NHS
West Suffolk
NHS Foundation Trust

Board of Directors (In Public)

Schedule	Friday 25 March 2022, 9:15 AM — 12:30 PM GMT
Venue	via MS Teams - see outlook invite
Description	A meeting of the Board of Directors will take place on Friday, 25 March 2022 at 9:15am.
Organiser	Ruth Williamson

Agenda

9:15 AM AGENDA

_WSFT Public Board Agenda - 25 March 2022.docx

1. GENERAL BUSINESS

1.1. Apologies for absence:
To Note - Presented by Jude Chin

1.2. Declaration of interests for items on the agenda
To Assure - Presented by Jude Chin

1.3. Minutes of the previous meeting - 28 January 2022
To Approve - Presented by Jude Chin

Item 1.3 - Open Board Minutes 2022 01 28 Jan Draft.docx

1.4. Action log and matters arising
To Review - Presented by Jude Chin

Item 1.4 - Action Points - Active.pdf

Item 1.4 - Action Points - Complete.pdf

9:20 AM 1.5. Staff story
To Note - Presented by Susan Wilkinson

	1.6. Questions from Governors and the Public To Note - Presented by Jude Chin
9:50 AM	1.7. Chief Executive's report To inform - Presented by Craig Black Item 1.7 - CEO Board report - March 2022 FINAL.docx
10:00 AM	2. CULTURE
	2.1. West Suffolk Review - Organisational development plan To Assure - Presented by Jeremy Over Item 2.1 - ODP.docx
	2.2. Report of the West Suffolk Review - Governor/Director working group To Assure - Presented by Richard Davies Item 2.2 - Report of West Suffolk Review Governor Director Working Group - board version.docx Item 2.2a - West Suffolk Review Working Group - Terms of Reference-revised.docx
	3. STRATEGY
10:50 AM	3.1. Future system board report To Assure - Presented by Craig Black Item 3.3 - Future Systems Update.docx
11:00 AM	Comfort Break
11:15 AM	4. ASSURANCE

NHS
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4.1. Insight Committee Report - February & March 2022 - Chair's Key Issues from the meeting

To Assure - Presented by Richard Davies

Item 4.1 - Chair's Key Issues Feb - Insight.docx

Item 4.1 - Chair's Key Issues Mar - Insight.docx

4.2. Finance and Workforce Report

To Note - Presented by Nick Macdonald

Item 4.2 - Finance_Board_Report_front sheet_M11_2122_FINAL.docx

Item 4.2a - Finance Report - M11 2122_Final.docx

4.3. IQPR - January 2022 data

To Note - Presented by Susan Wilkinson and Nicola Cottington

Item 4.3 - IQPR - Jan 22.pdf

11:30 AM

4.4. Improvement Committee Report - January & February 2022 Chair's key issues from the meetings

To Assure - Presented by Jude Chin

Item 4.4 - CKI - Improvement - January 2022.docx

Item 4.4 - CKI Improvement - February 2022.docx

4.5. Quality and Nurse Staffing Report

To Assure - Presented by Susan Wilkinson

Item 4.5 - Quality & Nurse Staffing Report.docx

4.6. Maternity services quality & performance report

To Assure - Presented by Susan Wilkinson and Karen Newbury

Item 4.6 - Maternity Quality Safety Perfomance Board Report.docx

Annexe B - TRUST OPEN BOARD MARCH 2022 Ockenden Progress report 1 year on.docx

Annexe C - Recommendations from Morecambe Bay review 2022.docx

Annexe D - 2021 ATAIN Quarter 3 Oct-Dec 2021 progress report (002).pdf

Annexe E - Audit of the Operational Pathway of Care into Neonatal Transitional Care March 22.docx

Annexe F - Training needs analysis and tracker March 22.pdf

Annexe G - Anaesthetic staffing March 22.docx

Annexe H - HSIB and Early Notification Reporting Q3 22.docx

12:00 PM 4.7. Involvement Committee Report - February 2022 Chair's key issues

To Assure - Presented by Alan Rose

Item 4.7 - CKI - Involvement Committee - Feb 22.docx

4.8. People & OD highlight report

To Assure - Presented by Jeremy Over

Item 4.8 - People OD highlight report March 2022 FINAL.docx

Item 4.8a - Freedom to Speak Up.doc

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5. GOVERNANCE

12:10 PM 5.1. BAF Summary and risk report

To Assure - Presented by Richard Jones

Item 5.1 - BAF Summary and Risk Report.docx

12:15 PM 5.2. Governance report

To inform - Presented by Richard Jones

Item 5.2 - March 2022 Governance Report.docx

12:25 PM 6. OTHER ITEMS

6.1. Any other business
To Note

6.2. Reflections on meeting
For Discussion

6.3. Date of next meeting - 27 May 2022
To Note - Presented by Jude Chin

RESOLUTION
The Trust Board is invited to adopt the following resolution:
“That representatives of the press, and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest” Section 1 (2), Public Bodies (Admission to Meetings) Act 1960

Annexes for Item 4.5 - Quality & Nurse Staffing Report
To inform

- Annexe 1 - IPC.docx
- Annexe 2 - nurse staffing.docx
- Annexe 3 - Quality and Learning report.docx
- Annexe 3a - 2022-23 PSIRF.pdf

AGENDA

WSFT Board of Directors – Public Meeting

Date and Time	Friday, 25 March 2022 9:15 – 12:30
Venue	Via MS Teams – see Outlook invitation

Time	Item	Subject	Lead	Purpose	Format
1.0 GENERAL BUSINESS					
09.15	1.1	Apologies for absence	Chair	Note	Verbal
	1.2	Declarations of Interests	All	Assure	Report
	1.3	Minutes of meeting – 28 January 2022	Chair	Approve	Report
	1.4	Action log and matters arising	All	Review	Report
09:20	1.5	Staff Story	Chief Nurse	Note	Verbal
	1.6	Questions from Governors and the Public	Chair	Note	Verbal
09:50	1.7	CEO Report	CEO	Inform	Report
2.0 CULTURE					
10:00	2.1	West Suffolk Review – Organisational development plan	Director of Workforce	Assure	Report
	2.2	Report of the West Suffolk Review – Governor/Director working group	Senior Independent Director	Assure	Report
3.0 STRATEGY					
10:50	3.3	Future System Board Report	Chief Executive	Assure	Report
11:00 Comfort Break					
4.0 ASSURANCE					
11:15	4.1	**Insight Committee Report** – February & March 2022 – Chair's Key Issues from the meeting	NED Chair	Assure	Report
	4.2	Finance and Workforce Report	Interim Director of Resources	Assure	Report
	4.3	IQPR – January 2022 data	COO/ Chief Nurse	Note	Report
11:30	4.4	**Improvement Committee Report** – January & February 2022 Chair's Key Issues from the meeting	NED Chair	Assure	Report
	4.5	Quality and Nurse Staffing Report	Chief Nurse	Assure	Report
	4.6	Maternity Services Quality & Performance Report	Chief Nurse	Assure	Report
12:00	4.7	**Involvement Committee Report** – February 2022 Chair's Key Issues	NED Chair	Assure	Report

Time	Item	Subject	Lead	Purpose	Format
	4.8	People and OD Highlight report	Director of Workforce	Assure	Report
5.0 GOVERNANCE					
12:10	5.1	BAF Summary and Risk Report	Trust Secretary	Assure	Report
12:15	5.2	Governance Report	Trust Secretary	Inform	Report
6.0 OTHER ITEMS					
12.25	6.1	Any Other Business	All	Note	Verbal
	6.2	Reflections on meeting	All	Discuss	Verbal
	6.3	Date of next meeting **27 May 2022**	Chair	Note	

Resolution

The Trust Board is invited to adopt the following resolution: “that representatives of the press, and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicly on which would be prejudicial to the public interest” Section 1(2) Public Bodies (Admission to Meetings) Act 1960

Appendices

Trust Board Purpose
The general duty of the Board of Directors and of each Director individually, is to act with a view to promoting the success of the Trust so as to maximise the benefits for the members of the Trust as a whole and for the public.

Our Vision and Strategic Objectives			
Vision Deliver the best quality and safest care for our local community			
Ambition	First for Patients	First for Staff	First for the Future
Strategic Objectives	• Collaborate to provide seamless care at the right time and in the right place • Use feedback, learning, research and innovation to improve care and outcomes	• Build a positive, inclusive culture that fosters open and honest communication • Enhance staff wellbeing • Invest in education, training and workforce development	• Make the biggest possible contribution to prevent ill-health, increase wellbeing and reduce health inequalities • Invest in infrastructure, buildings and technology

Our Trust Values	
Fair	We value fairness and treat each other appropriately and justly.
Inclusivity	We are inclusive, appreciating the diversity and unique contribution everyone brings to the organisation.
Respectful	We respect and are kind to one another and patients. We seek to understand each other's perspectives so that we all feel able to express ourselves.
Safe	We put safety first for patients and staff. We seek to learn when things go wrong and create a culture of learning and improvement.
Teamwork	We work and communicate as a team. We support one another, collaborate and drive quality improvements across the Trust and wider local health system.

Our Risk Appetite

Key Elements	None (Avoid Risk)	Low (As little as possible)	Moderate (preference for safe options)	High (willingness to take risk if other benefits)	Significant (willing to take high risks for higher rewards)
Financial / Value for money					
Compliance / Regulatory					
Innovation					
Quality (Patient Safety)					
Quality (Patient Experience)					
Quality (Clinical Effectiveness)					
Infrastructure					
Workforce					
Reputation					
Commercial					

1. GENERAL BUSINESS

1.1. Apologies for absence:

To Note

Presented by Jude Chin

1.2. Declaration of interests for items on the agenda

To Assure

Presented by Jude Chin

1.3. Minutes of the previous meeting - 28 January 2022

To Approve

Presented by Jude Chin

DRAFT

MINUTES OF BOARD OF DIRECTORS MEETING

HELD ON 28 JANUARY 2022
Via Microsoft Teams

COMMITTEE MEMBERS			
		Attendance	**Apologies**
Nicola Cottington	Chief Operating Officer	•	
Craig Black	Interim Chief Executive	•	
Jude Chin	Interim Chair		•
Richard Davies	Non Executive Director (Maternity Safety Champion)	•	
Christopher Lawrence	Non Executive Director	•	
Nick Macdonald	Interim Executive Director of Finance	•	
Paul Molyneux	Interim Executive Medical Director (Maternity Safety Champion)	•	
Jeremy Over	Executive Director of Workforce and Communications	•	
Louisa Pepper	Non Executive Director	•	
Alan Rose	Non Executive Director	•	
Sue Wilkinson	Executive Chief Nurse	•	
In attendance			
Ann Alderton	Interim Trust Secretary		
Helen Davies	Head of Communications		
Georgina Holmes	Trust Office Manager *(minutes)*		
Richard Jones	Trust Secretary		
Clement Mawoyo	Director of Integrated Services		
Daniel Spooner	Deputy Chief Nurse		
Kate Vaughton	Director of Integration and Partnerships		
Governors in attendance (observation only): Allen Drain, Sarah Judge, Amanda Keighley, Ben Lord, Joe Pajak, Jane Skinner, Liz Steele, Clive Wilson			

RESOLUTION

The board agreed to adopt the following resolution:
"That representatives of the press, and other members of the public, be excluded from the meeting having regard to the guidance from the Government regarding public gatherings."

It was noted that this meeting was being streamed live Teams Live to enable the governors and public to observe the meeting.

Action

22/01 GENERAL BUSINESS

01.1 APOLOGIES FOR ABSENCE

Apologies for absence were noted above.

- Alan Rose chaired the meeting in his role as deputy Chair.

01.2 DECLARATION OF INTERESTS FOR ITEMS ON THE AGENDA

No declarations of interest were received.

01.3 MINUTES OF MEETING HELD ON 17 DECEMBER 2021

The minutes of the previous meeting were approved as a true and accurate record.

01.4 MATTERS ARISING ACTION SHEET

The ongoing actions were reviewed and the following updated provided:

Ref 1997; board discussion/workshop required to discuss Trust's priorities and what it would not be able to do. The next strategic workshop was scheduled for 25 February. Clarification was requested as to which workshops were for the board and which included governors.

ACTION: clarify dates for strategic workshops and attendees. **R Jones**

The completed actions were reviewed and no issues were raised.

01.5 APPOINTMENT OF INTERIM CHAIR

- Jude Chin had been appointed as interim Chair until the appointment of a substantive Chair, the process for which had begun.
- The board recognised the contribution that Sheila Childerhouse had made to the Trust and would miss the kind, measured and caring way in which she approached chairing this Trust.

  She had guided the Trust through difficult times and it was sad that she had had to leave in the manner that she had.

Q In the absence of Sheila Childerhouse and Jude Chin. What would happen if the board was required to vote on anything at this meeting as there was an imbalance of NEDs compared to executive directors around the table?

A It was important not to confuse quoracy and being compliant with FT governance arrangements. The board was not Higgs compliant but this would not affect voting, as long as the board was quorate the vote would be valid.

- In addition to the Chair appointment process governors had also started the process of appointing up to three NEDs.

01.6 PATIENT STORY

- The board welcomed Cassia Nice, head of patient experience, who explained that this story, from a female patient, had been through the formal complaint process.
- The patient was unable to wear any sort of face covering due to an incident she had experienced some years ago. She had always worn a lanyard and had not experienced any issues until she attended WSFT for an appointment.
- She explained the events that took place which had resulted in her being extremely distraught and shaken by the whole experience for a number of days.
- As a result of this complaint a discussion had taken place with the member of staff involved and all staff in the department had receiving coaching in managing this type of issue.
- As the rest of the country moved into step down of Covid restrictions, eg wearing masks etc, healthcare organisations were still required to follow the guidance and encourage patients to wear a face covering. This complaint highlighted a need to provide education and support for staff to manage this in a difficult situation.

- Cassia Nice would be working with the communications team on the issue of face coverings and chaperones across the whole organisation.
- It was suggested that trauma informed approaches and trauma informed leadership could be beneficial to everyone in the organisation and that this should be considered as a part of board development.
- It was explained that the work to refresh the Trust's values would provide the foundation to explore this, ie lack of empathy and awareness.
- This had been a difficult story to listen to and accept responsibility for the behaviour of people in the organisation. A way for discharging responsibility was through focussing on values and trying to minimise this type of incident as far as possible.
- The board asked Cassia Nice to thank the patient for this story and also to thank Charlie Firmin for the way he managed this.

ACTION: look at training/support for staff in this type of situation. **J Over**

01.7 CHIEF EXECUTIVE'S REPORT

- The organisation continued to be under considerable pressure over the last two months, particularly due to the increase in Covid cases in the community and the impact it had on the whole health service.
- The changing nature of Covid had impacted differently on the organisation and wider health economy. The most significant factor had been the impact of community based Covid and availability of staff both within and outside the organisation, which had resulted in challenges with staffing, both in the Trust and in primary and social care.
- The Trust needed to be mindful of the impact this had had on staff, as they had been asked to deliver care under circumstances they wouldn't have experienced before; ie lack of staff and having to compromise on the standards they aspired to. This would have an impact both on individuals and the services that the Trust provided as an organisation.
- As well as focussing on recovering waiting lists there was also a need to consider the recovery of individuals.

Q Was Craig Black getting support from colleagues, the ICS and wider system?

A There was a huge amount of support internally and this was also true in the wider sense across networks outside the organisation. Everyone was in a similar situation and providing mutual support to one another.

Q Re the deadline for mandatory vaccinations for staff; to what extent would the Trust be impacted by this and what was its approach to this?

A This was a very real issue for the Trust and would be addressed under agenda item 2.10

- In addition to acknowledging all the hard work of consultants, junior doctors and nurses, the board also recognised and commended the operations team who had worked tirelessly to manage patient flow and beds. This was an example of work that went on behind the scenes and without it the Trust could not have got through these difficult times.
- The board congratulated Kate Foxwell who had been awarded the title of 'Queen's Nurse' in recognition of her commitment to high standards of patient-centred care and continually improving practice.

22/02 FIRST FOR PATIENTS – ASSURANCE

02.1 INSIGHT COMMITTEE REPORT – JANUARY 2022

- The Insight committee was very much a data-driven committee, therefore it needed to make sure that data was complete, reliable and valid.
- Work was currently being undertaken to ensure that the data in the IQPR was relevant and appropriate and development of the new Trust digital dashboard continued.
- Appraisal rates were not improving across the organisation. This had been escalated to the Improvement committee which had been asked to look at this in more detail and how this could be moved forward.
- Issues around waiting times, ie long waits (104 weeks) and two week wait pathways in breast care and dermatology were discussed. A trajectory for improving breast two week wait performance had been presented to the committee and this would continue to be monitored. Dermatology had a new piece of digital technology which was making a significant difference and had been well received by consultants and patients.

Q Although this committee was very much data-driven, it was also expected that committees would discuss issues and there did not appear to have been much discussion in recent months around finances. Was the board sighted on all the financial pressures facing the organisation which would become more challenging?

A This committee did discuss financial issues; it also received a report from the governance group and discussed key issues and concerns. A finance report also went to the board. This meant that there was the opportunity for both the Insight committee and board to look at any issues or concerns around finance.

02.2 FINANCE AND WORKFORCE REPORT

- The Trust continued to break-even and was forecast to break-even at the end of the financial year, due to funding it had received.
- The focus was now on putting together the financial plan for next year.
- Guidance around funding was still not complete, but the latest indication was that the Trust would lose £7-£8m of income which meant a cost improvement programme (CIP)/Sustainability Programme of 2.5% would be required in order to break-even next year.
- The finance team were currently going through this in detail. The ICS was expected to submit a plan that would break-even, as were individual organisations across the ICS. The budget for next year would be presented to the board meeting in March.
- A 2.5% CIP/Sustainability Programme related to the assumption that Covid related costs would be lower, therefore the Trust should be able to deliver some of this relatively easily. However, there was also a plan to continue with some Covid related expenditure, eg staff psychological support service, which would not receive any central funding next year.
- The proposal was for a dashboard so that each division's financial performance could be looked at in greater detail. There would also be a similar format for HR and other metrics.

Q The income and expenditure summary table showed that every division was over spent with the exception of corporate, which had a big surplus. If there was an over spend there was a risk of loss of control; what would happen next year?

A This was a product of the way that the Trust had been funded this year, which meant that some funding had gone into the corporate division, rather than being divided between divisions. The corporate division also held the Trust's reserves which should have been allocated to divisions. This would be rectified through budget setting.

Q As the organisation moved into having to make savings next year, were there any decisions the board would need to make in terms of trade-offs, eg CIP/Sustainability Programme opportunities at corporate level.?

A There were two aspects to next year's budget, ie size of CIP/Sustainability Programme and size of any investments that the Trust would want to put forward. An investment board would be set up to approve investments, some of which should pay for themselves, or deliver CIPs, but some may be mandated.

This would result in a need to prioritise what the organisation could afford and the investment board would need to make this decision; depending on this the CIP/Sustainability Programme could change.

However, there was also a concern about engagement to deliver a sustainable programme. Currently teams were focussing on operational issues and therefore development of a CIP/Sustainability Programme for next year was a risk. If this became an issue it would need to be escalated to the board and decisions may need to be made.

Re allocation of resources from Covid funding etc; it was very important to note that a number of expenditures had underpinned a lot of quality and safety work around patient care and some of this expenditure would need to remain in place. Therefore, there would be a need to be very careful about how to risk assess holistically across all the domains, looking at the broader picture and the impact that this would have on the organisation, patients and staff etc. This would need to be included in any discussions.

Q The CIP/Sustainability Programme was very important as it involved different ways of working with more effective use of resources. With ICSs coming into effect in July the strategic oversight framework would change. How would the interactions with the system impact on the WSFT's CIP/Sustainability Programme etc?

A The Trust would be expected to breakeven but also work collaboratively with ESNEFT and compare opportunities for savings. A benchmarking exercise would be undertaken with ESNEFT.

There would also be a requirement to break-even across the ICS, but organisations were not yet in a position for one to subsidise another. This may result in collaborative working and streamlining of services across sites, particularly corporate services.

- With regard to operational engagement in budget setting, this was challenging as it was agreed a couple of weeks ago to enable the operational teams to focus on operational delivery. However, they wanted to be engaged and it was the executive team's responsibility to facilitate this.

  This would help to refocus people on the importance of good governance around finance, as everyone had been focussing on caring for patients during Covid.

ACTION: ensure operational teams are given the opportunity to engage in budget setting and CIP/Sustainability Programmes. — **N Macdonald/ N Cottington**

02.3 IQPR – NOVEMBER 2021 DATA

- 104 week waits; the forecast was to reduce this to 210 patients by the end of March this year. However due to operational pressures a number of patients' appointments had to be cancelled, including patients who had been waiting over 104 weeks.
- Appointments for these patients had been rescheduled, some through the BMI or ESNEFT, but there would be 246 patients who had been waiting over two years by the end of March. This was a significant issue that the Trust had plans to address going forward.
- The team were working on bringing forward the reopening of elective wards to next week.
- The other key area of concern was two week waits for breast and skin cancer. Breast cancer waits continued to be a difficult issue and performance was not where the organisation would like it to be. A trajectory had been presented to the Insight committee for two weeks waits, which would mean that the Trust was compliant overall for this. However, the exception to this was breast symptomatic two week waits, which would still not be compliant.
- There was also a focus on discharging patients from acute and community settings as soon as possible. There was currently significant national focus on this and a challenging target had been set which the Trust had met. This was a whole system metric; therefore, alliance and system input needed to be recognised when revising the IQPR and dashboard.
- The alliance effort in improving patient flow showed the maturity of partnership working in west Suffolk and the wider care market. It was important to continue to work alongside the care market to support each other in managing system flow overall.

Q Would the IQPR look different for the next board meeting?

A Yes, it was evolving and should start to look different re contractual metrics and SPC charts with appropriate narrative.

- The need for the board to recognise the importance of certain indicators rather than trying to focus on everything was reiterated, eg inpatients not meeting the criteria to reside.

02.4 IMPROVEMENT COMMITTEE REPORT – DECEMBER 2021

- The committee had met again in January, since this report was written, and had discussed the quality issues around the dashboard which Nick Macdonald and Nicola Cottington were leading on.
- PSIRF priorities, eg diabetes were also discussed. A new group had been established with a multi-disciplinary approach and networking with other committees including the deteriorating patient group. This was an issue that affected both community and acute services.
- National safety priorities/infection prevention issues were now incorporated under one umbrella on the risk register, which would take into account the learning from Covid report.
- The Insight committee had referred the issue relating to appraisals to this committee. This was not just about numbers, but also about quality and the buy-in of individuals and the benefits that they perceived from the appraisal system. Therefore, the committee was going to look at an analytical product to focus on and understand the issues around this and come up with some sustainable solutions.

Q When the Improvement committee was assured that improvements had happened, was there a way that this could be shared with the organisation, ie how was the loop closed?

A This was the next step and part of how to evolve and develop. It was important that the outcomes of the 3i committees were embedded, then communications could highlight this as the evidence developed.

ACTION: discuss with executive team when and how to share outcomes of 3i committees with the organisation as a whole. **J Over / H Davies**

02.5 Maternity services quality and performance report

Karen Newbury, Head of Midwifery, joined the meeting for this item.

- The board was reminded that Paul Molyneux and Richard Davies provided additional support in their role as Maternity & Neonatal Safety Champions.
- It was noted that, following a recommendation from the last meeting ,it was hoped to take this report to the Insight committee for greater scrutiny.
- The maternity improvement plan was not moving forward at the rate that Karen Newbury would have liked it to, due to people being required to do more clinical work over the last two months, which had hindered work on this. The maternity improvement board continued to monitor this.
- The safety champion walkabouts continued and details of these and discussions that took place were provided in the report.
- The Local Maternity and Neonate System (LMNS) had raised a concern with the safety champion that parents should not be treated as visitors. WSFT was an outlier as it was the only Trust which charged parents for parking.
- Continuing to listen to staff was an ongoing focus and the freedom to speak up guardians held drop-in sessions for members of the team. In depth exit interviews were also being undertaken by the HR team.
- The report had been published on the external thematic review of three intrapartum still births that occurred a year ago. As a result, an action plan had been produced and would be shared at the closed board meeting.

Q Richard Davies referred to car parking charges for parents and the fact that WSFT was an outlier. Could this be discussed, and if it was decided that WSFT was going to continue to charge parents the reason for this understood, ie why WSFT was an outlier? Parents were carers not visitors.

A It was agreed that the executive team would discuss this and bring a solution to the next meeting.

ACTION: agree solution to parents being charged for car parking. **S Wilkinson**

Q Re elective caesarean rates; the narrative said that trends had been reviewed and there was an expected variance in conjunction with patient choice, however the trend chart showed a special cause variant. What had changed about patient choice to make this happen? Was the Trust benchmarking against other organisations and were the reasons for this understood?

A Karen Newbury did not know the reasons for this. However, as it became possible to look at pregnant women in more detail, more issues were identified, ie the more you

look, the more you find, therefore more people elected for a caesarean. This was about patient choice, as long as they were able to make an informed decision.

- Nationally, the production of an Ockendon 2 report was anticipated in the near future. It was expected that boards would be asked to revisit actions in response to both the Morecombe Bay and Kirkup reports. This would entail a lot of further work and assurance which the board would need to be sighted and assured on. This would put the maternity team under significant pressure to produce the information. The board would support Karen Newbury and her teams as much as possible.

ACTION: share Ockendon 2 report with board before next meeting. **S Wilkinson**

- Maternity staffing felt very different and people were feeling more positive and that the Trust was a good place to be.
- The requirement for mandatory vaccinations was causing some unrest, as a considerable percentage of staff were not vaccinated, ie approximately 10%; 18 staff across the whole of maternity, 11 of whom were midwives. One to one conversations were taking place with each of these members of staff.

Q Were there redeployment opportunities for these people?

A No; Karen Newbury had tried to think outside the box but this organisation and everyone else was in the same position, therefore there would not be any redeployment.

- Maternity care across the whole NHS was in particular experiencing issues with mandatory vaccinations. In general, the population of young, child-bearing women and pregnant women was the cohort that had a lower vaccination uptake than others.
- This was a significant concern, as it had the potential to undo all the good work around recruitment that the maternity service had been doing and was set to do over the coming months.

02.6 Infection prevention control and assurance framework

- The main focus of the team was to start to reassess and recover the business as usual process for the management of infection prevention and control (IPC).
- The board assurance framework particularly related to Covid, which the Trust had been asked to deliver as part of the Covid response. The IPC committee had now incorporated all health care associated with infection within this framework, so that a fully robust process was in place.
- The Trust was hit particularly hard in January with Covid and nosocomial infections and outbreaks. This continued to be monitored and there was robust governance in place.
- The Trust should now not just focus on Covid but also on other infections as part of business as usual.
- There was also the need to acknowledge that in some areas of infection control there was a lot that the Trust could not do anything about, eg ventilation in a number of wards, which was very challenging due to the position of windows and from a safety perspective windows could only be opened a small amount. Mitigation for this was put in place wherever possible and advice was also being taken externally and internally as to how this could be managed going forward

Q Could assurance be given that the IPC team were fully resourced and ready to move forward in the next year?

A Budget setting for next year was being reviewed to look at how the current capacity met requirements and the capacity that would be needed for the next financial year. There was currently a shortfall in the team, as it was not robust enough to fulfil the requirements of community services as well as the acute hospital. Therefore, the structure and team was being reviewed for next year.

02.7 Nurse staffing report

Dan Spooner, deputy chief nurse, joined the meeting to present this report.

- The report this month included a reflection on the challenges that had been experienced so far in 2022.
- The past couple of months had been very challenging, particularly January, and a personally addressed letter from Sue Wilkinson had been sent to all nursing staff and nursing assistants thanking them for their support.
- Fill rates remained under 90% with some concerning reduction in fill rates for nursing assistants, which linked with the level of absences over the last two months.
- A number of mitigations had been put in place to respond the significant pressures as a result of staff absences in January.
- In December a metric-driven bank enhancement was launched to try to improve staffing levels in areas where there was the biggest risk. The success of this was yet to be realised, but December and January's data would be reviewed to understand the effectiveness of this.

Q Had the probability of a 'super surge' now reduced?

A The early signs were that the Trust was potentially through this period. F9 had been opened as a super surge ward which was being staffed within the current nursing establishment. This had put additional pressure on nursing and medical teams, but the Trust was now out of this, as of this week.

However, there was still a need to be cautious about the potential for a surge, as some organisations in the area had seen a further escalation in numbers.

From this week staffing levels had improved but this was still a challenge.

Q The fill rates were a cause for concern and it was good news that they were improving. Were there any areas that were particularly at risk due to fill rates and was there anything that the board could do to support this or was the system supporting these areas?

A Anything under 90% was a concern and anything under 80% even worse. The biggest area of concern was AAU, which was also an additional surge area in times of significant demand. With any area that had a significant gap there were mitigations to use the best resources available.

- National data indicated that community prevalence of Omicron had plateaued. However, from the Trust's point of view it was expected that staff sickness and absence may continue for several weeks.

- WSFT was bringing as may staff back to work as possible. It was following all of the national guidance, with a robust risk assessment process via Teams twice a day. More staff were being brought back to work than previously.

Q How does this work with community staff?

A Community teams were involved in the quality huddle every day and risk assessments panels applied to the entire Trust. Sue Wilkinson and Dan Spooner had met with community teams to discuss community surge planning and a community staff surge paper would be brought to the next board meeting.

02.8 Quality and learning report

- Throughout all of the challenges the team had continued with its quality and safety processes and governance and weekly emergent review panels. The team would be looking at next year's priorities for patient safety.
- A report on completed patient safety incident reports would be reviewed at the closed board.
- The emerging incident review panels were a good way of establishing a different culture in the Trust. It was suggested that this was a way that could be modelled in other interactions with staff, particularly when things went wrong.
- This was something that could be looked at when reviewing complaints; and it was suggested focussing on the experience of people involved in these. It was important to think about the language being used and reassure staff that they were not being blamed, but asked for their input into these.

Q What action was being taken to address the learning from deaths data issue; ie preventable deaths?

A This had been discussed by the learning from deaths group and a separate meeting would take place to look at how to decide what was preventable; there was no simple metric for this.

It would be timely to review the whole structure of mortality reviews as this was very complex and involved a huge amount of resource, which meant there was an opportunity for overlap. There was a need to look at how deaths were reviewed as the under-performance on preventable deaths indicated something about the mechanism that was currently being used. The newly-appointed associate medical director for patient safety would be involved in this.

Q Re best practice; were there any mechanisms for accessing and learning from this?

A The new associate medical director for quality and safety was looking at board papers from trusts across the country to help identify good practice from elsewhere.

02.9 Involvement Committee Report

Nothing to report; no meeting since last board meeting.

02.10 People & OD Highlight Report

- The citation for the Putting You First Award for January was read out. Volunteers Trevor Webber, Sue Feather and Barbara Bradshaw were nominated for all their work in restoring the hospital courtyards following their neglect during lockdown.

  The board thanked them for all their hard work, which was much appreciated by everyone.

- Mandatory vaccinations as a condition of deployment were currently taking up the majority of the HR team's time. The Trust was learning more about this every day and getting clarity around the data.
- Approximately 10% of staff had been written to, to clarity their vaccination status. A lot of responses had been received confirming that they were vaccinated, however there was still a significant number for whom there were queries.
- The HR teams was supporting line managers with individual conversations with staff. Specific areas of concern included midwifery, A&E, AAU and the housekeeping team.
- This report included a more detailed updated on mandatory training and appraisals.
- A project group had been set up to look at staff retention, including flexible working, ie 'flex for the future'.
- It was requested that the board was kept updated on staff vaccinations and any related issues in between board meetings.

ACTION: update board on any issues re mandatory staff vaccinations before next board meeting. **J Over**

02.11 CHARITABLE FUNDS ANNUAL REPORT

- This report was for information only. The auditors had approved the annual report and accounts for MyWish, with no exceptions, and these had been submitted to the Charities commission on Monday.

Q Had new auditors been appointed for MyWish for the coming year?

A KPMG had been appointed for the Trust but it was not known if this included the accounts for MyWish.

ACTION: confirm future situation with auditors for MyWish. **N Macdonald**

02.12 INTEGRATION REPORT – Q3

- It was noted that the team would be working on streamlining this report.
- There had been a very well publicised drive on the booster programme and the system had risen to the challenge. The Trust played a vital and innovative role in providing a service that supported individuals to receive their vaccination; eg people with learning disabilities, serious mental illness and broader anxiety issues.

  The workforce had been relocated to 39 clinics that were offering vaccinations.

- CCGs had been extended from April to July, when ICSs would become official. However, this would not have any impact in terms of business as usual for the alliance.
- The range of work taking place within the alliance was highlighted, with a particular focus on the rough sleeper case studies which showed the wider determinants of

health and the alliance's approach within west Suffolk to address some of the inequalities within society.

- The case studies in this report supporting marginalised vulnerable adults were very powerful and a good way of learning how to bring some of these outcomes to life.

Q Re mandatory vaccinations for staff; was there any synergy with work undertaken with people who were vaccine-hesitant, or from communities where it was more difficult for people to come to a decision, eg utilising some of the skills that the vaccinators had developed in focussing on some of these groups of people?

A It was felt that this was a good idea and could be followed up.

Q A lot was going on and there were some very good case studies of projects that had made a big difference to individuals. How were these multiple projects prioritised and how did they fit into a broader strategy?

A Projects were linked as part of the alliance's strategy and a delivery plan that underpinned this, which was based on the place-based needs assessments (PBNA) that had been undertaken.

There was a need to look at how to measure progress that was being made and linking them into the future system programme and changes to the model of care as a system; ie how to integrate WSFT's strategy with the alliance's strategy.

It was confirmed that the work of the alliance was highlighted in the green sheet, but there was more that could be done.

- Craig Black referred to the breadth of the integration report and the significance of some of the things which had made a considerable difference to people's lives. The work Kate Vaughton had done would change people's lives, as was evident in the vaccination campaign and the reflection of the relationships that she had improved across the system. It was a real shame that she was leaving this role and she would be greatly missed. On behalf of everyone he wished her well in her new role with the ambulance service.

  Kate said that it had been a privilege to sit on the board and she had learnt a huge amount. She wished the Trust and everyone well in the future.

22/03 CULTURE

03.1 WEST SUFFOLK REVIEW – ORGANISATIONAL DEVELOPMENT PLAN

- This was the second board meeting since the publication of the West Suffolk Review and this paper detailed the work that had been undertaken since then. The aim was to provide assurance that the Trust was responding in the correct way; many stakeholders were involved in this.
- Since preparing this report clarity had been received from the regional team around the next steps, ie to share a detailed action plan with them by 11 February. Colleagues in the national people directorate will be involved in providing feedback and advice to support this work.
- This report represented a comprehensive look at what the review had highlighted and how the Trust should respond.
- Everyone would need to be assured that this was not a tick box exercise for completing actions; it would take time to convince people that the organisation was making necessary changes.

- There needed to be a structure and framework for this and significant engagement was required so that everyone worked on this together. The specific role of governors was highlighted in this report and how this engagement would be taken forward.
- Ann Alderton had produced a report which collated feedback from governors on their views and concerns and a West Suffolk Review next steps group had been set up to work on specific areas and actions. This group consisted of seven governors and three directors; the first meeting was taking place on 17 February where the terms of reference would be agreed together with the outcomes the group wanted to achieve and a forward plan and timing for this. This plan would be shared with the rest of the governors and the board.
- With regard to support from the national people team, it had been noted that the issues that were highlighted in the review resonated in a number of organisations at the moment. Therefore, work was being undertaken nationally by the team and they would be looking at learning from actions taken by WSFT.

Q There were different dimensions to how the Trust did things, ie governance, but there was also a need to do more work on values. Would the response be circulated to board members before its submission on 11 February?

A This was about what values meant and ensuring that people were embracing these values when interacting with others.

The report talked about values and the board's role in modelling these values with the expectation that they would be cascaded through the organisation. The way in which the strategy was implemented in the organisation would also be key.

Q How do we open this up to the whole organisation, recognising that things that took place involved people throughout the organisation? There was a need to be very transparent and invite feedback on a regular basis from the rest of the organisation. This report had been developed in response to the review as requested, would this be the one plan as to how to move forward as an organisation and did anything else need to be picked up through this, e.g. equality, diversity and inclusion (EDI)?

A There would be a need to engage with and involve staff around how improvements were measured. Engagement was also about the way in which success was measured or not. This was also a key opportunity for repeating What Matters to You, to ensure that staff's priorities are understood and inform future actions.

- As well producing a response to the review for submission by 11 February, the board needed to think about developing improvement metrics, involving staff, public perception and the broader culture challenge.

ACTION: include comments/feedback from this meeting and circulate response to board members for final comment before submission on 11 February. **J Over**

- The board agreed to delegate authority to Craig Black and Jude Chin to sign off the final version on behalf of the board.

ACTION: Consider how to communicate final response to governors. **J Over / A Alderton / R Jones**

Q Would this response be in the public domain?

A Yes, an update will be included at the next board meeting in public.

03.2 SAFE STAFFING GUARDIAN – QUARTERLY REPORT

- The board received and noted the content of this report.
- The outstanding work of junior doctors through the current wave of Covid was highlighted. They had gone above and beyond during this period, due to staff shortages, particularly in paediatrics. They had also been very flexible in moving from one area to another in order to cover for staff sickness and absence.

22/04 STRATEGY

04.1 DIGITAL STRATEGY

- This strategy was based on the IM&T strategy which was presented to the board in 2018.
- Nick Macdonald welcomed and introduced Liam McLaughlin, chief information officer, who had been working on the strategy over the last few months.
- He explained the digital drivers and engagement that had been undertaken during 2021, ie 'putting people at the heart of digital'.
- Board support for this was very important and the way in which it was proposed to go about this was highlighted. This was equally important to what was going to be delivered, ie integrity, transparency and co-production through the future system.
- Due to time constraints at this meeting it was proposed that a workshop should be arranged for the board to go through this presentation in more detail.

ACTION: arrange board workshop on the digital strategy and its implications. **R Jones / N Macdonald**

Q Did this strategy link with the ICS strategy or digital futures?

A The team was working closely with other organisations across the ICS.

Q Had there been any patient engagement as well as staff engagement? Was there an inter-dependence with future system work and timescales?

A There had been some patient engagement through work on the future system, partly through Healthwatch. In addition, a lot of the staff who had been engaged with were also patients, so could bring this perspective to discussions.

With regard to the future system, this was very much about thinking about the technology that needed to go into the new facility, which was fairly clear. The challenge was more about technology that needed to be implemented in order to build the new model of care. This was why technology was being brought in advance, in order to experience and integrate these before the organisation moved into the new building.

Q It was very good that the organisation was moving into the digital era, however one of the barriers to this was staff engagement and helping them to transition from the old to the new and to embrace the new. Had the need to support staff been considered?

A There was a big emphasis on optimisation and some of this was being revisited with more care and attention to the feedback from people. Work was also being undertaken on the corporate side around engagement first and discussions with teams as to what was possible and what they might like to see. This was proving very beneficial.

- Three years ago doctors were asked for their experiences of using IT systems; 50% responded, which was very positive. The IT team listened to the feedback, both good and bad, and had put together an IT strategy based on the results of this survey. A lot of work had gone into the implementation of this.
- It was suggested that a more formal exercise should be undertaken around engagement, which could provide important information on ways in which this could continue to improve.

04.2 FUTURE SYSTEM BOARD REPORT

- The main areas of concern were within the estates workstream and the six key issues were detailed in this report.
- Developing an effective strategy for the protection of fungi was a particular concern and work was being undertaken around this.

Q How secure was the funding for 2022/23?

A This had not yet been clarified for next year, but based on history the project had so far been funded for everything required.

- A session had recently taken place, with directors from ESNEFT, Suffolk County Council and a team from the ICS, around demand management modelling. This had been very positive and it was recognised that this piece of work was not just about a new hospital, but the level of demand that the system was going to have to deal with linked to the wider footprint.

04.3 DIGITAL PATHOLOGY BUSINESS CASE

- It was noted that this was fundamentally about patient care and would help to provide quality care for patients moving forward; ie increased speed of test results, second opinions etc.
- This was a very exciting opportunity and would help to bring WSFT into the 21st century and enable inter-operable and end to end patient information flow across the organisation. It would also enable a closer link with Addenbrooke's and other organisations.
- The board approved the revenue costs associated with digital pathology to enable WSFT to access the capital funding provided by NHSI.

04.4 TRUST STRATEGY

- This had been presented to the board previously and to a number of other forums. It now included animations and would constitute one of the ways that the strategy would be launched in the organisation.
- This strategy was linked with other Trust strategies, eg digital strategy, nursing strategy.
- The next steps were for the executive team to start to roll this out within their own areas of the organisation, ie an implementation phase.
- The communications team also had a launch campaign. There were a number of phases in the launch plan which would cover a number of years, in order to ensure that this was embedded in the organisation.
- The strategy would be launched to staff next week and there would also be some external communications.

- Teams would be invited to refresh their divisional strategies and map these to the Trust's strategy.
- It was noted that everything that the board did linked with the strategy, including the IQPR and risk register, therefore this would be continually revisited.

22/05 GOVERNANCE

05.1 BAF SUMMARY AND RISK REPORT

- The main change to this document was that the CIP/Sustainability Programme and financial sustainability risk had been combined.
- The top corporate operational risks had also been included.

05.2 GOVERNANCE REPORT

- As explained at the previous meeting, a letter had been received from the region about the new oversight framework. WSFT had automatically been put into segment three due to its CQC rating and was still waiting to hear from the region what the support would be. This would then be discussed with the board.

05.3 REGISTER OF INTERESTS ANNUAL REPORT

- The board received and noted the content of this report.

22/06 OTHER ITEMS

06.1 QUESTIONS FROM GOVERNORS AND THE PUBLIC

- Liz Steele thanked Ann Alderton for everything she had done during her time as interim Trust secretary to support her and the governors, as well as the Trust.

Q Re infection control and learning from other organisations, had WSFT any links with organisations such as Addenbrooke's in terms of work on infection control and prevention (IPC) and in the use of HEPA filter machines on surge wards and reducing viruses in the air?

A The Trust had links with Addenbrooke's through the IPC networks to see what it could do to potentially employ some of these air filter systems.

06.2 ANY OTHER BUSINESS

- There was no further business.

06.3 DATE OF NEXT MEETING

Friday 25 March 2022, 9.15am

RESOLUTION

The Trust board agreed to adopt the following resolution:-
"That representatives of the press, and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest" Section 1 (2), Public Bodies (Admission to Meetings) Act 1960

1.4. Action log and matters arising

To Review

Presented by Jude Chin

Board meeting - action points

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery	Date Completed
1974	Open	28/05/21	Item 14.3	Provide further information to the board on the ward accreditation programme. .	Using a codesign methodology, the Ward accreditation steering group has been meeting weekly since May to scope the needs of the project, identify stakeholders and relevant workstreams. The steering group has now moved to monthly meetings and a smaller project group will take the actions identified forward in creating tools, process and pilot schedule. The project plan will be presented to the board in September. Project continues, update at October board. Verbal update provided at today's meeting (15.10.21). Current ongoing pressures have precluded progress in this matter. However, the Trust continues to focus on combining work with the info team on quality dashboard to support the infrastructure. **Uprecedented staffing and capacity issues have precluded provision of an update for this month's meeting.**	SW	~~30/07/2021~~ ~~03/09/2021~~ 15/10/2021	Amber	
1997	Open	15/10/21	Item 10.2	Board discussion/workshop required to discuss Trust's priorities and what it would not be able to do	**Board strategic workshops are being developed as part of the Board evaluation undertaken with Integrated Development Ltd.**	JC/AA/RJ	~~17/12/2021~~ 28/2/2021	Green	
2019	Open	28/1/22	Item 02.5	Maternity services - share Ockendon 2 report with board before next meeting.	**Report awaited.**	SW	25/03/22	Green	
2021	Open	28/1/22	Item 02.11	Charitable Funds - confirm future situation with auditors for MyWish.	**Quotes obtained, for discussion at next Charitable Funds Committee meeting on 1st April, 2022.**	NM	25/03/22	Green	
2024	Open	28/1/22	Item 04.1	Digital Strategy - arrange board workshop on the digital strategy and its implications.	**Arrangements being made to coincide with one of the Board Development dates already held in the diary. Further details to follow.**	RJ/NM	25/03/22	Green	

Red	Due date passed and action not complete
Amber	Off trajectory - The action is behind schedule and may not be delivered
Green	On trajectory - The action is expected to be completed by the due date
Complete	Action completed

Board meeting - action points

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery	Date Completed
2015	Open	28/1/22	Item 01.6	Patient Story - look at training/support for staff in this type of situation.	**Support provided by Patient Experience team. Propose that we establish an equivalent checklist for the Board to help ensure it provides appropriate support to those attending in person.**	JO	25/03/22	Complete	25/03/2022
2016	Open	28/1/22	Item 02.2	Finance & Workforce - ensure operational teams are given the opportunity to engage in budget setting and CIP/Sustainability Programmes.	**Today's finance paper (25.3.22) refers.**	NM/NC	25/03/22	Complete	25/03/2022
2017	Open	28/1/22	Item 02.4	Improvement Committee - discuss with executive team when and how to share outcomes of 3i committees with the organisation as a whole.	**To be incorporated in communications strategy for the year ahead.**	JO/HD	25/03/22	Complete	25/03/2022
2018	Open	28/1/22	Item 02.5	Maternity services - agree solution to parents being charged for car parking.	**Actioned.**	SW	25/03/22	Complete	25/03/2022
2020	Open	28/1/22	Item 02.10	People & OD - update board on any issues re mandatory staff vaccinations before next board meeting.	**Complete. Additionally the People & OD highlight report includes an update.**	JO	25/03/22	Complete	25/03/2022
2022	Open	28/1/22	Item 03.1	WS Review OD Plan - include comments/feedback from this meeting and circulate response to board members for final comment before submission on 11 February.	**Actioned.**	JO	11/02/22	Complete	25/03/2022
2023	Open	28/1/22	Item 03.1	WS Review OD Plan - consider how to communicate final response to governors.	**Included in open Board papers today with further specific communication planned.**	JO/AA/RJ	25/03/22	Complete	25/03/2022

Red	Due date passed and action not complete
Amber	Off trajectory - The action is behind schedule and may not be delivered
Green	On trajectory - The action is expected to be completed by the due date
Complete	Action completed

1.5. Staff story

To Note

Presented by Susan Wilkinson

1.6. Questions from Governors and the Public

To Note

Presented by Jude Chin

1.7. Chief Executive’s report

To inform

Presented by Craig Black

Board of Directors – Friday 25 March 2022

Report Title:	Item 1.7 - CEO report
Executive Lead:	Craig Black
Report Prepared by:	Dan Charman, Helen Davies
Previously Considered by:	N/A

For Approval	For Assurance	For Discussion	For Information
☐	☐	☐	☒

Executive Summary
This report provides an overview of some of the key national and local developments, achievements and challenges that the West Suffolk NHS Foundation Trust (WSFT) is addressing. More detail is also available in the other board reports.
Action Required of the Board
For information

Risk and assurance:	-
Equality, Diversity and Inclusion:	-
Sustainability:	-
Legal and regulatory context	-

Launch of new Trust strategy 2021 – 2026: First for patients, staff and the future

Last month, we launched our new five-year Trust strategy, which focuses on three equal ambitions – 'First for patients'; 'First for staff' and 'First for the future'. This strategy sets the direction of our organisation for the next five years and we will use this as key platform to help us deliver our vision "to deliver the best quality and safest care for our community".

While we continue to navigate the challenges that Covid-19 brings us, the launch of the new strategy gives us an opportunity to be optimistic about the future. Our aim is to use this new strategy to open a new chapter for the Trust - to reset; build a fair, open and listening culture; transform the care we provide; and plan for the much needed new and modern healthcare facility for the people of west Suffolk.

Ultimately this strategy will only be successfully delivered if everyone across the organisation feels like they have a stake in it. Whilst the Board and the senior team takes responsibility for it and will help drive it, it's through divisional strategies and day to day work that it will come alive, staff will feel ownership of it and it will be successfully delivered. The Trust strategy should be the anchor for all of our work – helping us to prioritise what we're doing and equally important, allowing us to say no to the things that won't help us deliver this plan.

Pressures remain across the Trust

While we are moving away from winter and entering spring, the Trust is still continuing to face significant service pressure as a result of seeing an unexpectedly high number of unwell patients. As ever, our colleagues throughout our hospitals and the community are working as hard as possible to mitigate the extreme pressures they have seen recently and we continue to work alongside external partners to deliver care to those who need it.

Throughout Suffolk, we continue to see Covid-19 cases rise after self-isolation rules have come to an end so while we're no longer considered to be in the heart of the pandemic, coronavirus is still having a huge effect on healthcare across the county.

Vaccine taskforce

Our incredible vaccine taskforce is continuing to visit locations across west Suffolk to support the vaccine rollout, meeting local need as well as delivering vaccines to those between the ages of 12-15.

The work undertaken by the taskforce has been a true team effort – combining the skills of our IT team, pharmacy colleagues, facilities team as well as volunteers to ensure the clinics are running smoothly. Every person in these teams have risen to the challenge of ensuring the population of west Suffolk has been able to access a vaccination.

Supporting patients

As a Trust we are continuing to work through our waiting lists and we are working hard and innovating to try to see patients as soon as possible.

One way we're working on supporting patients whilst they're having to wait, is through our Waiting Well pilot.

The pilot aims to offer support to patients by reducing the risk of deterioration of their mental and physical health while they are waiting for their procedure. It's really important that every patient's health is optimised as far possible so they are in as good condition as possible for their surgery.

By offering our patients health and lifestyle information and providing coordinated interventions that provide personalised support, it ensures that while they are on the waiting list, their physical and mental health do not deteriorate.

Hospital visiting

At the end of last month, we were able to bring in some relaxation to our inpatient visiting. It's really positive that most of our patients in our hospitals are now able to have a visitor come in for up to an hour each day. We see every day how important visiting is to both patients and their loved ones. Suspending visiting for several months was a very difficult decision to make, but this was to help stop the spread of Covid-19 amongst the most vulnerable in our society and to help protect our staff.

While the majority of visiting has returned, we are keen to minimise the chance of any infection spreading, so we are asking all visitors to take a lateral flow test before they visit and to wear a surgical mask during their visit. Our dedicated Keeping in Touch and Clinical Helpline teams continue to offer support to those who are unable to visit.

CQC Maternity Survey

We recently received feedback from the 2021 CQC NHS Maternity Survey which noted the experiences of 188 mothers who had births at our Trust in February 2021. We received positive responses from mothers around a number of aspects such as being asked about their mental health by colleagues, being given information on Covid-19 restrictions and mothers being able to see or speak to a midwife as much as they wanted during their care after birth.

However, the feedback has shown there are areas where we can improve as a Trust. Since the survey took place, a lot of work has happened to make improvements – for example, supporting people with infant feeding via increased social media content as well as the reopening of external support groups. The maternity service will be working with the patient experience team to further look at areas of improvement and will continue its work with West Suffolk Maternity Voices partnership.

Supporting staff well-being

The middle of March saw us celebrate our third Love Yourself Week with the aim to encourage our staff, who care for others, to care for themselves too. Two years on from the first lockdown, the week focused on new beginnings in Spring and hosted a wide array of opportunities for colleagues to get involved in. From drawing and photography on Hardwick Heath through to self-compassion support from our own staff support psychological service; it offered something for everyone. I want to thank all the people involved in making it a reality.

Staying on the theme of wellbeing, our very successful Abbeycroft leisure offer has been extended which has delighted a lot of staff at our Trust. If you're not familiar, the offer gives WSFT colleagues free access to Abbeycroft's facilities which include gym, swimming and group exercise and has been a hit since we introduced it last year with over 60% of staff signing up in the first year.

Community continues to help shape the new healthcare facility

Looking to the future, our busy Future Systems team are continuing to work with the local community in designing the new hospital which will arrive later this decade. They are currently asking staff, patients and residents to participate in workshops that take place all

through March – this feedback is vital in helping shaping the new healthcare facility that is fit for the 21st century. To find out more information, please click here.

2. CULTURE

2.1. West Suffolk Review - Organisational development plan

To Assure

Presented by Jeremy Over

Board of Directors – 25 March 2022

Report Title:	Item 2.1 - West Suffolk Review – Organisational Development plan
Executive Lead:	Jeremy Over, Executive Director of Workforce & Communications
Report Prepared by:	Jeremy Over, Executive Director of Workforce & Communications
Previously Considered by:	Involvement Committee Senior Leadership Committee

For Approval	For Assurance	For Discussion	For Information
☒	☐	☒	☐

Executive Summary

Background and Introduction

The West Suffolk Review, commissioned by NHS England on behalf of the Department for Health and Social Care, was published in December 2021.

At the meeting of the Board of Directors on 17 December, the chief executive Craig Black responded on behalf of the Board: *"As a Trust we accept full responsibility for the failings and shortcomings which led to the review; we got it wrong and remain truly sorry to the staff and families affected.*

"We know the actions taken by the Board which led to the independent review have understandably caused upset and anger amongst many of our staff, patients and their families, as well as our community, and this has brought unwanted attention to the Trust. We know for the individuals most directly affected the impact on their wellbeing has been significant.

"Whilst the investigation has been taking place, we have been working hard to build an open, learning and restorative culture. Our aim is to help staff feel confident to speak up and be supported when they raise concerns, and for issues to be dealt with sensitively and appropriately".

Referring to the main themes of The Healthy NHS Board, the Board's responsibilities are formulating strategy, ensuring accountability and shaping culture. The Board's performance fell short on both ensuring accountability and shaping culture and that needs to be the main focus of its response.

This plan sets out the Board's response and plan to address and adopt the learning from the report including the organisational development actions that have already been taken and require further embedding. It also highlights the engagement undertaken to date, and what more needs to happen, to ensure our plans are based on the priorities for staff, governors, patients and teams and can carry the confidence of stakeholders.

Our approach to this plan

During the period since publication our priority has been to engage with and provide support to a number of different groups. First and foremost, those colleagues most affected by the actions rightly criticised in the report; our staff and teams more broadly; the families involved and our wider community; through being open and engaging with media queries; and the

council of governors, whose role is to hold the non-executive directors (NEDs) individually and collectively to account for the performance of the Board and represent the interests of members and the public.

We are grateful to the many individuals who have spoken up during this period, which has involved a range of views and ideas around how we move forward together. We are also conscious that, for a significant portion of the period since publication, the Trust has faced severe operational and staffing pressures and has spent time in a state of 'critical internal incident'. This is likely to have affected the extent to which people may have been able to contribute, and spend time, forming our development plan. We are also mindful that it will take considerable time not just to work together on actions to grow our culture, but to convince and reassure people that change has happened and to restore trust where this has been lost.

We are also grateful to the review team for taking time to consider the improvements we have already been working on together at West Suffolk NHS Foundation Trust (WSFT) over the past two years, and the positive comments attributed to this in the report.

With all this in mind, we are approaching this as a longer-term *organisational and cultural development plan*, to try and avoid the mistake that a simple action plan, delivered in a matter of weeks or months, would remedy the situation, post-publication. There is a risk that quickly producing an action plan might also give the impression that there is no further engagement work to do around our priorities, which would be a mistake.

Actions since the January 2022 meeting of the Board

At our meeting in January the Board received a briefing on discussions with the Governors to date, (given their role in holding the NEDs individually and collectively to account for the performance of the Board and representing the interests of members and the public), and the emerging cultural themes to address the learnings in the report. Since the meeting actions have included:

- The first meeting of the agreed Governor-Director working group on 17 February
- Creation of the detailed Organisational Development plan described above (and attached) which subsumes the nine themes into five key areas of work
- Sharing of the draft plan with Board colleagues for informal feedback
- Sharing of the draft plan:
    - With the NHS England east of England regional team and the Chair and AO of the Suffolk and North East Essex ICS
    - With the people directorate within the national NHS England team – feedback has been provided and incorporated
    - With the Chair of the West Suffolk Review for any feedback she felt able to provide
    - With the WSFT Involvement Committee and Senior Leadership Team

Action Required of the Board

The Board is asked to:

- Discuss, approve and formally adopt the Organisational Development plan, ensuring it is reflective of the Board's collective response in relation to how we learn and improve
- Actively support the communication of the plan with staff and stakeholders and demonstrate ownership
- Support a recommendation to delegate oversight of the delivery of the plan to the Involvement Committee

Risk and assurance:	If we do not address the reflections and learning of the West Suffolk Review within an appropriate timeframe and fail to manage the governance consequences in a just and fair manner, this will cause Board instability, uncertainty and loss of public confidence and increase the risk of regulatory intervention and loss of autonomy
Legal and regulatory context	NHS Act 2006, Health and Social Care Act 2012 Your Statutory Duties: A reference guide for NHS Foundation Trust Governors – Monitor 2013 The NHS Foundation Trust Code of Governance July 2014

Our Trust Values	
Fair	We value fairness and treat each other appropriately and justly.
Inclusivity	We are inclusive, appreciating the diversity and unique contribution everyone brings to the organisation.
Respectful	We respect and are kind to one another and patients. We seek to understand each other's perspectives so that we all feel able to express ourselves.
Safe	We put safety first for patients and staff. We seek to learn when things go wrong and create a culture of learning and improvement.
Teamwork	We work and communicate as a team. We support one another, collaborate and drive quality improvements across the Trust and wider local health system.

The OD Plan

This OD plan sits within the broader aims of our 5-year strategy and People Plan. It incorporates how we are specifically responding to the learning from the findings of the West Suffolk Review. It should not be seen to represent the totality of everything we are doing to develop our culture.

First and foremost, our priorities for developing our culture are founded on the feedback from our staff and teams. These were set by our *What Matters to You* programme, described in section 5. Progress with these priorities will be explored with staff as we take forward this work during 2022 and beyond. The learning from the West Suffolk Review, and associated actions, overlap with and augment this work.

1. Strategy and values

It is clear from the review report that the identified failings stem from the attitudes and behaviours of senior leaders which contributed to poor and uncompassionate decision-making, and a failure to listen and respond to others' views.

This plan is founded on our FIRST Trust Values. HOW we lead is as important as WHAT we work on by way of actions, and the right leadership behaviours are a central pillar to ensuring previous failings are not repeated. Our FIRST Trust values have recently been refreshed with our staff and stakeholders alongside the process of creating our new 5-year strategy, which is available for review as an attachment to this paper (link in the appendix):

- FAIR – we value fairness and treat each other appropriately and justly
- INCLUSIVITY – we are inclusive, appreciating the diversity and unique contribution everyone brings to the organisation
- RESPECTFUL – we respect and are kind to one another and patients. We seek to understand each other's perspectives so that we all feel able to express ourselves
- SAFE – we put safety first for patients and staff. We seek to learn when things go wrong and create a culture of learning and improvement
- TEAMWORK – we work and communicate as a team. We support one another, collaborate and drive quality improvements across the Trust and wider local health system

As our strategy states: *"Our First Trust Values are the guiding principles and behaviours which run through our organisation and will help us deliver our vision and ambitions in the right way. We will use them to always strive to improve the services we provide to our community and the way that we work as a team and with our partners. To reflect the changes the Trust has been through in recent years, we have updated these values to reflect the evolution of the organisation, the journey it is on and the culture we are striving to create across the Trust."*

Actions already undertaken or in progress:

- A new 5-year strategy has been developed for WSFT with staff and other stakeholders, which overtly recognises past failings and the importance of learning lessons to develop our culture

• Our FIRST Trust values have been refreshed with staff and stakeholders and are built in to the new strategy • Staff (and their well-being) are now an overt strategic priority, with investment in staff psychology support services and other well-being measures			
Additional actions:			
#	*Action*	*Lead*	*Timeframe*
1a	Launch the new strategy and refreshed values	Chief executive (CEO)	Feb 2022
1b	Build alignment through divisions and teams using the new strategic ambitions and objectives to develop their own strategies and plans	Executive directors	By Oct 2022
1c	Develop a work programme to embed the values in working practices and everyday life across the Trust, and then deliver it	Executive director for workforce and communications (EDWC)	Develop plan by April 2022 Deliver from May 2022 onwards
1d	The Board and the Council of Governors to consider and agree a plan for how they will role model the values and how this should be evaluated as part of their development programmes	Chair	Develop plan by April 2022 Deliver from May 2022 onwards

2. Board development and accountability

Culture change starts at the very top of organisations. What leaders pay attention to, talk about and model in their own behaviour tells those in the organisation what it is they should value. This in turn impacts on outcomes, as exemplified in this summary gained from Professor Michael West and through our leadership development session delivered by him in October 2021:

- Compassionate leadership → staff satisfaction
- Staff satisfaction → patient satisfaction, care quality
- Poor leadership → work overload, high staff stress
- High work pressure → less compassion, privacy, respect.
- High staff stress→ poorer care quality and finances etc.

The criticisms detailed in the review are clear - that significant failings lay within Board governance - which had ramifications for the culture of the organisation. This in turn has impacted on staff and teams affected through and post these events. Rebuilding the Board and focusing on its development to deliver a change in culture will require significant focus.

