCP review began in August 2023, concluded in March 2024, and the final report delivered to the NNUHFT in February 2025.

The report identified several areas for improvement, including an under-coding of comorbidities, high palliative care activity, opportunities for data quality enhancements, and specific patient pathway groups including sepsis, fractured neck of femur, and congestive cardiac failure that require further review.

What you are aiming to achieve over the next 12 months and beyond.

In response to the report's findings, the Trust has developed an action plan aimed at improving clinical data capture, coding practices, and patient pathways which also interlink with the Trust quality priorities. These improvements are expected to enhance both mortality data accuracy and the delivery of patient care. Progress on the action plan is being monitored within the Trust's recently reinvigorated Mortality Action and Review Group under new clinical leadership.

We continue to utilise and monitor HSMR+ (previously HSMR) and SHMI mortality data to provide insights for diagnosis groups in which relative risk of mortality is higher than expected. We expect and determine a reduction in HSMR+ and SHMI values demonstrating improvements in mortality statistics.

Our aim is to have an HSMR+ and SHMI value less 100 by September 2027. The date of September 2027 has been identified to allow the introduction of the Trusts EPR system supporting wider mortality improvements.

We are committed to reducing our mortality values as a key performance indicator on the quality of safety and care delivered across the NNUHFT.

Falls

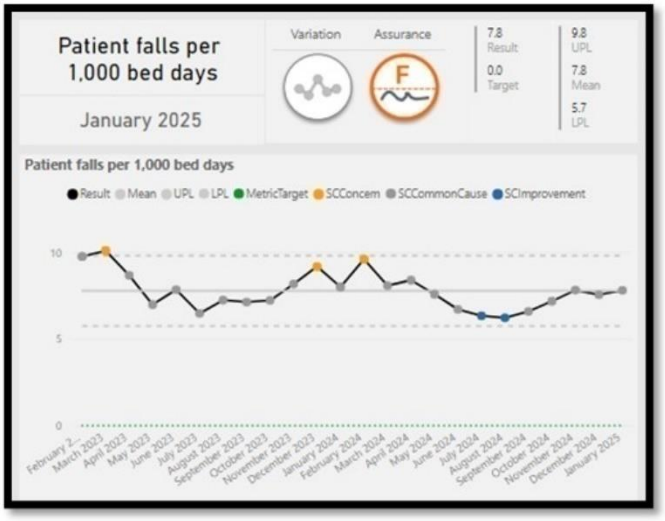
Baseline: what increased the focus for the Falls work you have been doing?

Falls are a common cause of injury in older people with 1 in 3 adults over the age of 65 falling each year, and is among the most frequently reported patient safety incidents in NHS Hospitals. No fall is harmless and can have devastating consequences to patients and their loved ones, and they are extremely costly to the NHS system as a whole. Evidence shows that a co-ordinated multidisciplinary team approach can reduce their incidence.

NNUHFT started its falls work early in 2022 with the appointment of a Falls Lead taking a multifactorial approach to falls prevention in line with NICE Guidance. Norfolk and Waveney have one of the oldest populations in the country, with 25% of the county's population now aged over 65 years. The projected trend is that by 2040 there will be a 55% increase in people aged 75 and over. Therefore, it is vitally important that the safety of our patients from a falls perspective remains high on our agenda as frailty and incidence of diagnoses such as delirium will increase with our ageing population.

What you are measuring success on:

Our successes have been measured through our falls per thousand bed days data which has shown a 7.4% reduction when comparing 2023 to 2024, and based on the findings from the NHS financial regulator the average falls cost in 2017 was £2600 and £3,373 when uplifted for inflation in 2023/2024, this gave us a Trust saving of £775,790 due to reducing total falls by 230 in 2024.



The journey so far this year (April 2024 – March 2025) including successes and challenges:

From April 2024 we rolled out falls assistive technology across NNUHFT, comprising of bed, chair and bathroom sensors. This technology project has supported a sustained improvement in falls reduction, alongside ongoing multidisciplinary team

education, development of falls simulation training and collaborative system working with our stakeholders.

Our most successful collaborative projects have included Alice's Story High Res - Falls Prevention - Age UK Norwich and Norfolk and Norwich University Hospital which follows the missed opportunities across healthcare from a falls prevention perspective. This video animation was co-produced with service users at Age UK Norwich who were attending their falls prevention classes, their anonymised stories were used to create the content for the video.

We have also created a Falls Support Pathway for patients presenting at NNUHFT Emergency Department and Cromer Minor Injuries Unit post fall and being discharged home. These patients after discharge are followed up with their District Councils who will offer holistic support opportunities with a view to preventing further falls and subsequent attendances at hospital.

As always, falls prevention within the hospital environment becomes increasingly challenging during the winter months when infections increase, admissions rise and temporary escalation spaces come into use, not only affecting our patients but also our staffing levels, this then makes a sustained focus on falls prevention more challenging. We also see increased deconditioning in our patients, which in turn increases their risk of falling.

We have also seen that despite a significant reduction in falls, the number of deaths associated from falls have increased; this is likely due to our ageing population who are presenting as increasingly frail due to the pandemic community acquired deconditioning.

What you are aiming to achieve over the next 12 months and beyond.

We are aiming to achieve a further 5% reduction in falls per 1,000 bed days.

Our areas of focus over the next 12 months include:

- Delirium – supporting implementation of screening for all admitted patients aged 65 and over with subsequent monitoring during admission.
- Side Room Safety – developing a protocol for patients who are isolated in a side room, often for infection control reasons, which often lead to delirium increasing the patient safety risk in this environment.
- Working with our Acute Trust partners on the EPR implementation planning from a Falls perspective.
- Increasing our library of falls simulation training resources which have been very well received and have enhanced the education of the multidisciplinary teams.

Expansion of Community Midwifery Services at Cromer Hospital

A new Community Midwifery Clinic at Cromer will open following a charitable grant of £98,000 in Spring

The Norfolk and Norwich Hospitals Charity has awarded the sum to create a dedicated space for the Walsingham Community Midwifery team.

Currently the team sees pregnant women in several locations depending on availability. The new base at Cromer Hospital will provide a permanent base to hold clinics, with access to equipment, IT systems and phlebotomy services.

Pam Sizer, Community Midwifery Matron, said: "*Having easy access to a dedicated local clinic seven days a week will improve choice for women around their appointments, enable us to see more women in their own locality and reduce unnecessary travel time to collect equipment and consumables from the central base in Norwich. Having our own space to use outside routine clinic hours will enable us to further develop our midwifery provision.*

"In addition, it gives us flexibility to support our vulnerable and hard-to-reach families and provide the dedicated space for us to work with our partners, such as our Tobacco Dependency Advisors, to provide additional care at appointments. It will also enable us to continue our strong working relationship with the GP surgery just across the road. The change will support community midwifery staff within their everyday work. Maternity Services would like to thank the Charity on behalf of all the Walsingham team for their support."

Director of N&N Hospitals Charity, John-Paul Garside, said: "*The Charity has been pleased to support the Community Midwives over a number of years, and we are delighted to fund this work which will provide them with a stable base for improved services.*

"We're committed to supporting developments in North Norfolk which will benefit patients and their families. This latest grant means that the Charity has awarded more than £3m to Cromer Hospital over the last five years. Our thanks go to everyone who fundraises for our Charity, and to those who leave gifts in wills, which enable these grants to be made."

Work has begun and the new clinic is due to open in the Spring.

To find out more about the N&N Hospitals Charity or to make a donation please visit: https://nnhospitalscharity.org.uk/

Photo of the front of Cromer Hospital

Clinical Effectiveness

Virtual Ward

Baseline: what increased the focus on the virtual ward
On the 13th of January 2021 all NHS Trusts were asked by NHS England/Improvement to set up a virtual ward (VW) to support inpatients with COVID. Within Digital Health we had already purchased and piloted a number of remote monitoring kits and were able to launch our VW at pace, on the 3rd February 2021 we admitted our first patients. Our initial focus was COVID, but we knew we wanted to use the VW to support recovery.

Since its launch, the VW has gained national recognition as being an exemplar acute hospital VW, winning 3 local and national awards.

In 2022, Integrated Care Systems (ICS) across England were asked to deliver VW capacity equivalent to 40 to 50 VW 'beds' per 100,000 (equivalent to the delivery of up to 24,000 VW beds), by December 2023.

There was a requirement for the Norfolk and Waveney Integrated Care System (N&W ICS) VW, which NNUHFT is part of, to meet the following trajectory:

- 173 virtual wards beds by April 2023
- 368 virtual wards beds by April 2024

Ongoing work with our community providers and the other 2 acute NHS hospitals in Norfolk and Waveney present a significant opportunity to optimise and scale up the current setup. The NNUHFT itself has been asked to support the trajectory by maintaining 60 VW 'beds'.

In the last year we have seen great strides forward in the expansion of the NNUHFT VW and continuing collaboration with our wider Norfolk and Waveney organisations. We have maintained 60 beds with the ability to flex higher to support the needs of the Trust. We continue with Feebris remote monitoring to ensure all organisations within the ICS are using the same technology.

What you are measuring success on

- 98% patient satisfaction of service
- New flexible way of working and more time for 1:1 patient interaction
- Treatment costs reduced by 20-30%
- Patients are three times more likely to be satisfied, and lower incidence of complications in comparison to physical acute bed
- Sets a platform for integrated Virtual Care across the ICS, to improve patient flow through the whole system
- 6,387 patients now seen through Virtual Ward since Feb 2021

The journey so far this year (April 2024 – March 2025)

Successes

- Maintained 60 beds (often above this number).
- A below national average number of readmissions – 8.25%
- 2,830 patients through this year saving 19,700 bed days (Nearly doubled last year's patients which was1,431) This is an average of nearly 8 new patients every day.
- Introduction of three more pathways including our Hyperemesis Pathway which is achieving National Recognition.
- Increasing our Clinical Consultant Champions who support engagement and pathway expansion for the VW.
- Very high satisfaction rating -98.6% of patients "Very Satisfied" with the Service using the Trust approved Friends and Family survey.
- Bimonthly Governance and Morbidity & Mortality Meetings.
- Continue with Feebris in line with Norfolk & Waveney (N&W) system
- NNUHFT model still being requested and followed nationally/international
- Onboarded our first shared patients with the Community Virtual Ward – this means there is a smooth pathway between step up and step down provision.
- Introducing Remote pre assessments with Papworth Hospital which means that patients do not have to travel for these. We are the first Virtual Ward to do this and is now being followed throughout the Country.

Challenges

- Continuing to increase engagement among some clinical colleagues.
- Moving to smaller premises with no clinical treatment area changing working environment and offering for staff and patients.
- Different models of care throughout the ICS Virtual Wards.

What you are aiming to achieve over the next 12 months and beyond:

- We continue to support the ambition of a single ICS wide VW hub so that no matter where you are in across the ICS as a patient you have equal access to the same care.
- Continue to work with community colleagues to explore opportunity of an integrated community and acute VW
- In line with new proposed care group – work to onboard from Emergency Department
- Standardised approach particularly across the 3 acutes.
- Focus on specialities with low referrals across the Trust.

