Our Vision
The best care
for every patient

NHS
Norfolk and Norwich
University Hospitals
NHS Foundation Trust

Annual Quality Account




2025/2026

Quality Account 2025/26 – Contents

Foreword

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

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

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

Scope and Structure of the QA

This report summarises how well the Norfolk & Norwich University Hospitals NHS Foundation Trust ('NNUH' or 'the Trust') did against the quality priorities and goals we set ourselves in 2025/2026. It also sets out the quality priorities we have agreed for 2026/27 and how we intend to achieve them.

The report is divided into three parts:

Part One: includes statements from our Chief Executive and Managing Director.

Part Two: Looks at our performance in 2025/2026 against our quality priorities we set for the year and also sets out the quality priorities for 2026/2027. Part two also includes statements of assurance relating to the quality of services and describes how we review them.

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

The annexes towards the end of the report include comments from Healthwatch, the Integrated Care Board (ICB) and our Governors. If you would like this document in another language, large print, Easy Read or braille, please email: communications@nnuh.nhs.uk

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

Part 1 - Joint Group Chief Executive and Executive Managing Director Statement on Quality

We are delighted to introduce the Norfolk and Norwich University Hospitals NHS Foundation Trust (NNUH) Quality Account for 2025/26. This report sets out our progress over the last year, the areas where we know further improvement is required and the priorities, we have agreed for 2026/27.

Our commitment remains clear: to provide the best care for every patient. That means care which is safe, effective, compassionate, timely and centred on the needs of patients, families and carers. It also means creating the conditions in which our staff can do their best work, feel supported, speak up, learn, improve and take pride in the services they provide.

The last year has been one of significant change for NNUH. We have continued to work within a challenging NHS environment, with sustained pressure across urgent and emergency care, high demand for inpatient beds and ongoing patient flow challenges. We have also had to make difficult decisions at times to maintain safety and access to care. We remain clear that temporary escalation spaces (also known as corridor care) should not become normal practice. Reducing reliance on these spaces, improving flow through the hospital, and supporting timely discharge remain key priorities for the organisation.

Despite these pressures, there has been important progress. Elective and cancer pathways have shown improvement during the year, including stronger performance against the 28-day Faster Diagnosis Standard and improving 62-day cancer performance. Our National Oversight Framework position has also improved, reflecting progress in cancer performance, waiting list reduction and delivery against our financial plan. We also exited enhanced regional expenditure controls, which restores greater local autonomy and provides a stronger platform for sustained improvement.

We have continued to invest in services that improve access, experience and outcomes for patients. The Community Diagnostic Centre has completed its first year, increasing diagnostic capacity across MRI, CT, ultrasound and X-ray, improving performance and reducing reliance on mobile diagnostic units. We also marked 10 years of robotic surgery at NNUH, supported by charitable funding that has enabled the arrival of two additional da Vinci robots. This investment has doubled our robotic surgery capacity and will help more patients benefit from less invasive procedures, improved precision and faster recovery.

Patient safety has remained central to our quality improvement work. During 2025/26, we strengthened our approach to the recognition and escalation of clinical deterioration, including the successful launch of Martha’s Rule across adult, maternity, paediatric, neonatal and emergency care. This provides an important additional safety route for patients, families, carers and staff to raise concern where a patient’s condition may be deteriorating. We have also continued work to improve NEWS2 training and escalation, sepsis recognition, and the reliability of senior clinical review.

We have made further progress in frailty services. The Frailty Hub has continued to develop, the Clinical Frailty Scale app is now available on Trust devices, and work with community partners is helping to support care closer to home where this is clinically appropriate. The development of pathways with care homes, Frailty Same

Day Emergency Care and community virtual ward services reflects the importance of working with partners to provide the right care, in the right place, first time.

Learning from deaths, incidents, complaints, patient experience and clinical outcomes continues to inform our quality priorities. For 2026/27, we have agreed a focused set of priorities that reflect the areas where improvement will have the greatest impact. These include speaking up, psychological safety and the civility & respect programme, inclusive leadership and ward leader development. We are also focusing on mortality reviews, clinical documentation, coding accuracy and system learning, recognition and escalation of clinical deterioration, and reducing avoidable harm from healthcare-associated infections.

These priorities deliberately bring together safety, culture, leadership and learning. We know that sustainable improvement in patient care depends on a culture where staff feel able to raise concerns, where teams are treated with respect, where leaders are visible and supportive, and where learning leads to action. The 2025 National Staff Survey results show that staff experience has deteriorated across a number of important areas, although flexible working remains above the national acute trust average and the inclusion sub-theme improved. We take these findings seriously. They reinforce the need for sustained focus on leadership visibility, communication, support to line managers, civility, psychological safety and ensuring colleagues' voices are heard during organisational change.

This year has also seen further development of the Norfolk and Waveney University Hospitals Group. The Group model gives us an opportunity to work more closely with partners at James Paget University Hospitals and The Queen Elizabeth Hospital, King's Lynn, reducing unwarranted variation, strengthening clinical resilience, improving sustainability and sharing learning across our hospitals. While NNUH will retain its local identity and focus on the communities it serves, we believe that working together across Norfolk and Waveney will help us improve care for patients and provide greater opportunities for staff.

We would like to thank our staff, volunteers, governors, partners, patients, families and carers for their contribution during the year. We are grateful to colleagues across the Trust for their commitment, professionalism and compassion, often in very pressured circumstances. We are also grateful to those patients and families who have shared their experiences with us, whether positive or negative. Their feedback is essential to helping us understand what matters most and where we need to improve.

We are proud of the progress made during 2025/26, but we are not complacent. There is more to do to improve urgent and emergency care, reduce long waits, strengthen safety systems, improve staff experience, and ensure consistently high-quality care across all services. Our Ambition for Excellence sets out our direction: improving quality and safety, strengthening flow and access, making better use of our workforce, estate and finances, and embedding education, research and innovation as core parts of how we improve.

We confirm that, to the best of our knowledge, the information contained within this Quality Account reflects a true, accurate and balanced picture of our performance.

Lesley Dwyer
Group Chief Executive
Norfolk and Waveney
University Hospitals Group

Shane Gordon
Executive Managing Director
Norfolk and Norwich University
Hospitals NHS Foundation Trust

Our Trust PRIDE Values

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

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

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

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

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

Part 2 – Priorities for improvement and Board Statement

Part 2.1 – Priorities for Improvement

New Quality Priorities

QP1 – Speaking Up, Psychological Safety and the Vanderbilt Patient Safety Programme	
Rationale	By 31 March 2027, create a psychologically safe culture where staff feel confident to raise concerns, are treated with civility and fairness, and see timely action and learning from issues raised, supported by the implementation of the Vanderbilt Patient Safety Programme. **Purpose:** To create a psychologically safe culture where staff feel confident to speak up, are treated with civility and fairness, and see timely action and learning from the concerns they raise. Implementing the Vanderbilt Patient Safety Programme will provide a consistent structure for teams to identify risks, learn from defects, strengthen teamwork and embed Just Culture principles in everyday practice.
How these will be monitored and measured	**Outcome measures:** • NHS Staff Survey we each have a voice that counts from 6.15% to 6.3% by March 2027 and ≥6.6 by March 2028 • Psychological safety pulse improves by ≥10 percentage points by March 2027 **Process measures:** • ≥85% staff aware of Freedom to Speak Up • ≥90% FTSU contacts acknowledged within 2 working days • ≥80% concerns receive “You said – We did” feedback within 30 days • Detriment risk assessment training for all line managers ≥90% by March 2027 • Speak up and listen up training for all line managers ≥90 % March 2027 • Business case for the Vanderbilt Patient Safety Programme approved by September 2026. • Commencement of training for the Vanderbilt Patient Safety Programme September 2026.
Executive Lead and Delivery Leads	Director of Workforce Freedom to Speak Up Guardian Deputy Responsible Officer Care Group Associate directors

QP2 – Civility, Respect, Inclusive Leadership and Ward Leader Development	
Rationale	By 31 March 2027, embed civility, respect and inclusive leadership behaviours across all teams and strengthen leadership capability through the development of a structured Ward Leader Development Programme to reduce variation in staff experience and support safe, effective care. **Purpose:** To build a consistently compassionate, respectful and inclusive culture across all wards and teams by strengthening leadership capability through a structured Ward Leader Development Programme. This programme will equip leaders with the skills and behaviours needed to foster psychological safety, positive team climates and fair, supportive people management, enabling staff to feel valued, heard and able to deliver safe and effective care.
How these will be monitored and measured	**Outcome Measures:** • NHS Staff Survey: Inclusive & Compassionate Leadership metrics from 6.7% to 7.0% by March 2027 and ≥7.4 by March 2028 • NHS Staff Survey: We are a team from 6.4% to 6.7% by March 2027 and ≥7.0 by March 2028 • Improved leadership confidence scores following Ward Leader Development Programme **Process Measures:** • ≥90% managers complete license to lead training by March 2027. • ≥90% ward leaders enrolled in the Ward Leader Development Programme by March 2027 • Bottom 10% scoring teams in the NHS staff survey metrics of Inclusive & Compassionate Leadership supported with targeted leadership interventions
Executive Lead and Delivery Leads	Chief Nurse Associate Director of Clinical Risk & Governance, Quality Improvement and Patient Safety Unplanned Care Nurse Director Planned Care Nurse Director

QP3 – Mortality Reviews, Clinical Documentation, Coding Accuracy and System Learning	
Rationale	By 31 March 2027, strengthen mortality review processes, improve the quality and timeliness of clinical documentation and coding, and enhance triangulated system learning so that insights from deaths, incidents, deterioration and patient experience reliably drive timely improvement, accurate reporting, and early identification of risk. **Purpose:** To ensure that every patient's care is accurately documented, reviewed and learned from, so that risks are identified earlier, avoidable harm is reduced, and improvements are delivered swiftly and consistently across the whole organisation.
How these will be monitored and measured	**Outcome Measures:** • Summary Hospital-level Mortality Indicator (SHMI) reduced to 110 by March 2027, and further to 95 by March 2029 following Electronic Patient Record (EPR) implementation • Reduction in the proportion of Structured Judgement Review (SJRs) identifying problems in care **Process Measures:** • ≥75% mortality reviews completed within 60 days • ≥75% mortality review learning actions agreed and completed within 60 days • ≥95% episodes coded within Trust standard time frame • Care Group oversight at Directorate Operations Manager (DOM) with regular triangulation of SHMI, mortality themes, deterioration data and coding audits. • Updated and revised learning from deaths policy in situ by September 2026 • Review of the mortality governance system and feasibility study to transition to InPhase.
Executive Lead and Delivery Leads	Medical Director Head of Clinical Business & Reporting Clinical Lead for Clinical Audit, Morbidity and Mortality Care Group Associate Directors

QP4 – Recognition and Escalation of Clinical Deterioration	
Rationale	By 31 March 2027, we will reliably recognise and escalate clinical deterioration to reduce avoidable harm and minimise unplanned critical care admissions. This will be achieved through high-quality physiological monitoring, timely escalation and senior clinical review, and full integration of Martha's Rule across all inpatient areas. **Purpose:** Is to ensure that all deteriorating patients are recognised early and escalated reliably, reducing avoidable harm and preventing unnecessary unplanned critical care admissions. Creating a consistent, high-reliability safety system in which physiological deterioration is detected promptly through high-quality monitoring, and escalation pathways are followed without delay, supported by timely senior clinical review.
How these will be monitored and measured	**Outcome Measures:** • A reduction in the number of moderate or severe harm level related to incidents of failed escalation of a deteriorating patient on InPhase by March 2027. • ≥15% reduction in unplanned critical care admissions with a NEWS2 ≥10 by March 2027 • ≥10% reduction the number of patients scoring a NEWS2 ≥10 on referral to RRT by March 2027. • ≥10% increase in patients who have been diagnosed with sepsis receiving antibiotics within one hour of NEWS2 rise by March 2027. **Process Measures:** **Recognition** • ≥90% compliance with NEWS2 repeated within recommended timeframe by March 2027. • ≥ 90% compliance with NEWS2 eLearning by March 2027. **Escalation** • ≥90% documented evidence of escalation when a patient scores a 3 in one parameter or ≥5 on their NEWS2 score by March 2027. • ≥90% compliance with medical review taking place within recommended timeframe by March 2027. • ≥20% reduction in median time from NEWS2 trigger to first clinical review by March 2027. **Martha's Rule Implementation** • ≥90% compliance with completion of the Patient Wellness Questionnaire by March 2027. • ≥95% of staff aware of Martha's Rule and the escalation processes by March 2027.
Executive Lead and Delivery Leads	Medical Director Lead Critical Care Consultant Specialist Nurse Practitioner in Recognise and Respond Team Care Group Associate Directors

QP5 – Reduce healthcare-associated infections and harm by strengthening prevention, early identification and system reliability	
Rationale	By 31 March 2027, reduce avoidable harm from healthcare-associated infections at NNUH by strengthening prevention, early identification and management of MRSA bacteraemia, Clostridioides difficile and E. coli ensuring sustained compliance with national surveillance requirements, reducing hospital-onset infection, and improving assurance to the Board and regulators. **Purpose:** To reduce avoidable harm from healthcare-associated infections by improving the prevention, early detection and effective management of MRSA bacteraemia, Clostridioides difficile and E. coli infections across NNUH. Creating a consistent, proactive approach to infection prevention by strengthening clinical vigilance, ensuring timely recognition of early warning signs, and embedding reliable processes for antimicrobial stewardship and source control.
How these will be monitored and measured	**Outcome Measures:** **Hospital-onset MRSA bacteraemia** • **Baseline:** Most recent confirmed UKHSA annual position (FY 2024/25) • **Target:** Zero tolerance for preventable hospital-onset MRSA (all HOHA & COHA cases reviewed) **Hospital-onset C. difficile infection (CDI) (HOHA & COHA)** • **Baseline:** FY 2024/25 UKHSA data • **Target:** Remain within the UKHSA objectives for 2026/27 by March 2027. Sustained performance at or better than expected range relative to peers **Hospital onset E.coli infection (HOHA & COHA)** • **Baseline:** FY 2024/25 UKHSA data • **Target:** Remain within the UKHSA objectives for 2026/27 by March 2027. Sustained performance at or better than expected range relative to peers **Process Measures:** **Prevention and early identification** **MRSA screening compliance** • **Measure:** % of eligible screened within policy timeframe. • **Target:** ≥95% compliance for eligible emergency and elective admissions by Month 6, sustained **Appropriate isolation for suspected or confirmed infection (C.diff, MRSA BSI, multi resistant E.coli BSI)** • **Measure:** % patients isolated within policy timeframe • **Target:** ≥90% compliance by Month 6; ≥95% by Month 12 **Environmental cleaning assurance** • **Measure:** % IPC environmental audits rated compliant

	• **Target:** ≥95% compliant audits Trust-wide by Month 12 **Antimicrobial stewardship and clinical practice** **Antibiotic review and optimisation for Blood Stream Infection (BSI)** • **Measure:** % of patients on antibiotics reviewed within 48–72 hours of the positive blood culture being reported via microbiology discussion with clinical team. (MRSA and E.coli BSI) • **Target:** ≥90% compliance by Month 9 **C. difficile care bundle compliance** • **Measure:** % CDI cases meeting full care bundle (isolation, monitoring, treatment, review) (*parameters if required isolation within 2 hours of onset of symptoms, review and monitoring at least weekly, treatment reviewed on MDT ward round) • **Target:** ≥95% compliance by Month 6, sustained **Learning, review and assurance** **Case review quality** **MRSA BSI** • **Measure:** % MRSA BSI (HOHA & COHA) cases reviewed using a structured, just-culture approach • **Target:** 100% of cases reviewed within 30 days by Month 6 **Learning to action** • **Measure:** % IPC review actions implemented within agreed timescale • **Target:** ≥80% actions closed within 60 days by Month 12 **Feedback to frontline teams** • **Measure:** % cases where learning is shared with the originating ward/team • **Target:** ≥80% feedback provided within 30 days by Month 9 **CDI** • **Measure:** % CDI (HOHA &COHA) cases reviewed using a structured, just-culture approach • **Target:** 100% of cases reviewed by Post Infection Review (PIR) through the first available monthly meeting by Month 6 **Learning to action** • **Measure:** % action review of learning identified through PIR process reported back to HICC via care group quarterly report • **Target:** ≥80% actions closed within 60 days by Month 12 **Feedback to frontline teams** • **Measure:** % cases where learning is shared with the originating ward/team • **Target**: ≥80% feedback provided within 30 days by Month 9

	E.coli BSI • **Measure:** % E.coli BSI (HOHA & COHA) cases reviewed using a structured, just-culture approach • **Target:** 100% of cases reviewed within 30 days by Month 6 **Learning to action** • **Measure:** % action review of learning identified through review at IP&C surveillance meeting reported back to HICC via care group quarterly report • **Target:** ≥80% actions closed within 60 days by Month 12 **Feedback to frontline teams** • **Measure:** % cases where learning is shared with the originating ward/team • **Target:** ≥80% feedback provided within 60 days by Month 9
Executive Lead and Delivery Leads	Chief Nurse Deputy Director Infection Prevention & Control Clinical Lead for Infection Prevention & Control Care Groups Associate Directors

Patient Safety

QP1 – Care of patients who are frail: Develop Comprehensive Acute Frailty Services	
Rationale	Patients who are frail make up a substantial proportion of patients presenting to urgent and emergency care settings. Early, comprehensive assessment of these patients can improve outcomes by ensuring the acute care, management pathway, and future care plans are all tailored appropriately to the patient's needs. An Acute Frailty service routinely and systematically identifies and grades frailty in people who present acutely to Urgent and Emergency Care services. These services then consider the personalised needs of individuals living with frailty, considering their grade of frailty and degree of illness, supported by clear reliable pathways into and out of hospitals, aligned to the grade of frailty identified. The aim is to provide care in the right place, first time. This may be in the patient's home for a group of patients or through Same Day Emergency Care (SDEC) aiming to get the patient home with onward care as soon as initial diagnostics and treatment have been initiated. SDEC aims to reduce admissions and thus deconditioning of patients who would otherwise be admitted to hospital.
How these will be monitored and measured	• Standardised mortality rates • Patient experience • Quality Indicator 'Identification and response to frailty in emergency departments'
Executive Lead and Delivery Leads	Medical Director
Progress during 2025/2026	• The Frailty Hub was introduced in July 2025 following a reconfiguration of older people services and spaces. • Clinical Frailty Scoring (CFS) app to support scoring CFS is now available on all Trust devices. • Pathway developed with Frailty and UCCH to case hold patients in Care Homes overnight and transport arranged to bring patient into Frailty Same Day Emergency Care (FSDEC) the next morning for assessment, radiology with return transport prebooked. • Frailty Directorate and Governance meetings commenced and plans to meet monthly. • Work commenced with community colleagues to reduce admissions from Care Homes through neighborhood health. • Portfolio of missed opportunities and shared learning for patients where care could have been managed in the community shared through EPIN (External provider incident notification). Learning also discussed at Frailty Governance. • Provider engagement workshop to improve Care Home or Nursing Home discharge information attended by stakeholders including members of the JPH, QEH, SS and ICB teams. • Frailty therapy working group to discuss challenges to the discharge process and patient's flow.

	• Working with Community virtual ward to develop working relationship to increase numbers of patients being discharged with Community virtual ward.
Workplans for 2026/2027	• OPM Bed flow Nurses to manage all OPM/ frailty beds. • Increasing frailty training with East of England and community partners. • Continuing work with neighborhood health and community partners to develop pathways of admission avoidance through the silver line and virtual links to CH's. • Continue to share learning from missed opportunities. • Provider engagement workshop to continue monthly to increase engagement and Trusting relationships through the sharing of learning and presentations. • Delirium working group to increase education and development of a delirium pathway, including an assessment bundle of 4AT, CFS and News 2 within 1 hour of admission in unplanned admission areas.

