Board of Directors Meeting in Public (Part A)

Fri 28 March 2025, 10:00 - 12:30

Lecture Theatre, Burrage Centre

James Paget University Hospitals NHS Foundation Trust

The quorum required for the Trust Board of Directors is one third of the whole number of the Directors appointed, including one Non-executive Director, and one Executive Director. An Officer in attendance for an Executive Director without formal acting up status shall not count towards the quorum.

Agenda

10:00 - 10:05
5 min

1. Introduction

Meeting Formalities *Chair*

1.1. Chair's Welcome and Apologies for Absence

To Note *Chair*

1.2. Declarations of Interest

To Note *Chair*

To consider any new declarations of interest or any interests in relation to matters on the agenda.

Meeting Transparency and Probity

The Chair shall ascertain, at the beginning of each meeting, the existence of any actual, potential, or perceived conflicts of interest with matters on the agenda or related matters.

Such conflicts of interest shall be managed by the Chair and recorded in the minutes and if appropriate, the public Register of Declarations of Interest.

1.2 Declarations (updated 31-01-2025).pdf (5 pages)

10:05 - 10:25
20 min

2. Staff and Patient Experience Programme

Stakeholder Engagement *Chief Medical Officer*

2.1. Departmental Presentation - Research

Staff Engagement *Team members*

(10 minutes for presentation and 10 minutes for questions)

10:25 - 10:30
5 min

3. Minutes and Matters Arising

For Approval *Chair*

To approve the draft Minutes of previous meetings and to review the status of actions recorded on the Action Log.

3.1. Minutes

For Approval *Chair*

- 31 January 2025

3.1 Minutes_Board of Directors Meeting in Public (Part A)_310125.pdf (15 pages)

3.2. Action Log

For Review *Chair*

To confirm the status of actions identified at previous meetings.

3.2 Action Log - Board of Directors Public MASTER.pdf (1 pages)

10:30 - 10:40
10 min

4. Chair's and Chief Executive's Updates

To Note *Chair and Chief Executive*

To receive briefings from the Chair and Chief Executive on developments since the previous meeting.

4.1. Chair's Update

To Note *Chair*

4.2. Chief Executive's Update

To Note *Chief Executive*

4.2 Board of Directors CEO Report - 28 March 2025 DRAFT v1 - JB.pdf (12 pages)

10:40 - 10:52
12 min

5. Board Committee Chairs' Reports

For Assurance *Board Committee Chairs*

To present the assurance and scrutiny activities of Board Committees, including:

- Items considered (the Committee Agenda)
- Review of risk and Board Assurance Framework Reports
- Reporting of:
  - Assurance
  - Advice and alerts for the Board
  - Shared learning

To note the reports for assurance.

5.1. Patient Safety and Quality Committee

For Assurance *Committee Chair*

- 18 February 2025

5.2. Finance and Performance Committee

For Assurance *Committee Chair*

- 19 February 2025

5.3. People and Culture Committee

For Assurance *Committee Chair*

- 20 February 2025

5.4. Audit Committee

For Assurance *Committee Chair*

- 20 February 2025

10:52 - 11:02
10 min

6. Risk and Board Assurance

6.1. Board Assurance Framework Report

For Review *Chief Executive*

To review the Board Assurance Framework Report.

- 6.1 BAF Report - Board of Directors - 2025-03-28.pdf (3 pages)
- 6.1. BAF Risk Register 2025-03-28.pdf (4 pages)

11:02 - 11:22
20 min

7. Performance

7.1. Integrated Performance Report

For Review *Executive Leads*

To review the Trust's key performance indicators.

- 7.1 Integrated Board Report - Feb-25.pdf (8 pages)

11:22 - 11:47
25 min

8. Quality, People, and Finance

8.1. Chief Nurse Staffing Report

For Assurance *Chief Nurse*

- 8.1 Chief Nurse Board Report - Feb-25 (1).pdf (22 pages)
- 8.1. Nursing Fill Summary - Feb-25.pdf (2 pages)

8.2. Equality Delivery Scheme

Review *Director of People and Culture*

- 8.2 mar25 Board re 2024-25 EDS assessment.pdf (2 pages)
- 8.2. 2024-25 EDS assessment FINAL.pdf (34 pages)

8.3. Gender Pay Gap Report

To Note *Director of People and Culture*

- 8.3 mar25 Board re Gender Pay Gap Report.pdf (4 pages)

8.4. Ethnicity Pay Gap

To Note *Director of People and Culture*

- 8.4 mar25 Board re Ethnicity Pay Gap Report.pdf (4 pages)

8.5. Modern Slavery Act

Ratification *Director of People and Culture*

- 8.5 mar25 Board re Modern Slavery Statement.pdf (3 pages)

11:47 - 11:52
5 min

9. Strategy and Business Planning

9.1. Norfolk and Waveney Acute Hospital Collaborative (NWAHC) - Update Report

Information *Deputy Chief Executive*

9.1 Board (public) - Assurance report from Committees in Common March 2025.pdf (4 pages)

11:52 - 12:12
20 min

10. Corporate Governance

10.1. Board Risk Appetite Statement

Approval *Head of Corporate Affairs*

10.1 Board Risk Appetite Report 2025-03-28.pdf (3 pages)
10.1. DRAFT Board Risk Appetite Statement 2025-03-28.pdf (6 pages)

10.2. Board and Committee Performance Evaluation and Terms of Reference

Approval *Chair*

10.2 Board Committee Self-assessment and Terms of Reference Review 2025-03-28.pdf (5 pages)
10.2. Audit Committee Terms of Reference DRAFT 2025-02-20.pdf (16 pages)

10.3. Fit and Proper Persons Compliance

To Note *Head of Corporate Affairs*

10.3 Annual Board FPPR Compliance Statement.pdf (2 pages)

12:12 - 12:22
10 min

11. Questions from the Public and Trust Governors

Stakeholder Engagement *Chair*

To respond to questions submitted by members of the public or Trust Governors.

12:22 - 12:27
5 min

12. Meeting Review

12.1. Matters for Consideration by other Entities

For Decision *Chair*

12.2. Reflection

For Discussion *Committee Chair*

- Is there scope for improvement in efficiency or effectiveness?
- Was the meeting conducted in accordance with the Trust's values?

Our Values shape how we approach everything we do, and align to the NHS People Promise, which applies to everyone working in the NHS.

Collaboration - We work positively with others to achieve shared aims.

Accountability - We act with professionalism and integrity, delivering what we commit to, embedding learning when things for not go to plan.

Respect - We are anti-discriminatory, treating people fairly and creating a sense of belonging and pride.

Empowerment - We speak out when things don't feel right, we are innovative and make changes to support continuous improvement.

Support - We are compassionate, listen attentively and are kind to ourselves and each other.

12:27 - 12:30
3 min

13. Next Meeting

For Information *Chair*

- Friday, 30 May 2025 - Lecture Theatre, Burrage Centre

NHS
James Paget University Hospitals NHS Foundation Trust

Board of Directors - Declarations of Interest

Name	Role	Description of Interest	Relevant Dates		Comments/Reasoning for acceptance of a material interest (where required)
			From	To	
Mark Friend	Chair	Provide CIC – Non-executive Director	Jan 2023	Ongoing	Member of the main Board, Chair of Audit Committee
		Artis Foundation - Chair	July 2023 (Trustee since 2018)	Ongoing	Charity providing creative learning for schools in deprived areas, unpaid role
		National Centre for Circus Arts – Director and Trustee	May 2022	Ongoing	Main UK centre for undergraduate and postgraduate training in circus skills and performance, unpaid role
		Circus Space Events Ltd – Director	May 2022	Ongoing	Unpaid role
		Circus Space Property Company Ltd – Director	May 2022	Ongoing	Unpaid role
		Reeval Ltd – Director	Feb 2021	Ongoing	Joint director of company providing consulting and coaching services to media companies and charities
		IC24 – Non-executive Director	01/01/2025	Ongoing	This was discussed and checked by the Trust last Autumn, no conflicts of interest are seen
Joanne Segasby	Chief Executive	None			
Mark Flynn	Director of Strategic Projects	Sister-in-Law holds employment as Patient Services Manager at Spire Norwich Hospital	01/07/2018	Ongoing	
Paul Morris	Chief Nurse	CQC – Adviser in Emergency Care on inspections	Since 2016	Ongoing	
		Hon Commander for RAF Lakenheath		Ongoing	
Vivek Chitre	Chief Medical officer	Minor shareholdings in pharmaceutical companies AstraZeneca and GSK		Ongoing	

Name	Role	Description of Interest	Relevant Dates		Comments/Reasoning for acceptance of a material interest (where required)
		Patron of the Norwich Undergraduate Surgical Society (NUSS)	2010	Ongoing	Involves supporting surgical teaching and training opportunities for undergraduates of Norwich Medical School.
		Assessor of MRCS examinations for Intercollegiate Committee for Basic Surgical Examinations (ICBSE)		Ongoing	Unpaid post, travel, accommodation, and subsistence reimbursed by ICBSE (via Royal College of Surgeons).
Jonathan Barber	Deputy Chief Executive	Ad Hoc Consultancy work abroad with Council of Europe		Ongoing	no conflicts - in own time
		Non-Executive Director with Broadland St Benedicts Limited		Ongoing	This is a commercial developer.
Charlotte Dillaway	Chief Operating Officer	Husband is a majority shareholder of Mizaic Ltd	May 2024	Ongoing	The company provides an Electronic Document Management System (EDMS) to the NHS
		CLDCS Ltd - Director	May 2024	Ongoing	Sole Director of company providing consultancy services and investment property – any services undertaken in own time
		Husband is sole Director of IRB Consultancy Services Ltd	May 2024	Ongoing	Consultancy services providing IT advice to NHS organisations
Edmund Taylor	Chief Finance Officer	Married to Professor Lisa Taylor, Associate Dean for Employability for the Faculty of Medicine and Health Sciences, University of Easy Anglia	Sept 2016	Ongoing	
Sarah Goldie	Director of People & Culture	Friend of an Employment Partner at Birketts LLP		Ongoing	The Trust sometimes uses Birketts LLP for employment law advice and investigations, although not the Trust's primary legal providers. Head of HR Business Partnering/Deputy Director to lead any procurement exercises to be undertaken related to employment law advice. Head of People & Culture leads day to day relationships and management of cases involving solicitors.
Charlie Helps	Head of Corporate Affairs	Member of the Health Advisory Board of the Tutu Foundation, UK	Aug 2016	Ongoing	
		Member of the Advisory Board of the UK Social Value Portal	Aug 2014	Ongoing	

Name	Role	Description of Interest	Relevant Dates		Comments/Reasoning for acceptance of a material interest (where required)
Stephen Javes	Non-Executive Director	Consultancy work for Kerseys Solicitors, Ipswich		Ongoing	
		Lowestoft Places Board	12/2/20	Ongoing	
		Consultancy role at Langham Park Homes		Ongoing	Chair of Board
John Hennessey	Non-Executive Director	None			
Caitlin Notley	Non-Executive Director	Employed by the University of East Anglia as Professor of Addiction Sciences		Ongoing	Based within the Norwich Medical School, involved with teaching, supervision of students and planning for new educational opportunities.
		Chief Investigator for the 'Babybreathe trial'	Oct 2020	Ongoing – 39 months study	Smoking relapse prevention intervention for women who quit smoking during pregnancy, funded by the NIHR Public Health Research scheme.
		Principal Investigator leading recruitment in the South-East for the SCETCH trial	Sept 2021	Ongoing – 36 months study	Smoking cessation for people experiencing homelessness. This is also funded by the NIHR Public Health Research scheme.
		Leading project on 'Smoking cessation within primary care'	Feb 2024	Ongoing	With the ICB as the host organisation.
		Director of Lifespan Health Research Centre	April 2024		Within the UEA role.
		Chair of the National Institute for Health Research East of England Research for Patient Benefit Funding Committee	April 2024		External to UEA.
Susanne Lindqvist	Non-Executive Director	Employed by the University of East Anglia as Professor of Interprofessional Practice and holing the role as Associate Dean (AD) for Learning and Teaching Quality for the Faculty of Medicine and Health Sciences (FMH)		Ongoing	Based within the Norwich Medical School (NMS), involved with teaching, advising of medical students, management of NMS colleagues. Involved in the quality assurance of current courses and strategical decisions made about future courses in FMH. Prior to being AD, Teaching Director for Norwich Medical School (5 yrs), working closely with many staff at JPUH.

Name	Role	Description of Interest	Relevant Dates		Comments/Reasoning for acceptance of a material interest (where required)
					Involved in course approval processes linked to courses in development and involving JPUH colleagues.
		Principal Investigator for a study investigating the long-term effect of the healthcare assistant project on doctors.	Spring 2023	24 months	Medical students working as health care assistants, including at JPUH and ECCH. Interest in developing this initiative and other interprofessional placement opportunities.
		Part of Norfolk Initiative for Costal and Rural Health Equalities (NICHE) programme team	February 2023	Ongoing	Part of interview panel for fellowships and working closely with the team incl. Jonathan Webster.
		Delivering leadership in health care module in Sharjah, supporting development of other courses there and their implementation of IP learning opportunities.	2018	Ongoing	Working closely with prof Salman Guraya who know co-leads the online coloproctology course with Kamal Aryal.
Sally Collier	Non-Executive Director	Employed part time by Cabinet Office as Head of Place for the Civil Service in the East and commercial advisor.	July 2023	Ongoing	
		Employed by Home Office Police Leadership College as external assessor.	July 2023	Ongoing	
		Independent patient choice and procurement panel member, NHS England.	May 2024	Ongoing	
Sarah Whiteman	Non-Executive Director	Employed by BLMK ICB as Chief Medical Director	April 2022	Ongoing	Is part of an Integrated Care System in the East of England
		Sessional GP	April 2017	Ongoing	
		Director of AKESO Coaching, a Community Interest Company	2022	Ongoing	Offering coaching and mentoring to people working in Primary Care
		Non-executive Director – Milton Keynes Hospital	May 2024	Ongoing	

Name	Role	Description of Interest	Relevant Dates		Comments/Reasoning for acceptance of a material interest (where required)
		Non-executive Director – Lincolnshire Hospitals Partnership Trust	February 2024	Ongoing	

Board of Directors Meeting in Public (Part A)

Fri 31 January 2025, 10:00 - 12:15

MS Teams

NHS
James Paget University Hospitals
NHS Foundation Trust

Attendees

Board members

Mark Friend (Chair), Sally Collier (Non-executive Director), John Hennessey (Non-executive Director), Susanne Lindqvist (Non-executive Director), Caitlin Notley (Non-executive Director), Jonathan Barber (Deputy Chief Executive), Vivek Chitre (Chief Medical Officer), Charlotte Dillaway (Chief Operating Officer), Mark Flynn (Director of Strategic Projects), Sarah Goldie (Director of People and Culture), Joanne Segasby (Chief Executive), Edmund Taylor (Chief Finance Officer)

Attendees

Richard Chilvers (Member of the public), Jane Fuller (Matron-Renal), Charlie Helps (Head of Corporate Affairs), Ian Lacey (Member of the public), Dr Jean Patrick (Consultant-Nephrology), Gemma Stebbings (Divisional Operations Manager), Angela Sutton (Deputy Head of Midwifery), Jayne Geddes (Executive Assistant (Minutes))

Apologies

Stephen Javes (Non-executive Director and Senior Independent Director (SID)), Paul Morris (Chief Nurse), Sarah Whiteman (Non-executive Director)

The quorum required for the Trust Board of Directors is one third of the whole number of the Directors appointed, including one Non-executive Director, and one Executive Director. An Officer in attendance for an Executive Director without formal acting up status shall not count towards the quorum.

Meeting minutes

1. Introduction

Meeting Formalities

Chair

1.1. Chair's Welcome and Apologies for Absence

To Note

Chair

The Chair welcomed everyone and noted apologies received.

1.2. Declarations of Interest

To Note

Chair

The Chair declared a new interest, stating that he has started as a non-executive director at IC24, which is based in Kent and provides urgent response and 111 services. This has been checked by the Trust and will be added to the records.

2. Staff and Patient Experience Programme

Stakeholder Engagement

Chief Nurse

2.1. Departmental Presentation - Renal

Staff Engagement

Team members

The Chair welcomed Gemma Stebbings-Divisional Operational Manager, Jane Fuller-Matron and Dr Jean Patrick-Consultant Nephrologist/Clinical Lead who gave a presentation on Renal Services.

John Hennessey (JH) asked if the renal department had considered joint ventures with the private sector to provide facilities and staff, mentioning that other parts of the NHS have done this. Gemma Stebbings confirmed that the options paper recommends progressing a unit in partnership with a private provider, taking advantage of economies of scale. The Chair asked if the options paper will be submitted to the Hospital Management Group. Gemma confirmed that the options paper will be submitted to HMG in due course.

JH inquired about the seriousness of moving the renal unit off-site, given the pressures for the size of the new hospital. Gemma explained that patient surveys showed mixed feelings about moving off-site, but concerns such as parking, transport, and access in emergencies were noted.

Joanne Segasby (JS) asked about patient engagement, noting that the renal department has a captive patient group seen frequently. Gemma acknowledged the need to expand patient engagement and make it more visible, especially if enacting changes for the future.

Sarah Goldie (SG) inquired about the secret behind the excellent mandatory training and appraisal rates in the renal department. Jane Fuller explained that the importance of appraisals and mandatory training is promoted within the team, and the well-being of staff is a key focus.

Susanne Lindqvist (SL) asked about the innovative approach to including other professions, such as pharmacists, and how to address the rising curve of dialysis needs. Dr Jean Patrick discussed targeting primary care, improving transplantation rates, and promoting home therapies to manage the rising dialysis needs.

The Chair raised the issue of transport, noting that it came through as a significant concern during his visit to the wards in November. He emphasised the importance of managing the transport contract tightly to ensure delivery against it. Gemma acknowledged the ongoing issue with transport and mentioned that monthly meetings with HTG have been established to address it. Additionally, a champion within the renal unit has been appointed to take the lead on transport issues, and urgent matters can be escalated directly.

The Board acknowledged the impressive metrics, presentation and thanked the Team for their work.

The Chair thanked Gemma, Jane and Jean for their attendance.

3. Minutes and Matters Arising

For Approval

Chair

3.1. Minutes

For Approval

Chair

The minutes of the 29 November 2024 were approved as a true record.

3.2. Action Log

For Review

Chair

The Chair initiated the discussion on the action log, noting that all actions were proposed to be closed. He asked if there were any actions that anyone was unhappy with being closed.

JS raised a concern about action 6.1 related to the board assurance framework. She mentioned that although the Board had a seminar and discussed risk appetite, a finalised risk appetite statement for the Trust was not yet available. She proposed reopening the action and bringing back a revised risk appetite statement to the next Board meeting. The Chair agreed with this proposal.

JS also commented on the health and safety annual report action, stating that she was happy for it to be closed. She added that health and safety would be included in the internal audit for 2025-2026 to ensure coverage next year.

JH mentioned that risk appetite is on the Audit committee meeting for the next month, he will discuss this with Charlie Helps, and asked if the Audit committee should make a first pass of the statement and bring it back to Board. The Chair agreed, suggesting that the Audit committee should review it first and then feed it through to the Board in March.

The discussion concluded with the agreement to leave action 6.1 open and to review the risk appetite at the Audit committee before bringing it back to the Board, and all remaining To Close actions Closed.

4. Chair's and Chief Executive's Updates

To Note

Chair and Chief Executive

4.1. Chair's Update

To Note

Chair

The Chair provided an update on the significant pressures faced by the organisation. He has focused his visits on Teams facing high pressure including ED, maternity, and the discharge lounge. He commended the hard work of staff during a pressurised period and emphasised the importance of balancing patient safety, experience, operating targets, staff well-being, and financial targets. He highlighted the importance of improving hospital flow, length of stay and discharge of non-criteria to reside (NCTR) patients. The Chair visited the urgent care coordination hub in Norwich, noting its success in handling over 10,000 hospital admittance avoidances. System discussions emphasised the pressure to hit financial targets in a system running a large deficit.

4.2. Chief Executive's Update

To Note

Chief Executive

JS highlighted the positive feedback from patients and the improvement work that has enhanced the trust's national reputation, particularly in maternity and research. The staff survey response rates remained consistent with the previous year, and a full analysis will be undertaken once results are received. The acute hospital collaborative work is progressing, ensuring the local voice and patient representation are maintained. The purchase of a new robot for surgical procedures was announced, with installation planned after theatre refurbishment. Operational pressures were significant in December and January, with numerous critical incident declarations due to high demand. Length of stay remains a key priority, with ongoing work to reduce non-criteria to reside (NCTR) numbers and improve internal processes. Collaboration with East Coast Community Healthcare is ongoing to enhance virtual ward offerings and intermediate care provision. The Orthopaedic Elective Hub opened in January, with operations starting the following week. Ward 11 (maternity) was moved to Ward 7 to accommodate RAAC work, and a new triage and assessment area. The Trust remains a front runner for the New Hospital Programme as a RAAC Hospital with the timeframe for construction 2027-2028 and the outline business case will be submitted to Board later in the year.

The Chair asked what could be done differently to reduce the number of non criteria to reside patients and improve hospital flow. JS emphasised the need for senior decision-makers at the front end, early clinical decisions, and ongoing senior clinical decision-making. She mentioned the opening of the same-day emergency care unit by autumn and the work led by Vivek Chitre (VC) on medical leadership and internal professional standards.

Jonathan Barber (JB) mentioned that the Urgent and Emergency Care (UEC) Programme Board had a workshop in January to identify new steps and initiatives to address LOS. He emphasised the reinvigoration of efforts through the UEC Board, with additional multi-agency disciplinary events (MADE) planned to focus on reducing LOS. He highlighted the importance of setting specific LOS targets for each ward, considering factors outside their control, to ensure achievable and motivating goals. He mentioned that the Trust is working on a more forensic approach to setting these targets.

ACTION: JS to update the Board at the March meeting on the NCTR targets and approach that will reduce the number to less than 100 over the next 6 months.

5. Board Committee Chairs' Reports

For Assurance

Board Committee Chairs

5.1. Patient Safety and Quality Committee

For Assurance

Committee Chair

Caitlin Notley (CN) provided an update on the meetings held:

17 December 2024 Meeting:

- **Neonatal IPR:** Good assurance around the metrics, with the neonatal lead attending PSQ monthly, indicating improved collaboration between neonatal and maternity.
- **Maternity IPR:** Reasonable assurance around metrics but limited assurance around risk register processes. Noted items for review and ongoing work on the Board Assurance Framework (BAF).
- **Concerns:** Highlighted concerns about a vacancy for the Joint Fire Officer and some outstanding risks.

21 January 2025 Meeting:

- **Maternity Metrics:** Substantial assurance on maternity metrics, with positive trends noted.
- **Perinatal Mortality Review Tool:** Good assurance on the tool and the mortality quarterly report, showing trends in line with national averages.
- **Research and Development:** Good assurance on research activities, with active research in nursing and midwifery.
- **Falls and Pressure Ulcers:** Partial assurance due to a slight increase in falls and associated harms, with mitigations in place. Continued concerns about high numbers of pressure ulcers.
- **Risk Register:** Ongoing review and reporting, with some outstanding risks still to be reviewed.
- **Complaints Backlog:** Limited assurance on the complaints backlog, with ongoing work to improve response times and processes.
- **E3 Maternity System:** Non-compliance with a national patient safety alert due to a national issue with the software, managed until a new electronic patient record system is in place.
- **Operational Pressures:** Discussed the impact of operational pressures on patient safety, particularly around resource constraints and staff sickness.

5.2. Finance and Performance Committee

For Assurance

Committee Chair

Susanne Lindqvist (SL) provided an update of the meetings held on 18 December 2024 and 22 January 2025:

Operational Performance:

- **Assurance:** The committee was assured about the 62-day cancer and 28-day faster diagnosis targets being met, and the increasing virtual ward occupancy.
- **Reasonable Assurance:** The committee had reasonable assurance around waiting list targets, noting that the 65-week waits are still not met but the position is improving compared to a year ago.
- **Limited Assurance:** Concerns were raised about urgent and emergency care (UEC) performance, high levels of elective cancellations, and the high number of non-criteria to reside (NCTR) patients, reported at 154 in January.

Financial Performance:

- **Assurance:** The committee was assured about the financial recovery plan, including temporary pay savings and a freeze on vacancies and overtime.
- **Reasonable Assurance:** Concerns were noted about the deterioration in financial performance, with a year-to-date deficit of £6m, a negative variance to plan of £5.1m, and efficiency savings falling behind.
- **Limited Assurance:** The committee was not assured about achieving the recurrent savings outlined in the financial recovery plan, with a forecast adverse variance to plan of £8.1m.

Strategic Projects:

- **Future Paget:** The second version of the Strategic Outline Case (SOC) was submitted, with the Outline Business Case (OBC) expected by December. The completion date for the new hospital is now 2032.
- **RAC Remedial Works:** The committee was assured about the progress made in mitigating risks related to RAAC.
- **EPR Implementation:** The committee was assured about the implementation program, but concerns were raised about the number of red risks early in the project.
- **Orthopaedic Elective Hub:** The orthopaedic elective hub opened in January, but operations were delayed due to technical issues, with surgeries expected to start next week.

Alerts to the Board:

- **Operational Performance:** The committee highlighted concerns about UEC performance, high elective cancellations, and the high number of NCTR patients.
- **Financial Performance:** The committee noted the deteriorating financial position, with a significant adverse variance to plan and challenges in achieving recurrent savings.

Advice to the Board:

- **Operational Performance:** Work closely with the council to address issues around care homes and social care, and consider the impact of enhanced rehabilitation work at Carlton Court.
- **Financial Performance:** Improve contract management expertise to address financial performance challenges.

5.3. People and Culture Committee

For Assurance

Committee Chair

The Chair read the update received following the meeting held 19 December 2024:

- **HCA Grade 2 Regrades:** Discussions regarding HCA regrades and triple lock process.
- **Staff Survey:** The committee reviewed raw data from the staff survey, noting some improvements in four of the people promise areas but also a slight worsening in areas such as listening, morale, and communication.
- **Employment Rights Bill:** The committee noted the potential impact of the upcoming Employment Rights Bill, which includes day one employment rights and the changes impacting zero-hours contracts. This could affect bank staff usage and the flexibility of staff deployment.
- **Freedom to Speak Up Reports:** The committee continues to monitor these reports, particularly noting the work pressures on staff and the potential impact on patient safety. This was highlighted to the Chair of the PSQ Committee.

Sarah Goldie (SG) provided an update on the arbitration meeting with ACAS regarding the Healthcare Assistant re-bandings, which took place on 9 January 2025. An agreement in principle was reached. The detailed agreement is being developed and approval for the funding of the settlement is going through the triple lock process.

SG reassured the board that while there is some variation between different teams and staff groups, the overall turnover rate is good, with voluntary turnover at 4%.

SL inquired about the well-being focus in appraisal paperwork. SG confirmed that this is part of the co-designed appraisal form for all staff except medical staff, who have a different process.

5.4. Audit Committee

For Assurance

Committee Chair

JH advised the Audit Committee last met on 29 November 2024. The committee discussed expectations for the board seminar in December, focusing on risk appetite. There is ongoing work on this topic. The committee is hopeful to move back to a reasonable assurance from the internal auditors by the end of the current audit cycle. Recent conversations indicate that the audits are on track to be completed on time, with no extraordinary worrying recommendations. The committee noted that the Trust is implementing audit recommendations effectively, which is a significant improvement compared to 12-15 months ago. The next Audit Committee meeting is scheduled for February.

6. Risk and Board Assurance

6.1. Board Assurance Framework Report

For Review

Chief Executive

JS introduced the BAF, noting that significant work had been done following the board seminar. She mentioned that the updates from SG's work on the people and culture entries were not fully reflected yet but would be included in the next Board meeting. The maternity-specific BAF entry was split into a second entry for clarity. An AI tool was used to generate the report, resulting in a different style that highlighted various aspects for the Board to focus on. JS emphasised the efficiency programme, capacity concerns, and the delivery of maternity improvement work as key areas of focus. She suggested that the new risk entry related to maternity needed further work for clarity and recommended not approving it at this meeting. The people and culture entries would be reviewed again at the People and Culture Committee in February.

Sally Collier (SC) appreciated the additional commentary in the BAF report but pointed out a mismatch between the commentary and the BAF, particularly regarding financial constraints. She suggested that the financial target risk (risk 413), might not be sufficiently highlighted and recommended bringing it back through the Finance and Performance (F&P) Committee.

SG reassured the board that retention was not an area of concern, with a voluntary turnover rate of 4%, indicating a good turnover rate comparatively.

ET provided reassurance that changes to the finance risks were discussed at the F&P Committee, and further work was underway to ensure the BAF reflects the sustainable financial position on a medium-term basis.

The Chair observed that many residual risks were above the risk appetite, reflecting the difficulty in balancing financial, operational, patient safety, and staff well-being targets. He emphasised the importance of setting realistic targets and being clear about what success looks like.

The discussion concluded with an agreement to continue refining the BAF, ensuring it accurately reflects the current risks and targets, and to bring back updates to the relevant committees before the next Board meeting.

7. Performance

7.1. Integrated Performance Report

For Review

Executive Leads

JS introduced the IPR in the absence of Paul Morris (PM), highlighting that quality and safety metrics remained largely within normal variation and were being closely monitored. She mentioned that the stroke metrics reporting was changing, and future updates would be provided to the Board.

CD provided key points on operational performance:

- December and January saw increased pressure from the front door, with a Level 3 regional incident declared on New Year's Eve and 23 days in critical incident status.
- Several initiatives were planned to improve the situation, including multi-agency disciplinary events (MADE), a criteria to admit audit, and the commencement of Aristot work.
- Elective delivery faced challenges, with a slowing down of achieving 65-week targets due to UEC pressures.
- Cancer performance was a highlight, with the trust achieving the faster diagnosis standard and being informed by NHS England that they would come out of tiering for cancer in Q4 2024-2025.
- The planning guidance for 2025-2026 was released, and the team would digest it and bring updates to the F&P Committee and Board in due course.

The Chair noted the absence of NCTR numbers in the IPR and suggested their inclusion for better tracking. CD confirmed that NCTR numbers are included in the Finance and Performance committee report but not in the Board IPR. She agreed to include them in future Board IPRs.

ACTION: CD to include NCTR details within the Board IPR.

SG discussed the people metrics:

- Mandatory training performance was good and above target, with a new national memorandum of understanding signed for portability of training between organisations.

- Non-medical appraisals were below target but showed an improving trend, with a working group in place to implement an improvement plan.
- Sickness absence rates remained high, with a focus on identifying cases with the highest Bradford scores and ensuring robust support and management plans.

SC noted that during her walk round, she heard from various staff that there were significant issues with not having enough staff due to both long-term and short-term sickness. She highlighted that staff themselves were struggling to access the treatment they needed to get back to work, mentioning that other public sector bodies, like the County Council, have access to very fast physiotherapy services. She inquired whether the trust had something similar in place.

SG acknowledged the complexity of the issue, noting that the symptoms of staff sickness are partly due to the extended period of operational pressures, including the pandemic. She mentioned that the trust does have a fast-track physiotherapy service as part of their occupational health offer, along with enhanced psychological support for staff. She emphasised the importance of supporting staff with basic needs such as breaks, regular holidays, and access to well-being services.

SL noted that during her walk round she had a discussion with an admin person who had surgery on their hands and they had discovered that the Norfolk and Norwich University Hospitals (NNUH) had AI software that significantly sped up the dictation process for admin staff. SL inquired why the Trust did not have similar technology and whether it was due to cost or compatibility issues. She also noted that the upcoming EPR might solve this but felt it was a long time to wait.

MFl acknowledged the observation and requested more details from SL to follow up. He mentioned that the Trust is already researching AI and digital dictation technologies and has signed off on an AI policy recently. He assured that they are actively pursuing these technologies to improve efficiency. CD added that the Hospital Management Group had discussed the need to avoid stagnation while waiting for the EPR. They are considering actions like using AI and digital dictation to improve current processes.

ET provided an update on the financial performance:

- The financial position continued to be challenged, with a £6m actual deficit at the end of month nine, driven by pay inflation, ICS stretch targets, and efficiency plan shortfalls.
- The forecast outturn risk was projected at £8.1m off plan, with formal reporting on plan due to NHS rules.
- Agency costs showed signs of being well controlled, with a reduction in spending compared to the previous year.
- The elective recovery fund income was slightly off plan due to industrial action and the delayed opening of the orthopaedic elective hub.
- Efficiency plans were £1.5m off plan, with a significant gap in recurrent delivery.

The Chair asked about the forecast position for the end of the year, noting that all Trusts are expected to hit their targets. He sought clarification on where the Trust stands in relation to its year-end target. ET explained that the year-end target started with a £13.4m deficit, which was adjusted with deficit support funding from NHS England, bringing the plan down to a £1.1m deficit. He mentioned that formally, they must report on plan until NHS England authorises a deviation through a protocol process. The current risk assessment shows an £8.1m off-plan projection, which will be formalised through the protocol process expected to occur during February.

JH asked about the timetable to complete the protocol for changing the projection. ET indicated that NHS England is expected to receive applications for the protocol process based on the month 10 results, which means the process would likely occur during February. He also mentioned that preparations for financial governance arrangements are underway in anticipation of this timeline.

8. Quality, People, and Finance

8.1. Chief Nurse Staffing Report

For Assurance

Chief Nurse

JS introduced the report on behalf of PM noting the combined overall shift fill rate for nursing, HCAs, and midwifery was 84.5%, the lowest since March 2023. Sickness played a significant role in this reduction.

- Temporary staff shift fill rates were high for registered nurses and HCAs, with rates in the high 90s. However, there were anomalies due to short notice absences not being put out to the bank.
- Agency fill rates continued to show a downward trend, which was seen as positive.
- Care hours per patient per day remained consistent with previous reports.
- There was a reduction in red flag reports across adult areas, mainly related to enhanced supervision and registered nurse gaps. No concerns were reported from Peadiatrics or maternity red flags.
- Vacancies across the board were low, and retention rates were good. However, there were issues with covering maternity leave, with 62 whole-time equivalents on leave. Work continues to address the cover issues.
- Pipeline plan is on track.

SC noted a strange correlation between the significant deterioration in shift fill rates and the increase in care hours per patient per day. She expected to see a decrease in care hours per patient day given the lower shift fill rates. The Chair suggested taking SC's observation as an action item for PM to look into and provide a comment in the next Board meeting.

ACTION: PM to review the correlation between the significant deterioration in shift fill rates and the increase in care hours per patient per day and provide a verbal update at the next Board meeting.

JH asked if the downward trend in planned fill rates was a concern and whether corrective action would be needed if it continued. JS acknowledged the balance between finance and quality/patient safety. She suggested waiting for January's data to see if the trend continued and mentioned the possibility of revising controls if necessary.

ACTION: PM to review January's data to determine if the downward trend in planned fill rates continues and consider revising controls if necessary.

8.2. Clinical Negligence Scheme for Trusts (CNST) Submission

Approval

Chief Nurse

Angela Sutton (AS), Deputy Head of Midwifery, presented the CNST submission for approval, covering the period from 2 April 2024 to 30 November 2024. She summarised that all 85 actions required for compliance were met within the specified timeframe. AS provided a background on the CNST journey, including the identification of safety action leads, gap analysis, and the collation of evidence to demonstrate compliance. Monthly updates were presented at the Executive Maternity Improvement Group, and evidence was reviewed at Perinatal Evidence Review meetings with attendance from NHS England, the Trust Board, executive teams, and the local maternity and neonatal system (LMNS).

JH asked about the financial consequences of not meeting the CNST requirements and whether there was a financial benefit for compliance. AS confirmed that there were no financial risks as all aspects of the CNST had been met with high scrutiny. She also mentioned that the Trust benefited from meeting the scheme last year, which supported the maternity improvement plan.

ET provided specific financial details, stating that the incentive scheme for 2024-2025 would earn the Trust £401k if approved.

The Chair asked for congratulations to be passed to the Team for the fantastic work undertaken.

SC echoed the congratulations and noted that some actions in Annex One were left hanging and suggested updating them before submission. AS acknowledged SC's point and agreed to review and update Annex One before submission.

The decision reached on the CNST submission was to approve it. The Board members expressed their congratulations to AS and the team for achieving full compliance with all 85 actions required for the CNST. The approval was given with the understanding that Annex One would be reviewed and updated to ensure all actions are clearly stated and aligned with the compliance status before submission.

9. Strategy and Business Planning

9.1. Estates Plan Progress Review - 6 Monthly

Information

Director of Strategic Projects

MFl presented the Estates Plan Progress Review, highlighting the significant capital budget and the progress made on various projects. He acknowledged some delays in completing works in the kitchens and HSDU, but overall, the Trust is on track to meet the year-end spend target.

MFl mentioned the delay in the Community Diagnostic Centre project at Northgate, and although it was initially marked as green, it should be considered amber due to the delays. He noted that the RAAC remedial works and bearing work are progressing well, but the kitchen and HSDU projects are taking longer than anticipated. He assured that solutions are in place to address these delays.

MFl advised the energy centre project involves two components: the high voltage electrical upgrades, which have been completed, and the enabling work for the new hospital program, which is ongoing. He will update the language in the report to clarify the distinction between the two energy centre projects and ensure accurate reporting of the Community Diagnostic Centre project status.

The residential accommodation project is progressing, with external auditors providing a view on financing options. The team is actively pursuing these options, including refurbishment and previous opportunities.

The land purchase and car park extension project is partially complete, with the purchase of plot two and the car park extension finished. The team is still working on finalising the remaining land purchase.

JS emphasised the importance of having a master plan to ensure that any future investments align with the new hospital program and potential funding opportunities. MF agreed with JS's point and mentioned that the team is working on developing a master plan to ensure strategic alignment with future investments and the new hospital program.

9.2. JPUH Green Plan and Sustainability - 6 Monthly

Assurance

Director of Strategic Projects

MFl presented the six-monthly update on the Green Plan and Sustainability, noting mixed success in various areas. He emphasised the Trust's commitment to achieving net-zero carbon through the New Hospital Programme. He mentioned that the progress in the report demonstrates the Trust's alignment with the national NHS commitment to achieve net-zero carbon by 2040.

