Board of Directors Meeting in Public (Part A)

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

MS Teams

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*

- Paul Morris, Chief Nurse

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 301224).pdf (5 pages)

10:05 - 10:25
20 min

2. Staff and Patient Experience Programme

Stakeholder Engagement *Chief Nurse*

2.1. Departmental Presentation - Renal

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*

- 29 November 2024

3.1 Minutes_Board of Directors Meeting in Public (Part A)_291124 DRAFT - MFr.pdf (11 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.pdf (1 pages)
3.2. Briefing on challenges relating to alcohol service - relating to action 2.1.pdf (2 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 - 31 January 2025 DRAFT v2.pdf (14 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*

- 17 December 2024
- 21 January 2025

5.2. Finance and Performance Committee

For Assurance *Committee Chair*

- 18 December 2024
- 22 January 2025

5.3. People and Culture Committee

For Assurance *Committee Chair*

- 19 December 2024

5.4. Audit Committee

For Assurance *Committee Chair*

- No meetings held

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 - 2025-01-31.pdf (3 pages)
6.1. BAF Risk Register 2025-01-31.pdf (5 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 - Dec-24.pdf (8 pages)

11:22 - 11:32
10 min

8. Quality, People, and Finance

8.1. Chief Nurse Staffing Report

For Assurance *Chief Nurse*

(5 minutes)

8.1 Chief Nurse Board Report - Dec-24.pdf (22 pages)
8.1. NStf-Fil V44.12 December 2024 Unprotected.pdf (1 pages)

8.2. Clinical Negligence Scheme for Trusts (CNST) Submission

Approval *Chief Nurse*

(5 minutes)

8.2 CNST - Cover.pdf (1 pages)
8.2. CNST - Report - Board of Directors -January 2025.pdf (23 pages)

11:32 - 11:52
20 min

9. Strategy and Business Planning

9.1. Estates Plan Progress Review - 6 Monthly

Information *Director of Strategic Projects*

(5 minutes)

9.1 Board of Directors cover sheet for Estates Plan Update report Dec24.pdf (1 pages)
9.1 JPUH Estates strategy - six monthly update report December 24 REVISED FINAL.pdf (15 pages)

9.2. JPUH Green Plan and Sustainability - 6 Monthly

Assurance *Director of Strategic Projects*

(5 minutes)

- 9.2 Board of Directors cover sheet for Six monthly Green Plan and Sustainability report Dec24'.pdf (1 pages)
- 9.2. JPUH Green Plan and Sustainability Update Report - Dec 24.pdf (24 pages)

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

Assurance *Deputy Chief Executive*

(10 minutes)

- 9.3 Trust Strategy Delivery Plan Year 2 Update Trust Board January.pdf (2 pages)
- 9.3. Appendix A - JPUH Strategy Delivery Plan Year 2 Final Q3 Updates.pdf (4 pages)

11:52 - 11:52
0 min

10. Corporate Governance

- Nothing for consideration

11:52 - 12:02
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.

12:02 - 12:07
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.

12:07 - 12:10
3 min

13. Next Meeting

For Information *Chair*

- Friday, 28 March 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
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 29 November 2024, 10:00 - 12:00

Lecture Theatre, Burrage Centre

James Paget University Hospitals NHS Foundation Trust

Attendees

Board members

Mark Friend (Chair), Sally Collier (Non-executive Director), John Hennessey (Non-executive Director), Stephen Javes (Non-executive Director and Senior Independent Director (SID)), Susanne Lindqvist (Non-executive Director), Caitlin Notley (Non-executive Director), Sarah Whiteman (Non-executive Director), Jonathan Barber (Deputy Chief Executive), Vivek Chitre (Chief Medical Officer), Charlotte Dillaway (Chief Operating Officer), Mark Flynn (Director of Strategic Projects), Paul Morris (Chief Nurse), Joanne Segasby (Chief Executive), Edmund Taylor (Chief Finance Officer)

Attendees

Richard Chilvers (Member of the public), Peter Hargrave (Appointed Governor), Charlie Helps (Head of Corporate Affairs), Jacquie Pamphilon (The Guardian Service), Jo Penniston (The Guardian Service), Jayne Geddes (Executive Assistant (Minutes))

Apologies

Sarah Goldie (Director of People and Culture)

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 to the meeting.

1.2. Declarations of Interest

To Note

Chair

The Chair noted changes will be made for Sarah Whiteman (SW).

2. Staff and Patient Experience Programme

Stakeholder Engagement

Chief Nurse

2.1. Departmental Presentation - Gastroenterology and Endoscopy

Staff Engagement

Team Members

The Chair welcomed Jo Brown, Divisional Operational Manager and the Gastroenterology Endoscopy Medical/Clinical Team who gave a presentation on Gastroenterology & Endoscopy services.

The Chair noted the challenges raised and asked for Executive reactions to the presentation. Paul Morris (PM) noted the improvements during the relocation of the ward. Vivek Chitre (VC) recognised the challenges with oncology and agreed to review the alcohol team challenges outside of the meeting. Jon Barber (JB) noted the ward space issue had been highlighted during the quality visit earlier carried out earlier in the day.

The Chair asked who funds the alcohol team. Jo Brown explained the team is funded by NHSE, however, this is not match funded. Funding is agreed in February/March, with staff employed on fixed term contracts. The impact of not having robust finances affects all services within the gastro team. The Chair requested VC to provide update on the issue and feed back to the Board.

ACTION: VC to provide update on financial issues for funding within the Gastro Team and feedback to the Board.

JB asked if the virtual ward opportunities were being maximized and if there were any issues that needed to be addressed. The team indicated that the virtual ward is currently used for liver patients, but there is potential to expand it to other gastroenterology patients but additional staffing would be required. The Team further noted that there is no fast track admission to the virtual ward, patients still have to go come into the Hospital through A&E.

Sally Collier (SC) asked what specific improvements were achieved by relocating the gastroenterology ward. The Team highlighted several benefits, including reduced noise levels, better patient monitoring, and improved staff and patient experience.

Caitlin Notley (CN) asked about the liaison with the Community Drug and Alcohol Team and any challenges faced. The Team indicated that while there are good relationships with external support services, there are challenges related to a "postcode lottery" and the need for improved detox support.

VC commended the team for their work and asked about the challenges related to providing seven-day endoscopy services. The Team reiterated the staffing challenges and the potential to reduce the service to five days if necessary, while also considering future endoscopy developments.

The Chair thanked the Team for the service they provide.

3. Minutes and Matters Arising

For Approval

Chair

3.1. Minutes

For Approval

Chair

Item discussed after 3.2 Action Log

The Chair asked for any changes to the minutes of 27 September 2024.

Joanne Segasby (JS) noted a spelling mistake on page 5, ESIS to read ECIST.

Sally Collier (SC) noted a spelling mistake on page 4, Thurlwell to read Thirwell.

SC requested clarity on 6.1 second bullet point. JS confirmed a new interim regional chief nurse has been appointed and during our initial meeting it was highlighted to her the lack of response from the CQC regarding the maternity service and reinspection.

The Chair confirmed that, subject to the changes highlighted, the Board approved the Minutes as a true record.

3.2. Action Log

For Review

Chair

5.1.3 - Stephen Javes (SJ) gave an update and will continue to be monitored at Committee level. Action to be closed.

2.1 - Charlotte Dillaway (CD) advised spelling error should read patients not papeties.

6.1 - Joanne Segasby (JS) advised to be discussed further during BAF item and requested action to be

reopened which the Chair agreed.

8.6 - Vivek Chitre (VC) highlighted the 7day audit will provide a baseline audit to Finance & Performance Committee and the length of stay metrics are included within the IPR. JS advised the 7day services details a 14hour review by consultants which will impact on length of stay. The length of stay project will improve the audit results for the 7day services. Further detail following the RIO project including learning from the project is requested and will be monitored through the Committee. Action to be closed.

The Board reviewed the action log and agreed for all appropriate To Close actions to be 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 gave an update, noting the following:

- **Paget Awards:** Highlighted the success of the Paget Awards with 800 entries and thanked the charity and events team for organizing the event.
- **Board and Governor Development Seminars:** Mentioned the seminar with Patricia Hewitt, Chair of the ICB, who attended the recent Council of Governors meeting.
- **System Discussions:** Noted various system discussions, including a visit from the ICB non-executive directors and an ICS conference.
- **Financial Targets:** Emphasised the strong focus on hitting financial targets and commended the executive team's grip on finances.
- **Balancing Priorities:** Stressed the importance of balancing finances, patient safety, operating targets, and staff well-being.

4.2. Chief Executive's Update

To Note

Chief Executive

JS gave a report, noting the following:

- The positive outcomes from the UEC CQC Patient Survey and the maternity CQC national results, which showed improvements and recognised the good patient experience provided by the emergency department team.
- The activities during Speak Up Month, promoting listening and responding to concerns, and the launch of a microaggression portal for staff to raise issues anonymously.
- The ongoing staff survey, with a response rate to date of about 40%, equivalent to the previous year. Results are expected by January or February, with public release around March or April.
- The success of the long service staff awards, celebrating staff with over 30 and 40 years of service, and the positive reception of these awards.
- The landing of the EPR software, with teams starting to work on its setup for the go-live in March 2026, and emphasised the need for engagement with teams using demos and test sites.
- Advised the board about being placed back into Tier 1 oversight due to the number of patients waiting over 65 weeks, despite ongoing efforts to improve performance and the upcoming opening of the orthopaedic elective hub in January.

John Hennessey (JH) questioned the rationale behind being labelled as Tier 1 despite being in the top half of the country for some performance metrics. Charlotte Dillaway (CD) explained that the Tier 1 designation was based on the proportion of the total waitlist waiting over 65 weeks and was relative to other organisations.

JH inquired about the timetable for moving out of Tier 1. CD responded that the expectation was to move out of Tier 1 by the next quarter, with ongoing efforts to improve performance.

Stephen Javes (SJ) asked about the Step Up program and whether it was empowering all staff or just the team doing the work. JS clarified that the program's ethos was to promote patient mobility and that the therapy staff were driving this initiative, which would then influence the nursing teams.

5. Board Committee Chairs' Reports

For Assurance

Board Committee Chairs

5.1. Patient Safety and Quality Committee

For Assurance

Committee Chair

Sarah Whiteman (SW) provided a summary of the meetings held on 22 October 2024 and 19 November 2024 noting the following:

- **Assurance Provided:**
  - High confidence in the achievements and ongoing efforts of the surgery, women's, and children's services.
  - Assurance on managing the complaints backlog, with a plan to address it by the end of December.
- **Alerts to the Board:**
  - **Pressure Ulcers:** Identified as an extreme risk with ongoing concerns about the effectiveness of current measures.
  - **Metrics Concerns:** Only one metric met the target, with high rates of falls, a reduction in the Sentinel Stroke National Audit program to level C, and data quality issues related to venous thromboembolism assessments.
  - **Maternity Metrics:** Concerns about reduced normal vaginal delivery rates, breastfeeding, smoking cessation, and two neonatal deaths under review.
  - **Mental Health Integration:** Issues with the joint post with NSFT affecting the integration of mental health-trained staff and delays in assigning responsible clinicians for under-eighteens.
- **Risk Register Process:**
  - Analysing the time taken to identify and address risks, ensuring a streamlined process for getting risks onto the register if appropriate.
- **Balance Between Risk and Performance:**
  - Emphasised the need for the board to review the balance between risk and performance in its delivery plans, considering feedback from the Patient Safety Committee.

PM addressed the concerns about pressure ulcers, mentioning that an extreme risk remains unchanged and that a business case and review of service provision around pressure ulcer management will be presented to HMG shortly.

5.2. Finance and Performance Committee

For Assurance

Committee Chair

Susanne Lindqvist (SL) provided a summary of the meetings held on 23 October 2024 and 20 November 2024 noting the following:

23 October 2024 Committee meeting Assurance Provided:

- **Cancer Faster Diagnostic Standard:** Partly assured, with a shortfall noted but improvements expected by November.
- **Agency Spend:** Assured about the plan in place, despite high spending, with a trajectory for improvement noted.
- **ERF Income:** Partly assured, with concerns about the risk in the second half of the year.
- **Deficit Plan:** Partly assured, with a deficit of £13.4 million noted, later replaced by a £1.1 million deficit plan due to deficit funding.
- **Efficiencies Plan:** Not assured, with a £0.7 million shortfall noted.
- **Strategic Projects:** Assured about the RAAC work progress, partly assured about EPR due to staffing and timing concerns.
- **Alerts to the Board:**
  - **Non-Criteria to Reside Patients:** High number of 143 patients, with a target of 80.
  - **Drop and Go Initiative:** Concerns about the 45-minute drop and go initiative for ambulance staff.
- **Advice to the Board:**
  - **Operational Performance:** Continued evaluation of new processes linked to UEC.
  - **Financial Performance:** Noted the positive movement around agency spend and the trajectory for improvement.

20 November 2024 Committee meeting Assurance Provided:

- **62-Day Cancer Performance:** Assured, with improvement to the 70% standard for the first time since March.
- **Agency Spend:** Continued positive movement noted.
- **Partly Assured:**
  - **ERF Income:** Ahead of plan but declining.
  - **Deficit Funding:** Limited assurance around meeting the new end-of-year target, with a potential £10 million deficit noted.
- **Alerts to the Board:**
  - **Elective Recovery Delivery:** Deceleration and many cancellations of surgery noted.
- **Advice to the Board:**
  - **Non-Criteria to Reside Patients:** Suggested changing how this is reported.
  - **Business Cases:** Recommended approval for several business cases, including the orthopaedic elective hub, UEC capital, and the strategic outline case for the future Paget.

5.3. People and Culture Committee

For Assurance

Committee Chair

Stephen Javes (SJ) provided a summary of the meeting held on 24 October 2024 noting the following:

Assurance Provided:

- **Guardian of Safe Working Report:** Substantial assurance on compliance and safe working hours for junior doctors.
- **Board Assurance Framework, Integrated Performance Report, Staff Experience Plan:** Reasonable assurance, with a focus on improving engagement and retention.
- **Freedom to Speak Up:** Reasonable assurance, with an emphasis on improving feedback loops and ensuring staff feel heard.
- **No Areas of Limited Assurance:**
  - No specific areas were identified as having limited assurance.

Shared Learning and Board Advisory:

- **Freedom to Speak Up:**
  - Emphasized the need to improve feedback loops and ensure staff feel heard, with a focus on active listening in leadership practices.
- **Appraisal Activity:**
  - Highlighted the need to improve appraisal activity, with a focus on breaking the chain and engaging staff.
- **Medical Staff Turnover:**
  - Noted a slight increase in medical staff turnover, which is not a concern but something to monitor.
- **Healthcare Assistants Dispute:**
  - Mentioned the potential industrial action by healthcare assistants and the need to be mindful of the situation.

5.4. Audit Committee

For Assurance

Committee Chair

JH provided a summary of the meeting held on 22 November 2024 noting the following:

No Formal Escalations to the Board

Internal Audit Reports: Three Reports Received:

- **Staff Recruitment and Retention:** Reasonable assurance provided by RSM.
- **Budget Setting Control:** Reasonable assurance provided by RSM.
- **Risk Management:** Reasonable assurance provided by RSM.

Board Assurance Framework (BAF): Discussion on BAF.

Risk Register: PM discussed the risks related to the Chief Nurse and Chief Medical Officer, highlighting that the risk register is dynamic and real.

Outstanding Audit Recommendations: The majority of outstanding audit recommendations were deemed to have reasonable assurance. Some recommendations missed their target due to high standards for documentation, but the auditors concurred with the closures.

Internal Audit Plan: The internal audit plan is on track, with no high-risk recommendations so far. The committee expects an improvement in the final year-end score compared to the previous year.

6. Risk and Board Assurance

6.1. Board Assurance Framework Report

For Review

Chief Executive

JS highlighted the following points:

- The BAF underwent a six-month review, with several changes made in response to committee conversations. The review highlighted three main areas of concern: maternity quality and safety, efficiency program and operational performance.

JS emphasised the need for the board to discuss at the Board workshop, risk appetite, priorities, and whether the current focus is appropriate. The discussion aimed to determine if the board is inadvertently tolerating certain risks and if re-prioritisation is necessary.

SC raised concerns about the BAF's assessment, suggesting it might be optimistic in certain areas. She questioned whether the EPR and new hospital projects should have their own place in the BAF due to their significant impact. SC also highlighted the need for better differentiation between workforce shortages and capacity risks, as the controls for these risks are intermingled. JS acknowledged the concerns and agreed to take away the comments raised.

SL questioned the impact of the new clinical roles on the workforce and whether the trust is considering expanding successful initiatives like the physician associate program. JS responded that the trust is waiting for the outcome of a national review on physician associates before making any changes to their approach.

The Chair confirmed that the board will discuss the BAF in more detail at a Board development seminar, focusing on risk appetite, priorities, and potential re-prioritization.

7. Performance

7.1. Integrated Performance Report

For Review

Executive Leads

JS introduced the IPR, highlighting the alignment with the Board Assurance Framework (BAF) and the focus on operational performance, efficiency delivery, and quality and safety. Flagging the increasing concern regarding sickness rates, which are disproportionately higher than the regional average, impacting shift fill rates and quality and safety. JS proposed adding preterm birth rate and general nursing fill rate as new metrics to the IPR for better tracking and monitoring. The board approved the addition of preterm birth rate and general nursing fill rate as new metrics in the IPR.

SC raised concerns about the deterioration in planned versus actual shift fill rates for nurses and midwifery support workers between July and September. JS explained that the decrease in shift fill rates is due to increased sickness rates and challenges in backfilling maternity leave.

SL asked about the impact the trust can have on preventing preterm births. JS responded that the trust can have a significant impact through antenatal care and support for high-risk women, as well as managing care during the third trimester.

Stephen Javes (SJ) asked about the progress and impact of the project addressing sickness rates among HCAs and facilities staff. JS explained that the project is in the setup phase, with recruitment ongoing for a project lead. The project aims to address leadership and management practices, as well as modernising work practices.

The Chair sought assurance on the controls and support in place to help staff return to work quickly when they are sick. JS detailed the enhancements in the well-being service, changes in the occupational health contract, and the new leadership program for managers to support staff effectively. The Chair noted that this will be tracked through P&C Committee.

Charlotte Dillaway (CD) provided an update on the flow and discharge initiatives, highlighting the positive impact of criteria-led discharges and the reduction in long length of stay. CD mentioned the support from NHS England to embed Optica for better data capture and reporting.

SL asked if Optica would provide data on non-criteria to reside patients due to social care capacity issues. CD confirmed that Optica would provide such data, and the trust already has this information.

ET provided an update on the financial performance, noting that the trust is £2.4 million off plan but has maintained a stable position for the last four months. ET flagged the risk of a £3.5 million gap to the plan and the potential for a worst-case forecast outturn of £9.5 million.

8. Quality, People, and Finance

8.1. Chief Nurse Staffing Report

For Assurance

Chief Nurse

PM introduced the Chief Nurse Staffing Report, highlighting the decrease in shift fill rates and the impact of workforce challenges, including vacancies and maternity leave. He mentioned the ongoing efforts to address these challenges, including growing their own workforce and retaining staff within the organisation. He flagged the concern regarding the increase in falls and the trust's status as an outlier for the third consecutive month.

Sarah Whiteman (SW) asked PM to mention the initiative discussed at the Patient Safety and Quality Committee (PSQ) regarding falls and caffeine. PM highlighted the initiative to switch to decaffeinated drinks as a trial to reduce falls, supported by evidence that decaffeinated drinks can help reduce falls.

The Chair asked about the red flag incidents on specific wards (14, 12, 18, and 7) and whether this was expected or unexpected. PM explained that these wards have higher reporting for red flags, particularly around 1:1 supervision and being short-staffed due to enhanced supervision needs.

The Chair asked how the trust manages risks when staff are not coming forward to fill shifts. PM explained that the trust tries to mitigate risks by relocating resources, but there remains a gap in demand and available staff, which is a concern.

8.2. Freedom to Speak Up Bi-Annual Report

To Note

Director Of People And Culture

The Chair welcomed Jo Penniston and Jacquie Pamphilon from the Guardian Service.

Jo introduced the Freedom to Speak Up Bi-Annual Report, covering the period from May 1st to September 30th, during which 79 concerns were raised by staff members. Jo highlighted that the majority of concerns came from estates and facilities departments, nursing and midwifery, and additional clinical services. The top three themes for concerns were management issues, system and processes, and patient safety or quality concerns.

Jo noted that over half of the staff raising concerns felt they had not been listened to previously. Concerns included lack of staffing on wards, unsafe practices, patient and staff safety, and the impact of formal processes on staff well-being. Jo emphasized the importance of leaders modelling speaking up principles and providing support to managers to handle concerns effectively.

Jo highlighted the following recommendations from the report:

- that leaders at every level role model speaking up principles to help workers feel safe and valued.
- providing soft skills training for managers, including listening, emotional intelligence, and empathy.
- the need for regular check-ins with staff following formal processes to ensure effective coping strategies are in place.

CN agreed that the high level of concerns raised is positive but noted the issue of staff feeling they haven't been listened to previously. She emphasized the need for better feedback mechanisms.

The Chair asked if there were specific actions the board could take to model speaking up principles. Jacquie suggested that board members be visible on the floor, engage with staff, and actively promote the Freedom to Speak Up service.

SL commented that while listening up is generally good, the challenge lies in communicating actions taken in response to concerns. She emphasized the importance of breaking down the fear of speaking up to senior staff.

VC asked if there was a way to analyse concerns proportionately to the workforce size to identify any unusual patterns. Jacquie explained that this analysis could be done by comparing the percentage of concerns to the staff size, but it would require workforce data from the trust.

The Chair thanked Jo and Jacquie for their update.

8.3. Health and Safety Annual Report

Approval

Director Of Strategic Projects

Mark Flynn (MFl) introduced the Health and Safety Annual Report, highlighting the key areas of priority, including managing violence and aggression, launching the smoke-free site, and addressing issues related to RAC (Reinforced Autoclaved Aerated Concrete). He mentioned the significant work done to improve parking and manage high levels of estates work. MF concluded that the trust can provide good assurance about its approach to health and safety.

SJ asked how often, if ever, the Health and Safety Annual Report is externally scrutinised by an independent party. MFl acknowledged the importance of external scrutiny and mentioned that he would take this question away to provide a more detailed response later.

ACTION: MFl to provide update on if the Health and Safety Annual Report is externally scrutinised by an independent party.

SC noted the high and stubbornly persistent numbers of violence and aggression incidents. She expressed concern about the lack of a sustained drop despite various initiatives and asked for clarity on the plan to address this issue. MFl responded that a report with a clear plan to address violence and aggression is coming to the Hospital Management Group (HMG) soon. He mentioned that an independent assessment had been done, and they are looking at reforming and focusing efforts to resolve these issues.

The board approved the Health and Safety Annual Report.

9. Strategy and Business Planning

Nothing for consideration

10. Corporate Governance

Nothing for consideration

11. Questions from the Public and Trust Governors

Stakeholder Engagement

Chair

The Chair confirmed no written questions had been received in advance of the meeting.

The Chair asked if there were any questions from the public or Trust Governors who were in attendance.

Peter Hargrave (Governor) asked about the potential benefits of improving patient flow, including whether it would allow the trust to treat more patients, see them earlier, achieve better outcomes, and whether it is beneficial for patients to stay in the hospital when no treatments are available. JS responded, agreeing with Peter's points and highlighting the importance of reducing length of stay. She mentioned that various programs are in place to manage patients differently and improve communication with partners for ongoing care needs. JS emphasized that this is an ongoing effort due to the increasing age and comorbidities of patients.

Richard Chilvers (member of the public) inquired about the current figures for patients ready for discharge from both the hospital and Carlton Court. CD provided the figures, stating that there are 135 patients who do not meet the criteria to reside, including those at Carlton Court. She noted that some of these patients are not ready for discharge due to ongoing rehab needs.

Richard Chilvers (member of the public) asked if there is a triangulation between patient safety concerns, staff shortages, and violence and aggression, and whether staff feel the need to make representations on behalf of patients due to these issues. JS explained that staff do flag concerns about patient safety and staffing levels on a daily basis, which are monitored through the safer staffing process. She mentioned that incidents of violence and aggression are reported and managed through the incident reporting tool, ensuring that all information is triangulated and addressed.

Richard Chilvers (member of the public) asked if the costs of community support are likely to increase to meet the needs of discharged patients, considering the changes in costs for care homes and other services. JS responded that there is a clear government pledge to shift care out of acute hospitals into community services, which will involve moving some of the funding as well. She emphasized the need to work as a system through the ICS to configure and fund these services in the long term.

12. Meeting Review

12.1. Matters for Consideration by other Entities

For Decision

Chair

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 thanked Peter Hargrave and Richard Chilvers for their attendance, and appreciated the Freedom to Speak Up Guardians report and attendance.

13. Next Meeting

For Information

Chair

Friday, 31 January 2025, MS Teams @ 10:00

Date of Meeting	Minute Reference	Subject	Action	Responsibility	Target Due Date	Update	Status	Status Date
26/07/2024	5.1.3	People and Culture Committee	Committee Chair to ensure 3-5 year forward staffing plan is reviewed.	Committee Chair/s	27/09/2024	Verbal update to be given at the meeting. **27/09/24** - staff plan is being worked through the committee structure, action to be left open to next Board meeting. **22/11/2024** - Update to be provided at the meeting. **29/11/2024** - SJ provided update and will continue to be monitored at Committee level. Action to close.	To Close	
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	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.	To Close	
27/09/2024	8.6	Seven Days Hospital Services Baseline Audit	CMO to ensure length of stay review reports into F&P Committee.	CMO	29/11/2024	Update to be provided at the meeting. **29/11/24** - VC sought clarity of action. JS confirmed length of stay is reported through IPR in F&P and further detail following the RIO project including learning from the project has been requested. Monitored via committee. Action to be closed.	To Close	
29/11/2024	2.1	Departmental Presentation - Gastroenterology and Endoscopy	CMO to provide update on financial issues for funding within the Gastro Team and feedback to the Board.	CMO	28/03/2025	**24/01/2025** - action update follows this log.	To Close	
29/11/2024	8.3	Health and Safety Annual Report	DoSP to provide update on if the Health and Safety Annual Report is externally scrutinised by an independent party.	DoSP	31/01/2025	**21/01/2025** - MF advised it has been confirmed that the Health & Safety Annual Report is not subject to additional external scrutiny. Action to be closed.	To Close	

ACTION 2.1 (PUBLIC TRUST BOARD): To understand financial issues around alcohol related services.

BACKGROUND

Alcohol specific admissions, readmissions and mortality are at an all-time high, with those from the lowest 3 socioeconomic deciles accounting for over 50% of admissions. These patients tend to be the most complex and experience the worst outcomes.

This increase in demand is costly at the point of admission, due to the complexity of care and number of teams which are often required to contribute to a safe inpatient stay but alcohol as a contributory factor extends length of stay from 3 to 5 days, irrespective of cause of admission.

Particularly, alcohol related liver disease (ARLD) has seen a significant rise (24%) over the last 10 years. Care for ARLD, especially end of life ARLD, is intensive and requires a lot of NHS and social care resource. Alcohol Care Teams (ACTs) have a role in early identification of liver disease and supported access to an appropriate liver pathway which can minimise or even revert harm in some cases of liver fibrosis.

Harm from alcohol and demand on NHS services is often regarded as an A&E issue. Acute intoxication and harm through altercations/violence account for just a small amount of the cost of overall harm, loss of productivity and early morbidity. 1 in 10 inpatients are estimated to have an alcohol dependence compared to just 2% of the general adult population [though it is estimated that 24% of the population have some level of alcohol-use disorder] demonstrating the heightened risk of requiring a hospital stay where alcohol is involved and the demand for expertise in patient care at an acute level.

A 7-day alcohol service is recommended as best practice in the management of patients with alcohol related issues by Public Health England, the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) 'Measuring the Units', the British Society of Gastroenterologist and NICE. This enables equitable access for patients independent on the day of the week they are admitted and reduces the chances of important care being delayed – especially over the weekend.

CHALLENGES TO PROVIDING AN ADEQUATE ALCOHOL SERVICE

1. **ACT team funding: T**he JPUH was an early implementer site of the Alcohol Prevention Programme in 2020/21. However, the funding allocation for the ACT service has been reduced year on year (see table below), resulting in the loss of workforce. In addition to funding reductions, the annual fixed-term nature of the contract creates instability for the workforce and hinders the delivery of a consistent and effective service. The funding may be completely withdrawn in 2025/26.

Year	Consultant PA	Band 7 Specialist Alcohol Nurse	Band 6 Alcohol Nurse	Band 4 Assistant Practitioner	Band 4 Administrator	Total Cost	Provided Funding
2021/2022	£60,000	£46,451	£77,802	£0	£26,977	£211,230	£181,230
2022/2023	£60,000	£60,332	£102,664	£0	£26,977	£249,973	£199,023
2023/2024	£60,000	£57,702	£46,619	£0	£26,977	£191,298	£198,000
2024/2025	£60,000	£57,702	£46,619	£0	£26,977	£191,298	£153,000
2025/2026 projected	£60,000	£0	£46,619	£26,977	£0	£133,596	TBC

This ongoing underfunding and contractual instability pose significant challenges to the sustainability and effectiveness of the JPUH ACT service. A business case is being drafted locally and also separately by the ICB Clinical Programme Manager (NHS Long Term Plan – Prevention)

2. **Medical workforce:** One WTE Consultant is required to cover the increased demand for Liver & Gastroenterology Services, to increase clinic capacity & have a positive effect on admission avoidance & saving bed days. The consultant will also help to support other initiatives such as one-stop clinics & collaboration with other specialties such as Endocrinology & Dietetics outpatient clinics.

INDICATIVE COSTS
(These are tentative numbers that the Division is working on)

One WTE Consultant = £145k

For ACT, if we were to go with 1 x B7, 4 x B6, 2 x B4, assuming no unsocial or weekend working:

1.00 Wte B7	£ 66,434
4.00 Wte B6	£225,504
2.00 Wte B4	£ 72,126
Total	£364,094

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

31 January 2025

CEO Report

Board of Directors, 31 January 2025

James Paget University Hospitals NHS Foundation Trust

Our Patients

Year 2 Delivery Plan Objective: We will deliver the Maternity Improvement Plan covering the leadership, culture, safety and governance of the maternity service.

- Maternity services at the James Paget University Hospital are rated better than comparable hospitals, according to the outcomes of the CQC's Maternity Survey that focuses on the care of people while they were pregnant, their experience of labour and giving birth, the care in the ward after birth, feeding their baby, and care after birth.
- In 11 response areas, the James Paget's maternity services are in the top 20% of responses for all hospitals in the country.
- The Trust scored highly in the support for people's mental health and wellbeing during pregnancy, and how midwives listened during antenatal check-ups, and for the support in understanding elements of an individual's pregnancy and birth plans.

CEO Report

Board of Directors, 31 January 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 National Hip Fracture Database annual report published by the Royal College of Physicians has highlighted the James Paget for its work in increasing numbers of patients who are mobilised soon after undergoing hip fracture surgery.
- This year's report showcases the James Paget's 'Out of Bed Project' with links to both an academic paper and a video presentation. The Out of Bed Project was launched to help the hospital improve early mobilisation of patients after hip fracture surgery – a practice which is linked to better outcomes for patients and reducing length of stay.
- 'Out of Bed' enables physiotherapists to focus on early discharge planning and give more time to complex mobilisation cases.

CEO Report

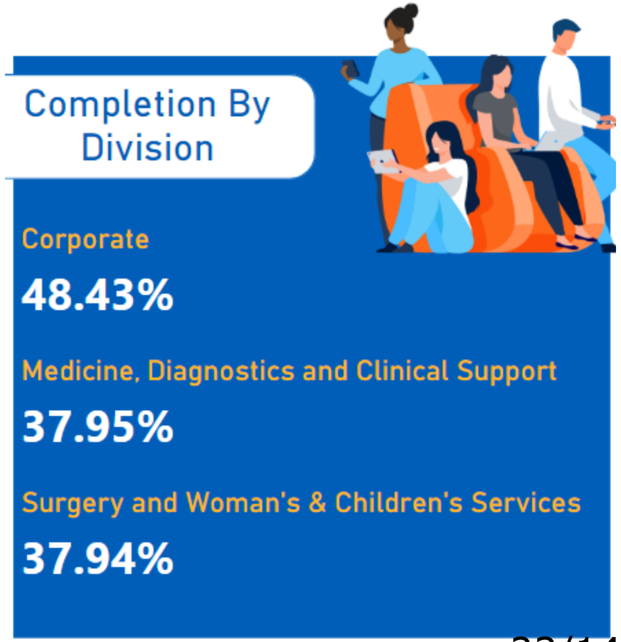
Board of Directors, 31 January 2025

James Paget University Hospitals
NHS Foundation Trust

Our People

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

- The annual NHS Staff Survey finished in November 2024
- More people took the survey than in 2023 – a significant achievement given how busy all services are during the survey period. 40.5% of substantive staff completed the survey, and 15.8% of bank staff. Full results are issued in March 2025.
- January's Pulse Survey is currently live, focusing on staff awareness of flexible working at our hospital, and the 'Martha's Rule' initiative, introduced last year. The survey also looks at awareness of the Government's 10-year plan for the NHS.



CEO Report

Board of Directors, 31 January 2025

James Paget University Hospitals NHS Foundation Trust

Our People

Year 2 Delivery Plan Objective: We will review our occupational health provision including our psychological support offer to ensure it meets the needs of our staff

- During periods of sustained demand, we continue to remind staff of the wellbeing and support available, including the Employee Assistance Programme provided by Vivup.
- The Organisational Development and Wellbeing Team also provide support and signposting for staff, and are looking to develop a Coaching Network, bringing together all qualified coaches within the Trust to form a network where coaches can meet to share best practice, learn from one another and benefit from group supervision.

CEO Report

Board of Directors, 31 January 2025

James Paget University Hospitals NHS Foundation Trust

Our People

Year 2 Delivery Plan Objective: We will review our occupational health provision including our psychological support offer to ensure it meets the needs of our staff

- We continued to remind staff to access the staff vaccination programme to fight against the rise in respiratory illnesses over the autumn and winter.
- We provided a flu and Covid vaccine service for our staff between October and December, with an additional roaming service in January to support staff that wished to be vaccinated.
- 1503 members of staff received the Covid vaccine across this period; 2413 members of staff received the flu vaccine

CEO Report

Board of Directors, 31 January 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.
- The final case for change is now close to completion and work on the new governance arrangements required is in its final stages. It is anticipated the new group model will begin being implemented in April 2025.
- We expect the appointment processes for the Chair and the CEO will be agreed in late January and recruitment for both these posts is set to begin shortly after so that the positions are filled in time for April. Meanwhile NHSE will conduct a focused review during February for assurance and approval purposes.

CEO Report

Board of Directors, 31 January 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

- The Norfolk and Waveney Acute Hospital Collaborative, in partnership with MEDITECH, has successfully passed the ‘FD Stage 3.5’ assessment. This milestone confirms we are firmly on track to deliver the EPR across the three Acute Trusts.
- This transformative initiative, supported by NHS England’s Frontline Digitisation (FD) Programme, aims to strengthen digital foundations across our trusts, improve patient care, empower clinicians, and harness the power of data.
- The NHS England assessment evaluated key areas of our programme, with strong results achieved in all areas particularly Clinical Engagement, Clinical Safety, Operational Readiness, Organisational Readiness and Data Quality. Opportunities for further focus were identified in Data Security, Test Assurance, and Service Management.

CEO Report

Board of Directors, 31 January 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)

- Thanks to the dedication of our fundraisers, the generosity of our donors, and contributions from the charity's existing reserves, along with a substantial legacy gift from a loyal supporter, we have reached our fundraising target, and have purchased a surgical robot for our hospital.
- This fantastic achievement has been underpinned by the dedication and kindness of our charity supporters and donators, who have raised over £1m towards the appeal.
- The hospital will soon acquire a Da Vinci robotic-assisted surgical system, provided by Intuitive, which can be used in a range of surgical specialties including urology, gynaecology, and general surgery, and will be used as one of the options suitable in the treatment of cancers.

CEO Report

Board of Directors, 31 January 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 faced sustained demand for urgent and emergency care services over the Christmas and New Year period and into January. The hospital has received additional support from NHS England's ECIST (Emergency Care Improvement Support Team) and GIRFT (Getting It Right First Time) teams as part of the Rapid Improvement Offer nationally.
- As part of the Seasonal Resilience plan, the Trust has implemented its 'full capacity protocol' aimed at expediting flow and therefore reducing overcrowding in ED through moving suitable patients to their designated receiving ward before a 'ready-for discharge' patient has left the ward.
- The protocol is in line with NHS accepted practice and has been introduced in other hospitals across the country.

CEO Report

Board of Directors, 31 January 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 continues to focus on reducing patient Length of Stay as a key driver in improving performance across a number of domains.

- The Urgent and Emergency Care Programme Board has developed metrics for measuring performance moving forward.

Programme Metrics Overview

Metric	Target
12 Hours in the Department (Mental Health)	20
AM Discharges	30.0%
Weekend Discharges	No Target
Acute Adult Bed Occupancy	95.0%
Non Criteria to Reside	80
Virtual Ward Occupancy Rate	80.0%
Non Criteria to Reside as a Percentage of Funded Beds	No Target
ED 4 Hour Performance	78.0%
12 Hour DTAs	0
Length Of Stay - Elective	3
Length Of Stay - Non Elective	8

CEO Report

Board of Directors, 31 January 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 James Paget Orthopaedic Centre and Oulton Suite Community Diagnostic Centre were formally opened on Friday 10 January 2025 by by Stella Vig, NHS England's Medical Director for Secondary Care and Quality, and National Clinical Director for Elective Care.
- The Orthopaedic Centre will provide 1400 theatre sessions per year, allowing us to operate on more than 3000 patients
- The Oulton Suite will provide more than 500 additional diagnostic tests per week for local patients, using the latest tests and medical devices, specialising in tests to help diagnose heart and lung conditions.