QP2 – Reducing our standardised mortality scores through specific pathway improvement and clinical data quality improvement: Early recognition of Deterioration and Sepsis, and implementation of Martha's rule	
Rationale	Acute physical deterioration can occur in any health and care setting and is a dynamic process in which a patient becomes suddenly more ill, potentially leading to death. It can be identified by changes in standard physiological indicators. Early identification of clinical deterioration is important in preventing subsequent cardiopulmonary arrest and to reduce mortality. Sepsis is a life-threatening emergency in which timely diagnosis and emergency therapy has been shown to reduce mortality. Evidence indicates that access to a rapid review from a critical care outreach team (CCOT) or paediatric critical care outreach team is an additional and beneficial safety net in the identification, escalation and response to deterioration.
How these will be monitored and measured	• Reducing standardised mortality scores from current baseline • Patient experience 'being listened to' and achievement of key milestones for implementation of Martha's Rule. • Increase in the percentage of patients with timely repeat observations • Monitor Trust compliance of NEWS2 eLearning Package • Timely medical response to NEWS2 score trigger
Executive Lead and Delivery Leads	Medical Director Rapid Response Team Matron Consultant Lead for Acute Medical Unit (AMU)
Progress during 2025/2026	**<u>Early detection and treatment of deterioration</u>** During this financial year, the NEWS2 escalation sticker has been made available to all inpatient ward areas to aid in the ease of documentation when a patient triggers on their NEWS2 score. Audits show documented evidence of

	escalation has increased from 33% in December 2024 to an average of 57% in December 2025. Slight improvement in the number of patients who received repeat observations and a medical review within correct timeframe, but significant progress still required. NEWS2 eLearning updated to include sepsis and Martha's Rule. Compliance with eLearning dropped throughout this year but has improved for the last 2 months and continues to be disseminated to Care Groups to encourage annual completion. NEWS2 AIMS audit transferred from Tendable to InPhase and improvements made to make the results from these audits more robust. Setting up of Deteriorating Patient Working Group in progress to take audit findings and drive improvement plans. **Early detection and treatment of sepsis** Trust SOP and audit templates updated to reflect changes in antibiotic guidance and updated NICE Guidance from NG253. Sepsis screening included as part of recent audit to assess current compliance and is encompassed into the NEWS2 escalation sticker to improve compliance. Ongoing work with digital team to build red and amber flag sepsis processes into the EPR alongside mandatory sepsis screening. Sepsis deep dive completed to assess where the delays are in the process of recognising, diagnosing and treating sepsis in relation to mortality data. This showed sepsis was not always the cause of death despite this being the coded diagnosis. Annual sepsis audit showed an improvement in both the percentage of patients diagnosed within one hour and receiving their antibiotics within one hour. Again, this remains far off our target but shows an improvement on last year. **Martha's Rule component 1 – Patient Wellness Questionnaire** Patient Wellness Questionnaire has been trialled and approved and is available for staff to use in electronic and paper formats. Patient Wellness Questionnaire rolled out across all adult inpatient areas as of 3rd March. All inpatient areas compliant with Component 1 with MEWS and PEWS covering maternity and paediatric areas. **Martha's Rule component 2&3 – Martha's Rule Telephone Escalation Service** Martha's Rule Telephone Escalation Service rolled out on 3rd March 2026 to all adult, maternity, paediatric and neonatal inpatients as well as the emergency department. SOP in final stages of development and approval to cover the whole Martha's Rule process. Robust processes in place to ensure appropriate review for all patients, depending on their speciality.
Workplans for 2026/2027	This will continue as a Quality Priority into 2026/2027 see the detail in new Quality Priority 4.

QP3 – Reducing our standardised mortality scores through specific pathway improvement and clinical data quality improvement: Heart Failure Pathways	
Rationale	Across Norfolk there are 8,600 patients who have been diagnosed with heart failure by their GP, but there are probably another 6,000 to 10,000 who haven't been diagnosed yet. Heart failure patients can rapidly deteriorate, leading to long hospital admissions, and this condition is the most frequent cause of hospitalisation for over 65-year-olds. Currently there are gaps in provision and many undiagnosed patients are seen in our Emergency Department. By establishing a dedicated service, we can achieve better continuity of care and a better experience for patients, their families and the clinicians. Last year there were 1,600 admissions, accounting for 17,000 hospital bed days for patients with heart failure. Hospitals admissions are expensive, they can also be harmful for patients, reducing their mobility and independence, and by intervening earlier we hope to avoid them.
How these will be monitored and measured	• Reducing our standardised mortality scores for heart failure pathways • Improve patient experience: by removing delays, provide appropriate assessment to support shared decision making about priorities of care and treatments. • Evidence of a standardised approach to the treatment of heart failure patients across all the healthcare providers in Norfolk and Waveney.
Executive Lead and Delivery Leads	Medical Director Cardiology Consultant (Heart Failure)
Progress during 2025/2026	**<u>Improvement in 6 month rolling SHMI through increased depth of coding and improvements in clinical care</u>** In the 2 year period since the 2022/23 SHMI data suggested significantly high mortality, there has been a stepwise reduction in standardized mortality. For 2022/23 the NNUH SHMI was 138, which at the time was the largest outlier in the country. In 2023/24 the figure was 130, 2024/25 120 and in the 12 months to July 2025 (the latest data available), 115. This reduction has been across both Cardiology and OPM (which each take around 45% of heart failure admissions), with Cardiology's SHMI reducing from 96 to 68, and OPM from 165 to 143 over the period from 2022/23 to July 2025. OPM remains an outlier more than 2 standard deviations from the mean but has significantly improved. Analysis of the data suggests that initial improvements in 2023/24 were likely strongly contributed to by increase in coding depth, as there was an increase in mean codes and expected deaths increased without a change in number of admissions, but that subsequent improvements were predominantly due to clinical factors. Local analysis of patient-level coding data matched to patient level heart failure audit data has shown that patients reviewed by the heart failure nursing team (established to current numbers in 2023) are 60% less likely to die, in

	multivariate analysis. Univariate analysis has shown that HFSN review is associated with a 10% absolute reduction in risk of dying, and that the effect is more pronounced in patients cared for by non-cardiology teams. Combined, these data sources suggest that increased coding depth has contributed to a reduction in standardized mortality, but clinical improvements led by the heart failure nursing team have significantly contributed due to improved care. **Establishment of HF specialist nurse posts within the cardiology budget** Extensive work marrying NNUH data from NHFA with Business Intelligence coding data has allowed analysis of more detailed heart failure audit date with more complete coding data. This has shown that inpatient heart failure nurse review is associated with a significantly lower risk of dying. Interim analysis of effect of Cromer heart failure nurse medication optimisation clinic has shown significant reduction in risk of admission. NNUH HFNS team Nurse-led medication optimisation clinics: Norwich 19 patients per week. **North Norfolk Community pilot** A 12-month pilot was launched in North Norfolk in March 2025 to provide a tailored HF service, reflecting the area's ageing population, focussing on regular patient reviews to optimise medication, adherence, and support lifestyle management. Operating across 6 GP practices and referring to the Cromer heart failure clinic for initiation and titration of Sacubitril-Valsartan, early outcomes showed increased medication uptake within the first three months, with further opportunities for expansion identified. A review will take place in early 2026 to determine whether the pilot should continue. **ICS HF programme board** • Service gap analysis • Triage HF remote HF monitoring • Shared care agreements with primary care • Beat to Treat early diagnosis pathway • Ortis i-Health pilot and representation on the ICS virtual hospital work programme. • Focused echo project JPUH, QEH.
Workplans for 2026/2027	• To continue developing the HF referral pathway and integration of an automated NT-ProBNP triangulation process to improve early intervention rates. • To embed HF services at the forefront of system-wide Virtual Ward workstreams and ensure Cardiology specialist representation across the various Task and Finish groups. • To fully utilise the TriageHF monitoring system and expansion into similar devices for all eligible patients fitted with a CIED who have HF. • To increase the equity of access of HF services for in-patients under the OPM teams.

	• To establish a Primary Care HF Interest Group aimed at fostering improved collaboration, facilitating shared learning, and enhancing the provision of advice and guidance between primary and secondary care providers. • To maintain Transformation support for HF Board activities.

QP4 – Hospital@Night (H@N) transformation programme optimising out of hours care to deliver high quality safe care at night and supporting the wellbeing of those working at night.	
Rationale	Hospital at Night is a clinically driven and patient focused approach to managing care out of hours, which has the capacity to call in specialist expertise when necessary. It advocates supervised multi-speciality handovers; other staff taking on some of the work traditionally done by resident doctors and moving a significant proportion of non-urgent work for the night to the evening or daytime. There is an emphasis on team working and flexibility across Specialities. The existing Hospital at Night model has been in place since January 2012 when the Trust made a commitment to working towards a 24/7 approach to the deteriorating ward patient and Hospital at Night was renamed Hospital 24/7. This Quality Priority will review the current hospital 24/7 model to ensure that it encompasses all hospital wide escalation processes including but not limited to, Recognise and Respond Team, and use of Alertive to provide safe care at night.
How these will be monitored and measured	• Response times to H@N requests • Staff experience of H@N • Evidence of updated 24/7 handbook
Executive Lead and Delivery Leads	Medical Director H@N Site Matron Medicine Division Chief of Division
Progress during 2025/2026	• A feedback survey for the H@N service was created and rolled out to understand staff experience and areas for improvement which has helped build a clear picture of process refinements required to better support staff. • We continue to monitor the number of jobs that are put through on to the H@N system overnight and the suitability of these jobs for H@N, providing education to both nursing and medical teams on whether they are appropriate, this has appeared to have a positive impact on the number of jobs that we are receiving. • Following feedback from our Learning from Incidents Oversight Group all abnormal lab results received by H@N are shared with the appropriate teams as an additional safeguard. • Surgical teams have moved to using H@N rather than the previous system. The teams have adapted well to inputting jobs on H@N and now medical and surgical teams have the same support methods across the Trust. • H@N Doctor's sickness has reduced in comparison to previous periods.
Workplans for 2026/2027	• Continue with current strategies to ensure safe delivery of care overnight • Continue to work with Business Intelligence to design a H@N dashboard

Clinical Effectiveness

QP5 – Reducing our standardised mortality scores through specific pathway improvement and clinical data quality improvement: Frailty and Fragility Fractures, Management of Older Major Trauma Patients	
Rationale	The care of patients with fragility fractures of the femur has long demonstrated the importance of the coordinated input of multiple specialties in improving patient outcome. Concerted and effective pathways involve nurses, doctors, therapist and allied healthcare professionals both in hospital and in the community setting. Ageing, comorbid disease, medications and frailty may all affect the expected physiological presentation of major trauma in older people. Many patients with orthopaedic trauma injuries have to be admitted to hospital, most frequently due to associated frailty, immobility or co-morbidities. Older patients have been consistently shown to have poorer outcomes following rib fractures, which may be related to: • Multiple comorbidities; • Reduced physiological reserve; • Greater difficulty in assessing and managing hemodynamics.
How these will be monitored and measured	• Reducing our standardised mortality scores for specific pathways • Improve patient experience: by removing delays, provide appropriate assessment to support shared decision making about priorities of care and treatments
Executive Lead and Delivery Leads	Medical Director Deputy Medical Director
Progress during 2025/2026	**<u>Neck of Femur Pathway</u>** Over 94% NOFs were admitted to the dedicated OMU SHIMI for NOF Nov 24 – October 25 as expected (slightly lower than expected) **<u>Fracture Liaison:</u>** A bid as part of the neighborhood health programme for the Fracture Liaison Service was submitted and to be reviewed via HLT/Neighborhood programme. A review of the current provision in all three Trusts was completed as part of this process. The new service proposed is going to provide a best practice option where previously we were looking at minimal changes to address service critical issues. This will result in a better service for our patients in the future. **<u>ED Silver Trauma Sieve</u>** Audit data available for silver trauma alerts with targeted project assigned to TIGER (Trauma Interest Group Emergency) Sieve is now being reviewed on the back of numbers of expected calls (NMTR data) vs Alertive data on actual calls and parameters tweaked to ensure early identification of silver trauma

Workplans for 2026/2027	Will be progressed via the Group neighborhood health programme. It is proposed that new outpatient clinics be introduced in the Trust to meet the expected requirement of 2500 new and 4000 follow up patients per year in 5 half day clinics per week. It is expected this will positively affect patient independence and mobility by reducing recurrent fractures and LoS for patients. Consideration for colocation of Silver Trauma across wards – 'OMU' outreach service to be considered

QP6 – Improving Patient Flow to improve patient and staff experience and reduce number of patients cared for in escalation areas	
Rationale	Improving patient flow is not just about resourcing and expanding urgent and emergency care capacity to keep pace with rising demand – it is also about delivering transformation in how services are delivered, expanding out-of-hospital capacity, embedding preventative approaches and realising the benefits of emerging technologies.
How these will be monitored and measured	Improvement measures to include: • Patient experience • Reduction in the number of escalation beds • Virtual ward dashboard metrics • Door to needle time (AOS)
Executive Lead and Delivery Leads	Director of Operations Medicine Division Triumvirate
Progress during 2025/2026	Work completed has included:- • Establishing correct bed bases with all our of newly formed Care Groups. • All new doctors inductions have been updated to include information on the right patient in the right place and the associated protocols. • Rollout of a specialty report to allow each Speciality to easily identify where their patients are and afford them ownership of the "problem" - find their own solutions as to how to accommodate their patients within their bed base. The idea is to empower teams drive what is needed to do to accommodate their patients as opposed to feel "done to". • Pilot set up with Older Peoples Assessment Service as well to take direct referrals from Emergency Department and Older Peoples Emergency Department to help support early care for this patient cohort • Success pilot of Overnight Admissions Avoidance Pathway. Though small patient numbers however saves up to 4 admissions per day.
Workplans for 2026/2027	This will be reviewed at a group level as part of the One Recovery programme.

QP7 – Elective care recovery and Theatre Transformation / Cancer services	
Rationale	In line with 2024-2025 operational planning guidance to support elective care, a Theatre Transformation Programme has been implemented. The aim of this programme is to first drive an increase in theatre utilisation towards 85% and second, increase the level of day case procedures to 85%. This increase in both theatre utilisation and increased levels of day case procedures will help to reduce current waiting lists, whilst ensuring patients are getting the right care in the right location.
How these will be monitored and measured	• Reduction in on-the-day cancellations • Improved theatre utilisation tracked through Data Matrix System • Theatre utilisation rates target 85% • Rate of Day case target 85% • Reduction in agency spend
Executive Lead and Delivery Leads	Director of Operations Transformation lead(s)
Progress during 2025/2026	• Aimed to book all lists to 90%+ utilisation. Introduced no adjustments to planned times, to improve booking quality and ensure correct use of procedure codes. • Removed paper on-the-day cancellation forms, digitised the process – improving data quality. • 6- week forward look for anaesthetic cover, reducing the short notice cancellation of theatre lists and as a result patients. • 80% utilisation between April – September.
Workplans for 2026/2027	**<u>Patient Value Board Workstreams</u>** • Text messaging service particularly across the specialties with highest on the day cancellations. • Continue to support the 6-4-2 list booking process, look back meetings and monitor attendance of senior representatives from specialty teams. Work with the specialty teams to review booking practices and create action plans. • Explore and implement a ‘standby patient’ process where able to do so. • POA – increase physical space capacity, increase time between POA and TCI. **<u>Pilot “No change May”</u>** • Theatre lists to be locked at 2 and 1 week as per 642 guidance and no additions to lists to be granted. • This will support POA to catch up with overwhelming demand of POAs at short notice, allow the bed base configuration work to be finalised so booking teams know what parameters they can freely work within without request. • Support booking teams to get further ahead and therefore POA requests with more notice.

	Accepted risks: • Lower booking percentage as short notice cancellations come in and requests to replace are declined. • Understanding that most of the time the last minute booked cases are resulting in OTD cancellations and therefore not increasing throughput or utilisation but purely putting pressure on POA and booking teams.

QP8 – Pharmacy Transformation Programme: delivering high quality efficient, productive care.	
Rationale	Recruitment and retention challenges (national shortages, plus competition with primary care roles and band inflation at neighbouring acute trusts) Inadequate job cover and succession planning for key roles (single point of failure). Inadequate levels of pharmacy staff to be able to provide reliable services to ward / departments and train new starters / students. Low staff morale and full potential of Pharmacist and Pharmacy Technician roles not understood or utilised by wider Trust. Lack of capacity to participate in clinical and practice research, and to deliver value added pharmaceutical clinical support for in patients and outpatient clinics.
How these will be monitored and measured	• % automation, patient & staff satisfaction, error rate, medicines reconciliation (MR) rate • Patient satisfaction, Dispensing Turnaround time, Reduction in Missed doses • Error rates and critical incidents • % growth of clinical trials and practice research • Cost Improvement Programme (CIP) Savings
Executive Lead and Delivery Leads	Medical Director Chief Pharmacist Clinical Support Services Division Director of Operations
Progress during 2025/2026	• Pharmacist workforce more stable, with fewer resignations in this financial year. Large increase in the number of trainee pharmacists interested in employment with the Trust as a newly qualified pharmacist. • New specialist pharmacist posts created and embedded within care groups delivering specialist clinical care as well as delivering CIP. • No pharmacy technician resignations, and all pre-registration pharmacy technicians qualifying in the 12-month period recruited to substantive pharmacy technician posts. • No science manufacturing technician resignations and all trainee science manufacturing technicians qualifying in the 12-month period recruited into substantive science manufacturing posts. • Skill mix of all posts and grades as staff turnover to ensure appropriate workforce for the present time. • Pharmacy robot was installed and switched on 30th March.

	• Pyxis cabinet delivered and in use for the emergency drug cupboard. • CII safe installed and in use managing controlled drugs within the department. • Clinical trial work continues to expand, with the team fully staffed and now looking to recruit a clinical trial specialist working in the aseptic unit to support oncology/haematology trials. • New dispensary facility is planned for the Quadram Institute to help with space issues that are experienced within the main department. • New methods of clinical working adopted in ward areas, with the aspiration of delivering care closer to the patient (limited by staffing levels currently). • £7million saving on medicines procurement for CIP.
Workplans for 2026/2027	• Collection of baseline data following robot implementation. • Collection of data for the benefits realization of the robot project including Pyxis cabinet and CII safe. • Management meeting to explore staff roles and activity following the implementation of the robot. • Development of medium to long term workforce plan. • Skill mixing of staff budget to ensure 2 x PTPTs due to qualify in September can be retained as qualified staff. • Continued work on SOC for aseptic unit and isolator replacements.

QP9 – Health Inequalities: Equality, Diversity and Inclusion (EDI) and Diversity, Inclusion and Belonging (DIB) including developing and delivering a Core20PLUS5 plan	
Rationale	For some people there are still unfair and avoidable inequalities in their health as well as their access to and experiences of NHS services. Health inequalities are the preventable, unfair and unjust differences in health status between groups, populations or individuals that arise from the unequal distribution of social, environmental, and economic conditions within societies. They can determine the risk of people getting ill, their ability to prevent sickness, or their opportunities to take action and access treatment when ill health occurs. The approach defines a target population cohort – the 'Core20PLUS' – and identifies '5' focus clinical areas requiring accelerated improvement.
How these will be monitored and measured	• Completed self-assessment. • Approved improvement plan based on self- assessment. • Evidence of ongoing progress against improvement plans for each workstream.
Executive Lead and Delivery Leads	Medical Director Associate Medical Director Primary Care and Integration Named workstream leads
Progress during 2025/2026	We have introduced new anti-racism signage and digital screen savers across the Trust to reinforce inclusive values and awareness for patients, visitors and staff. We delivered a Medical Grand Round to educate, engage, and inspire staff across the Trust to become better informed and make mindful improvements that help reduce health inequalities experienced by our patients. Improvement delivery projects include the introduction of the Interpreter on Wheels service which helps ensure patients who require translation services can communicate effectively. The Interpreter on Wheels offers over 240 foreign languages 24/7 and British Sign Language 8-5 Monday – Friday. Within the last year, we have also undertaken a review of our Accessible Information Standards (AIS). These standards ensure people with disabilities, impairments, or sensory loss receive information in accessible formats. This has included a local staff survey, education, and promotion of resources and policies available in the Trust. Finally, the Trust has agreed contractual changes with the ICB for 2026/27, strengthening the focus and requirements on health inequalities.
Workplans for 2026/2027	Introduce a local Health Inequalities Ambassadors programme in 2026/27 to support engagement, awareness, and delivery of improvement initiatives at a local level. Develop and implement targeted interventions within priority pathways (e.g. maternity, mental health, long-term conditions) where inequalities are most pronounced, using population health data to guide focus. Align health inequalities within the transformation and left shift work. Engage with EPR teams to ensure health inequalities metrics are measurable within reporting once EPR live.