MFl highlighted the progress made in reducing energy use through LED investments, which have resulted in cost savings and reduced energy consumption. He noted that these investments are part of the Trust's broader strategy to improve sustainability while also achieving financial efficiencies. He mentioned the challenges in switching from certain types of medical gases, which can have financial implications. He explained that while some sustainability initiatives have clear cost-saving benefits, others may involve higher initial costs but are necessary for long-term environmental impact.

MFl addressed the increase in business mileage, explaining that the rise is due to a return to normal levels post-COVID, rather than an actual increase in travel. He clarified that the reported 201,000 miles for 2023-2024 is consistent with pre-COVID levels, and the increase is not indicative of a new trend.

The report also covered the progress in waste reduction initiatives, which have both environmental and cost-saving benefits. MFl emphasised the importance of these initiatives in reducing the Trust's overall carbon footprint and improving operational efficiency.

MFl mentioned that the Trust is awaiting national guidance for the Green Plan beyond April 2025, which will help shape the future direction of sustainability efforts. He noted that the ultimate goal is to achieve net-zero carbon through the New Hospital Programme and other strategic initiatives.

SC emphasised the need for clear targets and metrics in the refreshed Green Plan to assess progress effectively. She noted that while the report mentions progress in various areas, it is difficult to assess whether the Trust has achieved its intended goals without specific targets and metrics. MFl confirmed that the team is working on developing clear targets and metrics for the refreshed Green Plan. He acknowledged the need for a more structured approach to tracking progress and ensuring that sustainability initiatives align with the Trust's financial goals.

The Chair inquired about the financial implications of the sustainability initiatives and whether the Trust is under pressure to slow down any of these efforts due to the overall financial situation. He asked if the sustainability initiatives are cost-neutral or if they involve higher initial costs with long-term benefits. MFl addressed the financial implications of the sustainability initiatives, noting that while some initiatives have clear cost-saving benefits, others may involve higher initial costs but are necessary for long-term environmental impact. He emphasised the importance of balancing sustainability goals with financial constraints and ensuring that investments in sustainability are strategically aligned with the Trust's overall objectives.

9.3. Trust Strategy Delivery Plan 2024/25 - Q3 Update

Assurance

Deputy Chief Executive

JB presented the Q3 update on the Trust Strategy Delivery Plan for 2024/25, highlighting that the Trust is on track for most objectives despite the challenges faced in the last quarter. He noted that the delivery plan updates show progress across various strategic objectives, with most areas marked as green or amber. He mentioned that the Board will receive a new delivery plan for 2025/26, which will be more strategically focused on the key priorities for the next year.

The Chair asked for clarification on the difference between green and amber ratings and whether the Trust is confident in achieving the targets marked as amber.

JB explained the BRAG ratings:

- **Green**: Indicates that the objective or action is on track and expected to be completed as planned without significant issues. The trust is confident in achieving these targets based on current progress and available resources.
- **Amber**: Indicates that there are challenges or risks associated with the objective or action, but actions are in place to address them. The trust is confident that these challenges can be managed, and the targets can still be achieved.
- **Red**: Indicates that the objective or action is off track, and there are significant issues or risks that cannot be mitigated with the current plans. The trust is not confident in achieving these targets without substantial changes or additional resources.
- **Blue**: Indicates that the objective or action has been completed successfully. No further actions are required, and the target has been fully achieved.

JS raised concerns about the accuracy of some of the ratings in the delivery plan, particularly in relation to operational and financial performance. She noted that while some actions may be on track, the overall outcomes may not meet the intended targets, and it is important to be realistic about what can be achieved given the current pressures.

JS emphasised the need to streamline the delivery plan for the next year, focusing on the key priorities and being transparent about the challenges and limitations faced by the Trust. She suggested that it is acceptable not to achieve all the objectives if it means maintaining a balance between quality, safety, and financial performance.

JB acknowledged the need for a more realistic assessment and agreed to take the feedback on board and work with colleagues to review the ratings to ensure they accurately reflect the current situation and provide a realistic assessment of the Trust's progress.

ACTION: JB to review the ratings to ensure they accurately reflect the current situation and provide a realistic assessment of the Trust's progress.

10. Corporate Governance

Nothing for consideration

11. Questions from the Public and Trust Governors

Stakeholder Engagement

Chair

The Chair noted that no questions had been submitted in advance of the meeting and opened up for questions from those in attendance.

Richard Chilvers (member of the public) asked for clarification on the definition of the new hospital plan and whether it involves an expansion of the current hospital, considering the ongoing capital works. He sought details on what constitutes the new hospital and the future plans. MFl responded by explaining that the new hospital plan involves a complete replacement of the James Paget Hospital, reflecting the national recognition of the need to replace RAAC hospitals. He mentioned that the Trust has submitted the first business case and is awaiting feedback. The new hospital is expected to open in 2032, and the plan includes using national designs and layouts for new wards, theatres, and outpatient areas. JS added that new buildings, such as the Orthopaedic Elective Hub, have been designed with the future hospital in mind and will be retained. She emphasised the importance of having a master plan to ensure that any investment aligns with the long-term goals of the New Hospital Programme.

12. Meeting Review

12.1. Matters for Consideration by other Entities

For Decision

Chair

Nothing to report.

12.2. Reflection

For Discussion

Committee Chair

Our Values shape how we approach everything we do, and align to the NHS People Promise, which applies to everyone working in the NHS.

Collaboration - We work positively with others to achieve shared aims.

Accountability - We act with professionalism and integrity, delivering what we commit to, embedding learning when things for not go to plan.

Respect - We are anti-discriminatory, treating people fairly and creating a sense of belonging and pride.

Empowerment - We speak out when things don't feel right, we are innovative and make changes to support continuous improvement.

Support - We are compassionate, listen attentively and are kind to ourselves and each other.

The Chair initiated the meeting review by reflecting on the importance of setting realistic targets and accurately assessing progress. He emphasised the need for clear and achievable goals to ensure that the trust can celebrate successes and address challenges effectively.

SC supported the Chair's point by highlighting the importance of having clear targets and a structured plan to measure progress. She stressed that the intent is not to push for unachievable targets but to set realistic goals and celebrate achievements.

The Chair concluded the review by acknowledging the challenges faced by the Trust and the importance of balancing financial constraints, operational targets, patient safety, and staff well-being. He reiterated the need for clear targets and realistic assessments to guide the Trust's efforts and ensure success.

13. Next Meeting

For Information

Chair

Friday, 28 March 2025 - Lecture Theatre, Burrage Centre

Date of Meeting	Minute Reference	Subject	Action	Responsibility	Target Due Date	Update	Status	Status Date
27/09/2024	6.1	Board Assurance Framework Report	Board to review Risk Appetite Statement in the context of persistent risks reported in BAF Risk Register	HoCA	~~29/11/2024~~ 28/03/2024	All Committee briefed by TSEC and prepared for further discussion at appropriate opportunity. **29/11/2024** - JS noted to be discussed further during BAF item and requested to be reopened; Chair approved. Action to be reopened **24/01/2025** - covered within the 13/12/2025 Board Development Seminar. Suggest to close. **31/01/2025** - Action to be reopened. Revised risk appetite statement to be submitted to the next Board meeting (March 2025), following the Audit Committee's review at February Committee. **24/02/2025** - added to March Agenda.	To Close	
31/01/2025	4.2	Chief Executives Update	JS to update the Board at the March meeting on the NCTR targets and approach that will reduce the number to less than 100 over the next 6 months.	CEO	28/03/2025	**21/03/2025** - Verbal update to be given at the meeting	Open	
31/01/2025	7.1	Integrated Performance Report	CD to include NCTR details within the Board IPR.	COO	28/03/2025	**21/03/2025** - NCTR metric now included in IPR.	To Close	
31/01/2025	8.1	Chief Nurse Staffing Report	CN to review the correlation between the significant deterioration in shift fill rates and the increase in care hours per patient per day and provide a verbal update at the next Board meeting.	CN	28/03/2025	**21/03/2025** - Increase in care hours per patient day (CHPPD) relates to higher levels in some specialist areas which increases the overall aggregated average. Covers shift fill affected by high sickness levels and consistant use of escalatyion areas, which stretches the capacity available to meet funded templates in general areas. Suggest to close.	To Close	
31/01/2025	8.1	Chief Nurse Staffing Report	CN to review January's data to determine if the downward trend in planned fill rates continues and consider revising controls if necessary.	CN	28/03/2025	**21/03/2025** - Verbal update to be given at the meeting	Open	
31/01/2025	9.3	Trust Strategy Delivery Plan 2024/25 - Q3 Update	DCEO to review the ratings to ensure they accurately reflect the current situation and provide a realistic assessment of the Trust's progress.	DCEO	28/03/2025	**11/02/2025** - This will be addressed in the annual summary of 24/25 Delivery Plan report to Board in early 2025/26. Action to close.	To Close	

BUILDING A HEALTHIER FUTURE TOGETHER

OUR PATIENTS

OUR PEOPLE

OUR PARTNERS

OUR PERFORMANCE

James Paget University Hospitals NHS Foundation Trust

CEO Report

Board of Directors

28 March 2025

CEO Report

Board of Directors, 28 March 2025

Our Patients

Year 2 Delivery Plan Objective: Deliver our Quality Priorities for Patient Safety, Clinical Effectiveness and Patient Experience

- The Trust is currently working through the final stages of a new Visitor's Charter to implement CQC guidance that outlines a changed approach to managing visitors, and encourages an 'open door' approach to patient visiting and accompaniment
- From the beginning of April, the James Paget will be implementing the Visitor's Charter and adopting a new approach – moving away from set visiting hours to an 'open door' approach, giving families, friends and carers the benefit of more flexibility to visit their loved ones.
- The charter outlines that visiting can take place during core hours of 7am and 10pm – and that numbers are limited to two per patients. It also provides a comprehensive list of expectations of our visitors covering privacy, dignity, communication and infection control

CEO Report

Board of Directors, 28 March 2025

James Paget University Hospitals NHS Foundation Trust

Our Patients

Year 2 Delivery Plan Objective: Deliver our Quality Priorities for Patient Safety, Clinical Effectiveness and Patient Experience

- The Trust took part in a special national day of reflection on 9th March, to mark the fifth anniversary of the COVID-19 pandemic.
- Our hospital shared some short staff stories via our social media channels and website, giving their experiences of working in a hospital during the pandemic.
- The Trust also hosted a COVID-19 reflection session for staff in the Lecture Theatre, the Burrage Centre

CEO Report

Board of Directors, 28 March 2025

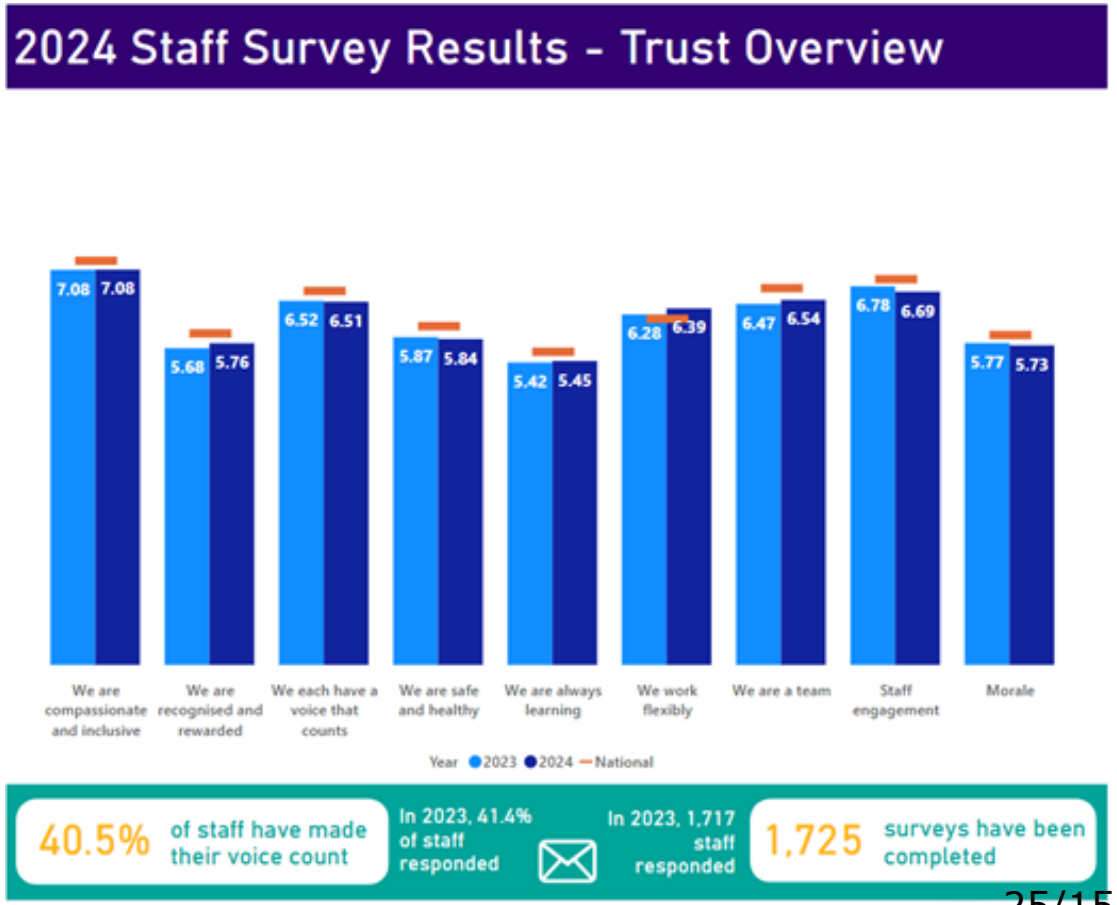
We each have a voice that counts

NHS
James Paget University Hospitals
NHS Foundation Trust

Our People

Year 2 Delivery Plan Objective: We will implement our new Trust Values and Behaviours Framework; We will continue to embed the Just & Learning Culture

- The results of the NHS Staff Survey were published on 13th March; a number of areas have stayed at a similar level to the 2023 survey but there is much we can be proud of, including positive outcomes for flexible working, improved Freedom to Speak Up support, and an increase in compassionate leadership.
- The Trust score below the national average across most of the People Promise elements, showing we need continued focus on these in delivering our People Plan



CEO Report

Board of Directors, 28 March 2025

James Paget University Hospitals NHS Foundation Trust

Our People

Year 2 Delivery Plan Objective: We will implement our new Trust Values and Behaviours Framework.

- The Trust has launched its Managers Induction programme, open to any new line manager in the last five months, cover expectations of line managers here at the Trust and what it takes to become a great line manager.

- The Trust has also launched its 7-month Growing into Leadership programme, designed to provide aspiring managers an insight into a management role at JPUH while starting to build the necessary skills to become our future leaders.

CEO Report

Board of Directors, 28 March 2025

James Paget University Hospitals NHS Foundation Trust

Our Partners

Year 2 Delivery Plan Objective: We will collaborate with acute hospital partners to deliver the Joint Acute Clinical Strategy (supporting EPR & NHP)

- The Norfolk and Waveney Acute Hospital Collaborative is continuing to work on its move to a group model of operation from April 2025, which will comprise of a Group Chair, Group Chief Executive, and a Group Board to lead decision making.
- Recruitment processes for an Interim Group Chair and Group Chief Executive are already underway and, because the posts are ring fenced to the current Chairs and CEOs, we anticipate being able to announce the Interim Group Chair in the last week of March and the substantive CEO in early April. A single set of Group Executive and Non-Executive Directors will be appointed soon after.
- The Interim Group Chair and Group Chief Executive will also work on a management structure, scheduled for early May. Each hospital will have a Managing Director who will be a full member of the Group Board and these three posts will be some of the first appointed to.

CEO Report

Board of Directors, 28 March 2025

James Paget University Hospitals NHS Foundation Trust

Our Partners

Year 2 Delivery Plan Objective: Work with acute partners to progress the implementation of an Electronic Patient Record

better joined-up care
Electronic Patient Record (EPR) Programme

- Our Electronic Patient Record project has taken a significant step forward – with the demonstration of a prototype of the system. Prototype 1 has been built, tested and now demonstrated virtually to more than 120 members of staff across the three Norfolk acute hospitals.
- The EPR programme is also engaging with all staff to develop training which staff will need to undertake to use the new system. Its creation has been overseen by the 10 design, build and test (DBT) teams, which are made up of various staff roles from the three Trusts covering areas including Inpatients, Outpatients, Theatres, Maternity, ED and Pharmacy.

- The EPR programme is also engaging with all staff to develop training which staff will need to undertake to use the new system.

CEO Report

Board of Directors, 28 March 2025

James Paget University Hospitals NHS Foundation Trust

Our Performance

Year 2 Delivery Plan Objectives: We will develop and commence delivery of a robust Financial Improvement Plan with a focus on productivity and efficiency

- To address the Trust's financial deficit, NHS England have taken regulatory intervention within the Norfolk and Waveney Integrated Care System. Hunter Healthcare has recently started working jointly with JPUH, NNUH and QEH to deliver its Financial Intervention Programmes, alongside existing monitoring of our operational performance and clinical quality standards.
- The Financial Intervention Programme will strengthen processes we already have in place, such as the existing non-pay and vacancy control approval panels.
- Two new forums have been developed to help deliver the Financial Intervention Programme - the Financial Intervention Programme Board, chaired by the Chief Executive, and fortnightly Divisional / Corporate Financial Intervention Review meetings

CEO Report

Board of Directors, 28 March 2025

James Paget University Hospitals NHS Foundation Trust

Our Performance

Year 2 Delivery Plan Objectives: Deliver the operational targets as outlined in the NHSE planning guidance for Elective, Cancer and Urgent and Emergency Care

- The Trust has continued to face demand for urgent and emergency care services and for reduced patient flow, particularly patients on a ‘pathway1’ – those who can be discharged home but need some additional health or social care support – which have increased significantly over recent months.
- The Trust has worked with Norfolk and Waveney with ICB and NHSE regional colleagues to address this, and the ICB has commissioned additional capacity for James Paget patients, which will support an extra 30 discharges up to the start of April
- This extra support aims to improve bed capacity and better patient flow – and help us move out of escalation areas including Ward 22 that were opened over the winter period to manage demand.

CEO Report

Board of Directors, 28 March 2025

James Paget University Hospitals NHS Foundation Trust

Our Performance

Year 2 Delivery Plan Objectives: Deliver the operational targets as outlined in the NHSE planning guidance for Elective, Cancer and Urgent and Emergency Care

- The new Orthopaedic Outpatient Centre is currently being installed next to the Orthopaedic Centre and Oulton Suite.
- The centre will house services including those provided by our current fracture clinic, and will have nine consultation and examination rooms and a modernised plaster bay, as well as improved staff office and rest areas.
- The Outpatient Centre is scheduled for opening in May, freeing space for an expanded Same Day Emergency Care service.

CEO Report

Board of Directors, 28 March 2025

James Paget University Hospitals NHS Foundation Trust

Our Performance

Year 2 Delivery Plan Objectives: We will deliver the key agreed milestones regarding RAAC mitigation works as part of the agreed Trust Estate Strategy.

- The construction of our new kitchen, which commenced in February 2024, and has run in tandem with the RAAC programme, has been completed, upgrading a kitchen that has been in place for 40 years.

- The project required installing new ventilation, flooring and drainage; installing wall covers, updating electrical and fire safety systems and installing new kitchen equipment. The £1.5 million project has provided us with a modern kitchen which is fully compliant with modern hygiene standards.

CEO Report

Board of Directors, 28 March 2025

James Paget University Hospitals NHS Foundation Trust

Our Performance

Year 2 Delivery Plan Objectives: We will develop the business case for our new hospital build, meeting national timescale requirements

- Our ‘Masterplan’ for our new hospital will be shared with staff and the public from 1st April, and the Trust will be engaging with staff, patients and the public as part of the submission of planning application to Great Yarmouth Borough Council on the size and position of the new hospital and associated works.
- The Trust will be running drop-in events both at the hospital and at venues across Great Yarmouth and Waveney across April and May to gather feedback, as well as running an online survey where people can provide their views

NHS
James Paget University Hospitals
NHS Foundation Trust

Report to the Trust Board of Directors dated Friday, 28 March 2025

Title: Board Assurance Framework Report

Sponsor:	Chief Executive
Author:	Head of Corporate Affairs
Previous scrutiny:	Board Committees February 2025
Purpose:	The paper is presented for Assurance.
Relevant strategic priorities:	✓ 1. Caring for our patients ✓ 2. Supporting our people ✓ 3. Collaborating with our partners ✓ 4. Enhancing our performance
Impact assessments:	☐ Quality ☐ Equality ☐ GDPR and DPA ✓ Not applicable

Does this paper have any impact of the Norfolk and Waveney Integrated Care System or Great Yarmouth and Waveney Place partners? ☐ Yes ✓ No

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Introduction

This report presents the final Board Assurance Framework (BAF) Report of the fiscal year, summarising key risks, changes since the last review in January 2025, and the overall risk position at year-end.

As we embark on a new fiscal year and transition into the Group Governance Framework, this report should serve as more than a record of risk status. The strategic application of this BAF Report and the lessons learned across Board Committees throughout the year must be used to review and revise the Trust's strategic objectives, align risk control resources accordingly, and ensure governance and risk oversight remain responsive to evolving pressures.

Financial sustainability, operational performance challenges, and maternity oversight continue to demand the Board's close attention. These areas, along with workforce and system-wide governance risks, will inform how the Trust positions itself within the new governance framework, ensuring that risk oversight and management provisions remain fit for purpose and align control resources where they are most needed to protect patient safety, patient experience, and clinical effectiveness (service quality).

Changes Since January 2025

Several developments have taken place since the January 2025 Board review of the BAF Risk Register Report:

Refinement of Risk Categories and Prioritisation

- Workforce-related risks have been consolidated into BAF005 (Staff Capacity), BAF006 (Staff Capability), and BAF007 (Staff Engagement) for a more focused approach to managing recruitment, retention, and staff well-being.
- The financial sustainability risk (BAF015) has been expanded to capture funding and commissioning-related constraints, ensuring the risk reflects both internal financial control and external system-wide pressures.
- BAF016 (Operational Performance) has been formalised to account for ongoing challenges in meeting national performance standards, particularly in urgent and elective care.

Movement in Risk Ratings

- Workforce shortage risk (BAF001) has improved and is now within risk appetite, reflecting improved recruitment and retention outcomes.
- Maternity regulatory oversight (BAF012) remains above risk appetite, though ongoing improvements continue to stabilise compliance levels.
- Financial sustainability (BAF015) and operational performance (BAF016) remain the most pressing concerns, requiring robust risk control measures into 2025/26.

Year-end Risk Position 2025

The table below provides a final summary of the Trust's strategic risks:

BAF ID	Risk Title	Current (residual) Rating	Target Rating	Risk Appetite Status
BAF001	Workforce shortages	9	≤ 12	Within Appetite
BAF002	Learning & feedback systems	9	≤ 6	Above Appetite
BAF003	Patient information availability	9	≤ 6	Above Appetite
BAF004	Health inequalities	4	≤ 4	Within Appetite
BAF005	Staff capacity	12	≤ 12	Within Appetite
BAF006	Staff capability	9	≤ 9	Within Appetite
BAF007	Staff engagement	12	≤ 9	Above Appetite
BAF008	Estates & digital infrastructure	12	≤ 8	Above Appetite
BAF009	Digital security risks	8	≤ 8	Within Appetite
BAF010	Capacity & demand pressures	15	≤ 8	Above Appetite
BAF011	ICB Collaboration & partnerships	6	≤ 6	Within Appetite
BAF012	Maternity regulatory oversight	16	≤ 8	Above Appetite
BAF013	Adherence to clinical best practice	8	≤ 8	Within Appetite
BAF014	Fundamental care compliance	12	≤ 8	Above Appetite
BAF015	Financial deficit & sustainability	16	≤ 8	Above Appetite
BAF016	Operational performance	15	≤ 8	Above Appetite

Of these, the following stand out:

- BAF015 (Financial Sustainability) – A priority concern given anticipated immediate pressures on NHS commissioning budgets and financial controls.
- BAF016 (Operational Performance) – Performance against national standards remains high-risk and requires continued oversight.
- BAF012 (Maternity Regulatory Oversight) – While considerable progress has been made, sustained compliance remains a key focus.

Strategic Implications for 2025/26

The strategic application of this BAF Report and the lessons learned across Board Committees throughout the year should be applied to:

- Formulating the Trust's strategic objectives for 2025/26 in the context of current risk profiles and pressures.
- Ensuring control resources are allocated proportionately to mitigate the most pressing risks without compromising patient safety, patient experience, or clinical effectiveness (quality).
- Refining risk oversight mechanisms, ensuring that financial and operational performance risks do not escalate further. This will require closer to real-time, evidence-led Board Intelligence compared to traditional retrospective performance reporting.

Integration of Risk Oversight with Governance Changes

With the Trust transitioning to a Group Governance Framework beginning in April 2025, there is a clear need for embedding enhanced risk management standards within the group governance provisions to ensure strategic board oversight, performance accountability, control effectiveness, and evidence-based board assurance. Hence, the Board must prepare for a transition from NED-led, report-heavy scrutiny through oversight and assurance committees to near real-time, systematic intelligence-based risk oversight.

Secretary's Recommendations

To ensure that this report actively informs the Trust's strategic direction, the Board is recommended to:

1. Consider the draft 2025-26 Objectives in the context of the current risk status and appetite, to prioritise the allocation of control resources to mission-critical risk areas.
2. Consider the year-end risk position of the Trust and review the Board's Risk Appetite Statement, including trigger thresholds and escalation frameworks (see Risk Appetite Report).
3. Endorse the revised risk appetite monitoring approach, ensuring that risk escalation pathways are clear and effective in 2025/26 (see Risk Appetite Report).
4. Actively support the integration of the Board's BAF-led learning into the new Group Governance Framework, preserving the value created through three years of refinement of the risk management and internal control system by both Non-executive and Executive Directors.

BAF Serial	Title	Strategic Priorities Impacted	Exec Owner	Review Committee	Initial Risk Rating	1st Line of Defence (Executive Mangement, Operational Controls, and People)	2nd Line of Defence (Risk & Compliance Functions, Policies & Monitoring)	3rd Line of Defence (Independent Assurance)	Actions to close Gaps	Control Effectiveness	Residual Risk Rating	Board Risk Appetite	≥0 == ≥Appetite	Risk Appetite Status
BAF001	Workforce shortages and skill mix gaps may compromise delivery of strategic objectives including patient quality and safety, potentially leading to increased clinical errors and adverse health outcomes.	P1 A1: Provide the best and safest care for our patients	Chief Medical Officer	PSQ P&C	20	• Daily staffing summit to review staffing levels and shortages due to staffing gaps and or increases in acuity. this enables redeployment of staff, requests for bank/agency staff • Annual Job Planning of medical workforce • Ward 21 in place to provide short notice shift fill (Rostered temp staffing ward), staff report to site matron (onsite 12 hrs a day, 7 days a week) which helps to address short term absences with JPUH trained staff • Use of bank / locums for cover • E-rostering in place for all staff areas • Use of red flag reports • Daily review of incident reports and safety huddles • Escalation for filling gaps in rota by moving staff, bank, incentives or Agency, • Vacancy Management Panel • Process for Executive approval short notice staffing developed and in place • Annual Medical Consultant Workforce Review undertaken by both clinical divisions • Developing new clinical roles such as Physician Associates including grow-your-own. developing new clinical competencies such as prescriber-pharmacists	• Monthly Chief Nurse staffing report presented to Board using a recognised assessment tool and professional judgement linking quality and safety to staffing numbers and acuity • Matrix approach to Nursing, Midwifery and AHPs twice yearly establishment review undertaken on a 6 monthly basis (Nursing and Midwifery) and yearly all other areas and results reported to HMG, Sub Board Committee, and Board • Erostering policy and KPIs monitored via Digital Workforce Programme Board and Divisional Performance Groups • NHS Staff Survey ('there are enough staff') • Medical Job Planning policy in place. • Monthly report of job planning compliance to DPM, oversight by Job Planning Consistency Group with escalation to HMG • Annual Medical Consultant Workforce Review considered by People and Culture to optimally utilise available staff. • Steering Group, with escalation to HMG as required.	• External review of nursing establishment process completed by NHSE 2023. • Bench marking data submitted to regional and national teams via regular data returns. • Internal Audit Temporary Staffing	**1st Line:** • Implement Team Job Planning for medical staff. • Recruit Joint Consultant Posts with UEA. **2nd Line:** • Design a nursing staffing tool to electronically support demonstrating the balancing of risk assessment (by 30/09/2024). • External review of e-rostering practices and performance (Oct-Nov 2024). • Workforce plans, including new clinical roles. **3rd Line:** • Implementation of Internal Audit 2024-25: Staff Recruitment and Retention recommendations.	Effective	9	12	-3	Within Appetite
BAF002	Inadequate systems for capturing, embedding, and disseminating learning and feedback prevent effective monitoring of quality of care, and quality improvement resulting in diminished standards of care quality.	P1. A1: Provide the best and safest care for our patients P1 A2: Continuously improve patient experience	Chief Nurse	PSQ	15	• PALS & Complaints Service in place • Regular feedback loop from Healthwatch, Maternity Voices Partnership and other stakeholders • PSIRF framework in place • Clinical Mortality Review Group (CMRG) identifies and implements learning from deaths. • Mortality Surveillance Group (MSG) monitors quality indicators and emerging themes around mortality.	• Integrated performance report - feedback (Data relating to Complaints, PALS enquires compliments and FFT) • National Patient surveys including cancer, inpatient, outpatients, maternity, and Emergency Care. Results analysed and action plans developed • FFT monthly reports and actions monitored via Caring and Patient Experience Group • Patient Experience and Engagement Plan • PSIRF implementation plan • Learning from deaths policy	• Internal Audit of PSIRF/incident reporting • Internal Audit 2024-25: Complaints / PALs Processes	**1st Line** None recorded **2nd Line** • Develop digital feedback system in house due for Implementation by 30/09/24 (was June 2024) • Digital internal and external options to assist in patient feedback due for implementation by June 2024 • 7-day review of our patient experiences and feedback project due for completion by June 2024 • Explore further development of the patient portal and the ability to text patients regarding their feedback • Embed Just and Learning Culture approach through incorporation in Trust policies and delivery of training • Full roll out of QSAFE system: linking data and information across a number of quality and safety areas **3rd Line** None recorded	Partly Effective	9	6	3	Above Appetite
BAF003	Insufficient information for patients prevents them from making informed decisions about their care, leading to mismanagement of patient expectations and suboptimal health outcomes.	P1 A2: Continuously improve patient experience	Chief Nurse	PSQ	12	• Multidisciplinary care booklet in use for all patients where electronic patient records are not available • Patient information leaflets from a standardised, validated external provider cover wide range of conditions and treatments available including surgical and endoscopic procedures • Standardised process of providing patient information leaflets at consultation prior to consent, reconfirmation of consent on day of procedure. • 'Check-in' process prior to start of procedure. • Patient Decision Aids (PDAs) are provided to patients offered surgical and endoscopic procedures; currently this is in the form of information leaflets from a standardised, validated library of an external provider (EIDO). In future, EPR will enable patients to access online resources including video and animations	• Consent policy in place, sets the standard for fully informed and voluntary consent for all procedures. Policy developed jointly by the 3 acute Trusts, and incorporates all current national guidance including from Department of Health and the General Medical Council • ReSPECT (Recommended Summary Plan for Emergency Care and Treatment) and DNACPR Policy empowers people to participate in decision making about the treatment they receive in advance of an emergency situation • LocSSIPS (Local Safety Standards for Invasive Procedure) in place for procedures under local anaesthesia.	• Consent audit in annual clinical audit programme monitored by Clinical Effectiveness Group that provides assurance to Patient Safety and Quality Committee • Annual ReSPECT policy audit in annual clinical audit programme monitored by Clinical Effectiveness Group and reported to Patient Safety and Quality Committee • Themes regarding complaints included in yearly Complaints report	**1st Line** None recorded **2nd Line** • Electronic PDAs (Patient Decision Aids) to become available after EPR implementation. • Electronic Consent (with built-in indicators of patient engagement) to become available after EPR implementation. • Mandatory Consent Training (currently being sourced as previous NHS training package not available) • Consent training used to part of annual mandatory training before the move to electronic platform via ESR. An electronic training package has been sourced on eLfH (an NHS resource), and the plan is to import this to ESR and re-establish it as mandatory training for in-scope clinicians (including all doctors) • LocSSIP audit to be included in next annual audit plan (2025). **3rd Line** • Independent validation of patient engagement may become feasible after implementation of electronic	Partly Effective	9	6	3	Above Appetite
BAF004	Insufficient consideration of diverse needs and health inequalities (HE) when planning and providing services that cause worsening disparities in healthcare outcomes, negatively affecting service and care quality (patient safety, patient experience, and clinical efficacy). [includes retired risk 424]	P1 A3: Reduce health inequalities, ensuring equitable access for all	Deputy CEO	PSQ P&C	12	• Joint working groups with system partners, including a specific workstream at the GY&W Place Board	• Speciality Development Plans in place with specific content relating to health inequalities • Trust Strategy has a clear objective for health inequalities and is monitored by Board • Equality Delivery System annual assessment • Health Inequalities included in Clinical Harm Reviews • HMG have approved the Health Inequalities Improvement plan that sets out a clear plan for addressing HI across the Trust and in partnership with system partners • PTL analysed for protected characteristics • Health Inequalities Framework approved by Norfolk and Waveney Health and Wellbeing Board in September 2024 • Great Yarmouth and Waveney Place Board has agreed focus on HI supported by Public Health • Place Board, through a dedicated HI subgroup, addresses Health Inequalities across local partners	• None recorded	**1st Line** None recorded **2nd Line** • 24/25 Health Improvement Delivery Plan includes specific areas for health inequalities • ICB Framework will be implemented at Place and locally • Metrics to be monitored by HMG • Develop suite of metrics to demonstrate progress in tackling local health inequalities, aligned to N&W HE Framework • Wellbeing Plan to include tackling health inequalities relating to staff **3rd Line** None recorded	Partly Effective	4	4	0	Within Appetite

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BAF005	A lack of staff **capacity** (sufficient staff) may compromise the delivery of the Trust's strategic objectives	1.1 Deliver the best and safest care for our patients 1.2 Continuously improve patient experience 2.3 Attract, engage, develop and deploy our staff to deliver the best care for our patients 2.4 Promote wellbeing opportunities to keep our staff healthy and well 3.2 Embrace our role as an anchor institution, working together for the best outcomes 4.1 Make the best use of our physical and financial resources 4.3 Future-proof our service for the people we serve	Director of People and Culture	P&C	20	• Recruitment and Medical Staffing Team • 'Ward 21' peripetetic ward • E-rostering • Job-Planning • Short-staffing escalation process • Use of temporary staffing cover • Workforce planning	• Daily safer staffing summits • Daily review of incident reports and 'red flag' monitoring through Chief Nurse's reports to Board • Safety huddles • Twice annual nursing safe staffing reports using national assessment tool, reported to Hospital Management • Group, People and Culture Committee and Board • Erostering policy • E-roster and Temporary Staffing Key Performance • Indicators monitored through Divisional Performance Meetings, Digital Workforce Programme Board, People and Culture Committe and Board • Temporary Staffing Policy • Job Planning Policy • Job Plan Consistency Group, reporting to the People and Culture Steering Group • Annual Job Plan report to People and Culture Committee • Vacancy Management Standard Operating Process • Vacancy Management Panel • Temporary Staffing Controls • Annual Workforce Plan to Hospital Management Group (alongside Finance and Operational PLans) • Recruitment and Selection Policy • Attendance at Work Policy • Vacancy and retention key performance indicators reported to Divisional Performance Meetings, People and Culture Committee and Board • Nursing Retention Plan	• NHS Staff Survey ('there are enough staff') • Internal Audits	**1st Line** None recorded **2nd Line** • Implementation of workforce plans associated with strategic programmes of work (e.g. EPR - to 2026, Future Paget - to 2030, CDC, DAC, OEH 2024/25) • Implementation of Year 2 Staff Experience Plan (covering fundamentals, kindness and respect, #chooserespect (violence and aggression plans), wellbeing) - by March 2025 - For approval by Hospital Management Group and People and Culture Committee. • Review of 2024 Staff Survey results when available and Staff Experience Plan developed for 2025/26 - March 2025 **3rd Line** • None recorded	Partly Effective	12	12	0	Within Appetite
BAF006	A lack staff **capability** (skills, knowledge, experience) may compromise the delivery of the Trust's strategic objectives	1.1 Deliver the best and safest care for our patients 1.2 Continuously improve patient experience 2.3 Attract, engage, develop and deploy our staff to deliver the best care for our patients 4.3 Future-proof our service for the people we serve 4.4 Improve services through digital transformation, research and new models of care	Director of People and Culture	P&C	16	• Education Team • Organisational Development Team • Apprenticeship Team • Continuous Professional Development fund and plans • Annual Appraisals and Personal Development Plans • Human Resources Team • Person Specifications and Recruitment assessment processes • Transformation team	• Mandatory Training Policy • Study Leave Policy • Workforce Plans • Education, Training and Development Steering Group • Appraisal Guidance • Supervision Policy • Appraisal and mandatory training compliance monitoring through Divisional Performance Meetings, People and Culture Committee and Board • Speciality Development Plans including workforce requirements? • Recruitment and Selection Policy • Education Plan • Quality Improvement Methodology	• NHS Staff Survey ('appraisal helped me do my job'; access to training relevant to role) • National Education and Training Survey	**1st Line** None recorded **2nd Line** • Implementation of 2024/25 Continuous Professional Development Plan (by end March 2025) and identification of plans for 2025/26 (by March 2025) • Implementation of 2024/25 Education Plan (by March 2025). Review of plan by Hospital Management Group and People and Culture COmmittee. • Implementation of Appraisal Improvement Plan to improve appraisal compliance to Trust target and continue to focus on quality improvement (by March 2026). • Change management and transformation delivery development for senior leaders (2025/6). **3rd Line** None recorded	Partly Effective	9	9	0	Within Appetite
BAF007	A lack of staff **engagement** (morale, equity and inclusion, alignment to Trust Values) may compromise delivery of the Trust's strategic objectives	1.1 Deliver the best and safest care for our patients 1.2 Continuously improve patient experience 2.1 Promote an incusive, fair and safe workplace 2.2 Develop compassionate and effective leadership 2.3 Attract, engage, develop and deploy our staff to deliver the best care for our patients 2.4 Promote wellbeing opportunities to keep our staff healthy and well	Director of People and Culture	P&C	20	• Guardian Service (Freedom to Speak Up) • Leadership development programmes • People and Culture Team (with qualified Human Resources professionals) • Equity, Diversity and Inclusion Manager • Staff unions • Divisional Your Voice sessions • Occupational Health • Staff Networks • Line manager training • Quarterly Leadership Summits • Exit questionnaires / interviews and Stay Conversations • Employee Assistance Programme • Enhanced Psychological Support Service • Managers' Induction	• Freedom to Speak Up reports to People and Culture Steering Group, People and Culture Committee and twice-yearly to Board • Trust's People Plan • Staff Experience Plan • Equity, Diversity and Inclusion Plan • Equity, Diversity and Inclusion Steering Group • People and Culture Steering Group • Joint Partnership Meetings • Trust policies, including equity, diversity, and inclusion, freedom to speak up, just and learning workplace and associated toolkits • Just and Learning Culture Working Group, reporting to the People and Culture Steering Group • Staff Experience Programme Board, reporting to the People and Culture Steering Group • Staff Survey and People Pulse results reported to People and Culture Committee and Board • Equity, Diversity, and Inclusion (EDI) reports (e.g. Equality Delivery Standards, Gender Pay Gap, Workforce Race Equality Standards, Workforce Disability Equality Standards) • Annual Staff Wellbeing Deep Dive reported to People and Culture Steering Groups • Annual Retention Deep Dive reported to People and Culture Steering Groups • Trust Values and Behaviours Framework • Fair Recruitment Working Group • Violence and Aggression Working Group • People metrics included in Integrated Performance Report, reported to Divisional Performance Meetings, People and Culture Committee and Board • Violence and aggression action plan • Bi-monthly Staff Voice sessions at the People and Culture Committee	• Annual NHS Staff Survey • NHS People Pulse	**1st Line** None recorded **2nd Line** • Implementation of Year 2 People Plan priorities (covering fundamentals, kindness and respect, violence and aggression and wellbeing), including implementation of 2024/25 Staff Experience Plan - by March 2024 • Review 2024 Staff Survey results when available and develop 2025/26 Staff Experience Plan - March 2025 - for approval by Hospital Management Group and People and Culture Committee. **3rd Line** • None reorded	Partly Effective	12	9	3	Above Appetite