Patient Initiated Follow Up (PIFU)

Patient-Initiated Follow-Up (PIFU) has been a key component of the NHS' outpatient transformation strategy, as outlined in the 2022/23 Operational Planning Guidance. PIFU plays a crucial role in addressing the backlog created by the COVID-19 pandemic, helping healthcare providers manage waiting lists more efficiently while ensuring that patients most in need receive timely care.

At the NNUHFT, three forms of PIFU are offered to provide flexibility and efficiency in patient management. These approaches allow stable, low-risk patients to be monitored digitally, reducing the need for face-to-face (F2F) consultations while maintaining quality care standards. The three models include:

- **PIFU** – Patients are added to the PIFU pathway and are automatically discharged once their target date is reached through Robotic Process Automation (RPA). Patients are generally placed on standard PIFU for up to two years, with reviews at intervals of 3, 6, 12, and 18 months.
- **Extended Patient Initiated Follow Up (XPIFU)** – This model includes a mandatory clinical review before discharge. Patients can remain on an XPIFU pathway for up to five years.
- **Extended Patient Initiated Follow Up Questionnaire (XPIFUQ)** – Similar to XPIFU but integrates a Digital Questionnaire sent to patients. Clinical reviews can be conducted based on their responses, streamlining care through digital means (integrated with DrDoctor/Liaison)

Increased Focus on PIFU

The implementation and success of PIFU at NNUHFT has been driven by dedicated efforts from the Transformation Team, with a strong emphasis on clinical and administrative engagement. Key factors contributing to the increased focus include:

- Providing specialties with knowledge, support, and guidance to establish PIFU pathways effectively.
- Engaging with clinicians to understand the specific needs of their services and identifying suitable patient cohorts for PIFU.
- Conducting presentations, meetings, and one-on-one interactions to foster clinician buy-in.
- Utilising Trust intranet and internal communications to raise awareness and encourage adoption.
- Offering Business Intelligence (BI) reports, allowing specialties to track and act upon their PIFU pathway data efficiently.

These combined efforts have significantly contributed to the successful adoption and expansion of PIFU at NNUHFT.

Measuring Success

Success in PIFU implementation is primarily assessed based on the national 5% requisite set by NHS England (NHSE). This is monitored through both national and local reporting tools, including NHSE, NHS Futures, and internal Business Intelligence (BI) dashboards.

Key performance indicators include:

- Achievement of the national 5% requisite – NNUHFT successfully met this benchmark in July 2023 and has consistently maintained and exceeded it, positioning itself in the national upper quartile.
- Current patient count on PIFU pathways – As of the reporting period, NNUHFT has 37,438 patients on a PIFU pathway.
- Patient discharge rates – 89.5% of PIFU patients are discharged without requesting an appointment, indicating effective patient selection and engagement.
- Utilisation of digital tools (DrDoctor platform) – The Patient Engagement Portal (PEP) provides statistical data supporting patient engagement, reinforcing PIFU's effectiveness in managing follow-ups efficiently

Progress in 2024 and Challenges Encountered

Key Successes:

- Continued expansion of PIFU pathways across multiple specialties.
- Consistent maintenance of 5%+ requisite, ensuring compliance with national guidelines,
- Enhanced clinician engagement through regular training, meetings, and communication updates.
- BI integration, providing real-time monitoring of PIFU activity.
- Sustained patient engagement, ensuring a high discharge rate without unnecessary appointments.

Challenges:

- Encouraging wider adoption across all specialties remains a gradual process, requiring continuous engagement.
- Slow progress on the lab integration project due to technical development constraints and limited support, affecting full-scale implementation.
- Ensuring that clinicians maximise digital solutions such as XPIFUQ and DrDoctor for enhanced efficiency and patient monitoring.

Goals for the Next 12 Months and Beyond

Short-Term Objectives (Next 12 Months):

- Go live with the lab integration project, enabling automated data sharing and influencing the expansion of PIFU pathways.
- Increase PIFU pathway utilisation to 8%, surpassing the national requisite and strengthening NNUHFT's position in the upper quartile.

- Identify and transition patients currently on outpatient waiting lists (especially those past their target date by 12 months) to PIFU pathways, ensuring proactive follow-up and patient empowerment.

Long-Term Vision:

- Maintain and enhance digital patient engagement tools, optimising XPIFUQ pathways to further streamline care.
- Continue national leadership in PIFU adoption, positioning NNUHFT as an exemplar in outpatient transformation.
- Expand clinician training and awareness programs to reinforce best practices and standardise PIFU utilisation across all specialties.

Conclusion

NNUHFT's PIFU program has made significant strides in improving patient care, reducing unnecessary appointments, and effectively managing outpatient pathways. The success in surpassing the 5% national requisite highlights the impact of a well-structured implementation strategy supported by digital innovation, clinician engagement, and robust reporting mechanisms.

Moving forward, the continued expansion of PIFU, successful lab integration, and increased patient engagement will be pivotal in achieving the 8% target and maintaining national excellence in outpatient transformation. While challenges remain, the focus on innovation and efficiency ensures that NNUHFT remains at the forefront of PIFU adoption within the NHS.

Executive Long Stay meeting

Progress and Initiatives

The Executive Length of Stay Reviews commenced on 7th November 2022, with the objective of reducing the number of patients experiencing hospital stays of 100 days or more. At the outset, 21 patients met the criteria. The review group was established under the leadership of the Chief Nurse Office comprising Divisional Representatives, System Partners, and subject matter experts, including specialists in complex health, virtual wards, and tissue viability. The scope of the review has since expanded to include all patients with an inpatient stay of 21 days or more, as well as those flagged through Red2Green Board rounds due to complex discharge requirements.

Clinical Harm Review Group

In response to concerns raised in weekly length of stay meetings, we also established the Executive Length of Stay Clinical Harm Review Group. This group reviews patients whose inpatient stay consists of over 50% of their time being deemed 'no criteria to reside.' To date, 103 patients have been reviewed, with each case presented in detail, including timelines, changes in criteria to reside, and ward transfers.

Key Improvements and Outcomes

Several themes have emerged through these reviews, leading to targeted improvements:

- Optimising Multi-Disciplinary Team (MDT) Meetings within the Stroke Pathway to reduce delays.
- Addressing challenges related to securing nursing home placements for patients under 65.
- Minimising unnecessary ward transfers within the hospital to improve continuity of care.
- Embedding a social worker at the point of admission to support early intervention and avoid unnecessary admissions.
- Enhancing mental health referral and discharge processes, particularly with partners such as Julian Hospital.

Education and Training Initiatives

To further enhance discharge efficiency and patient flow, we have implemented education and training programs for ward teams:

- Training staff on behaviour diary completion for improved patient assessments.
- Delivering Think Norfolk Emergency Access Team education at the hospital's front door to facilitate rapid decision-making.
- Escalating complex patient cases to system partners for multidisciplinary review.

- Strengthening the ‘Think Home First’ approach to promote timely discharges.
- Collaborating with Primary Care teams to ensure that Packages of Care are in place upon patient admission.
- Reviewing the Community Dementia Pathway to enhance continuity of care.

Next Steps

Our next focus area will be the Fast Track Process, specifically addressing the time taken between referral and a patient’s passing before reaching their preferred place for end-of-life care. This review will also assess the interplay between falls, tissue viability concerns, and end-of-life pathways to drive further improvements in patient care.

These ongoing efforts reflect our commitment to reducing unnecessary hospital stays, enhancing patient outcomes, and improving system-wide collaboration.

Norfolk and Waveney Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) Policy

ReSPECT stands for Recommended Summary Plan for Emergency Care and Treatment. The ReSPECT process creates a summary of personalised recommendations for a person's clinical care in a future emergency in which they do not have capacity to make or express choices. Although anyone can have a ReSPECT form it has increasing relevance for people who have complex health needs, people who are nearing the end of their lives or people who are at risk of sudden deterioration or cardiac arrest.

Just before lockdown in March 2020 the ReSPECT initiative was launched in Norfolk and Waveney, including the three acute hospital Trusts, before this 'Ceiling of Treatment' was documented and were relevant a 'Do not attempt cardiopulmonary resuscitation' (DNACPR) forms completed and stored in the persons healthcare records.

Policy alignment is part of the Acute Hospital Collaboratives (AHC) strategic clinical ambition to work together to standardise procedures and processes. The ReSPECT policy was highlighted for alignment, the Trust Leads were all in agreement that this should be a Norfolk and Waveney Integrated Care System (N&W ICS) ReSPECT Policy to optimise the potential quality improvement for patients. Working in isolation would only be working on part of the problem, a joined-up approach with the Integrated Care Board (ICB), Primary, Community, Mental Health, Children and Young People services and Social Care would be more impactful.

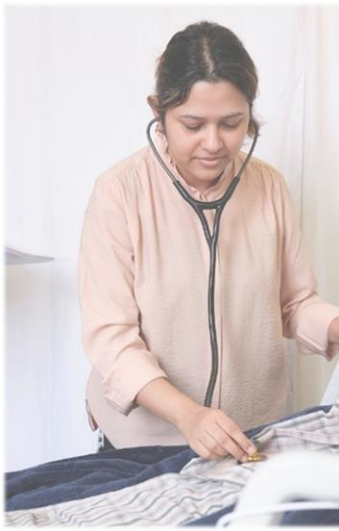
The ReSPECT Policy working group was set up with the initial meeting in December 2023 using the contacts from the initial ReSPECT Project Team that transitioned to business as usual in March 2020. This policy working group was facilitated by the Acute Hospital Collaborative, in addition to the healthcare settings previously mentioned it also included representation from:

- Patient/Carer/Family
- Later Lives Network/Marie Curie
- Adult Hospice
- East of England Ambulance Service Trust

Progress in 2024

An Accelerated Design Event (ADE) was held on the 5th March 2024, this was a face to face meeting to map the existing ReSPECT process and agree policy principles. We reached out to colleagues in the NHS who were leading the way in advanced care planning, but no one had embarked on an ICS policy. Task and fish groups were set up to compose the text for each section of the policy, which were all incorporated into a single document. After the policy working group had reviewed and agreed upon a final draft this was sent out for consultation to all the organisations involved in the creation of the document and Healthwatch Norfolk, Carers Voice and NNUHFT Patient Panel.

Key reporting metrics and methods have been agreed with the Macmillan Palliative and End of Life Care Transformation Lead at the Norfolk and Waveney Integrated care Board.



With no financial cost implication, a ReSPECT Training Faculty has been formed via the policy working group, with all three acute Trusts playing an active role in delivering the Levels 1,2 and 3 ReSPECT training.

Goals for the Next 12 Months and Beyond

Currently the N&W ICS ReSPECT policy has been submitted to the N&W ICB Urgent and Emergency Care Board for approval. When approved, the policy will be implemented alongside the training being provided by the ReSPECT Training Faculty.

The success of the policy and training will be monitored by the agreed reporting metrics and methods.

Conclusion

We have developed a N&W ICS ReSPECT policy with a whole system approach to increase the quality of conversations and documentation in relation to emergency treatment and care. To encourage conversations with patients in relation to emergency care planning to take place and be recorded earlier, when a patient has the capacity and time to make an informed decision. Once the policy has been approved there is an aim to launch both in public and healthcare provider forums.

Our Health Records Department

The Health Records department provides an important service to the wider Trust in terms of the provision of health records and records management.

