Board of Directors (In Public)

Schedule	Friday 25 November 2022, 9:15 AM — 1:15 PM GMT
Venue	Conference Room, Denny Brothers, Kempson Way, Bury St. Edmunds. IP32 7AR
Description	A meeting of the Board of Directors will take place on Friday, 25 November 2022 at 9:15am.
Organiser	Ruth Williamson

Agenda

AGENDA

_WSFT Public Board Agenda - 25 November 2022 - Final.docx

1. GENERAL BUSINESS

1.1. Apologies for absence: Hilary McCallion, Paul Molyneux (Ravi Ayyamuthu deputising), Craig Black
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 - 30 September 2022
To Approve - Presented by Jude Chin

Item 1.3 WSFT Minutes Open Board 30 Sept 2022 final draft.docx

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

Item 1.4 - Action Points - Active - 25.11.22.pdf

Item 1.4 - Action Points - Complete - 25.11.22.pdf

1.5. Patient / staff story
To Note

1.5.1. Early Supported Discharge
Ehab Georgy, Service Manager, Suffolk Early Supported Discharge Service, in attendance.
To inform

1.5.2. Virtual Ward (10 am)
Vivian Yui, Clinical Lead, Virtual Ward, in attendance
To inform - Presented by Susan Wilkinson

1.6. Questions from Governors and the Public (Verbal)
To Note - Presented by Jude Chin

1.7. Chief Executive's report, incorporating SNEE Integrated Care Board
To inform - Presented by Craig Black

Item 1.7 - CEO board report November 2022 V2.docx

2. CULTURE

2.1. People & OD highlight report
To Assure - Presented by Jeremy Over

Item 2.1 - People OD highlight nov2022.docx

3. STRATEGY

3.1. Future System board report
To Assure - Presented by Craig Black

Item 3.1 - WSFT FS public board nov 2022.docx

3.2. System update - WSFT & ESNEFT Collaboration Report
To Assure - Presented by Nicola Cottington

Item 3.2 - Cover sheet for collaboration paper.docx

Item 3.2 - Collaborative Board Paper - November 2022 v5.docx

3.2.1. Alliance

To inform - Presented by Clement Mawoyo

- Item 3.2.1 - WSFT Board Cover Sheet CM 251122.docx
- Item 3.2.1 - Alliance.pptx

3.3. Digital Board Report

To Assure - Presented by Craig Black

- Item 3.3 - Digital board report _Nov2022.docx

11.40 COMFORT BREAK

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4. ASSURANCE

4.1. Insight Committee Report - 7 November, 2022 - Chair's Key Issues from the meeting

To Assure - Presented by Richard Davies

- Item 4.1 - Chair's Key Issues November 2022_Insight.docx

4.1.1. Self Certification

To Assure - Presented by Nicola Cottington

- Item 4.1.1 - Self certification cover paper board.docx
- Item 4.1.1 - WSFT Elective Letter Gap Analysis.pdf

4.1.2. Cancer Performance Standards

To Assure - Presented by Nicola Cottington

- Item 4.1.2 - Cancer Performance Standards - 71122 Insight.docx
- Item 4.1.2 - Cancer Performance Update - Insight.pptx

4.2. Finance and Workforce Report

To Assure - Presented by Nick Macdonald

- Item 4.2 - Finance Cover - October_2022_FINAL.docx
- Item 4.2a - Finance Report- October_2022_FINAL.docx

4.3. Seasonal Planning - Presentation

To Assure - Presented by Nicola Cottington and Clement Mawoyo

4.4. Improvement Committee Report - 10 October, 2022 & 14 November, 2022 - Chair's Key Issues from the meeting
To Assure - Presented by Louisa Pepper

- Item 4.4 - 22-10 Chairs key issues - Improvement Committee.docx
- Item 4.4 - 22-11 Chairs key issues - Improvement Committee November.pdf
- Item 4.4a - Quality and Learning report (addendum).docx

4.5. Quality and Nurse Staffing Report
To Assure - Presented by Susan Wilkinson

- Item 4.5 - Quality and nurse staffing report.docx

4.5.1. Maternity services Quality & Performance Report
Karen Newbury, Simon Taylor & Wendy Matthews in attendance
For Approval - Presented by Susan Wilkinson

- Item 4.5.1 - November22 Maternity Quality Safefy and Performance Board Report.docx

4.6. Involvement Committee Report - 17 October, 2022 Chair's key issues
To Assure - Presented by Alan Rose

- Item 4.6 - CKI Involvement Oct '22 - final.docx

5. GOVERNANCE

5.1. Audit Committee Report - 1 November, 2022 - Chair's Key Issues
To inform - Presented by Alan Rose

- Item 5.1 - CKI Audit Nov '22 - draft.docx

5.2. Remuneration Committee Report - 28 September, 2022 - Chair's Key Issues
To inform - Presented by Alan Rose

- Item 5.2 CKI RemCom 280922.docx

5.3. Governance report

To inform - Presented by Richard Jones

- Item 5.3 Governance Report.docx
- Item 5.3 Annex A BAF Summary and Risk Report (004).docx
- Item 5.3 Annex B NEDs responsibilities Nov 2022 v2.doc
- Item 5.3 Annex C Draft agenda items.docx

5.4. West Suffolk NHS Foundation Trust Annual Report & Accounts - 2021-22
To inform - Presented by Craig Black and Nick Macdonald

- Item 5.4 - WSFT cover sheet Annual Report & Accounts.docx
- Item 5.4 - WSFT-Annual-Report-and-Accounts-2021-22 published.pdf

6. OTHER ITEMS

6.1. Any other business
To Note

6.2. Reflections on meeting
For Discussion

6.3. Date of next meeting - 2 February, 2003
To Note - Presented by Jude Chin

6.3.1. Board & Committee Meeting Dates 2023
For Approval - Presented by Jude Chin

- Board Subcommittee Meeting DATES FOR 2023 - 2024 v4.doc

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

SUPPORTING ANNEXES

4.5.1 Maternity Papers - Annexes B-G

- Item 4.5.1b - Annex B 2022 ATAIN Quarter 2 July- Sept 2022 progress report.pdf
- Item 4.5.1c - ANNEX C SA 5 Midwifery Staffing Report November 2022 V6 for approval.docx
- Item 4.5.1d - ANNEX D Safety Action 4 Obstetric November 2022.docx
- Item 4.5.1e - ANNEX E Q2 Final Report 22-23 Neonatal Transitional Care Report.docx
- Item 4.5.1f - ANNEX F WSFT SCREENING ANNUAL REPORT 21-22_FINAL_to board 18_11_22.docx
- Item 4.5.1g - ANNEX G Training needs analysis and tracker current OCT (002).pptx

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5.3 - Governance Report - TOR Review - Appendices A-E

- Supporting annex 5.3 ToR Appendix A Insight Committee Terms of Reference Nov 2022.docx
- Supporting annex 5.3 ToR Appendix B Improvement Committee ToRs Nov 2022.docx
- Supporting annex 5.3 ToR Appendix C Involvement Committee Terms of Reference Nov 2022 11 Nov.docx
- Supporting annex 5.3 ToR Appendix D Audit Committee Terms of Reference 2022-23 Nov 2022.docx
- Supporting annex 5.3 ToR Appendix E Board Remuneration and Nomination Committee Tor.docx

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5.3 Governance Report - Council of Governors Meeting - GGI report and improvement plan

- Supporting annex 5.3 CoG GGI report action plan Oct 2022.doc
- Supporting annex 5.3 CoG GGI_WSH_CoG_Report_Oct_2022 Final 27 Oct 2022.pdf

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AGENDA

WSFT Board of Directors – Public Meeting

Date and Time	Friday, 25 November 2022 9:15 – 13:15
Venue	Conference Room, Denny Brothers, Kempson Way, Bury St. Edmunds. IP32 7AR

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 – 30 September 2022**	Chair	Approve	Report
	1.4	**Action log and matters arising**	All	Review	Report
09:20	1.5	**Patient / staff story**			
	1.5.1	**Early supported discharge**	Ehab Georgy, Service Manager, Suffolk Early Supported Discharge	Inform	Verbal
10:00	1.5.2	**Virtual ward (10am)**	Clement Mawoyo / Vivian Yiu, clinical lead	Inform	Verbal
	1.6	**Questions from Governors and the public**	Chair	Note	Verbal
10:20	1.7	**CEO report**	Chief Executive	Inform	Report
2.0 CULTURE					
10.30	2.1	**People and organisational development highlight report** including: - FTSU guardian report	Director of Workforce Amanda Bennett	Assure	Report
3.0 STRATEGY					
11:15	3.1	**Future system board report**	Chief Executive	Assure	Report
	3.2	**System update:** - West Suffolk NHS Foundation Trust (WSFT) and East Suffolk and North Essex NHS Foundation Trust (ESNEFT) collaboration report	COO	Assure	Report
	3.2.1	**Alliance**	Clement Mawoyo	Inform	Report
	3.3	**Digital board report**	Chief Executive	Assure	Report
11:40 Comfort Break					
4.0 ASSURANCE					

Time	Item	Subject	Lead	Purpose	Format
11:50	4.1	**Insight committee report** – Chair's key issues from the meetings	NED Chair	Assure	Report
	4.1.1	**Self-certification**	COO	Assure	Report
	4.1.2	**Cancer Performance Standards**	COO	Assure	Report
	4.2	**Finance and workforce report**	Director of Resources	Assure	Report
	4.3	**Seasonal planning**	COO & Clement Mawoyo	Assure	Presentation
12:10	4.4	**Improvement committee report** – Chair's key issues from the meetings	NED Chair	Assure	Report
	4.5	**Quality and nurse staffing report**	Chief Nurse	Assure	Report
	4.5.1	**Maternity services:** - Quality Safety & Performance Report	Chief Nurse Karen Newbury, HOM,/Simon Taylor, Service Manager/Wendy Matthews, Regional Chief Midwife	Approval	Report
12:40	4.6	**Involvement committee report** - Chair's key issues from meetings	NED Chair	Assure	Report
5.0 GOVERNANCE					
12:55	5.1	**Audit committee report** – Chair's key issues from the meetings	NED Chair	Inform	Report
	5.2	**Remuneration committee report** – Chair's key issues from the meetings	NED Chair	Inform	Report
	5.3	**Governance Report**	Trust Secretary	Inform	Report
	5.4	**West Suffolk NHS Foundation Trust annual report and accounts 2021-22**	CEO / Director of Resources	Inform	Report
6.0 OTHER ITEMS					
13.10	6.1	**Any Other Business**	All	Note	Verbal
	6.2	**Reflections on meeting**	All	Discuss	Verbal
	6.3	**Date of next meeting** • **TBC 2023**	Chair	Note	Report

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

Supporting Annexes

Agenda item	Description
4.5.1	Maternity papers – Annexes B-G
5.3	Governance Report – terms of reference review: • Appendix A Insight committee • Appendix B Improvement committee • Appendix C Involvement committee • Appendix D Audit committee • Appendix E Board Remuneration and Nomination committee
5.3	Governance Report – Council of Governors Meeting • GGI report and improvement plan

Guidance notes

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



1. GENERAL BUSINESS

1.1. Apologies for absence: Hilary McCallion, Paul Molyneux (Ravi Ayyamuthu deputising), Craig Black

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 - 30 September 2022

To Approve

Presented by Jude Chin

NHS
West Suffolk
NHS Foundation Trust

WEST SUFFOLK NHS FOUNDATION TRUST

DRAFT MINUTES OF THE BOARD OF DIRECTORS MEETING OPEN

Held on 30 September 2022 9.15 – 12.45
At Ashlar House, Bury St Edmunds

Members:		
Name	**Job Title**	**Initials**
Jude Chin	Chair	JC
Alan Rose	Deputy Chair/Non-Executive Director	AR
Louisa Pepper	Non-Executive Director	LP
Richard Davies	Non-Executive Director/Senior Independent Director	RD
Christopher Lawrence	Non-Executive Director	CL
Craig Black	Interim Chief Executive	CB
Nicola Cottington	Chief Operating Officer	NC
Sue Wilkinson	Executive Chief Nurse	SW
Nick Macdonald	Interim Executive Director of Finance	NMD
Paul Molyneux	Interim Executive Medical Director	PM
Jeremy Over	Executive Director of Workforce and Communications	JO
In attendance:		
Richard Jones	Trust Secretary & Head of Governance	RJ
Pooja Sharma	Deputy Trust Secretary	PS
Clement Mawoyo	Director of Integrated Adult and Social Care Services	CM
Peter Wightman	West Suffolk Alliance Director	PW
Helen Davies	Head of Comms	HD
Melissa Williams	Clinical lead, Glemsford Surgery (item 1.5.1 only)	MW
Sinead Collins	Service Manager, Glemsford Surgery (item 1.5.1 only)	SC
Dan Spooner	Deputy Chief Nurse (from item 3.2.1)	DS
Claire Sorenson	DDW&C (from item 3.2.1)	CS
Justyna Skonieczny	Deputy Head of Midwifery (for item 4.4.1 only)	JS
Simon Taylor	Associate Director of Operations (for item 4.4.1 only)	ST
Ruth Berry	Foundation Trust Officer Manager (minute taking)	RB
Apologies: None		
Governors:		
Florence Bevan	Public Governor	FB
Clive Wilson	Public Governor	CW
Liz Steele	Public Governor - Lead	LS
Jane Skinner	Public Governor	JS
Staff:		
Heidi Rolfe-Hill	Physiotherapist with community health services	HRH
Paul Pearson	Unison	PP

Members of the public:		
Cllr Margaret Marks	West Suffolk Council	MM
Charlie Masters	Journalist from Suffolk News	CM

1	**Welcome and apologies for absence**	**Action**
1.1	The Chair welcomed all to the meeting and noted apologies for absence.	
2.	**Declarations of interest**	
2.1	No declarations of interest were received.	
3.	**Minutes of the previous meeting**	
3.1	The minutes of the previous meeting held on 22 July 2022 were approved as a true and accurate record.	
4.	**Action log and matters arising**	
4.1	• 2029 paper being presented at meeting as an item 1.5 – **action closed** • 2041 training details have been circulated to Board (Aug) for completion during September) – **action closed** • 2053 – Report to be presented at the November Board meeting • 2057 further planned comms, another meeting planned – this is ongoing, will updated at November meeting • 2058: Report to be presented at the November meeting • 2060: Report to be presented at the November meeting	
5.	**STAFF STORY**	
5.1	**Glemsford primary care practice** Melissa Williams (Lead GP) commended presentation to the Board on 'through the pandemic and beyond' and drew attention to the following: Prior to vertical integration with WSH, there was a growing workload, with staff retiring; the surgery was on the brink when WSH took over the practice and it became integrated between primary and secondary care. The practice was voted best surgery in Suffolk 2019, but it didn't reflect what actually goes on at the practice. Vertical integration took place on 1st April 2020, during the first lockdown of Covid pandemic. Early pandemic was quiet at the beginning, however, both GPs got Covid during this time. Changes were made to start making virtual appointments. There were concerns around PPE in the beginning of the pandemic and they had to give some face-to-face consultations for some long-term patients. The practice re-opened quickly and workloads went back up and added to the backlog. The locum pool dried up with lots of doctors taking on permanent salaried roles. There was long term sickness within the practice, which	

	further affected performance. There was a frustration amongst the public, who were unhappy about the overall situation. GP numbers were decreasing nationally. The practice then lost the lead GP and Melissa was left as the de-facto lead GP, making it a very difficult situation. There were concerns around recruitment and they had to work within the budget to meet the need to diversify workforce and to be able to take some workload off the GPs. It was noted that the request to NHS for removing out of area patients was very unpopular with the patients effected. The practice eventually returned to more face-to-face working, with things settling down and staff returning to work. Again, there were challenges with one GP moving to private practice, a nurse reducing their working hours and more covid outbreaks within the staff. WSH was approached to grant more funding to recruit more staff to allow the continuity in the service. Funding for building projects was agreed which allowed more space for all the new staff. At the time, there was a team of 4 GPs, 2 practice nurses, a pharmacist, a social prescriber and a cancer care coordinator. CQC inspection was then announced and Melissa had not experienced the new format of inspection before and now it being an in person, field inspection, lasting 2 days with data dives. The CQC report noted that the practice was already working on areas recognised as lacking. It was a positive experience, and the practice achieved an overall good rating. The report recognised the reviews made. The working day has changed multiple times over the pandemic. It is now a hybrid of face to face and virtual. Lots of patients actually prefer telephonic appointments rather than coming into the practice itself. The practice now caps the number of appointments slated for each day barring emergencies. Patient satisfaction appears to be rising again and the practice is now starting to look at improvement efforts including restarting patient groups, working on becoming a training practice to train potential GPs and improving links with community care homes. General Practices take on the majority of the work in the NHS, but it's worth only 9% of the NHS budget. More smaller surgeries will struggle and are not attractive for recruitment and retention. Advanced clinical practitioners (ACPs) staff are not a replacement for GPs and a solution needs to be found with more services going back to GPs and back into the community rather than in the hospital. <u>Q. What are the key benefits of joining the WSH?</u> Some of the key benefits of the practice being within the Trust are that it gives back to the community. It helps with recruitment and the support that the WSH staff can offer has been a huge help. The practice can	

	access the staff services at the WSH which is a great benefit and attraction too. There is a need to reflect on having the practice within the Trust as it would help to understand the functionality of the services. It benefits the Trust to have a diverse portfolio, including primary and community care. <u>Q. How is the practice now in terms of resilience?</u> The practice now is at a different place not as compared to 8 months ago with having additional staff, with a mix of experience, the ethos is strong and happy. Looking after staff keeps them at the practice and they give more back to the practice. Q. How can Chief Operating Officer & Executive Medical Director help on a clinical perspective e.g., with virtual wards/future system? From a clinical perspective, it would help to be more integrated in the future. The community links have helped and thanks to Sinead Collins (Service Manager, Glemsford Surgery) and James Heathcote (deputy clinical director) who have helped with the primary care aspect of this integration. The flow between primary and secondary care are key. Communication with the community is needed re Glemsford Surgery working with the WSH and the community links. It helps for other practices to see this move to integration as a positive. The Board noted the concerns around GP voice not being heard in the ICS setting. It is not strong enough at the moment and there is a misunderstanding of what primary care does. A lack of understanding on all sides of what happens comes from not being represented. GP surgeries have moved on from just basic medical services to more diverse services and reaching in the community and beyond. The Board also thanked the other team members for their efforts and contributed to the primary care aspect of this integration. Q. What can Glemsford do in the Primary Care Network PCN? A mutual aid paper has been drafted for the next PCN meeting. The discussions will drive the next course of action. **Action: To include greater visibility of primary care and alliance developments in the Board's work programme.** **The Board noted the staff story and thanked team for sharing the experience and for highlighting the areas in which the Trust can learn and make improvements.**	**CM/PW**
5.2	**Response and reflections from patient story received in July**	

	The board needed time to reflect on the points raised in the patient story and stressed the importance of being aware of this situation. PALS took on a number of the actions raised, which does give some assurance that it was heard, and they checked in with the person who came to the meeting. The board listened and heard them. The patient was informed on the action points that came about from the board meeting. It stresses the fact that the quality of the service provided is entirely based on brief interactions. There is a need to have accountability of staff, and a culture of doing the right thing. Interaction with patients is not transactional, its staff who are able to help with more than just what brought the patient to hospital. It was asked that how to ensure that we work with the external parties/community to provide a holistic approach as the Trust moves into the autumn/winter period? There are system and operational factors that have an impact upon services that lead to the pressures facing the health care system. The Trust has plans in place and integrated approach to meet winter challenges. **Action: To schedule time for wider discussion on winter planning (including context of response to cost of living).**	**CB/NC**
6.	**Questions from Governors and the public**	
6.1	<u>Hospital transport: Lead Governor, Liz Steele</u> This was the biggest issue raised by staff following a recent ward visit. Patients are waiting long in the cold waiting area, with staff having to stay late to ensure collections happen. The Trust is aware of the transport issues being reported by the staff on a regular basis. The non-urgent provider is a company called Esec. The service is not improving in the way we want it to be. They are understaffed which leads to delays in service. The contract is coming up for renewal and better checks will be required. Staff are looking at better processes for after discharge patient collection. Reception staff give out blankets to patients while they wait <u>Patient view: Councillor Margaret Marks</u> How to change the general perception amongst public to make them understand primary care better that seeing doctor in a hospital is a better provision and option than seeing a GP in practice, the latter being lesser than the former. With the developments around the integration of services over the last few years, hopefully, will change perception. The language used by the NHS has changed. Communication is key to ensure there is no confusion in the message being presented. The WSH Comms team are careful of clinical language in WSH communication with the public.	
7.	**CEO report incorporating SNEE ICB**	

7.1	CB presented the report and highlighted the following: The vaccine programme and the team have been phenomenal, with well over a quarter of staff vaccinated in 10 days. With Covid levels rising, it is important that staff get vaccinated, to help avoid absences. Visits have been made to Brandon and Mildenhall hubs. Having the link to services within a community hub helps patients and the community itself. Mildenhall is top in the UK due to the locational link between police, library and leisure centre. There was a query around flu vaccination and it was noted that flu programme is well established with 70% staff being vaccinated last year. This year the Trust has received stock early as compared to the previous year.	
8.	**CULTURE**	
8.1	**People And OD Highlight Report** JMO talked through the report and drew attention to the following: There is a high cost of living pressure on some staff and the Trust is trying to help and support where possible. The Trust is running several staff involvement programmes over the autumn season and are calling on colleagues to have their say on what matters to them. There is a need to ensure that we celebrate staff achievements within the Trust. **The Board noted the people and organisational development report.**	
8.2	**Responsible officer's annual revalidation report and statement of compliance** Responsible officer's annual revalidation report and statement of compliance is a NHSE requirement to present to the Board to ensure it can then be submitted nationally. **The Board approved the annual revalidation report and statement of compliance confirming that the organisation, as a designated body, is in compliance with the regulations and this will be signed by the authorised for return to NHS England.**	
9.	**STRATEGY**	
9.1	**Future System Board Report** The key activity is the planning application for the WSH site. Additional work on the highways impact and the key areas around the future site are being undertaken by the team at present. Within the new hospital programme, McKinzie have been commissioned, so learning is spread throughout the hospital schemes.	

	WSH was selected as one of five that are looking at a build on a greenfield site, which is a great achievement for the FS team. The feedback will be invaluable and provide an external perspective on what we are undertaking. There is some additional money being funded into the system, to ensure the Trust continues with the programme as planned. Workforce updates required to come to Board. It was noted that going forward, this report would be presented by Peter Wightman, West Suffolk Alliance Director. **Action: To include workforce workstream in future FS reports (need to avoid duplication with the Alliance and ICS workstream focus)**	**PW**
9.2	**SYSTEM UPDATE**	
9.2.1	**West Suffolk Alliance Report** Looking at the future direction of the alliance and the future approaches through the Live Well framework. Virtual wards approach to be brought to the next meeting. The main focus of the group, via various subgroups is Live Well. A query was made around staffing risks and the virtual ward and it was told that staffing for the VW will be through agency and mutual aid arrangement with WSH. Mitigation measures will be considered and so will career progression and a 'grow your own' practice. **Action: To provide greater visibility of the key activities of the Alliance**	**CM/PW**
10.	**ASSURANCE**	
10.1	**Insight Committee Report – Aug and Sept 2022 – Chair's Key Issues** The Insight Committee Chair (RD) informed the Board that the high administrative workload in relation to cancer results endorsement and communication with patients is causing concern. The community paediatrics and pain service provision are both areas of concern and the focus is on ongoing work. RD said that more in-depth discussion happened on the Western Way development and some key actions were agreed which will be the subject of ongoing work prior to further discussion by the Board. There were concerns around increasing rates of staff turnover **The Board noted the report.**	
10.2	**Finance And Workforce Report** The Interim Executive Director of Resources (NM) presented the report and said that there is a small deficit against budget of £0.1m (YTD £0.4m	

	deficit). However, anticipating a break-even position for 2022/23 which is in line with the budget, there being sufficient mitigations to be able to offset any emerging risks to this position. NM explained that brokerage of system capital will be repaid to ESNEFT through a reduction in the Trust's capital allocation in 2023-24 but as this is an inter-year re-allocation there will be no net impact on the Trust. This also represents a positive example of working with ESNEFT and the brokerage is in the best interests of the SNEE ICS. If agreed by the Board, the Trust will be using this capital to bring forward into 22/23 the replacement of items on the capital programme scheduled for later years. **The Board approved the brokerage of the capital of £4-5m from ESNEFT in 2022/23, to be repaid from WSFT's capital allocation in 2023/24.**	
10.3	**Improvement committee report – Aug and Sept 2022 chair's key issues** The Improvement Committee Chair (JC) drew attention to the improvement being made across areas and the committee is in a good place in terms of its main focus. There are opportunities for deep dive into quality & safety topics on a month-on-month basis. The committee noted the successes and challenges highlighted from the stroke deep dive. WSFT has been a top performing Trust. Key measure demonstrating impact of challenges is the deteriorating four-hour admission to Stroke unit (SSNAP data). Nurse staffing is a concern in common with other wards. There is pressure from ward closures etc., that means the target is not always met, benchmark is very high, but the struggle with capacity is nationwide. Looking at improvement to get stroke patients into the specialist bed as quickly as possible. CT coronary angiogram, a process that helps identifies the blockage has helped break down the hurdles, including out of hours. Assurance has been given to staff that they are supported with out of hours. The improvement committee can look at this area too. The Pathology report was very encouraging. Accreditation from UKAS was a testament to the staff. They feel valued that they have a voice and are being heard. The pathology group is called upon by everyone and to be acknowledged is great. The Board thanked the team. The CQC report data is very in-depth and committees should look at this to really understand the data. It must fall in the remit of committees to ensure this is done. **Action: Involvement committee to consider the issue of staff shifts and rota patterns (inc in radiology)**	**JMO**
10.4	**Quality and nurse staffing report** The Deputy Chief Nurse presented the report for July and August and stated that over the last 2 months, nursing fill rates have remained static,	

	with vacancy rates improving in community teams and NA workforce. The summer safer staffing establishment review audit has now completed and a review of recommendations is in process. Trust continues to recruit monthly cohorts of overseas nurses and has received national accreditation for the pastoral care provided to the international nurses WSH staff have been shortlisted for a number of nursing awards in the Nursing Times and will attend awards ceremony in November Q. How do we make sure that we can accommodate opening an additional ward with current staffing levels? The response might not be to open wards each time, there are other things that can be done to improve flow and pathways. Covid rates are changeable and may further impact on the ability to open additional capacity. The Trust is working with other organisations to review support staff pay and role definition. There is a need to be clear when recruiting and the realities of working in care to address the high turnover of this staff group.	
10.4.1	**Maternity services: quality safety and performance report** The report was presented by the Deputy Head of Midwifery (JS) & Associate Director of Operations (ST) and stated that the maternity services have now gone through both an internal and external process and review and have now formally exited from maternity safety support programme. There is a national shortage of midwives and the Trust is looking at ways to increase recruitment including exploring national and overseas recruitment programmes, along with bringing nurses into the maternity services. In addition we are looking into skill mixes which include how we might use RNs to augment maternity services. An education and training lead has been recruited to support the continuous training of the staff. There are ongoing increasing induction labour rates and policies are reviewed which are in line with our national policies. The neonatal unit has been successfully awarded the Bliss Baby Charter Accreditation and have achieved gold standard which is a huge achievement and they are 1 among 14 to receive this award.	
10.5	**Involvement committee report –Chair's key issues** The involvement committee chair (AR) presented the report and noted that there were four areas of focus at the last involvement meeting and the committee received assurance on the issue around raising concerns but encouraged to continue to expand and embed this to be the normal way we all work together with reaching out to the community teams to night-shift staff and others and to consider ways of measuring the impact.	

	The 'what matters to you 2022' programme is ongoing. Staff were included in the discussion regarding questions and the act of raising concerns is getting into the culture of the WSH. The results are expected around Christmas time. The complaints process and PALS service are performing well. More emphasis to be placed in letters on the learning and actions that may resulted from patient feedback. The committee noted the use of library and knowledge services and consideration to be made on how to ensure improved awareness and access for community and alliance colleagues.	
10.6	**Integrated Quality and Performance Report (IQPR)** The Chief Operating Officer (NC) and Executive Chief Nurse (SW) presented the IQPR and briefly highlighted the items for escalation based on those indicators that are failing the target, or are worsening including ambulance handovers, 12 Hour waits, cancer waits, 6-week elective diagnostic performance, and RTT. The Board noted that the assurance grid in the report is very helpful as it shows that improvement is continuing.	
11.	**GOVERNANCE**	
11.1	**Governance Report** The Trust Secretary & Head of Governance (RJ) talked through the governance report and noted that the action plan to address the areas of concern highlighted in the CQC report has been submitted to the CQC. The Improvement Committee will review progress and provide assurance to the Board that the areas of concern identified by the CQC are addressed. Based on the interviews and discussions, the Council of Governors approved appointment of the five recommended candidates and the Trust has successfully recruited 5 new NEDs due to start as soon as possible. An additional meeting was scheduled on 14 September to consider the annual report and accounts 2021-22. Following the consideration and finalisations by the auditors, the committee was able to recommend the annual report and accounts for approval by the Board. RJ summarised the BAF risks and a programme of deep dives for red and BAF risks through the assurance committees and governance groups will provide great assurance to the Board on the effective management of the risk and control environment. The updated modern slavery statement was presented to the board for approval which will be reflected on the Trust website.	

	The Board noted the report and approved the revised modern slavery statement 2022-23.	
12.	**OTHER ITEMS**	
12.1	**Any Other Business** The chair mentioned that the success of 2022 Annual Members Meeting in September was a testament to the engagement with the community and makes it more important to enhance communication with the community services. MyWish charity and volunteer services are commendable as well.	
12.2	**Reflections On Meeting** • The seating arrangement in terms of mixing Board members with other attending worked well • Glemsford Surgery presentation was well received by the Board • Governors and other members attending the meeting should also be encouraged to provide feedback and reflections on the meeting	
12.3	**Date Of Next Meeting** Trust Board Open: Friday 25 Nov 2022	

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
2057	Open	22/7/22	4.3	For more information to be brought to the next Board meeting on how to communicate the waiting list challenges to the public and patients	**Discussion held with Head of Communications. The Trust has communicated via local media the waiting list challenges and there is considerable national coverage of waiting list challenges. There is likely to be increased coverage in light of the publication of "Our plan for patients". Further meeting planned with communications and head of elective access to consider further communications plan.**	NC	25/11/22	Green	
2058	Open	22/7/22	4.4	For the new CQC model assessment to be discussed at a future board meeting	**New model is now published and engaging with national programme for delivery. Review scheduled for Improvement committee in January '23**	NC/SW	30/01/23	Green	
2064	Open	30/9/22	5.1	Include in the Board's work programme greater visibility of primary care and Allaince developments	Links with action 2069. Include: sustainable primary care networks and focus with ICB to consider primary care representation	CM & PW	31/01/23	Green	
2066	Open	30/9/22	6.1	To consider how to report situation regarding transport	Verbal update to be provided on the improvement plan that has been put in place.	SW	25/11/22	Green	
2070	Open	30/9/22	10.3	Involvement committee to consider the issue of staff shifts and rota patterns (inc in radiology)	Matter referred to involvement committee	JMO	31/01/23	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
2060	Open	22/7/22	6.2	To consider options for the location of future board meetings - WSH and other sites across the county	**Folowing approval of the dates for 2023 these will be used to schedule regular meeting in locations we deliver services. This will include Newmarket, Mildenhall and Haverhill AGENDA ITEM**	RJ	25/11/22	Complete	25/11/22
2065	Open	30/9/22	5.2	Schedule time for wider discussion on winter planning (including context of response to cost of living)	Winter planning part of agenda	CB / NC	25/11/22	Complete	25/11/22
2068	Open	30/9/22	9.1	Include workforce workstream in the future system (FS) report (avoiding duplication with the Alliance and ICS workstream)focus)	Included in FS report and will be developed in future reports.	CB	25/11/22	Complete	25/11/22
2069	Open	30/9/22	9.2.1	Provide greater visibility of the key activities of the Alliance	Deep dive - plan for coordinated programme for the next year based on key areas of work and virtual ward and early supported discharge for 25/11/22	CM & PW	25/11/22	Complete	25/11/22

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. Patient / staff story

To Note

1.5.1. Early Supported Discharge

Ehab Georgy, Service Manager, Suffolk Early Supported Discharge Service, in attendance.

To inform

1.5.2. Virtual Ward (10 am)

Vivian Yui, Clinical Lead, Virtual Ward, in attendance

To inform

Presented by Susan Wilkinson

1.6. Questions from Governors and the Public (Verbal)

To Note

Presented by Jude Chin

1.7. Chief Executive’s report, incorporating SNEE Integrated Care Board

To inform

Presented by Craig Black

Board of Directors

Report title:	**CEO Report**
Agenda item:	1.7
Date of the meeting:	Friday 25 November 2022
Sponsor/executive lead:	Craig Black, Interim CEO
Report prepared by:	Dan Charman, Helen Davies

Purpose of the report:			
For approval ☐	**For assurance** ☒	**For discussion** ☒	**For information** ☒
Trust strategy ambitions			
Please indicate Trust strategy ambitions relevant to this report.	☒	☒	☒

Executive Summary
A round up of key issues and projects across the Trust
Action Required of the Board
For information

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

Winter challenges

As we get closer to winter, the Trust is more aware than ever of the challenges colder weather brings to our staff, our patients and our community. Some challenges will be the same as we face every year such as flu, some will have only existed for the last few years like Covid-19, but some will be new to us.

One of these 'known unknowns' is the impact of the cost-of-living crisis that we're seeing hit every town and village across the country, and west Suffolk and its communities are no exception. Our statistics show that when the temperature drops by just two degrees in the wintertime, the number of attendees we see for respiratory and cardiac conditions increases by 10% and due to the increase in the cost of fuel, this will likely be a lot worse this year.

This month, nurses from west Suffolk voted in favour of the Royal College of Nursing (RCN) ballot to take industrial action. I understand the issues which led them to vote in favour of this action, and are aware that for many colleagues who did vote to strike, they have done so with a heavy heart.

In due course, the RCN will announce dates for nation action, with 14 days' notice given if strike action is going ahead. The RCN have said that patient safety will be prioritised with care in emergency settings protected. In partnership with local union representatives, we will work to ensure that staff and patients are supported throughout the duration of any industrial action.

Elective recovery

The team continues to work hard to recover our elective position and reduce waiting times for patients. We recognise that waiting times remain high, and we are sorry to all those who experience a delay to their care.

The Trust is taking action. We are working with the independent sector and regional NHS partners; offering extended clinics, such as Saturday appointments; providing extended theatre lists; weekend working; and increasing theatre productivity to bring these down over the coming months.

The completion of estates work in numerous areas of the hospital is also helping us complete a greater number of treatments.

As a Trust, we're on trajectory to clear our 78 week waiting times by the end of March 2023, which is a great achievement. After this, the goal is to bring the total of patients waiting 52 weeks down. We will continue to do all we can to reduce waiting times.

Virtual wards

We are also working to bring in new ways to help care for patients. One of these is through 'virtual wards', which will be launching at the end of November.

The virtual ward, as a model, has been running across the country for some time – even before Covid-19 – where the NHS was looking at ways to deliver inpatient care slightly differently.

A virtual ward means caring for suitable patients at home with remote monitoring and is proven to be safe and efficient. It's seen as a real alternative to the traditional 'bedded' model that we all know.

The feedback gathered from both staff and patients who have used a virtual ward has been overwhelmingly positive and the model is a real opportunity to alleviate the pressures on the NHS while still providing quality care to patients in their own homes.

In a lot of cases, a virtual ward prevents a patient having to be physically admitted into a hospital in the first place, but also enables our Trust to support others to be discharged earlier using cutting-edge digital technology and clinically-led medical teams.

I want to thank Dr Vivian Yiu and her team for their work on this exciting new way of offering care. As a Trust, we are always looking to new technology to better the care of our patients and this is something which does exactly that.

Staff Covid-19 and flu vaccinations

It's fantastic to know that over 2700 colleagues at our Trust have received their Covid-19 vaccine and over 2450 have received their flu jabs. This would never have been possible without the incredible work and energy of the vaccination team – who continue to go out of their way to vaccinate Trust staff across all our sites.

As well as vaccinating staff, our wonderful team provides vaccinations to the most vulnerable in our community, including the housebound and those with the most challenging mental and physical health issues. Reaching these groups is so important and is a testament to the team's hard work and dedication.

Earlier this month, the Suffolk and North East Essex Integrated Care System as a whole remained top of the national league table for a fifth week in a row for the greatest number of Covid autumn booster vaccinations administered, which reflects a magnificent team effort.

Listening to colleagues

We are currently undertaking a staff engagement programme, called 'What Matters To You' where we're asking staff for their feedback about the issues most important to them at work.

To do this we have a survey staff can complete and the team are also undertaking an intensive period of face-to face consultation with staff. This started with our community teams and will now move into a phase of engagement across our acute based teams in the West Suffolk Hospital. We would like as many colleagues as possible to have their say.

Once we have completed the face-to-face engagement and the survey closes, we will work through the data and the issues raised and make a plan to take action on those things which staff tell us are really important to them. We want to make West Suffolk the best place possible, so colleagues thrive.

Love Yourself Week

It was really positive to see 'Love Yourself Week' return to our Trust earlier this month. The programme, which has become a regular fixture on our staff health and wellbeing calendar, has this time been tailored to reflect the autumn weather and offers something for everyone.

The latest week included a guided mindful drawing session provided by a local artist; health checks with our friends at One Life Suffolk; a virtual wildlife park visit; and support around confidence with money.

Initiatives such as Love Yourself Week are so important to our colleagues as it offers everyone a chance to try something different and gives us all a chance to turn off and relax.

While on the subject of our health and wellbeing offer, we still work closely with Abbeycroft Leisure to give all our staff the chance to access free gym, swimming and exercises classes all year round. This, alongside the support provided by our staff psychological service, means there is always support for our colleagues when they want it.

Update from the Suffolk and North East Essex Integrated Care System

The ICS has recently launched a programme encouraging students looking for paid work, recently retired health workers and people interested in a career in healthcare to become NHS reservists.

A series of webinars are being held across November to explain how part-time recruits can support local NHS services in Suffolk and north east Essex. The reservist programme, initiated to help relieve workforce challenges during a time of increased demand, was launched nationally earlier this year. Work can be anything from hospital administration, assisting recently discharged patients or supporting the Covid-19 vaccination programme.

Elsewhere, the 111 option for mental health crisis services has been updated to create a consistent approach. Instead of selecting ‘option 2’, people calling the service will be asked to ‘choose the mental health option’.

The change has been made to make sure services across the UK are consistent and that options are the same however the call is made, whether that is via landline, mobile or through the internet. The service was previously called First Response and was open to the public and professionals.

The 111 mental health option is a crisis mental health triage service for individuals who require urgent mental health support. The service is available to all ages, regardless of whether they are an existing service user. It should not be used for advice about medication and existing service users should contact their mental health team prior to calling 111 as the teams have an escalation process to support service users in crisis.

2. CULTURE

2.1. People & OD highlight report

To Assure

Presented by Jeremy Over

Board of Directors

Report title:	**People & OD Highlight Report**
Agenda item:	2.1
Date of the meeting:	Friday 25 November 2022
Sponsor/executive lead:	Jeremy Over, executive director of workforce & communications
Report prepared by:	Members of the workforce and communications directorate Freedom to Speak Up Guardian

Purpose of the report:			
For approval ☐	**For assurance** ☐	**For discussion** ☒	**For information** ☒
Trust strategy ambitions			
Please indicate Trust strategy ambitions relevant to this report.	☐	☒	☐

Executive summary:	The regular People & OD highlight report to the Board is appended.
Action required/ recommendation:	To note and provide comment and/or feedback on the report.

Previously considered by:	N/A
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:	A core purpose of our 'First for Staff' strategic priority is to build a culture of inclusion.
Sustainability:	Our role as an anchor employer, and 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.

People and OD highlight report

1.	**Introduction**
1.1	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 CKI report 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 (October/November) • Freedom to Speak Up Guardian Report Q2 2022/23 • What matters to you 2 – update / progress • Developing & improving our library service • Preparing for industrial action across the NHS • Strengthening our OD capacity & capability
2.	**Putting You First Awards (October/November)**
2.1	*Clair Bacon* - nominated by Helen Ballam I would like to nominate Clair Bacon, Rosemary Ward Care Co-ordinator for a Putting You First award. Clair has worked very hard to secure a discharge for one of our patients, who had become homeless. Housing had nothing to offer him, and he did not meet criteria for residential placement so has been resident on the ward for months. Clair has been very proactive exploring different options, assisting him to complete forms and obtaining documentation. Looking on-line, contacting housing agents on his behalf, getting phone numbers, speaking to charities, and organising virtual tours of property for him. She has not given up and has really gone over, above and beyond for this patient. All with kindness, compassion and a sense of humour. She has had challenging conversations in a professional manner and made sure the patient was fully involved. She deserves recognition for this.
2.2	*John Songkip and Gill Cooksey* - nominated by Diane Last I would like to nominate John Songkip and Gill Cooksey for a Putting You First Award. Gill and John provide excellent support and guidance to our international nurses through the OSCE preparation programme. However, Gill and John also provide support outside of their normal working day to ensure that our new international staff feel welcomed and included. They have organised a number of parties on the heath which have been attended by both staff and their families. These have taken place at the weekend and within their own hours. They have also started a walking group for international staff, again another way of promoting inclusion, keeping healthy and showing the places that are nearby and accessible. John and Gill work tirelessly to ensure our international staff feel part of the WSFT team and are highly deserving of this award.
2.3	Mireille Connolly and Te-Ahna Hanns - *nominated by Allan Morrison*

	After the Transfusion Laboratory Manager left us in August, Te-Ahna and Mireille have, without question, stepped up to the mark to take on additional roles such as budgetary approval and implementation of new equipment. They have maintained a number of additional activities necessary to ensure continued delivery of a safe and effective Blood Transfusion service for the Trust and maintained an ambitious and challenging programme of change necessary to maintain regulatory compliance and to continue the laboratory's transition to ISO15189 accreditation. All of this has been carried out in the context of staff shortages and the delivery of demanding training delivery requirements in order provide current and future service resilience. Although their efforts and tenacity are greatly appreciated in the department they have done all of this without hesitation, prompting or renumeration and without formal recognition. These two people are dedicated to their roles, to our department and to the service they deliver to patients and to users of the WSFT Blood Transfusion Service and I strongly believe that they deserve to be considered for a Putting You First award.
3.	**Freedom to Speak Up Guardian report – Q2 2022/23**
	Amanda Bennett, Freedom to Speak Up Guardian will present her Q2 report at the Board meeting on 25 November, which is included as an appendix to this item.
4.	**What matters to you 2 – update / progress**
4.1	As previously reported to the Board, we are running several staff involvement programmes over the autumn season and are calling on colleagues to have their say on what matters to them. We know that work pressures continue to have an impact on staff's day to day lives and ideally, we would not have all these exercises so close together. However, the timings for some of them are driven externally or certain deadlines are on the horizon and seeking their views is crucial for the development of some projects. Staff have an important role to play in making positive change happen. The most significant programme as part of this work is *What matters to you 2.*
4.2	The 'What matters to you' staff engagement exercise is returning following the programme carried out in 2020, which originally focused on how Covid-19 had impacted on colleagues and ways of working. The aim is to continue conversations so that we as leaders hear about what is important to colleagues and can take action to improve. Five key themes emerged from the first WMTY staff engagement: • The importance of great line managers • Creating an empowered culture • Building relationships and belonging • Appreciating all our staff • The future and recovery These themes will be revisited in this year's programme, to provide a direct comparator, while also identifying further areas to improve and understanding current issues of the day. In addition to a questionnaire, WMTY drop-in sessions have been running. Individuals who wish to ask questions or leave feedback can attend these. Likewise, if managers want to share more about the WMTY exercise with their teams but want to know more before carrying out a team exercise, attending a drop-session might be useful. A short manager briefing is also being prepared to help guide managers in this way. We are incredibly grateful to all colleagues who have taken the time to either complete the WMTY survey or have spoken to the WMTY engagement team face to face. It has been good being out and about, hearing what really matters to them and what WSFT as an organisation should be prioritising for colleagues.

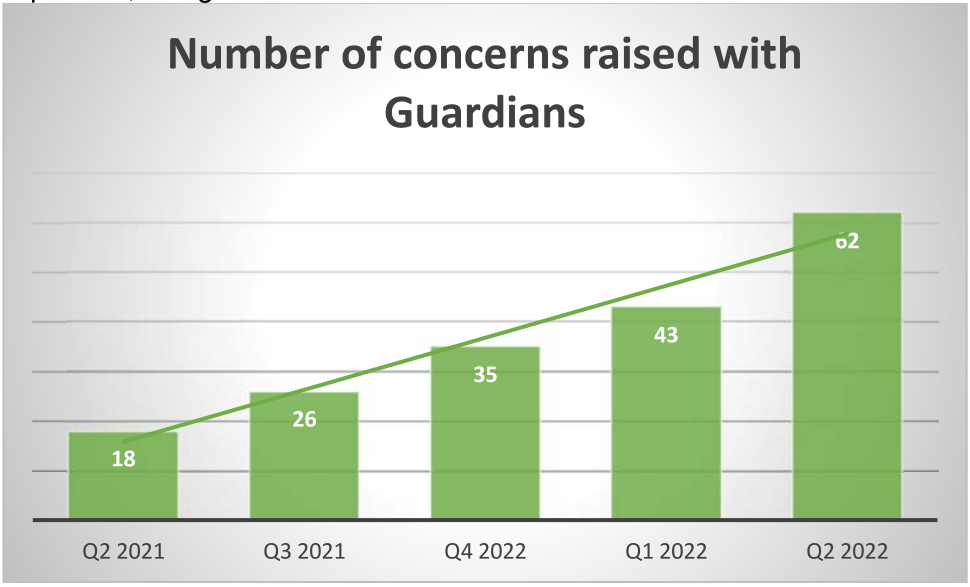
	The WMTY team has been identifying “quick win” changes we can support and influence, that will make a difference to individuals, teams or groups of staff, following feedback. We will keep those teams or individuals up to date with progress. Questions or ideas can be shared anytime via WMTY2@wsh.nhs.uk Furthermore, we have been completing thematic analysis on the larger body of feedback. Every comment has been incredibly useful, and we can see from the listening events held already, that there are some emerging themes: • Developing an empowered culture, including current ways of working • Communication, including being listened to • Leadership and management, including feeling supported and developed in role • Process inconsistency across a range of clinical and non-clinical service areas. The WMTY2 team have spoken to more than 200 staff to date and visited over 19 locations in the community. *Next steps* If any team or department would like a member of the WMTY engagement team to visit your location or to attend a team meeting to support any face-to-face feedback, they can contact WMTY2@wsh.nhs.uk We have taken the decision to extend the listening events to the end of the year and are setting up additional activities on the main West Suffolk Hospital site and in those community locations we have not yet visited.
5.	**Developing and improving our library service**
5.1	In October, the Library and Knowledge Services Team, supported by Estates and the portering team, installed new shelving in our Library at the West Suffolk Hospital site. The effect has really opened up the space making it a much more flexible learning environment. Three separate study areas have been created for users to use installed computers or their own devices, and a large wellbeing area has also been created with comfy seating and a bright leafy view. Feedback from users has been very positive. The library is open for all staff in the Education Centre – board members are invited to visit anytime. 
6.	**Preparing for industrial action across the NHS**
6.1	Board colleagues will be aware of the potential for industrial action across the NHS, as mooted by a number of different trade unions and staff organisations who have been holding indicative ballots

	and making plans for full ballots of their memberships. This has been particularly prompted by the outcomes of the national pay review processes for 2022/23. Within the past few weeks, the Royal College of Nursing has released the results of its balloting process, which has been conducted at an organisational level. As a consequence of this, certain NHS Trusts will see action taken by RCN members and some will not – dependent on the local ballot outcome. At WSFT, the 50% turnout threshold was met and RCN members voted in favour of taking industrial action. At the time of writing this report the RCN was seeking negotiations with the government and has not yet confirmed any dates for industrial action. The NHS has released resources to Trusts to support the work involved in industrial action preparedness. Workforce and Operational colleagues are currently reviewing these as part of our local planning. We continue to foster open, supportive working relationships with staff representatives at West Suffolk which will be a crucial channel of communication, discussion and planning should any action take place. Patient safety will be the overriding priority in terms of our response, whilst supporting colleague's right to take part in legal action. The GMC and NMC have issued updated guidance to their registrants in relation to the topic of industrial action, drawing attention to relevant sections of *Good Medical Practice*, and the *NMC Code of Conduct*, respectively.
7.	**Strengthening our OD capacity and capability**
7.1	This month the investment panel approved funding for the enhancement of learning and organisational development work. This investment will enable new posts to be recruited which will design and deliver leadership and management development interventions, as well as wider staff development support. Plans also include the development of a new online learning area for staff to enable flexible and self-directed learning. Coaching is also a key area of focus which is planned for growth. The investment will also enable an expansion in the support for the health, wellbeing and inclusion agendas, which are growing in significance at the Trust, as well as a focus on career development and succession planning.
8.	**Recommendation**
8.1	To note and provide comment and/or feedback on the report.

Appendix: Freedom to Speak Up: Guardian's Report Q2 2022: October 2022

Introduction

The number of concerns raised with the guardians has consistently increased over the past 5 quarters, rising to 62 concerns in Q2 2022/23.



Data

There have been slight changes in the data required for the National Guardian's office. Data submitted for Q2 is shown below:

Total number of cases	**62**
Raised by professional group:	
Allied Health professionals	1
Medical and Dental	2
Ambulance	0
Registered Nurse and Midwife	15
Administrative and Clerical	11
Additional professional and scientific and technical	0
Additional clinical services	6
Estates and Ancillary	10
Healthcare Scientists	2
Students	0
Not known	14
Other	1

Number raised anonymously	15
Number with an element of patient safety / quality	13
Number with an element of worker safety or wellbeing	40
Number with an element of bullying and harassment	8
Number with an element of inappropriate attitudes and behaviours	16

What were people speaking up about?

15 people spoke up about staffing, 6 about excessive workload, 6 related to a specific incident, 2 concerned with HR processes, 2 regarding pay and 2 regarding insufficient facilities for staff.

Themes from Q2

Themes seen in previous quarters continue to dominate as concerns, the most significant being staffing concerns and workload pressures.

Feedback from staff indicate that there is a feeling that staff are consistently going “above and beyond” and working under excessive pressure. Feedback shows staff’s perception is that this way of working is now expected as normal and not recognised by senior leaders and executives.

Executive walkabouts are very well received, and feedback indicates that visits by senior staff and executives are welcome and reassuring. However increased visibility would be greatly appreciated.

Feedback on the Freedom to Speak Up Process

Following closure of each FTSU case, the person speaking up is sent an evaluation form to report their experience of the process. As of Q2 2022/23 this form has been made anonymous. The figures below show a summary of evaluations received in Q2.

9 responses were received.

7 people said they would not like any further action, and two said they would. One of these was subsequently followed up by the FTSUG, the other had no contact details attached so was impossible to address.

2 people said they suffered detriment. One was anonymous, one has been contacted and the Guardian is working with the individual to identify next steps.

6 said they would speak up again, one said they would not, two said maybe.

The themes emerging from the FTSU process evaluation indicated that it was a positive experience being able to talk to an independent and impartial person, but colleagues are frustrated by the lack of change as a result of speaking up. Staffing in the community nursing teams was highlighted as an area where staff felt nothing had changed as a result of Speaking up.

Feedback also indicated the need to continue focus on changing the culture to enable Speaking up to become Business as usual.
Feedback from the evaluations and from conversations indicate that there are colleagues within the Trust who fear detriment (especially losing their job) as a result of speaking up. Details of the feedback have been shared with the HR Business partners and used for improvement.

Summary of learning points

- There is a need for increased feedback / wider communications to staff at all levels to show how concerns are being responded to and changes made, to maintain and grow trust in the Speak up process.

- Work to enable Speaking up to become "business as usual" is necessary so that concerns can be dealt with as and when they occur.
- More needs to be done to create a psychologically safe working environment to give people confidence in the Speak up process, particularly for those staff in the lower paid bandings.

The Guardian and champions 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:

- Promotion and training continue to be given across the Trust
- New posters displayed throughout the Trust
- Increased visibility by work of Champions and visits to departments by Guardian.
- Guardian has regular presence at overseas induction, preceptorship and expert navy programmes.

Even better if:

- Renewed focus in community areas to promote FTSU and increase the role of the Champion.

Speaking up policies and processes are effective and constantly improved

What's going well:

- New FTSU policy adopted and adapted to suit WSFT in final stages of circulation with policy working group

Even better if:

- WSFT FTSU Policy to be updated and launched by end of year.

Senior leaders are role models of effective speaking up

What's going well:

- Questionnaire developed from the recent NHS FTSU reflection tool to be shared with senior leaders in Q3.
- Senior leaders asked to complete FTSU Follow up training. (link to follow up training)

Even better if:

- Senior leaders responsible for FTSU to complete the new FTSU Reflection and planning tool (published June 2022)
- FTSU pledge to be established for Board (following training)

All workers are encouraged to speak up

What's going well:

- Increasing number of concerns raised to the Guardians and Champions active in teams
- Mandatory Speak up and Listen up Training for managers promoted Trust wide.
- Continued promotion at team meetings to encourage all staff to complete training
- FTSU Champions promoting WMTY2 within their teams

- More teams showing an interest in setting up suggestion boxes to enable Speaking up become business as usual.
- Speaking up promoted at interview stage for overseas nurses

Even better if:
- Culture continues to improve to enable psychological safety

Individuals are supported when they speak up

What's going well:
- Individual's report feeling listened to by the Guardian when raising concerns
- Champions available to support staff to speak up

Even better if:
- Face to face listening training for managers to support e-learning delivery.
- Increased promotion regarding Trust's stance on protecting staff who speak up and a zero-tolerance approach to detriment as a result of speaking up

Barriers to speaking up are identified and tackled

What's going well:
- The difficulty faced by international staff in speaking up recognised and actions taken to try to overcome
- Face to face visits to staff who do not use computers to explain FTSU and introduce Guardian
- Evening session provided to enable night workers the opportunity to access a drop-in session
- Inclusion training booked for Champions

Even better if:
- Increased transparency / openness regarding actions taken as a result of speaking up

Information provided by speaking up is used to learn and improve

What's going well:
- Where possible and obvious, swift action is taken to address concerns, to learn and improve.
- Working with HRBP to implement improvements from feedback

Even better if:
- Changes as a result of speaking up are communicated more effectively, particularly in relation to inadequate staffing levels and staff exhaustion, Staff report feeling that "there is no point in speaking up because nothing changes"

Freedom to speak up is consistent throughout the health and care system, and ever improving

What's going well:
- Guardian co-leading community of practice events for East of England FTSU Guardian Network
- Trust working in line with NHS and NGO guidance on speaking up

Even better if:
- Work with ICS partners to improve FTSU

3. STRATEGY

3.1. Future System board report

To Assure

Presented by Craig Black

Board of Directors

Report title:	Future System Board Report
Agenda item:	3.1
Date of the meeting:	Friday 25 November 2022
Sponsor/executive lead:	Craig Black
Report prepared by:	Gary Norgate

Purpose of the report:			
For approval ☐	**For assurance** ☒	**For discussion** ☐	**For information** ☒
Trust strategy ambitions			
Please indicate Trust strategy ambitions relevant to this report.	☐	☐	☐

Executive Summary

Executive Summary

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

1. Following additional work undertaken to model the impact of the proposed hospital on neighbouring road junctions, a third round of public consultation has been undertaken by our Local Planning Authority (LPA) and concluded on 11th November.
2. As of 16th November, only six additional comments had been received from our public and our application has formally received support from all statutory consultees (Highways, Suffolk Wildlife Trust etc.).
3. Having identified a preferred strategy for compensating the inevitable environmental impact of a new hospital, work is commencing to conclude the mechanism through which the delivery of this strategy can be guaranteed. The delivery of this compensation strategy will be made a pre-commencement condition of planning consent.
4. We remain confident that the actions taken to consult, reflect and respond to concerns and ideas raised throughout the planning process will maximise the likelihood of a positive determination from the planning committee that is scheduled to meet on 30th November.

5. The exercise undertaken by New Hospitals Programme (NHP)[1] and their partners McKinsey, aimed at baselining the realistic costs of delivering new hospitals (termed "minimum viable product") has been completed and its results will be used to inform the national programme business case[2] (PBC) which is scheduled to be presented to the Major Projects Review Group (MPRG)[3] on 6th December.
6. Work within the clinical workstream has commenced to identify a 5th phase of co-production aimed at refining our 1:200 plans in light of the emerging national design standards.
7. We have received additional funding of £300k from NHP to cover the survey work necessary to progress towards full planning consent.
8. West Suffolk remains heavily engaged with colleagues from across the New Hospitals Programme to co-create the aforementioned national standards. The value attached to our contribution can be demonstrated by a request for our teams to remain engaged for an additional 12 week sprint.
9. That said, the next 6 weeks represent a significant watershed for our project as we expect to; secure a determination on our planning application, receive the first of the co-produced national standards / designs and learn the outcome of the PBC presentation (which will inform the likely size of our capital envelope).

Estates Workstream

Securing a positive determination for our planning application remains the most critical risk in our programme and the key developments can be summarised thus:

Modelling of the impact that a new hospital will have upon 5 key road junctions; Spread Eagle, Wilkes Road, Rougham Hill and the East and Westbound junctions of the A14, has been completed and has not highlighted issues likely to undermine our planning application.

In light of the additional information that has resulted from the modelling described above, a third round of public consultation was launched and concluded on 11th November. At the time of writing, six additional public comments had been received, none of which give rise to additional concern.

A Section 106 agreement[4] is in draft and being finalised by legal teams. This agreement will contain a number of commitments that the Trust will need to honour before commencing its build. These include construction of sustainable pedestrian / cycle routes, the posting of a bond for future traffic mitigations (should they prove necessary) and the provision of funds to cover the costs of the development and implementation of various traffic regulation orders. The signing of this document is **not** a condition of the planning determination and so WSFT Board sign-off will be sought independently.

The local planning authority (LPA) have completed their case officers report (COR) and the Council's Democratic Services Department will publish this to the public at some time between 21st and 23rd November.

On 30th November the Planning Committee will sit to hear and determine our application.

Along with the obligations covered by the Section 106 agreement there will a number of pre-commencement conditions applied including the construction of other off-site active travel routes and the realisation of an agreed ecology compensation strategy.

New Hospitals Programme Update

[1] The New Hospitals Programme is the central body appointed by Department of Health to oversee the delivery of the Government's commitment to build 48 'new hospitals' by 2030.
[2] The Programme Business case sets the approach, strategic fit, benefits and budget for the entire New Hospital Programme, i.e. is the case for all 40 / 48 projects in the programme.
[3] MPRG is an advisory panel for His Majesty's Treasury, they provide detailed scrutiny of major projects and advise HMT on the readiness of a programme to proceed.
[4] Section 106 of the Town and Country Planning Act 1990 allows a local planning authority to enter into a legally binding agreement or planning obligation with an applicant as part of the granting of planning permission.

As mentioned last month, our West Suffolk project had been identified as one of five 'architypes' that would be analysed with a view to establishing the costs of building new hospitals. This "sprint" has now been completed and its findings will be used to inform the program business case that remains on track for presentation to Treasury / MPRG on 6th December.

The Programme Business Case has started its journey through the Department of Health and will go through the joint investment committee before being presented to MPRG. On the positive side, the NHP has just passed its latest gateway review conducted by the infrastructure project authorities and has been rated "Amber" which is as good as could be expected until the funding has been agreed (indicating confidence that if funding is provided the programmes objectives are likely to be delivered). That said, the potential impact of the fiscal statement expected in mid-November and the stance adopted by the latest Secretary of State for health remain as risks to the allocation of sufficient capital.

The outcome from the MPRG, if positive, is now expected to provide individual schemes with a capital "range" rather than a specific number. The objective of this range will be to provide sufficient detail to allow the construction of individual outline business cases. The range will to some degree be defined by the planned date for construction – the later the construction the greater the inflationary costs and the greater the expected economies associated with use of the standardised modern methods of construction.

NHP remain on track to deliver the first drop of their "Hospital 1.0" model hospital design in December / January 2023.

This means that the early part of next year will allow the Future System Team to progress with phase 5 of its co-production process aimed at aligning our plans with the standards and capital budget emerging from the NHP.

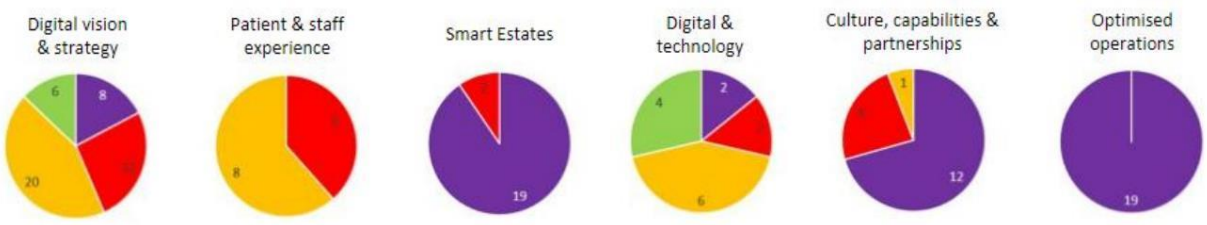
Clinical / Digital Workstream

West Suffolk Foundation Trust was delighted to learn that it has secured funding for the creation of a community diagnostics hub on the site of its Newmarket Hospital. This development provides the potential for services currently provided at West Suffolk Hospital to be provided in an optimal location rather than within a new acute hospital.

This development is similar to the solution being sought for outpatients, endoscopy and radiology, where relocating services to a building such as Western Way removes the need for patients to visit the main hospital site, whilst also exploiting opportunities for colocation of complimentary services. The business case to explore this move is under construction.

All of the aforementioned developments will impact the eventual design of a new hospital and as such will be factored into the next round of co-production which will also seek to reflect the emerging national design standards.

Following a previously reported assessment of WSFT's digital maturity against the NHP intelligent hospital guidance (below), a workplan has been devised to address the gaps identified.



Purple: no information presented; Red: not sufficiently developed; Amber: largely developed; Green: sufficiently developed

A report detailing a range of actions and recommendations is due to be published and socialised in January 2023. The resulting Future System digital strategy will support both the existing Trust digital strategy as well as the ambitions and opportunities associated with the building of a new hospital.

Phase 5 and future iterations of the co-production process will progressively integrate clinical, digital, physical and workforce designs.

Communications and Engagement

As stated above, the case for outline planning consent will be discussed by the West Suffolk Planning Committee on 30th November. In advance of this meeting, we will have constructed three communication streams, each tailored to fit a positive, negative or deferred outcome. All will seek to; re-iterate the need for a new hospital, communicate the outcome of the planning application, thank contributors (staff, public and partners) and outline next steps and how to be involved. Independently, I will personally inform key members of the New Hospital Programme, NHS England, MPs and other senior stakeholders.

Workforce

A critical part of any hospital is, obviously, its staff, and a substantial part of the outline business case will be the revenue costs of staffing the future clinical model. With this thought firmly in mind we have been working towards defining a plan for understanding the future staff and skills needs of the future system. Any such plan needs to reflect all the changes to working practice (e.g.virtual wards), demand and capacity, digital enablement, service adjacencies, new infrastructure etc. that stem from moving to a new hospital / future system. Consequently, we have started by engaging our service managers and co-production leads in the definition of their foreseen resource requirements. The next step will be the agreement of the clinical strategy, the release of Hospital 1.0 and a view of our capital envelope. Armed with this information we then intend to engage the whole Trust and its partners in a formal business planning cycle aimed at producing a congruent view of future workforce, the associated implications and a plan for transitioning to this future state. Unfortunately, our timescales may mean this will need to precede any workforce outputs of the joined-up ICS-wide demand & capacity project, however, it will be pursued cognisant of the system-level work that is also going on.

Finance

Our project continues to progress in line with its defined budget and is expected to outturn the year on target, this includes receiving additional funding of £300k from NHP to cover the survey work necessary to progress towards full planning consent.

Discussions with NHP as to the extent to which they would be able and willing to support solutions that involve leases have concluded positively and, in essence, we are empowered to pursue the optimal solution, rather than slavishly adhering to traditional ‘capital only’ builds.

All in all, this has been a period in which progress has been maintained in the key areas of our planning application, the development of our clinical design and the development and application of national standards. That said, the next period should see the culmination of several key activities:

- The results of the MPRG presentation will be known
- The first national workstreams will start to produce outcomes.
- We will have a determination of our outline planning application.
- We should have a view of capital budget

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

Risk and assurance:	*[Please reference if this relates to a BAF risk or a new risk that is being escalated for the Board's attention or delete line if not applicable]*
Equality, Diversity and Inclusion:	*[Please reference any equality, diversity or inclusion implications arising from this paper or delete line if not applicable]*
Sustainability:	*[Please reference any sustainability implications arising from this paper or delete line if not applicable]*
Legal and regulatory context	*[Please reference any relevant legislation or regulatory requirements in this section or delete line if not applicable]*

3.2. System update - WSFT & ESNEFT Collaboration Report

To Assure

Presented by Nicola Cottington

Board of Directors

Report title:	**West Suffolk NHS Foundation Trust (WSFT) and East Suffolk and North Essex NHS Foundation Trust (ESNEFT) collaboration report**
Agenda item:	3.2
Date of the meeting:	25.11.22
Sponsor/executive lead:	Nicola Cottington, chief operating officer
Report prepared by:	Dr Shane Gordon, director of strategy, ESNEFT Nicola Cottington, chief operating officer, WSFT Neill Moloney, managing director, ESNEFT

Purpose of the report:			
For approval ☒	**For assurance** ☐	**For discussion** ☐	**For information** ☐
Trust strategy ambitions			
Please indicate Trust strategy ambitions relevant to this report.	☒	☒	☒

Executive summary:	The 2019 NHS Long Term Plan set out a "duty to collaborate" which was further developed in Working Together at Scale (2021), which requires NHS providers to be part of one or more provider collaboratives. This paper has been jointly produced by WSFT and ESNEFT and summarises the collaborative working between the two Trusts to date, including the two Board-to-Board meetings which have taken place. Clinical and operational collaboration has already led to benefits for the population we serve, demonstrated by a case study of orthopaedic services. Further areas for collaboration have been identified and the paper proposes a draft vision and principles for this work. It is recognised that there is a need for a shared programme function to be resourced to facilitate further work and more detailed proposals will follow. The same report is being presented to both boards.
Action required/ recommendation:	The Boards are recommended to: 1. Note the progress of collaboration to date and the themes for future work. 2. Agree the Vision, Principles and Ways of Working. 3. Agree the establishment of a collaborative oversight mechanism, with detailed proposals to follow. 4. Support the development of shared programme support for the priorities identified at the October Board-to-Board and provide regular reporting on

	collaborative activity to both Boards. Further proposals for joint investment will follow.

Previously considered by:	ESNEFT board in public 3rd November 2022
Risk and assurance:	Working collaboratively provides opportunities to address critical risks together, at a larger scale. There is relevance to all risks on the Board Assurance Framework.
Equality, diversity and inclusion:	Equality, Diversity and Inclusion was one area considered for the sharing of good practice and learning between the two organisations.
Sustainability:	Working together to ensure the most efficient and effective use of our collective resources would contribute to a more sustainable health care system
Legal and regulatory context:	Both Trusts are legal entities and subject to the regulatory framework

Trust Boards in Public

November 2022

Report Title:	WSFT & ESNEFT collaboration report
Report author(s):	Dr Shane Gordon, Director of Strategy, ESNEFT Nicola Cottington, Chief Operating Officer, WSFT Neill Moloney, Managing Director, ESNEFT

Purpose

This report provides our Boards with a summary of collaborative activity and proposed next steps for collaboration between West Suffolk NHS Foundation Trust (WSFT) and East Suffolk and North Essex NHS Foundation Trust (ESNEFT).

Background

The 2019 NHS Long Term Plan[1] set out the need for all providers to contribute to the success of their integrated care systems (ICS). It set out a 'duty to collaborate' which was expanded in the 2021 guidance Working Together At Scale[2] which created a requirement for all NHS providers to be part of one or more provider collaboratives by April 2022. The 2022 Health and Care Act[3] removed the requirement for competition between providers and the need for collaboration was further reinforced in the 2022-23 NHS planning guidance[4].

Collaborative working to date

During the COVID-19 pandemic and subsequently, WSFT and ESNEFT have successfully supported each other with mutual aid in elective care services including Orthopaedics, Urology, Ophthalmology, ENT and Gynaecology. A joint elective care committee has been established, with co-chairs and there has also been joint working in relation to procurement.

In May 2022, a Board-to-Board meeting was held between our Trusts to review the potential for further collaboration. At this meeting the Boards discussed the importance of collaboration for the sustainability of our services and the equity of access to high quality care in our Integrated Care System. Six areas for continuing collaboration were identified:

- Clinical and clinical support services
- Workforce Development
- Estates & Facilities
- Corporate Services
- Organisational policies and protocols

[1] NHS Long Term Plan v1.2 August 2019, NHS England
[2] B0754-working-together-at-scale-guidance-on-provider-collaboratives.pdf (england.nhs.uk)
[3] Health and Care Act 2022 (legislation.gov.uk)
[4] 20211223-B1160-2022-23-priorities-and-operational-planning-guidance-v3.2.pdf (england.nhs.uk)

- Digital infrastructure

Two case studies of existing collaboration are provided at Appendix 1.

At a second meeting, in October 2022, our Boards reviewed progress in collaboration to-date and considered what further action was needed. Key themes from this meeting were:

1. **The need to make our collaborative work visible** and to engage our staff, governors and communities, and to celebrate and promote our successes. A regular report should be provided to both Boards on collaborative activity.
2. **The need to recognise the diversity of cultures and expectations** in our Trusts and communities.
3. **The support required for bottom-up collaboration led by clinicians and services**. The need to identify and support champions of collaborative working.
4. **The desire to develop our shared strategic focus including collective vision, principles and ways of working**, the development of a joint oversight mechanism, investment of resources to facilitate change including programme support.

Our Boards identified some priorities for future collaboration:

1. The selection and implementation of an Electronic Patient Record (EPR) for ESNEFT, in collaboration with WSFT. This was recognised as a key to the standardisation of practice and reduction of variation which is critical to quality of care. It is a key enabler to the integration of care across the ICS. Collaborative planning is required in the short and long term.
2. Collaboration and improvement in equality, diversity and inclusion (EDI) was identified as a moral priority for our staff, patients and communities. There are opportunities to share learning and work jointly between our staff networks.
3. Collaboration in the development of virtual wards. The Boards recognised the importance of standardisation of clinical protocols and pathways, governance structures and the opportunities to create shared workforce plans, recruitment and training activity, and even joint appointments. The Boards acknowledged the good work already underway to share learning in 2022/23 and identified the development of a common operating model as a priority for 2023/24.

Next steps

To support further collaborative work, our Boards are recommended to:

- adopt a shared vision for collaboration between WSFT and ESNEFT, recognising that this collaboration is part of a wide network of collaboration between NHS and other public sector organisations;
- adopt common Principles for collaboration;
- establish a minimum level of governance through a collaborative oversight mechanism; and
- create a share programme support function to support the development of a shared vision

Draft Vision

Our shared vision is:

As integrated Acute and Community Trusts and anchor organisations, we are uniquely positioned to improve the health and care of our communities. Working together and learning from each other we will offer the highest quality and access to care for the people of Suffolk and north-east Essex. We

will work collaboratively to reduce variation in the services available to our communities and to improve the wider determinants of health.

Draft Principles for Collaboration

Our proposed shared principles are:

1. We will work together to deliver the best quality and access to care.
2. We will challenge and hold each other to account for the delivery of our vision.
3. We will make shared decisions where this supports positive transformation, improves sustainability of services for our communities and reduces variation in quality. We recognise and respect our separate duties and accountabilities, acknowledging that we will need to act separately in other matters.
4. We will support and empower our staff to work together, for the benefit our patients and communities, through standardising care and reducing variation in quality.
5. We recognise the importance of clinical leadership and governance in all our work, and the vital role of operational leadership in delivering high-quality, sustainable services.
6. We will actively involve our staff, patients, partner organisations and communities in our work.
7. We will take shared responsibility for delivering agreed priorities and managing risks.

Oversight of collaborative work

Our Boards have identified the need for shared oversight of collaborative work. A number of models from informal oversight to formal joint governance have been shared with the Boards. Our Boards have expressed the desire to avoid the development of complex governance structures in the short term, due to the risk of distraction from the immediate challenges of the care of our patients, whilst acknowledging that some shared oversight is now desirable. Proposals for this will be developed and presented to our Boards in due course.

A shared programme support function

Our Boards recognised the need for a shared programme support function, to co-ordinate collaborative activity, support and facilitate services to plan and work together and provide regular reporting and insight on progress. There was recognition that joint investment would be required to give this sufficient impetus, and the ICS will be requested to offer support. Detailed proposals will be presented to our Boards in due course.

Recommendations

The Boards are recommended to:

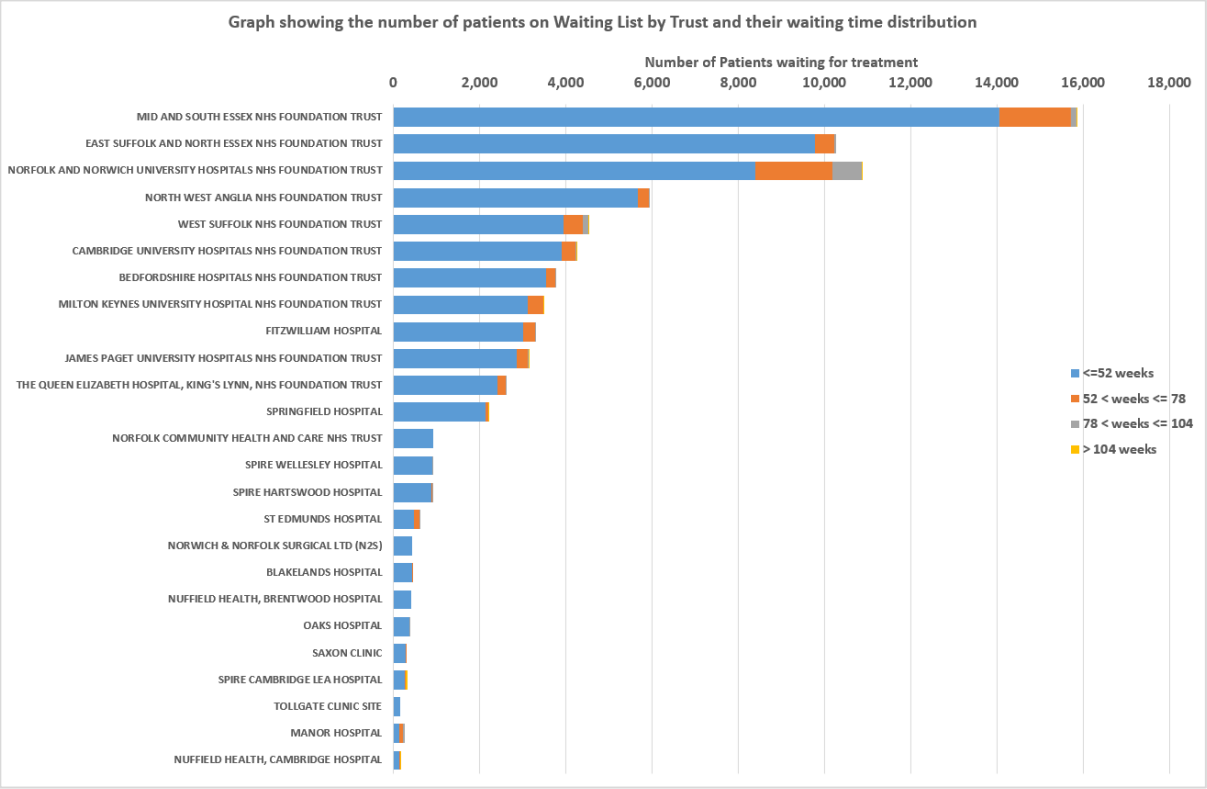
1. Note the progress of collaboration to date and the themes for future work.
2. Agree the Vision, Principles and Ways of Working.
3. Agree the establishment of a collaborative oversight mechanism, with detailed proposals to follow.
4. Support the development of shared programme support for the priorities identified at the October Board-to-Board and provide regular reporting on collaborative activity to both Boards. Further proposals for joint investment will follow.

Appendix 1 – collaboration case studies

Case study 1: Orthopaedic services

During the last year, orthopaedic services at WSFT and ESNEFT have collaborated to treat our longest waiting patients for hip and knee surgery, reducing unwarranted variation in waiting times. This included surgeons operating on some of their patients at a different hospital. As a result the proportion of very long waits in both Trusts is now significantly better than in most of the region:

ICS	*Patients waiting (Aug 22)*	*Patients waiting 52+ wks*
BLMK	8,313	863 (**9.3%**)
C&P	14,102	1,048 (**6.9%**)
MSE	20,361	2,037 (**9.3%**)
N&W	18,036	3,744 (**16.5%**)
SNEE	15,961	1,445 (**7.8%**)



Source: NHS England Consultant-led Referral to Treatment Waiting Times Data 2022-23 (August 2022) Statistics » Consultant-led Referral to Treatment Waiting Times Data 2022-23 (england.nhs.uk)

On the 18th October, clinical and operational leaders in orthopaedics and anaesthetics met to discuss strategy for musculoskeletal services in SNEE. Supported by executives from both Trusts, they considered the challenges facing our services and communities due to the likely growth in demand for hip and knee replacements (up to 25% over the next 20 years) and how we should approach the development of our services in terms of the model of care, workforce, governance, innovation and technology.

Significant priorities were identified for a shared approach to planning and working, including:

- The critical importance of adopting the same Electronic Patient Record (EPR) system to enable collaborative working
- Standardisation of clinical practice.
- A common approach to the use of virtual care, patient portals, self-care apps and wearable technology to improve the engagement of patients in their own care, reduce outpatient contacts and increase access to services.
- Rationalisation of surgical implants and a combined procurement for these.
- A combined approach to recruitment, education and training of staff.

Case Study 2: Procurement

The working relationship between ESNEFT and WSFT Procurement teams has continued to develop with momentum over the last 12 months. The overarching aim is to align the functions to reflect the strategic objectives and benefits as promoted in NHSE's ICS Procurement Target Operating Model (PTOM) and more recently the newly formed Central Commercial Function (CCF). Recent progress includes the joint decision to standardise our procurement systems and data sets. This involves both ESNEFT and WSFT transitioning to the Atamis Online Procurement System, which will provide transparency on our contracting activities and increase our opportunity to undertake collaborative procurements to achieve both quality and value for money outcomes. Other strategic developments include a joint plan to develop and implement the PTOM over the next 2-years, the introduction of Social Value, Zero Net Carbon, and Sustainability into all tender activity, and the alignment of quote and tender thresholds policy to achieve standardisation of processes and to utilise resources more strategically.

Global supply constraints, especially relating to clinical supplies, continue to present real and tangible problems that can impact the ability to provide healthcare to patients. Our Clinical Procurement and Materials Management Teams (stock replenishment) have developed processes that quickly identify and source alternative substitutes to ensure patient procedures can continue as scheduled. Where alternative sourcing is not possible, we have developed effective escalation procedures for mutual aid across our ESNEFT and WSFT hospital and community sites.

Working in collaboration with WSFT enables both Trusts to review non-clinical supply opportunities for joint procurements and efficiencies. Examples include:

- ✓ Minor Works
- ✓ Digital Histopathology Project - which has created a network between West Suffolk and ESNEFT for the sharing of digital clinical images within Pathology. This project has been completed and is being implemented. This also has the scope to incorporate NNUH in the future.
- ✓ Coagulation Blood Testing
- ✓ Laboratory Information Management Systems
- ✓ Electronic Patient Records

Clinical Procurement is progressed via regular meetings between the procurement teams at ESNEFT, WSFT and NHS Supply Chain. Examples include:

- ✓ Minimal Invasive Surgery – Working across the provider Trusts we implemented a standardisation programme for surgical stapling and energy devices with Johnson & Johnson which is delivering both financial and clinical outcome benefits
- ✓ Wound Care – Suffolk Wide wound care formulary, now working to incorporate North East Essex with a ICS based formulary in 2023

- ✓ Needle Free Devices – Standardised product in use across ICS delivering both training and financial benefits
- ✓ Patient Appliances – Continence – working with ICS medicines management team to align products used in hospital to those available via community formulary
- ✓ Mutual Aid – Working closely during supply disruption to support each organisation with inter-site transfer of products and replacement
- ✓ Trauma & Orthopaedics – Sharing best practice and looking for opportunity to collaborate

The Procurement Departments at ESNEFT and WSFT have an excellent working relationship with collaboration at the heart of everything we do. Our current phase of development is the implementation of the joint PTOM plan that will deliver greater integration of our processes across the SNEE ICS and improve resource utilisation.

3.2.1. Alliance

To inform

Presented by Clement Mawoyo

West Suffolk NHS Foundation Trust Board Meeting

Report title:	**West Suffolk Alliance Committee – October 2022**
Agenda item:	3.2.1
Date of the meeting:	25 November 2022
Sponsor/executive lead:	Clement Mawoyo
Report prepared by:	Rebecca Jarvis

Purpose of the report:			
For approval ☐	**For assurance** ☐	**For discussion** ☐	**For information** ☒
Trust strategy ambitions			
Please indicate Trust strategy ambitions relevant to this report.	☐	☐	☒

Executive summary:	
Action required/ recommendation:	This report is provided to the WSFT Board to give an overview of the work taking place across the wider West Suffolk Alliance. Additional or any specific information can be obtained from either Clement Mawoyo or Peter Wightman.

Previously considered by:	
Risk and assurance:	
Equality, diversity and inclusion:	
Sustainability:	
Legal and regulatory context:	

WEST SUFFOLK ALLIANCE
about people & places

Alliance Committee October 2022

Aims:

- Empower people to live healthy and connected lives
- Create environments that enable people to thrive
- Develop services that are joined up, accessible, responsive and wrapped around people and families in the communities in which they live

Part A – delegated ICB responsibilities

Virtual Ward Business Case
The Committee received and approved the business case for Virtual Ward transferring the funding from the ICB to WSFT. The Committee were assured the mitigation of risks associated with the go live date would support the soft launch as planned in mid November for full delivery by December.

Alliance Finance Report
The Committee were presented with the Finance Report - Delegated Budgets at Month 06 (September 2022). The forecast for year-end is an underspend of £268k which is mainly driven by underspends in Mental Health offset by a small overspend in Community. YTD variance driven by timing differences on expenditure plans and non recurrent prior year benefits.
Although Primary Care is showing an underspend of £94k it is driven by

- Higher than predicted prescribing cost and arising price pressures relating to Category M drugs causing £576k cost pressure by year-end.
- Currently offset by a £41k surplus year end creditor, as final actual costs for 21/22 were lower than estimated, and an underspend of £200k on the Additional Roles Reimbursement Scheme (ARRS) in delegated GP budgets.

Personalisation – Community Wellbeing
The Committee approved utilisation of uncommitted funds from the Community Wellbeing Fund top up the existing funding for a dedicated post in the west for one year.

Part B – improving health through partnership

Live Well Domains
The Committee received and approved a paper outlining the approach to implementing the Domains across the Alliance

Mental Health Collaborative – update on Dementia
The Committee received a report on the implementation of the Dementia Strategy, the assessment and diagnostic pathway and associated performance challenges. The Committee sought that the collaborative aligns with the Live Well Domains to deliver the ambitions of the strategy. Noted the long waiting times for dementia diagnosis and business case to level up with I&E Suffolk.

Primary Care Medicines Rebate Scheme
The Committee were advised on the list of rebate schemes we have signed up to as a system which will be visible on the website. The Committee endorsed the recommendations and requested the overarching policy to come back to a future committee meeting.

Healthy Behaviours
The Committee agreed in principle to submit a consortium bid in response to the Healthy Behaviours procurement led by Public Health at Suffolk County Council. The Committee agreed that action was required to identify what resource was required to develop this bid.

Peter Wightman- Alliance Director October 2022

WEST SUFFOLK ALLIANCE
about people & places

Alliance Committee November 2022 Aims:

- Empower people to live healthy and connected lives
- Create environments that enable people to thrive
- Develop services that are joined up, accessible, responsive and wrapped around people and families in the communities in which they live

Part A – delegated ICB responsibilities

Director update
The committee received and noted update from the Alliance Director on Primary care and medicines optimisation. Future reports to include more details of PCN Additional Roles and medicines optimisation budget and performance action plans
The committee explored how to better understand and respond to pressures in primary care as a system. A "perfect week" concept is being developed to take this further.

Seasonal plan
The committee reviewed and approved the seasonal winter plan and associated funding streams and noted the risks to delivery and their mitigations.

Part B – improving health through partnership

Live Well Domains
The Committee approved the proposed leadership model of each Domain and acknowledged the alignment with the development of the ICP strategy and joint forward plan. Draft Domain plans will be shared at Committee meetings in December, January and February and final plans sign off at the March Meeting.

Premises
The Committee approved in principle the case for Hardwicke House development to address primary care capacity issues in Sudbury.

Diabetes performance in primary care
The Committee received a report on compliance with the 8 care processes showing WS data below national average, but improving. A recovery plan was presented. Reporting errors have been identified, including links with WSFT laboratory and these are being remedied urgently. Committee to review in December or January the progress with this.
The group also noted the prevention agenda to increase referrals to the National Diabetes Prevention Programme.

Third space pilot – working at the primary and secondary care boundary
Monoclonal Gammopathy of Uncertain Significance (MGUS) is a blood condition affecting 3% of people aged over 50 years with about 1% developing myeloma. The project is testing a new pathway to work virtually across primary and secondary care to monitor patients and thereby improve safety and prevent avoidable attendances. The project needs to increase scale to achieve value for money. A 2nd pilot year is needed to allow this to develop and be demonstrated. The Committee requested the project team seek external funding for year 2, noted that the ICB will underwrite the cost in year 2 (c£164k) and that larger scale be tested across ICS or for wider patient group in WS.

Peter Wightman - Alliance Director November 2022

Highlights of Groups reporting into Alliance Committee (October)

Cross cutting themes

Quality Group

The Committee received a report from the Quality Group that outlined the following updates:

- Quality assurance/patient safety visit to WSFT and Newmarket Hospital with a focus on falls and frailty was undertaken in October
- Infection Prevention and Control surveillance continues and new governance framework for the ICB awaiting sign off
- Two primary care CQC inspection reports received with Good ratings

Start Well Domain (Sponsor: Garry Joyce) (from J Mills)

- Development of a Start Well workshop to identify key partners in shaping the local priorities, taking the learning from Northeast Essex.
- With the increasing pressures on Special Educational Needs placement, a specific piece of work identifying the organisational responsibilities for therapeutic intervention. This will be undertaken in collaboration with West Suffolk Foundation Trust, Suffolk County Council and other key stakeholders
- Deep dive into the increasing pressure for Neurodevelopmental assessments and how this can be addressed as a system. This will include the role of both the respective diagnostic services and voluntary providers, who deliver the commissioned early intervention offers.

Be Well Domain (Sponsor: Ian Gallin/Kathy Nixon)

VCSE network and engagement –Community Discovery report completed and shared with Alliance Delivery Groups. Next steps are to develop a communication and engagement plan to consider how to use the findings inform our longer-term approach to how we work with communities

- Volunteer MDT that was stood up to bring the voluntary sector together at place is now renamed as a VCSE network meetings , this continues to have good engagement from contacts across the VCSE. Additional funding to develop this further as part of the system approach to supporting flow and discharge.

Integrated health and activity

Three new managers have started in post in Haverhill, Sudbury and M&B appointed to rollout physical activity model in 3 localities in West Suffolk. Leadership group agreed to consider approach to work with wider system to agree priorities for increasing activity across population.

Social Prescribing core design team

Recruitment complete for additional Life-Link Co-ordinators within Integrated Neighbourhood Teams

- Service spec written and signed off for green social prescribing with Green Light Trust as part of redesign test and learn and supporting flow and discharge. Plan to take to PCN and high intensity user MDT next month
- inequalities data has been framed into a database for LifeLink social prescribers to take a needs-based approach to developing a case load

Stay Well Domain (Sponsor: Nicola Cottington)

Operational Resilience Group - The Committee was informed of the following updates:

- The ambulance service continues to be challenged with demand and response times remain a concern. Our work supporting the waiting stack is therefore an important element of our system plan
- Focus this month was on Discharge with feedback of the system wide review and the recommendations to improve discharge capacity and reduce length of stay
- The Group noted and welcomed the impact of the County Council plan to improve the resilience of the home care market particularly in our rural areas
- The Group were pleased to learn that the new social prescriber post at West Suffolk Hospital was now in place supporting the discharge pathways
- The West Suffolk Urgent Community Response Service (UCRS) is meeting well beyond the national target of >70% response with 2 hours (91.37%)
- The system will shortly be providing support to the ambulance service by taking patients from their waiting stack and expected to commence early November.
- The Virtual Ward is expected to soft launch on 14 November with focus on respiratory and frailty, intravenous antibiotics and Acute Kidney Injury
- Support has been agreed from the Local Government Association to work with west Suffolk partners to undertake a system review of our admission prevention services
- The Frailty Assessment Hub is progressing as planned aiming to go live 5 days a week in early November within the Same Day Emergency Unit – the Hub will not be able to operate 7 days a week this winter due to Consultant Geriatrician capacity. The Hub will provide proactive support to urgent care pathways and form part of our Directory of Services offer to NHS 111
- Work is about to commence on strengthening the integration of the UCRS at Integrated Neighbourhood Team level and developing locality based urgent care teams.

Population Health Management

- Task and finish groups progressing through the implementation of the waiting well T&O project. Go live is predicted to be early 2023. The trust has created a draft website for First Outpatient appointment average waits per speciality. Plan is to build upon to include estimated waits for surgery.
- Cerner have started the mapping exercise of primary care data for inclusion into the PHM dataset. Starting with Glemsford, Breckland and Forest Heath practices. This exercise is lively to take approx. 3 months.
- Atrial Fibrillation – DSA complete and dataset shared with University of Essex for evaluation. EAHSN bidding for funds to extend the work – decision due in early November.
- Frailty risk stratification – Follow-up care complete and letters in progress (n=30) to be sent. Data collation and evaluation underway. Respiratory risk stratification – Agreed to focus on Breckland PCN service gaps initially.

Future System community group

The first round of the patient questionnaires to establish Denosumab patient satisfaction prior to service transfer are underway. This will produce the baseline for evaluating any patient satisfaction changes going forward.

- The additional on line workshop to discuss the locality needs within Mildenhall, Lakenheath and Brandon took place on 6th October with a good attendance count. Work currently underway to collate all feedback ahead of next step plans.
- Demand and capacity modelling for the community services (including adult social care) remains on track and the decision was taken at the last meeting to continue as the output is so valuable, It will be reviewed every two weeks and an end date agreed when either we have a date to start the next phase of the OBC for the FSP or we are reaching the end in terms of its benefits.

Diabetes Recovery Group

The Group is specifically focussing on recovery of delivery of the 8 primary care processes. Latest data (based on the 19 practices extracting to eclipse) is showing a stepped improvement bringing West Suffolk above the national average but clearly there is more that needs to be done to bring us back to near pre Covid performance including understanding the lessons learnt from the delivery model implemented in North East Essex. The recovery plan in place aims to provide a detailed summary next month of the root cause of the performance issues and opportunities for improvement

Age Well Domain, Sponsor: Clement Mawoyo

Frailty Steering Group –The Frailty Steering Group has adopted the following west Suffolk system priorities:

1. Frailty framework – To adopt a pan Suffolk framework developed initially by east Suffolk and amended by west Suffolk partners
2. Education and training - adopt the national training, and associated Frailty Competencies split into two in year actions: Education and training implementation for healthcare - including the request to add to mandatory training and to include in WSFT induction. Broader roll out of education and training (to include communications plan) for Care homes, community health and social care teams, primary care, Integrated Neighbourhood Teams, Voluntary & Community Sector, Public Health, East of England Ambulance Service Trust
3. Frailty Virtual Ward and the frailty pathway

Die Well Domain, Sponsor: Sue Wilkinson

End of Life Programme Group –, A 5 Year action plan now agreed and informed by Health Watch Report 2022, WSFT 2022 National Audit of Care at End of Life report, Long Term Plan, National Ambitions for Palliative and EOL Care and aligned to the ICS EOL Strategy. It has been coproduced through a series of workshops locally and outlines 6 fundamental ambitions. The detail of this plan will be presented to the Committee in December as part of the Die Well Domain.

- The specific Year 1 2022/23 priorities are outlined below

Outcome	Deliverable	RAG
Early identification and Personalised, compassionate care	Implementation of ReSPECT – a process creating personalised recommendations for a person's clinical care and treatment in a future emergency in which they are unable to make or express choices. These recommendations are created through conversations between a person, their families, and their health and care professionals to understand what matters to them and what is realistic in terms of their care and treatment. A dedicated resource in place supporting this across the ICS	
A single digital care record	Test and Learn of RoSi – a single record that can be accessed by all authorised people including the patient, informal carers via any device. West Suffolk are leading the way nationally to test this APP with potential, subject to evaluation, to roll out across the ICS from next year.	
Delivery of enhanced 24/7 support that is coordinated	Training and Education Specialist helpline Implementation of Hospice Enhanced Team	

Digital Domain - Current Sponsor Clement Mawoyo

Digital Change –The digital change group agreed the following key priorities : clinical leadership, shared evaluation, governance and communication.

- The first draft of an evaluation model for digital change, using a logic model approach, has been developed with engagement from leads across the ICS/West.
- A range of engagement was delivered across the workforce, across the acute and in the community.

3.3. Digital Board Report

To Assure

Presented by Craig Black

Board of Directors

Report title:	**Digital Board Report**
Agenda item:	3.3
Date of the meeting:	Friday 25 November 2022
Sponsor/executive lead:	Craig Black, Interim CEO
Report prepared by:	Sarah Judge, Deputy CIO

Purpose of the report:			
For approval ☐	**For assurance** ☒	**For discussion** ☐	**For information** ☐
Trust strategy ambitions			
Please indicate Trust strategy ambitions relevant to this report.	☐	☐	☐

Executive summary

This paper provides an update on items discussed at the digital board meeting of 6 October 2022.

Action required

None.

Recommendation

The Trust Board is asked to note the report.

Previously considered by:	n/a
Risk and assurance:	n/a
Equality, Diversity and Inclusion:	n/a
Sustainability:	n/a

Legal and regulatory context:	n/a

Update from Digital Board

The Trust's digital programme is governed under four pillar programme groups as shown below:

- Pillar 1: Clinical systems
- Pillar 2: Population health and single care record
- Pillar 3: Community digital programme
- Pillar 4: Infrastructure

The digital board continues to oversee the entire digital programme, and this paper describes items that were discussed at the digital board meeting on 6 October 2022.

General update

The digital board noted the increasing complexity of the digital programme and the significant amount of work that both clinical and infrastructure teams are undertaking. The e-Care programme in particular remains challenging with regards to the number of projects in the pipeline and the complexity of managing the domains to ensure that these are both designed and tested to an appropriate level prior to any go lives. The e-Care programme is made up of departmental and outpatient improvements as well as any transformational projects that need implementing. These will benefit the Trust now and prepare us for new technologies that can be used in the Future System programme. Most recently, the e-Care team have been working to create one of the more digitally advanced approaches to virtual wards that will enable clinicians to work from within e-Care (Cerner Millennium) seamlessly. The next phase of e-Care projects includes deployments in critical care and update to outpatient functionality.

There are a number of infrastructure projects underway to leverage our Microsoft licensing spend, including the further rollout of security features and updates to our Microsoft Office estate. The technical teams continue with a strong focus on cyber security and DSP Toolkit approval as well as ongoing measures to address new cyber threats.

A revision to the digital governance structure is underway with proposal due to be presented to the next Digital Board meeting. It was agreed that the Digital Board would provide direction and recommendations based on internal divisional business plans, with alignment to the Trust, Alliance and ICS strategies.

Community digital programme

A proposal had been put to the pillar three programme group to close pillar three in the face of a revision to the digital governance structure, and some resource challenges. This was agreed, with the few outstanding projects being diverted to report into other pillars. This was discussed at length to ensure that there was no loss of focus on community digital projects. It was emphasised that most projects within the pillar three programme group were actually supporting transformational or infrastructure change across the Trust as a whole and very

few impacted community services in isolation. It was agreed that the other programme boards would support this trust wide approach to delivering digital projects and programmes and that some key members of staff will remain focused on the community division.

The team continues to work closely with the SystmOne support service provided by ESNEFT in the delivery of the SystmOne EPR, including monitoring of performance and support of transformational and contractual projects.

Operational digital services

The digital board received an update on business as usual activities undertaken by teams in digital services. This highlighted the immense workload required from the teams to 'keep the lights on' and whose resources are often involved in project work as well. This is particularly well highlighted through the tremendous work the teams have done to support the virtual ward programme that is due to go live imminently.

Data and the wider digital programme

The health information exchange (HIE) has made significant developments including the contribution of the Norfolk and Suffolk NHS Foundation Trust (NSFT) mental health data and further updates for both Suffolk County Council and CUH data that is included.

The information services team are in the process of procurement for a replacement data warehouse with a business case submitted to the capital strategy board that took place in October 2022.

The board also received update on the ROSI (Record Once Share Insight) project - the strategic platform for shared care plan information that can be used across different organisations. WSFT has played a key role in the operation and supporting delivery locally in collaboration with the ICS team leading on the project.

Future System programme digital update

The Future System programme now has a dedicated digital workstream lead who provided an update on the current work stack. A number of assessments and deep dives have been completed in preparation for a Future System digital strategy which will support the existing Trust digital strategy (2022-2026). This will provide the roadmap for our digital ambitions in the new hospital and how we support care differently in the west of Suffolk.

The Trust is at a high level of digital maturity in comparison to some other NHP Schemes, which will allow WSFT to focus on future technologies. Similar techniques for sharing of learning are coming out of the NHP and we should be in a good position based on our GDE programme, blueprinting and national programme work that was undertaken previously.

Learning from others

Staff from across the Trust attended the Oracle Cerner Health Conference in Kansas during October. There was a particular focus on looking at digital technologies that will be available to support the Future System programme as well as supporting operational challenges with digital technology. The trip included a site visit to a hospital in New Jersey that utilises

technologies that will be key to success in the new hospital such as smart rooms, wayfinding and asset tracking. Feedback from the conference will be available at further Digital Board meetings.

11.40 COMFORT BREAK

4. ASSURANCE

4.1. Insight Committee Report - 7 November, 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 November 2022
Chaired by	Richard Davies	Lead Executive Director	Nicola Cottington

Item	Details of Issue	For: Approval/ Escalation/Assurance	BAF/ Risk Register ref	Paper attached? ✓
Patient Access Governance Group Report	Lot of positives in relation to progress on: - Elective 104 and 78 day waits (13 patients over 104 weeks at end of September, all due to patient choice or being unfit. Ahead of trajectory for 78 week waits with 100 patients forecast at end of March 2023) - Community wheelchair service - Stroke metrics - Diagnostics (CT, Echo, Ultrasound) Concerns remain about endoscopy and MRI. Action plan in place for endoscopy and discussed as possible target (perhaps alongside other diagnostics) for future internal audit (see below re MRI) Concerns also regarding 12 hour waits in the Emergency Department, an increasing trend with 572 in September. Plan to be shared at Medicine Divisional Board and to come to Insight committee in December.	**Assurance**	**BAF 3**	
Finance and Workforce Governance Group Report	Trust continues to aim for financial break-even this financial year. However, there are recognised risks to this position, and emerging risks in relation to current national financial challenges. Importance of ongoing transparency emphasised to ensure there are no unexpected surprises at the end of the financial year Issues raised: - Need for clear process for prioritisation around investment funding for the next financial year, informed by the Trust business planning process - Following an incident where a contract was signed without correct authority, the need to review and re-emphasise the scheme of delegation, appropriate controls and staff training	**Assurance**	**BAF 5**	

Cancer Standards Deep Dive	Thorough articulation of those areas where cancer targets are not currently being met, with good assurance that the problems facing cancer services are understood within the Trust and that there are clear plans in place to mitigate the challenges. Key messages: - 2WW target will be removed at some point over the next 12 months by NHSE with, instead, a focus on the more clinically relevant 28 day diagnostic and 62 day treatment targets - For WSFT focus needs to be on 28 day diagnostic target – as performance from diagnosis to treatment within the Trust is good. September performance for 28 day diagnostic target was 67.2% against the target of 75% with a variable trend and non-compliance with the target over the last 18 months. - Colorectal, skin, and urology are areas of particular challenge, however there are plans in place to improve performance in all of these areas (for example: colorectal – focus on evidence based triage and appropriate diagnostic pathways, working with primary care colleagues on FIT testing in the community, and work on CTC and lower GI endoscopy; urology – plans for specialist nurse led prostate biopsy service; skin – further refinements in the successful AI diagnostic pathway)	**Assurance**	**BAF 3**	
Community Paediatrics Deep Dive	An important discussion on the very real challenges faced within community paediatrics as a result of increasing workload, pressures on other parts of the system (education, CMHS, primary care) and difficulties filling staff vacancies. It is clear that this is very much a system (and national) problem Key messages: - Staff within the service are working effectively to triage and treat those children who are at most need (for example children with complex health and developmental needs) - Main challenges are around the diagnosis and management of children with possible neurodiversity problems such as ASD - Whilst some actions have been proposed – the situation is complex and it has been agreed that in the first instance a detailed review of	**Partial Assurance**	**BAF 3**	

	the service using external expert resource should be commissioned prior to development of a formal action plan. It was acknowledged that this will not be a quick-fix – and it was agreed that progress will be reported back to Insight in 3 months. In the meantime performance will continue to be monitored through PAGG and the IQPR			
MRI Recovery	MRI is a key (and increasingly important) diagnostic modality and capacity is significantly limited at present. Options for recovery were discussed – including the favoured option of a new scanner and interim use of a mobile scanner. This proposal is subject to further work prior to submission of a formal business case – but it is encouraging to see that there are plans and options to improve MRI performance	**Partial Assurance**	**BAF 3**	
Date Completed and Forwarded to Trust Secretary		**11.11.22**		

4.1.1. Self Certification

To Assure

Presented by Nicola Cottington

Board of Directors

Report title:	**WSFT Elective letter gap analysis submission**
Agenda item:	4.1.1
Date of the meeting:	25.11.22
Sponsor/executive lead:	Nicola Cottington, chief operating officer
Report prepared by:	Hannah Knights, head of operations- elective care Moira Welham, associate director of operations- surgery and anaesthetics

Purpose of the report:			
For approval ☐	**For assurance** ☐	**For discussion** ☐	**For information** ☒
Trust strategy ambitions			
Please indicate Trust strategy ambitions relevant to this report.	☒	☐	☐

Executive summary:	West Suffolk NHS Foundation Trust continues to recover elective activity following the Covid-19 pandemic and the reduction of capacity during RAAC remedial work in theatres and inpatient wards. Significant progress has been achieved in reducing very long waits and elective recovery plans and performance are monitored through the Patient Access Governance Group and Insight Committee. NHS England has introduced a tier system to provide scrutiny and support for those Trusts most challenged in recovery of elective performance. On 3rd November 2022, all tier 1 and tier 2 providers were written to requesting completion of a self-assessment. The Eastern region of NHSE has subsequently requested that all non-tier 1 and 2 providers also complete the self-assessment, to be submitted by 18th November. The gap analysis checklist, self-assessment and original letter as included in the attached document. The ESNEFT and ICB sections will be completed by those colleagues.
Action required/ recommendation:	The Board is requested to note the submission of the WSFT section of the self-assessment for submission to NHSE, following approval by the Executive Team

Previously considered by:	Approved for submission by Executive Team 16.11.22

Risk and assurance:	BAF risk 3: If we 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.
Equality, diversity and inclusion:	Monitoring of waiting times by deprivation score and ethnicity are monitored at ICB level.
Sustainability:	N/A
Legal and regulatory context:	The submission is required by NHSE.

SNEE Elective Recovery Gap Analysis October 2022			
Theme	**Requirements**	**WSFT**	**RAG**
Waiting List Review	All patients past 62 days for cancer and 78 weeks for wider elective care should be reviewed and the actions required to progress them to the next step in their pathway prioritised	Clinical harm review policy is in place to enable reviews of long waiting patients. This policy is currently under review with a view to becoming a more proactive approach. Options to be presented at Board assurance committee in December.	G
Theme	**Requirements**	**WSFT**	**RAG**
Validation	a) By 23rd December 2022 Any patient waiting over 52 weeks on an RTT pathway (at 31 March 2023) who has not been validated in the previous 12 weeks should be contacted	This is specific to non-admitted RTT patients, all patients over 52 weeks are validated and evidence can be provided via LUNA PTL	G
	b) By 24th February 2023 Any patient waiting over 26 weeks on an RTT pathway (at 31 March 2023) who has not been validated in the previous 12 weeks should be contacted	The requirement is specific to non-admitted RTT patients. WSFT is linking with NNUH who have developed an effective process for contacting patients on the waiting list. Options will be included in the paper to Board assurance committee in December 2022 to achieve this requirement by the target date.	A
	c) By 28th April 2023 Any patient waiting over 12 weeks on an RTT pathway (at 20 April 2023) who has not been validated in the previous 12 weeks should be contacted	The requirement is specific to non-admitted RTT patients. WSFT is linking with NNUH who have developed an effective process for contacting patients on the waiting list. Options will be included in the paper to Involvement committee in December 2022 to achieve this requirement by the target date.	A
Theme	**Requirements**	**WSFT**	**RAG**
	Adhere to the maximum timeframes for diagnostic tests within each tumour-specific Best Practice Timed Pathway with a maximum backstop timeframe of 10 days from referral to report [>62d cancer pathway specific]	The Trust is not currently compliant in all tumour sites. Best Practice Timed Pathway (BPTP) audits are currently being undertaken and will be complete by end of December 2023 which will provide oversight and indication of focus areas to improve compliance. The national target is to achieve compliance by April 2023 but there is risk relating to this which has been noted by the ICB Cancer Programme Delivery Committee. It will be necessary to evaluate the outcomes of the audits before setting realistic timescales for compliance.	R
	Undertake a comprehensive review of current turnaround times and what further prioritisation of cancer over more routine diagnostics would be required to meet this backstop requirement.	This will form part of the evaluation of the BPTP audits as above.	R
	Ensure that existing community diagnostic centres (CDCs) capacity is fully utilised by ringfencing it for new, additional, backlog reducing activity	There is not a current CDC in the West of Suffolk, however Newmarket is planned to be open from April 2024	

Theme	Requirements	WSFT	RAG
Appropriate surgical and diagnostic prioritisation	Accelerate local approval of business cases CDCs, additional acute imaging and endoscopy capacity and expedite delivery of those investments once approved	Newmarket CDC has been approved by ICB and NHSE and is due to be operational by April 2024 and will provide additional diagnostic capacity in West Suffolk and potentially the Cambridgeshire system	G
	Work towards a single PTLs across the system.	The 2 ESNEFT sites have merged into a single PTL but this has not progressed to a full system single waiting list. Waiting time performance data is joined up across the two Trusts and compared as part of management of elective capacity and recovery on a weekly basis. A single PTL is not a current priority within the ICB but would be an enabler in future. A single electronic patient record and shared data warehouse would be requirements for moving this forwards. A shared access policy is being developed to ensure equity of access across the ICS.	R
	Explore partnerships with the independent sector to draw on or build additional diagnostic capacity	Insourcing currently happening in endoscopy and mobile scanner for CT. Independent sector also providing minimal surveillance endoscopy.	G
	Surgical prioritisation should continue to follow the guidance set out in the letter of 25 July (Performance against the 31 day standard from decision to treat to treatment should be used to assess whether the first of these objectives is being met)	100% compliance against 31 day standard - no specific issues currently	G
	Ringfenced elective capacity for cancer patients (particularly P3 and P4 urology and breast patients) and 78ww patients.	Local prioritisation processes in place with capacity being used flexibly and reflected in recently updated trajectories	G
Theme	**Requirements**	**WSFT**	**RAG**
	Lower GI: Full Implementation of FIT in the 2ww pathway - do not automatically offer endoscopic investigation but consider alternative, non two week wait, pathways	FIT Pathway in place, continuing to embed. New BSG Guidance shared with primary care with incentivisation. Colorectal 2WW form updated to reflect changes. Audit will take place to review secondary care pathway and associated outcome.	G

Theme	Requirements	WSFT	RAG
Cancer pathway re-design for a) Lower GI, b) Skin and c) Prostate	Skin: Full implementation of teledermatology in the suspected skin cancer pathway - work with their ICS to implement teledermatology and digital referral platforms to optimise suspected skin cancer pathways and reduce unnecessary hospital attendances	Teledermatology triage platform in place.	G
	Skin: Provision for dermoscopic images to be taken for Urgent Suspected Cancer Skin cancers.	In place via skin analytics	G
	Skin: Capacity must be in place for daily dermatologist triage of images, as either additional activity or as part of existing job plans.	In place via job plans	G
	Skin: Following triage, the consultant or a member of their team should communicate with the patient (via telephone, video or face-to-face consultation) and be booked directly for surgery and receive appropriate preoperative advice and counselling if required	In place	G
	Prostate: Full implementation of the Best Practice Timed Pathway for prostate cancer centred on the use of multiparametric MRI (mpMRI) before biopsy and local anaesthetic transperineal biopsy where clinically indicated	In place	G
	Prostate: patients to be booked in for both mpMRI and biopsy at the point of triage, with triage taking place no later than 3 days from the date the referral is received (Prebiopsy mpMRI and biopsy procedures should take place no later than 9 days from the date the referral is received.)	Pathway in place, recent audit will confirm compliance	G
	Prostate: Ring-fenced mpMRI slots should be in place – weekly demand analysis from radiology requesting systems should be used to inform the level at which this is set	In place	G
Theme	**Requirements**	**WSFT**	**RAG**
Outpatient Transformation:	a) As part of this, trusts are asked to continue the expansion of patient initiated follow up (PIFU) to all major outpatient specialties, especially increasing the volume of PIFU activity in specialties where it is now well established.	PIFU is in place, roll out programme underway to support reporting of accurate figures with expected completion by end of Q3/start of Q4	G
	Continue to deliver at least 16 specialist advice requests per 100 first outpatient appointments. Providers are asked to focus efforts on pre-referral advice models.	Significantly below target at only 8% for advice and guidance, just below trajectory to get to 16% by March 2023. Reviewing oversight mechanisms for advice and guidance performance and linking with ESNEFT to capture learning.	R

Theme	Requirements	WSFT	RAG
Work to deliver a 25% reduction in outpatient follow up appointments by March 2023	Further initiatives to support outpatient follow-up (OPFU) reduction should also include improved and standardised discharge procedures and more effective administrative processes – including focusing on reducing DNAs in outpatient settings	Ongoing work, with targeted calling of patients before appointments to reduce DNAs. DNA rate is below national average. Text reminders also in place.	A
	Outpatient appointments should continue to be delivered via video and telephone, at a rate of 25% of all outpatient appointments	Performance has recently dropped to 23%, having consistently been at over 25%. Currently telephone only, video options coming on line next year which will support increased %.	A
Theme	**Requirements**	**WSFT**	**RAG**
Surgical and theatre productivity	a) Review the senior responsible officer(s) (SROs) and oversight arrangements in relation to theatre productivity and strengthen these if necessary. Ideally, it should consist of a senior manager working 'shoulder-to-shoulder' with a senior clinician	Moira Wellham SRO and Vijay Gopal, Clinician. Theatre Plan currently discussed at weekly DMT assurance meeting.	G
	b) Drive up theatre utilisation to 85%, underpinned by the cases per list standards set out within the GIRFT high volume low complexity (HVLC) programme.	Capped touchtime utilisation is 69%, uncapped at 75% (taking into account overruns), position driven by DSU. Currently utilisation is measured against delivery of 100% of available capacity, rather than planned capacity- most services staff and deliver to 92%. Senior Operations Manager liaising with Informatics to adjust performance data in line with how other Trusts report.	A
	c) Make elective surgery daycase by default, delivering daycase rates across all surgery of 85%	Opportunity for improvement current rate 78%, continues to be monitored. • Day case arthroplasty- adoption of daycase approach has seen reduction in LoS. Mean LoS for TKR reduced from 5.2 days (Q1) to 2.65 days (Aug 22)	A
	d) Maximise Right procedure right place, taking simple surgical procedures out of theatre into procedure rooms, e.g. hand surgery, cystoscopy, hysteroscopy	As part of RPRP initiative WSFT are moving the below procedures into DSU/satellite provision:- • Plastic s minor ops- moving to Newmarket January 23 • Breast procedures- moving to DSU, first list 28th Nov and then monthly • Carpal Tunnel- task and finish group set up	A
	e) Adopt best practice pre & peri-operative medicine pathways	Registered to be part of CQC's Peri-operative pathway pilot. Fitter for Surgery business case going to Investment Panel, Jan 23	A

Theme	Requirements	WSFT	RAG
	f) Optimise the booking & scheduling processes, ensuring that patients are ready for surgery prior to being offered a surgery date, with an embedded data driven, clinically led approach	•Implementation of scripts for booking to ensure Access Policy is considered • Daily booking report to identify reasonable offers and variation in booking practice • Cross pollination of practice across SNEE, aim for Ipswich and WSFT to share good practice, building on orthopaedic deep dive	G
	g) Not performing those interventions identified as 'must not do' on EBI lists 1 and 2 and following the stated process for those List 1 and 2 interventions that should only be performed after applying the specific criteria.	The Trust has reviewed EBI 1 and 2 procedures and can confirm we are not delivering aesthetic only procedures.	G

Elective Recovery Self certification	WSFT	RAG
a) Has a lead Executive Director(s) with specific responsibility for elective and cancer services performance and recovery.	Yes - Nicola Cottington, Executive Chief Operating Officer	G
b) That the Board and its relevant committees (F&P, Safety and Quality etc) receive regular reports on elective, diagnostic and cancer performance, progress against plans and performance relative to other organisations both locally and nationally.	Yes as per Insight committee and Board papers	G
c) Has an agreed plan to deliver the required 78ww and 62 day trajectories for elective and cancer recovery, and understands the risks to delivery, and is clear on what support is required from other organisations.	Yes - revised trajectories submitted on 7th October 2022. Mutual aid requested for 78 weeks for gynae	G
d) Has received a report on the current structure and performance of Lower GI, Skin and Prostate cancer pathways (including the proportion of colonoscopies carried out on patients who are FIT negative or without a FIT; the proportion of urgent skin referrals for whom a face to face appointment is avoided by use of dermoscopic quality images; and a capacity/demand analysis for MRI and biopsy requirements on the prostate pathway), and agreed actions required to implement the changes outlined in this letter.	Performance is provided with summary figures by service however not the detail included in the brackets currently as this was not part of the standard national or local reporting requirements. The Trust is providing a two week snapshot of FIT pathways and will review the outputs of the BPTP audits to identify further areas for monitoring.	A
e) Is pursuing the opportunities, and monitoring the impacts, presented by Outpatient transformation and how this could accelerate their improvement, alongside GIRFT and other productivity, performance and benchmarking data and opportunities.	Yes through the outpatient transformation workstream	G
f) Have received a report on Super September and have reviewed the impact of this initiative for their Organisation.	The Trust has initiated super Saturdays e.g. in Breast Unit. The Trust used September to focus on PIFU compliance and will review this in November reports.	G

Elective Recovery Self certification	WSFT	RAG
g) Have received reports on validation, its impact and has a validation plan in line with expectations in this letter.	The plan will form part of the options presented to a board assurance committee in December	A
h) Have challenged and received assurance from the lead Executive Director, and other Board colleagues, on the extent to which clinical prioritisation (of both surgical and diagnostic waiting lists) can help deliver their elective and cancer objectives. This should include receiving a review of turnaround times for urgent suspected cancer diagnostics and agreeing any actions required to meet the backstop maximum of 10 days from referral to report.	Diagnostic turnaround times will form part of Cancer dashboard, currently under development	A
i) Discuss theatre productivity at every trust board; we suggest with the support of a non-executive director to act as a sponsor.	Currently presented at Divisional board, in future this will come to Insight committee and form part of the Integrated Quality and Performance Report to Board	A
j) Routinely review Model Health System theatre productivity data, as well as other key information such as day-case rates across trusts.	Yes- embedded in Divisional processes	G
k) Confirm your SROs for theatre productivity.	Moira Wellham - ADO Surgery Vijay Gopal - Clinical Lead for Surgery & Anaesthetics	G
l) Ensure that your diagnostic services reach at least the minimum optimal utilisation standards set by NHS England.	Compliant and in some cases exceed.	G

NHS England

To: NHS Trust and Foundation Trust chief executives and chairs

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

25 October 2022

Dear colleague,

Next steps on elective care for Tier One and Tier Two providers

On 18 October, NHS England wrote to the NHS outlining further plans to boost capacity and resilience for services over the coming challenging winter period. This letter now sets out immediate next steps for tier one and tier two of the elective recovery programme to ensure that our phase two objectives around 78 week waiters and 62 day cancer waits are met.

The NHS has delivered a massive reduction in patients waiting two years and is also now steadily reducing the number of people waiting more than 18 months and 62 days respectively. Activity levels compared to pre-pandemic are increasing but we can still do more. There is no one silver bullet, but through a combination of getting the basics right and data-led management and innovation, particularly on outpatient and diagnostic activity, we firmly believe that we can continue to make genuine progress.

We realise that there are a lot of asks on providers and that each of you will know best your local circumstances and what works well. However, through each wave of Covid over the past two years, hospitals have got better and better at protecting elective and cancer care. There are significant learnings from individual organisations across the country that can make a huge difference if adopted collectively. That is why we are now asking all colleagues to step up efforts on all of the measures outlined below. With this in mind, we ask that you complete the Board self certification, (see appendix A) to allow us to support you where you are having the greatest challenges. The fundamentals that we have, collectively, proven to work are:

Excellence in the Fundamentals of Waiting List Management
Ensuring operational management and oversight of routine elective and cancer waiting lists aligns with best practice as outlined/directed within the national programme and current Cancer Waiting Times guidance. All patients past 62 days for cancer and 78 weeks for wider elective care should be reviewed and the actions required to progress them to the next step in their pathway prioritised.

Validation
The validation and review of patients on a non-admitted waiting list is important for the appropriate use of outpatient capacity and to provide clean visible waiting lists to ensure timely and orderly access to care. There are three phases to validating waiting lists that providers are required to undertake routinely – technical, administration and clinical and, following on from guidance sent out on 16 August available here, we expect providers to meet this timeline:

a) By 23rd December 2022
Any patient waiting over 52 weeks on an RTT pathway (at 31 March 2023) who has not been validated* in the previous 12 weeks should be contacted

b) By 24th February 2023
Any patient waiting over 26 weeks on an RTT pathway (at 31 March 2023) who has not been validated* in the previous 12 weeks should be contacted

c) By 28th April 2023
Any patient waiting over 12 weeks on an RTT pathway (at 20 April 2023) who has not been validated* in the previous 12 weeks should be contacted

Appropriate surgical and diagnostic prioritisation
We know that 85% of patients waiting longer than 62 days from their referral for urgent suspected cancer are waiting for a diagnostic test. For cancer in particular, the significant demand for additional diagnostic capacity means that Trusts need to adhere to the maximum timeframes for diagnostic tests within each tumour-specific Best Practice Timed Pathway, but should at all times have a maximum backstop timeframe of 10 days from referral to report. Trusts should undertake a comprehensive review of current turnaround times and what further prioritisation of cancer over more routine diagnostics would be required to meet this backstop requirement.

Trusts should ensure that existing community diagnostic centres (CDCs) capacity is fully utilised by ringfencing it for new, additional, backlog reducing activity, and working with their wider ICS partners to use a single PTLs across the system. Trusts should work across their systems to accelerate local approval of business cases CDCs, additional acute imaging and endoscopy capacity; and expedite delivery of those investments once approved, and should continue to explore partnerships with the independent sector to draw on or build additional diagnostic capacity.

Surgical prioritisation should continue to follow the guidance set out in the letter of 25 July, providing ringfenced elective capacity for cancer patients (particularly P3 and P4 urology and breast patients) and 78ww patients. Performance against the 31 day standard from decision to treat to treatment should be used to assess whether the first of these objectives is being met.

Cancer pathway re-design for Lower GI, Skin and Prostate
There are three pathways making up two-thirds of the patients waiting >62 days and where increases over the past year have been the largest: Lower GI, Skin and Urology. Service Development Funding was made available to your local Cancer Alliance to support implementation of these changes and additional non-recurrent revenue funding has also been made available nationally.

Lower GI: Full Implementation of FIT in the 2ww pathway
As set out in the joint guidance on FIT issued by the British Society of Gastroenterology and Association of Coloproctology of Great Britain and Ireland (ACPGBI), and reinforced in this letter, most patients with suspected colorectal cancer symptoms but a FIT of fHb <10 µg Hb/g, a normal full blood count, and no ongoing clinical concerns should not be referred on a LGI urgent cancer pathway. Where referred, teams should not automatically offer endoscopic investigation but consider alternative, non two week wait, pathways as set out in the letter.

Full implementation of teledermatology in the suspected skin cancer pathway
All Trusts should work with their ICS to implement teledermatology and digital referral platforms to optimise suspected skin cancer pathways and reduce unnecessary hospital attendances to tackle the backlog and meet increasing demand. NHS England's guidance on the implementation of teledermatology pathways is endorsed by the British Association of Dermatologists and supports a Best Practice Timed Pathway for skin cancer which has been published this week.

Implementation will require provision for dermoscopic images to be taken for Urgent Suspected Cancer Skin cancers. This could be delivered by primary care, a separately contracted service delivered by primary care, in a community image taking hub setting, or by medical illustration departments in secondary care. Capacity must be in place for daily dermatologist triage of images, as either additional activity or as part of existing job plans. Following triage, the consultant or a member of their team should communicate with the patient (via telephone, video or face-to-face consultation) and be booked directly for surgery and receive appropriate preoperative advice and counselling if required.

Full implementation of the Best Practice Timed Pathway for prostate cancer
All provider Trusts should implement the national 28-day Best Practice Timed Pathway for prostate cancer, centred on the use of multiparametric MRI (mpMRI) before biopsy. Using pre-biopsy mpMRI means patients can be triaged towards a biopsy so at least 25% can avoid it, over 90% of significant cancers can be diagnosed on imaging and fewer insignificant cancers are diagnosed. Use of local anaesthetic transperineal biopsy where clinically indicated provides increased accuracy and reduced risk of infection, without the resource intensity of procedures done under general anaesthetic.

