#Proud of the Paget

NHS

James Paget University Hospitals

NHS Foundation Trust

QUALITY ACCOUNT 2025/26

- Patient Safety
- Clinical Effectiveness
- Patient Experience

Quality Account 2025/26 – Contents

Foreword

What is a Quality Account?

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

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

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

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

Scope and structure of the Quality Account

This report summarises how well the James Paget University Hospitals NHS Foundation Trust (JPUH) ('the Trust') as part of the Norfolk and Waveney University Hospitals Group (NWUHG) did against the quality priorities and goals we set ourselves for 2025-26 (Looking back)

It also sets out the Quality Priorities we have agreed for 2026/27 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 Executive Managing Director (EMD) and NWUHG Chief Executive Officer (CEO) that looks at our performance in 2025/26 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 2026/27 for the same categories and explains how we decided on them, how we intend to meet them, and how we will track our progress. Part 2 also includes statements of assurance relating to the quality of services and describes how we review them, including information and data quality. It includes a description of audits we have undertaken and our research work. We have also looked at how our staff contribute to quality.

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

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

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

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

Part 1

Statement on Quality from the JPUH EMD and NWUHG CEO

Foreword by the JPUH Executive Managing Director and NWUH Chief Executive Officer

Jonathan Gardner, JPUH Executive Managing Director
Professor Lesly Dwyer, NWUH Chief Executive Officer

Welcome to our Quality Account for 2025/26, which provides an overview and an opportunity to reflect on our performance and outcomes over the last year.

As Executive Managing Director of the James Paget University Hospitals NHS Foundation Trust and Chief Executive Officer of the Norfolk and Waveney University Hospitals Group we are pleased to present this report as positive progress the hospital has delivered, as well as areas where we will continue to strive to do better in our ongoing commitment to providing high quality, safe and compassionate care to our patients, and the communities we serve.

This work has been crucial for the hospital in addressing the increasing demand for services and meeting NHS England's performance and outcome frameworks over the past year, as we move into our new working arrangements with hospital partners within the Norfolk and Waveney University Hospitals Group.

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

These achievements result from the organisation's commitment to openness and learning, embracing learning opportunities, and an improvement approach to enhance the quality and safety of services provided. The report demonstrates how we have applied this to our approach in various areas of our programme of quality priorities covering 2024-27.

Our continued commitment to patient safety, and embedding the Patient Safety Incident Response Framework (PSIRF) methodology, has supported strong engagement with and involvement of our patients, families, and carers, as well as supporting staff by understanding that unforeseen events occur, and developing skills to identify and implement learning within their teams and for trust wide improvement.

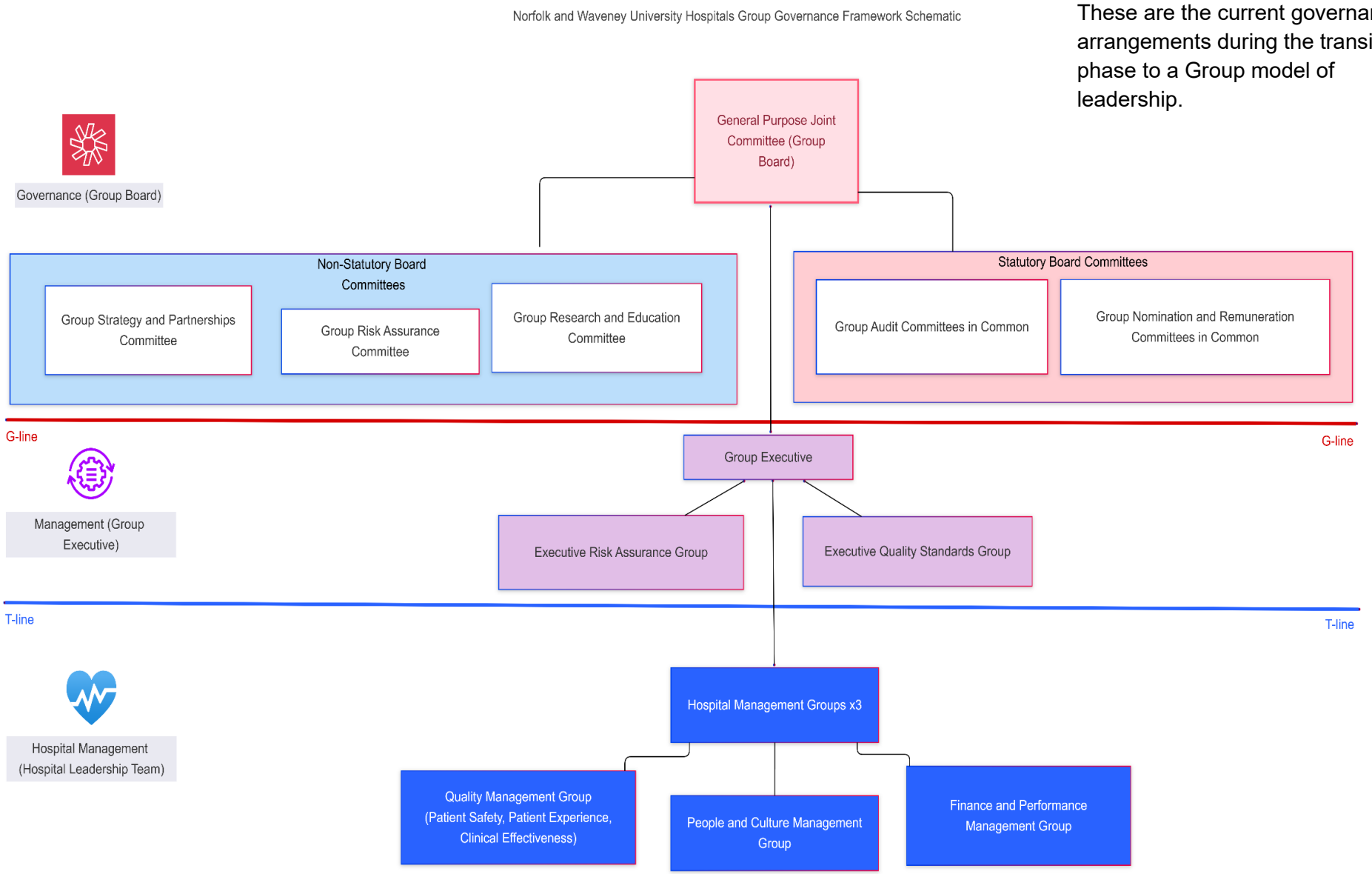
We are equally pleased to see that our extensive audit programme helps us all understand where service gaps exist and how we work together to address them as well as being able to celebrate when areas of good practice are identified and shared for others to learn from us.

By integrating these advancements throughout our Trust and collaborating closely with our partners in the Hospitals Group and wider NHS services locally, we can significantly enhance the care we provide to all patients. This further motivates us to display our dedication and commitment to learning and continuous improvement across the hospital.

Looking ahead, the work on developing a group leadership model across the hospitals in Norfolk and Waveney presents an opportunity to address systemic performance and sustainability challenges and provide consistent and clear decision making that positively influences healthcare for all patients using services across Norfolk and Waveney. This will be vital in delivering the Electronic Patient Record (EPR) and Acute Clinical Strategy programmes of work (linking into the Group One Recovery program), both of which are a key enabler for the two new hospitals builds in Norfolk and Waveney.

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

Organisational Trust Structure for Quality Performance



These are the current governance arrangements during the transition phase to a Group model of leadership.

Part 2

Priorities for improvement and statements of assurance from the Board

2.1 Quality Priorities for Improvement

The Trust Senior Leadership Team, formerly the Trust Board of Directors, agree key quality priorities annually under the three domains of quality for:

- Patient Safety
- Clinical Effectiveness
- Patient Experience

These are identified from and/or aligned to the:

- Trust Improvement Approach Strategy 2023-2026
- Care Quality Commission (CQC) five Key Lines of Enquiry (KLOE)
  - Safe
  - Effective
  - Caring
  - Responsive
  - Well-led
- Governors/Trust Members/local population feedback via questionnaires
- Quality Account priorities from the past year
- Issues identified from the CQC's Quality Assurance Framework
- Priorities identified by:
  - NHS England
  - Health Education England
  - Public Health England
  - National Institute for Health and Care Excellence (NICE)
- National Patient Safety Strategy (2019) and Patient Safety Incident Response Framework (August 2022)
- NHS Oversight Framework 2025/26
- Patient Safety Healthcare Inequalities Reduction Framework 2025
- NHS National directives from reviews i.e. Ockenden, Kirkup, Thirlwall, etc

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 Senior Leadership Team, (formerly the Trust Board of Directors), has continued to include focused patient experience feedback at each monthly meeting to help identify, manage and mitigate key risks
- Patients and relatives are involved in addressing issues identified through complaints, claims, Patient Advice and Liaison (PALS) and incidents via involvement in investigation and identification of learning
- Patient Satisfaction Surveys
- Engagement and involvement of Patient Safety Partners

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

- There are Foundation Trust meetings at all levels with members of the Integrated Care Board at which risk is assessed
- Health Overview and Scrutiny Committees
- Partnership working with Social Services; and
- Joint working with other health and social care providers as part of the Norfolk and Waveney University Hospitals Group and 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 for Patient Safety, Clinical Effectiveness, Patient Experience Agreed For 2025/26

The table below lays out a list of all the agreed Trust Quality Priorities for 2025/26 by domain with their end of year status, with corresponding supplementary information reported below each section.

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

Quality Priority Domain(s):

☐ Patient Safety ☒ Clinical Effectiveness ☒ Patient Experience

i	90% of our staff will be trained in Level 1 Patient Safety Syllabus	**Achieved**
ii	90% of clinical and governance staff will be trained in Level 2 Patient Safety Syllabus	**Achieved**
iii	For 100% of Patient Safety Incident Investigations (PSIIs), there will be evidence that staff, patients and relatives have been involved in the investigation process.	**Achieved**
Iv	All level 1 and 2 investigations will be supported by an agreed PSIRF tool and be fully utilised across the organisation	**Achieved**
v	Monitor and see a reduction, year on year in complaints relating to any form of communication	**Not achieved**

i. 90% of our staff will be trained in Level 1 Patient Safety Syllabus

This Priority was **Achieved** for 2025/26.