Patient and Staff Experience

QP10 – Transition Pathways for young people	
Rationale	The transfer of health care for children and young people into adult services can often be difficult. In many cases, the health needs of young people will have been met by the same people who have looked after them for as long as the child or young person can remember. As they reach adulthood, they 'transition' to an adult healthcare environment and may be faced with having to consult with several different health teams, therapy teams and adult social care services. This Quality Priority will ensure that no child or young person will become lost in the gaps between children and adult services, and their experience of moving between services will be safe, well planned and prepared for. They will feel supported and empowered to make decisions about their health and social care needs.
How these will be monitored and measured	• Evidence that Quality Standards (QS140) have been met • Patient experience
Executive Lead and Delivery Leads	Chief Nurse Lead Transition Nurse
Progress during 2025/2026	• At start of year there was no data on number of transition patients in each specialities • Gathered initial Transition data from specialities on number of patients within Transition age and where possible number of patients within each stage of transition. • Identified Transition link within each specialty with Paediatric **<u>Pathway planning</u>** • Rheumatology • No defined transition pathway for Rheumatology. • Ready steady was completed by clinicians but not all patients getting paperwork in a timely manner. • Pathway is now developed • First full Adult and paediatric MDT in November 2025, including consultants, nurses, physio and OTs. **<u>Transition clinics</u>** • Epilepsy transition is now taking place monthly. ▪ Adult community Epilepsy nursing team attend ▪ Waiting list for transition has been reduced all 18 year old have transitioned into adult services. • Rheumatology ▪ First full Transition clinic completed attended by adult and paediatric nurses and physio, OT and Paediatric consultant ▪ Liasing with adult rheumatology team for adult, consultant to attend

	▪ Positive feedback from patient and staff • Diabetes ▪ Diabetes Transfer clinic is now in place with full team from adults and paediatrics and feedback from staff and patient is very positive • Introduction of Ready steady go clinic to support specialties with no Clinical Specialist Nurses (Renal, Cardiology, Neurology) Exploring Digital Ready Steady Go Transition Package • Would provide ▪ Data gathering ▪ Ease of use for patient, no printing required (currently 22 colour pages per patient) can be sent via email or QR code ▪ Document that can be uploaded to mediviewer/EPR ▪ Ability to monitor transition for all services
Workplans for 2026/2027	• Continue with process for Digital ready steady go • Continue work around accurate transition data • General Ready Steady Go Clinic to capture those without CNS to support for Transition • Continue with gathering feedback for inpatient experience of young people in adult services • Continue with conversation with EPR team to build how transition will look going into EPR

QP11 – Improving Communication around End-of-Life Care	
Rationale	Poor communication with patients as they approach the end of their life is a recurring theme in complaints, feedback from the Medical Examiner reviews, Structured Judgement Reviews and in the results of the National Audit of Care at the End of Life (NACEL). NNUFT has around 3000 deaths per year during admission or in the 30 days after discharge, and it is estimated that 30% of inpatients in acute hospitals are likely to be in their final year of life. As stated in the "Ambitions for Palliative and End of Life Care National Framework", end of life care "has to be considered as everybody's business". This is because the majority of end-of-life care will be carried out by generalists working in all specialties across the hospital. Good communication, advance care planning and individualisation of care are recognised to be essential components of good end-of-life care in the National End of Life Care Strategy (2008), Ambitions for Palliative and End of Life Care National Framework 2021-2026, and National Institute for Health and Clinical Excellence (NICE) Quality Standard QS144 (2017). The Integrated Care Board has recently carried out a review which identified the actions that are urgently required to ensure that it delivers its statutory duty in the provision of palliative and end-of-life Care for Norfolk and Waveney, in accordance with the National Delivery Plan. The delivery of personalised care and to support planning was one of those urgent priorities. Improving the timing, quality and effectiveness of communication with patients and their loved ones offers an opportunity to greatly enhance the quality of the care experienced by our patients. By identifying and clarifying patient's wishes and preferences as they approach the end of their life, good communication has the potential to not only enhance patient autonomy but can also reduce unwanted attendances at the Emergency Department, reduce admission to hospital, and shorten length of stay in hospital.
How these will be monitored and measured	• Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) audit • Individualised Plan of Care (IPOC) audit • Reduction in complaints related to communication at End of Life (EOL) • Improvement in communication identified through Structured Judgement Review (SJR) • Increase in numbers of patients with a documented Advanced Care Plan (ACP) • EOL care lead appointed Increase in patients achieving preferred place of death (via Inter Deanery Transfer (IDT) data)
Executive Lead and Delivery Leads	Chief Nurse Palliative Care Consultant and Specialty leads
Progress during 2025/2026	• ReSPECT training, Finding the words/ACP, Sage and thyme training all continue. • ACP Clinic in Cromer continues 100% achievement in ACP.

	• Memory maker service implemented, supporting patients and families and facilitating EOL conversations.
Workplans for 2026/2027	**<u>Education and Raise Awareness</u>** Continue of Courses, Education and role modelling. With additional requests to management to support staff attending. **<u>Accreditation of Excellence Program Audits</u>** Continue completing audits, identifying gaps and provide bespoke training focused on PEOLC **<u>ICB N&W ReSPECT Policy – NNUH SOP</u>** Working with Resus Lead to implement new SOP which will then be communicated to all stakeholders. **<u>ReSPECT training</u>** Continuing to review new ideas on how to ensure all CNSs attend the training with their management support. **<u>NACEL Audit Completion</u>** Nacel Audit to continue **<u>Community Support and Information Hub</u>** Plan volunteers and ongoing works **<u>Systems</u>** Continue development on EPR and new EPACS system, MCCR

QP12 – Improving learner experience	
Rationale	To meet requirement of education contract, and obligation as a University Teaching Hospital, ensure we are supporting our future workforce and meet our responsibility to be an exporter of excellence. To satisfy the General Medical Council standards and exit enhanced monitoring for Curriculum coverage, Staff behaviour; Supportive environment and Time for training
How these will be monitored and measured	• Data from the various surveys of learner and trainee experience: • National Education and Training Survey (NETS) • GMC and Staff Survey questions • Health Education England (HEE) Quality Assurance Framework
Executive Lead and Delivery Leads	Medical Director Director of Medical and Dental Education Associate Director for Education
Progress during 2025/2026	1) Purple flag is now on InPhase and we have had one issue which was raised this quarter. 2) Student feedback form has now been launched at the last Learner and Engagement Experience Group (LEEG) meeting (11 March 2026) and sent to UEA 1.1 student nurses. It has also been circulated to other professional groups. 7 learners have completed it so far (5 x 1.1 adult nurse students; 2 therapeutic radiology students). We will be reviewing the feedback on a monthly basis as part of the process to feedback to Care Group Leads. 3) NETS feedback has been published. We have contacted professional groups to share feedback and develop appropriate actions plans. 4) LEEG 12/03/2026: Attendance: 19 x BSc Nursing Students (UEA), 1 x MSc Nursing Student (UEA). Please note approximately 5 more nursing students attended but did not sign in As for all LEEG meetings feedback was gathered using the framework of the Safer Learning Environment Charter (SLEC) in small groups. Positive and negative feedback will be shared with areas that were named and the 'You said, we did' summary has been shared on the Beat. **<u>Summary of LEEG feedback (using SLEC headings):</u>** <u>Respect and feeling valued:</u> the majority of learners felt valued and respected. MSc student felt that in her area there could have been more awareness around the MSc programme. In one area learners felt that their role was not always respected, and they were asked to fulfil escort and HCSW roles more than they felt was reasonable. In some areas nursing staff could be more welcoming, and "wards are too busy for us to progress" and "acuity too high to facilitate effective learning" was also shared. <u>Positive identity as a learner:</u> majority of learners in the group felt that their uniform identified them well and that they were viewed positively, but MSc learner suggested potentially a specific uniform for MSc learners might be helpful for better identification. It was identified that being called 'the student' a

	lot of the time was not positive, and one person fed back that “staff gossiping about us at the front desk does not make us feel welcome”. Wellbeing: all students feel that support is easily available and supportive and were aware of services. In one area they commented that educators hadn’t visited them yet on their area Raising concerns and speaking up: majority of learners are aware of how to raise concerns including via the Freedom to Speak Up and Purple Flag. One learner from this group has used the Purple Flag. Positive comments that the PD&E team “are easily reachable, and students feel happy and supported in raising concerns”. One area was identified where a student felt their concerns were not supported. Placement Induction: majority received an induction – in one area a local induction was missed by the learners then received an induction from relevant clinical educator. In another area the induction was very limited. Communication/support: communication and support offered via emails, lectures, check ins from clinical educators, university advisors and academic assessors Flexibility: good feedback unanimously regarding flexibility Supervision: there was mixed feedback for this section, e.g., “we feel like we are being supervised well”; “it depends on what nurse you are with”; “lack of time for supervision, low priority for nurses because of other stressors while on shift” Teaching and learning needs: mainly positive feedback in relation to this criterion for most areas although one area was identified that it “doesn’t feel like they want students particularly in the teaching sense used as an HCA” Time and space for learning: majority of learners would like more time to reflect and process learners, some areas do not give time for reflection, others do. General positive feedback: the student lectures, and LEEG are valued. Learners are appreciating the many learning opportunities and areas that are organising spokes for them. General constructive feedback: Provide more introduction to students so that placements have more awareness of what the student responsibilities are. Some HCSWs are not welcoming, speak in their own language so students feel outsiders. Where a clinical educator is on A/L it is important to offer another person to contact. In some areas there are too many students – hard to learn with 2 learners to 1 nurse. Any other comments: in two particular areas it was felt that there were too many students, and some supervisors show that they are not overly happy to have students. Overall, however the LEEG meeting was a helpful session because it is a safe place to feedback
Workplans for 2026/2027	1) Student feedback form to be used by multi-professional learners and tested 2) Taking action in relation to NETS data and LEEG as appropriate

Review of services

During 2025/2026 the Norfolk and Norwich University Hospitals NHS Foundation Trust provided and/or sub-contracted 82 relevant health services.

The Norfolk and Norwich University Hospitals NHS Foundation Trust has reviewed all the data available to them on the quality of care in 82 of these relevant health services.

The Trust remains mostly funded in 2025/2026 by block/fixed funding, with a variable element for elective activity. The elective activity is paid on a unit price basis, with the Trust's performance included within the clinical income total. The clinical income total represents 87% of the Trust's overall income for the 2025/2026 financial year.

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

During 2025/26, 65 of the Quality Account national clinical audits and 4 Quality Account national confidential enquiries covered relevant health services that Norfolk and Norwich University Hospitals NHS Foundation provides.
During that period Norfolk and Norwich University Hospitals NHS Foundation participated in 98% national clinical audits and 100% national confidential enquiries of the Quality Account national clinical audits and national confidential enquiries that it was mandated to participate in.

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

- Fracture Liaison Service Database (FLS-DB) (part of the Falls and Fragility Fracture Audit Programme). Trust does not have a Fracture Liaison Service and therefore was not eligible to participate in the audit.
- National Obesity Audit (NOA) NHS Digital. Audit requires the use of the Community Services Data Set, which the Trust does not use and is not mandated to use, which was confirmed to Commissioning by NHS England. Data from complications for excess weight (CEW) clinics is exempt from the NOA audit.
- Evaluating the Management Pathway for Suspected Testicular Cancer Referrals (EMPAST) Unable to participate as Information Governance approval not secured prior to submission deadline.

We participated in another 12 National Audits which fall outside of the Quality Account recommended list.

The national Quality Account clinical audits and national confidential enquiries that Norfolk and Norwich University Hospitals NHS Foundation participated in during 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.

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

Trust Quality Account Audit Participation 2025-26

Project Name	Workstream Name	Eligible Y/N	Took Part Y/N	Participation Rate Cases Submitted Figures and percentage	Completed/ In-progress / Ongoing
BAUS Data & Audit Programme	a) British audit of the investigation and referral of women with recurrent urinary tract infection using recent Guidance (BOOMERANG)	Y	Y	8/8 (100%)	Completed
	b) Evaluating the Management Pathway for Suspected Testicular Cancer Referrals (EMPAST)	Y	N	Unable to participate as Information Governance approval not secured prior to submission deadline	Completed
Breast and Cosmetic Implant Registry		Y	Y	36/66 (55%)	Ongoing (but not a Quality Account for 2026/27)
British Spine Registry		Y	Y	385/445 (86.5%)	Ongoing
Case Mix Programme (CMP)		Y	Y	1695 (100%)	Ongoing
Child Health Clinical Outcome Review Programme[1]		Y	Y	Stabilisation of the Critically Ill Child: 5/8 (63%)	Ongoing
Cleft Registry and Audit NEtwork (CRANE) Database		N	N/A	N/A	N/A
Emergency Medicine QIPs:	a) Adolescent Mental Health	Y	N	Audit has only just been launched and data will be submitted once access have been given	N/A
	b) Care of Older People	Y	Y	200/200 (100%)	Ongoing
	c) Mental Health Self Harm	Y	Y	217/217 (100%)	Completed
	d) Time Critical Medications (TCM)	Y	Y	Form data: 331/331 (100%) TCM doses data: 422/422 (100%)	Ongoing
Epilepsy12: National Clinical Audit of Seizures and Epilepsies for Children and Young People[1]		Y	Y	7/40 (17.5%) (Expected number approximated due to lack of admin support for data entry	Ongoing

Project Name	Workstream Name	Eligible Y/N	Took Part Y/N	Participation Rate Cases Submitted Figures and percentage	Completed/ In-progress / Ongoing
Falls and Fragility Fracture Audit Programme (FFFAP)[1]:	a) Fracture Liaison Service Database (FLS-DB)	Y	N	Service not commissioned	Ongoing
	b) National Audit of Inpatient Falls (NAIF)	Y	Y	37/37 (100%)	Ongoing
	c) National Hip Fracture Database (NHFD)	Y	Y	913/913 (100%)	Ongoing
Learning from lives and deaths – People with a learning disability and autistic people (LeDeR)		Y	Y	19/19 (100%) January - December 2025	Ongoing
Maternal, Newborn and Infant Clinical Outcome Review Programme[1]		Y	Y	44/44 (100%)	
Medical and Surgical Clinical Outcome Review Programme[1]		Y	Y	Acute Illness in People with a Learning Disability: 3/5 (60%) Pleural Procedures (chest drains): 6/7 (86%) Rib Fractures: in progress Deadline for submissions is 10/04/2026.	Ongoing
Mental Health Clinical Outcome Review Programme[1]		N	N/A	N/A	N/A
National Adult Diabetes Audit (NDA)[1]:	a) National Diabetes Core Audit. Includes: - Care Processes and Treatment Targets - Complications & Mortality - Type 1 Diabetes - Learning Disability and Mental Health - Structured Education - Prisons and Secure Mental Health Settings	Y	Y	Data collected from 01/04/25 to 31/03/2026 Deadline is 07/05/26 and data is uploaded as a bulk upload. Expected to be 100%	Ongoing
	b) Diabetes Prevention Programme (DPP) Audit	N/A	N/A	N/A	N/A
	c) National Diabetes Footcare Audit (NDFA)	Y	Y	280/280 (100%)	Ongoing
	d) National Diabetes Inpatient Safety Audit (NDISA)	Y	Y	17/17 (100%) anticipated to be 100% of cases submitted	Ongoing

Project Name	Workstream Name	Eligible Y/N	Took Part Y/N	Participation Rate Cases Submitted Figures and percentage	Completed/ In-progress / Ongoing
	e) National Pregnancy in Diabetes Audit (NPID)	Y	Y	64/64 (100%)	Ongoing
	f) Transition (Adolescents and Young Adults) and Young Type 2 Audit	Y	Y	n/a – This audit draws data from 2 other audits we participate in, the National Diabetes Audit and the National Paediatric Diabetes Audit.	Ongoing
	g) Gestational Diabetes Audit	Y	Y	100% (Taken automatically from Maternity Services Data Set)	
National Audit of Cardiac Rehabilitation		Y	Y	2640/3265 (81%) Will be 100% once all patients complete rehabilitation	Ongoing
National Audit of Cardiovascular Disease Prevention in Primary Care (CVDPrevent)[1]		N	N/A	N/A	N/A
National Audit of Care at the End of Life (NACEL)[1]		Y	Y	142/142 (100%)	Ongoing
National Audit of Dementia (NAD)[1]		Y	N/A	Suspended until 2027	Ongoing
National Audit of Eating Disorders (NAED)[1]		N	N/A	N/A	N/A
National Bariatric Surgery Registry		N	N/A	N/A	N/A
National Cancer Audit Collaborating Centre (NATCAN):	National Audit of Metastatic Breast Cancer (NAoMe)[1]	Y	Y	38/38 (100%)	Ongoing
	National Audit of Primary Breast Cancer (NAoPri)[1]	Y	Y	659/659 (100%)	Ongoing
	National Bowel Cancer Audit (NBOCA)[1]	Y	Y	404/404 (100%)	Ongoing
	National Kidney Cancer Audit (NKCA)[1]	Y	Y	119/119 (100%)	Ongoing
	National Lung Cancer Audit (NLCA)[1]	Y	Y	852/852 (100%)	Ongoing
	National Non-Hodgkin Lymphoma Audit (NNHLA)[1]	Y	Y	210/210 (100%)	Ongoing
	National Oesophago-Gastric Cancer Audit (NOGCA)[1]	Y	Y	228/228 (100%)	Ongoing
	National Ovarian Cancer Audit (NOCA)[1]	Y	Y	93/93 (100%)	Ongoing

Project Name	Workstream Name	Eligible Y/N	Took Part Y/N	Participation Rate Cases Submitted Figures and percentage	Completed/ In-progress / Ongoing
	National Pancreatic Cancer Audit (NPaCA)[1]	Y	Y	125/125 (100%)	Ongoing
	National Prostate Cancer Audit (NPCA)[1]	Y	Y	680/680 (100%)	Ongoing
National Cardiac Arrest Audit (NCAA)		Y	Y	109/109 (100%)	Ongoing
National Cardiac Audit Programme (NCAP):	a) National Adult Cardiac Surgery Audit (NACSA)	N	N/A	N/A	N/A
	b) National Congenital Heart Disease Audit (NCHDA)	N	N/A	N/A	N/A
	c) National Heart Failure Audit (NHFA)	Y	Y	739/739 (100%)	Ongoing
	d) National Audit of Cardiac Rhythm Management (NACRM)	Y	Y	2471/2487 (99%)	Ongoing
	e) Myocardial Ischaemia National Audit Project (MINAP)	Y	Y	727/915 (79%)	Ongoing
	f) National Audit of Percutaneous Coronary Intervention (NAPCI)	Y	Y	1407/1531 (92%)	Ongoing
	g) UK Transcatheter Aortic Valve Implantation (TAVI) Registry	N	N/A	N/A	N/A
	h) Left Atrial Appendage Occlusion (LAAO) Registry	N	N/A	N/A	N/A
	i) Patent Foramen Ovale Closure (PFOC) Registry	N	N/A	N/A	N/A
	j) Transcatheter Mitral and Tricuspid Valve (TMTV) Registry	N	N/A	N/A	N/A
National Child Mortality Database (NCMD)[1]		Y	Y	100% - All child deaths are registered as required via the Child Deaths Overview Panel (CDOP) and the national database takes its data direct from the CDOPs.	Ongoing
National Clinical Audit of Psychosis (NCAP)[1]		N	N/A	N/A	N/A

