#Proud of the Paget

NHS
James Paget University Hospitals
NHS Foundation Trust

QUALITY ACCOUNT 2024/25

- Patient Safety
- Clinical Effectiveness
- Patient Experience

Quality Account 2024/25 – Contents

Foreword

What is a Quality Account?

All providers of NHS services in England have a statutory duty to produce an annual account to the public about the quality of services they deliver. This is called the Quality Account and includes the requirements of the NHS (Quality Accounts) Regulations 2010 as amended by the NHS (Quality Accounts) Amendments Regulations 2011 and the NHS (Quality Accounts) Amendments Regulations 2012. The Quality Accounts (and hence this report) 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)

Some of the information contained within this Quality Account is mandatory. This report contains all of NHS England's detailed requirements for quality reports, but most is decided by patients and carers, Foundation Trust Council of Governors, staff, commissioners, regulators, and our partner organisations, collectively known as our stakeholders.

Scope and structure of the Quality Account

This report summarises how well the James Paget University Hospitals NHS Foundation Trust ('the Trust') did against the quality priorities and goals we set ourselves for 2024-25 (Looking back)

It also sets out the Quality Priorities we have agreed for 2025/26 and how we intend to achieve them (Looking forward)

This report is divided into three Parts, the first of which includes a statement from the Chief Executive and looks at our performance in 2024/25 against the priorities and goals we set for patient safety, clinical effectiveness and patient experience.

Part 2 sets out the quality priorities and goals for 2025/26 for the same categories and explains how we decided on them, how we intend to meet them, and how we will track our progress. Part 2 also includes statements of assurance relating to the quality of services and describes how we review them, including information and data quality. It includes a description of audits we have undertaken and our research work. We have also looked at how our staff contribute to quality.

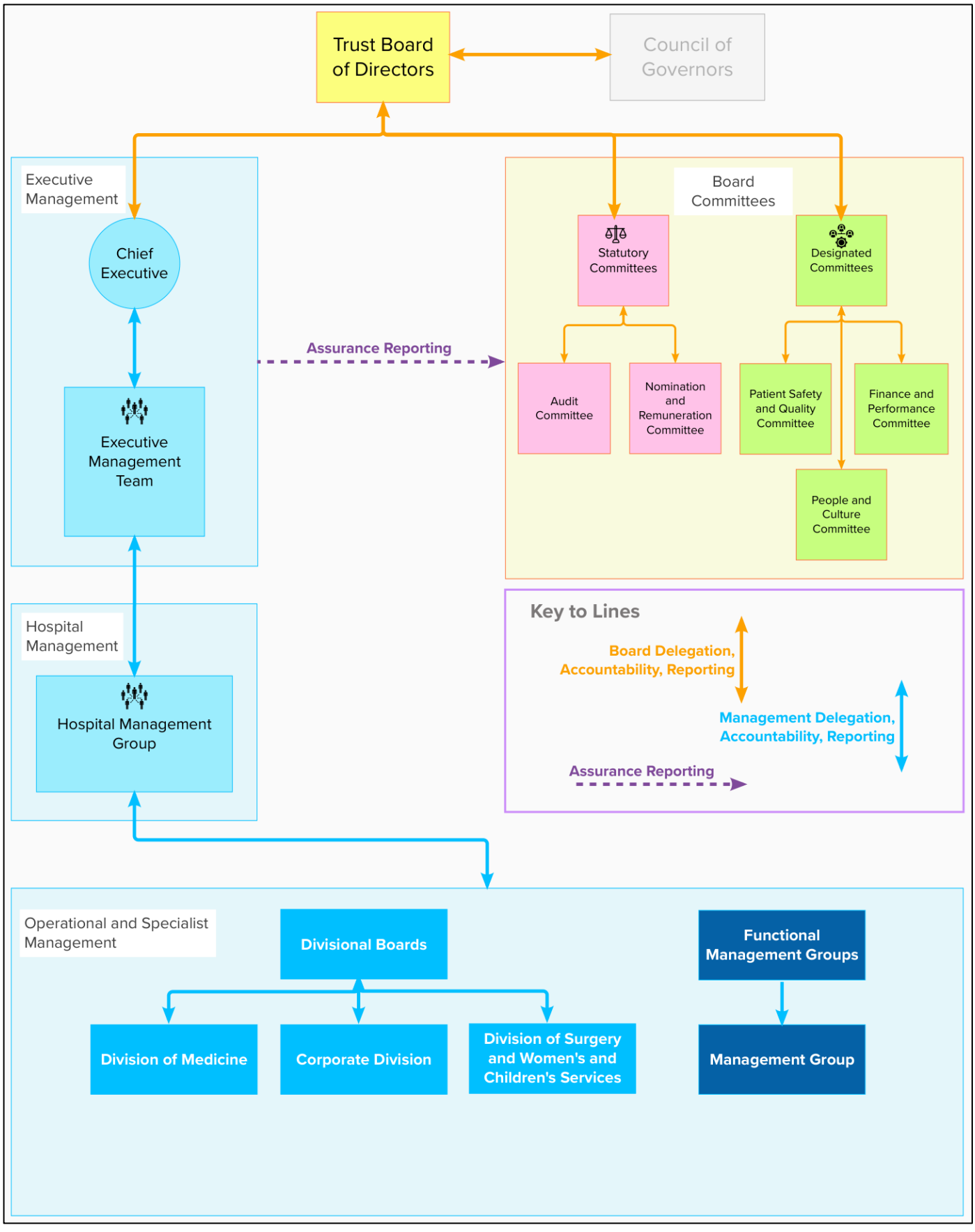
Part 3 sets out how we identify our own priorities for improvement and gives examples of how we have improved services for patients. It also includes performance against national priorities and our local indicators.

The annexes at the end of the report include the comments of our external stakeholders. The annexes also include a glossary of terms used.

Any text shown in blue boxes is a compulsory requirement to be included in the Quality Account as mandated within the NHS England's (formerly NHS Improvement's) Annual Quality Accounts

If you or someone you know needs help understanding this report, or would like the information in another format, such as large print, easy read, audio or Braille, or in another language, please contact our Assistant Director of Patient Safety and Quality by calling 01493 452887 or emailing hannah.sullivan@jpaget.nhs.uk.

Organisational Structure for Quality Performance



Part 1

Statement on Quality from the Chief Executive

Foreword by the Chief Executive

Jo Segasby, Chief Executive

Thank you for taking the time to read our 2024/2025 Quality Account which gives us an opportunity to reflect on the last year and to openly share our performance and outcomes with you.

As Chief Executive of the James Paget University Hospitals NHS Foundation Trust I am pleased to present this report as positive progress the hospital has delivered over the last year and areas where we continue to strive to do better in our ongoing commitment to providing high quality, safe and compassionate care to our patients, and the communities we serve.

This work has been crucial for the hospital in addressing the increasing demand for services and meeting NHS England's performance framework over the past year.

Throughout our efforts, we remain dedicated to ensuring the core aspects of care: the quality and safety of our services, the experience of our patients, and the training and development of our staff. This year's Quality Account illustrates our ongoing success in numerous areas.

These achievements result from the organisation's commitment to openness and learning. Embracing learning opportunities and an improvement approach to enhance the quality and safety of services provided. The report demonstrates our approach in various areas including year two of our three year programme of quality priorities. Building on year one this extended approach continues to give us the opportunity to create enduring change to achieve our ambition to build a healthier future together

We have reflected on the last 18 months of implementing the PSIRF methodology, which continues to increase engagement with patients, families, and carers, as well as supporting staff by understanding that unforeseen events occur and developing skills to identify and implement learning within their teams and for trust wide improvement. The focus is now driving forward the learning achieved to improve the care we deliver.

Our extensive audit programme helps us all understand where service gaps exist and how we work together to address them as well as being able to celebrate when areas of good practice are identified and shared for others to learn from us.

By integrating these advancements throughout our Trust and collaborating closely with our partners, we can significantly enhance our services. This further motivates us to display our dedication to learning and continuous improvement across the hospital.

Looking ahead, the work on developing a group leadership model across the hospitals in Norfolk and Waveney presents an opportunity to address systemic performance and sustainability challenges and provide consistent and clear decision making. This will be vital in delivering the Electronic Patient Record and Acute Clinical Strategy programmes of work, both of which are a key enabler for the two new hospitals builds in Norfolk and Waveney.

To the best of my knowledge, the information in this document is accurate

Jo Segasby
Chief Executive
James Paget University Hospitals NHS Foundation Trust

Part 2

Priorities for improvement and statements of assurance from the Board

2.1 Quality Priorities for Improvement

The Board of Directors agree key quality priorities annually under the three domains of quality for:

- Patient Safety
- Clinical Effectiveness
- Patient Experience

These are identified from and/or aligned to the:

- Trust Improvement Approach Strategy 2023-2026
- Care Quality Commission (CQC) five Key Lines of Enquiry (KLOE)
  - Safe
  - Effective
  - Caring
  - Responsive
  - Well-led
- Governors/Trust Members/local population feedback via questionnaires
- Quality Account priorities from the past year
- Issues identified from the CQC Quality Assurance Framework
- Priorities identified by:
  - NHS England
  - Health Education England
  - Public Health England
  - National Institute for Health and Care Excellence (NICE)
- National Patient Safety Strategy (2019) and Patient Safety Incident Response Framework (August 2022)

The public and patients are involved in identifying risk and bringing this to the attention of the Foundation Trust in a variety of ways, including:

- Via Healthwatch.
- Via our Council of Governors (involved in setting the priorities within the Quality Account).
- Priorities Questionnaire sent to all members via post, social media and Trust website.
- The Trust Board of Directors has continued to include personal patient experience feedback at each monthly meeting to help identify, manage and mitigate key risks.
- Patients and relatives are involved in addressing issues identified through complaints, claims, Patient Advice and Liaison (PALS) and incidents via involvement in investigation and identification of learning.
- Patient Satisfaction Surveys.
- Engagement and involvement of Patient Safety Partners

Public Stakeholders are involved in managing risks that affect them, for example:

- There are Foundation Trust meetings at all levels with members of the Integrated Care Board at which risk is assessed.
- Health Overview and Scrutiny Committees.
- Partnership working with Social Services; and
- Joint working with other health and social care providers as part of the Integrated Care System (ICS) i.e. Norfolk and Norwich University Hospitals NHS Foundation Trust, The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust, East of England Ambulance Service NHS Trust, Norfolk and Suffolk NHS Foundation Trust, and East Coast Community Health Community Interest Company.

Summary of Achievement for Quality Priorities Agreed For 2024/25

The table below lays out a list of all the agreed Trust Quality Priorities for 2024/25 by domain with their end of year status, with corresponding supplementary information reported below each section.

Quality Priority 1:
We will implement and optimise our Patient Safety and learning Culture through the implementation of the Patient Incident Response Framework (PSIRF), QSAFE and learning from incidents
Quality Priority Domain(s):

☒ Patient Safety ☒ Clinical Effectiveness ☒ Patient Experience

i	100% of our staff will be trained in Level one Patient Safety Syllabus (National Priority for achievement by April 2026)	**Not Yet Due** (Deadline April 2026)
ii	85% of our staff will be trained in Level 2 Patient Safety Syllabus (National Priority for achievement by April 2026)	**Not Yet Due** (Deadline April 2026)
iii	At least 90% of staff, patients and relatives will be involved in the incident management process	**Achieved**
Iv	Implementation of "Hot" debriefs, Action After Reviews, Times lines to be fully utilised by all staff across the organisation	**Achieved**
v	Monitor and see a reduction, year on year in complaints relating to poor communication when things go wrong, delays in responding to Patient, Families and staff concerns and not being informed of the outcome/findings	**Achieved**

i. 100% Of Our Staff Will Be Trained In Level One Patient Safety Syllabus

This Priority was **Not Yet Due** for 2024/25, as it is set for achievement by April 2026, and is aligned to a National Patient Safety Syllabus standard.

Quarter 4 and Year End Update

End of 2024/25 Patient Safety Level 1 Compliance across all staff was 83%. Level 1 Patient Safety Syllabus Training has been incorporated into the Trust mandatory training programme for all staff and continues to be monitored monthly.

ii. 85% Of Our Staff Will Be Trained In Level 2 Patient Safety Syllabus

This Priority was **Not Yet Due** for 2024/25, as it is set for achievement by April 2026, and is aligned to a National Patient Safety Syllabus standard.