Quarter 4 and Year End Update

End of 2025/26 Patient Safety Level 1 Compliance across all staff was 95.43%. Level 1 Patient Safety Syllabus Training has been incorporated into the Trust mandatory training programme for all staff and continues to be monitored monthly.

ii. 90% of clinical and governance staff will be trained in Level 2 Patient Safety Syllabus

This Priority was **Achieved** for 2025/26.

Quarter 4 and Year End Update

End of 2025/26 Patient Safety Level 2 Compliance across all staff was 94.14%. Level 2 Patient Safety Syllabus Training has been incorporated into the Trust mandatory training programme for all clinical staff, as well as staff who have a requirement to have enhanced understanding of patient safety. Compliance with this training continues to be monitored monthly.

iii. For 100% of Patient Safety Incident Investigations (PSIIs), there will be evidence that staff, patients and relatives have been involved in the investigation process

This Priority was **Achieved** for 2025/26.

Quarter 4 and Year End Update

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

iv. All level 1 and 2 investigations will be supported by an agreed PSIRF tool and be fully utilised across the organisation

This Priority was **Achieved** for 2025/26.

Quarter 4 and Year End Update

Since the implementation of PSIRF in September 2023, the Trust has introduced a suite of learning response tools which are utilised across the organisation for “hot debriefs”. These include AARs, learning response timelines, round table discussions, case notes reviews. These are used by a range of multidisciplinary roles. Performance data for this aspect is reported monthly at the Patient Safety Improvement Management Meetings (PSIMM). 140 Trust staff have been trained in After Action Review Conductor methodology.

v. Monitor and see a reduction, year on year in complaints relating to any form of communication

This Priority was **Not Achieved** for 2025/26

Quarter 4 and Year End Update

There has been a 30% increase in complaints relating to poor communication, with 39 complaints within 2025/26 versus 31 within 2024/25. The Trust provides multiple initiatives to support enhanced communication skills, such as Sage & Thyme, Conflict Resolution & Challenging conversations training, as well as quality sessions to senior staff and clinical leaders. A focussed campaign supported by a task and finish group to reduce communication related incidents and improve patient experience will take place across 2026/27.

Quality Priority 2:
Deliver Personalised, Safe Care for Maternity and Neonatal service users through our Maternity Improvement Plan (MIP)
Quality Priority Domain(s):

☒ Patient Safety ☒ Clinical Effectiveness ☐ Patient Experience

I	Ensuring the lessons learnt from Ockenden and Kirkup are monitored through robust action plans delivered through the MIP demonstrating sustained and embedded improvements in practice, culture, leadership and governance.	**Achieved**
Ii	Annual reduction of preventable still births per 1000 live births	**Achieved**
Iii	Annual reduction of preventable Neonatal deaths per 1000 live births	**Achieved**
Iv	Smoking at time of delivery 6% (national average)	**Partially Achieved**
V	Have 0 maternal deaths	**Achieved**

i. Ensuring the Lessons Learnt From Ockenden And Kirkup Are Monitored Through Robust Action Plans Delivered Through The Maternity Improvement Plan Demonstrating sustained and embedded improvements in practice, culture, leadership and governance.

This Priority was **Achieved** for 2025/26.

Quarter 4 and Year End Update

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

All 92 actions are now meeting the Ockenden recommendations. All actions are now complete and signed off.

ii. Annual Reduction of Preventable Still Births Per 1000 Live Births

This Priority was **Achieved** for 2025/26.

Quarter 4 and Year End Update

The Trust reported 3 still births during 2025/26, against a baseline of 2 still births during 2024/25. There were 2 still births during Quarter 1, 0 during Quarter 2, 0 during Quarter 3, 1 during Quarter 4. Of the 2 stillbirths in Quarter 1, following Perinatal Mortality Review Tool 1 still birth was deemed to be unavoidable, and the other identified care issues which were considered may have made a difference to the outcome for the baby (compliance with diabetes management and smoking). The stillbirth within Q4 has undergone review utilising the Perinatal Mortality Review Tool and care issues were identified but were considered to have made no difference to the outcome for the baby. This means at end of year 1 still birth was deemed to be potentially preventable, and two were deemed not to be preventable following Perinatal Mortality Review Tool.

iii. Annual Reduction of Preventable Neonatal Deaths Per 1000 Live Births

This Priority was **Achieved** for 2025/26.

Quarter 4 and Year End Update

The Trust reported one neonatal death for 2025/26 against a baseline of three for the 2024/25 financial year. The neonatal death occurred in Quarter 2, and was reviewed by Perinatal Mortality Review Tool (PMRT) and deemed to be unavoidable.

iv. Smoking At Time Of Delivery 6% (National Average)

This Priority was **Partially Achieved** for 2025/26.

Quarter 4 and Year End Update

The Trust percentage for smoking at time of delivery was an overall 8.2% average for 2025/26. The 6% target was met in October 2025, January 2026 and March 2026, and the overall trajectory for smoking at time of delivery across 2025/26 demonstrated improvement, with a Quarter 4 average of 6%. This is a significant reduction from 13.6% during 2024/25.

v. Have 0 Maternal Deaths

This Priority was **Achieved** for 2025/26.

Quarter 4 and Year End Update

The Trust has reported 0 maternal deaths for 2025/26.

Quality Priority 3:
Patients in our care do not come to avoidable harm by reducing the incidence of harm monitored by our quality matrix, including LFD, SJR, GIRFT, NICE recommendations
Quality Priority Domain(s):

☒ Patient Safety ☒ Clinical Effectiveness ☒ Patient Experience

i	5% year on year reduction in falls per 1000 bed days, based on the previous year's metric	**Partially Achieved**
ii	5% year on year reduction in Hospital Acquired Pressure Ulcers per 1000 bed days, based on the previous year's metric	**Not Achieved**
iii	10% year on year reduction in medication incidents, based on the previous year's metric	**Not Achieved**
iv	15% reduction year on year for nationally reportable Gram Negative Infection, based on the previous year's metric	**Not Achieved**
v	>90% compliance with MUST Nutrition assessment completion within 6 hours of admission, based on the previous year's baseline metric	**Achieved**
vi	10% reduction year on year with Sepsis– Delivery of Antibiotics (CCORT, Sepsis Audit)	**Achieved**
vii	Improvement in all of the End of Life Metrics year on year. (NACL Audit/MAD audit)	**Achieved**
viii	100% of clinical areas assessed for ward accreditation and have achieved and maintained at least good	**Partially Achieved**

i. 5% year on year reduction in falls per 1000 bed days, based on the previous year's metric

This Priority was **Partially Achieved** for 2025/26.

Quarter 4 and Year End Update

The Trust reported 5.29 falls per 1000 bed days for 2024/25. The Trust target for 2025/26 was 5.04 per 1000 bed days. The Trust's Final end of year position is 5.19 falls per 1000 bed days for 2025/26. Whilst this represents an improvement in the rate of falls, the reduction has not been large enough to reach the quality priority target for percentage reduction. The trust remains in a favourable position when compared against the national average of 6.63.

ii. 5% year on year reduction in Hospital Acquired Pressure Ulcers per 1000 bed days, based on the previous year's metric

This Priority was **Not Achieved** for 2025/26.

Quarter 4 and Year End Update

The Trust reported 0.77 hospital acquired pressure ulcers per 1000 bed days for 2024/25. The Trust target for 2025/26 was 0.73 per 1000 bed days. The Trust's Final end of year position for 2025/26 is 0.79 hospital acquired pressure ulcers per 1000 bed days, therefore representing an increase in the rate of hospital acquired pressure ulcers for 2025/26.

iii. 10% year on year reduction in medication incidents, based on the previous year's metric

This Priority was **Not Achieved** for 2025/26.

Quarter 4 and Year End Update

The Trust reported 699 medication incidents for 2024/25. The Trust Target for 2025/26 for medication incidents was 629. The Trust's Final end of year position is 700 medication incidents. This metric is across all medication categories.

iv. 15% reduction year on year for nationally reportable Gram Negative Infection, based on the previous year's metric

This Priority was **Not Achieved** for 2025/26.

Quarter 4 and Year End Update

The Trust reported 80 gram negative infections during 2024/25. The Trust Quality Priority Target for 2024/25 for gram negative infections was 68. The Trust's final end of year position is 81 gram negative infections.

v. >90% compliance with MUST Nutrition assessment completion within 6 hours of admission, based on the previous year's baseline metric

This Priority was **Achieved** for 2025/26.

Quarter 4 and Year End Update

The Trust's 'Making a Difference' Audits demonstrate that during 2025/26, 92.1% of patients had Malnutrition Universal Screening Tool (MUST) completed within 6 hours of admission. 96.5% had MUST completed since admission.

vi. 10% Reduction Year On Year With Sepsis – Delivery of Antibiotics within one hour (CCORT, Sepsis Audit)

This Priority was **Achieved f**or 2025/26.

Quarter 4 and Year End Update

Delivery of antibiotics within 1 hour of observations if prescribed in time was 94.4% at end of Q4 versus 92.3% in 2024/25.

vii. Improvement in all of the End of Life Metrics year on year. (NACL Audit/MAD audit)

This Priority was **Achieved** for 2025/26

Quarter 4 and Year End Update

The Trust Making a Difference Audits demonstrate that the Trust has increased compliance with end of life practice and theory in 2025/26 versus 2024/25.

EOL Practice: 2024/25 - 95%

2025/26 – 95.7%

EOL Theory: 2024/25 – 93.4%

2025/26 – 93.9%

viii. 100% of clinical areas assessed for Ward Accreditation and have achieved and maintained at least good

This Priority was **Partially Achieved** for 2025/26.

Quarter 4 and Year End Update

During 2025/26. 100% of wards were assessed for Ward Accreditation, and 94% of wards achieved good or outstanding. 6% (1 ward) was assessed as requires improvement

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

Quality Priority Domain(s):

☐ Patient Safety ☐ Clinical Effectiveness ☒ Patient Experience

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

This Priority was **Achieved** for 2025/26.

We intended to achieve:

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

Quarter 4 and Year End Update

- Patient experience and public engagement plan progressing well and on trajectory
- PALS team fully established and relocated to patient facing office in main foyer.
- Patient Safety Incident Response Framework (PSIRF) implemented.
- PSIRF Level 1 investigations carried out by Patient Safety Investigators and involve patients/families.
- Carer Friendly Tick renewal accreditation achieved and valid for the next two years – next due for re-accreditation in 2027.
- Additional recruitment of two new patient representatives onto the James Paget User Group – Advert remains live to recruit additional members
- Engagement Principles in place following stakeholder events.
- Partnership working with Healthwatch colleagues and Voluntary, Community, Faith and Social Enterprise (VCFSE) sectors continue
- Patient Safety Partners (PSPs) are core members of the Carer & Patient Experience (CAPE) Management Meeting, the Trust User Group and Patient Safety Improvement Management Meeting (PSIMM).
- Accessible Information Officer roles not able to be progressed due to current financial constraints, however Accessible Information Standards Policy in place and Patient Experience Team signpost and support staff to meet patients' communication needs.

