NHS
West Suffolk
NHS Foundation Trust

Board of Directors (In Public)

Schedule	Friday 27 May 2022, 9:15 AM — 12:30 PM BST
Venue	Ashlar House, 23 Eastern Way, Bury St Edmunds IP32 7AB
Description	A meeting of the Board of Directors will take place on Friday, 27 March 2022 at 9:15am.
Organiser	Karen McHugh

Agenda

AGENDA

_WSFT Public Board Agenda - 27 May 2022.docx

1. GENERAL BUSINESS

1.1. Apologies for absence: Clement Mawoyo (Gylda Nunn deputising)
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 - 25 March 2022
To Approve - Presented by Jude Chin

Item 1.3 - Open Board Minutes 2022 03 25 March Draft.docx

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

Item 1.4 - Matters Arising - Open.pdf

Item 1.4 - Matters Arising - Closed.pdf

1.5. Patient story
To Note - Presented by Susan Wilkinson

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

1.7. Chief Executive's report
To inform - Presented by Craig Black

Item 1.7 - CEO Board report - May 2022 FINAL.docx

2. CULTURE

2.1. People & OD highlight report
- Freedom to Speak Up Guardian
To Assure - Presented by Jeremy Over and Amanda Bennett

Item 2.1 - People OD highlight May 2022.docx

3. STRATEGY

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

Item 3.1 - WSFT Future System public board June 2022.docx

Comfort Break

4. ASSURANCE

4.1. Insight Committee Report - April & May 2022 - Chair's Key Issues from the meeting
To Assure - Presented by Richard Davies

Item 4.1 - Insights Chairs key issues - April May 2022 meetings.pdf

4.2. Finance and Workforce Report
To Note - Presented by Nick Macdonald

Item 4.2 - Finance_Board_Report_front sheet_M1_2223_Final.docx

Item 4.2 - Finance Report- April 2022_Final.docx

4.3. IQPR

To Note - Presented by Susan Wilkinson and Nicola Cottington

Item 4.3 - IQPR Board report March 2022 V3.pptx

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

To Assure - Presented by Jude Chin

Item 4.4 - Chairs key issues - Improvement Committee report for board - April 2022.docx

Item 4.4 - Chairs key issues - Improvement Committee - May 2022.docx

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4.5. Quality and Nurse Staffing Report

To Assure - Presented by Susan Wilkinson

Item 4.5 - Quality and Nurse staffing report March April 2022.docx

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4.6. Maternity services quality & performance report

To Assure - Presented by Susan Wilkinson and Karen Newbury

Item 4.6 - May 2022 Maternity Quality Safety Perfomance Board Report v2..docx

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

To Assure - Presented by Alan Rose

Item 4.7 - Chair's Key Issues - Involvement Comm May2022.docx

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5. GOVERNANCE

5.1. BAF Summary and risk report

To Assure - Presented by Richard Jones

Item 5.1 - BAF Summary and Risk Report (003).docx

5.2. Governance report

To inform - Presented by Richard Jones

Item 5.2 - Governance Report.docx

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6. OTHER ITEMS

6.1. Any other business
To Note

6.2. Reflections on meeting
For Discussion

6.3. Date of next meeting - 22 July 2022
To Note - Presented by Jude Chin

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

Annexes for information:

To inform

- Item 2.1 - Appendix 1 FTSU.docx.doc
- Item 2.1 - Appendix 2 SS2021.docx
- Item 4.6 Annex C - 2021-22 ATAIN Quarter 4 Jan-March 2022 progress report.pdf
- Item 4.6 Annex D - Report on Anaesthetic Staffing within Maternity Services 22.docx
- Item 4.6 Annex E - Audit Consultant Ward Rounds - High risk women admitted to Labour Suite 22 v2.docx
- Item 4.6 Annex F - Maternity HSIB and Early Notification ReportingQ4 22 v2.docx
- Item 4.6 Annex G - Compliance with Saving Babies Lives V2 Assessing Smoking Status 22 v2.docx
- Item 4.6 Annex H - 05.22 Audit of Compliance with Element 2 Assessment of Risks for Fetal Growth Restriction in Pregnancy.docx
- Item 4.6 Annex I - 05.22 Audit report - Women with a BMI 35 at booking being offered serial growth scans.docx
- Item 4.6 Annex J - 05.22 Audit of Compliance with Element 3 Reduced Fetal Movements Best Practice Guidance v2.docx
- Item 4.6 Annex K - 05.22 Response to the Royal College of Obstetricians and Gynaecologists (RCOG) Recommendations from the Publication June 2021.docx
- Item 4.6 Annex L - 05.22 Paed staffing submitted for approval 21_22_030522.docx
- Item 4.6 Annex M - 05.22 Q4 Neonatal Transitional care Report January - March 2022 FINAL 2.docx
- Item 4.6 Annex N - 22 Training needs analysis and trackerQ4.pptx
- Item 4.6 Annex O - Midwifery Staffing Report May 2022 Final (002).docx
- Item 4.6 Annex P - Review of Maternity CoC Roll Out Plans May 2022 - Final Version.pdf
- Item 4.6 Annex Q - EoE ODN Workforce Template V1 (002) 05.22.docx

AGENDA

WSFT Board of Directors – Public Meeting

Date and Time	Friday, 27 May 2022 9:15 – 12:45
Venue	Ashlar House, 23 Eastern Way, Bury St Edmunds IP32 7AB

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 – 25 March 2022**	Chair	Approve	Report
	1.4	**Action log and matters arising**	All	Review	Report
09:20	1.5	**Patient Story**	Sue Wilkinson	Note	Verbal
	1.6	**Questions from Governors and the Public**	Chair	Note	Verbal
09:50	1.7	**CEO Report**	CEO	Inform	Report
2.0 CULTURE					
10.00	2.1	**People and OD Highlight report** • **Freedom to speak up guardian`**	Director of Workforce FTSU guardians	Assure	Report
3.0 STRATEGY					
10:40	3.1	**Future System Board Report**	Chief Executive	Assure	Report
10:55 Comfort Break					
4.0 ASSURANCE					
11:10	4.1	**Insight Committee Report** – April & May 2022 – Chair's Key Issues from the meeting	NED Chair	Assure	Report
	4.2	**Finance and Workforce Report**	Director of Resources	Assure	Report
	4.3	**Integrated Quality and Performance Report (IQPR)**	COO / Chief Nurse	Note	Report
11:35	4.4	**Improvement Committee Report** – April & May 2022 Chair's Key Issues from the meeting	NED Chair	Assure	Report
	4.5	**Quality and Nurse Staffing Report**	Chief Nurse	Assure	Report
	4.6	**Maternity Services Quality & Performance Report**	Chief Nurse	Assure	Report

Time	Item	Subject	Lead	Purpose	Format
12:00	4.7	**Involvement Committee Report – May 2022 Chair's Key Issues**	NED Chair	Assure	Report
5.0 GOVERNANCE					
12:20	5.1	**BAF Summary and Risk Report**	Trust Secretary	Assure	Report
12:30	5.2	**Governance Report**	Trust Secretary	Inform	Report
6.0 OTHER ITEMS					
12.40	6.1	**Any Other Business**	All	Note	Verbal
	6.2	**Reflections on meeting**	All	Discuss	Verbal
	6.3	**Date of next meeting 22 July 2022**	Chair	Note	
	Resolution The Trust Board is invited to adopt the following resolution: "that representatives of the press, and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicly on which would be prejudicial to the public interest" Section 1(2) Public Bodies (Admission to Meetings) Act 1960				

Supporting Annexes

Item 2.1 – People & OD highlight report – Appendix 1 & 2

Item 4.6 – Maternity Services quality & performance report – Annex C-Q

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: Clement Mawoyo (Gylda Nunn deputising)

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 - 25 March 2022

To Approve

Presented by Jude Chin

DRAFT

MINUTES OF BOARD OF DIRECTORS MEETING

HELD ON 25 MARCH 2022
Via Microsoft Teams

COMMITTEE MEMBERS			
		Attendance	**Apologies**
Craig Black	Interim Chief Executive	•	
Jude Chin	Interim Chair	•	
Nicola Cottington	Chief Operating Officer	•	
Richard Davies	Non Executive Director (Maternity Safety Champion)	•	
Christopher Lawrence	Non Executive Director	•	
Nick Macdonald	Interim Executive Director of Finance	•	
Paul Molyneux	Interim Executive Medical Director (Maternity Safety Champion)	•	
Jeremy Over	Executive Director of Workforce and Communications	•	
Louisa Pepper	Non Executive Director	•	
Alan Rose	Non Executive Director	•	
Sue Wilkinson	Executive Chief Nurse	•	
In attendance			
Ann Alderton	Interim Trust Secretary		
Helen Davies	Head of Communications		
Georgina Holmes	Trust Office Manager *(minutes)*		
Richard Jones	Trust Secretary		
Clement Mawoyo	Director of Integrated Services		
David Holden	Consultant, Good Governance Institute		
Zoe Robinson	CQC-Interim Head of Inspection, Eastern Region		
Governors in attendance (observation only): Florence Bevan, Carol Bull, Rachel Darrah, Margaret Rutter, Liz Steele, Clive Wilson			

RESOLUTION

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

It was noted that a recording of this meeting would be available for the public to view following the meeting.

Action

1.0 GENERAL BUSINESS

1.1 APOLOGIES FOR ABSENCE

There were no apologies for absence.

1.2 DECLARATION OF INTERESTS FOR ITEMS ON THE AGENDA

No declarations of interest were received.

1.3 MINUTES OF MEETING HELD ON 17 DECEMBER 2021

The minutes of the previous meeting were approved as a true and accurate record subject to the following amendment;
Item 02.5; question raised by Richard Davies referred to parents with babies in the neonatal unit being charged for parking. (Action sheet also to be amended).

1.4 ACTION LOG AND MATTERS ARISING

The ongoing actions were reviewed and the following updates provided:

Ref 1974; provide further information to the board on the ward accreditation programme. It was explained that due to the pressures of the Covid pandemic this had now become a long-term project. The board agreed that this should be removed from the action log and monitored through the ward accreditation steering group and appropriate 3i committee.

Ref 1997; board discussion/workshop required to discuss Trust's priorities and what it would and would not be able to do. This would be discussed at the board workshop on 8 April.

Ref 2019; share Ockendon 2 report with board before next meeting. The report was due to be published on 31 March; once it had been received and assimilated within the organisation it would be circulated to board members.

Ref 2021; confirm situation with future auditors for MyWish. This was scheduled to be discussed at the charitable funds committee meeting next Friday (1 April). An update would be provided at the next board meeting.

Ref 2024; arrange board workshop on the digital strategy and its implications. This would be scheduled into a board workshop.

The completed actions were reviewed and the following updates provided:

Item 2015; patient story - look at training/support for staff in this type of situation. Jeremy Over had reflected on this further and proposed that the board needed to think about how to welcome and support individuals who presented to the board.

Item 2018; agree solution to parents of babies in the neonatal unit being charged for car parking. It was confirmed that parents would not be charged for parking and the management/administration for this was being addressed.

1.5 STAFF STORY

- Sue Wilkinson welcomed and introduced Shelley Lee, senior matron in the community, who would be recounting two days in the life of a district nursing team.
- Shelley gave a brief resume of her background and qualifications and explained that she and Amanda Keighley were the two senior matrons in the community. She would be talking about 23 and 24 December 2021 in the Bury Rural team which was one of the six community teams.
- She explained the structure of the community nursing teams and their roles and qualifications. Unfortunately, a number of members of staff had left over the past few months, particularly the Bury Rural team.
- The ways in which patients could be referred and the referral types were explained, including patients with diabetes or requiring complex care. Patients were RAG rated, ie red, amber or green, and prioritised. It was important that patients, particularly those requiring complex care, were seen by the right person.

- The patients on the list for 23 December included five who were on palliative care. The team was very short staffed due to four registered nurses having left and an increase in the number of staff who were off sick. Shelley explained how they mitigated for the staff shortage and the support provided by other agencies, including the hospice.
- On 24 December a further six patients were referred who required end of life care, equalling a total of 11 patients over the past two days; there were also a number of red referrals who needed to be seen that day. The team was supported by members from other teams in the community and the early intervention team assisted in undertaking routine visits. The palliative care patients were RAG rated as to whether they required a visit that day.
- The team did not have enough syringe drivers and had to obtain them from other teams, as well as purchasing enough storage boxes for each patient. In addition, they had to contact dispensaries to ensure that patients had enough drugs for the bank holiday period.
- The other important role was undertaking wellbeing checks with staff who were under a lot of pressure and working extremely hard.
- It was stressed that this was an unprecedented day as they had to ensure that everything necessary was in place to cover for Christmas day.
- A slide illustrating the attributes of a district nurse was shown and it was reiterated that community nurses were lone workers.
- There was often a perception that despite all these attributes district nurses were not of the same status or as skilled as acute hospital nurses. However, this was not the case; a different skill mix was required in the community.
- The board considered this perception of community nurses to be very concerning.

Q This presentation emphasised that the community teams were going above and beyond in caring for patients. It was concerning that they were short staffed and having to obtain supplies from other areas. What did Shelley think was needed to make this better, eg more staff, more money?

A More staff were definitely needed, although with alliance working this was moving in the right way. However, it was difficult to recruit staff as this was a complex role and patients were becoming more and more complex.

Q Re the reduction in staff numbers in December and January, did Shelley have a perspective as to why this was happening? Was it universal or was it a trend?

A Nurses were being lost in the Bury Rural team as the workload was higher and there were more complex patients; nothing was easy. The team had also been unsettled and the environment had changed. Community nurses worked out of doctors' surgeries and were being offered practice nurse jobs which were perceived as more attractive.

The model of care had also changed and patients were more complex; frailty was higher and there were more end of life patients. A new team was now being established and new registered nurses recruited so it was hoped that things would improve and settle down.

Q Did Shelley consider that the change in case mix was a long-term trend and why was it happening?

A This was a long-term trend and was due to a number of changes in practice which were very positive and meant that people were being discharged to be looked after in the community. This needed to be linked with the future system programme and there was a need to understand the level of investment required in community services as an alliance.

- Partnerships with the voluntary sector, in particular the hospice, were very important and needed to continue to be strengthened.
- As well as considering the approach to investing in technology and how technology could alleviate some of the pressure in the community, there was also a need to focus on recruitment and retention of good quality staff in the system. Nurses needed to be encouraged to join the community and these roles made as attractive as possible.
- It was noted that hospital staff considered it to be very positive that they had discharged a number of patients on 23 and 24 December so they could go home for Christmas. However, the full impact this would have on the community teams was probably not fully considered and there was a need to get better at this.
- The majority of patients were still not dying where would like to, ie at home, and this needed to be improved upon.

Q It was good that nurses could now be offered progression up the career ladder in the community. In practice did Shelley think that this was a career aspiration for young nurses in the community all the way through and could staff be supported to do this?

A Yes, this was very possible and there were a number of opportunities to progress in the role. There were a lot of academic modules and courses that people could go on, including a district nursing course, and there had been lots of applications. The introduction of band six nurses in the community had also been very beneficial.

- The board thanked Shelly for a very interesting and enlightening presentation which had helped give greater understanding of the role and challenges of the community nursing teams.

ACTION: consider staffing levels in community services at a future board meeting. **S Wilkinson**

1.6 QUESTIONS FROM GOVERNORS AND THE PUBLIC

- Liz Steele referred to the staff story and explained that she had nursed her husband at home until he died. Without the support of community nurses for her and her family, especially at night, this would not have been possible and from a personal point of view she thanked them for this.
- On behalf of the governors she thanked the Trust for communicating the news item this week before it appeared in the media. She requested that an update was provided at the closed session of the CoG meeting on 29 March as patients and the public may be concerned about this and governors represented these people. Jeremy Over confirmed that he would be attending the meeting and would provide an update if any further information was available that could be shared.

ACTION: update governors on incident that was reported to the media at closed CoG meeting on 29 March, if further information available. **J Over**

Q Item 5.1, board assurance framework (BAF) showed Helen Beck and Nick Jenkins as leads for pillar 3 and pillar 4 respectively. Did this section of the report refer to old pillar groups or was this an oversight and would it be updated with the new leads?

A This would be addressed under item 5.1.

1.7 CHIEF EXECUTIVE'S REPORT

- The Trust's updated strategy was being launched across the organisation. It had already been presented to various groups of staff in the organisation as well as to external partners and had been very positively received. It now now needed to be disseminated throughout the organisation. The process and approach to this would be discussed in greater detail at the board development day on 8 April.
- The organisation continued to be under significant pressure, as was the case across the region. Covid numbers in the community were currently very high and this was having a significant impact on staff availability rather than acuity of patients.
- Due to the high Covid rates in the community there were still some restrictions on visiting and these were likely to continue. This placed a significant burden on patients, relatives and also on staff who had to provide additional support to some patients as they could not have visitors.
- The focus on wellbeing continued and the Trust held a 'Love Yourself' week for staff last week. The teams involved in organising this were credited for all their hard work.
- As part of supporting staff wellbeing the arrangement with Abbeycroft Leisure for staff to have free membership would continue. To date over 2000 staff had taken advantage of this which was very positive.

Q Re hospital visiting and asking people to take a lateral flow test (LFT) before they visited, how would be this managed when free LFTs were withdrawn?

A There was real confusion about some of the messages being put out to the public and the lifting of restrictions and the reality of the situation the Trust was facing. Covid had not gone away and Craig Black requested that everyone continued to wear in mask in public places, eg supermarkets. The Trust would not be able to supply visitors with LFTs and people would be asked to purchase their own in order to maintain the safety of patients and staff. Visitors were also being encouraged to wear the type of mask supplied by the Trust rather than their own face coverings, and not to come in if they felt unwell.

All trusts across the country had been asked to try and open up to visitors as much as possible. However, WSFT had had to take the difficult decision not to fully open up to visitors due to the number of wards affected by Covid.

2.0 CULTURE

2.1 WEST SUFFOLK REVIEW – ORGANISATIONAL DEVELOPMENT PLAN

- This plan had progressed considerably since the last board meeting and had been developed and shared as described in the report.
- The development of the plan tried to strike a balance between everything that had been worked on in the course of the past two years and areas that needed to be developed further. It addressed the criticisms and themes of the West Suffolk review and also fitted into the wider strategy and values of the organisation.
- This report explained how the plan had been shared within and outside the organisation. Feedback had been received from the directorate within the national NHS England team which led on culture and people across the NHS. A lot of positive comments and helpful suggestions had been received together with areas that required further clarification.

- As well as describing work that had been going on over the last couple of years the plan also referred to changes in behaviour which is for members of the Board to role-model. The board would continue to receive feedback on this, eg through results from the staff survey and also through interaction with people across the organisation (soft intelligence).
- To date it had been challenging to engage staff on the detail of the plan due to operational pressures. It was important to create time for people to do this and this was part of the cultural change required which the executive team would need to support.
- Freedom to speak up provided an opportunity as a board to demonstrate how it received challenges, bad news etc and this required a shift in how it operated.
- The day to day actions of the board and senior leadership would demonstrate to staff that cultural and behavioural changes were being made, and this is what would make a difference.
- This was about board members holding themselves to account for every interaction with staff at all times and it would be very helpful for colleagues to hold each other to account when relevant. This would also be very important in developing relationships at board level.
- Achieving this was based on compassionate leadership and would require constant work and challenging conversations and people accepting when they were wrong. The board needed to understand this and develop skills to be compassionate leaders and consider how to get feedback on this in practice.
- This needed to be communicated across the organisation but the process of implementation started with the board and they needed to think carefully about their behaviours and interactions with one another and staff. The board needed to reflect on how they were going to do this.

ACTION: consider how board members would implement cultural changes through their own behaviour and interactions and how they would get feedback on this in practice. **All**

- The board approved the West Suffolk review organisational development plan and that the involvement committee would have oversight of its delivery.

2.2 REPORT OF THE WEST SUFFOLK REVIEW GOVERNOR/DIRECTOR WORKING GROUP

- This was still in the early stages; the group had met for the first time and should be an effective channel of communication between governors and the board.
- Governors had an important role in holding the NEDs to account for the performance of the board. They also represented members and the public and were therefore accountable for making sure that the expectations of staff, members and the public were being met.

Q Re the independent review of the Council of Governors, would the Good Governance Institute be engaging with members of the board to gain their input and response to this?

A They would be looking at how the Council of Governors fulfilled its role and held the NEDs to account for the performance of the board, that they understood the role of the board and the communication they received, eg how the board communicated with the Council of Governors.

2.2a WEST SUFFOLK REVIEW GOVERNOR DIRECTOR WORKING GROUP TERMS OF REFERENCE

- The board approved the terms of refence of the West Suffolk Review governor director working group.

3.0 STRATEGY

3.1 FUTURE SYSTEM BOARD REPORT

- This report reflected the vast amount of work that was being undertaken by the team. The outline planning permission application was about to be submitted and the work that had been undertaken on this was detailed in the plan.
- Work would continue on others areas including the estates team who would be working on environmental assessments for the next few months and, in some cases, years.
- A lot of work was also going on around clinical co-production and a considerable number of workshops had taken place. These had been universally positive with a number of very interesting outputs about how the provision of services would need to change in years to come.
- Details of the ongoing engagement process were also described in this report. Constructive criticism and comments had been received as well as positive feedback.
- A visit from the senior leadership team of the new hospitals programme had provided the opportunity to present WSFT's approach. This was different to some of the other hospitals in the programme as it was genuinely inclusive which had not been seen in other programmes and could become a model for how this should be done.
- Although WSFT was part of cohort 4, there was a realisation that it was much further forward in the programme that others in the cohort. However, there were also things that it could learn from others in the programme.
- It would be important not to cut any corners in the delivery of the scheme if WSFT was progressed up the programme.

Q The involvement committee had discussed this report last week and there were two marginal areas of concern. As well as the need to ensure that governors were regularly updated on this, it was unclear about collaboration with other acute hospitals. Could an update be provided on this?

A A lot of good work was going on between the acute areas of WSFT and ESNEFT, particularly around demand and capacity planning that had gone into the future system programme. The team was now looking at rolling this out across the whole ICS so that everyone was working from a consistent base.

There had also been some very helpful discussions between clinical leads across the ICS, particularly in surgery. These discussions were progressing well and progress had also been made operationally over the last few months.

However, there was a need to be cautious as there was a degree of concern expressed by some clinicians relating to previous experiences of collaborative working, most notably in pathology.

This needed to be addressed as it was putting collaborative working at risk; it was important for everyone to keep talking to one another so that trust between organisations improved. Conversations between organisations already felt much more

positive than six to twelve months ago and it was important that any concerns about this were shared with ESNEFT's board/senior leadership.

It was explained that teams were already collaborating and providing support for community diagnostics at Newmarket and discussions continued on this.

4.0 ASSURANCE

4.1 INSIGHT COMMITTEE REPORT – February & March 2022 – Chair's Key Issues

- One of the issues that was regularly discussed by this committee was the ongoing pressures on access targets. Although plans were in place to recover these it was not easy in the current climate and people needed to be honest about this.
- Patient access sub-groups produced a helpful report highlighting the areas that needed to be focussed on. However, assurance was still required that these groups were getting access to the appropriate data.
- There was also some concern about duplication between the three committees and the way they communicated up to the board.
- It was explained that a six-month review of the three committees was being undertaken to look at duplication of some of the elements of their work. A proposal had gone to all members of the 3i committees to make some reflections and clarification around this. It was also the responsibility of individual committees to take forward areas of improvement within their own scope of responsibility. This would be discussed in more detail at the board development day on 8 April.
- It was noted that the improvement committee was not assured that all the specialist committees were operating effectively in the way they should be. Therefore, an exercise was being undertaken to look at their terms of reference, resources etc and if they had access to the most appropriate data to enable them to identify issues and work on improvements.

Q Why was the IQPR considered to be uninformative as it was very detailed and had a lot of useful information? However, it was acknowledged that there was a need to understand how to identify priorities, trends etc.

A It was important to understand how to present the IQPR in a way that highlighted areas of concern. Some work had been undertaken on the narrative that went alongside the graphs. A number of metrics were now out of date and community metrics were not broad enough to reflect the pressures and challenges within community services.

Challenges were not often received around information in the IQPR which raised the question as to whether it was as effective as it should be.

4.2 FINANCE AND WORKFORCE REPORT

- The Trust had planned to break-even at the end of the financial year. However, funding that it had been unclear about throughout the year had now been clarified; this would improve the final year position but could not be carried forward to next year. Therefore, WSFT was now forecasting an I&E surplus of £5-6m; other trusts were also forecasting a similar surplus comparable with their size.

Q Did anyone think that there was anything that could have been have done if it was known that more cash would be available, ie an additional £5m that could have been spent?

A

There were some things that could be done differently in the future. Every year the Trust was offered funding, eg to help with winter pressures, on a non-recurring basis, which was announced late. Learning from what has happened this year, the Trust needed to approach this differently and think about more sustainable changes that could be put in place and take a calculated risk that money would be provided.

The board had a higher appetite for risk in relation to finances than it did for other aspects within the organisation. This was a risk worth taking if it was going to improve quality and safety and the provision of care.

One aspect that could be considered was accelerated investment in the community through training, rotational opportunities and encouraging acute based staff to think about working in the community.

It was noted that this calculated risk was an approach used previously with the capital programme which had benefited from this; something similar could be done in this respect, eg winter planning.

There was a need to consider how unplanned resources could be used to further mitigate risk or enhance services, however this would need to be planned in advance and prioritised.

It was explained that it was easier with capital as a scheme could be set up and ready. It was more difficult with revenue as this was likely to involve the recruitment of staff which would take time. Ways in which this money could be spent needed to be planned for ahead as this would be more effective, ie have schemes ready that could be implemented quickly if money was received.

- The benchmarking information provided in this report was in the early stages and the associate directors of operations (ADOs) were currently looking at this in more detail. The numbers were gross and comparative information from ESNEFT was not in the same format and based on their activity, whereas it needed to be based on WSFT's activity so that a like for like comparison could be made. Further work would be undertaken on this.
- It was important to benchmark against other organisations and the challenge was set re service quality. However, the evidence was not available to say whether or not service quality was the same. There were some areas where WSFT was very successful, eg ambulance handover, but this could then have an adverse effect on performance in another area of the Trust. This demonstrated the need to be careful about assumptions that were made.
- It was agreed that there was a need to be very cautious when looking at benchmarking and it needed to be looked at more widely. This was a starting point; clinical input would be very useful and might produce a guide as to where these discussions could most usefully take place.
- A break-even I&E budget had been set for next year and this together with the budget for the capital programme, including the RAAC programme and future systems, would be discussed in more detail in the closed session of this meeting.
- It was noted how important assumptions were in arriving at the final figure and how fragile some of these were due to pay and non-pay inflation which would have a material impact on the Trust's financial position. Assumptions were fairly fundamental and very volatile.
- The guidance stated that any pay award above 2% would be funded, however non-pay inflation would not be funded and this would be a real risk.

- The allocation of income to the corporate division this year was discussed at the last board meeting. This was being addressed so that next year it would be allocated more appropriately across the divisions.

Q Re the sustainability programme for next year; would the divisions/teams be given the necessary time to appropriately consider this and what could be achieved and the options available?

A Some detailed conversation had taken place about this. This needed to be about true sustainability in its widest sense, linking to the future systems programme and delivering services in a very different way that were sustainable. It was also about moving activity out of the acute setting into the community, whilst ensuring that the community was sustainable. Therefore, the financial savings may be a consequence that came out of this rather than the focus and priority as to how this programme was structured.

- It was stressed that everyone needed to be very clear that the sustainability programme was not the same as the cost improvement programme (CIP). This was about delivering more sustainable services linked with the future system programme, community etc and one aspect of this would be financial sustainability.

4.3 IQPR – JANUARY 2022 DATA

- This report would continue to evolve and the team was also working on an alternative format and content. The aim was to set out what that variation and exception was, what was driving it, what action was being taken to resolve it and how this improvement would be monitored and assured. Currently the report also included some metrics that were not relevant.
- 104 week wait performance was very concerning; the predicted number for the end of March was now 268 patients for WST, which meant that there would be just under 300 patients for the whole of the ICS. There had been a shift of patients from WSFT to ESNEFT as it was supporting WSFT with its recovery programme.
- This figure had deteriorated due to staff sickness in January and February which had continued into March due to the impact of Covid. However, WSFT was predicting that it would have no patients waiting over 104 weeks by the end of June.
- There had also been a deterioration in the two week wait performance, specifically for the breast symptomatic pathway. New equipment had been ordered to improve productivity and a new breast pain pathway would be implemented in June/July which had already been successfully implemented by ESNEFT and was considered to be a very positive step.
- Urgent and emergency care performance had also been a challenge due to an increase in demand which was reflected across all areas of the health and social care system. Measures were being taken to address this through pathway changes.
- There had been a reduction in 18 wait week performance in the community, particularly in speech and language therapy. This had been highlighted previously and related to difficulties in providing services during Covid and staff sickness due to Covid.
- It was considered that it would be helpful if there could a closer link between the improvement committee and the IQPR. It would also be helpful if the insight or improvement committee could spend more time on the IQPR so that they could come to the board with the areas that it needed to focus on.

Q Re community metrics; there appeared to be a disconnect between Shelley Lee's presentation earlier and what was in the IQPR, ie what was actually happening in the

community from the staff's perspective and data in the IQPR. Was the data for community being looked at for the future?

A The metrics for community performance for inclusion in the IQPR were currently in the process of being looked at.

Q It appeared that the 104 week wait was linked to theatre capacity. Were all theatres due to be fully operational again in May?

A All theatres, plus an additional one, would be operational from the middle of May. This was why the recovery programme had been back loaded.

Q To what extent were measures in the IQPR mandatory?

A Metrics were historic and driven by the contract but not necessarily still required. Therefore, these were being revisited as there was an opportunity to do things differently.

- There had been a significant increase in Covid positive patients in January across the whole country although acuity had reduced. However, there were still some very sick and dependent patients in the organisation and a high number of staff were off sick or isolating.
- The complaints related to the emergency department area were linked to the increase in the pressures and demands on the Trust and this was likely to continue, ie people were getting frustrated as to why hospitals were not returning to business as usual in the same way as the rest of the country. Therefore, the Trust needed to help service users to understand why things were not yet back to how they were before, eg visiting and relatives/friends accompanying patients to appointments etc.

Q It was good to hear that ESNEFT was helping to reduce waiting lists in some areas of WSFT. Was WSFT reciprocating this in areas where ESNEFT required support?

A WSFT was working with ESNEFT to provide support for dermatology.

Q At a recent regional meeting it was requested that trusts reviewed ambulance handover times as this was a concern, particularly category 2. Was it possible to show some metrics on this in the IQPR?

A WSFT's ambulance handover times were good, therefore it was proposed that this should be reviewed/monitored through one of the 3i committees.

ACTION: confirm which 3i committee would review/monitor ambulance handover times. **R Jones**

4.4 IMPROVEMENT COMMITTEE REPORT – January & February 2022 Chair's Key Issues

- PSIRFs had been set for the year and would be reviewed by inviting the relevant specialist committee member to attend an improvement committee meeting, eg pressure ulcers.
- One PSIRF that the committee was not able to look at was around safe and effective discharge, as there was no specialist group for this. Therefore, the challenge for the executive teams was how to gain assurance in this area.
- As part of the quality assurance programme colleagues from the CCG had undertaken assurance visits to maternity, theatres and the emergency department

and positive feedback had been received. However, due to the increase in Covid the programme had been paused but it was planned to move forward again with this next month with a table top exercise and further visits to departments/areas the hospital.

4.5 QUALITY AND NURSE STAFFING REPORT

Infection prevention and control (Annex 1)

- The board received and noted the content of this report.
- As of next month the infection prevention and control team would report to the quality and safety group; any concerns or highlights would then be reported to the board.

Nurse staffing report – January and February 2022 (Annex 2)

- It was noted that this report referred to January and February. The position had continued to be very challenging with fill rates for registered nurses at under 90%.
- There had been a small increase in vacancy rates for registered nurses and nursing assistants due to a small uplift in the one of the units. However, substantive numbers remained constant.
- In January staff isolation rates started to decline, however this increased again in February and had continued to do so in March.
- In January the surge staffing plan had been implemented with additional mitigation to support the challenges being experienced, but it had been possible to reduce this sooner than anticipated in February. However, as of yesterday (24 March) the surge staffing plans had been implemented again following the opening of additional surge areas and the number of staff absences. This would continue for the next two weeks and then be reviewed.
- Key performance indicators (KPIs) for maternity continued to show good performance.
- This report now included an additional section on community, including the number of referrals that had been seen. There had been a significant upturn in district nurse referrals over the past six months.
- During the last year members of the nursing team had taken on a pastoral role within the education team to support new healthcare students. This had had a very positive effect and reduced the number of leavers within the first twelve weeks from 23% to 12% over the year.
- The board were reminded of the emotional and physical exhaustion being experienced by nursing staff due to the constant demand and increase then decrease in surge capacity. There were significant pressures across the Trust and staff were regularly asked to cover escalation areas.
- A number of staff had been to the freedom the speak up guardians about staffing levels and this had been acknowledged and the Trust was trying to address this.

Quality and learning report (Appendix 3)

- It was noted that five incidents reports had been approved since the last meeting.
- The board approved the PSIRF year 2 plan.

4.6 MATERNITY SERVICES QUALITY & PERFORMANCE REPORT

Justyna Skonieczny, Deputy Head of Midwifery, joined the meeting for this item.

- The board was reminded that Paul Molyneux and Richard Davies provided additional support in their role as Maternity & Neonatal Safety Champions.
- The board noted the papers and annexes that were included with this report. A number of these had been to the LMS prior to being presented to the board and had already been through any recommendation/approval processes required by the executive team.
- Two of these reports that were of particular importance were the Ockenden 1 review of maternity services, one year on report and the Morecambe Bay recommendation and review of maternity services.
- WSFT was partially compliant with the Ockenden 1 report and was working towards full compliance.
- The publication of the Ockendon 2 report was awaited and the Trust would be benchmarking its services again the new recommendations.
- The Morecambe Bay report contained 44 recommendations relating to safety in maternity services. WSFT was currently compliant with 15 of these and partially compliant with a further 15. The remaining 14 recommendations related to wider governance that was being addressed at regional and national level.

Q WSFT was not fully compliant with all the recommendations in either the Ockendon or Morecambe Bay report. How could the board be assured about what progress was being made with the remaining recommendations and when would the Trust be compliant with some of these, particularly some of those in the Ockendon report, eg immediate and essential?

A The main reason a target date had not been set for these was because the reports came in the middle of the pandemic and the pressure that services were under. After a year NHSEI would be asking what progress had been made and what processes were in place. The team would continue to work on this, particularly the actions that still needed to be addressed.

Q Would the recommendations from the Morecambe Bay and Ockendon reports become the new CQC expectations for the future?

A The CQC was currently reviewing the way it inspected organisations and these were likely to be included in these.

Q Reflecting on feedback from Richard Davies, in his role as maternity and neonatal safety champion, around some staff having to work clinically which meant that there was an issue around collection of data. Given that the pressure on the team was likely to continue and increase with the publication of the Ockendon 2 report, was there anything the board could do to facilitate this and alleviate that some of the burden around data production etc and support staff.

A A review of the neonatal unit was currently being undertaken and there would be a number of recommendations coming out of this. Maternity activity was quite variable which meant that there were times when people were asked to help out in a clinical role, but there were also times when they could focus on other areas. NHSEI had also provided funding for an additional admin support role, however further admin/ data support would be greatly appreciated.

- It was important for everyone to recognise that when staff were not working clinically they were working on producing data for report etc.

- Seven new midwives had been welcomed to the organisation this week and would help towards supporting continuity of carer teams. This was very positive and would boost the morale of staff.
- The Trust was also in the process of recruiting internationally and it was expected that 8 additional midwives would be joining the Trust this year.
- It was noted that the unit would be moving into other areas of the organisation over the next few months due to the decant programme which would increase pressures on the teams in this service.

4.7 INVOLVEMENT COMMITTEE REPORT – February 2022 Chair's Key Issues

- Four of the items highlighted in this report had already been discussed at this meeting.
- The involvement committee had also discussed the staff psychology service. This had required a large investment but was a very important part of the Trust's people plan and overall health and wellbeing strategy. The service had been very successful to date but there were still some improvements that could be made.

4.8 PEOPLE AND ORGANISATIONAL DEVELOPMENT (OD) HIGHLIGHT REPORT

- The board noted the citations for Putting You First awards for February and March for the following members of staff and congratulated them on going above and beyond in their roles and their commitment to both their colleagues and patients.
  - Sandra Varela, nursing assistant, G8
  - Andre Santos, interim ward manager, F6
  - Sally Giles, dietetics
- Since last month the legislation around mandatory vaccinations has been formally revoked by the government. The Trust needed to be mindful of the impact that this may have in the future, eg flu vaccinations and potential Covid boosters.
- The board noted the appointment of Dr Tayyaba Aamir, Acute Consultant in General Paediatrics & Neonatology.

Freedom to Speak Up Guardians' Report

Amanda Bennett and James Barratt joined the meeting for this item.

- It was noted that this report related to quarter three, ie September- December 2021.
- There had been an increase in cases of people speaking up and there was likely to be a further increase in quarter 4.
- One of the key issues was around staffing and people feeling unable to do their job safely and/or to the standard they would like to. The board was asked to note this concern.
- The number of cases with an element of bullying and harassment (11) had increased since the previous period.
- At the end of quarter four the number of cases and type of concerns would be compared with the previous year.

Q One of the concerns voiced by staff was that they had spoken to a freedom to speak up guardian but nothing had happened. How could the board ensure that staff felt assured that they had been listened to and taken seriously, ie people felt that they were speaking up but not being heard? Was this because they were being listened to but it was not possible to give them the answers they were looking for, particularly in the nursing and midwifery workforce?

A This was an issue which James and Amanda had discussed with Jeremy Over. They were trying to understand what else they could do as they did not want people to lose faith in the freedom to speak up service. An effective feedback mechanism needed to be found, however there may be some people who would continue to feel dissatisfied.

Q What was happening with the freedom to speak up champions and was this a route for cases to go directly to Amanda or James?

A A difference was already being made through freedom to speak up champions, eg staff had not realised that the marquees were available when they took their breaks and had previously sat in their cars.

ACTION: provide an update on freedom to speak up champions in future Freedom to Speak Up Guardian's reports. **J Over**

Q Re the pressure on the emergency department leading to a higher number of complaints; how much could be attributed to operational circumstances at the moment and was it expected to see fewer complaints next winter when the effects of the RAAC programme and Covid had reduced?

A It was not possible to give a definitive answer to this question.

Q Re diversity monitoring; it was important to monitor what services had been put in place to support people and ensure that everyone's needs were being responded to, was this being done?

A After a case had been closed an evaluation form was sent out and demographics were collected to ensure that this reflected the population of staff.

Q Re people feeling frustrated that issues they raised were not being resolved, there were a number of different ways for raising concerns, ie through line managers, freedom to speak up guardians and champions, the media. The fact that staff were going to the freedom to speak up guardians represented a deviation from the norm.

What Matters to You highlighted the difference that good leadership made and there were likely to be a number of people who were going to their line managers. If the Trust continued to invest in line management and this improved would there be fewer people going to the freedom to speak up guardians?

A The Trust was trying to encourage people to speak up in many different ways, one of which was through the freedom to speak up guardians. However ideally, they should go to their line managers; it was difficult to distinguish between the number of people who did this or went to the freedom to speak up. The main message was that people should be able to raise concerns and be listened to and responded or fed back to.

Q When staff contacted the freedom to speak up guardians were they asked if they had already spoken to their line manager or if there was a reason why they had not done so? This would help to understand if people were using the freedom to speak guardians because they were not getting the appropriate response from their line manager.

A The freedom to speak up guardians did try to have this conversation, sometimes staff had not even thought about going to their line manager first and in this case they were encouraged and supported to do this. However, some line managers or ward managers were encouraging staff to go the freedom to speak up guardians as they were not able to provide the appropriate support or answers due to the pressure that the organisation was under.

- The increase in the number of people coming forward was considered to be very positive as it showed that they were feeling able to speak up.
- One of the most crucial things was communication and the more conversations that could take place or information that could be given to people the better, particularly around staff and what the Trust was trying to do to mitigate things. Uncertainty had led to stress and there was a need to communicate what was being done to alleviate the situation as much as possible.
- Work needed to continue to provide appropriate feedback to staff that they had been listened to, even if it was not possible to put in place a solution. The board needed to consider how it could assist with this.

ACTION: find effective feedback mechanism to ensure that people who speak up feel they have been listened to, even if their concern cannot be addressed. **J Over**

5.0 GOVERNANCE

5.1 BOARD ASSURANCE FRAMEWORK (BAF) SUMMARY AND RISK REPORT

- It was confirmed that the names for the leads for pillars 3 and 4 would be updated.
- The allocation of BAF risks across the board's governance committees was being reviewed and updated. This would also be used to strengthen the deep dive process of the audit and sub-committees.

Q Had the future system programme been removed from the BAF and embedded into other areas?

A Yes, this had been incorporated into other risks.

5.2 GOVERNANCE REPORT

- The board received and noted the content of this report.
- It was explained that a more detailed papers on the building insurance renewal would be discussed in the closed session of this meeting due to the commercial and confidential nature of the content.

6.0 OTHER ITEMS

6.1 ANY OTHER BUSINESS

- There was no further business.

6.2 REFLECTIONS ON MEETING

- The Chair had tried to take the comments made by the board after the January meeting into account in terms of structure of the agenda. This would continue to evolve.

- Using the first half of the meeting to talk about strategic issues was considered to have been an improvement.
- It was suggested that there were still some items that could be considered by other committees. This meeting had lasted 3½ hours which might not the most effective use of time.

6.3 DATE OF NEXT MEETING

Friday 27 May 2022, 9.15am

RESOLUTION

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

1.4. Action log and matters arising

To Review

Presented by Jude Chin

Board meeting - action points

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery	Date Completed
2029	Open	25/3/22	1.5	Staff story: consider staffing levels in community services at a future board meeting.		SW	22/07/22	Green	
2031	Open	25/3/22	2.1	West Suffolk Review ODP:consider how board members would implement cultural changes through their own behaviour and interactions and how they would get feedback on this in practice.	**Executive director 360 feedback exercise completed this month. NED 360 agreed at COG meeting on 18 May. To be completed by the end of July.** **WMTY2 to define behaviours (inc. leadership behaviours) that reflect FIRST values.**	JO	22/07/22	Green	

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

Board meeting - action points

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery	Date Completed
2019	Open	28/1/22	Item 02.5	Maternity services - share Ockendon 2 report with board before next meeting.	Report due to be published on 31 March; once+F1987 received and assimilated within the organisation it would be circulated to board members. **Actioned.**	SW	27/05/22	Complete	27/05/2022
2021	Open	28/1/22	Item 02.11	Charitable Funds - confirm future situation with auditors for MyWish.	Quotes obtained, for discussion at next Charitable Funds Committee meeting on 1st April, 2022. Update to be provided to board meeting on 27 May. **Lovewell Blake appointed as auditors from 1.4.22 and are currently undertaking take-on procedures.**	NM	27/05/22	Complete	27/05/2022
2032	Open	25/3/22	4.3	IQPR: confirm which 3i committee would review/monitor ambulance handover times.	**The IQPR is being reviewed in terms of assurance and governance groups but this will be incorporated in the the scope of Insight with appropriate management review supporting this.**	RJ	27/05/22	Complete	27/05/2022
2033	Open	25/3/22	4.8	People & OD Highlight report: provide an update on freedom to speak up champions in future Freedom to Speak Up Guardians' reports.	**Today's (27.5.22) Agenda refers.**	JO	27/05/22	Complete	27/05/2022
2034	Open	25/3/22	4.8	People & OD Highlight report: find effective feedback mechanism to ensure that people who speak up feel they have been listened to, even if their concern cannot be addressed.	**Today's (27.5.22) Agenda refers.**	JO	27/05/22	Complete	27/05/2022

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

1.5. Patient story

To Note

Presented by Susan Wilkinson

1.6. Questions from Governors and the Public

To Note

Presented by Jude Chin

1.7. Chief Executive’s report

To inform

Presented by Craig Black

Board of Directors – Friday 27 May 2022

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

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

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

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

Response to external review into whistleblowing

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

As part of our commitment to learning from and adopting the lessons from the West Suffolk Review, we have been working on an 'organisational development plan'. The plan is forward-looking in nature and focuses on our long-term approach to developing our culture at West Suffolk NHS Foundation Trust. It considers the priorities of staff, governors, patients and teams so it can take forward the confidence of all our stakeholders.

As well as capturing the significant work already undertaken to date on the issues investigated as part of the Review, it reflects our ongoing journey to embed these actions as well as taking forward progress in other areas to help us improve. This is a 'live' document which has been developed and shared with our Board as well as regional and system colleagues.

This plan forms the bedrock of how we will seek to make positive changes across the organisation and will shortly be communicated to staff.

This plan sits alongside our new five-year Trust strategy and together will help us drive the improvement we all want to see.

International day of the midwife

On 5 May we shone a light on the amazing work of our midwives through International Day of the Midwife. Organised by the International Confederation of Midwives and led in this country by the Royal College of Midwives, the theme for this year was "100 years of progress".

As well as sharing photos and videos of some of our midwives at West Suffolk Hospital, our Professional Midwifery Advocates put together a 'board of thanks' on a wall in the labour suite to highlight some of the messages received from women our midwives have supported. They included comments such as "I really felt well looked after and confident in the doctors' and midwives' professional judgement." Another person had said "every single member of staff showed kindness and compassion towards us. Nothing was too much trouble."

Against the backdrop of the recently published Ockenden report, being able to showcase the fantastic work our midwives do day-in, day-out is extremely important. The team continues to work phenomenally hard, using feedback from all service users, to drive improvement to ensure the families using our services are safe and well-cared for.

International Nurses Day

International Nurses Day, which took place on 12 May, gave us the opportunity to highlight the incredible work our nurses do on a daily basis. The day coincides with the birthday of Florence Nightingale, the founder of modern nursing, and is celebrated across the globe. The theme this year was to demonstrate the #BestOfNursing.

Our social media channels showcased profiles of nurses throughout the Trust – ranging from nurses in the emergency department through to the community neighbourhood teams as well as our education team. The profiles received a lot of very positive feedback, with former patients and colleagues commenting how they've been treated by or worked with the nurses previously. A particular highlight was someone commenting on Nap, a charge nurse in our paediatric ward, saying: "He is amazing, he looked after my eldest last year, he was fabulous. We are very lucky to have him, he is brilliant."

Our chief nurse Sue Wilkinson took over the reins of our monthly Bury Free Press column, telling her story of coming into the Trust at the start of the Covid-19 pandemic and how she felt humbled to be around staff who were absolutely committed to providing care and support to anyone who came through our doors during such uncertain times. If you five minutes, I do recommend going to the BFP website and having a read.

Some of our Trust's nurses were also featured in the Royal College of Nursing's video that was created for International Nurses Day. The video focused on the experience, knowledge and compassion needed to be a nurse, and it was really nice to see some of our brilliant colleagues featured doing what they do every single day – providing the #BestOfNursing.

Working together with partners to support men with cancer

Earlier this month, a new cancer support programme for men was launched to help keep male cancer patients active throughout their treatment journey. This is a joint scheme, with our Trust working with the fantastic Macmillan team based here and Abbeycroft Leisure.

The free 12-week programme, enables patients to access to a host of activities including a weekly class, specifically designed to be safe and suitable for anyone living with cancer.

This is a fantastic example of partnership working. This service is available at the Abbeycroft centres in Mildenhall, Brandon, Sudbury, Haverhill and Newmarket. This follows on from our very successful promotion with Abbeycroft where we are able to offer all our staff free gym and swimming membership to support their wellbeing.

Chaplaincy upgrades

Thanks to upgrades to our West Suffolk Hospital chaplaincy, more staff, visitors and patients will now be able to benefit from support given by colleagues in the chaplaincy.

The upgrades are as a result of a very kind donor and the new facilities include a new fully-equipped kitchen, a private room for counselling as well as a dedicated washing area (wudu) for Muslim colleagues and visitors.

I know how important the chaplaincy is to a lot of people and the important work undertaken by Rufin and his colleagues goes a long way in offering pastoral, spiritual and religious support to everyone in our Trust.

Outline planning application submitted for new hospital

At the beginning of April, we submitted outline planning application for our new hospital on the Hardwick Manor site. This is a significant milestone and follows a huge amount of work from the team to enable us to get to this stage.

The planning application can be seen on the local planning authority planning portal https://planning.westsuffolk.gov.uk/online-applications/

We are expecting an outcome to the application later in the year.

Living with Covid-19

With the country having moved into a new phase of living with Covid-19, we have made a number of changes as part of our response.

This includes returning to pre-pandemic social distancing in most areas, scrapping the one-way system round the hospital and altering some of our testing and isolation guidance for inpatients. We have also very recently re-introduced open visiting back to the hospital and welcomed our volunteers back to patient bedside roles.

Of course, Covid-19 has not gone away and it will be with us for the foreseeable future. However, thanks to the dedication and hard work of staff, our position has been improving and the changes we have made in response to Covid-19 are also having a positive effect in easing some of the pressures we have seen during the pandemic. That said, we are still experiencing challenges with high numbers of patients accessing our services.

We continue to work hard with our system and alliance partners as a joined-up team, supporting patients when they're discharged from hospital and providing care and support for people closer to their homes.

Covid-19 'recognition and reward payment' for all staff

Throughout the last two years of the pandemic, our staff have responded magnificently. Time and again they went, and continue to go, above and beyond to care for our community - working extra hours and under extra stress.

To show our appreciation and as a genuine "thank you" to all staff for their dedication and hard work, the Board recently agreed to a one-off 'Covid-19 recognition and reward' payment.

We have made looking after our staff one of our top priorities. This payment is being made in addition to other measures to look after staff - such as free gym membership; a dedicated staff psychology support team, free tea and coffee and free parking.

The Board hopes that together these measures, alongside the recognition and reward payment, goes some way in making staff feel appreciated and valued.

Staff survey results

Last month the NHS staff survey results were published. At West Suffolk, we received more than 2,000 responses.

The survey, undertaken in October and November last year, is one of the largest staff feedback exercises for any employer in the world, with around 500,000 staff across England taking part.

Our report for West Suffolk is available to read here:
https://cms.nhsstaffsurveys.com/app/reports/2021/RGR-benchmark-2021.pdf

Looking at the results, it is perhaps not surprising, given the two years we have lived through, to see that these experiences are reflected in the survey results at a national level, whereby national average scores have declined significantly across a number of areas.

The picture at West Suffolk is very similar and broadly mirrors the national trends. It provides a deep picture of what it has been like for staff over the pandemic and how they are feeling. The results show we compare reasonably well to other trusts (with all key scores at WSFT being above or equal to the national average). However, that does not detract from the fact that, similar to other trusts, the feedback at WSFT is less positive than it was a year ago.

We have been going through the data from the staff survey in detail and are reporting back to staff on the results. Later in the year, we plan to hold another 'What Matters To You' staff engagement programme. We will be using the data from this survey to inform the content and direction of that programme as we move forward to build on actions already taken to help us improve and develop further activity.

National recognition shines light on research achievements

I am delighted that Angharad Williams, a member of our Trust's research team, has been recognised for her brilliant work with an award from the Academy of Healthcare Science (AHCS).

Angharad, who has a degree in bioscience as well as clinical training, has been named as the recipient of the Clinical Research Practitioner (CRP) Leadership Award in the 2022 Advancing Healthcare Awards.

Clinical research practitioners such as Angharad are members of the allied health professional (AHP) workforce, undertaking research as well as clinical practice. Angharad won the AHCS award in recognition for her work developing a regional network and national work to develop approved accreditation scheme and register for CRPs. Congratulations Angharad!

National recognition for educators

Continuing the theme of awards, two members of our clinical education team have been shortlisted in the Student Nursing Times Awards, which celebrate the next generation of nurses and their educators.

James Metcalf has been shortlisted as Practice Supervisor of the Year and Alex Levitt-Powell as Learner of the Year: post-registration.

James works in the cardiology unit and among other roles manages the trans-oesophageal echocardiogram lists, and is active in a number of multi-disciplinary teams.

Alex is a clinical practice facilitator who came from a community environment and had previously worked with a number of students as a mentor, assessor and supervisor.

The winners will be announced at the end of this month at a ceremony in London. Good luck James and Alex.

Live music returns to the Trust

One of the things many of us missed during the Covid-19 lock-downs and restrictions were the opportunities to go and see live music and events.

I'm delighted to say that last month we welcomed a string quartet, from the Suffolk Philharmonic Orchestra, to perform to staff in our newly re-furbished chapel and to the residents of Kings Suite in Glastonbury Court Care Home.

The orchestra played as part of their series of free community concerts. I know the concerts provided a much-needed boost to staff and patients alike.

2. CULTURE

2.1. People & OD highlight report - Freedom to Speak Up Guardian

To Assure

Presented by Jeremy Over and Amanda Bennett

Board of Directors – Friday 27 May 2022

Report Title:	Item 2.1 - People & OD Highlight Report
Executive Lead:	Jeremy Over, Executive Director of Workforce & Communications
Report Prepared by:	Amanda Bennett & James Barrett, Freedom to Speak Up Guardians Helen Davies, Head of Communications Helen Kroon, Medical Staffing Manager (Ops) Jeremy Over, Executive Director of Workforce & Communications
Previously Considered by:	N/A

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

Executive Summary

The People & OD highlight report was established during 2020-21 as a regular report to strengthen the Board's focus on how we support our people, grow our culture and develop leadership at all levels. This format will continue to be developed, alongside the 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 (April/May)
- Quarterly report to the Board from our Freedom to Speak Up Guardians
- Staff Survey 2021 overview
- Consultant appointments

Action Required of the Board

For discussion and noting

Risk and assurance:	Research demonstrates that staff that feel more supported will provide better, higher quality and safer care for our patients.
Equality, Diversity and Inclusion:	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.

Putting You First – April/May awards

Dr Will Petchey
Nominated by Matt Youngman, Angharad Williams, Angel Smith & Annika Wallis

Will Petchey is a fantastic role model to the Trust as a whole, placing the care of his patients above all else and goes above and beyond the call of duty.

Will is involved in many key projects, including branching his expertise into the care of Covid-19 patients. He always makes time to speak with all members of staff, providing both insight and encouragement. Consistent contributions into various clinical governance groups is greatly appreciated.
…

Dr Petchey has been a strong leader during difficult times and rapidly set up Covid pathways, including ensuring newly licenced drugs are promptly available. He is tirelessly available to guide junior doctors, who regularly express how helpful and patient he is.

He also keeps abreast of all relevant research and ensures all Covid or renal patients get access to all the possible treatments that are suitable. He is an excellent leader and very kindly as a person.
…

Even though Dr Petchey has been extremely busy manning G10, coordinating Covid-19 treatment trials and continuing with his nephrology duties and clinical director role, he has always made time for the nephrology office team, making sure we are all ok and continue to feel supported.

Beverley Walsh, WSFT librarian
Nominated by Laura Wilkes and Emily Baker

Beverley is really efficient, professional and helpful. What I've been most impressed with is how she keeps you updated about what is happening so you know that your query is being processed and dealt with and is so positive and upbeat in her responses. She has a can-do attitude and is an asset to the library service and really helpful at maximising access to the resources we need to do our jobs well.
…

I would like to add that Beverley always lives the Trust values and puts our service users first. She is professional and meticulous in her approach as well as genuinely caring about our users' welfare, particularly during the pandemic. For my part, I know I could not have got through the last two years without her encouragement and support. In a crisis situation, she rose to the challenge and has ensured that we were able to continue to offer a consistent presence and service throughout the various lockdowns.

Sarah Clarke, sister, ward G9
Nominated by Elizabeth Jose

I would like to nominate Sister Sarah Clarke for upholding the Trust values in her daily working life.

Throughout the pandemic, when our staff were working under extraordinary pressure, she always made sure her team was well supported. When the staff are off sick, she makes a wellbeing phone call to them at home. This make us feel valued as member of the team.

Sarah also make us aware of services available to us, such as staff wellbeing initiatives. She goes above and beyond for her patients and is caring and compassionate. She is kind, supportive, approachable and always listens to staff.

I feel that the service and dedication shown by Sister Sarah to her patients and colleagues deserves recognition and will also boost the morale of the ward and help us with staff retention.

Speak Up Report

Our Freedom to Speak Up Guardians, Amanda Bennett and James Barrett, have shared their quarterly report (Q4, 2021/22) which is attached as **appendix 1**. This reflects their learning, influence and experience over the past quarter, and advice to the Board. They will be in attendance to present and discuss the report at our meeting on 27 May.

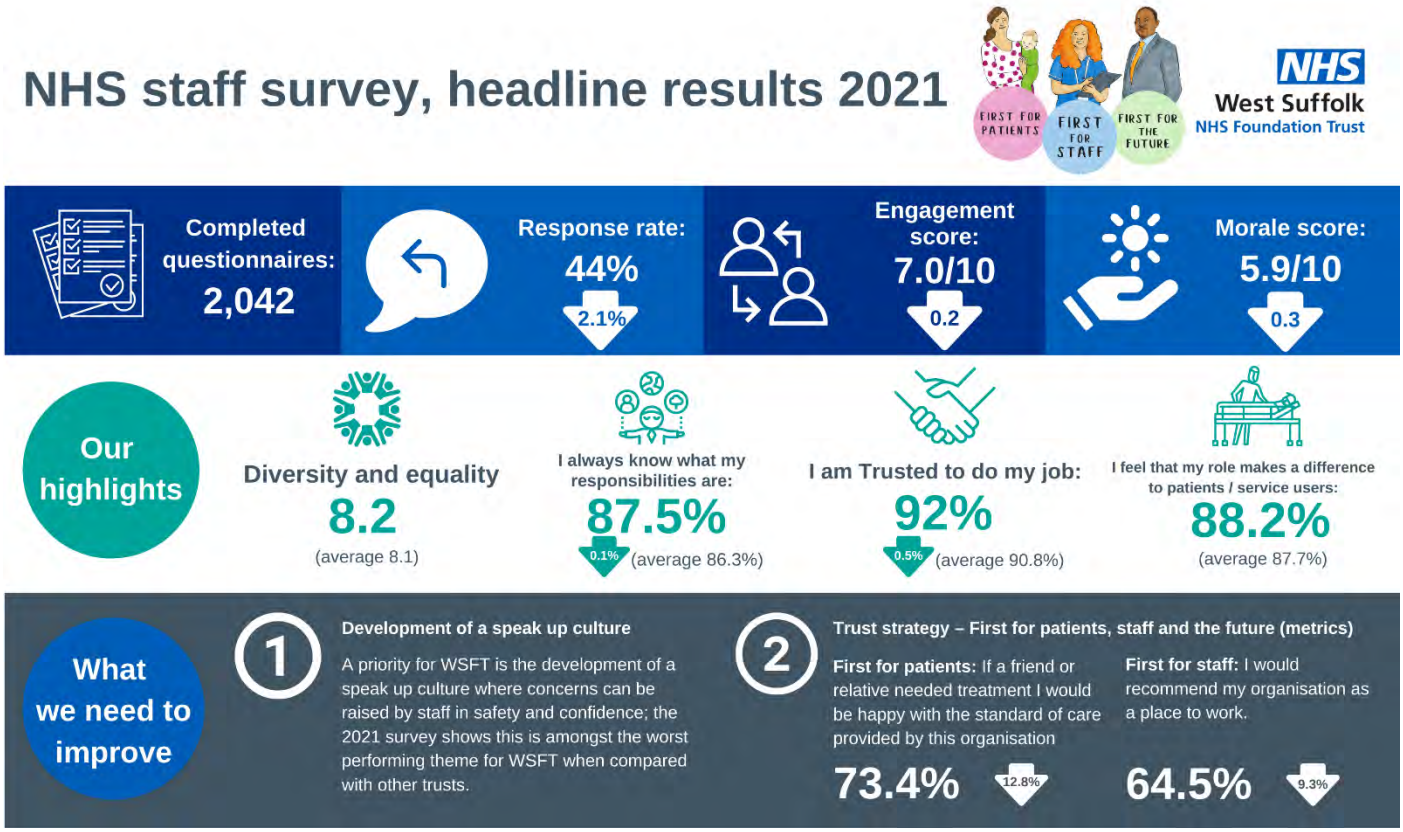
Staff Survey 2021 overview

The NHS staff survey is run on an annual basis across the service in England. It is one of the largest staff feedback and benchmarking exercises for any employer in the world and provides deep insights into the views and experiences of our staff. The results provide a significant opportunity to understand our current position, check whether we are prioritising the right things in our improvement work, and involve our teams in how the report's findings are interpreted and taken forward.

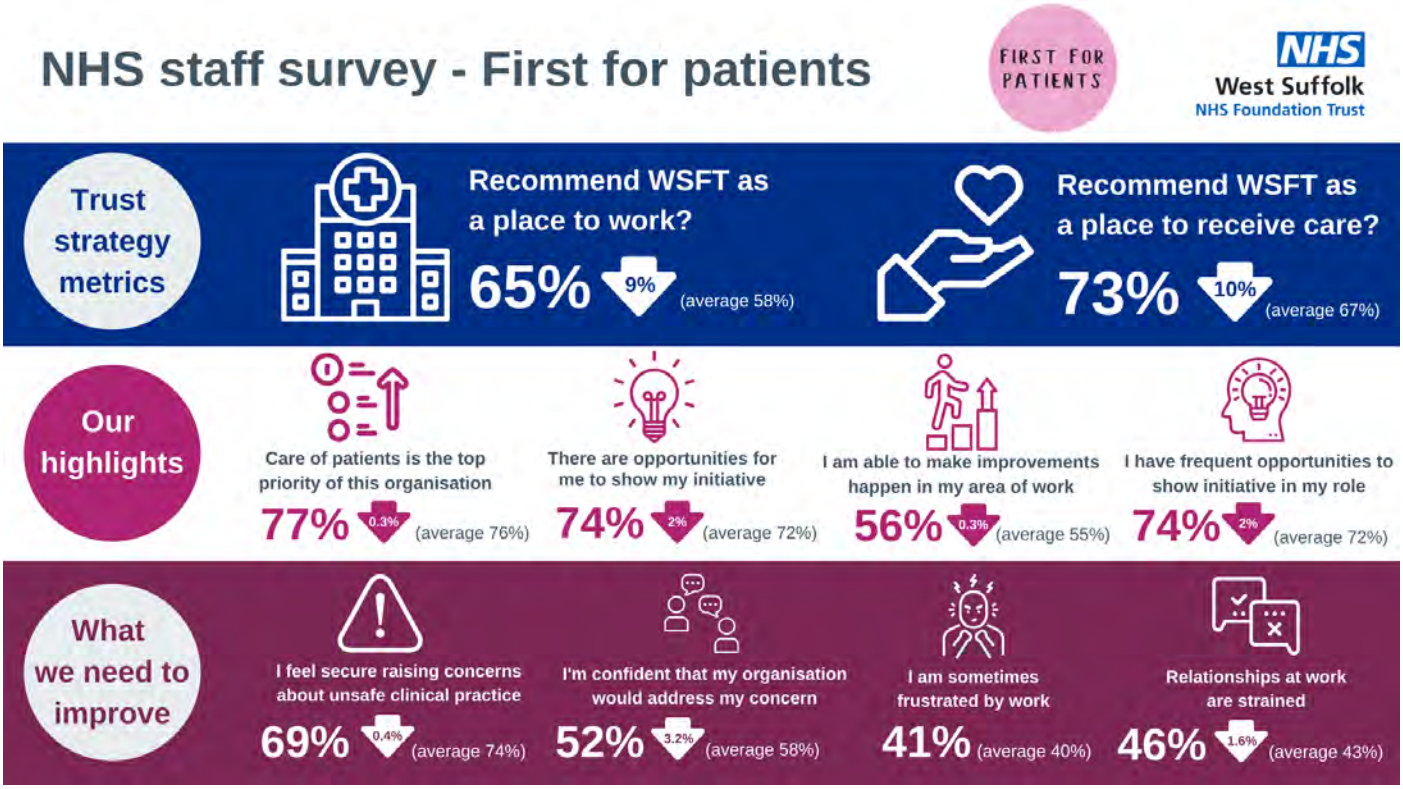
The results from the most recent survey, undertaken in October-November 2021, were published at the end of March. We have shared the results with staff and are using these to update our understanding of staff's views and any changes to our priority areas for action. In addition, our clinical divisions are delving deeper into the results to understand their own position and priorities.

Headlines:

- The survey was undertaken across England following eighteen months of working during a global pandemic. The results at a national level appear to reflect the impact of this with unprecedented reductions in average scores as compared with the previous year. It is likely that most if not all Trusts have experienced a deterioration in their scores
- The situation at West Suffolk reflects the national position, with the majority of scores reducing at a similar level to the national average. There are a number of measures where the reduction is more pronounced, and a number that have fared better as compared with the national average.
- We already appreciate that a particular priority for WSFT is the development of a speak up culture where concerns can be raised by staff in safety and confidence. The 2021 survey continues to show that this is amongst the worst performing theme for WSFT when compared with other Trusts.
- Overall, the 9 key measures for the survey show that WSFT compares favourably to the national average. One of the 9 measures is equal to the national average, the other 8 are better than the national average. None are below the national average, although there are certain component scores that contribute to these 9 measures that are weaker.



To support our understanding of the results, and to help share them with staff, we have developed the following two infographics, aligned to the ‘First for Patients’ and ‘First for Staff’ strategic goals:



Attached to this report as appendix 2 is the detailed analysis that underpins these two infographics.

The Involvement Committee discussed a presentation of these results at its most recent meeting in April, including analysis of where the trend at West Suffolk appears better and worse than the national average trend. This will also help check that we are prioritising the right things.

This work aligns with the content of our OD plan, developed as part of the response to the West Suffolk Review, which reflects how we wish to lead and support the cultural development of our organisation.

Helen Davies, Head of Communications will join me in presenting this item at the Board meeting, in particular to share how her team have led the sharing of these results with staff and mechanisms in place for staff to provide feedback.

Recent Consultant Appointments

Post:	Consultant Radiologist
Interview:	3 May 2022
Appointee:	Dr Saranya Vickramarajah
Start date:	TBC

Current post: ST5 Radiology, Barts NHS Trust
March 2022 to present

Previous Position:
March 2019 – December 2020
ST4/5 Radiology, Barts NHS Trust

Post: Consultant Obstetrician & Gynaecologist (labour ward lead)
Interview: 17 May 2022
Appointee: Dr Laura Minns
Start date: 5 September 2022

Current post: ST7 Obstetrics & Gynaecology, West Suffolk NHS FT
August 2021 to present

Previous Position:
August 2018 – August 2021
ST5-7 Obstetrics & Gynaecology, Norfolk & Norwich University Hospitals FT

Post: Consultant in Trauma & Orthopaedics (upper limb)
Interview: 19 May 2022
Appointee: Dr Michael John Dunne
Start date: TBC

Current post: Post-CCT Fellow (shoulder & elbow), Nottingham University Hospitals
August 2021 to present

Previous Position:
August 2020 – August 2021
ST8 T&O (shoulder, elbow & hand surgery), Norfolk & Norwich University Hospitals FT

Post: Consultant in Trauma & Orthopaedics (upper limb)
Interview: 19 May 2022
Appointee: Mr Georgios Konstantopoulos
Start date: 20 May 2022

Current post: Fixed-term consultant in Trauma & Orthopaedics, West Suffolk NHS FT
May 2021 to present

Previous Position:
Dec 2020 – May 2021
Locum Consultant in Trauma & Orthopaedics, Princess Alexandra Hospital

3. STRATEGY

3.1. Future system board report

To Assure

Presented by Craig Black

Public Board Meeting – 27th May 2022

Report Title:	Item 3.1 - Future System Board Report
Executive Lead:	Craig Black
Report Prepared by:	Gary Norgate
Previously Considered by:	Future System Programme Board

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

Executive Summary

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

1. Following the successful submission of our outline planning application, our Local Planning Authority has launched formal consultation on our plans to build a new hospital on Hardwick Manor. Consultees include in excess of 3000 households and statutory organisations. The consultation window closes on 18th May and, to date, 19 neighbour responses and 12 consultee comments have been received.
2. The main area of concern raised by the public focuses on highways, traffic management and the impact of the new build on bio-diversity.
3. The primary areas of focus during the planning period remain; the modelling and agreement of a sustainable flood strategy, negotiation and agreement of a bio-diversity compensation plan and reacting to the questions and concerns raised during consultation.
4. The New Hospitals Programme (NHP)[1] has committed to support the successful completion of our planning application and a funding plan / budget has been agreed.
5. Details of how NHP intend to develop standard templates for key construction elements and outline business cases (OBC) continue to emerge and workshops have been planned to co-produce a governance structure, a model OBC, a construction template and a common approach to demand and capacity modelling. The WSFT team are fully engaged in each initiative.
6. The NHP Programme Business Case[2] has now been formally presented to the Joint Investment Committee and Major Projects Review Group[3], we expect an outcome (i.e. ministerial sign-off) before the summer recess.
7. The 1:200 level designs for the new West Suffolk Hospital are almost complete and will continue to be co-refined as the project progresses.
8. In light of the increased focus on working with NHP on the co-creation of central designs, a revised workplan, that removes the risk of abortive work whilst ensuring our team doesn't lose

[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] The MPRG works with HM Treasury and other government departments to provide independent assurance on major projects.

momentum on those areas that are, and always will be, unique to West Suffolk has been agreed.