Project Name	Workstream Name	Eligible Y/N	Took Part Y/N	Participation Rate Cases Submitted Figures and percentage	Completed/ In-progress / Ongoing
National Comparative Audit of Blood Transfusion:	2025 Major Haemorrhage Audit	Y	Y	40/40 (100%)	Ongoing
National Early Inflammatory Arthritis Audit (NEIAA)[1]		Y	Y	37/37 (100%) Anticipated to be 100% of cases	Ongoing
National Emergency Laparotomy Audit (NELA)[1]	Laparotomy	Y	Y	264/264 (100%)	Ongoing
	No Laparotomy	Y	Y	19/19 (100%)	Ongoing
National Joint Registry		Y	Y	1687/1687 (100%) Anticipated to be 100% of cases	Ongoing
National Major Trauma Registry (NMTR)		Y	Y	April 2025, 7 cases submitted. Major Trauma Team informed NMTR focus is on 2026 entries (nationwide) so 45 submitted January 2026. For April 2025 – December 2025 there are 1120 eligible cases informed these will be entered at a later date	Ongoing
National Maternity and Perinatal Audit (NMPA)[1]		Y	Y	100% Submission data is taken automatically by NHS Digital	Ongoing
National Neonatal Audit Programme (NNAP)[1]		Y	Y	841/841 (100%)	Ongoing

Project Name	Workstream Name	Eligible Y/N	Took Part Y/N	Participation Rate Cases Submitted Figures and percentage	Completed/ In-progress / Ongoing
National Obesity Audit (NOA)[1]		Y (Paeds)	N	Audit relies on the use of the Community Services Data Set, which the Trust does not use and is not mandated to use, which was confirmed to Commissioning by NHS England.	Ongoing
National Ophthalmology Database (NOD):	a) Age-related Macular Degeneration Audit	Y	Y	2235/2235 patients (2994/2994 eyes) 100%	Ongoing
	b) Cataract Audit	Y	Y	2230/2230 (100%)	Ongoing
National Paediatric Diabetes Audit (NPDA)[1]		Y	Y	335/335 (100%)	Ongoing
National Perinatal Mortality Review Tool (PMRT)		Y	Y	36/36 (100%)	Ongoing
National Pulmonary Hypertension Audit		N	N/A	N/A	N/A
	a) COPD Secondary Care	Y	Y	330 (100%)	Ongoing
	b) Pulmonary Rehabilitation	Y	N	Service not available in this Trust	N/A
	c) Adult Asthma Secondary Care	Y	Y	305 (100%)	Ongoing
	d) Children and Young People's Asthma Secondary Care	Y	Y	31/31 (100%)	Ongoing

Project Name	Workstream Name	Eligible Y/N	Took Part Y/N	Participation Rate Cases Submitted Figures and percentage	Completed/ In-progress / Ongoing
National Vascular Registry (NVR)[1]		Y	Y	**Mandated elements** Aortic Aneurysm 70 Carotid Endarterectomy 22 **Non-mandated elements** Lower limb angioplasty 341 Lower limb bypass 36 Lower limb amputation 92 Rate of submission anticipated to be above the required 95% threshold	Ongoing
Out-of-Hospital Cardiac Arrest Outcomes (OHCAO)		N	N/A	N/A	N/A
Paediatric Intensive Care Audit Network (PICANet)[1]		N	N/A	N/A	N/A
Perioperative Quality Improvement Programme (PQIP)		Y	Y	17 (100%) Although on Quality Accounts, this is a research project. The NNUH recruits patients undergoing elective thoracic surgery.	Ongoing
Prescribing Observatory for Mental Health (POMH):	a) Improving the quality of valproate prescribing in adult mental health services	N	N/A	N/A	N/A
	b) Use of clozapine	N	N/A	N/A	N/A
	c) Use of medicines with anticholinergic (antimuscarinic) properties in older people's mental health services	N	N/A	N/A	N/A
Sentinel Stroke National Audit Programme (SSNAP)[1]		Y	Y	1014/1014 (100%)	Ongoing
Serious Hazards of Transfusion (SHOT): UK National Haemovigilance Scheme		Y	Y	27/27 (100%)	Ongoing

Project Name	Workstream Name	Eligible Y/N	Took Part Y/N	Participation Rate Cases Submitted Figures and percentage	Completed/ In-progress / Ongoing
UK Cystic Fibrosis Registry	a) Cystic Fibrosis – Adults	Y	Y	98/99 (99%)	Ongoing
	b) Cystic Fibrosis – Children	Y	Y	59/59 (100%)	Ongoing
UK Interstitial Lung Disease (ILD) Registry		Y	Y	19 (est 100%)	Ongoing
UK Parkinson's Audit		Y	Y	OPM 40 (100%) Neurology TBC	Completed
UK Renal Registry Chronic Kidney Disease Audit		Y	Y	Quarter 118 (Apr - Jun 2024) 877 (100%) Quarter 119 894 (100%) Quarter 120 913 (100%) Figures are expected to be 100%.	Ongoing
UK Renal Registry National Acute Kidney Injury Audit		Y	Y	2303 (100%) in Q1, and 2341 (100%) in Q2. NNUH hasn't submitted their figures for Q3 yet.	Ongoing

Footnote:

[1] National Clinical Audit and Patient Outcomes Programme (NCAPOP) N=33.

Participation in research and development

The number of patients receiving relevant health services provided or sub-contracted by the Norfolk and Norwich University Hospitals NHS Foundation Trust in 2025/2026 that were recruited during that period to participate in research approved by a research ethics committee was 4446.

Commissioning for Quality and Innovation (CQUIN)

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

Care Quality Commission (CQC) reviews

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

The Care Quality Commission has not taken enforcement action against Norfolk & Norwich University Hospitals NHS Foundation Trust during 2025/2026.

Norfolk and Norwich University Hospitals NHS Foundation Trust has participated in special reviews or investigations by the Care Quality Commission relating to the following areas during 2025/2026:

- In June 2025, the Norfolk and Norwich University Hospitals NHS Foundation Trust had 2 announced inspections of compliance with the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) 2017, of the Nuclear Medicine and the Radiotherapy department. This inspection does not provide a rating.

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

Table 1: CQC Areas of Improvement from IR(ME)r inspection report.

Regulation	**Action Required**
6(1)(a) Schedule 2 (f) Employer's duties: establishment of general procedures, protocols and quality assurance programmes	The employer's written procedures for exposures must include procedures for the use and review of dose reference levels (DRLs)

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

Norfolk and Norwich University Hospitals NHS Foundation Trust has made the following progress by 31st March 2026 in taking such action:

Table 2: CQC Areas of Improvement from IR(ME)r inspection report.

Regulation	**Action Required**	**How this will be addressed**	**Completion date**
6(1)(a) Schedule 2 (f) Employer's duties: establishment of general procedures, protocols and quality assurance programmes	The employer's written procedures for exposures must include procedures for the use and review of dose reference levels (DRLs)	A project group has been set up to allocate resources to this work. Dosetrack will be used to record and audit LDRLs.	Expected to be completed by 31st May 2026 – Dosetrack software is installed – Mapping and communication of the Linear accelerators to Dosetrack is underway.

Data Quality

The Norfolk and Norwich University Hospitals NHS Foundation Trust submitted records during 2025/2026 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

Table 3: Records of published Data: Month 10

The % of records in the published data which included:	the patient's valid NHS number was:		the patient's valid General Medical Practice Code was:	
	NNUH	Nat Avg.	NNUH	Nat Avg.
Admitted patient care	99.9%	99.7%	100%	99.8%
Outpatient care	100%	99.8%	100%	99.6%
Accident & emergency care	99.5%	98.4%	100%	99%

Participated in the 3 National Validation Sprints as per NHSE directives, used findings to deliver learning and coaching via the Referral to Treatment Operational Management Group Meetings (RTTOMG).

Commissioning Assurance Programme evolving, the above dashboard confirms compliance in key areas and ad hoc audits have been completed as required

The Clinical Threshold and IFR audit programmes have been reviewed and updated to capture patients added to a waiting list in real time, records are audited to ensure the patient meets the clinical criteria to be listed. If they do not meet the criteria, the patient is removed from the waiting list as the trust is not funded to carry out the procedure in this instance. To date the audits have saved the Trust over £81,763, £71,315 in 2025.

Referral to Treatment and Data Quality web pages reviewed and updated, providing guidance documents and SOPs to further support staff with policy, process and progressing patient pathways.

Admin Managers, Admin Leads and Departmental RTT Validators in new positions / Specialties post the restructure are completing the Trust Induction Programme to support continuity with education.

Provide monthly 'RTT back to basics', 'Referral Management', and 'DQ Metric' training sessions for all other staff.

Policies reviewed and updated to provide further clarity and understanding.

Continue to use benchmarking tools such as the SUS dashboard and DQMI Dashboards to ensure the NNUH are meeting national averages and proactively work with stakeholders to ensure resolution in areas of weakness if identified. If there is a change to the contract Data Set, this can reflect in the scores on the SUS dashboard, an example being, historically the Trust used clinics set up under generic 'Combined' codes for operational reasons such as capacity management and rota cover. These included clinics set up under 'Combined Consultant' (C9999998), 'Combined Nurse' (N9999998), 'Combined Midwife' (M9999998) and 'Combined Other Health Professional' (H9999998).

Due to the change made by NHS England to the Commissioning Data Set, these codes are no longer valid and should not be used. This caused the trust to flag as an outlier on the Commissioning Data Set (CDS) as we were extensively using these codes. Work has progressed towards correcting this issue as new clinic requests must now include a named practitioner before the sign off, and current combined clinics are being changed to a named consultant diary owner. This is a huge task so we are working through the specialties, 60% of combined clinics now have a named diary owner responsible for the service.

There are now 50 Data Quality Metrics which identify incorrect or incomplete data on PAS. Completing the metrics will ensure patient pathways are correct and patients are progressed through their pathways in a timely manner. There is a dashboard to give an overview of performance immediately and the metrics have been prioritised, so the most important ones linked to care are completed first.

Electronic Patient Record Preparation
Have cleansed over 100,000 records removing duplicate records, added deaths to PAS from DBS trace and updated/corrected patient demographic details

Information Governance Data Security & Protection Toolkit Attainment Levels

Norfolk and Norwich University Hospital Foundation Trust's Data Security & Protection Toolkit overall score for 2024/25 was of an approaching standards assurance status.

Clinical Coding error rate

The Norfolk and Norwich University Hospitals NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2025/2026 by the Audit Commission.

Improving Data Quality

The Norfolk and Norwich University Hospitals NHS Foundation Trust will be taking the following actions to improve data quality:

Monthly Data Quality Referral to Treatment Operational Meetings (RTTOMG) to discuss RTT performance by Specialty, discussing RTT issues / concerns, this is a forum to share best practice. Minutes are provided and can be used as a reference tool.

Continue to review data recording issues raised via DQ SUS dashboards, Commissioning issues and ad-hoc audits and review anomalies as they arise.

Continue training with staff impacted by the restructure.

Manage the Information Standard Notice Data Base to ensure the trust works towards compliance by the implementation date, escalate when necessary and ensure risks are highlighted and recorded if the Trust is non-compliant.

Complete ad-hoc commissioning audits to support business needs.

Complete ad-hoc PAS audits to support EPR and System working

Review current practices to see how we can work differently/smarter, simplify and ensure continuity of practice.

Work with the System to ensure the 3 trusts are recording data/activity with continuity, this includes the management of RTT pathways.

Introduce new Data Quality Metrics to highlight performance issues and enhance patient pathway progression

Set up project group or agree a plan with Trust Management to support the booking of non RTT patient pathways

Learning from Deaths

During the financial year 2025/2026 3,359 of the Norfolk & Norwich University Hospital NHS Foundation Trust in-patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:

903 in the first quarter, of which 4 were patients with Learning Difficulties, 7 had a Severe Mental Illness, 4 were Still Born and 2 were Neonatal Deaths.

880 in the second quarter, 13 were patients with Learning Difficulties, 7 had a Severe Mental Illness, 3 were Still Births and 8 were Neonatal Deaths.

929 in the third quarter, 8 were patients with Learning Difficulties, 5 had a Severe Mental Illness, 6 were Still Births and 3 were Neonatal Deaths.

647 in the fourth quarter, 6 were patients with Learning Difficulties, 3 had a Severe Mental Illness, 5 were Still Births and 6 were Neonatal Deaths.

Table 4: Summary of In-Hospital deaths and deaths within 30 days of discharge for the financial year 2025/2026 (as of 21/04/2026)

Financial Year 2025/2026	Total Discharges	Deaths within 30 days of Discharge	In-hospital deaths	Total Deaths	In-hospital Deaths with Learning Difficulties	In-hospital Deaths with Severe Mental Illness	In-hospital Still births	In-hospital Neonatal Deaths
Q1	52,754	300	603	903	4	7	4	2 (1*)
Q2	54,808	297	583	880	13	7	3	8 (1*)
Q3	54,396	32	600	929	8	5	6	3 (1*)
Q4	35,128	210	437	647	6	3	5	6 (2*)
Total	197,086	1,136	2,223	3,359	31	22	18	19 (5*)

*The numbers in brackets are the medical terminations that resulted in a live birth and neonatal death

Case Record Reviews:

Table 5: All Structured Judgement Reviews completed during the 2025/2026 reporting period, including a breakdown by vulnerable group.

Financial Year 2025/2026	Total Number of SJR's completed during the reporting period	Number of SJRs completed for patients with Learning Disabilities	Number of SJRs completed for patients with Severe Mental Illness	Number of SJRs completed for patients who were Homeless
Q1	24	4	3	0
Q2	35	5	6	0
Q3	28	9	8	0
Q4	13	2	2	0
Total	100	20	19	0

Note: these are total SJRs completed in the 2025/26 period regardless of the date of death.

Table 6: SJRs reviews completed in relation to the deaths which occurred during the 2025/2026 reporting period, including a breakdown by vulnerable group.

Financial Year 2025/2026	Total Number of SJR's completed during the reporting period	Number of SJRs completed for patients with Learning Disabilities	Number of SJRs completed for patients with Severe Mental Illness	Number of SJRs completed for patients who were Homeless
Q1	4	3	0	0
Q2	16	8	2	0
Q3	25	1	5	0
Q4	17	0	2	0
Total	62	12	9	0

Table 7: Case Record Review - Perinatal Mortality Review Tool (PMRT) –

Financial Year 2025/2026	Total Number of PMRTs completed during the reporting period on Neonatal/Post Neonatal deaths	Total Number of PMRTs completed during the reporting period on Still Births
Q1	2	4
Q2	7	3
Q3	4	5
Q4	2	4
Total	15	16

Note: these are total PMRT's completed in the 2025/26 period regardless of the date of death.

Patient Safety Incident Investigations

From the 1st September 2023, the Trust implemented the Patient Safety Incident Response Framework (PSIRF). Patient Safety Incident Investigations (PSII) are completed where a patient safety incident meets either a National or Local Priority criteria (Table 8). The Trust identified its first set of local priorities in September 2023. As planned, these were reviewed in the first quarter of 2025, and a new set of local priorities was identified and published in May 2025.

Period	Priority Type	Priority
01 September 2023 to 17th May 2025	National	➢ Patient safety incident is a Never Event (NE) ➢ Deaths more likely than not due to problems in care. This can be identified through an incident and/or the learning from deaths process.

Period	Priority Type	Priority
	Local	➢ Missed/ Delay in Diagnosis (Patients under the care of the Emergency Department or Medical Specialties where a missed or delay in diagnosis leads to a significant delay in the initiation of essential treatment.) ➢ Sub Optimal Care (Incidents affecting patients where care is being managed between more than 1 clinical specialty, where management resulted in the patient being transferred to multiple wards and there was a failure or delay in acting on an escalation of a deteriorating clinical situation.)
18th May 2025 to current	National	➢ Patient safety incident is a Never Event (NE) ➢ Deaths more likely than not due to problems in care. This can be identified through an incident and/or the learning from deaths process.
	Local	➢ Emergency Admission on Elective Waiting List. Patients under all specialties where there is an emergency admission requiring an inpatient stay and treatment whilst waiting for surgery. ➢ Unexpected Complication after a Procedure. Incidents affecting patients following surgery or an invasive procedure within Cardiology, Angiography and Gastroenterology.

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

Table 9: Patient Safety Incident Investigations reported, and investigations completed in relation to the deaths which occurred during the 2025/2026 reporting period:

Financial Year 2025/2026	Total Number of PSIIs reported in relation to the deaths which occurred during the report period	Total Number of PSIIs completed
Q1	2	0
Q2	0	0
Q3	2	1
Q4	1	2
Total	5	3

Total number of case record reviews and investigations in 2025/2026
By the end of Quarter 4, 62 case record reviews and 5 investigations have been carried out in relation to the 3,359 in-patient deaths reported during the 2025/2026 financial year.

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

The number of deaths in each quarter for which a case record review or investigation was carried out was: 6 in the first quarter; 16 in the second quarter; 27 in the third quarter; 18 in the fourth quarter.

Of the 62 deaths reviewed, 3 representing 0.9% of patient deaths (3,359) during 2025/2026 are judged to be more likely than not to have been due to problems in the care provided to the patient.

In relation to each quarter, this consisted of:
Quarter 1: 0 representing 0% of patient deaths during 2025/2026 (903)
Quarter 2: 0 representing 0% of patient deaths during 2025/2026 (886)
Quarter 3: 3 representing 0.32% of patient deaths during 2025/2026 (929)
Quarter 4: 0 representing 0% of patient deaths during 2025/2026 (677)

This number has been estimated using the following:

1. Case record reviews:

Table 10: SJR Case record reviews completed in relation to deaths which occurred during the 2025/2026 reporting period, where the death was judged to be more likely than not due to problems in care

Financial Year 2025/2026	Total Number of SJRs completed relating to deaths during the reporting period	Number of deaths judged at SJR to be more likely than not due to problems in care.	% of Total Number
Q1	4	0	-
Q2	16	0	-
Q3	25	3	12%
Q4	17	0	-
Total	62	3	4.3%

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

Note: Of the 3 deaths judged at SJR to be more likely than not due to problems in care all 2 are awaiting validation at an SJR scrutiny panel.

Table 11: PMRT Case record reviews completed in relation to Neonatal/Post Neonatal deaths which occurred during the 2025/2026 reporting period, where the death was judged to be more likely than not due to problems in care

Financial Year 2025/2026	Total Number of PMRT's completed relating to Neonatal/Post Neonatal deaths during the reporting period	Number of deaths judged to be more likely than not due to problems in care	% of Total Number
Q1	0	0	0%
Q2	7	0	0%
Q3	4	0	0%
Q4	2	0	0%
Total	13	0	0%

Table 12: PMRT Case record reviews completed in relation to Still Births which occurred during the 2025/2026 reporting period, where the death was judged to be more likely than not due to problems in care

Financial Year 2025/2026	Total Number of PMRT's completed relating to Still Births during the reporting period	Number of deaths judged to be more likely than not due to problems in care	% of Total Number
Q1	0	0	0%
Q2	3	0	0%
Q3	5	0	0%
Q4	4	0	0%
Total	12	0	0%

Table 13: PRMTs reviewed in 2025-2026 financial year, for deaths in 2024-2025 financial year, where the death was judged to be more likely than not due to problems in care

Financial Year 2025/2026	Total Number of PMRT's completed relating to Neonatal/Post Neonatal **deaths during 1st April 2024 – 31st March 2025, however reviewed during 1st April 2025 – 31st March 2026**	Number of deaths judged to be more likely than not due to problems in care	% of Total Number
Q1	2	0	0%
Q2	0	0	0%
Q3	0	0	0%
Q4	0	0	0%
Total	2	0	0%

Table 14: PRMTs reviewed in 2025-2026 financial year, for still births in 2024-2025 financial year, where the death was judged to be more likely than not due to problems in care

Financial Year 2025/2026	Total Number of PMRT's completed relating to **stillbirths during 1st April 2024 – 31st March 2025, however reviewed during 1st April 2025 – 31st March 2026**	Number of deaths judged to be more likely than not due to problems in care	% of Total Number
Q1	4	1	25%
Q2	0	0	0%
Q3	0	0	0%
Q4	0	0	0%
Total	4	1	25%

2. Investigations:

Table 15: Patient Safety Incident Investigations completed in relation to patients who have died during the 2025/2026 reporting period where the death was judged to be more likely than not due to problems in care

Financial Year 2025/2026	Total Number of PSII's completed	Number of deaths judged to be more likely than not due to problems in care following investigation	% of Total Number
Q1	1	1	100%
Q2	1	1	100%
Q3	0	0	n/a
Q4	2	2	100%
Total	4	4	100%

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

Learning from Case Record Reviews and Investigations

Methods and tools to share the learning include:

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

Below are areas where improvement work is required.