The former HRL at Francis Way

The department left the former Health Records Library (HRL) at Francis Way in September 2024 after the successful completion of a major project to digitise the Trust's paper records. Between 2021 and 2024 nearly 800,000 legacy records were digitised along with over 1.5 million day-forward records.

Our Retrieval and Dispatch team, based at the main hospital, creates daily consignments of health records for digitisation and ensures that all associated data is correct, thus ensuring that scanned records are available for the use of clinicians within the agreed timescale. This involves the constant use of PAS and the Mediviewer Electronic Document Management System. On average, 58 boxes of records are dispatched every day, equating to 15,500 records each week. They also liaise on a daily basis with colleagues from across the Trust to resolve issues such as missing records, as well as ensuring the flow of the folders which are used for the transport of the records within the Trust.

The Records Management team, based at Rouen Road, deals primarily with the end of the health record lifecycle, reviewing records which have reached their legal retention limit and deciding whether the record needs to be retained or can be disposed. Since the start of 2025 this has included the review of scanned records, utilising the Retention Module in Mediviewer. The team also deals with double registrations on the PAS system (where a patient has been registered twice with different numbers) merging the records when necessary to ensure that the data is accurate.

A third part of the department is the Patient Access team, also based at Rouen Road. This small team deals with patient's requests for copies of their health records under the Data Protection Act 2018 and Access to Health Records Act 1990. They typically process 100 such requests per month and have a 100% compliance rate against the 30-day compliance period.

The former HRL at Francis Way

The Health Records Management team is actively involved as Subject Matter Experts in the next step in the digitisation of our records, the EPR which is due to go live in March 2026.

The former HRL at Francis Way being cleared for the move

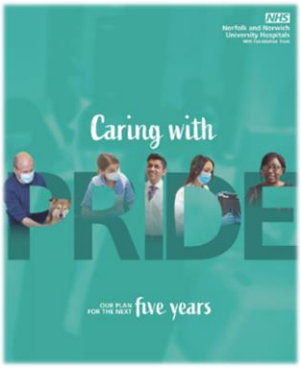
The new HRL at the NNUHFT (at the main hospital showcasing where the retrieval and dispatch team work – the team also work at Rouen Road)

The former Health Records Library at Francis Way

Patient Experience

Patient Experience

As agreed last year, the Patient Engagement & Experience Strategy was extended into 2025. The objectives of Partnership Working, Co-Production, Using Feedback, Supporting Staff and Volunteering were continued. Below we have charted progress and actions during this year against these objectives.



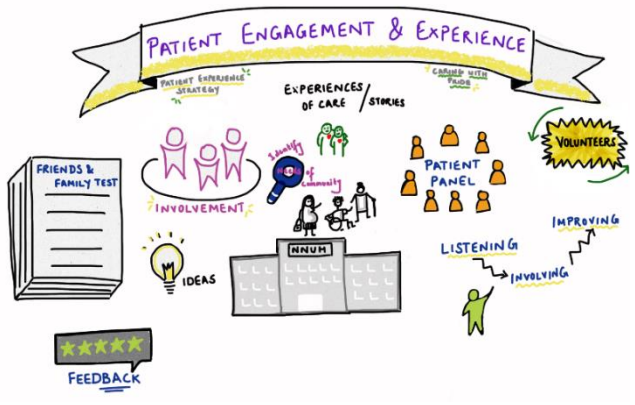
The NNUHFT Caring with Pride Strategy and Patient Engagement and Experience Strategy remain aligned to ensure 'Our Commitment to Patients' is a central tenet and objective for the Trust as a whole.

In 2025, the Trust will utilise the new NHSE Experience of Care Improvement Framework to identify next steps and improvement objectives going forward in support of over-all Trust objectives.

Partnership Working - Working in partnership with patients is normal - there is a strong Patient Voice including those who are seldom heard

Co-production - Services and Pathways are co-designed with patients, staff and other stakeholders

The Patient Engagement Team attended a total of 35 engagement events in 2024 to strengthen the voices of those less well heard or under-served. These ranged from Carers Information Days at The Forum, Norwich PRIDE to hear from lesbian, gay, bisexual, transgender communities; PositiviTea events in north Norfolk focusing on Dementia, People Living with Longterm Conditions and Grieving; Armed Forces Event; visits to His Majesty's Prison (HMP) Wayland, HMP Bure and HMP Norwich and Cromer Carers Meetings at Cromer Hospital.



The team also organised the Trust's Armed Forces Day event in June 2024 and worked with the Chaplaincy Team to organise a Remembrance Service in November that was attended by over 500 NNUHFT staff, patients and visitors. We also continued networking, raising awareness, work collaboratively to:

- Create a collaborative patient story in partnership with Age UK and service users covering falls prevention and the need to tackle this as a system;
- Present the outcomes from our Health Inequalities focussed Maternity and Neonatal Voices Partnership (MNVP) work at NHSE's Experience of Care Week;
- Running our largest Patient Led Assessment of the Care Environment (PLACE) to date with 19 Patient assessors taking part across three days.

This year the team built on the work with colleagues in the Complex Health Hub collecting feedback from prisoners who use our hospital services. By the end of March 2025, we had completed four visits to the prisons in our catchment area. We asked prisoners what has gone well with their care at NNUHFT and what could be improved. The feedback received from these visits has resulted in an action plan being formed to create improvements in communications between the prisons and the hospital.

The Patient Panel's breadth and depth of involvement and engagement across NNUHFT has grown enormously over the last year. As they have become 'embedded' they have developed their understanding of how best they can be 'deployed' to support and work with clinical and non-clinical staff across the Trust - whether on a Committee, Task & Finish Group or as part of a multi-disciplinary team undertaking audits, ward visits or improvement projects. Members' 'portfolios' reflect both the needs of the organisation and Patient/Carer Voices as well as reflecting the passions, interests and expertise of Panel members. This creates a mutual aid and benefit feeling for all involved. Positively supporting a shared ambition of working together as described in the Trust Strategy "Caring with Pride" and our commitment to patients that "together we will develop services so that everyone has the best experience of care and treatment."

The Panel has remained crucial to the PLACE annual audits alongside regular Care Assurance Visits which sees members, alongside clinical colleagues, visits wards and departments to observe and talk with patients and families about their experiences.

Members sit on a number of committees, working and project groups including the Patient Engagement & Experience Group, Mental Health and Complex Care Board, Dementia Strategy Group, Food & Drink Group and Infection Control Committee as well as supporting the production of appropriate patient information via the Patient Information Forum.

Carers Forum

The Carers Forum meets bi-monthly and has continued to work on improving identification of and recognition of carers and support for them when the cared for person is accessing hospital care. We have

been re-accredited the Carer Friendly Award Tick-Health from Caring Together.

The forum and the Patient Experience team supported the system wide co-production of a Carers Identity Passport, now in use across Norfolk and Waveney. This is supporting teams and staff with better identification of carers alongside continued carer awareness training. The forum has supported an ongoing review our Carers' Policy and have supported the co-production of projects providing valuable input to shape our service delivery. We partnered with Caring Together to deliver five online Carers Awareness Trainings to colleagues across the Trust.

Military Community Working Group
The Military Community Working Group (MCWG) has been set up in order to improve experiences of care for patients, staff and carers who have a military background. Supported by an Executive Lead the group is co-chaired by Veterans – a staff member and a Patient Panel member. The priority for the group this year has been to support the Veteran Aware (VA) reaccreditation award.

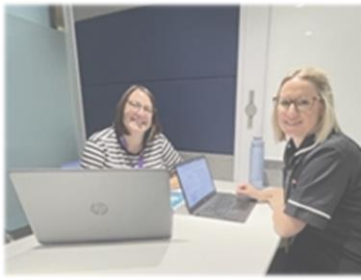
Our newly adopted action plan will continue to support staff with veteran awareness training and support for staff who are veterans. In March 2024, the MCWG supported a SSAFA (Soldiers', Sailors', and Airmen's Families Association - armed forces charity) caseworker (Mandy Small) who visited the hospital, supporting patients and families who are veterans to support discharge and community support. This year Mandy held numerous awareness stands on site where she spoke to 74 employees and over 80 patients/Carers/relatives. In her work on site Mandy referred two patients to Op Courage for ongoing mental health support and referred seven patients to SSAFA and a further eight to other local charities. Mandy also delivered training sessions to the Dementia and Substance Misuse teams about SSAFA and their services

The **Divisions** have continued to strengthen their local patient and carer engagement The hospital's clinical divisions have been strengthening their local patient and carer engagement further throughout the year:

Clinical Support Services Division have strengthened their own patient panel, promoting co-production in quality improvement projects; involvement in research projects, reviewing department patient feedback, external validation of services, sustainability in Pharmacy and capital build projects, including the prestigious new Community Diagnostic Centre (CDC).

One member who was invited on to the CDC Signage Task and Finish Group to resolve a variety of issues said: "I was asked my views on what the inside was going to look like, layout, seating areas and exits. I was shown round the site at the end of 2024. Seeing the building in the flesh and what we had talked about in the meetings I was amazed. It looks fantastic and the layout is really good for flow with colour-coded areas all on one level. It was really interesting to be involved. It is a great facility, which I'm sure it will benefit everyone who needs to access it."

The Maternity department has continued to develop and strengthen their relationship with MNVP supported by the Patient Experience Team. This strong partnership working with the MNVP and the Maternity Department has gone from strength to strength and the new way of working is fully embedded. The innovative Volunteer Outreach roles are working well and have embedded themselves nicely into the community. There have now been five volunteers recruited, with more on the way! The MNVP have made agreements with 30 community groups in the area to host a volunteer at their regular meet ups and they attend groups monthly. MNVP volunteers have attended 22 groups and 5 one-off events in 2024 which supports our aims to amplify people's voices within the NNUHFT maternity team. The focus of their engagement is on the Local Maternity and Neonatal System (LMNS) Equity and Equality Needs Assessment to ensure they focus on underrepresented communities. Attending these groups has led to an increase in anecdotal feedback that we wouldn't have heard without this level of community engagement. This has also helped develop trusted community connections including the 'mini futures' project located in the heart of the Marlpit Housing Estate. MNVP and NNUHFT maternity attend regular stay and play sessions at the centre which provides vital support to one of the most disadvantaged areas in the UK. They have also created links with the local Bengali community and plan to develop this further to encourage and offer opportunities for them to feedback their experience.



A particular highlight this past year has been that the Women's and Children's Division recruited a Youth Worker who has recruited a Youth Forum to work on a range of co-production improvement initiatives.

Following the successful recruitment to the role of Youth Worker within the Women's and Children's Division last year the **NNUHFT Youth Forum** has been formed.

The members, supported by the Divisional team, have been actively engaging young people in shaping healthcare services for just over a year. The forum comprises seven dedicated members who have contributed to various initiatives aimed at enhancing the hospital experience for children and young people.

Achievements in 2024:

- **Jenny Lind Website Enhancement**: The forum provided valuable feedback on updating the Jenny Lind Children's Hospital website, ensuring it is more informative and user-friendly for patients and families.
- **Christmas Fundraising Initiatives**: Members organized fundraising activities to purchase gifts for older age groups during the Christmas season, fostering a sense of community and care among patients.
- **Children and Young People's Plan Development**: Collaborating with the service lead for paediatrics, the forum played a pivotal role in shaping the Children and Young People's Plan, aligning hospital services with the needs and preferences of young patients.

