Board of Directors (In Public)

Schedule	Friday 30 September 2022, 9:15 AM — 12:45 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, 30 September 2022 at 9:15am.
Organiser	Ruth Williamson

Agenda

AGENDA

_WSFT Public Board Agenda - 30 Sept 2022 - Final.docx

1. GENERAL BUSINESS

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

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

1.3. Minutes of the previous meeting - 22 July 2022
To Approve - Presented by Jude Chin

Item 1.3 Open Board Minutes 22 July 2022 Draft.docx

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

Item 1.4 - Open Action Points - Sept 22.pdf

Item 1.4 - Complete Action Points - Sept 22.pdf

1.5. Patient / staff story
To Note

1.5.1. Glemsford primary care practice - staff experience
Melissa Williams, Lead GP in attendance
To Note - Presented by Paul Molyneux

1.5.2. Response and reflections from patient story received in July (Verbal)
Presented by Susan Wilkinson

Item 1.5 Patient story debrief.docx

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

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

Item 1.7 CEO Board Report.docx

2. CULTURE

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

Item 2.1 People OD highlight sept2022.docx

2.2. Responsible officer's annual revalidation report and statement of compliance
To Assure - Presented by Paul Molyneux

Item 2.2 HEE A-framework-of-quality-assurance-for-responsible-officers-and-revalidation - September 2022 final.docx

Item 2.2a HEE Submission Cover Sheet.docx

Item 2.2b Provider Self-Assessment - Guidance Document for Providers (1).pdf

Item 2.2c HEE Self Assessment.pdf

3. STRATEGY

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

Item 3.1 WSFT FS public board sept 2022.docx

3.2. System update

3.2.1. Alliance

To inform - Presented by Clement Mawoyo

- Item 3.2.1 WSFT boardcommittee report front sheet CM 30092022.docx
- Item 3.2.1 Integration report final.docx
- Item 3.2.1 Community wellbeing V4 with recommendations.pdf
- Item 3.2.1 Understanding Community Wellbeing - what keeps people connected Report FINAL.pdf

Comfort Break

4. ASSURANCE

4.1. Insight Committee Report - August & September, 2022 - Chair's Key Issues from the meeting

To Assure - Presented by Richard Davies

- Item 4.1 Insight Chair's Key Issues August 2022.docx
- Item 4.1 Insight Chair's Key Issues September 2022.docx
- Item 4.1 Insight CKI Appendix - 22-194 CP re Cancer Services - Recovery and Improvement 20221907341428.pdf

4.2. Finance and Workforce Report

To Assure - Presented by Nick Macdonald

- Item 4.2 Finance Report- August 2022_Front_Sheet_Final.docx
- Item 4.2 Finance Report- August_2022_Final.docx

4.3. Improvement Committee Report - August & September, 2022 Chair's key issues from the meetings

To Assure - Presented by Jude Chin

- Item 4.3 22-08 Chairs key issues - Improvement Committee.docx
- Item 4.3a STROKE SERVICES PRESENTATION FOR IMPROVEMENT COMMITTEE MTG AUGUST 2022.pptx

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

Item 4.4 Safer Staffing July August.docx

4.4.1. Maternity services Quality & Performance Report (10.00 am)
For Approval - Presented by Susan Wilkinson

Item 4.4.1 _September 22 Maternity Quality Safefy and Performance Board Report.docx

4.5. Involvement Committee Report - September 2022 Chair's key issues
To Assure - Presented by Alan Rose

Item 4.5 CKI involvement sept22.docx

4.6. Integrated Quality and Performance Report (IQPR) - See Annexes 7.0
To Note - Presented by Nicola Cottington and Susan Wilkinson

5. GOVERNANCE

5.1. Governance report
To inform - Presented by Richard Jones

Item 5.1 - Governance Report.docx

6. OTHER ITEMS

6.1. Any other business
To Note

6.2. Reflections on meeting
For Discussion

6.3. Date of next meeting - 25 November, 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

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7. Annexes for information:
   To inform

4.4.1 - Maternity Papers

- Item 4.4.1 B - HSIB and Early Notification Reporting Q1 2022 Annex B.docx
- Item 4.4.1 C - 2022 ATAIN Quarter 1 April-June 2022 progress report Annex C.pdf
- Item 4.4.1 D - Neonatal Nursing Staffing Assessment Report 22 Annex D.docx
- Item 4.4.1 E - Training needs analysis and tracker Q1 22 Annex E.pdf
- Item 4.4.1 G - NNU Medical staffing suveyAugust 2022 Annex G.docx
- Item 4.4.1 H - Transitional Care Report Q4 Annex H.docx
- Item 4.4.1 I - Transitional Care Report Q1 2022 Annex I.docx
- Item 4.4.1 J - WSFT Digital Strategy for Maternity v1.4 DRAFT Annex J.docx

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4.6 - Integrated Quality & Performance Report (full)

- Item 4.6 Board Report July 2022 v2 with front sheet.pdf

5.1 - Governance papers

- Item 5.1 Annex A CQC RGRX1 Glemsford Surgery (14_09_2022) INS2-12950580051.pdf
- Item 5.1 Annex B NHSEI Self-Certification 2021-22 Audit Committee 14 Sept 2022 PS.doc
- Item 5.1 Annex C Modern-slavery-statement 2022 PS CS - Clean.docx
- Item 5.1 Annex D BAF Summary and Risk Report (004).docx
- Item 5.1 Annex E Draft agenda.docx

AGENDA

WSFT Board of Directors – Public Meeting

Date and Time	Friday, 30 September 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 – 22 July 2022**	Chair	Approve	Report
	1.4	**Action log and matters arising**	All	Review	Report
09:20	1.5	**Patient story**			
	1.5.1	**Glemsford primary care practice – Melissa Williams, Lead GP**	Medical Director	Note	Report
	1.5.2	**Response and reflections from patient story received in July**	Chief Nurse	Review	Verbal
	1.6	**Questions from Governors and the public**	Chair	Note	Verbal
09:50	1.7	**CEO report incorporating SNEE Integrated Care Board**	CEO	Inform	Report
2.0 CULTURE					
10.00	2.1	**People and organisational development highlight report**	Director of Workforce	Assure	Report
	2.2	**Responsible officer's annual revalidation report and statement of compliance**	Medical Director	Assure	Report
3.0 STRATEGY					
11:00	3.1	**Future system board report**	Chief Executive	Assure	Report
	3.2	**System update**			
	3.2.1	**Alliance**	Clement Mawoyo	Inform	Report
11:30 Comfort Break					
4.0 ASSURANCE					
11:40	4.1	**Insight committee report** – Aug & Sep 2022 – chair's key issues from the meeting	NED Chair	Assure	Report
	4.2	**Finance and workforce report**	Director of Resources	Assure	Report
12:00	4.3	**Improvement committee report** – August & September 2022 chair's key issues from the meeting	NED Chair	Assure	Report
	4.4	**Quality and nurse staffing report**	Chief Nurse	Assure	Report

	4.4.1	**Maternity services:** - Quality Safety & Performance Report	Chief Nurse	Approval	Report
12:20	4.5	**Involvement committee report** - September 2022 chair's key issues	NED Chair	Assure	Report
	4.6	**Integrated Quality and Performance Report (IQPR)** Provided in Annex of meeting pack – reported via Insight, Involvement and Improvement	COO / Chief Nurse	Note	Report
5.0 GOVERNANCE					
12:40	5.1	**Governance Report**	Trust Secretary	Inform	Report
6.0 OTHER ITEMS					
12.55	6.1	**Any Other Business**	All	Note	Verbal
	6.2	**Reflections on meeting**	All	Discuss	Verbal
	6.3	**Date of next meeting** • **25 November 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

Agenda item	Description
4.4.1	Maternity papers – Annexes A-J
4.6	Integrated quality and performance report (full)
5.1	Governance Report Annexes A-E

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:

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 - 22 July 2022

To Approve

Presented by Jude Chin

DRAFT

MINUTES OF BOARD OF DIRECTORS MEETING

HELD ON 22 JULY 2022 9.15-12.45
ASHLAR HOUSE, BURY ST EDMUNDS

COMMITTEE MEMBERS			
		Attendance	**Apologies**
Jude Chin	Chair	•	
Alan Rose	Deputy Chair/Non-Executive Director	•	
Louisa Pepper	Non-Executive Director	•	
Richard Davies	Non-Executive Director (Maternity Safety Champion)	•	
Christopher Lawrence	Non-Executive Director (left after item 4.6.2)	•	
Craig Black	Interim Chief Executive	•	
Nicola Cottington	Chief Operating Officer	•	
Sue Wilkinson	Executive Chief Nurse	•	
Nick Macdonald	Interim Executive Director of Finance	•	
Paul Molyneux	Interim Executive Medical Director (Maternity Safety Champion)	•	
Jeremy Over	Executive Director of Workforce and Communications	•	
In attendance			
Richard Jones	Trust Secretary		
Pooja Sharma	Deputy Trust Secretary		
Clement Mawoyo	Director of Integrated Adult and Social Care Services		
Louise Kendall	EA to Dr Helena Jopling (minutes)		
Justyna Skonieczny	Deputy Head of Midwifery (for item 4.6 only)		
Kate Croissant	Deputy Clinical Director – Women & Children (for item 4.6 only)		
Francesca Crawley	Guardian of Safe Working (for item 2.2 only)		
Peter Wightman	West Suffolk Alliance Director		
Dan Spooner	Deputy Chief Nurse (for item 4.3 only)		
Governors in attendance (observation only): Florence Bevan, Clive Wilson Staff: Paul Pearson, Laura Wilkes, Juliet Fisher (all Staff Side)			
Members of the Public: Councillor Margaret Marks from West Suffolk Council, Journalist from East Anglian Daily Times (both left after item 3.2.2)			

Action

1.0 GENERAL BUSINESS

1.1 APOLOGIES FOR ABSENCE

There were no apologies.

1.2 DECLARATION OF INTERESTS FOR ITEMS ON THE AGENDA

No declarations of interest were received.

1.3 MINUTES OF MEETING HELD ON 27 MAY 2022

The minutes of the previous meeting were approved as a true and accurate record, subject to the following amendments:

- Agenda item 4.3 (IQPR), p. 7, first bullet point, second sentence - "They are from ward outbreaks….." to be amended to read "**Some of the positive patients** are from ward outbreaks…."

- P. 7, second bullet point, first sentence – "In March, patient falls went up above the national average, mainly due to staffing levels….." to be amended to read "In March, patient falls went up above the national average, **in part this may be** due to staffing levels….."
- Agenda item 4.6 (Maternity Services Quality and Performance Report), p. 8, second paragraph, third sentence – "Whilst this has improved, further improvement was required so that each session was an MDT." To be amended to read "Whilst this has improved, further improvement was required so that each session **was representative of the MDT**".

1.4 ACTION LOG AND MATTERS ARISING

The ongoing actions were reviewed and updated.

1.5 PATIENT STORY

A patient's daughter told the story of her mother who was admitted to WSH and sadly passed away. There were failings in communications with the patient's daughter which led to her being unable to see or speak to her mother before she became very seriously ill. The lady subsequently made a complaint to the Parliamentary Ombudsman, which resulted in mediation with senior hospital clinicians. The lady emphasised that she was speaking not for herself, but on behalf of her late mother.

The Chair (Jude Chin) thanked the patient's daughter and offered apologies for her poor experience. It was noted that there were lessons to be learnt and actions will be taken to improve the care of patients and their next of kin. Also, changes need to be made rapidly, including making sure that staff feel empowered to make the correct decisions in individual situations.

The Board noted that there are always opportunities to improve the PALS service and it is important that staff continue to live the experiences in order to learn from them. Rules and processes are in place to achieve efficiency but sometimes the most important things are sacrificed, and they should not override doing the right thing.

It was also noted that the Board requires assurance that lessons are being put into practice and that changes are being made. How best to do this will be decided following a period of reflection.

ACTION: The Board advised to follow-up on the process issues and how staff can be supported to ask questions in various situations, so that such incidents are not repeated. **S Wilkinson & J Over**

1.6 QUESTIONS FROM GOVERNORS AND THE PUBLIC

- Florence Bevan (Public Governor) expressed disappointment that Trust Governors had not been made aware of the Integrated Care System (ICS) event which took place in Newmarket on 1st July.

  The Interim Chief Executive (Craig Black) apologised, and noted that although the event had been publicised, it would appear that this was not done effectively. This will be looked in to, and efforts made to ensure that future events are publicised to staff, governors and the public where appropriate.

The West Suffolk Alliance Director (Peter Wightman) confirmed that ICB Board meetings would be open to governors and distribution lists would be updated accordingly.

1.7 CHIEF EXECUTIVE'S REPORT

The Interim Chief Executive (Craig Black) presented the report and provided an update on events in the last week since the report was produced.

The organisation is currently very busy and has been for the last couple of weeks. There have been patient experience issues as a result and staff have been working very hard across the organisation.

The pay award was announced earlier this week which has caused a degree of disquiet across the NHS. Staff side organisations are balloting their members on next steps. Different staff groups have received different pay awards and there are some considerable anomalies.

The CQC inspection of Glemsford took place on Wednesday 20th July. Immediate feedback was received which reflected the immense amount of preparation for the inspection, and was largely positive. The Interim Chief Executive thanked the staff at Glemsford for their hard work.

The current pressures and the impact on staff were noted. Staff are stoic about the pressure but comments from the Freedom to Speak Up Guardians showed the extent of the pressure and the desperation some are feeling. Sickness levels have also created problems not seen before. Problem-solving is a familiar task, but demand is not matched by the Trust's capacity. The distress of staff should be noted and to consider how to respond to the staffing level issues raised by staff with the FTSU Guardian.

It was also noted that the lack of a national workforce plan is a contributing factor, and local initiatives are needed in order to fill staff vacancies. The Trust's HR department has recruited additional staff, and technology also has a role to play. A new head of resourcing will be reviewing the effectiveness of processes and make recommendations on actions to be taken. Discussions with partner colleagues may help to alleviate staffing problems.

Concern was expressed about staff retention. The Executive Director of Workforce and Communications (Jeremy Over) reported that discussions are taking place about the response to staff pay and the results will be presented to the Board. It would be helpful to learn more about the SNEE-wide strategy.

ACTION: Future report to include results of discussions on staff pay and the coordinated plan for recruitment and retention for visibility at the board, which will also be shared across the organisation. **J Over**

2.0 CULTURE

2.1 PEOPLE AND OD HIGHLIGHT REPORT

The Executive Director of Workforce and Communications (Jeremy Over) presented the report and drew the Board's attention to the Putting You First Award for June/July to Liz Flett; the update on learning and development capacity; the latest results of the quarterly staff survey; and the Freedom to Speak Up Guardian's (FTSUG) report for Q1, highlighting the FTSUG's challenge to the Board to ensure that staff know that they are being listened to and that actions are taken.

It was noted that the FTSUG report shows an increasing trend of approaches to FSUGs. This indicates that more staff feel able to speak up and seek support. A

total of 43 concerns were raised, of which 12 related to staffing. Development work is ongoing and Board actions reflect the work on training for senior leaders. Instructions will be circulated to Board members about how to undertake training. The National Guidance Office has launched a new suite of guidance and policy for NHS organisations, and a new support scheme for whistle-blowers. –

ACTION: To circulate the new national FTSU training link. **J Over**

There is still a worrying trend in the number of cases of bullying and harassment, and the relationship with managers. Staff are worried about being told off if they have raised a concern or want to do so. However, managers should not be victimised, and support and training should be provided to them.

ACTION: Assurance was sought on effectiveness of action to address bullying and behaviours and supporting staff. **J Over**

The Board thanked the two FTSUGs for their work, and noted the challenge of ensuring that changes will be made as a result of issues raised. Some issues are not fully resolvable, but staff should continue to be listened to, and changes made where possible. Staff should be consulted for ideas about improvements.

ACTION: FTSUG report to be brought to the next meeting for further in-depth discussion. **J Over**

2.2 GUARDIAN OF SAFE WORKING REPORT

The Guardian of Safe Working (Francesca Crawley) presented the annual report on safe working, and highlighted the effect of the pandemic on junior doctors. The Trust has been hugely supportive, but more staff are needed to fill gaps.

The Interim Executive Medical Director (Paul Molyneux) acknowledged the work of Francesca Crawley in this area and gave thanks for her work over a number of years. He noted the effect of the pay award on junior doctors in particular, and the significant gaps across the system which was keenly felt by junior doctors and consultant colleagues. The future of the workforce is in developing and supporting clinical staff.

It was noted that exception reports are not always completed, the reasons for which are unclear, and doctors are encouraged to follow the correct process. The Emergency Department in particular has a low return, and this is being examined. The flexibility of junior doctors was acknowledged, and this has helped the service to continue. However, minimum staffing causes exception reporting to increase. The contribution of advanced care practitioners and physician associates to the work of the Trust was also acknowledged.

Attention was drawn to the apparent low number of gaps in the quantity of junior doctors. The Executive Director for Workforce and Communications informed that the problems of staffing can be attributed more to staff sickness. The supply of doctors is governed by Health Education England, but there are not enough doctors in the region to fill all vacancies. This is a problem which cannot easily be resolved.

2.3 MEDICAL REVALIDATION REPORT

The Interim Executive Medical Director (Paul Molyneux) presented the appraisal report which outlined key changes to the appraisal process within the organisation over the last 12 months. It was noted that appraisal numbers have improved over the last year. At the next Board a more detailed report will be presented. He acknowledged the work of Richard Davies in supporting the revalidation process.

ACTION: Detailed report on doctors' appraisals to be deliver at next Board meeting **P Molyneux**

Concern was raised about a doctor's ability to continue practising if revalidation is delayed. The Interim Executive Medical Director explained that it is not uncommon for revalidation to be delayed and this could be for a number of reasons, including in order to obtain information from other workplaces outside of the organisation, which in some cases took longer than we would have liked. However, it did not prevent doctors from working in the meantime.

A query was raised about the option to add elements into the revalidation process, e.g. on leadership abilities. The Interim Executive Medical Director informed that the Allocate system does not allow this, although it has been tried in the past. However, a new appraisal process is being introduced for clinical directors and clinical leads which will be independent of the revalidation process, and will include elements to instil and improve leadership behaviours.

2.4 CAR PARKING (STAFF BENEFITS)

The Interim Chief Executive (Craig Black) presented a paper about car parking proposals and other staff benefits. It was noted that the staff benefits introduced at the start of the pandemic were funded centrally, but this was withdrawn in April 2022, and the Trust has continued to fund the benefits without central support since then.

The proposals outlined are:

- to continue free membership of Abbeycroft Leisure;
- to continue funding for the staff psychology team;
- to stop the provision of free hot drinks and free food at night from 1st September 2022, and instead introduce a discounted rate for hot drinks for staff using reusable cups.

With regard to car parking, wide engagement about the proposals had been undertaken, and the Senior Leadership Team supported the proposal to continue free parking for staff until 31st March 2023. When charging is reintroduced on 1st April 2023, a different structure for charging will be considered which reflects the ability to pay. This will address some of the economic challenges being faced by staff, and they and the Staff Side will be engaged over the coming months to decide what a different charging structure might look like, and a proposal presented to the Board in good time before 1st April.

It was noted that the stopping of free food and drink could be disappointing for staff. This had to be balanced with some difficult financial decisions. The eligibility criteria will also be examined, along with other ways of supporting the lowest paid staff. Community colleagues do not benefit from the same benefits and this should be acknowledged.

The Board approved four recommendations:

1. **Free parking for staff to continue until 31st March 2023.**
2. **A full review of methodology and eligibility for staff car parking to be carried out with charges effective from 1st April 2023.**
3. **Implementation of parking charges for contractors.**
4. **Free hot meals and drinks to cease with effect from 1st September 2022.**

It was confirmed that staff will be informed of the decision on car parking as soon as possible, and new tariffs communicated by the end of 2022. The communication will

set the decisions in context and draw attention to the effect of these decisions on other investments.

3.0 STRATEGY

3.1 FUTURE SYSTEM BOARD REPORT

The Interim Chief Executive (Craig Black) presented the report and updated that the programme is on track and consistent with previous reporting. He highlighted that the decision to build Sizewell C along with other significant infrastructure programmes happening at the same time will require coordination throughout the public sector.

A query was raised about the possible adverse effect on the hospital build of multiple projects happening at the same time. It was noted that the New Hospitals Programme (NHP) are already focussed on this, and how they will manage 40 projects across the country, recognising the burden on construction partners.

3.2.1 ALLIANCE

The Director of Integrated Adult and Social Care Services (Clement Mawoyo) presented the report and highlighted the setting up of the governance of the Alliance with effect from 1st July 2022. Attention was also drawn to an event being held on 25th July to co-produce the enhancement of locality teams in partnership with integrated neighbourhood teams (INTs).