Implementation will require all patients to be booked in for both mpMRI and biopsy at the point of triage, with triage taking place no later than 3 days from the date the referral is received. Ring-fenced mpMRI slots should be in place – weekly demand analysis from radiology requesting systems should be used to inform the level at which this is set, with frequency of mpMRI slots sufficient to support delivery of timely biopsy. Maximum use of local anaesthetic transperineal prostate biopsy should also be ensured, with general anaesthetic biopsy used only where clinically indicated or for patient preference. Pre-biopsy mpMRI and biopsy procedures should take place no later than 9 days from the date the referral is received.

Outpatient transformation
Outpatients make up around 80% of the total waiting list and it is crucial that, over the winter period, providers continue to keep a strong operational focus on providing these services. Providers are asked to continue their work to deliver a 25% reduction in outpatient follow up appointments by March 2023.

a) As part of this, trusts are asked to continue the expansion of patient initiated follow up (PIFU) to all major outpatient specialties, especially increasing the volume of PIFU activity in specialties where it is now well established.
b) Continue to deliver at least 16 specialist advice requests per 100 first outpatient appointments. Providers are asked to focus efforts on pre-referral advice models.
c) Further initiatives to support outpatient follow-up (OPFU) reduction should also include improved and standardised discharge procedures and more effective administrative processes – including focusing on reducing DNAs in outpatient settings.
d) In order to enable a personalised approach for outpatients and where it is clinically appropriate to do so, outpatient appointments should continue to be delivered via video and telephone, at a rate of 25% of all outpatient appointments. Remote consultation guidance and implementation materials can be found on NHS Futures here.

Surgical and theatre productivity
It is essential that we make best use of available surgical capacity, to drive productivity improvements and protect elective activity through winter. As such we expect providers to:

a) Review the senior responsible officer(s) (SROs) and oversight arrangements in relation to theatre productivity and strengthen these if necessary. Ideally, it should consist of a senior manager working 'shoulder-to-shoulder' with a senior clinician – to succeed we need both groups working together.
b) Drive up theatre utilisation to 85%, underpinned by the cases per list standards set out within the GIRFT high volume low complexity (HVLC) programme.
c) Make elective surgery daycase by default, delivering daycase rates across all surgery of 85%, and helping to free up valuable inpatient beds for complex work.
d) Maximise Right procedure right place, taking simple surgical procedures out of theatre into procedure rooms, eg hand surgery, cystoscopy, hysteroscopy
e) Adopt best practice pre & peri-operative medicine pathways to reduce issues of under booking of lists, on the day cancellations, and pro-longed length of stay, as well as providing better care for patients.
f) Optimise the booking & scheduling processes, ensuring that patients are ready for surgery prior to being offered a surgery date, with an embedded data driven, clinically led approach.
g) Not performing those interventions identified as 'must not do' on EBI lists 1 and 2 and following the stated process for those List 1 and 2 interventions that should only be performed after applying the specific criteria.

Board Self-certification
As part of the above priorities, we are asking each provider to undertake a Board self certification process and have it signed off by Trust Chairs and CEOs by November 11, 2022. If you are unable to complete the self certification process then please could you discuss next steps with your Regional team. The details of this self certification can be found at Appendix A.

Thank you for all of your continued hard work in addressing what are two critical priorities for the NHS over the winter period. Please share this letter with your Board, key clinical and operational teams and relevant committees, and do email england.electiveopsanddelivery@nhs.net should you have any questions.

Yours sincerely,

Sir James Mackey
National Director of Elective Recovery
NHS England

Dame Cally Palmer
National Cancer Director
NHS England

4.1.2. Cancer Performance Standards

To Assure

Presented by Nicola Cottington

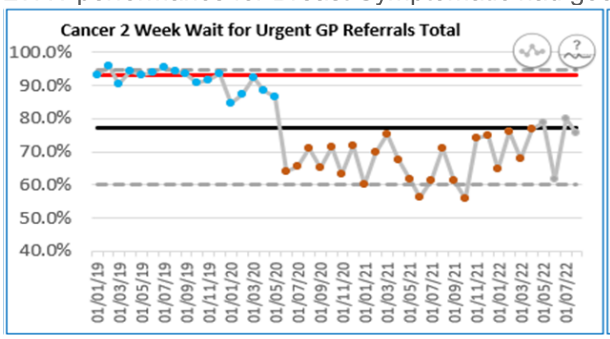
Board of Directors	
Report title:	**Cancer Performance Standards**
Agenda item:	4.1.2
Date of the meeting:	25th November 2022
Sponsor/executive lead:	Nicola Cottington
Report prepared by:	Hannah Knights

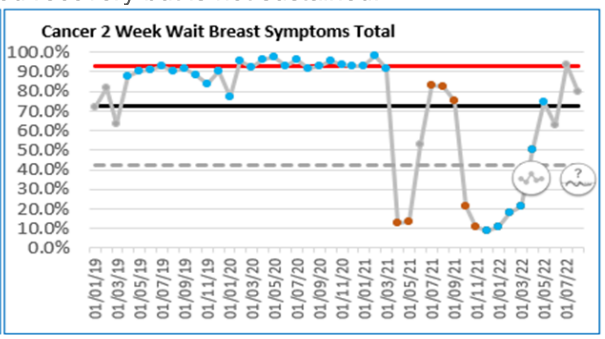
Purpose of the report:			
For approval ☐	**For assurance** ☒	**For discussion** ☐	**For information** ☐
Trust strategy ambitions			
Please indicate Trust strategy ambitions relevant to this report.	☒	☐	☐

Executive summary:	The delivery of a compliant and sustainable cancer services programme has been a significant challenge since before the Covid-19 pandemic. This document provides an update on the current performance against national standards and assurance on the actions which are being taken to recover services.
Action required/ recommendation:	To note the current performance and recognise the actions being undertaken.

Cancer Performance Standards

1.	**Introduction and Background**
1.1	Whilst improvements are being made in many areas via innovation and transformation pathways, with significant clinical engagement, these are not yet translating to an improved position against the national cancer standards. In addition, there is increased national and regional focus on the volume of patients over 62 days on a cancer pathway, with weekly monitoring from NHSe on our position against trajectories. Several factors impact on our ability to achieve the standards currently, which include the impact of Covid-19, including clinical absences and patient delays, higher numbers of referrals in key specialities such as Breast, Colorectal and Skin and consultant vacancies. Referral quality also plays a part in the ability to appropriately triage patients. There have however been several positive innovations over the past year, including the implementation of tele dermatology, with the aid of AI to ascertain the likelihood of malignancy and the implementation of both cytosponge and colon capsule.
3.	**Performance Standards**
3.1	**2 Week Wait** As can be seen, the 2WW standard has not ben achieved since February 2020, with performance variable month on month. 2WW performance for Breast Symptomatic had good recovery but is not sustained.

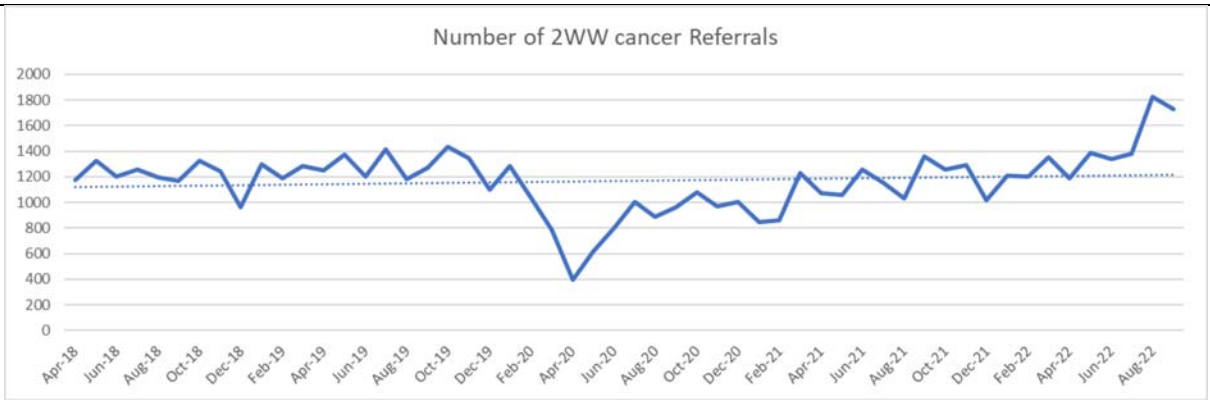




The most recent published performance is for August 2022 spilt by tumour site is as below, with Lung the only tumour site achieving the standard. High referrals, consultant vacancies and the impact of Covid absence are all contributing factors.

Cancer Type	Within 14 Days	Over 14 Days	Total	Mean Wait	% 14 days or less
Breast	113	18	131	13.3	86.3%
Colorectal	133	177	310	19.2	42.9%
Gynaecology	103	12	115	12.2	89.6%
Haematology	3	2	5	15.8	60%
Head & Neck	92	15	107	11.7	86%
Lung	57	2	59	6.3	96.6%
Skin	289	57	346	8.4	83.5%
Upper GI	111	22	133	11.6	83.5%
Urology	97	20	117	12.9	82.9%
TOTAL - Excluding Breast Symptomatic	998	326	1324	12.7	75.4%
Breast Symptomatic	116	29	145	13.4	80%

Whilst the referral numbers are on a steady increase, the areas with the greatest pressure in achieving the 2ww standard are Breast, Colorectal and Skin and these are the 3 tumour sites with the largest volumes of patients, which will impact on the bottom-line achievement of the standard.

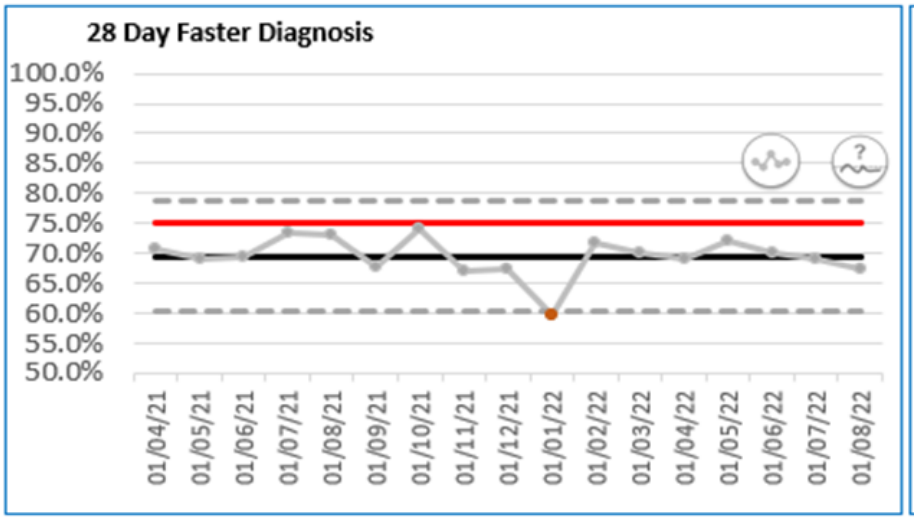


Actions that have already been taken to improve the 2WW performance include:

- The implementation of teledermatology – Skin Analytics, has supported the Skin 2WW performance, despite the referral numbers demonstrating a 20% increase from 18/19 to 21/22 and again from 21/22 to 22/23, the adoption of this has enabled the skin performance to maintain above 80%.
- Implementation of FIT triage – Patients with a below threshold FIT have been moved from a 2WW to Urgent pathway, whilst the impact of this has not yet been seen in the performance the number of patients seen as a 2WW has reduced from 310 in August to 204 in October. Early indication of referral behaviours from primary care are beginning to show a small reduction in the overall numbers coming through in October.
- Increased the threshold for patients who have a CTC

3.2 **28 Day Faster Diagnosis**

Since the implementation of the faster diagnosis standard in April 2021, there has been significant focus on shifting from the 2WW standard to the 28-day performance. As we can see we are not quite hitting the 75% standard, with the breakdown of performance by tumour site as below for August.



Cancer Site	Less than 28 Days	More than 28 Days	Total	Mean Wait	Max Wait	% 28 days or less
Breast	279	18	297	16.8	113	93.9%
Colorectal	159	188	347	38.7	155	45.8%
Gynaecology	91	58	149	30.9	121	61.1%
Haematology	3	3	6	33.7	66	50%
Head and Neck	68	24	92	25.1	123	73.9%
Lung	52	3	55	14.3	48	94.5%
Skin	179	105	284	28.6	156	63%
Upper GI	97	30	127	21.9	112	76.4%
Urology	50	49	99	34.2	127	50.5%
TOTAL	978	478	1456	27.9	156	67.2%

There has been significant investment from the cancer alliance to support the implementation of the faster diagnosis standard, with the first priorities being:

- Focus on implementing the best practice timed pathways in:
  - Lung
  - Prostate

- Colorectal
- Oesophagogastric

- Increasing the criteria for the vague symptom's pathway

Each of these tumour sites had investment where needed to ensure that there were compliant with the best practice timed pathways and whilst the steps to meet these are in place, the time frames in which they are to be delivered to meet the 28-day standard are not currently achieved in all areas. This included the development of Straight to test pathways in Colorectal, additional MDT support within Lung and additional CNS workforce in Urology.

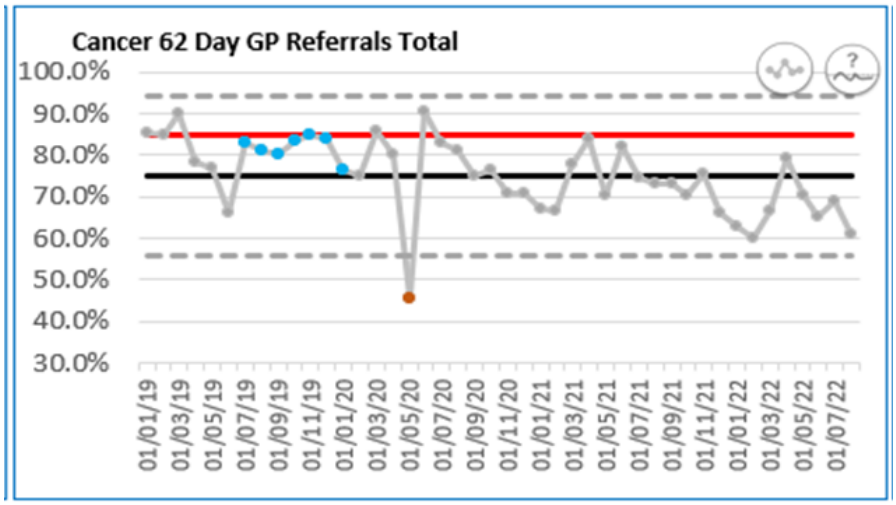
The below demonstrates the regional position for compliance against the FDS (as at July 2022).

	Patients with diagnosis communicated	Patients waiting >28 days	% in target	Change since last month
Milton Keynes University Hospital	1,397	292	**79.1%**	1.5%
James Paget University Hospitals	927	214	**76.9%**	3.8%
Cambridge University Hospitals	2,132	513	**75.9%**	0.5%
The Princess Alexandra	1,417	393	**72.3%**	-2.0%
East And North Hertfordshire	1,415	400	**71.7%**	1.1%
West Suffolk	1,219	372	**69.5%**	1.2%
Norfolk And Norwich University Hospitals	2,465	772	**68.7%**	-0.9%
Bedfordshire Hospitals	2,580	856	**66.8%**	0.0%
North West Anglia	2,268	782	**65.5%**	-0.2%
East Suffolk And North Essex	3,455	1,318	**61.9%**	-0.7%
Mid And South Essex	4,446	1,700	**61.8%**	3.8%
West Hertfordshire	1,750	694	**60.3%**	4.7%
The Queen Elizabeth Hospital King's Lynn	1,045	426	**59.2%**	0.8%
Region overall	**26,516**	**8,732**	**67.1%**	**0.9%**

3.3 **62 Day Treatment Performance**

Achievement of the 62-day treatment standard has not been sustained since pre-covid, with the breakdown by speciality for August detailed below.

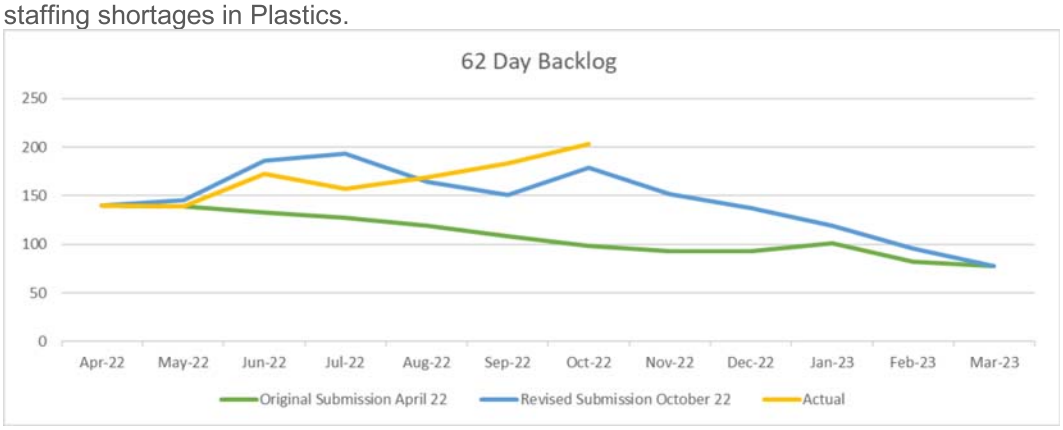
We know that the biggest area of focus in ensuring we are compliant with the 62-day standard is to ensure the actions to achieve the 28-day standard are achieved, as we continually hit the 31 day standard. In that patient receive their treatment within 31 days of a decision to treat.



Cancer Site	Within 62 days	Over 62 days	Total	Mean Wait	Max Wait	% 62 days or less
Breast	11	2	13	50.8	103	84.6%
Colorectal	9	11	20	72.3	148	45%
Gynaecology	4.5	1	5.5	50.7	103	71.4%
Haematology	1	0.5	1.5	75	88	50%
Head and Neck	0	0.5	0.5	82	82	0%
Lung	4	1	5	50.6	64	80%
Skin	8	6	14	59.7	108	57.1%
Upper GI	6	0.5	6.5	41.6	91	85.7%
Urology	9	5	14	73.6	193	60%
TOTAL - Excluding Breast Symptomatic	52.5	27.5	80	61.6	193	63.1%
Breast Symptomatic	2	2.5	4.5	61.2	77	40%

3.4 **62 Day Backlog**

There is significant focus on reducing the volume of patients waiting over 62 days on a cancer pathway. Our current position against trajectory is as below, whilst we are currently 20 over plan, most of the tumour sites are on or below plan. The majority of the backlog (116/203) is within Skin, and this is mostly attributed to staffing shortages in Plastics.



Many of the patients over 62 days are those that do not have cancer or have had a treatment waiting for confirmation of cancer/full excision and therefore one of the key areas of focus needs to be around how results are communicated with patients following diagnostics and treatment. As such, additional resource has been put in place on a temporary basis to work with each tumour site on a quality improvement initiative around patients being removed from the cancer pathway in a timely fashion. This work is underway and being recording in the Life QI tool and has commenced with Colorectal and Skin.
As well as reviewing the current pathways and looking for any 'quick wins', there will also be a review of the way in which we use the tools we have available i.e. e-Care, and what improvements could be made to prioritising results for these patients.

On a positive note, the Lower GI backlog has already seen reduction from 34% of patients over 62 days down to 12% and Skin from 66% to 57%.

4. Next steps

4.1 There are several key actions within the cancer recovery plan, these actions will support recovery of the 62-day backlog as well as the 28- and 62-day standards.

- Investment into the Breast Service – additional nursing and radiological resource and equipment will enable the Breast Service to respond to the peaks and troughs of referrals, and provide a minimum of 56 additional patients per month and support the stability of the pain clinics
- Further enhancement of the use of FIT – meeting to take place with primary and secondary care colleagues on how we can improve the referral quality and completion of FIT within primary care to reduce the rate of 2WW referrals into Colorectal
- Review of Gynaecology Referral Criteria - regional review of referral criteria and pre-referral guidance to try and reduce the demand
- Audit of our pathways against the best practice timed pathways – to evidence where are capacity pinch points are in secondary care and the impact that referral quality has on triage. The first audit is now ready for evaluation, which is Prostate, with Skin and Colorectal next in line to commence. All audits to be completed by the end of Q3.
- Commencement of nurse led prostate biopsies – current wait time for this is 4 weeks, meaning there is no opportunity to meet the 28 day standard. Insourcing of this service is supporting the reduction in wait times in the short term, with the longer-term plan for this to be nurse delivered

	• Reduction in the reading of Skin Analytics images – currently these are read by the SA dermatologist and then the WSFT team, this is now reducing to just the WSFT team and we anticipate a reduction in the turnaround time and an increase in removals from a cancer pathway as a result of this. • Re-look at development of one stop Head and Neck Clinics – currently the wait time for a neck ultrasound +/- biopsy is 4 weeks • Additional Plastic consultant resource to reduce the waiting times for excisions In additional to these specific actions, all these projects will be documented into the Life QI tool to allow us to monitor the impact and benefits realisation. Whilst the actions are in place and there is a 62-day recovery trajectory, we need to develop a robust and realistic trajectory for recovery of all the cancer standards.
5.	**Conclusion**
5.1	This report provides an overview of the current cancer performance. There is an increasing focus on recovery of these standards and there is recognition that cancer performance has been significantly challenged over the past 2-3 years. With the level of clinical and operational engagement, there is confidence that we can achieve the reduction in the backlog of patients waiting over 62 days on a cancer pathway and fully embed the best practice timed pathways in all relevant tumour sites and focus on a long term, sustained recovery.
6.	**Recommendations**
	To note the current performance and recognise the actions being undertaken.

NHS
West Suffolk
NHS Foundation Trust

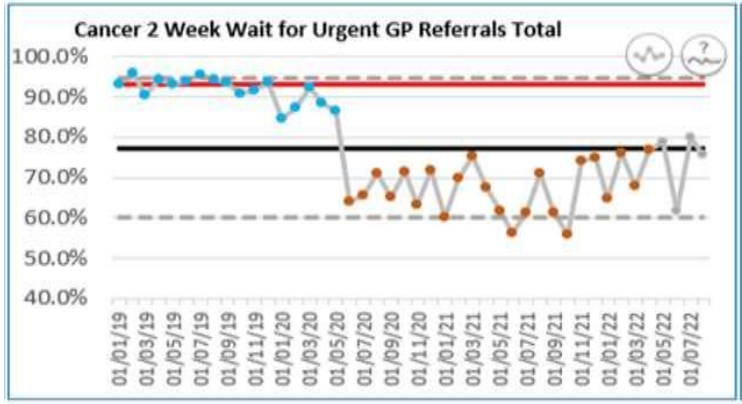
November 2022

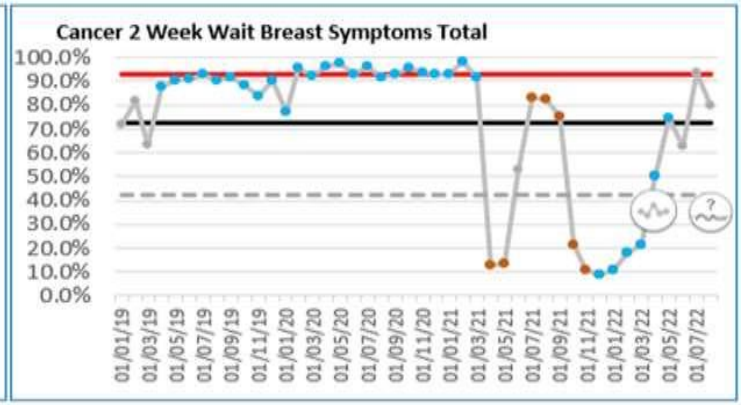
Cancer Performance Update

Hannah Knights – Head of
Operations, Elective Care

Putting you first

2 Week Wait Performance





As can be seen above, the 2WW standard has not ben achieved since February 2020, with performance variable month on month.
2WW performance for Breast Symptomatic had good recovery but is not sustained.
The most recent published performance is for August 2022 spilt by tumour site is as below, with Lung the only tumour site achieving the standard.
High referrals, consultant vacancies and the impact of Covid absence are all contributing factors.

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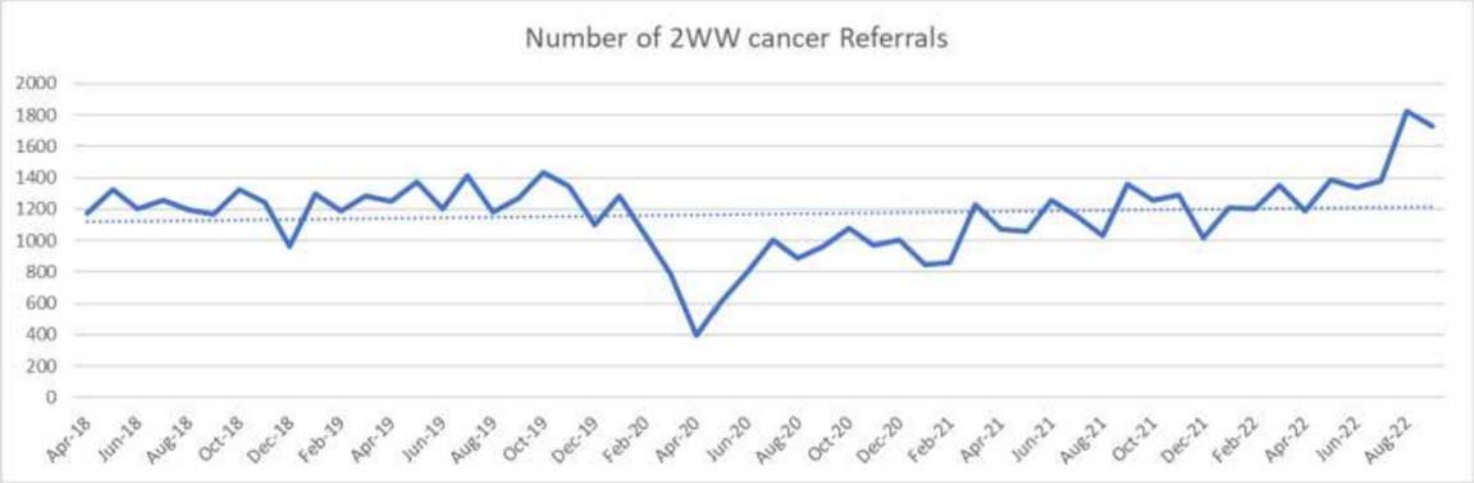
Breast Symptomatic	116	29	145	13.4	80%

2 Week Wait Performance

Whilst the referral numbers are on a steady increase, the areas with the greatest pressure in achieving the 2ww standard are Breast, Colorectal and Skin and these are the 3 tumour sites with the largest volumes of patients, which will impact on the bottom line achievement of the standard.



Actions already in place to aid 2WW performance:

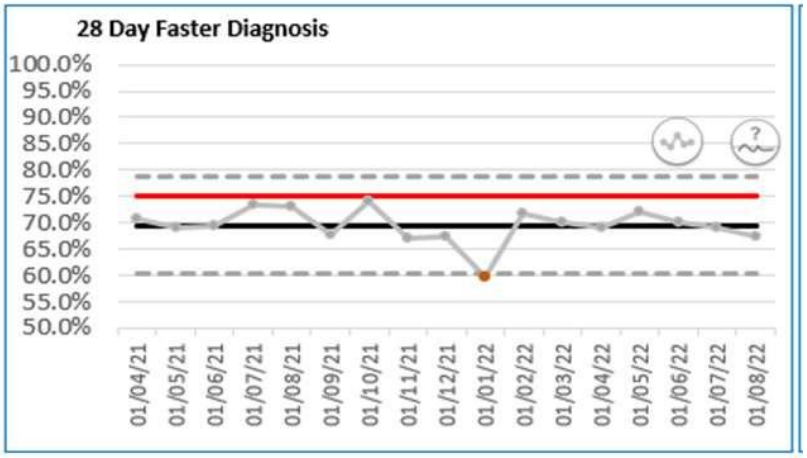
- Teledermatology – Skin Analytics
- Implementation of FIT triage
- Increased the threshold for patients who have a CTC

2 Week Wait Performance

Next Steps to improve performance:

- Investment into Breast Service
- Further enhance the use of FIT
- Best Practice timed pathway audit
- Review of Gynae referral criteria

28 Day Faster Diagnosis Performance



Since the implementation of the faster diagnosis standard in April 2021, there as been significant focus on shifting from the 2WW standard to the 28 day performance. As we can see from the above that we are not quite hitting the 75% standard, with the breakdown of performance by tumour site as below for August.

Cancer Site	Less than 28 Days	More than 28 Days	Total	Mean Wait	Max Wait	% 28 days or less
Breast	279	18	297	16.8	113	93.9%
Colorectal	159	188	347	38.7	155	45.8%
Gynaecology	91	58	149	30.9	121	61.1%
Haematology	3	3	6	33.7	66	50%
Head and Neck	68	24	92	25.1	123	73.9%
Lung	52	3	55	14.3	48	94.5%
Skin	179	105	284	28.6	156	63%
Upper GI	97	30	127	21.9	112	76.4%
Urology	50	49	99	34.2	127	50.5%
TOTAL	978	478	1456	27.9	156	67.2%

28 Day Faster Diagnosis Performance

There has been significant investment from the cancer alliance to support the implementation of the faster diagnosis standard, with the first priorities being:

- Focus on implementing the best practice timed pathways in:
  - Lung
  - Prostate
  - Colorectal
  - Oesophagogastric
- Increasing the criteria for the vague symptoms pathway

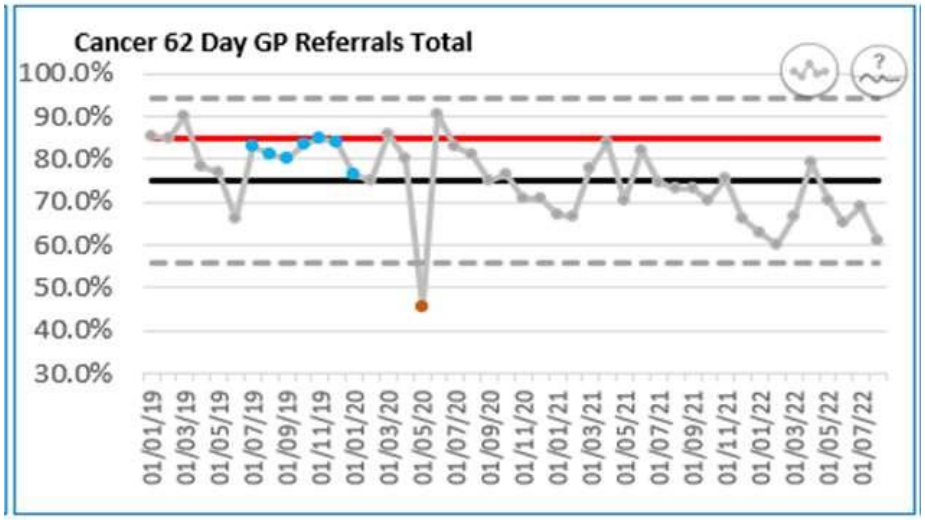
Next steps include:

- Evaluation of Prostate BPTP audit
- Commencement of Skin BPTP audit
- Commencement of nurse led prostate biopsies
- Further enhancement of FIT triage
- Reduction in reading of telederm images
- Re-look at development of one stop Head and Neck Clinics

	Patients with diagnosis communicated	Patients waiting >28 days	% in target	Change since last month
Milton Keynes University Hospital	1,397	292	**79.1%**	1.5%
James Paget University Hospitals	927	214	**76.9%**	3.8%
Cambridge University Hospitals	2,132	513	**75.9%**	0.5%
The Princess Alexandra	1,417	393	**72.3%**	-2.0%
East And North Hertfordshire	1,415	400	**71.7%**	1.1%
West Suffolk	1,219	372	**69.5%**	1.2%
Norfolk And Norwich University Hospitals	2,465	772	**68.7%**	-0.9%
Bedfordshire Hospitals	2,580	856	**66.8%**	0.0%
North West Anglia	2,268	782	**65.5%**	-0.2%
East Suffolk And North Essex	3,455	1,318	**61.9%**	-0.7%
Mid And South Essex	4,446	1,700	**61.8%**	3.8%
West Hertfordshire	1,750	694	**60.3%**	4.7%
The Queen Elizabeth Hospital King's Lynn	1,045	426	**59.2%**	0.8%
Region overall	**26,516**	**8,732**	**67.1%**	**0.9%**

Putting you first

62 Day Treatment Performance



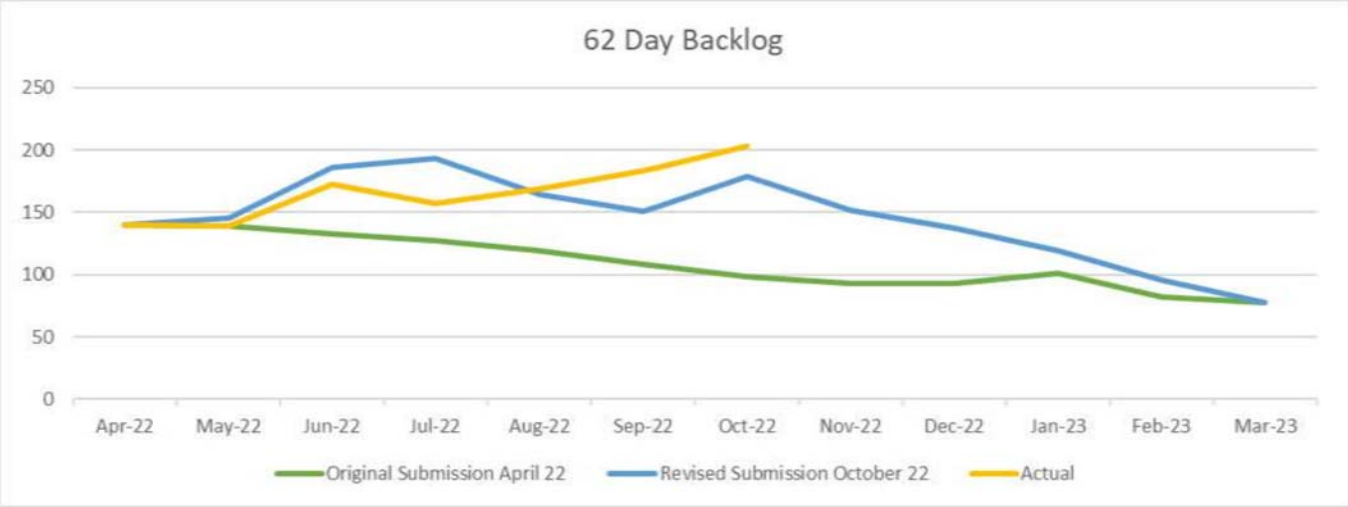
As can be seen, achievement of the 62 day treatment standard has not been sustained since pre-covid, with the breakdown by speciality for August detailed below. We know that the biggest area of focus in ensuring we are compliant with the 62 day standard is to ensure the actions to achieve the 28 day standard are achieved, as we continually hit the 31 day standard. In that patients receive their treatment within 31 days of a decision to treat.

Cancer Site	Within 62 days	Over 62 days	Total	Mean Wait	Max Wait	% 62 days or less
Breast	11	2	13	50.8	103	84.6%
Colorectal	9	11	20	72.3	148	45%
Gynaecology	4.5	1	5.5	50.7	103	71.4%
Haematology	1	0.5	1.5	75	88	50%
Head and Neck	0	0.5	0.5	82	82	0%
Lung	4	1	5	50.6	64	80%
Skin	8	6	14	59.7	108	57.1%
Upper GI	6	0.5	6.5	41.6	91	85.7%
Urology	9	5	14	73.6	193	60%
TOTAL - Excluding Breast Symptomatic	52.5	27.5	80	61.6	193	63.1%
Breast Symptomatic	2	2.5	4.5	61.2	77	40%

62 Day Backlog

There is significant focus on reducing the volume of patients waiting over 62 days on a cancer pathway.

Our current position against trajectory is as below, whilst we are currently 20 over plan, most of the tumour sites are on or below plan. The majority of the backlog (116/203) is within Skin and this is mostly attributed to staffing shortages in Plastics.



Additional Actions

- Commenced Quality improvement project
- Additional project management resource

62 Day Backlog

East of England Cancer Alliances

National Relative Cancer Backlog: All Trusts

Week ending 16th October 2022

NHS England

National ranking	Region	Trust	Total waiting list	Patients waiting >62 days	% past day 62	Change in last week	Change in last 4 weeks
1	M	UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST	5,094	1,122	22.0%	-103	-375
2	M	WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST	3,730	802	21.5%	-12	-28
3	NW	LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST	3,605	751	20.8%	-38	197
4	NEY	HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST	1,665	332	19.9%	15	-94
5	EoE	MID AND SOUTH ESSEX NHS FOUNDATION TRUST	7,880	1,554	19.7%	-169	-161
6	SW	UNIVERSITY HOSPITALS BRISTOL AND WESTON NHS FOUNDATION TRUST	2,626	453	17.3%	39	85
7	NW	LIVERPOOL UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	4,516	778	17.2%	27	-40
8	NEY	THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST	2,372	403	17.0%	-50	-66
9	M	UNIVERSITY HOSPITALS OF NORTH MIDLANDS NHS TRUST	5,354	904	16.9%	28	99
10	M	UNIVERSITY HOSPITALS OF DERBY AND BURTON NHS FOUNDATION TRUST	4,199	698	16.6%	-18	-64
11	M	UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST	4,604	756	16.4%	45	111
12	SE	DARTFORD AND GRAVESHAM NHS TRUST	1,310	214	16.3%	24	5
13	SE	ROYAL BERKSHIRE NHS FOUNDATION TRUST	2,697	436	16.2%	37	55
14	NEY	SHEFFIELD TEACHING HOSPITALS NHS FOUNDATION TRUST	2,511	405	16.1%	-38	-9
15	M	THE SHREWSBURY AND TELFORD HOSPITAL NHS TRUST	4,094	641	15.7%	3	-45
16	NW	EAST LANCASHIRE HOSPITALS NHS TRUST	2,160	334	15.5%	-21	-60
17	NEY	NORTH CUMBRIA INTEGRATED CARE NHS FOUNDATION TRUST	1,782	268	15.0%	-14	-63
18	NEY	YORK AND SCARBOROUGH TEACHING HOSPITALS NHS FOUNDATION TRUST	2,308	347	15.0%	-1	66
19	EoE	NORTH WEST ANGLIA NHS FOUNDATION TRUST	2,956	441	14.9%	-17	-23
20	NW	BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST	1,731	257	14.8%	-2	-25
21	M	UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST	1,271	185	14.6%	-1	-23
22	NW	MANCHESTER UNIVERSITY NHS FOUNDATION TRUST	7,287	1,048	14.4%	46	232
23	EoE	EAST AND NORTH HERTFORDSHIRE NHS TRUST	1,763	248	14.1%	28	25
24	SW	TORBAY AND SOUTH DEVON NHS FOUNDATION TRUST	2,162	299	13.8%	-20	26
25	M	UNITED LINCOLNSHIRE HOSPITALS NHS TRUST	4,242	583	13.7%	3	-34
26	EoE	EAST SUFFOLK AND NORTH ESSEX NHS FOUNDATION TRUST	4,584	630	13.7%	18	57
27	EoE	THE QUEEN ELIZABETH HOSPITAL, KING'S LYNN, NHS FOUNDATION TRUST	1,164	159	13.7%	-19	-116
28	M	NOTTINGHAM UNIVERSITY HOSPITALS NHS TRUST	2,856	390	13.7%	-2	7
29	SW	ROYAL DEVON UNIVERSITY HEALTHCARE NHS FOUNDATION TRUST	3,862	525	13.6%	-22	-20
30	SE	BUCKINGHAMSHIRE HEALTHCARE NHS TRUST	2,941	399	13.6%	38	-16
31	NW	MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST	2,060	278	13.5%	18	108
32	M	THE ROYAL WOLVERHAMPTON NHS TRUST	1,987	262	13.2%	5	13
33	SE	UNIVERSITY HOSPITAL SOUTHAMPTON NHS FOUNDATION TRUST	2,095	271	12.9%	-8	-15
34	NW	NORTHERN CARE ALLIANCE NHS FOUNDATION TRUST	6,606	848	12.8%	18	157
35	L	NORTH MIDDLESEX UNIVERSITY HOSPITAL NHS TRUST	1,771	225	12.7%	12	-24
36	NW	WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST	1,625	206	12.7%	8	25
37	EoE	NORFOLK AND NORWICH UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	4,432	559	12.6%	-27	-44
38	SE	SURREY AND SUSSEX HEALTHCARE NHS TRUST	2,834	344	12.1%	29	120
39	L	BARTS HEALTH NHS TRUST	3,977	469	11.8%	18	42
40	M	WYE VALLEY NHS TRUST	1,378	162	11.8%	22	-21
41	NEY	NORTHERN LINCOLNSHIRE AND GOOLE NHS FOUNDATION TRUST	1,625	191	11.8%	-20	19
42	M	WALSALL HEALTHCARE NHS TRUST	1,319	155	11.8%	-9	3
43	NW	COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST	1,731	203	11.7%	13	53
44	SW	GREAT WESTERN HOSPITALS NHS FOUNDATION TRUST	2,167	254	11.7%	-18	2
45	L	GUY'S AND ST THOMAS' NHS FOUNDATION TRUST	2,699	312	11.6%	-41	-83
46	EoE	WEST SUFFOLK NHS FOUNDATION TRUST	1,489	172	11.6%	1	-49
47	EoE	MILTON KEYNES UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	1,365	155	11.4%	12	-48
48	SW	NORTH BRISTOL NHS TRUST	3,933	444	11.3%	-49	-191
49	NW	SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST	1,488	165	11.1%	-7	-68
50	EoE	BEDFORDSHIRE HOSPITALS NHS FOUNDATION TRUST	3,421	374	10.9%	8	-25
51	SE	OXFORD UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	2,559	273	10.7%	-4	-34
52	NW	TAMESIDE AND GLOSSOP INTEGRATED CARE NHS FOUNDATION TRUST	1,515	152	10.0%	3	-14
53	NEY	LEEDS TEACHING HOSPITALS NHS TRUST	4,333	433	10.0%	15	-67
54	SW	GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST	2,491	247	9.9%	-7	-18
55	SE	UNIVERSITY HOSPITALS SUSSEX NHS FOUNDATION TRUST	5,381	520	9.7%	15	6
56	NEY	COUNTY DURHAM AND DARLINGTON NHS FOUNDATION TRUST	2,263	215	9.5%	-9	9
57	EoE	WEST HERTFORDSHIRE TEACHING HOSPITALS NHS TRUST	2,409	223	9.3%	-4	-23
58	L	CROYDON HEALTH SERVICES NHS TRUST	2,012	186	9.2%	3	-34
59	EoE	THE PRINCESS ALEXANDRA HOSPITAL NHS TRUST	1,711	154	9.0%	-2	0
60	L	UNIVERSITY COLLEGE LONDON HOSPITALS NHS FOUNDATION TRUST	1,775	158	8.9%	-4	17
61	SW	ROYAL UNITED HOSPITALS BATH NHS FOUNDATION TRUST	2,301	201	8.7%	13	34
62	SW	UNIVERSITY HOSPITALS PLYMOUTH NHS TRUST	2,728	234	8.6%	-22	-13
63	L	ROYAL FREE LONDON NHS FOUNDATION TRUST	4,627	378	8.2%	0	9
64	L	BARKING, HAVERING AND REDBRIDGE UNIVERSITY HOSPITALS NHS TRUST	3,380	263	7.8%	-12	28
65	SE	HAMPSHIRE HOSPITALS NHS FOUNDATION TRUST	2,196	168	7.7%	14	36
66	L	IMPERIAL COLLEGE HEALTHCARE NHS TRUST	2,410	182	7.6%	0	-61
67	L	LONDON NORTH WEST UNIVERSITY HEALTHCARE NHS TRUST	2,822	211	7.5%	7	-55
68	SW	UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST	3,908	290	7.4%	-35	-12
69	NW	ST HELENS AND KNOWSLEY TEACHING HOSPITALS NHS TRUST	2,305	170	7.4%	26	9
70	SE	EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST	3,531	259	7.3%	-4	-26
71	SE	FRIMLEY HEALTH NHS FOUNDATION TRUST	2,999	214	7.1%	-47	-13
72	L	CHELSEA AND WESTMINSTER HOSPITAL NHS FOUNDATION TRUST	2,610	179	6.9%	0	20
73	NEY	MID YORKSHIRE HOSPITALS NHS TRUST	2,823	185	6.6%	-12	6
74	NEY	SOUTH TEES HOSPITALS NHS FOUNDATION TRUST	2,340	150	6.4%	-33	-54
75	L	KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST	3,037	190	6.3%	4	-2
76	L	LEWISHAM AND GREENWICH NHS TRUST	2,860	159	5.6%	-3	-1

Method used
- Includes all urgent suspected cancer referrals, with exception of non site specific symptoms.
- Only trusts who have at least 150 patients past day 62 are included
  - For EoE – Papworth, James Paget and CUH have < 150 patients
- Trusts ranked by the proportion of patients on the waiting list past day 62

Source: NHSE/I National Cancer Programme. Figures shown are for 2ww patients waiting more than 62 days.

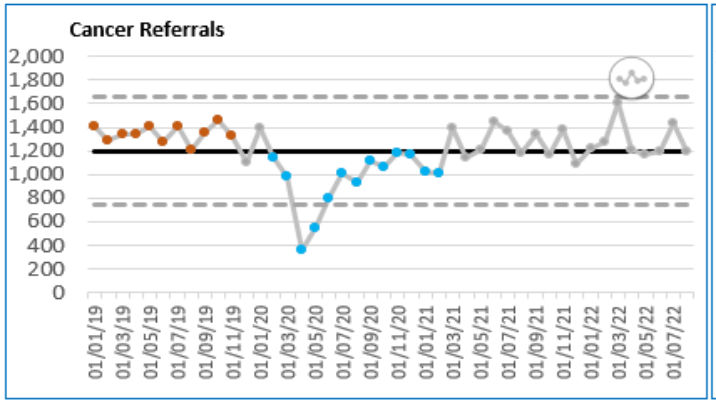
This file is not for sharing beyond the NHS

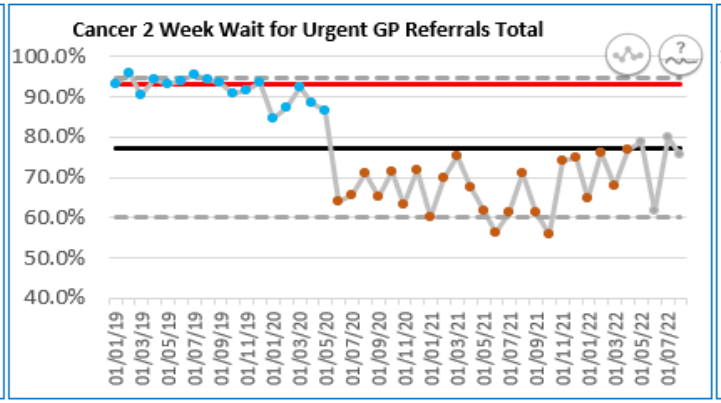
Pack produced: 25/10/2022

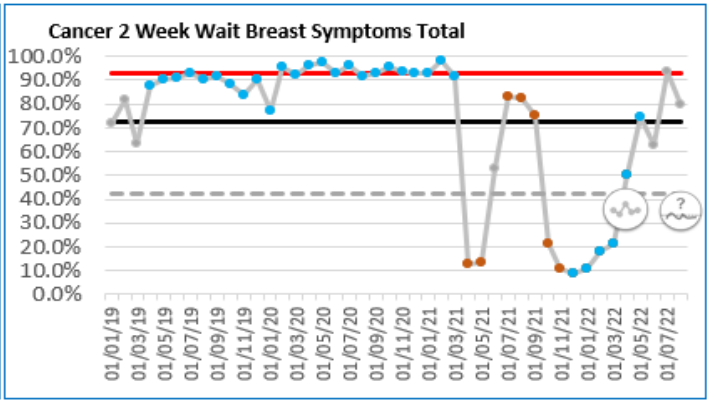
8

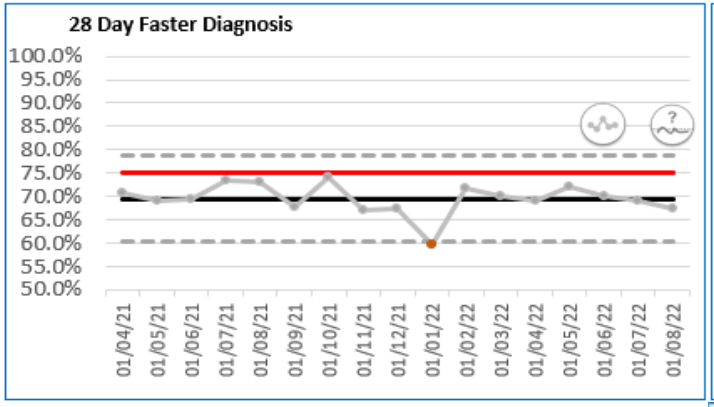
Putting you first

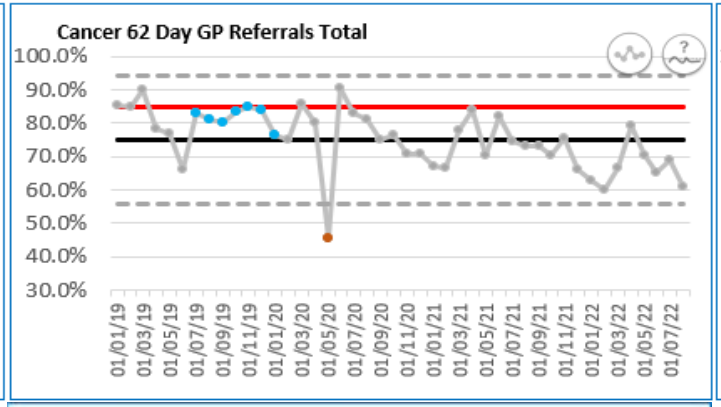
Cancer Access (August 22)

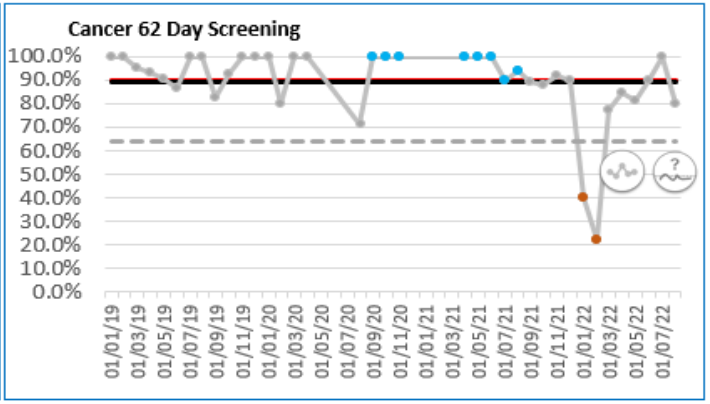


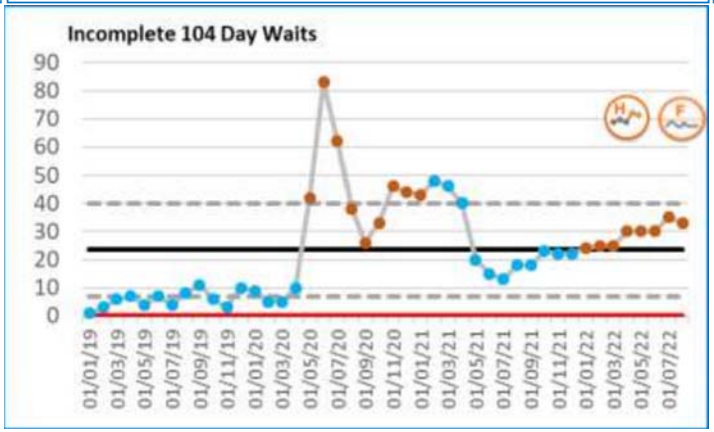












4.2. Finance and Workforce Report

To Assure

Presented by Nick Macdonald

Board of Directors	
Report title:	**Finance and Workforce Board Report – October 2022**
Agenda item:	4.2
Date of the meeting:	25th November 2022
Sponsor/executive lead:	Nick Macdonald, Executive Director of Resources (Interim)
Report prepared by:	Charlie Davies, Deputy Director of Finance (Interim)

Purpose of the report:			
For approval ☐	**For assurance** ☒	**For discussion** ☒	**For information** ☒
Trust strategy ambitions			
Please indicate Trust strategy ambitions relevant to this report.	☐	☐	☐

Executive summary

Income and Expenditure Summary as at October 2022

The reported I&E for October is breakeven (YTD £0.2m deficit). At present, it is still appropriate to anticipate a break-even position for 22/23 in line with our budget. There are a number of risks to the Trusts ability to breakeven this financial year, most notably:

- Any unanticipated costs of potential industrial action.
- Underfunding of increased depreciation for our RAAC programme (£2m)
- Unanticipated costs of winter pressures
- Impact of unfunded inflationary pressures. In the planning round the Trust was funded for inflation at ~6%
- Impact of unfunded pay awards (~£2m).
- Ongoing impact of Covid on our capacity and operational capability
- Any impact of unfunded Covid cost pressures such as temporary staffing, retained IP controls and staff sickness.
- Impact of RAAC programme on our operational capacity
- Lack of clarity on achievement of ERF and subsequent funding.
- Risks around the costs of additional sessions

At present we anticipate there being sufficient mitigations to be able to offset these risks and achieve break even. However, we continue to monitor the likelihood and impact of these risks arising so that we can plan for any impact on the financial position of the Trust as soon as possible. It should be noted that the position YTD includes £4.3m of the central CIP target.

Capital Forecast
The forecast capital spend as at month 7 is £38.3m and is in line with the plan. However this is expected to increase as the Trust is awarded further funding for specific projects such as the Community Diagnostic Centre at Newmarket and Imaging Equipment. The forecast spend is under rigorous review, with the Trust in discussion with NHSE to potentially defer £2.5m of RAAC spend to future years. Further details can be seen on page 9.
Action required of the Board
The Board is asked to review this report.
Recommendation
N/A

Sustainability:	The paper highlights potential risks to financial performance in 22/23.

FINANCE AND WORKFORCE REPORT
October 2022 (Month 7)

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

Financial Summary

I&E Position YTD	£0.2m	adverse
Variance against Plan YTD	£0.2m	adverse
Movement in month against plan	£0m	on-plan
EBITDA position YTD	£10.5m	favourable
EBITDA margin YTD	5%	favourable
Cash at bank	£9.1m	

Executive Summary

- The reported I&E for October is a breakeven (YTD £0.2m deficit).
- Forecast break-even position for 2022/23

Key Risks in 2022-23

- Any unanticipated costs of potential industrial action.
- Underfunding of increased depreciation for our RAAC programme (£2m)
- Unanticipated costs of winter pressures
- Impact of unfunded inflationary pressures. In the planning round the Trust was funded for inflation at ~6%
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SUMMARY INCOME AND EXPENDITURE ACCOUNT - October 2022	October 2022			Year to date			Year end forecast		
	Budget	Actual	Variance F/(A)	Budget	Actual	Variance F/(A)	Budget	Actual	Variance F/(A)
	£m	£m	£m	£m	£m	£m	£m	£m	£m
NHS Contract Income	25.9	25.9	0.0	186.8	186.8	(0.0)	310.9	315.3	4.4
Other Income	3.5	4.5	1.0	22.3	22.0	(0.4)	38.8	37.9	(0.9)
Total Income	**29.4**	**30.3**	**1.0**	**209.1**	**208.8**	**(0.4)**	**349.7**	**353.2**	**3.5**
Pay Costs	20.2	19.8	0.3	140.4	137.3	3.2	240.6	238.4	2.2
Non-pay Costs	8.0	8.8	(0.8)	59.5	61.0	(1.4)	93.9	96.8	(2.8)
Operating Expenditure	**28.2**	**28.7**	**(0.5)**	**200.0**	**198.2**	**1.7**	**334.5**	**335.2**	**(0.5)**
Contingency and Reserves	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
EBITDA	**1.2**	**1.7**	**0.5**	**9.2**	**10.5**	**1.4**	**15.2**	**18.0**	**3.0**
Depreciation	0.8	0.9	(0.2)	6.1	6.8	(0.7)	9.8	11.7	(1.9)
Finance costs	0.4	0.7	(0.3)	3.1	3.9	(0.8)	5.3	6.4	(1.1)
SURPLUS/(DEFICIT)	**(0.0)**	**0.0**	**0.0**	**(0.0)**	**(0.2)**	**(0.2)**	**0.0**	**(0.0)**	**0.0**

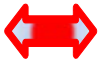
FINANCE AND WORKFORCE REPORT – October 2022

Contents:

- Income and Expenditure Summary Page 3
- Trends and Analysis Page 4
- Income and Expenditure by Division Page 5
- Balance Sheet Page 8
- Cash Page 8
- Debt Management Page 9
- Capital Page 9

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 – October 2022

Income and Expenditure Summary as at October 2022

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- Lack of clarity on achievement of ERF and subsequent funding.
- Risks around the costs of additional sessions

At present we anticipate there being sufficient mitigations to be able to offset these risks and achieve break even. However, we continue to monitor the likelihood and impact of these risks arising so that we can plan for any impact on the financial position of the Trust as soon as possible. It should be noted that the position YTD includes £4.3m of the central CIP target.

Capital Forecast

The forecast capital spend as at month 7 is £38.3m and is in line with the plan. However this is expected to increase as the Trust is awarded further funding for specific projects such as the Community Diagnostic Centre at Newmarket and Imaging Equipment. The forecast spend is under rigorous review, with the Trust in discussion with NHSE to potentially defer £2.5m of RAAC spend to future years. Further details can be seen on page 9.

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	1	↓	Green
YTD surplus/ (deficit)	(0)	(170)	(170)	↓	Amber
EBITDA YTD	9,159	10,546	1,387	↑	Green
EBITDA %	4.4%	5.1%	0.7%	↓	Green
Clinical Income YTD	(194,466)	(193,683)	(783)	↓	Amber
Non-Clinical Income YTD	(14,657)	(15,088)	431	↓	Green
Pay YTD	140,438	137,264	3,174	↑	Green
Non-Pay YTD	68,692	71,690	(2,997)	↓	Red

FINANCE AND WORKFORCE REPORT – October 2022

Trends and Analysis

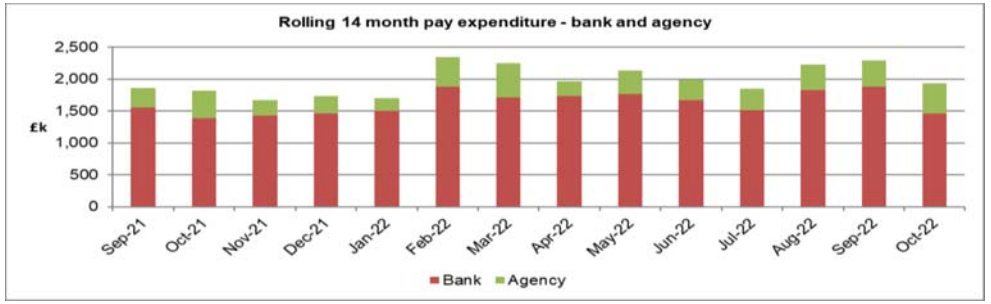
Workforce

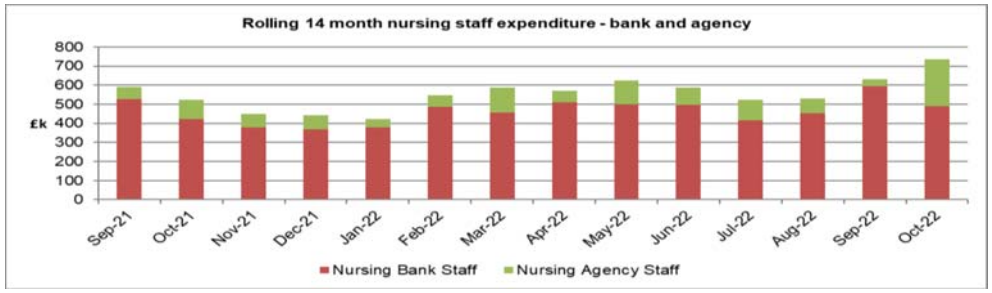
During October the Trust underspent by £0.3m on pay.

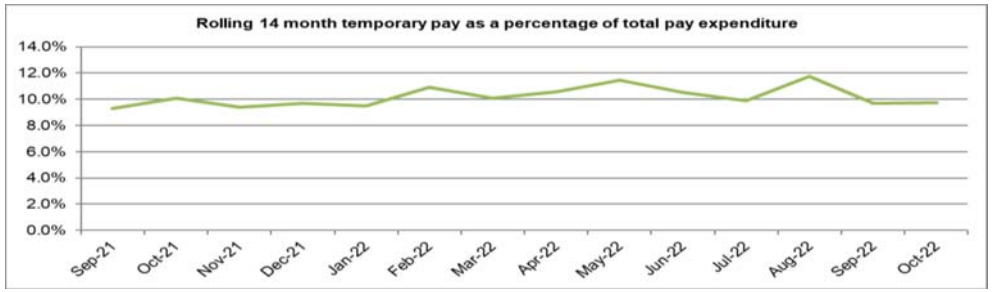
Monthly Expenditure (£)				
As at October 2022	Oct-22	Sep-22	Oct-21	YTD
	£000's	£000's	£000's	£000's
Budgeted Costs in-month	20,172	24,454	17,963	140,438
Substantive Staff	17,917	21,328	16,152	122,885
Medical Agency Staff	144	243	187	971
Medical Locum Staff	388	349	301	2,669
Additional Medical Sessions	(47)	264	225	1,714
Nursing Agency Staff	245	39	103	742
Nursing Bank Staff	490	593	422	3,459
Other Agency Staff	86	121	144	813
Other Bank Staff	246	300	178	1,671
Overtime	192	214	105	1,255
On Call	186	166	151	1,085
Total Temporary Expenditure	1,931	2,288	1,814	14,379
Total Expenditure on Pay	19,847	23,616	17,966	137,264
Variance (F/(A))	325	837	(3)	3,174
Temp. Staff Costs as % of Total Pay	9.7%	9.7%	10.1%	10.5%
memo: Total Agency Spend in-month	475	402	433	2,526

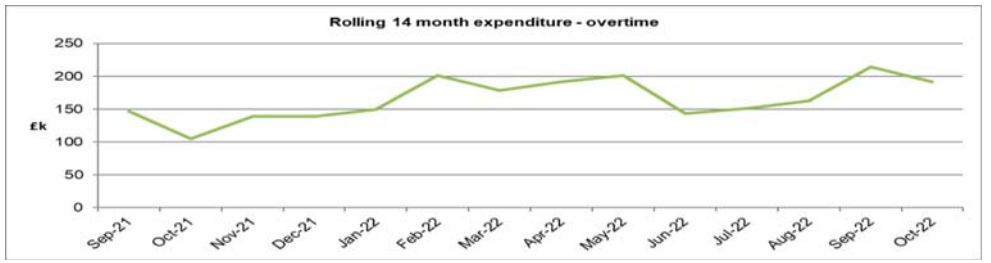
Monthly WTE				
As at October 2022	Oct-22	Sep-22	Oct-21	YTD
Budgeted WTE in-month	4,818.6	4,815.0	4,502.5	45,244.8
Substantive Staff	4,271.4	4,293.1	4,049.3	29,490.9
Medical Agency Staff	8.7	14.2	10.6	65.3
Medical Locum Staff	32.5	39.2	26.5	265.2
Additional Medical Sessions	7.5	5.0	4.9	30.0
Nursing Agency Staff	28.9	7.1	16.4	105.4
Nursing Bank Staff	120.6	121.5	122.9	866.4
Other Agency Staff	17.4	21.5	21.9	163.8
Other Bank Staff	82.4	83.9	73.0	554.6
Overtime	48.0	44.6	36.7	314.7
On Call	7.7	7.2	7.5	60.3
Total Temporary WTE	353.5	344.2	320.2	2,425.8
Total WTE	4,624.9	4,637.3	4,369.5	31,916.7
Variance (F/(A))	193.7	177.7	133.0	13,328.1
Temp. Staff WTE as % of Total WTE	7.6%	7.4%	7.3%	7.6%
memo: Total Agency WTE in-month	54.9	42.8	48.8	334.5

Pay Costs









FINANCE AND WORKFORCE REPORT – October 2022

Income and Expenditure Summary by Division

	Current Month			Year to date		
	Budget	Actual	Variance F/(A)	Budget	Actual	Variance F/(A)
MEDICINE	£k	£k	£k	£k	£k	£k
NHS Contract Income	(7,991)	(7,991)	0	(54,788)	(54,788)	0
Other Income	(353)	(515)	162	(2,453)	(2,481)	27
Total Income	**(8,344)**	**(8,506)**	**162**	**(57,241)**	**(57,268)**	**27**
Pay Costs	5,048	5,014	35	35,320	35,808	(488)
Non-pay Costs	1,813	2,042	(229)	13,120	13,558	(438)
Operating Expenditure	**6,861**	**7,056**	**(195)**	**48,440**	**49,366**	**(926)**
SURPLUS / (DEFICIT)	**1,483**	**1,450**	**(33)**	**8,801**	**7,902**	**(899)**
SURGERY						
NHS Contract Income	(5,736)	(5,738)	2	(39,329)	(39,405)	76
Other Income	(168)	(335)	167	(1,182)	(1,632)	450
Total Income	**(5,904)**	**(6,073)**	**169**	**(40,511)**	**(41,037)**	**526**
Pay Costs	4,158	3,999	159	29,136	27,592	1,544
Non-pay Costs	1,363	1,574	(211)	10,185	10,532	(346)
Operating Expenditure	**5,522**	**5,573**	**(51)**	**39,321**	**38,123**	**1,198**
SURPLUS / (DEFICIT)	**382**	**500**	**118**	**1,190**	**2,914**	**1,723**
WOMENS AND CHILDRENS						
NHS Contract Income	(2,193)	(2,193)	0	(15,043)	(15,231)	187
Other Income	(82)	(152)	70	(692)	(1,059)	367
Total Income	**(2,275)**	**(2,344)**	**70**	**(15,736)**	**(16,290)**	**554**
Pay Costs	1,750	1,832	(82)	12,270	12,063	207
Non-pay Costs	203	220	(17)	1,264	1,564	(299)
Operating Expenditure	**1,953**	**2,051**	**(99)**	**13,534**	**13,627**	**(92)**
SURPLUS / (DEFICIT)	**322**	**293**	**(29)**	**2,202**	**2,663**	**461**
CLINICAL SUPPORT						
NHS Contract Income	(652)	(652)	0	(4,508)	(4,587)	80
Other Income	(151)	(208)	58	(1,055)	(1,246)	192
Total Income	**(803)**	**(861)**	**58**	**(5,562)**	**(5,834)**	**272**
Pay Costs	2,366	2,364	2	16,579	16,461	118
Non-pay Costs	1,185	1,391	(206)	9,425	9,892	(467)
Operating Expenditure	**3,551**	**3,755**	**(204)**	**26,004**	**26,353**	**(349)**
SURPLUS / (DEFICIT)	**(2,748)**	**(2,894)**	**(146)**	**(20,442)**	**(20,519)**	**(77)**
COMMUNITY SERVICES						
NHS Contract Income	(2,968)	(3,300)	331	(20,757)	(21,025)	269
Other Income	(1,291)	(1,575)	285	(8,961)	(8,158)	(803)
Total Income	**(4,259)**	**(4,875)**	**616**	**(29,718)**	**(29,184)**	**(534)**
Pay Costs	3,274	3,204	71	22,804	22,241	563
Non-pay Costs	1,440	1,473	(32)	10,080	9,768	312
Operating Expenditure	**4,715**	**4,676**	**38**	**32,884**	**32,009**	**876**
SURPLUS / (DEFICIT)	**(456)**	**199**	**655**	**(3,166)**	**(2,825)**	**341**
ESTATES AND FACILITIES						
NHS Contract Income	0	0	0	0	0	0
Other Income	(488)	(314)	(174)	(3,417)	(2,009)	(1,408)
Total Income	**(488)**	**(314)**	**(174)**	**(3,417)**	**(2,009)**	**(1,408)**
Pay Costs	1,147	1,128	19	8,026	7,927	99
Non-pay Costs	881	1,015	(134)	5,995	6,110	(115)
Operating Expenditure	**2,028**	**2,143**	**(115)**	**14,021**	**14,037**	**(16)**
SURPLUS / (DEFICIT)	**(1,540)**	**(1,829)**	**(289)**	**(10,604)**	**(12,028)**	**(1,424)**
CORPORATE						
NHS Contract Income	(6,317)	(5,984)	(333)	(52,395)	(51,781)	(614)
Other Income	(960)	(1,414)	454	(4,508)	(5,523)	1,015
Total Income	**(7,277)**	**(7,398)**	**121**	**(56,904)**	**(57,304)**	**401**
Pay Costs	2,429	2,307	122	16,303	15,173	1,130
Non-pay Costs	1,106	1,106	0	9,428	9,427	0
Capital Charges and Financing Costs	1,185	1,703	(518)	9,154	10,980	(1,827)
Operating Expenditure	**4,720**	**5,116**	**(396)**	**34,884**	**35,580**	**(697)**
SURPLUS / (DEFICIT)	**2,557**	**2,282**	**(275)**	**22,020**	**21,724**	**(296)**
TOTAL						
NHS Contract Income	(25,857)	(25,857)	0	(186,820)	(186,817)	(2)
Other Income	(3,492)	(4,513)	1,021	(22,269)	(22,109)	(161)
Total Income	**(29,349)**	**(30,371)**	**1,021**	**(209,089)**	**(208,926)**	**(163)**
Pay Costs	20,172	19,847	325	140,438	137,264	3,174
Non-pay Costs	7,992	8,820	(828)	59,498	60,852	(1,354)
Capital Charges and Financing Costs	1,185	1,703	(518)	9,154	10,980	(1,827)
Operating Expenditure	**29,349**	**30,370**	**(1,021)**	**209,089**	**209,096**	**(7)**
SURPLUS / (DEFICIT)	**(0)**	**0**	**0**	**(0)**	**(170)**	**(170)**

Medicine (Sarah Watson)

The Medicine division reported an adverse variance of £899k for the seven-month period ending October 31st, 2022. For the month of October, the division was behind plan by £33k

Non-pay budgets reported an adverse variance of £438k (3.3%). The key drivers behind the non-pay budget variance for the ytd are:

- £0.5m for drugs (5.5%) - set against a national benchmark for NHS drug inflation of 9%, the division has is managing to contain the overall drugs costs thus far.
- £350k on accrued equipment leases in Cardiology Technology which is under review for accuracy.

Pay budgets reported a year-to-date adverse variance of £488k (1.4% budget) and in month positive variance of £35k. The key year to date variances are;

- £1.5m under budget for Registered Nurses. The Trust continues to struggle to recruit to registered nurse vacancies leading to a large underspend against plan.
- £442k unregister Nurses pay costs to partially compensate for Registered Nurses vacancies.
- £1.3m overspend on Medical Doctors. This is due to several reasons including cover arrangements (locums and Additional consultant sessions) for a several consultants on long term leave in the Division and higher than budgeted establishments for junior doctors.

It is anticipated that the year-to-date variances will continue, resulting in a forecast overspend position at the end of the financial year.

Surgery (Moira Welham)

In October, the division reported a surplus of £118k (£1,723k year to date)
Income reported an over recovery in month of £169k (£526k YTD) driven by a YTD adjustment to recognise additional educational funding. Clinical income is in line with the 22/23 plan.

Pay expenditure reported an underspend of £159k in month (£1.54m YTD). The main driver for the underspend is vacancies, predominantly within non-ward areas such as theatres and anaesthetics. Temporary staffing is being used to fill some of these vacant posts and accounts for 9.9% of the total pay spend. The division in month have also commenced the use of insourcing to support the vacancy gaps.

Non-pay expenditure reported an overspend of £211k in month (£346k YTD). The main reason for the adverse variance is the continued use of external providers to support the recovery work and the increased expenditure on clinical supplies within theatres.

Women and Children's (Simon Taylor)

In September, the Division reported an adverse variance of £29k (YTD favourable variance of £461k).

Paediatric income was significantly ahead of plan both in month (£58k) and YTD (£175k). As in M6, this related to Tricare income for one patient on F1 and is a further catch up on invoicing throughout the year. Women's income is ahead of plan YTD (£337k) due to doctor and other training income being higher than anticipated, plus funding received towards midwifery retention support.
Pay reported a £82k overspend in-month overall, as there was a significant overspend in obstetrics and paediatrics consultant locum and agency, which was greater than the underspend in Maternity Services. The Maternity Service continues to struggle to fill vacancies due to the national shortage of midwives. As such, the YTD position still shows an underspend of £207k due to the high level of vacancies in midwifery.

Non-pay costs are overspent in month (£17k) and YTD (£299k) predominantly due to drugs overspends. There is an increase of women on the obs & gynae waiting lists and therefore drugs spends increase whilst they wait for treatment; and also in paediatrics the drug treatments for respiratory illnesses started much earlier, and this trend is expected to continue.

Clinical Support (Simon Taylor)

In September, the Division reported an adverse variance of £146k (£77k YTD). Income was £58k ahead of plan in-month, which is due to HEE income this month for JETS endoscopy nursing programme.

Pay reported a £2k underspend in-month, with Pathology and Diagnostics both incurring additional costs, offset by vacancies in Pharmacy, Outpatients and Support. We are continuing to carry significant vacancies in both pharmacy and outpatients.

Non-pay reported a £206k overspend in-month as the Trust continued to overspend on recovery measures for CT and endoscopy, as well as increased activity in pathology (including Roche and Leica ongoing contracts which are unbudgeted). The service is continuing to progress replacement of CT 2 and the installation of the third CT scanner. Within non-pay costs this month we also incurred significant drugs costs within pharmacy, related to Covid-19 miscellaneous items at a cost of £52k in M7.

Community Services (Clement Mawoyo)

The Community Division reported a favourable variance of £655k in M7 of 2022/23 (£342k favourable YTD)

Income reported a £616k over recovery in October (£534k adverse YTD) due to higher than budgeted growth and inflation funding recognised in the Division. The Covid vaccination service transferred to Community in September and in October's position the division recognised additional income that was due to WSFT for prior-period activity.

Pay reported a favourable variance of £71k in October (£563k YTD). Pay expenditure has continued to increase in line with budget, to reflect recruitment to externally funded urgent community (responsive) additional roles as well as new roles funded via external business cases (such as roles supporting Autism Spectrum Disorder service recovery) or other external grants (such as MacMillan).

Due to the division's increased turnover and vacancies, bank and agency temporary staff were used to cover some vacant roles across services. Additional agency capacity has been utilised across Integrated Therapies and Integrated Neighbourhood Teams, to provide additional capacity to support services, particularly those delivering admission avoidance and our urgent care response. Recruitment to vacant roles is ongoing despite recruitment challenges. The division is working to improve recruitment and retention with a focus on staff engagement. This work should reduce expenditure on temporary staff including agency.

Non-pay reported a £32k adverse variance in October (£312k favourable YTD). Pressures noted under community equipment costs, driven by increased demand. Whilst partially offset by additional collection credits for returned core stock items of equipment, this was the main cause of the overspend in-month..

Estates and Facilities

In October, the division recorded an adverse variance of £289k, (YTD adverse variance of £1,424k). The financial year shortfall in income stands at £1,408k with non-pay costs overspent by £115k, pay costs are broadly in line with budgeted values.

Car parking income improved by 22% in the month to £100k, but was still adverse to budget by (£67k). Should the monthly figure achieved be consistent the £350k transfer from the investment panel will cover shortfalls for the year leaving the variance to budget as (£595k) for the financial year. Catering incomes continue to record monthly adverse variances to budget (£78k) as the Time Out Restaurant remains closed to patients and visitor. Pay costs both in month (£19k) and for the year (£99k) were favourable to budget owing to the current vacancy factor within the directorate.

Non-Pay costs gave an adverse variance to monthly budget of £134k driven by Utilities expenditure (£337k overbudget). A request from reserves will be made address this in M8.

Statement of Financial Position at 31 October 2022

STATEMENT OF FINANCIAL POSITION

	As at 1 April 2022	Plan 31 March 2023	Plan YTD 31 October 2022	Actual at 31 October 2022	Variance YTD 31 October 2022
	£000	£000	£000	£000	£000
Intangible assets	52,039	56,905	56,921	54,083	(2,838)
Property, plant and equipment	170,887	201,415	177,655	176,740	(915)
Right of use assets			14,190	14,168	(22)
Trade and other receivables	5,807	6,341	6,341	5,807	(534)
Total non-current assets	**228,733**	**264,661**	**255,107**	**250,798**	**(4,309)**
Inventories	3,574	3,689	3,689	3,852	163
Trade and other receivables	15,069	18,362	18,362	17,637	(725)
Cash and cash equivalents	33,323	10,767	9,865	9,117	(748)
Total current assets	**51,966**	**32,818**	**31,916**	**30,606**	**(1,310)**
Trade and other payables	(60,164)	(38,925)	(37,641)	(44,760)	(7,119)
Borrowing repayable within 1 year	(5,858)	(9,684)	(11,449)	(6,939)	4,510
Current Provisions	(38)	(46)	(46)	(12)	34
Other liabilities	(2,888)	(5,685)	(5,685)	(1,990)	3,695
Total current liabilities	**(68,948)**	**(54,340)**	**(54,821)**	**(53,701)**	**1,120**
Total assets less current liabilities	**211,751**	**243,139**	**232,202**	**227,703**	**(4,499)**
Borrowings	(44,002)	(47,927)	(49,225)	(51,791)	(2,566)
Provisions	(415)	(852)	(852)	(415)	437
Total non-current liabilities	**(44,417)**	**(48,779)**	**(50,077)**	**(52,206)**	**(2,129)**
Total assets employed	**167,334**	**194,360**	**182,125**	**175,497**	**(6,628)**
Financed by					
Public dividend capital	200,285	227,311	215,076	208,595	(6,481)
Revaluation reserve	11,704	11,704	11,704	11,704	0
Income and expenditure reserve	(44,655)	(44,655)	(44,655)	(44,802)	(147)
Total taxpayers' and others' equity	**167,334**	**194,360**	**182,125**	**175,497**	**(6,628)**

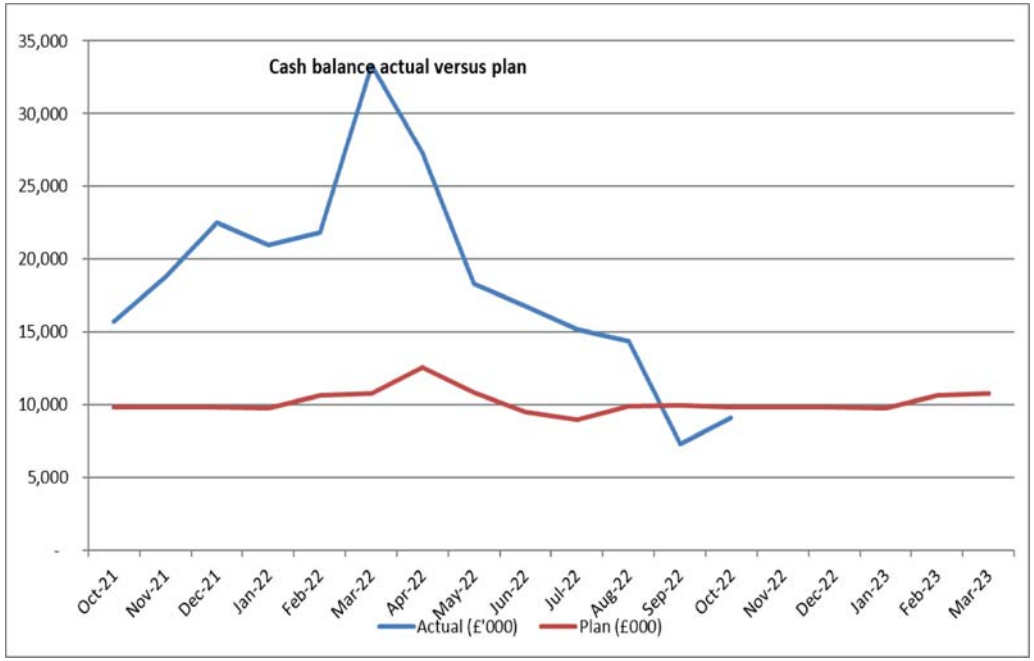
The impact of IFRS16 (right of use assets) is now reflected in the actual figures in the balance sheet above. The split in the actuals between property, plant and equipment and borrowing (current and non-current) to reflect the lease liability is now more accurate and therefore slightly different to the plan.

The phasing of the PDC is not in line with the plan, which is showing a significant movement in month 7. The same applies for trade payables, other liabilities and intangible assets. However, if the plan was corrected, these movements would net off to a minimal movement.

A better comparison of trade payables is to the prior year outturn and the prior month. The movement since the year end is in line with expectations as a number of aged creditors have been paid. The movement in creditors is in line with the previous month (£45m at month 6).

Cash Balance Forecast for the year

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



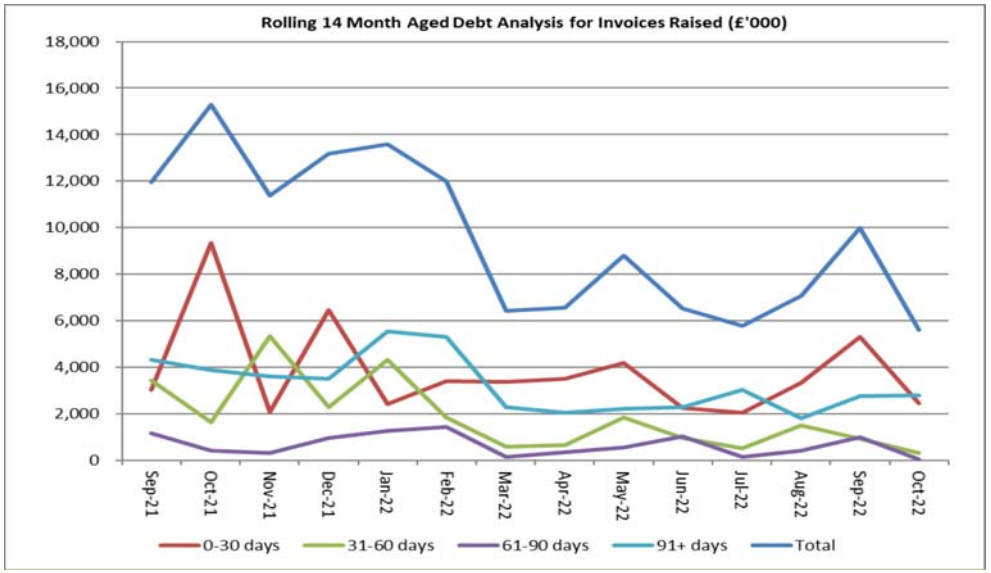
The cash position is slightly below plan at month 7, however we will closely monitor the position to ensure that it remains in line with the year-end forecast of £10.7m.

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 – October 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 has decreased showing an improved performed of cash collected as at month 7. A large proportion of the debts outstanding are historic debts, although these are reducing. Over 75% of these outstanding debts relate to NHS Organisations, with 50% 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.

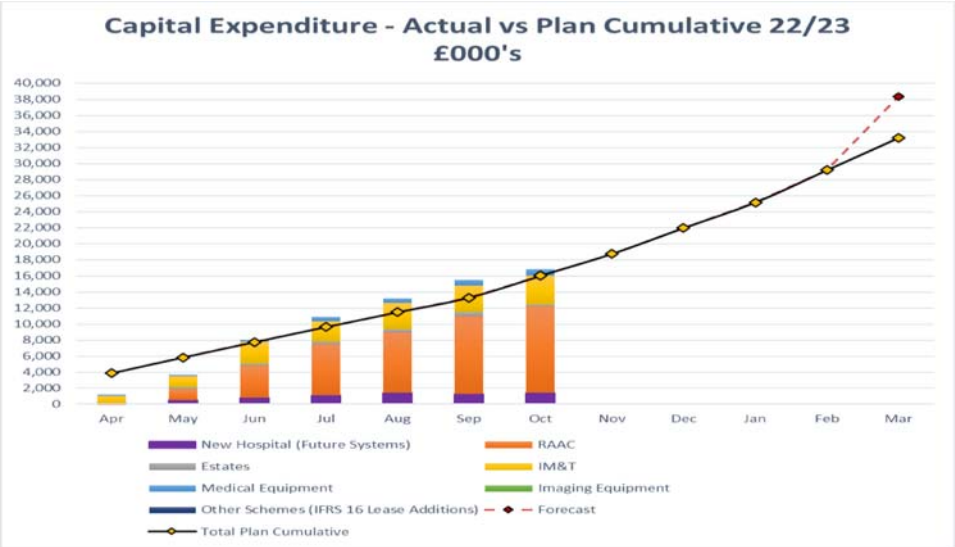
Capital Progress Report

The 2022/23 Capital Programme has been set at £33.2m with £21m of this relating to structure works. An additional £4m has been awarded for RAAC works, taking the plan figure for RAAC to £25m. However the Trust has recently held discussions with NHSE about the potential underspend on RAAC of £2.5m, with a view to deferring £2.5m of funding to future years.

The forecast of capital spend is being rigorously monitored and is under constant review. Since the Capital Plan was set, the Trust has been awarded additional PDC funding for specific capital items. These are noted in the table below. It is anticipated that additional funding will be received during the financial year, which will need to be spent by 31 March 2023. This includes funding for diagnostic and imaging equipment and the Community Diagnostic Centre at Newmarket. These will be reflected in future Board Reports and forecasts.

The year to date capital spend for month 7 was £16.8m. The table below shows the capital forecast as per the original plan, plus the additional PDC funding for which the final approved documentation has been received in month 7.

Capital Spend - 31st October 2022	Year to Date			Forecast			
Capital Scheme	YTD Original Plan	YTD Actual	Variance	Full year Original Plan	Funding Split		Full Year Forecast to 31st Mar 2023
					Internal	PDC Available	
	£000's	£000's	£000's	£000's	£000's	£000's	£000's
New Hospital (Future Systems)	620	1,434	- 814	1,060	1,000	1,332	2,332
RAAC	8,581	10,781	- 2,200	21,000		25,000	25,000
Estates	1,252	235	1,017	1,435	1,435	115	1,550
IM&T	3,376	3,614	- 238	5,675	5,675		5,675
Medical Equipment	300	717	- 417	400	400	759	1,159
Imaging Equipment	-	-	-	1,740	740		740
Other Schemes (incl. IFRS 16 Lease Additions)	1,891	-	1,891	1,891	1,891		1,891
Total Capital Schemes	16,020	16,782	- 762	33,201	11,141	27,206	38,347
Overspent vs Plan							
Underspent vs Plan							


Capital Expenditure - Actual vs Plan Cumulative 22/23
£000's
40,000
38,000
36,000
34,000
32,000
30,000
28,000
26,000
24,000
22,000
20,000
18,000
16,000
14,000
12,000
10,000
8,000
6,000
4,000
2,000
0
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
New Hospital (Future Systems)
RAAC
Estates
IM&T
Medical Equipment
Imaging Equipment
Other Schemes (IFRS 16 Lease Additions)
Forecast
Total Plan Cumulative

4.3. Seasonal Planning - Presentation

To Assure

Presented by Nicola Cottington and Clement Mawoyo

4.4. Improvement Committee Report - 10 October, 2022 & 14 November, 2022 - Chair's Key Issues from the meeting

To Assure

Presented by Louisa Pepper

Chair's Key Issues

Originating Committee	Improvement Committee	**Date of meeting**	10 Oct 22
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	IQPR (August data) four KPIs had a reported variance MRSA - special cause improving, VTE - special cause improving, patient safety incidents - special cause concerning, Verbal DoC - special cause concerning Noted increase in incidents reported potentially might be linked to concurrent staffing shortages, DoC measures now updated to reflect and will be reported from October data onwards. For consideration – should targets be raised for measures routinely meeting standard (e.g. VTE)?	**Assurance**		✓ IQPR in annex
4.2	Deep dive / in depth quality assurance review Subjects for future discussed. Provisional schedule agreed: Nov22 (digital), Dec22 (duty of candour), Jan23 (frailty), Feb23 (medication safety) Oversight of QI projects undertaken - governance is needed to monitor progress and celebrate successes. How to prioritise projects (and support from QI team) Change management process currently under review (encompassing Transformation/PMO/QI/sustainability) will provide a structure to ensure improvements are made (and supported) in priority areas.	**Assurance**		
5.1	PQAS September report and minutes provided. Reports provided for: Pressure ulcers (higher than usual numbers reported; potentially linked to concurrent staffing pressures),	**Assurance**		

Agenda item	Details of issue	For: Approval/ Escalation/ Assurance	BAF/ Risk Register ref	Paper attached? ✓
	'Learning from deaths' (no concerns raised), Infection prevention & control (peer review visit from ICB revealing concerns around standards of cleanliness, two C-diff outbreaks in reporting period and a Pseudomonas outbreak in Critical care), Nutrition (prolonged stay of patients with mental health needs (eating disorders) requiring nasogastric feeding), Falls (numbers increasing, links to bed rails a concern – bed rail policy now on intranet and included in NA induction and plan for elearning for RNs).			
5.2	CEGG September report provided. Reports provided for: Radiology (Radiation Protection Committee action plan received), Public health (governance structure formally agreed at meeting, re 'stop smoking schemes': eCare change request authorised and agreed PH to input into new medical staff intake to widen understanding of tobacco dependence), National and local clinical audits (Clinical audit policy PP214 approved, noted National Audit of Emergency Laparotomy (NELA) low compliance with the standard 'perioperative assessment by a consultant geriatrician for patients over 80 years and over, or 65 years old and frail'. Concern re lack of cover for Geriatrician absence noted for awareness / monitoring), CEGG formally accepted responsibility for oversight and monitoring of the Ockenden (wider organisational) gap analysis and improvement plan (scheduled for November meeting).	**Assurance**		
6.1	Patient Safety strategy Strategy to be launched at patient safety summit in November (delayed from September due to HRH's funeral) Implementation plan matched to trust objectives and 'what good looks like'. Oversight of progress through regular reporting to Improvement, no major concerns at this time, mostly green some delays (amber) in patient safety partner	**Assurance**		

Agenda item	Details of issue	For: Approval/ Escalation/ Assurance	BAF/ Risk Register ref	Paper attached? ✓
	(PSP) recruitment and implementation of the new LFPSE (national incident system replacing the NRLS)			
6.2	Ockenden Wider organisational learning and gap analysis will be reported through CEGG, liaising with Leeds Teaching Hospitals NHS Trust to share ideas.	**Assurance**		
7.1	Update from AMD (Clinical Effectiveness) Introduction to role which focuses on various specifics (examples: shared decision making, clinical audit & effectiveness, national best practice, NatSSips) and clinical leadership for barriers and enablers for clinical effectiveness. Highlighted priority to use digital services effectively to support safety, quality and clinical effectiveness. Trust needs to continue to embrace digital solutions (note – digital team have been invited to present to November Improvement committee meeting).	**Assurance**		
7.2	Quarterly quality and learning report – received for information on behalf of Board. Content: Learning from investigations in our PSIRP, Q1 thematic review of incidents, 'learning from deaths data and narrative, patient and public feedback (issues identified, learning and actions from complaints)	**Assurance**		✓ Report in annex
7.3	Glemsford CQC improvement CQC report issued on 14th Sept22 rating overall Good with SAFE the only key question rated as Requires Improvement. The report contained one MUST and three SHOULD items which are being addressed through the development of an improvement plan. Progress update to be scheduled in three months' time.	**Assurance**		
8.1	Risk Management and governance Improvement terms of reference updated and approved New NED Chair (Louisa Pepper) and two new NED members to join from November meeting. Outgoing Chair (Jude Chin) thanked for chairing Improvement committee.	**Assurance**		

Chair's Key Issues

Originating Committee	Improvement Committee	**Date of meeting**	14 November 2022
Chaired by	Louisa Pepper	**Lead Executive Director**	Sue Wilkinson

Agenda item	Details of issue	For: Approval/ Escalation/ Assurance	BAF/ Risk Register ref	Paper attached? ✓
All agenda items	Change management / Organisational prioritisation framework Key theme of meeting (multiple agenda items refer) The committee seeks assurance of how a prioritisation framework might be developed, applied and maintained to focus the change management approach. To include how/from where to receive intelligence to maintain that framework.	**Escalation**	Failure to maintain and further strengthen effective governance structures (BAF 1)	
4.2	Deep dive – 'Safe nurse staffing' audit Provides board assurance that current inpatient nursing establishment is fit for purpose and meets the needs of our patients and staff using a method which meets expectations set out in the 'developing workforce safeguards' document (NHSI, 2018) and expectations from the National Quality Board (2016).	**Assurance**	Value our workforce and look after their wellbeing and development (BAF 6)	✓ (Agenda item 4.4 nurse staffing paper refers)
4.3	Deep dive – Using Digital to support quality & safety Highlighted barriers and enablers for clinical effectiveness and how digital can support the embedding of transformation of services. Examples of implemented and future digital projects. Recognition that digital systems must become embedded within quality & safety and not as a standalone with the development of a digital governance framework currently in development.	**Assurance**	Digital adoption, transformation and benefits realisation (BAF 4)	
5.1	PQAS October report and minutes provided. Reports provided for:	**Assurance**	(BAF 1)	

Agenda item	Details of issue	For: Approval/ Escalation/ Assurance	BAF/ Risk Register ref	Paper attached? ✓
	Safeguarding children (Delayed health assessments for look after children, MCAs in 16/17-year-olds and increase complex cases admissions); Safeguarding Adults (MCA / LPS[1] outcome of consultation pending. Significant changes to work practice and process needed); Mental health Transformation (Use of Force act and implications for acute services, Ligature risk in ED and Rainbow ward still outstanding, positive assurance around legal frameworks applied to patients detained in our care); Learning disabilities (Learning from deaths of people with LD); Incidents (Reduction in reported patient harms); Duty of Candour (no emerging concerns noted); Human Factors(no emerging concerns noted)			
5.2.1	CEGG November report and minutes provided. Reports provided for: Pathology (Positive assurance re accreditation progress and output of recent GIRFT visit reflected in an improvement programme); QI (presented list of new / currently active QI projects grouped by theme), CQUIN (overall compliance for CQUIN programme excellent, meeting all but two areas of full compliance against the lower threshold); Ockenden (see 5.2.2) and Public health 'tobacco dependence' project.	**Assurance**	(BAF 1)	
5.2.2	Ockenden Gap analysis undertaken with key stakeholders. Identified areas of full compliance (with opportunities for future QA to be considered), partial/non-compliance (with organisational developments planned or in progress that might address findings of Ockenden as a side benefit) and other partial/non-compliance (requiring action / improvement to enable trust to respond to findings of Ockenden.	**Partial assurance**	(BAF 1)	

[1] MCA/LPS Mental capacity act / Liberty protection safeguards)

Agenda item	Details of issue	For: Approval/ Escalation/ Assurance	BAF/ Risk Register ref	Paper attached? ✓
	Reflection that the trust needs to better develop pathways for organisational response to national best practice publications (such as Ockenden) to include multidisciplinary coordinated response and oversight of timely ongoing improvements. Role of CEGG in process to be examined (may require change to ToR and membership)	**Need for action**		
6.1	Safety improvement group Received for information.	**Assurance**	(BAF 1)	
7.1	Medic Bleep From the multiple perspectives of patient safety, information governance compliance, operational efficiency and external provider contract support reliability the Trust is asked to explore alternative options to MedicBleep as a matter of priority to enable a solution to be found before the current contract is due for renewal in June 2023. To be escalated to Digital Board.	**Escalation**	(BAF 4)	
7.2	Quality accounts – quality improvement priorities (QIPs) reporting process Accepted reporting timeframes and methodology. Involvement committee to be recommended to adopt for relevant QIPs.	**Assurance**	(BAF 1)	
8.1 + 8.1	ToR and reporting template - formally approved by committee	**Approved**		
9.1	Escalation from Audit Committee - Internal audit of CQC Improvement plan Report to be re-issued with updated action plan. Audit opinion and management actions to be revisited as part of re-issue.	**Partial Assurance**	(BAF 1)	

Improvement committee – 10 October 2022

Quality & learning report	Patient safety and quality teams

Executive summary
Previously reported to the Board, this report is now presented to the Improvement committee and includes the following sections: • Learning from investigations in our PSIRP • Thematic review of incidents • Learning from deaths • Patient and public feedback This report provides examples of learning points and improvements, that have arisen from activities in the period since the last report.
This report does **not** provide updates on the patient safety & learning strategy implementation plan and major projects. These are provided in a separate report on the agenda.

1. Learning from incidents

1.1 PSII Reports approved since last meeting

The new EIR process enables incidents of concern that were reported as green to be escalated to the weekly panel for consideration of investigation method. This provides an opportunity for learning **before** a serious harm incident occurs.

Since the last report there have been four PSII reports approved at panel. This included two from our first year PSIRP (category A) and two from year two (category B)

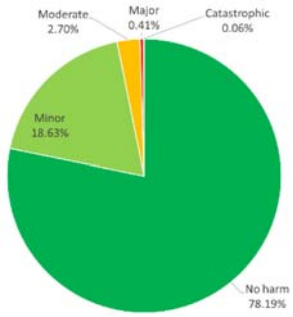
WSFT ref.	**PSIRP category**
WSH-IR-81521	2A Inpatients receiving shared care between specialties
WSH-IR-80819	10A Unexpected PSII
WSH-IR-82466	1B Potential for patient harm as a result of communication with multiple stakeholders for ongoing patient care
WSH-IR-82613	12B Deaths more likely than not due to problems in care

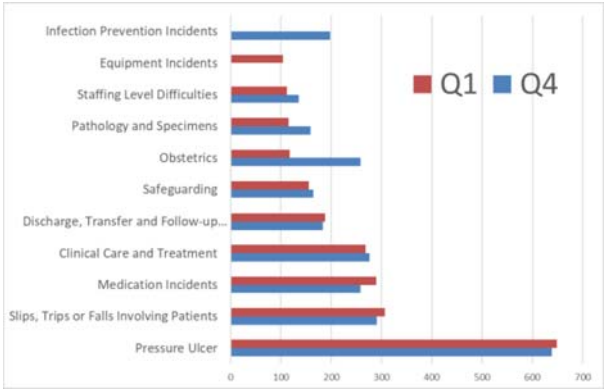
More details on the learning / areas for improvement can be found in annex one.

1.2 Quarterly thematic review of incidents reported

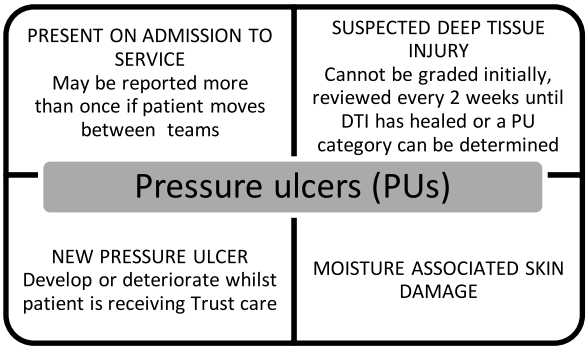
The most recent thematic review examined incidents reported in Q1. The detailed report is being presented to the Patient quality & safety governance group. Findings from the thematic reviews included the following:

Most incidents reported are no harm (including near miss). High reporting especially of near misses is indicative of a good safety culture.





The top four incident types each quarter are routinely: Pressure ulcers (including already present at beginning of community care episode or admission to hospital), Falls, Medication and Clinical care & treatment



<u>Thematic learning in pressure ulcers</u>

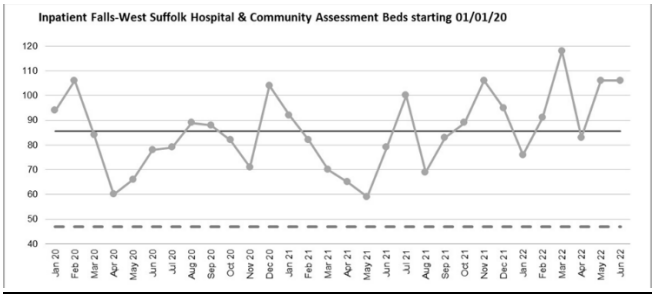
Most new PUs reported in community settings where patients are living with long term conditions or experiencing changing needs.

Two acute wards experiencing increased number participated in a learning opportunity for their staff around the subject of PUs.

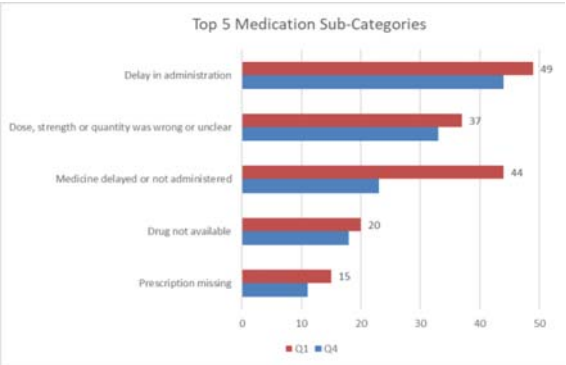
Positives around strong partnership working with staff in a care home highlighting benefit of involving community carers in After action review (AARs) where possible

<u>Themes from Falls analysis and AARs</u>

- Communication to patient's next of kin
- Identification / management of high falls risk patients within ED
- Prolonged stay in ED for patients with confusion
- Completion of the post fall protocol
- Using the Abbey pain score
- Strategies to support patients with delirium
- Identification of rib fractures
- Falls prevention strategies



- Lying and standing blood pressure completion
- Medication changes
- Handover
- Manual Handling following a fall



<u>Overarching medication themes and actions / improvement</u>

Insulin - diabetes management group set up in Dec21 to oversee diabetes management and areas of work/improvements required

Controlled drugs - quarterly audit of controlled drugs undertaken by Pharmacy team at ward level with feedback provided to staff on the ward

Drug patches, anti-coagulation, traceability tags other common occurring themes.

New Medication safety group being developed reporting into D&T

The clinical care & treatment category remains challenging to analyse overall for key trends and themes due to the number of different sub-categories and issues/topics included within. This category sees the highest number of cases requiring a PSII in our PSIRP. The learning is therefore quite wide-ranging (see Annex 1).	Delays in providing timely treatment or care represented the largest sub-category Other themes included: Discharge, delays with care and treatment, escalation of unwell patients, cancelations, transfers, care of lines, tubes and drains, communication/documentation, staffing/capacity issues, single sex accommodation breaches in critical care and obstetrics

2. Learning from Deaths

What is going well

- Many examples of excellent communication with family and relatives by junior doctors, when explaining care and treatment
- Regular comment upon excellent care provided by palliative care team who see patients quickly following referral and are supportive of clinical nursing and medical teams as well as families at the end of a patient's life

Opportunities for improvement

- Impact of reduced staffing and increased workload on ability to perform timely nursing assessment
- Delayed initiation of sepsis 6
- Inability to fast-track discharge enabling those who wish to die at home to do so

Plans for 2022/23

- Review of mortality processes within the Trust to develop streamlined processes to:

- Respond to deaths where medical examiner, family, staff or other stakeholders have raised concerns about patient care.
- Collaborate with speciality teams to ensure timely SJR and two way communication
- Provide structured reporting framework to provide divisional, specialty and board assurance and share learning with the clinical teams through new mortality oversight group and dashboard.
- Manage communication with bereaved families to avoid unnecessary multiple points of contact, enhance responses to family feedback and timely sharing of findings of reviews with families

- Implementation of ReSPECT tool to replace EPARS trust wide
- Increase in palliative care provision (7 day service and increase in consultant cover)

LfD data	Deaths			
	Total	SJR* completed	With an investigation** completed	Judged as >50% preventable***
Apr-Jun21	202	62/65	5	1
Jul-Sep21	215	67/76	3	3
Oct-Dec21	297	45/71	2	1
Jan-Mar22	277	17/47	3	1
Apr-Jun22	271	62/65	pending	pending

** SJR - Structured Judgement Review **PSII or PSR ***PSII only*

3. Patient and public feedback

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. More detail on the actions and learning can be found in Annex two.

Annex 1 – Learning, safety actions and areas for improvement from PSIIs approved in reporting period

Areas for Improvement (AFIs) These are broad areas for improvement, they do not define how improvement is to be achieved and are best created after aggregating learning across multiple investigations (and patient safety reviews) into a similar risk. The term 'areas for improvement' is now used instead of 'recommendations' to reduce the tendency to jump immediately to solutions at an early stage of the safety action development process.

Safety actions – These are SMART actions to reduce risk which can be generated in relation to each defined area for improvement. Some immediate safety actions will be identified during the investigation process of the PSII and others may be identified change ideas at a later stage and tested using improvement methodology. As part of the implementation of any safety action, the team should consider measures to monitor and assess their effectiveness. This might be for example through adding to the local audit programme or utilising the LifeQI system.

Report one – Complication post uterine artery embolisation (UAE) procedure.

There were 12 findings which resulted in one AFI

It is recommended that the findings from this patient safety investigation, pertinent to the plastic surgery management of the patient, be incorporated into the current clinical and service reviews of the plastic surgery service

Report two – Thematic review of major post-partum haemorrhage (PPH).

Two reference cases were examined within the PSII cross-referenced with the summary learning from an additional eight local maternity PPH reviews.

There were 12 findings which resulted in nine safety actions:

1. Measure any improvement which the change in the labour suite ward round has led to (e.g., reduction in time between recognition of PPH and instigation of treatment)
2. Consider enhanced prescribing opportunities for some midwives to reduce the time between recognising the need for and administration of second line medication treatment for PPH
3. Explore increasing the number of sets of scales available so that there is one in each room and measurement of bleeding can always be contemporaneous
4. Blood sciences team to continue to work with the clinical teams to identify any opportunities which could reduce the time taken to provide blood and blood products during a PPH
5. Explore how to further embed the 'overview role' during PPH major haemorrhage
6. Administrative staff checking printer defaults on computers regularly and paper in printers at the end of each day
7. Explore ways to ensure warmed intravenous fluids are brought to the room immediately (or have a fluid warmer of labour suite)
8. Explore the use of a wipeable 'grab bag' for key items stored in the emergency trolley.
9. Review the changes made in the theatre layout and use of the whiteboard to assess their effectiveness and identify any further improvements.

Report three – Transfer of a urology patient requiring bladder washouts to a medical ward.

Ten findings were categorised into three themes: i. urology pathway and patient risk factors for bleeding, ii. diagnosis of Covid-19 and Covid cases across the Trust and iii. Organisational capacity and pressures on bed availability.

Three safety actions were identified and one AFI

1. Ensure that the uses and contraindications to the use of TXA are communicated more widely across the Trust through use of this case in junior doctor training and through the publication of a Safety Bulletin for shared learning.
2. Ensure that during periods of very high demand on the service that the rationale for any transfer decisions made outside the normal/usual practice, and that may impact on patient safety, are risk assessed and clearly documented.
3. Surgical patients outlying on medical wards should remain under their primary/specialist Consultant and this should be recorded on e-Care. (Note: the allocation of the patient to a Medical Consultant in error was addressed by the Ward Manager at the time the incident and it is now the practice of the ward to ensure that any outlying patients remains under their specialty Consultant).

In the event that patients need to be transferred away from their primary/specialty ward, ensure that any arrangements/specific patient needs are put in place before the patient is moved and that these are recorded as part of the risk assessment process

Report four – Unexpected death whilst receiving inpatient care.

There were eight findings which resulted in three safety actions and two AFIs

1. Review and update the guideline in use for the administration of intrapleural fibrinolysis. Ensure this includes standards on the level of monitoring and any specific requirements for safe delivery of this treatment (including location).
2. Develop a flow chart on action to take if a patient requires transfer to an alternative ward within the acute trust.
3. Patient safety team to liaise with matron team and review documentation of escalation at Safety Huddle. Safety Recommendations Safety recommendations are broad areas for improvement, they do not define how improvement is to be achieved and are best created after aggregating learning across multiple investigations (and patient safety reviews) into a similar risk.

That key information about ward changes and mitigations planned are communicated effectively with ward teams.
Consider how to articulate the difference between straightforward and complex chest drain patients, add this to the chest drain list and use this term to trigger escalation to matrons.

Annex 2 – Issues identified, learning and actions from complaints

Of note, whilst complaint responses may refer to individuals ("x has reflected on the event", "staff reminded to xx") the detail below outlines some systems-based learning identified in the period.

Subject area	Learning points
Care and communication during caesarean section	Importance of early identification of poorly functioning epidurals. Importance of effective communication with patients when procedures such as epidurals/spinals are technically challenging highlighted to midwifery and anaesthetic teams
	When a patient raises concerns during labour it is beneficial to remain with them for observations to provide reassurance and determine if further examination is appropriate. Skin to skin contact should be initiated as quickly as practicably possible.
Post-surgical care and follow up	Importance of clear, timely and compassionate communication, maintaining patients' dignity and ensuring are analgesics given in a timely manner
	Water and patient call bells should be in patients reach
	Agree standard discharge advice to be given to patients including potential production of a patient information leaflet specific to pilonidal sinus or referring to the nhs.uk information source on this.
Scanning / imaging services	Importance of young children having scans being accompanied at all times.
	There will be occasions when adult patients require additional support, reassurance or care and staff should be sensitive to this. Communications with patients/relatives should be clearly documented, particularly any conversations regarding chaperones so that appropriate safety checks can be carried to accommodate this
Wound care	More robust dressings to be trialled particularly for wounds that have a small incision but require packing. To use a more robust highly absorbent dressing.
	Important to document of depth (or approximation of) of wound in theatre notes and dressings used to pack wounds.
	Complete a single point of access referrals to district nurses on patients' discharge for dressing changes. Should also ensure spare dressings given on discharge.
Cannula care	It is beneficial to consider whether it is possible and appropriate to use other methods, such as minimal adhesive tape or bandaging, to secure cannulas for patients with very fragile skin If removal of a cannula results in an injury such as a skin tear, a referral to community team should be considered so patients do not need to travel to GP surgery for dressing changes
	It is important to clearly document removal of patients' cannulas before being discharged.
Discharge including end of life / patients with a DNAR	Patient documents that need to be returned (e.g. yellow folder) should be placed in a sealed envelope before being transported by taxi
	Discharge checklist for palliative care referral discussed at ward governance meeting. Includes need to ensure DNR paperwork made available to patients and relatives at point of discharge.
	Need to ensure appropriate social assessment referrals are made before discharging patients
COVID-19	Most up to date procedures regarding antivirals and neutralising monoclonal antibodies (nMABs) have been shared with staff to raise awareness of process
Delays in diagnoses	Patients who attend a clinic multiple times within a short period of time for the same problem that is not resolving will be discussed at a senior level or department MDT meeting. Extended imaging will be arranged for any patients who have attended multiple times within a short period of time
	Need to review opportunities and expectations regarding interaction between members of MDT during daily review of patients and the communication process between virtual clinic and inpatient areas to ensure timely exchange of information with appropriate staff
Phlebotomy	Importance of escalation to colleague after one failed attempt of taking blood (>1 complaint from different locations)

4.5. Quality and Nurse Staffing Report

To Assure

Presented by Susan Wilkinson

Board of Directors	
Report title:	Quality and Workforce Report & Dashboard – Nursing September and October 2022
Agenda item:	4.5
Date of the meeting:	25th November 2022
Sponsor/executive lead:	Sue Wilkinson
Report prepared by:	Dan Spooner

Purpose of the report:			
For approval ☐	**For assurance** ☒	**For discussion** ☐	**For information** ☐
Trust strategy ambitions			
Please indicate Trust strategy ambitions relevant to this report.	☐	☐	☐

Executive Summary

This paper reports on safe staffing fill rates and mitigations for inpatient areas for September and October 2022. It complies with national quality board recommendations to demonstrate effective deployment and utilisation of nursing staff. The paper identifies planned staffing levels and where unable to achieve, actions taken to mitigate where possible. The paper also demonstrates the potential resulting impact of these staffing levels. It will go onto review vacancy rates, nurse sensitive indicators, and recruitment initiatives.

Highlights

- Decline in RN fill rates seen in October due to increase in planned demand
- RN turnover has improved; NA turn over continues to rise
- Total Trust RN WTE and total RN vacancy rate achieved Special Cause Improvement in October
- Inpatient NA WTE achieved special cause improvement in September
- Bi annual SNCT audit completed and presented to board assurance committee
- Sickness rates rose in October in both staff groups

Action Required of the Board

For assurance around the daily mitigation of nurse staffing and oversight of nursing establishments
No action needed

Risk and assurance:	Red Risk 4724 amended to reflect surge staffing and return to BAU
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 monthly, 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.

This paper will identify safe staffing and actions taken in September and October 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 September and October 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. Appendix 1a and 1b illustrates a ward-by-ward breakdown for September and October.

	Day		Night	
	Registered	Care Staff	Registered	Care staff
Average fill rate May 2022	87%	80%	89%	98%
Average fill rate June 2022	87%	74%	88%	92%
Average fill rate July 2022	87%	70%	89%	91%
Average fill rate August 2022	87%	78%	87%	95%
Average fill rate Sept. 2022	87%	76%	88%	95%
Average fill rate October 2022	83%	70%	87%	88%

Table 1: Fill rates are RAG rated to identify areas of concern (Purple >100%, Green: 90-100%, Amber 80-90%, Red <80).

An average of the fill rates for roles and shifts have been combined in chart 2 to illustrate the cumulative challenge to nurse staffing over the last year which has seen a deteriorating trend since summer 2021. This trend is consistent with deterioration of CHPPD which is illustrated in chart 3.

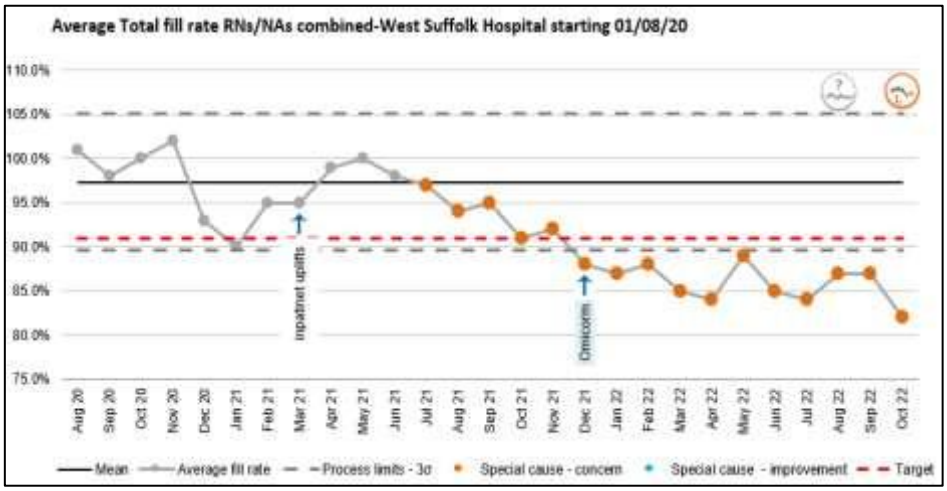


Chart 2.

Highlights

- RN fill rates remained static in September as seen in previous months. with a deterioration in October. On review of the data this is driven by an increased demand and an increase in planned RN hours in month of 1295 hours. Actual nursing hours was only 122 hours less in October than previous month
- CHPPD does show a decline in October but not the same extent in planned versus actual. Therefore, assumptions can be made that a significant drop in nursing hours was not seen but an increase in demand was seen in October. This was driven by several areas including Neonates, AAU, Rosemary ward, F6 and G4.

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). Using model hospital, the average Recommended CHPPD for an organisation of our size is 7.6. The chart below demonstrates our achievement of this. Since August 2021 we are not achieving this consistently and further demonstrates the staffing challenges over the last year.

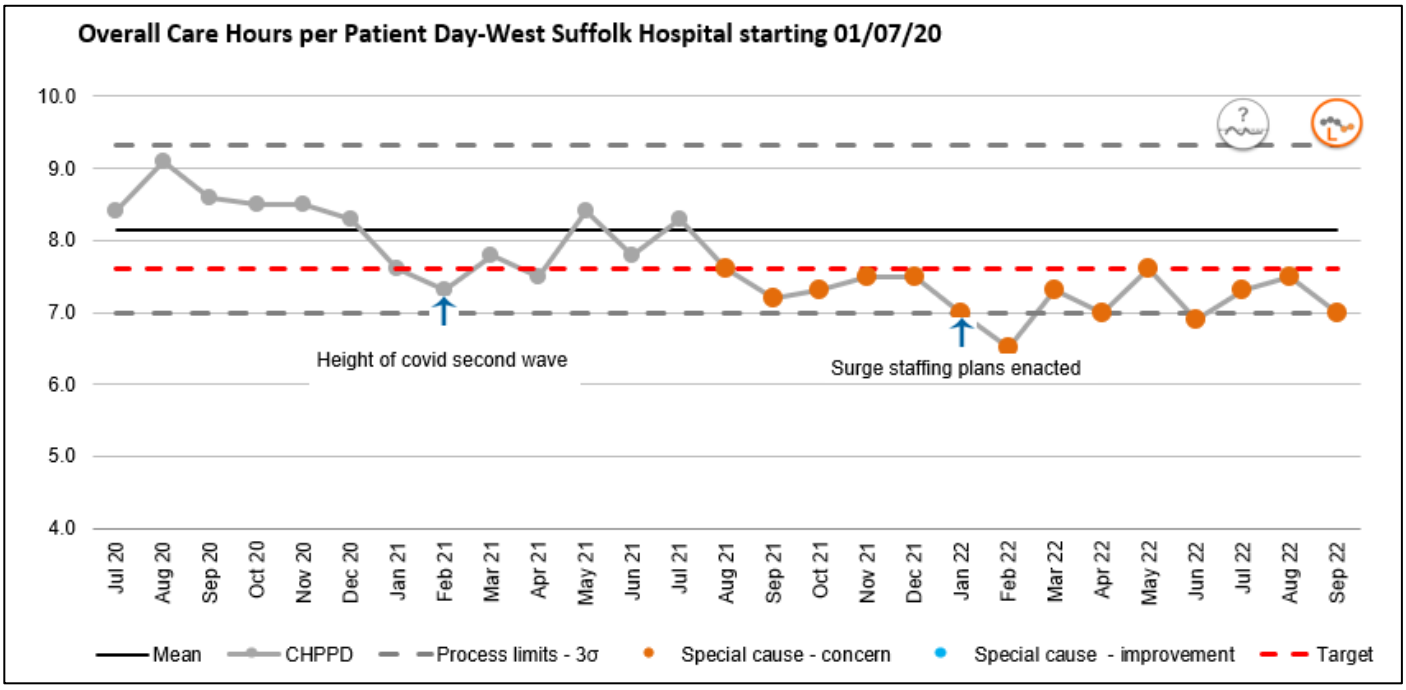


Chart 3 Adapted from model hospital/unify data

3. Sickness

Overall sickness rates increased in this period which would have added additional challenge to fill rates in October.

	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep 22	Oct 22
Unregistered staff (support workers)	10.24%	9.07%	7.32%	9.40%	9.54%	7.10%	6.75%	7.81%
Registered Nurse/Midwives	7.00%	6.27%	5.63%	5.43%	6.07%	4.40%	4.57%	5.38%
Combined Registered/Unregistered	**8.12%**	**7.25%**	**6.20%**	**6.76%**	**7.26%**	**5.32%**	**5.32%**	**6.21%**

Table 4

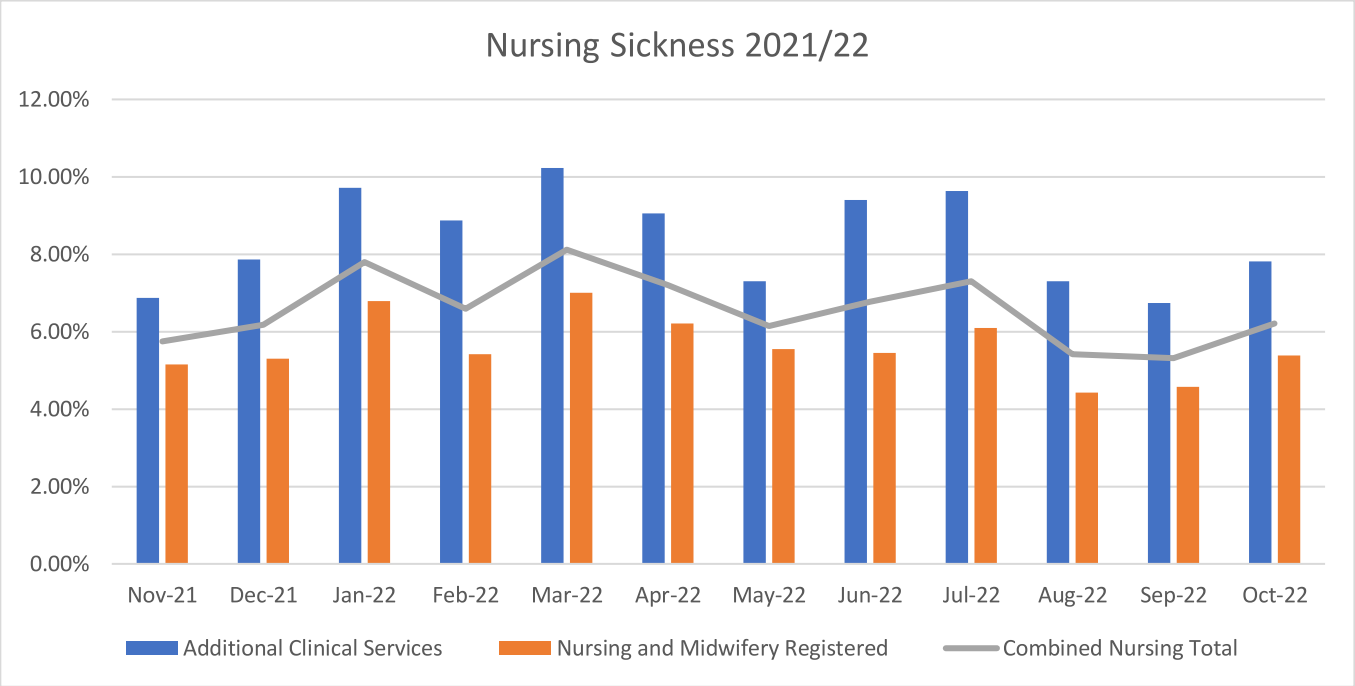


Chart 4a

4. 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.