Quarter 4 and Year End Update

End of 2024/25 Patient Safety Level 2 Compliance across all staff was 83%. Level 2 Patient Safety Syllabus Training has been incorporated into the Trust mandatory training programme for all clinical staff, as well as staff who have a requirement to have enhanced understanding of patient safety. Compliance with this training continues to be monitored monthly.

iii. At Least 90% Of Staff, Patients and Relatives Will Be Involved In The Incident Management Process

This Priority was **Achieved** for 2024/25.

Quarter 4 and Year End Update

- Daily Multidisciplinary Incident Triage meetings for review of all incidents are open to all staff.
- Three-times weekly Safety Action and Assurance Group (SAAG) Meetings for review of escalated incidents as part of PSIRF, ensuring appropriate scrutiny and effective decision making to achieve learning from each incident.
- Sharing of Completed Learning Response Tools with patients/relatives.
- 100% of staff and patients (or relatives where applicable) are involved in the incident management process for patient safety incident investigations (PSIIs). All patients (or relatives where applicable) for whom the Trust commissions a Patient Safety Incident Investigation (PSII) are:
    - assigned a key contact (a Patient Safety Incident Investigator) who maintains regular contact and offers face-to-face meetings.
    - provided with an explanation of the PSII process.
    - invited to contribute to the investigation terms of reference to ensure any concerns are addressed by the investigation.
    - invited to comment, alongside staff involved, on the draft investigation and proposed recommendations.
    - given the opportunity to share their experiences with clinicians as part of system-wide learning from the investigation.
- Participation of Patient Safety Partners in Quality Oversight Groups.

iv. Implementation Of "Hot" Debriefs, Action After Reviews, Times Lines to Be Fully Utilised By All Staff Across The Organisation

This Priority was **Achieved** for 2024/25.

Quarter 4 and Year End Update

Since the implementation of PSIRF in September 2023, the Trust has introduced a suite of learning response tools which are utilised across the organisation for "hot debriefs". These include AARs, learning response timelines, round table discussions, case notes reviews. These are used by a range of multidisciplinary roles. Performance data for this aspect is reported monthly at the Patient Safety Improvement Group (PSIG) Meetings. 128 Trust staff have been trained in After Action Review Conductor methodology.

v. Monitor And See A Reduction, Year On Year In Complaints Relating To Poor Communication When Things Go Wrong, Delays In Responding To Patient, Families And Staff Concerns And Not Being Informed Of The Outcome/Findings

This Priority was **Achieved** for 2024/25

Quarter 4 and Year End Update

There has been a 40% decrease in complaints relating to poor communication, with 31 complaints within 2024/25 versus 52 in 2023/24. The Trust provides multiple initiatives to support enhanced communication skills, such as Sage & Thyme, Conflict Resolution & Challenging conversations training, as well as quality sessions to senior staff and clinical leaders.

Quality Priority 2:

Deliver Personalised, Safe Care for Maternity and Neonatal service users through our Maternity Improvement Plan (MIP)

Quality Priority Domain(s):

☒ Patient Safety ☒ Clinical Effectiveness ☐ Patient Experience

i	Ensuring the lessons learnt from Ockenden and Kirkup are monitored through robust action plans delivered through the MIP developing a culture of openness, learning and compassionate leadership	**Achieved**
ii	Annual reduction of 10% of still births per 1000 live births	**Achieved**
iii	Annual reduction of 10% Neonatal deaths per 1000 live births	**Not Achieved**
iv	Smoking at time of delivery 6%	**Not Achieved**
v	Have 0 maternal deaths	**Achieved**

i. Ensure The Lessons Learnt From Ockenden And Kirkup Are Monitored Through Robust Action Plans Delivered Through The Maternity Improvement Plan Developing A Culture Of Openness, Learning And Compassionate Leadership

This Priority was **Achieved** for 2024/25.

Quarter 4 and Year End Update

Lessons learnt from Ockenden and Kirkup maternity reviews have been integrated into the Trust's maternity improvement plan. Maternity Services have been working to achieve compliance with the recommendations

92 actions identified are either already meeting the recommendations or are in progress.

- 82 actions complete and meet Ockenden standards. (23 of these complete actions have been reviewed by the trust board and signed off).
- 7 are non-provider actions.
- 3 actions have partial compliance with work underway which is being monitored to ensure that we meet compliance.

ii. Annual Reduction Of 10% Of Still Births Per 1000 Live Births

This Priority was **Achieved** for 2024/25.

Quarter 4 and Year End Update

The Trust reported six still births in 2023/24, two still births in 2024/25. This represents a 67% reduction within 2024/25.

iii. Annual Reduction Of 10% Neonatal Deaths Per 1000 Live Births

This Priority was **NOT Achieved** for 2024/25.

Quarter 4 and Year End Update

The Trust reported three neonatal deaths for 2024/25 against a baseline of two for the 2023/24 financial year.

iv. Smoking At Time Of Delivery 6%

This Priority was **NOT Achieved** for 2024/25.

Quarter 4 and Year End Update

The Trust percentage for smoking at time of delivery was 13.6% average for 2024/25, with 9.8% within March 2025. Smart Start was implemented in April 2024. This is an opt out service offering support from two full time Tobacco Dependence Advisors alongside pharmacotherapy (Nicotine Replacement). Q4 results of 2024-2025 show that the service received 90 referrals and of those, 5 women/birthing people were smoke free at 28 days and 12 were smoke free at delivery (13.3% of referrals quit). A full evaluation of the first year of this service is pending. Additional offers via the Smart Start service include Vapes Swap to Stop and Allen Carr 'Easy Way' Seminars.

v. Have 0 Maternal Deaths

This Priority was **Achieved** for 2024/25.

Quarter 4 and Year End Update

The Trust has reported 0 maternal deaths for 2024/25

Quality Priority 3:

Patients in our care do not come to avoidable harm by reducing the incidence of harm monitored by our quality matrix, including LFD, SJR, GIRFT, NICE recommendations

Quality Priority Domain(s):

☒ Patient Safety ☒ Clinical Effectiveness ☒ Patient Experience

i	5% reduction in falls	**Not Achieved**
ii	5% reduction in pressure ulcer	**Achieved**
iii	10% reduction in medication incidents	**Achieved**
iv	15% reduction year on year for Gram Negative infection	**Achieved**
v	>90% compliance with Nutrition assessment	**Partially Achieved**
vi	10% reduction year on year with Sepsis	**Not Yet Due** (Deadline September 2025)
vii	Improvement in all of the End of Life Metric's	**Not Yet Due** (Deadline September 2025)
viii	75% of clinical areas assessed for ward accreditation and have achieved and maintained at least good	**Not Achieved**

i. 5% Reduction In Falls

This Priority was **Not Achieved** for 2024/25.

Quarter 4 and Year End Update

The Trust reported 4.99 falls per 1000 bed days for 2023/24. The Trust target for 2024/25 was 4.74 per 1000 bed days. The Trust's Final end of year position is 5.29 falls per 1000 bed days for 2024/25.

ii. 5% Reduction In Pressure Ulcers

This Priority was **Achieved** for 2024/25.

Quarter 4 and Year End Update

The Trust reported 1.97 hospital acquired pressure ulcers per 1000 bed days for 2023/24. The Trust target for 2024/25 was 1.87 per 1000 bed days. The Trust's Final end of year position is 1.09 hospital acquired pressure ulcers per 1000 bed days.

iii. 10% Reduction In Medication Incidents

This Priority was **Achieved** for 2024/25.

Quarter 4 and Year End Update

The Trust reported 792 medication incidents for 2023/24. The Trust Target for 2024/25 for medication incidents was 712. The Trust's Final end of year position is 692 medication incidents.

iv. 15% Reduction Year On Year For Gram Negative Infection

This Priority was **Achieved** for 2024/25.

Quarter 4 and Year End Update

The Trust reported 98 gram negative infections during 2023/24. The Trust Target for 2024/25 for gram negative infections was 83. The Trust's Final end of year position is 80 gram negative infections.

v. >90% Compliance With Nutrition Assessment

This Priority was **Partially Achieved** for 2024/25.

Quarter 4 and Year End Update

The Trust's 'Making a Difference' Audits demonstrate that during 2024/25, 89.1% of patients had Malnutrition Universal Screening Tool (MUST) completed within 6 hours of admission. 98.1% had MUST completed since admission.

vi. 10% Reduction Year On Year With Sepsis

This Priority was **Not Yet Due** for 2024/25 (Deadline September 2025).

Quarter 4 and Year End Update

10% reduction year on year with Sepsis – due September 2025 but not on schedule due to data capture issues which will improve with the new EPR. Therefore this likely to be achieved by end of 2026/27 financial year.

vii. Improvement In All Of The End Of Life Metrics

This Priority was **Not Yet Due** for 2024/25 (Deadline September 2025).

Quarter 4 and Year End Update

The Trust 'Making a Difference' audits demonstrated that the Trust has significantly improved compliance within End of Life Practice in 2024/25, versus 2023/24. However, End of Life Theory compliance demonstrated a slight decline.

viii. 75% Of Clinical Areas Assessed For Ward Accreditation And Have Achieved And Maintained At Least 'Good'

This Priority was **Not Achieved** for 2024/25.

Quarter 4 and Year End Update

During 2024/25. 55% of wards have been assessed, 63% of which received good.

Quality Priority 4:
Embed and build on our patient and public engagement plan.

Quality Priority Domain(s):

☐ Patient Safety ☐ Clinical Effectiveness ☒ Patient Experience

i. Embed And Build On Our Patient And Public Engagement Plan

This Priority was **Achieved** for 2024/25.

We intended to achieve:

- Establishment of connecting workshops with both our community and service users
- Expansion and relocation of the PALS service to the main foyer – offering a visible, accessible service for patients, carers and service users to support early resolution
- Engagement and involvement of patients/families following a patient safety incident in line with the Patient Safety Incident Response Framework (PSIRF)
- Delivery of a Public Governor engagement plan – outreach into the community
- Achieve the Carer Friendly Tick accreditation – demonstrating collaborative working with Carers
- 2024/25
- Patient voice partners involvement in governance committees/groups – integration of patient voice into core business work streams
- Expand opportunities for digital feedback (SMS surveys) – to widen opportunities for feedback
- Development of Accessible Information Officer roles to support patients individual communication needs

Quarter 4 and Year End Update

- Plans drawn up and agreed for relocation of PALS service to cashier's office in main foyer. Work estimated to start imminently.
- Patient Safety Incident Response Framework (PSIRF) implementation commenced 1st September 2023.
- PSIRF Level 1 investigations carried out by Patient Safety Investigator and involve patients/families.
- Carer Friendly Tick accreditation achieved November 2023 – valid for two years.
- Additional recruitment of two new patient representatives onto the James Paget User Group
- Planning and coordination between Patient Experience team, Communications team and Trust Council of Governors over upcoming public and patient engagement within the Future
- Paget Programme and outreach opportunities.
- Partnership working with Healthwatch colleagues and Voluntary, Community, Faith and Social Enterprise (VCFSE) sectors.
- Co-production of Trust engagement principles with stakeholders.

Quality Priority 5:

To deliver high standards of care and access to services for our Older Peoples Medicine

Quality Priority Domain(s):

☒ Patient Safety ☒ Clinical Effectiveness ☒ Patient Experience

i	Establish an Older Peoples Medicine Multi disciplinary team	**Not Achieved**
ii	Develop and enhance OPM pathways with bespoke services that avoid admission	**Achieved**
iii	(TBC) reduction in LOS - this will be confirmed once the system wide approach to OPM has been finalised, led by the ICB.	**Metric Requires Clarification**
iv	(TBC) reduction in admission of those over 65/80 - this will be confirmed once the system wide approach to OPM has been finalised, led by the ICB.	**Metric Requires Clarification**
v	Development in research into non medical interventions and measuring impact – THEO	**Achieved**

i. Establish An Older Peoples Medicine Multi Disciplinary Team

This Priority was **Not Achieved** for 2024/25.

Quarter 4 and Year End Update

Currently trialling a diverse range of recruitment options to create an Older People's Medicine (OPM) substantive Multidisciplinary Team (MDT).

ii. Develop And Enhance OPM Pathways With Bespoke Services That Avoid Admission

This Priority was **Achieved** for 2024/25.

Quarter 4 and Year End Update

This is underway and ongoing. The Trust is engaging with system partners in the East locality to identify admission avoidance opportunities and efficiency/productivity savings.

iii. (tbc) Reduction in Lenth Of Stay - This Will Be Confirmed Once The System Wide Approach To OPM Has Been Finalised, Lead By The ICB.

This Priority was **Requiring Metric Clarification** for 2024/25.