CEO Report

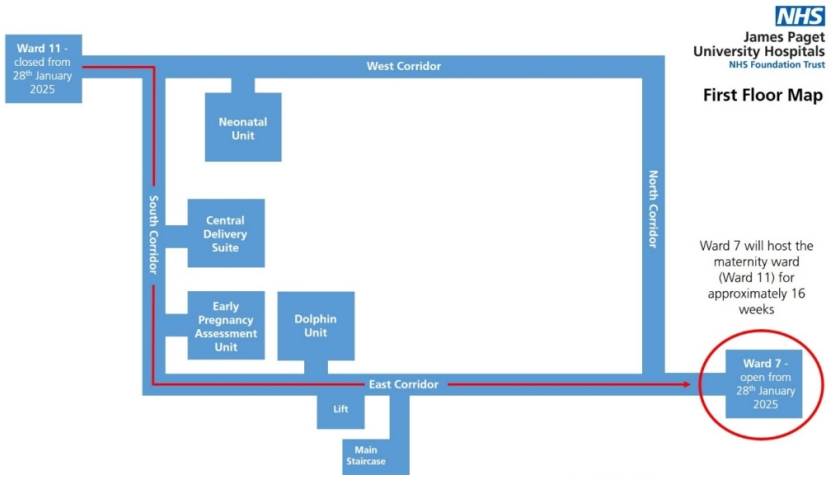
Board of Directors, 31 January 2025

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.

- Our scheduled programme of securing RAAC across our site has continued. Work in Ward 10 has been completed, meaning that the Ward 10 team has moved out of its temporary base it the Concept Ward and back into the main hospital building.
- Ward 22 has moved into the Concept Ward, which will become its permanent home to support the work of the Orthopaedic Centre.
- Ward 7 will be used as the new decant ward, to allow the programme of RAAC work to continue on schedule. Ward 11 (the maternity ward) will be the first to use Ward 7 as a decant space.



CEO Report

Board of Directors, 31 January 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.

- Our estates team is also overseeing RAAC work in the Hospital Sterilisation and Decontamination Unit (HSDU) - and using it as an opportunity to modernise and expand its facilities, in recognition of the additional surgical capacity in the hospital, following the opening of the Orthopaedic Centre.
- This work is taking place in phases, allowing HSDU to continue to operate - and will see the installation of new equipment, and a new building to house the unit's air handling plant, which is currently taking shape in the loading bay.

NHS
James Paget University Hospitals
NHS Foundation Trust

Report to the Trust Board of Directors dated Friday, 31 January 2025

Title: Board Assurance Framework Report

Sponsor:	Chief Executive
Author:	Head of Corporate Affairs
Previous scrutiny:	Board Committees January 2025
Purpose:	The paper is presented for Discussion.
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

Purpose of Report

A comparison of the December 2024 and January 2025 Board Assurance Framework (BAF) risk registers highlights key changes and ongoing challenges. Notably, Risk 438 (Maternity Services) has been split into two distinct lines to enhance clarity between regulatory compliance and patient safety risks, ensuring more focused action planning and oversight.

Progress has been made in financial risk management, with Risk 413 (Financial Constraints) showing a reduced residual score, reflecting improved budget control and strategic financial planning. However, capacity challenges (Risk 434) remain above appetite, despite mitigation efforts such as additional diagnostic capacity coming online in July 2024.

Workforce shortages (Risks 412, 418, and 421) persist as a significant challenge, with ongoing reliance on temporary staffing. Recruitment and retention strategies, including “grow-your-own” initiatives and skill-mix changes, are beginning to show early positive results.

Delayed implementation of the digital patient feedback system (Risk 414) and continued operational pressures highlight areas potentially requiring further Board oversight.

Recommendations

Detailed analysis of the trends evident across the financial year to date as reported in the BAF Risk Register suggest the following elements the Board may wish to consider:

1. **Workforce Strategy** - Explore long-term solutions to recruitment, retention, and well-being challenges.

2. **Service Demand -** Review operational capacity plans to identify further opportunities to manage demand and reduce service pressures.

3. **Digital Transformation** - Prioritise key digital initiatives, particularly patient feedback and e-consent rollout to enhance engagement and the responsiveness of the system of risk management and internal control.

BAF Risk Register Analysis – December 2024 to January 2025

Introduction

This report provides an analysis of the changes between the December 2024 and January 2025 Board Assurance Framework (BAF) risk registers. It highlights key changes, emerging themes, trends, exceptions, anomalies, and areas of improvement.

Risk Scores and Appetite Adjustments

A review of the risk ratings reveals the following significant changes:

Risk 413 – Financial Constraints

- December 2024: Residual risk score of 12, target score 8 (Above Appetite).
- January 2025: Residual risk score reduced to 8, indicating improved financial oversight and alignment with strategic financial objectives.

Risk 434 – Capacity to Meet Demand

- December 2024: Residual risk score of 15, target score 8 (Above Appetite).
- January 2025: Residual risk score remains 15, indicating ongoing operational pressures despite mitigation efforts. Additional diagnostic capacity (CDC) remains on track for July 2024 commissioning.

Risk 438 – Maternity Services vs Regulatory Compliance

Risk 438 has been separated into two distinct lines to improve clarity and focus:

1. Regulatory Compliance Risk – addressing adherence to national standards and regulatory expectations (e.g. CQC).
2. Maternity Quality and Safety Risk – focusing on patient safety outcomes and quality of care for mothers and babies.

This change enhances visibility and accountability and allows for targeted action plans to be recorded on the Register more clearly, ensuring a more effective approach to managing both compliance and patient safety.

Emerging Themes and Trends

Workforce Challenges Persist (Risks 412, 418, 421)

- Recruitment and retention remain significant concerns, with continued reliance on temporary staffing solutions. Enhanced focus on “grow-your-own” initiatives and international recruitment efforts is showing early promise.

Digital Transformation and Security (Risk 432)

- Continued efforts towards achieving Cyber Essentials Plus certification with positive audit results reinforcing progress.

Health Inequalities (Risk 416)

- Implementation of the Health Inequalities Improvement Plan is progressing well, with approved metrics now being monitored at system level.

Exceptions and Anomalies

Some things are not going according to plan:

Delayed Actions

- Implementation of the digital feedback system (Risk 414) has been pushed from June 2024 to September 2024, affecting timelines for improving patient experience reporting.

- Recruitment of joint consultant posts (Risk 412) with UEA continues to face delays due to national workforce shortages.

New Structure for Risk 438

- The distinction between regulatory compliance and maternity care quality provides improved clarity for reporting and action tracking.
- Key shared actions, such as “Just Culture” training and audit enhancements, will be aligned across both risk areas to avoid duplication.

Operational Pressures on Demand Management

- Despite mitigation efforts, service capacity risks remain above appetite, with demand exceeding current resource capabilities.

Improvements

Several key improvements in internal control have been observed between the two reporting periods:

Recruitment and Retention

- New workforce planning initiatives, including skill-mix reviews and investment in new clinical roles (e.g. prescribing pharmacists), are beginning to yield positive results.

Financial Recovery Progress

- The Trust’s financial risk management and control has improved with the implementation of revised budget control measures and cost-saving initiatives.

Regulatory Engagement

- Regular CQC engagement meetings and monitoring frameworks are in place to support the exit strategy for maternity services from regulatory oversight.

Recommendations to the Board

The following recommendations are proposed for Board consideration:

Workforce Strategy Deep Dive

- Explore long-term workforce sustainability, focusing on recruitment, retention, and well-being initiatives.

Maternity Services Action Tracking

- Continued close monitoring of the newly separated risk lines for maternity services to ensure that regulatory compliance and quality improvement efforts remain on track.

Digital Transformation Acceleration

- Further efforts to expedite key digital initiatives.

Service Demand Review

- A strategic review of current and projected service demands to explore additional mitigation options for capacity-related risks.

Conclusion

The comparison of the December 2024 and January 2025 BAF registers indicates positive progress in financial risk management and digital transformation. The restructuring of Risk 438 provides enhanced clarity between regulatory compliance and patient safety, enabling a more targeted approach to risk mitigation.

However, ongoing challenges remain in workforce shortages and operational capacity, necessitating sustained Board focus and potential strategic interventions.

Risk	Title	Strategic Priorities Impacted	Exec Owner	Review Committee	Initial Risk Rating	1st Line of Defence (Operational Controls)	2nd Line of Defence (Risk & Compliance Functions, Policies & Monitoring)	3rd Line of Defence (Independent Assurance)	Actions to close Gaps	Control Effectiveness	Residual Risk Rating Dec 2024	Board Risk Appetite	≥0 == ≥Appetite	Risk Appetite Status
412	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 prescribing, 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
413	Insufficient funding or resources may hinder the Trust's ability to execute priorities and ambitions, potentially resulting in unmet goals and reduced service effectiveness and transformation.	P1. A1: Provide the best and safest care for our patients P4 A1: Make the best use of out physical and financial resources	Chief Finance Officer	F&P	16	• Robust budget setting process in place following national guidance and operating plan. Proposed budget signed off by HMG, and Board • HMG prioritisation of resources in line with Strategic Objectives • Yearly Capital Plan including estates and digital agreed with system partners and within the trust • Efficiency plan and processes in place • Yearly commissioning intentions letter sent to ICB • Self-assessment against HFMA checklist	• All business cases/investments following the green book model and are prioritised by HMG • Board Risk appetite statement in place • Integrated Performance Report in place to link quality and safety to finance and performance monitored through DPM monthly • Financial Recovery Plan monitored via the Financial Recovery Group • Adopted ICB prioritisation model for revenue investments • Performance and financial accountability framework relaunched 2024	• External Audit of Annual report and Annual Governance Statement • Internal Audit 2024-25: Budget setting and control	**1st Line** None recorded **2nd Line** • Revised approach to Corporate DCIP to be implemented **3rd Line** • Develop a matrix to assess if our ability to innovate has been effected by the funding constraints: Need to work with colleague to be able to evaluate the impact of decreased investment and has this impacted innovation which leads to a reduction in quality and safety	Partly Effective	12	8	4	Above Appetite
414	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
415	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 consent.	Partly Effective	9	6	3	Above Appetite

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416	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
418	Inadequate or unsuitable workforce and policies, processes, plans and leadership capacity and capability (including a lack of focus on EDI) negatively affect staff experience, engagement, and well-being, leading to decreased productivity, higher sickness, and turnover rates, resulting in diminished standards of care quality.	P2 A1: Promote and inclusive, fair and safe workplace P2 A2: Develop compassionate and effective leadership P2 A3: Attract, engage develop and deploy our staff to deliver the best care for our patients P2 A4: Promote wellbeing opportunities to keep our staff healthy and well P2 Ob1: We will launch and embed our Trust Values P2 Ob2: We will achieve the Trust's People Plan year one objective P2 Ob3: We will achieve our Staff Experience plan P2 Ob4: We will ensure our psychological support offer meets the needs of our staff	Director of People and Culture	P&C	16	• Monitoring of staff concerns • Just and Learning Culture Working Group • Divisional Your Voice sessions • Monthly Board to Ward sessions • Fair Recruitment Working Group • Violence and Aggression Working Group • People and Culture Steering Group • EDI Steering Group • Joint Partnership Forum • Occupational Health • Qualified Human Resources professionals	• Trust People Plan • Staff Experience Plan • People and Culture Steering Group • Trust policies including equity, diversity, and inclusion, raising concerns policy, just and learning culture policy and toolkit • Attendance Management Policy, toolkit, and manager training • Staff Experience Programme Board • Divisional Performance meetings- Integrated performance report- staff indicators • Equality, Diversity, and Inclusion (EDI) reports • Annual Staff Wellbeing Deep Dive • Psychological support provision • Occupational Health and Employee Assistance programme service provision • Trust Values and Behaviours Framework • Monthly Board to Ward sessions • Quality and Health and Safety walkabouts • Leadership development programmes • Quarterly Leadership Summits • Guardian Service • People metrics included in Integrated Performance Reporting • Monitoring of staff concerns through Steering Group, Committee and Board reports e.g. Serious Employee Relations Issues, WRES, WDES, Equality Delivery System, Freedom to Speak Up • Violence and aggression action plan	• Annual NHS Staff Survey • NHS People Pulse	**1st Line** • Implement fair recruitment plans **2nd Line** • Values and behaviours implementation plan • Implement 2024/25 Staff Experience Plan • Develop longer term psychological support plans **3rd Line** • Internal Audit 2024-25: Violence and aggression	Partly Effective	9	6	3	Above Appetite
420	Inadequate education and development opportunities, including leadership development, prevent staff meeting organisational skills and capability requirements, leading to poorer health outcomes for patients, reputational damage and an increase in litigation and insurance (CNST) costs.	P1 A1: Provide the best and safest care for our patients P2 A2: Develop compassionate and effective leadership P2 A3: Attract, engage develop and deploy our staff to deliver the best care for our patients P2 Ob1: We will launch and embed our Trust Values P2 Ob2: We will achieve the Trust's People Plan year one objective P2 Ob3: We will achieve our Staff Experience plan	Director of People and Culture	P&C	16	• Quarterly leadership summits • Access to national, regional and local system level leadership development programmes • Management leadership development programmes and wider offer • Clinical Leads Training and Development Programme • Continuous Professional Development funded training for registered clinical professionals • Apprenticeship levy to support apprenticeship programmes • Study leave allocations for medical staff	• People metrics regularly reported in IPR • Monitoring of annual appraisal performance and personal development planning • Education, Training and Development Steering Group in place • Established structures and programmes for Nurses, AHPs in place • Medical School and clinical education infrastructures and leadership in place • Postgraduate Medical leadership and structures in place • Annual clinical Continuous Professional Development • Education Plan, with annual review by People and Culture Committee • Workforce Plans • Trust People Plan approved by Board with annual review by People and Culture Committee • Participant feedback following completion of leadership programme • Divisional Performance Meetings • Staff Experience Plan • Appraisal guidance and templates	• Annual review by East of England Deanery • Submission of annual self-assessment • Staff Survey • NHS People Pulse	**1st Line** None recorded **2nd Line** • Training needs analysis for non-registered clinical and non-clinical staff to inform development of short to longer term plans • Annual review of continuous professional development needs and funding allocation • Annual review of leadership development needs and offer • Improve compliance with Appraisals and Personal Development Planning, to Trust target **3rd Line** None recorded	Effective	6	6	0	Within Appetite
421	Inadequate recruitment, retention, and high staff absence rates cause staff shortages, resulting in compromised service provision, and unsustainable workloads and poor morale affecting standards of care quality.	P1 A1: Provide the best and safest care for our patients P2 A3: Attract, engage develop and deploy our staff to deliver the best care for our patients	Director of People and Culture	P&C	16	• Dedicated recruitment resources, including international recruitment team • Leavers questionnaire / exit interview and Stay Conversation processes • Range of recruitment videos and materials launched • Use of temporary staffing, as needed	• Annual recruitment / retention 'hotspot' reports • Annual Workforce Plan (part of local system plan) • Recruitment and retention metrics included in the Integrated Performance report • Sickness and other absence related policies / procedures • Industrial action mitigation planning • Staffing summits • Wellbeing Offer • People and Culture Steering Group • Trust People Plan in place	• NHS Staff Survey • NHS People Pulse	**1st Line** None recorded **2nd Line** • Implementation of Staff Experience Plan 2024/25 • Implement retention plans • Sickness absence reduction project for HCAs and Facilities staff groups • Bespoke recruitment plans, as needed **• 3rd Line** Internal Audit 2024/25: Staff Recruitment and Retention	Effective	9	9	0	Within Appetite

Risk	Title	Strategic Priorities Impacted	Exec Owner	Review Committee	Initial Risk Rating	1st Line of Defence (Operational Controls)	2nd Line of Defence (Risk & Compliance Functions, Policies & Monitoring)	3rd Line of Defence (Independent Assurance)	Actions to close Gaps	Control Effectiveness	Residual Risk Rating Dec 2024	Board Risk Appetite	≥0 == ≥Appetite	Risk Appetite Status
428	Failure to execute the efficiency program prevents the achievement of financial plans, leading to budget shortfalls, potentially resulting in reduced operational capability and effectiveness, resulting in increased regulatory oversight.	P4 A1: Make the best use of our physical and financial resources	Chief Finance Officer	F&P	16	• Delegation of efficiency target 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 • Extra-ordinary DPM meetings 2023/24 • 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	• 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	**1st Line** • Implement actions to deliver 2024/25 in -year financial recovery plan. **2nd Line** None recorded **3rd Line** • Independent review of financial governance (commissioned by ICB as directed by NHSE). • All outstanding gateway forms to be completed: process of completing gateway forms is not fully embedded, and some forms need to be retrospectively completed	Partly Effective	16	8	8	Above Appetite
430	Ageing estate infrastructure including RAAC and lack of adequate digital infrastructure impacts on service provision and compromises 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
431	The pace and scale of organisational change, including quality improvements and digital technological advances needed to meet demand outpaces staff capacity and capabilities, leading to implementation failures and resulting in diminished standards of care quality.	None recorded	Deputy CEO	P&C F&P	12	• Corporate transformation team and divisional project managers in place • Aligned transformation capacity across three acute hospitals • Clinical lead for transformation in place • Operation Lightbulb capturing improvement topics • NHP project managers supporting Acute Clinical Strategy Organisational Development team	• Four Outpatinets PB paused temporarily) main agreed Trust improvement programmes in place & regularly reviewed • Agreed improvement methodology adopted using data and best practice to drive improvements. This improvement methodology is being used across the three Trusts to support joint transformation work • QI platform in use • Transformation Programme (internal and system transformation) overseen by Hospital Management Group • Acute Clinical Strategy monitored by Acute Clinical Strategy Programme Board and N&W Hospitals Collaborative • A new Improvement Approach has been adopted and this is being embedded through close working with the operational divisions • Robust governance and reporting arrangements at Place and CiC level to ensure joint work is delivered and any resistance identified • A consistent methodology in place (PSIRF) and training programmes underway to ensure staff have the necessary skills	• None recorded	**1st Line** None recorded **2nd Line** • Leading change to be incorporated into the leadership development programmes • QI training across organisation to become embedded in practice **3rd Line** • None recorded	Partly Effective	9	6	3	Above Appetite
432	Failure to safely implement 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

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434	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
435	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
437	~~Regulatory oversight may lead to identification of noncompliance in service provision, potentially resulting in sanctions and reputational damage.~~ 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
438	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

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438	Non-adherence to national standards around appropriate fundamental care delivery due to challenges around staffing levels/ training/ skill mix/ demands on time. This could result in regulatory action and or a deterioration in ratings across the CQC domains.	P1 A1: Provide the best and safest care for our patients	Chief Nurse	PSQ	16	**1st Line** • Day to day Clinical and operational structures and processes are in place	**2nd Line** • Regualr 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	• Internal Audits • Discussions at DPM, Divisional Governance, PSQ and Board	**1st Line** • gaps in completion of daily, weekly audits **2nd Line** • Gaps in monitoring of actions due to the mulitple spread sheets in use and focus on operatrional "acute" demands on clinical staff **3rd Line** • Gaps in Internal Audits and asssurance matrixs • Discussions at DPM, Divisional Governance, PSQ and Board with action plan monitoring	Partly Effective	12	8	4	Above Appetite

James Paget University Hospitals NHS Foundation Trust

OUR PATIENTS

OUR PEOPLE

OUR PARTNERS

OUR PERFORMANCE

Integrated Performance Report

Dec-24

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NHS
James Paget University Hospitals
NHS Foundation Trust

Chief Executive Summary

2024/25 Priorities

Dec-24

Our patients | Our people | Our partners | Our performance

The challenge to balance the four domains and agreed strategic priorities continues and is evidenced by the IPR.
Quality demonstrated through operational continues to have a mixed picture of improvement as Elective and Urgent and Emergency care continue to impact on each other. The remaining quality and safety metrics remain within normal variation.
Financial performance remains off track with ERF income impacted by reduction in elective work due to emergency pressures and sickness rates continuing to impact on temporary pay spend and therefore overall pay spend.

Quality and Safety

Metric	Target	Actual	Perf
SHMI	1.13	1.12	✓
SSNAP	80	66	✗
12 Hour Mental Health in ED	20	33	✗
Complaints Received	16	13	✓
Complaints Responded to In 60 Days	100.0%	60.00%	✗
Inpatient Satisfaction	95.0%	97.72%	✓
VTE	95.0%	91.53%	✗
MRSA	0	0	✓
CDiff	3	3	✓
Gram-Negative	2	4	✗
Falls With Harm per 1000 Bed Days	0.130	0.136	✗
Registered Nurse and HCA Fill Rate	90.0%	85.23%	✗
Midwifery Fill Rate	90.0%	80.17%	✗
Still Birth Rate	3.5%	0.00%	✓
Preterm Birth Rate	6.0%	6.14%	✗

Operational Performance

Metric	Target	Actual	Perf
104+ Week Waits	0	0	✓
78+ Week Waits	0	6	✗
65+ Week Waits	0	154	✗
6 Week Diagnostics	90.5%	68.98%	✗
28 Day Faster Diagnosis	75.0%	79.20%	✓
Cancer 62 Day Treatment	70.0%	69.92%	✗
Cancer 62 Day Backlog	47	60	✗
First and Procedure Outpatients	46.0%	46.53%	✓
DNA Rate	5.0%	7.97%	✗
ED 4 Hour Performance	78.0%	62.30%	✗
Ambulance Handovers Over 30 Minutes	0	1,047	✗
ED 12 Hours in Department	0	733	✗
Non Elective LoS	8.00	11.22	✗

People and Culture

Metric	Target	Actual	Perf
Sickness Rate	4.6%	6.09%	✗
Leaver Rate	10.0%	6.30%	✓
Implied Productivity	15.80	12.23	✗
Mandatory Training	90.0%	91.73%	✓
Non Medical Appraisal	90.0%	80.93%	✗

Finance

Metric	Target	Actual	Perf
ERF Performance £000	0	-455	✗
Agency Expenditure £000	477	583	✗
Pay Per Unit of Activity	261	384	✗
Non Pay Per Unit of Activity	117	184	✗
Efficiency Plan £000	0	-387	✗
Better Payment Practice	95.0%	78.66%	✗
Financial Productivity	423	568	✗

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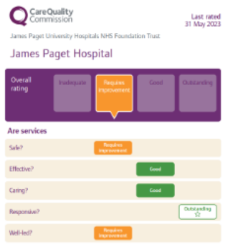
Quality and Safety

Mortality : remains within as expected range
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. Services will not be scored for the October-December period and no scores will be made public until the April-June 2025 reporting period. The Trust is awaiting DIY calculation formulas from SSNAP to enable the full detailed reporting previously provided to Trust groups for assurance. Indicative metrics for Nov. 2024 demonstrate the general trend is downward (e.g. lower percentages of patients reaching the HASU within 4 hours (47%), seeing a Stroke Cons within 14 hours (52%), Swallow (72%) and other therapies assessments within 24 hours) compared with the prior reporting period Oct 2024. The context is highest volume of stroke discharges for YTD (n = 52), bed availability (flow) was the primary cause for 4 hour to unit breaches, workforce challenges depending on the area of service saw sickness, vacancies, or skill mix. An improvement was observed in attainment of CT Head within 20 minutes at 59% scoring maximum 100 points. ED engagement sessions arranged and continue to support speciality to deliver timely stroke pathway
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
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.
Venous Thromboembolism (VTE): remaining in normal variation and zero Hospital Associated Thrombosis
Infection Prevention and Control : There has not been an MRSA Bacteraemia case since the end of January 2023
There were a total of 3 Cdiff Toxin cases for December. These were 1 HOHA cases. There were 2 COHA cases. Increase this year in total cases
Gram Negative we remain although higher in month, 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 has dropped and could be related to prolong periods in escalation and Critical incident resulting in staff not having time to report. This will be reviewed next month to look for continued trends
Maternity Fill Rate : 80.17% actual vs planned fill rate which is below mean but with in normal variation and has remained for around the past 10 months. 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: 85.23% actual vs planned fill rate which is below mean but with in normal variation , however there has been some data quality issues which are being resolved.
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	Jul-24	1.13	1.12	✓	H	?
SSNAP	Sep-24	80	66	✗		?
12 Hour Mental Health in ED	Dec-24	20	33	✗		?
Complaints Received	Dec-24	16	13	✓		?
Complaints Responded to In 60 Days	Dec-24	100.0%	60.00%	✗	H	?
Inpatient Satisfaction	Dec-24	95.0%	97.72%	✓		P
VTE	Dec-24	95.0%	91.53%	✗		?
MRSA	Dec-24	0	0	✓		P
CDiff	Dec-24	3	3	✓		?
Gram-Negative	Dec-24	2	4	✗		?
Falls With Harm per 1000 Bed Days	Dec-24	0.130	0.136	✗		?
Registered Nurse and HCA Fill Rate	Dec-24	90.0%	85.23%	✗		?
Midwifery Fill Rate	Dec-24	90.0%	80.17%	✗	L	?
Still Birth Rate	Dec-24	3.5%	0.00%	✓		?
Preterm Birth Rate	Dec-24	6.0%	6.14%	✗		?



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Operational Performance

December saw a deterioration across addition, metrics, primarily driven by significant operational pressures across the UEC portfolio. High levels of elective cancellations has exacerbated the risks to elective recovery with a further deteriorating 65 week position. The trajectory continues to be downwards but at a slower pace than originally planned. Risks are increasing to elective recovery due to the financial controls in place and the slow approval of posts through Triple Lock.

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 Deep Dive into NCTR is included in this pack for the Committee's Assurance.

The period towards the end of December and into January has been incredibly challenged with the East of England Region declaring a Level 3 Incident on 31 December 2024.
We surged into 67 escalation beds and at the time of writing, remain in 43 of these beds. This included opening Ward 22 which had been ringfenced for the schemes in our seasonal resilience plan.
In addition, the peak of flu numbers came over the Christmas and New Year period during a period of annual leave and lack of community services in place.

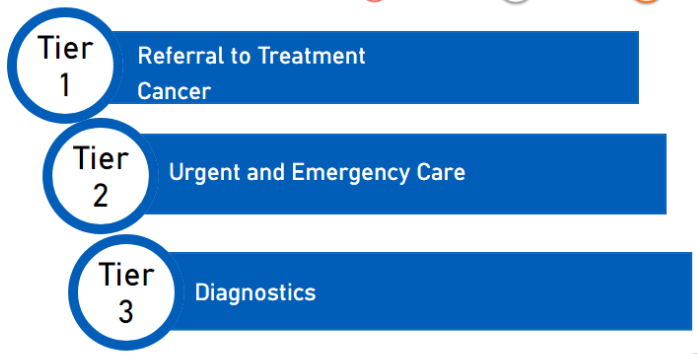
Members of the Committee will be aware that as a Trust we did not sign up to the EEAST initiative of Release to Respond (formerly Handover 45) and this was suspended as part of the Regional incident. We have now provided a trajectory of improvement for ambulance handover delays to ICB and EEAST colleagues.

Plans for January
- Completion of a Criteria to Admit audit by RiO team
- De-escalation from surge capacity and getting right patients in the right places
- Reinvigorate the implementation of our seasonal resilience plan
- Refocus teams on elective recovery and elimination of long waiters

A deep dive into non criteria to reside (NCTR) patients was presented to Finance & Performance Committee during January 2025.

Metric	Period	Target	Actual	Compliance	Variation	Assurance
104+ Week Waits	Dec-24	0	0	✓	L	P
78+ Week Waits	Dec-24	0	6	✗	L	F
65+ Week Waits	Dec-24	0	154	✗	L	F
6 Week Diagnostics	Dec-24	90.5%	68.98%	✗	L	?
28 Day Faster Diagnosis	Nov-24	75.0%	79.20%	✓	H	?
Cancer 62 Day Treatment	Nov-24	70.0%	69.92%	✗	~	?
Cancer 62 Day Backlog	Nov-24	47	60	✗	L	F
First and Procedure Outpatients	Dec-24	46.0%	46.53%	✓	~	?
DNA Rate	Dec-24	5.0%	7.97%	✗	~	F
ED 4 Hour Performance	Dec-24	78.0%	62.30%	✗	~	?
Ambulance Handovers Over 30 Minutes	Dec-24	0	1,047	✗	~	F
ED 12 Hours in Department	Dec-24	0	733	✗	~	F
Non Elective LoS	Dec-24	8.00	11.22	✗	~	F

NHS England Operational Performance Tiering



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People and Culture

Sickness Rate – High sickness absence continues to be a concern and is a driver for temporary staffing cover. Some improvement has been seen in long-term absence, but short-term absence has increased since August, peaking in December 2024, impacted by seasonal illness that has also been seen in the community. Sickness reduction working group established. Cases with highest Bradford scores being reviewed.

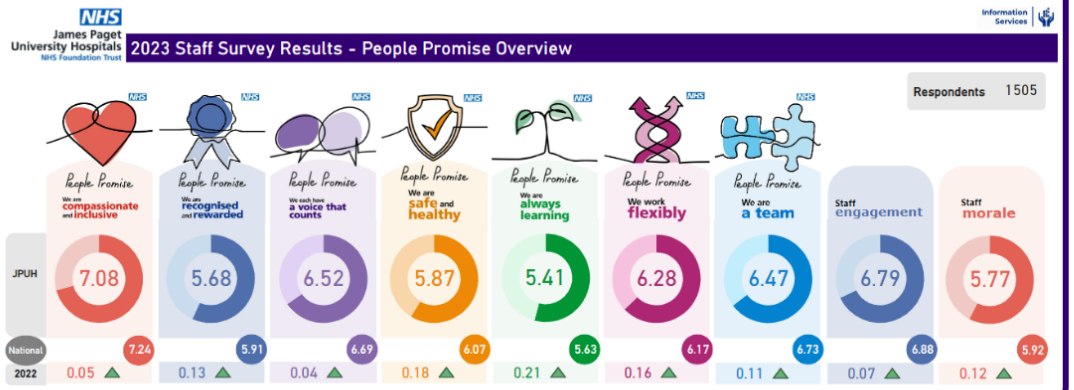
Leaver rate – Turnover remains low and stable. All staff groups below target (positively, excluding Additional Professional Scientific and Technical, but this is a very small staff group and no notable concern.

Implied Productivity – This is a measure of implied productivity and 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 (inclusive of bank and agency worked). The target is based on the baseline 2019 / 20 performance. Performance is below target and the mean average but with no common cause variation. Work to improve productivity is being overseen by the Financial Recovery Group.

Mandatory Training – Performance is above target and continuing to improve. There is variation by subject, however, which is a focus for the Education, Training and Development Steering Group and through Divisional Performance Meetings. An NHS Memorandum of Understanding for the portability of mandatory training between NHS organisations has been published and signed.

Non-Medical Appraisals – Whilst notably under target, there is an improving trend organisationally and across all three divisions. An appraisal compliance improvement plan was agreed by the Hospital Management Group and a working group is overseeing implementation.

Metric	Period	Target	Actual	Compliance	Variation	Assurance
Sickness Rate	Dec-24	4.6%	6.09%	⊗	H	F
Leaver Rate	Dec-24	10.0%	6.30%	✓	L	?
Implied Productivity	Dec-24	15.80	12.23	⊗	~	?
Mandatory Training	Dec-24	90.0%	91.73%	✓	~	?
Non Medical Appraisal	Dec-24	90.0%	80.93%	⊗	H	?



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Finance

This report provides information regarding the financial position up to 31 December 2024.
I&E Deficit The final 24/25 financial plan was for a £13.4m deficit. However, the ICS has received deficit funding, a total of £12.3m of which has been allocated to the JPUH as additional income, giving the Trust a revised annual plan of £1.1m deficit. £10.3m of this additional funding was added into the plan and actual income as at month 9. 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 financial performance at month 9 is £5.1m negative variance to plan. The implementation of temporary pay controls improved the financial performance from month 4, however pressures have deteriorated the position in months 8 and 9. Drivers of the YTD variance are efficiencies behind plan £1.5m, industrial action £0.7m, pay award cost pressure £1.1m, seasonal operational pressures £0.3m, and system unmitigated stretch target £1.5m.

Forecast Outturn (FOT) is formally reported as on plan, a £1.1m deficit. However, the Trust has an unmitigated gap to plan of £3.7m, mostly driven by the ICS stretch target of £3m. In addition, there is high delivery risk of £4.4m against the Financial Recovery Plan (FRP), leaving a risked assessed FOT of £8.1m adverse variance to plan. The Trust continues to pursue every opportunity to minimise its deficit and achieve its financial plan.

Efficiencies were slightly behind plan in month, and are £1.5m behind plan YTD. The key driver is temporary pay cost reductions below plan, and this has been targeted for remedial action through the Trust's Executive-led Financial Recovery Plan. The Trust has a £22.4m efficiency target for 2024/25, and delivery of this continues to be reported as an extreme risk in the risk register and BAF.

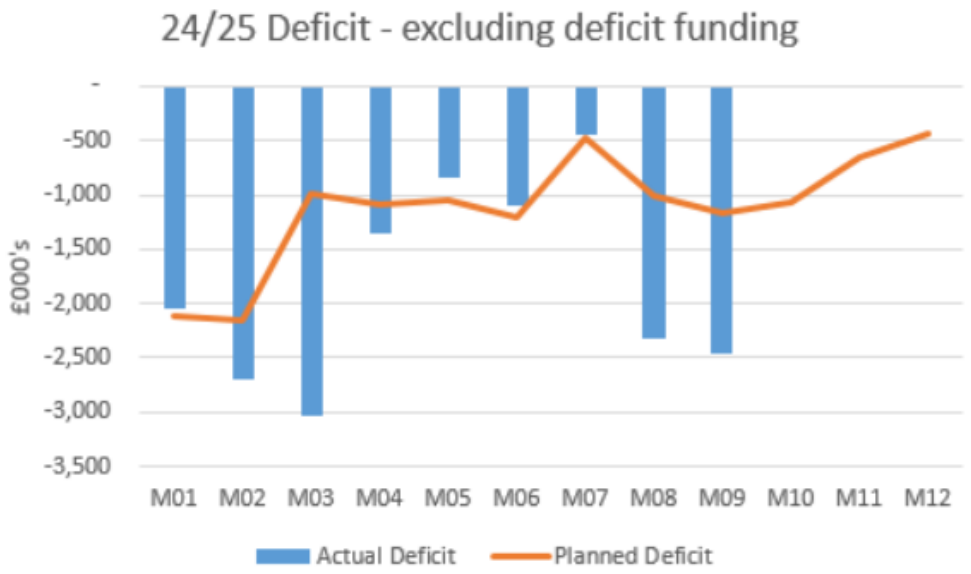
ERF income earned is £9.1m above the 109% target, but is £0.8m behind the financial plan.

Agency costs are £2.6m above plan YTD, although expenditure has reduced each month since May 2024 through financial recovery actions. Q3 expenditure in 2024 is less than the Q3 expenditure from 2023. Key drivers continue to be operational pressures, medical staffing vacancies, and additional elective activity, particularly in Anaesthetics, Theatres, and HSDU teams.

Cash Due to the cash backed deficit support funding of £12.3m, further cash to support the deficit is now not expected to be needed for 2024/25.

Capital expenditure year to date is £28.0m which is £14.0m behind plan. The largest variances are currently on the FPP, EPR, and CDC. These are timing differences and there are no causes for concern with regards to year end under or over-shoot of capital expenditure.

Metric	Period	Target	Actual	Compliance	Variation	Assurance
ERF Performance £000	Dec-24	0	-455	⊗	H	?
Agency Expenditure £000	Dec-24	477	583	⊗	~	?
Pay Per Unit of Activity	Dec-24	261	384	⊗	~	F
Non Pay Per Unit of Activity	Dec-24	117	184	⊗	~	F
Efficiency Plan £000	Dec-24	0	-387	⊗	~	?
Better Payment Practice	Dec-24	95.0%	78.66%	⊗	~	?
Financial Productivity	Dec-24	423	568	⊗	~	?