The positive work of the cognitive stimulation and communication group was noted, but some of the comments in the report appeared to indicate that it would be ending. The Director of Integrated Adult and Social Care Services reported that there was an opportunity for more to be done for this cohort, and the service did not necessarily need to stop.

With regard to governance of the alliance, learning could be strengthened not only through the alliance, but by feeding directly into the organisation. It was noted that in the past, not enough attention had been given to community services by the Board. Updates are very useful, and a regular report to the Public Board would be welcome.

ACTION: Regular Alliance reports to be presented to the Public Board meeting **C Mawoyo**

A query was raised about the timeline for the introduction of innovations such as virtual wards. The Director of Integrated Adult and Social Care Services confirmed that 43 virtual beds would be in operation by the end of October this year, and a robust plan was in place to increase the number to 102 beds, in partnership with the wider alliance.

The new West Suffolk Alliance Director, Peter Wightman, was introduced to the Board.

3.2.2 SNEE INTEGRATED CARE BOARD

The Interim Chief Executive (Craig Black) presented the report on the inaugural meeting of the Integrated Care Board. Of note was a discussion on diversity of Board, on which some work is required across the ICS.

A query was raised about allocations of funding now that the CCGs have been disbanded. It was noted that the interface between the ICB and the alliance will be clarified, as the delegation of authority was not yet clear.

4.0 ASSURANCE

4.1 INSIGHT COMMITTEE REPORT – June & July 2022 – Chair's Key Issues

The Insight Committee Chair (Dr Richard Davies) presented the report and noted the concerns about staffing levels, and access to diagnostics and elective and other care. However, progress is being made.

The Chair of the June meeting of the Insight Committee (Louisa Pepper) highlighted the issue of business cases for the sustainability improvement programme, and the debate on the capital programme and the replacement of CT scanners. It was noted that specific feedback on business cases is given when they are not supported, and discussion is very open and transparent.

4.2 FINANCE AND WORKFORCE REPORT

The Interim Executive Director of Finance (Nick Macdonald) presented the finance report and reported that income and expenditure for June showed an adverse variance of £0.2m. Breakeven was still forecast for 2022/23, and work continues to fully understand and potentially reduce the overspend. Some risks remain, particularly achieving ERF and ongoing covid costs. Teasing those out remain a challenge. In summary, there are risks around the position but breakeven is still forecast.

The Interim Executive Director of Finance reported that the sign off of the audit for 2021/22 is running slightly late due to unanticipated issues experienced by the Trust's new auditors, KPMG. The audit is now likely to be signed off in September and there is no suggestion that there is anything of concern in the accounts.

The Trust Secretary (Richard Jones) raised the question of the timing of presenting the audit report for approval at the closed Board meeting on 14th September. The Chair confirmed attendance at the next audit committee meeting, and the Board agreed with the approach to approve the signed accounts with two Board members absent at the next meeting, provided that the two absent members have sight of the report beforehand.

The Interim Executive Director of Finance reported that the Trust had anticipated a pay award of 2%. Anything above that will be funded from outside the organisation, source to be confirmed, but the Trust's funds will not be affected.

He noted that the £7.5m overall cost reduction target is being held centrally in 22/23. It will be a challenge to meet the CIPs, however division business plans will shortly be seen, and there may be additional mitigations not yet taken into consideration.

A query was raised about whether the budget for Medicine was set correctly, taking into consideration the non-pay overspend. The Interim Executive Director of Finance reported that the reasons for the overspend are not clear.

4.3 INTEGRATED QUALITY AND PERFORMANCE REPORT IQPR – MAY 2022 DATA

The Chief Operating Officer (Nicola Cottington) and the Executive Chief Nurse (Sue Wilkinson) presented the IQPR and noted that at the last Board meeting, an action was taken to explain the data on pressure ulcers. The Deputy Chief Nurse (Dan Spooner)

explained that the data indicates that the Trust is consistently failing on pressure ulcer targets. This may be due to the pandemic and the effect on both patient presentation and staff absences. Some pressure ulcers are unavoidable, particularly in end of life patients.

With regard to QI, bespoke QI methodology has been introduced in order to reduce the number of cases, and TVN training videos are now available to all staff.

Other points to note from the report include:

- the number of 104 week waits, which is being maintained at 0, and the trajectory for the reduction in 78-week waits is above target.
- Community paediatric waits and wheelchair waits have both reduced.

The Interim Executive Medical Director noted that more patients are arriving on waiting lists than leaving and this must be taken into consideration. Further, there is a need to consider how to communicate the waiting list challenges to the public and patients.

ACTION: For more information to be brought to the next Board meeting on how to communicate the waiting list challenges to the public and patients.

N Cottington

It was suggested that the statistics on reductions in 104, 78 and 54 week waits should be published as a positive news story. However, some patients choose other routes for their treatment, and it would be interesting to know how many choose to do so.

4.4 IMPROVEMENT COMMITTEE REPORT – June & July 2022 Chair's Key Issues

The Trust Chair and Improvement Committee Chair (Jude Chin) commended the report and highlighted the following issues, which had only partial assurance, or required escalation:

- Patient safety issues, over which there are some concerns about implementing action plans. A new Safety Improvement Group has been set up to put emphasis behind the implementation. The Improvement Committee will continue to closely monitor progress.
- The national move on to a new system of recording patient safety events. The information required is not readily available on Datix, which will need to be redesigned and will require a significant amount of work. The approach to this is being worked on together with ESNEFT, and an ICS-wide group is looking into how it can be resolved.
- The new CQC model assessment is now finalised and a Board discussion on this will be required.
- Pain assessment recording, which was part of the CQC improvement plan, has now become business as usual and will be treated as such.
- Use of data in specialist committees, and their understanding of the data. The Deputy Chief Nurse has agreed to work with those committees to provide a level of assurance that the correct data is being used, that committees know how to use the data, and that they have the right skill levels to do so.
- A reduction in the number of clinical audits which was raised in the Clinical Effectiveness Governance Group. There is no intention to reduce the number of audits, but because of work pressures, the number of senior staff involved in each audit is being reduced, although there still will be at least one senior staff member involved in each audit. There will be no reduction in quality.

ACTION: New CQC Model Assessment to be discussed at a future Board meeting.

N Cottington

The Board noted the report.

/S Wilkinson

4.5 QUALITY AND NURSE STAFFING REPORT

The Executive Chief Nurse (Sue Wilkinson) presented the report.

The Deputy Chief Nurse (Dan Spooner) noted how well staffing had been achieved in May and June. May was more comfortable than June due to the prevalence of covid cases in the latter month. The following points were highlighted:

- There was a slight rise in RN rates.
- There were opportunities to better staff inpatient clinical areas with changes to isolation guidance, however sickness rates increased.
- The RN vacancy rate in the community is significantly higher than in the acute, which is of concern. Opportunities are being sought to use other roles and upskill existing staff.
- Surge areas are consistently being used.

The Board noted the adverse effect on staff of high vacancy rates and absences, and that actions on reporting should be taken, as is the case in other areas. The Board agreed to continue discussions on this topic for the foreseeable future, and that it should be raised at the next Board in September.

ACTION: Board to discuss staffing levels and the effect on staff at the next Board meeting in September

S Wilkinson/ J Over

4.6 MATERNITY SERVICES:

4.6.1 QUALITY & PERFORMANCE REPORT

The Deputy Head of Midwifery (Justyna Skonieczny) presented the report and highlighted ongoing compliance on quality and safety. Attention was drawn to the Board's request for approval of the reporting framework for maternity quality, safety and performance.

The Deputy Head of Midwifery highlighted the summary of ongoing improvements, including feedback from quality champions and service users. The five areas of improvement have all been addressed.

A query was raised about action taken and scrutiny of the responses to patient feedback. The Deputy Head of Midwifery reported that problems had occurred with obtaining Friends and Family feedback due to the move of maternity services to different parts of the building. This would be resolved shortly with the delivery of new iPads for capturing feedback. The CQC survey highlighted the inability to visit patients but this was now improving with the lifting of covid restrictions. The pandemic had also affected the ability to hold clinics in the community. The problem of holding clinics in GP surgeries remained, and this has been escalated to the LMC.

The Board acknowledged the good work of the maternity department, despite several moves to different areas of the hospital.

4.6.2 MATERNITY SAFETY SUPPORT PROGRAMME

The Deputy Head of Midwifery drew attention to the request for the Board's approval to exit the Maternity Safety Support Programme. Maternity improvement advisers were allocated to the Trust and noted that significant improvements had been made. There is a risk that the Board may become less sighted on maternity issues, but this is unlikely as it will remain a priority for the Board for the foreseeable future. Any out of hospital issues can be raised with the ICS.

The Board agreed to the removal from the Board of the Maternity Safety Support programme.

The Deputy Head of Midwifery reported that the staffing situation is a concern of the department. It is participating in international recruitment which has proved a challenge, however the first overseas recruit is due to arrive today.

In answer to a question about the possibility of increasing the numbers of midwives in training, the Deputy Head of Midwifery reported that providing mentorship would prove challenging for the increasing numbers being trained, and learning would not be supported effectively.

The Interim Chief Executive commended the Deputy Head of Midwifery on her clear and articulate presentation.

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

The Deputy Trust Chair and Involvement Committee Chair (Alan Rose) presented the report and highlighted four issues:

- The staff physiotherapy service, which is regarded as being very successful. At present there is only one person providing the provision which is a risk. More structured feedback on the service and support from the Board would be welcomed, to ensure that the provision can grow and be made more resilient. It was noted that the service fits within the staff wellbeing strategy which is actively supporting the physiotherapy service to develop. Rapid access to the provision is very valuable.
- Patient Safety Partners, which is a new national concept. Consideration is being given as to whether they should be on a regional basis, and whether they should be paid. It is a challenging initiative and discussions are ongoing with the ICS to formulate a consistent approach.
- The Head of Patient Experience (Cassia Nice) is leading on a broader programme of patient engagement and it is noted that more outreach is required, with a number of initiatives planned. The Board may wish to consider receiving a presentation about patient involvement.
- The Involvement Committee has been asked to scrutinise the review of the Organisational Development tracker. It was noted that part of the organisation's cultural change is how we use the tools in place. However, how we are reporting back to the organisation is more important.

  The Executive Director for Workforce and Communications noted that the What Matters to You project group is designing what will be included in that programme, which is likely to be ready in September or October. There is much to be discussed with staff, including the pressures that have been highlighted today. Staff development and training will also be high on the agenda.

A point was raised about taking a holistic patient view across the system, in which the Future System Programme is also involved. This is one of the areas being examined

by the Alliance personalisation, which is seeking feedback and sharing across the locality.

5.0 GOVERNANCE

5.1 GOVERNANCE REPORT

The Trust Secretary (Richard Jones) highlighted two elements for approval:

1. Audit Committee annual report and updated terms of reference.
2. IG Steering Group delegated authority.

The Board approved both elements and noted the report.

6.0 OTHER ITEMS

6.1 ANY OTHER BUSINESS

There was no further business.

6.2 REFLECTIONS ON MEETING

- The patient representative talk was very powerful. It was respectful, and comments were measured. The Trust is improving on listening to the patient voice.
- It was noted that significant debate has taken place on car parking which was not borne out in the board discussion.
- The agenda could perhaps be more flexible to prevent clinical colleagues from waiting to speak.
- Staff side representatives should be encouraged to stay for the whole meeting and listen to discussions, particularly those relating to staff matters. It was noted that the meeting is being recorded and will be available playback. Board meetings should be much more accessible.

ACTION: To consider if the Trust really needs to go off site for future board meetings. **R Jones**

- It is beneficial for staff development to be able to attend and participate in Board meetings. It would be easier for staff if the meeting was held on staff premises.

6.3 DATE OF NEXT MEETING

Friday 30 September 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.	**Information captured and further work being undertaken.**	SW	22/07/22	Green	
2041	Open	27/5/22	2.1	The Board needs to complete senior leaders' training around 3 modules. "Follow up" training is also now available for Senior leaders. It is highly recommended that all board members, senior leaders and governors undertake this training.	An update is provided in the Freedom to Speak Up report in the 'Culture' section of today's agenda. **Training details circulated to Board members in August for completion during September.**	JO	22/07/22	Green	
2053	Open	22/7/22	2.1	To bring a FTSUG report to the next meeting for further in-depth discussion	**Q2 report to be presented at November 2022 Board meeting. Follow-up on FTSU issues incorporated in People & OD report and Involvement Committee report.**	JO	25/11/22	Green	
2057	Open	22/7/22	4.3	For more information to be brought to the next Board meeting on how to communicate the waiting list challenges to the public and patients	**Discussion held with Head of Communications. The Trust has communicated via local media the waiting list challenges and there is considerable national coverage of waiting list challenges. There is likely to be increased coverage in light of the publication of "Our plan for patients". Further meeting planned with communications and head of elective access to consider further communications plan.**	NC	30/09/22	Green	
2058	Open	22/7/22	4.4	For the new CQC model assessment to be discussed at a future board meeting	**New model is now assessed and engaging with national programme for delivery.**	NC/SW	25/11/22	Green	
2060	Open	22/7/22	6.2	To consider options for the location of future board meetings - WSH and other sites across the county	**Options for use of the Education Centre at the WSH as well as venues such as Haverhill and Mildenhall are being reviewed. This will be used for remaining Board meetings as well as dates being agreed for 2023**	RJ	30/09/22	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
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	Complete	30/09/2022
2040	Open	27/5/22	2.1	To consider a regular and more responsive way on how the horizon of these awards can be expanded to alliance working with the community to recognise staff across the alliance and be linked to the Trust Strategy	**Work is ongoing.** **Built into What Matters to You 2 – Autumn 2022.**	JO	22/07/22	Complete	30/09/2022
2044	Open	27/5/22	4.3	Present a report to the appropriate Board sub-committee to provide an assurance that actions are being taken or will be taken in future to improve Paediatric Community Standards and to include an update in the IQPR.	Report provided to Insight committee 4th July, and referenced in CKIs from Insight. Improvement trajectory to be presented to August Insight, also recognising system element of issues. **Report provided to Insight committee in August did not provide assurance of a robust plan to recover performance. The issues are system-wide and complex. It was agreed an in depth paper would come to Insight Committee and Executive Directors meeting on 28th September setting out options for a way forward. Business case for additional capacity being presented to Investment Panel 29th September.**	SW/NC	22/07/22	Complete	30/09/2022
2050	Open	22/7/22	1.5	The Board advised to follow-up on the process issues and how the staff can be supported to ask questions in various situations, so that such incidents are not repeated, following hearing the patient's story	**Part of discussion and reflection on today's agenda**	SW/JO	30/09/22	Complete	30/09/2022
2051	Open	22/7/22	1.7	For a future report to include results of discussions on staff pay and the co-ordinated plan for recruitment and retention for visibility at the board, which will also be shared across the organisation.	**Incorporated into People & OD report**	JO	30/09/22	Complete	30/09/2022

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery	Date Completed
2052	Open	22/7/22	2.1	To provide assurance on effectiveness of action to address bullying and behaviours and supporting staff	**Incorporated into work programme of Involvement Committee for later this year.**	JO	30/09/22	Complete	30/09/2022
2054	Open	22/7/22	2.3	To bring report on doctor's appraisals to next Board meeting	**See responsible officer's annual revalidation report**	PM	30/09/22	Complete	30/09/2022
2056	Open	22/7/22	3.2.1	For regular alliance report to be presented to the public board meeting	**Standing agenda items included for Alliance and ICS**	CM	30/09/22	Complete	30/09/2022
2059	Open	22/7/22	4.5	Board to discuss staffing levels and the effect on staff at the next Board meeting	**Staffing report and People & OD report refers**	SW/JO	30/09/22	Complete	30/09/2022

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 / staff story

To Note

1.5.1. Glemsford primary care practice - staff experience

Melissa Williams, Lead GP in attendance

To Note

Presented by Paul Molyneux

1.5.2. Response and reflections from patient story received in July (Verbal)

Presented by Susan Wilkinson

Trust Board of Directors

Report title:	**Patient story debrief**
Agenda item:	1.5
Date of the meeting:	30 September 2022
Sponsor/executive lead:	Sue Wilkinson, Executive Chief Nurse
Report prepared by:	Cassia Nice, Head of Patient Experience and Engagement

Patient story debrief

Following an in-person patient story, told by the daughter of a patient who died at West Suffolk Hospital, the Board should be assured that:

- The relative was grateful for the opportunity to be heard at the Trust Board meeting and felt that everyone listened and empathised with her experience
- She felt assured that the Board took her concerns seriously and would take action to address the issues raised.

Actions taken as a result of the formal complaint investigation were as follows:

- ED staff training debrief including ensuring that when a patient's loved one contacts reception requesting an update that this is passed to relevant clinical staff for action and reminded to clearly explain to patients' relatives why they are asking collateral history questions.
- The palliative care team will incorporate talking about what changes might occur in someone's last days of life when they meet with family members, to help reassure them what is normal and what might need intervention.
- The palliative care team will continue to promote privacy and dignity in the last days of life and maximise this wherever the person is being cared for.
- The palliative care team will work with ward teams to improve documentation of hydration status and the need for IV and subcutaneous fluids. A new individualised care plan template has recently been created in our electronic patient record system which will help with documentation in the last days of life.
- A referral can be made to St Nicholas Hospice family support team for support during her grief if she believes this would be beneficial. This has been made available.
- The Trust is incorporating the need for more side rooms in the new hospital build to allow for better privacy and dignity for patients who are end of life.

1.6. Questions from Governors and the Public (Verbal)

To Note

Presented by Jude Chin

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

To inform

Presented by Craig Black

REPORT TO:	Board meeting
MEETING DATE:	30 September 2022
SUBJECT:	Chief executive's report
AGENDA ITEM:	4
PRESENTED BY:	Craig Black, chief executive officer
FOR:	Information

Death of HM Queen Elizabeth II

Her Majesty's outstanding commitment to public service and her duty as head of state inspired millions across the Commonwealth and around the world. The Queen demonstrated steadfastness and compassion, and provided an anchor, which even in her passing united our country. We will remember with great fondness her enduring contribution to our nation.

We ran a number of our clinics, such as phlebotomy and obstetrics, over the bank holiday and our urgent and long waiting patients' procedures went ahead. We are re-booking any procedures which were postponed.

To help staff pay their respects, we held a service in our Chapel, set up televisions at multiple locations across both hospital sites, and have a condolence book for colleagues to sign.

Ongoing pressure since the last meeting

Since the last meeting, staff have continued to deal with periods of extreme pressure, which have been compounded with other challenges such as our ongoing estates maintenance programme, very hot weather and flooding due to intense rainfall.

Despite this, our staff continue to deliver high quality care for our patients with the utmost dedication and compassion, while looking after each other with empathy and humility.

Our staff rise to each challenge again and again, and I would like to take the opportunity to outline mine, and the Board's praise for our staff for the work they do.

Development of Newmarket Community Hospital site

Having applied to secure financial backing for the further development of the Newmarket Community Hospital site, unfortunately, the Trust was not successful. Therefore, our plan to build a 32-bed inpatient ward and operating theatres will not be going ahead at this time.

We continue to explore funding opportunities for this project, as developing this site remains a key part of the Trust's strategy, as does working with healthcare partners to ensure the needs of local communities are met.

Moreover, the Trust is delighted that the business case for a new Community Diagnostics Centre (CDC) at this site has been approved by the Suffolk and North East Essex Integrated Care Board.

This represents a capital investment of £14.74 million, with an annual recurrent revenue consequence of around £3.7 million, which has been estimated at 2022/23 prices.

This new facility will provide communities in and around Newmarket with quicker and easier access to a range of tests that will support earlier diagnosis for patients. It is expected that the CDC will support Newmarket, and rural communities towards Lakenheath and Mildenhall with access to almost 100,000 tests and scans every year. These will include tests such as MRI, CT scans, X-rays, ultrasound, cardiology, lung function and phlebotomy. We believe that by implementing this new healthcare facility in the west of the region, we can continue to reduce waiting times and tackle health inequalities.

We are appreciative of the ICB's support of this project. A decision on funding from NHS England is expected in the autumn. Should this be approved, we will engage with our staff, the public and stakeholders to further develop the project, which is expected to come online in April 2024.

Vaccine programme commences

Since Monday, 12 September, staff have been able to receive their Covid-19 and flu vaccines.

Multiple pop-up clinics have been established, and staff do not need to book. These are located across the region, including the West Suffolk Hospital site and West Suffolk House in Bury St Edmunds, Sudbury Community Health Centre and The New Croft in Haverhill.

The vaccines will go a long way in ensuring our staff are protected from illness during the upcoming months.

This Covid-19 booster will be the new Moderna bivalent vaccine. This is based on the original Moderna vaccine alongside a newer version, which is designed to increase protection against Omicron sub-variant BA.1.