- **Podcast Participation:** The forum contributed to the "Behind the Curtains" podcast, sharing insights and experiences to raise awareness and inform listeners about youth perspectives in healthcare.
- **Community Building**: Through regular meetings and collaborative projects, the forum has fostered a supportive community, providing members with a platform to connect, share ideas, and work collectively towards common goals.

Planned Initiatives for 2025:

- **15 Steps Challenge**: The forum plans to participate in the 15 Steps Challenge, an initiative that allows patients and visitors to experience care environments from a patient's perspective, providing feedback to improve services.
- **Adolescent Room Development**: Members will continue their involvement in the development of the adolescent room, aiming to create a space that meets the unique needs of teenage patients, enhancing their hospital experience.
- **Media Collaboration**: The forum aims to collaborate with local radio stations to promote its activities and raise awareness about the importance of youth engagement in healthcare, reaching a broader audience and encouraging more young people to get involved.

The NNUHFT Youth Forum has demonstrated a strong commitment to improving healthcare services for young patients. Through their diverse initiatives, members have not only contributed to tangible improvements within the hospital but have also built a supportive community that empowers young people to actively participate in shaping their healthcare experiences.

As part of the national patient safety strategy, we have introduced the **Patient Safety Partner** role. During the year we expanded to two Patient Safety Partners at the Trust. This is a new role, drawing in people with lived experience to focus specifically on patient safety strategy issues and initiatives. The two Patient Safety Partners (PSPs) operate at a strategic level as members of the Quality and Safety Committee and Clinical Safety and Effectiveness Sub-Board and support the review and sign off for the new Patient Safety Incident Investigations.

Healthwatch Norfolk Visits from Healthwatch Norfolk continued in several areas within the hospital. In 2024 Healthwatch Norfolk visited the Colney Centre, Acute Medical Units and Maternity Services. You can view all the reports produced by Healthwatch Norfolk on their website. Feedback collected from the visits and via the website is shared at the Patient Engagement and Experience Group sub-board quarterly. The Healthwatch Norfolk team also supported us with the PLACE assessment by joining two of the three assessment days, collected patient opinion on the Major Trauma Centre proposals and supported with our Equality Delivery System (EDS) submission by visiting the Elsie Bertram Centre and the Audiology Department. Healthwatch Norfolk staff gathered feedback from Diabetes and Audiology patients which informed our EDS report about those services.

Using Feedback - Feedback, whether complimentary or critical is proactively sought, coordinated, analysed & used to make improvement - "you said, we did …. Together"
Supporting Staff - All staff feel engaged, confident and empowered to proactively listen, respond and act - from the top and embedded throughout the organisation

Every day we collect feedback via the **Friends and Family Test (FFT)**. This is a nationally endorsed question asking about the quality and experience of care received. In the last year we had over 45,000 responses. Most of these were positive with the Trust highly rated for staff interactions and attitude.

There are multiple routes to collect this including SMS txt messages, QR codes, postcards, links on our website and volunteers playing a crucial role in collecting feedback on wards and via post-discharge phone calls.

Feedback collected from FFT has been used for example by our Divisional Nursing Directors to understand the impact of open visiting, follow a quality improvement methodology and test changes to our approach based on feedback from both staff, visitors and patients.

Responding to concerns and complaints is a key component of a caring and responsive organisation. The **PALS and Complaints** team are central to this and have continued to support patients and families raising concerns and providing support and answers to complaints and concerns and delivering resolution meetings between families and clinicians and other colleagues.

The team has continued to work adhering to the Parliamentary and Health Service Ombudsman (PHSO) framework. We continue to work closely with our Divisions to share themes and fluctuation via monthly meetings.

The Divisions then report to Patient Engagement and Experience Group on how they use the feedback from complaints and PALS to inform learning and improvements. For example: themes around caring for patients in corridors at times of intense pressure which led to the provision of essential extra equipment such as ‘big mack’ portable bells, improved risk assessments and senior oversight. They also identified improvements for end of life care including ‘home from home’ boxes supporting ‘hospice type care in acute settings and a fast-track home checklist. There have also been improvements made to pain management services and spinal care management training.

Through our joint collaboration with the Roald Dahl Marvellous Children’s Charity, we employed our own Children with Medical Complexities Clinical Nurse specialist to support our patients and families to navigate our multifaceted NHS services, enabling them to have more time as a family and alleviate the stresses often involved with attending multiple appointments and being under multiple professional teams. Improving support for new dads and meeting the needs of post-natal mothers has also been addressed.

EDS - During this year, our work with divisions and communities has continued,

using the Equality Delivery System as a tool to measure how we are performing against key equality priorities. The EDS tool has again been utilised by the Patient Engagement and Experience team to gather evidence and evaluate the patient focused Domain 1. The three areas chosen for a focused review this year were Diabetes, Audiology and Maternity.

The grading and evidence contribute evidence to the system wide EDS submission. This work will support the Trust's wider Health inequalities work supporting the most vulnerable and seldom heard communities.

Increased Provision for Interpreting Services

During the year, following feedback from patients and staff, we worked with our Interpreter provider to expand the provision of Virtual Interpreting – we now have a network of 25 'Interpreters on Wheels' (IOW) enabling on demand access to over 240 languages via audio 24/7 and over 40 languages via video. The technology is also available to use on all Trust iPhones and iPads.

Since we introduced this new technology into the Trust it's been used over 494 times across the hospital. The shortest call was 1 minute and the longest lasted 289 minutes. We've received glowing feedback from the departments who initially trialled the IOW devices in Radiology and Maternity.

"It was worth more than its weight in gold for us when we had an unexpected stillbirth with a family that spoke no English. The fact that it was so simple to connect, had an excellently clear loudspeaker and was portable made the process remarkably easier. It was honestly invaluable as a source of effective communication and easy to use." – Delivery Suite Midwife

"*We have been using an IOW device in Radiology since April. The device has been really well received with feedback from the different areas where it has been used being positive, and staff commenting that they love using it. The IOW has enabled patients to be examined efficiently rather than having to be rebooked and interpreters organised. The face to face function of IOW has been well received by patients. And the moveability/flexibility of the device has enabled patients to access an interpreter whilst laying on the scanning beds."*- Radiology Department

The Board have continued to hear **experience of care stories** at their meetings in public, supporting patient and carers having a voice 'at the top' and grounding the meetings in the reality and issues that matter to the people the Trust serves. Support for recording and utilising experience of care stories and for staff is widely available and experience of care stories are regularly shared as part of the Divisional deep dives at Patient Engagement and Experience Group as well as the Quality & Safety Committee.

Family Liaison

The Family Liaison Service came to an end in October 2024. We took lessons learnt from the service and created a Family Liaison Practice Facilitator role to embed the learning and approach at ward level directly. The post was supported by SCEC and Medicine divisions and works closely with Deputy Divisional Nurse Directors to develop a programme of support to divisions, wards and departments. The initial

focus will be on supporting opening up visiting and the review of the role of ward clerks and how they are instrumental in improving patient, family and carer communication.

Volunteering - Volunteers support the patient experience to be outstanding through innovative roles and opportunities

We are proud to have a vibrant volunteer community supporting a broad spectrum of areas within the hospital, and who provide an immeasurable contribution to the quality of care received by our patients and their families as well as the working life of our staff. We have over 500 volunteers (across five sites) providing around 3,000 hours of help throughout the Trust every week and we also benefit from the support of volunteers from many external voluntary, community and social enterprise (VCSE) organisations who are able to provide more specialised help.

People volunteer with us for many different reasons. They may be our recovering patients or retired with time on their hands, some are parents at home with a few spare hours to fit around their children, and some may be wishing to gain the confidence to return to work after a break. Students volunteer to gain valuable experience before embarking on medical studies or other hospital-related careers, and people with learning disabilities or physical and mental health disabilities find volunteering a rewarding way to participate in the workplace while feeling valued for the work they do.

The flexible nature of volunteering enables many volunteers to take on more than one role, this offers them a more varied volunteer experience and maximises their potential to make a positive impact throughout the Trust. Our volunteers are trained to support a huge range of areas.

Roles are generalist and specialist and support key milestone in patient journeys e.g. volunteers support patients in the Emergency Department, reducing anxiety and supporting practically with a range of tasks. Inpatients are supported to stay active and undertake gentle exercise, getting them ‘discharge ready’. Other volunteers support at point of discharge as drivers and settle in support; whilst yet more provide follow-up welfare checks post discharge.

Our butterfly volunteers who support people at the end of life have continued to go from strength to strength with more people offering this unique ad person-centred support than ever before.

Innovation is key and this year we have expanded the role of phone volunteer to include outpatient clinic calls – they support our clinics by calling patients a few days ahead of an appointment to check if they are intending to attend, if they understand the preparation for the appointment, if they have any barriers to attending or any concerns about the procedure. Patient concerns are fed back to the bookings teams who are able to address any queries and ultimately avoid non-attendance.

The Maternity Voices Partnership Outreach Volunteer role is another innovation and supports their engagement with and reaching out to less well heard communities to understand their experiences of Maternity Services at NNUHFT.

Our Ophthalmology Outpatients - Eye Clinic

Our outpatient department is a highly efficient and busy facility, managing an impressive average of 70,000 patients annually. We are proud to provide a comprehensive range of services for both adults and children, catering to a variety of needs from routine appointments to emergency care. Our team is equipped to manage a wide spectrum of ophthalmic disorders, including acute eye emergencies, trauma, corneal disorders, and diabetic eye diseases. Additionally, we offer specialised care for chronic eye conditions such as glaucoma and Age-related Macular Degeneration (AMD).

A significant aspect of our workload involves managing AMD, a condition that has become a central focus in our eye clinic. There are two types of AMD, wet and dry. Since the introduction of intravitreal injections in 2009, anti-vascular endothelial growth factor (VEGF) therapy has become the cornerstone of treatment for wet AMD. This medication, which is administered through intravitreal injections (injection directly into the eye through the white of the eye), has shown remarkable results in managing the disease, improving vision and preventing blindness. However, due to the nature of the treatment, patients with wet AMD often require regular and frequent injections, which creates a unique challenge in terms of capacity within the hospital eye services. On average, we administer up to 800 injection procedures per month across 3 sites.

The high demand for anti-VEGF injection treatment has been managed by training a significant number of Specialist Ophthalmic nurse injectors. This proactive approach has enabled us to meet the increasing need for treatments and maintain the high standards of care that our patients expect. By empowering our nursing staff with specialised skills, we have been able to expand our capacity and reduce wait times, ensuring that patients receive timely and effective treatment.

Our department continues to thrive in the face of high demand, utilising a collaborative approach that maximises resources, enhances patient care, and improves outcomes across the three departments - Eye Clinic, Nelson Day Unit and Ophthalmic Theatre. We are committed to providing high-quality ophthalmic care to all our patients, and our innovative solutions ensure that we can meet the evolving needs of our community.

Here at the Norfolk and Norwich we have a team of nurse injectors led by Specialist Nurse Hayley Hubbard. Hayley was appointed Medical Retina Nurse Specialist in 2017 and has since grown and thrived in her role. Hayley is a proficient nurse injector, running up to 4 list per week. This experience has enabled her to help to develop high standard competencies and training material for the 5 additional nurse injectors that she has recruited and who together, now deliver over 75% of the injection treatments across 3 sites.