Quality Priority 5:
To deliver high standards of care and access to services for our Older Peoples Medicine
Quality Priority Domain(s):

☒ Patient Safety ☒ Clinical Effectiveness ☒ Patient Experience

i	Establish an Older Peoples Medicine Multi disciplinary team	**Achieved**
ii	Develop and enhance OPM pathways with bespoke services that avoid admission	**Achieved**
iii	(TBC) reduction in LOS - this will be confirmed once the system wide approach to OPM has been finalised, led by the ICB.	**To be introduced in 26/27**
iv	(TBC) reduction in admission of those over 65/80 - this will be confirmed once the system wide approach to OPM has been finalised, led by the ICB.	**To be introduced in 26/27**
v	Development in research into non medical interventions and measuring impact – THEO	**Achieved**

i. Establish An Older Peoples Medicine Multi Disciplinary Team

This Priority was **Achieved** for 2025/26 and improvement work is ongoing.

Quarter 4 and Year End Update

OPM consultant and specialty doctor vacancies have been recruited to and are in place. Physician Associate and physiotherapist also in post specialising in frailty. Future recruitment plans to enhance the scope and reach of the Older People's Medicine (OPM) Multi-Disciplinary Team are in progress with appointments anticipated in the Summer 26 and additional Consultant recruitment plan. A proposal has been developed to expand the OPM team further with advanced practitioners.

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

This Priority was **Achieved** for 2025/26 and improvement work is ongoing.

Quarter 4 and Year End Update

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

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

This Priority is **to be introduced in 26/27**

Quarter 4 and Year End Update

This sub-priority metric target has not been confirmed. This will be confirmed once the system wide approach to OPM has been finalised, led by the ICB and reflective of the Long Term Plan for Neighbourhood healthcare delivery. It is anticipated that metrics will be set for 2026/2027.

iv. (Tbc) Reduction in Admission of Those Over within the Older Persons Medicine age range cohort (65/80) - This Will Be Confirmed Once The System Wide Approach To OPM Has Been Finalised, Lead By The ICB.

This Priority is **to be introduced in 26/27**

Quarter 4 and Year End Update

This sub-priority metric target has not been confirmed. This will be confirmed once the system wide approach to OPM has been finalised, led by the ICB. It is anticipated that metrics will be set for 2026/2027.

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

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

Quarter 4 and Year End Update

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

The intervention aspect of the THEO project ended in January 2026. This project sought to ascertain whether having two additional members of staff available on Wards in a supernumerary and supportive capacity, undertaking non-medical interventions, would reduce Length of Stay (LOS) and patient safety incidents.

The 'measuring impact' aspect is currently underway with analysis expected to be completed by the University of Staffordshire in June 2026.

Quality Priorities For Improvement Agreed For 2024- 2027

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

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

1. What we set out to do (Priority):
We will implement and optimise our Patient Safety and learning Culture through the implementation of the Patient Incident Response Framework (PSIRF), QSAFE and learning from incidents
Why we chose this (Rationale):
Following the introduction the PSIRF in 2023 it is vital we embed and develop our learning from incidents culture, to ensure we have continuous improvement and learning
What we intend to achieve (Goal):
• 90% of our staff will be trained in Level one Patient Safety Syllabus • 90% of clinical and governance staff will be trained in Level 2 Patient Safety Syllabus • For 100% of Patient Safety Incident Investigations (PSIIs), there will be evidence that staff, patients and relatives have been involved in the investigation process. • All level 1 and 2 investigations will be supported by an agreed PSIRF tool and be fully utilised across the organisation • Monitor and see a reduction, year on year in complaints relating to any form of communication
How we will deliver and monitor progress:
We will monitor and see a reduction, year on year in complaints relating to poor communication when things go wrong, delays in responding to Patients, Families and staff concerns and not being informed of the outcome/findings
Responsible Person
Chief Nurse

This is priority is aligned with Clinical Effectiveness and Patient Safety

2. What we set out to do (Priority):
Deliver Personalised and Safe Care for Maternity and Neonatal service users through our Maternity Improvement Plan (MIP)
Why we chose this (Rationale):
The National Review of Maternity Services (Amos) and supplementary reviews currently underway e.g. Ockenden (Nottingham) and Kirkup (East Kent) are indicating continued improvements are required within maternity services nationally.

What we intend to achieve (Goal):

- Ensuring the lessons learnt from Amos, Ockenden and Kirkup are monitored through robust action plans delivered through the MIP demonstrating sustained and embedded improvements in practice, culture, leadership and governance.
- Annual reduction of preventable still births per 1000 live births
- Annual reduction of preventable 10% Neonatal deaths per 1000 live births
- Smoking at time of delivery 6%
- Have zero maternal deaths

How we will deliver and monitor progress:

We will deliver this priority and monitor through the Maternity Improvement Plan, reviewed yearly.

Responsible Person:

Chief Medical Officer, Chief Nurse, Chief Operations Officer

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

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

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

Why we chose this (Rationale):

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

What we intend to achieve (Goal):

- 5% year on year reduction in falls per 1000 bed days, based on the previous year's metric
- 5% year on year reduction in Hospital Acquired Pressure Ulcers per 1000 bed days, based on the previous year's metric
- 10% year on year reduction in medication incidents, based on the previous year's metric
- Achievement of trajectory as set out in the National Oversight Framework (NOF) for nationally reportable Gram Negative infections.
- >90% compliance with MUST Nutrition assessment completion within 6 hours of admission, based on the previous year's baseline metric
- Year on year improvements with Sepsis - Delivery of antibiotics within one hour (CCORT, Sepsis Audit)
- Improvement in all of the End of Life Metric's year on year. (NACL Audit/MAD audit)
- 100% of clinical areas assessed for ward accreditation and have achieved and maintained at least good

How we will deliver and monitor progress:

This will be monitored monthly through monthly Trust Quality Reporting to the Board
Responsible Person:
Chief Medical Officer, Chief Nurse

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

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

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

5. What we set out to do (Priority):
To deliver high standards of care and access to services for our Older Peoples Medicine.
Why we chose this (Rationale):
The Great Yarmouth and Waveney area has a greater than national average of those over 65 and is in the top 20 most deprived areas in the United Kingdom
What we intend to achieve (Goal):

- Establish an Older Peoples Medicine Multi-Disciplinary Team
- Develop and Enhance the Older Peoples Medicine Pathway with bespoke services that avoid admission
- Achieve a reduction in the length of stay
- Achieve a reduction in admission of those over 65 to 80
- Development in Research into non-medical interventions and measuring impact

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

How we will deliver and monitor progress:

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

Responsible Person:

Chief Medical Officer, Chief Nurse, Chief Operations Officer

2.2 Statements of Assurance from the Board

During 2025/265 the James Paget University Hospitals NHS Foundation Trust provided and/or subcontracted 56 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 2025/26 represents **100%** of the total income generated from the provision of relevant health services by the James Paget University Hospitals NHS Foundation Trust for 2025/26.

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

Clinical Audits and National Confidential Enquiries

During 2025/26 **65** national clinical audits and **7** national confidential enquiries covered relevant health services that James Paget University Hospitals NHS Foundation Trust provides.

During that period James Paget University Hospitals NHS Foundation Trust participated in **64/65 (98%)** 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 participated in during 2025/26 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 2025/26, 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].

Please note that the grey-shaded sections in the table below are not applicable to the Trust.

Audit Title	Provider	Relevant to JPUH Services?	Trust participation	Case Ascertainment
BAUS Data & Audit Programme: a) British audit of the investigation and referral of Women with Recurrent Urinary Tract Infection using recent Guidance (BOOMERANG)	The British Association of Urological Surgeons (BAUS)	Yes	Yes	100% (All applicable patients within audit timeframe)
BAUS Data & Audit Programme: b) Evaluating the Management Pathway for Suspected Testicular Cancer Referrals (EMPAST)	The British Association of Urological Surgeons (BAUS)	Yes	Yes	100% of cases uploaded
Breast and Cosmetic Implant Registry	NHS England	Yes	Yes	91% (37/40) Data entry ongoing
Case Mix Programme (CMP)	Intensive Care National Audit &	Yes	Yes	100% (728/728)

Audit Title	Provider	Relevant to JPUH Services?	Trust participation	Case Ascertainment
	Research Centre (ICNARC)			
Emergency Medicine QIPs: a) Adolescent Mental Health	Royal College of Emergency Medicine	Yes	Yes	Audit ongoing (commenced Jan 2026). Case Ascertainment not available.
Emergency Medicine QIPs: b) Care of Older People	Royal College of Emergency Medicine	Yes	Yes	Case ascertainment figures for the audit were not available at the time of reporting due to lack of access to the audit portal this being addressed.
Emergency Medicine QIPs: c) Mental Health Self Harm	Royal College of Emergency Medicine	Yes	Yes	83% (199/240)
Emergency Medicine QIPs: d) Time Critical Medications	Royal College of Emergency Medicine	Yes	Yes	Case ascertainment figures for the audit were not available at the time of reporting due to lack of access to the audit portal this being addressed.
Epilepsy12: National Clinical Audit of Seizures and Epilepsies for Children and Young People	Royal College of Paediatrics and Child Health	Yes	Yes	17/17 (100%)
Falls and Fragility Fracture Audit Programme (FFFAP): a) Fracture Liaison Service Database (FLS-DB)	Royal College of Physicians	Yes	Yes	Case ascertainment based on local FLS inclusion criteria: 60% (1069/1780) as of 16/04/2026, final submission deadline 31/05/26. Local restriction is age 50-80 years who have sustained rib, metacarpals and metatarsals fractures, unless 80+ and the patient is seen by the Orthogeriatricians. FLS-DB inclusion criteria is 50+ years.
Falls and Fragility Fracture Audit Programme (FFFAP): b) National Audit of Inpatient Falls (NAIF)	Royal College of Physicians	Yes	Yes	100% (8/8) for fractured neck of femur cases.
Falls and Fragility Fracture Audit Programme (FFFAP): c) National Hip Fracture Database (NHFD)	Royal College of Physicians	Yes	Yes	100% (516 cases)

