



James Paget
University Hospitals
NHS Foundation Trust

QUALITY ACCOUNT 2022/23



Patient Safety



Clinical Effectiveness



Patient Experience

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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 and NHS Improvement'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 2022-23 (Looking back)

It also sets out the Quality Priorities we have agreed for 2023/24 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 2022/23 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 2023/24 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 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.

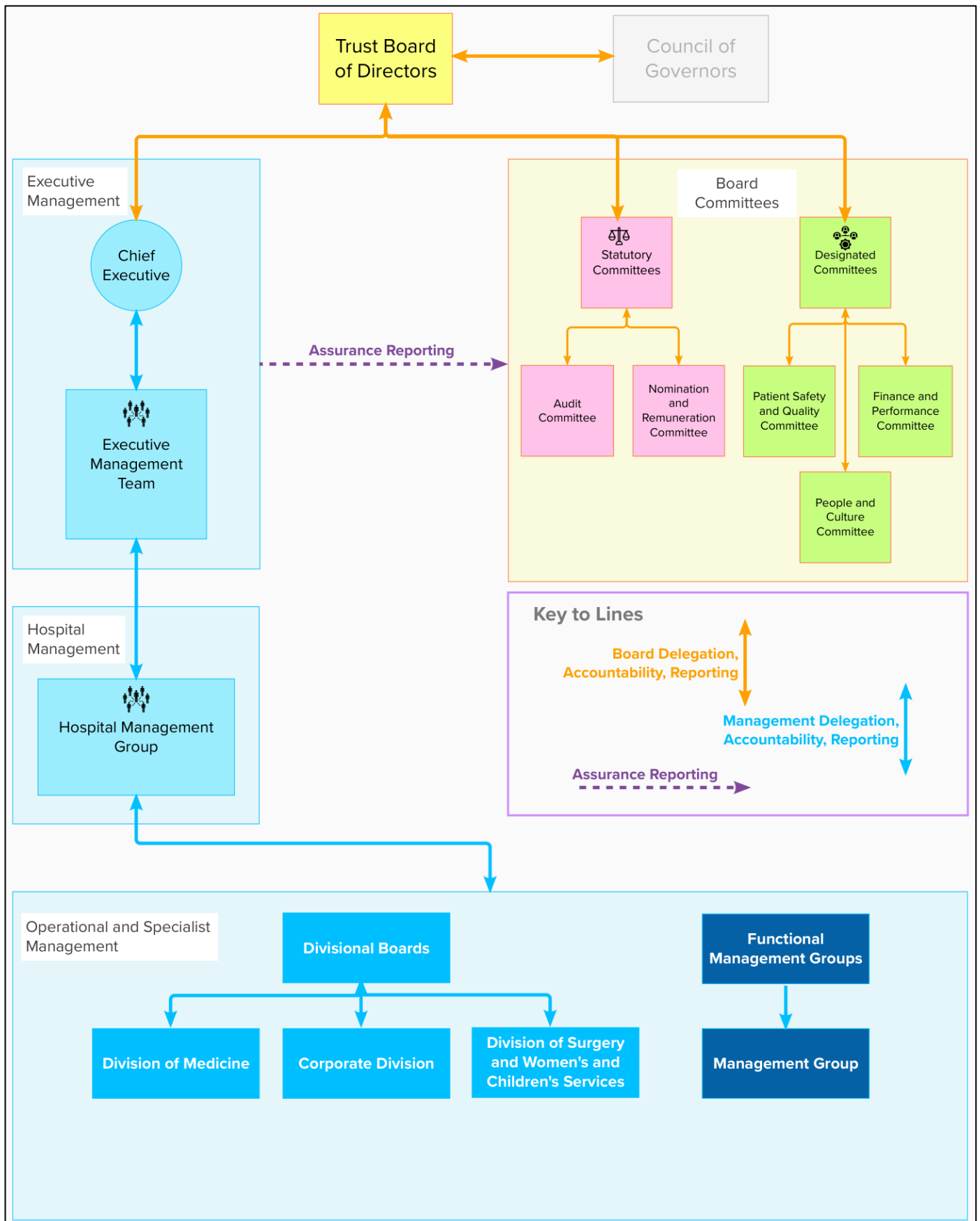
The annexes at the end of the report include the comments of our external stakeholders.

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 NHS Improvement's Annual Quality Accounts Regulations.

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

For over 40 years, James Paget University Hospitals NHS Foundation Trust has been a hospital that is committed to providing high quality, safe and compassionate care to its patients, and the communities we serve.

Our hospital, like all other NHS providers and health and care organisations, has faced significant challenges over the last years including supporting our patients and staff through an unprecedented global pandemic, ensuring the continuation of services, and making every effort to provide care to people that was delayed during the focus on tackling COVID-19.

Through all of this, our focus has been on the fundamentals of care – the safety of the care we provide, and the quality of services we provide and the experience of our patients, and the training and development of the people who provide that care. I am pleased to see that in this year's Quality Account, we have continued to achieve this in many areas.

Our hospital has also continued to grow over the last year. We have worked closely with our staff to understand what is important to them, so that we can renew the values and behaviours that underpin everything the James Paget stands for. We have spent a significant amount of time listening to the experience of our colleagues, and refined our vision and strategic ambitions based on these details.

We are on a journey to becoming a Just and Learning organisation – a hospital that demonstrates its compassion to its staff by understanding that unforeseen events do occur, and that our reaction to them and how we support everyone involved defines who we are. This is how we can learn meaningfully from situations that occur and therefore improve the quality and safety of our services.

Another important part of this work is partnership – with our patients, with our health and care colleague organisations, and with our regulators and NHS partners. It is vital that the James Paget continues to meet national commitments and quality and safety metrics, and work closely with our Norfolk and Waveney Integrated Care System partners, as well as regional and national NHS partners, to deliver these.

This leads us to our priorities for next year, building on reflections on performance during 2022-23. The Patient Safety Incident Response Framework roll-out provides a refreshed opportunity to engage with patients around improving the safety and quality of our services, through how we focus on the response to incidents. This will also inform the development of our Patients Advice and Liaison Service (PALS) to ensure it is providing the most effective support for our patients.

Through embracing these developments across our Trust, and working closely with our partners, we can show real improvement to our services, and address the key concerns raised regarding our services, most notably following the Care Quality Commission's inspection of our maternity services in 2023. This provides us further impetus to demonstrate our commitment to learning and continuous improvement across the hospital.

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's Quality Improvement Strategy 2018-2023
- Care Quality Commission (CQC) five Key Lines of Enquiry (KLOE)
 - Safe
 - Effective
 - Caring
 - Responsive
 - Well-led
- Governors/Trust Members/local population feedback via questionnaire
- Quality Account priorities from the past year
- Issues identified from the CQC Quality Assurance Framework
- Priorities identified by:
 - NHS England and NHS Improvement
 - Health Education England
 - Public Health England
 - National Institute for Health and Care Excellence (NICE)
- Learning taken from the Trust's response to the COVID-19 pandemic

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 action planning;
- Patient Satisfaction Surveys.

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 2022/23

The table below lays out a list of all the agreed Trust Quality Priorities for 2022/23 by domain with their end of year status, with corresponding supplementary information reported below each section.

Patient Safety

a	We will openly and fully engage with patients and relatives when things go wrong to improve patient safety in the future.	Partially achieved
b	We will reduce risk to patients whilst they are in hospital from falls, pressure ulcers etc.	Partially achieved
c	We will deliver the best training for all of our patient-facing staff so they are equipped to deliver high standards of patient care through the National Patient Safety Syllabus	Partially achieved
d	Embed a robust harm review process for patients on waiting lists for surgery or treatment	Achieved
e	We will assess maternity services against the recommendations of national reports such as Ockenden and develop robust safety assurance processes	Achieved
f	We will deliver the Commissioning for Quality and Innovation (CQUIN) schemes that include improvements to the cancer pathway/diagnosis, improvements to medicines available on discharge, mobilisation of patients post-surgery, all unplanned critical care (NEWS2), alcohol screening to diagnose cirrhosis or advanced liver fibrosis and a Specialised CQUIN of Shared Decision Making. All these schemes are written into the Trust's Contract.	Partially achieved

a. We will openly and fully engage with patients and relatives when things go wrong to improve patient safety in the future.

This Priority was **Partially Achieved** for 2022/23.

1. Develop a Patient Safety Incidence Response Plan (PSIRP) in line with the Patient Safety Incident Response Framework (PSIRF) guidance

Key Achievements:

- Engagement of staff internally including networking across the Integrated Care System with consideration of system learning.
- Sharing of the Trusts progress of PSIRF with key stakeholders including Healthwatch, Care Quality Commission, and Integrated Care System.
- Securing of education and training opportunities supported by internal education funding as allocated by Health Education England.
- Key staff supporting the Mersey Care Restorative culture programme which includes the Just Culture guide when care doesn't go to plan supported by the People and Culture Team

- The creation of a Psychological Safety Faculty following the training of ten staff from multidisciplinary backgrounds.
 - The Patient Safety Incident Investigator achieving the standard requirement of training to support quality investigations as per expectations
 - Appointment of a Patient Safety Partner (PSP) with continued recruitment of additional partners.
 - The 'bringing together' of teams across the Trust and individuals to support both quality and safety.
 - Psychological support pathway for patients and their loved ones when care does not go to plan provided by Norfolk and Suffolk Foundation Trust.
 - The mapping of systems and processes to support understanding of learning for both staff patients and loved ones, including pathways of medical examiners, bereavement support.
 - The testing of learning tools to support live learning
2. Support the meaningful involvement of patients in the investigation and provide a single point of contact for patients throughout the investigation process by creating Patient Safety Liaison roles

This element will be taken forward with the PSIRF implementation, September 2023 with actions to include:

- The acknowledgement of the requirement for a timely response for both patients and families when an adverse event occurs, to provide an opportunity for debriefing for staff, patients and their families.
 - To consider the established pathways to support both patients/loved ones and staff when care does not go to plan i.e. psychological harm support provided by Norfolk and Suffolk Foundation Trust (NSFT).
 - To support the inclusion of our first newly appointed Patient Safety Partner and to support the introduction of others.
3. Develop investigation processes and training that are easy to use and understand in accordance with the Patient Safety Incident Response Framework guidance

A Training Needs Analysis has been completed. The education provision is being finalised.