9. A prioritised schedule of when individual schemes within the NHP can expect to commence construction is expected to emerge from a further presentation to the Major Projects Review Group planned for October. This list is expected to reflect the unique challenges faced by RAAC[4] hospitals.

Business Cases and Project Plan

Recent discussions with NHP have illustrated how progress and funding of the overall programme has to be managed in a way that does not overwhelm the capacity that the construction sector has to build the 48 new hospitals[5]. To this end, NHP have constructed an overarching Programme Business Case that they expect to submit for ministerial agreement in May 2022[6]. Said case has the following aims:

a. Agree the concept of the programmatic approach
b. Agree the overspend of Cohort 1[7] Projects
c. Agree to commence the Cohort 2 projects and their associated capital envelopes
d. Agree a process through which to progress projects within Cohorts 3 and 4

This programme business case will provide the budget for the current spending review period which runs between 2020 to 2024 (this has previously been set at £3.7bn). Other key points emerging from our NHP discussions include:

1) There will be a separate set of decisions on how issues faced by all of the RAAC hospitals (not just those within the NHP) will be addressed.
2) There will be a process of prioritising Cohort 3 and 4 projects – in essence projects will be prioritised on readiness, deliverability and need (so I think we are very well placed to be prioritised).
3) The funding envelope being requested for all of those projects in Cohorts 3 and 4 is based on our stated preferred options (so, in our case, building a new hospital on Hardwick Manor for c. £700 million – a significant improvement on the initial allocation of £250m!!!)
4) NHP will be looking to co create outline business cases with Trusts - they want to influence inputs rather than review individual outputs.
5) 2022/23 funding –We, along with other schemes, have initially been allocated £1.06m to cover the continuation of our planning application.
6) A central Demand and Capacity model will be “road tested” and hot-housed with some trusts before being released and, given the maturity of our own work in this area, the Future System Programme will be among the first projects to engage in this activity.
7) Hospital 1.0 (The standard design template), is progressing well and we expect that by June we will be in a position to compare our own co-produced 1:200 level designs to this standard.

This centralised programmatic approach will initially cause the Future System Programme to de-prioritise activities related to the construction of a bespoke OBC, however, the ability to adopt the standards produced by NHP will accelerate the authorisation process and, ultimately, will only have a positive impact of our time, cost and quality objectives.

[4] RAAC = reinforced autoclaved aerated concrete – a form of lightweight concrete that was used extensively in the construction of our current hospital and those such as Queen Elizabeth Kings Lynne.
[5] It has been widely reported that some of the projects within the NHP are not actually new hospitals – however, although this is true, every scheme within the programme is of significant size and complexity and a as such requires careful management.
[6] The Programme business case was presented on 13th May – we await an outcome.
[7] The 48 schemes within the NHP have been sub divided into 5 cohorts, Cohort 1 are projects that have already commenced (e.g. Liverpool), Cohort 2 are smaller agile projects, Cohort 3 are those projects that have already made significant advances (e.g. West Herts), Cohort 4 are the next wave of projects initially announced in the second round of funding (includes West Suffolk) and Cohort 5 are 8 new schemes that have yet to be announced.

That said, this approach is not without risk. If NHP are delayed in the sign off of their programme business case and if they are late in the construction of Hospital 1.0 and the centralised demand and capacity model, there will, undoubtedly, be a knock-on impact to our project.

Other key activities and milestones:

- **The submission and conclusion of our application for outline planning consent**. Submission of our application was achieved on 31st March 2022 and we remain on track to secure a positive determination by the close of the summer / early Autumn (the planning committee sits on 7th September and 6th October).
- **The translation of our co-produced clinical model and its associated schedule of accommodation into a relatively detailed 1:200 outline design**. Clinical co-production workshops have been completed and have resulted in a set of 1:200 designs and accompanying comments / caveats. Designs for individual departments within the hospital are at various degrees of being entirely signed off (each are rated Red Amber and Green depending on their associated comments / level of agreement). These designs will be under continual review (in line with our principles of co-production) and will continue to reflect inputs received from planned patient workshops, technical input from our environmental and engineering partners and input from NHP.

In addition to these key activities and in light of the increased engagement with NHP, the project team have agreed to re-plan activities into three areas:

Conclusion of our outline planning application – NHP are committed to supporting the conclusion of our planning application and, as mentioned above, have provided funds of £1.06m to cover the outstanding activities.

Working with NHP to co-create central design, planning and commercial frameworks – The West Suffolk team are engaged in the co-creation of frameworks spanning; project governance, demand and capacity modelling, OBC chapters and clinical / technical design. Initial workshops have been held and work is expected to ramp-up over the summer period.

System and Trust Transformation - working across the Trust and Integrated Care System to identify and implement the transformational changes that will ensure the new hospital, its processes and its efficacy are sustainable and congruent. A breakdown of specific activities in this area are contained below in the clinical update.

This approach means that by the time of our next Board meeting we should:

- Know the extent to which the Programme Business Case is formally supported (including, therefore, a view of overall budget and an agreed method for progressing the entire programme).
- Understand the outcome of the first round of planning consultation and the nature of any associated risks.
- Have a clear method for the production of a model OBC and what it means for our Future System Plans
- Have a clear understanding of the depth to which standard hospital design intends to go and what this means for our own co-produced designs.
- Be in a position to triangulate the FS team view of demand and capacity with that which arises from the NHP model and that which is expected across the ICS.
- Have a full set of 1:200 drawings along with a set of comments and caveats that will be progressively reconciled.

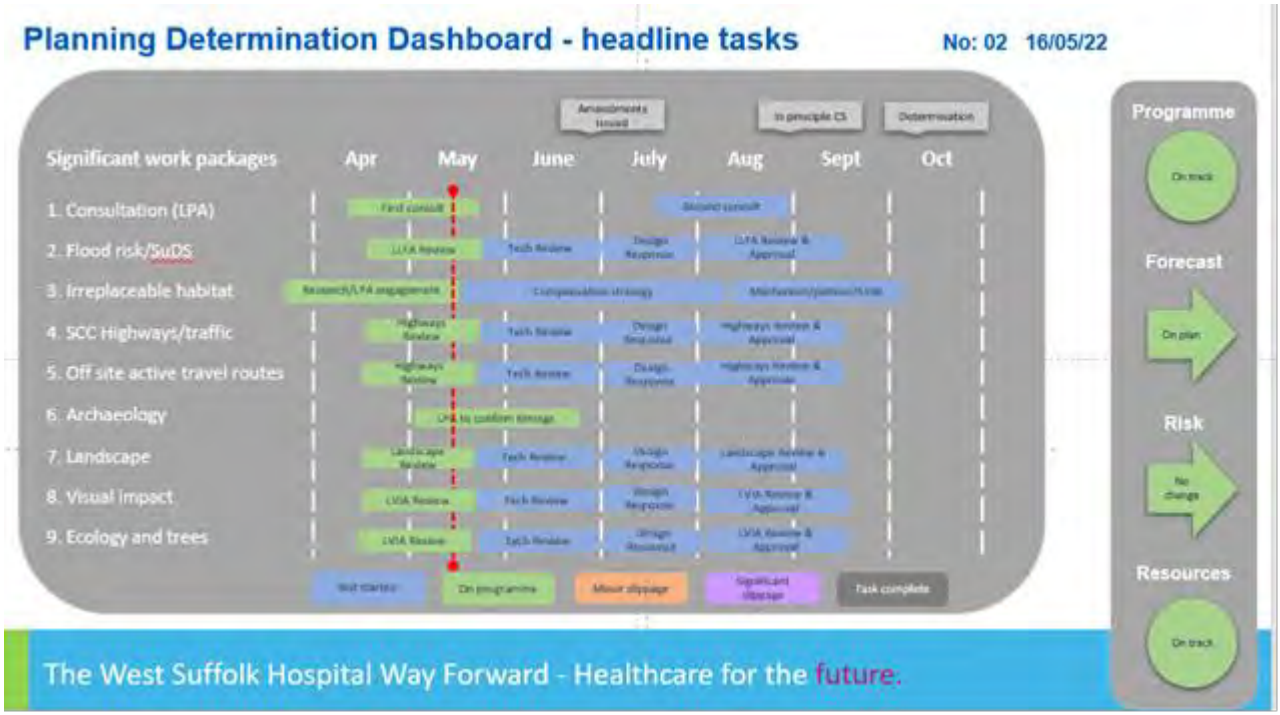
Looking further into the future, October represents another significant watershed by which time we should:

- Know the outcome of our planning application

- Have a view of scheme prioritisation within the NHP and understand the plans for how Government / Department of Health intend to treat RAAC[8] hospitals.

Estates Workstream

Securing a positive outcome for our outline planning application remains the single most important short-term milestone in our programme. Failure to secure consent to build on Hardwick Manor would represent a significant set-back that would almost certainly delay our construction date. With this in mind, we are carefully managing progress with use of the following dashboard:

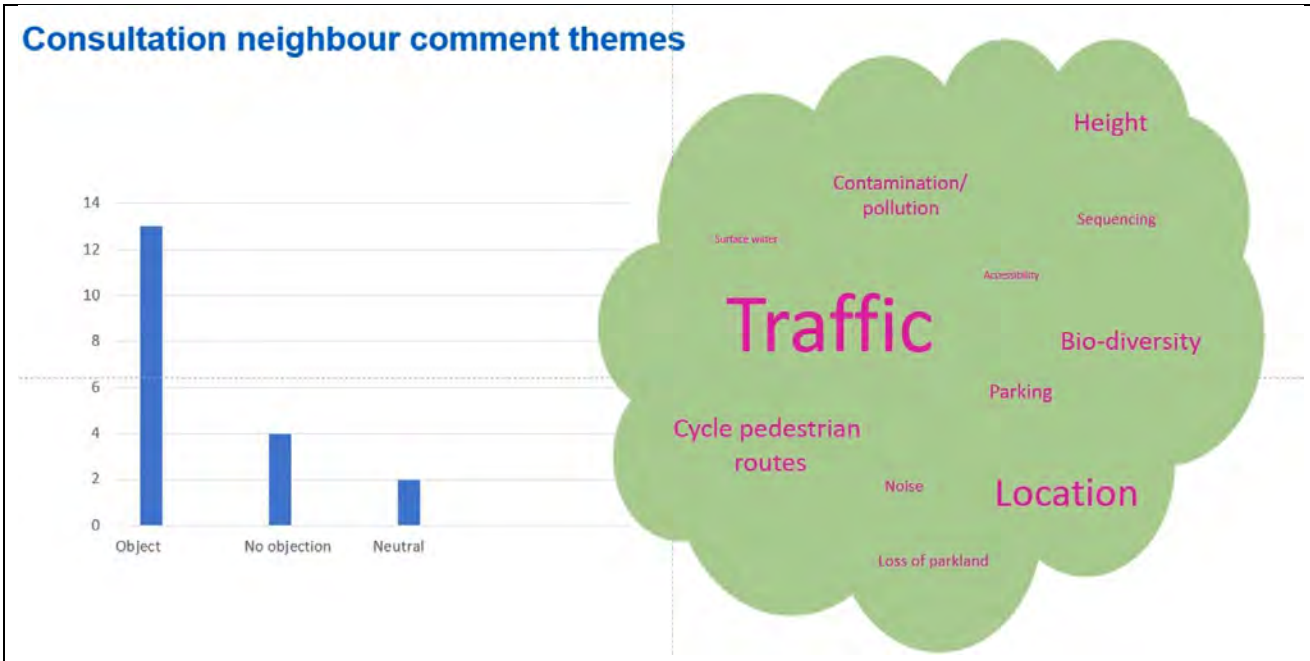


The dashboard above lays out the key activities that will be progressed in support of our outline planning application (if only it was easy as submitting the application and waiting for an answer!!). In essence, the team are focussed upon consulting with our public and statutory consultees to ensure we understand their concerns and develop solutions / suitable mitigations for issues such as; flood threat, impact on the ecology, compensation for damage to habitat, visual impact and traffic flows. Suffice to say, the key activities contributing to a successful outcome are fully understood, we continue to enjoy a strong working relationship with our local planning authority, we remain committed to protecting the ecology of our site and we are actively seeking and reviewing the concerns of our staff, patients and community.

At the time of writing this report we had consulted with over 3000 of our immediate neighbours and statutory consultees (e.g. Highways department and Suffolk Wildlife Trust) and had received 19 neighbour responses and 12 consultee comments. The “word cloud” below summarises the focus of the responses with each word proportionately sized to represent the number of times an issue has been raised. From this analysis, it becomes clear that traffic is the primary concern and, consequently, significant effort will be placed upon understanding and mitigating this matter. That said, I was particularly pleased to receive support for our plans from Bury Town Council[9], Horringer Council and the Bury Society.

[8] RAAC = reinforced aerated autoclaved concrete, a popular material used in the construction of buildings in the 1960s/70s that has limited future viability.

[9] Bury Town Council support our application in principle subject to environmental and traffic mitigations and an assurance that no part of the site will be used for commercial gain/residential development



Clinical / Digital Workstream

In light of the increasing focus on the development and application of common models and templates, the Clinical team have been identifying the activities that they can prioritise that will maximise progress whilst minimising the risk of duplicating or conflicting with the emerging NHP guidance. The top priorities are:

1. The community and primary care workstreams
2. The clinical design for the Western Way development
3. Apply the conclusions of our co-produced clinical visions to the construction of a trust-wide clinical strategy
4. Develop the business case for the refurbishment of the Education Centre
5. Agree which changes from the phase 4 workshops will go through formal change control; including maintaining the existing MRI suite and the location of some estates and facilities areas
6. Review the clinical and operational vision for Ophthalmology and create indicative designs
7. Understand the implications of the live transformation projects for the long-term capacity requirements in day surgery and emergency care
8. Develop sample designs for 1 or 2 staff hubs and flesh out the workplace strategy that will underpin the new ways of working in office space

Most of these priorities are focussed on areas that are closely related to our Future System Project without being a direct part of it – for example, the size of the new hospital will be to some degree dependent upon the services that move to Western Way (or any other location) , however, these moves will progress at their own pace regardless of whether we build a new hospital and a paper is due to be presented to the board with options and a recommendation in July. Focussing on these priorities will ensure important progress is maintained without the risk of decisions being taken that could be undermined or rendered obsolete by centrally developed guidance or templates.

In addition to these priorities, the clinical team will also engage with NHP in the co-production of the aforementioned central templates and in determining how any central construct can be made to work safely and effectively in the unique environment of the West Suffolk System.

Communications and Engagement

As well as continuing to run patient focus groups aimed at the co-production and co-refinement of the 1:200 designs, our communications and engagement lead will also be working with the clinical team to ensure any services changes associated with the potential move to Western Way (or any other of the transformational activities) are thoroughly and formally consulted upon.

Finance

As mentioned above, the NHP are fully committed to supporting our planning application and with this in mind have agreed funding of £1.06m to support a detailed budget and cash flow. Additional funding will be required to take our application beyond the 'outline' phase. There may also be a need to fund advanced development works associated with the planning of the underlying power network. This potential requirement has been discussed with NHP and funds will be sought through the emerging "enabling works" process. In any event, funding remains constrained and tightly controlled, however, there is a need to maintain the momentum of the core team and to this end, the Trust have agreed a budget to cover additional internal spend.
The same approach applies to all of the schemes within the national programme and ensures external spend on potentially duplicative and abortive work is minimised.

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

- The Programme Business Case should be signed off.
- The first round of public consultation on our planning application should have been completed and analysed.
- We should have a much clearer view on how the national co-production of design and commercial standards will be achieved and the role we have to play.
- We will have a full set of 1:200 scale plans and a detailed understanding of any outstanding areas requiring debate.

Action Required of the Board

To note the contents of this report.

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

Comfort Break

4. ASSURANCE

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

To Assure

Presented by Richard Davies

Board of Directors – 27 May 2022

Report Title:	Item 4.1 – Insight Committee April & May 2022 – Chair's key issues
Executive Lead:	Dr Richard Davies, NED, Insight Committee Chair
Report Prepared by:	Dr Richard Davies, NED, Insight Committee Chair
Previously Considered by:	n/a

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

Executive Summary
The Insight Committee met on 4 April & 9 May 2022. Below is the Chair's Key Issues documents which will constitute the standard template for Insight Committee reports to Board.
Action Required of the Board
To approve the report

Risk and assurance:	The development of and transition to a new structure for organisational governance may result in a failure to escalate significant risks to management, the executive team and the board of directors, caused by a disruption to the previous information and communication flows whilst new arrangements are being established.
Equality, Diversity and Inclusion:	*n/a*
Sustainability:	*n/a*
Legal and regulatory context	Well-Led Framework NHSI FT Code of Governance

Chair's Key Issues

Originating Committee	Insight Committee	Date of Meeting	5th April 2022
Chaired by	Richard Davies	Lead Executive Director	Nicola Cottington

Item	Details of Issue	For: Approval/ Escalation/Assurance	BAF/ Risk Register ref	Paper attached? ✓
Workforce Divisional Scorecards	Workforce indicators remain a concern: • Turnover and absence rising (with evidence that lower bands contribute higher absence levels – the potential reasons for this were discussed but remain unclear) • Appraisal rates and mandatory training below target Whilst the Involvement Committee is looking at specific reasons for the turnover rates, these are all indicators of a workforce under enormous pressure. It was agreed that supporting staff is the KEY issue for the organisation and needs to be a focus of all that we do.	**Limited Assurance**	**BAF 6**	
Ockenden Report	The second and final Ockenden Report has recently been published and contains a wide range of recommendations and requirements. Whilst some of these items are specific for maternity services (and will best be managed through the Maternity Improvement Plan), many are highly relevant to the organisation as a whole. It is essential that progress against the report is effectively monitored through the Trust Governance processes, but it is not immediately clear where this 'fits' within the current structure. This needs further thought outside of the committee with an action to report back to Insight.	**Partial Assurance**	**BAF 1**	
Patient Access	There have been some 'small wins' over the past month with improvements in ED 12 hour waits, Cancer 2WW performance and in the 104 day wait position. There are still concerns regarding diagnostic performance particularly CT and MRI. Delayed discharge as a result of social and community care capacity issues remains a significant problem for flow through the acute Trust. It was noted that there is a risk that the Trust focuses on its responsibility to ensure that the inpatient services are doing all they can to facilitate discharge from the hospital without acknowledging the WSFT responsibility for community services and for	**Partial Assurance**	**BAF 2**	

	engagement with partners in the wider health and social care system. We need to recognise that we share responsibility for the pressures on community and social services.			
Glemsford Surgery	The Committee discussed how Glemsford Surgery access and performance data feeds into the Trust governance and assurance processes. It was recognised that teams within the acute Trust have limited experience of understanding GP access and performance data (mostly managed through the Quality and Outcomes Framework – QOF), and this means that visibility of this data within the Trust and support for the Surgery has not been as effective as it could be. A review of how Glemsford Surgery fits into the Trust governance processes will be brought back to Insight.	**Limited Assurance**	**BAF 1**	
IQPR	The interim IQPR (pending development of the integrated dashboard – a significant piece of work) is evolving. The current iteration was reviewed and received very positively. In particular there was strong support for: • The grouping of data into relevant sections • Use of 'making data count' methodology such as SPC charts • A focus on key issues where there is significant variance • The improved narrative and assurance	**Information**		
Escalation to Improvement Committee	The Improvement Committee is currently reviewing the Specialist Committees and their ToRs. An outstanding action for the Insight Committee is to review data flow into the Specialist Committees and it was agreed that it would make sense to incorporate this action into the work already being undertaken by Improvement	**Escalation to Improvement**		
Escalation to Involvement Committee	Two issues were highlighted for escalation to the Involvement Committee from the Corporate Risk Governance Group: 1. There has been an increase in absence as a result of 'psychological harm', this is not only an important indicator of staff wellbeing but there is also concern that visibility of this indicator may be affected by the move to a new Occupational Health provider 2. The H&S committee need to be involved with the response to the recently published National Staff Survey	**Escalation to Involvement**		
Date Completed and Forwarded to Trust Secretary		**11.4.22**		

Chair's Key Issues

Originating Committee	Insight Committee	Date of Meeting	9th May 2022
Chaired by	Richard Davies	Lead Executive Director	Nicola Cottington

Item	Details of Issue	For: Approval/ Escalation/Assurance	BAF/ Risk Register ref	Paper attached? ✓
Insight Committee Developments	This was the first meeting of the Insight Committee with its new scope. • There was a recognition that the previous 3i structure risked work duplication, uncertainty around ownership of issues and an excessive number of metrics (potentially inhibiting effective discussion of the most important issues) • The Patient Safety & Quality Governance Group, and the Clinical Effectiveness Governance Group now report to the Improvement Committee. The Insight Committee now focuses on Finance & Workforce, Patient Access and Corporate Risk • The Insight Committee needs to be more data driven and it is important that the Committee provides assurance to the Board and the Council of Governors regarding the processes through which specialist subgroups and departmental Performance Review Meetings (PRMs) analyse and escalate Trust data. IQPR developments are a key part of this. More work needs to be done to provide this assurance.	**Partial Assurance**	**BAF 1**	
Sustainability Programme	• This new approach focuses on sustainability rather than cost improvement with an expectation that this will necessarily drive quality improvement and cost saving. • This significant change in focus requires a radical culture shift, not least within the Project Management Office (PMO) • There have been resultant delays in finalising budgets and processing business cases.	**Partial Assurance**	**BAF 5**	
Workforce	• The F&W Governance Group were unable to discuss workforce metrics at their last meeting in view of time constraints – so it is not possible to provide assurance on relevant workforce metrics at the May meeting	**No Assurance**	**BAF 2 and 3**	
Radiology Equipment	• A number of pieces of radiology equipment are past their expected working lifespan. Whilst there is a replacement programme included in	**Partial Assurance**	**BAF 3**	

	the Capital Programme, it will not be possible to replace all of these in the next financial year. • In meantime there is a risk of equipment failure (there have already been problems with one of the CT Scanners which is impacting on access performance). This will be recorded as a risk within the Trust Risk Register			
Patient Access	• Paediatric Community Standards were raised as a concern, particularly in relation to the ASD (Autism Spectrum Disorders) pathway for school age children, but also for paediatric speech and language and clinical psychology services. A recovery plan agreed with the CCG is being hampered by difficulties in staff recruitment. • Cancer performance remains challenging, particularly 2WW targets. These have been impacted by staff sickness and diagnostic performance (including the CT scanner breakdowns mentioned above).	**Partial Assurance**	**BAF 3**	
ED Performance	• ED length of stay figures have increased again, with 438 patients experiencing stays over 12 hours in March, reflecting the pressures on the department and problems with flow through the system. • Mental health problems. Although a relatively small (but increasing) proportion of ED attendees – they have a disproportionate impact on ED LOS figures because of difficulties accessing external mental health care services. This is a significant system wide problem with lack of capacity and although there is ongoing work system-wide to resolve this issue, progress is slow. There is an opportunity for the health care community to do more around mental health issues and we need to recognise our responsibilities in this area	**Partial Assurance**	**BAF 2**	
EPRR (Emergency Preparedness Resilience and Response)	• There are a number of weaknesses within the Trust's business continuity control framework, highlighted through Internal Audit. A number of actions have been outstanding for some time. • There is currently ongoing work to prioritise these actions and understand the resource needs • There is a commitment and expectation that actions will be closed by their due dates - Oct and Dec 2022	**Reasonable Assurance**		
Date Completed and Forwarded to Trust Secretary		**13.5.22**		

4.2. Finance and Workforce Report

To Note

Presented by Nick Macdonald

Board of Directors – 27 May 2022

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

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

Executive Summary

The reported I&E for April is breakeven.

After assessing the available guidance around activity plans, workforce plans and regulatory requirements the Trust has set a budget of break-even for 2022/23. This position does carry with it a number of risks:

- Ongoing impact of covid on our capacity and operational capability
- Impact of inflation
- Impact of RAAC programme

At present, we anticipate there being sufficient mitigations to be able to offset these risks. A key part of these mitigations is identifying opportunities to remove additional costs of COVID wherever possible and developing, embedding and delivering a robust sustainability programme.

Action Required of the Board

The Board is asked to review this report

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

FINANCE AND WORKFORCE REPORT
April 2022 (Month 1)

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

Financial Summary

I&E Position YTD	£0m	on-plan
Variance against Plan YTD	£0m	on-plan
Movement in month against plan	£0m	on-plan
EBITDA position YTD	£1.4m	favourable
EBITDA margin YTD	5%	favourable
Cash at bank	£27.3m	

Executive Summary

- The reported I&E for April is breakeven.

Key Risks in 2022-23

- Costs and income associated with revised activity plan
- Costs associated with increased capacity pressures relating to COVID-19 and RAAC planks.
- Impact of inflation
- Achievement of ERF

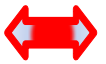
SUMMARY INCOME AND EXPENDITURE ACCOUNT - April 2022	April 2022 Budget £m	April 2022 Actual £m	April 2022 Variance F/(A) £m
NHS Contract Income	25.5	25.6	0.1
Other Income	3.0	2.7	(0.3)
Total Income	**28.5**	**28.3**	**(0.1)**
Pay Costs	18.9	18.6	0.3
Non-pay Costs	8.4	8.3	0.1
Operating Expenditure	**27.3**	**26.9**	**0.4**
Contingency and Reserves	0.0	0.0	0.0
EBITDA	**1.2**	**1.4**	**0.2**
Depreciation	0.8	0.8	(0.1)
Finance costs	0.4	0.6	(0.1)
SURPLUS/(DEFICIT)	**0.0**	**(0.0)**	**(0.0)**

FINANCE AND WORKFORCE REPORT – April 2022

Contents:

Key:

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

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

FINANCE AND WORKFORCE REPORT – April 2022

Income and Expenditure Summary as at April 2022

The reported I&E for April is breakeven.

After assessing the available guidance around activity plans, workforce plans and regulatory requirements the Trust has set a budget of break-even for 2022/23. This position does carry with it a number of risks:

- Ongoing impact of covid on our capacity and operational capability
- Impact of inflation
- Impact of RAAC programme
- Impact of winter pressures

At present, we anticipate there being sufficient mitigations to be able to offset these risks. A key part of these mitigations is identifying opportunities to remove additional costs of COVID wherever possible and developing, embedding and delivering a robust sustainability programme .

Summary of I&E indicators

Income and Expenditure	Plan/ Target £000'	Actual/ Forecast £000'	Variance to plan (adv)/ fav £000'	Direction of travel (variance)	RAG (report on red)
In month surplus/ (deficit)	0	(0)	(0)	⇔	Green
YTD surplus/ (deficit)	0	(0)	(0)	⇔	Green
EBITDA YTD	1,180	1,423	243	⇔	Green
EBITDA %	4.1%	5.0%	0.9%	⇔	Green
Clinical Income YTD	(26,579)	(26,577)	(1)	↓	Amber
Non-Clinical Income YTD	(1,875)	(1,730)	(146)	↑	Amber
Pay YTD	18,859	18,578	280	↑	Green
Non-Pay YTD	9,596	9,729	(133)	↓	Amber

FINANCE AND WORKFORCE REPORT – April 2022

Trends and Analysis

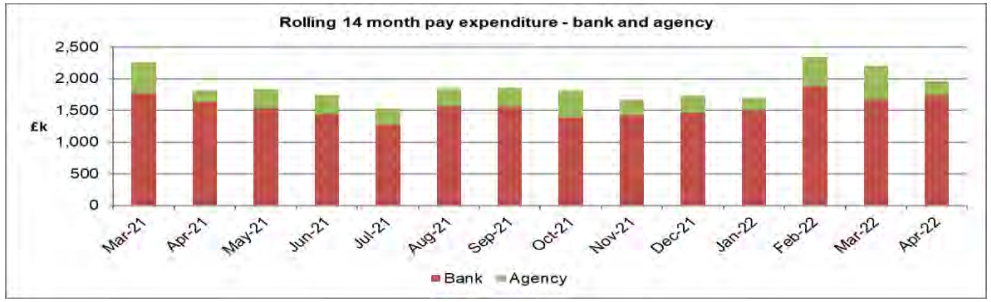
Workforce

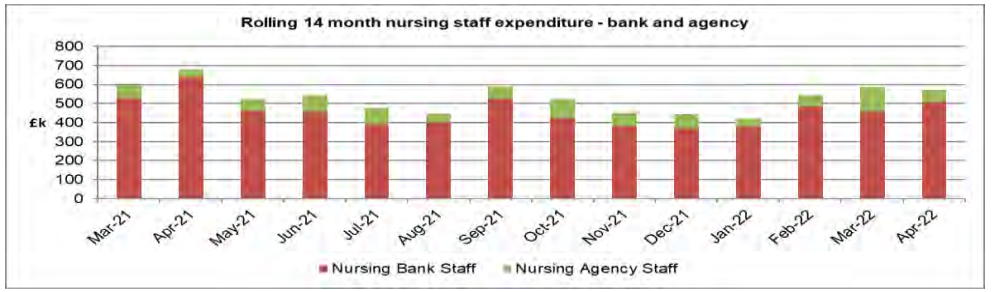
During April the Trust underspent by £0.2m on pay.

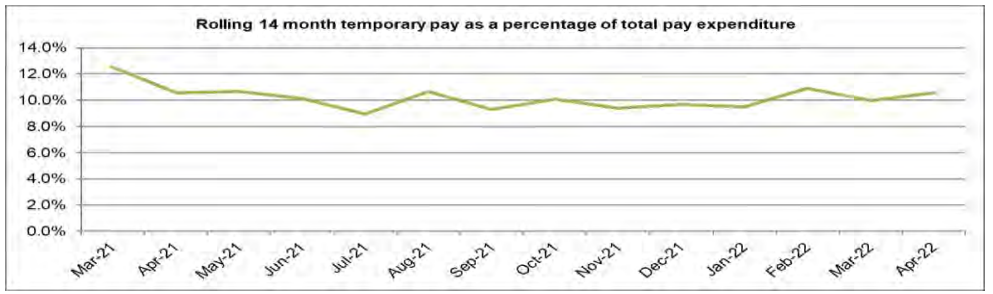
Monthly Expenditure (£)				
As at April 2022	Apr-22	Mar-22	Apr-21	YTD
	£000's	£000's	£000's	£000's
Budgeted Costs in-month	18,859	18,374	16,843	18,859
Substantive Staff	16,615	19,865	15,422	16,615
Medical Agency Staff	60	158	74	60
Medical Locum Staff	381	522	272	381
Additional Medical Sessions	253	168	182	253
Nursing Agency Staff	62	131	43	62
Nursing Bank Staff	509	455	638	509
Other Agency Staff	106	243	78	106
Other Bank Staff	244	224	301	244
Overtime	191	179	138	191
On Call	156	126	93	156
Total Temporary Expenditure	1,963	2,206	1,819	1,963
Total Expenditure on Pay	18,578	22,071	17,242	18,578
Variance (F/(A))	280	(3,696)	(399)	280
Temp. Staff Costs as % of Total Pay	10.6%	10.0%	10.6%	10.6%
memo: Total Agency Spend in-month	228	532	195	228

Monthly WTE				
As at April 2022	Apr-22	Mar-22	Apr-21	YTD
Budgeted WTE in-month	4,635.8	4,647.2	4,361.8	4,635.8
Substantive Staff	4,153.8	4,189.9	4,049.3	4,153.8
Medical Agency Staff	4.9	10.7	7.2	4.9
Medical Locum Staff	27.6	27.9	27.4	27.6
Additional Medical Sessions	0.6	6.7	2.9	0.6
Nursing Agency Staff	6.1	15.5	20.0	6.1
Nursing Bank Staff	139.7	119.9	175.5	139.7
Other Agency Staff	34.5	23.9	16.9	34.5
Other Bank Staff	84.8	72.8	118.4	84.8
Overtime	48.0	45.1	35.2	48.0
On Call	7.9	6.8	7.3	7.9
Total Temporary WTE	354.0	329.4	410.8	354.0
Total WTE	4,507.8	4,519.3	4,460.1	4,507.8
Variance (F/(A))	128.0	127.9	(98.3)	128.0
Temp. Staff WTE as % of Total WTE	7.9%	7.3%	9.2%	7.9%
memo: Total Agency WTE in-month	45.5	50.1	44.1	45.5

Pay Costs







FINANCE AND WORKFORCE REPORT – April 2022

Income and Expenditure Summary by Division

	Current Month		
	Budget	Actual	Variance F/(A)
MEDICINE	£k	£k	£k
NHS Contract Income	(7,883)	(7,401)	(483)
Other Income	(341)	(298)	(44)
Total Income	**(8,225)**	**(7,698)**	**(527)**
Pay Costs	4,862	4,844	18
Non-pay Costs	1,759	1,966	(207)
Operating Expenditure	**6,620**	**6,810**	**(190)**
SURPLUS / (DEFICIT)	**1,605**	**888**	**(716)**
SURGERY			
NHS Contract Income	(5,707)	(5,005)	(702)
Other Income	(174)	(181)	6
Total Income	**(5,881)**	**(5,185)**	**(696)**
Pay Costs	3,983	3,803	180
Non-pay Costs	1,143	1,291	(148)
Operating Expenditure	**5,125**	**5,094**	**31**
SURPLUS / (DEFICIT)	**756**	**91**	**(665)**
WOMENS AND CHILDRENS			
NHS Contract Income	(2,154)	(2,035)	(119)
Other Income	(82)	(22)	(60)
Total Income	**(2,236)**	**(2,057)**	**(179)**
Pay Costs	1,675	1,606	69
Non-pay Costs	180	240	(60)
Operating Expenditure	**1,855**	**1,846**	**8**
SURPLUS / (DEFICIT)	**381**	**210**	**(171)**
CLINICAL SUPPORT			
NHS Contract Income	(651)	(520)	(131)
Other Income	(138)	(170)	32
Total Income	**(789)**	**(690)**	**(99)**
Pay Costs	2,232	2,181	51
Non-pay Costs	1,012	1,268	(256)
Operating Expenditure	**3,244**	**3,449**	**(205)**
SURPLUS / (DEFICIT)	**(2,455)**	**(2,760)**	**(305)**
COMMUNITY SERVICES			
NHS Contract Income	(2,748)	(2,661)	(86)
Other Income	(1,276)	(1,174)	(102)
Total Income	**(4,023)**	**(3,835)**	**(188)**
Pay Costs	2,997	2,866	131
Non-pay Costs	1,234	1,176	59
Operating Expenditure	**4,232**	**4,042**	**190**
SURPLUS / (DEFICIT)	**(208)**	**(207)**	**2**
ESTATES AND FACILITIES			
NHS Contract Income	0	0	0
Other Income	(488)	(284)	(204)
Total Income	**(488)**	**(284)**	**(204)**
Pay Costs	1,061	1,033	28
Non-pay Costs	773	1,109	(336)
Operating Expenditure	**1,834**	**2,142**	**(308)**
SURPLUS / (DEFICIT)	**(1,346)**	**(1,858)**	**(512)**
CORPORATE			
NHS Contract Income	(6,354)	(7,991)	1,637
Other Income	(442)	(584)	142
Total Income	**(6,796)**	**(8,575)**	**1,779**
Pay Costs	2,050	2,246	(196)
Non-pay Costs	2,293	1,405	888
Capital Charges and Financing Costs	1,185	1,290	(105)
Operating Expenditure	**5,528**	**4,941**	**588**
SURPLUS / (DEFICIT)	**1,268**	**3,634**	**2,366**
TOTAL			
NHS Contract Income	(25,497)	(25,612)	115
Other Income	(2,942)	(2,712)	(230)
Total Income	**(28,438)**	**(28,324)**	**(115)**
Pay Costs	18,859	18,578	280
Non-pay Costs	8,395	8,456	(61)
Capital Charges and Financing Costs	1,185	1,290	(105)
Operating Expenditure	**28,438**	**28,324**	**115**
SURPLUS / (DEFICIT)	**0**	**(0)**	**(0)**

Medicine (Sarah Watson)

At M01 the Medicine division is behind plan by £716k.

Clinical income is behind plan by £483k in month. Significant sustained increases in A&E attendances has led to non-elective activity outperforming planned levels by 6%, the 2yr average by 9%, and the 19/20 average by 5%.

Outpatient attendance and procedure levels are below planned levels for April, but this has been offset by telephone appointments being significantly above plan, meaning that outpatient activity was 3% above plan for April, and in line with the 19/20 average, although 8% below the 2yr average. Elective activity is outperforming the 2yr average by 6%, but was 11% below planned levels for April, and 17% below the 19/20 average, primarily due to admitted patient care day case and ambulatory care numbers.

Excluding clinical income, the division is behind plan by £233k. Non-pay costs are £207k over budget in month, with pay costs being £18k under spent.

The key drivers behind these variances are:

- £91k over spend in month on Consultants' additional sessions across the Division due to a combination of cover for sickness (in particular due to the level of positive COVID cases) and annual leave, gaps in on-call rotas, backfill due to the nMABS service, vacant posts, demand levels exceeding current capacity, and part time posts leaving wards short.
- There is an in-month over spend of £61k on Junior Doctors, primarily due to the use of locums.
- £227k under spend on Registered Nursing across the Division. There has been an under spend on Registered Nursing pay costs for a number of months now, due to the number of vacancies here.

£158k pressure on drugs, £86k of which is on Clinical Haematology and Oncology and is likely to relate to costs related to the Cancer Drug Fund. This will be reviewed to ensure that all relevant costs are claimed for.

Surgery (Moira Welham)

The overall financial position for the division was £665k behind plan in month.

Clinical income is behind plan in month by £702k. The division has and continues to work to increase activity levels, through weekend working and improving theatre

utilisation in addition to working with external providers to support elective recovery work.

Elective activity has seen a positive improvement from previous month, 1% behind plan in month (March 9%). Outpatient activity is 3% behind plan in month (March 8%) and for Non-Elective activity is 4% ahead of plan in month (March 0.3%).

Pay expenditure reported an underspend of £180k in month. The underspend is driven by the vacancies within the division, predominantly within non-ward areas such as theatres and specialist nursing.

The non-pay budget is £148k overspent in month. Overspends are largely driven by the use of external providers to support elective recovery

Women and Children's (Simon Taylor)
In April, the Division reported an adverse variance of £171k.

Income was £179k behind plan in-month because elective, non-elective and neonatal activity was behind plan.

Pay reported a £69k underspend in-month as the Maternity Service continues to struggle to fill vacancies due to the national shortage of midwives. The maternity service has successfully appointed to a number of posts and plans to have the new staff starting shortly.

Non-pay reported a £60k overspend in-month due to large consumable orders and initial rental costs in Community Midwifery.

Clinical Support (Simon Taylor)
In April, the Division reported an adverse variance of £305k.

Income was £99k behind plan in-month because the Radiology Service was behind plan for outpatient, breast screening and direct access activity. The service has had issues with the second CT scanner and is continuing to progress the installation of the third CT scanner.

Pay reported a £51k underspend in-month due to vacancies in Pharmacy and Outpatients.

Non-pay reported a £256k overspend in-month as the Trust continued to overspend on recovery measures for CT and endoscopy.

Community Services (Clement Mawoyo)
The Community Division reported a favourable variance of £2k in M1 of 2022/23

Income reported a £188k under recovery in April. Clinical Income is anticipated to be in line with budget allocation in 22/23; M2 position to reflect adjustment needed to move acute contract income generated by Community Services. 2022/23 income from Aging Well to provide additional capacity to deliver urgent community (responsive) care is budgeted over 12 months, but allocated only to match actual expenditure.

Pay reported a favourable variance of £131k in April. Agency staff were used to cover some vacant Therapy roles in Adult Physiotherapy, Occupational Therapy and Dietetics. Additional agency capacity has been allocated to the Early Intervention Team to provide additional capacity to support admission avoidance and urgent care response. However, vacancies across the division, particularly in Integrated Therapies, has created an in-month under spend.

Recruitment to vacant roles is ongoing, with some recent recruitment successes. Areas of challenge include Reablement Support Workers and a focused review is underway to improve recruitment in these areas. Pay expenditure will increase in line with budget in quarter one of the 2022/23 financial year, to reflect full recruitment to the urgent community (responsive) additional roles.

Non-pay reported a £59k favourable variance in April. Pressures noted under community equipment costs (driven by increased need) were offset by in-month underspend on consumables, disposables, travel and commissioned beds (non-recurrent impact).

Estates and Facilities
Income was under-budget by £204k in month. This is driven by car park and restaurant income being significantly affected by the impact of Covid-19.

Non-pay costs are overspent in month by £336k. The Trust has recorded a number of overspends in month against utilities, rates and laundry services which will be phased appropriately in the coming months.

Statement of Financial Position at 30 April 2022

STATEMENT OF FINANCIAL POSITION

	As at 1 April 20212	Plan 31 March 2023	Plan YTD 30 April 2022	Actual at 30 April 2022	Variance YTD 30 April 2022
	£000	£000	£000	£000	£000
Intangible assets	52,039	56,905	56,951	52,297	(4,654)
Property, plant and equipment	170,887	216,642	191,705	170,315	(21,390)
Trade and other receivables	5,807	6,341	6,341	5,807	(534)
Total non-current assets	**228,733**	**279,888**	**254,997**	**228,419**	**(26,578)**
Inventories	3,574	3,689	3,689	3,589	(100)
Trade and other receivables	15,004	18,362	18,362	15,471	(2,891)
Cash and cash equivalents	33,323	12,134	13,926	27,300	13,374
Total current assets	**51,901**	**34,185**	**35,977**	**46,360**	**10,383**
Trade and other payables	(60,117)	(38,925)	(38,848)	(54,674)	(15,826)
Borrowing repayable within 1 year	(5,858)	(10,753)	(10,753)	(5,680)	5,073
Current Provisions	(38)	(46)	(46)	(38)	8
Other liabilities	(2,870)	(5,685)	(5,685)	(2,655)	3,030
Total current liabilities	**(68,883)**	**(55,409)**	**(55,332)**	**(63,047)**	**(7,715)**
Total assets less current liabilities	**211,751**	**258,664**	**235,642**	**211,732**	**(23,910)**
Borrowings	(44,002)	(62,085)	(64,768)	(44,002)	20,766
Provisions	(415)	(852)	(852)	(396)	456
Total non-current liabilities	**(44,417)**	**(62,937)**	**(65,620)**	**(44,398)**	**21,222**
Total assets employed	**167,334**	**195,727**	**170,022**	**167,334**	**(2,688)**
Financed by					
Public dividend capital	200,285	227,311	201,606	200,285	(1,321)
Revaluation reserve	11,704	8,743	8,743	11,704	2,961
Income and expenditure reserve	(44,655)	(40,327)	(40,327)	(44,655)	(4,328)
Total taxpayers' and others' equity	**167,334**	**195,727**	**170,022**	**167,334**	**(2,688)**

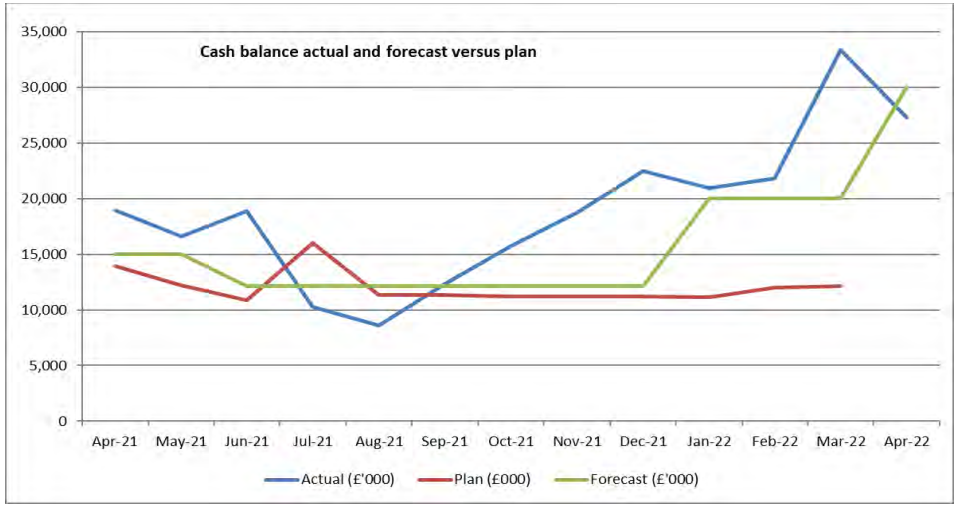
There has been little movement in the balance sheet against plan and the year end position and the balances are in line with expectations for month 1.

The significant variance between fixed assets and borrowings is due to right of use assets (leases). The plan has these included on the balance sheet, however these have not yet been reflected on the ledger. A project is underway to bring these assets on to the balance sheet.

The opening balances shown in the table above remain subject to audit.

Cash Balance Forecast for the year

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

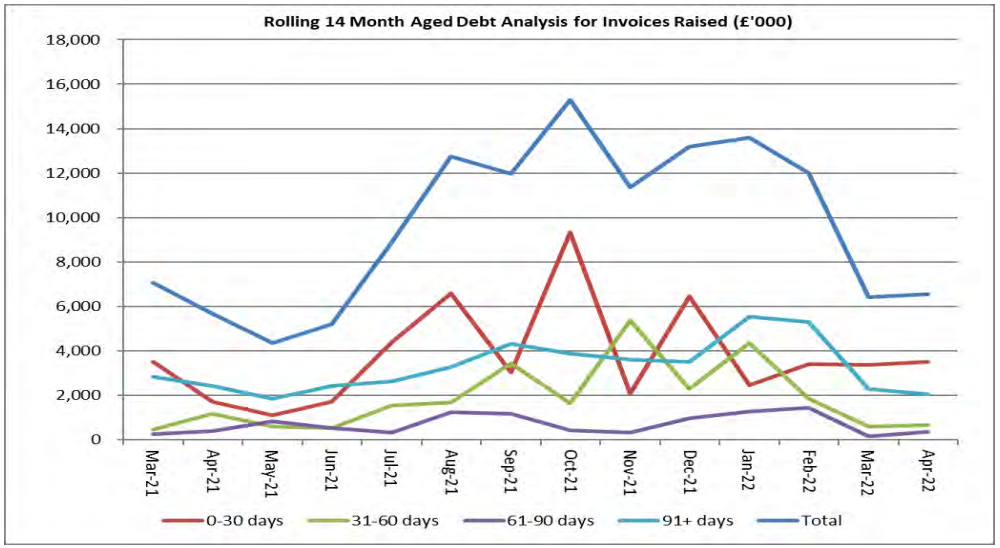


The cash position remains strong, however there has been a slight decrease in April as we paid a number of creditors just after the year end.

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

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 improved in month 1. The large majority of the debts outstanding are historic debts, although these are reducing. Over 75% of these outstanding debts relate to NHS Organisations, with 29% 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. The Trust is in the process of submitting the Business Case for the RAAC structure works to NHSE/I.

With the implementation of the new accounting standard in relation to leases (IFRS 16) the Trust will also be required to transfer any operating leases that the Trust had as at 31 March 2022 onto the balance sheet as a capital item. This will count towards the Trust's capital allocation, but will be fully funded for this transitional year.

The capital spend for month 1 was £1.7m. At this early stage the projects are all being forecast to come in at around the plan figure.

4.3. IQPR

To Note

Presented by Susan Wilkinson and Nicola Cottington

Integrated Quality and Performance Report Report

Agenda Item:				
Presented By:	Nicola Cottington & Sue Wilkinson			
Prepared By:	Information Team			
Date Prepared:	Mar-22			
Subject:	Integrated Quality and Performance Report			
Purpose:	**X**	**For Information**		**For Approval**

Executive Summary:

The Board is asked to note the following exceptions in relation to performance:
Patients are waiting up to 47 weeks for wheelchairs due to cancellations due to Covid, and it has been that identified additional resource is required. A business case will follow.
In March, 438 patients were in the emergency department for more than 12 hours against a target of 0, due to increased attendances and difficulty with flow out of the department to wards. A range of actions are planned to create better flow including implementing Criteria to Admit and increasing Same Day Emergency Care (SDEC). Monitoring is via the Patient Access Governance Group, Urgent and Emergency Care Steering Group, Insight Committee and Board, and also at Alliance and ICS Urgent and Emergency Care meetings.
There were 268 patients waiting over 104 weeks for an elective procedure at the end of March 2022, just over the revisd trajectory of 265. Recovery plans are in place including weekend lists, use of the independent sector and mutual aid across the ICS. WSFT are predicting to have 0 patients waiting over 104 weeks at the end of June 2022. Performance is monitored at Patient Access Governance Group, Insight Committee and Board, and also at ICS level weekly hub meetings and the SNEE Recovery and Restoration Board.
There has been no significant improvement in two week wait performance for cancer with breast symptomatic pathway significantly below the standard. A full recovery plan is in place for all cancer metrics. Performance against improvement trajectories is monitored at weekly Cancer PTL meetings, Cancer Board, Insight Committee and ICS Cancer Board. In the month of March we enacted our surge staffing plan to support increased capacity requirements across the trust. This has subsequently resulted in areas working below their core agreed establishment and have impacted on our quality metrics. We continue to monitor this and ensure we maintain patient safety across all areas of the trust, including the community settings.

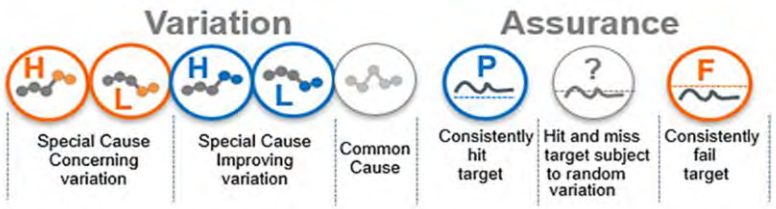
Trust Priorities [Please indicate Trust priorities relevant to the subject of the report]	**Delivery for Today**	**Invest in Quality, Staff and Clinical Leadership**	**Build a Joined-up Future**
	X		

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

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

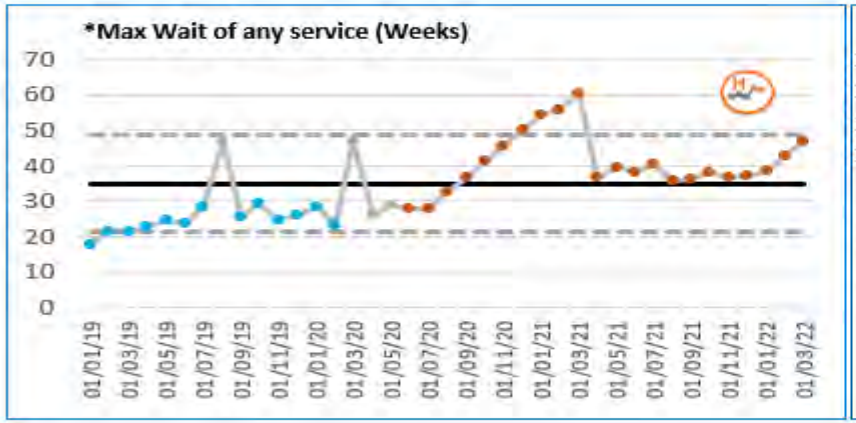
Recommendation:

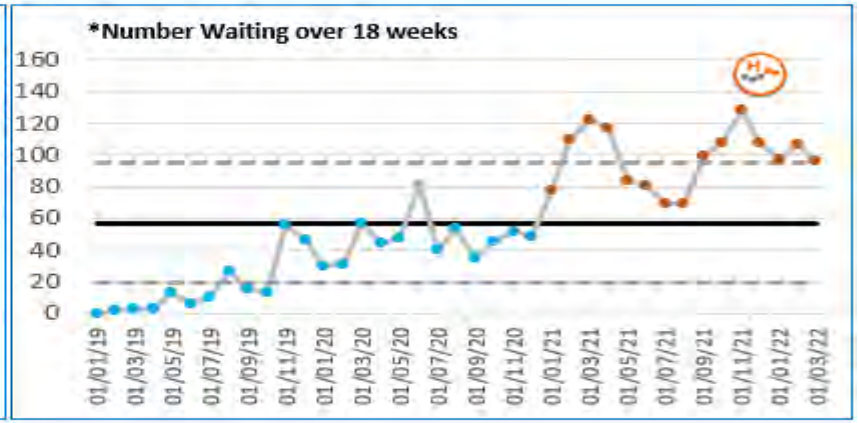
That Board note the report.

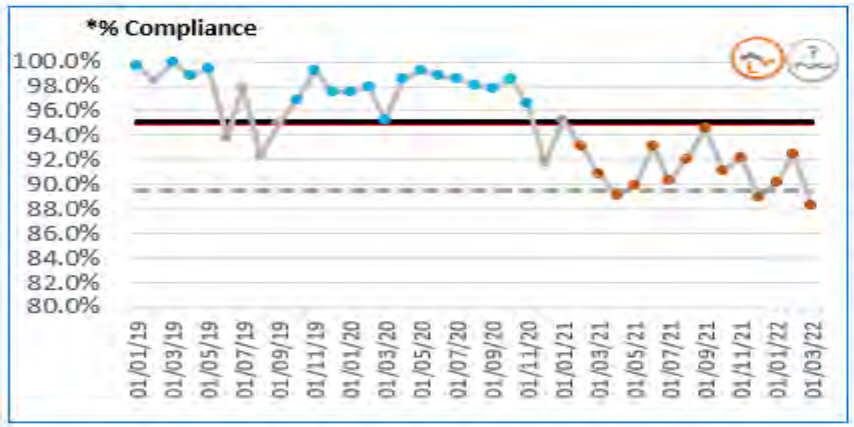


KPI	Latest month	Performance	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
*Max Wait of any service (Weeks)	Mar 22	47	-			35	21	49
*Number Waiting over 18 weeks	Mar 22	96	-			57	20	95
*% Compliance	Mar 22	88.3%	95.0%			95.1%	89.5%	100.7%
Urgent 2 hour response	Mar 22	81.6%	70.0%					

*The first 3 indicators cover all the non-consultant led community services of: Adult SLT, Heart Failure, Neurology Service, Parkinson's Nursing, Wheelchairs, Paediatric OT, Paediatric Physio and Paediatric SLT.







Summary

Wheelchairs:

- vulnerable patient group (previously shielding) complexity and additional visits, these are likely to remain for some time. 25% of appointments booked last 2 weeks were cancelled due to patients with COVID.
- Issues: continual supply chain issues of critical parts, care home closures creating with multiple cancellations
- Personal wheel chair budget work has remained funded by only 16% of resource required and on non-recurrent basis. CCG have advised business case to the trust for funding. **Paed SLT** - The lack of face to face group work and restrictions in schools etc are having a continued profound effect on Paed SLT activities, as are vacancies within the service

Action

Wheelchairs:

- Met with main supplier (60%) and they will now send through weekly order book report of items that are overdue and options for substitutes.
- Staff doing overtime and focussing on handovers to remove backlog. 17 extra handovers of longest waiters in April utilising overtime.
- Admin post filled but vacancy since January starting May 9th creating some booking delays.
- Patients that felt too vulnerable to refer themselves are now self referring again. (may have –ve impact on WL)

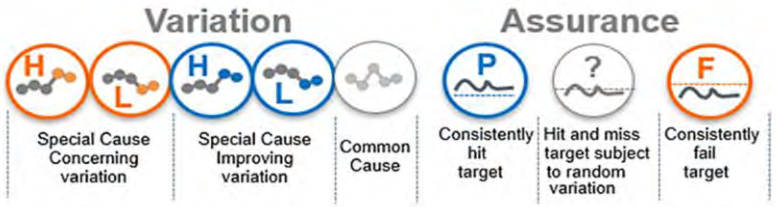
Assurance

Wheelchairs:

- Weekly waiting list management calls
- Monitoring stats on a weekly basis
- Started to review 14 week + waiters reports
- BEST(new IT system) implementation- also action rather than assurance

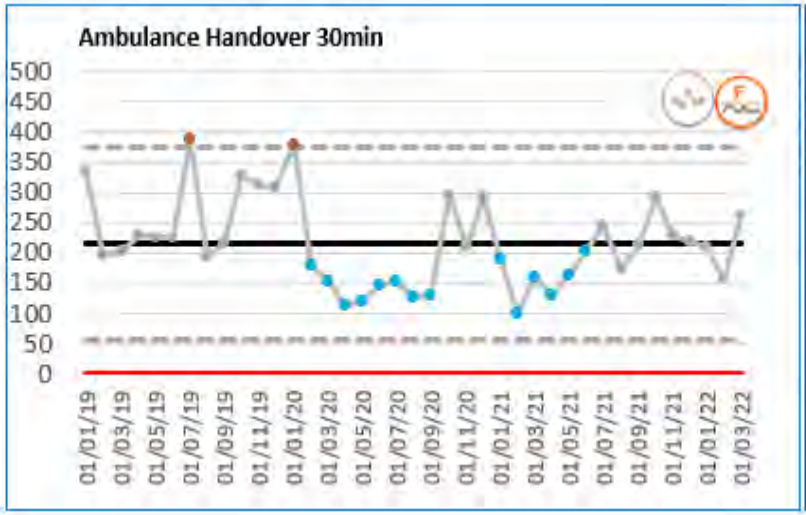
Unable to give full assurance on the current resource without additional funding, supply chain issues and increasing complexity of patients.

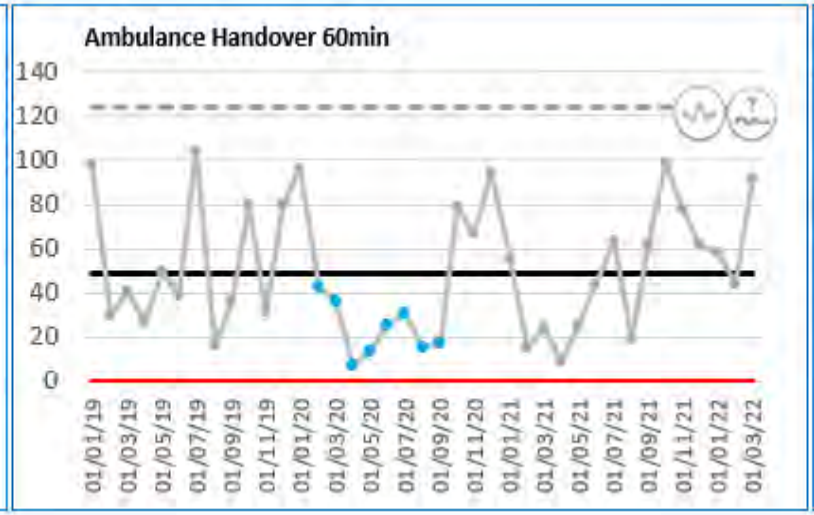
Urgent & Emergency Care summary

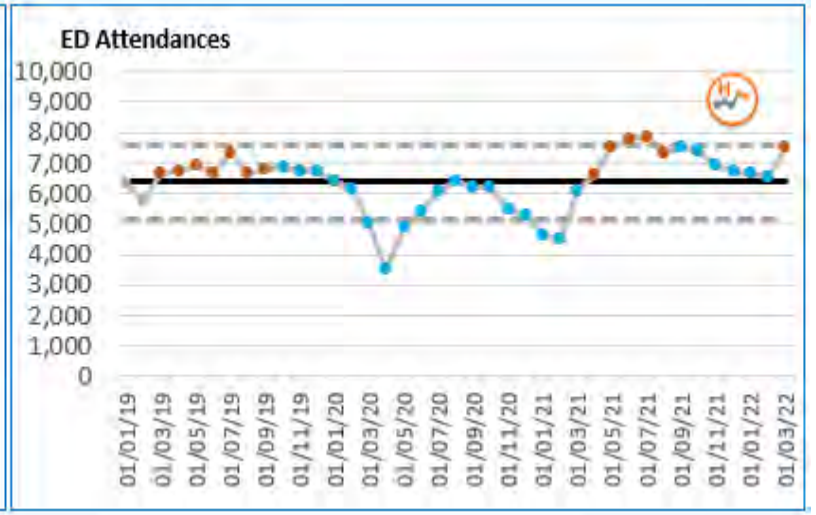


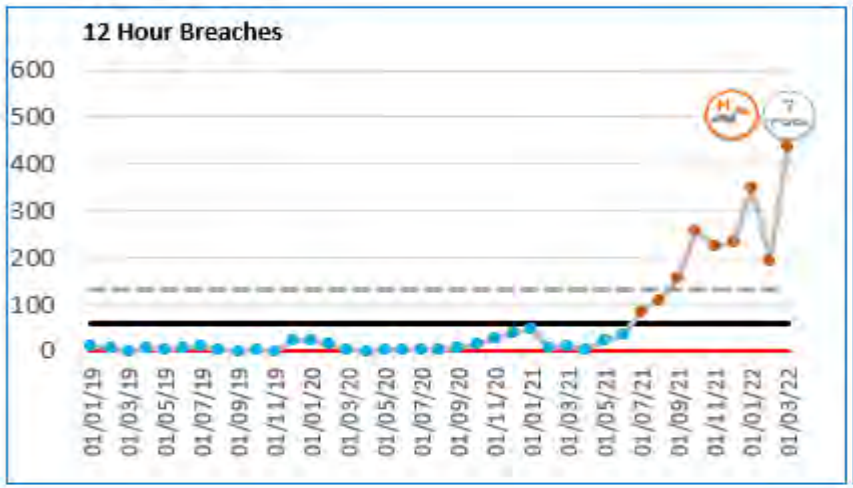
KPI	Latest month	Performance	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Ambulance Handover 30min	Mar 22	261	0		F	215	57	373
Ambulance Handover 60min	Mar 22	91	0		?	49	-26	124
ED Attendances	Mar 22	7507	-	H		6384	5155	7613
12 Hour Breaches	Mar 22	438	0	H	?	61	-10	132
Criteria to reside (numbers without reason to reside)	Mar 22	82	-					

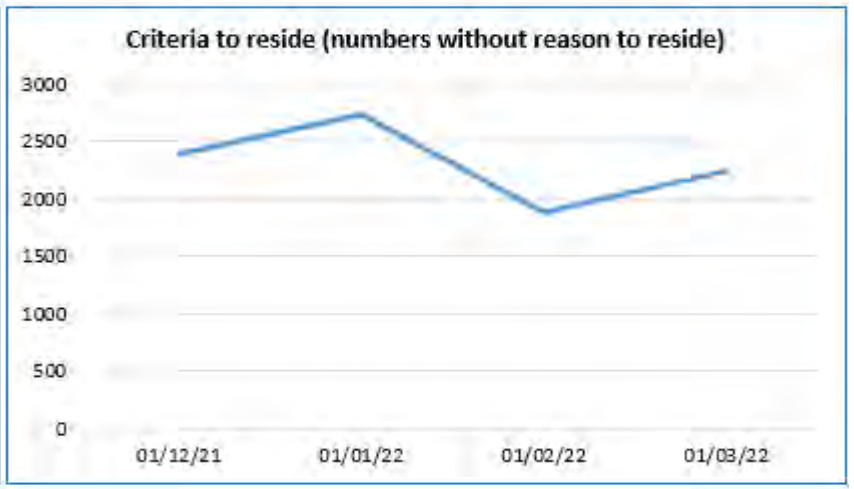
Urgent & Emergency Care





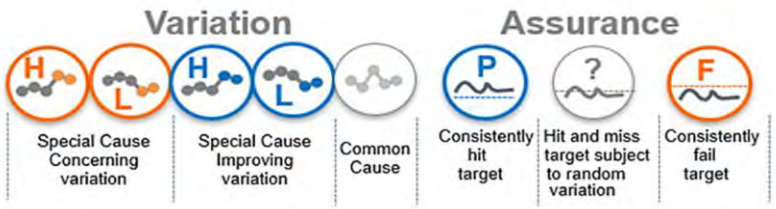






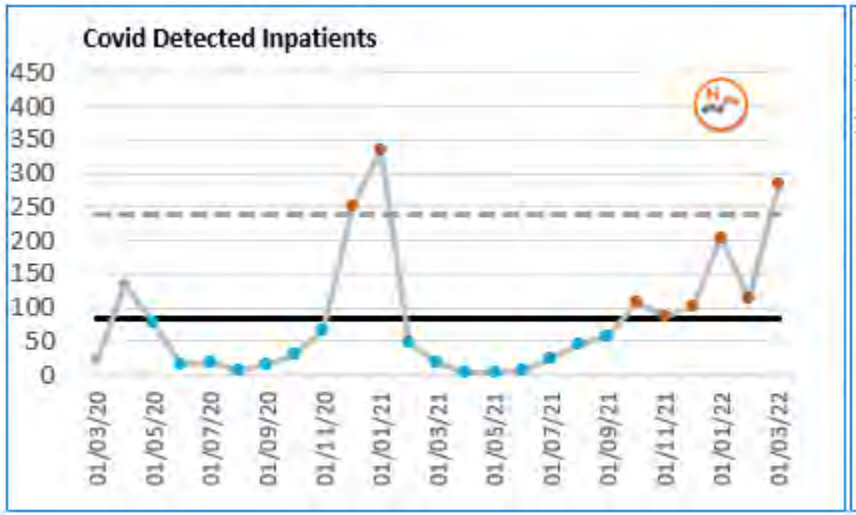
Summary	Action	Assurance
Metrics clearly show ED experienced increased pressure during March with high attendances and increased activity. Flow out of ED was compromised which is shown by the increase in 12 hour LOS. This is also reflected within the increased numbers of patients with no reason to reside, reflecting the challenge the trust has experienced with our discharge profile.	Focus continues on action plan for achieving ambulance handovers as per priorities from operational planning guidance. Actions to reduce 12 LOS with focus on SDEC and workstreams within UEC including virtual ward, criteria to admit, developments of hot clinics. These developments will reduce LOS in ED by reducing capacity and improving flow. Focus on improvement of completing criteria to reside – especially at weekends. QI and Powerbi dashboard supporting this improvement. Continue to highlight delays to system partners.	UEC metrics monitored via patient access insight group and through WSFT UEC steering group. Criteria to Reside- Numbers monitored via executive approval of daily discharge sitrep, and ToCH escalation to CCG/System partners. Plan for future reporting at access insight group.