James Paget University Hospitals NHS Foundation Trust

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	Nov-24	63.1%	70.4%	70.8%	13/14	70.7%	72.7%	114/141	50.7% 99.9%
ED 4 Hour Performance - Type 1	Nov-24	56.4%	57.1%	55.5%	8/13	57.0%	56.8%	62/122	37.2% 87.4%
RTT Performance	Nov-24	55.1%	53.7%	53.8%	7/13	58.2%	62.6%	119/155	.7% 100.0%
PTL Size	Nov-24	31,669	846,781	65,137	2/13	7,087,688	45,727	56/155	45 199,578
52+ Wks	Nov-24	1,534	35,747	2,750	5/13	217,202	1,401	99/155	0 9,972
78+ Wks	Nov-24	11	206	16	8/13	2,032	13	119/155	0 634
DM01 Performance	Nov-24	23.4%	33.1%	34.4%	5/14	20.4%	17.9%	113/156	.0% 80.3%
104+ Wks	Nov-24	0	6	0	1/13	45	0	1/155	0 6

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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Chief Executive Summary

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

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1 Quality and Safety

2 Operational Performance

3 People and Culture

4 Finance

Chief Nurse Report

Stebbings,Susan
07/04/2025 16:39:42

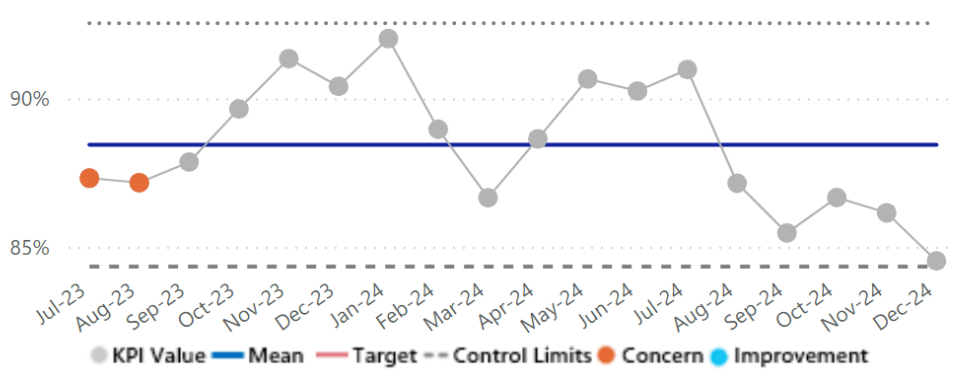
Dec-24

Summary - Shift Fill - Planned vs Actual

Metric Name	Current Month	Actual	Change	Target	Variation	Assurance
Planned v Actual Shift Fill - RN + HCA + RM + MSW	Dec-24	84.5%	-1.62%	None		N/A
Planned v Actual Shift Fill - Registered Nurses	Dec-24	80.9%	-1.40%	None		N/A
Planned v Actual Shift Fill - Health Care Assistant	Dec-24	91.0%	-1.35%	None		N/A
Planned v Actual Shift Fill - RN + HCA	Dec-24	85.2%	-1.46%	None		N/A
Planned v Actual Shift Fill - Registered Midwife	Dec-24	80.2%	-1.22%	None		N/A
Planned v Actual Shift Fill - Midwifery Support Worker	Dec-24	66.7%	-9.05%	None		N/A
Planned v Actual Shift Fill - RM + MSW	Dec-24	76.6%	-3.27%	None		N/A
Planned v Actual Day Shift Fill - Registered Nurses	Dec-24	78.9%	-2.26%	None		N/A
Planned v Actual Day Shift Fill - Health Care Assistant	Dec-24	83.0%	-0.32%	None		N/A
Planned v Actual Day Shift Fill - RN + HCA	Dec-24	80.7%	-1.43%	None		N/A
Planned v Actual Night Shift Fill - Registered Nurses	Dec-24	83.2%	-0.40%	None		N/A
Planned v Actual Night Shift Fill - Health Care Assistant	Dec-24	100.8%	-2.26%	None		N/A
Planned v Actual Night Shift Fill - RN + HCA	Dec-24	90.6%	-1.43%	None		N/A
Planned v Actual Day Shift Fill - Registered Midwife	Dec-24	80.9%	-3.64%	None		N/A
Planned v Actual Night Shift Fill - Registered Midwife	Dec-24	79.5%	1.26%	None		N/A
Planned v Actual Day Shift Fill - Midwifery Support Worker	Dec-24	61.7%	-10.07%	None		N/A
Planned v Actual Night Shift Fill - Midwifery Support Worker	Dec-24	75.0%	-7.34%	None		N/A

Planned v Actual Shift Fill - RN + HCA + RM + MSW — Dec-24

Target	Actual	Previous	Assurance	Variation
None	84.5%	86.2%	N/A	



The summary position for the combined registered RN/RM and unregistered HCA/MSW planned shift fill was 84.5%. This is the lowest level of combined shift fill achieved since March 2023. Common cause variation has been maintained however the month the level has hit the lower confidence level. All variation patterns have remained the same this month except for RN/HCA day shift moving from common cause to special cause neither improvement or concern to common cause, and RN night shift was special cause neither and is now common cause.

There were nine wards on day shifts and eight on nights who did not meet the 80% minimum target fill for registered nurses and eight on days and one on nights for healthcare assistants. Registered midwives did not achieve on nights and support workers on neither days nor nights.

NHSi SPC Icon Key

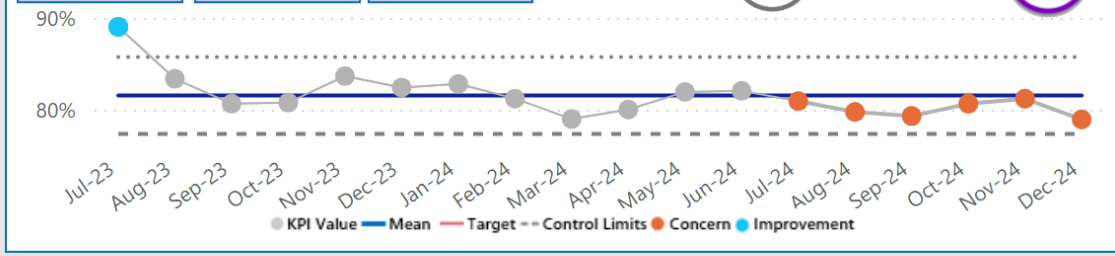
Variation				Assurance		
Common cause - no significant change	Special cause of concerning nature due to (H)igher or (L)ower values	Special cause of improving nature due to (H)igher or (L)ower values	Special cause neither improvement or concern	Variation indicates inconsistently passing/failing target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

Chief Nurse Report

Planned vs Actual Shift Fill

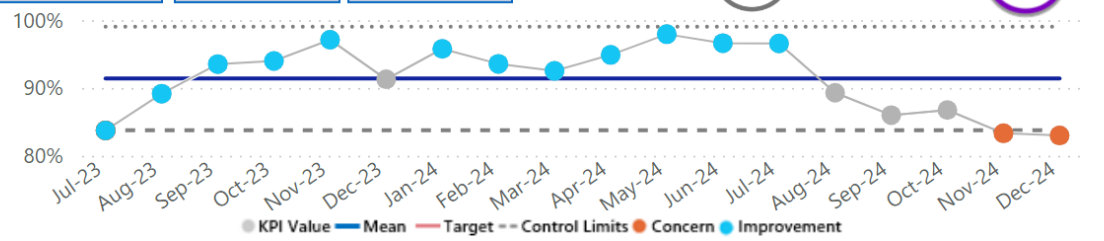
Planned v Actual Day Shift Fill - Registered Nurses — Dec-24

Target	Actual	Previous	Assurance	Variation
None	78.9%	81.2%	N/A	↘



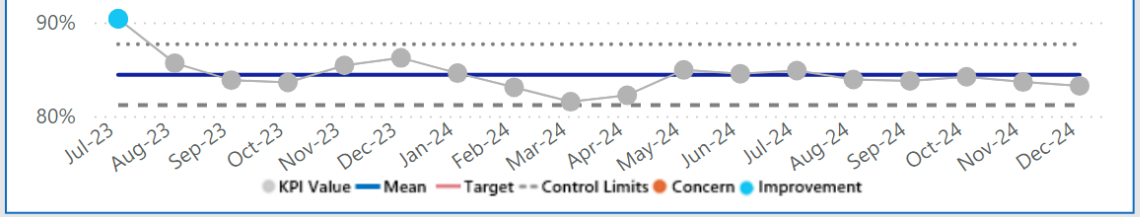
Planned v Actual Day Shift Fill - Health Care Assistant — Dec-24

Target	Actual	Previous	Assurance	Variation
None	83.0%	83.3%	N/A	↘



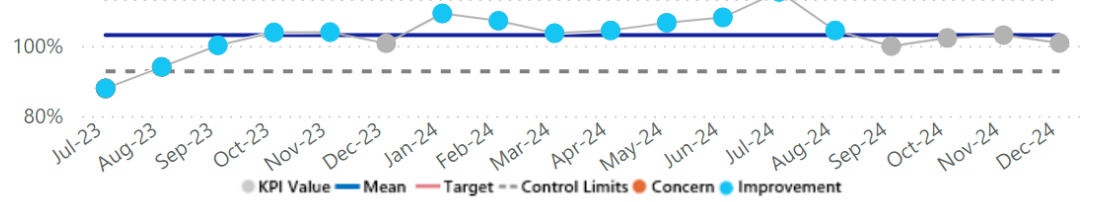
Planned v Actual Night Shift Fill - Registered Nurses — Dec-24

Target	Actual	Previous	Assurance	Variation
None	83.2%	83.6%	N/A	~



Planned v Actual Night Shift Fill - Health Care Assistant — Dec-24

Target	Actual	Previous	Assurance	Variation
None	100.8%	103.0%	N/A	~



What the data tells us

There was a reduction of 1.32 % shift fill for RNs in December. A continued pattern of concern has been observed for day shift fill. The night shift fill moved from concern to common cause variation. Shift fill ranges were;

- days 52 – 101 % nights 56 – 100%

HCA day shift fill was relative to November and continues with a pattern of concern. The night shift fill reduced by 2.2% with a pattern of common cause variation. Shift fill ranges were;

- days 45 – 114 % nights 75 –157%

Skill mix adaptations were risk assessed and agreed on several occasions during the month to reach least risk positions for managing below template situations.

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 the Chief Nurse daily staffing summit
- roster controls continue to be monitored including Executive approval for over template requests
- timely responses to vacancy management/recruitment processes. This will minimise the risk of prolonged periods with unfilled vacancies and subsequent impact on shift fill capability, available CHPPD and ability to provide safe and effective care delivery

From January 25, a twice daily Q Safe will be submitted to record the volume of template gaps outstanding once deployment allocations have been made.

Risks

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

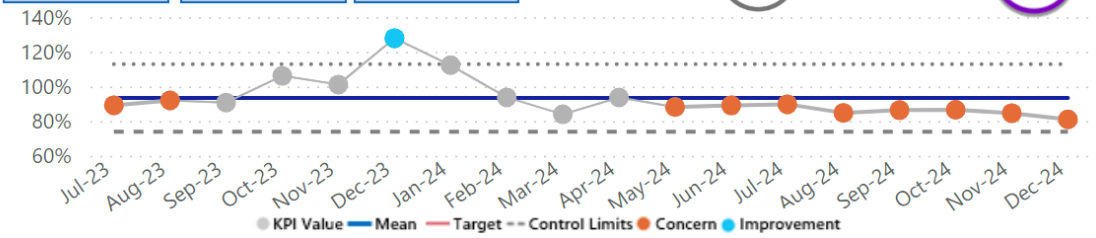
- compromise to patient safety and experience, reputational – regulatory, professionally and service user confidence, recruitment and retention impact
- impact on staff health and wellbeing, moral injury risk, stress induced behaviours, increase in short term absence
- risk of short cuts in working practice 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 patient care delivery and pathway progression
- Impact of stretching available staffing capacity to support escalation areas

Chief Nurse Report

Planned vs Actual Shift Fill

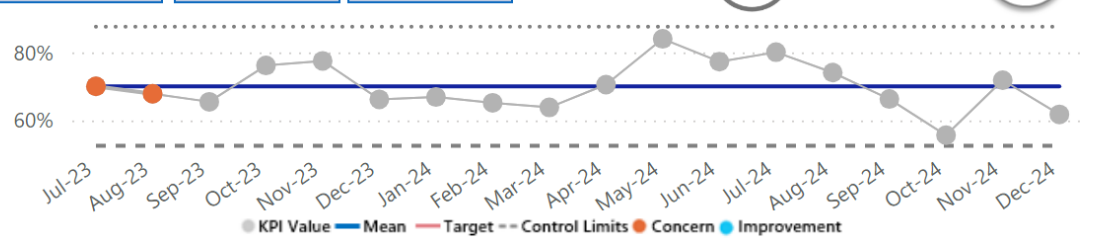
Planned v Actual Day Shift Fill - Registered Midwife — Dec-24

Target	Actual	Previous	Assurance	Variation
None	80.9%	84.5%	N/A	↘



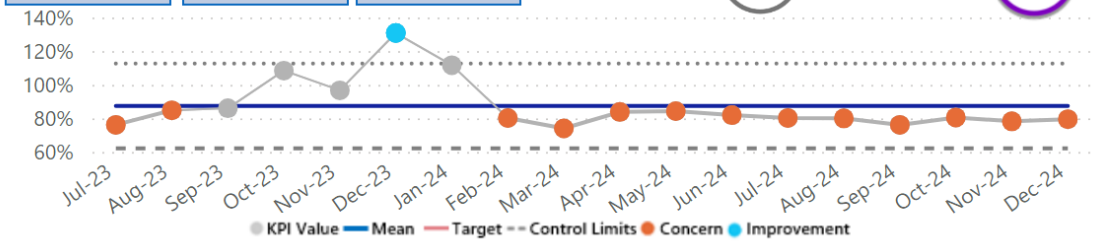
Planned v Actual Day Shift Fill - Midwifery Support Worker — Dec-24

Target	Actual	Previous	Assurance	Variation
None	61.7%	71.8%	N/A	↘



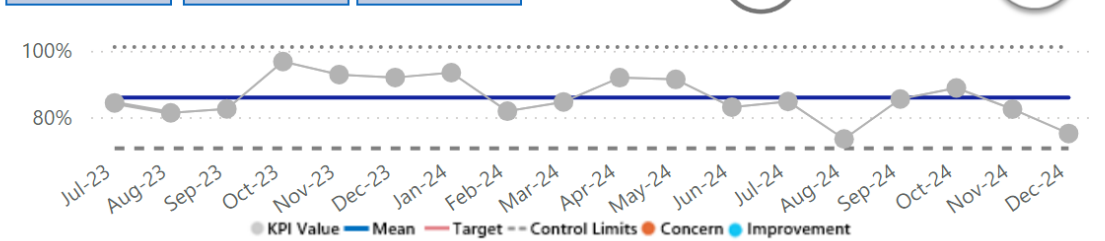
Planned v Actual Night Shift Fill - Registered Midwife — Dec-24

Target	Actual	Previous	Assurance	Variation
None	79.5%	78.2%	N/A	↘



Planned v Actual Night Shift Fill - Midwifery Support Worker — Dec-24

Target	Actual	Previous	Assurance	Variation
None	75.0%	82.4%	N/A	↘



What the data tells us

Registered midwife shift fill continues to demonstrate a pattern of concern for both day and night shifts. The shift fill also continues to be below the mean. There was a further reduction in shift fill on day shifts and a slight increase for nights.

Midwifery support worker is demonstrating common cause variation with reductions in fill on both shifts.

Contributory factors to shift fill include long and short-term sickness absence, maternity leave and depleted bank midwife capacity. Lost hours across all midwifery teams accounted for 1700 hours.

Next steps and planned impact

There are several different teams on the midwifery health roster. These will be reviewed in the next two months. This will ensure any anomalies are recognised and corrected to avoid planned template in accuracies.

Discussions are underway regarding the timing of the next Birth Rate + exercise. Of note, there is an outstanding Oracle invoice for payment (raised in October 24) to the company who provide the Birth Rate + platform. There is a risk this may impact on our ability to utilise the platform for the next formal Birth Rate + exercise.

Risks

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

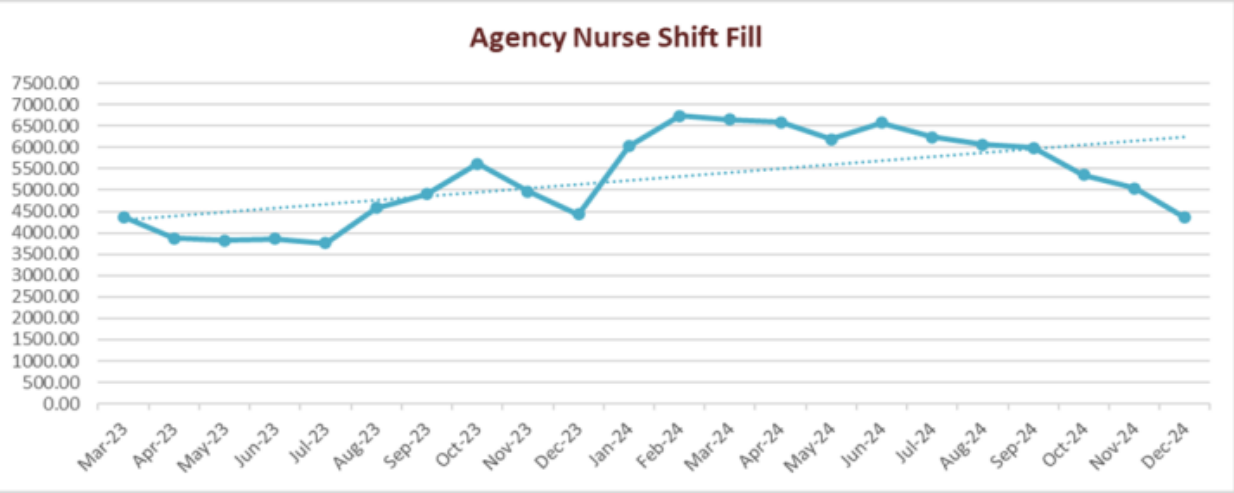
- delay in vital sign monitoring
- delays in antenatal CTG monitoring / reviews /interpretations
- delays in feeding support/advice/guidance
- Inability to provide 121 care in labour
- Matrons/specialist midwives required to redeploy to shop floor

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

Chief Nurse Report

Summary - Temporary Staffing

Metric Name	Current Month	Actual	Change	Target	Variation	Assurance
Nursing Temporary Staffing Request v Actual Shift Fill	Dec-24	97.0%	2.05%	None		N/A
HCA Temporary Staffing Request v Actual Shift Fill	Dec-24	98.0%	-1.03%	None		N/A
Midwives Temporary Staffing Request v Actual Shift Fill	Dec-24	52.9%	-45.00%	None		N/A
MSW Temporary Staffing Request v Actual Shift Fill	Dec-24	35.8%	-21.07%	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

What the data tells us

There has been one variation pattern change this month with midwifery support worker temporary staffing request fill moving from common cause to special cause variation.

RN requests decreased by 1053 hours with a total of 9999.25 overall hours being requested with a 97% fill rate. The fill rate was achieved with 53% bank and 43% agency. Agency nurse use continues on a downward trend and the previous equal balance observed between bank and agency fill, has now started to change as agency reduction is taking effect.

Registered midwife requested hours increased by 568. The fill rate was 535 hours. Midwifery support worker requests increased by 315 hours. Fill rate was 36%.

Next steps and planned impact

As previously reported, the senior nurse team have reviewed the benefits of putting out temporary staffing requests for short notice absence notifications. This is due to the concern regarding the vast discrepancy between overall shift fill and the perceived corresponding gap with temporary staffing requests.

With immediate effect, it has been agreed that all template gaps will be put out to bank with a review in 3 months to see if this accounts for some/all of the difference e.g., the registered nurse unmet demand for planned fill was 13761 hours and the temporary staffing requested hours were 9999. This is a difference of 3762 hours (327 shifts).

The temporary staffing hours fill in midwifery are more aligned to the unmet planned demand with a request of 1686 hours compared to a planned fill gap of 1645.84. However, temporary staffing fill is consistently low, and discussions will take place with the midwifery leadership team in the next few weeks to determine required actions to increase temporary staffing capacity e.g., bank midwife recruitment campaign.

Risks

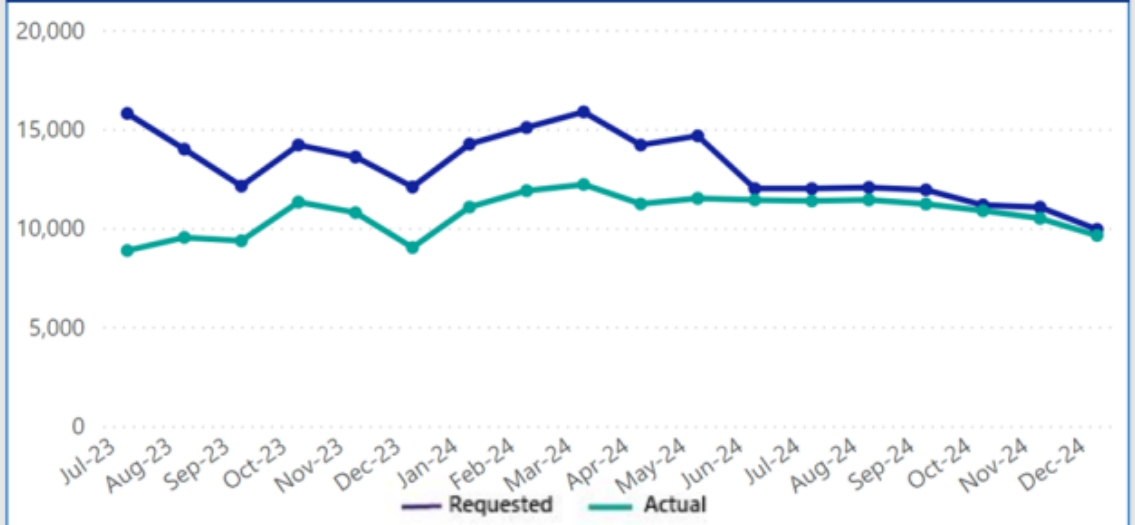
In addition to already noted patient safety and experience, staff health and wellbeing and financial risks there has been an increase in practice related concerns of registered nurse temporary staff in recent weeks. The Digital Workforce Team are supported to manage these situations by the Corporate nursing team. Issues are mainly in relation to perceived poor delivery of fundamental care.

There are a combination of factors which may contribute and include; substantiated poor practice/capability concerns, lack of induction to the Trust and individual clinical area, values and behaviours, reliability e.g. short notice cancellations/no shows. We are currently exploring actions for the Trust to take to minimise these issues however, it is recognised that there are such risk with a fluid and transient workforce.

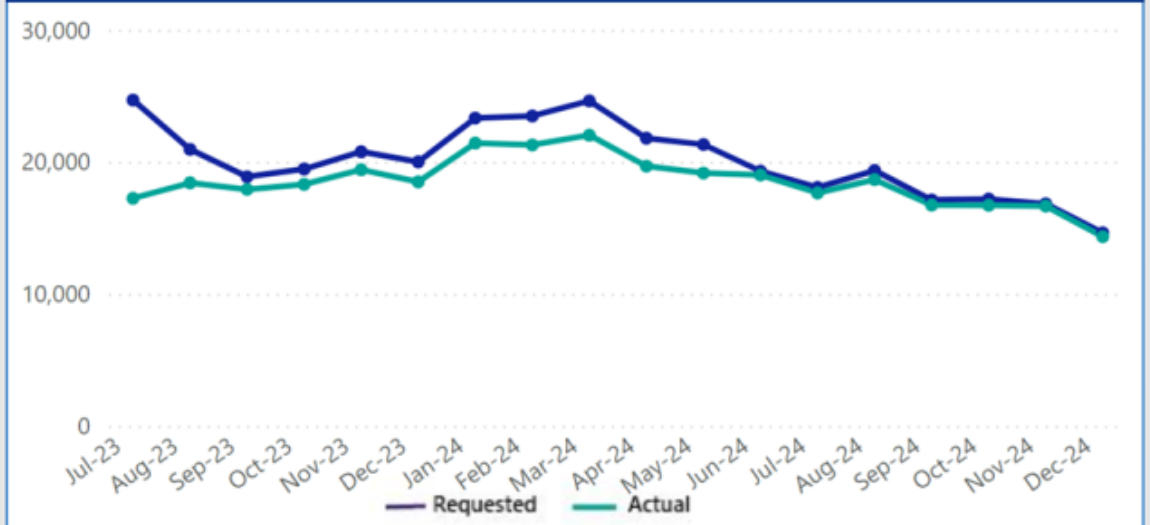
Chief Nurse Report

Temporary Staffing Shift Requests/Fill

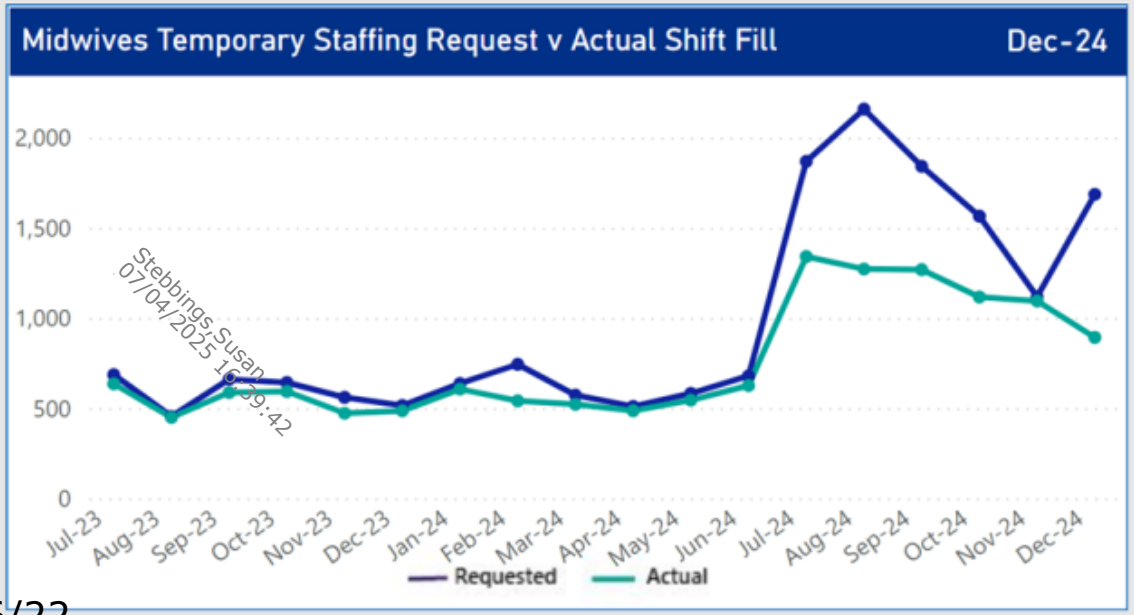
Nursing Temporary Staffing Request v Actual Shift Fill — Dec-24



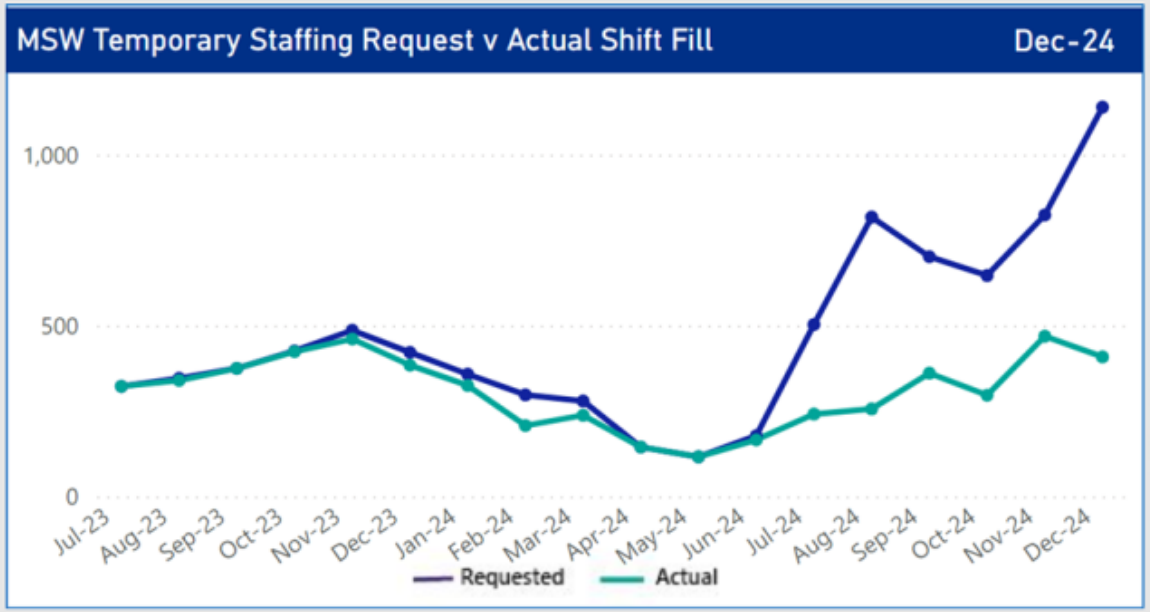
HCA Temporary Staffing Request v Actual Shift Fill — Dec-24



Midwives Temporary Staffing Request v Actual Shift Fill — Dec-24



MSW Temporary Staffing Request v Actual Shift Fill — Dec-24



Chief Nurse Report

Summary - Care Hour Per Patient Day (CHPPD)

Metric Name	Current Month	Actual	Change	Target	Variation	Assurance
CHPPD - Overall	Dec-24	8.09	0.12	None		N/A
CHPPD - Registered Nurses / Midwife	Dec-24	4.52	0.14	None	change	N/A
CHPPD - HCA / MSW	Dec-24	3.57	-0.02	None		N/A
CHPPD - CDS	Dec-24	60.49	14.70	None	change	N/A
CHPPD - Ward 11	Dec-24	11.56	3.59	None		N/A
CHPPD - ICU/HDU	Dec-24	26.33	-0.92	None	change	N/A
CHPPD - Paediatric (Ward 10, Neonatal)	Dec-24	12.29	-0.25	None		N/A
CHPPD - Non Specialist Ward	Dec-24	7.33	0.11	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

There was a minimal increase from November to December in the overall available CHPPD. Five metrics maintained the same variation pattern, RN/RM and ICU moved from common cause to special cause and CDS reverted back to common cause following one month in a special cause pattern.

CDS observed an average increase of nearly 15 CHPPD this month. Although this appears misaligned to the shift fill position there was a 30% (616 Nov v 430 in Dec) reduction in bed occupancy which meant less patients required care and consequently less demand on the available CHPPD.

CHPPD available for ICU/HDU patients increased slightly and was at an expected level for the environment. The Unit experienced a slight increase in patient throughput and the acuity of patients was high. The leadership contributed to available CHPPD capacity.

Paediatric CHPPD reduced slightly albeit on a background of Ward 10 experiencing a highly acute month with increased volumes of patients and NNU observing a 50% reduction in patient throughput.

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.

Chief Nurse Report

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 albeit with a small increase of CHPPD noted. This aligns to shift fill position and cumulative patient occupancy. The average registered v unregistered CHPPD distribution was 4.5 and 3.6 respectively.

The non specialist wards/depts are also maintaining a special cause variation and continue to be below the mean. The average CHPPD of 7.33 across the inpatient wards/depts is an overall improving picture however there remains a position of disparity between wards. CHPPD levels ranged from 5.9 (Ward 2) to 8.7 (Charnwood Suite). Twelve wards did not achieve a CHHPD of 7.5 or above. Five wards, 12, 3, 6, 18, 15, did not achieve a RN CHPPD of 3 or more. As previously reported the former three are as a result of intentional skill mix changes. The latter two are not and will require a period of monitoring. Both were included in the November 2024 Safe Staffing and Nurse Establishment Review recommendations to increase their funded establishments.

Next steps and planned impact

There are no new steps to report regarding CHPPD this month.

Risks

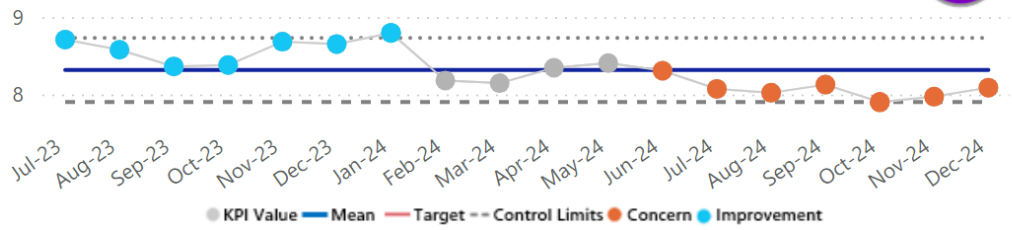
Risks associated with CHPPD reflect those noted through this report. The relationship to CHPPD is illustrated through over/under hours. The position for December 24 involved unmet demand rather above expected CHPPD;

- 13761.11 hours for registered nurses (1197 shifts – 107 more shifts than November)
- 4920.88 hours for healthcare assistants (428 shifts – 73 less shifts than November)
- 1645.84 hours for registered midwives (143 shifts – 14 more shifts than November)
- 992 hours for midwifery support workers (86 shifts – 25 more shifts than November)

In total this represents a total of 18681.99 excluding midwifery. This is an increase of 361 hours compared to last month. The unmet hours demand in midwifery were a total of 2638 which was an increase of 448 hours.

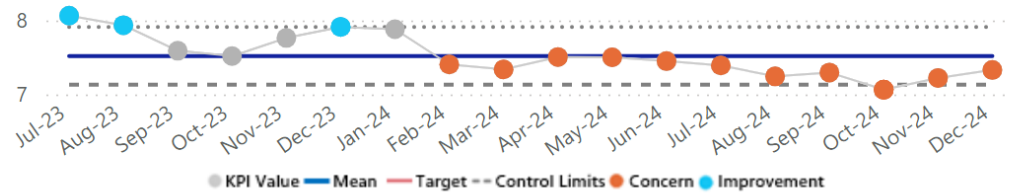
CHPPD - Overall — Dec-24

Target	Actual	Previous	Assurance	Variation
None	8.09	7.97	N/A	↘

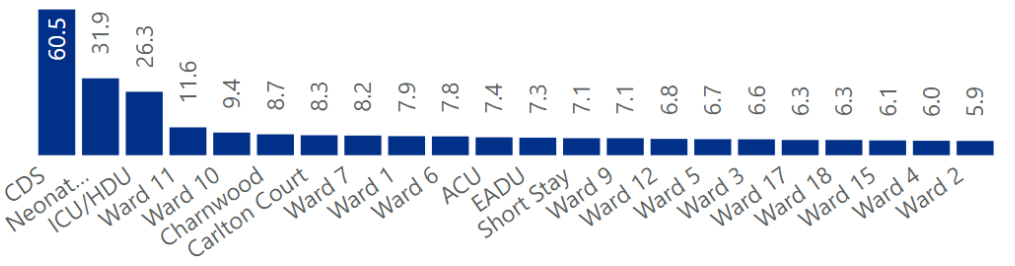


CHPPD - Non Specialist Ward — Dec-24

Target	Actual	Previous	Assurance	Variation
None	7.33	7.22	N/A	↘



CHPPD by Ward — Dec-24



Red Flag Index - Adults

Red Flag Descriptions and Totals

Unplanned omission in providing patient medications	0
Delay of more than 30 minutes in providing pain relief	3
Delay in the administration of IV antibiotics of > 60 mins	0
Patient observations not assessed or recorded as planned	0
Omission of planned intentional rounding	6
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)	224
Shortfall of 8 hours or 25% (whichever is reached first) of RN time available compared with actual requirement for shift	162
Total Adult Red Flags	395

Chief Nurse Report

Adult Red Flag Index

What the data tells us

Following review , the total number of red flag reports in December 24 was 395. This is a decrease of 41 compared to November.

Red flag 8 continues to be the highest reported incident with 224 occurrences. This is a decrease of 27 from last month and most reports relate to the day shift timings. Sixteen areas experienced this red flag across the month including the Emergency Department. Wards 12, 18, 4, 6 and 9 are the highest reporting areas. This continues to align to the clinical presentation of the patients cared for in these areas except for Ward 9 whereby the increase can be attributed to caring for both medical and trauma patients during this period as well as their own normal patient group. The volume of patient requiring enhanced supervision and engagement care featured strongly in the Safe Staffing and Nurse Establishment Review presented to HMG in December which represented the patient and acuity Safer Nursing Care Tool census undertaken in August 2024. From the data obtained and following professional judgement risk assessment, recommendations for establishment uplifts were made for Wards 1, 4, 12 ,15, 18 and EADU. There were 43 new Deprivation of Liberty (DOLs) applications during November and 22 carried over from October and November.

There were 162 red flag 9 reports in December. This is a reduction of 9 from November. This continues to be an under representation of the actual position. In January 25 data collection at the Chief Nurse Daily Staffing Summitt will change to enable Duty Matron/Site Team to make an accurate report of any below template positions that occur. For example, early indications are suggesting that on average there are template gaps of approximately 20 registered nurses both day and night shifts. Most gaps for healthcare assistants are in relation to enhanced supervision.
There are no exceptions to escalate from the remaining red flag categories.

Next steps and planned impact

Business as usual practice continues by the Trust Matrons and Senior Nurses to review and assess all red flag occurrences with actions being taken to minimise the potential for patient harm events and staff health and wellbeing compromise.

There remains work to undertake to improve accuracy of the pre validation red flag report submissions.

An evaluation of the changes made (Summer/Autumn 2024) to the enhanced supervision and engagement risk assessment and sign off process will be conducted in the next reporting period. This is to ensure that the expected processes have become embedded as intended and any additional changes can be made.

Risks

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.

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	0
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	2

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What the data tells us

There were two reported red flags in December. Both were relating no cover for 1:1 care of children with mental health needs. There were no other red flag triggers however the Paediatric Matron has confirmed that there have been several occasions whereby the staffing establishment template has not been met but not meet the red flag threshold.

Next steps and planned impact

There are no new steps to report this month regarding paediatric red flags.

Risks

There are no specific new risks to escalate this month regarding paediatric red flags. However, the Paediatric Safe Staffing Review will be presented to HMG in the next reporting period which will outline shortfalls in staffing numbers for the paediatric ward, neonatal unit and paediatric emergency department and associated risks.

Red Flag Index - Maternity

Red Flag Descriptions and Totals

Delayed or cancelled time critical activity	0
Missed or delayed care (for example, delay of 60 minutes or more in washing and suturing)	0
Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication)	0
Delay in providing pain relief	0
Delay between presentation and triage	0
Full clinical examination not carried out when presenting in labour	0
Delay between admission for induction and beginning of process	3
Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output)	0
Any occasion when 1 midwife is not able to provide continuous one-to-one care and support to a woman during established labour	0
Coordinator unable to maintain supernumerary status - NOT providing 1:1 care	2
Coordinator unable to maintain supernumerary status and providing 1:1 care	0
Total Maternity Red Flags	5

What the data tells us

A total of 5 red flags were raised in December 2024. 60% (3) was pertaining to the delay between admission for induction and beginning of process. 40% (2) was in respect of the senior midwife coordinator unable to remain fully supernumerary but not providing 1:1 care.

There were 1-2 occasions during December where staffing factors were recorded during assessment, but which did not influence the trigger of a red flag.