Audit Title	Provider	Relevant to JPUH Services?	Trust participation	Case Ascertainment
Learning from lives and deaths – People with a learning disability and autistic people (LeDeR)	NHS England	Yes	Yes	100% (19/19)
National Adult Diabetes Audit (NDA): a) National Diabetes Core Audit.	NHS England (formerly NHS Digital)	Yes	Yes	100%
National Adult Diabetes Audit (NDA): d) National Diabetes Inpatient Safety Audit (NDISA)	NHS England (formerly NHS Digital)	Yes	Yes	100%
National Adult Diabetes Audit (NDA): e) National Pregnancy in Diabetes Audit (NPID)	NHS England (formerly NHS Digital)	Yes	Yes	100%
National Adult Diabetes Audit (NDA): f) Transition (Adolescents and Young Adults) and Young Type 2 Audit	NHS England (formerly NHS Digital)	Yes	Yes	Participation is automatic based on NDA Core and NPDA
National Adult Diabetes Audit (NDA): g) Gestational Diabetes Audit	NHS England (formerly NHS Digital)	Yes	Yes	100%
National Audit of Care at the End of Life (NACEL)	NHS Benchmarking Network	Yes	Yes	100% - 20 per quarter, total 80 patients (requirement - 20 to 70 cases per quarter)
National Cancer Audit Collaborating Centre (NATCAN): National Audit of Metastatic Breast Cancer (NAoMe)	Royal College of Surgeons of England (RCS)	Yes	Yes	100%
National Cancer Audit Collaborating Centre (NATCAN): National Audit of Primary Breast Cancer (NAoPri)	Royal College of Surgeons of England (RCS)	Yes	Yes	100%

Audit Title	Provider	Relevant to JPUH Services?	Trust participation	Case Ascertainment
National Cancer Audit Collaborating Centre (NATCAN): National Bowel Cancer Audit (NBOCA)	Royal College of Surgeons of England (RCS)	Yes	Yes	100%
National Cancer Audit Collaborating Centre (NATCAN): National Kidney Cancer Audit (NKCA)	Royal College of Surgeons of England (RCS)	Yes	Yes	100%
National Cancer Audit Collaborating Centre (NATCAN): National Lung Cancer Audit (NLCA)	Royal College of Surgeons of England (RCS)	Yes	Yes	100%
National Cancer Audit Collaborating Centre (NATCAN): National Non-Hodgkin Lymphoma Audit (NNHLA)	Royal College of Surgeons of England (RCS)	Yes	Yes	100%
National Cancer Audit Collaborating Centre (NATCAN): National Oesophago-Gastric Cancer Audit (NOGCA)	Royal College of Surgeons of England (RCS)	Yes	Yes	100%
National Cancer Audit Collaborating Centre (NATCAN): National Ovarian Cancer Audit (NOCA)	Royal College of Surgeons of England (RCS)	Yes	Yes	100%
National Cancer Audit Collaborating Centre (NATCAN): National Pancreatic Cancer Audit (NPaCA)	Royal College of Surgeons of England (RCS)	Yes	Yes	100%

Audit Title	Provider	Relevant to JPUH Services?	Trust participation	Case Ascertainment
National Cancer Audit Collaborating Centre (NATCAN): National Prostate Cancer Audit (NPCA)	Royal College of Surgeons of England (RCS)	Yes	Yes	100%
National Cardiac Arrest Audit (NCAA)	Intensive Care National Audit & Research Centre (ICNARC)	Yes	Yes	100% (69/69 cases April 2025 – March 2026)
National Cardiac Audit Programme (NCAP): c) National Heart Failure Audit (NHFA)	National Institute for Cardiovascular Outcomes Research (NICOR)	Yes	Yes	Data is submitted for all heart failure patients that the cardiac nursing team are aware of. A case ascertainment figure cannot be provided because the exact number of patients is unknown.
National Cardiac Audit Programme (NCAP): e) Myocardial Ischaemia National Audit Project (MINAP)	National Institute for Cardiovascular Outcomes Research (NICOR)	Yes	Yes	Data is submitted for all patients identified by the cardiac nursing team as having a discharge diagnosis of non-ST elevation myocardial infarction (NSTEMI). A case ascertainment figure cannot be provided because the exact number of patients is unknown.
National Child Mortality Database (NCMD)	University of Bristol	Yes	Yes	100%. Data for the National Child Mortality Database is submitted by the relevant Local Child Death Overview Panels.
National Comparative Audit of Blood Transfusion: 2025 Major Haemorrhage Audit	NHS Blood and Transplant	Yes	Yes	100%. 19 cases were identified that fit the required criteria
National Early Inflammatory Arthritis Audit (NEIAA)	British Society for Rheumatology	Yes	Yes	53% (20/38)
National Emergency Laparotomy Audit (NELA): Laparotomy	Royal College of Anaesthetists	Yes	Yes	100% (161/161)
National Emergency Laparotomy Audit	Royal College of Anaesthetists	Yes	Yes	100% (11/11)

Audit Title	Provider	Relevant to JPUH Services?	Trust participation	Case Ascertainment
(NELA): No Laparotomy				
National Joint Registry	Healthcare Quality Improvement Partnership (HQIP)	Yes	Yes	100%
National Major Trauma Registry	NHS England	Yes	Yes	100% (All relevant cases)
National Maternity and Perinatal Audit (NMPA)	Royal College of Obstetricians and Gynaecologists	Yes	Yes	100% The NMPA uses routinely collected data.
National Neonatal Audit Programme (NNAP)	Royal College of Paediatrics and Child Health	Yes	Yes	100%
National Ophthalmology Database (NOD): a) Age-related Macular Degeneration Audit	The Royal College of Ophthalmologists (RCOphth)	Yes	No	The Trust intended to participate in this audit, however this has not been possible without the Medisight EMR system
National Ophthalmology Database (NOD): b) Cataract Audit	The Royal College of Ophthalmologists (RCOphth)	Yes	Yes	100%
National Paediatric Diabetes Audit (NPDA)	Royal College of Paediatrics and Child Health	Yes	Yes	100% (145/145)
National Perinatal Mortality Review Tool (PMRT)	University of Oxford / MBRRACE-UK collaborative	Yes	Yes	100%
National Respiratory Audit Programme (NRAP): a) COPD Secondary Care	Royal College of Physicians	Yes	Yes	For period 01/01/25 to 31/03/25: 89% (114/128) For period 01/04/25 - 30/06/25 = 92% (82/89) For period 01/07/2025 - 30/09/2025 = 100% (80/80) For period 01/10/25 to 31/12/25 = 100% (83/83) Unable to provide case ascertainment for the period final period 1st January 2026 till 31st March 2026 as the NRAP deadline is not till 16th May.
National Respiratory Audit Programme (NRAP): c) Adult	Royal College of Physicians	Yes	Yes	For period 01/01/25 to 31/03/25: 84% (21/25)

Audit Title	Provider	Relevant to JPUH Services?	Trust participation	Case Ascertainment
Asthma Secondary Care				For period 01/04/25 - 30/06/25 = 100% (23/23) For period 01/07/2025 - 30/09/2025 = 100% (17/17) For period 01/10/25 to 31/12/25 = 100% (23/23) Unable to provide case ascertainment for the period final period 1st January 2026 till 31st March 2026 as the NRAP deadline is not till 16th May.
National Respiratory Audit Programme (NRAP): d) Children and Young People's Asthma Secondary Care	Royal College of Physicians	Yes	Yes	March 1st - December 31st 100% (79 cases) Data collection window for January 1st - March 31st is still open.
National Vascular Registry (NVR)	Royal College of Surgeons of England (RCS)	Yes	Yes	100%
Perioperative Quality Improvement Programme (PQIP)	Royal College of Anaesthetists	Yes	Yes	22 Patients recruited. This is a research study, so participation is voluntary and the number of eligible patients cannot be calculated.
Sentinel Stroke National Audit Programme (SSNAP)	King's College London	Yes	Yes	90%+ for 01/04/2025 - 31/12/2025. Final quarter report not yet received.
Serious Hazards of Transfusion (SHOT): UK National Haemovigilance Scheme	Serious Hazards of Transfusion (SHOT)	Yes	Yes	100% of known cases submitted for 01/04/2025 - 31/03/2026
UK Parkinson's Audit	Parkinson's UK	Yes	Yes	100% - 10 PREM questionnaires from patients, 20 patient clinic area audit and service audit.
UK Renal Registry Chronic Kidney Disease Audit	UK Kidney Association	Yes	Yes	Data submitted from NNUH pathology labs
UK Renal Registry National Acute Kidney Injury Audit	UK Kidney Association	Yes	Yes	Data submitted from NNUH pathology labs

Audit Title	Provider	Relevant to JPUH Services?	Trust participation	Case Ascertainment
British Spine Registry	British Spine Registry	No	N/A	
Cleft Registry and Audit Network (CRANE) Database	Royal College of Surgeons of England (RCS)	No	N/A	
National Adult Diabetes Audit (NDA): b) Diabetes Prevention Programme (DPP) Audit	NHS England (formerly NHS Digital)	No	N/A	
National Adult Diabetes Audit (NDA): c) National Diabetes Footcare Audit (NDFA)	NHS England (formerly NHS Digital)	No	N/A	
National Audit of Cardiac Rehabilitation	University of York	No	N/A	
National Audit of Cardiovascular Disease Prevention in Primary Care (CVD Prevent)	NHS Benchmarking Network	No	N/A	
National Audit of Eating Disorders (NAED)	Royal College of Psychiatrists	No	N/A	
National Bariatric Surgery Registry	British Obesity & Metabolic	No	N/A	
National Cardiac Audit Programme (NCAP): a) National Adult Cardiac Surgery Audit (NACSA)	National Institute for Cardiovascular Outcomes Research (NICOR)	No	N/A	
National Cardiac Audit Programme (NCAP): b) National Congenital Heart Disease Audit (NCHDA)	National Institute for Cardiovascular Outcomes Research (NICOR)	No	N/A	
National Cardiac Audit Programme (NCAP): d) National Audit of Cardiac Rhythm Management (NACRM)	National Institute for Cardiovascular Outcomes Research (NICOR)	No	N/A	
National Cardiac Audit Programme (NCAP): f) National Audit of	National Institute for Cardiovascular Outcomes	No	N/A	