Actions already undertaken or in progress:

- An externally-facilitated Board development programme has been commissioned, which commenced in October 2021, including an in-depth 360 feedback exercise
- We have rebuilt the executive team and continue to be focused on its development
- The board assurance committee function has been strengthened
- We have supported our Council of Governors to develop their role of holding non-executive directors to account for performance of the Board
- We have an ongoing training programme for governors, externally-facilitated
- The minutes of closed Board meetings are now shared with our governors

Additional actions:

#	*Action*	*Lead*	*Timeframe*
2a	Detailed programme of Board development for 2022 to be finalised	Chair	Mar 2022
2b	2a to include development session with review author to support broader reflection and learning and the Board's response	EDWC	Apr 2022
2c	Person specifications for Board recruitment to reflect lessons learned from review	Trust secretary	Feb 2022
2d	Recruitment of new substantive Chair and to NED vacancies	Lead governor	April 2022
2e	Recruitment of new substantive chief executive	Chair	July 2022
2f	Establish an agreed governor-director working group to facilitate their role around holding NEDS to account for the performance of the Board.	Trust secretary	From Feb 2022
2g	Externally-facilitated programme for the Council of Governors to be commissioned to ensure culture change is reflected in the wider FT accountability framework	Trust secretary	Apr 2022

3. Building a speak up culture

There are significant failings identified in the review related to the organisational culture around freedom to speak up and it is clear that these failings have harmed staff's confidence in speaking up at West Suffolk.

The learning arising from this must address any real or perceived detriment to staff by raising their concerns. Critical to shifting this is the attitude and approach of the Board, and particularly executive directors, in being open to concerns, and ensuring that the management of speak up issues does not become conflated with any other process, including performance management.

The development of a culture where all staff feel confident to speak up and raise concerns at work, and their concerns listened to, is crucially important to us all. It has a direct impact on a culture of safety with positive benefits for patient care, quality and staff experience. We know from the most recent set of staff survey results that further effort is required to develop this culture at WSFT given that an increased number of colleagues reported that they did not feel confident to speak up.

The development already undertaken within the executive team with Dr Megan Reitz has focused on the awareness that all management teams within organisations should hold, including:

- Speaking up is *relational*. The dynamics and differences in role, position and context of the individual speaking up, and the individual they are speaking up to, will dictate the environment within which it happens.
- We are not as good at it as we think we are (speaking up or listening up). No one is likely to tell leaders they are "wrong".
- Those in senior roles typically hold an optimism bias about what it is really like in an organisation, which can lead to them existing in a 'bubble'.
- Senior leaders can immediately perceive speaking up as criticism, and thus act defensively.

Actions already undertaken or in progress:

- We have strengthened and expanded our Speak Up Guardian function, with two clinicians undertaking this role with dedicated time
- The Speak Up Guardians present to Board at its meeting in public on a quarterly basis, including challenge and feedback to the Board from the guardians
- The Guardians have established a Speak Up champion network during 2021, with training and support for individuals. 40 individuals have been trained and a further 20 are booked for future training
- The Board has used the NHSI self-assessment tool to assess its leadership approach to speaking up twice in 2021
- Essential 'speak up' training for all staff agreed and active

Additional actions:

#	*Action*	*Lead*	*Timeframe*
3a	Work with the National Speak Up Guardian's Office to learn from best organisational practice and explore further support	EDWC	June 2022
3b	Further expand our Speak Up staff champion network, particularly focusing on underrepresented areas	SU Guardians	Throughout 2022

3c	Evaluate the learning from staff champion model and promote positive examples of the difference that raising concerns can make	EDWC	October 2022
3d	Utilise the 2021 national staff survey results to provide focused support to teams where confidence in speak up processes is of most concern	EDWC	May 2022
3e	Design and deliver a development package for all leaders and managers, starting with Board, on how to grow safe speak up cultures within teams including the skills to respond non-defensively to concerns being raised	EDWC	June 2022
3f	Consider additional ways for staff to raise concerns and issues in psychological safety	SU Guardians	June 2022

4. Supportive and compassionate HR policy and practice

The review report considered the use of HR and other investigative processes, and drew criticisms from a number of angles. These include the inappropriate conflation of the handling of speak up concerns with other HR-related processes, and the incorrect focus on *who* was responsible for something happening, rather than *why* it had taken place. In addition, there is wider learning arising from a failure of checks and balances that should be part of the governance arrangements in any large organisation such as WSFT.

Just cultures that are restorative as opposed to retributive, are becoming increasingly recognised for their contribution in dealing with adverse events and serious incidents, managing employee relations, developing high performing teams and enabling the delivery of safe and high-quality care.

WSFT has undertaken significant work over the past two years, in partnership with staff representatives, to modernise its HR policy and practice. This has led to an increase in informal approaches to resolving concerns and a decreasing reliance on HR "process". Whilst it is necessary to have in place policies that set out how disciplinary and performance management issues will be handled, we will continue to embed our commitment, developed over the past eighteen months, to placing a far greater emphasis on mediation and informal resolution, prior to any process being enacted.

Actions already undertaken or in progress:

- We paused all active HR cases as part of a 'reset' to fully explore the options for informal resolution in all these situations
- A new conduct policy has been approved and is operational, founded on just culture principles. It includes a safeguard checklist process to review incidents and ensure a focus on support, resolution and compassionate approach for all parties, prior to any action being taken. It also overtly focuses on the learning when something goes wrong, and provides safeguards to avoid the conflation of conduct or performance management with speaking up matters
- We have invested in a new group of HR professionals to partner, support and coach managers and teams
- All formal HR cases, including any active MHPS (Maintaining High Professional Standards) cases, are reported (anonymously) to the closed session of Board to facilitate checks and balances discussions

Additional actions:

#	*Action*	*Lead*	*Timeframe*
4a	Continue HR policy transformation in partnership with staff representatives, ensuring these frameworks reflect refreshed FIRST Trust values and just culture principles	EDWC	Throughout 2022
4b	Develop plans to further invest in HR & People Services teams at WSFT to reflect the priorities identified through the national 'future of NHS HR & OD' report	EDWC	July 2022
4c	Training for new and existing board members, clinical directors and HR team in relation to Maintaining High Professional Standards, overtly drawing from the learning in the review	EDWC	June 2022

5. Staff engagement and feedback

A change in culture will take significant time to deliver. Typically in large organisations this can take a period of at least five years. The new strategy for West Suffolk sets the foundations and priorities for this culture change. Whilst the actions in this particular development plan are those overtly arising from learning from the review report, they will complement the broader approach to be identified in our longer-term People Plan. Furthermore, to help avoid the mistakes of the past, as senior leaders we need to make sure we hear and understand our staff's priorities, and use these in our decision-making.

WSFT delivered its first, interim People Plan in answer to the responses from staff to our 'What Matters to You' engagement programme, which took place in the summer of 2020.

Staff identified five priorities that have underpinned our approach since then:

- The importance of great line managers
- Creating an empowered culture
- Building relationships and belonging
- Appreciating all of our staff
- The future and recovery

We want to strengthen and grow our approach to staff feedback and engagement, and place even greater emphasis on this as we continually develop our plan for staff support and organisational culture over the coming years. We will also ensure we are aligned with, learn from, and deliver the commitments in the national People Plan for colleagues across the NHS. We are also mindful of a disconnect between executive directors and senior clinicians that was identified by the report's author within the events under scrutiny and the creation of a new leadership forum bringing together executives and clinical directors will help to address this.

Actions already undertaken or in progress:

- In summer 2020, we held our 'What Matters To You' (WMTY) staff engagement programme with feedback from around 2,000 colleagues
- WMTY was used to develop an interim People Plan, delivered during the period of the pandemic
- We held open staff briefings / Q&A in relation to the findings and learning from the West Suffolk Review
- Staff and partner consultation took place to develop our new strategy and to refresh our values
- We formed our new Senior Leadership Team to create a new senior decision-making forum bringing together executive directors and senior divisional clinical leaders
- Agreement that our new Board assurance committee for 'Involvement' will hold responsibility for overseeing this plan and monitoring its progress and impact, and reporting to full Board

Additional actions:

#	*Action*	*Lead*	*Timeframe*
5a	Analyse and learn from results from the national NHS staff survey (2021) when published, and use these to set any additional priorities for organisational development	EDWC	April 2022
5b	Plan and deliver 'What matters to you #2' for West Suffolk, to ensure that staff's priorities are	EDWC	August 2022

	heard and understood, and are at the heart of our planning and future		
5c	Ensure the active involvement of staff and staff representatives in the design and delivery of our staff feedback and engagement work to help ensure it is credible, authentic and meaningful – including how we measure our progress. This will include staff not in traditional leadership roles but who are passionate about staff support and building positive cultures	EDWC	March 2022
5d	Consider options to build analytical capacity and capability in our people and OD practice	EDWC	June 2022

Measuring our progress and providing assurance

As we gauge the impact of our development plan and seek assurance of how our culture is improving we will use qualitative and quantitative assessment.

Cultural and organisational development is challenging to measure, and there is a tendency for leaders to place greater emphasis on statistics that confirm their biases or expected outcomes. As such, it is essential to be open to the many and varied ways in which feedback might be available, and to ensure a non-defensive response to critical or challenging feedback. It is also the case that the improvement of culture is an ongoing task, with no 'end point' where the work is necessarily complete.

The following represents an initial set of measures that we will use based on the aspirations of this development plan. It is open to further review and development as we progress the work in this plan:

The **national staff survey** (and quarterly survey with a sub-set of questions) provide insight into both internal trends and external relativities across the domains of staff attitudes, satisfaction and experience. There are over 90 questions in the full survey which are broken down by various demographics. Of particular importance given the findings of the review and the priorities of this plan will be:

- % of staff recommending WSFT as a place to work
- % of staff feeling secure raising concerns about unsafe clinical practice
- % of staff feeling confident that organisation would address concerns about unsafe clinical practice
- % of staff feeling colleagues are understanding and kind to one another
- % of staff feeling colleagues are polite and treat each other with respect

We want to see improvement in these measures – a reversal of the downwards trend over recent years, and subsequent increase in scores. We will also analyse responses by staff group and at team level to provide assurance of improvement in any particular groups that report a low score in any of these domains.

In addition to the staff survey we will **monitor the following metrics**:

- % of staff taking part in freedom to speak up awareness training
- The number of managers taking part in speak up culture training (and correlation against staff survey analysis)
- % of staff aware of our values and the extent to which they make a positive difference
- The number of speak up champions trained and active across the organisation
- An increase in the number of staff taking part in What Matters to You, as compared with 2020
- The number of staff benefitting from MHPS training

From a qualitative perspective we anticipate that one area of focus of the planned ***What Matters to You*** **(#2) staff engagement programme** will involve feedback from staff and teams about how the organisational culture is changing. This will provide an opportunity to measure the extent to which staff are aware of this work, its relevance to them, and their level of confidence in it for the future.

Appendix:

Link to our five-year strategy for West Suffolk NHS Foundation Trust (launched February 2022):
https://www.wsh.nhs.uk/CMS-Documents/Trust-Publications/Strategy/WSFT-Strategy-%E2%80%93-First-for-our-patients-staff-and-the-future.pdf

2.2. Report of the West Suffolk Review - Governor/Director working group

To Assure

Presented by Richard Davies

REPORT TO:	Board of Directors
MEETING DATE:	25 March 2022
SUBJECT:	Report of the West Suffolk Review Governor Director Working Group
AGENDA ITEM:	2.2
PREPARED BY:	Ann Alderton, Interim Trust Secretary
PRESENTED BY:	Richard Davies, Senior Independent Director Clive Wilson, Public Governor and Working Group Chair
FOR:	Information

Background

Following the publication of the West Suffolk Review in December 2021, the Council of Governors agreed at its meeting on January 2022 to establish of a West Suffolk Review Governor Director Working Group to take forward the learning from that report.

By bringing together Governors and Directors, this working group will ensure that the Trust's response supports both the Board and the Council by ensuring that they meet their respective governance responsibilities in addressing the learning from the report of the review.

Meeting of the West Suffolk Review Governor Director Working Group 17 February 2022

The West Suffolk Review Governor Director Working Group held its first meeting on 17 February 2022. The minutes are attached for information but the key decisions taken were as follows:

- Members elected Clive Wilson, Public Governor, as Chair;
- Draft terms of reference were reviewed and amendments made **(Appendix 1);**
- It was noted that Christine Outram, the author of the West Suffolk Review, had agreed to meet with the Board of Directors and agreed that the invitation would also be extended to the governor members of the working group;
- It was also noted that Alan Rose had offered to attend a future meeting of the working group to discuss his reflections on the findings of the review.

West Suffolk Review – Organisational Development Plan

The working group discussed the above draft report. This had already been discussed by the Board of Directors on 28 January and it was noted that a final version would be presented to the meeting of the Board of Directors in public on 25 March.

Independent Review of the Council of Governors

Both the West Suffolk Review - next steps paper to the January 2022 meeting of the Council of Governors and the West Suffolk Review Organisational Development plan proposed that commissioning an independent effectiveness review of the Council of Governors would help reflection and learning of the boundaries between the role of the Executive, the NED and the

Council of Governors, as well as provide learning for both the Board of Directors and Council of Governors as regards communication and engagement.

Following consideration of four proposals, members of the committee selected the Good Governance Institute to conduct this review. This review has started and governors are asked to engage with colleagues from the Good Governance Institute in order to maximise the feedback and learning from this process.

Recommendation

The Board of Directors is asked to approve the terms of reference of the West Suffolk Review Governor Director working group and to note the content of this report.

West Suffolk Review Working Group

Terms of Reference

1. Introduction and Background

Following the publication of the West Suffolk Review in December 2021, West Suffolk NHS Foundation Trust is committed to taking appropriate action to meet the advisory recommendations and learnings in the report. To ensure that there is full accountability and engagement, it is establishing a Governor/Director Working Group to take this forward.

2. Role of the Working Group

Governors and Directors have distinct and separate roles in the governance of West Suffolk NHS Foundation Trust but have a shared responsibility to act in the best interests of the Trust.

The **Board of Directors** is collectively responsible for the performance of the Trust, which it performs through formulating strategy, ensuring accountability and shaping culture.

The **Council of Governors** has a statutory duty to hold the non-executive directors individually and collectively to account for the performance of the board of directors and for representing the interests of members and the public.

By bringing together Governors and Directors, this working group will ensure that the Trust's response supports both the Board and the Council in meeting their respective governance responsibilities in addressing the learning from the West Suffolk Review.

3. Membership

Directors
Chief Executive
Director of Workforce
Senior Independent Director
Governors
At least four governors, representing a broad range of stakeholders (Staff, Public, Partner)
Lead Governor

The working group will be chaired by a governor, selected by the members of the group.

4. Responsibilities

To secure Governors' views on the Trust's development plan in response to the West Suffolk Review in order to ensure that:

- the main themes for learning are understood and captured in an appropriate action plan.
- there is meaningful cultural change that is disseminated and understood across all levels of the organisation and that expected behaviours and attitudes when dealing with challenging situations are in accordance with the Trust's values.
- there are appropriate governance structures and other systems of internal control, which maintain an appropriate balance between openness and transparency over systems and processes and the need to respect the privacy of individuals and confidentiality of personal data.

- a process exists within the governance of the Trust to consider any outstanding issues of concern.

To consider activities and sources of assurance linked to the plan which support further development and evaluate progress with delivery.

5. Reporting Arrangements

The working group will meet at a frequency determined by the group but at least quarterly and report to the Board of Directors and Council of Governors.

3. STRATEGY

3.1. Future system board report

To Assure

Presented by Craig Black

Board Meeting – 25 March 2022

Report Title:	Item 3.3 - Future System Board Report
Executive Lead:	Craig Black
Report Prepared by:	Gary Norgate
Previously Considered by:	Future System Programme Board

For Approval	For Assurance	For Discussion	For Information
☐	☒	☐	☐

Executive Summary

As a general indication of health, the status of those tasks within the control of Future System Programme remain unchanged as 'Green' and significant strides having been made in several key areas:

1. We remain on track to formally submit our application for outline planning consent in the Spring of 2022.
2. Key planning application activities in the period since the last report include the negotiation of net bio-diversity gain, the completion of our flood risk assessment and the development of plans through which we can enhance pedestrian and cycle paths that aid access.
3. Phase 4 of the co-production of our hospital design has seen the completion of c.25 workshops and has emerged with an agreed view of clinical adjacencies and departmental floor areas.
4. Next step of co-production is to take these agreed plans from a 1:500 to a 1:200 level. These workshops are underway and will be completed by mid-April, by which time we will have held c.200 co-production workshops!
5. Following a highly positive Integrated Care System (ICS) workshop, the co-production of a system wide forecast of demand and capacity is underway.
6. Our finance workstream is continuing to work on the formal appraisal of our shortlisted options.
7. The work of the New Hospitals Programme (NHP) continues to gather pace and we can expect to see the outcome of their demand and capacity modelling and standard designs for "Hospital 1.0" in the next two months.
8. With these developments in mind it was with almost perfect timing that we welcomed the leadership team of the NHP to Hardwick Manor on 11th February. The meeting was extremely positive and allowed us to showcase the jeopardy of our existing infrastructure, the significant extent of our progress, the potential of our site and, ultimately, the deliverability of our project.
9. Having received funding for the 21/22 year, we are poised to enter negotiations for the 22/23 funding that will allow us to complete our outline business case.
10. As part of the related project to exploit the opportunities presented by the One Public Estate hub being built at Western Way, the Future System co-production team are leading on identifying, assessing and designing the services that could be recommended to move . This work will progress independently from the main Future System Programme and could require formal public consultation.
11. In an attempt to demonstrate that old dogs can learn new tricks, I have been selected to attend the Project Leadership Programme (PLP) that the NHP have co-developed with Cranfield University and the Infrastructure Projects Authority. The PLP is designed to help build the skills of project leaders and develop their capabilities, providing demonstrable improvements in the way that projects are led across the public service.

Business Cases and Project Plan

Key activities and milestones:

- **The submission and conclusion of our application for outline planning consent**. Submission of our application remains on track and we hope to secure a positive determination by the close of the summer.
- **The translation of our co-produced clinical model and its associated schedule of accommodation into a relatively detailed 1:200 outline design**. This 'phase 4' co-production is underway and remains scheduled to complete July 2022
- **Identification of benefits associated with operating a new hospital**. Work on these benefits has commenced and we expect a co-produced outcome by June 2022
- **Identification of the wider strategic changes necessary to address ever increasing demand.** Following the execution of a highly positive workshop with our ICS partners, work is underway to create a system wide view of capacity and demand. This activity will be used to derive the actions to underpin the sustainability of our health and care system. This work will run in parallel to the development of our outline business case and will underpin the demand assumptions contained within.
- **Creation of the 'Management Case'.** This work, aimed at establishing the plan and controls for the realisation of our project and its benefits is just starting and will be complete by 23rd September 2022
- **Completion and submission of an outline business case.** All of the work above will culminate in the creation and submission of a full outline business case which we expect to complete by the end of the calendar year.

All dates remain unchanged from my last report, although risks associated with securing a successful outcome to our outline planning application have slightly increased (see below).

The co-production workshops have been extremely well attended and positive. The sense of excitement is increasing as we get closer to an outline planning application and as the detail of our designs starts to make the project 'come to life'.

On 25th January we hosted a highly positive workshop with ICS colleagues aimed at sharing and discussing the outcomes and implications of the Future System demand and capacity modelling. The result is a tangible, pan-system action plan that will ensure alignment and unite teams behind the common challenge of arresting the otherwise perpetual, and ultimately unaffordable, growth in demand. The independent modelling of ESNFT demand and capacity will provide a constructive challenge to our own conclusions and I feel that this collaboration provides an excellent example of how the project to build a new hospital is creating fresh impetus to collaborate on long standing issues (just as we hoped it would when we named our project the Future System).

Craig Black and I were invited to attend a workshop with the New Hospitals Programme Leadership Team to receive and discuss an update on their progress towards building and implementing a standardised, programmatic approach to the development of the 40 (48[1]) "new hospitals".
It was explained that the New Hospital Programme is made of up of different cohorts on the basis of an assessment of individual scheme readiness and opportunity to realise benefits of a programme approach. This enables NHP to reach the right balance of ensuring projects reflect government commitments such as Net Carbon Zero and digitalisation, while not unduly delaying schemes. The NHP portfolio of projects are all at different levels of maturity and there is limited opportunity to influence projects already at a mature state. NHP's collaborative approach must therefore exercise different levels of influence for different projects. Our project has been categorised as "Cohort 4 – Full Adopter."

[1] In addition to the 40 hospital projects already announced, the Government is assessing applications for an additional 8 schemes – one of which is Queen Elizabeth Hospital Kings Lynn.

In one sense, this categorisation represents a risk of delay as funding and support within this cohort could become highly focussed to allow time for NHP to develop their designs, in another it represents an opportunity for our project to move quickly through the gears as we benefit from the lessons and conclusions drawn from previous cohorts.

That said, I believe that our project is at a uniquely advanced level of maturity and that the risks associated with our existing infrastructure provide us with the strongest possible justification for prompt and unfettered progress. These points were at the centre of the message presented to the NHP leadership team when they visited Hardwick Manor on 11th February. This meeting provided the Team with the perfect opportunity to demonstrate how the co-production of our clinical design, the acquisition of our preferred site, our extensive environmental impact analysis and the system-wide approach to managing demand have conspired to create an "oven ready" project that can play a valuable role of a "pathfinder". Feedback on the day was highly positive and evidence of the extent to which our message was accepted will be provided in the coming weeks as we negotiate funding for the 2022/23 financial year.

Estates Workstream

The main thrust of the Estates workstream continues to be the preparation of essential documentation for our outline planning application and the completion of our Environmental Impact Analysis. As well as negotiating potential remedies for disruptions to the bio diversity of Hardwick Manor and identifying opportunities for our project to promote cycle and pedestrian access, there remain three key issues that need to be resolved before our application can be validated:

Fungi surveys – In order to protect any rare fungi on site, we are required to thoroughly survey the developable area and ensure we have sensitively moved any specimens to safe locations. This work has been completed, however, there is an ongoing discussion as to whether; a single survey is sufficient, whether we can progress our application and carry out supplementary surveys before we build or whether we have to conduct supplementary surveys prior to our application progressing. Our team are preparing the documentation to support the validation of our application and we expect a decision in time for our submission.

Flood modelling – Our technical team have completed the statutory flood modelling and await formal acceptance of our plans to address the risks. Given the time needed to document these plans we have commenced the work while we await approval. If the approval calls for changes to our solution, we could face a delay to submission as we document the requested changes.

Sequential Test – Given the flood risk, we have to provide documentation that clearly shows Hardwick Manor as the only viable site for our proposed development. This work has been completed and submitted and we await a response. There is a risk that our planning officer rejects our assertions and is therefore unable to validate our application.

All three risks are expected to crystallise by in March and may be known in time for this Board meeting.

Clinical / Digital Workstream

The Clinical and Digital Workstreams are continuing to work towards understanding the impact of demand growth on the capacity that we need to provide and how we might work, across the system, to mitigate this impact.

This work, and its implications, have been debated with colleagues across the ICS and work is now underway to determine how we collectively ensure our system of health and care, including a new West Suffolk Hospital remains sustainable.

Alongside its work with the ICS, the clinical team are also conducting the next round of co-production workshops aimed at refining the designs of each department to a level of detail (1:200) required by the outline business case. In practice this level of detail extends to include the layout of each department and how they relate to each other (i.e. their adjacencies). Staff engagement is very high and this

process of co-production can be seen to have taken us to a broadly agreed set of designs in a very short space of time.

In the coming period we intend to share and test our modelling with the national team whilst continuing to develop a system wide approach to addressing the issues. In parallel we will continue to develop the future community model, contribute to the assessment of the opportunity to move outpatient and community services to Western Way and progress the trial of providing Denosumab injections at GP surgeries.

Communications and Engagement

As mentioned in the last Board update the second phase of the pre-application planning engagement has concluded. 908 feedback forms have now been analysed and have presented the following results;

Question 1 – Do you feel that you have had suitable opportunities to view and comment on our proposals as they have progressed? Yes - 88% No – 8% No answer – 4%

Question 2 – We've set out our proposed plans ahead of an outline planning application being submitted. Is there anything that still concerns you? Yes - 31% No – 64% No answer – 5%

Question 3 – Having viewed our indicative proposals and the potential location on the Hardwick Manor site, would you support our planning application for a new West Suffolk Hospital? Yes - 88% No – 7% No answer – 5%

Key themes highlighted from the feedback were;

Parking

• The issue of parking was once again a key theme for residents.
• They were particularly keen to understand more about the parking provision onsite.
• This included questions about the exact number of spaces proposed, as well as the layout of the car park.
• Some also raised the issue of disabled parking and whether or not there would be charges for those parking onsite.

Public transport

• A number of residents raised concerns about how the new hospital would link in with the existing public transport network.
• There was a desire for the new site to be well served by buses for longer hours in order that it was easily accessible for those who do not, or cannot, drive.
• Once discussions have been held with the bus companies, any update on this should be communicated at the same time as the parking update and included in the SCI.

Access

• In addition to questions about parking and public transport, many respondents raised questions and concerns about the access to the new hospital.
• Some indicated concerns about the safety of the proposed access, whilst others felt that it would be subject to major congestion.
• Some of the concerns tied into the comments on public transport, specifically on how residents who do not drive would access the site.
• Overall, access is a minor point as the comments are closely linked to parking and public transport rather than access in the traditional sense of the word.

Height

• A number of questions were raised during the online webinars or at the in-person events about the proposed building height and how many storeys this would mean.
• However, only four feedback responses include comments or questions about the possible height of the building. These range from “Yes. Good to look at up to 6 storeys to "future proof” through to “The outline of the building will cast light pollution in a rural setting to the south of the property”.
• The other comments which mention height is around the potential multi-storey car park which residents on the whole would like to see move forward. No negative comments in relation to this were identified.
These concerns will be addressed within our detailed outline planning application and as we progress the development of our plans.

In addition to the public pre-planning engagement, the Communications team have been leading a phase of public and patient co-production aimed at understanding the patient perspective of their journey through the hospital and the extent to which they value each of its facilities. The process has been carefully designed to maximise inclusivity and has included 22 workshops (2 per hospital speciality – one held in the evening, one in the day time) and a barrage of communications through traditional and social media channels (including personal text messages sent to 500 patients of each hospital-based speciality). To date we have had 60 workshop attendees and 200 responses to our surveys. The information supplied provides invaluable insight that compliments the views provided by our staff.

Finance

In an attempt to replace the irreplaceable, I am delighted to confirm the successful recruitment of Adrian Brooke as our new Finance Lead, replacing Zoe Selmes who leaves at the end of March. Adrian is an experienced finance manager who joins us from the Norfolk and Norwich NHS FT and benefits from having worked with Zoe in the past. Zoe and Adrian will be working together to ensure an effective handover, please join me in welcoming him to the team.

Having secured funding for our activities to the end of financial year, we are about to commence negotiations for the next round of funding aimed at supporting the conclusion of our planning application, the co-production of our 1:200 designs, the development of our economic case and, ultimately, the completion of our Outline Business Case. As mentioned above there is a real risk that funding could be constrained and limited to covering those tasks that are exclusively related to the specifics of our site, for example, we would be funded to complete our outline planning application, but would not be funded to produce detailed designs or commercial models for which NHP intend to produce central templates and frameworks.

All in all, this has been a period in which significant progress has been made in the development of our clinical design and the negotiation of our outline planning application. That said, the next period should see the culmination of several key activities:

1) We will understand whether we have a validated planning application that is recommended for approval by the Local Planning Authority.
2) We will have a clear indication of the extent to which the NHP are prepared to support our current trajectory.
3) We could have confirmation that the business case for the entire NHP has been signed off by HM Treasury.
4) We should have a clear understanding of what services could move to Western Way and a conclusion as to whether this represents a service change requiring formal public consultation.
5) We should have a view of NHPs approach to demand and capacity modelling (and, therefore, the impact that it has upon our own designs).

Exciting times!!!

Action Required of the Board
To note the contents of this report.

Risk and assurance:	-
Equality, Diversity and Inclusion:	-
Sustainability:	-
Legal and regulatory context	-

Comfort Break

4. ASSURANCE

4.1. Insight Committee Report - February & March 2022 - Chair's Key Issues from the meeting

To Assure

Presented by Richard Davies

Chair's Key Issues

Originating Committee	Insight Committee	Date of Meeting	7th February 2022
Chaired by	Richard Davies	Lead Executive Director	Nicola Cottington

Item	Details of Issue	For: Approval/ Escalation/Assurance	BAF/ Risk Register ref	Paper attached? ✓
Business Case Process and Templates	Allen Petchey (Senior Contracts Manager) presented the work that he and colleagues have done on the development of a new Business Case Process. This was felt to be excellent but there was a useful discussion around some key issues and potential refinements: • The process needs to be explicitly linked to the Trust strategy • The process and templates need to ensure that all key elements of the Business Case are addressed (including importantly the potential knock -on effect on other teams within the Trust), whilst also remaining user friendly for individuals who may have little experience of the process • Teams and individuals need to be appropriately supported in developing business cases to ensure maximum efficiency of the process and effectiveness of the case, taking into account a variety of viewpoints and stakeholder engagement Further work will be undertaken following a full discussion and a final version will be presented to Insight for ratification	**Information**		
Finance and Workforce Governance Group	The key financial issue at present is the development of a sustainability programme (previously called CIP). Funding uncertainties make this difficult but the Senior Leadership Group are imminently discussing this prior to presentation at the next Board	**Partial Assurance**	**BAF 5**	
Patient Access Governance Group 1	Emerging concern regarding MRI performance (from 96.21% in November to 70.12% compliance in December) as a result of staffing issues (including Covid sickness). Options are being explored including the possible use of mobile scanners. However options are limited at present and issue will need to remain under review	**Partial Assurance**	**BAF 3**	

Patient Access Governance Group 2	Community Access Standards • SLT – capacity and Covid issues. This is an ongoing problem affecting blocks of therapy rather than initial assessments, and remains a focus for improvement • Initial health assessments for children in care – significant drop in performance in December (28.57% against target of 95%)– largely due to a doubling in referral rate in December which should be a one-off. Figures should improve quickly	**Partial Assurance**	**BAF 3**	
Patient Access Governance Group 3	Ongoing concerns: • 104 week waits • Cancer performance – particularly some 2ww pathways (especially breast and colorectal) • Diagnostic performance – particularly non-obstetric ultrasound and endoscopy The causes are understood and there are plans in place for recovery, which will be monitored against clear trajectories. Some of the December figures will have been impacted by reduced service over Christmas as well as Covid issues. However, it should be noted that the issues are complex and solutions are not simple. On a positive note: • Skin continues to perform much better following the introduction of an AI pathway (> 80% in December) • There has been some early progress in a system wide 'mutual aid' process with ESNEFT taking 25 WSFT long wait orthopaedic cases	**Partial Assurance**	**BAF 3**	
Patient Quality and Safety Governance Group 1	Duty of Candour T&F group has identified that staff feeling unskilled in relation to DoC conversations is an important barrier to meeting DoC standards. An education programme has been developed in response	**Partial Assurance**		
Patient Quality and	Hospital Transfusion	**Partial Assurance**		

Safety Governance Group 2	Closed Loop blood system should have been implemented for transfusion (MHRA requirement) but current system unable to read bar code. It is not yet clear where the block is in resolving this issue, but this has been escalated as matter of priority			
IQPR	The Insight Committee discussed the role of the IQPR report which was felt to be relatively uninformative in its current format and time consuming to produce. Relevant data clearly needs to be available to the individual governance groups, and Insight needs assurance that it will have visibility of data that is a cause for concern or discussion. Various ways of presenting data were discussed, including the more effective use of SPC charts. Examples of alternative presentations of IQPR data from other Trusts were considered. It was agreed that these ideas would be worked up into a proposal to bring back to Insight. It is important to note that the proposals discussed would potentially get rid of the current IQPR document which is presented at Insight and Board. We would need to ensure that this did not impact on other stakeholders' (including Trust governors and regulators) ability to have full visibility of relevant Trust quality and performance data and that the processes for channelling data effectively through governance groups were robust.	**Information**	**BAF 1**	
Reflections on the meeting	The Insight committee is maturing into an increasingly effective Board governance committee, and the format (relying on governance sub-groups to identify and present key concerns) allows for thorough and helpful discussion of key issues. Further development in data analysis and presentation (as discussed above) is required and the communication with other 3i committees and Board needs further refinement. It was pointed out, for example, that papers written for Insight are not necessarily appropriate for Board and that linking Insight papers to the CKI document will not necessarily provide effective assurance to Board.	**Information**		
Date Completed and Forwarded to Trust Secretary		**7th February 2022**		

Chair's Key Issues

Originating Committee	Insight Committee	Date of Meeting	7th March 2022
Chaired by	Richard Davies	Lead Executive Director	Alex Baldwin (Nicola Cottington apologies)

Item	Details of Issue	For: Approval/ Escalation/Assurance	BAF/ Risk Register ref	Paper attached? ✓
Staff turnover rates	Concern regarding staff turnover rates (especially in Community, and Clinical Support services). There is ongoing work to understand this (e.g. exit interviews) but it was agreed that there needed to be further work to: • Ensure that underlying reasons for this issue are clearly understood • Consider preventative strategies to enhance staff retention This has been referred to the Involvement Committee for deeper analysis	**Escalation to Involvement Committee**	**BAF 7**	
Elective, Emergency, Cancer and Diagnostic performance	Challenges remain in relation to: • 104 week waits – position has deteriorated although there are plans in place to achieve zero patients waiting over 104 weeks by end of June 2022 • 2WW cancer performance continues to be a concern in some specialties – particularly Breast, and 62 day performance remains static (particular challenges in Urology and Colorectal) • Diagnostic performance remains static with particular concerns in Non-Obstetric Ultrasound and (increasingly) MRI • 12 hour ED waits The recognised Trust capacity issues have been exacerbated by Covid related staff absence and wider system pressures. Individual plans are in place in all challenged areas to try and improve the situation The Committee discussed: • Possibilities of increasing productivity in some areas • Opportunities for collaboration across the system • The reality that there may be no simple solutions	**Partial Assurance**	**BAF 2 and 3**	

	It was agreed that the Committee (and the Trust more generally) needs greater **transparency** and data to understand and communicate what is realistically possible and also what is not possible. Further information will be brought back to Insight for more detailed discussion			
National Audit and NICE baseline assessments	There is a significant backlog of assessments dating from as far back as 2015-18, the backlog has been exacerbated by Covid pressures on senior clinicians. Following a CD meeting it was agreed that: • Some of these Audits and Guidelines will have been superseded • Some will have little relevance to the work of WSFT • It is important to prioritise those which are most relevant and up to date CDs will review these and archive 'out of date' assessments. The Committee discussed assurance that archiving these baseline assessments would have no potential impact on future patient safety or quality of care. Each assessment will be reviewed by the relevant CD but oversight of the process will be provided through CEGG	**Assurance**	**BAF 1**	
Clinical Effectiveness Insight for specialist committees	This will also be discussed at Improvement. There is currently no standard framework to ensure that each specialist committee receives relevant insight data to inform its discussions and decisions. This links to a much wider issue about the place, use and assurance of Trust data to inform Trust decisions and governance processes. Insight Committee is reliant on specialist subgroups to analyse relevant data and escalate issues for further discussion. This frees up time to dicuss relevant issues in appropriate detail and allows specialist committees and governance groups a degree of independence. However, arguably by limiting visibility of the raw data at Insight Committee this impedes our ability to triangulate and provide full assurance to Board. How Trust data is presented, how it is triangulated and who gets to see it and provide assurance within the Trust governance structure remains a complex process in development and will appropriately form part of Board review of the new governance processes, and will include work on the IQPR and Trust Dashboard .	**Information**	**BAF 1**	
Date Completed and Forwarded to Trust Secretary		**14th March 2022**		

4.2. Finance and Workforce Report

To Note

Presented by Nick Macdonald

Board of Directors – 25 March 2022

Report Title:	Item 4.2 - Finance and Workforce Board Report – February 2022
Executive Lead:	Nick Macdonald, Executive Director of Resources (Interim)
Report Prepared by:	Charlie Davies, Deputy Director of Finance (Interim)
Previously Considered by:	N/A

For Approval	For Assurance	For Discussion	For Information
☐	☒	☒	☒

Executive Summary

The reported I&E for February is breakeven (YTD breakeven).

We previously agreed a budget for 2021-22 to deliver a deficit of £10.5m, with a Cost Improvement Programme (CIP) of 1%. However, due to the funding arrangements for 21/22 the Trust has recorded a break-even position up to Month 11. We are planning to achieve an overall breakeven position for the full financial year 21/22 however there are a number of discussions going on nationally, regionally and locally which may result in additional funding which will create a surplus.

Budget 22/23
After assessing the available guidance around activity plans, workforce plans and regulatory requirements the Trust proposes setting a budget of break-even for 2022/23. While this position does carry with it a number of risks we anticipate there being sufficient mitigations to be able to offset these risks. A key part of these mitigations is identifying opportunities to remove additional costs of COVID wherever possible and developing and delivering a robust sustainability programme.

Action Required of the Board

The Board is asked to review this report

Sustainability:	*The paper highlights a potential risk to financial performance in 22/23.*

FINANCE AND WORKFORCE REPORT
February 2022 (Month 11)

Executive Sponsor : Nick Macdonald, Director of Resources (Interim)
Author : Charlie Davies, Deputy Director of Finance (Interim)

Financial Summary

I&E Position YTD	£0m	on-plan
Variance against Plan YTD	£0m	on-plan
Movement in month against plan	£0m	on-plan
EBITDA position YTD	£14.4m	favourable
EBITDA margin YTD	5%	favourable
Cash at bank	£21.8m	

Executive Summary

- The reported I&E for February is breakeven (YTD breakeven)
- Planning for a breakeven position for the financial year 21/22.
- In-month variances in pay and income offset each other and are driven by a change in accounting policy.

Key Risks in 2021-22

- Costs and income associated with revised activity plan
- Costs associated with increased capacity pressures relating to COVID-19, RAAC planks and winter pressures
- Delivery of sustainability programme
- Funding arrangements for 2022-23

SUMMARY INCOME AND EXPENDITURE ACCOUNT - February 2022	February 2022 Budget £m	February 2022 Actual £m	February 2022 Variance F/(A) £m	Year to date Budget £m	Year to date Actual £m	Year to date Variance F/(A) £m
NHS Contract Income	22.9	26.9	4.0	264.3	267.4	3.1
Other Income	3.7	3.6	(0.1)	36.5	35.0	(1.5)
Total Income	**26.6**	**30.6**	**3.9**	**300.8**	**302.4**	**1.6**
Pay Costs	17.3	21.5	(4.2)	194.4	199.0	(4.6)
Non-pay Costs	8.2	7.8	0.3	93.4	89.0	4.4
Operating Expenditure	**25.4**	**29.3**	**(3.9)**	**287.8**	**288.0**	**(0.2)**
Contingency and Reserves	0.0	0.0	0.0	0.0	0.0	0.0
EBITDA	**1.2**	**1.3**	**0.0**	**13.0**	**14.4**	**1.3**
Depreciation	0.8	0.7	0.0	8.3	8.1	0.2
Finance costs	0.5	0.5	(0.1)	4.7	6.3	(1.6)
SURPLUS/(DEFICIT)	**(0.0)**	**(0.0)**	**0.0**	**0.0**	**0.0**	**0.0**

FINANCE AND WORKFORCE REPORT – February 2022

Contents:

Key:

Performance better than plan and improved in month	
Performance better than plan but worsened in month	
Performance worse than plan but improved in month	
Performance worse than plan and worsened in month	

Performance better than plan and maintained in month	
Performance worse than plan and maintained in month	
Performance meeting target	✓
Performance failing to meet target	✗

FINANCE AND WORKFORCE REPORT – February 2022

Income and Expenditure Summary as at February 2022

The reported I&E for February is breakeven (YTD breakeven).

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Budget 22/23

After assessing the available guidance around activity plans, workforce plans and regulatory requirements the Trust proposes setting a budget of break-even for 2022/23. While this position does carry with it a number of risks we anticipate there being sufficient mitigations to be able to offset these risks. A key part of these mitigations is identifying opportunities to remove additional costs of COVID wherever possible and developing and delivering a robust sustainability programme.

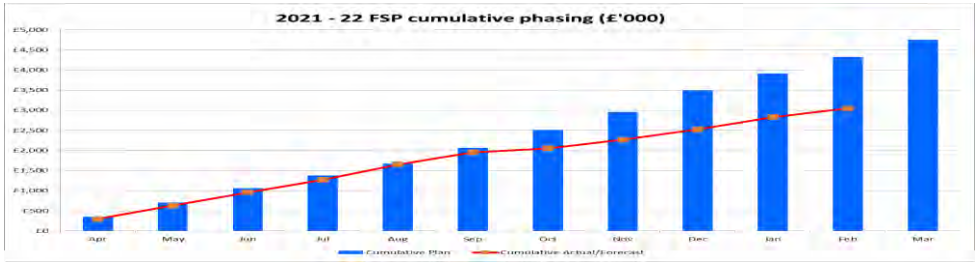
Summary of I&E indicators

Income and Expenditure	Plan/ Target £000'	Actual/ Forecast £000'	Variance to plan (adv)/ fav £000'	Direction of travel (variance)	RAG (report on red)
In month surplus/ (deficit)	(0)	(0)	0	⟺	Green
YTD surplus/ (deficit)	(0)	0	0	⟺	Green
EBITDA YTD	13,040	14,372	1,332	↑	Green
EBITDA %	4.3%	4.8%	0.4%	↑	Green
Clinical Income YTD	(278,138)	(280,426)	2,288	↑	Green
Non-Clinical Income YTD	(22,669)	(21,945)	(725)	↑	Amber
Pay YTD	194,372	199,001	(4,629)	↓	Red
Non-Pay YTD	106,444	103,381	3,063	↑	Green

Financial Sustainability Programme (FSP) 2021-22

The FSP (previously CIP) programme for 2021-22 is £4.8m. In the year to February we are forecast to achieve £3.0m (64%) against a plan of £4.32m (91 %), which is a shortfall of £1.28m.

Recurring/Non Recurring	2021-22 Annual Plan	Plan YTD	Forecast YTD
	£'000	£'000	£'000
Recurring			
Outpatients	-	-	-
Procurement	242	214	179
Activity growth	-	-	-
Additional sessions	101	101	101
Community Equipment Service	271	249	230
Drugs	51	38	38
Estates and Facilities	63	58	5
Other	394	352	329
Other Income	147	144	248
Pay controls	28	25	18
Service Review	-	-	-
Staffing Review	269	227	228
Theatre Efficiency	20	18	-
Contract Review	319	292	217
Workforce	-	-	-
Consultant staffing	-	-	48
Agency	-	-	-
Car Park income	75	69	-
Unidentified CIP	1,587	1,351	90
Recurring Total	**3,567**	**3,140**	**1,731**
Non-Recurring			
Pay controls	99	97	133
Theatre Efficiency	280	280	439
Staffing Review	-	-	-
Other	810	810	743
Estates and Facilities	-	-	-
Non-Recurring Total	**1,189**	**1,187**	**1,315**
Total FSP	**4,756**	**4,327**	**3,046**



Benchmarking Exercise

As part of SNEE wide efficiency working, a cost comparison exercise was commissioned in late 2021 to look at the difference in cost of similar services between the Trust and ESNEFT (building on a similar exercise carried out between the two ESNEFT sites). The aim of the exercise was to help inform both Trusts' Financial Sustainability Programmes through identifying any areas where the service costs at one site were significantly higher than at the other sites.

This exercise has focused upon cost and clinical activity. Service quality has not been part of this review although this may be a factor in any cost differences between the sites. To that extent, this exercise didn't seek to make any subjective judgements on whether higher costs are a reflection of greater service quality or lower productivity. The analysis does however, raise the question that if service quality is acceptable at the site with the lower service costs, could this not be replicated at the site with the higher costs?

Draft reports have been shared with ADOs summarising the findings of the analysis for each main service within the Divisions together with some commentary on the possible factors that may be causing any cost difference. The value of these initial opportunities across the Divisions are summarised in Table 1 (nb: Community data is still to be finalised).

These opportunities will then be subject to a period of validation by Divisions, understanding the performance and quality factors driving any differences. The output of this will result in agreed identified opportunities for Divisions to explore and understand with system partners.

Table 1

Division	Total opportunity identified	Areas
Clinical Support	£1.5m	Health Records, MRI, Pharmacy
Pathology	£6.0m	Haemotology/Chemistry, Microbiology, Histopathology
Womens & Children	£3.0m	Obs & Gynae Med Staff, Paeds Med Staff Midwifery non-pay
Medicine	£5.9m	A & E, Respiratory/Renal wards, Cardiac Centre, Dermatology
Surgery	£5.8m	PAU, Surgical Wards, Anaesthetics, T & O
Estates and Facilities	£1.2m	Car Parking costs, Security, Domestics
Corporate Services	£2.3m	OH, Training and Education, Trust office

FINANCE AND WORKFORCE REPORT – February 2022

Trends and Analysis

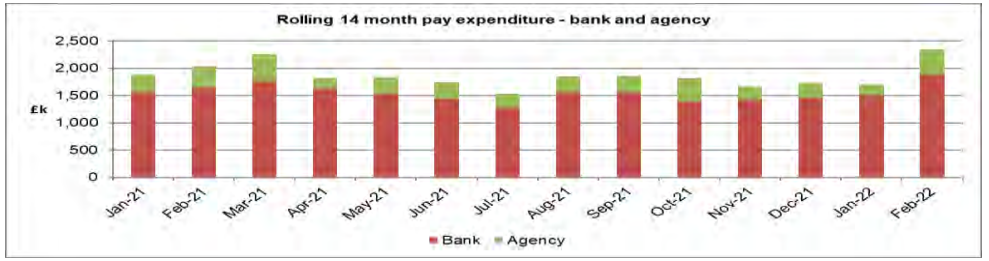
Workforce

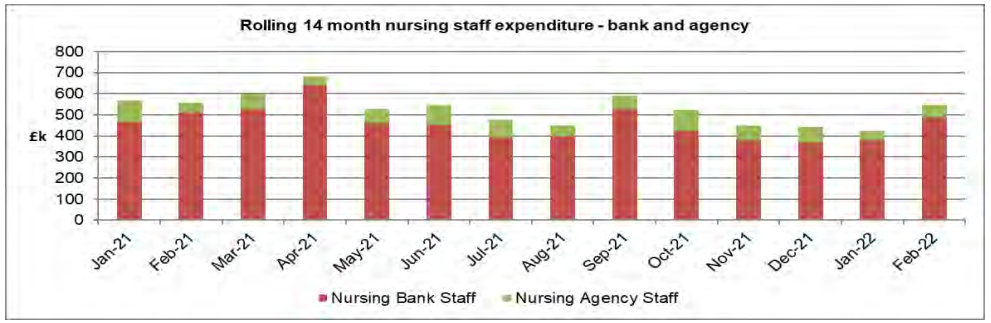
During February the Trust spent £4.2m more than budget on Pay costs (£4.6m overspent YTD).

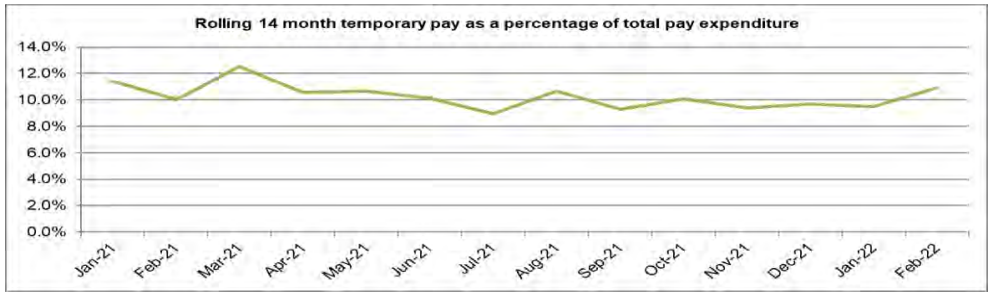
Monthly Expenditure (£)				
As at February 2022	Feb-22	Jan-22	Feb-21	YTD
	£000's	£000's	£000's	£000's
Budgeted Costs in-month	17,260	17,798	16,733	194,372
Substantive Staff	19,115	16,189	18,246	179,096
Medical Agency Staff	142	47	170	1,357
Medical Locum Staff	375	322	396	3,208
Additional Medical Sessions	249	298	114	3,068
Nursing Agency Staff	61	44	49	751
Nursing Bank Staff	485	378	509	4,902
Other Agency Staff	251	111	170	1,164
Other Bank Staff	384	228	294	2,506
Overtime	201	150	215	1,447
On Call	192	125	118	1,502
Total Temporary Expenditure	2,340	1,703	2,035	19,905
Total Expenditure on Pay	21,455	17,893	20,282	199,001
Variance (F/(A))	(4,195)	(95)	(3,549)	(4,629)
Temp. Staff Costs as % of Total Pay	10.9%	9.5%	10.0%	10.0%
memo: Total Agency Spend in-month	454	201	389	3,271

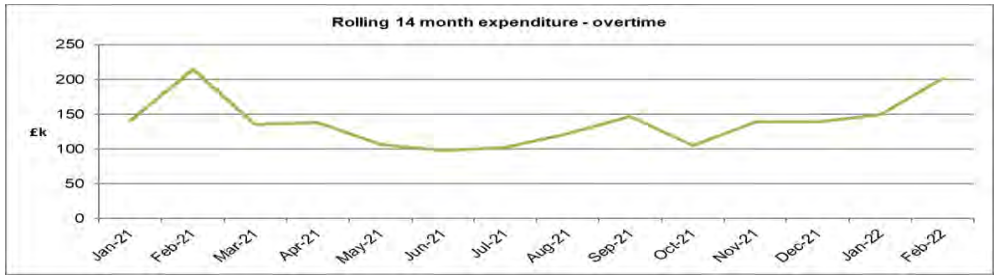
Monthly WTE				
As at February 2022	Feb-22	Jan-22	Feb-21	YTD
	£000's	£000's	£000's	£000's
Budgeted WTE in-month	4,551.5	4,534.3	4,229.4	51,973.8
Substantive Staff	4,176.3	4,053.6	4,004.4	44,700.1
Medical Agency Staff	10.1	4.4	11.2	75.0
Medical Locum Staff	29.9	29.3	34.9	297.0
Additional Medical Sessions	7.2	12.0	2.7	74.2
Nursing Agency Staff	9.5	7.3	10.1	112.6
Nursing Bank Staff	122.6	107.5	147.4	1,355.0
Other Agency Staff	26.7	11.2	29.8	167.8
Other Bank Staff	71.4	71.3	108.0	863.7
Overtime	44.8	38.5	56.9	362.7
On Call	8.4	6.3	9.8	83.6
Total Temporary WTE	330.5	287.8	410.7	3,391.4
Total WTE	4,506.7	4,341.4	4,415.1	48,091.5
Variance (F/(A))	44.8	192.9	(185.7)	3,882.3
Temp. Staff WTE as % of Total WTE	7.3%	6.6%	9.3%	7.1%
memo: Total Agency WTE in-month	46.3	22.9	51.1	355.3

Pay Costs









FINANCE AND WORKFORCE REPORT – February 2022

Income and Expenditure Summary by Division

Position by Income, Pay and Non Pay	Income		Pay		Non Pay		Capital Charges and Financing Costs		Total	
Division ▲	In-Month Variance £	YTD Variance £	In-Month Variance £	YTD Variance £	In-Month Variance £	YTD Variance £	In-Month Variance £	YTD Variance £	In-Month Variance £	YTD Variance £
Medicine	-1,692K	-3,477K	-146K	-1,709K	-101K	-1,056K			-1,939K	-6,241K
Surgery	-921K	-6,176K	-129K	659K	64K	154K			-986K	-5,363K
Women & Children	626K	409K	-101K	-193K	-493K	-1,861K			32K	-1,645K
Clinical Support	-261K	-955K	-150K	-630K	-223K	-2,566K			-634K	-4,150K
Community Services	-2K	298K	-202K	-800K	-78K	-909K	0K	2K	-281K	-1,409K
Estates and Facilities	-262K	-2,103K	-57K	-783K	-77K	-1,066K	0K	13K	-396K	-3,939K
Corporate	6,431K	13,566K	-3,410K	-1,173K	1,220K	11,702K	-36K	-1,346K	4,204K	22,749K
Trust	**3,918K**	**1,564K**	**-4,195K**	**-4,629K**	**313K**	**4,398K**	**-36K**	**-1,331K**	**0K**	**1K**

Medicine (Sarah Watson)

The Medicine division is behind plan by £1.94m in month and by £6.24m YTD.

Clinical income is behind plan by £1.66m in month and by £3.26m YTD. Non-elective activity has outperformed planned levels by 6% in month, and the 2yr average by 3% driven by A & E attendances. However, as a result of non-elective admitted patient care being lower than planned, total non-elective activity was 5% below the 19/20 average.

Outpatient attendance and procedure levels meant that outpatient activity was 8% below planned levels for February and 10% below the 19/20 average. Elective activity was 20% below planned levels for February and 17% below the 19/20 average, primarily due to admitted patient care day case numbers.

Excluding clinical income, the division is behind plan in month by £275k and £2.98m YTD. Non-pay costs are £101k over budget in month, which is due to a £103k pressure for non-pay CIPs, a phasing difference between CIP achievement and budget impact.

Pay costs account for £146k and £1.71m of the overall overspend (in month and YTD respectively). The monthly variance is driven by overspends on Unregistered Nursing (£41k), Consultants (£41k) and ED Registrars (£33k). These pressures were then partly offset by a £76k under spend on Registered Nursing across the Division. Significant YTD pay costs include:

- ED Registrars (£702k) and a further £377k pressure for Speciality Registrars in Stroke, Dermatology and across the division.
- Unregistered Nursing (£475k) – primarily relates to spend on band 2 bank and band 3 rotation nursing staff.
- Junior Doctors (£406k) – due to a combination of spend on F2s and locums.
- Consultants (£354k) – primarily due to spend on additional sessions and agency staff.
- Registered nursing overtime (£260k).

The above pressures have been partly offset by a £1.32m under spend on Registered Nursing across the Division.

Surgery (Sally Payne)
In February the division reported an adverse variance of £986k (£5.36m YTD).

Clinical income was behind plan by £884k in month and £6.02m YTD. Elective activity levels were consistent with January remaining 14% behind plan in month. Similarly, Outpatient activity was behind plan by 9% in month (mainly driven by shortfalls in Urology, Breast Surgery and Orthopaedics.

Inpatient activity continues to improve (16% increase month on month) with the increase in weekend lists and use of independent providers and non-elective activity in February exceeded plan by 8.29%, with the division seeing increases within Orthopaedic emergency long stays compared to previous month. During the month, the division's emergency bed capacity was reduced due to COVID contacts in turn increasing the pressure upon the rest of the bed capacity.

Excluding clinical income, the division was behind plan in month by £102k and ahead of plan by £659k YTD. Pay expenditure reported an overspend of £129k in month (underspend of £659k YTD) with the main drivers being increases in medical additional sessions and locums to support sickness and vacancies within the division. Some of this overspend has been offset by nursing vacancies.

Non-pay expenditure reported an underspend of £64k in month (£154k YTD) as activity continues to be reduced with the ongoing RAAC works.

Women and Children's (Simon Taylor)
In February, the Division reported a favourable variance of £32k and an adverse variance of £1.65m YTD.

The in-month variance for both Income (£626k positive) and non-pay (£493k) are driven by the in-month recognition Ockenden Funding (income) and ESNEFTs share of this funding (non-pay).

Elective, non-elective and outpatient activity were all behind plan in-month. Year to date, both Gynaecology and Paediatrics are behind plan (10% and 14% respectively) whilst both Obstetrics and neonatology are ahead of plan (7% & 46% respectively).

Pay reported a £101k overspend in-month and a £193k overspend YTD. Drivers include additional staff in the Paediatric Ward to provide additional COVID capacity, increased Paediatric medical staffing spend to covering the service and use of additional sessions and locums in Women's Services. A large number of unfilled midwife posts have offset cost pressures in FY 21/22 however a number of these posts have now been appointed to.

Clinical Support (Simon Taylor)
In February, the Division reported an adverse variance of £634k and an adverse variance of £4.15m YTD.

Income was £261k behind plan in-month (£955k YTD). In-month, the Radiology Service was behind plan for outpatient, breast screening and direct access activity. Year to date, Imaging is behind plan by 19% and interventional radiology is behind plan by 71%. The first of two business cases to provide more radiology capacity has been approved, helping to address the capacity issues that the department currently experiences.

Pay is overspent by £150k in-month (£630k YTD) driven by additional payments to address the backlog in Diagnostics and Pathology. Similarly, the YTD position is driven by overspends in Diagnostics (medical and non-medical pay to address the current backlog demand) and Pathology (providing the SAMBA testing service).

Non-pay reported a £223k overspend in-month (£2.57m YTD). In-month, Radiology continued to overspend on recovery measures for CT and endoscopy whilst Pathology overspent on blood products and blood tests. Year to date, the overspend has been driven by recovery related pressures in the radiology, pathology and outpatient budgets.

Community Services (Clement Mawoyo)
In February, the Division reported an adverse variance of £281k (YTD £1.41m).

Income reported £2k below plan in February (YTD £298k above plan) with YTD position driven by additional funding received from Aging Well and hospital discharge funding, covering additional pay costs already incurred by the Division.

Pay reported an adverse variance of £202k in month (YTD £800k). Agency staff were used to cover some vacant Therapy roles in Adult Physiotherapy, Occupational Therapy and Dietetics. Moreover, additional agency capacity has been allocated to the Early Intervention (EIT) and the Support to Go Home (Responsive Services) teams to provide additional capacity. Income will be allocated in M12 to offset this cost pressure
Non-pay reported an adverse variance of £78k in month (YTD £909k). The in-month adverse variance was due to:

- additional community equipment costs, incurred to enable timely hospital discharges. There continues to be demand for increase in faster response speeds; emergency, 4 hour and same day deliveries to support in response to acute capacity constraints, compared to prior year.
- A stepped increase in activity in Community Health Teams, notably nursing and therapy patient face to face contacts; higher than pre-Covid levels and resulting in non-pay expenditure increasing on dressings and consumables, as well as non-recurrent additional cost to support the transfer of services from Haverhill Health Centre and other smaller cost pressures.

Estates and Facilities

In February, the division recorded an adverse variance of £396k (£3.94m YTD).

Income is behind plan by £262k in month (£2.1m YTD). This is driven by car park and restaurant income being significantly affected by Covid-19, currently running at 35% of pre-pandemic levels (FY2019/20 to P11).

Non-pay costs are overspent in month by £77k (£1.0m YTD). During the period the Trust benefited from credit notes for Gas and VAT reclaims on Laundry helped to offset unanticipated variances across Estate Management in-month.

Pay costs for the month exceed budget by £57k (£783k YTD), a result of the higher than anticipated use of bank staff across Portering (22k), Domestic Staff (£19k) and Telephone service (£11k).

Corporate

Corporate areas have recorded an underspend in month of £4.20m (£22.7m YTD). This variance is largely a result of the unanticipated (at the time of budget setting) central funding received in the year supporting the Trust to:

- deliver services through the COVID 19 pandemic
- increase our elective and outpatient activity back to pre-pandemic levels.

The in-month variance (£3.41m) in pay costs is a result of a change in accounting policy regarding certain IT costs, with a corresponding adjustment in income to offset the impact of this.

Statement of Financial Position at 28 February 2022

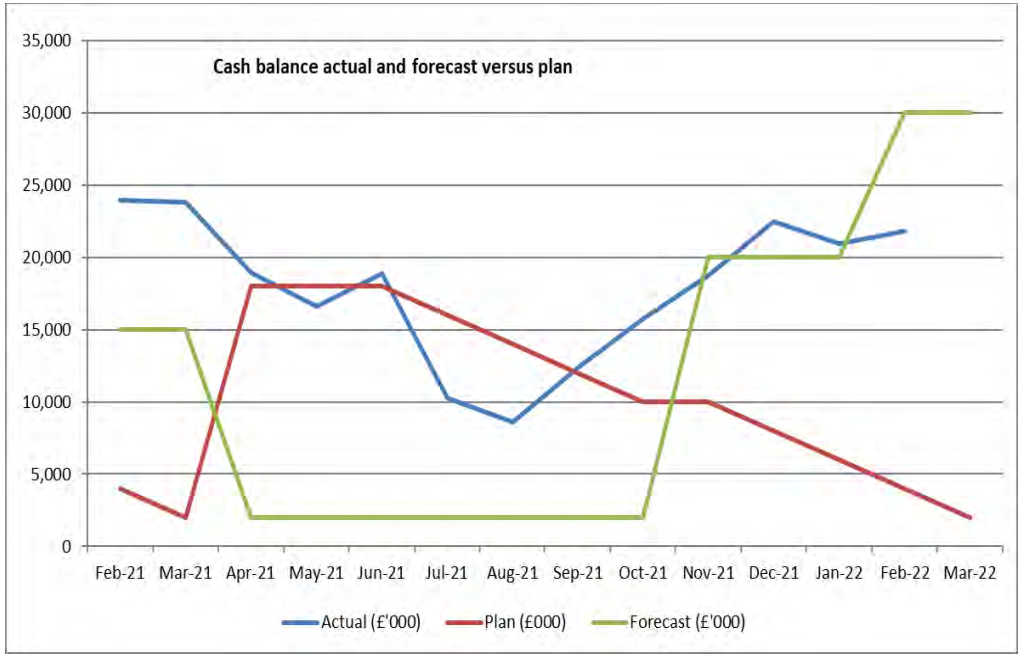
STATEMENT OF FINANCIAL POSITION

	As at 1 April 2021	Plan 31 March 2022	Plan YTD 28 February 2022	Actual at 28 February 2022	Variance YTD 28 February 2022
	£000	£000	£000	£000	£000
Intangible assets	52,198	54,398	54,198	60,517	6,319
Property, plant and equipment	137,103	168,603	165,603	159,605	(5,998)
Trade and other receivables	6,341	6,341	6,341	6,341	0
Total non-current assets	**195,642**	**229,342**	**226,142**	**226,463**	**321**
Inventories	3,481	3,481	3,481	3,940	459
Trade and other receivables	19,362	19,362	19,362	21,782	2,420
Cash and cash equivalents	23,788	2,006	4,006	21,835	17,829
Total current assets	**46,631**	**24,849**	**26,849**	**47,557**	**20,708**
Trade and other payables	(52,522)	(37,779)	(39,079)	(44,390)	(5,311)
Borrowing repayable within 1 year	(6,439)	(5,500)	(5,500)	(8,852)	(3,352)
Current Provisions	(46)	(46)	(46)	(46)	0
Other liabilities	(1,357)	(3,357)	(3,357)	(17,369)	(14,012)
Total current liabilities	**(60,364)**	**(46,682)**	**(47,982)**	**(70,657)**	**(22,675)**
Total assets less current liabilities	**181,909**	**207,509**	**205,009**	**203,363**	**(1,646)**
Borrowings	(47,719)	(43,319)	(43,819)	(43,096)	723
Provisions	(852)	(852)	(852)	(852)	0
Total non-current liabilities	**(48,571)**	**(44,171)**	**(44,671)**	**(43,948)**	**723**
Total assets employed	**133,338**	**163,338**	**160,338**	**159,415**	**(923)**
Financed by					
Public dividend capital	158,650	188,650	185,650	184,727	(923)
Revaluation reserve	8,743	8,743	8,743	8,743	0
Income and expenditure reserve	(34,055)	(34,055)	(34,055)	(34,055)	0
Total taxpayers' and others' equity	**133,338**	**163,338**	**160,338**	**159,415**	**(923)**

There has been little movement in the balance sheet against plan and the year-end position and the balances continue to be in line with expectations. The movement in cash and deferred income is noted below.