Quarter 4 and Year End Update

This sub-priority metric target has not been confirmed. This will be confirmed once the system wide approach to OPM has been finalised, led by the ICB

iv. (Tbc) Reduction In Admission Of Those Over 65/80 - This Will Be Confirmed Once The System Wide Approach To OPM Has Been Finalised, Lead By The ICB.

This Priority was **Requiring Metric Clarification** for 2024/25.

Quarter 4 and Year End Update

This sub-priority metric target has not been confirmed. This will be confirmed once the system wide approach to OPM has been finalised, led by the ICB

v. Development In Research Into Non Medical Interventions And Measuring Impact - THEO

This Priority was **Achieved** for 2024/25.

Quarter 4 and Year End Update

The THEO (Therapeutic Optimisation) Project has now commenced. THEO research team now in place, and in the process of recruiting co-researchers. THEO is a multi-centre quasi-experimental (before and after) study with embedded convergent mixed methods process evaluation to ascertain the effectiveness and impact of the implementation of a nurse-led 'Therapeutic Optimisation' (THEO) ward-level intervention in two older persons wards across two NHS Trusts within the Norfolk and Waveney Integrated Care System.

Quality Priorities for improvement agreed for 2024- 2027

Patient Safety. Aligned to CQC Key Lines of Enquiry: Safe, Caring, Responsive, Well led
Clinical Effectiveness. Aligned to CQC Key Lines of Enquiry: Effective, Safe, Caring
Patient Experience. Aligned to CQC Key Lines of Enquiry: Safe, Caring, Responsive, Well led

This is priority is aligned with Clinical Effectiveness, Patient Safety and Patient Experience.

1. What we set out to do (Priority):
We Will implement and optimise our Patient Safety and learning Culture through the implementation of the Patient Incident Response Framework (PSIRF), QSAFE and learning from incidents
Why we chose this (Rationale):
Following the introduction the PSIRF in 2023 it is vital we embed and develop our learning from incidents culture, to ensure we have continuous improvement and learning
What we intend to achieve (Goal):
• 100% of our staff will be trained in Level one Patient Safety Syllabus • 85% of our staff will be trained in Level 2 Patient Safety Syllabus • At least 90% of staff, patients and relatives will be involved in the incident management process Implementation of "Hot" debriefs, Action After Reviews, Timelines to be fully utilised by all staff across the organisation
How we will deliver and monitor progress:
We will monitor and see a reduction, year on year in complaints relating to poor communication when things go wrong, delays in responding to Patients, Families and staff concerns and not being informed of the outcome/findings
Responsible Person
Chief Nurse

This is priority is aligned with Clinical Effectiveness and Patient Safety

2. What we set out to do (Priority):
Deliver Personalised and Safe Care for Maternity and Neonatal service users through our Maternity Improvement Plan (MIP)
Why we chose this (Rationale):
Saving Babies lives, better births and our MIP all indicate the need to view and focus on maternity services
What we intend to achieve (Goal):

- Ensuring the lessons learnt from Ockenden and Kirkup are monitored through robust action plans delivered through the MIP developing a culture of openness, learning and compassionate leadership
- Annual reduction of 10% of still births per 1000 live births
- Annual reduction of 10% Neonatal deaths per 1000 live births
- Smoking at time of delivery 6%
- Have 0 maternal deaths

How we will deliver and monitor progress:

We will deliver this priority and monitor through the Maternity Improvement Plan, Reviewed Yearly.

Responsible Person:

Chief Medical Officer, Chief Nurse, Chief Operations Officer

This is priority is aligned with Clinical Effectiveness, Patient Safety and Patient Experience

3. What we set out to do (Priority):

Patients in our care do not come to harm by reducing the incidence of avoidable harm by reducing the incidence of harm monitored by our quality matrix including; Learning From Deaths (LFD) , Structured Judgment Reviews (SJR), Getting It Right First Time (GIRFT), National Institute of Health and Care Excellence (NICE) recommendations

Why we chose this (Rationale):

We know that a 1/3 of patients aged 65 or over and 1/2 of those aged 80 and over have poorer clinical outcomes, morbidity and psychological distress. As we know pressure ulcers increase length of stay, increase deconditioning and results in harm to the patient both physically and psychologically

What we intend to achieve (Goal):

- 5% reduction in falls
- 5% reduction in pressure ulcers
- 10% reduction in medication incidents
- 15% reduction in year on year Gram Negative infections
- >90% compliance with nutritional assessments
- 10% reduction year on year with Sepsis
- Improvement in all end of life Metrics
- 75% of clinical areas assessed for ward accreditation and have achieved and maintained at least good

How we will deliver and monitor progress:

This will be monitored monthly through monthly Trust Quality Reporting to the Board

Responsible Person:

Chief Medical Officer, Chief Nurse

Clinical Effectiveness. Aligned to CQC Key Lines of Enquiry: Effective, Safe, Caring
This is priority is aligned with Patient Experience

4. What we set out to do (Priority):
Embed and build on our Patient and Public Engagement Plan, delivery our second year objectives
Why we chose this (Rationale):
We are facing some of the most challenging times in the history of the NHS, but also we have some of the biggest opportunities to shape the way we deliver healthcare. It is therefore vital our communities and service user's views are heard to ensure these influence the future, with both a new hospital and Electronic Patient Record System coming in the next five years.
What we intend to achieve (Goal):
• Engagement workshops will be established to connect with both our local community and service users to ensure we develop accessible, high quality and responsive services. • Partnership working will be integrated into all patient experience work streams • Improvements in care, treatment and services will be evidenced through our patient experience feedback.
How we will deliver and monitor progress:
This will be monitored through the Carer and Patient Experience Group and reported to the Patient Safety and Quality Committee
Responsible Person:
Chief Nurse

This is priority is aligned with Clinical Effectiveness, Patient Safety and Patient Experience

5. What we set out to do (Priority):
To deliver high standards of care and access to services for our Older Peoples Medicine.
Why we chose this (Rationale):
The Great Yarmouth and Waveney area has a greater than national average of those over 65 and is in the top 20 most deprived areas in the United Kingdom
What we intend to achieve (Goal):
• Establish an Older Peoples Medicine Multi-Disciplinary Team • Develop and Enhance the Older Peoples Medicine Pathway with bespoke services that avoid admission • Achieve a reduction in the length of stay

- Achieve a reduction in admission of those over 65 to 80
- Development in Research into non-medical interventions and measuring impact

These will be confirmed once the system wide approach to Older Peoples Medicine has been finalised, led by the Integrated Care Board (ICB).

How we will deliver and monitor progress:

We will deliver over the next three years with a year on year improvement monitored through the Patient Safety and Quality Committee.

Responsible Person:

Chief Medical Officer, Chief Nurse, Chief Operations Officer

2.2 Statements of Assurance from the Board

During 2024/25 the James Paget University Hospitals NHS Foundation Trust provided and/or subcontracted 58 relevant health services, [listed in the table below].

The James Paget University Hospitals NHS Foundation Trust has reviewed all the data available to them on the quality of care in **all** of these relevant health services.

The income generated by the relevant health services reviewed in 2024/25 represents **100%** of the total income generated from the provision of relevant health services by the James Paget University Hospitals NHS Foundation Trust for 2024/25.

Specialties and services:	
Accident and Emergency (A&E)	Maternity Services
Anaesthetics	Medical Illustration
Antenatal Screening	Neonatology
Audiology	Nephrology and Renal Dialysis
Blood Transfusion	Neurology
Breast Surgery	Obstetrics
Cardiology	Older People's Medicine
Clinical Measurement	Oncology
Community Midwifery	Ophthalmology
Community Paediatric Service	Oral Surgery
Continence and Stoma Care	Orthotics
Coronary Care	Paediatric Surgery
Dermatology	Paediatrics
Diabetes	Pain Management
Diabetic Liaison	Palliative Care
Diagnostic Imaging	Pathology Services
Ear, Nose and Throat	Pharmaceutical Services
Endocrinology	Phlebotomy
Endoscopy	Respiratory Medicine
Fertility services	Rheumatology
Gastroenterology	Safeguarding Adults & Children
Gastro-intestinal Surgery	Sandra Chapman Centre
General Surgery	Sleep and Lung Function
Gynaecology	Stroke Services
Haematology	Therapies e.g. physiotherapy
Hyperbaric Services	Trauma and Orthopaedics
Intensive Care Services	Emergency/Urgent Care
Lymphoedema Service	Urology
General Medicine	Vascular Surgery

Clinical Audits and National Confidential Enquiries

During 2024/25 **57** national clinical audits and **9** national confidential enquiries covered relevant health services that James Paget University Hospitals NHS Foundation Trust provides.

During that period James Paget University Hospitals NHS Foundation Trust participated in **55/57 (96%)** national clinical audits and **100%** national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that James Paget University Hospitals NHS Foundation Trust was eligible to participate in during 2024/25 are as follows: [see table below].

The national clinical audits and national confidential enquiries that James Paget University Hospitals NHS Foundation Trust participated in during 2024/25 are as follows: [see table below].

The national clinical audits and national confidential enquiries that James Paget University Hospitals NHS Foundation Trust participated in, and for which data collection was completed during 2024/25, 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 [where available].

Audit Title	Provider	Relevant to JPUH Services?	Trust participation	Case Ascertainment
BAUS Penile Fracture Audit	The British Association of Urological Surgeons (BAUS)	Yes	Yes	N/A – No relevant cases
BAUS I-DUNC (Impact of Diagnostic Ureteroscopy on Radical Nephroureterectomy and Compliance with Standard of Care Practices)	The British Association of Urological Surgeons (BAUS)	Yes	Yes	7/7 (100%). Data submitted by NNUH as all JPUH patients underwent the applicable surgery at NNUH.
Environmental Lessons Learned and Applied to the bladder cancer care pathway audit (ELLA)	The British Association of Urological Surgeons (BAUS)	Yes	No	The BAUS Project Manager was contacted to request data collection forms but these were not provided, and as such no data was submitted.
Breast and Cosmetic Implant Registry	NHS England (formerly NHS Digital)	Yes	Yes	100%

Audit Title	Provider	Relevant to JPUH Services?	Trust participation	Case Ascertainment
British Hernia Society Registry	British Hernia Society	Yes	Yes	The audit has only recently started and data collection is still ongoing, with no data entry deadlines currently specified.
Case Mix Programme (CMP)	Intensive Care National Audit & Research Centre (ICNARC)	Yes	Yes	100% (654/654)
Emergency Medicine QIPs: Care of Older People	Royal College of Emergency Medicine	Yes	Yes	Year 2 Case ascertainment 18% (55/300)
Emergency Medicine QIPs: Time Critical Medications	Royal College of Emergency Medicine	Yes	Yes	Year 1 Case ascertainment 19% (57/300)
Epilepsy12: National Clinical Audit of Seizures and Epilepsies for Children and Young People	Royal College of Paediatrics and Child Health	Yes	Yes	100%
Falls and Fragility Fracture Audit Programme (FFFAP): Fracture Liaison Service Database (FLS-DB)	Royal College of Physicians	Yes	Yes	Case ascertainment based on local FLS inclusion criteria: 51% (1001 / 1956). Local restriction is age 50 - 80 years, unless 80+ and the patient is seen by the Orthogeriatricians. For the last quarter of 24/25, exclusion criteria expanded to patients aged 50-80 who have sustained rib, metacarpals and metatarsals fractures, due to constraints of the service. FLS-DB inclusion criteria is 50+years.
Falls and Fragility Fracture Audit Programme (FFFAP): National Audit of Inpatient Falls (NAIF)	Royal College of Physicians	Yes	Yes	100% (11/11 #NOFs only) Data entry for fractures other than NOFs is still ongoing, with no data entry deadlines currently specified.
Falls and Fragility Fracture Audit Programme (FFFAP): National Hip Fracture Database (NHFD)	Royal College of Physicians	Yes	Yes	100.76% (527/523)
Learning from lives and deaths – People with a learning	NHS England	Yes	Yes	100% (17/17)