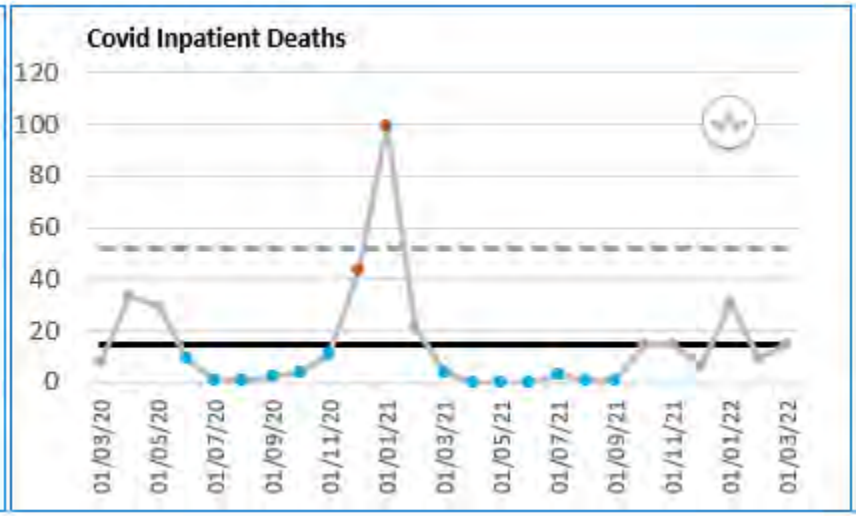
Covid Summary



KPI	Latest month	Performance	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Covid Detected Inpatients	Mar 22	285	-	H		83	-73	239
Covid Inpatient Deaths	Mar 22	15	-			14	-23	52

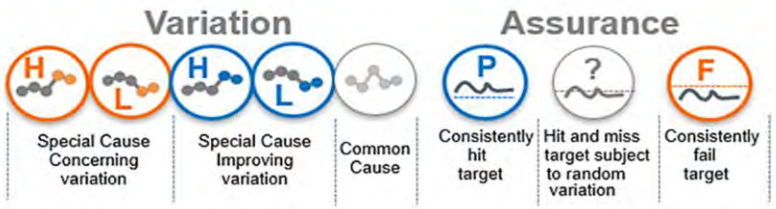
Covid





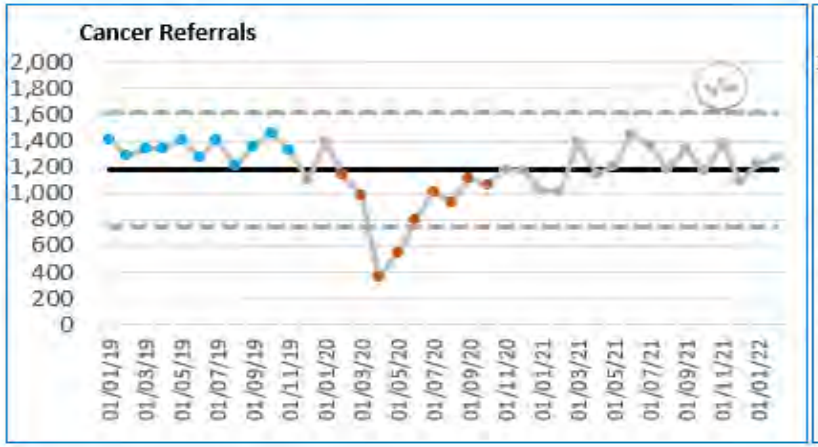
Summary	Action	Assurance
The number of inpatients with Covid continued to be high during February and March, reflecting the high rates of infection in our local community and mirroring the national pattern. Increases in nosocomial transmission following an increase in patients testing positive on day 3 and 5 of admission. Consistent with high community prevalence The fatality rate remains lower though than in the same period in 2021, demonstrating the impact of the vaccine programme and effective hospital treatment in reducing the rate of life-threatening illness.	14th April new national guidance was released and will be implemented into the trust following operational trial. New guidance includes • Admission swabbing (unchanged) • Asymptomatic swabbing day 3 and 5 moved to LFT (change) • Identified inpatient Covid contacts, no longer required to isolate (change) • Reduction in the isolation period from ten days to seven in Covid positive inpatients following negative LFT (change) • Social distancing will no longer be maintained in the emergency department and outpatient waiting areas (change) • Symptomatic patients will continue to be tested and isolated if positive.	• Daily monitoring of inpatient numbers • Nosocomial transmissions to be tracked by IPC team.

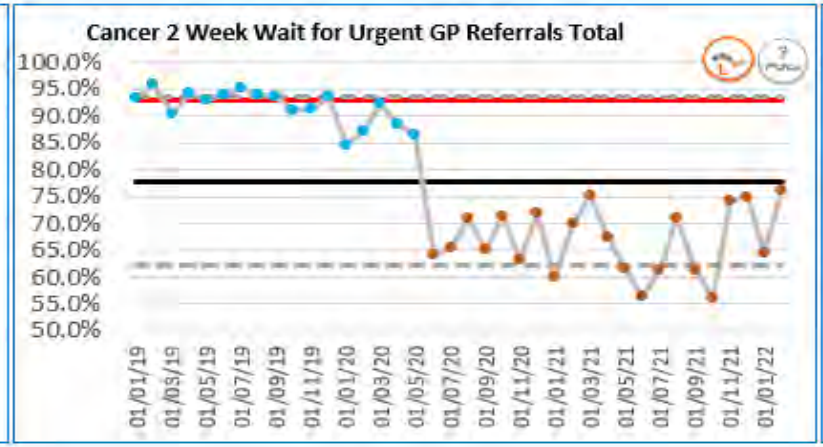
Cancer Access Summary (Month Behind)

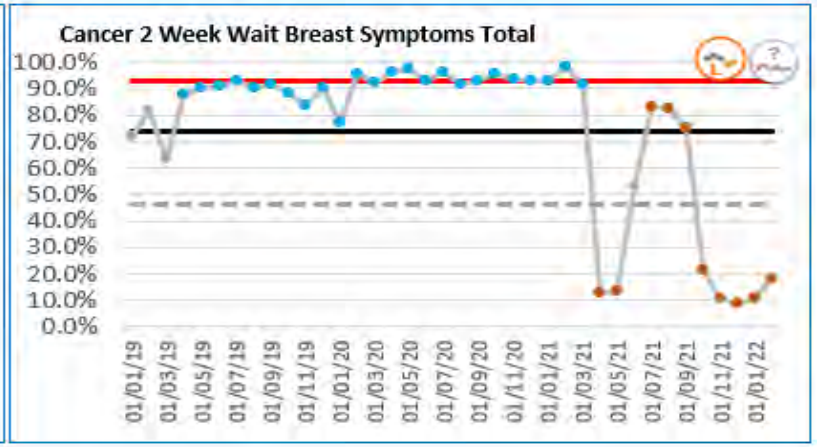


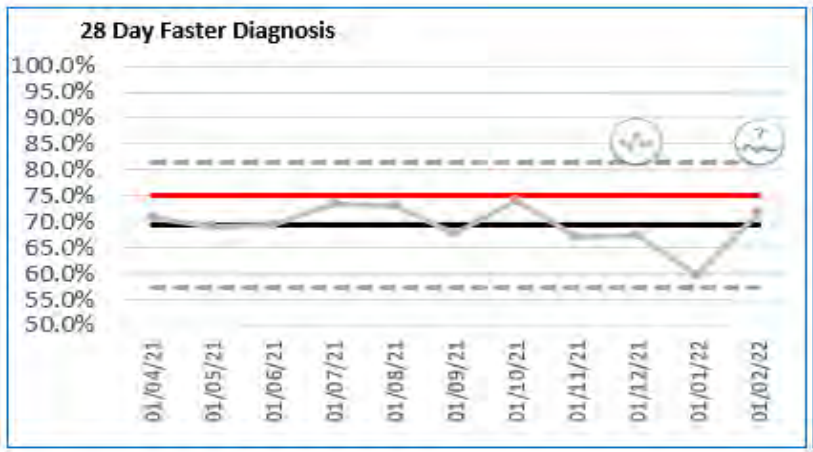
KPI	Latest month	Performance	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Cancer Referrals	Feb 22	1274	-			1180	740	1621
Cancer 2 Week Wait for Urgent GP Referrals Total	Feb 22	76.2%	93.0%	L	?	77.9%	62.2%	93.7%
Cancer 2 Week Wait Breast Symptoms Total	Feb 22	18.4%	93.0%	L	?	74.0%	46.6%	101.4%
28 Day Faster Diagnosis	Feb 22	71.8%	75.0%		?	69.4%	57.4%	81.3%
Cancer 62 Day GP Referrals Total	Feb 22	60.0%	85.0%	L	?	76.1%	57.1%	95.0%
Cancer 62 Day Screening	Feb 22	22.2%	90.0%	L	?	90.2%	68.8%	111.5%
Incomplete 104 Day Waits	Feb 22	25	0		P	22	4	41

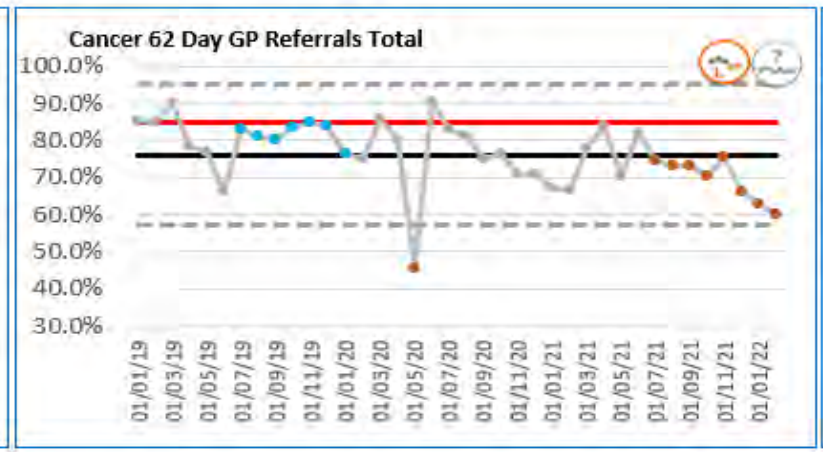
Cancer Access

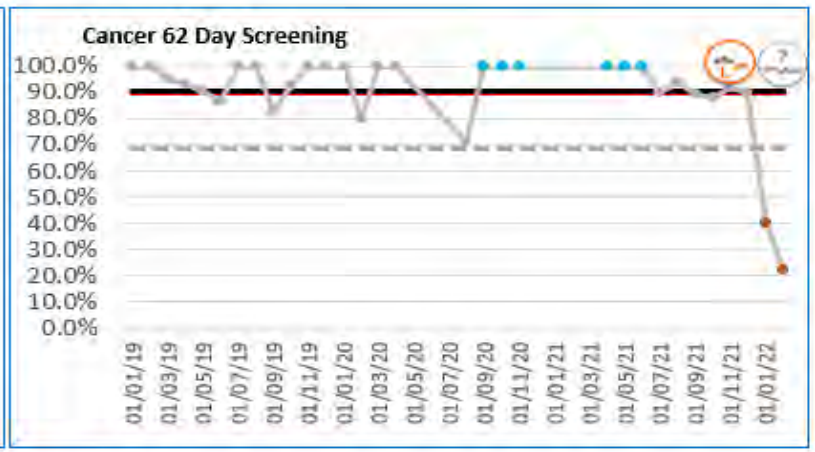


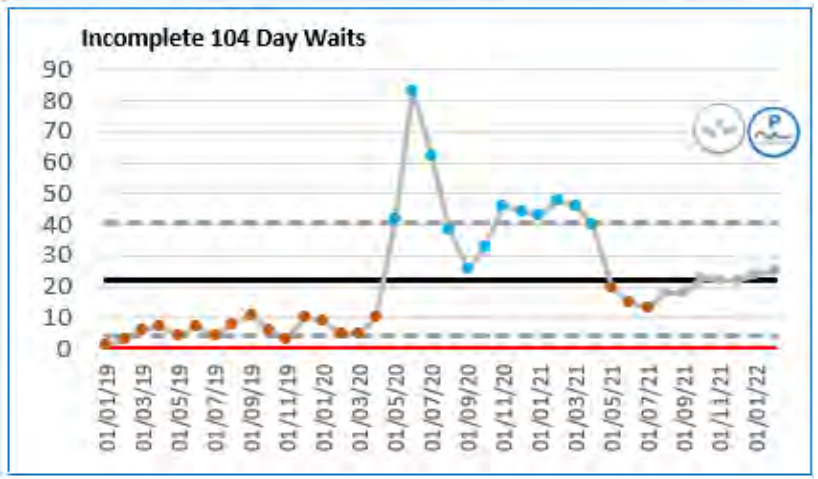








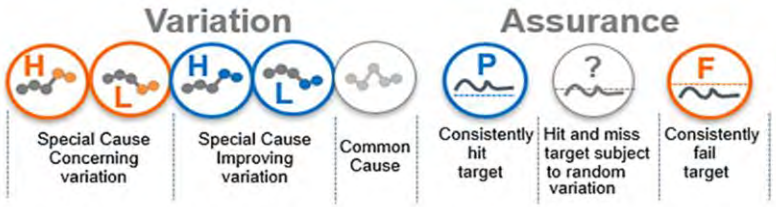




Cancer Access

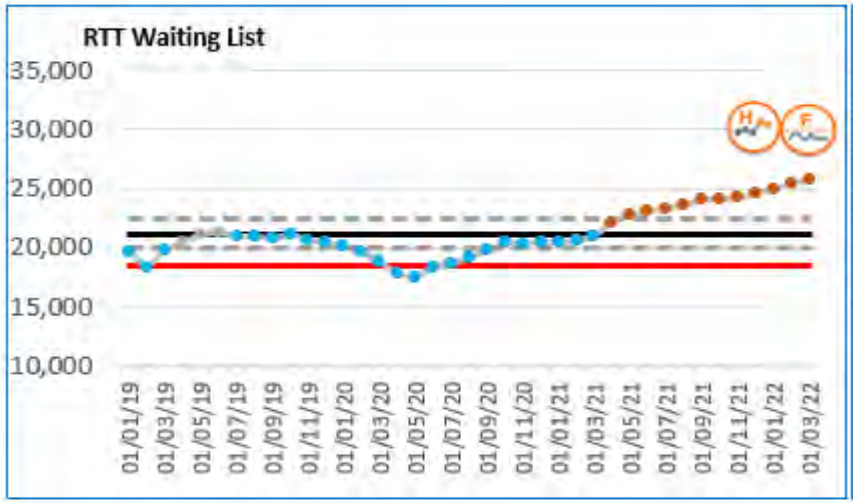
Summary	Action	Assurance
The 2 week wait performance continues to be a challenge with performance below the 93% standard. Breast continues to be the tumour site with the lowest performance following high levels of referrals towards the end of 2021, this is taking some time to recover from, however the overall waiting time is much improved. 28 day performance has shown improvement following the drop in performance in January and is back in line with trajectory. 62 day performance continues to be far below 85% standard at 60%, with a the largest proportions of patients treated over 62 days within Breast, Urology, Skin and Lower GI, all of which are mostly owing to delays at the front end of the pathways and delays in diagnostics.	A full recovery action plan is in place, this includes additional activity and transforming current pathways. The cancer team will be working with the wider ICS to manage the implementation of the new Faster Diagnosis Framework for SNEE Non Specific Symptoms (NSS) and the recommended Best practice treatment pathways for 2022/23.	Recovery in monitored through local Cancer PTL meeting as well as SNEE wide Cancer Board and Cancer alliance level forums. Performance against trajectory is monitored via insight committee.

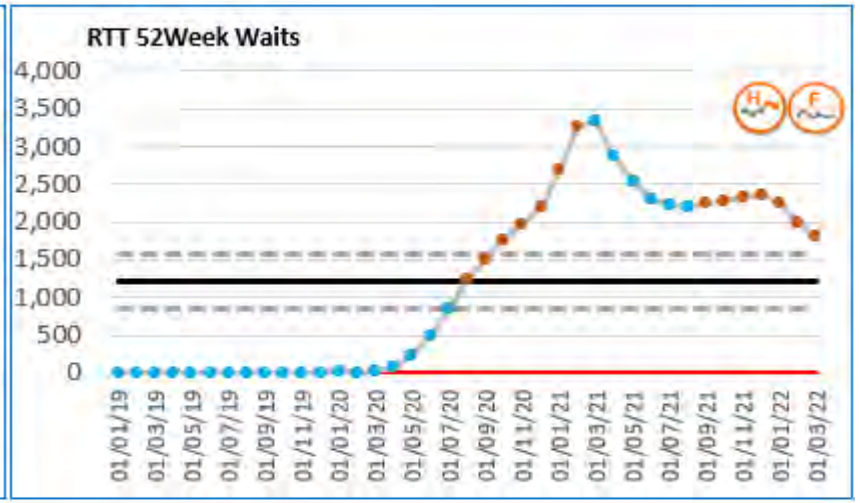
Elective Access - Summary

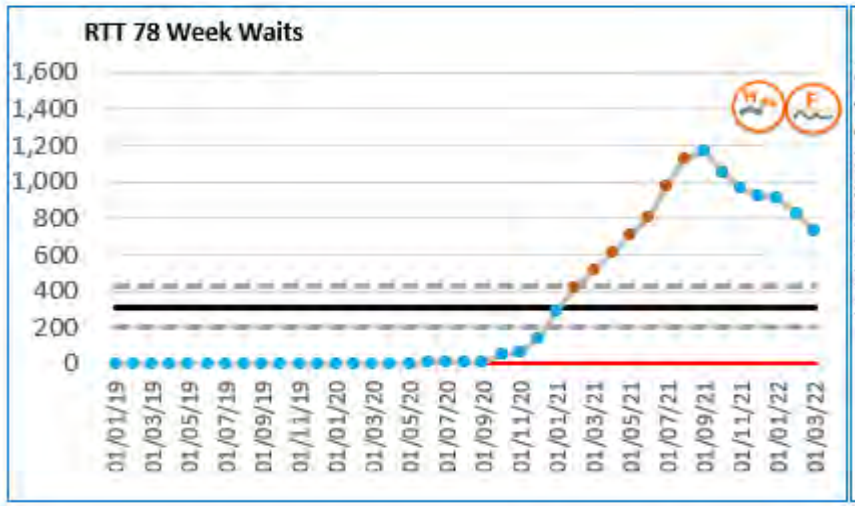


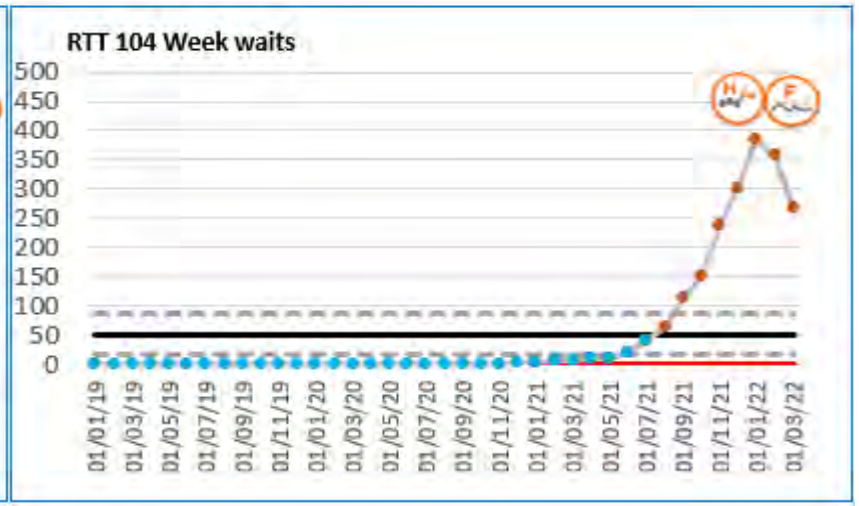
KPI	Latest month	Performance	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
RTT Waiting List	Mar 22	25797	18500	H	F	21183	19993	22374
RTT 52Week Waits	Mar 22	1807	0	H	F	1206	844	1567
RTT 78 Week Waits	Mar 22	725	0	H	F	315	202	427
RTT 104 Week waits	Mar 22	268	0	H	F	51	15	86
2 week wait rapid chest pain	Mar 22	100.0%	95.0%		P	99.5%	97.1%	101.9%
Diagnostic Performance- % within 6weeks Total	Mar 22	67.1%	99.0%		F	71.7%	58.0%	85.4%
Elective Operations (Excluding Private Patients & Community)	Mar 22	796	-			753	429	1076
Cancelled Operations	Mar 22	26	0		?	19	-4	41

Elective Access

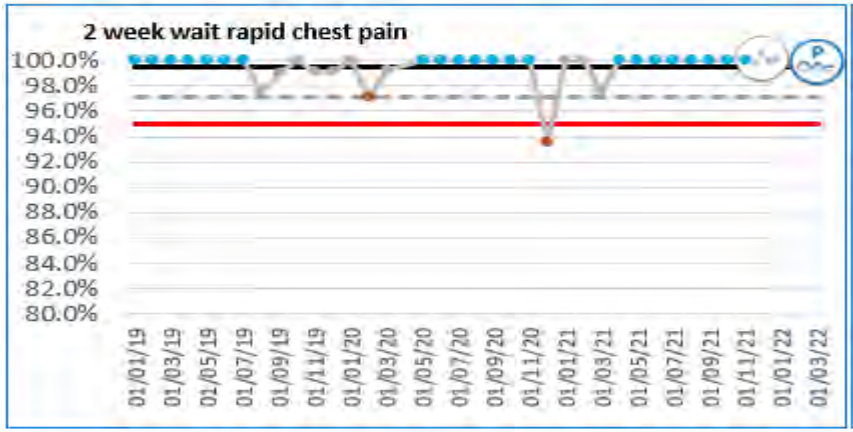


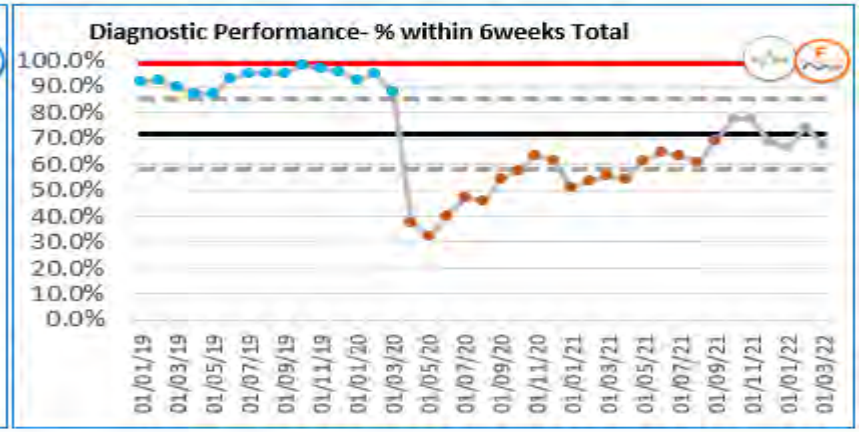


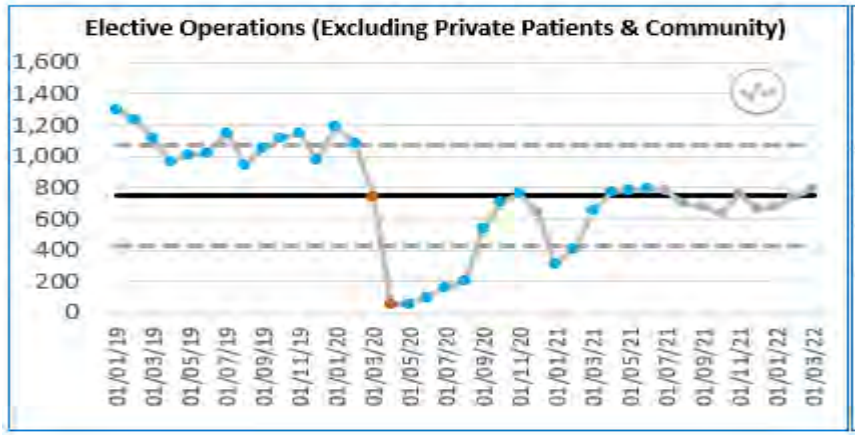


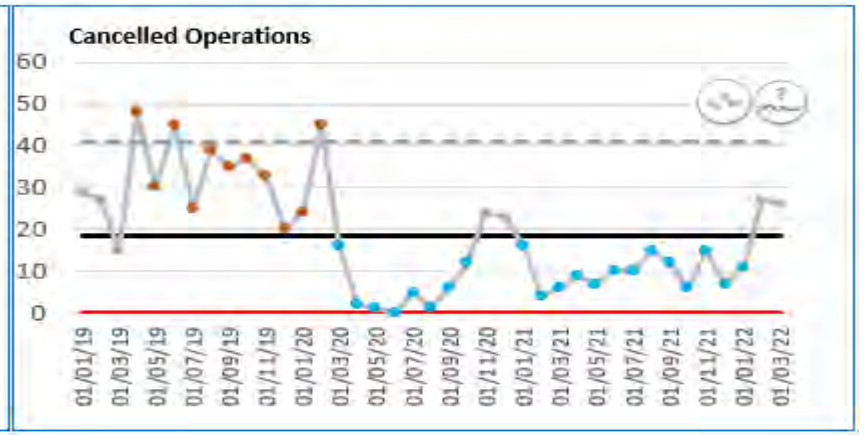


Summary	Action	Assurance
Whilst the overall waiting list continues to rise and the 104 week waits have not reduced significantly yet, the month end March position of 268 was close to the revised trajectory of 265.	The focus remains on the longest waiting patients and the trajectory to reduce the 104week wait to 0 by the end of June. Actions to achieve this include; re-opening of all theatres at the end of May 2022, extended theatre lists, weekend working, use of the independent sector and mutual aid.	Progress against trajectory and action plans are monitored at the weekly access meeting, which feeds into the insight committee at WSFT. This position is also reporting across the ICS within the SNEE recovery and restoration board.



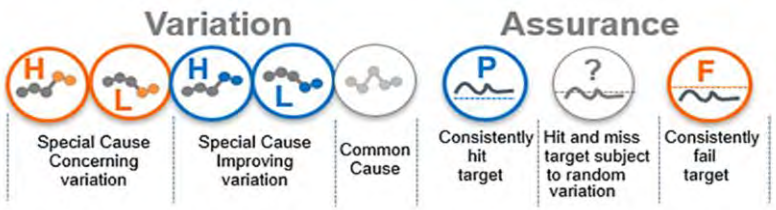






Summary	Action	Assurance
The SPC chart indicates common cause variation for diagnostic performance with consistent failure to meet the target. All modalities have been impacted by staffing absences during the month and there have been episodes of down time in both CT1 and CT2 during March. Staff absence has significantly impacted the ability to run additional weekend MRI lists and we have also experienced a short period of downtime in MRI. In Ultrasound ongoing vacancies constrain capacity despite active recruitment and the use of agency staff where available, again this is another modality impacted by high levels of Covid related absence. A similar picture of staff absence has impacted endoscopy activity.	• A business case for a third CT scanner has been approved at board and the purchase is progressing. This will assist in supporting recovery and provide resilience to unplanned scanner downtime. • Options for mobile MRI capacity are being explored but and performance will continue to be challenged without additional resource. A business case is being prepared around the options for a third MRI scanner but capital funding constraints may make this unachievable within the 2022/23 financial year. More flexible options are being explored as part of this case but scanner availability is known to be extremely limited. • The Division presented an options appraisal for a Community Diagnostics Centre to the SNEE Elective Care Recovery and Adaptation Board in March which was supported . The division is now beginning to draft a business case for regional and national approval with the proposed site being at Newmarket Community Hospital, with the aim of increased MRI and CT capacity as the particular focus. • In addition a staff consultation (non-medical) is planned to progress 7 day working across radiology, much of which is sustained on voluntary basis at present. • A recovery trajectory for endoscopy is being formulated using a Demand and Capacity tool with outsourcing continuing in the short to medium term.	Ongoing performance will be monitored at the weekly CSS access meeting and the Elective Access Insight Meeting

Safe- Summary



KPI	Latest month	Performance	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Average of Acuity Score - Total	Mar 22	35	-			40	36	43
Average of Dependency Score - Total	Mar 22	48	-			49	46	52
Average of Operational Factors Score - Total	Mar 22	36	-			37	35	40
MRSA	Mar 22	0	0			0	0	1
C-Diff	Mar 22	5	0			3	0	5
Hand hygiene	Mar 22	99.8%	100.0%			99.5%	97.8%	101.3%
Sepsis Screening for Emergency Patients	Mar 22	44.5%	100.0%			86.8%	54.1%	119.5%
VTE - all inpatients	Mar 22	95.6%	95.0%			95.8%	93.6%	98.0%
Mixed Sex Breaches	Mar 22	2	0			4	-7	14
Community Pressure Ulcers	Mar 22	32	5			30	13	48
Acute Pressure Ulcers	Mar 22	22	5			22	5	39
Acute Pressure Ulcers per 1000 Beds	Mar 22	2.0	5.6			2.1	0.6	3.6
Inpatient Falls Total	Mar 22	98	48			62	31	93
Acute Falls per 1000 Beds	Mar 22	6.6	5.6			5.5	3.2	7.7
Nutrition - 24 hours	Mar 22	93.0%	95.0%			90.5%	85.8%	95.3%
Patient Safety Incidents per 1,000 OBDs	Mar 22	69.7	-			65.5	52.6	78.5
Patient Safety Incidents Reported	Mar 22	861	-			733	585	880
Patient Safety Incidents Resulting in Harm	Mar 22	159	-			147	108	185
Verbal Duty of Candour	Mar 22	3	0			4	-1	10
Written Duty of Candour	Mar 22	7	3			5	-1	11
Within 10 Days Duty of Candour	Mar 22	61.0%	-			57.5%	15.8%	99.1%
New Complaints	Mar 22	15	-			16	1	31
Closed Complaints	Mar 22	15	-			15	-2	31
Overdue Responses	Mar 22	0	0			8	-6	22

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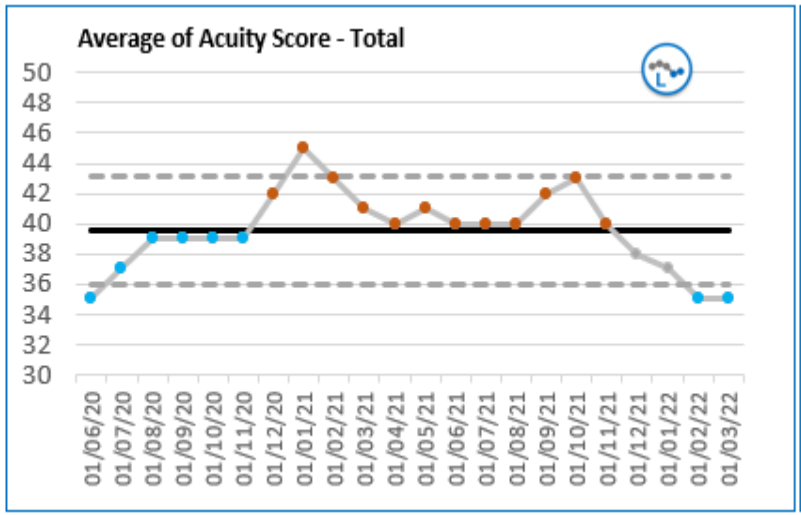
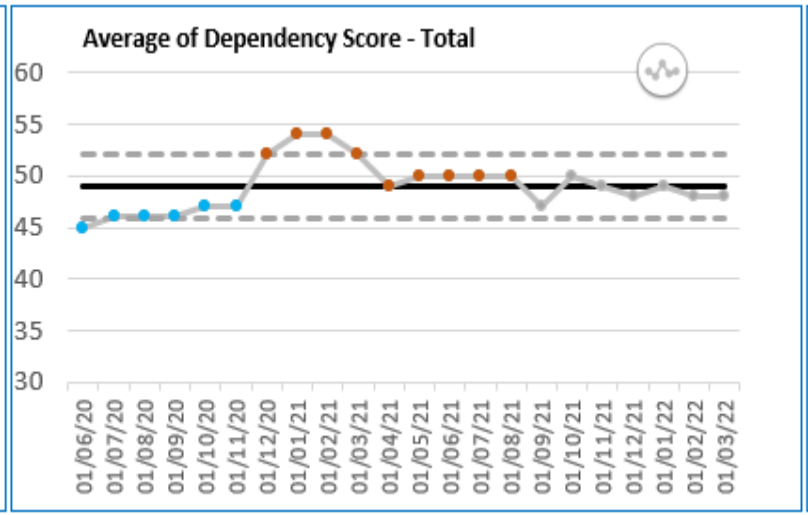
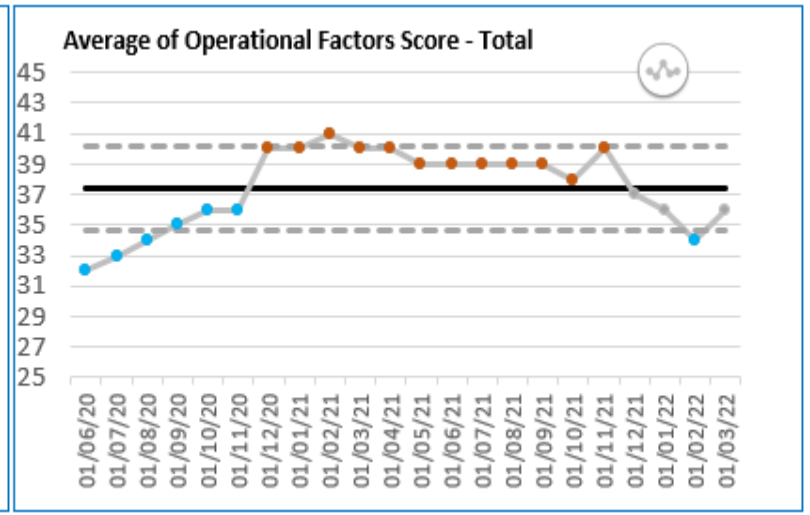
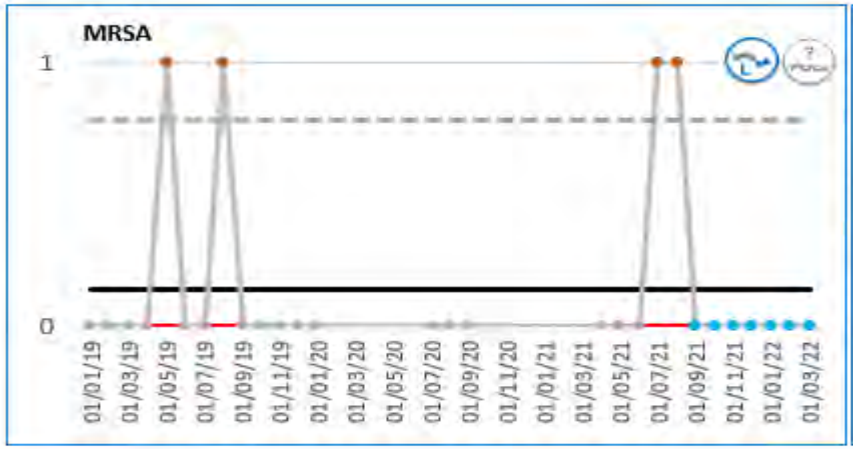


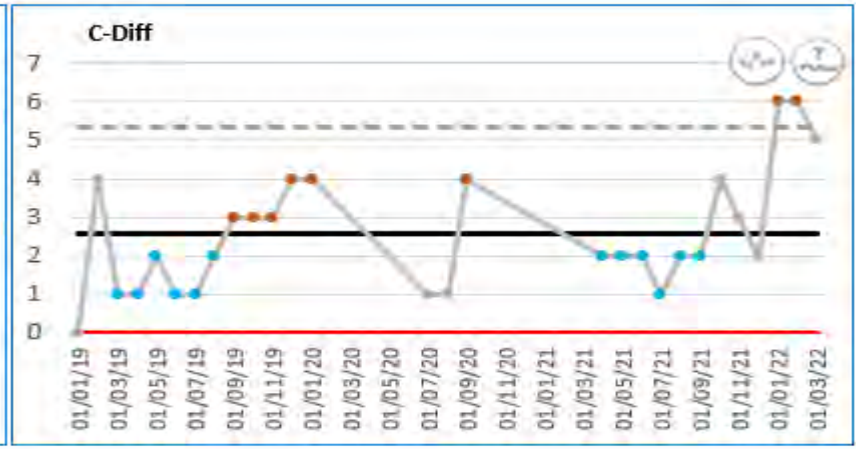


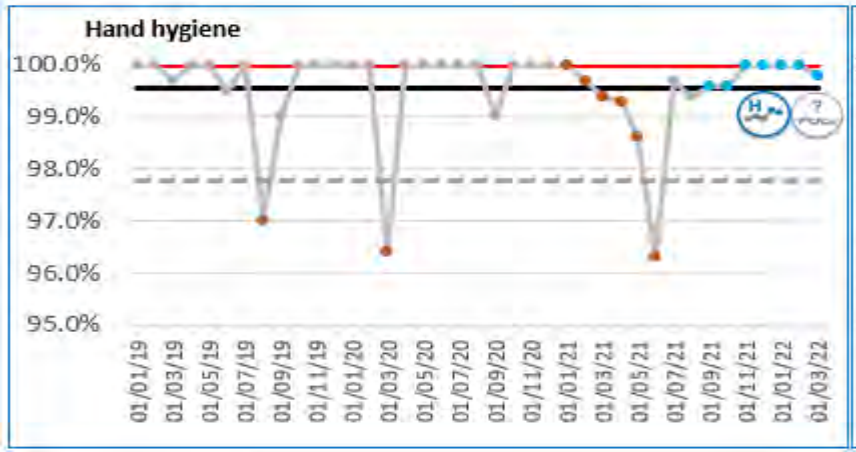


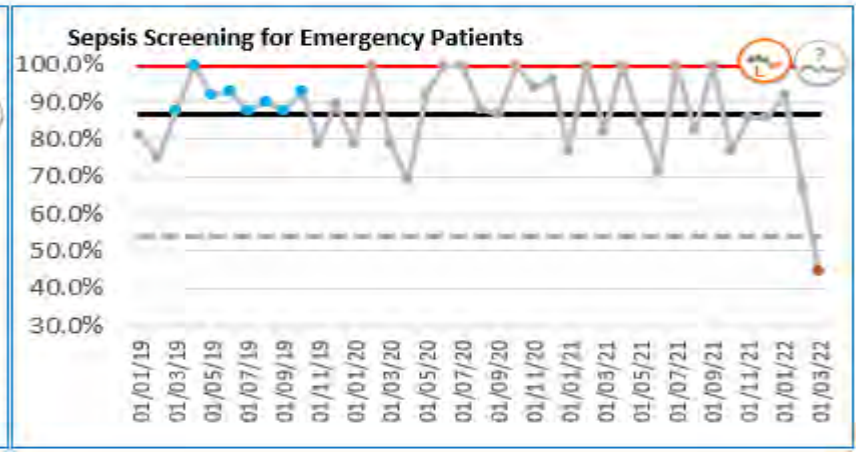
Summary	Action	Assurance
There has been a decrease in acuity scores, though dependency and operational pressures remain fairly static. This is reflective of the high number of medically optimised patients we have in the organisation.	We continue to monitor the levels of activity via these metrics and the Safecare data which is reviewed daily. There are multiple initiatives to improve discharges and reduce the number of 'stranded' patients, many who have dependency needs.	Review of reason to reside via board rounds and huddles. Review of safe staffing metrics daily.

Safe









Summary	Action	Assurance
Increase of Clostridium Difficile cases associated to G8 Stoke Ward. • Likely cause, cannot rule out 'environmental contamination'. • Lack of side room capacity with competing needs – Patients with COVID for example who would ordinarily be placed on a 'COVID' ward remaining on G8 due to Stroke specific treatment needs.	• IMT meetings held with system partners. • Increased frequency of environment, stand principles and antibiotic. • stringent review of antibiotic prescribing, with adhoc education from AMS Team provided. • Patients decanted and ward emptied for fogging. Enabling robust and through environmental cleaning. Well supported by housekeeping team • Additional actions included environmental declutter, macerator replacement and review of Covid curtains commenced	• Continued surveillance and reporting. • Regular weekly Trust walk about from IPC and Microbiology Infection Control Doctor have commenced. • Review of PIR paperwork and processes supported by CCG colleagues is in progress. • Review of process for data capture locally within IPT. • Plan to introduce ICNET over time in to routine IPC working.

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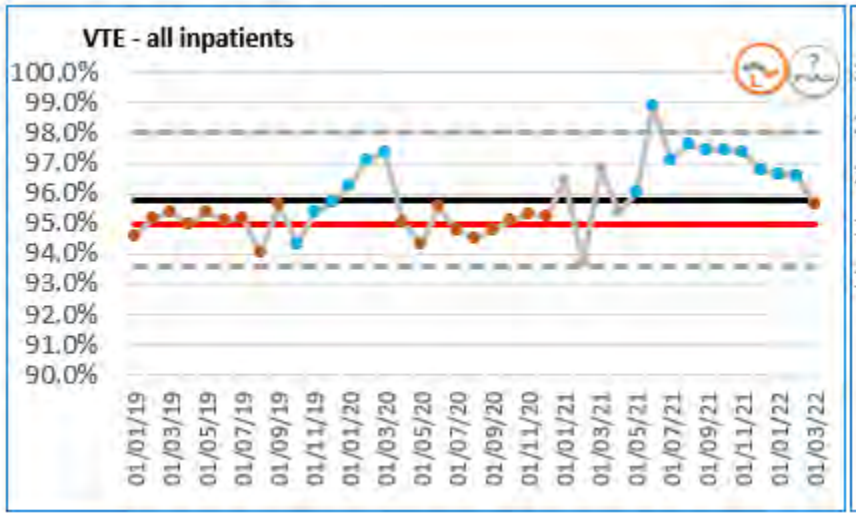

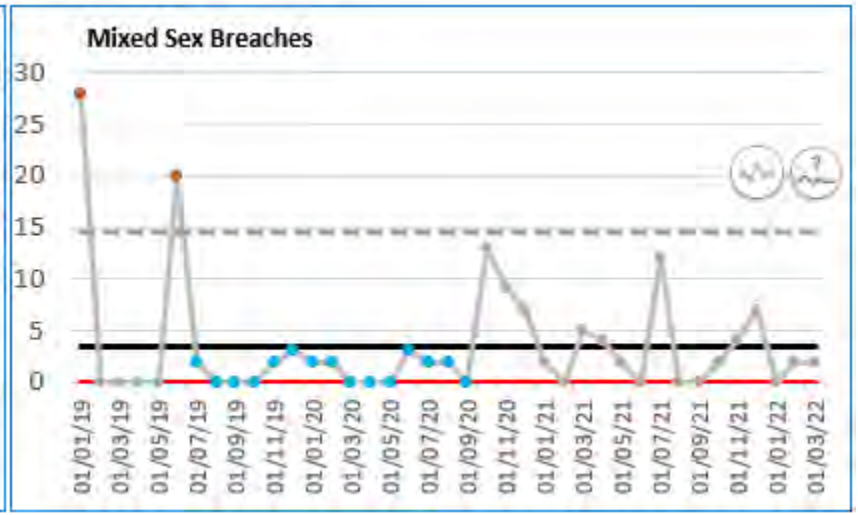

Summary	Action	Assurance
<u>VTE compliance</u> The March compliance is lower than the Trust median of 95.6%, although this is still above the national 95% compliance target. The mean for WSH Q4 was 96.36%. The mean for WSH Q3 was 97.4%. Area of concern continue to be DSU and AAU. This does in part relate to data cleansing issues (patients were being counted in AAU who had been discharged at<14 hrs which should not be included	• CD for specialist medicine will discuss this with information team for data cleansing • CD for specialist medicine to remind the clinical leads for these areas of the importance of these assessments.	Compliance will be monitored monthly and presented to PQSGG

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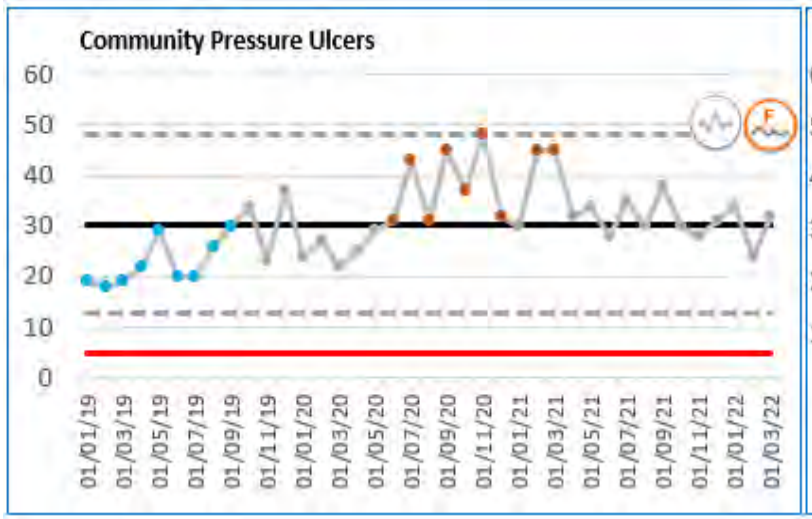
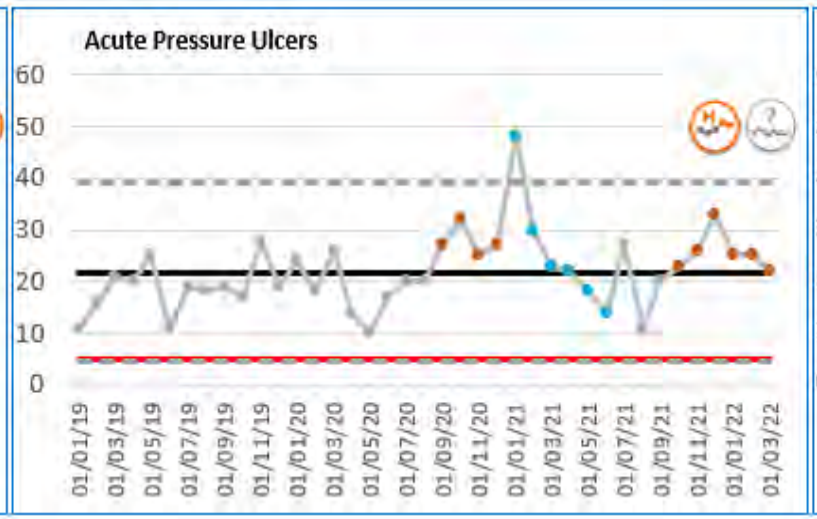
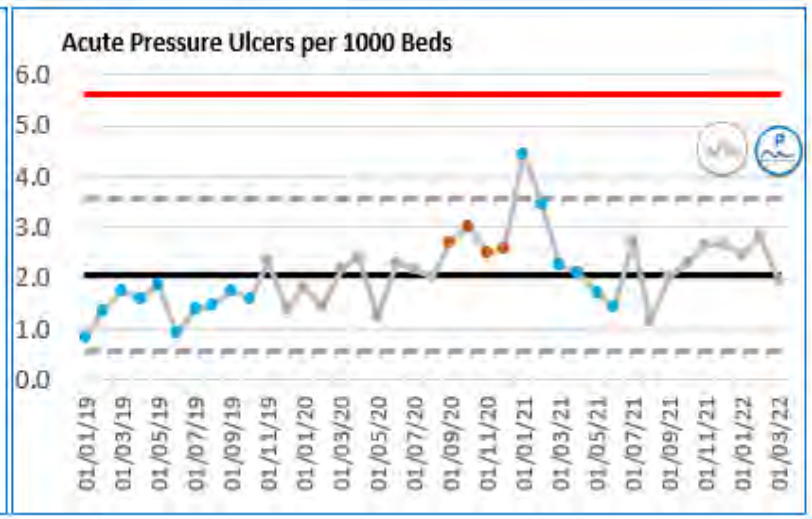
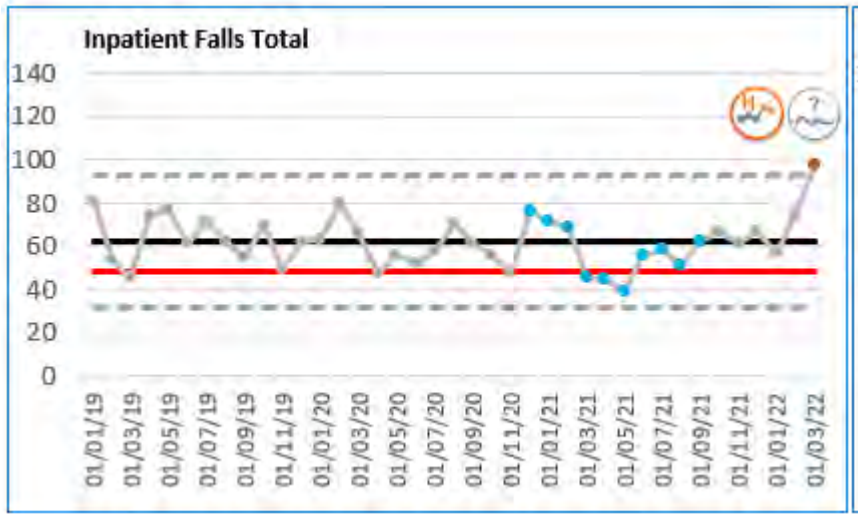


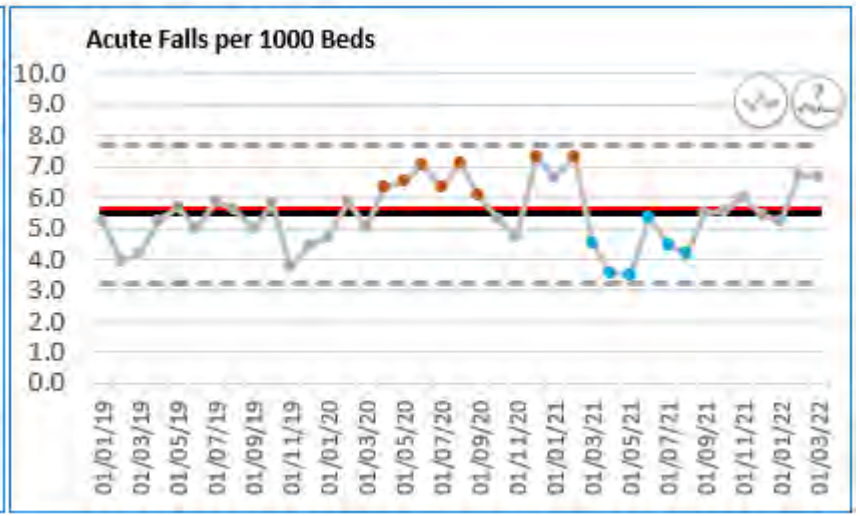




Summary	Action	Assurance
March has seen a further plateau in pressure ulcer incidents within the acute hospital with a small decrease although not significant. Challenging staffing deficits were experienced in March, which is likely to have had a direct impact the ability to frequently mobilise and reposition patients and also to properly inspect the skin and account for pre-existing damage. Community incidences have plateaued following a sustained rise in incidences last year.	Areas of higher than expected incidents include F3. Staffing challenges with the TVN team means that bedside teaching has been reduced as clinical visits take priority. The TVN team have been developing short videos 'TVNshorts', no longer than a few minutes and will give a visual aid to most wound care technique and pressure area management making it accessible and available to staff who already under considerable pressure. These will aim to support staff to better their wound care knowledge and skills while formal education is reduced.	Continuation of incidents recorded on Datix

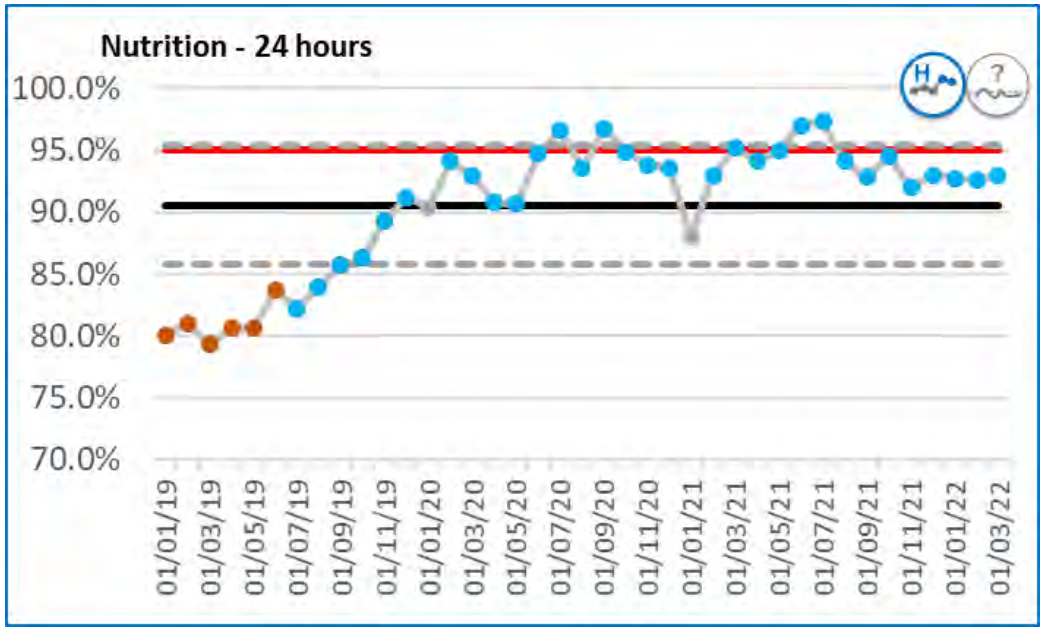
Safe





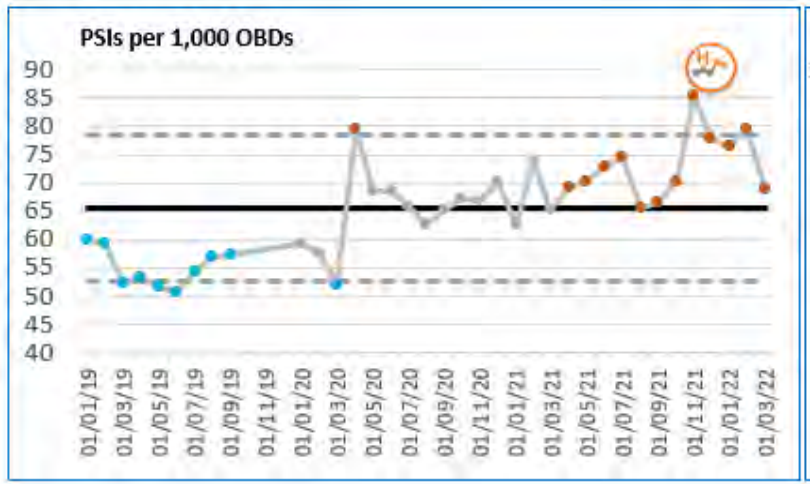
Summary	Action	Assurance
There was an increase in the number of falls reported in March compared to February. In March there were 23 reported as minor harm, 1 moderate harm (fracture humerus), 1 severe (fractured neck of femur) and 1 catastrophic (Subdural haemorrhage). During the month of March there were 17 repeat fallers, with 10 patients having two falls, 4 patients having three falls and 3 patients having four falls in the reporting month.	The National Audit of Inpatient Falls annual report 2021 has been published and a baseline assessment tool against these recommendations will be completed. The National Audit of Inpatients Falls facilities audit was completed in March..	The falls group meets bimonthly and receives multiple measures related to falls including the above data. The falls improvement plan is reviewed and updated. The falls group report quarterly to the Patient quality and safety governance group.

Safe



Summary	Action	Assurance
Nutrition assessment (MUST) within first 24 hours The results have currently plateaued. Staffing deficits are making compliance a challenge currently, though most areas continue to perform well.	**Nutrition and Dietetics**: To improve this compliance the dietetic service is offering regular MUST training to all ward staff. Uptake could be better but recognise there have been significant pressures on the wards. **Nursing:** Matrons and Ward Managers review monthly with the Heads of Nursing. Compliance is promoted amongst the teams. Tendable audits also monitor compliance.	Figures of compliance are taken to the NMCC meeting to encourage better uptake. Monthly reviews of audit data Feedback to teams and promotion of positive performance

Safe


PSIs per 1,000 OBDs
90
85
80
75
70
65
60
55
50
45
40
01/01/19
01/03/19
01/05/19
01/07/19
01/09/19
01/11/19
01/01/20
01/03/20
01/05/20
01/07/20
01/09/20
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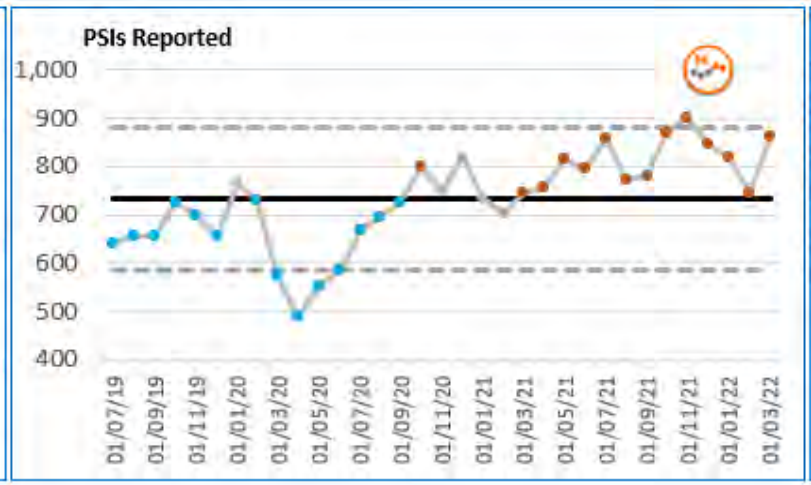
01/05/21
01/07/21
01/09/21
01/11/21
01/01/22
01/03/22


PSIs Reported
1,000
900
800
700
600
500
400
01/07/19
01/09/19
01/11/19
01/01/20
01/03/20
01/05/20
01/07/20
01/09/20
01/11/20
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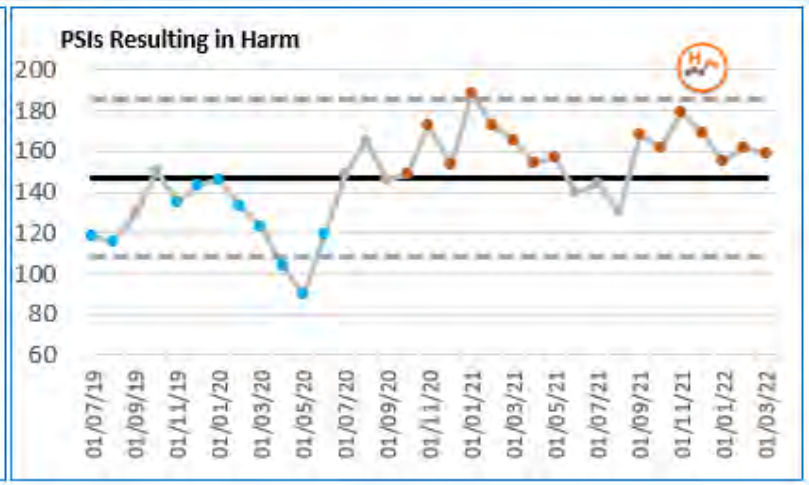
01/07/21
01/09/21
01/11/21
01/01/22
01/03/22


PSIs Resulting in Harm
200
180
160
140
120
100
80
60
01/07/19
01/09/19
01/11/19
01/01/20
01/03/20
01/05/20
01/07/20
01/09/20
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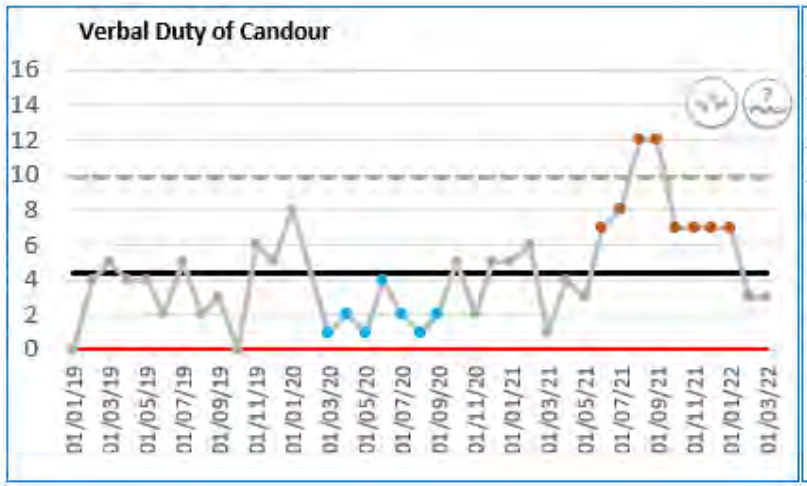
Verbal Duty of Candour
16
14
12
10
8
6
4
2
0
01/01/19
01/03/19
01/05/19
01/07/19
01/09/19
01/11/19
01/01/20
01/03/20
01/05/20
01/07/20
01/09/20
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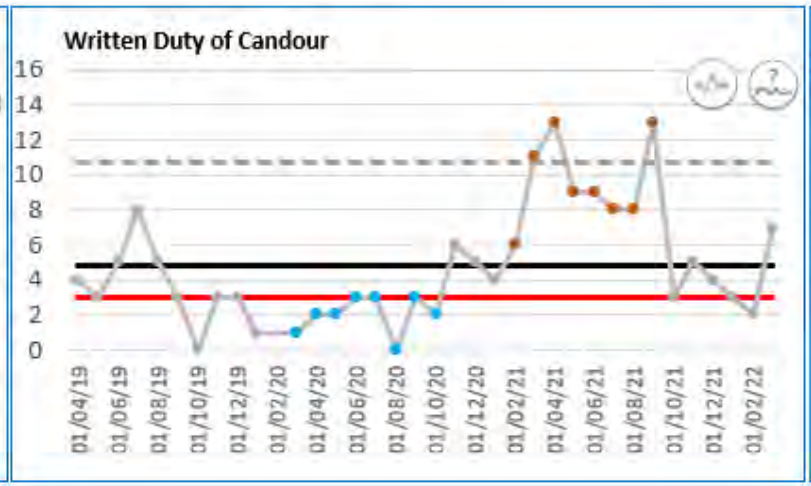
01/03/22


Written Duty of Candour
16
14
12
10
8
6
4
2
0
01/04/19
01/06/19
01/08/19
01/10/19
01/12/19
01/02/20
01/04/20
01/06/20
01/08/20
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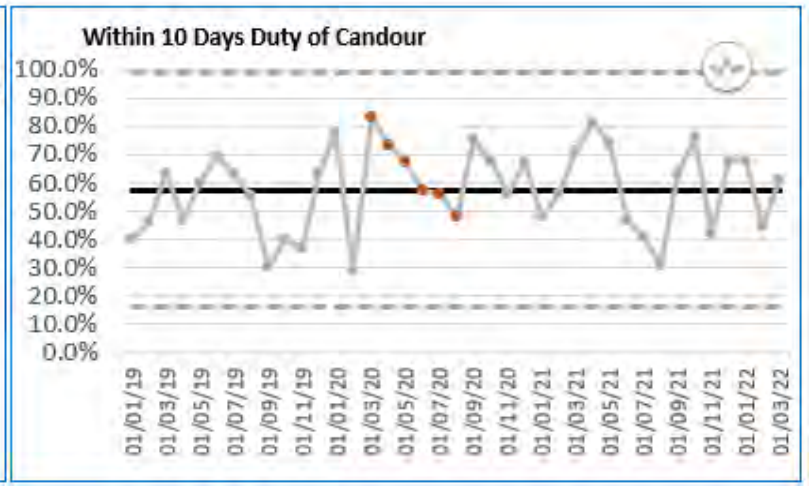
01/08/21
01/10/21
01/12/21
01/02/22


Within 10 Days Duty of Candour
100.0%
90.0%
80.0%
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
01/01/19
01/03/19
01/05/19
01/07/19
01/09/19
01/11/19
01/01/20
01/03/20
01/05/20
01/07/20
01/09/20
01/11/20
01/01/21
01/03/21
01/05/21
01/07/21
01/09/21
01/11/21
01/01/22
01/03/22

Safe

Summary	Action	Assurance
No recent significant variation. Higher level of patient safety incidents reported with lower level of harm. Higher levels of Patient Safety incidents reporting demonstrates good safety culture Spike in November 21 represents unlabelled sampling rise in reporting. Timely Duty of candour completion remains variable. The charts for written and verbal overdue Duty of Candour are no longer showing the special cause variation of concern from recent months. It is suggested this may be due to the work the patient safety team have done to strengthen the administrative process around Duty of Candour capture and escalation. The 'within 10 days' indicator shows random variance and no indication of meeting the 100% target but the measure is not a true indicator of progress as the data is not comparable (different incidents types) or statistically significant (too low a denominator for percentage reporting). The Duty of Candour task & finish group are working on developing more meaningful indicators	Continue to report data but use this alongside quality indicator which represent safety culture. Produce a quarterly thematic report of highest themes reported. Develop meaningful indicators to measure improvement. Suggestions to date are: • Monthly audit of all Duty of Candour cases > 5 days to assess if done 'as soon as reasonably practicable' • Audit of Duty of Candour record keeping in eCare / SystemOne • Continue to build upon work to involve patients and families throughout patient safety investigations to fully encompass the principles of Being Open rather than simply undertaking Duty of Candour at the beginning and sharing a report at the end	Quarterly reporting to the patient safety and quality governance group Quality improvement project recorded on LiveQI. Panel (Exec / CCG sign-off for investigation reports) includes specific oversight of patient involvement in report completion.