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BAF008	Ageing estate infrastructure including RAAC, timely New Hospital replacement and inadequate digital infrastructure impacts on service provision and compromises on achievement of net zero carbon programme	P4 A2: Lead the way towards achieving Net Zero Carbon P4 A3: Future-proof our services for the people we serve	Director of Strategic Projects	F&P	16	• Digital team in place to support Digital work programme (including EPR) and Strategy delivery • Estates Strategy & Green plan overseen by Estates & Facilities Team, via Estates & Facilities Programme Delivery Group and Sustainability Group • New Hospital Future Paget Programme (FPP) team in place • Key staff accredited with Better Business Case HM Treasury Business Case Training	• Approved Digital strategy in place (2022-2025) with delivery plan linked to EPR programme • EPR Programme Board and Digital Transformation Group in place to oversee EPR & Digital Programme • EPR FBC business case submitted May 2024 approved. • JPUH Digital Strategy is aligned to N&W Acute and ICB requirements • Estates Strategy 2022-32 states all new buildings to meet BREEAM Excellent as a minimum • Estates & Facilities Programme Delivery Group oversees programme of key projects (including RAAC) to support the Estates Strategy ensuring it is in line with master planning principles and New Hospital FPP schedule • Green Plan (2021-25) monitored via Sustainability Group & bi-annual updates to Board • All new builds to have evidence to meet net zero carbon in the business case • Future Paget Programme Board meets monthly to review and oversee progress with programme of work with regular reporting to HMG, F&PC as required • Board approved Strategic Outline Business Case - April 2022 - Second version updated November 2024 and submitted to NHP 3 December 2024 • Land Acquisition Business Case - Board approved October 2023 / (Plot 2 acquired March 2024)	• Premises Assurance Model (PAM) audit in Feb 2022 by PwC with Low Risk outcome • External advisers procured to support with key expert input as required	**1st Line** None recorded **2nd Line** • OBC/FBC deadlines to be agreed within NHP timeframes • Digital Maturity Assessment (DMA) second year self-assessment submitted to NHS Digital in July 2024. Awaiting national feedback to determine if any gaps exist in Digital Strategy to improve DMA scoring for 2025/26 DMA • Update Land business case acquisition for plots 1a, 1b and site 5/23 and re-present to NHP for decision. **3rd Line** • Considering PAM reciprocal peer reviews across N&W ICS	Partly Effective	12	8	4	Above Appetite
BAF009	Failure to safely implement new digital technology compromises information security, leading to security breaches and a loss of patient or public trust which causes non-attendance or non-compliance with treatment plans resulting in diminished standards of care quality	P4 A4: Improve services through digital transformation, research and new models of care	Director of Strategic Projects	F&P	16	• All systems password protected using secure devices • Mandatory Training for all staff • Multi Factor Authentication in place for all staff	• Compliance with data security and protection toolkit monitored through Digital Transformation Group and Information Governance Group	• DSPT Toolkit - audit completed 2024 by PwC with Substantial Assurance • Trust compliant with ISO 27001 • Trust holds Cyber Essentials Certification - valid until July 2025	**1st Line** None recorded **2nd Line** • Assess requirements of DPST 2025 - Assessment due 31 Dec 2024, compliance required by June 2025 **3rd Line** • Digital Team now focussing on achieving Cyber Essentials Plus	Effective	8	8	0	Within Appetite
BAF010	Insufficient capacity to meet demand prevents the hospital from executing the operating plan, potentially resulting in service delays and unmet patient needs.	P4 A1: Make the best use of our physical and financial resources	Chief Operating Officer	PSQ	16	• Day to day operational structure and processes in place	• Outpatient Improvement plan in place monitored monthly through the Outpatient Programme Board with key actions addressed • Urgent and Emergency Care Improvement plan in place monitored monthly through the UEC Programme Board with key actions addressed • Cancer Improvement Plan in place monitored through tumour site Remedial Action Plans • Elective Recovery Plan in place monitored through weekly PTL meetings • Monthly operational plan monitoring through Integrated Performance report • Divisional Performance Meetings and Operational Management Executive Group in place to monitor performance and put in place remedial action plans where required • Allocation of a senior ED clinician assigned to the non-admitted patient pathway to support better flow within ED • Opening of CDC on JPUH site in July 2024 to being additional diagnostic capacity online	• Internal Audits • 21/22 Elective Services Recovery • 22/23 Clinical review process • 22/23 Waiting list management • 23/24 Discharge processes • Fortnightly National/regional oversight meetings under the tiering regime for Cancer and RTT • Monthly National/system meetings in place under the tiering regime for UEC • System Elective Recovery Board	**1st Line** • Additional weekend, insourcing and outsourcing elective activity planned during 2024/25 • Piloting a GP heralded patient pathway that is suggesting an admission avoidance of a further 5-8 patients / day • Reduce length of stay (LOS) to national average, in line with processes in place. **2nd Line** • Working with ECIST to widen pathways to SDEC and develop a 'pull' model from ED to SAU and AMBU • Capital funding to expand SDEC footprint • CDC programme structure established to deliver increased diagnostic capacity • Further Faster GIRFT project established to drive implementation • Bed-modelling with ECIST towards dynamic bed model • OEH capacity to come on line January 2025 **3rd Line** • Follow-up of Discharge Planning audit from 2023/24	Partly Effective	15	8	7	Above Appetite
BAF011	Lack of collaboration and unilateral decisions by ICB members and Place partners undermine the achievement of Trust's goals and financial stability, leading to resource constraints, resulting in diminished standards of care quality and compromised health outcomes.	P3 A1: Collaborate to achieve seamless patient pathways both at place and system level	Deputy CEO	Trust Board	9	• The Trust has representation on key system boards including ICB/place/HWBPs • All key Trust strategic objectives link to partnership objectives including ICP/ICB strategy and priorities (in the Joint Forward Plan)	• Norfolk & Waveney Acute Hospitals Group (Committees in Common) • Board approved Standard Financial Instructions	• None recorded	**1st Line** None recorded **2nd Line** • Develop consistent feedback mechanism through robust reporting to HMG from representation on external groups • Ensure decisions by ICB and workstreams are reported back into the organisation for action/ consideration • The Trust is working with the other two acutes to develop a governance model that will enable the ICB decision to have a single acute budget to be delivered. This is being considered by the CEOs/Chairs before the next CiC **3rd Line** • None recorded	Effective	6	6	0	Within Appetite
BAF012	Regulatory oversight of Maternity following S29a, may lead to identification of non-compliance in service provision, potentially resulting in formal sanctions and reputational damage.	P1 A1: Provide the best and safest care for our patients	Chief Nurse	PSQ	25	• Trust is part of the National Maternity Support programme (MSP) with external support and oversight in place • Weekly Matron Quality walkarounds • Ward Accreditation Programme • Maternity Action Plan to cover all CQC must do's and should do's as well as regulation 29A in place • Clinical Effectiveness Group (CEG) ensures compliance with contractual obligations of commissioned clinical services • Clinical Effectiveness Group (CEG) ensures compliance with national screening programmes. • Non-compliance escalated to Hospital Management Group.	• Maternity Improvement Plan approved by Board overseen by Executive led Maternity Improvement Group • Rolling oversight of all Core services across the organisation, via monthly Patient Safety Improvement Group meetings • Trust wide CQC Action plan in place and monitored at DPM and then Patient Safety Improvement Group • Established regular CQC engagement meetings and process with relationship manager quarterly • Cultural aspects of maternity requiring improvement being monitored and addressed EMIG and following the leadership to care programme, phase 2 is roll out of "Just Culture" programme is to be rolled out to wider staff groups	• Internal Audit of 2022/2023 Ockenden Action Plan • External, independent review and ongoing support to maternity via independent CQC / HoM (retired), and regional review of services completed in Q1 of 2023	**1st Line** Development of pathway to ensure maternity review panel feeds into main trust wide review panel and has same level scrutiny completion aim 30/08/24 **2nd Line** • Request for clarity around exit plan from the MSP - Completion aimed for full approval for 30/08/24 • Phase 2 is roll out of "Just Culture" programme **3rd Line** • Internal Audit 2024-25: CQC Action Plan • CQC review of actions taken regarding regulation 29A outstanding and no confirmation of date available aimed for 30/09/2024	Partly Effective	16	8	8	Above Appetite

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BAF013	Non-adherence to evidence-based practice causes patients to receive suboptimal quality of care and treatment, resulting in poor personal and population health outcomes.	P1 A1: Provide the best and safest care for our patients	Chief Medical Officer	PSQ	20	• Processes to adopt and implement NICE and other national guidance in place; Divisional Medical Directors (DMDs) responsible for implementation • Processes to adopt and implement NICE and other national guidance in place. • Processes to develop local clinical guidelines where no national guidance available. • Divisional Medical Directors responsible for implementation of clinical guidelines • Annual clinical audit plan in place • Deputy DMDs and divisional clinical governance coordinators responsible for clinical audits • Structured Judgement Reviews (SJR) to review deaths that may be associated with suboptimal care • Deputy CMO and Clinical Mortality lead responsible for managing system and learning • Clinical practice reviewed against best practice and NICE Guidance when adverse events occur • GIRFT (Getting It Right First Time) benchmarking dashboard used for reporting to Divisions and CEG • Commissioned clinical services and screening programmes quality assurance annual reporting to CEG • Commissioned Clinical Services action plans in response to QA visits, annual reporting of KPIs, management of risks • Screening Programmes action plans in response to QA visits, annual reporting of KPIs, management of risks	• Clinical Effectiveness Group (CEG) monitors effectiveness, compliance and performance of the Clinical Effectiveness quality indicators and takes actions to address variance from expected standards • Learning from Deaths policy • Monitoring of relevant KPIs via Integrated Performance Report (IPR) in DPM and CEG • Clinical Audits managed, monitored and reported via QSAFE • GIRFT Dashboard for monitoring of outstanding recommendations • CEG provides oversight to Commissioned Clinical Services and Screening Programmes • CEG provides assurance to HMG and PSQ Committee • Standardised process for responding to external alerts and reports • Clinical practice is reviewed against national guidelines and local policies/guidelines when incidents, complaints and litigation cases occur	• Safeguarding Review April 2022 • Ockenden 2 Action Plan Review April 2023 • Annual report from National Audit Programmes • GIRFT report by national GIRFT team • Trust clinical audits against regional and national benchmarking • Commissioned Clinical Services external QA visits and reports • Screening Programmes external QA visits and reports • Process in place to respond to external alerts and reports	**1st Line** None recorded **2nd Line** None recorded **3rd Line** None recorded • Deep dive of GIRFT actions: The newly designed GIRFT dashboard enables drilling down to outstanding actions at specialty level. CEG agreed to bring individual specialties to CEG in rotation for a deep dive and focussed support. • Migration of Clinical Audits to QSAFE	Effective	8	8	0	Within Appetite
BAF014	Non-adherence to national standards inlcuding fundamental care delivery may result in regulatory action and reputational damage.	P1 A1: Provide the best and safest care for our patients	Chief Nurse	PSQ	16	• Day to day Clinical and operational bed meetings to review site safety and escalation of safety concerns and safe staffing. • Daily Matron Walk abouts and safety checks 24/7 Clinical Site presence of a band 8a • Process for reciving anf monitoring of CQC requests in place • Regular engagement meetings with CQC	• Regular audits of fundemental care standards • Working groups for monitoring compliance • Improvement Plans in place • Linked Themes from PSIRF and learning from incidents • Monthly operational monitoring through Integrated Performance report • Divisional Performance Meetings in place to monitor performance and quality and put in place remedial action plans where required • System wide monitoring of quality at ICS Quality group monthly meetings • Review of performance and themes at monthly DPM, Divisional Governance meetings, Board Sub-committees and Board • CQC compliance monitoring tool in place	• CQC reviews / inspections 2019 and 2023	**1st Line** None recorded **2nd Line** • Review audit tool and frequency to ensure compliance with completing audits. Fully populate the CQC compliance tool **3rd Line** • Request a CQC style mock assessment by the ICB quality team to ensure areas identifed have clear actions to address any short falls	Partly Effective	12	8	4	Above Appetite
BAF015	Underlying deficit for the Trust, potentially leading to a reduction in the organisation's future autonomy, and an impediment in the Trust's ability to continue providing care for patients.	P4 A1: Make the best use of our physical and financial resources	Chief Finance Officer	F&P	16	• Robust budget setting process in place following national guidance and operating plan. Budget signed off by HMG, and Board • HMG prioritisation of resources in line with Strategic Objectives, controlling unaffordable investments • Efficiency plan and processes in place • Yearly commissioning intentions letter sent to ICB • HFMA checklist and other grip and control measures overseen by FRG • Delegation of efficiency targets embedded into budgets • Robust gateway methodology in place to assess and approve efficiency projects • Enhanced temporary staffing pay controls implemented to enable delivery of in-year Financial Recovery Plan, effective from Q2 2024/25	• PMO resource aligned to delivery of CIP • Efficiency Delivery Group established and gateway process embedded • Efficiency Delivery Group receives monthly Divisional efficiency monitoring and oversight reports • Monitoring delivery of efficiency programme through IPR • Divisional performance meetings • 24/25 in-year financial recovery plan approved by the Board and monitored by Financial Recovery Group • Financial Recovery Group oversight of medium term (5-year) Financial Improvement Plan • Five-year Capital Plan regularly updated and agreed with system partners	• Internal Audit of CIP 2023/24 • Clean External Audit VFM opinion in 2023/24, in respect of financial sustainability • 24/25 internal audit review of budget setting process • External review of financial governance processes (Deloitte) 2024/25	**1st Line** • Implement actions to deliver 2024/25 in -year financial recovery plan. • Implement all actions resulting from 24/25 Deloitte financial governance review • Implement actions to deliver key milestones in financial improvement plan. **2nd Line** • I&I phase 2 intervention to be supported by Hunter Healthcare **3rd Line** None recorded	Partly Effective	16	8	8	Above Appetite
BAF016	Failure to achieve the operational performance standards potentially leading to regulatory action, reputational damage and contractual penalties	P1 A1: Provide the best and safest care for our patients P4 A1: Make the best use of our physical and financial resources	Chief Operating Officer	F&P	16	• Robust activity plan setting process • Daily 78 ww and 65 ww scrutiny meetings • Operational Management Executive Group held Monthly	• Outpatient Improvement plan in place monitored monthly through the Outpatient Programme Board with key actions addressed • Urgent and Emergency Care Improvement plan in place monitored monthly through the UEC Programme Board with key actions addressed • Cancer Improvement Plan in place monitored through tumour site Remedial Action Plans • Elective Recovery Plan in place monitored through weekly PTL meetings • Monthly operational plan monitoring through Integrated Performance report • Divisional Performance Meetings and Operational Management Executive Group in place to monitor performance and put in place remedial action plans where required • Allocation of a senior ED clinician assigned to the non-admitted patient pathway to support better flow within ED • Opening of CDC on JPUH site in July 2024 to being additional diagnostic capacity online • Opening of OEH in Febraury 2025 to bring additional orthopaedic capacity on line	• Internal Audits • 21/22 Elective Services Recovery • 22/23 Clinical review process • 22/23 Waiting list management • 23/24 Discharge processes • Fortnighlty National/regional oversight meetings under the tiering regime for Cancer and RTT • Monthly National/system meetings in place under the tiering regime for UEC • System Elective Recovery Board	**1st Line** • Additional weekend, insourcing and outsourcing elective activity planned during 2024/25 • Reduce length of stay (LOS) to national average, in line with processes in place. **2nd Line** • Working with ECIST to widen pathways to SDEC and develop a 'pull' model from ED to SAU and AMBU • Capital funding to expand SDEC footprint • CDC programme structure established to deliver increased diagnostic capacity • Further Faster GIRFT project established to drive implementation • Bed-modelling with ECIST towards dynamic bed model **3rd Line** • Follow-up of Discharge Planning audit from 2023/24	Partly Effective	15	8	7	Above Appetite

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NHS Foundation Trust

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Integrated Performance Report

Feb-25

NHS
James Paget University Hospitals
NHS Foundation Trust

Chief Executive Summary

2024/25 Priorities

Feb-25

Our patients | Our people | Our partners | Our performance

Performance across all domains remains challenging with the aim to deliver balance between quality, performance and finance. Performance was impacted primarily by significant operational pressures across the UEC portfolio which saw high levels of elective cancellations. A system response has resulted in additional community capacity equivalent to 30 additional discharges prior to the end of March.

Key priorities are to reduce in-patient Length of Stay, and reduction in shortterm sickness. Both are drivers for poor patient experience, performance and financial overspend. Reducing sickness absence is a key workstream under our financial recovery programme, however total annualized sickness absence remains above target.

As the Norfolk and Waveney system has been included in the NHSE interrogation and intervention regime a financial turnaround team is working with the trust to explore further opportunities to improve the financial position for 2024/25 and deliver a balanced position in 2025/26. This work is gathering pace with an emphasis now being placed on the 25/26 CIP delivery.

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Quality and Safety

Metric	Target	Actual	Perf
SHMI	1.14	1.13	✓
SSNAP	80	66	✗
12 Hour Mental Health in ED	20	34	✗
Complaints Received	16	15	✓
Complaints Responded to In 60 Days	100.0%	41.10%	✗
Inpatient Satisfaction	95.0%	98.47%	✓
VTE	95.0%	96.47%	✓
MRSA	0	0	✓
CDiff	3	1	✓
Gram-Negative	2	6	✗
Falls With Harm per 1000 Bed Days	0.130	0.209	✗
Registered Nurse and HCA Fill Rate	90.0%	83.94%	✗
Midwifery Fill Rate	90.0%	73.71%	✗
Still Birth Rate	3.5%	0.00%	✓
Preterm Birth Rate	6.0%	8.72%	✗

Operational Performance

Metric	Target	Actual	Perf
104+ Week Waits	0	0	✓
78+ Week Waits	0	12	✗
65+ Week Waits	0	166	✗
6 Week Diagnostics	90.5%	80.42%	✗
28 Day Faster Diagnosis	75.0%	71.74%	✗
Cancer 62 Day Treatment	70.0%	65.37%	✗
Cancer 62 Day Backlog	47	80	✗
First and Procedure Outpatients	46.0%	45.49%	✗
DNA Rate	5.0%	6.88%	✗
ED 4 Hour Performance	78.0%	64.64%	✗
Ambulance Handovers Over 30 Minutes	0	880	✗
ED 12 Hours in Department	0	717	✗
Non Elective LoS	8.00	12.34	✗
Non Criteria to Reside	80	144	✗

People and Culture

Metric	Target	Actual	Perf
Sickness Rate	4.6%	6.11%	✗
Leaver Rate	10.0%	6.52%	✓
Implied Productivity	15.80	12.53	✗
Mandatory Training	90.0%	93.22%	✓
Non Medical Appraisal	90.0%	80.05%	✗

Finance

Metric	Target	Actual	Perf
ERF Performance £000	0	-833	✗
Agency Expenditure £000	477	459	✓
Pay Per Unit of Activity	261	366	✗
Non Pay Per Unit of Activity	117	108	✓
Efficiency Plan £000	0	-352	✗
Better Payment Practice	95.0%	90.58%	✗
Financial Productivity	423	295	✓

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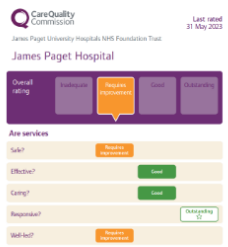
Quality and Safety

Mortality : remains overal within as “expected range”. Secondary malignancies remains ‘HIGHER THAN EXPECTED’. Multiple aspects of this have been reviewed with an association being found between the types of cancers and performance issues in these areas (lung, GI, gynae).
Stroke Metrics (SSNAP) : Stroke metrics are not incorporated within this month's quality and safety report, as October 2024 is the first period of the new national dataset for the SSNAP audit. The previous 10 domains, will be reducing to 7 but with an increased dataset overall.
12 hour Mental Health in ED : We exceeded the threshold for long waits for Mental Health patients waiting over 12 hours. Delays in mental health beds and assessments were the continued themes for the third month in a row
Inpatient satisfaction: We did not meet our response to complaints within 60 days for both complex and non-complex complaints. There is partial achievement of the recovery with completed or in final draft by the end of December 2025, Detailed updated reporting to HMG and PSQ continues. Patient satisfaction score was achieved.
Venous Thromboembolism (VTE): remaining in normal variation and zero Hospital Associated Thrombosis
Infection Prevention and Control : Zero MRSA Bacteraemia cases this month following the first case since January 2023 last month. There was 1 HOHA C-Diff case. Gram Negative we remain below in month threshold and under the year to date threshold
Patient Safety Metrics : Most categories are showing normal variation.
Hospital Acquired Pressure Ulcers per 1000 bed days are demonstrating an improving picture. Falls per 1000 bed days is showing continued improvement this month, however increase in harms resulting from a fall. Reporting incidences remains below the mean for a third month, impacts due to escalation and Critical incident resulting in staff not having time to report. However there is an upward trend of increasing incidents per 1000 bed days which has stabilised this month
Maternity Fill Rate : 73.71% actual vs planned fill rate which is below mean but with in normal variation and has remained for around the past year, but is on a downward trend. Short term sickness and maternity leave are main drivers for this and we are unable to cover maternity leave which then relies on Bank and limited agency.
Registered Nurse Fill Rate: 83.94% actual vs planned fill rate which is below mean but with in normal variation , this too is driven by short term sickness, maternity leave not covered and staff not picking up additional shifts due to loss of enhancements, secondary to financial controls.
Still Birth Rate ; there has been 4 cases, year to date
Preterm Birth Rate ; rate remains around the mean and with in normal variation limits

Metric	Period	Target	Actual	Compliance	Variation	Assurance
SHMI	Sep-24	1.14	1.13	✓	H	?
SSNAP	Sep-24	80	66	✗	~	?
12 Hour Mental Health in ED	Feb-25	20	34	✗	~	F
Complaints Received	Feb-25	16	15	✓	~	?
Complaints Responded to In 60 Days	Feb-25	100.0%	41.10%	✗	~	?
Inpatient Satisfaction	Feb-25	95.0%	98.47%	✓	~	P
VTE	Feb-25	95.0%	96.47%	✓	~	?
MRSA	Feb-25	0	0	✓	~	P
CDiff	Feb-25	3	1	✓	~	?
Gram-Negative	Feb-25	2	6	✗	~	?
Falls With Harm per 1000 Bed Days	Feb-25	0.130	0.209	✗	~	?
Registered Nurse and HCA Fill Rate	Feb-25	90.0%	83.94%	✗	L	?
Midwifery Fill Rate	Feb-25	90.0%	73.71%	✗	L	?
Still Birth Rate	Feb-25	3.5%	0.00%	✓	~	?
Preterm Birth Rate	Feb-25	6.0%	8.72%	✗	~	?



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Operational Performance

February saw a largely static month across performance metrics, primarily driven by significant operational pressures across the UEC portfolio. High levels of elective cancellations continued from January into February and has exacerbated the risks to elective recovery with only a marginal improvement in the 65 week position.
Whilst we are in Tier 2 for diagnostics and elective, there remain concerns around delivery, especially our rates of booking.

UEC metrics continue to be challenging to improve and Length of Stay remains a Trust area of focus, whether that be to reduce NCTR patients, focus on handovers. A further deep dive into the improvement of NCTR was reported to Finance and Performance Committee in March.

Increasing and more intense scrutiny is being applied across the UEC delivery portfolio. An NHSE chaired focused support session has held at the start of March 2025 with an aim to decompress the site and plan for additional actions to be taken to deliver the planning guidance. This has included the following:

- An injection of capacity equivalent to 30 additional discharges prior to the end of March
- Move Norfolk CC and Suffolk CC social workers on site to reduce the length of time for care act assessments to be undertaken and enhance team meeting
- On site support from ECIST and NHSE to provide intensive support to clinical colleagues and continue the programme of work from RiO
- On site support from ICB to bolster case manager resource
- A review of IDT and 7 day discharge services across the Trust

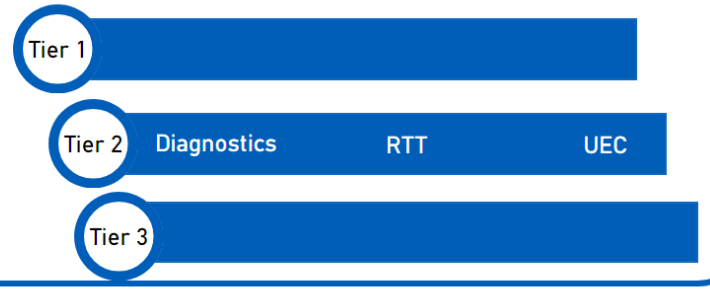
Plans for March

- Planning for Easter and May bank holidays
- Completion of booking for all March and April 65 ww cohort patients noting the changes to capacity as a result of planning round
- Refocus teams on elective recovery and elimination of long waiters coupled with an improvement of the 18 week position
- De-escalation from surge capacity and getting right patients in the right places
- Reinvigorate the implementation of our seasonal resilience plan
- Planning for 25/26

There was an in month deterioration in a number of cancer metrics but this does not show special cause variation as this stage.

Metric	Period	Target	Actual	Compliance	Variation	Assurance
104+ Week Waits	Feb-25	0	0	✓	L	P
78+ Week Waits	Feb-25	0	12	✗	L	F
65+ Week Waits	Feb-25	0	166	✗	L	F
6 Week Diagnostics	Feb-25	90.5%	80.42%	✗	~	?
28 Day Faster Diagnosis	Jan-25	75.0%	71.74%	✗	H	?
Cancer 62 Day Treatment	Jan-25	70.0%	65.37%	✗	~	?
Cancer 62 Day Backlog	Jan-25	47	80	✗	L	F
First and Procedure Outpatients	Feb-25	46.0%	45.49%	✗	~	?
DNA Rate	Feb-25	5.0%	6.88%	✗	L	F
ED 4 Hour Performance	Feb-25	78.0%	64.64%	✗	L	?
Ambulance Handovers Over 30 Minutes	Feb-25	0	880	✗	~	F
ED 12 Hours in Department	Feb-25	0	717	✗	~	F
Non Elective LoS	Feb-25	8.00	12.34	✗	~	F
Non Criteria to Reside	Feb-25	80	144	✗	H	F

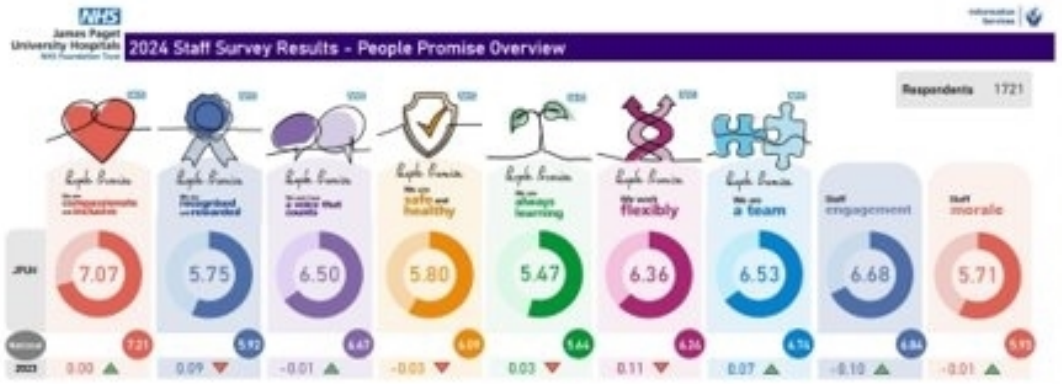
NHS England Operational Performance Tiering



People and Culture

- Total annualised S**ickness Absence,** a driver for temporary staffing demand, shows a deteriorating trend at 6.1%, well above the 4.6% target. There has, however, been an in-month reduction to 5.7% after a peak of seasonal-related absence in January 2025. Long-term sickness has shown improvement from almost 4% to 3% in the last month. Whilst there has been a small reduction in short-term in the last month, overall, this has been increasing since August 2024. Reducing sickness absence is a key workstream under our financial recovery programme. Immediate focus is on reviewing longest absences and those with the highest Bradford Scores (this is a mechanism for calculating absence that takes account of the number of episodes as well as absence duration). A working group is overseeing this work. Alongside this, a new Wellbeing Plan is under development which has a focus on prevention and our support offer.
- Our **Leaver Rate** remains positive at 6.52% and better than regional and national averages.
- **Implied Productivity** is below target at 12.5% with no common cause variation. Work to improve productivity is being overseen by the Financial Intervention Programme Board, however, there has been no notable change since this metric was introduced. (This indicator is calculated by dividing patient activity in the month based on Emergency Department attendances, outpatients and admitted patient care contacts by the total full time equivalent (FTE) staff in the month based on FTE employed and bank and agency worked. The target is based on the baseline 2019 / 20 performance.)
- Good overall **Mandatory Training** performance is being maintained, although there continues to be variation by subject, with face-to-face training compliance being lower due to challenges releasing staff to attend, impacted by sickness and operational pressures. The Education, Training and Development Steering Group is monitoring attendance by subject, with Subject Matter Expert attendance, as required, and assurance reporting through the People and Culture Committee.
- **Non-Medical Appraisals** continue an improving trend although far short of the Trust's target. Plans for improvement are being overseen by a working group, reporting to the People and Culture Steering Group and oversight through the People and Culture Committee. Our reported rate of 80.05% is less than the 85.76% staff reported in the 2024 Staff Survey indicating a recording gap, to be addressed through the improvement plan. There was improvement of more than 4% points in the Staff Survey from the previous year, with our performance now above the acute and acute and community Trust average. An important element of our appraisal process is a focus on wellbeing, which supports efforts to reduce sickness and improve productivity.

Metric	Period	Target	Actual	Compliance	Variation	Assurance
Sickness Rate	Feb-25	4.6%	6.11%	⊗		
Leaver Rate	Feb-25	10.0%	6.52%	✓		
Implied Productivity	Feb-25	15.80	12.53	⊗		
Mandatory Training	Feb-25	90.0%	93.22%	✓		
Non Medical Appraisal	Feb-25	90.0%	80.05%	⊗		



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James Paget University Hospitals NHS Foundation Trust

Finance

I&E Deficit The 24/25 financial plan was a £13.4m deficit. However, deficit funding of £12.3m was allocated to the JPUH, giving the Trust a revised annual plan of £1.1m deficit. Subsequently, a further £8.9m of income has been allocated allowing the Trust to achieve a break-even position (£1.1m favourable variance to plan). The chart opposite shows the original plan and performance excluding this additional deficit funding, to enable performance to be compared month on month. The Trust's YTD performance at month 11 is a deficit of £0.7m, a £0.4m positive variance to plan. The implementation of temporary pay controls improved the financial performance from month 4 to 7, however operational pressures deteriorated the position in months 8, 9 and 10. The month 11 improvement is due to additional income, with costs remaining stable with slight improvements despite operational pressures continuing.
Forecast Outturn (FOT) is for a break-even, £1.1m favourable variance to plan. Excluding the most recent allocation of deficit support funding, the projected deficit of £8.9m would have remained and the Trust would have been £7.8m off-plan. The key drivers for the previously anticipated £7.8m of variance, are set out in the table as mitigated risks.

Risk Area	Risk highlighted in financial plan £m	Risk Mitigated in YTD position	Risk realised in YTD position £m	Comments
Inflation Costs	1.2	1.3	0.0	Pay increases not fully funded but mitigated by deficit funding
ERF Income	13.0	2.2	0.0	£2.2m of lost income on ERF included in 3 rows below but mitigated by deficit funding
Savings	5.2	1.7	0.0	Savings currently £1.7m behind plan but mitigated by deficit funding
Operational pressures	4.0	1.9	0.0	Impact of pressures currently within YTD position but mitigated by deficit funding
Industrial Action	0.0	0.7	0.0	YTD Net cost of industrial action £1m - funding of £257k received and the remainder mitigated in position
Elective hub	0.0	0.0	0.0	Risk present from delayed OEH opening
System improvement	0.0	0.0	0.0	YTD position now includes planned system improvement
Total	**23.4**	**7.8**	**0.0**	

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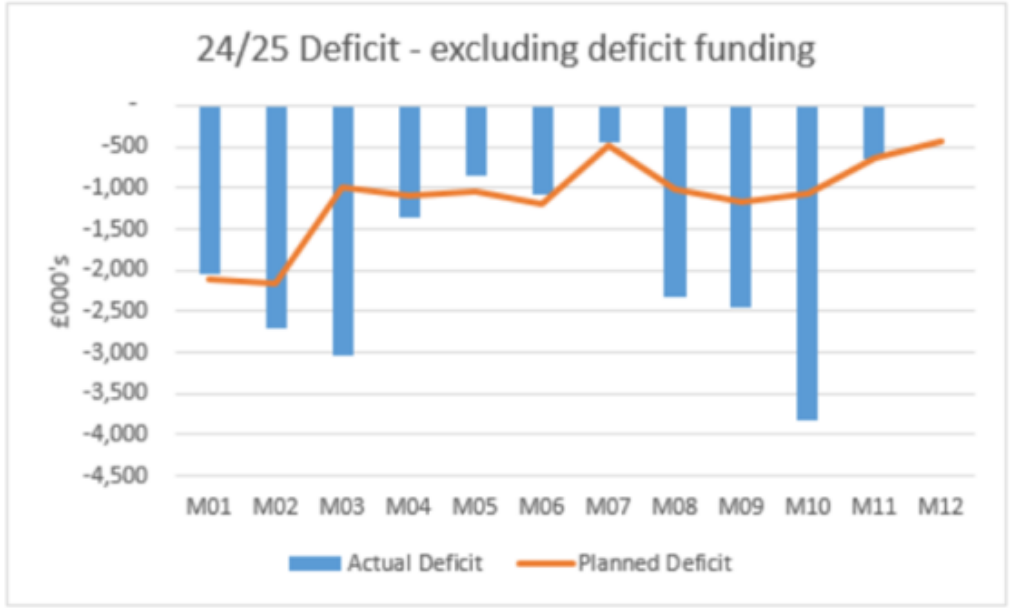
Efficiencies are £1.7m behind plan YTD, and FOT of £20.6m, £1.8m behind plan. The key driver is temporary pay cost reductions below plan.
ERF income earned is £9.5m above the 109% target, but is £3.4m behind the financial plan.
Agency costs are £2.7m above plan YTD, although expenditure has reduced each month since May 2024 through financial recovery actions.

Metric	Period	Target	Actual	Compliance	Variation	Assurance
ERF Performance £000	Feb-25	0	-833	✗	~	?
Agency Expenditure £000	Feb-25	477	459	✓	L	?
Pay Per Unit of Activity	Feb-25	261	366	✗	~	F
Non Pay Per Unit of Activity	Feb-25	117	108	✓	L	?
Efficiency Plan £000	Feb-25	0	-352	✗	~	?
Better Payment Practice	Feb-25	95.0%	90.58%	✗	~	?
Financial Productivity	Feb-25	423	295	✓	~	?