Audit Title	Provider	Relevant to JPUH Services?	Trust participation	Case Ascertainment
disability and autistic people (LeDeR)				
National Adult Diabetes Audit (NDA): National Diabetes Core Audit.	NHS England (formerly NHS Digital)	Yes	Yes	100% (976 cases submitted with a view to submit a further 566 before the deadline of 23/05/2025)
National Adult Diabetes Audit (NDA): National Diabetes Inpatient Safety Audit (NDISA)	NHS England (formerly NHS Digital)	Yes	Yes	100% of cases of DKA, HHS and Diabetic Foot Ulcers have been submitted. Episodes of hypoglycaemic rescue are submitted where identified however, a case ascertainment figure cannot be provided due to difficulties identifying cases
National Adult Diabetes Audit (NDA): National Pregnancy in Diabetes Audit (NPID)	NHS England (formerly NHS Digital)	Yes	Yes	100% (15/15)
National Adult Diabetes Audit (NDA): Transition (Adolescents and Young Adults) and Young Type 2 Audit	NHS England (formerly NHS Digital)	Yes	Yes	No local data collection required – data linkage between National Paediatric Diabetes Audit (NPDA) and the National Diabetes Audit (NDA).
National Adult Diabetes Audit (NDA): Gestational Diabetes Audit	NHS England (formerly NHS Digital)	Yes	Yes	100% (148/148)
National Audit of Care at the End of Life (NACEL)	NHS Benchmarking Network	Yes	Yes	100%
National Cancer Audit Collaborating Centre (NATCAN): National Audit of Metastatic Breast Cancer (NAoMe)	Royal College of Surgeons of England (RCS)	Yes	Yes	100%
National Cancer Audit Collaborating Centre (NATCAN): National Audit of Primary Breast Cancer (NAoPri)	Royal College of Surgeons of England (RCS)	Yes	Yes	100%
National Cancer Audit Collaborating Centre (NATCAN): National	Royal College of Surgeons of England (RCS)	Yes	Yes	100%

Audit Title	Provider	Relevant to JPUH Services?	Trust participation	Case Ascertainment
Bowel Cancer Audit (NBOCA)				
National Cancer Audit Collaborating Centre (NATCAN): National Kidney Cancer Audit (NKCA)	Royal College of Surgeons of England (RCS)	Yes	Yes	100%
National Cancer Audit Collaborating Centre (NATCAN): National Lung Cancer Audit (NLCA)	Royal College of Surgeons of England (RCS)	Yes	Yes	100%
National Cancer Audit Collaborating Centre (NATCAN): National Non-Hodgkin Lymphoma Audit (NNHLA)	Royal College of Surgeons of England (RCS)	Yes	Yes	100%
National Cancer Audit Collaborating Centre (NATCAN): National Oesophago-Gastric Cancer Audit (NOGCA)	Royal College of Surgeons of England (RCS)	Yes	Yes	100%
National Cancer Audit Collaborating Centre (NATCAN): National Ovarian Cancer Audit (NOCA)	Royal College of Surgeons of England (RCS)	Yes	Yes	100%
National Cancer Audit Collaborating Centre (NATCAN): National Pancreatic Cancer Audit (NPaCA)	Royal College of Surgeons of England (RCS)	Yes	Yes	100%
National Cancer Audit Collaborating Centre (NATCAN): National Prostate Cancer Audit (NPCA)	Royal College of Surgeons of England (RCS)	Yes	Yes	100%
National Cardiac Arrest Audit (NCAA)	Intensive Care National Audit & Research Centre (ICNARC)	Yes	Yes	100% - All eligible cases submitted.
National Cardiac Audit Programme (NCAP): National Heart Failure Audit (NHFA)	National Institute for Cardiovascular Outcomes Research (NICOR)	Yes	Yes	Data is submitted for all heart failure patients that the cardiac nursing team are aware of. A case ascertainment figure cannot be provided because the

Audit Title	Provider	Relevant to JPUH Services?	Trust participation	Case Ascertainment
				exact number of patients is unknown.
National Cardiac Audit Programme (NCAP): Myocardial Ischaemia National Audit Project (MINAP)	National Institute for Cardiovascular Outcomes Research (NICOR)	Yes	Yes	Data is submitted for all patients identified by the cardiac nursing team as having a discharge diagnosis of non-ST elevation myocardial infarction (NSTEMI). A case ascertainment figure cannot be provided because the exact number of patients is unknown.
National Child Mortality Database (NCMD)	University of Bristol	Yes	Yes	100% of data for the National Child Mortality Database is submitted by the relevant Local Child Death Overview Panels.
National Comparative Audit of Blood Transfusion: National Comparative Audit of NICE Quality Standard QS138	NHS Blood and Transplant	Yes	Yes	100%
National Comparative Audit of Blood Transfusion: National Comparative Audit of Bedside Transfusion Practice	NHS Blood and Transplant	Yes	Yes	100% (Minimum of 10 cases submitted)
National Early Inflammatory Arthritis Audit (NEIAA)	British Society for Rheumatology	Yes	Yes	71.2% (42/60)
National Emergency Laparotomy Audit (NELA): Laparotomy	Royal College of Anaesthetists	Yes	Yes	100% (150 cases) – To be confirmed by NELA on comparison of HES data.
National Emergency Laparotomy Audit (NELA): No Laparotomy	Royal College of Anaesthetists	Yes	Yes	100% (7/7)
National Joint Registry	Healthcare Quality Improvement Partnership (HQIP)	Yes	Yes	100%
National Major Trauma Registry	NHS England	Yes	Yes	459 cases entered from 01/01/24 - 31/03/25. NMTR have not provided a case ascertainment target for year 1 of the audit so no percentage can be reported.

Audit Title	Provider	Relevant to JPUH Services?	Trust participation	Case Ascertainment
National Maternity and Perinatal Audit (NMPA)	Royal College of Obstetricians and Gynaecologists	Yes	Yes	100%
National Neonatal Audit Programme (NNAP)	Royal College of Paediatrics and Child Health	Yes	Yes	100%
National Ophthalmology Database (NOD): Age-related Macular Degeneration Audit	The Royal College of Ophthalmologists (RCOphth)	Yes	No	The Trust intended to participate in this audit, however this is has not been possible without the Medisight EMR system
National Ophthalmology Database (NOD): Cataract Audit	The Royal College of Ophthalmologists (RCOphth)	Yes	Yes	100% (2564 cases)
National Paediatric Diabetes Audit (NPDA)	Royal College of Paediatrics and Child Health	Yes	Yes	100% (148/148)
National Perinatal Mortality Review Tool	University of Oxford / MBRRACEUK collaborative	Yes	Yes	100%
National Respiratory Audit Programme (NRAP): COPD Secondary Care	Royal College of Physicians	Yes	Yes	93.3% (113/121) Audit for Q4 is currently ongoing with a deadline of 16th May.
National Respiratory Audit Programme (NRAP): Adult Asthma Secondary Care	Royal College of Physicians	Yes	Yes	99% (120/121) Audit for Q4 is currently ongoing with a deadline of 16th May.
National Respiratory Audit Programme (NRAP): Children and Young People's Asthma Secondary Care	Royal College of Physicians	Yes	Yes	99% (78/79).
National Vascular Registry (NVR)	Royal College of Surgeons of England (RCS)	Yes	Yes	JPUH data submitted by the NNUH. 100% for mandatory cases. (100% case ascertainment for AAA and Carotid cases. Over 90% submissions for amputations and around 50-60% rates for peripheral bypasses and angioplasties)
Perioperative Quality Improvement Programme	Royal College of Anaesthetists	Yes	Yes	22 Patients recruited. This is a research study, so participation is voluntary and the number of eligible patients cannot be calculated.

Audit Title	Provider	Relevant to JPUH Services?	Trust participation	Case Ascertainment
Quality and Outcomes in Oral and Maxillofacial Surgery (QOMS): Oral and Dentoalveolar Surgery	British Association of Oral and Maxillofacial Surgeons (BAOMS)	Yes	Yes	The data collection period is still ongoing.
Sentinel Stroke National Audit Programme (SSNAP)	King's College London	Yes	Yes	107% (515/480)
Serious Hazards of Transfusion (SHOT): UK National Haemovigilance Scheme	Serious Hazards of Transfusion (SHOT)	Yes	Yes	100% (26/26)
Society for Acute Medicine Benchmarking Audit (SAMBA)	Society for Acute Medicine	Yes	Yes	100%
UK Renal Registry Chronic Kidney Disease Audit	UK Kidney Association	Yes	Yes	Renal Registry data submitted by Norfolk and Norwich University Hospitals for JPUH patients
UK Renal Registry National Acute Kidney Injury Audit	UK Kidney Association	Yes	Yes	Renal Registry data submitted by Norfolk and Norwich University Hospitals for JPUH patients
Cleft Registry and Audit NEtwork (CRANE) Database	Royal College of Surgeons of England (RCS)	No	N/A	
Emergency Medicine QIPs: Adolescent Mental Health	Royal College of Emergency Medicine	N/A	N/A	Audit delayed to 2025/26.
National Adult Diabetes Audit (NDA): Diabetes Prevention Programme (DPP) Audit	NHS England (formerly NHS Digital)	No	N/A	
National Adult Diabetes Audit (NDA): National Diabetes Footcare Audit (NDFA)	NHS England (formerly NHS Digital)	No	N/A	
National Audit of Cardiac Rehabilitation	University of York	No	N/A	
National Audit of Cardiovascular Disease Prevention in Primary Care (CVDPrevent)	NHS Benchmarking Network	No	N/A	
National Audit of Dementia (NAD)	Royal College of Psychiatrists	N/A	N/A	No data collection nationally in 24/25.

Audit Title	Provider	Relevant to JPUH Services?	Trust participation	Case Ascertainment
National Bariatric Surgery Registry	British Obesity & Metabolic Surgery Society	No	N/A	
National Cardiac Audit Programme (NCAP): National Adult Cardiac Surgery Audit (NACSA)	National Institute for Cardiovascular Outcomes Research (NICOR)	No	N/A	
National Cardiac Audit Programme (NCAP): National Congenital Heart Disease Audit (NCHDA)	National Institute for Cardiovascular Outcomes Research (NICOR)	No	N/A	
National Cardiac Audit Programme (NCAP): National Audit of Cardiac Rhythm Management (CRM)	National Institute for Cardiovascular Outcomes Research (NICOR)	No	N/A	
National Cardiac Audit Programme (NCAP): National Audit of Percutaneous Coronary Intervention (NAPCI)	National Institute for Cardiovascular Outcomes Research (NICOR)	No	N/A	
National Cardiac Audit Programme (NCAP): UK Transcatheter Aortic Valve Implantation (TAVI) Registry	National Institute for Cardiovascular Outcomes Research (NICOR)	No	N/A	
National Cardiac Audit Programme (NCAP): Left Atrial Appendage Occlusion (LAAO) Registry	National Institute for Cardiovascular Outcomes Research (NICOR)	No	N/A	
National Cardiac Audit Programme (NCAP): Patent Foramen Ovale Closure (PFOC) Registry	National Institute for Cardiovascular Outcomes Research (NICOR)	No	N/A	
National Cardiac Audit Programme (NCAP): Transcatheter Mitral and Tricuspid Valve (TMTV) Registry	National Institute for Cardiovascular Outcomes Research (NICOR)	No	N/A	
National Clinical Audit of Psychosis (NCAP)	Royal College of Psychiatrists	No	N/A	
National Obesity Audit (NOA)	NHS England (formerly NHS Digital)	No	N/A	

Audit Title	Provider	Relevant to JPUH Services?	Trust participation	Case Ascertainment
National Pulmonary Hypertension Audit	NHS England (formerly NHS Digital)	No	N/A	
National Respiratory Audit Programme (NRAP): Pulmonary Rehabilitation	Royal College of Physicians	No	N/A	
Out-of-Hospital Cardiac Arrest Outcomes (OHCAO)	University of Warwick			
Paediatric Intensive Care Audit Network (PICANet)	University of Leeds / University of Leicester	No	N/A	
Prescribing Observatory for Mental Health (POMH): Rapid tranquillisation in the context of the pharmacological management of acutely disturbed behaviour	Royal College of Psychiatrists	No	N/A	
Prescribing Observatory for Mental Health (POMH): The use of melatonin	Royal College of Psychiatrists	No	N/A	
Prescribing Observatory for Mental Health (POMH): The use of opioids in mental health services	Royal College of Psychiatrists	No	N/A	
Quality and Outcomes in Oral and Maxillofacial Surgery (QOMS): Oncology & Reconstruction	British Association of Oral and Maxillofacial Surgeons (BAOMS)	No	N/A	
Quality and Outcomes in Oral and Maxillofacial Surgery (QOMS): Trauma	British Association of Oral and Maxillofacial Surgeons (BAOMS)	No	N/A	
Quality and Outcomes in Oral and Maxillofacial Surgery (QOMS): Orthognathic Surgery	British Association of Oral and Maxillofacial Surgeons (BAOMS)	No	N/A	
Quality and Outcomes in Oral and Maxillofacial Surgery (QOMS): Non-	British Association of Oral and Maxillofacial Surgeons (BAOMS)	No	N/A	

Audit Title	Provider	Relevant to JPUH Services?	Trust participation	Case Ascertainment
melanoma skin cancers				
UK Cystic Fibrosis Registry	Cystic Fibrosis Trust	No	N/A	

The reports of **41** national clinical audits were reviewed by the provider in 2024/25 and James Paget University Hospitals NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

A selection of actions from the **41** national clinical audit reports reviewed:

Falls and Fragility Fractures Audit Programme (FFFAP) - National Audit of Inpatient Falls (NAIF)

- ✓ There is a current trial for rollout of a new process called SWARM to capture the fundamental elements of after action reviews. Currently on two wards. Plan for further rollouts.