47% (48) of occasions were due to unexpected absence/sickness, 6% (6) included redeployment of staff, 41% (41) of occasions where there were vacant shifts, registered and unregistered. There was also a 3% increase in patient transfer, meaning a reduction in midwifery staffing in the unit. On 17 occasions deployment of staff took place.

Next steps and planned impact

There are no new steps to report this month regarding midwifery red flags.

Risks

On five occasions the Matron was asked to work in the unit to support acuity and on 2 occasions a specialist midwife was asked to support the unit but working clinically. Acknowledging these latter actions are the result of risk assessment outcome and are taken to reduce associated risk factors to patient safety and experience, there is the residual potential risk, should these number of occasions increase, of delays in work outputs from Matrons and other Senior Midwives.

There are no new risks to escalate regarding midwifery red flags this month.

Chief Nurse Report

Summary - Harm Events

Metric Name	Current Month	Actual	Change	Target	Variation	Assurance
Patient falls	Dec-24	70	-2	None		N/A
Patient falls requiring professional intervention (Moderate Harm and above)	Dec-24	2	0	2		?
Patient falls - Delerium	Dec-24	8	0	None		N/A
Patient falls - Dementia	Dec-24	10	2	None		N/A
Patient Falls - Inpatient	Dec-24	57	-6	None		N/A
Patient falls requiring professional intervention (Moderate Harm and above) - Inpatient	Dec-24	2	0	None		N/A
Hospital Acquired Unstageable Pressure Ulcers	Dec-24	2	2	None		N/A
Hospital Acquired Category 1 Pressure Ulcers	Dec-24	2	-3	None		N/A
Hospital Acquired Category 2 Pressure Ulcers	Dec-24	15	1	0		F
Hospital Acquired Category 3 Pressure Ulcers	Dec-24	0	0	0		?
Hospital Acquired Category 4 Pressure Ulcers	Dec-24	0	0	0		?
Hospital Acquired Deep Tissue Injury	Dec-24	3	-1	0		?
Hospital Acquired Moisture Lesions	Dec-24	11	-3	0		F
Medicine Management Incidents	Dec-24	26	-1	None		N/A
Medicine Management Incidents with Moderate Harm and Above	Dec-24	0	-1	None		N/A

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Summary

All harm metrics are demonstrating common cause variation except for two changes in month, these being falls with patient with delirium and unstageable pressure ulcers. Both have moved to special cause neither concern nor improvement.

Compared to November the volume of actual/potential harm incndets changed by;

- 7 categories decreased
- 3 categories increased
- 5 categories remained the same

Inpatient falls reduced by 6 compared to last month. There was an increase of 2 patient falls involving patients living with dementia or experiencing delirium.

There was a reduction in category 1 pressure ulcers and moisture lesions however following validation the volume of moisture lesions increased to 24 across both Divisions.

There were 26 medicines management incidents.

There were several QSAFE reports this month which included reference to delays in care delivery resulting in incontinence not being dealt with in a timely way, unwitnessed falls, delays in medications, ability to respond to enhanced supervision and engagement needs. Red flag reports are not being used to supplement the QSAFE reports describing the actual patient care/safety/experience impact. Work is ongoing to improve this position.

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 has moved from common cause variation to special cause improvement this month. There was a reduction of six falls compared to November however this is a slight variance compared to Divisional DPM data. This will be reviewed to achieve data accuracy for this and the DPM reports.

Moderate and above harms falls occurred on Wards 15 and 18. Both patients sustained fractures (1 x trochanter and 1 x orbital). Both patients were assessed as requiring a level of enhanced supervision. Staffing shortfalls were reported for Ward 15.

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 the ward areas where falls occurred.

The three highest reporting inpatient areas for falls were: EADU (10), Ward 1 (8) and Ward 4 (6)., The associated average shift fill for those areas were; 97.1%, 81.8%, 87.9%, respectively. The Emergency Department also reported six falls and had an average shift fill rate of 84.3%

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

As previously noted, 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)

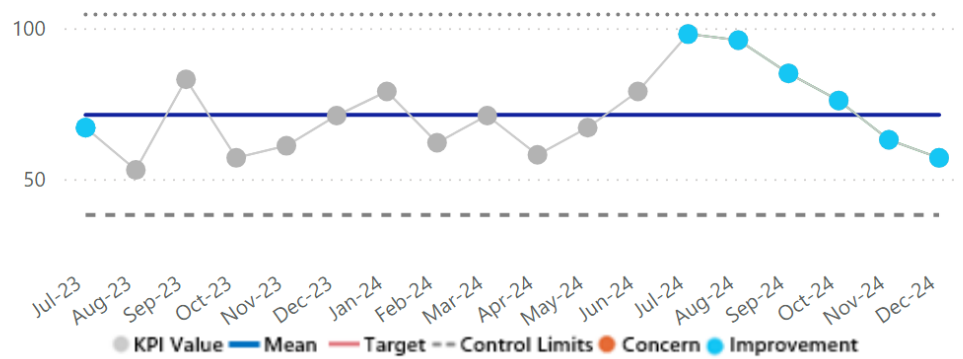
Risks

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
- financial impact of treating injuries from falls including increased length of stay costs

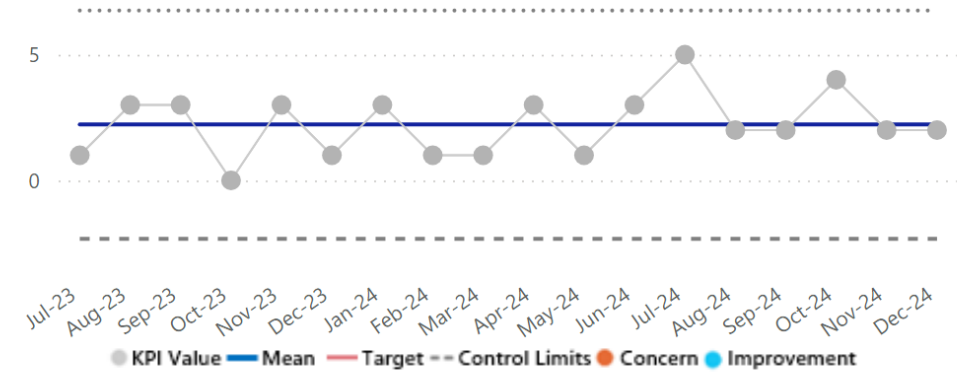
Patient Falls - Inpatient — Dec-24

Target	Actual	Previous	Assurance	Variation
None	57	63	N/A	



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

Target	Actual	Previous	Assurance	Variation
None	2	2	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 which has been sustained for a period of eight months. Including moisture lesions the current validated position for these incidents is each clinical Division in December is;

Division of Medicine x 30
Division of Surgery x 6

Ward 6 reported the highest number of skin integrity incidents. The average shift fill rate was 83.9%.

Next steps and planned impact

The action noted last month to review data accuracy of following Divisional validation of incident numbers has not yet taken place. The Deputy Chief Nurse will action this in the next reporting period.

Work has started between the PSIRF Level 3 Insight and Improvement Group and the Tissue Viability Nurse Specialist to develop and agree an updated education resource for ward-based education via the Quality Trolley.

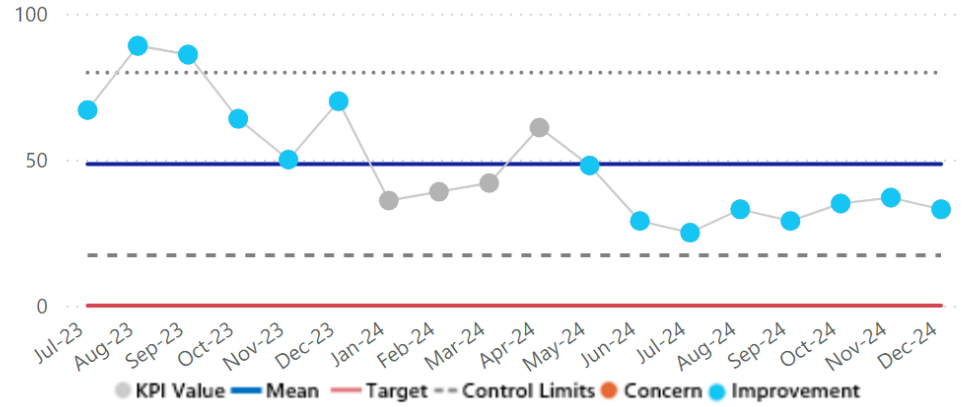
Risks

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 14) and slide 3.

As noted last month , the lack of capacity within the Tissue Viability Team, specifically the Tissue Viability Nurse Specialist, means that specialist advice and guidance is not always available at the level and time required. This is especially pertinent to Carlton Court who do not receive input form the TVN Team and therefor validation of incident reports do not take place..

Hospital Associated Skin Integrity Incidents — Dec-24

Target	Actual	Previous	Assurance	Variation
0	33	37	N/A	↘



Harm Events - Medicines Management

What the data tells us

Medicine management incidents remain in a pattern of common cause variation with a reduction if one incident from last month. Incident categories include; drug administration errors, controlled drugs, missed doses and insulin/diabetes related incidents.

There were no moderate or above harm incidents and the variation pattern remains common cause variation.

There is no reported correlation between the medicines management incidents and to safe staffing or skill mix concerns

Next steps and planned impact

There are no new steps to report this month regarding safe staffing and medicines safety

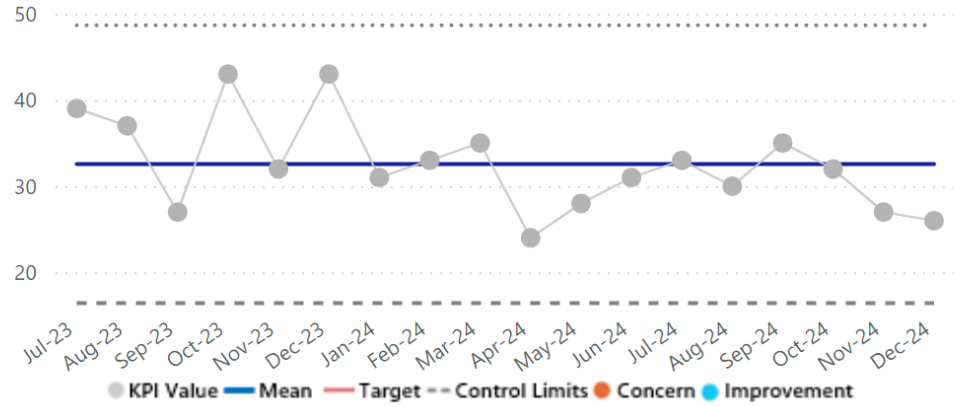
Risks

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, 14, and 15.

Stephanie Susan 07/04/2025 16:39:42

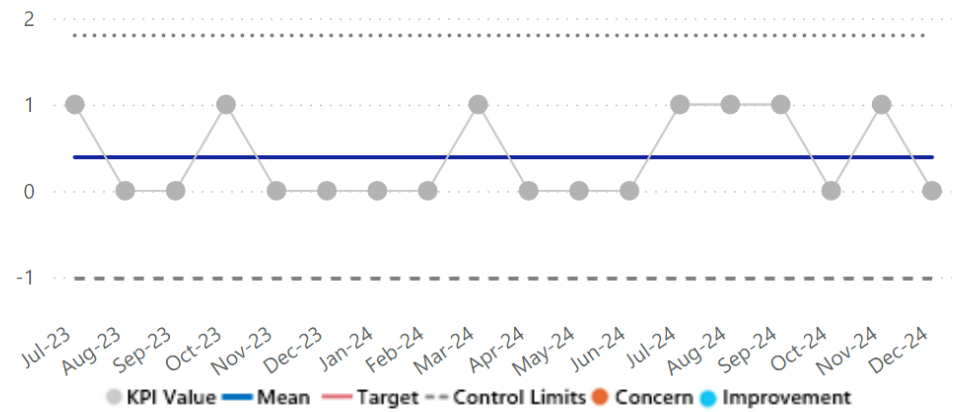
Medicine Management Incidents — Dec-24

Target	Actual	Previous	Assurance	Variation
None	26	27	N/A	



Medicine Management Incidents with Moderate Harm and Above — Dec-24

Target	Actual	Previous	Assurance	Variation
None	0	1	N/A	



Chief Nurse Report

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 December 2024 was 8.88 vacancies. This is a move out of the long standing over establishment status. Main contributory factors to the change are increased departmental vacancy levels and a reduction in over establishments, most notably in the Division of Surgery. Some over establishment in corporate departments continue to include externally funded posts.

Maternity leave levels remain consistent this month at 62.43 wte. This includes 50.48 wte band 5 nurses. Ten areas have two or more wte on maternity leave. In particular, Ward 4 (4), Theatres (5) Ward 21 (3.64) ICU (3), NNU (3.44), ED (3.64) and Ward 15 (3) are impacting on shift fill and available CHPPD.

The nursing associate vacancy level is 9.02 wte. The majority of this held in the Division of Surgery and currently off sets the band 5 over establishments on wards 22, 6 and 5. As has been previously reported, this current vacancy position is not truly representative of nursing associate vacancy levels because many of the band 4 positions are 'housing' other apprenticeships. This will take about another 12 months to correct itself and provide a true picture of nursing associate vacancy levels.

Next steps and planned impact

There are no new steps to report this month regarding vacancies. Recruitment and retention activities continue where relevant. The cross divisional Vacancy and Allocation meeting continues to be held monthly. In January 25 allocation will be confirmed for the nursing degree apprentices graduating in February and March.

With the closure of Ward 7 in the reporting period there will be a reduction of 15 registered nurse vacancies in the Division of Medicine once redeployment paperwork has been processed. This may revert us back into an overall over establishment position and will be monitored accordingly.

Recruitment and retention activities continue with collaboration between the people and culture and corporate and divisional nursing teams.

Risks

Current risks associated with vacancy levels 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

Registered Nurses — Dec-24

Overall	Corporate	Medicine	Surgery
Over Established	-20.65	-33.76	-34.91
Vacancies	11.77	55.51	30.84
Net Balance	-8.88	21.75	-4.07
Maternity Leave	5.00	36.40	21.03
Overall	-3.88	58.15	16.96

Inpatient Areas Only	Corporate	Medicine	Surgery
Over Established	-2.17	-11.75	-29.49
Vacancies	1.16	28.30	5.26
Net Balance	-1.01	16.55	-24.23
Maternity Leave	1.00	24.21	14.35
Overall	-0.01	40.76	-9.88

Nursing Associates — Dec-24

	Medicine	Surgery
Over Established	-3.98	-2.00
Vacancies	3.76	11.24
Net Balance	-0.22	9.24

Healthcare Assistants — Dec-24

	Corporate	Medicine	Surgery
Over Established	0.00	-41.29	0.00
Vacancies	9.62	53.52	12.67
Net Balance	9.62	12.23	12.67

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. This will balance out in the next few weeks as the band 5 preceptees achieve their sign off and move into the band 6 roles. This will leave a 0.68 wte vacancy level at band 6.

Maternity leave has slightly increased this month to 5.12 wte.

Midwifery support worker vacancies have reduced this month by 5.08 wte at band 3 and 1.12 at band 2. Following the national role profiling for unregistered healthcare support workers, work continues to determine midwifery support worker

Next steps and planned impact

In addition to this there are vacancies (not illustrated) for the maternity triage area which are currently working through relevant stages of the recruitment process.

Risks

There are no new risks to escalate this month regarding midwifery vacancy levels.

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Registered Midwives — Dec-24

	Band 5	Band 6	Band 7
Over Established	-7.36	0.00	-1.17
Vacancies	0.00	8.04	0.48
Net Balance	-7.36	8.04	-0.69
Maternity Leave	0.96	4.16	0.40

Midwife Support Workers — Dec-24

	Band 2	Band 3
Over Established	0.00	-0.56
Vacancies	0.40	2.97
Net Balance	0.40	2.41

Chief Nurse Report

Summary - Starters and Leavers

Metric Name	Current Month	Actual	Target	Variation	Assurance
Registered Nurse Starter - In Month	Dec-24	1.0	None		N/A
Registered Nurse Leavers - In Month	Dec-24	1.6	None		N/A
Registered Nurse FTE Growth Cumulative - Last 18 Months	Dec-24	-3.0	None		N/A
Registered Nurse % FTE Turnover rolling 12 months	Dec-24	4.4%	10.0%	L	P
Registered Midwife Starter - In Month	Dec-24	2.6	None		N/A
Registered Midwife Leavers - In Month	Dec-24	0.0	None		N/A
Registered Midwife FTE Growth Cumulative - Last 18 Months	Dec-24	5.6	None	↗	N/A
Registered Midwife % FTE Turnover rolling 12 months	Dec-24	4.2%	10.0%		P
Midwifery Support Worker Starter - In Month	Dec-24	0.0	None		N/A
Midwifery Support Worker Leavers - In Month	Dec-24	0.0	None		N/A
Midwifery Support Worker FTE Growth Cumulative - Last 18 Months	Dec-24	3.4	None	↗	N/A
Midwifery Support Worker % FTE Turnover rolling 12 months	Dec-24	3.2%	10.0%	L	?
Health Care Assistant Starter - In Month	Dec-24	1.6	None		N/A
Health Care Assistant Leavers - In Month	Dec-24	1.0	None		N/A
Health Care Assistant FTE Growth Cumulative - Last 18 Months	Dec-24	43.1	None	↗	N/A
Health Care Assistant % FTE Turnover rolling 12 months	Dec-24	4.7%	10.0%	L	P

Summary

There are no changes to the variation patterns for starters and leavers this month and generally, there is a picture of stability in all areas with no specific concerns noted from the data.

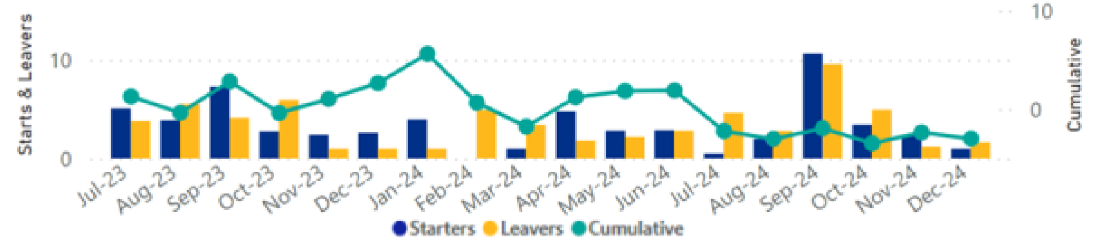
NHSi SPC Icon Key

Variation				Assurance		
	H L	H L	↘ ↗	?	P	F
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

Starters and Leavers - Registered Nurses & Health Care Assistants

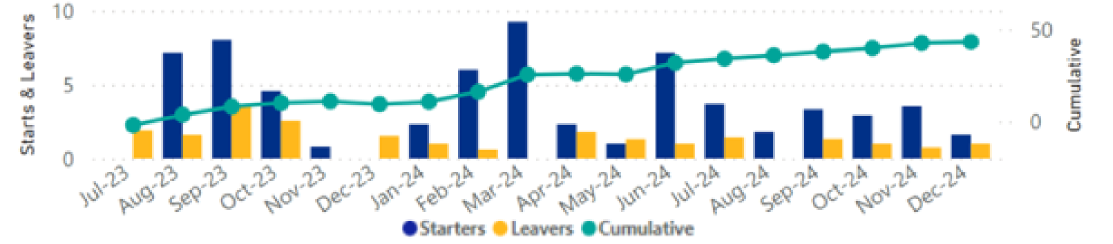
Registered Nurse FTE Growth Cumulative - Last 18 Months — Dec-24

Target	Actual	Previous
None	-3.0	-2.5



Health Care Assistant FTE Growth Cumulative - Last 18 Months — Dec-24

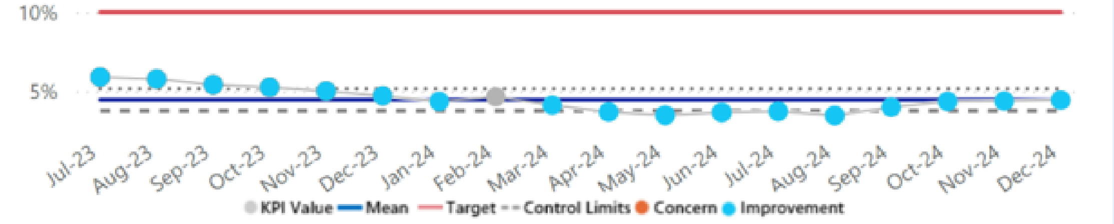
Target	Actual	Previous
None	43.1	37.0



Registered Nurse % FTE Turnover rolling 12 months — Dec-24

Target	Actual	Previous
10.0%	4.4%	4.4%

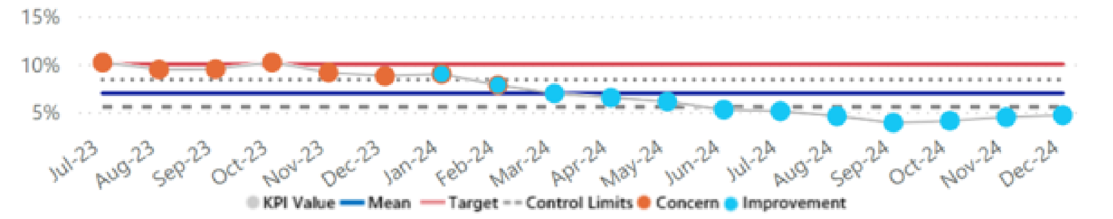
Assurance | Variation



Health Care Assistant % FTE Turnover rolling 12 months — Dec-24

Target	Actual	Previous
10.0%	4.7%	4.4%

Assurance | Variation



What the data tells us

The 18-month growth for registered nurse is relative to last month with a below zero growth rate for the past six months. Healthcare assistant 18-month growth further increased this month to 43.1 wte. There was no change in the 12-month rolling turnover for RNs and minimal change for HCAs. And both remain in special cause variation.

The 12-month average starter rate for RNs was 31.71 and 43.09 wte for leavers. Neither present a concern currently however, the cumulative leaver rate has increased by 8.18wte from 34.91 in May 24. Starter rates have increased by 3.32 wte for the same period. The in month starter rate decreased by 0.62 and leaver rate increased by 1.64 wte.

There were 1.6 wte HCA starters and 1 leaver. HCA recruitment continues for known vacancies.

Next steps and planned impact

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

- monthly vacancy and allocation review meeting
- regular review of the registered nurse (inc. nursing associates) workforce/pipeline plan

Delayed, but key actions to take forward with People and Culture team colleagues include;

- targeted 'stay' conversations
- exit interviews analysis
- develop a 'transfer window' process

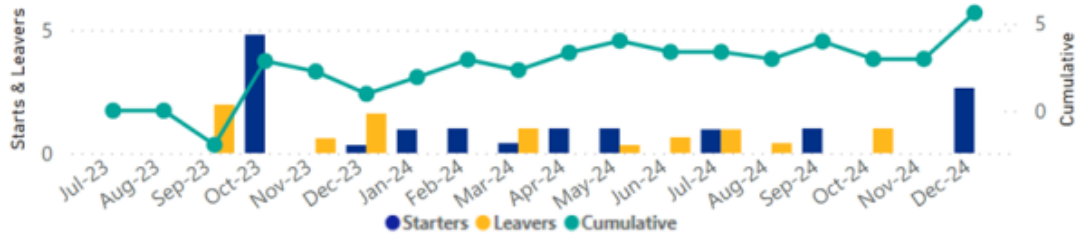
Risks

There are no new risks to escalate in regard of vacancy levels for registered nurses and healthcare assistants this month.

Starters and Leavers - Registered Midwives & Midwifery Support Workers

Registered Midwife FTE Growth Cumulative - Last 18 Months — Dec-24

Target	Actual	Previous
None	5.6	3.0

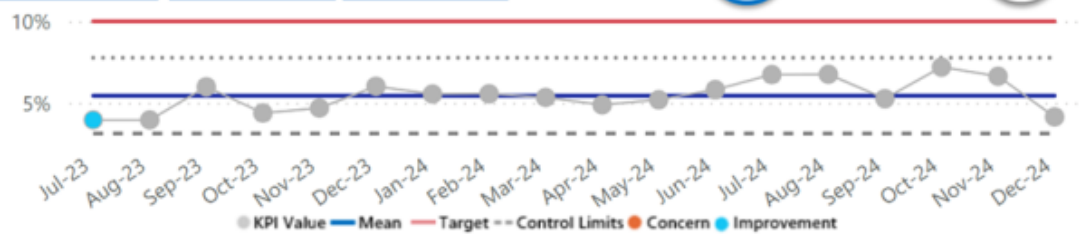


Midwifery Support Worker FTE Growth Cumulative - Last 18 Months — Dec-24

Target	Actual	Previous
None	3.4	2.8

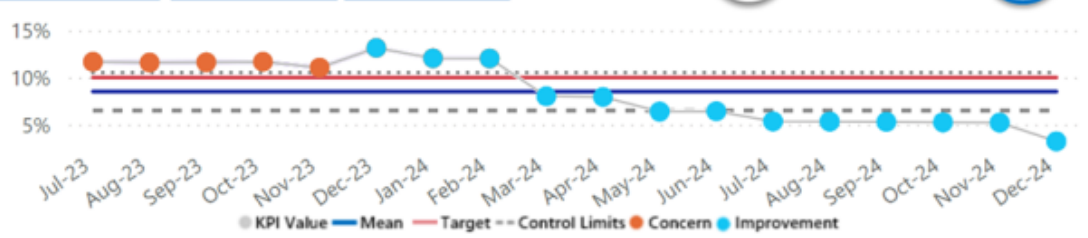
Registered Midwife % FTE Turnover rolling 12 months — Dec-24

Target	Actual	Previous	Assurance	Variation
10.0%	4.2%	6.6%	P	



Midwifery Support Worker % FTE Turnover rolling 12 months — Dec-24

Target	Actual	Previous	Assurance	Variation
10.0%	3.2%	5.2%	?	L



What the data tells us

The 18-month growth rate for registered midwives grew by 2.6 wte this month. Midwifery support worker for the same period increased by 0.6 wte.

The 12-month rolling turnover decreased for both staff groups moving by 2.4 and 2% respectively. The is no change to the variation patterns for either this month.

There were 2.6 RM starters and zero leavers. Midwifery support worker starters and leavers were both zero.

0 leavers and starters for MSW

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.

Nursing and Midwifery Pipeline and Workforce Planning

What the data tells us

2025 Registered Nurse Graduates			
	February 25	August 25	September/October 25
Direct Entry Nursing Degree			10
Nursing Degree Apprentice (2 yr)	5		6
Nursing Degree Apprentice (4 yr)	4	4	
Internationally Educated Nurses (x 10 in total)	if required	if required	If required

2025 Nursing Associate Graduates			
	Feb 25	Aug 25	Sept/Oct 25
Nursing Associates (Band 4)	4		5

2025 New Learners		
	February 25	September 25
Direct Entry Nursing Degree Learner (3 yr JPUH Scholarship)		15
Nursing Degree Apprentices (2 yr)	10	

The top two sections in the table to the left outline the volume of registered nurses and nursing associates graduating in 2025 as well as the planned internationally educated nurse recruitment numbers should it be required.
The last table shows the number of new learner we will be commissioning this year which includes the JPUH direct entry nursing degree scholarship.

Next steps and planned impact

The Safe Staffing and Nurse Establishment Review for Adult Inpatient Areas was presented to Hospital Management Group (HMG) in December 2024. The review outcomes were accepted in principle however further discussion is required regarding the affordability of the associated recommendations.

The Safe Staffing and Nurse Establishment Review for Paediatric Areas was scheduled to be presented to HMG in January 2025. There is a slight delay with this, and presentation will now take place in February.

The last six-monthly Midwifery Safe Staffing review was presented in November 2024 following which not all recommendations were supported, specifically concerning the proposed change in model for the Continuity of Carer. Plans are progressing to undertake the next Birthrate + exercise and the review period for this process are currently being negotiated.

The Safe Staffing and Nurse Establishment Review for the Emergency Department was scheduled to be presented to HMG in November 2024. There has been some data accuracy issues to resolve and therefore presentation will now be in March 2025.

The Trust has People and Culture and Nursing representation on the East of England Job Evaluation Collaboration which is in response to the national project reviewing job matching profiles for nursing and midwifery. This will be for bands 4 – 9 roles and reflective of the recent reviews for bands 2 and 3 healthcare support workers.

Risks

The greatest risk to our registered nurse and nursing associate pipeline plan is that we do not attract enough new registrants to meet the demand of our turnover losses. Should this occur there are obvious risks to our ability to meet shift requirements and have sufficient CHPPD capacity to meet the needs of our patients. Consequential associated risks are that to patient safety and experience, staff health and wellbeing, financial and reputational.

Work is ongoing to ensure that the workforce plan is reviewed regularly and any concerns regarding deviation or the need to review the projected requirements are escalated accordingly. Currently the workforce plan intention to attract 40 new registrants to work for the Trust in 2025 is on track however this is slightly below the current turnover number of 43 registered nurses.

Safe Staffing (Rota Fill Rates and CHPPD) Collection

Organisation: RGP JAMES PAGET UNIVERSITY HOSPITALS NHS FOUNDATION TRUST

Please provide the URL to the page on your trust website where your staffing information is available

(Please can you ensure that the URL you attach to the spreadsheet is correct and links to the correct web page and include 'http://' in your URL)

There may be issues with these data. Please review the Warnings tab for more information

Only complete sites your organisation is accountable for

Hospital Site Details			Main 2 Specialties on each ward		Day							
					Registered Nurses/Midwives		Non-registered Nurses/Midwives (Care Staff)		Registered Nursing Associates		Non-registered Nursing Associates	
Site code *The Site code is automatically populated when a Site name is selected	Hospital Site name	Ward name	Specialty 1	Specialty 2	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours
		Total			**43162.92**	**34209.94**	**31861.16**	**26035.02**	**0**	**0**	**0**	**0**
RGP75	JAMES PAGET UNIVERSITY HOSPITAL	JPH ACU	320 - CARDIOLOGY		1153.16	820.83	366.83	325.66				
RGP75	JAMES PAGET UNIVERSITY HOSPITAL	JPH Charnwood Suite	100 - GENERAL SURGERY		744	751	420	394.75				
RGP75	JAMES PAGET UNIVERSITY HOSPITAL	JPH Core Maternity	501 - OBSTETRICS		4216.15	3409.06	1863	1150				
RGP75	JAMES PAGET UNIVERSITY HOSPITAL	JPH EADU	300 - GENERAL MEDICINE		2571	2232.33	1524.41	1638				
RGP75	JAMES PAGET UNIVERSITY HOSPITAL	JPH ICU	192 - CRITICAL CARE MEDICINE		4187.66	3534	826.83	375.5				
RGP75	JAMES PAGET UNIVERSITY HOSPITAL	JPH Neonatal Unit	422 - NEONATOLOGY		1476.25	950.66	361.41	393.5				
RGP75	JAMES PAGET UNIVERSITY HOSPITAL	JPH Short Stay (Ward16)	300 - GENERAL MEDICINE		1948.98	1436.21	835.5	954.5				
RGP75	JAMES PAGET UNIVERSITY HOSPITAL	JPH Ward 1 Stroke Unit	328 - STROKE MEDICINE		2566.75	2073.83	2217.5	1409.83				
RGP75	JAMES PAGET UNIVERSITY HOSPITAL	JPH Ward 10	420 - PAEDIATRICS		3136.41	1635.33	1879.91	1430.66				
RGP75	JAMES PAGET UNIVERSITY HOSPITAL	JPH Ward 12	430 - GERIATRIC MEDICINE		2552.25	1856.16	2286	2194.91				
RGP75	JAMES PAGET UNIVERSITY HOSPITAL	JPH Ward 3	301 - GASTROENTEROLOGY		1941.75	1356.66	2155	1841.5				
RGP75	JAMES PAGET UNIVERSITY HOSPITAL	JPH Ward 17	303 - CLINICAL HAEMATOLOGY		1764	1162.25	920	840.25				
RGP75	JAMES PAGET UNIVERSITY HOSPITAL	JPH Ward 18	300 - GENERAL MEDICINE		1094.9	1098.31	1549.46	1394.98				
RGP75	JAMES PAGET UNIVERSITY HOSPITAL	JPH Ward 22	110 - TRAUMA & ORTHOPAEDICS		34.5	0	46	3.5				
RGP75	JAMES PAGET UNIVERSITY HOSPITAL	JPH Ward 22 Escalation	300 - GENERAL MEDICINE		1502.5	1190.5	1132.41	774.58				
RGP75	JAMES PAGET UNIVERSITY HOSPITAL	JPH Ward 2	320 - CARDIOLOGY		1184.91	1047.16	1238.33	1041.66				
RGP75	JAMES PAGET UNIVERSITY HOSPITAL	JPH Ward 15	340 - RESPIRATORY MEDICINE		1853.75	1454.08	1703.16	1279.33				
RGP75	JAMES PAGET UNIVERSITY HOSPITAL	JPH Ward 4	502 - GYNAECOLOGY		1805.5	1580.83	1806	1512.25				
RGP75	JAMES PAGET UNIVERSITY HOSPITAL	JPH Ward 5	100 - GENERAL SURGERY		1794	1741.75	1805	1297.25				
RGP75	JAMES PAGET UNIVERSITY HOSPITAL	JPH Ward 6	100 - GENERAL SURGERY		1782.5	1488.25	3220.5	2489.5				
RGP75	JAMES PAGET UNIVERSITY HOSPITAL	JPH Ward 7	300 - GENERAL MEDICINE		229	147.58	287.75	114.5				
RGP75	JAMES PAGET UNIVERSITY HOSPITAL	JPH Ward 9	100 - GENERAL SURGERY		1282.5	1155.5	1247	1072.25				
RGP75	JAMES PAGET UNIVERSITY HOSPITAL	JPH Carlton Court	300 - GENERAL MEDICINE		2340.5	2087.66	2169.16	2106.16				

	Night								Allied Health Professionals				
	Registered Nurses/Midwives		Non-registered Nurses/Midwives (Care Staff)		Registered Nursing Associates		Non-registered Nursing Associates		Registered allied health professionals		Non-registered allied health professionals		
Ward name	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Cumulative count over the month of patients at 23:59 each day
Total	**37558.32**	**31104.35**	**25600.32**	**25513.58**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**14456**
JPH ACU	745.5	721.83	366.83	366.83									301
JPH Charnwood Suite	744	746.83	120	119.5									232
JPH Core Maternity	4083.5	3244.75	1117	838									430
JPH EADU	1936.33	1938	1762.83	1756.5									1039
JPH ICU	4037.16	3341.08	366.83	331.33									288
JPH Neonatal Unit	1467.33	938.33	366.83	461.5									86
JPH Short Stay (Ward16)	1230.5	1173	1023.5	954.5									639
JPH Ward 1 Stroke Unit	2300	2134.81	2277	2043.6									968
JPH Ward 10	1977	1608	497	782.66									581
JPH Ward 12	2162	1450.81	2058.5	2405.25									1167
JPH Ward 3	1932	1346.91	1811.5	2128.5									1012
JPH Ward 17	793.5	782	644	644									542
JPH Ward 18	1094.5	1085.75	1173	1139.5									746
JPH Ward 22	34.5	34.5	23	23									112
JPH Ward 22 Escalation	1104	759.5	713	546.5									183
JPH Ward 2	1104	1012	575	543.5									615
JPH Ward 15	1529.5	1253.5	1667.5	1551.5									903
JPH Ward 4	1794	1541.5	1541	1473									1017
JPH Ward 5	1943.5	1408	1504.5	1499									894
JPH Ward 6	2035.5	1334	2576	2754.91									1032
JPH Ward 7	207	115	276	161									66
JPH Ward 9	1161.5	1070.25	1000.5	908									596
JPH Carlton Court	2141.5	2064	2139	2081.5									1007

	Care Hours Per Patient Day (CHPPD)						
Ward name	Registered Nurses/Midwives	Non-registered Nurses/Midwives	Registered Nursing Associates	Non-registered Nursing Associates	Registered allied health professionals	Non-registered allied health professionals	Overall
Total	**4.5**	**3.6**	**0.0**	**0.0**	**0.0**	**0.0**	**8.1**
JPH ACU	5.1	2.3	0.0	0.0	0.0	0.0	7.4
JPH Charnwood Suite	6.5	2.2	0.0	0.0	0.0	0.0	8.7
JPH Core Maternity	15.5	4.6	0.0	0.0	0.0	0.0	20.1
JPH EADU	4.0	3.3	0.0	0.0	0.0	0.0	7.3
JPH ICU	23.9	2.5	0.0	0.0	0.0	0.0	26.3
JPH Neonatal Unit	22.0	9.9	0.0	0.0	0.0	0.0	31.9
JPH Short Stay (Ward16)	4.1	3.0	0.0	0.0	0.0	0.0	7.1
JPH Ward 1 Stroke Unit	4.3	3.6	0.0	0.0	0.0	0.0	7.9
JPH Ward 10	5.6	3.8	0.0	0.0	0.0	0.0	9.4
JPH Ward 12	2.8	3.9	0.0	0.0	0.0	0.0	6.8
JPH Ward 3	2.7	3.9	0.0	0.0	0.0	0.0	6.6
JPH Ward 17	3.6	2.7	0.0	0.0	0.0	0.0	6.3
JPH Ward 18	2.9	3.4	0.0	0.0	0.0	0.0	6.3
JPH Ward 22	0.3	0.2	0.0	0.0	0.0	0.0	0.5
JPH Ward 22 Escalation	10.7	7.2	0.0	0.0	0.0	0.0	17.9
JPH Ward 2	3.3	2.6	0.0	0.0	0.0	0.0	5.9
JPH Ward 15	3.0	3.1	0.0	0.0	0.0	0.0	6.1
JPH Ward 4	3.1	2.9	0.0	0.0	0.0	0.0	6.0
JPH Ward 5	3.5	3.1	0.0	0.0	0.0	0.0	6.7
JPH Ward 6	2.7	5.1	0.0	0.0	0.0	0.0	7.8
JPH Ward 7	4.0	4.2	0.0	0.0	0.0	0.0	8.2
JPH Ward 9	3.7	3.3	0.0	0.0	0.0	0.0	7.1
JPH Carlton Court	4.1	4.2	0.0	0.0	0.0	0.0	8.3

	Day				Night				Allied Health Professionals	
Ward name	Average fill rate - Registered Nurses/Midwives (%)	Average fill rate - Non-registered Nurses/Midwives (care staff) (%)	Average fill rate - Registered Nursing Associates (%)	Average fill rate - Non-Registered Nursing Associates (%)	Average fill rate - Registered Nurses/Midwives (%)	Average fill rate - Non-registered Nurses/Midwives (care staff) (%)	Average fill rate - Registered Nursing Associates (%)	Average fill rate - Non-Registered Nursing Associates (%)	Average fill rate - registered allied health professionals (AHP) (%)	Average fill rate - non-registered allied health professionals (AHP) (%)
Total	**79%**	**82%**	**-**	**-**	**83%**	**100%**	**-**	**-**	**-**	**-**
JPH ACU	71%	89%	-	-	97%	100%	-	-	-	-
JPH Charnwood Suite	101%	94%	-	-	100%	100%	-	-	-	-
JPH Core Maternity	81%	62%	-	-	79%	75%	-	-	-	-
JPH EADU	87%	107%	-	-	100%	100%	-	-	-	-
JPH ICU	84%	45%	-	-	83%	90%	-	-	-	-
JPH Neonatal Unit	64%	109%	-	-	64%	126%	-	-	-	-
JPH Short Stay (Ward16)	74%	114%	-	-	95%	93%	-	-	-	-
JPH Ward 1 Stroke Unit	81%	64%	-	-	93%	90%	-	-	-	-
JPH Ward 10	52%	76%	-	-	81%	157%	-	-	-	-
JPH Ward 12	73%	96%	-	-	67%	117%	-	-	-	-
JPH Ward 3	70%	85%	-	-	70%	117%	-	-	-	-
JPH Ward 17	66%	91%	-	-	99%	100%	-	-	-	-
JPH Ward 18	100%	90%	-	-	99%	97%	-	-	-	-
JPH Ward 22	0%	8%	-	-	100%	100%	-	-	-	-
JPH Ward 22 Escalation	79%	68%	-	-	69%	77%	-	-	-	-
JPH Ward 2	88%	84%	-	-	92%	95%	-	-	-	-
JPH Ward 15	78%	75%	-	-	82%	93%	-	-	-	-
JPH Ward 4	88%	84%	-	-	86%	96%	-	-	-	-
JPH Ward 5	97%	72%	-	-	72%	100%	-	-	-	-
JPH Ward 6	83%	77%	-	-	66%	107%	-	-	-	-
JPH Ward 7	64%	40%	-	-	56%	58%	-	-	-	-
JPH Ward 9	90%	86%	-	-	92%	91%	-	-	-	-
JPH Carlton Court	89%	97%	-	-	96%	97%	-	-	-	-

James Paget University Hospitals NHS Foundation Trust

Report to the Trust Board of Directors dated Friday, 31 January 2025

Title: Clinical Negligence Scheme for Trusts (CNST) Year 6

Sponsor:	Chief Nurse
Author:	Charlotte Underdown, Project Manager
Previous scrutiny:	Each Safety Action is scrutinised through a framework where assurance is evidenced with the Local Maternity and Neonatal System (LMNS) in conjunction with the Maternity and Neonatal Voices Partnership (MNVP). CNST evidence has been scrutinised by the Trust Exec in two meetings reviewing Safety Actions 1 to 5 on 4th December 2024, and the second, Safety Actions 6 to 10 on 8th January 2025. Approval was given at EMIG, 13/01/2025 Patient Safety and Quality Committee, 21/01/2025
Purpose:	The paper is presented for Information.
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

NHS Resolution operated year 6 of the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) between the 2nd April 2024 to the 30th November 2024 to continue to support the delivery of safer maternity care. The full guidance for the 10 Safety Actions for year 6 was released on the 2nd April 2024 and the detail can be found here: MIS-Year-6-guidance.pdf (resolution.nhs.uk).To qualify for payment under the scheme, Trusts must be compliant with all elements contained within the 10 Safety Actions and submit a completed Board declaration to NHS Resolution by 12 noon on 3rd March 2025.To ensure compliance with these safety actions, a monthly update was presented at each Executive Maternity Improvement Group throughout the reporting period to demonstrate progress against the safety actions to date. Evidence was then presented for approval at the Perinatal Evidence Review Meeting (PERM) with attendance from NHS England, the trust board and executive teams, the LMNS and the wider multidisciplinary team. The aim of this was to enable early 'sign off' of these completed actions to assist with timely Board declaration.