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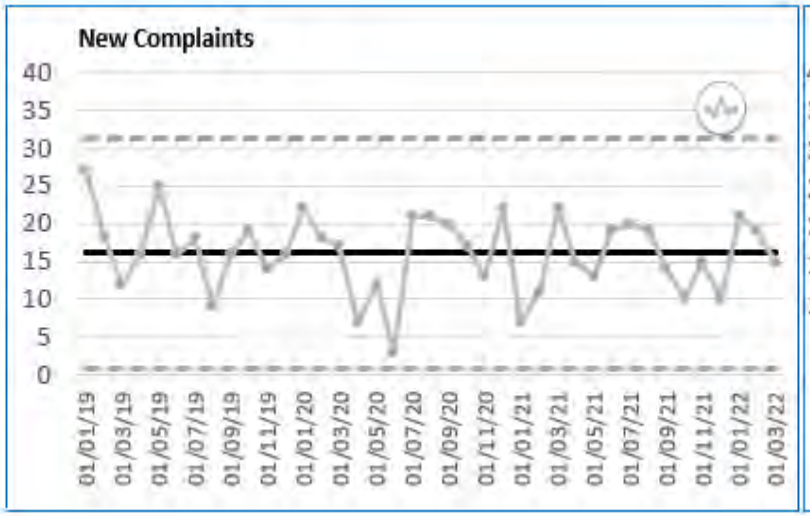
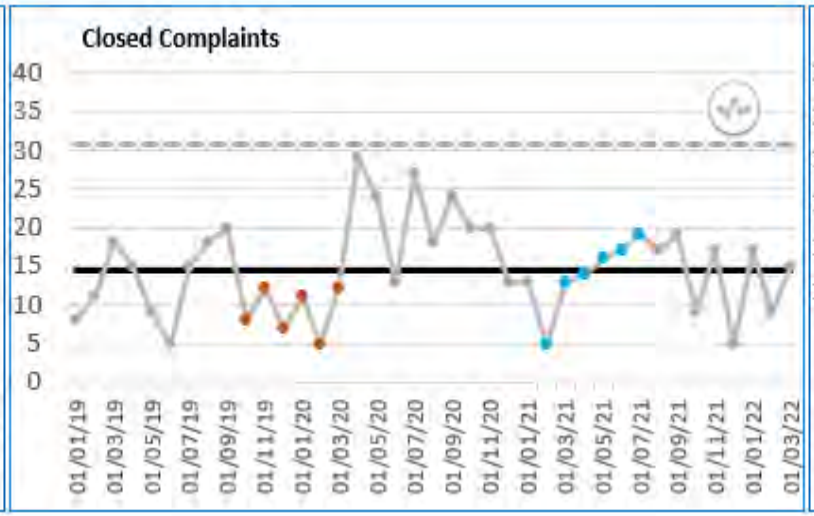
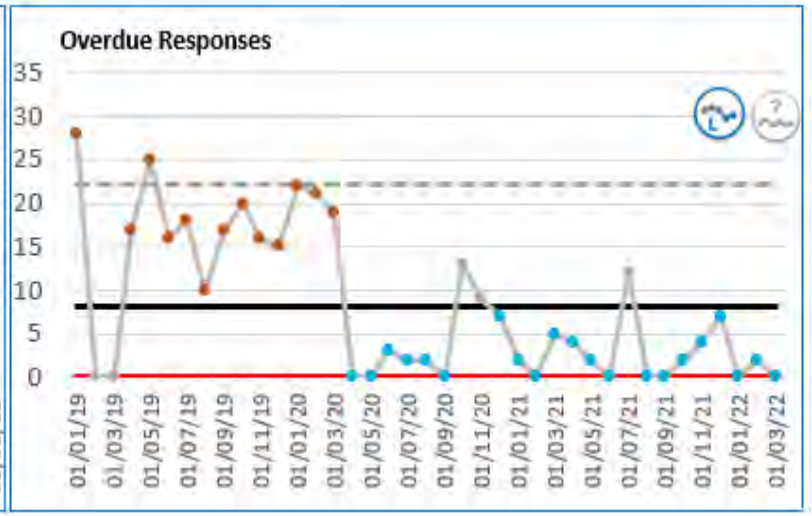
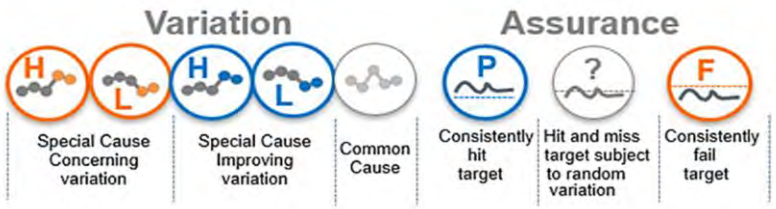






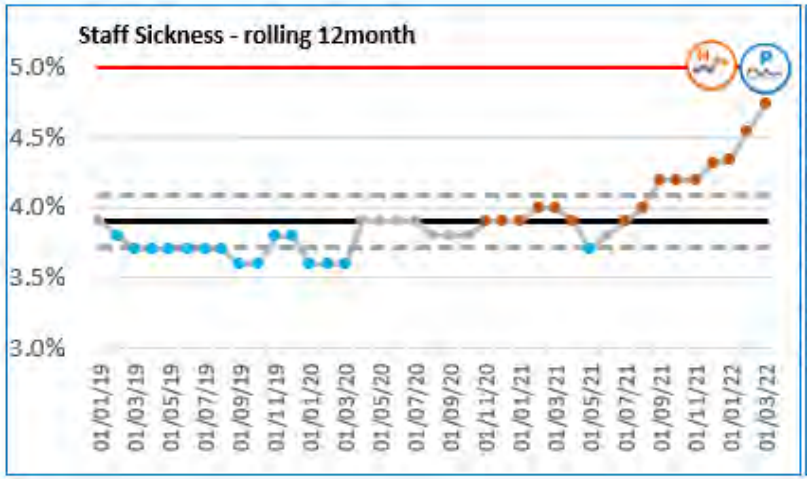
Summary	Action	Assurance
15 Complaints received with the same amount resolved within the same month. We have accepted some complaints via the formal complaints route which have been straightforward to resolve.	Complainants who make a complaint which is considerably less complex should not have to wait as long as complex cases. We are focussing on quick wins which has improved our complaints closed volume.	Overdue responses will remain low with an aim to achieve Zero (0) consistently.

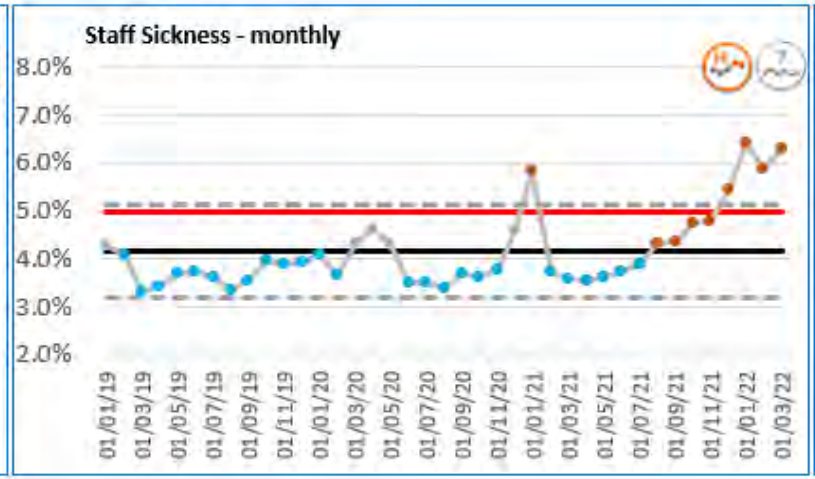
Well Led - Summary

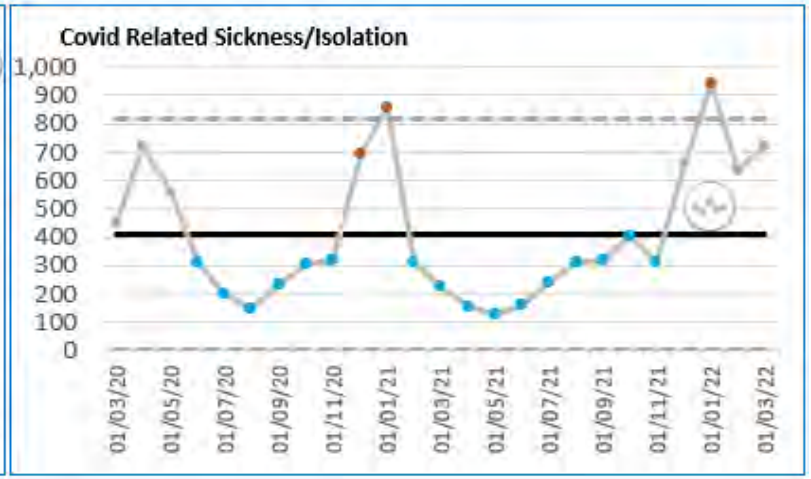


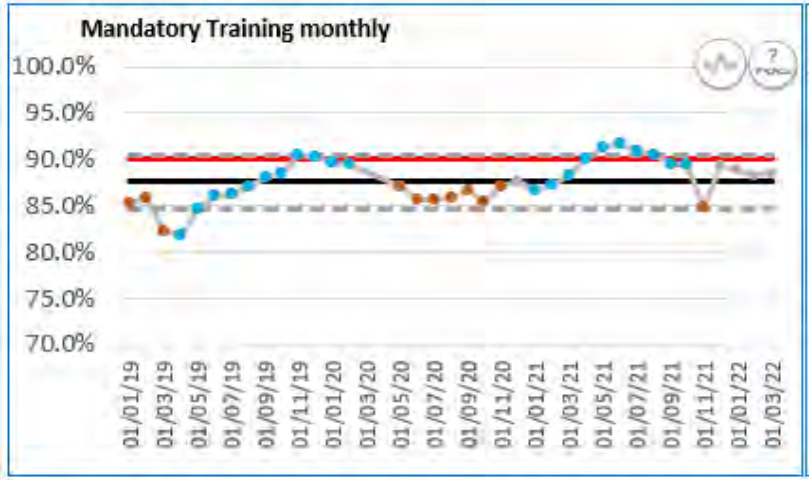
KPI	Latest month	Performance	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Staff Sickness - rolling 12month	Mar 22	4.7%	5.0%	H	P	3.9%	3.7%	4.1%
Staff Sickness - monthly	Mar 22	6.3%	5.0%	H	?	4.2%	3.2%	5.1%
Covid Related Sickness/Isolation	Mar 22	718	-			413	6	820
Mandatory Training monthly	Mar 22	88.6%	90.0%		?	87.6%	84.7%	90.5%
Appraisal Rate monthly	Mar 22	76.4%	90.0%	L	F	78.3%	74.3%	82.3%
Turnover rate monthly	Mar 22	12.0%	10.0%	H	P	8.1%	7.5%	8.8%

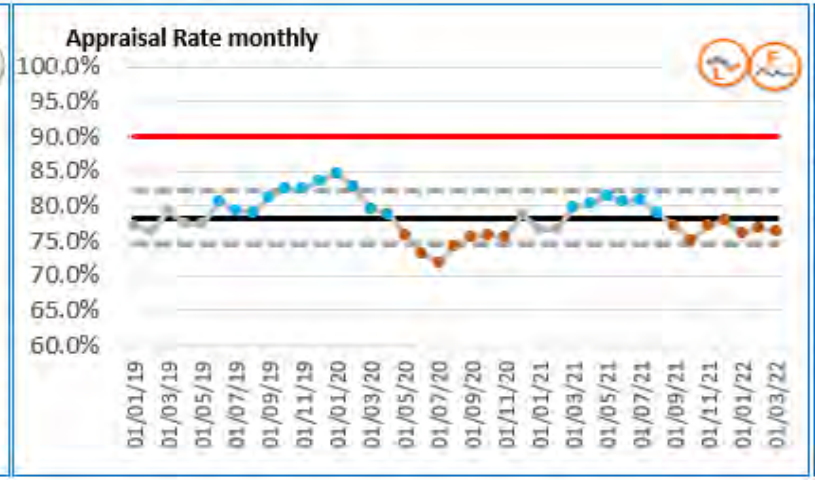
Well Led

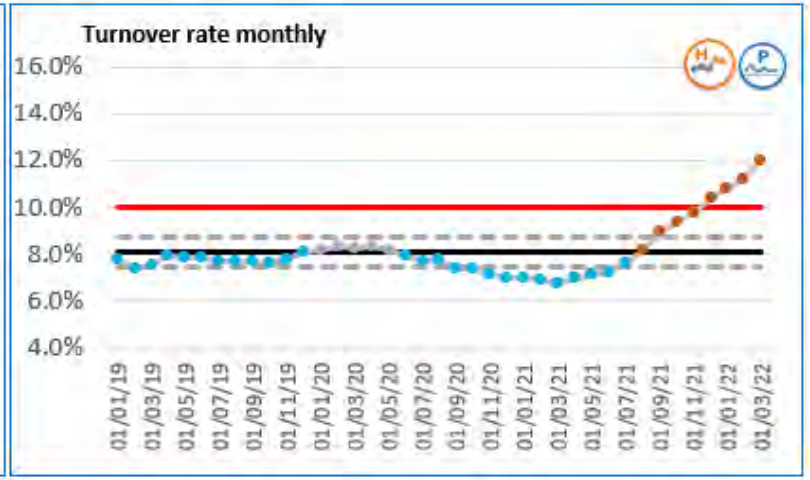












Summary	Action	Assurance
Sickness absence, 12 month rolling, continues to increase. March 2022 saw a peak in absence levels, equal to that of the unprecedented peak of January 2022. Mandatory training is just short of target yet Appraisal compliance remains well below target. Achieving compliance has been affected by the ongoing operational pressures the Trust continues to face. Turnover continues on a concerning upward trajectory and above target.	We continue to monitor absence and await national guidance on the future payments for Covid-19 related sickness absence and isolation payments. Appraisal guidance is being rewritten to focus on the quality conversation and not the paperwork, highlighting more wellbeing conversation prompts for line managers. An internal audit that covers both appraisals and mandatory training will commence at the end of April 2022. HR Business Partners are identifying departments of exceptionally high staff turnover.	Sickness absence is monitored on a daily basis on the Sitrep and at the Strategic meeting twice weekly. All Workforce KPI's are monitored on a monthly basis at the Finance and Workforce Committee, with escalation to the Insight Committee, if required. Increased divisional analysis of Workforce KPI's will improve with the reintroduction of the PRM meetings.

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

To Assure

Presented by Jude Chin

Board of Directors – 27 May 2022

Agenda item:	4.5			
Presented by:	Jude Chin, Interim Chair			
Prepared by:	Rebecca Gibson			
Date prepared:	14 April 2022			
Subject:	Improvement Committee report and Chair's Key Issues			
Purpose:	X	For information	X	For approval

Executive summary:

The Improvement Committee met on 11 April 2022. The transition to the committee operating as a board assurance committee is still in progress, further steps towards which included the approval of its terms of reference and the decommissioning of the Improvement Programme Board.

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

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

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

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

Recommendation: To approve the report

Chair's Key Issues

Part A

Originating Committee	Improvement Committee	**Date of meeting**	11 April 2022
Chaired by	Richard Jones/Nicola Cottington	**Lead Executive Director**	Sue Wilkinson

Agenda item	**Details of issue**	**For: Approval/ Escalation/Assurance**	**BAF/ Risk Register ref**	**Paper attached? ✓**
4.1 4.2 4.3	**Patient safety specialists (PSS) update**: Received local updates on three of the local work workstreams from the national PSS programme: Just Culture, Safety alerts and the National patient safety improvement programmes. Noted opportunities for joined up working across disciplines, departments and workstreams and key trust priorities such as the 'just and restorative culture' work overseen by the Involvement committee.	Assurance		
4.4	**PSIRP end of year one progress report**: Report received from CCG - review of WSFT Year one PSIRF including changes since the serious incident framework. Noted improvements in aspects of incident management including, but not limited to, patient and staff involvement and system-based (not person-based) approach to investigation methods. Further improvement opportunities highlighted for the systems in place to maintain oversight of action completion / oversight and ongoing monitoring of embeddedness and effectiveness. Action oversight group (AOG) still in forming stage and Improvement committee asked for assurances on timeframes to ensure pace.	Partial assurance		
5.1	**Development of 2022/23 quality priorities**: Being developed through a co-produced approach with divisional leads. To be linked to trust strategy ambitions and be relevant to whole organisation not service specific. Less focus on purely numerical indicators of measurable improvement.	Assurance		
7.2.1	**Ockenden**: Noted that Improvement will provide the Board level oversight for assurance of progress to address the recommendations of this report. Unless specific to individual services within maternity and neonates recommendations will be considered for trust-wide improvement opportunities not limited to maternity services.	Approval		
Date completed and forwarded to Trust Secretary		14 April 2022		

Part B

Receiving Committee	Board of Directors	Date of Meeting	
Chaired by		Lead Executive Director	Craig Black

Agenda Item	Record of Consideration Given (Approved/ Response/ Action)

Date Completed and Forwarded to Chair of Originating Committee	

Board of Directors – 27 May 2022

Agenda item:	4.4			
Presented by:	Jude Chin			
Prepared by:	Rebecca Gibson			
Date prepared:	23 May 2022			
Subject:	Improvement Committee report and Chair's Key Issues			
Purpose:	X	For information	X	For approval

Executive summary:

The Improvement Committee met on 16 May 2022. The updated terms of reference now include reporting from the Patient Safety & Quality Governance Group and Clinical Effectiveness Governance Group.

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

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

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

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

Recommendation: To approve the report

- To consider the escalation re data flow and analysis infrastructure
- To formally approve the proposal for IPB (Improvement programme board) decommissioning

Chair's Key Issues

Part A

Originating Committee	Improvement Committee	**Date of meeting**	16 May 2022
Chaired by	Jude Chin	**Lead Executive Director**	Sue Wilkinson

Agenda item	Details of issue	For: Approval/ Escalation/ Assurance	BAF/ Risk Register ref	Paper attached? ✓
3.1	Building appropriate data flow and analysis infrastructure (collection, collation, analysis and reporting) for use by Specialist Committees and Divisional Boards (and their subsidiaries) in Governance and Performance Main focus of discussion during meeting. • Principles overlap with multiple agenda items. • Concern re pace of trust dashboard project • Need for strengthened oversight, key milestones to be defined Two proposed recommendations were presented for consideration. 1. To discuss a joined-up, aligned, organisation data infrastructure concept with key Executive sponsors, the objective being to determining appetite and potential endorsement for an initiative. Subsequent next steps which can be presented at potential future updates. 2. To determine what the key contractual and IQPR indicator measures work with the relevant governance, operational and clinical groups to distribute these for oversight and monitoring.	Escalation		
4.1	Patient Safety & Quality Governance Group Report and minutes received. Noted that reporting template may need to change as currently designed for reporting to Insight committee.	Assurance		

Agenda item	Details of issue	For: Approval/ Escalation/ Assurance	BAF/ Risk Register ref	Paper attached? ✓
4.2	Clinical Effectiveness Governance Group Report received. Same issue re template redesign. One escalation re concerns around CQUIN data availability which may preclude full participation (but no financial penalties/incentives in 2022/23 so low impact)	Assurance		
5.1	Patient safety and learning strategy (draft 1 for comment) Link to trust strategy, draft approved. Will be supported by an implementation plan with scheduled updates to Improvement committee and the patient safety microsite on the new intranet.	Assurance		
5.2	Patient safety specialist updates: Framework for involving patients in patient safety and Patient safety education and training. Received for information	Assurance		
6.1	Quality assurance programme – planned schedule of CCG visits to provide 'critical friend' external assurance on key quality and safety topics. Received for information	Assurance		
6.2	Ockenden – Maternity and wider trust plan to respond to the recommendations Received for information. The framework for review of the multiple maternity documents requiring board receipt for Ockenden and CNST was discussed.	Assurance		
7.1	IPB (Improvement programme board) decommissioning Agreed IPB plan items could be **archived** as all subjects listed in 'must' and 'should' are either • complete (for discreet standalone actions) • overseen through the remit of one of the governance groups providing a source of assurance and / or escalation as required • part of the relevant department's reporting framework (e.g. Maternity or ED) The Board is asked to formally **approve** the decommissioning of the IPB	Escalation		

Agenda item	Details of issue	For: Approval/ Escalation/ Assurance	BAF/ Risk Register ref	Paper attached? ✓
7.2	Board Assurance Framework Received for information. Named committees have responsibility for oversight of named BAF items. The Patient safety & quality governance group will report on BAF 1.1 to the Improvement as part of its standard reporting framework in future (links to action in item 4.1 re governance groups reporting template redesign)	Assurance		
7.3	Quality priorities (Improvement and assurance) Will form part of annual report and quality accounts. Scheduled updates to Improvement committee will provide oversight.	Assurance		
Date completed and forwarded to Trust Secretary				

Part B

Receiving Committee	Board of Directors	Date of Meeting	
Chaired by		Lead Executive Director	Craig Black
Agenda Item	**Record of Consideration Given (Approved/ Response/ Action)**		
Date Completed and Forwarded to Chair of Originating Committee			

4.5. Quality and Nurse Staffing Report

To Assure

Presented by Susan Wilkinson

Trust Board – May 2022]

Report Title:	Item 4.5 - Quality and Workforce Report & Dashboard – Nursing March and April 2022
Executive Lead:	Sue Wilkinson
Report Prepared by:	Daniel Spooner
Previously Considered by:	N/A

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

Executive Summary

This paper reports on safe staffing fill rates and mitigations for inpatient areas for March and April 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

- Average RN fill rates in the day remain under 90% since October 2021 They have remained static this month following preceding months of decline
- Inpatient RN vacancy rate percentage has improved slightly, but a decline in WTE. This was in part driven by moves within ED budget
- NA vacancy has increased driven by an increase in budgeted establishment for 22/23 and reduction in WTE
- Reduction in sickness rates in both RN and NA groups, However April saw an increase in Covid isolation impacting on nurse staffing
- Surge staffing plans reinstated in March following significant capacity challenges and opening of additional capacity. BAU was achieved at end of April
- Maternity KPIs maintained good performance, Vacancy rates improving in non-specialist roles
- Winter SNCT (acuity and dependency audit completed and reported in this paper). No significant concerns or alterations required on this round of audit

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 on a monthly basis, actual staffing data is compared with expected staffing and reviewed alongside quality of care, patient safety, and patient and staff experience data. The trust is committed to ensuring that improvements are learned from and celebrated, and areas of emerging concern are identified and addressed promptly.

This paper will identify the safe staffing and actions taken in March and April 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 March and April 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 1 illustrates a ward by ward breakdown

	Day		Night	
	Registered	Care Staff	Registered	Care staff
Average fill rate for September 21	91%	92%	89%	107%
Average fill rate for October 21	88%	87%	87%	101%
Average fill rate for November 2021	89%	87%	88%	102%
Average fill rate for December 2021	88%	82%	86%	96%
Average fill rate for January 2022	87%	81%	82%	97%
Average fill rate February 2022	85%	81%	84%	100%
Average fill rate March 2022	84%	78%	83%	96%
Average fill rate April 2022	84%	76%	81%	93%

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

Highlights

- Reduction in fill rates across all shifts other than RN day shifts
- G8 area of concern consistently not filing its core staffing number and high vacancies. Recruitment improvement plan commenced in April 2022
- RN bank pool uptake increasing, assisting daily mitigation
- Surge staffing mitigations reinstated end of march and returned to BAU 25.4.22 which reflects the challenges demonstrated in this reporting period.

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).

3. Sickness

Following a further peak in sickness in February, sickness rates have fallen for both RNs and NAs in March and April.

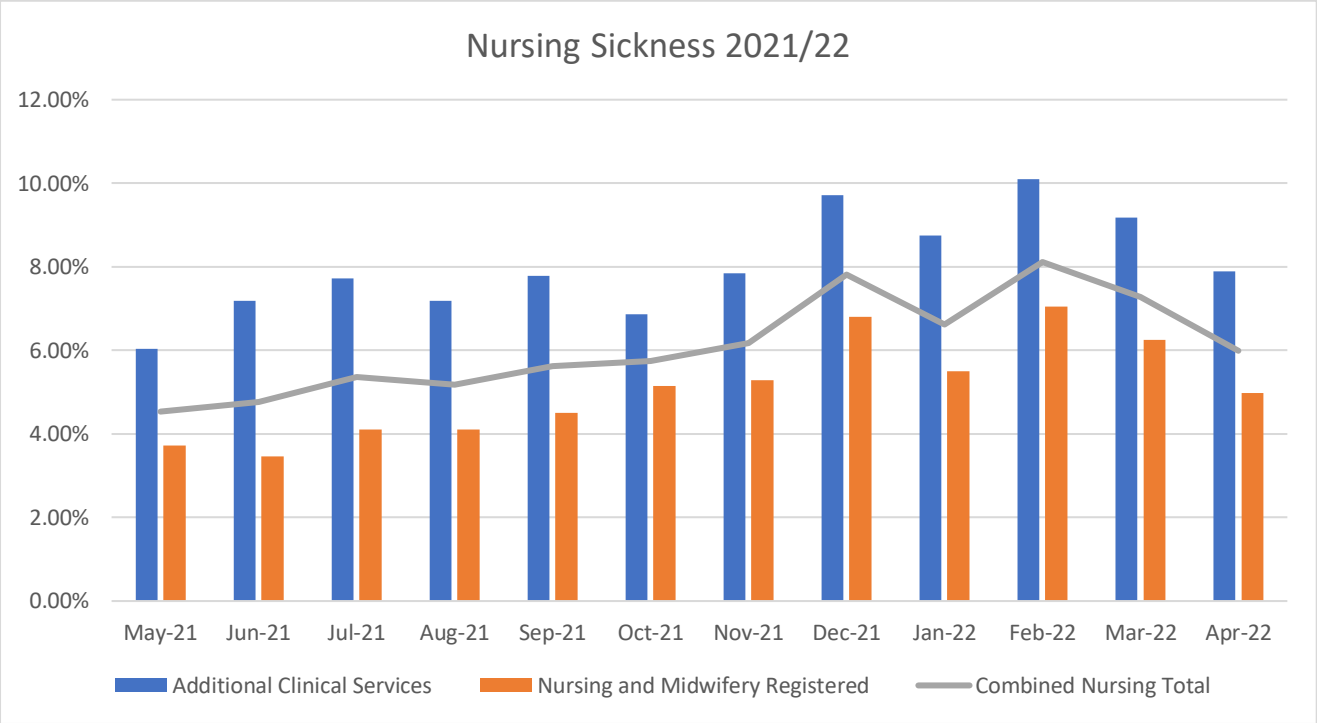


Chart 2.

	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22
Unregistered staff (support workers)	7.78%	6.87%	7.85%	9.71%	8.75%	10.09%	9.18%	7.89%
Registered Nurse/Midwives	4.50%	5.15%	5.29%	6.80%	5.50%	7.05%	6.25%	4.98%
Combined Registered/Unregistered	**5.62%**	**5.75%**	**6.17%**	**7.81%**	**6.62%**	**8.11%**	**7.28%**	**5.99%**

Table 2b

Challenges to providing safe staffing have also been exacerbated by staff that are required to self-isolate, either due to exposure to Covid 19, or due to a member of their household being symptomatic. This is captured separately to sickness and is demonstrated below (chart 3). Despite general sickness being lower in April, high numbers of staff were absent due to Covid self-isolation placing additional pressure on staffing mitigation. This correlates with increasing community prevalence and a move to risk assessments owned by divisions.

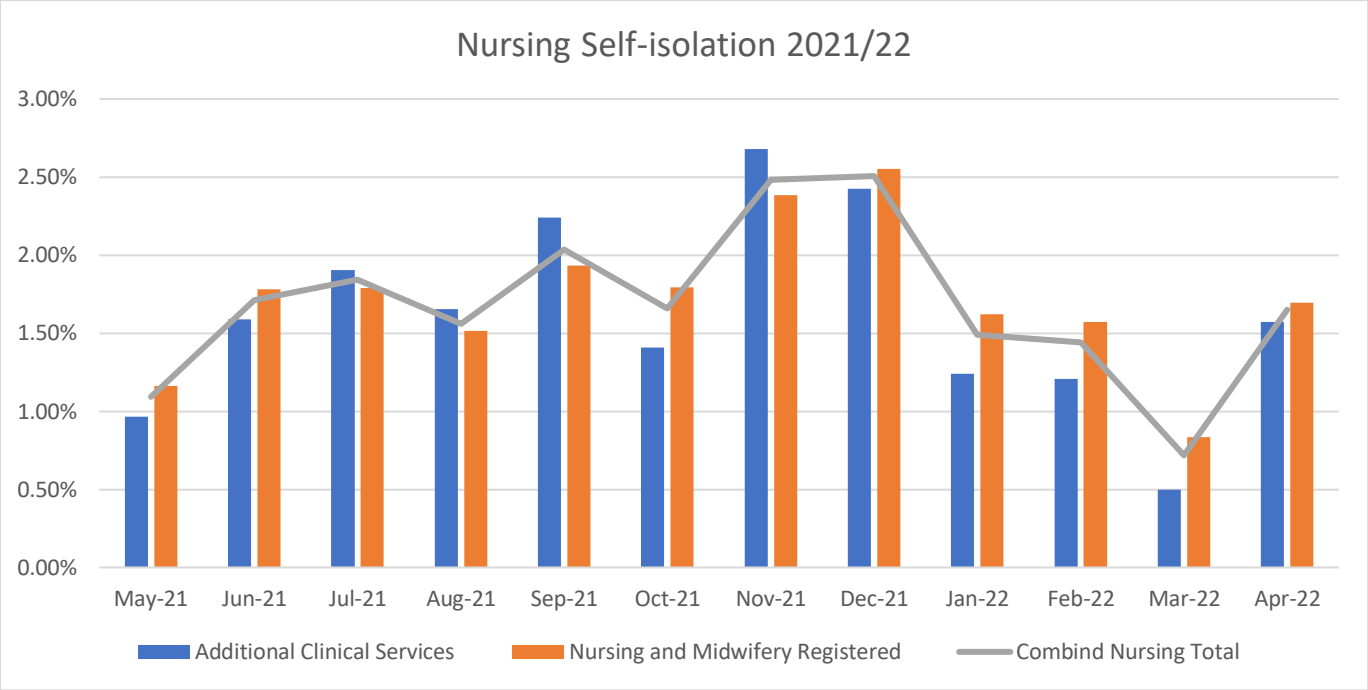


Chart 3

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.

For this reporting period an additional ward was reopened to enable flow through the emergency pathway and address significant capacity challenges. This was supported by the current nursing establishment. the ward was opened on 17th March following significant operational pressures and closed on the 28th April.

5. Recruitment and Retention

Vacancies: Registered nursing (RN/RM):

- Inpatient RN/RM WTE vacancies is 113.1 which is a reduction of 3.0 WTE form last reported month. (Chart 4a)
- Inpatient ward RN vacancies is 15.4 % (appendix 2), an increase of 0.4% last report
- Midwifery vacancies is 15.8% (excluding specialist roles) a reduction of 7.2% last report (appendix 2)
- Total RN/RM vacancies (all areas) has increased this month to has increased to 13.7%
- Nursing assistants and unregistered staff have remained reasonably static with inpatient vacancy at 12.7% and 11.4% for total Trust.

	Inpatient	Sum of Actuals Period 8 (Nov)	Sum of Actuals Period 9 (Dec)	Sum of Actuals Period 10 (Jan)	Sum of Actuals Period 11 (Feb)	Sum of Actuals Period 12 (Mar)	Sum of Actuals Period 01 (Apr)	WTE VACANCY at period 1
RN/RM Substantive	Ward WTE	611.7	610.8	611.1	611.3	612.5	603.5	113.1.
Nursing Unregistered Substantive	Ward WTE	379.9	385.4	378.6	379.1	385.9	376.7	54.8

Table 4. Ward/Inpatient actual substantive staff with WTE vacancy

The chart below demonstrates the total RN establishment for the inpatient areas (WTE). The total number of substantive RNs has seen an improving trend until March this year. A drop-in establishment has been seen in April. This driven in part by budget moves within ED and of course leavers. Full list of SPC related to vacancies can be found in appendix 2. Appendix 3 provides a full list of ward by ward vacancies.

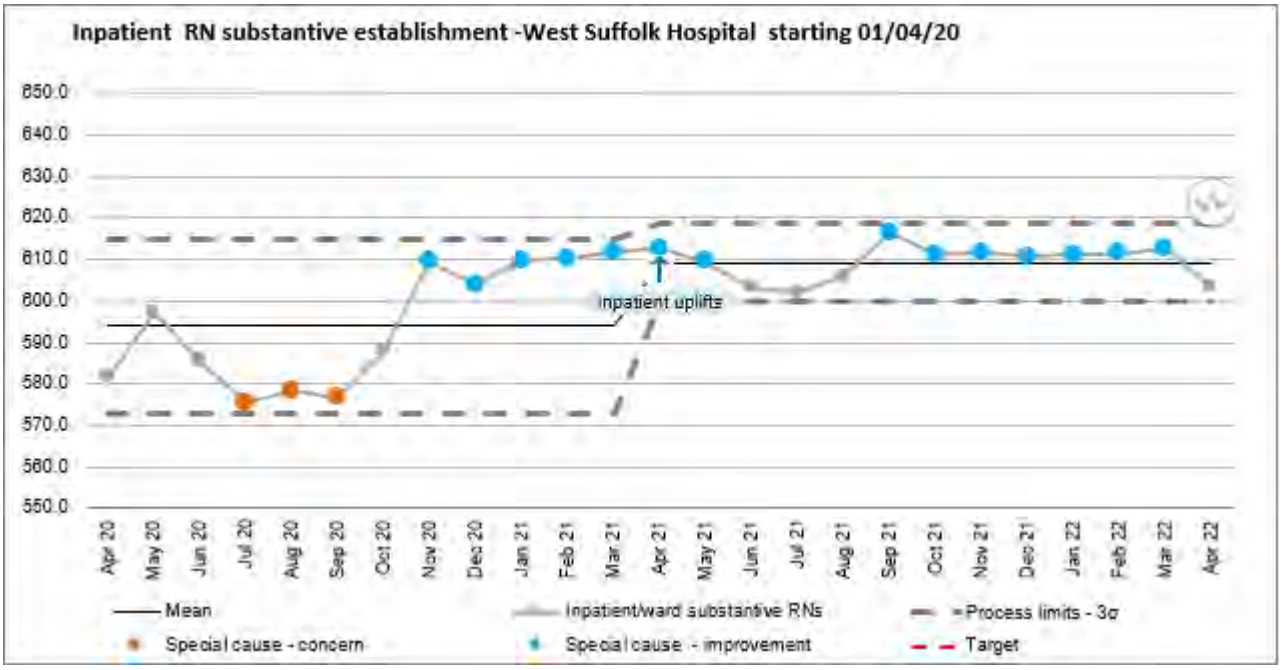


Chart 4a: SPC data adapted from finance ledger

6. New Starters and Turnover

International Nurse Recruitment:

In March, eight nurses arrived as planned to achieve our target recruitment for 21/22. In April issues with visa provision, outside of our internal controls, meant that the April cohort did not arrive until the first week of May and falling below our expected trajectory. Plans to recover the reduction in arrivals are being scoped and we remain on track for our target for 2022/23 recruitment

In addition, as part of the regional ambition to support displaced nurses, this month the trust welcomed two nurses from Lebanon, and will be supporting their transition into UK registration over the coming months.

New starters

	November	December	January 22	February 22	March 22	April 22
Registered Nurses*	14	17	15	28	23	23
Non-Registered	11	10	24	18	8	22

Table 6: Data from HR and attendance to WSH induction program
*8 international nurses attended RN induction in March despite not being registered at this point

- In March 2022 twenty-three RNs completed induction; of these; fourteen were for acute services, one for pure bank, seven midwives and one for community services joined this cohort
- In March 2022, eight NAs completed induction; of these four NAs are for the acute Trust, one for midwifery services and three for bank services

- In April 2022 twenty-three RNs completed induction; of these; fourteen were for acute services and three for bank services and one for midwifery
- In April 2022 twenty-two NAs completed induction; of these, thirteen NAs are for the acute Trust, four for bank services and four for community services and one for midwifery

Turnover

On a retrospective review of the last rolling twelve months, turnover for RNs has increased from 10.43% to 11.3%, this is now above the trust ambition of <10% and is increasing month on month. NA turnover has also increased from 16.72% to 18.83%. The escalating turnover has been escalated through the finance and workforce committee and is being captured at the Trust retention group

Turn Over 01/05/2021 - 30/04/2022								
Staff Group	Average Headcount	Avg FTE	Starters Headcount	Starters FTE	Leavers Headcount	Leavers FTE	LTR Headcount %	LTR FTE %
Nursing and Midwifery Registered	1,297	118.06	101	73.99	155	126.33	11.95%	11.30%
Additional Clinical Services	584.50	493.65	199	176.33	109	92.96	18.65%	18.83%

Table 7. (data from workforce)

7. Quality Indicators

Falls

Falls per 100 bed days exceeded the national average in March with a high point of concern seen within the SPCs, this returned to levels normally observed in April and below national average (per 1000 bed days). This is driven in part by patient with multiple falls and potentially the shortfall of nursing staff that has been experienced.

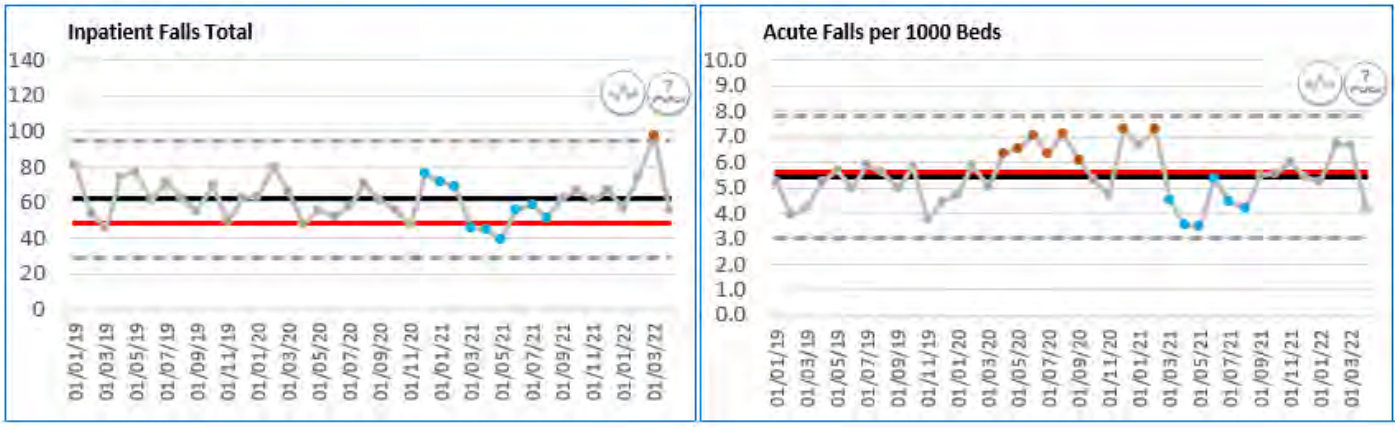


Chart 8

Pressure Ulcers

Both March and April saw a reduction in pressure ulcers within the acute, however the increasing trend continues, following positive reductions seen prior to the previous months. Both falls and pressure ulcers can be linked to staffing shortfalls which have also declined over the same periods. Staffing challenges within the TVN team have been resolved this month so additional capacity to support ward-based training and QI projects will improve. Full details of incidences and locations can be found in Appendix 4.

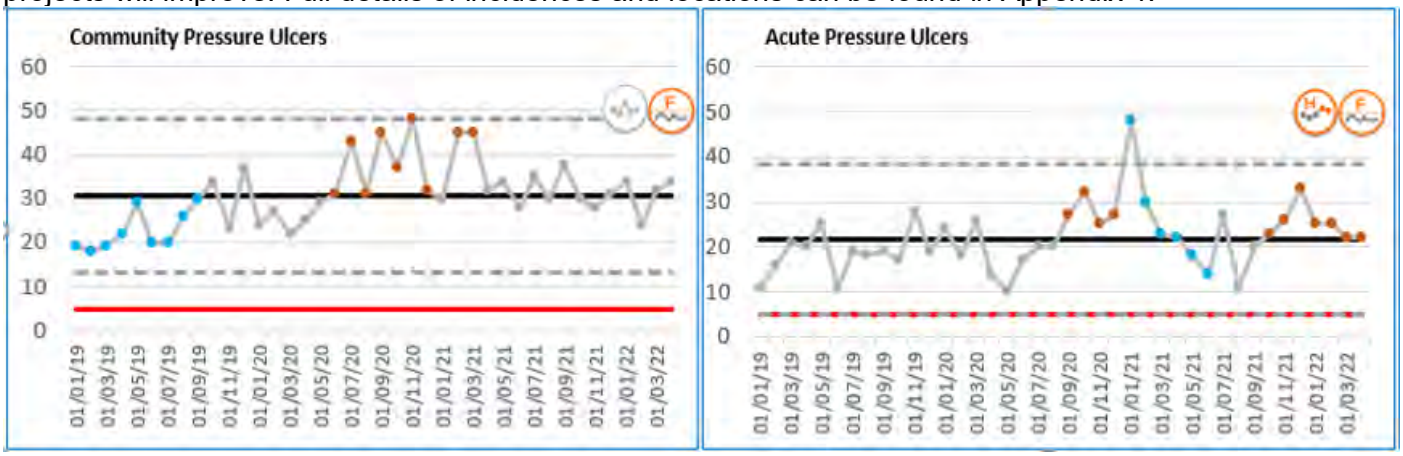


Chart 9a

8. Compliments and Complaints

In March the average number of calls to the clinical helpline was 138 and 144 per day in April. This is driven by reduced visiting since December 2021 following the emergence of the Omicron Covid variant. These visiting restrictions remined in place for March and April. At the time of writing visiting has reopened in the majority of inpatient areas.

Fifteen new complaints were received in March which is lower than the number previously received in February. The medical division received the highest number of complaints which was seven overall. Of this the Emergency Department received the highest number of three. The main theme of complaints for March was clinical treatment, this encompassed complaints from several areas including general medicine, obstetrics & gynaecology and surgery.

Seventeen new complaints were received in April which is an increase of two complaints on the previous month. Nine complaints received for the medical division. There was no area with a significant number of complaints than others

Table 10. demonstrates the incidence of complaints and compliments for this period.

	Compliments	Complaints
October 2021	15	10
November 2021	18	15
December 2021	22	10
January 2022	22	21
February 2022	19	19
March 2022	24	15
April 2022	14	17

Table 10

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 reviewed retrospectively.

- In March there were 53 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. These results are likely to be driven by staffing additional capacity and increasing sickness/absence rates seen in RNs and NAs

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

Red Flag	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22
Registered nursing shortfall of more than 8 hours or >25% of planned nursing hours	19	20	10	5	9	16	10
>30-minute delay in providing pain relief	2	5	4	2	3	1	6
Delay or omission of intention rounding	10	12	12	6	5	8	2
<2 RNs on a shift	6	7	5	4	3	8	6
Vital signs not recorded as indicated on care plan	3	3	1	2	2	4	3
Unplanned omissions in providing medication	0	0	1	3	2	2	-
Lack of appointments (local agreed red flag)	0	0	0	1	0	0	-
Delay in routine care (new descriptor)	-	-	-	-	10	12	17
Impact not described	-	-	-	-	-	2	-
Total	40	40	33	24	34	53	44

Table 11.

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	September	October	November	December	January	February	March	April
Supernumerary Status of LS Coordinator	100%	85%	93%	100%	99%	99%	99%	98.3%	100%
1-1 Care in Labour	100%	100%	100%	100%	100%	100%	99.5%	100%	100%
MW: Birth Ratio	1:28	1:30	1:29.8	1:26	1:23	1:28	1:27	1:28	1:26
No. Red Flags reported		15	22	3	43	46	27	40	6

Red Flag events

NICE Safe midwifery staffing for maternity settings 2015 defines Red Flag events as events that are immediate signs that something is wrong and action is needed now to stop the situation getting worse. Action includes escalation to the senior midwife in charge of the service and the response include allocating additional staff to the ward or unit. Appendix 4 illustrates red flag events as described by NICE. Red Flags are captured on Datix and highlighted and mitigated as required at the daily Maternity Safety Huddle;

- There were fifty-two flag events in March. 26 of these were related to staff absences due to Covid No harm was recorded as in impact of these incidents and the majority are related to Covid absences
- There were six red flag events in April . No harm was recorded as in impact of these incidents. These refer to delays in transfer of care to labour suite and IOL.

Midwife to Birth ratio

Midwife to Birth ratio was 1:28 in March and 1:26 in April, this has been achieved consistently for the past six months, where the unit has achieved this best practice metric of <1:28, or Birth-rate Plus recommendation of 1:27.7.

1:1 was achieved 100% in both March and April

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 however this requirement is currently under review by CNST as more clarification is required towards the meaning of supernumerary states, this is due to be published in May 2022.

- In March 98.3% compliance against this standard was achieved, this equals to 2 occasions. One due to Labour Suite coordinator triaging women as a Triage midwife was providing 1:1 care and on second occasion- LS coordinator was providing 1:1 care while awaiting arrival of an on-call midwife.

- In April 100% compliance was achieved.

11. Community & Integrated services division

11.1 Demand

Demand within the community setting can be illustrated by the number of referrals each service receives. Chart 12a and 12b are examples of the rise in demand for both community nursing and community therapy experienced in the last year. This will have a direct impact on nursing and therapy capacity and the ability to respond to rising demands.

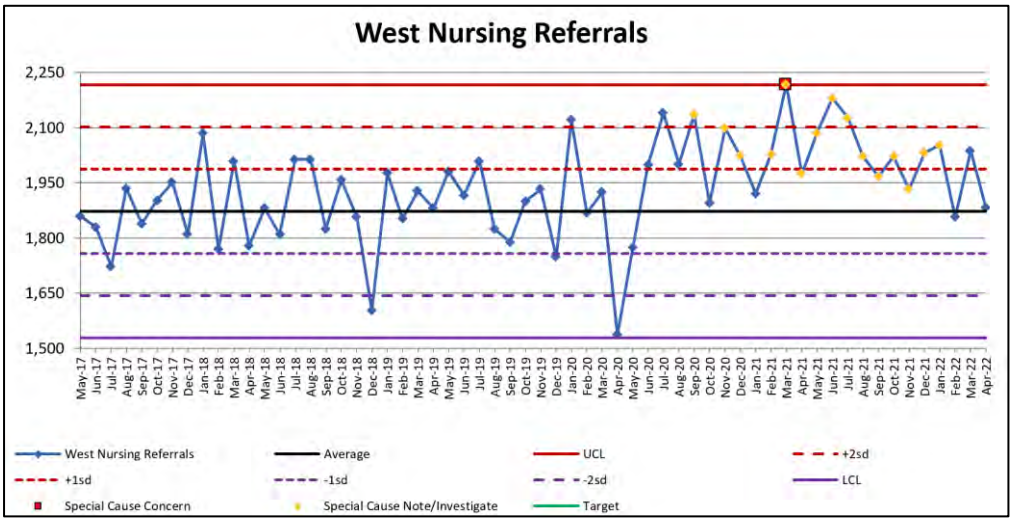


Chart 12a

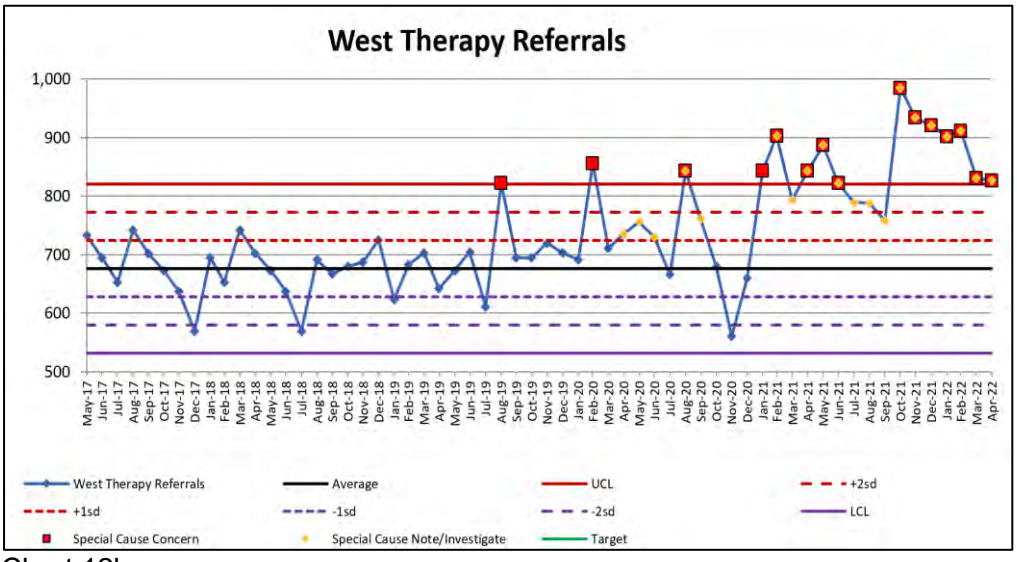


Chart 12b

11.2 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. Long term plans include the sourcing a license for a national modelling tool to support better demand and capacity modelling.

Incidents: Adverse staffing incidents – Incident reporting is at average levels for the division. Staffing level difficulties reported on Datix are down on previous months, but missed visits are up. These are being investigated to see if it is due to a scheduling error.

11.3 Sickness

Month	Community
January	7.09%
February	7.11%
March	8.89%
April	4.62%

11.4 Vacancies in CHTS

Role	Vacancy percentage	
	Last reported	This period
RNs	22 %	23%
Physiotherapists	23%	23%
Occupational therapists	9%	11%
Generic workers /unregistered	11%	16%

11.5 Ongoing actions being taken by division

- Piloting Integrated Neighbourhood Coordinator manually extract number of care plans per day & hours of workforce available.
- Follow surge plan & national OPAL policy
- CHTs to work with HealthRoster team to ensure accuracy of reporting, so that staffing fill rates can be accurately reported

12. Biannual staffing review

During January/February 2022 the bi-annual audit of staffing establishments based on acuity and dependency was completed. This was conducted using the Safer Nursing Care Tool (SNCT). Given the staffing challenges observed during this period five areas have been excluded due to incomplete audit data. Only three wards demonstrate a potential shortfall in establishment these are

- G8
- Rosemary ward
- G4

Both G4 and G8 had investment in April 2021 and at the time of audit, Rosemary ward was functioning as a winter escalation ward (with associated uplift).

Since initial SNCT in September 2020, the audit cycle has now produced 4 cycles of audit. Another audit will be scheduled in June/July 2022 and will provide a review of all audit data over the past two years to ensure that our nursing establishments are meeting the needs of our patients (appendix 6 illustrates audit outcome for this period)

No changes to establishments are recommended in this round of audit

13. Recommendations and Further Actions

- Not the impact of super surge capacity planning on nurse staffing and possible implications for patient care this month. However surge staffing returned to BAU at the end of this reporting period
- Note the information on the nurse and midwifery staffing and the impact on quality and patient safety
- Note the content of the report and that mitigation is put in place where staffing levels are below planned.
- Note that the content of the report is undertaken following national guidelines using research and evidence-based tools and professional judgement to ensure staffing is linked to patient safety and quality outcomes.

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

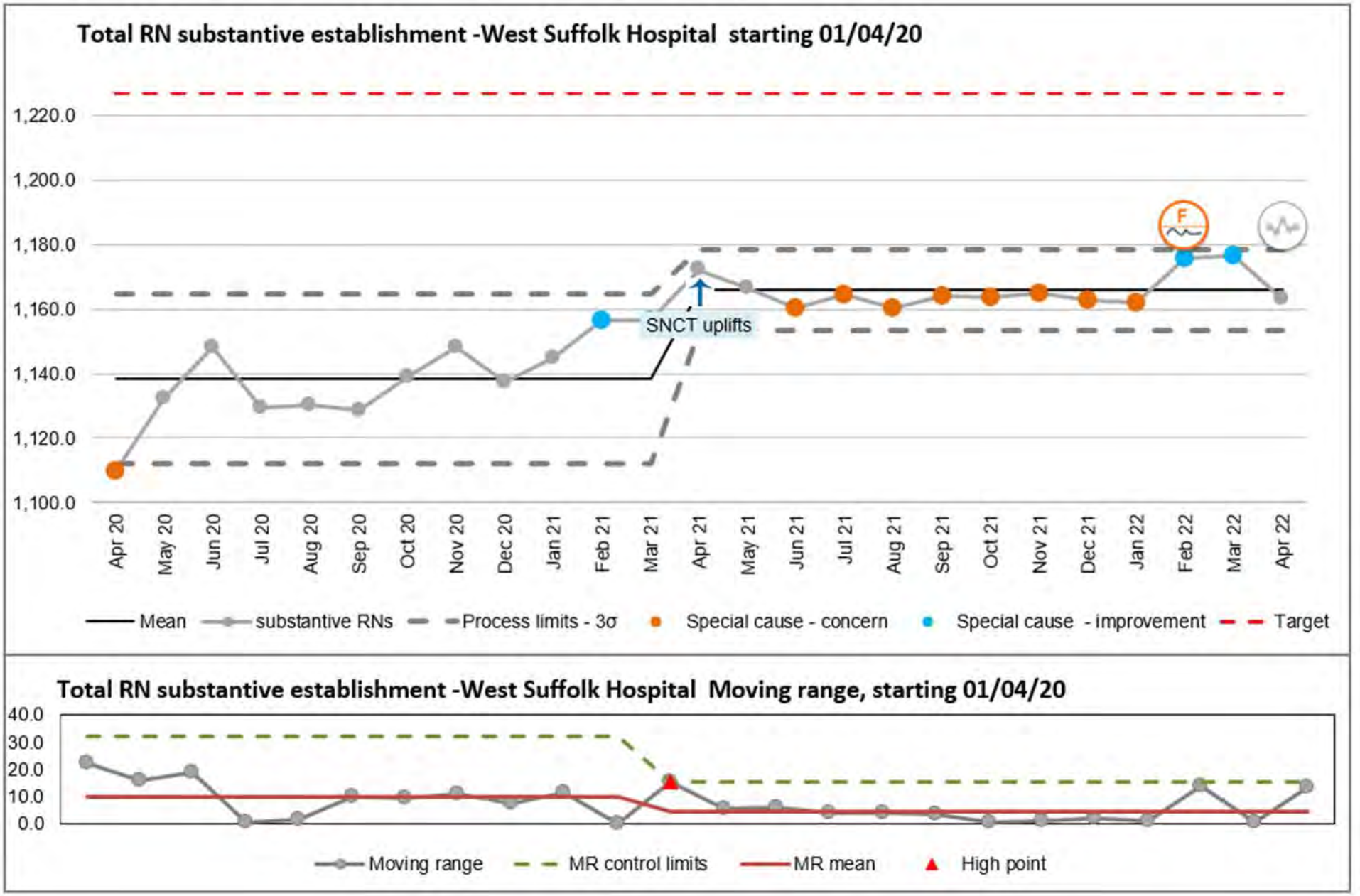
RAG: Red >79%, Amber 80-89%, Green 90-100%, Purple >100%

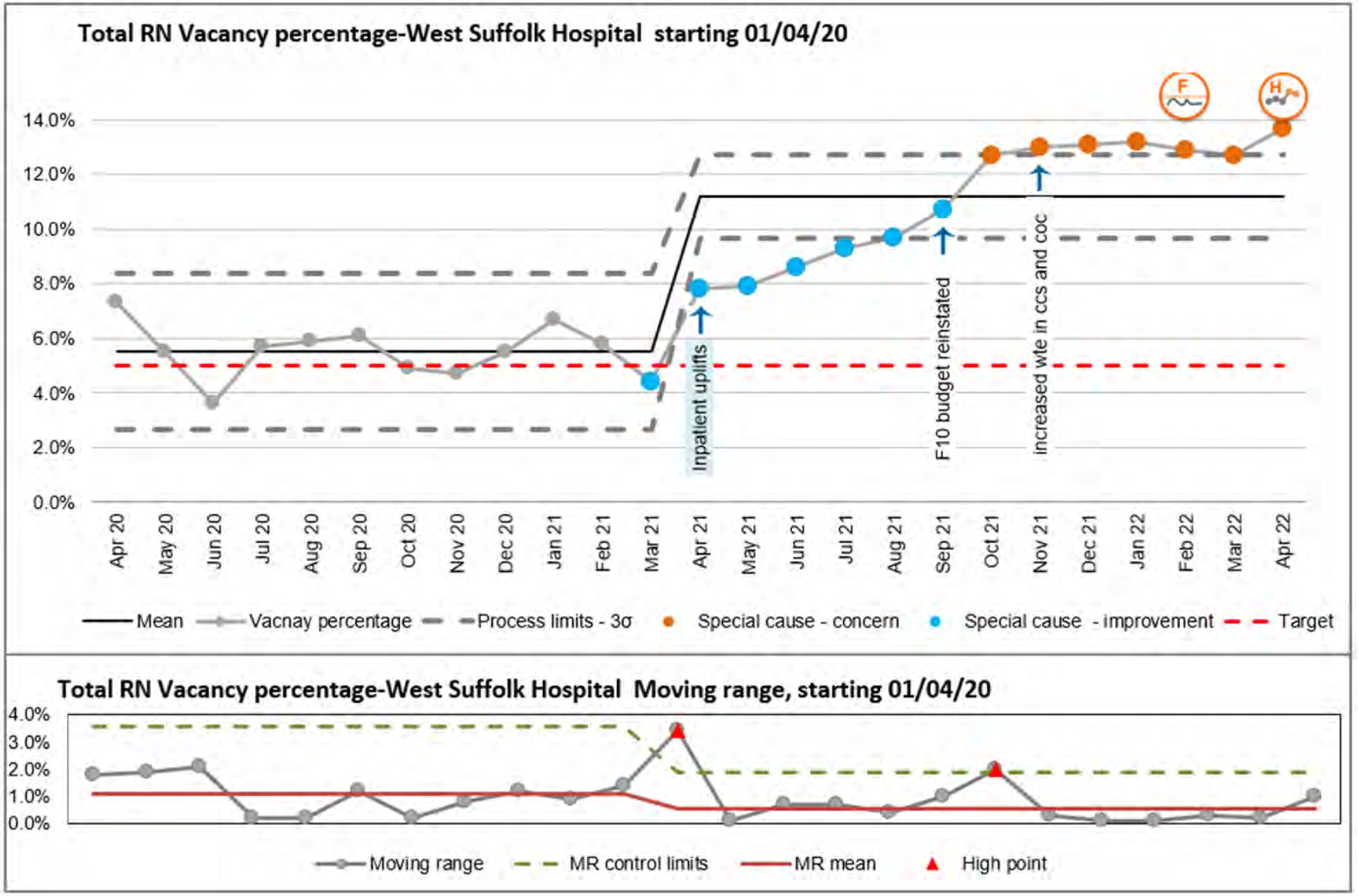
	Day				Night				Day		Night		Care Hours Per Patient Day (CHPPD)			
	RNs/RMN		Non registered (Care staff)		RNs/RMN		Non registered (Care staff)									
	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Average Fill rate RNs/RM %	Average fill rate Care staff %	Average Fill rate RNs/RM %	Average fill rate Care staff %	Cumulative count over the month of patients at 23:59 each	RNS/RMs	Non registered (care staff)	Overall
Rosemary Ward	1249.5	1114.25	2131.5	1682	1069.5	978	1414.5	1316.5	89%	79%	91%	93%	452	4.6	6.6	11.3
Glastonbury Cour	708.5	635.5	1065	909.5	706.5	646.5	536.5	485.5	90%	85%	92%	90%	384	3.3	3.6	7.0
Acute Assessme	2128.5	1651.5	2495.5	1761.1667	1782.5	1358	1426	1431.16667	78%	71%	76%	100%	761	4.0	4.2	8.1
Cardiac Centre	2910	2530	1358.5	1084	1782.5	1558.5	713	547	87%	80%	87%	77%	632	6.5	2.6	9.0
G10	1412.5	1162.25	1401	1188	1072.5	766	1422.5	1299.5	82%	85%	71%	91%	707	2.7	3.5	6.2
G9	1426	1328.5	1414	1131.5	1426	1150.5	1058	1078.5	93%	80%	81%	102%	752	3.3	2.9	6.2
F12	563.5	611.75	356.5	337	713	399.5	351.5	380	109%	95%	56%	108%	240	4.2	3.0	7.2
F7	1757	1334.8333	1777.5	1366.5833	1409.5	1058.333333	1783	1373	76%	77%	75%	77%	683	3.5	4.0	7.5
G1	1433	988.5	356.5	356.5	713	711.25	356.5	379	69%	100%	100%	106%	485	3.5	1.5	5.0
G3	1779	1421.5	1778.5	1533.6667	1069.5	966	1064.5	1382.5	80%	86%	90%	130%	864	2.8	3.4	6.1
G4	1704.5	1348.25	1751.5	1495	1012	747.5	1436	1264.5	79%	85%	74%	88%	896	2.3	3.1	5.4
G5	1774	1435.5	1766.5	1333.9667	1066.5	962	1425.5	1293	81%	76%	90%	91%	760	3.2	3.5	6.6
G8	2486.5	1538.0833	1788	1446.5	1782.5	1232.416667	1064	1054.25	62%	81%	69%	N/A	615	4.5	4.1	8.6
F8	1429.23333	1394.5	2106.5	1635.6667	1046.5	783.5	1414.5	1345.5	98%	78%	75%	95%	723	3.0	4.1	7.1
Critical Care	2853.5	2421.9167	341	261	2845	2297.416667	0	138.75	85%	77%	81%	*	388	12.2	1.0	13.2
F3	1771	1424	2128	1355.25	1069.5	908.5	1426	1246	80%	64%	85%	87%	732	3.2	3.6	6.7
F4	972	845.5	972	472.5	713	643.5	621	540.5	87%	49%	90%	87%	633	2.4	1.6	4.0
F5	1788.5	1419.5	1426	1190.5	1069.5	973	1052.25	936	79%	83%	91%	89%	698	3.4	3.0	6.5
F6	2035.5	1651.5	1656.91667	1077.6667	1426	1014.5	713	825.5	81%	65%	71%	116%	942	2.8	2.0	4.9
Neonatal Unit	1012	1151.5	180	210.5	944	944	156	168	114%	117%	100%	108%	116	18.1	3.3	21.3
F1	1215.75	1254.5	701.75	631.4	1069.5	1181.25	0	117.5	103%	90%	110%	*	115	21.2	6.5	27.7
F14	780	790.73333	319	350	732	733.5666667	0	0	101%	110%	100%	*	106	14.4	3.3	17.7
Total	35,189.98	29,454.07	29,271.67	22,809.87	26,520.50	22,013.73	19,434.25	18,602.17	**84%**	**78%**	**83%**	**96%**	**12684**	**4.1**	**3.3**	**7.3**

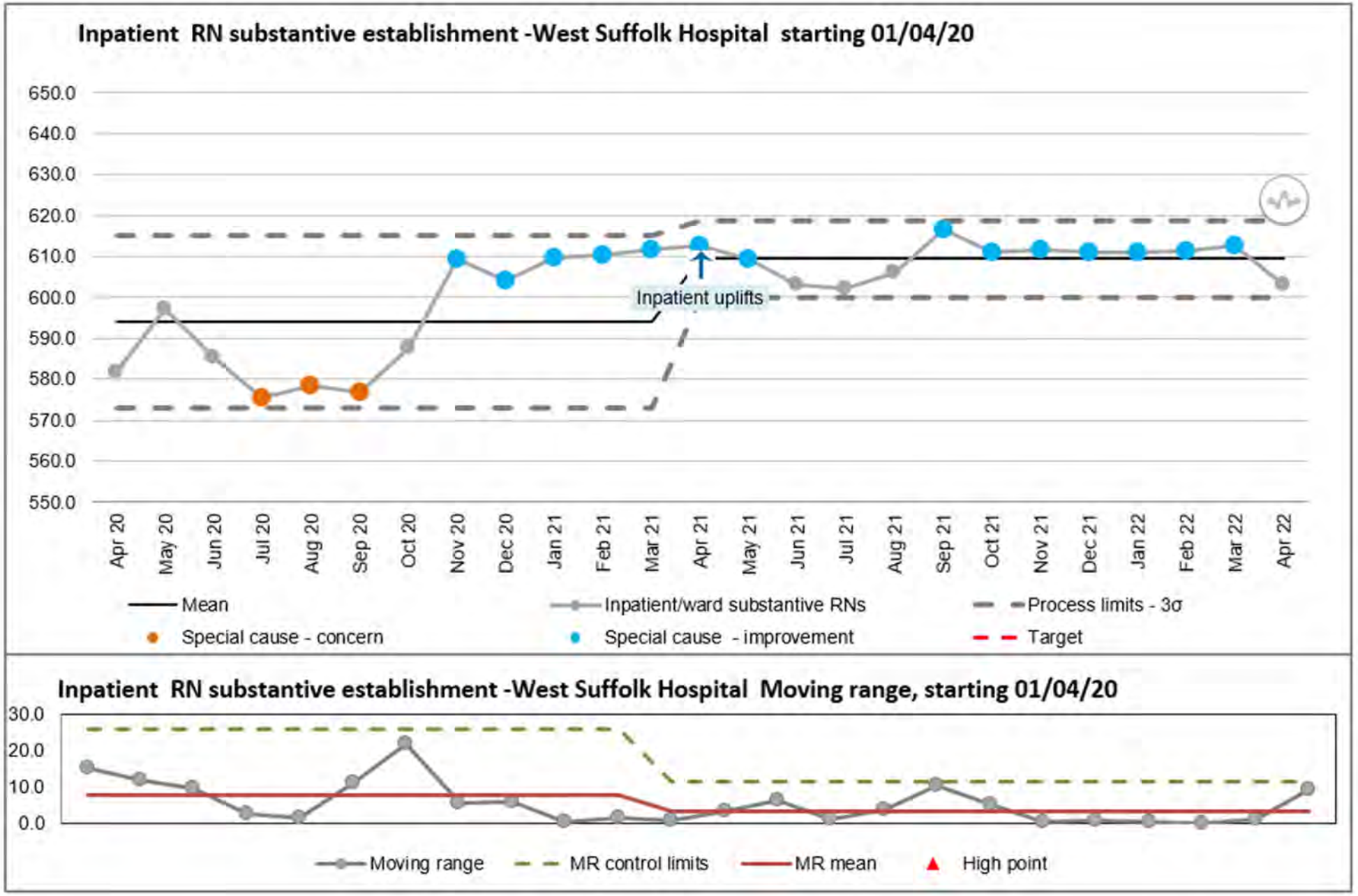
Appendix 1. Fill rates for inpatient areas (April 2022): Data adapted from Unify submission