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Benchmarking - Planned Care and UEC

Better than National | Worse than National | Trust | Regional Avg | National Avg

Metric	Date	Trust Performance	Region Performance	Regional Average	Regional Rank	National Performance	National Average	National Rank	Performance Summary
ED 4 Hour Performance	Dec-24	62.1%	68.4%	69.0%	10/14	69.6%	71.5%	115/141	47.1% 100.0%
ED 4 Hour Performance - Type 1	Dec-24	54.2%	53.6%	52.6%	5/13	55.3%	55.0%	67/122	35.7% 88.1%
RTT Performance	Dec-24	54.7%	53.4%	53.6%	6/13	58.0%	62.4%	116/155	.9% 100.0%
PTL Size	Dec-24	31,669	846,740	65,134	2/13	7,076,011	45,652	56/155	38 199,425
52+ Wks	Dec-24	1,474	32,444	2,496	5/13	195,762	1,263	105/155	0 9,091
78+ Wks	Dec-24	9	131	10	9/13	1,861	12	119/155	0 633
DM01 Performance	Dec-24	30.6%	36.1%	37.6%	6/14	23.2%	20.8%	120/156	.0% 85.7%
104+ Wks	Dec-24	0	3	0	1/13	42	0	1/155	0 7

Benchmarking data displayed above is presented in both numerical and graphical format - the performance summary visualisation shows where current Trust performance is in relation to regional and national performance on each metric. Vertical lines represent the current JPUH performance and the national and regional averages for the metric. The horizontal bar is coloured based on where the Trust is in relation to the national averages. A rank of 1 indicates the Trust is performing better or equal than all other organisations.

A blue horizontal bar indicates that the Trust is performing worse than average national performance

Vertical lines show Trust, regional and national average performance

If the horizontal bar is green this indicates that the Trust is performing better than the average national performance

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NHS
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Chief Executive Summary

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Quality and Safety

SHMI - Summary Hospital Mortality Indicator
SSNAP- Sentinel Stroke National Audit Programme
MRSA - Methicillin-resistant Staphylococcus aureus
CDIFF - Clostridium difficile

Operational

RTT - Referral to Treatment
ED - Emergency Department (also referred to as Accident and Emergency)

Finance

CIP - Cost Improvement Programme
ERF - Elective Recovery Fund
YTD - Year to date

SPC Icons

Variation			Assurance		
					
Common Cause - no significant variation	Special Cause of concerning nature due to (H)igher or (L)ower values	Special Cause of improving nature due to (H)igher or (L)ower values	Variation indicates inconsistently passing/failing target	Variation indicates consistently passing target	Variation indicates consistently failing target

NHS
James Paget University Hospitals
NHS Foundation Trust

1 Quality and Safety

2 Operational Performance

3 People and Culture

4 Finance

Chief Nurse Report

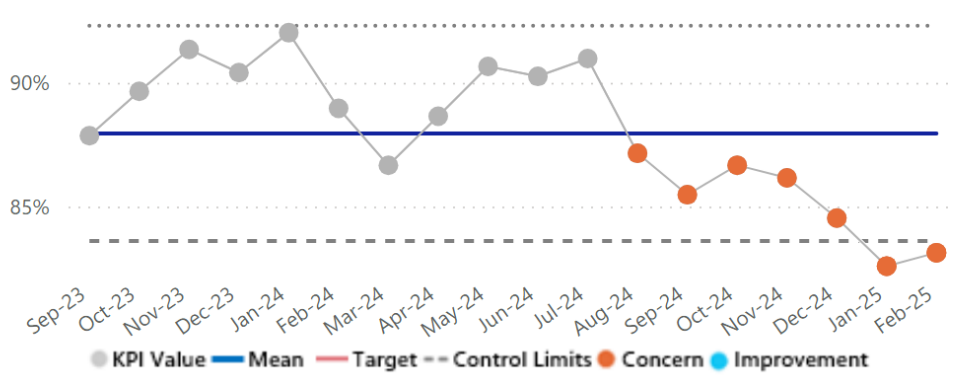
Feb-25

Summary - Shift Fill - Planned vs Actual

Metric Name	Current Month	Actual	Change	Target	Variation	Assurance
Planned v Actual Shift Fill - RN + HCA + RM + MSW	Feb-25	83.1%	0.54%	None		N/A
Planned v Actual Shift Fill - Registered Nurses	Feb-25	80.1%	1.15%	None	Change	N/A
Planned v Actual Shift Fill - Health Care Assistant	Feb-25	88.9%	0.38%	None		N/A
Planned v Actual Shift Fill - RN + HCA	Feb-25	83.9%	0.83%	None		N/A
Planned v Actual Shift Fill - Registered Midwife	Feb-25	73.7%	-3.21%	None		N/A
Planned v Actual Shift Fill - Midwifery Support Worker	Feb-25	72.7%	-2.28%	None		N/A
Planned v Actual Shift Fill - RM + MSW	Feb-25	73.4%	-2.95%	None		N/A
Planned v Actual Day Shift Fill - Registered Nurses	Feb-25	78.0%	0.65%	None		N/A
Planned v Actual Day Shift Fill - Health Care Assistant	Feb-25	81.1%	0.30%	None		N/A
Planned v Actual Day Shift Fill - RN + HCA	Feb-25	79.3%	0.50%	None		N/A
Planned v Actual Night Shift Fill - Registered Nurses	Feb-25	82.6%	1.75%	None	Change	N/A
Planned v Actual Night Shift Fill - Health Care Assistant	Feb-25	98.1%	0.35%	None	Change	N/A
Planned v Actual Night Shift Fill - RN + HCA	Feb-25	89.3%	1.21%	None	Change	N/A
Planned v Actual Day Shift Fill - Registered Midwife	Feb-25	75.4%	-3.43%	None		N/A
Planned v Actual Night Shift Fill - Registered Midwife	Feb-25	72.0%	-2.98%	None		N/A
Planned v Actual Day Shift Fill - Midwifery Support Worker	Feb-25	60.0%	-5.66%	None		N/A
Planned v Actual Night Shift Fill - Midwifery Support Worker	Feb-25	92.9%	2.03%	None		N/A

Planned v Actual Shift Fill - RN + HCA + RM + MSW — Feb-25

Target	Actual	Previous	Assurance	Variation
None	83.1%	82.6%	N/A	



The summary position for the combined registered RN/RM and unregistered HCA/MSW planned shift fill was 83.13% This is an increase of 0.54% compared to February 25 but a decrease of 5.3% compared to the same period in 2024. The variation pattern continues to demonstrate a pattern of concern.

There have been four changes in variation pattern and 11 out of the 17 metrics observed a degree of minor improvement, four metrics further decreased from last month and two additional metrics decreased. All levels of deterioration were observed in midwifery.

There were eight wards that didn't achieve 80% RN/RM shift fill on days and six on nights. The range was between 52 – 79%. The same measure for HCA/MSW was six wards on days and one on nights. Within this wards 1,15 and 10 all had below 80% on days shifts for both RNs and HCAs.

The aggregated average shift fill levels were; RN/RM days 80%, RN/RM nights 84%, HCA/MSW days 84%, HCA/MSW nights 103%.

NHSi SPC Icon Key

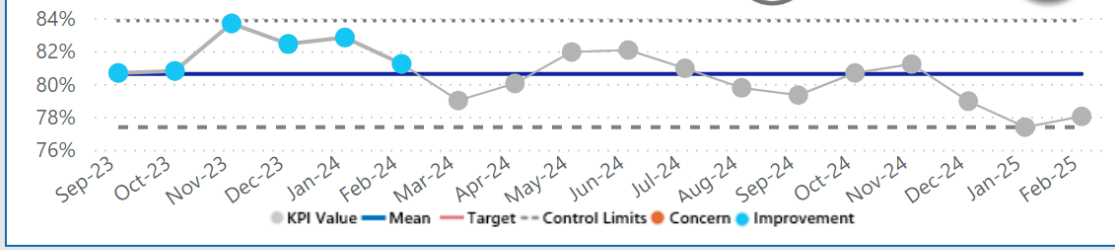
Variation			Assurance		
Common cause - no significant change	Special cause of concerning nature due to (H)igher or (L)ower values	Special cause of improving nature due to (H)igher or (L)ower values	Special cause neither improvement or concern	Variation indicates inconsistently passing/failing target	Variation indicates consistently passing target	Variation indicates consistently failing target

Chief Nurse Report

Planned vs Actual Shift Fill

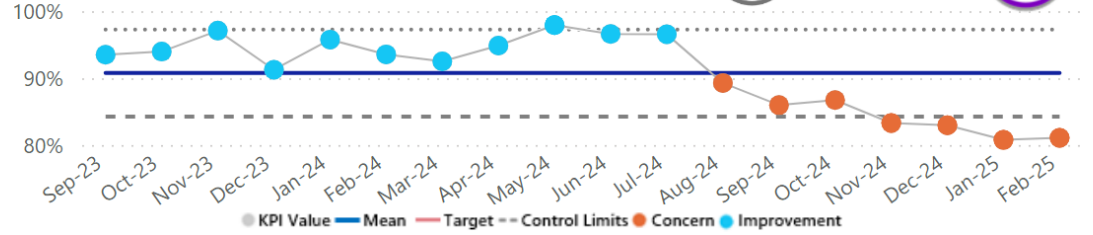
Planned v Actual Day Shift Fill - Registered Nurses — Feb-25

Target	Actual	Previous	Assurance	Variation
None	78.0%	77.4%	N/A	



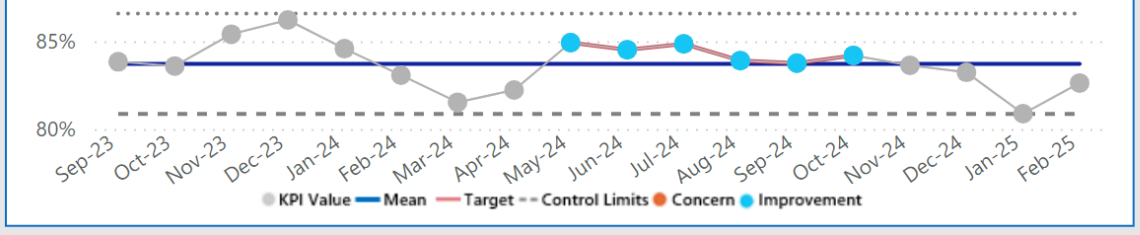
Planned v Actual Day Shift Fill - Health Care Assistant — Feb-25

Target	Actual	Previous	Assurance	Variation
None	81.1%	80.8%	N/A	



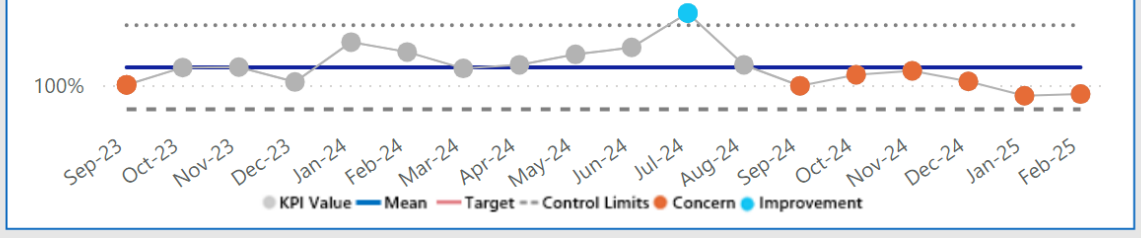
Planned v Actual Night Shift Fill - Registered Nurses — Feb-25

Target	Actual	Previous	Assurance	Variation
None	82.6%	80.9%	N/A	



Planned v Actual Night Shift Fill - Health Care Assistant — Feb-25

Target	Actual	Previous	Assurance	Variation
None	98.1%	97.7%	N/A	



What the data tells us

RN day shift fill continues to demonstrate a pattern of common cause with a shift fill increase of 0.6%. RN night fill moved from a isolated period of special cause concern to common cause variation with an increase of 1.7%. Shift fill ranges were;

- days 52 – 100% nights 66 – 100%

HCA shift increased by 0.3% on days and 0.4% on nights. There was no change in the variation pattern for days however nights moved from common cause to special cause concern for nights. Shift fill ranges were;

- days 42 (ICU) – 114% nights 76 (Charnwood) – 186% (ward 10)

Skill mix changes and enhanced supervision care needs account for HCA percentages greater than 100%.
Shift fill capability was challenged throughout the month due to escalation capacity requirements.

Next steps and planned impact

Business as usual actions continue to be implemented and reviewed daily;

- dynamic risk assessments across the 24-hour period at ward, divisional and Trust level including escalation, and deployment decision outcomes from each staffing review touchpoint. This includes patient acuity and dependency assessments, and staffing skill mix considerations
- roster controls continue to be monitored including Executive approval for over template requests

The table on slide 4 outlines the patterns of wards/depts who have not achieved at least 80% registered nurse/midwife shift fill across the past six months. A deep dive will take place in the next reporting period to further understand contributory factors and required mitigation actions/escalations.

Risks

Shift fill gaps and unplanned skill mix variances continue to contribute to the following risks;

- compromise to patient safety and experience including provision of enhanced supervision, reputational – regulatory, professionally and service user confidence, recruitment and retention impact
- impact on staff health and wellbeing, moral injury risk, stress induced behaviours, increase in short term absence
- risk of short cuts in working practice leading to new norms being created – impact on effectiveness and general standards of care
- financial risks associated with temporary staffing use if backfill staffing required
- decreased efficiencies and delays in fundamental care delivery and pathway progression
- Impact of stretching available staffing capacity to support escalation areas which were consistently open throughout the month

Registered Nurse/Midwife Shift Fill ≤ 80% - September 2024 – February 2025

Days						
	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25
Ward 12	69	76	78	73	74	74
Concept 22	79	79	78	79	73	
NNU	74	74		64	71	
Ward 6	76	72	72			
Ward 10	51	51	57	52	54	52
Core Maternity					79	75
Ward 3	72			70	79	
Ward 15	79			78	79	77
Ward 17		63	72	66	71	77
ACU	78		70	71	73	65
Ward 16	78		79	74		79
Ward 5						
Ward 1					73	76
ICU	79					

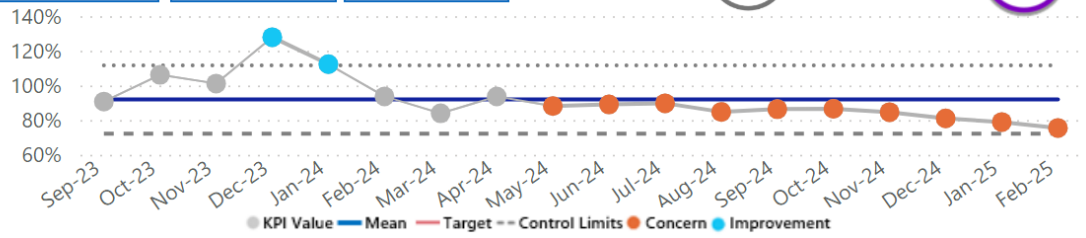
Nights					
Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25
61	64	63	67	66	66
68	68	67	69	74	71
79	78		64	63	
62	68	68	66		70
		71		77	
76		78	79	75	72
			70	69	71
75	68				
72					
70			72	71	74
77					

Chief Nurse Report

Planned vs Actual Shift Fill

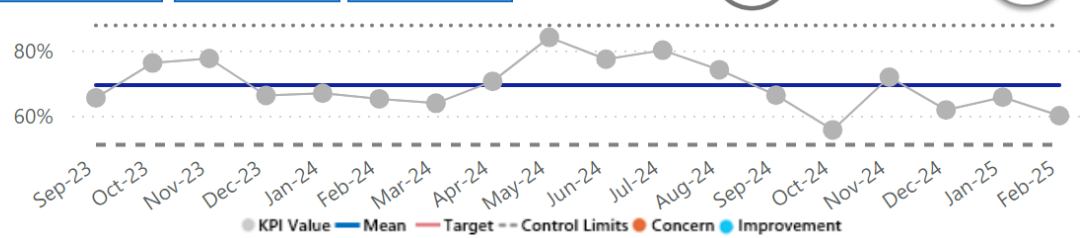
Planned v Actual Day Shift Fill - Registered Midwife — Feb-25

Target	Actual	Previous	Assurance	Variation
None	75.4%	78.8%	N/A	↘



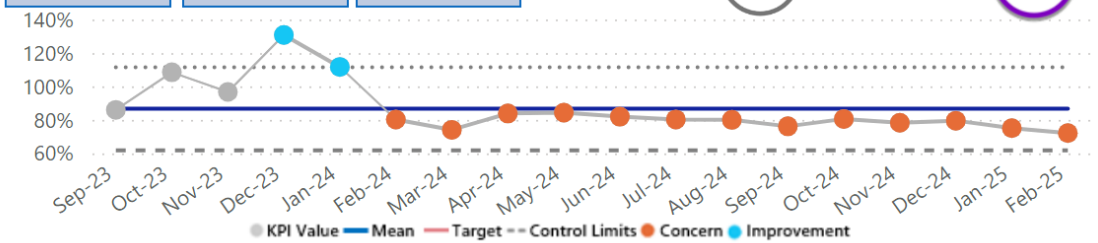
Planned v Actual Day Shift Fill - Midwifery Support Worker — Feb-25

Target	Actual	Previous	Assurance	Variation
None	60.0%	65.6%	N/A	



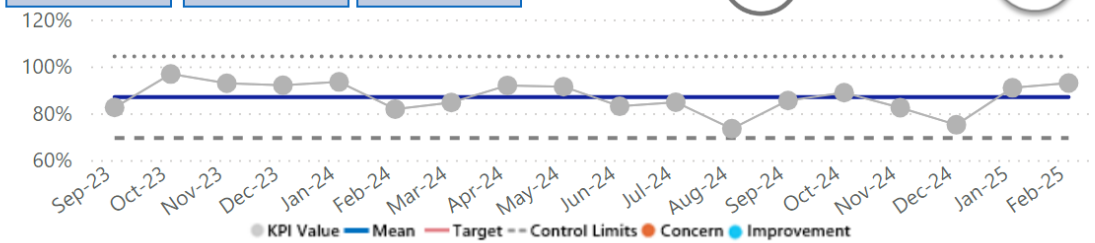
Planned v Actual Night Shift Fill - Registered Midwife — Feb-25

Target	Actual	Previous	Assurance	Variation
None	72.0%	75.0%	N/A	↘



Planned v Actual Night Shift Fill - Midwifery Support Worker — Feb-25

Target	Actual	Previous	Assurance	Variation
None	92.9%	90.8%	N/A	



What the data tells us

Registered midwife (RM) shift fill continues to demonstrate a pattern of concern for both day and night shifts. There was a decrease of 3.4% on days and 3% on nights. Matrons and specialist midwives also provided a proportion of shift fill either as part of their working day or on call rota (23 occasions).

A decreases in day shift fill of 5.6% and aan increase of 2.1% on nights were observed for midwifery support workers. Both shifts maintained common cause variation.

Two care delivery diversions from the JPUH to supporting Trusts occurred during February due to staffing levels.

Next steps and planned impact

A deep dive is required into the Core Maternity to ensure that all deployments are being captured appropriately and temporary staffing request match template gaps.

Sickness continues to be a main contributory factor to midwifery shift fill levels with a 15.9% sickness absence in February. Sickness management is a focus for the leadership team currently and a deep dive will be performed within the first three months of the new Head of Midwifery taking up post.

Risks

Risks associated with shortfalls in planned shift fill generally include all those noted on slide 3. Specific to patient safety and experience in the midwifery setting, this includes potential;

- delay in vital sign monitoring
- delays in antenatal CTG monitoring / reviews /interpretations
- delays in feeding support/advice/guidance
- lack of capacity to deliver health promotion eg smoking cessation
- Inability to provide 121 care in labour
- Matrons/specialist midwives required to redeploy to shop floor, meaning BAU work is not getting done
- Staff fatigue
- Staff reluctance to undertake bank/additional

Established escalation and deployment processes are in place. Midwifery form part of the Chief Nurse daily staffing summit meeting.

Summary - Temporary Staffing

Metric Name	Current Month	Actual	Change	Target	Variation	Assurance
Nursing Temporary Staffing Request v Actual Shift Fill	Feb-25	95.4%	-1.25%	None		N/A
HCA Temporary Staffing Request v Actual Shift Fill	Feb-25	98.0%	-0.74%	None		N/A
Midwives Temporary Staffing Request v Actual Shift Fill	Feb-25	46.3%	-6.57%	None	Change	N/A
MSW Temporary Staffing Request v Actual Shift Fill	Feb-25	60.9%	7.69%	None		N/A

Staff Group (days and nights combined)	Funded planned v Actual Fill Gap (hours)	Temporary Staffing Requests	Difference
Registered Nurse	**13,528.42**	**11,468.05**	**- 2060.37**
Healthcare Assistant	**5796.49**	**15,666.90**	**+ 9870.41**
Registered Midwife	**1964.51**	**2803.92**	**+ 839.41**
Midwifery Support Worker	**709.58**	**1079.25**	**+ 369.67**

NHSi SPC Icon Key

Variation				Assurance		
Common cause - no significant change	Special cause of concerning nature due to (H)igher or (L)ower values	Special cause of improving nature due to (H)igher or (L)ower values	Special cause neither improvement or concern	Variation indicates inconsistently passing/failing target	Variation indicates consistently passing target	Variation indicates consistently failing target

What the data tells us

There was one variation pattern change in month for temporary staffing metrics seeing midwife requests/fill move from common cause to neutral special cause variation. There were decreases in RN , RM and HCA shift fill levels and an increase of 7.69% for midwifery support worker fill.

RN requests increased by 7.6 hours with an overall total of 11468 hours being requested. The combined bank and agency temporary staffing fill was 95%, with 53% bank and 47% agency, the latter representing an decrease of 39.25 hours compared to January. The patterns of request v fill are shown on slide 7.

HCA shift requests decreased by 1041 hours and fill was maintained at 98%.

Registered midwife requests increased by 479 hours and midwifery support workers also increased, but a smaller scale of 17 hours. Temporary staffing shift fill for both staff groups was 46.29% (RM) and 60.9% (MSW).

Next steps and planned impact

Overall unmet shift fill demand continues to be a cause of concern, and although some improvement has been seen this month, a further deep dive is required to ensure that temporary staffing requests are being made in accordance with safe staffing risk assessment outcomes for registered nurses/midwives. This deep dive will include continued promotion and utilisation of the 'bank first' concept when template gaps require back fill.

Enhanced supervision, skill mix changes, and sickness will mostly account for the HCA additional hours and similarly sickness in midwifery.

Following identification of some common practice concerns with registered agency nurses, induction are in the process of being reviewed.

Risks

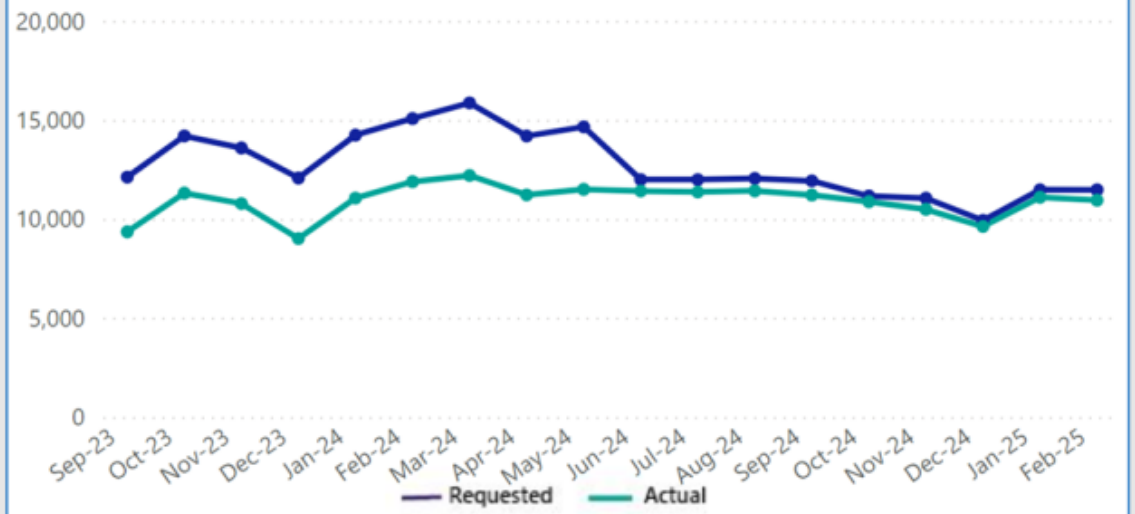
Risks and impact from the temporary staffing fill position reflect those outlined on slide 3.

Work continues to minimise the known risks of having a reliance on a transient workforce. This includes the risks of temporary staff refusing to move or work in their allocated area. Discussions are underway with the DRC Agency regarding management and support for such circumstances.

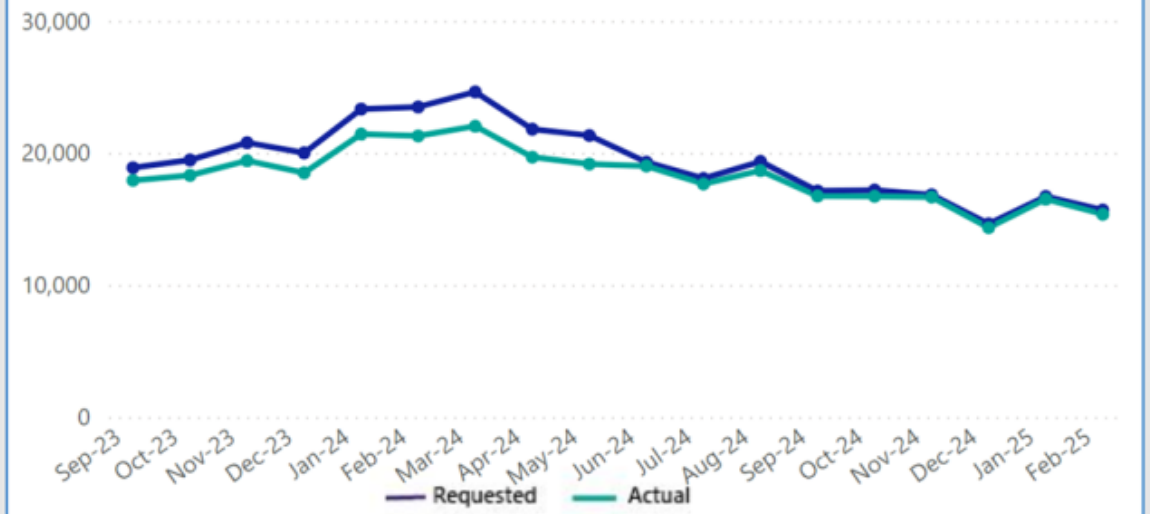
The corporate nursing team continues to support practice discussions when practice concerns are raised. Health and wellbeing factors affecting shift of bank workers are managed through the Digital Workforce Team.

Temporary Staffing Shift Requests/Fill

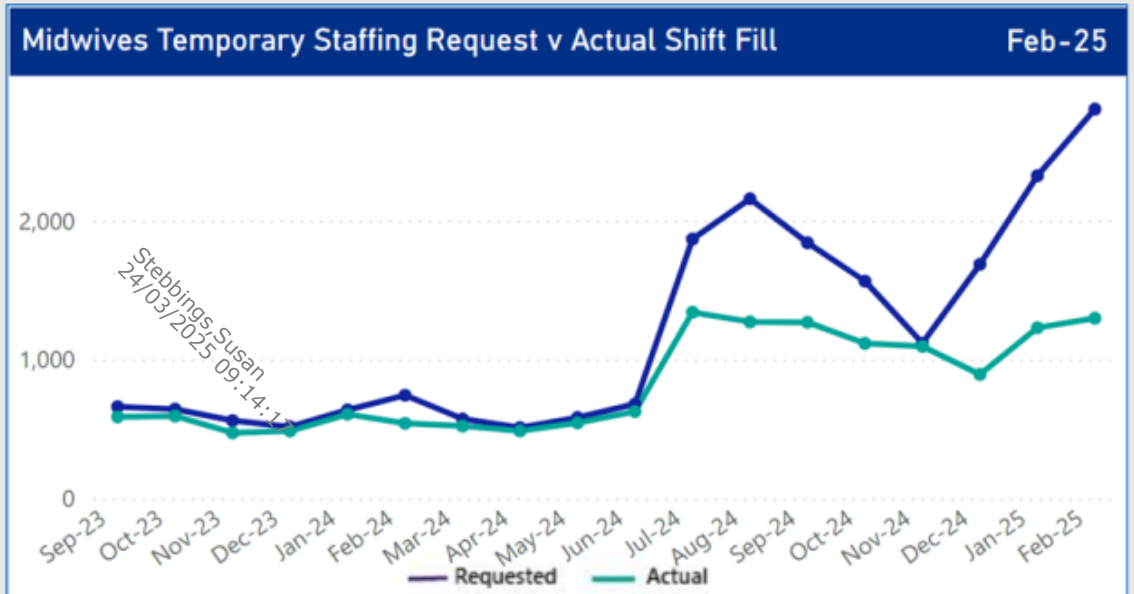
Nursing Temporary Staffing Request v Actual Shift Fill — Feb-25



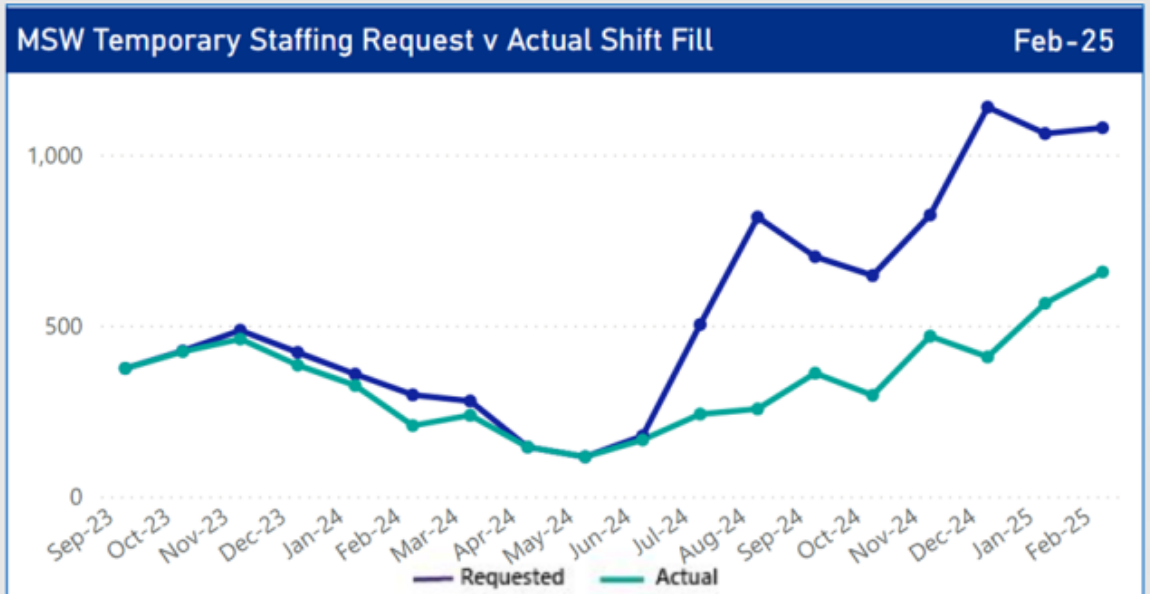
HCA Temporary Staffing Request v Actual Shift Fill — Feb-25



Midwives Temporary Staffing Request v Actual Shift Fill — Feb-25



MSW Temporary Staffing Request v Actual Shift Fill — Feb-25



Chief Nurse Report

Summary - Care Hour Per Patient Day (CHPPD)

Metric Name	Current Month	Actual	Change	Target	Variation	Assurance
CHPPD - Overall	Feb-25	7.50	-0.35	None		N/A
CHPPD - Registered Nurses / Midwife	Feb-25	4.16	-0.19	None		N/A
CHPPD - HCA / MSW	Feb-25	3.34	-0.16	None		N/A
CHPPD - CDS	Feb-25	20.67	-14.44	None		N/A
CHPPD - Ward 11	Feb-25	8.66	-1.65	None		N/A
CHPPD - ICU/HDU	Feb-25	25.89	-0.94	None		N/A
CHPPD - Paediatric (Ward 10, Neonatal)	Feb-25	11.08	-4.00	None		N/A
CHPPD - Non Specialist Ward	Feb-25	7.34	-0.35	None		N/A

NHSi SPC Icon Key

Variation				Assurance		
Common cause - no significant change	Special cause of concerning nature due to (H)igher or (L)ower values	Special cause of improving nature due to (H)igher or (L)ower values	Special cause neither improvement or concern	Variation indicates inconsistently passing/failing target	Variation indicates consistently passing target	Variation indicates consistently failing target

Summary

Overall available CHPPD decreased by 0.35 in February 25.

All metrics maintained the same variation pattern and every metric observed a decrease in CHPPD. Paediatrics and midwifery experienced the greatest reductions.

Slide 9 illustrates a month on month decline in overall CHPPD over the past eight months. This is clearly triangulated with shift fill levels and the challenges experienced in achieving funded template and skill mix levels.

CHPPD Definition

CHPPD is the measure used as recommended in the Carter Report (2016) to give consistency to the picture of the total nursing workforce on a ward/unit. It is split between registered nurses and unregistered support workers but reported as an overall combined figure. It is a useful metric but not one to be used in isolation.

A simple 'ready reckoner' conversion to support the identification of obvious anomalies and aid understanding is the working down from higher to lower intensity wards/units. A unit such as ICU, which provides 1:1 care, would have a RN- CHPPD of at least 24 (for every 24 hours of patient care hours, 24 hours of RN is required). Halving that (2 patients to 1 nurse) is an actual RN-CPPHD of at least 12, halving again (four patients to one nurse) is an actual RN-CHPPD of 6, halving again (8 patients to 1 nurse) is an RN-CHPPD of 3.

Care Hour Per Patient Day (CHPPD)

What the data tells us

The overall combined CHPPD (all inpatient wards and departments across nursing and midwifery) continues with a pattern of concern this month with eight months below the mean. The aggregated average registered v unregistered CHPPD distribution was 4.2 and 3.3 respectively.

The non specialist wards/depts continue in a pattern of common cause variation and but have dropped below the mean again this month. The average CHPPD of 6.7 across the inpatient wards/depts is an increase from last month by 0.93 CHPPD.

CHPPD levels ranged from 5.6 (Ward 2) to 8.5 (Carlton Court). 15 wards did not achieve a CHHPD of 7.5 or above. Six wards, 2, 3, 4, 6, 15 and 18 did not achieve a RN CHPPD of 3 or more. As previously reported wards 3,6 and 18 are because of intentional skill mix changes. The acuity and dependency of Wards 4 and 15 continue to be monitored in relation to ongoing lower levels of CHPPD and both were part of the recommendations from the November 2024 Annual Safer Staffing and Nurse Establishment Review.

Next steps and planned impact

The Annual Safe Staffing and Nurse Establishment Review was presented for information to the Patient Safety and Quality and People and Culture Committees in this reporting period.

Further discussions have also taken place regarding the financial considerations of the review recommendations, and it is anticipated that a supplementary paper will be presented to Hospital Management Group at the end of March/beginning of April for the final decision and approval of agree recommendations.

In the meantime, current processes will continue to inform safe staffing decisions regarding mitigation actions required to maintain patient safety and experience and staff experience considerations.

Work will start in the next quarter to review the skill mix composition of the current funded establishments to measure the gap against the national recommendation of 72% registered nurse skill mix.

Risks

As a direct correlation to shift fill, the risks associated with CHPPD are the same as have been described throughout this report and specifically whereby there is a level of unmet planned demand, or inability to meet enhanced supervision care needs.

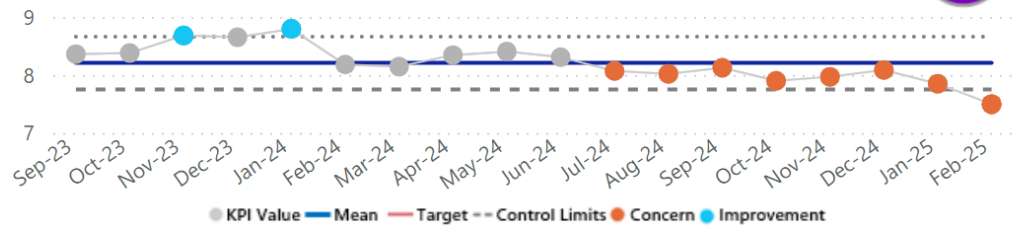
Unmet demand this month is as follows (NB some of the reduction may be attributed to February being a shorter month.);

- 13,528 hours for registered nurses (reduction of 2570 hours from January)
- 5796 hours for healthcare assistants (reduction of 994 hours from January)
- 1965 hours for registered midwives (increase of 41 hours from January)
- 710 hours for midwifery support workers (reduction of 49 hours from January)

This provides some context to the previously noted risks and concerns relating capacity to meet all patient care related nursing interventions.

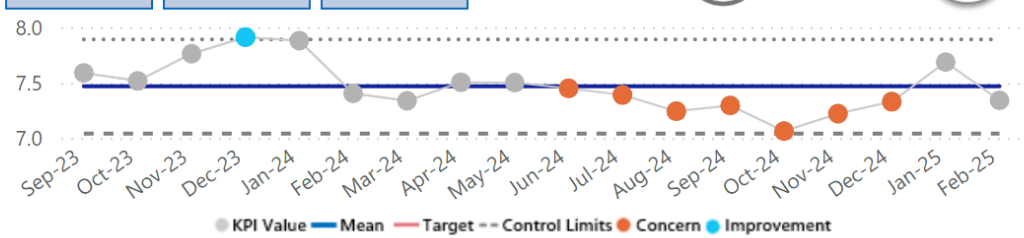
CHPPD - Overall Feb-25

Target	Actual	Previous	Assurance	Variation
None	7.50	7.85	N/A	

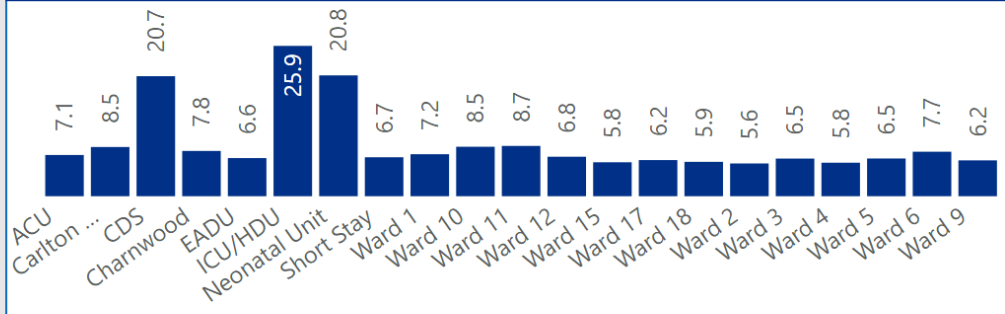


CHPPD - Non Specialist Ward Feb-25

Target	Actual	Previous	Assurance	Variation
None	7.34	7.69	N/A	



CHPPD by Ward Feb-25



Chief Nurse Report

Red Flag Index - Adults

Red Flag Descriptions and Totals

Unplanned omission in providing patient medications	1
Delay of more than 30 minutes in providing pain relief	4
Delay in the administration of IV antibiotics of > 60 mins	8
Patient observations not assessed or recorded as planned	1
Omission of planned intentional rounding	25
Less than 2 RN's present on the ward during any shift	0
No substantive RN available on any shift	0
Unavailability of planned 1:1 Enhanced Care (specials)	255
Shortfall of 8 hours or 25% (whichever is reached first) of RN time available compared with actual requirement for shift	229
Total Adult Red Flags	**523**

Chief Nurse Report

Adult Red Flag Index

What the data tells us

Following review, the total number of red flag reports in February 25 was 523. This is a decrease of 10 compared to January 25.