Recommendation

The Board of Directors is recommended to note the attached reports and contents they are in.

Current Compliance

The current compliance with MIS year 6 safety actions is summarised in the table below. All actions have met the standards with 85 out of the 85 actions meeting MIS compliance fully on or before the 30th November 2024. The evidence for Safety Action 1-5 which we had internally rated as **Green-Complete** were reviewed at the 4th December 2024 Perinatal Evidence Review Meeting (PERM) - with board level attendance, and all actions within Safety Action 1-5 were agreed as complete and RAG rating changed to **Blue – Final Evidence reviewed**. The evidence for Safety Action 6-10 which we had internally rated as **Green-Complete** was reviewed at the next PERM meeting on the 8th January 2025 and all actions were agreed as completed and RAG rating was changed to **Blue – Final Evidence reviewed**.

Following the 2 Perinatal Evidence Review Meetings (PERM), the CNST evidence was presented at the following:

- 13th January 2025 at Executive Maternity Improvement Group **(EMIG)**

Following this, the CNST evidence will be presented at the following:

- 15th January 2025 at **LMNS board**
- 21st January 2025 at **Patient Safety and Quality**
- 30th January 2025 at **JPUH Trust Board**.

Overview

Overview of progress on safety action requirements

Safety Action Requirements:

Safety Action	Red	Amber	Green	Blue	Total Requirements
1	0	0	0	6	6
2	0	0	0	2	2
3	0	0	0	4	4
4	0	0	0	20	20
5	0	0	0	6	6
6	0	0	0	6	6
7	0	0	0	7	7
8	0	0	0	17	17
9	0	0	0	9	9
10	0	0	0	8	8
Total	0	0	0	85	85

Key:

Red	Not compliant
Amber	Partial compliance - work underway
Green	Full compliance - evidence not yet reviewed
Blue	Full compliance - final evidence reviewed

Full details of the MIS action plan can be found in Appendix 1 of this report.

Breakdown

Safety Action 1: Are you using the National Perinatal Mortality Review Tool (PMRT) to review perinatal deaths from 8 December 2023 to 30 November 2024 to the required standard?

Current compliance: 100% Compliant. All actions RAG rated Blue.

Board sign off: Reporting period for Safety Action 1 is from the 8th December 2023 to the 30th November 2024. Board review off took place at the Perinatal Evidence Review meeting on the 4th December 2024 and board sign off was given.

Safety Action 2: Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?

Current compliance: 100% Compliant. All actions RAG rated Blue.

Board sign off: Reporting period for Safety Action 2 is from the 8th December 2023 to the 30th November 2024. Board review off took place at the Perinatal Evidence Review meeting on the 4th December 2024 and board sign off was given.

Safety Action 3: Can you demonstrate that you have transitional care (TC) services in place and undertaking quality improvement to minimise separation of parents and their babies?

Current compliance: 100% Compliant. All actions RAG rated Blue.

Board sign off: Reporting period for Safety Action 3 is from the 8th December 2023 to the 30th November 2024. Board review off took place at the Perinatal Evidence Review meeting on the 4th December 2024 and board sign off was given.

Safety Action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard?

Current compliance: 100% Compliant. All actions RAG rated Blue.

Board sign off: Reporting period for Safety Action 4 is from the 8th December 2023 to the 30th November 2024. Board review off took place at the Perinatal Evidence Review meeting on the 4th December 2024 and board sign off was given.

Safety Action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard?

Current compliance: 100% Compliant. All actions RAG rated Blue.

Board sign off: Reporting period for Safety Action 5 is from the 8th December 2023 to the 30th November 2024. Board review off took place at the Perinatal Evidence Review meeting on the 4th December 2024 and board sign off was given.

Safety Action 6: Can you demonstrate that you are on track to achieve compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?

Current compliance: 100% Compliant. All actions RAG rated Blue.

Board sign off: Reporting period for Safety Action 6 is from the 8th December 2023 to the 30th November 2024. Board review off took place at the Perinatal Evidence Review meeting on the 8th January 2025 and board sign off was given.

Safety Action 7: Listen to women, parents and families using maternity and neonatal services and coproduce services with users.

Current compliance: 100% Compliant. All actions RAG rated Blue.

Board sign off: Reporting period for Safety Action 6 is from the 8th December 2023 to the 30th November 2024. Board review off took place at the Perinatal Evidence Review meeting on the 8th January 2025 and board sign off was given.

Safety Action 8: Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?

Current compliance: 100% Compliant. All actions RAG rated Blue.

Board sign off: Reporting period for Safety Action 6 is from the 8th December 2023 to the 30th November 2024. Board review off took place at the Perinatal Evidence Review meeting on the 8th January 2025 and board sign off was given.

Safety Action 9: Can you demonstrate that there is clear oversight in place to provide assurance to the Board on maternity and neonatal, safety and quality issues?

Current compliance: 100% Compliant. All actions RAG rated Blue.

Board sign off: Reporting period for Safety Action 6 is from the 8th December 2023 to the 30th November 2024. Board review off took place at the Perinatal Evidence Review meeting on the 8th January 2025 and board sign off was given.

Safety Action 10: Have you reported 100% of qualifying cases to Maternity and Newborn Safety Investigations (MNSI) programme and to NHS Resolution's Early Notification (EN) Scheme from 8 December 2023 to 30 November 2024?

Current compliance: 100% Compliant. All actions RAG rated Blue.

Board sign off: Reporting period for Safety Action 6 is from the 8th December 2023 to the 30th November 2024. Board review off took place at the Perinatal Evidence Review meeting on the 8th January 2025 and board sign off was given.

Monitoring of compliance

The service identified safety action leads and completed gap analysis to identify areas of improvement required. This ensured the timely collation of evidence to demonstrate compliance with 10 MIS Safety Standards. Actions that required additional attention or resource were closely monitored by the Maternity Project Manager and an updated report will be presented to the relevant local meetings and Trust Boards in February 2025.

All safety actions have been reviewed at the Perinatal Evidence Review meetings which took place on the 4th December 2024 and the 15th January 2025. It was then taken to the Executive Maternity Improvement Group meeting (EMIG) on the 13th January 2025 where it was approved.

Following these meetings, the CNST evidence will be presented at the following:

- 15th January 2025 at LMNS Board
- 30th January 2025 at JPUH trust board.

All evidence demonstrating compliance is retained electronically in a shared folder which is accessible to view for any Trust staff member involved in MIS year 6 that requires information and/or assurance.

This ongoing work will enable the deadline for submission of the Board declaration by 12 noon on 3rd March 2025 to be met.

Appendix A: CNST Action Plan

	Requirement	Lead	Actions/progress	Next update due	Compliance status
1.1	Have all eligible perinatal deaths from 8 December 2023 onwards been notified to MBRRACE-UK within seven working days?	Sam Jones/ Victoria Brown	**19.11.24** further cases have occurred, all reported within 7 working days. **10.09.24** Two cases in August 2024 - both reported within seven working days. CNST Report to be printed at point of submission from PMRT Portal to include all cases in time period		
1.2	For at least 95% of all deaths of babies who died in your Trust from 8 December 2023, were parents' perspectives of care sought and were they given the opportunity to raise questions?	Sam Jones/ Victoria Brown	**19.11.24 no concerns of compliance.** **19.11.24** Two cases in August 2024 - both offered opportunities to express parent perspectives. Case 94585 - awaiting translation of letter Case 94644 - parents due to come in for debrief		
1.3	Has a review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies, suitable for review using the PMRT, from 8 December 2023 been started within two months of each death? This includes deaths after home births where care was provided by your Trust.	Victoria Lucas/PMRT Lead Obs Cons	**19.11.24** On Track **10.09.24** On track		
1.4	Were 60% of the reports published within 6 months of death?	Victoria Lucas/PMRT Lead Obs Cons	**19.11.24** On track **10.09.24** On track		

1.5	Have you submitted quarterly reports to the Trust Executive Board on an ongoing basis? These must include details of all deaths from 8 December 2023 including reviews and consequent action plans.	R&G Matron/ Victoria Lucas/PMRT Lead Obs Cons	**19.11.24 On track** PMRT Quarterly Report's to be written by PMRT Lead Obs Cons & VL. To be presented at Hospital Management Group (HMG) & Patient Safety & Quality (PSQ) & ' Trust Board'		
1.6	Were quarterly reports discussed with the Trust maternity safety and Board level safety champions?	R&G Matron/ Victoria Lucas/PMRT Lead Obs Cons	**19.11.24 On track** To be presented at MGC & Mortality Surveillance Group **10.09.24** Awaiting confirmation of dates/details of Mortality Surveillance Group to submit Q Report as EMIG has been replaced by this moving forward. Was originally Safety Champs, then EMIG.		
	Requirement	Lead	**Actions/progress**		
2.1	Was your Trust compliant with at least 10 out of 11 MSDS-only Clinical Quality Improvement Metrics (CQIMs) by passing the associated data quality criteria in the “Clinical Negligence Scheme for Trusts: Scorecard” in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2024? Final data for July 2024 will be published during October 2024.	Maternity Digital Team	**The Trust needs to give assurance following the E3 National Patient Safety Alert by the 7th June. E3 Update required before that and security patch planned for end of May 24.** **Toyah to complete 'how to' data cleansing notes so that Kelly Angel and Ellie Berresford can support with data cleansing. - done 23/04**		
2.2	Did July's 2024 data contain a valid ethnic category (Mother) for at least 90% of women booked in the month? Not stated, missing and not known are not included as valid records for	Maternity Digital Team	**Tracey to continue to work with community teams to improve ethnicity data input.**		

	this assessment as they are only expected to be used in exceptional circumstances. (MSD001)				
	Requirement	Lead	**Actions/progress**		
3.1	Was the pathway(s) of care into transitional care which includes babies between 34+0 and 36+6 in alignment with the BAPM Transitional Care Framework for Practice jointly approved by maternity and neonatal teams with a focus on minimising separation of mothers and babies? Evidence should include: - Neonatal involvement in care planning - Admission criteria meets a minimum of at least one element of HRG XA04 - There is an explicit staffing model - The policy is signed by maternity/neonatal clinical leads and should have auditable standards. - The policy has been fully implemented and quarterly audits of compliance with the policy are conducted.	Karen Wright	**Network have agreed that dedicated TC lead not required for unit of our size.** **02/09 staffing is still the same. The TC network guideline has been ratified but is not on the network website**		
3.2	Or Is there an action plan signed off by Trust and LMNS Board for a move towards the TC pathway (as above) based on BAPM framework for babies from 34+0 with clear timescales for implementation and progress from MIS Year 5.	Karen Wright	**N/A - Pathway in place.**		

3.3	By 6 months into MIS year 6, register the QI project with local Trust quality/service improvement team.	Josephine Baker / Kerry Burwood	**QI project registered 17/09**		
3.4	By the end of the reporting period, present an update to the LMNS and safety champions regarding development and any progress.	Josephine Baker / Kerry Burwood	**We will be presenting on the 6th November to LMNS regarding the ATAIN QI project and also will update about ATAIN QI at the November EMIG meeting. Presented to Safety Champions on the 14th November.**		
4.1	Locum currently works in their unit on the tier 2 or 3 rota?	Vandana Choudhary	**N/A we do not have any short term locums working 2 weeks or less**		
4.2	OR They have worked in their unit within the last 5 years on the tier 2 or 3 (middle grade) rota as a postgraduate doctor in training and remain in the training programme with satisfactory Annual review of Competency Progrssion (ARCP)?	Vandana Choudhary	**N/A we do not have any short term locums working 2 weeks or less**		
4.3	OR They hold a Royal College of Obstetrics and Gynaecology (RCOG) certificate of eligibility to undertake short-term locums?	Vandana Choudhary	**N/A we do not have any short term locums working 2 weeks or less**		
4.4	Implemented the RCOG guidance on engagement of long-term locums and provided assurance that they have evidence of compliance?	Vandana Choudhary			

4.5	Has the Trust implemented RCOG guidance on compensatory rest where consultants and senior Speciality and Specialist (SAS) doctors are working as non-resident on-call out of hours and do not have sufficient rest to undertake their normal working duties the following day, and can the service provide assurance that they have evidence of compliance?	Vandana Choudhary			
4.6	OR Has an action plan presented to address any shortfalls in compliance, to the Trust Board, Trust Board level safety champions and LMNS meetings?	Vandana Choudhary			
4.7	Has the Trust monitored their compliance of consultant attendance for the clinical situations listed in the RCOG workforce document: 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology' into their service when a consultant is required to attend in person?	Vandana Choudhary			
4.8	Were the episodes when attendance has not been possible reviewed at unit level as an opportunity for departmental learning with agreed strategies and action plans implemented to prevent further non-attendance?	Vandana Choudhary	**N/A no occurances.**		
4.9	Do you have evidence that the Trust position with the above has been shared with Trust Board?	Vandana Choudhary	**Shared via EMIG**		
4.10	Do you have evidence that the Trust position with the above has been shared with Board level Safety Champions?	Vandana Choudhary	**Shared via EMIG**		

4.11	Do you have evidence that the Trust position with the above has been shared with the LMNS?	Vandana Choudhary	**Shared via EMIG**		
4.12	Is there evidence that the duty anaesthetist is immediately available for the obstetric unit 24 hours a day and they have clear lines of communication to the supervising anaesthetic consultant at all times? In order to declare compliance, where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patients in order to be able to attend immediately to obstetric patients. (Anaesthesia Clinical Services Accreditation (ACSA) standard 1.7.2.1) - Representative month rota acceptable.	Lalani Induruwage	**See comments - Rajesh Dumpala and Lalani Induruwage confirmed fully meet CNST.**		
4.13	Does the neonatal unit meet the British Association of Perinatal Medicine (BAPM) national standards of medical staffing?	Lisa King / Justine Goodwin			
4.14	Is this formally recorded in Trust Board minutes?	Lisa King / Justine Goodwin	**Part of peer review - check that it went through clinical effectiveness group.**		
4.15	If the requirements are not met, Trust Board should agree an action plan and evidence progress against any action plan developed previously to address deficiencies.	Lisa King / Justine Goodwin	**Peer review as staffing in place. NA**		
4.16	Was the above action plan shared with the LMNS?	Lisa King / Justine Goodwin	**Peer review as staffing in place. NA**		

4.17	Was the above action plan shared with the ODN?	Lisa King / Justine Goodwin	**Peer review as staffing in place. NA**		
4.18	Does the neonatal unit meet the British Association of Perinatal Medicine (BAPM) national standards of nursing staffing?	Lisa King / Justine Goodwin	**Compliance**		
4.19	Is this formally recorded in Trust Board minutes?	Lisa King / Justine Goodwin	**Part of peer review - check that it went through clinical effectiveness group.**		
4.20	If the requirements are not met, Trust Board should agree an action plan and evidence progress against any action plan developed previously to address deficiencies.	Lisa King / Justine Goodwin	**N/A**		
4.21	Was the above action plan shared with the LMNS?	Lisa King / Justine Goodwin	**N/A**		
4.22	Was the above action plan shared with the ODN?	Lisa King / Justine Goodwin	**N/A**		
	Requirement	Lead	**Actions/progress**		

5.1	Submit a midwifery staffing oversight report that covers staffing/safety issues to the Board every 6 months (in line with NICE midwifery staffing guidance), during the maternity incentive scheme year six reporting period. It should also include an update on all of the points below.	Karen Erskine / Elita Mazzocchi	**Workforce paper complete and was presented in June 2024.**		
5.2	Has a systematic, evidence-based process to calculate midwifery staffing establishment been completed in the last three years? Evidence should include: A clear breakdown of BirthRate+ or equivalent calculations to demonstrate how the required establishment has been calculated.	Karen Erskine / Elita Mazzocchi	**Birthrate + completed in 2023**		
5.3	Can the Trust Board evidence midwifery staffing budget reflects establishment as calculated? Evidence should include: ● Midwifery staffing recommendations from Ockenden and of funded establishment being compliant with outcomes of BirthRate+ or equivalent calculations. ● Where Trusts are not compliant with a funded establishment based on the above, Trust Board minutes must show the agreed plan, including timescale for achieving the appropriate uplift in funded establishment. The plan must include mitigation to cover any shortfalls. ● Where deficits in staffing levels have been identified must be shared with the local commissioners. ● Details of planned versus actual midwifery staffing levels to include evidence of mitigation/escalation for managing a shortfall. ● The midwife to birth ratio ● The percentage of specialist midwives employed and mitigation to cover any	Karen Erskine / Elita Mazzocchi	**Workforce paper complete and was presented in June 2024.**		

	inconsistencies. BirthRate+ accounts for 8-10% of the establishment, which are not included in clinical numbers. This includes those in management positions and specialist midwives.				
5.4	Evidence from an acuity tool (may be locally developed), local audit, and/or local dashBoard figures demonstrating 100% compliance with supernumerary labour ward co-ordinator on duty at the start of every shift.	Karen Erskine / Elita Mazzocchi	**Provided monthly by KE and reported to RPQOG** **Reported to JC monthly by KE** **Going onto the Scorecard**		
5.5	Evidence from an acuity tool (may be locally developed), local audit, and/or local dashBoard figures demonstrating 100% compliance with the provision of one-to-one care in active labour	Karen Erskine	**Clinical Dashboard (TH)** **Quality Scorecard** **Acuity Report** **IPR**		
5.6	A plan is in place for mitigation/escalation to cover any shortfalls in the two points above.	Elita Mazzocchi	**Safety Huddle (inc Community), Community Morning Huddle, Daily Staffing Summits (Locally and Divisionally), Executive staffing touchpoints, Local escalation Policy currently under review. Trust escalation policy.** **Manager on call rota**		
	Requirement	Lead	**Actions/progress**		
6.1	Have you provided a signed declaration from the Executive Medical Director declaring that Saving Babies' Lives Care Bundle, Version 3 is fully / will be in place as agreed with the ICB ? (where full implementation is not in place,	Angela Sutton, Elita Mazzocchi	**EW met with action lead 18.04.2024 and confirmed action on track. Review July.**		

	compliance can still be achieved if the ICB confirms it is assured that all best endeavours – and sufficient progress – have been made towards full implementation, in line with the locally agreed improvement trajectory.)				
6.2	Have you continued the quarterly QI discussions between the Trust and the LMNS/ICB (as commissioner) from Year 5, and more specifically be able to demonstrate that at least two quarterly discussions have been held in Year 6 to track compliance with the care bundle? These meetings must include agreement of a local improvement trajectory against these metrics for 24/25, and subsequently reviews of progress against the trajectory.	Angela Sutton, Elita Mazzocchi	**Quarterly meetings take place. No Concerns**		
6.3	Have these quarterly meetings included details of element specific improvement work being undertaken including evidence of generating and using the process and outcome metrics for each element.	Angela Sutton, Elita Mazzocchi	**Quarterly meetings take place. No Concerns**		
6.4	Is there a regular review of local themes and trends with regard to potential harms in each of the six elements.	Angela Sutton, Elita Mazzocchi	**Quarterly meetings take place. No Concerns**		
6.5	Following these meetings, has the LMNS determined that sufficient progress have been made towards implementing SBLCBv3, in line with a locally agreed improvement trajectory?	Angela Sutton, Elita Mazzocchi	**Quarterly meetings take place. No Concerns raised from EW or NL.**		
6.6	Is there evidence of sharing of examples and evidence of continuous learning by individual Trusts with their local ICB, neighbouring Trusts and NHS Futures where appropriate?	Angela Sutton, Elita Mazzocchi	**CNST Monthly Forums**		

	Requirement	Lead	Actions/progress		
7.1	Evidence of MNVP engagement with local community groups and charities prioritising hearing from those experiencing the worst outcomes, as per the LMNS Equity & Equality plan.	Kaya Thorpe / Jenny Keys	**Community Engagement lead in post who will be responsible for management of social media, bookings with MNVP and social engagement. Volunteer coordinator recruited.** **MNVP and Nicky to work together to increase awareness of MNVP work and engagement. To** **Kaya to talk to Faye and Mary re ways to reach low income demographic. Kaya planning to meet Emma Cook (Homestart Lead for GY) re support.** **MNVP update / forum being held in September 2024.**		
7.2	Terms of Reference for Trust safety and governance meetings, showing the MNVP Lead as a member (Trusts should work towards the MNVP Lead being a quorate member), such as: • Safety champion meetings • Maternity business and governance • Neonatal business and governance • PMRT review meeting • Patient safety meeting • Guideline committee	Jenny Keys	**Safety Champion meeting time to be changed to allow MNVP attendance. PM has confirmed timings will change to accommodate.**		

7.3	Evidence of MNVP infrastructure being in place from your LMNS/ICB, such as: • Job description for MNVP Lead • Contracts for service or grant agreements • Budget with allocated funds for IT, comms, engagement, training and administrative support • Local service user volunteer expenses policy including out of pocket expenses and childcare cost	Jenny Keys	**JD to be reviewed in line with updated guidance.** **No service grant agreement or contract in place.** **LMNS aware and working on honourary contracts for JPUH. 31/05. Kaya has signed contracts for JPUH. Jenny to chase.**		
7.4	If evidence of funding support at expected level (as above) is not obtainable, there should be evidence that this has been formally raised via the Perinatal Quality Surveillance Model (PQSM) at Trust and LMNS level, and discussed at ICB Quality Committee as a safety concern due to the importance of hearing the voices of women and families, including the plan for how it will be addressed in response to that escalation is required.	Jenny Keys	**N/A Budget request granted.**		
7.5	Evidence of a joint review of annual CQC Maternity Survey data, such as documentation of actions arising from CQC survey and free text analysis, such as a coproduced action plan.	Jenny Keys / Kaya Thorpe	**Jenny and Kaya to meet to review current action log and update. Meeting regularly.** **Kaya to get Trust laptop so that action plan can be worked on off site. Contract now signed Charlotte to send to Jamie for access.**		
7.6	Has progress on the coproduced action above been shared with Safety Champions?	Jenny Keys / Kaya Thorpe	**To go to Safety Champion meeting but date not yet confirmed. Meeting 27/06/2024 check that it was discussed.**		

7.7	Has progress on the coproduced action above been shared with the LMNS?	Jenny Keys / Kaya Thorpe	**Monthly MNVP Lead meeting with LMNS takes place. Kaya or Hannah to present.** **Planning meeting takes place w.c 20th May with MNVP to ensure compliance.** **Ask AS when this was presented to LMNS.**		
8.1	90% of obstetric consultants	PDM Team	**No action at present**		
8.2	90% of all other obstetric doctors contributing to the obstetric rota (without the continuous presence of an additional resident tier obstetric doctor)	PDM Team	**clarification re SHOs**		
8.3	90% of midwives (including midwifery managers and matrons), community midwives, birth centre midwives (working in co-located and standalone birth centres and bank/agency midwives) and maternity theatre midwives who also work outside of theatres	PDM Team	**No action at present**		
8.4	90% of obstetric consultants	PDM Team	**No action at present**		
8.5	90% of all other obstetric doctors including staff grade doctors, obstetric trainees (ST1-7), sub speciality trainees, obstetric clinical fellows,foundation year doctors and GP trainees contributing to the obstetric rota	PDM Team	**SHOs currently not 90% compliant. Support needed to release. VB req an updated list of SHOs due to recent rotation and req that they have been booked onto PROMPT.**		

8.6	90% of midwives (including midwifery managers and matrons), community midwives, birth centre midwives (working in co-located and standalone birth centres) and bank/agency midwives	PDM Team	**No action at present**		
8.7	90% of maternity support workers and health care assistants (to be included in the maternity skill drills as a minimum).	PDM Team	**No action at present**		
8.8	90% of obstetric anaesthetic consultants and autonomously practising obstetric anaesthetic doctors	PDM Team	**VB emailed KH for up to date list of doctors to ensure compliance .**		
8.9	90% of all other obstetric anaesthetic doctors (including anaesthetists in training, SAS and LED doctors) who contribute to the obstetric anaesthetic on-call rota in any capacity. This updated requirement is supported by the RCoA and OAA.	PDM Team	**100% compliant 21.10.2024**		
8.10	Standard removed				
8.11	Can you demonstrate that at least one multidisciplinary emergency scenario is conducted in a clinical area or at point of care during the whole MIS reporting period?	PDM Team	**No action at present**		
8.12	90% of neonatal Consultants or Paediatric consultants covering neonatal units	Ellen Whaley	**For September, we are 100% for Consultants, SHOs, Regs and Nurse practitioners**		

8.13	90% of neonatal junior doctors (who attend any births)	Ellen Whaley	**For September, we are 100% for Consultants, SHOs, Regs and Nurse practitioners**		
8.14	90% of neonatal nurses (Band 5 and above who attend any births)	Kelly Melton	**For September, we are 100% for Consultants, SHOs, Regs and Nurse practitioners**		
8.15	90% of maternity support workers, health care assistants and nursery nurses *dependant on their roles within the service - for local policy to determine.	N/A	**N/A**		
8.16	90% of advanced Neonatal Nurse Practitioner (ANNP)	N/A	**N/A**		
8.17	90% of midwives (including midwifery managers and matrons, community midwives, birth centre midwives (working in co-located and standalone birth centres and bank/agency midwives)	PDM Team	**Naz / Vicki to provide an update. What is the current % of NLS trained staff? Confirmation of timeline for our plans for NLS in house training?**		
8.18	Is a formal plan in place demonstrating how you will ensure a minimum of 90% of neonatal and paediatric medical staff who attend neonatal resuscitations unsupervised have a valid resuscitation council NLS certification or local assessment in line with BAPM basic capability guidance by year 7 of MIS and ongoing.	Karen Wright	**N/A staff 100%**		
	Requirement	Lead	**Actions/progress**		

9.1	Are all Trust requirements of the Perinatal Quality Surveillance Model (PQSM) fully embedded (including the following)?	Angela Sutton / Elita Mazzocchi			
9.2	Has a non-executive director (NED) has been appointed and is visibly working with the Board safety champion (BSC)?	Elita Mazzocchi / Justine Goodwin	**04.11.2024 Sarah Whiteman in place as NED for NNU safety and quality issues. Caitlin Notley is NED in place for Maternity.Charlotte Dillaway now appointed Exec Lead for NNU, Maternity and Womens and Children.**		
9.3	Is a review of maternity and neonatal quality and safety undertaken by the Trust Board (or an appropriate trust committee with delegated responsibility) at every meeting using a minimum data set, and presented by a member of the perinatal leadership team to provide supporting context.	Elita Mazzocchi / Justine Goodwin	**Perinatal Quality Surveillance Meeting takes place for NNU. Neonates have co presented at PS&Q last month and will be presenting at EMIG going forward. NNU IPR developed and in place since September 2024.**		
9.4	Does the regular review include a review of thematic learning informed by PSIRF, themes and progress with plans following cultural surveys or equivalent, training compliance, minimum staffing in maternity and neonatal units, and service user voice feedback.	Angela Sutton			
9.5	Do you have evidence of collaboration with the local maternity and neonatal system (LMNS)/ICB lead, showing evidence of shared learning and how Trust-level intelligence is being escalated to ensure early action and support for areas of concern or need, in line with the PQSM.	Justine Goodwin	**Perinatal Quality Surveillance Meeting takes place for NNU. Neonates have co presented at PS&Q last month and will be presenting at EMIG going forward. Monitor for sustained performance. LMNS SQOG meeting and incident monthly meeting also.**		

			Check NNU attend SQOG or Risk Meeting.		
9.6	Ongoing engagement sessions with staff as per year 5 of the scheme. Progress with actioning named concerns from staff engagement sessions are visible to both maternity and neonatal staff and reflects action and progress made on identified concerns raised by staff and service users from no later than 1 July 2024.	Elita Mazzocchi / Justine Goodwin	**Ensuring FUP from Pulse and Score is shared with staff.**		
9.7	Is the Trust's claims scorecard is reviewed alongside incident and complaint data and discussed by the maternity, neonatal and Trust Board level Safety Champions at a Trust level (Board or directorate) meeting quarterly (at least twice in the MIS reporting period)?	Elita Mazzocchi / Justine Goodwin	**No action. Covered through HMG and Trust Board Exec Meetings.**		
9.8	Evidence in the Trust Board minutes that Board Safety Champion(s) are meeting with the Perinatal leadership team at a minimum of bi-monthly (a minimum of three in the reporting period) and that any support required of the Trust Board has been identified and is being implemented.	Elita Mazzocchi / Justine Goodwin	**NED (Caitlin) attends EMIG monthly. Undertakes walk arounds in the department at least monthly. Caitlin reports oversight to board usually as PSQ chair, but will ensure this is a formal reporting point in board reports also, from the perspective of her maternity oversight role. She also reports on maternity in the PSQ chair report to Governors each month.** **Sarah Whiteman is replicating the above for NNU and will work closely with Caitlin.**		

9.9	Evidence in the Trust Board (or an appropriate Trust committee with delegated responsibility) minutes that progress with the maternity and neonatal culture improvement plan is being monitored and any identified support being considered and implemented.	Elita Mazzocchi / Justine Goodwin	**EMIG membership covers this and agenda covers progress against Maternity Improvement Plan.**		
	Requirement	Lead	**Actions/progress**		
10.1	Have you reported of all qualifying cases to MNSI from 8 December 2023 to 30 November 2024.	Maternity Patient Safety Team	**19/11/24 - Yes 1 case reported**		
10.2	Have you reported of all qualifying EN cases to NHS Resolution's Early Notification (EN) Scheme from 8 December 2023 until 30 November 2024.	Maternity Patient Safety Team	**19/11/24 No Action - no eligible cases**		
10.3	Have all eligible families received information on the role of MNSI and NHS Resolution's EN scheme	Maternity Patient Safety Team	**19/11/24 - Yes 1 case reported**		
10.4	Has there has been compliance, where required, with Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of the duty of candour.	Maternity Patient Safety Team	**19/11/24 DoC letter sent the day after the 1 case reported**		
10.5	Has Trust Board had sight of Trust legal services and maternity clinical governance records of qualifying MNSI/ EN incidents and numbers reported to MNSI and NHS Resolution.	Maternity Patient Safety Team	**19/11/2024 PSIG contains information about all litigation cases. Ours are reported via PSIG and EMIG.**		

10.6	Has Trust Board had sight of evidence that the families have received information on the role of MNSI and NHS Resolution's EN scheme?	Maternity Patient Safety Team	**19/11/2024 Information is given to families, this is contained within the DoC PMRT Letter. No EN cases for this period. x1 MNSI case. Use R&G PMRT Spreadsheet. PSIG slides. Ask Hannah to include patient safety reports for evidence.**		
10.7	Has Trust Board had sight of evidence of compliance with the statutory duty of candour?	Maternity Patient Safety Team	**19/11/2024 Same as above.**		
10.8	Have you completed the field on the Claims reporting wizard (CMS), whether families have been informed of NHS Resolution's involvement, completion of this will also be monitored, and externally validated.	Trust Patient Safety Team			

James Paget University Hospitals NHS Foundation Trust

Report to the Trust Board of Directors dated Friday, 31 January 2025

Title: Trust Estates Strategy – six monthly update report December 2024

Sponsor:	Director of Strategic Projects
Author:	Steven Balls Head of Estates, Facilities and Planning
Previous scrutiny:	Finance & Performance Committee, 22/01/2025 Hospital Management Group, 28/01/2025
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

Executive Summary

The Estates Strategy six monthly update Report – December 2024 is presented to provide assurance to the Board of Directors of actions and progress made against the Trust's Estates Strategy 2022-2032.

The report provides evidence of completed actions, highlighting key achievements and those still in progress. The report also looks ahead into 2025/26 to show future actions and the Trust's journey to a replacement Hospital by 2030.

This report has been reviewed, discussed and presented to the Finance & Performance Committee and Hospital Management Group.

Recommendation

The Board of Directors is asked to approve the report as providing sufficient assurance of the actions and progress made regarding the Trust's Estates Plan.

Trust Estates Strategy – six monthly Update Report *December 2024*

Authored by;

Steven Balls – Deputy Director of Estates and Facilities

Contents

Introduction

The purpose of this is report is a six-monthly update to the Trust Board of Directors regarding the progress on ambitions and actions as laid out within the Site Strategy that was published in April 2022.

This will give a clear understanding of actions taken to meet the Objectives of site development to support the Trust's strategic ambitions.

Through the site strategy and our journey to the New Hospital to be constructed adjacent to the main hospital site, this Strategy aims to deliver new future retained buildings through capital investment, whilst reflecting the need to maintain our current Estate by reducing backlog maintenance and to provide healthcare in a clean and safe environment to support patients, staff and wider stakeholders in the future.

Aligned to ICS objectives and the UN sustainable goals, the actions are spread across areas of focus. This report provides a progress update on our overarching net zero ambitions, as well as highlights from the sustainable healthcare programme.

The priorities identified in the JPUH Estates Strategy 2022-2032 were initially reviewed, scrutinised and approved by the Strategic Projects Committee and was subsequently approved by the Board of Directors in April 2022.

The delivery of this Strategy will continue to be monitored via the Estates & Facilities Programme Delivery Group and the Deputy Director of Estates and Facilities or a senior responsible officer will provide six monthly progress update reports for Assurance to the Hospital Management Group, the Finance & Performance Committee and the Board of Directors as required.