No additional wards opened during this period which has greatly assisted in addressing staffing challenges. Surge areas as part of BAU have been used consistently in this reporting period which required the sourcing of 2 RNs and 2 NAs for the duration of its function. While this appears to be small numbers, it is additional pressure on the current shortfall and reduces the efficacy of the emergency care pathway and inpatient care

- F11 were decanted to F9 (since March 2022 to present)
- F14 were decanted to F10 (11 sept to present)

5. Recruitment and Retention

<u>Vacancies: Registered nursing (RN/RM):</u>

- Substantive Inpatient RN/RM WTE and vacancy rate is common cause variation. Inpatient vacancy rate is currently 16.3%, and 16.1% excluding Registered Midwives (RMs)
- Total RN/RM establishment and vacancy rate achieved special cause improvement in October and is at 11.8%
- Inpatient ward NA vacancies achieved special cause improvement in September and vacancy rate for inpatient areas is currently 13.2%
- Total NA vacancy rate is 12.9% and is common cause variation.

Table 5 demonstrates the total RN/RM establishment for the inpatient areas (WTE). The total number of substantive RNs has seen an improving trend until March this year. Full list of SPC related to vacancies and WTE can be found in appendix 2. Areas of concern remain within the non-registered staff group

	Inpatient	Sum of Actuals Period 02 (May)	Sum of Actuals Period 03 (Jun)	Sum of Actuals Period 04 (July)	Sum of Actuals Period 05 (Aug)	Sum of Actuals Period 06 (Sept)	Sum of Actuals Period 07 (Oct)	WTE VACANCY at period 5
RN/RM Substantive	Ward WTE	609.9	609.5	601.8	608.7	617.5	612.8	119
Nursing Unregistered Substantive	Ward WTE	373.1	364	374.4	387.9	407	391.6	65.4

Table 5. Ward/Inpatient actual substantive staff with WTE vacancy

Appendix 3 provides a full list of current ward-by-ward vacancies.

6. New Starters and Turnover

International Nurse Recruitment:

We remain on trajectory to achieve our annual target of international nurse recruitment as capacity with accommodation has increased to enable the arrival of ten nurses a month. This is made up of nurses supplied by agency engagement and direct recruitment where there is a shortfall. There is a national issue with delays in OSCE availability which is impacting on recruitment currently. Previously reported delays in OSCE exams, have begun to improve and an escalation process is now in place to highlight any delays our nurses are facing

In September only six nurses arrived, which was lower than our monthly ambition, however this will be rectified in the coming months and twelve arrived in October. Twenty-three international nurses are set to arrive in the next two months.

New starters

	May 22	June 22	July 22	August 22	Sept 22*	Oct 22
Registered Nurses*	7	16	18	18	43	21
Non-Registered	12	35	16	9	31	22

Table 6: Data from HR and attendance to WSH induction program. OSN arrivals will be included in RN inductions. *Two inductions ran this month

- In September, forty-three RNs completed induction; of these; thirty-two were for acute services, 6 for bank, 6 for maternity and 6 for community services joined this cohort
- In September, sixteen NAs completed induction; of these thirteen NAs are for the acute Trust, 1 for bank services, 1 for midwifery and 1 for community.

- In October eighteen RNs completed induction; of these; fifteen were for acute services, 2 for bank services, 2 for midwifery and 2 for community
- In October Twenty-two NAs completed induction; of these, nineteens NAs are for the acute Trust, 1 for bank services and 1 for midwifery and 1 for community services

Turnover

On a retrospective review of the last rolling twelve months, turnover for RNs has improved by 1% (11.87) last report) above the trust ambition of <10%. NA turnover has increased again from 21.64% to 22.96%. The increasing turnover has been escalated through the finance and workforce committee and is being captured at the Trust retention group. In addition, the DCN is working collaboratively with other trusts within our ICB to review the terms and conditions of the NA role following publications of national job profiles.

Turn Over 01/11/2021 - 31/10/2022								
Staff Group	Average Headcount	Avg FTE	Starters Headcount	Starters FTE	Leavers Headcount	Leavers FTE	LTR Headcount %	LTR FTE %
Nursing and Midwifery Registered	1,336.50	1,154.29	108	83.60	154	124.62	11.52%	10.80%
Additional Clinical Services	581.50	485.95	231	211.49	136	111.58	23.39%	22.96%

Table 7. (Data from workforce information)

7. Quality Indicators

Falls

Despite a special cause variation in March 2022 where staffing was extremely challenged and into surge staffing mitigation, falls have moved into common cause variation seeing incidnets between 55 to 85 falls a month. The width of variation between acute falls per 1000 bed days needs to be understood. This continues to be reviewed in the 'Patient Quality and Safety governance group'.

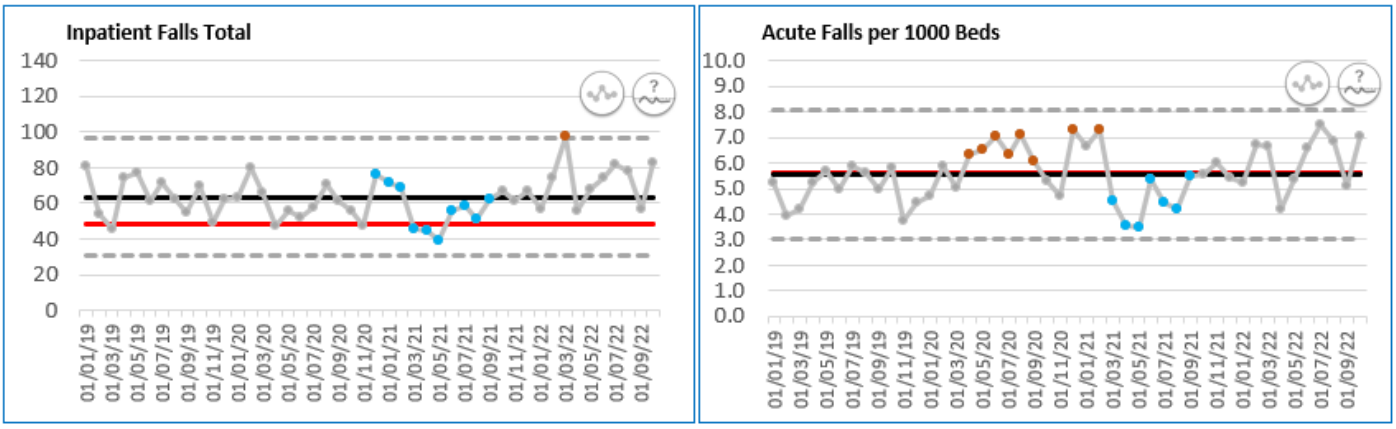


Chart 8

Pressure Ulcers

Within the inpatient areas (inclusive of CAB), the increasing trend above average expectation returned to common cause variation in May 2022. This variation continues. This is possibly driven by challenges with high NA absences and an increasing turn over for this group. Areas where high incidence have occurred have been supported with bespoke training and study days over the summer months. Pressure ulcers in September achieved target, however October above expected average was seen

Community prevalence has maintained common cause variation for over a year. The senior nursing team have been working with the national would care collaborative on improvement methods within the community.

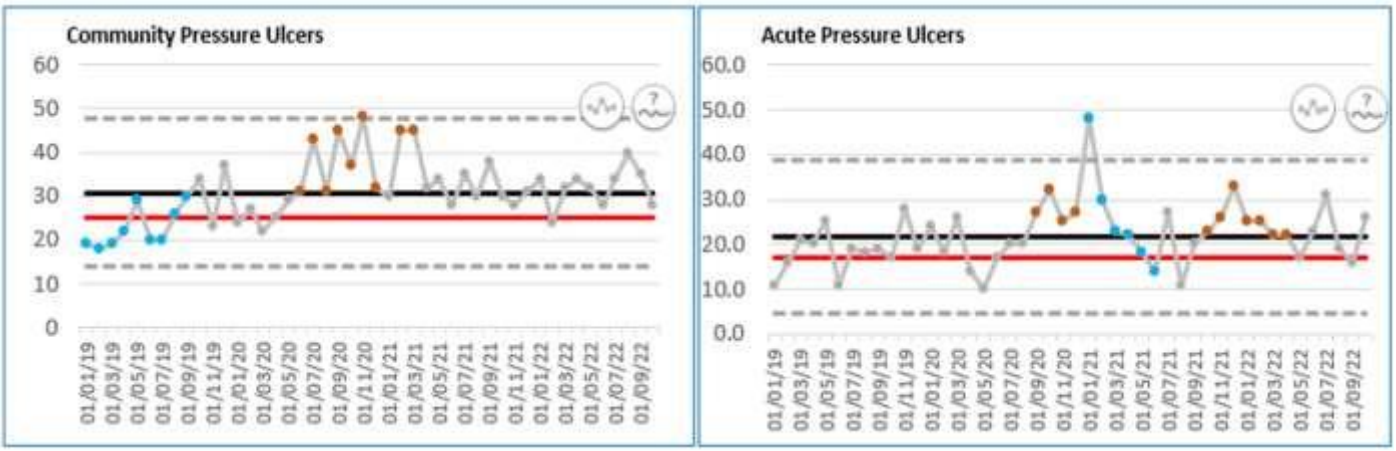


Chart 9

8. Compliments and Complaints

In September the average number of calls to the clinical helpline was 99 and 112 per day in October. This activity is well sustained since the relaxing of visiting restrictions in May 2022.

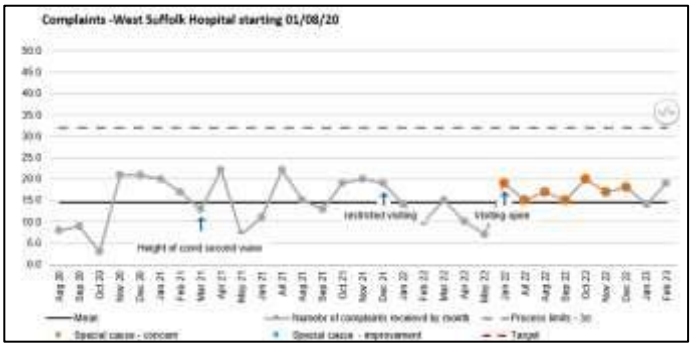
Fourteen new complaints were received in September The main subject for complaints received in September 2022 was Clinical Treatment – General Medicine group, with 4 complaints being listed under this subject. 2 of these complaints raised concerns about delays or failure to diagnose.

Nineteen new complaints were received in October. Of those received in October, eleven were related to the medical division, 2 for the surgical division, 4 for women & children's division, 1 for integrated community services and 1 for clinical support division.

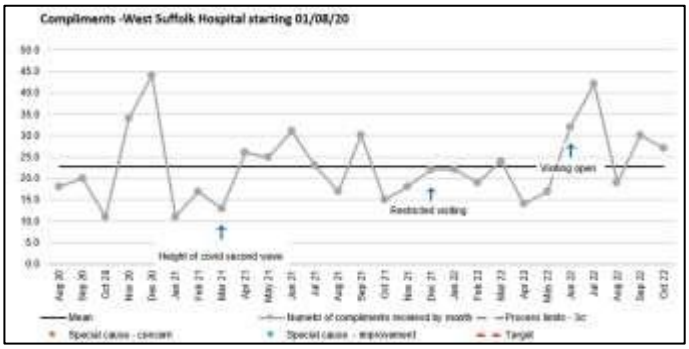
The main subject for complaints received in October 2022 was clinical treatment overall with a total of 8 formal complaints being listed under this subject. Accident and emergency received the highest number of complaints in this category, with 3 formal complaints listed under this subject. 2 of these raised concerns about delays or failure to diagnose.

On reviewing all complaints listed under clinical treatment in October, regardless of location, the main theme overall for these complaints is again delay or failure to diagnose with 5 complaints listed under this sub-subject.

Chart 10a and 10b demonstrates the incidence of complaints and compliments for this period.



10a Complaints



10b Compliments

9. 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 5). Nursing staff are encouraged to complete a Datix as required, so any resulting patient harm can be identified and if necessary, reviewed retrospectively.

Red Flag	Apr 22	May 22	June 22	July 22	Aug 22	Sept 22	Oct 22
Registered nursing shortfall of more than 8 hours or >25% of planned nursing hours	10	1	7	12	7	3	2
>30-minute delay in providing pain relief	6	1	-	2	2	3	2
Delay or omission of intention rounding	2	-	5	3	3	2	12
<2 RNs on a shift	6	-	5	1	5	8	7
Vital signs not recorded as indicated on care plan	3	1	-	1	2	1	2
Unplanned omissions in providing medication	-	-	-	-	-	-	-
Lack of appointments (local agreed red flag)	-	1	3	1	-	-	1
Delay in routine care (new descriptor)	17	11	18	14	18	10	17
Impact not described	-	-	-	-	-	-	1
Total	44	15	38	34	37	27	44

Table 11.

- In September there were 27 Datixs recorded for nurse staffing that resulted in a Red Flag event (see table 11.). No harm is recorded for these incidents at the time.

- In October there were 44 Datixs recorded for inpatient nurse staffing that resulted in a Red Flag event (see table 11). No harm recorded for these incidents at the time

10. 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 staffing crisis and the maternity team will be responding to regional and national assurances around staffing mitigation.

	Standard	May	June	July	August	September	October
Supernumerary Status of LS Coordinator*	100%	100%	98.8%	99%	98%	92%	99%
1-1 Care in Labour	100%	100%	100%	100%	98%	100%	100%
MW: Birth Ratio	1:28	1:27.5	1:25	1:27	1:27	1:29	1:29
No. Red Flags reported		9	24	13	9	15	11

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 fifteen red flag events in September. No harm was recorded as in impact of these incidents
- There were eleven red flag events in October. No harm was recorded as in impact of these incidents.

Midwife to Birth ratio
Midwife to Birth ratio was 1.29 in both September and October, this is above the national average of 1:28 and the Birthrate Plus recommendation of 1:27.7 and was due to increase staffing sickness and the demand on the service over this period

1:1 care was achieved 100% in both September and October.

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 September 92% compliance against this standard was achieved and in October 99%. This was due to staff shortages and increased acuity in the Unit. No adverse outcome resulted from the occurrence. *Changes to the technical guidance for Safety Action 5 in the CNST standards were published in October 2022 adding clarity to the assessment of supernumerary status. The technical guidance in the re-launched Safety Action 5 gives clarity to the supernumerary status of the LSC. This is clarified and explained in the full Midwifery staffing report.

Challenges to achieving his standard in these months was driven by the labour suite co-ordinator being required to triage patients in the Labour suite to prioritise care

11. 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. The demand on community healthcare teams, and community and integrated therapies in general remain high and above pre -pandemic averages and is special cause for concern. Referrals to therapy in the INTs had been reducing, although levels are still above our average. Other services such as Speech & Language therapy and Early Supported Stroke Discharge are of a similar picture. These increases reflect our growing older, frailer population and the required healthcare at home to maintain their health. The CHT therapists have QI projects in progress to ensure referrals are appropriate, and where we can signpost to alternative options at the point of referral, for example the care homes team or Abbeycroft leisure for exercise programmes.

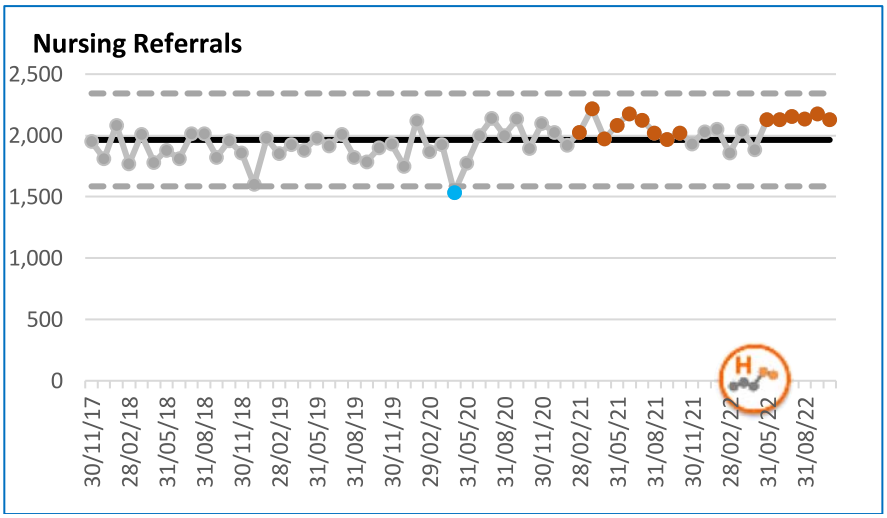


Chart 12a

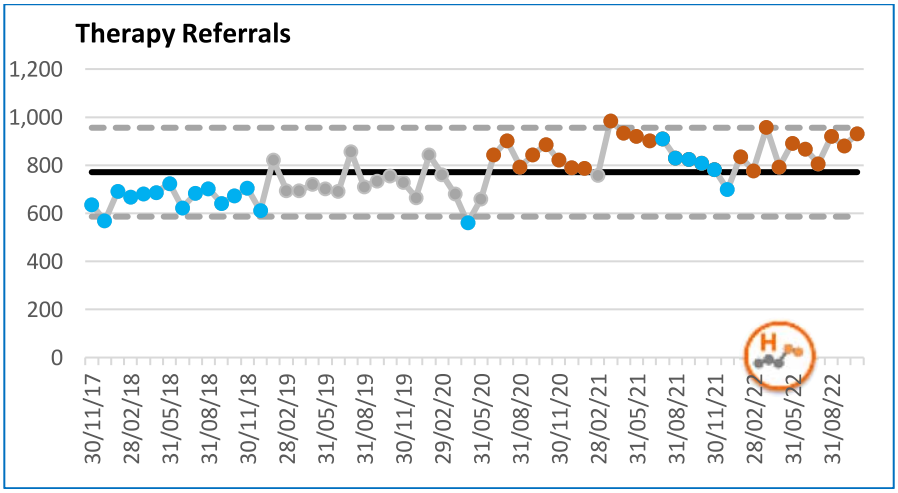


Chart 12b

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.

12.3 Sickness

Month	Community
April	4.62%
May	5.39%
June	5.92%
July	7.09%
August	4.86%
September	4.9

12.4 Vacancies in CHTS

Role	Vacancy percentage	
	Last reported	October
RNs	17%	16%
Physiotherapists	17%	31%
Occupational therapists	13%	9%
Generic workers /unregistered	11%	13%

A significant increase in Physiotherapy vacancies seen this month. In October a new post within the HR recruitment team has commenced purely focussing on AHP recruitment which will address this deficit seen in both the acute and community teams.

12.5 Ongoing actions being taken by division

- Vacancies that attract no applicants are always reviewed to see if a change in the skill mix might attract new applicants.
- Rapid pool CHT nursing went live in September. Since its start on 27 Sept, according to the escalation reports, we have had 7 out of 168 shifts filled (that's based on 4 shifts per weekday and 2 shifts per weekend days). This poor uptake needs further investigation.
- Video being used to promote recruitment for nurses in CHTs.
- Senior matron dedicated to CAB beds in post from October. Focus on recruiting to vacancies, recruiting from overseas (accommodation pending)
- Community Nursing Safe Staffing Tool (CNSST) licence has been acquired and training for key staff members of the audit process is being rolled out. This is a significant step forward in being able to assess the establishment of our community nursing teams.

12. Biannual staffing review

The summer round of Safer Nursing Care Tool audit was completed in June/July and following analysis of outcomes. A paper has been presented to the Improvement Sub Board committee on 14th November 2022 to provide assurance around the robustness of the review process and its compliance with expectations set out with the 'developing workforce safeguards' document (NHSE, 2018). The paper was received, and positive assurance was acknowledged around this process. The full paper can be found in Appendix 6.

A summary of the review is demonstrated in table 15 below with the financial implications by division in table 16. A full paper will be presented to investment panel from the corporate division recommending a number of weighted options to ensure that priority areas are considered.

Directorate	No change to establishment	Skill mix adjustment	Increase in WTE	Decrease in WTE	Areas reviewed
Medicine	7	2	3	0	12
Surgery	2	0	2	0	4
Community (CAB beds)	2	0	0	0	2
W & C	2	0	0	0	2

Total	**13**	**2**	**5**	**0**	20

Table 15.

Directorate	Cost pressure
Medicine	£404,725
Surgery	£134,595
Community (CAB beds)	0
W & C	0
Total	**£539,296.13**

Table 16.

Since the last report licences for the A&E audit tool and the community audit tool have been acquired and training for the delivery of the audit has commenced. A round of audit for both these services is being scoped for the next quarter.

13. Recommendations and Further Actions

- 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 (September 2022): Data adapted from Unify submission

RAG: Red <79%, Amber 80-89%, Green 90-100%, Purple >100%

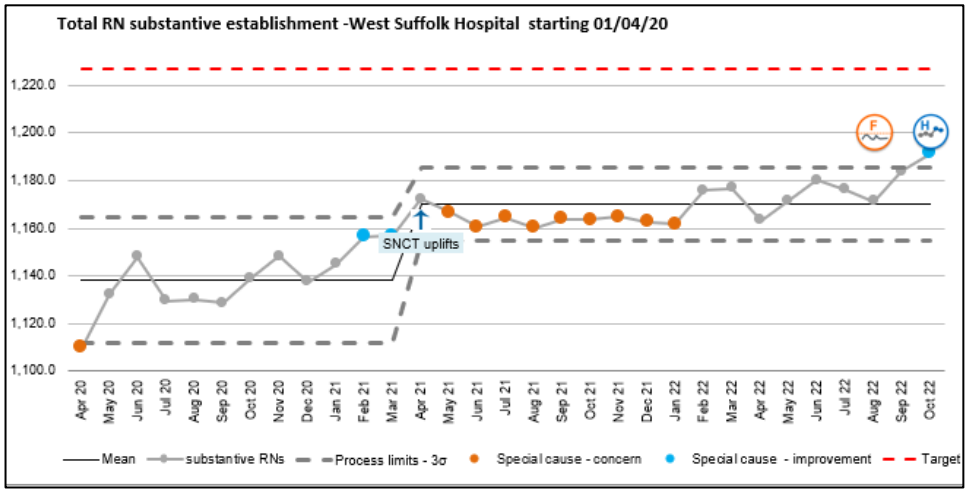
	Day				Night				Day		Night		Care Hours Per Patient Day (CHPPD)			
	RNs/RMN		Non registered (Care staff)		RNs/RMN		Non registered (Care staff)									
	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned 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	993.5	987.91667	1825	1398.25	1000.5	883.5	1357	1252.5	99%	77%	88%	92%	928	2.0	2.9	4.9
Glastonbury Cou	686.5	694	1023.5	901.5	690	689	525	521	101%	88%	100%	99%	508	2.7	2.8	5.5
Acute Assessme	2051.75	1729.25	2406	1245.5	1725	1546	1380	1010.5	84%	52%	90%	73%	761	4.3	3.0	7.3
Cardiac Centre	2891	2458.25	1268.5	991.5	1725	1437.5	690	701.5	85%	78%	83%	102%	632	6.2	2.7	8.8
G10	1578	1199.5	1573.5	1090	1033.5	931.5	1389.5	1346.5	76%	69%	90%	97%	707	3.0	3.4	6.5
G9	1375.5	1075.25	1380	1079.5	1380	1205.5	1035	1033.5	78%	78%	87%	100%	752	3.0	2.8	5.8
F12	542	642	345	262.5	690	493	345	402.5	118%	76%	71%	117%	240	4.7	2.8	7.5
F7	1720	1347.5833	1706.75	1261.5	1380	1108	1706.5	1244.5	78%	74%	80%	73%	683	3.6	3.7	7.3
G1	1548.5	1190.3333	345	271.5	690	690	345	276	77%	79%	100%	80%	485	3.9	1.1	5.0
G3	1688.25	1330.25	1726	1480.5	1000.5	891	1033.5	1380	79%	86%	89%	134%	864	2.6	3.3	5.9
G4	1729	1370.5	1774.5	1423	1035	837.5	1377.5	1252.33333	79%	80%	81%	91%	896	2.5	3.0	5.5
G5	1380	1401.5	1722	1394	690	959	1380	1261.75	102%	81%	139%	91%	760	3.1	3.5	6.6
G8	2417.5	1673.1667	1740.5	1485.3333	1730.5	1289	1035	1070.5	69%	85%	74%	103%	615	4.8	4.2	9.0
F8	1381.25	1315.1667	2074.5	1519.5	1035	714.5	1380	1309	95%	73%	69%	95%	723	2.8	3.9	6.7
Critical Care	2737.75	2329	330	229	2758.75	2378	0	33	85%	69%	86%	*	388	12.1	0.7	12.8
F3	1719	1578.25	2070	1372.5	1035	1009	1380	1311	92%	66%	97%	95%	732	3.5	3.7	7.2
F4	1000.5	908.5	943	685.5	690	655.5	598	456.5	91%	73%	95%	76%	633	2.5	1.8	4.3
F5	1718.5	1348	1366.5	1110	1035	927.5	1035	857	78%	81%	90%	83%	698	3.3	2.8	6.1
F6	1960.11667	1668.5	1604.5	1070	1368.5	1127.25	690	756	85%	67%	82%	110%	942	3.0	1.9	4.9
Neonatal Unit	1081.5	1430.8333	456	463.25	996	976	336	324	132%	102%	98%	96%	116	20.7	6.8	27.5
F1	1828.5	1674.25	690	632.5	1380	1185.5	0	140.5	92%	92%	86%	*	115	24.9	6.7	31.6
F14	752	840.5	312	339	719.5	719.75	0	95.5	112%	109%	100%	*	106	14.7	4.1	18.8
Total	34,780.62	30,192.50	28,682.75	21,705.83	25,787.75	22,653.50	19,018.00	18,035.58	**87%**	**76%**	**88%**	**95%**	**13284**	**4.0**	**3.0**	**7**

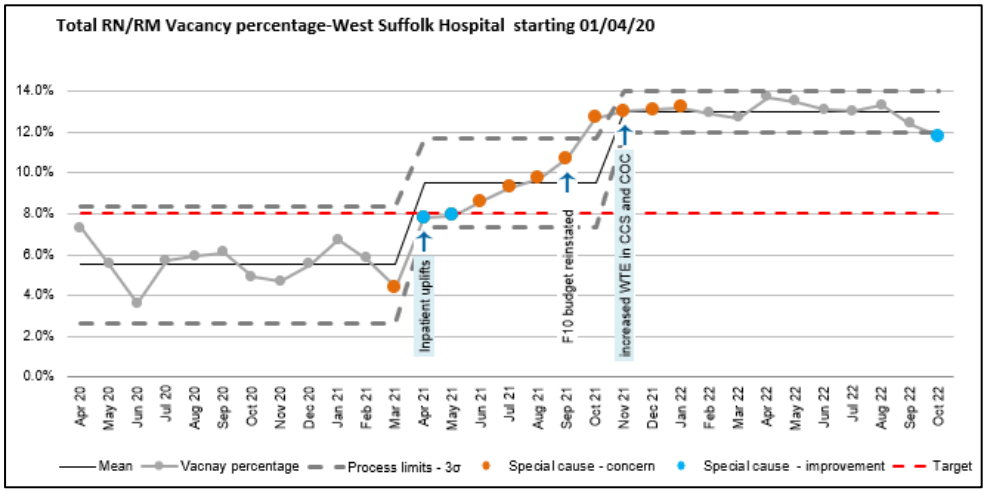
Appendix 1. Fill rates for inpatient areas (October 2022): Data adapted from Unify submission

	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 day	RNS/RMs	Non registered (care staff)	Overall
Rosemary Ward	1081.75	1021.5	1833.5	1103	1023.5	874.5	1426	1247	94%	60%	85%	87%	974	1.9	2.4	4.4
Glastonbury Cour	718.5	725.5	1068	960	713	713	542.5	554.5	101%	90%	100%	102%	527	2.7	2.9	5.6
Acute Assessmen	2128.48333	1806.75	2482.5	1162.5	1782.5	1553	1420	958.75	85%	47%	87%	68%	761	4.4	2.8	7.2
Cardiac Centre	2933.5	2361.25	1333.5	1027.75	1782.5	1498	710	670.5	80%	77%	84%	94%	632	6.1	2.7	8.8
G10	1612	1145.25	1615	1181.25	1070.5	933.5	1414.5	1325.66667	71%	73%	87%	94%	707	2.9	3.5	6.5
G9	1424.25	1150.9167	1426	973.25	1426	1174.5	1069.5	1066.5	81%	68%	82%	100%	752	3.1	2.7	5.8
F12	552	621	356.5	322	714	573.75	356.5	379.5	113%	90%	80%	106%	240	5.0	2.9	7.9
F7	1782.5	1324.3333	1782.5	1255.5	1425.98333	1144.483333	1760	1071.25	74%	70%	80%	61%	683	3.6	3.4	7.0
G1	1567	1148	356.5	231	713	713	356.5	264.5	73%	65%	100%	74%	485	3.8	1.0	4.9
G3	1713.5	1362.75	1769	1469.0667	977.5	942	1065.5	1296.25	80%	83%	96%	122%	864	2.7	3.2	5.9
G4	1786.75	1355.5833	1813.5	1495	1088	800.5	1426	1327.5	76%	82%	74%	93%	896	2.4	3.2	5.6
G5	1426	1348.5	1777	1162	713	955.5	1415.5	1131.5	95%	65%	134%	80%	760	3.0	3.0	6.0
G8	2495.5	1767.9167	1793.75	1270.8333	1782.5	1394.6	1058.75	996.083333	71%	71%	78%	94%	615	5.1	3.7	8.8
F8	1410.5	1313	2081	1381	1069.5	791.75	1426	1260.5	93%	66%	74%	88%	723	2.9	3.7	6.6
Critical Care	2762.5	2185.5	329.5	217.5	2828.5	2242.75	0	29	79%	66%	79%	*	388	11.4	0.6	12.0
F3	1782.5	1578.75	2141	1275.25	1069.5	1070	1388	1264	89%	60%	100%	91%	732	3.6	3.5	7.1
F4	1196	892	954.5	604.5	713	690	598	407	75%	63%	97%	68%	633	2.5	1.6	4.1
F5	1777.5	1486	1420	1089.5	1069.5	948.8333333	1058	928	84%	77%	89%	88%	698	3.5	2.9	6.4
F6	2014.13333	1691.5	1629.5	1094	1421.5	1138	713	695.25	84%	67%	80%	98%	942	3.0	1.9	4.9
Neonatal Unit	1273.5	1313.1667	744	578.5	1116	1020	744	432	103%	78%	91%	58%	116	20.1	8.7	28.8
F1	1870	1585.25	696	661	1426	1299.5	0	79.75	85%	95%	91%	*	115	25.1	6.4	31.5
F14	768	885.5	312	422.5	744	720.5	0	79.0166667	115%	135%	97%	*	106	15.2	4.7	19.9
Total	36,076.37	30,069.92	29,714.75	20,936.90	26,669.48	23,191.67	19,948.25	17,464.02	**83%**	**70%**	**87%**	**88%**	**13349**	**4.0**	**2.9**	**6.9**

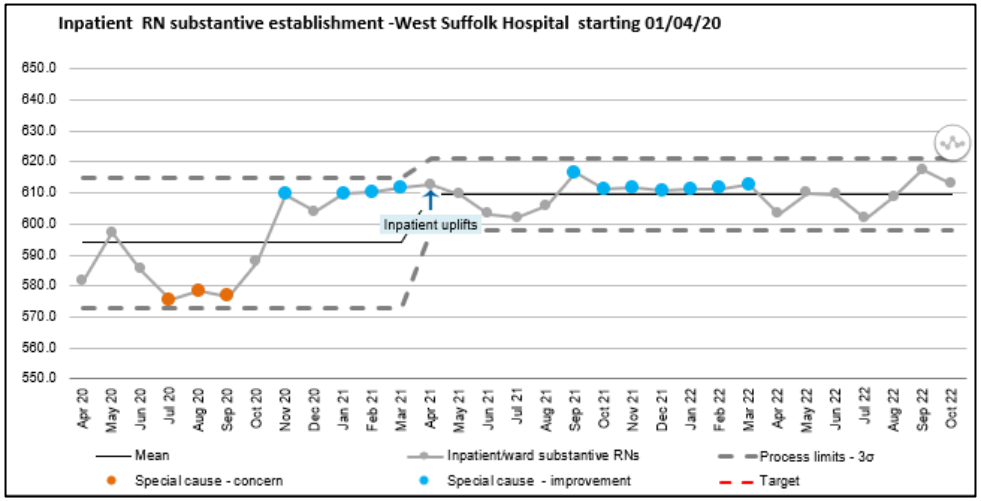
Appendix 2 SPC charts

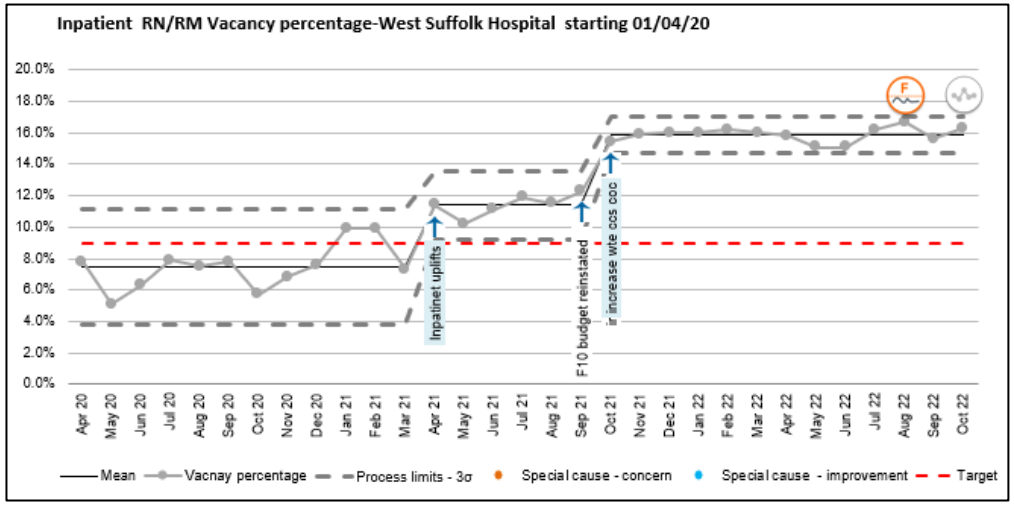
Total RN/RM establishments and vacancy percentage



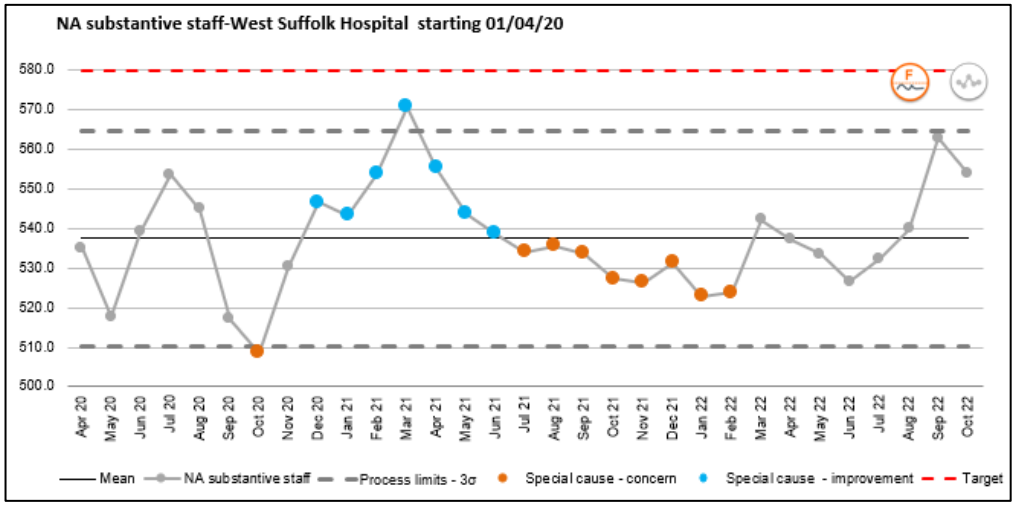


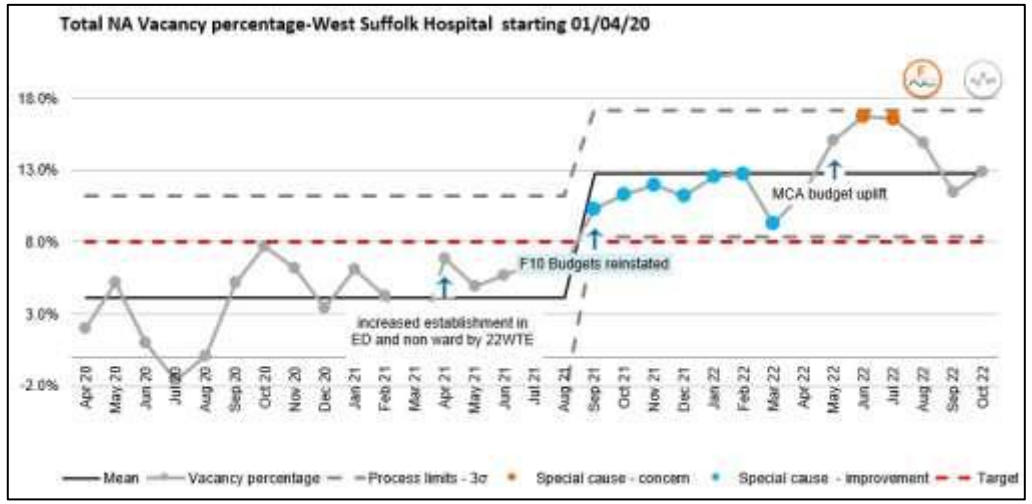
Inpatient RN/RM establishments and vacancy percentage



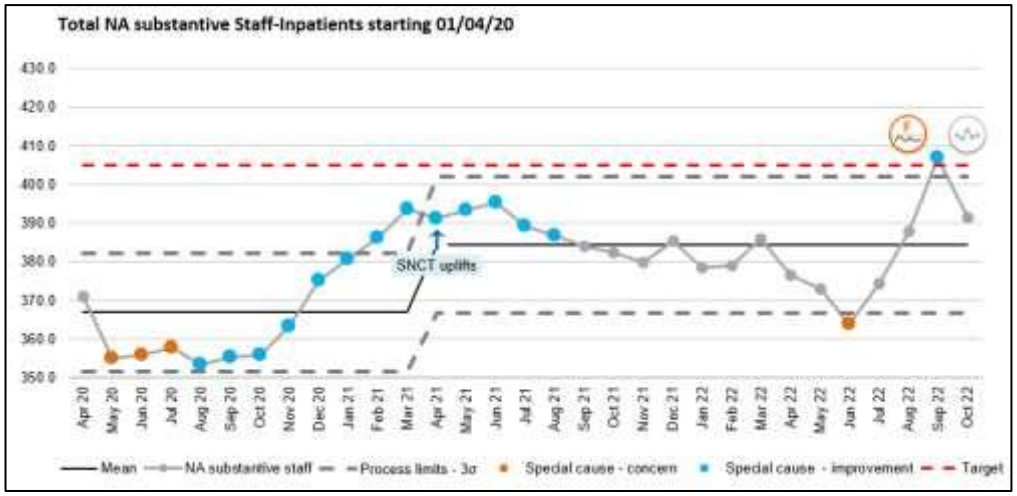


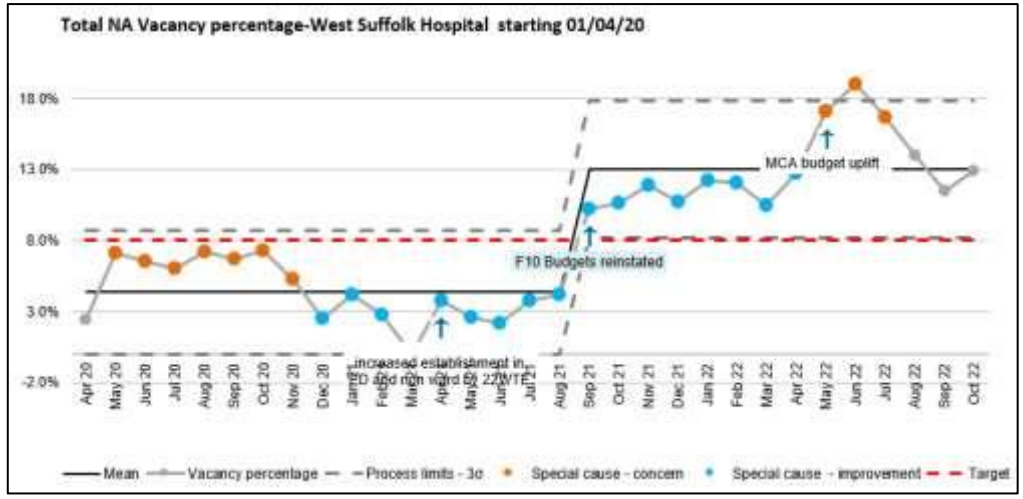
Total NA WTE numbers and vacancy percentages





Inpatient WTE numbers and vacancy percentage





Appendix 3. Inpatient ward vacancies (October 2022): Data adapted from finance report

Oct-22										
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	26.1	30.1	4.0	13.2	AAU	17.9	28.3	10.4	36.8	24.7
Accident & Emergency	53.8	69.5	15.7	22.6	Accident & Emergency	32.7	34.5	1.8	5.1	16.8
Cardiac Centre	35.2	40.7	5.5	13.5	Cardiac Centre	13.7	15.7	2.0	12.9	13.3
Glastonbury Court	11.8	11.7	-0.1	-1.1	Glastonbury Court	11.1	12.6	1.5	12.2	5.8
Critical Care Services*	44.5	50.0	5.5	11.0	Critical Care Services	1.6	1.9	0.3	14.9	11.1
Day Surgery Wards	10.5	11.0	0.5	4.3	Day Surgery Wards	2.9	3.9	1.0	26.0	9.9
Gynae Ward (On F14)	12.7	14.1	1.4	10.0	Gynae Ward (On F14)	2.0	2.0	0.0	0.0	8.8
Neonatal Unit	19.9	20.6	0.8	3.6	Neonatal Unit	8.9	10.1	1.2	11.9	6.4
Rosemary ward	14.8	18.4	3.6	19.3	Rosemary ward	19.0	24.8	5.8	23.4	21.7
Recovery Unit	25.8	27.3	1.5	5.6	Recovery Unit	0.9	0.9	0.0	1.2	5.5
Ward F1 Paediatrics	23.1	25.1	2.1	8.2	Ward F1 Paediatrics	6.4	7.7	1.3	16.9	10.2
Ward F12	6.9	11.9	5.1	42.4	Ward F12	6.2	5.9	-0.4	-6.0	26.5
Ward F3	22.4	22.2	-0.2	-0.9	Ward F3	19.3	25.8	6.5	25.3	13.2
Ward F4	12.6	15.0	2.4	15.7	Ward F4	12.4	12.4	0.0	0.0	8.6
Ward F5	20.7	22.2	1.5	6.7	Ward F5	14.3	18.1	3.8	20.7	13.0
Ward F6	21.5	26.6	5.1	19.3	Ward F6	14.1	17.4	3.3	18.7	19.1
Ward F7 Short Stay	20.7	24.9	4.2	16.9	Ward F7 Short Stay	17.6	25.8	8.2	31.7	24.4
Ward G5	17.3	21.8	4.5	20.6	Ward G5	17.5	23.2	5.7	24.5	22.6
Ward G1 Hardwick Unit	27.5	29.6	2.1	7.1	Ward G1 Hardwick Unit	10.7	10.5	-0.2	-1.6	4.8
Ward G3	19.5	22.1	2.6	11.6	Ward G3	24.3	23.0	-1.3	-5.7	2.8
Ward G4	17.2	22.1	4.9	22.2	Ward G4	21.8	23.5	1.7	7.2	14.5
Ward G8	19.4	32.7	13.3	40.5	Ward G8	23.2	20.6	-2.6	-12.6	20.0
Renal Ward - F8	15.2	19.5	4.3	22.0	Renal Ward - F8	21.2	25.8	4.6	17.7	19.5
Ward G10	14.9	19.0	4.1	21.6	Ward G10	17.1	24.1	7.0	29.0	25.8
Respiratory Ward - G9	15.8	23.7	7.9	33.3	Respiratory Ward - G9	19.3	18.0	-1.3	-7.0	15.8
Total	529.7	631.6	101.9	**16.1**	Total	356.0	416.3	60.3	**14.5**	**15.5**
Hospital Midwifery	47.3	58.9	11.6	19.7	Hospital Midwifery	27.3	28.5	1.2	4.2	14.6
Midwifery management	17.4	17.4	0.0	0.0						
Continuity of Carer Midwifery*	34.8	39.1	4.3	11.0						
Total	99.5	115.4	15.9	**13.8**	Total	27.3	28.5	1.2	**4.2**	**11.9**

Appendix 4:

Ward by Ward breakdown of Falls and Pressure ulcers September and October 2022

HAPU

Sep-22	Cat 2	Cat 3	Unstageable	Total
Critical Care Unit	1	0	0	1
F10	1	0	0	1
F12 Isolation Ward	0	0	1	1
Rosemary Ward	1	0	0	1
G3 - Endocrine and General Medicine	0	1	1	2
Gastroenterology Ward	2	0	0	2
Glastonbury Court	1	1	0	2
Renal Ward	2	0	0	2
F7	3	0	0	3
Respiratory Ward	3	0	1	4
Total	**14**	**2**	**3**	**19**

October 2022	Cat 2	Cat 3	Unstageable	Total
Cardiac Centre - Ward	1	0	0	1
G1 - ward	1	0	0	1
Respiratory Ward	1	0	0	1
Acute Assessment unit (AAU)	1	0	0	1
F5 - ward	1	0	0	1
F3 - ward	3	0	0	3
G10	3	0	0	3
Renal Ward	3	0	0	3
Rosemary Ward	2	1	0	3
F7	1	1	1	3
G3 - Endocrine and General Medicine	4	0	0	4
G8 - Stroke Ward	2	0	2	4
Total	**23**	**2**	**3**	**28**

Falls

September 2022	None	Negligible	Minor	Major	Total
CHT Sudbury	0	0	1	0	1
Macmillan Unit	1	0	0	0	1
Radiology Department	1	0	0	0	1
Support to go home	1	0	0	0	1
Ultrasound Department	1	0	0	0	1
Urology Department Offices	0	1	0	0	1
Physiotherapy Department	1	0	0	0	1
Cataract Clinic	1	0	0	0	1
F5 - ward	1	0	0	0	1
Cardiac Centre - Ward	2	0	0	0	2
F12 Isolation Ward	2	0	0	0	2
F4 - ward	2	0	0	0	2
Emergency Department	1	0	1	0	2
F6 - ward	2	0	0	0	2
F3 - ward	2	1	0	0	3
G1 - ward	2	1	0	0	3
G8 - Stroke Ward	1	1	1	0	3
G3	4	0	0	0	4
Gastroenterology Ward	2	0	2	0	4
Glastonbury Court	4	0	0	0	4
F7	2	0	2	0	4
Rosemary Ward	2	0	4	1	7
G10	7	0	1	0	8
G4 - ward	4	2	1	1	8
Renal Ward	8	0	0	0	8
Respiratory Ward	6	0	2	0	8
Acute Assessment unit (AAU)	7	1	1	0	9
Total	**67**	**7**	**16**	**2**	**92**

October 2022	None	Negligible	Minor	Total
CHT Bury Town	1	0	0	1
Physiotherapy Department	1	0	0	1
Renal Ward	1	0	1	2
F4 - ward	2	0	1	3
Gastroenterology Ward	2	1	0	3
F5 - ward	2	0	1	3
Respiratory Ward	1	0	3	4
Emergency Department	1	0	3	4
Acute Assessment unit (AAU)	4	0	0	4
Cardiac Centre - Ward	3	1	1	5
G1 - ward	4	0	1	5
Glastonbury Court	3	0	2	5
G4 - ward	5	1	1	7
G8 - Stroke Ward	6	0	1	7
Rosemary Ward	7	0	0	7
F7	5	1	1	7
F6 - ward	3	3	2	8
G3 - Endocrine and General Medicine	6	1	2	9
F3 - ward	8	0	2	10

G10	11	0	2	13
Total	**76**	**8**	**24**	**108**

Appendix 5: 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 6: Paper to Improvement Board

Improvement Committee	
Report title:	**Safer Nursing Care Tool overview**
Agenda item:	
Date of the meeting:	14th November 2022
Sponsor/executive lead:	Susan Wilkinson: Executive Chief Nurse
Report prepared by:	Daniel Spooner: Deputy Chief Nurse

Purpose of the report:			
For approval ☐	**For assurance** ☐	**For discussion** ☐	**For information** ☐
Trust strategy ambitions			
Please indicate Trust strategy ambitions relevant to this report.	☒	☒	☒

Executive summary:	The aim of this paper is to provide the board with assurance that the current nursing establishment is fit for purpose and meets the needs of our patients and staff at West Suffolk Hospital (WSH). This paper demonstrates the rationale and methodology of this process to provide assurance that the method meets expectations set out in the 'developing workforce safeguards' document (NHSI, 2018) and expectations from the National Quality Board (2016) This establishment review used nationally endorsed and evidence-based tools to audit patient acuity and dependency within our inpatient areas and community inpatient beds. Data was triangulated with clinical/professional judgement and nurse sensitive indicators (pressure ulcers, falls and medication incidents) resulting in recommendations for each of the audit areas. The review focused on 20 inpatient areas within the trust. The output of this audit, and subsequent triangulation, recommends the following: • 13 wards/departments require no change in establishment • 5 wards would benefit from an uplift in establishment • 2 wards would benefit from an adjustment to the skill mix of the establishment in favour of registered nurses (RNs)

Action required/ recommendation:	• Recommendations from this paper will be taken to investment panel for the required corporate investment to make the adjustment required • The board is requested to confirm assurance around the review process and support future recommendations from this process and future processes using the methodology

Previously considered by:	N/A
Risk and assurance:	Link risk of staffing shortfall. Risk 4274
Equality, diversity, and inclusion:	No impact
Sustainability:	
Legal and regulatory context:	

1. INTRODUCTION

Following the Francis Report (2013) and the government's published response to the inquiry, 'Hard Truth's', it is expected that boards receive assurance on the Nurse Staffing Position bi-annually. In November 2013, the National Quality Board (NQB) published staffing guidance, and this was strengthened by the publication of NICE guidance (2014), which supported providers and commissioners to make the right decisions about nursing, maternity staffing capacity and capability. The expectations set out in the guidance aimed to create a supportive environment where staff can provide compassionate care, of high quality and with the best possible outcomes for patients.

This national guidance was further strengthened by the NQB (2016) to support NHS providers to deliver the '*right staff, with the right skills, in the right place at the right time'.* This document contains recommendations to support trusts in making informed, safe, and sustainable workforce decisions, and identifies examples of best practice in the NHS.

It is well considered in nursing research and literature that appropriate staffing levels and the right skill mix both influences, and significantly impacts patient safety and patient harms (Needleman, 2017; Aiken et al 2017). However, despite these recommendations, variations in ward geography, skill mixes and patient profiles, there is no agreed national standard for nurse-to-patient ratios (NICE, 2014). This can lead to ambiguity around establishment settings and workforce planning. NHSI (2018) published the 'developing work force safeguards' document to provide recommendations to support making safe and sustainable workforce decisions. Robust staffing establishments reviews should triangulate evidence-based tools with professional judgement and patient outcomes, to ensure the right staff are in the right place at the right time (Figure 1).

This staffing review has used these principles within these recommendations to inform the outcomes of this establishment review process. The process described in the following sections will provide assurance that planned nursing establishments are meeting the needs of the patients within inpatient beds a WSHFT. The last significant investment in nurse staffing through this process was presented to the board in November 2020, which were included in financial budgets in April 2021

Areas/wards that are assessed as not meeting the needs of their patient group will have recommendations applied within this paper to address the shortfall



Figure 1. Taken from 'Developing Workforce Safeguards' (NHSI, 2018)

2. AIMS

This establishment review was undertaken for the following reasons: -

- To comply with Care Quality Commission requirements under the Essential Standards of Quality and Safety, including outcomes 13 (staffing) and 14 (supporting staff).
- To provide assurance from ward to board that staffing establishment are meeting the current need, acuity and dependency of the patients that are cared for within WSH.
- To ensure that nursing establishments are not purely based on historical models of care and budget setting
- To collaborate with senior nursing teams to improve engagement and confidence in agreed establishments
- To ensure that changes in ward environments and patient profiles over the last 12 months have appropriate staffing levels to meet the needs of our patients

3. ESTABLISHMENT REVIEW METHODOLOGY

A review of all relevant literature and guidelines was undertaken prior to commencement of this exercise and included:

- NICE Guidance on Safer Staffing for nursing in adult inpatient wards in acute hospitals (2014)
- Safer Nursing Care Tool (SNCT) Shelford Group
- National Quality Board (2016) Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time (Safe sustainable and productive staffing)
- NHSI (2018) Developing Workforce Safeguards: Supporting providers to deliver high quality care through safe and effective staffing

3.1 Safer Nursing Care Tool (SNCT) Output

The Safer Nursing Care Tool (SNCT), developed by the Shelford group, is the only nationally endorsed staffing tool by NICE and NHSI/E. The SNCT has been developed to help organisations measure patient acuity and dependency to inform evidence-based decision making on staffing and workforce provision. The tool, when allied to nurse sensitive indicators (NSIs) like falls and pressure ulcers, offers a reliable method against which to deliver evidence-based workforce plans. It uses an assessment of patient acuity and dependency scores and applies a nominal multiplier to suggest a whole time equivalent (WTE) to a ward/department (appendix A). This WTE is then applied to skill mix ratio of registered nurses (RNs) and nursing assistants (NAs) to propose an appropriate work force.

3.2 Training

To ensure reliability in data collection three senior staff from each ward were selected to be responsible for audit and data collection. In recognition of staff turnover and that an establishment review utilising this approach had not occurred recently, virtual workshops were provided to the audit teams in June 2022 to ensure that subjective interpretation of patient acuity and dependency was reduced as much as possible. The virtual workshops were rolled out two weeks before the audit commenced and were delivered to multiple members of the senior nursing team to ensure that all wards had sufficient staff trained in data collection

3.3 Audit Dates

The audit commenced on 27th June 2022 and ran for twenty working days, a full description of the audit process and quality assurance can be found in appendix B.

3.4 Nurse Sensitive Indicators

Nursing-sensitive indicators (NSIs) are the criteria for changes in a person's health status that nursing care can directly affect, and they form the foundation for monitoring the quality of nursing care. However, despite the considerable influence of nursing interventions on the quality of healthcare, measuring the quality of nursing care and its effects on patient outcomes and healthcare systems remains challenging. For this review NSIs will be used that are reflected in the NICE standards for assessing nursing care. These include hospital acquired pressure ulcers, Falls and medication incidences. These measures can be captured nominally to be able to produce a quantitative method of assessing quality of care. Trust level data for this can be found in appendix C.

4. Safer Nursing Care Tool (SNCT) Output

Table 3 shows the total current funded WTE for each Ward, the proposed WTE from the SNCT and the variance between the two. This is for illustration purposes only and caution should be applied when reviewing this data in isolation as significant variances (for example F4 and F7) may be attributed to changes for example, within the ward layout, or reduced activity, which is not reflective of normal or predicted future patient activity. These variances were explored in the ward-by-ward recommendations in section 5, where this data will be triangulated with professional judgement and NSIs.

	Split WTE		WTE	Audit Results			
	RN	NA	Budget at M3 2022	Jun-22		Average for last 3 fullSNCT audits	Diffference from current budget
Wards				FTE NHPDD	SNCT		
AAU	30.1	28.3	58.4	34.6	55.9	56.7	-1.7
Cardiac	40.7	15.7	56.4	45.73	36.2	36.3	-20.1
F12	11.9	5.9	17.8	10.33	13	8.3	-9.5
F7	24.9	25.8	50.7	43	49.9	53.1	2.4
F8	19.5	25.8	45.3	33.55	41.4	44.3	-1.0
G1	29.6	10.5	40.1	16.3	21.2	20.8	-19.3
G3	22.1	23.0	45.1	44.04	55	54.4	9.3
G4	22.1	23.0	45.1	41.47	51	50.4	5.3
G5	21.0	24.1	45.1	43.33	55.1	54.9	9.8
G8	32.7	20.6	53.3	64.95	49.6	47.3	-6.0
G9	23.7	18.0	41.7	33.58	40.7	40.2	-1.5
F10 / G10	19.0	23.2	42.2	36.01	45.9	45.9	3.7
F3	22.2	25.8	48.0	42.37	56.2	51.6	3.6
F4	13.6	14.6	28.2	28.05	31.9	23.3	-4.9
F5	22.2	18.1	40.3	39.49	43.9	44.1	3.8
F6	26.6	17.4	44.0	42.59	50.5	49.5	5.5
F14	14.1	2.0	16.1	9.05	8.8	9.5	-6.6
F1	24.1	6.7	30.8	22.01	25.6	25.6	-5.2
Rosemary	15.4	27.0	42.4	28.61	37.7	43.0	0.6
Kingsuite	11.8	12.6	24.4	22.29	25.7	24.7	0.3

There are a few limitations to the SNCT which will affect the output and WTE recommendations (Griffiths et al, 2020):

- The SNCT does not consider the nuances of ward activity, for example clinics based on wards or ward attenders
- Additional specialist or peripatetic roles with wards (stroke outreach), are not considered
- Layout and geography of ward environments, variations in side room provision, size of bays and the ward footprint may dictate additional nursing requirements not captured in the SNCT
- Small wards or those who have side rooms as the majority will often result in a proposed under establishment

Because of these variations it is important that the output of the SNCT is triangulated with professional clinical judgement and NSIs. This approach is advocated by the authors of the SNCT and the expectations within the developing workforce safeguards document (NHSI, 2018).

5. TRIANGULATION AND RECOMMENDATIONS

For this establishment review to fully comply with the NQB and NHSI expectations, outcome meetings were established with all relevant ward sisters and matrons to review the outputs of the SNCT. At these meetings, individual ward NSIs, clinical knowledge and professional judgement were used to triangulate and inform recommendations for their clinical area. Reviewing the SNCT outputs also included reviewing the patient profile against expected acuity and dependency of best practice wards (for example, comparing acute medicine with a best practice acute medical ward). This comparison would indicate if the patient scoring system was in line or around expected levels. Any significant deviations may suggest inaccuracies in patient acuity scoring. The outcomes of these review meetings would result in one of four potential outcomes, namely.

- No change to establishment
- Skill mix change
- Staffing uplift
- Staffing decrease

5.1 Ward examples

The following section describes the output of two wards and the subsequent summary of the triangulation and assessment of the area, to provide assurance around the quality of conversations that take place when triangulation the results of the SNCT, NSIs and professional judgement occurs

Ward	G9		
Current Budget WTE	RN	NA	Total WTE
	23.7	18.0	41.7
Av Patient Profile	0	8	
	1a	4	
	1b	12	
	2	2	
	3	0	
SNCT output	Jun 22	Mean last 3 audit	Difference with current WTE
	40.7	40.2	-1.5

Summary of G9 SNCT triangulation

Current staffing is 4:4-day shift, 4:3-night shift. No uplifts were made during April 2021 as the ward had moved to a smaller footprint. During covid there has been an increasing need for Non-invasive ventilation (NIV) and patients requiring high dependency respiratory

care, this change in patient provision continues. The layout of the ward compromises efficiency of nursing time, due to its large footprint and screen doors so on that basis a higher ratio of staff is needed than in a general ward layout. The SNCT supports that there are consistent Lv 2, HDU patients on the ward. NSI indicate increase in patient harm around falls and HAPU have occurred over the last year, potentially reflecting the inadequate staffing provision

Recommendation:
Increase WTE establishment by one RN during day shift to recognise the changing in acuity in patient profile.

Ward	F3		
Current Budget WTE	RN	NA	Total WTE
	22.2	25.8	48.0
Av Patient Profile	0	4	
	1a	10	
	1b	19	
	2	0	
	3	0	
SNCT output	Jun 22	Mean last 3 audit	Difference with current WTE
	56.2	51.6	3.6

Summary of F3 SNCT triangulation

SNCT suggests an uplift of 3.6 WTE. On review of weekly audit data, significant variation in patient profiles each week, questioning the validity of the data. There has been no significant change in patient group for this period. No significant trend in NSI.
Matron feels that ward numbers are meeting the needs of the patients when they are close to planned staffing. However, ward is consistently used to support other areas

Recommendations: Ensure training attendance at next round of audit to increase confidence of data. Increase quality assurance oversite to ensure that up scoring is not occurring

6. SUMMARY OF RECOMMENDATIONS

This review has provided a recommendation for all the twenty areas that have been reviewed. The recommendations a briefly summarised in the table below

Directorate	No change to establishment	Skill mix adjustment	Increase in WTE	Decrease in WTE	Areas reviewed
Medicine	7	2	3	0	12
Surgery	2	0	2	0	4
Community	2	0	0	0	2
W & C	2	0	0	0	2
Total	**13**	**2**	**5**	**0**	20

60% of the wards reviewed have not had any recommendations to change the current establishment. 25% wards reviewed have recommended an uplift and the remaining 10% have adjusted their skill mix.

7. FINANCIAL IMPLICATIONS

Costing related to changes in skill mix and uplift have assumed 20% head room, Band 5 RNs, and Band 2 NAs (unless specified to be a B4 nursing associate). Unsocial hours have also been calculated if adjustments include night shift and weekend working. Table illustrates the overall net cost pressure by division.

Table. Divisional recommendations and associated cost

Directorate	Net cost pressure
Medicine	£404,725
Surgery	£134,595
Community	0
W & C	0
Total	**£539,296.13**

The total cost from the recommendations within this review is £539,296

- This is primarily driven by the medical directorate where two wards are driving the cost. These two wards did not benefit from any investment in the 2020 review due to impending changes in the ward layout
- The biggest single cost pressure is related to ward G10, this ward was below the expected numbers on a 33 bedded ward plus has a larger footprint and decreased lines of sight which has driven additional WTE.

Staffing establishments are required to be both safe and sustainable and it is recognised that the total recommendation is a significant but necessary investment in nursing. The recommendations within this paper will be presented as an options appraisal with areas of priority and areas that although investment is required, can be delivered in a phased approach in recognition or the limitations of the financial envelope.

8. CONCLUSION

This review has looked solely at ward staffing levels and has brought together information from several sources. The principles of this review have been consistent with the recommendations of the NQB and the expectations of the developing workforce safeguards document (NHSI, 2018).

Many of the wards involved in this audit have nursing establishments that are meeting the needs of their patient group and service provision, this is informed by the SNCT and the professional judgement of staff working within these environments.

Additional benefits of increasing RNs within the skill mix are that it would provide the opportunity for ward managers who are funded as supernumery, to provide increase levels of supervision, innovation, quality improvement and staff support. Currently the ward managers are supporting staffing shortfalls clinically and are unable to consistently provide the leadership and quality improvement that the supernumery status is intended to provide.

Nest Steps:

- The board are asked to consider the recommendations within this paper and be assured that the assessments made here are in line with best practice expectations and robust establishment reviews practices.
- This process is consistent with the biannual establishment review process ensuring robust oversight and governance of nurse establishment reviews. Since September 2020 we have continued to review our inpatient ward establishments in line with best practice recommendations and will continue to do so.

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APPENDIX A: SNCT acuity and dependency indicators and multipliers

Illustration of the patient discriminators and multipliers used in data collection of the SNCT audit.

Level 0 (Multiplier =0.99*) Patient requires hospitalisation Needs met by provision of normal ward cares.	**Care requirements may include the following** • Elective medical or surgical admission • May have underlying medical condition requiring on-going treatment • Patients awaiting discharge • Post-operative/post-procedure care - observations recorded half hourly initially then 4-hourly • Regular observations 2 - 4 hourly • **Early Warning Score** is within normal threshold. • ECG monitoring • Fluid management • Oxygen therapy less than 35% • Patient controlled analgesia • Nerve block • Single chest drain • Confused patients not at risk • Patients requiring assistance with some activities of daily living, require the assistance of one person to mobilise, or experiences occasional incontinence
Level 1a (Multiplier =1.39*) Acutely ill patients requiring intervention or those who are UNSTABLE with a GREATER POTENTIAL to deteriorate.	**Care requirements may include the following** • Increased level of observations and therapeutic interventions • **Early Warning Score** - trigger point reached and requiring escalation. • Post-operative care following complex surgery • Emergency admissions requiring immediate therapeutic intervention. • Instability requiring continual observation/invasive monitoring • Oxygen therapy greater than 35% +/- chest physiotherapy 2-6 hourly • Arterial blood gas analysis - intermittent • Post 24 hours following insertion of tracheostomy, central lines, epidural or multiple chest or extra ventricular drains • Severe infection or sepsis

Levels of Care	Descriptor
Level 1b (Multiplier = 1.72*) Patients who are in a STABLE condition but are dependant on nursing care to meet most or all of the activities of daily living.	**Care requirements may include the following** • Complex wound management requiring more than one nurse or takes more than one hour to complete. • VAC therapy where ward-based nurses undertake the treatment • Patients with Spinal Instability/Spinal Cord Injury • Mobility or repositioning difficulties requiring the assistance of two people • Complex Intravenous Drug Regimes - (including those requiring prolonged preparatory/administration/post-administration care) • Patient and/or carers requiring enhanced psychological support owing to poor disease prognosis or clinical outcome • Patients on End of Life Care Pathway • Confused patients who are at risk or requiring constant supervision • Requires assistance with most or all activities of daily living • Potential for self-harm and requires constant observation • Facilitating a complex discharge where this is the responsibility of the ward-based nurse
Level 2 (Multiplier = 1.97*) May be managed within clearly identified, designated beds, resources with the required expertise and staffing level OR may require transfer to a dedicated Level 2 facility/unit	• Deteriorating/compromised single organ system • Post operative optimisation (pre-op invasive monitoring)/extended post-op care. • Patients requiring non-invasive ventilation/respiratory support; CPAP/BiPAP in acute respiratory failure • First 24 hours following tracheostomy insertion • Requires a range of therapeutic interventions including: • Greater than 50% oxygen continuously • Continuous cardiac monitoring and invasive pressure monitoring • Drug Infusions requiring more intensive monitoring e.g. vasoactive drugs (amiodarone, inotropes, gtn) or potassium, magnesium • Pain management - intrathecal analgesia • CNS depression of airway **and** protective reflexes • Invasive neurological monitoring
Level 3 (Multiplier = 5.96*) Patients needing advanced respiratory support and/or therapeutic support of multiple organs.	• Monitoring and supportive therapy for compromised/collapse of two or more organ/systems • Respiratory or CNS depression/compromise requires mechanical/invasive ventilation • Invasive monitoring, vasoactive drugs, treatment of hypovolaemia/haemorrhage/sepsis or neuro protection

APPENDIX B: SNCT audit process and quality control

1. Nominate somebody to quality control the data collection. This may be a Practice Facilitator, a member of your Critical Care Outreach Team or a senior member of the corporate nursing team. *The Matron team were responsible for quality assuring data collection and where paired with wards which they were not directly responsible to reduce confirmation bias*

2. Identify no more than three leaders per ward to complete the scoring daily for the duration of the data collection period. *Achieved*

3. The three leaders should include the Sisters / Charge Nurses. If no Sister / Charge Nurse is available, a nominated member of staff should be agreed with the Senior Nurse for the Directorate. *Achieved*

4. The data collection should take place at least twice per year in January and June. *Data collection was collated in September in recognition that there had not been a review for a significant amount time*

5. Data should be recorded on every patient from Monday until Friday for a total of 20 days as a minimum. *Achieved*

6. Acuity and dependency data should be collected for each patient in each bed at 1500hrs, as part of a bed to bed ward round review. *Achieved*

7. Where paper-based data collection is utilised, data collection forms should be stored in a folder on the ward / unit to await collection / input to the electronic system. *Achieved and was coordinated by the corporate nursing admin team*

8. Patient flow data should be collected for the 24-hour period leading to the data collection time; e.g., all admissions / discharges between 1500hrs that day and 1500hrs the previous day. *Achieved*

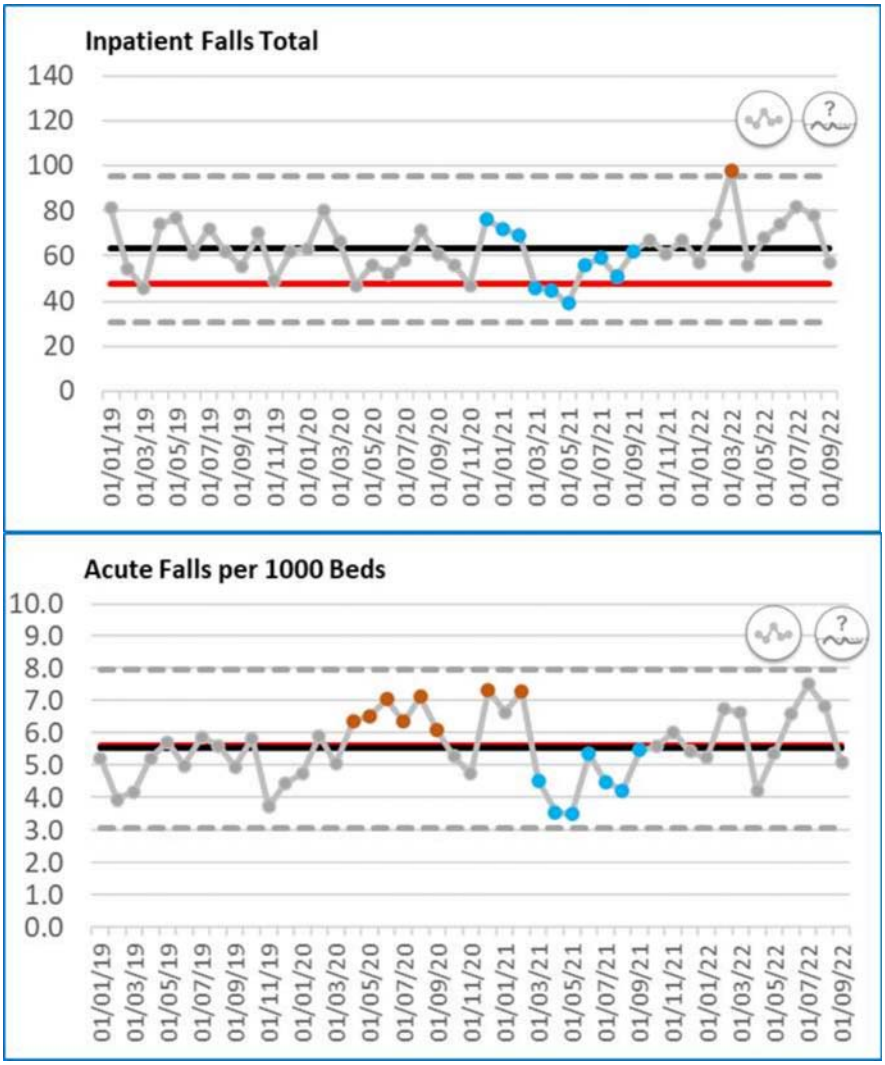
9. Nurse Sensitive Indicator data can be collected retrospectively by a senior nurse or directly pulled from the electronic incident reporting system. *Achieved and used in the outcome meetings to provide narrative and inform recommendations*

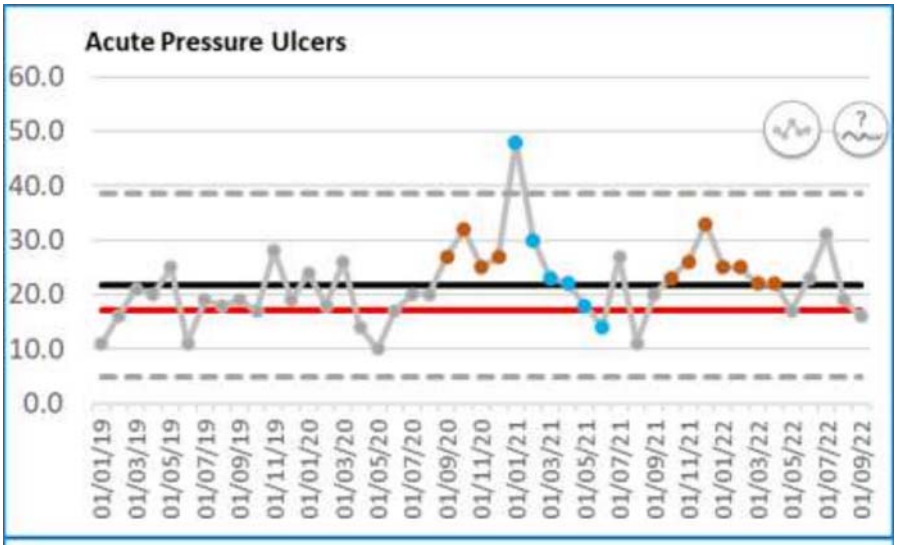
10. Data sheets should be collected weekly from participating wards / departments where central data entry management systems are in place. Achieved as per point 7.

11. Data should be entered onto the database as speedily as possible after collection or where this is completed electronically follow your local policy based on these principles. Achieved as per point 7.

12. Feedback results to Sisters and Charge Nurses, Matrons, Directors of Nursing and operational management teams as soon as possible. *Achieved*

APPENDIX C: Trust level Nurse sensitive indicators

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50.0
40.0
30.0
20.0
10.0
0.0
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01/03/19
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01/07/19
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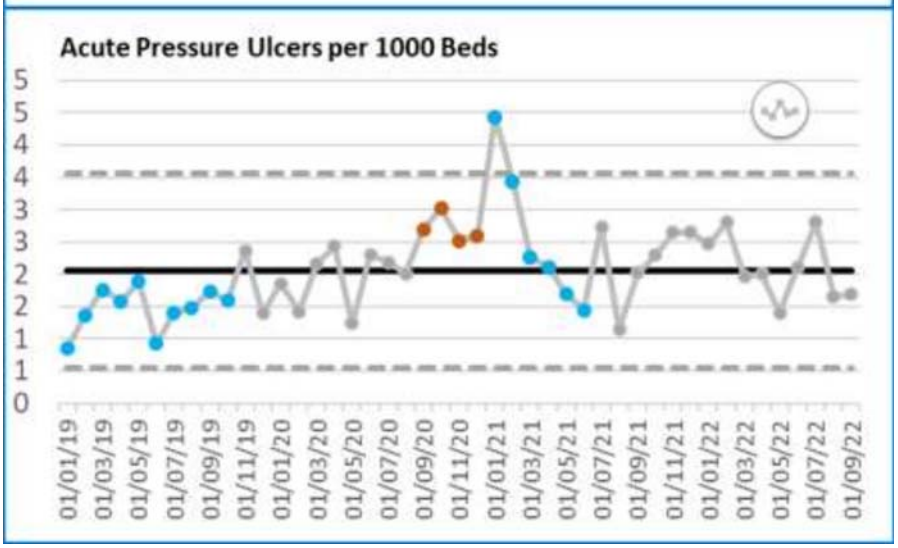
Acute Pressure Ulcers per 1000 Beds
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5
4
4
3
3
2
2
1
1
0
01/01/19
01/03/19
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01/07/19
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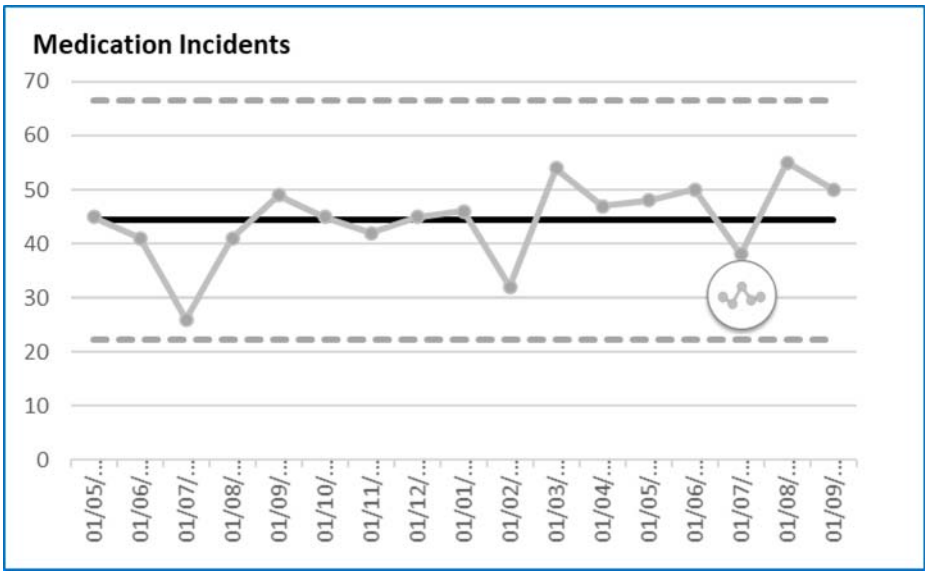
Medication Incidents
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60
50
40
30
20
10
0
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01/06/...
01/07/...
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01/10/...
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4.5.1. Maternity services Quality & Performance Report

Karen Newbury, Simon Taylor & Wendy Matthews in attendance

For Approval

Presented by Susan Wilkinson

Board of Directors

Report title:	**Maternity Services Quality & Performance Report**
Agenda item:	**4.5.1**
Date of the meeting:	Friday 25 November 2022
Sponsor/executive lead:	Sue Wilkinson, Executive Chief Nurse
Report prepared by:	Karen Newbury, Head of Midwifery, Justyna Skonieczny, Deputy Head of Midwifery

Purpose of the report:			
For approval ☒	**For assurance** ☐	**For discussion** ☐	**For information** ☐
Trust strategy ambitions	FIRST FOR PATIENTS	FIRST FOR STAFF	FIRST FOR THE FUTURE
Please indicate Trust strategy ambitions relevant to this report.	☐	☐	☐

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. The papers presented are for information only and issues to note are captured in this summary report. All of the attached papers have been through internal governance process including the Maternity and Neonatal Safety Champions and will then be shared with the Local Maternity and Neonatal Set Board.

This report contains;

- Maternity improvement plan
- Safety champion feedback from walkabout
- Listening to staff
- Service user feedback
- Reporting and learning from incidents
- Maternity Dashboards (Annex A included in this report)
- HSIB/EN reporting Q2 **Full report to CLOSED BOARD**
- ATAIN Q2– avoiding term admissions to NNU (Annex B)
- Perinatal Mortality Report Q2 July-September 2022 **Full report to CLOSED BOARD**
- Midwifery Staffing report April-September 2022 (Annex C)
- Obstetric staffing (Annex D)
- MSDS data quality
- Transitional Care Q2 July – Sep 2022 (Annex E)

- Antenatal and Newborn Screening Report October 1st 2021 – September 30th 2022 (Annex F)
- Maternity Training Compliance Quarter 2 (Annex G)

Maternity improvement plan

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. It has been agreed with the exit from the Maternity Safety Support Programme (MSSP) that NHSE regional team and ICS will be invited to attend the MIB monthly for additional assurance and scrutiny. An Assurance visit from the team is arranged for 25th November 2022.

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. An overview of the Walkabout content and responses is shared with all staff in the monthly governance newsletter 'Risky Business'.

Our NED Safety Champion Richard Davies visited the Antenatal Clinic on 24th October 2022 and discussion points as follows;
Richard was able to talk to midwives, consultants, ultra-sonographers, reception staff and families attending the clinic. Although Richard was focussing on key cultural issues arising out of the recent national maternity reports he was clear that he was keen to hear about any concerns.

Staff repeatedly emphasised good relationships and effective communication amongst the team. Families reported they were happy with the care that they were receiving and highlighted the good communication from midwives and doctors.
Staffing shortages were highlighted and how this can result in delays of care in particular induction of labour. General space to undertake role effectively was also raised in and the frustration with differing IT systems not communicating with each other.

In summary; this visit provided good triangulation with other sources of information (e.g. MVP, Maternity and Neonatal Safety Champions meetings and Board reports) that the various professional groups within maternity services work effectively together, communicate well and maintain excellent mutual respect, and that families attending the clinic feel that they are listened to appropriately and are effectively involved with their ongoing care

Paul Molyneux (Executive Safety Champion & Medical Director) visited the Gainsborough Midwives in Sudbury on 31st October 2022

Staffing shortages and the need to change ways of working were highlighted in addition to how the community are utilised during escalation. Newly recruited maternity care assistants

are seen as a positive addition to the team and a newly qualified midwife felt the hybrid preceptorship model was very positive. Women attending their appointments gave positive feedback regarding their care.
In summary Paul observed; “great physical environment, great team work, great clinical care with recognition of workforce constraints, feeling isolated and review of how community are utilised in escalation is required.”

In response; staffing across all areas of midwifery continues to be a priority and the senior leadership team are engaged with many differing projects to resolve this, including midwifery apprenticeships, international recruitment, recruitment events, reviewing current roles and responsibilities, increase of support staff and reviewing ways of working.

Any delays in care due to staffing shortages are reviewed to ensure safety upheld. The footprint of the antenatal clinic is being reviewed to ensure space is utilised to its maximum potential, however the triumvirate acknowledges that additional space is required which will fall outside the clinic’s footprint.

Listening to Staff

The National Staff Satisfaction Survey results were published in April 2022 and the triumvirate team have collated an action plan in response to this. A very short temperature check survey has been sent to all midwifery staff and the results are being collated.
In addition to the Freedom to Speak up Guardians, Safety Champions, Professional Midwifery Advocates, Unit Meetings and ‘Safe Space’ volunteers have now come forward to participate in focus groups to take ideas forward that arose from the last midwifery staff survey late last year.
The focus groups will also be planning the Maternity Listening Event as recommended by the Ockenden final report.

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. The patient experience team are working with the midwifery team to look at differing ways to increase returns further, to include the Neonatal Unit (NNU).

Ward/Dept	Sep Survey returns	Sep FFT score	Oct Survey returns	Oct FFT Score
F11	53	98	50	90
Antenatal	24	100	14	93
Postnatal Community	14	100	15	100
Labour Suite	29	97	26	100
Birthing Unit	6	100	nil	
NNU	nil		nil	

In addition to the FFT, feedback is gained via our and the Maternity Voice Partnership (MVP) social media, MVP and Healthwatch surveys.

5 compliments were shared with the patient experience team for women & children’s division for logging in September& October 2022.

In Sep and Oct 2022, a total of 7 PALS enquiries and 2 complaints were received for maternity and Neonatal Unit (NNU).

Reporting and learning from incidents

During September and October 2022 there were a small number of cases that met the criteria for referral to HSIB, and we are awaiting to hear if these will be accepted. Initial Patient Safety Reviews were undertaken with an external member on the panel and the immediate recommendations that were identified have been actioned. Once the full HSIB reports are available these will be shared with the Board as per Ockenden instructions.

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). 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	In September decision to delivery time for Grade 2 section was achieved in 81% cases, this is a great improvement compared to previous month however slight drop to 77% was noted in October. There is an ongoing work to improve this further
Post-partum Haemorrhages for LSCS >1500 mls	In line with increase of caesarean section and induction of labour, however QI project continues. The draft of the thematic review undertaken by the Trust governance team has been received and is being reviewed. When reporting rates to LMNS and region, preterm, multiple pregnancies are excluded in line with their criterion.
Total women delivered who breastfed within first 48 hours	New breastfeeding peer supporters have now completed their training and they are providing support with feeding on the ward and slight improvement has been noted. Further training for All staff has been planned with accordance to the BFI standards.
Smoking at the time of delivery	LMNS support requested to assist with reducing our rates of smoking in pregnancy. Additional funding of 2.7wte at band 3 level have been approved to provide further support in the community to improve up on this.
Compliance with DV questions	This has seen significant drop-in compliance rate and Safeguarding Lead Midwife has taken a lead with improving upon this.

HSIB/EN reporting Q2 July-September 2022 Full report to CLOSED BOARD

This report provides details of the Trust compliance for Quarter 2 2022/2023 with reporting of maternity incidents that meet the criteria for reporting to HSIB Maternity Investigations and the NHS Resolution Early Notification Scheme, duty of candour related to these unexpected events and some details of each case.
In quarter 2 – July 1st 2022 to September 30th 2022 – there were a small number of cases where therapeutic cooling was required for baby that met the initial criteria for reporting to the Maternity branch of the HSIB. However, as the brain MRI (Magnetic Resonance Imaging)

scans were within normal limits, HSIB would normally decline the investigations but as the mothers requested further details about their care, HSIB have agreed to undertake the investigations.
Whilst none of the cases meet the criteria for referral to the Early Notification Scheme (ENS), it was agreed that they would be referred as HSIB were undertaking the investigations. Formal duty of candour was completed with the mothers of the babies.
The Trust is assured that the processes are being followed for referral to HSIB and the ENS. The agreed reports from HSIB will be shared once completed.

ATAIN Q2 July- September 2022 report – avoiding term admissions to NNU (Annex B)

The aim of the ATAIN programme is to avoid unnecessary admissions of term babies to the neonatal unit.
Progress and learning with the key reasons for admission data collection during Quarter 2 (July-Sept) in 2022 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. This accounted for 16 of the 21 admissions (76%) and all required oxygen support (either Vapotherm or nasal cannula oxygen) and underwent a septic screen, receiving IV antibiotics. Over half of these babies had at least one risk factor for sepsis or respiratory distress, with no overarching theme apparent.

The remaining admissions were admitted due to: a result of suspected birth asphyxia and transferred out to a tertiary unit for therapeutic cooling (due to meeting criteria for external investigation they were not reviewed under ATAIN but are mentioned for transparency), jaundice treatment (however, this baby could have been cared for under Transitional Care (TC) had a parent been available to stay alongside) and “other” classification included admission for enteral feeding due to cleft lip and palate, and due to seizure like activity.
A rolling action plan is being maintained to address any avoidable issues related to term admissions. Some actions require involvement of staff outside of the maternity and neonatal services to complete these.

Perinatal Mortality Report Q2 July-September 2022 Full report to CLOSED BOARD

In this period, the Trust has reported <5 losses directly associated with the Trust. In addition, women who had losses at neighbouring centres have been included for information as the Trust provided antenatal and intrapartum care or had a perinatal loss at another unit having had antenatal care provided by WSH.

The Trust has **not 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. One surveillance report was completed outside of the one-month timeframe by three days. Clarification is awaited from MBRRACE and NHSR as to the effect on our overall compliance on our submissions for MIS Year 4.

The Trust is 100% 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 and started the review process for all of the losses reported within 2 months of the loss.

Midwifery Staffing report April-September 2022 (Annex C)

National tools, Local Maternity and Neonatal System (LMNS) collaboration and BirthRate Plus methodology have been used to determine the midwifery establishment and the funded establishment was agreed by the Trust Board in May 2022.
A robust escalation processes and team working has mitigated some staffing challenges due to absences but gaps on the rota are still a challenge.
Essential actions from the Ockenden report and subsequent cessation of target dates to implement Midwifery Continuity of Carer (MCoC) have resulted in temporary suspension of two community-based teams to assist with safe staffing of both the hospital and community services.
One to one care of women in labour over the 6-month period of the report has been maintained at **100% compliance**
In October 2022, the guidance for assessing the supernumerary status of the Labour Suite coordinator (LSC) was clarified. Using the new standards, the Trust can demonstrate compliance has been 100% except in September when the LSC assisted with a birth soon after a mother was admitted in advanced labour. **The aim is for 100%.** Clarification is awaited from MBRRACE and NHSR as to the effect on our overall compliance on our submissions for MIS Year 4.
Vacancies for experienced band 6 midwives are difficult to fill and whilst recruitment of band 5 midwives and those from overseas has been successful, the support and supervision required puts additional pressure on both midwives and service. Midwife vacancies at the end of September 2022 was 36.11 wte which equates to a **27% vacancy rate.** The service is currently employing approximately 10.00 wte midwives each month through the bank and staff working additional hours.
The impact of increasing student midwife numbers and return to practice courses will not be realised for at least another 2-4 years and West Suffolk is actively participating in the regional work of midwifery apprenticeship schemes with the intention of having places on the first cohort when these are in place.
The Midwife to Birth ratio as per BirthRate Plus is **1:27.7**; September was the only month when this was not met and a ratio of **1:29** was reported. This reflects the vacancy factor.
Red Flags continue to be monitored daily and collated monthly: delays in induction of labour remain the main clinical reason.

Obstetric staffing (Annex D)

The Trust has embedded the RCOG guidance for scenarios where the consultant obstetrician is expected to be present to assist with clinical management of complications or complex care and decision making. A robust process for monitoring compliance with this safety standard is now in place. The results from this first quarter demonstrate 100% compliance with the consultant obstetricians attending women with significant complications when required to do so.

MSDS data quality

The Maternity Incentive Scheme (MIS) Safety Action 2 relates to the provision of accurate data and information about maternity care to NHS Digital. The Trust submits data relating to the Maternity Services Data Set (MSDS) each month and this is verified by NHS Digital and a score is allocated to the Trust for the quality of the data against each criterion. For this report

and compliance, the data was analysed from July 2022. The Trust has received confirmation that the data submitted is **compliant with 10/11 and 6/6 of the MSDS**. Further work needs to be undertaken by the service provider to ensure that the Trust can reach and maintain compliance in the future. An exception report is included as a record of the commitment to achieve this over the next few months. This was submitted to the Board in September 2022.
In addition, the Maternity Digital Strategy has been developed and embedded to maintain high standards of data quality. This was approved by the Board in September 2022 and is embedded in this report to confirm compliance with this safety action.

Transitional Care Q2 July – Sep 2022 (Annex E)

Overall, the number of admissions to transitional care appears to have fallen slightly to 69. The main reason for babies receiving transitional care are babies referred from the community with neonatal jaundice – this figure has steadily risen. Neonatal jaundice is identified early and community staff carry transcutaneous bilirubinometers for recording jaundice levels. In addition, midwives can directly refer to a paediatric registrar. All admissions for jaundice were appropriate and required phototherapy treatment with one exception when the result was borderline.
The last two quarters has seen a reduction of babies admitted from birth. Whilst this seems positive, the data needs to be looked at against admissions to the neonatal unit. Most babies in this group requiring transitional care are because they need prophylactic antibiotics due to maternal sepsis however this quarter there were several babies who were recorded to have symptoms.

Next Steps

The maternity service is due to commence the Kaiser Neonatal Sepsis calculator; a tool which establishes risk factors and neonatal condition to estimate each baby's risk factor of early onset neonatal sepsis (EONS). Studies in the US have suggested that implementing this tool resulted in a reduction in antibiotic administration (48%) without evidence of adverse events (RCPCH). Depending on the criteria for what type of care these babies will receive it will have a bearing on the numbers of babies receiving transitional care transitional care.
Since July 2021 the Quality and Safety team has been recording data on late preterm babies 34-36+6 weeks and who are admitted to the neonatal unit. This is to inform future capacity management for late preterm babies who could be cared for on TC. 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. A report is being written as part of evidence for the MIS year 4 to identify the number of babies who may have Transitional Care in the future if the criteria is updated to include this group of babies.
Previously nasogastric tube feeding could not be supported in TC due to the service not having a dedicated workforce covering 24/7. The maternity service has employed several neonatal staff to provide 24 hours per day, 7 days per week cover in transitional care and once training has been completed, the service will be able to support this and the criteria and policies will be updated.
A co-produced system wide ATAIN and TC data collection tool has been developed between the Suffolk and Northeast Essex. It has been proposed this will commence in November 2022. This will allow consistency across the Local maternity and neonatal services.

Antenatal and Newborn Screening Report October 1st 2021 – September 30th 2022 (Annex F)

As a Trust we deliver six antenatal and newborn (ANNB) screening programmes commissioned by NHS England, with quality assurance provided by NHSE screening quality assurance service. Antenatal screening covers 17 conditions and newborn screening covers

15 conditions, with a total of 44 Key performance indicators (KPI's) and standards across the six programmes. The screening includes Sickle Cell and Thalassaemia (SCT); Infectious Diseases in Pregnancy Screening (IDPS) Programme for Hepatitis B, HIV and Syphilis; Fetal Anomaly Screening Programme (FASP), for Down's syndrome, Edwards' syndrome and Patau's syndrome, including the addition of non-invasive prenatal testing (NIPT) and a number of structural anomalies; Newborn and Infant Physical examination (NIPE) a detailed physical examination to screen newborn babies and infants for anomalies with their eyes, heart, testes and hips to help early detection and diagnosis of several conditions; Newborn Hearing (NHSP), a hearing screening test in the first few weeks of life to find those who are born with hearing loss; Newborn Blood Spot (NBS) – screens newborn babies for nine rare but serious genetics or metabolic conditions.
The main purpose of screening tests in pregnancy and for newborn babies
The screening programmes involve Maternity services, Obstetric ultrasound, Newborn hearing screening, in-house Pathology services for haematology and microbiology tests, the Department of Prenatal Screening and the Newborn Blood Spot at a regional laboratory.

Summary of findings within the report:

There is high compliance with offering and administering screening tests within the timeframes laid out in the screening programmes. The report highlights some local challenges to turnaround times (TaT) due in part to circumstances beyond the control of the practitioners such as transport of samples and mechanical failures within analysers and laboratories used. Defective equipment has been replaced.
There has been an increase in the number of pregnant women with infectious diseases in the Trust but the numbers remain small. Compliance with administration of Hepatitis B vaccines to newborn babies is lower than desirable as a result of only a small number of babies in the group. Relocation of services due to building work has led to reduced space for counselling at times. Communication between different teams has been observed as requiring a consistent approach to aid compliance.

Key Changes/Updates in the last year

The NIPT has been introduced in July 2022. There have been changes to leads in key areas of screening across the maternity and neonatal services. Pre-Covid processes are gradually being reintroduced with face to face booking appointments returning.

Next steps

Our vision

To reduce inequalities of outcomes experienced by women and pregnant people.

Our Commitment

- Specific packages of care will be developed for women and pregnant people of Black, Asian and mixed ethnicity women (BAME) experiencing multiple deprivations which will be additional to the core maternity care offered.
- Provide continuity of carer to improve outcomes for women and birthing people of BAME ethnicity and other vulnerable groups
- Prioritise the roll out of Continuity of Carer teams to the most disadvantaged geographical areas i.e. some neighbourhoods in Thetford, Bury St Edmunds, Mildenhall, Newmarket and Haverhill.
- All midwifery and maternity staff will be trained to help identify and support women and pregnant people who have additional needs and their subsequent referral pathways. This will include for example (but not exclusively) people who have a learning disability, refugees, homeless, gypsies and travelers and people who do not speak English and need translation services. Training programs will ensure that clinicians are aware of the additional risks and inequality in outcomes experienced and pathways to improve outcomes.

- ❖ Care will be provided by specialist teams which will include both voluntary, health and social care partners within the community.
- ❖ A personalised care plan will be developed to meet social, health and communication needs.
- ❖ Systems to evaluate women's experience and outcomes from maternity services and ensuring women's voices are captured in subsequent service developments.
- ❖ Bespoke parenthood education will be provided to targeted groups
- ❖ Services will be integrated with our community and voluntary sector partners.

Maternity Training Compliance Quarter 2: July 2022-September 2022 (Annex G)

The Multidisciplinary team (MDT) nature of the training was not achieved in the reporting period

MDT training was difficult to achieve due to staff absences, some being related to Covid 19 and the impact that this had for releasing medical staff to attend the training sessions.
MDT was not achieved within the Maternity Emergency and multi-professional training in August due to Anaesthetic medical staff not being able to attend the PROMPT training and for the Neonatal life support (NLS) training in July and September where Neonatal/ Paediatrics medical staff were not able to attend the sessions.
There is limited availability of data around Obstetric compliance with some elements of Six Core Competency Framework (highlighted in yellow), these have been escalated to Obstetric Lead.

Actions

- The Obstetric anaesthetic lead is overseeing the rotas to enable staff to attend the MDT sessions
- A training lead has been appointed who will be helping to facilitate MDT training for the NLS sessions and maintain records of external NLS training, competence and updates.
- There is ongoing work to ensure that all training attendance is captured on databases that can be maintained and interrogated for non-compliance.

Compliance with the expected levels of training completion does not currently meet the expected level of 90% and is not meeting the trajectory

The areas of significant concerns in meeting the standard are within the fetal monitoring training within all staff groups and Six Core Competency Framework for obstetric medical staff.
A decrease in attendance of the obstetric medical staff was also noted at the PROMPT training. This is due to:
Staff absences, some being related to Covid-19 and difficulties in releasing medical staff to attend the training, has been escalated to Clinical Leads and the Safety Champion.

Actions

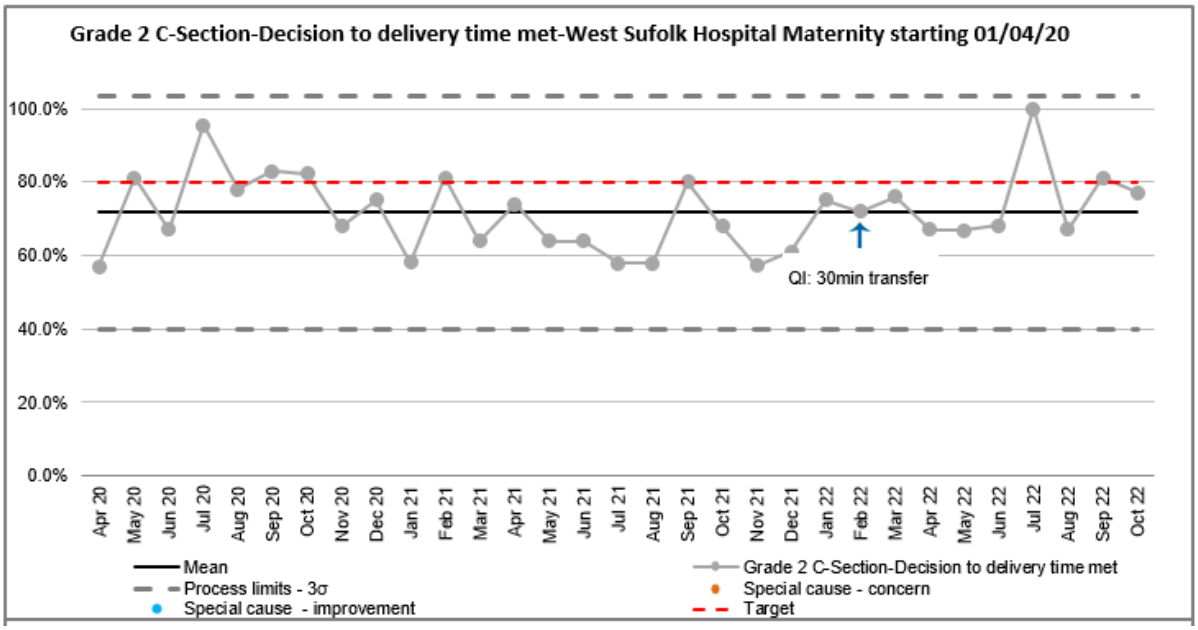
- An education and training lead was appointed who will be leading on improving on all aspects of training and education provision and attendance
- To improve on compliance within fetal monitoring, Fetal surveillance training have been introduced as face to face sessions as part of the PROMPT MDT training days from August 2022 as well as the case review forums. This will be MDT training facilitated by the Fetal Monitoring Leads.
- Limited availability of data around Obstetric compliance with some elements of Six Core Competency Framework (highlighted in yellow) has been escalated to the Obstetric Lead and there is ongoing work to develop and maintain an MDT training database.

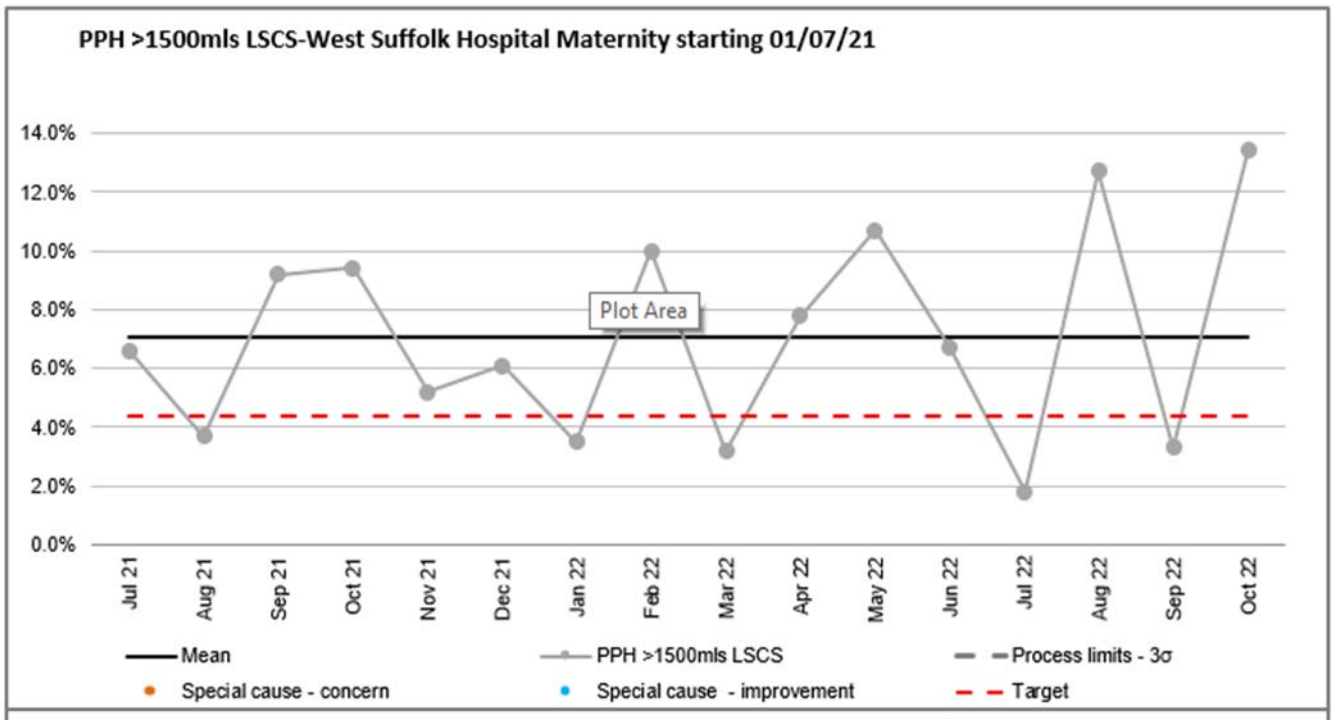
Trust priorities	Deliver for today	Invest in quality, staff	Build a joined-up

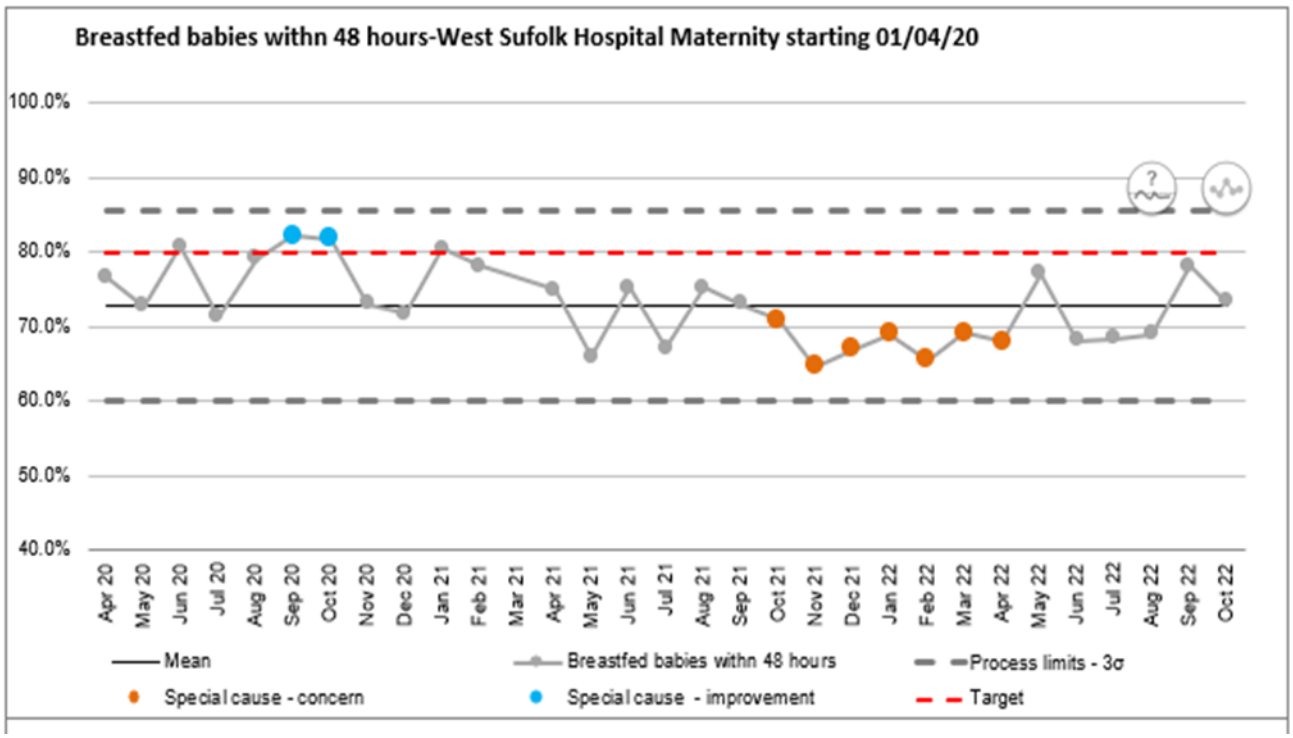
			and clinical leadership			future	
Trust ambitions	*Deliver personal care*	*Deliver safe care*	*Deliver joined-up care*	*Support a healthy start*	*Support a healthy life*	*Support ageing well*	*Support all our staff*
Previously considered by:	Maternity Quality and Safety Meeting						
Risk and assurance:	Maternity & Neonatal Safety Champion Meeting						
Legislation, regulatory, equality, diversity and dignity implications							
Recommendation: The Board to discuss content and approve papers including action plans.							

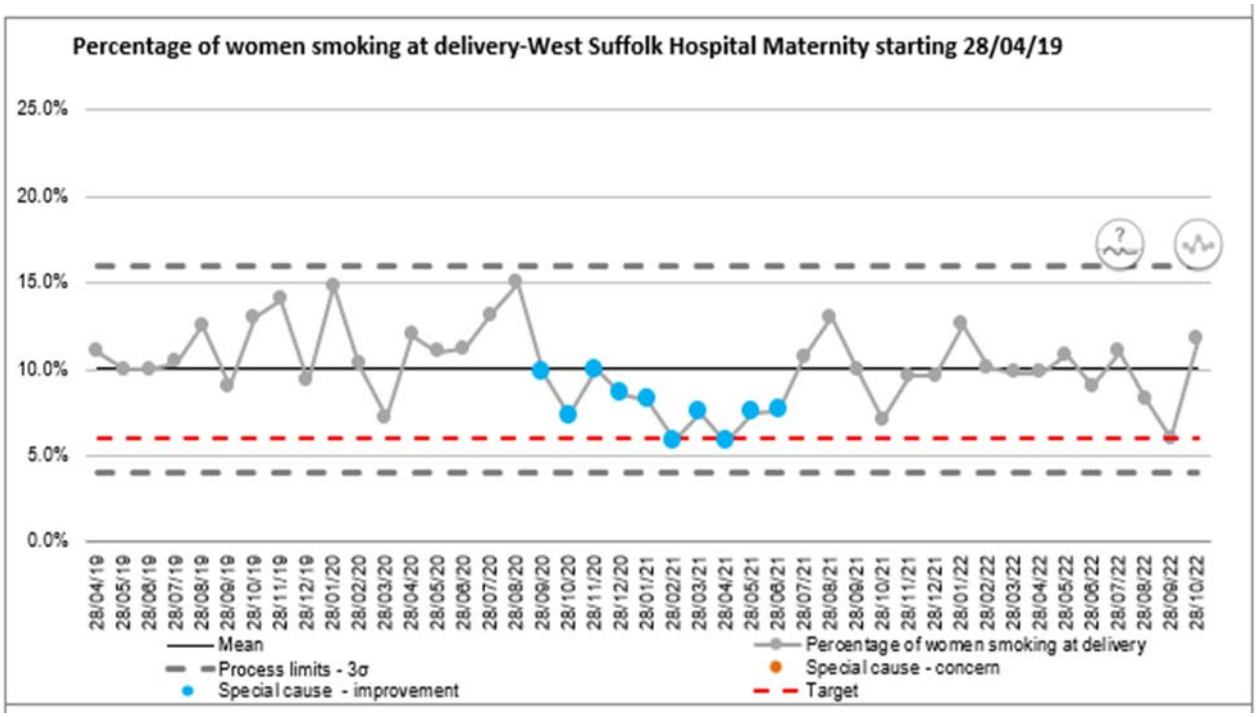
Annex A

Maternity Dashboard SPC Charts;






Breastfed babies withn 48 hours-West Sufolk Hospital Maternity starting 01/04/20
100.0%
90.0%
80.0%
70.0%
60.0%
50.0%
40.0%
Apr 20
May 20
Jun 20
Jul 20
Aug 20
Sep 20
Oct 20
Nov 20
Dec 20
Jan 21
Feb 21
Mar 21
Apr 21
May 21
Jun 21
Jul 21
Aug 21
Sep 21
Oct 21
Nov 21
Dec 21
Jan 22
Feb 22
Mar 22
Apr 22
May 22
Jun 22
Jul 22
Aug 22
Sep 22
Oct 22
Mean
Breastfed babies withn 48 hours
Process limits - 3σ
Special cause - concern
Special cause - improvement
Target


Percentage of women smoking at delivery-West Suffolk Hospital Maternity starting 28/04/19
25.0%
20.0%
15.0%
10.0%
5.0%
0.0%
28/04/19
28/05/19
28/06/19
28/07/19
28/08/19
28/09/19
28/10/19
28/11/19
28/12/19
28/01/20
28/02/20
28/03/20
28/04/20
28/05/20
28/06/20
28/07/20
28/08/20
28/09/20
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28/11/20
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28/01/21
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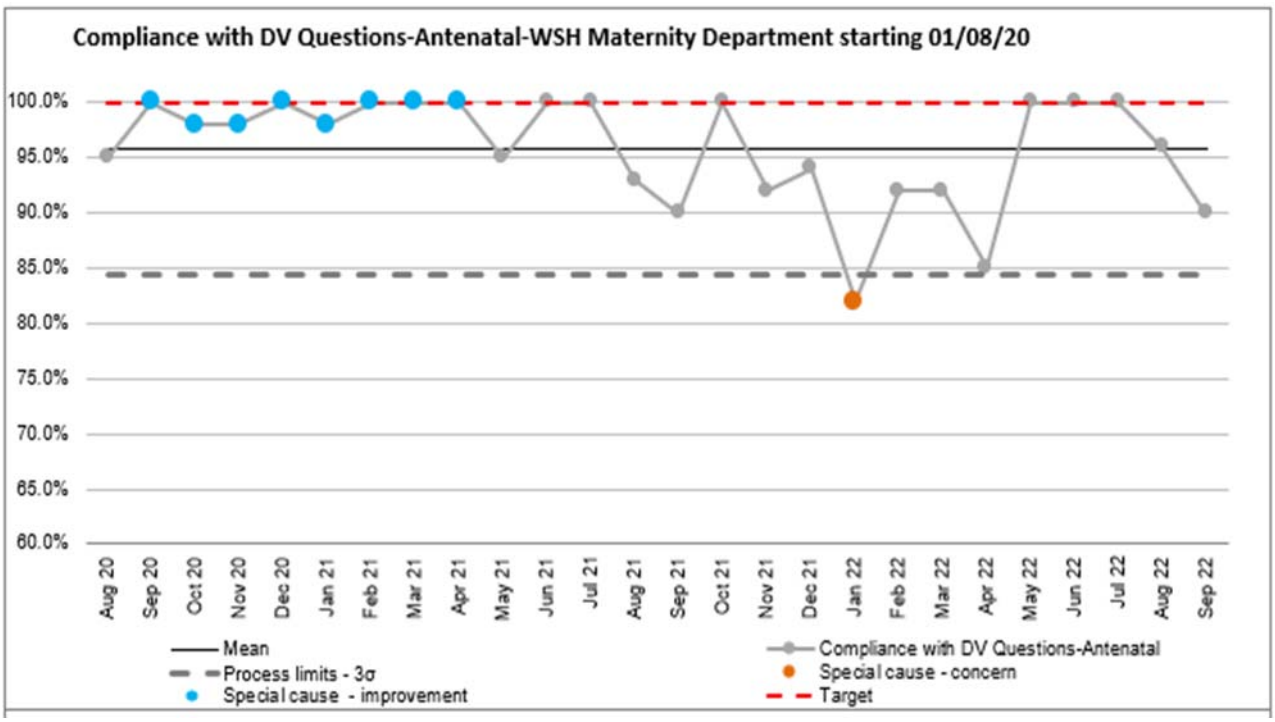
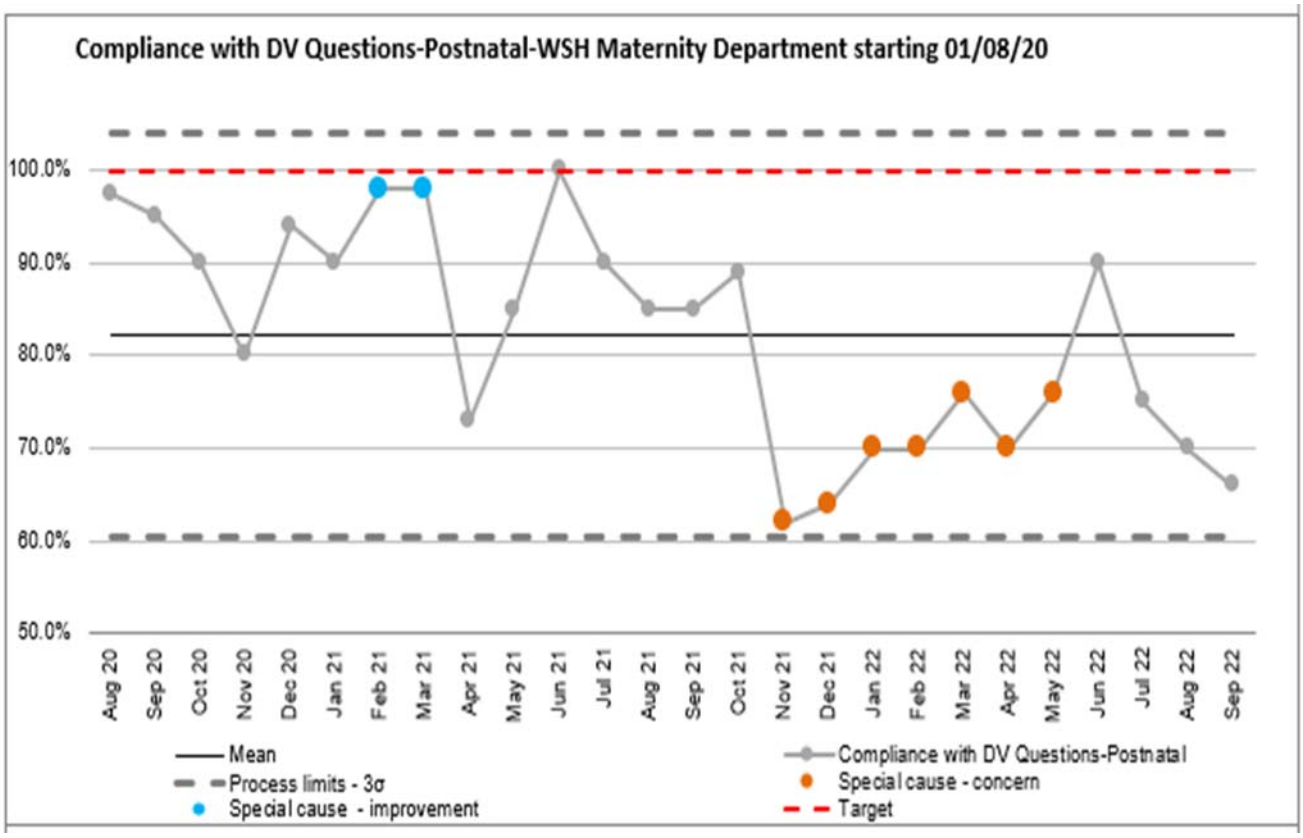
28/10/21
28/11/21
28/12/21
28/01/22
28/02/22
28/03/22
28/04/22
28/05/22
28/06/22
28/07/22
28/08/22
28/09/22
28/10/22
Mean
Process limits - 3σ
Special cause - improvement
Percentage of women smoking at delivery
Special cause - concern
Target


Compliance with DV Questions-Antenatal-WSH Maternity Department starting 01/08/20
100.0%
95.0%
90.0%
85.0%
80.0%
75.0%
70.0%
65.0%
60.0%
Aug 20
Sep 20
Oct 20
Nov 20
Dec 20
Jan 21
Feb 21
Mar 21
Apr 21
May 21
Jun 21
Jul 21
Aug 21
Sep 21
Oct 21
Nov 21
Dec 21
Jan 22
Feb 22
Mar 22
Apr 22
May 22
Jun 22
Jul 22
Aug 22
Sep 22
Mean
Process limits - 3σ
Special cause - improvement
Compliance with DV Questions-Antenatal
Special cause - concern
Target


Compliance with DV Questions-Postnatal-WSH Maternity Department starting 01/08/20
100.0%
90.0%
80.0%
70.0%
60.0%
50.0%
Aug 20
Sep 20
Oct 20
Nov 20
Dec 20
Jan 21
Feb 21
Mar 21
Apr 21
May 21
Jun 21
Jul 21
Aug 21
Sep 21
Oct 21
Nov 21
Dec 21
Jan 22
Feb 22
Mar 22
Apr 22
May 22
Jun 22
Jul 22
Aug 22
Sep 22
Mean
Process limits - 3σ
Special cause - improvement
Compliance with DV Questions-Postnatal
Special cause - concern
Target

4.6. Involvement Committee Report - 17 October, 2022 Chair's key issues

To Assure

Presented by Alan Rose

Chair's Key Issues

Originating Committee:	Involvement Committee	Date of Meeting:	17 October 2022
Chaired by:	Alan Rose	Lead Executive Director:	Jeremy Over

Item	Details of Issue	For: Approval/ Escalation/Assurance	BAF/ Risk Register ref.	Paper attached?