Red flag 8 continues to be the highest reported incident with 255 occurrences. This is a decrease of 9 from last month and approximately 80% of the reports relate to the day shift timings. Fourteen areas experienced this red flag across the month including the Emergency Department. In line with previous updates wards 12, 18, 4, 6 are high reporting areas. This continues to align to the clinical presentation of the patients cared for in these areas. In addition to this, wards 1, 5 and 15 are starting to develop a consistent pattern patients requiring enhanced supervision and engagement, Ward 9 experienced a higher than normal occurrences this month. There were 21 new Deprivation of Liberty (DOLs) applications during February and 12 carried over from December and 15 January.

There were 229 red flag 9 reports in February. This is a decrease of 8 from January. This continues to be an under representation of the actual position against funded templates but remains indicative of the shift fill challenges experienced throughout the month. The table below provides an example from the daily staffing summit which provides a summary records of the shift fill gaps for the next shift which, when referring to RNs, the red flag 9 submissions should reflect.

Although there were no red flag 6 and 7 reports there were occasions when substantive RNs had to be deployed from other areas to be the nurse in charge on wards with depleted skill mix and escalation areas. This includes the escalation areas pf Ward 22 and Daycare Unit which are solely staffed by deployment of Ward 21, temporary staffing and ward staff moves.

There are no exceptions to escalate from the remaining red flags however it is evident that the majority are linked to staffing shortfalls, mainly registered nurses.

Next steps and planned impact

Monday Day	Final Staffing Registered	Final Staffing Unregistered	Establishment		Final Staffing	FINAL SHORTFALL		% Fill vs. Template	
			Reg.	UnReg.	Reg. Sup.	Reg.	UnReg.	Reg.	UnReg.
Ward 1 (30)	4.5	5.5	7	6	0	-2.5	-0.5	64.3%	91.7%
ACU (8+1)	2	1	3	1	0	-1	0	66.7%	100.0%
Ward 2 (20)	1	3	3	3	0	-2	0	33.3%	100.0%
Ward 3 (33 +1)	3	6	5	6	0	-2	0	60.0%	100.0%
Escalation Ward	3	3	3	4	0	0	-1	100.0%	75.0%
Ward 4 (33)	4.5	4	5	4	0	-0.5	0	90.0%	100.0%
Ward 12 (38)	5	6.5	7	6	0	-2	0.5	71.4%	108.3%
Ward 15 (31)	4	3.5	5	4	0	-1	-0.5	80.0%	87.5%
Ward 16 (22)	4	3	5	2	0	-1	1	80.0%	150.0%
Ward 17 (18)	4	2	5	2	0	-1	0	80.0%	100.0%
Ward 18 (22+1)	3	3	3	4	0	0	-1	100.0%	75.0%
EADU (34)	5.5	3	7	4	0	-1.5	-1	78.6%	75.0%
Carlton Court (3 Bungalows)	6	6	6	6	0	0	0	100.0%	100.0%
ED	9	4	15	5	0	-6	-1	60.0%	80.0%
TOTALS	58.5	53.5	79	57	0	-20.5	-3.5		

The table to the left provides an actual example of template deficits for the Division of Medicine after Ward 21 allocations and ward move deployments have taken place. Although there are day by day variations in the overall deficits experienced this gives an indication of the potential gap in Red Flag 9 reports.

Risks

Business as usual actions/practice continues by the Divisional Matrons and Trust Senior Nurses to review and assess all red flag occurrences with interventions being taken to minimise the potential for patient harm events and any compromise to staff health and wellbeing. However, it continues to be evident from the month-on-month patterns of red flag reports that our greatest risks are related to our ability to adequately manage and provide the care needs of patients requiring enhanced supervision and engagement with below template staffing levels. Both these factors are a direct triangulation with previously noted risks to quality and safety, performance and finance. The impact of reduced shift fill of registered nurses is also an emerging concern in relation to the accuracy of the assessment, planning, implementation and evaluation processes which inform nursing care prescriptions. Specific workshops are planned with the ward managers to review effective planning and organisation of workload at ward level, to help maximise effective and efficient use of time required to achieve safe delivery for all aspects of care and treatment plans.

In this reporting period we have been informed that the previous staffing provided by NSFT for inpatients is being withdrawn for relevant patients who are detained under the Mental Health Act whilst waiting for transfer to a mental health care environment. This will further risk our ability manage the resource demand to provide and meet enhanced supervision and engagement care needs.

Red Flag Index - Paediatrics

Red Flag Descriptions and Totals

Observations not assessed or recorded hourly in PAU	0
Planned observations or interventions missed in HDU	0
Less than 4 RN's on weekday day shift	2
Less than 3 RN's on weekend day shift	0
Less than 3 RN's on a night shift	0
Zero nursery nurses on a day shift	0
1:1 Care of children with mental health needs	2
Cross cover to another paediatric area	0
Total Paediatric Red Flags	4

Stebbings,Susan 24/03/2025 09:14:29

What the data tells us

There were four reported red flags in February, two of which related to 121 care of children with mental health needs.
Two template gap were reported however, when taking into consideration the registered nurse shift fill gaps noted on slide 4, this is a clear misrepresentation. Additional discussions will be taking place with the Lead Nurse during the next reporting period to explore other possible reasons for data mismatches e.g. accuracy of health roster data and/or the way deployments within the overall paediatric services are recorded.

Next steps and planned impact

Following the rejection of the Paediatric Safe Staffing and Nurse Establishment Review at Hospital Management Group in January further discussions have taken place to understand in more detail the review outcomes. It is accepted that the evidence-based review recommendations are an accurate methodology however additional triangulation with safety metrics has been requested prior to any financial commitment.

Risks

There is a new potential risk identified that the current redeployment model used to balance staffing deficits across the paediatric service has not been reflected in red flags reporst. This is currently being reviewed alongside the shift fill data previously mentioned to ascertain if there is a connection.

Chief Nurse Report

Red Flag Index - Maternity

Red Flag Descriptions and Totals

Delayed or cancelled time critical activity	Text here
Missed or delayed care (for example, delay of 60 minutes or more in washing and suturing)	Text here
Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication)	Text here
Delay in providing pain relief	Text here
Delay between presentation and triage	Text here
Full clinical examination not carried out when presenting in labour	Text here
Delay between admission for induction and beginning of process	Text here
Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output)	Text here
Any occasion when 1 midwife is not able to provide continuous one-to-one care and support to a woman during established labour	Text here
Coordinator unable to maintain supernumerary status - NOT providing 1:1 care	Text here
Coordinator unable to maintain supernumerary status and providing 1:1 care	Text here
Total Maternity Red Flags	Text here

Stephens Susan 24/02/2022 09:14:17

What the data tells us

A total of 21 red flags were raised in February. There were two occasions (10%) where delayed or time critical activity was documented. Both occurrences have subsequently been confirmed as delayed inductions. Three occasions (14%) relate to delay between admission for induction of labour and the process beginning. Fourteen occasions (64%) was in respect of the labour ward coordinator unable to remain fully supernumerary but not providing 1:1 care. There was also one occasion (5%) noted where the labour ward coordinator was unable to maintain supernumerary status and was providing 1:1 care. Accuracy of this will be confirmed once the shift coordinator returns from leave and can provide more detail.

Next steps and planned impact

Following review of ongoing shift fill concerns with the Head of Midwifery additional actions are being put in place to improve the overall

- add in local red flag for staffing shortfalls
- revisit commencing a bank midwife recruitment campaign
- review of the current risk register entry with a proposed increase in the risk score
- represent the option of a continuity of carer service pause to create additional onsite core staffing capacity

Risks

There were 88 occasions during January where staffing factors were recorded during assessment. 42% of occasions were due to unexpected absence/sickness and 45% where there were vacant shifts, registered and unregistered. 4% included redeployment of staff, 28% of occasions where there were vacant shifts, registered and unregistered. Three occasions were reported this month whereby staff were unable to take their break. There were 23 occasions whereby the specialist midwives and/or matrons worked clinical shifts.

All descriptions above are representative of the staffing related risks being managed on a day-by-day basis. In addition to this, the impact of increased volumes of caesarean sections (57% of all birth in February) is one of reduced overall capacity due to potentially more midwifery resources being required.

Chief Nurse Report

Summary - Harm Events

Metric Name	Current Month	Actual	Change	Target	Variation	Assurance
Patient falls	Feb-25	70	-1	None		N/A
Patient falls requiring professional intervention (Moderate Harm and above)	Feb-25	3	0	2		?
Patient falls - Delerium	Feb-25	9	1	None		N/A
Patient falls - Dementia	Feb-25	9	1	None		N/A
Patient Falls - Inpatient	Feb-25	56	0	None		N/A
Patient falls requiring professional intervention (Moderate Harm and above) - Inpatient	Feb-25	2	-1	None		N/A
Hospital Acquired Unstageable Pressure Ulcers	Feb-25	3	2	None		N/A
Hospital Acquired Category 1 Pressure Ulcers	Feb-25	4	4	None		N/A
Hospital Acquired Category 2 Pressure Ulcers	Feb-25	16	5	0		F
Hospital Acquired Category 3 Pressure Ulcers	Feb-25	0	0	0		?
Hospital Acquired Category 4 Pressure Ulcers	Feb-25	0	0	0		?
Hospital Acquired Deep Tissue Injury	Feb-25	5	1	0		?
Hospital Acquired Moisture Lesions	Feb-25	4	-7	0		F
Medicine Management Incidents	Feb-25	38	9	None		N/A
Medicine Management Incidents with Moderate Harm and Above	Feb-25	1	1	None		N/A

Summary

All harm metrics are demonstrating common cause variation except for one in special cause variation, this being falls whereby the patient is experiencing dementia. Unstageable pressure ulcers have moved back into common cause variation. All other variation patterns are unchanged from last month.

Compared to January 24 the volume of actual/potential harm incidents changed by;

- 3 categories decreased
- 8 categories increased
- 4 categories remained the same

Inpatient falls decreased by 1 compared to last month. There was an increase of 2 patient falls involving patients living with dementia or experiencing delirium.

There were three (all validated) moderate harm or above incidents requiring professional intervention following inpatient falls. There was also a patient fall in the Emergency Dept (ED) resulting in a fracture. Staffing challenges were a contributory factors in some of the falls.

The skin integrity incidents represent a pre validation position which reduced following review and is explained on slide 16.

There were 38 medicines management incidents, an increase of 9 from last month.

There continues to be QSAFE submissions this month which included reference to not being able to respond to fundamental care needs in a timely way e.g. unwitnessed falls, delays in medications, ability to respond to enhanced supervision and engagement needs.

NHSi SPC Icon Key

Variation				Assurance		
Common cause - no significant change	Special cause of concerning nature due to (H)igher or (L)ower values	Special cause of improving nature due to (H)igher or (L)ower values	Special cause neither improvement or concern	Variation indicates inconsistently passing/failing target	Variation indicates consistently passing target	Variation indicates consistently failing target

Chief Nurse Report

Harm Events - Falls

What the data tells us

The overall incidence of inpatient falls remains common cause variation. There is a data mismatch with Divisional information which suggests there have been 65 falls across the inpatient areas. This correlates with the DPM reports.

Moderate and above harms inpatient falls occurred on Wards 15, 18 and EADU in addition to the fall in ED, and Carlton Court. All patients experienced a fracture as a result of the fall. Staffing shortfalls and enhanced supervision were reported as a contributory factor in two of the falls.

There were no specific staffing concerns noted for any of the remaining falls that occurred in either Division however staffing shortfalls occurred throughout the month in some of the ward areas where falls occurred.

The three highest reporting inpatient areas for falls were: EADU (13), Carlton Court (9) and Ward 15 (6). The associated average shift fill for those areas were; 96%, 97% and 86%, respectively.

Next steps and planned impact

Business as usual activities and actions via the PSIRF Insight and Improvement Group continue to progress falls prevention actions with input from the corporate and divisional teams:

- continuous, dynamic risk assessments regarding staffing levels and any impact on our ability to deliver safe and effective care
- staffing touch points throughout the day including the Chief Nurse daily staffing summit all of which include staff deployment decisions
- raising awareness of staffing and patient safety/experience in the operational meetings

Staffing template gaps have started to be QSAFE reported by the Duty Matron/Site Team at the end of each shift and a record kept as part of the daily staffing summit shift (live document, used 24 hours a day). This is in addition to any QSAFES submitted relating to patient specific incidents or gaps/omissions in care because of safe staffing levels.

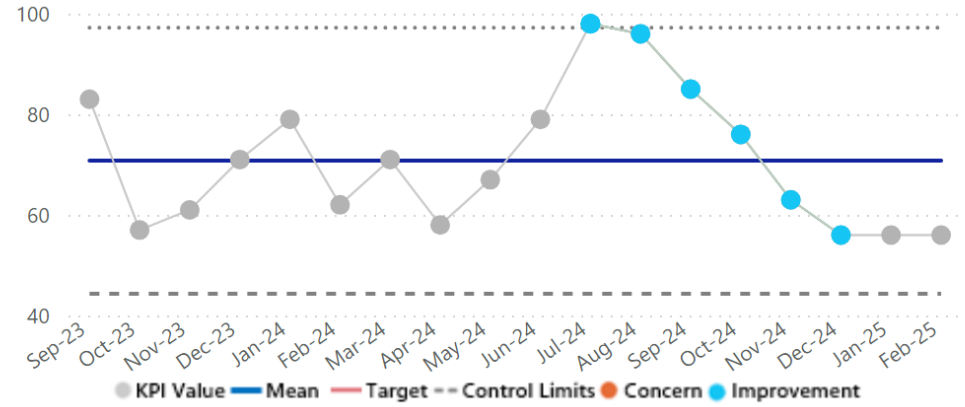
Risks

There are no new risks to escalate regarding falls and safe staffing this month. In addition to impact risks highlighted on slide 3, the following additional existing risks remain;

- impact on CHPPD and skill mix due to short notice absence and unfilled template gaps
- missed care due to reduced available CHPPD capacity
- impact of care diversion for patients who have enhanced supervision and engagement needs
- impact of theory practice gaps in care delivery
- patient compliance factors
- physical and psychological impact on patient recovery and reconditioning capability
- ongoing and consistent levels of enhanced supervision, specifically wards 12, 4 and 1
- lack of dedicated falls prevention specialist/team as per NICE guidance
- financial impact of treating injuries from falls including increased length of stay costs

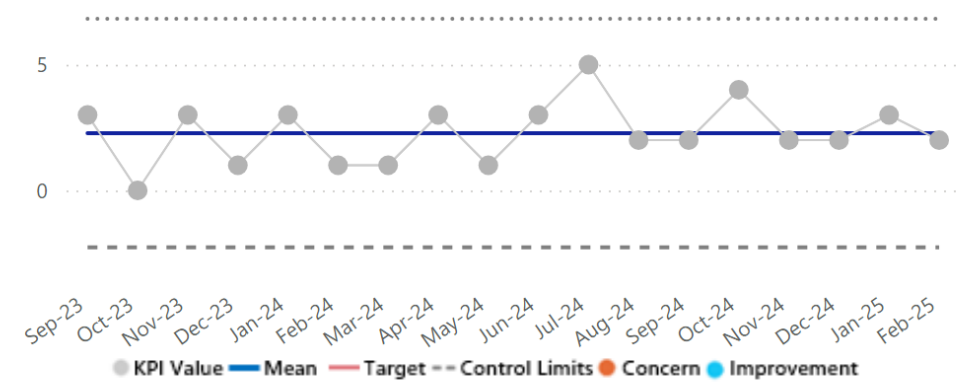
Patient Falls - Inpatient — Feb-25

Target	Actual	Previous	Assurance	Variation
None	56	56	N/A	



Patient falls requiring professional intervention (Moderate Harm and above) - Inpatient

Target	Actual	Previous	Assurance	Variation
None	2	3	N/A	



Chief Nurse Report

Harm Events - Skin Integrity

What the data tells us

Skin integrity/tissue viability incidents remain in a pattern of improvement, below the mean, which has been sustained for a period of nine months. Including moisture lesions, the current validated position for these incidents is each clinical Division in February is;

Division of Medicine x 17 (16 PUs and 1 ML)
Division of Surgery x 3 (2 PU and 1 ML)

There are no themes identified regarding volumes of pressure ulcer incidents on specific wards however, Ward 6 (24), 18 (12) and ICU (8) are the highest reporting areas across the past six months.

Staffing shortfalls occurred throughout the month on the wards reporting pressures ulcers and moisture lesions with some potential correlation to the occurrence of harm events.

Next steps and planned impact

Work continues between the PSIRF Level 3 Insight and Improvement Group, and the Corporate Nursing team continue to work with the Divisions to ensure that improvement actions effective and achievable.

The Division of Surgery continues to work up plans to increase specialist tissue viability capacity in the clinical areas.

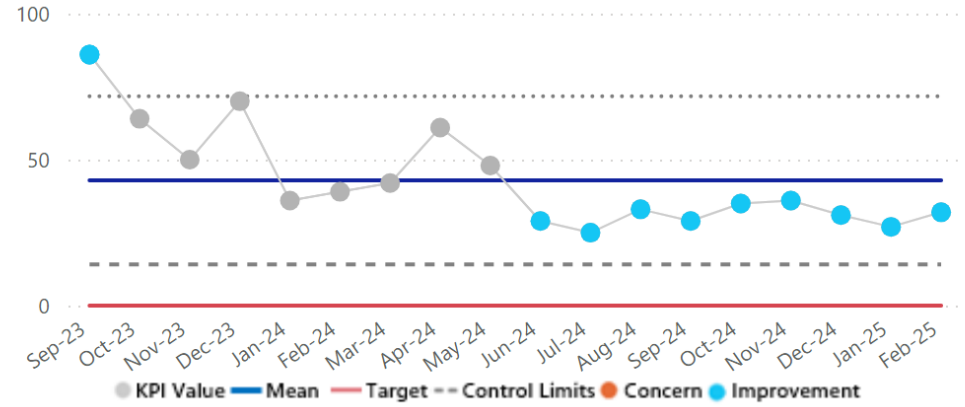
Risks

There are no new risks to report regarding pressure ulcer incidents/harms and safe staffing factors. Existing risks, contextual to pressure ulcers, reflect those outlined for falls on the previous slide (slide 15) and slide 3.

Existing risks relating to lack of specialist support, advice and guidance at the bedside by the tissue viability team, remain. This includes no additional education and training and gaps in validation for skin integrity incidents that occur at Carlton Court.

Hospital Associated Skin Integrity Incidents Feb-25

Target	Actual	Previous	Assurance	Variation
0	32	27	N/A	↘



Harm Events - Medicines Management

What the data tells us

Medicine management incidents remain in a pattern of common cause variation with an increase of nine incidents from last month. Incident categories include;

- drug administration errors (8)
- controlled drugs (20)
- missed doses (6)
- insulin/diabetes related incidents (4)

There was one moderate or above harm incident (diabetes related) reported this month relating to an incident in the ED. It is understood that this incident had no relationship to registered nurse safe staffing.

Next steps and planned impact

There are no new steps to report this month regarding safe staffing and medicines safety. Improvement actions continue to be implemented via the PSIRF Level 3 Insight and Improvement Group, Controlled Drugs Accountable Officer review meeting and Medicines Safety meeting.

Risks

There are no new risks to report regarding medicines management incidents and safe staffing/skill mix issues. Existing risks, contextual to medicines management, reflect those outlined on slides 3 and 15

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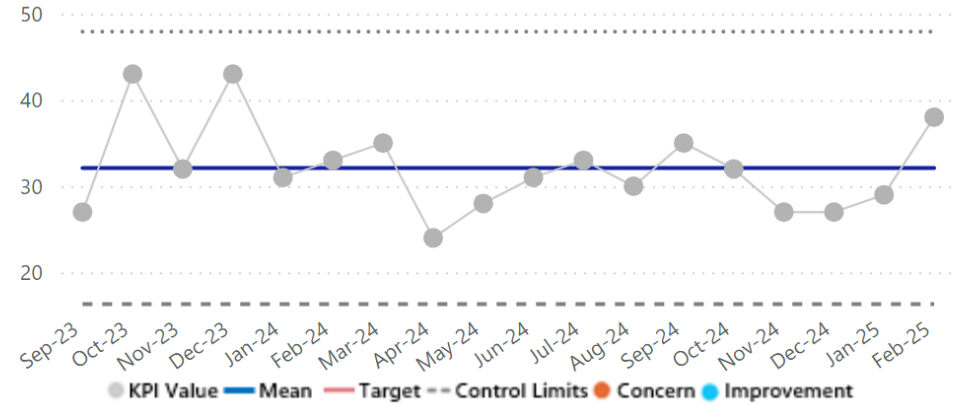
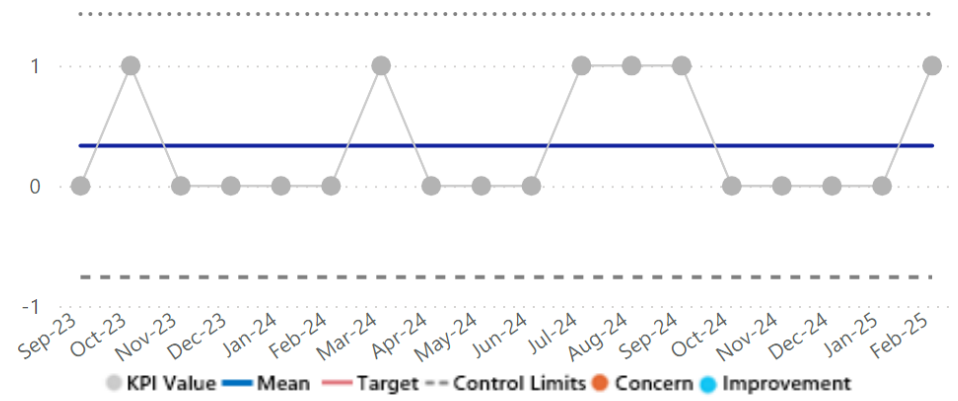
Medicine Management Incidents — Feb-25

Target	Actual	Previous	Assurance	Variation
None	38	29	N/A	



Medicine Management Incidents with Moderate Harm and Above — Feb-25

Target	Actual	Previous	Assurance	Variation
None	1	0	N/A	



Vacancies - Registered Nurses / Nursing Associates / Healthcare Assistants

NB A minus figure indicates an over-establishment

What the data tells us

The overall vacancy position for period ending February 2025 was a vacancy position of 25.33 wte. This equates to 2.63% and is the highest overall vacancy level observed for a significant period of time.

Both Clinical Divisions continue to have some reported over establishments which continue to be subject to some data anomalies which will impact (reduce) on the overall figure once corrected.

At band 5 level wards 5, 6 and 9 hold are carrying the biggest over establishments, whereas Carlton Court, Wards 1, 3,12 and 17 and ICU have the larger number of vacancies. Some over establishment in corporate departments continue to include externally funded posts. Maternity leave accounts for 61.16 wte in total of which 48 wte are at band 5 level. Vacancies and maternity leave combined equates to circa 86 wte template gaps.

Nursing associate vacancy levels this month do not represent the actual gap noted and this is thought to attributed to other staff groups being placed into the nursing associate vacant posts. Additional discussions are required with Lead Nurses and Management Accountants to address this. Also see slide 22 for more information.

Healthcare Assistant recruitment continues with support from the workforce team. However, the vacancy level appears to have doubled compared to last month. This is currently being reviewed.

Next steps and planned impact

As reported last month there are some unusual healthcare assistant vacancies levels/over establishments recorded eg the Department of Medicine (10.05 wte over established) and Ward 15 (16.52 vacancy) which need to be reviewed to ensure data accuracy. This review is in progress.

Discussions continue regarding identifying and agreeing the best way to manage maternity leave gaps going forward. A plan is currently being worked up to expand Ward 21 which will be updated on in future reports.

Following a delay in implementing the Band 2 – 3 transition competency framework, training has now commenced. Completion rates will be monitored accordingly.

Risks

Current risks associated with vacancy levels remain as previously reported and are;

- impact on overall available CHPPD from both RN and nursing associate vacancies
- impact on overall available CHPPD from maternity leave template gaps
- impact on corporate nursing team(s) outcomes where vacancies have not been supported to back fill into, mainly quality and education and practice development
- financial impact of cover to shifts related to template gaps from unfilled/waiting to be filled vacancies
- Impact on staff health and well being

Registered Nurses — Feb-25

Overall	Corporate	Medicine	Surgery
Over Established	-21.46	-22.12	-29.26
Vacancies	8.50	54.83	34.84
Net Balance	-12.96	32.71	5.58
Maternity Leave	4.00	40.86	16.30
Overall	-8.96	73.57	21.88

Inpatient Areas Only	Corporate	Medicine	Surgery
Over Established	-4.01	-7.06	-23.51
Vacancies	0.00	31.33	8.03
Net Balance	-4.01	24.27	-15.48
Maternity Leave	1.00	22.80	11.85
Overall	-3.01	47.07	-3.63

Nursing Associates — Feb-25

	Medicine	Surgery
Over Established	-2.73	-3.00
Vacancies	6.28	12.24
Net Balance	3.55	9.24

Healthcare Assistants — Feb-25

	Corporate	Medicine	Surgery
Over Established	0.00	-13.00	-1.12
Vacancies	12.94	51.58	16.01
Net Balance	12.94	38.58	14.89

Chief Nurse Report

Vacancies - Midwives and MSW's

NB A minus figure indicates an over-establishment

What the data tells us

The midwifery band 5 over establishment continues to be aligned to the vacancy levels at band 6. The transition of band 5 midwifery preceptees to band 6 continues to progress and will balance out in the coming weeks. This will leave an overall vacancy level of 0.2 wte at Band 6.

Maternity leave has maintained a position of 7.44 wte.

Midwifery support worker vacancies have increased this month by 1 wte at band 3. There is no change at band 2 level.

Next steps and planned impact

There are no new steps to report this month regarding midwifery vacancies. However, work continues to progress the telephone triage service which has now been fully funded by the LMNS. This equates to 5.24 wte midwives with 2.56 recruited and started in post with the remaining commencing on the 31st March 25.

Risks

There are no new risks to escalate this month regarding midwifery vacancy levels. However, a high level of concern continues to be present regarding shift fill and adequate template cover which is currently under review by the newly appointed Head of Midwifery and the midwifery leadership team.

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Registered Midwives — Feb-25

	Band 5	Band 6	Band 7
Over Established	-6.08	0.00	-0.77
Vacancies	0.00	6.28	0.48
Net Balance	-6.08	6.28	-0.29
Maternity Leave	0.96	5.12	1.36

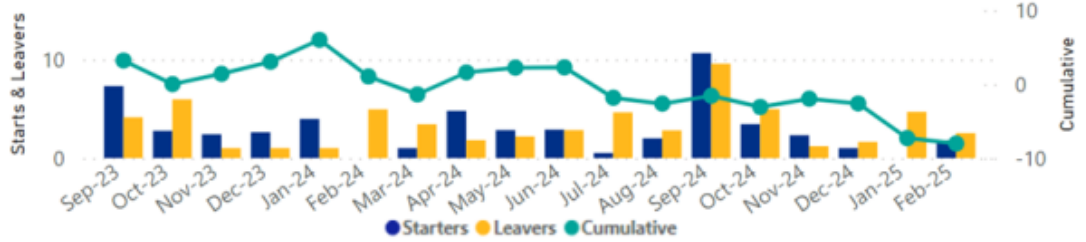
Midwife Support Workers — Feb-25

	Band 2	Band 3
Over Established	0.00	0.00
Vacancies	1.04	3.49
Net Balance	1.04	3.49

Starters and Leavers - Registered Nurses & Health Care Assistants

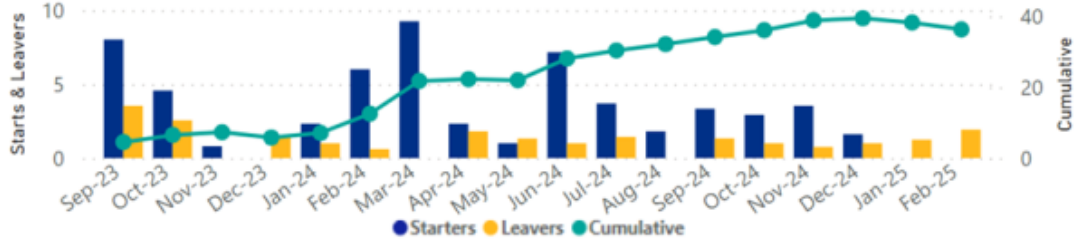
Registered Nurse FTE Growth Cumulative - Last 18 Months — Feb-25

Target	Actual	Previous
None	-8.0	-4.3



Health Care Assistant FTE Growth Cumulative - Last 18 Months — Feb-25

Target	Actual	Previous
None	36.3	45.0

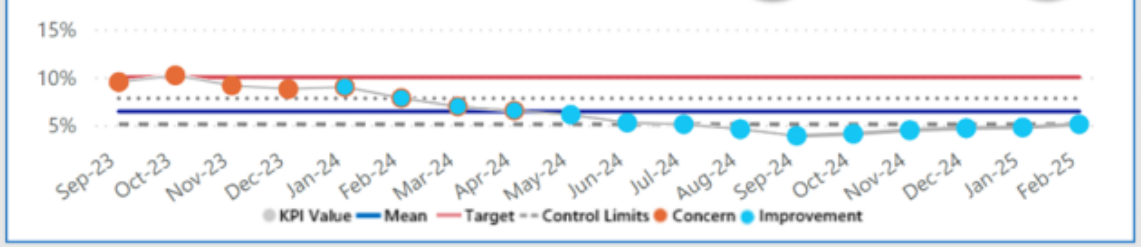


Registered Nurse % FTE Turnover rolling 12 months — Feb-25

Target	Actual	Previous	Assurance	Variation
10.0%	4.5%	4.7%	P	

Health Care Assistant % FTE Turnover rolling 12 months — Feb-25

Target	Actual	Previous	Assurance	Variation
10.0%	5.1%	4.7%	P	L



What the data tells us

The 18-month growth demonstrates a further reduction this month and a continuation of the below zero growth rate seen over the past few months. Healthcare assistant 18-month growth reduced by 8.7 when compared to the last reporting period. Regular recruitment and induction for HCAs continues and it is expected that the growth rate will increase over the next few months as new starters commence.

RN 12-month turnover remains in common cause variation and is demonstrating a stable position with some minor fluctuations noted on a month-by-month basis. There was a slight increase in the same metric for HCAs which also continues to demonstrate a stable position. The 12-month average starter rate for RNs was 29.55 wte and leavers 43.28 wte. This is an in-month increase of 1.8 wte for starters and an decrease if 2.41 wte leavers.
There were zero HCA starters and two leaver.

Next steps and planned impact

Business as usual actions regarding vacancy management and recruitment and retention activities continue. This includes;

- monthly vacancy and allocation review meeting
- regular review of the registered nurse workforce plan including nursing associates
- monthly assessment of the correlation between vacancies, maternity leave, apprenticeship learner time and pipeline capacity
- A graduate recruitment open day is being held on 27th March 2025
- placement agreed for return to practice pre-registration nurse in Sept 25

Risks

Previously reported risks regarding our ability to match starter and leaver rates with workforce pipeline requirements continue to be a focus of attention and regularly reviewed.

A new emerging risk that is being observed is a reluctance to support secondments whereby there is a concern that backfill be a challenge. This has both the potential to limit growth and development for staff and create an impact on the Trust being the 'employer of choice' but conversely does also have a patent safety and experience, staff experience and potentially financial impact when secondments are supported and there is no substantive backfill.

Chief Nurse Report

Starters and Leavers - Registered Midwives & Midwifery Support Workers

Registered Midwife FTE Growth Cumulative - Last 18 Months — Feb-25

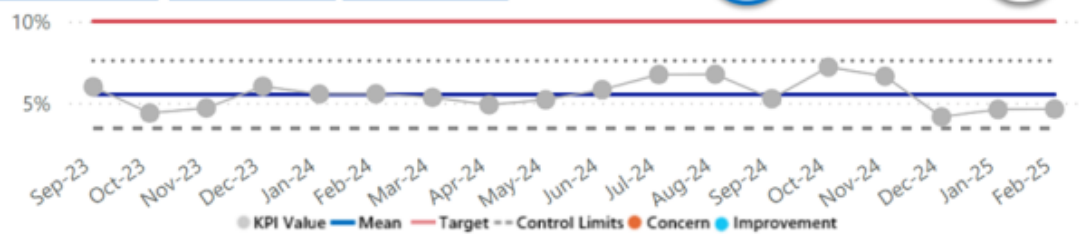
Target	Actual	Previous
None	7.7	5.6

Midwifery Support Worker FTE Growth Cumulative - Last 18 Months — Feb-25

Target	Actual	Previous
None	3.8	3.8

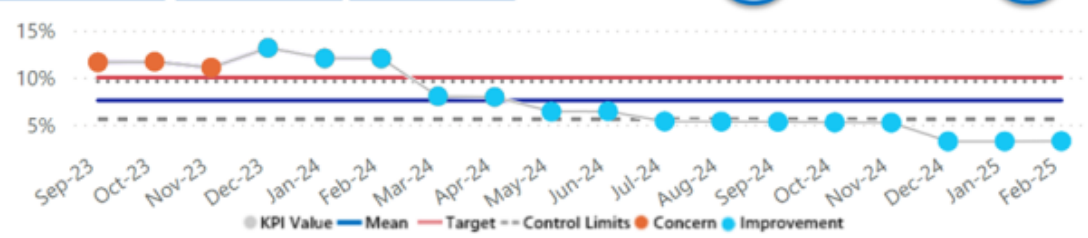
Registered Midwife % FTE Turnover rolling 12 months — Feb-25

Target	Actual	Previous	Assurance	Variation
10.0%	4.6%	4.6%	P	



Midwifery Support Worker % FTE Turnover rolling 12 months — Feb-25

Target	Actual	Previous	Assurance	Variation
10.0%	3.2%	3.2%	P	L



What the data tells us

The 18-month growth rate for registered midwives grew by 2.1 wte this month. There was no change in the growth rate for midwifery support workers for the same period.

There was no change in the 12-month rolling turnover for both staff groups. There is no change to the variation patterns for either this month.

Next steps and planned impact

There are no new steps to report this month regarding midwifery workforce growth and turnover.

Risks

There are no new risks to escalate this month regarding midwifery workforce growth and turnover.

Chief Nurse Report

Nursing and Midwifery Pipeline and Workforce Planning

What the data tells us

2025/26 Registered Nurse Graduates				
	Jun-25	Aug-25	Sept/Oct 25	Feb-26
Direct Entry Nursing Degree	0	0	10	0
Nursing Degree Apprentice (2 yr)	0	0	6	10
Nursing Degree Apprentice (4 yr)	4	5	9	0
Internationally Educated Nurses (x 10 in total per annum)	if required	if required	if required	if required
Totals	4	5	25	10

2025/26 New Learners		
	Sep-25	Feb-26
Direct Entry Nursing Degree	15	0
Nursing Degree Apprentices (2yr)	0	10 (tbc)
Apprentice Nursing Associates	0	0
Totals	15	10

2025/26 Registered Nursing Associate Graduates				
	Jun-25	Aug-25	Sept/Oct 25	Feb-26
Nursing Associates	0	0	5	2
Totals	0	0	5	2

Next steps and planned impact

The tables above provide a summary position of the pipeline intentions for the remainder of the 2025/26 financial year. In summary this indicates the following;

- plans are progressing positively to commence the JPUH Direct Entry Scholarships in September
- 44 registered nurse recruitment opportunities - this is six short of our agreed aim of 50 new recruits per annum but doesn't include any potential overseas recruitment, furthermore it also remain aligned to current turnover numbers. A decision is required regarding offers of employment to the new graduates, most specifically regarding the larger cohort in graduating September/October
- 7 nursing associate recruitment opportunities – once these seven learners have graduated this leaves only two apprentice nursing associates in training in the Trust

Risks

- Our band 4 nursing associate (NA) workforce is at significant risk of being eliminated if further apprentice nursing associate programs are not offered. Of the circa 65 wte originally factored into the ward based funded establishments there are currently;
  - 12 NAs in post in this role only
  - 15 NAs undertaking a nursing degree apprenticeship (50% learner time)
  - 9 apprentice NAs in training

Once the nursing associates undertaking a nursing degree apprenticeship have graduated, working on the basis that there are no further leavers in the short term, there will be only 19 NAs in post leaving a gap of approximately 45 wte. This presents risks to template shift fill, patient care delivery and potential financial burden of shift cover.