Table 16: Learning from Case Record Reviews – SJRs

	Themes identified through case record review	Update/ Action
1	**Documentation**	The main sub-themes within the documentation category are gaps in nursing and medical documentation. The Trust continues to use paper case records so there is a higher risk of poor legibility, misfiling, mishandling, loss, or damage. A shared Electronic Patient Record (EPR) across 3 acute trusts in Norfolk and Waveney is currently in the development phase. Implementation was planned for March 2026, however this was delayed and the revised date pending confirmation. Implementation of the EPR is expected to support a vast improvement in the clinical data quality captured. Furthermore, local audits conducted, previously undertaken via Tendable and now transitioned to InPhase are completed to provide assurance and support improvements at a departmental level regarding the quality of documentation.

	Themes identified through case record review	Update/ Action
2	**Nursing**	SJR findings have identified nursing care as a key theme, particularly in relation to falls prevention and aspects of nutritional care. In response, the Trust has continued a targeted falls reduction programme, focused on improving risk assessment, care planning, and timely interventions to reduce the incidence of inpatient falls. Ongoing monitoring and multidisciplinary collaboration support continuous improvement in this area. In relation to nutritional care, learning from SJR reviews has been shared through Trust-wide learning notices, reinforcing the importance of early assessment, appropriate escalation, and consistent monitoring of patients' nutritional needs. This has supported staff to embed best practice and improve the identification and management of patients at risk of malnutrition.
3	**Communication**	SJR findings have identified communication as the third highest reported care problem category but also as the highest reported notable practice. In response, the Trust has continued to strengthen communication with patients, families, and carers. This includes the use of dedicated relative liaison roles and the extension of ward visiting hours including further extended opening hours during Ramadam, enabling more consistent engagement between families and healthcare teams. The Trust has also worked to improve awareness and support for patients with additional communication needs through implementation of the Accessible Information Standard. This has supported staff to better identify, record, and meet individual communication requirements, promoting more inclusive and personalised care.

Table 17: Learning from Case Record Reviews – PMRT

	Themes identified through investigations	Update/ Action
1	**Social barriers to accessing care** – delays in booking	Active booking process for ethnic minority women and for those who do not speak English. Current booking processes require service users to fill an online booking form and to then call to book an appointment for midwifery 'booking' – often the phone call isn't happening in a timely fashion and opportunities to offer care are delayed. This is particularly the case for women who are not white British, and these women are known to have higher risk of pregnancy loss and maternal ill-health, so an approach of active administration is being taken to attempt to highlight higher risk women and proactively invite them for appointments. It is envisaged that a functional EPR may assist in this in the future.
2	**Preterm birth** – extreme preterm birth continues to be a leading cause of death	Update following last submission, the employment of a preterm birth/multiple birth specialist midwife to support the service. This has led to an Multidisciplinary Team (MDT) for cervical cerclage planning offering a consistent approach to care. Additionally, cervical assessment for multiple pregnancies has commenced to come in line with NICE guidance. And the SmartStart smoking cessation service is established and showing great tenacity in engaging service users with their assistance.
3	**Congenital abnormalities**	Obvious increase in families continuing pregnancies that have significant congenital abnormalities (that may have previously opted for termination of pregnancy for medical reasons) and bereavement care is being tailored for these unique circumstances by the MDT.

Table 18: Learning from investigations

	Themes identified through investigations	Comments
1	Proactively identifying patients with higher clinical risk and enabling responsive care	The need to ensure we have the right level of support available for patients at higher risk of falls The Acute Frailty Intervention Unit has been established to improve short stay frailty services, recognising the importance of the first 24 hours of admission for people living with frailty - The Acute Frailty Intervention Unit has been established to improve short stay frailty services, recognising the importance of the first 24 hours of admission for people living with frailty - An age-based mode of identifying frailty has been replaced with a Clinical Frailty Score rather than by age, which ensure patients with a greater frailty score and subsequent higher risk of falls are cared for in the most appropriate clinical area
2	Communication between teams	There has been some exemplary work by the cardiology team, including the introduction of daily safety conversations between the Norfolk and Norwich University Hospital and James Paget University Hospital and a monthly meeting to focus on patient safety.
3	Increased use of digital solutions	There have been improvements to how various digital clinical systems are used, for example - The Critical Care Metavision nursing digital assessments have been updated to align with the current cohort ward-based paper charts for tracheostomy and laryngectomy patients to ensure continuity of nursing care given [in line] with national and local guidelines. - The Emergency Department [has] developed an innovative way of enabling Alertive (communication messaging system) to pull through patient information from our digital Patient Administration System (PAS). This means information shared includes more relevant information and improves safe communication between clinical teams. This is now firmly established in [day-to-day] practice

In addition to applying patient safety learning to make real changes and improvements to patient care, we have reviewed how the organisation learns from patient safety events. This review included the mechanisms we have in place to ensure we are making tangible improvements. As a result of this review, the organisation aims to consolidate patient safety actions into a small number of improvement programmes, prioritising system redesign over training alone. These improvement programmes will clearly align to the new governance structure, with oversight from the organisation's Learning from Insights and Outcomes Group. The transition to this new approach has already started, and we anticipate it will be embedded by the end of 2026.

This supports a shift from a long list of individual actions to a focused, system-based improvement approach consistent with PSIRF principles: doing fewer things better, with clear ownership, maximising patient safety impact and organisational learning.

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

Update on Case Record Reviews and Investigations for 2025/2026

28 case record reviews and 3 investigations were completed after 1st April 2025 which related to in-patient deaths which took place before the start of the reporting period (2025/2026)

Of the 28 deaths reviewed, 5 representing 17.8% of in-patient deaths before the reporting period (2026/2026) are judged to be more likely than not to have been due to problems in the care provided to the patient.

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

Please note: 0 of the 5 deaths occurring before the reporting year (2025/2026) with reviews conducted within the reporting year have received confirmation through a full investigation, case review or SJR scrutiny panel to validate the if the death was more likely than not due to care problems in care. The remaining 5 are to be validated through the SJR scrutiny panel process.

Part 2.3 - Reporting against core indicators

Please note that the guidance 'Detailed requirements for quality reports 2020/21 published by NHS Improvement instructs that 'since 2012/13 NHS foundation Trusts have been required to report performance against a core set of indicators using data made available to the Trust by NHS Digital' (p17).

Summary Hospital Level Mortality Indicator (SHMI) value and banding						
Indicator	NNUHFT Nov 24 – Oct 25 Published by NHS Digital	National Average	Best performer	Worst performer	NNUHFT Nov 23 – Oct 24	NNUHFT Sep 22 – Aug 23
SHMI value and banding	1.1517	1.0103	0.1782	1.3956	1.1831	1.1979 Band 1

Location: **Summary Hospital-level Mortality Indicator (SHMI) - Deaths associated with hospitalisation, England, November 2024 - October 2025 - NHS England Digital**

Latest version available covers: November 2024 to October 2025, published 12th March 2026

The Norfolk and Norwich University Hospitals NHS Foundation Trust considers that this rate is as described for the following reasons:
The SHMI reports on mortality at Trust level across the NHS in England using a standard and transparent methodology. It is produced and published monthly as a National Statistic, published 5 months in arrears. Within the reporting year, the NNUH has moved from being statistically higher than expected, to reported within the 'as expected' reporting band by NHS England, this demonstrates sustained significant improvement.

Whilst the NNUH SHMI value is banded 'as expected', it remains higher than the NNUH target, and above national average.

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

- Clinical Data Quality to support Depth of Coding
- Community healthcare provision including limited community palliative care provisions
- Functionality of specific pathways of care –these include heart failure and septicaemia

The Norfolk and Norwich University Hospitals NHS Foundation Trust has taken and will take the following actions to improve this rate, and the quality of its services:
The Trust has updated and maintained its mortality action plan which is monitored for oversight through the Mortality Action and Review group. Key improvements already underway include:

- A Clinical Data Quality improvement workstream including 'probable month' on AMU to improve ability for coders to code probable diagnoses.
- A review of how episodes are recorded and managed on AMU
- Development and trial of a frailty proforma to help identify and document the comorbidities which contribute to frailty, enabling enhanced depth of coding for frailty and associated comorbidities.
- Review of Heart failure, Sepsis, and Falls and Fragility management within the Trust Quality Priorities framework.

- Improved recognition and triaging of frailty to appropriate clinical teams.
- Implementation of call for concern by the Trust RRT
- Appointment of a Clinical Lead for Morbidity, Mortality and Clinical Audit.

Further opportunities to improve our SHMI level include:

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

% of patient deaths with palliative care						
Indicator	NNUHFT Nov 25 – Oct 25 Published by NHS Digital	National Average	Lowest %	Highest %	NNUHFT Nov 23 – Oct 24	NNUHFT Sep 22 – Aug 23
% of patient deaths with palliative care coded at either diagnosis or specialty level for the reporting period	54%	44%	18%	69%	52%	55%

Location: Summary Hospital-level Mortality Indicator (SHMI) - Deaths associated with hospitalisation, England, November 2023 - October 2024 - NHS England Digital https://digital.nhs.uk/data-and-information/publications/statistical/shmi/2023-03> interactive data visualisation > page 13 (contextual indicators: Palliative Care)

Latest version available November 2024 to October 2025, published 12th March 2026

The Norfolk and Norwich University Hospitals NHS Foundation Trust considers that this rate is as described for the following reasons:
The SHMI methodology does not make any adjustment for patients who are recorded as receiving palliative care. This is because there is considerable variation between Trusts in the way that palliative care is recorded.

SHMI contextual metrics show that more deaths occur in the NNUHFT than the national average and fewer outside hospital within 30 days of discharge. In addition, more deaths have specialist palliative care recorded at either treatment speciality level than the national average. There has been little change in the number of deaths in hospital with palliative coding (52%, 55%, 54% over the three years). This reflects that there has been no change in the provision of community specialist palliative care beds, and as a result, we see above average deaths in hospital with palliative care input.

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

- Insufficient community social care provision resulting in more patients dying in hospital. Norfolk has an older population than average. While the proportion (count

per 1000 resident population) of people in both North and South Norfolk living in all care homes is close to the national average, the total supply of nursing home beds (as opposed to care) in Norfolk is very low at 2.5 per 100 residents aged 75 and above. There are also proportionately less deaths in hospice than for other parts of the country as a result of inadequate number of hospice beds in the region, leading to more patients being admitted to hospital at the end of their life than receiving hospice care.

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

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

The Trust is engaging with community care services as part of the NHS 10 year plan to review and support appropriate care placements for all patients.

PROMS

Indicator	2024/2025				NNUHFT 2023/2024
	NNUHFT	National Average	Best performer	Worst performer	
Patient reported outcome scores for groin hernia surgery	No longer measured	No longer measured	No longer measured	No longer measured	No longer measured
Patient reported outcome scores for varicose vein surgery	No longer measured	No longer measured	No longer measured	No longer measured	No longer measured
Patient reported outcome scores for hip replacement surgery	23.343	22.189	12.411	16.174	20.932
Patient reported outcome scores for knee replacement surgery	15.549	16.666	21.559	25.583	16.174

Location: [MI] Patient Reported Outcome Measures (PROMs) in England, Final 2024/25 data - NHS England Digital > Finalised PROMs for hip and knee replacements in England: Score Comparison Tool > Adjusted Average Health Gain from Oxford hip and Oxford knee score

Latest version available: April 2024 – March 2025, published 2nd April 2026

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

The Norfolk and Norwich University Hospitals NHS Foundation Trust will take the following actions to improve this rate, and the quality of its services:
We are trying to ensure the best usage of our new orthopaedic centre to maximise the patients that are done through that unit. This is with the overall aim to reduce those being sent to other healthcare providers they tend to be the fittest patients with the highest improvements in our QE-5D and Oxford hip and knee scores. We are also trying to improve our day case arthroplasty numbers.

28-day readmission rates						
Indicator	2025/2026 (NNUHFT reported based on the NHS Outcomes Framework Specification)				NNUHFT (Apr 24 – Mar 25)	NNUHFT (Apr 23 – Mar 24)
		National Average	Best performer	Worst performer		
28-day readmission rates for patients aged 0-15	2.61%	No data published	No data published	No data published	2.89%	Average Rate 5.6%
28-day readmission rates for patients aged 16 or over	14.56%	No data published	No data published	No data published	14.97%	Average Rate 10.8%
There is no data published since 2012/13. Data above has been based upon clinical coding within Norfolk & Norwich University Hospitals NHS Foundation Trust. **The Norfolk and Norwich University Hospitals NHS Foundation Trust has taken the following actions to improve this rate, and the quality of its services:** The Trust has projects to address this requirement including the Virtual Ward discussed in section 3.						

Trust responsiveness				
Indicator	CQC Adult Inpatient Survey 2024		NNUHFT 2023	NNUHFT 2022
	NNUHFT	National Average		
Trust's responsiveness to the personal needs of its patients during the reporting period.	7.9	'About the same as others'	2023 Data has not been published on the CQC website at the time of compiling this account.	7.8 'About the same as others'
Location: This data has been obtained from the CQC Adult Inpatient Survey – overall view of Inpatient Services. https://www.cqc.org.uk/provider/RM1/surveys/129 **Latest version available:** 2024, published 9th September 2025. **The Norfolk and Norwich University Hospitals NHS Foundation Trust have taken and will take the following actions to improve this rate, and the quality of its services:** The Trust has continued to implement its patient engagement and experience strategy successfully engaging with a number of communities which are the less well heard, such as our local prisoner populations and the deaf community. The NNUHFT strategy of the "Best Care for Every Patient" contains experience of care as a key component with continued emphasis on equality, diversity and inclusion. The Patient Engagement & Experience Group (PEEG) continues to oversee Care Group reporting against actions arising from all forms of feedback, including the Friends and Family Test (FFT), complaints and PALS and engagement with community groups including Healthwatch Norfolk, Carers Voice Norfolk and Waveney and the East of England Armed Forces group.				

% Staff employed who would recommend the trust						
Indicator	2025 NHS Staff Survey Results				NNUHFT 2024	NNUHFT 2023
	NNUHFT	National Average	Best performer	Worst performer		
NHS Staff Survey *Q25d If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation.*	50.38%	60.83%	88.41%	34.73%	54.80%	53.96%

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

The NNUH has been through a period of organisational change, including a move from Divisions to Care Groups.

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

The five streams of work within the People Promise priority actions have delivered the following achievements:

1. **Promoting a safe, inclusive workplace**
   A trust-wide culture programme has been delivered through a series of lectures, training and communications focused on sexual safety, civility, anti-racism, burnout and positive behaviours. Senior leadership communications and mandatory eLearning have reinforced grievance, civility and sexual safety expectations
2. **Empowering colleagues to speak up**
   Reporting routes for Sexual Safety, Freedom to Speak Up and postgraduate education have been centralised on the intranet, alongside targeted communications and engagement activity. A listening hub was launched, Speak Up Month promoted, and governance processes strengthened to track training compliance and share FTSU training data with Care Groups.
3. **Supporting managers to address performance**
   Managers have been supported through the NNUH leadership development programme, regular policy updates, HR toolkits, workshops and eLearning, covering performance management, difficult conversations, attendance, flexible working and reasonable adjustments.
4. **Improving wellbeing and reducing burnout**
   A range of wellbeing initiatives have been promoted, including toolkits, Schwartz Rounds, targeted drop-ins, menopause awareness, grief support and seasonal wellbeing campaigns, with a focus on reducing exhaustion and improving engagement.
5. **Streamlining processes and enabling effective working**
   Process improvements have included policy updates, organisational change guidance, e-Rostering support, service redesign workshops and awareness sessions on digital and AI developments to support colleagues in their roles.

% of patients assessed for Venous Thromboembolism (VTE)						
Indicator	2025/2026 (Trust data)				NNUHFT 24/25	NNUHFT 23/24
	NNUHFT	National Average	Best performer	Worst performer		
Percentage of patients who were admitted to the hospital and who were risk assessed for VTE during the reporting period.	99.21%	No data available	No data available	No data available	99.42%	99.52%

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

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

The Norfolk and Norwich University Hospitals NHS Foundation Trust has taken the following actions to improve this rate, and the quality of its services:
The National Quality Requirement, in the NHS Standard Contract for 2025/26, is 95% and our current level of 99.21%, which is above the standard, this is comparable to the previous year. There will be continued communication and education of staff of risk assessing patients for VTE.

Clostridium difficile						
Indicator	2024/2025 NHS Digital				NNUHFT 23/24	NNUHFT 22/23
	NNUHFT FT 24/25	National Average	Best performer	Worst performer		
Rate per 100,000 bed days of cases of C. difficile infection reported within the Trust amongst patients aged 2 or over during the reporting period	15.89	23	2	81	13.2	15.4

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

Latest data available for reporting period April 2024 to March 2025

Location: Clostridioides difficile (C difficile) infection (CDI): annual data - GOV.UK (drop down selection of rate and hospital onset)

The Norfolk and Norwich University Hospitals NHS Foundation Trust considers that this rate is as described for the following reasons:
Within the reporting period of 2024 and 2025, the NNUHFT reported a total of 82 cases of C. difficile (CDI), which remained below the threshold established by UKHSA. This is noteworthy given that, nationally, there was an observed increase in the number and rates of CDI cases across England (UKHSA, May 2025).

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

A thorough PIR investigation is completed for each hospital attributable CDI (HOHA and COHA) case using a standardised PIR process. The investigating group includes the clinical team responsible for the patient, Antimicrobial Pharmacist, Microbiologist, NNUHFT IP&C and a representative from the ICB infection control team. During the meeting, instances of best practices are recognised, and decisions are made regarding potential learning opportunities, both of which are communicated to the clinical teams and discussed at governance meetings.

A weekly multidisciplinary team ward round of CDI inpatients is undertaken by a consultant microbiologist, member of the IP&C team, antimicrobial pharmacist and consultant gastroenterologist.

Measures are in place to isolate and cohort-nurse patients with suspected and confirmed C. difficile, in order to contain the spread of infection, and our Infection Prevention & Control (IP&C) team works in a targeted way to quickly contain any 'Periods of Increased Incidence'. Clinical cleaning processes are in place to contain any suspected infections. National Standards of Healthcare Cleanliness 2025 are in place.

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

Patient Safety Incidents	
Indicator	These indicators are part of the NHS Outcomes Framework, developed by the Department of Health and Social Care to monitor health outcomes and provide an overview of NHS performance. A wide-ranging consultation on the NHS Outcomes Framework was conducted from December 2023 to March 2024, and the results are currently in the final stages of appro val. During this period, only five indicators were formally published under the framework, excluding patient safety incidents. Links to other relevant data sources were provided. Since September 2023, the publication of national and organisational patient safety incident reports has been paused. This pause allows NHS England to consider future publication strategies in alignment with the introduction of the Learn from Patient Safety Events (LFPSE) system, which has replaced the National Reporting and Learning System (NRLS). As a result, we are unable to provide data for this indicator at this time. However, further details on our work related to the Patient Safety Incident Response Framework can be found on page 72.
Number and rate of patient safety incidents per 1,000 bed days	
Number and percentage of patient safety incidents per 1,000 bed days resulting in severe harm or death	

Review of Implementation of 7 Day Services

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

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

Review of Speak Up Policy

The policy is practical and user-focused, providing clear guidance and support while underpinning safety, transparency and learning, the key foundations of a healthy speaking up culture.