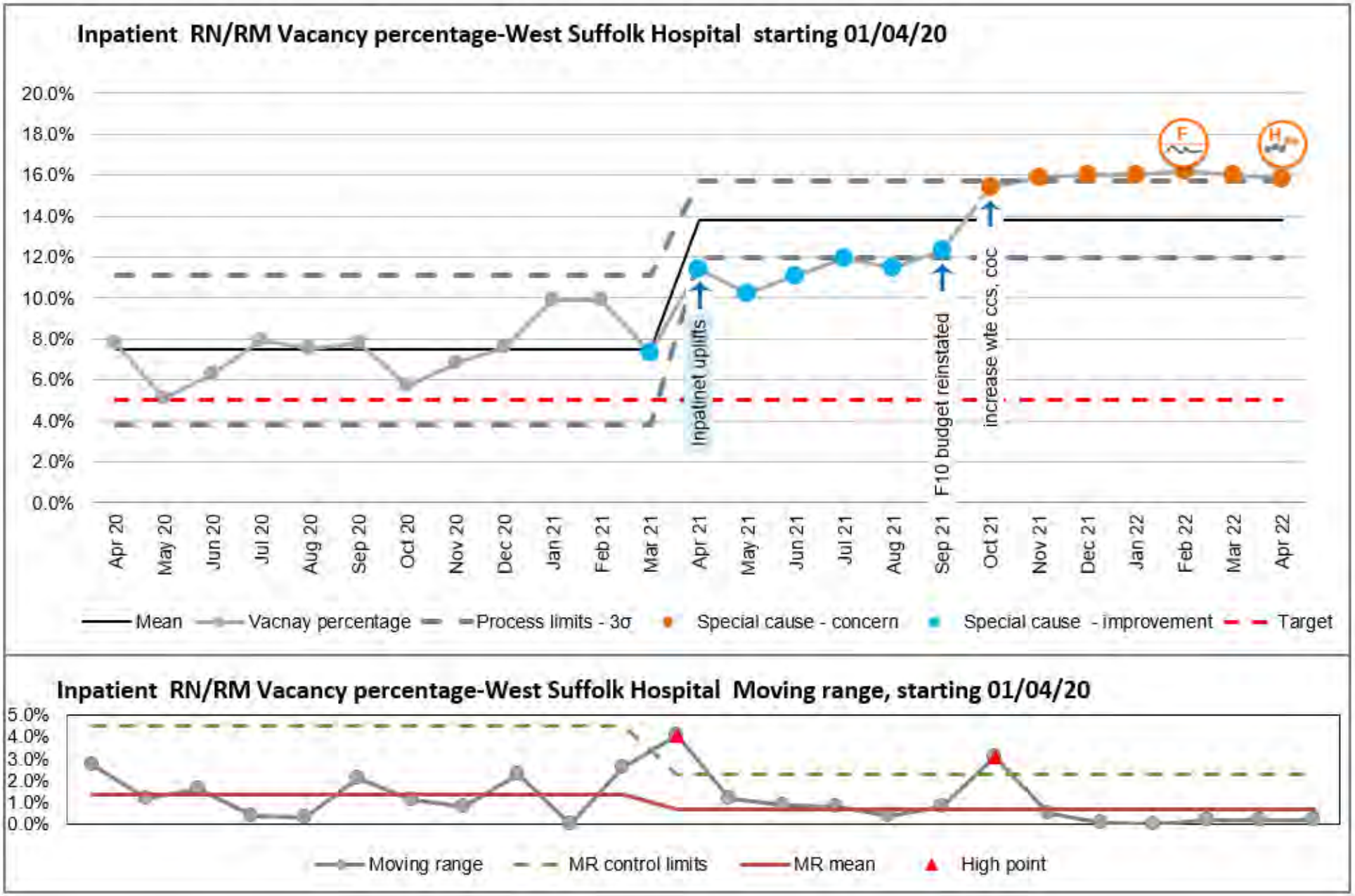
	Day				Night				Day		Night		Care Hours Per Patient Day (CHPPD)			
	RNs/RMN		Non registered (Care staff)		RNs/RMN		Non registered (Care staff)									
	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Average Fill rate RNs/RM %	Average fill rate Care staff %	Average Fill rate RNs/RM %	Average fill rate Care staff %	Cumulative count over the month of patients at 23:59 each	RNS/RMs	Non registered (care staff)	Overall
Rosemary Ward	1043	990.5	2068	1507.75	1012	793.5	1373.5	1291.5	95%	73%	78%	94%	452	3.9	6.2	11.3
Glastonbury Cou	690.5	697.5	1035	1018.5	690	680.5	525	541.5	101%	98%	99%	103%	384	3.6	4.1	7.0
Acute Assessme	2043.5	1761.7333	2409	1362.5	1713.5	1258.5	1380	1256.5	86%	57%	73%	91%	761	4.0	3.4	8.1
Cardiac Centre	2690.5	2319.75	1265	1020.75	1725	1426	690	563.5	86%	81%	83%	82%	632	5.9	2.5	9.0
G10	1381	1065	1370.5	1206	1035	760	1380	1162.5	77%	88%	73%	84%	707	2.6	3.4	6.2
G9	1368.5	1239.25	1365.5	1171.75	1368.5	1152	1034.5	1017	91%	86%	84%	98%	752	3.2	2.9	6.2
F12	550.25	568.5	345	304	690	373	345	387.5	103%	88%	54%	112%	240	3.9	2.9	7.2
F7	1709	1196.3333	1714.5	1194.5	1349.75	988.7666667	1725	1372	70%	70%	73%	80%	683	3.2	3.8	7.5
G1	1384.48333	863	345	321	690	691	345	314.5	62%	93%	100%	91%	485	3.2	1.3	5.0
G3	1725	1354	1706.5	1394.0833	1030.5	835	1035	1323.5	78%	82%	81%	128%	864	2.5	3.1	6.1
G4	1719	1279.5	1747	1474	1035	714.75	1380	1107.5	74%	84%	69%	80%	896	2.2	2.9	5.4
G5	1725	1366	1733	1108.5	1031	858.5	1380	1260	79%	64%	83%	91%	760	2.9	3.1	6.6
G8	2417	1420.3333	1728.5	1364.25	1725	1051.5	1035	1043.5	59%	79%	61%	N/A	615	4.0	3.9	8.6
F8	1357.5	1346.0167	2053	1406	989	758	1372	1254.5	99%	68%	77%	91%	723	2.9	3.7	7.1
Critical Care	2757	2568.65	330	252	2754	2423.75	0	147	93%	76%	88%	*	388	12.9	1.0	13.2
F3	1725	1394	2058.5	1481	1035	912.5	1374	1181.5	81%	72%	88%	86%	732	3.2	3.6	6.7
F4	931.5	808.5	926	434.5	690	575	586.5	465.366667	87%	47%	83%	79%	633	2.2	1.4	4.0
F5	1725	1270.5	1380	1177	1034	841	1023.5	872.5	74%	85%	81%	85%	698	3.0	2.9	6.5
F6	1941.5	1583.2667	1579	1249	1380	1052	684	767.5	82%	79%	76%	112%	942	2.8	2.1	4.9
Neonatal Unit	1080	1284	360	136	1056	997	360	168	119%	38%	94%	47%	116	19.7	2.6	21.3
F1	1162	1250	690	716.5	1035	1136.25	0	120.25	108%	104%	110%	*	115	20.8	7.3	27.7
F14	730	830	312	294	720	676.5	0	36	114%	94%	94%	*	106	14.2	3.1	17.7
Total	33,856.23	28,456.33	28,521.00	21,593.58	25,788.25	20,955.02	19,028.00	17,653.62	**84%**	**76%**	**81%**	**93%**	**12684**	**3.9**	**3.1**	**7**

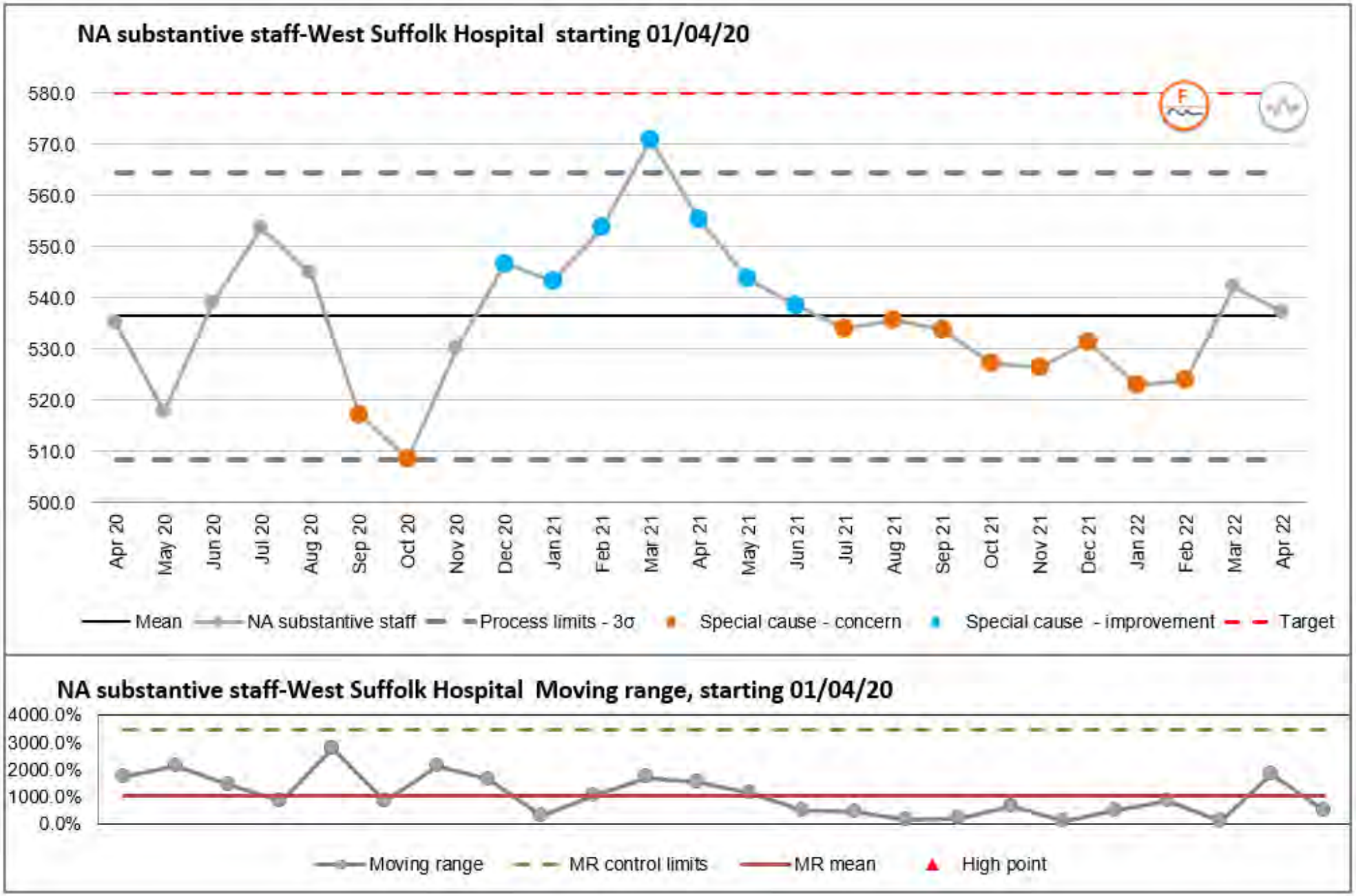
Appendix 2

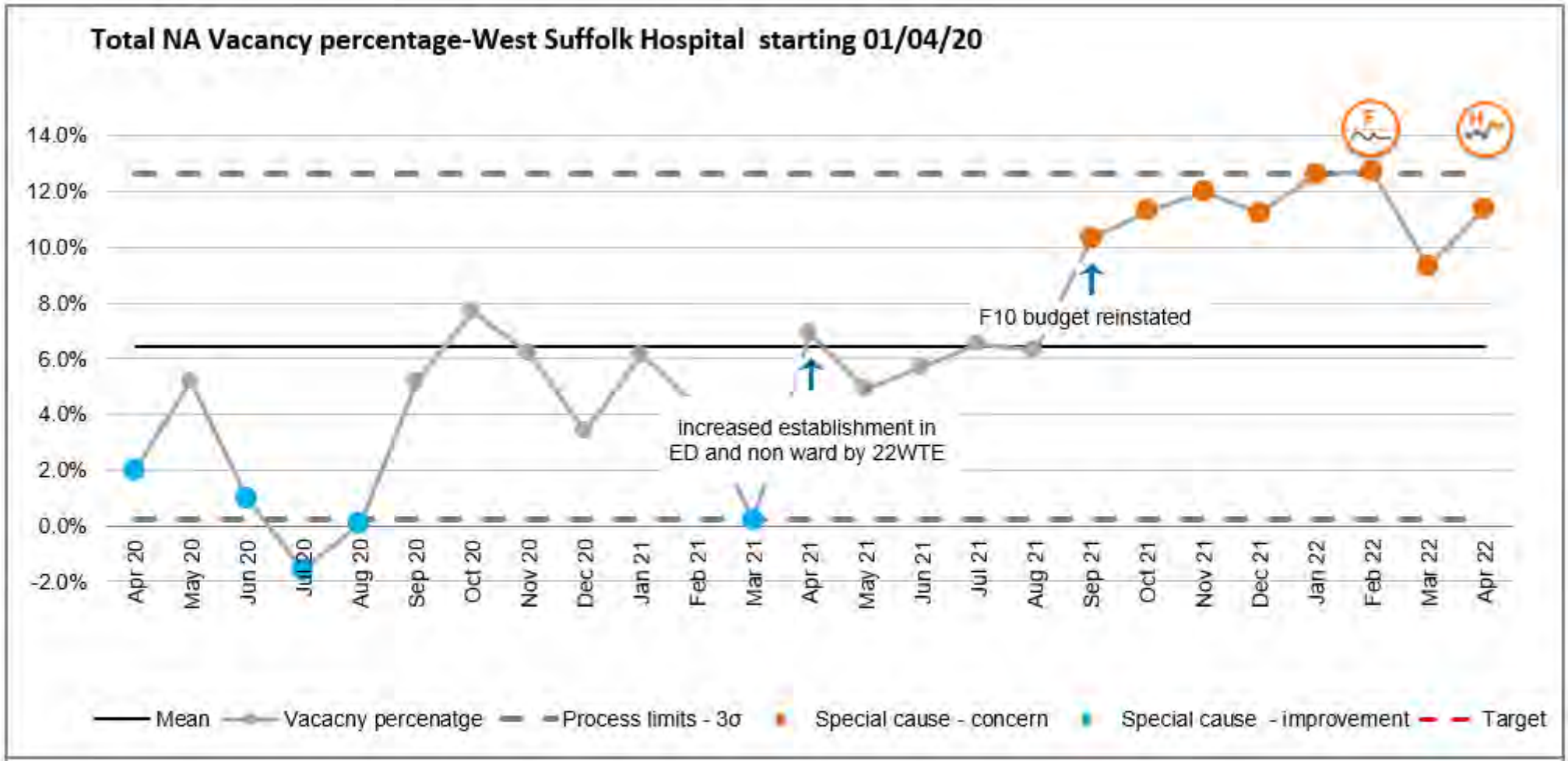

Total RN substantive establishment -West Suffolk Hospital starting 01/04/20
1,220.0
1,200.0
1,180.0
1,160.0
1,140.0
1,120.0
1,100.0
SNCT uplifts
Apr 20
May 20
Jun 20
Jul 20
Aug 20
Sep 20
Oct 20
Nov 20
Dec 20
Jan 21
Feb 21
Mar 21
Apr 21
May 21
Jun 21
Jul 21
Aug 21
Sep 21
Oct 21
Nov 21
Dec 21
Jan 22
Feb 22
Mar 22
Apr 22
Mean
substantive RNs
Process limits - 3σ
Special cause - concern
Special cause - improvement
Target
Total RN substantive establishment -West Suffolk Hospital Moving range, starting 01/04/20
40.0
30.0
20.0
10.0
0.0
Moving range
MR control limits
MR mean
High point

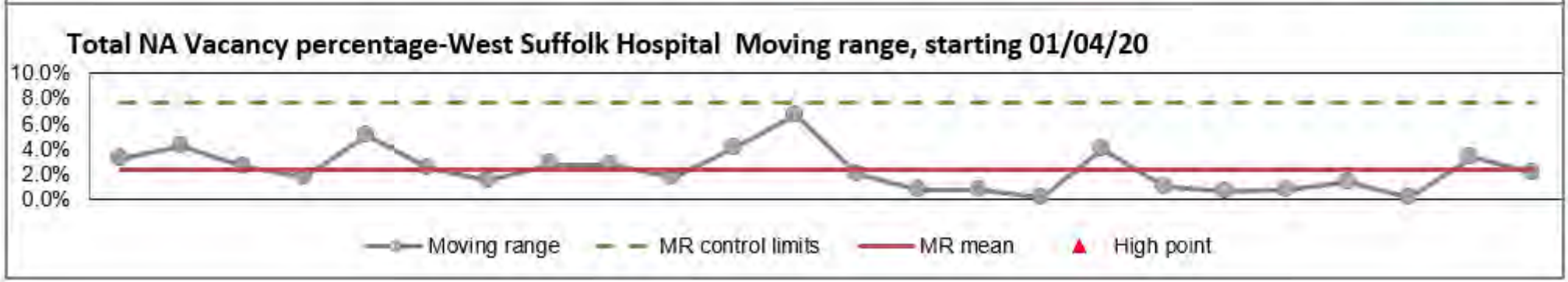

Total RN Vacancy percentage-West Suffolk Hospital starting 01/04/20
14.0%
12.0%
10.0%
8.0%
6.0%
4.0%
2.0%
0.0%
Apr 20
May 20
Jun 20
Jul 20
Aug 20
Sep 20
Oct 20
Nov 20
Dec 20
Jan 21
Feb 21
Mar 21
Apr 21
May 21
Jun 21
Jul 21
Aug 21
Sep 21
Oct 21
Nov 21
Dec 21
Jan 22
Feb 22
Mar 22
Apr 22
F
H
Inpatient uplifts
F10 budget reinstated
increased wte in ccs and coc
Mean
Vacnay percentage
Process limits - 3σ
Special cause - concern
Special cause - improvement
Target
Total RN Vacancy percentage-West Suffolk Hospital Moving range, starting 01/04/20
4.0%
3.0%
2.0%
1.0%
0.0%
Moving range
MR control limits
MR mean
High point


Inpatient RN substantive establishment -West Suffolk Hospital starting 01/04/20
650.0
640.0
630.0
620.0
610.0
600.0
590.0
580.0
570.0
560.0
550.0
Inpatient uplifts
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
Mean
Inpatient/ward substantive RNs
Process limits - 3σ
Special cause - concern
Special cause - improvement
Target
Inpatient RN substantive establishment -West Suffolk Hospital Moving range, starting 01/04/20
30.0
20.0
10.0
0.0
Moving range
MR control limits
MR mean
High point


Inpatient RN/RM Vacancy percentage-West Suffolk Hospital starting 01/04/20
20.0%
18.0%
16.0%
14.0%
12.0%
10.0%
8.0%
6.0%
4.0%
2.0%
0.0%
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
Inpatinet uplifts
F10 budget reinstated
increase wte ccs, coc
F
H
Mean
Vacnay percentage
Process limits - 3σ
Special cause - concern
Special cause - improvement
Target
Inpatient RN/RM Vacancy percentage-West Suffolk Hospital Moving range, starting 01/04/20
5.0%
4.0%
3.0%
2.0%
1.0%
0.0%
Moving range
MR control limits
MR mean
High point


NA substantive staff-West Suffolk Hospital starting 01/04/20
580.0
570.0
560.0
550.0
540.0
530.0
520.0
510.0
500.0
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
Mean
NA substantive staff
Process limits - 3σ
Special cause - concern
Special cause - improvement
Target
NA substantive staff-West Suffolk Hospital Moving range, starting 01/04/20
4000.0%
3000.0%
2000.0%
1000.0%
0.0%
Moving range
MR control limits
MR mean
High point


Total NA Vacancy percentage-West Suffolk Hospital starting 01/04/20
14.0%
12.0%
10.0%
8.0%
6.0%
4.0%
2.0%
0.0%
-2.0%
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
F10 budget reinstated
increased establishment in ED and non ward by 22WTE
Mean
Vacacny percenatge
Process limits - 3σ
Special cause - concern
Special cause - improvement
Target


Total NA Vacancy percentage-West Suffolk Hospital Moving range, starting 01/04/20
10.0%
8.0%
6.0%
4.0%
2.0%
0.0%
Moving range
MR control limits
MR mean
High point

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

Mar-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	18.7	30.1	11.4	37.9	AAU	24.4	28.3	3.9	13.9	26.3
Accident & Emergency	63.9	77.3	13.4	17.3	Accident & Emergency	32.1	34.5	2.4	6.8	14.1
Cardiac Centre	37.6	40.7	3.1	7.6	Cardiac Centre	14.0	15.7	1.7	11.0	8.5
Glastonbury Court	11.5	11.7	0.2	1.6	Glastonbury Court	12.5	12.6	0.1	1.1	1.4
Critical Care Services*	43.6	50.0	6.4	12.9	Critical Care Services	2.8	1.9	-0.9	-48.9	10.6
Day Surgery Wards	12.4	11.0	-1.4	-12.5	Day Surgery Wards	3.9	3.9	0.0	0.0	-9.2
Gynae Ward (On F14)	13.2	14.1	0.9	6.3	Gynae Ward (On F14)	3.0	2.0	-1.0	-50.0	-0.7
Neonatal Unit	19.2	20.6	1.4	6.8	Neonatal Unit	4.1	4.3	0.2	4.2	6.4
Rosemary ward	15.4	18.6	3.2	17.2	Rosemary ward	23.2	25.8	2.6	9.9	13.0
Recovery Unit	22.9	27.3	4.4	16.1	Recovery Unit	1.9	0.9	-1.0	-120.9	11.9
Ward F1 Paediatrics	21.5	22.1	0.7	3.0	Ward F1 Paediatrics	7.6	6.7	-0.9	-12.8	-0.7
Ward F12	8.3	11.9	3.6	30.4	Ward F12	6.1	5.9	-0.2	-4.3	19.0
Ward F3	22.3	22.2	-0.2	-0.7	Ward F3	21.9	25.8	3.9	15.2	7.9
Ward F4	11.0	13.6	2.6	19.2	Ward F4	9.7	14.6	4.9	33.8	26.8
Ward F5	19.9	22.2	2.2	10.1	Ward F5	14.1	18.1	4.0	22.2	15.5
Ward F6	22.3	26.6	4.3	16.0	Ward F6	18.7	17.4	-1.3	-7.7	6.7
Ward F7 Short Stay	19.5	24.9	5.4	21.8	Ward F7 Short Stay	22.4	25.8	3.4	13.2	17.5
Ward F9 (now G5)	18.4	21.8	3.4	15.5	Ward G5	18.7	23.2	4.5	19.3	17.5
Ward G1 Hardwick Unit	26.9	30.6	3.7	12.0	Ward G1 Hardwick Unit	10.1	10.5	0.4	4.1	10.0
Ward G3	19.8	22.1	2.3	10.4	Ward G3	25.1	23.0	-2.1	-9.2	0.4
Ward G4	18.6	22.1	3.5	15.8	Ward G4	18.0	22.8	4.8	20.9	18.4
Ward G8	17.6	32.7	15.1	46.1	Ward G8	18.6	20.6	2.0	9.8	32.1
Renal Ward - F8	19.7	19.5	-0.2	-1.1	Renal Ward - F8	22.0	25.8	3.8	14.6	7.8
Ward G10	14.4	19.0	4.6	24.2	Ward g10	16.6	23.2	6.6	28.4	26.5
Respiratory Ward - G9	18.6	23.7	5.1	21.5	Respiratory Ward - G9	16.4	18.0	1.6	9.0	16.1
Total	537.1	636.2	99.1	**15.6**	Total	367.8	411.1	43.3	**10.5**	**13.6**
Hospital Midwifery	53.9	58.9	5.0	8.5	Hospital Midwifery	18.4	15.6	-2.8	-18.1	2.9
Continuity of Carer Midwifery*	18.5	31.0	12.5	40.3	Continuity of Carer Midwifery	0.0	0.0	0.0	0.0	40.3
Community Midwifery	18.4	19.1	0.7	3.8	Community Midwifery	6.5	3.8	-2.7	-72.0	0.0
Total	90.8	109.0	18.2	**16.7**	Total	24.9	19.4	-5.5	**-28.6**	**9.9**

Appendix 3. Ward by ward vacancies (April 2022): Data adapted from finance report

Apr-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	18.6	30.1	11.5	38.3	AAU	24.0	28.3	4.3	15.3	27.1
Accident & Emergency	60.8	69.5	8.7	12.5	Accident & Emergency	31.0	34.5	3.5	10.0	11.7
Cardiac Centre	35.6	40.7	5.1	12.5	Cardiac Centre	14.6	15.7	1.1	7.2	11.0
Glastonbury Court	11.6	11.7	0.1	0.8	Glastonbury Court	12.3	12.6	0.3	2.7	1.8
Critical Care Services*	44.9	50.0	5.1	10.2	Critical Care Services	2.8	1.9	-0.9	-48.9	8.1
Day Surgery Wards	12.4	11.0	-1.4	-12.5	Day Surgery Wards	3.9	3.9	0.0	0.0	-9.2
Gynae Ward (On F14)	14.1	14.1	0.0	-0.2	Gynae Ward (On F14)	2.0	2.0	0.0	0.0	-0.2
Neonatal Unit	18.5	20.6	2.1	10.2	Neonatal Unit	4.1	4.3	0.2	4.2	9.2
Rosemary ward	15.3	15.4	0.1	0.6	Rosemary ward	21.2	27.0	5.8	21.5	13.9
Recovery Unit	23.5	27.3	3.8	13.9	Recovery Unit	0.9	0.9	0.0	-4.7	13.4
Ward F1 Paediatrics	20.7	22.1	1.4	6.5	Ward F1 Paediatrics	7.7	7.7	0.0	0.0	4.8
Ward F12	6.6	11.9	5.3	44.7	Ward F12	6.1	5.9	-0.2	-4.3	28.6
Ward F3	21.7	22.2	0.4	2.0	Ward F3	21.4	25.8	4.4	17.2	10.2
Ward F4	13.0	13.6	0.6	4.6	Ward F4	8.0	14.6	6.6	45.3	25.7
Ward F5	18.3	22.2	3.9	17.4	Ward F5	14.1	18.1	4.0	22.2	19.6
Ward F6	22.2	26.6	4.4	16.4	Ward F6	17.5	17.4	-0.2	-0.9	9.6
Ward F7 Short Stay	17.5	24.9	7.4	29.7	Ward F7 Short Stay	21.7	25.8	4.1	15.8	22.6
Ward F9 (now G5)	18.4	21.8	3.4	15.5	Ward G5	18.6	23.2	4.6	19.8	17.7
Ward G1 Hardwick Unit	28.8	29.6	0.8	2.7	Ward G1 Hardwick Unit	10.0	10.5	0.5	5.0	3.3
Ward G3	20.2	22.1	1.9	8.6	Ward G3	21.5	23.0	1.5	6.4	7.5
Ward G4	16.1	22.1	6.0	27.1	Ward G4	18.4	23.5	5.1	21.7	24.3
Ward G8	18.6	32.7	14.1	43.1	Ward G8	17.1	20.6	3.5	17.0	33.0
Renal Ward - F8	19.4	19.5	0.1	0.4	Renal Ward - F8	20.0	25.8	5.8	22.4	12.9
Ward G10	13.4	19.0	5.6	29.5	Ward G10	19.3	24.1	4.8	19.9	24.1
Respiratory Ward - G9	17.7	23.7	6.0	25.3	Respiratory Ward - G9	17.1	18.0	0.9	5.2	16.6
Total	527.9	624.2	96.4	**15.4**	Total	355.2	414.9	59.7	**14.4**	**15.0**
Hospital Midwifery	54.3	58.9	4.6	7.8	Hospital Midwifery	18.5	15.7	-2.8	-17.8	2.4
Continuity of Carer Midwifery	18.0	31.0	13.0	41.9	Continuity of Carer Midwifery	0.0	0.0	0.0	0.0	41.9
Community Midwifery	19.5	19.1	-0.4	-1.9	Community Midwifery	6.5	3.8	-2.7	-72.0	0.0
Total	91.8	109.0	17.2	**15.8**	Total	25.0	19.4	-5.6	**-29.1**	**9.0**

Appendix 4:

Ward by Ward breakdown of Falls and Pressure ulcers March and April 2022

HAPU

Mar-22	Cat 2	Cat 3	Unstageable	Total
Critical Care Unit	1	0	0	1
G3 - Endocrine and General Medicine	1	0	0	1
G8 - Stroke Ward	1	0	0	1
Glastonbury Court	1	0	0	1
Winter Escalation (Rosemary)	0	1	0	1
Acute Assessment unit (AAU)	1	0	0	1
F5 - ward	1	0	0	1
Cardiac Centre - Ward	2	0	0	2
G4 - ward	2	0	0	2
Gastroenterology Ward	2	0	0	2
Renal Ward	2	0	0	2
F3 - ward	3	0	0	3
Respiratory Ward	1	0	2	3
F7	2	0	1	3
Total	**20**	**1**	**3**	**24**

Apr-22	Cat 2	Cat 3	Unstageable	Total
Cardiac Centre - Ward	1	0	0	1
G10	1	0	0	1
G3 - Endocrine and General Medicine	1	0	0	1
Renal Ward	1	0	0	1
Winter Escalation (Rosemary)	0	1	0	1
F5 - ward	1	0	0	1
Gastroenterology Ward	0	0	2	2
F7	2	0	0	2
F6 - ward	2	0	0	2
F3 - ward	3	0	0	3
G4 - ward	3	0	1	4
Respiratory Ward	3	0	1	4
Total	**18**	**1**	**4**	**23**

Falls

March 22	None	Negligible	Minor	Moderate	Major	Catastrophic	Total
CHT Bury Rural	1	0	0	0	0	0	1
F11 -	0	1	0	0	0	0	1
Macmillan Unit	1	0	0	0	0	0	1
Cardiac Centre - Ward	1	0	0	1	0	0	2
F12 Isolation Ward	1	0	1	0	0	0	2
F4 - ward	2	0	0	0	0	0	2
Renal Ward	0	1	1	0	0	0	2
F6 - ward	1	1	0	0	0	0	2
F3 - ward	2	0	1	0	0	0	3
Emergency Department	2	0	0	0	0	1	3
Acute Assessment unit	4	0	0	0	0	0	4
F5 - ward	2	1	1	0	0	0	4
G5 Gastroenterology	4	0	1	0	0	0	5
Glastonbury Court	2	1	3	0	0	0	6
G4 - ward	7	0	0	0	0	0	7
Respiratory Ward	2	2	3	0	0	0	7
G3 - Endocrine	6	0	2	0	0	0	8
G1 - ward	8	0	1	0	0	0	9
G10	9	0	0	0	0	0	9
Rosemary	7	0	2	0	0	0	9
F7	8	1	2	0	0	0	11
G8 - Stroke Ward	15	0	3	0	1	0	19
Total	**85**	**8**	**21**	**1**	**1**	**1**	**117**

Apr-22	None	Negligible	Minor	Moderate	Major	Total
Cardiac Centre - Ward	1	0	0	0	0	1
CHT Newmarket	0	0	1	0	0	1
Eye Treatment Centre -	1	0	0	0	0	1
Integrated Therapies	0	1	0	0	0	1
F1 - Ward	1	0	0	0	0	1
Respiratory Ward	1	0	1	0	0	2
F10	2	0	1	0	0	3
G1 - ward	1	**2**	0	0	0	3
Glastonbury Court	2	0	1	0	0	3
F6 - ward	3	0	0	0	0	3
F3 - ward	2	2	0	0	0	4
G3 - Endocrine and General	3	1	0	0	0	4
Gastroenterology Ward	3	1	0	0	0	4
Emergency Department	2	0	1	0	1	4
G10	4	0	2	0	0	6
Rosemary Ward	4	0	1	1	0	6
G8 - Stroke Ward	6	0	1	0	0	7
Renal Ward	3	1	3	0	0	7
F7	5	1	0	1	0	7
Acute Assessment unit (AAU)	5	1	1	0	0	7
G4 - ward	7	0	1	0	0	8
Total	**56**	**10**	**14**	**2**	**1**	**83**

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: SNCT Output Jan/Feb 2022

Wards	Split WTE		WTE	SNCT Audit Results								Difference WTE - SNCT Jan
	RN	NA		Sep-20		Feb-21		Jul-21		Jan-22		
				NHPDD	SNCT	NHPDD	SNCT	NHPDD	SNCT	NHPDD	SNCT	
AAU	30.1	28.3	58.4	30.2	40.1	32.3	44.4	37.2	49.5			**58.4**
Cardiac	40.7	15.7	56.4	29.5	33.0	29.1	30.5	44.4	32.0	45.75	33.15	**23.25**
F10/G10				32.2	33.7	33.1	35.8			18.44	20.24	**-20.24**
F12	11.9	5.9	17.8	9.6	10.2	9.9	10.4	9.2	10.1	8.54	9.67	**8.13**
F7	24.9	25.8	50.7	22.9	24.2	17.4	19.4	45.4	51.0	41.03	46.62	**4.08**
F8	19.5	25.8	45.3	43.7	50.4	24.2	27.0	36.4	43.3	33.73	38.85	**6.45**
G1	30.6	10.5	41.1	13.2	13.0	15.4	17.4	16.3	18.1	16.3	18.75	**22.35**
G3	22.1	23	45.1	45.9	35.8	26.5	27.8	43.7	48.6	36.19	40.49	**4.61**
G4	22.1	22.8	44.9	39.4	43.9	20.9	22.0	40.1	43.2	41.71	47.17	**-2.27**
G5 -	21.8	23.2	45	40.4	42.3	32.6	34.0	43.7	49.4	20.49	23.92	**21.08**
G8	32.7	20.6	53.3	37.3	43.0	37.2	42.1	51.6	70.9	59.58	57.21	**-3.91**
G9	23.7	18	41.7	32.6	33.0	25.0	29.1	33.6	35.5	31.37	34.02	**7.68**
G10										18.44	20.24	**-20.24**
F3	22.2	25.8	48	42.5	46.4	29.1	31.8	41.3	46.9	37.09	41.89	**6.11**
F4	13.6	14.6	28.2	10.0	10.3	24.4	26.5	6.9	7.1	25.39	25.54	**2.66**
F5	22.2	18.1	40.3	36.1	33.7	36.8	38.7	36.3	37.8	36	36	**4.3**
F6	26.6	17.4	44	39.9	39.9	39.7	43.2	38.7	41.6	34.53	37.29	**6.71**
F14	13.1	2	15.1	6.7	5.7	6.8	5.8	11.7	10.2	8.87	7.65	**7.45**
F1	22.3	7.7	30	8.9	15.9	7.2	11.9	17.4	29.2	14.24	23.7	**6.3**
Rosemary	16.6	25.8	42.4	24.4	27.8	25.0	29.1	31.0	37.8	38.42	44.16	**-1.76**
Kingsuite	11.7	12.6	24.3	24.3	25.4	22.2	22.4	20.8	20.9	22.46	22.67	**1.63**

Key: Excluded due to incomplete data

4.6. Maternity services quality & performance report

To Assure

Presented by Susan Wilkinson and Karen Newbury

Trust Open Board– 27th May 2022

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

Executive summary:

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

This report contains;

- Maternity improvement plan
- Safety champion feedback from walkabout
- Listening to staff
- Service user feedback
- Reporting and learning from incidents
- Maternity Clinical and Quality dashboard (Annex A)
- PMRT (Perinatal Mortality Review Tool), Quarterly Report – Q4 (Annex B) *Reviewed at closed board session*
- ATAIN (Avoiding Term Admissions Into Neonatal units) Quarter 4 (Annex C)
- Report on Compliance with Obstetric Anaesthetist staffing standards (Annex D)
- Audit of Consultant Led Ward Rounds (Annex E)
- HSIB and Early Notification Reporting Q4 (Annex F)
- Audit of Compliance with Saving Babies Lives Element 1- Smoking Status and Support (Annex G)
- Audit of Compliance with Saving Babies lives Element 2- Fetal Growth risk assessment and management (Annex H)
- Audit of Women with a BMI 35 at booking being offered serial growth scans (Annex I)
- Audit of compliance with Saving Babies Lives Element 3- Fetal movements in pregnancy (Annex J)
- Response to the RCOG published paper entitled 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology' June 2021(Annex K)
- Compliance with Paediatric Medical Staffing of the Neonatal Services within the Trust (Annex L)
- Compliance with standards for Transitional Care Q4 (Annex M)
- Maternity Training compliance and training plans Q4 (Annex N)
- Midwifery Staffing report – 6 monthly report on compliance with staffing standards (Annex O)
- Revised plan for roll-out of Continuity of Carer (CoC) Teams (Annex P)
- East of England (EoE) Operational Delivery Network (ODN) Workforce template/ Workforce Scoping Template (Annex Q)

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. To note; completion of actions has been hindered due to the high demand on clinicians to work clinically due to Covid absences.

Safety Champion Walkabout feedback

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

The Safety Champion Walkabout took place on the 14th April 2022 Discussions raised:

1. Anaesthetic Documentation in eCARE inadequate for epidurals and spinals. Insufficient drop downs to properly document the procedures.
2. Consultant Anaesthetist providing out of hours support to labour suite. Issue of whether PROMPT training even once per revalidation cycle would be valuable.
3. Obstetric Anaesthetist attendance at MDT/clinical reviews (Wed and Mon am) and the need to find a way of facilitating regular anaesthetic input to these meetings.
4. Reliable availability of NRFIT still an issue.
5. Drug shortage; Diamorphine 1mg/ml syringes not available, leading to wastage and creating a risk.
6. Dedicated Elective Section midwives. In view of commencing timetabled elective caesarean section lists it would be of benefit to have a dedicated midwifery team.

In response to the concerns raised;

e-care issues to be discussed with the e-care team at a meeting later this month.

Anaesthetic team and wider Maternity and Trust team to review training, regular attendance to reviews etc. in light of the Ockenden report.

Procurement team are aware of unreliable NRFIT availability and are currently looking for the department to trial a different make of Epidural pump with reliable availability of NRFIT.

Pharmacy have clarified that there is an ongoing international supply problem with diamorphine. The pharmacy are looking at solutions but at present the smallest commercially available ampoules are 5mg. Ready to use syringes are not readily commercially available and we are unable to make our own here at this Trust.

The HOM is currently looking at all aspects of midwifery staffing in view of the latest Ockenden report

Listening to Staff

The National Staff Satisfaction Survey results were published in April 2022 and the triumvirate team are collating an action plan in response to this.

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.

Ward/Dept	Mar Survey returns	Mar FFT score	April Survey returns	April FFT Score
F11	14	86	23	96
Antenatal	45	96	38	100
Postnatal Community	25	100	17	88
Labour Suite	Nil		6	100
Birthing Unit	Nil		17	100

1 compliment was shared with the patient experience team for women & children's division for logging in March & April 2022.

In January and February 2022, a total of 10 PALS enquiries and 3 complaints were received for maternity and 0 PALS enquiry and 0 complaints for NNU.

Reporting and learning from incidents

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

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	Business case for F2 doctors approved- awaiting appointment and start dates. QI work continues- multi rationale identified and on-going work required. 9 cases in total did not meet the requirement, 3 cases missed the target by 1-2 mins, 3 cases due to theatre availability and 3 cases the reason was not documented – however 1 of these cases appears it should have been downgraded.
Induction of labour	Expected increase due to increase in antenatal surveillance. In line with region and national picture.
Post-partum haemorrhages >1500mls	In line with increase of caesarean section and induction of labour, however QI project continues. The Trust governance team are undertaking a thematic review for all cases in Feb 22 to identify any further learning.
Carbon Monoxide monitoring at 36 weeks	Improvement noted in compliance however still below the expected level. Digital midwife working closely with smoking cessation midwife to identify issues in compliance data collection.
Appraisal compliance	This reflects Covid absence; time and availability of staff to complete. Going forward line managers to have greater oversight of when appraisals due, this will be supported by correct data on ESR regarding line manager.
Training compliance	Reflects staffing shortages due to Covid and therefore clinicians foregoing training to work clinically.
Domestic Violence question being asked in the antenatal and postnatal period	Training and electronic notes review has been completed. Mandatory field added to electronic notes mid-February 22 to capture this data.
Swab Counts	Weekly reports now being run to quickly identify individuals who have not completed the documentation. Further training and support given to individuals as required.
Fresh ears review on Birthing Unit	Non-compliance relates to a second midwife not completing the 'fresh ears' care review. All staff reminded regarding the importance of completing reviews and audited monthly.

PMRT (Perinatal Mortality Review Tool), Quarterly Report – Q4 (Annex B) – Reviewed at closed board session

Five cases of perinatal loss were reported within this quarter. Whilst the losses were unavoidable in all cases, learning from each case has been shared and include earlier referral to the fetal medicine unit, storage of scans of the heart during pregnancy, transfer by ambulance to the Emergency Department and taking postnatal blood tests to inform discussions about cause of death.

The MBRRACE standards were met for reporting, Duty of Candour, completion of surveillance and completion of PMRT within the timeframes to date. It is expected that the remaining reports will be completed within the expected timeframes but as other units are involved in 3 of the reviews, this may affect the timeframes in some cases.

ATAIN (Avoiding Term Admissions Into Neonatal units) Quarter 4 (Annex C)

Term admission rates vary month on month. During the past quarter they have fluctuated, with only one month meeting the target level of < 5%. However, it should be noted that in January and February when

admissions where highest; a few admissions would have been suitable for immediate or earlier transitional care had there been parental availability, or adequate staffing levels, which has impacted on the data. Additionally, two other admissions in these months were classified as avoidable and two others were planned due to known abnormalities. Cases were reviewed carefully to identify any areas for learning and improvement. While respiratory support remains the predominant reason for admission this quarter, no overarching themes or common denominators were identified amongst those admissions. However, a trend in low admission temperatures was noted this quarter with 30% of babies recording temperatures of ≤36.5°C. While not the primary reason for admission, sub optimal body temperature is recognised as a contributory and exacerbating factor to respiratory distress. 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.

Report on Compliance with Obstetric Anaesthetist staffing standards (Annex D)

The rotas for anaesthetic staff have been independently reviewed to ensure that there is a named staff member covering the on call obstetric rota for each 24-hour period.

The findings confirm that there is allocation and identification of a dedicated anaesthetist for obstetric cases throughout this 3-month period. As this is the second 3-month period to be compliant it is recommended that a further report is made in 6 months' time to ensure that standards are maintained.

Audit of Consultant Led Ward Rounds (Annex E)

This was a re-audit of compliance following introduction of twice daily consultant led ward rounds for 7 days a week in 2021. The audit found that the Trust was 100% compliant with this RCOG recommendation which was part of the Ockenden initial recommendations. The next audit will also include whether the ward round is Multidisciplinary each time.

HSIB and Early Notification Reporting Q4 (Annex F)

This report provides details of the Trust compliance for Q4 2021/2022 with reporting of maternity incidents that meet the criteria for reporting to HSIB (Healthcare Safety Investigation Branch) Maternity Investigations and the NHS Resolution Early Notification Scheme. The Maternity Incentive Scheme (MIS) year 4 Safety Action 10 requires quarterly reports outlining the Trust's compliance with National Reporting requirements and duty of candour. In this quarter there was one incident that met the initial criteria for reporting to HSIB and EN. However, when the baby was subsequently found to have no hypoxic injury, the investigation reverted to a local Patient Safety Report as part of the Trust incident management processes. In accordance with the Duty of Candour Legal requirements, the mother of the baby was informed of the need to report this incident to HSIB and EN. She has subsequently been informed of the progress of the investigation. Early notification requirements have been updated and this will be reflected in the next report.

Audit of Compliance with Saving Babies Lives Element 1- Smoking Status and Support (Annex G)

This audit reviewed 40 consecutive cases.

Compliance at booking: Improvement from 2021 audit with 90% compliance. CO monitoring has been recommenced after being paused during the Covid 19 pandemic. Since the previous audit Ecare has been introduced into the maternity service and with the appointment of a Digital Midwife monitoring is now possible through Ecare reporting. A weekly oversight of compliance has been introduced enabling Matrons to have weekly oversight of all booking appointments and 36-week gestation appointment to ensure scrutiny of continued compliance. A return to face to face appointments has been made.

Compliance for 36 weeks: Compliance has been achieved at 95%, this is through the diligence and the commitment of the appointed smoking cessation midwife.

Further work will be required to specifically review outcomes for women on the basis of their CO levels at

booking and 36 weeks.

Audit of Compliance with Saving Babies lives Element 2- Fetal Growth risk assessment and management (Annex H)

This audit reviewed 40 consecutive pregnancies during January 2022.
All cases reviewed within this audit had had a risk assessment form completed at booking. Of these 40, 6 cases had not had the form correctly completed and subsequently risk factors such as smoking and BMI were not recorded on this form. Despite this, all 6 cases were referred appropriately for additional monitoring as per SGA guidance indicating that there was awareness that the risk factor was present and there were no adverse outcomes from missed monitoring. Compliance is therefore likely to be higher than the recorded 85%, however action identified to ensure that future audits return a compliance rate of >95%. Of the 23 cases that were identified with risk factors raised BMI >35 was the most frequently identified risk for SGA.

Recommendations
Further education is required to ensure that the risk assessment form is appropriately filled out to accurately document risks at booking.

Audit of Women with a BMI 35 at booking being offered serial growth scans (Annex I)

Findings show that compliance with the referral for a higher risk pathway and serial scans is met at 100%. Once referred, serial growth USS were undertaken as required 91% of the time. Whilst this standard has dropped slightly from the last audit, compliance is still high. Further audits as part of agreed audit plan.

Audit of compliance with Saving Babies Lives Element 3- Fetal movements in pregnancy (Annex J)

This audit of 40 consecutive women demonstrates that documentation of information on fetal movements in pregnancy by 28 weeks has been successfully implemented at 82%, however it is below the 95% expected. Compliance has reduced as a result of the new digital patient safety system being reported as difficult to navigate and midwives had not indicated the giving of the leaflet in the correct box. It is reassuring that midwives report the giving of information is embedded and we are providing a safe high-quality service. However, the audit does not support this. Additional communication has been sent to all community midwives.

Once identified, 95% of women are having appropriate fetal monitoring using an electronic recording (Dawes Redman).

Re-audit is planned.

Response to the RCOG published paper entitled 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology' June 2021(Annex K)

The purpose of this report is to acknowledge the contents of the RCOG publication from June 2021 which outlines the roles and responsibilities of the Consultant Obstetricians workforce and provide evidence of the existing compliance and progress towards the standards expected with actions taken to improve quality and safety of care within the Maternity Services provided by West Suffolk NHS Foundation Trust (WSNHSFT) at the time of this report (December 2021). The report was presented to the Maternity and Neonatal Safety Champions in December 2021 and Maternity Quality and Safety Meeting in April 2022. It now requires 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 every 6 months. Work is ongoing to put a process in place whereby the clinical situations requiring consultant obstetrician attendance can be more easily monitored to provide assurance of compliance with this requirement. This report is also required as evidence of compliance with the Maternity Incentive Scheme Year 4.

Compliance with Paediatric Medical Staffing of the Neonatal Services within the Trust (Annex L)

In order to evidence safe staffing levels within the neonatal and maternity services, a review of the paediatric junior medical staffing has taken place over a 6-month period to ensure the staffing meets the British Association of Perinatal Medicine (BAPM) standards for a level 1 Special Care Unit. This report is also submitted as evidence of compliance with the Maternity Incentive Scheme Year 4.

Conclusions: The Trust meets the standards expected during this period of time. This has been achieved by rota management, the use of locums and staff acting down when required to provide safe staffing levels. It is not always clear from the rotas when clinical activities or training has been restricted due to shortages. The amount of locum usage has increased in this period of time due to short and long-term absences, vacancies and delay in staff being in post.

Recommendations: Further work is required to ensure the process for obtaining safe staffing levels is formalised and embedded and the systems accurately reflect the work involved in maintaining standards. A written and agreed process would make this clear and available to all with evidence of escalation if there are concerns regarding the staffing establishment and allocation of trainees to the Trust. This would include business case presentation to the Division and Trust if required, for maintenance of a safe service, service development and improvement. With the pandemic easing, there should be quarterly reports on the use of locums to demonstrate that the appropriate staffing levels are in place and locum usage is appropriate and reducing if vacancies are filled and the establishment is correct. This report will need to be repeated every 6 months as assurance of standards being maintained and progress on other safety and quality actions.

Compliance with standards for Transitional Care (TC) Q4 (Annex M)

Overall the number of admissions remains fairly stable at 78 and is consistent with other quarters for 21-22. All babies appeared to be appropriately assessed for care on TC according to the Operational guidance criteria, with the exception of two babies who fell just outside of the criteria, however the neonatal team felt these were well babies, had management plans in place and appropriate for admission to TC. The majority of admissions immediately following birth - 33 (42.3%) - was due to suspected/confirmed maternal sepsis.

16 (20.5%) babies required readmission to the neonatal unit because of developing jaundice or needed support feeding. It was noted that babies re- admitted from the community into to TC appeared to be lower gestations < 38 weeks: audit findings to be shared with staff to ensure appropriate timing of their discharge and follow up plans are in place. The results of the audit to be shared with all staff. A separate audit is in progress to look at the follow up of care of these babies following discharge and who are readmitted.

The standards required in the updated Maternity Incentive Scheme Year 4 will be incorporated into the next report.

Maternity Training compliance and training plans Q4 (Annex N)

Areas of concern include: obstetricians' attendance or completion of all aspects of Saving Babies Lives training; completion of training by midwives and obstetricians for fetal surveillance in labour; recorded attendance of the neonatal medical staff at in-house neonatal life support training and completion of NLS where applicable.

- MDT attendance at each training session: whilst this has improved, further improvement is required so that each session is MDT.
- Quality of data from attendance reports and training databases: whilst this has improved, there are still gaps in training records on the training databases.
- Requirements of NLS (Neonatal Life Support) compliance for all staff groups: whilst this has been formally changed in the MIS year 4, work is required to embed the requirements from the initial Ockenden report and MIS year 3. The training plan and schedules will include these requirements and the compliance will be monitored by the Clinical Safety Champions
- Achieving 90% compliance for each staff group: The Maternity service has not achieved 90%

compliance in each staff group for all of the core competencies expected: this is again due to clinical priorities which has been escalated to Clinical Leads and Safety Champions as a risk. Funding from Ockenden to be used to backfill staff to attend mandatory training wherever possible.

Midwifery Staffing report – 6 monthly report on compliance with staffing standards (Annex O)

The maternity service monitors the staffing levels using a variety of methods. The establishment needed to fully implement the continuity of carer model, has been agreed by the Trust Board and made available from Month 11, 2021/22. There have been challenges in achieving minimum midwifery staffing levels in the period of this report with numerous shifts each week where RM (Registered Midwife) shifts have not been filled. Through appointing additional Band 7 midwives to undertake the bleep carrying role, the compliance with the labour suite co-ordinator being supernumerary has increased to just under 100%.

There has been a review of the sustainability of the continuity of carer teams whilst the midwifery vacancy rate remains high and the final Ockenden report gives further recommendations about this. Details of proposals for further roll-out or delays are included in a separate report.

Revised plan for roll-out of Continuity of Carer (CoC) Teams (Annex P)

This proposal includes an option appraisal for continuing with the existing CoC teams and any future roll-out plans for further teams in line with the National agenda. The Trust will need to formally approve the next steps.

East of England (EoE) Operational Delivery Network (ODN) Workforce template/ Workforce Scoping Template (Annex Q)

Operational Delivery Network (ODN) for East of England is undertaking review of the Neonatal Units workforce across the region. The aim of this work is to look at the challenges and aspiration within Neonatal Unit workforce to develop collaborative approach in addressing them. The areas covered within the report are:

1. Brief description of the Neonatal Unit at West Suffolk NHS Foundation Trust
2. Workforce establishment including recruitment/ retention strategy
3. Training needs analysis
4. Transitional Care settings

Trust priorities	**Deliver for today**	**Invest in quality, staff and clinical leadership**	**Build a joined-up future**
	x		**x**

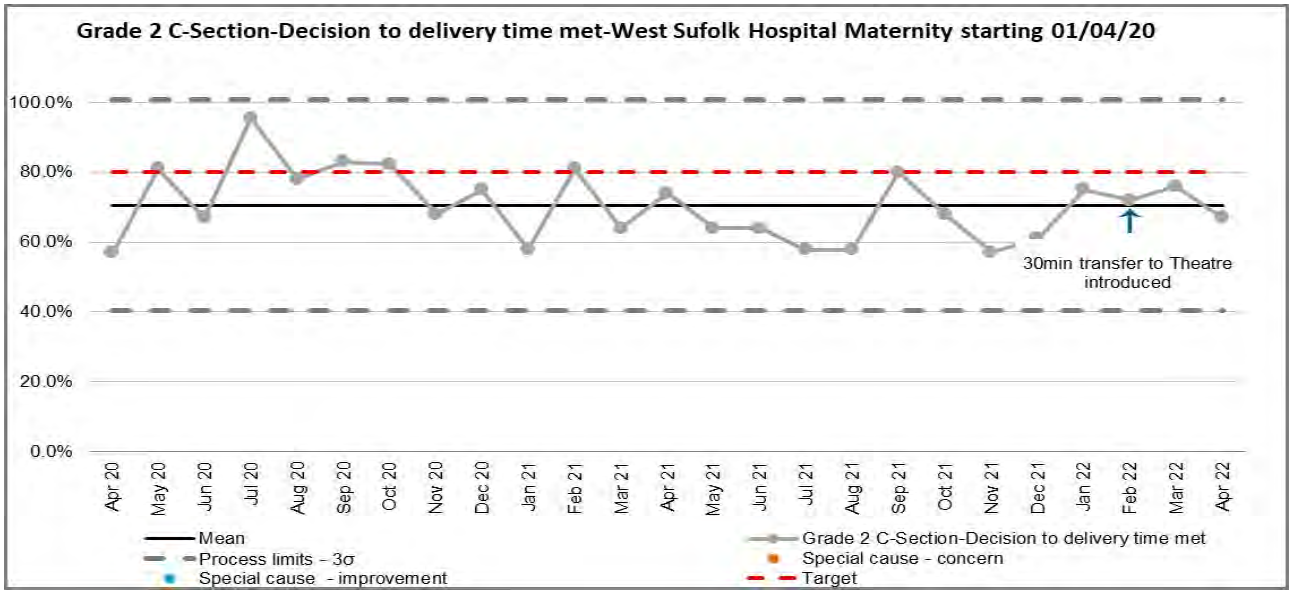
Trust ambitions	*Deliver personal care*	*Deliver safe care*	*Deliver joined-up care*	*Support a healthy start*	*Support a healthy life*	*Support ageing well*	*Support all our staff*
	x	x	x	x	x		

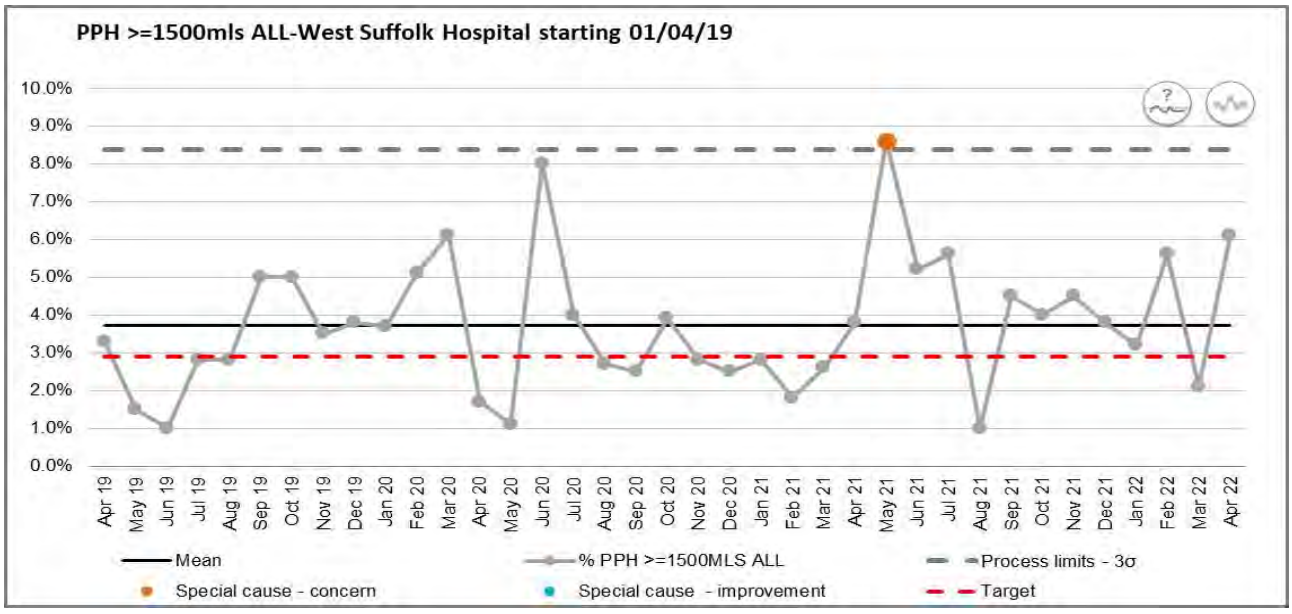
Previously considered by:	
Risk and assurance:	
Legislation, regulatory, equality, diversity and dignity implications	
Recommendation: Receive for information	

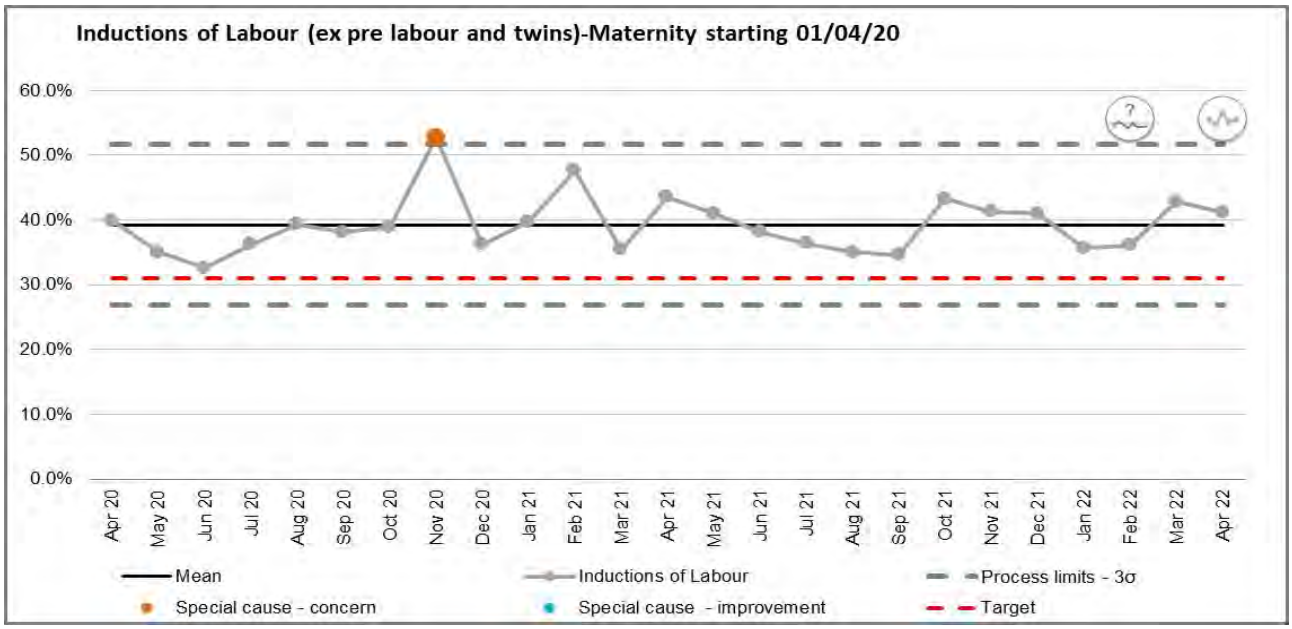
Annex A Maternity SPC charts from Clinical and Quality & Safety Dashboards – Red Rated

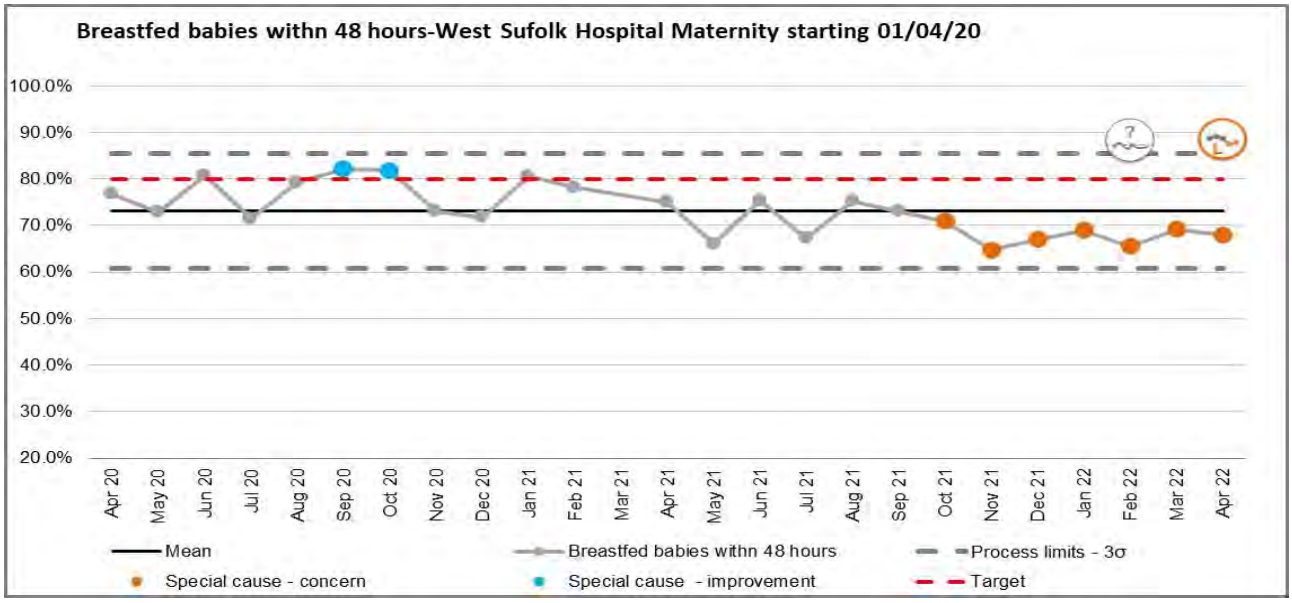
Quality& Safety Dashboard Red rated SPC charts

QUALITY DASHBOARD 2022				
Appraisal completion	Standard	February	March	April
Support Staff Community & ANC % in date	90%	80%	93 %	94%
Midwives Hospital % in date	90%	86%	92%	89%
Medical Staff (Consultant) % in date	90%	78.94%	84.20%	94.4%
Mandatory Training Overview	Standard	February		
Midwives: % compliance with K2 Fetal Monitoring training	90%	86.10%	91%	83%
Obstetric Medical Staff: % compliance with K2 Fetal Monitoring training	90%	81%	76%	92%
EQUIPMENT SAFETY				
Checking of Emergency Equipment	Standard	February	March	April
MLBU: Resuscitaires	100%	88%	92%	97%
Checking of Fridge Temperatures	Standard	February	March	April
MLBU		89%	100%	97%
Ambient Room Temperature (where medication is stored)	Standard	February	March	April
MLBU		89%	100%	97%
Checking of CD's	Standard	February	March	April
MLBU		93%	100%	97%
Carbon Monoxide Monitoring				
Smoking at booking recorded	95%	50%	80.10%	85.50%
Smoking at 36 weeks recorded	95%	65%	81.20%	94.50%
Compliance with DV questions				
Antenatal period	100%	92%	92%	85%
Postnatal period	100%	70%	76%	70%
Swab Count Compliance				
Birth	100%	70%		
Pre delivery	100%		79.10%	82.90%
Post delivery	100%		65.20%	64.50%
Fresh Ears				
MLBU	100%	66%	100%	87%
LSCS decision to delivery time met				
Grade 2 LSCS	80%	72%	76%	67%


Grade 2 C-Section-Decision to delivery time met-West Sufolk Hospital Maternity starting 01/04/20
100.0%
80.0%
60.0%
40.0%
20.0%
0.0%
30min transfer to Theatre introduced
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
Mean
Process limits - 3σ
Special cause - improvement
Grade 2 C-Section-Decision to delivery time met
Special cause - concern
Target


PPH >=1500mls ALL-West Suffolk Hospital starting 01/04/19
10.0%
9.0%
8.0%
7.0%
6.0%
5.0%
4.0%
3.0%
2.0%
1.0%
0.0%
Apr 19 May 19 Jun 19 Jul 19 Aug 19 Sep 19 Oct 19 Nov 19 Dec 19 Jan 20 Feb 20 Mar 20 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
Mean
% PPH >=1500MLS ALL
Process limits - 3σ
Special cause - concern
Special cause - improvement
Target


Inductions of Labour (ex pre labour and twins)-Maternity starting 01/04/20
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
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
Mean
Inductions of Labour
Process limits - 3σ
Special cause - concern
Special cause - improvement
Target


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%
30.0%
20.0%
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
Mean
Breastfed babies withn 48 hours
Process limits - 3σ
Special cause - concern
Special cause - improvement
Target

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

To Assure

Presented by Alan Rose

Item 4.7 - Chair's Key Issues – Involvement committee

Originating Committee	Involvement Committee	Date of Meeting	25 April 2022
Chaired by	Alan Rose	Lead Executive Director	Jeremy Over

Item	Details of Issue	For: Approval/ Escalation/Assurance	BAF/ Risk Register ref.	Paper attached?
Education & Training Report	Reflection from Sue, Paul and Jeremy on the respective range of activities in Nursing/Midwifery/AHP, Medical, the support workforce and leadership development, supported by integrated report from our teams. Several awards in this area and some good evidence of impact (e.g. much improved continuation rates for non-registered staff); considerable amount of activity that should receive more Board-level attention. Some potential concerns: - What challenges and opportunities ICS-working might bring to WSFT's existing relationships with education partners? - What is the impact of our approach to leadership development at WSFT and what are the next steps? - Is the link between individual objective-setting and organisational provision of training and development, strong enough?	**Good assurance for Board, but some focus to be given to improving feedback on and measurement of <u>quality</u> of education and training**	BAF Risk 7 (Workforce wellbeing)	
National Staff Survey (2021)	- Initial summary of the recently released data; although we continue to largely perform above national averages on the majority of metrics, there is concern about a number of scores that have deteriorated sharply in the last year – both locally and nationally and what this means for staff morale and engagement. - Staff's perspectives on speaking-up remains of significant concern, although is not a surprise. - The Workforce team will be developing more detailed analysis of these data for Board scrutiny and deeper analysis within the Trust.	**Assurance for Board of the veracity of the data, due to its statistical rigour, but considerable concern for the feelings and attitudes of staff in 2021 as expressed, and the direction of travel nationally and locally.**	BAF Risk 7 (Workforce wellbeing)	Board paper

Originating Committee	Involvement Committee	Date of Meeting	25 April 2022
Chaired by	Alan Rose	Lead Executive Director	Jeremy Over

Item	Details of Issue	For: Approval/ Escalation/Assurance	BAF/ Risk Register ref.	Paper attached?
Vaccination as a Condition of Deployment	- A reflection on Government policy that created considerable discomfort nationally and locally (in spite of relatively high vaccination levels at WSFT) - Subsequent reversal of the policy (prior to the proposed enactment date) eased the situation, but there has been considerable learning from the preparation phase and implications and concerns remain for the implementation of future vaccination campaigns	**Assurance for Board that we were ready to enact, but concern about the impact of the approach on future vaccination programmes**	BAF Risk 7 (Workforce wellbeing)	
Equality, Diversity & Inclusivity (EDI)	- An interim update on the significant range of ongoing initiatives aimed at improving our culture of inclusion. Examples include: autism; menopause; LGBTQ+ network; gender pay gap; facilities upgrades; managing difficult conversations; carers; recruitment and selection processes. - Discussion of what role role(s) the Board should play in supporting any or all of the above.	**Good assurance of activity, but we queried whether staff networks need the investment of (paid?) time to develop further**	BAF Risk 7 (Workforce wellbeing)	
Next time: (20/6/22)	- "Managing Change" toolkit - Patient Experience update - Staff physiotherapy - Clarity on the issues & themes (more than committees & groups) that the Involvement Committee needs to ensure is on its agendas going forward. - Update on how we will measure progress on the development of our culture and delivery of the West Suffolk Review OD plan			
Date Completed and Forwarded to Trust Secretary		**16 May 2022**		

5. GOVERNANCE

5.1. BAF Summary and risk report

To Assure

Presented by Richard Jones

Board of Directors – 27 May 2022

Report Title:	Item 5.1 - 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 March 2022

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

Executive Summary
The Board assurance framework is a tool used by the Board to manage its principal strategic risks. Focusing on each risk individually, the BAF documents the key controls in place to manage the risk, the assurances received both from within the organisation and independently as to the effectiveness of those controls and highlights for the board's attention the gaps in control and gaps in assurance that it needs to address in order to reduce the risk to the lowest achievable risk rating. The Board approved its risk appetite statement at the October meeting of the Board, following which the BAF risks were reviewed individually with the executive team during November 2021. BAF and red risks are allocated to Board governance committee for oversight. The process to manage and maintain this oversight is currently under review.
Action Required of the Board
a) To note the updated BAF

Risk and assurance:	Failure to effectively manage risks to the Trust's strategic objectives. Agreed structure for Board Assurance Framework (BAF) review with oversight by the Audit Committee. Internal Audit review and testing of the BAF.
Legal and regulatory context	The BAF underpins the Board's Annual Governance Statement within the annual report and is a critical part of the Head of Internal Audit's annual opinion.

Background

The Board assurance framework is a tool used by the Board to manage its principal strategic risks.

Focusing on each risk individually, the BAF documents the key controls in place to manage the risk, the assurances received both from within the organisation and independently as to the effectiveness of those controls and highlights for the board's attention the gaps in control and gaps in assurance that it needs to address in order to reduce the risk to the lowest achievable risk rating.

Appendix 1 shows the allocation of the BAF risks to each of the Board's assurance committees.

Appendix 2 provides supporting detail of current mitigating actions and the most recent assurances relating to those actions.

The role of the assurance committees

Board assurance committees are responsible for considering all relevant risks within the BAF and the corporate risk register as they related to the remit of the committee, as part of the reporting requirements, and to report any areas of significant concern to the audit committee or the board as appropriate. The committees will be responsible for recommending changes to the BAF relating to emerging risks and existing entries within their remit for the executive to consider. When the target risk in the BAF is met, a full report will be made to the committee recommending its removal from the BAF, which will the committee will consider and make an appropriate recommendation to the Board.

Risk Appetite Statement

The Trust's risk appetite statement has been reviewed and is being used as a tool to determine which risks should be prioritised by the board for controls assurance purposes. Where the Trust has a cautious view of risk (green to yellow), and the current risk is higher than this, this risk will be reviewed more frequently and in greater depth by the board and its committees. When a target risk is achieved and this is lower than the Trust's risk appetite, the Board will consider the removal of a risk from the Board Assurance Framework, though it will remain on the Trust's risk register for ongoing executive management.