Audit Title	Provider	Relevant to JPUH Services?	Trust participation	Case Ascertainment
Percutaneous Coronary Intervention (NAPCI)	Research (NICOR)			
National Cardiac Audit Programme (NCAP): g) UK Transcatheter Aortic Valve Implantation (TAVI) Registry	National Institute for Cardiovascular Outcomes Research (NICOR)	No	N/A	
National Cardiac Audit Programme (NCAP): h) Left Atrial Appendage Occlusion (LAAO) Registry	National Institute for Cardiovascular Outcomes Research (NICOR)	No	N/A	
National Cardiac Audit Programme (NCAP): i) Patent Foramen Ovale Closure (PFOC) Registry	National Institute for Cardiovascular Outcomes Research (NICOR)	No	N/A	
National Cardiac Audit Programme (NCAP): j) Transcatheter Mitral and Tricuspid Valve (TMTV) Registry	National Institute for Cardiovascular Outcomes Research (NICOR)	No	N/A	
National Clinical Audit of Psychosis (NCAP)	Royal College of Psychiatrists	No	N/A	
National Pulmonary Hypertension Audit	NHS England	No	N/A	
National Respiratory Audit Programme (NRAP): b) Pulmonary Rehabilitation	Royal College of Physicians	No	N/A	
Out-of-Hospital Cardiac Arrest Outcomes (OHCAO)	University of Warwick	No	N/A	
Paediatric Intensive Care Audit Network (PICANet)	University of Leeds / University of Leicester	No	N/A	
Prescribing Observatory for Mental Health (POMH): a) Improving the	Royal College of Psychiatrists	No	N/A	

Audit Title	Provider	Relevant to JPUH Services?	Trust participation	Case Ascertainment
quality of valproate prescribing in adult mental health services				
Prescribing Observatory for Mental Health (POMH): b) Use of clozapine	Royal College of Psychiatrists	No	N/A	
Prescribing Observatory for Mental Health (POMH): c) Use of medicines with anticholinergic (antimuscarinic) properties in older people's mental health services	Royal College of Psychiatrists	No	N/A	
UK Cystic Fibrosis Registry: a) Cystic Fibrosis - Adults	Cystic Fibrosis Trust	No	N/A	
UK Cystic Fibrosis Registry: b) Cystic Fibrosis - Children	Cystic Fibrosis Trust	No	N/A	
UK Interstitial Lung Disease (ILD) Registry	British Thoracic Society	No	N/A	
National Audit of Dementia (NAD)	Royal College of Psychiatrists	Audit did not take place	N/A	

The reports of **18** national clinical audits were reviewed by the provider in 2025/26 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 **18** national clinical audit reports reviewed:

Fracture Liaison Service Database (FLS-DB)

- ✓ Introduced direct-to-DXA (Dual-Energy X-ray Absorptiometry scan) pathways with more standardised documentation and templates to reduce admin time, and improved patient letters and invitation processes.

National Comparative Audit of Blood Transfusion

- ✓ Developed and approved a transfusion training tool for doctors, to be delivered as part of mandatory training.
- ✓ Introduced monthly ward-level documentation audits to be done by ward managers. Guide developed.

National Lung Cancer Audit (NLCA)

- ✓ Continuation of progress on existing action plan to expand Lung Cancer Screening programme. Coverage of the Lowestoft area is progressing. The major percentage of lung cancer diagnosis through this project were treated curatively.

UK Parkinson's Audit ✓ Joint guidelines are now place regarding critical medication management from the Pharmacy side.
National Asthma and COPD Audit Programme (NACAP/NRAP) ✓ Recruitment successful to fill gap in smoking cessation service. This is in support of the national recommendation to ensure that all people with COPD and asthma who smoke are offered evidence-based treatment and referral for tobacco dependency.
National Audit of Care at the End of Life (NACEL) – Round 5 ✓ Amendment made to the holistic needs assessment used by palliative care team to include question on ethnicity. This is in support of the national recommendation to have a comprehensive understanding of the population living in the local area including the palliative care and end of life care needs of those with intersectional disadvantage.

The reports of **141** local clinical audits were reviewed by the provider in 2025/26 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 (some of which have already been achieved) from local clinical audit reports reviewed:

NICE NG40 Major Trauma: Service Delivery – Recommendation 1.5.4 ✓ To implement a standardised pathway that clearly outlines the steps required for a rapid transfer process. This includes discussion with trauma network / specialty SpR, preparing the patient for transfer and arranging transportation within 10 minutes of the decision being made to transfer.	Trust-wide Cannulation and Caresite Audit ✓ Delivered Peripheral Vascular Access Workshops to train CSAs in ANTT (Aseptic Non-Touch Technique), caresite clamping, VIP scoring, and timely cannula removal.
Audit of DVT Ultrasound Scan Repeat Rates ✓ Implemented new departmental guidelines, incorporated into induction for rotating registrars and fellows to improve compliance with repeat imaging policy.	Assessing Diagnostic Sensitivity of CT & Ultrasound in Suspected Appendicitis ✓ Completed in-house training programmes for relevant staff including supervised scanning and tutorials. ✓ Ongoing training programme for sonographers with paediatric scanning for appendicitis has been introduced and is ongoing.
Door-to-Needle Time for Stroke Thrombolysis ✓ Established a local stroke thrombolysis / thrombectomy on-call system, following discussions at ICB level.	Management of Hyperkalaemia in Adults – Joint Guideline ✓ New "guideline" chart for hyperkalaemia introduced with glucose monitoring included. Approved in Emergency Department governance and implemented. ✓ Produced and disseminated a visual reference card and disseminated to nursing team and medical team (via teaching sessions).

Notification of Need for Irradiated Blood Components ✓ Implemented an ICU (Intensive Care Unit) Metavision electronic notes system prompt to prompt doctors to check special requirements especially if the patient has a history of haematological disease.	LDL-C (Low-Density Lipoprotein Cholesterol) Monitoring in Acute Coronary Syndrome ✓ Implemented a non-fasting lipid testing option on the ICE diagnostics system, removing a barrier to LDL-C measurement on admission.
Strong Opioid Prescribing in Palliative Care ✓ Updated the palliative care intranet tile with the latest Norfolk & Waveney opioid initiation and management guidance.	Virtual Fracture Clinic (VFC) Audit ✓ Injury Specific leaflets are available in Emergency Department containing QR code to VFC website. ✓ Clinics are run earlier in the day, to allow for same day follow up phone calls from consultants. ✓ A dedicated VFC typist has been employed to ensure patients receive their letters faster.
Time to first Consultant review round 2 ✓ Evening reviews of daytime admissions by the On Call Consultant are now carried out, as required.	Colposcopy Did Not Attend (DNA) Performance indicators Audit ✓ Text reminders have been put in place to send 1-2 months prior to follow up clinics reminding patients of their appointments.
Postnatal readmissions audit ✓ A new readmissions proforma has been implemented, with prompts of when to escalate to the senior medical team.	

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
Acute Illness in people with Learning Disabilities	To identify avoidable and modifiable factors in the care of patients with a learning disability who were admitted to hospital acutely unwell.	Yes	Yes	100%
Stabilisation of the Critically Ill Child	• To identify good practice and areas for improvement in the quality of care provided to patients 0-18th birthday who are critically ill and require stabilisation • To review the impact of delivering that care on staff, patients and parent carers	Yes	Yes	100%
Pleural Procedures	To identify areas for improvement in the quality of care for patients undergoing pleural procedures (chest drains). To review the incident investigations relating to 'pleural procedures (chest drains)' and associated lessons learned. To identify patient safety incidents that have not been reported.	Yes	Yes	100%
Rib Fractures	To identify areas for improvement in the quality of care for patients presenting to hospital with one or more rib fracture(s).	Yes	Yes	100%

Title	Aim	Relevant to JPUH Services	Trust participation	Percentage of Cases 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%
Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRRACE) - Maternal Morbidity Confidential Enquiries	Confidential enquiries into maternal deaths during and up to one year after the end of the pregnancy	Yes	Yes	100%
Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRRACE) - Maternal Morbidity confidential enquiry - annual topic based serious maternal morbidity	Confidential enquiries into cases of serious maternal morbidity on a rolling basis	Yes	Yes	100%
Mental Health Clinical Outcome Review Programme - Real-time data collection of probable suicide deaths by mental health in-patients and patients who died within 14 days of discharge	The NCISH database includes a national case series of suicide by patients under the care of mental health services over more than 25 years.	No	N/A	
Mental Health Clinical Outcome Review Programme - Suicide (& homicide) by people under mental health care	The NCISH database includes a national case series of suicide b patients under the care of mental health services over more than 25 years.	No	N/A	

Participation in Clinical Research

The number of patients receiving relevant health services provided or subcontracted by James Paget University Hospitals NHS Foundation Trust in 2025/26 that were recruited during that period to participate in research approved by a research ethics committee: 3313.

During 2025/26, Research & Development at the James Paget recruited 3313 patients to 48 research studies. Whilst this is a similar number of studies to that undertaken within 2024/25, this is a notable increase in the number of patients recruited this year (3313 in 2025/26 versus 1132 in 2024/25). This is mainly attributable to the 'Best4Screening' study, which was a community-led study focusing on early identification of oesophageal cancer, recruiting 2044 participants within the Norfolk and Waveney area.

Commissioning for Quality and Innovation (CQUIN) Framework

The amount of income in 2025/26 conditional upon achieving quality improvement and innovation goals is: **£0**

The amount of income received for the associated payment in 2025/26 was: **£0***

There were no nationally mandated CQUINs for 2025/26. This was a deliberate policy decision by NHS England, as opposed to an omission.

Care Quality Commission (CQC)

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

The Care Quality Commission **has not** taken enforcement action against James Paget University Hospitals NHS Foundation Trust during 2025/26.

The overall CQC rating for the James Paget University Hospital NHS Foundation Trust is 'Good'.

The Trust's most recent inspection from the Care Quality Commission (CQC) was of the hospital's maternity services, which took place on 16 September 2025. The outcome of this inspection was published on the 1st April 2026 with an improved rating of maternity services at our hospital from 'Inadequate' to 'Requires improvement'. Because of this outcome, the rating of the hospital overall has also been upgraded from 'Requires improvement' to 'Good'.

This inspection of maternity services came following an inspection in January 2023 where we were rated as 'Inadequate' and issued a warning notice, with the requirement of taking immediate actions to improve maternity services and reduce the risk of harm to mothers and babies. Since the outcome of the CQC's inspection in 2023, our hospital has worked hard to implement the immediate requirements following the warning notice, as well as the actions and recommendations from the full CQC report.