Photo of the Quadram Institute with surrounding land

Staff Experience

NHS Staff Survey

The NHS Staff Survey 2024 launched at NNUHFT on 7th October 2024 and closed on 29th November 2024. The response rate for the Trust was 47% with 4,508 staff sharing their views, this was the same as the 2023 response rate. The 2024 response rate was slightly lower than the national acute Trust 49% median response rate (benchmarked with 122 acute Trusts).

2024 Staff Survey - benchmark results

The NHS Staff Survey is aligned to the NHS People Promise which describes what NHS staff can expect from their leaders and from each other. These set out, in the words of NHS people, the things that would most improve their working experiences. The NHS Staff Survey therefore tracks progress towards the seven elements of the People Promise:

- We are compassionate and inclusive
- We are recognised and rewarded
- We each have a voice that counts
- We are safe and healthy
- We are always learning
- We work flexibly
- We are a team

In addition to the 7 People Promise themes, there are two additional themes Staff Engagement and Morale.

National benchmarking Results – 122 acute Trusts
When comparing the 108 NNUHFT question scores to the national Acute Trust average, 17 score comparable with or above average, 91 are below average, with 3 questions being equal to the lowest scoring Trust.

NNUHFT scored below the national acute trust average for 6 themes of the People Promise and Staff Engagement and Morale themes. The theme of We Work Flexibly scored above the Acute Trust average.

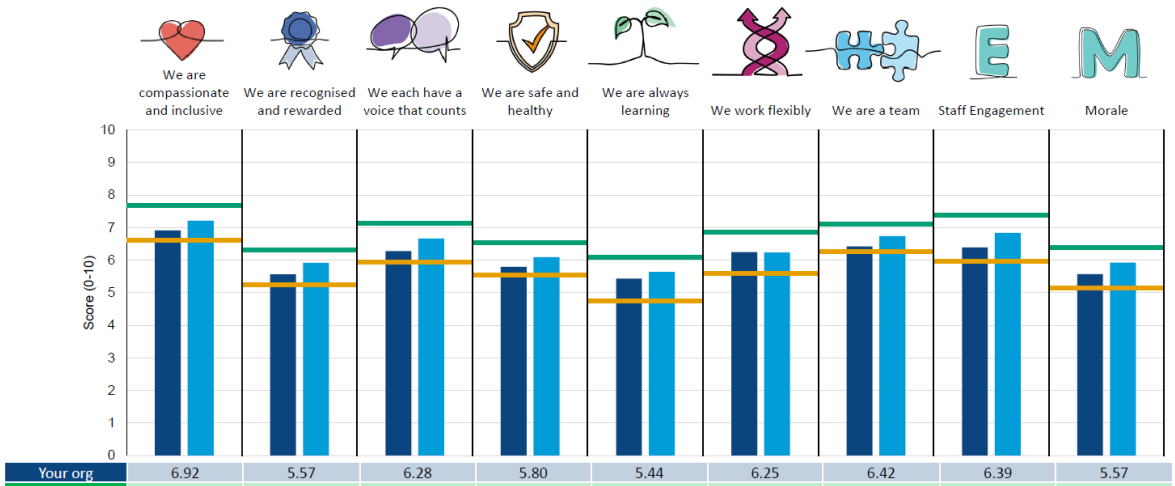
In comparison to 2023, four of the seven People Promise themes (We are Recognised and Rewarded, We are Safe and Healthy, We Are Always Learning, We Work Flexibly) and the two additional themes of staff engagement and morale have improved. The People Promise themes of We Are Compassionate and Inclusive, We Each Have a Voice That Counts, We Are a Team have decreased. All improvements and decreases are marginal and not considered statistically significant and therefore NNUHFT have maintained their position in 2024 when compared with 2023.

The nine themes have 21 sub-scores which make up the overall theme score. 11 sub-scores have improved and 10 decreased from 2023 to 2024. Again, these changes are not considered statistically significant.

When compared with the national acute Trust average:

- 1 is above the national acute average – flexible working
- 4 are aligned to the national acute average – negative experiences, development, support for work-life balance and thinking about leaving.
- 16 are below the national acute average - compassionate culture, compassionate leadership, diversity and equality, inclusion, autonomy and control, raising concerns, health and safety climate, burnout, appraisals, team working, line management, motivation, involvement, advocacy, work pressure and stressors.

NNUHFT 2024 theme scores compared to the benchmark of 122 acute Trusts



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Your org	6.92	5.57	6.28	5.80	5.44	6.25	6.42	6.39	5.57
Best result	7.69	6.30	7.14	6.53	6.09	6.86	7.12	7.39	6.38
Average result	7.21	5.92	6.67	6.09	5.64	6.24	6.74	6.84	5.93
Worst result	6.61	5.24	5.95	5.54	4.76	5.60	6.26	5.98	5.13
Responses	4496	4494	4460	4480	4366	4470	4489	4496	4500

Next Steps

We have built firm foundations in the commitments though our NNUHFT People Promise on which to develop and will continue to focus on delivering the key changes we have identified from staff feedback, that are needed to make NNUHFT a great place to work.

Each Division will examine their own results to identify actions they feel require escalation to our corporate People Promise action plan and those they will take forward themselves.

Our staff listening doesn't end with staff survey and we will continue to hear the views from staff from various channels such as the National Quarterly Pulse Survey, Connected, through our Staff Side, Staff Network and Staff Council representatives and local teams.

Our Hospital Volunteers

Our Volunteers have given over 485 years of service to our hospital

Fifty volunteers were honoured for their long service, including two with 50 years of service.

The award ceremony was also attended, by Stuart Dark, **Chairman of Norfolk County Council**, who along with our hospital **Chair** Tom Spink, presented the awards.

Tom said: "*What an outstanding achievement for the Hospital Radio team, who have brought so much joy to our patients over the last 50 years. I feel very privileged to be part of the long service awards and to recognise the commitment of all our volunteers, who deserve our gratitude and thanks for their contribution to hospital life*."

The long service winners were:
50 Years – Bob Proudfoot, Irenee Proudfoot
20 Years – Irene Haverson
15 Years – Angela Chisholm, Ralph Richley

Further awards were given out for 10 years of service, as well as 5 years.

Sally Dyson, **Voluntary Services Manager**, said: "*Our volunteers are invaluable to the hospital and an absolute inspiration to us all. We're delighted to spend some lovely quality time with them at the volunteers' Christmas party and to recognise those who have shown such long dedication to their voluntary roles. Their support truly enriches the lives of patients and staff across NNUHFT, and we are very grateful to them all*."

New Volunteer Project helps cut did not attend appointments in Radiology

The project has been funded for one year by the Norfolk and Waveney ICB to run at NNUHFT and QEH in King's Lynn. The project began here in Radiology in April and focused on the modality with the highest current did not attend (rate, bone density scans. The aim is to deliver cost savings on missed appointments with better clinic utilisation and improve patient experience by ensuring patients are better prepared for their appointment. Nine volunteers are currently on the project making calls over 36 hours a week.

In the first six months more than 3600 calls were made by volunteers who were able to address more than 500 barriers to attendance. Working closely with the Radiology booking team they have been able to help reduce the current waiting times for some modalities in Radiology and helped improve productivity within the department. The did not attend rate for bone density has been reduced from 7.4% to 1.7%. The team have also gathered positive feedback from patients who have felt better prepared for their appointments and had any worries or concerns alleviated.

Joshua Sperring, Diagnostic Radiology Volunteer Project Co-ordinator said: "*This project has had such a big impact on Radiology. It's great to see the volunteers have had a direct impact on patient experience and reducing waiting times, especially providing reassuring support and being able to comfort patients who are worried or have queries.*"

Volunteer Trevor Freeborn said: "Many people have waited a long time for their appointment and appreciate a reminder call from a real person. The interaction and some positive reassurance during a phone call goes a long way. If a patient was unable to make their appointment, we can ensure they are contacted the same day to reschedule and find another appointment for someone else, avoiding a last-minute cancellation and unused appointment."

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

Statement from Healthwatch Norfolk

Healthwatch Norfolk Statement – NNUHFT Quality Account 2024/2025

Introduction:
Thank you for the opportunity to comment on the NNUH Quality Account 2024/25. The document is, of necessity, technical and data focussed but interspersed with short illustrative examples and case studies. It requires knowledge of NHS methodology and processes to fully understand. There is an executive summary, a glossary and an easy read version. There is also availability in other formats such as Braille. In order to communicate effectively with a general public audience it might be worth considering production of a more accessible version, perhaps a few pages long and written in a journalistic style.

Quality Priorities:
You clearly state how the priorities are selected, the rationale behind this and progress made. To highlight and comment on a few:

Patient safety:

- frailty services; we particularly support the change from age-based triage to clinical needs triage.
- agree with the emphasis you place on the recognition of deterioration, especially the adoption of “Martha’s Rule”.

Clinical Effectiveness:

- support the emphasis on the management of older major trauma patients with the added complications associated with other conditions. Equally support the emphasis on frailty and fragility fractures.
- agree with the importance of patient flow and preventing longer than necessary hospital stays. The readmission rate in 28 days is quoted by this is difficult to place in context compared to other acute hospitals. We also note that increasingly rapid hospital discharges impact the rest of the system, potentially increasing the workload of primary and community care. A “whole system” view would be welcome.
- it is welcome that addressing Core20PLUS5 health inequalities remains a priority.

Patient and staff experience:

- pleased to see the work on transition pathways for young people.
- agree that improving communication around End of Life Care is very important, especially advanced care planning. We would also suggest that you add continuity as a measure of good care. This is important in all areas but especially so in the difficult matter of end of life where building a

relationship with staff members contributes so much to both patient and family satisfaction.

- we welcome the introduction of the ReSPECT policy and, once implemented look forward to a review of success, especially communication with patients and families with clear and careful explanation.
- support the progress on improving learner experiences for professional and other staff who may feel undervalued across the NHS.
- it is good that patient experience and feedback are taken into account by utilising the patient engagement team, patient's panel and carers forum.
- of great concern is that only 54.8% of staff employed would recommend the Trust. This compares to a national average of 61.54% (also worryingly low) and the best trust reporting 89.59%. What can be learnt from the best Trust with a significantly higher result?

Planned Care:
We note that patients waiting for procedures more than twelve weeks are contacted to see if the appointment is still required or priority may have changed.

- how often is this contact repeated, especially for long waits?
- what process is in place to make clinical judgements on the information received and by who?
- how is the outcome communicated to the patient?

Communication:
We welcome the move to an electronic patient record system and the intended improvement to communication both within teams and to patients/carers.

Data Quality:
Note that there are 46 data quality metrics linked to patient pathways which is clearly a thorough attempt to ensure good data collection.

- is there a method within this to ensure that multimorbidity is taken into account? Very few older patients have single clinical problems and judgement is required when selecting which, if any, is the primary problem.
- many of the metrics appear to be financially and managerially based rather than clinically based. Is the balance right?

Learning:
We were impressed with the learning from deaths process which appeared well structured with good learning points for the organisation. This was also reflected in the Patient Safety Incident Response Plan which has recently been introduced and is very impressive.