4. Ensure 100% compliance with statutory Duty of Candour process against an average of 39% a month in 2021/22.

For 2022/23, we averaged 94% compliance with the Duty of Candour requirements.

All cases are sent to the responsible clinicians with template letters to aid completion. Routine escalation of cases requiring Duty of Candour go to the department and division. Escalation to the Executive team occurs if confirmation has not been received by day seven and further escalation to the Chief Executive if the requirement has not been achieved by day nine.

We reviewed the reason for the reduction in compliance with the written element of the Duty of Candour in June 2022 and have taken action to ensure this would be avoided in future.

Month	Total cases eligible for Duty of Candour (DoC)	% Verbal DoC carried out within 10 working days	% Written DoC carried out within 10 working days	% compliance with DoC requirements per month
Apr-22	22	100	95	98
May-22	18	94	94	94
Jun-22	9	100	78	89

Month	Total cases eligible for Duty of Candour (DoC)	% Verbal DoC carried out within 10 working days	% Written DoC carried out within 10 working days	% compliance with DoC requirements per month
Jul-22	31	100	97	98
Aug-22	23	100	100	100
Sep-22	11	100	100	100
Oct-22	69	99	97	98
Nov-22	43	100	91	95
Dec-22	31	97	87	92
Jan-23	45	98	60	79
Feb-23	25	96	92	94
Mar-23	33	97	88	92
Average percentage per month				94

5. Ensure we receive and act upon regular feedback from patients and their families on their involvement with our patient safety processes.

This element will be taken forward with the PSIRF implementation, September 2023. Interim measures are being taken for incidents, complaints or inquests that do not meet incident panel requirements including communication with patients and families to understand any concerns they have and guide them through the investigation process.

b. We will reduce risk to patients whilst they are in hospital from falls, pressure ulcers etc.

This Priority was **Partially Achieved** for 2022/23.

1. Develop and implement a refresher training package for Registered nurses and nursing associates to improve patient care.

The Quality Trolley is well established around the ward areas - visiting three areas a day (two Medicine and one Surgery). A significant proportion of the Quality Trolley daily visits focuses on the principles of offloading (positioning a patient so there is no weight bearing on potential or existing pressure points) and available equipment for pressure ulcer prevention.

Nursing Essential Assessment and Care updates (NEACU) training has been reinstated which explains how to carry out risk assessments, their importance and how to establish appropriate care plans.

2. Reduce the number of annual inpatient falls with harm by 5%, whilst maintaining encouragement of mobilisation. The baseline in 2021/22 was 24 falls

Year-end saw a total of 15 falls with harm reported equalling a 38% reduction.

The Quality Trolley has a falls focus to support learning. In addition, falls is a quality topic for the Trust with each Division holding regular quality work streams for falls. The wards continue to implement the Baywatch initiative, cohorting of patients and the new RITA project. RITA stands for Reminiscence/Rehabilitation and Interactive Therapy Activities and involves the use of user-friendly interactive screens and tablets to blend entertainment with therapy and to assist patients (particularly those with memory impairments) in recalling and sharing events from their past through listening to music, watching news reports of significant historical events, listening to war-time speeches, playing games, karaoke and watching films. RITA has been shown to reduce falls through stimulation, distraction and improved sleep awake cycle

To support staff, quality topics have been introduced on the intranet under clinical areas, it is acknowledged this is in early stages; however, it does provide useful information including but not limited to falls prevention, pressure ulcer prevention and safeguarding.

Quarter (2022/23)	Maximum number threshold to achieve priority	Cumulative numbers reported
1	6	1
2	11	5
3	17	10
4	23	15

3. Reduce incidence of category 2 pressure ulcers by 5% with additional focus on preventing tissue damage to patients arriving on and Urgent and Emergency Care (UEC) pathway. The baseline in 2021/22 was 135 incidences.

Year-end saw a total of 236 category 2 pressure ulcers meaning the 5% reduction was not achieved. This issue is being revisited within our Quality Priorities for 2023/24.

Quarter (2022/23)	Maximum number threshold to achieve priority	Cumulative numbers reported
1	32	52
2	64	44
3	96	144
4	128	236

4. Map all Tendable clinical pathways to minimise gaps in clinical process to inform further operational improvement.

Tendable is a quality inspection app and platform for health and care settings. The Tendable app makes quality inspections, audits and reviews easier and more effective. By undertaking regular local audit/inspection helps us to understand how we are doing and where we need to carry out actions to improve the standard of care required. With Tendable, we can access and view instant results on the front line and take actions promptly to ensure our patients receive the best possible care. It enables teams to take immediate action to address areas requiring improvement and patient concerns. It turns ad hoc audit/inspections into business as usual and improves local autonomy and accountability.

All pathways have been mapped against national drivers. Tendable audits continue to demonstrate a good understanding of the theory base behind care interventions. Documentation to illustrate the patient's journey has been highlighted as an area for improvement. This is being monitored by the Deputy Chief Nurse and Lead Nurses including workshops with matrons and ward managers.

c. We will deliver the best training for all of our patient-facing staff so they are equipped to deliver high standards of patient care through the National Patient Safety Syllabus

This Priority was **Partially Achieved** for 2022/23.

1. Staff to undertake Essentials introduction:
 - All patient-facing staff by the end of 2022/23 for both levels 1 & 2
 - All staff by the end 2023/24
2. Develop Essentials e-learning educational model for all staff.
3. Develop Essentials e-learning module for Board members and Senior Leadership teams

A training needs analysis has been completed and the specifics of the education provision is being finalised. The training is available via a link and discussions are in process to enable this to be added to the mandatory training programme. A role-specific training matrix is to be completed and then uploaded onto the Electronic Staff Record (ESR) learning portal as a mandatory requirement. This will be added to the mandatory training tool under its own tab so that compliance can be monitored.

d. Embed a robust harm review process for patients on waiting lists for surgery or treatment

This Priority was **Achieved** for 2022/23.

1. Priority (P) codes to be assigned to all patients on waiting lists – Complete.
2. Identify higher-risk pathways and reprioritise the to-come-in (TCI) date.

Prioritisation of next steps for Clinical Harm Reviews is covered within the scope of the PricewaterhouseCoopers (PwC) internal audit. The fieldwork and reports are currently being reviewed.

3. Identify themes from harm reviews of those identified as experiencing moderate or above harm

Categories have been set up within our incident management system to aid data collection and onwards reporting. Reports go to each Clinical Harm Review meeting to discuss themes and trends and identify actions to improve.

4. Improved surveillance of patients who have delayed surgical treatment

Prioritisation of next steps for Clinical Harm Reviews is covered within the scope of the PwC internal audit. The fieldwork and reports are currently being reviewed

e. We will assess maternity services against the recommendations of national reports such as Ockenden and develop robust safety assurance processes

This Priority was **Achieved** for 2022/23.

All metrics as set out within the Key performance Indicator for this Priority have been achieved:

- Delivery method and location of birth (excluding Caesarean section)
- Place of birth risk assessment
- 1:1 care in labour
- Maternal mortality
- 3rd and 4th degree tears sustained upon delivery
- Unplanned admission rates
- Readmissions within 30 days
- At risk groups (>45yrs, black and minority ethnic (BAME) and other vulnerable groups)

f. We will deliver the Commissioning for Quality and Innovation (CQUIN) schemes All these schemes are written into the Trust's Contract

This Priority was **Partially Achieved** for 2022/23.

We have achieved or are on track to achieve seven out of the eight Commissioning for Quality and Innovation (CQUIN) schemes for 2022/23 (shown as green for achieved and orange for on-track).

Initial feedback:

- CQUIN 4 – we are querying the quarter 4 percentage. There appears to have been one specialty with a sharp increase in denominator (number of cases included in the review) but this does not explain why other specialities have seen a decrease, too. This is currently being reviewed.
- CQUIN 7 – quarter 3 deteriorating performance due to staffing issues within the Pharmacy

CQUIN active (included in the Trust Contract)	Target	Q1	Q2	Q3	Q4
CQUIN 3 - NEWS2 (Critical Care)	20-60%	90%	85%	82%	85%
CQUIN 4 - Cancer pathway/diagnosis	55-65%	29%	52%	61%	29%
CQUIN 7 - Discharge Medicines	0.5-1.5%	1%	1%	0.80%	1.5%
CQUIN 8 - Mobilisation for post-surgery patients	60-70%	91%	97%	89%	98%
CQUIN 9 - Alcohol screening	20-35%	34%	39%	39%	40%
PPS2 - Shared decision making	65-75%	Planning	89%	89.50%	89.5%

CQUIN Non-active (not included in the Trust Contract)	Target	Q1	Q2	Q3	Q4
CQUIN 1 - Staff 'flu vaccinations	70-90%	21%	45%	54%	54%
CQUIN 2 - Appropriate antibiotic prescribing for urinary tract infection (UTI) in adults aged 16+	40-60%	44%	61%	62%	65%
CQUIN 5 - Treatment of community acquired pneumonia in line with British Thoracic Society (BTS) care bundle	45-70%	6%	1%	26%	42%
CQUIN 6 - Anaemia screening and treatment for all patients undergoing major elective surgery	45-60%	76%	95%	98%	95%

Clinical Effectiveness

a	We will implement shared decision making in accordance with the National Institute for Health and Care Excellence (NICE) guideline: NG197 – Shared Decision Making.	Partially achieved
b	We will develop a strategy for supporting the holistic needs of our patients living with life limiting conditions, including those on a cancer pathway, and their families	Achieved
c	We will improve access to services for those from minority groups ensuring equity, inclusion and equality to reduce health inequalities	Achieved

a. We will implement shared decision making in accordance with the National Institute for Health and Care Excellence (NICE) guideline: NG197 – Shared Decision Making

This Priority was **Partially Achieved** for 2022/23.

1. Develop and publish new guidance on informed consent for use by patients and families.

The Consent Policy that has been ratified across the Integrated Care System includes all of the requirements to fulfil this Priority.