Equality, Diversity & Inclusivity (EDI):
 	
(FIRST for Staff and FIRST for Patients)
	- Catriona Cole, Wellbeing & Inclusion manager presented the annual Equality, Diversity and Inclusion report for WSFT, which includes a review of performance, compliance and action against a range of metrics, including national standards related to Disability and Race (WRES / WDES).
	- On behalf of the Board, the committee:
	  o Noted and discussed the WDES and WRES metrics for 2022, changes from 2021, and the engagement and experience of WSFT colleagues with disabilities, health conditions or neurodifferences, and of colleagues from a Black, Asian or other ethnic minority background. Recognised that other groups, including LGBT+ colleagues, may also be having a less positive work experience.
	  o Agreed an inclusion work plan and the report for publication on the WSFT public website, as per WDES and WRES mandatory requirements
	  o Recognised the need to align this work with other Trust priorities to ensure everything we do contributes to a fairer and more inclusive place to work for all colleagues
	  o We asked to consider personal actions and commitment to progress inclusion at WSFT
	- The data continues to show that at WSFT, as in the wider NHS and society as a whole, colleagues from minority groups report a worse experience. This is particularly manifested around perceptions of fair career progression, and workforce behaviours including bullying and harassment.
	- The 2022/23 inclusion work plan has the following aims:
	  o To contribute to developing a culture at WSFT where **everyone** feels they belong and can be themselves at work; where everyone feels seen and heard, that their contribution is valued and that their voice matters.
		Partial Assurance for the Board, with specific actions aimed at:
		- Delivery of the 2022/23 work plan
		- Exploration of these priorities explicitly in "What Matters to You 2".
		- Working on how to articulate inclusivity more explicitly in our statements, behaviours and actions.
		- Striving harder to offer and achieve "reasonable adjustments" in a wide variety of workplace contexts.
		- Focusing on our leadership for diversity & inclusion as a Board, including in our development
			BAF Risk 6 (Workforce wellbeing)	

Originating Committee:	Involvement Committee	Date of Meeting:	17 October 2022
Chaired by:	Alan Rose	Lead Executive Director:	Jeremy Over

Item	Details of Issue	For: Approval/ Escalation/Assurance	BAF/ Risk Register ref.	Paper attached?
	○ To develop the organisational understanding of existing inequalities, barriers to inclusion and challenges faced by certain groups, and to develop people's skills (everyone and especially leaders and managers) in removing or mitigating these and being intentionally inclusive. ○ To work towards becoming **institutionally inclusive** – where inclusion is forefront of our decision-making, policy and process development, cultures and attitudes, and planning for the future, for both colleagues and patients, so that WSFT can be a great place to work and provides the best possible patient care and services. - Our emphasis now is on equality of opportunity and evidence was discussed of how this can lead to a more effective workforce and outcomes. - These issues must not be regarded as "HR issues" – the whole organisation needs to embrace the philosophy of inclusivity, as stated in our FIRST values; e.g. across operations, patient experience, health outcomes, etc. - The Annual Report is now on our website.			
Workforce Culture Dashboard (FIRST for Staff)	- Jeremy updated progress on developing a set of metrics, partly inherited from the Insight Committee, which capture the drivers and outcomes of workforce culture. - We discussed how many of the standard workforce metrics (e.g. turnover, attendance, training, appraisals) are closely linked to the broader, underlying and prevailing culture of the organisation and are strong indicators. - The Committee has started to review the narrative and actions around some of these metrics. - The Committee feels we should seek more relative comparisons with other organisations, continually evolve the way we measure and present the	**Partial Assurance** for the Board, but concern about the challenges of improving performance on many of these metrics. Actions include "stay conversations" rather than pursuing "exit interviews".	BAF Risk 6 (Workforce wellbeing) and BAF Risk 1 (Quality and Safety)	

Originating Committee:	Involvement Committee	Date of Meeting:	17 October 2022
Chaired by:	Alan Rose	Lead Executive Director:	Jeremy Over

Item	Details of Issue	For: Approval/ Escalation/Assurance	BAF/ Risk Register ref.	Paper attached?
	data in the IQPR and be more ambitious and creative in the way we challenge ourselves to do better on these.			
Involvement Issues and alignment to BAF	- Richard Jones led a review of the alignment between the issues we have been discussing over the year in the Involvement Committee and the risks and assurance identified in our Board Assurance Framework (BAF). - He especially noted areas where weak or partial assurance had been identified by the Committee. - We challenged ourselves to strengthen this alignment, to ensure that the agenda reflects perceived areas of weak assurance and to focus on ensuring the Board is made aware that mitigating actions are being taken.	**Partial Assurance** for the Board; Focus on considered agenda planning for the Committee.		
Next time: (19/12/22)	- Industrial action preparedness - Board Member survey of Freedom to Speak Up processes - Follow-up on governance of our complaints process			
Date Completed and Forwarded to Trust Secretary		**15 Nov 2022**		

5. GOVERNANCE

5.1. Audit Committee Report - 1 November, 2022 - Chair's Key Issues

To inform

Presented by Alan Rose

Chair's Key Issues

Originating Committee:	Audit Committee	Date of Meeting:	1 November 2022
Chaired by:	Alan Rose	Lead Executive Director:	Nick MacDonald

Item	Details of Issue	For: Approval/ Escalation/Assurance	BAF/ Risk Register ref.	Paper attached?
Internal Audit (IA)	- RSM led the discussion of: o Progress on 21-22 audits, which have received partial or reasonable ratings, except for (unusually) an "unsatisfactory" rating on "Data Security and Protection" o On this latter point, a significant discussion took place during which management (led by Liam Mclaughlin as a "deep dive") gave its detailed response to the critique and an excellent set of actions that have quickly progressed to address the concerns raised, moving us now to a compliant status; RSM pointed-out that the Trusts around the country have all been in a similar position (we are not an outlier), as the new NHS protocols on this issue are (rightly) extremely demanding. o Management response in general to IA recommendations – most are now "closed", but a number are overdue, but are in progress. o Our mix of IA findings were benchmarked against the sector (we are fairly typical). o Counter-fraud processes are ongoing and satisfactory. - The Committee continues to enjoy full confidence in the capabilities and performance of our IA provider (currently one year into a 3 year contract extension)	**Assurance** for the Board, but noting that following action and further evidence submission our nationally reported status is now compliant	**N/A**	**N/A**

Originating Committee:	Audit Committee	Date of Meeting:	1 November 2022
Chaired by:	Alan Rose	Lead Executive Director:	Nick MacDonald

Item	Details of Issue	For: Approval/ Escalation/Assurance	BAF/ Risk Register ref.	Paper attached?
External Audit	- KPMG reported on their planning for the 22-23 Audit, which will mainly take place next Spring/Summer; nothing special to report. - Management and the Committee discussed the Annual Report on the performance of the External Auditor – to be presented to the forthcoming Council of Governors; The report is largely satisfactory, although the tight time constraints due to their rapid deployment as our new Auditor last Autumn clearly presented challenges); KPMG are now into the second year of their current three-year appointment.	**Assurance** for the Board	N/A	**N/A**
Other Matters	- The importance of the electronic patient information software provision at our Trust and elsewhere was mentioned as a key strategic issue in the coming year or so; changes will raise significant risks. - Normal and satisfactory reports were covered on: o Debtor write-offs o Review of Audit Committee Terms of Reference o Update on Committee self-assessment actions o Committee agenda planning o Awareness by Committee of the Chairs' Key Issues from our other Board Assurance Committees (which can contribute to the planning of the future IA work programme)	**Assurance** for the Board	N/A	Board discussion
Date Completed and Forwarded to Trust Secretary		**15 November 2022**		

5.2. Remuneration Committee Report - 28 September, 2022 - Chair's Key Issues

To inform

Presented by Alan Rose

Chair's Key Issues

Originating Committee:	Remuneration Committee	Date of Meeting:	28 September 2022
Chaired by:	Alan Rose	Lead Executive Director:	Jeremy Over

Item	Details of Issue	For: Information	BAF/ Risk Register ref.	Paper attached?
Executive Remuneration Review (w.e.f. 1/4/22)	- The Executive Workforce Director presented a contextual paper and a range of general options as background to this discussion. - Taking into account national guidelines, national benchmarking, remuneration uplifts in this year's awards for Agenda for Change (A4C) staff and the recommendations of the Chief Executive, the Committee agreed the remuneration uplift for each Executive.		N/A	**N/A**
Executive Appraisals and Objectives	- The Chief Executive joined the meeting to lead the discussion on each Executive's appraisal and objectives for the period ahead; - The Chair led the discussion on the Chief Executive's appraisal and objectives for the period ahead.		N/A	**N/A**

Pension Deferral	- The FT Secretary presented a paper describing the background and current context of potential NHS pension deferral. - The Committee agreed to continue the scheme currently running at WSFT, pending further expected proposals from Government on this matter. - The Workforce Director is in regular contact with Region to keep abreast of this issue.		N/A	N/A
Remuneration Committee Terms of Reference (ToR)	- These were considered, but it is recognised that the existing scope incorporates important issues related to Board development and other matters which require engagement and involvement with people outside this Committee (e.g. Executives, Governors). - The topics covered and their execution (whether inside or outside this Committee) therefore require further consideration, which the Trust Chair and substantive Chief Executive will lead on in the coming months.		**N/A**	**N/A**
Next time: (Date tbd)	- Appointment details of substantive Chief Executive - ToR development			
Date Completed and Forwarded to Trust Secretary		**15 Nov 2022**		

5.3. Governance report

To inform

Presented by Richard Jones

Board of Directors - Public	
Report title:	**Governance Report**
Agenda item:	5.3
Date of the meeting:	25 November, 2022
Sponsor/executive lead:	Richard Jones, Trust Secretary
Report prepared by:	Richard Jones, Trust Secretary Pooja Sharma, Deputy Trust Secretary

Purpose of the report:			
For approval ☒	**For assurance** ☐	**For discussion** ☐	**For information** ☒
Trust strategy ambitions			
Please indicate Trust strategy ambitions relevant to this report.	☐	☐	☐

Executive Summary

This report summarises the main governance headlines for May 2022, as follows:

1. Council of Governors meeting report, including GGI report and improvement plan
2. Board assurance framework (BAF) summary and risk report
3. NED responsibilities
4. Revised committee terms of reference
5. Use of Trust's seal
6. Draft agenda items for the next Board meeting

Annex A: BAF summary
Annex B: NED responsibilities
Annex C: Draft agenda items for the next Board meeting

Action Required of the Board

To note the report contents as outlined above and approve:

- Undertake a **board assurance review** with a focus on the BAF based on national methodology
- the **terms of reference** of insight committee; improvement committee; involvement committee; board remuneration and nomination committee; and audit committee

Legal and regulatory context	NHS Act 2006, Health and Social Care Act 2013

Governance Report

1. CoG meeting held on 10 November

10 November 2022

The Council of Governors noted the appointment of three Governors Louisa Honeybun (Staff Governor), Michael Durham (Public Governor) and Gordon McKay (Public Governor) and the resignation of Margo Elsworth (Staff Governor). The appointment of five new Non–Executive Directors Antoinette Jackson, Tracy Dowling, Hilary McCallion, Geraldine O'Sullivan and Krishna Yergol was also noted.

Non-Executive Directors gave an overview of the work on board development, pathology services and maternity services of the Trust.

The Council of Governors noted the report on External Audit performance received an assurance on the professionalism and independence of the auditor; and the positive relationship between the organisation and the External Auditor.

It was agreed that with the new NEDs taking up the post, the preparation of a recommendation for the Council of Governors on deputy chair's appointment would be revisited prior to the February 2023 meeting.

The Council of Governors approved the appointment of lead governor. Jane Skinner received the highest number of votes and was duly elected to take up the lead governor role. The CoGs also recorded its thanks to Liz Steele and Florence Bevan for their work in the lead and deputy lead governor roles.

The Council of Governors received the report from Standards Committee and noted the action plan which focussed on the work being done following the recommendations from the Good Governance Institute (GGI). Eight recommendations had been made, and the report included an action sheet which indicated how to take them forward. A training needs analysis for governors will be carried out, and through working with sub-committees, the standards committee will ensure delivery of the action plan. The GGI report and improvement plan are provided as an addendum to the Board pack.

The Annual Report and Accounts for 2021/22 were formally presented to the Council of Governors after being laid before the Parliament.

18 November 2022

The appointment panel made a recommendation to the Council of Governors for the appointment of the Chief Executive and the recommended candidate Dr Ewen Cameron was approved by the Council of Governors, in their closed meeting on 18 November, as the new Chief Executive of West Suffolk NHS Foundation Trust.

Following a review by the standards committee the Council of Governors approved the appointment of Ben Lord as the deputy lead governor.

2. Board assurance framework (BAF) summary and risk report (Annex A)

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 has an approved risk appetite statement which supports the organisation's approach to risk mitigation.

A programme of deep dives has been introduced for risks rated as red and BAF risks. This is delivered by the assurance committees and governance groups in order to provide assurance on the effective management of the risk and control environment.

As part of our process for continuous improvement we have looked externally at the arrangements for managing risk and the BAF within the NHS and other sectors. The publication **Board Assurance: A toolkit for health sector organisations (Do we really know what we think we know?)** [NHS Providers and Baker Tilly] provides a useful review and challenge to the definition, structure and implementation of the BAF and wider board assurance arrangements. The report also recommends that all organisation's assess themselves with regards to their board assurance arrangements preparedness.

Such a board assurance review is timely and will allow us to identify strengthens and areas for improvement within our existing arrangements. With the Board's approval this review will be conducted, and the results reported to the corporate risk governance group to consider and develop an improvement plan. This output of which will be considered by the Board.

A summary of the BAF is provided in Annex D.

3. NED responsibilities (Annex B)

As we welcome to the Board our new non-executive directors (NEDs) it has been timely to review the NED responsibilities, including committees and assurance roles.

While these will be subject to change and development Annex B summarises the key responsibilities for the NEDs on the Board.

4. Revised committee terms of reference (ToR)

The Trust secretariat is aiming to implement a consistent schedule of review and a standardised template for all Board committees' ToRs. As such, the following Board sub-committee ToRs are presented as part of annual review and approval. The committees have approved their terms of reference either in the committee meetings or via committee chair's action as indicated.

- Insight committee (reviewed by committee - 3 Oct 22)
- Improvement committee (reviewed by committee – 14 Nov 22)
- Involvement committee (reviewed by committee – 11 Nov 22, chair's action)
- Audit committee (reviewed by committee – 4 Nov 22, and chair's action)
- Board remuneration and nomination committee (reviewed by committee – 28 Sept 22)

Full copies of the terms of reference are provided as an addendum to the Board pack.

As part of the review of Board remuneration committee terms of reference, it was decided that the committee is renamed as Board Remuneration and Nominations Committee to reflect the wider scope of duties and responsibilities which will be delivered through an updated workplan which will be overseen by the committee.

The next iteration, planned for early 2023, will include the terms of reference for the Future Systems, Charitable Funds and Digital Board for approval by the Board.

The Board is asked to approve the terms of reference of Insight, Improvement, Involvement, Board Remuneration and Nomination and Audit committees.

5. Use of Trust Seal

None since last meeting.

6. Agenda Items for the Next Meeting (Annex C)

The annex 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.

Board of Directors – 25 November 2022

Report Title:	Item 5.3 Annex A - Board Assurance Framework
Executive Lead:	Richard Jones, Trust Secretary
Report Prepared by:	Richard Jones, Trust Secretary Mike Dixon, Head of Health, Safety and Risk Manager
Previously Considered by:	Board of Directors July 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. 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.

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
4499	Provision of thrombectomy service for stroke patients in our region	N	Red	Corporate Risk
4724	Staffing shortfalls	N	Red	Corporate 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
5147	Aging CT Scanners	N	Red	Operational Risk
5148	Aging MRI scanners	N	Red	Operational Risk
5151	No availability of a second obstetric team outside the hours of 8am and 8pm Mon-Fri	N	Red	Operational Risk
5230	Delay in Discharge Summaries being sent out	N	Red	Operational Risk
5381	Disharmonious working within Plastic Surgery team	N	Red	Operational Risk
5383	Non-endorsed results in ED pooled message centre	N	Red	Corporate Risk
5581	Water shed accommodation to small and in state of disrepair	N	Red	Operational Risk
5612	Lack of robust CTA service out of hours	N	Red	Operational Risk

Any new draft red risks are reviewed at the emerging risk review meeting and all red risks are reviewed every 3 months with the relevant Executive.

The timescale for the remediation work for the **main building structure (risk 24)** is reviewed at the relevant assurance committee on a monthly basis.

The original RAAC work programme was scheduled in line with the strategic direction that three decant wards would be available during the summer (April to September) and two decant wards over winter (October to March). Operational pressures resulted in only one ward being available in early 2022 and as such the matter was reviewed. The strategic direction was amended, and the programme is now working to the new strategic direction of two decant wards to be available for the remainder of the programme which results in a programme completion of May 2024.

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 risks have been allocated to the relevant assurance committee and governance/specialist group.

Appendix 1

Allocation of BAF Risks to Board Sub-Committees

BAF risk	**Board assurance committee** (Exec. lead)	**Governance (specialist) committee** (Specialist lead)
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	**Improvement** (Sue Wilkinson)	**Patient Safety and Quality** (Dan Spooner)
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	**Insight** (Nicola Cottington)	**Urgent and emergency care group** (Alex Baldwin)
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	**Insight** (Nicola Cottington)	**Patient access** (Alex Baldwin)
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]	**Digital programme board** (Nick Macdonald)	**Digital board** (Liam McLaughlin)
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	**Insight** (Nicola Cottington + Nick Macdonald)	**Finance and workforce** (John Connelly (operational) / Charlie Davies (finance))
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	**Involvement** (Jeremy Over)	**Senior Leadership Team** (Denise Pora/ Claire Sorenson)
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	**Core Resilience Team Red Risk Oversight Committee** (Craig Black)	**Core Resilience Team** (Barry Moss)

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	Sue Wilkinson
Development programme for ward managers and matrons to support ward accreditation	Sue Wilkinson
Align accreditation framework and KPIs with Nursing, midwifery and AHP strategy	Sue Wilkinson
Co-produce nursing, midwifery and AHP strategy to meet current and future system needs (reflecting the updated Trust strategy - pending)	Sue Wilkinson
Develop patient safety and learning strategy	Lucy Winstanley
Quarterly review of the CQC Insight publication with actions to address outlying indicators overseen by Insight Committee	Rebecca Gibson
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".	Sue Wilkinson
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	Richard Jones
Review to be undertaken of the structure and strategies for quality, safety and experience of care	Sue Wilkinson

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)	Nicola Cottington
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	Nicola Cottington
Transformation initiatives: - review of home IV therapy to inform business case (Apr 21) - expansion of the virtual ward concept	Nicola Cottington
Implement final versions of new ED access standard in line with national roll out	Nicola Cottington
Submitted a range of bids for funding to support admission avoidance and improved hospital flow – funding schemes to be implemented	Nicola Cottington

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)	Nicola Cottington
Outpatient transformation programme with focus on digital and embedding of Covid learning – delivering benefits to key milestones. Advice and guidance virtual consultation PIFU	Nicola Cottington
Development of longer term contract for additional Orthopaedic capacity with the BMI	Nicola Cottington
Continue to progress opportunities to fund an elective hub at Newmarket	Nicola Cottington
Development of Ophthalmic injection suite	Nicola Cottington
Development of an additional clinical area within the JFDU	Nicola Cottington
Improve operational efficiency in line with the GIRFT HVLC	Nicola Cottington
Develop business case for community diagnostic hub at Newmarket	Nicola Cottington

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)

Awaiting confirmation of de-escalation

	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
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

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	Nick Macdonald
Agree financial position with (including anticipated funding for 22-23) with the system and regional team	Nick Macdonald
Agree budget position internally	Nick Macdonald
Finalise CIPs to deliver financial plan for 2022/23 (dependent on response to system/ regulatory framework)	Nick Macdonald
Review divisional business plans (underpinned by sustainable clinical models) to reflect the requirements to deliver additional backlog activity)	Nicola Cottington
Develop a system-wide information strategy with underpinning tools to improve performance monitoring	Nick Macdonald
Respond to national guidance for operational planning cycle for 2022/23	Richard Jones

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	Jeremy Over	
Evaluation of additional staff support measures during pandemic and agreement of next steps	Jeremy Over	
Implementation of lessons learned from external review of whistleblowing matters	Jeremy Over	
Establish Mandatory staff vaccination implementation group and deliver action plan	Jeremy Over	

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)	Craig Black
Deliver approved capital programme for 2021/22, including key capacity developments	Craig Black
Confirmation of capital loan funding for 2021-22-, trust has sought approval for an up lift in the budget and is awaiting confirmation	Craig Black
Sudbury asset disposal as part of agreed plan	Craig Black
Secure capacity as part of one public estate (OPE) development at six hubs across West Suffolk	Craig Black
Communication strategy for structural risk based on agreed remediation plan with clinical model to support capacity requirements (linked to Attain work)	Craig 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)

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Non-executive directors' responsibilities – November 2022

	Primary responsibilities	Responsibilities as required	Lead assurance roles (Bold indicates mandated)
Jude Chin **Chair and Non-executive director** **Term:** 4 July 22 – 3 July 23	• Board – Public, Closed (**Chair**) • Council of Governors (**Chair**) • Audit Committee (in attendance) • Remuneration Committee Specialist committees: • *Option to attend any other Board committees* • ICS chairs meeting • NHS Confederation Chairs group	• Board Workshops • External relationships • Consultant appointments • Quality walkabouts • Governor meetings with NEDs • Investigations and appeals • CCG Board meetings	• Integrated care system • NHS England and Improvement • West Suffolk Alliance • NED link to CEO
Richard Davies **Non-executive director** **Term:** 1 Mar 2017 – 28 Feb 2020 **Reappointed:** 1 Mar 2020 – 28 Feb 2023	• Board meeting – Public, Closed • Audit Committee • Remuneration Committee Specialist committees: • Future System Programme Board • Insight Committee (**Chair**) • Learning from deaths group (**Chair**) • Board maternity and neonatal safety champion (sit on local maternity and neonatal system board, attend Trust's maternity and neonatal safety champions meetings and maternity voice partnership meeting) • Doctors' Revalidation Support Group	• Board Workshops • Consultant appointments • Quality walkabouts • Revalidation Support Group • Council of Governors and Governor meetings with NEDs • Investigations and appeals	• **Senior Independent Director** • **Board freedom to speak up guardian**, including whistleblowing • NED link to Medical Director • Patient safety, including learning from deaths • **Maternity and neonatal safety champion** • Safeguarding children • Doctor appraisal and revalidation

	Primary responsibilities	Responsibilities as required	Lead assurance roles (Bold indicates mandated)
Tracy Dowling **Non-executive director** **Term:** 1 November 2022 – 31 October 2025	• Board meeting – Public, Closed • Remuneration Committee Specialist committees: • Involvement Committee (**Deputy Chair)** • Improvement Committee	• Board Workshops • Consultant appointments • Quality walkabouts • Council of Governors and Governor meetings with NEDs • Investigations and appeals	• NED link to Director of Workforce, including OD • Diversity and inclusion
Antoinette Jackson **Non-executive director** **Term:** 1 November 2022 – 31 October 2025	• Board meeting – Public, Closed • Remuneration Committee Specialist committees: • Insight Committee (**Deputy Chair**) • Involvement Committee • Charitable Funds Committee	• Board Workshops • Consultant appointments • Quality walkabouts • Council of Governors and Governor meetings with NEDs • Investigations and appeals	• NED link to Director of Finance • Theatre utilisation
Hilary McCallion **Associate Non-executive director** **Term:** 1 November 2022 – 31 October 2025	• Board meeting – Public, Closed • Remuneration Committee Specialist committees: • Improvement Committee • Charitable Funds Committee (**Chair**)	• Board Workshops • Consultant appointments • Quality walkabouts • Revalidation Support Group • Council of Governors and Governor meetings with NEDs • Investigations and appeals	• NED link to Director of Integrated Services
Geraldine O'Sullivan **Non-executive director** **Term:** 1 November 2022 – 31 October 2025	• Board meeting – Public, Closed • Remuneration Committee Specialist committees: • Improvement Committee (**Deputy Chair**) • Involvement Committee	• Board Workshops • Consultant appointments • Quality walkabouts • Revalidation Support Group • Council of Governors and Governor meetings with NEDs • Investigations and appeals	• NED link to Chief Nurse

	Primary responsibilities	Responsibilities as required	Lead assurance roles (Bold indicates mandated)
Louisa Pepper **Non-executive director** **Term:** 1 Sept 2018 – 31 Aug 2021 **Reappointed:** 1 Sept 2021 – 31 Aug 2024	• Board meeting – Public, Closed • Audit Committee • Remuneration Committee Specialist committees: • Ethics Committee (**Chair**) • Improvement Committee (**Chair**) • Insight Committee • RAAC Risk Committee	• Board Workshops • Consultant appointments • Quality walkabouts • Council of Governors and Governor meetings with NEDs • Investigations and appeals	• **Health and wellbeing guardian** • NED link to Chief operating office • Emergency preparedness, resilience and response (EPRR) – including COVID response • Pathology • Volunteers • Chaplaincy • **Security**
Alan Rose **Deputy Chair and Non-executive director** **Term:** 1 April 2017 – 31 March 2020 **Reappointed:** 1 April 2020 – 31 March 2023	• Board meeting – Public, Closed (**Deputy Chair**) • Audit Committee (**Chair**) • Remuneration Committee (**Chair**) Specialist committees: • Involvement Committee (**Chair**) • Clinical Excellence & Discretionary Awards Committee	• Board Workshops • Consultant appointments • Quality walkabouts • Council of Governors and Governor meetings with NEDs • Investigations and appeals	• Patient experience and public engagement • Safeguarding - adults
Krishna Yergol **Associate Non-executive director** **Term:** 1 November 2022 – 31 October 2025	• Board meeting – Public, Closed • Remuneration Committee Specialist committees: • Digital Programme Board • Future System Board • Insight Committee	• Board Workshops • Consultant appointments • Quality walkabouts • Revalidation Support Group • Council of Governors and Governor meetings with NEDs • Investigations and appeals	• NED link to CIO • Cyber security

All NEDs will be invited to attend audit committees (including deep dive presentations) but only those specified above are members of the committee

Annex A: Scheduled draft agenda items for next meeting – January 2023

Description	Open		Closed	Type	Source	Director
Declaration of interests	✓		✓	Verbal	Matrix	All
General Business						
Patient/staff story, including end of life care provision	✓		✓	Verbal	Matrix	Exec.
Chief Executive's report	✓			Written	Matrix	CB
Culture						
Organisational development plan, including safe staffing guardian, FTSU guardian reports	✓			Written	Matrix	JMO
Report of the West Suffolk Review – Governor/Director working group	✓			Written	Matrix	RD
Strategy						
Future System Board Report	✓			Written	Matrix	CB
Nurse staffing strategy review	✓			Written	Matrix	SW
System update: West Suffolk Alliance and SNEE Integrated Care Board	✓			Written	Matrix	CB
Digital programme board report (qrtly)	✓			Written	Matrix	NM
Assurance						
MyWish annual report and accounts	✓			Written	Matrix	Charitable funds committee
Report from 3i Committees: Insight, Improvement & Involvement	✓			Written	Matrix	RD / AR / JC
Insight Committee Report - Finance and workforce report - Operational report – winter preparedness and self-certification - IQPR: including appraisal and mandatory training	✓			Written	Matrix	NM/NC/RD
Involvement Committee Report - People and OD Highlight Report o Putting you First award o Staff recommender scores - Patient and staff survey and recommender responses - Clinical Excellence Awards Scheme annual report	✓			Written	Matrix	JMO/AR
Improvement Committee Report - New CQC model of assessment *(action 2058)* - Maternity services quality and performance report (inc. Ockenden) - Nurse staffing report - Quality and learning report - Quality priorities progress report	✓			Written	Matrix	SW / PM
Integrated quality & performance report (IQPR) – annex to Board pack	✓			Written	Matrix	NM/NC/SW/PM

Description	Open		Closed	Type	Source	Director
Serious Incident, inquests, complaints and claims report			✓	Written	Matrix	SW
Governance						
Governance report, including - Use of Trust's seal - Senior Leadership Team report - Council of Governors meeting report - Board assurance framework and risk report - Annual review of governance - Register of interests - Agenda items for next meeting	✓			Written	Matrix	RJ
Confidential staffing matters			✓	Written	Matrix – by exception	JMO
Reflections on the meetings (open and closed meetings)	✓		✓	Verbal	Matrix	JC

5.4. West Suffolk NHS Foundation Trust Annual Report & Accounts - 2021-22

To inform

Presented by Craig Black and Nick Macdonald

Board of Directors Public

Report title:	**2021/22 Annual Report & Accounts**
Agenda item:	5.4
Date of the meeting:	25 November 2022
Sponsor/executive lead:	Nick Macdonald – Director of Resources (Interim)
Report prepared by:	Liana Nicholson – Assistant Director of Finance

Purpose of the report:			
For approval ☐	**For assurance** ☐	**For discussion** ☐	**For information** ☒
Trust strategy ambitions			
Please indicate Trust strategy ambitions relevant to this report.	☒	☒	☒

Executive summary:	The audit opinion for the Trust's 2021/22 Annual Report and Accounts was issued on 16 September 2022. An unqualified audit opinion was issued. The Annual Report and Accounts have been laid before Parliament and are publicly available on the Trust's website.
Action required/ recommendation:	For information.

Previously considered by:	Audit Committee and Trust Board.
Risk and assurance:	None.
Equality, diversity and inclusion:	None.
Sustainability:	None.
Legal and regulatory context:	The Annual Reports and Accounts have been prepared in accordance with DHSC 2021/22 Group Accounting Manual and the 2021/22 Foundation Trust Annual Reporting Manual.

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Annual report 2021-22



West Suffolk NHS Foundation Trust

Annual Report and Accounts 2021-22

Presented to Parliament pursuant to Schedule 7, paragraph 25 (4) (a) of the National Health Service Act 2006.

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Throughout this document the organisation West Suffolk NHS Foundation Trust is referred to as WSFT and West Suffolk Hospital as WSH.

1. Performance report

1.1 Overview

The purpose of this overview is to give a short summary that provides sufficient information to understand the organisation, its purpose, the key risks to the achievement of its objectives and performance during the year.

1.1.1 A message from the chair and chief executive

In February 2022 we launched our new five-year West Suffolk NHS Foundation Trust strategy which is founded on our updated FIRST Trust values of fairness, inclusivity, respect, safety and teamwork. It has three equal ambitions:

- First for patients
- First for staff
- First for the future.

The strategy has been developed to help us improve; build a fair, open and listening culture; transform the care we provide; and develop a modern healthcare facility. Teams and colleagues across the Trust are developing their own plans to ensure our progress meets the needs of our patients, staff and whole community. The continuing commitment of all our colleagues to provide high-quality, safe and effective care wherever our teams are at work is an inspiration.

After two years of continuous challenges, our strategy reflects what we have learned from our experiences, our staff and those who need our care. As well as the pressures of the pandemic, and the urgent need to recover from it, WSFT has been in the spotlight with high-profile issues that should have been handled better. We also have ongoing problems with maintaining our current hospital, while our new hospital is built as part of a national programme funded by the Government's New Hospitals Programme.

To maintain patient care during COVID-19 we had to adapt many of our services and practices, enhance our infection control measures, and respond as waves of the virus changed the levels of infection in the population. Ensuring our integrated community services and acute hospital teams work closely together to meet individual place-based needs; and developing the relationships with our Suffolk alliance partners have become increasingly important. Technology and digital solutions have continued to be a key element, with telehealth, online and phone contacts combined with face to face care.

The External Review into whistleblowing commissioned by NHS England/Improvement was published in December. The Trust Board accepted full responsibility for the failings that led to the review, and apologises wholeheartedly for the distress caused. Its findings have informed work already under way to improve our culture, especially in ensuring our staff feel confident to speak up about matters that concern them. Our new Freedom to Speak Up (FTSU) guardians and network of FTSU champions are working with the Board to help drive the culture change we need and want to see.

We have developed our Patient Safety and Quality Improvement (QI) teams and patient safety initiatives. We have marked the first anniversary of becoming a pilot organisation in the national Patient Safety Incidence Response Framework, which has given us many valuable insights into how we can better learn from incidents.

The 'First for staff' ambition in our new Trust strategy reflects the importance of staff being our greatest asset, and as well as working to build an inclusive and supportive culture where colleagues can freely raise concerns, we have focused on their general wellbeing.
We have invested more than £500,000 in our staff support psychology team; and committed further investment to a partnership with Abbeycroft Leisure that provides free gym

membership to all staff. Free parking, hot drinks and other benefits have been welcomed, as well as our communications teams running a bi-annual wellbeing week called ‘Love Yourself’. Our hard-working My WiSH charity team have also done so much to support staff wellbeing, such as providing and equipping breakout areas.

Staff have all responded to the challenges of the COVID-19 pandemic magnificently. Time and again they have gone, and continue to go, above and beyond to care for our community - working extra hours and under extra stress. We are truly humbled by their dedication and hard work. To show its appreciation, the board of directors agreed to a one-off ‘COVID-19 recognition and reward’ payment of £300 in respect of the work done over this unprecedented period. Whilst nothing can ever really reflect the magnitude of what our staff have dealt with, this reflects a genuine “thank you” for their dedication and hard work.

One of the greatest achievements during the pandemic has been the development of vaccines to protect against coronavirus. We successfully rolled out first, second and booster vaccines to our staff with an excellent take-up rate. Our vaccination taskforce continues to work with system partners throughout our community delivering vaccine in areas of low take-up and to some of the most vulnerable and isolated people in west Suffolk.

Along with the vaccine, research into drugs that can be used to treat COVID-19 patients and prevent serious illness and death is taking place throughout the country. Along with our many other research projects, WSFT has received recognition for its efforts as part of the national RECOVERY clinical trial that explores treatments for COVID-19.

Beyond caring for patients and staff, WSFT is committed to playing a leading role in securing a healthy and sustainable Suffolk, and we have recently published our Green Plan 2021-2025. We will be pushing ahead with a range of measures to minimise our impact on the environment, such as reducing energy consumption and waste and considering the environmental impact of all our future developments.

A key element of future development will be the building of a new healthcare facility to replace our existing hospital. We have recently submitted the outline planning permission for our preferred site of Hardwick Manor. Much may change in the coming years, but we will maintain the commitment to co-production in developing the plans that have seen us undertake extensive engagement with our community and with our system partners.

The Trust has had a number of changes in leadership, including the departure of our chief executive Steve Dunn, after seven years in the role. The chair of our Board of Governors, Sheila Childerhouse, also stepped down. Long-serving chief operations officer Helen Beck retired at the end of 2021; and medical director Nick Jenkins stepped down from that post due to family issues, although he remains with the Trust as a consultant in emergency medicine. All these colleagues have given the Trust unwavering commitment, dedication and leadership for many years and we thank them for their service.

Nicola Cottington, a former associate director of operations for medicine, has returned to WSFT as chief operating officer; and Paul Molyneux our former deputy medical director and consultant for more than 18 years, has taken on the role of interim medical director.

Our Governors have continued to work with the Board and colleagues to contribute to engagement activities and delivery of our strategy. This has been challenges during the COVID-19 restrictions and we look forward to doing even more during 2022-23.

We continue to work closely within the local system. This includes working with the new NHS Suffolk and North East Essex Integrated Care Board (ICB) and alliance and healthcare partners.

While many challenges remain for the whole of the NHS and our community, our team believes that with our new strategy and the promise of a new healthcare facility – and the continued commitment and compassion of every one of our staff – we can face the future with optimism.



Jude Chin
Chair
15 September 2022



Craig Black
Interim Chief executive
15 September 2022

1.1.2 About our Trust – a summary

The WSFT provides hospital and community healthcare services to people mainly in the west of Suffolk, and is an associate teaching hospital of the University of Cambridge.

The Trust serves a predominantly rural geographical area of roughly 600 square miles with a population of around 280,000. The main catchment area for the Trust extends to Thetford in the north, Sudbury in the south, Newmarket to the west and Stowmarket to the east. Whilst mainly serving the population of Suffolk, WSFT also provides care for parts of the neighbouring counties of Essex, Cambridgeshire and Norfolk.

As part of this we provide community services in the west of Suffolk, but also some specialist community services across the county. This includes the delivery of care in a variety of settings including people's own homes, care homes, community hospital inpatient units and clinics, day centres, schools, GP surgeries and health centres.

Our vision is to deliver the best quality and safest care for our local community

Our vision and priorities align with our partners, including NHS Suffolk and North East Essex Integrated Care Board (ICB)), whose mission is to deliver the highest quality health service in the west of Suffolk through integrated working. Through our new strategy, we put quality at the heart of everything we do.



The Board monitors quality through its **performance management arrangements** on a monthly basis. The Board also receives assurance regarding quality within the organisation through the three assurance committees of the Board, which ensure quality is delivered in a coordinated way to support safe, effective and patient-focused healthcare. During 2021-22 the Board made changes to the structure to provide a greater focus on culture, patient safety and quality:

- **Insight Committee** with a focus on operations, finance and organisational risk
- **Involvement Committee** with a focus on people and organisational development

- **Improvement Committee** with a focus on quality, patient safety and change management.

The NHS Long Term Plan sets out the need to do more to prevent illness and reduce inequalities in health experienced by different groups of people.

A key component of our First for the future ambition is to make the biggest possible contribution to prevent ill health, increase wellbeing and reduce health inequalities. Our new strategy reflects the ways in which we are working towards two common aims: improving the health of our community and reducing inequalities.

This means looking after the community's physical, mental, emotional, social, and economic needs. We're here to help make people better when they are ill, and to support them to help keep themselves well in the first place. To do this:

- We will adapt our services to do more to increase everyone's wellbeing and prevent ill health
- We will recognise and value the role people play in managing their own health and wellbeing, involving them in conversations and decisions about their health and care, moving from 'what's the matter with you?' to 'what matters to you?'
- We will maximise our social impact as an anchor institution rooted in our local community – providing training and employment opportunities for local people, buying from local businesses, supporting local charities and community groups
- We will minimise our environmental impact with our Green Plan.

We are creating a new role of a patient equalities officer who will work within the patient experience and engagement team with links to key stakeholders, such as our public health team. This role will focus on better understanding the equity and accessibility of the services and care we provide. The role will include regularly engaging with staff, patients and family carers in the hospital and community better to understand the issues they face with inequalities, with a particular focus on marginalised communities. It will also include analysing existing data, in the context of the patient demographic; and working with patients and staff to address health inequalities, access and communication needs and ensure representation of our diverse community.

Our sites and services

The Trust's main facility is West Suffolk Hospital (WSH), a busy district general hospital which provides a range of acute core services with associated inpatient and outpatient facilities. There is a purpose-built Macmillan Unit for the care of people with cancer, a dedicated eye treatment centre and a day surgery unit where children and adults are treated and are mostly able go home on the same day. WSH has around 500 beds and 14 operating theatres, including three in the day surgery unit and two in the eye treatment centre. Ongoing structural repairs to WSH continue to impact on this capacity. Access to specialist services is offered to local residents by WSFT networking with tertiary (specialist) centres, most notably Addenbrooke's and Royal Papworth hospitals. The Trust operates a streaming service embedded and co-located within the emergency department. Patients who attend the emergency department during the operating hours of the streaming service are assessed and directed to either the emergency department or the primary care unit, meaning they access the service that best addresses their healthcare need.

A range of nursing and therapy services are provided by our community health teams and specialist community teams; these services are provided in patients' own homes, health clinics/centres and community buildings, including a clinical assessment and prescribing service for a county-wide community wheelchair and equipment service, working with community therapists and community neurological nurse specialists among other specialist nursing services. We also have responsibility for Newmarket Community Hospital, a community hospital in Suffolk with approximately 33 beds. These inpatient beds provide rehabilitation care to patients referred by GPs, or who are transferred from an acute hospital as a step-down facility prior to discharge. The community hospital also has a radiology service and outpatient clinics which receive visiting clinicians from WSH. In addition, some

of our community teams use Newmarket Community Hospital as a base. Oakfield GP surgery is also based at the site.

Glastonbury Court is a care home in Bury St Edmunds run by Care UK. The Trust has commissioned a 20-bedded unit to provide ongoing assessment and reablement to patients who are medically optimised and no longer require the services of an acute hospital. The nursing and therapy staff are employed by WSFT, with ancillary staff and hotel services provided by Care UK.

We provide a number of outreach services to our population across various sites in Newmarket, Botesdale, Thetford, Stowmarket, Haverhill, Sudbury, Needham Market and Watton. This includes outpatient clinics and some diagnostic imaging – Newmarket Community Hospital (X-ray), Sudbury Community Health Centre (X-ray) and Thetford Healthy Living Centre (ultrasound and X-ray). Linked to our early intervention team (EIT), we also have in place a service to provide personal care to patients in their home. Delivered by a reablement support worker, this forms part of a wider service, working to prevent unnecessary admission to hospital.

The community midwifery teams operate from administrative bases in Stanton Health Centre, Thetford Healthy Living Centre, Mildenhall Community Health Clinic, Newmarket Community Hospital, Sudbury Community Health Centre, Haverhill Health Centre, Forbes Business Centre and Bury St Edmunds.

The Trust is also responsible for, through a contract with the East and West Suffolk clinical commissioning groups, the provision of adult community healthcare teams, adult speech and language therapy (SALT), and community paediatric services, as well as specialist nurses and therapists in Parkinson's, neurology, epilepsy, cardiac rehabilitation, chronic obstructive pulmonary disease (COPD), heart failure and pulmonary rehabilitation. This includes services for lymphoedema and pain.

The Trust provides primary care services at Glemsford Surgery via a sub-contracting arrangement of the existing General Medical Services (GMS) contract. Existing GP partners continue to hold the GMS contract and, as employees of the Trust, provide primary care services on our behalf.

Our operational services are structured into divisions led by a triumvirate – assistant director of operations, clinical director and head of nursing. Accountability for the operational divisions sits with the executive chief operating officer. Further detail of the Board and accountability framework is provided in section 2.2 (directors' report) and section 2.6 (annual governance statement).

Our staff

We are one of the largest employers in Suffolk, employing 4,845 staff as of April 2022.

We firmly believe in the benefits of working in partnership with staff and trade unions. Further detail is included in section 2.8 (staff report), including work we are doing regarding the employment of disabled people.

Our partners

The Trust works closely with other public, private and voluntary stakeholders. These include West Suffolk Clinical Commissioning Group (WSCCG), Suffolk County Council and the University of Cambridge as well as East Suffolk and North Essex NHS Foundation Trust (ESNEFT) and the new Suffolk & North East Essex Integrated Care System and other local NHS providers, integrated care systems (ICSs), Suffolk GP Federation and Care UK.

In Suffolk and north east Essex, the NHS, general practice and local government came together to develop an integrated care system (ICS). The ICS is a unified approach and subsequently plans to improve the health and care of our local people and bring the system back into a financially sustainable position. Our partnership includes all NHS organisations within the footprint including the ambulance service, local government, other health sector bodies, local hospices and community and

voluntary sector organisations. Leadership for the ICS is drawn from across these stakeholders.

Going concern

After making enquiries, the Directors have a reasonable expectation that the Trust will continue in operational existence for the foreseeable future. The financial reporting framework applicable to NHS bodies, derived from the HM Treasury Financial Reporting Manual, defines that the anticipated continued provision of the entity's services in the public sector is sufficient evidence of going concern. The Directors have a reasonable expectation that this will continue to be the case and for this reason, the Directors continue to adopt the going concern basis in preparing the accounts.

1.2 Performance analysis

The Trust uses its performance management framework to gather and analyse complex information across a range of quality, operational and financial measures and indicators. This allows the Board to ensure effective action is being taken to address risks or uncertainty to the delivery of plans and objectives. External assessment of the Trust is an important part of this risk and control environment.

The Trust's annual business planning cycle is informed by the performance management framework to ensure future objectives address areas of risk or uncertainty. Similarly, the strategic and operational plans for the Trust inform the performance management framework to ensure that the Board is sighted on indicators that are relevant to future plans.

This section of the report sets out key issues and risks for the Trust as well as opportunities and risks that could affect the delivery of Trust objectives and/or its future success and sustainability.

1.2.1 Performance management framework

The Trust has a board assurance framework (BAF) in place that sets out the principal risks to the delivery of the Trust's strategic corporate objectives. The executive director with delegated responsibility for managing and monitoring each risk is clearly identified. The framework identifies the key controls in place to manage each of the principal risks and explains how the Board of directors is assured that those controls are in place and operating effectively. Controls and assurances include:

Performance monitoring:

- Monthly quality and performance reports and performance dashboard. These include the Trust's priorities for improvement in the quality report, analysis of patient experience, incidents and complaints, review of serious incidents and ward-level quality performance
- Monthly financial performance reports
- Monthly quality and performance reports by divisions to executives
- Quarterly reports to the council of governors on the work of the board
- Reports to the Board and its assurance committees setting out quality improvement and learning from deaths
- Reports to the Board and its assurance committees from the Freedom to Speak Up guardian and guardian of safe working
- Risk assessments and analysis of the risk register.

Governance framework:

- Assurances provided through the work of the insight, involvement and improvement assurance committees of the Board
- Reports from the Future Systems programme board, digital board and the audit committee received by the Board
- Self-assessment against delivery of the Care Quality Commission (CQC) registration requirements
- Assurances provided through the work of internal and external audit, the CQC, NHS England / Improvement, NHS Resolution, patient-led assessments of the care environment (PLACE), and accountability to the council of governors (COVID-19 has impacted on some of these

activities).

Engagement and measurement:

- Quality walkabouts, including executive directors, non-executive directors and governors, have not been possible due to the social distancing requirements of COVID-19. Executives, non-executives and governors have engaged with staff through virtual meetings, including the regular all staff briefing. During June we restarted a programme to allow Board members and governors to engage with staff and the public within clinical areas. The programme is structured on NHS England's 15-steps challenge model
- External regulatory and assessment body inspections and reviews, including royal colleges, post-graduate dean reports, accreditation inspections and Health and Safety Executive (HSE) reports
- Benchmarking for clinical indicators
- The work of clinical audit, which within its scope includes national audits, audits arising from national guidance such as the National Institute for Health and Care Excellence (NICE), confidential enquiries and other risk and patient safety-related topics.

1.2.2 Principal activities and achievements

Care Quality Commission (CQC) registration

The Trust has unconditional registration with the CQC with no enforcement action. The Trust's overall rating is 'requires improvement'. The acute services are rated 'requires improvement' and the community services (adults, children and young people and inpatient services) are all rated as 'good'.

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute	Requires improvement ↓ Jan 2020	Good ↓ Jan 2020	Good ↓ Jan 2020	Requires improvement ↓ Jan 2020	Requires improvement ↓ Jan 2020	Requires improvement ↓↓ Jan 2020
Community	Good Jan 2020	Requires improvement Jan 2020	Good Jan 2020	Good Jan 2020	Good Jan 2020	Good Jan 2020
Overall trust	Requires improvement Jan 2020	Good Jan 2020	Good Jan 2020	Requires improvement Jan 2020	Requires improvement Jan 2020	Requires improvement Jan 2020

The Trust's maternity services were inspected in April 2021 (report published June 2021). The visit reflected the ongoing local scrutiny of the maternity improvement plan and noted the continued efforts to deliver improvements. The rating for Well-led improved although the overall rating remained unchanged.

Report issued	SAFE	EFFECTIVE	CARING	REPONSIVE	WELL-LED	OVERALL
January 2020	Requires Improvement	Requires Improvement	Good	Good	Inadequate	Requires Improvement
June 2021	→ Requires Improvement	→ Requires Improvement	→ Good	→ Good	↑ Requires Improvement	→ Requires Improvement

The report noted that there had been significant change within the maternity service leadership team which had provided stability to the triumvirate. This meant there now was a clearly defined management and leadership structure in place and the CQC observed joint working between leaders both within the department, the rest of the Trust and with external agencies and bodies to maximise care provision for women and babies. The report noted a high profile for the maternity service at board level which was an improvement from the previous inspection (2019).The findings of the CQC inspection visit have been incorporated into the maternity service improvement plan which also links to clinical negligence scheme for trusts (CNST), the 2022 Ockendon report and the Each Baby Counts national quality improvement programme from the Royal College of Obstetricians and

Gynaecologists..

In the last full assessment report (from an inspection in 2019 published in January 2020) CQC inspectors said staff ”treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions they worked well together for the benefit of patients, advised them on how to lead healthier lives and supported them to make decisions about their care”.

A structured CQC improvement plan was developed to address the findings of the 2019 inspection. The WSFT improvement board (a subcommittee of the board of directors) oversaw delivery of the agreed plan. This was led by the executive chief nurse and coordinated by the project management office in terms of action completion and moving activities and monitoring to a ‘business as usual’. The West Suffolk CCG provided an additional level of independent assurance through supportive and proactive clinically-led visits to review how well actions had been embedded.

During 2021-22, as described previously, the Trust implemented a new board assurance committee structure which incorporated the ongoing elements of the Trust’s improvement plan.

Our services

We provide a range of patient services:

Indicators	2021-22	2020-21	2019-20	2018-19	2017-18
Inpatient planned	**2,407**	1,722	3,475	3,548	3,730
Inpatient non-planned	**32,708**	29,623	32,374	32,832	32,505
Day cases	**28,903**	18,747	32,815	31,696	30,824
Outpatient attendances (inc. ward attenders)	**281,162**	234,464	271,316	266,157	249,460
Outpatient procedures	**58,503**	37,749	79,570	79,404	82,880
ED attendances	**86,312**	64,764	78,822	74,400	70,918

The 2021-22 activity has started to return to pre-COVID-19 levels. ED attendances and non-planned admissions are already at the expected levels, when comparing the growth from 17/18. The elective planned inpatient admissions, day case and outpatient activity have all increased, but are yet to reach the pre-COVID-19 levels. The elective recovery plan is in place for 2022-23 to increase this activity and therefore reduce waiting times.

Activity has generally returned to pre-COVID-19 levels for the wide-ranging community services. The referrals and activity for the integrated neighborhood teams (INTs) nursing and therapy teams are all above 2017/2018, 2018/19 and 2019/20 levels and the specialist teams and paediatric services are all similar to pre-COVID-19 levels despite most of their caseload coming under the vulnerable definition. The services are working on ways to reduce the waiting times for services where it has increased.

Further detail of our performance regarding quality and local or national targets is provided in the annual governance statement (section 2.6) along with arrangements for quality governance within WSFT.

Our financial performance

We recorded a surplus of £0.2 million for the year 2021-22. Due to COVID-19 we received top up payments of £24.8m which is included in this position.

We have also been reimbursed for all COVID-related expenditure (including vaccination costs), shortfalls against non-clinical income receipts as a result of COVID-19 and costs relating to annual leave carried forward to support a breakeven position.

	2021/22 £000s	2020/21 £000s	2019/20 £000s	2018/19 £000s	2017/18 £000s
Operating income	**352,198**	**321,282**	**283,173**	244,952	252,778
Operating costs	**(336,603)**	**(307,751)**	**(272,245)**	(242,770)	(245,906)
EBITDA * surplus/(deficit)	**15,595**	**13,531**	**10,928**	2,182	6,872
Depreciation, dividend and other costs	**(15,375)**	**(12,767)**	**(10,642)**	(8,226)	(7,159)
Fixed asset impairments**	**(4,647)**	**(1,496)**	**(7,903)**	(5,506)	0
Retained earnings	**(4,427)**	**(732)**	**(7,617)**	(11,550)	(287)

* EBITDA – measurement of earnings before interest, taxes, depreciation and amortisation
** Fixed asset impairments – these occur when the value of individual fixed assets reduces as a result of damage or obsolescence.

Note:
On 1 October 2015, WSFT began providing community services in Suffolk which increased income and expenditure by around £63m in a full year. From 1 October 2017, Ipswich Hospital NHS Trust (now East Suffolk and North East Essex NHS Foundation Trust) began providing community services in the east of Suffolk, which decreased income and expenditure at WSFT by around £18m between 2017/18 and 2018/19.

Highlights of the year

The publication of our five-year Trust strategy – First for patients, first for staff and first for the future (2021 – 2026) - has given us the opportunity to lay out our priorities and ambitions for the whole organisation. It is founded on our updated FIRST Trust values – fairness, inclusivity, respect, safety and teamwork; and the vision of delivering the best quality and safest care for our community.

First for patients

The pandemic has forced us to make the difficult decision to restrict or suspend visiting at various times over the past year to reduce transmission of the COVID-19 virus. To help patients and their loved ones stay informed and in touch with each other, we established a clinical helpline and Keeping in Touch team. The clinical helpline is staffed by colleagues with clinical backgrounds, who give updates on patients' conditions and answer queries. The team won a Patient Experience National Award in the support for caregivers, friends and family category. Digital technology allows the Keeping in Touch team to keep friends and relatives in contact with people on our hospital wards – for example the team enabled a patient to be a virtual guest at their daughter's wedding.

WSFT has a fantastic research team and the work it reports on and delivers to a wide variety of vital studies, with the support of our patients recruited to the projects, is helping to advance medical understanding and treatment. We were named as the top national recruiting site for the global RECOVERY trial for two consecutive weeks in November. The RECOVERY (Randomised Evaluation of COVID-19 Therapy) trial is investigating treatments that may benefit people hospitalised with COVID-19.

One of our clinical research practitioners, Angharad Williams, has been named as the winner of the 2022 award for Clinical Research Practitioner Leadership by the Academy for Healthcare Science. A wonderful achievement for her.

WSFT is one of 12 integrated care systems in England signed up as an "accelerator site" to tackle waiting lists and elective recovery, trialling new ways of working, implementing and evaluating innovative ways to increase elective operations. We are also part of the Waiting Well pilot which 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.

Across the NHS, digital technology has supported ways of working that allow clinicians to offer care and support to patients. Our Patient Portal and "DrDoctor" text messaging service enable patients to see their records, results, appointments and letters, so they can take more control of their treatment.

Our community services have increasingly used telehealth to offer enhanced care to patients where they live, allowing them to have the clinical oversight and support they need to stay out of hospital. Through our integrated care networks and multi-disciplinary way of working, we are expanding our virtual ward beds which means people can receive the individual care they need at home.

We are active members of the West Suffolk Alliance, and are committed to an “alliance way of working” with our partners across the system. In July, Clement Mawoyo was appointed director of integrated community health and adult social care, as part of the work driving further integration with our social care and other alliance colleagues.

Our Mildenhall integrated neighbourhood team is now based at the new Mildenhall Hub, co-located not only with social care, but also a school, leisure centre and other public services. The Brandon team is based at the town’s health and leisure hub, and all our teams are able to refer patients directly to trained Abbeycroft Leisure instructors working at local Abbeycroft leisure centres and gyms.

A network of integrated neighbourhood team co-ordinators has been established, who with our hospital-based locality liaison co-ordinator, support community teams and wards to facilitate admission and discharge. We are also working with partners to improve waiting times and ensure equity in access to treatment.

Working with the Suffolk and North East Essex integrated care system (SNEE) we have established a WSFT vaccine taskforce. After our successful vaccine rollout to our staff and colleagues from key partner organisations, the taskforce joined the campaign to vaccinate as many people as possible at the heart of their community. Giving people expert advice, taking time to answer questions and allay fears, the team has helped thousands to access the vaccines, including some of the most vulnerable. We recently marked the first anniversary of becoming an early adopter of the Patient Safety Incident Response Framework, a national initiative aimed at identifying risks and learning from incidents to improve quality and safety. Our Patient Safety and Quality Improvement (QI) team has been expanded and developed, and is undertaking projects across the Trust, embedding QI in all aspects of our work.

Improvements in our maternity services were noted by the Care Quality Commission after an unannounced inspection, which reported on progress being made, but also raised concerns which are being dealt with.

With our alliance partners East Suffolk and North Essex NHS Foundation Trust (ESNEFT) we have taken over the Early Supported Discharge service for stroke patients in the county, with the staff also transferred to the trusts.

We continue to perform well on the National Hip Fracture Database, where the data puts us at the top of all hospitals in England, Wales and Northern Ireland for meeting best practice criteria when assessing patients with a hip fracture.

Our cancer care teams have extended the hours for people to access routine screening or referral appointments; and innovative screening tools using artificial intelligence are helping us to increase the numbers of patients we see and reduce waiting times.

The Macmillan Unit based at the hospital was recently awarded the Macmillan Quality Environment Mark for the third time. The award champions cancer environments that go above and beyond to create welcoming and friendly spaces for patients.

First for staff

We continue to be inspired by the commitment, compassion and teamwork of each one of our colleagues, who have shown extraordinary resilience.

We recently received the results of the 2021 NHS Staff Survey, to which 2,000 of our staff

responded. The results compared reasonably well with Trusts across the country, with all our key scores above the national average. We are working with colleagues to examine the findings in detail, learn from them and use that learning to improve the working lives of our colleagues.

As part of our commitment to build an open, learning and restorative culture, we have appointed two new Freedom to Speak Up (FTSU) guardians: Amanda Bennett and James Barrett. We have also recruited FTSU champions across the Trust, who with the guardians, are working closely with the Board to identify and tackle concerns expressed by our staff.

We have invested in and developed our staff support psychology service, which was the recipient of a Suffolk Heroes award, nominated by the county's MPs, in recognition of their work during the pandemic. Laura Rawlings, manager of the countywide community equipment service, also received one of the awards – both richly deserved.

Another major investment has been a partnership with Abbeycroft Leisure, which has allowed any WSFT colleague to access free membership to the facilities and services at Abbeycroft gyms and leisure centres. Our staff have taken up this offer in large numbers, and shared their enthusiasm for the scheme which has been extended for a second year.

Our chaplaincy team has been expanded and the chapel refurbished, and the team works tirelessly to support staff, patients and visitors of all faiths and beliefs.

It has been very heartening to see members of our team recognised. Consultant anaesthetist Jeremy Mauger has been a volunteer with the Suffolk Accident Rescue Service for 20 years and volunteers hundreds of hours for the emergency responders each year. To mark Suffolk Day, he was awarded the county's highest honour, the Suffolk Medal.

While off-duty, critical care nurse Debbie Lavender performed CPR and used a defibrillator to revive a man who collapsed, and was awarded with a Resuscitation Certificate from the Royal Humane Society.

We are often humbled by the appreciation, gratitude and generosity of our patients. Breast cancer patient Chris Goddard was diagnosed and treated at the WSFT during the pandemic. She was inspired to paint portraits of all the staff who cared for her – her NHS heroes as she calls them – and her images of the masked clinicians are a poignant reminder of the journey that she – and we – have been on.

First for the future

The Trust is one of 40 in the country to receive funding for new build projects through the New Hospitals Programme, which will see the building of a new healthcare facility as part of a system to provide innovative, joined-up healthcare for west Suffolk.

Progress has been made this year, with the preferred site for the new facility at Hardwick Manor identified, outline planning permission applied for, and extensive face-to-face and online engagement undertaken to ensure we hear people's views on this great opportunity for our community. There is still much work to do and building is not expected to start before 2025. We are committed to taking on board – and learning from - the knowledge and opinions of our staff, patients and community. The existing hospital buildings on Hardwick Lane were built in 1974 with an intended 30-year life span. The Trust has invested heavily in their upkeep over the years, and an extensive programme of maintenance is under way to ensure the safety of everyone using the site until the new hospital is completed.

While those works go on, we have increased the flexibility we can offer with the building of a new "decant" 32-bed ward, G10. We have also increased the community beds we have commissioned to support the discharge of medically optimised patients.

Our Trust strategy reflects the importance with which we see our role at the heart of our community. Our place in the wider world is also a vital part of looking to the future, and with that in mind we have

published our Green Plan 2021 – 2025, which underlines our commitment to being part of a sustainable health system. We want to work within available resources and understand the social, environmental and economic impacts of our actions.

The My WiSH charity
Tireless in its support for the Trust and its staff, in September 2021 the charity saw the end of its #25 birthday appeal, smashing the target of raising £25,000 and ending the year with almost £31,000. This money will be used to provide a play specialist for the paediatric emergency department, and the department was able to welcome Claire Thompson during the year due to additional fundraising from the Help your NHS hospital appeal.

The charity matched Government funding to provide state-of-the-art toilet facilities for patients with complex disabilities with the completion of a new Changing Places facility. Changing Places are toilets with additional equipment for people who are not able to use the toilet independently, including adult-sized changing benches and hoists.

Refurbishment of the West Suffolk Hospital chapel, including a prayer facility for Muslim people, was also supported by My WiSH.

From providing and equipping quiet spaces for staff to go to during the worst of the pandemic; to giving every colleague a reusable cup for the free tea and coffee available to them, the charity has come up with imaginative ways to improve the working lives of our staff.

As well as their own fundraising activities, now being planned once more as restrictions ease, My WiSH is supported by hundreds of local people and businesses and to whom we extend our sincere thanks.

1.2.3 Quality and operational performance

Quality improvement priorities for 2022-23

Our quality priorities are driven by our strategy and set out key improvements we aim to deliver and the measures that we will use to understand progress and success. These measures are open to further review and development as we progress delivery.

Delivering our strategy • Use feedback, learning, research and innovation to improve our care and outcomes • Collaborate to provide seamless, accessible care at the right time and in the right place

Priorities for quality improvement
 	
• Improve care and outcomes for patients through:
  ○ Effective response to new and emerging guidance
  ○ Evidence shared learning from incidents to reduce patient harm
• Ensure patients' and families' experiences are captured and listened to in order to help us to improve through delivery of our experience of care strategy.

Measuring our progress and providing assurance <u>Safe and high quality care:</u> • Deliver improvements through our patient safety incident response framework (PSIRF) • Deliver improvements as measured by the CQUIN indicators for 2022-23 • Through shared learning deliver improvements to reduce patient harm • Effectively respond to national reports to support quality improvements • Develop our quality assurance framework to support systematic quality improvement • Percentage of patients recommending WSFT as a place receive care • Percentage of staff recommending WSFT as a place to receive care.

Experience of care:

- Deliver improvements through the experience of care strategy
- Celebrate good practice and share learning for experience improvements
- Ensure equality of access and the use of the accessible information standard (AIS) to improve the experience for all service users
- Provide opportunities for patients, carers and families to give feedback in a variety of accessible ways, and ensure this is listened to and acted upon
- Improve opportunities for patients to become involved with decisions affecting care, services and developments across WSFT
- Percentage of patients recommending WSFT as a place to receive care.

Performance against 2021-22 priorities

The quality priorities for 2021-22 were agreed during the pandemic response. It was felt appropriate to identify planned areas of work which reflected the priorities of WSFT and the local system. This included key organisational elements of our response to our CQC report and concerns around 'speaking up' as well as the national patient safety strategy first issued (pre-pandemic) in the summer of 2019. The following priorities were agreed:

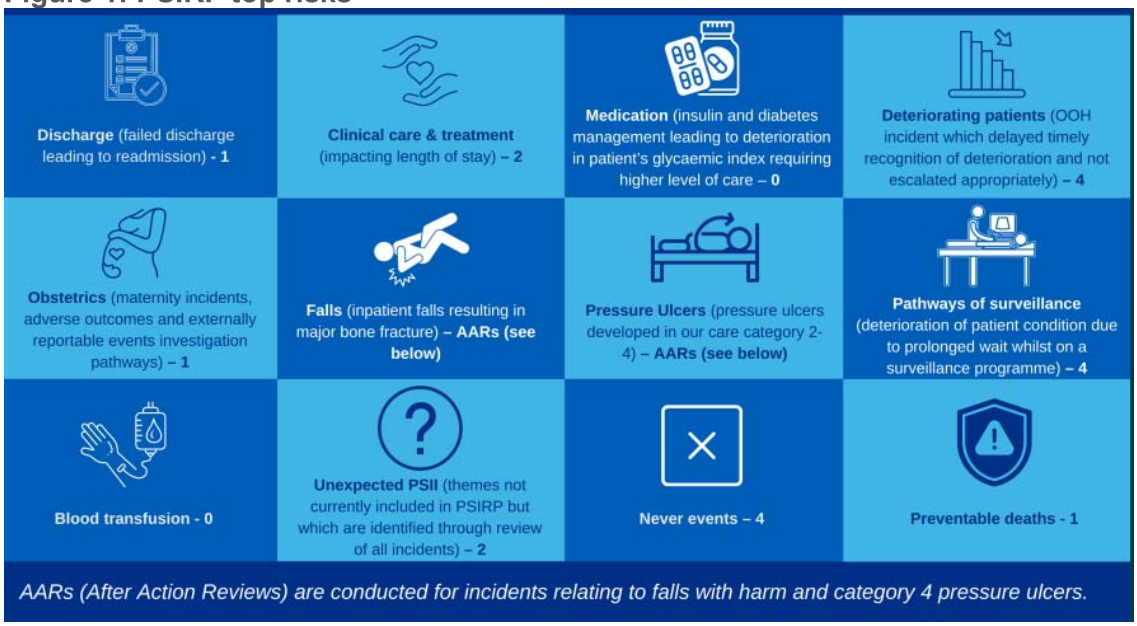
1. Learning and improvement through the implementation of the Patient Safety incident response framework (PSIRF).
2. Development of a reporting framework for quality using the National Patient Safety strategy model of Insight : Involvement : Improvement
3. Supporting all colleagues to speak up safely as part of a culture focused on staff support, wellbeing and learning.

Quality priority 1: Learning and improvement through the implementation of PSIRF

Patient safety incident response framework (PSIRF) reflects a new systems and outcome focused approach to learning from incidents. It responds to calls for a new approach to incident management, one which facilitates inquisitive examination of a wider range of patient safety incidents "in the spirit of reflection and learning" rather than as part of a "framework of accountability". It aims to recognise the needs of those affected, examining what happened to understand the causes and responding with action to mitigate risks remain essential to improving the safety of healthcare.

In 2021-22 WSFT became an early adopter of the new national PSIRF alongside other local trusts in the Integrated Care System (ICS). This is a national initiative designed to further improve safety through learning from patient safety incidents and forms part of the wider national patient safety strategy.

Figure 1: PSIRF top risks



PSIRP - Patient Safety Incident Response Plan
PSII - patient safety incident investigation

The Trust completed its first year of the new process in March and worked with stakeholders to develop the plan for 2022/23 which received board sign-off in March.

Figure 2: PSIRF plan for 2022/23

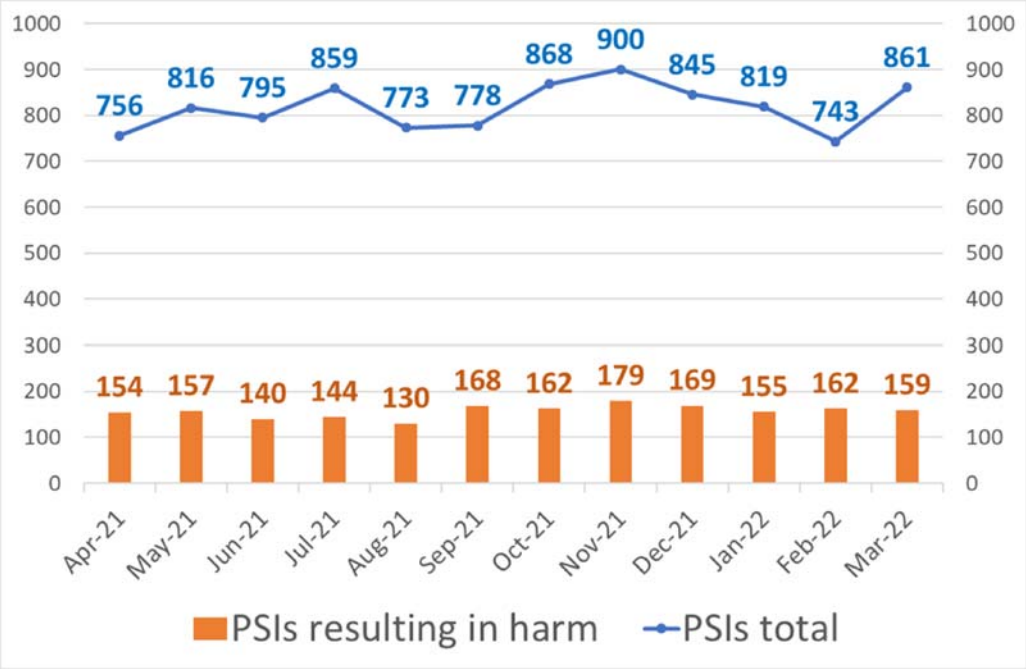
	Incident type	Description	Specialty
1	Transfer of care	Potential for patient harm as a result of communication with multiple stakeholders for on-going patient care	All specialties
2	Discharge	'Failed discharge' where a delay has led to an adverse outcome within the extended length of stay after the patient was medically optimised for discharge	All Inpatients specialties
3	Medication	Mis-selection of wrong medication or dose leading to harm or potential for harm	All specialties
4	Validation of results	Potential for patient harm as a consequence of non-communication and action of diagnostic results	All specialties
5	Digital systems	Emerging risks identified as a result of the use of our digital systems	All specialties
6	Clinical care & treatment	Wound care	Adult community services
7	Falls	Inpatient falls resulting in a bone fracture or haemorrhage	All specialties
8	Pressure ulcers	Pressure ulcers developed in our care category 2 -4.	All specialties
9	Medication	Opioids management, Gentamycin/vancomycin, Medication patches, Extravasation, Diabetes medicines management, Thromboprophylaxis	All specialties
10	Unexpected PSII	Identified increase in incidence of subject of theme which has potential for harm	All specialties

PSII - patient safety incident investigation

The Trust's web-based electronic incident reporting system (Datix) supports multidisciplinary incident reporting which includes a high level of reporting near misses, no harm and minor harm incidents. Reporting of these near-miss incidents is seen as a key driver for identification and management of risks to prevent more serious harm incidents. By reviewing investigations and thematic learning, key learning can be identified and actions put into place to prevent recurrence.

The organisation reviews this data on a monthly basis within the Integrated quality and performance report (IQPR) and recognises a high reporting rate as a positive reflection of an open culture within the organisation which supports learning from incidents.

Patient safety incidents: PSIs total (line) and PSIs resulting in harm (bar)



Source: Datix

The number of patient safety incidents (PSIs) reported in 2021-22 was higher than in the previous year however the percentage of total incidents resulting in harm fell in the same period from 21% down to 19%. A higher level of PSI reporting demonstrates a good safety culture. The number and percentage of incidents resulting in severe harm or death rose in 2021-22 although it remained low (0.61%). The increase in serious harm in 2021-22 was primarily as a consequence of higher numbers of category 4 (the most severe grading) pressure ulcers in the community.

	2020-21	**2021-22**
PSIs total	8,348	**9,990**
PSIs resulting in harm	1,737 (21%)	**1,891 (19%)**
PSIs resulting in severe harm or death	41 (0.49%)	**61 (0.61%)**

The tissue viability team have been using the various investigation pathways for pressure ulcers included within the Trust's patient safety incident response plan. This has enabled them to identify the main areas for improvement which will be monitored via the pressure ulcer and complex wound group. These include:

- Maximising patient compliance with care plans and pressure relieving equipment use. This will be supported by the use of the non-compliance pathway tool which is already in place to support staff. This tool takes staff through the options available to maximise patient compliance. Updates are being made so that it can be used more effectively. This involves looking at how the technology is used to support staff in their documentation and education for

staff who use the tool. Consistent mental capacity assessment and documentation is integral to support this work
- Ensuring that any circulatory component is always considered for lower limb pressure ulcers. This involves ensuring that staff have the necessary equipment, training and competence to assess lower limb circulation. Effective identification of a circulatory component will ensure patients receive the appropriate referrals and treatment
- Involvement of therapists for patients with complex repositioning issues. This will ensure that appropriate expertise is available to support equipment choice and its use
- Introducing a palliative care wound pathway. The team recognises that if a patient is approaching the end of their life, the planned care for a pressure ulcer should change as healing will no longer be a realistic expectation and comfort must become the focus. The aim of the pathway will be to empower the staff delivering care to make the appropriate decisions in a timely way.

Summary of PSIRF learning and improvement

PSIRF has given us the ability to prioritise where we would undertake a patient safety incident investigation (PSII) regardless of level of patient harm at the time of the incident. This has meant we can be proactive where we see issues of concern to put safety actions and recommendations in place sooner. An example of this is our maternity team where we saw a rise in moderate harm incidents in relation to post-partum haemorrhage. We are undertaking an independent investigation in conjunction with our maternity specialists to understand the learning prior to a major event happening.

As part of our preparation for our second year of PSIRF we co-produced our PSIRP with key divisional and specialist leads. Where some topics have remained on the plan, some have moved as there are now robust quality assurance mechanisms in place, for example auditing our pathways of surveillance.

Each PSII produces safety actions and safety recommendations. The actions are mitigations which need to be undertaken swiftly to prevent a similar event occurring again. Safety recommendations are improvement driven projects which can be themed together to enable us to prioritise quality improvement work. All recommendations from PSII are reviewed at the safety improvement group, a newly formed committee which will have representation from divisional and specialist leads, as well as quality and safety leads. This will allow us to plan and prioritise measurable improvement projects in response to our findings from PSII and other investigations.

We use the LifeQI platform to monitor and progress quality improvement projects and have programmes of work underway in relation to some of our key risks identified in 2021-22. Falls, pressure ulcer prevention and deteriorating patient are examples of programmes which have started in response to findings from safety investigations and are monitored through their relevant specialist committee.

We have other mechanisms for sharing learning as a result of PSIRF. We present learning from individual cases at relevant forums such as the postgraduate medical education sessions and the nursing and midwifery clinical council, as well as through divisional boards. We also share patient safety bulletins directly with ward staff. The maternity team have a publication called “Risky Business” which shares examples from practice for all maternity staff.

Currently we are exploring how we can utilise existing communication platforms we have in the Trust to share learning such as the all staff briefings, and our internal Trust publication weekly newsletter before restarting the all staff safety summit in the autumn of this year.

Quality priority 2: Development of a reporting framework for quality using the National Patient Safety strategy model of Insight : Involvement : Improvement

During 2020-21 options were co-produced with senior Trust leaders to establish a new framework for engagement and oversight for quality, safety and improvement. This was part of a planned review of the Trust’s governance committee structure. In 2021-22 a new reporting framework was introduced based on the key principles of the national patient safety strategy (issued summer 2019) and

structured around:

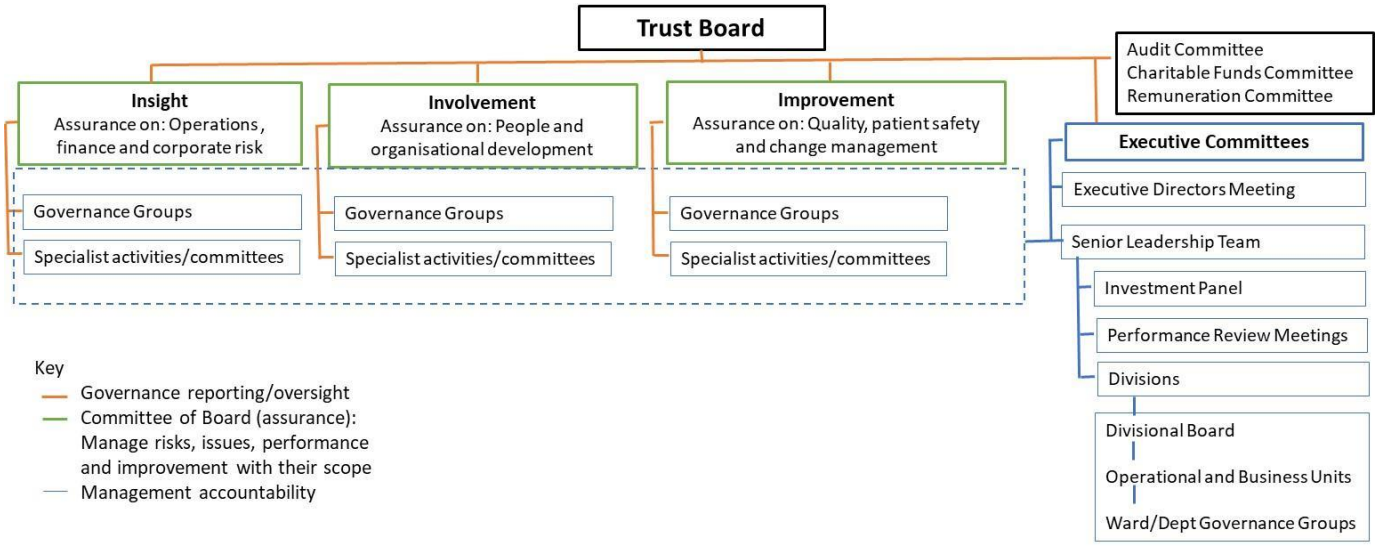
- **Insight** – improve understanding and provide assurance to the board on operational delivery, finance control and corporate risk
- **Involvement** – provide assurance to the board in relation to people and organisational development, including the Trust's strategies, plans and the management of risks, relating to staff engagement and involvement; patient engagement and involvement and system involvement and public engagement

- **Improvement** - improve understanding and provide assurance to the Board on delivery and improvements in relation to quality, patient safety and change management.

Three assurance committee of the Board were established to reflect this approach. This structure is underpinned by governance and specialist groups which provide a structured approach to the understanding, review and improvement of key areas of activity, including:

- People and culture
- Patient safety and quality
- Patient experience
- Patient access
- Clinical effectiveness
- Finance and workforce
- Corporate risk

Figure 3: WSFT board assurance structure



The Board continues to review and evaluate the working and effectiveness of the new structure, for example, changes have been made recently to provide greater focus on patient safety and quality. But during 2022 the Board, by taking confidence from the work of its assurance committees, has been able to restructure its own agenda to provide significantly greater focus on culture, engagement and strategy.

Quality priority 3: Supporting all colleagues to speak up safely as part of a culture focused on staff support, well-being and learning

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. 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.

The Board agreed the 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. The response also considered the engagement undertaken to that point, and what more needed to happen, to ensure our plans are based on the priorities for staff, governors, patients and teams and can carry the confidence of stakeholders.

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 five-year strategy:

- **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 five-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 into the new strategy
- Staff (and their wellbeing) are now an overt strategic priority, with investment in staff psychology support services and other wellbeing measures.

Further actions planned:

- Implementation of the new strategy and refreshed values
- Build alignment through divisions and teams using the new strategic ambitions and objectives to develop their own strategies and plans
- Develop a work programme to embed the values in working practices and everyday life across the Trust, and then deliver it
- The Board and the Council of Governors to consider and agree a plan for how they will role model the Trust values and how this should be evaluated as part of their development programmes.

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 he delivered 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 and which had ramifications for the culture of the organisation. This in turn has impacted on staff and teams affected during and after 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 began 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 shared with our governors
- Establish an agreed governor-director working group to facilitate their role around holding non-executive directors (NEDs) to account for the performance of the Board
- Externally-facilitated programme for the Council of Governors commissioned to ensure culture change is reflected in the wider FT accountability framework.

Further actions planned:

- Detailed programme of Board development for 2022, to include development session with review author to support broader reflection and learning and the Board's response
- Person specifications for Board recruitment to reflect lessons learned from review
- Recruitment to fill NED vacancies
- Recruitment of new substantive chief executive.

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 who raise

concerns. Critical to achieving 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 have 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 by the executive team with Dr Megan Reitz, a leadership expert, 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 Freedom to Speak Up (FTSU) Guardian function, with two clinicians undertaking this role with dedicated time
- The FTSU Guardians present to Board at its meeting in public on a quarterly basis, including challenge and feedback to the Board from the guardians
- The FTSU 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.

Further actions planned:

- Work with the National Speak Up Guardian's Office to learn from best organisational practice and explore further support
- Further expand our FTSU staff champion network, particularly focusing on underrepresented areas
- Evaluate the learning from staff champion model and promote positive examples of the difference that raising concerns can make
- Utilise the 2021 national staff survey results to provide focused support to teams where confidence in speak up processes is of most concern
- Design and deliver a development package for all leaders and managers, starting with the Board, on how to grow safe speak up cultures within teams including the skills to respond non-defensively to concerns being raised
- Consider additional ways for staff to raise concerns and issues in psychological safety.

Other quality indicators

WSFT has a comprehensive quality reporting framework that includes an array of quality indicators that are monitored and reported on a monthly basis. These include priorities identified by patients and staff, issues arising from national guidance and research, and other stakeholders such as West Suffolk CCG. Performance against agreed indicators is regularly monitored by the Board.

National targets

	2021-22 Target	2021-22 Actual	2020-21 Actual	2019-20 Actual	2018-19 Actual
C. *difficile* - Hospital onset health care associated [1]	16	37	27	25	12 (2)
18-week maximum wait from point of referral to treatment (patients on an incomplete pathway)	92%	64.6%	57.2%	81.6%	88.8%
Maximum waiting time of four hours in A&E from arrival to admission, transfer or discharge [2]	95%	-	-	-	90.7%
62-day urgent GP referral-to- treatment wait for first treatment - all cancers	85%	71.5%	75.0%	79.5%	84.6%
62-day wait for first treatment from NHS cancer screening service referral	90%	80.7%	94.2%	92.6%	92.4%
31-day wait for second or subsequent treatment - surgery	94%	100%	100%	99.6%	99.5%
31-day wait for second or subsequent treatment - anti- cancer drug treatments	98%	100%	100%	100%	99.8%
31-day diagnosis-to-treatment wait for first treatment – all cancers	96%	100%	100%	99.6%	99.8%
Two-week wait from referral to date first seen comprising all urgent referrals (cancer suspected)	93%	66.0%	71.5%	92.0%	90.7%
Two-week wait from referral to date first seen comprising all urgent referrals for symptomatic breast patients (cancer not initially suspected)	93%	35.2%	94.3%	89.2%	82.2%
Maximum six-week wait for diagnostic procedures	99%	67.1%	49.8%	93.3%	97.3%

1 Figures in brackets exclude cases that West Suffolk CCG deemed to be non-trajectory (no identified lapses in care). One case for 2018/19 is pending CCG final opinion

2 WSFT is piloting a new emergency department reporting standards and therefore has not reported performance against this standard since 2018/19.

We recognise the underperformance in a number of areas and this has been the subject of scrutiny at Board, assurance committees and governance groups.

In terms of two-week wait from referral to date first seen for symptomatic breast patients referral numbers have returned to pre-pandemic levels but show considerable variation from month to month which is difficult to plan for. In addition, during the waves of COVID-19 we have experienced staff sickness absences which have led to a reduction in capacity. A full recovery action plan is in place including the purchasing of additional equipment to increase capacity for people referred on the symptomatic breast pathway (cancer not initially suspected). Progress is monitored internally and externally.

Stroke services

Performance against the contractual stroke targets is detailed below. The focus nationally and within WSFT has been on performance against the national sentinel stroke audit programme (SSNAP). SSNAP is the national source of stroke data for the NHS and audits stroke services throughout the whole pathway of care: from admission to hospital, across the whole inpatient stay, including rehabilitation at home or in the community, and outcomes at six months after stroke.

Our stroke team has retained its top-grade A ranking for 16 quarters since April 2018. SSNAP is a major national health care quality improvement programme based in the school of life course and population sciences at King's College London. This reviews data from hospitals across the country as

part of the sentinel stroke national audit programme, assessing stroke care against 43 key indicators.

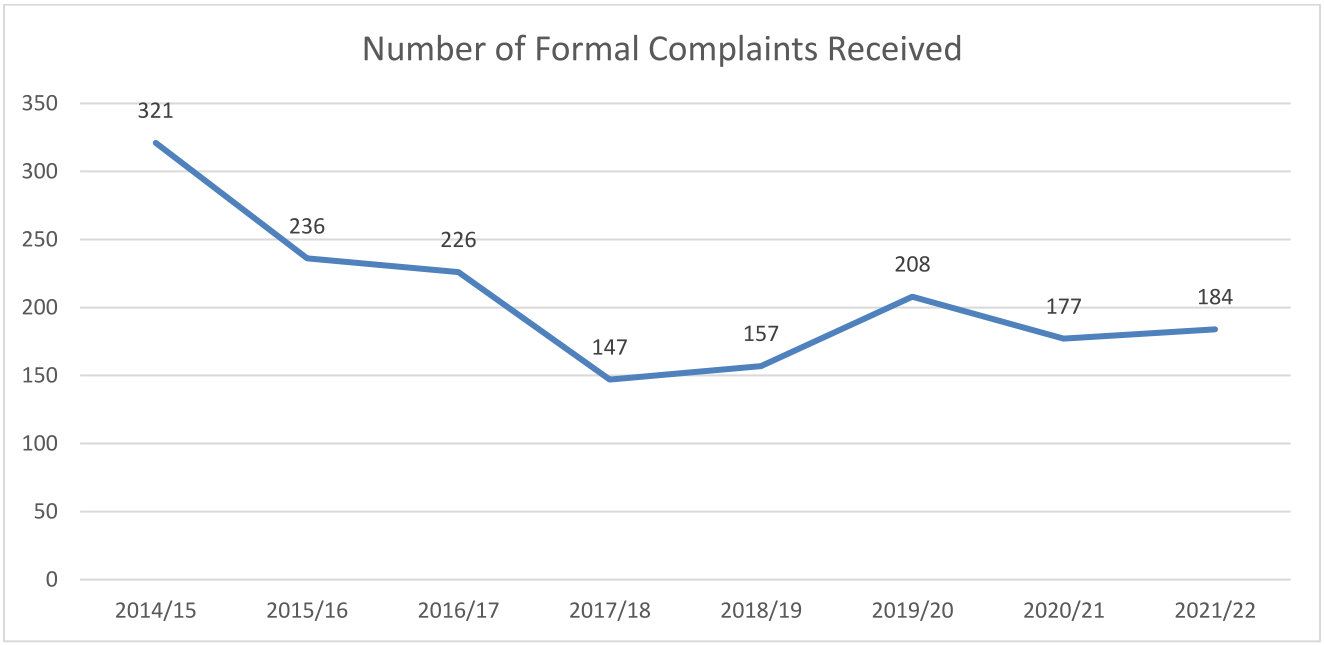
We have in place a contract to deliver an early supported discharge service (ESD) for stroke patients across Suffolk. This will provide up to six weeks of intensive stroke rehabilitation in patients' own homes following their discharge from an acute hospital, helping them to regain their mobility and independence. The service is provided by the Suffolk Alliance, which is a partnership of WSFT, East Suffolk and North Essex NHS Foundation Trust, and Suffolk County Council, and is supported by a variety of third sector partners.

Complaints management

WSFT is committed to providing an accessible, fair and effective means of communication for those persons who wish to express their concerns with regard to the care, treatment or service provided by the Trust. In responding to and reviewing complaints, WSFT adheres to the six principles for remedy as published in October 2007 by the Parliamentary and Health Service Ombudsman (PHSO).

Complaints are reviewed with service managers, associate directors, clinical directors and the senior nursing team to ensure that issues are addressed, learning takes place and trends identified. Examples of learning are detailed below. Themes and lessons learned are also reviewed within divisional board meetings and by the involvement committee.

WSFT received 184 formal complaints during 2021-22. The Board monitors complaints and learning each month as part of the quality reporting arrangements.

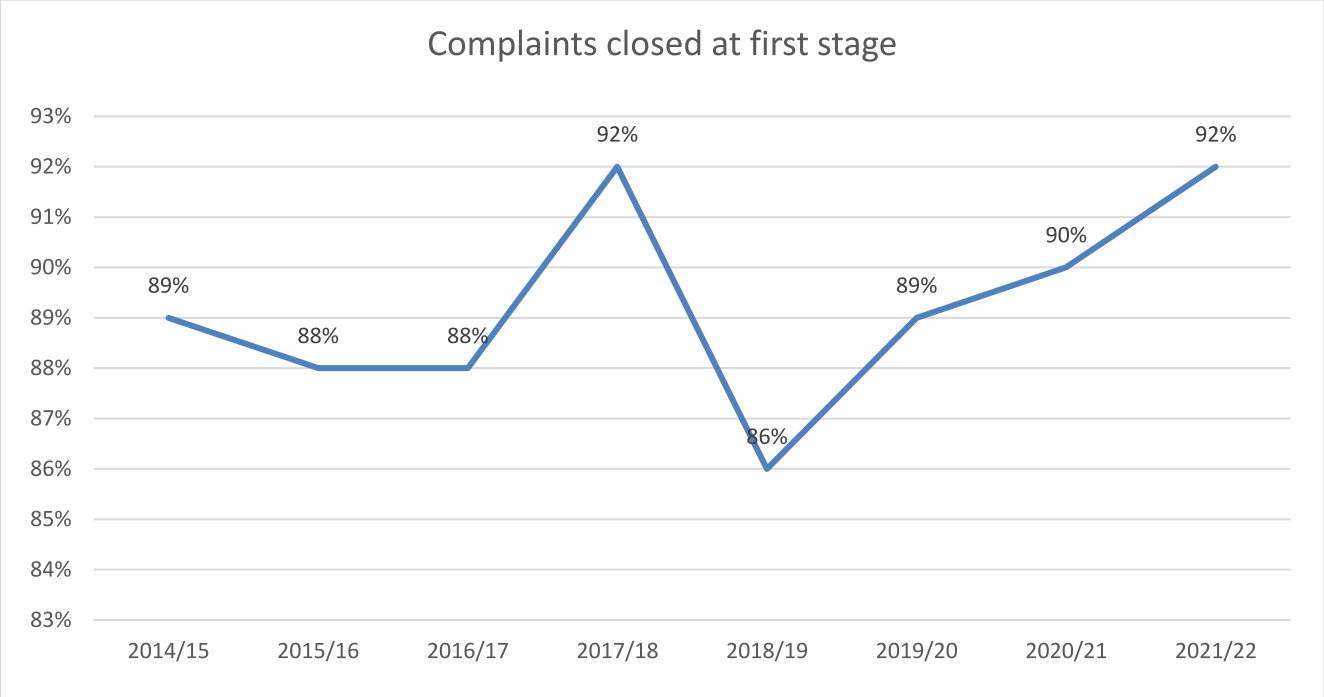


Source: Datix

As a Trust we aim to resolve complaints at the first stage, resolving a person's concerns upon receipt of their first contact. On occasions people are dissatisfied with the outcome of our investigations and request a review; at this stage we would consider this to have gone beyond the first stage.

In 2021-22 the Trust successfully resolved 169 complaints at first stage, with 15 investigations escalating to second stage throughout the year.

The increase in complaints resolved at first stage demonstrates quality investigations at local level. New complaints management processes were implemented to improve the complainants' experience with an aim to increase complainant involvement with the process to ensure complaints are resolved at the first stage.

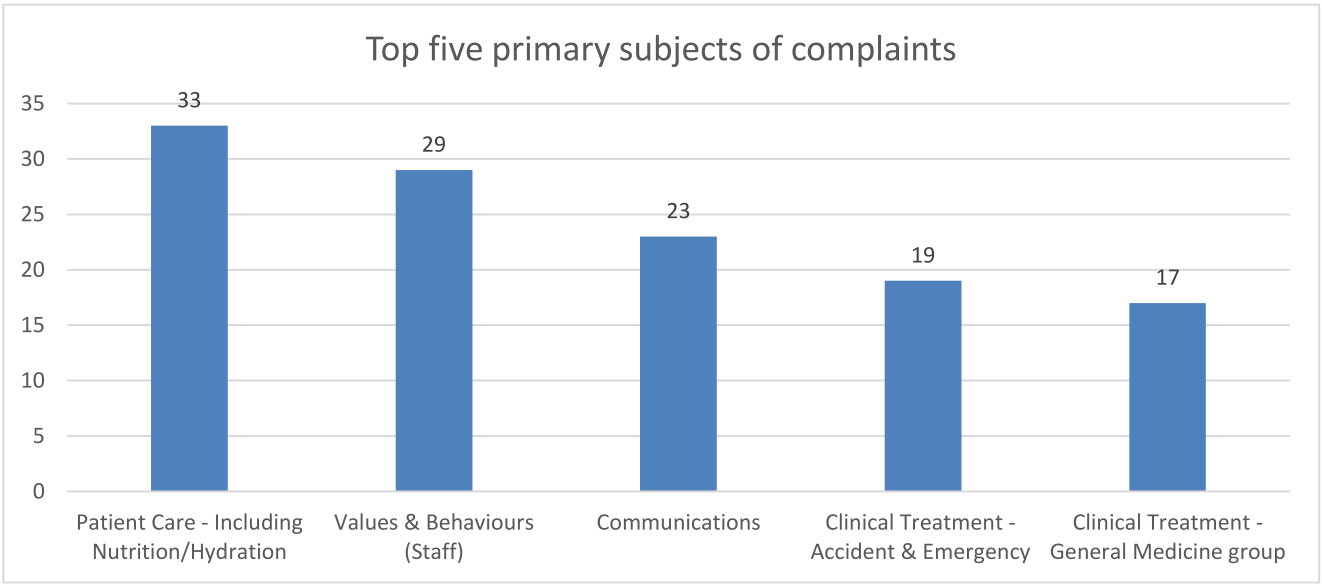


Source: Datix

Complainants who are dissatisfied with the Trust's response can refer their concerns directly to the PHSO for an independent review. During 2021-22, 1 complaint was referred to the PHSO, compared to 4 during 2021-22.

This complaint is still being investigated by the PHSO

This decrease of complaints accepted for investigation by the PHSO in 2021-22 demonstrates quality investigation processes at local level.



Source: Datix

The numbers identified in the chart above list only primary concerns; many complaints have multiple categories. Four out of five of the top categories have remained the same since the previous financial year; however, the clinical treatment for the general medicine group has replaced clinical treatment for the surgical group. This is most likely due to the reduction in elective procedures over the previous year.

Patient care is now the top category for concern increasing from 30 in 2020-21 to 33 in 2021-22. Values and behaviours of staff has increased from 19 in 2020-21 to 29 in 2021-22 showing a 52%

increase. Complaints in relation to communication have decreased from 33 in 2020-21 to 23 in 2021-22 reflecting in a 30% reduction. Communication was previously the top category for concern in 2020-21. Clinical treatment in the emergency department has decreased from 20 in 2020-21 to 19 in 2021-22.

Whilst clinical treatment within the general medicine group did not feature within the top five categories of concern for the previous financial year, it has increased from 13 in 2020-21 to 17 in 2021-22.

As well as responding to and learning from individual complaints, WSFT identifies themes and trends from local complaints and national publications such as the PHSO. Learning from complaints has supported WSFT's quality priorities and other service improvements including:

- A number of actions have been completed to improve communications between ward staff and relatives including the reintroduction of the clinical helpline and continuation of the keeping in touch service
- A learning disability liaison nurse has been appointed to ensure that referrals are handled in a timely manner and to provide support to wards
- Staff on the stroke unit will provide patients with a stroke passport as early in their admission as possible
- Training has been arranged for junior doctors rregularly during the year for mental capacity and lasting power of attorney involvement
- Ward teams have been reminded about the importance of taking patients weight on admission and recording this
- Further collaboration with the regional ambulance service and mortuary manager, ensuring that correct procedures are followed. Flow diagrams have been made available for emergency department staff
- In complex clinical circumstances, the departure summary for the GP Fwill now be written by the obstetric team
- Improvements have been made in the process for checking the drugs prior to administration as part of the spinal procedure. As well as the drug name, concentration, expiry date and the administration route will also be confirmed
- Regular junior doctor teaching sessions to be recommenced from the Trust's governance office to share learning from investigations. This will take place quarterly and will ensure all junior doctors in training are included
- Ward team are reviewing options to purchase a fridge for the ward to store expressed colostrum
- Additional ward clerks have been recruited to assist with answering ward phones
- The surgical consent process is being reviewed and a checklist has been implemented to ensure patients agree to treatment.

There were some complaints that were also investigated simultaneously with serious incident investigations and the actions identified through these investigations are being progressed and reported via this route.

Managing compliments

A total of 409 compliments have been formally received by WSFT. This figure only includes thank you correspondence shared with or sent directly to the patient experience team.

National CQC patient surveys

The CQC carries out a variety of patient surveys, the most frequent of which occurs annually. Feedback from national as well as local surveys is used to monitor service performance and focus on quality improvement. WSFT was involved in the following CQC surveys which have been reported on during 2021-22:

- 2020 Urgent and Emergency Care Survey (September 2021)
- 2020 Adult Inpatient Survey (October 2021)
- 2020 Children and Young People's Patient Experience Survey (December 2021)
- 2021 Maternity Survey (February 2022)

Interpreting our data

The 'better' and 'worse' categories are based on a statistic called the 'expected range', which determines the range within which a trust's score could fall without differing significantly from the average. If a trust's performance is outside of this range, its performance is significantly above or below what would be expected. If it is within this range, we say that its performance is 'about the same'. This means that where a trust's survey results have been identified as 'better' or 'worse' than the majority of trusts it is very unlikely that these results have occurred by chance.

Analysis

The 2021 Maternity Survey features a more in-depth analysis of results than we have seen in previous surveys. Going forward we can expect a similar presentation of results across all our surveys.

2020 Urgent and Emergency Care Survey (September 2021)

Respondents and response rate

- 447 West Suffolk NHS Foundation Trust patients responded to the survey
- The response rate for West Suffolk NHS Foundation Trust was 36.61%

Banding

Better

WSFT results were **better** than most trusts for three questions:

- Q5. Once you arrived at A&E, how long did you wait with the ambulance crew before your care was handed over to the A&E staff?
- Q12. Were you informed how long you would have to wait to be examined?
- Q32. In your opinion, how clean was the A&E department?

Worse

- WSFT results were **worse** than most trusts for 0 questions.

Same

- WSFT results were **about the same** as other trusts for 35 questions.

2020 Adult Inpatient Survey (October 2021)

Respondents and response rate

- 574 West Suffolk NHS Foundation Trust patients responded to the survey
- The response rate for West Suffolk NHS Foundation Trust was 49.1%

Scoring

For each question in the survey that can be scored, individual responses are converted into scores on a scale of 0 to 10. For each question, a score of 10 is assigned to the most positive response and a score of 0 to the least positive. The higher the score, the better the trust's results.

Banding

Better

WSFT results were **much better** than most trusts for 0 questions.
WSFT results were **better** than most trusts for four questions:

- Q4A. There were restrictions on visitors in hospital during the coronavirus pandemic. Were you able to keep in touch with your family and friends during your stay?
- Q5.4. Were you ever prevented from sleeping at night by hospital lighting?
- Q12. How would you rate the hospital food?
- Q13. Did you get enough help from staff to eat your meals?

WSFT results were **somewhat better** than most trusts for three questions:

- Q5.2. Were you ever prevented from sleeping at night by noise from staff?
- Q11. Were you offered food that met any dietary requirements you had?
- Q19. Did you have confidence and trust in the nurses treating you?

Worse

- WSFT results were **much worse** than most trusts for 0 questions.
- WSFT results were **worse** than most trusts for 0 questions.
- WSFT results were **somewhat worse** than most trusts for 0 questions.

Same

- WSFT results were **about the same** as other trusts for 38 questions.

2020 Children and Young People's Patient Experience Survey (December 2021)

Respondents and response rate

- 130 West Suffolk NHS Foundation Trust patients responded to the survey
- The response rate for West Suffolk NHS Foundation Trust was 25.69%

To note

The Trust overall has scored 'worse than expected' for the experiences of children and young people aged 8-15. This is based on variation of results at Trust level.

Banding

Better

WSFT results were **much better** than most trusts for 1 question:

- **Parents/carers of 0 to 15-year olds were asked:** Q5. For most of their stay in hospital what type of ward did your child stay on?

WSFT results were **better** than most trusts for 0 questions.
WSFT results were **somewhat better** than most trusts for 0 questions.

Worse

WSFT results were **much worse** than most trusts for 0 questions.
WSFT results were **worse** than most trusts for 2 questions:

- **Children/young aged 8 to 15 were asked:** Q59. Were you involved in decisions about your care and treatment?
- **Parents/carers of 0 to 15-year olds were asked:** Q20. Did hospital staff keep you informed about what was happening whilst your child was in hospital?

WSFT results were **somewhat worse** than most trusts for 2 questions:

- **Parents/carers of 0 to 15-year olds were asked:** Q17. Did you have confidence and trust in the members of staff treating your child?
- **Children/young people aged 8 to 15 were asked:** Q68. Did a member of staff tell you who to talk to if you were worried about anything when you got home?

Same

- WSFT results were **about the same** as other trusts for 55 questions.

Questions where our score has decreased significantly from 2018

Some of the CQC surveys allow for comparison against the Trust's results from the previous year, which is possible when the questions have remained the same.

The WSFT's score decreased significantly from 2018 in the following two questions:

- **Parents/carers of 0 to 7-year olds were asked:** Q9. Were there enough things for your child to do in the hospital?
- **Parents/carers of 0 to 15-year olds were asked:** Q30. Were you able to prepare food in the hospital if you wanted to?

2021 Maternity Survey (February 2022)

Respondents and response rate

- 188 West Suffolk NHS Foundation Trust patients responded to the survey
- The response rate for West Suffolk NHS Foundation Trust was 64%

Banding

Better

WSFT results were **much better** than expected on 0 questions
WSFT results were **better** than expected on 1 question:

- F2. When you were at home after the birth of your baby, did you have a phone number for a midwifery or health visiting team that you could contact?

WSFT results were **somewhat better** than expected on 1 question:

- B4. At the start of your care in pregnancy, did you feel that you were given enough information about coronavirus restrictions and any implications for your maternity care?

Worse

WSFT results were somewhat worse than expected on 0 questions.
WSFT results were worse than expected on 0 questions.
WSFT results were much worse than expected on 0 questions.

Same

- WSFT results were **about the same** as other trusts for 48 questions

Analysis

Where mothers' experience is best

✓ During antenatal check-ups, mothers being asked about their mental health by midwives
✓ At the start of their pregnancy, mothers being given enough information about coronavirus restrictions and any implications for their maternity care
✓ Mothers being able to see or speak to a midwife as much as they wanted to during their care after birth
✓ Mothers discharge from hospital being delayed on the day they leave hospital
✓ Mothers receiving help and advice from health professionals about their baby's health and progress in the six weeks after the birth.

Where mothers' experience could improve

- Partners or someone else involved in the mother's care being able to stay with them as much as the mother wanted during their stay in the hospital
- Mothers receiving help and advice from a midwife or health visitor about feeding their baby in the six weeks after giving birth
- Mothers being given a choice about where their postnatal care would take place
- Mothers feeling that the midwife or midwifery team always listened to them during care after birth
- Mothers feeling that midwives and other health professionals gave them active support and encouragement about feeding their baby.

Action plans

Results are reviewed within relevant groups and action plans established with the support of the patient engagement team alongside any existing work within the workstreams.

Actions from the CQC survey results include:

- The creation of focus groups in particular areas
- Local surveys to determine whether situations have improved
- A review of patient information leaflets given out at discharge
- Collation of feedback following the creation of a new post within the department.

Further details regarding quality and operational performance and risks are provided in the annual governance statement (section 2.6).

1.2.4 Principal risks and uncertainties

The Trust is able to demonstrate compliance with the corporate governance principle that the Board of directors maintains a sound system of internal control to safeguard public and private investment, WSFT's assets, patient safety and service quality through its board assurance framework (BAF).

Board assurance framework (BAF)

The BAF was regularly reviewed during 2021-22 to ensure that it provided an adequate evidence base to support the effective and focused management of the principal risks to meeting strategic objectives. The BAF illustrates the escalation processes to the Board and its sub-committees when risk, financial and performance issues arise which require corrective action.

The executive director with delegated responsibility for managing and monitoring each risk is clearly identified in the BAF. The BAF identifies the key controls in place to manage each of the principal risks and explains how the Board of directors is assured that those controls are in place and operating effectively.

The principal risks identified in the BAF are reviewed by the Board of directors. The Board reviews the potential impacts of these risks and considers the robustness of the existing controls and future plans to mitigate these. Assurance of the effectiveness of these controls and plans is also reviewed. A summary of the BAF is provided in the annual governance statement (section 2.6).

Incident reporting

The Trust's web-based electronic incident reporting system (Datix) supports multidisciplinary incident reporting which includes a high level of reporting near misses, no harm and minor harm incidents. Reporting of these 'near-miss' incidents is seen as a key driver for identification and management of risks to prevent more serious harm incidents. By reviewing investigations and thematic learning, key learning can be identified and actions put into place to prevent recurrence. The organisation reviews this data each month within the IQPR and recognises a high reporting rate as a positive reflection of

an open culture within the organisation which supports learning from incidents.

During 2021-22, a total of 9,990 patient safety incidents were reported (compared with 7,377 in 2019/20). In 2021-22 WSFT was an early adopter of the new national patient safety incident response framework (PSIRF) alongside other local trusts in the ICS. This is a national initiative designed to further improve safety through learning from patient safety incidents and forms part of the wider national patient safety strategy. The Trust completed its first year of the new process in March 2022 and worked with stakeholders to develop the plan for 2022/23 which received board sign-off in March.

Effective risk and performance management

The Trust has a robust risk management strategy which ensures effective clinical governance and monitoring of compliance with best practice. The Board maintains a framework which ensures timely escalation of risk to the Board by committees and specialist groups.

Performance and quality improvement are connected from 'board to ward'. This is achieved through two-way communication between the Board and operational areas, for example wards, across WSFT. The monthly quality and performance report to the Board provides an organisational and ward-level dashboard. This information is underpinned and informed by reviews from divisions and wards, with action-planning at these levels.

Delivery of improvement at an operational level is managed through directorate executive quality and performance meetings, and is also tested through observational visits by Board members and governors as part of weekly quality walkabouts. A programme of presentations and patient stories relating to the quality priorities and strategic/service developments is also delivered to the Board and its subcommittees.

The Trust actively engages with its Foundation Trust membership and the public through regular talks, events and communications but these have been limited during the year due to COVID-19 restrictions.

The Trust is a member of the NHS Resolution's Clinical Negligence Scheme for Trusts (NHSR CNST). Additional commercial insurance is in place to mitigate the risk for assets and services.

Mandatory service risk

The Trust's Board of directors was satisfied that:

- All assets needed for the provision of mandatory goods and services were protected from disposal
- Plans were in place to maintain and improve existing performance
- WSFT had adopted organisational objectives and managed and measured performance in line with these objectives
- WSFT was investing in change and capital estate programmes that would improve clinical processes, efficiency and, where required, release additional capacity to ensure the needs of patients could be met.

A review of the risks associated with mandatory service provision was undertaken and no significant risks were identified.

Risk of any other non-compliance with licence

The Board of directors ensured that WSFT remained compliant with relevant legislation. Executive directors assessed the risk against each of the conditions in the licence. No significant risks were identified.

Contractors and suppliers

The Trust is committed to sourcing, ordering and delivering a complete range of healthcare products, services and infrastructure, whilst maintaining value for money, and is a committed member of the East of England NHS Collaborative Procurement Hub. This network, together with our local team, allows us to keep up with developing markets, benchmark products and services, and build close relationships with suppliers. We own one quarter of Collaborative Procurement Partnership LLP which, following a successful bidding process in 2018/19, is working with three procurement partners to deliver three of the Department of Health's eleven procurement towers.

All purchasing falls in line with the European directive for procurement in addition to our standing financial instructions and standing orders.

We have assessed the risk of supplier failure. Where risks have been assessed as high due to credit risks or inability to find an alternative quickly, additional controls have been put in place.

Additional disclosures required by the financial reporting manual (FReM)

The accounts have been prepared under direction issued by NHS Improvement (NHSI) under the National Health Service Act 2006:

- Chief executive's responsibilities statement (section 2.5)
- Accounting policy note 1 (part of accounts).

The accounting policies for pensions and other retirement benefits are set out in note 9 to the accounts, and details of senior employees' remuneration can be found in section 2.7 (remuneration report).

Audit committee's review of the annual report and accounts

The audit committee did not identify or raise any significant issues when reviewing the annual report and accounts in relation to the financial statements.

Social, community, anti-bribery and human rights issues

The West Suffolk NHS Foundation Trust, as an NHS provider and employer, operates within the requirements of UK and European law, including its responsibilities for equity of access to services, employment and opportunities. The Trust operates within the NHS Constitution and has employment and service policies that address equality and human rights issues.

The Trust has applied policies during the financial year for:

- Giving full and fair consideration to applications for employment made by disabled persons, having regard to their particular aptitudes and abilities
- Continuing the employment of, and arranging appropriate training for, employees who have become disabled persons during the period
- The training, career development and promotion of disabled employees.

The Trust is committed to the effective implementation of policies and procedures in respect of fraud and corruption as well as the Bribery Act. It also has a nominated local counter fraud specialist (LCFS) whose role is to provide support and advice on all matters relating to fraud and to be a point of contact for fraud reporting. The LCFS reports to the audit committee.

Our modern slavery statement is published on our website and outlines the approach we have taken, and continue to take, to make sure that modern slavery or human trafficking is not taking place within our business or supply chain.

Emergency preparation, resilience and response (EPRR) core standards annual assurance report

In September 2021, the chief operating officer, as accountable emergency officer, reported that the Trust had substantial compliance with EPRR core standards. This is the means by which NHS England obtains assurance that NHS funded organisations are sufficiently able to respond to emergencies. This report stated that only the lack of full compliance with business continuity plans and staff created risk.

The substantial compliance level indicated that the Trust had a small number of core standards requiring improvement work in updating business continuity plans, and in fully training staff to deliver high-level decontamination of contaminated emergency department patients. The Trust has fully developed plans and programmes to rectify these small deficiencies.

1.2.5 Future business plans

1.2.5.1 Integrated care system (ICS)

West Suffolk Alliance is one of three place-based alliances that make up the Suffolk and North East Essex integrated Care System (ICS). The Alliance published its strategy in 2018 – All About People and Places - which established a shared set of ambitions which all alliance partners signed up to:

- strengthening the **support for children and adults** to stay well and manage their mental and physical health and wellbeing within their communities
- **focusing on individuals** and their needs and goals
- changing both the way we **work together** and how services are configured
- making effective **use of resources**.

Since the inception of the West Suffolk Alliance:

- membership has grown and now encompasses partners from the NHS, local government, the voluntary, community and social enterprise sectors and others, to form a broad collaboration of organisations signed up to work together to deliver our strategy
- the Alliance has shown throughout the pandemic that the relationships between partners allow for rapid implementation of changes to services, the ability to develop a joint approach to problems and issues, and that partners are willing to innovate and use their resources flexibly to meet need
- learning from the pandemic is being used to inform our future direction, priorities and opportunities
- the NHS White Paper - Integrating Care - has reinforced the importance of ‘place’ as a building block for alliance working within a wider integrated care system footprint.

Our alliance delivery plan for 2021-22 has been developed with these points in mind. We have agreed that we want to have a plan that:

- demonstrates that we are working differently - as partners rather than as individual organisations - showing the added value of the Alliance
- highlights where we are delivering our alliance ambitions
- gives visibility to the range of transformation programmes going on within the West Suffolk Alliance area
- allows us to prioritise investment (financial and other resources)
- helps us develop as an alliance to meet future opportunities and challenges
- champions innovation
- shows how organisational priorities can be delivered through alliance working.

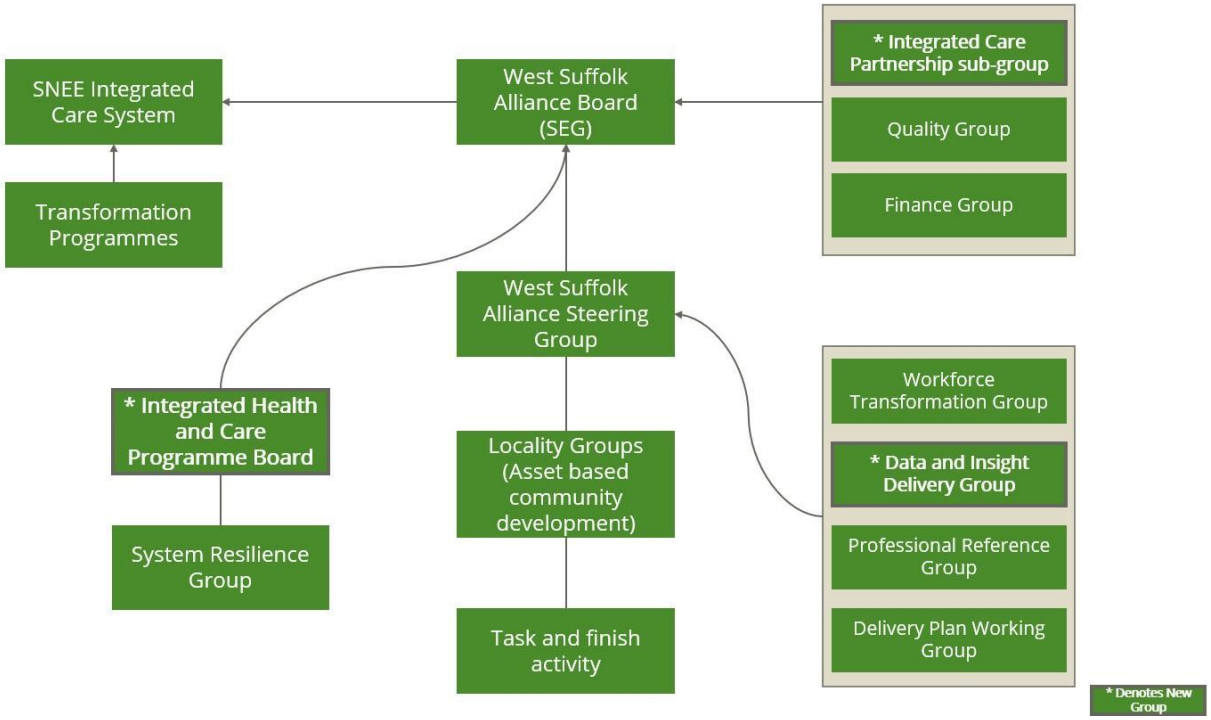
Actions include:

- building on our strategy to create a compelling mission and vision statement. The aim of this is to let people know what the Alliance is all about in a simple and straightforward way

- redesigning our governance to create a framework for action. This will mean a better understanding of where decisions are made and who holds accountability. Two new groups have been set up as part of the redesign to support health and care integration:
    - Integrate Care Partnership Sub-group – a smaller group of public service leaders responsible for shaping plans to formalise integration across health and local authorities, and consider how this could shape future integrated care partnerships in each alliance
    - Integrated Health and Care Programme Board – supporting the change programme that will deliver integrated care, allowing cross-divisional sharing of solutions and learning. The board will oversee the west implementation of the wider ICS transformation programmes, translating NHS priorities into place-based delivery
- creating a west Suffolk data and insight approach to better understand the complex challenges facing people in west Suffolk and identify the emerging trends to inform strategic and operational decision making
- developing a systems communications function that focuses on joint work, celebrating success and ensuring that our teams feel the benefits of alliance working
- taking a system approach to inequalities, starting with the COVID-19 vaccination programme, and working to make sure that people most at risk, and from disadvantaged communities, get targeted support.

Alongside these actions there are many projects and initiatives across the partnership where alliance working is in action.

West Suffolk Alliance governance



Alliance partners

- Abbeycroft Leisure
- Allied Health Professionals Suffolk
- Babergh and Mid Suffolk District Councils
- Care UK
- Citizens Advice West Suffolk
- Community Action Suffolk
- Healthwatch
- Home-Start
- Local Pharmaceutical Committee
- Norfolk and Suffolk NHS Foundation Trust

- Primary care (24 GP surgeries)
- St. Nicholas Hospice
- Suffolk Constabulary
- Suffolk County Council
- Suffolk GP Federation
- Suffolk MIND
- West Suffolk Clinical Commissioning Group
- West Suffolk College
- West Suffolk District Council
- West Suffolk Foundation NHS Trust

1.2.5.2 Performance improvements and efficiency savings

The COVID-19 pandemic has significantly impacted upon the operational performance and efficiency of WSFT.

We have continued to operate our joint transformation team with West Suffolk CCG. However, members of the team were redeployed from planned programmes of work to address the challenges we faced in responding to the pandemic and implementing new ways of working to ensure that we could continue to treat patients safely.

Whilst it is true that many of the planned transformation programmes were put on hold, the pandemic also created opportunities for us to take forward a number of schemes at pace, which have been part of our longer-term ambitions for some time, such as increased use of digital platforms to support remote working and virtual consultations.

The West Suffolk Alliance partners came together to strengthen pre-existing relationships and enhance the offer to our communities through the integrated neighbourhood teams, and through working with the voluntary sector and organisations such as Abbeycroft Leisure.

As we look forward to the next year we are committed to embedding learning from the experience of working through the pandemic to enhance services for the future.

Elective accelerator programme

As part of the Suffolk and North East Essex (SNEE) Integrated Care System (ICS), WSFT has been successful in bidding to become an elective accelerator site. Acceptance onto the programme provides £10m of additional system funding, over and above the elective recovery fund (ERF), of which £1.6m has been allocated to WSFT. The system is required to deliver additional activity above the levels set out in the annual planning guidance, along with an enhanced programme of transformation. For the SNEE system these targets are set at 100% of the 2019/20 baseline activity by July and 120% by September 2022. This recognises the challenges which will be faced by WSFT over the coming year in relation to the significant estates work programme.

There are three broad elements to the plan – capacity, transformation and sustainability. Each of the underpinning elements is in line with the expectations of the annual planning guidance.

Accelerator sites are expected to deliver above baseline planning guidance requirements and share learning with other trusts. The programme offers an opportunity to develop a rapid increase in elective capacity, and thus reduce the longest elective care waits, and to address long-standing access barriers, such as transformation of the outpatient service model.

The programme will be led jointly by the CCG, WSFT and East Suffolk and North Essex NHS Foundation Trust (ESNEFT) with named senior responsible officers (SROs) for each workstream.

Capacity

Priority one focuses on critical capacity increase and productivity initiatives to deliver additional activity and support a reduction in waiting times for elective patients.

The delivery model has been built via a combination of standalone service initiatives and specific capacity increases and critically focuses on joint working across all three trusts in the SNEE ICS to reduce inequities in waiting times. These can be summarised as follows:

- An increase in theatre capacity via the procurement of a vanguard theatre (located at Ipswich Hospital) but to be used to deliver WSFT activity in the initial phase
- Maximising independent sector capacity across the region
- Recommissioning of a mothballed theatre at WSFT
- Additional computed tomography (CT), magnetic resonance imaging (MRI) and endoscopy capacity to improve diagnostic waiting times
- Day case and theatre reprofiling – this includes productivity initiatives and rescheduling main theatre activity in the day surgery unit
- Increased weekend working in both main theatres and day surgery
- Review of infection prevention and control guidance to facilitate increased throughput
- High throughput focused activity in specific services such as super surge weekends.

Sustainability

Priority three is sustainability and the creation of a framework in which success is achieved and informs future service configuration. This includes formalised success metrics, reporting, benchmarking and performance management. There are clear synergies between the elective accelerator programme and the future system work and both teams are keen to take a joined up and collaborative approach. It is important that we avoid duplication and engage our clinical teams once collectively, rather than separately or in an uncoordinated way.

Primary care and community health

WSFT is a provider of both acute and community services. As a core member of the West Suffolk Alliance we play a key role in the delivery of the integrated care system (ICS) plan through the six localities of Sudbury, Bury Town, Bury Rural, Newmarket, Haverhill, and Brandon and Mildenhall. The localities are broadly aligned with the local primary care networks (PCNs) and working together to deliver local and system priorities.

As we emerged from the first wave of COVID-19 we commissioned a piece of work from ReThink partners to engage with our community teams about their experiences of being part of WSFT. This work has resulted in a major organisational restructure within community heath and social care to better enable the vision of integrated working. A new joint director post between adult health and social care has been created with the aim of strengthening joint working and reducing duplication and inefficiencies. This post will be supported by alliance delivery managers for health, social care, primary care and mental health and service transformation.

There has been successful transition of our community teams onto the West Suffolk IT infrastructure. This long-awaited move provided the platform for greater digital opportunities for the community teams as we work to develop parity with acute colleagues. Whilst there is still more to do, community teams are already seeing and feeling the benefits of this investment in new kit and infrastructure. We have implemented electronic staff rostering alongside a capacity and demand tool to enable us to plan our resources better to meet the needs of our communities. We are now working to deploy an electronic appointment/visit scheduling system to release clinical time to deliver patient care.

There has been significant focus on the development of pathway one discharges to support more people to continue to live in their own homes. This, along with the implementation of seven-day reactive services across the community, has enhanced the support available to patients to support admission avoidance and early discharge from hospital.

Urgent and emergency care

WSFT is one of 14 pilot sites undertaking field testing for new emergency care standards. Due to the impact of COVID-19, plans to roll out the pilot nationally were put on hold. However, it is anticipated that the national implementation will begin in a phased way later this year.

Our key area of work to support flow through the emergency department (ED) and the hospital is a length of stay programme supported by Emergency Care Improvement Support Team (ECIST).

The programme has four workstreams all aimed at reducing length of stay and improving discharge processes across the Trust:

- Frailty, including the creation of a new frailty unit at the front of the hospital
- Discharge to assess, maximising the full potential of this service
- Embracing risk, focused on implementation of right to reside guidance
- Length of stay overall, focused on benchmarking and data analysis to identify opportunities.

Transformation

The priority for transformation is to support the implementation of the NHSE/I priorities and operational planning guidance for 2022/23, increasing our capacity and resilience to deliver safe, high-quality services that meet the full range of people's health and care needs. This includes rising to the challenges of restoring services, meeting the new care demands and reducing backlogs that are a direct consequence of the pandemic.

We have set up an urgent and emergency programme board which will oversee the workstreams and report to the wider alliance and SNEE on progress.

Workstreams:

- Same day emergency care (SDEC) Medicine and SDEC surgery - provides same day care for people who would otherwise be admitted to hospital
- Criteria to Admit - a tool designed to support decision making endorsed by the clinical director for urgent and emergency care
- Virtual Wards - allow people to get the care they need at home safely and conveniently rather than being in hospital
- Hot clinic slots - aims to reduce the number of people who can wait safely at home for specialist advice in a clinic at a later date
- Frailty Clinic - allows people living with frailty to have a comprehensive geriatric assessment
- Emergency Department flow and streaming - aim to reduce overcrowding ensuring people get to the right place for their needs
- GP Streaming - a primary care service located in ED enables people with a minor illness to see a primary care clinician
- Ambulance referrals - to give the ambulance service the ability to seek advice prior with the aim of preventing conveyance where safe to do so
- Operational standards - standards to which the emergency department and staff reviewing patients work in order to prevent the ED becoming blocked with people waiting a specialist review
- Community services reduction in waiting lists - to ensure people in the community are not waiting to long for therapy support
- Transfer of care hub - leads on the discharge of patients on pathways 1, 2 and 3
- Community two-hour response - aims to meet people urgent care needs at home
- Digitalisation - digital support to enable people to be cared for outside of the acute environment

RAAC at West Suffolk NHS Foundation Trust

In 2019 a safety alert was issued about a product called reinforced autoclaved aerated concrete (RAAC) planks, which were used in the original build of the West Suffolk Hospital and the front residences in the 1970s. The alert detailed a reported failure of a single roof plank, in a non-NHS site. Since this alert, our estates development team have been proactive in mitigating this issue and in April 2021 a core resilience team (CRT) was formally developed to lead the oversight of the programme of works alongside operational demands.

During 2021-22 a significant amount of work has been completed with supports now in place to 66% of the roof (an increase from 20% the previous year). With a number of complex areas in the forthcoming plan which will take more time to complete, progress is expected to slow in 2022/23. The programme is expected to complete during 2024.

It was discovered in 2021 that a building which we leased in Haverhill had RAAC planks and this presented an unprecedented situation of managing two properties with RAAC issues. To ensure services were able to continue to be delivered safely, the services which operated from that property were temporarily moved to alternative buildings in the town whilst a long-term solution is sought.

Community paediatrics

WSFT is the provider of the Integrated Community Paediatric Services (ICPS) across the West Alliance and East Suffolk Alliance geography. Some of these services are also provided to Thetford children. The ICPS teams consist of the eight core services which include medical, therapy, nursing, audiology and clinical psychology teams supporting children in the community.

ICPS was involved with an independent review by ReThink, commissioned by both alliances, which had the remit of strengthening integration across paediatric services. The review highlighted that *"staff working in ICPS are committed, skilled and purposeful clinicians and professionals whose focus on children, young people and families shone through".* In addition to acknowledging strong areas of practice and collaborative working, there were also opportunities to improve integrated working and collaboration further. The associate director for ICPS is now a core member of the Suffolk children and young people leadership team alongside local authority and mental health system leads.

Throughout the year, ICPS has continued to respond flexibly to changing demands as a result of COVID-19 restrictions. Teams have embraced new technology and been instrumental in the Trusts development of IT platforms to deliver virtual workshops to parents to support their children's needs.

Priorities for the coming year for ICPS are to:

- Review and consider the amendment of divisional governance structure to better consider the requirements for children's services and priorities
- Develop workforce plan
- Undertake service recovery/review as a result of pandemic
- Continue to support the implementation of the Suffolk SEND Strategy, with particular focus on increasing capacity to meet growing need
- Improve access to community estates
- Implement the revised neurodevelopment pathway in Suffolk, alongside system partners.

Efficiency savings and sustainability

The programme management office (PMO) has worked flexibly to support key strategic projects through the pandemic, including the Improvement Programme Board (IPB), the vaccination and RAAC programmes, whilst continuing to facilitate the Trust's cost improvement programme. The Trust has achieved break even in 2021-22.

The PMO is currently working through a cultural transition to align ways of working with the

sustainability agenda and the NHS Green Plan with the introduction of the sustainability group, bringing together improvement leads from across the organisation and the system in to a shared learning improvement forum around an integrated sustainability plan. This evolution marks a significant cultural shift from a PMO which had historically been dedicated to the cost improvement programme with the development of an inclusive model that the majority of people can support in the context of pandemic recovery and shared concern for the environment.

West Suffolk Community and Integrated Services

The last year has continued to see unprecedented demand and pressure on community teams, exacerbated by the impacts of COVID-19 on staffing and operating procedures. Despite these challenges, our community teams have continued to provide a good level of service to our population.

In addition, we have implemented a number of improvements in the way we deliver our services which include:

- Using the care management system (CM2000), we have been able to improve our allocation processes to increase our capacity to support people effectively and quickly when they leave hospital
- Our Early Supported Discharge service has combined our therapy, rehabilitation and reablement resources with Suffolk County Council's Home First service to maximise support for people who have suffered strokes, enabling them to make the best recovery they can at home
- We have developed our physiotherapy services by working with in partnership with Allied Health Professionals Suffolk and Abbeycroft Leisure to help people recover from elective surgery
- We have been piloting new ways of undertaking mental health reviews in our primary care services to improve timeliness of interventions and reduce GP case loads
- We have been utilising funding available to increase and strengthen our workforce by introducing more physiotherapists, assistant practitioners, community matrons, independence and wellbeing practitioners, social workers and nurses amongst others.

In addition to the improvements we are making to the way we deliver our services, we have been making organisational changes to strengthen the integration between social care and health teams to create a more robust and resilient infrastructure for the future. We have:

- Improved relationships and practices with our system wide partners developing a stronger multi-disciplinary team approach to support patients
- Introduced Integrated Neighbourhood team co-ordinators who play a key role in co-ordinating care for patients with complex needs
- Restructured our social care and community health management to introduce integrated management roles and practices which will put us in a better position to support the development of our Integrated Care System
- We have re-aligned the operational boundaries in which our teams work to enable more effective and efficient integrated health and social care service delivery.