- There continues to be concerns regarding the uptake of direct entry nursing students with our local universities and the im[act this will have on future pipeline requirements/plans

Nursing Fill Rate - E-Roster Extract Summary

February-25

Ward	Day Reg Planned Hours	Day Reg Actual Hours	Day Unreg Planned Hours	Day Unreg Actual Hours	Night Reg Planned Hours	Night Reg Actual Hours	Night Unreg Planned Hours	Night Unreg Actual Hours
ACU	1,041.33	674.50	343.17	319.50	662.67	662.67	331.33	331.33
Charnwood	668.50	670.00	360.00	340.75	684.00	672.00	63.00	48.00
Core Maternity	3,796.67	2,861.33	1,593.50	955.67	3,677.00	2,647.83	1,003.50	931.75
EADU	2,349.17	1,939.67	1,389.33	1,442.33	1,715.83	1,737.83	1,630.00	1,537.42
ICU/HDU	3,780.58	3,146.87	757.33	314.33	3,621.00	2,991.00	331.33	331.33
Neonatal Unit	1,219.83	1,112.50	318.33	361.33	1,265.68	1,073.17	331.33	449.67
Ward 16 (Short Stay)	1,659.50	1,309.83	749.50	910.33	989.00	966.00	996.00	893.00
Ward 1	2,286.00	1,745.75	1,926.50	1,378.58	1,989.50	1,785.67	1,943.50	1,786.00
Ward 10 / Concept	2,768.50	1,450.67	1,626.92	1,164.25	1,823.17	1,471.83	312.67	581.00
Ward 12	2,257.50	1,662.83	2,011.00	2,007.83	1,978.00	1,299.50	1,759.50	2,311.08
Ward 3	1,640.50	1,308.92	1,938.50	1,600.75	1,690.50	1,208.50	1,644.50	1,928.50
Ward 17	1,568.25	1,201.92	671.25	644.00	874.00	828.00	506.00	506.00
Ward 18	1,058.00	955.67	1,349.00	1,173.50	977.50	957.33	1,069.50	1,033.25
Ward 22 - Escalation	999.50	943.25	990.00	821.17	1,012.00	909.42	1,000.50	983.50
Ward 22 / Concept	1,434.00	1,166.67	911.50	854.83	1,092.50	770.50	816.50	786.98
Ward 2	977.50	846.80	1,069.50	955.50	977.50	847.00	678.50	632.50
Ward 15	1,606.42	1,237.75	1,472.42	1,123.67	1,299.00	1,254.33	1,518.00	1,446.50
Ward 4	1,614.00	1,375.25	1,583.00	1,317.25	1,609.58	1,318.65	1,426.00	1,366.00
Ward 5	1,620.00	1,496.00	1,578.00	1,164.75	1,656.00	1,231.00	1,398.50	1,466.00
Ward 6	1,621.50	1,312.00	2,883.00	2,191.58	1,736.50	1,207.50	2,323.00	2,514.22
Ward 9	1,046.50	1,007.50	1,045.50	878.75	977.50	933.83	673.50	661.50
Carlton Court	2,110.42	1,944.08	1,952.67	1,909.33	1,924.48	1,894.33	1,932.67	1,912.17
Total	**39,124.17**	**31,369.76**	**28,519.92**	**23,829.98**	**34,232.91**	**28,667.89**	**23,689.33**	**24,437.70**

Ward	Beds
ACU	280
Charnwood	222
Core Maternity	589
EADU	1014
ICU/HDU	262
Neonatal Unit	144
Ward 16 (Short Stay)	607
Ward 1	926
Ward 10 / Concept	548
Ward 12	1071
Ward 3	933
Ward 17	511
Ward 18	696
Ward 22	551
Concept Ward	487
Ward 2	582
Ward 15	866
Ward 4	932
Ward 5	825
Ward 6	942
Ward 9	564
Carlton Court	904
Total	**14456**

Day	Nurse (Planned)	Nurse (Actual)	HCAs (Planned)	HCAs (Actual)
	36,615.50	28,565.93	28,214.42	22,874.31

Nurse (Planned)	Nurse (Actual)	HCAs (Planned)	HCAs (Actual)
3,796.67	2,861.33	1,593.50	955.67

Total Planned Day	Total Actual Day
70,220.09	55,257.24

Night	Nurse (Planned)	Nurse (Actual)	HCAs (Planned)	HCAs (Actual)
	31,521.91	26,043.06	23,962.33	23,505.95

Nurse (Planned)	Nurse (Actual)	HCAs (Planned)	HCAs (Actual)
3,677.00	2,647.83	1,003.50	931.75

Total Planned Night	Total Actual Night
60,164.74	53,128.59

Nursing Fill Rate - Unify Submission Template

Ward	Day Reg Planned	Day Reg Actual	Day UnReg Planned	Day Unreg Actual	Night Reg Planned	Night Reg Actual	Night Unreg Planned	Night Unreg Actual	Beds	CHPPD Reg	CHPPD UnReg	CHPPD Total	Average Fill Rate Day Reg	Average Fill Rate Day UnReg	Average Fill Rate Night Reg	Average Fill Rate Night UnReg
ACU	1,041.33	674.50	343.17	319.50	662.67	662.67	331.33	331.33	280	4.8	2.3	7.1	65%	93%	100%	100%
Charnwood	668.50	670.00	360.00	340.75	684.00	672.00	63.00	48.00	222	6.0	1.8	7.8	100%	95%	98%	76%
Core Maternity	3,796.67	2,861.33	1,593.50	955.67	3,677.00	2,647.83	1,003.50	931.75	589	9.4	3.2	12.6	75%	60%	72%	93%
EADU	2,349.17	1,939.67	1,389.33	1,442.33	1,715.83	1,737.83	1,630.00	1,537.42	1014	3.6	2.9	6.6	83%	104%	101%	94%
ICU/HDU	3,780.58	3,146.87	757.33	314.33	3,621.00	2,991.00	331.33	331.33	262	23.4	2.5	25.9	83%	42%	83%	100%
Neonatal Unit	1,219.83	1,112.50	318.33	361.33	1,265.68	1,073.17	331.33	449.67	144	15.2	5.6	20.8	91%	114%	85%	136%
Ward 16 (Short Stay)	1,659.50	1,309.83	749.50	910.33	989.00	966.00	996.00	893.00	607	3.7	3.0	6.7	79%	121%	98%	90%
Ward 1	2,286.00	1,745.75	1,926.50	1,378.58	1,989.50	1,785.67	1,943.50	1,786.00	926	3.8	3.4	7.2	76%	72%	90%	92%
Ward 10 / Concept	2,768.50	1,450.67	1,626.92	1,164.25	1,823.17	1,471.83	312.67	581.00	548	5.3	3.2	8.5	52%	72%	81%	186%
Ward 12	2,257.50	1,662.83	2,011.00	2,007.83	1,978.00	1,299.50	1,759.50	2,311.08	1071	2.8	4.0	6.8	74%	100%	66%	131%
Ward 3	1,640.50	1,308.92	1,938.50	1,600.75	1,690.50	1,208.50	1,644.50	1,928.50	933	2.7	3.8	6.5	80%	83%	71%	117%
Ward 17	1,568.25	1,201.92	671.25	644.00	874.00	828.00	506.00	506.00	511	4.0	2.3	6.2	77%	96%	95%	100%
Ward 18	1,058.00	955.67	1,349.00	1,173.50	977.50	957.33	1,069.50	1,033.25	696	2.7	3.2	5.9	90%	87%	98%	97%
Ward 22 - Escalation	999.50	943.25	990.00	821.17	1,012.00	909.42	1,000.50	983.50	551	3.4	3.3	6.6	94%	83%	90%	98%
Ward 22 / Concept	1,434.00	1,166.67	911.50	854.83	1,092.50	770.50	816.50	786.98	487	4.0	3.4	7.3	81%	94%	71%	96%
Ward 2	977.50	846.80	1,069.50	955.50	977.50	847.00	678.50	632.50	582	2.9	2.7	5.6	87%	89%	87%	93%
Ward 15	1,606.42	1,237.75	1,472.42	1,123.67	1,299.00	1,254.33	1,518.00	1,446.50	866	2.9	3.0	5.8	77%	76%	97%	95%
Ward 4	1,614.00	1,375.25	1,583.00	1,317.25	1,609.58	1,318.65	1,426.00	1,366.00	932	2.9	2.9	5.8	85%	83%	82%	96%
Ward 5	1,620.00	1,496.00	1,578.00	1,164.75	1,656.00	1,231.00	1,398.50	1,466.00	825	3.3	3.2	6.5	92%	74%	74%	105%
Ward 6	1,621.50	1,312.00	2,883.00	2,191.58	1,736.50	1,207.50	2,323.00	2,514.22	942	2.7	5.0	7.7	81%	76%	70%	108%
Ward 9	1,046.50	1,007.50	1,045.50	878.75	977.50	933.83	673.50	661.50	564	3.4	2.7	6.2	96%	84%	96%	98%
Carlton Court	2,110.42	1,944.08	1,952.67	1,909.33	1,924.48	1,894.33	1,932.67	1,912.17	904	4.2	4.2	8.5	92%	98%	98%	99%
Total	**39,124.17**	**31,369.76**	**28,519.92**	**23,829.98**	**34,232.91**	**28,667.89**	**23,689.33**	**24,437.70**	**14456**	**4.2**	**3.3**	**7.5**	**80%**	**84%**	**84%**	**103%**

Stebbings,Susan
24/03/2025 09:14:17

James Paget University Hospitals NHS Foundation Trust

Report to the Trust Board of Directors dated Friday, 28 March 2025

Title: EQUALITY DELIVERY SCHEME

Sponsor:	Director of People and Culture
Author:	Equity, Diversity and Inclusion Manager
Previous scrutiny:	Equity, Diversity and Inclusion Steering Group – 12.02.25 (virtual); Hospital Management Group – 25.02.25; People and Culture Committee – 20.02.25
Purpose:	The paper is presented for Approval.
Relevant strategic priorities:	✓ 1. Caring for our patients ✓ 2. Supporting our people ☐ 3. Collaborating with our partners ✓ 4. Enhancing our performance
Impact assessments:	☐ Quality ☐ Equality ☐ GDPR and DPA ✓ Not applicable

Does this paper have any impact of the Norfolk and Waveney Integrated Care System or Great Yarmouth and Waveney Place partners? ☐ Yes ✓ No

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Executive Summary

The Equality Delivery System (EDS) is a system designed to help NHS organisations improve the services they provide for their local communities and to provide better working environments, free of discrimination, for those who work in the NHS, while meeting the requirements of the Equality Act 2010.

The main purpose of the EDS is to help local NHS systems and organisations, in discussion with local partners and local populations, to review and improve their performance for people with characteristics protected by the Equality Act 2010. Completion of the EDS supports the Trust in meeting its Public Sector Equality Duty. The EDS has a strong, although not exclusive, focus on addressing health inequalities, including in relation to staff.

Each year, NHS providers are required to implement the EDS in line with the associated Oversight Framework and to publish the results.

The EDS involves using evidence and insight to assess against a range of outcome measures for each domain and rating each of these from 0-3 in line with scoring criteria (0 = Undeveloped; 1 = Developing; 2 = Achieving; and 3 = Excelling)[1]. In order to ensure the rating is a true reflection, patients, staff and networks are involved in the assessment. This then either provides assurance or is used to inform plans in response to the findings. The intention is to achieve delivery on the CORE20PLUS5 approach, the five Health Inequalities Priorities, and inequalities in elective recovery.

There are 11 outcomes rating patient and staff equality in 3 domains:

- commissioned or provided services;
- workforce health and well-being;
- inclusive leadership.

In line with national guidance, there is a move from single organisation evaluation to Integrated Care System (ISC) level evaluation. Our assessment for Domain 1 is therefore part of ICS level evaluation and the development of joint actions. The scores in that section therefore relate to our services only and the

[1] EDS Ratings and Score Card Guidance (england.nhs.uk)

system will publish its own scores in line with performance across all its services. For this year, three areas have been required to be evaluated – Maternity, Audiology and Adult Diabetes.

Domains 2 and 3 are assessed at Trust level only.

The assessment results, which have been led by the Head of Patient Experience, Risk & Governance and the Equity, Diversity & Inclusion (EDI) Manager, with wider stakeholder engagement, are at Appendix 1.

Overall, the assessment is that we are Developing i.e. that we have minimal / basic activities in place. This is the same level assessed last year, although the total score has increased slightly and there is evidence of progress across the domains. This means there is still much more to do to achieve our ambition of being a truly inclusive service provider and employer, having effectively tackled health inequalities.

To reach 'achieving activity' and with an ambition to move to 'excelling' across all domains requires ongoing senior leadership (including Board) commitment and will take time. It is anticipated, with appropriate focus and building on the existing foundations, it will take three to four years to reach 'excelling' across all domains. In a number of areas, however, we are close to achieving a higher rating. The following will support improvement:

- Domain 1: Better evidence of data use to support service decisions.
- Domain 2: Further alignment of staff wellbeing support to health inequality priorities and more extensive analysis of data by protected characteristics to inform plans.
- Domain 3: Increased diversity at senior leadership levels and adoption of the Leadership Framework for Health Inequalities Improvement[2].

The area of most concern is Domain 2. Whilst the People Plan, policies and processes set clear expectations and have created a good foundation for the culture change required and significant work has been undertaken, some staff continue to have negative experiences, including harassment, bullying, violence and aggression, although there is evidence of some improvement in the 2024 Staff Survey. Change will take time but ensuring a robust system of feedback on outcomes from concerns raised is a key achievable area for improvement and has progressed with the introduction of the Guardian Service, an independent channel for staff to raise issues of concern. The introduction of the Violence and Aggression Programme Board to oversee actions to tackle violence and aggression towards staff will also support improvement in this area.

Our EDS results compare to last year's, despite progress in a number of areas. For some of the domains, achieving the next level of score is challenging, as an example, domain 2D, staff recommending the organisation as a place to work and receive treatment requires more than 70% of staff recommending this when the average for acutes is 60.90% for recommending the organisation as a place to work and 61.54% as a place to receive treatment[3]; we score higher than the acute hospital average for these indicators (61.30% and 63.33% respectively), but much lower than the threshold for an 'achieving' assessment.

Where ratings show potential for improvement, it is expected that an improvement plan is created and enacted. Key areas of focus are included in Appendix 1. Actions will be incorporated into the over-arching equity, diversity and inclusion (EDI) action plan and associated plans (e.g. Staff Wellbeing) for 2025 and beyond, including identification of relevant leads. Progress with Domain 1 will be overseen by the Patient Safety & Quality Committee and Domains 2 and 3 will be monitored by the EDI Steering Group, with oversight through the People & Culture Committee.

Recommendation

It is recommended that the Board **approves** the assessment for publication and notes the actions being taken.

[2] NHS Confederation 2022
[3] 2024 Staff Survey

James Paget University Hospitals NHS Foundation Trust

NHS Equality Delivery System Report 2024 - 25

James Paget University Hospitals

13 February 2025

Contents

Equality Delivery System for the NHS

EDS Reporting

Implementation of the Equality Delivery System (EDS) is a requirement on both NHS commissioners and NHS providers.

The EDS is an improvement tool for patients, staff and leaders of the NHS. It supports NHS organisations in England - in active conversations with patients, public, staff, staff networks, community groups and trade unions - to review and develop their approach in addressing health inequalities through three domains: Services, Workforce and Leadership. It is driven by data, evidence, engagement and insight.

James Paget University Hospital Equality Delivery System (EDS)

Name of Organisation		**James Paget University Hospital (JPUH)**	**Organisation Board Sponsor/Lead**
			Chief Nurse (Domain 1) Director of People and Culture (Domains 2 and 3)
Name of Integrated Care System		Norfolk and Waveney	

EDS Lead	Head of Patient Experience, Risk & Governance (Domain 1) Equity Diversity and Inclusion Manager (Domains 2 and 3)		**At what level has this been completed?**	
				***List organisations**
EDS engagement date(s)	05/06/2024-31/01/2025		**Individual organisation**	Domains 2 & 3 - JPUH
			Partnership* (two or more organisations)	N/A
			Integrated Care System-wide*	Domain 1 – Norfolk and Waveney ICS

Date completed	February 2025	**Month and year published**	
Date authorised		**Revision date**	February 2026

EDS Rating and Score Card

Undeveloped activity – **organisations score out of 0** for each outcome	Those who score **under 8,** adding all outcome scores in all domains, are rated **Undeveloped**
Developing activity – **organisations score out of 1** for each outcome	Those who score **between 8 and 21,** adding all outcome scores in all domains, are rated **Developing**
Achieving activity – **organisations score out of 2** for each outcome	Those who score **between 22 and 32,** adding all outcome scores in all domains, are rated **Achieving**
Excelling activity – **organisations score out of 3** for each outcome	Those who score **33,** adding all outcome scores in all domains, are rated **Excelling**

Domain 1: Commissioned or provided services

Domain	Outcome	Evidence	Rating
Domain 1: Commissioned or provided services	1A: Patients (service users) have required levels of access to the service	**Maternity Services** • Maternity information including public health and parenting advice, is available on the 'Just One Norfolk' website and translated into multiple languages. • The Maternity and Neonatal Voices Partnership has worked hard to increase outreach and visibility to more vulnerable communities, with a community outreach lead now in post. • Those whose learning, social or mental health needs mean they require higher professional input during maternity care, are offered case loading by the Eden team of specialist midwives. **Audiology** • Webpage and letters provide information regarding the several different ways of contacting the Audiology Department which includes phone, email and text messaging • Some patients (especially those with significant hearing impairment) prefer to use email and/or text to contact the department as using the phone can be difficult for them. • Information is sent with the patient's appointment letter outlining what will happen during the appointment. • Patients who require hearing aid repairs can usually book on the day repair or within 7 working days • We also have a postal and a drop hearing aid repair service for patients who cannot attend an appointment	**2**

		• Inpatients can also access both the hearing aid repair service and the diagnostic service during their hospital stay. • If an in patient cannot attend the outpatient department then an Audiologist can visit the patient on the ward • We also provide a domiciliary service to housebound patients on request of the GP • The Trust has assistive communication devices in each outpatient area and ward for hearing impaired patients who either do not have a hearing aid or wish to use the loop system with their hearing aid. The Audiology department also has a supply for emergency use if a patient is admitted with a hearing loss and is not aided and cannot manage until they are fitted with a hearing aid. • For any baby that is referred from the Newborn Hearing Screening Programme further appointments are arranged with the parents for a mutually agreeable time. In exceptional circumstances further testing can be undertaken in the child's home. • Audiology is meeting the DMO1 target (6 weeks from referral to diagnostic testing) and is one of the highest performing in the region; the wait time for both assessment and hearing aid fitting is much lower than other Trusts regionally and nationally. • Audiology provides Audiology-led Direct Access services so that Primary Care can refer directly for Age Related Hearing Loss, Tinnitus, Paediatric Hearing Services 0-5 years and 5-16 years and Adult Hearing Testing rather than having to refer to consultant-led service where the waits are longer. • Audiology provides Transition clinics for young people moving to the adult service to enable them to be confident with the knowledge of their hearing loss and the management of their hearing aid(s). • Audiology has its own patient management system which stores demographics, hearing test, hearing aid data and patient notes so	

		that all patient information is accessible and in one place. The system also allows more than one alert to be added per patient which pops up once the patient record is opened • The Audiology department was one of 14 sites in England to pilot hearing testing in Residential schools for children with special educational needs. Although the tests were undertaken in the Ashley school we developed a referral pathway direct from the school to the Audiology department, with a referral form which documented the child's like and dislikes (to aid testing), accessible information documents for the child and a video walking the child through the route from the hospital to the test undertaken. A report of the pilot is currently in production • Annual follow ups are arranged for LD patients (often with the Specialist nurse) as they may not be able to identify when there is a change in their hearing or hearing aid(s) **Adult Diabetes** • Urgent line Monday to Friday 9-10am • Outside urgent line -contact administrator to arrange clinic appointment. Allocated within 4-8 weeks. There is a voicemail inbox managed by Administrator • Patients emails managed by Administrator • Portuguese Nurses that can review Portuguese patients • Language line is used for non-speaking patients **General** • All policies have an EIA • Rainbow lanyards • LGBTQ+ group • Accessible toilets • Multi-faith chaplaincy support • Translation policy in place • Accessible Information Standard Policy	

	1B: Individual patients (service users) health needs are met	**Maternity Services** • Personalised care has been a national and local focus of maternity care in recent months and 2024 saw the launch of 'Personalised Care and Support Plans'. This is a patient-owned booklet which allows women and birthing people to record, and share with health-care professionals, what is important to them and their families during their maternity care. An easy-read version is also available. • A newly formed 'Birth Choices clinic' provides care pathways and counselling for women and birthing people seeking care outside of clinical recommendations or guidelines. • All women and birthing people are risk assessed at each appointment and planned for either midwifery-led or consultant-led care. There are specialist midwives in place for Maternal Medicine, Multiple Pregnancies and Diabetes, who work with the multidisciplinary team to ensure wider health needs are addressed for complex pregnancies. Where service users are identified to have multiple complex needs or wish to have care plans outside of guidelines, a Multi-Disciplinary Team Meeting is arranged to provide information sharing and expertise, and to propose a plan of care. **Audiology** • The Audiology department provides a diagnostic and rehabilitative service for all ages this includes Newborn Hearing screening, Paediatric, Adults, Tinnitus, Hearing Therapy, Complex Adults, Balance and Balance rehabilitation. The service is person centered. We are very fortunate to be able to offer a seamless service between all aspects of provision within the department and including referrals from and to the ENT Service • The Audiology department provides digital Bluetooth enabled hearing aids as standard, which are fitted to the patient's hearing loss and adjusted for their individual needs ie additional programs set up for use with a loop system and/or music programme. The hearing aids are verified using Real Ear Measurements which deliver better results and patients who are happier with the sound	**2**

		quality of their hearing aids • Bluetooth enables streaming from the patient's phone. Intermediary devices can be purchased to allow steaming from TV, Laptop and landline phone • The department has an active Multidisciplinary Children Hearing Services Working Group which includes parent reps and representatives from the local and National Deaf Children's Society, SaLT, Health and Education. The group meets quarterly. • For patients who have issues with coming to terms with their hearing loss and /or need additional support for the management of hearing loss, tinnitus and balance issues the department can provide smooth access to other clinics it offers. • The department has a Cochlear Implant Champion who works with the Emmeline Cochlear Implant Centre at Addenbrookes to ensure that patients with severe to profound hearing loss are referred appropriately for assessment for a cochlear implant. The department also refers to the Audiology department at the NNUH for Bone Anchored Hearing Aid assessment as required. • If at any of the Audiology appointments an ear condition which warrants further investigation is discovered then the Audiology department can refer to the ENT service for further management of the patient as well are referring back to Primary Care. • The department can refer directly for wax removal which is very important now that this isn't routinely provided in Primary Care • The department has worked with the local Mental Health teams to ensure that there is a pathway for patients who need support with their mental health and for those in crisis. **Adult Diabetes** • Patients referred by consultants are reviewed and allocated appointments if needed. • Urgent line for urgent advice ensured for patients.	

		• Allocated appointments to patient in need of support both available face to face and tele clinic	

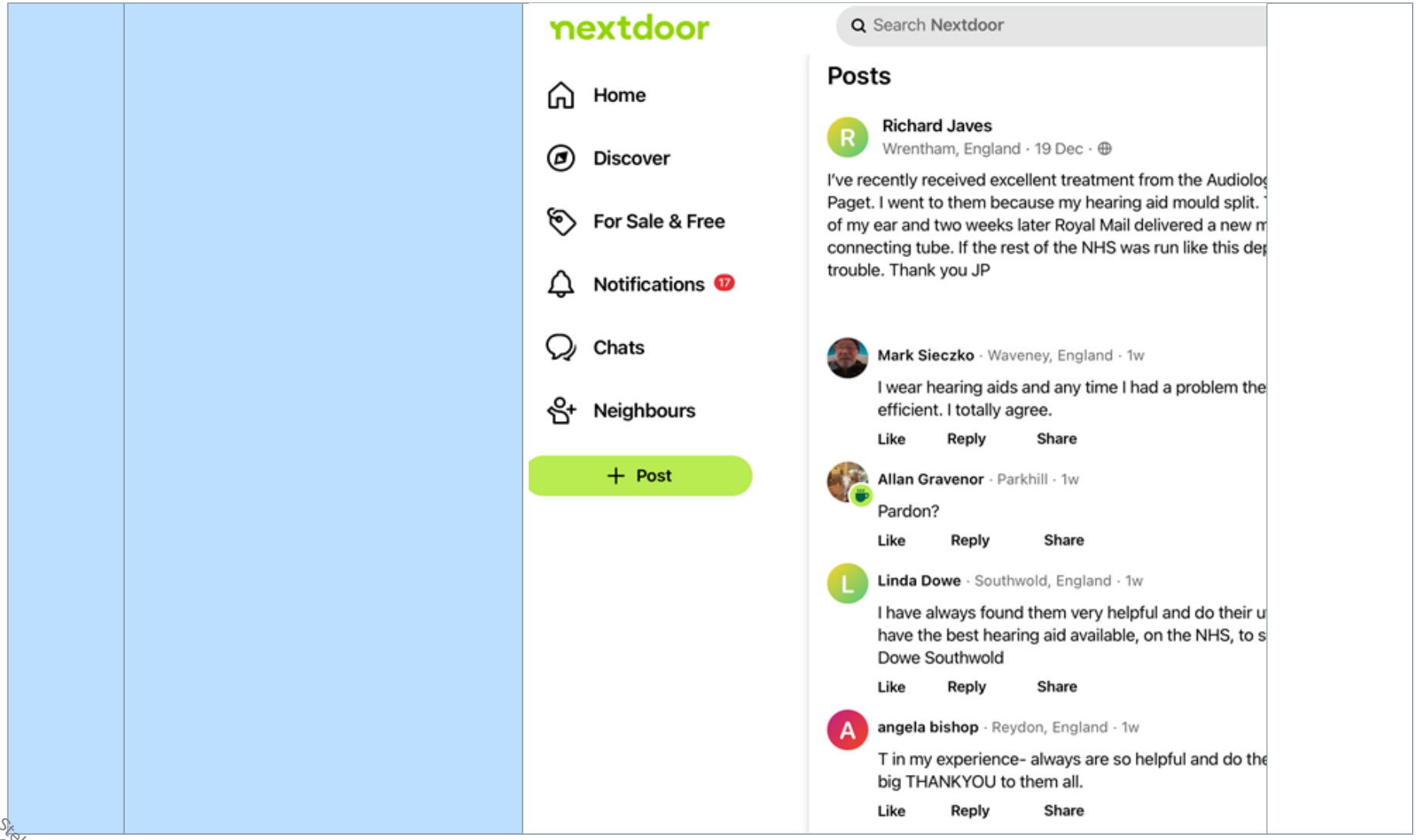
	1C: When patients (service users) use the service, they are free from harm	**Maternity Services** • The Eden Team is in place to support women and birthing people with higher mental health and social needs. The Eden Team works alongside the perinatal mental health team and social services to provide safe and personalised care for those with complex needs. • Clinical incidents are reviewed by a multidisciplinary team, with external expertise from other Trusts, within a set time period and learning and actions are identified and disseminated. • Wider learning from incidents and feedback is shared in a 'daily safety brief' at clinical handovers. **Audiology** • The Audiology service has a consent form for email and text to ensure that it has the patient's consent to use the email address and mobile number that they have provided. • All diagnostic equipment is calibrated and PAT tested annually. Daily Stage A calibration checks on relevant equipment are undertaken and recorded. • Other electrical equipment is PAT tested in line with Trust guidelines. • The department undertakes routine risk assessments, health and safety walk rounds and the QSAFE audits • The department has good estate facilities and up to date equipment	**2**

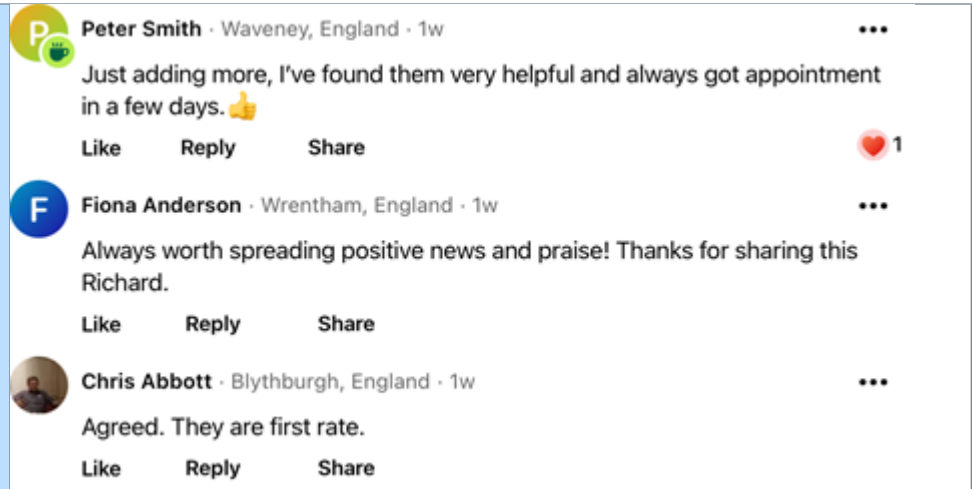
		• Equipment faults are reported immediately and equipment removed from service. This is recorded on a log and discussed at monthly staff meetings. • The department can now access rechargeable hearing aids for those who are in danger of swallowing hearing aid batteries and a tamperproof battery drawer is not appropriate • Staff are encouraged to keep up to date with their CPD and undertake Mandatory training. The department arranges regular training updates • The department has protocols and guidelines available on the Audiology Z Drive • The Audiology team are aware of Safeguarding processes and the referral pathway for mental health issues **Adult Diabetes** • Patients are reviewed by diabetes trained nurses to optimise diabetes management. All staff have been TREND trained. • National guidelines like TREND, JDBS and NICE are followed when making clinical decisions. **General** • Adverse events policy • Governance framework and reporting processes • ICS Clinical harm review policy • NHS Complaints Framework PALS and Complaints Processes • Duty of Candour	

	1D: Patients (service users) report positive experiences of the service	**Maternity Services** • There are multiple opportunities for families to feedback on their maternity experiences, including PALS team, Friends and Family, Complaints, MNVP Surveys, and the Birth Afterthoughts service. • Formal complaints in the last calendar year for maternity services were less than a third of the previous year, and the CQC Maternity Survey also showed significant improvement to the previous years. • In 11 response areas, maternity services were rated in the top 20% for all hospitals in the country. Friends and Family feedback rates has significantly improved in the last year, with the vast majority of feedback being positive for birth. **Audiology** • The Audiology department consistently achieve a very high positive response rate and excellent comments from patients (even in the "what we could do better section") • Members of staff are mentioned personally in the FFT and have been nominated for the Trust Annual Awards • Thank you cards and emails are regularly received as are emails to the executive team and online, please see examples below: FFT comments below: • Made clear and explained so I could understand • Always so helpful, explained everything so clearly • Both hearing aids broken- very quick appointment. Thank you • Had a new hearing aid fitted that gave me more control. Fantastic • Excellent service and seen on time • 2 ladies really lovely. Wonderful with my husband • Kind, patient, explained in age appropriate ways and answered questions • Helpful in answering questions and explained issues and solutions. First class care	**2**

		• Professional and 2 young nurses (audiologists)_ fitted my aids- it was a pleasure to be treated by them • Very thorough questions during assessment, everything clearly explained • Staff welcoming especially receptionists. Pleasant visit • Seen on time, very kind and efficient person who explained everything • Amazing with both children Audiology Department Patient Feedback: I attended the audiology department for a 1015 appointment on 3/6/24, all the staff I met were extremely polite and helpful in particular the audiologist that treated me was first class in every respect. Thank you. Please also see selection of some others we have received by email/post: Sam explained the results of my audiogram very clearly to me and the different types of aids available both Cros aids and hearing aids. She described what would be most likely to work for me and gave me plenty of opportunities to ask questions. I'm looking forward to my follow up appointment with her as I have complete confidence in her professionalism. Fri 8th.Dec 2023. Your lady Audiologist attended me, by appointment in my home, as wheelchair bound, cannot walk/stand. The Lady was very professional, & introduced herself, set up the necessary equipment & efficiently, carried out her tests, asking me relevant questions. In response to my request for best delivery, hopefully before Christmas, the Lady replied while she would do her best, normally would be couple of weeks. Very pleased to state actually received today Tuesday 12th.Dec. (One working day). Am actually wearing them having set up the Bluetooth connection to my smart phone. Wife doesn't have to shout any more, & I no longer have to guess what she said. Improves the quality of my life	

		immeasurably. The service cannot be faulted, please pass on my thanks🙏 to this lady. Compliments of the Season to you all. Subject: Positive NHS Website feedback for Audiology Audiology Appointment 2pm 15/08/023 ★★★★★ 5 star rating by Hugh Evans - Posted on 18 August 2023 First class treatment I received at my appointment. The Audiologist displayed a very caring, friendly and polite manner. The treatment was fully explained and carried out efficiently. Having suffered from tinnitus for a number of years is gives patients confidence knowing they can get effective treatment from this debilitating condition when the need arises from a knowledgeable Audiologist. Thank you. Visited August 2023 Sent: 16 January 2025 09:27 I attended your audiology department yesterday. The treatment I received is first class. The young lady was so efficient and very professional making my visit excellent. Many thanks to all of you. Seen on local social media:	





Adult Diabetes

- Friends and family feedback tests are given to patients post clinic.
- Direct emails into DSN email box

General

- Friends and Family feedback.
- "You said we did"
- Complaints, PALS and compliments data
- Local surveys
- Social media feedback
- Health watch
- NHS Website feedback National surveys

Domain 1: Commissioned or provided services overall rating	**8**

Domain 2: Workforce health and wellbeing

Domain	Outcome	Evidence	Rating

Domain 2: Workforce health and well-being	2A: When at work, staff are provided with support to manage obesity, diabetes, asthma, COPD and mental health conditions	**Wellbeing Support** • One of the four key elements of Paget's People, Our People Plan, is promoting wellbeing opportunities to keep our staff healthy and well. • Comprehensive Employee Assistance Programme, Occupational Health and wellbeing offer. • Adjustment Passport to support staff with long-term health conditions with reasonable adjustments and wider support, including self-management. • Wellbeing information booklet and wellbeing folders on wards. • Fortnightly Wellbeing Newsletter with advice and support. • Chaplaincy, Professional Midwifery and Nursing Advocate support. • Work-life balance is promoted through fortnightly newsletters, posters and events. • Annual sickness absence deep dive report to the People and Culture Steering Group includes analysis by protected characteristics. • Neurodiversity training and support has increased, improving understanding and staff relations in this area, with 100% training attendance from some teams. • Cancer support group for staff. • Staff reporting adequate adjustments increased by a further 2.9% on the 6.7% of the previous year, and is 2.1% above the NHS acute average. • Ability Staff Network. **Obesity / Diabetes** • Daily low-cost healthy canteen menu option and wider healthy choice options. • Free onsite physical health classes and other activities e.g. yoga, running etc and local physical health activities promoted. • Free onsite health checks offered to staff over 40 include diabetes. • Pilot of staff referrals to Your Health Norfolk. • Adjustment passports enable recording of agreed adjustments for management of diabetes, such as timely breaks.	**1**

		Asthma / COPD • Trust is a smoke free site**.** • Free smoking cessation support. • Physical health activities (as above). **Mental Health** • Mental Health First Aiders available to staff in some areas. • Counselling and in the moment support available via EAP. • On-site Psychological Wellbeing Practitioner sessions were available until June 2024. • Enhanced psychological support service providing trauma and complex mental health assessment and treatment. • Guidance flowcharts on mental health support and what to do if someone is in mental health crisis. • Mental-health related workshops such as managing bereavement and moral injury. • LGBTQ+, Disability, and Menopause specific mental health awareness sessions. **General** • Health Inequalities Strategy adopted. • Transformation and Organisational Development staff working with Councils and Voluntary, Community and Social Enterprises to link staff with services. • Flexible Working Policy. We perform better than the acute sector average for the We Work Flexibly People Promise Theme as per the 2024 Staff Survey (6.36 v 6.24).	

	2B: When at work, staff are free from abuse, harassment, bullying and physical violence from any source	• One of the four key elements of Paget's People, our People Plan, is to promote an inclusive, fair and safe workplace. Our Plan commits to taking firm action to address harassment, bullying and violence or aggression towards staff. • Trust has a policy that bullying and harassment are unacceptable and will not be tolerated. Bullying is defined by impact rather than intent, emphasising the detrimental effect on wellbeing. • Just and Learning Workplace Policy ensures compassionate and person-centred focus on managing issues of concern. • Trust carries out regular awareness campaigns that are both staff and public facing to make it clear that violence and aggression are unacceptable and to encourage reporting under the banner of #ChooseRespect. This has included a focus on preventing abuse against staff with protected characteristics. • Violence and Aggression Panel meets weekly to review incidents of abuse from patients and action that can be taken. • Staff provided with flowchart for addressing violence and aggression. • Dashboard of incidents created and available to relevant staff allowing use of most accurate and up-to-date information. • All system reported staff incidents are responded to by either the Deputy Director of People and Culture or a Human Resources Business Partner (in addition to managers) to ensure staff are appropriately supported. • Staff have multiple internal reporting routes including through their manager, an on-line incident reporting system, Human Resources, staff networks, independent Guardian Service, and an anonymous microaggression portal. • Action taken where staff raise concerns including appropriate interventions with reported perpetrators, in line with our just and learning approach. • Security, Safeguarding and Organisational Development & Wellbeing work with the local Police to report and try to prevent crimes, hate crimes and incidents. • Trust Values include the value of Respect – "We are anti-discriminatory, treating people fairly and creating a sense of	**2**

		belonging and pride". • A new Behaviours Framework and Kindness and Respect toolkit has been introduced (2024) and associated training (34 sessions delivered, as well as Leadership Summits). • The Trust is implementing recommendations from an independent review into conflict management overseen by a Violence and Aggression Programme Board. A training needs assessment is being undertaken. • Wide range of support available and provided to staff who have been affected by any level kind of abuse. • Whilst we have a clear strategy, policies, processes and leadership commitment to ensuring a culture free from harassment, bullying, aggression or violence, staff report higher than acute sector average experience of violence from patients, relatives or the public (5.2% higher than national average as per 2024 Staff Survey) and higher levels of harassment, bullying or abuse from colleagues and managers. Experience is significantly worse for ethnic minority colleagues. • Regular diversity awareness communications and events to create a greater sense of staff community. • Sexual Safety Working Group established. • Violence and Aggression Programme Board established.	