2. Introduce a new feedback questionnaire for patients who receive care to check their experience of informed consent – this will be progressed through 2023/24
3. Improved process for shared decision making regarding the Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) forms – education and training processes at levels 1, 2 and 3 are still under review. This will be picked up through the Clinical Effectiveness Group work programme.
4. Improved reporting and monitoring of compliance with all elements of shared decision making regarding ReSPECT forms through speciality/divisional governance meetings.

The audit carried out in October 2022 shows similar results to the previous one, with some areas requiring improvement. An action plan has been completed to address issues found. A re-audit will be conducted to ensure improvement actions have resulted in positive change. This will be monitored through the Clinical Effectiveness Group.

5. Ensure we receive and implement feedback from patients and their families – linked to element 2, above.
6. Achieve a reduction in patient complaints about poor communication. 2021/22 baseline was 29 in total.

The total number of complaints about poor communication for 2022/23 was 22, which equals a 24% reduction.

b. We will develop a strategy for supporting the holistic needs of our patients living with life limiting conditions, including those on a cancer pathway, and their families

This Priority was **Achieved** for 2022/23.

1. Develop a long-term plan for patients with cancer and other life limiting conditions to determine where this care and support is best provided.

We have successfully recruited to the cancer strategy role on a two year fixed term basis to work alongside our clinical teams in developing our strategy. We have a Norfolk and Waveney (N&W) wide strategy in place but this post holder will tailor this strategy for JPUH and our community early 2023/24.

2. Improve services to our patients through closer partnership working with the third sector. Taking a plan to the Patient Safety and Quality Committee (PSQ)

There is an ongoing work stream through the Integrated Care Board (ICB) discharge board focusing on best use of the voluntary sector and to identify further opportunities for partnerships. The Chief Nurse and Deputy Chief Operating Officer are the organisational links to that group.

The work of the discharge sub-group has seen a significant uplift in the use of Voluntary Norfolk welfare calls for our patients to support discharge.

c. We will improve access to services for those from minority groups ensuring equity, inclusion and equality to reduce health inequalities

This Priority was **Achieved** for 2022/23.

1. Enable access to tools to help support those accessing our services, such as language lessons

The Translation policy was updated and ratified in December 2022. A Carer and Patient Experience Committee (CAPE) workshop to focus on Accessible Information Standards (AIS), accessibility and translation services was held in February 2023 with regular communications released for staff.

INTRAN (providers of telephone, video and face-to-face interpreting in hundreds of languages and dialects, fully supported by British Sign Language, braille, translation, and many other communication support services) briefing session dates have been circulated for staff to attend to learn how to book translation services if they do not know or need a refresh

The Head of Patient Experience and Engagement is linking in, through Great Yarmouth Borough Council, with community champions and volunteers who network with different community groups supporting engagement and providing feedback opportunities for these hard to reach communities. Maternity services have introduced language lessons for pregnant people whose first language is not English and the Transformation team is working with Audiology and the Integrated Care Board (ICB) to improve the quality of referrals from GPs concerning patient language needs.

2. Embed gender-inclusive language in our documents and terminology.

The Trust LGBTQIA+¹ Network has had input into some policies and recognises that this is a larger piece of work than the Network can take on. The Equity and Diversity Group will take this forward.

3. Build upon our work as an NHS England pilot site for smoking cessation to bring about a reduction of incidence of smoking in in-patients and specifically bring about a reduction in smoking in pregnant people.

The Tobacco TDT (Tobacco Dependence Treatment) project is meeting key performance indicators (KPI) set by NHS England and Improvement (NHSE/I). Monthly reports are shared with NHSE&I and the Norfolk and Waveney (N&W) Integrated Care System (ICS) TDT Steering group. By end of quarter three a total of 805 inpatients were identified as smokers and referred to the smoking cessation service.

There were 13838 total Admissions in 2022/23, of these: 6539 (47.3%) had their smoking status recorded. Of the 6539 that had their smoking status recorded, 805 (12.3%) smokers were referred to stop-smoking services with 693 (86.1%) of those seen by the service. The total number of people referred and who were seen that were smoke-free at 28 Days was 628 (90.6%).

86% of total referrals have been seen by tobacco advisers, which is a 75% increase in comparison to 11% recorded in the period prior to TDT service commencement in April 2022.

The Local Maternity and Neonatal System (LMNS) Quitzy project commenced. We have a Quitzy practitioner in post but are yet to see benefits of this programme and any significant reduction in smoking at time of booking and time of delivery. A detailed work/action plan for the Quitzy practitioner has been developed with the aim to link in with Trust smoking

¹ Abbreviation for lesbian, gay, bisexual, transgender, queer or questioning, intersex, asexual, and more. These terms are used to describe a person's sexual orientation or gender identity.
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cessation team to enhance efficiency and progress plans for the team to engage pregnant people at community hubs.

4. Contribute to the development of Place governance and delivery structures.

The Great Yarmouth and Waveney (GY&W) Health Inequalities and Prevention Group (HI&PG) has started meeting and the Transformation Health Inequalities Lead is actively engaged. The group reports to the GY&W Place Board. Terms of Reference are still being agreed but it is expected this will oversee and report on the delivery of priorities/projects in the Place Health Inequalities Strategy, once it has been developed and aligned to the ICS Five Year Forward Strategy. This will include the Health Inequality projects agreed by the GY Partnerships group and those that are yet to be agreed by the Waveney Partnerships group. Meanwhile, the Transformation Health Inequalities Lead is working with members of the HI&PG on initiatives such as Making Every Contact Count, Social Prescribing and Smoking.

The GY&W Place Board has agreed to take a consistent approach to respiratory issues across all work streams. On the back of this collaborative approach GY&W is the first area within the Norfolk and Waveney (N&W) Integrated Care System (ICS) to have an Acute Respiratory Intervention hub – this will receive referrals from GPs, 111 etc. (not self-referrals). Outcomes are being assessed through nationally prescribed KPIs.

Patient Experience

a	We will improve patient experience through transformation in our delivery of care using technology	Partially achieved
b	We will improve the Clinical environment which improves patient experience and supports service transformation	Achieved
c	We will improve communication between patients their relatives and the clinical team	Partially achieved

a. We will improve patient experience through transformation in our delivery of care using technology

This Priority was **Partially Achieved** for 2022/23.

1. We will increase the use of technology to care for patients virtually when clinically appropriate with the aim of doubling our current average of 160 patients a month.

The Virtual ward is fully established and in Quarter 3 saw 538 patients in total. The current average is approximately 180 per month, hence only partial achievement of this Priority.

b. We will improve the Clinical environment which improves patient experience and supports service transformation

This Priority was **Achieved** for 2022/23.

1. Agree the design for a decant ward by May 2022 to enable work to mitigate the Reinforced Autoclaved Aerated Concrete (RAAC) panel risks to be undertaken.

The decant ward design is complete and construction work has commenced. Completion projected for May 2023.

2. Define a plan of Ward upgrades linked in with RAAC failsafe works.

The programme has been drafted with the order of works confirmed until the end of 2023/24. Ward 7 was completed on 2022/23 but work was paused during the winter period. Ward 6 will move into the concept ward first to restart the programme in June 2023.

c. *We will improve communication between patients their relatives and the clinical team*

This Priority was **Partially Achieved** for 2022/23.

1. We will recruit a team of 8-10 Family Liaison Officers (FLOs) to work in inpatient areas to enhance patient and relative experience and improve feedback in 2022/23.

Family Liaison Officers recruited and in role.

2. Improve communication-related feedback.

The total number of complaints about poor communication for 2022/23 was 22, which equals a 24% reduction on the 2021/22 baseline of 29 complaints.

3. Develop a more customer-facing Patient Advice and Liaison (PALS) service in 2022/23.

This has been carried forward as a Quality Priority for 2023/24 as unplanned absence resulted in this Priority being paused in-year.

Quality Priorities for improvement agreed for 2023/24

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

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

We will implement the Patient Safety Incident Response Framework (PSIRF) ensuring that we will openly and fully engage with patients and relatives to improve patient safety (continuation of 2022/23)

Why we chose this (Rationale):

NHS Patient Safety Strategy Framework for involving patients in patient safety. This provides guidance on how the NHS can involve people in their own safety as well as improving patient safety in partnership with staff: maximising the things that go right and minimising the things that go wrong for people receiving healthcare.
Patient Safety Incident Response Framework (PSIRF): Engaging and involving patients, families and staff following a patient safety incident.

What we intend to achieve (Goal):

- The meaningful involvement of patients throughout Trust learning processes.
- Asking patients directly if they have any queries about their care
- Provide patients with every opportunity to feed into the learning process

How we will deliver and monitor progress:

- Explore the development and use of structured communication tools so that individuals understand the information they are being given and feel safe in communicating their needs
- Quarterly reporting of progress to achievement of the Priority through the Patient Safety and Quality Committee

Responsible Person

Chief Nurse

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

We will reduce the risk of development of Category 2 pressure ulcers for patients whilst they are in hospital

Why we chose this (Rationale):

If a patient develops pressure damage, the impact on both their physical and psychological health is impacted. This can leave the patient with long-term effects, pain, increased length of stay, increased recovery.

What we intend to achieve (Goal):

Reduce incidence of category 2 pressure ulcers by 5% from 2022/23 baseline of 273. 2023/24 threshold = **259**

How we will deliver and monitor progress:

- Review processes for reporting and verification of category of pressure ulcers to ensure reported data is accurate
- Review the way we educate our staff regarding pressure area care
- Demonstrate impact of the training opportunities provided via the Quality Trolley for categorising pressure ulcers
- Review how we deliver pressure relieving care and the Central Treatment Suite delivery and function model.
- Monitored through the monthly Integrated Performance Quality Report (IPQR)

Responsible Person:

Chief Nurse

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

Demonstrate robust processes are in place to address the immediate and essential actions from the Maternity Improvement Plan

Why we chose this (Rationale):

Responding to reviews and self-assessment of our Maternity services, we have identified gaps in our assurances. We therefore commit to ensuring we keep our pregnant people safe, in an environment where our staff have the right skills and to be able to challenge and speak up when they are concerned

What we intend to achieve (Goal):

- Develop a strong governance structure encompassing leadership, culture and collaborative trust working.
- Ensure active engagement with the Local Maternity and Neonatal System (LMNS)
- Develop an internal maternity improvement plan.
- Delivery and monitoring of the 92 recommendations from the Ockenden report, CQC feedback, East Kent review.