National Asthma and COPD Audit Programme (NACAP) – COPD Secondary Care

- ✓ Resp. Consultant Workforce - appointment to 5.5 WTE compared to previous position of 4.0 WTE to enable increase in ward rounds and change to consultant on take for medical referrals of outliers. 1 additional consultant has now been recruited as of November 2024 to bring team to 5.0 WTE. Further plans to recruit another 0.5 WTE consultant from April 2026.
- ✓ Identification - Ongoing Clinical Lead communications to remind medical teams (including AMU when LoS anticipated less than 24 hours) to refer any patients with exacerbation of COPD to Respiratory Nursing Service.
- ✓ Identification - operational manager to meet with IS to review and update automated email notification system of "COPD" presentations to ED.

FFFAP - Fracture Liaison Service Database (FLS-DB)

- ✓ Action to meet Recommendation 5 (All FLSs should prioritise identifying patients with spine fractures over those with fractures below the knee). Agreements are already in place with Radiology to report incidental findings – to conduct an audit of fractures to identify how many were picked up or missed via screening.

National Comparative Audit of Blood Transfusion - Audit of NICE Quality Standard QS138

- ✓ Ward Managers will start auditing transfusion documentation on a monthly basis. Transfusion Practitioner has reviewed questions for implementation on QSAFE system and is developing guide to be sent to Lead Nurses for distribution. Auditing to commence from summer 2025.
- ✓ To develop and implement mandatory transfusion training for doctors. Tool has been developed and approved by Hospital Transfusion Team and Hospital Transfusion Group. To commence use from July 2025.

The reports of **142** local clinical audits were reviewed by the provider in 2024/25 and James Paget University Hospitals NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

A selection of actions from local clinical audit reports reviewed:

NICE QS22 Antenatal care - Statement 1 ✓ Audit highlighted the need for a new member of staff to coordinate and centralize the booking process. Successfully recruited a Community Bookings Coordinator across borders of Suffolk and Norfolk (Waveney) locality. ✓ Modified the patient bookings process and access/contact details for pregnant women to utilize maternity services. Set up a specific booking landline number, mobile number and a customized email address. ✓ Centralised the booking database platform.	CQUIN12: Assessment and documentation of pressure ulcer risk ✓ Nursing Essential Assessment and Care Update (NEACU) training now in place, including pressure ulcers and risks assessments ✓ Made information available Trust wide - Clinical Quality Topics pages now available on Intranet ✓ Education team and clinical educators are in place for each quality topic.
Use of the HEART score in ED in patients with suspected or confirmed Acute Coronary Syndrome ✓ Laminated A4 printouts of the chest pain pathway put up in A&E minors, majors, and resus.	Re-Audit of the MEOWs Chart ✓ Trust has switched over to the new national MEWS (Maternity Early Warning Score) ✓ Communications sent to staff to highlight the audit results and remind of how to complete the MEOWs chart when this scores high enough to trigger.
Trust wide Cannulation and Caresite (cannula Extension set) Audit ✓ "Scrub the Hub" training provided – focussing on ANTT (Aseptic Non-Touch Technique) when using care sites, clamping the caresites when not in use, VIP scores and when to remove the cannula. Good participation from staff reported in every ward area visited.	Smoking in Pregnancy ✓ Updated the Maternity E3 system to include the option of recording the CO status at 36 weeks.
Audit of Newborn Early Warning Trigger and Track 2 charts ✓ Action to maintain compliance with NEWTT2 (Newborn Early Warning Track and Trigger) training at >90% of staff: plan in place for non-complaint staff members to have individual training and those returning from long-term absence/maternity leave will be required to complete on first day of return to work.	Notification of need for irradiated blood components ✓ Improvement made to Metavision (ICU authorisation) to prompt doctors to check special requirements especially if the patient has a history of haematological disease
Adherence to nice guidelines for managing OHT and POAG ✓ Familiarise and train doctors with latest NICE guidelines: guidelines printed off and displayed in clinical areas, to help clinicians become familiar with the guidelines. ✓ Developing expertise in Gonioscopy: training sessions with relevant clinicians have been carried out.	Checking compliance of Catheter documentation against the guidelines ✓ Educate nurses and doctors on the wards of why catheter documentation is important and what should be done. Ward teaching and presentation of audit with teaching done in the orthopaedic Monday PM meeting - consultants and juniors were present. ✓ Implemented a guideline sticker to allow easier documentation of catheter insertions

✓ Direct triage of new referrals to glaucoma clinics as this comprises a major percentage of patients not treated as per guidelines. Triage pathways have been changed to optimise patient referrals.	
<u>Strong Opioid Prescribing in Palliative Care</u> ✓ Updated palliative care page on Trust intranet with latest Norfolk and Waveney Initiation and management of opioids in palliative care guidance ✓ Included poster on wards to prompt the prescribing doctors to give out opioid leaflets	

National Confidential Enquiries

<u>NCEPOD – What is it?</u>

National Confidential Enquiry into Patient Outcome and Death (NCEPOD) is an independent charitable organisation that reviews medical and surgical clinical practice and makes recommendations to improve the quality of the delivery of care for the benefit of the public. They do this by undertaking confidential surveys and research covering many different aspects of care and making recommendations for clinicians and management to implement.

Title	Aim	Relevant to JPUH Services	Trust participation	Percentage of Cases Submitted
End of Life Care	To identify and explore areas for improvement in the end-of-life care of patients aged 18 and over with advanced illness, focusing on the last six months of life.	Yes	Yes	100%
Blood Sodium	To identify and explore the avoidable and modifiable factors in the care of adults with abnormal levels of sodium in hospital.	Yes	Yes	100%
Rehabilitation following critical illness	To evaluate the rehabilitation provided to critically ill adults within intensive care units, as well as throughout the recovery pathway to encompass both ward based and community care.	Yes	Yes	100%

Title	Aim	Relevant to JPUH Services	Trust participation	Percentage of Cases Submitted
Emergency procedures in children and young people	To identify good practice and remediable factors in the delivery of care provided to children and young people (CYP) (0-18th birthday) undergoing emergency (non-elective) procedures under anaesthetic or sedation.	Yes	Yes	100%
Acute Limb Ischaemia	To explore current care pathways for patients with acute limb ischaemia (ALI); identify remediable clinical and organisational factors that can improve the delivery and quality of required care.	Yes	Yes	100%
Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRRACE) - Perinatal mortality and serious morbidity confidential enquiry	Confidential enquiries into stillbirths, infant deaths and cases of serious infant morbidity on a rolling basis	Yes	Yes	100%
Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRRACE) - Maternal Morbidity Confidential Enquiries	Confidential enquiries into maternal deaths during and up to one year after the end of the pregnancy	Yes	Yes	100%
Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRRACE) - Maternal Morbidity confidential enquiry - annual topic based serious maternal morbidity	Confidential enquiries into cases of serious maternal morbidity on a rolling basis	Yes	Yes	100%
Mental Health Clinical Outcome Review Programme - Real-time surveillance of patient suicide	The NCISH database includes a national case series of suicide by patients under the care of mental health services over more than 25 years.	No	N/A	

Title	Aim	Relevant to JPUH Services	Trust participation	Percentage of Cases Submitted
Mental Health Clinical Outcome Review Programme - Suicide (and homicide) by people under mental health care	The NCISH database includes a national case series of suicide by patients under the care of mental health services over more than 25 years.	No	N/A	
Mental Health Clinical Outcome Review Programme - Suicide by people in contact with substance misuse services	The NCISH database includes a national case series of suicide by patients under the care of mental health services over more than 25 years.	No	N/A	

Participation in Clinical Research

The number of patients receiving relevant health services provided or subcontracted by James Paget University Hospitals NHS Foundation Trust in 2024/25 that were recruited during that period to participate in research approved by a research ethics committee: 1132.

Commissioning for Quality and Innovation (CQUIN) Framework

The financial year 2024/25 CQUIN was postponed due to the NHS still being in recovery from the Covid-19 pandemic

The amount of income in 2024/25 conditional upon achieving quality improvement and innovation goals is: **£0**

The amount of income received for the associated payment in 2024/25 was: **£0***

*The CQUIN programme was suspended nationally in 2021/22 due to the Covid-19 pandemic.

Care Quality Commission (CQC)

James Paget University Hospitals NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is with no conditions attached to registration.

The Care Quality Commission **has not** taken enforcement action against James Paget University Hospitals NHS Foundation Trust during 2024/25.

The overall CQC rating for the James Paget University Hospital NHS Foundation Trust remains 'Good'. This rate includes all sites of the Trust.

As a hospital, the CQC rating for the James Paget Hospital remains rated 'Requires Improvement' since the Maternity and Midwifery Services Inspection completed in the period 2022/23. As a result of this inspection, the CQC issued a Section 29A[1] Warning Notice of the Health and Social Care Act 2008.

In order to best respond to the areas for improvement identified by the mentioned inspection and the Warning Notice, a comprehensive programme of improvement actions was developed and its implementation has continued during the period 2024/25. The monitoring and oversight of the progress and effectiveness of the improvement programme continues being undertaken by an Executive Maternity Improvement Group led by the Chief Executive.

James Paget University Hospitals NHS Foundation Trust **has not** participated in any special reviews or investigations by the CQC during the reporting period.

Secondary Uses Service

James Paget University Hospitals NHS Foundation Trust submitted records during 2024/25 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the published data:

- which included the patient's valid NHS number was:
  - 99.8% for admitted patient care
  - 99.9% for outpatient care and
  - 99.1% for accident and emergency care
- which included the patient's valid General Medical Practice Code was:
  - 100% for admitted patient care
  - 100% for outpatient care and
  - 100% for accident and emergency care.

[1] [1] The CQC can serve a warning notice under section 29A of the Health and Social Care Act 2008 when they identify concerns across either the whole or part of an NHS trust or NHS foundation trust and decide that there is a need for significant improvements in the quality of healthcare. This includes concerns that are probably systematic and affect the entire system or service rather than being an isolated matter and that result in the risk of harm or actual harm.

Information Governance Assessment Report

James Paget University Hospitals NHS Foundation Trust Information Governance Assessment Report overall score for 2024/25 was [not available at time of writing] and was graded Standards Not Met*****

	JPUH 2020/21	JPUH 2021/22	JPUH 2022/23	JPUH 2023/24	JPUH 2024/2025
Data Security Protection Toolkit Assessment	Standards exceeded	Standards met	Standards exceeded	Standards met	Standards not met

In September 2024, the Data Security & Protection Toolkit (DSPT) was changed to adopt the National Cyber Security Centre's Cyber Assessment Framework (CAF) as its basis for cyber security and Information Governance assurance. This change will lead to all NHS Trusts, Commissioning Support Units, Arm's Length Bodies and Integrated Care Boards seeing new CAF aligned requirements in terms of Objectives, Principles and Outcomes. Expectations of all organisations have been tightened in areas NHS England (NHSE) and the Department of Health and Social Care (DHSC) believe the now higher standards to be a necessary obligation. These include - NHS supply chain security, Multi Factor Authentication being rolled out across suppliers of essential functions in addition to our users, a new CAF aligned framework for Auditors of the DSPT and staff training in Information Governance and Cyber Security.

The DSPT is now considered to be a five-year plan for organisations to work towards, with some areas identified by NHSE and DHSC with an expectation that this year, they will not be achievable. Trust Digital Health, Information Governance IG and Cyber Teams are working to ensure that the DSPT meets standards again for next year's submission.

Payment by Results

James Paget University Hospitals NHS Foundation Trust **was not** subject to the Payment by Results clinical coding audit during 2024/25 by the Audit Commission.

Data Quality

James Paget University Hospitals NHS Foundation Trust will be taking the following actions to improve data quality.

To fulfil the obligations for Data Quality assurance as outlined in Data Security Standard 1, the Trust uses a combination of external and internal validation resources to ensure the completeness and validity of data.

Externally, this includes the Data Quality Maturity Index[2] (DQMI), Secondary Uses Service (SUS) Data Quality Dashboards and error reporting through submissions to Hospital Episode Statistics (HES). Internally, the Trust Data Quality team produce daily, weekly and monthly reports for the Divisional teams which identifies errors for immediate correction. Internal and external reporting covers admitted patient care, outpatients, waiting lists and emergency care (A&E).