I urge our staff, if eligible, to get their vaccines to protect not just patients, but themselves. Each and every member of our staff is vital and plays an integral part in helping us continue to provide high-quality and safe care.

It also important for the residents in our local communities to get the booster Covid-19 and flu vaccines. By doing so, you can help protect yourself against infection, reduce transmission, and prevent against being hospitalised.

Update from the Suffolk and North East Essex Integrated Care System

On Friday, 1 July 2022, the board of the new Suffolk and North East Essex Integrated Care System (SNEE ICS) was launched. This represents a new chapter for the NHS, with local health and care partners such as NHS trusts, GP teams, local authorities and the voluntary sector being brought together to work more closely. This new approach will ensure we meet the needs of our communities and they receive the best possible care, in the right place and at the right time.

This approach has been developed over several years, however, the changes will ensure that decisions on health and social care are collaborative, improve the quality of decision-marking, and ultimately, the services and care provided to our communities.

We are committed to this approach as it will enable us to make further progress on our ambition to provide personalised and holistic care to our patients.

I will represent the Trust on the Suffolk and North East Essex Integrated Care Board (SNEE ICB), which gives us a consistent voice in how decisions are made in relation to health and care in the region. I look forward to progressing this with our health and care partners, and I anticipate having exciting updates for you on this at future meetings.

Western Way Development

The Trust continues to work with colleagues at West Suffolk Council on plans for the Western Way Development.

However, new NHS finance rules means that the Trust requires more time to sign-off the proposed health facilities being planned to go into the new development.

Due to this, West Suffolk councillors will be asked to reaffirm their commitment to moving forward with the scheme in a phased approach, with the first phase being the re-building of the leisure centre in Bury St Edmunds.

As part of the initial phase, other community facilities can also move ahead, most likely including an initial small health facility, similar to those already successfully integrated with leisure centres in Haverhill, Mildenhall and Brandon and linked to NHS referral programmes.

With phase one secured, there would then be the scope to add the envisaged full NHS health facility at a later stage of the project once we have followed our required financial processes.

Recruitment to our Trust Board

Following a full recruitment process, the Council of Governors has confirmed five new non-executive directors to our Board.

The calibre of applicants was very strong, and we are fortunate to have such exceptional people with a range of experience and backgrounds join the team. I am sure they will bring a real benefit to patients and staff alike and help keep the organisation moving forward in a positive direction.

The process of recruiting a permanent chief executive has now begun. Through staff representatives, we are engaging with colleagues across the Trust so they can feed into the recruitment process.

2. CULTURE

2.1. People & OD highlight report

To Assure

Presented by Jeremy Over

x

Board of Directors

Report title:	**People & OD Highlight Report**
Agenda item:	2.1
Date of the meeting:	Friday 30 September 2022
Sponsor/executive lead:	Jeremy Over executive director of workforce & communications
Report prepared by:	Members of the workforce and communications directorate

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

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

Previously considered by:	N/A
Risk and assurance:	Research demonstrates that staff that feel more supported will provide better, higher quality and safer care for our patients.
Equality, diversity and inclusion:	A core purpose of our 'First for Staff' strategic priority is to build a culture of inclusion.
Sustainability:	Our role as an anchor employer, and staff retention.
Legal and regulatory context:	Certain themes within the scope of this report may relate to legislation such as the Equality Act, and regulations such as freedom to speak up / protected disclosures.

People and OD highlight report

1.	**Introduction**
1.1	The People & OD highlight report was established during 2020-21 as a regular report to strengthen the Board's focus on how we support our people, grow our culture and develop leadership at all levels. This format will continue to be developed, alongside the CKI report from Involvement Committee, to reflect the work that is ongoing, bringing together various reports that the Board has routinely received into one place. In addition to discussing the content of the report, and related issues, continued feedback is welcomed as to the structure and content of this report and how it might be developed in future. This month the report provides updates on the following areas of focus: • Putting You First awards (August/September) • Impact of cost of living pressures on our colleagues • Autumn staff listening and involvement programmes • Quarterly Staff Survey 2022/23 (Q2) headlines • Potential for industrial action across the NHS
2.	**Putting You First Awards (August/September)**
2.1	*Chris Lockwood (communications), nominated by Helen Davies:* "I would like to nominate Chris Lockwood for a Putting You First award for Chris's hard work, dedication and leadership in taking forward and delivering a new intranet for the Trust. "On top of his everyday work, Chris has led the project - involving and consulting with staff across the Trust - to develop this new platform to meet their needs. He has driven the project forward, through its launch in July, pulling over thousands of documents and pieces of information. "This new intranet is a vast improvement on the old version, meaning staff will be able to more easily and intuitively access the information they need to do their jobs. It will also revolutionise the way we communicate with staff, enabling more real-time information and news to be communicated. "Chris has led this enormous project with enthusiasm and dedication and would be a very deserving recipient of this award."
2.2	*Joanne Mitchell (sewing room) and Heather Baillie (procurement), nominated by Debbie Stevenson:* "I would like to nominate Joanne Mitchell in the sewing room and Heather Baillie in procurement as a team. "In February the Trust took the decision to replace the existing nursing uniform with scrubs. To achieve this requirement Heather and Joanne had to: • Identify all staff requiring new uniform. • Find a Trust preferred supplier • Issue samples of scrubs to each ward or department for the staff to try on and confirm sizing • Order and coordinate deliveries of scrubs • Undertake any alterations or badge requirement • Issue scrubs to every member of the nursing staff "This was a vast undertaking and is currently ongoing. Heather and Joanne have worked together to commence the roll out and between them have now measured, ordered and are in the process of delivering scrubs to all ground floor areas in the Trust before moving upstairs and then out into the community.

	"The challenges have been vast to name a few, ensuring supply of vast numbers of scrubs in a restricted market, communicating with staff and addressing issues and ensuring the majority of the requirements are being met."
2.3	*Ruth Nash – community services, Sudbury, nominated by Emma May:* "Ruth always goes above and beyond every day for our patients and is an incredible support to her colleagues. She is always first to offer to help other teams outside of our area when they are in a staffing crisis and she does this without complaint on a regular basis. She also regularly picks up bank shifts when we ourselves are short staffed. She is always professional and the patients speak very highly of her. She recently assisted a housebound patient who was unable to go to the shop to purchase a birthday card for his granddaughter – she took round a selection of cards for him to choose from. She is a credit to our team and the Trust!"
3.	**Impact of cost of living pressures on our colleagues**
3.1	The rising cost of living and its impact on NHS staff has led to organisations reviewing their current employment package along with additional measures that can support the wellbeing of staff. Having a comprehensive employment package will contribute to retaining valuable talent and help make us an attractive employer for new recruits. In the UK, one in eight workers are already unable to make ends meet or cover their essential living costs. It is predicted that this number will increase due to the rising costs of living expected during 2022. While we know that pay is important the pressure many of our colleagues are facing from rising costs, are linked to household income and overall expenditure. The NHS Employers organisation has highlighted four core areas to consider: • Pay processes and practices: supporting staff through providing a comprehensive benefits package • In-work progression: the offer available to colleagues to access development, training and experience including apprenticeships, to progress and enter higher paid work in the medium-to-longer term • Financial wellbeing and education: empowering staff through the offer provided • Flexible and agile working: approaches that support individuals in a way which helps them with managing household costs We are reviewing our position against these four priorities, and liaising further with staff representatives, and will update the Board in due course.
4.	**Autumn staff listening and involvement programmes**
4.1	We are running several staff involvement programmes over the autumn season and are calling on colleagues to have your say on what matters to them. We know that work pressures continue to have an impact on staff's day to day lives and ideally, we would not have all these exercises so close together. However, the timings for some of them are driven externally or certain deadlines are on the horizon and seeking their views is crucial for the development of some projects. Staff have an important role to play in making positive change happen. What follows is an overview of four opportunities for all colleagues to have their say and get involved over the coming months:
4.2	**The national NHS staff survey** Once again, the annual national NHS staff survey is about to get underway, launching here at the Trust in the next couple of weeks. All staff will be invited to complete the survey, co-ordinated by The Picker Institute. The fact that it is a full staff census again, means all staff can feed back on your working life at the Trust. New for 2022, bank only staff have been included in the national eligibility criteria. Bank staff should receive a paper invitation letter with a QR code that takes you to the online

	survey. Reaching these staff members, who are valued members of our team, will be able to enhance the understanding we get from this exercise and feel included in this work.
4.3	**What matters to You 2022** The 'What matters to you' staff engagement exercise is returning following the programme carried out in 2020, which originally focused on how Covid-19 had impacted staff and ways of working. The aim is to continue conversations with staff so that we as leaders hear about what is important to you and can take action to improve. *Five key themes emerged from the first WMTY staff engagement:* • The importance of great line managers • Creating an empowered culture • Building relationships and belonging • Appreciating all our staff • The future and recovery These themes will be revisited in this year's programme, to provide a direct comparator, while also identifying further areas to improve and understanding current issues of the day. In addition to a questionnaire, WMTY drop-in sessions have been set up during October. Individuals who wish to ask questions or leave feedback can attend these. Likewise, if managers want to share more about the WMTY exercise with their teams but want to know more before carrying out a team exercise, attending a drop-session might be useful. A short manager briefing is also being prepared to help guide managers in this way. Dates and times for drop-in sessions will be shared in the coming weeks. *Living our values* The next phase of WMTY will be a series of workshops / forums facilitating conversations about the new Trust values and the behaviours we should all be aspiring to, and to explore: • What the values mean to staff • What behaviours we should encourage • What behaviours we should discourage • How we hold each other accountable to display these values.
4.4	**Freedom to Speak Up month – October** Now in its fifth year, Trust freedom to speak up guardian Amanda Bennett will be leading activity for the annual 'Speak Up' month taking place throughout October. Speak Up Month is an opportunity to raise awareness of how much we value speaking up in our organisation. The general theme for the month is 'Freedom to Speak Up for Everyone' with each week having a specific focus: #SpeakUpforSafety; #SpeakUpforCivility; #SpeakUpforInclusion; #FTSUforEveryone. It is vitally important our staff feel confident to speak up about any aspect of work that is concerning them, and we support staff to listen up – with openness and in a non-defensive manner – to ensure all voices are heard. Our freedom to speak up guardian and our team of champions are doing great work in support of this goal. Speaking up helps keep patients and service users safe and creates a more positive working environment.
4.5	**Travel and car parking** We will also be asking staff to take part in a travel and sustainability survey, as well as contributing ideas to the ongoing work to review our car parking eligibility and tariff.
5.	**Quarterly staff survey report (Q2)**
5.1	In addition to the annual NHS staff survey a shorter, quarterly survey is run across the service in England. The results provide an opportunity to understand our current position and maintain and

build our focus on the experience of our people. The quarterly survey is built around three themes (each with three questions), to form an overall engagement score.

The results of the four most recent quarterly surveys are shown in the table below:

Section	Description	NQPS Q2 21/22	NQPS Q4 21/22	NQPS Q1 22/23	NQPS Q2 22/23
Advocacy	Would recommend organisation as place to work	7.00	6.93	6.73	6.62
	If friend/relative needed treatment would be happy with standard of care provided by organisation	7.40	6.95	7.26	7.01
	Care of patients/service users is organisation's top priority	7.00	6.35	7.69	7.51
	Advocacy overall	**7.40**	**7.23**	**7.23**	**7.05**
Involvement	Able to make suggestions to improve the work of my team/dept	6.90	7.69	6.94	6.98
	Opportunities to show initiative frequently in my role	6.80	6.74	6.92	6.90
	Able to make improvements happen in my area of work	6.30	7.27	6.35	6.35
	Involvment overall	**6.70**	**6.74**	**6.74**	**6.74**
Motivation	Often/always look forward to going to work	6.30	6.29	6.28	6.33
	Often/always enthusiastic about my job	7.20	7.17	7.16	7.13
	Time often/always passes quickly when I am working	7.40	7.54	7.54	7.57
	Motivation overall	**7.00**	**7.00**	**7.00**	**7.01**
Staff Engagment Score		**7.00**	**6.99**	**6.99**	**6.93**

NB: a quarterly survey is not run in Q3 as this is when the full national staff survey is carried out. Therefore, these results represent a 15-month period.

Headlines:

- The overall staff engagement score has remained broadly static over the course of the year. The WSFT score for staff engagement for the full survey in Q3 was 7.0. (The acute and community trust average for this score in the most recent full national survey was 6.8)
- There continues to be a reduction in the "recommend as a place to work" score in Q1.
- The other two 'advocacy' questions have fluctuated over the last year.
- Overall motivation and involvement scores remain unchanged.

These results will be presented for further discussion and analysis at the next meeting of the Involvement Committee of the Board.

6. Potential for industrial action across the NHS

6.1 Board colleagues will be aware of the potential for industrial action across the NHS, as mooted by a number of different trade unions and staff organisations who have been holding indicative ballots and making plans for full ballots of their memberships. This has been particularly prompted by the outcomes of the national pay review processes for 2022/23.

We continue to foster open, supportive working relationships with staff representatives at West Suffolk which will be a crucial channel of communication, discussion and planning should any action take place. Patient safety will be the overriding priority in terms of our response, whilst supporting colleague's right to take part in legal action.

The GMC and NMC have issued updated guidance to their registrants in relation to the topic of industrial action, drawing attention to relevant sections of *Good Medical Practice*, and the *NMC Code of Conduct*, respectively.

7. Recommendations

To note and provide comment and/or feedback on the report.

2.2. Responsible officer's annual revalidation report and statement of compliance

To Assure

Presented by Paul Molyneux

Classification: Official

Publication reference: PR1844

A framework of quality assurance for responsible officers and revalidation

Annex D – annual board report and statement of compliance

Version 1, July 2022

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Introduction:

The Framework of Quality Assurance (FQA) for Responsible Officers and Revalidation was first published in April 2014 and comprised of the main FQA document and seven annexes A – G.

In 2019 a review of the Annual Organisational Audit (AOA), Board Report template and the Statement of Compliance concluded with a slimmed down version of the AOA (Annex C) and a revised Board Report template (Annex D), which was combined with the Statement of Compliance (previously listed as Annex E) for efficiency and simplicity.

The AOA exercise has been stood down since 2020, but has been adapted so that organisations have still been able to report on their appraisal rates.

Whilst a designated body with significant groups of doctors (e.g. consultants, SAS and locum doctors) will find it useful to maintain internal audit data of the appraisal rates in each group, the high-level overall rate requested in the table provided is enough information to demonstrate compliance.

The purpose of this Board Report template is to guide organisations by setting out the key requirements for compliance with regulations and key national guidance, and provides a format to review these requirements, so that the designated body can demonstrate not only basic compliance but continued improvement over time. Completion of the template will therefore:

a) help the designated body in its pursuit of quality improvement,
b) provide the necessary assurance to the higher-level responsible officer,
c) act as evidence for CQC inspections.

Designated Body Annual Board Report

Section 1 – General:

The board / executive management team – [*delete as applicable*] of [*insert official name of DB*] can confirm that:

1. An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Interim Medical Director Dr Paul Molyneux remains as Responsible Officer

2. The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Yes

3. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.

Yes – Allocate software

4. All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Yes – appraisal and revalidation policy updated and live June 2022.

5. A peer review has been undertaken (where possible) of this organisation's appraisal and revalidation processes.

No.

6. A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.

The appraisal administrator regularly receives notification from human resources of all doctors entering and leaving the organisation. All new doctors are provided with an allocate account for use and offered appraisal training. Appraisal training goes on throughout the year.

Section 2a – Effective Appraisal

All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.[1]
Appraisal 2020 model adopted

[1] For organisations that have adopted the Appraisal 2020 model (recently updated aby the Academy of Medical Royal Colleges as the Medical Appraisal Guide 2022), there is a reduced requirement for preparation by the doctor and a greater emphasis on verbal reflection and discussion in appraisal meetings. Organisations might therefore choose to reflect on the impact of this change. Those organisations that have not yet moved to the revised model may want to describe their plans in this respect.

7. Where in Question 1 this does not occur, there is full understanding of the reasons why and suitable action is taken.

N/A

8. There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Appraisal and Revalidation policy updated and live June 2022.

9. The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

Due to the increased number of locally employed doctors, the number of doctors requiring medical appraisal has increased. There are currently 52 trained medical appraisers, each with responsibility for 6-10 appraisals.

10. Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[2] or equivalent).

Appraiser training commenced June 2022 following updated AOMRC guidance.

[2] http://www.england.nhs.uk/revalidation/ro/app-syst/

11. The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Annual report to the board.

Section 2b – Appraisal Data

1. The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions can be recorded in the table below.

Name of organisation:	
Total number of doctors with a prescribed connection as at 31 March 2022	328
Total number of appraisals undertaken between 1 April 2021 and 31 March 2022	278
Total number of appraisals not undertaken between 1 April 2021 and 31 March 2022	50
Total number of agreed exceptions	18

Section 3 – Recommendations to the GMC

1. Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

The revalidation support group meets regularly throughout the year to support the Responsible Officer with revalidation recommendations. The appraisal administrator ensures that these meetings are in advance of the doctor's revalidation date. Decisions are actioned by the Responsible Officer within the meeting. :

2. Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

Decisions are relayed back to the doctor after being actioned by the Responsible Officer within the meeting. Of note all doctors due for revalidation are informed in advance that their revalidation will be reviewed by the revalidation support group and the necessary criteria for revalidation are shared to the doctor by the appraisal administrator.

Section 4 – Medical governance

1. This organisation creates an environment which delivers effective clinical governance for doctors.

The board has access to summary information and data from clinical governance processes for doctors (including complaints, incident reporting, medical appraisal, management of concerns about doctors and clinical indicators) and the ability to interpret and scrutinise the information appropriately.

2. Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

All doctors in advance of their planned appraisal date receive an email from the governance support team with information regarding complaints/compliments/SI's linked to their name. This information is then uploaded by the doctor into their appraisal portfolio.

3. There is a process established for responding to concerns about any licensed medical practitioner's[1] fitness to practise, which is supported by an approved

responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Yes

4. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors.[3]

Concerns regarding Doctors are reported to Board every month which details the concerns and timeframes of any formal process; this does not currently detail protected characteristics and we can consider this in the future.

5. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.[4]

Yes

[3] This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.
[4] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

6. Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

The Trust would find it difficult to provide direct evidence to support this standard, however, there are many safeguards to ensure that any bias or discrimination, perceived or real, can be escalated to several colleague supporters. Some examples are Freedom to Speak Up Guardian and Champions, BAME Network, designated NED for all MHPS cases, Staff Wellbeing Services, and our Union colleagues.

Section 5 – Employment Checks

1. A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Yes.

Section 6 – Summary of comments, and overall conclusion

Allocate software utilised to provide appraisal accounts for doctor and support administrative duties incurred with the appraisal and revalidation process. Regular Appraisal training throughout the year for doctors new to appraisal. Appraiser training commenced June 2022 following updated guidance.

Section 7 – Statement of Compliance:

The Board / executive management team – [*delete as applicable*] of [*insert official name of DB*] has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of designated body: _ _ _ _ _ _ _ _ _ _ _ _

Name: _ _ _ _ _ _ _ _ _ _ _ _ Signed: _ _ _ _ _ _ _ _ _ _ _

Role: _ _ _ _ _ _ _ _ _ _ _ _

Date: _ _ _ _ _ _ _ _ _ _

NHS England
Skipton House
80 London Road
London
SE1 6LH

This publication can be made available in a number of other formats on request.

Publication reference: B1844

x

Board of Directors (Public)

Report title:	**HEE Provider Annual Self-Assessment 2022 for NHS Trusts**
Agenda item:	2.2
Date of the meeting:	30th September, 2022
Sponsor/executive lead:	Paul Molyneux, Executive Medical Director
Report prepared by:	Ruth Williamson, Trust Office Manager

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

Executive summary:	
Action required/ recommendation:	The Board are asked to approve submission of the self-assessment.

Previously considered by:	Executive Directors' Meeting – 14 September, 2022.
Risk and assurance:	-
Equality, diversity and inclusion:	-
Sustainability:	-
Legal and regulatory context:	-

HEE Provider Annual Self-Assessment 2022 – for NHS Trusts

1.	**Introduction**
1.1	Health Education England require the trust to undertake a Self-Assessment (SA) for both medical and non-medical staff. This process permits organisations to carry out their own quality evaluation against a set of standards indicating where we have or have not met the standards set out in the SA. It is based on the philosophy of continuous quality improvement, the identification of quality improvement potential, the development of action plans, implementation, and subsequent evaluation.
2.	**Background**
2.1	-
2.2	
2.3	
3.	**Detailed sections and key issues**
3.1	-
3.2	
4.	**Next steps**
4.1	Following approval – submission of assessment to be made.
4.2	
5.	**Conclusion**
5.1	
6.	**Recommendations**
	The Board are asked to approve submission of the self-assessment.