How we will deliver and monitor progress:

- Establish a reporting structure for the improvement plan
- Ensure the whole service is aware, updated and involved
- Local audit/reviews to give assurance that actions are both completed and embedded. Where assurance is not attained, actions plans are monitored and progressed
- Governance and oversight via the Executive Maternity Improvement Group, reporting to the Board of Directors

Responsible Person:

Chief Nurse
Chief Medical Officer
Chief Operating Officer

Clinical Effectiveness. Aligned to CQC Key Lines of Enquiry: Effective, Safe, Caring

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

To demonstrate effectiveness of multidisciplinary learning from deaths

Why we chose this (Rationale):

NHS National Quality Board National Guidance on Learning from Death

What we intend to achieve (Goal):

Consistent and rigorous process for learning from deaths that results in Trust wide improvement activities

How we will deliver and monitor progress:

- Establish consistency and rigour by adopting a National digital process for Structured Judgement Reviews (SJRPlus)
- Use the improved analytical capability to identify themes for learning via the Clinical Effectiveness Group (CEG) and Mortality Review Group
- Monitor progress and resultant learning via the CEG

Responsible Person:

Chief Medical Officer

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

Improve timeliness of access to care

Why we chose this (Rationale):

Requirements laid out in the annual NHS Planning Guidance and the NHS Constitution.
Reducing waiting times for services positively impacts on patients experience and potentially outcomes

What we intend to achieve (Goal):

- Delivery of the Activity and finance Plan
- Improvement in waiting times in line with Planning Guidance

How we will deliver and monitor progress:

- Integrated Performance Report
- Monthly Divisional Performance meetings
- Exception reports to Hospital Management Group (HMG)
- Monthly reports to Finance and Performance Committee

Responsible Person:

Chief Operating Officer

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

To optimise the Trust's clinical guideline process

Why we chose this (Rationale):

The Trust has numerous local clinical guidelines in circulation which could be replaced with recognised national guidance documents

What we intend to achieve (Goal):

- Easily accessible, up-to-date and evidence based clinical guidelines available to all staff.
- Collaboration with the Norfolk and Waveney Hospitals Partnership to align guidelines where applicable and appropriate.
- Removal of out-of-date and unnecessary guidelines.

How we will deliver and monitor progress:

- Review of clinical guidelines available on the trust's intranet
- Progress reports to Patient Safety and Effectiveness Committee
- Quarterly reporting of progress to achievement of the Priority through the Patient Safety and Quality Committee

Responsible Person:

Chief Medical Officer

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

To establish a robust process for participating in, and learning from, national clinical audits

Why we chose this (Rationale):

- We currently have limited assurance around participation and outcomes from National Audits. The Trust did not participate in one National Audit in 2022/23 due to unplanned staff shortages.

What we intend to achieve (Goal):

- Establish a Clinical Audit Annual Programme, led by the Assistant Medical Director (AMD) for Quality & Safety.
- Ensure that the annual programme reflects all applicable external requirements (Healthcare Quality Improvement Partnership (HQIP) as well as contractual governance arrangements).
- Ensure multidisciplinary learning from audits that results in improvement

How we will deliver and monitor progress:

- Annual audit programme to be approved by Clinical Effectiveness Group (CEG) with clearly assigned responsibility for individual audits.
- Action plans and reports to be monitored at the CEG
- Quarterly reporting of progress and annual report to CEG.
- Annual report to CEG

Responsible Person:

Chief Medical Officer

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

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

Redesign of the Patient Advice and Liaison Service (PALS).

Why we chose this (Rationale):

- To promote visibility and accessibility of the service
- To support early resolution for service users
- To improve PALS response timeframes and reduce call volume
- To improve the overall experience of staff/patients accessing the PALS service

What we intend to achieve (Goal):

- Relocate the PALS service to the front foyer
- Offer an accessible, confidential PALS drop-in service
- Improve overall communication and experience for service users

How we will deliver and monitor progress:

- PALS data will be collated via the Trust's safety and assurance system, QSAFE (provided by InPhase)
- Monitored via the Carer and Patient Experience Group
- Quarterly reporting of progress to achievement of the Priority through the Patient Safety and Quality Committee

Responsible Person:

Chief Nurse

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

Ensure we receive and act upon feedback from patients and their families on their experiences of their care and our services

Why we chose this (Rationale):

- NHS Patient Safety Strategy and the Patient Safety Incident Response Framework.
- Patients' involvement in their safety is a big focus
- Family carers are an under-recognised element in patient care/experience.
- Participation in the User Group is currently low as the initial set-up was hindered by the Covid lock-downs resulting in it being chaired by a member of Trust staff

What we intend to achieve (Goal):

- Requesting formal feedback following patients' involvement will help inform future developments in involving patients in patient safety.
- Achieve the Carer Friendly Tick accreditation to evidence that we work in partnership with family carers (adult and young carers).
- Ensure that family carers are given the recognition and support required to enhance the patient experience
- A patient-led User Group. Members of the group actively contributing to representing patients within the organisation as "expert patients".

How we will deliver and monitor progress:

- Analysis and theming of feedback provided by patients and their families reporting through the Carer and Patient Experience Group.
- Improved working with our local partners
- Listening to feedback and making changes
- Establish co-design and work streams to support shaping our services

Responsible Person:

Chief Nurse

2.2 Statements of Assurance from the Board

During 2022/23 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 2022/23 represents **100%** of the total income generated from the provision of relevant health services by the James Paget University Hospitals NHS Foundation Trust for 2022/23.

Specialties and services:	
Accident and Emergency (A&E)	General Surgery
Anaesthetics	Gynaecology
Antenatal screening	Haematology
Audiology	Hyperbaric services
Bereavement Services	Intensive Care Services
Blood Transfusion	Maternity services
Breast Surgery	Medical illustration
Cardiology	Neonatology
Care of the Elderly	Nephrology and renal dialysis
Children's Centre	Obstetrics
Clinical Measurement	Oncology
Community Dental Services	Ophthalmology
Community midwifery	Oral Surgery
Community Paediatric Service	Paediatric Surgery
Continence and Stoma Care	Paediatrics
Coronary Care	Pain Management
Dental and Orthodontics	Palliative Care
Dermatology	Pharmaceutical services
Diabetes	Rehabilitation
Diabetic Liaison	Respiratory Medicine
Diagnostic Imaging	Rheumatology
Ear, Nose and Throat	Safeguarding children
Endocrinology	Sandra Chapman Centre
Endoscopy	Stroke Services
Fertility services	Therapies e.g. physiotherapy
Gastroenterology	Trauma and Orthopaedics
Gastro-intestinal Surgery	Urology
General Medicine	Vascular Surgery

Clinical Audits and National Confidential Enquiries

During 2022/23 **47** national clinical audits and **seven** national confidential enquiry 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 **45/47 (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 2022/23 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 2022/23 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 2022/23, 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	Relevant to JPUH Services?	Trust participation	Case Ascertainment
Breast and Cosmetic Implant Registry	Yes	Yes	100% - Details for every implant case are captured prospectively perioperatively, and subsequently entered into the Implant Registry.
Case Mix Programme Intensive Care National Audit and Research Centre (ICNARC)	Yes	Yes	Total number of cases included for ICNARC between 01/04/2022-31/03/2023 was 663 with 100% of cases submitted.
Elective Surgery: National Patient Reported Outcome Measures (PROMs) Programme	Yes	Yes	100% of questionnaires distributed to patients. Completion and submission of questionnaires however is dependent on patients.
Emergency Medicine Quality Improvement Project (QIP): Pain in children	Yes	Yes	43% (221/520) for audit period 03/10/2021 – 04/10/2022.
Emergency Medicine QIP: Assessing for cognitive impairment in older people	Yes	No	Audit delayed, commencing in 2023/24. Intention to participate confirmed.
Emergency Medicine QIP: Mental health self-harm	Yes	Yes	<ul style="list-style-type: none"> Audit ongoing for a 2-year period. Requirement is to enter per week for a 2-year period from October 2022 to October 2024. Initial data submission for 4-month period was obsolete due to data entry issues with the Royal College of Emergency Medicine (RCEM) portal. Data entry recommenced 01/01/2023. Year to date case ascertainment figures of 17% (20/120).
Epilepsy 12 - National Clinical Audit of Seizures and Epilepsies for Children and Young People	Yes	Yes	100% (75/75) for 01/04/22 to 31/03/23.
Falls and Fragility Fracture Audit Programme: Fracture Liaison Service Database	Yes	Yes	32.7% (481/1471) for 01/06/22 to 28/02/23.

Audit Title	Relevant to JPUH Services?	Trust participation	Case Ascertainment
Falls and Fragility Fracture Audit Programme: National Audit of Inpatient Falls	Yes	Yes	100% (8/8) patients who meet the criteria submitted in reporting period January – December 2022.
Falls and Fragility Fracture Audit Programme: National Hip Fracture Database	Yes	Yes	100% (514/514) for January 2022 – December 2022. The data quality assurance process is currently being strengthened by additional checks to ensure that duplicates are removed and each case is only counted once.
Gastro-intestinal Cancer Audit Programme: National Bowel Cancer Audit (NBOCA)	Yes	Yes	“Good” case ascertainment (defined by NBOCA as >80%) for last reporting period of patients diagnosed up to 31/03/21, submitted in 2022/23. Data for patients diagnosed up to 31/03/22 is currently being checked and uploaded for the final deadline of 09/06/23.
Gastro-intestinal Cancer Audit Programme: National Oesophago-gastric Cancer	Yes	Yes	Unable to confirm case ascertainment.
Inflammatory Bowel Disease Audit (IBD Registry)	Yes	No	No cases submitted, due to lack of capacity to send out consent forms and to populate the database once consent obtained.
LeDeR - learning from lives and deaths of people with a learning disability and autistic people	Yes	Yes	100% case ascertainment for 2022/23.
Muscle Invasive Bladder Cancer Audit	Yes	Yes	100% (1/1) for 01/04/22 to 31/03/23.
National Adult Diabetes Audit: National Diabetes Core Audit	Yes	Yes	100% for 01/04/22 to 31/03/23.
National Adult Diabetes Audit: National Diabetes Inpatient Safety Audit	Yes	Yes	100% of cases of diabetic ketoacidosis (DKA), hyperosmolar hyperglycaemic state (HHS) and Diabetic Foot Ulcers have been submitted for 01/04/22 to 31/03/23. 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: National Pregnancy in Diabetes Audit	Yes	Yes	100% (18/18) for 01/04/22 to 24/02/23.
National Asthma and Chronic Obstructive Pulmonary Disease Audit Programme: Adult Asthma Secondary Care	Yes	Yes	100% (80/80) for 01/04/22 to 31/03/23.
National Asthma and Chronic Obstructive Pulmonary Disease Audit Programme: Chronic Obstructive Pulmonary Disease Secondary Care	Yes	Yes	100% for 01/04/2022 to 30/09/2022.
National Asthma and Chronic Obstructive Pulmonary Disease Audit Programme: Paediatric Asthma Secondary Care	Yes	Yes	100% for 01/04/22 to 31/03/23.
National Audit of Breast Cancer in Older Patients	Yes	Yes	100% case ascertainment for the previous reporting period (2021/22). Two new audits commencing with National Cancer Audit Collaborating Centre. Dates to be confirmed.