	2C: Staff have access to independent support and advice when suffering from stress, abuse, bullying harassment and physical violence from any source	• Range of support and advice routes available including through manager, Human Resources, trade unions, PNAs, PMAs, staff networks, EDI Manager, Freedom to Speak Up service, Chaplaincy. • Staff led networks for ethnically diverse, LGBTQ+, disabilities/ long term health conditions, and menopause meeting monthly or bimonthly. These each have Executive Director sponsorship and report to the Equity, Diversity and Inclusion Steering Group. They are well respected within the Trust for their knowledge and insight and are actively involved in the development and impact monitoring of EDI plans. • Non-Executive Director Freedom to Speak Up Guardian on the Board. • Union representatives are supported and engaged by the Trust. Fortnightly meetings held between staffside leads and Chief Executive and Director of People & Culture. • Range of wellbeing support available, as set out in Wellbeing booklet. Staff also have access to local, regional and national wellbeing support offers. • Counselling available through Employee Assistance Programme. Staff also have access to enhanced psychological support where trauma-informed high intensity support is required. • Equality impact assessments are undertaken for new/updated policies. • Network leads have access to funding to support network activities. • Our Freedom to Speak Up provision has been strengthened by embedding an external service with dedicated Freedom to Speak Up Guardian regularly visiting staff areas. • Deputy Director of People & Culture or a Human Resources Business Partner makes contact with all staff who have reported being involved in an incident involving violence or aggression to ensure appropriate support and all such incidents are considered by a panel that meets weekly. • Occupational Health Service and Employee Assistance Programme.	**2**

	2D: Staff recommend the organisation as a place to work and receive treatment	• Staff recommending the Trust as a place to work (61.3% recommend as a place to work, in line with national average) • Staff Experience Programme Board now well established with input from all staff areas. • Significantly better than regional or national average for staff turnover. • The Trust offers stay conversations in order to try and retain staff. 47 conversations were held in the last year with 50% retention rate resulting. • Exit questionnaires and interviews are undertaken, with learning reviewed. • Nursing staffing levels are regularly reviewed in line with national guidance. • A range of sickness data is reported to the People and Culture Committee and to Board. • Annual sickness absence deep dives are undertaken which include analysis by protected characteristic. • Established Your Voice forums for staff groups.	**1**
Domain 2: Workforce health and well-being overall rating			**6**

Domain 3: Inclusive leadership

Domain	Outcome	Evidence	Rating

Domain 3: Inclusive leadership	3A: Board members, system leaders (Band 9 and VSM) and those with line management responsibilities routinely demonstrate their understanding of, and commitment to, equality and health inequalities	• Strong Board level commitment to equality and health inequalities. Reducing health inequalities, ensuring equitable access for all is a key element of Building a Healthier Future Together, our Trust Strategy. One of the four key elements of our People Plan is to promote an inclusive, fair and safe workplace. It commits to ensuring equity, diversity and inclusion is a thread through all we do. Our wellbeing priority also includes refocusing our wellbeing support activities to improve health inequalities and the Trust has a health inequalities strategy. • Board members have EDI objectives. • The NHS Six High Impact Actions have been adopted and are monitored through an Executive led Steering Group. • Reports on health inequalities work are reported to the Board. • People and Culture Committee and Board receive EDI-related reports including Equality Delivery System, Workforce Race Equality Standard, Workforce Disability Equality Standard, Gender and Ethnicity Pay Gaps. • Improving the experience of all staff, including those with specific protected characteristics, is an organisational strategic aim. • Multiple Executive Directors and senior managers have participated in reciprocal mentoring in order to gain insight into the challenges faced by staff with protected characteristics. • Each Staff Network has an Executive sponsor who champions their work. • Senior leaders have worked on and championed a number of initiatives to support underrepresented or marginalised groups, for example, regarding violence and aggression and mentoring and development support for registered nurses. • Chief Executive regularly includes her diversity work in staff and Board updates	**1**

		• Executives continue to support various programmes that provide development opportunities for those facing inequalities. • The Trust is an Anchor Institution. • There is a clear desire and commitment from senior staff to improve equity, diversity and inclusion. The Trust is in a phase of harnessing this into effective actions and more visible role modelling at all levels. • Mandatory EDI training for all staff, including senior leaders, with good compliance (97%). • Increasing diversity is a focus for all Board recruitment. • Senior recruitment includes staff network member involvement as part of the selection panel / stakeholder panel. • EDI related issues are discussed through the EDI Steering Group, Hospital Management Group, People & Culture Committee (as a standing item) and Board. • Health inequalities are reviewed. Internal and ICS work being undertaken. • Board members and senior staff engage in and initiate diversity and inclusion events including for PRIDE, and Internationally Educated Staff.	

	3B: Board/Committee papers (including minutes) identify equality and health inequalities related impacts and risks and how they will be mitigated and managed	• Committee and Board templates include prompts for equality impact assessments and are reviewed by members. • Equality related issues recorded on Risk Register, reviewed by Groups / Committees / Board. Entries include mitigation and actions. • Dedicated Executive led EDI Steering Group reporting to the Hospital Management Group and with regular reporting to the People and Culture Committee, as evidenced by the agendas / minutes. EDI is a standing item for Committee meetings, with Chair's reports to each Board meeting. The Board has received reports on the EDS, WRES and WDES, gender pay gap and modern slavery within the last year. Equality issues referenced in multiple reports across different areas. • The Hospital Management Group and the Board receive reports on health inequalities. • Equality Impact Assessments are used for policy reviews. • WRES/WDES/Gender Pay Gap and other data has been used to develop action plans with monitoring via the EDI Steering Group. • Inclusion is an integral part of plans for the new hospital build.	**1**

	3C: Board members and system leaders (Band 9 and VSM) ensure levers are in place to manage performance and monitor progress with staff and patients	• Key assessments include action plans endorsed by relevant Committees. • Monitoring of workforce related plans via EDI Steering Group and via Patient Safety and Quality Committee for service related elements. • Staff Survey results are analysed and acted upon. • Detailed reports (EDS, WRES, WDES, gender pay gap) considered by Committees/Board. • Reports in the last year have highlighted progress in areas such as career development and diversity of workforce, and have identified areas requiring focus for improvement. • Exit questionnaires/interviews are undertaken and any concerns regarding bullying, harassment or discrimination are followed up. • There is further work to be undertaken to ensure senior leaders (bands 8c and above) are representative of our local population.	**1**
Domain 3: Inclusive leadership overall rating			**3**

EDS Organisation Rating (overall rating): **Developing (score = 17)**
Organisation name(s): James Paget University Hospital
Those who score **under 8,** adding all outcome scores in all domains, are rated **Undeveloped** Those who score **between 8 and 21,** adding all outcome scores in all domains, are rated **Developing** Those who score **between 22 and 32,** adding all outcome scores in all domains, are rated **Achieving** Those who score **33,** adding all outcome scores in all domains, are rated **Excelling**

EDS Action Plan	
EDS Lead	**Year(s) active**
Head of Patient Experience and Engagement (Domain 1); EDI Manager (Domains 2 and 3)	2024-25
EDS Sponsor	**Authorisation date**
Director of Nursing & Patient Safety (Domain1); Director of People and Culture (Domains 2 and 3)	

Action Plan

Domain	Outcome	Objective	Action
Domain 1: Commissioned or provided services	1A: Patients (service users) have required levels of access to the service	Improve use of data to support service development	Ensure patient responses to accessing services are collated and acted upon.
	1B: Individual patients (service users) health needs are met	Each patient with particular needs has them met in a way that works for them.	Ensure patients at higher risk due to a protected characteristic have personalised plans utilising the best practice.
	1C: When patients (service users) use the service, they are free from harm	Widen good practice to ensure all protected characteristics are covered	Use equality data to identify demographics of engaged patients. Work with VCSE to engage groups insufficiently heard from.
	1D: Patients (service users) report positive experiences of the service	Ensure all protected characteristics are considered in decision making	Review data sets for equality demographics and rectify any groups not currently represented.

Domain	Outcome	Objective	Action
Domain 2: Workforce health and well-being	2A: When at work, staff are provided with support to manage obesity, diabetes, asthma, COPD and mental health conditions 2B: When at work, staff are free from abuse, harassment, bullying and physical violence from any source 2C: Staff have access to independent support and advice when suffering from stress, abuse, bullying harassment and physical violence from any source 2D: Staff recommend the organisation as a place to work and receive treatment	To ensure adequate alignment of wellbeing support provision to the mentioned conditions. Staff feel supported to report abuse and are satisfied with the support they receive following an incident. Adequate arrangements are in place to protect staff from abuse and to manage concerns. Build staff trust in the reporting process particularly in terms of actions taken and any learning. Improve % of staff recommending the Trust as a place to work or receive treatment on a year by year basis, including a focus on staff with protected characteristics.	• Adoption of wellbeing plan, aligned to the People Plan with consideration of the monitoring of protected characteristics in relation to sick leave. • Build on work with VCSEs to ensure adequate support pathways specific to managing obesity, diabetes, asthma and COPD. • Implement the V&A action plan as agreed via the programme board. • Continue to raise awareness and use of the Kindness and Respect Toolkit. • Strengthen mechanisms for reporting to staff organisational learning and actions taken. • Review impact of Guardian Service. • Adoption of clear actions from the 2024 staff survey results including in relation to variations in experience by protected characteristic.

Domain	Outcome	Objective	Action
Domain 3: Inclusive leadership	3A: Board members, system leaders (Band 9 and VSM) and those with line management responsibilities routinely demonstrate their understanding of, and commitment to, equality and health inequalities 3B: Board/Committee papers (including minutes) identify equality and health inequalities related impacts and risks and how they will be mitigated and managed 3C: Board members and system leaders (Band 9 and VSM) ensure levers are in place to manage performance and monitor progress with staff and patients	Increase visibility of commitment and actions. Improve diversity at Band 8C and above (3-5 year objective).	• Introduce EDI Bulletin. • Assess position against Leadership Framework for Health Inequalities Improvement. • Maintain focus on EDI and Health Inequalities at various committees. • Continue with fair recruitment programme of work. • Identify opportunities to share career pathways and remove barriers to making senior roles more accessible to part-time and disabled workers, particularly through the use of flexible working opportunities.

James Paget University Hospitals NHS Foundation Trust

Report to the Trust Board of Directors dated Friday, 28 March 2025

Title: GENDER PAY GAP REPORT

Sponsor:	Director of People and Culture
Author:	Equity, Diversity & Inclusion Manager
Previous scrutiny:	Equity, Diversity and Inclusion Steering Group – 12.02.25 (virtual); Hospital Management Group – 25.02.25; People and Culture Committee – 20.02.25
Purpose:	The paper is presented for Approval.
Relevant strategic priorities:	✓ 1. Caring for our patients ✓ 2. Supporting our people ☐ 3. Collaborating with our partners ☐ 4. Enhancing our performance
Impact assessments:	☐ Quality ☐ Equality ☐ GDPR and DPA ☐ Not applicable

Does this paper have any impact of the Norfolk and Waveney Integrated Care System or Great Yarmouth and Waveney Place partners? ☐ Yes ✓ No

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Executive Summary

All employers with 250 or more employees must report and publish their gender pay gap figures on an annual basis. This must be reported by 30th March each year and is based on snapshot data for the previous year's 31st March.

The gender pay gap is the difference between the average pay of men and women in an organisation, based on hourly rate. It is different to equal pay, which is about equitable pay for the same jobs or work of equal value. Two different types of average are used – mean and median - mean being average and median being middle value of the range of rates paid.

The latest snapshot (taken 31/03/2024) has shown small improvement in the mean and median gender pay gap and no change to the mean or median bonus pay gap. The pay gap is impacted by the distribution of men within the highest pay quartile as a proportion of the overall male workforce compared to the higher distribution of women within the lower quartiles proportionate to the overall female workforce, as well as the higher proportion of male to female senior doctors. The improvement in the mean and median gender pay gap is impacted by an increase in the proportion of women in the higher pay quartile, as well as improvement in quartile 2. In June 2024, a gender pay gap target was set of improving the representation of females in quartile 4 by 3% for each of the following two years; this has been achieved for 2024. No change to the bonus pay gap is associated with a change to terms and conditions applicable to medical Consultants which resulted in no further local Clinical Excellence Award rounds from April 2024.

Actions taken since the previous report include additonal mentoring opportunities for nursing staff who are predominantly female; increased career development opportunities through leadership programmes; and increasing awareness of flexible working opportunites and other workplace adjustments. The 2024 Staff Survey shows improvements in these latter two areas, where we perform better than acute and acute and community Trust averages.

A comparison with other local acute Trusts shows that the James Paget is not an outlier and it performs better in gender distribution across the pay quartiles.

As greatest difference is seen within the medical staff group, work will be undertaken to assess and seek to address barriers to progression for female doctors. More generally, we will continue to apply fair recruitment principles and further embed a culture of flexible working which is particularly beneficial to people with caring responsibilities, which can otherwise be a barrier to progression.

Recommendation

The Board of Directors is recommended to note our gender pay gap position and actions being taken and to **approve** the report for publication.

1. Introduction

One of the priorities of our Trust Strategy, *Building a Healthier Future Together 2023-28* is Supporting Our People and Ambition 1 of *Paget's People*, our People Plan 2023-28, is to promote an inclusive, fair and safe workplace. This includes taking action to address inequalities.

2. What is the Gender Pay Gap report?

- Employers with 250 or more employees must publish statutory calculations every year showing the pay gap between male and female employees. For NHS Trusts, this means providing a 'snapshot' of pay differences on 31st March each year and bonus payments made during the year.
- Snapshot data is required to be reported and published by 30th March the following year. The data in this report therefore relates to the 31st March 2024. The results must be published on the Trust's website and a government website.
- Pay gap reporting supports and encourages action to eliminate pay inequities.
- Pay gap reporting is different to equal pay; equal pay deals with the pay differences between men and women who carry out the same jobs, similar jobs or work of equal value. The gender pay gap shows the difference in the average pay between all men and women in a workforce based on hourly pay. It takes account of mean and median averages[1], as well as 'bonus' payments. Clinical Excellence Awards, payable to medical Consultants, are classed as bonus payments.
- Within the NHS, excluding Very Senior Managers (VSM), pay scales are set nationally and terms and conditions prescribe pay arrangements on appointment. Jobs for all staff on Agenda for Change (all staff excluding medical and VSM) are subject to NHS Job Evaluation to determine appropriate pay bandings. This therefore has a significant impact on preventing gender related pay discrepancies.

3. The Gender Pay Gap Indicators

The six pay gap indicators are:

i. Average gender pay gap as a mean average
ii. Average gender pay gap as a median average
iii. Average bonus gender pay gap as a mean average
iv. Average bonus gender pay gap as a median average
v. Proportion of males receiving a bonus payment and proportion of females receiving a bonus payment
vi. Proportion of males and females by pay quartile ordered from lowest to highest pay.

4. Results for 31st March 2024

a. Hourly Gender Pay Gap

	Male	Female	Difference	Pay Gap	
Mean	£23.92	£18.12	£5.80	24.23%	
Median	£18.68	£16.58	£2.10	11.24%	

- When comparing mean hourly pay, women's mean hourly pay is 24.23% lower than men's. Over the last year, the gap has reduced by 1.33%.
- Women earn 89p for every £1 that men earn when comparing median hourly pay, 11% less than men.

[1] Mean being average and median being the middle value of the range of rates paid

b. Bonus Pay Gap

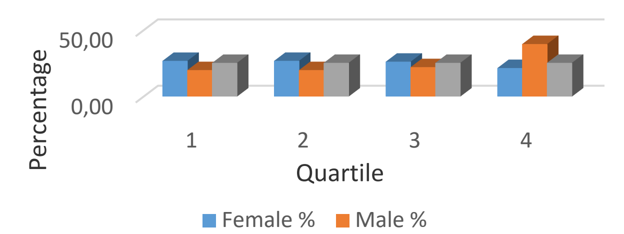
	Male	Female	Difference	Pay Gap
Mean	£8,693.19	£7,492.49	£1,200.70	13.81%
Median	£6,032.04	£6,032.04	£0.00	0.00%

- When comparing mean bonus pay, women's mean bonus pay is 13.81% lower than men's, roughly the same as the previous year.
- Women earn the equivalent for every £1 that men earn when comparing median bonus pay.
- Of those who received bonus pay, 77% were male.

c. Male and Female Spilt Across Four Pay Quartiles

	Q1 (lowest paid)	**Q2**	**Q3**	**Q4** (highest paid)
Female	83.20%	83.89%	81.58%	67.59%
Male	16.80%	16.11%	18.42%	32.41%

Women, as a proportion of the total male and female workforce per quartile, occupy 68% of the highest paid jobs (an increase of 3%) and 83% of the lowest paid jobs (no change), however, as demonstrated by the chart below, there is a far higher proportion of men, as a proportion of the total male workforce, in quartile 4. Alongside this, there is a disproportionately higher distribution of women in the lower quartiles (1 - 3).



Staff distribution across quartiles

5. Understanding the Trust Gender Pay and Bonus Gaps

The gender pay gap is impacted by:

- The much higher distribution of men within the highest pay quartile as a proportion of the overall male workforce.
- The lower distribution of women in quartile 4 proportionate to the overall female workforce.
- The higher proportion of male to female senior doctors (relevant to quartile 4 pay).
- The number and higher levels of Clinical Excellence Awards of male compared to female Consultants. (Local Clinical Excellence Awards schemes ended in April 2024 following a change to Consultant Terms and Conditions, but historical awards remain part of overall remuneration).

It is noteworthy that when comparing Agenda for Change salaried staff there is little difference between mean and median pay.

6. Comparison Between Years

- Between 31/03/2023 and 31/03/2024, the **mean gender pay gap** decreased by 3.2% to 24.2%. This is the lowest it has been over the previous six years.
- The **median gender pay gap** has decreased slightly from 12.07% to 11.24%, continuing its downward trajectory from the previous year.
- The **mean bonus gender pay gap** has remained almost the same. This is unsurprising given that it relates to Clinical Excellence Awards which are no longer awarded but remain as legacy payments.
- The **median bonus gender pay gap** has also remained the same at 0%.
- The overall trend over the last six years has been a reduction in the gap between the proportion of males and females receiving a bonus payment.
- The proportion of men in the highest pay quartile has decreased by 2.88% (to 32.41%) and the proportion of females in the highest quartile has therefore increased by the same amount. There has also been a notable increase in the proportion of women in quartile 2 (+2.32%) and an associated decrease in men. There have been no significant changes in quartiles 1 and 3.
- In June 2024, the Equity Diversity and Inclusion Steering Group agreed a target of improving female representation in quartile 4 by 3% for each of the following two years. This has been achieved for 2024.

7. Closing the Gender Pay Gap

- Actions taken since the previous report include additonal mentoring opportunities for nursing staff, who are predominantly female; increased career development opportunities through leadership programmes; and increasing awareness of flexible working opportunites and other workplace adjustments. The 2024 Staff Survey shows improvements in these latter two areas, where we perform better than acute and acute and community Trust averages.
- Benchmarking across the other local acute Trusts shows that James Paget is not an outlier in relation to the mean pay gap (highest being 28.5%) or the mean bonus pay gap (highest of 24.9%). We perform better when comparing gender split across quartiles.
- The gender pay gap has complex and multi-faceted causes and will take significant time to fully address. As a large employer, and one with a high proportion of female employees, the Trust is, however, in a position to remove internal barriers to pay parity and to influence wider societal factors.
- Females are more likely to take on additional caring responsibilities at home and voluntary roles in the workplace. They are also more likely to be in lower paid roles. It is therefore important that we continue to take measures to prevent these being barriers to employment and career progression within the Trust.
- The results show the need for continued focus on equality in progression opportunities into senior positions for female doctors, as this is where the greatest difference is seen. Work will be undertaken to assess and seek to address barriers in this area. Conversely, we should ensure that males are not discouraged from taking on caring responsibilities, flexible working or quartile 1 jobs due to organisational expectations, and ensure that development programmes for staff at this level continue to be accessible.

8. Recommendation

The Board of Directors is recommended to note our gender pay gap position and actions being taken and to **approve** the report for publication.

James Paget University Hospitals NHS Foundation Trust

Report to the Trust Board of Directors dated Friday, 28 March 2025

Title: ETHNICITY PAY GAP REPORT

Sponsor:	Director of People and Culture	
Author:	Equity, Diversity & Inclusion Manager	
Previous scrutiny:	Equity, Diversity and Inclusion Steering Group – 12.02.25 (virtual); Hospital Management Group – 25.02.25; People and Culture Committee – 20.02.25	
Purpose:	The paper is presented for Approval.	
Relevant strategic priorities:	✓ 1. Caring for our patients	✓ 2. Supporting our people
	☐ 3. Collaborating with our partners	☐ 4. Enhancing our performance
Impact assessments:	☐ Quality ☐ Equality	☐ GDPR and DPA ☐ Not applicable

Does this paper have any impact of the Norfolk and Waveney Integrated Care System or Great Yarmouth and Waveney Place partners? ☐ Yes ✓ No

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Executive Summary

As part of the NHS Six High Impact Equality Actions (2023), which the Trust has incorporated into its equity, diversity and inclusion (EDI) plans, the Trust is required to report and publish ethnicity pay gap figures on an annual basis. In line with the pre-existing Gender Pay Gap requirements, this report is based on snapshot data for 31st March 2024, to be published by 30th March 2025.

The ethnicity pay gap is the difference between the average hourly pay of staff identifying as a specific ethnicity (as per their ESR[1] record). Two different types of average are used – mean and median (mean being average and median being the middle value of the range of rates paid).

The snapshot (taken 31/03/2024) shows some disparity between the pay of different ethnicities, the reasons for which are complex. Overall, pay quartile 1 reflects the ethnic distribution of the local Norfolk and Waveney population, but higher quartiles, particularly quartile 3, reflect higher levels of Black and Minority Ethnic (BME) staff due to the use of national and international recruitment pools to support clinical skills shortages in particular roles, including medical, as well as greater societal orientation to some professional roles for some ethnicities. Overall, therefore, there is no adverse ethnicity pay gap for BME staff. The bonus pay gap, which relates to legacy Clinical Excellence Awards payments for Consultants, shows significant variation between different ethnicities. Local Clinical Excellence Awards rounds ceased in April 2024 following a change in medical terms and conditions so this variation should reduce over time. Once data is available, a comparison will be undertaken with the other local acute Trusts.

Ethnicity pay gap is complex and has multi-faceted causes, with different ethnicities having different experiences. We therefore need to be mindful in our interpretation of the data and our approach in addressing any issues. In addition to continuing our fair recruitment approach and engagement with our local communities on healthcare careers opportunities, a person-centred approach is important to explore barriers to progression and take proactive action to assist the development of under-represented groups through mentoring, skills support and development. We saw a 2.4% improvement in last year's Workforce Race Equality Standard for BME staff feeling there is equal opportunity for career progression and are hopeful to see further improvement in this year's results.

[1] Electronic Staff Record

Recommendation

The Board of Directors is recommended to note our ethnicity pay gap position and actions being taken and to **approve** the report for publication.

1. Introduction

One of the priorities of our Trust Strategy, *Building a Healthier Future Together 2023-28* is supporting our people and Ambition 1 of *Paget's People*, our People Plan 2023-28, is to promote an inclusive, fair and safe workplace. This includes taking action to address inequalities.

2. What is the Ethnicity Pay Gap report?

- The NHS Six High Impact Equality Actions (2023) for diversity and inclusion include introducing ethnicity pay gap reporting.

- In line with Gender Pay Gap reporting, snapshot data for the previous 31st March is to be reported and published by 30th March the following year. The data in this report therefore relates to 31st March 2024 and is the Trust's first year of Ethnicity Pay Gap reporting.

- Pay gap reporting supports and encourages action to eliminate pay inequities.

- Pay gap reporting is different to equal pay; equal pay deals with the pay differences between individuals who carry out the same job, similar jobs or work of equal value. Pay gap analysis, however, shows the difference in the average pay between staff groups based on hourly pay. It takes account of mean and median averages[2], as well as 'bonus' payments. Clinical Excellence Awards, payable to medical Consultants, are classed as bonus payments for pay reporting purposes.

- Within the NHS, excluding Very Senior Managers (VSM), pay scales are set nationally and terms and conditions prescribe pay arrangements on appointment. Jobs for all staff on Agenda for Change (all staff excluding medical and VSM) are subject to NHS Job Evaluation to determine appropriate pay bandings. This therefore has a significant impact on preventing pay discrepancies.

3. The Ethnicity Pay Gap Indicators

The six pay gap indicators are:

i. Pay gap as a mean average
ii. Pay gap as a median average
iii. Bonus pay gap as a mean average
iv. Bonus pay gap as a median average
v. Proportion of staff receiving a bonus payment
vi. Proportion of staff by pay quartile ordered from lowest to highest pay.

4. Results for 31st March 2024

It should be noted that the data is based on categories and figures drawn from the Electronic Staff Record (ESR). Analysis and conclusions drawn therefore have a margin of error associated with anomalies in ESR ethnicity categorisation. For example, staff identifying as White English rather than White British are categorised in ESR reporting White Other rather than White British. Whilst a relatively low rate, there are also some staff who have recorded their ethnicity as 'not stated'.

a. Hourly Ethnicity Pay Gap

	BME	White	Unknown	Difference (BME/White)	Pay Gap
Mean	£23.64	£18.34	£25.53	-£5.30	-28.9%
Median	£19.24	£15.92	£20.25	-£3.32	-20.84%

- When comparing mean hourly pay, Black and Minority Ethnic (BME) staff hourly pay is 28.9% more than the pay of White British staff. This is largely driven by active recruitment of internationally educated staff into some clinical roles due to national shortages and particular ethnic groups orientating more towards particular professional roles, with higher levels of pay.

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[2] Mean being average and median being the middle value of the range of rates paid

	Asian	Black	Mixed	Not Stated	Other	White British	White Other
Mean	£24.25	£20.82	£24.37	£25.53	£25.50	£17.97	£22.93
Median	£19.90	£18.10	£19.57	£20.25	£23.14	£15.70	£18.61

- Excluding Not Stated or Other, further break down of ethnicity categories (above) shows the average hourly pay of Asian and Mixed ethnicity staff groups are are the highest, with White British paid the least on average.

Difference to White British
(N.B. negative numbers mean higher pay)

	Asian	Black	Mixed	Not Stated	Other	White Other
Mean	-34.92%	-15.84%	-35.57%	-42.06%	-41.90%	-27.56%
Median	-26.69%	-15.26%	-24.61%	-28.95%	-47.33%	-18.51%

The table above shows the percentage difference in hourly pay by group.

b. Bonus Pay Gap

	Asian	Black	Mixed	White British	White Other
Mean	£6,694.14	£4,460.56	£16,489.65	£9,904.86	£9,043.95
Median	£9,789.69	£5,960.88	£16,489.65	£23,539.30	£10,547.87

- When comparing mean bonus pay, there are large variations between different ethnic groups. This is partly due to the low number of Clinical Excellence Award recipients (45 in total) meaning that one person can change the statistics significantly when reviewing this based on ethnicity.

- It should be noted that from April 2024 local Clinical Excellence Awards rounds stopped due to a change in medical Consultant terms and conditions but pre-existing rewards remain relevant.

c. Percentage of Eligible Staff Receiving a Bonus

	Asian	Black	Mixed	White British	White Other
Receiving Bonus	19.04%	1.67%	9.35%	0.35%	6.81%

- Nearly 20% of eligible Asian staff receive payment for a Clinical Excellence Award compared to 1.7% of eligible Black staff and 0.35% of White British staff.

d. Ethnicity Spilt Across Four Pay Quartiles

	Q1 (lowest paid)	Q2	Q3	**Q4** (highest paid)
Asian	2.29%	8.96%	20.21%	18.35%
Black	1.14%	3.78%	6.94%	2.81%
Mixed	0.62%	0.88%	1.49%	2.28%
Not Stated	0.53%	0.88%	1.05%	1.84%
Other	0.26%	0.88%	0.62%	2.11%
White British	90.12%	79.98%	64.41%	63.13%
White Other	5.01%	4.65%	5.27%	9.31%

- The vast majority of staff within quartile 1 are White whilst other ethnicities are more prevalent in quartile 3. This is reflective of international recruitment into hard to recruit clinical staff roles (including medical) and orientation of some ethnic groups to particular professions, some of which, such as Medicine, attract higher-level salaries.

- For context, 20% of the Trust's staff are BME, with 5% of the local population of Norfolk and Waveney being BME[3] and 5% of non-clinical roles within the Trust are occupied by BME staff. Q1 distribution is consistent with local ethnicity data which suggests around 5% of the population is not White. Quartile 1 is therefore fairly reflective of the local population.

5. Understanding the Trust Ethnicity Pay and Bonus Gaps

The ethnicity pay gap is impacted by:

- The much higher distribution of non-White staff in quartile 3 due to international recruitment to fill clinical skills shortages.

- Much higher distribution of White staff in quartile 1 due to local recruitment, representative of the local population.

- Our medical workforce is 40% White, 56% BME and 4% other. At Consultant level, this is 43% White, 52% BME and 3% Other. In line with the national picture, we have a higher proportion of doctors in the Asian staff group, including at Consultant level. Ethnic diversity is far greater in the higher quartiles due to immigration and societal expectations for different ethnicities.

6. Comparison

Once benchmark data is available, a comparison will be undertaken with other local acute Trusts.

7. Closing the Ethnicity Pay Gap

- The ethnicity pay gap has complex and multi-faceted causes. The Trust is, however, in a position to remove internal barriers to pay parity and to influence wider societal factors.

- Initial analysis of nursing recruitment data at bands 6 and 7 has already shown disparity in application standards between ethnicities which the Trust will continue to seek to address by providing potential applicants with clear guidance and support around quality applications and interview skills.

- We will continue to support 'growing our own' monitoring and focusing on under-represented groups through mentorship, development programmes and personal development plans. We saw a 2.4% improvement in last year's Workforce Race Equality Standard for BME staff feeling there is equal opportunity for career progression and are hopeful to see further improvement in this year's results, to be reported within the next couple of months.

- Local initiatives within the community, including early engagement through schools and colleges, to promote healthcare careers and share staff stories will support career aspirations and recruitment at all levels.

- It is important to recognise that all ethnicities have different experiences and not be tempted to classify staff on simplified statistical analysis. Person-centred approaches are key to equality of opportunity and our approach.

8. **Approval**

The Board of Directors is recommended to note our ethnicity pay gap position and actions being taken and to **approve** the report for publication.

Susan Hebbings
24/03/2025 09:14:17

[3] Office for National Statistics - 2021 Census

James Paget University Hospitals NHS Foundation Trust

Report to the Trust Board of Directors dated Friday, 28 March 2025

Title: MODERN SLAVERY STATEMENT

Sponsor:	Director of People and Culture
Author:	Equity, Diversity & Inclusion Manager
Previous scrutiny:	Equity, Diversity and Inclusion Steering Group – 12.02.25 (virtual); Hospital Management Group – 25.02.25; People and Culture Committee – 20.02.25
Purpose:	The paper is presented for Approval.
Relevant strategic priorities:	✓ 1. Caring for our patients ✓ 2. Supporting our people ☐ 3. Collaborating with our partners ☐ 4. Enhancing our performance
Impact assessments:	☐ Quality ☐ Equality ☐ GDPR and DPA ☐ Not applicable
Does this paper have any impact of the Norfolk and Waveney Integrated Care System or Great Yarmouth and Waveney Place partners?	☐ Yes ✓ No

Executive Summary

The Modern Slavery Act 2015 is intended to combat slavery, servitude, forced labour and human trafficking in service provision and through suppliers.

Each year, the Trust is required to review and republish its modern slavery statement covering the previous year, to include the steps taken to minimise modern slavery risks in both our services and supply chains.

The proposed statement is at Appendix 1. The only additions to our existing statement is to include reference to the Trust having adopted the national NHS Freedom to Speak Up Policy and our introduction of the Guardian Service as an external independent mechanism for concerns to be raised; these have both been introduced within the last year.

There have been no concerns raised or incidents reported over the last year.

The statement has been approved by the Equity, Diversity and Inclusion Steering Group, Hospital Management Group and the People and Culture Committee.

The Trust has a zero tolerance of slavery and human trafficking and is committed to preventing such activities and taking all reasonable actions to ensure our supply chains and activities are free from ethical and labour standards abuses.

Recommendations

It is recommended that the statement in Appendix 1 is approved by the Board of Directors for publishing in April 2025.

Stebbings,Susan 24/03/2025 09:14:17

Appendix 1

Modern Slavery Act 2015 and Human Trafficking Statement for 2024/25 Year

In accordance with section 54(1) of the Modern Slavery Act 2015, James Paget University Hospitals NHS Foundation Trust ('the Trust') has zero tolerance of slavery and human trafficking and is committed to preventing such activities, taking all reasonable actions to ensure our supply chains and activities are free from ethical and labour standards abuses.

The Trust provides services from its main hospital site in Gorleston-on-Sea, Norfolk and a small number of other local sites.

Policies, procedures, governance and legal arrangements are robust, to ensure that proper checks and due diligence are applied in employment procedures maintaining compliance with legislation and NHS employment check standards.

All colleagues working at the Trust have a personal responsibility for the prevention of slavery and human trafficking, with our procurement department having lead responsibility for overall compliance. Mandatory training for all staff includes awareness and consideration of duties in relation to modern slavery and human trafficking, taking appropriate action in relation to any concerns and working with partner organisations where relevant. The Trust's safeguarding policies provide further guidance and clear reporting procedures, and the Trust has adopted the NHS Freedom to Speak Up Policy. These policies are reviewed every three years as a minimum. Over the last year, the Trust has also introduced an external independent Guardian Service for improved staff assurance in raising any concerns. In addition, the Safeguarding Team is available to colleagues, providing specialist advice and support.

We use supply chains engaged through relevant NHS and public sector approved procurement framework arrangements to support temporary staffing needs, with compliance with NHS standards being a condition of engagement.

To ensure a high level of understanding of the risks of modern slavery and human trafficking in our supply chains and our business, our procurement staff receive training in this area.

In addition, we have continued to take the following steps:

- Include specific clauses that reflect our obligations under the Modern Slavery Act 2015 in terms and conditions for supply, with use of the NHS Standard Contract templates whenever possible.
- Include pass/fail criteria for Procurement led tender processes and new vendor requests.
- Upskill the Procurement and Supplies Team on the implications of the Act in order that they can support the wider organisation on its implementation.
- Communicate to all high risk suppliers providing an overview of the legislation, stating our intent and expectations.
- Include a specific right to audit against the obligations of the Modern Slavery Act 2015 for those contracts deemed to be of high risk.
- Ensure suppliers engaged outside the normal procurement processes comply with the Modern Slavery Act 2015.
- Ensure staff and other workers employed directly by the Trust are paid at or above National Minimum Wage requirements and in line with NHS terms and conditions (where appropriate).
- Commit to referring to the appropriate authorities/agencies any concerns of modern slavery or human trafficking that we may identify.
- Ensure compliance with the Public Contract Regulations 2015.

There have been no reported incidents in the year April 2024 to March 2025.

SUBJECT TO APPROVAL 28.03.25 - This statement has been approved by our Board of Directors on 28 March 2025 for the year ended 31st March 2025.

James Paget University Hospitals NHS Foundation Trust

Report to the Trust Board of Directors dated Friday, 28 March 2025

Title: Norfolk and Waveney Acute Hospital Collaborative (NWAHC) – Update Report

Sponsor:	Deputy Chief Executive
Author:	Strategy Directors JPUH, NNUH & QEKL
Previous scrutiny:	
Purpose:	The paper is presented for Approval.
Relevant strategic priorities:	✓ 1. Caring for our patients ✓ 2. Supporting our people ✓ 3. Collaborating with our partners ✓ 4. Enhancing our performance
Impact assessments:	☐ Quality ☐ Equality ☐ GDPR and DPA ☐ Not applicable
Does this paper have any impact of the Norfolk and Waveney Integrated Care System or Great Yarmouth and Waveney Place partners?	✓ Yes ☐ No

Executive Summary

This report provides an update of the March 2025 meeting of the Norfolk & Waveney Acute Hospital Collaborative (Committees in Common). The same report has gone to the Board's of the three acute hospitals.

Recommendation

The Board is asked to approve this report as sufficient assurance for the work of the Committees in Common.

Report in Common to the Trust Boards	
Report Title:	Development of the Norfolk and Waveney Acute Hospital Collaborative (NWAHC) Update - Boards of Directors in Public (March 2025)
Prepared/Presented by:	Jon Barber – Deputy CEO, JPUH Carly West-Burnham – Director of Strategy and Integration, QEH Alex Berry – Director of Transformation, NNUH
Date:	March 2025
Issues for escalation/ decision(s) required: The Boards of Directors are asked to note the outcomes from the March Committees in Common and the key areas of focus for the Norfolk and Waveney Acute Hospital Collaborative (NWAHC) moving forward.	

Progress Update

The NWAHC Committees in Common recognised that the governance arrangements across the provider collaborative are in transition and as such future meetings may well change both in structure and content.

Risks

N/A

Update on the Development of the Norfolk and Waveney Acute Hospital Collaborative

Acute Collaborative development

Simon Hackwell, Project Director provided an update on the significant work which is in train in relation to development of the Group Model and implementation of agreed deliverables by 1 April 2025. The update was supported by detailed papers.

The Committee discussed the proposals for establishing the Group Board in April focusing on its role during the transition period through to October 2025 alongside outlining the proposed scope of the Group Board, delegated powers and membership. It was noted that agreement around the role and function of the Group Board will form a key component of the Partnership Collaboration Agreement which Trust Boards will be asked to sign off at the end of March.

Subject to formal Trust Board approval, the Committee agreed the principle of the formation of a Joint Committee with Special Purposes ('SPJC') to oversee and guide the transition to the full group model. This would be known as The Group Board and would replace the existing NWAHC Committees in Common. It is planned to operate from 1st April 2025 up to 1st October 2025 or earlier, at which point it will be superseded by a Group Board with General Purposes. The membership of the SPJC was discussed alongside the purpose and the scope.