Cash Balance Forecast for the year

The graph illustrates the cash trajectory since February 2021. The Trust is required to keep a minimum balance of £1m.



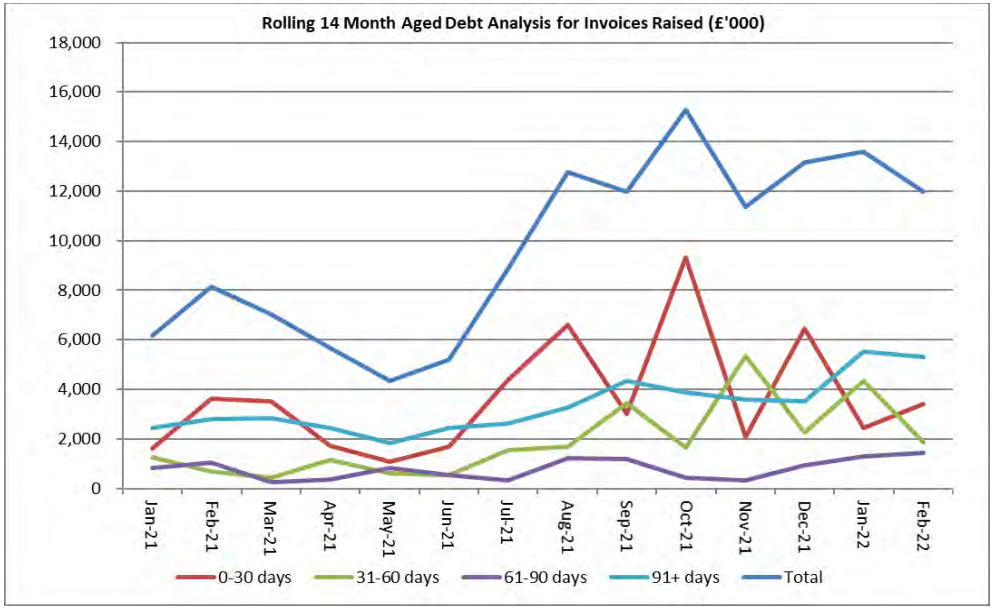
The Trust's cash position is currently being rigorously monitored during 2021/22 and we continually need to ensure that the timing of the capital payments is line with capital cash funding due to be received. The cash position is more favourable than expected and the forecast has been revisited. This is due to the fact that we have received income in advance from the CCG, which is being shown in deferred income. We are also expecting to receive additional PDC for capital funding rather than having to use cash reserves.

Cash flow forecasts continue to be submitted to NHS England every fortnight to ensure that adequate cash reserves are being held within the NHS.

FINANCE AND WORKFORCE REPORT – February 2022

Debt Management

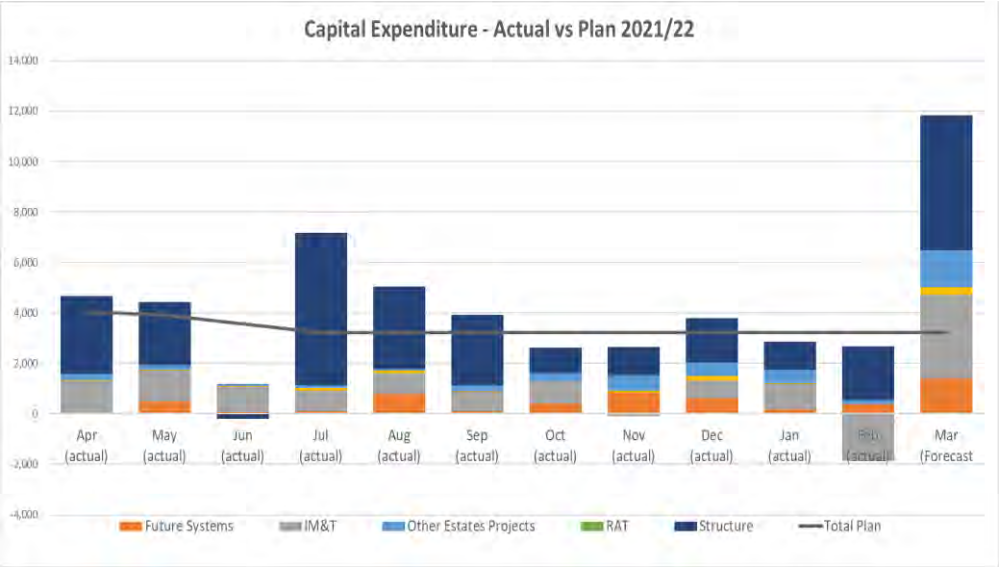
The graph below shows the level of invoiced debt based on age of debt.



It is important that the Trust raises invoices promptly for money owed and that the cash is collected as quickly as possible to minimise the amount of money the Trust needs to borrow.

The overall level of sales invoices raised but not paid continues to remain stable. The large majority of the debts outstanding are historic debts, although these are reducing. Over 83% of these outstanding debts relate to NHS Organisations, with 47% of these NHS debts being greater than 90 days old. We are actively trying to agree a position with the remaining corresponding NHS Organisations for these historic debtor balances and a significant amount of work has been completed in this area to help reduce these historic balances.

Capital Progress Report



	Apr Actual £'000	May Actual £'000	Jun Actual £'000	Jul Actual £'000	Aug Actual £'000	Sep Actual £'000	Oct Actual £'000	Nov Actual £'000	Dec Actual £'000	Jan Actual £'000	Feb Actual £'000	Mar Forecast £'000	Total 2021-22 £'000
Future Systems	10	492	63	82	780	80	415	850	636	172	372	1,394	5,346
IM&T	1,316	1,219	1,016	825	835	796	863	-87	681	1,011	-1,885	3,333	9,923
Medical Equipment	14	25	16	118	102	16	23	56	197	40	17	296	920
Other Estates Projects	254	191	101	101	42	225	312	634	523	529	166	1,450	4,528
Structure	3,088	2,507	-201	6,062	3,281	2,802	1,003	1,102	1,762	1,119	2,120	5,356	30,001
Total / Forecast	4,682	4,434	995	7,188	5,040	3,919	2,616	2,555	3,799	2,871	790	11,829	50,718
Total Plan	4,038	3,915	3,561	3,216	3,216	3,216	3,216	3,218	3,218	3,218	3,218	3,229	40,479

The plan figures shown in the table and graph match the plan submitted to NHSI. The 2021/22 Capital Programme has been set at £40.5m with £30m of this relating to structure works. The spend to date is £38.9m.

The forecast has been revisited due to the Trust being awarded additional capital funding for other projects. The Trust is now on track to achieve the capital allocation with no overspend, and to spend the additional funding that has been awarded, by the end of March 2022. An adjustment was made to IT staff costs, which are more appropriate to be shown within revenue than capital. This resulted in negative spend for IT in February.

4.3. IQPR - January 2022 data

To Note

Presented by Susan Wilkinson and Nicola Cottington

Trust Board Report - 25 March, 2022

Agenda Item:	Item 4.3 - IQPR			
Presented By:	Nicola Cottington & Sue Wilkinson			
Prepared By:	Information Team			
Date Prepared:	Jan-22			
Subject:	Performance Report			
Purpose:	**X**	**For Information**		**For Approval**

Executive Summary:

The Board is asked to note the following exceptions in relation to performance:

There were 384 patents waiting over 104 weeks for an elective procedure at the end of January 2022, caused by the reduction in capacity due to Covid, RAAC programme, and non elective pressures. Recovery plans are in place including weekend lists, use of the independent sector and mutual aid across the ICS. WSFT are predicting to have 246 patients waiting over 104 weeks at the end of March 2022 and zero by the end of June 2022. The is monitored at Patient Access Governance Group, Insight Committee and Board, and also at ICS level weekly hub meetings and the SNEE Recovery and Restoration Board.

Deterioration in Breast symptomatic two week wait pathways is observed due to higher than planned numbers of referrals. Additional equipment is being purchased to enable an additional weekly clinic. Performance against improvement trajectory is monitored at weekly Cancer PTL meetings, Cancer Board, Insight Committee and ICS Cancer Board.

There is a trend of increased demand on emergency department services. It is difficult to determine the specific cause of this, but access to other services and changing Covid activity could be contributing factors. A range of actions are planned including to continue to review front door/streaming model. Performance will be monitored though the Patient Access Insight Governance Group and in the future through a new WSFT UEC steering group.

Covid datix and Perfect ward Charts have been removed and that they will be presented within other board reports from the Chief Nurse.

Trust Priorities [Please indicate Trust priorities relevant to the subject of the report]	**Delivery for Today**	**Invest in Quality, Staff and Clinical Leadership**	**Build a Joined-up Future**
	X		

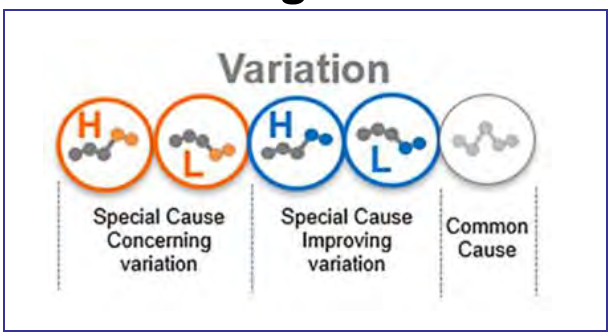
Trust Ambitions [Please indicate ambitions relevant to the subject of the report]	Deliver personal care	Deliver safe care	Deliver joined-up care	Support a healthy start	Support a healthy life	Support ageing well	Support all our staff
		X	**X**				**X**

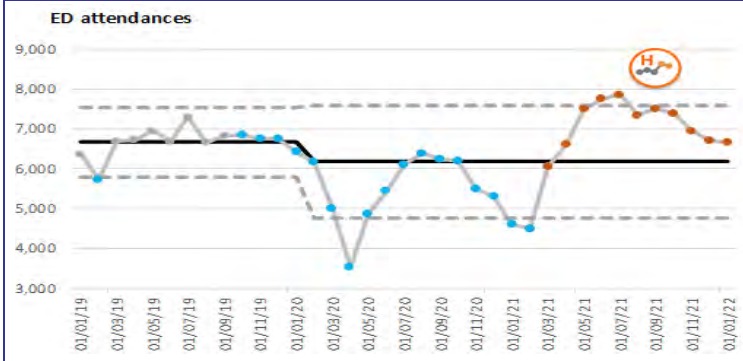
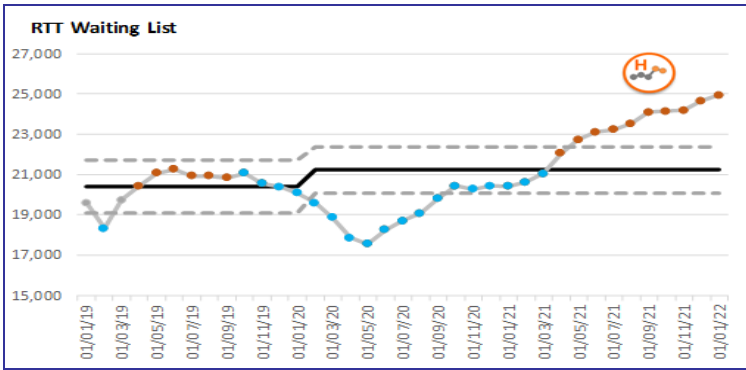
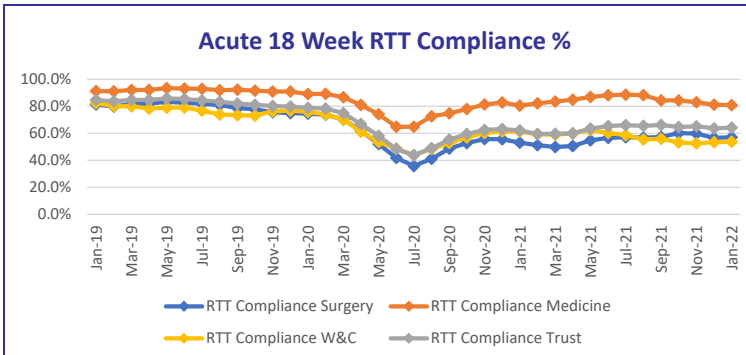
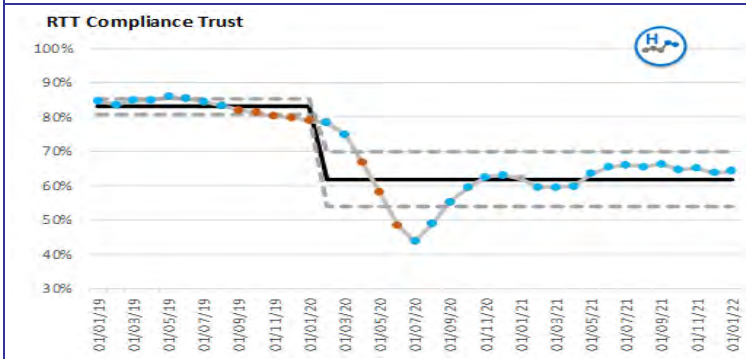
Previously Considered by:	
Risk and Assurance:	
Legislation, Regulatory, Equality, Diversity and Dignity Implications	

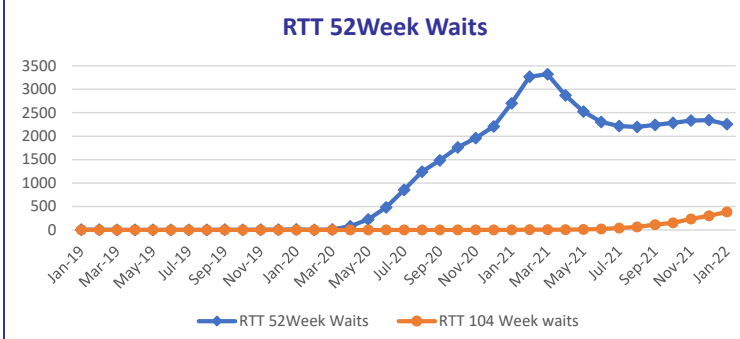
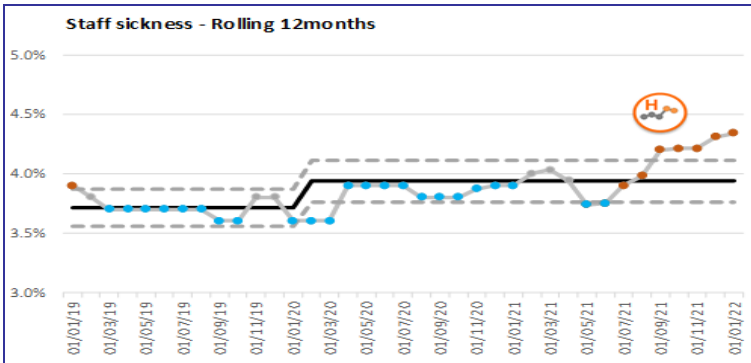
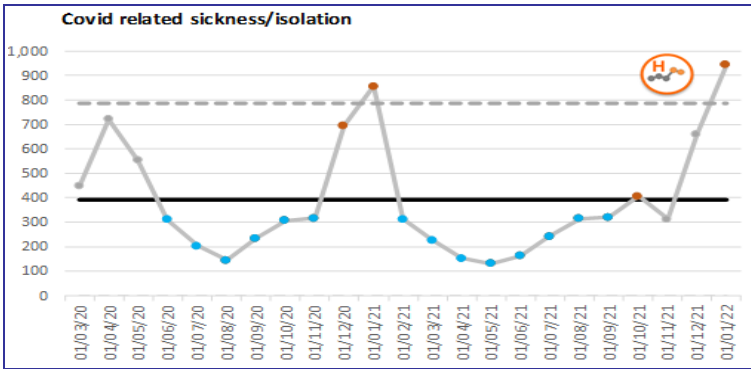
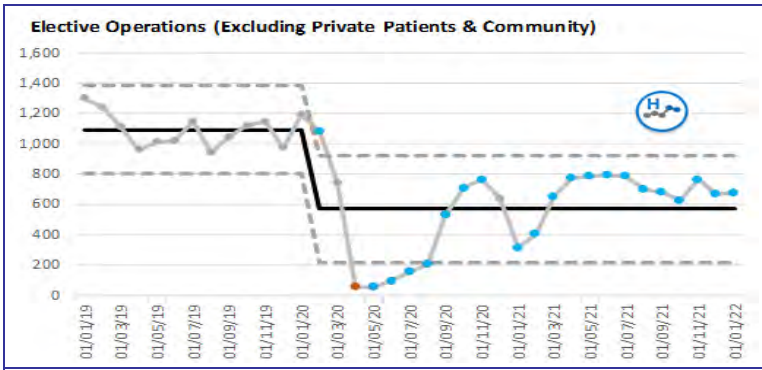
Recommendation:

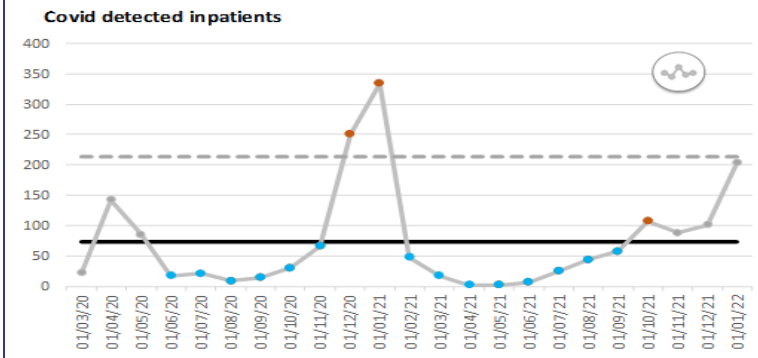
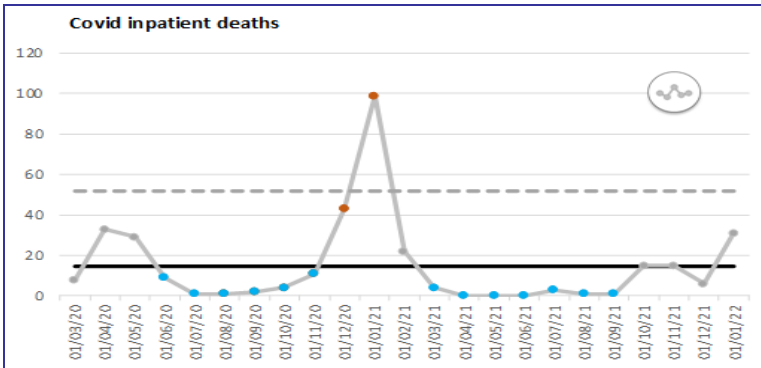
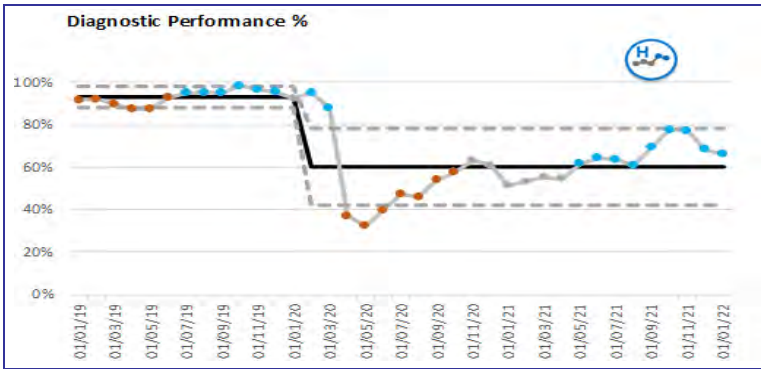
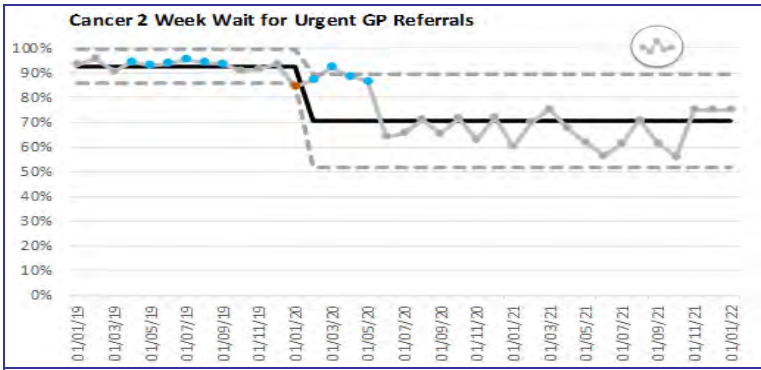
That Board note the report.

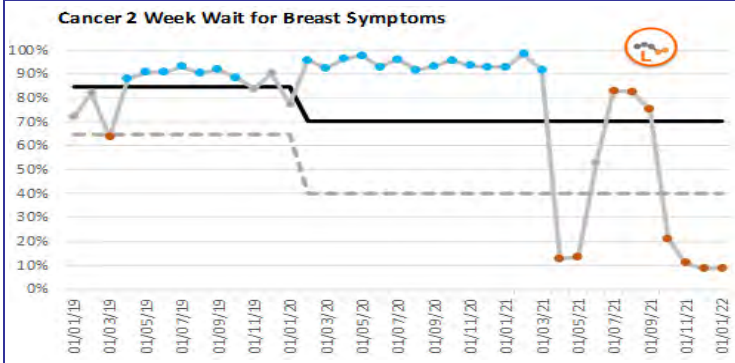
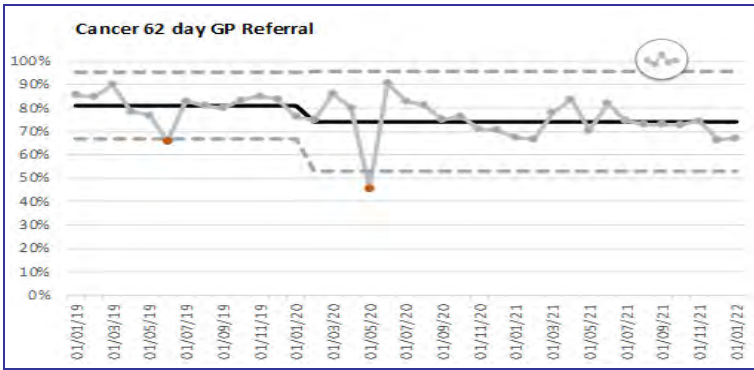
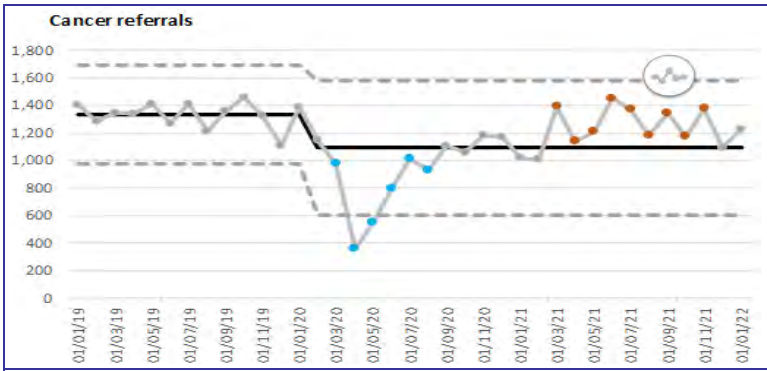
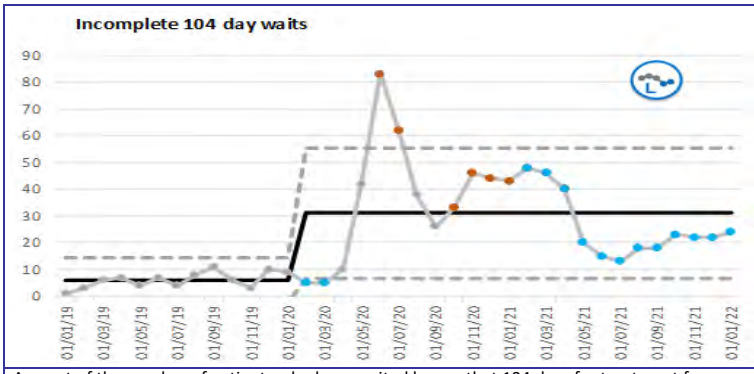
SPC Chart Legend

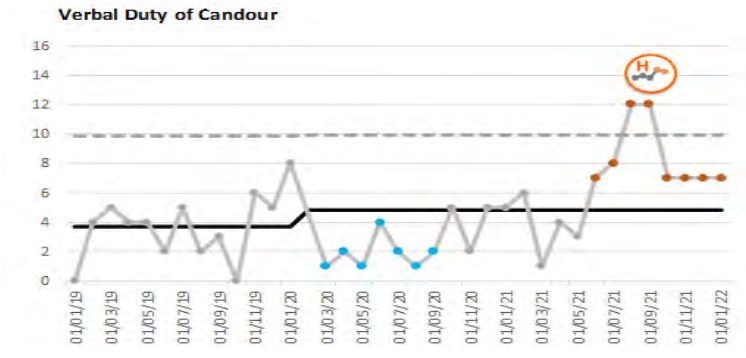
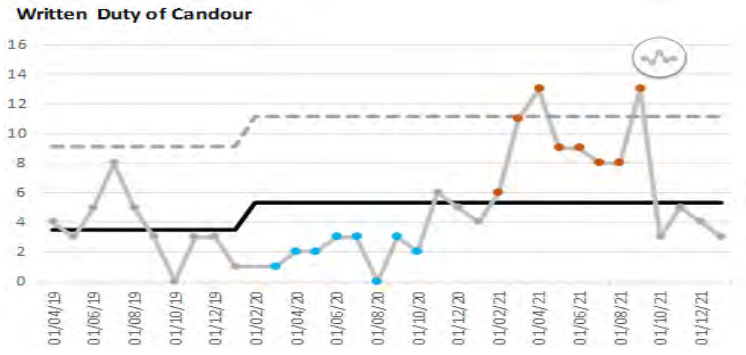
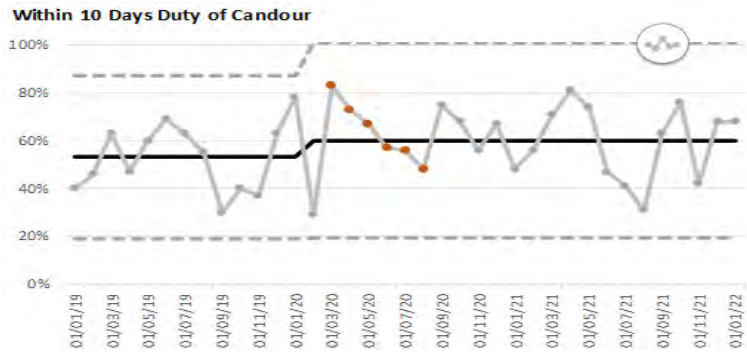


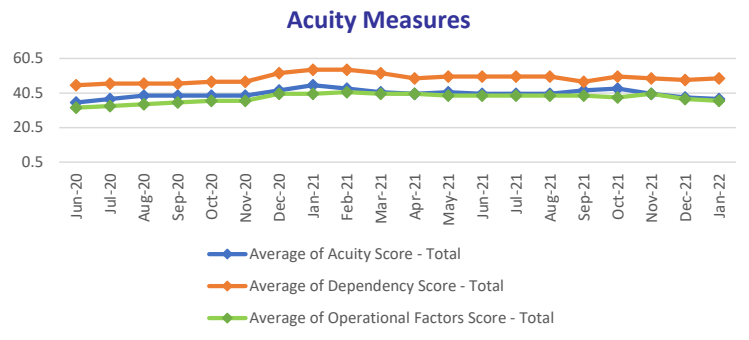
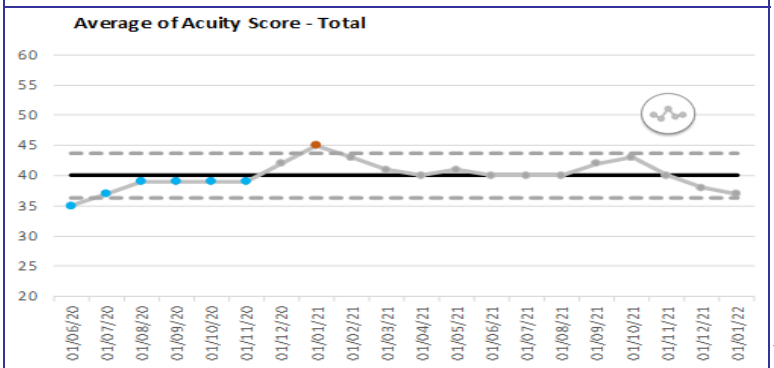
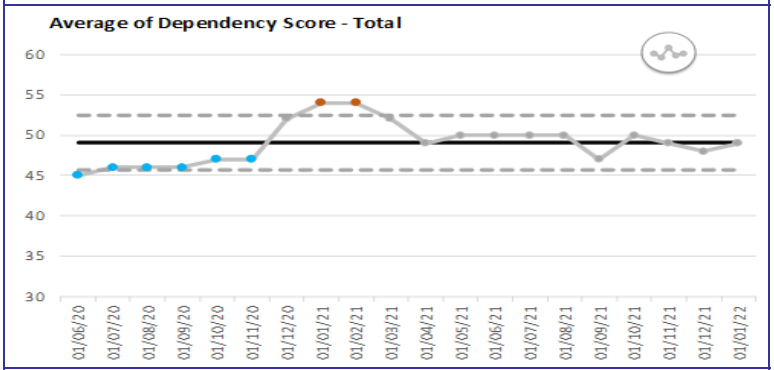
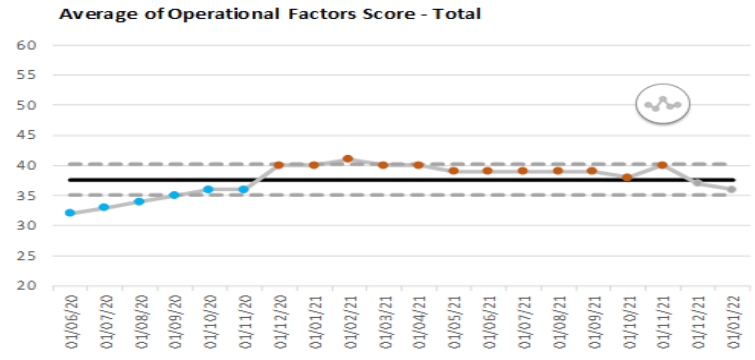
Board Report KPIs	Narratives
	Special cause concerning variation is due to the increased demand on ED services, however there has been a reduction in this demand for the last four consecutive months. It is difficult to determine the causation of this decline, but access to other services and changing Covid activity could be contributing factors. Actions - Continue to review front door/streaming model. This will be monitored though the Patient Access Insight Governance Group and in the future through a new WSFT UEC steering group.
A count of the arrivals at the Emergency Department. This metric has no national target but is key to understanding demand for non elective services.	
	Summary – There is currently an in balance in demand vs capacity with more RTT clocks starting than are being stopped, which is causing the overall waiting list to continually increase. The reduction in theatre capacity over the last 2 years, due to Covid-19 and the RAAC issues has had a big impact on the ability to treat patients. Action - Recovery plans are in place in line with the national requirements to reduce the longest waiting patients, which include patients being treated via the independent sector, insourcing options and mutual aid within the SNEE system which will all support the reduction in the overall waiting list. Assurance - Progress against the recovery plans will be monitored through the Trust access meetings, the elective access insight sub group and reporting to the SNEE recovery and restoration board and Insight committees.
A count of the patients on the waiting list for treatment.	
	Summary - Whilst the performance has not changed significantly this month, the performance is clearly under the national standard, the impact of Covid-19 and the elective backlog this has created alongside the Trust RAAC programme which has seen a large reduction in theatre capacity for routine elective patients has caused this position. Action - Recovery plans are in place in line with the national requirements to reduce the longest waiting patients, whilst this will improve the overall 18-week compliance slightly, it is unlikely we will see significant improvement in the overall 18-week position within the next 12 months whilst we continue to recover the very longest waits. Assurance - Progress against the recovery plans will be monitored through the Trust access meetings, the elective access insight sub group and reporting to the SNEE recovery and restoration board and Insight committees.
	
% of patients on incomplete RTT pathways	

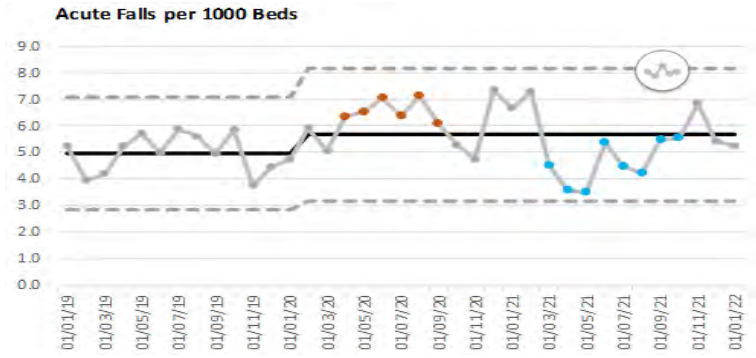
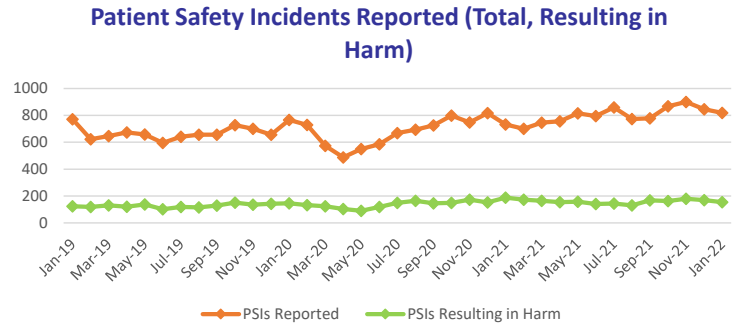
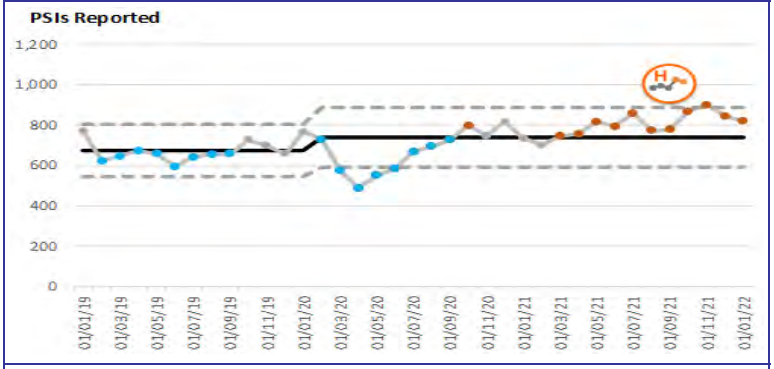
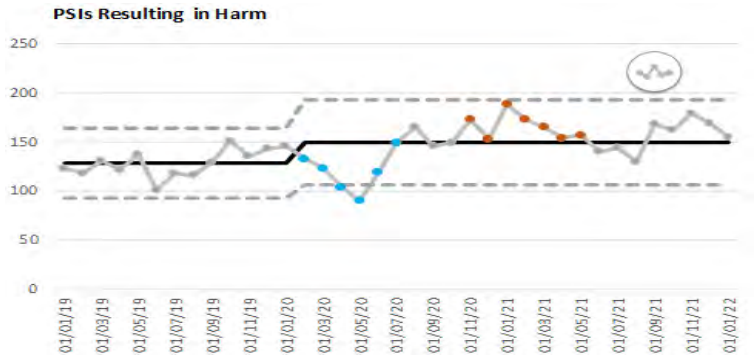
Board Report KPIs	Narratives
 A count of the number of patients who are waiting for treatment and have been waiting longer than 1 year for treatment. This is a national key performance indicator with a national expectation	Summary – The lack of surgical capacity over the last few months has meant an increase in patients waiting over 104 weeks, the loss of the elective ward for 3 weeks due to Covid and UEC pressures had an impact on the ability to clear more of these long waiting patients throughout the month of January. Action – Use of independent sector capacity, weekend lists and mutual aid are continuing to support the recovery of patients who have waited over 104 weeks as well as a continued focus on productively. Assurance - Progress against the recovery plans will be monitored through the Trust access meetings, the elective access insight sub group and reporting to the SNEE recovery and restoration board and Insight committees. The progress against the trajectory to achieve 246 patients over 104 weeks by the end of March 2022 and 0 patients over 104 weeks by the end of July will be monitored weekly by the SNEE operational hub meeting.
 Sickness based on the last 12 months.	The Trust's 12 month cumulative (rolling) absence figure at the end of January 2022 was 4.3%, which is line with the December figure also at 4.3%. This rate continues the increased trend we have experienced since July 2021. This increased absence level is being driven by COVID related sickness and isolation. To note this does remain under the Trust target of <5%.
 A count of our staff who have been off sick with Covid related symptoms or to isolate. This is a local metric to monitor the impact of Covid on our workforce.	This chart illustrates the number of sickness episodes related to COVID-19. In January 2022 there were 944 episodes recorded which is a large increase on December 2021 which recorded 660 episodes. This large increase was felt across the Trust throughout January where an internal critical incident was declared due to operational challenges and staffing levels.
 This is a count of the number of operations that were carried out. This is a local measure to monitor our productivity and recovery from Covid.	Summary: Continuing challenges in theatre and bed capacity for Elective Surgery has reduced activity, due to wards closed for RAAC and outbreaks, wards occupied by Covid +ve patients, Staff (Nursing & Medical) sickness, two theatres closed as part of the RAAC programme, Recovery department being based in the two closed theatres which reduces number of patients in recovery and reduces theatre productivity. Action: Utilising as much theatre capacity as possible, working across both Day Surgery Theatres and Main Theatres to ensure best use and maximising productivity. Ensuring all surgical patients are in the most appropriate ward – up to date communications with Ward Managers / Matrons and Tactical regarding elective plans (being mindful to allow capacity for emergency beds). Theatre planning to mitigate the issues with the recovery of patients in two operating rooms. Assurance: 08:30 huddle with Manager of day, Ops team and Senior Nursing Team and ADO to look at issues from previous day / night. Lessons learned. Mitigation planning for the day if immediate challenges are apparent. 4pm meeting with Ops Team to plan for the next 48 hours to mitigate possible blockers and anticipate overnight lack of capacity across Theatres, Recovery and the wards. RAAC programme meeting updates are communicated to Ops Team and Senior Nursing Team by ADO.

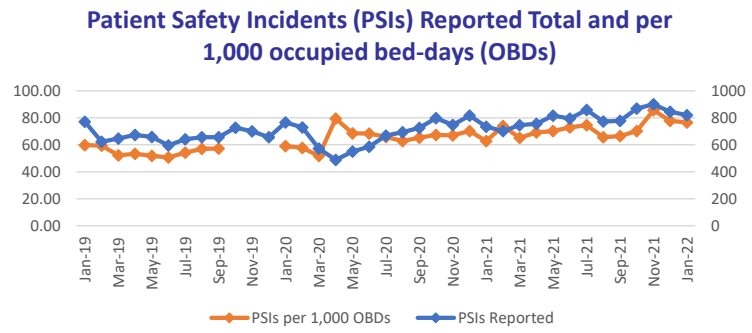
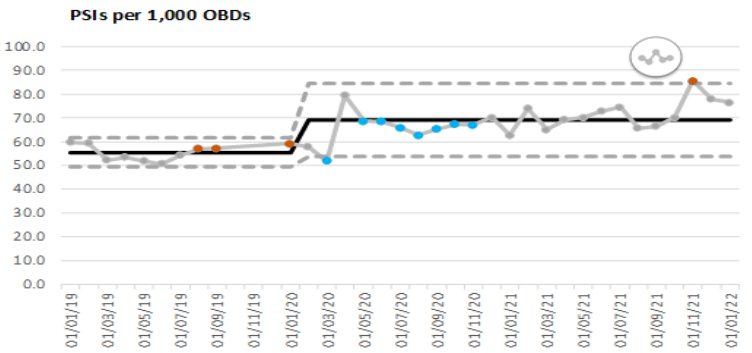
Board Report KPIs	Narratives
 This is a count of the number of patients admitted to the hospital who tested positive for Covid. This is a local measure to understand the local impact of Covid. This number is reported daily as part of national daily reporting requirements.	There were 203 individual patients admitted during January, who had their first diagnosis of Covid-19. Although this was a high month it shows common cause variation and is continuing an increase since May 2021 and reflecting the rise of the Omicron variant. In January the highest number of Covid positive inpatients residing in the trust on any one day was 86. The Trust continues to follow national infection control guidance to minimise Covid infections. Outbreaks are monitored through Incident Management Meetings, supported by regional colleagues.
 A count of the number of patients who have died following a positive Covid result. This is a local metric to understand the local impact of Covid. This number is reported daily as part of national daily reporting requirements.	There were 31 patients who died within 28 days of a positive Covid result in January. The total is now 338. These figures are as published by NHSE. Although this was a higher than average month, it still shows common cause variation.
 To measure compliance with the national standards for access to diagnostic treatment. This metric measures the percentage of patients who receive diagnostic treatment within 6 weeks of referral.	Despite stable performance in October and November overall performance has deteriorated again in January. However, the SPC chart demonstrates a special cause improving nature due to improving variation trend but which is still below the required 99% target as the division works to recover activity from the Covid-19 pandemic. Within the overall performance CT activity has fallen out of compliance for the first time since May 2021. This is due to a combination of scanner downtime and staff absence. A business case for a third CT scanner is in draft for further discussion and will assist in supporting recovery and provide resilience to unplanned scanner downtime. Options for mobile MRI capacity are being explored but availability is limited with an initial offer having been withdrawn and performance will continue to be challenged without additional resource. Endoscopy nurse staffing deficits have impacted capacity. An additional nurse endoscopist has been recruited and outsourcing of surveillance work continues. Ultrasound performance remains a challenge, but additional capacity is now available on site and in the community, with recruitment of agency sonographers progressing well; three have already been recruited and a fourth is due to start in March. All diagnostic modalities continue to be impacted by staffing constraints. Ongoing performance will be monitored at the weekly CSS access meeting and the Elective Access Insight Meeting.
 To measure compliance with the national standards for access to cancer diagnosis. This metric measures the percentage of patients who are seen within 2 weeks from referral from their GP for suspected cancer.	Summary – Static performance again in January at around 75%. Whilst there has been improvement in Skin, the January performance was impacted due to sickness and isolation. Breast continues to be a challenge with very low performance due, however the overall waiting time has reduced significantly. Covid related sickness has impacted the performance in most tumour sites, with particular capacity constraints within Endoscopy for straight to test pathways. Action – Breast has the lowest 2ww performance, a recovery trajectory is in place for this with an action plan, the key actions include additional equipment to enable an additional weekly clinic and development of the breast pain service, which will reduce the 2ww demand. Within lower GI, redesigning of the pathway from referral to endoscopy in underway to support earlier appointments. Assurance – Cancer performance is monitored at the weekly Cancer PTL meetings, cancer board and the ICS wide operational and board meetings. We also have a monthly Cancer trajectory overview meeting with the CCG to monitor progress.

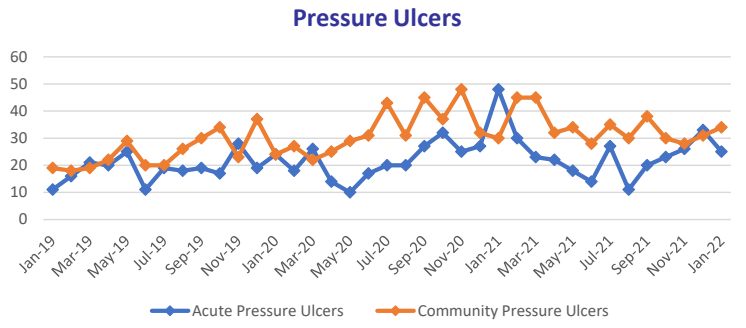
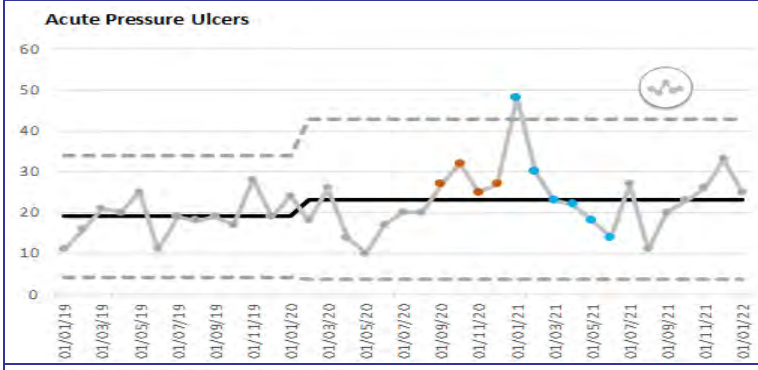
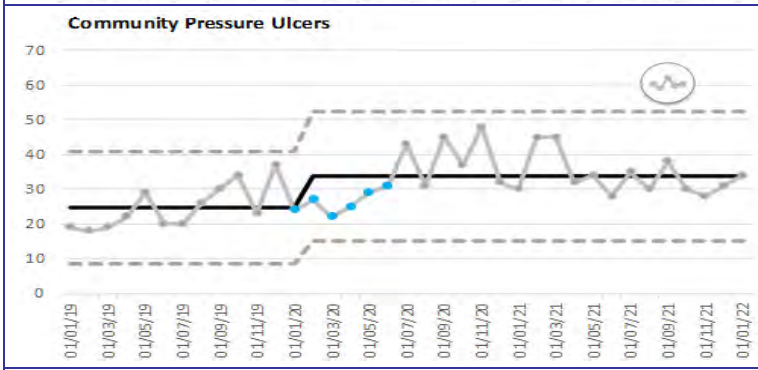
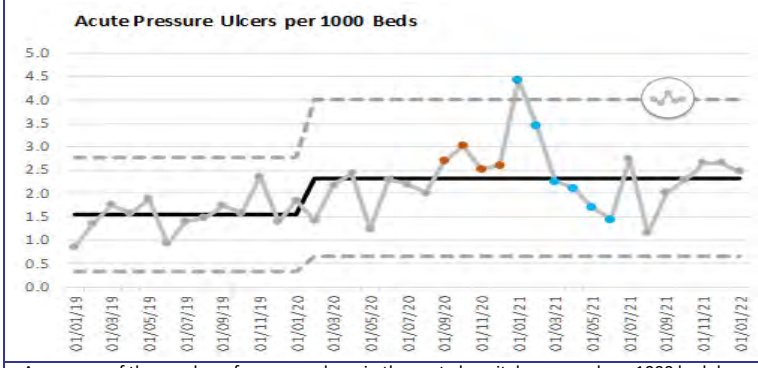
Board Report KPIs	Narratives
 This metric is a sub set of the national 2 week wait metric and measures those GP referrals specifically with breast symptoms.	Summary - Continued pressure with the number of Breast referrals, which is far exceeding the demand despite multiple additional clinics. The overall wait time has reduced significantly, throughout the month of January to around 3 weeks, from a previous 5. Action – Breast has the lowest 2ww performance, a recovery trajectory is in place for this with an action plan, the key actions include additional equipment to enable an additional weekly clinic and development of the breast pain service, which will reduce the 2ww demand. Assurance – Cancer performance is monitored at the weekly Cancer PTL meetings, cancer board and the ICS wide operational and board meetings. We also have a monthly Cancer trajectory overview meeting with the CCG to monitor progress.
 To measure compliance with the national standards for access to cancer treatment. This metric measures the percentage of patients receive cancer treatment within 62 days of referral by their GP.	Summary – Common cause variation but below 85% target with surgical specialities continuing to be challenged with theatre capacity, majority of these breaches are within Colorectal, Urology and Skin. Action – Ensure theatre capacity is aligned to cancer demand once theatres are fully back on line in May 2022. Review of patients waiting for surgery at weekly service and cancer team meetings with appropriate escalation. Review of all long waiting or no plan patients by tumour site at weekly cancer PTL meeting. Assurance – Cancer performance is monitored at the weekly Cancer PTL meetings, cancer board and the ICS wide operational and board meetings. We also have a monthly Cancer trajectory overview meeting with the CCG to monitor progress.
 A count of the number of patients referred to the hospital with suspected cancer, requiring investigation. This metric shows the activity by month for cancer services, which informs the national metric which measures the number of these patients that were seen within 2 weeks (further in the performance pack).	Summary – Common cause variation; Referrals up from December as we would expect, January numbers have however not been as high as we had seen in previous months. Action – Regular meetings held with GP lead for cancer and wider ICS to review demand and any referral trends. Assurance – Cancer performance is monitored at the weekly Cancer PTL meetings, cancer board and the ICS wide operational and board meetings. We also have a monthly Cancer trajectory overview meeting with the CCG to monitor progress.
 A count of the number of patients who have waited longer that 104 days for treatment for cancer from GP referral. This is a national standard and is expected to be 0.	Summary – Slight increase to 24 at the end of January, this continues to be a focus, but has been challenged in certain areas with clinical complexities or staffing constraints impacting the ability for clinical decisions to be made. Action – all long waiting patients reviewed and escalated on a weekly basis, discussed at the weekly cancer PTL meeting and escalated to MDT and cancer leads as appropriate. Assurance – Cancer performance is monitored at the weekly Cancer PTL meetings, cancer board and the ICS wide operational and board meetings. We also have a monthly Cancer trajectory overview meeting with the CCG to monitor progress.

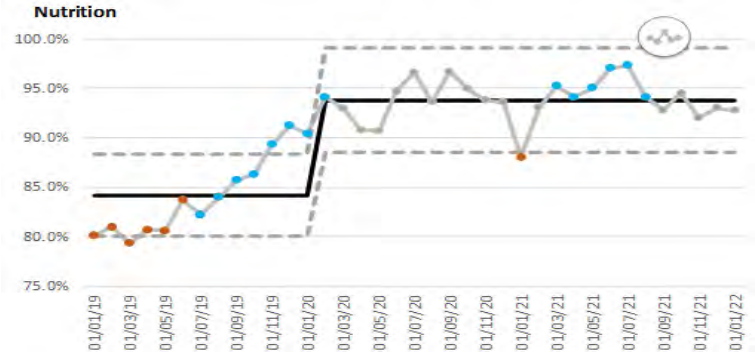
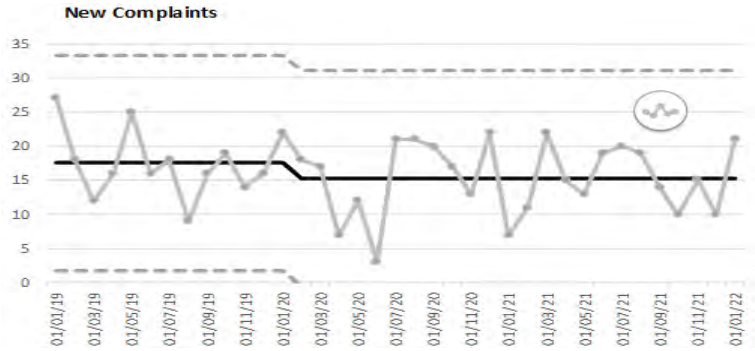
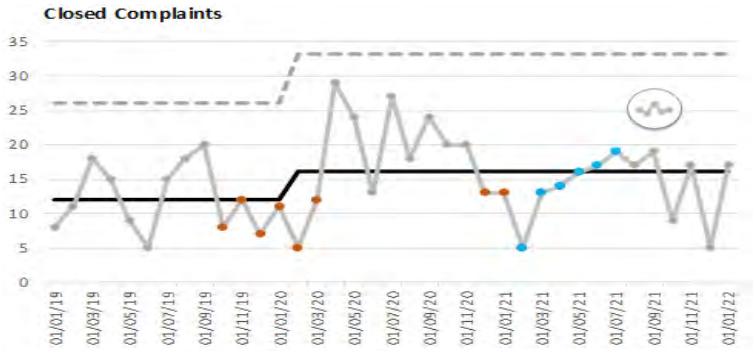
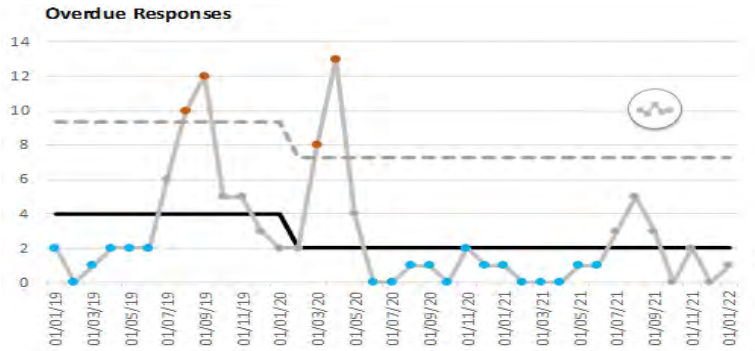
Board Report KPIs	Narratives
  This is a count of the number of verbal and written duty of candour overdue for the reporting month (and earlier) as at the date of report issue  The percentage of cases reported in that month where verbal duty of candour was completed within the nationally required 10 working day timeframe.	The percentage of timely duty of candour conversations and written notification has remained at 68% in January. There are still areas of improvement in relation to compliance and quality of duty of candour conversations which will be addressed and progressed by the task and finish group. An improvement project has been registered on Life QI.

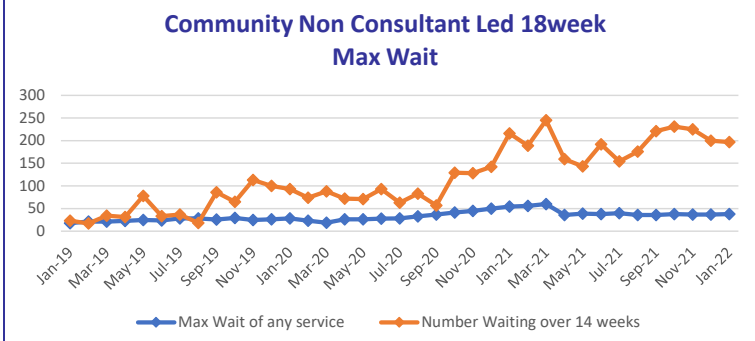
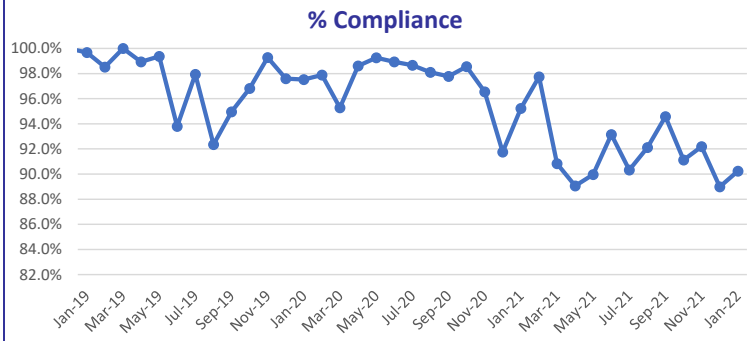
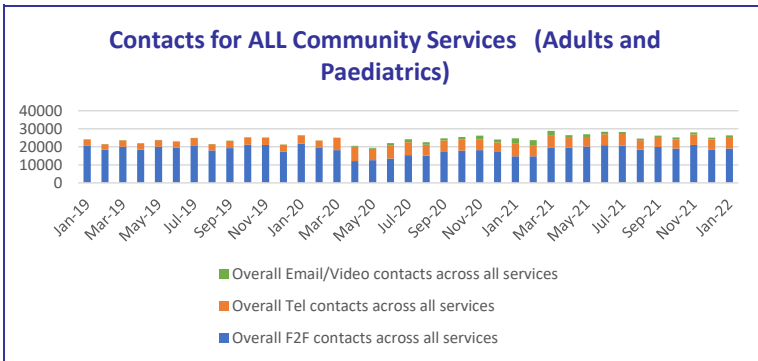
Board Report KPIs	Narratives
	In January we have seen a slight decrease in some of metrics, in particular the acuity. This is likely due to a decrease in capacity over this period due to bed closures due to outbreaks and isolation requirements. Despite this, the nurse and medical staffing picture has remained under pressure due to deficits across all disciplines. This intelligence has been acknowledged during the daily safety huddles, where senior clinical leads meet to discuss incidents and acuity pressures each day. During this period, it has been acknowledged that the dependency levels have remained high. There have been high numbers of stranded patients awaiting care packages and interim placements which has impacted the dependency metric. This information justifies the nurse staffing decisions and is utilised in conjunction with safecare data which is recorded by the wards daily. The staffing pressures have been influenced by vacancy, sickness and isolation, which is impacting on the organisation's ability to provide safe, effective and personalised care. Due to the pressures experienced in January, it was necessary to enact the super surge staffing plan, involving specialist's nurses, Matrons and Senior Nurses assisting clinically within the wards and departments.
	
	
	
A range of measures have been identified which are analysed to provide an overall acuity score, as displayed in this chart. This provides an overview of the acuity of admitted patients.	

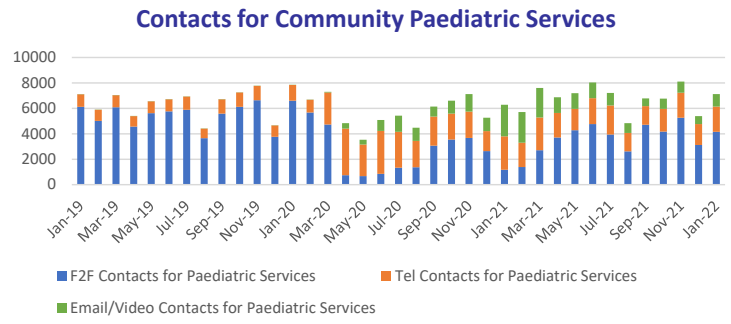
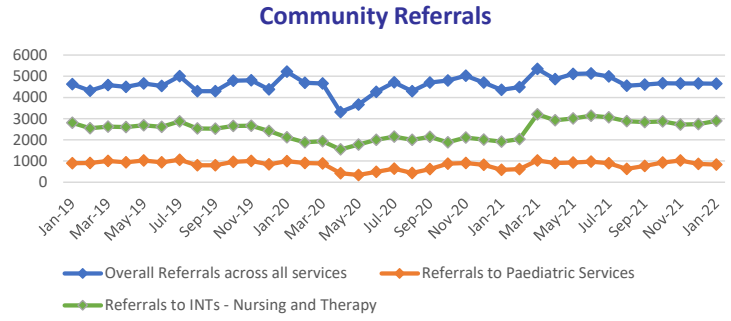
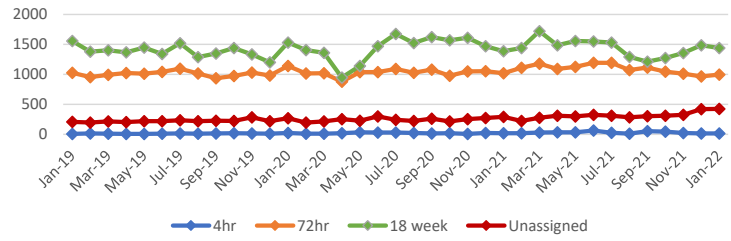
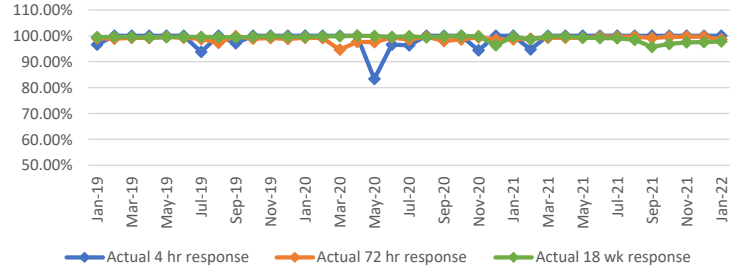
Board Report KPIs	Narratives
 A measure of the number of falls in the acute hospital measured per 1000 bed days. Community falls are excluded from this metric.	This is now reported in Staffing paper.
   A count of the number of patient safety incidents reported in total and those resulting in harm	The number of PSI and PSI with harm reported in January were lower than previous months but remain reflective of average occupied bed days. The patient safety team continue to review all incidents reported to ensure timely escalation and mitigation of safety concerns.

Board Report KPIs	Narratives
	The number of PSI and PSI with harm reported in January were lower than previous months but remain reflective of average occupied bed days. The patient safety team continue to review all incidents reported to ensure timely escalation and mitigation of safety concerns.
	