Audit Title	Relevant to JPUH Services?	Trust participation	Case Ascertainment
National Audit of Care at the End of Life	Yes	Yes	100% (50/50) for 01/04/22-14/04/22 and 09/05/22 – 22/05/22.
National Audit of Dementia	Yes	Yes	100% (80/80) for 20/09/22 to 01/02/23
National Cardiac Arrest Audit	Yes	Yes	Unable to confirm case ascertainment.
National Cardiac Audit Programme: Myocardial Ischaemia National Audit Project	Yes	Yes	Unable to confirm case ascertainment.
National Cardiac Audit Programme: National Heart Failure Audit	Yes	Yes	Unable to confirm case ascertainment.
National Early Inflammatory Arthritis Audit	Yes	Yes	49% (25/51) for 10/04/22 to 31/03/23
National Emergency Laparotomy Audit	Yes	Yes	100% for Quarter 1 (01/04/22 – 30/06/22) 100% for Quarter 2 (01/07/22 – 30/09/22) 94% for Quarter 3 (01/10/22 – 31/12/22).
National Joint Registry	Yes	Yes	100% for 01/04/22 to 31/03/23.
National Lung Cancer Audit	Yes	Yes	100% for 01/04/22 to 31/03/23.
National Maternity and Perinatal Audit	Yes	Yes	100% for 01/04/22 to 31/03/23.
National Neonatal Audit Programme	Yes	Yes	100% (410/410) for 01/04/22 to 31/03/23. Data is taken automatically from BadgerNet ² .
National Ophthalmology Database Audit	Yes	Yes	100% for 01/04/22 to 31/03/23.
National Paediatric Diabetes Audit	Yes	Yes	100% (148/148) for 01/04/22 to 31/03/23.
National Perinatal Mortality Review Tool	Yes	Yes	100% for 01/04/22 to 31/03/23.
National Prostate Cancer Audit (NPCA)	Yes	Yes	As the NPCA includes all men newly diagnosed with Prostate Cancer within the Cancer Registry, case ascertainment is per definition 100%.
Perioperative Quality Improvement Programme	Yes	Yes	Two patients recruited in March 2023. This is a research study, so participation is voluntary and the number of eligible patients cannot be calculated.
Respiratory Audits: Adult Respiratory Support Audit	Yes	Yes	Data collection ongoing to 31/05/23. Sample size is 25; case ascertainment is progressing as per plan.
Respiratory Audits: Smoking Cessation Audit- Maternity and Mental Health Services	Yes	No	Audit delayed, commencing in 2023/24. Intention to participate confirmed.
Sentinel Stroke National Audit Programme	Yes	Yes	100% (603/603) for 01/04/22 to 31/03/23
Serious Hazards of Transfusion UK National Haemovigilance Scheme	Yes	Yes	100% (23/23) for 01/04/22 to 31/03/23
Society for Acute Medicine Benchmarking Audit	Yes	No	Did not participate due to resource implications.
Trauma Audit and Research Network	Yes	Yes	43%-53% for 01/04/22 to 31/03/23.
UK Parkinson's Audit	Yes	No	Did not submit cases due to resource implications.
Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRRACE) - Maternal Mortality Surveillance	Yes	Yes	100%

² UK Platform for entering, viewing, and communicating information relating to the maternity care pathway.

Audit Title	Relevant to JPUH Services?	Trust participation	Case Ascertainment
MBRRACE - Perinatal Mortality Surveillance	Yes	Yes	100%
National Child Mortality Database	Yes	No	
National Vascular Registry	Yes	No	
Renal Audits: National Acute Kidney Injury Audit	Yes	No	
Renal Audits: UK Renal Registry Chronic Kidney Disease Audit	Yes	No	
Cleft Registry and Audit Network Database	No	N/A	
National Adult Diabetes Audit: National Diabetes Footcare Audit	No	N/A	
National Asthma and Chronic Obstructive Pulmonary Disease Audit Programme: Pulmonary Rehabilitation - Organisational and Clinical Audit	No	N/A	
National Audit of Cardiac Rehabilitation	No	N/A	
National Audit of Cardiovascular Disease Prevention (Primary Care)	No	N/A	
National Audit of Pulmonary Hypertension	No	N/A	
National Bariatric Surgery Registry	No	N/A	
National Cardiac Audit Programme: National Congenital Heart Disease Audit	No	N/A	
National Cardiac Audit Programme: National Adult Cardiac Surgery Audit	No	N/A	
National Cardiac Audit Programme: National Audit of Cardiac Rhythm Management	No	N/A	
National Cardiac Audit Programme: National Audit of Percutaneous Coronary Interventions	No	N/A	
National Clinical Audit of Psychosis	No	N/A	
National Obesity Audit	No	N/A	
Neurosurgical National Audit Programme	No	N/A	
Out-of-Hospital Cardiac Arrest Outcomes	No	N/A	
Paediatric Intensive Care Audit	No	N/A	
Prescribing Observatory for Mental Health: Improving the quality of valproate prescribing in adult mental health services	No	N/A	
Prescribing Observatory for Mental Health: The use of melatonin	No	N/A	
UK Cystic Fibrosis Registry	No	N/A	

The reports of **17** national clinical audits were reviewed by the provider in 2022/23 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 **17** national clinical audit reports reviewed:

<u>National Diabetes Inpatient Audit (NaDIA)</u>	
<ul style="list-style-type: none"> ✓ Diabetes nursing service offer a diabetes study day available for all staff. ✓ Safe use of insulin training is available to all staff. 	
<u>National Audit of Care at the End of Life (NACEL)</u>	
<ul style="list-style-type: none"> ✓ Business case approved and actioned to increase palliative care cover to 7 days a week. 	
<u>National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP) - COPD Secondary Care</u>	
<ul style="list-style-type: none"> ✓ Designated clinical leads are in place for both asthma and COPD. 	
<u>Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRRACE) - Perinatal Mortality Surveillance</u>	
<ul style="list-style-type: none"> ✓ A Pre-term prevention clinic has been commenced with nominated lead obstetrician. Monthly oversight of progress towards national ambitions via the Local Maternity and Neonatal System (LMNS). ✓ Adjusted the maternity system programme to introduce new workflows to highlight specific needs of the black and minority ethnic (BAME) population. New education section to midwifery mandatory update sessions, delivered by the risk and governance team. Also added a new tick box to triage system on central delivery suite, adjusted to identify and highlight ethnic origin. 	
<u>MBRRACE - Maternal Mortality surveillance and mortality confidential enquiries</u>	
<ul style="list-style-type: none"> ✓ Specialist midwifery team "Eden Team" provide care to vulnerable patients, which include mental health. They work in collaboration with the perinatal mental health team, as well as other mental health services. There is a trust inpatient mental health service available for support 24/7. 	
<u>National Maternity and Perinatal Audit (NMPA)</u>	
<ul style="list-style-type: none"> ✓ Information is given in different languages and formats. Consent stickers are available for all procedures. English language courses available free to all pregnant persons. IDECIDE to be considered when available. 	
<u>National Audit of Breast Cancer in Older Patients (NABCOP)</u>	
<ul style="list-style-type: none"> ✓ JPUH NABCOP unit data confirms that older patients receive the same standard of care as younger patients. ✓ Older patients receive the same package of care as younger patients at our unit - they have a named consultant and breast care nurse (BCN), are encouraged to bring a partner to appointments, and receive personal clinical letters following all appointments. All options are discussed with them- no treatment, endocrine treatment, surgery, etc. and they are allowed enough time to make an informed decision after consideration and discussion with family or their general practitioner (GP). 	
<u>National Neonatal Audit Programme (NNAP)</u>	
<ul style="list-style-type: none"> ✓ The Neonatal Unit is currently working towards Baby Friendly Initiative (BFI) accreditation, which will improve education and practices to increase the number of babies who receive their mother's breast milk. We now also have a stock of donor breast milk. 	
<u>National Paediatric Diabetes Audit (NPDA)</u>	
<ul style="list-style-type: none"> ✓ Paediatric diabetes nurse specialist team liaise with school staff, provide training and answer any queries regarding managing diabetes at school or college. ✓ Feedback from families and areas for improvement will be discussed in subsequent diabetes multidisciplinary team (MDT) meetings. ✓ A clinical psychologist who works with the diabetes team is already in post. 	

The reports of **95** local clinical audits were reviewed by the provider in 2022/23 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:

<u>Getting It Right First Time Peri-Operative Diabetes Pathway</u>	<u>Enoxaparin Venous Thromboembolism (VTE) Prophylaxis</u>
<ul style="list-style-type: none"> ✓ Quality Improvement Group established in Theatres in July 2022. Improvement from 60% appropriate monitoring for patients with diabetes in Theatres to 90% confirmed in September 2022. To be included in ongoing monitoring. 	<ul style="list-style-type: none"> ✓ The audit conclusions noted that University of East Anglia (UEA) graduates would fill in the VTE admission form more accurately than other doctors, probably reflecting recentness of training. Training packs on VTE admission form completion are now provided to doctors on induction training days.