To achieve changes and rapid improvement to services, we implemented a comprehensive programme of improvement actions and its implementation has continued since the

inspection. The monitoring and oversight of the progress and effectiveness of the improvement programme continues being undertaken by an Executive Maternity Improvement Group led by the Executive Managing Director.

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

James Paget University Hospitals NHS Foundation Trust submitted records during 2025/26 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the published data:

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

Information Governance Assessment Report

James Paget University Hospitals NHS Foundation Trust Information Governance Assessment Report overall score for 2025/26 was [not available at time of writing] and was graded [not available at time of writing] *****

	JPUH 2020/21	JPUH 2021/22	JPUH 2022/23	JPUH 2023/24	JPUH 2024/2025	JPUH 2025/26
Data Security Protection Toolkit Assessment	Standards exceeded	Standards met	Standards exceeded	Standards met	Approaching Standards	Not Available at Time of Writing

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

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

Payment by Results

James Paget University Hospitals NHS Foundation Trust **was not** subject to the Payment by Results clinical coding audit during 2025/26 by the Audit Commission.

Data Quality

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

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

Externally, this includes the Data Quality Maturity Index[1] (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 (ED).

The data quality report submitted to the Information Governance Committee includes analysis from national teams on data quality and completeness. Alongside national insights, internal audit findings are shared with Divisional teams to drive improvement in data quality and completeness.

Learning from Deaths

Item 1

In the period 2025/26, **1,135** patients of the James Paget University Hospitals NHS Foundation Trust died.

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

- **255** in the first quarter (01/04/2025 to 30/06/2025)
- **274** in the second quarter (01/07/2025 to 30/09/2025)
- **304** in the third quarter (01/10/2025 to 31/12/2025)
- **302** in the fourth quarter (01/01/2026 to 31/03/2026)

[1] 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.

Item 2

During the 2025/26 period, out of the 1,135 patient deaths occurred, **56** (5%) cases were reviewed and/or investigated. The number of these cases reviewed and/or investigated each quarter is listed below:

- **16** in the first quarter (01/04/2025 to 30/06/2025)
- **10** in the second quarter (01/07/2025 to 30/09/2025)
- **16** in the third quarter (01/10/2025 to 31/12/2025)
- **14** in the fourth quarter (01/01/2026 to 31/03/2026)

Of these 56 cases, **53** (94%) were identified as requiring a case record review. The methodology used for this review is the Structured Judgement Review (SJR).

Of these 53 cases requiring an SJR, **4** were also reviewed or investigated under the Patient Safety Incident Framework applicable.

In addition, **5** cases were reviewed or investigated as per the applicable Patient Safety Incident Framework.

Of the 53 cases requiring an SJR, **20 (**representing **1.7%** of the patient deaths during 2025/26) cases are still going through the SJR process.

Item 3

Two of the 53 cases reviewed using the SJR methodology has identified that it was considered the deaths had the possibility of being preventable (estimated greater than 50-50 chance). These deaths occurred in October and November 2025.

Of those deaths that have been reviewed or investigated, in 7 cases the incident has been considered to have affected the outcome of the incident:

Period	The incident possibly affected the outcome	The incident probably affected the outcome	The incident caused the outcome	Total
Quarter 1 (Apr – Jun 25)	**2**	**0**	**0**	***2***
Quarter 2 (Jul – Sep 25)	**2**	**0**	**0**	***2***
Quarter 3 (Oct – Dec 25)	**1**	**2**	**0**	***3***
Quarter 4 (Jan – Mar 26)	**0**	**0**	**0**	***0***
TOTAL: 2025/26	***5***	***2***	***0***	**7**

Item 4

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

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

- Recognition and Escalation of the Deteriorating Patient
- Timeliness of Investigation and Treatment
- Sedation and Respiratory Risk
- Communication, Handover, and Safety Netting

- End-of-Life Care and Palliative Planning
- Documentation, Governance, and Systems
- System Pressures and Flow
- Positive Practice Identified

Item 5
A description of the actions which the provider has taken in the reporting period, and proposes to take following the reporting period, in consequence of what the provider has learnt during the reporting period (see item 4)

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

- Share learning through Wider Learning Forums, Grand Rounds (formal medical educational meetings focussing on specific cases), M&M meetings, Emergency Department Governance meetings, and thematic sessions, including case-specific presentations.
- Use QSAFE, LRTs, LeDeR, and direct feedback to SJR reviewers and the Medical Examiner to ensure learning visibility, accuracy of death certification, and governance oversight.
- Engage resident doctors to understand and address barriers to escalation and communication.
- Reinforce mandatory NEWS calculation at first contact and clear escalation standards.
- Review and standardise ED sedation practice, particularly for patients with respiratory compromise.
- Strengthen escalation and communication pathways for palliative transitions and ensure early palliative care referral when prognosis is poor.
- Share specialty-specific learning through Grand Rounds and specialty forums, including:
    - Early specialist review and biopsy strategies for complex gastrointestinal cancers
    - Clear trust-wide guidance that necrotising fasciitis is a clinical diagnosis requiring urgent surgical review and must not be delayed by imaging
- Use teaching cases to highlight diagnostic pitfalls and limits of investigations.
- Reinforce IMCA referral guidance where capacity is lacking or uncertain.
- Strengthen identity checks, mortuary processes, and record accuracy, including correction of documentation and coding errors.

Item 6
An assessment of the impact of the actions described in item 5, which were taken by the provider during the reporting period

The actions outlined above have contributed to improvements in clinical practice, as well as to the safety and quality of care. They have also enhanced awareness and understanding among staff of the importance of learning from patient deaths, supported through the sharing of learning across a range of forums, including Grand Rounds, Morbidity and Mortality (M&M) meetings, Emergency Department (ED) governance sessions, and other relevant platforms.

The Trust has transitioned away from the NHS England SJR Plus platform following its cessation at the end of March 2026. In response, an SJR module has been developed within the QSAFE system, enabling staff to directly enter SJR reviews in a more streamlined and accessible way.

New protocols for sedation in the Emergency Department have been approved, with particular emphasis on the management of patients with respiratory compromise.

An audit of Respect form completion has been completed and the findings presented at both Surgical and Medical Governance meetings.

QSAFE entries, PSIRF Tools and aggregated learning provide system-wide insight, strengthen management oversight, and support the identification and implementation of preventative actions.

Item 7

48 case record reviews were completed after 1st April 2025, which related to deaths which took place before the start of the reporting period.

The 48 case record reviews referenced in item 7 are additional to the 56 case record reviews referenced in item 2.

Item 8

1 of the cases mentioned in 'item 7' above were judged to be more likely than not to have been due to problems in the care provided to the patient.

Item 9

7 cases, representing **0.6%** of all patient deaths during 2025/26 are judged to have affected the outcome of the case.

2.3 Reporting Against Core Indicators

Summary hospital-level mortality indicator (SHMI)

	JPUH 2023/24	JPUH 2024/25	JPUH 2025/26	National Average 2025/26	Highest SHMI for FT	Lowest SHMI for FT
(a) Value and (banding) of the SHMI for the Trust	1.11 (as expected)	1.13 (as expected)	1.17 (as expected)	1.00	1.32	0.72

The SHMI for 2025/26 (December 2024 to November 2025) 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, overseen by the Learning from Deaths meeting, supported by patient safety processes and governance systems.

Hospital re-admissions

	JPUH 2022/23	JPUH 2023/24	JPUH 2024/25	National Average	Highest score for Foundation Trusts	Lowest score for Foundation Trusts
Patients aged 0-15 years	10.2%	12.6%	11.8%	13.0%	23.4%	1.2%
Patients aged 16 or over	11.8%	11.7%	11.0%	14.9%	21.8%	3.7%

Latest values can be found here:
Compendium - Emergency readmissions to hospital within 30 days of discharge - NHS England Digital

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

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

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

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

Patient reported outcome measures (PROMs)

PROMs – What is it?

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

The two procedures are:

- hip replacements
- knee replacements

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

PROMs participation rates

	JPUH 2022/23	JPUH 2023/24	JPUH 2024/25
Hip replacement surgery	57.0%	96.0%	80.0%
Knee replacement surgery	57.1%	102.7%	94.6%
All procedures	57.1%	99.4%	87.8%

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

*PROMs data for 2025/26 is not yet published, latest publication is available here: [MI] Patient Reported Outcome Measures (PROMs) in England, Final 2024/25 data - NHS England Digital

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

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

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

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

Responsiveness to the personal needs of patients

JPUH 2019/20	JPUH 2020/21	JPUH 2021/22	JPUH 2022/23	JPUH 2023/24	JPUH 2024/25	England score 2021/22
75.6	73.8	*not available	*not available	*not available	*not available	74.5

* Data publication, which was due to be released March 2023, has been delayed following the merger of NHS Digital and NHS England on 1st February 2023. As a result, the future presentation of the NHS Outcomes Framework indicators has been reviewed but data is currently 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 most recent iteration of the National Inpatient Survey was published in 2025, and overall experience was rated as 8.4/10 indicating a 'good' patient experience.

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

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

The National NHS Staff Survey Advocacy Score

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

JPUH 2025	England 2025	Highest score for Foundation Trusts	Lowest score for Foundation Trusts
6.37	6.63	7.89	5.17

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

Each autumn NHS staff in England are invited to take part in the NHS Staff Survey. The survey offers a snapshot in time of how people experience their working lives, gathered at the same time each year. Its strength is in capturing a national picture alongside local detail, enabling a range of organisations to understand what it is like for staff across different parts of the NHS and work to make improvements. The aggregated survey results are official statistics, providing a rich source of data that is used by a wide range of NHS organisations to inform understanding of staff experience locally, regionally and nationally.

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.
- ✓ Regular dialogue sessions with leaders across the Trust where they can bring the concerns and issues their team are experiencing to the attention of senior leadership, and work proactively together to address these, to make the James Paget a great place to work.
- ✓ Monthly Divisional 'Your Voice' session, to provide staff with updates on the ongoing performance of their Division and discuss with Divisional leadership where further improvements need to be made.

Clostridioides difficile (C.difficile)

This measure shows the number of cases of *C.difficile* infection that have occurred within the Trust amongst patients aged two years or over during the reporting period.