The number of patient safety incidents reported as a percentage of occupied bed days to measure reporting rates	

Board Report KPIs	Narratives
	
	
	This is now reported in Staffing paper.
A count of the number of recorded new pressure ulcers across the Trust. This metric will include those recorded in the acute hospital and community settings	
	
A measure of the number of pressure ulcers in the acute hospital measured per 1000 bed days. Community inpatient pressure ulcers are excluded from this metric.	

Board Report KPIs	Narratives
 % of patients with a Malnutrition Universal Screening Tool (Adults)/Paediatric Yorkhill Malnutrition Score (Children) assessment completed within 24 hours of admission	This is now reported in Staffing paper.
 New formal complaints received and accepted, this counts both West Suffolk Hospital and Community	21 formal complaints received in January 2022 which is our highest received since March 2021. 5 complaints were raised in relation to the emergency department. There were no specific themes within these complaints although some complaints mentioned a delay in diagnosis which we are still investigating. 3 complaints related to community paediatric services in relation to access to treatment/services, in which we are working with the department to investigate and resolve.
 Formal complaints signed off by the CEO, this counts both West Suffolk Hospital and Community	17 complaints closed in January. A good amount of complaints closed which has subsequently led to a stable volume of open cases.
 Any complaints which were sent outside of the given timeframe and no extension was agreed, this counts both West Suffolk Hospital and Community	1 complaint was classed as overtime. These needed a more extensive review given the complexity of the case.

Board Report KPIs	Narratives
 Services covered: Adult SLT, Heart Failure, Neurology Service, Parkinson's Nursing, Wheelchairs, Paediatric Occupational Therapy, Paediatric Physio and Paediatric Speech and Language Therapy, There are no patients waiting over 52weeks for treatment from referral, so community look at number of patients waiting over 14 weeks. Historically, 14 weeks was agreed on as an internal measure because it gives an approx. number of patients who would breach the 18 week target at the end of the next month.	The number of services with patients waiting over 18 weeks has remained at 2 in January. At the end of January these services were: Paed SLT and Wheelchairs. The maximum wait for each of these services are: Paed SLT - 30 weeks (decreased from 37 weeks) Wheelchairs - 38 weeks (increased from 34 weeks) Paed SLT and Wheelchair services were both exceeding the wait times prior to COVID, these 2 services have papers and support from the CCG both in understanding demand and increasing resources. The lack of face to face group work and restrictions in schools etc are having a continued profound effect on Paed SLT activities, as are vacancies within the service. Wheelchairs have a vulnerable patient group (previously shielding) where the temporary suspension of the service created issues with complexity and additional visits, these are likely to remain for some time. Assessments and handovers continue to be impacted due to Covid isolation/restrictions with ongoing difficulties in accessing care homes and specialist schools. Covid Staffing remains challenging due to the specialist nature of the service. Significant supply chain delays continue to impact the lead time for equipment
 Services covered: Adult SLT, Heart Failure, Neurology Service, Parkinson's Nursing, Wheelchairs, Pead OT, Pead Physio and Pead SLT. RTT nationally is for consultant led services but the community services are required to report on compliance to 18 week Referral to Treatment locally to our CCG. Target is 95% of referrals are given a first definitive treatment within 18weeks	The aggregated % of patients treated within 18 weeks for all community services in January was 90.23% with the lowest individual service being Wheelchairs at 74.74%
 Activity is counted as a face to face/telephone/email/video contact with a patient/carer/parent which is clinically relevant. This means activity that a clinician carries out which is writing reports, liaising with other healthcare professionals is NOT counted as activity. This is in line with acute systems where there is an assumption that clinicians will carry out related activities that result from contact with a patient.	The total activity for community services has returned to pre-COVID levels and exceeded the values although the ratio of face to face and other means of contact (telephone, video and email) have altered.

Board Report KPIs	Narratives
	The Paediatric services have moved a high proportion of their activity to telephone and email/video contacts but they are still unable to carry out any group work due to social distancing requirements. There are also shortages in clinic availability in certain locations. The wearing of masks and social distancing means Speech and Language therapy is particularly hard to do. The services are reviewing all possible options.
Activity is counted as a face to face/telephone/email/video contact with a patient/carer/parent which is clinically relevant. This means activity that a clinician carries out which is writing reports, liaising with other healthcare professionals is NOT counted as activity. This is in line with acute systems where there is an assumption that clinicians will carry out related activities that result from contact with a patient.	
	Referrals to the majority of the community services for 2021 YTD has exceeded the same periods of 2019 and 2020.
There should be one reason per referral, i.e. if a patient is referred in to the INTs for 2 requirements either simultaneously or over time, eg leg ulcer dressing and phlebotomy, then	
	Referrals to the INT services have returned to pre-COVID numbers or exceeded them.
Referrals into the Integrated Neighbourhood Teams have urgencies of Red (within 4 hours), Amber within 72hrs) and Green (within 18 weeks). These contractual urgencies are locally agreed pan Suffolk with the CCG and there is a 98% response target for Red, Amber and Green response times have a 95% threshold (These are local contractual targets)	
	The Red, Amber and Green referral targets were all met in January.
Referrals into the Integrated Neighbourhood Teams have urgencies of Red (within 4 hours), Amber within 72hrs) and Green (within 18 weeks). These contractual urgencies are locally agreed pan Suffolk with the CCG and there is a 98% response target for Red, Amber and Green response times have a 95% threshold (These are local contractual targets)	

4.4. Improvement Committee Report - January & February 2022 Chair's key issues from the meetings

To Assure

Presented by Jude Chin

Board of Directors – 25 March 2022

Agenda item:	Item 4.4			
Presented by:	Jude Chin, Non-executive Director			
Prepared by:	Ann Alderton			
Date prepared:	16 February 2022			
Subject:	Improvement Committee report and Chair's Key Issues			
Purpose:	X	For information	X	For approval

Executive summary:

The Improvement Committee met on 17 January 2022. The transition to the committee operating as a board assurance committee is still in progress, further steps towards which included the approval of its terms of reference and the decommissioning of the Improvement Programme Board.

Attached is the Chair's Key Issues document which will constitute the standard template for Improvement Committee reports to Board.

Trust priorities *[Please indicate Trust priorities relevant to the subject of the report]*	**Deliver for today**	**Invest in quality, staff and clinical leadership**	**Build a joined-up future**
	X	**X**	**X**

Trust ambitions *[Please indicate ambitions relevant to the subject of the report]*	*Deliver personal*	*Deliver*	*Deliver joined-up*	*Support a healthy*	*Support a healthy*	*Support ageing*	*Support all our*
	X	X	X	X	X	X	X

Previously considered by:	N/A
Risk and assurance:	The development of and transition to a new structure for organisational governance may result in a failure to escalate significant risks to management, the executive team and the board of directors, caused by a disruption to the previous information and communication flows whilst new arrangements are being established.
Legislation, regulatory, equality, diversity and dignity implications	Well-Led Framework NHSI FT Code of Governance

Recommendation: To approve the report

Chair's Key Issues

Part A

Originating Committee	Improvement Committee	**Date of meeting**	17 January 2022
Chaired by	Jude Chin	**Lead Executive Director**	Sue Wilkinson

Agenda Item	**Details of Issue**	**For: Approval/ Escalation/Assurance**	**BAF/ Risk Register ref**	**Paper attached? ✓**
4.1	Safe and effective discharge: Consideration was needed as to whether this should be a quality priority.			
4.2	PSIRF: Year 2 was in development			
5.1	Quality priorities and quality accounts: These need to be considered and planned			
7.3	Committee structure review: There needs to be a review of how the 3k committees are working and how they/the structure could be improved.			
Date completed and forwarded to Trust Secretary				

Part B

Receiving Committee	**Board of Directors**	**Date of Meeting**	**3 September 2021**
Chaired by	**Sheila Childerhouse**	**Lead Executive Director**	**Craig Black**

Agenda Item	**Record of Consideration Given (Approved/ Response/ Action)**
Date Completed and Forwarded to Chair of Originating Committee	

Board of Directors – 25 March 2022

Agenda item:	4.4			
Presented by:	Jude Chin, Non-executive Director			
Prepared by:	Ann Alderton			
Date prepared:	2 March 2022			
Subject:	Improvement Committee report and Chair's Key Issues			
Purpose:	X	For information	X	For approval

Executive summary:

The Improvement Committee met on 14 February 2022. The transition to the committee operating as a board assurance committee is still in progress, further steps towards which included the approval of its terms of reference and the decommissioning of the Improvement Programme Board.

Attached is the Chair's Key Issues document which will constitute the standard template for Improvement Committee reports to Board.

Trust priorities *[Please indicate Trust priorities relevant to the subject of the report]*	**Deliver for today**	**Invest in quality, staff and clinical leadership**	**Build a joined-up future**
	X	**X**	**X**

Trust ambitions *[Please indicate ambitions relevant to the subject of the report]*	*Deliver personal*	*Deliver*	*Deliver joined-up*	*Support a healthy*	*Support a healthy*	*Support ageing*	*Support all our*
	X	X	X	X	X	X	X

Previously considered by:	N/A
Risk and assurance:	The development of and transition to a new structure for organisational governance may result in a failure to escalate significant risks to management, the executive team and the board of directors, caused by a disruption to the previous information and communication flows whilst new arrangements are being established.
Legislation, regulatory, equality, diversity and dignity implications	Well-Led Framework NHSI FT Code of Governance

Recommendation: To approve the report

Chair's Key Issues

Part A

Originating Committee	Improvement Committee	**Date of meeting**	14 February 2022
Chaired by	Jude Chin	**Lead Executive Director**	Sue Wilkinson

Agenda Item	Details of Issue	For: Approval/ Escalation/Assurance	BAF/ Risk Register ref	Paper attached? ✓
3.1	**Annual report and quality accounts**: work is progressing; a shortlist of priorities is being considered based on the Trust strategy.			
3.3	**Appraisal (escalation from Insight committee)**: A multi-level organisational piece of work may be required which will need project management resources.			
4.1	**Patient safety specialist:** This is a national strategy/requirement. The level of work required will need dedicated resources however there is no capacity within current teams to provide support. Key named leads need to be identified and a reporting schedule agreed.			
5.1	**Quality assurance programme:** Positive feedback from assurance visits to maternity, theatres/ED regarding medicines security, learning disabilities and trauma services. A visit to community services to be arranged.			
7.2.1	**Elective waits:** Goals had been set out in the elective recovery strategy which would be a challenge but the Trust would endeavour to aim for.			
7.3.1	**QI project update:** Continuation of funding for the programme being considered. Projects to be prioritised in order to focus resources and optimise outcomes. A prioritisation framework/business case be taken to the senior leadership team for guidance.			
Date completed and forwarded to Trust Secretary		2 March, 2022		

Part B

Receiving Committee	Board of Directors	Date of Meeting	3 September 2021
Chaired by	Sheila Childerhouse	Lead Executive Director	Craig Black

Agenda Item	Record of Consideration Given (Approved/ Response/ Action)
Date Completed and Forwarded to Chair of Originating Committee	

4.5. Quality and Nurse Staffing Report

To Assure

Presented by Susan Wilkinson

Board of Directors – 25 March, 2022

Report Title:	Item 4.5 – Quality & Nurse Staffing Report
Executive Lead:	Sue Wilkinson, Chief Nurse
Report Prepared by:	Rebecca Gibson – Head of Compliance & Effectiveness
Previously Considered by:	-

For Approval	For Assurance	For Discussion	For Information
☒	☐	☐	☐

Executive Summary

Infection prevention and control assurance framework (ANNEXE 1)

The Infection prevention & control (IPC) committee have responsibility for oversight and review of the risk assessment RR5204 Prevention of Healthcare associated infection (HAI) and the risk of occupational healthcare associated infection including quarterly review as currently rated as Red (major x weekly).

The trust continues to apply a hierarchy of controls to manage the ongoing COVID-19 pandemic. These are described in the gov.uk publication Infection prevention and control for seasonal respiratory infections in health and care settings (including SARS-CoV-2) for winter 2021 to 2022 (last updated Jan22).

Key points in the IPC Covid-19 dashboard:

- Admission swabbing compliance remains very high
- Peak in nosocomial Covid in January linked to multiple ward outbreaks
- Incident numbers high in January mainly Midwifery 'red flag' staffing incidents
- Covid related staff sickness / absence remains high

Please note – The assurance provided within this report will in future be incorporated within the infection prevention & control report to the patient quality & safety governance group (which reports upwards to the 3i committees) and so this standalone paper will no longer be provided directly to the board.

Nurse Staffing Report (ANNEXE 2)

This paper reports on safe staffing fill rates and mitigations for inpatient areas for January and February 2022. It complies with national quality board recommendations to demonstrate effective deployment and utilisation of nursing staff. The paper identifies how planned staffing levels were achieved and the resulting impact of these staffing levels. It will go onto review vacancy rates, nurse sensitive indicators, and recruitment initiatives.

Highlights

- Average RN fill rates in the day remain under 90% since October 2021
- Small rise in vacancy rate for RN and NA despite static substantive numbers
- Staff isolation rates dropped in January only to rise again in February
- Reduction in sickness rates in both RN and NA groups
- Surge staffing plans continued throughout January with a staged withdrawal to BAU in February
- Maternity KPIs maintained good performance
- Community challenges and concerns added to paper for first time

Quality and Learning Report (ANNEXE 3)

This report provides the following:

- Incident reports approved since last meeting
- Update on development of a Quality & Safety dashboard
- PSIRF year two plan (list of PSIRP subjects and investigation pathways provided in **annexe 3a**)
- Patient safety specialists workplan
- Learning from deaths
- Patient and public feedback
- National best practice reader panel

Action Required of the Board
Approval of the PSIRF priorities for 2022/23

Risk and assurance:	-
Equality, Diversity and Inclusion:	-
Sustainability:	-
Legal and regulatory context	-

4.6. Maternity services quality & performance report

To Assure

Presented by Susan Wilkinson and Karen Newbury

Trust Open Board– 25th March 2022

Agenda item:	Item 4.6			
Presented by:	Sue Wilkinson, Executive Chief Nurse/ Paul Molyneux, Interim Medical Director & Executive MatNeo Safety Champion/ Karen Newbury, Head of Midwifery			
Prepared by:	Karen Newbury – Head of Midwifery & Justyna Skonieczny – Deputy Head of Midwifery			
Date prepared:	March 2022			
Subject:	Maternity Quality & Safety performance Report			
Purpose:	x	For information		For approval

Executive summary:

This report presents a document to enable board scrutiny of Maternity services and receive assurance of ongoing compliance against key quality and safety indicators and provide an update on Maternity quality & safety initiatives.

This report contains;

- Maternity improvement plan
- Safety champion feedback from walkabout
- Listening to staff
- Service user feedback
- Reporting and learning from incidents
- Compliance with reporting incidents to HSIB
- Maternity Clinical and Quality dashboard (Annex A)
- Ockenden review of maternity service- One Year on report (Annex B)
- Morecambe Bay Recommendation and review of Maternity Service (Annex C)
- ATAIN Quarter 3 report (Annex D)
- Audit of the Operational Pathway of Care into Neonatal Transitional Care (Annex E)
- Training needs analysis and tracker (Annex F)
- Report on Anesthetic Staffing within Maternity Services (Annex G)
- Use of the National Perinatal Mortality Review Tool (PMRT) and Review of Perinatal deaths within West Suffolk NHS Foundation Trust for Quarter 3 (Full report to CLOSED BOARD)
- HSIB and Early Notification Reporting – Safety Action 10 Maternity Incentive Scheme Year 4 Quarterly Reports (Annex H)

<u>Maternity improvement plan</u>

The Maternity Improvement Board receives the updated Maternity improvement plan on a monthly basis. This has been created through an amalgamation of the original CQC improvement plan with the wider requirements of Ockenden, HSIB, external site visits and self-assessment against other national best practice (e.g. MBRRACE, SBLCBv2, UKOSS). In addition, the plan has captured the actions needing completion from the 60 Supportive Steps visit from NHSE/I and continues to be reviewed by the Maternity Improvement Board every two weeks. To note; completion of actions has been hindered due to the high demand on clinicians to work clinically due to Covid absences.

Safety Champion Walkabout feedback

The Board-level champion undertakes a monthly walkabout in the maternity and neonatal unit. Staff have the opportunity to raise any safety issues with the Board level champion and if there are any immediate actions that are required, the Board level champion will address these with the relevant person at the time. Individuals or groups of staff can raise the issues with the Board champion.

The Safety Champion Walkabout took place on the 17th February 2022 Discussions raised:

1. NNU storage. Difficulty in storing some clinical equipment on the ward. Preference for an external area to allow a less cluttered environment. Options have previously been explored but no solution identified
2. Car parking for parents attending NNU. This issue risks a Gold standard BLISS accreditation from being achieved
3. The need for a supernumerary shift leader, at least during the day. The advantages are to have a helicopter view without an allocation, to provide flexibility and oversight. It would support ambitions around Transitional Care.
4. An ask for a data clerk for NNU to help input, for example, audit data
5. Resilience around shift cover an issue, with an ask around receiving some sort of on call payment to be available to offer advice out of hours

In response to the concerns raised;

Parent car-parking charges has been raised to the Trust board and the executive team are to discuss further to look at potential solutions.

The deputy HOM is currently undertaking a NNU staffing review to address staffing concerns which will be shared with all on completion.

Space utilisation is a major issue for all and the NNU senior team, Deputy HOM and operational team will work together to try and find some solutions.

Listening to Staff

The National Staff Satisfaction Survey results were published in March 2021. On the back of the results, key elements of the survey were used to form a targeted questionnaire to band 5 & 6 midwives in April 2021, however survey returns were low in number. The division was keen to develop further action points by listening to staff in more detail and have led focus groups run by a manager from a different department. The division alongside their HR Business partner and Board Safety Champion continues to develop different methods to engage with staff to ensure support and that there is every opportunity for staff to be listened to in an open, supportive and productive way. Further to the whistleblowing within the maternity services, a very short survey was sent to all midwifery staff to gain further understanding of what support is required to move forward. The results were shared with all staff and volunteers were sought to attend solution focused groups, unfortunately none came forward. This will be reviewed again once the high Covid absence rate has decreased.

In the meantime, the department actively listens to all staff via the Safety Champion Walkabout and in addition we have introduced the following;

- Freedom to Speak Up Guardians attend the maternity unit to increase their profile, accessibility and explain their role to all staff including students.
- The Staff Support team have been attending the department at shift changes to offer support to any staff member and continue to work with individuals on a one-to-one basis.
- The HR team undertake detailed exit interviews and feedback any issues or themes arising.
- The Royal College of Midwives representation undertakes a weekly ‘Safe Space’ to empower staff to raise concerns and to support them in reporting their concern through the appropriate channels.

Service User feedback

The NHS Friends and Family Test (FFT) was created to help service providers and commissioners understand whether patients are happy with the service provided, or where improvements are needed. It's a quick and anonymous way to give views after receiving NHS care or treatment.

Ward/Dept	Jan Survey returns	Jan FFT score	Feb Survey returns	Feb FFT Score
F11	31	97	16	100
Antenatal	15	100	24	100
Postnatal Community	48	100	30	100
Labour Suite	7	100	1	100
Birthing Unit	13	100	9	100

0 compliments were shared with the patient experience team for women & children's division for logging in January & February 2022.

In January and February 2022, a total of 19 PALS enquiries and 3 complaints were received for maternity and 1 PALS enquiry and 0 complaints for NNU.

Reporting and learning from incidents

1 HSIB report received in Jan following a baby that required transfer to another unit for cooling in September 2021. No safety actions were identified The Full report will be shared at the closed board. There were no reports received in February.

Compliance with reporting incidents to HSIB and feedback

There were 2 incidents reported to HSIB in the last two months- 1 in January and 1 in February.

During the quarterly meeting with HSIB and the maternity team on 22.02.22 there was a discussion regarding the collaborative relationship between the HSIB and our maternity department. The HSIB praised our responsiveness, and the tripartite meetings which we facilitate to share the findings and actions with a family.

Quarterly meetings will continue to happen with HSIB and we will try to invite as many of the maternity team as possible to provide an opportunity for learning and wider discussion regarding cases.

Maternity dashboards (Annex A)

Indicators of maternity safety & quality are regularly reported and reviewed at monthly Maternity Governance meetings. A sub-set are provided for board level performance (the Performance & Governance dashboard). From this month onwards, red rated data will be represented in line with the national NHSI model of SPC charts.

Indicators	Narrative
Decision to delivery times for grade 2 sections	Business case for F2 doctors approved- awaiting appointment and start dates. QI work continues- multi rationale identified and on-going work required. 2 cases of Apgar's 7 and below reported, however no further adverse effects identified despite delay.
Induction of labour	Expected increase due to increase in antenatal surveillance. In line with region and national picture.
Post-partum haemorrhages >1500mls	In line with increase of caesarean section and induction of labour, however QI project continues. The Trust governance team are undertaking a thematic review for all cases in Feb 22 to identify any further learning.
Carbon Monoxide monitoring at 36 weeks	Improvement noted in compliance however still below the expected level. Digital midwife working closely with smoking cessation midwife to identify issues in compliance data collection.
Appraisal compliance	This reflects Covid absence; time and availability of staff to complete. Going forward line managers to have greater oversight of when appraisals due, this will be supported by correct data on ESR regarding line manager.
Training compliance	Reflects staffing shortages due to Covid and therefore clinicians foregoing training to work clinically. ANC non-compliance due to the small number of midwives in the team. 2 MW's were out of date and this has now been addressed.
Emergency checks on the Birthing Unit	This reflects the staff being pulled from the Birthing Unit for escalation. It has been identified that checks are more likely to not be completed at weekends when there are fewer staff around. Maternity bleep holder now responsible for completing checks if staff are utilised in other areas due to escalation.
Domestic Violence question being asked in the antenatal and postnatal period	Training and electronic notes review has been completed. Mandatory field added to electronic notes mid-February 22 to capture this data.
Swab Counts	Weekly reports now being run to quickly identify individuals who have not completed the documentation. Further training and support given to individuals as required.
Pain score	Auditing issue as clarification required regarding labour status. Pain score is not applicable in labour; however, this is not easily identifiable when auditing notes. Plan; to review audit tool.
Fresh ears review on Birthing Unit	Non-compliance relates to a second midwife not completing the 'fresh ears' care review. Compliance is normally 100%. All staff reminded regarding the importance of completing reviews and to re-audit next month.

Ockenden review of maternity service- One Year on (Annex B)

Evidence and information on the progress made by Maternity Service at WSFT towards implementation of the 7 immediate and essential actions (IEA) and workforce planning standards outlined in the Ockenden Report published in December 2020, was required to be shared with the Trust Board, LMNS, Regional and National NHSE/I team. The table below shows current compliance and areas of ongoing actions:

Trust: West Suffolk NHS Foundation Trust	Rating	Areas of ongoing actions
1. Enhanced Safety (Questions 1-8)		• Fully implement the Perinatal Quality Surveillance Model • Buddying arrangements to be fully implemented to enable external review to take place • Information gathering and sharing within the Trust/LMNS
2. Listening to Women and their Families (Questions 9-16)		• Enhanced the Maternity and Neonatal Safety Champions (MNSC) role at Board level
3. Staff Training and working together (Questions 17-23)		• Training compliance and evidence of MDT training • MDT ward rounds attendance and frequency
4. Managing complex pregnancy (Questions 24-29)		• Audit plan for regular monitoring of women with named consultant for complex pregnancies
5. Risk Assessment throughout pregnancy (Questions 30-33)		• Implementation and monitoring of Personal Support and Care Plans, risk assessment and discussion re place of birth at each antenatal contact and ongoing audits to monitor these issues
6. Monitoring Fetal Wellbeing (Questions 34-38)		• Embed the roles and responsibilities of the fetal monitoring (FM) leads • Compliance with FM training for the MDT in accordance with TNA.
7. Informed Consent (Questions 39-44)		• Embed process for responses to surveys, MVP reviews and improvement plans
Maternity Workforce , Midwifery Workforce NICE guidance and other guidance documents (Questions 45-49)		• Reports on workforce planning to be prepared, submitted and actioned in accordance with required timeframes.

Morecambe Bay Recommendation and review of maternity service (Annex C)

Evidence regarding the progress made by Maternity Service at WSFT towards achieving compliance with the recommendation of the Kirkup Report published in 2015 on maternity service delivered at Morecambe Bay NHS Foundation Trust, was also required to be shared with the Trust Board, LMNS, Regional and National NHSE/I team. There were 44 recommendations from the Kirkup report: the first 18 were related to Morecambe Bay but each Maternity Service had to assess their service to make sure there was sufficient assurance of safe working practices and organisational process in place to reduce the risk of similar safety concerns occurring in other Trust. Our current compliance is as below:

Compliance the first 18 recommendation related to Maternity Service:

5 out of the 18 recommendations	Compliant
13 out of the 18 recommendations	Partially Compliant

The remaining recommendations 19-44 were related to the Trust's wider Governance strategies and other external agencies and Health Care managers to enhance governance and safety processes on a local, regional and national level:

10 out of remaining 26 recommendations	Compliant
14 out of remaining 26 recommendations	N/A
2 out of remaining 26 recommendations	Partially Compliant

ATAIN (avoiding term admissions into neonatal units) Quarter 3 Report (Annex D)

This is a programme of work to reduce harm leading to avoidable admission to a neonatal unit for infants born at term, ie ≥ 37+0 weeks gestation.

The programme focuses on 4 key clinical areas which make up the majority of admissions to neonatal units, however it is expected that shared learning from local reviews will identify other reasons for admission.

The ATAIN programme uses tools developed by NHS improvement for the 4 areas under focus:

• Respiratory conditions

• Hypoglycaemia

• Jaundice

• Asphyxia (perinatal hypoxia – ischaemia)

Respiratory support as the predominant reason for admission each quarter. However, no underlying common theme has been identified at present. It is hoped with the new nursery nurses starting on Transitional Care in the next few months that there will be a reduction in term admissions to the Neonatal Unit as the Transitional Care is more appropriately utilised.

Audit of the Operational Pathway of Care into Neonatal Transitional Care (Annex E)

The aims of the audit are to identify whether the agreed standards within the local Policy 'Operational Policy for Neonatal Transitional Care (NCT) October 2021 enables mothers and Babies to receive appropriate Neonatal Transitional Care at the West Suffolk Hospital.

The objectives are to demonstrate whether the standards for clinical criteria for admission and the operational standards in relation to midwifery, neonatal and medical staffing are in accordance with the current policy including compliance with NHS Resolution Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme published in August 2021. Neonatal Transitional Care is included in Safety action 3: Can you demonstrate that you have Neonatal Transitional Care services to support the recommendations made in the Avoiding Term Admissions to the Neonatal units Programme.
In all cases the admissions met the criteria in the operational guidelines in relation to appropriate gestation, birthweight and reason for admission, however on-going actions have been identified to improve the overall service, which includes increasing the criteria for Transitional Care.

Training needs analysis and tracker (Annex F)

NHS Resolution (NHSR) is operating the Clinical Negligence Scheme for Trusts (CNST) and year 4 of Maternity Incentive Scheme to support the delivery of safer maternity care was launched on 9 August 2021. As in previous years, there are ten maternity safety actions. If WSFT can demonstrate they have achieved full compliance of all the ten safety actions, then the Trust will recover their contribution relating to the CNST maternity incentive fund and will also receive a share of any unallocated funds. Training needs analysis and tracker provide evidence that a local training plan is in place to ensure that all six core modules of the Core Competency Framework will be included in the training programme over the next 3 years and that at least 90% of each relevant maternity unit staff group has attended an 'in house', one-day, multi-professional training day which includes a selection of maternity emergencies, antenatal and intrapartum fetal surveillance and newborn life support to meet the recommendation of MIS Safety Action 8. Limited availability of data to fully complete the report has been raised with the training leads to improve up on compliance;

Although improvement has been seen over this quarter, it is recognised further action in required. Training plans have been put in place with the start date from January 2022 to meet the recommendation of MIS year 4 this includes attendance at the NLS training sessions. The agreement was made that the Neonatal/ Paediatric Consultants and Neonatal Junior doctors who attend a birth are required to attend annual NLS training sessions as part of the PROMPT training. This is booked by individual staff with Practice Development team. There have been difficulties in releasing medical staff to attend the training which is being reviewed/reflected by on-going job-planning and current compliance is escalated to Clinical Leads and Safety Champions.

Report on Anaesthetics Staffing within Maternity Services (Annex G)

NHS Resolution is operating a fourth year of the Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme to continue to support the delivery of safer maternity care. There are 10 safety actions for Trusts to have in place to assure the women, families and the NHS of their commitment to safety. This report presents a compliance with CNST Safety Action 4- "*Can you demonstrate an effective system of clinical workforce planning to the required standard?"* and relates directly to the anaesthetic element of clinical staffing. The obstetric anaesthetic rotas reflect the 24/7 cover of the obstetric services and therefore the Trust is assured that the standards are met for Anaesthesia Clinical Services Accreditation (ACSA) standard 1.7.2.1.

Use of the National Perinatal Mortality Review Tool (PMRT) and Review of Perinatal deaths within West Suffolk NHS Foundation Trust for Quarter 3

The full report will be shared at the CLOSED BOARD due to contents potential being patient identifiable. The report outlines the details of Perinatal deaths occurring within the Trust and the reviews and actions of these. The report includes completed investigations and actions from Quarter 3 – 1st October 2021 to 31st December 2021 for West Suffolk NHSFT. The Trust has met all of the standards for reporting all relevant incidents of perinatal mortality to the relevant national platforms within the appropriate time frames with regard to compliance with reporting to MBRRACE (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK) and completion of the surveillance information within the required time frames when required to date.

The Trust is also compliant with duty of candour and informing the women that a PMRT review will be undertaken when indicated and inviting comments or questions to aid the review process.

The Trust has completed all the PMRT reports that were due to be completed within this reporting timeframe

HSIB and Early Notification Reporting – Safety Action 10 Maternity Incentive Scheme Year 4 Quarterly Reports (Annex H)

NHS Resolution (NHSR) is operating the Clinical Negligence Scheme for Trusts (CNST) and year 4 of Maternity Incentive Scheme to support the delivery of safer maternity care was launched on 9 August 2021. As in previous years, there are ten maternity safety actions. If WSFT can demonstrate they have achieved full compliance of all the ten safety actions, then the Trust will recover their contribution relating to the CNST maternity incentive fund and will also receive a share of any unallocated funds. This report presents compliance with CNST Safety Action 10 where all qualifying cases which have occurred during the period 1st October 2021 to 31st December 2021 the Trust Board are assured that:

1. the family have received information on the role of HSIB and the EN scheme; and

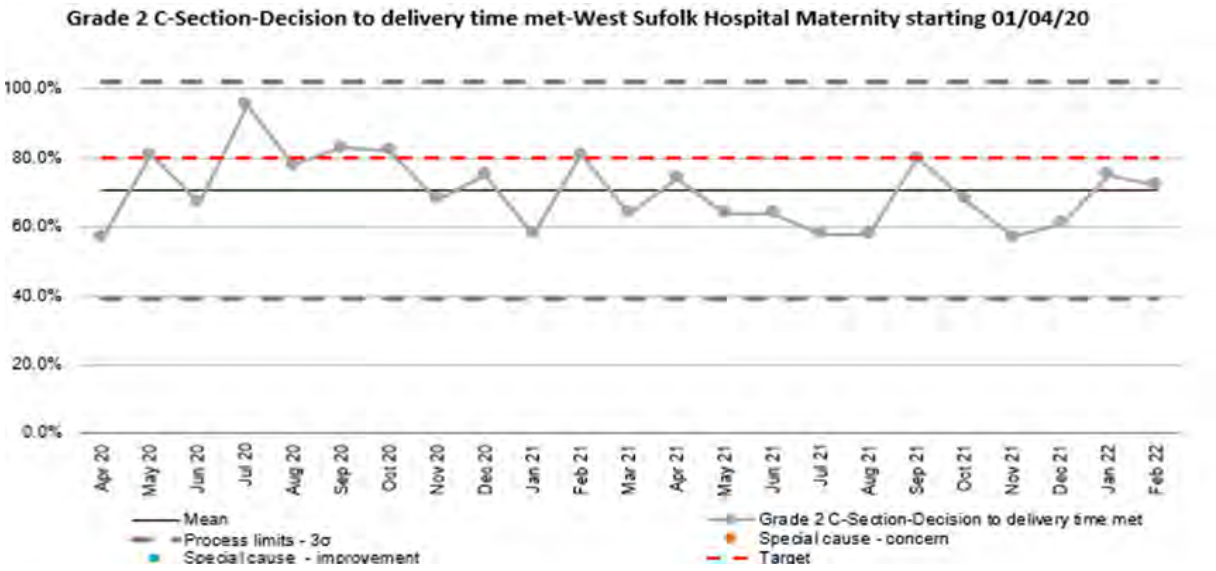
2. there has been compliance, where required, with Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of the duty of candour.

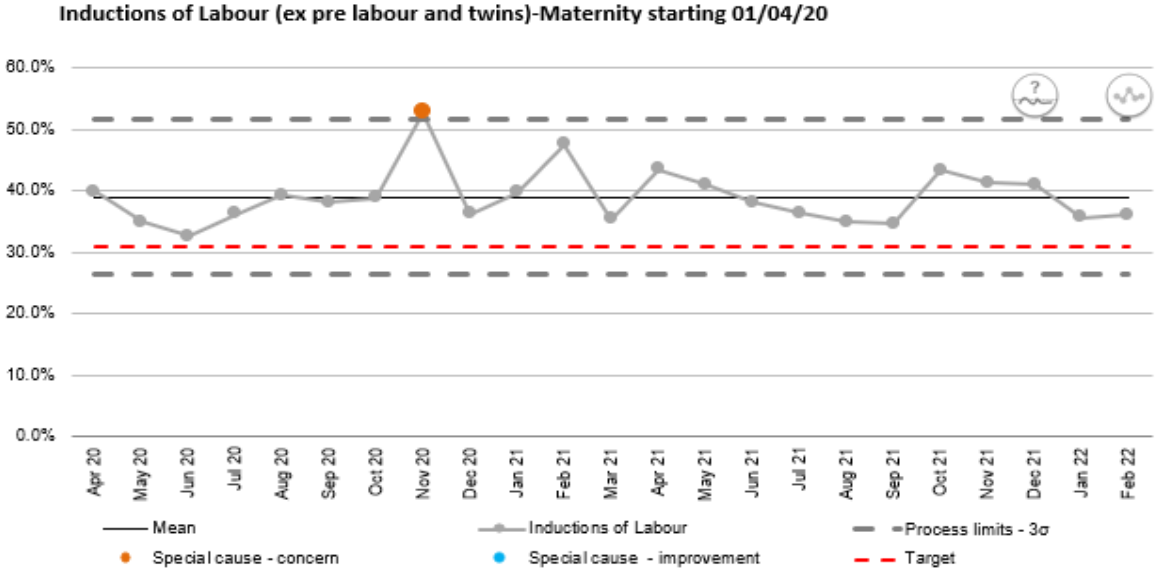
To note there were no cases reported to HSIB in this timeframe and therefore full compliance has been achieved.

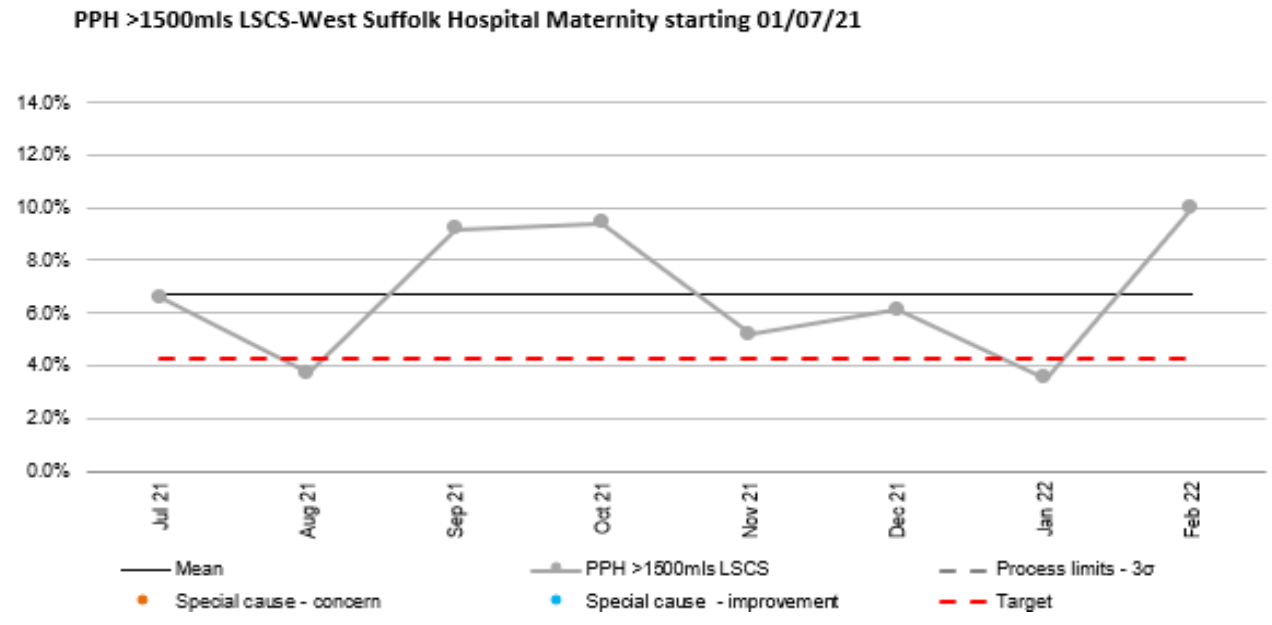
Trust priorities	**Deliver for today**		**Invest in quality, staff and clinical leadership**		**Build a joined-up future**		
	x				**x**		
Trust ambitions	*Deliver personal care*	*Deliver safe care*	*Deliver joined-up care*	*Support a healthy start*	*Support a healthy life*	*Support ageing well*	*Support all our staff*
	x	x	x	x	x		

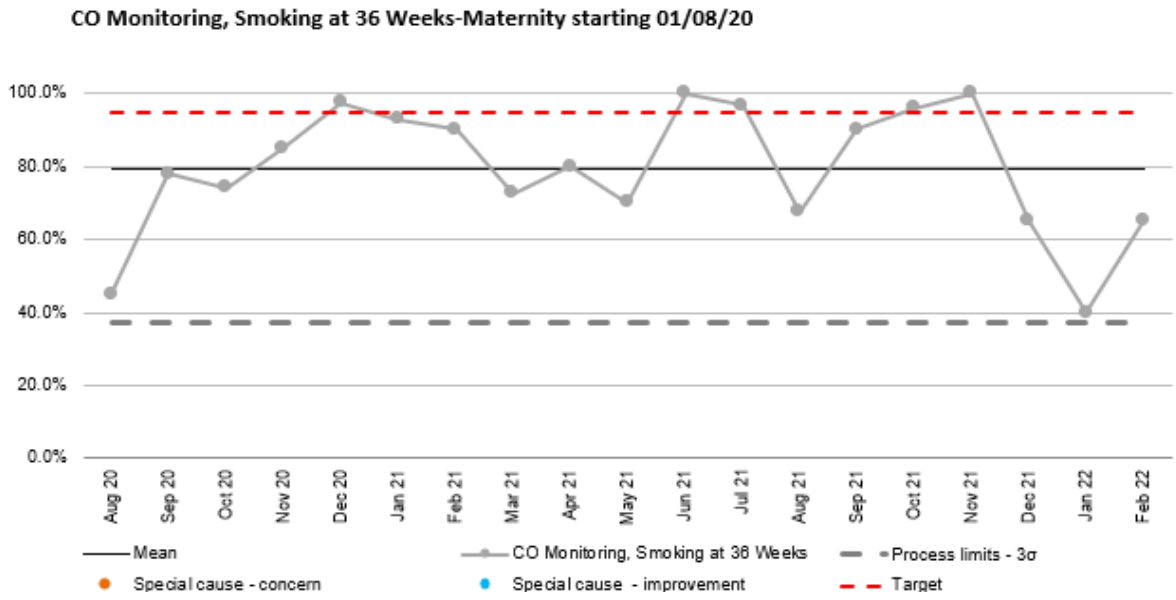
Previously considered by:	
Risk and assurance:	
Legislation, regulatory, equality, diversity and dignity implications	
Recommendation: Receive for information	

Annex A Maternity SPC charts from Clinical and Quality & Safety Dashboards – Red Rated





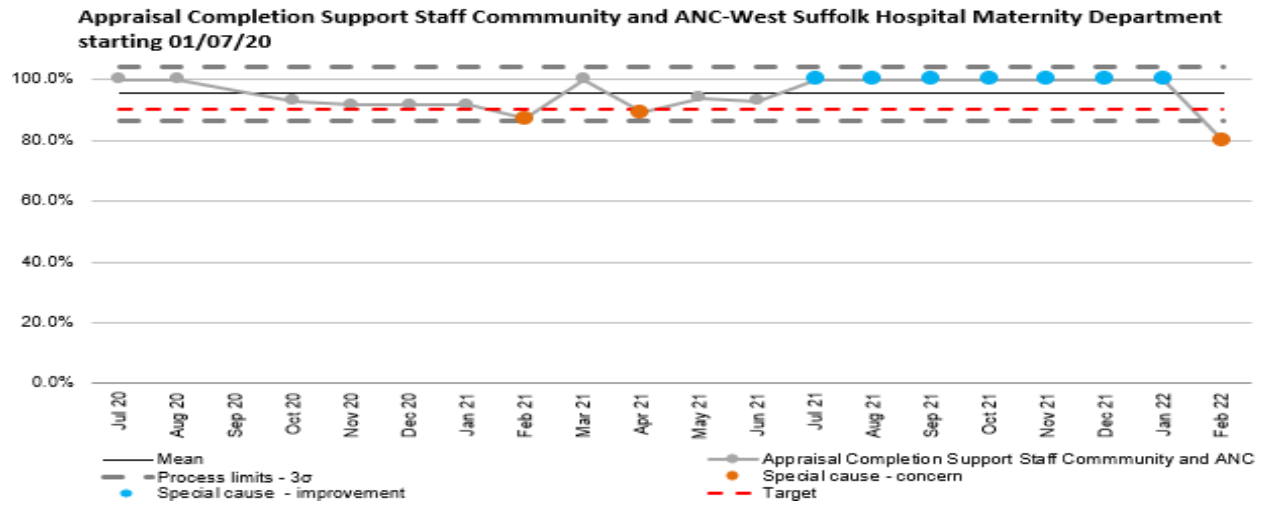




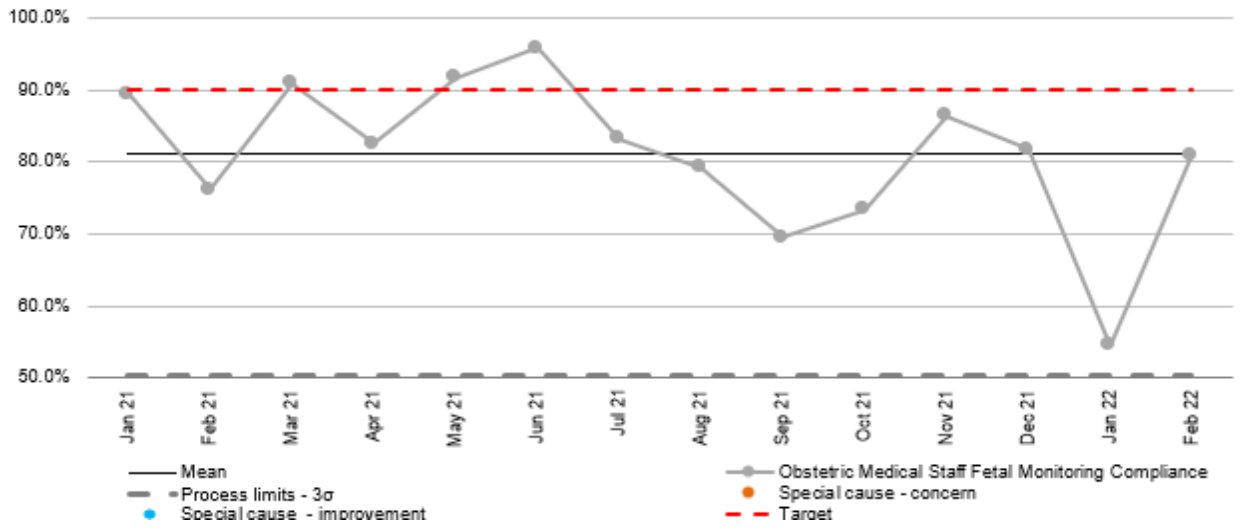
Quality& Safety Dashboard Red rated SPC charts

QUALITY DASHBOARD						
Appraisal completion	Standard	October	November	December	January	February
Support Staff Community & ANC % in date	90%	100%	100%	100%	100%	80%
Medical Staff (Consultant) % in date	90%	84.21%	61%	84%	84%	78.94%
Mandatory Training Overview	Standard	October	November	December	January	February
ANC Midwives: % compliance with All Fetal Monitoring training	90%	100.0%	100%	83.30%	83.30%	57.10%
Obstetric Medical Staff: % compliance with All Fetal Monitoring training	90%	73.4%	86.4%	81.80%	54.50%	81%
EQUIPMENT SAFETY						

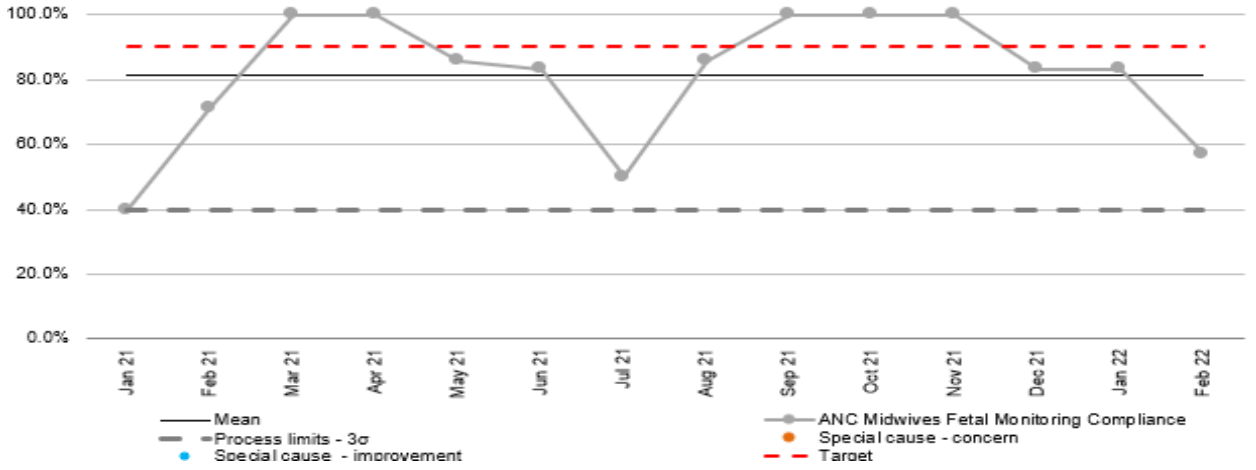
Checking of Emergency Equipment	Standard	October	November	December	January	February
MLBU: Resuscitaires	100%	Unit closed for roof work	Unit closed for roof work	Unit closed for roof work	88%	88%
Checking of Fridge Temperatures	Standard	October	November	December	January	February
MLBU		Unit Closed For Building Work	Unit closed for roof work	Unit closed for roof work	90%	89%
Ambient Room Temperature (where medication is stored)	Standard	October	November	December	January	February
MLBU		Unit Closed For Building Work	Unit closed for roof work	Unit closed for roof work	90%	89%
Checking of CD's	Standard	October	November	December	January	February
MLBU		Unit Closed For Building Work	Unit closed for roof work	Unit closed for roof work	94%	93%
Carbon Monoxide Monitoring						
Smoking at booking recorded	95%	100%	100%	100%	95%	97.4%
Smoking at 36 weeks recorded	95%	96%	100%	65%	40%	65%
Compliance with DV questions						
Antenatal period	100%	100%	92%	94%	82%	92%
Postnatal period	100%	89%	62%	64%	70%	70%
Swab Count Compliance						
Birth	100%	72%	95%	95%	90%	70%
Recording of Pain Score						
Labour Suite	100%	Perfect Ward	Perfect Ward	80%		Incomplete data
MLBU		Perfect Watrd	Perfect Ward	100%		Incomplete data
Fresh Ears						
MLBU	100%	100%	Unit closed for roof work	100%	100%	66%
LSCS decision to delivery time met						
Grade 2 LSCS	80%	68%	57.1%	61%	75%	72%



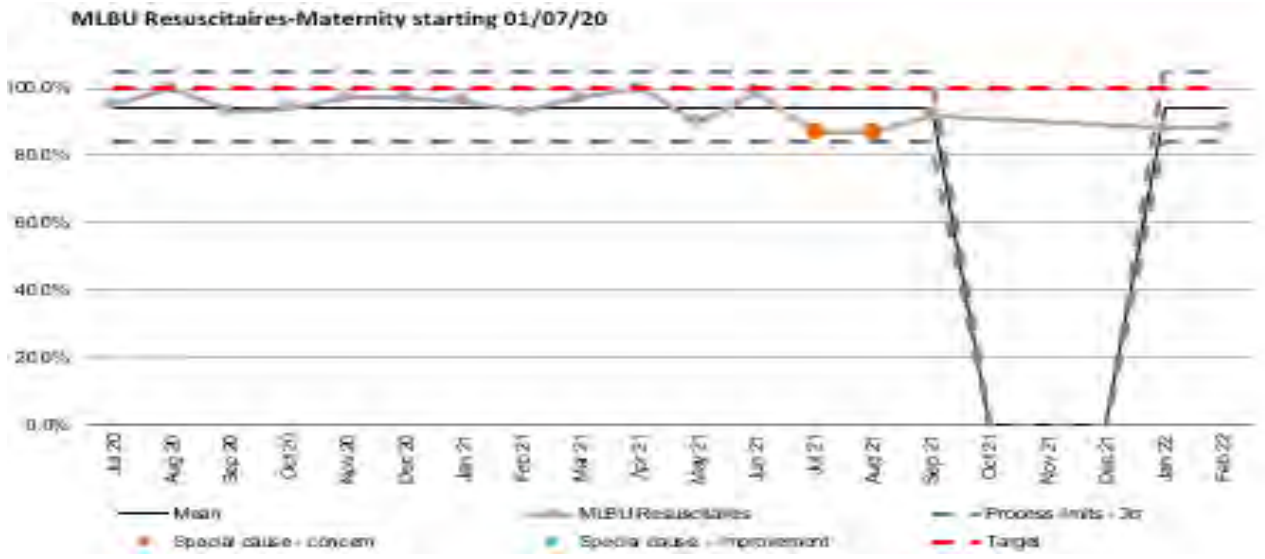
Obstetric Medical Staff Fetal Monitoring Compliance-Maternity starting 01/01/21



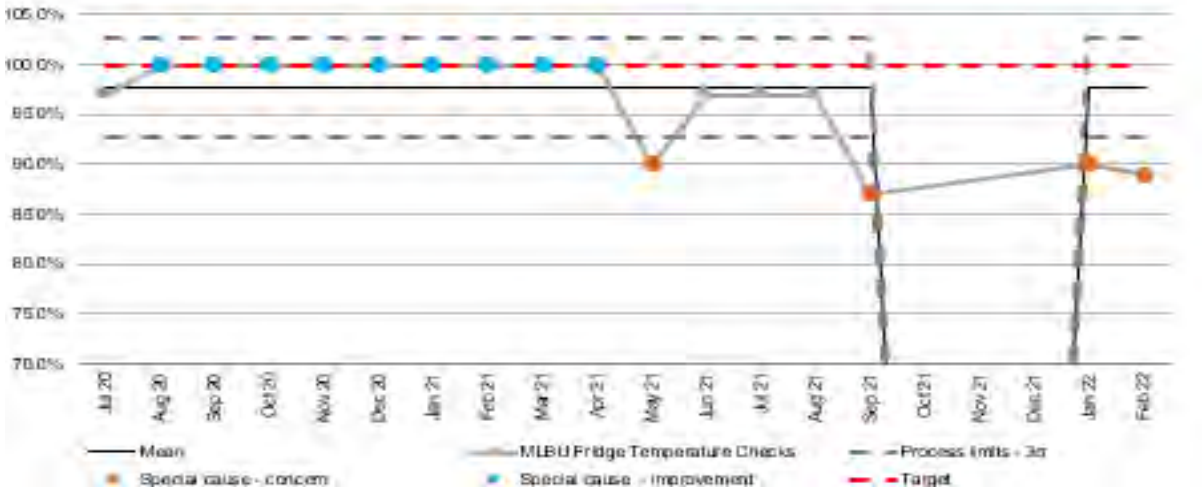
ANC Midwives Fetal Monitoring Compliance-West Suffolk Hospital Maternity starting 01/01/21



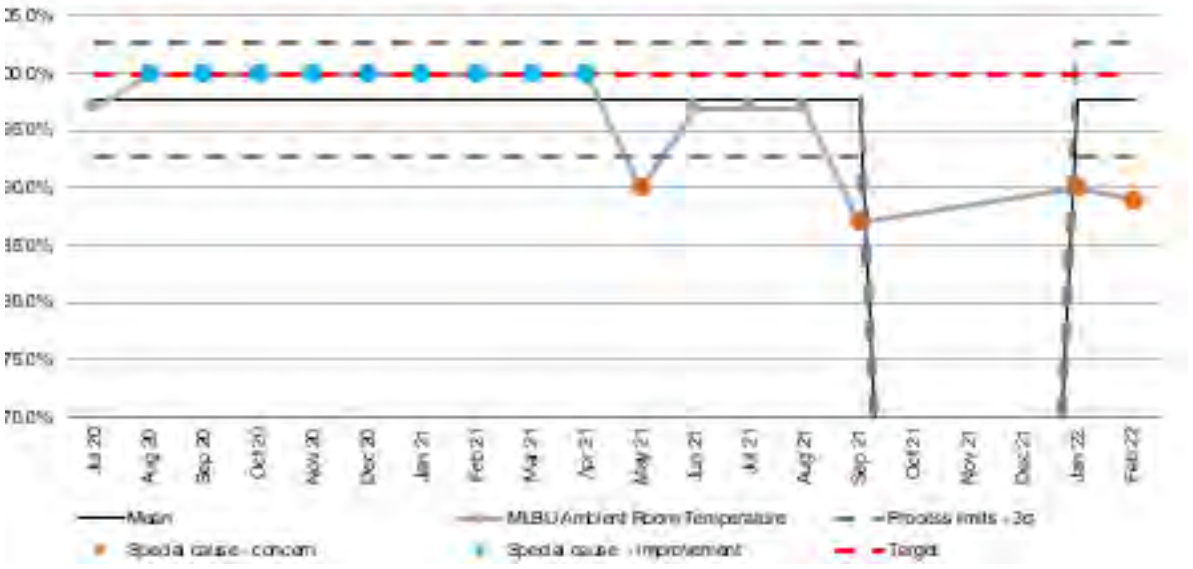
MLBU Resuscitaires-Maternity starting 01/07/20



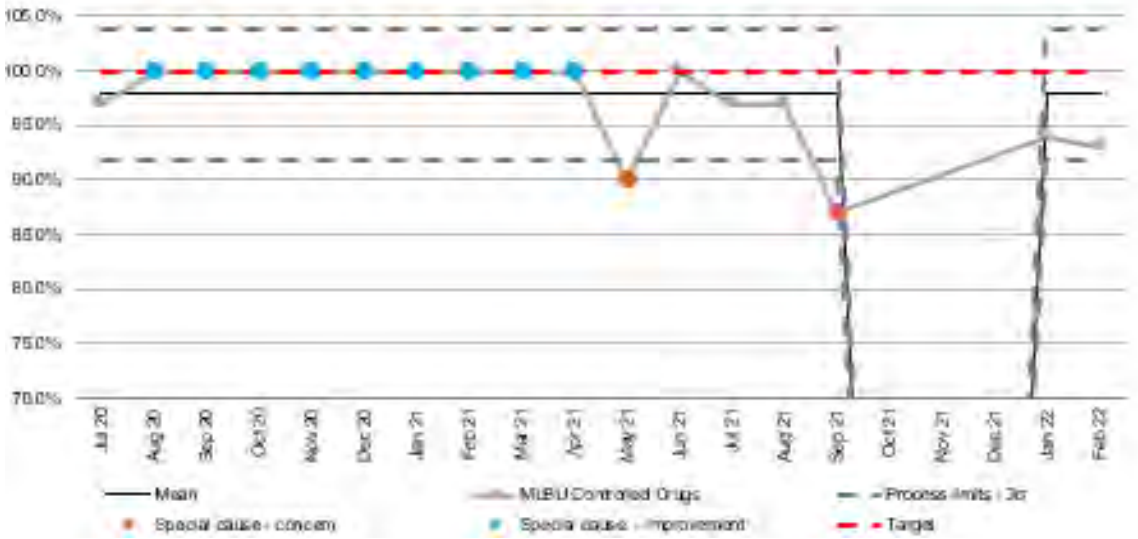
MLBU Fridge Temperature Checks-Maternity starting 01/07/20



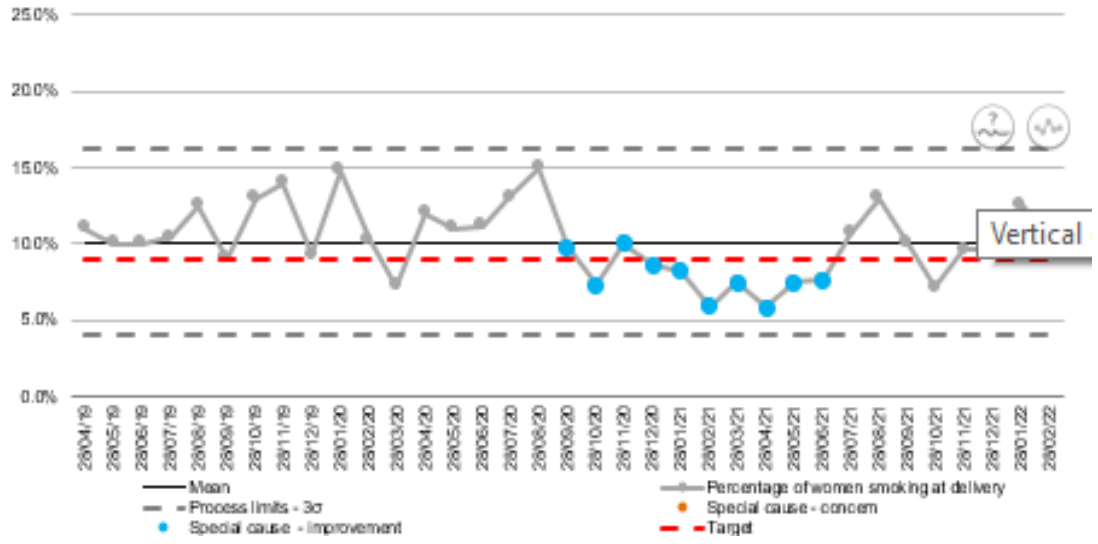
MLBU Ambient Room Temperature-West Suffolk Hospital Maternity starting 01/07/20



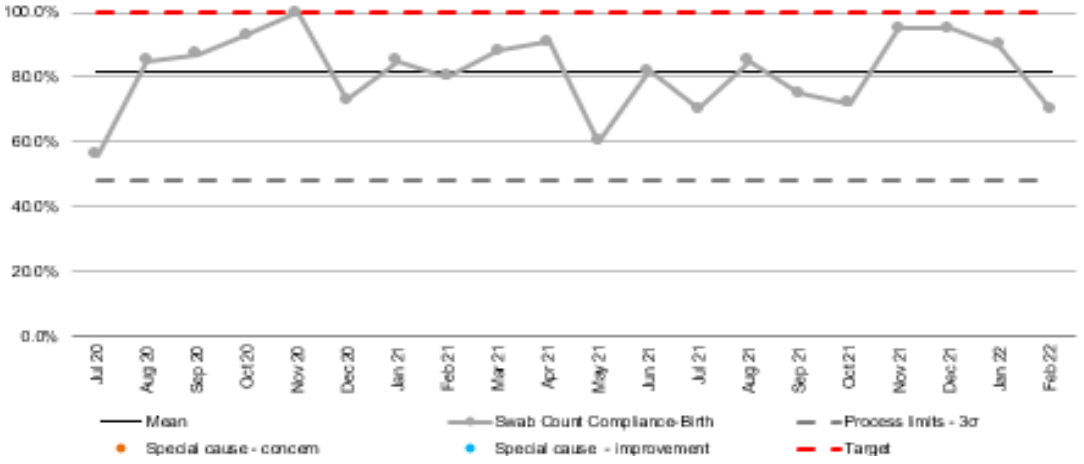
MLBU Controlled Drugs-West Suffolk Hospital Maternity starting 01/07/20



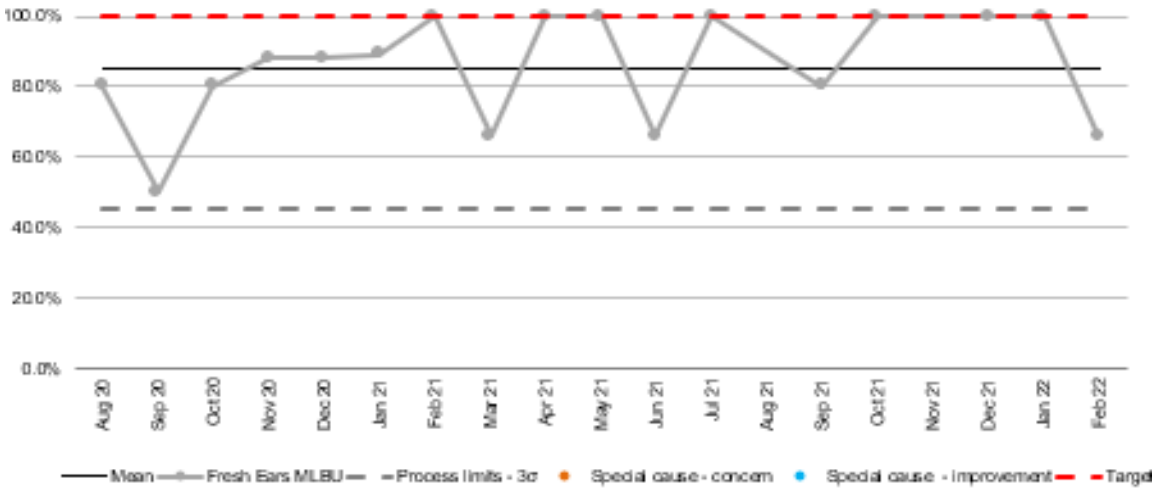
Percentage of women smoking at delivery-West Suffolk Hospital Maternity starting 28/04/19



Swab Count Compliance-Birth-Maternity starting 01/07/20



Fresh Ears MLBU-West Suffolk Hospital Maternity starting 01/08/20



Board of Directors – 25 March 2022

Agenda item:	Annexe B			
Presented by:	Sue Wilkinson, Executive Chief Nurse/ Karen Newbury, Head of Midwifery/Justyna Skonieczny, Deputy Head of Midwifery			
Prepared by:	Karen Newbury – Head of Midwifery/Beverley Gordon – Project Midwife/Justyna Skonieczny, Deputy Head of Midwifery			
Date prepared:	February 2022			
Subject:	**Ockenden review of maternity services – one year on**			
Purpose:	X	For information	X	For approval

Executive Summary

This report contains information to the Board on the progress made by West Suffolk NHS Foundation Trust Maternity Services towards implementation of the Immediate and Essential Actions (IEA) and workforce planning standards outlined in the Ockenden Report December 2020.