This report reflects the position in respect to the Site Strategy as of December 2024.

The Health, Safety and Staff Welfare Committee will oversee and ensure adequate arrangements are in place to safely and effectively manage all construction works.

All Estates projects will be completed in accordance with the Trust's Standing Financial Instructions.

Mark Flynn
Director of Strategic Projects

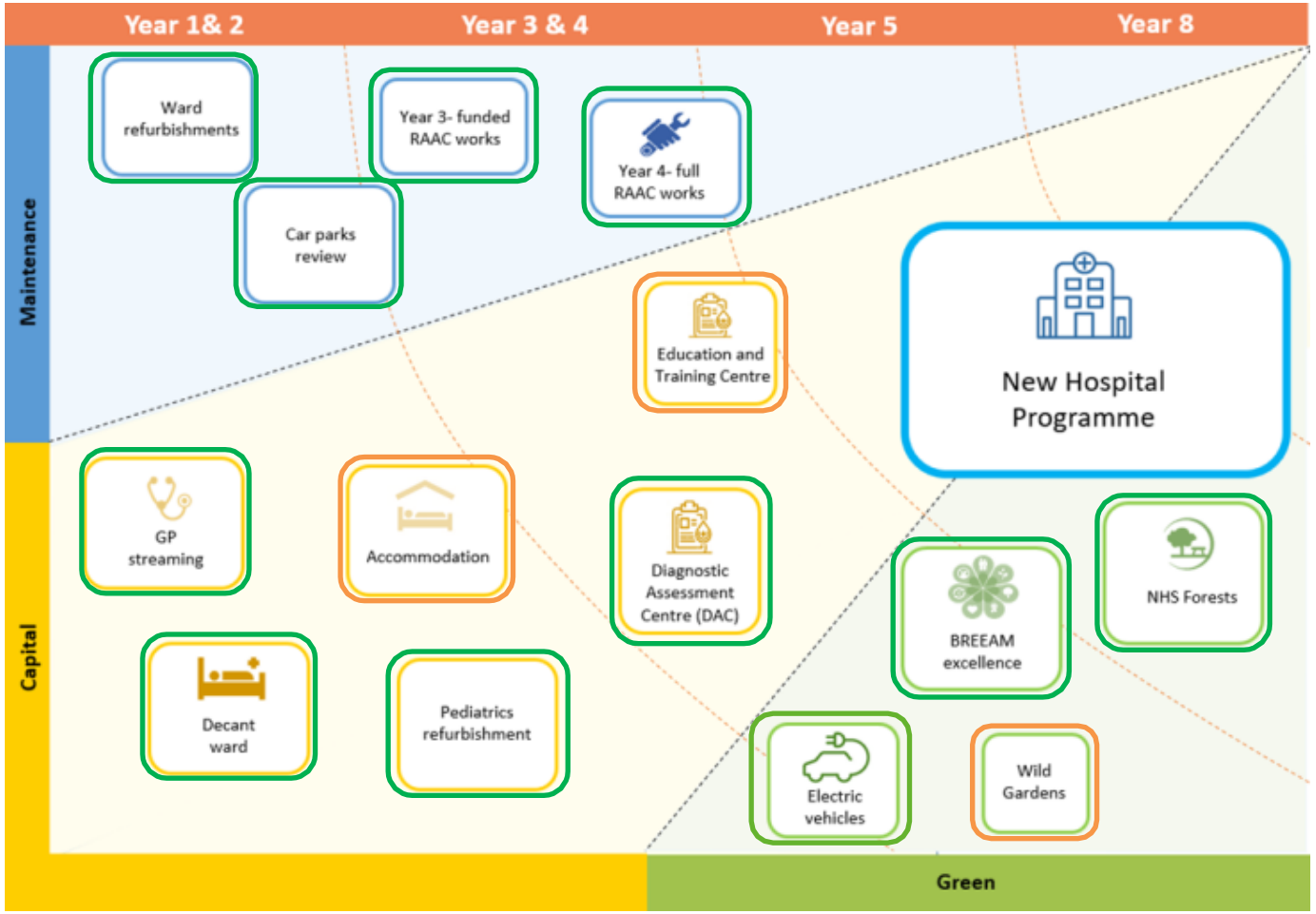
Vision & Overarching Ambitions

The Estates and Facilities vision is to develop a modern health and care campus specifically designed to serve the local population for the following 40 years.

Through the site strategy and our journey to the New Hospital to be constructed adjacent to the main hospital site, the Strategy aims to deliver this as described below. It reflects the need to maintain our high level of current services in the interim, the inadequacies with the current estate and the requirements of patients, staff and wider stakeholders in the future.

- *To maintain the current site to a high standard and complete capital projects to transition into the New Hospital in 2030.*
- *To maintain and improve standards through compliance with HBN's, HTM, Net Zero and Modern Methods of Construction (MMC).*

This report demonstrates how the Trust has and will help to achieve these goals in line with the national objectives of the NHS to tackle aging estate and increasing population by developing 40 New Hospitals. In doing so, we aim to be part of the world's leading healthcare Estates developments.



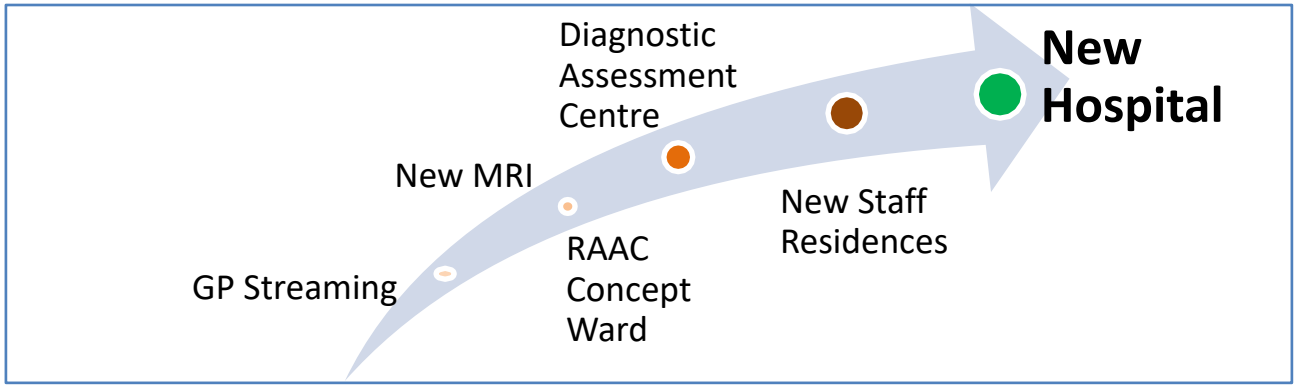
Strategic Intentions

Last year we outlined clear strategic intentions in line with supporting the Trust and the wider system.

These are still relevant today;

- Ensure that Trust land and property are used effectively to support commissioners' and the Trust's own priorities to best meet patient needs
- Provide and maintain an appropriate level of affordable NHS healthcare facilities in the right locations, which are fit for purpose, safe and compliant with legislation and relevant guidance
- Achieve continuous improvement and better efficiencies from the performance of the estate
- Help deliver the Trust's sustainability objectives and Green plan by taking all reasonable steps to minimise our adverse impact on the environment and work towards Net Zero Carbon (NZC)
- Alignment of the Green Plan, Transportation Plan and Transport Strategy for the new hospital is needed for better long-term positioning
- Identify and release surplus land for development or disposal in keeping with the new hospital master planning.

- Effectively mitigate the Trust RAAC infrastructure risk
- Align with and support delivery of the Trusts NHP including advancing use of digital, MMC and standardised/ repeatable design, Net Zero Carbon & sustainability solutions
- Sustain and develop the existing hospital site to enable delivery of the Trusts and the N&W ICS Clinical Strategies to deliver high quality healthcare
- Enable delivery of the NHS Long Term Plan to improve public health, integrate health & care services and provide patient centered care
- Effectively link with and support the deliverables of the N&W ICS Estates Strategy



Performance Report

The following section provides a summary of key developments and case studies from 2022/23, as well as expectations for achievements in 2023/24.

Effectively mitigate the Trust RAAC infrastructure risk

Six Monthly Overview

To date, the Trust has invested £28m to manage the RAAC infrastructure remedial works. During 2024/25, we are completing the 4th annual survey of the RAAC panels as the Concept Ward will now be used at elective surgery and we will utilise Ward 7 as a decant facility to enable RAAC remedial work. The RAAC Remedial work continues within the main kitchens for practical completion in December '24 this has been delayed by equipment failure and lead in times for replacement due for completion February '25. Ward 10 has been completed and is now operational. Full winter pressure plans are in place to continue with remediation work whilst supporting winter pressures. HSDU work is continuing with the RAAC remedial work and has allowed upgrading the facilities, however delays to this work to design and enable the increasing activity from elective recovery and support the opening of the Orthopedic Elective Hub (OEH), have been experienced.

Looking Forward

Regarding the 4th annual structural surveys with WSP, this year, our focus is on completing the previously unseen planks, a task of utmost importance. The end-bearing and mitigation works will continue in Ward 11, Ward 12, Neonatal, CDS, and 2 Theatres. With the completion of the HSDU and Kitchen remedial work, this will cover most of the remaining unseen planks. The Trust has now set out a Programme of work for RAAC mitigation within the main theatre complex, this will continue throughout 24/25 and complete in 27/28. The Programme includes the use of 1 decant theatre that was upgraded in 2020. The Programme will require 2 theatres at a time to be released due to the complexity of the work. Working with the operational teams and the new OEH complex, the team's expectations are to reduce clinical impact to a minimum.

action	update	Completion target date	RAG
Provide decant facility for movement of patients to enable RAAC mitigation work	The Concept ward will move into its operational duty of supporting the OEH in the increased activity through elective surgery by moving the current elective ward 22 to its new location. Ward 7 will now be used to support decant for RAAC mitigation work.	July 2022	
Complete RAAC remedial work and end bearing work in line with the NHSE regional and national target	The end bearing and mitigation work currently sits at 55% completion. Some delays to HSDU & Kitchen works in 2024/5, although overall spend on track. NHSE have set a new target date of 2028 for completion of mitigation work	March 2028	
Complete annual surveys of RAAC panels	The Trust is now nearing completion of the fourth year of surveys	Annual - Ongoing	

End Bearing Supports
(Estates Department, 2023)

Site development

Enable delivery of the NHS Long Term Plan to improve public health, integrate health & care services and provide patient centered care
Sustain and develop the existing hospital site to enable delivery of the Trusts and the N&W ICS Clinical Strategies to deliver high quality healthcare

Six Monthly Overview

The trust has invested over £48m in the last twelve months, which has seen the completion of the Diagnostic Assessment Centre (CDC). December 2024 will deliver practical completion of the Orthopedic Elective Hub and Community Diagnostic Centre Building. The Community Diagnostic Centre being constructed at Northgate Hospital site internal structural work being completed and the extension for the Scanner is under construction. Repairs to the roof and window replacement is 95 % complete, service connections being rerouted including installation of a new plant room. Ward upgrades have been supported by the CDEL Backlog maintenance funds alongside RAAC mitigation work with Ward 10. The work continues whilst maintaining high-quality service to minimise the effect on patients' experience and clinical activity.
Planning permission for a new VIE (oxygen Supply) has been granted by GYBC which will continue to give compliance to HTM standards following increased footprint to the existing site and support the retained buildings connect to the new hospital site in the future.
Design of a new Fracture clinic to enable the creation of a Same Day Emergency Care (SDEC) unit within the existing building is being designed and constructed with Planning permission submitted in December and has now been validated.

Looking forward

Northgate Community Diagnostic Centre is due for practical completion of Phase 1 in April 2025 and Phase 2 expected in June 2025.
A new fracture Clinic is to be constructed in Q3/4 2025 to allow a full refurbishment of the current area into a new SDEC unit to aid flow and reduce pressure on UEC performance. SDEC will utilise the area within Ward 22 for winter pressures in 2025/26 during construction of new areas. Retained buildings will be reviewed through the New Hospital Future Paget Programme to ensure consistency of approach to the new hospital and moving towards a net zero sustainable building as outlined in the strategy. Throughout the year, major projects including land purchase for the new hospital and subsequent enabling works are expected. The Estates and Facilities department will continue to invest in backlog maintenance to ensure the delivery of services in a safe and clean environment for our staff and patients, working with our clinical colleagues to deliver the RAAC mitigation work and further investment to assist with UEC and winter pressures.

action	update	Completion target date	RAG
Community Diagnostic Centre (CDC) JPUH	The CDC onsite at the JPUH received building control sign off and practical completion in January 2025 and will be operational ready on 6th Feb 2025	October 2024	
Community Diagnostic Centre (CDC) Northgate	The CDC being constructed at the Northgate, has received a 6 week delay due to structural issues that were identified during the refurbishment of the existing building. Phase 1 completion is due end of March 2025 with Phase 2 completing July 2025	December 2024	
Orthopedic Elective Hub (OEH)	The OEH consists of 2 theatres, 4 bed recovery and 8 single treatment rooms/ consulting Pods.	October 2024	

OEH/CDC
(3D render, 2023)

Site Development (continued)

Action	Update	Expected completion date	RAG
Education and Training Centre	There are several opportunities available to the Trust for developing Education and Training facilities on the James Paget Hospital site: • Increase the size of the existing Education and Training Centre by approximately 90% by developing the adjacent land; and • Provide Education and Training facilities as part of a flagship building on the south-west corner of the site. This could potentially attract funding/sponsorship from commercial organisation's Funding is still being reviewed to enable this project	2030 or sooner with the use of early enabling funding from NHP.	
Accommodation	The staff accommodation, though not funded by NHP, was expected to be an enabler to workforce planning. The land on site 5/23 could have potentially been allocated for the new accommodation and support contractors during the construction phase of the New Hospital. However, ongoing issues with capital funding has caused significant delays in a full and final clear solution. Other funding solutions are continuing to be explored, together with an options appraisal of upgrading or refurbishing the existing accommodation units for quality purposes and to meet national standards.	Ongoing with review of options paper.	
Land purchase for Car park extension	The Trust purchased site 2 and was able to utilise CDEL funding. This helped in expanding the car parking space, which in turn will alleviate the ever-increasing pressure of parking around the JPUH main site with the provision of 370 spaces.	April 2024	
Land purchase for New Hospital Programme	In October 2023, the case for purchasing the land required for the New Hospital was submitted to NHP. The Business case has been through NHP Investment Committee, with a further recommendations.	April 2024	

Ward / department Refurbishments

Six monthly overview

Over the last six months the refurbishment of ward 10 has taken place, the ward practical completion was delivered at the end of November, utilising the Programme of RAAC remediation work the Estates and facilities dept used the Backlog maintenance CDEL funding to upgrade the facilities in the area to ensure delivery of healthcare in a clean functional area. The ward was completely upgraded utilising the existing footprint. All these updates and progress were reported to the Estates and Facilities Programme delivery group.

The Kitchen area has proven to be a real challenge in terms of the unknown issues with hidden panels requiring further attention with the RAAC mitigation work. Operationally it was challenging to deliver a new way of working in less footprint, the team still managed to deliver a full patient meal service and continue to deliver staff and visitor meals.

Looking forward

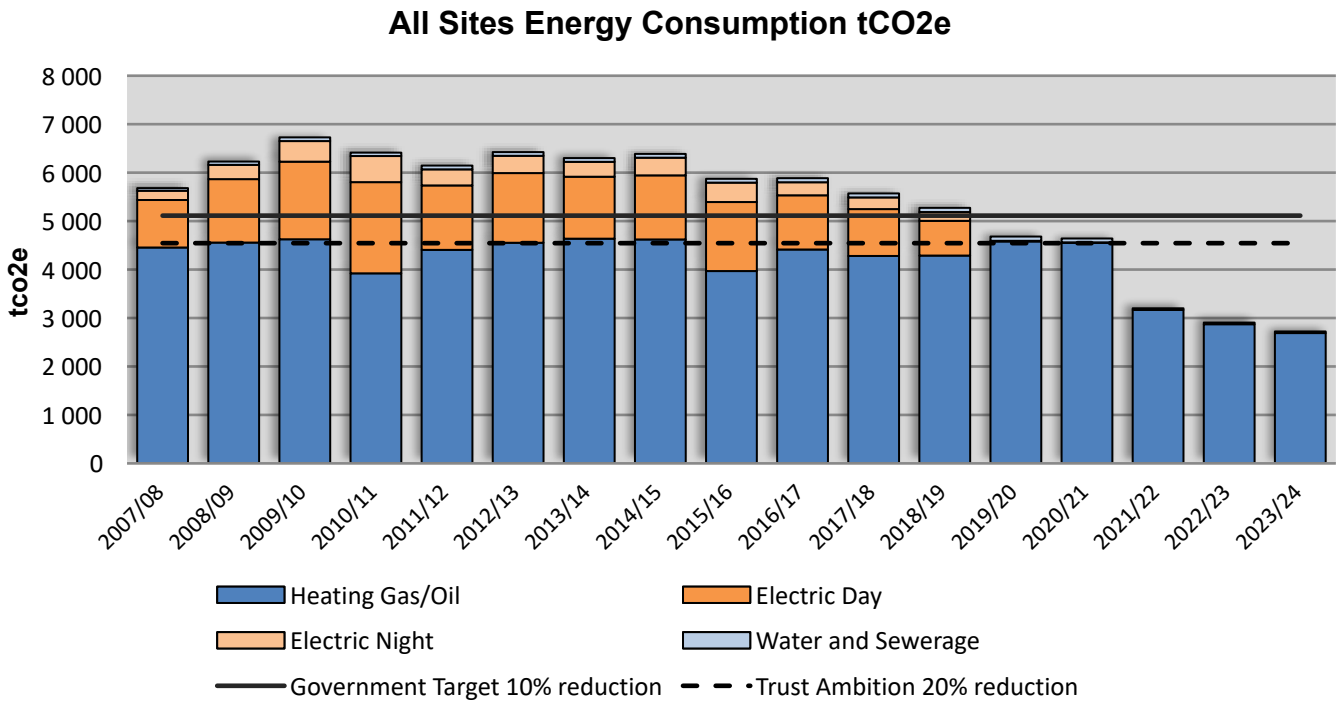
The ward area upgrades are continuing alongside the RAAC panel mitigation work; however, with the reduction of CDEL funding this financial year, full refurbishment will be difficult to complete. The Trust aims to carry out the upgrade of Ward 11, & ICU over the next few months. As we move into winter pressures it becomes integral to work alongside the operational teams to maintain progress in these areas whilst maintaining patient flow.

HSDU will continue over this period to enable delivery of increased activity with OEH coming online. Fracture Clinic and SDEC projects will progress with Phase 1 fracture clinic delivered in Q4.

Action	Completed areas	Completion Target date	RAG
Ward upgrades	Ward 5 completed Ward 4 completed Ward 3 completed Ward 10 completed Ward 7 completed	March 2028	On target
Department upgrade	Fracture Clinic	April 2025	On target
Department upgrades	Same Day Emergency Care (SDEC) unit	August 2025	On target

Energy Carbon Emissions 2023/24

Green plan statement



In the last year 2023-2024 we have seen a further 6% reduction in our CO2e emissions

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In 2023/24, JPUH have decreased: both the Carbon Footprint (those emissions we directly control) and the Carbon Footprint Plus (those emissions we influence, in addition to those we directly control).

- *In 2023/24 the Trust reported a further reduction of 6% tCO2e . This equates to a 52% reduction of carbon emissions since 2007 base data.*
- *Emissions from electricity were reduced from 2021/22 by securing Renewable Energy Guarantee of Origin (REGO) certificates, this allowed us to report our scope 2 carbon emissions as zero.*
- *From 2023/24 as a cost saving electricity consumption was purchased from a carbon zero source witch still allows us to report scope 2 carbon emission as zero.*
- *In June'23 pipework lagging to the main heating ring on the roof was completed. In the 9 months since completion, we have seen a reduction in gas consumption by 1.1m kWh compared to the pervious period, which equates to 206 tCO2e.*

Understanding the full extent for our carbon footprint will be one of our primary objectives as we move into next year.

New Hospital Future Project Programme update

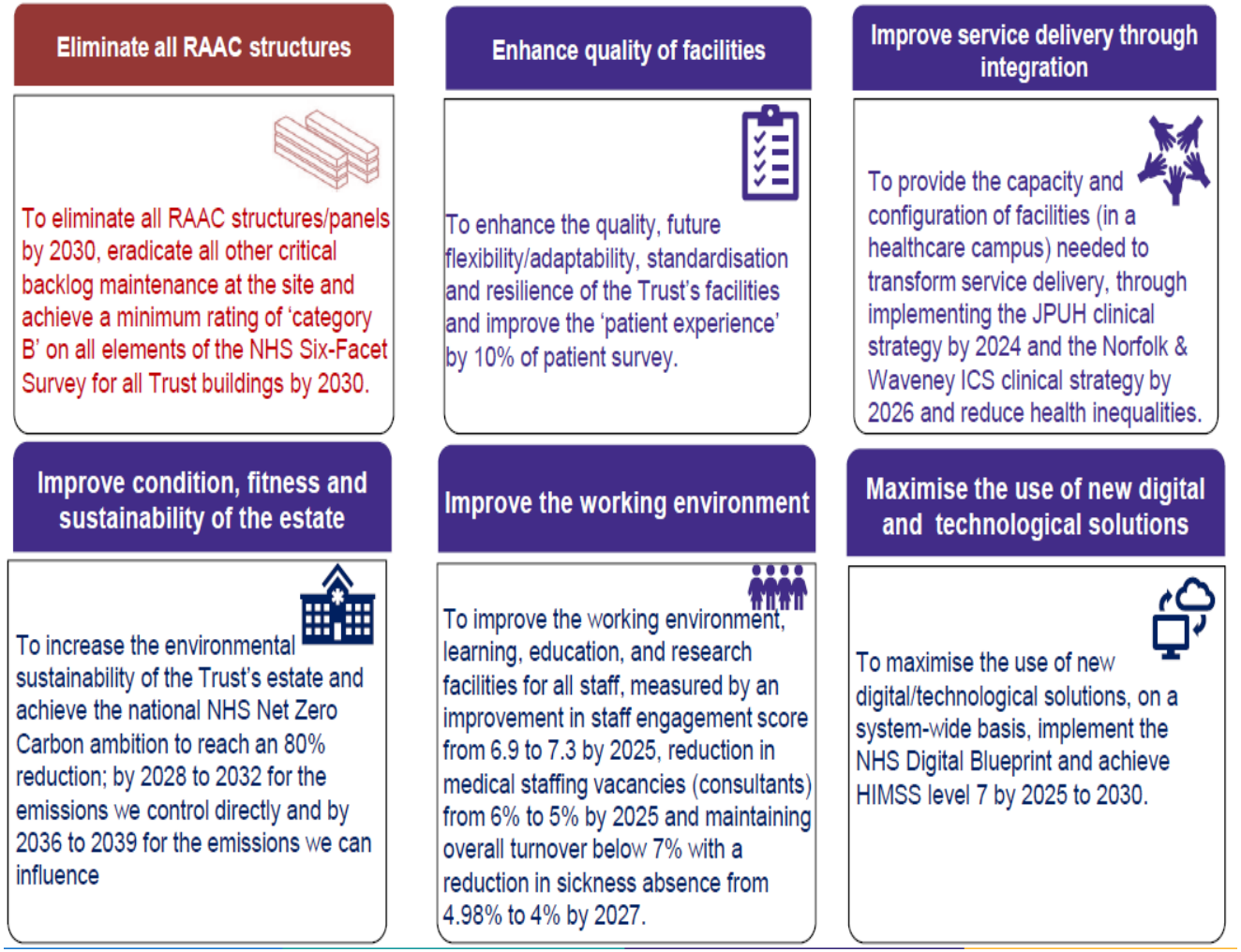
The Future Paget Programme team providing the New Hospital has delivered the requested review of the Strategic Outline Case (SOC) The new case has presented and approved at Trust Executive Board and ICB board. This will now be reviewed by the NHP subject matter experts and delivered to NCAT

As a trust, we have been reviewing the Demand and Capacity with the national work while working with the system on a full clinical strategy. This will enable us to have confidence in the bed numbers required within the New Hospital.

The project team has been working hard to meet all the national requirements while ensuring that we still progress the business case in line with the green book requirements, this means reviewing all sections of the business case with our subject matter experts.

Whilst we still await the final drop of the hospital 2.0 standard and design, a review of the master plan has taken place against the Hospital 2.0 design principles.

- Ensure that Trust land and property are used effectively to support commissioners' and the Trust's own priorities to best meet patient needs
- Provide and maintain an appropriate level of affordable NHS healthcare facilities in the right locations, which are fit for purpose, safe and compliant with legislation and relevant guidance
- achieve continuous improvement and better efficiencies from the performance of the estate
- Help deliver the Trust's sustainability objectives and Green plan by taking all reasonable steps to minimise our adverse impact on the environment and work towards Net Zero Carbon (NZC)
- Alignment of the Green Plan, Transportation Plan and Transport Strategy for the new hospital is needed for better long-term positioning
- Identify and release surplus land for development or disposal in keeping with the new hospital master planning.



Net Zero Building Standards

Hospital 2.0

BREEAM Excellent

NEW concept ward technologies

Intelligent buildings

KPI Dashboard / ERIC Data

Carbon: Currently only have tCO2e data for energy utilities but are looking to develop this section into 2024/25

Utilities: Gas consumption has been gradually falling as we work towards our sustainability targets (this is covered in more detail in our sustainability report and updates). In comparison to the 5% reduction is gas usage this has only seen a positive 0.1% increase in electricity from a zero-carbon sauced supple. Water consumption has seen a steady increase since hospital activity has returned to normal after COVID and the increase in footprint to the Hospital.

Medical & Anaesthetic Gases: Under review to include in 2024/25 data collections.

Waste: The parameters or reporting waste has changed within ERIC data which is why there is large increase in incineration waste and a reduction in alternative treatment. The Biffa domestic waste collections are sorted offsite resulting in all waste being diverted from landfill.

Travel & Transport: These figures have been added for this report and are annually reported in the Greener NHS Fleet return for NHS Digital.

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KPI	Units	2021/22	2022/23	2023/24	Trend from Prev Year (23/24 vs 22/23)
JPUH Carbon Footprint (Energy Only)	tCO_2e	3,153	2,888	2,713	-6% ↓
Community Carbon Footprint	tCO_2e				
Supply Chain Carbon Footprint	tCO_2e				
JPUH Carbon Footprint Plus	tCO_2e				
Natural Gas Consumption	kWh	16,845,989	15,583,777	14,811,216	-5.0% ↓
Heating Oil (Generators)	Litres	70,018	42,554	34,362	-19.3% ↓
Electricity Consumption (Zero Carbon)	kWh	5,349,371	5,463,701	5,471,812	0.1% ↑
On-Site Renewable Generation (PV Panels)	kWh	305,609	254,678	247,347	-2.9% ↓
Water Consumption	m^3	88,008	87,957	93,374	6.2% ↑
Volatile Anaesthetic Gases	tCO_2e				
Medical Gases	tCO_2e				
Total Waste (collected from site)	Tonnes	1,404	1,195	1,202	0.6% ↑
Incineration (clinical waste)	Tonnes	296	84	100	19.0% ↑
Alternative Treatment (clinical waste)	Tonnes	136	144	115	-20.3% ↓
Offensive Waste	Tonnes	288	309	323	4.6% ↑
Domestic Waste (landfill)	Tonnes	-	-	-	0.0% →
Domestic Waste (recycling)	Tonnes	116	112	145	29.1% ↑
Domestic Waste (food to Anaerobic Digester)	Tonnes	118	107	97	-8.7% ↓
Domestic Incineration	Tonnes	366	356	344	-3.4% ↓
Confidential Waste	Tonnes	84	84	78	-6.7% ↓
WEEE Electrical Items	Tonnes	8	4	5	15.6% ↑
Total Trust Fleet Volumn of Petrol Consumed	Litres	6,818	10,815	10,844	0.3% ↑
Total Trust Fleet Volumn of Diesel Consumed	Litres	7,288	7,972	4,724	-40.7% ↓
Total Trust Fleet Volumn of Electric Consumed	kWh	-	-	-	→
Total Business Travel Mileage (Grey Fleet)	Miles	94,375	132,348	201,571	52.3% ↑

*figures taken from James Paget University Hospitals ERIC and Greener NHS Fleet return 2023/24

Communication plan

- Site strategy published on the Trust's webpage, social media and email channel to raise awareness and support engagement
- Regular attendance at local health and care, and local government and VCSE, coordination networks and outreach forums to provide progress updates
- Dedicated regular Future Paget Programme briefings
- Stakeholder briefing sessions delivered with local councilors and members of Health and scrutiny committee, Healthwatch Norfolk and Healthwatch Suffolk, and local MP's
- The Trust is engaging with staff, patients and communities across a variety of internal and external networks, using a range of methods

PAGNET

*figures taken from James Paget University Hospitals ERIC return 2021/22

Conclusion

"This report provides an update on the Trust's progress towards achieving its Estates Strategy over the past six months. The Trust Estates and Facilities department has overseen the largest capital budget since the hospital's opening. The Trust is beginning to reap the rewards of this investment and the dedicated effort that has gone into not only constructing these buildings but also addressing the ongoing challenges of maintenance and backlog maintenance costs."

The plan outlines the introduction of a new Orthopedic Elective HUB and Community Diagnostic Centre, which has greatly benefited the Site Strategy. These newly constructed areas will be included as part of the New Hospital's retained buildings. The Estates Vision aims to develop a modern health and care campus that will serve the region for the next 50 years through our New Hospital and Future Paget Programme. The objectives and actions outlined in this report demonstrate progress towards mitigating the RAAC infrastructure risks and implementing modern standards.

All the newly constructed buildings meet the stringent requirements of the NHS Net Zero Carbon standards, incorporating the health building notices and health technical memorandums. We have used modern methods of construction and incorporated new digital technology while integrating with other Trust strategies, demonstrating our unwavering commitment to environmental sustainability. Our long-term goal is to have a new, fit-for-purpose hospital that is not just modern, but also environmentally responsible.

As we progress into the next stage of the Future Paget Programme the Estates Strategy will be refreshed to meet ongoing clinical need and the master planning for the Estates, the long-standing nature of some goals will be reviewed to ensure requirements meet that of the Outline Business Case for the new hospital. We will also work concurrently to enhance our current estate by reducing backlog maintenance. Over the next six months, the CDC, OEH, and DAC will all be utilised and introducing a new SDEC by repositioning fracture Clinic into a new building this will constitute a significant portion of the new strategy whilst investigating further opportunity of the estate to support master planning. Despite the ongoing competition with operational pressures, RAAC mitigation work will continue. We are working closely with our clinical teams to accomplish our programs while still ensuring a "clean, safe, secure, and suitable environment" for our patients to receive care.

We will maintain the current infrastructure to legislative standards, improve patient care through innovative ways of working and improvement, and provide continuing assurance to the Board of Directors to all relevant standards through compliance reporting.

Steven Balls

Deputy Director of Estates and Facilities

NHS
James Paget University Hospitals
NHS Foundation Trust

Report to the Trust Board of Directors dated Friday, 31 January 2025

Title: Six monthly Green Plan and Sustainability report December 2024

Sponsor:	Director of Strategic Projects
Author:	Steven Balls Head of Estates, Facilities and Planning
Previous scrutiny:	Finance & Performance Committee, 22/01/2025 Hospital Management Group, 28/01/2025
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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Executive Summary

The six monthly Green Plan and Sustainability report is presented to provide assurance to The Board of Directors of actions against the Trust's published Green Plan. The report provides evidence of completed actions and those still in progress. Further to the assurance the report aims to show future actions and the Trust's journey in accordance with the national standards set for delivering a Net Zero Carbon NHS.

This report has been reviewed, discussed and presented to the Finance & Performance Committee and Hospital Management Group.

Recommendation

The Board of Directors is asked to approve the report as providing sufficient assurance of the actions and progress made in relation to the Green Plan.

James Paget University Hospitals NHS Foundation Trust

Six Monthly Green Plan & Sustainability Report December 2024

Authored by;

Steve Balls – Deputy Director of Estates, Facilities and Planning

Lee Nicholson-Allen – Waste and Sustainability Manager

Contents

Introduction

This is a sustainability update report to the Board of Directors regarding the Trusts progress towards the net zero objectives as set out in the “Health and Care Act 2022” and “Delivering a Net Zero National Health Service”.

As per the JPUH Trust Strategy 2023-28:

AMBITION 4.2:
Lead the way towards achieving Net Zero Carbon
Our new hospital will be expected to be as close to carbon neutral as possible. We have a Green Plan which looks at what we can do now to improve things, and what opportunities there will be in the future, to ensure that net zero initiatives are embedded into the Trust’s models of delivery and capital development programme.

Our Green Plan encompasses actions aligned to the 17 UN’s Sustainable Development Goals and this report outlines our energy consumption, ICS alignment and performance within 10 specific areas of focus.

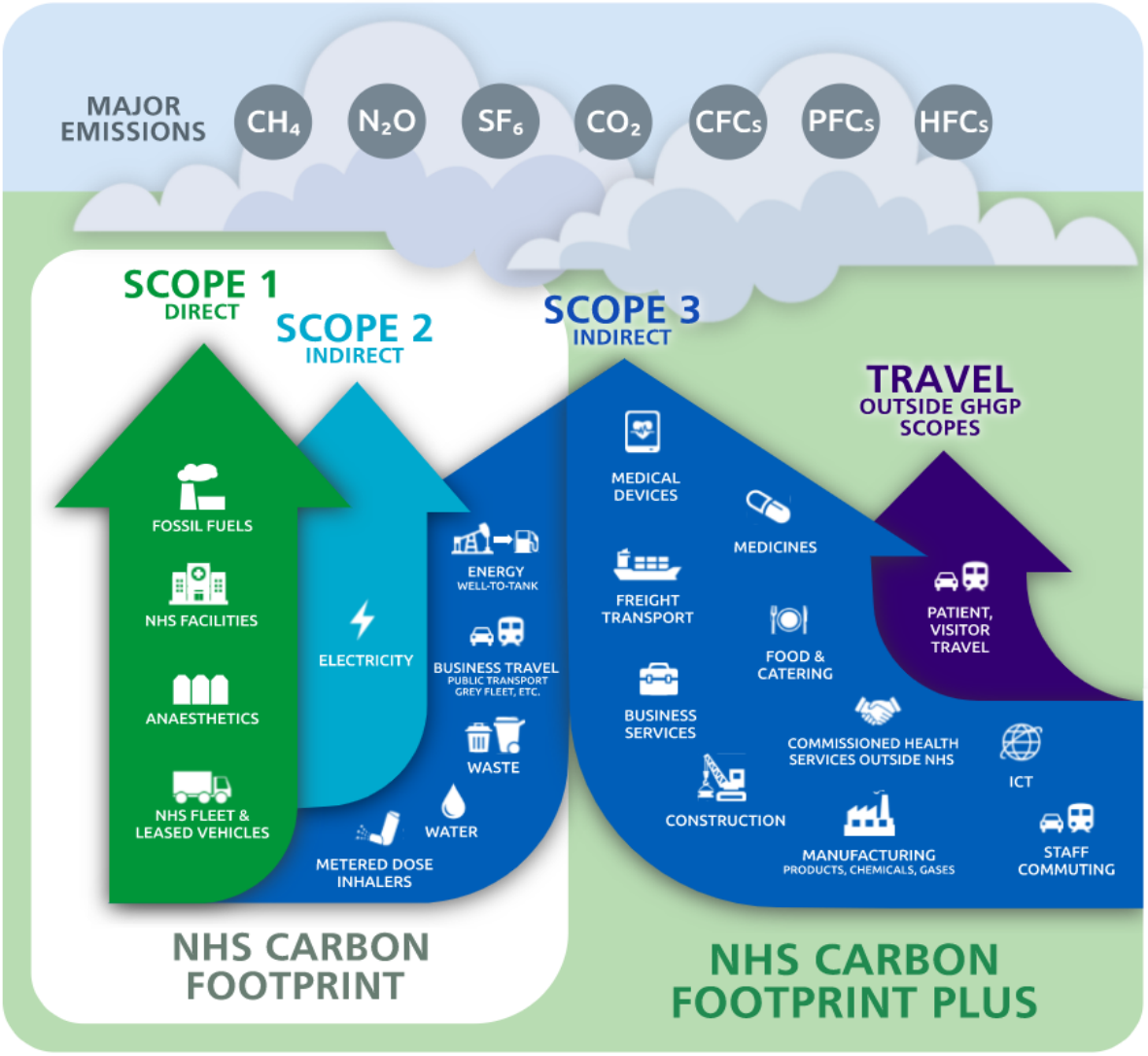
As our learning, engagement and adaptation of sustainability continue, individually and as an organization, areas of improvement and focus captured within this report will be reflected in our Green Plan refresh in 2025.