These changes will create a good platform for us to move forward with responding to the future demands on our services. With increasing focus on prevention and wellbeing, we are now embarking on an ambitious transformation programme that will see us focusing on building on our multi-disciplinary team approach with our alliance partners in all our localities to improve and increase service delivered in the community. Our priorities include:

- Working across the system to support recovery from Covid, including reducing waiting lists and supporting people's recovery from elective surgery
- Improving our urgent community response services
- Improving the provision of enhanced health care in care homes
- Using public health data at a local level to provide targeted preventative intervention and anticipate areas of care need

- Introducing virtual wards as a way of enabling early discharge from hospital with a network of care enabled by technology
- Refining how we work with system partners to improve our discharge from hospital processes
- Continuing to work with our home care providers to improve capacity and services that will support people in their own homes, including those with increasingly complex needs.

In undertaking the development of our services, we will be continuing our commitment to the personalisation agenda for our patients, ensuring they have control and influence of the care and support they receive, which will include safeguarding and advocacy support where needed. We will be continuing to improve the resilience of our workforce and exploring ways to manage demand effectively through using digital technology and investing in the wellbeing and development of our workforce.

New healthcare facility (Future System programme)

In September 2019, the Government announced its Health Infrastructure Plan, which aims to deliver a long-term programme of investment in health infrastructure, including the New Hospital Programme which is providing funding for 48 hospitals. The West Suffolk NHS Foundation Trust was named as one of the 48 hospitals and has embarked on a journey to bring a new hospital, replacing the existing West Suffolk Hospital, to fruition.

This is an exciting opportunity to transform the way that healthcare is currently delivered in west Suffolk. The aspiration is to create a state-of-the-art healthcare facility that provides a 21st century model of care; maximises use of digital technology for both clinical service delivery and building management. The aim is also that all new buildings will meet the net zero carbon standard. In essence, we want to provide the highest quality services in a new and improved setting, that are joined up appropriately with our local partners and most suited to the needs of our patients and community, in the greenest and most digitally advanced way possible. Better for our patients, community, staff and partners.

The Trust, its partners within the local integrated care system (ICS) and members of the central new hospitals programme (NHP) team and West Suffolk Alliance, are at the beginning of a comprehensive and inclusive programme of work that will encourage input from a broad set of stakeholders.

During 2021, we undertook an extensive engagement programme with our local community regarding the chosen preferred site and sharing designs about what may be possible on Hardwick Manor. This culminated in the Trust submitting an application for outline planning permission to the local planning authority at the end of March 2022. It is the result of, and represents many hours of, co-production, engagement and technical analysis.

The current clinical services model which has been developed for our outline planning application has been underpinned by findings from a number of workshops held both face-to-face and online, with members of the public and staff.

Next steps

Workshops will continue to inform our evolving schedule of accommodation (i.e. how many rooms are required, what they are and their size) and in particular will look at:

- Key room relationships
- The way patients, staff and facilities navigate and move around the hospital.

Although our outline planning application has been submitted, further extensive work into the ecology, flora, fauna and traffic as well as other areas will continue. We expect feedback on our outline planning application later in the year.

The team managing this project are progressing the outline business case and expect to submit this

in 2023.

The programme is governed by a board that has drawn its membership from across the Suffolk and North East Essex ICS as well as members from the central NHP team. This membership has collectively committed to making the new facility the most co-produced in the country – a tall ambition that confirms our commitment that the programme is designed by our people for our people.

For further information please visit https://www.wsh.nhs.uk/New-healthcare-facility/New-healthcare-facility.aspx

Trust digital programme

Clinical systems

Our electronic patient record, e-Care, has continued to develop in planned phases of work. This included work to enhance the latest implementations so we can streamline the workflows for staff and improve the quality of the data available from the system.

A significant project to upgrade e-Care to the latest release of the system was carried out during September and October. Whilst the change did not bring major benefits to users of the electronic patient record, it is complex and vital maintenance that needs to continue to remain on a supported release of the software and to enable us to take full advantage of future enhancements in functionality.

The existing endoscopy system was replaced with an improved system which provides much richer integration into e-Care and extends the scope of digitisation for the department. In a further leading development, a solution that brings artificial intelligence to help dermatologists to deal more effectively with backlog of patients was implemented and has achieved the expected reductions to their waiting lists.
The coronavirus vaccination programme for staff started in January 2021 and continued throughout the year. Our development team supported the programme with the creation of a booking system for staff and clinical recording of the vaccination together with onward transmission of the data into national systems and into the GP record.

Work continues with our partners to support the electronic patient record in use across the community teams. The Trust's use and scope of our learning management system, Totara, continues at pace with a rapidly growing number of use cases including supporting patient and carer education, and learning for health and care professionals in our area as well as core Trust education.

Supporting digital technology

In the early part of the year, delivery was taken of new 'workstations on wheels' that has enabled older devices to be retired. This has resulted in much more robust technology, freeing up both clinical time and reducing the number of calls to the service desk.

The roll out of Windows 10 to all computers, which started in 2020, was completed in August 2021. This represented a major upgrade of the core platform and included upgrades to hundreds of computers as well as the underlying operating system. A parallel project was undertaken to upgrade the server infrastructure onto supported versions of the Windows platform. This has required the scheduling of downtime and corresponding upgrade work to around 300 servers involved in running the wide range of Trust applications.

In August 2021 we provided the technology to support the treatment of West Suffolk patients at Ipswich hospital as part of a mobile Vanguard unit that provides an operating theatre, recovery area and ward for patients who need minor operations in a day surgery setting.

During the year, we implemented a more robust cyber-security solution, which integrates virus

checking with our firewall to give stronger and more comprehensive protection against cyber attacks. This gives us assurance that we are doing as much as possible to protect Trust data.

We have again been re-certified under ISO 9001 and ISO 27001 standards; this means we are maintaining industry standards for service provision and information security and data protection for our staff and patients.

Digital across the West Suffolk and wider community

The digital teams in the community completed the transfer of our community colleagues to WSFT-provided digital services, moving away from their previous IT provider and bringing all Trust staff onto Trust-supported computers and systems. This integration has been key to providing a level playing field across our whole Trust estate and no longer inhibits digital transformation outside the hospital walls. The community and integrated therapies staff have led the way in moving to Microsoft's cloud-based platform, SharePoint, and have embraced this new collaborative way of working.

As new services and technologies are brought online, the dependency on resilient networks increases. To meet this challenge the digital team continues to upgrade the existing network infrastructure whilst further expanding its reach to deliver services to the wider community. Earlier in the year it included providing digital infrastructure to support the opening of the health hub at Mildenhall Hub and later at Brandon Health and Leisure Centre that provides a range of health, public and leisure services, highlighting the importance of delivering integrated services.

In terms of system-wide working, we continue to run the shared care record program on behalf of the ICS. This is based around the health information exchange (HIE) platform that now hosts GP, community, acute, mental health, social care and hospice data. This information and data is displayed to users across all of these organisations, showing health and care interactions and documentation across the patient's journey to all professionals. Usage continues to grow as evidence of its value and now routinely exceeds 100,000 views per month.

Our Patient Portal, which gives patients visibility of their electronic record, has exceeded the target of 10,000 register users. The Dr Doctor service, that offers patients the option to receive clinic letters electronically and provides appointment reminders, has grown significantly throughout the year as we continue our journey to a paper-light Trust.

Future foundations

Throughout the year the digital team has worked closely with the future system team to build the vision of how digital technologies can support the new hospital programme. This started with a highly successful "digital fortnight" where the clinical and digital teams explored a wide variety of technologies that will become important and vital to a digitally advanced hospital. It has informed the clinical visions on the way digital solutions can support and promote changes to workflow and processes to become more efficient, effective, and safe. A key part of vision for the new hospital is a flexible and mobile workforce who can work effectively from a wide variety of locations; this builds on the remote and virtual working approach that has become the norm for many over the last two years. We have formed a Future System Digital Advisory Board to explore technologies that will be expected to be embedded both in the fabric of the building and also in the footprint across the wider health and social care system.

Much of this work has been built on the premise of coproduction and is based on the principal of being inclusive and not making digital a barrier to accessing services. At the same time, we recognise the efficiencies that technology can bring particularly when used to offer self-service, and on demand access to information.

Throughout the year we have been working on an updated digital strategy which aims to put people at the heart of digital. It aligns with the Trust strategy in focusing on three main areas of patient digital empowerment, digital culture, and strong digital foundations. It involved wide engagement

across the Trust and will be published shortly.

Finally, the department has been rebranded as 'Digital Services' to move away from the old label of IT and move more to digital, data and technology as the basis for the future.

We look forward to some exciting projects including the upgrade of the existing self check-in kiosk system to include screens that show the status of outpatient appointments, the implementation of ways to record electronically consent that then informs procedures that are carried out, a clinical decision support solution that provides advice and guidance on best practice and the roll out of upgraded infusion pumps both in critical care but also across the wider trust.

Procurement

The impact of the pandemic has changed the procurement landscape and, as such, supply chain routes, EU directives and procurement of goods is still not clear. The procurement department is working with all the national teams to review how procurement will evolve over the coming 12 months. The areas of direction currently under review are:

- Ensuring the new procurement regulations and requirements by all public sector bodies are implemented in 2022
- Implement 10% against social values as part of the evaluation criteria in all procurement tenders from April 2022
- The new National Commercial Standards that are planned to be introduced in 2022. The Trust's existing level one standard will remain until the new processes have been embedded. The Trust will then be required to undertake a self-assessment under the new standards by April 2023
- The new requirement to upload the Trust annual procurement workplan is currently being implemented. The Trust will be required to upload these on to the national system going forward. This will provide better visibility of contract spend and monitoring of key performance indicators, ensuring compliance and benefits realisation are being achieved
- The new revised model hospital metrics will be available in April 2022. The Trust will then be required to upload the data every month
- Continue to upload Trust spend on the national spend comparison service tool.

Priorities for Trust procurement over the coming twelve months are to:

- Support the directorates as we move back to business as usual
- Achieve the Trust workplan which links with NHS England / Improvement and NHS supply chain
- Support the move toward ICS working to ensure that overall the Trust is achieving value for money by working in collaboration with other bodies, testing the market and benchmarking.

Agency rules

The two main clinical staff groups where agency staff are used are doctors and nurses. During 2021-22 we continued to use the agencies on the collaborative procurement partnership (CPP) framework preferred supplier list for nursing staff and medical staff, which was developed in conjunction with the East of England procurement hub. The CPP framework is audited by the procurement hub for framework compliance.

In 2021-22, despite the huge increased demand on services during the ongoing pandemic, we have successfully reduced our reliance on agency, bringing down the usage by 6%. This has also had the effect of increasing the competition between agencies. The reduction in shifts put out to agencies has also improved our negotiating position for agencies to comply with capped rates.

Capital planning

The Trust has a five-year risk assessed capital strategy that focuses on addressing backlog issues and essential clinical developments both in community and acute services. This is further enhanced

by an annual prioritisation process for the assessment of investment of capital resources, this has been completed for 2022-23. This is assessed through a multi-professional group using a risk ranking process, which assesses the benefits of investment against four criteria: compliance with the estate strategy; operational/clinical need; financial impact; and statutory compliance.

The assessment ensures that:

- risk priorities remain relevant and have not changed
- any changes are incorporated from statute, alerts, NHS estates, etc.
- any previously unidentified issues arising in the year are considered and incorporated.

The Trust has a borough council-approved master plan for the development of the main hospital site. The key strategic developments included in the plan are linked to clinical service delivery, with each development subject to a Board-approved business case. The outline planning application for the Future Systems programme is a key stage of this master plan

A large part of the West Suffolk Hospital estate is approaching 50-years old with an original design life of 30 years - this is reflected in the backlog maintenance costs, with the hospital identified as an outlier in the Model Hospital data from NHS Improvement. In the longer term, the Trust faces the challenge of providing a level of care appropriate to the 21st century, within ageing buildings, making it increasingly difficult to meet this challenge. In May 2019 the Standing Committee on Structural Safety (SCOSS) published an alert advising that parts of the structure could be affected by shear failure with very limited warning. The alert related to a significant proportion of the hospital which is constructed of reinforced aerated autoclaved concrete (RAAC) planks, which have structural properties. The SCOSS alert has been updated in 2022 and this is aligned with how the Trust supports and monitors RAAC planks on-site.

The Trust has invested in Newmarket Community Hospital's electrical infrastructure as a key opportunity to reduce the risk on this site to support future phases of the Elective Recovery Hub (ERH) and Community Diagnostic Hub (CDH) programmes. Its location and available estate support Newmarket Community Hospital being part of the eastern region's response to the extended waiting lists as a result of the COVID-19 pandemic.

The annual review this year has been in-line with the COVID-19 pandemic, planning for the Future Systems programme and clinical priorities in the organisation. The 2017-2022 estates strategy is being rewritten for the 2022-2027 period to ensure effective management of the parts of the estate that are expected to be demolished; investment in estate expected to continue to be part of the WSFT asset (retained estate); and our responsibility to support One Public Estate (OPE) through the Community Hub programme.

This must take place in the context of the capital funding available across Suffolk and North East Essex (SNEE) Integrated Care System and the Trusts annual allocation within this of £9.25m for 2022-23, 2023-24 and 2024-25 (excluding investment in the RAAC programme)

Significant schemes planned for delivery in the period include:

- **Newmarket minor operations suite** – to support the elective recovery programme, a treatment room in Newmarket will be upgraded to support minor-invasive procedures allowing care closer to home for our patients and support theatre capacity at WSH where this activity currently takes place
- **Imaging equipment** – the Trust has a number of large imaging schemes either complete in 2022-23 or plan to take place at the start of 2023-23. These include a replacement CT, MRI and the interventional radiology suite; the replacement of this equipment now ensures the Trust and patients gets the best-use of these assets for the remaining life of the buildings where they are located **Structural issue** – the Trust will be in year two of the significant capital investment available to support RAAC across the site and minimise the risk to patients, staff and visitors. This is an incredibly complex programme to deliver, notably for staff continuing to provide high quality patient care whilst the work takes place. It is disruptive and noisy, and the continual need

to separate construction works and any dust created requires effective and active management.

Key schemes planned for 2022-23 include:

- Completion of re-roofing programme for the front residences
- Installation of supporting mechanisms and ongoing surveillance across much of the estate
- The temporary relocation of midwifery and antenatal along with access to link corridors which will impact two wards at a time.

Backlog projects are prioritised on an annual basis using risk-based methodology assessed by a range of disciplines including electrical, mechanical, architectural, etc.. Key schemes covered during 2022/23 include:

- Hot and cold water systems associated with Legionella
- Fire compartmentation upgrades
- Electrical infrastructure in operational areas
- Sluice room refurbishments
- Replacement cooling plant for main theatres, recovery and critical care.

Medical devices – the Trust has an allocation within the £9.25m to invest in medical device replacement. These are prioritised on a risk-based methodology through the multi-disciplinary medical devices group. Where possible, replacement devices are 'connected' to maximise the opportunity to interact with and record in the patient record to provide an assurance loop of patient safety

Digital – the Trust continues to invest in digital solutions wherever possible to support the Digital First but not Digital Only programme. Improving the network performance and communications across the organisation are central to this along with ensuring investment in cyber security.

Sustainability

As an NHS organisation, and a spender of public funds, we have an obligation to work in a way that has a positive effect on the communities we serve. Sustainability means spending public money well, the smart and efficient use of natural resources and building healthy, resilient communities. By making the most of social, environmental and economic assets we can improve health both in the immediate and long term even in the context of rising cost of natural resources. Demonstrating that we consider the social and environmental impacts ensures that the legal requirements in the Public Services (Social Value) Act (2012) are met.

In order to fulfil our responsibilities for the role we play, West Suffolk NHS Foundation Trust has the following sustainability mission statement in our Green Plan:

"West Suffolk NHS Foundation Trust will distinguish itself by making sustainability a part of all we do. In partnership with patients, staff and the local community, our plan captures the social, environmental and economic impact of our actions."

The Green Plan was approved by the Trust Board in December 2022. It describes the action we will take. It will evolve over time as we achieve our goals and set ourselves even more ambitious targets. We are committed to playing a leading role in securing a healthy and sustainable Suffolk. The executive lead for sustainability and net zero is the chief operating officer and the programme is managed by the sustainability net zero steering group. The NHS is committed to tackling climate change by reducing emissions to 'net zero'.

Two clear and feasible targets emerge for the NHS net zero commitment, based on the scale of the challenge posed by climate change, current knowledge, and the interventions and assumptions that underpin this analysis:

- for the **emissions we control directly** (the NHS carbon footprint), **net zero by 2040**, with an ambition to reach an 80% reduction by 2028 to 2032 from a 1990 baseline, equivalent to a 47% reduction from a 2019 baseline.
- for the **emissions we can influence** (our NHS carbon footprint plus), **net zero by 2045**, with an ambition to reach an 80% reduction by 2036 to 2039 from a 1990 baseline, equivalent to a 73% reduction from a 2019 baseline.

Delivering a 'Net Zero' National Health Service October 2020

In order to embed sustainability within our business it is important to explain where sustainability features in our process and procedures. The Board approved travel plan includes active travel approaches such as walking, cycling and car sharing and is reviewed annually. The procurement sustainability policy provides direction for the management of sustainable procurement which enables the Trust to contribute to the delivery of the Government's sustainable development aims, policy, strategy and targets.

As an organisation that acknowledges its responsibility towards creating a sustainable future, we help achieve that goal by running awareness campaigns that promote the benefits of sustainability to our staff.

Adaptation

Climate change brings new challenges to the Trust.

Examples in recent years include the effects of heatwaves, extreme temperatures and prolonged periods of cold, floods and droughts. Our Board-approved plans address the potential need to adapt the delivery of the organisation's activities and infrastructure to climate change and adverse weather events. Events such as heatwaves, cold snaps and flooding are expected to increase as a result of climate change.

The Trust has responsibility to ensure all current and future planning includes measures to address climate-induced hazards. The Trust's business continuity and emergency response plans for climate-induced incidents include such awareness, and the overarching command and control capability has a programme of training and exercising to reinforce this. In addition, all purchasing, transformation and improvement planning are to include the same requirement.

Partnerships

The NHS policy framework already sets the scene for commissioners and providers to operate in a sustainable manner. Evidence of this commitment is provided in part through our work with strategic partners.

Strategic partnerships are already established with the following organisations:

- West Suffolk Clinical Commissioning Group
- Suffolk and North East Essex Integrated Care System
- East of England Greener NHS
- Suffolk Growth Programme Board
- East of England Procurement Hub
- Alliance partners – Suffolk County Council, The Suffolk GP Federation, Norfolk and Suffolk NHS Foundation Trust, working closely with the West Suffolk CCG and with wider stakeholders such as the ambulance service, independent care providers, the voluntary community sector, employers, the education sector and business.

Energy

West Suffolk Hospital

Resource		2017-18	2018-19	2019-20	2020-21	2021-22
Gas	Use (kWh)	25,103,388	24,605,975	26,394,446	27,222,128	25,555,792
	tCO_2e	5,322	5,217	5,596	5,656	4,681
Oil	Use (kWh)	1,075,600	0	0	0	0
	tCO_2e	351	0	0	0	0
Electricity	Use (kWh)	2,808,885	4,594,967	5,578,407	5,217,833	5,694,398
	tCO_2e	1,252	2,048	1,946	1,503	1,209
Total energy CO_2e		6,925	7,265	7,542	7,159	5,890
Total energy spend		£1,047,805	£996,002	£1,040,357	£1,159,217	£1,515,326

Source of data 2017 – 2020 - ERIC returns to the Information Centre.
2021-22 data correct at 26/4/22 (include forecasts for gas usage)
*data unavailable

Newmarket

Resource		2021-22
Gas	Use (kWh)	1,495,016.79
	tCO_2e	274
Oil	Use (kWh)	0
	tCO_2e	0
Electricity	Use (kWh)	489,502.80
	tCO_2e	103
Total energy CO_2e		377
Total energy spend		£122,080.08

Photovoltaic Panels – energy generation

Energy **output** PV panels (kWh)	2018/19	2019/2020	2020/2021	2021-2022
Quince House	6,381	10,741	10,891	9,680
Accommodation (Beeton, Bloomfield and Clarke)	-	23,693	27,036	25,309
G10	N/A	N/A	N/A	10,824

2021-2022 data correct at 21/4/22

The Trust joined the Feed-in-Tariff (FIT) scheme and receives an income per kWh generated from the photovoltaic panels placed on Beeton, Bloomfield and Clarke House accommodation.

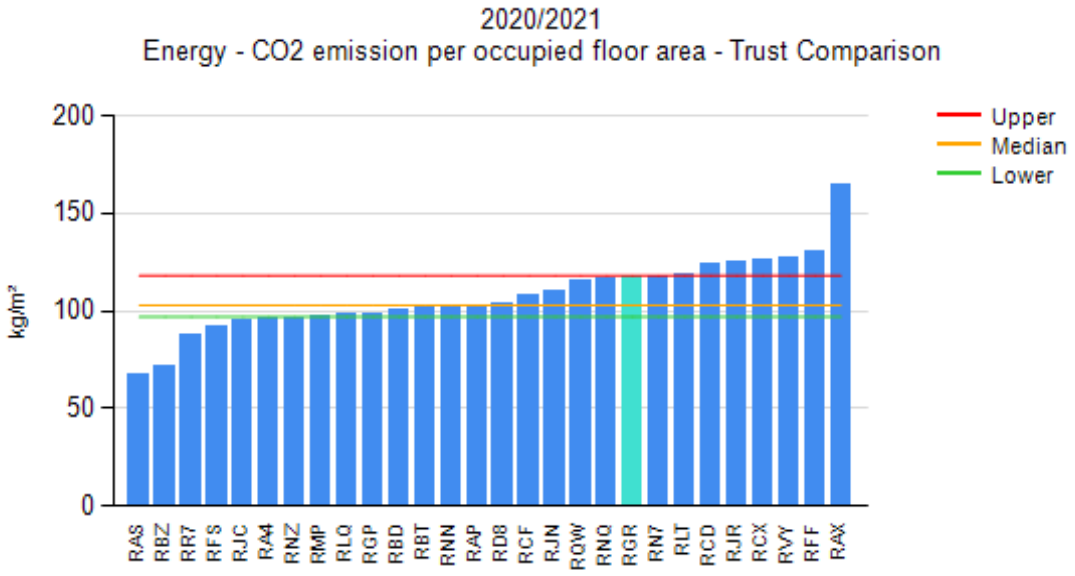
During 2021-2022 this has generated an income of £1,071 from this scheme.

Combined heat and power unit

	2017/18	2018/2019	2019/2020	2020/2021	2021-2022
Fossil energy **input** to the CHP system (kWh)	15,942,272	14,514,629	17,176,672	15,971,654	14,023,976.20
Electrical energy **output** of CHP system (kWh)	5,262,992	5,144,790	5,501,661	5,128,958	4,557,809

Thermal energy **output** of CHP system (kWh)	2,700,000 *	*4,160030	7,272,380	7,479,210	5,761,290

2021 - 2022 data correct at 21/4/21



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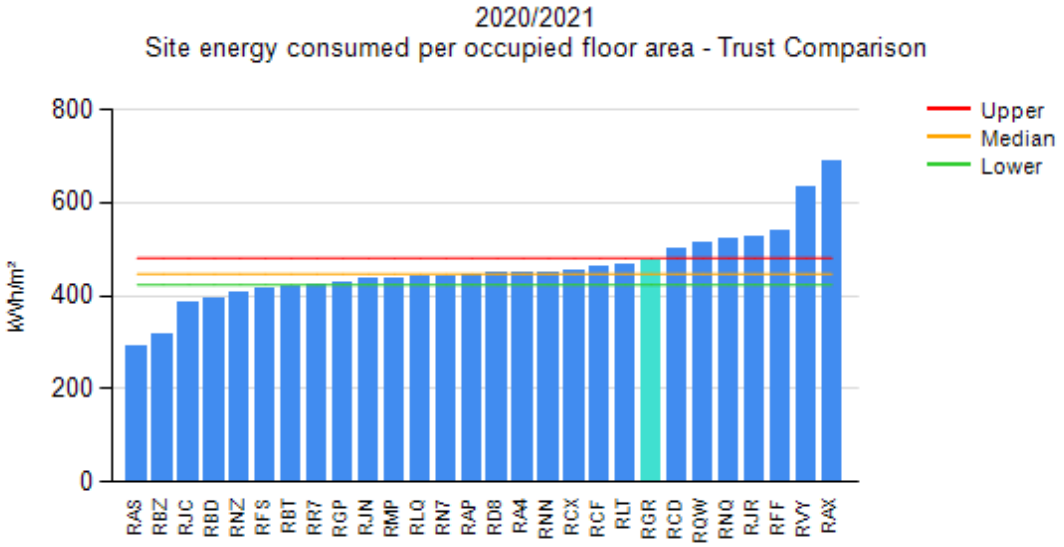

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Paper

Paper (A4)		2017/2018	2018/2019	2019/2020	2020/2021	2021-2022
Volume used	Tonnes	45	44	42	38	39.8
Carbon emissions	tCO_2e	43	41	40	36	29.4*

*The Trust purchases recycled A4 paper, so the carbon factor applied in 2021-2022 is ‘paper from a closed loop source’, in previous years the carbon factor used has been ‘paper from an open loop source’.

Travel

We can improve local air quality and improve the health of our community by promoting active travel – to our staff and to the patients and public that use our services

Every action counts and we are a lean organisation trying to realise efficiencies across the board for cost and carbon (CO2e) reductions. We support a culture for active travel to improve staff wellbeing and reduce sickness. Air pollution, accidents and noise all cause health problems for our local population, patients, staff and visitors and are caused by cars, as well as other forms of transport.

A travel expenses policy has been approved by the Trust executive group which reiterates the Trust travel hierarchy and the Trust expectations regarding business travel. In addition, the travel plan has been reviewed and active travel options are promoted through the staff newsletter.

The Trust reviews all requests for pool vehicles and ensures only low or ultra-low emission vehicles are leased. The option for electric and hybrid vehicles is also reviewed considering location, infrastructure and cost.

Data from the NHS fleet data collection 2021 shows that 100% of WSFT business use only lease and hire cars were Low Emissions Vehicles. (LEV definition: Vehicles that meet Euro 6 standard (Diesel) or Euro 4 standard (petrol) as confirmed by Transport for London ULEZ checker)

Business Travel – Agenda for change and junior doctors

	Mileage	tCO2e*
2019 - 2020	574,593	160
2020 - 2021	402,668	111
2021 - 2022	1,115,310	307

(*BEIS carbon factor 2021 average car, unknown fuel type 0.27596kgCO2e/m)

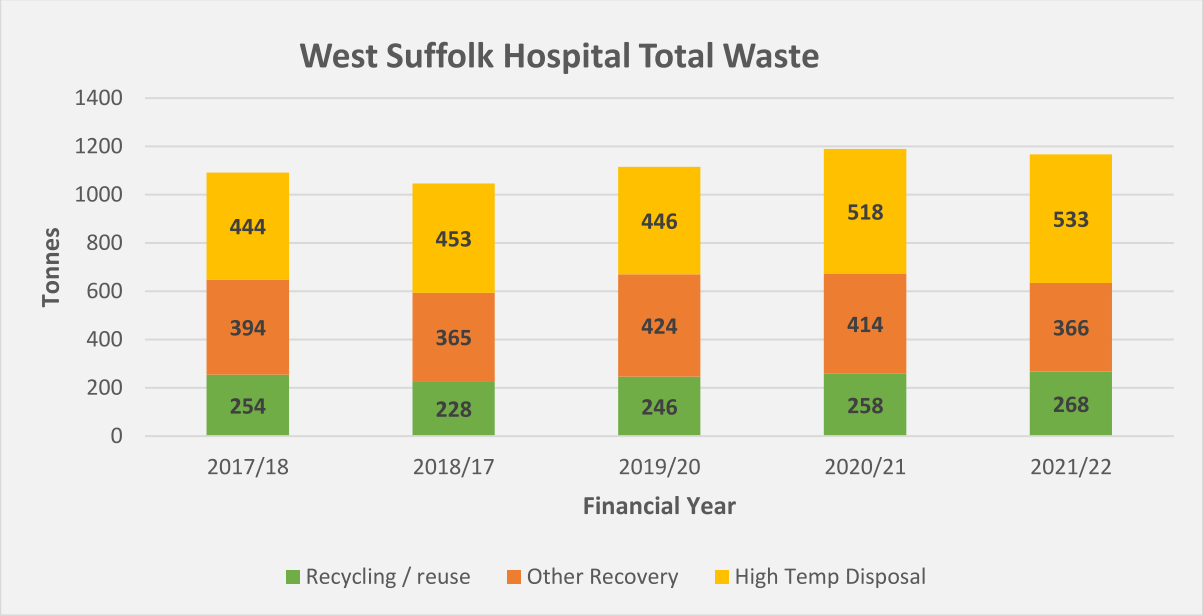
WEEE Waste

Through our contractor, CDL, the Trust sent 2.34 tonnes of waste electronic and electrical equipment (WEEE) on for reuse out of a total of 14.34 tonnes collected. The Trust Waste Management Policy outlines our commitment to applying the principles set out in the waste hierarchy.

West Suffolk Hospital Total waste (clincial and non clinical):

Waste		**2017/18**	**2018/17**	**2019/20**	**2020/2021**	**2021-2022**
Recycling/ re-use	(tonnes)	254.14	228.28	246.1	257.94	268
	tCO_2e	5.53	4.88	5.36	5.5	5.7
Other recovery	(tonnes)	393.94	364.94	423.74	414	366
	tCO_2e	8.57	7.81	9.22	8.82	7.79
High temp disposal	(tonnes)	444.10	452.76	445.54	517.71	533
	tCO_2e	97.70	99.7	98.02	113.90	117.26
Landfill	(tonnes)	0.00	0.00	0.00	0	0
	tCO_2e	0.00	0.00	0.00	0	0
Total waste (tonnes)		1092.18	1045.98	1,115.38	1,189.65	1168
% Recycled or re-used		**23%**	**21.8%**	**22%**	**22%**	**23%**
Total waste tCO_2e		111.80	112.39	112.60	128.22	130.75

Data source – quarterly waste returns, data correct at Apr 2022, BEIS carbon factors 2021-2022



Data source – quarterly waste returns, data correct at 26/04/21

Recycling target
Current recycling rate - 23%
Target – 30% by end of 2025/2026 financial year.

Recycling streams
The Trust sent 12.96 tonnes of plastic waste for recycling from West Suffolk Hospital. Further plastic recycling points will be introduced along with a metal can recycling trial.

In October 2021, the Trust introduced a pallet recycling stream and between October 21 and March 22, sent 2.18 tonnes for either recycling or reuse. This diverts any pallets that have not been back hauled by suppliers from entering the general waste stream, with a local supplier collecting our leftover pallets to prepare for recycling or reuse.

1.3 tonnes of glass waste produced at the Day Surgery Unit has been sent for recycling.

The food waste stream is now embedded and in 2021/2022 the Trust sent 41.3 tonnes of food waste to a local anerobic digestion facility.

Newmarket Community Hospital Total Waste

Waste		2021-2022
Recycling/ re-use	(tonnes)	8.20
	tCO_2e	0.17
Other recovery	(tonnes)	47.66
	tCO_2e	1.01
High temp disposal	(tonnes)	16.73
	tCO_2e	3.68
Landfill	(tonnes)	0.00
	tCO_2e	0.00
Total waste (tonnes)		72.58
% Recycled or re-used		11%
Total waste tCO_2e		4.86

Finite resource use – water

West Suffolk Hospital

Water		2017/18	2018/19	2019/20	2020/2021	2021-2022
Mains water	m^3	96,682	121,030	111,001	133,409	145,244.22
	tCO_2e	88	110	101	140.34	21.6 (supply) 35.4 (treatment)
Water and sewage spend	£	£205,547	£263,086	£189,056	£320,387	£333,994.65

Source of data 2017 – 2020 - Estates Returns Information Collection (ERIC)

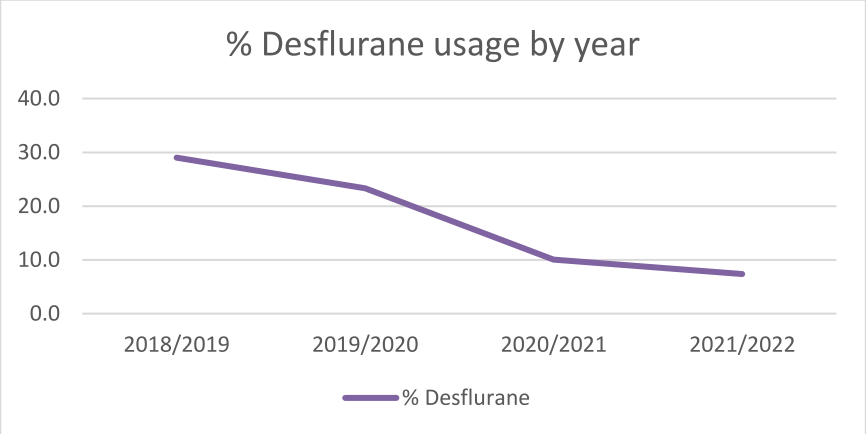
Newmarket Community Hospital

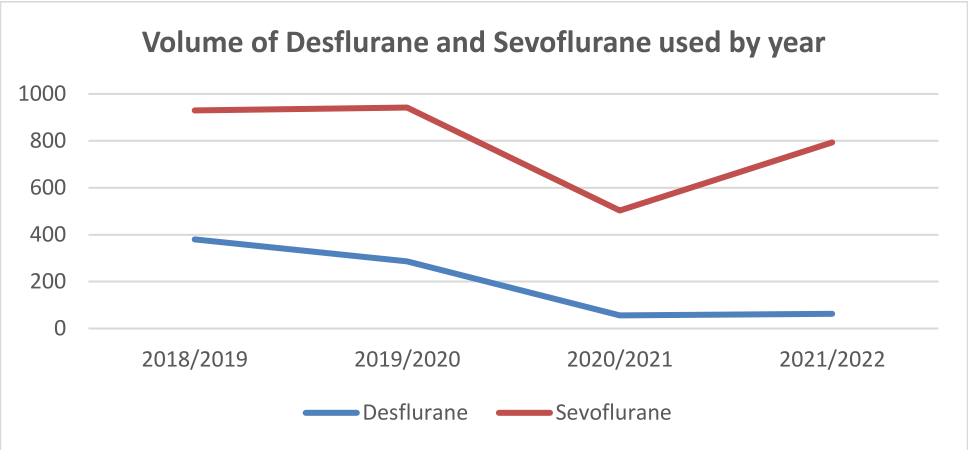
Water		2021-2022
Mains water	m^3	3,402
	tCO_2e	1.7 (supply) 0.79 (treatment)
Water and sewage spend	£	£10,139.99

Other initiatives

There are many examples of good sustainable development practice in the Trust, ranging from work in the community through the alliance partnership, health and wellbeing of staff, sustainable procurement practices, estates management and capital project development, for example:

The Trust has been reducing the use of desflurane in surgery, with an aim for it to be less than 10% by volume of total aesthetic gas use.





In 2022 – 2022 the aim is to further reduce the proportion of desflurane to all anaesthetic gases used in surgery to 5% or less by volume.

Theatres warming jackets

Theatres and DSU have moved from disposable warming jackets to reusable ones being washed by Elis, our linen supplier. These jackets are re-useable rather than single use, resulting in a reduction in waste and a cost saving following return on investment.

Waste reduction:

- 5 x boxes of 32 disposable jackets ordered weekly for Theatres and DSU over the winter months reducing to 2 x boxes a week in the summer will not be going in the waste steam to burn

Cost saving:

- approximate £3k saving after the return on investment in year one (approx. 6 months) of buying the jackets. Note: This does not include the savings cost for disposal but does include the wash cost.

Single use plastic

The catering department is reviewing the products available from different suppliers, these include replacements for plastic cutlery used in the two catering outlets. While wooden stirrers have already replaced plastic tea spoons, other suitable products are harder to source.

Catering no longer purchases expanded polystyrene cups and are actively seeking a replacement for the polystyrene food containers

The catering department has replaced single use plastic containers for fruit and juice and have moved to reusable containers with lids. They have also purchased reusable lids to replace plastic food wrap. All sandwich wraps used in the catering outlets are card based.

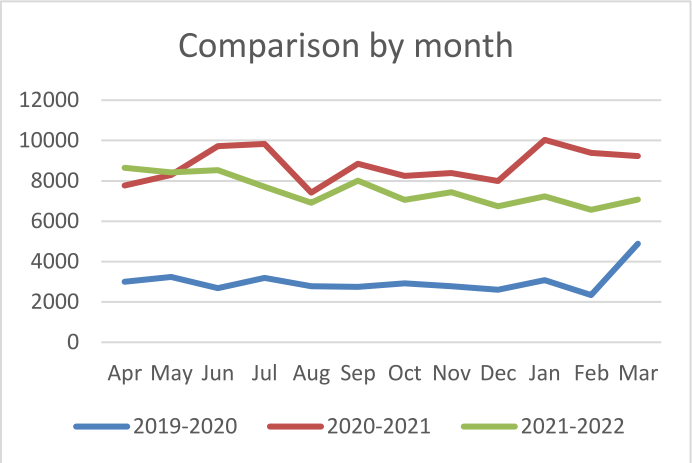
The Trust has removed plastic spoons from all areas outside catering and are looking to remove plastic bowls, jugs and kidney dishes from Theatres and DSU over the coming months

Reusable coffee cups

In March 2021 the My WiSH Charity, working with the catering department and the estates energy and waste officer, distributed 5,000 reusable coffee cups, one for each member of Trust staff. Despite this, a considerable number of single use cups were still being used by staff for free hot drinks. So, in an effort to reduce waste and keep costs to a minimum, from 17 January 2022, staff purchasing hot drinks must use a reusable to cup or mug to qualify for the staff rate at the till. The staff rate is still free of charge. This significantly reduced the number of single use cups used.

Remote appointments

Month	2019-2020	2020-2021	2021-2022
Apr	2997	7777	8,649
May	3238	8295	8,427
Jun	2683	9720	8,537
Jul	3183	9825	7,712
Aug	2785	7417	6,920
Sep	2753	8856	8,014
Oct	2922	8241	7,059
Nov	2785	8383	7,444
Dec	2600	7991	6,747
Jan	3072	10033	7,238
Feb	2339	9390	6,567
Mar	4885	9227	7,075



The number of remote appointments for patients in 2021-2022 was 90,389. The associated benefits, based on the avoidance of the appointments, are:

- **3,495,644 patient miles** saved, equivalent of going around the world **140** times.
- **1,506 hours** of patient time saved through avoided face to face appointments
- **41,808 car park spaces** saved
- A reduction of **644.4 tonnes** of CO2 emissions

(using the outpatient transformation benefits calculator v1 January 2021)

2022 – 2023

Walking aids for re-use or recycling
The Trust is implementing a six-month pilot working with Medequip (the Trust community equipment provider) to place returns bins in two locations around the Trust. Patients will then be able to drop off walking aids, that will be checked and reused by the Trust or Medequip. The Trust is also talking to the council to see if a bin can be placed at local recycling centres.

EV charge points

There are six electric vehicle charge points on the West Suffolk Hospital site, a site survey was undertaken in February 2022 and we are planning to increase the provision of electric vehicle charge points during 2022- 2023.

An electric van, Citroen E-Berlingo M - 800 100KW 50KWH Enterprise Pro Auto, is on order for estates department and is due for delivery in August 2022.

Procurement

With effect from 1 April 2022 the Trust has implemented the 10% social value model theme as part of all evaluation criteria. This incorporates fighting climate change, wellbeing, equal opportunity, tackling economic inequality and COVID-19 recovery.

Equality of service delivery to different groups

As a Trust we are developing and promoting an inclusive culture. This means we embrace all people irrespective of, for example, race, religion or belief, sex, gender identity or expression, sexual orientation, age, marital status, pregnancy, maternity or disability. We strive to give equal access and opportunities to all and get rid of discrimination and intolerance. We will do this both as an employer

and as a service provider.

Five of our nine objectives relate to patients, service users and carers:

- Improve the experience and care of patients and service users experiencing mental distress, those with learning disabilities and neurodiversity
- Improve the experience and care of people who are lesbian, gay, bisexual, trans and all other sexualities and gender identities
- Promote a culture of inclusion in delivery of care to all patients and staff
- Improve information and data collected, in respect of protected characteristics in order to understand what action may be required
- Tackle bullying and harassment of and by staff and support staff to respectfully and successfully challenge problem behaviours.

Our equality, diversity and inclusion plan sets out our priorities to achieve our objectives. Examples of work we have undertaken include:

- engaging with staff, patients and service users to ensure the chapel at West Suffolk Hospital is an inclusive space for all
- working with our patient administration system provider to enable us to record the preferred gender identity of all patients
- All patients and visitors to the Trust have access to a detailed access guide that lets them know what access will be like when they visit the West Suffolk Hospital site via a link on our website to AccessAble. This guide is being extended to Newmarket Community Hospital in summer 2022.

The link to our inclusion strategy and action plan can be found here.

2. Accountability report

2.1 Governors' report

2.1.1 Responsibilities

The council of governors is a key part of WSFT's governance arrangements. It works effectively with the Board of directors and represents the views of the population of the Trust's catchment area and its staff when considering WSFT's future strategy.

The council of governors holds the Board of directors collectively to account for the performance of WSFT, including ensuring that the Board of directors acts so the Trust does not breach the terms of its authorisation.

2.1.2 Composition

The council of governors is composed of 14 elected public governors, five elected staff governors and six partner nominated governors. The term of office for all governors is three years.

Public governors – representing and elected by the public members of WSFT

Florence Bevan
Derek Blackman(1)
Allen Drain
Keith Foss (2)
Robin Howe
Mark Krempel(3)
Ben Lord
Roy Mawford
Jayne Neal
Adrian Osborne
Joe Pajak
Margaret Rutter
Jane Skinner
Liz Steele (lead governor)
Clive Wilson

Staff governors – representing and elected by the staff members of WSFT

Rachel Darrah
Margo Elsworth(4)
Sarah Judge
Amanda Keighley
Sarah-Jane Relf(3)
Martin Wood

Partner governors – nominated by partner organisations of WSFT

Councillor Carol Bull	West Suffolk Council also representing Mid-Suffolk District Council and Babergh District Council
Dr Andrew Hassan	West Suffolk Clinical Commissioning Group
Councillor Rebecca Hopfensperger	Suffolk County Council
Laraine Moody	West Suffolk College also representing University Campus Suffolk
Dr Thomas Pulimood	University of Cambridge
Sarah Steele(5)	Friends of West Suffolk Hospital
Vacant (2nd representative)	West Suffolk Clinical Commissioning Group

(1) Resigned from Council of Governors June 2021
(2) Appointed to Council of Governors June 2021
(3) Resigned from Council of Governors February 2022
(4) Appointed to Council of Governors March 2022
(5) Resigned from Council of Governors March 2022

Governor attendance at council of governors' meetings 2021/2022

There were six formal meetings of the council of governors: 21 April 2021 (held in private); 17 June 2021; 21 September 2021 (Annual Members Meeting); 13 October 2021; 17 January 2022, 29 March 2022. In line with social distancing requirements all formal and informal meetings, training and briefing sessions have taken place virtually during the COVID-19 response. The following governors were in attendance (*note attendance at AMM is not recorded or included in figures below):

Name	Title	Attendance (out of five meetings*)
Florence Bevan	Public governor	5
Derel Blackman(1)	Public governor	2 (of 2)
Carol Bull	Partner governor	4
Rachel Darrah	Staff governor	3
Allen Drain	Public governor	5
Margo Elsworth(4)	Staff governor	0 (of 1)
Keith Foss(2)	Public governor	1 (of 3)
Andrew Hassan	Partner governor	2
Rebecca Hopfensperger	Partner governor	5
Robin Howe	Partner governor	2
Sarah Judge	Staff governor	5
Amanda Keighley	Staff governor	3
Mark Krempel(3)	Public governor	3 (of 4)
Ben Lord	Public governor	5
Roy Mawford	Public governor	4
Laraine Moody	Partner governor	2
Jayne Neal	Public governor	4
Adrian Osborne	Public governor	5
Joe Pajak	Public governor	5
Thomas Pulimood	Partner governor	5
Sarah-Jane Relf(3)	Staff governor	3 (of 4)
Margaret Rutter	Public governor	4
Jane Skinner	Public governor	4
Liz Steele (lead governor)	Staff governor	5
Sarah Steele(5)	Partner governor	3 (of 4)
Clive Wilson	Staff governor	5
Martin Wood	Staff governor	5

(1) Resigned from Council of Governors June 2021
(2) Appointed to Council of Governors June 2021
(3) Resigned from Council of Governors February 2022
(4) Appointed to Council of Governors March 2022
(5) Resigned from Council of Governors March 2022

In attendance at these meetings were: Craig Black, executive director of resources/interim chief executive (3); Sheila Childerhouse, chair (4); Jude Chin, non-executive director/interim chair (2); Nicola Cottington, chief operating officer (2); Dr Richard Davies, non- executive director (4); Dr Stephen Dunn, chief executive (1); Christopher Lawrence, non-executive director (2); Rosemary Mason, associate non-executive director (1); Louisa Pepper, non-executive director (4); Jeremy Over, executive director of workforce and communications (1); Alan Rose, non-executive director (4);

2.1.3 Register of interests

All governors are asked to declare any interests on the register at the time of their appointment or election. This register is reviewed and maintained by the Trust secretary. The register is available for inspection by members of the public. Anyone who wishes to see the register should contact the Trust secretary at the following address:

Trust secretary, Foundation Trust Office, West Suffolk NHS Foundation Trust, West Suffolk Hospital, Hardwick Lane, Bury St Edmunds, Suffolk IP33 2QZ.

2.1.4 Governors and directors working together

Governors and directors have developed a professional working relationship, on both a formal and informal basis. A number of governors attend and observe the monthly Board of directors' meetings. This gives them an insight into and an understanding of the performance of the Board, particularly from a quality and finance perspective, and provides an insight into the role and performance of the non-executive directors (NEDs).

The NEDs present a summary reports at the council of governors meetings. When required they also present reports on any other areas they lead on.

The senior independent director (SID) attends council of governors' meetings and workshops. Governors are aware that they should discuss any matters with the SID that they do not feel can be addressed through the chair.

A joint governor and NED training session took place on 22 September 2021 and to support governors in their role a range of joint board/governor briefings took place during 2021-22:

- 28 April 2021 – ICS and White paper
- 13 May 2021 – Future System and RAAC
- 19 October 2021 – Future System and big ideas
- 9 November 2021 – Operational challenges and strategic pressures
- 7 December 2021 – ICS and the future
- 19 January 2022 – Freedom to Speak Up
- 9 February 2022 – The people plan
- 9 March 2022 – The green plan
- 6 April 2022 – NHS finance and WSFT budget

At joint workshops, presentations and formal and informal meetings governors contribute to WSFT's forward plan.

To support governors in engaging with staff, patients and the public they have previously taken part in activities including quality and environmental walkabouts, area observations and engagement sessions in the Courtyard Café. In line with social distancing requirements these activities have been paused during the COVID-19 response, however governors have engaged with staff through virtual meetings, including the regular all-staff briefing.

The engagement committee, which is a sub-committee of the council of governors, meets quarterly. Governors provide feedback on key issues they have encountered when engaging with the public to the patient experience committee, which is attended by executive directors and NEDs. A report on how these issues are being addressed is provided to the council of governors meeting.

To support governors in their role a range of training and development sessions have been held during the year:

- finance with executive director of resources
- quality and performance with chief operating officer and executive chief nurse
- governor training session with external trainer – governance, the Board and the role of the governor; effective questioning and challenge
- joint governor and non-executive director training session with external trainer – the Board and council working together.

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 establishing a governor/director working group to take this forward. The work of this group recognizes that governors and directors have distinct and separate roles in the governance of WSFT but have a shared responsibility to act in the best interests of the Trust.

2.1.5 Membership

The membership of WSFT is split into public and staff constituencies.

Public membership

Any person aged 16 or over who lives within the membership area is eligible to be a public member. Public members are recruited on an opt-in basis.

Patients and members of the public who live in the following areas are eligible to join our public constituency:

Babergh:	All wards
Braintree:	Bumpstead, Hedingham and Maplestead, Stour Valley North, Stour Valley South, Upper Colne, Yeldham
Breckland:	Conifer, East Guiltcross, Harling and Heathlands, Mid Forest, Thetford-Abbey, Thetford-Castle, Thetford-Guildhall, Thetford-Saxon, Watton, Wayland, Weeting, West Guiltcross
East Cambridgeshire:	Bottisham, Burwell, Cheveley, Dullingham Villages, Fordham Villages, Isleham, Soham North, Soham South, The Swaffhams
Ipswich:	All wards
King's Lynn and West Norfolk:	Denton
Mid Suffolk:	All wards
South Norfolk:	Bressingham and Burston, Diss and Roydon
Suffolk Coastal:	All wards
Waveney:	All wards
West Suffolk:	All wards

In April 2021 the public membership area was extended to include the rest of Norfolk, Cambridgeshire and Essex (all wards not mentioned above) as part of second, separate public constituency.

Staff membership

All WSFT staff who are employed by the Trust under a contract of employment which has no fixed term; has a fixed term of at least 12 months; or have been continuously employed by the Trust under a contract of employment for at least 12 months are eligible to become staff members unless they choose to opt out.

In addition, staff who exercise functions for the purposes of the Trust, without a contract of employment, continuously for a period of at least 12 months are also eligible to become staff members unless they choose to opt out. For clarity this does not include individuals who exercise functions for the purposes of the Trust on a voluntary basis.

Membership numbers

At 31 March 2022 there were 7,044 public members and 4,845 staff members.

Membership strategy

The Trust's membership strategy is reviewed annually by the engagement committee for consideration by the council of governors and approval by the Board of directors. We aim to maintain and, where possible, increase our public membership and to ensure that staff membership is maintained at an appropriately high level. Experience has shown that engaging with the public is a very effective way of recruiting new members and gaining their views on WSFT.

Governors use a short questionnaire to engage with members of the public during recruitment initiatives. As well as recruiting new members this provides valuable feedback from patients and the public on their experiences and views of WSFT. In line with social distancing requirements these activities have been paused during the COVID-19 response.

The council of governors' engagement committee meets regularly to review the membership numbers and the targets set in the membership strategy to ensure that it is representative. It also considers ways of increasing membership in areas where numbers are low. The chair of this committee gives a report to the quarterly council of governors meeting. Performance against the agreed targets remains good.

A number of engagement activities have been paused as a result of the social distancing requirements, and a greater focus is being given to electronic communication and engagement methods.

Criteria	As at 31 March 2022	Target (Mar 2023)
1. Achievement of the recruitment target: a. Total number of public members b. Staff opting out of membership	 **7044** **<1%**	 6,000 <1%
2. Achieve a representative membership for our membership area, Priorities for action: a. Age – recruitment of under 50s b. Engagement and recruitment events in all market towns of Membership area (Thetford, Newmarket, Stowmarket, Haverhill and Sudbury)	 **1833** **20%[1]**	 1,250 40%
3. An engaged membership measured by: a. number of member events b. member attendance – total all events c. annual members' meeting attendance (each year)	 **2** **362[2]** **295 (2019)**	 3[3] 400[2 and 3] 200

[1] Figure as at March 2020 (paused due to COVID-19)
[2] Includes people attending annual members' meeting – figure as at March 2020 (paused due to COVID-19)
[3] Figures have been adjusted due to COVID-19

During the past year the Trust has paused its membership interest events on services provided by WSFT. The annual members meeting was held virtually via YouTube.

Contact procedures for members

Contact details for the foundation trust office are given on the website and queries/comments will be directed to the appropriate governors/directors.

A newsletter is sent to all members two or three times a year to update members on news at the Trust, and give details of how to contact the Trust.

2.1.6 Nominations committee

The governors' nominations, appointments and remuneration committee is responsible for making recommendations to the council of governors on the appointment of the chair and other non-executive directors. The committee also makes recommendations for chair and non-executive director remuneration and terms and conditions.

The committee is chaired by the Trust chair, except when considering the appointment, remuneration and terms and conditions of the Trust chair, or feedback from their appraisal, when it is chaired by the lead governor.

In June 2021 the committee reviewed the feedback from the appraisals of the NEDs and key messages that would be fed back to each individual. They also discussed the NED appointment process for an interim NED following the recent resignation of a NED and associate NED. Following a shortlisting meeting in July 2021 and subsequent interview process an interim NED was appointed and approved at a closed council of governors on 3 August 2021.

In October 2021 the committee received an update on a proposal for the number of NEDs to be increased to seven and the process for appointment of additional substantive NEDs. They were also updated on the process for the appointment of a substantive chief executive. The committee also discussed the reasons behind the resignations of a NED and associate NED. They also reviewed the remuneration of the Chair and NEDs and agreed a recommendation to be made to the council of governors.

In January 2022, following the resignation of the Chair, the committee undertook a process to appoint an interim Chair and a recommendation was agreed at a closed Council of Governors meeting on 17 January 2022.

In February 2022 the committee met to discuss the process and timetable for the recruitment of a substantive Chair and NEDs.

In March 2022 the committee met to consider the West Suffolk Review, determination in respect of criticised individuals, and a summary of their decision was presented to a closed Council of Governors meeting on 29 March 2022.

The committee also attended a meeting In March 2022 to longlist potential candidates for the substantive Chair position and a subsequent meeting was arranged in April to shortlist the Chair candidates and longlist the NED candidates.

Attendance at nominations committee meetings 2021-22

Name	Title	Attendance (out of seven)
Sheila Childerhouse (chair)	Chair	**3 (of 3)**
Jude Chin (chair) [2]	Interim Chair	**2 (of 2)**
Richard Davies	Senior Independent Director	**1 (of 1)**
Carol Bull	Partner governor	**4 (of 7)**
Roy Mawford	Public governor	**4 (of 7)**
Joe Pajak	Public governor	**7**
Jane Skinner	Public governor	**7**
Liz Steele	Public governor	**7**
Martin Wood	Staff governor	**6 (of 7)**

Meeting dates: 24 June 2021; 21 July 2021; 26 October 2021; 10 January 2022; 17 February 2022; 21 March 2022; 30 March 2022

[1] Committee chair until resignation in January 2021
[2] Committee chair following appointment as Interim Chair in January 2021

2.2 Directors' report

2.2.1 Responsibilities

The Board of directors' functions as a unitary corporate decision-making body. Non-executive directors (NEDs) and executive directors are full and equal members. The role of the Board is to consider the key strategic and managerial issues facing the Trust in carrying out its statutory and other functions in accordance with the constitution.

The Board of directors comprises executive directors and part-time NEDs; the latter chosen because of their experience and skills relevant to the organisation's needs. The role of the Board is to set the strategic aims, vision, values and standards of conduct for the Trust and to be responsible for ensuring that management delivers the Trust's strategy and operations against that framework.

Disagreements between the Board of directors and council of governors are resolved through a process which aims to achieve informal resolution in the first instance, following which a formal process will be taken that involves a resolution for discussion at a Board meeting.

The descriptions below demonstrate the balance, completeness and relevance of the skills, knowledge and expertise that each of the directors brings to WSFT.

2.2.2 Composition

(a) Non-executive directors

Mr Jude Chin – Interim NED and interim chair
(Appointed as interim NED from 1 September 2021 and interim Chair from 1 February 2022. Jude was appointed for a one-year term as the permanent chair on 4 July 2022)

Areas of special interest/responsibility: Chair of improvement committee, Member of remuneration committee and charitable funds committee and chair of the governors' nominations, appointments and remuneration committee. Jude is chair of the Board of directors and council of governors of WSFT.

Previously, Jude was vice-chair of Colchester Hospital University NHS Foundation Trust and partner at KPMG.

Independent director – yes (satisfies criteria of code of governance B. 1.1)

Dr Richard Davies – NED/ Senior Independent Director
(Appointed: 1 March 2017 until 28 February 2020; reappointed 1 March 2020 until 28 February 2023)

Areas of special interest/responsibility: senior independent NED; chair of the insight committee (from May 2021) and learning from deaths group; Trust wellbeing guardian, Board neonatal and maternity safety champion, member of the Future Systems programme board, remuneration committee, audit committee, and revalidation support group; NED link to medical director.

Richard was appointed to the Board through University of Cambridge; he is a general practitioner and worked from 2004 in a variety of roles within the Cambridge University School of Clinical Medicine; including director of GP studies, and from 2013 until 2020 as a sub-dean in the Clinical School, with a particular responsibility for student welfare. He retired from clinical practice and from his formal university roles in August 2020. He continues to work as a clinical advisor to the university COVID-19 helpdesk and as a vaccinator.

Independent director – yes (see Note 1)

Mr Christopher Lawrence
(Appointed on 1 June 2021 – 31 May 2024)

Areas of special interest/responsibility: Chair of audit committee and charitable funds committee and member of future system board, red risk oversight committee and remuneration committee.

Prior to joining the Trust in June 2021, Chris was a chairman at Hertfordshire Partnership University NHS Foundation Trust, Managing director at London Philharmonic Orchestra. He was also a director at Credit Commercial de France, assistant director at N M Rothschild and assistant vice president at Citicorp international.

Independent director – yes (satisfies criteria of code of governance B. 1.1)

Mrs Louisa Pepper – NED
(Appointed: 1 September 2018 until 31 August 2021; reappointed until 31 August 2024)

Areas of special interest/responsibility: Member of the audit committee, remuneration committee, chair of ethics committee, and second lead for improvement committee; lead NED for safeguarding adults, security and emergency preparedness, resilience and response (EPRR), access and pathology.

Louisa joined Suffolk Constabulary in 1991, gaining promotion through all ranks from constable to assistant chief constable, until her retirement in September 2017. She undertook a number of roles, working with partners at all levels in the public, private and voluntary sector, including

working for both Norfolk and Suffolk Constabulary as head of strategic change, head of professional standards and head of criminal justice.

Louisa is a trustee of Suffolk Community Foundation.

Independent director – yes (satisfies criteria of code of governance B. 1.1)

Mr Alan Rose – NED and deputy chair
(Appointed: 1 April 2017 until 31 March 2020; reappointed 1 April 2020 until 31 March 2023)

Areas of special interest/responsibility: member of audit committee, chair of remuneration committee, chair of involvement committee, member of clinical excellence & discretionary awards committee and lead NED for patient experience and public engagement.

Alan was chair of Colchester Hospital University NHS Foundation Trust, having previously been a NED and chair of York Teaching Hospital NHS Foundation Trust for nine years. Prior to this he worked in the commercial sector in strategy and marketing roles. He is a member of the board of governors of Anglia Ruskin University.

Independent director – yes (satisfies criteria of code of governance B. 1.1)

Non-Executive Directors who left the Trust during 2021-22

Mrs Sheila Childerhouse – NED and chair
(Appointed: 1 January 2018 until 31 December 2020; reappointed 1 January 2021 and stepped down on 31 January 2022)

Areas of special interest/responsibility: member of remuneration committee and chair of the governors' nominations, appointments and remuneration committee. Sheila was chair of the Board of directors and council of governors of WSFT and was also chair of the integrated care system (ICS) chairs group.

Until recently Sheila was chair of Anglian Community Enterprise (ACE) and a non- executive director of East of England Ambulance Service NHS Trust. She is a trustee of East Anglia's Children's Hospice (EACH) and works as an executive coach.

Independent director – yes (satisfies criteria of code of governance B. 1.1)

Mr Angus Eaton - NED
(Appointed: 1 January 2018 until 31 December 2020; reappointed 1 January 2021 and stepped down as NED on 31 May 2021)

Areas of special interest/responsibility: chair of audit committee and remuneration committee; member of the charitable funds committee and ethics committee; NED link to director of resources; lead NED for health and wellbeing programme.

Angus is a qualified lawyer with wide executive and board experience. Currently, he is group chief risk officer of Hastings Group. His previous experience is across the legal, insurance and fund management sectors in various roles, including managing director (MD) consumer legal services and chief risk officer at Slater and Gordon; UK strategy and transformation director at Aviva and a board director of Aviva's Turkish Life joint venture; MD of Aviva UK commercial general insurance business; chief risk officer, Aviva UK and Ireland general insurance business; Aviva Group regulatory and operational risk director and group legal director.

Angus is also a NED of the Motor Insurance Bureau.

Independent director – yes (satisfies criteria of code of governance B. 1.1)

Angus stepped down from his role as NED at the end of May. Christopher Lawrence was appointed to the vacancy, including chair of the audit committee

Mrs Rosemary Mason – Associate NED
(Appointed 24 August 2020 and stepped down on 22 June 2021)

Areas of special interest/responsibility: member of audit committee, member of involvement committee, link NED for the West Suffolk Alliance and link NED on WSH structural issues.

Rosemary has over 25 years' experience in senior leadership roles in the global manufacturing sector: including nine years in various leadership roles for Huhtamki Oyj, including MD Western Europe and the UK, and 15 years in leadership roles, including chief operating officer for Betts/Courtaulds plc.

Independent director – yes (satisfies criteria of code of governance B. 1.1)

Mr David Wilkes – NED
(Appointed 31 July 2020 and stepped down on 11 June 2021)

Areas of special interest/responsibility: chair of improvement committee (from May 2021) and charitable funds committee; member of remuneration committee and audit committee.

David has a background in the malting business and is currently a non-executive director of Pauls Malt Ltd (Boortmalt); having been deputy group CEO and chief commercial officer for Boortmalt. Previous to this he held board and senior level positions with Greencore Malt and Pauls Malt Ltd.

David has previously been a trustee and director of Age UK, Suffolk, vice chair and trustee of St Elizabeth Hospice, Ipswich and chair and trustee of East Anglia's Children's Hospices (EACH).

Independent director – yes (satisfies criteria of code of governance B. 1.1)

Note 1
Dr Richard Davies is a nominated appointment by the University of Cambridge. The appointment as a NED is reviewed and approved by the council of governors. This review considered relevant skills and experience, including his ability to provide independent challenge to the Trust. As such the role is considered to be an independent director, despite his nominated status.

(b) Executive directors

Mr Craig Black – interim chief executive (from August 2021)

Areas of responsibility: finance, capital investment, commissioning, IT, information and performance, estates and environment.

Craig joined the Trust in April 2011 from Cambridge University Hospitals NHS Foundation Trust, where he was director of commissioning. Following his role as executive director for resources and deputy chief executive at this Trust, Craig stepped into the role of interim chief executive in August 2021.

He was previously deputy director of finance at both Cambridge University Hospitals NHS Foundation Trust and The Ipswich Hospital NHS Trust.

Craig has 28 years' experience within the NHS. Having graduated from the national financial management training scheme he has worked in health authorities, a community and mental health trust and a primary care trust, as well as a number of acute hospitals in Surrey and East Anglia.

Nicola Cottington - chief operating officer (from 1 November 2021)

Areas of responsibility: prior to joining the Trust in November 2021, Nicola was deputy chief operating officer at James Paget University Hospitals NHS Foundation Trust, associate director of operations roles at West Suffolk NHS Foundation Trust and Mid Essex Hospital Trust and assistant director roles at Suffolk Community Healthcare and Bromley Healthcare.

Mr Jeremy Over – executive director of workforce and communications*

Areas of responsibility: oversees all aspects of the Trust's workforce strategy and practice, including: organisational development; leadership and management development; education and training; welfare and staff wellbeing including occupational health; equality, diversity and inclusion; pay and reward; employee relations, recruitment and workforce planning. He is also executive lead for communications (including public relations), fundraising and volunteers.

Prior to joining the Trust in November 2019 Jeremy was director of workforce at Norfolk and Norwich University Hospitals NHS Foundation Trust. He has over 20 years' experience in people management and development roles in the NHS, having started out as a training officer in his home town of Hereford. He also held an executive role at the University College London Hospitals NHS Foundation Trust.

Jeremy is a fellow of the Chartered Institute of Personnel and Development and former chair of NHS Employers medical workforce forum.

Mrs Susan Wilkinson – executive chief nurse

Areas of responsibility: joint operational responsibility with the chief operating officer and medical director for the operational management and delivery of all clinical services. Also, professional leadership for nurses, midwives and allied health professionals, nursing strategy and nurse management, professional education, clinical governance and quality, safeguarding children, vulnerable adults, risk management, integrated governance, complaints, litigation and chaplaincy. Sue is also the director of infection prevention and control; CQC lead for the Trust.

Sue was appointed as interim executive chief nurse in June 2020 and was successful in her substantive appointment in December 2020

Sue joined us from East and North Hertfordshire acute trust where she was deputy director of nursing. Prior to this she worked at Cambridge University Hospitals where she held a number of roles including clinical nurse specialist in colorectal surgery; divisional head of nursing for surgery, and assistant director of nursing. Sue is a registered nurse and has previously been a divisional head of nursing for surgery, and assistant director of nursing.

Sue is a registered nurse and has a BSc in health care studies, including advanced practice and non-medical prescribing and an MSc in health care management and leadership.

Nick Macdonald - interim executive director of resources (from 9 August 2021)

Areas of responsibility: prior to being appointed as interim executive director of resources, Nick was deputy director of finance at West Suffolk NHS Foundation Trust

Nick has also worked as head of financial management, Cambridge University Hospitals NHS Foundation Trust.

Dr Paul Molyneux - interim executive medical director (from 1 June 2021)

Areas of responsibility: prior to being appointed to the role of Interim Medical Director on 1st June, 2021,Paul was consultant in neurology at West Suffolk and Cambridge University Hospitals, Deputy Medical Director, at West Suffolk NHS Foundation Trust and clinical director for specialist medicine at WSFT and secondary care specialist at North East Essex CCG.

Executive directors who left the Trust during 2021-22

Mrs Helen Beck – chief operating officer (stepped down in November 2021)

Areas of responsibility: performance management and joint operational responsibility with the medical director and chief nurse for the operational management and delivery of all clinical services. Also responsible for transformation and service/business development. Board lead for emergency planning and preparedness.

Helen joined the Trust in September 2014 as deputy chief operating officer, having previously held positions at Cambridge University Hospital as senior operational manager and theatre manager.

Helen has 36 years' experience in the NHS and is a registered general nurse with a diploma in theatre nursing.

Dr Stephen Dunn CBE – chief executive (stepped down in August 2021)

Areas of responsibility: Stephen was responsible for meeting all the statutory requirements of WSFT, in addition to being the Trust's chief accounting officer to Parliament.

Stephen joined the Trust as chief executive in November 2014 from the NHS Trust Development Authority where he was regional director of delivery and development for the south.

Stephen's previous experience was as a director of policy and strategy at NHS Midlands and East; director of strategy and provider development at NHS East of England; and senior civil servant at the Department of Health. Trustee of Brightstars, a registered charity that supports five to 19-year-old children and young people with additional needs, a director of Helpforce and honorary commander of RAF Lakenheath. Stephen was appointed a Commander of the Order of the British Empire (CBE) in the New Year's Honours 2019.
Dr Nick Jenkins - executive medical director (stepped down in June 2021) **Areas of responsibility:** joint operational responsibility with the chief operating officer and chief nurse for the operational management and delivery of all clinical services. Also responsible for clinical audit; clinical networks; clinical research; GP liaison; post- graduate education and overarching responsibility for patient safety. Nick was the responsible officer for the General Medical Council (GMC) and Caldicott Guardian. He also led the Trust's vaccination programme. Nick is a consultant in emergency medicine and joined the Trust in October 2016 from Warrington and Halton NHS Foundation Trust, where he was deputy medical director. Prior to this he was a secondary care specialist for Haringey Clinical Commissioning Group. Nick was on the NHS Leadership Academy executive fast track programme. Nick stepped down from his role as medical director at the end of May 2021. Deputy medical director Dr Paul Molyneux took over in the interim while the recruitment process for a replacement takes place.

* Non-voting director

During 2021-22 Kate Vaughton, director of integration and partnerships who was employed and remunerated by West Suffolk Clinical Commissioning Group attended WSFT Board meetings on a regular basis along with Clement Mawoyo, director of integrated adult health and social care who is a joint appointment funded by West Suffolk NHS Foundation Trust and Suffolk County Council.

2.2.3 Register of interests

All directors are required to declare any interests on the register at the time of their appointment. This register is reviewed and maintained by the trust secretary. The register is available for inspection by members of the public. Anyone who wishes to see the register should contact the trust secretary at the following address: Trust secretary, Foundation Trust Office, West Suffolk NHS Foundation Trust, West Suffolk Hospital, Hardwick Lane, Bury St Edmunds, Suffolk IP33 2QZ.

2.2.4 Appointment of chair and non-executive directors

The council of governors has the responsibility for appointing the chair and non-executive directors in accordance with WSFT's constitution and in accordance with paragraph 19(2) and 19(3) respectively of schedule 7 of the National Health Service Act 2006.

The nomination, appointments and remuneration committee of the council of governors makes a recommendation for appointment for a non-executive director to the council of governors. This committee comprises the chair of WSFT, four public governors (including the lead governor), one staff governor and one partner governor. The committee is chaired by the Trust chair, except when considering the appointment, remuneration and terms and conditions of the Trust chair, when it is chaired by the lead governor.

Non-executive director appointments are normally for a term of three years. Following their first term, and subject to satisfactory appraisal, a non-executive director will normally be reappointed for a second term without competition. This assumes Board competency requirements have not changed. Following this second term, and subject to satisfactory appraisal, a non-executive director can be considered by the council of governors for a further term of office subject to annual renewal. Vacant non-executive directors' positions will

be subject to an openly-contested process with appointment by the council of governors.

The removal of a non-executive director requires the approval of three-quarters of the members of the council of governors. Details of the criteria for disqualification from holding the office of a director can be found in paragraph 31 of WSFT's constitution.

Disclosures of the remuneration paid to the chair, non-executive directors and senior managers are given in the remuneration report (section 2.7).

2.2.5 Evaluation of the Board of directors' performance

Attendance at Board of Directors meetings 2021-22

Name	Title	Attendance (out of 9)
Jude Chin [a]	Interim Chair	4 (of 5)
Craig Black [b]	Interim CEO	9 (of 9)
Nicola Cottington [c]	Chief operating officer	3 (of 3)
Richard Davies	Non-executive director	8
Jeremy Over	Executive director of workforce and communications	9
Louisa Pepper	Non-executive director	7
Alan Rose	Non-executive director	8
Susan Wilkinson	Executive chief curse	9
Nick Macdonald [d]	Interim Executive director of resources	4 (of 4)
Paul Molyneux [e]	Interim Executive medical director	6 (of 7)
Individuals no longer on the Board		
Sheila Childerhouse [f]	Chair	7 (of 7)
Stephen Dunn [g]	Chief executive	4 (of 4)
Angus Eaton [h]	Non-executive director	2 (of 2)
Nick Jenkins [i]	Executive medical director	2 (of 2)
Rosemary Mason [j]	Associate non-executive director	2 (of 2)
David Wilkes [k]	Non-executive director	2 (of 2)

(a) Jude Chin was appointed as interim NED from 1 September 2021 (attended 1 of 2 meetings) and interim Chair from 1 February 2022 (attended 3 of 3 meetings)
(b) Craig Black was executive director of resources (attended 4 of 4 meetings) and was appointed as interim CEO in August 2021 (attended 5 of 5 meetings)
(c) Nicola Cottington was appointed 1 November 2021
(d) Nick Macdonald was appointed 9 August 2021
(e) Paul Molyneux was appointed 1 June 2021
(f) Sheila Childerhouse stepped down in January 2022
(g) Stephen Dunn stepped down in August 2021
(h) Angus Eaton stepped down in May 2022
(i) Nick Jenkins stepped down in August 2021
(j) Rosemary Mason stepped down in June 2021
(k) David Wilkes stepped down in June 2021

Meeting dates

• 30 April 2021	• 28 May 2021
• 25 June 2021	• 30 July 2021
• September 2021	• 15 October 2021
• 17 December 2021	• 28 January 2022
• 25 March 2022	

Drawing on best practice from the commercial sector the Board undertakes a regular review of its governance arrangements. The review takes into account regulator guidance on quality and governance.

The Trust's governance structure was strengthened during 2021-22 to provide a greater focus on culture, patient safety and quality through three assurance committees of the Board:

- **Insight Committee** with a focus on operations, finance and organisational risk
- **Involvement Committee** on people and organisational development
- **Improvement Committee** on quality, patient safety and change management.

A report from each meeting of is received by the Board. The separation of this accountability and reporting line from the audit committee is fully consistent with good practice, allowing the audit committee to provide a truly independent and objective view of the Trust's internal control environment.

The escalation arrangements within the governance structure ensure timely and effective escalation from directorates and specialist committees to the Board via the trust executive group. The assurance committees' chair key issues reports, governance report and serious incident, inquests, complaints and claims report are standing agenda items on the Board and include escalation of risks from Board committees and other sources.

Committees of the Board of directors report on their activities through minutes and reports. These provide assurance to the Board on its committees' activities and effectiveness.

The chair and trust secretary have worked with the council of governors to develop an appropriate appraisal process for the chair and non-executive directors. The chair is formally appraised by the lead governor and senior independent director. Appraisal of non-executive directors is carried out by the chair. Governors and directors contribute to these appraisals through feedback questionnaires.

A 360º appraisal process is used for executive directors. The chief executive is subject to annual formal appraisal by the chair. Executive directors are subject to annual appraisal by the chief executive which informs development plans. Evidence of performance against objectives is monitored by the Board of directors through the remuneration committee, performance management arrangements and the board assurance framework.

The Board of directors has reviewed its skill set and uses this to inform a development programme for Board members. Appropriate external expertise is used to support delivery of this programme.

2.2.6 Audit committee

Membership of this committee is made up of non-executive directors and is chaired by a NED with appropriate financial expertise. The committee has overarching responsibility for monitoring specific elements of the systems and processes relating to governance, including financial systems, records and controls; financial information; compliance with law, guidance and codes of conduct; independence of internal and external audit; and the control environment (including measures to prevent and detect fraud). The committee is responsible for providing an opinion as to the adequacy of the integrated governance arrangements and board assurance framework.

The directors are responsible for preparation of the accounts under direction by NHS Improvement (NHSI) in exercise of powers conferred on it by paragraphs 24 and 25 of schedule 7 of the National Health Service Act 2006.

External audit

KPMG, was appointed as WSFT's external auditor in October 2021. KPMG reports to the council of governors through the audit committee. KPMG's accompanying report on the financial statements is based on its examination conducted in accordance with the audit code for NHS foundation trusts, as issued by NHSI, independent regulator of foundation trusts.

The responsibility of the Trust's external auditors is to independently audit the financial statements and the part of the remuneration report to be audited in accordance with relevant legal and regulatory requirements and International Standards on Auditing (UK and Ireland).

As part of the approval of the annual external audit plan, the external audit process is subject to review by the Trust in terms of competency, efficiency and the relationship between the Trust and its auditors. The audit

committee meets with the external auditor without officers present on an annual basis.

The council of governors in its closed session appointed KPMG as the Trust's external auditors for a three-year contract on 13 October 2021. The appointment covers three financial years 2021-22, 2022/23 and 2023/24. The estimated cost of statutory services/audit fee was £135k for the financial year 2021-22.

Non-audit work may be performed by the external auditors where the work is clearly audit related and the external auditors are best placed to do that work. For all such assignments the audit committee will be advised, which will ensure that objectivity and independence is safeguarded. No such work was undertaken in 2021-22.

Internal audit

RSM, WSFT's internal auditor, is responsible for undertaking the internal audit functions on behalf of the Trust. Its role is to provide independent assurance that an organisation's risk management, governance and internal control processes are operating effectively. The head of internal audit reports to each meeting of the audit committee on the audit activity undertaken.

System of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of the Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.

Attendance at audit committee meetings

Name	Title	Attendance (out of 5)
Jude Chin (start date 1 Sept 2021)	Interim non-executive director	1 (of 1) *
Richard Davies	Non-executive director	5 (of 5)
Louisa Pepper	Non-executive director	5 (of 5)
Alan Rose	Non-executive director	4 (of 5)
Christopher Lawrence (start date 1 June 2021)	Non-executive director (audit committee chair)	4 (of 5)
Angus Eaton (last date 31.05.2021)	Non-executive director (audit committee chair)	1(of1)
Rosemary Mason (last date 22.06.2021)	Associate non-executive director	1(of 1)
David Wilkes (last date 11.06.2021)	Non-executive director	1(of1)

(a) Jude Chin was appointed interim chair on 1 February 2022 and therefore no longer a member of the audit committee

Meeting dates: 30 April 2021, 25 June 2021, 30 July 2021, 5 November 2021 and 1 March 2022

2.2.7 Well-led framework

Quality, which encompasses patient safety, clinically effective outcomes and patient experience, is at the heart of the Board and organisation's agenda. In times of financial constraints the challenge for WSFT is making sure that every pound spent brings maximum benefit and quality of care to patients. Improving quality can help to reduce costs by getting it right first time and avoiding harm to patients.

Details of improvements that we have made in patient safety are given elsewhere in this report, including section 2.6 (annual governance statement). The annual governance statement also describes the arrangements the Board of directors has put in place to deliver and monitor quality.

The Board of directors reviews the arrangements in place to deliver quality as part of the annual governance review it undertakes. This includes a review of relevant assurances within the board assurance framework. During 2021-22 the Board engaged with senior leaders to review its subcommittee structure and assurance arrangements for quality, safety, engagement and improvement. Discussion will take place with NHS England and Improvement regarding timing of a well-led developmental review to evaluate the implementation and effectiveness of the new structure. Further details of the structure are provided in the annual governance statement (section 2.6).

2.2.8 Details of consultation

Local groups and the public and patient involvement activities

Public engagement has unfortunately been limited throughout the year due to COVID-19 restrictions. The Trust's patient and public engagement group, VOICE, has remained involved as much as has been possible. Its engagement activities have included:

- Assisting the Future System programme team with patient surveys
- Attended patient workshops organised by the Future System programme
- Supporting staff across the Trust in patient engagement projects
- Creating new project roles for VOICE members in accordance with Trust needs
- Input into the NHS England / Improvement framework for involving patients in patient safety
- Establishing links to local community networks and groups
- Attending local events
- Linking in with other patient groups and attending their meetings

The relaxation of regulations around volunteers being present on site in June 2021 allowed VOICE members to continue their patient project work in person. In addition, with more resource within the patient experience and engagement team being dedicated to engagement, this has provided more support to VOICE, enabling an increase in activity with local groups and service users.

Future System programme

A new healthcare facility is set to be built for the people of west Suffolk by the people of west Suffolk, Members of the local community, staff and stakeholders of West Suffolk NHS Foundation Trust (WSFT), will be involved in meaningful engagement, and invited to co-produce the building design and clinical model to be used. It means everyone, from patients and carers to staff and local partners – has an equal stake in developing the new hospital and its services.

The result will be a building design and clinical model that is fit for the needs of our population now and, in the future for generations to come.

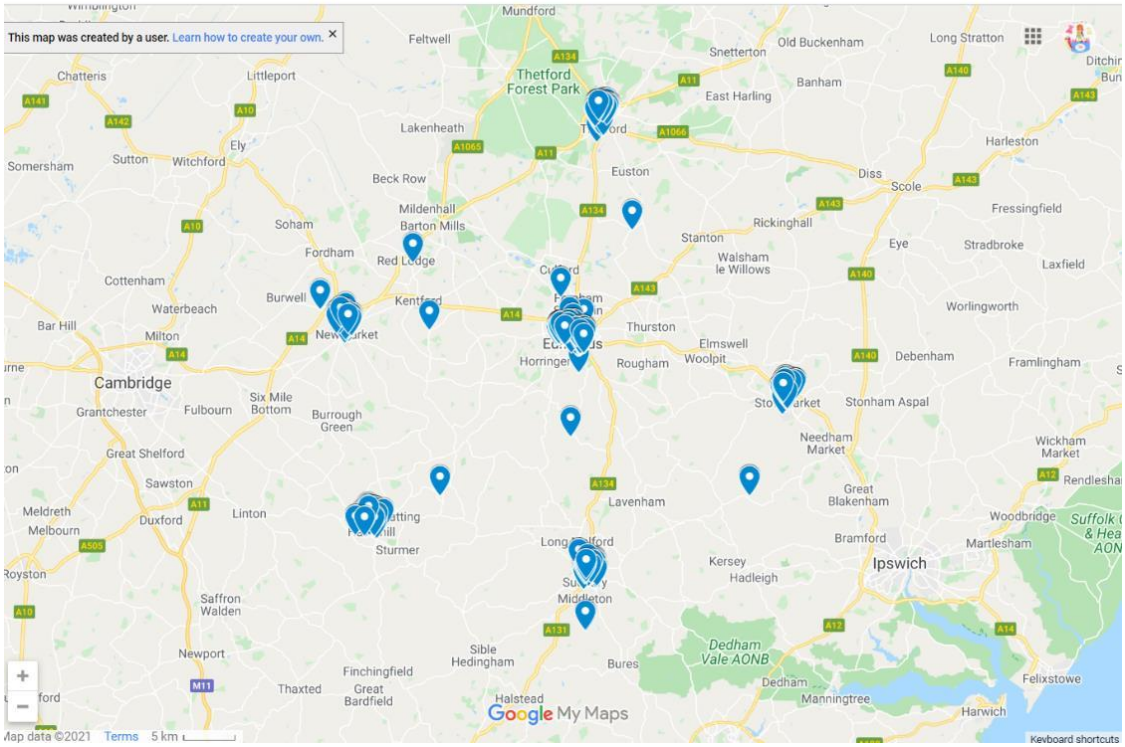
The engagement activity carried out so far has been focused separately on the estate and building work, and the clinical design.

Estate

Phase 1 pre-application outline planning engagement

In June 2021 the first phase of planning engagement was launched to gather people's views about the preferred site of Hardwick Manor. More than 800 feedback forms were received and 150 people spoke to us both face to face and virtually at our events. We reached nearly 60,000 people online via sharing social media posts via our channel, some of which were paid for ; and we received nearly 7,000 hits to the website.

Feedback was gathered across West Suffolk as demonstrated in the map below. The requirement for planning is to gather feedback within the immediate area (Bury St. Edmunds), however, the Trust was keen to carry out significant engagement and to gather views from across our patient catchment area.



Phase 2 pre-application outline planning engagement

The second phase of the pre-application planning engagement launched on schedule on 1 November and ran for six weeks until 12 December 2021.

A similar format was followed to the first round of pre-application planning engagement, with a range of digital and non-digital approaches taken to remain inclusive. These included:

- A leaflet and feedback form that was posted to nearly 30,000 members of the community within the vicinity of the hospital, and to those within a half-mile radius of each face to face event, ahead of the launch of the engagement period to ensure everyone had the maximum time available to digest the information
- Update sent to project newsletter mailing list with a circulation of more than 200 people
- Paid for advert placed in the Bury Free Press newspaper and Elmswell intouch magazine
- Community pop-up events in Bury St Edmunds, Haverhill, Thetford, Newmarket, Sudbury, Mildenhall, Brandon and Stowmarket
- Pop up events at West Suffolk Hospital on Hardwick Lane site and Newmarket Community Hospital
- Two virtual engagement events held for staff
- Virtual engagement event for local residents
- Virtual engagement event for the general public
- Social media adverts to publicise the engagement events and drive traffic to the website
- Social media posts
- Stakeholder meetings were arranged with local councillors, Thetford planning committee, Newmarket planning committee (cancelled by the council due to COVID-19) and Barrow Parish Council (cancelled by the council)
- Dedicated project website (including an online feedback form)
- Press releases to local media ahead of the launch of the phase to raise awareness and maximise the engagement time available
- Freepost address and project email address
- Opportunity shared with members of the project's community engagement group, Trust members, governors, charitable donors, volunteers, patient experience VOICE group and staff, through existing channels.

As always, the team were keen to hear from as many people as possible so the website and online feedback form were compatible with screen readers. The online feedback form could also be translated into several languages at a flick of a switch. The printed leaflet was available in easy read, large print, Portuguese, Polish and Russian and could be sent back at no cost using the Freepost address or handed in at any event.

In order to make the events suitable for as many people as possible, the first hour of each event was sensory friendly with lights turned down, quieter and limited numbers.

We were also mindful of the shifts and working patterns that our staff are committed to. Because of this, two face to face events were arranged for the Hardwick Lane and Newmarket Community Hospital sites. Originally this was for patients too, but in light of the latest WSFT COVID-19 visiting restrictions, it was limited to just staff. Two online events were also held for staff at 12noon and 8:00pm considering the time of people's shifts. In total this reached 95 people.

A number of stakeholder briefings were held with local councillors including councillors Soons, Stamp and Chung. Further briefings were due to be delivered to Newmarket planning committee and Barrow Parish Council however these were cancelled by the respective councils. Briefings were delivered to Thetford planning committee and Bury Residents' Association.

Nine face to face events were held, three more than during phase 1, following public feedback, and two online events. These events were not purely for Bury St. Edmunds but expanded across West Suffolk and South Norfolk recognising our patient catchment area. One of the face to face events was specifically for neighbours of the hospital to raise and discuss their concerns.

The two pre-application phases together, which took place during 2021, resulted in:

- 129,000 people reached online via social media posts and adverts, with significant likes and shares across Facebook, Instagram and Twitter; 12,711 visits to both our websites
- Speaking to nearly 450 people online and face to face at our events
- Receiving more than 1,792 completed feedback forms via the post, at events and online.

Over-arching feedback is broadly positive, with concerns raised around building height, traffic and car parking. Many individuals would like concrete plans for these elements, however, they do understand that we are not in a position to confirm these as yet.

An application for outline planning permission was submitted to the local planning authority at the end of March 2022. A complete overview of the pre-application public planning engagement can also be seen in the statement of community involvement, which was submitted as part of our outline planning application and can be accessed on the local planning authority portal.

Clinical services engagement

The current clinical services operating in the West Suffolk Hospital building at Hardwick Lane have been split into 12 co-production workstreams, each with their own lead(s) recruited from the WSFT workforce. The leads are forming planning groups to include the views and ideas of everyone who has an interest or viewpoint in each service.

Each workstream includes clinical and operational staff relevant to the workstream and includes viewpoints from patients and the local community. Co-production leads are also tasked with working with peers and partners across the health and care system to develop plans fit for now, the future, and fit for the healthcare system as a whole.

To support the clinical engagement co-production work, engagement with the public mirrored these phases of work.

Phase 1
Bespoke engagement events were carried out with key demographics including young adults and those under 16. Two surveys were launched – one aimed at staff and the other aimed at patients, which ran for

approximately eight weeks.

- Both the staff and patient survey were translated into Polish and Portuguese to increase accessibility
- Nearly 200 responses were received.

Phase 2
Phase 2 of the clinical patient and staff engagement was via an online survey.

In total 253 people responded. The feedback generated was predominately from patients, with 25% of responses from staff.

A number of areas were explored including remote appointments, the use of the Patient Portal and where appointments should be held.

To provide a snapshot:

- 57% of the public did not have a preference as to when their appointment was and subsequently 75% were happy to have an appointment in an evening or weekend, 62% were happy with either
- A majority of the public said that their appointment had not been delivered using technology which was concurrent with staff feeling that they could make better use of technology
- Staff felt they needed better connectivity, equipment and improved WiFi to make better use of technology
- Patients who did receive their appointment via video phone call or telephone felt the greatest benefits were less travelling time, the ability to have their carer present, and it was more comfortable and more convenient
- 88% of responders felt that mental health and social influences should be considered when treating an ailment
- In terms of ward configuration, 81% of the public who responded stated they would prefer to stay in a single room compared to 48% staff who preferred to treat patients in a single room.

The survey also detailed what would improve patient experience and what is expected of a 21st century facility as well as a breakdown of responses specific to each clinical area.

To supplement this work community engagement group sessions were carried out for all workstreams (14 in total). 80 people attended which averaged at six attendees per session. This is not representative of the number of views captured, for example one attendee spoke to 20 members prior to attending the meeting.

Phase 3
Specific engagement was carried out to cover three clinical areas. These included the delivery of the Denosumab injection, point of care testing and the medical termination of pregnancy service.

A survey was sent to 90 Denosumab patients via the DrDoctor mobile application. The survey received a response rate of 21%. There are a number of landline numbers where surveys can be completed over the phone and with additional resource it was recommended that this is pursued.

Literary and field engagement was carried out for point of care testing and this will be revisited in the future once the remit has been narrowed.

Surveys were handed out to patients waiting to be seen in the WSFT medical termination of pregnancy clinic. Despite each patient being given a survey the return rate was low.

Engagement reports were compiled for each area and supplied to the clinical workstream.

Phase 4
Phase 4 launched at the beginning of March 2021 and will culminate in May 2022. 26 focus groups were arranged throughout March, comprising two groups per department across 13 departments or services at various times of the day to capture as many people as possible. These groups were attended by 68 people. To support this, a survey ran that has received more than 400 responses.

In June 2022, those who attended the workshops will be invited back to see the latest designs that our co-

production leads and our architect, Ryders, has been working on (note – patients have not seen any departmental designs so far). The overall findings will be included in the 2022-2023 annual report.

It is important that we hear and include views from a range of perspectives. We have had meetings and conversations with audiences which have included:

- Those with learning disabilities
- Those with severe mental health needs
- Homeless and rough sleeper community
- Young adults and students
- Staff
- Patients who have suffered a stroke or care for someone who has
- Women's Institute groups
- Residents' associations
- Local councils and councillors.

Community Engagement Group and Peer Review Panel

Whilst there is a governance structure in place, which is important for a project of this magnitude, there is understanding and support for the co-production process throughout the project. This approach is not just an ethos but a way of working which will hopefully be replicated Trust-wide.

Peer review panel
Each of the co-production work streams is focusing on its service area and engaging with patients and clinical and operational staff. Prior to it being presented to the programme board, an independent peer group will provide a holistic view of the proposals from a staff and clinical perspective. The panel will provide knowledgeable peer review scrutiny of the methodology used and the recommendations generated from each of the workstreams. This provides a sense check against other policy mandates, prevailing trends and background intelligence.

The panel will comprise a designated deputy from each of the Trust executive directors to ensure that each director can have confidence in the recommendations being made. They will also provide an unbiased and independent assessment in scrutinising and approving recommendations.

The members of the panel are as follows:
- deputy chief operating officer
- deputy chief nurse
- a deputy medical director
- a suitable deputy for the director of integration
- a deputy director of workforce
- a deputy director of finance.

Once recommendations have been validated, they can be sent to external partners for any additional suggestions and inputs. On final endorsement of recommendations, papers can be submitted for approval to the programme board for ratification. Papers will then be submitted to the WSFT Board for final approval.

Community engagement group
To sit alongside this and provide an independent view from a community and patient perspective a community engagement group has been established.

The group discusses proposals before they are presented to the project board for final decision. They are advocates for the project and our eyes and ears in the community. This group meets on an ad hoc basis and has a rolling membership meaning that those who have requested to join the group do not have to attend every meeting.

We ask for people to express an interest in joining the group, and each meeting includes different individuals with an interest in the matters being discussed at that meeting. However, it is important that a broad

representation of views can be heard at every meeting.

The ethos of co-production is embedded in the future system programme. One of the key elements of this is developing clinical and design proposals with our patients, staff and stakeholders, such as governors and the community, working with those it affects the most.

In March 2021 we introduced the community engagement group (formerly known as the co-production community engagement group). To date we have nearly 200 members that we can call on to participate in bespoke focus groups and workshops to develop our clinical visions. The Trust's patient experience VOICE group assisted in developing a new name for the group.

Other engagement activity
The Trust has engaged closely with its key external stakeholders throughout the programme, including system partners, NHS England and Improvement, Suffolk and North East Essex Integrated Care System and the Department of Health and Social Care. All these stakeholders have representatives on the programme board and have played an active role in the governance of the programme. Other key groups with which we have a close relationship are:

- VOICE patient representatives
- West Suffolk Alliance engagement group.

Accessibility

All communication and engagement activities have considered accessibility needs, with mitigations made where possible. The Trust will continue to create items which can be accessed and understood by all, including working with adult speech and language therapist colleagues on language and layout.

The Trust will host briefings online which will be recorded and feature subtitles in various languages. As soon as restrictions allow, briefings will be held face to face to widen the reach of engagement as far as possible. These will be held at various times to ensure maximum participation by all audiences and members of the community.

The Trust is working with system partners to reach those seldom heard, including rough sleepers, homeless people, sex workers, refugees, asylum seekers, the Gypsy, Roma and Traveller communities, and the younger members of our community.

Bespoke sessions will be held which are accessible for those with learning disabilities or severe mental and physical disabilities.

Public consultation

As a part of the Future System clinical co-production, the team has been working with staff and patients to understand how clinical services could (and arguably should) look like in the future. This has included the possibility of some clinical services being delivered in a different way and/or from a different location.

As stated in the Health and Social Care Act 2012, Section 242 of the National Health Service Act 2006, and Equality Act 2010, if a service provision is changing from a service users perspective then this would require public consultation.

To evaluate the potential impact of any service change, templates have been developed. Should a feasible option be identified, this would be developed with members of staff and the community and presented to the local Health Overview Scrutiny Committee with a plan demonstrating how views would be captured.

Whilst the potential for service change has been identified through work initiated by the co-production process, its execution will take place within a time frame and budget that is independent to that of the Future System programme. Consequently, responsibility for any public and/or staff consultation and the construction/approval of a suitable business case sits with the team leading the necessary project.

With regard to the location of the new hospital, whilst the preferred site has been announced, the Trust is continuing to explore other avenues and has not ruled out other locations depending on feasibility. The current recommendation of Hardwick Manor as the Trust's preferred site means that the location of services provided by the Trust at the present acute site will not be significantly changed and thus the need for formal public consultation is not currently necessary. The decision to consult in the future will remain open until further decisions about changes to the location are made. At this point a formal consultation will be launched.

For any formal consultation, the Trust will follow advice to hold this over a minimum of 12 weeks to make sure it is in line with best practice guidelines.

Communications

Website
A website all about the new hospital is available at https://www.wsh.nhs.uk/New-healthcare-facility/New-healthcare-facility.aspx.

The website features engagement opportunities, up to date information on the programme, including news updates, frequently asked questions and contact details.

A dedicated website regarding the pre-application planning engagement and indicative designs was launched at https://www.wsh.nhs.uk/Planning/Planning.aspx

Newsletter
A newsletter has been launched and more than 300 people have subscribed to it.

Communication with residents
It is important for the programme team to maintain transparency and build good relations with our close neighbours. To this end, regular communications have been sent to local residents, particularly relating to milestones and updates which may impact them. Feedback routes are also clear, allowing the relationship to be mutually beneficial.

Stakeholder briefings
Briefings are supplied to key stakeholders at each milestone, providing clear and transparent information which may be of interest.

2.2.9 Other disclosures

Companies Act disclosures

To improve the readability of the annual report a number of disclosures relevant to the directors' report have been included in the strategic report. These are:

- important events since the end of the financial year affecting WSFT
- an indication of likely future developments
- actions taken in the financial year to provide employees with information on matters of concern to them
- actions taken in the financial year to consult employees or their representatives on a regular basis so that the views of employees can be taken into account in making decisions which are likely to affect their interests
- actions taken in the financial year to encourage the involvement of employees in WSFT's performance
- actions taken in the financial year to achieve a common awareness on the part of all employees of the financial and economic factors affecting the performance of WSFT.

Cost allocation
The Trust has complied with the cost allocation and charging requirements as set out in HM Treasury and Office of Public Sector Information guidance.

Income statement

The Trust has met the requirement of Section 43(2A) of the NHS Act 2006 (as amended by the Health and Social Care Act 2012) that the Trust's income from the provision of goods and services for the purposes of the health service in England must be greater than its income from the provision of goods and services for any other purposes. Other income that the Trust has received has had no impact on its provision of goods and services for the purposes of the health service in England.

Political donations

The Trust did not make any political donations during 2021-22.

Better payments practice code

The Trust is a signatory to the better payments practice code. This requires the Trust to aim to pay all undisputed invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later. The Trust has paid £3k of interest under the Late Payment of Commercial Debts (Interest) Act 1998 in 2021-22 (2020-21 £0).

	2021-22		2020-21	
	Number	£'000	Number	£'000
Total non-NHS trade invoices paid in the year	51,861	263,449	47,952	199,575
Total non-NHS trade invoices paid within target	32,417	208,951	35,411	160,185
Percentage of non-NHS bills paid within target	**62.5%**	**79.3%**	**73.8%**	**80.3%**
Total NHS trade invoices paid in the year	2,707	32,312	1,477	21,357
Total NHS trade invoices paid within target	1,661	24,104	664	13,177
NHS trade invoices paid within target (%)	**61.4%**	**74.6%**	**45.0%**	**61.7%**
Total percentage of bills paid within target	**62.5%**	**78.8%**	**73.0%**	**78.5%**

Statement regarding the annual report and accounts

It is the responsibility of the directors to present a fair, balanced and understandable assessment of the WSFT's position and prospects. The directors consider the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for stakeholders to assess WSFT's performance, business model and strategy.



Craig Black
Interim Chief Executive
15 September 2022

2.3 Foundation trust code of governance compliance

The Trust has applied the principles of the NHS foundation trust code of governance on a comply or explain basis. The NHS foundation trust code of governance, most recently revised in July 2014, is based on the principles of the UK corporate governance code issued in 2012.

The Board of directors supports the principles set out in the NHS foundation trust code of governance. The way in which the Board applies the principles and provisions is described within the various sections of the report and the directors consider that the Trust has been compliant with the code.

Disclosures relating to the council of governors and its committees are in the governors' report (section 2.1). Disclosures relating to the Board of directors and its committees are in the directors' report (section 2.2).

The Board was not fully compliant with code requirement B.1.2 that at least half the board of directors, excluding the chairperson, should comprise non-executive directors as there was a gap between the end of Gary Norgate's term of office on 31 May 2020 and David Wilkes' appointment from 31 July 2020.

2.4 NHS Improvement's single oversight framework

NHS England and NHS Improvement's NHS Oversight Framework provides the framework for overseeing providers and identifying potential support needs. The framework looks at five themes:

- quality of care
- finance and use of resources
- operational performance
- strategic change
- leadership and improvement capability (well-led).

Based on information from these themes, providers are segmented from 1 to 4, where '4' reflects providers receiving the most support, and '1' reflects providers with maximum autonomy. A foundation trust will only be in segments 3 or 4 where it has been found to be in breach or suspected breach of its licence.

Segmentation

The Trust has been placed in segment 3. This segmentation information is the Trust's position as at 16 May 2022. Current segmentation information for NHS trusts and foundation trusts is published on the NHS Improvement website.

2.5 Statement of accounting officer's responsibilities

Statement of the chief executive's responsibilities as the accounting officer of West Suffolk NHS Foundation Trust

The NHS Act 2006 states that the chief executive is the accounting officer of the NHS foundation trust. The relevant responsibilities of the accounting officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the NHS Foundation Trust Accounting Officer Memorandum issued by NHS Improvement.

NHS Improvement, in exercise of the powers conferred on Monitor by the NHS Act 2006, has given Accounts Directions which require West Suffolk NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of West Suffolk NHS Foundation Trust and of its income and expenditure, other items of comprehensive income and cash flows for the financial year.

In preparing the accounts and overseeing the use of public funds, the accounting officer is required to comply with the requirements of the Department of Health and Social Care Group Accounting Manual and in particular to:

- Observe the Accounts Direction issued by NHS Improvement, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- Make judgements and estimates on a reasonable basis
- State whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual (and the Department of Health and Social Care Group Accounting Manual) have been followed, and disclose and explain any material departures in the financial statements
- Ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance
- Confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS foundation trust's performance, business model and strategy
- Prepare the financial statements on a going concern basis and disclose any material uncertainties over going concern.

The accounting officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS foundation trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned Act. The accounting officer is also responsible for safeguarding the assets of the NHS foundation trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

As far as I am aware, there is no relevant audit information of which the foundation trust's auditors are unaware, and I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the entity's auditors are aware of that information.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in the *NHS Foundation Trust Accounting Officer Memorandum*.



Craig Black
Interim Chief Executive
15 September 2022

2.6 Annual governance statement

West Suffolk NHS Foundation Trust annual governance statement – 1 April 2021 to 31 March 2022

Scope of responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that *supports* the achievement of the NHS trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the NHS Trust Accountable Officer Memorandum.

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of [insert name of provider] NHS Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in West Suffolk NHS Foundation Trust for the year ended 31 March 2022 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

The system of internal control is underpinned by compliance with the Trust's terms of authorisation and the requirements of regulatory bodies relevant to foundation trusts. The Trust has a risk management policy and strategy which make it clear that managing risk is a key responsibility for the Trust and all staff employed by it.

The Board of directors and council of governors receive regular reports that detail quality, financial and operational performance risk, and, where required, the action being taken to reduce identified high-level risks.

The audit committee provides an independent and objective view of WSFT's internal control environment and the systems and processes by which the Trust leads, directs and controls its functions in order to achieve organisational objectives, safety, and quality of services, and in which they relate to the wider community and partner organisations. The audit committee independently reviews the effectiveness of risk management systems, ensuring that all significant risks are properly considered and communicated to the Board of directors. It reviews implementation of the board assurance framework to assure itself that risks are being appropriately identified and managed and appropriate assurance obtained. This is supported by "deep dive" review of risks from the board assurance framework, supported by internal audit.

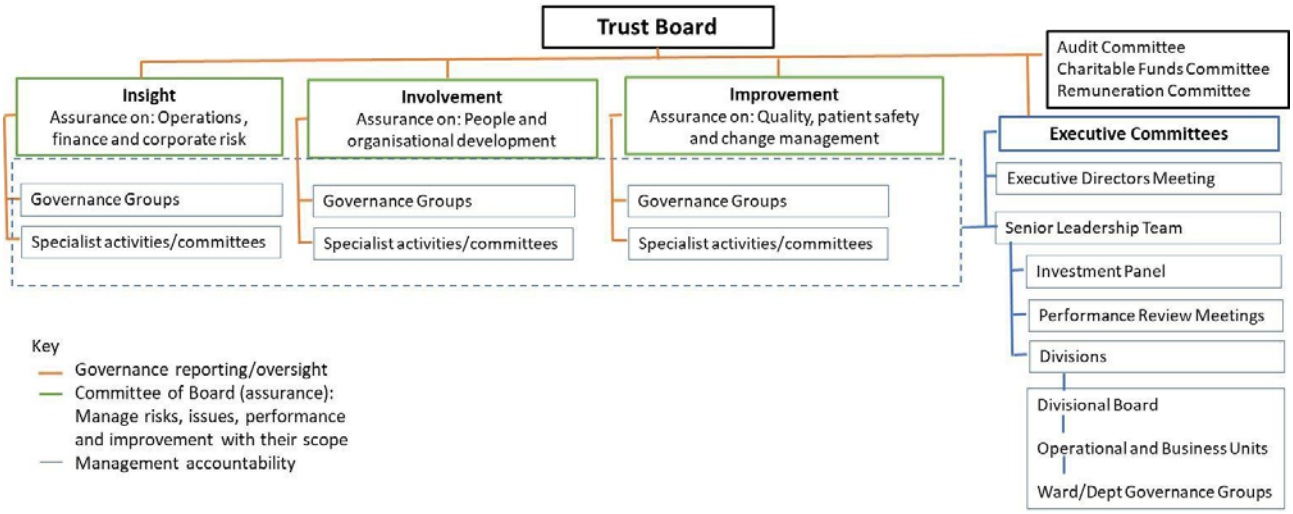
The audit committee is supported by the three assurance committees of the board in order to improve understanding and provide assurance to the board in relation to:

- **Insight Committee** – operational delivery, finance control and corporate risk
- **Involvement Committee** – people and organisational development, including the Trust's strategies, plans and the management of risks, relating to staff engagement and involvement; patient engagement and involvement and system involvement & public engagement
- **Improvement Committee** - quality, patient safety and change management.

The assurance committees of the Board are supported by a range of governance and specialist

groups. Management accountability for the remains with the executive and divisional leaders. This new framework was introduced in September 2021 and has been subject to review and refinement.

Chart 1: Governance structure



The council of governors hold the Non-Executive Directors individually and collectively to account for the performance of the Board of Directors.

The principles of risk management are included as part of the mandatory corporate induction programme and cover both clinical and non-clinical risk, an explanation of the Trust's approach to managing risk, and how individual staff can assist in minimising risk.

Guidance and training is also provided to staff through refresher programmes, specific risk management training, wider management training, policies and procedures, information on the Trust's intranet and feedback from audits, inspections and incidents. Included within all of this is sharing of good practice and learning from incidents. Further detail of the risk management arrangements are contained in the Trust's risk management policy.

The risk and control framework

The risk management strategy and policy sets out the key responsibilities for managing risk within the organisation, including the ways in which risk is identified, evaluated and controlled. This is supported by the Board approved Organisational Framework for Governance which outlines the structure, accountabilities and processes by which governance and onward assurance to the board is achieved.

Risk is assessed at all levels in the organisation from the Board of directors to individual wards and departments. This ensures that both strategic and operational risks are identified and addressed. Risk assessment information is held in an organisation-wide risk register. The level of risk that the Trust is willing to take (risk appetite) is managed through this structured framework of risk assessment and appropriate escalation. The Board reviewed its risk appetite during 2021-22.

The Trust has in place a board assurance framework which sets out the principal risks to delivery of the Trust's strategic corporate objectives. The executive director with delegated responsibility for managing and monitoring each risk is clearly identified. The board assurance framework identifies the key controls in place to manage each of the principal risks and explains how the Board of directors is assured that those controls are in place and operating effectively. These controls and assurances include:

- Performance management framework
- Monthly quality and performance reports, statistical process control (SPC) charts and performance dashboard. These include the Trust's priorities for improvement in the quality report,

analysis of patient experience, incidents and complaints, review of serious incidents, and ward-level quality performance
- Monthly financial performance reports
- Self-assessment against delivery of the CQC registration requirements
- Quarterly quality, performance and financial reports to the council of governors
- Assurances provided through the work of the three board assurance committees
- Reports from the future system board and the audit committee received by the Board
- Assurances provided through the work of internal and external audit, the Care Quality Commission, NHS Improvement, NHS Resolution, patient-led assessments of the care environment (PLACE), and accountability to the council of governors
- The work of clinical audit, whose scope includes national audits, audits arising from national guidance such as National Institute for Health and Care Excellence (NICE), confidential enquiries and other risk and patient safety-related topics
- 15 step challenge visits, including executive directors, non-executive directors and governors have not been possible due to the social distancing requirements of Covid-19. During these restrictions executives, non-executives and governors colleagues have engaged with staff through virtual meetings, including the regular all staff briefing
- Risk assessments and analysis of the risk register and board assurance framework
- Benchmarking for clinical indicators
- External regulatory and assessment body inspections and reviews, including Royal Colleges, post graduate dean reports, accreditation inspections and Health and Safety Executive (HSE) reports.

The following, which are covered in more detail in this annual report, are examples of the product of our risk and control environment:

- **Care Quality Commission (CQC)** – an overall rating of ”requires improvement”
- **Performance against national targets**, meeting a number of national targets in 2021-22
- **Maintaining status of global digital exemplar**
- **Excellent reputation for teaching** – both undergraduate and graduate.

It has been an unprecedented and challenging year for the Trust, the NHS, the nation and the world, but there are many achievements to be proud of.

The publication of our five-year Trust strategy – First for patients, first for staff and first for the future (2021 – 2026) - has given us the opportunity to lay out our priorities and ambitions for the whole organisation. It is founded on our updated FIRST Trust values – fairness, inclusivity, respect, safety and teamwork; and the vision of delivering the best quality and safest care for our community.

First for patients

The pandemic has forced us to make the difficult decision to restrict or suspend visiting at various times over the past year to reduce transmission of the COVID-19 virus. To help patients and their loved ones stay informed and in touch with each other, we established a clinical helpline and Keeping in Touch team. The clinical helpline is staffed by colleagues with clinical backgrounds, who give updates on patients’ conditions and answer queries. The team won a Patient Experience National Award in the support for caregivers, friends and family category. Digital technology allows the Keeping in Touch team to keep friends and relatives in contact with people on our hospital wards – for example the team enabled a patient to be a virtual guest at their daughter’s wedding.

WSFT has a fantastic research team and the work it reports on and delivers to a wide variety of vital studies, with the support of our patients recruited to the projects, is helping to advance medical understanding and treatment. We were named as the top national recruiting site for the global RECOVERY trial for two consecutive weeks in November. The RECOVERY (Randomised Evaluation of Covid-19 Therapy) trial is investigating treatments that may benefit people hospitalised with Covid-19.

One of our clinical research practitioners, Angharad Williams, has been named as the winner of the 2022 award for Clinical Research Practitioner Leadership by the Academy for Healthcare Science. A wonderful achievement for her.

WSFT is one of 12 integrated care systems in England signed up as an “accelerator site” to tackle waiting lists and elective recovery, trialling new ways of working, implementing and evaluating innovative ways to increase elective operations. We are also part of the Waiting Well pilot which 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.

Across the NHS, digital technology has supported ways of working that allow clinicians to offer care and support to patients. Our Patient Portal and “DrDoctor” text messaging service enable patients to see their records, results, appointments and letters, so they can take more control of their treatment.

Our community services have increasingly used telehealth to offer enhanced care to patients where they live, allowing them to have the clinical oversight and support they need to stay out of hospital. Through our integrated care networks and multi-disciplinary way of working, we are expanding our virtual ward beds which means people can receive the individual care they need at home.

We are active members of the West Suffolk Alliance, and are committed to an “alliance way of working” with our partners across the system. In July, Clement Mawoyo was appointed director of integrated community health and adult social care, as part of the work driving further integration with our social care and other alliance colleagues.

Our Mildenhall integrated neighbourhood team is now based at the new Mildenhall Hub, co-located not only with social care, but also a school, leisure centre and other public services. The Brandon team is based at the town’s health and leisure hub, and all our teams are able to refer patients directly to trained Abbeycroft Leisure instructors working at local Abbeycroft leisure centres and gyms.

A network of integrated neighbourhood team co-ordinators has been established, who with our hospital-based locality liaison co-ordinator, support community teams and wards to facilitate admission and discharge. We are also working with partners to improve waiting times and ensure equity in access to treatment.

Working with the Suffolk and North East Essex integrated care system (SNEE) we have established a WSFT vaccine taskforce. After our successful vaccine rollout to our staff and colleagues from key partner organisations, the taskforce joined the campaign to vaccinate as many people as possible at the heart of their community. Giving people expert advice, taking time to answer questions and allay fears, the team has helped thousands to access the vaccines, including some of the most vulnerable.

We recently marked the first anniversary of becoming an early adopter of the Patient Safety Incident Response Framework, a national initiative aimed at identifying risks and learning from incidents to improve quality and safety. Our Patient Safety and Quality Improvement (QI) team has been expanded and developed, and is undertaking projects across the Trust, embedding QI in all aspects of our work.

Improvements in our maternity services were noted by the Care Quality Commission after an unannounced inspection, which reported on progress being made, but also raised concerns which are being dealt with.

With our alliance partners East Suffolk and North Essex NHS Foundation Trust (ESNEFT) we have taken over the Early Supported Discharge service for stroke patients in the county, with the staff also transferred to the trusts.

We continue to perform well on the National Hip Fracture Database, where the data puts us at the top of all hospitals in England, Wales and Northern Ireland for meeting best practice criteria when

assessing patients with a hip fracture.

Our cancer care teams have extended the hours for people to access routine screening or referral appointments; and innovative screening tools using artificial intelligence are helping us to increase the numbers of patients we see and reduce waiting times.

The Macmillan Unit based at the hospital was recently awarded the Macmillan Quality Environment Mark for the third time. The award champions cancer environments that go above and beyond to create welcoming and friendly spaces for patients.

First for staff

We continue to be inspired by the commitment, compassion and teamwork of each one of our colleagues who have shown extraordinary resilience.

We recently received the results of the 2021 NHS Staff Survey, to which 2,000 of our staff responded. While there are areas we need to focus on and work hard to make things better the results compared reasonably well with trusts across the country, with all our key scores above the national average. We are working with colleagues to examine the findings in detail, learn from them and use that learning to improve the working lives of our colleagues.

As part of our commitment to build an open, learning and restorative culture, we have appointed two new Freedom to Speak Up (FTSU) guardians: Amanda Bennett and James Barrett. We have also recruited FTSU champions across the Trust, who with the guardians, are working closely with the Board to identify and tackle concerns expressed by our staff.
We have invested in and developed our staff support psychology service, which was the recipient of a Suffolk Heroes award, nominated by the county's MPs, in recognition of their work during the pandemic. Laura Rawlings, manager of the countywide community equipment service, also received one of the awards – both richly deserved.

Another major investment has been a partnership with Abbeycroft Leisure, which has allowed any WSFT colleague to access free membership to the facilities and services at Abbeycroft gyms and leisure centres. Our staff have taken up this offer in large numbers, and shared their enthusiasm for the scheme which has been extended for a second year.
Our chaplaincy team has been expanded and the chapel refurbished, and the team works tirelessly to support staff, patients and visitors of all faiths and beliefs.

It has been very heartening to see members of our team recognised. Consultant anaesthetist Jeremy Mauger has been a volunteer with the Suffolk Accident Rescue Service for 20 years and volunteers hundreds of hours for the emergency responders each year. To mark Suffolk Day, he was awarded the county's highest honour, the Suffolk Medal.

While off-duty, critical care nurse Debbie Lavender performed CPR and used a defibrillator to revive a man who collapsed, and was awarded with a Resuscitation Certificate from the Royal Humane Society.

We are often humbled by the appreciation, gratitude and generosity of our patients. Breast cancer patient Chris Goddard was diagnosed and treated at the WSFT during the pandemic. She was inspired to paint portraits of all the staff who cared for her – her NHS heroes as she calls them – and her images of the main masked clinicians are a poignant reminder of the journey that she – and we – have been on.

First for the future

The Trust is one of 40 in the country to receive funding for new build projects through the New Hospitals Programme, which will see the building of a new healthcare facility as part of a system to provide innovative, joined-up healthcare for West Suffolk.

Progress has been made this year, with the preferred site for the new facility at Hardwick Manor identified, outline planning permission applied for, and extensive face-to-face and online engagement undertaken to ensure we hear people's views on this great opportunity for our community. There is still much work to do and building is not expected to start before 2025. We are committed to taking on board – and learning from - the knowledge and opinions of our staff, patients and community.

The existing hospital buildings on Hardwick Lane were built in 1974 with an intended 30-year life span. The Trust has invested heavily in their upkeep over the years, and an extensive programme of maintenance is under way to ensure the safety of everyone using the site until the new hospital is completed.

While those works go on, we have increased the flexibility we can offer with the building of a new "decant" 32-bed ward, G10. We have also increased the community beds we have commissioned to support the discharge of medically optimised patients.

Our Trust strategy reflects the importance with which we see our role at the heart of our community. Our place in the wider world is also a vital part of looking to the future, and with that in mind we have published our Green Plan 2021 – 2025, which underlines our commitment to being part of a sustainable health system. We want to work within available resources and understand the social, environmental and economic impacts of our actions.

The My WiSH charity

Tireless in its support for the Trust and its staff, in September 2021 the charity saw the end of its #25 birthday appeal, smashing the target of raising £25,000 and ended the year with almost £31,000. This money will be used to provide a play specialist for the paediatric emergency department, and the department was able to welcome Claire Thompson during the year due to additional fundraising from the Help your NHS hospital appeal.

The charity matched Government funding to provide state-of-the-art toilet facilities for patients with complex disabilities with the completion of a new Changing Places facility. Changing Places are toilets with additional equipment for people who are not able to use the toilet independently, including adult-sized changing benches and hoists.
Refurbishment of the West Suffolk Hospital chapel, including a prayer facility for Muslim people, was also supported by My WiSH.

From providing and equipping quiet spaces for staff to go during the worst of the pandemic; to giving every colleague a reusable cup for the free tea and coffee available to them, the charity has come up with imaginative ways to improve the working lives of our staff.
As well as their own fundraising activities, now being planned once more as restrictions ease, My WiSH is supported by hundreds of local people and businesses and to whom we extend our sincere thanks.

But, we also have some challenges and these are considered in more detail in the conclusion of this annual governance statement:

- **Staff engagement and raising concerns**
- **Building structure**
- **Covid-19 response and access**

Risks to our strategic objectives are regularly reviewed by the Board as part of the board assurance framework (BAF). A summary of the BAF is provided below.

Board assurance framework summary

Category of risk	Description of risk	Potential impacts being mitigated by controls and future plans
Quality of care	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	Poor care and treatment of patients. Loss of public and GP confidence that leads to reduced referrals as a consequence of public choice. Restricted authorisation / licensing by regulators
	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	Patient safety. Reputational impact and poor patient experience/satisfaction. Regulatory action. Negative impact on staff wellbeing
	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	Poor care and treatment of patients. Loss of public and GP confidence. Negative impact on staff wellbeing.
Environment, effectiveness and continuous improvement	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	Ageing building environment suitability for patient care which could lead to reputation damage and loss of income. Unknown financial impact if reputational consequences. Risk of improvement notices if fail to effectively maintain building(s). Ability to fund the capital programme
	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	Delivery risk to patient safety and the operational effectiveness of the Trust. Ability to report patient care and activity both timely and accurately. Quality, service and financial impact of failure to deliver planned improvements and benefits

Category of risk	Description of risk	Potential impacts being mitigated by controls and future plans
Workforce	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	Quality and safety and reputation impact. Adverse employee relations and staff motivation. CQC regulatory action. Withdrawal of Royal College recognition. Failure to achieve reduction in non-contracted pay as part of financial plans. Poor staff engagement hinders deliver of transformation and efficiency. Inability to recruit/retain key staff
Governance	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	Quality and ability to deliver safe services. Non-compliance with national standards, targets and terms of authorisation leading to breach of licence (CQC or NHSE/I). Impact on cash flow and income and expenditure. Inability to generate sufficient surplus to support capital investment. Local position leads to tension between local health economy partners. Loss of provider sustainability funding to the local health system

In considering the risks and challenges we face the Board recognises that it is currently recruiting a new Chair and up to three new non-executive directors. These appointments provide an opportunity for the Trust to drive its value based recruitment but also represents a significant change in the senior leadership. The impacts will be mitigated through planning and appropriate handover.

Changes to the NHS landscape both locally and nationally will also play an important part in the future focus of the Board. Ensuring effective working with the new Suffolk & North East Essex Integrated Care Board (ICB) and maximising the benefits for patients and the population within our system through collaboration with partners.

Board assurance framework summary

The Trust ensures that short, medium and long-term workforce strategies and staffing systems are in place which provide assurance to the Board that staffing processes are safe, sustainable and effective; including compliance with the ”Developing Workforce Safeguards” recommendations. These systems include:

- activities of the involvement committee of the board
- integrated quality and performance report (IQPR) and finance and workforce report - both reports are received at each public Board meeting. These reports detail a range of metrics including patient outcomes, patient experience and staffing performance indicators
- nurse staffing monthly report to the Board which details the nurse staffing position and the Trust’s future plans for nurse staffing
- Board reporting is underpinned by monthly divisional workforce reports which details a range of performance indicators including sickness absence, turnover, maternity leave, training and average absence
- assessment of staff experience using the friends and family test (FFT), national staff survey and exit interviews. We have also established networks for staff with disabilities and LGBT+
- Freedom to Speak Up Guardian and Guardian of Safe Working reporting to the Board

- e-rostering and e-job planning system for medical staff
- the Trust's clinical workforce strategy group oversees the development of new roles to support sustainability within the labour market.

These arrangements are underpinned by review and oversight by the chief nurse and medical director to ensure that effective systems are in place.

The Trust is fully compliant with the registration requirements of the Care Quality Commission (CQC). An improvement plan is in place to address the concerns identified in the recent CQC inspection.

The Trust has published on its website an up-to-date register of interests, including gifts and hospitality, for decision-making staff (as defined by the Trust with reference to the guidance) within the past twelve months as required by the Managing Conflicts of Interest in the NHS guidance.

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the scheme are in accordance with the scheme rules, and that member pension scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with.

The Foundation Trust has undertaken risk assessments and has plans in place which take account of the 'Delivering a Net Zero Health Service' report under the Greener NHS programme. The trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

Review of economy, efficiency and effectiveness of the use of resources

The board assurance framework provides evidence of the effectiveness of controls that manage the risks to the organisation achieving its principal objectives and that these have been reviewed. The annual governance statement is also informed by the latest CQC inspection report (January 2020).

The board assurance framework was reviewed and updated routinely during 2021-22 to ensure the principal strategic risks to the Trust's objectives were identified, recorded and correctly evaluated for impact and likelihood. Overall, analysis of key controls and assurances revealed that the Trust was managing its risks to a reasonable level, that the Board of directors was adequately informed of the effectiveness of control measures and that, where possible, appropriate corrective action was being taken to reduce identified high-level risks. This review has identified gaps in control or assurance as set out in the significant internal control section of the annual governance statement. The board assurance framework is subject to independent review by internal audit.

In considering the principal risks to compliance with the Trust's conditions of authorisation we have had particular regard to the:

- Effectiveness of governance structures – which are subject to annual review and recommendations for improvement monitored through an agreed action plan
- Responsibilities of directors – directors' objectives and performance are regularly monitored by the remuneration committee
- Responsibilities of subcommittees - are considered as part of the annual governance review and the quality and risk committee and audit committee provide an annual report to the Board on their activities and performance
- Reporting lines and accountabilities between the Board, its subcommittees and the executive team - are considered as part of the annual governance review and clear reporting and escalation channels exist between the Board and executive team

- Submission of timely and accurate information to assess risks to compliance with the Trust's licence
- Degree and rigour of oversight the Board has over the Trust's performance – the Board continually reviews and develops its reporting arrangements to the Board. The monthly quality and performance report for the Board supports an open reporting culture and includes the results from the Friends and Family Test; the NHS safety thermometer, which covers falls, pressure ulcers and infection control; and patient and staff experience surveys building up a picture of care quality in our services. The range of indicators provides early warning of deterioration in performance and potential negative impact on quality. The finance and workforce report has been strengthened during the year including divisional reporting and performance against cost improvement programmes.

Information governance

The Trust's data security and protection assessment report overall score for 2020-21 was 'approaching standards'. 5 of the 118 mandatory evidence items were unable to be provided. The assessment for 2021-22 will be submitted in June 2022 and we anticipate a satisfactory score of 38/38 assertions being met consisting of 109 mandatory evidence items. An internal audit of the assessment has been completed and the Trust is committed to addressing the remedial actions identified prior to the submission.

The Trust reported 11 data breaches to the Information Commissioner's Office (ICO) in 2021-22, the majority involved inappropriate access of records by members of staff. All actions agreed with the ICO are being implemented.