NHS
Health Education England

Provider Annual Self-Assessment

Guidance Document – For Providers

June 2022

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1. Background

This guidance document applies to the completion of the provider annual Self-Assessment (SA). Health Education England (HEE) endeavour to achieve consistency in the format, content and sign off procedures.

What is the Self-Assessment?

The HEE SA is a process by which organisations carry out their own quality evaluation against a set of standards. It is based on the philosophy of continuous quality improvement, the identification of quality improvement potential, the development of action plans, implementation, and subsequent evaluation.

Providers are asked to complete an online form indicating where they have or have not met the standards as set out in the SA. Providers will also be able to list available evidence to support their responses, which may be requested once a triangulation exercise has taken place.

Why is the Self-Assessment conducted?

In accordance with the Care Act 2014, HEE is responsible for the leadership of all healthcare education and training for those employed by the NHS and for those seeking NHS employment. HEE also has the statutory obligations for the quality of the services delivered that it funds, as well as for the safety and protection of students and patients.

The HEE Quality Framework identifies the standards that organisations are expected to meet to provide high quality learning environments. The NHS Education Contract (2021-24) requests providers to fulfil the obligations of its roles and responsibilities set out in the HEE Quality Framework and to submit a return to HEE on their compliance with the contract. There is the requirement, via the NHS Education Contract that organisations will refresh their SA every year.

Who is required to complete the Self-Assessment?

The first roll-out of the SA will start **June 22nd 2022** and will be run for placement providers. It is expected that once established all education and training providers will complete an SA.

Placement providers for the June 2022 roll-out include:

- NHS Acute Trusts
- NHS Mental Health Trusts
- NHS Ambulance Trusts
- NHS Community Trusts

<u>One SA is to be completed per provider.</u>

2. Accessing the Self-Assessment

The SA will be hosted on the online platform Smart Survey. Providers will be sent a generic link to the SA by their respective HEE regional quality team directing them to the SA.

Creating your Placement Provider specific link

On receiving your generic link to the SA, it is important that you open this link and firstly complete your organisational details e.g., Provider Name then select the save and continue at the bottom of this page. This will create a bespoke organisational link which will be emailed to you, which you can then share with others in your organisation to ensure everyone completes the same survey (please do not share the original generic link).

Each time an individual inputs data into your SA via your organisational link and hits save and continue Smart Survey will generate an account for them and a link to the SA, as such they will be asked to register enter their name and email address, see section ‘Can the Self-Assessment be saved and completed later’. This will ensure everyone is working on the same survey with their own link.

3. Timelines

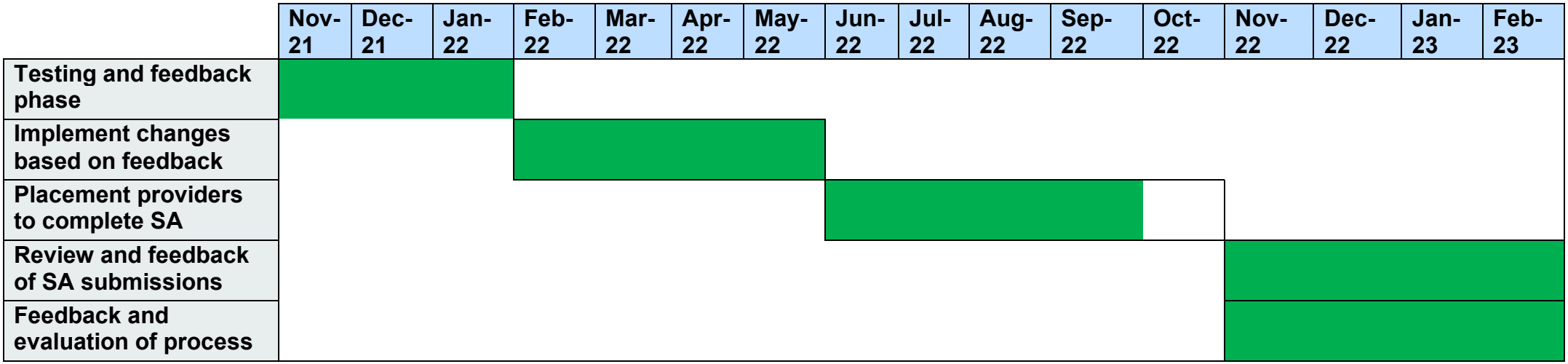
How often does the Self-Assessment process take place?

As per the Education Contract, providers will be asked to complete the SA annually. A review of the SA process will take place and placement providers will be asked to provide feedback to help inform the process of subsequent submissions.

When will providers be expected to complete the Self-Assessment?

The link to the SA as well as supporting documents will be sent to providers **June 22nd 2022.**

Providers will be given **a window of June 22nd to September 30th 2022** to complete the SA. The completed SA should be submitted via Smart Survey.



4. Structure of the Self-Assessment

The SA is divided in to three main sections:

• Section 1: Organisation details and board level sign-off
• Section 2: Education Contract KPIs
• Section 3: HEE Quality Framework Standard

5. What is expected when completing the Self-Assessment

Most questions ask for a yes or no response, this is to support analysis and benchmarking. There is the opportunity under most of the questions for providers to provide comments to support their answer, this is ***optional*** and not mandatory. Evidence is **not** requested as part of the SA; however, regional quality teams may request evidence once a triangulation exercise has taken place.

Section 1: Organisation details

This section asks for assurance that the SA has been reviewed and has received board level sign-off. HEE expect the governance of clinical education and training to directly link to the provider board given both, the importance of ensuring all learners and educators are fully supported, as well as the significant financial investment made by HEE each year via the NHS Education Contract.

There is also the opportunity in this section for providers to share three key achievements and up to three current challenges faced in relation to education and training.

Section 2: Education Contract KPIs

This section asks providers to report on compliance with the NHS Education Contract (2021-24).

Section 3: HEE Quality Framework Standards

Providers will be asked to report on compliance with the HEE Quality Framework Standards.

Some questions ask providers to submit a response per professional group. Throughout the SA professional groups are arranged by their regulators. For example, some questions will ask the provider to respond for GMC or NMC associated learners or educators.

The professional groups are split as follows:

Nursing and Midwifery Council (NMC)

In this section, consider HEE's Quality domains and standards and declare any areas where standards are not met.

In this section, please consider the following learner groups:

- Adult Nursing
- Child Nursing
- Community Nursing
- Health Visitors
- Learning Disabilities Nursing
- Mental Health Nursing
- Midwifery
- Nursing Associates

General Medical Council (GMC)

In this section, consider HEE's Quality domains and standards and declare any areas where standards are not met.

In this section, please consider the following learner groups:

- Postgraduate Medical Training
- Undergraduate Medical Training
- Physicians Associates

General Dental Council (GDC)

In this section, consider HEE's Quality domains and standards and declare any areas where standards are not met.

In this section, please consider the following learner groups:

- Dentists
- Dental Technicians
- Dental Therapists
- Dental Nurses
- Clinical Dental Technician
- Dental Hygienists
- Orthodontic Therapists

General Pharmaceutical Council (GPhC)

In this section, consider HEE's Quality domains and standards and declare any areas where standards are not met.

In this section, please consider the following learner groups:

- Pharmacy Technicians
- Pharmacists
- Pharmaceutical Scientists

Health & Care Professions Council (HCPC)

In this section, consider HEE's Quality domains and standards and declare any areas where standards are not met.

In this section, please consider the following learner groups:

- Arts therapists
- Biomedical scientists
- Chiropodists/ podiatrists
- Clinical Scientists
- Dieticians
- Hearing aid dispensers
- Occupational therapists
- Operating department practitioners
- Orthoptists
- Paramedics
- Physiotherapists
- Practitioner psychologists
- Prosthetists/orthotists
- Radiographers
- Speech and language therapists

General Osteopathic Council (GOsC)

In this section, consider HEE's Quality domains and standards and declare any areas where standards are not met.

In this section, please consider the following learner groups:

- Osteopath

Any other learner groups

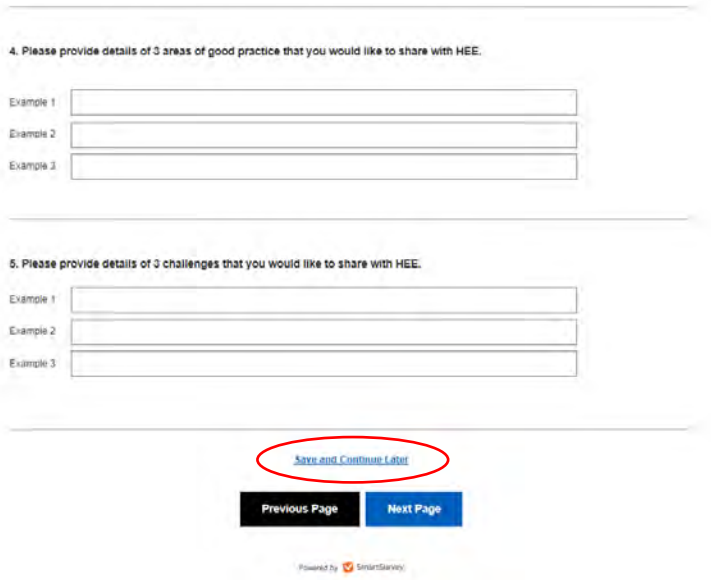
In this section, consider HEE's Quality domains and standards and declare any areas where standards are not met.

In this section, please consider the following learner groups:

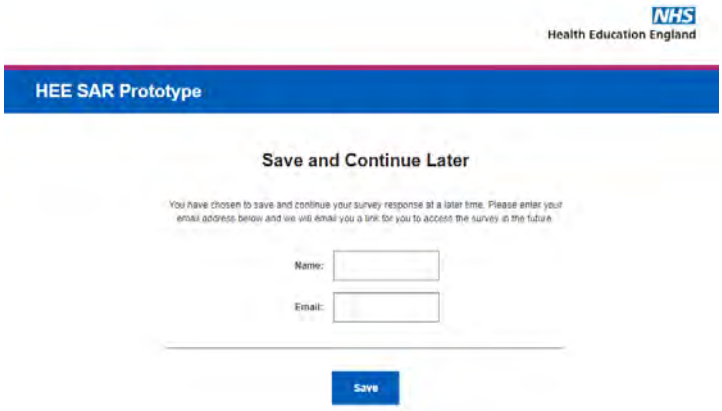
- Any other learners who are not regulated by any of the above regulators. Please define these groups in the notes section.

Can the Self-Assessment be saved and completed later?

Smart Survey does have the functionality to save the SA and to finish later, this is located at the bottom of the screen.



The individual completing the survey will be asked to enter their name and email address for the new survey link to be sent to.



6. Sending out and receiving of the Self-Assessment

<u>One SA is to be completed per provider</u>

The SA will be sent to the following people within your organisation on June 22nd:

Sent to: Named trust Self-Assessment Lead (if identified by trust)
Named person on the NHS Education Contract (if Self-Assessment Lead not identified by trust)

Copied to:
Medical Director
Chief Nurse
Chief Executive Officer
Director of Medical Education

The email will contain the following:

• Details of the requirements including deadlines
• SA link
• A word copy of the SA template
• A copy of the guidance document (this document)

The provider is responsible for ensuring input from appropriate representatives. **Prior to submission the SA is required to have sign off from a representative of the Trust Board.**

We are aware that some providers may require a hard copy of their draft SA completion to obtain board level sign off. Currently we do not have the functionality within the SA for providers to be able to print a copy themselves, however, this is something that we are working to incorporate in future SAs. In the interim we are attaching a Microsoft Word copy of the SA template in the initial email. Providers may find it helpful to complete the word copy of the SA before entering the information in the Smart Survey online form.

It is also possible to request a copy of a partial, or final submission. Please contact your regional HEE quality team via qualityframework.eoe@hee.nhs.uk and they will be able to send you an outline of your responses in Microsoft Word.

7. Analysis of the Self-Assessment by HEE and feedback

Qualitative data will form the basis of a regional themed report and a national HEE report. Providers will receive a PDF report of their SA.

The threshold for follow-up review meetings will be determined by regional teams as part of their ongoing quality management processes.

8. Feedback to providers

Feedback to providers will be done in a meaningful manner.

Information from the SA will be triangulated with other evidence gathered through existing quality processes. This combined picture is used to determine how well an organisation is fulfilling the requirements of the Education Contract. The SA is also an opportunity to identify and confirm best practice which could be shared within and across organisations.

9. Who will we share the Self-Assessment with?

The SA itself will not be a public document and as such will not be published on HEE's website.

The information contained within the SA (either whole or in part) may be shared with:
• Higher Education Institutes
• Undergraduate Medical and Dental Schools
• Healthcare Regulators
• HEE Internal Teams
• Other Arms-length Bodies

The SA could also be shared under a Freedom of Information Request.

Health Education England

HEE Provider Self-Assessment - 2022 (East of England)

1. HEE Self-Assessment Tool

Progress 0%

HEE Self-Assessment - Introduction

The HEE Self-Assessment (SA) is a process by which providers carry out their own quality evaluation against a set of standards. It is based on the philosophy of continuous quality improvement, the identification of quality improvement potential, the development of action plans, implementation, and subsequent evaluation.

Providers are asked to complete this online form indicating where they have or have not met the standards as set out in the SA. There is the opportunity under most of the questions for providers to provide comments to support their answer, this is optional and not mandatory.

Completing the SA

Some questions within the SA will ask you to provide some further information based on your responses.

Where standards have not been met: In these instances you will be asked to provide some information detailing why the standard has not been met and any work that is underway to ensure it will be met in future.

Where standards have been met: Where you have met the standards, some questions may give you the opportunity to add comments to support your answer.

Responses by Professional Group: In some questions we have asked you to provide a response per professional group. Throughout the SA we have arranged these groups by their regulators. For example, some questions will ask for you to respond for GMC or NMC associated learners or educators. There is an N/A option should these learner groups not be relevant for your organisation.

Further Questions

If you have any queries regarding the completion of the HEE SA, please review the FAQ document. If you still require further information, you can contact your regional HEE Quality Team.

Save and Continue Later

Next Page

Health Education England

HEE Provider Self-Assessment - 2022 (East of England)

2. East of England

Progress 8%

Please select your provider from the list below:

West Suffolk NHS Foundation Trust

Save and Continue Later

Health Education England

HEE Provider Self-Assessment - 2022 (East of England)

3. Section 1 - Provider

Progress 17%

1. Please provide details of 3 challenges within education and training that you would like to share with HEE. (100 word limit on each response)

Example 1	National reduction in people applying for nursing pre-registration programmes therefore reduced numbers on local
Example 2	Continued implementation of maternity/obs & gynae improvement plan in partnership with HEE
Example 3	Both medical and non medical workforce recruitment resulting in reduced morale. Also linked to some extent with

2. Please provide details of up to 3 key achievements within education and training that you would like to share with HEE.
(100 word limit on each response)

Example 1	Over 95% of our pre-registration nursing students work for the organisation upon registration. Excellent NETS sco
Example 2	Full utilisation of CPD funds each year with good governance structure and process
Example 3	Our GMC Survey for surgery has improved from last years results. Induction's have been upgraded to include 360

3. Please tick the box below to confirm that your Self-Assessment response has been signed off at board level before submission back to HEE.

◯ By selecting this box I confirm that the responses in this SA have been signed off at board level

4. Please confirm the date that board level sign off was received:

Date
(format: DD/MM/YYYY)

Save and Continue Later

Previous Page **Next Page**

Powered by

HEE Provider Self-Assessment - 2022 (East of England)

4. Section 2 - Contracting

Progress 25%

5. Do you have board level engagement for education and training?

- ○ Yes
- ○ No

If yes, please provide their name and job title; if no, please provide further detail.

Paul Molyneux - Interim Medical Director
Susan Wilkinson - Executive Chief Nurse
Jeremy Over - Executive Director of Workforce and Communication

6. Can the provider confirm that the funding provided via the education contract to support and deliver education and training is used for explicitly this purpose?

- (●) Yes
- ( ) No

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Yes – Optional comments to support your answer	Meeting held with finance upon receipt of schedule from HEE to ensure funding is transferred

No - Please provide further detail

If 'yes' please list any available evidence; if 'no' please provide further detail:

Yes – Optional comments to support your answer

No - Please provide further detail

7. Is an activity in the Education Contract being delivered through a third party provider?

- ○ Yes
- ○ No

If yes, please detail who with:

NA

8. Has the provider reported any breaches in relation to the requirements of the NHS Education Contract for any sub-contractor?

- ○ Yes
- ○ No
- ◉ N/A

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Yes – Optional comments to support your answer	

No - Please provide further detail	

9. Is the provider able to give assurance that they are compliant with all HEE education and training data requests?

- ◯ Yes
- ◯ No

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Yes – Optional comments to support your answer	Requests are completed and returned in a timely manner by DME & NMCT
No - Please provide further detail	

10. Have there been any health and safety breaches that involve a trainee or learner?

- (●) Yes
- ( ) No

If yes, please provide detail:

Any Exception Reports are completed and returned to HEE each quarter and the DME/MD are aware of these. Datixes are reviewed and support offered to learners as required.

11. Does the provider engage with the ICS for system learning?

- (●) Yes
- ( ) No

If ‘yes’ please add comments to support your answer; if ‘no’ please provide further detail:

Yes – Optional comments to support your answer	NMCT is working with ICS leads to develop and support a new education and learning strate
No - Please provide further detail	

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5. Section 3a - Quality

Progress 33%

12. Is the provider aware of the requirements and process for a HEE Quality Intervention, including who is required to attend and how to escalate issues with HEE?

- ○ Yes
- ○ No

If no, please provide detail:

13. Have any conditions been imposed on the provider from regulators?

	Yes	No	N/A
GDC	○	○	○
GMC	○	○	○
GPhC	○	○	○
HCPC	○	○	○
NMC	○	○	○
GOsC	○	○	○
Any other learner groups (please define in notes)	○	○	○

If yes, please provide further detail:

14. Has the provider actively promoted the National Education and Training survey (NETS) to learners?

- (●) Yes
- ( ) No

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Yes – Optional comments to support your answer	Sent to all learners. Advertised in organisational newsletter. Encouraged to complete by ass
No - Please provide further detail	

15. Has the provider reviewed and where appropriate taken action on the basis of the results of the National Education and Training Survey (NETS)

- ◯ Yes
- ◯ No

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Yes – Optional comments to support your answer	Meetings held with educational leads to review feedback and discuss actions required. Non
No - Please provide further detail	

16. Does the provider have a Freedom to Speak Up Guardian and do they actively promote the process for raising concerns through them to your learners?

- ◯ Yes
- ◯ No

If ‘yes’ please add comments to support your answer; if ‘no’ please provide further detail:

Yes – Optional comments to support your answer	Amanda Bennett - discusses F2SU role at all inductions. Contact information readily availabl
No - Please provide further detail	

17. Does the provider have a Guardian of Safe Working, and do they actively promote the process for raising concerns through them to their learners?

- (●) Yes
- ( ) No

If ‘yes’ please add comments to support your answer; if ‘no’ please provide further detail:

Yes – Optional comments to support your answer	Dr Francesca Crawley (GOSW) holds monthly GJDF Meetings, attends inductions, foundatio
No - Please provide further detail	

18. Please confirm whether you have an Equality, Diversity and Inclusion Lead (or equivalent):

- (●) Yes
- ( ) No

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Yes – Optional comments to support your answer	Catriona Cole - Wellbeing and Inclusion Manager
No - Please provide further detail	

19. Please confirm that the provider liaises with their Equality, Diversity and Inclusion Lead (or equivalent) to:

	Yes	No
Ensure reporting mechanisms and data collection take learners into account?	○	○
Implement reasonable adjustments for disabled learners?	○	○
Ensure policies and procedures do not negatively impact learners who may share protected characteristics?	○	○
Analyse and promote awareness of outcome data (such as exam results, assessments, ARCP outcomes) by protected characteristic?	○	○
Ensure International Medical Graduates (IMGs) receive a specific induction in your organisation?	○	○
Ensure policies and processes are in place to manage with discriminatory behaviour from patients?	○	○

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Yes – Optional comments to support your answer	Specific mandatory training is a requirement for all staff to ensure Equality, Diversity and Incl
No - Please provide further detail	

20. Patient Safety and the promotion of a Patient Safety culture is integral to the HEE Quality Framework. Can you confirm as a provider that you have the following:

	Yes	No
A named Board representative for Patient Safety	○	○
A named Patient Safety Specialist/s	○	○
A process to ensure that all staff are made aware of and can access the NHS Patient Safety Syllabus Level 1 training on the e-Learning for Healthcare platform	○	○

If ‘yes’ please add comments to support your answer; if ‘no’ please provide further detail:

Yes – Optional comments to support your answer	Lucy Winstanley - Head of Patient Safety & Richard Davies (Snr Independent Director) Provi
No - Please provide further detail	

21. Has the provider developed and implemented a service improvement plan to ensure progression through the Quality and Improvement Outcomes Framework for NHS Funded Knowledge and Library Services?