Conclusion:
Healthwatch Norfolk is committed to working with the Trust to ensure we fulfil our role of "critical friend". We wish to ensure that the views of patients, carers and families are welcomed and taken into account. We will make recommendations for change where appropriate.

We would welcome the opportunity to meet with appropriate Quality Leads at regular intervals.

NNUH is generally well regarded by the local population who understand the pressures and resource limitations effecting the whole NHS. The measurement of quality care and then constant improvement is vital, but we should not forget the human aspect of a hospital admission expressed by one local person: “I just want to feel cared for”.

Alex Stewart
Chief Executive Officer
Healthwatch Norfolk **June 2025**

Norfolk and Waveney
Integrated Care Board

NHS Norfolk and Waveney ICB
County Hall
Martineau Lane
Norwich
Norfolk
NR1 2DH

Date: 14th May 2025

Professor Lesley Dwyer / Chief Executive
Norfolk and Waveney University Hospitals Group
Rachael Cocker, Chief Nurse
Norfolk and Norwich University Hospitals NHS Foundation Trust,
Colney Lane,
Norwich, NR4 7UY

Dear Lesley and Rachael,

Re: Commissioner Response to The Norfolk and Norwich University Hospital (NNUHFT) NHS Foundation Trust's Quality Account 2024/2025

I am writing to confirm that NHS Norfolk and Waveney Integrated Care Board acknowledges the receipt of the draft 2024/2025 Quality Account from NNUHFT and welcomes the opportunity to provide this statement.

Based on the information and data available within the draft report, NHS Norfolk and Waveney ICB supports NNUHFT in the publication of its Quality Account for 2024/2025. Having reviewed the report we are satisfied that the Quality Account incorporates the mandated elements required. The ICB believes that the report captures the key elements of safety, clinical effectiveness, patient experience and well led and demonstrates the Trust's commitment to continuous improvement and quality.

The ICB recognises the Trust's progress and improvements across a range of areas over the last contractual year and the significant pressures and challenges that the workforce has faced with an increased demand on services. We congratulate the staff on the quality of their work and acknowledge the significant pressures that the workforce has faced during sustained system wide pressure. We understand the difficulty in making challenging decisions, particularly those associated with opening escalation and temporary escalation spaces. Whilst the Trust and the ICB have remained clear that this is not acceptable practice, we acknowledge the measures that are in place to keep patients safe, to release ambulances to provide first line emergency care. We note your plans to reduce the need to use escalation spaces.

The ICB recognises the challenges in meeting both the cancer and planned care standards and supports these being a key priority focus for this coming year. We acknowledge the effort that the Trust has made to reduce planned care waiting times

by holding additional clinics and evening and weekend theatre lists and would like to thank colleagues for this. The opening of the Norfolk and Norwich Orthopaedic and Community Diagnostics Centres is a positive step towards increasing capacity and improving patient experience.

We would like to note the Trust's commitment to collaboration with system partners within the Integrated Care System, to collectively strengthen and enhance integrated working practice, focussing resources where our patients need them most. The ICB is delighted with the move to bring patient care closer to your patients with the opening of a new clinic in Dereham for patients with chronic respiratory disease at Dereham Community Hospital and the establishment of a new clinic at Cromer Hospital for patients with heart failure.

The ICB supports the Trust's commitment to make transformational, sustained improvements for staff, in line with the NHS People Promise. We acknowledge the improvements within the staff survey responses, particularly around engagement, morale, and learning, plus recognition of the Trust's commitment to support flexible working. We encourage the continued efforts to increase response rates and deliver key changes identified within staff feedback.

The ICB acknowledges the considerable progress made in response to the enhanced monitoring by the General Medical Council. We recognise the work that has taken place to improve education and training experience for resident doctors, and we commend the Trust's commitment to making further improvements, particularly in relation to organisational culture.

We note the comprehensive update on progress against the quality improvement priorities for 2023/24 and support the rollover of these into the coming year as each remains relevant, with opportunities for further improvement. We acknowledge the extensive work that has taken place to improve patient safety, experience, and clinical effectiveness, particularly in relation to the implementation of Martha's Rule and patient flow and we look forward to continuing our collaborative working with you on these. We acknowledge the work undertaken by the Royal College of Physicians (RCP) mortality review and note the recommendations made to take forward.

The ICB acknowledges the Trust's clear focus on patient care and experience. We are pleased to see the positive implementation of extended visiting hours to ensure significant people for your patients can see and advocate for their loved ones.

The ICB is pleased to see the focus on Children and Young People with the setting up of a forum to align hospital services with the needs and preferences of children and the enhancement of your Jenny Lind website.

We would like to acknowledge your progress with work undertaken to address the Care Quality Commission (CQC) regulatory conditions and additionally recognise and support the Trust's proactive management of the Patient Safety Incidence Response Plan (PSIRP) and learning from Patient Safety Event (LFPSE).

The ICB recognises the significant changes that are taking place within the Trust, including the recent restructure from larger divisions to that of Clinical Care Groups.

The Trust have also entered a group model alongside the other two acute Trusts within Norfolk and Waveney, and we look forward to collaborating closely with you all to provide a locally focused delivery of care to meet the specific needs of our communities, whilst reducing unwarranted variation.

The ICB recognises the challenges ahead and values the commitment from all staff within the Trust. The report provides an opportunity to share with patients, families, carers, and staff the extensive work the organisation is undertaking and demonstrates its commitment to improvement. The ICB supports the Trust's corporate priorities and quality improvement initiatives for 2025/2026.

On behalf of NHS Norfolk and Waveney ICB, I would like to personally thank you, the individuals involved in developing and producing this account and all Trust staff, for the warm welcome we receive and for your transparency and openness. We look forward to building on our collaborative relationship to ensure safe, effective care for our patients and local population during 2025/2026.

Kind regards

Karen Watts
Director of Nursing and Quality
NHS Norfolk and Waveney Integrated Care Board
cc. Patricia D'Orsi, Executive Director of Nursing, NHS Norfolk, and Waveney ICB

Feedback from Governors

Feedback on the Quality Account from Elaine Bailey, Lead Governor, NNUHFT:

Thank you for providing the Norfolk and Norwich University Hospitals Foundation Trust (NNUHFT) Governors with the opportunity to comment on the draft NNUHFT Quality Account (QA) for 2025/26. As Governors, we are tasked with representing patients, public and staff members, ensuring accountability and supporting the continuous improvement of services. Highlighting as it does the Trust's achievements and plans for improvement, the QA provides us with the underpinning evidence base to support our own ongoing endeavours.

Part 2:

The inclusion of both Executive and Non-Executives' statements at the outset of the document sends out a very powerful message of the Trust's 'top down' commitment to the quality agenda and to clinical leadership. The alignment of both the CEO's and the ICS's strategic commitments to support continuous improvement and to mitigate risk with the Trust's 10 quality priorities (QPs) serves to further endorse this.

We note the continuation of focus on the same key QPs for the coming year and are encouraged to see the Trust's progress over the last 12 months. At time of document review, some information on the measures in place for 2025/26 had not been populated. All impactful change is notable and very positive news. Of particular note to Governors is:

- The work around the frailty pathway and the significant reduction in patient stays that have resulted
- Significant progress in reducing standardised mortality scores – we commend the Trust for being an early implementer of Martha's law
- Improving patient flow: we appreciate the huge focus and commitment over the last months to move away from escalation beds. At time of review, details of progression were not available: however, we do note the measures for 2025/26 and are encourage to note the focus on admissions avoidance and acknowledge the work undertaken collaboratively across health and social care in support.
- QP7 and QP8 – incomplete at time of review
- Transition pathways for young people: though not cited as an ongoing priority in the documents, we assume that the development of epilepsy and diabetes pathways will remain ongoing into 2025/26.
- The depth and breadth of Board assurance statements and core indicators evidences the Trust's continuous evaluation and benchmarking of services against both national and local requirements: so too that the Board is effectively overseeing the Trust's performance and risk. This constant evaluation assures the governor group that checks and balances are in place to deliver high quality, safe and effective care and to enable deficits to be promptly highlighted.

Part 3

The inclusion of the Patient Safety Incident Response Framework and Patient Safety Incident Response Plan is helpful in providing an overview of the investigation process. It would be very helpful for governors to understand how staff have reacted to the different way in which events are supported and progressed. It would also be really good to add some examples of learning outcomes and practice change that have resulted from the process.

Congratulations to the Trust for its progression on the virtual ward service. This represents an innovative step in local health care delivery, enhancing patient outcomes whilst optimising our stretched hospital resources. The very high patient satisfaction rates bear testimony to this patient focussed service. We note that the NNUHFT model is regarded as a service exemplar and is still being replicated and followed nationally/internationally.

We also note the NNUHFT's continued national leadership in the Patient Initiated Follow Up adoption, positioning it as an exemplar in outpatient management transformation. It is truly commendable to see such a strong focus on public engagement within the QA. This emphasis reflects a deep commitment to transparency, inclusivity, and patient-centred care. By actively involving patients, families, and the wider community in shaping healthcare services, the Trust demonstrates its dedication to aligning its priorities with the needs and expectations of those it serves.

The public engagement initiatives outlined in the report showcase the Trust's efforts to listen to diverse voices, incorporate feedback into service improvement plans, and foster a culture of partnership. Such a focus on public engagement ensures that the Trust remains accountable, adaptive, and responsive in a rapidly evolving healthcare landscape.

The results of the most recent staff survey indicate both strengths and challenges for the Trust. While NNUHFT scored at or above the national average in 17 areas, highlighting pockets of strong performance and satisfaction, it is concerning that 91 areas were identified as below average.

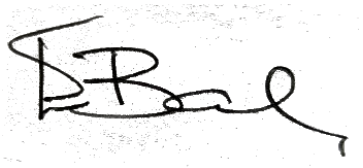
These findings signal a clear need for significant and focused efforts over the next year to address the concerns raised by staff. A motivated, engaged, and supported workforce is essential for delivering high-quality patient care and the Trust must prioritise actions that enhance staff experience, wellbeing, and morale. We appreciate that the Trust remains committed to acting on these survey results and ensuring that every member of the workforce feels valued and supported.

In terms of general layout, the document is clear, concise and the addition of good news stories, case studies and clinical excellence exemplars reflect true patient focus and very positive intra-Trust and wider health and social care collaborations.

The NNUHFT QA provides a comprehensive overview of the Trust's commitment to quality. We commend the significant progress made across the last year against all 10 QPs - this despite the challenges posed by the significant changes across the health and social care landscape.

As Governors, we remain committed to supporting the Trust and ultimately the Group in its journey of continuous quality improvement, ensuring it fulfils its mission to deliver outstanding care to the local and wider community.

We look forward to working collaboratively with the Trust to address the future challenges highlighted in the report and to further enhance the quality of care provided.



Elaine Bailey
Lead Governor
Norfolk and Norwich University Hospitals Foundation Trust

Research offers valuable opportunities to improve health outcomes, for example by identifying patients at risk of developing a disease, slowing disease progression and management of long-term health conditions.

Research is important across all of NNUHFT and key to NNUHFT Caring with PRIDE: Our plan for the next 5 years.