<p><u>Medicines Reconciliation Audit</u></p> <ul style="list-style-type: none"> ✓ Allocated two ward technicians on each weekend – one to Emergency Admissions and Discharge Unit (EADU) and the other to undertake critical medical patients around the Trust. This has worked well and reflects in numbers on Mondays. ✓ Successfully put in business case and employed two fixed-term ward based pharmacy assistants, trained to undertake dispensing on the wards, freeing up technicians to concentrate on medicines reconciliation. 	<p><u>Inhaled therapy prescribing in exacerbations of Obstructive Pulmonary Disease (COPD)</u></p> <ul style="list-style-type: none"> ✓ Liaised with Pharmacy to ensure Electronic Prescribing and Medicines Administration (EPMA) will identify the appropriate interactions between ipratropium nebulisers and inhalers containing anticholinergic agents. ✓ Placed print outs of the guideline within the Emergency Admissions and Discharge Unit (EADU) office (where the majority of medical clerking takes place), and the respiratory wards. This reminder sheet included a breakdown of the agents included in the most common combined inhalers prescribed to patients within this region. ✓ Following implementation of the above strategies, and a Foundation Year³ (FY) doctor training session in February 2022, the second data collection cycle in May-June 2022 showed improved compliance from 66% to over 90%. Use of the guideline reminder sheets was noted as successful.
<p><u>Management of Atrial Fibrillation at JPUH</u></p> <ul style="list-style-type: none"> ✓ Patients that are frail/ elderly or have an increased risk of falls should not have their anticoagulation stopped solely due to these reasons and a thorough assessment of risk vs benefit must be done using CHA₂DS₂-VASc⁴ and Outcomes Registry for Better Informed Treatment of Atrial Fibrillation (ORBIT) criteria prior to making this decision. Worked with IT to introduce a new box on eDischarge to record the decision taken to commence/stop anticoagulation including the reasons for this decision. Tested by cardiologists and made live June 2022. 	
<p><u>Audit of Renal/Ureteric Colic management pathway in accordance to the British Association of Urological Surgeons (BAUS) and National Institute for Health and Care Excellence (NICE) guidelines</u></p> <ul style="list-style-type: none"> ✓ Education leaflet and pathway will be put in A&E to remind staff about the standard guidelines. 	<p><u>Neutropenic Sepsis Audit for Oncology</u></p> <ul style="list-style-type: none"> ✓ New Ward 17 and Emergency Department nursing staff are now being trained in cannulation. <p>System to send alert emails to the Oncology Team for patients on chemotherapy admitted to hospital now including Ward 17.</p>
<p><u>Rehabilitation in ICU</u></p> <ul style="list-style-type: none"> ✓ Changes made with IT to increase compliance and avoid errors when completing Rehabilitation form on discharge. Rehabilitation button moved to the top of the discharge form, and a new rehabilitation form will open automatically, making it impossible to fill in the wrong form. 	<p><u>Audit of World Health Organisation (WHO) Surgical Safety Checklist for Elective Ear, Nose and Throat (ENT) Surgery</u></p> <ul style="list-style-type: none"> ✓ JPUH WHO surgical safety checklist designed for theatre use. ✓ Created large and small laminated surgical safety checklist cards to be installed on theatre walls and to be used by theatre teams.
<p><u>Intrapartum Risk Assessment</u></p> <ul style="list-style-type: none"> ✓ Added the intrapartum and fetal monitoring risk assessment tool to aid the Interpretative Phenomenological Analysis (IPA)⁵, this risk assessment tool includes a prompt for psychiatric history and anaesthetic risk. 	<p><u>An Audit Cycle of Consent Form Completion</u></p> <ul style="list-style-type: none"> ✓ Risk stickers have been developed and made available in the outpatient department for elective cases. This is to ensure standards are met as well as improve consent form process for the patient.

³ Grade of medical practitioner undertaking the Foundation Programme, a two-year, general postgraduate medical training programme which forms the bridge between medical school and specialist/general practice training.

⁴ Clinical prediction rules for estimating the risk of stroke in people with non-rheumatic atrial fibrillation, a common and serious heart arrhythmia associated with thromboembolic stroke. Such a score is used to determine whether or not treatment is required with anticoagulation therapy or antiplatelet therapy, since AF can cause stasis (non-movement) of blood in the upper heart chambers, leading to the formation of a thrombus that can dislodge into the blood flow, reach the brain, cut off supply to the brain, and cause a stroke.

⁵ The aim of IPA is to explore in detail how participants are making sense of their personal and social world

National Confidential Enquiries

NCEPOD – What is it?

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
Community Acquired Pneumonia	To identify and explore avoidable and modifiable factors in the care of adults presenting to hospital with a presumed diagnosis of community acquired pneumonia.	Yes	Yes	100%
Crohn's Disease	To review of remediable factors in the quality of care provided to patients aged 16 and over with a diagnosis of Crohn's disease who underwent a surgical procedure.	Yes	Yes	100%
Endometriosis	To review remediable factors in the quality of care provided to patients aged 18 and over with a diagnosis of endometriosis between the 1st February 2018 - 31st July 2020	Yes	Yes	Study has not yet commenced. Patient Identifier spreadsheet submitted.
Testicular Torsion	To review the complete pathway and quality of care provided to children and young people 2 – 24 years of age who present to hospital with testicular torsion.	Yes	Yes	100%
Transition from child to adult health services	To explore the barriers and facilitators in the process of the transition of young people with complex chronic conditions from child to adult health services.	Yes	Yes	100%
Juvenile Idiopathic Arthritis (JIA)	Will include young people aged 0 to 24 years, inclusive, with JIA/inflammatory arthritis. All providers of healthcare where patients with JIA might be cared for will be asked to participate in the study; this will include acute, community and independent organisations.	Yes	Yes	Study has not yet commenced. Patient Identifier spreadsheet submitted.
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%

Title	Aim	Relevant to JPUH Services	Trust participation	Percentage of Cases Submitted
Mental Health Clinical Outcome Review Programme - The National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH)				
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. This internationally leading database allows us to make recommendations for clinical practice and policy that will improve safety locally, nationally, and internationally.	No	N/A	
Suicide (and homicide) by people under mental health care		No	N/A	
Suicide by people in contact with substance misuse services		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 2022/23 that were recruited during that period to participate in research approved by a research ethics committee: **1289***.

* Figures based on projected final recruitment as confirmed figures are not available at the time of writing.

Commissioning for Quality and Innovation (CQUIN) Framework

A proportion of James Paget University Hospitals NHS Foundation Trust's income in 2022/23 was conditional on achieving quality improvement and innovation goals agreed between James Paget University Hospitals NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.

Further details of the agreed goals for 2023/24 and for the following 12-month period are available electronically at: [NHS England » 2023/24 CQUIN](#)

The amount of income in 2022/23 conditional upon achieving quality improvement and innovation goals is: **£2,809,000**

The amount of income received for the associated payment in 2021/22 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** taken enforcement action against James Paget University Hospitals NHS Foundation Trust during 2022/23.

Following the CQC Maternity and Midwifery Services Inspection on the 10th January 2023, a Section 29A⁶ Warning Notice of the Health and Social Care Act 2008 was issued to the Trust based on the following concerns:

- There were insufficient numbers of suitably qualified, skilled, competent, and experienced staff in the Maternity Service to keep women and babies safe from avoidable harm and meet their needs.
- There was a breakdown of relationship between the Midwifery and Obstetric staff. The culture within the service was having a negative impact on the safety and care provided for women.
- Governance systems are not operating effectively to ensure risk and performance issues are identified, escalated appropriately and addressed with timely action. Incidents are not consistently reported and there is limited evidence of learning from incidents. Key audits are not undertaken, do not identify or address quality issues.
- Midwifery staff do not receive adequate high dependence training.

To address the concerns, the CQC have requested:

- Significant improvements are made in Governance and Oversight by 1st June 2023
- Significant improvements are made in Maternity and Consultant staffing by 1st August 2023
- Significant improvements are made in the culture of the service by 1st September 2023
- Significant improvements are made in care for women who require additional observation/high dependency care by 1st September 2023

The CQC focused on two domains – Safe and Well-led – and the Maternity service was rated inadequate for both. The overall rating for the service has fallen from 'Good' to 'Inadequate'. These ratings mean that the overall rating of the James Paget Hospital is 'Requires Improvement'. The CQC also rates us as a Trust, which includes all of our sites i.e. Carlton Court, Newberry Clinic etc. – the Trust rating remains as 'Good'.

An Executive Maternity Improvement Group led by the Chief Executive has been established to monitor and oversee the Trust's provision for improving the quality of Maternity Services, and the progress with the improvement actions and assurance.

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

⁶ 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.

Secondary Uses Service

James Paget University Hospitals NHS Foundation Trust submitted records during 2022/23 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:
 - 99.6% for admitted patient care
 - 99.8% for outpatient care and
 - 99.3% 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.

Information Governance Assessment Report

James Paget University Hospitals NHS Foundation Trust Information Governance Assessment Report overall score for 2022/23 was [not available at time of writing] and was graded Standards met*

	JPUH 2020/21	JPUH 2021/22	JPUH 2022/23
Data Security Protection Toolkit Assessment	Standards exceeded	Standards met	<i>Standards met*</i>

*Projected outcome from baseline data submitted – this and the overall score will not be confirmed until our full submission, to be made at the end of June, is assessed.

Payment by Results

James Paget University Hospitals NHS Foundation Trust **was not** subject to the Payment by Results clinical coding audit during 2022/23 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 Index⁷ (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).

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.

The Trust has an approved Data Quality Strategy that will establish a new monitoring forum for Data Quality at the Trust and commits the Trust to the creation of a Data Quality Kitemark to quality assure board-level metrics.

⁷ 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.
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Learning from Deaths

Item 1: During 2022/23 **1177** of the James Paget University Hospitals NHS Foundation Trust patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:

291 in the first quarter;
269 in the second quarter;
301 in the third quarter;
316 in the fourth quarter.

Item 2: By **31/03/2023**, **178** case record reviews and **11** investigations have been carried out in relation to **1177** of the deaths included in item 1.