There were 7 IEAs in the recommendations as well as key elements related to maternity workforce planning.

The Trust submitted evidence against all of the recommendations in June 2021 and received a report on areas where the Trust needs to improve and develop. The Trust was given the opportunity to challenge areas where it was considered that sufficient assurance had been provided against some of the actions. After support from NHS England, some of these challenges were upheld and the overall compliance from the Trust improved. This report outlines the final compliance report received.
It should be noted that it was the lack of evidence available to support the submissions rather than the fact that the Trust was not undertaking the work which was a factor in some areas of non-compliance.

The percentage compliance over the 7 IEAs and Workforce Planning (3 elements) was 44% to 93%.

The key themes where further assurance and improvements were required are:

- Confirmation of the implementation of the Perinatal Quality Surveillance Model (PQSM)
- Audit planning and actions from audits
- Education and training plans and compliance from the multidisciplinary team (MDT)
- Confirmation of communication and support with and from the Integrated Care Systems (ICS), Local Maternity and Neonatal System (LMNS) with regard to shared learning, training compliance, dashboards and implementation and embedding of the PQSM
- Confirmation of shared learning through the Trust, LMNS and Regional Forums

Background

The Ockenden report was published in December 2020 following reviews of the care of 250 mothers and babies who had received maternity and neonatal care from Shrewsbury and Telford Hospitals Trust. Local learning and actions were put in place in the following aspects of maternity and neonatal care:

- **Maternity Care**
- **Maternal Deaths**
- **Obstetric anaesthesia**
- **Neonatal Services**

The lessons learned and actions taken were translated into a national 'survey' of all maternity units to answer the main question which was whether we can be assured as a Trust that our governance and safety processes are sufficiently embedded to reduce the likelihood of similar maternity patient safety issues occurring at WSH and avoidance of harm to mothers, babies and staff.

The Ockenden report had recommendations against **7** Immediate and Essential Actions in section 1 of the report. The headings for these 7 recommendations were:
1. Enhanced Safety
2. Listening to Women and Families
3. Staff Training and Working Together
4. Managing Complex Pregnancies
5. Risk Assessment Throughout Pregnancy
6. Monitoring Fetal Wellbeing
7. Informed Consent

In addition, in section 2 under the heading 'Workforce Planning', there were a further **3** categories for consideration of evidence making **10** in total. These categories were:
Maternity Workforce
Midwifery Workforce
NICE guidance and other guidance documents

An initial assessment/assurance tool was completed in February 2021 giving information on how the Trust assessed itself against the minimum requirements at this stage and what was required to demonstrate the Trusts commitment to improving safety and quality within Maternity Services. In May 2021, a more detailed self-assessment tool was received with the requirement to submit evidence against 47 out of the 49 questions related to the 7 IEAs and Workforce recommendations. that needed to be answered with evidence submitted to provide assurance of compliance or progress towards compliance.

Submission of evidence

The Trust submitted 223 pieces of evidence against the 47 questions. An initial response was received from the assessment panel in October 2021 and the Trust then had an opportunity to challenge areas where it was thought we were compliant. These challenges were reviewed by the NHS England East of England Regional Maternity Quality Lead and if agreed were submitted for further review with the Ockenden assessment panel. This resulted in uplifts in 5 of the Sections. The following table reflects the final assessment of compliance received at the end of this process.
A summary of the progress made towards compliance is also included with review dates and a RAG rating indicating whether we have evidence to confirm we have met the recommendations – green being evidence available and processes embedded, amber - some evidence or assurances still needed and red – insufficient evidence available currently.

Details of Results on Compliance

Immediate and Essential Action	Compliance	Areas of Non-Compliance and actions needed	Progress (February 2022)	RAG rating
1. Enhanced Safety (Questions 1-8)	63%	**Information gathering and sharing** – need more robust methods for obtaining minutes of and actions from key meetings within the Trust/LMNS ensuring that there is sufficient evidence that key issues such as data dashboards, shared learning are being discussed and actions taken to address safety issues. **Fully implement the Perinatal Quality Surveillance Model** within and outside the Trust. **Buddying arrangements** to be approved within and outside the LMNS to enable external review to take place when required.	Some progress has been made with sharing of information at Trust Board and LMNS and the quarterly reports and notes/actions from meetings reflect this. Evidence that quality and safety data is discussed, disseminated and monitored as part of the Perinatal Quality Surveillance Model and Framework needs further work within the Trust and at LMNS level. The LMNS has agreed a perinatal surveillance scorecard for the provision of key safety and quality data and outcomes from each of the Trusts which, alongside the narrative from reports and presentations, provides oversight of progress towards a safer maternity service. This scorecard will be utilised from April 2022. Buddying arrangements with another LMNS have been agreed by the Trust, awaiting sign off at the 2 LMNS Boards **Review 30th April 2022**	**AMBER**
Immediate and	**Compliance**	**Areas of Non-Compliance and actions**	**Progress (February 2022)**	**RAG rating**

Essential Action		needed		
2. Listening to Women and Families (Questions 9-16)	76%	**Roles and responsibilities of the Maternity and Neonatal Safety Champions (MNSC)** at Board level to be enhanced – **Board minutes/attendance log** indicating MNSC there as representative of this as well as substantive roles.	MNSC guidance updated and roles of the Board level safety champions defined. Board meeting attendance to include MNSC role. Needs monitoring to confirm implementation. Review notes and actions from MNSC meetings and walkarounds to ensure these are being actioned and addressed over a period of time. Open Board meetings recordings on You Tube and not clear who attended. Minutes available with attendance but does not indicate the presence and representation from MNSC as well as in their substantive Board role. MNSC to be asked to assist with this. **Review 30th April 2022**	**AMBER**
3. Staff Training and Working Together (Questions 17-23)	44%	**Training plans and evidence of MDT training** Monthly monitoring of MDT elements of training MDT ward rounds – attendance and frequency. MDT **neonatal resuscitation training** and updates.	Training schedules and plans to be updated to ensure there are MDT sessions being held and data administration to ensure that compliance is visible and can be managed. **Review progress on MDT training 31st March 2022**	**AMBER**
Immediate and	**Compliance**	**Areas of Non-Compliance and actions**	**Progress (February 2022)**	**RAG rating**

Essential Action		needed		
4. Managing Complex Pregnancies (Questions 24-29)	93%	**Audit plan** for regular monitoring of women with named consultant for complex pregnancies	Audit plan being updated in order that auditing takes place when required and actions are completed following analysis of results. **Review date 31st March 2022**	**AMBER**
5. Risk Assessment Throughout Pregnancy (Questions 30-33)	80%	Implementation and monitoring of **Personal Support and Care Plans, risk assessment and discussion re place of birth** at each antenatal contact and ongoing audits to monitor these issues – inclusion in an **audit plan.**	Ongoing work on ensuring that PSCP are in place for more women. Antenatal Care guideline for booking and ongoing assessments in pregnancy being updated February 2022. Risk assessment guidance and monitoring added to audit plan. Needs audit results to identify progress towards requirements. **Review date 31st March 2022**	**AMBER**
6. Monitoring Fetal Wellbeing (Questions 34-38)	61%	**Roles and responsibilities of the fetal monitoring (FM) leads** embedded and they are involved in incident reviews, shared learning and forums within and outside the Trust. **Compliance with FM training** for the MDT in accordance with TNA.	Evidence needed to ensure that FM leads are able to fulfil their roles in improving safety and reduce harm by effective fetal monitoring training and education and involved in reviews. Midwife lead new to role, 0.4 WTE hours allocated. Training compliance to be improved and maintained at a high level by FM leads. **Review date 31st March 2022**	**AMBER**
Immediate and	**Compliance**	**Areas of Non-Compliance and actions**	**Progress (February 2022)**	**RAG rating**

Essential Action		needed		
7. Informed Consent (Questions 39-44)	86%	Embed process for **responses to surveys, MVP reviews and improvement plans** and ensure that analysis of results of these and reports presented to all governance platforms within and outside the Trust. Part of **audit plan** to ensure there is a regular monitoring of user input into their care and the wider organisation of maternity services.	Action plan from MVP review is currently being progressed. Monthly meetings held to identify any issues identified with progress. Responses to surveys etc to be part of improvement plans and overseen at Q&S meetings. Audit plan to include actions as a result of surveys and user input etc. **Review date 30th April 2022**	**AMBER**
Maternity Workforce Midwifery Workforce NICE guidance and other guidance documents (Questions 45-49)	70%	**Reports on workforce planning** to be prepared, submitted and actioned in accordance with required timeframes.	Reports being submitted in accordance with MIS guidance on safety actions and programme or reports to be submitted to the Board. Recruitment to vacancies and new posts as identified from reviews. **Review progress reports 30th April 2022**	**AMBER**
		Process for **gap analysis of new or updated NICE guidance** to be embedded with risks raised for non-compliance to NICE guidance if relevant.	Improvement plan to include compliance with NICE Gap analysis and resulting risks if not compliant. **Review compliance and improvement plan 30th April 2022**	**AMBER**

Summary of progress against the Immediate and Essential Actions and Recommendations

- The roles and responsibilities of the Maternity and Neonatal Safety Champions (MNSC) have been enhanced. Set agenda items have helped to ensure that safety concerns and actions taken are clearly documented and escalated. Recording the MNSC role on attendance records at Board meetings as well as the substantive Trust role would further evidence that the Board Safety Champions are highlighting maternity and neonatal issues at Board level. A request has been made for this to be confirmed at Board meetings.
- Formal reports on key safety and quality issues are being prepared and submitted through the Trust's Governance processes within the agreed timeframes – a number of issues need quarterly progress and compliance reports to the Division, Maternity and Neonatal Safety Champions and Trust Board. Thereafter, these reports are shared with the Local Maternity and Neonatal System (LMNS) to be included in the Perinatal Quality Surveillance framework and sharing and learning forums.
- The Perinatal Surveillance scorecard has been developed for the LMNS and this will be in use from April 2022. This forms an overview of progress towards embedding the Perinatal Quality Surveillance Model.
- The annual clinical audit plan is being updated to ensure the quality and frequency of auditing and monitoring practice and actions as a result of audits are accurately recorded, presented and managed in accordance with local and national requirements for reporting.
- Full maternity investigation reports – internal and HSIB reports are now presented to the closed Trust Board and LMNS.
- The training plan for the next 3 years has been updated and the multidisciplinary (MDT) element of training is being progressed and recording of training being enhanced. There remain challenges with meeting the MDT elements in full, being able to retrieve training records easily when required and manage non-compliance with training requirements when indicated.
- The LMNS has developed a buddying arrangement standard operating procedure (SOP) to involve another LMNS in mandatory external reviews of certain incidents and unexpected outcomes within maternity and neonatal care. This SOP is awaiting signoff at the LMNS Board and for the other LMNS to sign the data sharing agreement. This is required to provide an external independent view on what has happened, why and what can be put in place to avoid the same thing happening again.
- Action and improvement plans from work with the Maternity Voices Partnership (MVP) are progressing with improvements to the website, signposting and information for patients and families being enhanced to meet the needs of all patients.

Workforce

- To reduce variation in experience and outcome for women and their families across England, NHS England and Improvement has invested money into maternity workforce to support sustained improvement in Maternity Service across the country. The national response to the Ockenden report included an investment into Maternity Service workforce by funding:

➢ **Additional midwifery roles**

Following on from the Birth rate + (BR+) survey which highlighted a gap in midwifery establishment across England, additional funding has been allocated to reduce variation in experience and outcomes for women and their families across England. NHS England and Improvement invested £95.9m in 2021/22 to support the system to address all 7 Immediate and Essential Actions highlighted in the Ockenden report to bring sustained improvements in our maternity services. Each Trust was encouraged

to complete their BR+ review and submit their result to LMNS as a collaborative approach to receive additional funding. As part of the review, the Trust's Maternity Service had a shortfall of 6 wte (whole time equivalent) midwives to meet the recommendation of the BR+ assessment. The funding for 6 wte midwives has been allocated to the Trust and have been recruited into. The Trust already had leads in key midwifery and obstetric specialist roles and as staff have left or changed roles, the updated job descriptions have enabled the maternity service to further enhance progress made in key areas of maternity care.

- **Backfill consultant obstetricians**

  The Trust received funding from Ockenden for 8 PAs related to obstetric workforce improvements and development of roles to improve safety.
  Prior to the funding becoming available, the maternity service in the Trust had previously increased the Consultant Obstetrician's presence to lead twice daily face to face ward rounds to 7 days a week.
  Obstetric specialist roles and responsibilities were clarified and leads for certain higher risk pregnancies and other aspects of safety and governance were confirmed.
  Due to the exceptional circumstances throughout the pandemic, shortages of staff due to absences and leave, some elective gynaecology work was deferred in order to provide urgent and emergency care when required and consultants were asked to provide more/additional direct clinical care sessions to protect patients and staff.
  A new on-call rota pattern was implemented from January 2022 that ensured that there was an adequate rest period after an overnight on-call shift and creation of an acute gynaecology on call consultant role. This has improved the focus on care of women in labour and complicated pregnancies and improved working conditions for the obstetric staff.
  There has been a review of job plans and timetables for obstetric sessions. Following this review, a 10 PA substantive resident On-Call Consultant in Obstetrics & Gynaecology that includes a Labour Ward Lead role and taking over the role of Fetal Monitoring Lead, has been created using the Ockenden funding and is due to be advertised with expected recruitment in April.
  Recruitment is also underway to replace two consultants who have left or are due to leave in recent months. One of these posts will be a fixed term contract. This will enable the service to be fully operational and for staff to have protected time to undertake their specialist and supportive roles within the maternity services as well as providing clinical care to the pregnant population.

- **Backfill for MDT training**

  Due to clinical commitments to cover for unexpected absences and vacancies, there has not been any opportunity to backfill obstetricians to allow for training to take place.

- **International recruitment programme for midwives**

  The Maternity International Recruitment project is a national scheme supporting Maternity Services to reduce their midwifery vacancy rate by July 2022, through ethical international recruitment process. Maternity international recruitment (IR) is a part of a comprehensive workforce strategy with overall aim to support Maternity Service within recruitment, retention and developing sustainable collaborative Maternity IR models, and developing and sharing best practice and resources to support organisations conducting Maternity IR.
  Following the launch of the Maternity International Recruitment programme lead by NHS England and Improvement, all Trusts were encouraged to submit their expressions of interest and bids to their Regional Teams to work collaboratively as Midwifery Working Group to support this project. The original bid submitted by the Trust

included a request for financial support around the recruitment of 14 midwives as well as funding to recruit staff to provide safe onboarding, induction and pastoral support for these recruits. As a result of the bid submitted, the Maternity Services at the Trust have been allocated funding to support 8 internationally recruited midwives and a funding for a 1-year fixed term Clinical Educator/ Clinical Practice Facilitator to support newly recruited midwives. The primary purpose of this role is to develop and deliver pastoral support as well as deliver and ensure appropriate education and training for the internationally recruited midwives, ensuring safe and effective transition into the Trust and life in the UK.

Recruitment is led by the Midwifery Working Group and is still on-going. The Trust has been actively participating in this process. Recruited midwives are expected to undertake an English language and Test of Competency before arriving into UK and will then undertake a preparation course for their final OSCE examination before obtaining their registration with the NMC. Internationally recruited midwives have been divided into 4 Cohorts and are due to arrive in UK in March, April, June and July. As of 1st of February 2022, 6 internationally recruited midwives have been allocated to the Trust with expected dates of arrivals in April and June 2022. The one-year fixed term role of Clinical Practice Facilitator / Clinical Educator has been advertised with a closing date of 14th February 2022.

- **Support to the recruitment and retention of maternity support workers**

As part of the ongoing commitment from NHS England and Improvement to support improvement in maternity services, additional funding became available to accelerate the recruitment and development of the maternity support workforce. This funding was designed to offer pastoral support and career progression to the maternity support workforce to enhance retention, improving support for registered midwives and ultimately improving quality of care across Maternity Services. A total amount available for each Trust was just under £140k and Maternity Service at the Trust has submitted their expression of interest and in the bid submitted included the request for funding of additional roles to support recruitment, retention and pastoral support for staff and a full amount of funding available has been allocated to the Maternity Services. The roles included in the proposal were:

- Education and Practice Development coordinator band 4: To support existing and new maternity support workers and provide ongoing learning and development opportunities. The post holder will be part of Practice Development team whose main focus will be to expand on education and learning experience of maternity care assistants, maternity support workers and other non-clinical staff. The post holder will be responsible for participating in the recruitment process, organisation and support during induction programme for newly appointed staff, support with the Fundamental of Care Certificate as well as ongoing development of existing staff.
- Maternity Rota Administrator band 3: To support the Bleep Holders and Matrons to coordinate and organised an efficient administration for Maternity services by ensuring staff rotas (including co-ordinating off duty movements; annual leave requests, shift swaps, extra hours/ bank shifts and sickness/ absence) and enquiries are dealt with in an efficient and timely manner. To develop and maintain effective administration systems in order to support high quality clinical service.
- Midwifery Administrator support band 3: To support the team of specialist midwives in their roles as administrative support. The post holder will be responsible for providing a specialist administration service that is comprehensive and confidential in accordance with Department, Trust and National standards, policies and procedures. The postholder will be responsible for ensuring that information relevant to the efficient running of the services are recorded on the relevant databases for audit and monitoring purposes. This will support the new way of working, while making the best use of the

full range of resources and increase time to provide care.

- Digital champion band 5: The post holder will support and work within the current maternity IT system team and will undertake a range of support activities relating to the new IT system, E-care. The post holder will provide support to registered and non-registered staff to familiarise them with the use of the new system.
- Pastoral Care Coordinator band 3: This post holder would be responsible for providing pastoral support and advice for candidates commencing work with the maternity service. As well as supporting the candidates in this specific project, the Pastoral Care Coordinator will also work closely with the Practice Development Midwives (PDMs). Under the supervision and with the support of the PDMs, act as a focus of support and guidance for new staff joining the organisation/maternity service for the first time. The post holder will offer emotional and social support, with practical assistance to help people feel safe and supported in their first few days, weeks and months.

  The job descriptions have been completed and are awaiting banding review before advertising.

Areas of good practice

- Identifying and referring women who need additional care due to medical complexities
- A number of Standard Operating Procedures (SOPs) have been developed that outline processes underpinning the services provided by the Trust
- Embedding of the Clinical and Quality Dashboards into the Trust
- Embedding of the Maternity and Neonatal Safety Champions and oversight of safety issues
- Work with Maternity Voices Partnership to enhance and improve services through involvement in evaluation of care and environments, surveys, guideline development and review, service improvements, and review of information and multimedia for women and families.
- Embedded processes for assurance of workforce planning and safe staffing levels
- Reporting pathways to the Trust are structured to aid with timeframes

Next Steps

1. Embed the processes developed during the assessment process in 2021 including involvement of the MNSC and MVP in developing and sustaining safe care which is of a high quality.
2. Work as an MDT to enhance the approach to training and keeping accurate records of training attended and compliance with requirements.
3. Work with the LMNS to ensure that there is seamless sharing of learning and education within and outside the LMNS and enabling the buddying arrangements to be embedded across the LMNS's.
4. Embed the Perinatal Quality Surveillance Model and Framework at Trust and LMNS level
5. Audit plans to be further developed and maintained to ensure that there is oversight and improvement in elements of care when required
6. Processes for ensuring notes and actions from key meetings demonstrate sharing and learning within and across the organisations providing maternity care within the LMNS and within the region.
7. Review of actions and progress to be undertaken as indicated on the plan.

Recommendations from Morecambe Bay Review Template

Advisory notes:

- The template is to support you to benchmark where maternity services are now with regard to the Morecambe Bay recommendations in the Kirk-up report 2015.
- If the evidence is within your Ockenden report 2020 action plans you could choose to embed and reference where it is in the document.
- Please amend the examples of evidence column to meet compliance for your maternity services.
- The wording of the recommendations is not exactly the same as in the actual report. This is because the recommendations were extremely lengthy, and we have summarised what the ask was.

Maternity Unit:- West Suffolk NHS Foundation Trust **Date:-** 17/2/22 **Completed by:-** Maternity Team

Recommendations for the University Hospitals of Morecambe Bay NHS Foundation Trust for other Trusts to benchmark against.	**Linked to further reviews/regulation**	**Evidence**	**Embedded Compliance** Red none Amber partially Green fully	**Actions to be embed compliance fully**
1. Is an apology given to those affected, for the avoidable damage caused and any previous failures to act. **Action: Trusts**	Duty of Candour legislation regulation 20 CQC Safe Domain	Duty of Candour Policy in place; timeframes met when indicated including for PMRT. Weekly emails sent to the Quality and Safety team regarding DOC	**GREEN**	
2. Review the skills, knowledge, competencies, and professional duties of care of all obstetric, paediatric, midwifery and neonatal staff, and agency, locums caring for the critically ill in anaesthetics and intensive and high dependency care, against all relevant guidance from professional and regulatory bodies. **Action: Trusts**	CNST SA8 Ockenden IEA 3 CQC Effective Domain	PROMPT training for managing obstetric emergencies and use of MEOWS. Induction programme for all staff regarding maternity recovery. The training day, MM2 covers immediate recovery/postnatal care in 2022. Specific recovery care was delivered in training day MM2 2021 and will be repeated on MM2 training day in 2023 as part of the 3 year rolling training plan.	**AMBER**	Recovery training on mandatory training day from 2023 as part of the 3 year rolling training plan.

		Women having a general anaesthetic are recovered in the recovery area with trained recovery practitioners. HDU and Critical Care is not provided in the maternity unit. Patients are transferred to the general HDU/CCU. Level 1 Special Care Neonatal Unit and neonatal unit medical and nursing staff maintain competencies and standards as part of Qualified in Speciality.		
3. Identify opportunities to broaden staff experience in other units, including by secondment and by supernumerary practice. **Action: Trusts**	CNST SA8 CQC Well Led Domain Ockenden IEA 3	Preceptorship Programme in place within the unit. Clinical secondments to other Units are not offered currently but staff are seconded to different roles within and outside the Trust when required / available or as part of leadership development programmes and staff attend other units as part of revisions to service development. Induction Programme for new staff including period of supernumerary practice and experience in all areas. Co-located MLBU. Individual action plans in line with HR policy as required.	**AMBER**	Review availability of secondments and prioritise according to professional and service needs.
4. Continuing professional development of staff and link this explicitly with professional requirements including revalidation. **Action: Trusts**	CNST SA 8 Ockenden IEA 3 CQC Safe Domain	All staff meet revalidation requirements – overseen by HR revalidation team and line managers and staff notified in advance of their revalidation being expected. Appraisals undertaken <90% in some staff groups but good progress being made January 2022 data: 93% community midwives; 90% support staff; 83%	**AMBER**	Progress towards >90% for appraisals – ongoing work towards >90% compliance by end March 2022. Newly appointed senior staff undertaking appraisal training.

		Hospital based midwifery staff; 84% consultant obstetricians; SPC charts presented at monthly Q&S meetings. TNA identifies needs of each staff group, training is not MDT in some cases – neonatal resuscitation and fetal monitoring. PMA support in place for midwives' revalidation process and educational supervisors with professional development of trainees.		MDT training – paediatricians to attend PROMPT training. Database for training to be formulated and maintained for each staff group.
5. Promote effective MDT working, joint training sessions. **Action: Trusts**	CNST SA 8 Ockenden IEA 3 CQC Effective Domain	MDT Mandatory Training – compliance improving but Neonatal resuscitation not currently MDT and records of NLS training amongst paediatricians are not up to date. Fetal Monitoring training – compliance <90%. Live Skills & Drills – deferred during Covid	**AMBER**	Improve compliance for fetal monitoring training in both staff groups. MDT training programme for neonatal resuscitation needs to be progressed and paediatricians will attend PROMPT from Reintroduce live skills and drills – Baby abduction training February 2022 and to have drills in March 2022. Evacuation from the birthing pool drill March 2022. The remainder of the skills and drills training will commence as a rolling programme from April 2022.

6. Protocol for risk assessment in maternity services, setting out clearly: who should be offered the option of high or low risk care. **Action: Trusts**	Ockenden IEA 5 CQC Safe Domain	Clinical risk assessment guidelines in date, SOP in place for risk assessments at each contact. Audit plan being updated to ensure these are carried out monthly. Field in e-care for risk assessment at each contact and in labour. At 34-36 weeks risk assessment for birth on the MLBU and at home are completed and again on admission – evidence report is required to confirm compliance. The quality of the data was poor previously. With the appointment of a digital midwife and improved and additional fields added to e-care, data is now more robust and of an auditable standard. The data for January 2022 will be analysed and a report written on progress towards compliance.	**AMBER**	Maintain frequent audits and monitoring with lessons learned and improvements made as required. Improvements and actions required will be shared on weekly Take 5 communications and results and lessons learned will be shared on the monthly Risky Business newsletter.
7. Audit the operation of maternity and paediatric services, to ensure that they follow risk assessment protocols. **Action: Trusts**	CNST SA 6 Ockenden IEA 5 CQC Effective Domain	Clinical risk assessment guidelines in date Audit of a proportion of case notes monthly as part of Perfect Ward – 5 sets of notes audited weekly. The quality of the data was poor previously. With the appointment of a digital midwife and improved and additional fields added to e-care, data is now more robust and of an auditable standard. The data for January 2022 will be analysed and a report written on progress towards compliance. Quarterly reports for TC and ATAIN are submitted to MNSC and Trust Board.	**AMBER**	Awaiting outcomes of audits to demonstrate achieving and maintaining compliance. Review of regional and national data to support local improvements as required.

		NNAP reports every quarter to check data and any improvements needed are actioned. ODN monthly dashboards with Badgernet extractions.		
8. Identify a recruitment and retention strategy achieving a balanced and sustainable workforce with the requisite skills and experience. **Action: Trusts**	CNST SA 4 & 5 Ockenden IEA Workforce CQC Safe Domain	BR+ assessments and evidence to agree funding – carried out annually and BR+ APP used by LW coordinator. Board reviews of midwifery and clinical work force – midwifery 6 monthly reports and other clinical workforce reports are annual based on 6 months of rotas. LMNS RPQOG monthly midwifery workforce data submitted via LMNS Board; quality dashboard outlines staffing. Ongoing workforce challenges – escalation policy and plan used when required. HR report including return to work policy and procedure, flexible working meetings and plans made when required. International recruitment in progress. Specialist Midwife posts recruited to. Staff survey identifying how working lives can be improved. Retention webinars and flexible working options within the Trust. Staff supported through wellbeing service and the PMA. Exit interviews are offered to all staff leavers – monthly report is compiled by HR and information sent to HoM.	**AMBER**	No internal policy for recruitment and retention but programmes being put in place to maintain retention of staff. International recruitment plan for the Trust for staff to be in place by July 2022. Review of 6 months of rotas for neonatal medical staff, nursing staff and obstetric anaesthetists undertaken in accordance with MIS year 3 and 4. This is repeated annually rather than 6 monthly. Midwifery staffing report prepared and submitted 6 monthly. Monthly establishment meetings to be in place from April 2022.

9. Joint working between its main hospital sites, including the development and operation of common policies, systems and standards. **Action: Trusts**	CNST SA 9 Ockenden IEA 1 & NICE CQC Effective Domain	Joint LMNS policies/guidelines/projects discussed but no decision as to taking this forward. The Trust is a single site with a co-located MLBU so guidelines, pathways and policies are the same. Perinatal Quality Surveillance Framework proposed June 2021 – LMNS scorecard from April 2022. Governance processes and procedures apply to the whole of the maternity services provide by WSNHSFT.	**AMBER**	Monitor implementation of PQS scorecard when implemented in April 2022. This will be monitored at the LMNS Board meetings which occur every other month.
10. Forge links with a partner Trust, to benefit from opportunities for learning, mentoring, secondment, staff development and sharing. **Action: Trusts**	CNST SA 8 Ockenden IEA 1 & 4 CQC Well Led Domain	Regional PDM forum Regional PMA forum Lead MW Educator meetings LMNS buddy SOP External review of SI's and PMRT From March 2022 – joint CCG meetings to discuss SI's. SIs presented at LMNS Board and shared with other LMNS's as requested.	**AMBER**	Buddying arrangements with another LMNS – to be agreed and embedded once agreed by all Trusts – awaiting partner Trust sign off as at 22/2/22. Terms of reference for other groups / meetings / forums / pathways where learning is shared are to be formalised and agreed at LMNS/CCG and regional level.
11. Staff awareness of incident reporting, review its policy of openness and honesty. Duty of Candour compliance. **Action: Trusts**	CNST SA 8 Ockenden IEA 2 & 9 CQC Safe Domain	Mandatory training includes incident reporting and Duty of Candour. Shared learning with newsletter – 'Risky Business'. Handovers and Safety Huddles discuss incidents that have been reported or need to be reported.	**GREEN**	Maintain shared learning, openness and honesty with MNSC.

		Ward to board round – NED and medical director are Safety Champion and involved in Safety Champions meetings and walkarounds and attendance at MVP. Weekly emails sent to the Quality and Safety team regarding DOC		
12. Review the structures, processes and staff involved in investigating incidents, RCA, learning, training. Include arrangements for staff debriefing and support following a serious incident.	CNST SA 3 Ockenden IEA 1 CQC Safe Domain	Maternity Risk and governance framework in place. Incident management pathway updated to include updated PSIIRF. Psychological support for staff – debriefs; PMA support; AAR; psychological first aid and de-briefs; lessons learnt shared at handovers, newsletter, notice boards, email, closed media forums	**GREEN**	Maintain safe supportive processes
13. Review the structures, processes and staff involved in responding to complaints, and learning are the public involved. **Action: Trusts**	CNST SA 1 & 7 Ockenden IEA 2 CQC Effective Domain	Complaints policy in date PP(19)002 May 2022 PALS You said we did responses MVP involvement All PMRT cases, SI's and HSIB reports reflect the family's voice/feedback	**GREEN**	Maintain and continue to learn and provide a responsive caring service
14. Review arrangements for clinical leadership in obstetrics, paediatrics and midwifery, to ensure that the right people are in place with appropriate skills and support. **Action: Trusts**	CNST SA 8 Ockenden IEA 3 & Workforce CQC Safe Domain	Mandatory Training compliance 90% in some staff groups – improvement needed in NN resuscitation and Fetal Monitoring training. NN resuscitation Q3 compliance 45% paediatric consultants; 33% trainee paediatric staff; 96% NN nursing staff; 98% midwives Fetal monitoring training (K2) Q3: 91% midwives; 79% obstetric staff. Other training sessions for fetal monitoring training sessions twice weekly led by the FM leads	**AMBER**	Increase MDT training for NN resuscitation by paediatricians attending PROMPT started February 2022 – to be embedded from April 2022. Fetal monitoring training reports to include both K2 and face to face training – report needed to be in

		Board reviews of midwifery and clinical work force – midwifery 6 monthly reports and other clinical workforce reports are annual based on 6 months of rotas. RCM leadership requirements RCOG workforce issues/role-responsibilities guidance – guidelines updated. Evidence of Leadership development programme and succession planning for Clinicians – currently 53% of obstetric consultants have attended a leadership course		place from end of Quarter 4. Complete update of guidelines for RCOG compliance for attendance for clinical scenarios and monitoring process embedded from March 2022. Leadership programmes being put in place for staff throughout 2022.
15. Review of governance systems clinical governance, so that the Board has adequate assurance of the quality of safe care. **Action: Trusts**	Ockenden IEA 1 CQC Well Led Domain CNST 10 SA	Maternity Risk and Governance Framework in place. Incident Management pathway which includes PSIRF being updated 2021/2022 and planning 2022/2023. Maternity clinical and quality dashboards in place. Risk Register maintained. Governance structure for the Board – being reviewed. HOM presents directly to Board not sub-committees.	**AMBER**	Trust Corporate Governance framework being embedded.
16. Ensure middle managers, senior managers and non-executives have the requisite clarity over roles and responsibilities in relation to quality, and provide appropriate guidance and training. **Action: Trusts**	CNST SA 4,5 & 8 Ockenden IEA Workforce CQC Well Led Domain	Appraisals for senior staff where job descriptions, roles and responsibilities and professional development is discussed and agreed. JD include roles and responsibilities MNSC – Medical Director and NED walk rounds engagement.	**AMBER**	Evidence to be provided of the Senior Leadership Team walkarounds. Review of training needs for middle,

		SLT visibility – limited to MNSC as a regular occurrence; other senior staff to provide evidence of regular visits to the clinical areas. Safety Champions walk rounds engagement. Some Consultants have had leadership training 53% currently completed a course.		senior managers and other Executive and non-executive staff.
17. Review access to theatres, and ability to observe and respond to all women in labour and ensuite facilities; arrangements for post-operative care of women. **Action: Trusts**	CNST SA 9 Ockenden IEA 4 & 5 CQC Safe Domain	Immediate access to 2nd theatre. Recovery staff are trained, and competency assessed in line with national guidance – provided by Theatres and anaesthetics – recovery practitioners in place for women who have a general anaesthetic. Induction programme for all staff regarding maternity recovery. The training day, MM2 covers immediate recovery/postnatal care in 2022. Specific recovery care was delivered in training day MM2 2021 and will be repeated on MM2 training day in 2023 as part of the 3 year rolling training plan. Women having a general anaesthetic are recovered in the recovery area with trained recovery practitioners. MEOWS training for maternity staff at PROMPT.	**AMBER**	Maintain compliance with labour suite coordinators being supernumerary >98%. This is monitored daily and reported on the monthly quality dashboard and RPQOG (LMNS) dashboard presented at LMNS board bi-monthly. Reported as part of the 6 monthly midwifery staffing report and submitted to the Board. Discussions with region about an agreed definition of supernumerary status so that effective comparisons can be made with other Trusts.

		Midwifery Staff are not providing level 2 HDU care – this is not mandatory for Trusts. LW coordinators supernumerary >98% for the last 3 months. 1-1 care given in established labour – 100% compliance Ensuite facilities in all birthing rooms – dedicated bathrooms in close proximity to side rooms on the wards.		Report on compliance with Recovery training to be prepared.
18. All of above should involve CCG, and where necessary, the CQC and Monitor. **Action: Trusts**	CCG assurance visits CQC regulation visits	Outcomes of visits reported at Q&S meetings and Maternity Improvement Board (MIB) CQC ratings Action plans Actions plans monitored floor to Board – Board reports and overarching action/improvement plans. Feedback to staff External supportive visits completed and actions and improvements monitored within and outside the Trust.	**GREEN**	Maintain progress and communication with staff.

The recommendations below were allocated to be actioned by the wider NHS and selected stakeholders we suggest reviewing how these apply at provider level				
19. Professional regulatory bodies should review the findings of this report: **Action: NMC, GMC**	None Known	To follow up	N/A	
20. National review of the provision of maternity care and paediatrics in challenging circumstances, including areas that are rural, difficult to recruit to, or isolated. This should identify the requirements to sustain safe services under these conditions: **Action: NHSE, CQC, RCOG, RCPCH, NICE**	CNST 10 safety actions CQC Safe Domain	Local Assessment Better Births report LMNS implemented Maternity transformation Maternity Services Improvement Programme in place. Consider incentives for working at the Trust	**GREEN**	Maternity Services Improvement Programme in place and progress being monitored.
21. We recommend that NHS England consider the review of requirements to sustain safe provision to services difficult to recruit to or isolated is not restricted to maternity care and paediatrics: **Action: NHSE**	Ockenden IEA 1 CQC Safe Domain CNST SA 4 & 5	Regional workforce workstream Local assessment. NICE safer staffing guidelines BR+ LMNS to implement maternity transformation workstream	N/A	
22. Review of the opportunities and challenges to assist remote or smaller units in promoting services and the benefits to larger units of linking with them. **Action: HEE, RCOG, RCPCH, RCM**	Ockenden IEA 1 CQC Safe Domain CNST SA 4, 5 & 9	Local Assessment Girth visits Mergers of some Trusts LMNS to implement maternity transformation workstream	N/A	
23. Clear standards should be drawn up for incident reporting and investigation in maternity services. These should include the mandatory reporting and investigation as serious incidents of maternal deaths, late and intrapartum stillbirths and unexpected neonatal deaths. **Action: CQC, DOH**	Ockenden IEA 1 CQC Safe Domain CNST SA 10	Maternity Risk Management strategy in date – pathways and national reporting guidance followed Governance structure NHS resolution HSIB	**GREEN**	Monitor reporting to HSIB and MBRRACE through quarterly reports.
24. Introduction of the duty of candour for all NHS professionals. **Action: CQC, NHSE**	Ockenden IEA 3 CQC Safe Domain	CQC DOC guidance for providers DOC policy in date	**GREEN**	Monitor compliance with DoC

		Weekly emails sent to the Quality and Safety team regarding DOC		
25. NHS Boards to report openly the findings of any external investigation, including prompt notification of relevant external bodies such as the CQC and Monitor. **Action: DOH, CQC**	CNST SA 10 Ockenden IEA 1 CQC Safe Domain	Reports from external reviews Action Plans Evidence of notification emails	**GREEN**	Maintain reporting to HSIB and PMRT and monitoring actions. Buddying arrangements being confirmed
26. Introduction of a clear national policy on whistleblowing. **Action: DOH**	CQC Well Led Domain	Whistleblowing policy in date? FTSUG policy FTSUG representatives Mandatory e-learning package in place	**GREEN**	
27. Reinforce the duty of professional staff to report concerns about clinical services, and patient safety issues. **Action: GMC, NMC, PSAHSC**	CNST SA 8 Ockenden IEA 1 CQC Safe Domain	WB policy Governance structure Staff training Mandatory e-learning package in place	**GREEN**	
28. Clear national standards should be drawn up setting out the professional duties and expectations of clinical leads at all levels Trusts should provide evidence to the CQC. **Action: CQC, NMC, GMC, NHSE**	CQC Well Led Domain Ockenden Workforce	JD's Internal leadership structure RCM leadership requirements RCOG workforce issues/role-responsibilities guidance – SOP in place and clinical guidelines updated and Job plans updated.	**AMBER**	Leadership programmes to be offered throughout 2022. JDs reflect responsibilities in leadership roles. Monitor consultant presence as per RCOG.
29. Clear national standards should be drawn up setting out the responsibilities for clinical quality of other managers, should provide evidence to the Care Quality Commission. **Action: CQC, NHSE**	CQC Well Led Domain Ockenden Workforce	JD's Internal leadership structure RCM leadership requirements RCOG workforce issues/role-responsibilities guidance – SOP in place and clinical guidelines updated, job plans JDs for mw specialist	**AMBER**	Leadership programmes embedded JDs and job plans reflect responsibilities in leadership roles
30. A national protocol should be drawn up setting out the duties of all Trusts and their	CQC Well Led Domain	HSIB Process followed	? N/A if national	

staff in relation to inquests. To include, the avoidance of attempts to 'fend off' inquests, a mandatory requirement not to coach staff or provide 'model answers', the need to avoid collusion between staff on lines to take, and the inappropriateness of relying on coronial processes or expert opinions provided to coroners to substitute for incident investigation. **Action: NHSE, CQC**		Internal legal team guidance and support for staff attending coroners court – nominated staff member for Inquests. Maternity Risk Management Strategy	protocol coming	
31. A fundamental review of the NHS complaints system is required, with particular reference to strengthening local resolution and improving its timeliness, introducing external scrutiny of local resolution and reducing reliance on the Parliamentary and Health Service Ombudsman to intervene in unresolved complaints. **Action: DOH, NHSE, CQC**	CNST SA 7 Ockenden IEA 2 CQC Effective Domain	Complaints policy including how to contact Ombudsman in date PALS You said we did responses MVP involvement All PMRT cases, SI's and HSIB reports reflect the family's voice/feedback	**GREEN**	
32. Local Supervising Authority system for midwives was ineffectual at detecting manifest. Urgent review and reform is required. **Action: DOH, NHSE, NMC**	CQC Well Led Domain	A-EQUIP model introduction of PMA's – in place. PMA SOP MatSOP 21	**GREEN**	
33. Organisations draw up a memorandum of understanding specifying roles, relationships and communication of regulation by CQC and financial and performance by Monitor. **Action: CQC, DOH, Monitor**	None Known	In place NHS Improvement performed Finance inspections alongside CQC inspections	? N/A	
34. A memorandum of understanding be drawn up clearly specifying roles, responsibilities, communication and follow-up, including explicitly agreed actions where issues overlap with complaints. **Action: CQC, PHSO**	None Known	To follow up	? N/A	

35. NHS England draw up a protocol that clearly sets out the responsibilities for all parts of the oversight system, including itself, in conjunction with the other relevant bodies; the starting point should be that one body, the Care Quality Commission, takes prime responsibility. **Action: CQC, NHSE, DOH, Monitor**	None Known	Local meetings CQC and NHSEI sharing intelligence Quality summits held when required	? N/A	
36. DOH should review how it carries out impact assessments of new policies to identify the risks as well as the resources and time required. **Action: DOH**	None Known	HSCSC Report into Maternity Services – published June 2021	? N/A	
37. An explicit protocol be drawn up setting out how such processes will be managed in future Organisational change that alters or transfers responsibilities and accountability carries significant risk, which can be mitigated only if well managed. **Action: DOH**	None Known	CQC report any concerns to NHSEI prior to a merger LMNS Board Regional Perinatal Quality Oversight Group includes all stakeholders	? N/A	
38. Recording systems are reviewed and plans brought forward to improve systematic recording and tracking of perinatal deaths. This should build on the work of national audits such as MBRRACE-UK, and include the provision of comparative information to Trusts. **Action: NHSE**	Ockenden IEA 1 CQC Safe Domain CNST SA 1	PMRT Tool completed to the required standards of reporting as per MIS and PMRT guidance (this is not 100% of PMRT completed). Demonstrated in quarterly Perinatal mortality/PMRT reports.	**GREEN**	Maintain standards as per guidance from MIS and PMRT
39. There is no mechanism to scrutinise perinatal deaths or maternal deaths independently, to identify patient safety concerns and to provide early warning of adverse trends. **Action: DOH**	Ockenden IEA 1 CQC Safe Domain CNST SA 1 & 10	PMRT Tool completed to the required standard (NB this does not have to be 100%). HSIB reporting 100% if consent received. Reported in quarterly reports	**GREEN**	
40. Given that the systematic review of deaths by medical examiners should be in place, as above, we recommend that this system be extended to stillbirths as well as	Ockenden IEA 1 CQC Safe Domain	Risk Management Strategy Policy for review of deaths – learning for deaths.	N/A	Requires national policy change

neonatal deaths, thereby ensuring that appropriate recommendations are made to coroners concerning the occasional need for inquests in individual cases, including deaths following neonatal transfer. **Action: DOH**		Medical Examiner currently involved in NND and MD only.		
41. Systematic guidance drawn up setting out an appropriate framework for external reviews and professional responsibilities in undertaking them. **Action: Academy of Medical Royal Colleges, RCN, RCM**	Ockenden IEA 1 CQC Safe Domain	GIRTH visits CQC core service framework NHSEI self-assessment framework	?N/A	
42. All external reviews of suspected service failures be registered with the CQC and Monitor, and that the CQC develops a system to collate learning from reviews and disseminate it to other Trusts. **Action: CQC, Monitor**	Ockenden IEA 1 CQC Safe Domain	MMSP Programme National HSIB Report CQC maternity reports	N/A	
43. The importance of putting quality first is re-emphasised and local arrangements reviewed to identify any need for personal or organisational development, including amongst clinical leadership in commissioning organisations. **Action: NHSE, DOH**	National NHSEI team ICS	CQC report any concerns to NHSEI prior to a merger LMNS Board Regional Perinatal Quality Oversight Group includes all stakeholders	?N/A	
44. Establish a proper framework, on which future investigations could be promptly established. This would include setting out the arrangements necessary to access to documents, clarifying responsibilities of current and former health service staff to cooperate. **Action: DOH**	National NHSEI team ICS	Information Governance Policy IG training SLT support for staff before, during and after external investigations.	Corporate level	

NHS
West Suffolk
NHS Foundation Trust

ATAIN Programme

Avoiding Term Admissions to the Neonatal Unit

Progress Report
Quarter 3
October-December 2021

December 2021

Rebecca Warburton - Clinical Risk Midwife
Dr Ian Evans - Neonatal Safety Champion
Dr Jageer Mohammed – Acting Lead Neonatologist
Karen Ranson - Ward Manager NNU

Background to project

ATAIN (an acronym for 'avoiding term admissions into neonatal units') is a programme of work to reduce harm leading to avoidable admission to a neonatal unit for infants born at term, ie ≥ 37+0 weeks gestation.

The programme focuses on 4 key clinical areas which make up the majority of admissions to neonatal units, however it is expected that shared learning from local reviews will identify other reasons for admission.

The ATAIN programme uses tools developed by NHS improvement for the 4 areas under focus:

- Respiratory conditions
- Hypoglycaemia
- Jaundice
- Asphyxia (perinatal hypoxia – ischaemia)

The local definition of an admission is a baby who is on the neonatal unit for more than 4 hours.

Local reviews

For all unplanned admissions to the neonatal unit for medical care at term, a joint clinical review by maternity and neonatal services takes place each month to identify learning points to improve care provision, and considers the impact that transitional care service has on reducing admissions and identifies avoidable harm. Learning is identified and included on a rolling action plan. The review group includes:

- Neonatal ward manager / neonatal practice development nurse
- Clinical risk manager / clinical risk midwife
- Consultant paediatrician
- Consultant obstetrician (either attends the meeting or reviews records outside of the ATAIN meeting)

Process for review

The neonatal and midwifery team review the maternal and neonatal records prior to the ATAIN meeting using the approved NHS improvement tools. Cases identified which require in depth obstetric review are discussed with a consultant obstetrician to determine if different care in labour may have reduced the risk for the baby.

A Review of Terminology

In line with the newly implemented patient safety incident response framework (PSIRF), of which the Trust is an early adopter, the perspective of reviewing incidents and the terminology used has been amended to better promote shared learning and improved care. As such, we have moved away from the term "avoidable and unavoidable" and are instead looking at if the admissions where appropriate and if there is any learning to be gained from the circumstances

around their admission; including what steps could be made to improve care, with the aim of reducing the overall term admission rate.

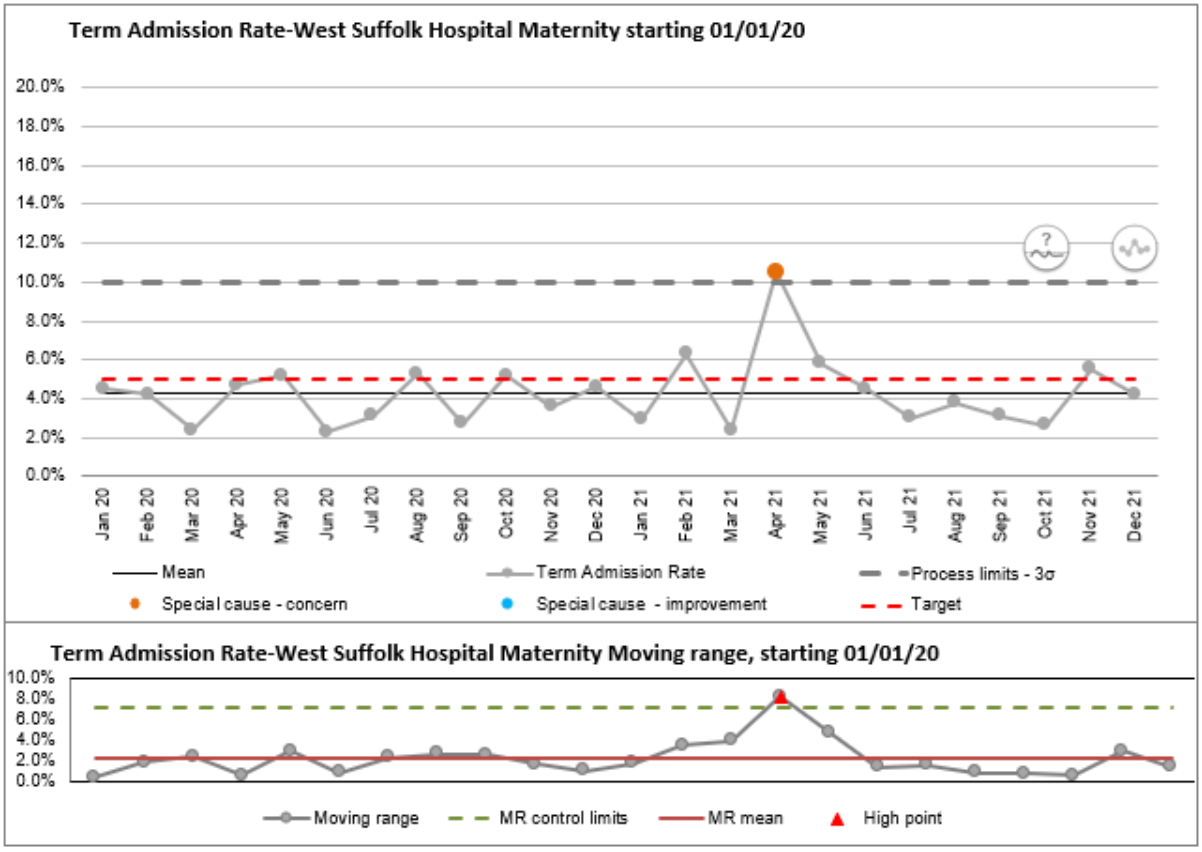
Findings

Term admission rates vary month on month. During the past quarter they have remained stable, with only one month exceeding the target level of < 5%. However, it should be noted that a few admissions this quarter would have been suitable for transitional care had there been parental availability, or adequate staffing levels, which has impacted on the data.

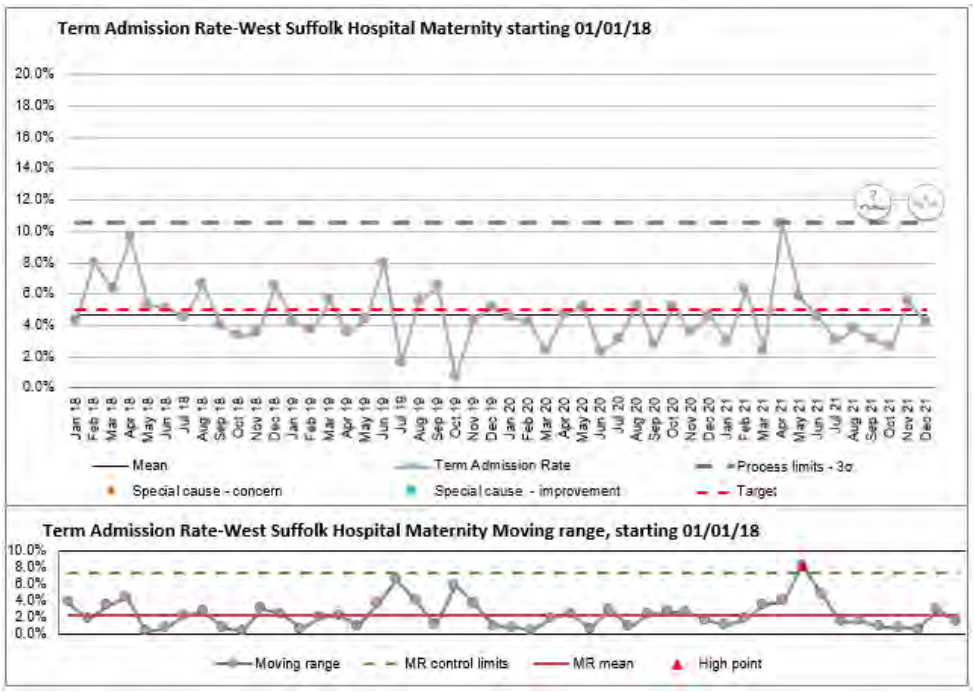
Cases were reviewed carefully to identify any areas for learning and improvement. While respiratory support remains the predominant reason for admission this quarter, no overarching themes or common denominators were identified.

Any opportunities for learning or improvement that were identified on an individual case basis were discussed and any appropriate action plans created. These have been added to the rolling action plan and actions are on-going.

Progress



Overall progress since programme began (2018)



Opportunities for learning

In the past quarter, all of the admissions were classified as appropriate, in terms of our current guidelines and criteria for transitional care (TC).

However, 6 cases were deemed to have been potentially more appropriate for TC (rather than Neonatal Unit (NNU) which could have been facilitated in 2 of these cases if there was adequate staffing available to run the transitional care bay on a full-time basis, or as with the other 4 of these cases, a parent was available to stay with the baby.

Currently, this bay is not able to be staffed by neonatal unit staff full time due to staffing constraints. Instead, nurses and nursery nurses visit the ward when care is required. If a member of staff was able to be present consistently to care for babies in TC, the criteria for TC could be reviewed and expanded and more babies would be able to remain by their mothers' side.

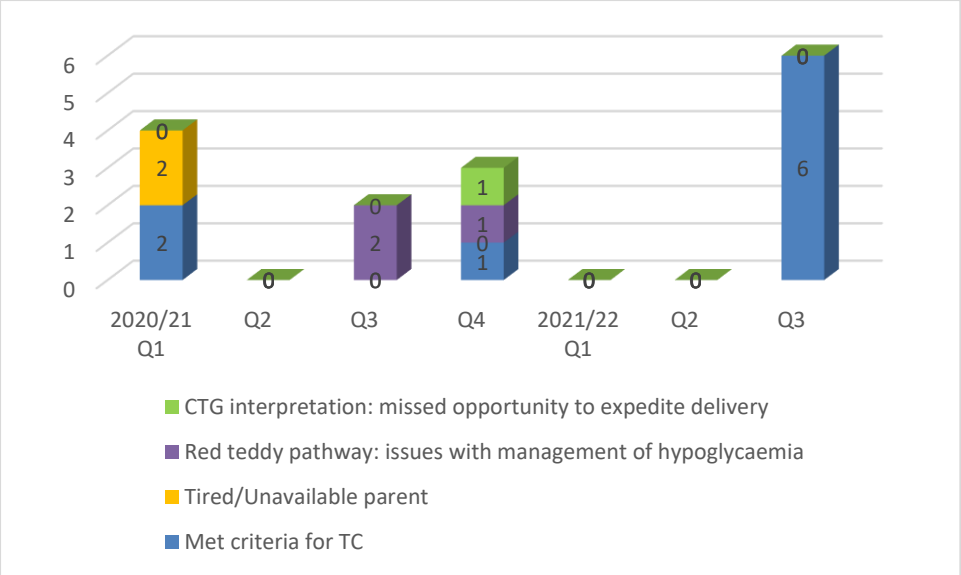
The NNU have recently received funding to hire 5.8 WTE Nursery Nurses who will be utilised to run the TC service 24 hours a day, 7 days a week; with oversight from an NNU nurse who will continue to be based on the Neonatal unit. This has the potential to significantly reduce the number of Term admissions to the NNU.

However, in incidences where parents decline to stay with their baby for personal reasons -it is appropriate to admit the baby to the NNU as this is considered to be the safest option in terms of clinical care and treatment, while continuing to support the ethos of providing personal and individualised care.

Historical reasons for term admission to NNU

This table shows the reasons previously identified as being the cause of potentially avoidable term admissions. In this quarter all admissions were appropriate but as discussed above, 6 may have been suitable for transitional care were the facility and/or parental presence available.

(Please note this graph has been amended from previous reports to reflect the quarterly data within the context of the financial year).



Action Plans

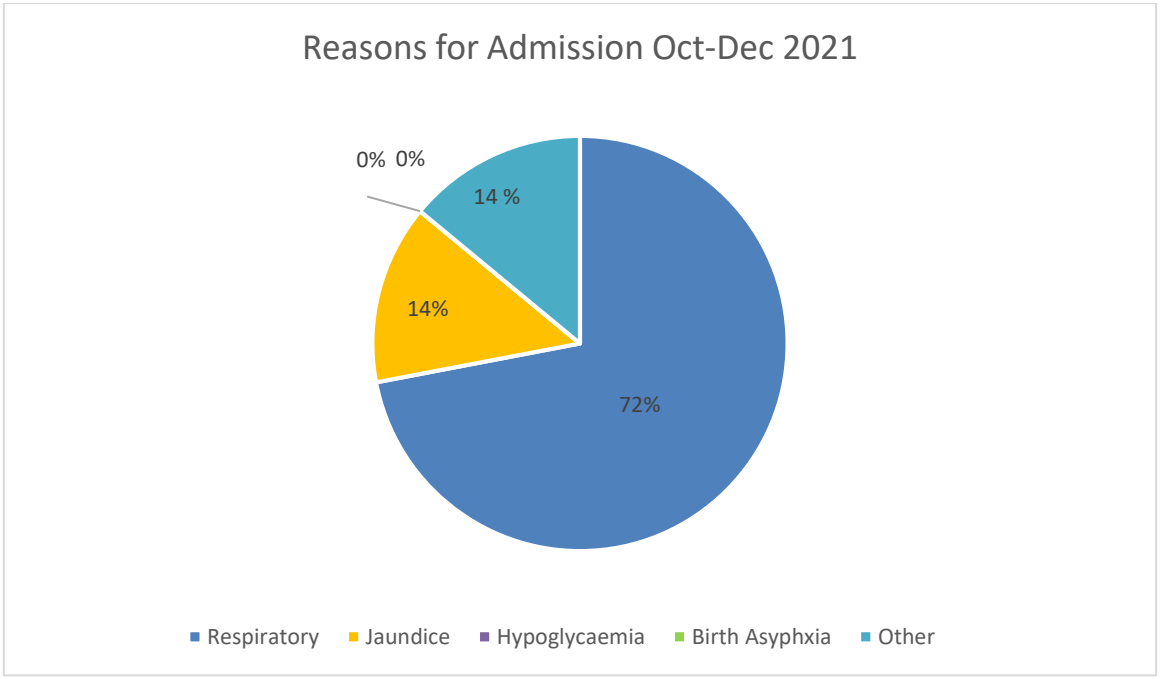
The group uses cases that have flagged opportunities for learning and care improvement to guide learning and improvement actions in order to reduce unnecessary separation of mothers of babies.

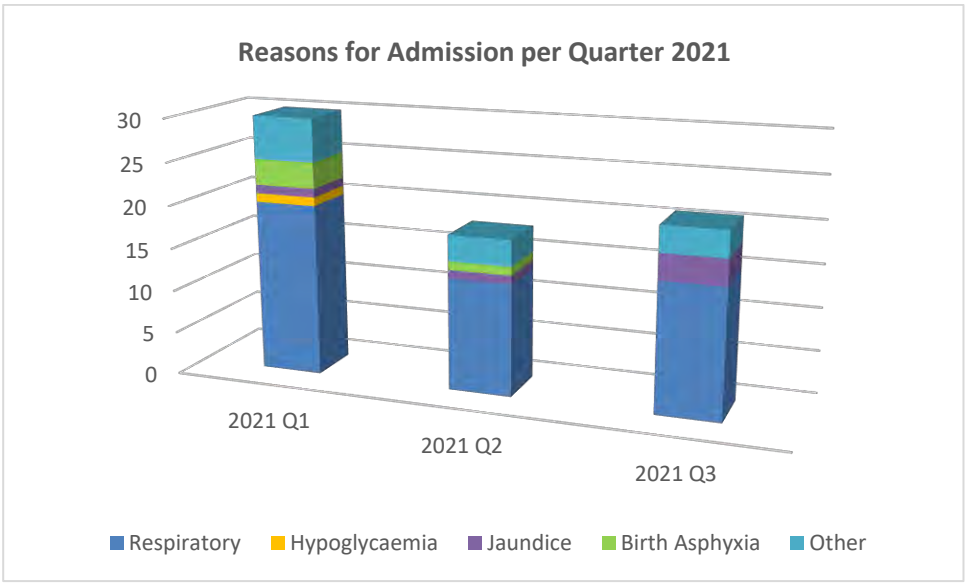
Learning is also often picked up and actioned even when it would not have reduced separation, but has the potential to improve care in other areas.