It signposts staff to a range of available resources, including safety teams and key contacts within care groups, ensuring that appropriate routes for escalation are clearly understood. The policy also reinforces the normality of speaking up as an integral part of everyday practice.

A detriment risk assessment has been added as an appendix, offering a practical tool to help identify and mitigate potential risks. Where an individual feels they may have experienced detriment, the policy clearly outlines how concerns can be raised with a manager or a Freedom to Speak Up (FTSU) Guardian. Data relating to detriment is reported externally to the National Guardian's Office by FTSU Guardians, supporting transparency and national oversight.

The policy also sets out how speaking up matters are handled, helping staff understand what happens once a concern is raised and strengthening organisational accountability. Overall, this policy is a valuable resource for anyone involved in, or supporting, a speaking up matter.

Freedom to Speak Up (FTSU) Guardian Service

The Freedom to Speak Up (FTSU) Service has strong vertical and horizontal representation across NNUH, with established senior oversight and a network of trained Guardians and Champions drawn from a wide range of roles and services.

Governance and leadership arrangements include:

- **Designated Non-Executive Director:** Dr William Van't Hoff
- **Senior Lead:** Director of People and Culture
- **Lead FTSU Service and Guardian:** Frances Dawson

Following a recent restructure of reporting and governance arrangements, the FTSU Service now presents quarterly, in person, to the People and Culture Management Group, and annually to the Hospital Management Group.

Reports focus on key themes including patient and staff safety, bullying, harassment, discrimination and detriment alongside emerging themes or newly identified risks.

Assurance is sought not only on the effectiveness of the FTSU service itself, but also on organisational progress against the ambition to become an exemplary NHS speaking up organisation. Trends and learning are explored, and clear recommendations are made.

Key performance indicators, including response times and time to case closure, are monitored routinely, with any exceptions scrutinised.
Staff can book an appointment directly with the Lead Guardian and can choose to meet in person in a private office, via Microsoft Teams, or discuss matters by telephone, ensuring flexibility and accessibility. Anonymous routes are also available as is meeting off site if staff felt it was required.

Barriers to accessing the service are continually considered. Anonymous feedback is used to capture service user profiles, providing valuable insight into where barriers may still exist for staff or groups and informing targeted improvement work.

The FTSU Service is proactive in organisational work, including reviews of NHS Staff Survey results, pulse surveys, the NHS People Promise (We Each Have a Voice That Counts), and, more recently, the patient safety domain of the NHS Oversight Framework, where raising concerns is a key sub-score.

The recent establishment of the Norfolk and Waveney University Hospitals Group has increased regional collaboration. This has included the development of memoranda of understanding, for example to support colleagues undergoing TUPE transfer, ensuring that clear routes to support are consistently available to staff.

The service remains active within the East Regional FTSU Network and Communities of Practice, and continues to engage with NHS England as it moves to absorb the support functions of the National Guardian's Office.

Rota Gaps

This year, approximately 513 Resident Doctors and Dentists in training joined the Trust as part of Foundation and Specialty training programmes coordinated through Workforce, Training and Education Directorate (WTED) within NHS England.

Ensuring Resident Doctors receive a high-quality educational and employment experience remains a central priority to the NNUHFT. While we continue to make progress, we acknowledge there is more to do, especially as more Resident Doctors opt for Less Than Full Time training (LTFT). Currently 20.3% of our Resident Doctors are working LTFT, with the majority working at 80% of full-time working hours.

Our ongoing efforts are collaborative, engaging with stakeholders, system partners, and Resident Doctors themselves to provide a sustainable, supportive training and working environment.

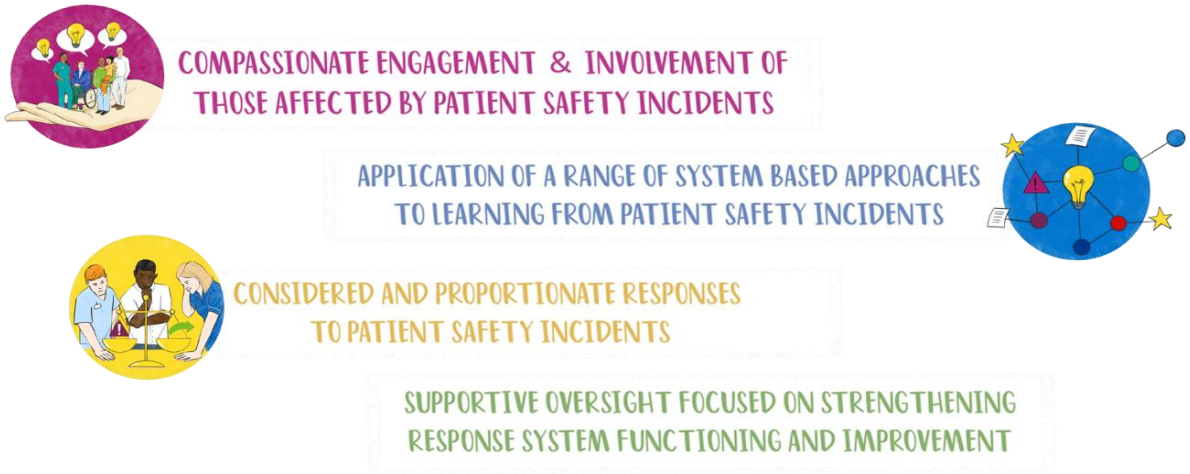
To drive improvements in rota coverage and the overall experience of our Resident Doctor workforce, we have continued to focus on the following initiatives:

1. A strengthened partnership with WTED: We maintain proactive communications to secure timely allocations and data through the Training Information System (TIS), supporting a smooth induction and rota planning.
2. Rota and Work Schedule Development: Our rosters/rotas and work schedules are designed in full alignment with the national 2016 Terms and Conditions for Doctors and Dentists in training (England), ensuring roster compliance whilst supporting wellbeing and service needs. Working with departmental roster leads to draft roster patterns ensuring service need is aligned and supported by the rosters.
3. Supplementing the Workforce: We continue to address gaps through the recruitment of Locally Employed Doctors (LEDs), Advanced Nurse Practitioners (ANPs), and Physician Associates, improving consistency of care and reducing pressures on the Resident Doctors in training posts.
4. Listening to Feedback: Insights from the General Medical Council's (GMC) National Training Survey and the National Education and Training Survey (NETS) inform targeted improvements across departments. We will continue to work closely with partners to demonstrate improvements.
5. Empowering Resident Doctors: Our Resident Doctors Forum provides a structured platform for colleagues to raise any concerns, share ideas, and influence change.
6. Championing Safe Working: Our newly appointed Guardian of Safe Working Hours ensures safe staffing principles are upheld and responds to concerns raised by Resident Doctors regarding their working hours or conditions. Proactively reviewing Exception Reporting data to ensure challenges with roster design are highlighted and addressed.
7. Technology-Driven Solutions: The implementation of Optima, our electronic rostering system for Resident Doctors, has brought increased visibility, flexibility, and operational efficiency which we will continue to embed within NNUHFT to ensure benefits are realised.
8. The Trust's efforts reflect our commitment to cultivating a positive and sustainable training environment which not only meets the expectations of our Resident Doctors but also supports the delivery of safe, high-quality patient care.

Patient Safety

Patient Safety Incident Response Framework (PSIRF)

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



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

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

Our Patient Safety Incident Response Plan (PSIRP)

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

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

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

Through analysis of our patient safety insights, 2 local patient safety priorities were identified that would undergo an in-depth Patient Safety Incident Investigation (PSII) during the period 01 September 2023 – 17 May 2025. These were:

Table 19: Local Priorities 2023-26

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

During January – March 2026 the organisation conducted a thematic analysis of national audits, and local complaints, structured judgment reviews, incidents, and claims to identify the organisation's new local priorities, for the period May 2025– October 2026.

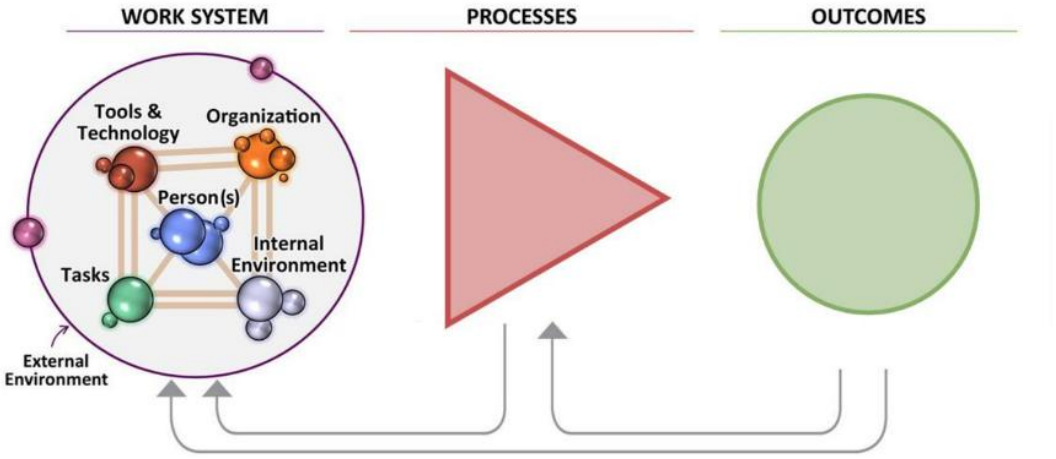
Table 20: Local Priorities 2025-26

Key Theme	Key Risks from Activity
Emergency Admission on Elective Waiting List	Patients under all specialties where there is an emergency admission requiring an inpatient stay and treatment whilst waiting for surgery. This was the highest reported Incident for moderate and above harm and the 3rd highest reported incident resulting in lower level of harm. It was also identified as a theme in complaints and claims.
Unexpected Complication after a Procedure	Incidents affecting patients following surgery or an invasive procedure within Cardiology, Angiography and Gastroenterology. This was the 3rd highest reported Incident for moderate and above harm and 4th highest reported incident resulting in lower levels of harm. It was also identified as a theme in complaints, claims and national audit outcomes.

Patient Safety Incident Investigation

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

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



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

Table 21: April 2025 – March 2026 PSIIs

Incidents meeting Never Event Criteria to undergo PSII	3
Incidents resulting in death, assessed as more likely than not due to problems in care following Structured Judgement Review to undergo PSII	7
National Priority - Other	1
Sub – optimal care to undergo PSII	1
Unexpected Complication after a Procedure	1
Emergency Admission on Elective Waiting List	1

A single Patient Safety Incident Investigation for the local priority of Emergency Admission on Elective Waiting List has been commissioned. This PSII will complete a thematic analysis of 50 cases across 5 specialities and is expected to be completed by June 2026

Patient Safety Learning Responses

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

Table 22: Learning Response Approaches

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

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

Learning Response	Total
AAR	26
SWARM	18
MDT Review	48
Case Note Review (including SJR)	703
Thematic Review	5
Total	800

Next Steps

We will be undertaking data analysis from multiple sources of insight to inform the Trust's local PSII priorities for the next iteration of our Patient Safety Incident Response Plan (PSIRP). The refreshed version of our PSIRP will be signed off by the Hospital Leadership Team at the end of 2026.

Never Events

'Never Events' are a sub-set of Incidents and are defined nationally as largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers.

In our hospitals there were four never events during the period covered by this Quality Account

Table 24: April 2024 – March 2025 Never Events

Month reported	Never Event Type
May 2025	Retained Foreign Object Post-Procedure
September 2025	Wrong site surgery
September 2025	Wrong site surgery
September 2025	Wrong site surgery

The NHS Never Events Framework remains active whilst currently under consultation. The organisation will continue to manage Never Events as a national priority that requires a full Patient Safety Incident Investigation under the PSIRF until alternative guidance is issued.

Martha's Rule

Following participation in the NHS England Worry and Concern Collaborative in 2021, NNUH were chosen to be part of Phase 1 of the Martha's Rule roll out in 2024. As part of this, we committed to rolling out all components of Martha's Rule to inpatient areas by March 2026. This encompassed the three core components:

1. Patients will be asked, at least daily, about how they are feeling, and if they are getting better or worse, and this information will be acted on in a structured way.
2. All staff will be able, at any time, to ask for a review from a different team if they are concerned that a patient is deteriorating, and they are not being responded to.
3. This escalation route will also always be available to patients themselves, their families and carers and advertised across the hospital.

It has been recognised that the patient, or those who know them best, may be the first to notice early signs of deterioration and the importance of acting on these. Implementing all three Martha's Rule components supports early identification of deterioration to improve both patient outcomes and experience.

Component 1

Since April 2025, Component 1 has been implemented across all adult inpatient areas using the Patient Wellness Questionnaire. This means it is now in place across all inpatient areas, including maternity and paediatrics through their respective Early Warning Scores.

The Patient Wellness Questionnaire was trialled on 5 wards from September 2025, with regular feedback from staff instigating small changes to the paperwork and the processes followed. Progressing to implement this Trust wide by March 2026 has been a key success over the previous year, with positive feedback received from staff and patients regarding the impact of this implementation on patient safety. We are continuing to work with our EPR colleagues to ensure this is built into digital systems.

There were multiple challenges faced when implementing a new piece of paperwork into the nursing documentation. Educating staff on the importance of Martha's Rule and the impact this can have on patient safety was paramount. Collecting data on compliance with the paperwork has also been a key challenge due to the time constraints associated with paper auditing. We are working with the Quality Improvement team to embed these audits into day-today practice for wards.

Components 2 & 3

In March 2026, the existing Call for Concern Service, which was available to adult and paediatric inpatients, was relaunched as the Martha's Rule Telephone Escalation Service. This is now available for all adult, maternity, paediatric and neonatal inpatients as well as patients in the emergency department.

Launching the Telephone Escalation Service across all inpatient areas and into the emergency department was a key success, requiring collaboration between multiple different teams to ensure robust processes were developed. This included ensuring a timely response to the call by a healthcare professional appropriately trained in the speciality.

The most significant challenge in the process has been the technology behind setting up the telephone system to allow direct transfer to specialities. This has been mitigated by Martha's Rule being launched with the Recognise and Respond Team receiving all calls and escalating the details to the specific speciality. This has been escalated for a resolution as there is a potential risk of delay and misinformation throughout the process.

A total of 117 calls were received in 2025 through the Call for Concern service. Of these, deterioration was identified in 11% of calls and this led to a change in treatment in 4% of cases. 21 calls have been received since the launch of Martha's Rule at the beginning of March 2026.

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

Over the next 12 months, we aim to have the Patient Wellness Questionnaire embedded into the EPR system, both to improve staff experience and allow easy data collection and analysis. We are also aiming to work alongside outpatients and the Learning Disability team to ensure the Martha's Rule Telephone Escalation Service is available and accessible for all patient groups.

Falls

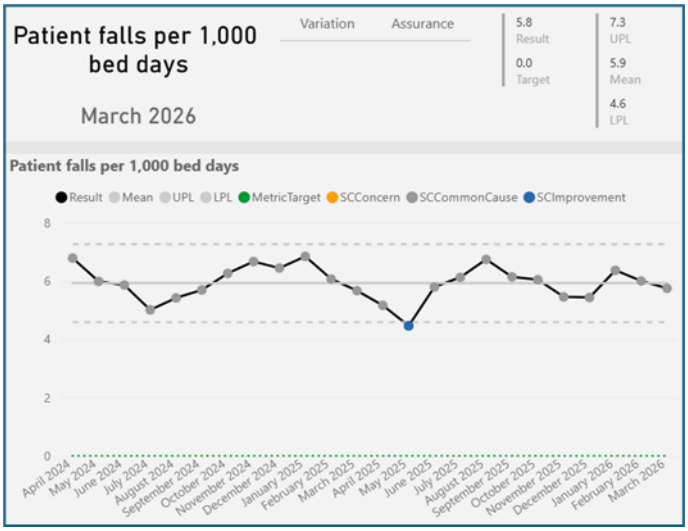
Baseline: what increased the focus for the Falls work we have been doing?

Falls remain a high priority for NNUH inline with NICE Guidance NG249 and a continued co-ordinated multidisciplinary team approach across all areas of the hospital can reduce their incidence. NNUH continues to follow the recommendations set out by the Royal College of Surgeons – National Audit of Inpatient Falls and their focus on a multidisciplinary approach on key performance indicators for falls such as compliance with delirium screening, lying and standing blood pressure measurement and assessing falls risk through a multifactorial approach to safe activity, which includes a focus on deconditioning.

Norfolk's expanding older population continues to be affected by the post pandemic frailty wave and this combined with areas of deprivation and health inequalities results in increased risks of falling, hospital admissions and social isolation, often reducing confidence and independence. This continues to drive our collaborative work with community and VCSE services, adapting how we work and ensuring a neighbourhood approach is embedded.

What we are measuring success on:

Our success have been measured through our falls per thousand bed days data which has shown a 12.6% reduction when comparing 2024 to 2025 against a 5% target which was set at the end of 2024. Most importantly this is a significant reduction in harm and distress to our patients and their families and carers after reducing the total falls number by 318 in 2025 and continues our year on year journey of falls reduction and sustained improvements in patient safety.



The journey so far this year (April 2025 – March 2026) including successes and challenges:

Success:

- National recognition as a recipient of HSJ Highly commended award for Alice's Story a service user co-produced animation created by NNUH and AGE UK Norwich.

- NNUH has led on the Tri Trust development of the Falls EPR development, which will see risk assessment expanding into Outpatients as well as ED and Inpatient areas.

- Continuation of the North Norfolk Falls Support Pathway for patients presenting at NNUH Emergency Department and Cromer Minor Injuries Unit post fall and being discharged home. These patients after discharge are followed up with their District Councils who will offer holistic support opportunities with a view to preventing further falls and subsequent attendances at hospital. 1972 patients were identified through the service, 2552 onward referrals made across 792 individuals. 282 of these individuals were also referred into Active NoW a single point of access into physical activity provision. A full data review is expected soon and qualitive data themes are demonstrated below and has shown the positive impact the project has had on the North Norfolk fallers, highlighted in this quote from a service user…
  "I'm very excited to get started with all this, i shall be a whole new woman. I'm very happy to be helped in the way I was helped, and I'm no longer frightened of being frail. This service is a huge benefit to lifting strain on the NHS and providing what they might not be able to. Before I fell, I was feeling very lonely and worried about the future, and I'm actually happy that I fell. The service I have received is a wonderful gift and I'm now very excited with all the interactions I have"

- Expansion of the Falls Team with the recruitment of a new Band 4 Clinical Associate post and development into the Clinical Excellence portfolio,

combining fundamentals of care such as nutrition, hydration and deconditioning and Accreditation of Excellence.

- Development of a Falls Learning and Governance Group (FLAGG) which will support our Care Groups to proactively address their falls themes, develop action plans and share learning.
- A trust wide campaign around side room safety including a poster campaign, patient leaflets and an updated falls risk assessment which includes improved sections to cover Delirium, side room safety. Use of the Delirium side room safety simulation video training across the Trust.
- Development of a falls retrieval simulation video which was created in collaboration with patient safety and manual handling teams.
- Updated falls risk assessment, focussing on assessing safe activity and emphasising screening for delirium, side room safety and deconditioning.
- Introduction of a new national training around the safe use of bed rails and entrapment risk.
- Creation of an external facing resource for falls prevention on the NNUH website Norfolk and Norwich University Hospitals NHS Foundation Trust » Falls Programme

Challenges:

- Moderate harm falls is 5% higher than in the previous year despite a continued reduction in falls numbers. It is apparent from the Shared Care record that many of the patients with the most injurious falls that occur in the hospital are also having multiple falls in the community. It is likely that the increasing frailty of the population continues to play a part in both Community and inpatient falls.
- The ability to measure deconditioning within the hospital and also combat it at ward level remains one of the biggest challenges. There is currently no standardised tool available to measure deconditioning although one is expected in 2026.