In **11** cases **11** deaths were subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was:

39 in the first quarter;
14 in the second quarter;
93 in the third quarter;
32 in the fourth quarter

Item 3: **11** cases representing **0.93%** of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient.

In relation to each quarter, this consisted of:

6 representing **2.06%** for the first quarter;
1 representing **0.37%** for the second quarter;
4 representing **1.33%** for the third quarter;
0 representing **0%** for the fourth quarter [at the time of reporting].

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 the **11** cases included:

- ✓ Late recognition of End of Life Care
- ✓ Lack of documentation in relation to Treatment Plan
- ✓ Missed opportunity to recognise deteriorating patient
- ✓ Ambulance handover delays
- ✓ Increased time on Trauma Board
- ✓ Delayed transfer of care to tertiary referral centre
- ✓ Non-compliance with the Sepsis Six Bundle
- ✓ Delayed review of postoperative patients
- ✓ Suboptimal communication with family
- ✓ Delayed review by Specialist Team

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)

- ✓ The introduction of the Urgent and Emergency Care (UEC) Improvement Plan to support to support flow through the Emergency Department
- ✓ Improved communication with families and relatives with introduction of the Family Liaison Officers and the Patient Safety Incident Response Framework
- ✓ Continuous audits of the Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) forms to measure outcomes during End of Life
- ✓ Introduction of a Standard Operating Procedure (SOP) for the safe transfer of patients to Tertiary Referral Centres
- ✓ Education of Nurses and Junior Doctors through Learning Slides and Team meetings to improve escalation of the deteriorating patient
- ✓ Reintroduction of the Documentation and Consent Audit to understand outcomes and introduce improvements in the Trust wide documentation process
- ✓ Improved handover process to support timely Specialist referrals
- ✓ Revised terms of reference of the Mortality and Morbidity meetings to allow dissemination of learning within the Multidisciplinary Team (MDT).

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 Structured Judgement Review (SJR) process has been strengthened by the introduction of the NHS England SJRPlus platform. This allows the efficient capture of and monitoring of outputs from the completed mortality reviews. This has enhanced learning across the Trust and strengthened the Quality Improvement from Learning from Deaths.

The introduction of the revised Specialty mortality and morbidity Terms of Reference has ensured robust governance and oversight of learning from mortality and morbidity.

The introduction of a work plan to support execution of the Mortality Surveillance Group has led to improved mortality governance.

Item 7: **22** case record reviews and **3** investigations were completed after 1st April 2023 which related to deaths which took place before the start of the reporting period.

Item 8: **3** cases representing **0.25%** of the patient deaths before the reporting period, were reviewed after 1st April 2022 and are judged to be more likely than not to have been due to problems in the care provided to the patient.

Item 9: **11** Cases representing **0.93%** of the patient deaths during 2022/23 are judged to be more likely than not to have been due to problems in the care provided to the patient.

2.3 Reporting against core indicators

Summary hospital-level mortality indicator (SHMI)

	JPUH 2020/21	JPUH 2021/22	JPUH 2022/23	National Average 2022/23	Highest SHMI for FT	Lowest SHMI for FT
(a) Value and (banding) of the SHMI for the Trust	1.0866 (within expected limits)	1.0723 (within expected limits)	10.721 (within expected limits)	1.0000	1.2219	0.7173

The SHMI for 2022/23 (December 2021 to November 2022) 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

Hospital re-admissions

	JPUH 2020/21	JPUH 2021/22	JPUH 2022/23	National Average 2022/23	Highest score for Foundation Trusts	Lowest score for Foundation Trusts
Patients aged 0-15 years	10.97%	12.03%	10.73%	12.55%	19.73%	2.29%
Patients aged 16 or over	13.20%	13.24%	12.12%	14.85%	25.00%	2.15%

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 work stream is in place to review and improve clinical unwarranted variation across all specialities. 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 Hospital Portal 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 2019/20	JPUH 2020/21	JPUH 2021/22	JPUH 2022/23
Groin hernia surgery	No longer collected			
Varicose vein surgery	No longer collected ⁸			
Hip replacement surgery	87.8%	95.8%	*not available	*not available
Knee replacement surgery	86.7%	86.2%	*not available	*not available
All procedures	87.3%	91.2%	*not available	*not available

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%.

*2021/22 and 2022/23 data 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.
- The pause in elective surgery due to the COVID-19 pandemic resulted in a lower participation rate for 2019/20 and overall participation improved in 2021/22.

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.

Responsiveness to the personal needs of patients

JPUH 2019/20	JPUH 2020/21	JPUH 2021/22	JPUH 2022/23	England score 2021/22 ⁹
75.6	73.8	*not available	*not available	74.5

⁸ Varicose vein and groin hernia PROMs are no longer collected following a consultation undertaken by NHS England.

⁹ 2022/23 data not available

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.

Friends and Family Test (FFT) – Staff

Percentage of staff employed by, or under contract to, the trust during 2022/23 who would recommend the trust as a provider of care to their family or friends.

JPUH 2020	JPUH 2021	JPUH 2022	England 2022	Highest score for Foundation Trusts	Lowest score for Foundation Trusts
79.2%	71.5%	63.3%	61.9%	86.4%	39.2%

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.

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 2020/21	JPUH 2021/22	JPUH 2022/23	National Average 2022/23	Highest score for Foundation Trusts	Lowest score for Foundation Trusts
Rate per 100,000 bed days <i>C.diff</i> infection	12.39	13.01	18.70	*Not available	*Not available	*Not available
Number of cases of <i>C.diff</i> infection	15	21	30	*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	Highest score for Acute (non-specialist) trusts (Feb 22 to Jan 23) ¹⁰	Lowest score for Acute (non-specialist) trusts (Feb 22 to Jan 23)
Number of patient safety incidents	5461	6009	6272	36,342	5110
				JPUH 7513	
Rate per 1000 bed days	39.9	37.2	37.4	*Not available	*Not available
				JPUH 44.8	
Percentage of incidents resulting in Major Harm	0.5%	0.48%	0.3%	1.37%	0.04%
				JPUH 0.36%	
Percentage of incidents resulting in Death	0.09%	0.07%	0.08%	1.11%	0%
				JPUH 0.13%	

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:

- ✓ New incident reporting system implemented that allows people to report incidents without logging in
- ✓ 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 will come into effect, greatly changing the face of how we look at incidents
- ✓ Incident Review Panels continue to facilitate prompt discussion of harm incidents and Near Miss incidents
- ✓ Incident reporting and learning is 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.

¹⁰ This date range has been selected as this is the most current data available from the National Reporting and Learning Service.

NHS Oversight Framework Indicators

Performance against the relevant indicators and performance thresholds set out in the oversight documents issued by NHS England and NHS Improvement. For 2022/23 these are:

Indicator		Threshold 2022/23	JPUH 2022/23
Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate – patients on an incomplete pathway		92%	51.57%
A&E: maximum waiting time of four hours from arrival to admission/transfer/discharge		95%	69.69%
All cancers: 62 day wait for first treatment from:	urgent GP referral for suspected cancer	85%	86.47%
	NHS Cancer Screening Service referral	90%	78.82%
<i>C difficile</i> : variance from plan		33	30
Summary Hospital-level Mortality Indicator (also included in quality accounts regulations)		1	1.0721
Maximum 6-week wait for diagnostic procedures		1%	23.92%
Venous thromboembolism (VTE) risk assessment		95%	95.21

For definitions for all Indicators, please see the *NHS Oversight Metrics for 2022/23: (Updated June 2022)*¹¹ or via the link: [Report template - NHSI website \(england.nhs.uk\)](https://www.england.nhs.uk/quality/reports-and-metrics/)

¹¹ Still current at the time of writing
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Guardian of Safe Working Hours end of year report

The work schedules for JPUH doctors are compliant with the new contract and the monitoring system for exception reporting are being well utilised, with the Trust continuing to work on ensure that any exceptions are raised in the appropriate manner and that there is an open and transparent culture within the trust for doing so.

Rota Gaps / Vacancies

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

Table 1 - Trainees and Trust Doctors

Row Labels	Establishment FTE	Actual FTE
Foundation Year 1	40.00	40.39
Foundation Year 2	42.00	36.00
Specialty Registrar	98.43	97.12
Trust Grade Doctor - Specialty Registrar	3.00	2.81
Grand Total	183.43	176.32

Specialties with Trainee Gaps:

- Emergency Department
- Acute Medicine / General Medicine including haematology.
- Obstetrics and Gynaecology
- Orthopaedics

Submitted Exception Reports 2021/2022

Total number of exception reports received	92
Number relating to immediate patient safety issues	6
Number relating to hours of working	72
Number relating to pattern of work	10
Number relating to educational opportunities	5
Number relating to service support available for the doctor	5

Summary of Response to Exception Reports with immediate Patient Safety Concern

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.

Three Exception Reports relating to immediate patient safety issues were from the same doctor; they were working in ICU as a supernumerary once a week. The working hours of permanent staff in the ICU are from 07:00 to 19:00 but Junior Doctors leave at their rostered time of 17:00; which this individual was not made aware. They therefore stayed until 19:00 for a few weeks (working only one day per week in ICU). On exception reporting the individual was offered time off in lieu (TOIL) or payment, and they accepted payment for the extra hours worked.

A further three Exception Reports were from the same doctor working in the Department of Medicine and occur within a fortnight. On investigation, there was minimal staffing shortage because of sickness but the department was unusually busy. All three reports related more towards service support than immediate patient safety concerns. The doctor concerned received payment for the extra hours worked as a choice.

Resolution: The numbers of Exception Reports during 2022/23 were slightly less than in 2021/22, (92 reported vs. 117 reported). When the rota hours are breached this can incur a fine; this has not occurred during 2022/23.

Outcome and Resolution

Action taken by the Educational Supervisor, Guardian of Safe Working:

Total number of exceptions where time off in lieu (TOIL) was granted	15
Total number of overtime payments	70
Total number of work schedule reviews	0
Total number of reports resulting in no action	7
Total number of organisational changes	0
Compensation	0
Unresolved	0
Total number of resolutions	92
Total unresolved exceptions	0

Details and response to Unresolved Exception Reports

There were no Unresolved Exception Reports throughout 2022/23.