Current risk profile

All but one of the BAF risks are red. All of the red risks are outside the Trust Board's agreed risk appetite.

The amber risk relates to digital transformation. Assessed at Annual x Major = Amber, this has achieved its target risk and is within the Trust Board's agreed risk appetite. We are awaiting confirmation that this has been formally de-escalated from the BAF.

Red Risk Report

This report now also includes an update on the corporate and operational **red risks** previously reported separately.

Risk No.	Title	BAF Y/N	Risk level (current)	Risk Subcategory
24	Potential failure of the main building structure and front residencies structure (Oak, Cedar, Birch, Larch, Pine, Willow)	N	Red	Corporate Risk
4168	Impact of Managing COVID-19 (Coronavirus) on Trust business as usual activity	N	Red	Corporate Risk
4499	Provision of thrombectomy service for stroke patients in our region	N	Red	Corporate Risk
4724	Staffing shortfalls	N	Red	Corporate Risk
4890	Evacuation of the West Suffolk Hospital primarily due to RAAC issue	N	Red	Operational Risk
4917	Missing samples causing a delay to getting results to the right patient at the right time.	N	Red	Operational Risk
5092	Capacity and demand of the e-Care Meds Team	N	Red	Operational Risk
5107	Post the collapse of RAAC planks, it is assessed that there will be the release of large amounts of dust into the air	N	Red	Operational Risk
5136	Saving Not Signing Documents on e-Care	N	Red	Corporate Risk
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
5190	RAAC plank concerns within Antenatal	N	Red	Operational Risk
5199	Extreme weather and concerns how it affects the RAAC roof and walls	N	Red	Operational Risk
5230	Delay in Discharge Summaries being sent out	N	Red	Operational Risk
5381	Disharmonious working within Plastic Surgery team	N	Red	Operational Risk

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)** was reviewed at the relevant assurance committee on 9 May 2022.

The original RAAC work programme was scheduled assumed that three decant wards would be available during the summer (April to September) and two decant wards over winter (October to March). Unfortunately, over recent weeks the programme has been working with just one decant ward due to operational pressures and capacity issues. Planning is now in place to delivery the programme with two decant ward by 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]	**Insight** (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)

	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)

5.2. Governance report

To inform

Presented by Richard Jones

Board of Directors – 27 May 2022

Report Title:	Item 5.2 - Governance Report
Executive Lead:	Richard Jones, Trust Secretary
Report Prepared by:	Richard Jones, Trust Secretary Pooja Sharma, Deputy Trust Secretary
Previously Considered by:	N/A

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

Executive Summary

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

1. Urgent decisions
2. Delegate authority to improvement committee to approve the Quality Accounts
3. Chair and NED appointment process
4. Senior Leadership Team report
5. Audit committee
6. Board development/seminar sessions
7. CoG and membership strategy
8. ICB partner member nomination
9. Draft agenda items for the next Board meeting
10. Use of Trust seal

Action Required of the Board

To note the report and approve the recommendations:

- Delegated authority to approve the annual quality report to the improvement committee

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

Governance Report

1. Urgent decision

The standing orders of the Board makes provision for 'Emergency Powers and urgent decisions'.

These powers were used to approve the extension of two managed services contracts with Chrystal Consulting relating to radiology and endoscopy. It was confirmed that the extension represents value for money over this period, and that the full tendering process will ensure this continues. The outcomes of this process will be brought to the Board in due course for approval.

2. Delegate authority to improvement committee to approve the quality accounts

The requirement to publish annual quality accounts is set out within the Health Act 2009 and subsequent Health and Social Care Act 2012. The draft document has been prepared and shared with key partners for comment and feedback, including Governors, Healthwatch Suffolk, West Suffolk CCG and the local authority.

The improvement committee considered the drafted quality priorities at its meeting in May (see below) and the full quality accounts will be received by the Improvement Committee at its June meeting. The draft quality accounts are also available for review by any Board members wishing to see the full document.

Recommendation

The Board is asked to provide delegated authority to the Improvement Committee to approve the annual quality accounts.

Quality priorities 2022-23 (DRAFT)

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 avoidable 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

Safe and high quality care

- 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 avoidable harm
- Effectively respond to national reports to support quality improvements

- Develop our quality assurance framework to support systematic quality improvement
- % of patients recommending WSFT as a place receive care
- % 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 experience across all patient groups, including minorities and underrepresented patients
- 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
- % of patients recommending WSFT as a place receive care

3. Recruitment of permanent Chair

The appointment of a Foundation Trust chair and non-executive directors is one of the statutory duties of the Council of Governors and requires approval at a general meeting. The Nominations Committee of the Council of Governors is leading the process of appointing a new Chair. Following a review of the Constitution, in December 2021, the Nominations Committee has also started the process for appointing up to three new non-executive directors to the Board.

Stage 1 meetings were held with the Chair candidates on 5 and 9 May. These were based on MS Teams discussions with the candidates with the following:

- Lead Governor (Public)
- Staff Governor
- Partner Governor
- Interim Chair
- In attendance was Jeremy Over, Director of Workforce

As a result three candidates have been identified for stage 2 interviews and stakeholder events. Interviews will take place on 23 June 2022.

The NED shortlisting will be scheduled when the recruitment agency have confirmed when the preliminary interviews for the long listed candidates will be completed (21 in total).

4. Senior Leadership Team Report

The Senior Leadership Team is a decision-making forum which provides strategic leadership for the organisation and is responsible for the implementation and delivery of the Trust's strategic direction, business plan and associated objectives, ensuring that a cohesive decision-making process and co-operative approach is applied to issues which have an impact across the organisation.

The Team is still in a developmental stage but has considered a number of strategic issues in its recent meetings, which has included discussion of: Western Way feasibility study; Staff support psychology business case (approved); and the sustainability programme. The latter reflects the Trust's commitment to the local delivery of the NHS Green Plan by making the Sustainability Programme a focal point for improvement across the organisation to align with the new Trust Strategy; First for Patients, First for Staff and First for the Future.

5. Audit committee

The committee provides 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.

At its last meeting it considered:

- BAF assurance – the evolving role of the assurance committee and how the governance and specialist committee will support the review and oversight of the BAF was discussed
- Review of draft annual governance statement (AGS) which will form part of the annual report and accounts 2021-22
- Internal audit plan for 2022-23 – aspects inclusion in the plan were reviewed. It was agreed that execs would review plan/scope/focus for each of their areas and also that the timeframes for those areas were correct
- RSM draft Head of Internal Audit opinion was received
- RSM internal audit progress report – including management action progress
- Local counter fraud services (LCFS) annual plan 2022-23
- Draft value for money (VFM) assessment and progress report from external audit
- Internal/external audit findings of subsidiaries or partner organisations

6. Board development/seminar sessions

The Board is continuing to work with Integrated Development on a programme to support our model of working. A session took place on 8 April, with two further sessions planned for the year.

The session on 8 April included:

- Assurance verses reassurance
- What:
    - Types of evidence- data and supporting narrative
    - Validity – measures, source and triangulation
- So what:
    - Value – real intelligence and clarity to board understanding; decision making based on strategic options/cultural awareness
- Quality of evidence
    - Diamond - Provides genuine insight on areas that matter
    - Dubious - Appealing, may hold the fallacy of insight, but lacks rigour/reliability – so add rigour
    - Distracting - Collect it efficiently, report it if you have to, but don't waste time examining
    - Dangerous - 'Dung data' – avoid, reject, challenge, dump, delete
- Support and challenge - productive exploration through questioning

Integrated Development also provided active coaching during the Board meeting held in the afternoon.

A board seminar was also held on 29 April which included:

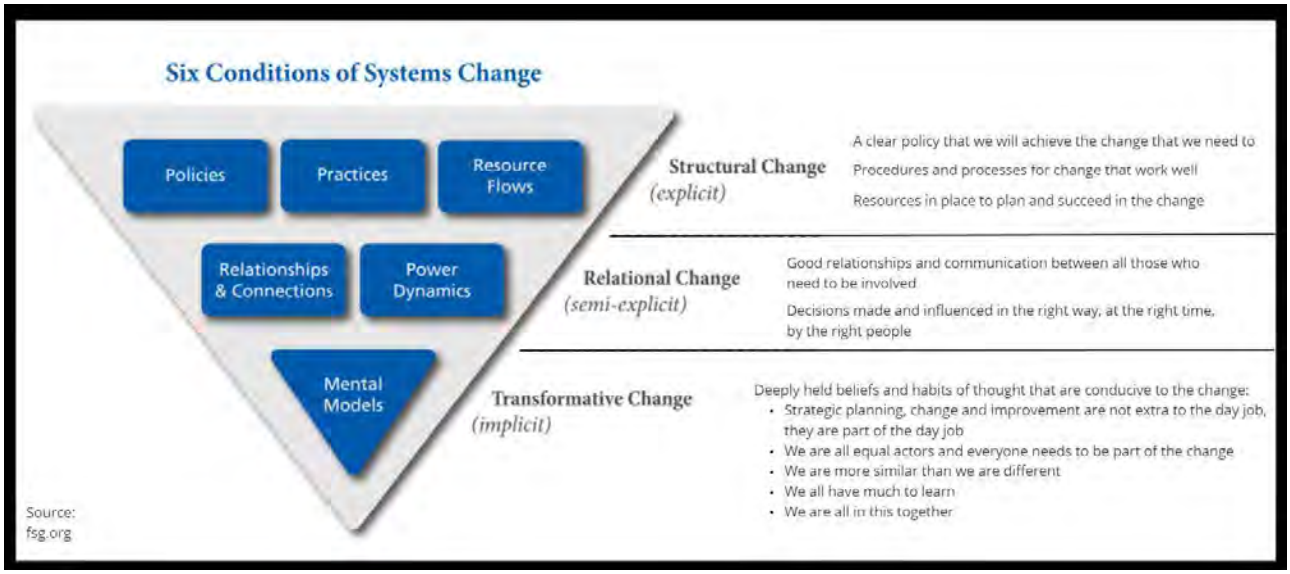
- Focused on the nature of change
- Strategy implementation – clinical strategy and the digital strategy

The discussion on change focused on three main themes: change, culture and integration. More specifically:

1. The extent of the change we need to achieve as an organisation, over the next 10 years, if we are to make the Future System a success
2. How our organisational culture helps or hinders us in achieving change

3. Integration with the alliance and ICS partners, and indeed between the different parts of the trust itself, being one of the changes that we need to achieve, and an important one.

The emphasis on creating a culture-led change plan with a focus on change of behaviours, not mindsets' and how that compared and contrasted with people's experience of change. Consideration was given to behaviour change theory and frameworks. The six conditions of system change model was reviewed.



The recommendations were made as an asset-based approach to starting to improve the conditions for change in the Trust. It was recognised that they will not be enough on their own – there is no end to this work, only continuous improvement – but they will make a substantial start and achieving them will allow us to generate the next set of ideas.

Asset-based approach to change – statements and recommendations

1. An explicit cultural programme to heal and re-form as Team WSFT after the stress and distress of the last 2 years
2. Adopting the future models of care and business that have been created by the Future System programme as policy and combining and/or harmonising other strategic objectives and existing plans with them.
3. Make better use of the large amount of capability and capacity we already have in the people with expertise in change and improvement
4. Identify and increase strategic thinking and planning ability within multi-professional teams
5. Understand that most of the solutions for the future lie in the Alliance and the ICS working
6. Use co-production to determine how to deliver the change
7. Set and use schemes of delegation much more effectively and lift senior leaders out of operational decision making.

The recommendations and actions were agreed as follows:

Recommendation 1 will be taken forward as part of the board development programme in 2022/23. It will need to be designed as an extension or addition to the organisational development programme recently agreed, and it will need to be co-produced.

Recommendation 2 was accepted. The digital strategy is an example of how this can happen well. The clinical strategy will be the next output, and it will be inclusive of the changes that the corporate departments need to make in order to enable the clinical strategy. The Future System

programme team will also create a common narrative which will be used to communicate the need for change - the business case for the future state.

Recommendation 3 will be actioned by the chief operating officer, medical director and associate medical director (future system) with help from the non-executive directors who have experience in management consultancy. It will begin with an inventory of all the roles and resources we have in the improvement disciplines at the moment, followed by comparison to best practice elsewhere to identify any resource gaps. The aim will be for the teams to begin working in a more coordinated way in the first instance, moving to a combined team structure in the longer term. The board will also learn about the improvement disciplines themselves as part of the 2022/23 board development programme.

Recommendations 4 and 7 were accepted. An action will be delegated by the chief operating officer to the associate directors of operations, to create a proposal for how they would like to see each of these objectives achieved, with input from stakeholders.

Recommendation 5 was accepted with an immediate action taken by all executive directors to engage with the existing West Suffolk Alliance and ICS projects and the fora. The board will also learn about integration as part of the 2022/23 board development programme. This learning will have two components:

- the principles of integration, with examples of best practice from the UK and beyond
- the local goals which have been adopted at alliance and ICS level

Recommendation 6 was accepted.

Further actions were also taken:

- Agreed to formally report these discussions in public board meeting and communicate within the organisation
- Develop a clear and compelling narrative committing to the change statements proposed, laying out the conditions for systems change that it aspires to create
- To provide regular updates on progress on this work to reports to the Board

7. CoG meeting held on 18 May and membership strategy

The Register of Governors' interests was formally received and noted by the Council of Governors. At each Council of Governors (CoGs) meeting declarations are also received for items to be considered as part of the agenda. An update on completion of returns will be provided at the next meeting. It was reminded that any changes in interests should be declared at the next Council of Governors meeting following the change occurring.

As reported above the Nominations Committee of the Council of Governors leading recruitment for a new Chair and NEDs. Clive Wilson was appointed as a new Public Governor to the committee.

The Council of Governors noted the Chair and NED appraisal process and timescale. Nominations were sought for Governors wishing to act as observers (appraisers) using the appraisal questionnaires.

The Council of Governors were encouraged to join the engagement committee as members to develop and take forward the engagement programme. Following this process an additional engagement committee meeting will be setup to welcome new members and elect a committee chair.

The Council of Governors approved the proposed work programme for WSFT Governors, subject to periodical review, which included various briefing and development sessions to run across 2022-23.

The Council of Governors noted the timetable for 2021-22 annual report and accounts. Four Governors were identified as readers for the Annual Report and Quality Accounts, as well as drafting commentary from the Governors for inclusion in the Quality Accounts.

Reports from the lead governor and staff governors were also received and noted.

8. ICB partner member nomination

The Trust along with other local NHS providers was invited to put forward nominations for the partner members of the new Suffolk and North East Essex Integrated Care Board. The partner members seats were for acute, community and mental health.

In collaboration with colleagues in ESNEFT Craig Black and Nick Hulme were nominated as the acute and community partner members respectively.

9. Agenda Items for the Next Meeting (Annex A)

Annex A provides a summary of scheduled items for the next meeting and is drawn from the Board reporting matrix, forward plan and action points. The final agenda will be drawn-up and approved by the Chair.

10. Use of Trust Seal

None to report.

Annex A: Scheduled draft agenda items for next meeting – 22 July 2022

Description	Open		Closed	Type	Source	Director
Declaration of interests	✓		✓	Verbal	Matrix	All
General Business						
Patient/staff story	✓		✓	Verbal	Matrix	Exec.
Chief Executive's report	✓			Written	Matrix	CB
Culture						
Organisational development plan, including guardian of safe working report	✓			Written	Matrix	JMO
Report of the West Suffolk Review – Governor/Director working group	✓			Written	Matrix	RD
Strategy						
Asset-based approach to change	✓			Written	Matrix	CB
Future System Board Report	✓			Written	Matrix	CB
Nurse staffing strategy review	✓			Written	Matrix	SW
Strategic update, including Trust strategy next steps, Alliance, System Executive Group, Integrated Care System, Integration report	✓			Written	Matrix	CB
Assurance						
Annual report and accounts			✓	Written	Matrix	CB/NmacD/RJ
Report from 3i Committees: Insight, Improvement & Involvement	✓			Written	Matrix	RD / AR / JC
Insight Committee Report - Budget and capital programme - Finance and workforce report - Operational report - IQPR	✓			Written	Matrix	NM/NC/RD
Involvement Committee Report - People and OD Highlight Report o Putting you First award o Staff recommender scores o Mandatory training analysis (qtrly) o Appraisal o Car park review o Medical Revalidation annual report	✓			Written	Matrix	JMO/AR
Improvement Committee Report - Maternity services quality and performance report (inc. Ockenden) - Nurse staffing report - Quality priorities - R&D annual report	✓			Written	Matrix	SW / PM

Description	Open		Closed	Type	Source	Director
Serious Incident, inquests, complaints and claims report			✓	Written	Matrix	SW
Annual report and accounts (draft)			✓	Written	Matrix	NM/RJ
Governance						
Governance report, including - Agenda items for next meeting - Use of Trust's seal - Senior Leadership Team report - FT membership strategy - General condition 6 and Continuity of Services condition 7 certificate - Audit Committee annual report	✓			Written	Matrix	RJ
Board assurance framework and risk report	✓			Written	Matrix	RJ
Confidential staffing matters			✓	Written	Matrix – by exception	JMO
Reflections on the meetings (open and closed meetings)	✓		✓	Verbal	Matrix	JC

6. OTHER ITEMS

6.1. Any other business

To Note

6.2. Reflections on meeting

For Discussion

6.3. Date of next meeting - 22 July 2022

To Note

Presented by Jude Chin

RESOLUTION

The Trust Board is invited to adopt the following resolution:

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

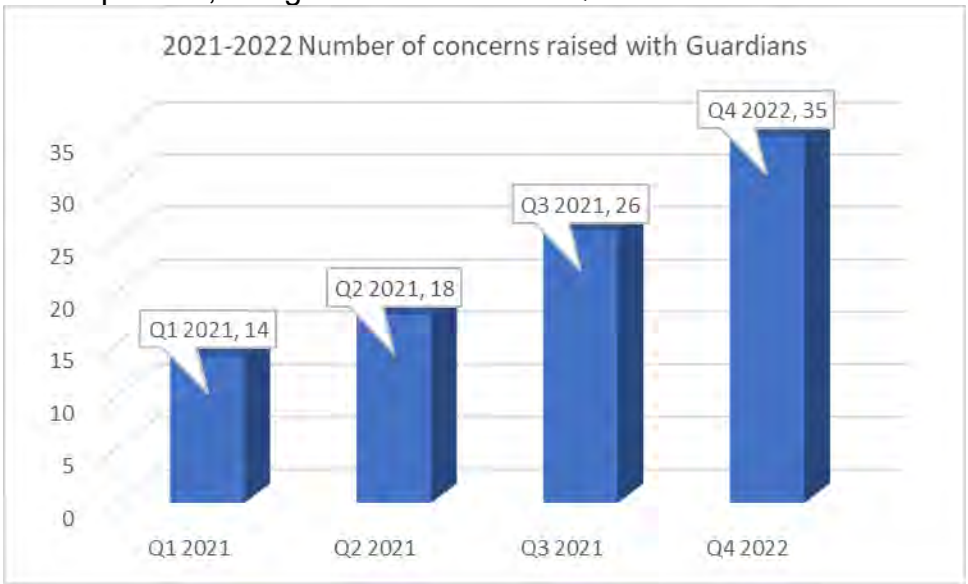
Annexes for information:

To inform

Appendix 1: Freedom to Speak Up Guardian's Report Q4 2022 - May 2022

Introduction

The number of concerns raised with the guardians has consistently increased over the past 4 quarters, rising to 35 concerns in Q4.



James and Amanda continue to promote Freedom to Speak Up, expanding the Champions network presenting at team meetings and the staff briefing.

Data

Data Submitted to NGO for Q4 2022

Number of cases brought to FTSUGs / Champions per quarter	35

Numbers of cases brought by professional level

Worker	20
Manager	6
Senior leader	2
Not disclosed	7

Numbers of cases brought by professional group

Allied Health Professionals	1

Medical and Dental	1
Registered Nurses and Midwives	9
Nursing Assistants or Healthcare Assistants	3
Corporate Services	1
Administration, Clerical & Maintenance/Ancillary	9
Not Known	10

Of which there is an element of

Number of cases raised anonymously	8
Number of cases with an element of patient safety/quality	9
Number of cases with an element of bullying or harassment	12
Number of cases where disadvantageous and/or demeaning treatment as a result of speaking up (often referred to as 'detriment') is indicated	0
Number of cases with an element of worker safety	9

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

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

Common themes from feedback in Q4

- Poor relationship with managers / seniors 7
- Staffing levels / shift allocation 8
- Pay banding / HR process 4
- Incivility / poor relationships/ bullying/ equality and inclusion 7
- Patient Transport (ongoing issue)

Summary of learning points

- There is a need for continuing education and support for managers.
- The length of time to resolve HR concerns and decisions around pay banding is an ongoing issue.
- Anxiety and stress caused by reallocation of staff, both of those moved and those left behind to cope.
- In our experience incivility/bullying concerns best addressed at the local level ("Informal cup of coffee" level as in the civility and respect toolkit

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

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

What's going well:

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

Even better if:

- Increased visibility across the Trust planned for next quarter
- Continue to grow Champions network

Speaking up policies and processes are effective and constantly improved

What's going well:

- Guardians contributing to policy working group ensuring FTSU represented and in line with policy updates
- Guardians work closely with HR Business Partners and expanding leaders and mangers network of contacts
- Champions are enabling and supporting staff to speak up.

Even better if:

- FTSU Policy to be updated on publication of national policy guidelines from NGO, (awaiting policy.)
- Processes to be reviewed to ensure feedback is given in a timely manner

Senior leaders are role models of effective speaking up

What's going well:

- Quarterly meetings in place with CEO, Chair of Board, COO and Senior independent director and Executive Director of Workforce and Communications

- Meeting undertaken between Trust directors, FTSU Guardians and the NGO following publication of the Independent Review. This provided reassurance that our processes are in line with NGO guidance.

Even better if:

- "Follow up" training now available for Senior leaders. It is highly recommended that all board members, senior leaders and governors undertake this training. To access please follow this link to follow up training (and scroll to the bottom of the page).

- 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
- Evidence that Champions are enabling speaking up within their teams through referrals, support at meetings and signposting.
- On-line Champion's training developed to be rolled out in June.

Even better if:

- Align with Trust Strategy – First for Patients and First for Staff so that Freedom to Speak Up is promoted
- Link with Safe Spaces project to encourage colleagues from minority groups to speak up.

Individuals are supported when they speak up

What's going well:

- Individuals report feeling supported by the Guardians when raising concerns
- Excellent support given to Guardians and individuals by Non-executive Director responsible for FTSU and Executive Director of Workforce.
- Managers are promoting Speaking up and supporting their staff to Speak up. Excellent example in Critical Care from managers enabling opportunities for staff to speak up.

Even better if:

- Continue to expand Champion network to support areas/groups not currently covered
- Training session for managers to support staff when they speak up

Barriers to speaking up are identified and tackled

What's going well:

- Challenging the negative connotations of "whistle blowing or speaking up" as trouble making and promoting Speaking up is always the right thing to do.
- At the meeting undertaken between Trust directors, FTSU Guardians and the NGO following publication of the Independent Review, reiterated the importance of listening to the message rather than judging the person speaking up.

Even better if:

- Review 2021 staff survey with HRBPs to identify areas for targeted support.

Information provided by speaking up is used to learn and improve

What's going well:

- Relationships between FTSUG and senior leaders enable open discussion and therefore learning to be shared and acted upon.
- Patient transport concerns have been passed to quality team at CCG who are using feedback to assess service. In addition, patient waiting area has been allocated to out patients awaiting extended periods for transport.

Even better if:

- Learning communications channel established to enable dissemination of learning throughout the organisation

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

What's going well:

- Members of East of England FTSU Guardian Network and have attended quarterly meetings.
- NGO GAP analysis carried out
- Working with Deputy medical director (Patient safety) to involve in all concerns raised with an element of patient safety.

Even better if:

- Adoption of updated NGO guidance in near future

People & OD Highlight report – Appendix 2: staff survey analysis by theme

People Promise theme: We each have a voice that counts – autonomy and control

How WSFT compares nationally on this theme	
WSFT 6.7/10 National 6.7/10	

Question	**2021 results** (Symbol shows WSFT result compared to national average)	**WSFT and national average trend from 2020** (Arrow shows WSFT trend compared to 2020)
I always know what my work responsibilities are	WSFT: 87.5% National: 86.3% 	WSFT down 0.1% National down 0.2% 
I am trusted to do my job	WSFT: 92.0% National: 90.8% 	WSFT down 0.5% National down 0.4% 
There are frequent opportunities for me to show initiative in my role	WSFT: 74.4% National: 72.4% 	WSFT up 2.2% National up 0.5% 
I am able to make suggestions to improve the work of my team / department	WSFT: 73.0% National: 69.8% 	WSFT down 2% National down 3.2% 
I am involved in deciding on changes introduced that affect my work area / team / department	WSFT: 53.8% National: 48.9% 	WSFT up 1.7% National down 1.5% 

I am able to make improvements happen in my area of work	WSFT 55.7% National: 53.3%	WSFT up 0.3% National down 2.1%
I have a choice in deciding how to do my work	WSFT: 55.1% National: 51.5%	WSFT down 3.2% National down 2.7%

People Promise theme: We each have a voice that counts – raising concerns

How WSFT compares nationally on this theme

WSFT 6.2/10
National 6.4/10

Question	**2021 results** (Symbol shows WSFT result compared to national average)	**WSFT and national average trend from 2020** (Arrow shows WSFT trend compared to 2020)
I would feel secure raising concerns about unsafe clinical practice	WSFT: 68.7% National: 73.9%	WSFT down 0.4% National up 2.1%
I am confident that my organisation would address my concern	WSFT: 51.6% National: 57.6%	WSFT down 3.2% National down 1.5%
I feel safe to speak up about anything that concerns me in this organisation	WSFT: 59.1% National: 60.7%	WSFT down 4.2% National down 4.3%

If I spoke up about something that concerned me I am confident my organisation would address my concern	WSFT: 46.8% National: 47.9 % 	New question so no trend data

People Promise theme: We are safe and healthy – health and safety climate

How WSFT compares nationally on this theme WSFT 6.0/10 National 5.9/10 		
Question	**2021 results** (Symbol shows WSFT result compared to national average)	**WSFT and national average trend from 2020** (Symbol shows WSFT trend compared to 2020)
I am able to meet all the conflicting demands on my time at work	WSFT: 44.0% National: 43.3% 	WSFT down 5.2% National down 5.2% 
I have adequate materials, supplies and equipment to do my work	WSFT: 59.9% National: 55.3% 	WSFT down 2.7% National down 3.2% 
There are enough staff at this organisation for me to do my job properly	WSFT: 27.9% National: 26.0% 	WSFT down 11.5% National down 10.9% 
I have unrealistic time pressures	WSFT: 22.8% National: 22.5% 	WSFT down 2.0% National down 1.8% 

My organisation takes positive action on health and well-being	WSFT: 61.7% National: 56.4% 	New question so no trend data
The last time you experienced harassment, bullying or abuse at work, did you or a colleague report it?	WSFT: 42.9% National: 46.5% 	WSFT down 3.3% National up 0.3% 

People Promise theme: We are safe and healthy – burnout

How WSFT compares nationally on this theme
WSFT 4.8/10  National 4.8/10 

Question	**2021 results** (Symbol shows WSFT result compared to national average)	**WSFT and national average trend from 2020** (Symbol shows WSFT trend compared to 2020)
How often, if at all, do you find your work emotionally exhausting?	WSFT: 38.1% National: 37.7 % 	New question so no trend data
How often, if at all, do you feel burnt out because of your work?	WSFT: 35.0% National: 35.2% 	New question so no trend data
How often, if at all, does your work frustrate you?	WSFT: 41.3% National: 39.9 % 	New question so no trend data
		New question so no trend data

How often, if at all, are you exhausted at the thought of another day/shift at work?	WSFT: 32.3% National: 32.2% 	
How often, if at all, do you feel that every working hour is tiring for you?	WSFT: 22.8% National: 21.9% 	New question so no trend data
How often, if at all, do you not have enough energy for family and friends during leisure time?	WSFT: 32.1% National: 32.1% 	New question so no trend data

Theme: Staff engagement

How WSFT compares nationally on this theme:

WSFT 7.0/10
National 6.8/10 

WSFT down 0.2% on 2020
National down 0.2% on 2020 

Sub-theme	Question	2021 results (Symbol shows WSFT result compared to national average)	WSFT and national average trend from 2020 (Symbol shows WSFT trend compared to 2020)
Motivation	I look forward to going to work	WSFT: 55.7% National: 52.0 % 	WSFT down 6.1% National down 6.6% 
	I am enthusiastic about my job	WSFT: 69.4% National: 67.6% 	WSFT down 5.6% National down 5.5% 

	Time passes quickly when I'm working	WSFT: 75.6% National: 72.9%	WSFT down 3.5% National down 3.1%
Involvement	There are frequent opportunities for me to show initiative in my role	WSFT: 74.4% National: 72.4%	WSFT up 2.2% National up 0.5%
	I am able to make suggestions to improve the work of my team / department	WSFT: 73.0% National: 69.8%	WSFT down 2.0% National down 3.2%
	I am able to make improvements happen in my area of work	WSFT: 55.7% National: 55.3%	WSFT up 0.3% National down 2.1%
Advocacy	Care of patients/service users is my organisation's top priority	WSFT: 77.2% National: 75.5 %	WSFT down 7.4% National down 4%
	I would recommend my organisation as a place to work	WSFT: 64.5% National: 58.4%	WSFT down 9.3% National down 8.6%
	Trust strategy metric If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation	WSFT: 73.4% National: 66.9%	WSFT down 9.2% National down 7.4%

Theme: Morale

How WSFT compares nationally on this theme:

WSFT 5.9/10
National 5.7/10

WSFT down 0.3% on 2020
National down 0.3% on 2020

Sub-theme	Question	2021 results (Symbol shows WSFT result compared to national average)	WSFT and national trend from 2020 (Symbol shows WSFT trend compared to 2020)
Thinking about leaving	I often think about leaving this organisation	WSFT: 29.1% National: 31.3 %	WSFT up 5.5% National up 4.9%
	I will probably look for a job at a new organisation in the next 12 months	WSFT: 19.7% National: 22.1%	WSFT up 3.3% National up 3.4%
	As soon as I can find another job, I will leave this organisation	WSFT: 13.9% National: 16.0%	WSFT up 2.8% National up 2.8%
Work pressure	I am able to meet all the conflicting demands on my time at work	WSFT: 44.0% National: 43.3%	WSFT down 5.3% National down 4.3%
	There are enough staff at this organisation for me to do my job properly	WSFT: 27.9% National: 26.0%	WSFT down 11.5% National down 10.9%

Stressors	I always know what my work responsibilities are	WSFT: 87.5% National: 86.3% 	WSFT down 0.1% National down 0.3% 
	I am involved in deciding on changes introduced that affect my work area/team/department	WSFT: 53.8% National: 48.9% 	WSFT up 1.7% National down 1.5% 
	Relationships at work are strained	WSFT: 46.1% National: 42.8% 	WSFT down 1.6% National down 2.6% 
	I receive the respect I deserve from my colleagues at work	WSFT: 71.9% National: 69.7% 	WSFT down 0.4% National down 0.7% 
	My immediate line manager encourages me at work	WSFT: 69.2% National: 69.0% 	WSFT up 0.6% National down 0.2% 

People Promise theme: We are compassionate and inclusive – compassionate culture

How WSFT compares nationally on this theme
WSFT 7.2/10 National 7.1/10 

Question	**2021 results** (Symbol shows WSFT result compared to national average)	**WSFT and national average trend from 2020** (Arrow shows WSFT trend compared to 2020)

I feel that my role makes a difference to patients/service users	WSFT: 88.2% National: 87.7%	New question so no trend data
Care of patients / service users is my organisation's top priority	WSFT: 77.2% National: 75.5%	WSFT down 7.4% National down 4.0%
My organisation acts on concerns raised by patients / service users	WSFT: 65.7% National: 71.0%	WSFT down 6.3 % National down 3.0 %
Trust strategy metric: I would recommend my organisation as a place to work	WSFT: 64.5% National: 58.4%	WSFT down 9.3% National down 8.6%
Trust strategy metric: If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation	WSFT: 73.4% National: 66.9%	WSFT down 9.2% National down 7.4%

People Promise theme: We are compassionate and inclusive – compassionate leadership

How WSFT compares nationally on this theme
WSFT: 6.9/10 National: 6.8/10

Question	**2021 results**	**WSFT and national average trend from 2020**

	(Symbol shows WSFT result compared to national average)	(Arrow shows WSFT trend compared to 2020)
My immediate manager works together with me to come to an understanding of problems	WSFT: 66.8% National: 65.4%	New question so no trend data
My immediate manager is interested in listening to me when I describe challenges I face	WSFT: 69.2% National:67.9%	New question so no trend data
My immediate manager cares about my concerns	WSFT: 69.6% National: 66.9 %	New question so no trend data
My immediate line manager takes effective action to help me with any problems I face	WSFT: 64.6% National: 63.3%	New question so no trend data

People Promise theme: We are compassionate and inclusive – diversity and equality

How WSFT compares nationally on this theme WSFT 8.2/10 National 8.1/10

Question	**2021 results** (Symbol shows WSFT result compared to national average)	**WSFT and national average trend from 2020** (Symbol shows WSFT trend compared to 2020)
	WSFT: 57.6% National: 55.7%	WSFT down 1.4% National down 1.5%

Does your organisation act fairly with regard to career progression / promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age?		
In the last 12 months have you personally experienced discrimination at work from patients / service users, their relatives or other members of the public?	WSFT: 7.1% National: 6.9% 	WSFT up 0.5% National 0.6% 
In the last 12 months have you personally experienced discrimination at work from manager / team leader or other colleagues?	WSFT: 7.2% National: 8.8% 	WSFT up 0.1% National up 0.8% 
I think that my organisation respects individual differences (e.g. cultures, working styles, backgrounds, ideas, etc).	WSFT: 67.4% National: 68.8% 	New question so no trend data

People Promise theme: We are compassionate and inclusive - inclusion

How WSFT compares nationally on this theme WSFT 7.0/10 National 6.8/10 		
Question	**2021 results** (Symbol shows WSFT result compared to national average)	**WSFT and national average trend from 2020** (Symbol shows WSFT trend compared to 2020)
I feel valued by my team	WSFT: 69.4% National: 67.9% 	New question so no trend data

I feel a strong personal attachment to my team	WSFT: 67.1% National: 63.6%	New question so no trend data
The people I work with are understanding and kind to one another	WSFT: 74.1% National: 68.9%	New question so no trend data
The people I work with are polite and treat each other with respect	WSFT: 75.9% National: 70.2%	New question so no trend data

People Promise theme: We are recognised and rewarded

Question	**2021 results** (Symbol shows WSFT result compared to national average)	**WSFT and national average trend from 2020** (Symbol shows WSFT trend compared to 2020)
The recognition I get for good work	WSFT: 53.0% National: 50.5%	WSFT down 5.8% National down 5.8%
The extent to which my organisation values my work	WSFT: 43.2% National: 40.7%	WSFT down 8.0% National down 6.3%
My level of pay	WSFT: 32.7% National: 31.9%	WSFT down 6.6% National down 4.2%
The people I work with show appreciation to one another	WSFT: 70.5% National: 65.8%	New question so no trend data

My immediate manager values my work	WSFT: 70.0% National: 69.4% 	WSFT down 3.0% National down 2.3% 

Theme: We are safe and healthy – negative experiences

How WSFT compares nationally on this theme:
WSFT 7.7/10 National 7.7/10 

Question	**2021 results** (Symbol shows WSFT result compared to national average)	**WSFT and national trend from 2020** (Symbol shows WSFT trend compared to 2020)
In the last 12 months have you experienced musculoskeletal problems (MSK) as a result of work activities?	WSFT: 30.9% National: 30.9% 	WSFT up 1.3% National up 2.1% 
During the last 12 months have you felt unwell as a result of work-related stress?	WSFT: 46.8% National: 46.8% 	WSFT up 3.7% National up 2.7% 
In the last three months have you ever come to work despite not feeling well enough to perform your duties?	WSFT: 52.9% National: 54.9% 	WSFT up 7.3% National up 8.4% 
In the last 12 months, how many times have you personally experienced physical violence at work from	WSFT: 15.7% National: 14.0% 	WSFT down 1.3% National down 0.3% 

patients/service users, their relatives or other members of the public?		
In the last 12 months, how many times have you personally experienced physical violence at work from managers?	WSFT: 0.3% National: 0.6% 	WSFT down 0.2% National up 0.1% 
In the last 12 months, how many times have you personally experienced physical violence at work from other colleagues?	WSFT: 1.4% National: 1.6% 	WSFT up 0.1% National up 0.2% 
In the last 12 months, how many times have you personally experienced harassment, bullying or abuse at work from patients / service users, their relatives or other members of the public?	WSFT: 25.3% National: 27.3% 	WSFT down 1.5% National up 1.2% 
In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from managers?	WSFT: 10.0% National: 11.9% 	WSFT down 1.6% National down 1.3% 
In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from other colleagues?	WSFT: 18.8% National: 19.5% 	WSFT down 1.8% National down 0.3% 

Theme: We are always learning – development

How WSFT compares nationally on this theme:
WSFT 6.3/10 National 6.3/10 

Question	**2021 results**	**WSFT and national trend from 2020**

	(Symbol shows WSFT result compared to national average)	(Symbol shows WSFT trend compared to 2020)
This organisation offers me challenging work	WSFT: 71.0% National: 68.4%	New question so no trend data
There are opportunities for me to develop my career in this organisation	WSFT: 51.5% National: 52.1%	New question so no trend data
I have opportunities to improve my knowledge and skills	WSFT: 67.9% National: 65.9%	New question so no trend data
I feel supported to develop my potential	WSFT: 53.2% National: 51.3%	New question so no trend data
I am able to access the right learning and development opportunities when I need to	WSFT: 56.0% National: 54.4%	New question so no trend data

Theme: We are always learning – appraisals

How WSFT compares nationally on this theme:
WSFT 4.4/10 National 4.2/10

Question	**2021 results**	**WSFT and national trend from 2020**

	(Symbol shows WSFT result compared to national average)	(Symbol shows WSFT trend compared to 2020)
In the last 12 months, have you had an appraisal, annual review, development review, or Knowledge and Skills Framework (KSF) development review	WSFT: 83.4% National: 80.1%	Question not asked in 2020
It helped me to improve how I do my job	WSFT: 18.8% National: 19.8%	Question not asked in 2020
It helped me agree clear objectives for my work	WSFT: 29.9% National: 30.2%	Question not asked in 2020
It left me feeling that my work is valued by my organisation	WSFT: 32.7% National: 29.3%	Question not asked in 2020

Theme: We work flexibly – support for work/life balance and flexible working

How WSFT compares nationally on this theme (work/life balance):

WSFT: 6.0/10
National: 5.9/10

Flexible working:

WSFT: 6.0
National: 5.9

Question	2021 results (Symbol shows WSFT result compared to national average)	WSFT and national trend from 2020 (Symbol shows WSFT trend compared to 2020)
My organisation is committed to helping me balance my work and home life	WSFT: 44.7% National: 42.6% 	New question so no trend data
I achieve a good balance between my work life and my home life	WSFT: 50.4% National: 51.1% 	New question so no trend data
I can approach my immediate manager to talk openly about flexible working	WSFT: 67.9% National: 65.0% 	New question so no trend data
The opportunities for flexible working patterns	WSFT: 53.1% National: 51.8% 	WSFT down 5.9% National down 3.7% 

Theme: We are a team – team working

How WSFT compares nationally on this theme:
WSFT: 6.6/10 National: 6.5/10 

Question	2021 results (Symbol shows WSFT result compared to national average)	WSFT and national trend from 2020 (Symbol shows WSFT trend compared to 2020)

The team I work in has a set of shared objectives	WSFT: 73.3% National: 71.9%	WSFT down 0.1% National up 0.3%
The team I work in often meets to discuss the team's effectiveness	WSFT: 54.3% National: 55.6%	WSFT down 2.5% National down 1.1%
I receive the respect I deserve from my colleagues at work	WSFT: 71.9% National: 69.7%	WSFT up 0.4% National down 0.7%
Team members understand each other's roles	WSFT: 73.6% National: 71.3%	New question so no trend data
I enjoy working with the colleagues in my team	WSFT: 83.0% National: 80.7%	New question so no trend data
My team has enough freedom in how to do its work	WSFT: 60.7% National: 56.6%	New question so no trend data
In my team disagreements are dealt with constructively	WSFT: 55.2% National: 54.7%	New question so no trend data
Teams within this organisation work well together to achieve their objectives	WSFT: 54.2% National: 52.2%	New question so no trend data

Theme: We are a team – line management

How WSFT compares nationally on this theme:
WSFT: 6.7/10 National: 6.6/10 

Question	**2021 results** (Symbol shows WSFT result compared to national average)	**WSFT and national trend from 2020** (Symbol shows WSFT trend compared to 2020)
My immediate manager encourages me at work	WSFT: 69.2% National: 69.0% 	WSFT up 0.6% National down 0.2% 
My immediate manager gives me clear feedback on my work	WSFT: 61.4% National: 60.7% 	WSFT down 0.6% National up 0.1% 
My immediate manager asks for my opinion before making decisions that affect my work	WSFT: 58.5% National: 55.7% 	WSFT up 2.6% National up 1.2% 
My immediate manager takes a positive interest in my health and wellbeing	WSFT: 68.5% National: 66.3% 	WSFT down 0.9% National down 2.9% 

NHS
West Suffolk
NHS Foundation Trust

ATAIN Programme

Avoiding Term Admissions to the Neonatal Unit

Progress Report
Quarter 4
January-March 2022

April 2022

Rebecca Warburton - Clinical Risk Midwife
Dr Jageer Mohammed – Acting Lead Neonatologist
Karen Ranson - Ward Manager NNU

Background to project

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

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

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

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

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

Local reviews

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

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

Process for review

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

A Review of Terminology

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

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

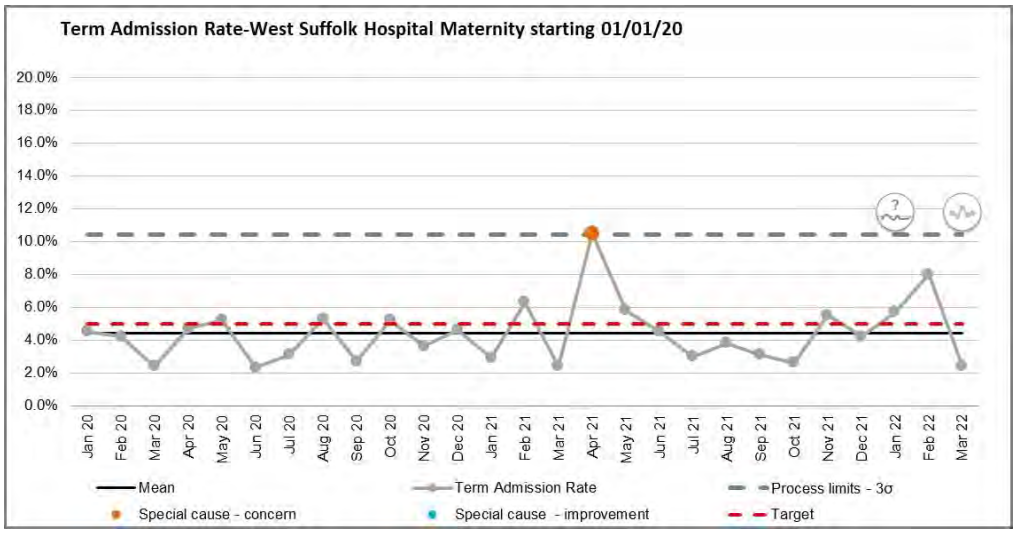
Findings

Term admission rates vary month on month. During the past quarter they have fluctuated, with only one month meeting the target level of < 5%. However, it should be noted that in January and February when admissions where highest; a few admissions would have been suitable for immediate or earlier transitional care had there been parental availability, or adequate staffing levels, which has impacted on the data. Additionally, two other admissions in these months were classified as avoidable and two others were planned due to known abnormalities.

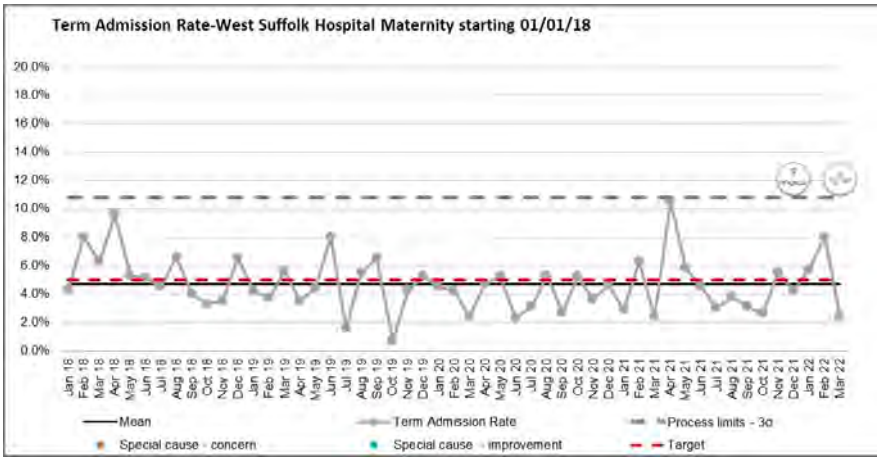
Cases were reviewed carefully to identify any areas for learning and improvement. While respiratory support remains the predominant reason for admission this quarter, no overarching themes or common denominators were identified amongst those admissions. However, a trend low admission temperatures was noted this quarter with 30% of babies recording temperatures of ≤36.5°C. While not the primary reason for admission, sub optimal body temperature is recognised as a contributory and exacerbating factor to respiratory distress.

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



Overall progress since programme began (2018)



Opportunities for learning

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

The two avoidable admissions were a result of the insertion of an umbilical vein catheter (UVC), when peripheral cannulation was unsuccessful, for the administration of antibiotics. Babies with an UVC are not suitable for transitional care which would have otherwise been appropriate in these cases. It was noted that intramuscular administration would have been a more appropriate next step after failing to insert a peripheral line.

Additionally, 3 cases this quarter were deemed to have been appropriate for earlier step down to TC which could have been facilitated in 2 of these cases if TC were able to support care of babies with nasogastric tubes (NGT). The care of babies with an NGT is something that will be possible when there is adequate staffing available to run the transitional care bay on a full-time basis. The 3rd case was not suitable for TC due to family safeguarding concerns.

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

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

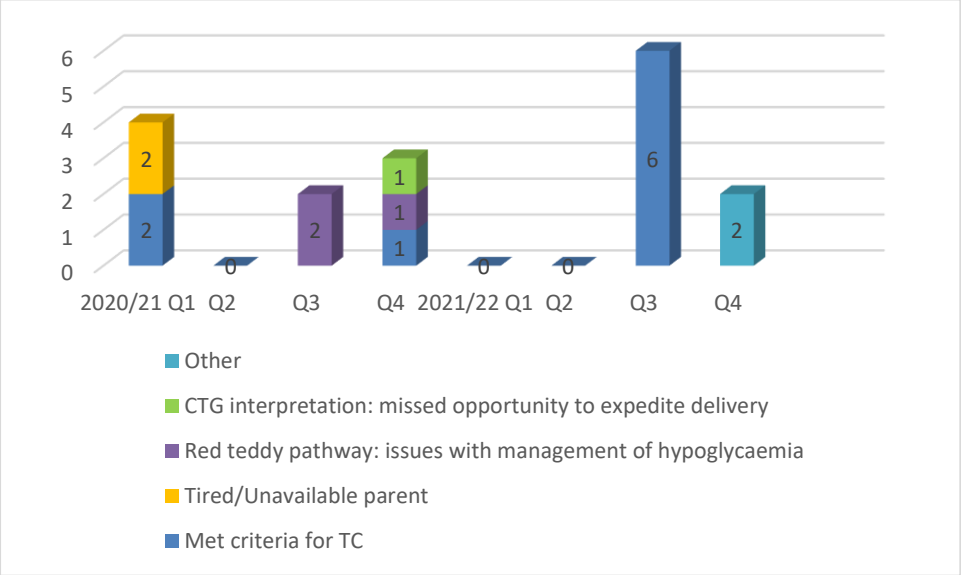
Two mothers in this quarter, who were delivered via planned ELCS between 37+0 and 38+6 weeks, did not have antenatal steroids. While it can not be concluded that this directly resulted in the admission of the infants to the NNU, it was noted by the Neonatal and Obstetric representatives that there may be some inconsistency in information given to mothers during

the antenatal period. As such an action has been made to develop an information sheet for Clinicians, in line with RCOG guidance, to help minimise variations in information during antenatal counselling.

Reasons for admission to NNU

This graph shows the reasons previously identified as being the cause of potentially avoidable term admissions. In this quarter all admissions were appropriate with the exception of 2 babies who underwent the insertion of an Umbilical Vein Catheter instead of a peripheral intravenous access which would have been more suitable; this was due to the individual clinician's inexperience.

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



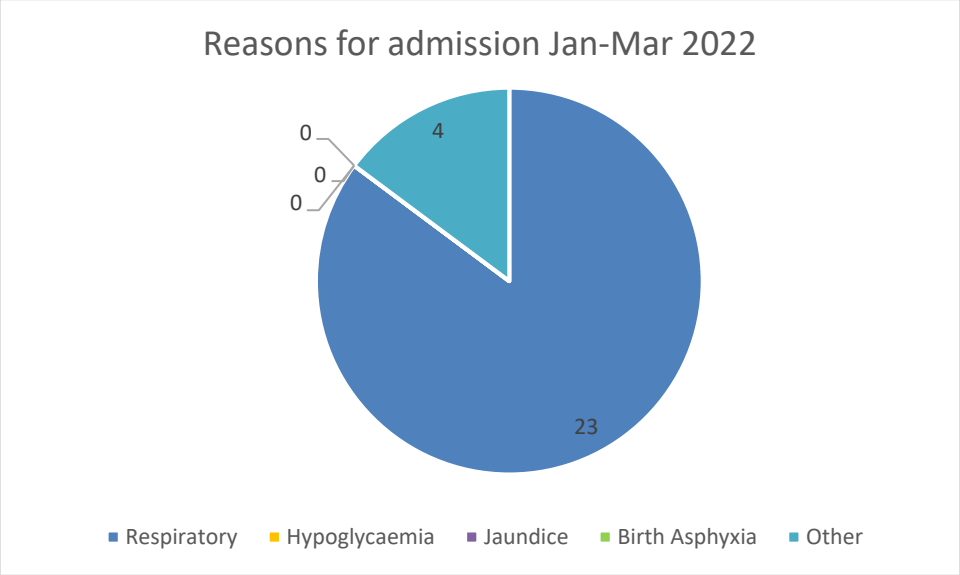
Action Plans

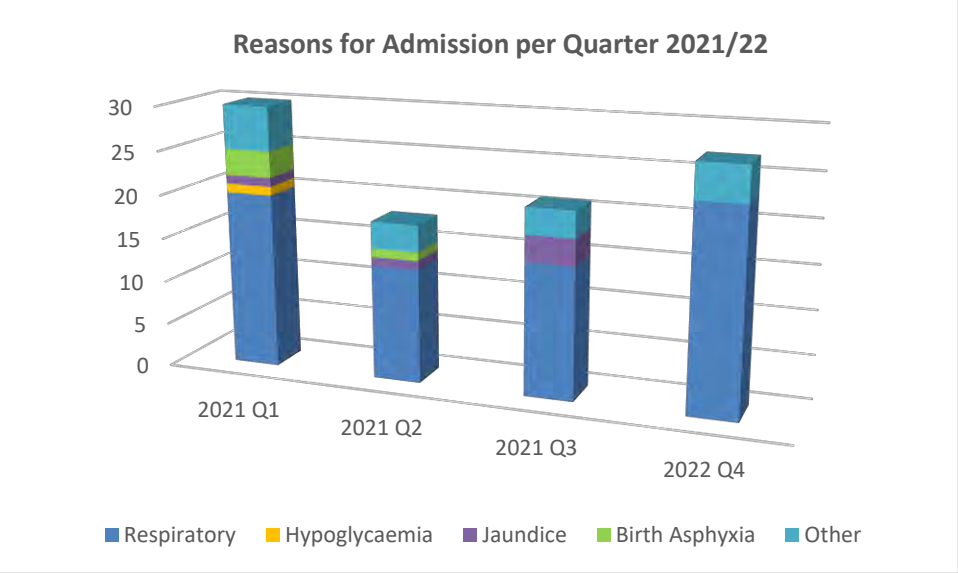
The group uses cases that have flagged opportunities for learning and care improvement to guide learning and improvement actions in order to reduce unnecessary separation of mothers of babies. Learning is also often picked up and actioned even when it would not have reduced separation, but has the potential to improve care in other areas.

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

Progress and learning with the four key reasons for admission

Data collection during Quarter 4 (Jan-March) 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. Two of the four that fell in to the "Other" category were both planned admissions and the other two were due to insertion of an UVC.





The chart above shows the reasons for admission per quarter in the 2021-2022 year; demonstrating Respiratory support as the prodominant reason for admisson each quarter. No underlying common theme has been identified at present but a rise in sub-optimal body temperatures on admission to NNU has been noted and is discussed below.

Quality improvement in this quarter

A trend of babies being admitted with low temperatures (≤36.5°c) was first identified in May 2021 and a comprehensive action plan put in place, resulting in a notable improvement in the following months. This quarter, another rise has been noted with 30% of babies found to have low temperature on admission, the causes of which could not be conclusively determined but are suspected to be environmental.

May 5/10 (50%)

June 1/7 (14%)

July 3/6 (50%)

Nov 2/9 (22%)

Jan 2/10 (20%)

Feb 5/13 (38%)

Mar 1/4 (25%)

In all cases, this 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. Some new actions have now been created and are on-going; these are highlighted as bold text. This included engagement with, and support from Theatres, Labour Suite and NNU teams.

Action	Plan	Comments
Raise awareness among the NNU nursing team who check and record the obstetric theatre temperature daily re. changing the temperature if the theatre is too cool.	• Wise words • Discussion at handover	NNU Manager met with Theatre Team Lead to discuss the problems, and find out how to correctly set the temperature. It was reported that the theatre doors are frequently left open when the theatre is not in use, so steps were taken to remind all the thetare staff to keep the doors closed.
Raise awareness among the maternity team	• Take 5 – urgent message to all • Risky Business • Daily safety huddles • Share learning via email with senior midwives on Labour Suite (air conditioning in birth rooms).	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

	• Room temperature audit attempted (see comments) • **Educational piece in Risky Business** • **Message in Take 5**	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.
Instructions added to Warming Cots on F11	• Add instructions to all warming cots to ensure correct usage of equipment	
Explore possibility of procurement of Towel Warmer	• Towel warmer for Theatre/LS	For Theatres/LS. Promote maintainance of appropriate temperature at delivery and in early newborn period.

As a result of the original shared learning across the maternity unit, including: Midwives, MCA's, Obstetric and Anaesthetic Doctors and the Theatre and Neonatal Teams, there had been a significant reduction in babies admitted to NNU with a concurrent low temperature. Quarter 3 showed only two babies who were admitted with temperatures below the recommended threshold, accounting for 9.5% of total babies admitted at term. However, with such a stark increase noted in Quarter 4 new actions are required to raise awareness again across all teams in the maternity unit.

Other Actions for Quarter 4

Additional actions identified in Quarter 4 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 women and their babies.

Action	Plan	Comments
Education around UVC insertion	Educate and familiarise new Paediatric Registrars on guideline for Antibiotic administration	In progress – Dr Jageer Mohammed to provide feedback to team
Learning: GBS status not updated on eCare or buff notes	Highlight issue in Risky Business and Take 5	Completed
Learning: Low birth weight centile requiring specialised care plan	Amend local maternity guideline to reflect NNU guideline re: care of infants born on birth centile <0.4.	Proposal made to Guideline Midwife – awaiting guideline update.
Consistent information regarding antenatal steroids.	Information sheet in line with RCOG guidance to be produced for clinicians.	Project being overseen by Senior Obstetric Registrar.

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

West Suffolk NHS
NHS Foundation Trust

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

Report Title	**Report on compliance with Safe Obstetric Anaesthetic staffing from January to March 2022**
Report for	**Information and Approval of Actions**
Report from	Women's & Children's Services in collaboration with Theatres & Anaesthetics
Report Author	Beverley Gordon, Project Midwife, WSH
Dates and groups for approval	1. Maternity Quality and Safety 25th April 2022 2. Maternity and Neonatal Safety Champions 28th April 2022 3. Trust Board May 2022

Executive Summary

Background
This report has been written to confirm compliance with safe staffing requirements for obstetric anaesthesia within the Maternity Unit of West Suffolk NHS FT (WSNHSFT). The previous report provided evidence of compliance with safety standards for October -December 2021. This report covers the period January to March 2022.

Findings
The rotas for anaesthetic staff have been independently reviewed to ensure that there is a named staff member covering the on call obstetric rota for each 24-hour period. The findings confirm that there is allocation and identification of a dedicated anaesthetist for obstetric cases throughout this 3-month period.

Next steps
As there have been 2 periods of compliance, the next review and report will be completed in 6 months.

1. Background

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

2. Standards to be met

Safety action 4:

Can you demonstrate an effective system of clinical workforce planning to the required standard?

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

b) Anaesthetic medical workforce
A duty anaesthetist is immediately available for the obstetric unit 24 hours a day and should have clear lines of communication to the supervising anaesthetic consultant at all times. Where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patients in order to be able to attend immediately to obstetric patients. (ACSA standard 1.7.2.1)

Anaesthesia Clinical Services Accreditation (ACSA) standards and action

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

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

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

There is no fixed period of time that the rotas need to be reviewed so the Trust has taken the decision to review a further 3-month period from January to March 2022 and thereafter provide 6 monthly reports to ensure there is sustainability within the rota management.

3. Methodology

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

Rotas for this period of time were reviewed for evidence that there was a dedicated duty anaesthetist allocated for providing support to the maternity patients. These rotas were accessed directly from the electronic rota after the period of the audit was ended

so that any changes due to staff absence were accounted for, making it the most accurate record that it could be.

4. Results

All the rotas demonstrated that a staff member was allocated to hold the on-call bleep 770 during this period of time from January 1st 2022 to March 31st 2022. The rotas show that where the bleep holder is allocated to other duties – e.g. the elective caesarean section list – the bleep holder is working with other anaesthetists who can either continue with the planned activity or attend to provide obstetric anaesthetic services.

5. Current Compliance with Standards

Clinical Workforce Group	Standard to be met	WSH compliance	Progress Report	Evidence Source
Anaesthetic medical workforce	**Anaesthetic medical workforce** A duty anaesthetist is immediately available for the obstetric unit 24 hours a day and should have clear lines of communication to the supervising anaesthetic consultant at all times. Where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patients in order to be able to attend immediately to obstetric patients. (ACSA standard 1.7.2.1)			
	1.7.2.1 A duty anaesthetist is available for the obstetric unit 24 hours a day, where there is a 24-hour epidural service the anaesthetist is resident If this service is offered, rotas should be provided as evidence. If this service is not provided, patient information should be seen which relays exactly what services can be offered	**Yes**	**January - March 2022**	Rotas demonstrate 100% compliance for this period of time.

6. Conclusions

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

7. Recommendations

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

West Suffolk NHS
NHS Foundation Trust

Consultant Ward Rounds - High risk women admitted to Labour Suite

Woman and Children Health Division

Gill Hudson
Senior Midwifery Matron for Inpatient services

Project Team

Name: Gill Hudson	Title/grade: Senior Midwifery Matron for inpatient services

21.03.2022

Report status – complete

Background/Rationale

The process of twice daily consultant led ward rounds has been in place since January 2021. The Ockenden Report (2020) advised that there should be twice daily consultant led ward rounds as an important aspect of a strong safety culture within a maternity service.

Aim

Reaudit of compliance following initial audit in May 2021.To confirm adherence to standards of twice daily ward round by the consultant on call, to ensure women receive regular senior review of their care plans. Furthermore, to ascertain if the SIP communicated by a Senior Obstetrician for the same standard has been embedded.

Objectives

To ensure adherence to implemented standard of twice daily ward rounds as per MAT0064 Handover of Care

Standards

Adherence to MAT 0082 Handover of Care twice daily ward rounds by the On-Call Consultant Obstetrician.
http://staff.wsha.local/Intranet/MaternityGuidelines/docs/MAT-0082---Handover-of-Care-Dec2020.pdf

Adherence to Essential Action 3 Ockenden Report- Staff training and working together.
OCKENDEN REPORT - MATERNITY SERVICES AT THE SHREWSBURY AND TELFORD HOSPITAL NHS TRUST (ockendenmaternityreview.org.uk)

No.	Standard	Target %	Exceptions	Definitions
1.	Consultant led face to face ward round twice daily 7 days a week of all high-risk women on Labour Suite	100%	Women undergoing elective LSCS who will be seen on admission by the surgeon Women who are admitted to, and deliver on the MLBU. Postnatal women not requiring review.	

Methodology

This is audit was undertaken by the author of this document in her role as the Senior Midwifery Matron for Inpatient services. The findings of the audit will inform as to the success or the challenges of this service improvement and to offer assurance to the HSIB and CCG that actions arising from external investigations have been suitably addressed and also as evidence to support our implementation of the actions from the Ockenden report.

This audit was a simple snap shot retrospective review of all women who were admitted to Labour suite between 01/01/22 and the 08/01/22. Data was retrieved from the patient's

hospital maternity records via eCare for admissions between 1st and the 8th January. The data was collected and analysed, and the report compiled by the author of this document.

Results

No.	Standard	Target %	Findings		Comments
			n	%	
1.	Consultant led face to face ward rounds twice daily for all high-risk inpatients on Labour Suite	100%	34/34	100%	34 women received the consultant ward round appropriately 3 women excluded due to not meeting the criteria for ward rounds (MLBU, elective LSCS and uncomplicated postnatal not requiring review)

Conclusions

- 34 sets of notes were audited, 3 excluded.
- 34 women who were present on labour suite during the ward rounds received all reviews as set out in MAT 0082. All women had written documentation by the consultant or scribed by the registrar/SHO to support this.
- 12 women were on Labour suite for both the morning and the evening ward rounds and received comprehensive reviews.
- 10 women were present for one ward round and were either transferred to F11 or discharged home prior to the second ward round therefore not required.
- 11 women had rapid progress in labour and ward round review was not indicated.
- All of the reviews showed very good examples of robust well documented reviews by consultants outlining care plans.
- Twice daily face to face consultant labour ward round appears to be well embedded, there was good evidence of compliance (100%).

Recommendations

- Results show twice daily consultant led ward rounds are well embedded for women on the labour suite.

- Consideration should be given to consultant led ward rounds on the antenatal/postnatal ward. This would capture those inpatients whose labour commences following the evening ward round and birth prior

- Continue to audit to gain a greater understanding and assurance.

- An obstetric review template is now used on eCare which captures who is present on ward rounds to provide assurance that they are MDT. There was evidence this was utilised much more

References

Ockenden d, 2020, Maternity Services at the Shrewsbury and Telford Hospital NHS Trust

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/943011/Independent_review_of_maternity_services_at_Shrewsbury_and_Telford_Hospital_NHS_Trust.pdf *[Accessed 04.01.2021]*

Action Plan

Project title	Consultant Ward Rounds - High risk women admitted to Labour Suite

Action plan lead	Name: Gill Hudson	Title: Senior Midwifery Matron-Inpatient Services	Contact: gillian.hudson@wsh.nhs.uk

Ensure that the recommendations detailed in the action plan mirror those recorded in the "Recommendations" section of the report. The "Actions required" should specifically state what needs to be done to achieve the recommendation. All updates to the action plan should be included in the "Comments" section.

Recommendation	**Actions required** *(specify "None", if none required)*	**Action by date**	**Person responsible** *(Name and grade)*	**Comments/action status** *(Provide examples of action in progress, changes in practices, problems encountered in facilitating change, reasons why recommendation has not been actioned etc)*
To remain on audit plan for regular audit	Audit	Yearly	G Hudson (GH) / K Croissant (KC)	

West Suffolk NHS
NHS Foundation Trust

Maternity HSIB and Early Notification Reporting

Agenda item:	Item 4.6 Annex F			
Presented by:	Sue Wilkinson, Executive Chief Nurse/ Karen Newbury, Head of Midwifery/Justyna Skonieczny, Deputy Head of Midwifery			
Prepared by:	Karen Green, Clinical and Quality Matron; Beverley Gordon – Project Midwife			
Date prepared:	April 2022			
Subject:	**HSIB and Early Notification Reporting Quarterly Reports on Compliance – Report for Quarter 4 2021/22**			
Purpose:	X	For information	X	For approval

Executive summary:

This report provides details of the Trust compliance for Q4 2021/2022 with reporting of maternity incidents that meet the criteria for reporting to HSIB Maternity Investigations and the NHS Resolution Early Notification Scheme.

The Maternity Incentive Scheme (MIS) year 4 Safety Action 10 requires quarterly reports outlining the Trust's compliance with National Reporting requirements and duty of candour. In this quarter – January 1st 2022 to March 31st 2022 – there was one incident that met the initial criteria for reporting to HSIB and EN. However, when the baby was subsequently found to have no hypoxic injury, the investigation reverted to a local Patient Safety Report as part of the Trust incident management processes.

In accordance with the Duty of Candour Legal requirements, the mother of the baby was informed of the need to report this incident to HSIB and EN. She has subsequently been informed of the progress of the investigation.

The Trust is assured that the processes are being followed.

Previously considered by:	**Maternity Quality & Safety Group**	25/4/22
	Maternity and Neonatal Safety Champions	28/4/22
	Trust Board	***27/05/22***
Risk and assurance:	Immediate learning from the incidents have bee shared with the relevant staff.	
Legislation, regulatory, equality, diversity and dignity implications	Statutory duty of candour and referral to HSIB and EN	
Recommendation: For approval		

Introduction

In August 2021, Year 4 of the NHSR Maternity Incentive Scheme was published with 10 safety actions that Trusts are required to comply with or make progress towards complying with.

There were updates in December 2021 and further updates are awaited following the decision to update timeframes for submission of information and compliance. This report is part of the assurance of the Trust's compliance with Safety Action 10.

Safety action 10: Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) and to NHS Resolution's Early Notification (EN) scheme for 2021/22

Required standard

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

Qualifying cases:
In accordance with these defined criteria, eligible babies include all term babies (at least 37+0 weeks of gestation) born following labour, who have one of the following outcomes:
Intrapartum stillbirth: when a baby was thought to be alive at the start of labour and was born with no signs of life.
Early neonatal death: when a baby dies within the first week of life (0-6 days) of any cause.
Potentially severe brain injury diagnosed in the first seven days of life, when a baby:
• was diagnosed with grade III hypoxic ischaemic encephalopathy (HIE) or
• was therapeutically cooled (active cooling only) or
• had decreased central tone and was comatose and had seizures of any kind.

The defined criteria for maternal death investigations are: Maternal death: death of a mother while pregnant or within 42 days of the end of the pregnancy*, from any cause related to or aggravated by the pregnancy or its management, and not from accidental or incidental causes.
• Direct: deaths resulting from obstetric complications of the pregnant state (pregnancy, labour and puerperium), from interventions, omissions, incorrect treatment or from a chain of events resulting from any of the above. This excludes cases of suicide.
• Indirect: deaths from previous existing disease or disease that developed during pregnancy and which was not the result of direct obstetric causes, and which was aggravated by the physiological effects of pregnancy in the perinatal period (during or within 42 days of the end of pregnancy).