Vision & Overarching Ambitions

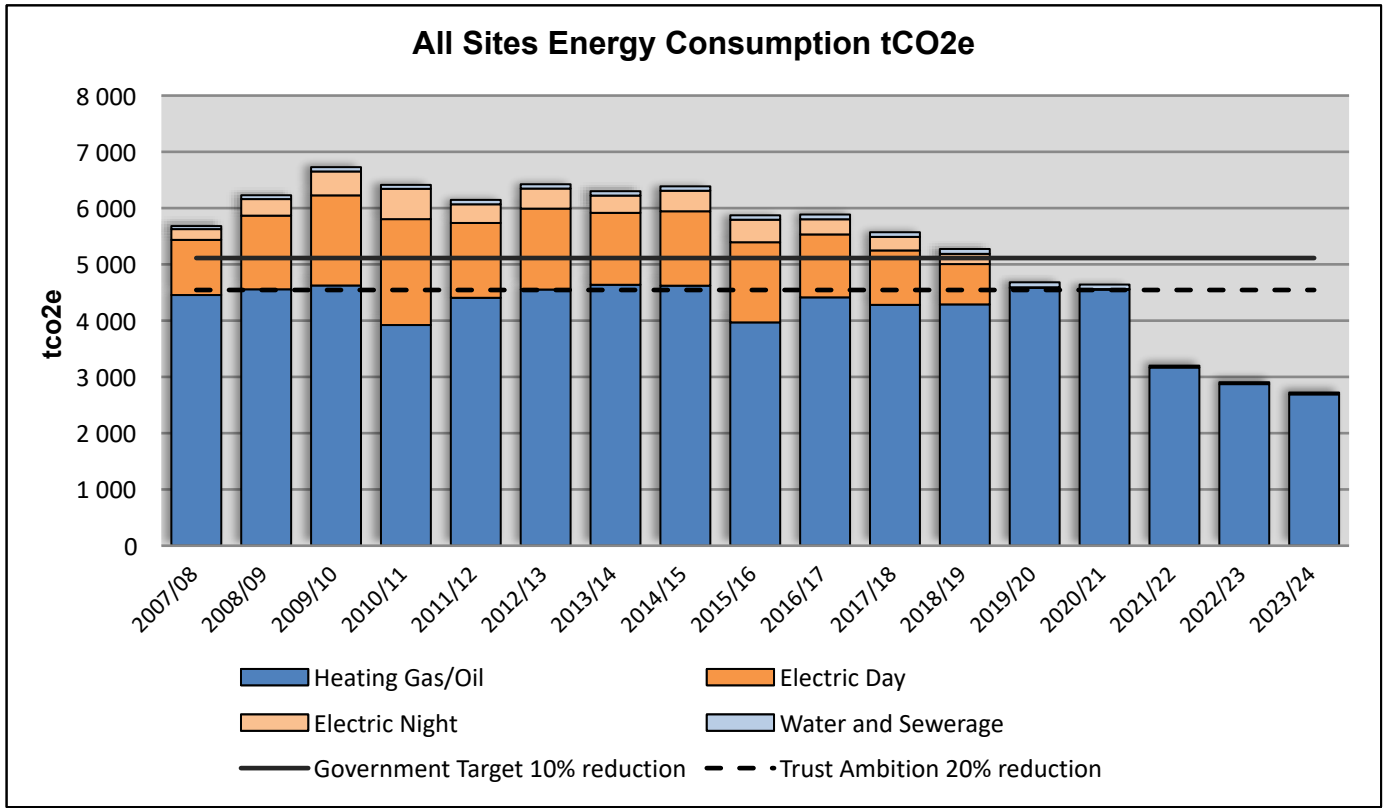
The Trust's green vision is to foster an environment that supports a safer, more sustainable, green Trust that integrates net zero ambitions, objectives and actions in line with regional and national targets. Therefore, the reduction of carbon needs to be a decision for patients, staff and suppliers for a collaborative approach that is preventative and constant.

- ***For the emissions we control directly (the NHS Carbon Footprint), to be net Zero by 2040, with an ambition to reach 80% reduction by 2032.***
- ***For the emissions we can influence (our NHS Carbon Footprint Plus), to be net Zero by 2045, with an ambition to reach an 80% reduction by 2039***

This report demonstrates how the Trust has and will help to reduce its carbon emissions in line with the national objective of the NHS to tackle climate change by reducing emissions to 'net zero'. In doing so, we aim to be part of the world's first 'net zero' National Health Service.



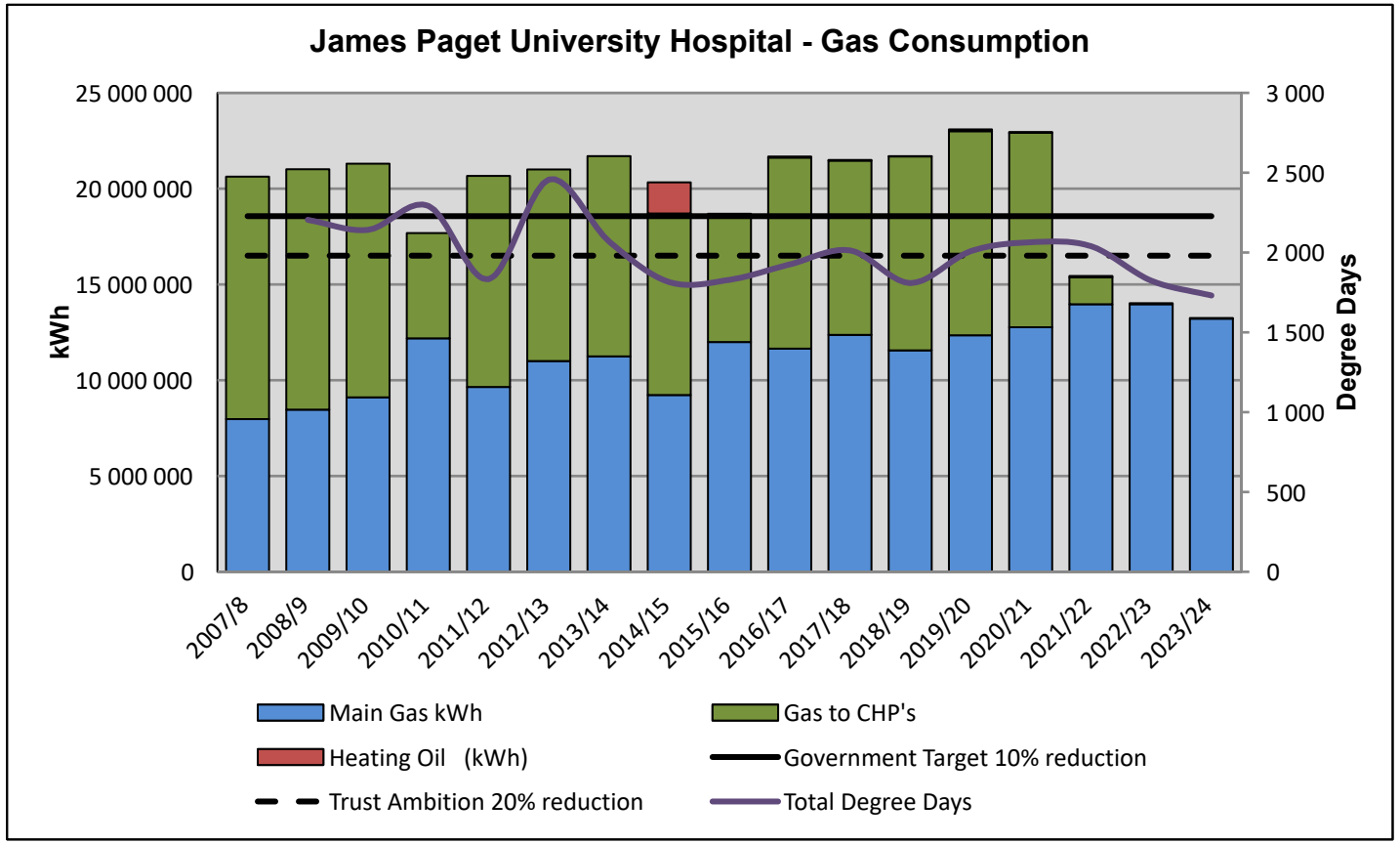
Energy Carbon Emissions



Year	Total Gas and Electric (tCO2e)	% Increase/Decrease in tCO2e from previous year
2007/08	5,681	-
2008/09	6,229	9.65%
2009/10	6,728	8.01%
2010/11	6,413	-4.68%
2011/12	6,146	-4.16%
2012/13	6,424	4.52%
2013/14	6,300	-1.93%
2014/15	6,387	1.38%
2015/16	5,872	-8.06%
2016/17	5,886	0.24%
2017/18	5,571	-5.35%
2018/19	5,274	-5.33%
2019/20	4,681	-11.24%
2020/21	4,641	-0.85%
2021/22	3,201	-31.03%
2022/23	2,906	-9.22%
2023/24	2,723	-6.30%

- The Trust continues to reduce tCO2e through energy consumption. A **46.5% reduction** since the Trust 2021 Green Plan and a **6% reduction in 2023/24**
- In 2023/2024 JPUH continued its LED lighting replacement scheme, reporting an estimated **50% LED coverage**. This will be confirmed in the 2023/24 ERIC return.
- In the 9 months since completion pipework lagging we have seen a reduction in gas consumption by **1.1m kWh** compared to the pervious period, which equates to 206 tCO2e**.**

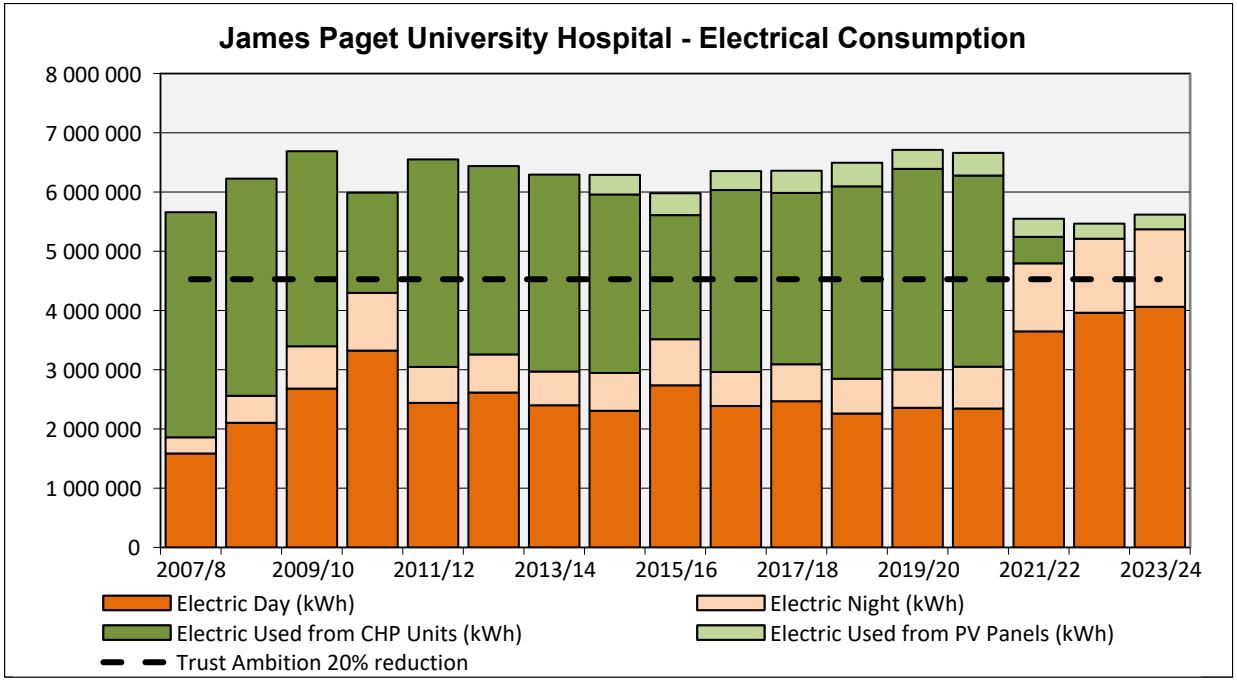
Gas Consumption



Financial Year	Total Gas Consumption (kWh)
2007/8	20,627,014
2008/9	21,013,746
2009/10	21,303,516
2010/11	17,681,893
2011/12	20,665,336
2012/13	21,002,699
2013/14	21,698,334
2014/15	20,329,171
2015/16	18,690,202
2016/17	21,677,457
2017/18	21,498,388
2018/19	21,696,807
2019/20	23,094,140
2020/21	22,956,222
2021/22	15,372,172
2022/23	13,967,756
2023/24	13,213,789

- Main Gas consumption has continued to since 2021/22.
- The current trajectory for 2024/25 suggests this will continue however clearly heading into winter months pulls more energy from our heating systems.
- Progress is being researched for medium-long term strategies for heat decarbonisation, reducing our reliance on gas, one of the most carbon intensive fuels. A feasibility study regarding the use of geothermal technology is currently being procured.

Electrical Consumption



Month	Main PV Panels kWh	Grid Electic Day Rate kWh	Grid Electic Night Rate kWh
Apr-2023	25,709	310,848	105,257
May-2023	26,973	325,632	105,179
Jun-2023	28,380	345,383	108,736
Jul-2023	17,578	341,203	108,104
Aug-2023	36,038	337,432	107,118
Sep-2023	39,763	331,370	105,243
Oct-2023	20,726	339,404	107,841
Nov-2023	8,409	346,472	108,695
Dec-2023	2,766	357,368	115,286
Jan-2024	5,686	376,007	121,454
Feb-2024	12,013	330,186	107,527
Mar-2024	23,306	321,036	108,288
Apr-2024	27,175	297,272	103,866
May-2024	36,853	309,753	103,024
Jun-2024	37,519	295,521	97,600
Jul-2024	31,613	324,799	103,292
Aug-2024	34,794	331,220	104,494
Sep-2024	27,752	323,881	103,848
Oct-2024	18,762	331,977	108,741

- Total Grid Electric Day Rate kWh between **April 24- Oct 24 is 116,848 lower** than the same period in 2023 (April 23 – Oct 23)
- Since 2020 all the Trust's electricity has been sourced from a renewable source.
- Electrical energy consumption will be expected to increase due to imminent opening of The Oulton Suite (CDC) and Elective Orthopaedic Hub

Ongoing and Completed Actions

Reducing our use of fossil fuels

- ••Use of clean and renewable energy, Generating 'green' electricity locally with our Photovoltaic Solar Farm.
- ••Reducing gas usage by the reduction and removal of equipment and plant requiring steam.
- ••100% of the James Paget Hospitals electrical power was generated from ‘green’ technologies in 2023/24.
- ••efficient Theatre ventilation systems which recover heat from extract air continued to be designed into new areas.
- ••Turning off computers automatically when they are inactive.
- ••New buildings to be construction and BREEAM excellent certified with net zero carbon.

Promoting Sustainable Procurement

- ••Ensuring we purchase goods and services from local where possible
- ••SV 10% minimum is mandatory for all PCR2015 procurements for which the current threshold is £139668.00 (inc vat)
- ••Sustainability is a consideration on all business cases
- ••Adapting CO2e savings as well as financial savings when collating new suppliers
- ••Buying food from local sources and cooking meals locally in our hospital.
- ••Designing and constructing buildings to the latest BREAM standards and the NHS net zero Building Standards.

Ongoing and Completed Actions

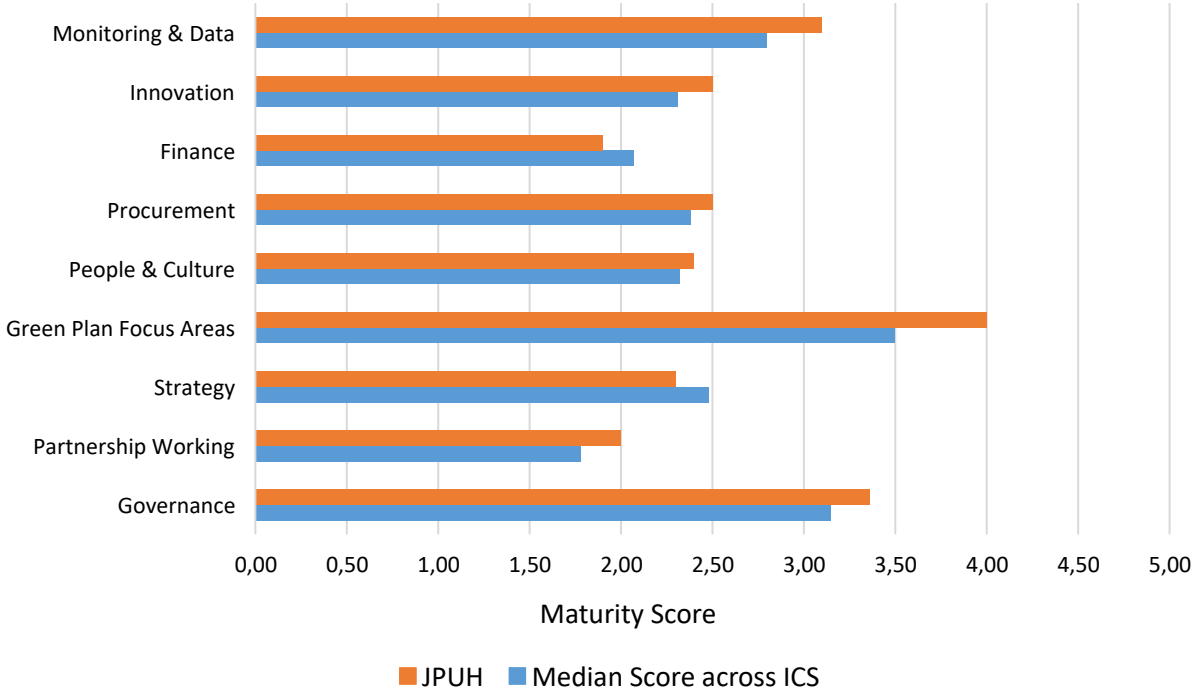
Promoting Sustainable Travel & Transport

- Establishing a Health and Wellbeing group which promotes walking and cycling to work.
- Providing bicycle storage facilities for staff and visitors
- Flexible working opportunities for staff to reduce travel
- Bike security and maintenance opportunities
- Reducing any high emission vehicles from Trust fleet
- Promoting low emission vehicles for all lease cars.

Reducing and Correct Segregation of Waste

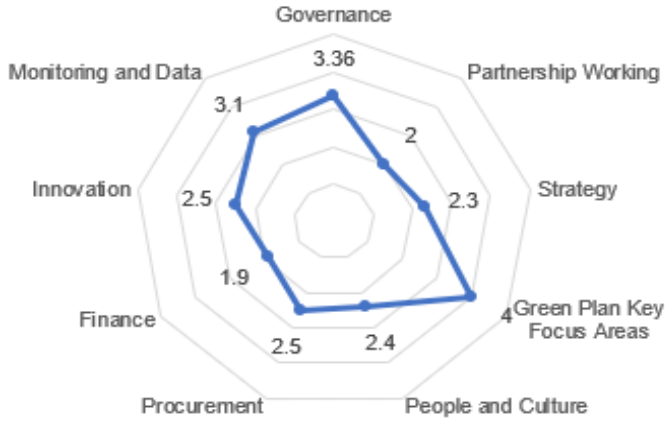
- The Trust is providing offensive and infectious clinical waste streams as per HTM 07 01
- Promotion of correct waste segregation to ensure that only appropriate waste is being incinerated
- Currently 20%-24% of dry mix recycling is actually recycled
- No waste goes to landfill – Non recyclable items are sent to energy from waste
- Reducing printing by the use of electronic documents and tablets etc.
- Recycling of food waste into alternative fuels

ICS Alignment and Maturity



JPUH are making good progress on its Green Plan and are inline with the rest of the ICS hospitals, in some categories ahead in our progress.

JPUH Net Zero Maturity Report



Risks:

- No Funding allocated for support and on ongoing delivery of the Green Plan e.g. EV charging points and work around embedding net zero into the capital program.
- JPUH Governance structure in place with an active Sustainability Committee.
- Lack of Sustainability Committee engagement.
- Green Plan not embedded into operational delivery.

JPUH Priorities:

- Develop processes/ tools to monitor Green Plan performance beyond what is provided by ERIC and Greener NHS returns.
- Senior leaders should set personal net zero commitments and be upskilled in carbon literacy.
- Identify finance to support development of a dedicated Green Plan team.
- Identify what additional resource and skills capabilities is needed to embed Green Plan activity within operational activity.

Performance Report

The following section provides a summary of key sustainability developments and case studies across the ten areas of focus.

Travel and Logistics

Implement immediate strategies to reduce commuting CO2 emissions and encourage healthy modes of travel by staff, patients and visitors

Action	Update	Target completion date	Current RAG rating with new target date
ANPR	Currently working work go-live of ANPR	Early 2025	Ongoing
Promote staffing car sharing options and local transport opportunities	Review of options to alternative to car travel	2025/26	Ongoing
Staff parking permit and ticketing process	Staff applications and ticketing process to minimise disruption and unauthorised parkings	Summer 2024	Completed
Car Park E extension	Extension of Car Park E completed	Summer 2024	Completed
Flexible working policy - Home working fully integrated	Offers home working - reducing staff travel	2022/23	Completed

- The Trust has continued to offer a cycle-to-work scheme and encourages working from home, and the use of digital meetings to reduce commuting and business travel. To support flexible working and reduce scope 3 emissions, the Trust has created hot desk spaces
- Car Park E was successfully extended and ticketing systems installed to removing unauthorized vehicles on the ring road, large numbers of vehicle on site and reducing health and safety risks
- The Trust has also installed on-site EV charging facilities to support the use of electric vehicles and plans to introduce 6 additional points in 2025/26.

Looking Ahead 2025

- The Trust is looking to implement an ANPR system, which should continue reduce the number of non-authorised vehicles on site, reducing CO2 emissions.
- Encouraging schemes that will reduce the number of staff vehicles on site with healthier modes of transport.

Green Spaces and Biodiversity

Nurture existing green space and protect biodiversity within and around the hospital.

Action	Update	Target completion date	Current RAG rating with new target date
Additional no mow options	Norfolk Wildlife Trust visit	2025/26	Ongoing
Green waste segregation	Grounds team to secure green waste skip to ensure segregation	2025/26	Ongoing
Green/outside incorporated to DAC	Grass areas and seating provided for staff, patients and visitors	Summer 2023	Completed
Armed Forces Courtyard	Wellbeing space opened for staff, patients and visitors	Summer 2023	Completed
No mow area by Southside	Completed and fenced	2022/23	Completed

- The Trust continues to maintain the importance of access to courtyards and gardens for staff, patients and visitors with a particular focus on the Armed Force courtyard.
- A no mow area is incorporate to southside to increase wildlife
- An in house grounds team maintain on green spaces around site.
- The gardens associated with our new builds continue to be completed to support staff wellbeing and patient recovery. This is part of our goal to make wildlife visible and wrap the green environment around new models of care.

Looking Ahead to 2025

- Increasing our awareness and use of green space for the wellbeing of our patients and staff
- Involve Norfolk Wildlife Trust in conversations and ideas for our green spaces
- Ensure green waste is segregated to ensure treatment process is appropriate

Capital Projects

Provide robust processes with contractors through full project cycles and estates strategy.

Action	Update	Target completion date	Current RAG rating with new target date
Main Kitchen - move to electric	Changeover from natural gas to eletric	Early 2025	Ongoing
Steam boilers - move to electric	Changeover from natural gas to eletric	2025/26	Ongoing
Ward upgrades	As a part of ward upgrades windows are being replaced with double glazing	2025/26	Ongoing

- CDC and OEH are on track to receive BREEAM excellent.
- Progress on the LED program, reducing the impact of national supply and the rising cost of electricity.
- Future sustainability has been considered on every project.
- The new main kitchen will be switching from natural gas to fully electric

Looking Ahead to 2025

- Steam boilers will also be moving from natural gas to electric during 2025/26
- All ward upgrades are having their single glazed windows upgraded to double glazing

Sustainable use of Resources

Evaluate how we handle waste and apply a hierarchy of thinking to formally structure new processes and develop new avenues, building towards circular economies.

Aim to reduce the use of fossil fuels immediately and in line with the new hospital.

Action	Update	Target completion date	Current RAG rating with new target date
Reusable coffee cups	Pursuing option to move away from disposable coffee cups to reusable resulting in cost saving, CO2e savings and waste reductions	Early 2025	Ongoing
Medicines waste/reuse scheme	Pharmacy working with wards to review unused/discarded medicines to reduce overall waste	Trial in place	Ongoing
Theatres	Instruments packs according to procedures	Summer 2024	Completed

- Theatres have reviewed theatre instruments packs to ensure only appropriate items are placed for the procedure reducing waste and cleaning materials
- Pharmacy are trialing a system to review medicinal waste and assess whether any medicines can be reused
- The Trust is reviewing the use of disposable coffee cups with a view to moving to reusable cups in the Aubergine restaurant. Providing a cost saving, CO2e saving, waste reduction and providing a continual sustainability reminder to all staff.

Looking Ahead to 2025

- Continued promotion of a preventative waste outlook and where possible a re-use option
- Clinical teams to assess market for re-usable options
- Improved furniture/equipment re-use scheme

Corporate Approach

Sustainability is rooted in our vision to be outstanding in everything we do. Maintaining our assured governance and engaging accountable stakeholders and staff will ensure we do not compromise operations, policy and reporting.

Action	Update	Target completion date	Current RAG rating with new target date
Increased sustainability awareness and discussion at divisional and departmental level	Incorporating sustainability into governance meetings and Trust documents	2025/26	Ongoing
Sustainability awareness	Providing sustainability awareness sessions	2025/26	Ongoing
Green Plan refresh	Review and refresh of JPUH Green Plan	2025/26	Ongoing
Green Champion Group	Installed and embedded	Sep-24	Completed
0.5 WTE Sustainability Manager	Incorporated in Waste Manager role in Facilities	Jul-24	Completed

- Sustainability Manager incorporated into Waste Manager within facilities to provide sustainability insight, support and connectivity around Trust
- Engaged Green Champion group looking to make positive behavioral changes and creativity
- Waste and Sustainability Manager proving sustainability insight at departmental level, at Your Voice and discussing additional option with OD and Well-being

- **Looking Ahead to 2025**
- The current JPUH Green Plan will be refresh during 2025 leading the Trust to the new hospital
- Increased use of corporate tools to promote sustainability, ensuring sustainability is a constant conversation and consideration.

Carbon and Green House Gases

Through the analysis and measurement of our current emissions, we can identify and implement targets and technologies to reduce carbon output

Action	Update	Target completion date	Current RAG rating with new target date
Energy Source	Continuation of Zero Cxarbon for Business for our electricity source as per 2024/25	2025/26	Ongoing
ERIC reporting	We annually report our CO2 usage into ERIC as a form of national monitoring and will be following the new monitoring standards as they are released.	Apr-22	Completed
Reduction of Anaesthetic Gases	Though Pharmacy reported a very small use of desflurane in July and August 2024 as a Trust we have removed the use of desflurane	2024/25	Completed

- The Trust has removed Desflurane as an Anaesthetic gas
- Annual ERIC reporting continues. Data collation and monitoring of gases and energy use updated monthly within the Trusts Z Drive
- NHSE have advised that “REGO's is a discretionary decision by each individual Trust”

“Many NHS Trusts have been buying REGOs (Renewable Energy Guarantees of Origin) on an annual basis to demonstrate that energy purchased is from renewable sources. However, NHS England think there is potentially better value to be gained for the investment that NHS Trusts made in REGOs last year. Energy purchased from the national grid is generated by a greater proportion of renewable energy, as we move away from fossil fuels we are seeing the energy grid mix de-carbonising.”

“Whilst the decision to invest in REGOs is for each Trust to make, NHS England are not expecting NHS Trusts to buy REGOs.”

Looking Ahead to 2025

- Reduction of piped N2O
- Continued review and improved of our carbon/energy use

Climate Change Adaption

Mitigate the risk of climate change to the Trust by ensuring hospital wide awareness of how and why our actions impact the changes seen happening in the world around us.

Action	Update	Target completion date	Current RAG rating with new target date
Mass Casualty Plan	Policy published for departmental implementation and annual revew	Mar-23	Completed
Business Continuity Policy	Policy published for departmental implementation and annual revew	Apr-23	Completed
Emergency Planning Lead	In post and inputting into Emergency response relating to cliamte change	Summer 2022	Completed

- Action for climate change adaptation has largely taken place in the form of infrastructure upgrades increasing our resilience and reducing our dependency on the national grid which can be vulnerable during extreme weather events.

- Emergency Planning Lead has updated and implemented business continuity policies

- Emergency Planning Lead engages with site operations, Executives and departmental leads in preparation and response to any critical situations to ensure patient and staff safety and a continuation services.

Looking Ahead to 2025

- A review of the Trustour preparation in response to increasing extreme weather related issues as seen around the UK such as flooding, heatwaves, high winds – ensuring the community, staff and patients can still access the Hospital services

Asset Management and Utilities

Reduce our dependence of fossil fuels (e.g., natural gas) and move towards sustainable alternatives within the existing building.

Action	Update	Target completion date	Current RAG rating with new target date
Simpler recycling	Introduction of simplet recycling from 01/04/2025	2025/26	Ongoing
Clinical Waste Management - 60:20:20	JPUH nearing full compliant of 60:20:20 offensive and infectious clinical waste segregation	2025/26	Ongoing
Extension of Estates Management System into Facilities	Docket system to be implemented into areas of Facilities	2025/26	Ongoing
Estates management software	Electronic docket system fully implemented for Estates requests	Apr-23	Completed

- Work has been carried out regarding the installation of pipework lagging on the main heating run. This has allowed us to reduce the temperature within the main ring and has resulted in a reduction in the reliance of gas.
- All newly constructed buildings are fully electric utilising sustainably sourced energy.
- PV Panels continue to be in use generating electric to site.
- Clinical waste management is currently averaging 64:22:14 in response to the HTM guidance of 60:20:20

Looking Ahead to 2025

- Infectious waste to be reduced from 22% to under 20% - A review of Theatres waste streams to be assessed
- Simpler recycling to be introduced from 1sr April 2025 – Requiring all large business to separate food and dry mix recycling. Awaiting further guidance.
- Continued changeover to LED lighting
- Potential for 6x additional EV car charging points near education and training centre

Our People

Strive to further support staff in their sustainable development and empower them to lead with it in mind.

Aim to develop and improve staff accommodation to support quality of life, wellbeing and integrated work systems.

Action	Update	Target completion date	Current RAG rating with new target date
Sustainability Awareness	Increased sustainability conversation and consideration in all departments	2025/26	Ongoing
Sustainability Training	Possibility to add a local sustainability training module	2025/26	Ongoing
Green Champion Network	Implemented in September with monthly meetings	Sep-24	Completed
Promotion of healthy living	OD and Wellbeing newsletter provides signposting to health living and wellbeing opportunitiies	Apr-23	Completed
Louise Hamilton Service	Supportive networks for patients, relatives and visitors	Apr-23	Completed
Armed Forces Advocate	Armed Forces lead support staff and patients	May-22	Completed

- The Green Champion network and OD and Wellbeing team are continually looking at creative ideas to support staff in living healthier lives both physically and mentally
- The Louise Hamilton Centre continues to support our staff, patients and visitors with various networks, classes and wellbeing support
- The Trusts Armed Forces Advocate supports all staff and patients from military backgrounds that require support
- Our Transformation team and Research departments are continuing to promote sustainability through projects

Looking Ahead to 2025

- Increasing staff awareness of Sustainability, the legislative requirements and the need for change
- Looking at options for in-house sustainability training
- Management teams to incorporate Sustainability into meetings, discussions and decision making

Sustainable Models of Care

Update the Clinical Strategy with the objective of delivering the finest quality of care that supports social, environmental and economic systems, and Improve the offer of virtual care.

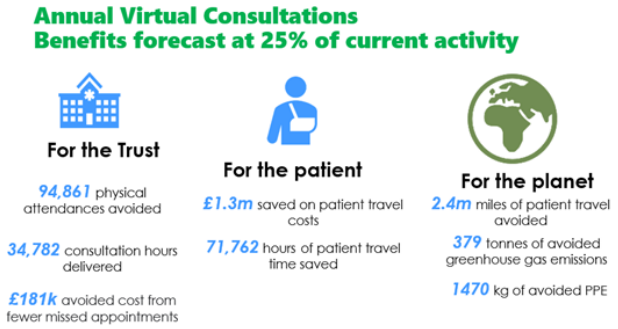
Action	Update	Target completion date	Current RAG rating with new target date
Virtual outpatient appointments	Continued use and increase of Virtual resources	2025/26	Ongoing
Opening of Virtual Outpatient Consultation Hub	Consultant hub opened in summer 2024	Summer 2024	Ongoing
JPUH Virtual Ward	Continued use of JPUH Virtual to 40 patients and increasing pathways	2020/21	Ongoing
Paget at Home	HomeLink Healthcare support Paget at Home	2020/21	Ongoing

- Virtual Consultation Hub opened during 2024 for continued virtual outpatient booking opportunities
- JPUH Virtual Ward continues to be an integral extension of the hospital services. Enabling an additional 40 patients to be monitoring virtually at any one time.
- Paget at Home, supplied through HomeLink Healthcare, continues to support patients discharge from the hospital setting, allowing nursing care in their on home

Looking Ahead to 2025

- Increase virtual outpatient appointments towards 25% objective – currently a reduction in Virtual outpatient appointments than 2023/24
- A view to bring the Paget at Home service in-house to align with the Virtual Ward

	2023/24	2024/25
Virtual Appointment	11.22%	9.01%
Telephone Appointment	10.25%	8.55%
Video Appointment	0.97%	0.46%



KPI Dashboard
2022/23 vs 2023/24

Carbon reporting: We currently have tCO2e data for energy utilities but we are looking to develop this section further

Utilities:

Gas consumption fell by 5%

The largest reduction is our use of heating oil generators – 19%

Our use of PV Panels dropped by 2.9% and the water consumption increased by 6.2%

Medical & Anaesthetic Gases: Under review to include in 2023/24 data collections.

Waste:

Incinerated clinical waste saw an increase in 2023/24 whereas alternative treatment waste dropped by 20.3%.

No waste goes to landfill and 29.1% of waste sent for recycling was recycled.

Travel & Transport:

Business travel mileage increased in 2023/24 (52.3%) however the diesel consumed has been reduced by 40.7%. A move to reduced diesel fleet and introducing electric charging points and vehicles will support this.

KPI	Units	2021/22	2022/23	2023/24	Trend from Prev	
JPUH Carbon Footprint (Energy Only)	tCO_2e	2,888	2,888	2,713	-6%	↓
Community Carbon Footprint	tCO_2e					
Supply Chain Carbon Footprint	tCO_2e					
JPUH Carbon Footprint Plus	tCO_2e					
Natural Gas Consumption	kWh	16,845,989	15,583,777	14,811,216	-5.0%	↓
Heating Oil (Generators)	Litres	70,018	42,554	34,362	-19.3%	↓
Electricity Consumption (Zero Carbon)	kWh	5,349,371	5,463,701	5,471,812	0.1%	↑
On-Site Renewable Generation (PV Panels)	kWh	305,609	254,678	247,347	-2.9%	↓
Water Consumption	m^3	88,008	87,957	93,374	6.2%	↑
Volatile Anaesthetic Gases	tCO_2e					
Medical Gases	tCO_2e					
Total Waste (collected from site)	Tonnes	1,404	1,195	1,202	0.6%	↑
Incineration (clinical waste)	Tonnes	296	84	100	19.0%	↑
Alternative Treatment (clinical waste)	Tonnes	136	144	115	-20.3%	↓
Offensive Waste	Tonnes	288	309	323	4.6%	↑
Domestic Waste (landfill)	Tonnes	-	-	-	0.0%	→
Domestic Waste (recycling)	Tonnes	116	112	145	29.1%	↑
Domestic Waste (food to Anaerobic Digester)	Tonnes	118	107	97	-8.7%	↓
Domestic Incineration	Tonnes	366	356	344	-3.4%	↓
Confidential Waste	Tonnes	84	84	78	-6.7%	↓
WEEE Electrical Items	Tonnes	8	4	5	15.6%	↑
Total Trust Fleet Volumn of Petrol Consumed	Litres	6,818	10,815	10,844	0.3%	↑
Total Trust Fleet Volumn of Diesel Consumed	Litres	7,288	7,972	4,724	-40.7%	↓
Total Trust Fleet Volumn of Electric Consumed	kWh	-	-	-		→
Total Business Travel Mileage (Grey Fleet)	Miles	94,375	132,348	201,571	52.3%	↑
Modelled Staff Commuting Mileage	km					
Modelled Patient & Visitors Mileage	km					

Conclusion

This December 2024 sustainability reports continues to evidence a growing consideration of sustainability in certain areas around the Trust with many completed actions from previous years now embedded into practice.

As new buildings and services increase the Trust continues to work to construction net zero standards and BREEAM excellence, however the existing infrastructure remains challenging as we aim to decarbonise heating across the estate.

The Trusts increase of staff Car Park E, reduced unauthorised parking, and a view to ANPR and additional EV car charging points seek to improve staff and patients on site experience and the flexible working policy normalising remote working has reduced staff journeys. Staff travel will continue to be assessed.

There is a focus on the social element of sustainability with increased staff led support networks and patients and community initiatives as led by the Louise Hamilton Centre.

An introduction of a Green Champion Group will provide creativity and a voice for our staff, though will also need those staff to action and support positive behavioural challenge.

Clinical teams, like the Theatres Green Group, Radiology and Pharmacy, to name a few, are working to improve their sustainability however improvements need to made to ensure all departments are considering, discussing, implementing and communicating sustainable actions within their divisions.

Tenders and business cases considering sustainability has enabled positive progress and will need to be continued improved upon to reap the benefits of long term financial savings and CO2e savings when assessing new products and services.

As we re-assess our current Green Plan, develop our Green Plan beyond 2025 and have our New Hospital Programme team working on sustainable initiatives towards our net zero target, we must use the opportunity to ensure our vision for sustainable healthcare is allowed to progress, giving staff the opportunity to learn, develop and implement positive change for the patients and community we serve.

James Paget Green Champion

Find Out More

View the James Paget -

https://www.jpaget.nhs.uk/media/588253/The-Green-Plan.pdf

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James Paget University Hospitals NHS Foundation Trust

Report to the Trust Board of Directors dated Friday, 31 January 2025

Title: Trust Strategy: Delivery Plan 2024/25 – Q3 Update

Sponsor:	Deputy Chief Executive
Author:	Will Brown, Assistant Director of Strategy and Transformation, Jessica Calder Senior Project Support Officer
Previous scrutiny:	Trust Board - July 2024
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

Executive Summary

The Delivery Plan 2024/25 has been approved by Trust Board, and it includes an agreed set of objectives which will support delivery for year 2 of the Trust Strategy ('Our Strategy') 2023-28. Full report can be found in Appendix A.