Data quality and governance

The Trust places a high priority on the quality of its clinical outcomes, patient safety and patient experience and strives to deliver the principles outlined in NHSI's well-led framework and its eight key lines of enquiry (KLOEs):

1 Is there the **leadership capacity and capability** to deliver high quality, sustainable care?	2 Is there a clear **vision** and credible **strategy** to deliver high quality, sustainable care to people, and robust plans to deliver?	3 Is there a **culture** of high quality, sustainable care?
4 Are there clear responsibilities, **roles** and systems of accountability to support good governance and management?	**Are services well led?**	5 Are there clear and effective processes for managing **risks**, issues and **performance**?
6 Is appropriate and accurate **information** being effectively processed, challenged and acted on?	7 Are the **people** who use services, the public, **staff** and **external partners engaged** and involved to support high quality sustainable services?	8 Are there robust systems and processes for **learning**, continuous **improvement** and **innovation**?

Indicators relating to the quality report were identified following a process which included the Board of directors, clinical directors and senior managers of the Trust and have been incorporated into the key performance indicators reported regularly to the Board of directors as part of the performance

monitoring arrangements.

Scrutiny of the information contained within these indicators and its implication as regards to patient safety, clinical outcomes and patient experience takes place at the Board as well as the board assurance committees and the groups and activities that report into them.

The inter-relationship between the indicators in the quality report and other measures of the Trust's performance (financial and operational) is reviewed through the assurance structure and reported to the Board of directors. Reviews of data quality and the accuracy, validity and completeness of all Trust performance information fall within the remit of the audit committee, which is informed by the reviews of internal and external audit and internal management assurances.

The Board has developed the use of statistical process control (SPC) charts to allow quality and performance indicators to be more systematically reviewed and to target action to the areas that require attention. The SPC method allows areas affected by change to be more easily identified and investigated, whether this change is positive or negative. The use of SPC intelligence will be developed to be used more widely across the Trust. During the Trust's Covid response reporting to the Board was amended to maintain the required oversight but recognising that many of the normal activity and access indicators were not meaningful.

Reviews of data quality, and the accuracy, validity and completeness of Trust performance information, fall within the remit of the audit committee, which is informed by the reviews of internal and external audit and internal management assurances.

Review of effectiveness

As accounting officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the board, the audit committee and the quality and risk committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The Board of directors' role is to determine the overall strategic direction and to provide active leadership of the Trust within a framework of prudent and effective controls which enables risk to be assessed and managed. The Trust's strategic objectives are derived from the priorities determined in the Trust's strategy.

The Board of directors has put in place a robust escalation framework which ensures timely and effective escalation from divisions and specialist committees to the Board. Executive directors and their managers are responsible for maintaining effective systems of control on a day-to-day basis.

In accordance with the public sector internal audit standards updated in 2017, internal audit provides the Trust with an independent and objective opinion to the accounting officer, the Board of directors and the audit committee on the degree to which risk management, control and governance support the achievement of the Trust's agreed objectives. Internal audit reported 16 reports from the 2021-22 plan; the "opinion levels" are summarised below:

Level of assurance	Number
Advisory report – no assessment made of the level of assurance	1
Substantial assurance - controls are suitably designed, consistently applied and operating effectively.	2
Reasonable assurance - identified issues that need to be addressed	8
Partial assurance - action is needed	5
No assurance - urgent action is needed	0

The conclusions from the five partial assurance internal audit reports are set out below and action to address the concerns have been reviewed by the audit committee:

- **Patient Safety Checklist (PSC) – Emergency Department Processes** (partial assurance) – review identified a number of weaknesses in the control framework, including a lack of guidance and assigned responsibility for oversight and monitoring. Issues regarding clarity of data and calculations were also identified. Action to address the weakness includes development of standard operating procedures; training and briefings; clarity of oversight and reporting; and action to support improved validation and performance.

- **Business Continuity Planning (BCP)** (partial assurance) –review identified weaknesses in the business continuity control framework. Specifically, relating to operational BCPs across the Trust functions; need for an overarching BCP supported by a formal testing schedule; and clarity over Trust-level and divisional governance around business continuity. Action to address the weakness includes identifying resource to review, develop and update operational and tactical BCPs underpinned by a testing programme in line with policy.

- **Rolling Improvement Plan – Part 2** (partial assurance) –review found areas of weakness in relation to the assessments undertaken to review the embedded status of the processes put in place to address actions, the retention of evidence to provide support for the decisions made in moving the action status, and in obtaining approval from the improvement programme board (now improvement committee) prior to changing the action status.

- **Staff Grievance Process** (partial assurance) – review found well-designed policy and procedural documents in place which clearly defined the roles and responsibilities of delegated leads, the HR Team and Trade Union representatives in relation to the management of grievances and lessons learnt from closed cases had been communicated to the closed Trust Board alongside senior management and line managers. Control weaknesses were identified relating to provision of formal training to delegated leads on the management and resolution of raised issues/concerns alongside the formal recording of all cases (informal and formal) on ESR. It was also noted that resolution meetings and the overall processing of investigations and the issue of investigation outcomes were not always conducted in a timely manner.

- **Appraisals, Mandatory Training and Workforce KPIs** (partial assurance) –review confirmed that the Trust Board had received timely and accurate data regarding appraisal completion and mandatory training compliance. We also noted that Divisional Performance Scorecards are generated monthly and detailed the Trust's workforce KPI performance, with figures for appraisals, staff turnover and absences agreeing back to reports from ESR. We also confirmed that the Trust's approach to mandatory training was defined within its Mandatory Training Policy, with a matrix in place detailing the training required for each role. The review found weaknesses and compliance. This included action plans to address low appraisal completion rates and low training compliance levels for divisions, staff groups and subjects, as well as NHS staff survey finding in relation to appraisals. Issues were also identified regarding assigning the correct mandatory training modules, inaccurate training compliance levels being reported.

The framework for monitoring and review of action in response to internal audit reports has resulted in reasonable progress against recommendations being reported by internal audit throughout the year.

For the 12 months ending 31 March 2022, the head of internal audit's opinion for WSFT is that: "The organisation has an adequate and effective framework for risk management, governance and internal control. However, our work has identified further enhancements to the framework of risk management, governance and internal control to ensure that it remains adequate and effective".

External audit reports that the annual report and accounts are true and fair.

In preparing this annual governance statement, as required under NHS foundation trust conditions, all relevant internal and external assurance have been taken into account regarding WSFT performance in respect of quality and finance.

Conclusion

In considering any significant internal control issues the following were recognised:

- ### Staff engagement and raising concerns

  The development of a culture where all staff feel confident to speak up and raise concerns at work is crucially important to us. We affirm its direct impact on a culture of safety with positive benefits for patient care, quality and staff experience and engagement.

  The publication of the West Suffolk Review in December 2021 marked the end of a two-year independent investigation into significant failures of governance and decision-making related to 'speaking up'. First and foremost, we know the actions taken by the Board, which led to the review, understandably caused upset and anger amongst many of our staff, patients and their families, as well as our community. For those most affected it has also negatively impacted their wellbeing.

  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.

  Furthermore, the impact of working during the pandemic has impacted on NHS staff across the country; the 2021 staff survey results show an unprecedented deterioration in reported staff satisfaction and experience across England. This impact is no less felt at West Suffolk and the ongoing pressures arising from when demand outstrips capacity (whether that be physical capacity or workforce capacity – both numbers of staff and their resilience), continue to exacerbate this situation. As such, levels of staff engagement will understandably be at risk, which demands a response.

  The Board has developed and endorsed an organisational development plan in order to respond to these issues, which reflects work already taken forward that requires further embedding, and additional actions. This was approved at the meeting in public of the Board of Directors in March 2022, and identifies five themes of work:

1) Strategy & values
2) Board development
3) Speak up culture
4) HR practice
5) Staff engagement

The detailed action plan is available separately. Progress with this will be overseen by the Involvement Committee of the Board and reported in public. Our internal audit function has been tasked to undertake a review of the Board's response to the West Suffolk Review, the results and recommendations of which will also be reported in public.

- **Building structure**

The building structural challenges we face at West Suffolk Hospital are well known and we have long documented that, according to structural engineer experts, our building's 'shelf life' likely won't extend beyond 2030.

The Trust has faced estate challenges regarding its roof for a number of years, and has put approved mitigations in place, like reducing weight on it. These mitigations are: recommended by structural engineers, well-managed, and reported to our regulators as part of our planned estates works.

The need for a new hospital has been nationally acknowledged and WSFT, and the rest of the west Suffolk health system, were delighted that the Trust was named as one of 40 to benefit from the Government's New Hospital Programme. However, whilst this news is very much welcome, any new facility will not be open for several years and we have a duty to ensure that the existing hospital is appropriately maintained and we are able to continue to provide high quality health services for our community.

In 2019 an additional, specific structural risk was identified about a product called reinforced autoclaved aerated concrete (RAAC) planks, which were used in the original build of West Suffolk Hospital and the front residences in the 1970s.

The alert received was from the Standing Committee on Structural Safety (SCOSS), which reported one sheer RAAC plank failure in a non-NHS site built of similar material and construction. The alert recommended that inspection work be carried out on buildings of RAAC construction, giving guidance on how to further assess the condition and structural adequacy of the planks.

Our estates teams have been proactive, robust and on the front foot in tackling this issue.

Since receiving the alert, they have mapped every plank across the organisation, and implemented an assessment programme using sophisticated radar equipment and other approved tests to check all planks for signs of stress. The teams are carrying out remedial repairs across the estate as part of this; work has not stopped throughout the pandemic.

The Trust has engaged experienced structural engineers and experts to support the inspection work. All planks will be continually assessed in a rolling programme of routine estates work until we move to a new hospital site. In addition, proactive programmes of precautionary maintenance work are well underway around the hospital to further ensure the safety of our patients, visitors, and staff.

We are not complacent - this has and will continue to have our absolute attention and focus. Staff, patient and visitor safety matters to us above all else.

This issue has not been caused by a failing of the Trust, which has managed its estates repairs

well within the means available, but by the ageing of a product in our roof that cannot be replaced. We want to be transparent about our challenges and to reassure our patients, staff and community.

The programme of works to inspect the building structure and implement required mitigating action continues and we have received additional funding to support the programme during 2022/23.

- **Covid-19 response and access (including referral to treatment (RTT) and cancer)**

In 2022-23 the Trust is required to meet the standards set out in the NHS England and Improvement priorities and operational planning guidance in order to recover activity and reduce waiting times following the impact on the pandemic.

Whilst the RAAC remedial work in theatres is now mostly complete and therefore not impacting on theatre capacity, there is an operational impact of remedial work in ward areas. In addition, subsequent waves of COVID-19 are predicted to continue to impact on staff availability and patient fitness for surgery.

Access, including referral to treatment (RTT), diagnostics and cancer

Whilst the Trust has faced significant challenge in regards to COVID-19 waves, increased urgent and emergency care demand and the RAAC remedial work, there has been significant focus on our patients who are waiting the longest, with trajectories in place and on track to meet the performance standards set out in our 2022-23 planning submission.

The key aspects of RTT recovery fall into four key areas of delivery, our priorities are:

- Increasing health service capacity:
  - Continued work with system partners to meet the national thresholds
  - Mutual aid has been established and progressed well for ENT, gynaecology and orthopaedics
  - Additional capacity has been sourced with the independent sector (orthopaedics, general surgery, urology, gynaecology, ophthalmology diagnostics) and this will continue in 2022-23
  - Maximising use of existing capacity through weekend working and extended sessions has progressed
  - Theatre productivity workstreams, with particular focus on day surgery unit.

- Prioritising treatment:
  - Ensuring the order in which patients are seen reflects clinical judgement on need
  - Targeting support to reduce the number of people waiting a long time
  - Recovery plans are in place for all services with a review to treat out longest waiting patients, starting with those that have waited over two years
  - Clinical validation to ensure consistent clinical prioritisation across all points of delivery
  - Facilitating mutual aid and full use of the independent sector where possible.

- Transforming the way we provide elective care:
  - Implementation of community diagnostic centre
  - Personalised outpatient programme (which includes work on digital transformation, virtual appointments, advice and guidance and patient initiated follow up)
  - Nationally identified pathways which can be considered high volume, low complexity (HVLC). With 29 designated pathways in the following specialties: cardiology; trauma and orthopaedics; muscular skeletal; ophthalmology; gynaecology; ear, nose and throat; general surgery; and urology
  - Productivity opportunities via review of available benchmarking data (such as model hospital and the Getting It Right First Time (GIRFT) national programmes).

- Better information and support for patients:
  - Waiting well pilot for patients waiting for surgery
  - Implementation of Surgery school
  - Suffolk and North East Essex (SNEE) wellbeing website which offer patients ways to wait well
  - Additional schemes on communication to patients are being developed.

For diagnostics, the priority is recovery to 95% of patients having their diagnostic test within six weeks by March 2025, the actions in place to achieve this include:

- Maximising the use of our current capacity utilising weekend, evening and mobile capacity
- Continuing to engage with and expand the cytosponge, a non-endoscopic diagnostic tool and colon capsule capacity, with an increase in the volume of patients going through these pathways to free up capacity within endoscopy
- Implementation of community diagnostic centre
- Implement digital histopathology.

For cancer, the priorities are that: by March 2024 75% of patients who have been urgently referred by their GP for suspected cancer are diagnosed or have cancer ruled out within 28 days by March 2024; and return the number of people waiting more than 62 days from an urgent referral back to pre-pandemic levels by March 2023. The key actions to delivery these priorities include:

- The cancer programme will continue to link into the development of the community diagnostic centres, reviewing pathways available to primary care for pre referral testing and additional opportunities for secondary care in relation to diagnostics.
- Rollout of faecal immunochemical test (FIT) pathway for lower gastrointestinal (GI)
- Continued engagement and implementation of innovation projects
- Continue to work as a system to support improvements in 62-day and 104-day breaches, by working with our quality teams we have continued to review themes from root cause analysis and implementing transformation following the learning, we currently have a pre-diagnosis nurse pilot running following learning relating to complex patients on our patient tracking list (PTL) and we have recently recruited a psychological project lead to support the development of a psychological pathway and measuring psychological harm
- Implement a clinical decision tool in primary care to support patients to arrive at secondary care with pre-referral tests completed, this will ensure there are minimal delays on first days of the two-week wait pathway
- Continue the implementation of the best practice time pathways. Ensuring pathways are compliant and developing action plans to support those that require improvement
- Encourage appropriate access to advice and guidance across primary and secondary care to promote referring the right patient on the right pathway at the right time.

Covid-19 – operational response and impact

As a Trust, we have a ”command, control and coordination plan”, also known as a ”C3” plan. It covers the arrangements we use when responding to an incident that might affect our business as usual, or stop us from delivering services in the way we would normally. Responding to COVID-19 falls into that category, so we have followed the C3 plan with enhanced capability and resources to support our response. These included:

- **Strategic commander**: the strategic commander has overarching responsibility for the Trust’s response to COVID-19. Our strategic commander is the chief operating officer (COO). Supported by members of the executive team, the COO leads a strategic group that considers and approves recommendations from the core resilience team (CRT), and tactical group.

- **Tactical**: looks after the day-to-day issues, that is things that need action immediately. It also decides how to put strategic group decisions into practice, and implements them. It's sub-groups include:

    - Operational: how we put decisions into practice in a way that works
    - Resources: managing things like personal protective equipment (PPE) stocks
    - Divisional operational command centres (DOCCs): this is a technical name for the teams looking after specific operational areas – including surgery, community, medicine, women and children's services, and patient flow. Staff can contact them directly for operational issues related to these areas.

- **Core resilience team**: looks after the 'mid-term' issues. It includes the following sub-groups:

    - Clinical: made up of clinical colleagues from across the Trust. It covers things like making sure we are following and implementing the right clinical guidelines
    - Community: community teams face very different challenges to acute colleagues, so this group looks at those specifically. It includes how we link with other providers, like care homes
    - Workforce: all things 'staff', including wellbeing and risk assessments, linking in with occupational health
    - Future planning: considers how we will turn services back on, in what order, and what support the Trust might need moving forward
    - Ethical: a group to temperature check some of the difficult decisions we've had to make. For example, the temporary suspension of, and then reinstating, services and activities.

The structures we put in place through our emergency planning arrangements supported us in responding to internal and external requirements and allowed the Trust to continue to provide emergency and urgent care to our patients. Significant changes to the operational arrangements were managed and delivered in a timely and considered manner. However, we do not underestimate the impact of the decisions and changes we made had on patients, relatives and our staff. It is significant to note that the head of internal audit's opinion is a position opinion despite the challenges placed on us through Covid-19, demonstrating that we were able, through our existing plans, to implement an effective control environment.

Despite the challenges that COVID-19 presented there are also opportunities for us to achieve sustainable improvements based on how we responded, such as the transformation of our outpatient services to enable virtual consultations by phone and video and the cross-agency collaboration to meet patients' needs. These and other changes were underpinned by a clinically-led approach to developing and delivering solutions – the value of this has been clear and we must further strengthen this clinical engagement in our managerial structures and decision-making. We will use a formal review process to capture learning, positive and negative, and this will inform future developments.

I am confident that the internal control systems are operating well and that the work we have done to maintain and develop our risk management systems will help us to consolidate this position in the future. The Trust is committed to the continuous improvement of processes of internal control and assurance. This includes the effective tracking of action to mitigate significant control issues through the board assurance framework.



Craig Black
Chief executive
15 September 2022

2.7 Remuneration report

The Trust has identified the individuals in a senior position who have authority to control or direct major activities to be the executive and non-executive members of the Board.

The purpose of the remuneration report is to provide a statement to stakeholders on the decisions of the remuneration committee relating to the executive directors of the Board of directors. In preparing this report, the Trust has ensured it complies with the relevant sections of the Companies Act 2006 and related regulations and elements of the NHS Foundation Trust Code of Governance.

The following parts of the remuneration report are subject to audit:

- single total figure table of remuneration for each senior manager
- pension entitlement table and other pension disclosures for each senior manager
- fair pay disclosures
- staff report: exit packages, analysis of staff numbers and analysis of staff costs.

Annual statement on remuneration

Directors are employed on service contracts whose provisions are consistent with those relating to other employees within the Trust. There are no components within the remuneration relating to performance measures or bonuses.

Senior managers' remuneration policy

Senior managers' pay consists of the following elements:

- senior managers' salaries are reviewed on an annual basis by the remuneration committee. The objectives of the committee are set out below.
- benefits in kind – in line with the Trust policy for all employees, senior employees are eligible to access salary sacrifice schemes such as lease cars and computer equipment. These may be considered as benefits in kind and are declared to HM Revenue and Customs and employees pay any additional tax due as appropriate.

To determine senior manager salaries the remuneration committee may use one or more of the following:

- an assessment of the Trust's performance
- an assessment of an individual's performance against agreed objectives
- NHS cost of living pay rise, based on the national NHS pay award
- benchmarking data, including NHS Improvement guidance and established ranges
- NHS and other relevant advertised jobs
- the prevailing market position, including the ability to recruit and retain individuals.

Remuneration committee

The aim of the remuneration committee is to make appropriate recommendations to the Board on the Trust's remuneration policy and the specific remuneration and terms of service of the chief executive, executive directors, and other staff as determined by the Board. The committee will:

- advise the Board about appropriate remuneration and terms of service for the chief executive, other executive directors and other senior employees including:
  - all aspects of salary (including any performance-related elements/bonuses)
  - provisions for other benefits, including pensions and cars
  - arrangements for termination of employment and other contractual terms

- make recommendations to the Board on the remuneration and terms of service of executive directors and senior employees to ensure they are fairly rewarded for their individual contribution to the Trust - having proper regard to the Trust's circumstances and performance and to the provisions of any national arrangements for such staff
- scrutinise the proper calculation of termination payments taking account of such national guidance as is appropriate, advise on and oversee appropriate contractual arrangements for such staff
- monitor and evaluate the performance of individual executive directors (and as agreed by the Board other senior employees) including:
  - establishing the objectives of the chief executive and review the performance of the chief executive against these objectives which support the Trust's priorities
  - scrutinising the objectives of the executive directors (to be established by the chief executive and to support the Trust's priorities) and review performance reports on the executive directors prepared by the chief executive
- scrutinise the recommendations of the clinical excellence awards committee
- review the terms of reference of the committee every two years
- report the frequency of meetings and the members of the remuneration committee in the Trust's annual report
- the committee shall report in writing to the Board the basis for its recommendations
- consider the Trust's equality, diversity and inclusion policy in all decisions made, the objectives of which are linked to the Trust's overall strategy. Further detail regarding diversity and inclusion is provided within the staff report (see page 88 for further details on this policy)

The committee comprises the Trust chair and non-executive directors of the Board. The committee is chaired by a non-executive director (Mr A Eaton until May 2021 and Alan Rose from May 2021). The chief executive, executive director of workforce and communications and trust secretary may be present to advise but not for any discussions concerning their personal remuneration at the discretion of the remuneration committee's chair.

A quorum will consist of the committee chair (or nominated representative) and at least two non-executive directors. A nominated representative for the chair must be a non-executive director.

The committee acts with delegated authority from the Board and will usually meet at least annually. Minutes are taken and a report submitted to the Board showing the basis for the recommendations. Five meetings of the remuneration committee were held during 2021/22.

Attendance at remuneration committee meetings

Name	Title	Attendance (out of 5)
Sheila Childerhouse[4]	Trust chair	4/4
Richard Davies	Non-executive director	5
Angus Eaton [1]	Non-executive director (remuneration committee chair until May 2021)	1/1
Rosemary Mason[2]	Associate non-executive director	1/1
Louisa Pepper	Non-executive director	2
Alan Rose	Non-executive director (remuneration committee chair from May 2021)	4
David Wilkes[3]	Non-executive director	1/1
Christopher Lawrence[5]	Non-executive director	3/4
Jude Chin[6]	Interim Trust Chair	1/1

Meeting dates: 8 April, 15 July, 8 August, 23 September 2021, 17 March 2022

[1] Angus Eaton resigned as a non-executive director on 31 May 2021
[2] Rosemary Mason resigned as associate non-executive director on 22 June 2021

(3) David Wilkes resigned as non-executive director on 11 June 2021

Senior managers' (executive directors') pay is annually reviewed by the remuneration committee. The committee is presented with benchmarking information to demonstrate where each executive director's salary sits alongside similar posts in the NHS market in the context of pay awards to other staff groups. Decisions to increase salaries are based on this information, internal equity, affordability, whether there has been a significant change in a director's portfolio and thus responsibility. Through these arrangements the committee must be satisfied that the remuneration for senior managers is reasonable, including any senior manager paid more than £150,000. In addition, each director can receive the NHS cost of living pay rise which is based on the national NHS pay award. In recent years the Department of Health and Social Care has advised the chair on the expected level. The arrangement for managing the remuneration policy for senior managers was strengthened from 2018/19 to include engagement with staff and public governors.

The Trust does not have a performance-related pay scheme. The committee, however, has the delegated authority to pay one-off discretionary payments in exceptional circumstances. The chief executive presents an annual report on executive directors' performance (in the case of the chief executive this is presented by the chair) based on the outcome of their annual appraisal.

The senior managers' salary does not include separate components and there are no performance measures that apply. Clinical elements are included in the salary of the Medical Director as part of the work undertaken in their medical role.

Service contracts obligations

The Trust's executive directors hold substantive service contracts. Notice periods apply based on the early termination of their contract. The notice periods are as follows:

- chief executive – six months
- executive directors – three months.

The non-executive directors hold a term for 3 years. Further details can be found on page 45 of this report.

Policy on payment for loss of office

Approval for any non-contractual severance payments should be obtained from the remuneration committee and NHS Improvement following submission of a business case. In respect of individuals earning over £100,000, any severance payment should include a provision requiring the repayment of the severance payment where the individual returns to work for the NHS in England within 12 months and/or before the expiry date of the period for which they have been compensated (as measured in equivalent months/part-months of salary). In such circumstances the employee would be required to repay any unexpired element of their compensation. This would be reduced to take account of any appointment to a lower grade post or reduced hours basis and reflect net salary.

Annual report on remuneration

In the financial year the directors' costs decreased to £1,077k from £1,286k. There were no exit packages paid to Board members in the 2021/22 financial year or the comparative year.

A cash equivalent transfer value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme; or arrangement to secure pension benefits in another pension scheme; or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures

and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real increase in CETV reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement) and uses common market valuation factors for the start and end of the period.

Both directors and governors are able to reclaim expenses necessarily incurred during the course of their duties. Details of these are shown below. The numbers include individuals who have acted in their capacity as director or governor for any part of the financial year.

	2021/22		2020/21	
	Directors	Governors	Directors	Governors
Total number in office during the year	18	27	15	39
Total number receiving expenses	8	3	4	0
Aggregate total of expenses paid during the year (£)	10,895	105	3,994	0

Fair pay disclosure

NHS Foundation Trusts are required to disclose the relationship between the remuneration of the highest- paid director in their organisation and the lower quartile, median and upper quartile remuneration of the organisation's workforce.

The banded remuneration of the highest paid director in the organisation in the financial year 2021/22 was £195k - £200k (2020/21, £195k - £200k). There has been no change in the banded remuneration of the highest paid director between periods.

Total remuneration includes salary, non-consolidated performance-related pay, benefits in kind, but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

For employees of the Trust as a whole, the range of remuneration in 2021/22 was from £17,417 to £240,111 (2020/21, £18,005 to £224,242). The increase in the high end of the range between periods is a result of additional medical sessions provided by consultants. The percentage change in average employee remuneration (based on total for all employees on an annualised basis divided by full time equivalent number of employees) between years is 10.8%. Nine employees received remuneration exceeding that of the highest-paid director in 2021/22 (2020/21, nine employees).

The remuneration of the employee at the 25th percentile, median and 75th percentile is set out below. The pay ratio shows the relationship between the total pay and benefits of the highest paid director (excluding pension benefits) and each point in the remuneration range for the organisation's workforce.

2021/22	25th Percentile	Median	75th Percentile
Total pay and benefits exc. pension benefits	22,549	31,534	42,121
Salary component of pay	22,549	31,534	42,121
Pay and benefits excluding pension:pay ratio for highest paid director	8.8	6.3	4.7

The mid-point of the highest paid director's salary and allowances band was 6.3 times (2020/21, 8.2 times) the median remuneration of the workforce, which was £31,534 (2020/21, £24,157). This is calculated based on all staff employed, including agency staff covering vacancies, as at 31 March

2022. The ratio reduced because the median remuneration of the workforce increased but the mid-point of the highest paid director's remuneration band did not. A contributing factor to the median increase, and also to the percentage change in average employee remuneration, is pay increases awarded to the workforce generally and incremental progression within salary bands. The highest paid director is a different individual in 2021/22 after the 2020/21 highest paid director ceased to be in post during 2021/22. An increase in the salary and allowances of individuals whose earnings exceeded the highest paid director also contributed to the reduction in ratio between highest paid director and rest of workforce remuneration.

Table A – Single total figure

Name and title	Year to 31 March 2022				Year to 31 March 2021			
	Salary (bands of £5,000)	Expense payments (taxable) to nearest £100	All pension-related benefits (bands of £2,500)	Total (bands of £5,000)	Salary (bands of £5,000)	Expense payments (taxable) to nearest £100	All pension-related benefits (bands of £2,500)	Total (bands of £5,000)
	£'000	£'00	£'000	£'000	£'000	£'00	£'000	£'000
Mrs H Beck - Chief Operating Officer (Note 1)	90 - 95	-	-	90 - 95	125 - 130	1	30 - 32.5	155 - 160
Mr C Black – Interim Chief Executive (Note 2)	190 - 195	29	-	195 - 200	165 - 170	68	0 - 2.5	170 - 175
Mrs S Childerhouse - Chair (Note 3)	40 - 45	-	-	40 - 45	45 - 50	2	-	45 - 50
Mr J Chin - Chair (Note 4)	15 - 20	5	-	15 - 20	-	-	-	-
Mrs N Cottington - Chief Operating Officer (Note 5)	45 - 50	-	85 - 87.5	135 - 140	-	-	-	-
Dr R Davies - Non Executive Director	10 - 15	-	-	10 - 15	10 - 15	-	-	10 - 15
Dr S Dunn – Chief Executive (Note 6)	55 - 60	52	42.5 - 45	105 - 110	185 - 190	128	70 - 72.5	270 - 275
Mr A Eaton - Non Executive Director (Note 7)	0 - 5	-	-	0 - 5	10 - 15	-	-	10 - 15
Dr N Jenkins - Executive Medical Director (Note 8)	50 - 55	2	-	50 - 55	190 - 195	-	22.5 - 25	210 - 215
Mr C Lawrence - Non Executive Director (Note 9)	10 - 15	-	-	10 - 15	-	-	-	-
Mr N Macdonald - Executive Director of Resources (Note 10)	100 - 105	6	-	100 - 105	-	-	-	-
Mrs R Mason - Associate Non Executive Director (Note 11)	0 - 5	-	-	0 - 5	5 - 10	-	-	5 - 10
Dr P Molyneux - Interim Executive Medical Director (Note 12)	160 - 165	3	167.5 - 170	330 - 335	-	-	-	-
Mr J Over – Executive Director Workforce & Communications	115 - 120	6	7.5 - 10	125 - 130	120 - 125	-	20 - 22.5	140 - 145
Mrs L Pepper - Non Executive Director	10 - 15	-	-	10 - 15	10 - 15	-	-	10 - 15
Mr A Rose - Non Executive Director	10 - 15	7	-	10 - 15	10 - 15	14	-	15 - 20
Mr D Wilkes - Non Executive Director (Note 13)	0 - 5	-	-	0 - 5	5 - 10	-	-	5 - 10
Mrs S Wilkinson - Executive Director Chief Nurse	120 - 125	-	150 - 152.5	275 - 280	25 - 30	-	147.5 - 150	170 - 175

No additional performance pay and bonuses were paid to directors in 2021/22 or 2020/2021.

Table B – Pension benefits to 31 March 2022

Name	Real increase in pension at pension age (bands of £2,500)	Real increase in pension lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 31 March 2022 (bands of £5,000)	Lump Sum at pension age related to accrued pension at 31 March 2022 (bands of £5,000)	Cash equivalent transfer value at 1 April 2021	Real increase in cash equivalent Transfer Value	Cash equivalent transfer value at 31 March 2022
	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Craig Black (Note 15)	-	-	-	-	-	-	-
Nick Jenkins (Note 17)	-	-	35 - 40	60 - 65	685	-	588
Stephen Dunn (Note 16)	0 - 2.5	-	80 - 85	-	1,039	10	1,100
Helen Beck (Note 14)	-	-	-	-	-	-	-
Jeremy Over (Note 17)	0 - 2.5	-	35 - 40	55 - 60	478	1	498
Susan Wilkinson (Note 17)	5 - 7.5	20 - 22.5	45 - 50	145 - 150	954	177	1,153
Nicola Cottington (Note 17)	0 - 2.5	2.5 - 5	30 - 35	60 - 65	437	24	515
Nick Macdonald (Note 18)	-	-	-	-	-	-	-
Paul Molyneux (Note 17)	5 - 7.5	12.5 - 15	75 - 80	175 - 180	1,347	145	1,556

The value of pension benefits accrued during the year is calculated as the real increase in pension multiplied by 20, less the contributions made by the individual. The real increase excludes increases due to inflation or any increase or decrease due to a transfer of pension rights. This value derived does not represent an amount that will be received by the individual. It is a calculation that is intended to provide an estimation of the benefit that being a member of the pension scheme could provide. The pension benefit table provides further information on the pension benefits accruing to the individual.

Notes

1. H Beck was Chief Operating Officer to November 2021.
2. C Black was Executive Director of Resources to, and appointed Interim Chief Executive from, August 2021.
3. S Childerhouse was Chair to January 2022.
4. J Chin was appointed NED from September 2021 and Interim Chair from January 2022.
5. N Cottington was appointed Chief Operating Officer from November 2021.

6. S Dunn was Chief Executive to August 2021.

7. A Eaton was NED to May 2021.
8. N Jenkins was Executive Medical Director to June 2021. Remuneration includes payments for clinical sessions during period in Medical Director post.
9. C Lawrence was appointed NED from June 2021.
10. N Macdonald was appointed Interim Executive Deputy Director of Resources from August 2021.
11. R Mason was Associate NED to June 2021.
12. P Molyneux was appointed Interim Executive Medical Director from June 2021. Remuneration includes payments for clinical sessions during period in Medical Director post.
13. D Wilkes was NED to June 2021.
14. H Beck was over normal retirement age in prior year, therefore a CETV calculation was not applicable, and retired in the current year.
15. C Black opted out of the pension scheme in January 2020. As the member is no longer active in the pension scheme there are no figures available to calculate by the NHS Pension Agency.
16. Lump Sum is zero as a member of 2008 Section and 2015 Section which does not provide an automatic lump sum.
17. Lump Sum increase may be zero or low as now a member of 2015 Scheme which does not provide an automatic lump sum.
18. N Macdonald opted out of the pension scheme in December 2020. As the member is no longer active in the pension scheme there are no figures available to calculate by the NHS Pension Agency.



Craig Black
Interim Chief Executive
15 September 2022

2.8 Staff report

2.8.1 Our staff

The Trust is one of the largest employers in west Suffolk, employing 4,845 staff in April 2021. It firmly believes in the benefits of working in partnership with staff and the trade unions, and this was highlighted during 2021-22 with the following activities:

- the Trust achieved an above average rating for trusts for the staff engagement theme in the 2021 national NHS staff survey
- the percentage of staff recommending WSFT as a place to work in the 2021 national NHS staff survey was well above average for trusts
- our two Freedom to Speak Up Guardians, and Guardian of Safe Working for junior doctors, continue to support an open and inclusive culture
- staff governors also continue to support staff to discuss challenges and achievements and report on these
- as part of the Trust's health and wellbeing programme we continue to focus on both emotional and physical health and wellbeing. We provide a clinical psychologist-led staff support psychology service and offer a wide range of benefits to support staff.
- staff continue to receive financial assistance in the form of low-interest loans which are arranged by an external organisation, and have access to a staff physiotherapist
- all staff continue to have access to free membership of Abbeycroft Leisure which includes access to physical facilities and virtual classes
- all staff were offered both an influenza and COVID-19 vaccination in 2021-22
- we have introduced a full-time staffside lead role, replacing our part-time convenor role.
- we continue to develop our partnership working through the following groups:
  - Trust council
  - Trust negotiating committee (medical and dental)
  - health and wellbeing steering group
  - equality, diversity and inclusion steering group.

2.8.2 Staff costs

Staff costs

	Permanent	Other	2021-22 Total	2020-21 Total
	£000	£000	£000	£000
Salaries and wages	178,892	251	**179,143**	171,125
Social security costs	17,999	-	**17,999**	16,229
Apprenticeship levy	864	-	**864**	792
Employer's contributions to NHS pension scheme	29,653	-	**29,653**	27,485
Pension cost - other	66	-	**66**	66
Temporary staff	-	4,071	**4,071**	4,329
Total gross staff costs	**227,474**	**4,322**	**231,796**	**220,026**
Recoveries in respect of seconded staff	-	-	**-**	-
Total staff costs	**227,474**	**4,322**	**231,796**	**220,026**
Of which				
Costs capitalised as part of assets	1,651	-	**1,651**	3,938

2.8.3 Average number of employees (whole time equivalent (WTE) basis)

Average number of employees (WTE basis)

	Permanent Number	Other Number	2021-22 Total Number	2020-21 Total Number
Medical and dental	493	41	**534**	539
Administration and estates	837	49	**886**	807
Healthcare assistants and other support staff	812	106	**918**	937
Nursing, midwifery and health visiting staff	1,172	88	**1,260**	1,234
Scientific, therapeutic and technical staff	763	19	**782**	662
Total average numbers	**4,077**	**303**	**4,380**	**4,179**
Of which:				
Number of employees (WTE) engaged on capital projects	103	-	**103**	103

2.8.4 Reporting of compensation schemes - exit packages 2021-22

There were no compensation schemes/exit packages recorded in 2021-22.

2.8.5 Breakdown at year end of the number of male and female staff

	Male	Female	Total
Executive directors (including CEO)	4	2	6
Non-executive directors (including chair)	4	1	5
Other senior managers (band 8d and above)	10	5	15
Employees	940	3,879	4,845

2.8.6 Sickness absence data

The Trust has systems and processes in place to manage both long- and short-term sickness absence, in accordance with best practice and legislative requirements. The performance for the year is available via https://digital.nhs.uk/data-and-information/publications/statistical/nhs-sickness-absence-rates.

2.8.7 Trade Union facility time information

Number of employees who were trade union officials	Whole time equivalent
23	22.5
Percentage of time spent on facility time	**Number of employees**
0%	18
1%-50%	4
51% - 99%	1
100%	0
Total cost of facility time	**Costs**
Total pay bill	£226,408,000
Percentage of pay bill spent on facility time	0.25%
Time spent on trade union activities as percentage of total facilities time	**Percentage**
857	38%

2.8.8 Equality and diversity

The Trust is committed to the provision of high quality, safe care for all members of the communities it serves and to the development of a culture of inclusion where all people are valued and respected for their individual differences; as evidenced by our strategf: 'First for our patients, staff and the future'.

This means we will embrace all people irrespective of, for example, race, religion or belief, gender identity or expression, sexual orientation, age, marital status, pregnancy, maternity or disability. We will give equal access and opportunities and remove discrimination and intolerance. We will do this both as an employer and as a service provider.

Our **inclusion strategy objectives** are:

For **patients, service users and carers**:

- Improve the experience and care of patients and service users experiencing mental distress; those with learning disabilities and neurodiversity
- Improve the experience and care of people who are lesbian, gay, bisexual, trans and all other sexualities and gender identities.

For **staff:**

- Promote and support inclusive leadership at all levels of the Trust
- Ensure recruitment and selection processes are bias-free and inclusive
- Facilitate the voices of all staff, providing fora for individuals to come together, to share ideas, raise awareness of challenges, provide support to each other and feedback to the Trust on issues of equality, diversity and inclusion
- Take action to support the mental health and wellbeing of all staff.

For **patients, service users, carers and staff**:

- Promote a culture of inclusion in delivery of care to all patients and staff
- Improve information and data collected, in respect of protected characteristics in order to understand what action may be required
- Tackle bullying and harassment of and by staff and support staff to respectfully and successfully challenge problem behaviours.

Our objectives have been drawn from an in-depth analysis of progress to date with our equality delivery system (EDS), a review of EDS2 goals and outcomes, a review of our performance against the nine NHS Workforce Race Equality Standard indicators, national staff survey results, our gender pay gap report, the Trust's strategy and the requirements of the Equality Act (2010), including the Public Sector Equality Duty (PSED).

Our objectives were reviewed and updated in the summer of 2019 for August 2019 to July 2021. Progress is monitored quarterly by the equality and diversity steering group and an annual report is received by the Board. Progress towards our equality, diversity and inclusion objectives can be seen in the inclusion plan published on our website.

The data shows all current employees and public members broken down by protected characteristics (data is not available for all the characteristics protected by the Equality Act):

Employees and public members protected characteristics

	Staff in post				Public Members			
	2021-22	2020-21	2019-20	2018-19	2021-22	2020-21	2019-20	2018-19
Age								
16	0	0	0	0	0	0	0	0
17-21	60	75	54	64	62	60	71	51
22+	4785	4673	4299	3981	6874	6077	6,105	5,800
Not specified	0	0	0	0	108	114	120	123
Total	4845	4748	4353	4045	7044	6251	6,296	5,974
Ethnicity								
White	3801	3765	3500	3382	6180	5540	5,600	5,331
Mixed	65	55	49	44	45	32	34	29
Asian or Asian British	517	485	461	312	167	106	95	88
Black or Black British	95	60	29	31	41	28	28	23
Other ethnic group	67	48	39	42	39	34	35	30
Not stated	162	186	198	213	572	511	504	473
Undefined	138	149	77	21	0	0	0	0
Total	4845	4748	4353	4045	7044	6251	6,296	5,974
Gender								
Female	3887	3833	3544	3281	4663	3953	3,932	3,673
Male	958	915	809	764	2381	2298	2,364	2301
Total	4845	4748	4353	4045	7044	6251	6,926	5,974
Disability								
No	2754	2436	2104	1770	-		-	-
Not declared	291	325	365	327	-		-	-
Undefined	1225	1370	1227	1276	6265	5670	5,661	5,338
Prefer not to answer	387	455	516	558	177	-	-	-
Yes	188	162	141	114	602	581	635	636
Total	4845	4748	4353	4045	7044	6251	6,296	5,974

Source: Electronic Staff Record (as at 1/4/2022)

	Male	Female	Total
Executive directors (including CEO)	4	2	6
Non-executive directors (including chair)	4	1	5
Other senior managers (band 8d and above)	10	5	15
Employees	940	3,879	4,845

Source: Electronic Staff Record (as at 1/4/2022)

Disability and equal opportunities policies

The Trust is committed to a policy of equal opportunities in employment and service delivery. Everyone who comes to the Trust, either as a patient or visitor, or who works in the Trust, or applies to work in the Trust, should be treated fairly and valued equally. Our Trust policies and strategies (the equality delivery system, recruitment and retention of people with disabilities, supporting people who are trans policy and equal opportunities policy) all support this focus.

The Trust completes an annual action plan based on its performance against the NHS Workforce Race Equality Standard, Workforce Disability Equality Standard and gender pay gap reporting, the national NHS staff survey and other locally identified priorities.

Gender pay gap legislation requires all employers of 250 or more employees to publish their gender pay gap as at 31 March each year. You can download our gender pay gap report via https://www.wsh.nhs.uk/CMS-Documents/EqualityandDiversity/GPG-Report.pdf.

The Trust seeks to provide equitable employment opportunities for people with disabilities, ensuring that they benefit from all available training and opportunities for career development, and WSFThas a policy to support the recruitment and retention of people with disabilities. Additionally, our policy on appraisal, personal development planning and the knowledge and skills framework supports and promotes the equal access of all staff to training and development.

The Trust has systems and processes in place to review staff turnover. Information for the year is available via https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics

2.8.9 Health and safety report

The Trust's health and safety performance is reported to and monitored by the health and safety committee which then escalates any issues of concern to the corporate risk governance group. Issues that cannot be resolved or which need to be escalated are reported up to the insight committee and the board of directors accordingly.

Risk assessment

The strategy for the management of risk in WSFT continues to be developed and promoted Trust-wide. The Datix risk register is a tool for capturing, prioritising and managing the Trust's significant risks and is integral to the Trust's risk management framework.

The risk register allows all divisions to manage, monitor and review their own risks. The responsibility lies with each departmental manager to ensure all their significant risks are captured on the risk register. Risk register training is provided by the head of health, safety and risk and the Trusts health and safety advisor.

Between April 2021 to March 2022,nine members of staff were trained in the principles of health, safety and risk assessment. This has improved the quality and quantity of risk assessments and has helped to promote the use of the risk register.

Workplace inspections are undertaken by health and safety link persons who are qualified with the Royal Society for Public Health (RSPH) Level 2 award in health and safety. This qualification gives the link person the knowledge and understanding to undertake the inspection. 254 members of staff have now gained this qualification. Once completed, the inspection is captured on the risk register so actions can be monitored.

Reporting of Injuries, Diseases and Dangerous Occurrence Regulations 2013 (RIDDOR)

Between April 2021 to March 2022 16 incidents were reported to the Health and Safety Executive (HSE) as required under RIDDOR. This is a decrease of five from the previous year.

There were no RIDDOR reportable incidents relating to asbestos or needlesticks. There was a decrease in the category of moving and handling from six to two incidents; slips, trips and falls from six to four incidents. Violence and aggression incidents increased from two to five while health and safety related incidents remained at five.

RIDDOR description	2021-22
Moving and handling incidents	2
Slips, trips and falls	4
Health and Safety	5
Violence and aggression	5

The Trust continues to improve standards which has helped to reduce the number of moving and handling incidents, this includes:

- Handling patients and safe handling of loads policy and procedure
- All front-line staff attend mandatory moving and handling training via e-learning and classroom sessions
- Improved moving and handling advisor and trainer resource
- All wards and departments are required to have moving and handling risk assessments.

Of the 16 incidents reported to the HSE, 12 (75%) were due to being off work for more than seven days following an incident. The health and safety committee reviews incident trends, including RIDDORs to ensure that appropriate learning takes place and action is taken.

Incident reporting system

The Datix incident reporting system is used to capture all clinical and non-clinical incidents. Non-clinical incidents include reports of personal accidents, violence and aggression, abuse and harassment, fire, and security breaches. All incidents, no matter the grade, are investigated and reported according to the Trust's incident policy and procedure. Actions taken as a result of investigations are communicated through the divisional governance groups. The Board of directors receives a quarterly report summarising incident trends and action.

For the period April 2021 to March 2022 there were 367 violence, abuse and harassment incidents - a increase of 30 from the previous year. These incidents take into account physical assaults, verbal abuse, harassment and physically threatening behaviour towards staff by patients. Out of the 337 incidents reported there were 128 physical assaults, and 90 were recorded as having a clinical cause. Clinical-caused incidents are those whereby the patient is not aware or has no control of their actions. This can be postoperative due to having a general anaesthetic or, more commonly, the patient is suffering from dementia or is cognitively impaired. During 2017 new training to support staff in managing challenging behaviour was introduced.

There were 1,813 reported incidents of personal accident/ill-health during 2021-22. This is an increase of 33 incidents (2%) from the previous year. This figure includes staff, patients, visitors and others and is broken down into specific incident categories, which include slips/trips/falls, contact with an object, contact with a sharp, e.g. needle, lifting and handling, self-harm, exposure to a harmful substance, contact with electricity and a category of 'other'. Further detail of learning and action is provided in section 3 (quality report).

2.8.10 Occupational health report / occupational health and wellbeing service

Occupational health and wellbeing vision:

To deliver a professional, quality occupational health and wellbeing service to the West Suffolk NHS Foundation Trust and become an essential component in the quality service delivered to the local community by taking a public health approach to occupational health and wellbeing.

Promoting the health and wellbeing of all our staff is important to support them in delivering excellent care for our community as well as being a marker of a good employer.

Our health and wellbeing steering group oversees our programme of action to support our staff and our wellbeing plan sets out our annual priorities.

In October 2021 we entered into a new partnership with Workplace Health and Wellbeing, part of the Norfolk and Norwich University Hospitals NHS Foundation Trust, to provide comprehensive occupational health services for all our staff.

We continue to focus on the emotional, physical and financial wellbeing of our staff. Offering, for example, a clinical psychologist-led staff support psychology service, free membership of Abbeycroft Leisure for all our staff, access to a staff physiotherapy service and a debt management service for any staff who may be experiencing financial stress.

All our staff have had easy access to both an influenza and COVID-19 vaccination through our inhouse vaccination programmes.

2.8.11 Staff survey

The NHS staff survey is each year across the service in England. It is one of the largest staff feedback and benchmarking exercises for any employer in the world. A set of standard questions is used, with each Trust required to appoint an independent survey contractor to administer the process, collate results and submit these to the national staff survey centre. This then leads to all Trusts receiving a standardised report which benchmarks them against their own historical performance, and against comparator organisations. The WSFT is benchmarked against other acute and acute & community trusts.

The staff survey provides deep insights into the views and experiences of our staff. We use the results to understand our current position and involve our teams in how the report's findings are interpreted and taken forward.

Staff support and engagement

The WSFT moved from a partial survey to a full census of all its staff for the 2019 survey. This was done so the Trust could better understand the thoughts of the staff on what was working well and how we can better improve our services for the benefit of patients and the public. The Trust encourages open and honest communication throughout the organisation. A number of methods have been developed to encourage all staff to feel that they can contribute:

- All-staff briefing – weekly live briefing and Q&A with executives
- 'What Matters to You' survey – staff discussion workshops during the pandemic
- Monthly team briefings
- Freedom to Speak Up guardians
- Guardian of safe working for junior doctors
- Senior independent director – non-executive director lead for whistleblowing
- Weekly executive director open door session in Time Out restaurant (impacted by COVID-19)
- Executive and environmental walkabouts (impacted by COVID-19)
- Electronic staff briefing issued at least once a week
- Monthly medical director's bulletin for medical staff
- The Green Sheet weekly staff newsletter
- The 5 o'clock club - our leadership and culture development forum
- Staff recognition programme
- Staff health and wellbeing focus groups
- Staff networks – LGB&T+, BAME and disability networks
- Staff engagement on corporate social media, e.g. Twitter and Facebook

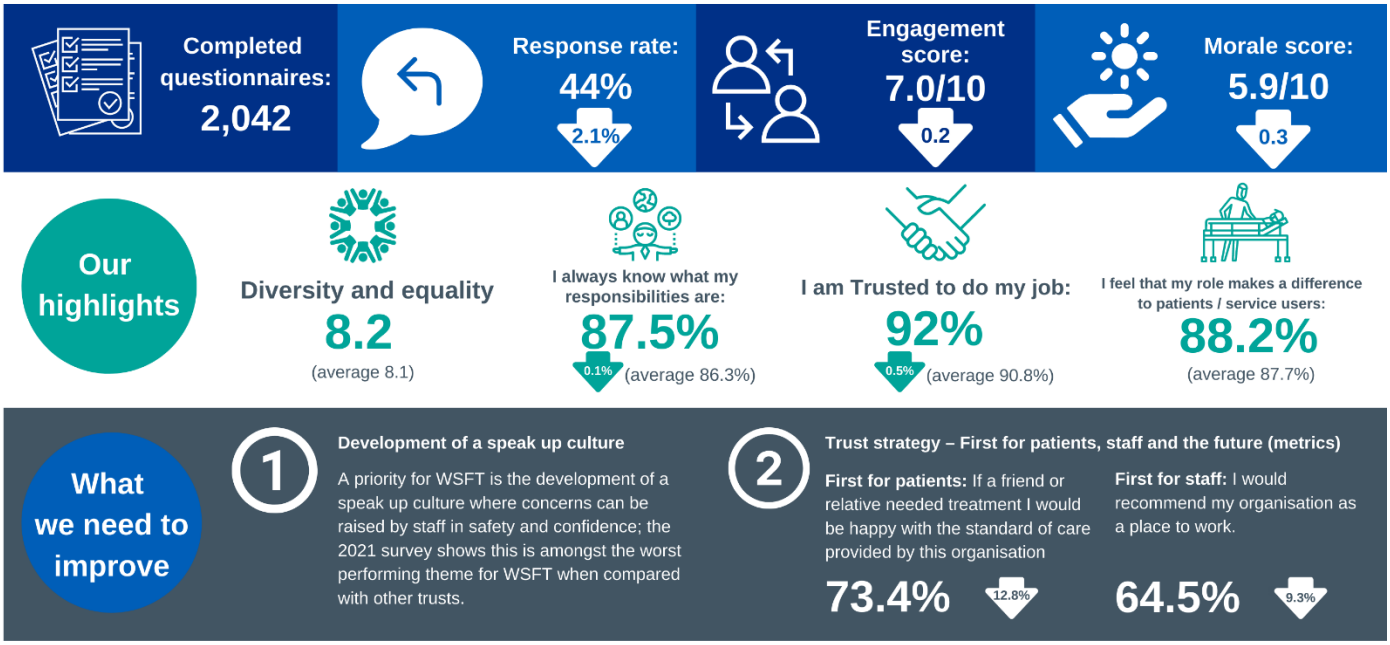
- A telephone hotline and web-based reporting for raising concerns anonymously
- Network of FTSU champions.

Summary of staff survey

From 2021 onwards, the results from questions were grouped to give scores in nine indicators. The themes of the new indicators are centered around the NHS People Promise. The indicator scores are based on a score out of 10 for certain questions with the indicator score being the average of those.

In all of the themes the Trust is considered to be average or above average, we are average in only one theme.

NHS staff survey – headline results 2021



The themes have changed from the previous years, and though some themes have the same name, the questions that make up that theme also differ. The themes that have data for 2020 and 2019 are those that have a similar tone to the new themes.

	2021		2020		2019	
	Trust	Benchmarking group	Trust	Benchmarking group	Trust	Benchmarking group
We are compassionate and inclusive	7.3	7.2	-	-	-	-
We are recognised and rewarded	5.9	5.8	-	-	-	-
We each have a voice that counts	6.7	6.7	-	-	-	-
We are safe and healthy	6.0	5.9	6.6	6.8	7.1	7.0
We are always learning	5.4	5.2	-	-	-	-
We work flexibly	6.0	5.9	-	-	-	-
We are a team	6.7	6.6	6.6	6.5	6.9	6.6
Staff engagement	7.0	6.8	7.2	7.0	7.5	7.0
Morale	5.9	5.7	6.4	6.2	6.6	6.1

Summary of staff survey response

The following summaries provide details on the response rates to the recent staff survey and how this compares to the previous years.

	2021	2020	2019

Response rate	44%	45.7%	51.8%
Benchmarking group	52%	45.4%	47.5%

Best and worse scores against benchmarking

Best scores

	2021-22		2020-21		2019-20	
Indicator	**Trust**	**Benchmarking group**	Trust	Benchmarking group	Trust	Benchmarking group
q21d. If friend/relative needed treatment would be happy with standard of care provided by organisation	**74%**	**66%**	83%	74%	86%	71%
q21c. Would recommend organisation as place to work	**65%**	**59%**	74%	67%	77%	63%
q11a. Organisation takes positive action on health and well-being	**63%**	**57%**	-	-	-	-
q8c. Colleagues are polite and treat each other with respect	**76%**	**71%**	-	-	-	-
q3e. Involved in deciding changes that affect work	**54%**	**49%**	52%	50%	58%	53%

Worst scores

	2021-22		2020-21		2019-20	
Indicator	**Trust**	**Benchmarking group**	Trust	Benchmarking group	Trust	Benchmarking group
q17b. Would feel confident that organisation would	**52%**	**59%**	55%	59%	67%	59%
q21b. Organisation acts on concerns raised by patients/service users	**66%**	**71%**	72%	74%	80%	73%
q14d. Last experience of harassment/bullying/abuse reported	**43%**	**48%**	46%	46%	45%	46%
q17a. Would feel secure raising concerns about unsafe clinical practice	**69%**	**73%**	69%	72%	75%	71%
q13d. Last experience of physical violence	**65%**	**67%**	71%	68%	72%	68%

Next steps on our journey

The staff survey theme results have been shared with our colleagues and there are plans to share more detail through all-staff briefings, this is to provide staff with an opportunity to share their thoughts on the report.

The Trust will include a check-in in relation to the things they are working on to make improvements, and the opportunity for staff to suggest other improvements.

Later in the year we plan to hold another 'What Matters to You' programme, this will provide further opportunities for the staff to input into our priorities for improving WSFT as a place to work – as a whole, and across individual teams.

2.8.12 Pension liabilities for ill-health retirement

There were three ill-health retirements during the year to 31 March 2022 (2020-21: two); the additional pension liability borne by NHS Pensions was estimated as £69k (2020-21: £120k).

2.8.13 Policies and procedures for fraud and corruption

The Trust is committed to the elimination of fraud and corruption and is determined to protect itself and the public from such unlawful activities, whether they are attempted from within the Trust, or by an outside individual, group or organisation.

The Trust is committed to ensuring that opportunities for fraud and corruption are reduced to the lowest possible level by creating an anti-fraud culture that:

- Deters fraud
- Prevents fraud that cannot be deterred
- Detects fraud that cannot be prevented.

To achieve this WSFT will:

- Ensure that employees, contractors, suppliers and users of our services understand that fraud is unacceptable and that they are able to raise serious concerns easily
- Share information with other Trusts and organisations to deal with fraud and corruption locally and nationally, working within the law
- Increase awareness of fraud and corruption through a programme of training and communication
- Investigate all allegations of fraud and corruption in a professional manner
- Apply appropriate sanctions such as disciplinary action, criminal proceedings and recovery of losses when necessary
- Where appropriate, WSFT will publicise cases demonstrating the Trust's commitment to fighting fraud.

By creating an anti-fraud culture, the Trust will help ensure that money is not lost to the organisation that could have been invested in patient care. It will also provide an environment in which employees have the confidence to report any fraud concerns they may have.

To support this commitment the Trust has policies and procedures in respect of fraud and corruption as well as a Bribery Act policy. It also has a nominated local counter fraud specialist (LCFS) whose role is to provide support and advice on all matters relating to fraud and to be a point of contact for fraud reporting. The LCFS reports to the audit committee. the assistant director of finance is the nominated Fraud Champion at the Trust.

2.8.14 Off-payroll engagements

As required by HM Treasury per Public Expenditure System (PES) (2022)01, the Trust must disclose information regarding off- payroll engagements.

Highly paid off-payroll engagements as at 31 March 2022 earning £245 per day or greater:

No. of existing engagements as of March 2022	6
Of which:	
No. that have existed for less than one year at the time of reporting	0
No. that have existed for between one and two years at time of reporting	1
No. that have existed for between two and three years at time of reporting	0
No. that have existed for between three and four years at time of reporting	1
No. that have existed for four or more years at time of reporting	4

All highly paid off-payroll workers engaged at any point during the year ended 31 March 2022 earning £245 per day or greater:

No. of off-payroll workers engaged during the year ended 31 March 2022	0
Of which:	
Not subject to off-payroll legislation	0
Subject to off-payroll legislation and determined as in scope for IR35	0
Subject to off-payroll legislation and determined as out of scope for IR35	0
No. of engagements reassessed for compliance or assurance purposes during the year	6
No. of engagements that saw a change to IR35 status following the consistency review.	0

For any off-payroll engagements of Board members, and/or senior officials with significant financial responsibility, between 1 April 2021 and 31 March 2022:

No. of off-payroll engagements of Board members, and/or, senior officials with significant financial responsibility, during the financial year.	0
No. of individuals that have been deemed 'Board members, and/or senior officials with significant financial responsibility', during the financial year. This figure should include both off-payroll and on-payroll engagements.	26

All existing off-payroll engagements, outlined above, have at some point been subject to a risk-based assessment as to whether assurance is required that the individual is paying the right amount of tax and, where necessary, that assurance has been sought. All invoices relating to off-payroll engagements are subject to authorisation through the normal expenditure control processes.

The Trust has reviewed all off-payroll arrangements and from 6 April 2017, all arrangements have been terminated or moved on to payroll unless they are assessed as meeting HMRC's requirements to be paid gross. There were no off-payroll engagements of Board members and/or senior officials with significant financial responsibility between 1 April 2021 and 31 March 2022.

During 2021-22, the Trust spent £238k on consultancy costs (2020-21 £365k). Consultancy is commissioned when the Trust does not have its own internal resource or expertise to undertake the work in-house or when specific additional resource is required for a project.

2.8.15 Other disclosures

Other relevant disclosures for this section of the annual report are including within section 2.2 (directors report).

West Suffolk NHS Foundation Trust

Annual accounts for the year ended 31 March 2022

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Foreword to the accounts

West Suffolk NHS Foundation Trust

These accounts, for the year ended 31 March 2022, have been prepared by West Suffolk NHS Foundation Trust in accordance with paragraphs 24 & 25 of Schedule 7 within the National Health Service Act 2006.

Signed 

Name **Craig Black**
Job title **Chief Executive Officer (Interim)**
Date **15 September 2022**

INDEPENDENT AUDITOR'S REPORT TO THE COUNCIL OF GOVERNORS OF WEST SUFFOLK NHS FOUNDATION TRUST

REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS

Opinion

We have audited the financial statements of West Suffolk NHS Foundation Trust ("the Trust") for the year ended 31 March 2022 which comprise the Statement of Comprehensive Income, Statement of Financial Position, Statement of Changes in Taxpayers Equity and Statement of Cash Flows, and the related notes, including the accounting policies in note 1.

In our opinion the financial statements:

- give a true and fair view of the state of the Trust's affairs as at 31 March 2022 and of the Trust's income and expenditure for the year then ended; and
- have been properly prepared in accordance with the Accounts Direction issued under paragraphs 24 and 25 of Schedule 7 of the National Health Service Act 2006 and the Department of Health and Social Care Group Accounting Manual 2021/22.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) ("ISAs (UK)") and applicable law. Our responsibilities are described below. We have fulfilled our ethical responsibilities under, and are independent of, the Trust in accordance with, UK ethical requirements including the FRC Ethical Standard. We believe that the audit evidence we have obtained is a sufficient and appropriate basis for our opinion.

Going concern

The Directors have prepared the financial statements on the going concern basis as they have not been informed by the relevant national body of the intention to dissolve the Trust without the transfer of its services to another public sector entity. They have also concluded that there are no material uncertainties that could have cast significant doubt over its ability to continue as a going concern for at least a year from the date of approval of the financial statements ("the going concern period").

In our evaluation of the Directors' conclusions, we considered the inherent risks to the Trust's business model and analysed how those risks might affect the Trust's financial resources or ability to continue operations over the going concern period.

Our conclusions based on this work:

- we consider that the Directors' use of the going concern basis of accounting in the preparation of the financial statements is appropriate;
- we have not identified and concur with the Directors' assessment that there is not a material uncertainty related to events or conditions that, individually or collectively, may cast significant doubt on the Trust's ability to continue as a going concern for the going concern period.

However, as we cannot predict all future events or conditions and as subsequent events may result in outcomes that are inconsistent with judgements that were reasonable at the time they were made, the above conclusions are not a guarantee that the Trust will continue in operation.

Fraud and breaches of laws and regulations – ability to detect

Identifying and responding to risks of material misstatement due to fraud

To identify risks of material misstatement due to fraud ("fraud risks") we assessed events or conditions that could indicate an incentive or pressure to commit fraud or provide an opportunity to commit fraud. Our risk assessment procedures included:

- Enquiring of management, the Audit Committee and internal audit and inspection of policy documentation as to the Trust's high-level policies and procedures to prevent and detect fraud, including the internal audit function, and the Trust's channel for "whistleblowing", as well as whether they have knowledge of any actual, suspected or alleged fraud.
- Reading Board and Audit Committee minutes.
- Using analytical procedures to identify any unusual or unexpected relationships.
- Reviewing the Trust's accounting policies.

We communicated identified fraud risks throughout the audit team and remained alert to any indications of fraud throughout the audit.

As required by auditing standards, and taking into account possible pressures to meet delegated targets, we performed procedures to address the risk of management override of controls and the risk that Trust management may be in a position to make inappropriate accounting entries.

In line with the guidance set out in Practice Note 10 Audit of Financial Statements of Public Sector Bodies in the United Kingdom we also recognised a fraud risk related to expenditure recognition, particularly in relation to year-end accruals and provisions.

On this audit we did not identify a fraud risk related to revenue recognition due to the block nature of the funding provided to the Trust during the year. We therefore assessed that there was limited opportunity for the Trust to manipulate the income that was reported.

We did not identify any additional fraud risks.

We also performed procedures including:

- Identifying journal entries and other adjustments to test based on risk criteria and comparing the identified entries to supporting documentation. These included:
    - Unexpected postings to cash and expenditure codes; and
    - Any material post-close journals.
- Assessing significant estimates for bias.
- Assessing the completeness of disclosed related party transactions and verifying they had been accurately recorded within the financial statements.
- Assessing the appropriateness of expenditure recognised with specific emphasis placed on cut-off. This included:
    - Sample testing of year-end accruals;
    - Review of year-end journals posted to increase expenditure accounts;
    - Sample testing of invoices and bank payments post year-end;

Identifying and responding to risks of material misstatement related to non-compliance with laws and regulations

We identified areas of laws and regulations that could reasonably be expected to have a material effect on the financial statements from our general sector experience and through discussion with the directors and other management (as required by auditing standards), and from inspection of the Trust's regulatory and legal correspondence and discussed with the directors and other management the policies and procedures regarding compliance with laws and regulations.

As the Trust is regulated, our assessment of risks involved gaining an understanding of the control environment including the entity's procedures for complying with regulatory requirements.

We communicated identified laws and regulations throughout our team and remained alert to any indications of non-compliance throughout the audit.

The potential effect of these laws and regulations on the financial statements varies considerably.

The Trust is subject to laws and regulations that directly affect the financial statements, including the National Health Service Act 2006 and financial reporting legislation. We assessed the extent of compliance with these laws and regulations as part of our procedures on the related financial statement items.

Whilst the Trust is subject to many other laws and regulations, we did not identify any others where the consequences of non-compliance alone could have a material effect on amounts or disclosures in the financial statements.

Context of the ability of the audit to detect fraud or breaches of law or regulation

Owing to the inherent limitations of an audit, there is an unavoidable risk that we may not have detected some material misstatements in the financial statements, even though we have properly planned and performed our audit in accordance with auditing standards. For example, the further removed non-compliance with laws and regulations is from the events and transactions reflected in the financial statements, the less likely the inherently limited procedures required by auditing standards would identify it.

In addition, as with any audit, there remained a higher risk of non-detection of fraud, as these may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal controls. Our audit procedures are designed to detect material misstatement. We are not responsible for preventing non-compliance or fraud and cannot be expected to detect non-compliance with all laws and regulations.

Other information in the Annual Report

The Directors are responsible for the other information presented in the Annual Report together with the financial statements. Our opinion on the financial statements does not cover the other information and, accordingly, we do not express an audit opinion or, except as explicitly stated below, any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether, based on our financial statements audit work, the information therein is materially misstated or inconsistent with the financial statements or our audit knowledge. Based solely on that work:

- we have not identified material misstatements in the other information; and
- in our opinion the other information included in the Annual Report for the financial year is consistent with the financial statements.
- in our opinion that report has been prepared in accordance with the requirements of the NHS Foundation Trust Annual Reporting Manual 2021/22.

Annual Governance Statement

We are required to report to you if the Annual Governance Statement has not been prepared in accordance with the requirements of the NHS Foundation Trust Annual Reporting Manual 2021/22. We have nothing to report in this respect.

Remuneration and Staff Reports

In our opinion the parts of the Remuneration and Staff Reports subject to audit have been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2021/22.

Accounting Officer's responsibilities

As explained more fully in the statement set out on page 85, the Accounting Officer is responsible for the preparation of financial statements that give a true and fair view. They are also responsible for: such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; assessing the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the Trust without the transfer of their services to another public sector entity.

Auditor's responsibilities

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue our opinion in an auditor's report. Reasonable assurance is a high level of assurance, but does not guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements.

A fuller description of our responsibilities is provided on the FRC's website at www.frc.org.uk/auditorsresponsibilities.

REPORT ON OTHER LEGAL AND REGULATORY MATTERS

Report on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice, we are required to report if we identify any significant weaknesses in the arrangements that have been made by the Trust to secure economy, efficiency and effectiveness in its use of resources.

During December 2021, the West Suffolk Review, commissioned by NHS England on behalf of the Department for Health and Social Care, was published. The report noted that the Trust's Board performance fell short on both ensuring accountability and shaping culture.

We acknowledge that the Trust has acted on some of the recommendations made by the Review and, following the publication of the formal Review report, the Trust has developed a detailed Action Plan which was approved by the Board in March 2022. However, for the year under review, there was a significant weakness in the Trust's governance arrangements.

We have raised a recommendation within our Auditor's Annual Report for the Trust to ensure that implementation of the action plan to respond to the recommendations of the independent review is appropriately monitored and the agreed actions are implemented.

Respective responsibilities in respect of our review of arrangements for securing economy, efficiency and effectiveness in the use of resources

The Trust is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

Under Section 62(1) and paragraph 1(d) of Schedule 10 of the National Health Service Act 2006 we have a duty to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice and related statutory guidance having regard to whether the Trust had proper arrangements in place to ensure financial sustainability, proper governance and the use of information about costs and performance to improve the way it manages and delivers its services. Based on our risk assessment, we undertook such work as we considered necessary.

Statutory reporting matters

We are required by Schedule 2 to the Code of Audit Practice issued by the Comptroller and Auditor General ('the Code of Audit Practice') to report to you if we refer a matter to the relevant NHS regulatory body under paragraph 6 of Schedule 10 of the National Health Service Act 2006 because we have reason to believe that the Trust, or a director or officer of the Trust, is about to make, or has made, a decision which involves or would involve the Trust incurring unlawful expenditure, or is about to take, or has taken, a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency.

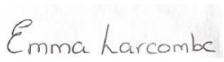
We have nothing to report in this respect.

THE PURPOSE OF OUR AUDIT WORK AND TO WHOM WE OWE OUR RESPONSIBILITIES

This report is made solely to the Council of Governors of the Trust, as a body, in accordance with Schedule 10 of the National Health Service Act 2006 and the terms of our engagement by the Trust. Our audit work has been undertaken so that we might state to the Council of Governors of the Trust, as a body, those matters we are required to state to them in an auditor's report, and the further matters we are required to state to them in accordance with the terms agreed with the Trust, and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors of the Trust, as a body, for our audit work, for this report, or for the opinions we have formed.

CERTIFICATE OF COMPLETION OF THE AUDIT

We certify that we have completed the audit of the accounts of West Suffolk NHS Foundation Trust for the year ended 31 March 2022 in accordance with the requirements of Schedule 10 of the National Health Service Act 2006 and the Code of Audit Practice.



Emma Larcombe
for and on behalf of KPMG LLP
Chartered Accountants
Botanic House
100 Hills Road
Cambridge
CB2 1AR

16 September 2022

Statement of Comprehensive Income for the year ended 31 March 2022

	Note	2021/22 £000	Restated 2020/21 £000
Operating income from patient care activities	3	328,976	264,518
Other operating income	4	23,203	56,764
Operating expenses	6, 21	(120,875)	(103,806)
Employee Benefits	8, 21	(230,145)	(216,088)
Operating surplus/(deficit) from continuing operations		**1,159**	**1,388**
Finance income		13	3
Finance expenses		(1,701)	(2,378)
PDC dividends payable		(3,918)	(2,832)
Net finance costs		**(5,606)**	**(5,207)**
Other gains / (losses)		20	(42)
Surplus / (deficit) for the year		**(4,427)**	**(3,861)**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments - taken to the revaluation reserve	7	(77)	(574)
Revaluations	12.4	3,038	2,605
Other reserve movements		-	30
Total comprehensive income / (expense) for the period		**(1,466)**	**(1,800)**

Statement of Financial Position as at 31 March 2022

	Note	31 March 2022 £000	Restated 31 March 2021 £000
Non-current assets			
Intangible assets	11, 21	52,039	46,025
Property, plant and equipment	12	169,487	135,703
Investment property		1,400	1,400
Receivables	13	5,807	6,341
Total non-current assets		**228,733**	**189,469**
Current assets			
Inventories		3,574	3,481
Receivables	13	15,069	19,362
Cash and cash equivalents	14	33,323	23,788
Total current assets		**51,966**	**46,631**
Current liabilities			
Trade and other payables	15	(60,164)	(52,522)
Borrowings	16	(5,858)	(6,439)
Provisions		(38)	(46)
Other liabilities		(2,888)	(1,357)
Total current liabilities		**(68,948)**	**(60,364)**
Total assets less current liabilities		**211,751**	**175,736**
Non-current liabilities			
Borrowings	16	(44,002)	(47,719)
Provisions		(415)	(852)
Total non-current liabilities		**(44,417)**	**(48,571)**
Total assets employed		**167,334**	**127,165**
Financed by			
Public dividend capital		200,285	158,650
Revaluation reserve		11,704	8,743
Income and expenditure reserve	21	(44,655)	(40,228)
Total taxpayers' equity		**167,334**	**127,165**

The notes on pages 135 to 167 form part of these accounts.



Name Craig Black
Position Chief Executive Officer (Interim)
Date 15 September 2022

Statement of Changes in Equity for the year ended 31 March 2022

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2021 - restated	**158,650**	**8,743**	**(40,228)**	**127,165**
Surplus/(deficit) for the year	-	-	(4,427)	**(4,427)**
Impairments	-	(77)	-	**(77)**
Revaluations	-	3,038	-	**3,038**
Public dividend capital received	41,635	-	-	**41,635**
Taxpayers' and others' equity at 31 March 2022	**200,285**	**11,704**	**(44,655)**	**167,334**

Statement of Changes in Equity for the year ended 31 March 2021

	Public dividend capital	Revaluation reserve	Restated Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2020 - brought forward	**74,065**	**6,942**	**(33,583)**	**47,424**
Prior period adjustment (see note 21)	-	-	(3,044)	**(3,044)**
Taxpayers' and others' equity at 1 April 2020 - restated	**74,065**	**6,942**	**(36,627)**	**44,380**
Surplus/(deficit) for the year (restated - see note 21))	-	-	(3,861)	**(3,861)**
Other transfers between reserves	-	(230)	230	**-**
Impairments	-	(574)	-	**(574)**
Revaluations	-	2,605	-	**2,605**
Public dividend capital received	84,585	-	-	**84,585**
Other reserve movements	-	-	30	**30**
Taxpayers' and others' equity at 31 March 2021 - restated	**158,650**	**8,743**	**(40,228)**	**127,165**

Information on reserves

Public dividend capital
Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. Additional PDC may also be issued to Trusts by the Department of Health and Social Care (DHSC). A charge, reflecting the cost of capital utilised by the Trust, is payable to DHSC as the public dividend capital dividend.

Revaluation reserve
Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

Income and expenditure reserve
The balance of this reserve is the accumulated surpluses and deficits of the Trust.

Statement of Cash Flows for the year ended 31 March 2022

	Note	2021/22 £000	Restated 2020/21 £000
Cash flows from operating activities			
Operating surplus / (deficit)	21	1,159	1,388
Non-cash income and expense:			
Depreciation and amortisation	6, 21	9,800	7,243
Net impairments	7	4,647	1,496
Income recognised in respect of capital donations	4	(149)	(371)
(Increase) / decrease in receivables and other assets		4,997	12,678
(Increase) / decrease in inventories		(93)	(609)
Increase / (decrease) in payables and other liabilities		11,945	14,464
Increase / (decrease) in provisions		(445)	85
Other movements in operating cash flows		-	-
Net cash flows from / (used in) operating activities		**31,861**	**36,374**
Cash flows from investing activities			
Interest received		13	3
Purchase and sale of financial assets / investments		-	-
Purchase of intangible assets		(8,174)	(12,983)
Sales of intangible assets		-	-
Purchase of PPE and investment property		(45,736)	(27,526)
Sales of PPE and investment property		20	6
Net cash flows from / (used in) investing activities		**(53,877)**	**(40,500)**
Cash flows from financing activities			
Public dividend capital received		41,635	84,585
Public dividend capital repaid		-	-
Repayment of loans from DHSC		(2,307)	(56,258)
Repayment on other loans		(442)	560
Capital element of finance lease rental payments		(1,567)	(1,287)
Interest on loans		(1,107)	(1,525)
Interest paid on finance lease liabilities		(573)	(981)
PDC dividend (paid) / refunded		(4,088)	(3,025)
Net cash flows from financing activities		**31,551**	**22,069**
Increase / (decrease) in cash and cash equivalents		**9,535**	**17,943**
Cash and cash equivalents at 1 April - brought forward		**23,788**	**2,441**
Impact of prior period adjustment	21		3,404
Cash and cash equivalents at 31 March	14	**33,323**	**23,788**

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

NHS Improvement, in exercising the statutory functions conferred on Monitor, has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2021/22 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts

Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

Note 1.2 Going concern

These accounts have been prepared on a going concern basis. The financial reporting framework applicable to NHS bodies, derived from the HM Treasury Financial Reporting Manual, defines that the anticipated continued provision of the entity’s services in the public sector is normally sufficient evidence of going concern. The directors have a reasonable expectation that this will continue to be the case. The Trust achieved an adjusted financial surplus position (after adjusting for impairments and donated items) during the financial year and is forecast to breakeven in the forthcoming year.

The Directors have a reasonable expectation that the Trust has adequate resources to continue in operational existence for the foreseeable future. They have not identified any material uncertainties that may cast significant doubt on the Trust's ability to continue as a going concern. For this reason, they continue to adopt the going concern basis in preparing the accounts.

Note 1.3 Interests in other entities

The Trust has a 25% share in Collaborative Procurement Partnership Limited Liability Partnership (LLP) with three other NHS Organisations. The LLP was established in 2017/18 and the investment in this is not yet material to the Trust. Therefore assets have not been reflected in the accounts. No income has been accrued for in 2021/22 as no profits are expected to be distributed (Nil in 2020/21).

MyWish charity has not been consolidated into the Trust's accounts on the grounds of materiality.

Note 1.4 Revenue from contracts with customers
Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS).

Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, the Trust accrues income relating to performance obligations satisfied in that year. Where the Trust's entitlement to consideration for those goods or services is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

Revenue from NHS contracts
The main source of income for the Trust is contracts with commissioners for health care services. In 2021/22 and 2020/21, the majority of the Trust's income from NHS commissioners was in the form of block contract arrangements. The Trust receives block funding from its commissioners, where funding envelopes are set at a Integrated Care System level. For the first half of the 2020/21 comparative year these blocks were set for individual NHS providers directly, but the revenue recognition principles are the same. The related performance obligation is the delivery of healthcare and related services during the period, with the Trust's entitlement to consideration not varying based on the levels of activity performed.

The Trust also receives additional income outside of the block payments to reimburse specific costs incurred and, in 2020/21, other income top-ups to support the delivery of services. Reimbursement and top-up income is accounted for as variable consideration.

In 2021/22, the Elective Recovery Fund enabled systems to earn income linked to the achievement of elective activity targets including funding any increased use of independent sector capacity. Income earned by the system is distributed between individual entities by local agreement. Income earned from the fund is accounted for as variable consideration.

Note 1.5 Expenditure on employee benefits

Short-term employee benefits
Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

Pension costs
NHS Pension Scheme

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Both schemes are unfunded, defined benefit schemes that cover NHS employers, general practices and other bodies, allowed under the direction of Secretary of State for Health and Social Care in England and Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as though it is a defined contribution scheme: the cost to the Trust is taken as equal to the employer's pension contributions payable to the scheme for the accounting period. The contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the Trust commits itself to the retirement, regardless of the method of payment.

Note 1.6 Expenditure on other goods and services
Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

Note 1.7 Property, plant and equipment

Recognition
Property, plant and equipment is capitalised where:

• it is held for use in delivering services or for administrative purposes
• it is probable that future economic benefits will flow to, or service potential be provided to, the Trust
• it is expected to be used for more than one financial year
• the cost of the item can be measured reliably
• the item has cost of at least £5,000, or
• collectively, a number of items have a cost of at least £5,000 and individually have cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, e.g., plant and equipment, then these components are treated as separate assets and depreciated over their own useful lives.

Subsequent expenditure
Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Measurement
Valuation

All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

Assets are measured subsequently at valuation. Assets which are held for their service potential and are in use (i.e. operational assets used to deliver either front line services or back office functions) are measured at their current value in existing use. Assets that were most recently held for their service potential but are surplus with no plan to bring them back into use are measured at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying values are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost on a modern equivalent asset basis.

For specialised assets, current value in existing use is interpreted as the present value of the asset's remaining service potential, which is assumed to be at least equal to the cost of replacing that service potential. Specialised assets are therefore valued at their depreciated replacement cost (DRC) on a modern equivalent asset (MEA) basis. An MEA basis assumes that the asset will be replaced with a modern asset of equivalent capacity and meeting the location requirements of the services being provided.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees and, where capitalised in accordance with IAS 23, borrowings costs. Assets are revalued and depreciation commences when the assets are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful lives or low values or both, as this is not considered to be materially different from current value in existing use.

Depreciation

Items of property, plant and equipment are depreciated over their remaining useful lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated. Assets in the course of construction are not depreciated until the asset is brought into use.

Revaluation gains and losses

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating expenditure.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

Impairments

In accordance with the GAM, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.
Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

Donated and grant funded assets

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

In 2020/21 this included assets donated to the Trust by the Department of Health and Social Care as part of the response to the coronavirus pandemic. As defined in the GAM, the Trust applies the principle of donated asset accounting to assets that the Trust controls and is obtaining economic benefits from at the year end. The Trust did not receive any dontated property, plant and equipment from the Department of Health and Social Care in 2021/22.

Useful lives of property, plant and equipment

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

	Min life Years	Max life Years
Buildings, excluding dwellings	13	86
Dwellings	49	87
Plant & machinery	5	25
Information technology	5	10
Furniture & fittings	10	10

Finance-leased assets (including land) are depreciated over the shorter of the useful life or the lease term, unless the Trust expects to acquire the asset at the end of the lease term in which case the assets are depreciated in the same manner as owned assets above.

Note 1.8 Intangible assets

Recognition

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the Trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the Trust and where the cost of the asset can be measured reliably.

Software

Software which is integral to the operation of hardware, e.g. an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware, e.g. application software, is capitalised as an intangible asset.

Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Amortisation

Intangible assets are amortised over their expected useful lives in a manner consistent with the consumption of economic or service delivery benefits.

Useful lives of intangible assets

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

	Min life Years	Max life Years
Information technology	5	10
Software licences	5	10

Note 1.9 Cash and cash equivalents
Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash and bank balances are recorded at current values.

Note 1.10 Financial assets and financial liabilities

Recognition
Financial assets and financial liabilities arise where the Trust is party to the contractual provisions of a financial instrument, and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument. The GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax by the Office of National Statistics.

This includes the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements and are recognised when, and to the extent which, performance occurs, i.e., when receipt or delivery of the goods or services is made.

Classification and measurement
Financial assets and financial liabilities are initially measured at fair value plus or minus directly attributable transaction costs except where the asset or liability is not measured at fair value through income and expenditure. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices or valuation techniques.

Financial assets or financial liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with the accounting policy for leases described below.

Financial assets and liabilities are classified as subsequently measured at amortised cost.

Financial assets and financial liabilities at amortised cost
Financial assets and financial liabilities at amortised cost are those held with the objective of collecting contractual cash flows and where cash flows are solely payments of principal and interest. This includes cash equivalents, contract and other receivables, trade and other payables, rights and obligations under lease arrangements and loans receivable and payable.

After initial recognition, these financial assets and financial liabilities are measured at amortised cost using the effective interest method less any impairment (for financial assets). The effective interest rate is the rate that exactly discounts estimated future cash payments or receipts through the expected life of the financial asset or financial liability to the gross carrying amount of a financial asset or to the amortised cost of a financial liability.

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and recognised in the Statement of Comprehensive Income and a financing income or expense. In the case of loans held from the Department of Health and Social Care, the effective interest rate is the nominal rate of interest charged on the loan.

Impairment of financial assets
For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets, the Trust recognises an allowance for expected credit losses.

The Trust adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected losses as at an amount equal to lifetime expected losses. For other financial assets, the loss allowance is initially measured at an amount equal to 12-month expected credit losses (stage 1) and subsequently at an amount equal to lifetime expected credit losses if the credit risk assessed for the financial asset significantly increases (stage 2).

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of estimated future cash flows discounted at the financial asset's original effective interest rate.

Expected losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.

Derecognition
Financial assets are de-recognised when the contractual rights to receive cash flows from the assets have expired or the Trust has transferred substantially all the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Note 1.11 Leases
Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

The Trust as a lessee
Finance leases

Where substantially all risks and rewards of ownership of a leased asset are borne by the Trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease. The implicit interest rate is that which produces a constant periodic rate of interest on the outstanding liability.

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for as an item of property plant and equipment or intangible asset.

The annual rental charge is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to finance costs in the Statement of Comprehensive Income.

Operating leases

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially in other liabilities on the Statement of Financial Position and subsequently as a reduction of rentals on a straight-line basis over the lease term. Contingent rentals are recognised as an expense in the period in which they are incurred.

Leases of land and buildings

Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

The Trust as a lessor
Operating leases

Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised as an expense on a straight-line basis over the lease term.

Note 1.12 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using the discount rates published and mandated by HM Treasury.

Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the Trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the Trust is disclosed at note 18 but is not recognised in the Trust's accounts.

Non-clinical risk pooling

The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to NHS Resolution and in return receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses when the liability arises.

Note 1.13 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

The Secretary of State can issue new PDC to, and require repayments of PDC from, the Trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the Trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, with certain additions and deductions as defined by the Department of Health and Social Care.

This policy is available at https://www.gov.uk/government/publications/guidance-on-financing-available-to-nhs-trusts-and-foundation-trusts.

In accordance with the requirements laid down by the Department of Health and Social Care (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the “pre-audit” version of the annual accounts. The dividend calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

Note 1.14 Value added tax

Most of the activities of the Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

Note 1.15 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2021/22.

Note 1.16 Standards, amendments and interpretations in issue but not yet effective or adopted

IFRS 16 Leases

IFRS 16 Leases will replace *IAS 17 Leases, IFRIC 4 Determining whether an arrangement contains a lease* and other interpretations and is applicable in the public sector for periods beginning 1 April 2022. The standard provides a single accounting model for lessees, recognising a right of use asset and obligation in the statement of financial position for most leases: some leases are exempt through application of practical expedients explained below. For those recognised in the statement of financial position the standard also requires the remeasurement of lease liabilities in specific circumstances after the commencement of the lease term. For lessors, the distinction between operating and finance leases will remain and the accounting will be largely unchanged.

IFRS 16 changes the definition of a lease compared to IAS 17 and IFRIC 4. The Trust will apply this definition to new leases only and will grandfather its assessments made under the old standards of whether existing contracts contain a lease.

On transition to IFRS 16 on 1 April 2022, the Trust will apply the standard retrospectively without restatement and with the cumulative effect of initially applying the standard recognised in the income and expenditure reserve at that date. For existing operating leases with a remaining lease term of more than 12 months and an underlying asset value of at least £5,000, a lease liability will be recognised equal to the value of remaining lease payments discounted on transition at the Trust's incremental borrowing rate. The Trust's incremental borrowing rate will be defined by HM Treasury. For 2022, this rate is 0.95%. The related right of use asset will be measured equal to the lease liability adjusted for any prepaid or accrued lease payments. For existing peppercorn leases not classified as finance leases, a right of use asset will be measured at current value in existing use or fair value. The difference between the asset value and the calculated lease liability will be recognised in the income and expenditure reserve on transition. No adjustments will be made on 1 April 2022 for existing finance leases.

For leases commencing in 2022/23, the Trust will not recognise a right of use asset or lease liability for short term leases (less than or equal to 12 months) or for leases of low value assets (less than £5,000). Right of use assets will be subsequently measured on a basis consistent with owned assets and depreciated over the length of the lease term.

The Trust has estimated the impact of applying IFRS 16 in 2022/23 on the opening statement of financial position and the in-year impact on the statement of comprehensive income and capital additions as follows:

	£000
Estimated impact on 1 April 2022 statement of financial position	
Additional right of use assets recognised for existing operating leases	11,603
Additional lease obligations recognised for existing operating leases	(11,603)
Changes to other statement of financial position line items	-
Net impact on net assets on 1 April 2022	**-**
Estimated in-year impact in 2022/23	
Additional depreciation on right of use assets	(2,258)
Additional finance costs on lease liabilities	(101)
Lease rentals no longer charged to operating expenditure	2,315
Other impact on income / expenditure	-
Estimated impact on surplus / deficit in 2022/23	**(44)**
Estimated increase in capital additions for new leases commencing in 2022/23	**190**

Other standards, amendments and interpretations

IFRS 17 Insurance Contracts

Application required for accounting periods beginning on or after 1 January 2023, but not yet adopted by the FReM: early adoption is not therefore permitted. This is not expected to have a material impact on the Trust.

Note 1.17 Sources of estimation uncertainty

The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year:

• **Equipment Deposits**: The Trust pays a deposit to an external company for equipment issued to patients in the community. If the equipment is returned and the company is able to re-use it, the deposit is returned. Based on experience in the last 6.5 years it is assumed that 68% of deposits outstanding at the balance sheet date will be recovered, which equates to £7.9m million for 2021/22.

• **Valuation of Land & Buildings**: The Trust employs a professional Valuer to value all land and buildings and to estimate their useful economic lives which are used to calculate depreciation. Assets are revalued by the Valuer every five years and the last full valuation was undertaken in 2018/19. Every year the Trust requests that the Valuer considers the accuracy of this valuation and to apply a desktop valuation to ensure that the value of land and buildings remains materially accurate. The value of the Trust's land and buildings equates to £130m as at 31 March 2022. Further details can be found in note 12.

The Trust does not consider to have undertaken any critical judgements in applying accounting policies that do not involve the estimates noted above.

Note 1.18 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis.

The losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

Note 2 Operating Segments

The Trust reports to the Board, which is considered to be the Chief Operating Decision Maker, the performance at a divisional level on a monthly basis. Segments are considered where the total income is 10% or more of the Trust's total income. The Trust has identified five reportable segments. The main source of income for the Trust is from Commissioners in respect of healthcare services from CCGs who are under common control and classified as a single customer. In 2020/21 and 2021/22 the Trust received block contract income rather than income based on activity performed. As a result the majority of income is shown against the corporate function for 2020/21 and 2021/22.

Net assets are not reported to the Board on a segmental basis therefore have been excluded for the purposes of this note.

The Trust reports to the Board by directorate down to an operating contribution.

	Medicine	Surgery	Women and Children	Corporate	Community	Other	Total
2021/22	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
Income	89,805	59,884	26,381	119,176	46,016	10,936	352,198
Expenditure	(82,212)	(60,453)	(22,452)	(72,713)	(51,224)	(62,924)	(351,978)
Contribution	**7,593**	**(569)**	**3,929**	**46,463**	**(5,208)**	**(51,988)**	**220**

	Medicine	Surgery	Women and Children	Corporate (Restated)	Community	Other	Total (Restated - note 21)
2020/21	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
Income	74,721	44,076	20,143	130,902	42,180	9,260	321,282
Expenditure	(78,773)	(54,655)	(19,964)	(61,907)	(46,616)	(57,979)	(319,894)
Contribution	**(4,052)**	**(10,579)**	**179**	**68,995**	**(4,436)**	**(48,719)**	**1,388**

These segments represent the management structure in the organisation. This note analyses total income by management unit within the Organisation.

Note 3 Operating income from patient care activities

All income from patient care activities relates to contract income recognised in line with accounting policy 1.4

Note 3.1 Income from patient care activities (by nature)	2021/22 £000	2020/21 £000
Acute services		
Block contract / system envelope income	231,571	186,052
High cost drugs income from commissioners (excluding pass-through costs)	15,929	13,108
Other NHS clinical income	16,683	16,794
Community services		
Block contract / system envelope income	33,001	29,571
Income from other sources (e.g. local authorities)	9,784	9,455
All services		
Private patient income	1,500	966
Elective recovery fund	11,001	-
Additional pension contribution central funding*	9,004	8,222
Other clinical income	503	350
Total income from activities	**328,976**	**264,518**

*The employer contribution rate for NHS pensions increased from 14.3% to 20.6% (excluding administration charge) from 1 April 2019. Since 2019/20, NHS providers have continued to pay over contributions at the former rate with the additional amount being paid over by NHS England on providers' behalf. The full cost and related funding have been recognised in these accounts.

Note 3.2 Income from patient care activities (by source)

Income from patient care activities received from:	2021/22 £000	2020/21 £000
NHS England	27,982	13,210
Clinical commissioning groups	285,318	240,537
Other NHS providers	12,477	8,104
Local authorities	1,196	1,351
Non-NHS: private patients	1,462	934
Non-NHS: overseas patients (chargeable to patient)	38	79
Injury cost recovery scheme	503	303
Total income from activities	**328,976**	**264,518**
Of which:		
Related to continuing operations	328,976	264,518

Note 3.3 Overseas visitors (relating to patients charged directly by the provider)

	2021/22	2020/21
	£000	£000
Income recognised this year	38	79
Cash payments received in-year	62	36
Amounts added to provision for impairment of receivables	16	216
Amounts written off in-year	1	9

Note 4 Other operating income

	2021/22			2020/21		
	Contract income	Non-contract income	Total	Contract income	Non-contract income	Total
	£000	£000	£000	£000	£000	£000
Research and development	709	-	**709**	565	-	**565**
Education and training	8,328	456	**8,784**	7,485	-	**7,485**
Non-patient care services to other bodies	8,420		**8,420**	16,224		**16,224**
Reimbursement and top up funding	510		**510**	24,791		**24,791**
Receipt of capital grants and donations		149	**149**		371	**371**
Charitable and other contributions to expenditure		871	**871**		3,859	**3,859**
Support from the Department of Health and Social Care for mergers		-	**-**		-	**-**
Rental revenue from operating leases		96	**96**		118	**118**
Other income*	3,664	-	**3,664**	3,234	117	**3,351**
Total other operating income	**21,631**	**1,572**	**23,203**	**52,299**	**4,465**	**56,764**
Of which:						
Related to continuing operations			23,203			56,764

*Other income includes £665k of car parking (2020/21 £400k) and £650k of catering income (2020/21 £600k).

Note 5 Income from activities arising from commissioner requested services

Under the terms of its provider licence, the Trust is required to analyse the level of income from activities that has arisen from commissioner requested and non-commissioner requested services. Commissioner requested services are defined in the provider licence and are services that commissioners believe would need to be protected in the event of provider failure. This information is provided in the table below:

	2021/22	2020/21
	£000	£000
Income from services designated as commissioner requested services	328,976	264,518
Income from services not designated as commissioner requested services	23,203	56,764
Total	**352,179**	**321,282**

Note 6 Operating expenses

	Note	2021/22	Restated 2020/21
		£000	£000
Purchase of healthcare from NHS and DHSC bodies		-	81
Purchase of healthcare from non-NHS and non-DHSC bodies		3,802	1,743
Staff and executive directors costs	21	230,145	216,088
Remuneration of non-executive directors		126	127
Supplies and services - clinical (excluding drugs costs)		41,270	37,610
Supplies and services - general		3,362	3,239
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)		24,380	21,825
Inventories written down		265	244
Consultancy costs		238	365
Establishment		7,129	3,893
Premises		5,761	8,264
Transport (including patient travel)		1,323	1,281
Depreciation on property, plant and equipment		6,806	5,179
Amortisation on intangible assets	21	2,994	2,064
Net impairments		4,647	1,496
Movement in credit loss allowance: contract receivables / contract assets		(6)	187
Increase/(decrease) in other provisions		24	13
Change in provisions discount rate(s)		7	117
Fees payable to the external auditor			
audit services- statutory audit*		135	62
Internal audit costs**		163	150
Clinical negligence		9,304	8,967
Legal fees		203	196
Insurance		232	156
Education and training		1,623	628
Rentals under operating leases		6,497	5,680
Car parking & security		19	27
Hospitality		61	22
Other		510	190
Total		**351,020**	**319,894**
Of which:			
Related to continuing operations		351,020	319,894

* The audit fees are disclosed net of VAT. VAT is not recoverable and the VAT element is included in 'other'.

** All internal audit costs are non-staff related as the service is provided by an external firm.

Note 6.1 Limitation on auditor's liability
The limitation on auditor's liability for external audit work is £2 million (2020/21: £1 million).

Note 7 Impairment of assets

	2021/22 £000	2020/21 £000
Net impairments charged to operating surplus / deficit resulting from:		
Over specification of assets	-	421
Abandonment of assets in course of construction	-	-
Unforeseen obsolescence	4,647	-
Changes in market price	-	1,075
Total net impairments charged to operating surplus / deficit	**4,647**	**1,496**
Impairments charged to the revaluation reserve	77	574
Total net impairments	**4,724**	**2,070**

Impairments arose in 2021/22 as a result of a desktop revaluation exercise carried out at the end of the year. The Valuer has reviewed the value of the Trust's land and buildings and a reduction in asset value has occurred as follows:

	Net Impairment £000
Main Hospital Block	5,369
Land	(108)
Other Buildings	(537)
Total	**4,724**

The impairment on the main hospital block is due to unforseen obsolescnce with the structure and the works required to bring the asset into repair and back in to use.

Note 8 Employee benefits

	2021/22 Total £000	Restated 2020/21 Total £000
Salaries and wages	179,143	167,721
Social security costs	17,999	16,229
Apprenticeship levy	864	792
Employer's contributions to NHS pensions	29,653	27,485
Pension cost - other	66	66
Temporary staff (including agency)	4,071	4,329
Total staff costs	**231,796**	**216,622**
Of which		
Costs capitalised as part of assets (restated - see note 21)	1,651	534

Remuneration of non-executive Directors is excluded from this note and is disclosed separately in note 6.

Note 8.1 Retirements due to ill-health

During 2021/22 there were 3 early retirements from the Trust agreed on the grounds of ill-health (2 in the year ended 31 March 2021). The estimated additional pension liabilities of these ill-health retirements is £69k (£120k in 2020/21).

These estimated costs are calculated on an average basis and will be borne by the NHS Pension Scheme.

Note 9 Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2022, is based on valuation data as 31 March 2021, updated to 31 March 2022 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 at 20.6%, and the Scheme Regulations were amended accordingly.

The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap set following the 2012 valuation. Following a judgment from the Court of Appeal in December 2018 Government announced a pause to that part of the valuation process pending conclusion of the continuing legal process.

HMT published valuation directions dated 7 October 2021 (see Amending Directions 2021) that set out the technical detail of how the costs of remedy are included in the 2016 valuation process. Following these directions, the scheme actuary has completed the cost control element of the 2016 valuation for the NHS Pension Scheme, which concludes no changes to benefits or member contributions are required. The 2016 valuation reports can be found on the NHS Pensions website at https://www.nhsbsa.nhs.uk/nhs-pension-scheme-accounts-and-valuation-reports.

Note 10 Operating leases

Note 10.1 West Suffolk NHS Foundation Trust as a lessee

This note discloses costs and commitments incurred in operating lease arrangements where West Suffolk NHS Foundation Trust is the lessee.

	2021/22 £000	2020/21 £000
Operating lease expense		
Minimum lease payments	6,488	5,680
Contingent rents	9	-
Total	**6,497**	**5,680**

	31 March 2022 £000	31 March 2021 £000
Future minimum lease payments due:		
- not later than one year;	1,134	632
- later than one year and not later than five years;	1,810	664
- later than five years.	42	647
Total	**2,986**	**1,943**
Future minimum sublease payments to be received	-	-

The lease costs in this note include properties on licence from NHS Property Services used for the delivery of community services. No leases have been signed for in relation to these properties so £0 has been included in future commitments. The remaining leases relate to equipment.

Note 11 Intangible assets - 2021/22

	Software licences	Internally generated information technology	Intangible assets under construction	Total
	£000	£000	£000	£000
Valuation / gross cost at 1 April 2021 - brought forward (restated)	**3,145**	**54,078**	**-**	**57,223**
Additions	992	8,016	-	**9,008**
Valuation / gross cost at 31 March 2022	**4,137**	**62,094**	**-**	**66,231**
Amortisation at 1 April 2021 - brought forward	**218**	**10,980**	**-**	**11,198**
Provided during the year	410	2,584	-	**2,994**
Amortisation at 31 March 2022	**628**	**13,564**	**-**	**14,192**
Net book value at 31 March 2022	**3,509**	**48,530**	**-**	**52,039**
Net book value at 1 April 2021 (restated)	**2,927**	**43,098**	**-**	**46,025**

Note 11.1 Intangible assets - 2020/21

	Software licences	Internally generated information technology (restated - see note 21)	Intangible assets under construction	Total
	£000	£000	£000	£000
Valuation / gross cost at 1 April 2020 - as previously stated	**1,490**	**45,578**	**9,256**	**56,324**
Prior period adjustments	-	(3,044)	-	**(3,044)**
Valuation / gross cost at 1 April 2020 - (restated)	**1,490**	**42,534**	**9,256**	**53,280**
Transfers by absorption	-	-	-	**-**
Additions (restated)	1,655	7,924	-	**9,579**
Revaluations	-	582	-	**582**
Reclassifications	-	9,256	(9,256)	**-**
Disposals / derecognition	-	(6,218)	-	**(6,218)**
Valuation / gross cost at 31 March 2021 - (restated)	**3,145**	**54,078**	**-**	**57,223**
Amortisation at 1 April 2020 - as previously stated	**134**	**15,218**	**-**	**15,352**
Prior period adjustments	-	-	-	**-**
Amortisation at 1 April 2020 - (restated)	**134**	**15,218**	**-**	**15,352**
Provided during the year	84	1,980	-	**2,064**
Disposals / derecognition	-	(6,218)	-	**(6,218)**
Amortisation at 31 March 2021 - (restated)	**218**	**10,980**	**-**	**11,198**
Net book value at 31 March 2021 (restated)	**2,927**	**43,098**	**-**	**46,025**
Net book value at 1 April 2020 (restated)	**1,356**	**27,316**	**9,256**	**37,928**

Note 12 Property, plant and equipment - 2021/22

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2021 - brought forward	**10,870**	**82,083**	**10,741**	**16,205**	**15,285**	**-**	**12,185**	**135**	**147,504**
Transfers by absorption	-	-	-	-	-	-	-	-	**-**
Additions	-	21,766	-	17,742	1,476	-	1,292	-	**42,276**
Impairments	-	(6,814)	(38)	-	-	-	-	-	**(6,852)**
Reversals of impairments	108	1,076	868	-	-	-	-	-	**2,052**
Revaluations	752	(727)	25	-	-	-	-	-	**50**
Reclassifications	-	7,985	-	(7,985)	-	-	-	-	**-**
Disposals / derecognition	-	-	-	-	(20)	-	-	-	**(20)**
Valuation/gross cost at 31 March 2022	**11,730**	**105,369**	**11,596**	**25,962**	**16,741**	**-**	**13,477**	**135**	**185,010**
Accumulated depreciation at 1 April 2021 - brought forward	**-**	**4**	**-**	**-**	**8,380**	**-**	**3,290**	**127**	**11,801**
Provided during the year	-	2,878	186	-	1,381	-	2,354	7	**6,806**
Impairments	-	(76)	-	-	-	-	-	-	**(76)**
Reversals of impairments	-	-	-	-	-	-	-	-	**-**
Revaluations	-	(2,802)	(186)	-	-	-	-	-	**(2,988)**
Disposals / derecognition	-	-	-	-	(20)	-	-	-	**(20)**
Accumulated depreciation at 31 March 2022	**-**	**4**	**-**	**-**	**9,741**	**-**	**5,644**	**134**	**15,523**
Net book value at 31 March 2022	**11,730**	**105,365**	**11,596**	**25,962**	**7,000**	**-**	**7,833**	**1**	**169,487**
Net book value at 1 April 2021	**10,870**	**82,079**	**10,741**	**16,205**	**6,905**	**-**	**8,895**	**8**	**135,703**

Note 12.1 Property, plant and equipment - 2020/21

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2020 - as previously stated	**7,900**	**74,237**	**10,690**	**6,830**	**17,744**	**4**	**9,962**	**135**	**127,502**
Additions	-	9,349	-	13,757	1,962	-	5,317	-	**30,385**
Impairments	(14)	(3,090)	-	-	-	-	-	-	**(3,104)**
Reversals of impairments	80	796	158	-	-	-	-	-	**1,034**
Revaluations	740	(842)	(110)	(582)	-	-	-	-	**(794)**
Reclassifications	2,164	1,633	3	(3,800)	-	-	-	-	**-**
Disposals / derecognition	-	-	-	-	(4,421)	(4)	(3,094)	-	**(7,519)**
Valuation/gross cost at 31 March 2021	**10,870**	**82,083**	**10,741**	**16,205**	**15,285**	**-**	**12,185**	**135**	**147,504**
Accumulated depreciation at 1 April 2020 - as previously stated	**-**	**-**	**-**	**-**	**11,396**	**4**	**5,391**	**118**	**16,909**
Provided during the year	-	2,638	183	-	1,356	-	993	9	**5,179**
Revaluations	-	(2,634)	(183)	-	-	-	-	-	**(2,817)**
Disposals / derecognition	-	-	-	-	(4,372)	(4)	(3,094)	-	**(7,470)**
Accumulated depreciation at 31 March 2021	**-**	**4**	**-**	**-**	**8,380**	**-**	**3,290**	**127**	**11,801**
Net book value at 31 March 2021	**10,870**	**82,079**	**10,741**	**16,205**	**6,905**	**-**	**8,895**	**8**	**135,703**
Net book value at 1 April 2020	**7,900**	**74,237**	**10,690**	**6,830**	**6,348**	**-**	**4,571**	**17**	**110,593**

Note 12.2 Property, plant and equipment financing - 2021/22

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2022								
Owned - purchased	11,730	100,746	11,596	25,962	2,517	7,709	1	**160,261**
Finance leased	-	-	-	-	3,675	94	-	**3,769**
Owned - donated/granted	-	4,619	-	-	808	30	-	**5,457**
NBV total at 31 March 2022	**11,730**	**105,365**	**11,596**	**25,962**	**7,000**	**7,833**	**1**	**169,487**

Note 12.3 Property, plant and equipment financing - 2020/21

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2021								
Owned - purchased	10,870	77,449	10,741	16,205	2,332	8,771	8	**126,376**
Finance leased	-	11	-	-	3,675	94	-	**3,780**
Owned - donated/granted	-	4,619	-	-	898	30	-	**5,547**
NBV total at 31 March 2021	**10,870**	**82,079**	**10,741**	**16,205**	**6,905**	**8,895**	**8**	**135,703**

Note 12.4 Revaluations of property, plant and equipment

A desktop valuation exercise on the land and properties comprising the West Suffolk NHS Foundation Trust estate was carried out with a valuation date of 31 March 2022. This desktop valuation was undertaken by an external Valuer, Gerald Eve LLP, a regulated firm of Chartered Surveyors. The desktop valuation was prepared in accordance with the Royal Institute of Chartered Surveyors (RICS) Valuation Global Standards 2020 ('Red Book').

Property, Plant and Equipment and Investment Properties on the Statement of Financial Position has a carrying amount of £183m. Within this, £116m is considered to be specialised property which is valued on a depreciated replacement cost basis. This includes the hospital site and residences. Here the Valuer bases their assessment on the cost to the Trust of replacing the service potential of the assets.

The key assumptions that are most likely to affect the valuations are:

- **Cost data**: The Valuer uses actual cost data where it is available however this is adjusted to reflect price changes since the construction date and any differences between those costs and the costs that would be incurred in constructing the modern equivalent asset. Where actual cost data is not available the Valuer relies on published construction price data. Published price data is an estimate of the costs that would be incurred in constructing a modern equivalent asset and may differ to the costs that would actually be incurred in practice. If the cost data were 5% higher this would have an impact on the value of specialised properties recorded in the balance sheet of an increase of £4.6m.

- **Adjustments for obsolescence**: Once the cost of constructing a modern equivalent asset has been determined an adjustment is made to reflect the difference between the modern equivalent and the actual asset being valued. This adjustment is made by the Valuer based on his knowledge and experience, it takes into account physical deterioration, functional obsolescence and economic obsolescence. Had the adjustment for obsolescence been 2% higher than the Valuer assumed, this would have an impact on the value of specialised properties recorded in the balance sheet of a decrease of £5.8m.

The valuer also reviewed the useful economic lives of the Trust buildings. Useful economic lives reflect the total life of an asset and not the remaining life of an asset. The range of useful economic lives by category of asset are detailed in note 1.7.

Note 13 Receivables

	31 March 2022 £000	31 March 2021 £000
Current		
Contract receivables	10,417	14,362
Allowance for impaired contract receivables / assets	(221)	(365)
Deposits and advances	2,412	2,820
Prepayments (non-PFI)	1,265	1,034
PDC dividend receivable	500	330
VAT receivable	603	1,134
Corporation and other taxes receivable	90	47
Other receivables	3	-
Total current receivables	**15,069**	**19,362**
Non-current		
Deposits and advances	5,475	5,560
Other receivables	332	781
Total non-current receivables	**5,807**	**6,341**
Of which receivable from NHS and DHSC group bodies:		
Current	6,576	10,847
Non-current	332	781

Note 13.1 Exposure to credit risk

	31 March 2022 £000	31 March 2021 £000
Ageing of impaired financial assets		
0 - 30 days		0
31-60 Days		0
61-90 days		0
91 days- 1 year	8	44
1 year and over	213	321
Total	**221**	**365**

	31 March 2022 £000	31 March 2021 £000
Ageing of non-impaired financial assets past their due date (not including accruals)		
0 - 30 days	3,384	3,511
31-60 Days	593	439
61-90 days	159	262
91 days- 1 year	1,137	875
1 year and over	935	1,593
Total	**6,208**	**6,680**

£4.3m of the non-impaired financial assets past their due date are owed by NHS organisations (£4.9m in 2020/21).

Note 14 Cash and cash equivalents movements

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	2021/22	2020/21
	£000	£000
At 1 April	**23,788**	**2,441**
Net change in year	9,535	21,347
At 31 March	**33,323**	**23,788**
Broken down into:		
Cash at commercial banks and in hand	6	6
Cash with the Government Banking Service	33,317	23,782
Total cash and cash equivalents as in SoFP and SoCF	**33,323**	**23,788**

Note 15 Trade and other payables

	31 March 2022	31 March 2021
	£000	£000
Current		
Trade payables	11,638	11,078
Capital payables	3,875	6,650
Accruals	36,619	27,665
Social security costs	2,778	2,451
VAT payables	-	-
Other taxes payable	2,371	2,028
Other payables	2,883	2,650
Total current trade and other payables	**60,164**	**52,522**
Of which payables from NHS and DHSC group bodies:		
Current	2,721	8,632

Note 16 Borrowings

	31 March 2022 £000	31 March 2021 £000
Current		
Loans from DHSC	2,393	2,397
Other loans	444	441
Obligations under finance leases	3,021	3,601
Total current borrowings	**5,858**	**6,439**
Non-current		
Loans from DHSC	40,460	42,767
Other loans	2,420	2,865
Obligations under finance leases	1,122	2,087
Total non-current borrowings	**44,002**	**47,719**

Note 16.1 Reconciliation of liabilities arising from financing activities - 2021/22

	Loans from DHSC	Other loans	Finance leases	Total
	£000	£000	£000	£000
Carrying value at 1 April 2021	**45,164**	**3,306**	**5,688**	**54,158**
Cash movements:				
Financing cash flows - payments and receipts of principal	(2,307)	(442)	(1,567)	**(4,316)**
Financing cash flows - payments of interest	(1,025)	(82)	(573)	**(1,680)**
Non-cash movements:				
Application of effective interest rate	1,021	82	595	**1,698**
Other changes	-	-	-	**-**
Carrying value at 31 March 2022	**42,853**	**2,864**	**4,143**	**49,860**

Note 16.2 Reconciliation of liabilities arising from financing activities - 2020/21

	Loans from DHSC	Other loans	Finance leases	Total
	£000	£000	£000	£000
Carrying value at 1 April 2020	**101,552**	**2,746**	**6,769**	**111,067**
Cash movements:				
Financing cash flows - payments and receipts of principal	(56,258)	560	(1,287)	**(56,985)**
Financing cash flows - payments of interest	(1,434)	(91)	(981)	**(2,506)**
Non-cash movements:				
Additions	-	-	206	**206**
Application of effective interest rate	1,304	91	981	**2,376**
Carrying value at 31 March 2021	**45,164**	**3,306**	**5,688**	**54,158**

Note 17 Finance leases

Note 17.1 West Suffolk NHS Foundation Trust as a lessee

Obligations under finance leases where the trust is the lessee.

	31 March 2022	31 March 2021
	£000	£000
Gross lease liabilities	**4,143**	**5,688**
of which liabilities are due:		
- not later than one year;	3,021	3,601
- later than one year and not later than five years;	1,122	2,087
Net lease liabilities	**4,143**	**5,688**
of which payable:		
- not later than one year;	3,021	3,601
- later than one year and not later than five years;	1,122	2,087

All finance leases relate to equipment. In 2018/19 the Trust entered into a seven year lease arrangement for Cerner applications and services. The current capitalisable value is £1.9m (£2.6m in 2020/21).

Note 18 Clinical negligence liabilities

At 31 March 2022, £177,989k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of West Suffolk NHS Foundation Trust (31 March 2021: £117,138k).

The Trust also held £19k (31 March 2021: £12k) of contingent liabilites for legal claims managed by NHS Resolution.

Note 19 Contractual capital commitments

	31 March 2022 £000	31 March 2021 £000
Property, plant and equipment	23,685	22,272
Intangible assets	6,446	10,033
Total	**30,131**	**32,305**

Note 20 Carrying values of financial assets

Carrying values of financial assets as at 31 March 2022	31 March 2022 Held at amortised cost £000	31 March 2021 Held at amortised cost £000
Trade and other receivables excluding non financial assets	18,860	23,523
Other investments / financial assets	-	-
Cash and cash equivalents	33,323	23,788
Total at 31 March 2022	**52,183**	**47,311**

£6.4m of the Trust's financial assets relate to income owed from other NHS Organisations (2020/21: £11.6m). Of the remaining balance as at 31 March 2022, £7.9m relates to deposits recoverable when community equipment is returned based on the likely proportion that will be returned.

The remainder of the balance is money owed from non-NHS Organisations. The collection of this debt is monitored closely and the balance is impaired or written off when the collection looks unlikely.

There are no individually material debts owed by non-NHS Organisations and the risk profile of the asset is assessed as low, which is the same as in 2020/21.

Note 20.1 Carrying values of financial liabilities

Carrying values of financial liabilities as at 31 March 2022	31 March 2022 Held at amortised cost £000	31 March 2021 Held at amortised cost £000
Loans from the Department of Health and Social Care	42,853	**45,164**
Obligations under finance leases	4,143	**5,688**
Obligations under PFI, LIFT and other service concession contracts	-	**-**
Other borrowings	2,864	**3,306**
Trade and other payables excluding non financial liabilities - with DHSC group bodies	2,535	**8,488**
Trade and other payables excluding non financial liabilities - with other bodies	52,480	**39,555**
Provisions under contract	29	**19**
Total at 31 March 2022	**104,904**	**102,220**

Borrowing excluding finance leases is at a fixed rate and, apart from £2.9m from a commercial loan provider, is from the Department of Health and Social Care.

There are no identified risks with the balance of payables which are almost exclusively UK based. This is the same as in 2020/21.

Note 20.2 Maturity of financial liabilities

The following maturity profile of financial liabilities is based on the contractual undiscounted cash flows. This differs to the amounts recognised in the statement of financial position which are discounted to present value.

	31 March 2022	31 March 2021
	£000	£000
In one year or less	61,872	55,609
In more than one year but not more than five years	12,162	16,935
In more than five years	40,431	40,431
Total	**114,465**	**112,975**

Note 20.3 Fair values of financial assets and liabilities

The fair value of the financial instruments is based on book value (carrying value) because this is not considered to be significantly different to the initial transactions recognised.

Note 21 Prior Period Adjustment

A prior period adjustment has been required to the current year accounts. During the financial year it was identified that certain staff costs incurred in 2019/20 and 2020/21 had been incorrectly capitalised as intangible assets rather than expensed through the SOCI. This has been corrected by restating the accounts in the prior periods. The effect of the restatement on these financial statements is summarised below.

	2020/21 As previously stated	Adjustment	2020/21 Restated
	£'000	£'000	£'000
SOCI			
Staff costs	**(212,684)**	(3,404)	**(216,088)**
Amortisation	**(2,339)**	275	**(2,064)**
Operating Expenditure	**(316,765)**	(3,129)	**(319,894)**
Operating Surplus	**4,517**	(3,129)	**1,388**
(Deficit) for the year	**(732)**	**(3,129)**	**(3,861)**
Non-current assets			
Fixed Assets - Intangibles	52,198	(6,173)	(6,173)
Total non-current assets	**195,642**	**(6,173)**	**(6,173)**
Total assets employed	**133,338**	**(6,173)**	**(6,173)**
Reserves			
Income & Expenditure Reserve: Opening balance	(33,583)	(3,044)	(36,627)
Income & Expenditure Reserve: Closing balance	**(34,055)**	**(6,173)**	**(40,228)**
Total taxpayers equity	**133,338**	**(6,173)**	**127,165**

Note 22 Related parties

	Income		Expenditure	
	2021/22	2020/21	2021/22	2020/21
	£000	£000	£000	£000
Cambridge Univeristy Hospitals NHS Foundation Trust	1,152	1,093	2,939	**2192**
East Suffolk and North Essex NHS Foundation Trust	13,259	11,347	3,526	6,720
NHS West Suffolk CCG	235,921	184,181	92	521
NHS Ipswich And East Suffolk CCG	29,345	22,332	50	-
NHS Norfolk & Waveney CCG	19,147	18,382	0	3
NHS Cambridgeshire and Peterborough CCG	3,533	3,519	0	-
Health Education England	8,209	7,611	30	5
NHS England	17,552	45,716	202	118
NHS Resolution (formerly NHS Litigation Authority)	-	-	9,447	9,094
NHS Property Services	329	44	874	788
Total	**328,447**	**294,225**	**17,160**	**19,441**

	Receivables		Payables	
	2021/22	2020/21	2021/22	2020/21
	£000	£000	£000	£000
Cambridge Univeristy Hospitals NHS Foundation Trust	285	996	-	2120
East Suffolk and North Essex NHS Foundation Trust	1,231	1,256	129	2,927
NHS West Suffolk CCG	1,296	663	715	777
NHS Ipswich and East Suffolk CCG	177	741	50	-
NHS Norfolk & Waveney CCG	8	189	-	8
NHS Cambridgeshire and Peterborough CCG	-	11	-	-
Health Education England	1,500	7	86	105
NHS England	284	5,313	1,515	319
NHS Resolution (formerly NHS Litigation Authority)	-	-	-	1
NHS Property Services	120	168	927	2,428
Total	**4,901**	**9,344**	**3,422**	**8,685**

The Trust is the Corporate Trustee of My Wish Charity. During the year the Charity spent £149k on behalf of the Trust on capital items plus a further £325k on revenue items (2020/21: £112k on capital items plus a further £230k on revenue items). At the year end the Charity owed the Trust £57k (2020/21 £62k).
The Trust has disclosed transactions with NHS bodies where the income, expenditure, receivable or payable balance is over £2 million.

Note 23 Losses and special payments

	2021/22		2020/21	
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	Number	£000	Number	£000
Losses				
Cash losses	12	5	45	4
Bad debts and claims abandoned	28	45	35	21
Stores losses and damage to property	3	265	4	244
Total losses	**43**	**315**	**84**	**269**
Special payments				
Extra-contractual payments	3	3	-	-
Ex-gratia payments	24	168	16	580
Total special payments	**27**	**171**	**16**	**580**
Total losses and special payments	**70**	**486**	**100**	**849**

Ex-gratia payments includes corrective payments made to staff in relation to overtime payments (also referred to as the 'Flowers' judgement). £561k was paid in 2020/21 and was funded nationally. £142k was paid in 2021/22 and related to additional amounts that were locally agreed and funded. Approval from HM Treasury was obtained for these locally agreed payments.

Note 24 Reporting of compensation schemes - exit packages

	2021/22		2020/21	
	Number of compulsory redundancies	Number of other departures agreed	Number of compulsory redundancies	Number of other departures agreed
Exit package cost band (including any special payment element)				
<£10,000	-	-	-	-
£10,000 - £25,000	-	-	-	-
£25,001 - 50,000	-	-	-	-
£50,001 - £100,000	-	-	-	1
£100,001 - £150,000	-	-	-	-
£150,001 - £200,000	-	-	-	-
>£200,000	-	-	-	-
Total number of exit packages by type	**-**	**-**	**-**	**1**
Total cost (£)	0	0	0	**£63,000**

Exit packages: other (non-compulsory) departure payments

	2021/22		2020/21	
	Payments agreed	Total value of agreements	Payments agreed	Total value of agreements
	Number	£000	Number	£000
Voluntary redundancies including early retirement contractual costs	-	-	-	-
Mutually agreed resignations (MARS) contractual costs	-	-	1	63
Early retirements in the efficiency of the service contractual costs	-	-	-	-
Contractual payments in lieu of notice	-	-	-	-
Exit payments following Employment Tribunals or court orders	-	-	-	-
Non-contractual payments requiring HMT approval	-	-	-	-
Total	**-**	**-**	**1**	**63**

6. OTHER ITEMS

6.1. Any other business

To Note

6.2. Reflections on meeting

For Discussion

6.3. Date of next meeting - 2 February, 2003

To Note

Presented by Jude Chin

6.3.1. Board & Committee Meeting Dates 2023

For Approval

Presented by Jude Chin

Board & Subcommittee Meeting Dates 2023-2024

SCHOOL HOLIDAYS

13 – 17 February
3 April – 16 April (Easter)
29 May – 2 June
24 July – 1 September (Summer Holiday)
23 – 27 October
21 December – 2 January, 2024
19 - 23 February, 2024

BANK HOLIDAYS

2 January
7 & 10 April (Easter)
8 May (King's Coronation)
1 May
8 May
29 May
28 August
25 December
26 December

Committee	Board Dates (Open & Closed)	Board Development Session	Insight Committee	Improvement Programme Board	Involvement Committee	Audit Committee	Charitable Funds Committee	Remuneration Committee	Future Systems Board	Council of Governors
Time	**9:15am – 2.30 pm**	**9.00 am – 5.00 pm**	**1.30 – 3.30 pm**	**12.45 – 3.15 pm**	**1.00- 3.00 pm Bi monthly**	**10 am – 12 noon quarterly**	**10:00 am – 12 noon quarterly**		**10 am – 12 noon**	**5.30 – 7.30 pm**
January			9 (2nd is BH)	16 (1 week late)		10 – 11am to 12pm	10 – 10am to 11am	TBC	17	
February	2	23	6	13	20				28	7
March	31		6	13		15				
April			3	10	17		4	TBC	18	
May	26	4	8 (1st is BH)	15					23	4
June		29	5	12p	19	27 AC Annual Accounts Sign off meeting – and full meeting combined Closed Board Sign off for 30mins after AC meeting				
July	28		3	10			11	TBC	4	
August			7	14	21				15	
September	29		4	11		20				4 COG 26 AMM (5pm)
October			2	9	16	18 Annual Accounts Sign off Meeting with CF members and charity accountants		TBC	3	
November		2	6	13					7	7
December	1		4	11	18	13	5		19	

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

SUPPORTING ANNEXES

4.5.1 Maternity Papers - Annexes B-G

NHS
West Suffolk
NHS Foundation Trust

ATAIN Programme



Avoiding Term Admissions to the Neonatal Unit

Progress Report
Quarter 2
July-Sept 2022

Sept 2022

Rebecca Warburton - Clinical Risk Midwife
Dr Jageer Mohammed – Acting Lead Neonatologist
Karen Ranson - Ward Manager NNU
Laura Minns - Obstetrician

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, i.e. ≥ 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)

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)
- Members of the senior Midwifery team

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.

Updated safety actions for CNST state that the care of all babies transferred or admitted to the NNU for *any period of time* should be reviewed, in some capacity, and reported under the ATAIN project. This is a change from previous guidance which required review only for babies admitted to NNU. Therefore, since May 2022 any baby that attends NNU briefly prior to transfer to transitional care (TC) has also been recorded. From July 2022 these babies, and any baby that attends NNU for care while an inpatient on the maternity unit, will be recorded and reported to the East of England Neonatal operational delivery network along with information on reason for attendance, parental accompaniment and any emerging themes.

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 were 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 continue to vary month on month. During the past quarter they have fluctuated, with only one month exceeding the target level of < 5%. September 2022 exceeded the target level by 0.2%. Two babies admitted to NNU in August were subsequently transferred to a tertiary unit for therapeutic cooling. These cases no longer meet the ATAIN criteria due to undergoing independent investigations of care.

Cases were reviewed carefully to identify any areas for learning and improvement. While respiratory distress remains the predominant reason for admission this quarter, no overarching themes or common denominators were identified amongst those admissions. All babies admitted for respiratory support also underwent a septic screen; the majority of whom had risk factors for sepsis (risk factors varied with no dominating themes apparent). All of the admissions this quarter were deemed appropriate based on their clinical or social needs.