[2] The Data Quality Maturity Index (DQMI) is a monthly publication intended to highlight the importance of data quality in the NHS. It provides data submitters with timely and transparent information about their data quality.

The output from external and internal validation sources forms part of the Data Quality report submitted to the Information Governance Committee and internal audits are also shared with divisional teams to support the Trust has an approved Data Quality.

Learning from Deaths

Item 1
In the period 2024/25, **1,184** patients of the James Paget University Hospitals NHS Foundation Trust died.

The number of patient deaths in each quarter is detailed below:

- **287** in the first quarter (01/04/2024 to 30/06/2024)
- **266** in the second quarter (01/07/2024 to 30/09/2024)
- **312** in the third quarter (01/10/2024 to 31/12/2024)
- **319** in the fourth quarter (01/01/2025 to 31/03/2025)

Item 2
During the 2024/25 period, out of the 1,184 patient deaths occurred, **73** (6%) cases were reviewed and/or investigated. The number of these cases reviewed and/or investigated each quarter is listed below:

- **26** in the first quarter (01/04/2024 to 30/06/2024)
- **18** in the second quarter (01/07/2024 to 30/09/2024)
- **20** in the third quarter (01/10/2024 to 31/12/2024)
- **17** in the fourth quarter (01/01/2025 to 31/03/2025)

Of these 73 cases, **60** (82%) were identified as requiring a case record review. The methodology used for this review is the Structured Judgement Review (SJR).

Of these 60 cases requiring an SJR, **6** were also reviewed or investigated under the Patient Safety Incident framework applicable.

In addition, **7** cases were reviewed or investigated as per the applicable Patient Safety Incident framework.

Of the 60 cases requiring an SJR, **10 (**representing **0.84%** of the patient deaths during 2024/25) cases are still going through the SJR process.

Item 3

One of the 60 cases reviewed using the SJR methodology has identified that it was considered that death had the possibility of being preventable (estimated greater than 50-50 chance). This death occurred in August 2024.

Of those deaths that have been reviewed or investigated, in 10 cases the incident has been considered to affect the outcome of the incident:

Period	The incident possibly affected the outcome	The incident probably affected the outcome	The incident caused the outcome	Total
Quarter 1 (Apr – Jun 23)	7	0	0	7
Quarter 2 (Jul – Sep 23)	1	1	0	2
Quarter 3 (Oct – Dec 23)	0	0	0	0
Quarter 4 (Jan – Mar 24)	1	0	0	1
TOTAL: 2024/25	9	1	0	10

Item 4

A summary of what the provider has learnt from case record reviews and investigation conducted in relation to the deaths identified in item 3

Learning from deaths where incidents and care may have had an effect on the outcome include the following subjects:

- Improved communication between medics and nurses and between different specialties.
- Clear documentation in clinical records and comprehensive documentation of patient health risks.
- Timely communication with bereaved families.
- Completion of capacity assessments.
- Importance of nutrition and hydration.
- Using ReSPECT forms for identifying patient decision in relation to DNACPR and to identify ceilings of care and clear escalation plans.
- Early involvement of palliative care.
- Appropriate NEWS scoring and escalation.
- Early involvement of senior colleagues following post-procedure complications e.g. PEG.

Item 5

A description of the actions which the provider has taken in the reporting period, and proposes to take following the reporting period, in consequence of what the provider has learnt during the reporting period (see item 4)

Below are some of the key actions undertaken to address the opportunities for improvement identified during the reviews and investigation of deaths:

- Educational sessions for relevant staff (this has been included to support several of the lessons learnt identified above).
- Contact made via letter with clinicians involved in patients care to ensure they are aware of the SJR outcome and any concerns raised.

- Correct documentation of Cardiopulmonary Resuscitation discussed at Medical Morbidity and Mortality Meeting.
- Development of a trust wide process to improve escalation of NEWS escalation.
- Process of obtaining a second opinion to be developed.
- Discussion of SJR cases where learning is evident at the Grand Round.
- Champions of Wider Learning present SJR cases where learning is evident at foundation teaching sessions.

Item 6

An assessment of the impact of the actions described in item 5, which were taken by the provider during the reporting period

The actions mentioned above have contributed not only to drive improvements in the clinical practice, the safety and quality of care. They have improved the awareness and recognition amongst all members of staff of the importance of learning from the death of patients.

In addition to the changes driven by the learning highlighted above, the Learning from Deaths processes have been updated to detail the link between learning from deaths and Patient Safety Incident Response Framework.

The Trust has continued to embed the NHS England SJR Plus platform which has enabled the development of an electronic dashboard. This dashboard is driving a more in depth learning from SJRs and a more effective management of the process to manage the Mortality Register and the review of patient deaths.

The combination of the SJR Dashboard and the existing Mortality Dashboard has enabled the triangulation of the general mortality data and the mortality review data. This is complemented by the use of a model for the prediction of mortality data.

These changes have allowed the production of more responsive and comprehensive reports, which are included in the portfolio of multiple Trust governance forums to inform and provide assurance to all levels, including the Trust's Board.

Item 7

37 case record reviews were completed after 1st April 2024, which related to deaths which took place before the start of the reporting period.

Item 8

None of the cases mentioned in 'item 7' above were judged to be more likely than not to have been due to problems in the care provided to the patient.

Item 9

10 cases, representing 0.8% of all patient deaths during 2024/25 are judged to have affected the outcome of the case.

2.3 Reporting Against Core Indicators

Summary hospital-level mortality indicator (SHMI)

	JPUH 2022/23	JPUH 2023/24	JPUH 2024/25	National Average 2024/25	Highest SHMI for FT	Lowest SHMI for FT
(a) Value and (banding) of the SHMI for the Trust	1.07 (as expected)	1.11 (as expected)	1.13 (as expected)	1.0000	1.30	0.70

The SHMI for 2024/25 (November 2023 to October 2024) currently remains within expected limits.

James Paget University Hospitals NHS Foundation Trust considers that this data is as described for the following reasons:

Data is taken from Secondary Users Service (SUS) Hospital Episode Statistics (HES) data, which is audited on an annual basis by external auditors.

James Paget University Hospitals NHS Foundation Trust has taken the following actions to improve these percentages, and so the quality of its services, by:

A monitoring and improvement programme is in place led by the Trust's Chief Medical Officer and overseen by the Mortality Surveillance Group, which receives information from Mortality & Morbidity Groups at specialty level, Clinical Mortality Review Group and the patient safety processes and governance systems.

Hospital re-admissions

	JPUH 2022/23	JPUH 2023/24	JPUH 2024/25	National Average	Highest score for Foundation Trusts	Lowest score for Foundation Trusts
Patients aged 0-15 years	10.7%	13.6%	11.3%	12.8%	20.6%	4.4%
Patients aged 16 or over	13.0%	12.7%	10.8%	13.7%	32.6%	3.0%

James Paget University Hospitals NHS Foundation Trust considers that this data is as described for the following reasons:

- Data is taken from Secondary Users Service (SUS) Hospital Episode Statistics (HES) data, which is audited on an annual basis by external auditors.

James Paget University Hospitals NHS Foundation Trust has taken the following actions to improve these percentages, and so the quality of its services, by:

✓ This will include reviewing readmission rates and other clinical improvements emerging from various sources such as the national Getting it Right First Time programme, information presented on the Model Health system and the NHS benchmarking tool service peer reviews and any contract breaches

Patient reported outcome measures (PROMs)

PROMs – What is it?

Patient Reported Outcome Measures (PROMs) assess the quality of care delivered to NHS patients from the patient perspective. Currently covering two clinical procedures, PROMs calculate the health gains after surgical treatment using pre- and post-operative surveys.

The two procedures are:

- hip replacements
- knee replacements

PROMs have been collected by all providers of NHS-funded care since April 2009.

PROMs participation rates

	JPUH 2020/21	JPUH 2021/22	JPUH 2022/23	JPUH 2023/24
Groin hernia surgery	No longer collected			
Varicose vein surgery	No longer collected[3]			
Hip replacement surgery	95.8%	76.9%	57.0%	96.0%
Knee replacement surgery	86.2%	62.1%	57.1%	102.7%
All procedures	91.2%	69.8%	57.1%	99.4%

PROMs expected number of participants is calculated using Hospital Episode Statistics data. As such, the final number of participants may exceed the expected number from HES and result in a percentage of above 100%.

*PROMs data for 2024/25 is not yet published

James Paget University Hospitals NHS Foundation Trust considers that this data is as described for the following reasons:

- There is a process in place within pre-operative assessment for PROMs to ensure that all patients eligible for participation are given the opportunity to participate. Staff keep a record of how many PROMs are distributed and how many are completed.

James Paget University Hospitals NHS Foundation Trust has taken/intends to take the following actions to improve these percentages, and so the quality of its services, by:

✓ Estimated PROMs participation rates are monitored monthly and any actions will be implemented based on those figures.

[3] Varicose vein and groin hernia PROMS are no longer collected following a consultation undertaken by NHS England.

Responsiveness to the personal needs of patients

JPUH 2019/20	JPUH 2020/21	JPUH 2021/22	JPUH 2022/23	JPUH 2022/23	England score 2021/22[4]
75.6	73.8	*not available	*not available	*not available	74.5

* Data publication, which was due to be released March 2023, has been delayed following the merger of NHS Digital and NHS England on 1st February 2023. As a result, the future presentation of the NHS Outcomes Framework indicators is being reviewed.

James Paget University Hospitals NHS Foundation Trust considers that this data is as described for the following reasons:

- This indicator is based on questions from the National Inpatient Survey and patients have scored the Trust highly on the five aspects taken as part of this indicator.
- The Trust score is in line with the national average indicating a 'good' patient experience.

James Paget University Hospitals NHS Foundation Trust intend to take the following actions to improve these percentages, and so the quality of its services, by:

✓ Quality Improvement actions and bespoke surveys are carried out in response to the national survey.

The National Quarterly Pulse Survey

The advocacy score represents the degree to which staff advocate their organisation as a place to work or to be treated. The score is based on a scale of 0-10. The most favourable response will be scored 10, while the worst will be scored 0

JPUH 2024	England 2024	Highest score for Foundation Trusts	Lowest score for Foundation Trusts
5.4	6.4	8.3	4.0

James Paget University Hospitals NHS Foundation Trust considers that this data is as described for the following reasons:

✓ Staff at the trust have a strong sense of pride in relation to the care they provide and towards colleagues and the organisation.

James Paget University Hospitals NHS Foundation Trust has taken the following actions to improve these percentages, and so the quality of its services, by:

✓ Encouraged a higher level of participation through multiple communications exercises.

[4] 2022/23 data not available

Clostridioides difficile (C.difficile)

This measure shows the rate per 100,000 bed days of cases of *C.difficile* infection that have occurred within the Trust amongst patients aged two years or over during the reporting period.

	JPUH 2022/23	JPUH 2023/24	JPUH 2024/25	National Average 2023/24	Highest score for Foundation Trusts	Lowest score for Foundation Trusts
Rate per 100,000 bed days *C.diff* infection	18.70	10.38	14.34	*Not available	*Not available	*Not available
Number of cases of *C.diff* infection	30	22	26	*Not available	*Not available	*Not available

*Data due to be published later in the year (month not specified).

James Paget University Hospitals NHS Foundation Trust considers that this data is as described for the following reasons:

- ✓ Continuing strong focus on prevention as well as control
- ✓ Symptomatic carriers are isolated, so the Trust is proactive in controlling the risk

James Paget University Hospitals NHS Foundation Trust has taken the following actions to improve these percentages, and so the quality of its services, by:

- ✓ Encouraging prudent use of antibiotics through:
  - Antibiotic policies
  - Encouraging the use of narrow-spectrum antibiotics
  - Limiting the duration of antibiotics usage
  - Engagement with clinicians around their practice
- ✓ Encouraging intravenous to oral switch.

Patient Safety Incidents

	JPUH 2020/21	JPUH 2021/22	JPUH 2022/23	JPUH 2023/24	JPUH 2024/25	Highest score for Acute (non-specialist) trusts	Lowest score for Acute (non-specialist) trusts
Number of patient safety incidents	5461	6009	6272	*13689	*11645	*Not available	*Not available
						JPUH	
Rate per 1000 bed days	39.9	37.2	37.4	*77	*70.4	*Not available	*Not available
						JPUH	
Percentage of incidents resulting in Major Harm	0.5%	0.48%	0.3%	0.4%	*0.19%	*Not available	*Not available
						JPUH	
Percentage of incidents resulting in Death	0.09%	0.07%	0.08%	0.2%	*0.19%	*Not available	*Not available
						JPUH	

*This data was previously based on the National Reporting and Learning Service (NRLS) data. Nationally we have moved over to the Learning from Patient Safety Events (LFPSE) Service, which does not specify patient safety incidents as a metric. The increase is due to the data being based on patient related incidents which is the closest metric we report on, but not directly comparable. The highest and lowest score data is not available.