- (●) Yes
- ( ) No

If ‘yes’ please add comments to support your answer; if ‘no’ please provide further detail:

Yes – Optional comments to support your answer	Laura Wilks - Library Manager. HEE recommend submission of QIOF action plan as evidenc
No - Please provide further detail	

22. Has the provider been actively promoting, to all learners, use of the national clinical decision support tool funded by HEE?

- (●) Yes
- ( ) No

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Yes – Optional comments to support your answer	'UpToDate' is available on the trust intranet for all learners. UpTODate has been promoted b
No - Please provide further detail	

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6. Section 3b - HEE Quality Framework Domain 1 - Learning environment and culture

Progress 42%

For each learner group, please confirm whether the provider meets the following standards from the HEE Quality Framework (https://healtheducationengland.sharepoint.com/Comms/Digital/Shared%20Documents/Forms/AllItems.aspx?id=%2FComms%2FDigital%2FShared%20Documents%2Fhee%2Enhs%2Euk%20documents%2FWebsite%20files%2FQuality%2FHEE%5FQuality%5F

23. The learning environment is one in which education and training is valued and championed.

	Yes	No	N/A
GDC Learners	○	○	○
GMC Learners	○	○	○
GPhC Learners	○	○	○
HCPC Learners	○	○	○
NMC Learners	○	○	○
GOsC Learners	○	○	○
Any other learner groups (please define in notes)	○	○	○

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Yes – Optional comments to support your answer	We are reactive to the NETS and GMC survey.
No - Please provide further detail	

24. The learning environment is inclusive and supportive for learners of all backgrounds and from all professional groups.

	Yes	No	N/A
GDC Learners	○	○	◉
GMC Learners	◉	○	○
GPhC Learners	◉	○	○
HCPC Learners	◉	○	○
NMC Learners	◉	○	○
GOsC Learners	○	○	◉
Any other learner groups (please define in notes)	○	○	○

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Yes – Optional comments to support your answer	No issues raised by learners regarding non-inclusive behaviour
No - Please provide further detail	

25. The organisational culture is one in which all staff, including learners, are treated fairly, with equity, consistency, dignity and respect.

	Yes	No	N/A
GDC Learners	○	○	●
GMC Learners	●	○	○
GPhC Learners	●	○	○
HCPC Learners	●	○	○
NMC Learners	●	○	○
GOsC Learners	○	○	●
Any other learner groups (please define in notes)	○	○	○

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Yes – Optional comments to support your answer	
No - Please provide further detail	

26. There is a culture of continuous learning, where giving and receiving constructive feedback is encouraged and routine.

	Yes	No	N/A
GDC Learners	○	○	●
GMC Learners	●	○	○
GPhC Learners	●	○	○
HCPC Learners	●	○	○

	Yes	No	N/A
NMC Learners	○	○	○
GOsC Learners	○	○	○
Any other learner groups (please define in notes)	○	○	○

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Yes – Optional comments to support your answer	A coaching model is encouraged throughout the trust. Regular feedback is gathered and rev
No - Please provide further detail	

27. Learners are in an environment that delivers safe, effective, compassionate care and prioritises a positive experience for patients and service users.

	Yes	No	N/A
GDC Learners	○	○	○
GMC Learners	○	○	○
GPhC Learners	○	○	○
HCPC Learners	○	○	○
NMC Learners	○	○	○
GOsC Learners	○	○	○
Any other learner groups (please define in notes)	○	○	○

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Yes – Optional comments to support your answer	NETS and GMC surveys reviewed in partnership with HEI and organisational feedback to prc
No - Please provide further detail	

28. The environment is one that ensures the safety of all staff, including learners on placement.

	Yes	No	N/A
GDC Learners	○	○	◉
GMC Learners	◉	○	○
GPhC Learners	◉	○	○
HCPC Learners	◉	○	○
NMC Learners	◉	○	○
GOsC Learners	○	○	◉
Any other learner groups (please define in notes)	○	○	○

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Yes – Optional comments to support your answer	
No - Please provide further detail	

29. All staff, including learners, are able to speak up if they have any concerns, without fear of negative consequences.

	Yes	No	N/A
GDC Learners	○	○	●
GMC Learners	●	○	○
GPhC Learners	●	○	○
HCPC Learners	●	○	○
NMC Learners	●	○	○
GOsC Learners	○	○	●
Any other learner groups (please define in notes)	○	○	○

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Yes – Optional comments to support your answer	Variety of ways to speak up including F2SU, clinical psychology team, well-being conversatio
No - Please provide further detail	

30. The environment is sensitive to both the diversity of learners and the population the organisation serves.

	Yes	No	N/A
GDC Learners	○	○	●
GMC Learners	●	○	○
GPhC Learners	●	○	○
HCPC Learners	●	○	○
NMC Learners	●	○	○
GOsC Learners	○	○	●

	Yes	No	N/A
Any other learner groups (please define in notes)	○	○	○

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Yes – Optional comments to support your answer	Adaptations are made to the working environment of learners to help accommodate specific n
No - Please provide further detail	

31. There are opportunities for learners to take an active role in quality improvement initiatives, including participation in improving evidence led practice activities and research and innovation.

	Yes	No	N/A
GDC Learners	○	○	●
GMC Learners	●	○	○
GPhC Learners	●	○	○
HCPC Learners	●	○	○
NMC Learners	●	○	○
GOsC Learners	○	○	●
Any other learner groups (please define in notes)	○	○	○

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Yes – Optional comments to support your answer	Medical staff regularly undertake QI projects, Surveys, research projects, present at conferen
No - Please provide further detail	

32. There are opportunities to learn constructively from the experience and outcomes of patients and service users, whether positive or negative.

	Yes	No	N/A
GDC Learners	○	○	◉
GMC Learners	◉	○	○
GPhC Learners	◉	○	○
HCPC Learners	◉	○	○
NMC Learners	◉	○	○
GOsC Learners	○	○	◉
Any other learner groups (please define in notes)	○	○	○

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Yes – Optional comments to support your answer	Reflective learning is actively encouraged for all staff.
No - Please provide further detail	

33. The learning environment provides suitable educational facilities for both learners and supervisors, including space and IT facilities, and access to library and knowledge services and specialists.

	Yes	No	N/A
GDC Learners	○	○	●
GMC Learners	●	○	○
GPhC Learners	●	○	○
HCPC Learners	●	○	○
NMC Learners	●	○	○
GOsC Learners	○	○	●
Any other learner groups (please define in notes)	○	○	○

If 'yes' please add comments to support your answer; if 'no' please provide further detail for each facility:

Yes – Optional comments to support your answer	NETS Survey highlighted staff are aware and use facilities. Dr's Mess also provides space fc
No - Please provide further detail	

34. The learning environment promotes multi-professional learning opportunities.

	Yes	No	N/A
GDC Learners	○	○	●
GMC Learners	●	○	○
GPhC Learners	●	○	○
HCPC Learners	●	○	○
NMC Learners	●	○	○
GOsC Learners	○	○	●

	Yes	No	N/A
Any other learner groups (please define in notes)	○	○	○

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Yes – Optional comments to support your answer	89% (NETS) stated that they witnessed multi-professional team working. Many learning oppc
No - Please provide further detail	

35. The learning environment encourages learners to be proactive and take a lead in accessing learning opportunities and take responsibility for their own learning.

	Yes	No	N/A
GDC Learners	○	○	●
GMC Learners	●	○	○
GPhC Learners	●	○	○
HCPC Learners	●	○	○
NMC Learners	●	○	○
GOsC Learners	○	○	●
Any other learner groups (please define in notes)	○	○	○

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Yes – Optional comments to support your answer	Use of coaching model within clinical environments encouraging leadership, delegation and c
No - Please provide further detail	

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7. Section 3c - HEE Quality Framework Domain 2 - Educational governance and commitment to quality

Progress 50%

For each learner group, please confirm whether the provider meets the following standards from the HEE Quality Framework: (https://healtheducationengland.sharepoint.com/Comms/Digital/Shared%20Documents/Forms/AllItems.aspx?id=%2FComms%2FDigital%2FShared%20Documents%2Fhee%2Enhs%2Euk%20documents%2FWebsite%20files%2FQuality%2FHEE%5FQuality%5F

36. There is clear, visible and inclusive senior educational leadership, with responsibility for all relevant learner groups, which is joined up and promotes team-working and both a multi-professional and, where appropriate, inter-professional approach to education and training.

	Yes	No	N/A
GDC Learners	○	○	◉
GMC Learners	◉	○	○
GPhC Learners	◉	○	○
HCPC Learners	◉	○	○
NMC Learners	◉	○	○
GOsC Learners	○	○	◉
Any other learner groups (please define in notes)	○	○	○

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Yes – Optional comments to support your answer	DME and NMCT work meet to discuss quality self-assessment and HEE development plans.
No - Please provide further detail	

37. There is active engagement and ownership of equality, diversity and inclusion in education and training at a senior level.

	Yes	No	N/A
GDC Learners	○	○	◉
GMC Learners	◉	○	○
GPhC Learners	◉	○	○
HCPC Learners	◉	○	○
NMC Learners	◉	○	○
GOsC Learners	○	○	◉
Any other learner groups (please define in notes)	○	○	○

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Yes – Optional comments to support your answer	
No - Please provide further detail	

38. The governance arrangements promote fairness in education and training and challenge discrimination.

	Yes	No	N/A
GDC Learners	○	○	◉
GMC Learners	◉	○	○
GPhC Learners	◉	○	○
HCPC Learners	◉	○	○
NMC Learners	◉	○	○
GOsC Learners	○	○	◉
Any other learner groups (please define in notes)	○	○	○

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Yes – Optional comments to support your answer	
No - Please provide further detail	

39. Education and training issues are fed into, considered and represented at the most senior level of decision making.

	Yes	No	N/A
GDC Learners	○	○	◉
GMC Learners	◉	○	○
GPhC Learners	◉	○	○
HCPC Learners	◉	○	○
NMC Learners	◉	○	○

	Yes	No	N/A
GOsC Learners	○	○	◉
Any other learner groups (please define in notes)	○	○	○

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Yes – Optional comments to support your answer	Reports for Education and Training are sent to the Board for review and ratification
No - Please provide further detail	

40. The provider can demonstrate how educational resources (including financial) are allocated and used.

	Yes	No	N/A
GDC Learners	○	○	◉
GMC Learners	◉	○	○
GPhC Learners	◉	○	○
HCPC Learners	◉	○	○
NMC Learners	◉	○	○
GOsC Learners	○	○	◉
Any other learner groups (please define in notes)	○	○	○

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Yes – Optional comments to support your answer	Robust governance system in place for CPD and tariff funding. Financial reports discussed a
No - Please provide further detail	

41. Educational governance arrangements enable organisational self-assessment of performance against the quality standards, an active response when standards are not being met, as well as continuous quality improvement of education and training.

	Yes	No	N/A
GDC Learners	○	○	◉
GMC Learners	◉	○	○
GPhC Learners	◉	○	○
HCPC Learners	◉	○	○
NMC Learners	◉	○	○
GOsC Learners	○	○	◉
Any other learner groups (please define in notes)	○	○	○

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Yes – Optional comments to support your answer	
No - Please provide further detail	

42. There is proactive and collaborative working with other partner and stakeholder organisations to support effective delivery of healthcare education and training and spread good practice.

	Yes	No	N/A
GDC Learners	○	○	●
GMC Learners	●	○	○
GPhC Learners	●	○	○
HCPC Learners	●	○	○
NMC Learners	●	○	○
GoC Learners	○	○	●
Any other learner groups (please define in notes)	○	○	○

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Yes – Optional comments to support your answer	Work closely with ICS to provide best practice across the trust and the wider system
No - Please provide further detail	

43. Consideration is given to the potential impact on education and training of services changes (i.e. service re-design / service reconfiguration), taking into account the views of learners, supervisors and key stakeholders (including HEE and Education Providers).

	Yes	No	N/A
GDC Learners	○	○	●
GMC Learners	●	○	○
GPhC Learners	●	○	○
HCPC Learners	●	○	○
NMC Learners	●	○	○

	Yes	No	N/A
GOsC Learners	○	○	◉
Any other learner groups (please define in notes)	○	○	○

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Yes – Optional comments to support your answer	Learning environments have been closely monitored and changes made over the past 2 year
No - Please provide further detail	

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8. Section 3d - HEE Quality Framework Domain 3 - Developing and supporting learners

Progress 58%

For each learner group, please confirm whether the provider meets the following standards from the HEE Quality Framework: (https://healtheducationengland.sharepoint.com/Comms/Digital/Shared%20Documents/Forms/AllItems.aspx?id=%2FComms%2FDigital%2FShared%20Documents%2Fhee%2Enhs%2Euk%20documents%2FWebsite%20files%2FQuality%2FHEE%5FQuality%5F

44. There is parity of access to learning opportunities for all learners, with providers making reasonable adjustments where required.

	Yes	No	N/A
GDC Learners	○	○	◉
GMC Learners	◉	○	○
GPhC Learners	◉	○	○
HCPC Learners	◉	○	○
NMC Learners	◉	○	○
GOsC Learners	○	○	◉
Any other learner groups (please define in notes)	○	○	○

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Yes – Optional comments to support your answer	Adjustments made when organisation is made aware of need. All learners have access to ec
No - Please provide further detail	

45. The potential for differences in educational attainment is recognised and learners are supported to ensure that any differences do not relate to protected characteristics.

	Yes	No	N/A
GDC Learners	○	○	◉
GMC Learners	◉	○	○
GPhC Learners	◉	○	○
HCPC Learners	◉	○	○
NMC Learners	◉	○	○
GOsC Learners	○	○	◉
Any other learner groups (please define in notes)	○	○	○

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Yes – Optional comments to support your answer	
No - Please provide further detail	

46. Supervision arrangements enable learners in difficulty to be identified and supported at the earliest opportunity.

	Yes	No	N/A
GDC Learners	○	○	◉
GMC Learners	◉	○	○
GPhC Learners	◉	○	○
HCPC Learners	◉	○	○
NMC Learners	◉	○	○
GOsC Learners	○	○	◉
Any other learner groups (please define in notes)	○	○	○

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Yes – Optional comments to support your answer	Good partnership with HEIs to identify learners, who may be struggling, at the earliest opport
No - Please provide further detail	

47. Learners receive clinical supervision appropriate to their level of experience, competence and confidence, and according to their scope of practice.

	Yes	No	N/A
GDC Learners	○	○	◉
GMC Learners	◉	○	○
GPhC Learners	◉	○	○
HCPC Learners	◉	○	○

	Yes	No	N/A
NMC Learners	○	○	○
GOsC Learners	○	○	○
Any other learner groups (please define in notes)	○	○	○

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Yes – Optional comments to support your answer	Training given for non-medical supervisors and assessor with support from education team a
No - Please provide further detail	

48. Learners receive the educational supervision and support to be able to demonstrate what is expected in their curriculum or professional standards to achieve the learning outcomes required.

	Yes	No	N/A
GDC Learners	○	○	○
GMC Learners	○	○	○
GPhC Learners	○	○	○
HCPC Learners	○	○	○
NMC Learners	○	○	○
GOsC Learners	○	○	○
Any other learner groups (please define in notes)	○	○	○

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Yes – Optional comments to support your answer	All ES's do meet the learners in a timely fashion and if any support is needed beyond their ca
No - Please provide further detail	

49. Learners are supported to complete appropriate summative and/or formative assessments to evidence that they are meeting their curriculum, professional and regulatory standards, and learning outcomes.

	Yes	No	N/A
GDC Learners	○	○	◉
GMC Learners	◉	○	○
GPhC Learners	◉	○	○
HCPC Learners	◉	○	○
NMC Learners	◉	○	○
GOsC Learners	○	○	◉
Any other learner groups (please define in notes)	○	○	○

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Yes – Optional comments to support your answer	This is evidenced on their portfolios which is reviewed at ARCP and equivalent
No - Please provide further detail	

50. Learners are valued members of the healthcare teams within which they are placed and enabled to contribute to the work of those teams.

	Yes	No	N/A
GDC Learners	○	○	◉
GMC Learners	◉	○	○
GPhC Learners	◉	○	○
HCPC Learners	◉	○	○
NMC Learners	◉	○	○
GOsC Learners	○	○	◉
Any other learner groups (please define in notes)	○	○	○

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Yes – Optional comments to support your answer	All learners have access to a variety of teams should any issues arise i.e. MEM, PSW, DME,
No - Please provide further detail	

51. Learners receive an appropriate, effective and timely induction and introduction into the clinical learning environment.

	Yes	No	N/A
GDC Learners	○	○	◉
GMC Learners	◉	○	○
GPhC Learners	◉	○	○
HCPC Learners	◉	○	○

	Yes	No	N/A
NMC Learners	○	○	○
GOsC Learners	○	○	○
Any other learner groups (please define in notes)	○	○	○

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Yes – Optional comments to support your answer	A robust induction process is in place for both medical and non medical learners on which re
No - Please provide further detail	

52. Learners understand their role and the context of their placement in relation to care pathways, journeys and expected outcomes of patients and service users.

	Yes	No	N/A
GDC Learners	○	○	○
GMC Learners	○	○	○
GPhC Learners	○	○	○
HCPC Learners	○	○	○
NMC Learners	○	○	○
GOsC Learners	○	○	○
Any other learner groups (please define in notes)	○	○	○

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Yes – Optional comments to support your answer	
No - Please provide further detail	

53. Learners are supported, and developed, to undertake supervision responsibilities with more junior staff as appropriate.

	Yes	No	N/A
GDC Learners	○	○	◉
GMC Learners	◉	○	○
GPhC Learners	◉	○	○
HCPC Learners	◉	○	○
NMC Learners	◉	○	○
GOsC Learners	○	○	◉
Any other learner groups (please define in notes)	○	○	○

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Yes – Optional comments to support your answer	Supervisor and preceptor training is given on preceptorship
No - Please provide further detail	

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HEE Provider Self-Assessment - 2022 (East of England)

9. Section 3e - HEE Quality Framework Domain 4 - Developing and supporting supervisors

Progress 67%

For each learner group, please confirm whether the provider meets the following standards from the HEE Quality Framework: (https://healtheducationengland.sharepoint.com/Comms/Digital/Shared%20Documents/Forms/AllItems.aspx?id=%2FComms%2FDigital%2FShared%20Documents%2Fhee%2Enhs%2Euk%20documents%2FWebsite%20files%2FQuality%2FHEE%5FQuality%5F

54. Formally recognised supervisors are appropriately supported, with allocated time in job plans/ job descriptions, to undertake their roles.

	Yes	No	N/A
GDC Learners	○	○	◉
GMC Learners	◉	○	○
GPhC Learners	◉	○	○
HCPC Learners	◉	○	○
NMC Learners	◉	○	○
GOsC Learners	○	○	◉
Any other learner groups (please define in notes)	○	○	○

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Yes – Optional comments to support your answer	All job plans are in the process of being reviewed to ensure consistency
No - Please provide further detail	

55. Those undertaking formal supervision roles are appropriately trained as defined by the relevant regulator and/or professional body and in line with any other standards and expectations of partner organisations (e.g. Education Provider, HEE).

	Yes	No	N/A
GDC Learners	○	○	◉
GMC Learners	◉	○	○
GPhC Learners	◉	○	○
HCPC Learners	◉	○	○
NMC Learners	◉	○	○
GOsC Learners	○	○	◉
Any other learner groups (please define in notes)	○	○	○

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Yes – Optional comments to support your answer	
No - Please provide further detail	

56. Clinical Supervisors understand the scope of practice and expected competence of those they are supervising.

	Yes	No	N/A
GDC Learners	○	○	◉
GMC Learners	◉	○	○
GPhC Learners	◉	○	○
HCPC Learners	◉	○	○
NMC Learners	◉	○	○
GOsC Learners	○	○	◉
Any other learner groups (please define in notes)	○	○	○

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Yes – Optional comments to support your answer	
No - Please provide further detail	

57. Educational Supervisors are familiar with, understand and are up-to-date with the curricula of the learners they are supporting. They also understand their role in the context of leaners' programmes and career pathways, enhancing their ability to support learners' progression.

	Yes	No	N/A
GDC Learners	○	○	◉
GMC Learners	◉	○	○
GPhC Learners	◉	○	○
HCPC Learners	◉	○	○

	Yes	No	N/A
NMC Learners	○	○	○
GOsC Learners	○	○	○
Any other learner groups (please define in notes)	○	○	○

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Yes – Optional comments to support your answer	All ES'S are encouraged to keep their ES appraisals up to date along with their professional a
No - Please provide further detail	

58. Clinical supervisors are supported to understand the education, training and any other support needs of their learners.