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

We will once again aim for a continued reduction of 5% in falls per 1000 bed days.

Areas of focus will include:

- Continuing our work with community colleagues including the council driven proactive intervention project, which is likely to include expansion of the North Norfolk Falls and Frailty pathway.
- Support the drive to increase screening for Delirium of all patients aged 65 and over at admission which remains a priority focus for the Falls Team.
- Drive compliance with safe activity documentation, thematic review and learning from falls through accountability at Care Group and ward level through FLAGG.

- Joining together education on fundamentals of care through on ward micro teaching sessions through Clinical Educators.
- A proposal to look at developing health coaching / reablement roles on ward to combat deconditioning and also continue this provision on discharge as well as targeting the wider determinants of health through community VCSE support.

Virtual Ward

Baseline:

In 2022, England's Integrated Care Systems (ICS) were tasked with delivering up to 24,000 virtual ward (VW) beds by December 2023—equivalent to 40-50 VW beds per 100,000 people.

Norfolk and Waveney ICS, including NNUHFT, had targets of:

- 173 VW beds by April 2023
- 368 VW beds by April 2024

Collaboration with local community providers and other NHS hospitals in Norfolk and Waveney offers a chance to improve and expand virtual wards. NNUHFT was directed to maintain 60 VW beds, recently increasing to 90 beds.

What we are measuring success on:

- 98.6% patient satisfaction of service 97.9% would use the service again
- Flexible way of working and more time for 1:1 patient interaction
- Treatment costs reduced by 20-30%
- Patients are three times more likely to be satisfied, and lower incidence of complications in comparison to physical acute bed
- Sets a platform for integrated Virtual Care across the ICS, to improve patient flow through the whole system
- 9449 patients now seen through Virtual Ward since Feb 2021 with more than 71,000 bed days saved.

The Journey so far this year:

- Aligned with new care group model
- We have maintained 60 acute beds and are often above capacity
- Below national average number of 30-day readmissions at 7.5%
- 3904 patients through the service an increase of 37.9% from the previous year
- 26,598 bed days saved, an increase of 35% from the previous year
- National recognition and HSJ safety award and HSJ Highly commended for our hyperemesis pathway
- Continued national and international recognition, Gynaecology pathway and data presented to international ESGE conference in Istanbul

Challenges

- Our biggest challenge remains our geographical footprint within the trust, with no dedicated clinical space available to review or onboard patients
- Organising bloods and physical reviews can be very complex and time intensive, placing significant burdens on nursing time
- Onboarding patients has to happen in physical beds on the wards – impeding flow
- Different models of care across the ICB and little appetite for clinical engagement to align models

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

- Clinical and office space to expand the service
- Standardised approach across the ICB – particularly the 3 acute trusts
- Plans are in place to increase Virtual Ward capacity to 90 beds ahead of winter, with further expansion to up to 120 beds by the end of the financial year.
- Growth will be focused on the development of new clinical pathways, including direct admission from the Emergency Department, to support admission avoidance and improve flow.
- Community partnerships will be reviewed and refreshed to ensure alignment with the expanded model and evolving demand.
- Several development projects are already underway, including exploration of the potential development of MoIRRA (Mobile Integrated Rapid Respiratory Assessment) as part of future capacity and pathway solutions

Sustainability

Baseline: what increased the focus for the sustainability work we have been doing?

One of the largest contributors to the NHS' carbon footprint are operating theatres. Surgical activity generates between 20-30% of total hospital waste and is 3 to 6 times more energy-intensive than any other hospital department. This project was initiated to reduce environmental impact, improve cost efficiency, and maintain high standards of patient care within our surgical service. This project was undertaken within the Norwich Hand Unit, involving the entire multidisciplinary team. Approximately 240 cases are undertaken each month with around 7 staff per day, per Ambulatory Procedure Unit (APU) theatre. This team was well-placed to deliver change due to its cohesive structure, prior engagement with sustainability efforts, and alignment with organisational priorities.

Several practices were identified as resource-intensive with limited clinical benefit, including:

- Use of large, non-streamlined sterile packs.
- Use of visor masks, which are more expensive and often unnecessary.
- Inefficient scrubbing practices (water-based rather than sanitising gel).
- Daily use of single-use surgical hats.
- Oversized surgical sets.
- Routine prescribing of paracetamol and ibuprofen post-operatively.
- Routine distribution of bottled water post-operatively.

What we are measuring success on:

Project	Implemented (Y/N)	Annual GHG emission savings (kgCO2e)	Annual financial savings (£)
Scrubbing up			
Reusable hat	N	Savings not calculated as part of project	
Reduction of visors and masks (3 scrubs per case)	Y	2,530	631
Streamlining sterile packs	Y	9,716	28,325
Reusable gowns (3 scrubs per case)	Y	6,104	
Scrubbing: adoption of alcohol base gel to replace traditional scrubbing after the initial first scrub of the day (3 scrubs per case)	Y	2,177	672
Surgical sets	N	Savings not calculated as part of project	
Post operative			
Medications	Y	193	914
Bottled water	Y	111	2,160
Total savings of implemented projects		20,831	32,702

The journey so far this year (April 2025 – March 2026) including successes and challenges:

Key successes included no complications or negative outcomes, strong staff engagement and a transferable model for other units seeking similar gains.

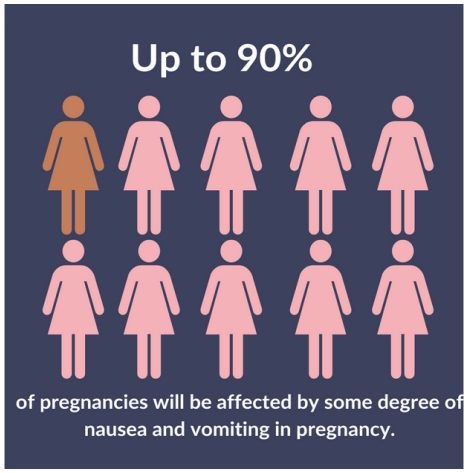
Challenges were encountered during implementation with procurement delays and time for Trust sign off slowing progress on streamlining packs. For TTO packs, patient expectations at discharge initially presented a barrier. Education and reassurance for patients, alongside staff engagement at all stages of the process, proved effective. Pre-operative discussions in the Emergency Department also supported this by advising patients about analgesia early in their pathway.

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

Charitable funds are being explored for the procurement of reusable theatre hats with staff engagement ongoing to ensure compliance and understanding of washing procedures. A review of surgical sets has been initiated to match set size to actual usage, aiming to reduce unnecessary sterilisation for equipment that has been

opened but not used. The team are also initiating conversations with sterile services to look at feasibility to move forward with this project. Reducing size of the sets will allow more sets to be sterilised within one cycle, thus improve efficiency and reduce environmental impact.

As the winning team of NNUH's Charity-funded Green Team Competition led by the Centre of Sustainable Healthcare, colleagues in the Hand Unit are working with Investors in the Environment to boost their knowledge through learning to able enable delivery of more initiatives across the Unit over the coming year.



Hyperemesis Gravidarum

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

Nausea and vomiting of pregnancy (NVP) affects up to 90% of pregnant women, with approximately 4% experiencing severe symptoms in the form of Hyperemesis Gravidarum (HG). HG is frequently associated with repeated GP consultations, emergency department attendances and inpatient admissions.

Local data, including service user feedback, clinical outcomes and patient testimony, highlight significant challenges in accessing timely, evidence-based and effective care for NVP and HG, a challenge mirrored nationally. Evidence consistently demonstrates that women often make multiple contacts with different healthcare professionals before receiving appropriate treatment. Throughout this process, many report feeling dismissed or that their symptoms are minimised as being ‘normal’ in pregnancy. Where care is provided, limited follow-up and advice can result in frequent readmissions.

This pattern of care impacts not only women and their families but also service capacity, contributing to additional pressures on emergency services and delays to elective care where inpatient beds are required.

NNUH is a 5,400-birth maternity unit. A review of attendances for NVP between 2023 and 2024 demonstrated that women attending on more than one occasion accounted for over 50% of all admissions. This suggests that the prevalence and impact of HG may be underestimated.

Our aim was to improve care for women and birthing people experiencing NVP and HG by bringing together multiple strands of practice development and service-user insight to design a sustainable model of high-quality care. This model focuses on reducing physical, psychological and social harm through improved access, proactive follow-up and medication optimisation, including the introduction of virtual clinics. The approach has resulted in reduced hospital stays, improved patient experience and increased efficiency across services.

What we are measuring success on:

Success was measured through reductions in inpatient bed days related to readmissions for NVP/HG, alongside analysis of clinical outcomes, financial impact, environmental sustainability and service user feedback.
Following implementation of the new HG pathway, inpatient bed days reduced from 22.9 to 9.8, equating to a projected annual cost saving of over £700,000. While reductions in bed days are not always recognised as cash releasing savings, the operational benefit to the Trust is significant. Freed capacity has supported improved patient flow, earlier elective surgical activity and reduced pressures on gynaecology waiting lists.

The reduction in bed days also delivered an estimated carbon saving of 6,461.5 kgCO2e per annum, equivalent to more than 23 return car journeys from Land's End to John O'Groats.

Despite these measurable outcomes, service user feedback has been the most meaningful indicator of success. Women described the new pathway as life changing, reporting improved ability to remain in work, care for their families and develop a bond with their unborn baby.

The journey so far this year including successes and challenges:

A new NVP and HG pathway has been developed and embedded across maternity services. The Trust maternity website has been updated to provide early, accessible information and signposting to support.

Written information has been co-produced for women attending the Early Pregnancy Unit, outlining what to expect, providing practical advice and clarifying next steps following discharge.

A weekly virtual clinic has been introduced to review women with NVP and HG, optimise antiemetic treatment and personalise care. This has significantly reduced the need for readmission.

A key success has been collaboration with the Virtual Ward and Community IV teams. Women can now receive daily symptom review and assessment on the Virtual Ward, attend the hub for IV therapy or receive IV treatment at home. This has provided an effective bridge between inpatient care and oral medication stabilisation, reducing length of stay and preventing readmission.

Education and engagement have been central to implementation. Teaching has been delivered to community and hospital midwives, GP trainees, gynaecology nurses, Virtual Ward staff and Community IV teams, with further sessions planned for GPs and student midwives.

The project has received national recognition, including winning the Centre for Sustainable Healthcare's Green Maternity Challenge (2025) and presentations at the RCOG Green Maternity Conference and RCOG World Congress. In September 2025, the team won 'Virtual or Remote Care Initiative of the Year' at the HSJ Patient Safety Awards and was highly commended for 'Digitalising Patient Care' at the HSJ Awards in November 2025.

The most significant challenge was achieving a cultural shift across multiple specialties. This represented a fundamental change in the management of NVP and HG. Ongoing MDT working, consistent education, early stakeholder engagement

and strong clinical leadership were critical to overcoming this challenge and embedding sustainable change.

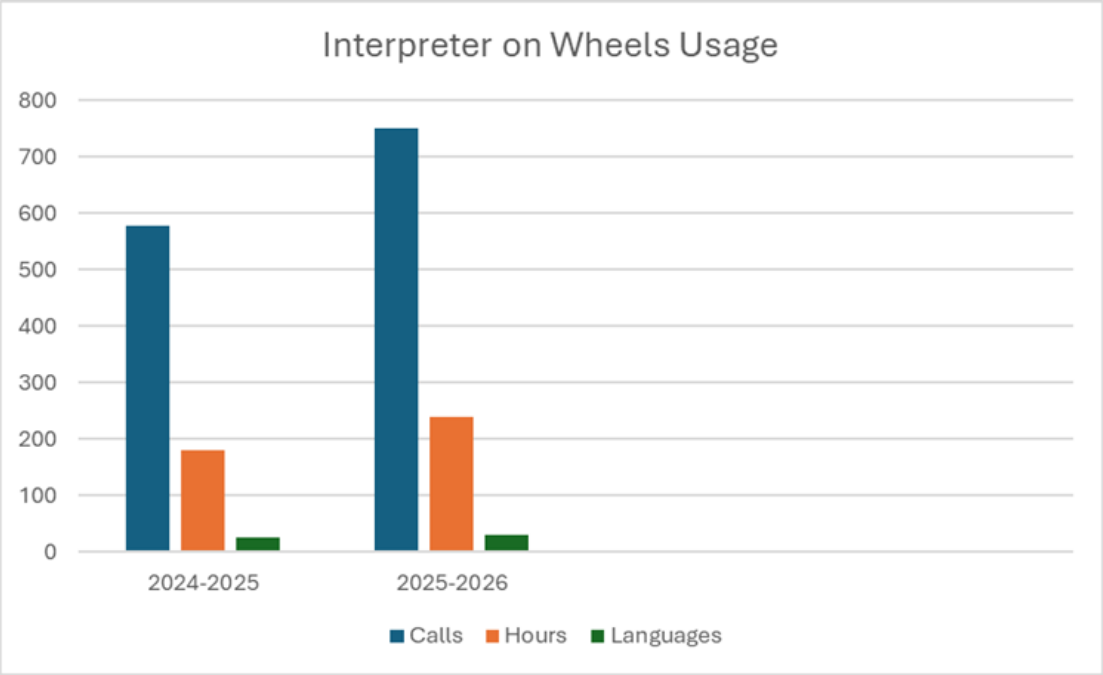
What we are aiming to achieve over the next 12 months and beyond

Over the coming year, the service will continue to evolve through co-production with service users, including further refinement of patient information resources and continued education across all professional groups.

The team has been approached by multiple NHS trusts and international services seeking support to implement the pathway. In March 2026, in collaboration with the RCOG and the Centre for Sustainable Healthcare, funding was sought to support national spread, with the ambition of enabling 12 trusts to replicate the improvements achieved at NNUH.

Patient & Public Involvement & Voice

In 2025 we worked hard to improve access to interpretation services for our patients and Carers. After a successful trial, we adopted the new technology provided by LanguageLine Solutions that gives us 24/7 on demand access to interpreters who speak over 240 languages. This is delivered through an app that can be found on all trust iPhones and iPads and we also have 30 wheeled units called Interpreters on Wheels (IoW). Since embedding this service into practice across all areas of the Trust, there has been a demonstrable increase in the use of this interpretation service.



Supporting our staff to have access to interpretation at the bedside, increases accessibility and equitability of care, patient engagement and satisfaction, patient compliance and adherence to treatment plans. All underpinned by improved patient safety, via the reduction of risks around misdiagnosis, medication errors, avoidance of unnecessary tests and interventions and enhanced safety in terms of escalation of care.

We've collected staff feedback from departments who have adopted this service, and it has been overwhelmingly positive. Here are some examples:
"Whilst working a weekend shift on Blakeney I borrowed the interpreter on wheels machine from the Antenatal clinic for a patient who was unable to speak English. The machine was easy to use, and it had full instructions attached for new users. Once the language required was selected, an interpreter was available almost immediately and allowed me to communicate effectively with the woman in my care in a timely manner. I was very impressed with how easy it was to use, brilliant service." ~ NNUH Midwife

"*We have been using an IoW device in Radiology since April 2024. The device has been really well received with feedback from the different areas where it has been used being positive, and staff commenting that they love using it. The IOW has enabled patients to be examined efficiently rather than having to be rebooked and interpreters organised. The face to face function of IOW has been well received by patients. And the moveability/flexibility of the device has enabled patients to access an interpreter whilst laying on the scanning beds.*" ~ NNUH Radiology Department

Cromer Hospital Staff receiving their IOW.

In partnership with Patient Safety & Medical Illustration we created videos for staff and patients that show staff and a patient using an IOW in our hospital.

We plan to continue the expansion of this service this year by increasing the communications about the IOWs with patients and staff.

Focus for 2026/27 is expanding our community engagement with a focus on seldom-heard voices in our community. We already have a Deaf Awareness training session planned as part our recognition of Deaf Awareness Week in May, this is open to the whole Trust and will be delivered by Deaf Connexions. We plan to proactively interpret and analyse our Friends and Family Test (FFT) data to deliver real changes in patient experience. This will be in collaboration with our patient panel and staff working alongside our patients in all areas. Reaccreditation on our Veteran Aware status. The NNUH has held Veteran Aware accreditation since 2018. We are planning some key engagement, training and awareness activities throughout the year to develop our staff and patients' awareness of the support available to them as part our veteran community

Patient Advice and Liaison Service (PALS) and Complaints

The PALS team are central to providing confidential, on the spot advice and support to patients and families raising concerns, helping to resolve concerns promptly and at the earliest opportunity, de-escalating complaints wherever possible. Where this hasn't been possible, they will assist patients and families if they wish to make a formal complaint. The Complaints team support the investigation of concerns relating to treatment and care, aiming to provide explanations and apologies in a formal written response and identify service improvements.

In this last year we have undertaken a review of the PALS and Complaints team, in response to a need to improve the accessibility and responsiveness of services. The review saw the separation of the teams, with distinct leadership and support to focus on delivery of each service.

Within the PALS service there has been a focus on improved availability, visibility and presence, which have led to enhanced service user experience and relationships across the Trust. The service is now supporting 'here and now' concerns, helping to support those who raise concerns about their care whilst inpatients. There has been an increase in ward visits to support patients and ward staff, with improved patient experience and engagement. The team have over 1300 contacts per month with people accessing the service, through email, phone call or drop in that may require signposting, escalation or mediation between staff and patients to achieve early resolution. The service is helping to de-escalate concerns by engaging early and increasing accessibility, with an observed reduction in formal complaints.

Our work within the Complaints service has concentrated on enhanced management and support of our complaints officers to provide professional, high-quality responses and case management. Following this review, we now have dedicated, specialist management of complaints with an over-arching senior leadership, enhancing leadership and management for better team morale, engagement and experience.

The review and investment into these teams are beginning to demonstrate improvements in the activity and performance of both teams, with an overall improvement in patient and family experience.

Our current complaints process has undergone a significant review, with a shift in the approaches taken to support patients and families to receive timely responses to their concerns. From April 2026, the team have been set the challenge to overhaul the complaints process, the vision being to create a single consistent approach to the management of complaints, ensuring equity of access to patients and their representatives who use our services and have concerns or wish to raise a complaint.

The new process will see improved collaboration with care groups, to facilitate and support a timely response to complaints. There will be an opportunity within the new process to resolve a complaint at the earliest opportunity through telephone and face to face communication which will enhance the engagement with patients and families, resulting in an improved patient experience. It will also enable the trust to learn from their complaints and these lessons will inform future service development and improvement.

Voluntary Services

Welfare and Safety Netting Call Service – Quality and Learning Summary

Over the past 12 months, the Welfare and Safety Netting Call Service has continued to demonstrate strong performance and positive impact, further consolidating its role in supporting patients following discharge from hospital. During this period, the team has completed more than 58,000 post-discharge calls, providing timely reassurance, practical support and an additional layer of safety for patients as they transition home.

The service has benefited from increased volunteer capacity, with three new team members joining during the year. This has enabled contact to be made with over 90% of patients discharged on the zero pathway across the Trust. More recently, the team has achieved a sustained 100% contact rate, representing a significant milestone and reflecting the commitment and effectiveness of the service model.

Learning from Patient Feedback

Feedback gathered through follow-up calls continues to provide valuable insight into patient experiences of discharge and early recovery at home. Several recurring themes have been identified which highlight both strengths in current arrangements and opportunities for further improvement.

One recurring area for learning relates to the timely implementation of Packages of Care. A small number of patients, particularly older people, reported returning home with the expectation that care support would commence immediately; however, follow-up calls identified occasions where this support had not been in place within the first 24 hours. These situations were escalated promptly, with close liaison between the Safety Netting team and ward staff to ensure appropriate care was established and potential deterioration or readmission was avoided.

These examples clearly demonstrate the added value of the Safety Netting Call Service. Early contact, combined with swift escalation and collaborative problem-solving, has played a key role in mitigating risk, improving patient experience and supporting safer outcomes following discharge.