Please refer to the rolling action plan for details of work undertaken. In summary, there has been no recurrence in the areas previously identified as potentially contributing to term admission (as shown in the table above). There was a particular drive to improve education and awareness of the correct management of neonatal hypoglycaemia in previous quarters, and this is evidence that learning has taken place.

Progress and learning with the four key reasons for admission

Data collection during quarter 3 (Oct-Dec) in 2021 demonstrates that respiratory issues (needing respiratory support in some form) continue to be the primary reason for the admission of term babies into the Neonatal Unit.





The chart above shows the reasons for admission per quarter in the 2021-2022 year so far; demonstrating Respiratory support as the prodominant reason for admisson each quarter. However no underlying common theme has been identified at present.

Quality improvement in this quarter

A trend of babies being admitted with low temperatures (≤36.5°c) was first identified in May. This quarter, two further babies (both in the November admissions), were found to have low body temperatures on admission, the causes of which could not be determined.

May 5/10 (50%)

June 1/7 (14%)

July 3/6 (50%)

Nov 2/9 (22%)

In all cases, this was not the primary reason for the admission, but a review of the notes picked this problem up.

A number of actions were agreed and completed by the multi-disciplinary team. This included engagement with, and support from Theatres, Labour Suite and NNU teams.

Action	Plan	Comments
Raise awareness among the NNU nursing team who check and record the obstetric theatre temperature daily re. changing the temperature if the theatre is too cool.	• Wise words • Discussion at handover	NNU Manager met with Theatre Team Lead to discuss the problems, and find out how to correctly set the temperature. It was reported that the theatre doors are frequently left open when the theatre is not in use, so steps were taken to remind all the thetare staff to keep the doors closed.
Raise awareness among the maternity team	• Take 5 – urgent message to all • Risky Business • Daily safety huddles • Share learning via email with senior midwives on Labour Suite (air conditioning in birth rooms). • Room temperature audit attempted (see comments)	As well as sharing the key messages, an audit was attempted to check the average room temperatures on Labout Suite. Unfortunately the week that this action was planned was extremely busy and the data collected could not be used to draw any meaningful conclusions. However, this exercise in itself helped to raise awareness among the team of Labour Suite Co-ordinators and was therefore another useful rool to raise awareness about appropriate birth room temperatures.

Raise awareness among the Theatre team	• Display poster next to air condition control unit in theatre (displaying correct temp range) • Share learning about theatre temperature with Theatre Team Lead to cascade to team.	Colourful, eye-catching posters were displayed in theatre next to the air conditioning control panel. The theatre team lead expressed an interest immediately in supporting the team to make this improvement.
Raise awareness among Anaesthetists and Obstetricians to encourage a whole team responsibility / approach to this issue.	• Email to share learning with Anaesthetists and Obstetricians. • Discussed on daily MDT safety huddles	
Monitor progress	• Continue to record admission temperatures for term admissions as part of ongoing monthly reviews in order to monitor this closely.	Admission temperatures continue to be reviewed, and a significant improvement has resulted from these combined actions.

As a result of this shared learning, and raised awareness, amongst all teams across the maternity unit, including: Midwives, MCA's, Obstetric and Anaesthetic Doctors and the Theatre and Neonatal Teams, there has been a significant reduction in babies admitted to NNU with a concurrent low temperature. Quarter 3 showed only two babies who were admitted with temperatures below the recommended threshold, accounting for 9.5% of total babies admitted at term.

Actions identified in Quarter 3 included the amendment of certain key guidelines, and while it is acknowleged that this would not have prevented any of the term admissions these actions are in place to help improve future care given, which will only serve to benefit women and their babies.

Action	Plan	Comments
Add consideration of decision to delivery time to guideline for cases where level of emergency is re-graded with evolving clinical situation.	Add additional guidance to Instrumental delivery guideline	Out of review with Obstetric team
Add specific guidance on when to offer IV antibiotics for women who present with pre-labour rupture of membranes at term	Add additional guidance to Prevention of early onset GBS disease guideline	Proposal made to Audit Midwife – awaiting response.

This evidence of positive improvement has been shared with all teams involved, and progress will continue to be monitored routinely as part of the ATAIN programme.

West Suffolk NHS
NHS Foundation Trust

Audit of the Operational Pathway of Care into Neonatal Transitional Care
October - December 2021

Date: Report February 2022

Introduction

Neonatal Transitional Care (NTC) is not a place but a service and can be delivered either in a separate Neonatal Transitional Care area, within a postnatal ward, within the neonatal unit and /or in the postnatal ward setting.

The principals of NNTC include the need for a multidisciplinary approach between maternity and neonatal teams; an appropriately skilled and trained workforce, robust system for data collection with regards to activity and appropriate admissions and a link to community services.

Keeping mothers and babies together should be at the cornerstone of newborn care. Neonatal Transitional Care (NTC) supports resident mothers to be the primary care providers for their babies when they have care requirements in excess of normal well newborn care, but do not need continuous monitoring in a special care setting.

NTC avoids separation of the mother and baby and facilitates the establishment of breast feeding whilst enabling safe and effective management of a baby with additional care needs.

NTC also has the potential to prevent admission to the neonatal unit and to provide additional support for small and/or late preterm babies and their families.

NTC helps in the smooth transition to discharge home from the neonatal unit for recovering sick or preterm babies whilst providing specialised support away from the more intensive clinical setting.

At the West Suffolk babies meeting the criteria for Neonatal Transitional Care, are admitted to a defined 5 -bedded area within F11, the postnatal ward and cared for by midwifery and neonatal teams. Babies admitted from home requiring NTC are admitted to a side room on the Neonatal Unit.

CNST maternity incentive scheme

NHS Resolution is operating a fourth year of the Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme published August 2021 to continue to support the delivery of safer maternity care.

Neonatal Transitional Care is included in Safety action 3: **Can you demonstrate that you have Neonatal Transitional Care services to support the recommendations made in the Avoiding Term Admissions to the Neonatal units Programme**

CNST Required Standards revised and updated March 2021 (new to year 4 in red)

A) Pathways of care into Neonatal Transitional Care have been jointly approved by maternity and neonatal teams with neonatal involvement with the focus on minimising separation of mothers and babies. Neonatal teams are involved in decision making and planning care for all babies in transitional care.

B) The pathway of care into Neonatal Transitional Care has been fully implemented and is audited quarterly. Audit findings are shared with the neonatal safety champion. Local Maternity and Neonatal System (LMNS), commissioner and Integrated Care System (ICS) quality surveillance meeting each quarter.

C) A data recording process for capturing existing Neonatal Transitional Care activity, (regardless of place - which could be a Neonatal Transitional Care (NTC), postnatal ward, virtual outreach pathway NTC.) has been embedded.

If not already in place, a secondary data recording system is set up to inform future capacity management for late preterm babies who could be cared for in an NTC setting. The data should capture babies between 34+0-36+6 weeks gestation at birth, who neither had surgery nor were transferred during any admission, to monitor the number of special care or normal care days where supplemental oxygen was not delivered.

D) Commissioner returns for Healthcare Resource Groups (HRG) 4/XA04 activity as per Neonatal Critical Care Minimum Data Set (NCCMDS) version 2 are available to be shared on request, with the Operational Delivery Network (ODN) and commissioners to inform capacity planning as part of the family integrated care component of Neonatal Critical Care Transformation Review and to inform future development of transitional care to minimise separation of mothers and babies.

E) Reviews of term admissions to the neonatal unit to continue on a quarterly basis and findings shared quarterly with the Board level Safety Champion. The reviews should report on the number of admissions to the neonatal unit that would have met the current NTC admissions criteria but were admitted to the neonatal unit due to capacity or staffing issues. The review should also record the number of babies that were admitted to, or remained on Neonatal Units because of their need for nasogastric tube feeding, but could have been cared for on a TC if nasogastric feeding was supported there. Findings of the review have been shared with the maternity, neonatal and board level safety champions, LMNS and ICS quality surveillance meeting on a quarterly basis.

F) An action plan to address local findings from the audit of the pathway (point b) and Avoiding Term Admissions into Neonatal units (ATAIN) reviews (point e) has been agreed with the maternity and neonatal safety champions and Board level champion.

G) Progress with the revised ATAIN action plan has been shared with the maternity, neonatal and Board level safety champion, LMNS and ICS quality surveillance meeting.

Audit Aim

The aims of the audit are to identify whether the agreed standards within the local Policy ‘Operational Policy for Neonatal Transitional Care (NCT) October 2021 enables mothers and Babies to receive appropriate Neonatal Transitional Care at the West Suffolk Hospital.

The objectives are to demonstrate whether the standards for clinical criteria for admission and the operational standards in relation to midwifery, neonatal and medical staffing are in accordance with the current policy.

The overall aim is to determine whether there are modifiable factors which can be addressed as part of an action plan in order to improve the care for mothers and babies.

Methodology

A review of the data collected monthly of the pathway of all cases identified between October 2021 to December 2021 (Quarter 3) The data was taken using BadgerNet, eCare Maternity system and Neonatal Admission book.

Brief Summary of Results

October 2021 30 babies were admitted to NTC

16 babies admitted from birth to NTC from labour Suite /MLBU / Home

Clinical Standards		Criteria for admission met
Criteria for immediate admission		
Gestational age >34+6 weeks	All babies between 37+1- 42+1.	100%
Not requiring intensive or high dependency care	None	100%
Birthweight >1800g	All babies between 2.9 and 4.3 kilograms	100%
Maternal suspected /confirmed sepsis in labour	15 Mothers were on the sepsis pathway during labour	100%
Neonatal risks of Sepsis.	1 baby was admitted to TC with hypoglycaemia suspected sepsis. Maternal group B streptococcus present.	100%
Preterm with Risk factors	No babies were preterm	N/A

4 babies admitted to NTC due to clinical conditions developing on the Postnatal ward

Clinical Standards		Criteria for admission met
Criteria for admission – developing: Risk factors		
Risk factors for sepsis requiring IV antibiotics	4 babies required IV antibiotics for suspected sepsis. and were transferred to NTC. 1 mother developed signs of sepsis post birth, baby admitted to NTC for septic screening. 3 babies developed symptoms of suspected neonatal sepsis • 2 became Tachypnoeic • 1 Premature with risk factor maternal GBS	100%
Neonatal hypoglycaemia	No babies were transferred to NTC due to hypoglycaemia.	

5 babies admitted to NTC from the community setting

Clinical Standards		Criteria for admission met
Criteria for readmission from community met:		
Requiring phototherapy and serum bilirubin monitoring	5 babies were admitted from the community setting with Jaundice Gestation • 4 between 37+2 and 37+5 • 1 at 38+6 Phototherapy • All babies were treated with phototherapy	100%
Weight loss poor feeding	1 of the above babies admitted with Jaundice was a weight loss of 12%	100%

5 babies stepped down care from NNU to NTC

Clinical Standards		Criteria for admission met
Criteria for step down from NNU:		
Corrected gestational age > 33+0 and clinically stable.	All babies were over 33+5 and clinically stable	100%
Observations required no more than 3 hourly	All babies met these criterion	100%
Stable baby with sepsis requiring antibiotics	• 4 babies continued on antibiotics but were stable.	100%
Continuing phototherapy when bilirubin has stabilised	No babies required continuing phototherapy.	N/A
Comments • 1 baby needed closer observations for prematurity prior to discharge home the following day. • One mother was Covid 19 positive, baby was found to be negative.		
Criteria for discharge met:		
Feeding established and baby is maintaining or gaining weight.	All babies met this criterion on discharge home	100%
Course of IV antibiotics is complete	All babies met this criterion on discharge home.	100%

November 2021 - 20 babies were admitted to NTC

10 babies were admitted to NTC from birth from labour Suite / MLBU / Home

Clinical Standards		Criteria for admission met
Criteria for immediate admission		
Gestational age >34+6 weeks	1 premature baby at 35 + 0 weeks 9 term Babies between 39 - 40+5	**100%**
Not requiring intensive or high dependency care	None	**100%**
Birthweight >1800g	Birth weights range from 2430 kg – 3700 kg	**100%**
Maternal Sepsis suspected /confirmed	5 mothers had suspected /confirmed sepsis in labour.	100%
Neonatal risks of sepsis	4 babies with suspected sepsis • 2 babies' Respiratory distress • 1 baby with neonatal pyrexia • 1 baby PROM and transient grunting	**100%**
Preterm with Risk factors	1 baby with risk factors for sepsis (Preterm 35+0 and maternal GBS)	**100%**

4 babies admitted due to developing clinical conditions on the Postnatal ward

Clinical Standards		Criteria for admission met
Criteria for admission – developing: Risk factors		
Risk factors for sepsis requiring IV antibiotics	4 babies required IV antibiotics for suspected sepsis. • 3 mothers commenced on the sepsis pathway post birth. • 1 baby developed espiratory symptoms for possible sepsis-tachypnoeic.	**100%**

7 babies admitted from the community service

Clinical Standards		Criteria for admission met
Criteria for readmission from community met:		
Requiring phototherapy and serum bilirubin monitoring	7 babies admitted were due to jaundice – gestations 35+5 – 40+1 (2 preterm 35+5 & 36+2) • 2 Admitted on day 2 • 2 Admitted on day 3 • 2 admitted on day 4 • 1 admitted on day 5 All babies required phototherapy	**100%**

Comments	• 4 of the above babies admitted with jaundice additionally had weight loss 10% requiring feeding support and monitoring of weight

4 babies stepped down care from NNU to NTC

Clinical Standards		Criteria for admission met
Criteria for step down from NNU:		
Pre-term born >33+5 following 48 hours observation on NNU and clinically stable	2 babies at term 2 babies were preterm at 36+6 & 35+3.	100%
Observations required no more than 3 hourly	Yes	100%
Stable baby with sepsis requiring antibiotics	3 babies continued on antibiotics.	100%
Continuing phototherapy when bilirubin has stabilised	1 baby continuing phototherapy treatment	100%
Criteria for discharge met:		
Feeding established and baby is maintaining or gaining weight.	Yes	100%
Course of IV antibiotics completed	Yes	100%

December 2021 - 24 Babies were admitted to NTC

9 babies required admission following birth from labour Suite / MLBU / Home

Clinical Standards		Criteria for admission met
Criteria for immediate admission		
Gestational age >34+6 weeks	2 preterm babies 35+ 6 & 36+2 7 term babies	**100%**
Not requiring intensive or high dependency care	None	**100%**
Birthweight >1800g	Birth weight between 2360 kg and 3670 kg	**100%**
Maternal Sepsis suspected /confirmed	6 had suspected/confirmed maternal sepsis in labour	100%
Neonatal risks of sepsis	3 babies had risks requiring antibiotics • Hypoglycaemia & hypothermia suspected sepsis • Preterm and PPROM • Neonatal pyrexia	**100%**
Risks		

1 baby were transferred to NNTC from the Postnatal ward

Clinical Standards		Criteria for admission met
Criteria for admission – developing: Risk factors		
Risk factors for sepsis requiring IV antibiotics	1 baby developed transient tachypnoea	100%

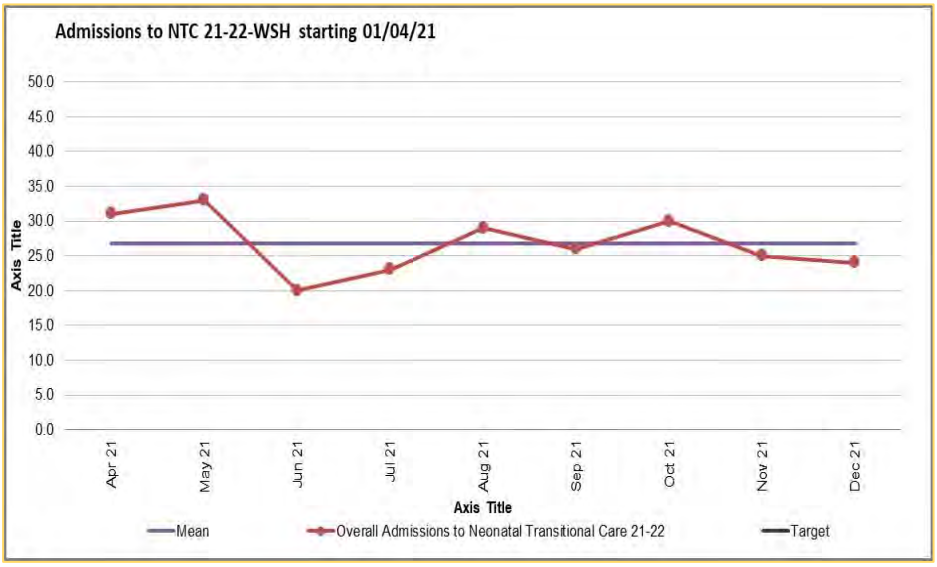
10 babies admitted from community services

Clinical Standards		Criteria for admission met
Criteria for readmission from community met:		
Requiring phototherapy and serum bilirubin monitoring	6 babies admitted due to jaundice – • Gestations from 37+3 to 39+4 one 1 preterm 36+1 • Babies admitted between day 3 and day 7. • 5 babies received phototherapy, 1 baby was just below the treatment line admitted for observation.	100%
Weight loss and issues around feeding poor feeding	2 babies admitted with weight loss >10% 2 for support with Issues around feeding associated with prematurity and congenital ventriculomegaly.	100%

4 Babies stepped down care from NNU to NTC

Clinical Standards		Criteria for admission met
Criteria for step down from NNU:		
Pre-term born >33+5 following 48 hours observation on NNU and clinically stable	3 term babies 1 preterm 36+1	100%
Observations required no more than 3 hourly	Yes	100%
Stable baby with sepsis requiring antibiotics	All remained on IV antibiotics but were stable babies.	100%
Continuing phototherapy when bilirubin has stabilised	No	100%
Criteria for discharge met:		
Feeding established and baby is maintaining or gaining weight.	Yes	100%
Course of IV antibiotics is complete	Yes	100%

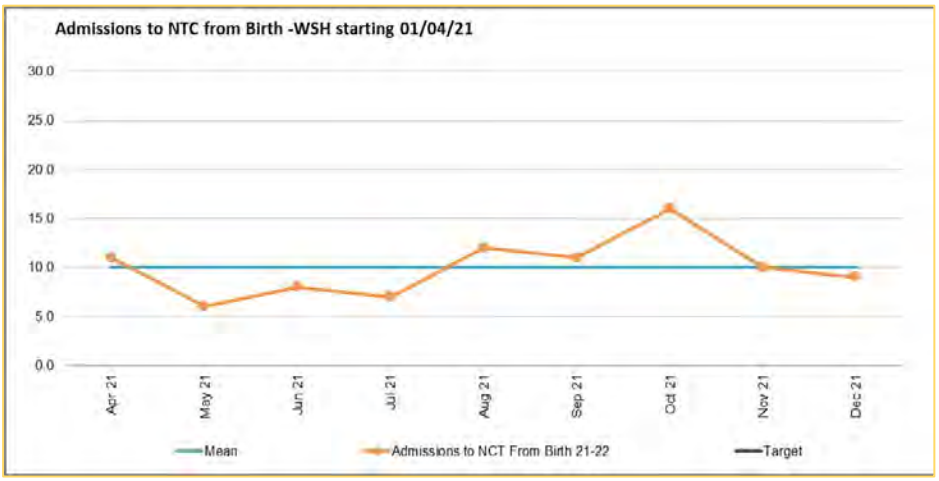
Chart Summary of Number of babies admitted for Quarter 3



Overall admissions numbers remain the same over the last three quarters. The majority were at term with 11.3% 37 weeks.

Quarter 3 - 79 babies were admitted to NTC (78 previous quarter)

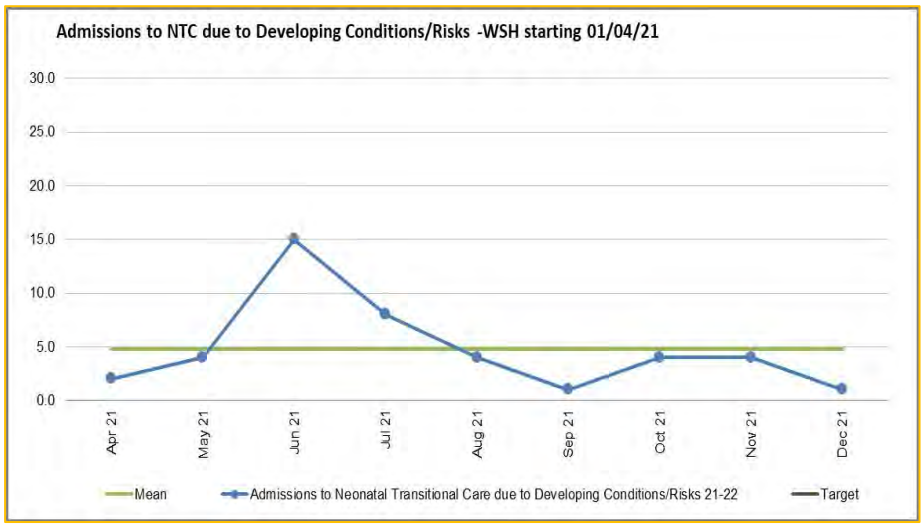
35 babies were admitted to NTC <u>from birth</u> (previous quarter 30 admissions)



- 26 babies followed the local pathway for septic screening and intravenous antibiotics when the mother was treated for suspected or confirmed sepsis in labour.
- 9 babies followed the local pathway due to risks associated with sepsis and had partial sepsis screening and intravenous antibiotics.
- Of the above 3 babies were admitted for reasons relating to prematurity with associated risks such as maternal Group B streptococcus, PPROM.

All cases were appropriately referred for NTC and in accordance with local and national guidelines.

9 babies admitted from the postnatal ward with developing or new risk factors: (13 previous quarter)



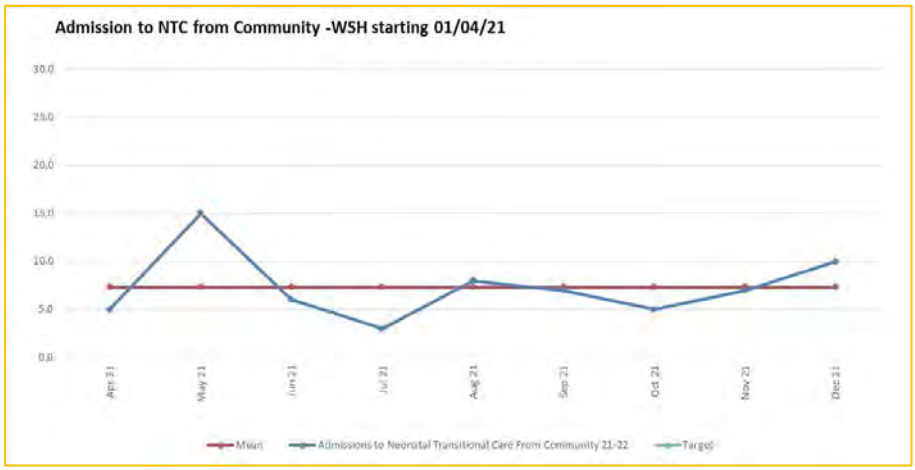
- 4 women developed suspected/ confirmed sepsis postnatally requiring IV antibiotics. as per the East of England Neonatal Antibiotic Policy 2019, all babies were appropriately referred for sepsis screening and commenced on IV antibiotics.

- 4 babies developed signs of confirmed suspected sepsis e.g. tachypnoea which had not been present at birth therefore required sepsis screening and intravenous antibiotics as per the above policy.

- 1 premature baby was transferred to NTC due to maternal positive GBS not known at birth.

All cases were appropriate for NTC and transfer in accordance with local and regional guidelines.

23 Babies readmitted from the community service (18 previous quarter)



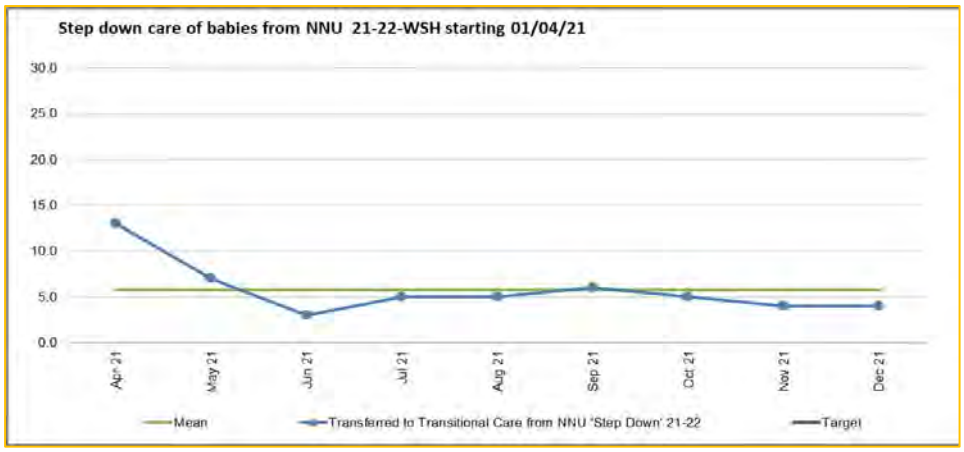
- 18 babies were admitted with jaundice of which 17 required treatment with phototherapy, 1 baby was just below the phototherapy treatment line.

- 5 babies were admitted to NTC for support with feeding associated with weight loss preterm and congenital ventriculomegaly.

All cases were appropriate for NTC and transfer in accordance with local and regional guidelines.

NB. There were 2 babies readmitted from the community both babies met the criteria for NTC, however were admitted to neonatal care as the parent declined to remain in hospital.

13 babies had their care from the Neonatal Unit stepped downed to Neonatal Transitional Care (16 previous quarter)



13 babies were 'stepped down' to transitional care from the neonatal unit.

- 8 babies continued on antibiotic therapy
- 3 babies continued with phototherapy
- 2 babies required continued observations

All babies met the criteria within local guidelines.

Conclusions

The number of babies cared for on NTC has remained relatively unchanged month on month in quarter 3. The majority of babies were at term 87%.
In all cases the admissions met the criteria in the operational guidelines in relation to appropriate gestation, birthweight and reason for admission.

Whilst the aim of the audit is establishing that the operational pathway of care been adhered to and that NTC has been fully implemented. In achieving these goals, the service needs to look at whether the impact of NTC has prevented admissions of babies to the neonatal unit as well as allowing a smoother transition to discharge home of babies who have spent time in the neonatal unit.

An action has been included in the action plan.

Accurate Data collection

Quarter 3 audit highlights some positive improvements in the accuracy of data on BadgerNet in relation to type of care a baby is receiving, however there is still further improvement to be made before we can be reassured that the live data is correct. This will not only give a more accurate picture of activity each month, but also allows more effective and timely completion and reduce the amount of cross-checking of different systems.

It is recommended that the staff continued to be made aware of the audit data and supported to ensure they input the correct data of the type of care at the outset.

An action has been included on the action plan

Timely Data Collection

There continues to be delays in collecting the data on a monthly basis. Currently the neonatal unit does not have dedicated time to collect data for NTC admissions particularly around 'Step down care 'and relies on staff to review admissions to NTC as and when they can. This can result in delays in Quality and Safety team producing a quarterly report. This appears to be partly due to Covid 19 which is having an impact on staffing levels. Management is aware of the issue and it is hoped to be resolved over the coming months following the recent recruitment of 7 nursery nurses to NTC.

Themes for admission

56% of babies admitted to NTC are due to confirmed or suspected sepsis in either the mother or/and baby. This is identified at birth or develops in the early postnatal period. All these babies required intravenous antibiotics, these continue for 36 hours or > 5 days depending on the Blood, microbiology and condition of baby. Sepsis as a reason for admission has shown consistent numbers over the last 3 quarters.

29% of babies required re-admission from home of which 78% of these babies were due to jaundice with the exception of 1 baby all required treatment with phototherapy. 21% were admitted for support due to weight loss or feeding problems.

Undertaking clinical audits in particular sepsis in late pregnancy and during labour and those readmitted from home was highlighted in the previous audit. Although these have been included in the maternity audit plan. Due to reduced capacity during Covid 19 there has been a delay in moving forward. The service is beginning to see improvements and auditing of care for NTC mothers and babies should be undertaken to identify if there are any modifiable factors and addressing these as required.

An action has been included in the audit plan.

16% of babies step down care from the neonatal unit. The numbers have not changed over the last 2 quarters. The number of babies stepping down care from the neonatal unit has not changed over the last two quarters. The majority 'stepping down' one or two days before discharge.

Moving forward the service should look at the number of babies who are admitted to, or have to remain on the neonatal unit because of their need for naso-gastric tube feeding, but could be cared for on the NTC if nasogastric feeding was supported there. It is hoped that with the

new recruitment of staff the pathway for admission will have been fully implemented and the criteria for admission reviewed.

An action has been included in the action plan

Audit of Operational standards staffing

Operational Standards - Midwifery Staffing:		**Criteria met**
Midwife from F11 is allocated to care for women every day and night shift	A midwife is allocated on every shift to NTC on the postnatal ward to care for women and undertake joint care of babies with the allocated neonatal nurse.	**100%**

Operational Standards – Neonatal Staffing:		**Criteria met**
A Neonatal nurse or nursery nurse from the NNU is allocated to care for babies on NTC every day and night shift	A neonatal nurse is allocated on every shift to care for babies receiving Neonatal Transitional Care whether the baby is receiving care on the NNU side room or on the postnatal ward.	**100%**

Currently the allocated NTC neonatal nurse is based on the neonatal unit and may have other babies to care for on the Neonatal Unit. Therefore, not physically present on NTC on the postnatal ward. There has been recruitment of seven neonatal nursery nurses to allow for a member of the neonatal team to be present on F11 NTC 24/7.

Operational standards Neonatal medical staff		**Criteria met**
A daily review of babies on NTC is conducted by a consultant paediatrician or the paediatric registrar allocated to the NNU.	A Paediatric ward round led by a consultant or allocated registrar ward round is undertaken daily for all babies receiving NTC on the postnatal ward and on the neonatal unit.	**100%**

Neonatal Ward rounds

The paediatric team should undertake a daily ward round for babies receiving NTC, however on some occasions the presence of the parent/ parents /carer was not always clear in the records, either BadgerNet or eCare, therefore the audit could not be completely assured that this was undertaken at least daily. This has already been highlighted to the Neonatal team on the previous audit.
The Quality and Safety team are currently working with eCare to have this question included on their system.

An action has been included to highlight this ongoing issue.

Recommendations

- Review the impact of the introduction of NTC to the maternity service in preventing admissions of babies to the neonatal unit. The Audit recommends that the service reviews data from April 2021-April 2022 as the data collection has become more robust during this time.

- Support the paediatric team to improve the accuracy of documentation on BadgerNet Neonatal data system of the type of care a baby is receiving.

- Review of mothers who receive antibiotics in labour for possible sepsis and the outcome the extent of whether sepsis was confirmed in either mother and /or baby.

- Review the care of mothers and babies whose baby is re-admitted to NTC with jaundice.

- Review the number of babies who are admitted to, or have to remain on the neonatal unit because of their need for naso-gastric tube feeding, but could be cared for on the NTC if nasogastric feeding was supported there.

- Support the paediatric team to improve documentation of parental presence on ward rounds on a daily basis, followed by an audit in Spring 2022 to demonstrate full compliance with this standard.

- Work with the ATAIN team to review the number of babies who are well enough to step down their care but have to remain on the neonatal unit because of their need for naso-gastric tube feeding, but could be cared for on the NTC if nasogastric feeding was supported there.

Audit findings are shared with the

- Maternity and neonatal clinical staff
- Maternity and Neonatal Safety Champions
- Maternity and Gynaecology Quality & Safety meeting
- Paediatric governance

References:

British Association of Perinatal Medicine A Framework for Neonatal Transitional Care 2017

'Operational Policy for Neonatal Transitional Care (NCT) June 2020.

East of England Neonatal ODN East of England Neonatal Antibiotic Policy 24th October 2019 amended February 2020.

Maternity Incentive Scheme (CNST) Year Four Ten Maternity Safety Actions. Safety Action 3

Action Plan

Project title	Quarterly 3 Audit of the Operational Pathway of care into Neonatal Transitional Care

Action plan lead	Name: Jane Lovedale	Title: Midwife Quality & Risk	Contact: 3275

	Recommendation	**Actions required** *(specify "None", if none required)*	**Action by date**	**Person responsible** *(Name and grade)*	**Comments/action status**	**Status of Action**
1.	Review the impact of the introduction of NTC to the maternity service in preventing admissions of babies to the neonatal unit. The Audit recommends that the service reviews data from April 2021-April 2022 as the data collection has become more robust during this time.	Review the data of admissions to NTC against NNU 21-22. To disseminate findings and identify any recommendations	May 31th 2022	Mohammed Jageer Lead paediatrician for NNU	Ongoing	
2	Support the paediatric team to improve the accuracy of documentation on BadgerNet Neonatal data system of the type of care a baby is receiving.	Issue raised with lead neonatologist. Q3 Audit forwarded to Neonatal team.	February 28th 2022	Mohammed Jageer Neonatal medical lead	Email received from lead paediatrician confirming he will discuss the issues outlined in the report with the neonatal team.	Completed ACTIONS from Quarterly NTC audit .r Re_ ACTIONS from Quarterly NTC audit .r

3	Review of mothers who receive antibiotics in labour for possible sepsis to understand the extent of whether sepsis was actually confirmed in either mother and /or baby.	Undertake a review of mothers who gave birth in January 2022 and were commenced on the sepsis pathway in labour and babies admitted to the NTC for septic screening.	April 30th 2022	Jane Lovedale Maternity Q&S team	Ongoing	
4.	Support the paediatric team to improve documentation of parental presence on ward rounds on a daily basis, followed by an audit in Spring 2022 to demonstrate compliance.	Issue raised with lead neonatologist Share the Q3 Audit with the Neonatal team.	February 28th 2022	Jane Lovedale Maternity Q&S team		Completed  ACTIONS from Quarterly NTC audit .r
		Undertake an audit of parental present during ward rounds on NTC	May 30th 2022	Jane Lovedale Maternity Q&S team	Ongoing	
5.	Review the case notes of mothers and babies whose baby is re-admitted to NTC with jaundice.	Audit of babies readmitted to NTC in January 2022 with Jaundice to identify any modifiable factors.	April 30th 2022	Jane Lovedale Maternity Q&S team	Ongoing	

6.	Work with the ATAIN team to identify the number of babies who were well enough to step down their care but have to remain on the neonatal unit because of their need for naso-gastric tube feeding, but could be cared for on the NTC if nasogastric feeding was supported there.	Work with the ATAIN team to identify babies at the monthly review where a baby was prevented admission to NTC because of naso gastric feeding. To include this information in the monthly ATAIN report and report into the TC quarterly reports.	February 9th 2022	Rebecca Warburton Maternity Q&S team Jane Lovedale Maternity Q&S team	The number of babies unable to step down care to NTC due to needing NGT feeding to identified monthly and reported in the ATAIN programme Quarterly reports.	Completed  Action from Quarter 3 NTC Audit .msg

CNST requirement	Meeting	By Whom	Date presented
Quarterly Audit findings shared with the Neonatal Safety Champion, Local Maternity and Neonatal System and (LMNS), Quality Surveillance meeting and Trust Board.	Neonatal Safety Champion,	Quality and Safety team	
	Local Maternity and Neonatal System and (LMNS),	K Newbury HOM	
	Quality Surveillance meeting	K Newbury HOM	
	Trust Board.	K Newbury HOM	

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TRAINING NEEDS ANALYSIS AND TRACKER

CORE COMPETENCY TRAINING FRAMEWORK TRAINING COMPLIANCE (TARGET 90%)

Must include consideration of human factors, local transfer processes and policies (hospital and community settings), use of locally agreed safety language and communication with women, families and staff, particularly where debrief is required as part of emergency scenario training. Training should include sharing of local learning from maternal and neonatal outcomes (including learning from in-situ simulation) and ideally benchmarked against other units.

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SAVING BABIES LIVES CARE BUNDLE

MINIMUM REQUIREMENT	Number of attendees in month (TARGET 90%)	July 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	April 22	Current %age completion
Smoke free pregnancy	Midwives	100%	100%	100%	100%	99.29%	98.65%					99.65%
	Obstetrician*	NA	NA	NA	NA	NA	NA					TBC
Monitoring growth restriction (as for GAP)	Midwives	81.7%	91.3%	90.1%	95.10%	95.7%	97.18%					91.85%
	Obstetrician	96%	95.8%	95.8%	100%	100%	91.3%					96.48%
Fetal movements & Fetal monitoring	Midwives	89.6%	94.1%	88.6%	88.7%	87.8%	97.6%					91%
	Obstetrician	83.3%	79%	69.9%	73.4%	86.4%	81.8%					79%
Pre-term birth *	Midwives	NA	NA	NA	NA	NA	NA					TBC
	Obstetrician	NA	NA	NA	NA	NA	NA					TBC

GAP AND GROW TRAINING

MINIMUM REQUIREMENT	Number of attendees in month	July 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	April 22	Current %age completion
Training and competency assessment in: • Measuring SFH with a tape measure • Plotting measurements on charts • Appropriate interpretation • Appropriate escalation and referral (TARGET 90%)	MIDWIVES	81.7%	91.3%	90.1%	95.1%	95.7%	97.18%					91.85%
	CONSULTANT OBSTETRICIANS	96%	95.8%	95.8%	100%	100%	91.3%					96.48%

* This sessions were not cover within 2021/2022 training programme. MIS year 4 standard were published in August 2021 during the running of already agreed programme.

CORE COMPETENCY TRAINING FRAMEWORK TRAINING COMPLIANCE (TARGET 90%)

Must include consideration of human factors, local transfer processes and policies (hospital and community settings), use of locally agreed safety language and communication with women, families and staff, particularly where debrief is required as part of emergency scenario training.
Training should include sharing of local learning from maternal and neonatal outcomes (including learning from in-situ simulation) and ideally benchmarked against other units.

FETAL SURVEILLANCE IN LABOUR

MINIMUM REQUIREMENT	Number of attendees in month	July 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	April 22	Current %age completion
Risk assessment throughout labour Fetal monitoring – Intermittent auscultation (IA) Fetal Monitoring – Electronic Fetal Monitoring (EFM) Use of local case histories (TARGET 90%)	MIDWIVES	89.6%	94.1%	88.6%	88.7%	87.8%	97.6%					91%
	CONSULTANT OBSTETRICIANS	83.3%	79.2%	69.6%	73.9%	86.4%	81.8%					79%
	ALL OTHER OBSTETRICIANS											

NB: Fetal monitoring training should be based on the previously recommended: multi-professional case history discussions that demonstrate the use of local fetal monitoring tools and resources for risk assessment, classification and escalation.
All content should be based on current evidence, national guidelines and local systems and risk issues.
Training should also include human factors and situational awareness.
Completion of an electronic training package such as Health Education England's e-Learning for Healthcare Learning Paths on eFetal Monitoring or the Fetal monitoring modules of the K2 Perinatal Training Programme would count as one half day' worth of training.

MATERNITY EMERGENCIES AND MULTIPROFESSIONAL TRAINING												
MINIMUM REQUIREMENT	Number of attendees in month	July 21	Aug 21*	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	April 22	Current %age completion
Locally identified training needs relating to emergency scenarios which might include: Antepartum Haemorrhage and Postpartum Haemorrhage Impacted fetal head Pre-eclampsia/eclampsia, severe hypertension Uterine rupture Maternal resuscitation Vaginal breech birth Shoulder dystocia Cord prolapse Include: • The use of maternal critical care observation charts • Structured review proformas • Deterioration and escalation thresholds • Timing of birth and immediate postnatal care (TARGET 90%)	OBSTETRIC CONSULTANTS	1	NA	0	3	2	3					91.43%
	ALL OTHER OBSTETRIC DOCTORS CONTRIBUTING TO THE ROTA	0	NA	4	4	3	3					
	OBSTETRIC ANAESTHETIC CONSULTANTS	1	NA	1	2	2	1					100%
	ALL OTHER OBSTETRIC ANAESTHETIC DOCTORS CONTRIBUTING TO THE ROTA	1	NA	2	2	1	3					
	MIDWIVES	14	NA	16	15	18	16					98.58%
	MATERNITY CRITICAL CARE STAFF **	NA	NA	NA	NA	NA	NA					NA
	MATERNITY SUPPORT WORKERS AND HEALTH CARE ASSISTANTS	5	NA	2	2	3	3					100%

NB:

- * 10 PROMPT training sessions are run over the 12 months period. August is one of the month where no PROMPT training is provided
- These training sessions should also cover an understanding of Covid-19 specific therapies in pregnancy and the importance of twice-daily multidisciplinary structured reviews to ensure comprehensive, multi-disciplinary and coordinated care across different care settings. Training should include a general overview of care principles, and individual susceptibility e.g. ethnicity, hypertension and diabetes.
- All other obstetric doctors = Staff grade doctors, obstetric trainees (ST1-7), sub specialty trainees, obstetric clinical fellows and foundation years doctors contributing to the obstetric rota.
- All other obstetric anaesthetic doctors = staff grade and anaesthetic trainees contributing to the rota.
- ** Maternity critical care staff = operating department practitioners, anaesthetic nurse practitioners, recovery and high dependency unit nurses providing care on the maternity unit- NA for WSFT

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PERSONALISED CARE												
MINIMUM REQUIREMENT	Number of attendees in month Target 90%	July 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	April 22	Current %age completion
Ongoing antenatal and intrapartum risk assessment with a *holistic view from a woman's personal perspective, offering her informed choice.* *	Midwives	This topic will be covered within CNST year 5 training sessions starting from January 2023										
	Obstetrician											
Maternal mental health	Midwives	98%	100%	99%	100%	99.33%	98.65%					99.2%
	Obstetrician*	NA	NA	NA	NA	NA	NA					TBC
Vulnerable women and families Social factors requiring referral	Midwives	98%	100%	99%	100%	99.33%	98.65 %					99.2%
	Obstetrician	96%	93%	93%	TBC	TBC	TBC					TBC
Families with babies on NICU *	Midwives	This topic will be covered within CNST year 5 starting from January 2024										
	Obstetrician											
Bereavement care	Midwives	98%	100%	99%	100%	99.33%	98.65%					99.2%
	Obstetrician	NA	NA	NA	NA	NA	NA					TBC

NB:

- * This sessions were not cover within 2021/2022 training plans. MIS year 4 standard were published in August 2021 during the running of already agreed programme.
- There should be training for all maternity carers to recognise, triage and care for women with mental health and safeguarding concerns in pregnancy. This should include information on local pathways and procedures to ensure face-to-face assessments and fast-track access to specialist perinatal mental health and safeguarding support services.
- Training should also include recognition of concerning "red flags", particularly repeated referrals that should prompt urgent review.

CARE DURING LABOUR AND THE IMMEDIATE POSTNATAL PERIOD

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MINIMUM REQUIREMENT	Number of attendees in month TARGET 90%	July 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	April 22	Current %age completion
Management of labour	MIDWIVES	N/A	N/A	N/A	N/A	N/A	N/A					TBC
	OBSTETRICIANS											
VBAC and uterine rupture	MIDWIVES	This topic will be covered within CNST year 5 training sessions starting from January 2023										
	OBSTETRICIANS											
GBS in labour	MIDWIVES	N/A	N/A	N/A	N/A	N/A	N/A					TBC
	OBSTETRICIANS											
Management of epidural anaesthesia	MIDWIVES	N/A	N/A	N/A	N/A	N/A	N/A					TBC
	OBSTETRICIANS											
Operative vaginal birth – ROBuST	MIDWIVES	This topic will be covered within CNST year 6 training sessions starting from January 2024										
	OBSTETRICIANS											
Perineal trauma – prevention of and OASI pathway	MIDWIVES	This topic will be covered within CNST year 5 training sessions starting from January 2023										
	OBSTETRICIANS											
Maternal critical care including care of pregnant and postpartum women with suspected or confirmed Covid-19	MIDWIVES	97%	NA	98%	95.42%	97.81%	98.58%					98.58%
	OBSTETRICIANS	96%	NA	100%	90.32%	90.63%	91.43%					91.43%
Recovery care after general anaesthetic		This topic will be covered within CNST year 5 starting from January 2024										

NB:

- * This sessions were not cover within 2021/2022 training plans. MIS year 4 standard were published in August 2021 during the running of already agreed programme.
- ROBuST = RCOG Operative Birth Simulation Training
- OASI = Obstetric Anal Sphincter Injury
- These training sessions should also cover an understanding of Covid-19 specific therapies in pregnancy and the importance of twice-daily multidisciplinary structured reviews to ensure comprehensive, multi-disciplinary and coordinated care across different care settings. Training should include a general overview of care principles, and individual susceptibility e.g. ethnicity, hypertension and diabetes.

NEONATAL LIFE SUPPORT

West Suffolk NHS Foundation Trust

MINIMUM REQUIREMENT	Number of attendees in month Target 90%	July 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	April 22			Current %age completion
Identification of a baby requiring resuscitation after birth and support immediate neonatal resuscitation until specialist neonatal help is available Assessed ability to deliver inflation breaths Knowledge and understanding of the NLS algorithm How to call for help within the organisation Situation, Background, Assessment, Recommendation (SBAR) or equivalent communication tool handover on arrival of help Recognition of the deteriorating newborn infant with actions to be taken	NEONAL CONSULTANTS OR PAEDIATRIC CONSULTANTS COVERING NEONATAL UNITS	NA	NA	NA	NA	NA	2							45% **
	NEONATAL JUNIOR DOCTORS WHO ATTEND ANY DELIVERIES	NA	NA	NA	NA	NA	5							33% **
	NEONATAL NURSES BAND 5 AND ABOVE	0	1	2	8	8	0							96%
	ADVANCED NEONATAL NURSE PRACTITIONERS (ANNPs) *	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
	MIDWIVES	14	x	16	15	18	16							98.58%

- ANNP's not in post
- ** % of staff attended NLS training in the last 12 months

SUMMARY

Unit: Maternity Service at West Suffolk NHS Foundation Trust

Reporting period (quarter): October 2021- December 2021

Was MDT nature of training achieved as required during the period? No, however some improvement have been seen.

If not, why not, and how was this/will this be mitigated?

- Availability of data has improved since the last review however there is still some gaps. This is having an impact on ability to fully complete this report, especially around the NLS training;
- The requirements of NLS compliance for all staff group has changed in the MIS year 4. All staff in attendance at birth are now required to attend annual local neonatal life support training even if they are NLS instructor. This is a significant change as in previous years this staff group was exempt form annual up-dates for as long as their status as instructor remained active;
- MDT training was difficult to achieve due to staffing absence some being related to Covid 19 and impact this had for releasing medical staff to attend the training;

Is training completion meeting the expected trajectory? No

If not, why not, and how was this/will this be mitigated?

- Limited availability of data to fully complete the report has been raised with the training leads to improve up on compliance;
- Training plans put in place with the start date from January 2022 to meet the recommendation of MIS year 4 this includes attendance at the NLS training sessions. The agreement was made that the Neonatal/ Paediatric Consultants and Neonatal Junior doctors who attend a birth are required to attend annual NLS training sessions as part of the PROMPT training. This is booked by individual staff with Practice Development team.
- Difficulties of releasing medical staff to attend the training which is being reviewed
- Current compliance escalated to Clinical Leads and Safety Champion

Report on Anaesthetic Staffing within Maternity Services – West Suffolk NHS Foundation Trust

Report Title	**Interim Report on compliance with Safe Obstetric Anaesthetic staffing from October 2021 to December 2021**
Report for	**Information and Approval of Actions**
Report from	Women's & Children's Services in collaboration with Theatres & Anaesthetics
Report Author	Beverley Gordon, Project Midwife, WSH

Report Title
Evidence of safe standards of obstetric anaesthesia in the Maternity Unit of WSH NHSFT.

1. Purpose of the Report

To provide assurance that the anaesthetic support provided to the Maternity Unit meets the standards expected to provide safe effective care.

2. Background
NHS Resolution is operating a fourth year of the Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme to continue to support the delivery of safer maternity care. There are 10 safety actions for Trusts to have in place to assure the women, families and the NHS of their commitment to safety.
The on-call anaesthetist holds bleep 770 and this is a baton bleep and handed over directly to the oncoming doctor. The role of the bleep 770 holder is described in the Standard Operating Procedure (SOP) and the operational aspects of the Obstetric Anaesthetic service is described in the Operational Plan – both documents were approved in 2021.

3. Standards to be met

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

This report relates directly to the anaesthetic element of clinical staffing – section b). The requirement for this element is as follows:

b) Anaesthetic medical workforce
A duty anaesthetist is immediately available for the obstetric unit 24 hours a day and should have clear lines of communication to the supervising anaesthetic consultant at all times. 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. (ACSA standard 1.7.2.1)

Anaesthesia Clinical Services Accreditation (ACSA) standards and action

1.7.2.1
The rota should be seen to allow obstetrics to take priority where the duty anaesthetist has other responsibilities. A policy should be made available at staff induction regarding prioritising and junior staff should provide verbal confirmation that they have been inducted in this way.

Anaesthetic medical workforce
The rota should be used to evidence compliance with ACSA standard 1.7.2.1.

Trusts to evidence position by Thursday 30 June 2022 at 12 noon

Technical guidance	
Anaesthesia Clinical Services Accreditation (ACSA) standard and action	
1.7.2.1	A duty anaesthetist is immediately available for the obstetric unit 24 hours a day. Where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patient in order to be able to attend immediately to obstetric patients.

There is no fixed period of time that the rotas need to be reviewed so the Trust has taken the decision to review a 3-month period October to December 2021 and to repeat this process for January -March 2022 to ensure there is sustainability within the rota management.

Methodology
On the rotas the cover will be seen in one of 3 ways:
1. As an allocated doctor in the section labelled 'Obs junior 770' for evenings weekends and public holidays
2. Marked in a different section with a purple star: these staff members may be allocated to be part of a team of 2-3 doctors undertaking other duties e.g. elective caesarean lists in theatre but are available for obstetric anaesthetic work as well. One of the team, sometimes a consultant, sometimes a trainee, will hold the on-call bleep 770. During the period of audit, the usual obstetric theatre was having building work undertaken so the theatre being used for elective and emergency obstetric work changed.
3. If additional support is needed for the trainee out of hours, the consultant named in the section labelled 1st theatre/obstetric on call consultant will be called to assist.

Rotas for this period of time were reviewed for evidence that there was a dedicated duty anaesthetist allocated for providing support to the maternity patients. These rotas were accessed directly from the electronic rota after the period of the audit was ended so that any changes due to staff absence were accounted for, making it the most accurate record that it could be.

Results

All the rotas demonstrated that a staff member was allocated to hold the on-call bleep 770 during this period of time – October – December 2021. The rotas show that where the bleep holder is allocated to other duties – e.g. the elective caesarean section list – the bleep holder is working with other anaesthetists who can either continue with the planned activity or attend to provide obstetric anaesthetic services.

4. Current Compliance with Standards

Clinical Workforce Group	Standard to be met	WSH compliance	Progress Report	Evidence Source
Anaesthetic medical workforce	**Anaesthetic medical workforce** A duty anaesthetist is immediately available for the obstetric unit 24 hours a day and should have clear lines of communication to the supervising anaesthetic consultant at all times. 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. (ACSA standard 1.7.2.1)			
	1.7.2.1 A duty anaesthetist is available for the obstetric unit 24 hours a day, where there is a 24 hour epidural service the anaesthetist is resident If this service is offered, rotas should be provided as evidence. If this service is not provided, patient information should be seen which relays exactly what services can be offered	**Yes**	**October- December 2021**	Rotas demonstrate 100% compliance for this period of time.

5. Conclusions

The obstetric anaesthetic rotas reflect the 24/7 cover of the obstetric services and therefore the Trust is assured that the standards are met for Anaesthesia Clinical Services Accreditation (ACSA) standard **1.7.2.1.**
Copies of the relevant sections of the rotas have been saved for review if these are not accessible if required for confirmatory evidence.

6. Recommendations

Continue to monitor the standard to provide assurance that the maternity patients are receiving obstetric anaesthetic services when required.
Any delays in care and/or adverse outcomes due to shortages or lack of/delay in providing obstetric anaesthetic services will be highlighted as an incident using the Trusts incident recording system and investigated by the multidisciplinary Quality and Safety team alongside clinical leads in order to identify learning and remedial actions required to improve practice/services.
A further report will be presented in April 2022.
No actions have been identified directly as a result of this report.

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HSIB and Early Notification Reporting – Safety Action 10 Maternity Incentive Scheme Year 4

Quarterly Reports on Compliance – Report for Quarter 3 2021/22

A) Reporting of all qualifying cases to HSIB for 2021/22

B) For qualifying cases which have occurred during the period 1st October 2021 to 31st December 2021 the Trust Board are assured that:
1. the family have received information on the role of HSIB and the EN scheme; and
2. 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.

Baby/Mother ID	Date of birth (baby)	EN reportable?	Information given to parents re HSIB/EN	Date of Report to HSIB	Confirmed DoC
Nil	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**

Summary of Compliance for Quarter 3 2021/22

No cases reportable for HSIB in Q3

4.7. Involvement Committee Report - February 2022 Chair's key issues

To Assure

Presented by Alan Rose

Chair's Key Issues

Originating Committee	Involvement Committee	Date of Meeting	21 February 2022
Chaired by	Alan Rose	Lead Executive Director	Jeremy Over

Item	Details of Issue	For: Approval/ Escalation/Assurance	BAF/ Risk Register ref	Paper attached? ✓
Future System	Gary Norgate, Programme Director, gave a detailed summary of the considerable, wide-ranging and ongoing processes to engage with the workforce, public and others on the gradual development of the future health facilities and services being planned for implementation later this decade. At its best, a great example of genuine co-production. Gary is conscious of the need for continual evolution, iteration and communication with hard-to-reach groups. Two current actions include: - participating in the discussion related to acute provider collaboration - the importance of keeping our Governors well-briefed on the emerging concepts and plans.	**Assurance**	BAF Risk 9	
The West Suffolk Review: Trust Response	Jeremy Over led the discussion on how the Trust is acting in a range of ways to learn and change. Key components are: - Our Strategy & Values - Board accountability and development - A culture that supports speaking-up - A supportive and compassionate HR approach - Improved staff engagement and feedback Jeremy is planning ways for the workforce and other stakeholders to be regularly updated on how we are progressing on the range of initiatives underlying these themes.	**Partial Assurance:** recognition of continual self-awareness of behaviour, active listening and an array of monitoring of progress.	BAF Risk 7	

Originating Committee	Involvement Committee	Date of Meeting	21 February 2022
Chaired by	Alan Rose	Lead Executive Director	Jeremy Over

Item	Details of Issue	For: Approval/ Escalation/Assurance	BAF/ Risk Register ref	Paper attached? ✓
Staff Psychology Service	Anne Swift led the first evaluation of this new service; It is one component of the broader Health and Wellbeing of Staff strategy and is perceived as successful to date; close to £500k has been invested in this service; On reflection, the service is striving to elicit more comprehensive feedback on its impact and will attempt to focus more on prevention than "treatment".	**Assurance:** but some clear recommendations for improvements	BAF Risk 7	
Abbeycroft Leisure Centre	A high level of staff participation in the "offer" to the entire workforce by the Trust of access to these leisure facilities; Positive feedback, especially as one of the actions taken during the stresses of Covid. More evaluation required to hone the offer for the future. Close to £100k invested in this service.	**Assurance**	BAF Risk 7	
Next time:	- Reflections on the learning from staff vaccination issues - Embedding "Involvement" in all trust change processes			
Date Completed and Forwarded to Trust Secretary		**21 March 2022**		

4.8. People & OD highlight report

To Assure

Presented by Jeremy Over

Board of Directors – 25 March 2022

Report Title:	Item 4.8 - People & OD Highlight Report
Executive Lead:	Jeremy Over, Executive Director of Workforce & Communications
Report Prepared by:	Members of the Workforce & Communications directorate Amanda Bennett & James Barrett, Freedom to Speak Up Guardians
Previously Considered by:	N/A

For Approval	For Assurance	For Discussion	For Information
☐	☐	☐	☒

Executive Summary

The People & OD highlight report was established during 2020-21 as a regular report to strengthen the Board's focus on how we support our people, grow our culture and develop leadership at all levels. This format will continue to be developed, alongside the escalation reports from Involvement Committee, to reflect the work that is ongoing, bringing together various reports that the Board has routinely received into one place.

In addition to discussing the content of the report, and related issues, continued feedback is welcomed as to the structure and content of this report and how it might be developed in future.

This month the report provides updates on the following areas of focus:

- Putting You First awards
- Quarterly report to the Board from our Freedom to Speak Up Guardians
- Vaccination as a Condition of Deployment (VCOD) - update
- Consultant appointments

Action Required of the Board

For discussion and noting

Risk and assurance:	Research demonstrates that staff that feel more supported will provide better, higher quality and safer care for our patients.
Equality, Diversity and Inclusion:	The work described around mandatory vaccination included an assessment of the impact on minority groups and by protected characteristic.
Sustainability:	Staff retention.
Legal and regulatory context	Certain themes within the scope of this report may relate to legislation such as the Equality Act, and regulations such as freedom to speak up / protected disclosures.

Putting You First – February/March awards

Sandra Varela, nursing assistant, ward G8
Nominated by Leanne Boyce

In addition to working on G8, Sandra can be seen picking up shifts around the hospital when they are short. Sandra is what the NHS needs… if we could clone her, we would!

She is 100% dedicated to her job and puts patients' needs at the heart of everything she does - nothing is too much trouble. If a patient wants to watch a film, she will find it for them; if they want a particular food item, she will get it; if they want their nails painted, Sandra will do it. You will often see our female patients with brightly coloured nails because Sandra has taken the time to sit and listen to all of their worries while giving them some TLC.

You will hear patients time and time again asking if Sandra is on shift today. She really is much loved by every person she comes into contact with. Someone like Sandra is rare to find these days and we are all so very lucky to have her working with us on G8.

In September, she will embark on a new journey and fulfil her dream to become a nurse… and what a nurse she will make. I can't think of anyone better to receive this award.

Andre Santos, interim ward manager, F6
Nominated by Gellie Lamina

I am nominating Andre for doing a great job looking after our staff's welfare during the staffing difficulties. There have been a lot of absences and when most of us feel so tired, stressed and helpless, he never ceases to offer support, cheering us up every day and granting requests when we are in need.

Andre promotes inclusiveness and diversity in our workplace and is open-minded to our cultural differences. As a Filipino nurse I feel at home by his warmth treatment of us all. He really deserves recognition.

"I whole heartedly support this nomination, Andre works so hard to support his team and it is lovely to see this acknowledgement." **Dr Marianne Meadows, clinical psychologist.**

Sally Giles, dietetics
Nominated by the dietetics team

Sally is the lead administrator for the dietetics team, initially working in our community department when it was at the Old Hospital Road site, before moving to the acute department here at West Suffolk Hospital.

Sally worked her way up from general administrator to lead administrator for dietetics, co-ordinating and line managing our admin team. Over her 30 years of service she has developed a breath of knowledge in our dietetic systems, capturing data for both our inpatient and outpatient services.

Sally has adapted her way of working where needed e.g., helping with the dietetic department move from our original office of many years upstairs near the time out restaurant, down to the new office within therapies department, as well as moving to more

IT based systems e.g., from hand-written snack/feed labels to the printed labels programme, from the PAS system, to EVOLVE to e-Care, helping to trial new electronic systems like MModal and Visionable.

She has also been our department's Health & Safety Representative, attending trust meetings and feeding back to our team, keeping our First Aid book stocked up to helping complete assessment of safety in our office environment, including managing safe office staff levels during the Covid pandemic.

Sally also helps to look after the team personally, completing regular tea/coffee rounds to help keep our staff hydrated and so they can get on with their busy workloads, she gets on well with both young and old, past and present members of the team. She is known throughout the Trust having links with the post room staff, purchasing, stores, TAC, Health and Safety team, etc.

Sally is a local girl, growing up in Bury St Edmunds. She is a stickler for spelling & grammar, likes earl grey tea, loves her food, enjoys walking, spending time with her family (children and grandchildren), friends (in and outside of work), she can talk for England, but is also a good listener and shoulder to cry on.

She is loyal, kind and selfless and is a very valued colleague and friend.

As well as her 30 years' service, Sally is soon to formally retire at the end of March, but luckily for us, she is staying on to help do some part time shifts for us, so all ins not lost. And in the words of Joni Mitchell, 'don't it always seem to go that you don't know what you've got 'til it's gone.' Well, we know what we've got and we're glad Sally's not gone just yet.

I'm sure others would like to join dietetics in congratulating Sally on her 30 years of loyal service and hard work within the Dietetics team, West Suffolk Hospital and the NHS and we would also like to take the opportunity to wish her a happy semi-retirement.

Speak Up Report

Our Freedom to Speak Up Guardians, Amanda Bennett and James Barrett, have shared their quarterly report which is attached as **appendix 1**. This reflects their learning, influence and experience over the past quarter. They will be in attendance to present and discuss the report at our meeting on 25 March.

Vaccination as a condition of deployment (VCoD) – mandatory staff vaccination within healthcare settings in England

In the period of time since the January 2022 meeting of the Board the Government has revoked the legislation requiring individuals undertaking CQC regulated activities in England to be fully vaccinated against COVID-19 no later than 1 April 2022.

I would like to place on record my thanks to colleagues from a number of our teams who came together to prepare for the implementation of the legislation and support staff and managers through this. Whilst the overwhelming majority of our staff had already taken-up the two-course vaccination dose, there was a number of staff who had not yet done so and were understandably anxious about the consequences of the pending legislation. Whilst the revocation of the legislation has removed

a significant risk associated with staff availability, recruitment and retention, the saga is not without consequence.