Summary

The Medical time to hire for 2022/23 is similar to that of 2021/22. Gateway Doctors, Locally Employed Doctors (LED), Medical Training Initiative (MTI) and Physician Associates (PA) are employed to mitigate medical trainee gaps left by Covid absence, maternity leave, and long-term sickness in order to support the remaining trainee workforce.

This led to the Trust being over-established (having more people in posts than the service requires on paper) in some grades as detailed above in Table 1.

The Trust continues promotion of well-being offers and other external support is available specifically for the medical workforce.

Guardian of Safe Working Hours

Annex 1

Statements from Stakeholders

Norfolk and Waveney Integrated Care Board

Norfolk and Waveney Integrated Care Board (ICB) acknowledges the receipt of the draft 2022/2023 Quality Account from James Paget University Hospitals (JPUH) NHS Foundation Trust and welcomes the opportunity to provide this statement.

Based on the information and data available within the draft report NHS Norfolk and Waveney Integrated Care Board (ICB) supports James Paget University Hospitals NHS Foundation Trust (JPUH) in the publication of its Quality Account for 2022-23. 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 the workforce has faced. The ICB thanks the Trust and staff for their sustained commitment in caring for those using your services.

The Trust has worked in collaboration with system partners within the Integrated Care System (ICS) to strengthen and enhance integrated working practice, focussing resources where our patients need them most.

The ICB acknowledges the Trust's clear focus and commitment to patient safety through a culture of openness and engagement with patients and relatives. The ICB acknowledges the work undertaken in progressing their Patient Safety Incidence Response Plan (PSIRP) aligned to the Patient Safety Incident Response Framework (PSIRF) guidance and is confident the Trust is on trajectory for the implementation date of 01 September 2023.

The ICB notes the positive progress and improvements against the 2021/2022 priorities and acknowledges plans to embed and develop the partially achieved priorities. The internal work on preventing falls has made substantial progress demonstrating a 38% reduction in falls with harm and a 5% reduction in category two pressure ulcers. We welcome your continued collaborative approach to improve patient falls and reduce pressure ulcers across the broader system.

It is reassuring to see that staff training is a continued a priority and we are pleased to see the progress made towards achieving the standards set out in the National Patient Safety Syllabus.

The ICB recognises the work undertaken by the Trust by implementing a harm review process for patients to ensure the prioritisation and the safety of patients waiting for surgery or treatment. It is good practice to see PricewaterhouseCoopers (PwC) are undertaking an internal audit and look forward to collaborating with you with regarding any recommendations they may make.

The ICB notes the work that the Trust has undertaken to assess maternity services against the national recommendations and the development of a safety assurance processes. The ICB anticipates working collaboratively with the Trust to support on-going developments in Local Maternity and Neonatal systems (LMNS), including the three-year delivery plan for Maternity and Neonatal services and the NHS Long Term plan.

The ICB recognises the development of a strategy supporting the holistic needs of patients living with life limiting conditions. The ICB welcomes the appointment of a Cancer Strategy Lead who will support the Trust's clinical teams to develop a Norfolk and Waveney wide strategy.

The ICB recognises the work undertaken to improve access to services for those from minority groups to better reflect the experience of all service users to reduce inequalities. The ICB is pleased to see the Trust has become a pilot site for smoking cessation and welcomes the collaborative approach we have taken in supporting the development of maternity led smoking cessation in the pregnancy service.

The ICB acknowledges the transformation of care delivery using technology, demonstrated by the establishment of a Virtual ward.

The ICB supports the Trust's strategic objectives for 2023/2024 and welcomes the opportunity to collaborate with you, focusing on the following domains: patient safety, clinical effectiveness, and patient experience, and support the following objectives:

- Implementation of PSIRF
- Category two pressure ulcers risk reduction
- Maternity Improvement Plan
- Effectiveness of multidisciplinary learning from deaths
- Improve timeliness of access to care
- Optimise the Trust's clinical guideline process
- Robust process to participate in and learn from national clinical audits
- Redesign the Patient Advice and Liaison Service (PALS)
- Receive and act upon people on their experiences of care and the Trust's services.

The ICB recognises the challenges ahead and values the commitment from all staff within the Trust. The ICB believes the report capture key elements of safety, clinical effectiveness, and patient experience and well led Trust and demonstrates the Trust's commitment to continuous improvement and quality.

On behalf of NHS Norfolk and Waveney ICB, I would like to thank you, the individuals involved in developing and producing this account and all the staff. I look forward to building on our joint working relationship to ensure safe, effective care for our patients and local population during 2023/24.

Yours sincerely,



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

Suffolk Health Scrutiny Committee

As has been the case in previous years, the Suffolk Health Scrutiny Committee does not intend to comment individually on NHS Quality Accounts for 2022-23. This should in no way be taken as a negative response. The Committee acknowledges the significant ongoing pressures faced by NHS providers and wishes to place on record our thanks for everything being done to maintain NHS services for the people of Suffolk in the most challenging of times.

County Councillor Jessica Fleming
Chair of the Suffolk Health Scrutiny Committee

HealthWatch Norfolk

Name of provider	Comments
Readability	
Is there an executive summary/CEO statement?	The foreword provides a summary of the structure of the report but at the time of HWN review of the draft document there was no CEO statement.
Is the document well laid out, easy to read?	As commented previously we recognise that much of the information is mandatory which restricts the ability for the Trust to make the document more 'user friendly' and meaningful for the general public.
Is there a glossary?	Yes, and this is clearly signposted in the foreword.
Is the document available in different formats? e.g. electronic, hard copy, Braille, other languages	Yes, but as previously highlighted by HWN, the information relating to different formats is in the same font size as the rest of the document and we are disappointed that the Trust has not responded to our previous suggestions on this aspect. ¹²
Are priorities for the past year clearly identified?	Yes, the priorities for the past year are clearly laid out.
Have the priorities been achieved?	We congratulate the Trust on those priorities that have been achieved including a reduction in the number of falls with harm and a significant increase in the number of referrals seen by tobacco advisers. However we note that a number of priorities have been partially achieved. We look forward to learning about the impact of the planned Patient Safety Incident Response Framework (PSIRF) in September 2023.
Are the priorities for the forthcoming year clearly identified?	Yes
Are the following areas included	
Patient safety?	Please see comments above regarding the PSIRF. Further details as to how the Trust plan to involve patients in their own safety would be useful together with an explanation of the use of 'structured communication tools.'
Clinical quality and effectiveness?	We congratulate the Trust on achieving 2 out of 3 priorities in this section and note that it plans to re audit the use of Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) forms as part of actions to improve shared decision making.
Patient experience inc family & friends test?	As the main focus for HWN is the feedback from patient experience we very much welcome the priority for 2023/24 relating to improvements on this aspect including the redesign of the Patient Advice and Liaison Service (PALS), improved patient experience feedback and a patient led user group.
Incident reporting & never events?	See above comments regarding patient safety incident response framework implementation. It is not clear from the document if the increase in incidents is due to the new reporting system. There is no data relating to never events in the document.
Complaints?	Although there is no detailed information relating to complaints, we are pleased to note the reduction in the number of complaints relating to communication.
Workforce?	We fully acknowledge the continuing struggle (nationally) to recruit, retain and support staff. However we are concerned to note the example given of an unplanned absence resulting in a failure in reporting procedures (under the heading of compliance with duty of candour) and trust that this experience prompted the Trust to ensure there are no similar failings relating directly to the unplanned absence of one member of staff.

¹² Apologies, this was rectified in the next iteration of the report.
James Paget University Hospitals NHS Foundation Trust
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Audits including participation in national audits?	At the time of this review there was no data included relating to national or local clinical audits
Data quality?	We have no issues relating to data quality (albeit at the time of this review, the data is incomplete in the sections headed statements of assurance from the board and reporting against core indicators.
Feedback from CQC?	HWN is pleased to note there was no enforcement action during 2022-23.
New services?	No new health services identified.
CQUIN?	It is good to note that the Trust will have attained 7 out of 8 CQUIN schemes by year end. We note the target for staff flu vaccinations has not been met but there are no details of intended actions to remedy this.
Patient Led Assessment of the Care Environment (PLACE) results?	No information included in the document relating to PLACE visits during the year.
18-week target (where applicable)?	We note that waiting times continue to reflect the national picture but congratulate the Trust on achieving its target relating to the harm review process for patients on waiting lists. We welcome the Trust including the improvement to timeliness of access to care as one of its priorities for next year although there are no specific details as to how it proposes to achieve this.

Any other comments/observations

HWN is pleased to note a number of improvements made by the Trust during the year. As the health and social care sector moves forward, we firmly believe every opportunity should be taken for agencies to work proactively together and note the work being undertaken by the Trust in working with Voluntary Norfolk and the Red Cross around discharge procedures.

Healthwatch Norfolk look forward to continuing to work with the Trust to fully engage with the public regarding the developments in line with the New Hospital Programme. More generally we will continue to work with the Trust to help to ensure that it listens to, and implements changes, based on feedback from patients, families, and carers.

Alex Stewart
Chief Executive Officer

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 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 2022/23* 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 April 2022 to 31/03/2023
 - papers relating to quality reported to the board over the period April 2022 to 31/03/2023
 - feedback from commissioners dated **15/05/2023**
 - feedback from governors dated – none received
 - feedback from local Healthwatch organisations dated – **05/05/2023**
 - feedback from Overview and Scrutiny Committee dated – **15/05/2023**
 - the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated **27/05/2022**
 - the 2021 national patient survey **30/09/2022**
 - the 2021 national staff survey **30/03/2022**
 - the Head of Internal Audit's annual opinion of the trust's control environment dated – not required this year
 - CQC inspection report dated **13/05/2022**
- 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 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: 30/06/2023



Interim Chair

Date: 30/06/2023



Chief Executive

Glossary of terms and abbreviations

Term	Meaning
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
<i>C.difficile</i> or <i>C.diff</i>	<i>Clostridioides difficile</i>
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
LGBTQIA+	Lesbian, Gay, Bisexual, Transgender, Queer or Questioning, Intersex, Asexual, and More
MBRRACE	Mothers and Babies: Reducing Risk Through Audits And Confidential Enquiries
MDT	Multidisciplinary Team
N&W	Norfolk and Waveney

Term	Meaning
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
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
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
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