James Paget University Hospitals NHS Foundation Trust considers that this data is as described for the following reasons:

- Anonymous reporting and the ability to report incidents without logging in has been introduced.
- Awareness has been raised as to what constitutes a patient safety incident (PSI) through training and communications.
- Monthly monitoring of what has or, more importantly, has not been submitted as a PSI.

James Paget University Hospitals NHS Foundation Trust has taken the following actions to improve these percentages, and so the quality of its services, by:

- ✓ Web-based Trust wide incident reporting system in place and embedded that allows people to report incidents without logging in to facilitate anonymous reporting.
- ✓ Quality checking of incidents will continue with the Learning From Patient Safety Events Service (LFPSE) being implemented – we will no longer have to manually upload patient safety incidents, the LFPSE is a live reporting platform
- ✓ From September 2023, the Patient Safety Incident Response Framework (PSIRF) came into effect, greatly changing the process for incident management and providing enhanced emphasis on learning and engagement with patients, relatives and staff.
- ✓ Trust patient safety priorities have been agreed and detailed in the trust Patient Safety Incident Reporting Plan (PSIRP)
- ✓ Daily Triage and Multi Disciplinary review takes place of all incidents reported and escalation to the three times weekly Safety Assurance and Action Group (SAAG), with external attendance from the ICB. This facilitates timely discussion of incidents and Near Miss incidents, allocation of patient safety priority incident category and agreement of the harm and learning pathway and immediate actions required.
- ✓ Patient Safety Improvement Group (PSIG) receives escalation of themes and trends relating to patient safety topics and reporting of the learning achieved in the trust, related to patient safety and quality activity and implementation of PSIRF.
- ✓ Incident reporting and learning is also discussed at Divisional governance meetings monthly with trends and themes analysed and cascaded to wider teams.
- ✓ All data is provided by bed days/number of contacts for Divisions to provide context when analysing incident data.

NHS Oversight Framework Indicators

Performance against the relevant indicators and performance thresholds set out in the oversight documents issued by NHS England. For 2024/25 these are:

National NHS objectives 2024/25	Threshold 2024/25	Actual 2024/25
UEC: Improve A&E waiting times, compared to 2023/24, with a minimum of 78% of patients seen within 4 hours in March 2025	78%	63.4%
Elective Care: Eliminate waits of over 65 weeks for elective care as soon as possible and by September 2024 at the latest (except where patients choose to wait longer or in specific specialties)	0	117
Elective Care: Deliver (or exceed) the system specific activity targets, consistent with the national value weighted activity target of 107%	107%	116.0%.
Elective Care: Increase the proportion of all outpatient attendances that are for first appointments or follow-up appointments attracting a procedure tariff to 46% across 2024/25	46%	46.5%
Cancer: Improve performance against the headline 62-day standard to 70% by March 2025	70%	69.9%
Cancer: Improve performance against the 28 day Faster Diagnosis Standard to 77% by March 2025 towards the 80% ambition by March 2026	75%	74.5%
Diagnostics: Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95%	90.5%	73.0%

For definitions for all Indicators, please see the use the link:
https://www.england.nhs.uk/publication/priorities-and-operational-planning-guidance-2024-25/

Guardian of Safe Working Hours End of Year Report

This report summarises progress to the year ending 31 March 2025, ensuring that doctors are safely rostered and enabled to work safe hours.

The work schedules for the doctors are now compliant with the new contract, and the monitoring system for exception reporting is being used well.

The Trust continues to work to ensure that any exceptions are raised appropriately and that the Trust has an open and transparent culture.

Rota Gaps / Vacancies

Medical and Dental Establishment v Actual Full Time Equivalent (FTE)

Grade	FTE Establishment	Actual FTE
Foundation Year 1	42.60	43.00
Foundation Year 2	34.00	33.00
Specialty Registrar	102.01	82.00
Trust Grade Doctors – Foundation Level	0.00	10.00
Trust Grade Doctors – Specialty level	3.00	14.00
Grand Total	**181.61**	**182.00**

Specialties with Trainee Gaps:

- Acute Medicine / General Medicine
- General Surgery
- Obstetrics and Gynaecology
- Anaesthesia
- Trauma and orthopaedics

These deficiencies were similar to those in previous years.

The Medical time to hire for 2024/25 in relation to 2023/24 and how it was managed.

The Medical time to hire for 2024/25 was similar to that of 2023/24. Locally Employed Doctors (LED), Medical Training Initiative (MTI), and Physician Associates (PA) were employed to mitigate medical trainee gaps. Any gap left after that was filled with locums.

Wellbeing

There were further improvements in the doctors' mess and rest facilities. Continued promotion of well-being offered by trust, including BMA, HEE PSA, and other external support available for the medical workforce.

Submitted Exception Reports 01.04.2024 to 31.03.2025

Total number of exception reports received	298
Number relating to immediate patient safety issues	8
Number relating to hours of working	245
Number relating to pattern of work	4
Number relating to educational opportunities	21
Number relating to service support available for the doctor	28

Exception Reports with Immediate Patient Safety Concerns

There were 8 exceptions reported related to Immediate Patient Safety Concerns in the last year. The following table summarises these exceptions with outcomes and comments.

	Date	Speciality	Grade	Reason	Details	Comments
1	03/4/24	Acute Medicine	FY1	Service Support	Busy night on call, night SHO support was not available but ward SHO helped	As registrar, consultant and ward SHO support was available therefore no real immediate patient safety issue.
2	16/7/24	General Surgery	FY1	Extra hours	Worked 45 minutes extra because of low staffing level.	Low but not critically low staffing level. Paid for extra time worked.
3	08/8/24	Acute Surgery	FY1	Pattern	Worked 45 minutes extra because of low staffing level (sickness).	Low but not critically low staffing level. Paid for extra time worked.
4	21/9/24	General Medicine	FY1	Service Support	No FY2 support available.	As registrar, consultant and support was available there for no real immediate patient safety issue.
5	21/9/24	General Medicine	FY1	Extra hours	Low staffing (sickness), stayed extra to finish jobs.	Low but not critically low staffing level Paid for extra hours worked.
6	1/11/24	General Medicine	FY1	Extra hours	Low staffing stayed extra to finish jobs.	Not critically low staffing level. Paid for extra hours worked.
7	05/3/25	General Medicine	FY1	Extra hours	Registrar support was not available in afternoon as the registrar was called to do a clinic because of	Paid for extra hours worked.

					sickness of rostered registrar therefore stayed extra.	
8	28/3/25	ENT	ST1	Service Support	Covered 2 SHO work as one ENT SHO was on leave.	Rota co-ordinator arranged support from other specialities.

Note: Within the reporting system, an Exception relating to hours of work, pattern of work, educational opportunities and service support have the option to specify if it is an immediate Patient Safety Concern (ISC), therefore ISC is not an exception type by itself.

Exception Reports Relating to Educational Opportunities

There were 21 exception reports related to educational opportunities in the last year. The following table summarises these exceptions with outcomes and comments.

	Date	Speciality	Grade	Reason	Details	Comments
1	21/11/24	Medicine (Respiratory Medicine)	FY2	Missed Teaching	Missed teaching as very busy ward, no one able to hold bleep. Also stayed extra to finish work.	TOIL granted to give time to learn missed topics (default option) also payment for extra time worked.
2	14/8/24	Medicine (General Medicine)	FY1	Missed STD (partial)	Self-development time (STD) started 1 hour late because of busy ward.	TOIL granted to give time to learn missed topics.
3	28/8/24	Surgery (General Surgery)	FY1	Missed Teaching	Unable to leave ward for 15:00 teaching.	TOIL granted to give time to learn missed topics.
4	04/9/24	Surgery (General Surgery)	FY1	Missed Study Leave (partial)	Unable to leave for afternoon study leave (45 minutes).	TOIL granted for hours missed.
5	08/9/24	Medicine (General Medicine)	FY1	Missed STD (partial)	STD started 45 minutes late because of busy wards.	TOIL granted for missed time.
6	17/9/24	Medicine (General Medicine)	FY1	Missed STD (partial)	STD started 1 hour late because of busy ward.	TOIL granted.
7	24/9/24	Medicine (Acute Medicine)	FY2	Missed Teaching	Unable to attend fortnightly foundation training because of low staffing level.	TOIL granted to give time to learn missed topics.
8	29/9/24	Surgery (General Surgery)	FY1	Missed Teaching	Unable to attend Career's fair because was on call.	No compensation.
9	1/10/24	Medicine (General Medicine)	ST1	Missed teaching	Missed GP training due to busy ward and low staffing level.	TOIL granted to give time to learn missed topics.
10	9/10/24	Medicine (General Medicine)	FY1	Missed STD	Missed STD busy ward and low staffing level.	TOIL granted

11	13/11/24	Anaesthetics	ST4	Missed Teaching list.	Teaching list changed to service list because of enough senior doctors.	Extra teaching list arranged.
12	1/11/24	Medicine (General Medicine)	FY1	Missed STD (partial)	STD started 90 minutes late because of busy wards and low staffing level.	TOIL granted (90 minutes).
13	1/12/24	Medicine (General Medicine)	FY1	Missed STD (partial)	STD started 30 minutes late because of busy wards and low staffing level.	TOIL granted (30 minutes).
14	17/12/24	Medicine (General Medicine)	FY2	Missed STD	Missed STD busy ward and low staffing level.	TOIL granted.
15	4/2/25	Medicine (Acute Medicine)	FY1	Change of duty type.	Normal working day duty changed to on call because of sickness	No compensation.
16	8/2/25	Medicine (Acute Medicine)	FY1	Change of duty type.	Normal working day duty changed to on call because of sickness	No compensation.
17	20/2/25	ENT	CT2	Missed Teaching list.	Removed from teaching list to cover emergency clinic.	No compensation.
18	4/3/25	Medicine (Acute Medicine)	FY1	Missed Teaching	Missed foundation teaching because of low staffing level from sickness and leaves.	TOIL granted to give time to learn missed topics.
19	19/3/25	Surgery (General Surgery)	FY1	Missed Teaching	Missed foundation teaching because of low staffing level from sickness and leaves.	TOIL granted to give time to learn missed topics.
20	20/3/25	ENT	FY2	Change of duty type	Asked to move from renal (base ward) to cover medical outliers.	No compensation.
21	28/3/25	Surgery (General Surgery)	ST1	Change of duty type	Instead of doing teaching supervised clinic asked to cover on call.	Extra teaching list arranged.

Details and Response to Unresolved Exception Reports

No unresolved exception reports in the last year.

Fines

There have been no fines to trust in the last 12 months.

Work Schedule Reviews

No work schedule review in this year (2024-25).

Junior Doctor Forums

Few rostering issues raised from Resident Doctors Meeting which will be discussed in next Local Negotiation Committee meeting.

Summary

There was minimal increase in exception reports in the last year compared to the previous year (298 v 277) Most of this increase was from encouragement resulting in better Exception Reporting

The Medical time to hire for 2024/25 was similar to that of 2023/24. Gateway Doctors, Locally Employed Doctors (LED), Medical Training Initiative (MTI) and Physician Associates (PA) were employed to mitigate medical trainee gaps. Any gap left after that was filled with locums.

The Trust continued promoting well-being offers and other external support which are available specifically for the medical workforce.

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Annex 1

Statements from Stakeholders

1. Norfolk and Waveney Integrated Care Board

Karen Watts, Director of Nursing & Quality
NHS Norfolk & Waveney ICB
Floor 8, County Hall
Martineau Lane
Norwich
NR1 2DH

Sent by email to:
Jacky Copping, Interim Chief Nurse,
James Paget University Hospitals NHS Foundation Trust
Email:
jacky.copping@jpaget.nhs.uk

05 June 2025

Dear Jacky,

Re: Commissioner Response to James Paget University Hospitals NHS Foundation Trust Quality Account 2024/2025

Norfolk and Waveney ICB acknowledges the receipt of the 2024/2025 Quality Account from James Paget University NHS Foundation Trust and welcomes the opportunity to provide this statement.

Based on the information and data available within the report, the ICB supports JPUH in the publication of its Quality Account for 2024/2025. We are satisfied that it incorporates the required mandated elements.