*Includes giving birth, ectopic pregnancy, miscarriage or termination of pregnancy

B) For qualifying cases which have occurred during the period 1 April 2021 to 31 March 2022 the Trust Board are assured that:
1. the family have received information on the role of HSIB and the EN scheme; and
2. there has been compliance, where required, with Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of the duty of candour

Qualifying incidents are term deliveries (≥37+0 completed weeks of gestation), following labour, that resulted in severe brain injury diagnosed in the first seven days of life. These are any babies that fall into the following categories:

- Was diagnosed with **grade III hypoxic ischaemic encephalopathy** (HIE) [OR]

- Was **therapeutically cooled** (active cooling only) [OR]
- Had **decreased central tone AND was comatose AND had seizures** of any kind.

A letter from NHSR in March 2022, outlined updated responsibilities:

'During the pandemic period NHS Resolution and the Healthcare Safety Investigation Branch (HSIB) were able to reduce reporting requirements with qualifying Early Notification (EN) cases being reported to NHS Resolution via HSIB. This was enabled by the Control of Patient Information (COPI) notice which allowed data-sharing between NHS and public bodies. This is due to expire at the end of March 2022.
With effect from 1 April 2022, trust legal teams are to notify NHS Resolution, via the Claims Reporting Wizard, of qualifying EN cases once they have been confirmed by HSIB as under investigation. Trusts will be required to continue to report their maternity incidents to HSIB via their electronic portal.
The statutory duty of candour continues to require trusts to communicate all investigatory processes underway to families including the HSIB and EN processes.

Key actions for trusts:

- *Trusts' legal teams to report incidents to NHS Resolution only where HSIB have confirmed they are investigating. These will concern cases where a baby has clinical or MRI evidence of neurological injury*
- *When reporting incidents to NHS Resolution, please include the HSIB reference in the 'any other comments' box*
- *Please select Sangita Bodalia, Head of Early Notification at NHS Resolution on the Claims Reporting Wizard*
- *Undertake statutory duty of candour conversations and inform families of the EN process.*
- *Please upload the final HSIB report to the corresponding CMS file when you have received this via DTS.*

What happens next?
Once the HSIB report has been shared by the trust, the EN team will triage and then confirm to the trust which cases will proceed to a liability investigation.'

Whilst the qualifying period was for all cases 2021/2022, the Trust will continue to provide quarterly reports on compliance throughout 2022 and 2023 to provide assurance that the process is embedded.

Quarter 4 2021/2022 Compliance Report

A) Reporting of all qualifying cases to HSIB

One case met the criteria for referral to HSIB in this period of time due to needing therapeutic cooling but this was subsequently declined by HSIB as the baby's MRI was deemed to be normal. A local Patient Safety Report is being completed due to learning identified in the review of the incident.

B) For qualifying cases which have occurred during the period 1st January 2022 to 31st March 2022 the Trust Board are assured that:
1. the family have received information on the role of HSIB and the EN scheme; and
2. there has been compliance, with Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of the duty of candour.

Baby/Mother ID	Date of birth (baby)	EN reportable?	Information given to parents re HSIB/EN	Date of Report to HSIB	Confirmed DoC
[redacted]	[redacted]	Initially yes but now No	Yes	11/2/22 – declined 24/2/22 – normal MRI.	Yes

Summary of WSH Compliance for Quarter 4 2021/22

One case was referred to HSIB in Q4 but under the revised criteria for investigation, this was declined by HSIB as the baby had a normal MRI prior to discharge home and he had not abnormal signs and symptoms of hypoxic injury at this stage. A clinical review was undertaken and a local Patient Safety Report will be undertaken by the Trust. A number of early learning points were identified and learning from this is being shared with the teams. The initial MDT meeting included an external reviewer from the CCG.

The mother had already been informed in a duty of candour letter 11/2/22 of the need to refer to HSIB and Early notification. She is being kept up to date with the progress of the local Patient Safety Report.

As a Trust, we are assured that incidents that need referral to HSIB and EN are being identified and appropriate duty of candour is being undertaken and the mothers and families are kept informed.

Next Steps

The Committees and Board are asked to receive and approve this report.

The next compliance report will be provided in July 2022 for Q1 2022-2023.

As any changes occur to the reporting and notification criteria, the Trust processes will be updated.

West Suffolk NHS
NHS Foundation Trust

Audit

Assessing Smoking Status
In women at booking and at 36 weeks gestation

Compliance with Saving Babies Lives V2
Element 1
and
Maternity Incentive scheme ten maternity safety actions
Safety Action 6

Women and Children's Health Division

Project Team

Karen Green	Clinical Quality and Governance Matron

Report date March 2022

Background/Rationale

There is strong evidence that reducing smoking in pregnancy reduces the likelihood of stillbirth. It also impacts positively on many other smoking-related pregnancy complications, such as preterm birth, miscarriage, low birthweight and Sudden Infant Death Syndrome (SIDS). Whether or not a woman smokes during her pregnancy has a far-reaching impact on the health of the child throughout his or her life.

Reducing smoking in pregnancy will reduce instances of fetal growth restriction, intrapartum complications and preterm birth.

Element 1 in Saving Babies Lives a Care Bundle V2 also reflects the wider prevention agenda, impacting positively on long term outcomes for families and society. It will enhance the midwives role in promoting public health messages and interventions.

Aim

Maternity providers are encouraged to focus improvement in the following areas:
For the purpose of this audit

- Effective identification of women who smoke during their pregnancies.

A threshold score of 80% compliance should be used to confirm successful implementation.

If the process metric scores are less than 95% Trusts must also have an action plan for achieving >95%

Objectives

- Measure the percentage of women where there is evidence of smoking status discussed at booking (in the absence of CO monitoring during the COVID pandemic)

- Measure the percentage of women where there is evidence of smoking status discussed at 36 weeks gestation (in the absence of CO monitoring during the COVID pandemic)

- Record that smoking cessation referral and advice on quitting has been offered

This data items for these indicators should be recorded on the provider's Maternity Information System (MIS) and included in the April 2020 MSDS submission to NHS Digital.

If there is a delay in the provider trust MIS's ability to record these data at the time of submission an in-house audit of 40 consecutive cases using locally available data or case records should have been undertaken to assess compliance with this indicator.

Currently the MIS does not include CO measurement at 36 weeks gestation therefore a review of records to assess compliance has been undertaken.

Standards

No.	Standard	Target %	Exceptions	Definitions
1.	Smoking in Pregnancy			
	All women should be offered Carbon Monoxide testing at their booking appointment and 36 weeks or status recorded if CO monitoring not available	>80% implemented >95% full compliance	Women who decline Must be documented Women who do not receive antenatal care with WSFT	
	CO measurement should be recorded in the records if available or smoking status recorded	>95% for compliance	Women who decline monitoring should have this documented Women who do not receive antenatal care with WSFT	
	Record that smoking cessation referral has been offered and documented if declined	100%		

Methodology

A retrospective audit of 40 women's maternity records who booked between 01/03//2022 to 04/03/2022 was undertaken to assess compliance with these indicators. Consecutive cases were identified as women birthing from the 01/04/21 until the 40th case was reached on the 10/04/21. At this time, CO monitoring had not been fully implemented after the Covid19 pandemic.

A data collection tool was developed to complete for all notes audited.

The data was analysed against the standards set out in SBLV2 after reading the relevant NICE guidance and recommendations will be made according to the findings. The findings will be discussed with the Head of Midwifery and the Clinical Quality and Governance Matron; report findings and actions will be presented at the Maternity and Gynaecology Quality and Safety Group and Divisional Board.

Results

No	Standard	Target %	Findings		Comments
			n	%	
1	Status CO monitoring at booking	>80% Or >95%	36/40	90%	Action plan in place

2	CO monitoring recorded at 36 weeks	>80% Or >95% no actions needed	38/40	95%	Compliant
3	Record that referral for advice and support with smoking cessation has been offered	100%	7/7	100%	Compliant

Presentation/Discussion

The audit results will be presented at the Maternity and Gynaecology Quality and Safety Group, Maternity Safety Champions meeting and Divisional Governance meeting for highlighting to the Trust Board.

Conclusions

Compliance at booking

The audit demonstrated a considerable improvement from the 2021 audit and is an interim audit to prepare for saving babies lives submission later this year. CO monitoring has been recommenced after being paused during the Covid 19 pandemic. Since the previous audit Ecare has been introduced into the maternity service and with the appointment of a Digital Midwife monitoring is now possible through Ecare reporting. This continues to be continually monitored through the monthly dashboard, presented and discussed at the MDT monthly Maternity and Gynaecology Quality and Safety Meeting.

A weekly oversight of compliance has been introduced enabling Matrons to have weekly oversight of all booking appointments and 36-week gestation appointment to ensure scrutiny of continued compliance

Compliance for 36 weeks

Compliance has been achieved at 95%, this is through the diligence and the commitment of the appointed smoking cessation midwife. The maternity department continues to measure ongoing compliance via the monthly quality dashboard, presented and discussed at the MDT monthly Maternity and Gynaecology Quality and Safety Meeting.

Learning Points

Telephone booking appointments continue to make data collection problematic by women attending a face to face appointment within 2 weeks where CO monitor can be achieved. The service should review the return of face to face antenatal booking appointments, to potentially save resources and assist in CO monitoring.

Action Plan

Project title	Assessing smoking status in women at booking and at 36 weeks gestation (in the absence of CO monitoring during COVID19 pandemic)

Action plan lead	Name: Karen Green	Title: Clinical Quality and Governance Matron	Contact: 01284 713275

Recommendation	Actions required	Action by date	Person responsible	Comments/action status
Continue to monitor compliance monthly on Quality Dashboard and weekly at the Ecare oversight meeting	None.	Ongoing	Clinical Quality and Governance Matron	Ongoing
Communicate and celebrate the 95% compliance at the 36-week appointment and communicate a positive message regarding the improvement of CO monitoring at booking.	Share in Risky Business – Maternity communication newsletter	31/05/22	Clinical Risk Midwife	
Present findings at maternity and Gynaecology Quality and Safety Meeting	Presentation	April 2022	Clinical Quality and Governance Matron	Complete
Consider the return to pre Covid face to face appointments at booking	Outpatient Service Manager to review the provision of face to face bookings	July 2022	Outpatient Service Matron	
Repeat audit in 1 year	Repeat audit April 2022	July 2022	Clinical Quality and Governance Matron	Included in annual audit plan

Audit of Compliance with Element 2 – Assessment of Risks for Fetal Growth Restriction in Pregnancy

April 2022

Audit completed by: Victoria McEwen-Smith. Clinical and Quality Assurance Midwife

Background/Rationale

This audit is to assess against the Saving Babies Lives Care Bundle Element 2: **Risk assessment, prevention and surveillance of pregnancies at risk of fetal growth restriction (FGR)**

This audit relates to effective assessment of women at their maternity booking using best practice guidance to identify women who may need additional growth surveillance based on social and physical risk factors and obstetric history.

Aim

To ensure that women who need additional fetal growth surveillance in pregnancy are identified at booking and offered a growth scan pathway.

Objectives

Percentage of pregnancies where a risk status for FGR is identified and recorded at booking.

This data items for these indicators should be recorded on the provider's Maternity Information System (MIS) and included in the April 2020 MSDS submission to NHS Digital.

If there is a delay in the provider trust MIS's ability to record these data at the time of submission an in-house audit of 40 consecutive cases using locally available data or case records should have been undertaken to assess compliance with this indicator.

Standards

No.	Standard	Target %	Exceptions	Definitions
1.	Percentage of pregnancies where a risk status for FGR is identified and recorded at booking.	A threshold score of **80%** compliance should be used to confirm successful implementation. If the process indicator scores are less than **95%** Trusts must also have an action plan for achieving >95%.	Multiple pregnancy	

Methodology

A retrospective audit of 40 consecutive cases of women who booked between 01/01/2022 and 06/01/2022 was undertaken to assess compliance with these indicators.

A data collection tool was developed and created for all notes that were included within this audit.

The data was analysed against the standards set out in SBLV2 after reading the relevant NICE guidance and recommendations will be made according to the findings. The findings will be discussed with the Head of Midwifery and the Clinical Quality and Governance Matron; report findings and actions will be presented at the Maternity and Gynaecology Quality and Safety Group and Divisional Board.

Results

No.	Standard	Target %	Findings		Comments
			n	%	
1.	Percentage of pregnancies where a risk status for FGR is identified and recorded at booking.	1. >80% 2. >95%	34/40	85	6 cases not recorded on Booking risk assessment form however appropriate follow up arrangements and scans completed. Action identified
2.	Number of women with risk factors for FGR at booking	N/A	23/40		

Presentation/Discussion

The results will be presented to the Maternity and Gynaecology Quality and Safety Group for information and monitoring. The Maternity Safety Champions will review this as part of the overall compliance with the 5 elements of Saving Babies Lives Care Bundle v2 and reporting to the Trust Board via the Head of Midwifery's and MSC monthly reports on Maternity Risk and Governance, Quality and Safety. This will also be part of the submission of the SBL survey reports to the Regional Maternity Clinical Network Quality Improvement Manager and as part of the highlight report to the Local Maternity and Neonatal Services (LMNS) Board.

Conclusions

This audit reviewed 40 consecutive pregnancies during January 2022. All cases reviewed within this audit had had a risk assessment form completed at booking. Of these 40, 6 cases had not had the form correctly completed and subsequently risk factors such as smoking and BMI were not recorded on this form. Despite this, all 6 cases were referred appropriately for additional monitoring as per SGA guidance indicating that there was awareness that the risk factor was present and there were not adverse outcomes from missed monitoring.

Compliance is therefore likely to be higher than the recorded 85%, however action identified to ensure that future audits return a compliance rate of >95%

Of the 23 cases that were identified with risk factors raised BMI >35 was the most frequently identified risk for SGA

Recommendations

This audit should remain as part of the annual audit plan to ensure that compliance is maintained at a high level, along with other elements of fetal growth management with

confirmation of growth scans taking place, offering of aspirin, measurement and recording of the symphyseal fundal height measurement when indicated.

It has been identified that further education is required to ensure that the risk assessment form is appropriately filled out to accurately document risks at booking. Whilst all cases had the appropriate additional monitoring required as per this standard, an incorrectly filled out form impacts upon data collection and reporting

Learning Points

From SBLCB v2:
2.15 Maternity providers are encouraged to focus improvement in the following areas:

a. Appropriate risk assessment at the beginning of pregnancy for placental dysfunction and the associated potential for growth restriction and robust referral processes to appropriate care pathways following this.
b. Appropriate prescribing of aspirin in line with this risk assessment in women at risk of placental dysfunction.
c. Effective measurement and recording of SFH.

2.16 Maternity providers will share evidence of these improvements with their Trust Board and the LMNS and demonstrate continuous improvement in relation to process and outcome measures

References

Maternity incentive scheme – year three: Conditions of the scheme: Ten maternity safety actions with technical guidance **Revised safety actions - updated March 2021**

Mothers and Babies Reducing Risk through Audits and Confidential Enquiries across the UK – MBRRACE UK – Perinatal surveillance and Confidential Enquiries

Ockenden Report: Emerging Findings and Recommendations from the Independent Review of Maternity Services at the Shrewsbury and Telford NHS Trust (December 2020)

Royal College of Obstetricians and Gynaecologists (2013). RCOG Green-Top Guideline 31: The Investigation and Management of the Small for Gestational Age Fetus. London: RCOG. Available from: https://www.rcog.org.uk/en/guidelines-research-services/guidelines/gtg31/

Royal College of Obstetricians and Gynaecologists (2011) RCOG Green-Top Guideline 57: Reduced Fetal Movement. London: RCOG. Available from: https://www.rcog.org.uk/en/guidelines-research-services/guidelines/gtg57/

Saving Babies' Lives Version Two A care bundle for reducing perinatal mortality March 2019

Woman and Children Health Division

West Suffolk NHS
NHS Foundation Trust

Action Plan

Project title	Audit of risk assessment for FGR babies at Booking appointment

Action plan lead	Name: Victoria McEwen-Smith	Title: Clinical and Quality Assurance Midwife	

Ensure that the recommendations detailed in the action plan mirror those recorded in the "Recommendations" section of the report. The "Actions required" should specifically state what needs to be done to achieve the recommendation. All updates to the action plan should be included in the "Comments" section.

Recommendation	Actions required	Action by date	Person responsible	Comments/action status	RAG rating
To ensure risk assessment form filled out correctly to document all risks	Communication to midwifery teams and those responsible for completing bookings to ensure correct documentation	31/05/2022	Outpatient Service matron/ Digital midwife	Escalated to persons responsible	
Repeat Audit in one year	Re-audit in April 2023	April 2023	Clinical Quality and Effectiveness Midwife	Included as part of Annual Audit plan	
Present findings at maternity and Gynaecology Quality and Safety Meeting	Presentation	April 2022	Clinical Quality and Effectiveness Midwife		
Continue Quarterly audit of SGA rates and present outcomes	Quarterly reports to be presented to Audit and Education meeting	Quarterly	Clinical Quality and Effectiveness Midwife		

RAG Key:

	No action required. Trust process that meets current recommendations in place and evidenced.
	Process in place. Minor action only required; in progress and on target to achieve.
	Action required and on target.
	Action required and overdue.

Audit report - Women with a BMI >35 at booking being offered serial growth scans in line with Saving Babies Lives Version 2

Women and Children's Health
Maternity Services

Project Team

Name Karen Green……..	Role…Clinical Quality and Governance Matron

Date March 2022

Background/Rationale

Saving Babies Lives Care Bundle Version 2 (SBLCB v2) has been produced to build on the achievements on version 1. While version 2 of this document continues to focus on the risk assessment, prevention and surveillance of pregnancies at risk of fetal growth restriction, it does so by focusing more attention on pregnancies at higher risk of fetal growth restriction (FGR).

This audit focuses on the surveillance for FGR in women with a BMI >35. Obesity is arguably the biggest challenge facing maternity services today. It is a challenge due to almost one in five of pregnant women being in this category. Surveillance for FGR for women with a BMI <35 is undertaken by midwives through fundal height measurement. This method is not suitable for women whose BMI exceeds 34.9. Serial US are required at 32, 36, and 39 weeks gestation to ensure that the fetal growth remains within normal limits.

Aim

To seek assurance that we have appropriate local guidance that supports the recommendations in SBLCB v2, and that the appropriate FGR surveillance is offered to women with a BMI >35. For further assurance scheduling and attendance of these serial USS was audited to ensure that the referral and communication processes were effective

Standards

The audit standards are included within the Maternity Clinical Guidelines:

MAT0005 ‘Prevention, detection and management of small for gestational babies ‘
MAT0014 ‘Care of Women with Obesity in Pregnancy’

No.	Standard	Target %	Exceptions	Definitions
1.	Women with a BMI of >35 will be referred for a higher risk pathway and serial growth ultrasound scans will be organised from 32 weeks.	>80% for embedding of guidance >95% for satisfactory standard	Woman who decline or scans not available	
2.	Serial growth scans were scheduled and attended by this cohort of women from 32 weeks	>80% for embedding of guidance >95% for compliance	None unless woman did not attend for individual reasons	

Methodology

40 women with a BMI >35 at booking, were identified though the maternity system. Records were reviewed for referral and scans undertaken. The cohort was identified from women delivering consecutively in March 2022 whose BMI was above 35 at booking.

Results

No.	Standard	Target %	Findings		Comments
			n	%	
1.	Women with a BMI of >35 at booking were referred to a high-risk pathway with serial scans from 32 weeks.	>80% 1st >95% 2nd	39/39	100%	97.5% last year 4 women excluded as upon investigation BMI was less than 35
2.	Serial growth scans were scheduled and attended by this cohort of women	>80% 1st >95% 2nd	31/34	91%	95% last year

Presentation/Discussion

100% attended 32-week appointment, 4 women had appointments arranged outside 1 week of their 32nd week of pregnancy. There is no supporting evidence why these were arranged at this gestation, it must be considered that these were rearranged at the patients request.

At 36 weeks 34 women attended their USS. Of those that didn't one woman had delivered, one could not attend due to being unwell with Covid and two had appointment in the 37th week of their pregnancy and therefore we did not meet the time frame suggested by SBL.

One woman did not receive an USS at 36 weeks, this appointment was unfortunately cancelled and not rebooked. She did receive a telephone appointment the week following her cancelled appointment. When she attended her 39-week USS appointment macrosomia and polyhydramnios identified earlier in pregnancy persisted and an elective caesarean section was performed soon after. The baby's birth was a difficult extraction in the presence of a general anaesthetic and was born with APGAR of 2,6,8. The baby was transferred to NNU. A Datix will be submitted for investigation.

At 36 weeks only 14 women required an USS and all of them attended within the time frame, the others had either birthed their baby of were undergoing the induction of labour process.

The results show that the standard demonstrated outstanding compliance with identification at booking for the required USS. This was a slight increase from last year.

Women attending the USS throughout pregnancy generally shows high compliance. One that is of concern is those USS that are booked or have been rearranged outside of the SBL timeframe. There was no documentation to support why this may have happened. The scheduled for USS scan must meet the standards as set out in SBL, if a woman requires an appointment to be rearranged there should be clear documentation of this.

Of concern is the case of a missed USS due to the appointment being cancelled on the patient appointment booking system. No further USS was offered until 38 weeks in a very high-risk pregnancy. A Datix will be submitted for this case.

The results of this audit will be submitted as part of evidence against the Trust's SBL ambition and will be shared with staff at the Maternity and Gynaecology Quality and Safety Group, Maternity Safety Champions Group and as part of the Divisional Board report for Maternity Quality and Governance.

Conclusions

Findings show that compliance with the referral for a higher risk pathway and serial scans is met to a high standard. Once referred, serial growth USS were undertaken as required 91% of the time. Whilst this standard has dropped slightly from the last audit, compliance is still high. Further work is required to improve to 100%

Recommendations

Feedback results to staff groups in all areas.

Ensure the current guidelines for scan schedules are embedded in practice and any changes disseminated to all relevant staff groups.

Re-audit in 1 year as part of the audit plan or sooner for SBL CNST submission

Learning Points

Risk assessment at each contact will ensure that if the previous indications for growth scans have been missed, this can be picked up and rectified at any stage.

References

National Guidance
Saving Babies Lives Care Bundle version 2 March 2019
RCOG Small for Gestational Age (green top guideline)

Trust Maternity Clinical Guidelines
MAT0005 'Prevention, detection and management of small for gestational babies '
MAT0014 'Care of Women with Obesity in Pregnancy'

Action Plan

Project title	Women with a BMI >35 at booking being offered serial growth scans in line with Saving Babies Lives Version 2

Action plan lead	Name: Karen Green	Title: Clinical Quality and Governance Matron	Contact: 3219

Recommendation	Actions required	Action by date	Person responsible	Comments/action status
Staff awareness of the findings of the Audit	Present results at Maternity Risk and Governance Group, Maternity and Gynaecology Quality and Safety Group; Maternity Safety Champions, and through HOM Quality report.	31/3/22	Clinical Quality and Governance Matron	Presented April 2022
	Share on Maternity Risky Business Newsletter	31/5/22	Clinical Risk Midwife	
Antenatal Clinic should ensure that USS are arranged within the standards set out in SBL	Feedback from audit and re-audit in 6 months	01/10/22	Antenatal Clinic Lead Midwife	
Datix submission for the case of cancelled USS	Datix investigation and actions on Datix system	01/06/212	Antenatal Clinic Lead Midwife	
Re-audit to establish that guidance is embedded and care is appropriate and effective	Add to annual audit plan	31/7/22	Clinical Quality and Governance Matron	Added to audit plan

Audit of Compliance with Element 3 Reduced Fetal Movements Best Practice Guidance

April 2022

Audit completed by:
Karen Green, Clinical Quality and Governance Matron
Alayna Gates, MDAU Lead Midwife

Background/Rationale

This audit is to assess against the Saving Babies Lives Care Bundle (SBLCB v2 March 2019) Element 3: Raising awareness amongst pregnant women of the importance of reporting reduced fetal movements (RFM), and ensuring providers have protocols in place, based on best available evidence, to manage care for women who report RFM.

Aim

To ensure that women are offered information on monitoring fetal movements in pregnancy by 28 weeks and know who to contact if they have concerns.

Objectives

To ascertain that women are receiving the information they need to be able to identify and report RFM in accordance with SBLCBv2:

3.1 Information from practitioners, accompanied by an advice leaflet (for example, RCOG or Tommy's leaflet) on RFM, based on current evidence, best practice and clinical guidelines, to be provided to all pregnant women by 28+0 weeks of pregnancy and RFM discussed at every subsequent contact.

3.2 Use provided checklist to manage care of pregnant women who report RFM, in line with national evidence-based guidance (for example, RCOG Green-Top Guideline 5737).

Standards

No.	Standard	Target %	Exceptions	Definitions
1.	Percentage of women booked for antenatal care who had received leaflet/information by 28+0 weeks of pregnancy.	A threshold score of **80%** compliance should be used to confirm successful implementation. If the process indicator scores are less than **95%** Trusts must also have an action plan for achieving >95%.	Women decline information Women who receive antenatal care from neighbouring Trusts	Information will usually be in written information in a language that women can understand. Information will be available on websites and information boards and other media forums.

2.	Percentage of women who attend with RFM who have a computerised CTG.	A threshold score of **80%** compliance should be used to confirm successful implementation. If the process indicator scores are less than **95%** Trusts must also have an action plan for achieving >95%.		

Methodology

Audit of 20 consecutive women who attended MDAU with reduced fetal movements from 1/1/22 and discontinued when 20 cases reached.

Results

No.	Standard	Target %	Findings		Comments
			n	%	
1.	Women receiving the reduced fetal movement leaflet by 28/40 75% - Compliance not reached	1. >80% 2. >95%	14/17	82%	3 excluded due to care received at neighbouring Trust
2.	Women attending MDAU and receiving a Dawes Redman CTG	1. >80% 2. >95%	20/20	95%	No documentation on the electronic system that DR was used

Presentation/Discussion

The results will be presented to the Maternity and Gynaecology Quality and Safety Group for information and monitoring. The Maternity Safety Champions will review this as part of the overall compliance with the 5 elements of Saving Babies Lives Care Bundle v2 and reporting to the Trust Board via the Head of Midwifery's and MSC monthly reports on Maternity Risk and Governance, Quality and Safety. This will also be part of the submission of the SBL survey reports to the Regional Maternity Clinical Network Quality Improvement Manager and as part of the highlight report to the Local Maternity and Neonatal Services (LMNS) Board. They will also be shared with neighbouring Trusts where non-compliance has been identified in order to improve practice and documentation.

Conclusions

This audit demonstrates that documentation of information on fetal movements in pregnancy by 28 weeks demonstrates successful implementation, however it is below the compliance we

anticipated. This compliance has been impacted by the introduction of the new digital patient records.

Where non-compliance was found midwives were contacted to explore the challenges and barriers to providing information to women regarding reduced fetal movements. In all cases midwives report the sign posting to the leaflet to be an important and routine aspect of the care they provide and felt that the digital patient safety system was difficult to navigate and that they hadn't indicated the giving of the leaflet in the correct box. It is reassuring that midwives report the giving of information is embedded and we are providing a safe high-quality service. However, the audit does not support this. Additional communication must be sent to all community midwives at the soonest opportunity.

Once identified, 95% of women are having appropriate fetal monitoring using an electronic recording (Dawes Redman).

Learning Points

Ecare is a barrier to capturing compliance and this must be addressed by the Digital Midwife to ensure that we are capturing an accurate representation of the service we are giving.

OOA women were excluded in this audit which differs from previous audits. This decision has been taken due to these women receiving antenatal care from a team not affiliated with WSFT.

Recommendations

As compliance falls below an acceptable standard, the audit of information sharing will need to be repeated by the team leaders. Compliance with the provision of the RFM leaflet will be added to the weekly Ecare oversight meeting. Additionally, this audit should be part of the annual audit plan to ensure that compliance is maintained at a high level, along with other elements of SBLCB v2.

References

Maternity incentive scheme – year three: Conditions of the scheme: Ten maternity safety actions with technical guidance

Mothers and Babies Reducing Risk through Audits and Confidential Enquiries across the UK – MBRRACE UK – Perinatal surveillance and Confidential Enquiries

Ockenden Report: Emerging Findings and Recommendations from the Independent Review of Maternity Services at the Shrewsbury and Telford NHS Trust (December 2020)

Royal College of Obstetricians and Gynaecologists (2013). RCOG Green-Top Guideline 31: The Investigation and Management of the Small for Gestational Age Fetus. London: RCOG. Available from: https://www.rcog.org.uk/en/guidelines-research-services/guidelines/gtg31/

Royal College of Obstetricians and Gynaecologists (2011) RCOG Green-Top Guideline 57: Reduced Fetal Movement. London: RCOG. Available from: https://www.rcog.org.uk/en/guidelines-research-services/guidelines/gtg57/

Saving Babies' Lives Version Two A care bundle for reducing perinatal mortality March 2019

Action Plan

Project title	Audit of Information given to women regarding fetal movements by 28 weeks and compliance with electronic CTG for RFM

Action plan lead	Name: Karen Bassingthwaighte	Title: Antenatal and Community Senior Matron	

Recommendation	Actions required	Action by date	Person responsible	Comments/action status
Digital midwife to provide communication to community midwives regarding the appropriate use of Ecare	Communication email	01/05/22	Digital Midwife	
Weekly oversight at the Ecare oversight meeting attended by all Matrons	Add to the weekly audit	01/05/22	Clinical Quality and Governance Matron	
Audit in 6 months and annually as per SBL submission	Add to audit plan and re-audit	30/09/22	Clinical Quality and Effectiveness Midwife	

West Suffolk NHS
NHS Foundation Trust

Response to the Royal College of Obstetricians and Gynaecologists (RCOG) Recommendations from the Publication June 2021

Report Title	Obstetric Clinical Workforce and Roles and Responsibilities – West Suffolk NHS Foundation Trust
Report for	Approval and Information
Report from	Maternity Services
Lead for Safety Action	Kate Croissant
Report Author	Kate Croissant Beverley Gordon
Report Submitted for Information and Approval	1. Maternity and Neonatal Safety Champions – December 23rd 2021 2. Quality and Safety April 25th 2022 3. Trust Board – May 27th 2022
Date of Report	17/12/21

1. Purpose

In **June 2021**, the RCOG published a paper entitled 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology' (https://www.rcog.org.uk/en/careers-training/workplace-workforce-issues/roles-responsibilities-consultant-report/). The purpose of this report was to strengthen the roles and responsibilities of consultants within Obstetric and Gynaecology Services. The initial statement within the document reads as follows:

'Successive maternity reports have identified the important role consultants play in being key clinical decision makers, maintaining standards, reducing variations in patient care and role modelling professional behaviour. There is a need for consultants to be visible and effective leaders across both acute obstetrics and gynaecology.
This Paper refines the previous RCOG Good Practice Paper 'Responsibility of Consultant On-Call' published in 2009. It defines the roles and responsibilities of the consultant and examines the organisational support required.'

The document goes on to give a disclaimer:

'Disclaimer
The Royal College of Obstetricians and Gynaecologists (RCOG) has produced this guidance as an aid to good clinical practice and clinical decision-making. This guidance is based on the best evidence available at the time of writing, and the guidance will be kept under regular review as new evidence emerges. This guidance is not intended to replace clinical diagnostics, procedures or treatment plans made by a clinician or other healthcare professional and RCOG accepts no liability for the use of its guidance in a clinical setting.
Clinicians and other healthcare professionals may consider it appropriate to depart from specific guidance in certain circumstances, such as serious staff shortages, emergencies or unforeseen absences. In such cases, RCOG strongly recommends that any such departure from local clinical protocols or guidelines should be fully documented in the patient's case

notes at the time the relevant decision is taken, and that the rationale for such departure is recorded elsewhere and reported, as appropriate.'

In **August 2021**, the Year 4 Maternity Incentive Scheme was launched and Safety Action 4 – Clinical Workforce – part a) Obstetric Workforce - indicates that the Trusts should review the RCOG publication and provide evidence against 2 aspects of this:

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 https://www.rcog.org.uk/en/careers-training/workplace-workforce-issues/roles-responsibilities-consultant-report/

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 the Local Maternity and Neonatal Service (LMNS).

Evidence required:
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 every 6 months.

The purpose of this report is to acknowledge the contents of this publication and confirms the areas that the Trust has already committed to and outlines how it proposes to take other aspects of organisational management forward.

2. Review of RCOG document and Trust progress

The Trust has reviewed the RCOG document against the current clinical and operational aspects of the obstetric workforce and this document provides evidence of progress towards the standards expected and actions taken to improve quality and safety of care within the Maternity Services provided by West Suffolk NHS Foundation Trust (WSNHSFT) at the time of this report (December 2021).

The RCOG document is divided into 2 main sections – 'Roles and Responsibilities' and Organisational Support and Structure.

Roles and Responsibilities:

Team Leader and Role Model
Leadership roles and structures are in place as follows:

- Leads are appointed for aspects of clinical sub-specialities including all aspects of clinical governance – guidelines; audit, safety, training and education (including supervision of staff); named leads for fetal monitoring, labour ward, maternal medicine, perinatal mental health, maternity day assessment unit, antenatal screening, fetal medicine, as well as having a named Clinical Lead for Obstetrics.
- Multi-disciplinary (MDT) consultant led ward rounds twice daily, safety huddles, labour ward forum, Quality and Safety meetings
- Educational Supervisors for each trainee

- Networking with local and regional MDT groups such as the LMNS and Maternal Medicine networks

Clinician

- There is clarity within the Standard Operating Procedure relating to the roles and responsibilities of the Consultant Obstetrician and expectations for attendance and presence within the unit for certain clinical situations
- The rota is actively managed to ensure there is an effective, safe, skill mix for each shift, with a dedicated on call Consultant available 24/7. Whilst on call, the consultant will not have responsibility for managing planned activities such as clinics and elective surgery lists
- The named Consultant leads on individualised care pathways for women, referring for additional specialist support when indicated
- The consultants comply with the need for revalidation 5 yearly
- The annual appraisal is completed to identify objectives to improve and enhance practice and to celebrate successes and achievements
- Lead fetal monitoring training and participate in assessment of competence
- Skilled in leading and undertaking clinical and emergency procedures, including attendance at MDT training

Trainer and supervisor

- Educational supervisors are allocated for all trainees and are involved in supporting staff involved in incidents, complaints and external investigations
- Induction programme for new staff with local introduction programme for trainees
- GMC surveys results provide positive feedback for the maternity teams
- HEE assessments and reports indicate a high level of support within the learning environment
- Peer support when required
- Debrief sessions following incidents
- Formal process for sharing of training needs
- Allocation of 'trainee in need' trainees to the Trust for supportive learning and experience

Risk manager

Managing risk is everyone's business and the Consultants are involved in this as they participate in activities that are in place within the Governance structures and processes:

- Incidents are discussed at the daily Maternity huddle and there is consultant involvement in clinical reviews of incidents, mortality and morbidity cases and complaints and concerns raised about care
- Consultants are involved in risk assessments of women and clinical care, anticipating any potential for harm or for patient safety incidents to occur or recur.
- Involvement in review of the maternity risk register
- Planned activity is cancelled to allow staff to attend audit and education meetings where learning is shared

Patient advocate

The Consultant is an advocate for women by:

- Participating in completing 'Duty of Candour' with patients and families following incidents and unexpected outcomes, answering questions or escalating any concerns or issues raised by the patient or family
- Providing support for women who request care outside of guidance and/or need a specific care pathway in place

- Working with PALS and being part of the review of complaints and learning from these – including feeding back to staff when indicated and ensuring that lessons are learned and shared
- Providing opportunities for feedback meetings with women and families following incidents and concerns being raised. This includes feeding back on what the Trust will change if needed
- Involvement in MVP meetings and patient focussed working groups such as discussions about induction of labour

Innovator

The consultants participate in:

- Introducing new procedures and techniques to improve safety and quality of care – e.g. Dilipan for IOL
- Quality Improvement (QI) projects
- Covid responses and responding to national safety drivers e.g. from face to face to telephone appointments
- Responding to complaints and surveys on patient experience and environmental concerns
- Responding to changes and updates to clinical practice and recommendations from national reports such as NICE guidance and confidential enquiries such as Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE) as well as local and national reports from nationwide partners such as HSIB.

Organisational support and structure:

Adequate staffing

- Rota management – increase in consultant complement with an additional tier for covering the service
- Management of short- and long-term sickness and absence – ongoing challenges during the last 2 years
- Business case to increase the establishment

Compensatory rest

- Changes to job plans and on-call commitments have taken place to allow for compensatory rest with a maximum 24 hours on call in any period of time
- If required to 'act down' a compensatory rest period is given following this period of duty

Job planning

- The annual job planning process is in progress December 2021 to recognise the increase in demands and to allow roles and responsibilities to be undertaken

Continuing professional development

- Professional leave can be applied for to undertake other learning activities outside of the mandatory training in place in the Trust
- 1.5 (6hours) SPA (Supporting professional activity) is given each week to undertake specific roles and duties
- Attendance at local MDT training and education sessions

Conflict with scheduled activities

- The Trust is moving to a full separate Elective caesarean section (CS) team (in addition to the on-call team) for 3 lists per week. Currently the on-call theatre team cover

emergency and elective cases which can impact on delayed decision to delivery times. A separate consultant obstetrician is allocated to undertake or oversee the CS lists. The CS lists are managed to ensure the correct level of expertise is available for complex cases

- The job planning has also taken into consideration and reduced the number of clinical areas covered by the on-call team to enable focus on labour ward/inpatient activity only

Prioritising wellbeing

The Trust has invested in a number of resources to support staff wellbeing:

- Wellbeing courses and activities for all staff are advertised and encouraged
- There is signposting to the Trust wellbeing team
- Freedom to Speak Up Guardians have been appointed
- Peer support
- Debriefing for staff and support following incidents and during investigations
- Celebrating successes – Greatix, compliments and positive feedback to staff
- Staff spaces outside of the clinical areas have been allocated
- Team meetings take place – face to face or on TEAMS if needed

3. Actions taken

- The standard operating procedure regarding the Roles and Responsibilities of the Consultant Obstetrician has updated and is awaiting final approval and publication
- Clinical guidelines are being updated to reflect responsibilities and escalation of clinical situations where the consultant should attend. The monitoring process is being developed so that each of these situations can be assessed to ensure the consultant has been asked and attends when required
- The Job Planning process is in the latter stages of completion and the funding from the Ockenden workforce planning has been released

4. Conclusions

- The Trust has made significant progress in addressing the recommendations from the RCOG publication to ensure the Consultant Obstetricians are able to undertake their work safely and effectively.
- The job planning processes has addressed many of the aspects of service provision and safety for the staff that have previously been a concern.
- The process for monitoring of the consultant presence in certain clinical scenarios is being piloted and confirmed so that this is in place from January 2022.
- The Maternity Service is utilising the available resources to ensure that the consultants understand and are able to undertake their roles and responsibilities

5. Next steps

a) Complete job planning process and receive confirmation of sign off of plans **– by 31/1/22**
b) Ockenden funds utilised for posts to be advertised **– by 31/1/22**
b) Dedicated Elective CS teams – **in place from March 2022**
c) Dedicated area for on call team to be able to attend to administrative duties **– 31/12/22 or once work on fabric of building completed and/or effects of the pandemic have eased**
d) Further developments in supporting staff with Schwartz rounds and other learning events **– 31/12/22 or sooner if the effects of the pandemic are eased**
e) Ongoing monitoring of Consultant presence for clinical scenarios **– from 1/1/22**
f) Complete review and report on further progress **– Review April 2022, interim report to Board May 2022, thereafter 6 monthly reports.**

Report on Paediatric Medical Staffing for the Neonatal Unit - Report for September 2021 to February 2022

Report Title	**Paediatric Medical Staffing in the Neonatal Unit 1st September 2021 to 28th February 2022**
Report for	Information and Approval
Report from	Women's & Children's Services
Report Author	Beverley Gordon, Project Midwife, WSH Dr Jageer Mohamed, Neonatal Safety Champion

Executive Summary

In order to evidence safe staffing levels within the neonatal and maternity services, a review of the paediatric junior medical staffing has taken place over a 6-month period to ensure the staffing meets the British Association of Perinatal Medicine (BAPM) standards for a level 1 Special Care Unit.

Conclusions
The Trust meets the standards expected during this period of time. This has been achieved by rota management, the use of locums and staff acting down when required to provide safe staffing levels. It is not always clear from the rotas when clinical activities or training has been restricted due to shortages.
The amount of locum usage has increased in this period of time due to short and long-term absences, vacancies and delay in staff being in post.

Next steps
Further work is required to ensure the process for obtaining safe staffing levels is formalised and embedded and the systems accurately reflect the work involved in maintaining standards. Whilst this work is being undertaken effectively and there are no concerns with the rota cover or management, a written and agreed process would make this clear and available to all.

There should be evidence of escalation if there are concerns regarding the staffing establishment and allocation of trainees to the Trust. This would include business case presentation to the Division and Trust if required, for maintenance of a safe service, service development and improvement.

With the pandemic easing, there should be quarterly reports on the use of locums to demonstrate that the appropriate staffing levels are in place and locum usage is appropriate and reducing if vacancies are filled and the establishment is correct.

This report will need to be repeated every 6 months as assurance of standards being maintained and progress on other safety and quality actions.

1. Background

NHS Resolution is operating a fourth year of the Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme to continue to support the delivery of safer maternity care. There are 10 safety actions for Trusts to have in place to assure the women, families and the NHS of their commitment to safety.

The neonatal unit at the West Suffolk Hospital NHS Trust is a designated Special Care Baby Unit (level 1).

In the submission for evidence in year 3 of the Maternity Incentive Scheme in July 2021, the Trust declared that they were compliant with the BAPM requirements and therefore an action plan was not required.

In August 2021, year 4 Maternity Incentive Scheme was launched the Safety Action was relatively unchanged and the expectation is that Trust embeds the process for assessing and responding to the findings on a 6-monthly basis. This is to ensure that medical staffing of neonatal services continues to meet the standards expected for safety and quality of care for neonates from birth.

Processes involved in review and rota management

The rotas have been reviewed for the period of time covered by this report – 1st September 2021 to 28th February 2022.

The Paediatric medical staff rotas are kept up to date by the Assistant Service Manager who is also currently fulfilling the role of the rota coordinator, and one of the personal assistants to the consultant paediatrician.

The consultant paediatrician rota is recorded on an Excel spreadsheet and includes data on the consultant paediatrician's rota for 4 key areas: the consultant paediatrician on call for the week (or day); the consultant paediatrician on call for the night; the consultant paediatrician who is allocated/dedicated to the neonatal unit cover Monday, Wednesday and Friday mornings; the consultant allocated to Children's Assessment Unit (CAU) and the Emergency Department (ED) 9.00-13.00 and 13.00-17.00 Monday to Friday (except Public Holidays). There are 15 consultants on the rota, 3 of these are acute consultants.

The rota does not give details of any other clinical activity such as clinics so the information on how the escalation works in practice when consultant paediatricians have to be diverted from one activity to cover the on call is limited.

An electronic health roster is used for the Tier 1 and Tier 2 paediatric staff. The roster gives details of the Tier 1 and Tier 2 doctors allocated to various aspects of the paediatric service. During the normal working day – Mondays to Fridays 9.00-17.00 – there is specific Tier 1 and Tier 2 cover to the Neonatal Unit, Maternity wards and attendance at births when required. From 17.00-21.00 and overnight and weekends there is one Tier 1 and one Tier 2 doctor covering the paediatric services including neonatal unit, maternity wards and attendance at births.

Some support for neonatal care is provided by Registered Nurses who have completed training to Advanced Children's Nurse Practitioner level (NB not neonatal nurse practitioner level). The nurse practitioners who cover neonatal care undertake the Neonatal Life Support (NLS) training locally and the 3 yearly external training. They are not included on the on-call rota. In addition, Physician Associates (PA's) are employed to assist the Tier 1 doctors. They are also not on the on-call rota.

The health roster gives details of the consultant paediatrician's leave – planned and unplanned, planned training days/courses and indicates if the consultant is covering

the rota at Tier 1 and Tier 2 level. Some of this cover is planned as part of their role (the acute consultants for example) and some as part of escalation to cover staffing shortages.

The electronic health roster gives the names of locums used across all grades. If the shift is not covered, this will be in red on the roster. Usually a locum is requested if time allows and if this is not successful, existing staff will be asked to provide cover either by reallocating planned work or by providing cover as a locum. If this is also unsuccessful, the consultants will be asked to 'act down' and another consultant will take over the on-call duties.
Some of the 'acute' consultants cover the work of the Tier 2 on a regular, planned basis. The experienced Specialist doctor (Staff, Associate Specialist and Speciality doctor - SAS) provides cover at Consultant level when required as well as at Tier 2.
The consultants usually cover the day and night from Friday morning through to Monday morning and the full 24 hours of public holidays.

2. Standard to be achieved:

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

This report relates to the neonatal medical workforce specifically.

Standard expected for the Neonatal medical workforce
The neonatal unit meets the British Association of Perinatal Medicine (BAPM) national standards of junior medical staffing.

Neonatal medical workforce
The Trust is required to formally record in Trust Board minutes whether it meets the recommendations of the neonatal medical workforce training action. If the requirements are not met, Trust Board should evidence progress against the action plan developed in year 3 of MIS to address deficiencies.

If the requirements had not been met in both year 3 and year 4 of MIS, Trust Board should evidence progress against the action plan developed in year 3 of MIS as well include new relevant actions to address deficiencies.

If the requirements had been met in year 3 without the need of developing an action plan to address deficiencies, however they are not met in year 4, Trust Board should develop an action plan in year 4 of MIS to address deficiencies.

Technical Guidance: Neonatal Workforce standards and action

Do you meet the BAPM national standards of junior medical staffing depending on unit designation?
If no, Trust Board should outline progress with the action plan developed in year 3 of MIS and submit this to the Neonatal ODN.
There should also be an indication whether the standards not being met is due to insufficient funded posts or no trainee or/suitable applicant for the post (rota gap). There should also be a record of the rota tier affected by the gaps.

BAPM
"Optimal Arrangements for Neonatal Intensive Care Units in the UK. A BAPM Framework for Practice" 2021
or

"Optimal arrangements for Local Neonatal Units and Special Care Units in the UK including guidance on their staffing: A Framework for Practice" 2018

Special Care Unit (SCU)
Tier 1
A resident tier 1 practitioner dedicated to the neonatal service in day-time hours on weekdays and a continuously immediately available resident tier 1 practitioner to the unit 24/7. This person could be shared with a co-located Paediatric Unit out of hours.
Tier 2
A resident tier 2 to support the tier 1 in SCUs admitting babies requiring respiratory support or of very low admission weight <1.5kg. This Tier 2 would be expected to provide cover for co-located paediatric services but be immediately available to the neonatal unit

Reporting Period
A review has been undertaken any 6-month period before 30 June 2022. Whilst this is a fixed period of time set by the MIS year 4 safety actions, it is expected that this process is an ongoing process of assessment and review each and every year. The Ockenden recommendations indicate that a 6 monthly reporting process is required to maintain standards and identify areas we need to escalate and manage.

3. Findings

Review of rotas
Having reviewed the rotas, there were 'red' areas on the rota where it appeared that shifts were not covered. On closer inspection, however, and a review of all the staff on duty, all of these shifts appeared to be covered with existing staff being reallocated, locum staff or acting down meaning that the rota has no unfilled shifts and the red banner was inaccurate.

This review and analysis confirm that **the Trust meets the BAPM standards of junior medical cover** for the Neonatal Services provided by the Trust and the Special Care Baby Unit during this period of time.

Additional findings

- There were a number of absences when staff across all grades had to isolate due to Covid 19 restrictions and high levels of infection in this period of time.

- **Consultant Paediatricians:**
  It is noted that during this period of review that there was one consultant paediatrician who retired – the Neonatal Safety Champion – and there has been a delay in the recruited consultant starting due to personal reasons. This is expected to be resolved in August.
  In addition, there were 3 consultants who had long term sick leave.
  Some short and long-term shifts have been covered by reallocation of duties, locum consultants and the SAS doctor has also provided consultant cover in addition to covering Tier 2 shifts as a routine basis.

- **Tier 1 and 2:**
  The use of locums has increased in the period of time covered by this report – the table below indicates an approximation of the number of shifts month by month, and the locums used at each tier. The amount of money spent on locums has therefore increased alongside this. The shortage of Tier 1 doctors

is due to not having a full complement of trainees due to resignations, maternity leave, and staff requiring non-clinical work for various reasons as well as short and long-term sick leave. It is also in part due to not having the required number of trainees allocated. This has been raised through the clinical tutor.

There are internal and external locums: the internal locums are staff who do additional hours to their contracted hours. The number of additional hours undertaken is kept within the maximum hours allowed under these circumstances for any one individual doctor. The external locums are obtained through the agreed Trust processes.
In addition, some consultants will be required to act down to fill rota gaps, especially if this is required at short notice. If the consultant on call needs to act down, another consultant will be requested to take over the on-call role.
As the consultants usually cover the day and night cover from Friday morning through to Monday morning and the full 24 hours of public holidays, where the consultant is covering as a locum in these periods of time, only one session for the whole 24 hours has been counted in the numbers. At all other times, during normal week days and nights, this is counted as individual sessions of locum cover for day and/or night.

Table 1 Use of Locum medical staff September 2021 to February 2022

MONTH	CONSULTANT	TIER 2	TIER 1
September	0	7	5
October	1	0	7
November	5	5	2
December	5	4	7
January	12	16	13
February	4	16	3

The use of locums is set to decrease with long term sick leave coming to an end, the Tier 1 and Tier 2 trainee gaps being filled and the consultant posts being filled.

4. Compliance with Standards - Does the Trust meet the BAPM national standards of junior medical staffing depending on unit designation?				
Workforce Group	**Standard to be met**	**WSH compliance**	**Progress Report**	**Evidence Source**
Neonatal medical workforce	The neonatal unit meets the British Association of Perinatal Medicine (BAPM) national standards of junior medical staffing. If the requirements had not been met in both year 3 and year 4 of MIS, Trust Board should evidence progress against the action plan developed in year 3 of MIS as well include new relevant actions to address deficiencies. If the requirements had been met in year 3 without the need of developing an action plan to address deficiencies, however they are not met in year 4, Trust Board should develop an action plan in year 4 of MIS to address deficiencies. If no, please submit a Trust board approved action plan to the Neonatal ODN. There should also be an indication whether the standards not being met is due to insufficient funded posts or no trainee or/suitable applicant for the post (rota gap). There should also be a record of the rota tier affected by the gaps. BAPM "Optimal Arrangements for Neonatal Intensive Care Units in the UK including	**Yes**	**GREEN**	**Neonatal medical workforce** Neonatal medical workforce Six-month period between 1st September 2021 and 28th February 2022. Evidence received to say rota covered with correct tiers as per guidance - rotas reviewed as evidence. Physical rotas for consultants and Health Roster analysed for Tier 1 and Tier 2. Report written and submitted through the Divisional Governance processes and formal record in Trust Board minutes that the Trust meets the recommendations of the neonatal medical workforce training action or if the requirements are not met, action plan to meet the recommendations and evidence that this is signed off by the Trust Board.

	guidance on their Medical Staffing" 2014 or "Optimal arrangements for Local Neonatal Units and Special Care Units in the UK including guidance on their staffing: A Framework for Practice" 2018 **SCU Special Care Unit** **Tier 1** A resident tier 1 practitioner dedicated to the neonatal service in day-time hours on weekdays and a continuously immediately available resident tier 1 practitioner to the unit 24/7. This person could be shared with a co-located Paediatric Unit out of hours. **Tier 2** A resident tier 2 to support the tier 1 in SCUs admitting babies requiring respiratory support or of very low admission weight <1.5kg. This Tier 2 would be expected to provide cover for co-located paediatric services but be immediately available to the neonatal unit.			

4. Conclusions

The Trust meets the expected standards for medical staffing of the Neonatal Unit according to BAPM levels of care and the rotas are covered appropriately, albeit with the use of locums on regular occasions during this period of time.

Whilst the Trust is compliant with the BAPM standards, the review included the way in which we can continue to be compliant and provide evidence on this by streamlining some of the processes:

- The paediatric medical staff rotas are split between a spreadsheet basis for the consultant rota and an electronic rota for the Tier 1 and 2 staff. The consultant rota will become electronic when the rota coordinator is filled.
- It has not been possible to capture how often training and learning opportunities are lost for individuals and when training may have been postponed due to shortages of staff.

There is also a need to ensure that there are adequate plans and mitigations put in place to ensure that the establishment is set correctly and business cases written in response to service demands and improvements if required: this will improve team working, ability to comply with mandatory and essential training and improve staff morale and wellbeing as well as reduce costs for locum cover.

5. Recommendations

- It is recommended that a staffing plan is developed which describes the processes for ensuring that the BAPM standards are consistently met.
- This review of staffing is to be repeated over the next 6 months to monitor the use of locums to manage the services, recruitment to vacancies and to ensure that the establishment is correct for the needs of the service. The next report to be prepared and submitted September 2022 based on March to August staffing rotas.
- To build on the electronic rota to include the consultants when the rota coordinator is in post.
- Monitor the use of the escalation plan for short- and long-term shortages and cover of the service in all areas and present findings as part of a regular report to the Governance meeting.

6. Action Plan

Action plan lead	Name: Dr Jageer Mohammed/ Paediatric Clinical Lead	Title: Neonatal Safety Champion and Paediatric Clinical Lead	Contact:

Recommendation	Actions required	Action by date	Person responsible	Comments/action status
It is recommended that a staffing plan is developed which describes the processes for ensuring that the BAPM standards are consistently met.	Paediatric medical staffing operational plan to be developed	30/6/22	Clinical Director Neonatal Lead Assistant Service Manager	Supported by Project Midwife
This review of staffing is repeated over the next 6 months to monitor the use of locums to manage the services, recruitment to vacancies and to ensure that the establishment is correct for the needs of the service. The next report to be prepared and submitted September 2022 based on March to August staffing rotas.	Repeat staffing review against BAPM standards. Information to be gathered over the 6-month period March to August 2022	30/9/22	Neonatal Leads Assistant Service Manager	Supported by the Project Midwife and other administrative staff
Once rota coordinator is in place, to build on the existing electronic rota to include the consultants.	To further develop Health Roster to include all grades of paediatric medical staff	30/9/22	Assistant Service Manager	Vacant role to be filled with bank until suitable applicant appointed.

Monitor the use of the escalation plan for short- and long-term shortages and cover of the service in all areas.	Use of escalation to be reported at the Paediatric Governance meetings	From July 2022	Clinical Director Neonatal Lead Assistant Service Manager	From July 2022

Appendix 1 Documents reviewed as part of evidence

British Association of Perinatal Medicine (BAPM) Optimal Arrangements for Neonatal Intensive Care Units in the UK including guidance on their Medical Staffing A Framework for Practice June 2014
https://www.bapm.org/resources/31-optimal-arrangements-for-neonatal-intensive-care-units-in-the-uk-2014

Optimal arrangements for Local Neonatal Units and Special Care Units in the UK including guidance on their staffing: A Framework for Practice November 2018
https://www.bapm.org/resources/2-optimal-arrangements-for-local-neonatal-units-and-special-care-units-in-the-uk-2018

Rotas – Consultant and juniors

Report Title	**Audit of the Operational Pathway of Care into Neonatal Transitional Care January - March 2022**
Report for	Information and Approval
Report from	Women's & Children's Services
Report Author	Jane Lovedale
Date of Report	May 2022
Presented to:	Maternity and Gynaecology Quality and Safety 16/5/22 Maternity and Neonatal Safety Champions 26/5/22 Trust Board 27/5/22

Audit of the Operational Pathway of Care into Neonatal Transitional Care January - March 2022

Introduction and Background

CNST maternity Incentive scheme

- Neonatal Transitional Care Safety Action 3
- CNST required standards revised March 2021
- Compliance with Maternity incentive scheme Year 4 published August 2021

Audit

- Aims
- Methodology
- Summary of Results for Quarter 4
- Conclusions for Quarter 4
- Summary Overall findings for 2021-022
- Improvements and developments opportunities for 2022-23

Audit of operational standards

- Midwifery staffing
- Neonatal staffing
- Neonatal medical teams

Audit of the Operational Pathway of Care into Neonatal Transitional Care
January - March 2022

Report date: May 2022

Introduction

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

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

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

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

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

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

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

CNST maternity incentive scheme

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

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

CNST Required Standards revised and updated August 2021

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

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

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

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

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

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

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

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

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.

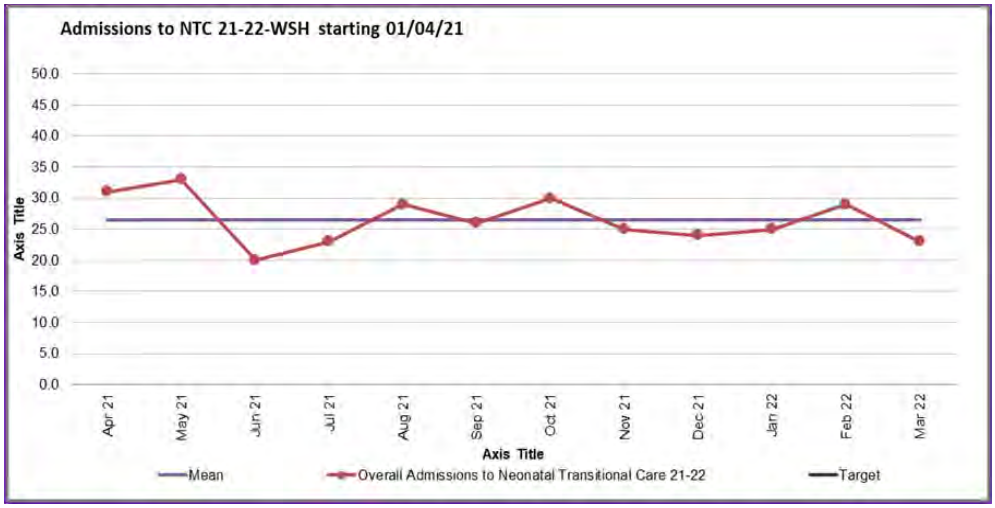
Aims of the Audit

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 in order to improve the care for mothers and babies.

Methodology
A review of the data collected monthly of the pathway of all cases identified between January 2022 to March 2022 (Quarter 4) The data was taken using BadgerNet, eCare Maternity system and Neonatal Admission book.

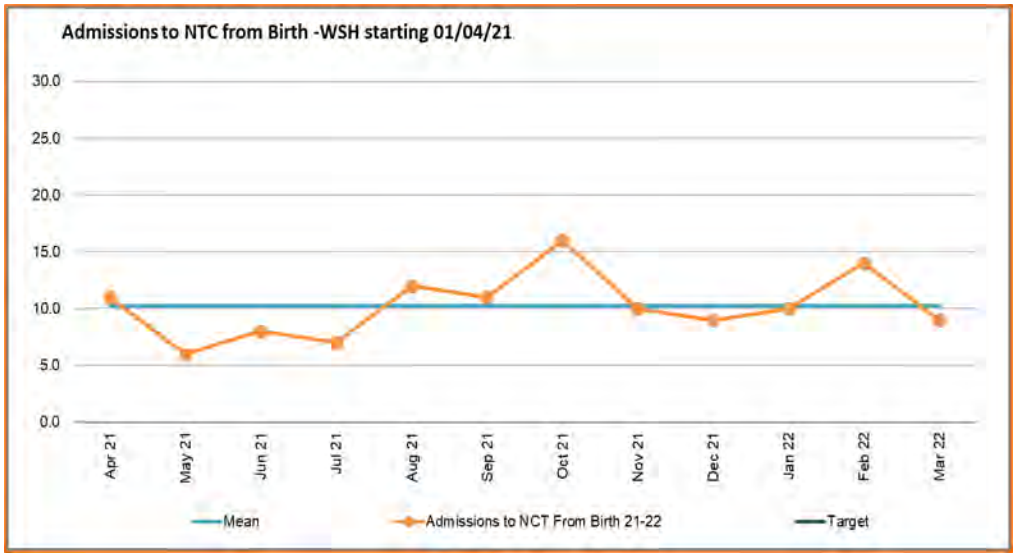
Brief Summary of Results for Quarter 4

A total of 78 babies were admitted to transitional care between April 21 and March 22



33 babies were admitted from birth to TC from labour Suite / MLBU / Home

Clinical Standards		Criteria met
Criteria for immediate admission		
Gestational age >34+6 weeks	32 babies had gestations greater than 34+6 (1 baby 34+5)	97%
Not requiring intensive or high dependency care	None	100%
Birthweight >1800g	All babies between 1.8kg to 4.1kgs	97%
Maternal suspected /confirmed sepsis in labour	22 (67%) of mothers were on the sepsis pathway during labour	100%
Neonatal risks of Sepsis.	5 (18%) of babies had risks of developing sepsis.	100%
Preterm	6 babies were preterm with associated risks.	100%



- 22 babies followed the local pathway for sepsis screening and intravenous antibiotics when the mother was treated for suspected or confirmed sepsis in labour.

- 5 term babies followed the local pathway for sepsis screening due to risks associated with sepsis at birth such as GBS, pyrexia, PROM and had partial screening and were commenced on intravenous antibiotics.

- 6 babies were admitted due to prematurity with associated risks such as PPROM, low temperature, maternal drug use and reduced growth.

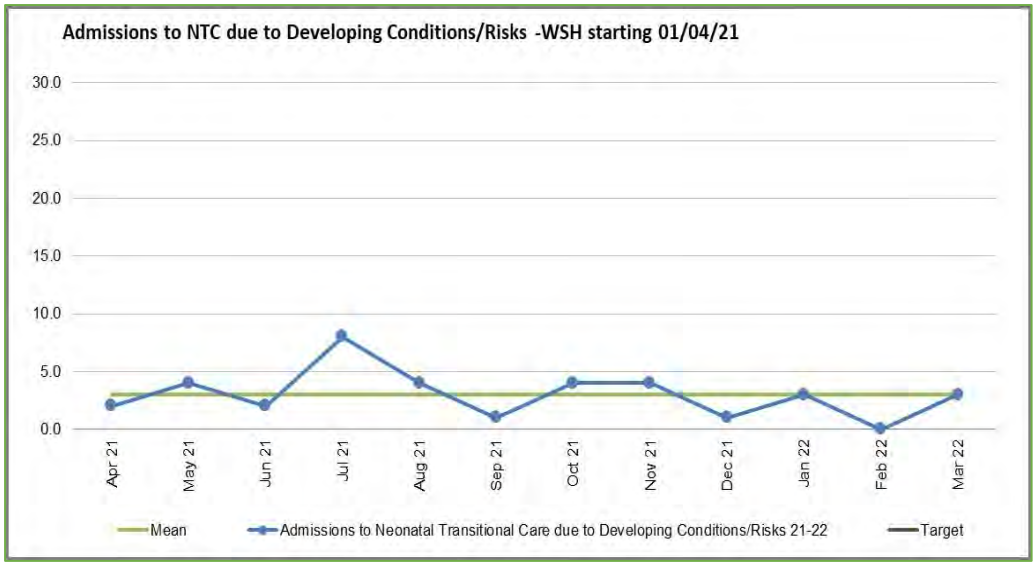
Two babies were just outside the criteria for TC on admission, gestation 34+6 and 1800gm.

These babies were reviewed by the neonatal team:

- Baby 1. Had a gestation one day off the criteria, was bottle feeding and nursed in a warming cot.
- Baby 2 1800g was just below the appropriate weight, but appropriate gestational at 35+2.
- Both babies had management plans for increased monitoring the neonatal teams were happy for the baby to be cared for on transitional care avoiding separation from their babies.

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

Clinical Standards		**Criteria met**
Criteria for admission – developing: Risk factors		
Risk factors for sepsis requiring IV antibiotics	6 babies were transferred to TC due to suspected sepsis requiring IV antibiotics. • 2 mothers developed signs of sepsis post birth. • 4 babies developed respiratory symptoms post birth	100%
Neonatal hypoglycaemia	One of the above babies additionally developed hypoglycaemia.	100%



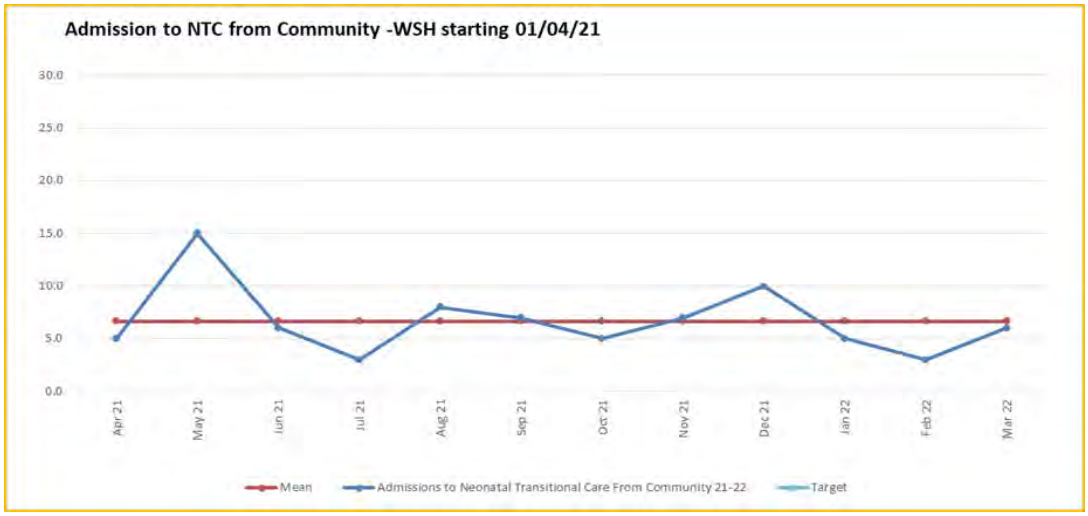
- 2 mothers women developed suspected/ confirmed sepsis postnatally requiring IV antibiotics as per the East of England Neonatal Antibiotic Policy 2019, all babies were appropriately transferred to TC for sepsis screening and commenced on IV antibiotics.

- 4 babies developed respiratory symptoms which had not been present at birth, therefore followed the local pathway of sepsis screening and intravenous antibiotics. None of the babies required respiratory support and were appropriately admitted to NTC for close monitoring and antibiotics.

The audit noted that three of the 4 babies with respiratory symptoms were delivered by elective caesarean section. Babies delivered at early term 37-38 weeks are at increased risk of neonatal respiratory morbidity particularly if delivered by CS. The audit reviewed the gestations of these babies and appeared to have been appropriately managed. Two were over 38 weeks and the third a twin pregnancy at 37+2 requiring early delivery for intrauterine growth restriction.

16 babies admitted to NTC from the community setting

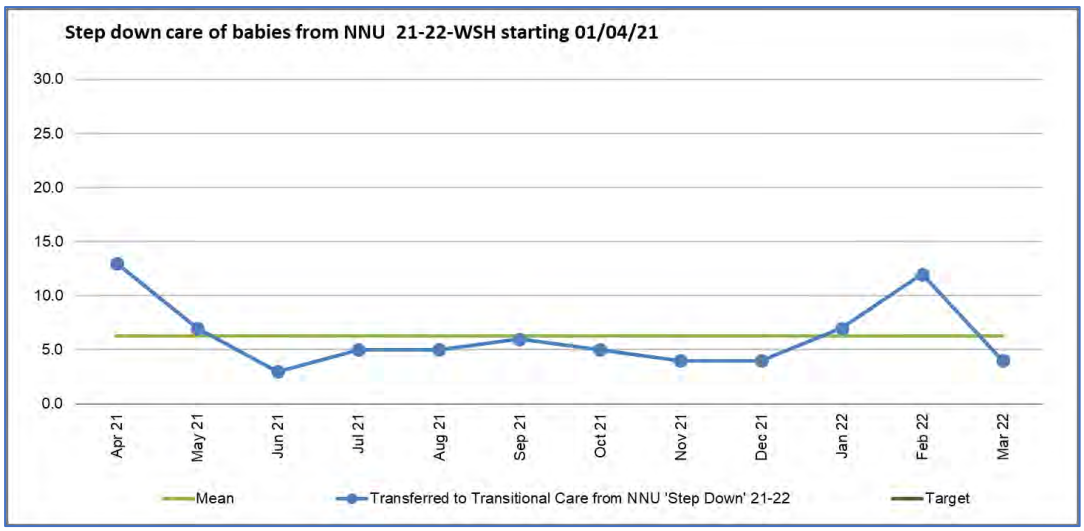
Clinical Standards		**Criteria met**
Criteria for readmission from community met:		
Requiring phototherapy and serum bilirubin monitoring	16 babies were admitted from the community setting. 14 admitted with jaundice all required phototherapy. • 5 premature < 37 weeks • 8 between 37 & 38 weeks • 2 between 38 & 40 weeks	100%
Weight loss poor feeding	2 were admitted with poor feeding or weight loss at term.	100%



The audit showed a reduction this quarter in babies requiring readmission from the community. Those babies admitted met the standard for admission to TC and the majority were discharged after 24 hours of monitoring. It was noted that 90% of babies were under 38 weeks gestation, this is fairly consistent theme during the of babies being readmitted. This is not surprising as babies of lower gestation are at increased risk of developing jaundice and /or feeding problems. It is important that the postnatal and community teams are particularly aware of the details of the audit so discharge and follow up care is managed appropriately for this slightly more vulnerable group of babies.