	Yes	No	N/A
GDC Learners	○	○	○
GMC Learners	○	○	○
GPhC Learners	○	○	○
HCPC Learners	○	○	○
NMC Learners	○	○	○
GOsC Learners	○	○	○
Any other learner groups (please define in notes)	○	○	○

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Yes – Optional comments to support your answer	
No - Please provide further detail	

59. Supervisor performance is assessed through appraisals or other appropriate mechanisms, with constructive feedback and support provided for continued professional development and role progression and/or when they may be experiencing difficulties and challenges.

	Yes	No	N/A
GDC Learners	○	○	◉
GMC Learners	◉	○	○
GPhC Learners	◉	○	○
HCPC Learners	◉	○	○
NMC Learners	◉	○	○
GOsC Learners	○	○	◉
Any other learner groups (please define in notes)	○	○	○

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Yes – Optional comments to support your answer	
No - Please provide further detail	

HEE Provider Self-Assessment - 2022 (East of England)

10. Section 3f - HEE Quality Framework Domain 5 - Delivering programmes and curricula

Progress 75%

For each learner group, please confirm whether the provider meets the following standards from the HEE Quality Framework (https://healtheducationengland.sharepoint.com/Comms/Digital/Shared%20Documents/Forms/AllItems.aspx?id=%2FComms%2FDigital%2FShared%20Documents%2Fhee%2Enhs%2Euk%20documents%2FWebsite%20files%2FQuality%2FHEE%5FQuality%5F

60. Practice placements must enable the delivery of relevant parts of curricula and contribute as expected to training programmes.

	Yes	No	N/A
GDC Learners	○	○	◉
GMC Learners	◉	○	○
GPhC Learners	◉	○	○
HCPC Learners	◉	○	○
NMC Learners	◉	○	○
GOsC Learners	○	○	◉
Any other learner groups (please define in notes)	○	○	○

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Yes – Optional comments to support your answer	Practice placements supported by educational teams. Educational teams meet regularly with
No - Please provide further detail	

61. Placement providers work in partnership with programme leads in planning and delivery of curricula and assessments.

	Yes	No	N/A
GDC Learners	○	○	◉
GMC Learners	◉	○	○
GPhC Learners	◉	○	○
HCPC Learners	◉	○	○
NMC Learners	◉	○	○
GOsC Learners	○	○	◉
Any other learner groups (please define in notes)	○	○	○

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Yes – Optional comments to support your answer	
No - Please provide further detail	

62. Placement providers collaborate with professional bodies, curriculum/ programme leads and key stakeholders to help to shape curricula, assessments and programmes to ensure their content is responsive to changes in treatments, technologies and care delivery models, as well as a focus on health promotion and disease prevention.

	Yes	No	N/A
GDC Learners	○	○	◉
GMC Learners	◉	○	○
GPhC Learners	◉	○	○
HCPC Learners	◉	○	○
NMC Learners	◉	○	○
GOsC Learners	○	○	◉
Any other learner groups (please define in notes)	○	○	○

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Yes – Optional comments to support your answer	
No - Please provide further detail	

63. Placement providers proactively seek to develop new and innovative methods of education delivery, including multi-professional approaches.

	Yes	No	N/A
GDC Learners	○	○	◉
GMC Learners	◉	○	○
GPhC Learners	◉	○	○

	Yes	No	N/A
HCPC Learners	○	○	○
NMC Learners	○	○	○
GOsC Learners	○	○	○
Any other learner groups (please define in notes)	○	○	○

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Yes – Optional comments to support your answer	Several Multi professional platforms involving Sim is inbuilt within each clinical area
No - Please provide further detail	

64. The involvement of patients and service users, and also learners, in the development of education delivery is encouraged.

	Yes	No	N/A
GDC Learners	○	○	○
GMC Learners	○	○	○
GPhC Learners	○	○	○
HCPC Learners	○	○	○
NMC Learners	○	○	○
GOsC Learners	○	○	○
Any other learner groups (please define in notes)	○	○	○

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Yes – Optional comments to support your answer	
No - Please provide further detail	

65. Timetables, rotas and workload enable learners to attend planned/ timetabled education sessions needed to meet curriculum requirements.

	Yes	No	N/A
GDC Learners	○	○	◉
GMC Learners	◉	○	○
GPhC Learners	◉	○	○
HCPC Learners	◉	○	○
NMC Learners	◉	○	○
GOsC Learners	○	○	◉
Any other learner groups (please define in notes)	○	○	○

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Yes – Optional comments to support your answer	
No - Please provide further detail	

HEE Provider Self-Assessment - 2022 (East of England)

11. Section 3g - HEE Quality Framework Domain 6 - Developing a sustainable workforce

Progress 83%

For each learner group, please confirm whether the provider meets the following standards from the HEE Quality Framework (https://healtheducationengland.sharepoint.com/Comms/Digital/Shared%20Documents/Forms/AllItems.aspx?id=%2FComms%2FDigital%2FShared%20Documents%2Fhee%2Enhs%2Euk%20documents%2FWebsite%20files%2FQuality%2FHEE%5FQuality%5F

66. Placement providers work with other organisations to mitigate avoidable learner attrition from programmes.

	Yes	No	N/A
GDC Learners	○	○	○
GMC Learners	○	○	○
GPhC Learners	○	○	○
HCPC Learners	○	○	○
NMC Learners	○	○	○
GOsC Learners	○	○	○
Any other learner groups (please define in notes)	○	○	○

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Yes – Optional comments to support your answer	Regular conversations with educational providers to review learner progress. Organisation h
No - Please provide further detail	

67. Does the provider provide opportunities for learners to receive appropriate careers advice from colleagues

	Yes	No	N/A
GDC Learners	○	○	◉
GMC Learners	◉	○	○
GPhC Learners	◉	○	○
HCPC Learners	◉	○	○
NMC Learners	◉	○	○
GOsC Learners	○	○	◉
Any other learner groups (please define in notes)	○	○	○

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Yes – Optional comments to support your answer	Annual Careers Fair for medical learners is organised and also appropriate career guidance i
No - Please provide further detail	

68. The provider engages in local workforce planning to ensure it supports the development of learners who have the skills, knowledge and behaviours to meet the changing needs of patients and service.

	Yes	No	N/A
GDC Learners	○	○	●
GMC Learners	●	○	○
GPhC Learners	●	○	○
HCPC Learners	●	○	○
NMC Learners	●	○	○
GOsC Learners	○	○	●
Any other learner groups (please define in notes)	○	○	○

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Yes – Optional comments to support your answer	
No - Please provide further detail	

69. Transition from a healthcare education programme to employment and/or, where appropriate, career progression, is underpinned by a clear process of support developed and delivered in partnership with the learner.

	Yes	No	N/A
GDC Learners	○	○	●
GMC Learners	●	○	○
GPhC Learners	●	○	○
HCPC Learners	●	○	○

	Yes	No	N/A
NMC Learners	◉	○	○
GOsC Learners	○	○	◉
Any other learner groups (please define in notes)	○	○	○

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Yes – Optional comments to support your answer	Multi-professional preceptorship programme. Same educational team supports pre-registrati
No - Please provide further detail	

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3. STRATEGY

3.1. Future System board report

To Assure

Presented by Craig Black

Public Board Meeting – 30th September 2022

Report Title:	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

Executive Summary

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

1. The Future System Team successfully responded to the comments received from the initial public planning consultation and its revised plans have now been subjected to a second round of consultation[1] which commenced, on time, on 8th August and closed on 9th September.
2. These revised plans represent a huge amount of technical work and reflect a new traffic management approach, a bio-diversity strategy, an improved drainage solution and adjustments to the proposed roofline that reduces visual impact.
3. Our local planning authority wrote to c.3500 people and at the time of writing (post closure) we had received comments from 16 different neighbours and the majority of statutory consultees.
4. Of the neighbour responses, 1 was supportive and 15 relayed concerns relating, principally, to traffic and the environment.
5. Statutory consultees are broadly supportive and acknowledge the efforts that have gone into mitigating the concerns raised in the first round of consultation.
6. The Council Highways department have specifically asked us to re-model the traffic impact that the proposed hospital will have on three local road junctions (e.g. Spread Eagle Junction).
7. The determination of our planning application remains on track for October / November and we expect to report the outcome of the application at the next meeting of the Board.
8. The Future System Team has committed resources to working with The New Hospitals Programme (NHP)[2] and other Schemes on the co-production of a series of standard 'products' that will inform the way in which new hospitals are delivered. This work is underway and our engagement will ensure our lessons are shared and that the integrity of our own co-produced design is protected.
9. Phase 4 of our clinical co-production has been concluded with the completion of a report, compiled by our architects, Ryder, that documents the designs along with the caveats and comments that will be taken forward into the next phase of co-production.

[1] Note, all public consultations associated with our planning application are carried out by the West Suffolk Council Planning Authority.

[2] 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.

10. The report detailing the lessons learned from our trial of moving the administration of Denosumab to the community is complete and was shared and discussed at the Future System Programme Board.
11. The clinical workstream has been enagaging our staff in the latest series of "Action Learning"[3] workshops through which 1:200 designs will continue to be co-refined and attendees were apprised of the latest progress. These actions are a significant investment in time and showcase the team's ongoing commitment to the process of co-production.
12. Work continues on the development of an ICS wide model of future demand and capacity. Independent consultants, Grant Thornton, have validated the approach adopted by the FS Team and will now apply a slightly adapted model to the wider system (they are challenging us to take a slightly more aggressive approach to the reduction of outpatient volumes),
13. Our digital workstream team have been working with peers from Hillingdon Hospital to test our digital roadmap against the criteria being applied by NHP.
14. Our West Suffolk project has been selected as a point of national focus from which a baseline for the cost of building a new hospital will be established.
15. October / November represents a significant watershed for our project as we expect to; secure a determination on our planning application, conclude an independent deep-dive into the size, cost and scope of our project and start to receive the first of the co-produced national standards / designs.

National Hospital Programme Update

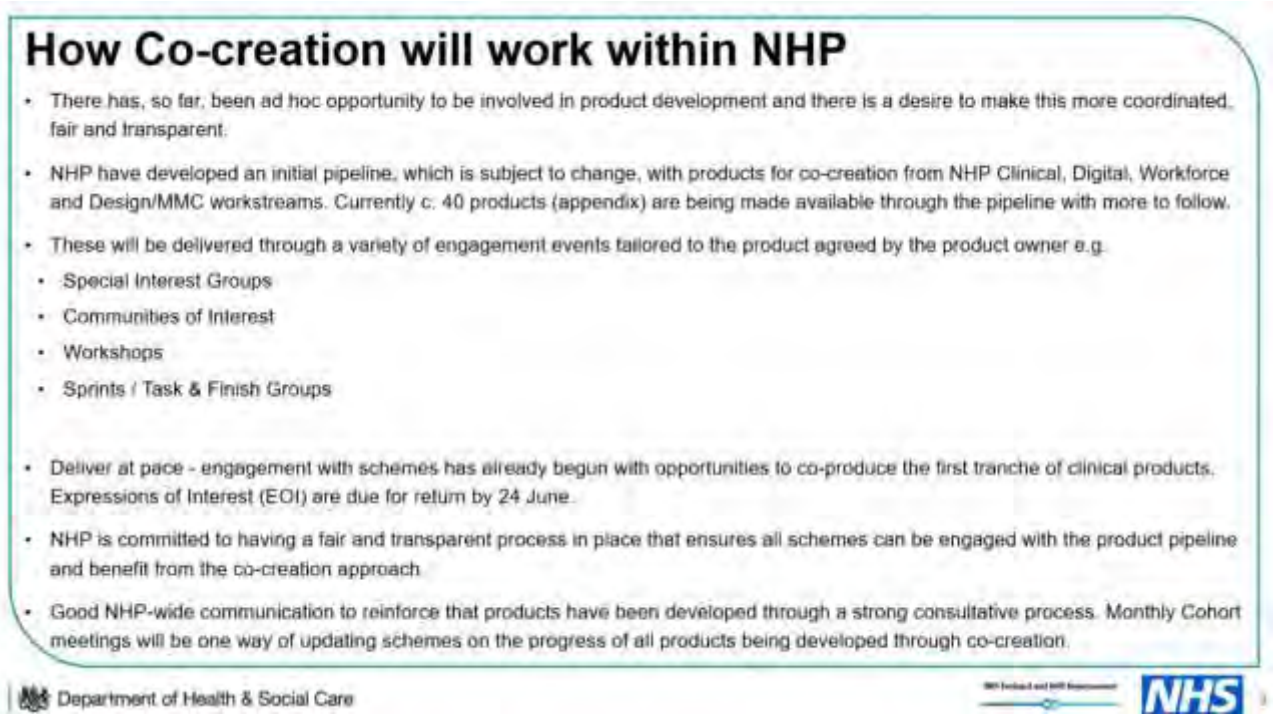
- Programme Business Case[4] (PBC)

The initial PBC has been signed off. This formally establishes the New Hospitals Programme as a national programme and agrees the spend of the £3.7bn budget allocation on the completion of Cohort 1 (projects such as Liverpool which are already 'in-flight') and Cohort 2 (7 smaller agile projects such as the new cancer hospital at Addenbrookes) schemes. The next step will be the presentation of a budget[5] and schedule for Cohort 3 (relatively developed schemes such as West Herts & Whipps Cross) and 4 (relatively immature projects such as West Suffolk and James Paget) schemes.
This presentation is likely to be made to the Major Projects Review Group (MPRG) in December and the output should be a clear understanding of the overall capital envelope. It is also expected that this meeting will decide on how to resolve the issue of replacing RAAC hospitals (both those within the NHP and those, like QE Kings Lynn, that aren't) and a decision on the outstanding eight programme slots for which several Trusts have been applying.
In preparation for this presentation, NHP have announced an exercise to establish the optimum scope of a "new hospital". This exercise will work with five schemes over the next four weeks to assess the various design options for each and arrive at an optimal configuration upon which additional layers of value can then be added and justified. This work will establish an extra level of detail to that provided by each scheme's "preferred way forward"[6] and will allow the creation of a more informed program budget for consideration by Treasury. West Suffolk have been selected as one of these five schemes and will provide a benchmark for all "greenfield builds".

- Co-development of national standards.

[3] Action Learning Sets are a means of bringing together people within a workplace to meet with the specific intention of solving / changing workplace challenges / opportunities.
[4] 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.
[5] The original allocation for the 40 hospital schemes was £12.5bn. £3.7bn was released to cover funding requirements until 2025 with the outstanding amount set to be released as part of the public spending review expected in that same year. This new revised budget is likely to request a higher amount that reflects the expanded scope of the schemes, the 8 new projects and factors such as inflation.
[6] Preferred way forward is the term used to describe the best of those options analysed within the strategic outline business case. In the case of The Future System Programme, the preferred way forward is the construction of a new hospital on the site of Hardwick Manor.

NHP have now structured the work streams to co-produce (alongside the individual schemes) the common design standards that will inform the ways in which new hospitals will be built. These workstreams include; the digital blueprint, analysis of the ratio of single bedded bays, demand and capacity modelling and net zero carbon. The Future System team and other key members of the Trust will be represented across these streams which will allow us to apply our significant experience whilst protecting the integrity of our own co-produced designs.



- Funding for Enabling Works

The process for the funding of enabling works is now available. The FS team successfully submitted requests for the following items in time for the 31st August deadline:

- Establish screening to mitigate the disruption of construction to our immediate neighbours (i.e. plant the trees now so they have time to grow before we start building).

- Acquire land and commence execution of our bio diversity compensation strategy – providing us with the maximum time to ensure we translocate the otherwise irreplaceable habitat that will be disturbed during construction

- Work with UK Power Networks to ensure the trenches and cables are in place to support the additional power requirements of the new hospital.

- Conservation payment in relation to great crested newt conservation.

WSFT have also been approached with an opportunity to secure additional funding in support of the next phase of its planning journey. A request has been made for the funding of surveys that will be required to secure full planning consent and we await a decision.

- NHP Flagship Event and Industry Day

In light of the size and scale of the challenge to build 40 new hospitals by 2030, NHP have arranged a flagship event for all potential partners at which they intend to cover the following agenda:

- Hear from New Hospital Programme leaders, industry experts, and clinical professionals on how the New Hospital Programme is building Better and future-proofing our hospitals for generations to come

- Learn about Hospital 1.0 and how our teams are standardising best practice in design through an evolutionary process that will allow the New Hospital Programme to build hospitals Faster
- Understand the Sustainable Legacy hospitals of the future must provide by meeting the net zero challenge and delivering social and economic value for communities across the country
- Listen to how the New Hospital Programme's commercial approach is responding to these opportunities with the forthcoming procurement launch of the New Hospital Programme's Framework Alliance
- Join in collaborative and interactive sessions to add your knowledge to ours
- Network with industry leaders and peers to uncover opportunities for collaboration

The event was scheduled for 20th September[7] in Birmingham and the Future System team have been asked to present our scheme and experiences.

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. Key points to note include:

1) We remain on track to determine the outcome of our outline planning application in October / November 2022 (depending upon the date of the Development Control Committee hearing).
2) Collaboration between our local planning authority, statutory consultees and the FS technical team remains entirely constructive and underpins our positive progress.
3) Our application has been revised in light of feedback and went live on the council planning portal on 8th August. This second round of consultation ran until September 9th. At the time of writing, the majority of the statutory consultees (Environment Agency, West Suffolk Fire and Rescue and West Suffolk Carbon team, Suffolk Wildlife Trust, Flood Risk Agency etc.) had responded without raising any significant objections. We have also received 16 public responses, one of which was positive and the rest of which raised concerns relating, principally, to traffic, highways and the environment.
4) With highways and traffic in mind, the council highways team has asked us to re-visit the modelling completed to understand the pressure that a new hospital would have upon three local junctions – Spread Eagle, Wilkes Road roundabout and Rougham Hill roundabout. In the event that the findings require mitigation, suggestions will be made and a decision will be taken on whether or not to trigger a third round of public consultation.
5) The main changes from the first application centre on the definition of a bio diversity compensation scheme, changes to the ways in which vehicles will access the site, clearer definition of the agreed sustainable drainage solution and a revised building height to address concerns of visual impact.

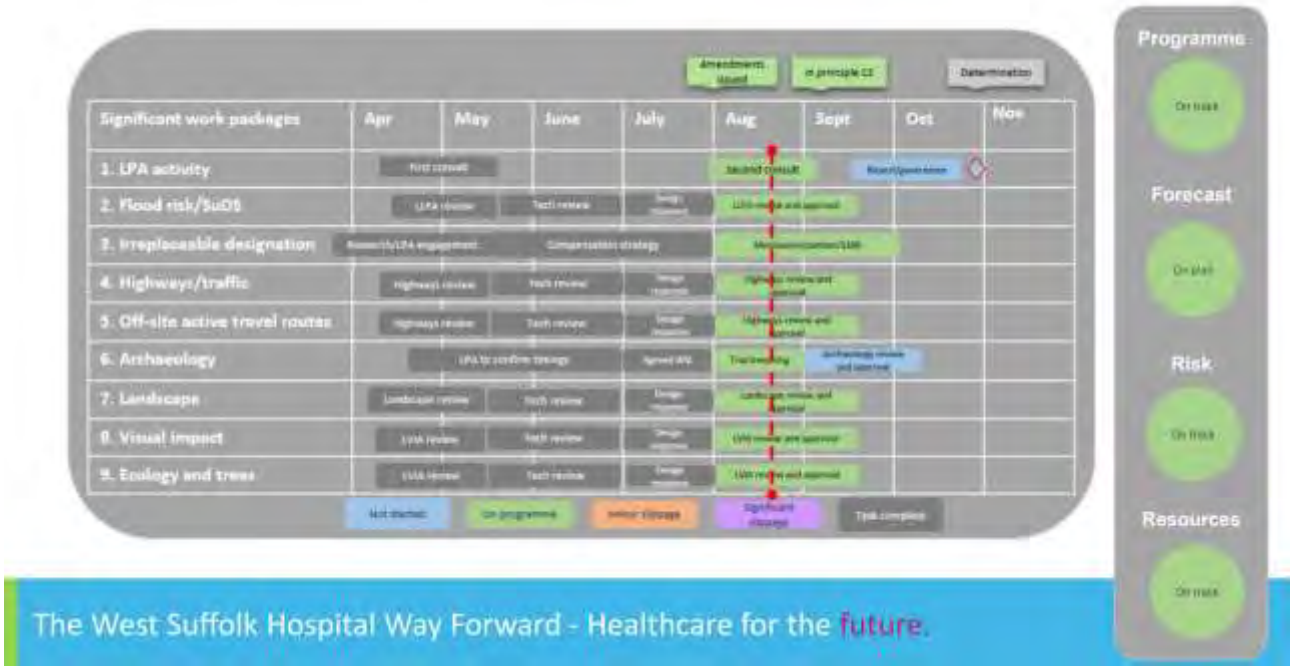
The amended application was accompanied by 76 new documents which provides an indication of the level of work and detail that has gone into ensuring our application remains congruent with the widest requirements and preferences of our community and other stakeholders

The revised / supplementary information has been uploaded to West Suffolk Councils planning portal under reference DC/22/0593/HYB, which can be viewed at Simple Search (westsuffolk.gov.uk).