The NHS Confederation rightly drew attention to the impact of these events, stating that *"the way in which the decision to pause the VCOD processes was made and communicated to employers and their people generated a significant amount of ill-feeling. The poor communication and late U turn further damaged trust between team members, individuals and their employer and the system, following what was already an emotionally charged and divisive policy decision."*

There is a risk that future vaccination programmes across the NHS may be impacted which will need to be factored-in to our approach at West Suffolk.

Recent Consultant Appointments

Post:	Acute Consultant in General Paediatrics & Neonatology
Interview:	21 January 2022
Appointee:	Dr Tayyaba Aamir
Start date:	25 July 2022

Current post: Specialty Trainee, University Hospitals Plymouth
September 2021 to present

Previous Position:
September 2020 – August 2021
ST8 Paediatric Trainee, University Hospitals Plymouth

Freedom to Speak Up: Guardian's Report March 2022

Introduction

The number of concerns raised with the guardians has increased from 18 in Q2 to 26 in Q3.
In the National Guardian's Office Freedom to Speak Up Index 2021
James and Amanda continue to promote Freedom to Speak Up and have trained 40 Freedom to Speak Up Champions and have 20 further expressions of interest from candidates awaiting training.

Data

Data Submitted to NGO for Q3 2021/2022

Number of cases brought to FTSUGs / Champions per quarter	26
Numbers of cases brought by professional level	
Worker	21
Manager	1
Senior leader	0
Not disclosed	4
Numbers of cases brought by professional group	
Allied Health Professionals	4
Medical and Dental	1
Registered Nurses and Midwives	7
Nursing Assistants or Healthcare Assistants	3
Corporate Services	0
Administration, Clerical & Maintenance/Ancillary	3
Not Known	4
Other	3
Of which there is an element of	
Number of cases raised anonymously	3

Number of cases with an element of patient safety/quality	9
Number of cases with an element of bullying or harassment	11
Number of cases where disadvantageous and/or demeaning treatment as a result of speaking up (often referred to as 'detriment') is indicated	2
Number of cases with an element of worker safety	10

Response to the feedback question,
'Given your experience, would you speak up again?

Total number of responses	2
The number of these that responded 'Yes'	2
The number of these that responded 'No'	0
The number of these that responded 'Maybe'	0
The number of these that responded 'I don't know'	0

Common themes from feedback in Q3

Short staffing / unmanageable caseload 4
Work environment stressful 1

Fear detriment speaking up 1
Datix use leading to admonishment 1
Poor speaking up culture 1

Lack of understanding and support from managers 2

Bullying 3
Discrimination 3
Incivility from staff members 3

Employment / HR Recruitment processes 4
Banding concerns 1

Summary of learning points

Workload stress due to decreased staffing levels and increased workload means that civility between staff and support from managers is even more important. This highlights the importance of ongoing communication and gratitude from managers. These stresses also negatively affect the speaking up culture.

Importance of confidentiality in HR and recruitment processes.

The Guardians are working to improve the culture of speaking up throughout the WSFT. Our actions are categorised under 8 key workstreams:

Workers throughout the organisation have the capability, knowledge, and skills they need to speak up themselves and to support others to speak up.

What's going well:

- Rolling programme of training given to overseas nurses and Foundation year doctors
- NGO e-learning programme ("Speak Up" and "Listen Up") has been made part of Mandatory training either through induction training or as a "one-off" update
- Continuing to promote Speaking Up, Listening Up and Following Up at team meetings, Nursing and Midwifery Clinical Council (NMCC) and Medical Staff Committee meetings
- Induction given for student midwives
- Continuing to offer drop in sessions to teams
- Continue to distribute posters around Hospital and community sites

Even better if:

- As COVID restrictions relax to introduce more "face to face" presentations and meetings to promote FTSU
- Increased visibility across the Trust

Speaking up policies and processes are effective and constantly improved

What's going well:

- Guardians both members of the policy working group ensuring FTSU represented on policy updates
- Guardians work closely with HR Business Partners
- Guardians working with the NGO to help develop new national FTSU policy
- Champions are helping support Speak up opportunities in their teams such as suggestion boxes and standing agenda items at team meetings.

Even better if:

- FTSU Policy to be updated on publication of national policy guidelines from NGO, expected April 2022.

Senior leaders are role models of effective speaking up

What's going well:

- Quarterly meetings in place with CEO, Chair of Board, COO and Senior independent director
- Meeting with Governors to clarify and align FTSU process
- Planned meeting between Trust directors, FTSU Guardians and the NGO following publication of the Independent Review

Even better if:

- National Guardian's Office e-learning recommended to all senior leaders when available (still awaiting publication)
- FTSU pledge to be established for Board (following training)
- Encourage Board Members to read NGO publication The National Guardian Office's response to the West Suffolk Review

All workers are encouraged to speak up

What's going well:

- Continuing number of concerns raised to the Guardians
- Development of the FTSU Champions network to support staff in speaking up and to signpost to most appropriate service. Training completed by 40 staff members (including representatives from the Patient Safety Incident Investigation Team,) 20 Champions awaiting training.

Even better if:

- Development of on-line Champion training in collaboration with other Trusts.
- "Learning Bulletin" developed to complete feedback loop and show that speaking up leads to change and improvement

Individuals are supported when they speak up

What's going well:

- Individuals report feeling supported by the Guardians when raising concerns
- Volunteer network offered support to Speak up from Guardians' letter and the volunteer co-ordinator becoming a Champion

Even better if:

- Continue to expand Champion network to support areas/groups not currently covered

Barriers to speaking up are identified and tackled

What's going well:

- Good relationships with HR Business Partners
- Links made with local GMC representative

Even better if:

- Speaking up rewarded and embraced within teams
- Integration of FTSU within the Just and Learning culture, so that speaking up is "business as usual"

Information provided by speaking up is used to learn and improve

What's going well:

- Working with Patient Safety colleagues and co-published an article in the Green Sheet to explain how Datix concerns are investigated and feedback given.
- Following concerns raised about redeployment of ward staff and general staffing concerns, joint presentation with Deputy Chief Nurse at NMCC meeting to give feedback on actions
- FTSU Teams Channel established to help communication within the FTSU Guardians and Champions

Even better if:

- Learning communications channel established to enable dissemination of learning throughout the organisation

Freedom to speak up is consistent throughout the health and care system, and ever improving

What's going well:

- Members of East of England FTSU Guardian Network and have attended quarterly meetings.
- Shared learning from the Rapid Review discussed with regional colleagues at East of England NGO meeting and Suffolk RCN event

Even better if:

- NGO GAP analysis carried out by Trust

Summary of Rapid Review published in late 2021 into events from 2018

- Doctors raised concerns: Motivation of those speaking up questioned, decided it was an operational matter. Concerns were not heard and responded to.

FTSU Learning:

- The importance of listening to the message rather than the person
- Need to separate FTSU concerns from performance management/disciplinary
- High threshold required for judging concerns are not genuine
- Identify that individuals are raising concerns even when they do not cite FTSU
- Ensure policy is followed

5. GOVERNANCE

5.1. BAF Summary and risk report

To Assure

Presented by Richard Jones

Board of Directors – 25 March 2022

Report Title:	Item 5.1 - Board Assurance Framework
Executive Lead:	Richard Jones, Trust Secretary
Report Prepared by:	Richard Jones, Trust Secretary
Previously Considered by:	Board of Directors January 2022

For Approval	For Assurance	For Discussion	For Information
☐	☒	☐	☒

Executive Summary

The Board assurance framework is a tool used by the Board to manage its principal strategic risks.

Focusing on each risk individually, the BAF documents the key controls in place to manage the risk, the assurances received both from within the organisation and independently as to the effectiveness of those controls and highlights for the board's attention the gaps in control and gaps in assurance that it needs to address in order to reduce the risk to the lowest achievable risk rating.

The Board approved its risk appetite statement at the October meeting of the Board, following which the BAF risks were reviewed individually with the executive team during November 2021.

BAF and red risks are allocated to Board governance committee for oversight. The process to manage and maintain this oversight is currently under review.

Action Required of the Board

a) To note the updated BAF

Risk and assurance:	Failure to effectively manage risks to the Trust's strategic objectives. Agreed structure for Board Assurance Framework (BAF) review with oversight by the Audit Committee. Internal Audit review and testing of the BAF.
Legal and regulatory context	The BAF underpins the Board's Annual Governance Statement within the annual report and is a critical part of the Head of Internal Audit's annual opinion.

Background

The Board assurance framework is a tool used by the Board to manage its principal strategic risks.

Focusing on each risk individually, the BAF documents the key controls in place to manage the risk, the assurances received both from within the organisation and independently as to the effectiveness of those controls and highlights for the board's attention the gaps in control and gaps in assurance that it needs to address in order to reduce the risk to the lowest achievable risk rating.

Appendix 1 shows the allocation of the BAF risks to each of the Board's assurance committees.

Appendix 2 provides supporting detail of current mitigating actions and the most recent assurances relating to those actions.

The Role of the Assurance Committees

Board assurance committees are responsible for considering all relevant risks within the BAF and the corporate risk register as they related to the remit of the committee, as part of the reporting requirements, and to report any areas of significant concern to the audit committee or the board as appropriate. The committees will be responsible for recommending changes to the BAF relating to emerging risks and existing entries within their remit for the executive to consider. When the target risk in the BAF is met, a full report will be made to the committee recommending its removal from the BAF, which will the committee will consider and make an appropriate recommendation to the Board.

Risk Appetite Statement

The Trust's risk appetite statement has been reviewed and is being used as a tool to determine which risks should be prioritised by the board for controls assurance purposes. Where the Trust has a cautious view of risk (green to yellow), and the current risk is higher than this, this risk will be reviewed more frequently and in greater depth by the board and its committees. When a target risk is achieved and this is lower than the Trust's risk appetite, the Board will consider the removal of a risk from the Board Assurance Framework, though it will remain on the Trust's risk register for ongoing executive management.

Current Risk Profile

All but one of the BAF risks are red. All of the red risks are outside the Trust Board's agreed risk appetite.

The amber risk relates to digital transformation. Assessed at Annual x Major = Amber, this has achieved its target risk and is within the Trust Board's agreed risk appetite. We are awaiting confirmation that this has been formally de-escalated from the BAF.

Red Risk Report

This report now also includes an update on the corporate and operational **red risks** previously reported separately.

Risk No.	Title	BAF Y/N	Risk level (current)	Risk Subcategory
24	Potential failure of the main building structure and front residencies structure (Oak, Cedar, Birch, Larch, Pine, Willow)	N	Red	Corporate Risk
4168	Impact of Managing COVID-19 (Coronavirus) on Trust business as usual activity	N	Red	Corporate Risk
4499	Provision of thrombectomy service for stroke patients in our region	N	Red	Corporate Risk
4724	Staffing shortfalls	N	Red	Corporate Risk
4890	Evacuation of the West Suffolk Hospital primarily due to RAAC issue	N	Red	Operational Risk
4917	Missing samples causing a delay to getting results to the right patient at the right time.	N	Red	Operational Risk
5092	Capacity and demand of the e-Care Meds Team	N	Red	Operational Risk
5107	Post the collapse of RAAC planks, it is assessed that there will be the release of large amounts of dust into the air	N	Red	Operational Risk
5136	Saving Not Signing Documents on e-Care	N	Red	Corporate Risk
5151	No availability of a second obstetric team outside the hours of 8am and 8pm Mon-Fri	N	Red	Operational Risk
5181	Fukuda Spirometry tubing is currently not available	N	Red	Operational Risk
5190	RAAC plank concerns within Antenatal	N	Red	Operational Risk
5199	Extreme weather and concerns how it affects the RAAC roof and walls	N	Red	Operational Risk
5230	Delay in Discharge Summaries being sent out	N	Red	Operational Risk
5235	Interim relocation of recovery into theatres 5 and 6 due to roof issues	N	Red	Operational Risk

The corporate risks are currently being managed through management committees (RAAC Red Risk, Senior Leadership Team, Executive Directors). Operational risks are reviewed quarterly with the relevant risk owner.

Future Reporting Arrangements

The Board Assurance Committees will update the board at every meeting when they receive updates on any of the BAF strategic risks.

The BAF will be updated following each update and reported to the public board at every other meeting.

Appendix 1

Allocation of BAF Risks to Board Sub-Committees

Board Assurance Committee	Well-Led Key Lines of Enquiry	BAF Risks Assigned	Current Risk
Improvement	• **Is there a culture of high quality, sustainable care?** • **Are there robust systems for learning, continuous improvement and innovation**	1. If we do not establish effective governance structures, systems and procedures over safety and quality, this will lead to poor standards of care to all patients and service users, potential harm, service failure, reputation damage, poor patient experience and regulatory action	Quarterly x Major = Red [No change}
Insight	• **Are there clear and effective processes for managing risks, issues and performance** • **Is appropriate and accurate information being effectively processed, challenged and acted upon**	2. If we do not manage emergency capacity and demand in the context of Covid activity and delivery of the RAAC remediation plan, this will affect our ability to deliver safe, effective and efficient services and care to patients	Weekly x Major = Red [Increased]
		3. If we do not deliver elective access standards based on clinical priorities in the context of Covid activity, this will affect our ability to deliver safe, effective and efficient services and care to patients	Weekly x Major = Red [No change]
		4. If we do not progress our programme of work for digital adoption, transformation and benefits realisation, the digital infrastructure will become obsolete and vulnerable to cyber-attack, resulting in poor data for reporting and decision support, digital systems failure, loss of information and inability to provide optimum patient care, safety and experience [Risk is being considered for de-escalation by Insight Committee]	Annual x Major = Amber [No change]
		5. External financial constraints (Revenue and Capital) impact on Trust and system sustainability and model of service provision in the west Suffolk system *(even when services delivered in the most efficient way possible).* This includes failure to identify and deliver cost improvement and transformation plans that ensure sustainable clinical and non-clinical services while delivering the agreed control total	Quarterly x Major = Red [No change]

Board Assurance Committee	Well-Led Key Lines of Enquiry	BAF Risks Assigned	Current Risk
Involvement	**Are the people who use the services, the public, staff and external partners engaged and involved to support high quality sustainable services?**	6. If we do not value our workforce and look after their well-being, particularly in the context of the Covid-19 pandemic, this may affect patient safety and quality of care due to lower levels of staff engagement and morale, and staff choosing to leave WSFT	Quarterly x Major = Red [No change]
Core Resilience Team Red Risk Oversight Committee		7. If we do not implement the estates strategy to provide an adequately maintained building environment suitable for patient care caused by the deteriorating state of Trust buildings, lack of access to capital to fund the remediation programme, this may result in potential harm incidences, capacity pressures and improvement notices	Quarterly x Major = Red [No change]

Appendix 2

Summary mitigating actions and gaps in assurance

	Residual Risk	Target Risk
1. Failure to maintain and further strengthen effective governance structures, systems and procedures over safety and quality, leading to poor standards of care to all patients and service users, potential harm, service failure, reputation damage, poor patient experience and regulatory action (BAF 1)	Quarterly x Major = Red	Annual x Major = Amber

Description of additional controls required (actions being taken)	Lead
Safe staffing - see separate BAF risk	-
Build assurance dashboard and framework for quality indicators to support development of ward accreditation programme	SW
Development programme for ward managers and matrons to support ward accreditation	SW
Align accreditation framework and KPIs with Nursing, midwifery and AHP strategy	SW
Co-produce nursing, midwifery and AHP strategy to meet current and future system needs (reflecting the updated Trust strategy - pending)	SW
Develop patient safety and learning strategy	LW
Quarterly review of the CQC Insight publication with actions to address outlying indicators overseen by Insight Committee	RG
IQPR refresh project (this will enable reinstatement of the previously listed control "IQPR including key quality indicators (including community) – reported to open board and also reported to Insight Committee. This supports timely identification, escalation and action to address issues of concern".	NC
Review 2021/22 Quality Priorities and develop 2022/23 quality priorities through the Improvement Committee with Board sign-off as part of the Annual Report/Quality Accounts	RG
Review to be undertaken of the structure and strategies for quality, safety and experience of care	JMcF

Assurances

- Organisational Framework for Governance approved by Board September 2021
- Serious incidents, complaints, claims and inquests report to board (every meeting)
- Maternity reporting to Board and attendance of head of midwifery (every meeting)
- Quality reporting to Board on key performance indicators e.g. infection prevention and control, maternity (every meeting)
- Learning from Deaths report to board
- Monthly breakdown of nurse staffing levels reported to board
- Programme of IPB external reviews
- External review of maternity services (CCG, region and CQC) – supportive (June '21)
- Maternity external support – reported as part of maternity plans to IPB
- Regulatory PSIRF sign-off of WSFT framework
- Internal audit reporting:
    - Responsive internal audit programme linked to IPB assurance requirements (draft programme for 2021/22)
    - Risk Management - Reasonable Assurance (Nov 2020)
    - CQC Improvement Plan – Stage 1 Substantial Assurance (Nov 2020)
    - Data Quality – Paused Activity and Recovery Reasonable Assurance (Jan 2021)
    - Fit and Proper Persons - Partial Assurance (Jan 2021)

	Residual Risk	Target Risk
2. If we do not manage emergency capacity and demand in the context of Covid activity and delivery of the RAAC remediation plan, this will affect our ability to deliver safe, effective and efficient services and care to patients	Weekly x Major = Red	Quarterly x Moderate = Amber
Description of additional controls required (actions being taken)	Lead	
Operational and staffing plans to safely deliver winter escalation and surge capacity (see separate BAF risk)	COO	
Implementation of: length of stay and discharge programme supported by ECIST to include system out of hospital capacity programme, frailty programme, the application of right to reside	COO	
Transformation initiatives: - review of home IV therapy to inform business case (Apr 21) - expansion of the virtual ward concept	COO	
Implement final versions of new ED access standard in line with national roll out	COO	
Submitted a range of bids for funding to support admission avoidance and improved hospital flow – funding schemes to be implemented	COO	

Assurances

- Access and performance reporting arrangements to Board e.g. IQPR, operational report and transformation report (qrtly)
- External monitoring of stranded and super stranded and medically optimised for discharge
- Monitoring of bed utilisation
- Attain report – informs and validates the decant plans to support RAAC remediation
- NHSE/I oversight meeting (quarterly)
- Internal audit reporting:
    - Civil Contingencies Act - Advisory (July 2020)
    - Risk Management - Reasonable Assurance (Nov 2020)
    - Data Quality – Paused Activity and Recovery Reasonable Assurance (Jan 2021)
    - COVID-19 Financial Governance & Key Financial Controls - Reasonable Assurance (Jul 2020)
    - Private and Overseas Patients - Reasonable Assurance (Nov 2020)

	Residual Risk	Target Risk
3. If we do not deliver elective access standards based on clinical priorities in the context of Covid activity, this will our ability to deliver safe, effective and efficient services and care to patients ***(emergency standard is considered separate BAF entry)***	Weekly x Major = Red	Quarterly x Moderate = Amber

Description of additional controls required (actions being taken)	Lead
Theatre 1 recommissioned (delayed due to RAAC remediation and Covid)	COO / DoR
Outpatient transformation programme with focus on digital and embedding of Covid learning – delivering benefits to key milestones. Advice and guidance virtual consultation PIFU	COO
Development of longer term contract for additional Orthopaedic capacity with the BMI	COO
Continue to progress opportunities to fund an elective hub at Newmarket	COO
Development of Ophthalmic injection suite	COO
Development of an additional clinical area within the JFDU	COO
Improve operational efficiency in line with the GIRFT HVLC	COO
Develop business case for community diagnostic hub at Newmarket	COO

Assurances

- Board reports and monitoring (every meeting)
- Weekly SNEE activity level review
- Cancer and diagnostics activity progress against trajectory (monthly)
- Internal audit reporting:
    - Data Quality – Paused Activity and Recovery Reasonable Assurance (Jan 2021)
    - COVID-19 Financial Governance & Key Financial Controls - Reasonable Assurance (Jul 2020)
    - Private and Overseas Patients - Reasonable Assurance (Nov 2020)

	Residual Risk	Target Risk
4. If we do not progress our programme of work for digital adoption, transformation and benefits realisation, the digital infrastructure will become obsolete and vulnerable to cyber-attack, resulting in poor data for reporting and decision support, digital systems failure, loss of information and inability to provide optimum patient care, safety and experience	Annual x Major = Amber	Annual x Major = Amber

Description of additional controls required (actions being taken)	Lead
Preparation 2022/23 digital programme plan with funding envelope to Digital Programme Board review	Craig Black
Agreed plan for the delivery of HIMSS 6 and 7 (with key external organisational dependencies) with NHSD/NHSX. To include closed loop blood and medication	Sarah Judge Liam McLaughlin
Deliver programme for population health management in the west of Suffolk, working with local partners and Cerner to develop the solution	Helena Jopling
Deployment of new Antivirus solution to support further strengthening of Cyber Security defences	Rob Howorth
Ensure engagement with ICS process to secure HSLI funding for developments in the west of Suffolk	Craig Black
Review of digital governance structure/framework	Liam McLaughlin
Key deliverable to support Future System programme: - Support for the Future systems engagement fortnight - Commission first services from an offsite data centre - Engagement with architects and surveyors on development of a digital twin for the new buildings	Craig Black
Regular updates from Pillar Groups to Digital Board and onto Trust Board: - Pillar Group 1 Acute Developments - Pillar Group 2 (Wider Health Community [SNEE]) - Pillar Group 3 Community Developments - Pillar Group 4 Infrastructure	Craig Black Sue Wilkinson Craig Black Helen Beck Nick Jenkins

Assurances
• Digital Programme Board reporting to Board, including NED membership (quarterly) • Cyber Essential Plus audit report • Cyber security penetration test report • Data Security and Protection Toolkit assessment

	Residual Risk	Target Risk
5. External financial constraints may impact on Trust's sustainability through tariff, contract and pattern of service provision in the west Suffolk system resulting in inequitable allocation of resources to meet the care and service need of the local community	Quarterly x Major = Red	Quarterly x Major = Red
Description of additional controls required (actions being taken)	Lead	
Delivery of year end position (Board reporting) with escalation as required	DoR	
Agree financial position with (including anticipated funding for 22-23) with the system and regional team	DoR	
Agree budget position internally	DoR	
Finalise CIPs to deliver financial plan for 2022/23 (dependent on response to system/ regulatory framework)	COO/DoR	
Review divisional business plans (underpinned by sustainable clinical models) to reflect the requirements to deliver additional backlog activity)	COO	
Develop a system-wide information strategy with underpinning tools to improve performance monitoring	DoR	
Respond to national guidance for operational planning cycle for 2022/23	RJ	

Assurances

Internal – level 2

- Monthly reporting to Board through finance and performance reports (monthly)
- Operational plan approved by Board
- Controls and assurance for internal efficiency set out in CIPs

External - level 3

- Control total agreed with NHSE/I
- Delivery of year end position
- Alliance partnership working for services in west Suffolk – Alliance strategy

	Residual Risk	Target Risk
6. If we do not value our workforce and look after their wellbeing and development, particularly in the context of the Covid-19 pandemic, this may affect patient safety and quality of care due to lower levels of staff engagement and morale and staff choosing to leave WSFT	Quarterly x Major = Red	Annual x Major = Amber

Description of additional controls required (actions being taken)	Lead
Development of next iteration of People Plan in support of the new WSFT strategy and reflecting national priorities	JO
Evaluation of additional staff support measures during pandemic and agreement of next steps	JO
Implementation of lessons learned from external review of whistleblowing matters	JO
Establish Mandatory staff vaccination implementation group and deliver action plan	JO

Assurances

- Safer staffing - trust-wide establishment review approved by Board (Jan ’21)
- Approved WSFT people plan, with monthly reporting to Board
- Vacancy levels – reported monthly
- National staff survey – reported to board
- Friends and family and staff recommender scores

	Residual Risk	Target Risk
7. If we do not implement the estates strategy to provide an adequately maintained building environment suitable for patient care caused by the deteriorating state of Trust buildings, lack of access to capital to fund the remediation programme, this may result in potential harm incidences, capacity pressures and improvement notices *[Linked to structural risk assessment (ref. 24) rated as Red]*	Quarterly x Major = Red	Annual x Major = Amber
Description of additional controls required (actions being taken)	Lead	
Implementation of controls associated with red risk re RAAC planks (Datix 24) potential failure of the main building structure and front residencies structure (Oak, Cedar, Birch, Larch, Pine, Willow): - Emergency planning - Assessment and repair - Remediation (failsafe installation) - Communication - Research and development - Site and system risk (including continued occupation of WSH site)	C Black	
Deliver approved capital programme for 2021/22, including key capacity developments	C Black	
Confirmation of capital loan funding for 2021-22-, trust has sought approval for an up lift in the budget and is awaiting confirmation	C Black	
Sudbury asset disposal as part of agreed plan	C Black	
Secure capacity as part of one public estate (OPE) development at six hubs across West Suffolk	C Black	
Communication strategy for structural risk based on agreed remediation plan with clinical model to support capacity requirements (linked to Attain work)	C Black	

Assurances

- Reporting to Board (monthly)
- Monthly risk review meeting – monitors progress and escalates issues/concerns
- Legal opinions on activity undertaken (latest Jan 2021)
- Regional office Charles Hanford (pending) - Charles undertakes a quarterly review of performance in completing the surveys etc. to report to the national oversight group
- Engagement in 'best buy' hospital forums ongoing (ongoing)
- EPRR feedback from exercise Hodges (Oct 20)
- Internal audit reporting:
    - Civil Contingencies Act - Advisory (July 2020)
    - Risk Management - Reasonable Assurance (Nov 2020)

5.2. Governance report

To inform

Presented by Richard Jones

Board of Directors – 25 March 2022

Report Title:	Item 5.2 - Governance Report
Executive Lead:	Richard Jones, Trust Secretary
Report Prepared by:	Richard Jones , Trust Secretary
Previously Considered by:	N/A

For Approval	For Assurance	For Discussion	For Information
☐	☐	☐	☒

Executive Summary

This report summarises the main governance headlines for December 2021, as follows:

- Chair appointment process
- Senior Leadership Team report
- Board assurance committee review
- Board development
- Draft agenda Items for the next Board meeting
- Use of Trust seal
- Building insurance renewal

Action Required of the Board

To note the report

Legal and regulatory context	NHS Act 2006, Health and Social Care Act 2013

Governance Report

1. Recruitment of permanent Chair

The appointment of a Foundation Trust chair and non-executive directors is one of the statutory duties of the Council of Governors and requires approval at a general meeting. The Nominations Committee of the Council of Governors has started the process of appointing a new Chair. Following a review of the Constitution, in December 2021, the Nominations Committee has also started the process for appointing up to three new non-executive directors to the Board.

2. Senior Leadership Team Report

The Senior Leadership Team is a decision-making forum which provides strategic leadership for the organisation and is responsible for the implementation and delivery of the Trust's strategic direction, business plan and associated objectives, ensuring that a cohesive decision-making process and co-operative approach is applied to issues which have an impact across the organisation.

The Team is still in a developmental stage but has considered a number of strategic issues in its recent meetings, which has included discussion of: capital planning and budgets; the West Suffolk review – Organisational development plan; Trust Strategy; elective care strategy; business case planning process; and community structures. There are no issues escalated for the Board's attention.

3. Board assurance committee review

The new committee structure has been in place for just over six months and therefore it is appropriate to reflect on our initial experience and consider areas for development. To support this the Board is specifically considering how to strengthen the focus on patient quality and safety within the structure.

To support the Board in this review it has asked members of the three assurance committees to reflect on options and provide views as to the advantages and disadvantages. The outcome of this review will be reported at the next meeting.

4. Board development

The Board is continuing to work with Integrated Development on a programme to support our model of working. The next session is scheduled for April, with two further sessions in June and October. A summary of the April session will be reported at the next meeting.

5. Agenda Items for the Next Meeting (Annex A)

Annex A provides a summary of scheduled items for the next meeting and is drawn from the Board reporting matrix, forward plan and action points. The final agenda will be drawn-up and approved by the Chair.

6. Use of Trust Seal

None to report.

7. Building insurance renewal

The property insurance renewal for the Trust is due and relevant quotations have been sought from a range of providers. This insurance covers our buildings (Hardwick Lane site, Newmarket Hospital and Hardwick Manor) and business interruption over and above our insurance cover with NHS Resolution (NHSR). NHSR property insurance has a limit of £1million on any claim, hence the requirement for cover over and above that amount.

The 2022 increase reflects:

- Increased value of buildings on a square foot basis
- increased building materials costs
- increased labour/construction costs.

Annex A: Scheduled draft agenda items for next meeting – 27 May 2022

Description	Open		Closed	Type	Source	Director
Declaration of interests	✓		✓	Verbal	Matrix	All
General Business						
Patient/staff story	✓		✓	Verbal	Matrix	Exec.
Chief Executive's report	✓			Written	Matrix	CB
Report from 3i Committees: Insight, Improvement & Involvement	✓			Written	Matrix	RD / AR / JC
Culture						
West Suffolk Review – Organisational development plan	✓			Written	Matrix	JMO
Report of the West Suffolk Review – Governor/Director working group	✓			Written	Matrix	RD
National staff survey report	✓			Written	Matrix	JMO
Strategy						
Budget and capital programme						
Future System Board Report	✓			Written	Matrix	CB
Strategic update, including Trust strategy next steps, Alliance, System Executive Group, Integrated Care System, Integration report	✓			Written	Matrix	CB
Assurance						
Insight Committee Report - Finance and workforce report - Operational report - IQPR	✓			Written	Matrix	NM/NC/RD
Involvement Committee Report - People and OD Highlight Report o Putting you First award o Safe staffing guardian report o Freedom to speak up guardian o Staff recommender scores o Mandatory training analysis (qtrly) o Car park review - The People Plan	✓			Written	Matrix	JMO/AR
Improvement Committee Report - Maternity services quality and performance report (inc. Ockenden) - Nurse staffing report - Quality priorities	✓			Written	Matrix	SW / PM
Serious Incident, inquests, complaints and claims report			✓	Written	Matrix	SW

Description	Open		Closed	Type	Source	Director
Annual report and accounts (draft)			✓	Written	Matrix	NM/RJ
Governance						
Governance report, including - Agenda items for next meeting - Use of Trust's seal - Senior Leadership Team report - Board assurance committee review - FT membership strategy	✓			Written	Matrix	RJ
Board assurance framework and risk report	✓			Written	Matrix	RJ
Confidential staffing matters			✓	Written	Matrix – by exception	JMO
Reflections on the meetings (open and closed meetings)	✓		✓	Verbal	Matrix	JC

6. OTHER ITEMS

6.1. Any other business

To Note

6.2. Reflections on meeting

For Discussion

6.3. Date of next meeting - 27 May 2022

To Note

Presented by Jude Chin

RESOLUTION

The Trust Board is invited to adopt the following resolution:

“That representatives of the press, and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest” Section 1 (2), Public Bodies (Admission to Meetings) Act 1960

Annexes for Item 4.5 - Quality & Nurse Staffing Report

To inform

Board of Directors – 25 March 2022

Report Title:	Annexe 1 - Infection prevention & control
Executive Lead:	Sue Wilkinson Exec Chief Nurse (DIPC)
Report Prepared by:	Rebecca Gibson – Head of Compliance & Effectiveness
Previously Considered by:	Infection prevention & control committee

For Approval	For Assurance	For Discussion	For Information
☐	☒	☐	☒

Executive Summary

Please note – The assurance provided within this report will in future be incorporated within the infection prevention & control report to the patient quality & safety governance group (which reports upwards to the 3i committees) and so this standalone paper will no longer be provided directly to the board.

The trust recognises the ongoing risk of COVID-19 and other healthcare acquired infections and the role the Infection prevention & control (IPC) team and committee have in managing this risk. The Infection prevention & control (IPC) committee have responsibility for oversight and review of the risk assessment RR5204 *Prevention of Healthcare associated infection (HAI) and the risk of occupational healthcare associated infection* including quarterly review as currently rated as Red (major x weekly).

The trust continues to apply a hierarchy of controls to manage the ongoing COVID-19 pandemic. These include evaluation of the ventilation in the area, operational capacity, physical distancing and prevalence of COVID-19. This is further described in the gov.uk publication *Infection prevention and control for seasonal respiratory infections in health and care settings (including SARS-CoV-2) for winter 2021 to 2022* (last updated Jan22). The main changes / updates in the January update are:

- Addition of a section within the 'hierarchy of controls' to further support organisations/services with maximum workplace risk mitigation
- Recommendation for universal use of face masks for staff and face masks/coverings for all patients/visitors to remain as an IPC measure within health and care settings over the winter period.
- Recommendation that physical distancing should be at least 1 metre, increasing whenever feasible to 2 metres across all health and care settings and that physical distancing should remain at 2 metres where patients with suspected or confirmed respiratory infection are being cared for or managed.
- Recommendation that screening, triaging and testing for SARS-CoV-2 continues over the winter period. Testing for other respiratory pathogens will depend on the health and care setting according to local/country-specific testing strategies/frameworks and data.
- Recommendation that the inpatient isolation period for COVID-19 cases or contacts is reduced from 14 days to 10 days. There are some exceptions to reducing the isolation period and this should be considered as part of a clinical risk assessment.

Annex 1 provides this month's IPC Covid-19 dashboard.

Action Required of the Board

Receive for information and assurance

Risk and assurance:	RR5204 Prevention of Healthcare associated infection and the risk of occupational healthcare associated infection

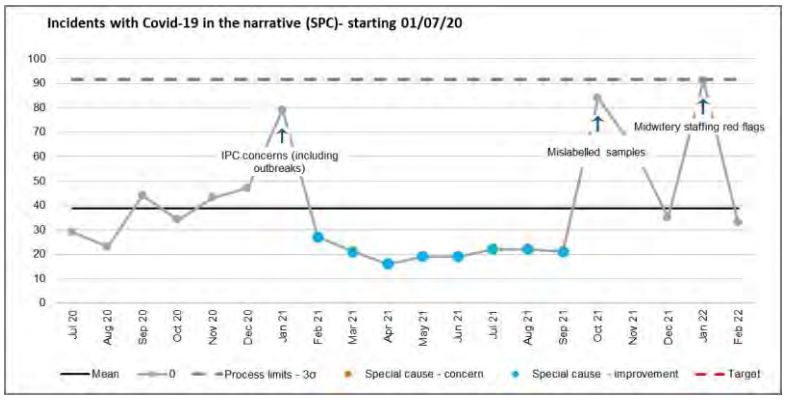
Legal and regulatory context	NHSE - Local systems must assure themselves, with commissioners, that a trust's infection prevention and control interventions (IPC) are optimal, the Board Assurance Framework is complete, and agreed action plans are being delivered and review system performance and data; offer peer support and take steps to intervene as required.

Annex 1 - IPC dashboard

Measure (Dec-21 data)	Data for last three reporting months		
	Dec	Jan	Feb
Nosocomial C19 (probable + definite)	9	64	11↓
Incidents relating to C19 management	14	91	33↓
Admissions swabs within 24 hours of DTA	99%		99% →
Staff sickness / absence due to C19	660	944	637↓

C-19 admission swabs

The total number of patients swabbed in February remained very high with compliance of over 99% of patients having a swab taken within 24 hours of the DTA. 11 patients (0.8%) did not have a record of having a swab taken in this episode.



Incidents with COVID in narrative description

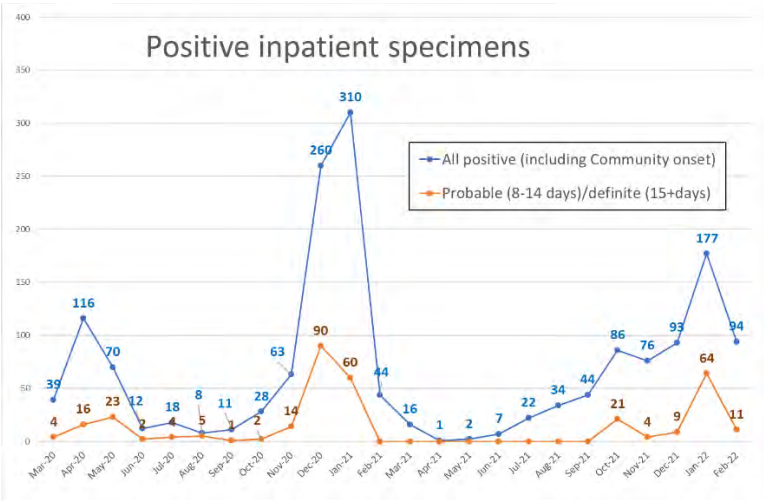
The total number of incidents relating to C-19 rose considerably in January and then fell again in February. This was mainly due to Midwifery staffing red flags.

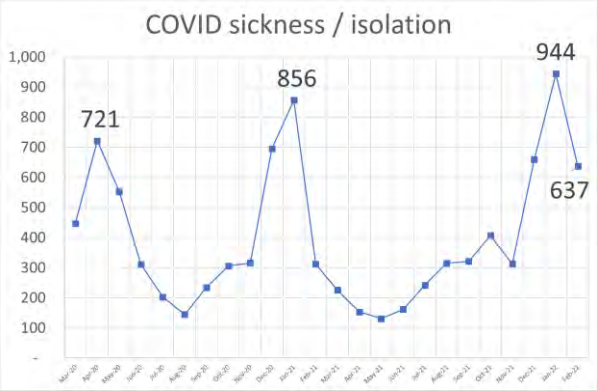
Nosocomial (Hospital-Onset) C-19

There were 64 cases identified in January; definite (27) and probable (37) and 11 in February; definite (5) and probable (6).

There is a comparable clear rise in community infections in the recent months which peaked in January. Cases fell in February but remained higher than previous months in 2021.

The significant number of nosocomial cases in January were related to multiple outbreaks on a number of different medical and surgical wards.





COVID-19 related sickness / isolation

This is a count of our staff who have been off sick with a Covid related symptoms or required to isolate.

In January this rose to the highest since the reporting began, it has fallen in February however it remains high (similar to December's figures and significantly above the previous nine months .

We have continued to review all national guidance throughout the pandemic and assure that our local processes align to the national guidance.

Trust Board – 25 March, 2022

Report Title:	Annexe 2 - Quality and Workforce Report & Dashboard – Nursing January and February 2022
Executive Lead:	Sue Wilkinson, Chief Nurse
Report Prepared by:	Daniel Spooner, Deputy Chief Nurse
Previously Considered by:	N/A

For Approval	For Assurance	For Discussion	For Information
☐	☒	☐	☐

Executive Summary

This paper reports on safe staffing fill rates and mitigations for inpatient areas for January and February 2022. It complies with national quality board recommendations to demonstrate effective deployment and utilisation of nursing staff. The paper identifies how planned staffing levels were achieved and the resulting impact of these staffing levels. It will go onto review vacancy rates, nurse sensitive indicators, and recruitment initiatives.

Highlights

- Average RN fill rates in the day remain under 90% since October 2021
- Small rise in vacancy rate for RN and NA despite static substantive numbers
- Staff isolation rates dropped in January only to rise again in February
- Reduction in sickness rates in both RN and NA groups
- Surge staffing plans continued throughout January with a staged withdrawal to BAU in February
- Maternity KPIs maintained good performance
- Community challenges and concerns added to paper for first time

Action Required of the Board

For assurance around the daily mitigation of nurse staff.
No action needed

Risk and assurance:	*New risk raised with opening of ward F9:*
Equality, Diversity and Inclusion:	*N/A*
Sustainability:	*N/A*
Legal and regulatory context	*Compliance with CQC regulations for provision of safe care*

1. Introduction

Whilst there is no single definition of 'safe staffing', the NHS constitution, NHS England, CQC regulations, NICE guidelines, NQB expectations, and NHS Improvement resources all refer to the need for NHS services to be provided with sufficient staff to provide patient care safely. NHS England cites the provision of an *"appropriate number and mix of clinical professionals"* as being vital to the delivery of quality care and in keeping patients safe from avoidable harm. (NHS England 2015).

West Suffolk NHS Trust is committed to ensuring that levels of nursing staff, which includes Registered Nurses, Midwives and Nursing Associates and Assistant Practitioners, match the acuity and dependency needs of patients within clinical ward areas in the Trust. This includes ensuring there is an appropriate level and skill mix of nursing staff to provide safe and effective care using evidence-based tools and professional judgement to support decisions. The National Quality Board (NQB 2016) recommend that on a monthly basis, actual staffing data is compared with expected staffing and reviewed alongside quality of care, patient safety, and patient and staff experience data. The trust is committed to ensuring that improvements are learned from and celebrated, and areas of emerging concern are identified and addressed promptly.

Since March 2020 the NHS has managed the Coronavirus outbreak. Coronavirus has become a global health emergency. Matrons and Heads of Nursing and Midwifery review staffing on a daily basis to ensure; sufficient ward care capacity, to support the surge in critical care capacity, with appropriate estate, equipment, expertise and support in place to deal with the increase demands that coronavirus has created. This paper will identify the safe staffing and actions taken in January and February 2022.

The following sections identify the processes in place to demonstrate that the Trust proactively manages nurse staffing to support patient safety.

2. Nursing Fill Rate

The Trust's safer staffing submission has been submitted to NHS Digital for January and February within the data submission deadline. Table 1 shows the summary of overall fill rate percentages for these months and for comparison, the previous four months.

	Day		Night	
	Registered	Care Staff	Registered	Care staff
Average fill rate for September 21	91%	92%	89%	107%
Average fill rate for October 21	88%	87%	87%	101%
Average fill rate for November 2021	89%	87%	88%	102%
Average fill rate for December 2021	88%	82%	86%	96%
Average fill rate for January 2022	87%	81%	82%	97%
Average fill rate February 2022	85%	81%	84%	100%

Table 1: Fill rates are RAG rated to identify areas of concern (Purple >100%, Green: 90-100%, Amber 80-90%, Red <80).

Highlights

- Reduction in fill rates across all shifts other than Night shifts for Nursing assistants
- Provision of staffing additional ward will have impacted on fill rates in January
- G8 area of concern consistently not filing its core staffing number.

3. Care Hours per Patient Day (CHPPD)

CHPPD is a measure of workforce deployment and is reportable to NHS Digital as part of the monthly returns for safe staffing (Appendix 1)

CHPPD is the total number of hours worked on the roster by both Registered Nurses & Midwives and Nursing Support Staff divided by the total number of patients on the ward at 23:59 aggregated for the month (lower CHPPD equates to lower staffing numbers available to provide clinical care).

4. Sickness

Since a sustained increase, peaking in December 2021, sickness rates have fallen for both RNs and NAs

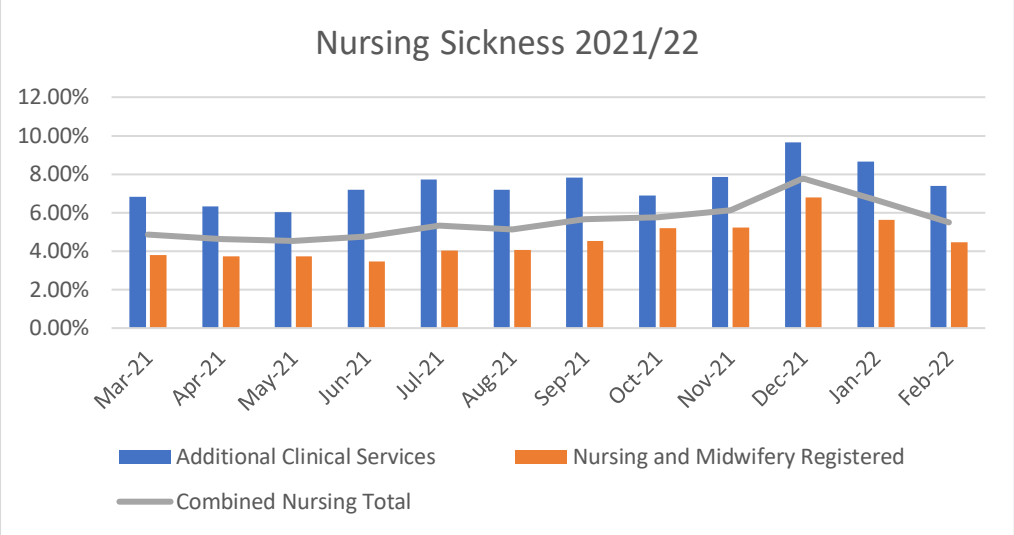


Chart 2.

	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
Unregistered staff (support workers)	7.73%	7.20%	7.82%	6.88%	7.85%	9.64%	8.64%	7.39%
Registered Nurse/Midwives	4.04%	4.06%	4.52%	5.18%	5.22%	6.80%	5.61%	4.46%
Combined Registered/Unregistered	**5.33%**	**5.14%**	**5.65%**	**5.77%**	**6.13%**	**7.78%**	**6.64%**	**5.48%**

Table 2b

Challenges to providing safe staffing have also been exacerbated by staff that are required to self-isolate, either due to exposure to Covid 19, or due to a member of their household being symptomatic. This is captured separately to sickness and is demonstrated below (chart 3). Following a reduction in January, staffing isolating due to contact has increased in February. This is consistent with high community prevalence within our region.

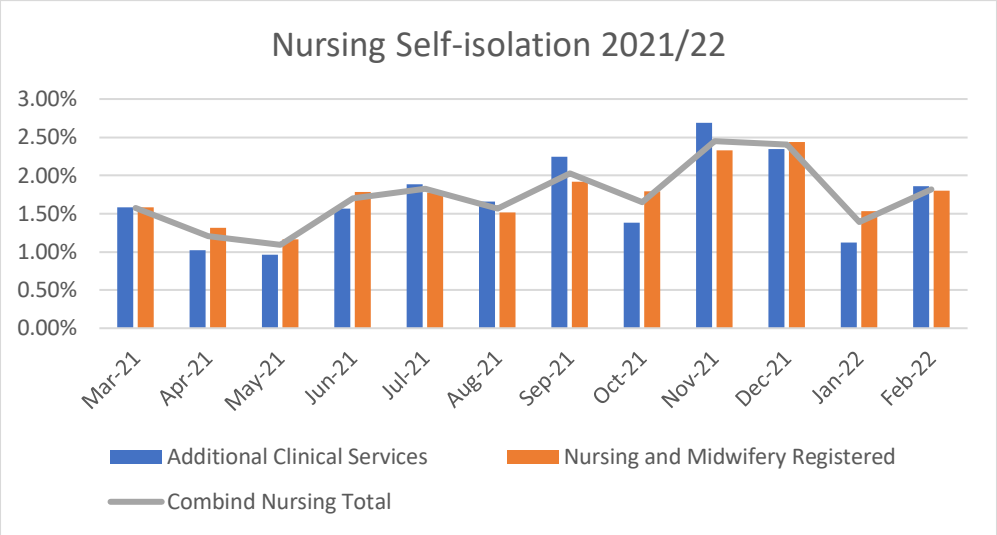


Chart 3

5. Patient Flow and Escalation

Good patient flow is central to patient experience, clinical safety and reducing the pressure on staff. It is also essential to the delivery of national emergency care access standards (NHSI 2017). Ward closures and moves can add additional staffing challenges and opportunities. In recent months ward relocations and structural repair have challenged flow and staffing.

Significant capacity challenges in late December, continued into January and the provision of an additional ward continued through this month. This was staffed through existing staffing numbers creating addition demand within the nursing resource.

This ward was opened on 28th December and closed on the 26th January reducing the additional burden of staffing an additional area.

NHSI released a framework for winter/surge preparation within acute providers. The trust's review and response to this can be found in Appendix 5. There are no significant gaps within the approach already taken by the organisation.

6. Recruitment and Retention

Vacancies: Registered nursing (RN/RM):

- Inpatient RN/RM WTE vacancies is 116. WTE numbers have remained static since last report. Inpatient vacancies have increased marginally due to uplifts within recovery.
- Inpatient RN vacancies is 15%
- Midwifery vacancies is 23%
- Total RN/RM (all areas) has reduced marginally this month to 12.9%
- Nursing assistants and unregistered staff have remained reasonably static with inpatient vacancy at 12.1% and 12.9% for total Trust.

	Inpatient	Sum of Actuals Period 6 (Sept)	Sum of Actuals Period 7 (Oct)	Sum of Actuals Period 8 (Nov)	Sum of Actuals Period 9 (Dec)	Sum of Actuals Period 10 (Jan)	Sum of Actuals Period 11 (Feb)	WTE VACANCY at period 11
RN/RM Substantive	Ward	616.4	611.1	611.7	610.8	611.1	611.3	116.

Nursing Unregistered Substantive	Ward	384.1	382.5	379.9	385.4	378.6	379.1	52.3

Table 4. Ward/Inpatient actual substantive staff with WTE vacancy

The chart below demonstrates the total RN establishment for the inpatient areas (WTE). While we have seen an increase in vacancy rate this financial year due to the increased establishment in many areas, the total number of substantive RNs is not a declining trend (chart 4a).

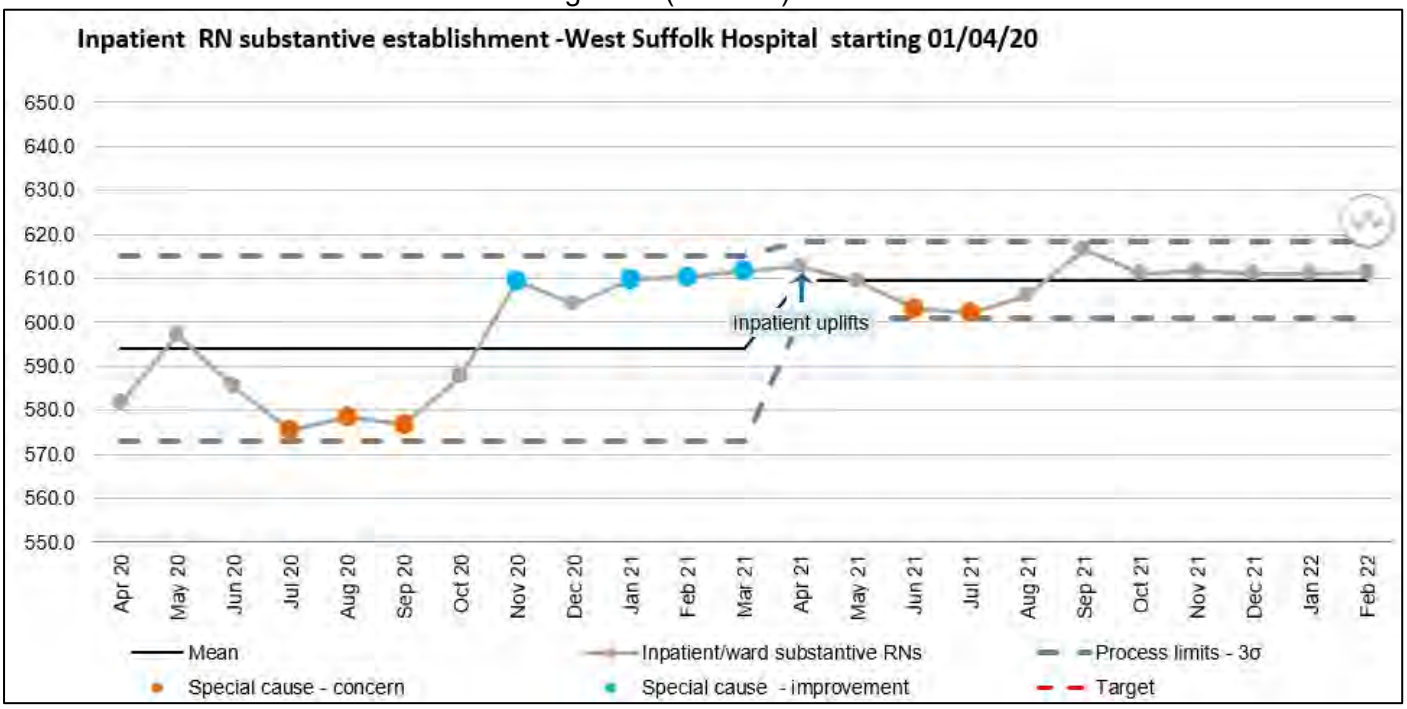


Chart 4a: SPC data adapted from finance ledger

7. New Starters and Turnover

International Nurse Recruitment:

International recruitment (IR) continues and we are on track to deliver our target number by April 2022. Eleven IR Nurses arrived in January and eight arrived in February. The IR team are also supporting the displaced talent program where nurses with refugee status are supported to employment in the UK. The IR team have sourced offsite education rooms to improve the efficiency and experience of the OSCE program, however the recruitment of IR nurses above the intended eight per month is restricted due to challenges with sourcing onsite accommodation

New starters

	September*	October	November	December	January 22	February 22
Registered Nurses	36	14	14	17	15	28
Non-Registered	12	11	11	10	24	18

Table 6: Data from HR and attendance to WSH induction program
*two inductions ran this month

- In Jan 2022 fifteen RNs completed induction; of these; twelve were for acute services, two for pure bank and one midwife joined this cohort
- In Jan 2022, twenty-four NAs completed induction; of these eighteen NAs are for the acute Trust, three for midwifery services and three for bank services

- In February 2022 twenty-eight RNs completed induction; of these; nineteen were for acute services and one for bank services and seven for midwifery
- In February 2022 eighteen NAs completed induction; of these, nine NAs are for the acute Trust, six for bank services and two for community services and two for midwifery

Turnover

On a retrospective review of the last rolling twelve months, turnover for RNs has increased from 9.22% to 10.43, this is now above the trust ambition of <10% and is increasing on month. NA turnover has seen a minimal improvement from 16.79% to 16.72%

Turn Over 01/03/2021 - 28/02/2022								
Staff Group	Average Headcount	Avg FTE	Starters Headcount	Starters FTE	Leavers Headcount	Leavers FTE	LTR Headcount %	LTR FTE %
Nursing and Midwifery Registered	1,288	1,111.68	99	73.61	142	115.99	11.02%	10.43%
Additional Clinical Services	584.00	493.42	197	172.90	95	82.51	16.27%	16.72%

Table 7. (data from workforce)

Over the past year the education team have funded a pastoral care certificate team to provide support to staff new to the organisation and to healthcare. The ambition is to provide 1:1 support and guidance to those new to healthcare and facilitate a smooth transitioning into working in the NHS. In previous years approximately 23% of new Nursing Assistants leave within the first 12 weeks of employment. Since the introduction of these roles, leavers within the first 12 weeks has reduced to 12%. The education team will be presenting this retention initiative to regional teams in near future

8. Quality Indicators

Falls

Falls per 1000 bed days is 6.7 just above the national average (set in 2015) of 6.63. A full list of falls and locations can be found in appendix 3. Falls incidents are reviewed with the falls lead and After-Action Reviews (AAR) are completed as required. Staffing is always reviewed for any contributing factor to any incident.

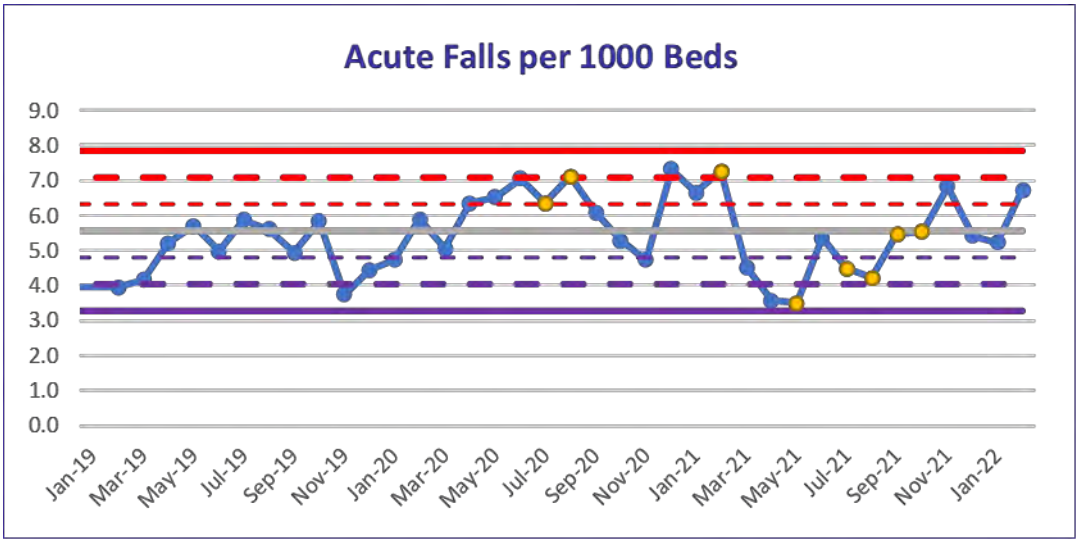


Chart 8

Pressure Ulcers

HAPU numbers remain static at 25 (which is the same as last month) particular spikes have been on medical wards F8, G3 and F3. The team will make attempts to provide some support to these areas and hopefully bring down some of the pressure ulcer incidences, the main area of focus will be on F3, due to a slow increase over a period of time.

Despite staffing challenges within the community support for TVNs, community incidents are on a positive trajectory. The community TVN team post is currently being advertising. Following successful recruitment it is anticipated that this will allow us to move a senior nurse back into the acute and provided more proactive education and support.

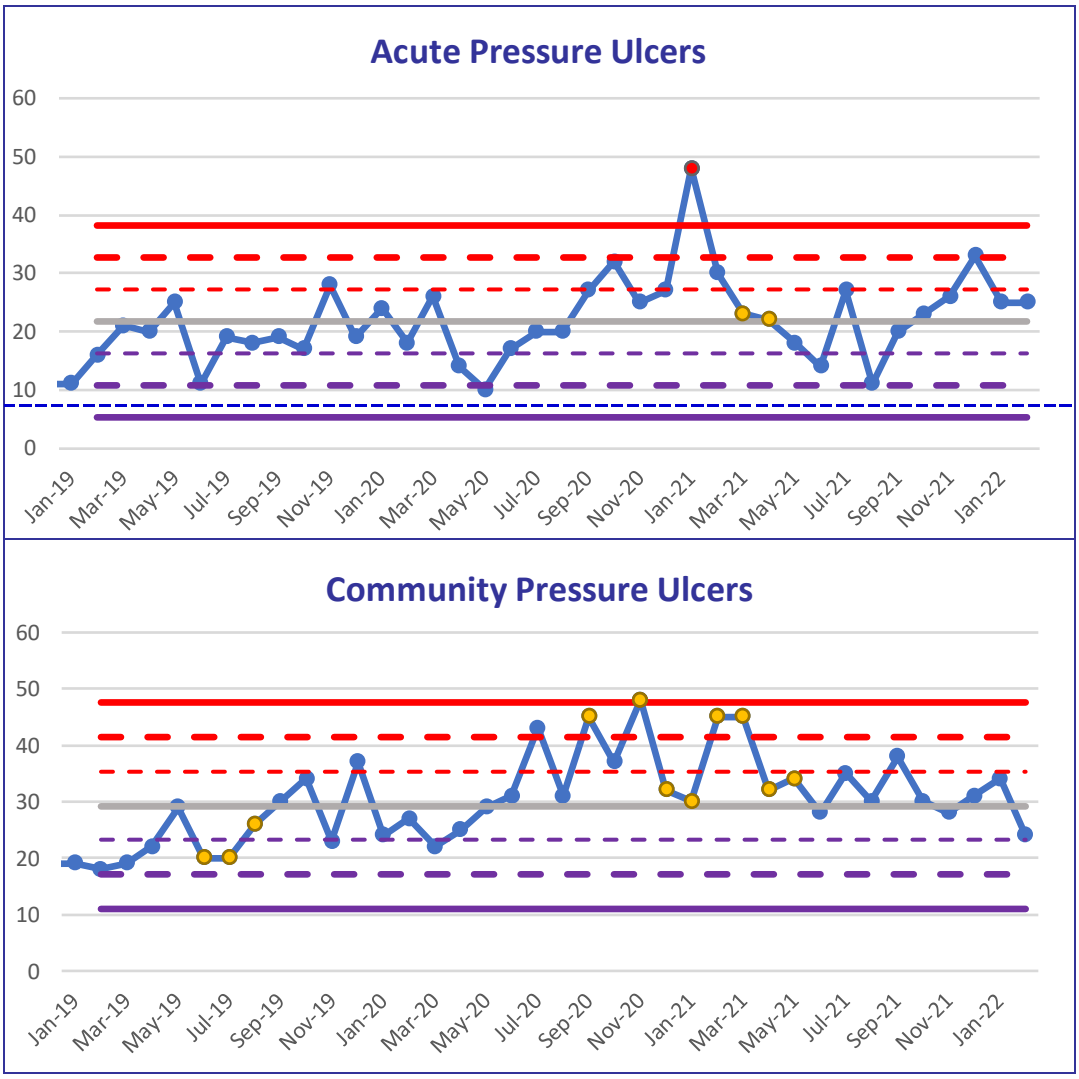


Chart 9a

9. Compliments and Complaints

In January the average number of calls to the clinical helpline was 167 and 140 per day in February. This is driven by reduced visiting since December 2021 following the emergence of the Omicron Covid variant. These visiting restrictions remined in place for January and February

21 formal complaints received in January 2022. 5 complaints were raised in relation to the emergency department. There were no specific themes within these complaints although some complaints mentioned a delay in diagnosis which are still investigating under investigation. 3 complaints related to community paediatric services in relation to access to treatment/services.

19 new complaints were received in February. The highest subject for complaints was clinical treatment, with several relating to delay in treatment, diagnosis or ordering tests. The second most prevalent theme was related to staff values and behaviours, more specifically the attitude of staff. The area that received the highest number of complaints in February was the emergency department.

Table 10. demonstrates the incidence of complaints and compliments for this period.