Draft feedback from the NHSE System Assurance Regulation unit which conducted a review of the plans to form a group model across the three Norfolk and Waveney acute trusts in February 2025 was received and

discussed. The recommendations were noted including the imperative to develop a clear programme of work to support delivery of the Group priorities.

In light of the imminent appointments of the Interim Group Chair and the Croup Chief Executive Officer, it was agreed that a more proactive approach to communication and engagement is required with a focus on staff.

Place development
Further to recent discussion by all Provider CEOs and Chairs within Norfolk and Waveney, a discussion took place around the importance of Place and local delivery as we move towards a Group model, recognising the broader changes which are in train in relation to Local Government Reorganisation and the alignment of NCH&C and CCS. Tracey Bleakley, Accountable Officer N&W ICB noted that discussions are in train within the ICB to strengthen delivery at Place in order to ensure that the needs of our local communities are met effectively.

N&W ICB Financial Recovery Board
Lesley Dwyer, SRO for the ICB Financial Recovery Board provided a detailed update. The work of the Financial Recovery Board is being reset to ensure clear focus and delivery of key priorities recognising the challenging financial position of the Norfolk and Waveney Integrated Care System. It was noted that work continues across all Partner organisations to identify and discuss opportunities for financial improvement considering the associated impact, risks and interdependencies. The FRB will then consider both local and system wide impact assessments of the proposed work. This work is in train to align with the national planning timescales.

Aligned approach to transformation
A detailed update on the work was shared by Carly West-Burnham, Director of Strategy and Integration, QEH. Cross programme (Acute Clinical Strategy / Electronic Patient Record, New Hospital and Trust Transformation teams) alignment continues with a focus on development of a clear view of the programme inter-dependencies and risks underpinned by development of an action plan which is focused on delivery.

The emergence of the Group Model has provided clear impetus for the further development of the work with agreement of timescales for development of an aligned approach to PMO / Quality Improvement and Transformation across the three Trusts.

Implementation of a Shared Electronic Patient Record (EPR)
A detailed update on the Programme was shared by Carly West-Burnham, Director of Strategy and Integration, QEH on behalf of Alice Webster, Programme SRO. Progress on the programme was discussed and noted including the current focus on Design, build and Test and recruitment to key roles to support delivery.

Acute Clinical Strategy
An update on the Programme was shared by Jo Segasby, Programme SRO. The progress of the Phase One Specialty Clinical Networks was highlighted with finalisation of Strategic Service Development Plans for all 22 Networks planned for the end of March. Work continues at pace for the priority specialties; Maternity, Oncology and Stroke. Planning is now in train for the Phase 2 specialties.

Community Diagnostic Centre Programme
An update on the Programme was shared by Julia Kazimierczak, DAC Deputy Programme SRO. Progress on the programme was noted including the successful opening of the NNUH CDC facility in late February 2025. The planned programme closure process was discussed including the outstanding actions required in relation to Digital RIS integration and implementation of an aligned Policy Management System which has been procured.

Thanks were given to the Programme team for their work on delivery recognising the significant progress that has been made for the benefit of our local populations with the opening of three Community Diagnostic Centres within Norfolk and Waveney.

Norfolk and Waveney New Hospitals Programmes
Lesley Dwyer, CEO NNUH gave an overview of the latest position for both the QEH and JPUH schemes. The Terms of Reference for the Norfolk and Waveney New Hospital Programme Reference Group were discussed and approved.

Trust Boards are asked to note and approve the key outcomes from the March Committees in Common meeting.

James Paget University Hospitals NHS Foundation Trust

Report to the Trust Board of Directors dated Friday, 28 March 2025

Title: Board Risk Appetite Statement

Sponsor:	Chief Executive
Author:	Head of Corporate Affairs
Previous scrutiny:	Board Risk Workshop December 2024
Purpose:	The paper is presented for Approval.
Relevant strategic priorities:	✓ 1. Caring for our patients ✓ 2. Supporting our people ✓ 3. Collaborating with our partners ✓ 4. Enhancing our performance
Impact assessments:	☐ Quality ☐ Equality ☐ GDPR and DPA ✓ Not applicable

Does this paper have any impact of the Norfolk and Waveney Integrated Care System or Great Yarmouth and Waveney Place partners? ☐ Yes ✓ No

Executive Summary

This report presents the revised Board Risk Appetite Statement (the RAS) for consideration by the Paget's Board. Developed through Board-wide discussions, including a workshop in December 2025, and endorsed by the Audit Committee. This RAS provides a structured approach to risk management, appetite, and escalation.

The framework aligns with ISO risk management principles and the NHS National Patient Safety Agency (NPSA) 5x5 Risk Scoring Matrix, ensuring a clear, standardised approach to assessing and managing risks. Key elements include:

- Defined Risk Categories: Clear appetite levels for Quality, People and Culture, Operations, Finance, Compliance, Facilities, Reputation, and Research & Innovation.
- Escalation Protocols: A structured response for risks exceeding defined tolerance levels, ensuring timely governance intervention.
- Proactive Risk Monitoring: The planned RA Dashboard will provide real-time insights, supporting proactive decision-making.
- Strategic: Future scalability, facilitating potential adoption by the Group Board without costly adjustments.

The Board is invited to review this Risk Appetite Statement as a key governance document, ensuring risk is managed effectively and in alignment with globally recognised risk treatment practices.

Secretary's Recommendation

The Board is recommended to approve the Risk Appetite and supporting schedules for adoption with immediate effect across the Trust.

Stebbings,Susan 24/03/2025 09:14:17

Introduction

This report presents the Board Risk Appetite Statement for approval, following its development through a Board-wide workshop in December 2024 and endorsement by the Audit Committee. It has endorsement from the Executive Directors and Non-executive Directors (through designated Board Committees).

The statement provides a structured and standardised approach to risk management, aligning with ISO risk principles and the NHS National Patient Safety Agency (NPSA) 5x5 Risk Scoring Matrix. It defines clear risk categories, appetites, and escalation protocols to ensure risks are managed within agreed tolerances while enabling informed decision-making.

Key Features of the Risk Appetite Statement

Risk Categorisation and Appetite

The framework establishes clear risk appetite levels for the following categories:

- Quality (including Patient Safety, Patient Experience, and Clinical Effectiveness)
- People and Culture (covering capacity, capability, and staff engagement)
- Operational Performance
- Finance (including financial sustainability and “going concern”)
- Regulatory & Compliance
- Facilities & Estates
- Reputation
- Research & Innovation

Risk Escalation & Governance:

- Risks are assessed using the NPSA 5x5 Risk Matrix (scored based on Likelihood and Impact).
- Defined escalation triggers ensure timely governance intervention, particularly for risks rated High (8-12) or Extreme (15-25).
- The framework integrates directly with the Board Assurance Framework (BAF) to strengthen oversight.

Proactive Risk Monitoring:

- The forthcoming Risk Appetite (RA) Dashboard will enhance real-time risk intelligence, allowing the Executive to act before risks exceed tolerance levels.
- The 2025-26 BAF Risk Register revision will incorporate trigger points for early risk identification and response.

Benefits for Paget’s Board

- Ensures risk management consistency across all governance levels.
- Enhances regulatory compliance by aligning with ISO standards and recognised healthcare risk practices.
- Supports informed decision-making, balancing risk mitigation with strategic opportunities.
- Facilitates potential future adoption by the Group Board, without requiring costly adjustments.

Conclusion and Next Steps

The Board is invited to review and approve this Risk Appetite Statement as a key governance framework. Approval will ensure that risks are managed effectively, escalated appropriately, and aligned with best practices in NHS risk management.

Pending approval, the next steps will include:

- Integration of the statement into operational governance processes.
- Implementation of the RA Dashboard for enhanced risk visibility.
- Ongoing monitoring and refinement as part of the Board Assurance Framework (BAF) review in 2025-26.

Board Risk Appetite Statement

We recognise the importance of setting our risk approach to define how we manage risk and opportunity. Once we have set it, we work to it, minimising risks that could harm patient care, endanger the safety of our colleagues, or compromise strict safety and professional standards.

We look at all risks to help us work effectively with our money and do properly what the public, patients, and the Department of Health and Social Care (DHSC) expect of us.

We carefully consider every decision to ensure risks are known, measured, managed, and kept within our acceptable levels. This also allows us to make sure opportunities are used effectively.

This approach helps us to achieve our strategic objectives and achieve the best outcomes, especially prioritising safety and wellbeing for all.

Risk Categories, Appetite, Tolerance, and Escalation Framework

This Risk Appetite Statement aligns with the NHS National Patient Safety Agency (NPSA) 5x5 Risk Matrix, which defines risks based on a combination of Likelihood (1-5) and Impact (1-5). This ensures risk assessment is structured, standardised, and supports clear escalation thresholds. Risks are categorised as Low (1-3), Moderate (4-6), High (8-12), or Extreme (15-25), with governance responses calibrated accordingly.

To ensure consistency across all risk domains, the Board adopts a standard escalation framework aligned with NHS best practice. Risks rated High (8-12) or above must be escalated to the appropriate governance level, ensuring proactive intervention before risks exceed tolerance thresholds.

Category	Risk Appetite	Risk Tolerance[1]	Response and Escalation if outside of risk tolerance range (see list below)[2]
1. Quality[3]			To be established by the Group Board
a. Patient Safety	Low	1-3	
b. Patient Experience	Moderate	4-6	
c. Clinical Effectiveness	Moderate	4-6	
2. Operational Performance			
a. Operational Targets[4]	Low	1-3	
3. People and Culture			To be established by the Group Board

[1] Specify metric triggers for escalation (e.g., risk score exceeds 3, regulatory non-compliance identified).
[2] This section provides actionable steps for addressing risks outside the Risk Tolerance range. Tailor Responses to Risk Type: For instance, "Enhance First Line of Defence" applies more to operational risks, while "Escalation to Board Intervention" might suit strategic risks. Also categorise interventions by urgency or impact. For example: Immediate Action Required: Enhance First Line of Defence, Increased Communication.
[3] NHS Quality is defined as Patient Safety, Patient Experience, and Clinical Efficacy (effectiveness)
[4] Such as length of stay and NCTR.

Category	Risk Appetite	Risk Tolerance[1]	Response and Escalation if outside of risk tolerance range (see list below)[2]
a. Capacity	Low	1-3	
b. Capability	Low	1-3	
c. Culture/ engagement	Moderate	4-6	
4. Financial			To be established by the Group Board
a. Capital	Moderate	4-6	
b. Revenue	Moderate	4-6	
c. Going Concern[5]	Low	1-3	
5. Regulatory and Compliance			To be established by the Group Board
a. Statute	Low	1-3	
b. Regulation	Low	1-3	
c. Codes[6]	Moderate	4-6	
d. Practice standards[7]	Low	1-3	
6. Facilities and Estate			To be established by the Group Board
a. Clinical facilities and estate	Low	1-3	
b. Administrative facilities and estate	Moderate	4-6	

[5] Going concern is fundamentally tied to financial sustainability, it also encompasses operational and strategic risks, making it a multifaceted category within corporate risk assessments.
[6] Codes of conduct and governance codes.
[7] Such as NICE guidance.

Category	Risk Appetite	Risk Tolerance[1]	Response and Escalation if outside of risk tolerance range (see list below)[2]
7. Reputation[8]			To be established by the Group Board
a. Public	Moderate	4-6	
b. Staff[9]	Low	1-3	
8. Research and Innovation[10]			To be established by the Group Board
a. Harm to participants	Low	1-3	
b. Failure of R/I	High[11]	8-12	

Rating 1-3 = Low risk	Rating 4-6 = Moderate risk
Rating 8-12 = High risk	Rating 15-25 = Extreme risk

[8] Example: Public: Media relations, patient satisfaction surveys. Professions: Professional body audits or staff feedback.
[9] Such as recruitment and retention of staff affected by reputation, publicity, social media.
[10] Note: In Research and Innovation, “High” appetite is considered good because taking opportunities that may not succeed leads to innovation and learning.
[11] This highlights how a “High” risk appetite in R&I aligns with the Trust’s innovation goals but still requires safeguarding participants through robust ethics and compliance frameworks.

Risk Exception Responses (for risks out of agreed tolerance range)

The extant Board Assurance framework Report (BAF) does not provide obvious trigger points for risks outside of tolerance. A revised version in 2025-26 will identify trends, anomalies, and control effectiveness in near real-time. Risks approaching escalation thresholds will be flagged ion this “RA dashboard”, allowing the Board to make proactive interventions before they exceed tolerance levels. This will ensure risk management is intelligence-driven rather than reactive.

These responses, interventions, or escalations will be documented in the applicable SOP.

1. Enhance/ strengthen First Line of Defence (people managing risk hands-on)
2. Conduct QIA
3. Measuring Resilience
4. Staff Wellbeing and Engagement
5. Patient Engagement
6. Increased Communication
7. Escalation to other authority
    - Hospital Leadership Team Intervention
    - Group Executive Support
    - Enhanced Board Support
    - Direct Board Intervention (akin to “special measures”)

8. Revise Risk Appetite

9. Revise strategic direction and policy

NHS
James Paget University Hospitals
NHS Foundation Trust

Report to the Trust Board of Directors dated Friday, 28 March 2025

Title: Board Committee Self-assessment and Terms of Reference Review 2025

Sponsor:	Chair			
Author:	Head of Corporate Affairs			
Previous scrutiny:	Board Committees Q4 2024/25			
Purpose:	The paper is presented for Approval.			
Relevant strategic priorities:	✓ 1. Caring for our patients	✓ 2. Supporting our people		
	✓ 3. Collaborating with our partners	✓ 4. Enhancing our performance		
Impact assessments:	☐ Quality	☐ Equality	☐ GDPR and DPA	✓ Not applicable

Does this paper have any impact of the Norfolk and Waveney Integrated Care System or Great Yarmouth and Waveney Place partners? ☐ Yes ✓ No

Introduction

This report summarises the findings of the 2025-26 Committee Self-Assessment survey, providing an overview of committee performance, key strengths, and areas for refinement. The assessment is timely, aligning with the upcoming planned transition to a unified risk and assurance committee under the Group Governance Framework. The three Audit Committees too are expected to meet as Audit Committees in Common.

The report also confirms the review of Board Committee Terms of Reference to remain current with changing industry standards.

Secretary's Recommendation

The Board is recommended to:

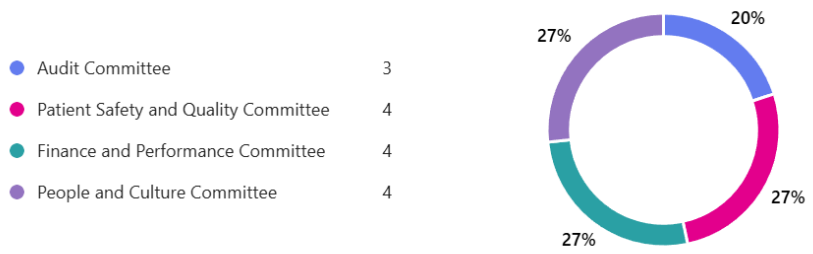
- Note the Committee Self-assessment for assurance,
- Approve the revised Audit Committee Terms of Reference, and,
- Note the imminent transition to the group governance framework and its potential implications for Trust Board Committees.

Board Committee Self-assessment

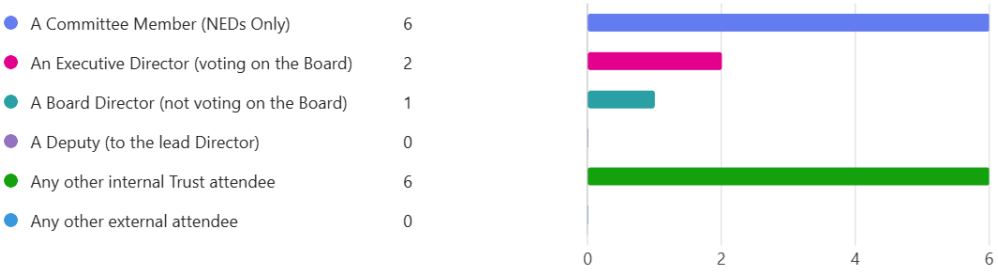
The Survey

The self-assessment was conducted using an anonymised online form with returns analysed impartially.

There were fifteen returns:



Distributed as follows:



Key Findings

Best Performing Indicators

- Committee Objectives – All committees demonstrated strong alignment with strategic priorities.
- Committee Role Clarity – Members have a clear understanding of their oversight responsibilities.
- Decision-Making Processes – Committees effectively ensure governance decisions are actioned.
- Committee Engagement – Strong participation and challenge across governance matters.

Top Performing Committees

- Audit Committee – Strongest in governance oversight, ensuring compliance and robust decision-making.
- Finance and Performance Committee – High engagement, with structured discussions on financial stewardship.
- Patient Safety and Quality Committee – Effective participation, particularly in oversight of patient safety and care quality.

Areas for Improvement

While committee structures are effective overall, the transition to a unified risk and assurance committee presents an opportunity to refine key areas:

Committees Needing Further Strengthening

- Finance and Performance Committee – Requires refinement in strategic oversight and assurance reporting.
- Patient Safety and Quality Committee – Some challenges in balancing operational pressures with governance focus.
- People and Culture Committee – Needs improved integration of cross-cutting themes and more structured engagement.

Indicators Needing Enhancement

- Chair's Reporting to Board – Committee findings and governance implications should be communicated with greater clarity and conciseness.
- Committee Leadership Feedback – Some variability in leadership effectiveness; structured facilitation could be improved.
- Efficiency Improvements – Refinements in meeting structures, reporting processes, and operational integration are required.

Governance Expectations: Active Engagement

While committee engagement is generally strong, the self-assessment revealed instances of perceived "low engagement" during meetings. Committee members are expected to:

- Maintain active participation in discussions.
- Ensure their contributions support governance oversight and assurance.
- Approach committee work with full engagement, diligence, and attentiveness.

Recommendations for the Unified Committee Model

The transition to a unified risk and assurance committee is an opportunity to:

Preserve Best Practices

- Retain clear committee objectives and well-defined governance roles.
- Maintain structured decision-making processes with clear action tracking.
- Ensure strong engagement and active participation from all members.
- Leverage shared learning across committees to enhance triangulation of governance intelligence.
- Leverage data-driven "Board Intelligence" to inform NED scrutiny and assurance deliberations.

Refine and Retire Ineffective Practices

- Reduce duplication in committee assurance activities.
- Retire agenda items that do not add strategic governance value.
- Clarify the distinction between governance oversight and operational management.
- Minimise the verbose reporting requirement on Hospital leadership Teams to ensure the Board's governance and assurance provisions do not hamper service provision and take unnecessary preparation time.

Provisional Steps for Implementation

- April 2025 – Committees begin operating under a unified agenda.
- Mid-Year Review – Assessment of effectiveness and adjustments as required.

- October 2025 – Full transition to a unified risk and assurance committee.

Conclusion

The Committee Self-Assessment confirms strong governance oversight while identifying areas for improvement that will inform the transition to a unified risk and assurance committee.

This structured approach will ensure:

- A clear separation between Board Governance and Hospital Management.
- A more efficient, intelligence-led, and strategic committee structure.
- Greater alignment with governance best practices and assurance principles.
- Reduction of reporting effort for Hospital Leadership Teams to ensure the Board's governance and assurance provisions do not hamper service provision and take unnecessary preparation time.

Board Committee terms of Reference Review

Introduction

Terms of Reference for each Board Committee were reviewed by the Trust Secretary to ensure they remain fit for purpose as the Trust heads into a group governance framework. The Board's designated committees (non-statutory committees) did not require amendment.

The statutory Audit Committee Terms of Reference were reviewed in detail to ensure they remained inclusive of all the most recent HFMS Audit Committee Handbook recommended clauses and extend to the technologically advance operating environment to include oversight of:

- digital transformation,
- cybersecurity risks,
- artificial intelligence (AI) systems, and,
- the environmental and social implications of corporate governance ("ESG").

Process

A diligent exercise in aligning the revision to the HD+FMS Handbook was undertaken in preparation of the redraft by the current Audit Committee Chair, and the previous Audit Committee Chair (the SID) so as to apply their experience to the redraft, rather than simply copy from the handbook.

The Trust Secretary edit these changes into the ToRs to ensure consistency and to avoid duplication.

The Audit Committee received the redrafted Terms of Reference and having discussed these with the Trust's Auditors undertook to recommend the redraft to the Board for adoption and implementation.

This version of NHS FT Audit Committee Terms of Refence represents the most up to date and thorough going set of AC ToRs across the region to date.

Draft for Approval

The redrafted Audit Committee Terms of Reference are attached for the Board's approval.

There are no changes proposed to the designated Board Committee Terms of Reference.

James Paget University Hospitals NHS Foundation Trust

Terms of Reference – Audit Committee

Document Control

Document Author:	Head of Corporate Affairs		
Document Owner:	Board of Directors		
Electronic File Name:	Audit Committee Terms of Reference		
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For Use By:	Trust Board of Directors		

Version History

Version	Date	Revision Description	Editor
1.0	July 2012	Version number added	AD Governance, Safety & Compliance
1.1	July 2013	Annual review	Audit Committee
1.2	September 2014	Annual Review	Audit Committee
1.3	September 2015	Annual Review	Audit Committee
1.4	July 2016	Annual Review	Audit Committee
1.5	July 2017	Annual Review	Audit Committee
1.6	October 2018	Annual Review	Audit Committee
1.7	September 2019	Annual Review	Audit Committee
1.8	September 2021	Annual review	Audit Committee
1.9	September 2022	Annual review	Head of Corporate Affairs
2.0	March 2024	Annual Review	Head of Corporate Affairs
2.1	February 2025	Annual Review	Head of Corporate Affairs

Table of Contents

1. Introduction

The Audit Committee (the **Committee**) is a statutory committee established by the Trust Board of Directors (the **Board**) to monitor, review and report to the Board on the suitability and efficacy of the Trust's provisions for governance, risk management, and internal control. This includes oversight of digital transformation, cybersecurity risks, artificial intelligence (AI) systems, and environmental, social, and corporate governance (including "ESG[1]") considerations.

The Committee is a non-executive committee of the Board and has no powers other than those specifically delegated in these terms of reference.

To ensure that the powers and activities of the Committee are undertaken in a transparent and accountable manner, the Code of Governance for NHS Provider Trusts[2] recommends that the committee's terms of reference should be made publicly available.

2. Purpose and Function

The Committee shall provide the Board with tested assurance that an appropriate and effective system of governance, risk management, and internal control is in place to ensure that business is conducted in accordance with the law and proper standards, and that affairs are managed to secure safe, economic, efficient, and effective use of resource regarding value for money as directed by the Board. This function of the Committee shall include both the clinical and non-clinical activities of the Trust. This includes both the clinical and non-clinical activities of the Trust, as well as digital governance, cybersecurity, and AI systems.

In carrying out its duties, the Committee shall primarily utilise the work of Internal Audit, External Audit, Local Counter Fraud Services (LCFS), and other assurance functions but will not be limited to these sources.

It shall seek reports and assurances from directors and managers as appropriate, concentrating on the overarching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

3. Authority and Accountability

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[1] ESG stands for Environmental, Social, and Governance, and it acts as a framework to measure a business's ethical and sustainable behaviour. It is a set of standards that indicate how a corporation operates regarding the planet and its people. ESG assesses how an organisation manages risks and opportunities related to these criteria.

[2] The new Code of Governance for NHS Provider Trusts (the Code) came into force on 1 April 2023. NHS England has issued the Code to help NHS Providers deliver effective corporate governance, contribute to better organisational and system performance and improvement, and discharge their duties in the best interests of patients, service users and the public.

The Committee is authorised by the Board to:

- Investigate any activity falling within its terms of reference.
- Seek any information it requires from any member of staff and all members of staff are directed to co-operate with any request by the Audit Committee.
- Obtain outside legal or other independent professional advice, particularly to ensure compliance with the new Global Internal Audit Standards (GIAS) effective from January 2025.
- Request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary or expedient to the carrying out of its functions.

The Committee is accountable to the Board for the discharge of the duties and responsibilities set out in these terms of reference.

4. Membership and Attendees

The Committee shall be appointed by the Board and shall consist of three Non-executive Directors, one of whom should be appropriately qualified, ~~for example~~i.e., be an accountant or have financial expertise, and one of whom shall be a member of the "Patient Safety and Quality Committee." The Committee should also include members with expertise in digital governance, cybersecurity, and AI systems.

One of the members shall be appointed Chair of the Committee by the Board. The Chair of the Trust shall not be a member of the Committee.

Members of the Committee should aim to attend all scheduled meetings.

The following Officers of the Trust shall be required to attend, but shall not contribute to the quorum of the Committee:

- Chief Finance Officer
- Head of Financial and Commercial Accounting

The Head of Internal Audit and a representative of the External Auditors shall attend meetings as determined by the agenda and the Chair's requirements.

A representative of the local counter fraud service may be invited to attend meetings of the Committee as required.

The Chief Executive and other Executive Directors shall be invited to attend at least annually to discuss the process for assurance that supports the Annual Governance Statement (the **AGS**) and to discuss the areas of risk that are the responsibility of that director.

The Chair of the Trust may be invited to attend meetings of the Committee as appropriate.

5. Quorum

The quorum necessary for the transaction of business shall be two members.

A duly convened meeting of the Committee at which a quorum is present shall be competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the Committee.

6. Frequency of Meetings

Meetings shall be held not less than five times a year, aligned with key reporting and audit cycles, especially considering the new requirements and standards.

The Chair, any member of the Committee, the External Auditor, Head of Internal Audit and Trust Secretary may request a meeting if they consider that one is necessary.

At least once a year the Committee shall meet privately with the External and Internal Auditors.

7. Secretariat Functions

The Trust Secretary will arrange for the recording of meetings and for appropriate support to the Chair and Committee members.

Formal records of the meeting (Agenda, Minutes, Decision Log, and Action Log) will be prepared using the Trust's standard.

Notice of each meeting confirming the medium or venue, time, and date, together with an agenda of items to be discussed, shall be made available to each member of the Committee no less than 5 clear (working) days before the date of the meeting. Supporting materials shall be made available no later than 3 clear (working) days before the date of the meeting. Ideally, meeting materials should accompany publication of the Agenda.

Draft records (minutes, decision log, action log, recorded exceptions) shall be agreed promptly with the Chair of the Committee. Once authorised by the Chair of the Committee, the draft records may be published to the other members of the Board.

8. Meeting Transparency and Probity

The Chair shall ascertain, at the beginning of each meeting, the existence of any actual, potential, or perceived conflicts of interest with matters on the agenda or related matters.

Such conflicts of interest shall be managed by the Chair and recorded in the minutes and if appropriate, the public Register of Declarations of Interest.

9. Duties of the Committee

The duties of the Committee shall include:

9.1 Review of Governance, Risk Management, and Internal Control

The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management, and internal control across the whole of the Trust's activities (both clinical and non-clinical), that supports the achievement of the Trust's objectives. This includes the management of digital transformation risks, AI systems, and ESG responsibilities.

The Committee shall review the adequacy of:

- all risk- and control-related disclosure statements, together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to submission to the Board;
- the underlying assurance processes that indicate the degree of achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure notices;
- the policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and any related reporting and self-certifications; and,
- policies and procedures for all work related to counter fraud, bribery and corruption as required by the NHSCFA.

9.2 Internal Audit

The Committee shall ensure that there is an effective internal audit function established by management that meets the mandatory Public Sector Internal Audit Standards and the upcoming Global Internal Audit Standards, providing appropriate independent assurance to the Audit Committee, the Chief Executive, and the Board~~The Committee shall ensure that there is an effective internal audit function established by management that meets mandatory Public Sector Internal Audit Standards and provides appropriate independent assurance to the Audit Committee, the Chief Executive, and the Board~~.

To achieve this the Committee shall:

- Consider the provision of the Internal Audit service, the cost of the audit services and any questions of resignation and dismissal.
- Review and approve the Internal Audit strategy and operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the Trust as recommended by the Executive.
- Consider the findings of internal audit work (and management's response) and seek evidence of effective co-ordination between the Internal and External Auditors and LCFS providers to optimise resources.
- Consider the effectiveness of Trust management in implementing agreed recommendations from audit reports on a regular basis.
- Review the resourcing and standing of the Internal Audit function.
- Seek assurance on the independence of Internal Auditor.
- Review annually, the effectiveness of the Internal Audit service.

9.3 External Audit

The Committee shall review the work and findings of the External Auditors and consider the implications and management's response to their work. The Committee shall:

- Oversee the conduct of a market testing exercise for the appointment of an External Auditor at least once every five years, and make recommendations in relation to the appointment, reappointment, or removal of the External Auditor for approval by the Council of Governors.
- Discuss and agree with the External Auditor, before the audit commences, the nature and scope of the audit as set out in the Annual Plan;
- Discuss with the External Auditors their local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee;
- Where relevant, develop and implement a policy on the engagement of the External Auditor to supply non-audit services; and
- Review all External Audit reports, including the report to those charged with governance (the Board), agreement of the annual Audit Findings Report before submission to the Board and any work carried outside the annual audit plan, together with the appropriateness of management responses.

9.4 Financial Reporting

The Committee shall monitor the integrity of the financial statements of the Trust and any formal announcements relating to the Trust's financial performance.

The Committee should also ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board.

The Committee shall seek assurance from the External Auditors and the finance team to review and reflect on:

- The Annual Governance Statement and other disclosures relevant to the Terms of Reference of the Committee.
- Changes in, and compliance with, accounting policies, practices, and estimation techniques.
- Unadjusted misstatements in the financial statements.
- Losses and compensations.
- Significant judgements in preparation of the financial statements.
- Significant adjustments resulting from the audit.
- The Auditor's letter of representation.

- Qualitative aspects of financial reporting.

9.5 Annual Accounts

The Committee shall review the annual statutory accounts, before they are presented to the Board, to determine their completeness, objectivity, integrity, and accuracy. This review shall cover but not be limited to:

- The meaning and significance of the figures, notes, and significant changes.
- Areas where judgment has been exercised.
- Adherence to accounting policies and practices.
- Explanation of estimates or provisions having material effect.
- The schedule of losses and special payments.
- Any unadjusted statements.
- Any reservations and disagreements between the External Auditors and management which have not been satisfactorily resolved.

9.6 Quality Report

While it is the responsibility of the Patient Safety and Quality Committee to review the content of the Quality Report before it is presented to the Board, the Committee shall receive any external audit assurance opinion that may be required, and oversee the audit plan, if required, in relation to the Quality Report.

9.7 Clinical Audit Function

In reviewing the work of the Patient Safety and Quality Committee relating to clinical risk management, the Committee will wish to satisfy itself on the assurance that can be gained from the clinical audit function. This shall include requesting specific reports by exception from clinical audit as may be appropriate to the overall arrangements.

9.8 Governance and Procedural Documentation

The Committee shall review on behalf of the Board, proposed changes to the principal governance and procedural documentation including the FT Constitution, Standing Orders and Standing Financial Instructions, the Scheme of Reservation and Delegation, the Policy for Declarations of Interest, Gifts, and Hospitality, Standards of Business Conduct, and related Codes of Conduct.

The Committee shall examine, at least annually the circumstances of any significant departure from the requirements of any of the foregoing, whether those departures relate to a failing, an overruling, or a suspension.

9.9 Counter Fraud

The Committee shall satisfy itself that the organisation has adequate arrangements in place for countering fraud and shall review the outcomes of counter fraud work.

In so doing the Committee shall:

- Consider the provision of the LCFS service, the cost of the audit services and any questions of resignation or dismissal, and review:
    - Resourcing of the LCFS service.
    - The periodic LCFS status reports.
- Approve the:
    - LCFS annual report.
    - Annual LCFS work plan.

9.10 Other Assurance Functions

The Committee shall review the work of other Board Committees which may provide relevant assurance to the Audit Committee's own scope of work.

The Committee shall also:

- Examine any other matters referred to the Committee by the Board and initiate any investigation as determined necessary by the Audit Committee.
- Review annually the suitability accounting policies of the Trust and make appropriate recommendations to the Board on any proposed changes.

10. Reporting Arrangements

The Committee shall report to the Board and the Council of Governors on its work in support of the Annual Governance Statement, specifically commenting on the fitness for purpose of the Board Assurance Framework, the completeness and embeddedness of risk management in the Trust, the integration of governance arrangements, the appropriateness of evidence compiled to demonstrate fitness to register with the CQC, and the robustness of the processes behind the quality accounts~~The Committee shall report to the Board and the Council of Governors on its work in support of the Annual Governance Statement, specifically commenting on the fitness for purpose of the Board Assurance Framework, the completeness and 'embeddedness' of risk management in the Trust, the integration of governance arrangements, the appropriateness of evidence compiled to demonstrate fitness to register with the CQC and the robustness of the processes behind the quality accounts~~.

The minutes of Committee meetings shall be submitted to the Board and the Chair of the Committee shall draw to the attention of Board any issues that require disclosure to the full Board or require executive action.

The Committee shall report to the Board at least annually in a report which sets out how the Committee has discharged its responsibilities and met its terms of reference.

11. Review of Effectiveness and Terms of Reference

The Committee shall, at least once a year, review its own constitution and terms of reference to ensure it is operating at maximum effectiveness and recommend any changes it considers necessary to the Board for approval.

The Committee shall utilise the self-assessment checklist provided in the NHS Audit Committee Handbook published by the HFMA (or equivalent) to conduct the review.

12. Trust Values and Behaviours

Implementation of these Terms of Reference by the Committee is required to conform to the Trust's values and behaviours which are available here: https://bit.ly/PAGETValues.

Or scan this QR code with your mobile camera:

13. Distribution Control

Printed copies of this document should be considered out of date. The current version is available from the Trust Intranet.

14. Key References

- NHS Audit Committee Handbook, HFMA Fourth Edition 2018
- NHS Providers Guidance
- UK Corporate Governance Code, Financial Reporting Council, 2018
- The Chartered Governance Institute UK and Ireland Guidance, Terms of Reference for the Audit Committee, May 2022
- NHS Foundation Trust Code of Governance, Monitor, July 2014
- National Health Service Act 2006 (NHS Act 2006)
- Healthy NHS Board 2013: Principles for Good Governance, NHS Leadership Academy, 2013
- Financial Reporting Council: Guidance on Audit Committees, 2016
- The NHS Provider Licence: Monitor, 2014
- Trust Standing Orders and Standing Financial Instructions

15. Model Committee Meeting Agenda

Topic 1. Chair's welcome and Declarations of Interest

Topic 2. Minutes and Actions

Topic 3. Governance and Risk

Topic 4. Quality (patient safety, patient experience, clinical effectiveness), including ~~and~~ Clinical Audit

Topic 5. Financial Reporting

Topic 6. Internal Audit

Topic 7. External Audit

Topic 8. Counter Fraud

Topics may be taken in an order that suits the availability of required attendees and does not require their being attendance for topics not within their specialism.

James Paget University Hospitals NHS Foundation Trust

Report to the Trust Board of Directors dated Friday, 28 March 2025

Title: Annual Board Statement of Compliance with the Fit and Proper Persons Regulations 2025

Sponsor:	Chair			
Author:	Head of Corporate Affairs			
Purpose:	The paper is presented for Assurance.			
Relevant strategic priorities:	✓ 1. Caring for our patients	✓ 2. Supporting our people		
	✓ 3. Collaborating with our partners	✓ 4. Enhancing our performance		
Impact assessments:	☐ Quality	☐ Equality	☐ GDPR and DPA	✓ Not applicable

Does this paper have any impact of the Norfolk and Waveney Integrated Care System or Great Yarmouth and Waveney Place partners? ☐ Yes ✓ No

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Introduction

This report provides assurance to the Board that the Trust remains fully compliant with the NHS Fit and Proper Persons Regulations (FPPR). The Trust has implemented robust systems to ensure all Board members meet the regulatory requirements, with all documentation appropriately recorded for future reference. This report outlines the specific actions taken to demonstrate compliance during a Care Quality Commission (CQC) inspection.

Key Points

1. Appointment Checks

Comprehensive pre-employment checks are conducted for all newly appointed directors. These include:

- Disclosure and Barring Service (DBS) checks
- Full employment history verification
- Validation of professional qualifications, skills, and experience

Additional checks include reviewing the Employment Tribunal Decision register and verifying learning records and appraisals.

2. Ongoing Monitoring

The Trust has implemented an annual self-attestation process, requiring all directors to confirm their continued fitness and propriety.

Regular monitoring is conducted, including:

- Checks against disqualified directors and bankruptcy/insolvency registers
- Verification of professional registration status, repeated annually to ensure continued compliance.

3. Record Keeping

All FPPR checks, appraisals, and learning records are maintained securely in systems such as Electronic Staff Record (ESR).

Improvements in record-keeping standards ensure that personnel files are complete, facilitating monitoring and auditing of compliance.

4. Policy and Framework Implementation

The Trust adheres to the Fit and Proper Person Test Framework developed by NHS England, ensuring standardised processes for:

- New starters – comprehensive pre-appointment verification
- Existing directors – annual reassessment and validation
- Leavers – ensuring exit procedures align with compliance requirements

The Chair of the Board provides assurance to the Regional Director, using a template mandated by NHS England.

5. Governance and Reporting

Compliance with FPPR is reported in the Trust's Annual Report, ensuring transparency and adherence to regulatory expectations.

Any concerns regarding an individual's fitness or propriety are addressed through appropriate procedures, such as capability or disciplinary processes.

6. Appraisal

Directors undergo regular appraisals, with records of learning and development maintained to evidence ongoing competence. Guidance is provided to ensure directors fully understand their responsibilities under FPPR and remain informed of regulatory updates.

Conclusion

The Trust has taken the necessary steps to ensure compliance with the NHS Fit and Proper Persons Regulations. Robust processes are in place for appointment checks, ongoing monitoring, record-keeping, oversight, and appraisal. The Board can be assured that all relevant individuals have been assessed against the necessary criteria, with compliance records diligently maintained.

Recommendation

The Board is recommended to note the assurances provided in this report and confirm continued compliance with the NHS Fit and Proper Persons Regulations for the record.