The ICB recognises the challenges experienced by the Trust over the last contractual year and the significant pressures that the workforce has faced during sustained system wide pressure. Whilst the Trust has remained very clear that the use of Corridor Care is not normal practice, we acknowledge the frameworks that have been put in place by the Trust to keep patients safe. This has supported the timely release of ambulances to attend to critical emergency calls within our community. The ICB welcomes the Trust's continued focus on this.

The ICB supports the Trusts commitment to its identified Quality Priorities, and the achievements made in implementing the Patient Safety Incident Response Framework (PSIRF) and acknowledges that the Trust is making good progress.

The achievements made against avoidable harm are pleasing to see, especially in relation to the reduction of hospital acquired pressure ulcers, reduction of medication incidents and a year-on-year reduction for Gram Negative Blood Stream Infections. Where targets have not been met or partially met, we note the Trusts ongoing focused commitment to improving quality in these areas as part of your three-year quality priorities.

The ICB notes the significant improved compliance with Palliative and End of Life Care metrics and recognises the ongoing work of the Trust in this area to continue to drive improvements to practice. This has a significant impact on the experience of care and support received by people at the end of their lives as well as their families and loved ones.

Norfolk and Waveney ICB acknowledge the Trust's ongoing response to the section 29A Warning Notice of the Health and Social Care Act, for Midwifery and Maternity Services, which was put in place by the CQC following the 2022/2023 inspection. We are pleased to note that there is senior oversight of this work by the Trust's Executive Maternity Improvement Group. Implementation of learning from national reviews, via the Trust's Maternity Delivery Plan, is also noted alongside a number of completed actions that meet Ockenden standards we recognise there is more to do. The ICB looks forward to continued achievement against both elements in 2025/26.

We would like to note that the Trust has entered a new group model alongside the other two Acute Hospital Trusts within Norfolk and Waveney and we look forward to working closely with you all to provide a locally focused delivery of care model which meets the specific needs of our diverse communities and geographical challenges, whilst reducing unwarranted variation in services and outcomes.

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.

On behalf of NHS Norfolk and Waveney ICB, I would like to extend our gratitude to everyone involved in developing and producing this account, as well as all Trust staff. We look forward to strengthening our collaborative relationship to ensure safe, effective care for our patients and local population during 2025/2026.

Yours sincerely,

Karen Watts, Director of Nursing and Quality
NHS Norfolk and Waveney ICB

cc. Patricia D'Orsi, Executive Director of Nursing, NHS Norfolk and Waveney ICB

2. Healthwatch Norfolk

Healthwatch Norfolk (HWN) is pleased to have the opportunity to comment on the Quality Account 2024-25. Earlier in the year we were able to meet with the Quality Lead to discuss the proposed content of the Account and believe this to have been a useful meeting for all parties. As in previous years, we are aware of the difficulties faced by the Trust to produce an accessible, easy to read document whilst also having to ensure the mandatory requirements of the NHS Annual Quality Accounts Regulations are included in the document. We also recognise that this has been another challenging year for all those working in the NHS and applaud the progress made in terms of the Trust's performance against many quality priorities identified and agreed last year, at a time when the government has announced the need for stringent reforms across the NHS.

Looking at the performance against the quality priorities set for patient safety, clinical effectiveness and patient experience in 2024-5 in more detail, we note that many of the proposed aims and targets have duly been met. The document also identifies where further work is planned or already in place in order to meet those targets not met or partially met.

In particular we welcome the fact that 100% of staff and patients (or relatives where applicable) are involved in the incident management process for patient safety incident investigations, including the opportunity to share their experiences with clinicians. HWN fully supports opportunities for clinicians to learn directly from the investigation of patients' experiences. We also note the reduction in the risk of patients developing pressure ulcers and the significant reduction in the number of complaints relating to communication, delays in responding and not being informed of outcomes. It is clear work has successfully been undertaken to make improvements Whilst we recognise the priority to reduce smoking at time of delivery to 6% has not been achieved, we are pleased to note that there has been a reduction to 9.8% in March 2025. It is disappointing to note that the target to reduce the number of falls in elderly patients by 5% was not met during the year. It would be useful for there to have been some information about the Trust's further endeavours in this area and perhaps a brief analysis as to the reason for the increase in the number of falls compared to last year.

Turning to patient and public engagement, hopefully the completion of the move of PALS to the main foyer be more visible and accessible will also help to prevent the escalation of concerns from patients, their families and staff. In next year's report some statistical data on PALS and complaints would help to demonstrate the positive impact of the work undertaken by the Trust, including the increase in the number of PALS officers in 2023 and the imminent move to make the PALS office more visible.

HWN is pleased to work with the Trust on its patient and public engagement plan, and we note that collaborative working with the Voluntary, Community, Faith and Social Enterprise Sectors (VCFSE) is also taking place. We support sharing resources across health and social care organisations wherever possible to ensure that the voice of service users is at the forefront of all decision making.

We note that there are some areas in the Quality Account requiring metric clarification to the system wide approach on Older People's Medicine. We trust that once the new Integrated Care Board model has been completed later this year, the work on defining the system wide approach to Older Peoples' Medicine can be successfully completed and appropriate action taken by the Trust to implement a number of improvements to benefit the patients in this particular category.

Looking ahead to 2025/26 we note the continuing quality priorities and goals as previously identified in the 2023-4 three-year plan and look forward to seeing a year-on-year improvement, building on the achievements of the past 12 months.

The report indicates a significant increase from the previous year in the number of actions resulting from the national and local clinical audit reports that have been reviewed. It is clear that the Trust has implemented a variety of improvements to the quality of healthcare provided based on the audits. A number of very specific actions are listed and demonstrate the learning from the audits including the need to recruit additional staff in some areas and sharing of audit outcomes with relevant staff. It is good to see a link put in place between learning from death processes and the patient safety incident response framework (PSIRF). Finally we are pleased to note the significant reduction in waiting times of over 65 weeks for elective care compared with last year.

HWN does not underestimate the amount of work required by many members of staff to prepare the document for publication. Overall we would like to congratulate the Trust on its achievements as detailed in the Quality Account and we look forward to continuing to develop our working relationship in this area during the coming year. At a time when the Trust is dealing with national and local economic unrest, the building of a new hospital and the continuing work to develop a Group Leadership Model in the county it is reassuring to note that patient, family and carers' experiences remain the focus of the Trust in providing a safe and quality service.

Alex Stewart
Chief Executive Officer
June 2025

Annex 2

Statement of directors' responsibilities for the quality account

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

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

In preparing the quality account, directors are required to take steps to satisfy themselves that:

- the content of the quality account meets the requirements set out in the *NHS foundation trust annual reporting manual 2023/24* and supporting guidance *Detailed requirements for quality reports 2019/20*

- the content of the quality account is not inconsistent with internal and external sources of information including:
  - board minutes and papers for the period **01.04.2024 to 31.03.2025**
  - papers relating to quality reported to the board over the period **01.04.2024 to 31.03.2025**
  - feedback from commissioners dated **-05.06.25**
  - feedback from local Healthwatch organisations dated –**09.06.25**
  - CQC inspection report dated **31.05.23**

- the Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered.

- the performance information reported in the quality report is reliable and accurate.

- there are proper internal controls over the collection and reporting of the measures of performance included in the quality report, and these controls are subject to review to confirm that they are working effectively in practice.

- the data underpinning the measures of performance reported in the quality report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review.

- the quality report has been prepared in accordance with NHS England's (Formerly NHS Improvement's) annual reporting manual and supporting guidance (which incorporates the quality accounts regulations) as well as the standards to support data quality for the preparation of the quality report.

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

By order of the board: **Date**: **XX/XX/XXXX** **Chair**

Date: **XX/XX/XXXX** **Chief Executive**

Glossary of terms and abbreviations

Term	Meaning
AAR	Action After Review PSIRF Tool
A&E	Accident and Emergency Department
AMD	Assistant Medical Director
BAME	Black and Minority Ethnic
BAUS	British Association of Urological Surgeons
BCN	Breast Care Nurse
BFI	Baby Friendly Initiative
BTS	British Thoracic Society
C.difficile or *C.diff*	*Clostridioides difficile*
CAPE	Carer and Patient Experience Committee
CEG	Clinical Effectiveness Group
COPD	Chronic Obstructive Pulmonary Disease
COVID-19	Coronavirus Disease 19
CQC	Care Quality Commission
CQUIN	Commissioning for Quality Improvement and Innovation
DKA	Diabetic Ketoacidosis
DoC	Duty of Candour
DQMI	Data Quality Maturity Index
EADU	Emergency Admissions and Discharge Unit
ENT	Ear, Nose and Throat
EPMA	Electronic Prescribing and Medicines Administration
ESR	Electronic Staff Record
FFT	Friends and Family Test
FLO	Family Liaison Officer
FTE	Full Time Equivalent
FY	Foundation Year
GP	General Practitioner
GY&W	Great Yarmouth and Waveney
HES	Hospital Episode Statistics
HHS	Hyperosmolar Hyperglycaemic State
HMG	Hospital Management Group
HQIP	Healthcare Quality Improvement Partnership
IBD	Inflammatory Bowel Disease
ICB	Integrated Care Board
ICNARC	Intensive Care National Audit and Research Centre
ICS	Integrated Care System
IPA	Interpretative Phenomenological Analysis
IPQR	Integrated Performance Quality Report
JIA	Juvenile Idiopathic Arthritis
JPUH	James Paget University Hospitals NHS Foundation Trust
KLOE	Key Lines of Enquiry
KPI	Key Performance Indicators
LeDeR	Learning from Lives and Deaths - People with a Learning Disability and autistic people
LFPSE	Learning From Patient Safety Events Service
LMNS	Local Maternity and Neonatal System
LOS	Length of Stay
LQBTQIA+	Lesbian, Gay, Bisexual, Transgender, Queer or Questioning, Intersex, Asexual, and More

Term	Meaning
MBRRACE	Mothers and Babies: Reducing Risk Through Audits And Confidential Enquiries
MDT	Multidisciplinary Team
MIP	Maternity Improvement Plan
N&W	Norfolk and Waveney
N/A	Not Applicable
NABCOP	National Audit of Breast Cancer In Older Patients
NACAP	National Asthma and COPD Audit Programme
NACEL	National Audit of Care at the End of Life
NaDIA	National Diabetes Inpatient Audit
NBOCA	National Bowel Cancer Audit
NCEPOD	National Confidential Enquiry Into Patient Outcome And Death
NCISH	The National Confidential Inquiry Into Suicide and Safety in Mental Health
NEACU	Nursing Essential Assessment and Care Updates
NHS	National Health Service
NHSE/I	NHS England and Improvement
NICE	National Institute for Health and Care Excellence
NMPA	National Maternity and Perinatal Audit
NNAP	National Neonatal Audit Programme
NNUH	Norfolk and Norwich University Hospital NHS Foundation Trust
NPCA	National Prostate Cancer Audit
NPDA	National Paediatric Diabetes Audit
NSFT	Norfolk and Suffolk Foundation Trust
ORBIT	Outcomes Registry for Better Informed Treatment of Atrial Fibrillation
PALS	Patient Advice and Liaison Service
PROMs	Patient Reported Outcome Measures
PSI	Patient Safety Incident
PSII	Patient Safety Incident Investigation
PSIG	Patient Safety Improvement Group
PSIRF	Patient Safety Incident Response Framework
PSIRP	Patient Safety Incident Response Plan
PSP	Patient Safety Partner
PSQ	Patient Safety and Quality Committee
PwC	PricewaterhouseCoopers
QIP	Quality Improvement Programme
QSAFE	Quality, Safety, Assurance, Feedback, Excellence - The Trust's Safety and Assurance System
RAAC	Reinforced Autoclaved Aerated Concrete
RCEM	Royal College of Emergency Medicine
ReSPECT	Recommended Summary Plan for Emergency Care and Treatment
RITA	Reminiscence/Rehabilitation and Interactive Therapy Activities
RTT	Referral to Treatment
SAAG	Safet Action And Assurance Group
SHMI	Summary Hospital Level Mortality Indicator
SJR	Structured Judgement Review
SOP	Standard Operating Procedure
SUS	Secondary Uses Service
TCI	To-Come-In
TDT	Tobacco Dependence Treatment

Term	Meaning
THEO	Therapeutic Optimisation Project
TOIL	Time Off In Lieu
UEA	University of East Anglia
UEC	Urgent and Emergency Care
UK	United Kingdom
UTI	Urinary Tract Infection
VTE	Venous Thromboembolism
WHO	World Health Organisation