NNUHFT's Research and Development department comprises multi-professional teams (e.g. finance, legal, governance, research administration and delivery) to support the set up and delivery of research studies across a broad range of specialities. Research takes place across all of NNUHFT's wards and outpatient settings together with dedicated clinical research facilities in the main hospital, Neonatal Intensive Care in the Jenny Lind Children's Hospital. NNUHFT clinical research studies are also delivered in the state-of-the-art outpatient Clinical Research Facility housed in the Quadram Institute.

Quadram Institute Clinical Research Facility (CRF)– a Special Partnership

The Quadram Institute, which opened in 2018, represents a unique partnership between NNUHFT, Quadram Institute Bioscience (QIB), University of East Anglia (UEA) and the Biotechnology and Biological Sciences Research Council.

The Partnership jointly supports the CRF-QI and the Norwich Research Park (NRP) Biorepository (a translational research service housed in the Bob Champion Research and Education Building working collaboratively with the CRF-QI) and is a key goal of NNUHFT Research Strategy 2020-2025 to *'Consolidate and deepen the special partnership with the University of East Anglia and Quadram Institute Bioscience'.*

The CRF-QI provides high quality outpatient research facilities for delivering NNUHFT research studies and, reflecting the partnership, studies led by QIB and UEA and supported by NNUHFT's research teams. This covers a range of clinical specialties such as cancer, cardiology, diabetes, gastroenterology, hepatology, infectious diseases, neurology, nutrition, orthopaedics, podiatry and respiratory medicine and training of PhD students in clinical research delivery and support their studies.

In September 2022, NNUHFT successfully secured (£1.3m over 7 years) from the National Institute of Health and Care Research (NIHR), to become the **NIHR Norfolk Clinical Research Facility**, a prestigious award that supports infrastructure (e.g. workforce development) rather than individual research studies positioning NNUHFT alongside 27 other NIHR CRFs in England.

The NIHR Norfolk CRF award is supporting:

- Development of a sustainable highly skilled workforce allowing NNUHFT to participate in complex clinical trials sponsored by commercial sponsors in life sciences.

- Expansion of clinical trials pharmacy with additional satellite pharmacies to support vaccine trials, microbiome research and, in collaboration with QIB, becoming a centre of excellence for Faecal Microbiota Transplantation.
- Enhanced clinical spaces and friendly spaces to support paediatric research participants, well equipped clinic rooms, laboratory space to store research study supplies.

A business development plan (incorporating workforce development) has opened up access to Clinical Research Facility – Quadram Institute (CRF-QI's) additional capacity by:

- Transferring Oncology, Orthopaedics, Respiratory research clinics from the main hospital building with plans for other specialties to follow.
- Delivery of new areas of research in the CRF-QI including paediatric research and early phase clinical trials (i.e. first steps in investigating new medicines) such as two Phase 2 flu vaccine trials. In addition to creating a safe and child friendly environment, this involved enhanced professional competencies of CRF staff in paediatric life-saving skills. Supported by NNUHFT colleagues, research specific risk assessments gave assurance for safe conduct of early phase clinical research (often complex, higher risk) in the CRF-QI and a high-quality experience for research participants.
- A programme of education and engagement regularly offering CRF-QI tours to pharmaceutical companies, overseas academic scientists, research showcase events (including Public Patient Participant Engagement and Involvement), university and high school students and prominent figures (e.g. HRH Princess Royal, the Dutch Ambassador to the UK, Members of Parliament).
- In 2024/25 we welcomed 1,674 research participants in the 34 studies delivered in the CR-QI (monthly average), supported by 26 members of staff.

Further NIHR funding was secured for capital equipment to extend NNUHFT's capabilities to deliver research in neonatal intensive care, maternal health, nutrition and establish research facilities at Cromer Hospital to better serve under-represented populations in North Norfolk.

The NIHR Norfolk Joint Strategic Management Committee (JSMC) oversee the NIHR Norfolk CRF with membership (including the Public Panel sub-group) includes NIHR Norfolk CRF Directors, Public Contributors and NNUHFT, QIB, UEA and NRP representatives to set strategic direction and priorities and monitor performance. All research sponsored by either NNUHFT, QIB or UEA is monitored for regulatory compliance by the Joint Research Governance Committee (JGRC) for compliance with research regulations including patient safety. Both JGRC and JSMC reported to NNUHFT's Research Oversight Board.

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

The Directors are required under the Health Act 2009, National Health Service (Quality Accounts) Regulations 2010 and National Health Service (Quality Account) Amendments Regulation 2011, 2012 and 2017 to prepare Quality Accounts for each financial year. The Department of Health has issued guidance on the form and content of the annual Quality Accounts (which incorporate the above legal requirements).

In preparing the Quality Account, Directors are required to take steps to satisfy themselves that:

- The Quality Account presents a balanced picture of the Trust's performance over the period covered.
- The performance information reported in the Quality Account is reliable and accurate.
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, 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 Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and the Quality Account has been prepared in accordance with Department of Health guidance.

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

Tom Spink Date: 23/06/2025
Chair

Lesley Dwyer Date: 23/06/2025
Chief Executive

Each year some our wonderful staff are nominated for awards, to reflect how hardworking and caring they are.

One of these awards includes the 'Patient Choice Award' for an individual member of staff. Below showcases our incredible winner:

Gill Gray, Consultant

A patient with a young family diagnosed with a rare cancer, nominated Gill for her exemplary care, treatment and kindness. The patient always felt that Gill cared for her holistically and remembered the important things going on in their home life as well as their care and treatment. When the patient was in Priscilla Bacon Lodge for a few months Gill visited the patient regularly after long days at work and spent time on regular visits during the patient's stays on Mulbarton ward. The patient always felt they received the very best care from Gill and also that Gill cared for them as a whole person and took an interest in the patient's home life and family.

Another award includes the 'Patient Choice Award' for a team. Below highlights our fantastic team winner:

Endometriosis Team

The patient nomination for this team describes their outstanding teamwork, support, and exemplary care during treatment for endometriosis. Their unwavering dedication, compassion, and guidance have made a profound difference in their patients' lives. Patients have been deeply grateful for their exceptional care, commitment and compassion. Their wealth of knowledge, empathy, and advocacy on behalf of patients with endometriosis have been truly exceptional and they make sure patients are empowered to make informed decisions about their healthcare. Together, the Endometriosis Team exemplifies the true meaning of teamwork, collaboration, and patient-centred care.

A further award includes the 'Team of the Year Clinical Award', which is sponsored by the Hospitals Charity. This award in the clinical category recognises an outstanding team which really makes a difference to patients. Below demonstrates our extraordinary winner:

N&N and Cromer Minor Injuries team

The team is truly dedicated and has great team spirit working well together over both the N&N and Cromer sites. They always help each other and provide excellent care for our patients which is both informative and holistic. They also provide a high level of support in their department to those training to become autonomous practitioners. The whole team is highly skilled and always share their knowledge with the trainees in the team regardless of workload, providing encouragement and feedback. Everyone in the team is approachable and communicates well, and demonstrate the PRIDE values, creating an environment to provide excellent care.

Please see below for some of the further awards received by our fantastic staff members:

This is the 'Team of the Year Non-Clinical Award', which is sponsored by the N&N Hospitals Charity. This award in the non-clinical category recognises an outstanding team which really makes a difference to patients. Below demonstrates our extraordinary winner:

Cancer Care Navigators Team

The Cancer Care Navigators support patients from the beginning of their pathway for as long as the patient or family carer need them. Since their launch in 2022 they have contacted more than 3000 patients to offer their help. They offer non-clinical advice and support such as information on nutrition, exercise and fatigue and signposting to professional services. The team acts as a listening ear to patients and their families at what can be the most difficult time in their lives. The Cancer Care Navigators are an integral and complementary service to our Clinical Nurse Specialists colleagues in supporting our patients and ensure personalised care is available to each and every patient. They receive excellent patient feedback and every day they continue to provide support to our patients with sensitivity, compassion and kindness.

Another award includes the 'Research Team Award'. This award will go to the team who has made a significant contribution to research at NNUHFT and the University of East Anglia/Norwich Research Park (NRP). Below highlights our excellent winner:

Clinical Research Delivery Team

The Clinical Research Delivery Team comprises over 70 dedicated members, including administrators, data managers, nurses, midwives, practitioners, and allied health professionals (AHPs). This team ensures the smooth operation of research initiatives, from logistical coordination to patient care, emphasising the collaborative nature of their efforts. Through close collaboration with the Clinical Research Network, they have provided numerous training opportunities to the wider Trust, including Greenshoots, associate Principal Investigator training, and an internship scheme. The team has introduced innovative techniques, refined current practices, and challenges conventional wisdom to push the boundaries of knowledge and practice and contributes to the evolution of patient care and scientific understanding.

Apart from fostering collaboration within NNUHFT and UEA/NRP, the team also works with stakeholders from other institutions and organisations in the region, always with an inclusive approach. They are committed to the goal of ensuring equitable access to research opportunities for all patients and has diligently worked to embed research at the forefront of patient care.

Annex 3- Glossary of terms

BATTLE Score	The BATTLE score, also known as the STUMBL (STUdy of the Management of BLunt chest wall trauma) score, is a risk stratification tool used to assess the risk of complications and guide management decisions for patients with blunt chest wall trauma, particularly those with rib fractures
Clinical Audit	The process of reviewing clinical processes to improve them
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.
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.
Dementia	The loss of cognitive ability (memory, language, problem-solving) in a previously unimpaired person, beyond that expected of normal aging
DNA	A self-replicating material that is present in nearly all living organisms as the main constituent of chromosomes. It is the carrier of genetic information.
GPs	General Practitioners i.e., family doctors
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.
LeDeR	Learning from Lives and Deaths - people with a learning disability and autistic people
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
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.