	Compliments	Complaints
August 2021	17	19
September 2021	30	14
October 2021	15	10
November 2021	18	15
December 2021	22	10
January 2022	22	21
February	19	19

Table 10

10. Adverse Staffing Incidences

Staffing incidences are captured on Datix with recognition of any red flag events that have occurred as per National Quality Board (NQB) definition (Appendix 4). Nursing staff are encouraged to complete a Datix as required so any resulting patient harm can be identified and reviewed.

- In January there were 24 Datixs recorded for nurse staffing that resulted in a Red Flag event (see table 11.). No harm is recorded for these incidents

- In February there were 34 Datixs recorded for inpatient nurse staffing that resulted in a Red Flag event (see table 11). No harm is recorded for these incidents

Red Flag	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	FEB 22
Registered nursing shortfall of more than 8 hours or >25% of planned nursing hours	12	22	19	20	10	5	9
>30-minute delay in providing pain relief	7	3	2	5	4	2	3
Delay or omission of intention rounding	12	7	10	12	12	6	5
<2 RNs on a shift	2	10	6	7	5	4	3
Vital signs not recorded as indicated on care plan	0	5	3	3	1	2	2
Unplanned omissions in providing patient medication	0	2	0	0	1	3	2
Lack of appointments available to book patients onto (local agreed red flag)	0	0	0	0	0	1	0
Delay in routine care (new descriptor)	-	-	-	-	-	-	10
Total	33	49	40	40	33	24	34

Table 11.

11. Maternity Services

A full maternity staffing report will be attached to the maternity paper as per CNST requirements.

The maternity service has experienced increasing challenges this month and this is reflected in the number of red flag events, Midwife to birth ratio and the supernumery status of the labour suite coordinator. This is now recognised as a national staff crisis and the maternity team will be responding to regional and national assurances around staffing mitigation.

	Standard	August	September	October	November	December	January	February
Supernumerary Status of LS Coordinator	100%	82%	85%	93%	100%	99%	99%	99%
1-1 Care in Labour	100%	100%	100%	100%	100%	100%	100%	99.5%
MW: Birth Ratio	1:28	1:30	1:30	1:29.8	1:26	1:23	1:28	1:27
No. Red Flags reported		18	15	22	3	43	46	27

Red Flag events

NICE Safe midwifery staffing for maternity settings 2015 defines Red Flag events as events that are immediate signs that something is wrong and action is needed now to stop the situation getting worse. Action includes escalation to the senior midwife in charge of the service and the response include allocating additional staff to the ward or unit. Appendix 4 illustrates red flag events as described by NICE. Red Flags are captured on Datix and highlighted and mitigated as required at the daily Maternity Safety Huddle;

- There were fifty-two flag events in January. No harm was recorded as in impact of these incidents and the majority are related to Covid absences
- There were twenty-seven red flag events in February. No harm was recorded as in impact of these incidents. nine of these were related to staff absences due to Covid 19 sickness or isolation

Midwife to Birth ratio

Midwife to Birth ratio was 1:28 in January and 1:27 in February, this is the fourth consecutive month where the unit has achieved this best practice metric of <1:28, or Birth-rate Plus recommendation of 1:27.7.
1:1 care in labour dropped to 99.5%. There was a delay in providing 1:1 care for one woman in established labour, this was due to acuity in the Unit and the on-call midwife was called in to provide the support which caused the initial delay.

Supernumerary status of the labour suite co-ordinator

This is a CNST 10 steps to safety requirement and was highlighted as a 'should' from the CQC report in January 2020. The band 7 labour suite co-ordinator should not have direct responsibility of care for any women. This is to enable the co-ordinator to have situational awareness of what is occurring on the unit and is recognised not only as best but safest practice

- In January and February 99% compliance was achieved

12. Community & Integrated services division

12.1 Demand

Demand within the community setting can be illustrated by the number of referrals each service receives. Chart 12a and 12b are examples of the rise in demand for both community nursing and community therapy experienced in the last year. This will have a direct impact on nursing and therapy capacity and the ability to respond to rising demands.

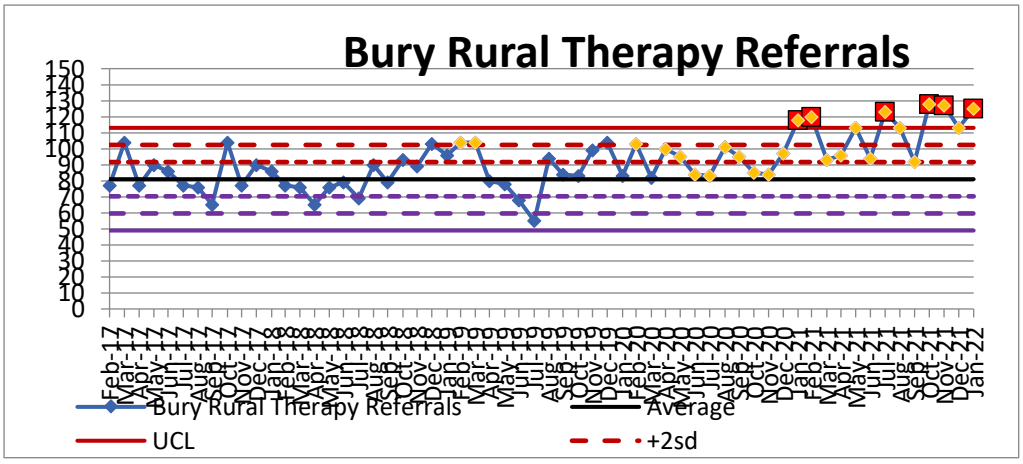


Chart 12a

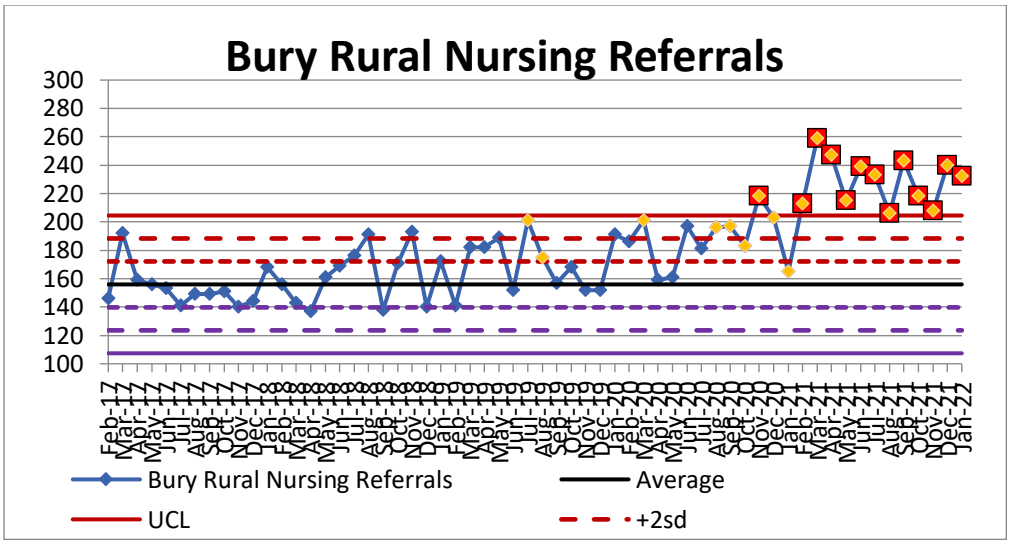


Chart 12b

12.2 Prioritisation of nursing patients

All patients are prioritised using rag rated care plans. This allows the senior team to identify, from the 120-140 number of visits expected to occur that day, which are most urgent and require prioritisation. This allows the team to have flexibility when managing nursing/therapy resource and can defer low urgency visits to the following day. There is currently no automated method to calculate the care hours. Care plan hours are calculated manually, and balanced against WTE staffing levels.

Incident adverse staffing incidents – there have been no missed visits in January or February. There have been 4 Datix reporting staffing difficulties each month. There is an average of 5-8 medication incidents each month, all were green no harm, and investigated with sign off by senior matron.

12.3 Sickness-

Month	Trust	Community
January	6.38%	7.09%
February	5.92%	7.11%

12.4 Vacancies in CHTS

Role	Vacancy percentage
RNs	22 %
Physiotherapists	23%
Occupational therapists	9%
Generic workers /unregistered	11%

As recruitment to qualified posts has been challenging, the community is actively recruiting more unregistered staff to develop a grow your own approach, with emphasis on career progression.

12.5 Additional actions being taken by division

- Piloting Integrated Neighbourhood Coordinator manually extract number of care plans per day & hours of workforce available.
- Follow surge plan & national OPAL policy
- CHTs to work with HealthRoster team to ensure accuracy of reporting, so that staffing fill rates can be accurately reported

13. Recommendations and Further Actions:

- Not the impact of super surge capacity planning on nurse staffing and possible implications for patient care.
- Note the information on the nurse and midwifery staffing and the impact on quality and patient safety
- Note the content of the report and that mitigation is put in place where staffing levels are below planned.
- Note that the content of the report is undertaken following national guidelines using research and evidence-based tools and professional judgement to ensure staffing is linked to patient safety and quality outcomes.

Appendix 1. Fill rates for inpatient areas (January 2022): Data adapted from Unify submission

RAG: Red >79%, Amber 80-89%, Green 90-100%, Purple >100%

	Day				Night				Day		Night		Care Hours Per Patient Day (CHPPD)			
	RNs/RMN		Non registered (Care staff)		RNs/RMN		Non registered (Care staff)									
	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	Average Fill rate RNs/RM %	Average fill rate Care staff %	Average Fill rate RNs/RM %	Average fill rate Care staff %	Cumulative count over the month of patients at 23:59 each	RNS/RMs	Non registered (care staff)	Overall
Rosemary Ward	1020	1277	2084.75	1533.75	1058	952	1391.5	1301	125%	74%	90%	93%	452	4.9	6.3	11.2
Glastonbury Cour	714	680.5	1069.5	1059.5	713	687	542.5	600.5	95%	99%	96%	111%	384	3.6	4.3	7.9
AAU	2125	1676.7833	2480.5	1912.6667	1775.5	1227.5	1420	1524.5	79%	77%	69%	107%	761	3.8	4.5	8.3
Cardiac Centre	2730	2353.75	1286.5	1184.5	1782.5	1472	713	586.5	86%	92%	83%	82%	632	6.1	2.8	8.9
G9	1421	1304.8333	1419.5	1227.5	1426	1080.5	1069.5	1295.5	92%	86%	76%	121%	752	3.2	3.4	6.5
F12	552	655.25	356.5	323	713	452.5	356.5	386	119%	91%	63%	108%	240	4.6	3.0	7.6
F7	1782.5	1374	1739.5	1426	1425.5	1067.083333	1782.5	1395	77%	82%	75%	78%	683	3.6	4.1	7.7
F9	1758.5	1340.5	1766	1108.25	1069.5	849.5	1426	1144.16667	76%	63%	79%	80%	744	2.9	3.0	6.0
G1	1126	943.25	333.25	377.5	701.5	702	347.5	415	84%	113%	100%	119%	485	3.4	1.6	5.0
G3	1713.5	1254.5	1723.5	1300.25	1058	874.5	1069.5	1205	73%	75%	83%	113%	864	2.5	2.9	5.4
G4	1598	1349.75	1798.5	1521.5	1045.5	827.5	1435	1261.16667	84%	85%	79%	88%	896	2.4	3.1	5.5
G8	2499.5	1735.75	1822.5	1472	1782.5	1269.166667	1069.5	1201.98333	69%	81%	71%	112%	615	4.9	4.3	9.2
F8	1416.5	1292.2167	2130.25	1621.6667	1069.5	758.5	1426	1309	91%	76%	71%	92%	723	2.8	4.1	6.9
Critical Care	2814.75	2350.5833	337	302.5	2852	2261.75	0	111	84%	90%	79%	N/A	388	11.9	1.1	13.0
F3	1564	1411.75	2033	1591	1035	943	1426	1299.5	90%	78%	91%	91%	732	3.2	3.9	7.2
F4	948	906.5	652	525.66667	632.5	633	534	507.5	96%	81%	100%	95%	633	2.4	1.6	4.1
F5	1782.5	1431	1427	1218	1069.5	862	1069.5	974.5	80%	85%	81%	91%	698	3.3	3.1	6.4
F6	1970	1621.5	1660.5	1346	1426	1068.5	713	832.5	82%	81%	75%	117%	942	2.9	2.3	5.2
Neonatal Unit	1056	1197.5	180	156	1032	1060	144	108	113%	87%	103%	75%	116	19.5	2.3	21.7
F1	1217.5	1474.5	713	720.75	1069.5	1253.25	0	137.5	121%	101%	117%	100%	115	23.7	7.5	31.2
F14	596	598.5	312	277.5	744	709.5	0	0	100%	89%	95%	N/A	106	12.3	2.6	15.0
F10	1429.5	1193.75	1410	1132	1070	797.5	1409.5	1196.5	84%	80%	75%	85%	707	2.8	3.3	6.1
G5	517.5	460	285.983333	233.16667	506	391.5	195.5	172.5	89%	82%	77%	88%	760	1.1	0.5	1.7
Total	34,352.25	29,883.67	29,021.23	23,570.67	27,056.50	22,199.75	19,540.50	18,964.82	**87%**	**81%**	**82%**	**97%**	**13428**	**3.9**	**3.2**	**7**

Appendix 1. Fill rates for inpatient areas (February 2022): Data adapted from Unify submission

	Day				Night				Day		Night		Care Hours Per Patient Day (CHPPD)			
	RNs/RMN		Non registered (Care staff)		RNs/RMN		Non registered (Care staff)									
	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	Average Fill rate RNs/RM %	Average fill rate Care staff %	Average Fill rate RNs/RM %	Average fill rate Care staff %	Cumulative count over the month of patients at 23:59 each	RNS/RMs	Non registered (care staff)	Overall
Rosemary Ward	996.5	1050.5	1919	1506.25	966	871	1276	1285	105%	78%	90%	101%	452	4.3	6.2	10.4
Glastonbury Cour	647.5	643.5	949.75	894	644	644.5	490	496	99%	94%	100%	101%	384	3.4	3.6	7.0
Acute Assessme	1932	1687	2254	1644.75	1610	1228	1288	1421	87%	73%	76%	110%	761	3.8	4.0	7.9
Cardiac Centre	2588.5	2243.5	1180.83333	1180.3333	1610	1460.5	644	506	87%	100%	91%	79%	632	5.9	2.7	8.5
G10	1279.98333	980.75	1269.48333	1110	966	621	1276.5	1160.5	77%	87%	64%	91%	707	2.3	3.2	5.5
G9	1283	1179.5	1283.5	1037.1667	1287.5	1000	966	1019	92%	81%	78%	105%	752	2.9	2.7	5.6
F12	505	552.5	322	319.25	644	417	322	324	109%	99%	65%	101%	240	4.0	2.7	6.7
F7	1593.5	1267.9167	1610.75	1279.1667	1288	952.0833333	1610	1313.58333	80%	79%	74%	82%	683	3.3	3.8	7.0
G1	1288	880.75	322	309	632.5	632.5	323	293.5	68%	96%	100%	91%	392	3.9	1.5	5.4
G3	1553	1255.5	1575.5	1376.9167	943	909	966	1336.5	81%	87%	96%	138%	864	2.5	3.1	5.6
G4	1607.5	1342.75	1652.25	1418	966	736	1267	1328	84%	86%	76%	105%	896	2.3	3.1	5.4
G5	1610	1316.5	1616.25	1494.25	966	842.5	1288	1329	82%	92%	87%	103%	760	2.8	3.7	6.6
G8	2249.25	1391.9	1620.25	1205.75	1610	1089.333333	966	885.5	62%	74%	68%	N/A	615	4.0	3.4	7.4
F8	1288	1260.5	1924	1443.75	954.5	714	1287.933333	1230.75	98%	75%	75%	96%	723	2.7	3.7	6.4
Critical Care	2576	2134.5	308	287	2571	2197	0	219.5	83%	93%	85%	*	388	11.2	1.3	12.5
F3	1610	1313	1932	1378.5	966	907.5	1287	1218.5	82%	71%	94%	95%	732	3.0	3.5	6.6
F4	874	744	874	474.5	643.5	621	550	377.5	85%	54%	97%	69%	633	2.2	1.3	3.5
F5	1610	1215	1284	1056.5	966	885.5	966	828.5	75%	82%	92%	86%	698	3.0	2.7	5.7
F6	1820.5	1484.25	1480	1074.5	1278	951	632	747.5	82%	73%	74%	118%	939	2.6	1.9	4.5
Neonatal Unit	984	1121	132	144	840	843	156	168	114%	109%	100%	108%	116	16.9	2.7	19.6
F1	1085.25	1152.5	641.75	593	960.25	1080.25	0	115	106%	92%	112%	*	115	19.4	6.2	25.6
F14	704	707.5	252	264	669	658.5	0	24	100%	105%	98%	*	106	12.9	2.7	15.6
Total	31,685.48	26,924.82	26,403.32	21,490.58	23,981.25	20,261.17	17,561.43	17,626.83	**85%**	**81%**	**84%**	**100%**	**12588**	**3.5**	**2.9**	**6.5**

Appendix 2. Ward by ward vacancies (Jan 2022): Data adapted from finance report

Ward/Department	Register Nurses/Midwives				Ward/Department	NA/MCA				Combined RN/NA
	Actual establishmet	Budgetted establishment	Vacancy rate (WTE)	Vacancy percentage %		Actual Establishment	Budgeted Establishment	Vacancy rate (WTE)	Percentage Vacancy %	Total Vacancy %
AAU	23.2	30.1	6.9	23.0	AAU	21.5	28.3	6.9	24.2	23.6
Accident & Emergency	63.5	77.3	13.7	17.8	Accident & Emergency	36.2	34.5	-1.8	-5.2	10.7
Cardiac Centre	37.1	40.7	3.6	8.9	Cardiac Centre	16.5	15.7	-0.8	-5.1	5.0
Glastonbury Court	11.3	11.7	0.4	3.2	Glastonbury Court	12.8	12.6	-0.1	-0.9	1.0
Critical Care Services*	42.2	50.0	7.9	15.7	Critical Care Services	2.4	1.9	-0.6	-29.8	14.1
Day Surgery Wards	13.0	11.0	-2.0	-18.6	Day Surgery Wards	3.4	3.9	0.5	13.0	-10.4
Gynae Ward (On F14)	13.1	14.1	0.9	6.8	Gynae Ward (On F14)	3.0	2.0	-1.0	-50.0	-0.3
Neonatal Unit	19.5	20.6	1.1	5.1	Neonatal Unit	3.9	4.3	0.4	10.0	6.0
Rosemary ward	13.9	18.6	4.7	25.3	Rosemary ward	21.5	25.8	4.3	16.5	20.2
Recovery Unit	24.2	25.4	1.2	4.8	Recovery Unit	0.9	0.9	0.0	1.2	4.7
Ward F1 Paediatrics	19.9	22.1	2.2	10.1	Ward F1 Paediatrics	7.2	6.7	-0.5	-6.7	6.2
Ward F12	9.7	11.9	2.3	19.0	Ward F12	4.5	5.9	1.4	23.9	20.6
Ward F3	23.7	22.2	-1.5	-6.8	Ward F3	21.4	25.8	4.4	17.1	6.1
Ward F4	13.8	13.6	-0.2	-1.4	Ward F4	8.6	14.6	6.0	41.1	20.6
Ward F5	18.4	22.2	3.8	17.2	Ward F5	13.2	18.1	4.9	26.9	21.6
Ward F6	19.6	26.6	7.0	26.2	Ward F6	16.9	17.4	0.4	2.5	16.8
Ward F7 Short Stay	21.5	24.9	3.4	13.8	Ward F7 Short Stay	20.1	25.8	5.6	21.8	17.9
Ward F9 (now G5)	19.8	21.8	2.0	9.3	Ward F9	21.7	23.2	1.5	6.4	7.8
Ward G1 Hardwick Unit	27.3	30.6	3.3	10.7	Ward G1 Hardwick Unit	9.7	10.5	0.9	8.3	10.1
Ward G3	18.9	22.1	3.2	14.3	Ward G3	21.7	23.0	1.3	5.4	9.8
Ward G4	20.9	22.1	1.2	5.6	Ward G4	19.1	22.8	3.7	16.0	10.9
Ward G8	18.1	32.7	14.6	44.6	Ward G8	19.1	20.6	1.6	7.6	30.2
Renal Ward - F8	18.0	19.5	1.5	7.8	Renal Ward - F8	19.7	25.8	6.0	23.4	16.7
Ward F10	14.0	19.0	5.0	26.3	Ward F10	19.2	23.2	4.0	17.2	21.3
Respiratory Ward - G9	17.7	23.7	6.0	25.3	Respiratory Ward - G9	18.1	18.0	-0.1	-0.4	14.2
Total	542.1	634.3	92.2	14.5	Total	362.2	411.1	48.9	11.9	13.5
Hospital Midwifery	48.8	58.9	10.1	17.2	Hospital Midwifery	15.2	15.6	0.4	2.4	14.1
Continuity of Carer Midwifery*	18.4	31.0	12.6	40.6	Continuity of Carer Midwifery	0.0	0.0	0.0	0.0	40.6
Community Midwifery	17.5	19.1	1.6	8.5	Community Midwifery	3.8	3.8	0.0	-0.5	0.0
Total	84.7	109.0	24.4	22.3	Total	19.0	19.4	0.4	1.9	19.2

Appendix 2. Ward by ward vacancies (Feb 2022): Data adapted from finance report

Ward/Department	Register Nurses/Midwives				Ward/Department	NA/MCA				Combined RN/NA
	Actual establishmet	Budgetted establishment	Vacancy rate (WTE)	Vacancy percentage %		Actual Establishment	Budgeted Establishment	Vacancy rate (WTE)	Percentage Vacancy %	Total Vacancy %
AAU	21.6	30.1	8.6	28.4	AAU	22.2	28.3	6.2	21.8	25.2
Accident & Emergency	66.9	77.3	10.4	13.4	Accident & Emergency	32.4	34.5	2.1	6.1	11.2
Cardiac Centre	37.6	40.7	3.1	7.6	Cardiac Centre	15.6	15.7	0.2	1.0	5.7
Glastonbury Court	10.8	11.7	0.9	7.5	Glastonbury Court	12.7	12.6	-0.1	-0.4	3.4
Critical Care Services*	42.9	50.0	7.1	14.3	Critical Care Services	2.8	1.9	-0.9	-48.9	12.0
Day Surgery Wards	12.4	11.0	-1.4	-12.5	Day Surgery Wards	3.9	3.9	0.0	0.0	-9.2
Gynae Ward (On F14)	13.1	14.1	0.9	6.8	Gynae Ward (On F14)	3.0	2.0	-1.0	-50.0	-0.3
Neonatal Unit	19.2	20.6	1.4	6.6	Neonatal Unit	3.8	4.3	0.5	12.1	7.6
Rosemary ward	15.9	18.6	2.7	14.4	Rosemary ward	24.0	25.8	1.8	7.0	10.1
Recovery Unit*	23.2	27.3	4.1	15.2	Recovery Unit	0.9	0.9	0.0	1.2	14.7
Ward F1 Paediatrics	20.8	22.1	1.4	6.2	Ward F1 Paediatrics	7.2	6.7	-0.5	-7.4	3.0
Ward F12	8.6	11.9	3.3	27.8	Ward F12	6.5	5.9	-0.6	-10.3	15.3
Ward F3	22.7	22.2	-0.5	-2.3	Ward F3	21.5	25.8	4.3	16.7	7.9
Ward F4	12.0	13.6	1.6	12.0	Ward F4	9.5	14.6	5.1	34.8	23.8
Ward F5	20.3	22.2	1.9	8.4	Ward F5	14.0	18.1	4.1	22.7	14.8
Ward F6	21.4	26.6	5.1	19.3	Ward F6	16.0	17.4	1.4	8.0	14.8
Ward F7 Short Stay	21.2	24.9	3.8	15.1	Ward F7 Short Stay	23.1	25.8	2.7	10.4	12.7
Ward F9 (now G5)	18.8	21.8	3.0	13.6	Ward G5 (Was F9)	19.8	23.2	3.4	14.6	14.1
Ward G1 Hardwick Unit	26.6	30.6	4.0	13.1	Ward G1 Hardwick Unit	8.4	10.5	2.2	20.4	14.9
Ward G3	17.7	22.1	4.4	20.0	Ward G3	27.0	23.0	-4.0	-17.3	1.0
Ward G4	19.1	22.1	3.0	13.4	Ward G4	18.0	22.8	4.8	20.9	17.2
Ward G8	18.4	32.7	14.3	43.7	Ward G8	17.3	20.6	3.3	16.1	33.0
Renal Ward - F8	18.9	19.5	0.6	3.0	Renal Ward - F8	20.5	25.8	5.3	20.4	12.9
Ward G10 (was F10)	13.4	19.0	5.6	29.5	Ward G10 (was F10)	16.2	23.2	7.0	30.2	29.9
Respiratory Ward - G9	17.5	23.7	6.2	26.1	Respiratory Ward - G9	18.1	18.0	-0.1	-0.4	14.6
Total	540.8	636.2	95.3	15.0	Total	364.1	411.1	47.1	11.4	13.6
Hospital Midwifery	50.8	58.9	8.1	13.8	Hospital Midwifery	14.8	15.6	0.8	5.0	11.9
Continuity of Carer Midwifery	16.5	31.0	14.5	46.8	Continuity of Carer Midwifery	0.0	0.0	0.0	0.0	46.8
Community Midwifery	16.7	19.1	2.4	12.7	Community Midwifery	5.3	3.8	-1.5	-40.2	0.0
Total	84.0	109.0	25.0	23.0	Total	20.1	19.4	-0.7	-3.8	18.9

*areas that have received an establishment uplift this month CCS (7wte) and Continuity of Carer (12.7wte)

Appendix 3:

Ward by Ward breakdown of Falls and Pressure ulcers November and December 2021

HAPU

Jan-22	Cat 2	Unstageable	Total
Critical Care Unit	1	0	1
F3 - ward	1	0	1
F5 - ward	1	0	1
F6 - ward	1	0	1
F9 escalation / surge ward	1	0	1
G3 - Endocrine and General Medicine	2	0	2
G4 - ward	2	0	2
G8 - Stroke Ward	2	0	2
Gastroenterology Ward	3	0	3
Renal Ward	4	0	4
F7	3	1	4
Early Intervention Team	4	0	4
Total	25	1	26

Feb-22	Cat 2	Cat 3	Unstageable	Cat 4	Total
F12 Isolation Ward	1	0	0	0	1
F4 - ward	1	0	0	0	1
G8 - Stroke Ward	0	0	1	0	1
F6 - ward	1	0	0	0	1
G1 - ward	2	0	0	0	2
Respiratory Ward	2	0	0	0	2
F3 - ward	3	0	0	0	3
Gastroenterology Ward	2	0	0	1	3
F7	2	1	0	0	3
G3 - Endocrine and General Medicine	2	1	1	0	4
Renal Ward	4	0	0	0	4
Total	20	2	2	1	25

Falls

Jan 22	None	Negligible	Minor	Moderate	Total
Cardiac Centre - Diagnostics	0	0	1	0	1
Critical Care Unit	1	0	0	0	1
Day Surgery Unit - Ward / Adjacent Area	1	0	0	0	1
F12 Isolation Ward	1	0	0	0	1
F3 - ward	1	0	0	0	1
F4 - ward	1	0	0	0	1
F6 - ward	0	1	0	0	1
G1 - ward	0	0	1	0	1
Glastonbury Court	0	0	1	0	1
Macmillan Unit	1	0	0	0	1
Physiotherapy Department	1	0	0	0	1
CHT Sudbury	2	0	0	0	2
Renal Ward	1	0	1	0	2
Respiratory Ward	2	0	0	0	2
Emergency Department	0	0	2	0	2
Cardiac Centre - Ward	2	1	0	0	3
F9 escalation / surge ward	2	0	1	0	3
Gastroenterology Ward	3	0	0	0	3
Winter Escalation (Rosemary)	0	0	3	0	3
G4 - ward	4	0	0	0	4
Acute Assessment unit (AAU)	1	0	3	0	4
G3 - Endocrine and General Medicine	5	0	2	0	7
F7	6	0	1	0	7
G8 - Stroke Ward	7	0	0	1	8
G10	11	2	2	0	15
Total	53	4	18	1	76

February 2022	None	Negligible	Minor	Total
F12 Isolation Ward	1	0	0	1
F4 - ward	0	0	1	1
Ultrasound Department	1	0	0	1
F1 - Ward	1	0	0	1
F5 - ward	1	0	0	1
G1 - ward	2	0	0	2
Renal Ward	2	0	0	2
Emergency Department	2	0	0	2
F3 - ward	3	0	0	3
G10	2	0	1	3
Gastroenterology Ward	2	1	0	3
Glastonbury Court	0	0	3	3
Cardiac Centre - Ward	3	1	0	4
Respiratory Ward	3	1	0	4
G8 - Stroke Ward	5	0	0	5
G3 - Endocrine and General Medicine	2	1	3	6
Acute Assessment unit (AAU)	5	0	1	6
F6 - ward	3	2	2	7
F7	5	0	4	9

G4 - ward	11	0	2	13
Winter Escalation (Rosemary)	10	1	2	13
Total	64	7	19	90

Appendix 4: Red Flag Events

Maternity Services

Missed medication during an admission
Delay of more than 30 minutes in providing pain relief
Delay of 30 minutes or more between presentation and triage
Delay of 60 minutes or more between delivery and commencing suturing
Full clinical examination not carried out when presenting in labour
Delay of two hours or more between admission for IOL and commencing the IOL process
Delayed recognition/ action of abnormal observations as per MEOWS
1:1 care in established labour not provided to a woman

Acute Inpatient Services

Unplanned omission in providing patient medications.
Delay of more than 30 minutes in providing pain relief
Patient vital signs not assessed or recorded as outlined in the care plan.
Delay or omission of regular checks on patients to ensure that their fundamental care needs are met as outlined in the care plan. Carrying out these checks is often referred to as 'intentional rounding' and covers aspects of care such as: • pain: asking patients to describe their level of pain level using the local pain assessment tool • personal needs: such as scheduling patient visits to the toilet or bathroom to avoid risk of falls and providing hydration • placement: making sure that the items a patient needs are within easy reach • positioning: making sure that the patient is comfortable and the risk of pressure ulcers is assessed and minimised.
A shortfall of more than eight hours or 25% (whichever is reached first) of registered nurse time available compared with the actual requirement for the shift
Fewer than two registered nurses present on a ward during any shift.

Appendix 5:

Winter Preparedness 2021/22: Nursing and Midwifery safer staffing					
Ref	**Details**	**Controls**	**Assurances**	**Risk register reference if appropriate**	**Further action needed**
1: Staffing Escalation / Surge and Super Surge Plans					
1.1	**Staffing Escalation plans have been defined to support surge and super surge plans which includes triggers for escalation through the surge levels and the corresponding deployment approaches for staff. Plans are detailed enough to evidence delivery of additional training and competency assessment, and expectations where staffing levels are contrary to required ratios (i.e intensive care) or as per the NQB safe staffing guidance**	**PP (21) 342:Staffing Escalation for Nursing - Inpatient areas and Community Health Teams**	**Policy in place**	**ID 4724**	**Nil**
1.2	**Staffing escalation plans have been reviewed and refreshed with learning incorporated into revised version in preparation for winter.**	**PP (21) 342**	**Staffing escalation plans reviewed and updated September 2021**	**ID 4724**	**Nil**
1.3	**Staffing escalation plans have been widely consulted and agreed with trust' staff side committee**	**PP (21) 342**	**Most recent update was shared with and contributed to from staff side leads.**	**ID 4724**	**Nil**

1.4	Quality impact assessments are undertaken where there are changes in estate or ward function or staff roles (including base staffing levels) and this is signed off by the CN/MD	If additional areas open, these are risk assessed, Datixs and mitigation actions logged. QIA not routinely used Formal changes to establishments managed through bi-annual inpatient establishment review, with DCN sign off	Most recent opening of escalation area F9 (since closed). Documented and raised through Datix with embedded assurances and actions closed	ID 5174	Formal QIAs to be completed for further. Changes to ward demographic and or patent locations
2.0 Operational delivery					
2.1	There are clear processes for review and escalation of an immediate shortfall on a shift basis including a documented risk assessment which includes a potential quality impact. Local leadership is engaged and where possible mitigates the risk. Staffing challenges are reported at least twice daily via Bronze.	PP (21) 342 Section 2.4	RAG rating assessed using SafeCare module. Triangulated and professional judgement applied by senior nursing team. Oversight of SafeCare data and risk assessments presented to deputy Chief Nurse at 09:30 safety huddle and 15:30	ID 4724	Nil
2.2	Daily and weekly forecast position is risk assessed and mitigated where possible via silver / gold discussions. Activation of staffing deployment plans are clearly documented in the incident logs and assurance is gained that this is successful and that safe care is sustained.	PP (21) 343	Weekly forward look report, generated by health roster teams every Friday to plan for weekend staffing and the week ahead	ID 4724	Nil
2.3	The Nurse in charge who is handing over patients are clear in their responsibilities to check that the member of staff receiving the patient is capable of meeting their individual care needs	CG10284-2 Admission and transfer of a patient	Nurse in charge competencies reviewed daily in SafeCare review		Policy is past review data and requires an update

2.4	Staff receiving the patient (s) are clear in their responsibilities to raise concerns they do not have the skills to adequately care for the patients being handed over.	CG10284-2 Admission and transfer of a patient	Matron of Day bleep holder receives escalations of wards struggling to manage with workload or skill mix		Policy is past review data and requires an update
2.5	There is a clear induction policy for agency staff. There is documented evidence that agency staff have received a suitable and sufficient local induction to the area and patients that they will be supporting	Document Ref. No: PP (19) 333 TEMPORARY STAFF ENGAGEMENT			Audit of agency nurse induction to be completed to understand compliance with expectation
2.6	The trust has clear and effective mechanisms for reporting staffing concerns or where the patient needs are outside of an individual's scope of practice. The trust can evidence that the mechanisms for raising concerns about staffing levels or scope of practice is used by staff and leaders have acted to address these risks to minimise the impact on patient care.	Document Ref No: PP (21)056 FREEDOM TO SPEAK UP - WHISTLEBLOWING - STAFF CONCERNS ABOUT PATIENT CARE AND OTHER HEALTHCARE RELATED MATTERS	F2SPU guardians are regular attenders to NMCC meeting to share themes and incidents of referral to the team. Guardians have direct link with Deputy Chief Nurse to escalate concerns that require response		Nil
2.7	The trust can evidence that the mechanisms for raising concerns about staffing levels or scope of practice is used by staff and leaders have acted to address these risks to minimise the impact on patient care.	https://www.wsh.nhs.uk/covid-staff-zone/Your-wellbeing/Your-wellbeing.aspx	Datix also supports completion of incidents and Red Flags described as per NQB expectations. Reported monthly to Board		Nil
2.8	The trust can evidence that there are robust mechanisms in place to support staff physical and mental wellbeing. The trust is assured that these mechanisms meet staff needs and are having a positive	https://www.wsh.nhs.uk/covid-staff-zone/Your-wellbeing/Your-wellbeing.aspx	Staff wellbeing hub within intranet. Clearly signposted and visible on internal website. Signposting to Staff psychological support, physical wellbeing		Nil

	impact on the workforce and therefore on patient care.				
2.9	The trust has robust mechanisms for understanding the current staffing levels and its potential impact on patient care. These mechanisms consider both those staff who are absent from clinical duties due to required self-Isolation, shielding, and those that are off sick. Leaders and board members therefore have a holistic understanding of those staff not able to work clinically not just pure sickness absence.	Monthly 'safe staffing report' presented to board and available on public website	Absence data is inclusive of staff isolation		Nil
2.10	Staff are encouraged to report incidents in line with the normal trust processes. Due to staffing pressures, the trust considers novel mechanisms outside of incident reporting for capturing potential physical or psychological harm caused by staffing pressures (e.g. use of arrest or peri arrest debriefs, use of outreach team feedback etc) and learns from this intelligence.	Document Ref. No: PP (22)105 Incident Reporting and Management Policy Document ref. no: PP (22)105b Incident Reporting and Management Procedure	Emerging Incident Response meetings have adopted PSIRF framework and explore and staff support required following incidences. Debrief of arrest and peri arrests lead by outreach team as required		Nil
3.0 Daily Governance via EPBR route (when /if applied					

3.1	Where necessary the trust has convened a multidisciplinary clinical and or workforce /wellbeing advisory group that informs the tactical and strategic staffing decisions via Silver and Bronze to provider the safest and sustained care to patients and its decision making is clearly documented in incident logs or notes of meetings.	Trust convened a staff wellbeing working group that has since been disbanded.			No further action required
3.2	Immediate, and forecast staffing challenges are discussed and documented at least daily via the internal incident structures (bronze, silver, gold).	Staffing reviewed at daily bed meeting and reported to tactical (silver) command. Review at 09:15, 12:15, 15:15, 17:00, 22:00	Forecast planning covering weekends and extended weekends. Supported by information flows from internal bank team		No further action required
3.3	The trust ensures system workforce leads and executive leads within the system are sighted on workforce issues and risks as necessary. The trust utilises local/ system reliance forums and regional EPRR escalation routes to raise and resolve staffing challenges to ensure safe care provided to patients.	Work force leads and DCN are members of the system workforce groups and are able to escalate concerns as needed.	Regular attendance to ICS workforce committee by either director or workforce/Deputy or DCN		No further action required
3.4	The trust has sufficiently granular, timely and reliable staffing data to identify and where possibly mitigate staffing risks to prevent harm to patients.	SafeCare tool is used to assess real time staffing data Twice daily review of SafeCare model that provides Realtime, risk assessments of clinical areas to identify staffing risk. Actions and mitigations captured in MOD log book	PP (21) 342. Section 2.3		No further action required
4.0 Board Oversight and Assurance (BAU Structures)					

4.1	The quality committee (or other relevant designated board committee) receives regular staffing report that evidences the current staffing hotspots, the potential impact on patient care and the short- and medium-term solutions to mitigate the risks.	Monthly 'safe staffing report' presented to board and available on public website	Staffing related incidents are captured and reported via the learning/ patient safety reports to board. Safer staffing report captures all NQIs and red flags		Nil
4.2	Information from the staffing report is considered and triangulated alongside the trusts' SI reports, patient outcomes, patient feedback and clinical harms process.	Nurse sensitive indicators, incidents and patient feedback are used within the paper to triangulate impact on patient care	Divisional governance meetings, EIR and safer staffing paper		Nil
4.3	The trusts integrated Performance dashboard has been updated to include COVID/winter focused metrics. COVID/winter related staffing challenges are assessed and reported for their impact on the quality of care alongside staff wellbeing and operational challenges.	Incorporated in the IQPR and learning reports	Monthly IQPR, safer staffing paper, IPC BAF report and patient safety and quality reports		Nil
4.4	The Board (via reports to the quality committee) is sighted on the key staffing issues that are being discussed and actively managed via the incident management structures and are assured that high quality care is at the centre of decision making.	strategic oversight meetings, safer staffing report, daily staffing review and update to CN,			Nil
4.5	The quality committee is assured that the decision making via the Incident management structures (bronze, silver, gold) minimises any potential exposure of patients	Senior oversight and reporting via the internal incident process			Nil

	to harm than may occur delivering care through staffing in extremis.				
4.6	The quality committee receives regular information on the system wide solutions in place to mitigate risks to patients due to staffing challenges.	Direct reporting to board for system wide solutions including overseas nursing program, student recruitment, RTP nursing and Nursing support roles Finance and Workforce governance group (reporting to Insight subcommittee)	Staffing returns and reports.		Nil
4.7	The Board is fully sighted on the workforce challenges and any potential impact on patient care via the reports from the quality committee. The Board is further assured that active operational risks are recorded and managed via the trusts risk register process.	Monthly 'safe staffing report' presented to board and available on public website	Staffing issues on risk register and updated as part of BAF		A predictive forward-looking recruitment pipeline is being created to further highlight workforce challenges and/or improvements
4.8	The trust has considered and where necessary, revised its appetite to both workforce and quality risks given the sustained pressures and novel risks caused by the pandemic The risk appetite is embedded and is lived by local leaders and the Board (i.e. risks outside of the desired appetite are not tolerated without clear discussion and rationale and are challenged if longstanding)	Surge staffing plans, presented to Board and Exec team for short term escalation including, reduction in planned staffing levels given the predicted modelling of Covid and impact on staffing absences	Presented to Board January 2022		Nil

4.9	The trust considers the impact of any significant and sustained staffing challenges on their ability to deliver on the strategic objectives and these risks are adequately documented on the Board Assurance Framework	Reviewed at strategic meetings and managed through core resilience team meetings	Strategic Priorities have been reviewed by strategic team, Jan 22. And is documented in action logs		Update of BAF to record these decisions and assumptions
4.10	Any active significant workforce risks on the Board Assurance Framework inform the board agenda and focus	Staffing risk on Trust Risk register ID 4724	Reived every 6 weeks. By DCN	ID 4724	Nil
4.11	The Board is assured that where necessary CQC and Regional NHSE/I team are made aware of any fundamental concerns arising from significant and sustained staffing challenges	Staffing challenges discussed and escalated at regional level through engagement with ICS leads. Regular meeting with CQC engagement officer where staffing issues have been raised	CQC meeting minutes		Nil

Trust Open Board – 25 March 2022

Report Title:	Annexe 3 - Quality & learning report
Executive Lead:	Sue Wilkinson – Executive Chief Nurse
Report Prepared by:	Rebecca Gibson – Head of Compliance & Effectiveness
Previously Considered by:	N/A

For Approval	For Assurance	For Discussion	For Information
☐	☐	☐	☒

Executive summary
This report provides a summary of key learning points, trend analysis and opportunities for improvement that have arisen from activities in the period since the last report. It includes the following sections.
1: Learning from incidents 1.1 Reports approved since last meeting **2: Quality & Safety dashboard** **3: National patient safety updates** (*one or more from: PSIRF, patient safety syllabus, 'learning from patient safety events' incident reporting system, patient safety specialists workplan, patient safety partners. Further information on all of these subjects can be found on NHS England's patient safety webpage https://www.england.nhs.uk/patient-safety/)* 3.1 PSIRF 3.2 Patient safety specialists workplan **4: Learning from other sources:** *(one or more from: LfD, staff, external, claims, patient & public)* 4.1 Learning from deaths 4.2 Patient and public feedback **5: Other safety and quality activity** *(one or more from: HSIB and other national best practice reports, clinical audit and QI, external quality assurance visits, 'Greatix' and a focus on one (or more) subject(s) within the PSIRP).* 5.1 National best practice reader panel Appendix 1 - List of PSIRP subjects and investigation pathways
Action Required of the Board
Receive for information

1. Learning themes from incident investigations

1.1 Reports approved since last meeting

Since the last Board report there have been five reports (no PSIIs) approved at panel:

• WSH-IR-77878 – Fall resulting in fracture (AAR completed) • WSH-IR-73303 – Pressure Ulcer category 4 - deteriorated in our care (AAR completed) • WSH-IR-78864 – Right distal ureteric injury identified in postnatal period (PSR completed) • WSH-IR-71174 – Care of a learning disability patient (PSR completed) • WSH-IR-68078 – Delay in diagnosis of fractured neck of femur (PSR completed)
AAR - After Action Review, PSR - Patient safety review

The approval process is undertaken by a panel which asks three questions:

- Has there been opportunity for patient / family input into the review (wherever possible this should be **during** not **after** the report is drafted) and is the final version written in such a way as to be supportive and respectful as well as informative and understandable?
- Do the recommendations reflect the findings? It should be possible to see how one leads to the other.
- Are the actions and/or recommendations clearly 'owned' by a relevant group (maybe a specialist committee or a local department/team).

Safety recommendations will be aggregated with other investigations and linked with appropriate improvement work/projects. The Action Oversight Group will be responsible for overseeing the follow-up of all the safety recommendations, either as standalone or via the specialist groups reporting frameworks in the new 3i committee structure.

2. Quality & Safety dashboard

(*being developed – this will include key KPIs and quality measures in future*)

This development work is being reported into and overseen by SLT. There are series of task & finish groups taking place during March (chaired / led by Nick Macdonald / Nicola Yates) to establish the following:

- Context
- Terms of reference
- Process to identify requirements – 'stakeholders' / metrics / headings / alignment to Trust strategy and values / CQC alignment / etc.
- Governance structure / Accountability framework / Performance reporting framework

3. National patient safety updates

3.1 PSIRF

Year two PSIRP is under development. **Insight** has been gathered from the quarterly incident analysis of 2021/22 (Q1-Q3 completed to date), learning from death reviews (SJRs), thematic review of complaints and PALS contacts, claims and inquests. This was corroborated with the output of three TEAMs workshops which invited a range of representatives from across the divisions to attend and discuss what are the key risks relevant to their areas of work or trust wide (**Involvement**).

Local CCG and NHS England links have also been invited to comment and the draft list of subjects for PSII was presented to the senior leadership team on the 21st March.

The formal sign-off for our PSIRP will be undertaken within March with the aim to start from 1st April 2022. (See Appendix 1 for the list of PSIRP subjects and investigation pathways).

The year one PSIRP outturn report and areas of **Improvement** both planned and already underway will be provided to the May Board meeting and shared with all our staff. It is envisaged that our quality priorities will link with patient safety improvement plans as well as the CQUIN programme and all will be linked to the trust strategy.

3.2 Patient safety specialists workplan

In July 2019 the NHS issued its national Patient Safety Strategy: Safer culture, safer systems, safer patients. https://www.england.nhs.uk/patient-safety/the-nhs-patient-safety-strategy . As part of this strategy NHS England required each trust / CCG to identify one or more individuals as their patient safety specialist(s). More details can be found here: https://www.england.nhs.uk/wp-content/uploads/2020/08/identifying-patient-safety-specialists-v2.pdf.

Our WSFT Patient safety specialists are: Lucy Winstanley – Head of Patient Safety & Quality, Megan Pontin / Olive Freeman – Patient safety incident investigators and soon to be joined by Dr Patricia Mills – AMD Patient Safety

There are nine areas that the Patient Safety Specialists have been asked to prioritise the local implementation of. Two of these (PSIRF and COVID recovery) are not included in this update. The other seven will report on progress to the Improvement committee on a quarterly basis.

1. **Just culture** Local systems to set out how they will embed principles of a safety culture on an ongoing basis include monitoring and response to NHS staff survey results and other safety culture assessments, and adoption of the NHS England and NHS Improvement 'A Just Culture Guide' or equivalent.
2. **National Patient Safety Alerts (NatPSAs) Central Alerting System**: NHS organisations to support the introduction of the new alerts by identification and appropriate escalation routes to ensure organisation-wide coordination and senior oversight.
3. **Improving quality of patient safety incident reporting** Using organisation's NRLS explorer reports to help improve incident capture locally and most effectively described to the board and supporting patient safety leads to ensure free text information provided in local incident reports is sufficient to enable national learning.
4. **Support transition from NRLS and STEIS to LfPSE** (Learning from patient safety events) Local systems (i.e. Datix) to connect to the new system subject to local software compatibility.
5. **Implement the Framework for Involving Patients in Patient Safety** Local systems and regions aim to include two PSPs on their safety related clinical governance committees (or equivalent) by April 2022 and elsewhere as appropriate
6. **Patient safety education and training** Support all staff to receive training in the foundations of patient safety by April 2023
7. **National Patient Safety Improvement Programmes** Local systems to deliver key enablers of patient safety improvement with support from the national patient safety team and PSCs

4. Learning from other sources

4.1 Learning from Deaths (LfD)

The LfD bulletins are available to all staff on the intranet

http://staff.wsha.local/Intranet/Documents/E-M/LeadershipandQualityImprovementFaculty/Sharedlearningbulletin.aspx

Table: LfD data Q4 (19/20) – Q3 (20/21)

	Deaths	Deaths with an SJR* completed	SJRs classified as Poor / Very poor care	Deaths judged as >50% preventable**
Jan21-Mar21	346	61 (197 for SJR)	8	0
Apr21-Jun21	202	27 (69 for SJR)	5	0
Jul21-Sep21	215	18 (59 for SJR)	6	0
Oct21-Dec21	297	4 (95 for SJR)	2	0

** SJR - Structured Judgement Review **National reporting requirement*

The new Associate Medical Director for patient safety is undertaking a review of all the elements of mortality including LfD with a view to developing a mortality oversight group. This will also include the medical examiner workflows, inquests, review of SHMI data, end of life, relevant aspects of PSIRF and the decision making around preventability decisions which have required clarification for some time. The redesigned group will provide operational escalation, identify themes, opportunities for improvement and help ensure that the organisation enacts appropriate change.

Cases referred to LfD for review include the nationally mandated groups of severe mental health illness and learning disability (and recently autism has been added by the national medical examiners group). Trust priority referrals include coroner, inquest, patient safety investigations, complaints and cases referred from the medical examiner.

Summary Level Hospital Mortality Index (SHMI) data for Oct 2020-Sept 2021 (published 11/02/2022) records the trust-wide figure “as expected” however the diagnosis groups *fluid and electrolyte disorders* is flagged as “above expected”. This has been escalated to the Medical Director’s office for further review by the two AMDs.

4.2 Patient and public feedback

25 complaints were responded to in January & February 2022 in total. Actions / learning opportunities from these are set out in **Annex 1**. The Patient Experience team work closely with the Patient safety team to ensure any incidents of concerns identified through complaints are captured and recorded and collaborate to produce timely feedback on investigations to the complainants.

5. Other safety and quality activity

5. HSIB national best practice publication review

The organisation is undertaking a trial of reviewing identified national best practice publications. This is an extension of the original CQC improvement plan addressing the finding.

The trust must ensure that processes for governance and oversight of risk and quality improvement become consistent across the organisation. There must be robust processes in place to ensure that implementation and impact of clinical, internal and national audit processes, mortality reviews, incidents and complaints are monitored and reviewed to drive service improvement. Regulation 17(1)(2).

A small central group is running this trial (made up of QI, clinical audit team, AMD (Clinical Effectiveness) and representatives from eCare and deteriorating patients). The trial is focussing on the publications issued by the Healthcare Safety Investigation Branch (HSIB). which issue national safety recommendations e.g. to the royal colleges or other national bodies such as NHSE). There is already a process in place for responding to publications from the national audit programme and NICE.

This pilot pathway consists of identification, allocation to a reader panel (a few relevant clinical leads – will be different for each report), confirmation of any local action (such as more detailed review of practice) and reporting to the clinical directors group* for ongoing management.

* where a publication does not meet the requirement for allocation by CDs, an alternative route will be discussed and proposed at reader panel.

The first two publications under review are:

www.hsib.org.uk/investigations-and-reports/weight-based-medication-errors-in-children/

https://www.hsib.org.uk/investigations-and-reports/unintentional-overdose-of-paracetamol-in-adults-with-low-bodyweight/

Annex 1 Actions / learning opportunities from complaints

Ref.	Issues identified	Actions and learning
2040	Patient complains about interactions with staff during appointment. Also raises concerns about treatment plan.	Department reviewing informed consent process and implementing a checklist to ensure patients agree to treatment.
2033	Family complains that whilst child was admitted to the ward a window broke and some glass hit the child.	Glass protection measures and adherence to designated walkways, install movable shutters over glazing, Update sub-contractors risk assessment for works to include glass protection measures, Update site induction to specifically address risk of breaking glass and control measures. All site staff to be made expressly aware of this change.
2041	Patient complains staff did not investigate source of pain, despite stating was not in the area x-rayed. Patient readmitted and found to have fractures to toes.	Staff will be more mindful in future of exploring source of pain further if appropriate.
2049	Family of patient raises concerns about communication when not allowed to visit his parent who was end of life.	Additional ward clerks have been recruited to assist with answering ward phone. Trust clinical helpline reinstated so that relatives can obtain information about patients when they are unable to visit or get through to ward.
2065	Family unhappy child has been discharged after lengthy wait for appointment as being 'too old' and not being informed this would happen.	A further attempt at a formal assessment will be carried out and, if unsuccessful, a joint approach to patient's care between paediatrics and other specialty will be attempted
1999	Patient complains able to feel caesarean section incision despite anaesthesia and had to be changed to emergency general anaesthetic and she missed birth of baby.	Patient given details of birth reflections and peri-natal mental health service Staff would be happy to meet with patient if there are outstanding questions.
2053	Patient complains that foreign matter was not noticed in wound.	Error with diagnosis of foreign matter has been highlighted to the wider team and will be discussed in risk management lecture to try and prevent this from happening again.
2030	Patient felt unsupported during labour and raises concerns about ward facilities.	Ensure patient are offered appropriate food whilst on the ward and exploring the option of purchasing a fridge for the ward to store expressed colostrum. Parent's consent should be gained before giving babies formula feed.
2032	Concerns patient was discharged too early despite having temperature. Also has concerns that staff took patient's temperature incorrectly.	ED practice nurse to provide refresher training for staff on the most reliable way to use tri temp thermometer. Staff reminded to update relatives when patients ready for discharge and have been transferred to DWA
2042	Patient's regular medication not available as a liquid alternative when nil by mouth, which led to them experiencing a psychotic episode.	Surgical team to be more mindful of ensuring that there is early liaison with psychiatry team for in person review where indicated and with pharmacy if a patient requires alternatives to oral medication. Staff reminded of importance of understanding mental health disorders and ensuring that regular medications are recommenced as soon as possible and when appropriate. Pharmacy to discuss at surgical, medical and emergency admission meeting for reflection / wider learning.
2038	Patient's family feels there was a delay in diagnosis of cancer, despite multiple attendances.	Multiple human factors which need reflecting on across medical division. Case will be presented at the quarterly divisional clinical governance meeting in early 2022 to share learning. Will also be circulated in minutes. Clinical director has suggested that all staff involved attend human factor training. Regular junior doctor teaching sessions to be recommenced from the Trust's governance office to share learning from investigations such as these. This will happen on a quarterly basis and will capture all junior doctors in training.
2036	Patient's family informed her patient had died before patient had actually passed away.	Staff reminded to ensure they obtain patient details from relatives visiting prior to any conversations taking place. Discussed at unit's safety huddle as part of team reflection and learning
2031	Patient's family did not understand condition and that patient was end of life due to medical phrases used. Patient deteriorated suddenly following discharge and had to be readmitted.	Ensure communication with patients' relatives is tailored in a way that can be better understood and try to minimise use of medical language when communicating with relatives. Ensuring consideration of broader range of scenarios when producing a discharge care plan and include backup emergency care plans to be implemented in the case of any unforeseen rapid deterioration. Ensure that relatives have a complete understanding and agree with patients' proposed discharge care plan.
2055	Patient's complains that pain was not managed effectively and that staff made upsetting comments.	Patient's experience shared across wider team for learning and reflection

Annexe 3a

NHS
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PSIRF – WORKSHOPS 2022/23

Lucy Winstanley – Head of Patient Safety & Quality
Rebecca Gibson – Head of Compliance & Effectiveness

Putting you first

Objectives for workshops

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To review the top risks that are identified in the current plan

Receive information from your area or speciality for potential inclusion in the plan

Use feedback within the development of subject list for 2022/23 PSIRP

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How we identified 2021 list

- Analysis of three years of Datix incident data

- Key themes from complaints/PALS/claims/inquests

- Divisional / local team discussions of concerns (not necessarily supported with hard data but ‘feel relevant’)

- Key themes from Learning from deaths programme

- Pharmacy / D&T group review of medication incidents

The top ten risks (in 2021/22 plan)

	Incident type	Specialty
1	Discharge	All
2	Medication	All
3	Clinical care & treatment	All
4	Falls	All
5	Pressure ulcers	All
6	Pathways of surveillance	All
7	Deteriorating patients	Obstetrics
8	Diagnostic delays	All
9	End of life	All
10	Blood transfusions	Pathology

Last year's top ten in more detail

NHS West Suffolk NHS Foundation Trust

Incident type	Specific risk (or incident subtype) identified through risk assessment process
Discharge	Failed discharges. Patient requiring unplanned readmission related to medicines management
Clinical care & treatment	Inpatients receiving shared care between specialties (internal): Incidents affecting inpatients where the care of the patient is being managed between two or more clinical specialties and where the management of the care resulted in the patient having an extended length of stay or requiring additional treatment/surgery
Medication	Insulin and diabetes management leading to deterioration in patient's glycaemic index requiring interventional treatment at higher level of care (level 2/3)
Deteriorating patients	Incidents occurring out of hours where the assessment of the patient was delayed and timely recognition of deterioration was not escalated appropriately.
Obstetrics	See table 3 – Maternity incidents, adverse outcomes and externally reportable events investigation pathways
Falls	Inpatient falls resulting in a major bone fracture
Pressure ulcers	Pressure ulcers developed in our care category 2 -4.
	Pressure ulcers present on admission to service.
Pathways of surveillance	Deterioration of patient condition due to prolonged wait whilst on a surveillance programme
Blood transfusion	As set out in the National reporting requirements of the MHRA and SHOT/SABRE

Subject suggestions from 2022 workshops

Incident type
Results validation
eCare related adverse events
Communication and handover of care to another service
Wound care in community
Complex patients / challenging patients (including ownership)
Failed / delayed discharge
Missed or delayed diagnosis
Transfers of care within WSFT
Sepsis
Interface with Mental health services

Other topics from Quality and Safety teams

Incident type (*source*)
Drug errors (*LfD*) – *captured in plan for PSII*
Diabetes care and blood sugar recording and documentation of actions (*LfD*) – *thematic review of incidents reported progressed through the Diabetes Management Group for improvement work, organisationally and locally*
Fluid balance (*LfD*) - *incidents and learning form PSR/PSII progressed through the Deteriorating patient group for improvement work, organisationally and locally*
Aspiration pneumonia (LfD) - *thematic review of incidents reported progressed jointly through the Nutrition steering group and the antimicrobial management group for improvement work*
Delay or failure to diagnose when attending ED (*Complaints*) – *individual incidents managed according to local policy*
Opioids, gentamycin/vancomycin, medication patches, extravasation, mis-selection (*Pharmacy / Medication safety*) *see next slide for detail of Patient Safety Audits*
Sepsis (*Deteriorating patient*) – *patient safety audit of compliance with sepsis 6 reported and progressed through the Deteriorating patient group*
AKI (Deteriorating patient) – *inpatients deteriorating from AKI stage 2-3 will undergo patient safety audit with results actioned though the deteriorating patient group*
Nothing specific identified from Inquests or claims

Proposed top risks for 2022/23 plan

NHS West Suffolk NHS Foundation Trust

	Incident type
1	Transfer of care
2	Discharge
3	Medication
4	Validation of results
5	Digital systems
6	Clinical care & treatment
7	Falls
8	Pressure ulcers
9	Unexpected themes / increase in incidence
10	National ‘must do’

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Proposal for PSIRP 2022/23 - Incidents for PSII

NHS West Suffolk NHS Foundation Trust

Risk / Incident type	Specific risk / incident subtype	Example cases previously reported
Transfer of care	Potential for patient harm as a result of communication with multiple stakeholders for on-going patient care	• Repatriation from tertiary unit • Obstetric patient under medical care • Discharge requirements not communicated to community team
Discharge	Adverse patient outcome occurring during an inpatient extended length of stay after patient no longer meets 'reason to reside'	• HAI related • Fall on discharge unit • EOL
Medication	Wrong medication or dose leading to harm or potential for harm	• Weight based dosing • Medication allergy
Management of results	Potential for patient harm as a consequence of non-communication and action of diagnostic results	• Missed fractures • Pathology results • Radiology results • Communication of results from ED
Interactions with digital systems	Emerging risks identified as a result of the use of our digital systems (e-Care, SystemOne and other systems)	• Discharge letters • Lost to surveillance • Deletion of stent register
Emerging theme	Identified increase in incidence of incident type / theme which has potential for harm	
Never Events	https://improvement.nhs.uk/Never_Events_list	National requirement
Deaths more likely than not due to problems in care	Medical Examiner has identified an issue in care which has made death of a patient more than likely preventable (>50%)	National requirement

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Proposal for PSIRP 2022/23 - Other methods

NHS West Suffolk NHS Foundation Trust

Risk / Incident type	Specific risk / incident subtype	Method of review
Clinical care & treatment	Wound care within community services	AAR – After action review
Falls	Inpatient falls resulting in a bone fracture or haemorrhage	De-brief and AAR
Pressure ulcers	Pressure ulcers developed in our care category 2 -4	Patient safety audit (PSA) – Cat 2 & 3 AAR – Cat 4
Medication	• **Opioids management** • **Drug interaction** • **Therapeutic drug monitoring** *including Gentamycin/vancomycin/Heparin/Warfarin* • **Medication patches** – *lidocaine and opioids* • **Diabetes medicines management** - *administration/prescribing/insulin selection/ oral preparations* • **Thromboprophylaxis** - *weight based issues* • **Antimicrobials** – overseen by the AMG - *inappropriate or excessive course length and allergy/interaction*	PSA programme for incidents relating to medications listed
Other (red incident or divisional escalation to EIR)	incident graded as major or moderate harm escalated to the EIR (Emerging Incident Review) which does not fit a category in our PSIRP but has the potential for learning through a review of care	Patient Safety Review (PSR)
Other (review by LfD team)	Case note review using template produced by the Royal College of Physicians (RCoP) to identify potential opportunities for improvement in care including learning from excellence	Structured judgment review (SJR)

Approval process

- Workshop output narrative sent to divisions for comment and confirmation of accurate reflection of subjects discussed [04/03/22]
- Integration of workshop feedback and other quality & safety sources into a suggested PSIRP list [14/03/22]
- Executive and CCG review / discussion of plan [15/03/22]
- PSIRP presented to Senior Leadership team for discussion and approval [21/03/22]
- Board sign off [25/03/22]

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