	JPUH 2023/24	JPUH 2024/25	JPUH 2025/26
Number of cases of *C.diff* infection	22	26	34

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 and stewardship
  - Encouraging the use of narrow-spectrum antibiotics
  - Limiting the duration of antibiotics usage
  - Engagement with clinicians around their practice
- ✓ Encouraging intravenous to oral switch.

Patient Safety Incidents

	JPUH 2020/21	JPUH 2021/22	JPUH 2022/23	JPUH 2023/24	JPUH 2024/25	JPUH 2025/26	Highest score for Acute (non-specialist) trusts	Lowest score for Acute (non-specialist) trusts
Number of patient safety incidents	5461	6009	6272	*13689	*11645	*11424	*Not available	*Not available
							JPUH	
Rate per 1000 bed days	39.9	37.2	37.4	*77	*70.4	*69.9	*Not available	*Not available
							JPUH	
Percentage of incidents resulting in Major Harm	0.5%	0.48%	0.3%	0.4%	*0.19%	*0.22%	*Not available	*Not available
							JPUH	
Percentage of incidents resulting in Death	0.09%	0.07%	0.08%	0.2%	*0.19%	*0.08%	*Not available	*Not available
							JPUH	

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

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

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

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

- ✓ Web-based Trust wide incident reporting system in place and embedded that allows people to report incidents without logging in to facilitate anonymous reporting.
- ✓ Quality checking of incidents continues on the Learning From Patient Safety Events Service (LFPSE) live reporting platform.
- ✓ The Trust's current position in terms of reporting of Patient Safety Incidents represents a stable position.
- ✓ From September 2023, the Patient Safety Incident Response Framework (PSIRF) came into effect, greatly changing the process for incident management and providing enhanced emphasis on learning and engagement with patients, relatives and staff.

- ✓ Trust patient safety priorities have been agreed and detailed in the trust Patient Safety Incident Reporting Plan (PSIRP)
- ✓ Daily Triage and Multi Disciplinary review takes place of all incidents reported and escalation to the three times weekly Safety Assurance and Action Group (SAAG), with external attendance from the ICB. This facilitates timely discussion of incidents and Near Miss incidents, allocation of patient safety priority incident category and agreement of the harm and learning pathway and immediate actions required.
- ✓ Patient Safety Improvement Management Meeting (PSIMM) receives escalation of themes and trends relating to patient safety topics and reporting of the learning achieved in the trust, related to patient safety and quality activity and implementation of PSIRF.
- ✓ Incident reporting and learning is also discussed at Divisional governance meetings monthly with trends and themes analysed and cascaded to wider teams.
- ✓ All data is provided by bed days/number of contacts for Divisions to provide context when analysing incident data.

NHS Oversight Framework Indicators

Performance against the relevant indicators and performance thresholds set out in the oversight documents issued by NHS England. For 2025/26 these are:

National NHS objectives 2025/26	Threshold 2025/26	Actual 2025/26
UEC: Improve A&E waiting times, with a minimum of 78% of patients admitted, discharged and transferred from ED within 4 hours in March 2026 and a higher proportion of patients admitted, discharged and transferred from ED within 12 hours across 2025/26 compared to 2024/25	4 Hours: 78% 12 Hours: 6.9%	71.02% 8.30%
Elective Care: Improve the percentage of patients waiting no longer than 18 weeks for treatment to 65% nationally by March 2026, with every trust expected to deliver a minimum 5% point improvement	60.1%	55.07%
Elective Care: Improve the percentage of patients waiting no longer than 18 weeks for a first appointment to 72% nationally by March 2026, with every trust expected to deliver a minimum 5% point improvement	69.4%	62.89%
Elective Care: Reduce the proportion of people waiting over 52 weeks for treatment to less than 1% of the total waiting list by March 2026	1%	3.95%
Cancer: Improve performance against the headline 62-day cancer standard to 75% by March 2026	75%	69.47%

For definitions for all Indicators, please see the use the link:
NHS England » 2025/26 priorities and operational planning guidance

Guardian of Safe Working Hours End of Year Report

This report summarises progress for the year ending 31 March 2026, ensuring that doctors are safely rostered and able to work within safe hours.
The doctors' work schedules are now compliant with the new contract, and the monitoring system for exception reporting is being used effectively. From 4th February 2026, a new reform has been implemented.
The Trust continues to ensure that any exceptions are raised appropriately and that an open and transparent culture is maintained.

1. Rota Gaps / Vacancies

We are now over-recruited in some specialities. See the table below for **Medical and Dental**.

Staff Group	**FTE Budgeted**	**FTE Actual**	**FTE Vacancy**	**FTE % Vacancy**
Add Prof Scientific & Technic	93.89	78.28	15.61	16.63%
Additional Clinical Services	801.49	719.25	82.24	10.26%
Administrative and Clerical	815.93	249.23	81.82	10.03%
Allied Health Professional	260.13	366.41	10.90	4.19%
Estate and Ancillary	377.23	43.39	10.82	2.87%
Healthcare and Scientist	50.67	471.92	7.28	14.37%
Medical and Dental	**461.89**	**471.92**	**- 10.03**	**- 2.17%**
Nursing & Midwifery Registered	1,139.01	1,093.23	45.78	4.02%
Total	**4,000.24**	**3,755.83**	**244.42**	**6.11%**

2. The Medical time to hire for 2025/26 in relation to 2024/25 and how it was managed

The Time to Hire (TTH) reporting system began in 2025, so a comparison of February 2025 and 2026 is provided.

Time to Hire is a key NHS Workforce Plan metric, aiming to reduce recruitment to eight weeks from advert to pre-employment checks, improving candidate experience and faster hiring.

The Provider Workforce Return (PWR) captures monthly data from NHS Trusts via TRAC online onboarding management and recruitment system, enabling consistent tracking across recruitment stages. This data supports NHS England's workforce planning and assurance activities.

Overall, the goal is to reduce Time to Hire, streamline recruitment, and improve candidate experience while maintaining effective local induction processes.

Table 1 **February 2025**

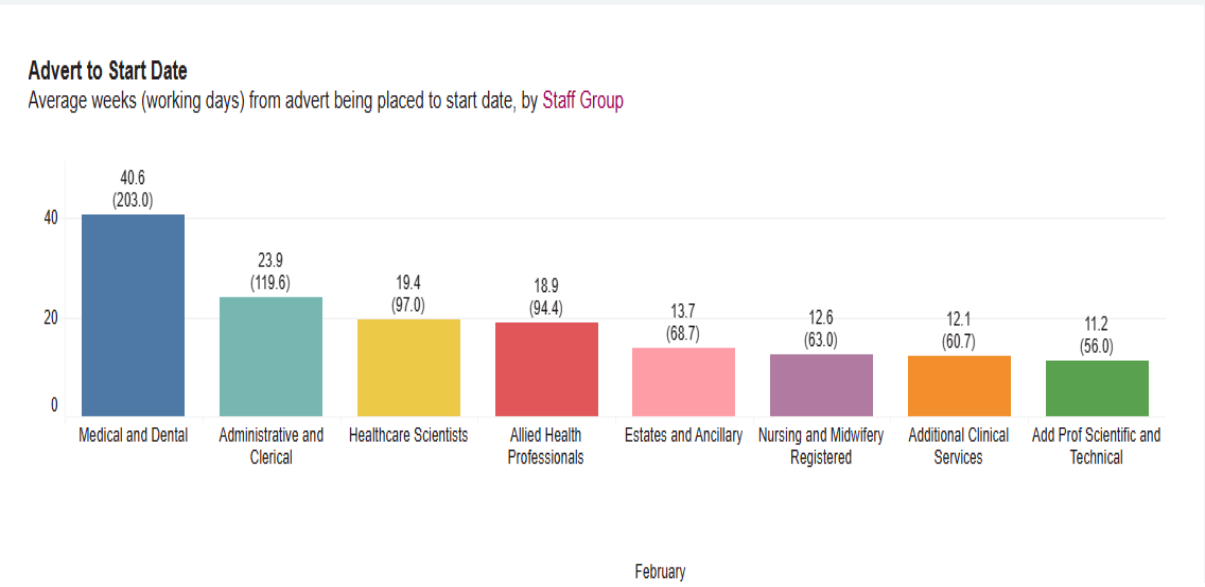
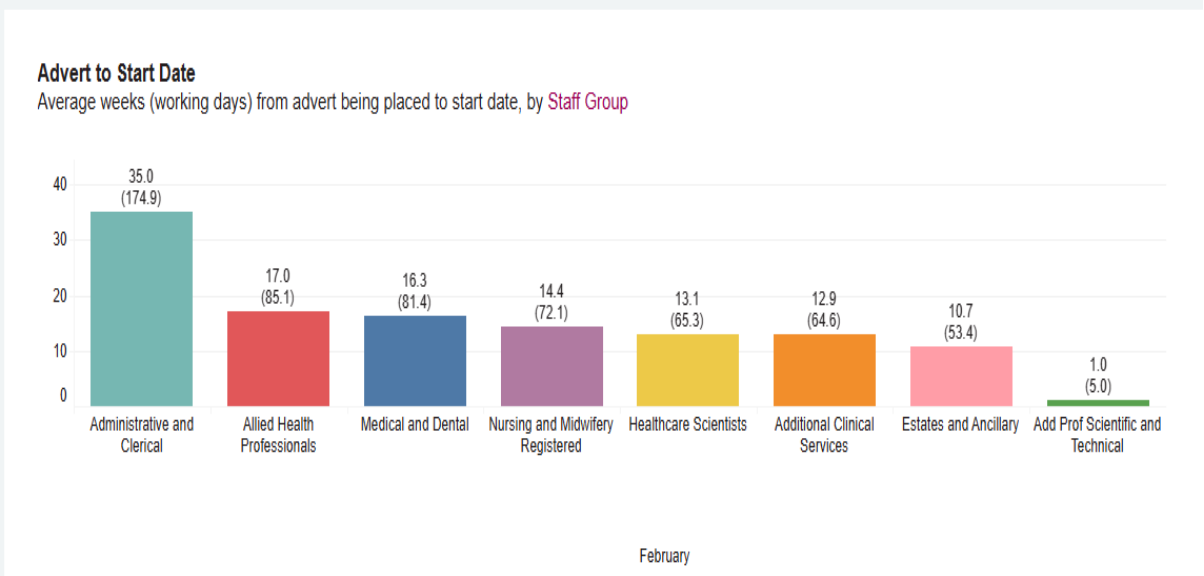


Table 2 **February 2026**



3. Specialties with Trainee Gaps:

No significant trainee gaps were identified in any specialty. There is now some over-recruitment in certain specialties (2.17%).