Monthly Summaries

July 2022

In July there were 6 term admissions; 5 babies were admitted with signs of respiratory distress and suspected infection. All received treatment with vapotherm oxygen therapy and IV antibiotics, undergoing a septic screen. None of the babies had any known risk factors for Sepsis. Low saturations were a common theme amongst all 5 babies. The 6th baby was admitted due to a cleft lip and palate. This was diagnosed antenatally and the decision was made at delivery for feeding via oral gastric tube until a review by the cleft team could be arranged. Babies with oral or nasal gastric tubes cannot currently be cared for on TC.

August 2022

In August there were 5 term admissions; 3 of which were admitted with signs of respiratory distress and suspected infection. All 3 required Vapotherm oxygen therapy and received IV antibiotics. Common themes included the same mode of delivery (Emergency c-section) and known risk factors for sepsis. The other 2 admissions were due to suspected birth asphyxia and were subsequently transferred out for therapeutic cooling; as they qualify for independent investigation they do not meet criteria for review under ATAIN.

September 2022

In September there were 10 term admissions. Eight were admitted due to symptoms of respiratory distress, one for jaundice and one for seizure like activity. The infant admitted with jaundice had been admitted earlier in the month for respiratory distress and so represents two of the ten admissions. All 8 infants admitted with RDS also underwent a septic screen and were treated with IV antibiotics; 6 of these had risk factors for sepsis.

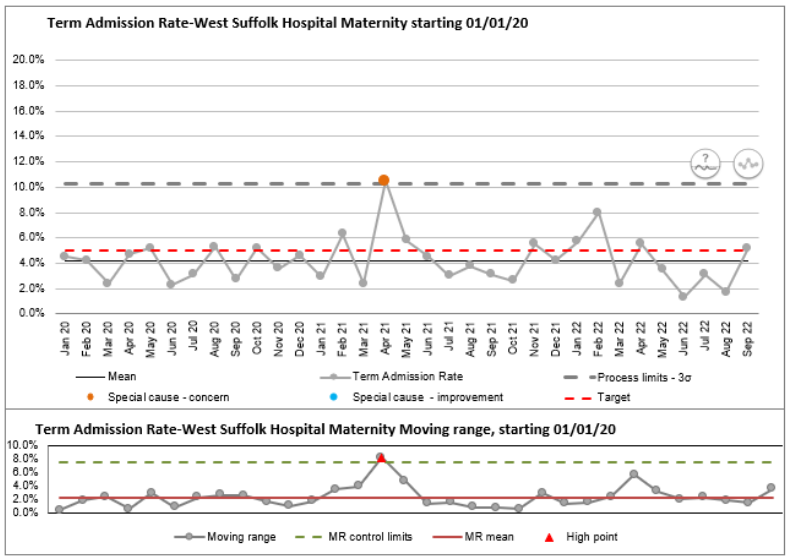
Thermoregulation

A trend of low admission temperatures remained this quarter with 28% of babies recording temperatures of ≤36.5°C on admission to NNU. While not the primary reason for admission, sub-optimal body temperature is recognised as a contributory and exacerbating factor to respiratory distress. As a response to this a Quality Improvement project has been commenced to address this ongoing issue. These cases are discussed in more detail under the quality improvement section.

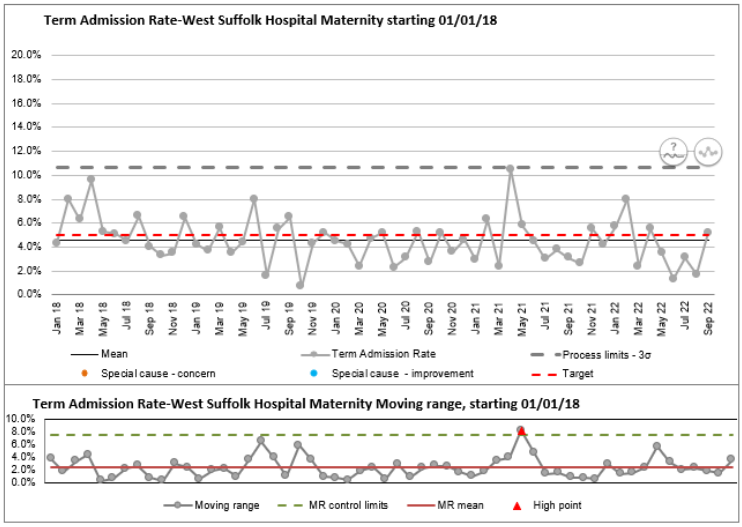
Any opportunities for learning or improvement that were identified on an individual case basis were discussed and appropriate action plans created. These have been added to the rolling action plan and actions are on-going.

Progress

(Monthly admission rates since Jan 2020)



Overall progress since programme began (2018)



Opportunities for learning and improvement

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, two admissions could have been avoided if – for one case, TC was equipped to care for an infant with an oral gastric tube, and for the other if a parent was available to be admitted alongside.

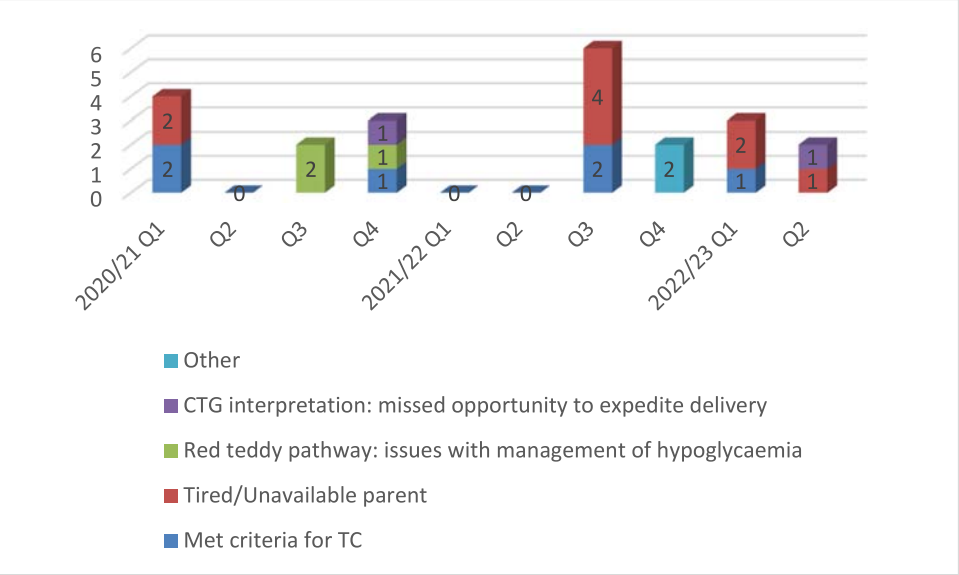
One infant, admitted in September, may have benefitted from earlier delivery and the CTG has been referred to the lead obstetric consultant for second opinion and escalation if required. However, due to other existing and recognised risk factors it could not be concluded if earlier delivery would have prevented admission to the NNU. It should also be noted that this infant was born in good condition with normal APGARs and did not require any resuscitation; however, due to low oxygen saturations, oxygen support was provided and the infant was transferred to NNU.

Thermoregulation of the new-born remains an on-going theme which is discussed in more detail under quality improvement. Other, smaller, incidental opportunities for learning were identified that did not contribute to neonatal admissions but were felt to be valuable to care improvement. Learning from these issues have been shared with the appropriate teams.

Potentially preventable admissions

The graph below shows the reasons previously identified as being the cause of potentially avoidable term admissions. As discussed above, in this quarter, all admissions were appropriate in the clinical or social circumstances with the exception of one baby that was suitable for TC but without an available parent to stay with them. Additionally, it was felt that one delivery could have been expedited but it could not be concluded that this would have prevented admission.

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



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 and 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. There remains an unavoidable trend of admitting babies to the NNU when a parent either declines or is unavailable to stay with them under TC, or where TC is not currently suitable to provide care despite meeting criteria, due to staffing constraints.

Progress and learning with the key reasons for admission

Data collection during Quarter 2 (July-Sept) in 2022 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. This accounted for 16 of the 21 admissions (76%) and all required oxygen support (either Vapotherm or nasal cannula oxygen) and underwent a septic screen, receiving IV antibiotics. Over half of these babies had at least one risk factor for sepsis or respiratory distress, with no overarching theme apparent.

Two of the remaining 5 admissions were admitted as a result of suspected birth asphyxia and transferred out to a tertiary unit for therapeutic cooling. Due to meeting criteria for external investigation they were not reviewed under ATAIN but are mentioned for transparency.

Of the remaining 3; one admission was for jaundice treatment; however, this baby could have been cared for under TC had a parent been available to stay alongside. The two admissions

classified as “other” included an admission for enteral feeding due to cleft lip and palate, and one due to seizure like activity.

Figure 1: Reasons for Admission July-Sept 2022

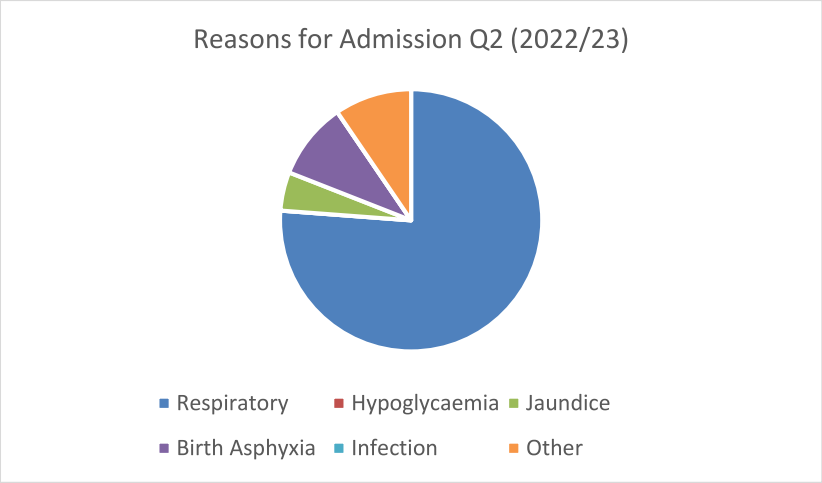
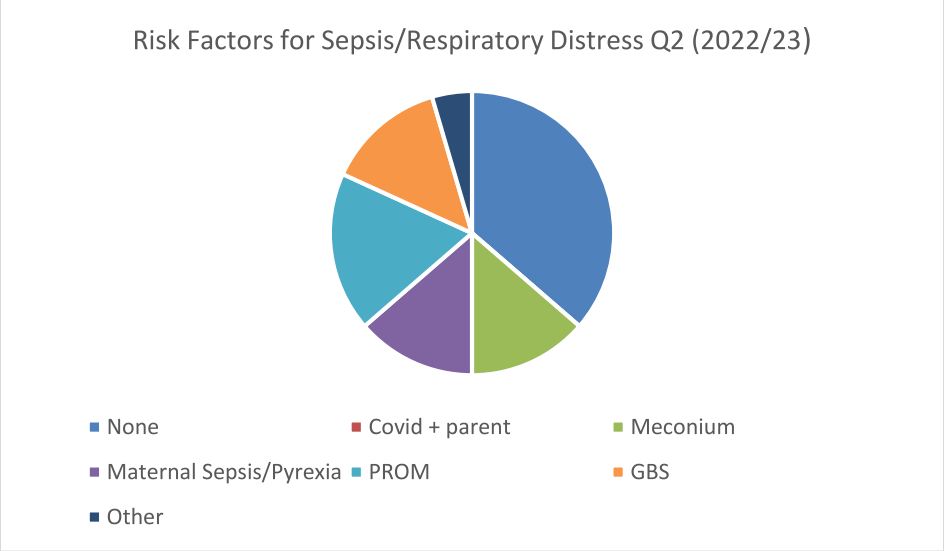


Figure 2: Risk Factors for Sepsis/Respiratory Distress

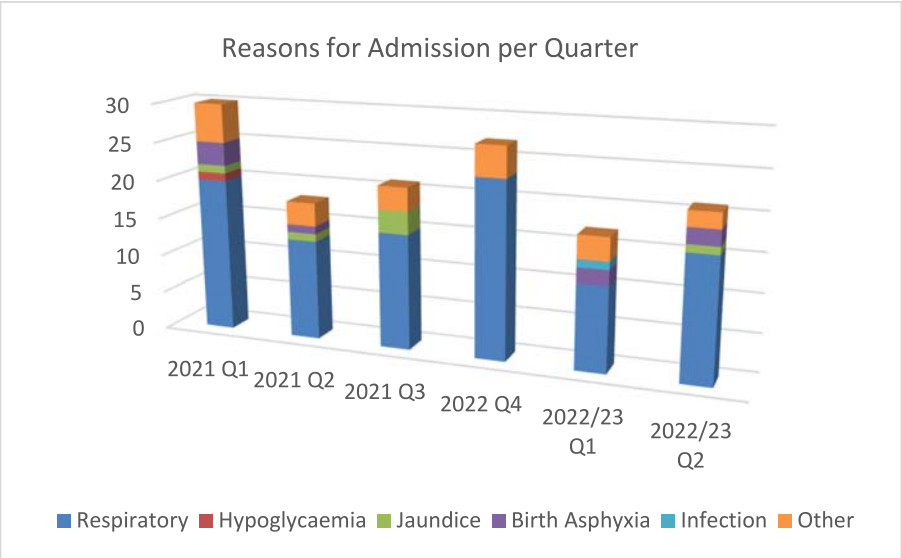
(NB: some infants may have more than one risk factor)



Quarterly Comparison

The chart below shows the reasons for admission per quarter in the 2021-2022 and 2022-23 year; demonstrating respiratory issues as the prodominant reason for admisson each quarter. No underlying common theme has been identified to date though it was noted that over 50% of babies admitted with respiratory concerns had recognised risk factors.

Figure 3: Reasons for Admission - Quarter by Quarter comparison



Transitional Care admissions via NNU

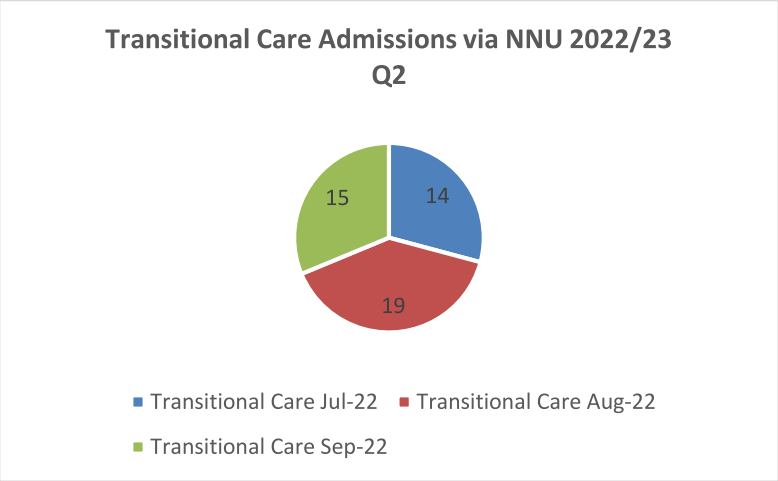
Since May 2022; new national guidance recommends that all babies attending or admitted to the NNU for any period of time should be reviewed, in some form, as part of the ATAIN project. This includes any baby who visits the NNU prior to being admitted to transitional care, and any baby who attends NNU for care while an inpatient on the unit.

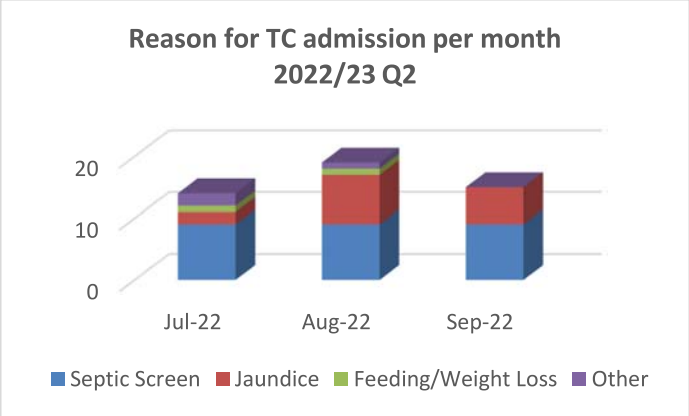
Further guidance from the regional clinical oversight group has clarified that any baby who attends NNU for care, without being admitted, (e.g. IV cannulation, repeat blood test) should have the following information recorded: parental acompaniment, reason for attendance and any themes or learning identified. Only babies who are admitted to NNU should be reviewed under the ATAIN framework which continues to involve a detailed review of antenatal, intrapartum and postnatal care using a new national proforma.

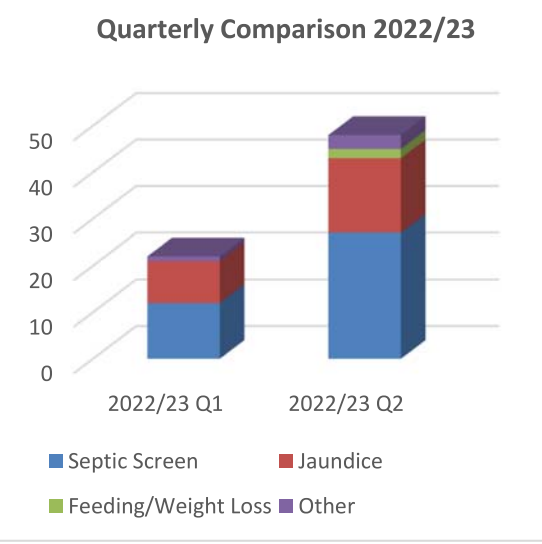
The Neonatal Unit are currently recording any short term NNU attendances from babies undergoing inpatient care on the maternity unit (under TC or Midwifery care) along with parental acompaniment data that is being reported to the East of England Neonatal operational delivery network on a monthly basic (commenced July 2022).

Currently, transitional care is not operational full time due to staffing constraints. Instead, nurses and nursery nurses visit the ward regularly or transfer the baby to NNU for tests or medications as required. However, a number of nursery nurses have now been hired and are currently undergoing training. Once trained, TC will have the capacity to be staffed 24/7 facilitating a reduction in infant/parent separation.

The charts below detail the infants who attended NNU this quarter prior to transfer to Transitional Care.







Quality improvement in this quarter

Thermoregulation QI Project

There is an ongoing drive to improve admission temperatures of babies admitted to NNU. A trend of babies being admitted with low temperatures (≤36.5°c) was first identified in May 2021 and an action plan put in place, resulting in a notable improvement in the following months. Last quarter rates remained steady but due to the on-going issue a thermoregulation quality improvement project has been commenced to try to reduce rates.

This quarter has remained stable with 28% of babies (6 out of 21) found to have a sub-optimal temperature on admission, the causes of which could not be conclusively determined in most cases but are suspected to be a combination of environmental and underlying pathology. In one case the cause was known and was due to the environmental conditions surrounding transport in to the hospital from home.

There was no common theme this quarter regarding pre-admission location, with two babies being admitted from labour suite, one from MLBU, one from Theatre, one from the Postnatal ward and one from home. It should be noted that in the majority of cases the infant was admitted shortly following delivery and had been receiving care on the resuscitaire under an overhead heater, which suggests potentially underlying issues that impacted their ability to maintain a normal body temperature, independent of environmental factors.

Quarter 4 (2021/22)	**No. of babies with sub-optimal temp (≤36.5)**	**%**
January 2022	2/10	20%
February 2022	5/13	38%
March 2022	1 /4	25%
Quarter 1 (2022/23)		
April 2022	2/9	22%
May 2022	2/6	33%
June 2022	1/2	50%
Quarter 2 (2022/23)		
July 2022	2/6	33.3%
August 2022	1/3 (2 additional admissions for cooling not inc)	33.3%
September 2022	3/10	30%

In all cases, hypothermia was not the primary reason for the admission, but a review of the notes identified this issue and appropriate actions have been made.

Historically, a number of actions were agreed and completed by the multi-disciplinary team. A thermoregulation quality imporvement project has been launched to tackle the re-emerging trend and new actions have now been created and are on-going; these are highlighted in a separate table. This included engagement with, and support from Theatres, Labour Suite and NNU teams.

Historical Actions

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.

Current/On-going Actions

Action	Plan	Comments
Raising awareness among the maternity team	• Educational piece in Risky Business • Message in Take 5	Monthly updates from ATAIN and learning in Risky Business – **Ongoing Action**
Instructions added to Warming Cots on F11	• Add instructions to all warming cots to ensure correct usage of equipment	Updated warming cot instructions added to warming cots on unit. **Action completed.**
Explore possibility of procurement of Towel Warmer for Theatre	• Towel warmer for Theatre/LS	For Theatres/LS. Promote maintainance of appropriate temperature at delivery and in early newborn period. In-progress
Information videos for Staff facebook page	• Informational video "Thermoregulation of the Newborn" on staff facebook page.	Video awaiting sign off. **In-progress**
Handover "Hot Topic"	• Remind staff at handover about importance of keeping babies warm (in Theatre, LS and F11)	Facilitated by inpatient matron in communications to Band 7 area leads. **Action Completed.**
Parental Education Poster/Leaflet	• Poster/Leaflet to display in LS rooms/F11 bays to increase awareness in parents	In development. **In-progress**
Parental Education – Cot Cards "Keep me Warm"	• Cot cards for all cots on LS, MLBU and F11	**Action completed**
Signs for Resuscitaires demonstrating how to keep babies warm	• Posters made with visual aid for resuscitaires in Theatre, LS and MLBU	**Action Completed**

Other Actions for Quarter 2

Additional actions identified in Quarter 2 are summarised below, and while it is acknowleged that this may not have prevented any of the term admissions these actions are in place to help improve future care, which will only serve to benefit parents and their babies.

Action	Plan	Comments
Opportunities for learning noted during review (which did not impact on need for admission). • Need to prioritise cord gasses where indicated • Correct use of Oxygen Sats monitor	Highlight in Risky Business	**In-progress (Deadline 30/11/22)**

• Utilisation of CFM monitoring • Improved detail in documentation		

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.

Women and Children's & Clinical Support Services Division

MATERNITY SERVICES

Midwifery Staffing Report - an effective system of midwifery workforce planning to the required safe standard

Report Title	Bi-Annual Report on Midwifery Workforce – November 2022 for period 1st April 2022 to 30th September 2022
Report for	Approval and Information
Report from	Karen Newbury, Head of Midwifery
Lead for Report	Karen Newbury, Head of Midwifery
Report Authors	Karen Newbury, Head of Midwifery Christine Colbourne, Midwifery Advisor
Report presented for information and approval	Maternity Quality and Safety Group – 21st November 2022
	Maternity and Neonatal Safety Champions – 24th November 2022
	Trust Board – 25th November 2022
Date of Report	November 2022
Risk and assurance:	There are financial risks associated with non-compliance with the Maternity Incentive Scheme Year 4 requirements as this report outlines the Trust's position against safe midwifery staffing
Legislation, regulatory, equality, diversity and dignity implications	The information contained within this report has been obtained through due diligence. There are no equality and diversity issues related to this report

Executive summary:

- National tools, LMNS collaboration and BirthRate Plus methodology have been used to determine the midwifery establishment.
- The funded establishment was agreed by the Trust Board in May 2022.
- Robust escalation processes and team working has mitigated some staffing challenges due to absences but gaps on the rota are still a challenge.
- Essential actions from the Ockenden report and subsequent cessation of target dates to implement MCoC have resulted in temporary suspension of two community-based teams to assist with safe staffing of both the hospital and community services.
- One to one care of women in labour over the 6-month period of the report has been maintained at **100% compliance**
- In October 2022, the guidance for assessing the supernumerary status of the Labour Suite coordinator (LSC) was clarified. Using the new standards, the Trust can demonstrate compliance has been 100% except in September when the LSC assisted with a birth soon after a mother was admitted in advanced labour. The aim is for 100%.
- Vacancies for experienced band 6 midwives are difficult to fill and whilst recruitment of band 5 midwives and those from overseas has been successful, the support and supervision required puts additional pressure on both midwives and service.
- Midwife vacancies at the end of September 2022 was 36.11 wte which equates to a **27% vacancy rate.** The service is currently employing approximately 10.00 wte midwives each month through the bank and staff working additional hours.
- The impact of increasing student midwife numbers and return to practice courses will not be realised for at least another 2-4 years.
- West Suffolk is actively participating in the regional work of midwifery apprenticeship schemes with the intention of having places on the first cohort when these are in place.
- The Midwife to Birth ratio set by BirthRate Plus **1:27.7**; September was the only month when this was not met and a ratio of **1:29** was reported. This reflects the vacancy factor.
- Red Flags continue to be monitored daily and collated monthly: delays in induction of labour remains the main clinical reason

Recommendations:

- Close monitoring of the supernumerary status of the LSC will continue, with each instance of non-compliance investigated and themes identified.
- Active recruitment to vacancies will continue, with an effective preceptorship process in place to retain and develop staff.
- Further MCoC teams will be on hold until safe staffing levels can be assured throughout the service.
- Recurring themes from ‘red flags’ relating to staffing will be reviewed and where appropriate and possible further mitigations in place.
- Escalation plans will be used to promote safe care

Introduction

This report is written to provide evidence of the Trust's commitment to safe midwifery staffing levels.

The Trust has assessed the staffing levels using the Maternity Incentive Scheme (MIS) for Trusts and other national reports that have been published where staffing levels have contributed to adverse outcomes and events. This report relates to the required compliance with Year 4 of the MIS, Safety Action 5 which focusses on midwifery staffing and asks if the Trust can provide evidence to demonstrate ***'an effective system of midwifery workforce planning to the required safe standard'.***

The Year 4 Safety Actions were re-launched in October 2022 with a few minor revisions to Safety Action 5. To meet the required standards the service now needs to demonstrate and evidence:

- **a.** A systematic, evidence-based process to calculate midwifery staffing establishment is completed.
- **b.** Trust Board to evidence midwifery staffing budget reflects establishment as calculated in a) above.
- **c.** The midwifery co-ordinator in charge of labour ward must have supernumerary status; (defined as having no caseload of their own during their shift) to ensure there is oversight of all birth activity within the service.
- **d.** All women in active labour receive one-to-one midwifery care
- **e.** Submit a midwifery staffing oversight report that covers staffing/safety issues to the Board every 6 months during the MIS year four reporting period.

In addition, the final Ockenden[1] report published in March 2022 contains several 'Must Do's' pertaining to midwifery staffing. These are consistent with the requirements for the MIS Year 4 in that the Maternity and Neonatal Service have staffing levels that provide safe, quality care. The potential impact of the required Ockenden actions are highlighted in this paper to inform the Trust Board and enable the required investment in midwifery services.

Consideration is being given to developing the senior midwifery workforce with a Director of Midwifery and a Consultant Midwife who is involved in undertaking and implementing research and reviews/audits of practice. Discussions continue with the Trust Executive team to agree the way forward.

The purpose of this report is to provide evidence against criteria a)- e) of the MIS Safety Action 5 and give the Trust Board assurance that progress is being made towards meeting safe staffing standards within the midwifery workforce including:

- A clear breakdown of BirthRate+ or equivalent calculations to demonstrate how the required establishment has been calculated.
- In line with midwifery staffing recommendations from Ockenden, Trust Boards must provide evidence (documented in Board Minutes) of funded establishments being compliant with outcomes or BirtRate+ or equivalent calculations.
- Where Trusts are not complaint with a funded establishment based on BirtRate+ or equivalent calculations, Trust Board minutes must show the agreed plan, including

[1] OCKENDEN REPORT – FINAL FINDINGS, CONCLUSIONS AND ESSENTIAL ACTIONS from the Independent Review of Maternity Services at The Shrewsbury and Telford Hospital NHS Trust (DOH: 2022)

timescale for achieving the appropriate uplift in funded establishment. The plan must include mitigation to cover any shortfalls.

- The plan to address the findings from the full audit or table-top exercise of BirthRate+ or equivalent undertaken, where deficits in staffing levels have been identified must be shared with the local commissioners.
- Details of planned versus actual midwifery staffing levels. To include evidence of mitigation/escalation for managing a shortfall in staffing.
    - The midwife to birth ratio
    - The percentage of specialist midwives employed and mitigation to cover any inconsistencies. BirthRate+ accounts for 8-10% of the establishment, which are not included in the clinical numbers. This includes those in management positions and specialist midwives.
- Evidence from an acuity tool (may be locally developed), local audit and/or local dashboard figures demonstrating 100% compliance with supernumerary status and the provision of 1-1 care in labour. Must include plan for mitigation/escalation to cover any shortfalls.

Whilst no longer an essential requirement, it is recommended that this report continues to include information on the monitoring of red flag events associated with midwifery staffing.

Evidence against MIS Safety Action 5

a) Assessment of required midwifery staff

A full BirthRate Plus (BR+) assessment was last completed in April 2019 which demonstrated the actual funded establishment of clinical midwives was in line with their recommendations at that time. In partnership working with the LMNS and the Trust's finance team, the midwifery managers have collaborated to ensure the national recommendations relating to midwifery staffing numbers and skill mixes have been applied. This includes maintaining a core service within the hospital service, a traditional community team to care for cross border women, the required specialist midwives and managers to safely support the service and continued commitment to the roll out of the midwifery continuity of carer model (MCoC), when safe staffing levels can be achieved.

Following submission of a variety of business cases, the Trust Board has supported the additional funding required to enable full roll out of MCoC and this was made available in budget from month 11, 2021/21 and into the new financial year. The overall increase in midwifery establishment also includes the 6.00 wte made available with Ockenden monies from earlier in 2021/22.

The agreed funded midwifery establishment for 2022/23 is as follows:

Band	Funded WTE 2022/23
Band 5	9.12
Band 6	89.07
Band 7	30.73
Band 8	4.00
TOTAL	**132.92**

As there have been multiple challenges with employing midwives the decision was made to use band 6 monies to employ staff at band 2 to support the clinical function in the community service. Staff have been employed on a year's fixed term contract and this has made a positive improvement at clinical level.

In 2021/22 the midwifery team at West Suffolk introduced 3 MCoC teams into the service. Subsequently, the full Ockenden report was published in March 2022 with one of the essential actions being for services to *'review and suspend, if necessary, the existing provision and further roll out of midwifery continuity of carer unless they can demonstrate staffing meets safe minimum requirements*'.

b) Agreement of midwifery staffing establishment and budgets

The agreement of midwifery staffing establishment and associated budgets were endorsed by the Trust Board along with the proposal to suspend the introduction of further MCoC teams in May 2022.

In September 2022, NHS England reaffirmed the essential and immediate actions outlined in the Ockenden report in relation to MCoC and removed all target dates associated with achieving compliance with the MCoC model. In response to the Ockenden essential actions the service at West Suffolk has reduced to one community team, and the caesarean section team.

Recruitment and retention of midwifery staff and strategies employed to mitigate shortages

The number of midwife vacancies at the end of September 2022 was 36.11 wte which equates to a 27% vacancy rate. The service is currently employing approximately 10.00 wte midwives each month through the bank and staff working additional hours.

Recruitment of qualified midwives continues to pose significant challenge to maternity services nationally and at West Suffolk Hospital. The service has explored the recruitment of registered nurses to join the team on the postnatal ward which has resulted in 1 RN from overseas successfully being appointed. This has proven to be successful as the role of the nurse on the postnatal ward can be vital with providing support to women with more complex medical needs or post operative care, releasing the midwife to undertake midwifery tasks. The team are keen to recruit more substantive nurses, but in the meantime, bank nurse shifts have been used when staff are available.

There continues to be a concentrated effort for recruitment of midwives including:

- Regular advertising on NHS jobs including recruitment into specialist midwife and governance roles.
- Rolling advert for midwives on NHS jobs which is constantly monitored with suitable applicants fast tracked and interviewed within 2 weeks of application.
  Collaborative work with LMNS culminating in successful recruitment of midwives from overseas. Midwives from Zambia and Jamaica have successfully been recruited to the service. At the time of this report 2 have commenced work with a further 3 midwives awaiting start dates. They are unable to be entered on the Nursing and Midwifery Council register as midwives until they have completed the Objective Structured Clinical

Examination (OSCE), the employment of the midwives is not without challenges and places additional pressure on services. Practise in their homeland is significantly different to that in the UK and the required support, training and supervision is considerable. Additional Clinical Practice facilitator hours have been funded externally to support this but the impact on the clinical care and women's experience with the numbers of student and junior midwives needing supervision will need to be monitored.

- An increase in midwifery students to enable a larger pool of newly qualified midwives to recruit from in future years.
- Focussed work with HR partners to look at improved ways of retaining staff. This includes work exploring themes around why staff are leaving the Trust following exit interviews.
- 'Growing our own' future midwifery workforce, through:
    - Collaborative working with local HEI's leading to an increase in student midwife places each cohort
    - Accessing the 18-month course to encourage nurses to train as midwives.
    - Offering Return to Practice course for midwives whose registration has lapsed.
    - A programme to develop Midwifery Apprenticeships is being developed across the East of England region. West Suffolk midwifery service are actively participating in this, with a view to having students on the first cohort.

Work on retention of midwives is being undertaken at local, regional and national level. Initial work indicates that the service has not had a significant increase in the number of 'leavers' in the last 4 years with an average of 8-10 staff leaving each year. The recruitment of staff to replace these has been positive with a similar number of staff joining the Trust each year. However, this is often experienced band 6 midwives being replaced by newly qualified band 5 midwives who need to complete their preceptorship programme.

The service also notes an increase of substantive staff requesting a reduction in hours to enable a better work/life balance. Work is underway to review the current on call arrangements and introduce more flexible working. The current exit interview process will be made more robust and thematic analysis improved.

All Trusts in the country are facing similar challenges to recruitment with an uplift in staff establishment to meet the national agenda which adds to the difficulty in attracting staff and encouraging them to move to West Suffolk when they are being offered similar opportunities elsewhere.

Midwifery Staffing Levels

Maintaining safe staffing levels, continues to provide significant challenges to the service. To mitigate against this the service has a robust escalation policy and at times of heightened activity the following actions are deployed:

- The service employs midwives from the established in-house bank plus some staff have also been willing to undertake hours in addition to contract.
- The midwifery service has the support and flexibility to offer an uplift in pay at times when safe staffing levels cannot be achieved. When initiated this does assist the service in filling shifts that are proving difficult to cover.
- Midwives working in specialist roles work clinically to ensure women receive safe care.
- The community midwifery service in times of escalation has been utilised on several occasions. Whilst this can impact on the availability of a midwife for a home birth and

access to the MCoC midwife, maintaining safe care and staffing levels in the hospital service remains a priority.

Monitoring staffing levels

- There is regular liaison with the matrons, deputy HOM and HOM to discuss strategies and actions needed to balance acuity against staffing levels across the day and planning for the next 48 hours.
- The BR+ app is completed 4-hrly with information informing decision making by the senior team.
- Staffing levels are discussed and recorded at the daily safety huddle and actions shared with the MDT.
- There is a midwifery manager on call for each 24-hr period and a unit bleep holder (band 7 Midwife) on site for both day and night shifts 7 days a week.
- Weekly staffing meetings with ward managers and matrons take place to plan ahead and discuss gaps in the rosters and options for maximising staff deployment. The Chief Nurse and Deputy Chief Nurse are kept up to date of the staffing situation in the Unit via weekly Senior Team Management.

The Head of Midwifery provides information on midwifery staffing that is included in Trust Board papers on a bi-monthly basis. Key elements of this report include the number of shifts not filled, 1-1 care in labour and the MW to birth ratio.

NUMBER OF RM SHIFTS NOT FILLED: 2022/23		
Month	**WTE**	**Shifts per month**
April	3.20	59.5
May	4.77	97
June	4.76	120
July	7.50	156
August	6.40	118
September	6.00	114

Overall, these figures show an increase of 3.58 wte unfilled shifts between April -September in comparison to the previous 6 months to March 2022. This is likely related to the vacancy rate rising.

The service currently publishes the number of staff on duty against the minimum staffing levels expected in each clinical area. E-Roster gives more detailed information on the numbers of staff on duty, absences, unfilled shifts and bank shifts utilised. Due to the uncertainty about future midwifery staffing models, it has not been possible to develop the system to deliver bespoke staffing reports. This will continue as an action when future midwifery staffing models have been implemented.

Midwife to birth ratio

The monthly midwife to birth ratio is calculated using information from both e-roster for staffing and E-Care for activity. The Head of Midwifery takes responsibility for this, with the calculations

being based on the actual number of midwives in post and working rather than the funded establishment. This is the most accurate way of calculating the true midwife to birth ratio as it enables adjustments to be made for vacant posts, staff on long term sickness and maternity leave. Likewise, midwives employed for additional hours or on a bank contract are included to formulate a true measure of the number of available midwives. This figure is measured against the actual number of births each month and reported on the service dashboard. The figure will fluctuate month on month, due to activity and availability of midwives.

The BirthRate Plus funded establishment gives an overall achievable ratio of 1 Midwife (MW) to 27.7 births which is in line with current national BirthRate Plus recommendations. Except for September, the service has met or exceeded the service ratio.

MW TO BIRTH RATIO Standard = 1:27.7	
Date	**Ratio**
April	1:26
May	1:27.5
June	1:25
July	1:27
August	1:27
September	1:29

This data is recorded on the quality dashboard and is monitored monthly at the Maternity Quality and Safety Group.

Specialist Midwives (SpMW) in post
The service employs a variety of specialist midwives at Band 6 and 7 to support the service. All specialist midwives have a clinical component to their role contributing to the care of women. How this is attributed, depends on the role function, and contracted hours the SpMW works and is discussed and agreed between the SpMW and their line manager. This is managed fairly and equitably, to ensure the specialist function of the midwife's role is not eroded. Specialist MWs also contribute to the service escalation plan at times of heightened activity and acuity.

The service also has two band 7 MW and 1 band 6 posts that are externally funded to support the clinical practice facilitator function and Better Births initiative.

The total establishment of specialist MW and clinical managers needed to lead the service, constitutes approximately 9% of the total midwifery workforce, which is in line with current BirthRate Plus methodology.

c) Status of the labour suite co-ordinator (LSC) in relation to being supernumerary

Safer Childbirth (RCOG 2007) states that 'each labour ward must have a rota of experienced senior midwives as labour ward shift co-ordinators, supernumerary to the staffing numbers required for one-to-one care to ensure 24-hour managerial cover'. The lack of a supernumerary LSC has been identified as a contributory factor in many cases of maternal and perinatal morbidity

and mortality reported at national forums. The LSC role is nationally recognised as being at Band 7.

Changes to the technical guidance for Safety Action 5 in the CNST standards were published in October 2022 adding clarity to the assessment of supernumerary status. The technical guidance in the re-launched Safety Action 5 gives clarity to the supernumerary status of the LSC by stating:

- *The Trust can report compliance with the supernumerary status of the LSC if it is a one-off event and the co-ordinator is not required to provide 1-1 care for a woman in established labour during this time.*
- *If this is a recurrent event (i.e. occurs on a regular basis and more than once a week), the Trust should declare non-compliance with the standard and include actions to address this specific requirement going forward in their action plan.*
- *The role of the co-ordinator includes providing oversight of the labour ward and support and assistance to other midwives. For example: providing CTG 'fresh eyes', giving second opinion and reviews, providing assistance to MW at birth when required, supporting junior midwives undertaking suturing etc. This should not be counted as losing supernumerary status.*
- *Supernumerary status will be lost if the LSC is required to be solely responsible for any 1:1 care for a labouring women or relieve for breaks (or any short period of time) a midwife who is providing 1:1 care for a high-risk woman requiring constant observation. This includes supervising a student midwife providing 1:1 care.*
- *If 100% supernumerary status of the LSC cannot be achieved an action plan detailing how the service intends to achieve 100% supernumerary status for the LSC which has been signed off by the Trust Board and includes a timeline for when this will be achieved. Completion of an action plan will not enable the Trust to declare compliance with this sub-requirement in year 4 of MIS.*

Following review, the service is confident that the methodology deployed meet the standard and no changes are needed in the way supernumerary status is assessed. Robust monitoring of the supernumerary status of the LSC takes place on a daily and monthly basis:

- Every 4 hours the BirthRate Plus app is updated and this includes information on the supernumerary status.
- At the daily Safety Huddle the status of the LSC in last 24-hour period is checked and documented.
- When the LSC is not supernumerary, this is reported as a 'Red flag' event
- Monthly compliance is collated, calculated, and published on the Quality and Safety dashboard.
- Monthly analysis of the reasons why compliance has not been achieved is undertaken and any identified themes highlighted.

Two band 7 MW's are deployed on both day and night shifts to ensure the presence of senior midwifery staff on a 24/7 basis. One of these will be the unit bleep holder who can support the labour suite at times of heightened activity and acuity.

Date	% Compliance: Previous Standards	% Compliance: New Guidance
April	100%	100%
May	100%	100%
June	98.8%	100%
July	99%	100%

August	98%	100%
September	92%	98%*

This was one instance * where a woman arrived in advanced labour and gave birth within 10 minutes at a time when there was no other midwife available so the LSC assisted the birth and was therefore not supernumerary for a short period of time. This was unavoidable and the LSC needed to prevent harm to the mother and baby by managing the birth themselves.
Whilst the service aspires to achieve 100%, the safety of mothers and babies has to be the priority and these figures show great improvement and will continue to be monitored on a daily and weekly basis and actions taken when required.

d)Provision of 1-1 care in labour

Monitoring of compliance to this standard is provided monthly using the maternity information system e-Care. Midwives enter the information as part of their delivery records and this information is collated monthly and reported on the service quality dashboard.

The provision of 1-1 care is prioritised by the senior management team with staff movement and escalation processes being deployed to ensure women are provided with safe care. The service has been able to maintain 100% compliance to this standard in this six-month period

1-1 Care in Labour	
Date	% Compliance
April	100%
May	100%
June	100%
July	100%
August	100%
September	100%

Monitoring of Red Flags in relation to midwifery staffing

Red flags in maternity services are defined as ‘warning signs that something may be wrong with midwifery staffing’. The Red Flag incidents/events currently monitored in relation to midwifery staffing are as follows:

RED FLAGS RELATING TO MIDWIFERY STAFFING:
Redeployment of staff to other services/sites/wards based on acuity
Delayed or cancelled time critical activity
Missed or delayed care (for example, delay of 60 minutes or more in washing or suturing)
Missed medication during admission to hospital or MLBU
Delay of more than 30 minutes in providing pain relief
Delay of 30 minutes or more between presentation and triage
Full clinical examination not carried out when presenting in labour
Delay of two hours or more between admission for induction and beginning process and/or delay of more than 2 hours during the process.
Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output)

Any occasion when one midwife is not able to provide continuous 1-1 care in established labour
Unable to facilitate women's choice of birthplace
Labour suite co-ordinator not supernumerary

The service no longer collects specific information regarding staff absences in relation to Covid-19 infection. Since the government guidance changed in relation to staff no longer needing to isolate when a family member tests positive for Covid, the number of absences has noticeably decreased.
Red flags are discussed and recorded at the daily safety huddle which is attended by medical and midwifery staff. These are reported on the Datix incident system. The number of red flags each month is recorded on the quality dashboard and monitored at the Maternity Quality and Safety Group meeting. Actions taken to mitigate and escalate issues and themes are documented and when a red flag datix is submitted, care is reviewed by the senior team to assess impact and identify trends.

The number of Red Flags submitted each month is as follows:

RED FLAGS - 2022	
Month	**Number**
April	6
May	9
June	24
July	13
August	9
September	15
TOTAL	**76**

75% of all Red Flags submitted during this period were in relation to delays in commencing induction of labour and continuing the process once started.

Conclusions

The maternity service continues to strive to achieve safe and effective care for women through the provision of a midwifery workforce that is competent, skilled and trained to meet the needs of the local population.

The service has been supported by the Trust with a significant increase in funding to achieve an establishment of midwives that will meet:

- maintaining safe staffing levels for both in-patient and outpatients' areas in the hospital
- provide enough specialist MW and managers currently needed to safely run the service
- the MCoC agenda
- deliver a community service for out of area women

In the last 6-months successfully recruiting into vacant posts has been difficult to realise with changes to national advice coupled with the challenges of recruiting new midwives to the service. There have been new overseas MW starting with the service with more planned in coming months, coupled with new students qualifying which will increase the clinical workforce in time once they have been supported in clinical practise. The additional pressure this puts on the staff and service will continue to be monitored.

Maintaining safe levels of staffing has been a particular challenge in the last 6 months in the main due to the number of vacant MW posts. Other strategies are in place to improve future staff availability with the increase in students, midwifery apprenticeships and return to practice courses but the benefits of these may not be realised for at least another 2-4 years. All adopted practices around improving staff recruitment will be continued until the vacant posts are filled.

The service has been proactive in maintaining a safe level of staff in the hospital service, particularly for women in labour. This has been achieved by having a robust escalation plan and good multi-disciplinary team working to ensure available staff are accessed and moved to areas where needed. This has disrupted normal working for some staff especially those in the community, management, and specialist roles. The positive outcome of the day-to-day operational scrutiny, decision making and action by all members of the midwifery team has enabled the service to achieve high compliance with supernumerary status of the LSC and all women in labour received 1-1 care.

The service has also made the decision to use midwife monies to over establish band 2 and 3 clinical support staff on fixed term contracts, particularly in the community environment.

The covid sickness rates have significantly reduced and with the cessation of one of the MCoC teams temporarily, the service is able to concentrate on the utilisation of staff in the core service. The roll out of MCOC will resume once the vacant midwife posts are filled and further guidance is received from NHS England.

An action plan has been developed and attached as Appendix 1 to highlight where (and how) the service needs to improve compliance. Some actions from the previous report have been carried over for continued monitoring and completed actions have been highlighted. This action plan will be monitored quarterly at the Maternity Quality and Safety meeting and will be updated for the next Board Report due in May 2023.

The completed actions from the previous report in May 2022 and progress against these and new actions are included in the updated action plan below.

Recommendations:

- Close monitoring of the supernumerary status of the LSC will continue, with each instance of non-compliance investigated and themes identified.
- The Trust Board to sign-off the action plan below in response to not achieving the 100% target for supernumerary status of the LSC.
- There will continue to monitoring of safe staffing levels, 1-1 care in labour, staff to birth ratios and red flags as part of the processes in place.
- Active recruitment to vacancies will continue, with an effective preceptorship process in place to retain and develop staff.
- Further MCoC teams will be on hold until safe staffing levels can be assured throughout the service.
- Recurring themes from 'red flags' relating to staffing will be reviewed and where appropriate and possible further mitigations in place.
- Escalation plans will be used to promote safe care
- The discussions on further roles within maternity services such as a Director or Midwifery and Consultant Midwife are continuing with the Trust Executive team.

Appendix 1 Action Plan

Action Plan Owner:	Karen Newbury	**Role Title:** Head of Midwifery	**Contact:** Karen.newbury@wsh.nhs.uk

RECOMMENDATION		**ACTIONS REQUIRED**	**TARGET DATE**	**PERSON RESPONSIBLE**	**COMPLIANCE MAY 2022**	**COMPLIANCE / PROGRESS OCTOBER 2022**
1.	Recruitment and retention of workforce	NHS Recruitment and Retention NHS Self-assessment to be completed.	End December 2022	HOM Matrons HR	N/A	Self-assessment completed October. To be shared at Governance forums and Trust Board
		Review on-call requirements and introduce more flexible working.	End March 2023	HOM Matrons HR		Workshops and focus groups
		Improve quality of exit interviews including thematic reviews annually	End March 2023	HOM Matrons HR		Ongoing work – to be evaluated by the end of March 2023
		Ongoing recruitment plans and commitment to exploring apprenticeships with NHS England	Review progress End March 2023	NHS England with local Trusts		Ongoing work – to be evaluated by the end of March 2023
		Staff surveys regarding staff satisfaction and areas for further development	Review progress End March 2023	PDM's CPF's Deputy HOM	N/A	Ongoing work – to be evaluated by the end of March 2023

2.	Aim for supernumerary status of the LSC to be 100%	Communication to LSC team clarifying supernumerary status	On-going monitoring	Head of Midwifery	N/A	Ongoing work – to be evaluated by the end of March 2023
		Review escalation policy	Jan 2023			Ongoing work to encompass Neonatal Unit and regional guidance
		Trust Board to sign off this action plan in line with CNST requirements.	End Nov 2022			To be presented at Board 25/11/22
3.	Trust Board to evidence midwifery staffing budget reflects calculated staffing establishment.	Full BR + assessment using the agreed tool to be completed	March 31st 2023	Trust Secretary and Head of Governance	N/A	Being arranged
		Annual budget setting to be approved	March 31st 2023	Finance and Maternity leads		Work in progress
		Trust Board to provide evidence (documented in Board minutes) of funded establishment being compliant with outcomes of BirthRate+ or equivalent calculations.	June 2022	Finance and Maternity leads Trust Board Secretary and Head of Governance		Staffing papers approved at Trust Board, papers available for May 2022.

4.	Enable accurate electronic recording of planned versus actual staffing on E-Roster	Review rules and templates on E-Roster to enable the system to generate accurate reports on planned versus actual staffing levels.	Dependent on filling vacant posts and guidance from NHS England	Matron IP services. Ward Managers	Successful completion of this will be dependent on roll out of continuity of carer model of care, which is currently suspended following publication of the Ockenden Report and is out of the services control.	Currently on-hold due to national guidance on MCoC therefore no current actions required
5.	Review staffing levels once MCoC is implemented to ensure safe standards of care are maintained	Review all methodology of monitoring safe staffing levels and acuity when MCoC teams are implemented and established.	Currently no published dates for recommencement of MCOC	HOM Matrons LMNS CCG	Successful completion of this will be dependent on roll out of continuity of carer model of care, which is currently suspended following publication of the Ockenden Report and is out of the services control.	Currently 'on-hold due to national guidance on MCoC
6.	Review the implementation of Must Do's arising from the Ockenden Report	Full Ockenden recommendations are currently under assessment by the MDT and executive. Particular actions in relation to midwifery staffing will be monitored and reported on in this bi-annual report.	On going	HOM Matrons LMNS CCG		Review completed – included in other aspects of staffing reports and developments

West Suffolk NHS
NHS Foundation Trust

Women's and Children's Division

Obstetric Staffing

Report Title	**Compliance with Safe Obstetric Staffing Arrangements and Standards**
Report for	Approval and Information
Report from	Maternity Services
Lead for Report	Kate Croissant, Clinical Lead Laura Minns, Labour Ward Lead
Report Authors	Laura Minns, Labour Ward Lead Beverley Gordon, Project Midwife
Report presented for information and approval	Maternity Quality and Safety Group – 21st November 2022
	Maternity and Neonatal Safety Champions – 24th November 2022
	Trust Board – 25th November 2022
Date of Report	November 2022
Risk and assurance:	There are financial risks associated with non-compliance with the Maternity Incentive Scheme Year 4 requirements
Legislation, regulatory, equality, diversity and dignity implications	The information contained within this report has been obtained through due diligence. There are no equality and diversity issues related to this report

Executive summary:
The Trust has embedded the RCOG guidance for scenarios where the consultant obstetrician is expected to be present to assist with clinical management of complications or complex care and decision making. A robust process for monitoring compliance with this safety standard is now in place. The results from this first quarter demonstrate 100% compliance with the consultant obstetricians attending women with significant complications when required to do so.

Recommendation:
Monthly data collection and submission to the Maternity Quality Dashboard.
Quarterly Trust Board reports to be formalised and submitted.

Introduction

The Maternity Incentive Scheme run by NHS resolution is in its fourth year and builds on the progress made in the previous 3 years. The safety action that this report relates to Safety Action 4a to ensure that the obstetric staff are able to provide support to clinical care when required and staffing levels are within agreed standards.

Year 4 safety actions were published in August 2021. In December 2021, the requirements for evidence and submission were put on hold due to the effects of the pandemic on maternity services across the country. These were reissued in May 2022 but were further relaunched In October 2022, with updated timeframes and requirements where required.

This report relates to the requirements for **Safety Action 4** '**Can the Trust demonstrate an effective system of clinical* workforce planning to the required standard?'**
4a relates to the provision of safe clinical staffing levels within the Obstetric Service.

Required Standards

a) Obstetric medical workforce

1. The obstetric consultant team and maternity senior management team should acknowledge and commit to incorporating the principles outlined in the RCOG workforce document: 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology' into their service:
2. Units should monitor their compliance of consultant attendance for the clinical situations listed in this document when a consultant is required to attend in person. Episodes where attendance has not been possible should be reviewed at unit level as an opportunity for departmental learning with agreed strategies and action plans implemented to prevent further non-attendance. Trusts' positions with the requirement should be shared with the Trust board, the board-level safety champions as well as LMNS.

Minimum Evidence

Obstetric medical workforce
Sign off at Trust Board level acknowledging engagement with the RCOG document along with an action plan to review any non-attendance to the clinical situations listed in the document. Trusts should evidence their position with the Trust Board, Trust Board level safety champions and LMNS meetings at least once from the relaunch of MIS year 4 in May 2022.

Time Frames
a) Obstetric medical workforce
1. By 16 June 2022
2. By 29 July 2022 and monitored monthly from then.

Evidence

1. The response to the RCOG document was written and submitted for approval through the Safety Champions meeting in December 2021, the Maternity Quality and Safety Group in April 2022 and the Trust Board in May 2022.

2. The indications for consultant obstetrician presence were included in relevant clinical guidelines when these were updated and the Standard Operating Procedure for the Roles and Responsibilities of the Obstetric Consultants was updated and agreed with these standards in place in October 2021.

3. The process for monthly monitoring of the consultant presence was agreed on the 12th July 2022 and embedded in practice from 1st August 2022.
   The criteria for consultant presence have been summarised and displayed on the labour suite. At each daily safety huddle, the question is asked about any of the clinical scenarios that have occurred in the previous 24 hours. The Labour Ward Lead collects the data for compliance at the start of the month for the previous month from the safety huddle and in addition the birth register data is used to verify the information is complete and accurate. This data is reported on the Maternity Quality Dashboard each month.
   Any incidents where the consultant has not been present when required are reviewed and analysed by the labour ward lead and quality and safety team and any remedial actions or learning shared.

Results of compliance for quarter August to October 2022

Month	No. of days where relevant incidents occurred *	Consultant Attendance
August	9	9/9 100%
September	8	8/8 100%
October	7	7/7 100%

On some days * more than one potential harm event may have occurred to the same woman or more than one woman so these are classified in days rather than the total number of incidents/women on those days. To be compliant, all the incidents on that day have to have been attended by the consultant obstetrician.

Conclusions

The Trust has embedded the guidance for scenarios where the consultant obstetrician is expected to be present to assist with clinical management and decision making. A robust process for monitoring compliance with this safety standard is now in place. The results from this first quarter demonstrate that the consultant obstetricians are attending women with significant complications when required to do so.

Recommendations

Quarterly reports on compliance with consultant presence will continue until such time that the Trust is assured of the safety standards. Once maintained at a safe level, the reports will be reduced to 6-monthly.

Compliance with Standards				
Clinical Workforce Group	**Standard to be met**	**WSH compliance**	**Progress Report**	**Evidence Source**
Obstetric Workforce	1. The obstetric consultant team and maternity senior management team should acknowledge and commit to incorporating the principles outlined in the RCOG workforce document: 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology' into their service https://www.rcog.org.uk/en/careers-training/workplace-workforce-issues/roles-responsibilities-consultant-report/	**GREEN**	**Completed**	Guideline or SOP outlining responsibilities  Response to the RCOG Trust Board a  SOPConsultant Obstetric roles v 2.0

	2. Units should monitor their compliance of consultant attendance for the clinical situations listed in this document when a consultant is required to attend in person. Episodes where attendance has not been possible should be reviewed at unit level as an opportunity for departmental learning with agreed strategies and action plans implemented to prevent further non-attendance. Trusts' positions with the requirement should be shared with the Trust board, the board-level safety champions as well as LMS.	**GREEN**	In place by July 29th 2022 then monthly reports	Reviews and reports with actions when required.

Action plan

Action plan lead	Name: Laura Minns	Title: Labour Ward Lead	Contact: laura.minns@wsh.nhs.uk

Recommendation	Actions required	Action by date	Person responsible	Comments/action status
Monthly monitoring pf compliance	Data collected within the first week of the month	Monthly	Laura Minns	
Quarterly reports on compliance	Compliance data will be formalised into a Board report each quarter	Next report due February 2023	Laura Minns	

Report Title	Audit of the Operational Pathway of Care into Neonatal Transitional Care July to September 2022 (Q2)
Report for	Information and Approval
Report from	Women's & Children's Services
Report Author	Jane Lovedale
Date of Report	November 2022
Presented to:	Maternity and Gynaecology Quality and Safety 21st November 2022 Maternity and Neonatal Safety Champions 24th November 2022 Trust Board 25th November 2022

Audit of the Operational Pathway of Care into Neonatal Transitional Care July -September 2022

Introduction and Background

CNST maternity Incentive scheme

- Neonatal Transitional Care Safety Action 3
- CNST required standards revised May 2022
- Compliance with Maternity incentive scheme Year 4 published May 2022

Audit

- Aims
- Methodology
- Summary of Results for Quarter 2
- Conclusions and Summary of Overall Findings and learning opportunities
- Improvements and future developments

- Midwifery staffing
- Neonatal staffing
- Neonatal medical teams

- Appendix 1 Clinical Reasons for babies requiring Neonatal Transitional Care April 2022 – September 2022
- Action plan

Audit of the Operational Pathway of Care into Neonatal Transitional Care
July - September 2022

Report date: November 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 more than 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 May 2022 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 transitional care services in place to minimise separation of mothers and their babies and to support the recommendations made in the Avoiding Term Admissions into Neonatal units**

CNST Required Standards revised and updated May 2022

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 (electronic and/or paper based for capturing all term babies transferred to the neonatal unit, regardless of the length of stay, is in place.

D) A data recording process for capturing existing transitional care activity, (regardless of place - which could be a Transitional Care (TC), postnatal ward, virtual outreach pathway etc.) has been embedded. If not already in place, a secondary data recording process is set up to inform future capacity management for late preterm babies who could be cared for in a TC 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.

E) 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.

F) Reviews of babies admitted to the neonatal unit continue a quarterly basis and findings are shared quarterly with the Board Level Safety Champion. Reviews should now include all neonatal unit transfers or admissions regardless of their length of stay and/or admission to Badger Net. In addition, reviews should report on the number of transfers to the neonatal unit that would have met current TC admissions criteria but were transferred or admitted to the neonatal unit due to capacity or staffing issues. The review should also record the number of babies that were transferred or admitted 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.

Standards G) & H) have been excluded in this report as they relate to the ATAIN project relate.

Compliance with Maternity incentive scheme A-C

An operational Policy for Neonatal Transitional Care CG10602 is in place. This was reviewed and updated in October 2021. A data recording process captures transitional care activity each month by the Neonatal unit and the Maternity Quality and Safety team. A quarterly audit is undertaken to identify whether the agreed standard has been embedded. 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.

Aims of the Audit

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 to improve the care for mothers and babies.

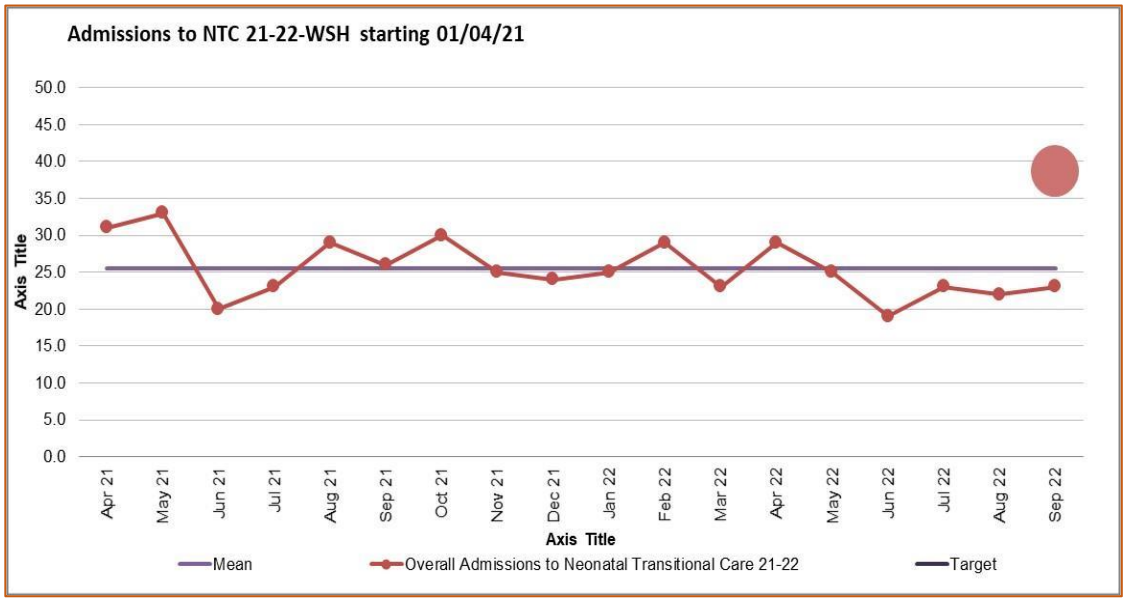
Methodology

A review of the data collected monthly of the operational pathway of all cases identified between July - September 2022. (Q2) The data was taken from Badger Net, e-Care Maternity system and Neonatal Admission book.

NB. The audit noted that during this quarter the postnatal ward (F11) remained was relocated to another ward in the hospital to allow structural work to be undertaken. The new ward did not allow for a specific transitional care bay, however during this period all babies requiring transitional care continued to receive this type of care beside their mothers within the ward area.

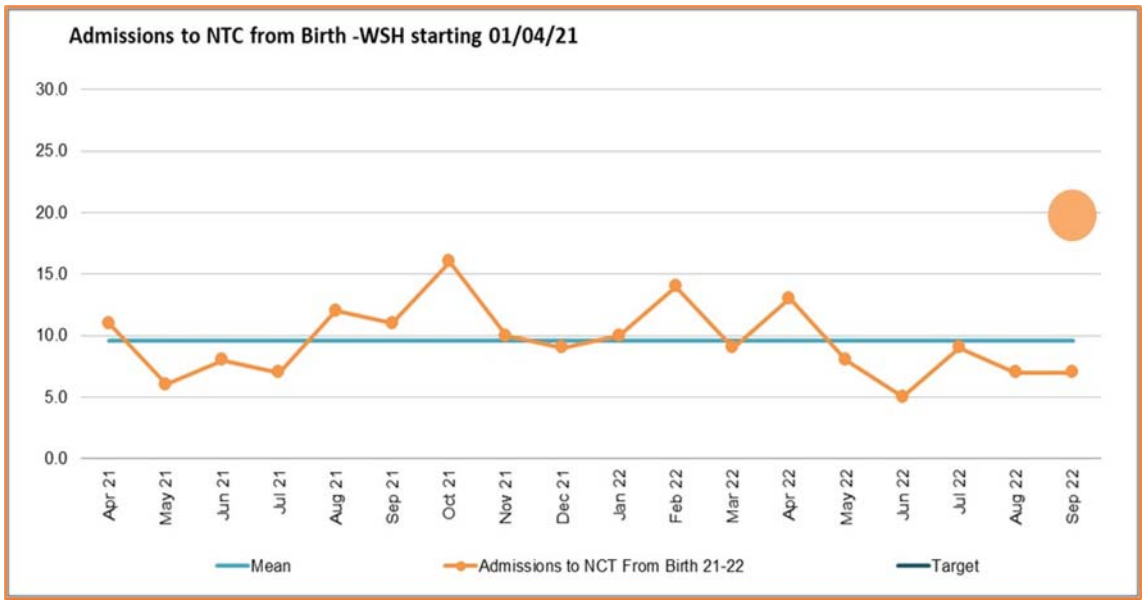
Summary of Results for Quarter 2

69 babies received neonatal transitional care



23 (33%) babies received Transitional care following from birth from labour Suite / MLBU / Home

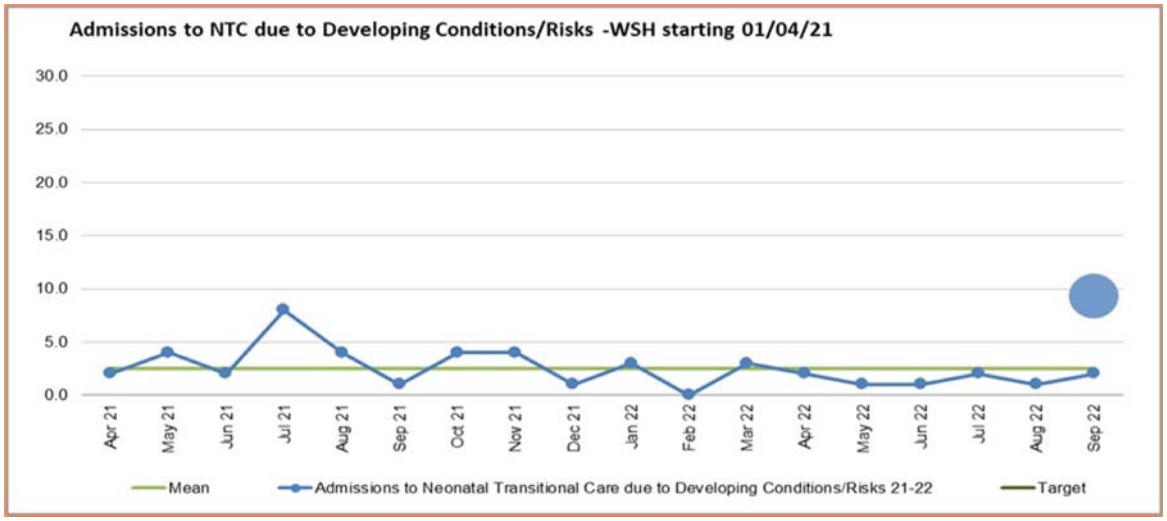
Clinical Standards		Criteria met
Criteria for immediate admission		
Gestational age >34+6 weeks	All babies above the guideline criteria	100%
Not requiring intensive or high dependency care	No babies required intensive care	100%
Birthweight >1800g	All babies had birthweights above 1800g	100%
Maternal suspected /confirmed sepsis in labour	14/23 (61%)	100%
Maternal and Fetal symptoms of suspected sepsis.	6/23 (26%)	100%
Neonatal risks of Sepsis.	3/23 (13%)	100%
Preterm within the cohort	1 /23 (4.3%) at 35+6 weeks gestation	100%



33% of babies this quarter received transitional care following their birth.

- 14 babies followed the local pathway for sepsis screening and intravenous antibiotics when the mother was treated for suspected or confirmed sepsis in labour.
- 6 Both mother and baby showed signs of sepsis.
- 3 babies followed the local pathway for sepsis screening due to risks associated with sepsis at birth.
- One baby in this group was preterm 35+ 6 weeks gestation

5 (7.2%) of babies were transferred to TC from the postnatal due to clinical conditions developing on the Postnatal ward which required closer monitoring



Clinical Standards		Criteria met
Criteria for admission – developing: Risk factors		
Risk factors for sepsis requiring IV antibiotics	4 (5.7%) babies developed or had persistent respiratory symptoms where sepsis was suspected.	100%
Maternal risk factors for babies requiring TC	1 (1.4%) baby required IV antibiotics due to their mother developing sepsis.	100%

7.2% of babies this quarter developed symptoms postnatally requiring transfer from normal care to transitional care.

- 4 babies developed or persisted with respiratory symptoms and followed the local pathway for sepsis screening and intravenous antibiotics. Neither baby required respiratory support and received transitional care allowing for closer observation and treatment with antibiotics.

- 1 asymptomatic baby was transferred due to their mother having suspected sepsis requiring antibiotics shortly after birth.

24 (34.7%) babies were re-admitted from the community setting and received transitional care



Clinical Standards		Criteria met
Criteria for readmission from community met:		
Requiring phototherapy and serum bilirubin monitoring	20 babies were re-admitted with neonatal jaundice.	100%
Weight loss /poor feeding	4 babies were readmitted due to problems with feeding one baby had associated weight loss.	100%

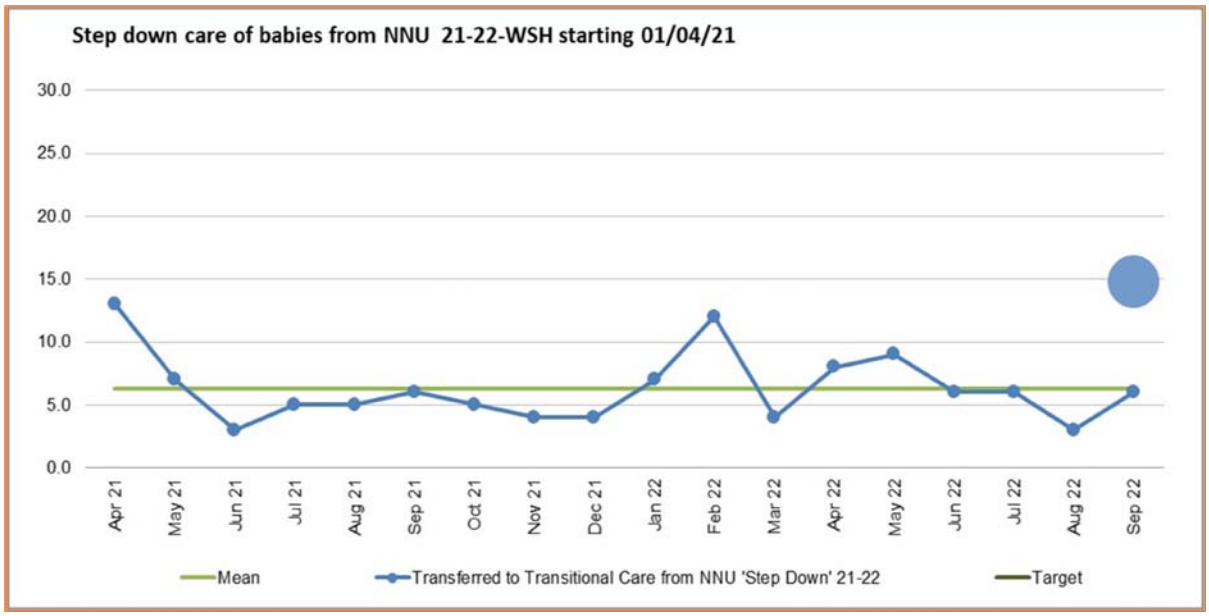
34.7% of TC babies this quarter required re-admission from the community setting.

- 20 babies with neonatal jaundice were referred by the community midwife and admitted with jaundice. 19 required phototherapy treatment. Apart from one baby all were discharged after 24 hours. 9 babies were less than 38 weeks gestation.

- 4 babies were admitted due to problems feeding their babies and requiring continuous support.

- All babies re-admitted from the community setting were cared for with their mothers in a side room on the neonatal unit.

15 (21.7%) babies had their care 'Stepped Down' from NNU to Transitional Care



Clinical Standards		Criteria met
Criteria for step down from NNU:		
Corrected gestational age > 33+0 and clinically stable.	All babies were within the agreed criteria for gestation.	100%
Observations required no more than 3 hourly	No babies required more than 3 hourly observations	100%
Stable baby with sepsis requiring antibiotics	14 babies were continuing IV antibiotic treatment.	100%
Continuing phototherapy when bilirubin has stabilised	0 babies additionally continued with phototherapy treatment.	100%
Criteria for discharge met:		
Feeding established and baby is maintaining or gaining weight.	Criteria met	100%
Course of IV antibiotics is complete	All babies completed their antibiotics prior to discharge home	100%

21.7% of babies this quarter babies of all babies who received transitional care were babies who had stepped down care from the neonatal unit. All babies met the criteria for step down of their care.

Conclusions

Overall, the number of admissions to transitional care appears to have fallen slightly. To understand its significance the rate needs to be reviewed against the number of admissions to the neonatal unit admitted within the same criteria. All admissions this quarter met the agreed criteria.

The main reason for babies receiving transitional care are babies referred from the community with neonatal jaundice. This has shown a steady rise in the last few months. A recent audit demonstrated that the maternity service has robust processes in place to ensure neonatal jaundice is identified early and community staff carry transcutaneous bilirubinometers for recording jaundice levels. In addition, midwives can directly refer to a paediatric registrar. All admissions for jaundice were appropriate and required phototherapy treatment with one exception when the result was borderline. Most babies were discharged the following day after 24 hours of treatment.

This last two quarters has seen a reduction of babies admitted from birth. Overall, this could be seen as a positive note, however the data needs to be looked at against admissions to the neonatal unit. Most babies in this group requiring transitional care are because they need prophylactic antibiotics due to maternal sepsis however this quarter there were several babies who were recorded to have symptoms. An audit was undertaken of mothers early in February 2022 who had received intravenous antibiotics in labour because of confirmed or suspected sepsis and their babies reported that none of the mothers or the babies had positive microbiology/ histopathology reports.

Improvements and future planning.

The maternity service is due to commence the Kaiser Neonatal Sepsis calculator; a tool which establishes risk factors and neonatal condition to estimate each baby's risk factor of early onset neonatal sepsis (EONS). Studies in the US have suggested that implementing this tool resulted in a reduction in antibiotic administration (48%) without evidence of adverse events (RCPCH). Depending on the criteria for what type of care these babies will receive it will have a bearing on the numbers of babies receiving transitional care transitional care.

Since July 2021 the Quality Safety team has been recording data on late preterm babies 34-36+6 weeks and who are admitted to the neonatal unit. This is to inform future capacity management for late preterm babies who could be cared for on TC. 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.
An audit is being undertaken of the data collected to date which will inform management of the number of days babies are receiving neonatal care and not requiring any supplemental oxygen therefore could be suitable for TC.

Previously nasogastric tube feeding could not be supported in TC due to the service not having a dedicated workforce covering 24/7. The maternity service has employed several neonatal staff to provide 24 hours per day, 7 days per week cover in transitional care and once training has been completed, the service will be able to support this.

A Co-produced system wide ATAIN and TC data review tool has been developed between the Suffolk and Northeast Essex. It has been proposed this will commence in November 2022. This will allow consistency across the Local maternity system.

In October 2022 NHS Resolution published maternity incentive scheme year -four. There are no changes relating to Safety Action 3.

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%**

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%**

Learning opportunities

There were no specific learning opportunities identified. However, to understand the significance of the data of babies receiving neonatal transitional care this needs to be looked at in relation to babies within a certain criterion who are admitted to the neonatal unit.

The findings of this audit to be shared with all staff via Risky Business monthly publication Audit findings are shared with:

- Maternity and Neonatal Safety Champions
- Maternity and Gynaecology Quality & Safety meeting
- Neonatal teams
- Local Maternity and Neonatal System and (LMNS)
- Quality Surveillance meeting and Trust Board.

References:

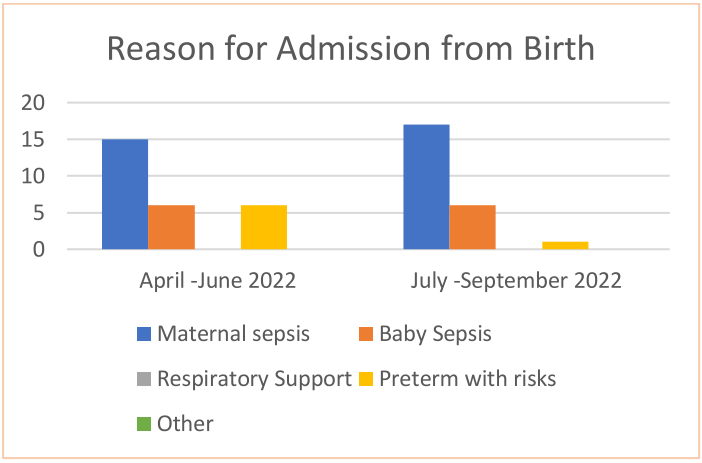
British Association of Perinatal Medicine A Framework for Neonatal Transitional Care 2017

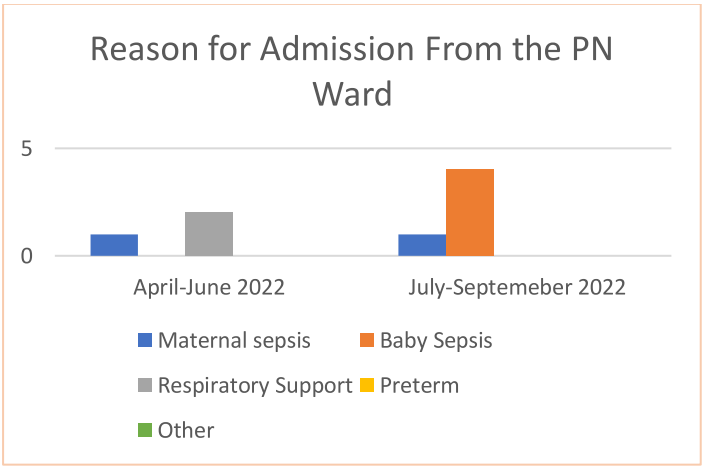
'Operational Policy for Neonatal Transitional Care (NCT) June 2020.

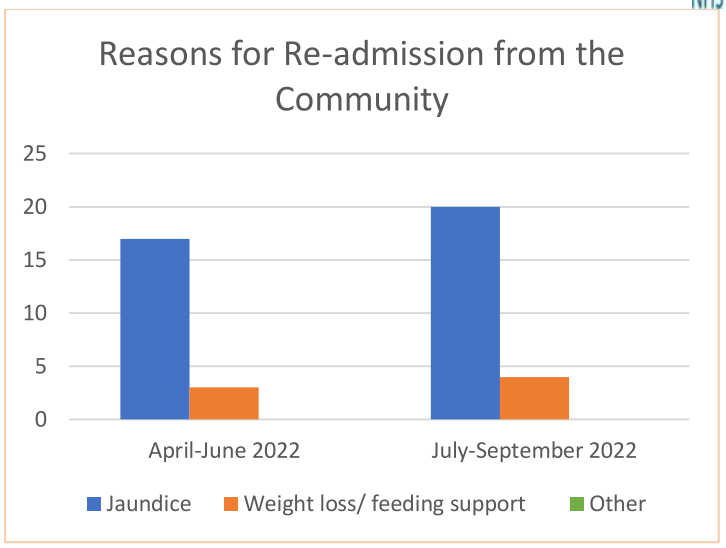
Maternity Incentive Scheme (CNST) Year Four Ten Maternity Safety Actions. Safety Action 3. May 2022

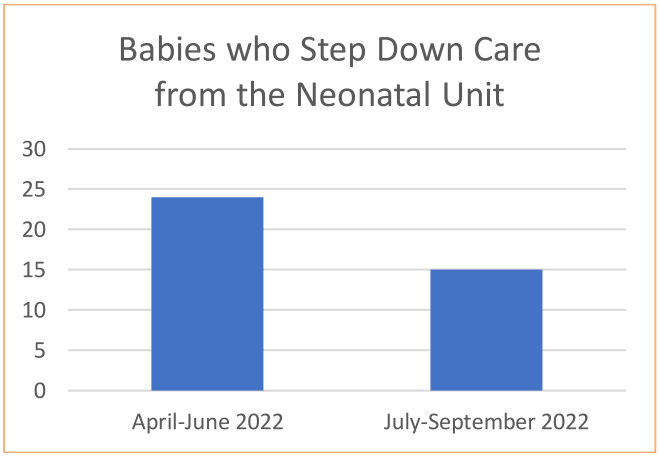
Appendix 1

Reasons for admission to TC 2022-2023






Reasons for Re-admission from the Community
25
20
15
10
5
0
April-June 2022
July-September 2022
Jaundice
Weight loss/ feeding support
Other


Babies who Step Down Care from the Neonatal Unit
30
25
20
15
10
5
0
April-June 2022
July-September 2022

Opportunities for Learning and Sharing

Project title	Quarterly 2 Audit of the Operational Pathway of care into Neonatal Transitional Care

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

	Learning Opportunity	Actions required	Action by date	Person responsible	Comments/action status	Status of Action
1.	Share findings of the audit with all staff.	Risky Business publication	31st December 2022	Rebecca Warburton Q&S Midwife		
		Maternity Quality & Safety meeting	21st November 2022	Karen Green Q&S Manager		
2	Audit findings shared with the Maternity and Neonatal Safety Champions,	Shared audit findings at the MNSC meeting	24th November 2022	Karen Newbury HOM		
4	Local Maternity and Neonatal System and (LMNS),	Share findings and learning opportunities at the LMNS meeting.	TBC	Karen Newbury HOM		
4.	Quality Surveillance meeting and Trust Board.	Share findings at Trust Board	25th November 2022	Karen Newbury HOM		

ANTENATAL AND NEWBORN SCREENING

ANNUAL REPORT
1st October 2021- 30TH September 2022

Written by lead midwives / ANNB screening coordinators:
Sarah Bennett-Day and Leah Goodchild

Contributions from:

IDPS – Marcus Milner, Microbiology laboratory lead, WSFT.
SCT – Claire Boorman, Senior Biomedical scientist, WSFT
FASP – Lisa Jacobs, Screening support sonographer, WSFT.
NBBS – Kelly Oxford, Healthy child professional lead, Child Health, Sarah Hogg, director of regional CUH laboratory
Hearing – Tracy Stutters, NHSP local manager, WSFT
Diabetic Eye – Kay Young, Diabetic Midwife, WSFT

PRESENTED TO:

Clinical Audit and Education meeting – 9th November 2022
ANNB Screening Steering Group – 28th November 2022
NHS England Programme Board – January 2023
Local Maternity and Neonatal Services – December 2022

APPROVED BY:
Maternity Quality & Safety Group – 21st November 2022
Maternity & Neonatal Safety Champions Group – 24th November 2022
Trust Board – 25th November 2022

Awaiting approval



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Awaiting approval

Introduction

This report provides detail on antenatal and newborn screening performance and issues at West Suffolk NHS Foundation Trust (WSFT). The report covers trust key performance and standards data, operational issues, quality improvement, challenges and inequalities in the period 1st October 2021 to 30th September 2022.

Reported performance data however sits concurrently with NHSEI KPI / Screening standard annual national data returns from 1st April 2021 to 30th March 2022.

As a Trust we deliver six antenatal and newborn screening programmes commissioned by NHS England, with quality assurance provided by NHSE screening quality assurance service. Antenatal screening covers 17 conditions and newborn screening covers 15 conditions, with a total of 44 Key performance indicators (KPI's) and standards across the six programmes.

What do we screen for?

- Sickle Cell and Thalassaemia (SCT) – uses a questionnaire about family origin and offers blood tests to screen pregnant women for conditions of sickle cell and Thalassaemia. Mothers identified at potential risk are offered further testing (including partner testing). The Programme is linked to the Newborn Blood Spot Programme to identify babies at risk of sickle cell anaemia to be given the best support and treatment at the earliest opportunity.

- Infectious Diseases (IDPS) - Programme recommends screening for all pregnant women for Hepatitis B, HIV and Syphilis so appropriate follow-on tests and treatments can be offered to reduce risk of passing on infections to babies.

- Fetal Anomaly Screening Programme (FASP) – Offers the choice of screening for Down's syndrome, Edwards' syndrome and Patau's syndrome, including the addition of non-invasive prenatal testing (NIPT) and a number of structural anomalies.

- Newborn and Infant Physical examination (NIPE) – uses a detailed physical examination to screen newborn babies and infants for anomalies with their eyes, heart, testes and hips to help early detection and diagnosis of several conditions.

Awaiting approval

- Newborn Hearing (NHSP) – Offers a hearing screening test in the first few weeks of life to find those who are born with hearing loss.

- Newborn Blood Spot (NBS) – screens newborn babies for nine rare but serious genetics or metabolic conditions. Babies who test positive are then offered early treatment and intervention to reduce the chance of long-term disability.

To meet the requirements of the screening programmes different professionals and departments work collectively:

- Maternity services
- Obstetric ultrasound department
- Newborn hearing screening department
- Pathology services are provided in- house for haematology and microbiology requirements
- The Department of Prenatal Screening at Addenbrookes, Cambridge
- Newborn Blood Spot regional laboratory at Addenbrookes, Cambridge

Throughout this report attention will be given to the annual summary of screening Key Performance Indicators (KPI's) (Appendix 1) and screening standards (Appendix 2).

Awaiting approval

Reflections on Antenatal and Newborn Screening programmes 2021-22

Infectious Disease in Pregnancy Screening Programme (IDPS)

Summary Statistics 2021-2022

Coverage

HIV / Hepatitis / Syphilis - 2559 eligible pregnant.	• 99.7% women screened (0.2% declined).

Test Turnaround times

Test turnaround time, reported ≤ 8 working days Acceptable standard ≥ 95% Achievable ≥ 97%	• HIV / Hepatitis B / Syphilis - 99% (1 x HIV breach due to issue at UKHSA confirmatory lab)

Awaiting approval

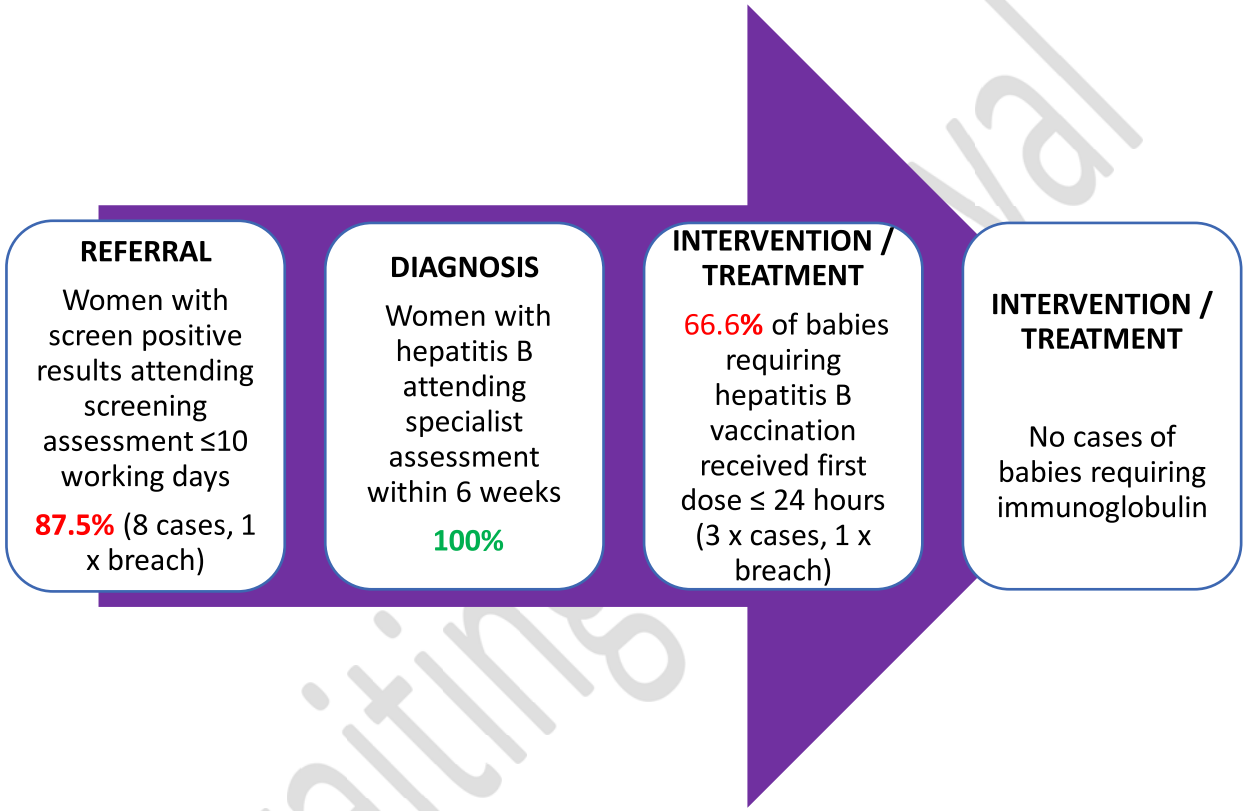
Screen positive rates

HIV	• No screen positive cases
Hepatitis B	• 0.16 % of eligible pregnant women screened positive
Syphilis	• 0.16 % of eligible pregnant women screened positive

Awaiting approval



NHS
West Suffolk
NHS Foundation Trust



Awaiting Approval

IDPS Programme Updates and changes to pathway

- National NHSE IDPS laboratory Handbook updated April 2022 – significant changes

Laboratory Update

- The new DiaSorin Liaison XL® analyser has been introduced. Samples are run on the DiaSorin® analyser when they arrive in the lab Monday to Friday.
- UKHSA syphilis confirmation lab at Colindale service suspended. Samples are now referred to the UKHSA lab at Bristol due to failed IGM (immunoglobulin) kit. This was withdrawn due to inability to provide RPR testing.
- Treponema pallidum particle agglutination (TPPA) syphilis testing will end shortly as the testing kit has been withdrawn. IDPS reports will look differently moving ahead.
- No external quality assurance (EQA) issues

IDPS and SCT United Kingdom Accreditation Body (UKAS) Laboratory Accreditation / Audits

IDPS and SCT WSH laboratories are not currently UKAS accredited. Progress and assurance to regaining accreditation is being monitored by NHSEI as part of regional commissioning assurance. Regular audits are being submitted to NHSE and all are on schedule for assessment in Q3/Q4 2022.

Maternity Update

- Overall increasing numbers and complexity of IDPS cases seen at WSH.
- Return of more face-to-face community bookings, vulnerable women prioritised for face-to-face bookings and trust agreement for in person translators for bookings.

Awaiting approval

Challenges and quality improvement

- Significant changes to updated NHSE IDPS Lab handbook – Issues with external confirmatory labs not compliant in reporting terminology regarding equivocal results / lack of national patient resources re false positive results process.

- Language used in national IDPS handbook confusing re the phrase “living with Hepatitis B”. There are no national pathways for resolved / cleared Hep B, causing confusion in processes at booking for women who report known IDPS status. Raised at national IDPS lab meeting. 1 x local case of known Hep B at booking, but Hepatitis B Surface Antigen (HBsAg) negative – no pathway for this.

- Have introduced standardisation of how labs inform ANNB team of screen positives / inconclusive / not completed results (email rather than phone reporting)

- The maternity update training day - MM2 - training time remains at 30 mins currently. There has been agreement to increase to 60 mins from January 2023.

Incidents: Lessons Learnt

- Several steps have been introduced to remind midwives to urgently inform the ANNB team of known IDPS positive woman at booking to ensure screening consultation <10 working days (see Appendix two S05b) - This includes additional risk assessment processes within ANC and IT e-care prompts.
- The ANNB team now attend daily safety huddles which incorporates information regarding unbooked women / transfers in
- All IDPS women are now included on obstetric MDT for information and added to Labour suite special cases board. Flags and alerts routinely added to maternal and neonatal records with details of antenatal neonatal management plans (1 x case of Hep B vaccine >24 hours, appendix 2, S07).
- Improved local maternity documentation is required for women who transfer in with IDPS results from alternative UK based laboratories

Quality Improvement Priorities for the next 12 months

- Ethnicity data collection to be introduced into lab reporting data
- Lab reporting of screen positive / inconclusive / incomplete results needs to be increased to weekly (currently monthly)

Awaiting approval

- TaT data reporting change required, currently reporting in consecutive days, not working days.
- Urgently need to introduce BASSH syphilis neonatal management plans into local guidelines.
- Review of IDPS lab handbook required by labs and maternity depts
- Late bookers / unbooked pathways – local pathways need urgent review.
- Patient leaflet related to national changes to false positive / equivocal results pathways required.

Education / Training / Staffing

Staffing in the laboratory is at acceptable levels, all staff are employed by WSFT having transferred from PHE (now UKHSA) in November 2021.

Inequalities

- Ethnicity data collection to be introduced into laboratory data

Awaiting approval

Sickle Cell and Thalassaemia (SCT)

Summary statistics 2021-2022

Coverage

2548 eligible pregnant women screened.	• 99.8 % (4 x declines). Average number of booking bloods per month =217.

Test

Timeliness of Screening Acceptable ≥ 50% Achievable ≥ 75%	• 72.9% of results available ≤ 10 weeks + 0 days. (For Q1 in line with NHSEI technical guidance screening bloods obtained at dating USS rather than within community.)
Completion of family origin questionnaire Acceptable ≥ 95% Achievable ≥ 99%	• 97.9 % of all antenatal samples for SCT testing received with a completed FOQ. Average of incomplete FOQ's per month = 2.5
Test turnaround time Acceptable ≥ 90% Achievable ≥ 95%	•95.1% ≤ 3 working days

Approval

Diagnosis / Intervention / Referral

Partner testing for SCT	- 3 x women eligible for PND
	- PND offered in 3 cases, 2 x declined, 1 x accepted >12/40 (care of private midwife, transfer into WSH at 13/40, (Appendix 2, S06)
	- No baby confirmed with Sickle Cell Anaemia

SCT Programme update and changes to pathway

Laboratory update

Reflections on antenatal and newborn screening programmes 2021-2022

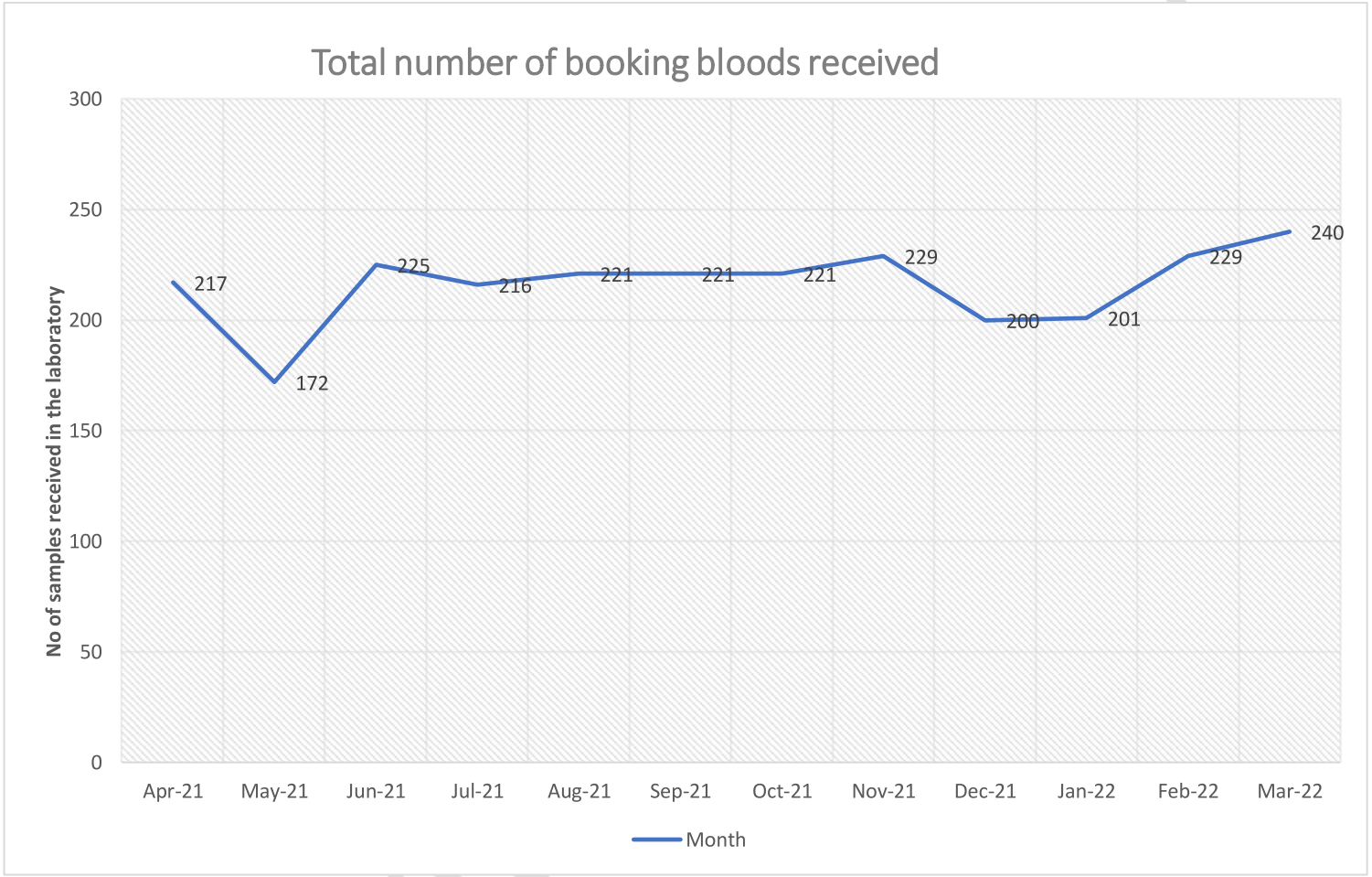
March 2022 to June 2022 there was a drop in the turn-around time due to the analyser TOSOH G11® being out of action and a contingency plan instated to refer samples daily to Ipswich Hospital using an Ipswich courier. Results were all transferred via email and input as soon as received by all Senior staff in Haematology.

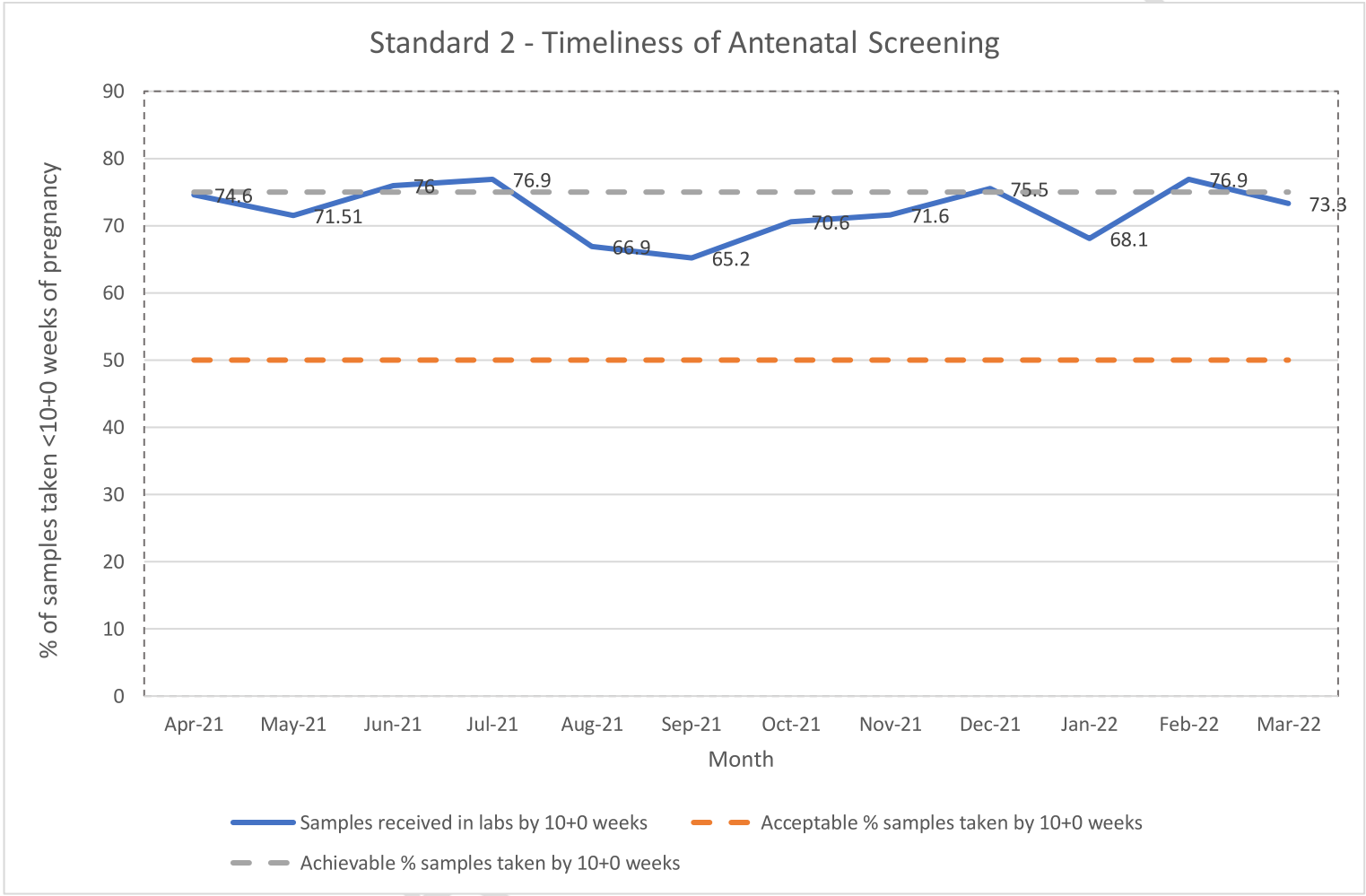
An additional TOSOH G11® analyser just for haemoglobinopathy screening was delivered, validated and placed in use in June 2022. Previously the TOSOH G11® analyser was shared but now Haematology have their own analyser there is now have more access to the analyser and it has been possible to process samples more regularly.

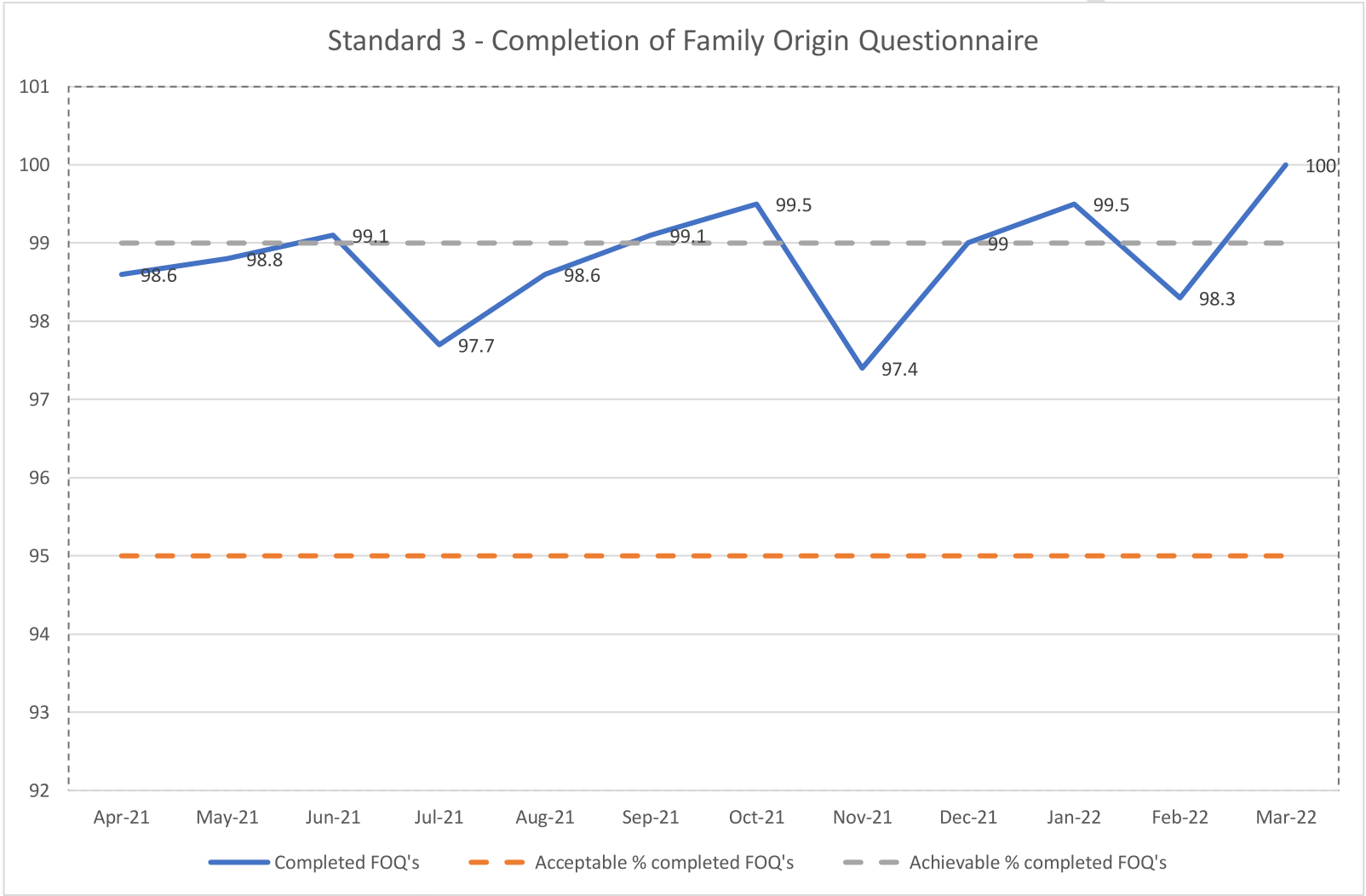
The new TOSOH G11® analyser is performing well both with Internal Quality Control (IQC) and External Quality Assurance (EQA).

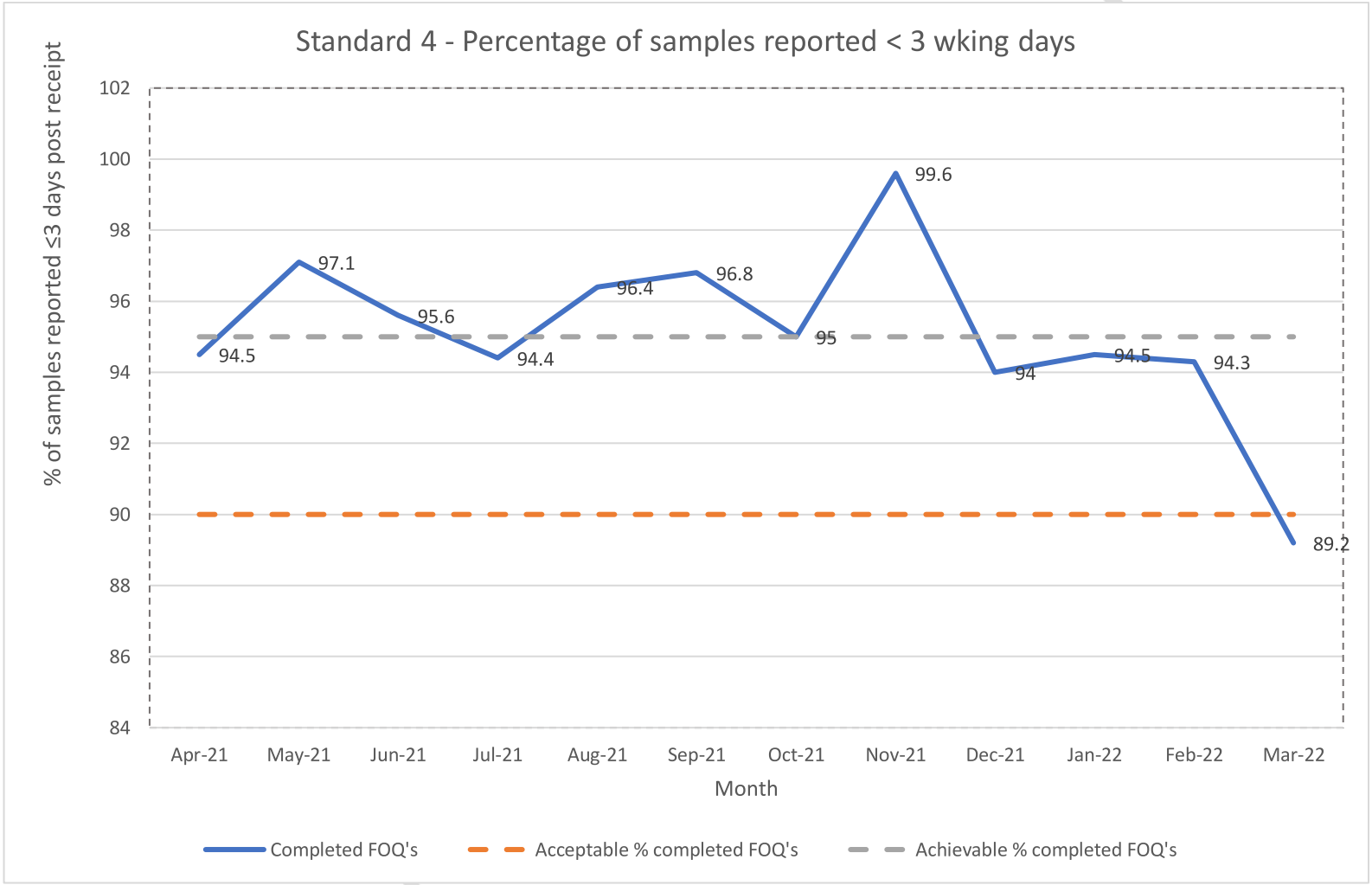
TOSOH were unable to determine the cause of the original TOSOH G11 failing to perform in Beta Thalassaemia mode.

Awaiting approval


Total number of booking bloods received
No of samples received in the laboratory
300
250
200
150
100
50
0
217
172
225
216
221
221
221
229
200
201
229
240
Apr-21
May-21
Jun-21
Jul-21
Aug-21
Sep-21
Oct-21
Nov-21
Dec-21
Jan-22
Feb-22
Mar-22
Month


Standard 2 - Timeliness of Antenatal Screening
% of samples taken <10+0 weeks of pregnancy
90
80
70
60
50
40
30
20
10
0
74.6
71.51
76
76.9
66.9
65.2
70.6
71.6
75.5
68.1
76.9
73.3
Apr-21
May-21
Jun-21
Jul-21
Aug-21
Sep-21
Oct-21
Nov-21
Dec-21
Jan-22
Feb-22
Mar-22
Month
Samples received in labs by 10+0 weeks
Acceptable % samples taken by 10+0 weeks
Achievable % samples taken by 10+0 weeks


Standard 3 - Completion of Family Origin Questionnaire
101
100
99
98
97
96
95
94
93
92
98.6
98.8
99.1
97.7
98.6
99.1
99.5
97.4
99
99.5
98.3
100
Apr-21
May-21
Jun-21
Jul-21
Aug-21
Sep-21
Oct-21
Nov-21
Dec-21
Jan-22
Feb-22
Mar-22
Completed FOQ's
Acceptable % completed FOQ's
Achievable % completed FOQ's


Standard 4 - Percentage of samples reported < 3 wking days
% of samples reported ≤3 days post receipt
102
100
98
96
94
92
90
88
86
84
94.5
97.1
95.6
94.4
96.4
96.8
95
99.6
94
94.5
94.3
89.2
Apr-21
May-21
Jun-21
Jul-21
Aug-21
Sep-21
Oct-21
Nov-21
Dec-21
Jan-22
Feb-22
Mar-22
Month
Completed FOQ's
Acceptable % completed FOQ's
Achievable % completed FOQ's

Maternity update

- Public Health England (PHE) paper Family Origin Questionnaire (FOQ) form was discontinued – new WSH FOQ created and ordered Oct 22.
- I x case of a baby at 25% risk of sickle cell anaemia – Counselled by haematology consultant, pre-natal diagnosis (PND) was initially accepted, chorionic villus sampling (CVS) was not possible on the first attempt, and there was subsequent decline of PND. 'At risk of SCT' notifications were sent – the neonate was confirmed as a carrier only in October 2022.
- Daily attendance at safety huddle and failsafe process to ensure SCT blood offer to unbooked women / transfers.

Incidents: Lessons learnt

- There has been an issue with samples being accidentally placed in an inappropriate area and not taken to the haematology laboratory, and is currently under investigation by the Specimen Reception Manager. New processes introduced for date stamping.

- The TOSOH G11® analyser stopped working in March 2022, and was unable to perform calibrations and provide accurate HbA2 values. TOSOH attended numerous times and obtained the same poor results, due to being unable to fix analyser TOSOH said the only option was to provide us with a new analyser. New analyser installed and tested.

Education / Training / Staffing

- Two training sessions provided by TOSOH and so six members of staff have had external training and completed TOSOH online assessments.

- Laboratory staffing short at present and although training for Junior staff is on-going, the training of more experience BMS's that are covering shifts has not occurred. Senior staff are currently performing the majority of analysis with support from Junior staff.

Awaiting approval

- Laboratory competency paperwork for performing analysis is active, interpretation SOP and competency needs to be finished and activated. Documentation has increased with a number of quick reference guides being generated, an over-arching SOP for use of TOSOH G11 is in draft but now requires modification due to no longer sharing the analyser. An overarching interpretation SOP is currently in progress but work has slowed due to staffing issues within the laboratory and the high training pressure.

- National shortage of Biomedical Scientists and despite a number of Band 6 interviews the standard of candidates received are not Band 6, all lack haematology knowledge. A large number of trainees and Band 5 staff have been employed however these all require a high level of training and supervision which takes staff from main benches.

- New ANNB team members require Kings SCT training
- An Antenatal and Newborn (ANNB) team member needs Kinds SCT update

Quality Improvement Priorities for the next 12 months

- Completion of Interpretation laboratory SOP
- New WSH FOQ needs implementing with training

Fetal Anomaly Screening Programme (FASP)

Summary Statistics 2021-2022

Awaiting approval

Coverage

T21/T18/T13 trisomy screening 2134 Eligible population	• 94 % opt in
Fetal Anomaly Ultrasound 18+0-20+6 2126 Eligible Population	• 99.6 % first screen between 18+0-20+6

Test

Completion of Laboratory Request forms Acceptable Standard ≥ 97% Achievable standard ≥ 100 %	• 94.3 %
Test turnaround time, T21 / T18 / T13 results reported within 3 working days of sample receipt	• 100%

Test Performance

		Detection rate	Screen positive rate

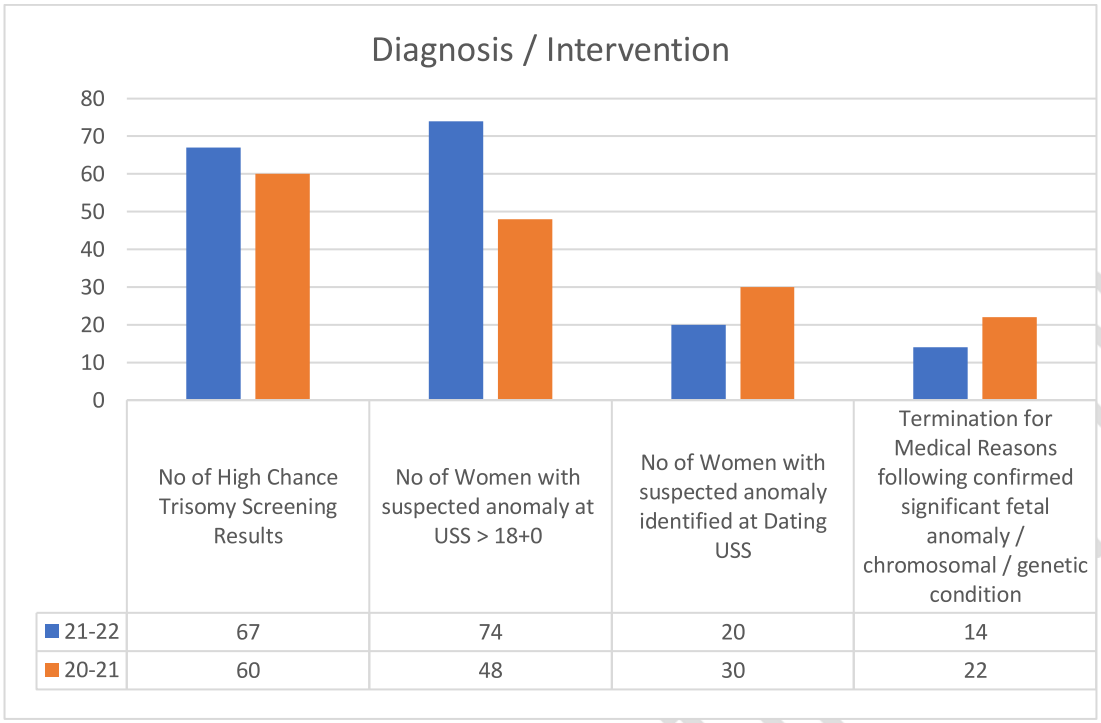
approval

Combined	T21/T18/T13	93%	2.4%
	T18/T13	85%	0.2%
Quad test	T21 only	81%	2.9%

Diagnosis /Referral / Intervention

Awaiting approval





	No of High Chance Trisomy Screening Results	No of Women with suspected anomaly at USS > 18+0	No of Women with suspected anomaly identified at Dating USS	Termination for Medical Reasons following confirmed significant fetal anomaly / chromosomal / genetic condition
21-22	67	74	20	14
20-21	60	48	30	22

Awaiting Approval

% of women with higher chance results received consultation with screening midwife within 3 working days	• 100 % (67 high chance cases)
% of women with a suspected anomaly referred to a tertiary fetal medicine unit within 5 working days. Acceptable standard ≥ 97%	•82.9% (58 women referred, 4 x breaches due to tertiary capacity issues, 6 x personal choice) Appendix 2, S08b
NIPT coverage (from July 21) 67 high chance cases	• 49 % opt in
Timeliness of sample receipt in genomics lab (<l or within 2 working days) NIPT turn around time (TaT)	•85%, 2 x affected by xmas post, 1 x sample sent late from WSH. (Appendix 2 S02) •100 % reported within 5 working days

Awaiting approval

FASP Programme update

Ultrasound

Ultrasound have continued to face increased pressure to provide extra capacity for Uterine Artery Doppler (UAD) scans, cervical length and growth scans in response to Saving Babies lives 2 care Bundle. There has also been addition the calculation of the estimated fetal weight (EFW) at the anomaly scan. This in turn has put additional pressure on the department to offer the screening service. An amber risk has been added to radiography risk register

Audits

The Down's Syndrome Screening Quality Assurance Support Service (DQASS) audits are regularly undertaken –all sonographers are completing the required amount of first trimester scans. DQASS Cycle 32 was issued August 2022. Currently all staff are either fully compliant (green) or amber apart from one who has recently received a red flag for quality of images. A supportive action plan is in place for this sonographer. In-house image review audits are up to date, with all staff achieving acceptable or good. DQASS compliance continues to be monitored and reported to Trust governance and to the regional screening commissioning team.

We have adjusted the timings of the anomaly scan and now aiming to do this at 19+6 (previously 20+6) with a view to reduce those not completed by 20+6.

Maternity update

Non-Invasive Prenatal Testing (NIPT)

- NIPT pathways, introduced 1st July 2022, are running smoothly and have provided equitable access to this test for all women who have an initial high screening result from combined or quadruple screening. Around 49% opt into the NIPT test, 36% opt for PND and around 15% opt for no further testing. Sample receipt in the genomics labs and reporting times are overall really positive, with just minor holdups related to Christmas postage back logs and one sample delayed from leaving the WSH post room. Additional measures have been taken to ensure no delays leaving WSFT post room.

Awaiting approval

Local Fetal Medicine Unit (FMU) services / Referral to Tertiary FMU

As of October 2022, no local FMU pathways related to screening have been established. A local high-risk clinic has been established for follow up after discharge from tertiary FMU. We continue to refer all women with fetal anomalies identified at dating or anomaly ultrasound to tertiary specialist FMU centres to meet national screening standards of specialist referral/intervention within 5 working days.

Since April 2022 there has been limited capacity at our contracted tertiary FMU unit due to staffing issues. Therefore, we are referring to alternative tertiary FMU units to ensure both choice and national time frames for referral / intervention are met. To date the communication both at referral and in terms of outcome reports from alternative units has been very smooth. As such, long-term block FMU contracts are being examined from a variety of financial and patient experience perspectives.

Completion of laboratory trisomy forms

The Trust performance for accuracy of trisomy forms remains below an acceptable level. There is a drive for a return to face-to-face community bookings in some community teams, with monthly overview of compliance to this by the outpatient service manager. This should lead to improvement.

Anomaly data reporting

There has been a regional emphasis on reporting the number of repeat anomaly USS completed by 23/40. This has fuelled a drive to provide the first anomaly USS at 19+6, rather than where we previously offered @20+5. The aim is to reduce the numbers of repeats >20+6, and also improve timeliness of interventions and choice / care pathways for women when a structural anomaly is identified. An audit regarding timeliness of the completion of anomaly USS's is planned by sonography.

Temporary Relocation of services

Due to urgent hospital wide roof works there has been a temporary relocation of USS scanning, Antenatal clinics, antenatal phlebotomy services, screening counselling rooms and antenatal and screening offices. This has been over a 12-week period July – October 2022 and has resulted in patient feedback re poor counselling room environment, and potentially contributed towards higher than usual incidents, as a result of communication issues between teams who are spread over the hospital site.

Awaiting approval

Incidents

Between July – October 2022 we have had a higher than normal number of incidents in the FASP programme, with 4 open Screening Incident Assessment Forms (SIAF's) currently as of October 2022. A number of themes have been identified, alongside contributory factors of new screening leads (obstetricians, new ANNB lead midwife, no designated sonography lead, new paediatric screening lead, new ANNB failsafe member), alongside a temporary relocation of FASP screening services across the hospital site.

Lessons learnt from incidents

- Theme identified – Communication links between Early pregnancy assessment unit and ANNB screening required improvement to reduce missed trisomy / anomaly screening.
- New screening failsafe processes are required to reduce missed trisomy / anomaly screening
- All team members involved in maternity pathways to be reminded of anomaly USS timeframe window (in light of moving anomaly USS apt closer to 19/40, rather than 20+6) to prevent missed FMU tertiary referrals.
- Additional processes and checks instigated to ensure NIPT samples are posted out of WSH in a timely manner.

Education / Training / Staffing

Sonography

Staffing has continued to be very challenging due to covid absences.
One sonography student has just qualified and another about to do so. We have a new sonographer starting with us in November. Our third student will qualify in the spring, and we have a new student starting in the new year.

Our two superintendent sonographers have retired, a new superintendent has been appointed with no start date as yet. The fragility of sonography staffing has been added to the departmental risk register.

Awaiting approval

Quality Improvement Priorities for the next 12 months

- Audit / examination of processes to reduce the number of repeat anomalies completed >20+6.
- Twin screening counselling pathways
- Continued training drive on accuracy of trisomy form completion
- Confirmation of local contractual arrangements to tertiary FMU's to ensure referral / interventions standards and timely communication of outcome reports
- Establish systematic local reporting processes for national congenital rare disease reporting service (NCARDRS), (new NCARDRS data reporting anticipated for 2022-23).

User Feedback

Four user feedbacks have been received in a six-month period related to lack of information related to screening choices once it is identified that combined screening using nuchal translucency measurements cannot be offered.

A patient leaflet has been written regarding patient choices for quadruple / Private NIPT screening. Ongoing reminders to sonography staff have been sent to encourage this leaflet to be provided, however continued user feedback has identified this is not occurring robustly. A new screening failsafe process has been introduced as a mechanism to ensure timely quadruple appointments are in place and that all women receive written information regarding trisomy screening choices if combined screening cannot be completed.