Common Themes Identified (Last Six Months)

Analysis of patient feedback has identified a number of consistent themes for Trust-wide learning, including:

- Patients not receiving a discharge letter at the point of discharge
- Perceptions of discharge occurring earlier than expected

- Confusion regarding medication changes or instructions
- Prescribed medications not available on discharge
- Challenges coping independently at home in the initial post-discharge period
- Difficulties with meal preparation
- Concerns about the home environment, including cleanliness
- Financial hardship, including limited access to food or heating

These themes are shared regularly with Care Groups and improvement teams to support learning and pathway development.

Partnership Working and Holistic Support

The effectiveness of the Safety Netting Call Service is significantly enhanced through close partnership working, particularly with the Norfolk & Waveney Community Support Service. This collaboration enables patients identified as vulnerable to be rapidly referred for additional practical and emotional support.

Interventions include welfare checks, emotional reassurance, signposting to specialist services, assistance with daily living tasks, and provision of essential items such as food. Feedback from partner organisations consistently demonstrates positive outcomes, including improved wellbeing, increased confidence and successful stabilisation following discharge.

Managing Concerns and Continuous Improvement

While the majority of patients report positive experiences, a small number have raised concerns relating to aspects of their care. These include:

- Pain management and delays in accessing medication
- Communication at the point of discharge
- Delays in receiving discharge documentation or medicines
- Transport delays or logistical challenges
- Isolated reports of dissatisfaction with care

In several cases, the Safety Netting team has been able to intervene directly, for example by locating missing medications, arranging delivery, or escalating concerns to the appropriate clinical teams. This responsive approach has provided reassurance to patients and supported timely resolution of issues.

Role of the Discharge Support Volunteer Project Coordinator

The Discharge Support Volunteer Project Coordinator remains central to the success of the service. Issues identified during calls are addressed promptly through direct engagement with ward teams or referral to partner services, including the Norfolk & Waveney Community Support Team and the Settle In Service. This rapid-response model supports early resolution of concerns and contributes to reducing the risk of avoidable readmission.

Addressing Wider Determinants of Health

The service continues to identify and respond to wider determinants of health. Some patients experience emotional distress or crisis following discharge, and coordinated support is arranged when needed. This includes practical help such as cleaning, shopping and meal preparation, alongside emotional support. The close integration between the Safety Netting and Settle In services provides a holistic and person-centred approach to care.

Data, Learning and Next Steps

All call data and transcripts are recorded within Power BI, ensuring that information is accessible to Care Groups, the Improvement Team and the Transformation Team. This supports Trust-wide learning, service improvement and ongoing development of patient pathways.
Overall, the Welfare and Safety Netting Call Service continues to add clear value to the discharge process. Ongoing learning from patient feedback, alongside strong partnership working and data driven improvement, will remain essential in ensuring the service continues to enhance patient safety, experience and quality of care.

Aims for 2026/ 2027

Evidence shows that patients and visitors find it difficult to navigate the size and layout of the NNUH site, particularly those with reduced mobility who may need to move between multiple buildings during a single visit. This can make what should be a straightforward appointment more challenging and, in some cases, very physically demanding.

To address this, a new volunteer led patient transport service is being proposed for 2026/27. The introduction of electric buggy vehicles would provide a simple and practical way of supporting patients to travel between key areas of the site, including the Community Diagnostic Centre (CDC), the Quadrum Building (QI) and the public multistorey car park. This would make it easier for patients to attend follow-on assessments and return visits safely, while also reducing the physical strain associated with moving across the site.

The proposal includes the purchase of two electric buggy vehicles, which will be funded by the hospital charity.

From a quality perspective, this initiative supports safer patient movement across the site, reduces the likelihood of missed or delayed appointments, and helps ensure patients arrive in a condition that enables effective clinical assessment. It also contributes to a more dignified and compassionate experience, aligning with expectations around patient-centred care and continuous improvement in service delivery.

NHS Staff Survey

The NHS Staff Survey 2025 launched at NNUHFT on 6th October 2025 and closed on 28th November 2025. NNUH saw an improvement in participation in 2025 at 48% compared to 47% in 2024. This is slightly higher than the Acute Trust average of 47% (benchmarked with 121 acute Trusts). There was an increase in completed questionnaires with 4732 staff completing the survey compared to 4508 in 2024.

2025 Staff Survey - benchmark results

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

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

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

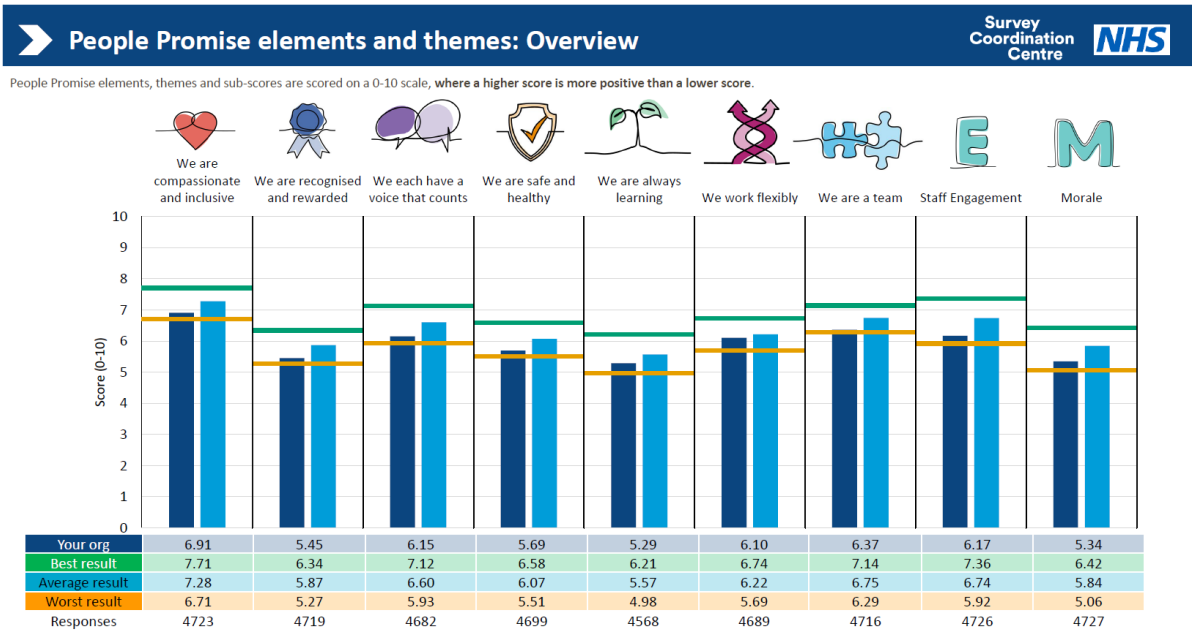
National benchmarking Results – 121 acute Trusts

When comparing the 111 NNUHFT question scores to the national Acute Trust average, 17 score comparable with or above average, 94 are below average, with 5 questions being equal to the lowest scoring Trust.

NNUHFT scored below the national acute trust average for the 9 themes of the People Promise and Staff Engagement and Morale themes. The sub-theme of We Work Flexibly scored above the Acute Trust average.

In comparison to 2024, 5 of the 7 People Promise themes (We are Recognised and Rewarded, We Each Have a Voice That Counts, We are Safe and Healthy, We Are Always Learning, We Work Flexibly) and the 2 additional themes of staff engagement and morale have declined. The changes in the People Promise themes of We Are Compassionate and Inclusive and We Are a Team are not considered statistically significant and therefore NNUHFT have maintained their position with these 2 themes in 2025 when compared with 2024.

NNUHFT 2025 theme scores compared to the benchmark of 121 acute Trusts



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Your org	6.91	5.45	6.15	5.69	5.29	6.10	6.37	6.17	5.34
Best result	7.71	6.34	7.12	6.58	6.21	6.74	7.14	7.36	6.42
Average result	7.28	5.87	6.60	6.07	5.57	6.22	6.75	6.74	5.84
Worst result	6.71	5.27	5.93	5.51	4.98	5.69	6.29	5.92	5.06
Responses	4723	4719	4682	4699	4568	4689	4716	4726	4727

Next Steps

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

Our staff listening doesn't end with staff survey and we will continue to hear the views from staff from various channels such as the National Quarterly Pulse Survey, Connected, through our Staff Side, Staff Network and Staff Council representatives and local teams. As an organisation there will be continued provision of support from the People Team including the redesign of our leadership development programme, a suite of wellbeing support and further staff experience initiatives at a Group Level.

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

Statement from Healthwatch Norfolk

Healthwatch Norfolk Statement – NNUHFT Quality Account 2025/2026

Introduction:
Thank you for the opportunity to comment on the NNUH Quality Account 2025/26. The document is, of necessity, technical and data focussed but includes examples and case studies. It requires knowledge of NHS methodology and processes to fully understand and we note the requirements of mandatory wording from NHSE. There is a glossary and an easy read version. There is also availability in other formats such as Braille. In order to communicate effectively with a general public audience it might be worth considering production of a more accessible version, perhaps a few pages long and written in a journalistic style. This comment might also include communication with staff.

Given the length and complexity of this document our comments are highly selective.

Quality Priorities:
You clearly state how the priorities are selected, the rationale behind this and progress made.
How does your measurement of Quality reflect the views of the public?

To highlight and comment on a few:

Patient safety:
-falls prevention: it is good to see the overall success in falls prevention but note the uncertainty on how to manage and prevent deconditioning and hope this will be resolved in the future.
-agree with the emphasis you place on the recognition of deterioration, especially the adoption of “Martha’s Rule”. It will be interesting to see the clinical effectiveness and figures for any resulting changes in treatment once established.

Clinical Effectiveness:
-we are impressed by the establishment of a service providing comprehensive care for Hyperemesis and Nausea/Vomiting in pregnancy. It is welcome that this is clearly patient centred and cuts across hospital/community/General Practice barriers.

Patient and staff experience:
-of great concern is that only 50.38% of staff employed would recommend the Trust. This compares to a national average of 60.83% (also worryingly low) and the best trust
reporting 89.59%. What can be learnt from the best Trust with a significantly higher result?
Staff experience scores have declined since last year, including morale, Of course, some of this may reflect national concerns but we would welcome specific examples of how problems can be addressed locally. Good staff morale is vital to be able to provide the best service to patients and relatives.

-improving communication around End of Life Care is very important given that there appears to be public misunderstanding about the ReSPECT policy.

Communication:
We welcome the planned move to an electronic patient record system and the intended improvement to communication both within teams and to patients/carers. Unfortunately implementation appears to be delayed and there is continued use of paper records.

Data Quality:
Note that you participated in 98% of national clinical audits and 100% of national confidential enquiries reflecting a thorough approach to data collection.
-we would welcome an approach that includes qualitiative as well as quantitative data.
Perhaps attempting to measure factors that patients highly value such as continuity of
care and good communication could be considered first?
-note that the Clinical Threshold & IFR audit involves removing patients from the waiting list who do not meet criteria. How is this communicated to patients and what alternative clinical provision is put in place?

Learning:
We were impressed with the learning from deaths process which appeared well structured with good learning points for the organisation. This was also reflected in the
Complex Care Review Group, Patient Safety Incident Investigation and Structured Judgement Reviews.
You give details of how learning is shared and the learning themes identified. To choose just one, you comment on the intention to increase specialist palliative care. We wonder if the emphasis should be that good palliative care should be delivered by all clinicians with specialised input required only for complex circumstances?

Conclusion:
Healthwatch Norfolk is committed to working with the Trust to ensure we fulfil our role of “critical friend”. We wish to ensure that the views of patients, carers and families are
welcomed and taken into account. We will make recommendations for change where appropriate.
We would welcome the opportunity to meet with appropriate Quality Leads at regular intervals.

The single most important problem to be addressed is the poor staff morale recorded.

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

Alex Stewart

Chief Executive Officer
Healthwatch Norfolk June 2026

Statement from the Integrated Care Board (ICB)

Norfolk and Suffolk
Integrated Care Board

Karen Watts, Director of Nursing and Quality,
NHS Norfolk and Suffolk ICB,
County Hall,
Martineau Lane,
Norwich,
NR1 2DH

Date 02 June 2026
Lucy Weavers, Interim Chief Nurse,
Norfolk and Norwich University Hospital Foundation Trust

Dear Lucy,

Re: Commissioner Response to Norfolk and Norwich University Hospital NHS Foundation Trust Quality Account 2025/2026.

Norfolk and Waveney ICB acknowledge the receipt of the 2025/2026 Quality Account from Norfolk and Norwich University NHS Foundation Trust and welcomes the opportunity to provide this statement.

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

The ICB recognises the ongoing challenges experienced by the Trust over the last contractual year. The wider system has continued to experience significant and sustained pressures. We acknowledge the continued transition to the new group model across the three acute NHS trusts in Norfolk. In addition, this year has brought organisational changes within NHS commissioning, resulting in the establishment of the Norfolk and Suffolk Integrated Care Board. The broader ICS footprint offers opportunities to strengthen collaboration with a wider range of system partners to support high-quality healthcare delivery, while maintaining a strong focus on local needs.

The ICB acknowledge the significant progress made across several key areas of quality. Notable achievements include the establishment of the Frailty Hub, the Trust-wide implementation of Martha's Rule and the work to support a reduction in health inequalities. We recognise the Trust's commitment to improving patient experience, including enhanced interpretation support and strengthened PALS and complaints processes. The introduction of Interpreter on Wheels will continue to be a positive improvement initiative in enhancing communication and patient assessment.

The improvement and expansion of the virtual ward is commendable, and its success is evident within the patient feedback, national recognition, and the positive impact that it

continues to have on lowering incidence of complications, reducing physical bed days and cost savings. Collaborative working with system partners to provide integrated virtual care will remain pivotal in improving patient flow.

We would also like to acknowledge the success of the introduction of the Hyperemesis Gravidarum pathway which has also had a positive impact on patient experience, clinical outcome, reduced bed days, cost savings and environmental sustainability. This is a prime example of how a collaborative approach with virtual wards and community teams can have beneficial outcomes and we are pleased to see that there is an ambition to support other trusts to replicate the improvements achieved at NNUHFT.

The ICB acknowledge the Trust's strong performance in reducing inpatient falls, noting a 12.6% reduction when comparing the number per 1000 bed days in 2025 to 2024, plus the ongoing work to support elective care recovery and theatre transformation. We're pleased to see not only the progress to date for the 2025/2026 quality priorities but also the workplans for the coming year, aiming to support further improvement and enhance patient experience.

The ICB endorses the Quality Priorities set out for 2026/2027 and will continue to work collaboratively with the trust to support the delivery of these. We welcome the Trust's continued focus on reducing mortality, strengthening clinical documentation and coding, and improving recognition and escalation of deterioration. This will be pivotal in reducing avoidable harm. We note the improvements in NEWS2 escalation documentation and support the continuation of this work as a priority for 2026/27.

While progress is evident, the ICB supports the Trust's identification of areas requiring continued focus, including infection prevention, workforce culture, data quality, and end-of-life care. The priorities set out to create a psychologically safe culture for staff to speak up and to create a consistently respectful, inclusive culture across the trust are acknowledged and will support the improvements that have been made to date in response to the medical education GMC condition.

The ICB recognise 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 2026/2027.

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.

Kind regards

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

Feedback from Governors

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

Thank you for providing the Council of Governors with the opportunity to comment on the Norfolk and Norwich University Hospitals NHS Foundation Trust Quality Account for 2025/26.

As Governors, our role includes representing the interests of patients, carers, members, staff and the wider public and the Quality Account remains an important document in supporting this role, providing a comprehensive overview of the Trust's achievements, challenges and priorities for improvement.

The Quality Account demonstrates a strong commitment to continuous improvement across the three domains of quality: patient safety, clinical effectiveness, and patient and staff experience. Governors welcome both the progress reported during 2025/26 and the ambition reflected within the quality priorities for 2026/27.

Patient Safety

Governors are encouraged by the Trust's continued focus on patient safety and learning. We are particularly pleased to see the implementation of Martha's Rule. This, together with the introduction of the Patient Wellness Questionnaire and clear escalation routes demonstrates the Trust's commitment to listening to patients and involving them as partners in care. As an early adopter of Martha's Rule, the Trust has shown a willingness to embrace innovation that strengthens both patient safety and patient voice.

We also welcome the emphasis placed on organisational learning through mortality reviews, improved clinical documentation and the triangulation of learning from incidents, complaints, deaths and patient experience feedback. The continued focus on psychological safety, speaking up and the development of a just culture provides assurance that staff are supported to identify risks, raise concerns and contribute to improvement.

Clinical Effectiveness

Governors welcome the progress made in improving clinical outcomes and reducing variation in care. In particular, we are encouraged by the continued focus on reducing standardised mortality measures and by developments within frailty, fragility fracture and older trauma pathways, where multidisciplinary approaches are helping to improve outcomes and patient independence.

The Trust's focus on improving patient flow, reducing unnecessary admissions and ensuring patients receive care in the most appropriate setting is also welcomed. Developments in frailty services, virtual wards, community-based pathways and transition services demonstrate a clear commitment to delivering more integrated, preventative and person-centred care closer to home. We recognise these developments as being closely aligned with the ambitions of the NHS 10-Year Health Plan and the wider shift towards neighbourhood health and care models.

The breadth of clinical audits, benchmarking activity and assurance processes described throughout the report provides confidence that services continue to be measured against national standards and that opportunities for improvement are systematically identified and acted upon. As governors, we also value the clear presentation of performance information and would encourage continued use of comparative and trend data wherever possible to support understanding of progress and outcomes.

Patient and Staff Experience

Governors were particularly pleased to see the continued emphasis on patient engagement, inclusion, co-creation and co-production throughout the Quality Account. The Trust's commitment to involving patients, carers and communities in service design and improvement reflects a genuine dedication to person-centred care.

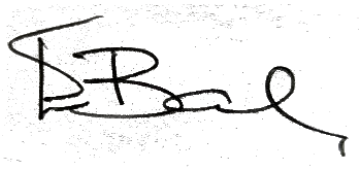
Through Care Assurance and Accreditation of Excellence audits and governor engagement activities, governors continue to see evidence that feedback is actively sought, valued and acted upon. We welcome the Trust's work to reduce health inequalities, improve accessibility through initiatives such as Interpreter on Wheels and strengthen compliance with Accessible Information Standards.

The Patient Advice and Liaison Service (PALS), complaints processes and wider patient feedback mechanisms remain important sources of learning and improvement. Governors were particularly encouraged by the review of the PALS and Complaints service during the year. We trust that the separation of the two functions, the introduction of dedicated leadership for each service and increased visibility and accessibility to the PALS team have strengthened support for patients and carers and will lead to improved responsiveness. Whilst the narrative within the PALS/Complaints section demonstrates positive progress, governors would welcome the inclusion of additional outcome measures and performance data in future reports to further evidence the impact of these improvements.

As governors, we recognise the strong relationship between staff experience and patient outcomes. Whilst we acknowledge that the Trust has experienced a period of significant organisational and system-wide change during the last year, and that this may have influenced some of the staff survey results, we note with concern the downward trajectory seen across a number of survey indicators.
A supported, engaged and empowered workforce is fundamental to delivering outstanding patient care. Given the importance placed throughout the report on the Trust's PRIDE values, governors will be keen to see how these values continue to be embedded in everyday practice and reflected in future staff survey results. By continuing to invest in staff support, development and engagement, the Trust will be better placed to create an environment in which colleagues feel listened to and valued.

Overall, Governors commend the considerable efforts of staff across the Trust and acknowledge the progress made during a period of significant challenge and change across the NHS. The Quality Account demonstrates a strong commitment to learning, transparency and continuous improvement, and provides confidence that the Trust remains focused on delivering safe, effective and compassionate care.

We remain committed to supporting the Trust in its pursuit of excellence and look forward to continuing to work collaboratively with patients, staff, partners and the Board to ensure that high-quality, inclusive and patient-centred care remains at the heart of everything we do.



Elaine Bailey
Lead Governor
Norfolk and Norwich University Hospitals Foundation Trust

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

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

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

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

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

David Roberts Date: 25th June 2026
Chair

Lesley Dwyer Date: 25th June 2026
Chief Executive