4. Wellbeing

There have been continuing improvements to the doctors' mess and rest facilities. Continued promotion of well-being support offered by the Trust, BMA, PSW EoE, and other external organisations remains in place for the medical workforce.

5. Exception Reports

Submitted Exception Reports 01.04.2025 to 31.03.2026

Exception Reports (ER) over past quarter	
Reference period of report	01/04/25 - 31/03/26
Total number of exception reports received	430
Number relating to immediate patient safety issues	17
Number relating to hours of working	371
Number relating to pattern of work	9
Number relating to educational opportunities	33
Number relating to service support available to the doctor	17
***Note** : Within the system, an exception relating to hours of work, pattern of work, educational opportunities and service support has the option of specifying if it is an Immediate Safety Concern (ISC). ISC is not an exception type by itself.*	

Exception Reports with Immediate Patient Safety Concerns
There were 17 exceptions reported related to Immediate Patient Safety Concerns in the last year, compared to 8 in the previous year. Most of these exceptions were in the first half of last year due to sickness and leave. No real immediate safety concerns identified.

Exception Reports Relating to Educational Opportunities
There were 33 exception reports related to educational opportunities in the last year. Almost all of them were either from missed teaching or self-development time (STD), busy ward and low staffing level.

Details and Response to Unresolved Exception Reports
No unresolved exception reports in the last year.

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

Work Schedule Reviews
No work schedule review in this year (2025-26).

6. Summary

There was a significant increase in exception reports over the past year compared with the previous year (430 v 298), largely due to encouragement to report and recent reforms to the exception reporting process.

Medical time to hire in 2025/26 improved compared with 2024/25, with over-recruitment observed in some specialties.

The Trust has continued to promote wellbeing initiatives and external support available specifically for the medical workforce.

Annex 1

Statements from Stakeholders

1. Norfolk and Suffolk Integrated Care Board

NHS
Norfolk and Suffolk
Integrated Care Board

Our Ref: JPUH QA25-26
26 May 2026

County Hall
Martineau Lane
Norwich
NR1 2DH

Direct Tel: 0800 389 6819
Web: www.norfolkandsuffolk.icb.nhs.uk
Email: nwicb.contactus@nhs.net

By email to Jacky Copping, JPUH
Chief Nurse

Dear Jacky

Quality Account Statement from Norfolk and Suffolk ICB (2025-26)

This letter confirms that the NHS Norfolk and Suffolk Integrated Care Board (ICB) has received the draft 2025/2026 Quality Account from James Paget University NHS Foundation Trust and welcomes the opportunity to provide this statement.

Based on the information and data available within the draft report, the ICB supports JPUH in the publication of its Quality Account for 2025/2026. The ICB is satisfied that the Quality Account incorporates the mandated elements. The ICB believes that the report includes some key elements of quality, as defined by the National Quality Board. It demonstrates the Trust's commitment to continuous improvement and quality improvement.

The ICB recognises the continual challenges experienced by the Trust over the last contractual year. There have been significant and sustained pressures across the health care system. The ongoing changes associated with the new group model for the three acute NHS trusts in Norfolk is acknowledged again this year. This year there have also been changes associated with NHS commissioning bodies, hence the newly formed Norfolk and Suffolk ICB. The wider footprint of the ICS provides the opportunity to work closely with additional system partners to influence the provision of high-quality healthcare, whilst still focusing on local places too.

The ICB has been pleased with the outcome from the recent CQC inspection of the maternity services in September 2025 and the published report in April 2026 regarding the safe and well-led domains. Maternity services are now rated as 'requires improvement' rather than 'inadequate'. This influences the overall rating of the Trust, and it is rated as 'good'. The enormity of the work undertaken within the maternity improvement plan is recognised, with 92 actions completed. Furthermore, the additional assurance through this being aligned to the Ockenden and Kirkup recommendations is noted.

The achievements within the quality priorities for 2025/2026 are noted. In particular, the work undertaken to promote patient safety is recognised. For example, the training compliance for the national patient safety syllabus exceeds the thresholds set. The ongoing work to embed the PSIRF tool into patient safety investigations provides assurance. This quality initiative is complemented and augmented by the quality initiative to reduce avoidable harm. The positive

outcome of the work to improve compliance with the MUST assessments at admission is commendable and it is acknowledged that the threshold set as an objective was exceeded. The expansion and relocation of the PALS service is commendable, creating a more visible and accessible service for patients and carers.

The ICB supports the Trusts commitment to its identified Quality Priorities for the forthcoming year. These build on the quality objectives set in the previous year.

The quality initiative to optimise the patient safety and learning culture is pleasing to see and it will be of interest to understand how this develops in the year ahead. It is likely that Martha's Law will have a positive impact and complement the work in relation to patient safety.

Particularly the aspiration to have a reduction in complaints associated with communication. The new quality initiative relating to safe and personalised maternity and neonatal care is particularly pertinent given the ongoing reviews, such as the Amos review and the importance of learning, implementing change, embedding new initiatives and monitoring for assurance. The planned pathway development for older people's medicine will be pivotal in promoting effective care and mitigating some admissions to hospital for older people. The ability of the Trust to work effectively with system partners will help to realise this ambition.

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

On behalf of NHS Norfolk and Suffolk ICB, I would like to thank you, the individuals involved in developing and producing this account and all Trust staff. We look forward to building on our collaborative relationship to ensure safe, effective care for our patients and local population during 2026/2027.

Yours sincerely

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

1. Health Watch Norfolk

Once again Healthwatch Norfolk (HWN) welcomes the opportunity to comment on the Quality Account 2025-26. We fully acknowledge the continuing economic and political turbulence within which the Trust is endeavouring to provide a quality service to all its patients, carers and families across Norfolk and Waveney.

Whilst it is a lengthy document to allow for the mandatory requirements of NHS England, it clearly demonstrates the work carried out by the Trust in terms of its quality priorities and goals for both 2025-26 and looking forward. Accessibility to the document incorporates its availability in different formats and includes a glossary of terms and abbreviations to aid ease of reading. The specific examples of work the Trust has done help to clearly illustrate the improvements to patient experience. This statement focusses on patient experience to reflect the core work undertaken by HWN.

Looking at the performance against the quality priorities set for patient safety, clinical effectiveness, and patient experience in 2025-6 in more detail, we note that many of the targets have duly been achieved. It is useful that, in many sections, the statistics relating to 2024-5 are included in the narrative to highlight progress (or not as the case may be). In particular, the continuing work around the involvement of patients and relatives in the investigations of patient safety incidents is welcomed by HWN. With regard to the failure to see a reduction in complaints about poor communication, HWN is willing to share examples of best practice in this area from the extensive engagement it has with a variety of patient groups. It would be useful to have a breakdown of the categories of complaints in order to understand any trends in other areas of complaints.

With regard to maternity services, whilst the target for the year on smoking at time of delivery was not met consistently throughout the past 12 months, we note that there have been significant improvements since 2024/25.

Whilst we appreciate that some of the quality priorities under the heading of Quality Priority 3 were not achieved (reduction in falls, in Hospital Acquired Pressure Ulcers, in medication incidents, in reportable Gram Negative infections

and 100% clinical areas assessed for ward accreditation achieved and maintained as at least good), it would be useful to learn of how work will be delivered by the Trust to help to ensure these targets are met during the forthcoming year.

In accordance with HWN's role in representing patients and the public we commend the Trust in the number of initiatives to improve patient and public engagement being successfully completed.

As the percentage of older people residing in Norfolk and Waveney is predicted to rise, HWN welcomes this area continuing to be reviewed and enhanced by all organisations working within the Norfolk and Waveney University Hospitals Working Group.

Looking ahead to 2026-27 we note the continuing quality priorities and goals as previously identified. We look forward to the Trust maintaining the improvements achieved in the past 12 months as detailed in the quality initiatives and we note the proposals to achieve improvements in those areas where targets have been missed. In particular we fully support the proposed goals relating to Engagement workshops, integrated partnership working and Older Peoples Medicine (reflecting the number of residents over 65 in the Great Yarmouth and Waveney area and it being in the top 20 of most deprived areas in the United Kingdom). It would be useful to have further details about the Trust's work on engagement workshops as this was also stated as a goal in last year's Quality Account.

The report details a considerable number of actions resulting from the Trust's involvement in many national and local clinical audit reports that have been reviewed. We also note the considerable number of patients (2044) recruited by the Research and Development team to participate in the community-led 'Best4Screening' study on early identification of oesophageal cancer.

HWN congratulates the Trust on the recently published Care Quality Commission (CQC) report on its Maternity and Midwifery Services Inspection which moved the rating from 'Inadequate' to 'Requires Improvement.' We are pleased to note the Trust's continued monitoring and oversight of improvements to these services.

As referenced above, the health and social care arena continues to face many challenges but despite that, we note that the staff survey advocacy score has improved from last year. We also note the additional initiatives put in place to offer more options for communication with staff.

Finally we are pleased to note the improvement in A&E waiting times over last year.

HWN fully acknowledges the challenging times for all organisations involved in the provision of health and social care services across Norfolk and Waveney including the building of two new hospitals and establishing the Electronic Patient Record System. We are fully committed to continuing to work with the Trust (alongside all our partners) to ensure the experiences of all patients, families and carers are reflected in the opportunities to provide a quality service. We would welcome an opportunity to meet with senior management at the Trust to discuss future quality priorities and goals.

Overall we would like to congratulate the Trust on its achievements as detailed in the Quality Account and we look forward to continuing to develop our working relationship in this area during the coming year to ensure the provision of a safe and quality service remains a priority.

Alex Stewart
Chief Executive Officer
May 2026

Annex 2

Statement of directors' responsibilities for the quality account

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

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

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

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

- the content of the quality account is not inconsistent with internal and external sources of information including:
  - Trust minutes and papers for the period **01.04.2025 to 31.03.2026**
  - Papers relating to quality reported to the Trust over the period **01.04.2025 to 31.03.2026**
  - feedback from commissioners dated **26.05.26**
  - feedback from local Healthwatch organisations dated **19.05.26**
  - CQC inspection report dated **01.04.26**

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

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

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

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

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

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

By order of the board: **Date: 25/06/2026** **Chair**

Date: 25/06/2026 **Chief Executive**

Glossary of terms and abbreviations

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

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

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