Awaiting approval

Newborn Blood Spot (NBS)

Summary Statistics 2021-2022

Awaiting approval

Coverage

No of avoidable repeat tests Acceptable standard ≤ 2% Achievable standard ≤ 1%	• 2448 tests, avoidable repeats 1.02%
Sample collected on day 5 Acceptable standard ≥ 90% Achievable standard ≥ 95%	• 95%
Standard received in lab within 3 working days Acceptable standard ≥ 95% Achievable standard ≥ 99%	•98.9%
Percentage of all blood spot cards including bar-coded baby's NHS number Acceptable standard ≥ 90% Achievable standard ≥ 95%	•86%

For approval



Quality of Blood sample

Acceptable Standard: The avoidable repeat rate is less than or equal to 2%
Achievable Standard: The avoidable repeat rate is less than or equal to 1%

No of first samples received	Too young for reliable screening	Insufficient sample	Incorrect blood application	Compressed / damaged	NHS no missing / inaccurate	Missing / inaccurate Date of sample	Missing / inaccurate DOB	Expired card used	Avoidable repeat
2448	1	0	4	1	4	9	3	3	1.02%

Child Health NBS data

Transfer into WSH	Carrier SCD	Carrier C	Carrier D	Carrier E	Carrier Cystic Fibrosis	Suspected Sickle cell disease	Suspected Cystic Fibrosis	Suspected CHT	Suspected PKU	Suspected other	Suspected MCADD	Avoidable Repeat
31	8	1	2	0	0	0	1	2	1	0	1	2

NBBS Programme Update

Maternity Update

Focus has been on performance improvement of use of barcoded NHS NBS labels (Appendix 2, S03). A retrospective audit of 25 samples identified 32% of cards were from babies born at alternative facilities and 68% born at WSH. A training drive within inpatient services has recently commenced to ensure all babies are discharged from the maternity unit with a barcoded label. Initial impression shows a slight improvement in performance. Continued improvement actions are planned.

Awaiting approval

The trust is not part of the national pilot to assess newborn blood spot screening for severe combined immunodeficiency (SCID). However, the introduction of SCID in other regions has resulted in national changes to BCG neonatal pathways.

The ANNB team are working closely with paediatrics and child health and have introduced a new local failsafe system to ensure all babies eligible for BCG are documented appropriately on S4N to enable BCG referral via child health / Community school age immunisation services.

Regional NBS Laboratory update

The East Anglian Newborn Screening Laboratory is accredited by UKAS under ISO 15189:2012 standards, for all assays associated with the blood spot screening programme and for the screening programme pathway itself. A comprehensive NBS annual report has been received from the regional laboratory and has been shared to screening leads within paediatrics and maternity. The report can be viewed on request.

Regional NBS Laboratory Future plans

As reported last year, the regional NBS laboratory plans to upgrade the software and move it to a web-based server. The upgrade is expected to bring benefits to the laboratory allowing some processes to be more streamlined. The web-based server will be brought under the control of the third-party supplier which should make trouble-shooting by the third-party supplier more straightforward and robust.

The laboratory still awaits further instruction from the national newborn screening committee regarding the new code of practice for the storage and retention of blood spot cards requiring them to be kept for 5 years which was later revoked (March 2018).

Child Health update

2021-22

The Suffolk Health Visiting Service has a Standard Operating Procedure (SOP) for the Newborn Bloodspot Screening Pathway. This was created in 2020 to standardise practice across the county and conform to national policy. This was reviewed and updated in 2022. Any incidents that have occurred have been reported by completion of a local incident form and a SIAF. All incidents are analysed, and relevant changes are made to improve practice and service delivery.

Awaiting approval

The bloodspot service is co-ordinated by the Healthy Child Professional Leads (HCPL). The HCPLs are also responsible for giving carrier results to parents/carers and completing the carrier counselling visits. The Community Staff Nurses (CSNs) take the bloodspot samples.

Data for the service is collected manually and a local yearly data report is created. KPI data is received from the Newborn Screening Laboratory and the Child Health Information Service (CHIS).

Changes to our record templates should mean that data can be extracted automatically by the system on a monthly basis, ensuring auditing processes are easier and undertaken monthly.

Some changes to our process have been implemented with time frame expectations to help meet the 21-day KPI for movers in.

We raise awareness of the newborn screening programme county wide through our team briefs, training, and update days.

Covid Response

The Newborn Screening Pathway continued to run throughout the COVID19 pandemic. Appointments for sample collection are now being offered in a local clinic setting, a home visit is offered if they are unable to attend a clinic for any reason.

Child Health User feedback

We have a patient smart survey to collect client feedback relating to the bloodspot service. This is an online survey with a link that is sent to the parent after discharge from the service for them to fill in anonymously. We have created a different set of questions for different parts of the service, one set for movers in and one for carrier counselling.

Incidents

Nil of significance

Awaiting approval

Quality Improvement Priorities for next 12 months

Child Health

- We have an adequate number of Staff Nurses to take the samples, due to their workload it has been challenging to find space at short notice to book appointments. We are now piloting booking regular slots in each of the Staff Nurses diaries so there is protected time to complete the bloodspots. The aim is to improve the turnaround time to help meet the 21-day KPI for movers in.

- We currently have 2.6 FTE Healthy Child Professional Leads (HCPLs) across the service. There is 1FTE on maternity leave and 2 0.5 FTE vacancies. The bloodspot service has been identified as a key priority and the HCPLS are now covering larger areas to ensure the service continues to run across the county. The HCPL role is currently under review, the HCPLS plan to map their bloodspot role to highlight the importance of service provision for this area.

Maternity

- Focus on Barcoded NHS number – continued performance below acceptable level. Safety risk assessment of printing NBS labels from national failsafe system

- A quality improvement project between maternity and paediatrics regarding BCG vaccination referrals is planned. Further work is required to enhance the local e-care IT system regarding ethnicity data collection. An additional focus is on improvement in discharge information provision to GP's regarding babies at risk of disseminated BCG infection.

Awaiting approval

Inequalities

Child Health

We work with language line frequently to offer telephone interpreters to all families where English is a second language. This ensures full understanding of all information given and enables parents to make an informed decision. We also offer copies of written information in different languages. A phone interpreter will also be used when the bloodspot samples are taken. We are looking into interpreting our trust letters into the most common languages we have in the area.

Where possible a face-to-face interpreter will be used for carrier consultations and follow up appointments again to ensure full understanding for the family and due to the sensitive information that is being given. A misunderstanding of information given could be distressing for parents.

We have worked with the NHS outreach service for the Roma (travelling Romanian) families who can be hard to reach / get hold of. The outreach service has good relationships with the Roma community and therefore working collaboratively with them we have been able to arrange consultations with the families to discuss and offer the bloodspot.

Education, Training and staffing

Child Health

We are in the process of educating 2 more community staff nurses (CSNs) to take the samples. The training package includes e-learning, observing samples and being observed taking samples. We have recently reviewed and updated the staff nurse bloodspot competencies to reflect local and national changes. The staff nurses have online training that they have access to when needed – to be completed a minimum of yearly. There is group supervision held quarterly for the CSNs which offers a platform for reflection and education, and the HCPLs are able to update them on any changes to process or to the service. 1:1 sessions are also offered for avoidable repeats to look at the image of the card and review why it did not meet the standard.

The HCPLs currently in post are undertaking the KCL Genetic Risk Assessment Counselling course, this will be valuable for our carrier counselling role and ensure service delivery is of the highest standard.

Awaiting approval

HCPLS are allocated to attend the local ANNB steering groups.

We currently have:
HCPL 0.5 FTE vacancy North Suffolk
HCPL 0.5 FTE vacancy Central and South Suffolk
HCPL 1 FTE on maternity leave

Maternity

The regional NBS lab is currently unable to offer training / visits to new ANNB team members due to covid restrictions.

Refresher / and induction NBS training has recently been completed to inpatient paediatric wards.

Regional NBS labs

Vacant laboratory manager post with no suitable applicants at second advert. Role is being partially covered by previous incumbent whist pathology operational management team at regional laboratory assesses the way forward.

Newborn Hearing Screening Programme (NHSP)

Summary Statistics 2021-2022

See annual KPI chart Appendix 1

Awaiting approval

NHSP Programme Updates 2021-22

Operationally as of October 2022 WSH Newborn Hearing Screening team is fully staffed.

- All staff are currently in the process of keeping their mandatory training up to date.
- The NSP lead screener has been accepted into the role of NHSP user rep for the East of England, at which User representatives commit to:
  - assist in the testing of new S4H software releases/developments
  - report back to other users following the meetings and actively seek input from the wider community of users
  - read occasional reports or papers and make comments between meetings
  - participate in workshops, as agreed

- All screeners have now completed the Health Screening diploma.

- To counteract the numbers of DNA's the service is experiencing, more clinics are running in Haverhill and Sudbury alongside our regular Bury, Newmarket and Thetford clinics.

- Audit for NH1 breech's over an annual time period has been completed – Reported to NHSE screening Programme Board July 2022.

Education / Training / Staffing

Audiology Update

A full time paediatric clinical scientist is on maternity leave. There has been a struggle to obtain locum cover so support has been obtained from Addenbrookes during this period.

As of October 2022, a vacancy approval framework has been completed for an additional paediatric clinical scientist and is going to advert shortly.

Awaiting approval

User Feedback

During Q1 2022, Surveys have been sent out to parents post screen, this has been useful for feedback and tailoring service.

Incidents

Nil of significance.

Newborn Infant and Physical Examination screening programme (NIPE)

Summary Statistics 2021-22

Coverage

NIPE test within 72 hours of birth Acceptable ≥ 95 % Achievable ≥ 99.5%	• 2272 screens, 99.1 %.

Awaiting approval

Referral / Intervention / Diagnosis

Timeliness of Intervention, abnormality of the EYE Acceptable standard ≥ 95% Achievable standard ≥ 100%	•2 referrals •100%
Timeliness of Intervention of DDH, assessment by USS btwn 4-6 weeks of age for babies born >34+. Or if born <34 weeks to attend at 38+0 corrected age. Acceptable standard ≥ 95% Achievable standard ≥ 100%	•195 referrals •89.8% (largely as result of patient DNA's, 1 x episode of clinics rearranged for staffing issues due to covid). Appendix 2, S03
Timeliness of Intervention, Timeliness of hip clinical assessmenet or discharge (Decision <42 days (babies born >34 weeks) or <240 days (babies born <34+0) No performance set (new standard).	• 195 referrals • 86.9%
Timeliness of Intervention, bilateral undescended tests Acceptable standard ≥ 100%	•2 referrals •100%

NIPE Programme updates

- New NIPE combined DDH pathways and new orthopaedic assessment standards were introduced April 2021. Pathways are now well embedded, with oversight of breaches by SQAS and SIT. The majority of breaches relate to patient choice or DNA, with several cases of delayed USS due to covid infections amongst patients. Reduced staffing in radiology related to a covid-19 outbreak affected timeliness of USS appointments over a short 2-3-week period in Quarter 1. There was good restoration following this.

- Screening failsafe S4N data entry errors were identified related to the new screening orthopaedic / discharge from DDH standard. This resulted in poorer performance reported than reality. Training has been provided to the failsafe team to help mitigate future data entry errors.

NIPE clinical leadership

- The NIPE clinical lead continues to monitor databases regarding the number of clinical NIPE's undertaken by NIPE qualified midwives.
- A NIPE meeting with screening leads is planned in the next month. Focus for this meeting is recording of Dr's NIPE training / completion of e-learning for health and processes to reduce "bed blocking" whilst awaiting NIPE prior to discharge.

Incidents: Lessons Learnt

Incidents have largely been isolated events of minimal significance. We had two episodes of data entry errors on the S4N national failsafe system which resulted in two records inadvertently being removed from the responsibility of West Suffolk on the national failsafe system. Both affected babies received full NIPE examinations. We have re-trained staff and provided user feedback to the national failsafe team to alert them to the potential for inadvertently marking babies as ineligible for screening. Locally additional failsafe processes have been introduced to reduce reoccurrence.

Quality Improvement Priorities for the next 12 months

- Development of online training / assessment resource for S4N IT site for paediatric doctors on rotation.
- Development of register of NIPE clinical training / NIPE updates for paediatric doctors

Awaiting approval

Diabetic Eye

A diabetic specialist midwife is in post at WSFT.

Any pregnant woman who is identified as Type 1 or Type 2 diabetic is offered retinal screening at appointments throughout her pregnancy- with the aim of eye screening being carried out in both the 1st and 3rd trimesters. A list is kept by the diabetic nurse for audit, monitoring and review. Liaison between the regional diabetic quality assurance team and the diabetic midwife has been instigated.

Staffing – Maternity Screening Team

Three new members have joined the ANNB screening team – maternity cover for ANNB lead, failsafe officer and a new screening obstetric consultant.

Local training has been provided to midwifery/ failsafe teams. Unfortunately, regional SQAS training sessions have been fully booked to date, and capacity issues in tertiary FMU's has limited networking / training opportunities. It is hoped some external training resources can be booked shortly.

Composition of screening team

Band 7 ANNB lead midwife 1.2 WTE (two part time members, working 22.5 hrs each)
Band 6 ANNB midwife – 0.6 WTE
Band 6 ANNB bank cover – 0.2 WTE
Failsafe Officer – 0.9 WTE (two part time members, working 14 hrs and 21 hrs)

Midwifery vacancy within the Trust as a whole – 36 WTE vacancy.

Plans for Recruitment

Maternity Dept - International recruitment campaign underway, 1 new international midwife recently commenced in the Trust but registration is not fully complete.

Awaiting approval

Within screening team – Business case for Band 4 public health / data member 0.8 WTE progressing, aiming for recruitment Jan 23.

Contingency plans for staff absence or clinical deployment

Band 6 ANNB midwife has an additional 12-hour contract within the main unit. Potential for deployment to screening if required.
Failsafe cover currently by bank failsafe officers. Once band 4 public health / data member recruited, will provide contingency coverage.

Local ANNB steering group

- Regular steering group meetings were postponed during Covid-19, as a result of poor attendance and Trust focus on prioritisation of covid restoration. Written overview was provided to membership during this period.
- Steering group meetings recommenced in Summer 2022. Changes to the format of the meeting were agreed to assist with meeting attendance. Timed meeting slots are now present within the agenda, with each screening pathway having a designated timed slot. Minutes of the full meeting / associated actions plans are sent to all following the meeting.
- There have been no changes to escalation routes (Escalation via maternity clinical and safety meeting).
- Screening quality, performance and audit reports are taken to maternity clinical audit and education governance.

Inequalities

WSH draft maternity strategy and neonatal strategy

WSH have a **draft** maternity and neonatal strategy, five-year vision for 2021-2025. Reducing inequalities in maternity care are a key objective of this strategy.

Women from Black, Asian and mixed ethnicity (BAME) as well as those residing in the social economically less advantaged areas are more likely than other women to die during birth or within the first year of their baby's life (MBRRACE, 2020). For example, in comparison to white women, black women were almost five times more likely to die from pregnancy and childbirth related causes, and Asian women were nearly twice as likely. Inequalities in infant mortality rates also exist between white and ethnic minority groups in England and Wales and those living in our most deprived communities.

Awaiting approval

Our vision

To reduce inequalities of outcomes experienced by women and pregnant people of Black, Asian and mixed ethnicity and women experiencing multiple deprivations by providing targeted integrated enhanced support and continuity of carer by named midwives and obstetricians.

Our Commitment

- Specific packages of care will be developed for women and pregnant people of Black, Asian and mixed ethnicity women (BAME) experiencing multiple deprivations which will be additional to the core maternity care offered.
- Provide continuity of carer to improve outcomes for women and birthing people of BAME ethnicity and other vulnerable groups
- Prioritise the roll out of Continuity of Carer teams to the most disadvantaged geographical areas i.e. some neighbourhoods in Thetford, Bury St Edmunds, Mildenhall, Newmarket and Haverhill.
- All midwifery and maternity staff will be trained to help identify and support women and pregnant people who have additional needs and their subsequent referral pathways. This will include for example (but not exclusively) people who have a learning disability, refugees, homeless, gypsies and travellers and people who do not speak English and need translation services. Training programs will ensure that clinicians are aware of the additional risks and inequality in outcomes experienced and pathways to improve outcomes.
- Care will be provided by specialist teams which will include both voluntary, health and social care partners within the community.
- A personalised care plan will be developed to meet social, health and communication needs.
- Systems to evaluate women's experience and outcomes from maternity services and ensuring women's voices are captured in subsequent service developments.
- Bespoke parenthood education will be provided to targeted groups
- Services will be integrated with our community and voluntary sector partners.

How we will deliver this

How we deliver it / Co-production

To ensure we deliver our vision of giving an excellent maternity service to each and every woman and her family, we want to ensure our improvement plans meet their needs.

Co-production is when people work equally with professionals and decision-makers to design, evaluate and improve health and social care services.

West Suffolk Hospital maternity services will effectively work with services users to coproduce and create, high quality, efficient and sustainable maternity services.
We understand that women and pregnant people need information they need at the right time and communicated throughout their pathway.

Our local Maternity Voices Partnership (MVP) groups will have a key role in helping us to design, deliver and evaluate our service going forward.

We will also work closely with Healthwatch Suffolk and build on their expertise and knowledge in co-production.

Screening: Inequalities

Specifically with regard to screening we follow the national PHE screening inequalities strategy PHE Screening inequalities strategy - GOV.UK (www.gov.uk)
The national PHE "Screening tests for you and your baby" leaflet has been added to the trust main internet page in the 5 most common languages, alongside easy read versions. QR codes link to animated videos and videos in BSL.

Digital links to national screening booklets are also sent as part of initial response to self-notification of pregnancy.

We have returned largely to face to face booking appointments wherever possible and have recommenced face to face interpreters for non-English speaking families at booking appointments and dating / anomaly USS.

Appendix One - WSH KPI's April 2021-March 2022

	Description	Acc	Ach	Q1	Q2	Q3	Q4
	ANTENATAL SCREENING						
	IDPS						
ID1	HIV coverage	≥ 95%	≥ 99%	99.7	99.8	100	99.8
ID2	Timely referral of Hep B + for specialist assessment	≥ 70%	≥ 90%	No high infectivity cases	No high infectivity cases	No high infectivity cases	100
ID3	Hepatitis B coverage	≥ 95%	≥ 99%	99.8	99.8	100	99.8
ID4	Syphilis coverage	**≥ 95%**	≥ 99%	99.8	99.7	100	99.8
	FASP						
FA2	Fetal anomaly USS coverage	≥ 90%	≥ 95%	99.7	99.4	99.8	99.4
FA3	Coverage for T13, T18, T21	Not set	Not set	93% opt in	92.4% opt in	94.6% opt in	95.1% opt in
FA4	Test: inadequate samples for T13, T18, T21	Not set	Not set	3.3	4.5	7.9	4.1
	Test: inadequate sample for T21 (quad)			7.5	5.7	6.3	8.8
	SCT						
ST1	SCT coverage	≥ 95%	≥ 99%	99.8	99.7	99.8	99.9
ST2	Timeliness of Test	≥ 50%	≥ 75%	76.9	69.5	72.5	73
ST3	Completion of FOQ	≥ 95%	≥ 99%	98.8	98.5	96.3	92.7

Awaiting approval

ST4a	SCT screening -timely offer of PND to women at risk	To be set	To be set	No cases	No case	No cases	No cases
ST4b	SCT screening -timely offer of PND to couples at risk	To be set	To be set	50	No cases	No cases	100
	NEWBORN SCREENING						
NEWBORN BLOODSPOT							
NB1	Neonatal Bloodspot coverage	≥ 95%	≥ 99%				
NB2	Avoidable repeat tests	≤2%	≤1%	0.5	0.9	1.6	0.8
NB4	Coverage (movers in)	≥ 95%	≥ 99%	98.6	97.1	97.5	
HEARING							
NH1	Hearing Coverage	≥ 97%	≥ 99.5%	99.3	99.3	98.6	98.1
NH2	Timely assessment for screen referrals	≥ 90%	≥ 95%	92.9	100	37.5	89
NIPE							
NP1	NIPE coverage	≥ 95%	≥ 99%	99	99.2	99.1	99.1

Awaiting approval

Appendix 2 - WSH Standards report 2021/ 2022

	Description	Acc	Ach	Q1	Q2	Q3	Q4
	ANTENATAL SCREENING						
			IDPS				
SO4	IDPS TaT	≥ 95%	≥ 97%	99	99.1	98.8	99.5
SO5	HIV timely intervention - s/b MDT <10 working days	≥ 97%	≥ 99%	No cases	No cases	No cases	No cases
SO5b	Hep B timely intervention – s/b MDT <10 working days	≥ 97%	≥ 99%	No cases	0	100	100
SO6	Hep B timely assessment to specialist with 6 weeks	≥ 70%	≥ 90%	No cases	No cases	No cases	100
SO7	Hep B neonatal Vaccination and HBIG within 24 hrs	≥ 97%	≥ 99%	100	0	No cases	100
			FASP				
SO 3a	Test performance screen + rate (T13/T18/T21 combined	1.8-2.5%		2.4			
SO 3b	Test performance DR (T13/T18/T21)	85%		95%			
SO4	Test performance DR cardiac	>50%		No cases	No cases	No cases	100
SO5	Test TaT						
SO7	Time to intervention (T13/T18/T21) within 3 working days	≥ 97%	≥ 99%	100 (14 cases)	100 (15 cases)	100 (17 cases)	100 (21 cases)

Awaiting approval

NIPT SO1	NIPT coverage	No threshold	No threshold	N/A	40% opt in	41% opt in	66.7% opt in
SO2	Timeliness of NIPT receipt in genomics lab	≤ 2 working days		N/A	100	57	100
SO3	NIPT TaT	≤ 10 working days		N/A	100	100	100
SO4	NIPT higher chance. No of days to discuss results			N/A	No cases	No cases	100 (2 cases)
SO5	PND results – no of days for PND to be completed	≤ 3 working days		N/A	No cases	No cases	50%
SO8a	Time to intervention – 18+0-20+6. Referred locally when anomaly suspected within 3 working days	≥ 97%	≥ 99%	0 (1 case)	No cases	100 (1 case)	100 (2 cases)
SO8b	Time to intervention – 18+0-20+6. Tertiary FMU when anomaly suspected	≥ 97%	Not set	75	86.6	75	95
SCT							
SO6	Timeliness of PND for at risk SCT	≥ 50%	≥ 75%	0	No cases	No cases	1 case
SO7	Timely reporting of PND performed within 5 working days	≥ 70%	≥ 90%	100	No cases	No cases	No cases
SO8	Reporting NBS + results to parents			HV team	HV team	HV team	HV team
SO9	Timely referral / diagnosis / treatment of screen + within 90 days of age			CHIS	CHIS	CHIS	CHIS

Awaiting approval

	NEWBORN SCREENING						
HEARING							
SO2	Test performance hospital no clear response (well babies)	≤27%	≤22%		20.7	16.7	20.9
SO3	Test performance hospital referral to diagnostic audiology assessment	≤3%	≤2%		1.2	1.6	2.4
SO4	Intervention – screening outcome to apt for diagnostic audiology assessment	≥ 97%	≥ 99%		100	50	97.8
SO5	Intervention – screening outcome to attendance at audiology assessment	≥90%	≥95%		100	37.5	89
NEWBORN BLOOD SPOT							
SO3	Use of barcode label	≥90%	≥95%	84.9	88	81	88.7
SO4	Sample collected on day 5	≥90%	≥95%	94.4	95.8	96	95.3
SO5	Sample received in lab within 3 working days	≥95%	≥99%	99	98.9	98.7	99.2
NIPE							
SO2	Timeliness of intervention (abnormality of eye) assessment within 2 weeks of age	≥95%	≥100%	100	100	No cases	No cases
SO3	USS within 4-6 weeks of age	≥90%	≥95%	79.2	100	94	86.3
SO4	Diagnosis / Intervention – timeliness of hip clinical assessment or discharge (decision by <42 days babies born >34+0 or <240 days, babies born <34+0	To be set	To be set	75.5	97.6	92	82.4
SO5	Timeliness of Intervention – Bilateral undescended testes. Assessment within 24 hrs	≥100%		100	No cases	100	No case

Awaiting

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TRAINING NEEDS ANALYSIS AND TRACKER

Justyna Skonieczny
Deputy Head of Midwifery

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%)	October 2021–December 2021	January 2022-March 2022	April 2022	May 2022	June 2022	July 2022	August 2022	September 2022	Current % age completion
Smoke free pregnancy	Midwives	99%	99%	97%	99%	98%	99%	99%	98%	98%
	Obstetrician*	NA	78%	71%	67%	81%	81%	81%	81%	77%
Monitoring growth restriction (as for GAP)	Midwives	95%	96%	94%	95%	96%	94%	90%	90%	93%
	Obstetrician	97%	92%	90%	95%	81%	85%	83%	91%	87%
Fetal movements & Fetal monitoring	Midwives	90%	84%	83%	77%	76%	71%	71%	78%	83%
	Obstetrician	80%	72%	92%	80%	66%	66%	50%	100%	79%
Pre-term birth *	Midwives	NA	99%	100%	100%	99%	99%	99%	98%	98%
	Obstetrician	NA	0%	0%	0%	0%				

GAP AND GROW TRAINING

MINIMUM REQUIREMENT	Number of attendees in month (Target 90%)	October 2022–December 2021	January 2022-March 2022	April 2022	May 2022	June 2022	July 2022	August 2022	September 2022	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	95%	96%	94%	95%	96%	94%	90%	91%	93%
	CONSULTANT OBSTETRICIANS	97%	92%	90%	95%	81%	85%	83%	91%	89%

* 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 (TARGET 90%)	January 2022-March 2022	April 2022	May 2022	June 2022	July 2022	August 2022	September 2022	Current %age completion
Risk assessment throughout labour Fetal monitoring – Intermittent auscultation (IA) Fetal Monitoring – Electronic Fetal Monitoring (EFM)	MIDWIVES	84%	83%	77%	76%	71%	71%	78%	77%
	CONSULTANT OBSTETRICIANS	72%	92%	80%	66%	66%	50%	100%	75%
	ALL OTHER OBSTETRICIANS								
Use of local case histories	MIDWIVES	66%	78%			68%			70%
	OBSTETRICIANS	48%	72%			56%			58%

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.
*** New module added to the K2 Perinatal Training Programme.**

MATERNITY EMERGENCIES AND MULTIPROFESSIONAL TRAINING										
MINIMUM REQUIREMENT	Number of attendees in month	October 2022–December 2021	January 2022-March 2022	April 2022	May 2022	June 2022	July 2022	August 2022	September 2022	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	OBSTETRIC CONSULTANTS	8	1	2	5	3	3	1	1	73.%
	ALL OTHER OBSTETRIC DOCTORS CONTRIBUTING TO THE ROTA	10	5	0	2	0	0	4	3	
	OBSTETRIC ANAESTHETIC CONSULTANTS	5	0	1	1	1	1	1	1	91.%
	ALL OTHER OBSTETRIC ANAESTHETIC DOCTORS CONTRIBUTING TO THE ROTA	6	3	2	1	2	1	0	1	
	MIDWIVES	49	31	17	15	13	14	11	13	97%
	MATERNITY SUPPORT WORKERS AND HEALTH CARE ASSISTANTS	8	10	5	5	3	3	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.

PERSONALISED CARE

MINIMUM REQUIREMENT	Number of attendees in month Target 90%	July 2022 - September 2021	October 2022– December 2021	January 2022-March 2022	April 2022	May 2022	June 2022	July 2022	August 2022	September 2022	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	99%	99%	98%	97%	99%	98%	98%	98%	98%	98%
	Obstetrician*	93%	94%	95%	90%	93%	93%	90%	90%		
Vulnerable women and families Social factors requiring referral	Midwives	99%	99%	98%	97%	99%	98%	98%	98%	98%	98%
	Obstetrician	94%	87%	95%	90%	93%	93%	90%	90%		
Families with babies on NICU *	Midwives	This topic will be covered within CNST year 5 starting from January 2024									
	Obstetrician										
Bereavement care	Midwives	99%	99%	98%	97%	99%	96%	100%	97%	98%	98%
	Obstetrician**	NA	NA	NA	NA	NA	NA				

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.
- ** NA- this topic will be covered from August 2022 as part of the Induction programme for medical staff

CARE DURING LABOUR AND THE IMMEDIATE POSTNATAL PERIOD

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MINIMUM REQUIREMENT	Number of attendees in month TARGET 90%	July 2022 - September 2021	October 2022– December 2021	January 2022- March 2022	April 2022	May 2022	June 2022	July 2022	August 2022	September 2022	Current %age completion
Management of labour	MIDWIVES	NA	NA	99%	100%	100%	96%	100%	99%	98%	98%
	OBSTETRICIANS**	NA	NA	NA	NA	NA	NA				
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	NA	NA	99%	100%	100%	96%	100%	99%	98%	98%
	OBSTETRICIANS**	NA	NA	NA	NA	NA	NA				
Management of epidural anaesthesia	MIDWIVES	This topic will be covered within CNST year 6 training sessions starting from January 2023									
	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%	96%	98%	97%	96%	97%	100%	99%	98%	98%
	OBSTETRICIANS	98%	90%	91%	88%	92%	96%	100%	100%	73%	92%
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.
- ** NA- this topic will be covered from August 2022 as part of the Induction programme for medical staff

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NEONATAL LIFE SUPPORT

MINIMUM REQUIREMENT	Number of attendees in month	July 2022 - September 2021	October 2022– December 2021	January 2022- March 2022	April 2022	May 2022	June 2022	July 2022	August 2022	September 2022	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	2	5	2	1	0	0	5	0	88% **
	NEONATAL JUNIOR DOCTORS WHO ATTEND ANY DELIVERIES	NA	5	2	1	3	0	0	6	0	88% **
	NEONATAL NURSES BAND 5 AND ABOVE	3	16	0	7	6	0	0	1	8	92%
	ADVANCED NEONATAL NURSE PRACTITIONERS (ANNPs) *	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
	MIDWIVES	30	49	31	17	15	13	14	11	13	97%

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

SUMMARY

Unit: Maternity Service at West Suffolk NHS Foundation Trust Reporting period (quarter): July 2022-September 2022

Was MDT nature of training achieved as required during the period? No

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

- MDT training was difficult to achieve due to staff absences, some being related to Covid 19 and the impact that this had for releasing medical staff to attend the training sessions
- MDT was not achieved within the Maternity Emergency and multi-professional training in August due to Anaesthetic medical staff not being able to attend the PROMPT training and for the Neonatal life support (NLS) training in July and September where Neonatal/ Paediatrics medical staff were not able to attend the sessions.
- There is limited availability of data around Obstetric compliance with some elements of Six Core Competency Framework (highlighted in yellow), these have been escalated to Obstetric Lead

Actions

The Obstetric anaesthetic lead is overseeing the rotas to enable staff to attend the MDT sessions

A training lead has been appointed who will be helping to facilitate MDT training for the NLS sessions and maintain records of external NLS training, competence and updates.

There is ongoing work to ensure that all training attendance is captured on databases that can be maintained and interrogated for non-compliance.

Is training completion meeting the expected trajectory? No

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

The areas of significant concerns in meeting the standard are within the fetal monitoring training within all staff groups and Six Core Competency Framework for obstetric medical staff. This is due to:

A decrease in attendance of the obstetric medical staff was also noted at the PROMPT training. This is due to:

Staff absences, some being related to Covid-19 and difficulties in releasing medical staff to attend the training – this has been escalated

Actions

An education and training lead was appointed to lead on improvements required

To improve on compliance within fetal monitoring, Fetal surveillance training have been introduced as part of the MDT training days from August .

There is ongoing work to develop and maintain an MDT training database to capture accurate data and monitor compliance

5.3 - Governance Report - TOR Review - Appendices A-E

INSIGHT COMMITTEE

Terms of Reference

1. Purpose of the Committee

1.1. The Trust Board hereby resolves to establish an assurance committee to be known as the Insight Committee (the committee). The committee has no executive powers other than those specifically delegated in these terms of reference. The scope of this assurance committee will focus on operations, finance and organisational risk.

1.2. In line with the NHSI Well-led Framework, the committee is authorised to provide the board with assurance that there are clear and effective processes in place for managing risks, issues and performance and that appropriate and accurate information is being effectively processed, challenged and acted upon.

1.3. The committee will consider all relevant risks within the Board Assurance Framework and corporate risk register as they relate to the remit of the committee, as part of reporting requirements, and to report any areas of significant concern to the board as appropriate. The committee will also recommend changes to the BAF relating to emerging risks and existing entries within its remit for the executive to consider.

2. Level of Authority

2.1. The committee is authorised by the Trust Board to investigate any activity within its terms of reference. It is authorised to request any information from any employee and all employees are directed to cooperate with any request made by the committee. The committee is authorised by the Trust Board to obtain legal advice and to secure the attendance of experts and external representatives or persons with relevant experience/expertise if it considers it necessary.

2.2. The committee has authority to make decisions on behalf of the Board but in compliance with the Trust's Standing Financial Instructions and Scheme of Delegation.

2.3. The Committee may establish sub-groups/committees reporting to it. It shall remain accountable to the Board for the work of any group reporting to it.

3. Duties and responsibilities

3.1. The key responsibilities of the committee shall be to:

- Receive a regular report on financial and workforce efficiency, noting any trends, exceptions and variances against plans on a Trust-wide and divisional basis and to seek assurance relating to any major performance variations as appropriate
- Receive a regular report on operational performance noting any trends, exceptions and variances against plans on a Trust-wide and divisional basis and to seek assurance relating to any major performance variations as appropriate

- Receive a regular report on clinical effectiveness, noting any trends, exceptions and variances against plans on a Trust-wide and divisional basis and to seek assurance relating to any major performance variations as appropriate
- Advise the board and/or relevant board committee of any risks and issues relating to performance, the assurances it has received of any actions relating to them and any gaps in control or assurance that need to be escalated for attention
- To review significant risks including those in the BAF and are relevant to the scope of the committee as allocated by the Board.

4. Membership

4.1. Membership of the Committee will comprise:

Executive Leads:
- Director of Resources
- Chief Operating Officer

Other Members
- Two non-executive directors, one of whom will chair the meeting
- Chief Nurse
- Medical Director

The Chairman and Chief Executive have an open invitation to attend meetings of the committee.

Others in attendance would be:

Attendees who are not members of the committee but who will be reporting to the committee on risks and assurances within their remit include the following:
- Deputy Director of Finance
- Deputy Chief Operating Officer
- Deputy Director of Workforce
- Head of Access
- Associate Director of Quality Improvement
- Deputy Chief Nurse
- Deputy Medical Director
- Head of Information Services
- Trust Secretary

4.2. The Committee may invite members of staff, other key stakeholders and advisors to attend meetings as appropriate.

4.3. The Committee may ask any other officials of the organisation or representatives of external partners to attend to assist it with its discussions on any particular matter. The Committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters

4.4. Attendance at meetings is essential. In exceptional circumstances when an executive member cannot attend they must arrange for a fully briefed deputy of

sufficient seniority to attend on their behalf. Members will be required to attend as a minimum ~~50%~~ 75% of the meetings per year.

5. Quorum

5.1. The quorum necessary for the transaction of business shall be four members of whom at least one must be a non-executive director. A duly convened meeting of the committee at which a quorum is present shall be competent to exercise all or any of the authorities, powers and discretions invested in, or exercised, by the committee

5.2. Members are requested to send a deputy with the appropriate skills and knowledge to represent them if they are unable to attend a meeting. Deputies will be counted for the purposes of the quorum.

5.3. 'Virtual' attendance will count towards the quorum.

6. Frequency of meetings

6.1. The committee shall operate as follows:

- The committee will meet monthly until agreed otherwise
- Items for the agenda should be submitted to the committee secretary a minimum of 6 working days prior to the meeting. Papers on other matters will be put on the agenda only with the prior agreement of the chair
- The monthly meetings will alternate between the following:
    - Month 1: Scrutiny and assurance in relation to the reports received from the sub committees listed below, covering two months' activity and performance
    - Month 2: Deep dives into specific performance issues identified through the assurance process, in order to gain deeper understanding of the causes, the actions being taken to remediate issues and the process of improvement
- Papers will be sent out by the committee secretary at least 4 days before each meeting.
- Membership and terms of reference will only be changed with the approval of the committee and ultimately the board.

7. Sub Committees

7.1. The committee shall receive regular reports from the sub-groups and speciality Committees in place.

8. Arrangements for meetings and circulation of minutes/Administrative support

8.1. The committee shall be supported by Trust office with regard to arrangements for meetings and circulation of minutes/administrative support

8.2. Minutes will be prepared after each meeting of the committee within 5 working days and circulated to members of the committee and others as necessary once confirmed by the Chair of the committee. Once the committee has approved the full minutes, a copy will be available, for information, to the board at its next meeting.

9. Accountability and reporting arrangements

9.1. The committee shall be directly accountable to the Board.

9.2. There should be a formal report from the committee to the next meeting of the Board of Directors. The chair of the committee shall draw to the attention of the Trust Board, in private or public as appropriate, any issues that require disclosure to the Board or require executive action. The speed of communication should be proportionate to the seriousness and likely impact of the issue.

9.3. The key issues of the committee will be included in the Board of Directors' agenda and papers. Once the committee has approved the full minutes, a copy will be available, for information, to the board at its next meeting.

9.4. The committee shall submit an annual report to the Trust Board within the first three months of the new financial year.

10. Monitoring effectiveness and compliance with Terms of reference

10.1. In order to support the continual improvement of governance standards, this committee is required to complete a self-assessment of effectiveness at least annually and advise the Trust Board of any suggested amendments to these terms of reference which would improve the trust governance arrangements.

11. Ratification of terms of reference and review arrangements

11.1. The Terms of Reference shall be reviewed annually and submitted to the Board for approval.

Date approved by the Insight Committee: 03 October 2022
Date approved by the Board of Directors:
Next review date: November 2023

IMPROVEMENT COMMITTEE

Terms of Reference

1. Purpose of the Committee

1.1. The Trust Board hereby resolves to establish an assurance committee to be known as the Improvement Committee (the committee). The committee has no executive powers other than those specifically delegated in these terms of reference. The scope of this assurance committee will focus on quality, patient safety and change management.

1.2. In line with the NHSI Well-led Framework, the committee is authorised to provide the board with assurance that there is a culture of high quality, sustainable care and robust systems for learning, continuous improvement and innovation.

1.3. The committee will consider all relevant risks within the Board Assurance Framework and corporate risk register as they relate to the remit of the committee, as part of reporting requirements, and to report any areas of significant concern to the board as appropriate. The committee will also recommend changes to the BAF relating to emerging risks and existing entries within its remit for the executive to consider.

2. Level of Authority

2.1. The committee is authorised by the Trust Board to investigate any activity within its terms of reference. It is authorised to request any information from any employee and all employees are directed to cooperate with any request made by the committee. The committee is authorised by the Trust Board to obtain legal advice and to secure the attendance of experts and external representatives or persons with relevant experience/expertise if it considers it necessary.

2.2. The committee has authority to make decisions on behalf of the Board but in compliance with the Trust's Standing Financial Instructions and Scheme of Delegation.

2.3. The Committee may establish sub-groups/committees reporting to it. It shall remain accountable to the Board for the work of any group reporting to it.

3. Duties and responsibilities

3.1. The key responsibilities of the committee shall be to provide assurance to the board in relation to:

- The effectiveness of the Trust's systems and processes for ensuring clinical governance, quality governance and patient safety is embedded from ward to board
- The Trust's compliance with statutory and regulatory standards, particularly in relation to the Care Quality Commission, Clinical Negligence Scheme for Trusts and the well-led framework
- Oversight of the delivery of statutory and mandatory requirements relating to Quality and Safety of care
- The provision of a platform and forum for the sharing of best practice and improvement learning throughout the Trust

- Trust performance in relation to patient safety outcomes and effectiveness with particular focus on providing assurance to the Board on actions taken to address any major performance variations
- Reports on significant concerns or adverse findings highlighted by external bodies in relation to clinical quality and safety and the actions being taken by management to address them
- The systems and processes in place in the Trust in relation to infection control and to review progress against identified risks to reducing hospital acquired infections
- Reports on actions to address trends relating to adverse events (including serious incidents), complaints, claims and litigation.
- Key strategic risks relating to quality and patient safety and consider plans for mitigation as appropriate
- Ensuring that lessons are learnt and implemented across the Trust from patient feedback, including patient safety data and trends, compliments, complaints, patient surveys, national audits/confidential enquiries and learning from the wider NHS community
- Systems within the Trust for obtaining and maintaining licences and accreditations relevant to clinical activity, receiving such reports as required
- To review significant risks including those in the BAF and are relevant to the scope of the committee as allocated by the Board.

4. Membership

4.1. Membership of the Committee will comprise:

Executive Leads:
- Chief Nurse
- Medical Director

Other Members
- At least two non-executive directors, one of whom will chair the meeting
- Chief Operating Officer

The Chairman and Chief Executive have an open invitation to attend meetings of the committee.

Others in attendance would be:

- Associate Director of Quality Improvement
- Head of Patient Safety
- Head of Compliance and Effectiveness
- Chair of Patient Quality and Safety Governance Group
- Chair of Clinical Effectiveness governance group
- Clinical directors as required
- Associate Medical Director
- Trust Secretary/Head of Governance

4.2. The Committee may invite members of staff, other key stakeholders and advisors to attend meetings as appropriate.

4.3. The Committee may ask any other officials of the organisation or representatives of external partners to attend to assist it with its discussions on any particular matter. The Committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters

4.4. Attendance at meetings is essential. In exceptional circumstances when an executive member cannot attend they must arrange for a fully briefed deputy of sufficient seniority to attend on their behalf. Members will be required to attend as a minimum 75% of the meetings per year.

5. Quorum

5.1. The quorum necessary for the transaction of business shall be four members of whom at least one must be a non-executive director. A duly convened meeting of the committee at which a quorum is present shall be competent to exercise all or any of the authorities, powers and discretions invested in, or exercised, by the committee.

5.2. Members are requested to send a deputy with the appropriate skills and knowledge to represent them if they are unable to attend a meeting. Deputies will be counted for the purposes of the quorum.

5.3. Virtual attendance will count towards the quorum.

6. Frequency of meetings

6.1. The committee shall operate as follows:

- The committee will meet monthly until agreed otherwise
- Items for the agenda should be submitted to the committee secretary a minimum of 6 working days prior to the meeting. Papers on other matters will be put on the agenda only with the prior agreement of the chair.
- Papers will be sent out by the committee secretary at least 4 days before each meeting.
- Membership and terms of reference will only be changed with the approval of the committee and ultimately the board.

7. Sub Committees

7.1. The committee shall receive regular reports from the Patient Quality and Safety Governance Group and the Clinical Effectiveness Governance Group.

8. Arrangements for meetings and circulation of minutes/Administrative support

8.1. The Committee shall be supported by Trust office with regard to arrangements for meetings and circulation of minutes/administrative support

8.2. Minutes will be prepared after each meeting of the committee within 5 working days and circulated to members of the committee and others as necessary once confirmed by the Chair of the committee. Once the committee has approved the full minutes, a copy will be available, for information, to the board at its next meeting.

9. Accountability and reporting arrangements

9.1. The committee shall be directly accountable to the Board.

9.2. There should be a formal report from the committee to the next meeting of the Board of Directors. The chair of the committee shall draw to the attention of the Trust Board, in private or public as appropriate, any issues that require disclosure to the Board or require executive action. The speed of communication should be proportionate to the seriousness and likely impact of the issue.

9.3. The key issues of the committee will be included in the Board of Directors' agenda and papers.

9.4. The committee shall submit an annual report to the Trust Board within the first three months of the new financial year.

10. Monitoring effectiveness and compliance with Terms of reference

10.1. In order to support the continual improvement of governance standards, this committee is required to complete a self-assessment of effectiveness at least annually and advise the Trust Board of any suggested amendments to these terms of reference which would improve the trust governance arrangements.

11. Ratification of terms of reference and review arrangements

11.1. The Terms of Reference shall be reviewed annually and submitted to the Board for approval.

Date approved by the Improvement Committee: 14 November 2022
Date approved by the Board of Directors:
Next review date: November 2023

INVOLVEMENT COMMITTEE

Terms of Reference

1. Purpose of the Committee

1.1. The Trust Board hereby resolves to establish an assurance committee to be known as the Involvement Committee (the committee). The committee has no executive powers other than those specifically delegated in these terms of reference. The scope of this assurance committee will focus on people and organisational development.

1.2. In line with the NHSI Well-led Framework, the committee is authorised to provide the board with assurance that the Trust is engaging and involving people who use the services, the public, the staff and external partners to support high quality sustainable services.

1.3. The committee will consider all relevant risks within the Board Assurance Framework and corporate risk register as they relate to the remit of the committee, as part of reporting requirements, and to report any areas of significant concern to the board as appropriate. The committee will also recommend changes to the BAF relating to emerging risks and existing entries within its remit for the executive to consider.

2. Level of Authority

2.1. The committee is authorised by the Trust Board to investigate any activity within its terms of reference. It is authorised to request any information from any employee and all employees are directed to cooperate with any request made by the committee. The committee is authorised by the Trust Board to obtain legal advice and to secure the attendance of experts and external representatives or persons with relevant experience/expertise if it considers it necessary.

2.2. The committee has authority to make decisions on behalf of the Board but in compliance with the Trust's Standing Financial Instructions and Scheme of Delegation.

2.3. The Committee may establish sub-groups/committees reporting to it. It shall remain accountable to the Board for the work of any group reporting to it.

3. Duties and responsibilities

3.1. The key responsibilities of the committee shall be to provide assurance to the board in relation to the Trust's strategies, plans and the management of risks, pertaining to:

(a) First for staff: staff engagement and involvement

- Organisational values, leadership & cultural development (inc. speak up culture)
- Staff engagement & feedback (inc. staff survey/s)
- Diversity & inclusion: workforce
- Support for staff health and wellbeing
- Education, training & workforce development

- HR & employment practice

(b) First for patients: patient engagement and involvement
- Patient and carer engagement & feedback (inc. patient survey/s)
- Co-production of improvements to quality & service provision
- Diversity & inclusion: patient care
- Sharing and adoption of learning from complaints & incidents

(c) First for the future: system involvement & public engagement
- The approach to and development of partnership working with our Alliance and ICS
- Our responsibilities and contribution as an anchor institution
- Meeting statutory duties for public and patient involvement in relation to the planning and provision of services
- Member and governor engagement activities, and their alignment with the Trust's strategic priorities

4. Membership

4.1. Membership of the Committee will comprise:

Executive Lead
- Executive director of workforce and communications

Other Members
- Two non-executive directors, one of whom will chair the meeting
- Executive chief nurse
- Executive medical director
- Executive chief operating officer

The chair and chief executive have an open invitation to attend meetings of the committee.

Others in attendance would be:

- Associate director of quality improvement
- Governor representative
- ICS representative
- Trust secretary

4.2. The Committee may invite members of staff, other key stakeholders and advisors to attend meetings as appropriate.

4.3. The Committee may ask any other officials of the organisation or representatives of external partners to attend and to assist it with its discussions on any matter. The Committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of matters.

4.4. Attendance at meetings is essential. In exceptional circumstances when an executive member cannot attend, they must arrange for a fully briefed deputy of sufficient seniority to attend on their behalf. Members will be required to attend as a minimum 75% of the meetings per year.

5. Quorum

5.1. The quorum necessary for the transaction of business shall be three members of whom at least one must be a non-executive director. A duly convened meeting of the committee at which a quorum is present shall be competent to exercise all or any of the authorities, powers and discretions invested in, or exercised, by the committee.

5.2. Members are requested to send a deputy with the appropriate skills and knowledge to represent them if they are unable to attend a meeting. Deputies will be counted for the purposes of the quorum.

5.3. 'Virtual' attendance will count towards the quorum.

6. Frequency of meetings

6.1. The committee shall operate as follows:

- The committee will meet every other month until agreed otherwise
- Items for the agenda should be submitted to the committee secretary a minimum of 6 working days prior to the meeting. Papers on other matters will be put on the agenda only with the prior agreement of the chair.
- Papers will be sent out by the committee secretary at least 4 days before each meeting.
- Membership and terms of reference will only be changed with the approval of the committee and ultimately the board.

7. Sub Committees

7.1. The committee shall receive regular reports from the sub-groups and speciality committees in place like:

- Patient Carer Experience Group
- VOICE
- Specialist groups: Trust Negotiating Committee – Medical & Dental and General; Trust Council; Equality, Diversity and Inclusion steering group; Frail Elderly Steering; Group/Dementia/Family Carers; PEAG/PLACE reviews

7.2. Other groups may be invited to report into or attend the meeting on an ad hoc basis to report on various themes, topics and initiatives taken by the organisation.

7.3. The Terms of Reference of the above groups and their effectiveness will be reviewed by the committee annually.

8. Arrangements for meetings and circulation of minutes/Administrative support

8.1. The Committee shall be supported by Trust office.

8.2. Minutes will be prepared after each meeting of the committee within 5 working days and circulated to members of the committee and others as necessary once confirmed by the Chair of the committee. Once the committee has approved the full minutes, a copy will be available, for information, to the board at its next meeting.

9. Accountability and reporting arrangements

9.1. The committee shall be directly accountable to the Board.

9.2. There should be a formal report from the committee to the next meeting of the Board of Directors. The chair of the committee shall draw to the attention of the Trust Board, in private or public as appropriate, any issues that require disclosure to the Board or require executive action. The speed of communication should be proportionate to the seriousness and likely impact of the issue.

9.3. The key issues of the committee will be included in the Board of Directors' agenda and papers.

9.4. The committee shall submit an annual report to the Trust Board within the first three months of the new financial year.

10. Monitoring effectiveness and compliance with Terms of reference

10.1. In order to support the continual improvement of governance standards, this committee is required to complete a self-assessment of effectiveness at least annually and advise the Trust Board of any suggested amendments to these terms of reference which would improve the trust governance arrangements.

11. Ratification of terms of reference and review arrangements

11.1. The Terms of Reference shall be reviewed annually and submitted to the Board for approval.

Date approved by the Involvement Committee: via Chair's action on 11 Nov 2022
Date approved by the Board of Directors:
Next review date: November 2023

AUDIT COMMITTEE

Terms of Reference

1. Purpose of the Committee

1.1. The Board of Directors hereby resolves to establish a committee of the Board to be known as the Audit Committee (the committee). The committee is a non-executive committee of the Board of Directors and has no executive powers, other than those specifically delegated in these Terms of Reference.

1.2. The committee will provide an independent and objective view of the Trust's internal control environment and the systems and processes by which the Trust leads, directs and controls its functions in order to achieve organisational objectives, safety, and quality of services, and in which they relate to the wider community and partner organisations.

1.3. The committee will consider all relevant risks within the Board Assurance Framework and corporate risk register as they relate to the remit of the committee, as part of reporting requirements, and to report any areas of significant concern to the board as appropriate. The committee will also recommend changes to the BAF relating to emerging risks and existing entries within its remit for the executive to consider.

2. Level of Authority

2.1. The committee has overarching responsibility for monitoring specific elements of the systems and processes relating to governance, including financial systems, records and controls; financial information; compliance with law, guidance and codes of conduct; independence of internal and external audit; and the control environment (including measures to prevent and detect fraud). The Committee is responsible for providing an opinion as the adequacy of the integrated governance arrangements and Board Assurance Framework.

2.2. The Board of Directors authorises the committee to investigate any activity within its duties (as detailed below) and grants to the Committee complete freedom of access to the Trust's records, documentation and employees. This authority does not extend, other than in exceptional circumstances, to confidential patient information.

2.3. The committee may seek any information (excluding confidential patient information, other than in exceptional circumstances) or explanation it requires from the Trust's employees who are directed to co-operate with any request made by the Committee.

2.4. The Trust Board authorises the committee to obtain external professional advice or expertise if the committee considers this necessary.

2.5. The committee has a statutory role in respect of assurance, controls, compliance, data and probity. The aim is to ensure complete coverage while avoiding duplication by close liaison and cross-representation between the board assurance committees.

2.6. The committee has authority to make decisions on behalf of the Board but in compliance with the Trust's Standing Financial Instructions and Scheme of Delegation.

2.7. The Committee may establish sub-groups/committees reporting to it. It shall remain accountable to the Board for the work of any group reporting to it.

3. Duties and responsibilities

The key duties and responsibilities of the Committee are as follows:

3.1 Governance and Assurance

3.1.1 The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives. The Audit Committee will look to the Trust's other Board Assurance Committees for assurance on items of clinical quality and corporate risk, including: health & safety, research and information governance.

In particular, the Committee shall independently monitor and review:

3.1.1.1 the Annual Governance Statement (AGS) and the assurance system for all other external disclosure statements such as declarations of compliance with the Care Quality Commission registration, and any formal announcements relating to the Trust's financial performance, together with any accompanying Head of Internal Audit opinion, External Audit opinion or other appropriate independent assurances, prior to endorsement by the Board of Directors in order to advise (when requested by the Board or as the Committee deems appropriate) on whether such disclosures taken as a whole are fair, balanced and understandable.

3.1.1.2 the effectiveness of systems of internal financial and budgetary control and the integrity of reporting statements.

3.1.1.3 the effectiveness of systems for ensuring the optimum collection of income.

3.1.1.4 the effectiveness of risk management systems.

3.1.1.5 the effectiveness of the Board Assurance Framework (BAF).

3.1.1.6 The Committee will use a programme of 'deep dive' reviews to test the BAF and its priority areas as part of an assurance programme. The Committee's assessment of the effectiveness of the BAF should be included in the Committee's Annual Report to the Board of Directors.

3.1.1.7 the Quality Report assurance and review alongside the annual report and accounts.

3.1.1.8 the systems for ensuring that there is compliance with relevant regulatory, legal and code of conduct requirements, including the NHS Constitution, as set out in relevant guidance.

3.1.1.9 the policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by the NHS Counter Fraud Authority.

3.1.1.10 the adequacy and security of arrangements by which staff or contractors may raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters, ensuring that arrangements are in place for the proportionate and independent investigation of such matters and for appropriate follow-up action.

3.1.2 In carrying out this work, the Committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these audit functions. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the overarching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

3.1.3 This will be evidenced through the Committee's use of an effective Assurance Framework to guide its work and that of the audit and assurance functions that report to it.

3.1.4 The Committee will receive the minutes from the Trust's other Board Assurance Committees for the purpose of ensuring: that there is no duplication of effort between the two Committees; that no area of assurance is missed and; as part of its responsibility for reviewing the Annual Governance Statement prior to submission to the Board of Directors.

3.1.5 The Audit Committee shall ensure that there is a system for reviewing the findings of other significant assurance functions, both internal and external to the organisation and consider the implications to the governance of the organisation. These will include, but will not be limited to, NHS Improvement, any reviews by The Department of Health and Social Care or arm's length bodies, regulators/inspectors (CQC, NHS Resolution etc) and professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies etc.)

3.1.6 In addition, the Committee will review the work of other Board Assurance Committees within the organisation, whose work can provide relevant assurance to the Audit Committee's own scope of work. This will particularly include items in relation to quality, risk, governance and assurance. The conclusion of this review should be referred to specifically in the Committee's Annual Report to the Board of Directors.

3.1.7 The Committee will consider how its work integrates with wider performance management and standards compliance and include this within the Annual Report to the Board of Directors.

3.1.8 In reviewing the work of other Board Assurance Committees and issues around clinical risk management, the Audit Committee will wish to satisfy themselves on the assurance that these Board Assurance Committees gain from the clinical audit function.

3.1.9 The Audit Committee will receive assurance on the arrangements for clinical audit within the Trust, including the process by which clinical audits are selected and agreed actions implemented.

3.2 Internal Audit

The Committee shall ensure that there is an effective internal audit function established by management, which meets mandatory Public Sector Internal Audit Standards and provides appropriate independent assurance to the Audit Committee, Chief Executive and the Board of Directors. An Internal Audit Charter will be agreed annually which will include objectives, responsibilities and reporting lines. This will be achieved by:

3.2.1 considering the appointment of the internal audit service, the audit fee and any questions of resignation and dismissal.

3.2.2 the review and approval of the internal audit strategy, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the Board Assurance Framework.

3.2.3 consideration of the major findings of internal audit investigations, the effectiveness of the management's response and ensuring co-ordination between the Internal and External Auditors to optimise audit resources.

The will include exception reports of management action beyond deadline and consideration of the findings of Internal Audit "testing" of completed actions.

3.2.4 ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the Trust.

3.2.5 assessing the quality of internal audit work on an annual basis.

3.2.6 Ensuring any material objection to the completion of an assignment which has not been resolved through negotiation is brought to the Committee by the Chief Executive Officer or Director of Resources with a proposed solution for a decision.

3.3 Counter Fraud

The Committee shall ensure that there is an effective counter fraud function established by management that meets the Standards set out by the NHS Counter Fraud Authority and provides appropriate independent assurance

to the Audit Committee, Chief Executive and Board of Directors. This will be achieved by:

3.3.1 consideration of the provision of the Counter Fraud service, the cost of the audit and any questions of resignation and dismissal.

3.3.2 consideration of the major findings of counter fraud work (and management's response).

3.3.3 ensuring that the Counter Fraud function is adequately resourced and has appropriate standing within the organisation.

3.3.4 receiving an annual review of the work undertaken by the counter fraud function.

3.4 External Audit

The Committee shall review the work and findings of the External Auditor appointed by the Council of Governors and consider the implications and management's responses to their work.

3.4.1 Consideration of the appointment, performance and cost effectiveness of the External Auditor, making a recommendation to the Council of Governors on appointment of External Audit.

3.4.2 To ensure that the External Auditor remains independent in its relationship and dealings with the Trust and to review the effectiveness of the audit process, taking into consideration relevant UK professional and regulatory requirements;

3.4.3 To review the annual audit plan and to discuss with the External Auditor, before the audit commences, the nature and scope of the audit.

3.4.4 As part of the audit plan, discuss with the External Auditors of their local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee

3.4.5 To review External Audit reports, including value for money reports and management letters, together with the management response.

3.4.6 To develop and implement a policy on the engagement of the External Auditor to supply non-audit services, considering the impact this may have on their independence, taking into account the relevant regulations and ethical guidance in this regard and reporting to the Board on any improvement or action required.

3.4.7 To develop and implement policy on the engagement of the External Auditor to supply non-audit services, taking into account relevant ethical guidance regarding the provision of non-audit services by the external audit firm; and

3.4.8 To assess the quality of External Audit work on an annual basis.

3.5 Financial Reporting

3.5.1 The Audit Committee shall review the Annual Report and Financial Statements of the Trust and its Charitable funds before submission to the Board, to determine their completeness, objectivity integrity and accuracy. This review will cover but is not limited to:

- the wording in the Annual Governance Statement (AGS) and other disclosures relevant to the Terms of Reference of the Committee;
- changes in, and compliance with, accounting policies and practices;
- explanation of estimates and provisions having material effect;
- unadjusted mis-statements in the financial statements;
- major judgemental areas;
- the schedule of losses and special payments; and
- significant adjustments resulting from the audit.

3.6 Key Trust Documents

3.6.1 Review proposed changes to Standing Orders, Standing Financial Instructions, Scheme of Delegation and Matters Reserved to the Board for approval by the Board of Directors.

3.6.2 To examine the circumstances of any significant departure from the requirements of any of the foregoing, whether those departures relate to a failing, an overruling or a suspension.

3.6.3 To review the Standing Orders, Standing Financial Instructions, Scheme of Delegation and Matters Reserved to the Board on a two-yearly basis for approval by the Board of Directors.

3.7 Other

3.7.1 Review compliance with Standing Orders and Standing Financial Instructions through a schedule of waivers.

3.7.2 Review schedules of losses and compensations.

3.7.3 Monitor the process to ensure that Supply Chain Risk is identified and appropriate actions have been taken.

3.7.4 Entries recorded in the gifts and hospitality register would be considered on an exception basis as reported by the panel considering the entries made.

3.7.5 The Committee shall at its discretion request and review reports, evidence and assurances from Directors and Managers on the overall arrangements for governance, risk management and internal control.

4. Membership

Membership of the Committee will comprise:

4.1. The Committee shall be appointed by the Board of Directors from amongst the Non-Executive Directors of the Trust and shall consist of no fewer than three members, one of whom has recent and relevant finance experience. One of the members will be appointed Chair of the Committee by the Board of Directors.

4.2. At least one member will have a formally recognised professional accountancy qualification and/or a level of relevant financial experience assessed as being appropriate to the role by the Nominations Committee, on behalf of the Board of Directors.

4.3. The Trust Chair will ensure that there is cross-representation by non-executive directors on the Audit Committee and any of the Trust's other Board Assurance Committees.

4.4. The Chair of the Trust shall not be a member of the Committee.

4.5. The committee may invite members of staff, other key stakeholders and advisors to attend meetings as appropriate.

4.6. The committee may ask any other officials of the organisation or representatives of external partners to attend to assist it with its discussions on any particular matter. The committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters

4.7. The Head of Internal Audit and representative of External Audit have a right of direct access to the Chair of the Committee

In attendance:

4.8. The Director of Resources and the Trust Secretary will normally attend all Committee meetings.

4.9. The Head of Internal Audit, the Counter Fraud Specialist and a representative of the Trust's External Auditors will attend as necessary.

4.10. Other members of the Board of Directors have the right of attendance at their own discretion.

4.11. All other attendances will be at the specific invitation of the Committee.

4.12. The Committee will have the over-riding authority to restrict attendance under specific circumstances.

4.13. The Committee will meet with the External and Internal Auditors, without any other Board Director present at least once a year.

4.14. Attendance at meetings will be recorded as part of the normal process of the meeting. A record of attendance will be reported as part of the Committee's Annual Report.

5. Quorum

5.1. The quorum necessary for the transaction of business shall be two members. A duly convened meeting of the committee at which a quorum is present shall be competent to exercise all or any of the authorities, powers and discretions invested in, or exercised, by the committee.

5.2. Members are requested to send a deputy with the appropriate skills and knowledge to represent them if they are unable to attend a meeting. Deputies will be counted for the purposes of the quorum.

5.3. 'Virtual' attendance will count towards the quorum.

6. Frequency of meetings

6.1. The committee shall operate as follows:

- Meetings will normally be held at least three times a year
- Special meetings may be convened by the Board of Directors or the Chair of the Committee
- The External Auditors or Internal Auditors may request a meeting if they consider that one is necessary

7. Sub Committees

7.1. The committee shall receive regular reports as appropriate from the sub-groups and speciality committees in place.

8. Arrangements for meetings and circulation of minutes/Administrative support

8.1. The Minutes of Audit Committee meetings shall be formally recorded and a summary of the minutes, which includes a report of the Committee's activities, is submitted to the Board of Directors no less often than three times a year. The Chair of the Committee shall draw to the attention of the Board any issues that require disclosure to the full Board, or require executive action. Once the committee has approved the full minutes, a copy will be available, for information, to the board at its next meeting.

8.2. The Committee shall be supported by Trust office.

9. Accountability and reporting arrangements

9.1. The committee shall be directly accountable to the Board.

9.2. There should be a formal report from the committee to the next meeting of the Board of Directors. The chair of the committee shall draw to the attention of the Trust Board, in private or public as appropriate, any issues that require disclosure to the Board or require executive action. The speed of communication should be proportionate to the seriousness and likely impact of the issue.

9.3. Minutes will be prepared after each meeting of the committee within 5 working days and circulated to members of the committee and others as necessary once confirmed by the Chair of the committee. Once the committee has approved the

full minutes, a copy will be available, for information, to the board at its next meeting.

9.4. The key issues of the committee will be included in the Board of Directors' agenda and papers.

9.5. The committee shall submit an annual report to the Trust Board within the first three months of the new financial year.

9.6. An annual report of the activities of the Audit Committee shall be presented to the Board of Directors and the Council of Governors, identifying any matters in respect of which it considers that action or improvement is needed and making recommendations as to the steps to be taken.

9.7. A separate section of the Trust's Annual Report will describe the work of the Committee in discharging its responsibilities.

9.8. The Committee will report to the Board planned future workload and priorities for approval.

9.9. The Committee will agree on an annual basis a reporting framework for all areas of it terms of reference. This determines standing items for the agenda and items for regular reporting.

9.10. Maintain and monitor performance against the agreed reporting framework.

9.11. Follow-up agreed actions to ensure these are implemented in a timely and effective manner.

10. Monitoring effectiveness and compliance with Terms of reference

10.1. In order to support the continual improvement of governance standards, the Audit Committee shall carry out a self-assessment in relation to its own performance no less than once every two years, reporting the results to the Board of Directors and advise the Trust Board of any suggested amendments to these terms of reference which would improve the trust governance arrangements.

11. Ratification of terms of reference and review arrangements

11.1. The terms of reference shall be reviewed annually and submitted to the Board for approval.

Date approved by the Audit Committee: via Chair's action on 4th Nov 2022
Date approved by the Board of Directors:
Next review date: November 2023

BOARD REMUNERATION AND NOMINATION COMMITTEE

Terms of Reference

1. Purpose of the Committee

1.1. The Board Remuneration and Nomination Committee (known as "the committee" in these terms of reference) is established by the Board of Directors for the purpose of:

- The nomination of the Chief Executive and other Executive Directors for the Trust
- The determination of the remuneration, terms of service and allowances for the Chief Executive and other Executive Directors
- The appointment and removal of the Trust Secretary does not fall within the scope of this committee but is a matter for the Chief Executive and Chair jointly[1]

1.2. The committee is accountable to the Board of Directors and any changes to these terms of reference must be approved by the Board of Directors.

1.3. When appointing the Chief Executive, the committee shall be the committee described in Schedule 7,17(3) of the National Health Service Act 2006 (the Act). When appointing other executive directors the committee shall be the committee described in Schedule 7,17(4) of the Act[2].

2. Level of Authority

The committee is authorised by the Trust Board to investigate any activity within its terms of reference. It is authorised to request any information from any employee and all employees are directed to cooperate with any request made by the committee. The committee is authorised by the Trust Board, at the Trust's expense, to obtain legal advice and to secure the attendance of experts and external representatives or persons with relevant experience/expertise if it considers it necessary.

[1] *The NHS Foundation Trust Code of Governance* Monitor July 2014 p 58

[2] NHS Act 2006 Schedule 7 17(3) It is for the non-executive directors to appoint or remove the Chief Executive.

(4) It is for a committee consisting of the chairman, the chief executive and the other non-executive directors to appoint or remove the executive directors.

3. Duties and responsibilities

The key responsibilities of the committee shall be to:

[1] *The NHS Foundation Trust Code of Governance* Monitor July 2014 p 58

[2] *The NHS Foundation Trust Code of Governance* Monitor July 2014 p 58

3.1. Regularly review the structure, size and composition (including the skills, knowledge, experience and diversity) of the Board, making use of the output of the board evaluation process as appropriate and make recommendations to the Board and, where relevant, the Council of Governors, with regard to any changes.

3.2. Give full consideration to succession planning for executive board directors in the course of its work, taking into account the challenges and opportunities facing the Trust, and the skills and expertise needed on the Board in the future.

3.3. Keep under review the leadership needs of the Trust, with a view of ensuring the continued ability of the Trust to undertake its obligations under the terms of its licence.

3.4. Be responsible for identifying and appointing candidates to fill executive Board vacancies as and when they arise.

3.5. Before any new appointment is made by the Board, evaluate the balance of skills, knowledge, experience and diversity on the Board, and, in the light of this evaluation, prepare a description of the role and capabilities required for new appointments to the Board. In identifying suitable candidates the committee shall:

- Consider its advertising strategy and the need for external search consultants to support the search
- Consider candidates from a wide range of backgrounds
- Consider candidates on merit and against objective criteria and with due regard for the benefits of diversity on the Board.

3.6. Make recommendations to the Board concerning formulating succession plans for executive directors and in particular for the key role of Chief Executive.

3.7. Take decisions on any matters relating to the continuation in office of any executive director at any time including the suspension or termination of service of an executive director as an employee of the Trust subject to the provisions of the law and their service contract.

3.8. Select members of the committee to form an appointments panel which will be responsible for making recommendations on the appointment of Executive Directors.

REMUNERATION

The committee shall:

3.9. Have responsibility for setting the remuneration policy for all executive directors and senior managers not on agenda for change or clinical contracts, including pension rights and any compensation payments. No director shall be involved in any decisions as to their own remuneration.

3.10. In determining such a policy, take into account all factors which it deems necessary including relevant legal and statutory requirements, the provisions and recommendations of the Code and associated guidance. The objective of such policy shall be to attract, retain and motivate executive management of the quality required to run the Trust successfully without paying more than is necessary, having regard to the risk appetite of the Trust and alignment to the Trust's long strategic term goals.

3.11. When setting remuneration policy for executive directors, review and have regard to pay and employment conditions across the Trust and the NHS, especially when determining annual salary increases.
3.12. Review the ongoing appropriateness and relevance of the remuneration policy.
3.13. Within the terms of the agreed policy and in consultation with the chair or chief executive, as appropriate, determine the total individual remuneration package of each executive director and the CEO.
3.14. Obtain reliable, up-to-date information about remuneration in other Trusts of comparable scale and complexity. To help it fulfil its obligations, the committee shall have full authority to appoint remuneration consultants and to commission or purchase any reports, surveys or information which it deems necessary.
3.15. Monitor, and assess the output of the evaluation of the performance of individual executive directors, and consider this output when reviewing changes to remuneration levels.
3.16. Advise upon and oversee contractual arrangements for executive directors, including but not limited to termination payments to avoid rewarding poor performance.
3.17. Review and agree the policy for authorising claims for expenses from the directors.
3.18. Scrutinise the recommendations of the Clinical Excellence Awards committee
3.19. Where appropriate, to authorise any redundancy payments, settlements and compromise agreements as determined within current NHS rules on severance payments, including such payments which require final approval by HM Treasury/NHS Improvement
3.20. Have responsibility for setting and overseeing implementation of the Trust's pension deferral policy.

4. Membership

Membership of the committee will comprise of:

4.1. The chair and all non-executive directors. the committee will be chaired by the chair or one of the other non-executive directors.
4.2. The chief executive shall be a member of the committee for the appointments or removal of executive directors only as described in Schedule 7,17 (4) of the Act (see also paragraph 1.3 above).
4.3. The chief executive, director of workforce and Trust Secretary will be in attendance at its meetings, as and when appropriate and necessary.
4.4. The committee can request the attendance of any other director or senior manager if an agenda item requires it.
4.5. Members will be required to attend as a minimum 75% of the meetings per year.

5. Quorum

5.1. The quorum necessary for the transaction of business shall be three non-executive directors. For matters relating to executive board appointments (other than the appointment of the chief executive), the quorum shall include the chief executive.

6. Frequency of meetings

6.1. The committee shall operate as follows:

- The committee will meet quarterly until agreed otherwise
- Items for the agenda should be submitted to the committee secretary a minimum of 6 working days prior to the meeting. Papers on other matters will be put on the agenda only with the prior agreement of the chair
- Papers will be sent out by the committee secretary at least 4 days before each meeting
- Membership and terms of reference will only be changed with the approval of the committee and ultimately the board

7. Sub-Committees

7.1. The committee may constitute sub-groups/speciality committees to ensure the actual work with regard to broad scope of committee is executed and delivered in an appropriate manner that is transparent, inclusive and effective.

8. Arrangements for meetings and circulation of minutes/administrative support

8.1. The committee shall be supported by the Trust office with regard to arrangements for meetings and circulation of minutes/administrative support.
8.2. The Trust Secretary shall arrange for the proceedings and resolutions of all committee meetings to be minuted, including the names of those present and in attendance.
8.3. Draft minutes of the committee meetings shall be circulated promptly to all members of the committee.
8.4. The committee will provide an annual report to the Board.
8.5. The committee shall have access to sufficient resources to carry out its duties, including access to the Trust secretariat for assistance as required;
8.6. It shall be provided with appropriate and timely training, both in the form of an induction programme for new members and on an on-going basis for all members;
8.7. It will give due consideration to laws and regulations, the provisions of the FT Code of Governance and any other applicable rules, as appropriate;

9. Accountability and reporting arrangements

9.1. The committee chair shall report to the Board on its proceedings, as appropriate, after each meeting on all matters within its duties and responsibilities;

9.2. The committee shall make whatever recommendations to the Board it deems appropriate on any area within its remit where action or improvement is needed;

9.3. When appointing a chief executive, the committee shall report their decision to appoint to the Council of Governors for approval prior to reporting to the Board.

9.4. The committee shall produce a report to be included in the Trust's annual report about its activities, the process used to make appointments and explain if external advice or open advertising has not been used. Where an external search agency has been used, it shall be identified in the annual report and a statement made as to whether it has any connection with the Trust;

9.5. The report referred to in 9.4 above should include a statement of the Board's policy on diversity, including gender, any measurable objectives that it has set for implementing the policy, and progress on achieving the objectives.

10. Monitoring effectiveness and compliance with Terms of reference

10.1. In order to support the continual improvement of governance standards, this committee is required to complete a self-assessment of effectiveness at least annually and advise the Trust Board of any suggested amendments to these terms of reference which would improve the Trust governance arrangements and committee performance.

11. Ratification of terms of reference and review arrangements

11.1. The Terms of Reference shall be reviewed annually and submitted to the Board for approval.

Date approved by the Board Remuneration & Nomination Committee: 28 Sept 2022
Date approved by the Board of Directors:
Next review date: November 2023

5.3 Governance Report - Council of Governors Meeting - GGI report and improvement plan

ACTION SHEET FOR GGI REPORT RECOMMENDATIONS – Ongoing from September 2022

In order of scheduled completion date

Ref	Recommendation	Response	Action by	Completion date
R1	The Trust should undertake a governor knowledge and skills audit, to inform the governor development programme for the forthcoming year.	• Create a knowledge & skills survey for governors – opportunity for governors to highlight areas of interest they have in the Trust • Collect information about governor skill sets to inform future roles and focus, but also potentially skills gaps which need to be developed • Share proposal at CoG meeting using tested model with balanced focus between technical responsibilities and qualities/behaviors (skills) • Propose that this forms part of the responsibility of the standards committee, to sit alongside and inform its consideration of training and development	Standards committee	Nov 2022 Audit completed
R7	Governors should have the opportunity to observe NEDs in board committee meetings, in order to witness their contribution to the conduct of the meeting and the level of challenge they present to trust directors.	• Develop a proposal which supports Governors to observe Board and relevant assurance committees to provide greater oversight of board and NED activities ○ Set out clear expectation of observer role – for governors, chair, NEDs and Execs • To form part of the standards committee responsibility to develop this approach. This will be underpinned by a framework and guidance to support Governors and committee members on the expectations of how these activities will be conducted and reported	Standards committee	Jan 2023 Procedure in place and process to provide rotating observation role for governors

Ref	Recommendation	Response	Action by	Completion date
R8	The CoG should develop a clear rationale for its committee(s) and working groups and regularly revisit their effectiveness and fitness for purpose.	• CoG should set a regular review schedule for its committees and working groups, to ensure their effectiveness and whether they are still fit for purpose • The Standards committee will develop a framework and templates for this work which will set out requirements for each committee/working group to undertake and report (at least) annual self-assessment	Standards committee	Jan 2023 Template in place with reporting schedule
R2	The Trust should devise and deliver a comprehensive, topical and varied development programme each year, reflecting the needs of the governors and the Trust.	• Create a schedule of training opportunities available and update/circulate throughout the year • Informed by training audit (R1) – balance focus between technical responsibilities and qualities/behaviors (skills) • Structured programme: o Face-to-face training day o Targeted topic-based sessions o Development sessions (monthly) • The focus within the aspiration comments of the report were entirely focused on ICS • To form part of the standards committee responsibility to review, development and undertake an annual assessment of need	Standards committee	Feb 2023 Programme for 2023 prepared for CoG
R4	The Trust should support the CoG to develop a recruitment strategy, giving particular attention to the female / male ratio and BME representation among other factors.	• Look at current engagement and recruitment processes and ensure they are aligned with Trust diversity policy • Work with partners to target engagement to diverse population including ICS, Healthwatch Suffolk and voluntary organisations • Propose that this forms part of the responsibility of the engagement committee	Engagement committee	Feb 2023 Programme of engagement events, including focus on diversity

Ref	Recommendation	Response	Action by	Completion date
R5	The Trust should review the level of support it currently provides the CoG and how this may be enhanced to ensure the CoG may operate effectively and meet its statutory responsibilities.	• A measure of need and success will be progress with development and delivery of these recommendations alongside other activities of CoG • A targeted response will be taken to address the issues set out in the report: o Increase governor profile on WSH website – include bios/pictures and increase presence in other forms of communication - o staff and public • Ensure governors are invited to be involved in planning/supporting member and public events	Engagement committee	Feb 2023 Website update and procedure for governor invites in place
R6	The Trust should have a 'Policy for Engagement' between the Board and the CoG, which clearly sets out how the two bodies will interact with one another for the benefit of the Foundation Trust.	• To form part of the standards committee responsibility for development, as part of its work on practices and behaviors as well as training/development to support Governors in undertaking their role. To include: o Clarify roles and responsibilities of Board & CoG and indicate the information flow between them o Confirm the involvement of governors in forward planning o Clarify role governors play in holding NEDs to account o Set out process should governors have for concerns about Board performance, compliance with the license or welfare of the Trust o Set out process should governors have significant concerns about the performance of Chair or NEDs • Incorporate response to these points into the training programme and as part of the updated Governor Handbook (to be reviewed by the standards committee annually) • What does 'good' look like in terms of the working relationship?	Standards committee	Feb 2023 Programme for 2023 prepared for CoG

Ref	Recommendation	Response	Action by	Completion date
R3	The Trust should consider whether public governors should represent the interests of a defined geographical area within the Trust's catchment area.	• How representative of the area is our membership and our council? Based on these findings, consider what action is required • Options for this to be considered, including: ○ No further action required – existing arrangements considered adequate ○ Structure engagement events across our geography supported by a rotating set of governors ○ Develop engagement activities to cover the membership area (focused to membership numbers) ○ Allocate governors to geographical areas to have an oversight of engagement activities and needs for targeted work engagement activities (not solely responsible for delivery)	Engagement committee	May 2023 *This was felt to be a lower priority in the current climate and other priorities*

Council of Governors' review highlights opportunities for development

A governance review commissioned by the Trust's Council of Governors (CoG) has made recommendations focused on encouraging development for our governors; and building on the progress the council has made in challenging times.

The report from the Good Governance Institute (GGI) said: "There is much to commend the CoG, the chair and the executive team for their demonstrable commitment to create an effective council." The key roles of the CoG include scrutinising the strategy and actions of the Trust Board; and supporting and advising Trust executive and non-executive directors (NEDs).

Key recommendations included:

- The Trust should create a programme of continued development for all members of the council that reflects their individual knowledge, skills and experience

- With support from the Trust, the council should promote its work to the membership and agree a plan for recruitment that aims to ensure a diverse and representative CoG

- As a key responsibility for the council is to hold the NEDs individually and collectively to account for the performance of the Board, governors should have the opportunity to observe NEDs in board committee meetings.

It was noted that the governors had expressed the wish to understand how the integrated care system will operate and how the CoG will participate in system working.

- The Council of Governors includes public governors elected by the local community; staff governors elected by colleagues; and partner governors from organisations with whom we work closely, such as the county council.

  There are currently 23 members, who join for a three-year term, with the next elections scheduled for November 2023.

- You can find out more about the CoG and read the GGI report here: https://www.wsh.nhs.uk/Corporate-information/How-we-are-run/Council-of-Governors.aspx

West Suffolk NHS Foundation Trust

Council of Governors Governance Review

A report from the Good Governance Institute

October 2022

www.good-governance.org.uk

The Good Governance Institute exists to help create a fairer, better world. Our part in this is to support those who run the organisations that will affect how humanity uses resources, cares for the sick, educates future generations, develops our professionals, creates wealth, nurtures sporting excellence, inspires through the arts, communicates the news, ensures all have decent homes, transports people and goods, administers justice and the law, designs and introduces new technologies, produces and sells the food we eat - in short, all aspects of being human.

We work to make sure that organisations are run by the most talented, skilled and ethical leaders possible and work to build fair systems that consider all, use evidence, are guided by ethics and thereby take the best decisions. Good governance of all organisations, from the smallest charity to the greatest public institution, benefits society as a whole. It enables organisations to play their part in building a sustainable, better future for all.

www.good-governance.org.uk

West Suffolk NHS Foundation Trust

Council of Governors Governance Review

Document name:	Report
Date:	October 2022
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Reviewed by:	David Holden, Principal Consultant, GGI
Designed by:	Emiliano Rattin, Brand and Creative Manager, GGI

This document has been prepared by GGI Development and Research LLP. This report was commissioned by West Suffolk NHS Foundation Trust. The matters raised in this report are limited to those that came to our attention during this assignment and are not necessarily a comprehensive statement of all the opportunities or weaknesses that may exist, nor of all the improvements that may be required. GGI Development and Research LLP has taken every care to ensure that the information provided in this report is as accurate as possible, based on the information provided and documentation reviewed. However, no complete guarantee or warranty can be given regarding the advice and information contained herein. This work does not provide absolute assurance that material errors, loss or fraud do not exist.

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Executive Summary

The Good Governance Institute (GGI) was asked to undertake a governance review of the West Suffolk NHS Foundation Trust Council of Governors (CoG). The review commenced in March 2022 and concluded in August 2022. During this time, the GGI team conducted eleven interviews, three focus groups, attended by sixteen governors representing all constituencies, and attended and observed a meeting of the council of governors on 29 March 2022.

This report makes eight recommendations that seek to progress the development of the CoG over the next 12 months. Key findings from the review are as follows:

- **Working as a collective** – The trust should take the opportunity to develop a programme of continued development for all members of the council that reflect their individual knowledge, skills and experience.
- **A diverse and representative council** – With support from the trust, the council should promote its work to the membership and agree a plan for recruitment that aims to ensure a diverse and representative CoG.
- **Holding non-executive directors to account** – A key responsibility for the council is to hold the nonexecutive directors individually and collectively to account for the performance of the board. Governors should have the opportunity to observe NEDs in board committee meetings in order to witness their contribution to the conduct of the meeting and the level of challenge they present to trust executive directors.

The last two years have been an exceptional time for the NHS and West Suffolk NHS FT, a time during which the trust and the council have experienced significant change and considerable challenge. In our view, there is much to commend the CoG, the chair and the executive team for their demonstrable commitment to create an effective council.

The tasks set for governors are difficult to fulfil. There is no single model that works across the range of different types, and the scales of foundation trusts and integrated care systems (ICSs) are a new challenge. When asked to identify aspirations for the CoG over the next 12 months, governors expressed the wish to understand how the integrated care system will operate and how the CoG will participate in system working.

It is hoped the recommendations made in this report build on the progress that has been made to date and offers an opportunity for the work of the council to continue its contribution to the success of the trust.

Recommendations

R1.	Members of the CoG are at different levels in terms of their understanding of what their roles and responsibilities are. The trust should undertake a governor knowledge and skills audit to inform the governor development programme for the forthcoming year. The survey could also be an opportunity for governors to highlight specific areas of interest they have in the trust.
R2.	The trust should devise and deliver a comprehensive, topical and varied development programme each year reflecting the needs of the governors and the trust.
R3.	The trust should consider whether public governors should represent the interests of a defined geographical area within the trust's catchment area.
R4.	The trust should support the council to develop a recruitment strategy, giving particular attention to the female/male ratio and BME representation, among other factors.
R5.	The trust should review the level of support it currently provides the CoG and how this may be enhanced to ensure the council operates effectively and meets its statutory responsibilities.
R6.	Every foundation trust should have a Policy for Engagement between the trust board and the council of governors, which clearly sets out how the two bodies will interact with one another for the benefit of the trust.
R7.	Governors should have the opportunity to observe NEDs in board committee meetings in order to witness their contribution to the conduct of the meeting and the level of challenge they present to trust directors. The governor observing the meeting would be expected to report key issues discussed at the board committee meeting at the next CoG meeting.
R8.	The CoG should develop a clear rationale for its committee(s) and working groups and regularly revisit their effectiveness and fitness for purpose.

1. Methodology and scope

The main activities undertaken as part of the assessment were as follows:

- A series of interviews with members of the trust and CoG, including the lead governor, as well as those who regularly engage with the council, such as board members.

GGI conducted twelve interviews. Each participant was invited to offer their individual views and experiences of working with the trust and CoG and to suggest how the governance and effectiveness of the CoG might be enhanced. A list of those interviewed is reported in Appendix One.

- Focus groups to include all CoG members

Members of the CoG were asked to complete a questionnaire based on the GGI Council of Governors Maturity Matrix. The results of the questionnaire, completed by sixteen members of the CoG, were discussed at three virtual focus group meetings. Attendees were presented with findings from the questionnaire and asked to identify action to be taken to progress the maturity of the CoG over the next twelve months. A copy of the GGI Council of Governors Maturity Matrix is included in Appendix Two.

- Observation of a CoG meeting

A meeting observation provides the opportunity for GGI to witness individual member contributions and behaviours, as well as review the accuracy, brevity and clarity of meeting papers and assess the overall effectiveness of the meeting in relation to its stated terms of reference. GGI attended and observed a CoG meeting held on 29 March 2022.

- Document review and research

A review of any previous external review documentation that is relevant to the assessment, CoG meeting papers and Terms of Reference (ToR), relevant trust policies and procedures, and others as agreed with the interim trust secretary.

- Benchmarking

GGI has been reviewing NHS organisations for more than a decade, and we have drawn on the learning from our work with governors in a range of trusts to give credibility to our findings and recommendations.

2. Council of Governors Maturity Matrix

The maturity matrix to support the development and improvement of a council of governors (CoG) is a practical, developmental tool which provides a structured means of assessing performance against a range of indicators. A copy of the maturity matrix is set out in Appendix One.

Key elements and levels of progress defi ned in the tool are based on knowledge and evidence gained from work undertaken by GGI in the health sector in the UK, with the support from University Hospitals Birmingham NHS Foundation Trust and Heart of England NHS Foundation Trust. The matrix is intended to be used either as a framework for reflective self-assessment, or as part of an independent assessment of the effectiveness of a CoG, whether to meet statutory requirements or to provide a stock-take for other reasons.

The matrix allows progress to be assessed in a nuanced, consistent and effective way over time. For example, an initial assessment will provide a clear indicator of the relative maturity of development. The trust can then put in place a developmental programme intended to strengthen the effectiveness of the CoG over a longer period.

The matrix is structured around six themes and five levels of maturity, which represent the main building blocks of effective development and improvement of a CoG. Each level sets out statements against which an assessment can be made. These levels are progressive in terms of maturity from basic to exemplar. A single assessment is made for each theme based on an assessment of maturity.

The score, or range, indicates the level of achievement that respondents consider the CoG has currently reached. Results from the self-assessment were presented at three focus group meetings. During the focus group meetings, respondents were asked to review the results of the self-assessment for each theme and suggest what action should be taken to improve the maturity and effectiveness of the CoG.

A summary of the results from the self-assessment of each theme is set out below.

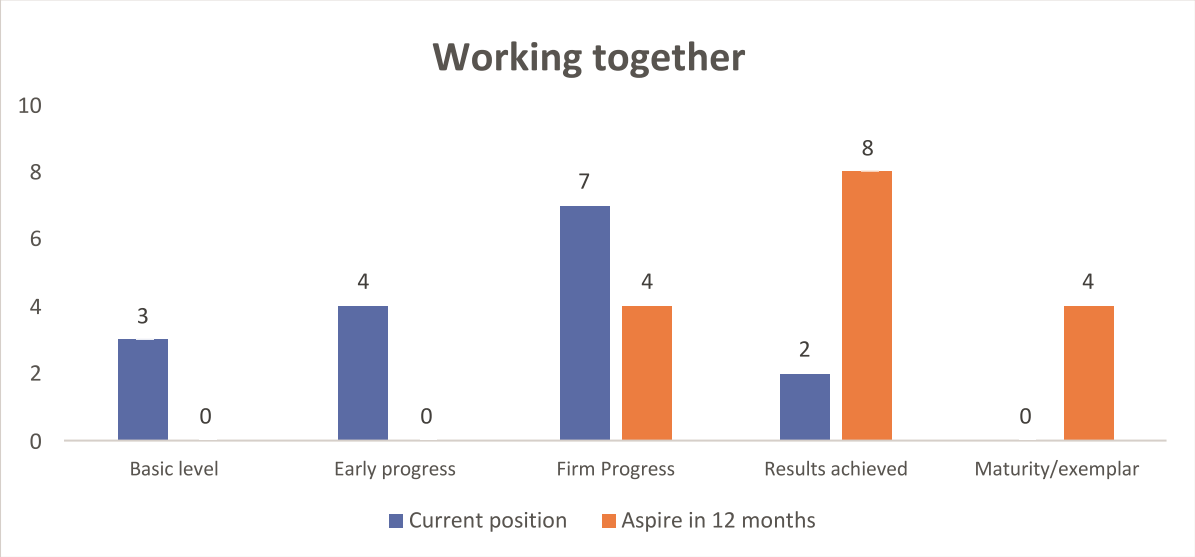
2.1 Working together

The CoG is the collective body through which executive and non-executive directors explain and justify their actions. It works closely with the trust board to make sure services meet the needs of the local community. In order to operate as an effective collective, all members of the CoG should have the opportunity to reflect on their joint purpose and understand their roles and responsibilities. All members of the CoG should be comfortable working as a collective and can bring challenges where necessary and seek proactive solutions when challenges arise.

Members of the council were asked to rate and comment on the level of progress the CoG has made in the way it works as a collective and identify what action the CoG should take over the next twelve months to improve. The results of the survey are set out in Table One.

Table One: Working Together

0	Basic	Early Progress	Firm Progress	Results being achieved	Maturity / Exemplar
	Council members are familiar with one another and had both formal and informal opportunities to interact.	Council members can reflect collectively on their joint purpose and understand their roles and responsibilities.	Council members can bring challenges at formal and informal meetings and are vocal on matters concerning their duties and responsibilities.	Council members are comfortable working as a collective, bring challenges where necessary and seek proactive solutions when challenges arise.	All Council members are comfortable challenging each other and have a thorough understanding of their duties and responsibilities. They are vocal and proactively involved in the wider life of the trust.



- The pandemic prevented the CoG meeting in-person. Governors have not yet been able to get into the organisation, walk around, meet patients, meet staff and get a feel for what is going on.
- At times, some governors said they felt isolated. The trust and the CoG need to start working together as a team, get to know and work to understand each other.
- Virtual meetings work well for training and briefing events and attendance at such events has increased during the pandemic. Where there is a need for discussion and debate it is better to hold those meetings in person. For members of the council that have other commitments, the use of virtual meetings has enabled access to more meetings.
- Members of the CoG are at different levels in terms of their understanding of what their roles and responsibilities are.
- Some governors questioned how the council could operate as a collective and build consensus during a virtual meeting when it can be difficult to ensure all members have the opportunity to be heard.
- Informal meetings between governors and NEDs before the pandemic were very useful and governors welcomed the opportunity to re-establish those meetings when it was safe to do so.
- Governors commented the organisation had gone from being a trust that was recognised externally as having great strengths, to a trust that has huge challenges.
- The trust needs to do more to recognise and value the skills, knowledge and experience that all governors bring to the council. The trust needs to nurture the potential that all governors have to offer, and in doing so, they will become more effective in meeting their statutory roles and responsibilities.
- The council needs to be more proactive and more involved in decisions being taken by the trust. Some governors felt the trust did not provide enough opportunity for all governors to ask questions and feel they have been heard.
- Governors need to be kept more informed. Governor's act as an interface between the community and the trust. For example, governors stated; how can governors represent the interests of the communities they represent if the trust does not keep its governors as informed as they should?

- New governors had a two-day online induction. The monthly briefings have been particularly helpful.
- The trust has facilitated training and development for its governors over the course of the last year using materials and resources from NHS Providers. The trust received good feedback from governors.
- Collective responsibility and collective behaviours are very important.

Recommendations

R1. Members of the CoG are at different levels in terms of their understanding of what their roles and responsibilities are. The trust should undertake a governor knowledge and skills audit to inform the governor development programme for the forthcoming year. The survey could also be an opportunity for governors to highlight specific areas of interest they have in the trust.

R2. The trust should devise and deliver a comprehensive, topical and varied development programme each year reflecting the needs of the governors and the trust.

2.2 Council Size and Agility

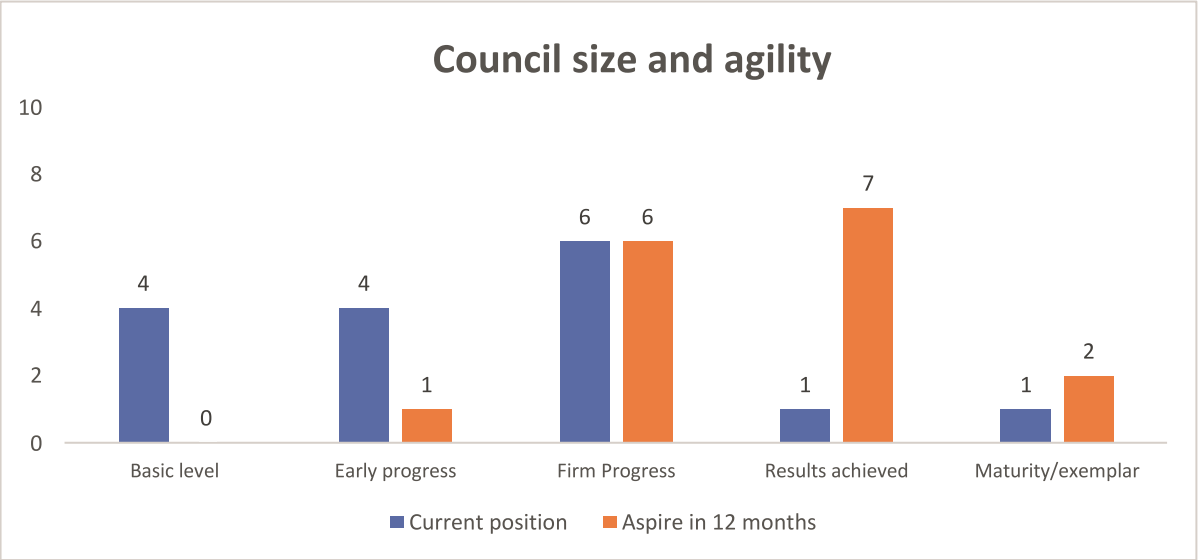
NHS foundation trusts were created with a governance structure designed to ensure that people from the communities served by the trusts can take part in governing them. NHS foundation trust governors are the direct representatives of local communities. Governors do not manage the operations of the trusts; rather, they challenge the board of directors and hold the non-executive directors to account for the performance of the board. Governors also represent the interests of NHS foundation trust members and the public and provide them with information on the trust's performance and forward plan.

The Health and Social Care Act 2012 specifies that publicly elected governors must form a majority on the CoG. There must be at least three staff governors and one governor appointed by a local authority. The composition of the council of governors is decided locally by a trust whilst ensuring that the balance of staff, public and appointed governors is maintained. The council of governors should not be so large as to be unwieldy. The council of governors should be of sufficient size for the requirements of its duties. The trust's CoG is represented by twenty-six governors, fourteen public governors, five staff governors and seven appointed governors from partner organisations. A CoG should have an appropriate level of representation where every member is felt to add value and there is sufficient capacity for effective decision making from appointed and elected governors.

Members of the council were asked to rate and comment on the level of progress made by the council to review its size and agility and identify what action the CoG should take over the next twelve months. The results of the survey are set out in Table Two.

Table Two: Council size and agility

0	Basic	Early Progress	Firm Progress	Results being achieved	Maturity / Exemplar
	The council has been established as a collective.	The council has given thought to how public and appointed governors are split and represented.	The council has reflected on the implication of size on decision-making and found an appropriate ratio of representation.	The council has reached an appropriate level of representation where every member is felt to add value.	The council's size falls within the sector average. There is a dedication to community representation and effective decision-making from both appointed and elected governors.



- A working group reviewed the size of the CoG and level of representation as part of a review of the trust's constitution.
- The present size of the CoG is considered to work well where every member has the opportunity to participate.
- Governors knew of other trusts with much larger councils who often find it difficult to reach a consensus of opinion as a CoG.
- When a governor is elected, they stand as a public governor, not as a governor for a specific area.
- Historically, most of the staff governors have had a clinical background and corporate services have been under-represented. The council needs a greater breadth of representation from all staff groups in the trust.

Recommendations

R3. The trust should consider whether public governors should represent the interests of a defined geographical area within the trust catchment area.

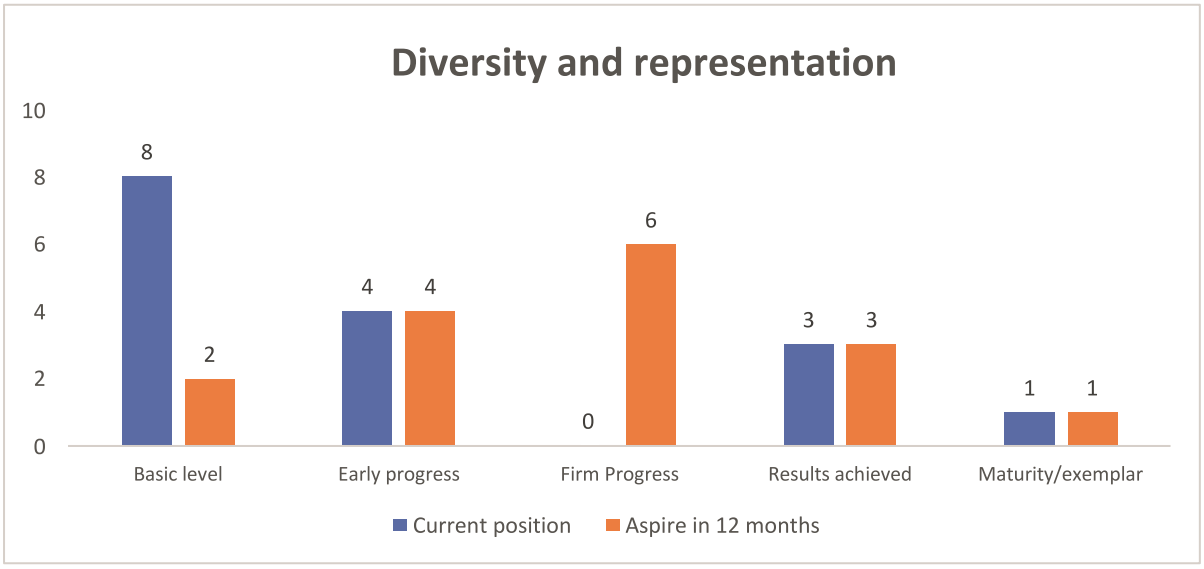
2.3 Diversity and representation

The council should recruit and retain a diverse membership with consideration of the female/male ratio and ethnic minority representation that reflects the cultural and ethnic diversity of the communities the trust serves.

Members of the council were asked to rate and comment on the level of progress made by the council to develop a diverse and representative membership and identify what action the CoG should take over the next twelve months to review the size and composition of the CoG. The results of the survey are set out in Table Three.

Table Three: Diversity and representation

0	Basic	Early Progress	Firm Progress	Results being achieved	Maturity / Exemplar
	The council recruits members from its pool of applicants.	The council has thought about, and is actively developing, its wider recruitment strategy, including age, gender, and BME-related representation.	The council has developed its recruitment strategy, giving particular attention to the female/male ratio and BME representation among other factors.	The council can recruit and retain diverse members of the community.	The council has reached a level of representation and diversity that is roughly representative of the community it serves.



The trust is due to appoint three non-executive directors in September and it is hoped that there is an opportunity to increase the levels of diversity and likewise, there needs to be a greater level of diversity within the CoG.

- There is a genuine question as to what extent the CoG is representative of the trust's population across a whole list of demographics, whether that is ethnicity, age, disability status and so on. More needs to be done in the longer term to improve the public's awareness of what governors do and to improve the diversity of the council.
- The trust needs to do more to promote the role of governors in the trust and the work they do to represent their communities.
- The process of appointing governors relies on members putting their names forward. The trust and the council need to broaden the visibility of governors and their role by any means possible. This must be a priority for the engagement committee.
- The trust is due to upload the profile and pictures of its CoG on the public website.
- Greater engagement with members of the public will help to raise awareness of the role of governors in the trust.
- The council is said to be poor on diversity and could do better. It is considered by some to be a poor excuse to say the council reflects its community.
- The trust does not have a diverse enough group of non-executive directors or CoG. There needs to be a particular focus on how the trust recruits governors at the next round of governor appointments. The trust should target ethnic communities around the west of Suffolk. For example, we heard that the local population has areas of Filipino and Portuguese communities. Some of these minority groups work in the trust.
- The trust needs to consider how it can recruit more working age governors and encourage younger people to become involved in the work of the CoG, for example, working with West Suffolk College. People wishing to stand as a governor should be informed of the level of commitment that is required to fulfil the roles and responsibilities of a governor.
- Whilst it is noted that West Suffolk is largely a white community. That does not mean the trust should not engage with all members of the community, especially those groups that are hard to reach. If the council is to encourage people to stand as governors, it needs the support of the trust to promote the work of governors and the council.

Recommendations

R4. The trust should support the council to develop a recruitment strategy, giving particular attention to the female/male ratio and BME representation among other factors.

2.4 Public and membership engagement

Robust governance structures that encourage proper engagement with stakeholders and strong local accountability will help foundation trusts to maintain the trust and confidence of the people and communities that they serve. The role of the CoG is to work alongside the board of directors holding non-executive directors to account for the performance of the board. The council also has a statutory duty to represent the interests of the trust members who elected them and the public. To be able to meet its statutory responsibilities, there must be effective engagement between the council and those it represents, the members and the public. This must be a two-way process:

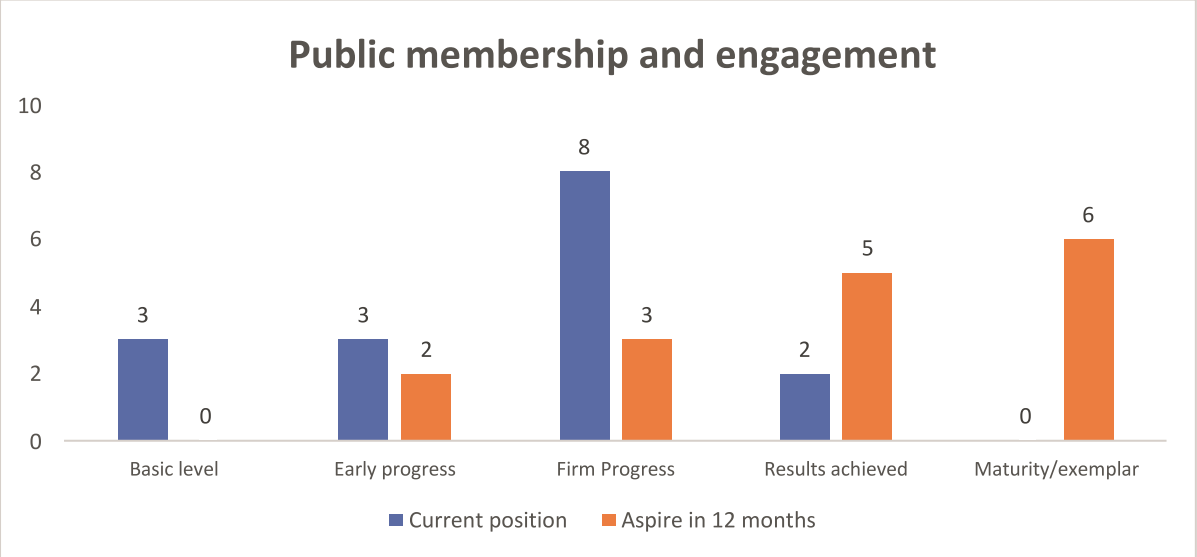
- from governors to public members, staff and the general public, in order to raise awareness of the role of governors, provide updates on the work being done and the outcomes achieved and to encourage membership growth and involvement.

- to governors from staff and public members, and the general public, in order to provide intelligence which will then be used to facilitate governor challenge of non-executive directors, to inform the board and provide insights to inform service development opportunities.

Members of the council were asked to rate and comment on the level of progress the CoG had made to engage with its membership, staff and the general public and the level to which the CoG should aspire over the next twelve months. The results of the survey are set out in Table Four.

Table Four: Public and membership engagement

0	Basic	Early Progress	Firm Progress	Results being achieved	Maturity / Exemplar
	The council is aware of the need to engage with staff, patient membership and the wider public and stakeholders.	The council holds annual or bi-annual events to raise visibility and attends local and community events where appropriate.	The council has started developing an engagement strategy, thinking of creative ways to interact with its membership and the wider public.	The council has developed a sustainable engagement strategy that allows governors to interact with its membership and the public (including attending ward rounds, meeting staff and attending community and stakeholder events).	The council has a sustainable and long-term engagement strategy that has attracted diverse membership and a steady flow of candidates for prospective governors. Governor profiles are known to the community and stakeholder organisations.



- The pandemic has prevented the council from holding events with its membership and the wider public.
- A lot of the mechanisms for engagement are based on the membership and the membership is based on the users of the hospital so, by definition, that is not representative of the local population. There is a need to look outside its membership.
- The ICS offers an opportunity for a systems approach to engagement that would include local authorities and other system partners.
- The Medicine Matters Meetings were enormously successful and well attended.
- A way to help people engage better is to hold focus groups to co-produce strategies with the trust.
- There are five staff governors and around 4,500 staff. Despite support received in the past from colleagues in the community, it can be difficult to represent all staff groups.
- There is a whole programme of work that the trust has branded as the future systems programme. It is not just about a new hospital; it is about a new pattern of healthcare provision that properly utilises or delivers healthcare within a community setting. It is a multi-year programme. The trust needs to get the community involved and governors are an important part of that. The trust has governor representation on working groups for the future system programme, and there are regular updates where the programme director comes and talks to the governors.

- The CoG engagement committee has a new chair. The council is working to provide more information about governors and the work they do on the trust's website.

  The trust should continue to provide support to assist the CoG with promoting the work of the council and promoting engagement with the membership.
- Despite providing governor profile information to the trust in February this year, governors are still waiting for the trust website to be updated to advise of governor profiles and the work they undertake.
- A small minority of governors expressed the opinion that the communications team did not understand or sufficiently support the work of the CoG. The CoG cannot progress the work for which it is responsible without the support of the trust's communications team. However, it was stated that the director responsible for communications was very supportive.

Recommendations

R5. The trust should review the level of support it currently provides the CoG and how this may be enhanced to ensure the council operates effectively and meets its statutory responsibilities.

Examples of support required include the following:

- Updating the trust website to include biography/profile information for each governor, in order that each governor's profile is known to community and stakeholder organisations.
- Supporting the planning and delivery of member and public events.
- Keeping governors informed on matters developing in the trust that may become subject to wider public interest.

2.5 Engagement with the non-executive directors

There is no one "right way" to hold non-executive directors to account and local approaches are emerging that include:

- appointing or removing the chair, non-executive directors or auditors
- questioning non-executive directors on how the board is delivering on the goals identified in the forward plan
- inviting members of the board to meetings of the council of governors to answer questions

The following are key principles that should guide a governor's understanding of what it means to hold nonexecutive directors to account:

- The overall responsibility for running an NHS foundation trust lies with the board of directors.
- The council of governors is the collective body through which the directors explain and justify their actions, and the council should not seek to become involved in running the trust.
- Governors must act in the best interests of the NHS foundation trust and should adhere to its values and code of conduct.
- Directors are responsible and accountable for the performance of the foundation trust; governors do not take on this responsibility or accountability. This is reflected in the fact that directors are paid while governors are volunteers.

To hold the non-executives individually to account:

- Receive performance information for the chair and other non-executive directors as part of a performance appraisal process, as well as to inform decisions on remuneration terms for the chair and the other nonexecutive directors.
- Observe the contributions of the non-executive directors at board and committee meetings and during meetings with governors.

To hold the non-executive directors collectively to account:

- Receive the quality report and accounts and question the non-executives on their content.
- Ask about the CQC's judgements on the quality of care provided by the trust.

- Receive in-year information updates from the board of directors and question the non-executives on their content, including the performance of the trust against the goals of the forward plan.

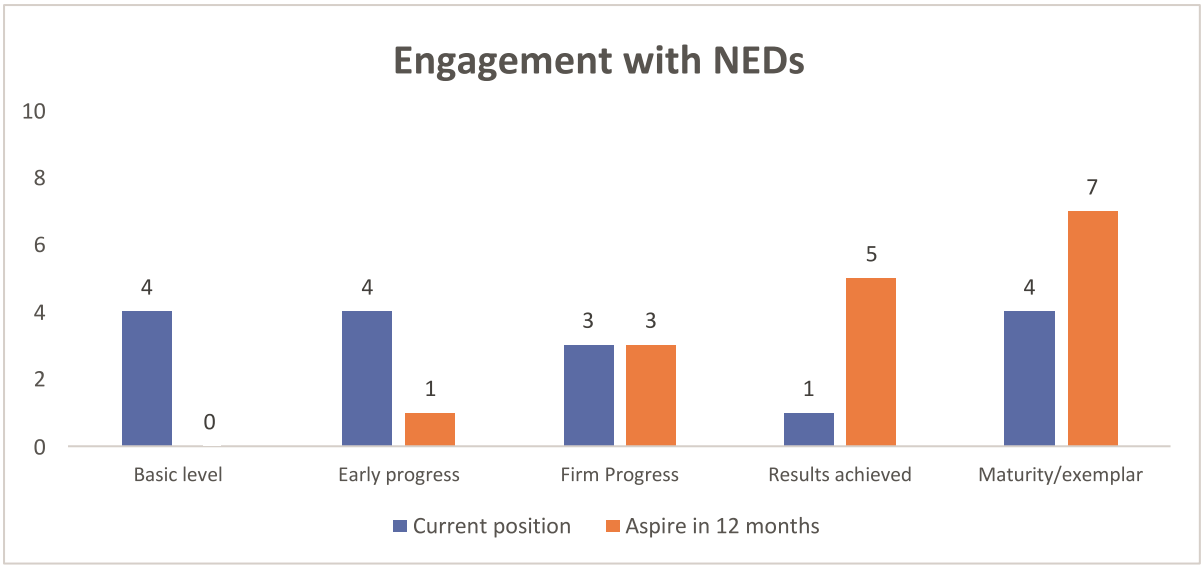
Invite the chief executive and/or other executive and non-executive directors to attend council of governors meetings as appropriate and use these opportunities to ask them questions.

- Engage with the non-executive directors to share concerns, such as by way of joint meetings between the council of governors and non-executive directors.
- Receive information on proposed significant transactions, mergers, acquisitions, separations or dissolutions and question the non-executives on the board's decision-making processes, and then, if satisfied, approve the proposal.
- Receive information on documents relating to non-NHS income, in particular, any proposal to increase the proportion of the trust's income earned from non-NHS work by 5% a year or more and question the nonexecutives on the board's decision-making processes; then, if satisfied, approve the proposal.

Members of the council were asked to rate and comment on the level of progress the CoG had made engaging with non-executive directors and the level to which the CoG should aspire over the next twelve months. The results of the survey are set out in Table Five.

Table Five: Engagement with the non-executive directors

0	Basic	Early Progress	Firm Progress	Results being achieved	Maturity / Exemplar
	The governors have met the NEDs in formal settings or meetings.	The governors can interact with the NEDs informally (during ward rounds or Q&A events), and they also work together in formal settings during council meetings. Governors are invited and encouraged to attend sub-committees of the board.	The governors engage with the NEDs both in formal and informal settings. They interact with the NEDs in formal meetings of the council and attend sub-committees of the board.	The governors can engage with the NEDs, collectively and individually, and are able to bring challenges when necessary.	The governors have a professional working relationship with the NEDs and feel comfortable challenging them on matters relating to board effectiveness.



Prior to the pandemic, the trust held quality walkabouts every Tuesday morning where a governor, a nonexecutive and an executive director would visit an area in the organisation and share reflections after the visit. It was a valuable and valued activity that needs to be started again.

- Governors do not have the opportunity to observe NEDs in board committee meetings and therefore it is difficult to take a view as to their contribution to the conduct of the meeting and the level of challenge they present to trust directors.
- Governors need to have the information in their hands in order to challenge NEDs. In the past, governors have not always received the information they need; however, it is reported to be getting better.
- The trust needs to engage with its governors, make use of their skills and experience and engage with them so they may collectively and individually bring challenge when necessary.

Recommendations

R6. Every foundation trust should have a Policy for Engagement between the trust board and the council of governors, which clearly sets out how the two bodies will interact with one another for the benefit of the trust.

The purpose of a policy for engagement is to:

- Clarify the respective roles and responsibilities of the board and the council of governors and describes the information flow between the two groups.
- Describe the involvement of governors in forward planning, and the role they play in respect of holding non-executive directors to account.
- Set out a process should governors have a concern about the performance of the board, ensuring compliance with the licence or the welfare of the trust.
- Describe the process should governors have significant concerns about the performance of the chair or non-executive directors.

R7. Governors should have the opportunity to observe NEDs in board committee meetings in order to witness their contributions to the conduct of the meeting and the level of challenge they present to trust directors. The governor observing the meeting would be expected to report key issues discussed at the board committee meeting at the next CoG meeting.

2.6 Council of governors' committees

Trusts and governors may choose to have working groups and sub-committees on which governors may sit to help in specific areas of work, such as audit and finance, recruitment, patient experience and membership committees. The full council should set the terms of reference of such working groups and sub-committees, including how governors are elected or appointed to the group. The council of governors has no power of delegation, so governor working groups and committees can make recommendations to and advise the full council but cannot make decisions on its behalf.

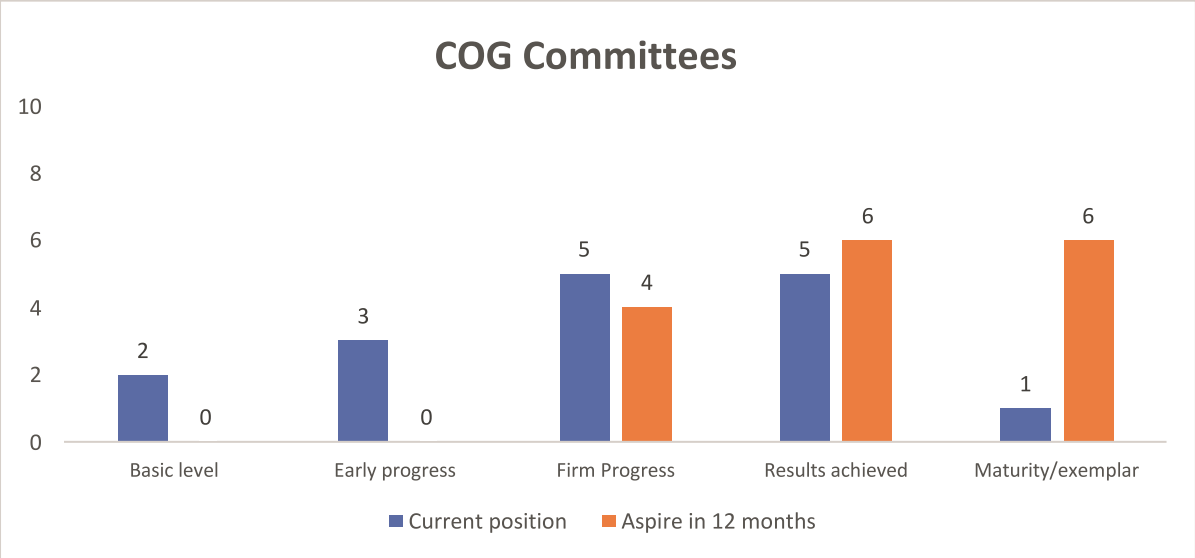
Some trusts have found it helpful to set up a variety of governor working groups where governors can contribute and add value. It is up to each NHS foundation trust to decide which governor working groups it would like to have in place and which topics these cover. Examples of groups some trusts have included:

- clinical quality
- membership strategy and engagement
- strategic planning and policy
- patient experience
- auditor appointment

Members of the council were asked to rate and comment on the level of progress the CoG had made with setting up and running sub-committees and working groups, and the level to which the CoG should aspire over the next twelve months. The results of the survey are set out in Table Six.

Table Six: Council of governor committees

0	Basic	Early Progress	Firm Progress	Results being achieved	Maturity / Exemplar
	The council has reflected on the effectiveness of committees and working groups in achieving its aims.	The council has set up committee(s) and working groups where necessary.	The council has set up committee(s) and working groups where necessary, considering the best use of the governors' time (including attending board sub-committees and community events).	The council has committee(s) that are closely in line with governors' duties. Working groups (where they exist) complement the wider duties and development of governors.	The council has a clear rationale for its committee(s) and working groups and regularly revisits their effectiveness and fitness for purpose.



- Every member of the CoG should have the opportunity to attend and participate in a committee of the CoG. All governors should be given the opportunity to observe the board and committees of the board.
- The monthly briefing sessions are relatively new, but they have been very worthwhile and a welcome addition to helping governors understand the trust. It is understood the briefing sessions will continue on a bi-monthly basis.
- Staff governors have their own informal meeting with the trust. The meeting is attended by the director of workforce and communications, and the lead governor, who reports back to the CoG.
- The ICS is at the developmental stage. There should be room for CoG representation on the integrated care partnership (ICP). CoG representation on the ICP can report back to each CoG and the alliances where the community engagement is.
- One governor sits on the ICP for Suffolk County Council (SNI/SNEE) and would be happy to take forward action to arrange CoG representation on the ICP.
- The CoG has a good range of committees with good representation on them. The committees of the CoG are effective; however, the CoG should review their effectiveness and fitness for purpose.
- Informal working groups that focus on specific projects, for example, the West Suffolk Review, offer an opportunity for governors to get involved in work alongside hospital staff and other patient and service user representatives.

Recommendations

R8. The CoG should develop a clear rationale for its committee(s) and working groups and regularly revisit their effectiveness and fitness for purpose.

3. Aspiration for the role of the council of governors

When asked to identify aspirations for the CoG over the next twelve months, the following comments were made:

- "The council of governors need to be active in developing their individual and collective understanding of the ICS at each stage of progression. A starting point could be a specific agenda item at each council, perhaps with an update presentation of key developments."
- "Governors should be able to contribute to the ICS and make suggestions as to the way integrated care can work in the community."
- "There is a lack of clarity on where the council of governors sits in relation to the ICS. Will its input be significant?"
- "I would like to meet other CoGs across the ICS and share ideas to ensure the ICS is fully engaged with its CoG representatives and their role in the organisation's development to a full ICS and beyond."
- "I would like to see representation from the CoG on ICS boards/committees. At the very least, we should be able to observe them."

All comments focused on how the trust will support the CoG in developing its understanding of the ICS, how it will operate and what role the CoG will play in its future development and work.

Appendix One

Interviews:

- Jeremy Over – Executive Director of Workforce and Communications
- Clive Wilson – Public Governor
- Louisa Pepper – Non-Executive Director
- Craig Black – Interim Chief Executive
- Florence Bevan – Public Governor
- Alan Rose – Non-Executive Director
- Richard Davies – Non-Executive Director
- Jude Chin – Interim Chair
- Chris Lawrence – Non-Executive Director
- Liz Steele – Public Governor
- Ben Lord – Public Governor Observations:

- Council of Governors Meeting (March 2022) Documentation reviewed:

- West Suffolk Review Report
- West Suffolk Review Terms of Reference
- WSR Ministerial Statement
- FTSU Review Summary for the Private Board
- Governors Work Programme 2022-2023
- WSFT Constitution December 2021

Appendix Two

Good Governance Institute

COUNCIL OF GOVERNORS MATURITY MATRIX

VERSION 1.0 FEBRUARY 2017

PROGRESS LEVELS / KEY ELEMENTS	0 No	1 BASIC LEVEL	2 EARLY PROGRESS	3 FIRM PROGRESS	4 RESULTS BEING ACHIEVED	5 MATURITY/EXEMPLAR
WORKING TOGETHER		Council members are familiar with one another and had both formal and informal opportunities to interact.	Council members are able to reflect collectively on their joint purpose and have an understanding of their roles and responsibilities.	Council members are able to bring challenge at formal and informal meetings and are vocal on matters concerning their duties and responsibilities.	Council members are comfortable working as a collective, bring challenge where necessary and seek proactive solutions when challenges arise.	All Council members are comfortable to challenge each other and have a thorough understanding of their duties and responsibilities. They are vocal and proactively involved in the wider life of the Trust.
COUNCIL SIZE AND AGILITY		The Council has been established as a collective.	The Council has given thought to how public and appointed governors are split and represented.	The Council has reflected about the implication of size on decision-making and found an appropriate ratio of representation.	The Council has reached an appropriate level of representation where every member is felt to add value.	The Council's size falls within the sector average. There is a to community representation and effective decision-making from both appointed and elected governors.
DIVERSITY AND REPRESENTATION		The Council recruits members from its pool of applicants.	The Council has thought about and is actively developing its wider recruitment strategy including age, gender, and BME-related representation.	The Council has developed its recruitment strategy, giving particular attention to the female/male ratio and BME representation among other factors.	The Council is able to recruit and retain diverse members of the community.	The Council has reached a level of representation and diversity that is roughly representative of the community it serves.
PUBLIC AND MEMBERSHIP ENGAGEMENT		The Council is aware of the need to engage with the staff and patient membership and the wider public and stakeholders.	The Council holds annual or bi-annual events to raise visibility and attends local and community events where appropriate.	The Council has started developing an engagement strategy, thinking of creative and ways to interact with its membership and the wider public.	The Council has developed a sustainable engagement strategy that allows Governors to interact with its membership and the public (including attending ward rounds, meeting staff, attending community and stakeholder events).	The Council has a sustainable and long-term engagement strategy that has attracted diverse membership and a steady flow of candidates for prospective governors. Governors' profile is known to community and stakeholder organisations.
ENGAGEMENT WITH THE NEDs		The Governors have met the NEDs in formal settings or meetings.	The Governors are able to interact with the NEDs informally (during ward rounds or Q&A events), they also work together in formal settings during Council meetings. Governors are invited and encouraged to attend sub-committees of the Board.	The Governors engage with the NEDs both in formal and informal settings. They interact with the NEDs in formal meetings of the Council and attend sub-committees of the Board.	The Governors are able to engage with the NEDs, collectively and individually, and are able to bring challenge when necessary.	The Governors have a professional working relationship with the NEDs and feel comfortable to challenge them on matters relating to Board effectiveness.
CoG COMMITTEES		The Council has reflected on effectiveness of committees and working groups in achieving its aims.	The Council has set up committee(s) and working groups where necessary.	The Council has set up committee(s) and working groups where necessary taking into account the best use of Governors' time (including attending Board sub-committees and community events).	The Council has committee(s) that are closely in line with Governors' duties. Working groups (where they exist) complement the wider duties and development of governors.	The Council has a clear rationale for its committee(s) and working groups and regularly revisits their effectiveness and fitness for purpose.

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