As an example, the following slides show how the application has reflected concerns relating to the visual impact of the proposed parameter plan. The revised design lowers the height of occupied rooms and keeps all but roof plant and lift risers within the main tree belt.

[7] Due the passing of her Royal Highness Queen Elizabeth II, the event is being rescheduled.

The following dashboard provides detail on progress being made towards the critical determination of our outline planning application:



Clinical / Digital Workstream

The expert experience and knowledge of our clinical team is now in national demand as NHP seek to develop standards and designs that will apply across all the schemes within the programme.

On top of this work, the team continue to explore and develop the business case for the potential movement of services into the community (subject to independent Board discussion).

The final report that concludes Phase 4 of our co-production process has been produced by Ryder Architects. This work documents our 1:200 designs and records all the caveats and concerns that accompany them. In addition, the team have conducted a detailed gap analysis to ensure any key points from the previous phases of clinical co-design are collected and allocated to work-stream leads to be acted upon.

An independent assessment of the Future System demand and capacity model has been completed by consultants Grant Thornton. The methods and approaches within the model were largely endorsed, with some welcome recommendations about topics to look at in more detail, in particular the future demand for outpatient services. This model is now being synthesised into a wider piece of work aiming to understand the demand and capacity requirement of the ICS which will, in turn, provide the basis for the construction of initiatives aimed at containing demand and ensuring any future hospital and other facilities remain sustainable.

In parallel to the work being conducted within our ICS, NHP have now commenced the development / validation of a central demand and capacity model that will provide contrast and the basis for challenge to the conclusions drawn from local modelling.

Having concluded its pilot investigations into the movement of the administration of the Denosumab injection to the community, the clinical team have now published the report highlighting the key lessons learned from the project and will seek to apply them to any future developments of this nature. The main areas for improvement were around project participation and hygiene, readiness of the service for transfer and understanding the true costs of service delivery.

On the digital front, Liam and team have agreed to work with NHP on the development of central standards and have already engaged Hillingdon Hospital to help our own understanding of how our own digital progress would stand up against the assessment criteria applied to other trusts in earlier cohorts. Despite being significantly more advanced that many Cohort 3 and 4 Trusts, there is work to do to ensure we fully integrate the development and implementation of our digital strategy with the realisation of our new hospital, examples of the actions recorded are below for information:

- Initiate a digital communications plan to better manage and promote stakeholder engagement both internally and externally
- Update the Trust digital blueprint with the aid of a traceability matrix and ensure that alignment to the future models of care, and the analysis conveying this, is reflected and evidenced
- Establish the longlist of technology being taken forward for the OBC, prioritised and agreed through relevant governance structures
- Assess the Trust's current capability to implement major digital change including identification of change blockers and enablers to ensure adoption

Communications and Engagement

The action learning sets mentioned above are ensuring our staff are kept up to date however, we were unable to communicate publicly about any planning developments during the LPA consultation period which ended on 9th September.

To ensure that the process of engaging with stakeholders and the public is transparent, and that a decision can be taken without any undue influence, the FS team have decided that we will not be holding any stakeholder meetings or providing separate briefings outside of the statutory LPA periods.

Efforts have been made with Suffolk Chamber of Commerce to ensure Suffolk business partners are fully aware of the NHP Flagship event – we will need all hands to the pump to ensure a timely realisation of our plans – whilst maximising its contribution to the local economy.

Local and national media outlets have been reporting the risks associated with RAAC infrastructure and a solution to this issue is expected to be announced in October.

Finance

The FS programme is currently spending in line with budget. Additional NHP funding will be made available to cover the support provided by the FS team in the development of national standards. As mentioned above, the process for securing enabling funds has been released and our request was lodged in advance of the 31st August deadline.

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

- The results of the "minimum viable product" exercise should be known.
- The first national workstreams will have delivered their standard "products".
- We should have the outcome of our outline planning application.
- We should have a clear view of future demand and capacity for the Hospital and across the ICS.
- An outcome from our application for enabling works funding should be known and we could, therefore, be in a position to demonstrate deliverability of our bio diversity strategy.

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

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

3.2. System update

3.2.1. Alliance

To inform

Presented by Clement Mawoyo

WSFT Board Meeting – 30 September 2022

Report Title:	Integration Report – West Suffolk Alliance
Executive Lead:	Clement Mawoyo
Report Prepared by:	Rebecca Jarvis and others
Previously Considered by:	-

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

Executive Summary
This report is provided to the WSFT Board to give an overview of the work taking place across the wider West Suffolk alliance. Additional or any specific information can be obtained from either Clement Mawoyo or Peter Wightman.
Action Required of the Board
For information purposes.

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

Integration report – West Suffolk Alliance

1. Alliance transition and development

West Suffolk Alliance Partnership Group was introduced to the Live Well Framework.

The Partnership Group agreed to

- Develop the Live Well Domain framework for West Suffolk Alliance and plan how we use the framework to deliver our vision for West Suffolk, including what resource we might need to do so
- Assure progress at the Alliance Committee meeting in October

2. Community Wellbeing

2.1 Community Discovery

The community discovery concluded, and the report will be shared with West Suffolk Alliance in September. The aims of the discovery were to reach into and engage with communities to better understand people and places, to listen and experience what is important to them and what impact this has on their health and wellbeing,

The following principles were agreed to deliver the discovery:

- Build on what we know
- Build on good practice already happening in West Suffolk
- Utilise people in the system and work collaboratively
- Listen, explore, and challenge ourselves to innovate and think differently about how we work with communities
- Be agile but think longer-term
- Be mindful of people's capacity and current pressures

The scope for the discovery was agreed as follows:

- West Suffolk Alliance footprint
- 2 places in West Suffolk, one in the West Suffolk Council boundary and one in Babergh and Mid Suffolk

- One rural community
- One urban community
- Identified cohorts of people, known as seldom listened to.

The output of this work has been produced by Rethink Partners into a report, Understanding Community Wellbeing in West Suffolk. The report is attached to this paper as **appendix 1a**, and the 7 key cross cutting findings summarised below:

- Every community has a history and story that influences what is happening now.
- A feeling of belonging is crucial to a person's individual and community wellbeing
- It is harder to organise outside of your own social and friendship groups
- Informal encounters enable us to feel connected
- Community facilities enable us to live connected lives
- A lack of local services polarises communities
- The power in communities is fragmented, difficult to access and sometimes held in unexpected people and places

This insight will now be used to consider what we could do differently to promote wellbeing, tackle inequalities and drive better health outcomes for the population in West Suffolk, aligning to the strategic priorities of the Alliance including locality development.

2.2 Population Health Management

- Placed based programme completed in August – learning event delivered to Partnership Group on 7th September. West Suffolk positioned nationally as a mature system and shared learning with other ICBs on experience through programme.
- Working to increase GP engagement and data sharing agreements are starting to come in from practices as part of looking at adding primary care data to PHM dataset – currently received approx. 50%, enough to start looking at a phased data extraction selection.
- Atrium Fibrillation individual-level data now being collated by WSH to inform evaluation by partners at University of Essex (data sharing / IG processes under way). Data to be supplied by end September
- Frailty – case finding complete for identified cohort (n=38), with 30 contacts made. Interventions delivered, health coaching and PAM (n=9), Home visit (n=3). Follow-up care and letters in progress (n=30). Respiratory – Mapping of current pathway differences between Norfolk and Suffolk complete.
- Cassius+ anticipatory care – co-design workshop planned to explore potential use of risk-stratification dashboard to identify cohort

3. Future System

- The transference of the Denosumab service to Suffolk GP Federation is going well with patients receiving their injections as planned. A lessons learned exercise has been completed to look at how the project went and what could be used and shared to help future similar projects.
- A second workshop took place in the Mildenhall, Lakenheath and Brandon locality to look at the health, care, and wellbeing needs. The information gathered from Mildenhall, Lakenheath Brandon and Haverhill will be compiled so a plan of action can be devised on what the Future System Programme community group can work on to assist each locality.

- Demand and capacity modelling for the community services (including adult social care) to reflect the changes that will be created by the new clinical model is continuing. The modelling currently encompasses virtual wards, same day emergency care, discharge pathways, end of life care, and frailty assessment. The validation and alignment of the FSP demand and capacity model (across both acute and community services) to the ICB-wide demand and capacity project referenced below is also underway.

Demand and Capacity across the Integrated Care Board

- Alignment review of acute models completed with national benchmarking included.
- Community model including social care progressing in West and across wider ICB.
- Primary Care high-level demand and capacity model developed
- Engagement workshop with system planned for 6th October

4. Digital change

- First Digital Change group met, chaired by Director of Integrated Community Services to agree vision and purpose of the group. There was a collective agreement in the value of coming together at place to maximise the opportunity of digital technology in service re-design and culture change

- Partners in West Suffolk have voiced concerns about the HUMA technology procured to support the rollout of virtual wards. The ICB programme have reviewed this and agreed as an interim measure and whilst the ICB work with partners to plan and longer-term strategic approach to include Current Health as part of the suite of technology available.

- Clinical reference group stood up led by Gylda Nunn and supported by Nicola Chalk

- Clinical safe practice now set out by ICB – Despite attempts to clarify hasn't been clearly set out previously so need to work through what needs to be done and the implications for timeline for Cassius+. Due to go live with deployment of kit mid-September

5. Proactive Care and Focus on Discharge.

5.1 Urgent Community Response (UCR) - The national standard for UCR is mapped locally below:

UCR Standard	WSRAG
Where possible, accelerate coverage and capacity of UCR services in line with the 2-hour guidance, to make an impact in January 22	
A crisis response is delivered by a community-based service typically provided by a multidisciplinary team to adults in their usual place of residence with an urgent care need (required within two hours), and involves an assessment and short-term intervention(s) (typically lasting up to 48 hours).	
This includes supporting equipment purchases such as lifting chairs and point of care testing (POCT) equipment.	
Work together with local councils and providers of local pendant alarm/Technology Enabled Care (TEC) providers and reduce the demand on 999 ambulance services through the re-direction of appropriate patients	
These services should be provided 0800-2000, seven days a week, as a minimum and referrals should be accepted from all appropriate sources with a no wrong door ethos. All referrals should be placed with the best matched professional without the need for further and repeated assessments	
Refresh your local Directory of Services (DoS) so that NHS Service Finder profiles are accurate, up to date and are updated to show that UCR teams will accept referrals from all health & social care colleagues including TEC providers and through a single point of access	
Ensure accurate and complete data via the Community Services Data Set for UCR, so you can track how much the services are being used and helping reduce pressures.	

Overall, our UCR response continues to perform well and is exceeding the national response time metric of 2 hours working closely with the Integrated Neighbourhood Team and Social

Prescribing link workers. More work is needed to operationalise the response across the 24-hour period, but a plan is in place to deliver this by December.

Most of the funding from UCR supports the enhanced Integrated Neighbourhood Teams and this is currently under evaluation.

UCR commenced taking referrals for non-injured fallers on 1st August 2022 and initial feedback has been very positive including preventing people who have fallen lying on the floor for long periods; preventing admission to hospital and ensuring people are monitored and ongoing risks assessed and managed.

Funding for new Advanced Care Practitioners (ACP) to UCR has been secured and recruitment is currently in progress with a good response. It is hoped that through collaborative working with the ambulance service we can secure rotational posts with EEAST to strengthen integrated working and opportunities for workforce development.

The ambulance service response Category 3 and 4 Stack Portal project continues, coordinated by NHS England with a go live date of 1st November for a 6-month test and learn. This will link the UCR response to the ambulance waits and help to improve response times and support more people to stay at home.

An additional allocation from NHS England of £70k has been awarded to Suffolk and Northeast Essex to further improve our UCR offer in year during Q3 and Q4, some of which is allocated to the stack portal project with the remaining assigned to funding options to improve access to medical support to UCR, developing a carer's advice line and improving data quality.

5.2 Anticipatory Care

The long anticipated national anticipatory care model was published late in August and is currently under review locally by the Ageing Well leads across the ICS.

The ICS has lead responsibility for the coordination of Anticipatory Care, of which the following PCN requirements form a part:

- By 30 September 2023, a PCN must agree a plan with their ICS and local partners.
- This plan must be in line with forthcoming national model and guidance on delivering anticipatory care.

The improved Better Care Fund has been used to resource a test and learn in Mildenhall using a risk stratification approach across an Integrated Neighbourhood Team.

5.3 Discharge to Assess

A Transfer of Care review commissioned by the Director of Integrated Health and Care has been completed with a final report going to the September Alliance Delivery Group. The review involved a baseline assessment against the national best practice guidance for discharge and is highlighting several system changes to improve our response to transfer from acute and community hospital.

Home First efficiencies have increased its average weekly hours delivered from 1100 hours in January 2022 to 1675 hours in August 2022, achieved through working smarter by reviewing on-call systems and shift patterns.

5.4 Home care market

Suffolk County Council has been leading on the resilience planning for the home care market which has really struggled to recover following the pandemic. Although we are experiencing

progressive and sustained improvements in west Suffolk particularly in rural areas where targeted interventions have been successful, partners have agreed with SCC to establish a local task and finish group to further accelerate the recovery work with a more detailed focus on demand and capacity planning.

Home care market – we've seen an improved picture with the home care market and reduced waiting lists as a result of targeted intervention, a snapshot from 01/09/22 was a waiting list of 22 when comparing to same time last year the waiting list was at 61. The impact of this is that Home First are holding less packages as provider of last resort, which means their capacity is being utilised more effectively.

5.5 Virtual Ward

This is a national requirement to create additional acute bed-based capacity with 47 acute beds in the community due to open by December with another 103 by December 2023. The pathways west Suffolk Alliance have chosen are outlined below:

Phase 1 – 47 beds by December 2022	Phase 2 – 103 beds by December 2023
Frailty – falls	Trauma and Orthopaedics
Heart Failure	General surgery
Respiratory – COPD	Expansion of frailty pathway
IV Antibiotics	Expansion of respiratory pathway
Acute Kidney Injury (AKI)	

The business case has been approved by NHS England/Improvement but only to 90% of the funding requested and a review of the local finances is now in progress.

Locally, West Suffolk is on target for soft launch by 31 October increasing bed numbers to 47 by end of December 2022. We have successfully recruited to the Operational Manager role, Ward manager and Advanced Care Practitioner. There are however some risks associated to low level interest to clinical staff roles.

The Digital Toolkit HUMA and Current Health platforms are in place under a contract with ESNEFT and there is likely to be further financial support needed for delivery of our local pathways in west Suffolk.

6.0 Urgent and Emergency Care

West Suffolk Alliance will host a new one-year fixed term post supporting the ICS to develop a system Urgent and Emergency Care Strategy.

The West Suffolk Operational Group has focused on resilience planning and development of two West Suffolk proposals:

- A proposal to increase acute bed-based capacity by 10% as per the national requirement. Given the physical constraints of WSFT, this proposal has looked to commission an additional 36 community assessment beds to support discharge and reduce length of stay. Funding for this is yet to be approved.

The 'Third Space: Monoclonal gammopathy of undetermined significance (MGUS) pilot'

MGUS is defined by the presence of an abnormal protein in the blood that has no impact on the patient's health. Most people will be unaware that they have MGUS but it carries a 1% risk each year of developing into a malignant blood disorder. About one in 30 people aged 50 years or older will have the condition - c. 2,400 in West Suffolk, most of whom will be undiagnosed. Recommended monitoring involves blood tests [every 3-4 months for one year and then 6-12 monthly] and routine enquiry after key symptoms.

MGUS is one of a growing number of conditions that are now identified as needing surveillance which is currently not explicitly commissioned from either primary or secondary care – the 'Third Space' and a test and learn pathway is in place to manage this demand.

The project is hugely popular and is being followed closely by the ICS Cancer Steering Committee as a possible area to expand upon across the ICS. 15 Practices have signed up with 262 patients being monitored. An interim evaluation report will be going to the Alliance Delivery Group in September.

7.0 Locality development

The last meeting of the Alliance Delivery Group focussed on developing our next steps around localities building on the work already in development. The meeting was extended to other partners and members of the community and worked through:

- a set of principles for how we work together to deliver our shared vision as West Suffolk Alliance
- the learning from locality development since 2018, building on what has worked and learning from what hasn't.
- How we listen and build on the voice of people living in communities to inform how we plan, develop and deliver locality working
- a common definition and vision for partnerships at a neighbourhood level
- formulated a shared plan to accelerate partnerships at a neighbourhood with recommendations for delivery

7.1 Integrated Neighbourhood Teams – Health and Social Care Integration

Health and Social Care Managers Integration Programme

- Fortnightly Sessions with Health and Social Care Managers to provide time and space to develop relationships, learn about each other's services and develop integration opportunities
- To date have had sessions on getting to know each other sharing ideas about how to develop each INT area, personalisation, managing change, Health Coaching & Signs of Safety
- Senior Managers have been mapping out purpose and remit of their roles

There has been an ongoing focus on creating capacity across Health and Social Care including a programme of recruitment and completion of a business plan for community services.

Integrated Neighbourhood Team are continuing to develop as part of localities in West Suffolk. Life Link Coordinators have been recruited to align with Localities and test how we can reach into communities to promote health, wellbeing and prevent ill-health. Some examples of how the impact of this for people are set out below:

Mildenhall and Newmarket Integrated Neighbourhood Team

Recently in Mildenhall we had an older gentleman who was end of life. He was living with his daughter who was identified to be extremely vulnerable. Health colleagues raised their concerns regarding the daughter's vulnerability, in particular her accommodation status in the event of her father's death i.e. the tenancy/ property would not be transferred to her. Additional concerns regarding the daughter reflected how she will cope when her father passes away. Although the daughter has no formal diagnosis of a learning disability, colleagues identified she is presenting with a degree of intellectual limitation and emotional fragility reflecting a person of many years younger. Health colleagues provided transport support to the daughter to visit her father when he was moved to the hospice. A Social Worker was allocated too and also provided the daughter with transport support to see her father in the hospice. Alternative accommodation was identified, and the housing provider agreed that the daughter would be accepted despite her age not being over 55 years old. The support to the older customer and daughter reflected a holistic and MDT approach.

Bury Rural Integrated Neighbourhood Team

Recently the Social Prescriber and the Comm Matron reported concerns surrounding a customer and the demands she placed on her son whose relationship with his partner had broken down due to the mother's behaviour as a result of her dementia. He was worried that ACS would remove his mother and that he would be held accountable for causing her harm (following safeguarding referral alleging he had tried to overdose his mother). He was therefore reluctant to engage with ACS. ACS quickly arranged respite and the community matron was able to talk to the son and explain the rational as he was reluctant to place his mother (no capacity) in respite. The INT coordinator arranged transport for the respite. The communication during INT meetings was vital information in understanding what had been happening – the community matron had seen the interactions with son and mother first hand and had a relationship build with the family which really helped - ACS would have struggled to get the family to engage without them.

Whilst integration continues to mature across the workforce, the estates and physical logistics of working together can sometimes create challenges for how we continue to mature as an Alliance.

Appendices

Understanding Community Wellbeing

Community wellbeing V4 with recommendat

Understanding Community Wellbeing in West Suffolk

Purpose of this report

To share the output of a focused discovery to better understand the impact of community activity and set out recommendations of how the Alliance can use this to develop a long-term plan for how we work with communities to promote wellbeing in West Suffolk.

Strategic context – nationally

The Health and Care Act 2022 sets out an approach to designing shared outcomes which will place person-centred care, improving population health and reducing health disparities at the centre of our plans for reform. The act proposes to strengthen health and care services in places that feel familiar to the people living in them. While strategic, at-scale planning is carried out at the integrated care system level, places will be the engine for the delivery and reform.

Health is determined by where a person lives, how they live, the environment around them and the opportunities to grow and prosper. These factors are known as wider determinants of health. To activate behaviour, change across the population, promote health and wellbeing, and pro-actively tackle the societal and structural imbalances that have created entrenched inequality across society, we need to reach into the places people live, connect with them, work with communities and build on what's strong to create the conditions that enable these places to thrive.

The reform as set out in the Health and Social Care Act 2022 gives a platform and a real opportunity to make it happen.

Strategic context – Why was a focused community discovery commissioned?