NICU – Neonatal Intensive Care Unit	The unit in the hospital which cares for very sick or very premature babies
No criteria to Reside	Term for patients who are medically fit to leave a hospital but are waiting for social care or primary care services to facilitate transfer
Norovirus	Sometimes known as the winter vomiting bug, the most common stomach bug in the UK, affecting people of all ages
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)
Prescribing	The process of deciding which drugs a patient should receive and writing those instructions down on a patient's drug chart or prescription
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
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
Stroke	The rapidly developing loss of brain function due to a blocked or burst blood vessel in the brain.
Thrombolysis or thrombolysed	The breakdown of blood clots through use of clot busting drugs
Thrombus	A clot which forms in a vein or an artery
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 4 -Acronyms A-Z

AAR	After Action Review
ACP	Advanced Care Plan
AAT	Animal-Assisted Therapy
ADE	Accelerated Design Event
AHC	Acute Hospital Collaboratives
AHPs	Allied Health Professionals
AI	Artificial Intelligence
AMD	Age-related Macular Degeneration
AMU	Acute Medical Unit
ANPs	Advanced Nurse Practitioners
AOS	Door to Needle Time
BAUS	British Association of Urological Surgeons
BHS	British Hernia Society
BI	Business Intelligence
CAP	Clinical Associate Professor
C.difficile (C. diff)	Clostridium difficile
CCOT	Critical Care Outreach Team
CCRG	Complex Case Review Group
CDC	Community Diagnostic Centre
CDOP	Child Deaths Overview Panel
CDS	Commissioning Data Set
CEO	Chief of Operations
CEOG	Clinical Effectiveness Operational Group
CERP	Clinical Expert Review Panels
CEW	Complications For Excess Weight
CFS	Clinical Frailty Score
CIP	Cost Improvement Programme
CMP	Case Mix Programme
COP's	Communities of practice
COPD	Chronic Obstructive Pulmonary Disease
CQC	Care Quality Commission
CQUIN	Commissioning for Quality Improvement and Innovation
CRANE	Cleft Registry and Audit Network
CRF	Clinical Research Facility
CRF-QI	Clinical Research Facility – Quadram Institute
CRM	Cardiac Rhythm Management
CSS	Clinical Support Services
DCP	Divisional Performance Committee
DIB	Diversity, Inclusion and Belonging
DNACPR	Do not attempt Cardiopulmonary Resuscitation
DQMI	Data Quality Maturity Index
DPC	Divisional Performance Committee
DEXA	Bone Density
DPP	Diabetes Prevention Programme
ECG	Electrocardiogram

ECHO	Echocardiogram
ED	Emergency Department
EDI	Equality, Diversion and Inclusion
EDS	Equality Delivery System
ELLA	Environmental Lessons Learned and Applied
ENT	Ear, nose and throat
EOL	End of Life
EPR	Electronic Patient Record
F2F	Face-to-face
FFFAP	Falls and Fragility Fractures Audit Programme
FFT	Friends and Family Test
FLS-DB	Fracture Liaison Service Database
FTSU	Freedom to Speak Up
GP	General Practitioner
GIRFT	Getting It Right First Time
GMC	General Medical Council
GoSWH	Guardian of Safe Working Hours
H@N	Hospital @ Night
HEE	Health Education England
HEEoE	Health Education East of England
HFACS	Human Factors Analysis and Classification System
HMP	His Majesty's Prison
HRL	Health Records Library
HSMR	Hospital Standardised Mortality Ratio
ICB	Integrated Care Board
ICS	Integrated Care Systems
IDT	Inter Deanery Transfer
IFR	Individual Funding Requests
IG	Information Governance
IOW	Interpreters on Wheels
IP	Inpatient
IPOC	Individualised Plan of Care
IP&C	Infection Prevention & Control
IR(ME)R	Ionising Radiation (Medical Exposure) Regulations
JGRC	Joint Research Governance Committee
JPUH	James Paget University Hospitals NHS Foundation Trust
JSMC	Joint Strategic Management Committee
LAAO	Left Atrial Appendage Occlusion
LeDeR	Learning Disability Death Review
LFPSE	Learning from Patient Safety Events
LIOG	Learning from Insights and Outcomes Group
LMNS	Local Maternity and Neonatal System
M&M	Morbidity and Mortality
MBE	Member of the Most Excellent Order of the British Empire

MBRRACE	National Maternal and Newborn Infant Clinical Outcome Review Programme
MCA	Maternity Care Assistant
MCWG	Military Community Working Group
MDC	Medical Devices Committee
MDT	Multi-Disciplinary Team
MINAP	Myocardial Ischaemia National Audit Project
MIU	Minor Injures Unit
MNVP	Maternity and Neonatal Voices Partnership
MPI	Master Patient Index
MR	Medicines Reconciliation
MRI	Magnetic Resonance Imaging
MVLR	National Audit of Mitral Valve Leaflet Repairs
N/A	Not applicable
NACAP	National Asthma and Chronic Obstructive Pulmonary Disease Audit Programme
NACEL	National Audit of Care at the End of Life
NACSA	National Adult Cardiac Surgery Audit
NAD	National Audit of Dementia
NAIF	National Audit of Inpatient Falls
NAFF	Non-Ambulatory Fragility Fractures
NaNOC	Norfolk and Norwich Orthopaedic Centre
NAoME	National Audit of Metastatic Breast Cancer
NAoPri	National Audit of Primary Breast Cancer
NAPCI	National Audit of Percutaneous Coronary Intervention
NATCAN	National Cancer Audit Collaborating Centre
NBOCA	National Bowel Cancer Audit
NCA	National Clinical Audits
NCAA	National Cardiac Arrest Audit
NCAP	National Clinical Audit of Psychosis
NCE	National Confidential Enquiry
NCEPOD	National Confidential Enquiry into Patient Outcome and Death
NCHDA	National Congenital Heart Disease Audit
NCMD	National Child Mortality Database
NDA	National Adult Diabetes Audit
NDFA	National Diabetes Footcare Audit
NDISA	National Diabetes Inpatient Safety Audit
NE	Never Event
NEIAA	National Early Inflammatory Arthritis Audit
NELA	National Emergency Laparotomy Audit
NETS	National Education and Training Survey
NHFA	National Heart Failure Audit
NHFD	National Hip Fracture Database
NHS	National Health Service
NHS E	NHS England
NICE	National Institute for Health and Care Excellence

NICU	Neonatal Intensive Care Unit
NIHR	National Institute for Health Research
NKCA	National Kidney Cancer Audit
NLCA	National Lung Cancer Audit
NNAP	National Neonatal Audit Programme
NNUHFT	Norfolk and Norwich University Hospital NHS Foundation Trust
NNHLA	National Non-Hodgkin Lymphoma Audit
NNMC	North Norfolk Macmillan Unit
NMPA	National Maternity and Perinatal Audit
NOA	National Obesity Audit
NOCA	National Ovarian Cancer Audit
NOD	National Ophthalmology Database
NOGCA	National Oesophago-Gastric Cancer Audit
NPaCA	National Pancreatic Cancer Audit
NPDA	National Paediatric Diabetes Audit
NPID	National Pregnancy in Diabetes Audit
NPCA	National Prostate Cancer Audit
NRAP	National Respiratory Audit Programme
NRLS	National Reporting and Learning Service
NRP	Norwich Research Park
N&W	Norfolk & Waveney
N&W ICS	Norfolk and Waveney Integrated Care System
NVR	National Vascular Registry
OHCAO	Out-of-hospital Cardiac Arrest Outcomes
OP	Outpatient
PALS	Patient Advice and Liaison Service
PAS	Patient Administration system
PAT	Pets as Therapy
PBCP	Personalised Breast Cancer Programme
PEEG	Patient Engagement and Experience Governance Sub-Board
PEOLC	Palliative and End of Life Care
PEP	Patient Engagement Portal
PFOC	Patent Foramen Ovale Closure
PHSO	Parliamentary and Health Service Ombudsman
PIFU	Patient Initiated Follow Up
PLACE	Patient-Led Assessments of the Care Environment
PMRT	National Perinatal Mortality Review Tool
POMH	Prescribing Observatory for Mental Health
PROMs	Patient Reported Outcome Measures
PSII	Patient Safety Incident Investigation
PSP	Patient Safety Partner
PSIRF	Patient Safety Incident Response Framework
PSIRP	Patient Safety Incident Response Plan
QA(s)	Quality Account(s)
QEHKL	Queen Elizabeth Hospital Kings Lynn

QI	Quality Improvement
QIB	Quadram Institute Bioscience
QIP	Quality Improvement Programme
QOMS	Quality and Outcomes in Oral and Maxillofacial Surgery
QPB	Quality Program Board
QS	NICE Quality Standard
RCP	Royal College of Physicians
RDF	Resident Doctors Forum
ReSPECT	Recommended Summary Plan for Emergency Care and Treatment
RPA	Robotic Process Assurance
RRT	Recognise and Respond Team
RTT	Referral to Treatment
RTTOMG	Referral to Treatment Operational Management Group Meetings
SAMBA	Society for Acute Medicine Benchmarking Audit
SCEC	Surgery, Critical and Emergency Care
SDEC	Same Day Emergency Care
SEIPS	Systems Engineering Initiative for Patient Safety
SHMI	Summary Hospital Level Mortality Indicator
SHOT	Serious Hazards of Transfusion
SMART	Specific, Measurable, Achievable, Relevant, and Time-bound
SJR	Structured Judgement Review
SI	Serious Incident
SMR	Structured Medication Reviews
SOP	Standard Operating Procedure
SSAFA	Soldiers', Sailors', and Airmen's Families Association - armed forces charity
SSNAP	Sentinel Stroke National Audit Programme
SUS	Secondary Users Service
TARN	Trauma audit Research Network
TAVI	Transcatheter Aortic Valve Implantation
TES	Temporary Escalation Spaces
TIS	Training Information System
TMTV	Transcatheter Mitral and Tricuspid Valve
UEA	University of East Anglia
VA	Veteran Aware
VCSE	Voluntary, Community and Social Enterprise
VEGF	Vascular Endothelial Growth Factor
VTE	Venous Thromboembolism
VW	Virtual Ward
WESB	Workforce Education Sub-Board
WHO	World Health Organisation
WTE	Whole Time Equivalent
XPIFU	Extended Patient Initiated Follow Up
XPIFUQ	Extended Patient Initiated Follow Up Questionnaire

Our new Community Diagnostic Centre (CDC)

Our CDC is one of three new outpatient imaging centres which have been built at each of the three hospitals in the Norfolk and Waveney area. The other two are at the James Paget University Hospital (JPUH), based in Gorleston, Norfolk, and The Queen Elizabeth Hospital King's Lynn (QEHKL). It follows a combined £85.9 million capital investment from the Department of Health and Social Care, the local health system and a £1.6m grant from the N&N Hospitals Charity, in partnership with the Norfolk Heart Trust.

Outside of the CDC at NNUHFT

The centres are the result of a collaborative programme between our hospitals and the wider ICB. The services they provide will:

- Increase capacity for diagnostic imaging – across the region there will be up to an additional 900 scans per day
- Separate GP referrals and Outpatient appointments from Inpatient and Emergency demand, improving waiting times
- Improve health outcomes with earlier diagnoses
- Provide modern, bright facilities and state-of-the-art equipment to improve the experience for patients and staff
- Standardise practices and collaborative working in Imaging services across the three hospitals.

Each of the sites houses MRI and CT scanners as well as X-ray and Ultrasound imaging. These are used for diagnosis and monitoring of a very wide range of conditions, including cancer, heart disease, stroke, respiratory diseases, trauma, musculoskeletal diseases and neurology. To help deliver the scans, more staff are being recruited including radiographers, radiologists, and support staff.

The building has purposefully been created to offer a calm, soothing and relaxing environment for our patients, as coming for diagnostic imaging can cause anxiety for some.

These larger facilities are being delivered as part of Norfolk and Waveney Integrated Care System's strategy for diagnostic imaging.

The centre will be open between 8am and 8pm seven days a week and is one of three built at the three hospitals across Norfolk and Waveney. The buildings are funded through an £85.9m capital investment from the Department of Health and Social Care.

Inside of the CDC at NNUHFT

The centre has already seen their first patients. Amongst the first in were Philip Hunt and Karen Playford, who were in for CT and MRI scans respectively.

Philip said: "*I am very happy with everything so far – and I was seen bang on time*."

Karen added: "*It is so lovely, clean, fresh and calming. I love it. And the staff have been very helpful explaining everything to me*."

How to contact us

Write to us:

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Email: communications@nnuh.nhs.uk

PALs and Complaints

If you are worried about your care, or your families care, or have some positive feedback to share, please contact our Patient Advice Liaison service (PALs) and Complaints Team on:

Telephone Number: 01603 289036

Email: **palsandcomplaints@nnuh.nhs.uk**