23 babies had their care stepped down care from NNU to NTC

Clinical Standards		**Criteria met**
Criteria for step down from NNU:		
Corrected gestational age > 33+0 and clinically stable.	All babies were over 33+5 in this cohort and clinically stable	100%
Observations required no more than 3 hourly	All babies met these criterion	100%
Stable baby with sepsis requiring antibiotics	23 babies continued on antibiotics but were stable.	100%
Continuing phototherapy when bilirubin has stabilised	2 babies required continuing phototherapy.	N/A
Comments • 14 babies were able to be discharged from TC before 24 hours • 4 babies discharged before 48 hours • 3 babies between remained on TC for between 4 and 5 days.		
Criteria for discharge met:		
Feeding established and baby is maintaining or gaining weight.	All babies met this criterion on discharge home	100%
Course of IV antibiotics is complete	All babies met this criterion on discharge home.	100%



23 babies had their care stepped down from transitional care

There was an increase in this quarter in the number babies whose care was stepped down from the Neonatal unit to transitional care. This not only prevents the number of babies being unnecessarily cared for on the neonatal unit but more importantly prevents the separation of mothers and babies. All babies met the criteria for transfer to TC. More than 75% of babies required less than 24 hours on TC before being discharged home.

Conclusions for quarter 4

Overall the number of admissions remains fairly stable at 78 and is consistent with other quarters for 21-22.

All babies appeared to be appropriately assessed for care on TC according to the Operational guidance criteria, with the exception of two babies who fell just outside of the criteria, however the neonatal team felt these were well babies, had management plans in place and appropriate for admission to TC.

The majority of admissions were immediately following birth 33 (42.3%) in most cases this was due to suspected/confirmed maternal sepsis.

16 (20.5%) babies required readmission to the neonatal unit because of developing jaundice or needed support feeding. It was noted that babies re- admitted from the community appeared to be lower gestations < 38 weeks, although this was not a surprise considering lower gestation babies are at increased risk of developing jaundice and weight loss and issues around feeding, however it is important to share the audit findings with staff to ensure appropriate timing of their discharge and have follow up management plans for these vulnerable group. The results of the audit to be shared on Risky Business monthly publication. An audit is in progress to look at the follow up of care of these babies following discharge and who are readmitted.

There was an increase this month in babies who stepdown their care to TC 23 (29.4%) It is important when the criteria are met that babies are stepped down promptly reducing the number of days babies are separated from their mothers as well as ensuring a successful transition to discharge home.

During the audit it was noted that one baby receiving care on TC subsequently required admission to the neonatal unit because of the need for naso gastric tube feeding. Currently this is not supported on TC due to staffing but when the newly recruited staff have started and have been fully trained, there are plans are to support nasogastric tube feeding on TC.

Overall findings for 2021/2022

Between April 2021 and March 22 there were 2209 babies born at the WSH of which 14% received Neonatal Transitional Care. Overall this has been relatively stable in numbers throughout the year, around 25 per month.

The largest group of babies requiring TC were babies were admitted at birth and almost always due to suspected maternal sepsis in labour. As per the neonatal antibiotic policy requires babies to receive prophylactic antibiotics.

Admissions from the community has steadily decreased Covid 19 may have had an impact on the increased admissions and changes to face to face visiting.

Improvements and developments for years 2022/2023

There are some very positive developments planned for the next year. In particularly around staffing of TC. Seven new staff have been recruited to the neonatal teams. Their starting date is May 2022 following module-based training programme they will be working with the neonatal and midwifery teams to provide 24/7 transitional care solely for those mothers and babies within the postnatal area. This is anticipated to have positive improvements in breast feeding rates, educating mothers and continuity of care.

It is hoped that they will assist midwives in undertaking some of the routine observations on the mothers in their care. With the important goal of reducing the amount of time mothers and babies are separated following birth it is hoped that transitional care will be able to support babies who require nasogastric tube feeding currently cared for on the NNU.

In addition, there are plans to review the babies suitable for TC but currently being transferred to NNU for Intravenous cannulation siting before transferring to transitional care.

Audit of Operational standards staffing

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

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

Currently the allocated NTC neonatal nurse is based on the neonatal unit and may have other babies to care for on the Neonatal Unit. Therefore, are not physically present on NTC on the postnatal ward.
However, with the successful recruitment of seven nursey nurses to the neonatal team we will be able to provide 24-hour cover on the transitional care unit.

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%**

Recommendations

Audit findings 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.

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

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

Opportunities for learning and Sharing

Project title	Quarterly 4 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** *(specify "None", if none required)*	**Action by date**	**Person responsible** *(Name and grade)*	**Comments/action status**	**Status of Action**
1.	Share findings of the audit with all staff. In particular Focus on readmissions from the community setting.	Risky Business publication	30th June 2022	Rebecca Warburton Q&S Midwife		
		Maternity Quality & Safety meeting	31st May 2022	Karen Green Q&S Manager		
	Audit findings shared with the Maternity and Neonatal Safety Champions,	Shared audit findings at the MNSC meeting	30th June 2022	Karen Newbury HOM		
3	Local Maternity and Neonatal System and (LMNS),	Share findings and learning opportunities at the LMNS meeting.	31st July 2022	Karen Newbury HOM		
4.	Quality Surveillance meeting and Trust Board.	Share findings at Trust Board	30th June 2022	Karen Newbury HOM		

West Suffolk NHS
NHS Foundation Trust

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.

West Suffolk NHS
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SAVING BABIES LIVES CARE BUNDLE

MINIMUM REQUIREMENT	Number of attendees in month (TARGET 90%)	July 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Current % age completion
Smoke free pregnancy	Midwives	100%	100%	100%	100%	99.29%	98.65%	100%	98.6%	100%	99.6%
	Obstetrician*	NA	NA	NA	NA	NA	NA	80%	80%	74%	78%
Monitoring growth restriction (as for GAP)	Midwives	81.7%	91.3%	90.1%	95.10%	95.7%	97.18%	97.18%	96.6%	97.33%	96.6%
	Obstetrician	96%	95.8%	95.8%	100%	100%	91.3%	91.3%	95.24%	90.48%	95%
Fetal movements & Fetal monitoring	Midwives	89.6%	94.1%	88.6%	88.7%	87.8%	97.6%	74.2%	86.1%	92%	89%
	Obstetrician	83.3%	79%	69.9%	73.4%	86.4%	81.8%	54.5%	81%	83%	77%
Pre-term birth *	Midwives	NA	NA	NA	NA	NA	NA	100%	98.6%	100%	99.6%
	Obstetrician	NA	NA	NA	NA	NA	NA				TBC

GAP AND GROW TRAINING

MINIMUM REQUIREMENT	Number of attendees in month	July 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Current % age completion
Training and competency assessment in: • Measuring SFH with a tape measure • Plotting measurements on charts • Appropriate interpretation • Appropriate escalation and referral (TARGET 90%)	MIDWIVES	81.7%	91.3%	90.1%	95.1%	95.7%	97.18%	97.18%	96.6%	97.33%	93.6%
	CONSULTANT OBSTETRICIANS	96%	95.8%	95.8%	100%	100%	91.3%	91.3%	95.24%	90.48%	95%

* 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%)	July 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22 *	Feb 22	Mar 22	Current %age completion
Risk assessment throughout labour Fetal monitoring – Intermittent auscultation (IA) Fetal Monitoring – Electronic Fetal Monitoring (EFM)	MIDWIVES	89.6%	94.1%	88.6%	88.7%	87.8%	97.6%	74.2%	86.1%	92%	89%
	CONSULTANT OBSTETRICIANS	83.3%	79.2%	69.6%	73.9%	86.4%	81.8%	54.5%	81%	83%	77%
	ALL OTHER OBSTETRICIANS										
Use of local case histories	MIDWIVES	13%			21%			48%			27%
	OBSTETRICIANS	28%			50%			66%			48%

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	July 21	Aug 21*	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Current %age completion
Locally identified training needs relating to emergency scenarios which might include: Antepartum Haemorrhage and Postpartum Haemorrhage Impacted fetal head Pre-eclampsia/eclampsia, severe hypertension Uterine rupture Maternal resuscitation Vaginal breech birth Shoulder dystocia Cord prolapse Include: • The use of maternal critical care observation charts • Structured review proformas • Deterioration and escalation thresholds • Timing of birth and immediate postnatal care (TARGET 90%)	OBSTETRIC CONSULTANTS	1	NA	0	3	2	3	0	0	1	93.33%
	ALL OTHER OBSTETRIC DOCTORS CONTRIBUTING TO THE ROTA	0	NA	4	4	3	3	3	1	1	
	OBSTETRIC ANAESTHETIC CONSULTANTS	1	NA	1	2	2	1	0	0	0	90.48%
	ALL OTHER OBSTETRIC ANAESTHETIC DOCTORS CONTRIBUTING TO THE ROTA	1	NA	2	2	1	3	2	0	1	
	MIDWIVES	14	NA	16	15	18	16	11	12	8	97.9%
	MATERNITY CRITICAL CARE STAFF **	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
	MATERNITY SUPPORT WORKERS AND HEALTH CARE ASSISTANTS	5	NA	2	2	3	3	3	2	5	95.65%

NB:

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

PERSONALISED CARE

MINIMUM REQUIREMENT	Number of attendees in month Target 90%	July 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Current %age completion
Ongoing antenatal and intrapartum risk assessment with a *holistic view from a woman's personal perspective, offering her informed choice.* *	Midwives	This topic will be covered within CNST year 5 training sessions starting from January 2023									
	Obstetrician										
Maternal mental health	Midwives	98%	100%	99%	100%	99.33%	98.65%	96%	99.34%	100%	99.2%
	Obstetrician*	NA	NA	93%	86%	98%	98%	93%	97%	97%	95%
Vulnerable women and families Social factors requiring referral	Midwives	98%	100%	99%	100%	99.33%	98.65 %	96%	99.34%	100%	99%
	Obstetrician	96%	93%	93%	84%	86%	93%	93%	97%	97%	92%
Families with babies on NICU *	Midwives	This topic will be covered within CNST year 5 starting from January 2024									
	Obstetrician										
Bereavement care	Midwives	98%	100%	99%	100%	99.33%	98.65%	96%	99.34%	100%	98.9%
	Obstetrician	NA	NA	NA	NA	NA	NA				TBC

NB:

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

CARE DURING LABOUR AND THE IMMEDIATE POSTNATAL PERIOD

MINIMUM REQUIREMENT	Number of attendees in month TARGET 90%	July 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Current %age completion
Management of labour	MIDWIVES	N/A	N/A	N/A	N/A	N/A	N/A	100%	98.6%	100%	99.5%
	OBSTETRICIANS										
VBAC and uterine rupture	MIDWIVES	This topic will be covered within CNST year 5 training sessions starting from January 2023									
	OBSTETRICIANS										
GBS in labour	MIDWIVES	N/A	N/A	N/A	N/A	N/A	N/A	100%	98.6%	100%	99.5%
	OBSTETRICIANS										
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%	NA	98%	95.42%	97.81%	98.58%	98.58%	99.3%	97.9%	98.58%
	OBSTETRICIANS	96%	NA	100%	90.32%	90.63%	91.43%	91.67%	91.67%	93.33%	91.43%
Recovery care after general anaesthetic		This topic will be covered within CNST year 5 starting from January 2024									

NB:

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

NEONATAL LIFE SUPPORT

MINIMUM REQUIREMENT	Number of attendees in month Target 90%	July 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Current %age completion
Identification of a baby requiring resuscitation after birth and support immediate neonatal resuscitation until specialist neonatal help is available Assessed ability to deliver inflation breaths Knowledge and understanding of the NLS algorithm How to call for help within the organisation Situation, Background, Assessment, Recommendation (SBAR) or equivalent communication tool handover on arrival of help Recognition of the deteriorating newborn infant with actions to be taken	NEONAL CONSULTANTS OR PAEDIATRIC CONSULTANTS COVERING NEONATAL UNITS	NA	NA	NA	NA	NA	2	0	2	3	65% **
	NEONATAL JUNIOR DOCTORS WHO ATTEND ANY DELIVERIES	NA	NA	NA	NA	NA	5	1	0	1	73% **
	NEONATAL NURSES BAND 5 AND ABOVE	0	1	2	8	8	0	0	0	0	96%
	ADVANCED NEONATAL NURSE PRACTITIONERS (ANNPs) *	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
	MIDWIVES	14	x	16	15	18	16	11	12	8	97.9%

- 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): January 2022-March 2022

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

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

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

Is training completion meeting the expected trajectory? No

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

- Difficulties of releasing medical staff to attend the training which has been escalated to Clinical Leads and Safety Champion
- Availability of data to fully complete the report has been raised with the training leads to improve up on compliance;
- Training plans put in place from January 2022 to meet the recommendation of MIS year 4 this includes attendance at the NLS training sessions. The Neonatal/ Paediatric Consultants and Neonatal Junior doctors who attend a birth are required to attend annual NLS training sessions as part of the PROMPT training. This is booked by individual staff with Practice Development team.
- Training programme plans up-dated to reflect the management of non compliant for midwifery staff. This has been communicated with staff and line managers will have 1:1 discussion with individual staff members who are non compliant.

West Suffolk NHS Foundation Trust
Women and Children's & Clinical Support Services Division

MATERNITY SERVICES

Midwifery Staffing Report

Report Title:	Bi-Annual Report on Midwifery Workforce – May 2022 for period 1st October 2021 to 31st March 2022
Report for:	Information and approval
Report from:	Head of Midwifery
Lead for safety action:	Head of Midwifery
Report authors:	Karen Newbury Christine Colbourne
Frequency of report:	Bi-Annual information report for Trust Board for the year 2021/2022 Reporting periods: 1/4/2021 – 30/9/2021. Ratification at November 2021 Maternity Quality and Safety Meeting prior to submission to Trust Board in December 2021. 1/10/2021 – 31/3/2022 Ratification at May 2022 Maternity Quality and Safety Meeting prior to submission to Trust Board in May 2022. All reports will be shared with Maternity Safety Champions and the LMNS.
Date of this report:	1 May 2022

Executive Summary:

- The maternity service monitors the staffing levels required using a variety of methods, including the BirthRate + establishment tool.
- Following joint work undertaken with the LMNS to calculate the establishment needed to fully implement the continuity of carer model, the required investment of midwives has been agreed by the Trust Board and made available from Month 11, 2021/22.
- Challenges in achieving minimum midwifery staffing levels in the period of this report have been immense, due in the main to covid absences and vacant posts. Robust escalation process and team

working has mitigated some absences, but there have been numerous shifts each week where RM shifts have not been filled.

- Whilst this has impacted on community and postnatal care, the senior team have strived to protect the care of women in labour and over the 6-month period of the report, only 1 women did not receive 1-1 care in labour.
- Through appointing additional Band 7 midwives to undertake the bleep carrying role, the compliance with the labour suite co-ordinator being supernumerary has increased to just under 100%.
- An active recruitment programme is in place but delays in the process and availability of midwives nationally, can lead to a hiatus between staff leaving or vacancies being advertised and the staff being in post.
- Multiple strategies are in place to improve future staff availability with the increase in students and return to practice courses but the benefits of these may not be realised for at least another 2 years. All adopted practices around improving staff recruitment will be continued until the vacant posts are filled.
- The midwife to birth ratio has been positively impacted due to increases in funded establishment and subsequent recruitment into some of the vacant posts. It is worth noting that the MW to Birth ratio has been set historically based on old methodology that doesn't consider the continuity of carer agenda. Review of the BR+ methodology is an immediate and essential action in the Ockenden Report, which may lead to a review of these figures in due course.
- The number of red flags reported in the last 3 months of the reporting period has significantly increased. The service now records staff absences due to covid and this alone has led to 138 Red Flags being submitted. Delays in induction of labour are the main clinical reason for the recording of a Red Flag, with 48 occurrences of this in the reporting period.
- It is anticipated that with covid absences receding, staffing levels in hospital and community services will improve, leading to less escalation and related disruption to care and staff movement.
- The senior midwifery team have been proactive in reviewing the sustainability of the continuity of carer teams whilst the midwifery vacancy rate remains high. The decision to temporarily dissolve one of the two continuity of carer teams has been made. Continuity of carer remains a service priority and will be rolled out when all the vacant posts have been appointed into and a safe service for all women can be sustained.
- The impact of the Ockenden report, published in March 2022, is currently being assessed. Any future midwifery staffing adjustments will be clarified and presented at Trust Board and any additional resources/funding needed to fully implement the actions from the report will be requested.

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1. Background

In 2018 NHS Resolution introduced a Maternity Incentive Scheme (MIS) to support the delivery of safer maternity care. Comprising a total of 10 Maternity Safety Actions, Safety Action 5 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'.***

Each year NHS Resolution updates the Safety Actions to reflect progression and improvement maternity services are expected to make against the published standards. The Year 4 Safety Actions were released

in August 2021 with a number of revisions to Safety Action 5 and to meet the required standard the service now needs to demonstrate and evidence:

a. A systematic, evidence based process to calculate midwifery staffing establishment is completed
b. 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.
c. All women in active labour receive one-to-one midwifery care
d. Submit a midwifery staffing oversight report that covers staffing/safety issues to the Board every 6 months during the MIS year four reporting period (August 2021 - June 2022)

This report will provide evidence against the Year 4 Maternity Incentive Scheme (MIS) Safety Action 5 and includes an action plan that will be monitored at the service Maternity Quality and Safety Meeting and Women's and Children's Divisional Board.

The final Ockenden[1] report published in March 2022 contains a number of 'Must Do's' pertaining to midwifery staffing. The service is currently undertaking a review of current staffing to identify any gaps where further investment is needed. The potential impact of the required Ockenden actions will be highlighted in this paper to ensure the Trust Board can plan the required investment in their midwifery services.

The purpose of this report is also to provide evidence and give Board assurance that work continues to be undertaken within maternity services at West Suffolk to demonstrate progress towards meeting safe staffing standards within the midwifery workforce.

2. Year 4 evidential requirement:

In response to section (d) of the Year 4 Safety Standards, this report for Trust Board will provide information to meet the minimum evidential information including:

- A clear breakdown of BirthRate+ or equivalent calculations to demonstrate how the required establishment has been calculated.
- Details of planned versus actual midwifery staffing levels. To include evidence of mitigation/escalation for managing a shortfall in staffing.
- An action plan to address the findings from the full audit or tabletop exercise of BirthRate+ or equivalent undertaken, where deficits in staffing levels have been identified.
- Maternity services should detail progress against the action plan to demonstrate an increase in staffing levels and any mitigation to cover shortfalls.

[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)

- 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, including plans for mitigation/escalation to cover any shortfalls.
- Information on the monitoring of red flag events associated with midwifery staffing.
- Information on service compliance with 1-1 care in labour.

The information in the sections below provides information on all these elements.

3. Assessment of required midwifery staff.

A full BirthRate Plus (BR+) assessment was completed in April 2019 which demonstrated the actual funded establishment of clinical midwives was in line with their recommendations at that time. A further assessment using the BR+ methodology is planned later in 2022.

Within the BR+ report, it highlights that staffing in smaller maternity units may require senior management to set their own minimum staffing levels to safely staff all clinical areas and this has been applied at West Suffolk.

In partnership working with the LMNS and Trust's finance team, the midwifery managers have worked to ensure the national recommendations relating to midwifery staffing numbers have been applied. This includes long term commitment to the roll out of continuity of carer, maintaining a core service within the hospital service and the required specialist midwives and managers to safely support the service.

Following submission of a variety of business cases, the Trust Board has supported the additional funding required to enable full roll out of continuity of carer and this was made available in budget from month 11. The overall increase in midwifery establishment also includes the 6.00 wte made available with Ockenden monies from earlier in the year.

As a breakdown, the midwife establishment needed to enable full continuity of carer at West Suffolk is 50.19 wte. A further 82.73 wte is required to provide a community service for out of area women, maintain safe staffing levels for both in-patient and outpatients areas in the hospital and provide enough specialist MW and managers currently needed to safely run the service.

The increase in midwifery establishments is demonstrated in the following table:

MIDWIFERY ESTABLISHMENTS 2021/22			
Band	Funded WTE M6	Funded WTE from Month 11	Net Increase
Band 5	9.12	9.12	=
Band 6	77.07	89.07	+12.00
Band 7	30.73	30.73	=
Band 8	4.00	4.00	=
Grand Total	**119.92**	**132.92**	**+12.00**

To date the midwifery team at West Suffolk have introduced 3 continuity of carer teams. Further rollout of continuity of carer and maintenance of the existing teams has been hampered by a number of factors:

- Ability to recruit the additional numbers of staff
- Shortages of staff as a result of the impact of covid absences.
- The majority of midwives recruited have been Band 5, newly qualified staff. Their need for robust preceptorship and support has had impact on both the staff and the service.

In light of the Ockenden Report recommendations 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'*, the service is recommending to the Trust Board and LMNS that temporary suspension of one of the continuity of carer teams is actioned. This recommendation also supports another of the report actions, to have more robust support for Newly Qualified Midwives and to delay community placement until a year post registration. Existing NQM, currently based in the community setting are being well supported and work a significant element of their time in the hospital environment. These MW have been given the choice of place of work with all currently choosing to continue with their current work patterns.

4. Recruitment of midwifery staff

Recruitment of qualified midwives continues to pose significant challenge to maternity services nationally and at West Suffolk Hospital. The service has also 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 on the postnatal ward. The team are keen to recruit more substantive nurses, but in the meantime, bank nurse shifts have been utilised.

There continues to be concentrated effort placed into 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 to target attraction of midwives to work in Suffolk and North Essex. This has culminated in successful recruitment of midwives from overseas, although start dates have yet to be finalised.
- 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 has led to an increase in student midwife places each intake
    - Accessing the 18 month course to encourage nurses to train as midwives
    - Successfully offering Return to Practice course for midwives whose registration has lapsed.

The number of vacancies at the end of March 2022 was 22.63 wte midwives which equates to a 17% vacancy rate.

The service is currently employing approximately 10.00 wte midwives each month through the bank and staff working additional hours. As additional substantive staff are proving a challenge to recruit, further roll out of continuity of carer has not taken place and will not progress until there are enough suitably trained staff to safely staff this new way of working. This strategy has been supported with the publication of the Ockenden Report in March 2022 with recommendations to suspend continuity of carer until maternity services can fulfil all staffing needs without impacting on the core service in the hospital.

The effort to recruit midwives and nurses into the current vacancies will continue as a high priority for the service. The national 'pool' of available midwives is currently reduced as all Trusts in the country are facing similar challenges with the uplift in staff to meet the continuity of carer agenda. This coupled with the alarming reports that a number of midwives are considering leaving the profession adds to the difficulty in attracting staff and encouraging them to move to West Suffolk when they are being offered similar opportunities elsewhere. The longer term strategy of 'growing our own' will help ease the problem in future years, but there is going to be a time lag of at least 2 years before this realises noticeable gains due to the length of training.

5. Monitoring midwifery staffing

Midwifery staffing is monitored on a daily basis:

- There is a daily midwifery manager on call plus a unit bleep holder (band 7 Midwife) who liaise with the matrons, deputy HOM and HOM to discuss strategies and actions needed to balance acuity against staffing levels.

- A unit bleep holder is rostered for the day and night shifts 7 days a week. This additional band 7 senior midwifery presences offers additional support to the clinical team in an operational and when needed, a clinical role.
- 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.
- 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.

Maintaining safe staffing level, has again, over the last 6-months provided significant challenges to the service.

To mitigate against this:

- The service employs midwives from the established in-house bank plus staff have also been willing to undertake hours in addition to contract.
- An uplift in pay for staff working these shifts has been agreed and welcomed by the staff and has had the effect of encouraging more cover. Initiated to give support during the unprecedented number of covid absences, this initiate is still in place at the end of March 2022.
- The escalation plan has been initiated appropriately with staff in specialist roles working clinically to ensure women receive safe care.
- The use of the community service in times of escalation has been initiated on a number of occasions. Whilst this can impact on the availability of a midwife for a home birth and access to their continuity of carer midwife, maintaining safe care and staffing levels in the hospital service has had to be a priority.

The Head of Midwifery provides a bi-monthly report to the Trust Board highlighting the staffing issue faced in the previous month. Key elements of this report are number of shifts not filled, 1-1 care in labour and the MW to birth ratio.

6. Details of planned versus actual midwifery staffing levels

The service currently publishes the daily record of 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, and unfilled shifts. Developments on E-Roster continue to ensure a robust system is in place to easily calculate the fill rates.

The Head of Midwifery provides information monthly on the wte number of registered midwife shifts that have not been filled:

Number of RM shifts not filled		
Month	WTE	Shifts per week
October	6.15	18
November	3.61	11
December	4.09	12
January	3.5	10
February	4.9	15
March	6.8	20

7. 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. It defines their role as being pivotal in facilitating communication between professionals and in overseeing appropriate use of resources. The lack of a supernumerary LSC has also been identified as a contributory factor in many cases of maternal and perinatal morbidity and mortality which have been reported at national forums. The role of the LSC is nationally recognised as being at Band 7.

The table below shows compliance with the supernumery status of the LSC between October 2021 and March 2022:

Supernumerary Status of Labour Suite Co-ordinator	
Date	% Compliance
October	93%
November	100%
December	99%
January	99%
February	99%
March	98.3%

There has been significant improvement in the last 6 months in the services ability to maintain the supernumerary status of the LSC. Whilst not at the desired 100%, to be consistently within 2% of this since November 2021 is recognised attainment of a key safety standard, particularly at a time when minimum staffing levels have not been achieved. This has predominantly been achieved due to the presence of 2 band 7's on each shift, with the unit bleep holding MW able to support labour suite at times of heightened activity and acuity.

The BirthRate Plus® app for acuity has been introduced and monitoring of the supernumerary status of the labour suite co-ordinator is now established and reported monthly on the service Quality Dashboard. It is also discussed and recorded at the daily safety huddle as assurance and confirmation that the

supernumerary status is maintained. There is some minor inconsistency with the submission of Red Flags when the LSC co-ordinator is not supernumerary, which will need addressing.

8. Provision of 1-1 care in labour

NICE published a Quality Statement on 1-1 care in 2015 (QS105 Intrapartum Care; updated 2017) which states that women in established labour have one-one care and support from an assigned midwife.

Established labour is defined as the presence of regular painful contractions and progressive cervical dilatation from 4 cms. For service providers, one-one care in labour means that a woman in established labour is cared for by a midwife who is just looking after that one woman. She might not have the same midwife for the whole labour, but the service needs to ensure there are enough midwives on duty every 24-hour period to enable this to happen.

Monitoring of 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. This has been a challenge in the last 6 months due to the number of staff absences due to Covid related issues. This has resulted in the increased use of community and continuity of carer teams in providing support to labour suite and the ward managers, specialist MW, matrons, deputy and Head of Midwifery working clinically to maintain safe staffing levels.

1-1 Care in Labour	
Date	% Compliance
October	100%
November	100%
December	100%
January	100%
February	99.5%
March	100%

From July to September, all women attending for birth with the maternity service at West Suffolk have received 1-1 care in labour with the exception of one women in February 2022.

9. 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 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 realistic measure of the number of available midwives. This is then measured against the actual 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 27 births to 1 wte MW. The service has set a ratio of 1 wte to 28 births as the standard to be achieved, which is in line with current national standards. Due to the increase in establishment and subsequent recruitment the service has experienced an improvement it the Midwife to Birth ratio. However, this is based on standards set by BR+ before continuity of carer was set as the national ambition. A national review of the feasibility and accuracy of the BR+ tool and associated methodology is an immediate and essential action recommendation in the Ockenden report, which may lead to a review of these figures in due course.

MW to Birth Ratio Standard = 1:28	
Date	**Ratio**
October	1:30
November	1:26
December	1:23
January	1:28
February	1:27
March	1:28

This data is recorded on the quality dashboard and is monitored monthly at the Maternity Quality and Safety Group.

10. 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 associated with maternity services are as follows:

RED FLAGS relating to midwifery staffing:
Redeployment of staff to other services/sites/wards based on acuity
Staff absences due to illness/isolation/shielding/symptoms for Covid-19
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.
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 number of red flags submitted via the service reporting system over the last 12 months is as follows:

Number of Red Flags reported each month	
Date	**Number**
October	25
November	3
December	54
January	52
February	25
March	44
TOTAL	**203**

Since the last staffing report submitted in November 2022, the service have developed a more robust mechanism to collect data relating to staff sickness and absence in relation to covid. This has had a significant impact on the number of 'Red Flag' incidents being reported. The following table splits out the covid related red flags from those associated with patient care. There were no instances where staff have been redeployed to other areas in the hospital to work between October and March.

Number of Red Flags reported each month		
Date	**Number related to staff absence due to Covid**	**Number related to patient care issues.**
October	10	15
November	1	2
December	45	9
January	43	9
February	9	16
March	30	14
TOTAL	**138**	**65**

Information relating to the submission of red flags for non-covid reasons are broken down further in the table below:

Red Flag	Number submitted
Delays in induction of labour	48
Labour Suite Coordinator not being supernumery	7
Delay in treatment/care	3
Inability to facilitate Home Birth	3
Delayed analgesia	1
Delayed medication	1
1-1 care delayed	1
Missed PN visit in the community	1

The number of red flags each month is recorded on the quality dashboard and is monitored at the Maternity Quality and Safety Group meeting. Red flags are discussed and recorded at the daily safety huddle which is attended by medical and midwifery staff. Actions taken to mitigate and escalate are documented and the team ensure reporting via the datix system has taken place. When a red flag datix is submitted care is reviewed by the senior team to assess impact and identify trends.

11. Specialist Midwives (SpMW) in post

The funded establishment for Band 7 specialist MW post is totalled as 9.49 wte and the following are in post:

- 1.20 wte Antenatal and Newborn Screening MW (2 x 0.60)
- 1.76 wte Practice Development MW. (1 x 1.00, 1 x 0.60)
- 2.40 wte Clinical Risk MW. (1 x 1.00, 1 x 0.80, 1 x 0.40, 1 x 0.20)
- 1.00 wte Clinical and Quality Assurance MW
- 0.80 wte Perinatal Mental Health
- 0.40 wte Fetal Monitoring MW
- 0.80 wte Bereavement MW
- 0.60 wte Safeguarding MW.
- 0.53 wte Diabetes MW.

The funded establishment for band 6 SpMW is 2.37 wte and this comprises:

- 0.60 wte Infant Feeding MW
- 0.80 wte Smoking Cessation MW
- 0.33 wte Clinical Practice Facilitator, plus an additional 0.27 externally funded.
- 0.64 wte Antenatal Screening MW

The service has two band 7 MW posts that are externally funded:

- 0.60 wte Clinical Practice Facilitator
- 0.43 wte Better Births Lead

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 midwives' roles is not eroded. Specialist MW also contribute to the service escalation plan at times of heightened activity and acuity.

The establishment of specialist MW and clinical managers needed to lead the service, constitutes approximately 10% of the total midwifery workforce, which is in line with current BirthRate Plus methodology.

12. Impact of the Ockenden Report

Whilst this report primarily focusses on midwifery staffing issues up to March 2022, elements of the Ockenden report published in the same month will have impact on midwifery staffing going into the new financial year. The service is taking the opportunity to highlight the major impacts on midwifery staffing within this report.

There are significant elements and 'Must Do's' within the Ockendon report that impact on midwifery staffing.

The key actions that will particularly impact on future midwifery staffing at West Suffolk are:

- Funding maternity and neonatal services appropriately requires a multi-year settlement to ensure the workforce is enabled to deliver consistently safe maternity and neonatal care across England.
- Minimum staffing levels should be those agreed nationally, or where there are no agreed national levels, staffing levels should be locally agreed with the LMNS. This must encompass the increased acuity and complexity of women, vulnerable families, and additional mandatory training to ensure trusts are able to safely meet organisational CNST and CQC requirements.
- Minimum staffing levels must include a locally calculated uplift, for all absences including sickness, mandatory training, annual leave and maternity leave.
- The feasibility and accuracy of the BirthRate Plus tool and associated methodology must be reviewed nationally by all bodies.
- All trusts must implement a robust preceptorship programme for newly qualified midwives (NQM), which supports supernumerary status during their orientation period and protected learning time for professional development as per the RCM (2017) position statement for this.
- All NQMs must remain within the hospital setting for a minimum period of one-year post qualification.
- A proportion of maternity budgets must be ring-fenced for training in every maternity unit should be implemented
- All trusts must ensure all midwives responsible for coordinating labour ward attend a fully funded and nationally recognised labour ward coordinator education module, which supports advanced decision-making, learning through training in human factors, situational awareness and psychological safety, to tackle behaviours in the workforce.
- All trusts must ensure the labour ward coordinator role is recognised as a specialist job role with an accompanying job description and person specification

- All trusts to ensure newly appointed labour ward coordinators receive an orientation package which reflects their individual needs.
- All trusts must develop a core team of senior midwives who are trained in the provision of high dependency maternity care. The core team should be large enough to ensure there is at least one HDU trained midwife on each shift, 24/7
- All trusts must develop a strategy to support a succession-planning programme for the maternity workforce to develop potential future leaders and senior managers. This must include a gap analysis of all leadership and management roles to include those held by specialist midwives.
- All trusts must review and suspend if necessary, the existing provision and further roll out of Midwifery Continuity of Carer (MCoC) unless they can demonstrate staffing meets safe minimum requirements on all shifts. The reinstatement of MCoC should be withheld until robust evidence is available to support its reintroduction
- All trusts must ensure there are visible, supernumerary clinical skills facilitators to support midwives in clinical practice across all settings
- Newly appointed Band 7/8 midwives must be allocated a named and experienced mentor to support their transition into leadership and management roles

Work has already commenced on some of these elements of the Ockenden report. There has been discussion with NHS England regarding many of the actions and further information and guidance is awaited.

13. Conclusions

The maternity service continues to strive to achieve safe and effective care for women through the provision of a robust midwifery workforce that is skilled and trained to meet the needs of the local population.

The service has been supported by the Trust with the significant increase in funding to achieve an establishment of midwives that will meet the continuity of carer agenda, deliver a community service for out of area women, maintain safe staffing levels for both in-patient and outpatients areas in the hospital and provide enough specialist MW and managers currently needed to safely run the service.

Maintaining safe levels of staffing has been a particular challenge in the last 6 months due to two key factors: the number of covid absences and vacant posts. Multiple strategies are in place to improve future staff availability with the increase in students and return to practice courses but the benefits of these may not be realised for at least another 2 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 by having a robust escalation plan and working together as a team ensuring 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 good compliance with supernumery status of the LSC and with the exception of one women in this 6 month period, all women in labour received 1-1 care.

The covid absences do now appear to be receding and with the cessation of one of the continuity of carer teams temporarily, the staffing levels will now be improved in the core services. The roll out of continuity of carer will resume once the vacant midwife posts are filled and further guidance is received from NHS England.

The 'must do's' from the Ockenden report will impact on future midwifery staffing requirements and ongoing work will realise the full extent of this. Where required, business cases will be developed and presented to Trust Board for approval.

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 December 2022.

The completed action plan for the previous report in April 2021 is available below. Where actions are still 'work in progress', these have been carried over into the action plan in appendix 1.

Completed%20Actio
n%20Plan%20Staffinc

Appendix 1 Action Plan

Action Plan Owner:	Name: Karen Newbury	Role Title: Head of Midwifery	Contact: Karen.newbury@wsh.nhs.uk

RECOMMENDATION		ACTIONS REQUIRED	ACTION BY DATE	PERSON RESPONSIBLE	COMMENTS/ACTION STATUS
1.	Monitoring of vacancies	Monthly monitoring of vacancies against recruitment plan	On-going monthly	HOM, Deputy HOM, Midwifery Matrons	
2.	Monitoring of Red Flag information	Ensure staff are completing Red Flags when required.	On-going monthly	Risk & Governance team	
		Refresh staff on the Red Flag trigger list and reporting processes.	Q1 2022/3	Risk & Governance team	
		Red flags will continue to be reported through the BR+ app and datix and discussed at the daily safety huddle.	On-going monthly	All maternity staff	
3.	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 form 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

		Data continues to be collected and collated by the senior midwifery team on a monthly basis.	On-going	Head of Midwifery	
4.	Review staffing levels once Continuity of Carer is implemented to ensure safe standards of care are maintained	Review all methodology of monitoring safe staffing levels and acuity when continuity of carer teams are implemented and established.	Currently no published dates. Service will work in partnership with LMNS and CCG to progress with any recommended implementation.	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
5.	Implementation or 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	

Revised Plan for roll out of Midwifery Continuity of Carer

Report Title	Revised Plan for Roll out of Midwifery Continuity of Carer
Report for	Decision by the LMNS Board
Report from	Maternity Services
Lead for Safety Action	Karen Green
Report Author	Sarah Spall, Better Births Project Lead
Date prepared	13 May 2022

1. **Report Title –** Revised Plan for Roll out of Midwifery Continuity of Carer

2. **Purpose of the Report**

To provide an update on our approach to the roll out of Midwifery Continuity of Carer (MCoC) following the publication of the final report of the Ockenden Review published 30 March 2022. This report made a number of immediate and essential actions (IEAs) to improve care and safety in maternity services across England which directly impact on our plans for roll-out, specifically in relation to IEA 1: Workforce planning and sustainability and IEA 2: Safe staffing.

We have subsequently reviewed our own plans with senior midwives across the maternity system against these 2 actions. This report explores three options to change our plans for the roll out of continuity of carer:

Option 1	**Continue with 3 teams and bring the NQMs back into the hospital setting**
Option 2	**Continue with 2 teams i.e. Iceni and Sapphire, dissolve Willow and bring the NQMs back into the hospital setting**
Option 3	**Continue with 2 teams i.e. Iceni and Willow and continue with the 'Shared Preceptorship' model for NQM's**

The decision made by the LMNS Board will ultimately shape our plans for roll out and subsequent ability to meet the national requirements for MCoC to become the default model

of care for all women by end March 2024. This revised timescale was set out in the *The Local Maternity System: 22/23 deliverables and transformation (March 2022) funding letter*).

3. Background

In January 2022 our plans for roll out were approved by the Trust Board. Based on the number of eligible women (2085) it was agreed that we would need a total of 8 MCoC teams with a head count of 8 midwives per team (7.2 WTE) to make MCoC the default model of care for all eligible women by end March 2023. This would enable us to roll out at both scale and safely, operating within the national guidelines on caseload size of 1:36 for a full-time midwife. In order for us to maintain safe staffing we had funding agreed for an additional 18 WTE midwives, taking the establishment from 114.92 WTE midwives to 132.92 WTE.

We have 3 Wave 1 MCoC teams up and running to build from including:

- Iceni covering Thetford and Brandon (covering 10% most deprived area)
- Willow covering Bury and Woolpit and
- Sapphire for women who have had 2 or more Caesarean births or who declined a VBAC following consultant review (area wide)

We also have the following key building blocks in place:

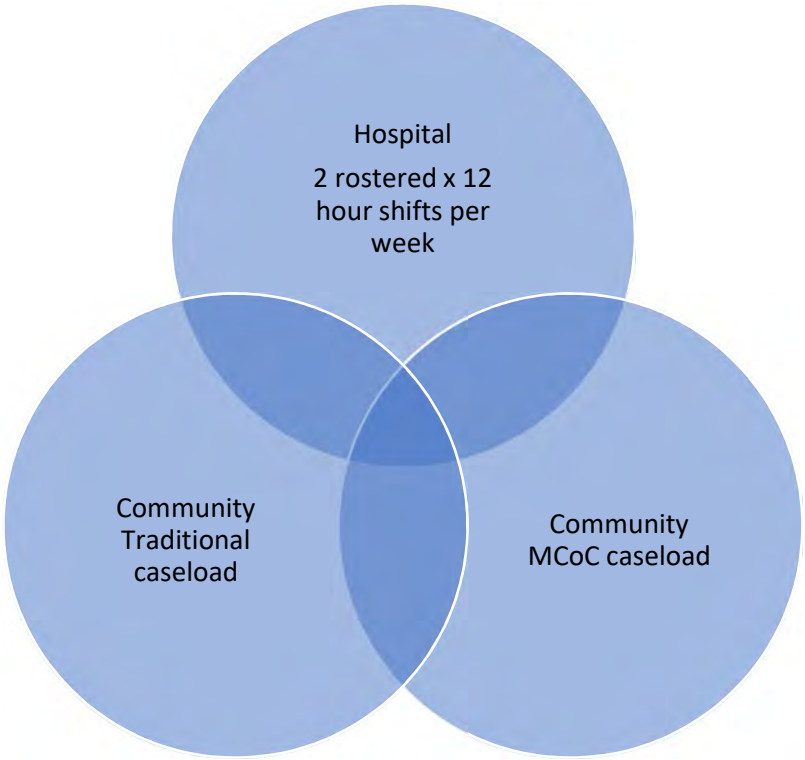
- **Working towards a caseload size of 1:36** - This had been achieved for Iceni and Sapphire, but ongoing staffing issues meant this continued to be a challenge for Willow. From October 2021 Willow have not been offering full continuity of care as only had the capacity to offer birth availability during the day. This means that with a head count of 8 midwives or 7.2 WTE per team they will be able to have an annual caseload 260 women.
- **Training Needs Analysis -** for each midwife and team links with the PDM's and PMA's.
- **Named Lead Obstetrician for Continuity of Care** - each of the current teams has a linked Obstetrician.
- **Standard operating Policy (SOP)** - reviewed in January 2022.
- **Shared Preceptorship Model for Newly Qualified Midwives (NQMs)** – we have developed our model for supporting newly qualified Band 5 midwives based on the learning from James Paget Hospital (JPH), who successfully support their Preceptors going straight out into their MCoC teams as soon as they qualify. However, we have adapted this model to fit our own preferred way of ensuring the right balance between the support the NQMs receive and getting the necessary hospital experience to continue to build on their skills and knowledge so that they become confident, competent, rounded, safe midwives. We believe this shared model of preceptorship will equip the

NQM's so that they are ready to take on the role of becoming a MCoC midwife and feel more comfortable with the fluidity of working between the hospital and community environments.

At West Suffolk Hospital the NQM's have 2 rostered 12 hour shifts per week in the hospital in order to complete their necessary competencies and their remaining contracted hours are spent in the community. For a midwife this equates to 0.64 WTE of their contracted hours spent in the hospital. For NQM's in MCoC teams these 2 rostered shifts replace the birth availability working pattern. To reflect this all NQMs have a smaller caseload whether in an MCoC team or Traditional community team.

The NQM's are supported by the Professional Development Midwives (PDMs) who meet regularly with them and monitor the progress they're making towards getting their competencies signed off. In addition they receive weekly caseload supervision with their Team Leader which is recorded.

WSFT Shared Preceptorship Model



The shared preceptorship model was implemented at West Suffolk Hospital at the beginning of March 2022. The 7 NQMs that qualified in March have all been placed within a

community team – either a MCoC team or a Traditional community team so that they were strategically positioned and ready for roll out continuity of carer over the next 12 months.

- **Recruitment** – a rolling programme of recruitment is in place, including International Recruitment. We are also planning a Recruitment event in July 2022 to promote the service and try to attract new midwives to WSH. However, our ability to recruit midwives at pace has been a significant challenge and has remained the single, biggest risk to the successful roll out. All we have managed to achieve over the last year is to tread water with recruitment and we have not managed to recruit a sufficiency of midwives to give the critical mass required to roll out CoC at the pace needed. There is no doubt that the national shortage of midwives and Covid have impacted negatively on our ability to progress our plans for further roll out of teams as originally planned. We are also going to focus on the retention of midwives and make provision for pastoral support.

- **Monitoring of vacancies –** monthly vacancies are reported to Trust board bi-monthly. Below is the April vacancy figure which is -22.63, with significant vacancies at Band 6 midwives. The high number of vacancies at Band 6 is why minimum staffing requirements can not be met for all 3 existing teams or for further roll out in the very near future.

Table 1: All Establishments April 2022

	Funded	WTE in post	Variance
Band 8A	4.00	4.00	0.00
Band 7	31.17	31.17	0.00
Band 6	88.63	59.41	-29.22
Band 5	9.12	15.71	6.59
MW total	**132.92**	**110.29**	**-22.63**
Band 4	0.00	0.00	0.00
Band 3	8.68	9.27	0.59
Band 2	28.04	21.69	-6.35
Clinical Support Total	**36.72**	**30.97**	**-5.75**
TOTAL	**169.64**	**141.26**	**-28.38**

Note: There is currently a vacancy rate of 8.11 WTE in the hospital in-patient service. The rostered shifts for the NQM's based in community teams equate to 4.48 WTE midwifery hours going back into the hospital, thereby reducing the overall in-patient vacancy rate to 3.63 WTE. This gap will be filled when we have the International Recruitment midwives starting towards the end of the summer, plus there are 3 students due to qualify at the end August/beginning of September and another 0.8 WTE Band 6 midwife has recently been recruited awaiting a start date.

See Appendix 1 for the monitoring of midwives in post on a monthly basis and progress being made towards closing the vacancy gap to meet the target Establishment of 132.92 WTE.

- **Established the MCoC Steering Group -** to support the operational implementation of Continuity of Carer across West Suffolk.

4. Ockenden Review – 30 March 2022

There are 2 immediate actions (IEAs) in the final report of the Ockenden review that will directly impact on how we proceed with the roll out of our plans for MCoC at WSH are:

IEA 1: Workforce planning and sustainability

All NQMs must remain within the hospital setting for a minimum period of one year post qualification. This timeframe will ensure there is an opportunity to develop essential skills and competencies on which to advance their clinical practice, enhance professional confidence and resilience and provide a structured period of transition from student to accountable midwife.

IEA 2: Safe Staffing

All trusts must review and suspend if necessary the existing provision and further roll out of Midwifery Continuity of Carer (MCoC) unless they can demonstrate staffing meets safe minimum requirements on all shifts. This will preserve the safety of all pregnant women and families, which is currently compromised by the unprecedented pressures that MCoC models place on maternity services already under significant strain.

The reinstatement of MCoC should be withheld until robust evidence is available to support its reintroduction

5. Review of the existing provision

On 14th April 2022 a group of senior midwives reviewed the existing provision from the perspective of:

- Current Staffing across both MCoC and traditional Community midwifery teams
- Current Caseload size
- The Shared Preceptorship model
- Feedback from the midwives.

A combination of this information has been used to shape the 3 options for roll-out of MCoC.

Option	Advantages/benefits	Disadvantages/drawbacks	Comments
Option 1: **Continue with 3 teams and bring the NQMs back into the hospital setting**	• Would meet the Ockenden recommendation of EIA 1: Workforce	• Would not meet the Ockenden recommendation 2: Safe staffing as Willow not operating within national guidelines in terms of caseload as team has just 4.5 WTE midwives in place (without the NQM's) • As of 1st July we will lose another 1.0 WTE midwife from Willow.	It was agreed by senior midwives to suspend Willow at the meeting held on 14th April as not meeting safe staffing requirement. Therefore, this is not an Option to continue with the 3 teams as not safe to do so.
Option 2: **Continue with 2 teams i.e. Iceni and Sapphire, dissolve Willow and bring the NQMs back into the hospital setting**	• Would meet the Ockenden recommendation of EIA 1: Workforce. • Would meet the Ockenden recommendation of EIA 2: Safe staffing • Provide opportunity to further develop and refine the model/evidence base and outcomes prior to the roll out of further teams. • Provide opportunity for a more positive narrative around MCoC to be developed • Continues to provide MCoC team (Iceni) in the 10% most disadvantaged area.	• Will lose momentum with MCoC and due to the high levels of vacancies to fill, unlikely to get another team out until March/April 2023 • MCoC will not became the default model of care for all women by end March 2024. • Willow midwives may have to be re-deployed to meet gaps in other Traditional community teams • The increase in NQMs on Labour Suite will create pressure in terms of managing a high number of NQMs to get their competencies signed off. The NQMs may end up spending more time than they need in other areas of the unit and miss out on valuable community experience • Skill mix on Labour Suite as majority will be Band 5s • This will create 2 vacancies in Iceni which will need to be filled asap – otherwise Iceni won't be operating with safe staffing levels and in same situation as Willow is currently. • Has the ability to completely de-stabilise MCoC and future roll out.	7 NQMs placed in community teams at beginning of March under the new Shared Preceptorship model are currently in limbo and needing clarity on the decision as to whether they are expected to go back into the hospital or stay with the community setting. What they want is what's best for their development. Due to off duty that has already been agreed they will be unable to return to hospital setting until beg July. In the meantime, the majority are settled where they are in their community teams and feeling supported by their Team Leader and PDM. They have been focused on getting their competencies signed off during their 2 days on Labour Suite. We need to plan our staffing and the next team to roll out. It may not necessarily be Willow.

		• NQM's will miss out on the 'sisterhood of support' from being part of a smaller community team and ad-hoc opportunities for debrief	
Option 3: **Continue with 2 teams i.e. Iceni and Sapphire and continue with the 'Shared Preceptorship' model for NQM's in both MCoC and Traditional Community teams**	• Would meet the Ockenden recommendation of EIA 2: Safe staffing • Provide opportunity to further develop and refine the model/evidence base and outcomes prior to the roll out of further teams. • Provide opportunity for a more positive narrative around MCoC to be developed • The Shared Preceptorship model will enable NQMs to gain experience in both hospital and community settings. The ability to feel comfortable and flex/adapt across both hospital and community is a key skill for a MCoC midwife and they will consolidate their experience in all areas. • The NQM's will not miss out on the Sisterhood of support • Continues to provide MCoC team (Iceni) in the 10% most disadvantaged area.	• Would not strictly meet the Ockenden recommendation of EIA 1: Workforce. • With suspending Willow it will take time to build up the momentum again, even with the Shared Preceptorship Model.	The majority of NQMs are settled where they are in their community teams and feeling supported by their Team Leader and PDM. They have been focused on getting their competencies signed off during their 2 days on Labour Suite. By the time they would be able to go back into the hospital they will already have completed 4 months of their preceptorship. The question is – what is there to gain by this? We need to develop a sustainable model for supporting NQMs across the midwifery system, particularly as the cohort of students are getting bigger. Placing NQMs in community teams will help this spread and better support the skill mix on Labour Suite in the longer term. We provide students with experience of managing a small caseload in the community. We need to plan our staffing and the next team to roll out. It may not necessarily be Willow.

The preferred option is Option 3: Safe staffing can be met for 2 teams – with 1 team being suspended. The service continues to provide MCoC (Iceni team) for women living in the 10% most disadvantaged area. However, safe staffing cannot currently be met for further roll out.

This option provides the current NQM's with stability during their important first year post qualifying as they have already started in the community under the new 'Shared Preceptorship' model and it will end the current 'limbo' they are feeling. They are just beginning to feel settled in their new role and they will be able to consolidate their experience in all areas. This will ultimately mean they will have the skills and resilience they need to cope with the fluidity of moving between the community and hospital setting. This is a key skill for a Continuity of Carer midwife. This will enable us to review our plans for roll out and continue to roll-out further teams as and when safe staffing permits and our vacancies are filled.

The latest NHS planning guidance (6 May 2022) states that in relation to NQM's a national working group is being convened to guide the implementation of the IEA's and services should therefore wait until national guidance before redeploying NQMs currently in MCoC teams.

Option 2: whilst it meets both the IEAs in the Ockenden report with regards to workforce and staffing, this will in effect destabilise and slow down all plans for any further roll out for at least a year and we will have lost all momentum with the roll out and make it harder.

Option 1: is not a safe option as it is recognised that Willow team needs to be suspended because we're unable to support safe staffing.

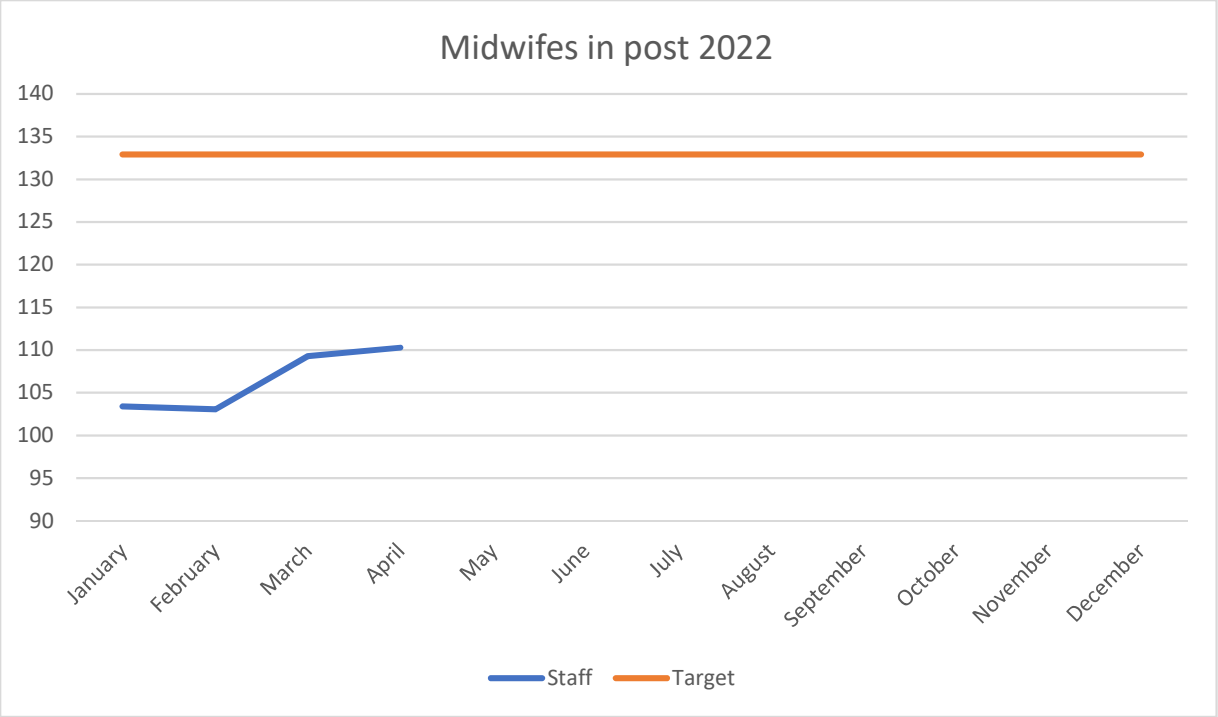
Recommendations

- That the LMNS Board support Option 3 unless there is a strong view to the contrary.
- The LMNS Board accepts that (following the 1 April letter from the Chief Executive, Chief Nursing and Chief Medical Officers at NHSE/I) the Trust has assessed its staffing position and has made the following decision for the service:
  'That staffing demonstrably meets safe minimum requirements for the continuation of 2 of the current teams, but these cannot currently be met for further roll out'

Next Steps

- Submit revised trajectory for achieving roll out of all 8 teams so that MCoC becomes the default model of care by end March 2024
- Review Birthrate Plus
- Put forward Iceni team for Enhanced MCoC

Appendix 1: Midwives in post 2022



We have 8 International Midwives in the pipeline but due to delays in their visas they are unlikely to be in post until the summer at the earliest.

We still need to map the new NQMs and new starters against our plans for roll out.

Workforce Scoping Template

Date: 12th May 2022

Name of trust: West Suffolk NHS Foundation Trust

Name of LMNS: Suffolk & North East Essex LMNS

1. **Brief description of unit**: The West Suffolk NHS Foundation Trust Neonatal Unit is a Level One Unit equipped to care for babies ranging from 30 weeks gestation to full term, according to their clinical needs. There are 12 cots- 1 Intensive care, 3 High Dependency Care and 8 Special Care. The designated Level 3 Unit is Addenbrookes in Cambridge, a baby needing more intensive care is stabilised within the Unit, and transferred to the nearest Level two or three Unit via designated transport service. Once stable, the baby is transferred back for on-going care. The Unit is supported and care standardised by the EoE Neonatal Network.

Unit designation	NICU	LNU	SCU
Number of cots	ITU	1	
	HDU	3	
	SC	8	

2. Gaps between those in post v's establishment v's Neonatal Nursing Workforce calculator

Workforce establishment- Staff providing cot site care only			
Staff group	**BAPM standard**	**Actual**	**Gap**
Nurse leader B 8	0	0	0
Nurse leader B7	0	0.32*	0
Nurse QIS B6	Total QIS required- 15.16 wte	9.52	-2.24 wte
Nurse QIS B5		3.40	
Nurse B5	3.44	4.44	+1.0 wte
Nurse B4	3.28wte	Band 4- 2.64 wte Band 3- 0.64wte	0
Practice Educator		0.32*	
Patient safety		0	
Feeding lead		0	

* Ward Manager band 7 contracted hours- 1.0 wte (working clinically 0.32wte)
* Practice Educator band 7 contracted hours – 1.0wte (working clinically 0.32wte)

NNU Staffing is above the national target of 70% qualify in speciality with current compliance of 74.2%. Currently 3 staff members undertaking the QIS training with an expected completion date of November/ December 2022.

NNU has a low turnover rates and there is currently a vacancy of 1.24wte at band 6 Senior Nurse level only, the post has been advertised and interviews scheduled for w/c 16th May 2022.

3. Recruitment strategy; overseas, recruitment days, open days apprenticeships etc.

Recruitment strategy	Outcome
International	NA
Recruitment events: Local/National	NA
Other:	Local recruitment only
Recruitment plans	Vacant post advertised and interviews scheduled for w/c 16th May 2022
Time frame for plans	4 months
Challenges experienced or envisaged: Potential delays of obtaining/ receiving recruitment checks and references, subsequently delaying ability to confirm offers	

4. **International Nurses**

Do you offer an in-house or external adaptation program for International Nurses?
~~Yes~~ ~~No~~ N/A √
Do the International Nurses access the network QIS program?
~~Yes~~ ~~No~~ NA √

Do you restrict clinical practice (unable to care for a baby requiring intensive care) until the International Nurses have undertaken a QIS program?
~~Yes~~ ~~No~~ NA √

Comments: There is an ongoing recruitment of International Nurses in the Trust that NNU can participate in if required. An in-house training and adaptation program would be provided for IR nurses allocated to NNU

5. **Student on clinical placement**
   a. What students do you currently provide placement for?
      i. Midwives:

ii. Adult nursing:

iii. Nursing Associate:

iv. Child health branch:

v. If no to any of these would you consider including them?

Yes, placement for student midwives, midwives, student paramedics, paramedics have been provided in the past

6. **Nursing Associates**
   a. Do you currently employ NA √ ~~Yes~~ ~~No~~
   b. Would you consider training Yes √ ~~No~~

7. **Quality roles:**

Roles	Hours/FTE	Clinical component
Patient safety	0	N/A
Education	1.0	PDN-0.32 wte
Feeding lead	0	N/A
Safeguarding	0	N/A
Infection control	0	N/A
Mental health	0	N/A
FIC	0	N/A
Other:		

***** We do not have dedicated hours for the above roles, but these are allocated to staff as Link Roles in an area of interest to them, and there is an expectation that they will dedicate some time to the role within their Clinical worktime. There is also an access to a Safeguarding Midwife, Mental Health Midwife and Infant Feeding coordinator which are part of Maternity workforce.

8. **Training needs analysis:**
   a. How do you determine your TNA:

BAPM standards for QIS

Mandatory requirements for the Trust

Equipment competencies

Network Skills days

Feedback or requests for training for staff

Training specific for Link Roles

Gap Analysis for specific Clinical Skills

QIS	3	0	CPD	0	Registered Nurse
ANNP	0	0	N/A	N/A	N/A
ENP	0	0	N/A	N/A	N/A
ANNP	0	0	N/A	N/A	N/A
Education	4	28	CPD/Free	0	Reg & Non-Reg Staff
Leadership	1	0	Pilot Free	0	Senior Registered Nurse
Other:					

9. **Course/service attrition**: over the last 2 years

Course	Left course	Left service	Reasons
Preceptorship	0	0	
QIS	0	0	
ENP	0	0	
ANNP	0	0	
Education	0	0	
Leadership	0	0	
Other:			

10. **Projected numbers of staff leaving service in next 12 months**

a.

Staff Group	Number	Reasons	Strategy
Nurse leader B 8	N/A		
Nurse leader B7	1	Retirement	
Nurse QIS B6	3	Retirement/New career	
Nurse QIS B5	0		
Nurse B5	0		

Nurse B4	1	Returning to previous job	Found working pattern unsuitable
Practice Educator	0		
Patient safety	0		
Feeding lead	0		
Fi Care lead	0		
Other			

b. Do you offer "retire and return": Yes √ ~~No~~

11. **Succession planning** – What succession planning do you have in place and what does this look like/involve

Rolling programme for QIS Nurses.

Expert Navy In House Training.

Senior Team encouraged to 'cross work' to have an overview of different Senior Roles.

12. **Innovative models of staffing and care provision**– e.g. apprenticeships, Nursing Associates, clinician's assistants, additional training such as SC/TC modules/ competency frameworks individual to your particular unit – NN caring for babies on oxygen/high flow/ extended roles ….

No registered staff to undertake SC /TC Module (on completion of training, and set competencies Band 4 Nursery Nurses will be indirectly supervised in extended roles)

Criteria Led discharge and implementation of PGD's for the Band 6 staff.

Enhanced skills ie cannulation and removal of Long Lines.

FINE Level 1 & 2, and Brazleton Course.

Band 6 attend deliveries.

Multiple Nursing staff on the NLS Faculty.

MDT Training with Maternity and Paediatrics, and supporting Medical skills training and SIM Training.

13. **Advancing practice**:

Role	In post	BAND	Funding	Rota	Training	Band	HEI
ENP	2	6&7	CPD	------	------	------	-------
ANNP	0						
AHP	0						
Other							

In House ENP skills training completed by 15 Registered Nurses currently in post.

14. **Have you considered advertising staff vacancies as an LMNS?**

    a. If yes, what do these include?

    No, however this can be explored further if the needs arise.

    b. If no would you consider this in the future?
    NA

15. **Do you have any plans for rotational posts across paediatrics/maternity *to* improve recruitment and skill acquisition?**
    a. If yes, what does this include?
    Not currently however this can be explored further if the needs arise.

    b. **If no would you consider this in the future?**
    Yes

16. **Would you consider staff working across sites i.e., SC staff working on LNU/NICU to upskill?**
    a. **If yes, what would need to be considered?**
    WSFT is a single site Trust however staff undertaking the Quality in Speciality course (QIS) are required to undertake 12 weeks placement in a level 3 unit (NICU) to upskill.

17. **Flexible working**
    a. **What do you offer in terms of flexible working?**
    WSFT will aim to promote flexible working options from the point of recruitment, and will regularly discuss flexible working and how this can continue to support colleague wellbeing. All trust colleagues are eligible to submit a flexible working request, regardless of the length of service, or whether previous applications have been made. The variation can relate to hours, days or place of work. The following is a non-exhaustive list of some of the Flexible Working Options available to colleagues as per Trust policy, depending of the clinical needs of each service:

- Part Time
- Annualised Hours
- Term Time (3 year fixed term period)
- WSP Professional/Bank
- Home Working
- Job Share
- Career Break
- 9 day Fortnights

On NNU 4 staff members have an HR flexible working pattern, which is reviewed every 6 months.

b. **Are sabbatical and/or secondment opportunities supported by the service?**
Yes, if requested and deemed appropriate.

c. **Are staff supported to take extended leave for compassionate reasons: care of a partner, parent, and child?**
Always.

18. **Do you have a transitional Care Unit in your service?**

a. **What is the management structure?**
Transitional Care is part of the antenatal and postnatal ward. Midwives provide a care to mothers/ birthing people managed by the ward manager and babies care is provided by NNU staff managed by NNU Manager

b. **What is the staffing model?**
Band 4 Nursery Nurses holding or completing the TC/SC Module.
Supervised by the Senior Team on the Neonatal Unit and a band 6 Senior Nurse lead for Transitional Care.

c. **How is it funded?**
Currently from the Maternity Budget following a successful Business Case. This has been transferred to Neonatal Unit budget from April 2022

d. **What training is provided for the staff?**
Comprehensive induction programme, jointly led by the Neonatal PDN and a dual trained Neonatal Nurse/Midwife.
Supernumerary status to work alongside experienced staff until competent, confident and capable.
TC/SC Module compulsory.

19. **Black and Ethnic minority staff**

a) What percentage of your staff identify as BAME?

13%

b) What recruitment strategies are in place to attract BAME staff?

WSFT has an Equal Opportunities Policy aiming to promote equality and diversity in all employment processes. This Recruitment and Selection policy aims to ensure that the Trust has fair, open and non-discriminatory systems for recruiting, developing and promoting people based on high standards to ensure the recruitment and retention of high-quality staff. Values Based Recruitment (VBR) has been identified as a key objective for the Trust and NHS overall. The VBR method aims to attract and select employees on the basis that their own individual values and behaviours align with the values and behaviours of the Trust. The Trust's Recruitment & Selection process is moving towards VBR to ensure that employees are selected against the Trust values to enable us to recruit the right workforce (with the right skills and in the right numbers) and also with the right values to support our teams in the delivery of excellent patient care and experience.

VBR can be delivered using a range of recruitment methods including pre-screening assessments, values based interviewing techniques, role play, written responses to scenarios and assessment centre approaches.

What professional development opportunities are offered to BAME staff?

West Suffolk NHS Foundation Trust is committed to a policy of equality, diversity and inclusion in employment and service delivery. Everyone who works in the Trust, or applies to work in the Trust, should be treated fairly and valued equally. The West Suffolk NHS Foundation Trust is committed to the education, training and development of its staff to assist in achieving the objectives of the organisation, and to

assist with recruitment and retention. The provision of study leave supports this objective by extending the opportunities both for formal learning and development activities. Continuing professional development (CPD) is an essential component of lifelong learning is available to all staff equally.

c) Do you provide Cultural Competency training for staff in your service?

All staff required to complete Equality and Diversity Unconscious Bias, and Equality & Diversity Mandatory Training.

d) Are you aware of "Workforce Race Equality Standard" (WRES) data?

Yes, the Workforce Race Equality Standard (WRES) is included in the NHS standard contract and its main purpose is:

• To help local, and national, NHS organisations (and other organisations providing NHS services) to review their data against the nine WRES indicators.

• Produce action plans to close the gaps in workplace experience between white and Black and Ethnic Minority (BME) staff and

• To improve BME representation at the Board level of the organisation.

The Trust will review its performance against the WRES indicators annually and develop a plan to take action as necessary.

20. **Have you submitted or in the process of submitting Neonatal Workforce plans to achieve compliance with Maternity Incentive Scheme Action 4?**

Yes: √ **No:**

Comments:

In the process of writing.

21. **We would really like to know how the ODN can support you.**

We feel our engagement with the ODN utilises their support, they are always approachable. **We feel we have a good working relationship.**

22. **Any other comments/suggestions**.

We feel that a rotational Network post/ Secondment for trained staff within the Network/ Cluster groups would beneficial in terms of maintaining skills and being aware of the needs and working within Units of different Levels.

Thank you from the Workforce team.