Each objective directly links to the 4 key priority areas which are:

- Caring for Our Patients
- Supporting Our People
- Collaborating with Our Partners
- Enhancing our Performance

Each of the objectives has a list of key deliverables which include – 'how the objective will be achieved' and 'how the objective will be measured/ provide the relevant outcomes'. This ensures that the Trust is effectively monitoring both quantative and qualitative benefits in order to achieve the overall Trust Strategic ambitions over the 5 year life cycle (2023-28).

Executive responsibility is allocated relating to their portfolio, so all objectives are covered. Updates have been provided for Quarter 3 of 2024/25. A 'BRAG' rating has also been included which shows the current status of delivery for each objective, BRAG stands for:

- Blue – objective already delivered (on time or early)
- Red – objective off track and no mitigations in place to recover;
- Amber – actions in place to deliver objective
- Green – objective on track for delivery

In summary, good progress has been achieved across all areas with no 'red' status objectives, and any 'amber' status having plans in place to bring back on track for delivery by the end of 2024/25.

Irrespective of the move to a Group model we are developing high level objectives for the JPUH for the year 2025/26 and this will come to Board in March.

Recommendation

Trust Board is asked to **Note** progress against each of the objectives, and highlight any areas where more focus is needed.

EXEC LEADS - CHIEF NURSE / CHIEF MEDICAL OFFICER / CHIEF OPERATING OFFICER / DEPUTY CHIEF EXECUTIVE

Priority 1	Ambitions 2023-2028 (our vision)	Exec Lead	BRAG status	2024-25 Objectives	How will we achieve these?	KPIs	Q1/Q2 update	Q3 update	Who is doing the work? (a management group)	How is the Board Scrutiny being done? (on behalf of the Board)
Caring for Our Patients	1. Deliver the best and safest care for our patients 2. Continuously improve patient experience 3. Reduce health inequalities, ensuring equitable access for all 4. Empower patient choice and personal responsibility for health	PM		1. We will deliver the agreed quality priorities for 2024/27 for Patient Safety, Clinical Effectiveness & Patient Experience, and build a quality partnership aligned to the delivery of the Norfolk & Waveney Integrated Care Board's four quality priorities. **[Specific KPIs are as set out in the approved Quality Priorities]**	•We will embed the quality priorities into our governance and reporting structures •We will develop dashboards to monitor progress and outcomes •We will ensure our quality priorities align with the N&W Quality priorities over a three year term.	•Delivery of the Board approved Quality Priorities and associated KPIs which include the following areas [See specific targets in Quality Priorities 2024-27]. - *Year-on-year reduction in complaints referring to poor communication through the implementation of the Patient Incident Response Framework (PSIRF), QSAFE and learning from incidents (April 2026)* - *Avoiding unavoidable harm to patients including ; B% reduction in falls, 5% reduction in Pressure Ulcers; 10% reduction in medication incidents; 10% reduction in Sepsis year on year; 75% of clinical areas assessed for ward accreditation and have achieved and maintained at least good* - *deliver high standards of care and access to services for our Older Peoples Medicine including through establishing an Older Peoples Medicine Multi disciplinary team; Develop and enhance OPM pathways with bespoke services that avoid admission; demonstrable reduction in LOS and reduction in admission of those over 65/80* - We will establish with our partners a working group to look at hospital avoidance and the development of services required and commence piloting these approaches.	We have made progress across all our Quality Priorities as set out in the 2024-27 Quality Priority Plan. . We have started to embed the Action after Reviews (AAR) and the roll out of our Patient Safety Training L1 and L2 syllabus. Work is underway in the development of the dashboards to clearly show progress in each of the areas. We have not seen a reduction in Pressure Ulcers and falls so a further review of how this can be remedied within existing budgets is underway. Despite operational demands and a reduced number of clinical support posts, we continue to make progress with Ward accreditation however this is behind plan. Our PALS and complaints team have been, and continue to be, under significant pressure resulting in a delay in establishing our 'expert by experience' forums and connecting with our community and service users. Whilst frailty is a priority, we continue to experience challenges, including through difficulties in medical workforce recruitment. Further work to support this should be forthcoming with the system Ageing Well Strategy and the alignment of capacity across the three hospitals which is likely to be expanded to focus on frailty.	We have made progress across all our Quality Priorities as set out in the 2024-27 Quality Priority Plan. . We have embedded the Action after Reviews (AAR) and the roll out of our Patient Safety Training L1 and L2 syllabus. We have seen a small reduction in Pressure Ulcers and falls following a period of increased incidence with increased in harm. Despite operational demands and a reduced number of clinical support posts, we continue to make progress with Ward accreditation however this is behind plan. Our PALS and complaints team have been, and continue to be, under significant pressure resulting in a delay in establishing our 'expert by experience' forums and connecting with our community and service users, and responses to complaints have exceeded our timescales of 60 days. Whilst frailty is a priority, we continue to experience challenges, including through difficulties in medical workforce recruitment and have not made much progress in this quarter.	• Patient Safety and Experience Group • Clinical Effectiveness Group • Hospital Management Group •Carer and Patient Experience Group (CAPE)	Patient Safety and Quality Committee
		PM		2. We will deliver the Maternity Improvement Plan covering the leadership, culture, safety and governance of the maternity service.**[Specific KPIs are set out in the Maternity Improvement Plan]**	•Continue with oversight and reporting to the Executive Maternity Improvement Group with external input.	- Delivery of the Maternity Delivery Plan to result in an annual reduction of 10% of still births & an annual reduction of 10% Neonatal deaths (both per 1000 live births). - Reduction in smokers at time of delivery to 6%.	We have made progress with our Maternity Improvement Plan (MIP) which is monitored through Executive Maternity Improvement Group which is chaired by the CEO and reports into Patient Safety & Quality Committee monthly. We have been successful in seeing a reduction in smoking at 'time of booking' and at delivery, but this remains above the threshold of 6%. We are now focusing on other key aspects of the MIP, including further development of the team's culture and the embedding peer support involving our local partners from the Norfolk & Waveney system. An assurance group for approval of the evidence and progress made against the MIP is being finalised.	We have made progress with our Maternity Improvement Plan (MIP) which is monitored through Executive Maternity Improvement Group which is chaired by the CEO and reports into Patient Safety & Quality Committee monthly. We have been successful in seeing a reduction in smoking at 'time of booking' and at delivery, but this remains above the threshold of 6%. Further development of the team's culture and the embedding peer support involving our local partners from the Norfolk & Waveney system and peer reviews of the cases seen at MIRE has been developed in conjunction with NNUH. An assurance group for approval of the evidence and progress made against the MIPis in place and CNST submission has completed its assurance review	• Executive Maternity Improvement Board • Hospital Management Group •Divisional Governance	Patient Safety and Quality Committee
		JB		3. We will develop robust data and reporting and oversight mechanisms to identify groups who are at risk of poor access to healthcare, poor experience of healthcare services or outcomes from it and deliver targeted actions to reduce health inequalities.	•We will develop a suite of metrics and regular reports to highlight areas of focus. •We will embed the areas of focus in the Speciality Development Plans. •We will align our focus on health inequalities with the N&W ICB Health Inequalities Strategy	• By March 2025, 100% of current QI projects to be reviewed to understand impact on Health Inequalities and a mechanism to ensure HI is a key factor in establishing a QI project going forward; •All clinical specialities to submit their opportunities to reduce HI in their areas via the Service Development Planning process, and where appropriate, these will be incorporated into the Trust HI Programme by March 2025; • By March 2025 Health Inequalities datasets are complete including improved data collection on ethnicity, postcode, deprivation index and any associated links to length of stay and DNA's for all patients; • 90% of adult patients provided with the opportunity to access healthcare communications digitally, to further support digital inclusion and equip patients with relevant information to participate in decisions about their care by March 2025.	The QI lead and HI leads are in the process of agreeing a plan to ensure all current projects are reviewed to understand HI impact, and also to develop a way of ensuring this is understood for any future projects at the point of their development. Strategic Specialty Development Plans (SSDPs) will be developed by the Specialty Clinical Networks and there is a section for clinical leads to outline current and future projects to improve health inequalities. Dataset and Reporting workstream is in place to ensure regular reports and areas of focus are identified - these reports will be developed by end of Q2. JPUH has representation at the Health Inequalities Oversight Group and the Anchor Institution monthly meetings to support alignment of plans with ICB and Place Partners. Patient Engagement Portal (PEP) roll-out plan has been agreed and full implementation for agreed specialties will take place by March 2025, therefore all patients within this cohort will be offered opportunities to access healthcare communications digitally.	HI elements of any QI project are now embedded with any new project and ongoing support from both teams is available to JPUH QI project leads. SSDP process is drawing to a conclusion and specialties are including their developments relating to HI and improving access across all patient groups. Reporting datasets are now being shared on a monthly basis to HMG, with specific focus on CORE20PLUS5 areas (Respiratory, Cancer and Maternity) and this has demonstrated the high level of patients who sit in the highest decile of deprivation. These reports have supported services agree projects which will support the complex needs of our population. AD of Strategy and Transformation represents JPUH at Anchor Institution and HI Oversight meetings, to ensure joined up working is taking place to support the population across System and Place partners. PEP roll-out plan will be achieved in Q4 as planned.	• Hospital Management Group • Place Board	Patient Safety and Quality Committee
		CD		4. We will improve the booking of outpatient appointments by implementing the Patient Engagement Portal which will provide improved booking services for patients and reduce the number of patients failing to attend.	•We will include robust patient feedback mechanism in the deployment of the Patient Engagement Portal (PEP) •We will demonstrate a reduction in the waiting lists for outpatient appointments, reduction in DNAs and financial savings	• Digital Patient Letters - 90% of specialities will be sending patients appointment letters digitally by January 2025 • Digital Text Notification - 70% of all in-scope patients will be contacted by text informing them an appointment letter is accessible digitally for in-scope specialities by January 2025 [*target to have active mobile number for 70% of patients is stretching*]. • Digital Access of the patients that have access to digital appointment letters - 65% of patients will actually log on to retrieve their letters • Appointment Reminders - 70% of all in-scope patients will receive two appointment reminders. 7 and 3 days prior to the appointment date. • DNA Reduction - Significant reduction in 'Did Not Attend' across all in-scope specialities by Jan 2025 [% reduction to be calculated for each speciality as they go live] • Cost Reduction - £50,000 cost saving to be achieved through the use of digital letters by January 2025.	PEP rollout has been delayed due to technical issues with the print server interface. As of the end of August 2024, these issues have been resolved and a specialty rollout plan agreed with the clinical divisions. Demonstration of PEP has been undertaken to the booking teams Caldicott sign off has taken place of the proposed structure of texts Additional funding request for PIFU functionality in the system - bid submitted and awaiting feedback	PEP has now been successfully rolled out across most specialties and is ahead of plan. Additional PIFU funding was not secured but continued monitoring and support for PIFU continues via the Divisional Performance meetings. Phase 2 delivery plan being worked up to continue to optimise PEP functionality	• Outpatients Programme Board •Hospital Management Group	Patient Safety and Quality Committee

EXEC LEAD - DIRECTOR OF PEOPLE AND CULTURE										
Priority 2	**Ambitions 2023-2028 (our vision)**	**Exec Lead**	**BRAG status**	**2024-25 Objectives**	**How will we achieve these?**	**KPIs**	**Q1/Q2 update**	**Q3 update**	**Who is doing the work? (a management group)**	**How is the Board Scrutiny being done? (on behalf of the Board)**
Supporting Our People	1. Promote an inclusive, fair and safe workplace	SG		1. We will implement our new Trust Values and Behaviours Framework.	•We will deliver the Staff Experience Plan •We will implement Kindness and Respect Toolkit; •We will embed into recruitment and appraisal processes; align managers' induction and leadership programmes.	• Improvement in Staff Survey Staff Engagement and Morale scores, in line or better than the acute /acute and community Trust average (baseline: 6.78 and 5.75 respectively; target 6.91 and 5.91 respectively)	Paget CARES, our new Values and Behaviours Framework approved and launched. - Kindness and Respect Toolkit developed. - New appraisal form introduced. - Review of managers induction and leadership programmes commenced. - Regular updates provided to People and Culture Committee.	Managers' induction and leadership development content reviewed. 2024 Staff Awards aligned to new Trust Values. Work progressing on sexual safety, led through a working group. Leadership Summits and Grand Round held. National framework reviewed and being adapted for local implementation. Regular updates provided to People and Culture Committee	• People and Culture Group • Hospital Management Group	People and Culture Committee
	2. Develop compassionate and effective leadership	SG		2. We will implement our Freedom to Speak up Service .	•We will commission an external independent provider and monitor outcomes and impact of the service.	• Staff will report feeling more confident in raising concerns and that their concerns will be taken seriously, with Staff Survey scores for We Have Voice in line or better than the acute/acute & community Trust average (baseline 6.51; target 6.7)	New Freedom to Speak Up Service launched and is being well used. Regular update reports being provided to People and Culture Committee. Twice yearly reports to be provided to the Board, with the first due in November.	New Guardian Service continues to be well used with positive feedback from staff who use it. Regular reports provided to People and Culture Committee and first six monthly report provided to Board in November. Learning review from first six months underway.	• People and Culture Group • Hospital Management Group	People and Culture Committee
	3. Attract, engage, develop and deploy our staff to deliver the best care for our patients	SG		3. We will continue to embed the Just & Learning Culture.	•We will deliver through the Staff Experience Plan •We will embed into recruitment and appraisal processes; align managers' induction and leadership programmes.	• Staff feel that concerns and issues are managed fairly and learning is embedded (measured through relevant Staff Survey We Are Compassionate and Inclusive and We Are Always Learning) (baseline 7.07 and 5.43 respectively; targets 7.24 and 5.61 respectively based on acute averages)	New Just and Learning Workplace Policy being embedded. Ongoing manager training and coaching. Learning Reviews introduced. Employee Relations deep dive reported to the People and Culture Steering Group in May 2024 evidenced impact over the last year: 23.5% reduction in number of formal cases; no suspensions from September 2023; 83% reduction in 'no formal action' outcomes.	Just and Learning Workplace Policy being reviewed to incorporate early learning following implementation. Number of formal cases have unfortunately increased significantly in the last quarter. Manager capacity and skills to prevent grievance issues escalating and capacity pressures within the Human Resources team are impacting.	• People and Culture Group • Hospital Management Group	People and Culture Committee
	4. Promote wellbeing opportunities to keep our staff healthy and well	SG		4. We will review our occupational health provision including our psychological support offer to ensure it meets the needs of our staff	•We will review contracts and service specifications, evaluate impact of interim psychological support services and procure a new service.	• Reduction in sickness absence, in line with Trust targets (baseline 5.7%; target 4.5%) • Improvement in Staff Survey Wellbeing scores for Safe and Healthy (baseline 5.84; target 6.06)	Agreement across NHS system partners to collaborate on Occupational Heath services through shared service or joint procurement. Standardised service specification being developed. Sickness absence performance has deteriorated, now at 6%, largely impacted by long term sickness. Project to be undertaken focused on staff groups with highest rates of absence.	System workshop held on shared service model for Occupational Health and headline specification developed and being costed.	• People and Culture Group • Hospital Management Group	People and Culture Committee

				EXEC LEADS - DEPUTY CHIEF EXECUTIVE / CHIEF MEDICAL OFFICER							
Priority 3	**Ambitions 2023-2028 (our vision)**	**Exec Lead**	**BRAG status**	**2024-25 Objectives**	**How will we achieve these?**	**KPIs**	**Q1/Q2 update**	**Q3 update**	**Who is doing the work? (a management group)**	**How is the Board Scrutiny being done? (on behalf of the Board)**
Collaborating With Our Partners	1. Collaborate to achieve seamless patient pathways both at place and system level 2. Embrace our role as an anchor institution, working together for the best outcomes	JB		1. We will collaborate with acute hospital partners to deliver the Joint Acute Clinical Strategy (supporting EPR & NHP)	•Speciality triumvirates will work across NNUH and QEH to establish Speciality Clinical Networks. •Focus will be on the development and completion of collaborative service development plans, which will include detail on the reconfiguration of services as per the Acute Clinical Strategy (and Macro Model of Care) supporting the EPR and NHP activities.	• Macro Models of Care Completed and signed off by Trust Boards by September 2024 • Delivery of the Acute Clinical Strategy - each priority 1 speciality (21 in total) will have a signed off 'collaborative strategic service development plan' (collaborative SDP which will inform speciality planning in each hospital for 25/26) by March 2025.	We continue to work with our 21 phase 1 specialties to ensure completion of Modules 1 and 2 of our toolkit by the end of September. We will then launch Module 3 at a planned "Divisional Leadership Summit" (DLT) on the 3rd October and this will initiate work on the Strategic Service Development Plans (SSDPs), in line with our March 25 deadline for completion. DLT will also include an update on the Macro Model of Care development. The paper will go to Trust Boards in September. A significant programme of work 'Macro Models of Care' has been completed and is being presented to the Boards of the 3 Trusts for next steps and resourcing to be agreed.	Speciality Clinical Network (SCN) Development: Work has progressed across all of our Phase 1 specialties, with module 3 nearing completion, resulting in Strategic Service Development Plans (SSDPs) for each specialty. Clinical networks are now in the process of sharing these plans with divisional leadership teams in readiness for a series of divisionally led "Check and Challenge" sessions at the end of January / early February. The "Check and Challenge" sessions bring together a broad range of stakeholders with vested interests in ensuring the plans reflect key strategic goals over the next 5 years. The panel therefore encompasses divisional triumvirates, HR and Finance leads and key members of the EPR and New Hospital programmes. A final Executive Panel will take place in late February and will provide the final sign off for all plans. Macro Model Of Care: To progress this work at pace, funding has been allocated for clinical leads in three specialties: Oncology, Maternity, and Stroke. The selection process for Maternity and Oncology will seek expressions of interest, while Stroke funding is pending further ICB discussions. Progress updates include: - Maternity: A letter of intent has been sent; a workshop is being planned with meetings starting January 2025. - Oncology: A workshop has produced a draft hub-and-spoke model and workforce plan, set to be piloted next year. - Stroke: To support New Hospital business case development, the initial focus of the acute workstream will be on developing a case for change and proposed ambition for acute stroke for Norfolk and Waveney. A recommendation will be put through acute governance end March/early April 2025. Connected Leaders: To further support the Macro Model of Care work, teams from Maternity, Oncology and ED/AMU SCNs will be attending the course from February onwards.	• Acute Clinical Strategy Oversight Group	• Trust Board • Committees in Common • [Integrated Care Board]
	3. Be an effective partner to achieve both our ambitions and our partner's ambitions	JB		2. We will deliver an agreed programme of work at the Great Yarmouth & Waveney Place Board, focusing on local priorities and aligning to the Integrated Care Partnership priorities.	•In Q1 we will refresh the work of the GY&W Place Board to ensure work is undertaken to support shared priorities as identified in the agreed robust KPIs. This will align with delivery plans of the two Health and Wellbeing Partnerships. •We will work with the ICB to ensure appropriate arrangement are put in place responding to the review of community services. •We will deliver an agreed roadmap to find innovative solutions to support primary care.	• Robust plans in place for each of the workstreams and highlight reporting to HMG commenced August 2024 • Completed and signed MoU between JPUH and ECCH by August 2024 and delivery of agreed workstreams (including Carlton Court) delivered to plan. • Comprehensive roadmap agreed between JPUH, primary care partners and the ICB to support and enhance primary sustainability by September 2024 and delivered to plan for 24/25.	N&W ICB has been through a significant organisational restructure which included commitment to a review of the role and function of the Place Boards in N&W, plus enhancing the Place Board reporting and governance arrangements. This work is still to be completed. Furthermore a new Place Director role has been identified in the restructure and the new post holder started in post in the near future. In the meantime, the GY&W Place Board continues to act as a conduit for local collaboration and has captured the activity of the board via a new monthly communication briefing for partners. JPUH has supported the ICB with the review of community services both at a Trust and a Place level, this is now the responsibility of the ICB to make a decision on the future delivery of community services. Further work is ongoing to cement the relationships to drive the future configuration of services jointly. N&W ICB (through the Health and Wellbeing Board) has agreed a Primary Care framework, which will help to inform local partners on the opportunity for collaboration and supporting sector sustainability	The GY&W Place Board continues to progress the key workstreams that have been agreed across our Place partners, those being •Prioritising Prevention and Reducing Health Inequalities •Urgent and Emergency Care (UEC)Transformation and Resilience •PCN Development & Primary Care resilience •System integration & place led transformation We await the appointment of a Place Director from the ICB, and greater clarity of responsibilities of Place from the N&W Health & Wellbeing Board and the ICB. A Senior Manager of Place Development has been recruited to and will cover both East and West Place with a view to sharing best practice and consistency across both areas. Place Board has made good progress through the engagement of public health to set out the health inequalities of the local population. This is supporting the workstreams in gaining collaborative traction to address the key challenges faced by our local population in GY&W. The Place Board is now being used as a board to support the development of the new hospital, and the new care models that need to be developed to support this key infrastructure. This work is ongoing and is bringing further partners to the Board including those that will enable improved pathways for palliative care.	• Hospital Management Group • Place Board	• Great Yarmouth & Waveney Place Board •Finance & performance Committee •Trust Board
		VC		3. We will work with acute partners to progress the implementation of an Electronic Patient Record	We will be an active partner in the EPR programme Board and deliver requirements set out in the implementation plan	Completion of Pre-implementation phase planning activities including (not limited to, as majority of implementation phase activities continue into 25/26) • Refresh and implementation of refreshed EPR Programme governance • Approval of guiding principles for EPR implementation • Current state process mapping (aiming for completion by Aug 2024) • Recruitment into EPR implementation roles • Commencement of future state process design and Design/Build/Test processes for EPR modules (to start in September 2024 and continuing into 25/26)) • Approval of EPR Clinical risk management Strategy	Guiding principles proposed by the CXIO leadership team and approved by Programme Steering Group. All workshops for Phase 2 of process mapping completed at end of August. Validation and sign-off by senior leadership of all process maps completed will continue into early September. Recruitment process of additional roles required for Implementation phase commenced. 80+ roles to be recruited and on-boarded by start October to support planned programme activity due to commence when Design/Build/Test commences. Work on future state process design has commenced with the Workflow Optimisation consultancy work led by the PWC team 09.09.2024. Focus of their input will be ED, Inpatients & Outpatient processes. Collaborative EPR Clinical risk management strategy being established. Working draft currently going through process of consideration towards final ratification and sign off.	• Pre-implementation phase activities completed, implementation phase commenced November 2024. • Guiding principles for implementation phase agreed. • Current state mapping completed. • Recruitment into implementation roles commenced. • Future state process design and Design/Build/Test work commenced.	•3 Trust Collaborative Programme Team	•3 Trust Boards, •Regional and National Approval from NHSE.

EXEC LEADS - CHIEF FINANCE OFFICER / CHIEF OPERATING OFFICER / DIRECTOR OF STRATEGIC PROJECTS / DEPUTY CHIEF EXECUTIVE

Priority 4	Ambitions 2023-2028 (our vision)	Exec Lead	BRAG status	2024-25 Objectives	How will we achieve these?	KPIs	Q1/Q2 update	Q3 update	Who is doing the work? (a management group)	How is the Board Scrutiny being done? (on behalf of the Board)
Enhancing Our Performance	1. Make the best use of our physical and financial resources	ET		1. We will develop and commence delivery of a robust Financial Improvement Plan with a focus on productivity and efficiency	•Ensure financial controls are adequate and effective through working with NHSE to review selected areas of focus, and moving to Future Focused Finance level 2 accreditation. •Deliver productivity improvements through a combination of increasing activity within existing resources and reducing indirect costs and overheads. •Reduce underlying financial deficit through delivery of the second year of Financial Improvement Plan	• Achievement of level 2 FFF accreditation • £13.4m deficit achieved as per 24/25 financial plan • Exit 2024/25 with £24.0m underlying deficit as per Financial Improvement Plan • £22.4m efficiency programme delivered as per 24/25 financial plan	• Gap analysis against FFF level 2 requirements is in progress, including obtaining local support from FFF assessors and other Trusts. Independent assessment from Deloitte on behalf of the ICB continues and will be reported early in Q3. • As at month 5 the Trust is off plan for 2024/25 and hence an in-year financial recovery is required to achieve the Trust's financial targets. • The Trust's continues to work on improving its underlying financial deficit, working towards the £24.0m target for 31 March 2025. • As of month 5 the Trust is falling short of the profiled efficiency target and is also forecasting a risk to achieving the £22.4m total for the year. This is being escalated through efficiency delivery group, Divisional Performance meetings and DCIP meetings.	Independent assessment from Deloitte on the Trust's financial governance has concluded and an action plan is to be approved in February. Timescale for FFF level 2 accreditation has slipped into new year 2025/26. • Even with the support of in-year financial recovery, as at month 9 the Trust is off plan for 2024/25 by £5.1m with a risk assessed forecast outturn of £8.1m adverse variance to plan. • The Trust continues to work on improving its underlying financial deficit, working towards the £24.0m target for 31 March 2025. As at month 9 the underlying deficit is £32.0m. • As of month 9 the Trust is falling short of the profiled efficiency target by £1.5m, and is also forecasting to achieve £19.9m of the £22.4m target for the year. This is being escalated through efficiency delivery group, Divisional Performance meetings and DCIP meetings.	• Financial Recovery Group • Hospital Management Group	•Finance and Performance Committee
	2.Lead the way towards achieving Net Zero Carbon	CD		2. We will deliver the operational targets as outlined in the NHSE planning guidance for Elective, Cancer and Urgent and Emergency Care, through the UEC, RTT , Cancer and Outpatient improvement plans	•We will have robust operational improvement plans in place for UEC, RTT, Cancer, outpatients and theatres. •We will deliver on opening additional capacity through the DAC, CDC and Elective Theatre Hub this financial year. •We will focus on productivity opportunities to release capacity and deliver additional activity using model health data to benchmark. • We will adopt further faster workbooks consistently across specialities.	• 78% of patients seen in ED within 4 hours • 52% of all appointments are 'first appointments' (exceeding the national target of 46%) • Deliver the cancer and diagnostic targets as set out in the National Operational Plan • To achieve nil patients waiting in excess of 78 weeks by the end of June 2024 • To achieve nil patients waiting in excess of 65 weeks by the end of September 2024 • To achieve ambulance handover within 15 minutes with no patients waiting more than 30 minutes • Reduction in overall average length of stay by between 0.5-1.0 days	ED performance remains challenged and we have recently engaged with the NHS England Rapid Improvement Offer to support an improvement trajectory for ED UEC Capital funding secured to expand SDEC Ambulance handover times also remaining challenging Analysis reported to F&P indicates front door performance is largely attributable to longer LOS therefore programmes in place through the UEC Programme Board to address led by the Chief Medical Officer 78 week position largely achieved Target to have nil 65 week waiters by the end of September at risk due to a number of factors. Reported to F&P monthly and to NHSE fortnightly	ED performance remains challenged and we have completed the NHS England Rapid Improvement Offer to support an improvement trajectory for ED Ambulance handover improvement trajectory agreed by HMG UEC Capital funding secured to expand SDEC - project due to commence in January 2025 LOS therefore programmes in place through the UEC Programme Board to address led by the Chief Medical Officer 78 week position largely achieved Target to have nil 65 week waiters by the end of December was not achieved and continues to be at risk. Reported to F&P monthly and to NHSE fortnightly	• UEC Programme Board • Outpatients Programme Board • Trust Access Group • Hospital Management Group	•Finance and Performance Committee
	3. Future-proof our services for the people we serve	JB		3. We will embed the improvement approach, focussing on continuous improvement and empowerment of staff to deliver meaningful, lasting and sustainable change into service delivery	• We will provide training for staff in line with agreed improvement approach •We will continue to use a programme of 'scrums' across the trust • We will develop feedback mechanisms and 'you said we did' communication channels for staff	•Improvement approach adopted and embedded, including toolkits to support QI for staff by August 2024 •'Always Learning' scores in People Promise above national average	To date we have delivered training to staff members: Introduction to QI - 48 QSIR Fundamentals – 24 QSIR Practitioner – 16 These are now referred to as Safety Huddles – the Nursing and Quality Team are leading a project to embed across the Trust (awaiting update on figures) As part of the Operation Lightbulb communications plan, staff members are kept informed of activity around the idea they submitted. Completed ideas are periodically shared on CEO Brief. The Improvement provides a framework to drive continuous improvement across the trust. As part of the Trust Strategy, Building a Healthier Future Together 2023-28, our Director of People and Culture is encouraging trust leaders to incorporate QI objectives in staff appraisals. A QI Toolkit is available on the QI intranet site and training in the use of QI tools is part of the QSIR training package	Building QI Capability and Capacity: To date we have delivered training to staff members: Introduction to QI - 99 QSIR Fundamentals – 73 QSIR Practitioner – 25 QI now has an introductory slide set on the Trust Induction Day signposting new staff how to find QI support and training. Operation Lightbulb continues to be promoted on CEO brief and the Your Voice forum. To date 63 ideas have been suggested. WardBoard meetings are being led through the UEC Programme to promote flow and reduce LOS Work underway with the Comms, New Hospital and Patient Experience teams to include the patient voice in to projects (experts with lived experience) - Through Co-production/Co-design more meaningful and sustainable change can be achieved. In recent months staff engagement has been challenging due to operational pressures.	• Hospital Management Group	Finance and Performance Committee
	4. Improve services through digital transformation, research and new models of care	MF		4. We will deliver the Trust's Digital Strategy to transform our services	• We will have an agreed programme of work and focus on delivery of the plan to improve our digital maturity.	• Completion of Digital Programme by March 2025 • Review and consider refresh of Digital Strategy for JPUH for the period 2025-2028 aligning with Acute and system partners by March 2025 Mark - can we add this? •Digital maturity assessment improves by X% Discussed at Exec Team 23.04.2024 - a DMA improvement % until EPR is delivered is not likely to be possible.	• Digital Programme progress report received at DTG on 10 July 2024, demonstrating progress being made on Digital Strategy deliverables. • Digital Strategy refresh options considered at DTG in July 2024 and being discussed with Norfolk Acute partners to attempt to align Digital Strategies. • JPUH Digital Maturity Assessment submitted to national team for review in July 2024 following review at DTG and FPC, awaiting final outcome. • Cyber Essentials secured on 12 July 2024. Work is now focussed on achieving Cyber Essentials Plus.	• Digital Programme progress report received at DTG on 28 November 2024, demonstrating progress being made on Digital Strategy deliverables, with some delays due to team resourcing constraints. • Digital Strategy refresh approach agreed with Norfolk Acute partners to align Digital Strategies from April 2025 onwards to support EPR and New Hospital requirements in N&W. • JPUH Digital Maturity Assessment initial results report received at DTG on 28 November 2024 showing JPUH Trust score of 2.5 out of 5 compared to a national average NHS score of 2.4 out of 5 overall. • Cyber Essentials secured on 12 July 2024. Work is now focussed on achieving Cyber Essentials Plus.	• Digital Transformation Group • Hospital Management Group	Finance and Performance Committee
		MF		5. We will develop the business case for our new hospital build, meeting national timescale requirements	• We will continue to respond to NHP requests and redraft the Strategic Outline case • We will develop the Outline Business case in line with national templates and timeframes. • We will take an active part on the system wide NHP programme sharing learning and expertise with QEH and regional trusts within the NHP.	• Submit a second version of the Strategic Outline case to NHP by September 2024, which meets the expectations of the central NHP team in relation to number of beds, modular design and care pathway innovation • Get excellent feedback from key N&W stakeholders on the system-wide NHP programme, sharing learning and expertise with QEH and regional trusts within the NHP by March 2025. • We will take an active part on the system wide NHP programme sharing learning and expertise with QEH and regional trusts within the NHP by March 2025.	• Submission of the second version of the Strategic Outline (SOC) is proving difficult as NHP have still not engaged on the JPUH hospital sizing, however this is still targeted for completion by end of October 2024. • The NHP CSU Demand and Capacity model report was completed in August 2024 and confirmed the number of beds is in alignment with the previous SOC and current Trust modelling. • JPUH engaged in two SOC Clinics with NHP at which the second SOC options were confirmed and a series of Multi Disciplinary Check-In (MDCI) meetings to support SOC delivery have been arranged. • JPUH FPP team will define the baseline hospital area to allow SOC costings w/c 9 September 2024. HMG / Execs can then consider further "Left Shift" and account will also be taken for the Macro Model of Care and ASR. • Engagement and feedback continues with key N&W stakeholders on the system-wide NHP programme, sharing learning and expertise with QEHKL, other RAAC hospitals, and regional trusts within the NHP by March 2025. • We continue to take an active part in the system wide NHP programme sharing learning and expertise with QEHKL and other trusts within the NHP by March 2025.	• The NHP CSU Demand and Capacity model report was completed in August 2024 and confirmed the number of beds is in alignment with the previous SOC and current Trust modelling and was used to underpin the second SOC key assumptions. • The second version of the Strategic Outline (SOC) was approved by the N&W ICB and JPUH Board of Directors in November 2024. It was subsequently submitted to the National NHP team for review in December 2025. • JPUH have commissioned B&B and PSC to support models of care work to move from mitigator assumptions as set out in the second SOC into clearer plans with our system partners. • Engagement and feedback continues with key N&W stakeholders on the system-wide NHP programme, sharing learning and expertise with QEHKL, other RAAC hospitals, and regional trusts within the NHP by March 2025. • We continue to take an active part in the system wide NHP programme sharing learning and expertise with QEHKL and other trusts within the NHP by March 2025. • Focus in now on planning for OBC and securing related required resources to commence OBC during 2025.	• Future Paget Programme Board • Hospital Management Group	Finance and Performance Committee
		MF		6. We will deliver the key agreed milestones regarding RAAC mitigation works as part of the agreed Trust Estate Strategy.	• We will have an agreed programme of work and focus on delivery of the plan taking into account operational impact.	• Completion of RAAC works plan agreed with NHS England to the value of £7.202m by March 2025	• WSP Structural Engineers have commenced their year 4 survey report, to include all RAAC areas. • Work to install timber end bearing extensions has continued within kitchens, HSDU and Pain Clinic. To date a total of 8,220 plank ends (49.5% of RAAC roof area) have been fitted with end bearing extensions. • Remedial works within the main kitchens has further progressed. Construction of a scaffold deck within courtyard 12 to accommodate storage of kitchen paniers has released the whole kitchen area for RAAC works. A revised programme completion date of 22nd November 24 for 'go live' of the main kitchen is now in place. RAAC works will then be paused, allowing catering operations to transition into the new kitchen along with preparation of a detailed plan for installing RAAC supports to the adjacent café and servery area. • 36 failsafe supports were fitted within this reporting period (June & July 2024) within the main Kitchen (25) and Pain Clinic (11), of these 10 are from WSP's list of planks with major cracking, the remainder are precautionary supports. • RAAC mitigation work within HSDU has continued (Phase 1) with the installation of RAAC supports and preparations for new air handling plant, ductwork and fit out. The tight working area has presented a number of logistical challenges as stores, deliveries, waste and HSDU services have to remain operational during the construction works. This has caused some delays together with the need for additional enabling works. The planned completion date for all works within HSDU is January 25.	• WSP Structural Engineers continue to undertake their year 4 survey of all RAAC planks within the Trust, circa 85% of areas have been inspected to date. • Work to install timber end bearing extensions has continued within Ward 10, EAPU and Kitchens. To date a total of 8,921 plank ends (53.7% of RAAC roof area) have been fitted with end bearing extensions. • Major RAAC mitigation work continues within, main kitchens, HSDU and Ward 10. In addition the contractor's night works team has undertaken mitigation works within the Marks & Spencer shop. Ward 10 works were completed at the end of November allowing a successful ward move to take place from the Concept Ward back to Ward 10, additionally Ward 22 moved in to the Concept Ward and Ward 7 has been vacated to make way as a future RAAC decant ward. • A draft copy of the 2025/26 Business Case for RAAC mitigation work (see Appendix 3) has been submitted to the NHSE regional RAAC team for comment. Once feedback is received and considered a final version will be submitted to the NHSE national RAAC team for approval. The aim is for an MOU to be issued before April 2025 allowing ongoing RAAC works to progress uninterrupted, as planned. • Regular meetings have taken place with NHSE to ensure there is a consistent approach to both reporting and risk mitigation across NHS England Regionally and Nationally for RAAC Hospitals.	Estates & Facilities Programme Delivery Group • Multi-Disciplinary RAAC Group •Hospital Management Group	Finance and Performance Committee
		MF		7. We will deliver the Trust's Green Plan	• We will have an agreed programme of work and focus on delivery of the plan engaging wider staff groups as needed	• Completion of agreed Green Plan actions by March 2025	• The Trust has employed a sustainability manager to oversee the implementation of actions as identified within the Green Plan. • The CDC practical completion and subsequent hand over to the Trust to achieve BREEAM 'Excellent' standard and adopting Modern Methods of Construction whilst being constructed. Net Zero Building standards introduced as Part of all new construction projects. • The Estates and Facilities team continue to work on digitalisation of the department to reduce its requirement of paper resources.	• The Trust has employed a sustainability manager to oversee the implementation of actions as identified within the Green Plan. • The OEH completion in January 2025 and subsequent hand over to the Trust to achieve BREEAM 'Excellent' standard and adopting Modern Methods of Construction whilst being constructed. Net Zero Building standards introduced as Part of all new construction projects. • The Estates and Facilities team continue to work on digitalisation of the department to reduce its requirement of paper resources, with the first pilot of digital menus taking place in late January 2025.	• Estates & Facilities Programme Delivery Group •Hospital Management Group	Finance and Performance Committee