COVID saw communities stepping up and in, looking after each other and often strengthening community wellbeing through adversity. People organised themselves around a shared purpose and we wanted to explore how this generated action and enabled people to manage their health and wellbeing at home and in their community. Some of this activity was based on groups already in existence, but some were new groups of individuals coming together for the first time.

We know Community wellbeing is intrinsically linked to individual wellbeing, but it can be hard to understand how it operates and how to influence it. People present to the NHS and local government because of a deterioration in their health, and or because they either don't meet the threshold for support or find it challenging to access the information or support, they need. This misses the opportunity for prevention.

West Suffolk Alliance are currently reviewing the local social prescribing offer and the ICB is moving to a greater emphasis on place-based services and community. Working in partnership with communities and the formal VCSE sector is key to this.

The formal VCSE sector means registered charities and social enterprises, generally with paid staff and volunteers. The sector is a great asset, but cuts in budgets, short-term funding and fragmented commissioning arrangements can often mean the sector has stretched resources. Whilst the COVID-19 pandemic put a spotlight on the VCSE and the crucial role it has in reaching vulnerable members of our communities, this has generated demand that is at risk of outstripping the stretched resources the VCSE have. We need to understand about the capacity and capability in the sector and how best to utilise this.

There is genuine curiosity about informal grass roots activity and people's lives in local communities. Informal activity and groups are also a great asset, these can be described as

hyper-local volunteer led community groups. Partners had a desire to observe, understand and respect communities as they really are, to consider how statutory service can benefit from, nurture, connect to and respect community wellbeing and what happens in local communities.

Our Alliance vision was reset in 2021 to:

Working together in West Suffolk to make lives better.

The Alliance identified 3 clear mission statements and priorities:

- Empower healthy and connected lives
- Create environments that enable people to thrive
- Develop joined up, accessible and responsive services wrapped around a person

West Suffolk Alliance committed to develop a shared approach to wellbeing and prioritised the following lines of enquiry to support the system to do so:

- ❖ Better understand and support the voluntary, community and social enterprise VCSE sector
- ❖ Think differently about the role of Social Prescribing and how as a system we fund it.
- ❖ Promote physical and social activity in tackling inequalities and living healthy and connected lives
- ❖ Keep a focus on wellbeing in death and bereavement
- ❖ Creating a circle of support around an individual/family to ensure those who needed increased support could access it

There was a shared agreement across the system of the need to reach into our communities to better understand wellbeing and the relationship with the voluntary, health and care sectors as a foundation to deliver the wider lines of enquiry.

Community discovery – approach

A community reference group was established to co-design a process of discovery and use this to build a long-term approach, which if agreed could be developed into a plan for how we work with communities to promote wellbeing in West Suffolk. The group recognised the wealth of activity happening across the Alliance to engage and deliver activity in communities and the need to better understand the impact of this activity to plan what we could do differently to promote wellbeing, tackle inequalities and drive better health outcomes for the population.

The community reference group agreed the following key principles to deliver the discovery:

- ❖ Build on what we know
- ❖ Build on good practice already happening in West Suffolk
- ❖ Utilise people in the system and work collaboratively

Version 3 02.02.2022

- Listen, explore, and challenge ourselves to innovate and think differently about how we work with communities
- Be agile but think longer-term
- Be mindful of people's capacity and current pressures

The reference group recognised to deliver the ambition; the system needed extra capacity. A proposal was signed off by West Suffolk Alliance System Executive Group and an independent consultancy commissioned. System partners continued to shape the work as part of the core reference group and a follow up workshop in July.

The scope for the discovery was agreed as follows:

- West Suffolk Alliance footprint
- 2 places in West Suffolk, one in the West Suffolk Council boundary and one in Babergh and Mid Suffolk
- One rural community
- One urban community
- Identified cohorts of people, known as seldom listened to.

With the aim to:

- Reach into and engage with communities to better understand people and places in 2 distinct locations, (Red Lodge and Glemsford), as a window to West Suffolk. To listen to what is important to people, how they feel and experience where they live, love and work, and what impact this has on their health and wellbeing

- Learn what shapes the identity of the range of communities in West Suffolk, what makes them different and what matters to them. Identify who are the community influencers, where are there shared spaces and how are people engaging with these assets.

The output of this work has been produced by Rethink Partners into a report, Understanding Community Wellbeing in West Suffolk. The report is attached to this paper as **appendix 1a**, and the 7 key cross cutting findings summarised below:

- Every community has a history and story that influences what is happening now.
- A feeling of belonging is crucial to a person's individual and community wellbeing
- It is harder to organise outside of your own social and friendship groups
- Informal encounters enable us to feel connected
- Community facilities enable us to live connected lives
- A lack of local services polarises communities
- The power in communities is fragmented, difficult to access and sometimes held in unexpected people and places

Key considerations for West Suffolk Alliance

Every community has a story that effects who they are, how people feel they belong and what they do - Do we know the story of each of our communities in West Suffolk, who are the people organising activities in these communities? How are we using these stories to wrap around communities, deliver personalised services and connect people to information tools and support to live well?

It is harder to organise outside of your own social and friendship groups – Informal encounters enable us to feel connected lives – Is WSA committed to developing communities and devolving resource to reach into and engage with communities? How are we utilising assets, (both physical and people) in communities to connect in this way? What might this mean for our Social Prescribing operating model?

Community facilities enable us to live connected lives — How can we be more creative about our community assets to design, develop and sustain vibrant hubs of activity in our local communities? How can we work with communities to design, deliver and own this?

A lack of local amenities and services polarises communities - In a rural alliance area such as West Suffolk there is significant challenges around access leading to isolation and loneliness, community transport. How can we work pro-actively to support communities to address rural health inequalities?

The power in communities is fragmented, difficult to access and sometimes held in unexpected people and places – There is a wealth of assets in our communities which supports people to feel like they belong, connect with each other, and prosper. There are also people who feel disconnected, many of whom might be struggling with their health or wellbeing. How can we collectively stimulate behaviour change across our population and connect people to opportunities that impact positively on their health outcomes?

Recommendations

1. Socialise and playback 'Understanding Community Wellbeing in West Suffolk' with key stakeholders including those in Red Lodge and Glemsford

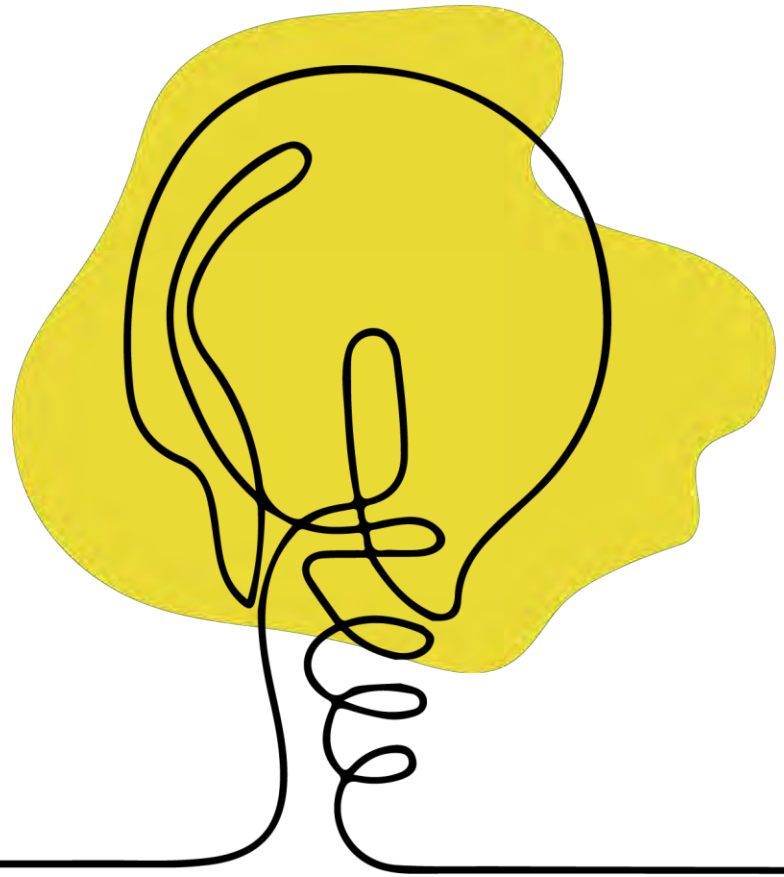
2. Consider how we use the learning from this report to shape how we work together differently and mature as an Alliance, delivering our shared strategic priorities including how we pool resources, (including time, people, and investment), into developing and delivering our shared outcomes as Alliance.

3. Define our commitment as an Alliance to co-production and engagement with communities

4. Using the Live Well framework to create a delivery plan for the Be Well Domain, incorporating the key lines of enquiry set out in the wellbeing programmes and developing the output of this report into agreed next steps. This includes alignment of strategic priorities across partners and development of shared outcomes at place.

5. Take a case for investment to West Suffolk Alliance Committee to include the delivery of this plan and proposing options for a new model of social prescribing.

Report: Understanding Community Wellbeing in West Suffolk



September 2022

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Executive Summary

Community wellbeing – what keeps people connected, well, with a sense of belonging and able to organise around what matters - is intrinsically linked to individual wellbeing but it can be hard to understand how it operates and how to influence it. NHS West Suffolk Clinical Commissioning Group (WSCCG), on behalf of West Suffolk Alliance, commissioned Rethink Partners to undertake an insight programme to understand what helps people to be connected to other people, to be able to ask for and offer to help, and get things done in their communities. This work was commissioned at a time when we might amplify the importance of partnership and communities; the new Integrated Care Systems (ICS) are coming into being and we are noticing and living through differences in the dynamics of our communities with Covid.

Rethink Partners developed a methodology to engage with community wellbeing in two distinct locations – as a window to wider West Suffolk: Glemsford and Red Lodge. Working with system partners to make sense of existing knowledge, connections with and experience of communities in West Suffolk; to iteratively engage with known organisers, informal connectors and a range of residents; finding new routes into and connections amongst those communities.

In Spring/Summer 2022, we had 78 conversations with people: 25 conversations with system partners across Suffolk and West Suffolk: health, District Councils, County Council, infrastructure and Voluntary, Community and Social Enterprise (VCSE) delivery organisations – also working through a reference group to listen, explore and build on existing knowledge and connections. We then had a further 53 conversations with people living, working, accessing activities and volunteering in the communities of Red Lodge and Glemsford. We spent over 12 days of face-to-face fieldwork time engaging with residents and organisers, building up a rich picture of what is helping and hindering community wellbeing, and the dynamics of these places.

We sense-checked our work with the system partners and Reference Group as we went along and shared and discussed insights with a group of 30 system partners in June 2022.

Executive Summary: key findings

We discovered 7 key cross-cutting findings from the engagement with Red Lodge and Glemsford, which are:

1. Every community has a history and story that influences what is happening now
2. A feeling of belonging is crucial to a person's individual and community wellbeing
3. It is harder to organise outside of your own social and friendship groups
4. Informal encounters enable us to feel connected
5. Community facilities enable us to live connected lives
6. A lack of local amenities and services polarises communities
7. The power in communities is fragmented, difficult to access, and sometimes held in unexpected people and places

We shared this with a group of 30 system partners on 29 June 2022, where we began to make sense of what this and our observations about the whole 'Community Wellbeing Discovery' process means for practice in the West Suffolk Alliance area.

Executive Summary: priorities to work on

Building on the participation at the System Partner workshop in June 2022, we are recommending 4 priorities to work on:

1. How to build and sustain community wellbeing through social prescribing
2. How to work in localities to wraparound and nurture community wellbeing
3. How to scale and replicate discovery work for community wellbeing
4. What are Red Lodge and Glemsford asking for action on?

Rethink Partners has been delighted to be involved with this work for but a short period of time, and we leave you with some prompts to help you take this forward in the West Suffolk Alliance.

- See Chapter 4, for full details

Chapter 1 Context and Approach

- Why this work was commissioned
- Objectives
- Methodology
- Co-designing fieldwork locations
- Early findings
- Who we spoke to

Why this work was commissioned

- Community wellbeing is intrinsically linked to individual well-being, but it can be hard to understand how it operates and how to influence it
- Covid saw communities stepping up and in, looking after each other and often strengthening community wellbeing during adversity
- People present to the NHS, and local government services when they are in crisis – missing the opportunity for a stronger focus on prevention; service thresholds can prevent peoples' needs from being met earlier or people presenting earlier
- West Suffolk Alliance is currently reviewing the local social prescribing offer and the ICS is moving towards a greater emphasis on place-based services and community. Demand is increasing and resources are limited
- The formal voluntary sector is a great asset – there are limited resources available to support it
- There is a genuine curiosity about informal and grass roots activity and people's lives in local communities - this is an opportunity to explore that

There was therefore a desire to observe, understand, and respect communities as they really are, in order to understand the role of community action and activity in people's wellbeing and consider how the system can benefit from, nurture, connect to, and respect what happens in local communities.

rethink partners

Objectives

- Observe and understand where are the strengths, assets and gaps in communities across the West Suffolk Alliance area
- Strategic advice and insights - not mapping
- Provide strategic challenge, connection and facilitation
- Gather independent evidence of what is happening in communities in order that decision makers could amplify and scale strengths and successes to enable people to live good lives
- Help West Suffolk Alliance identify and describe some of the factors/activities that help keep people and communities resilient and self-sufficient

Methodology

- Scoping Phase discovery conversations to understand context and build relationships with system partners, including the Reference Group (to work with throughout)
- Semi-structured (open) conversations with individuals in communities to:
  - Understand what helps community connections, participation, build a sense of belonging
  - Notice and begin to make sense of the underlying dynamics that support (and get in the way of) community wellbeing
- Three-phase approach:
  - One to one conversations with people who 'make things happen' in their communities – who can then link us into their connections
  - Groups/one to ones with wider community
  - Analysis and 'sense-making' at each stage, leading to deeper dives where necessary
- System Partner Workshop to explore the findings and move into action

rethink partners

Co-designing fieldwork locations

- Members of the Reference Group suggested a range of locations including the major towns and smaller settlements and villages.
- Having these early conversations around location allowed us to surface what matters to the partners involved, and how the system is thinking about communities.
- We talked about the learning in how to engage being applicable across our communities, but that the context and so the particular dynamics of community wellbeing will be different across our communities.
- We advised taking two locations where the context is more ripe for learning – there are known differences amongst them, some changes occurring, and not too 'busy' to make it difficult to engage.
- We began inviting people in Red Lodge and Glemsford to participate in the interviews at the beginning of May 2022.

Early Findings: conversations with system partners

1. **There is no 'perfect' place to start:** we're looking for new insights into old issues – there's no blank sheet of paper. Go where the system partners don't usually go. Where there is more curiosity to learn.
2. **All communities are distinct and different:** it's not going to be possible to translate findings from one location to another. There will be learning beyond what comes out for each of the two locations. The principles of the what and the how, is helping and hindering.
3. **Drop existing perceptions and go in with 'eyes wide open'** building on the data, the experiences and the relationships that enable colleagues to be welcomed into the communities.
4. **Faith and other Communities of Interest:** the Reference Group was curious about how to make use of these untapped networks and sources of participation
5. **West Suffolk is very rural as a whole:** keep that in mind when you describe urban and rural distinctions. We are interested in the spectrum within that. We think there are distinct patterns in how easy and difficult it is for people to participate in and contribute towards thriving communities.
6. **Health Inequalities can be hidden from view in rural areas:** wealthy villages and neighbourhoods can have hidden pockets of deprivation. There are different health impacts amongst small pockets of poverty.

Who we spoke to

Throughout Spring 2022 Rethink Partners were commissioned to conduct a range of interactions: 16 community conversations in two locations and four interviews with members of the reference group. We exceeded our initial targets.

We visited Red Lodge seven times and Glemsford five times during May and June 2022, mostly spending a full day there for each visit and also conducting three virtual interviews (at request of participants).

We have had a total of 78 conversations:

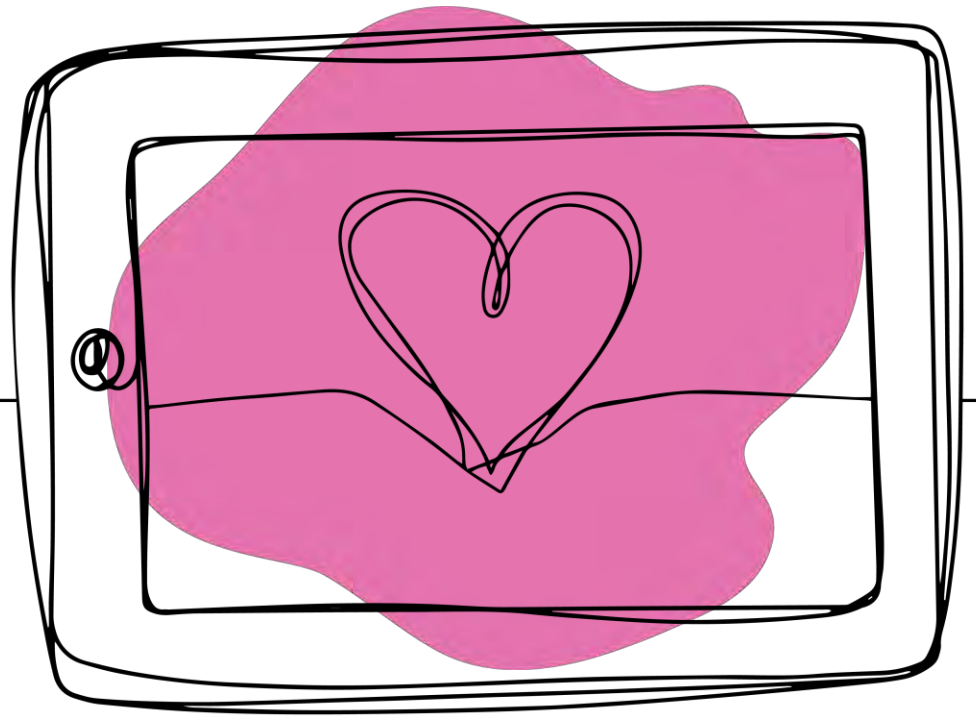
- 4 conversations with system leaders
- 11 conversations with reference group members
- 10 conversations with system partners across Suffolk and West Suffolk: health, District Councils, County Council, infrastructure and VCSE delivery organisations
- 53 conversations with the communities of Red Lodge and Glemsford
    - 44 residents
    - 9 organisers or others who were present but not resident in the community
    - In Red Lodge we spoke to 20 residents, of which 6 also had either a paid VCSE/public sector or unpaid organising role, and 4 others who were connected but not resident
    - In Glemsford we spoke to 24 residents, of which 11 also had either a paid VCSE/public sector or unpaid organising role, and 5 others who were connected but not resident

Stakeholders	Target	Actual
Community conversations in two locations	16	53
One-to-one interviews with reference group members	4	11 sessions with 8 people
Conversations with system leaders	0	4
Conversations with system partners	0	10
Total	**Target 20**	**Actual 78**

We worked with members of the reference group to introduce the community discovery work and open up conversations. We invited colleagues to get involved and open up their networks involved. Stakeholders were diverse and spanned people living, working, accessing activities and volunteering/ organising in West Suffolk: commissioning and provision; statutory organisations, private, not for profit and third sector; health, social care and education; clinicians, allied health professionals, faith groups and youth workers.

rethink partners

Chapter 2
Key Findings



- What's working well?
- The 7 Cross-Cutting Findings
- Engaging with Narratives of the findings
- Pen Portraits of 3 Residents

What's working well?

We looked at community wellbeing through the following lens: it's what keeps people connected, well, with a sense of belonging and able to organise around what matters.

- There are key figures – connectors – in every community; they make things happen, they know the networks, they can connect people; they are not necessarily people in paid, formal roles
- Where we found a strong sense of community, it was created through people having a common purpose or interest, for example: children; pets; faith; peers/common lived experience
- We found that older residents are active in organising and participating in activities in the Red Lodge and Glemsford
- We observed that younger residents who identified as feeling a sense of belonging are starting to come forward to take the lead and organise
    - in some cases this will change the landscape of what is available rather than sustain what is already there (meeting the needs of new generations)
- One person often acts as the 'spark' – likely to be confident; secure in their place in the community; ownership of it; 'anchored'. They can be a catalyst for empowering others to get involved
- The assets in communities creating opportunities for people to simply 'be' (e.g. community café, community organisations, social media groups) were formal and informal. Sometimes these emerged as a result of direct grass roots community organisation
- Life stage/age often connects people around a shared sense of identity and interests and situation
- Not all people who were volunteering their time and skills saw themselves as "volunteers" – it was more organic

7 Key Cross-Cutting Findings

1. Every community has a history and story that influences what is happening now
2. A feeling of belonging is crucial to a person's individual and community wellbeing
3. It is harder to organise outside of your own social and friendship groups
4. Informal encounters enable us to feel connected
5. Community facilities enable us to live connected lives
6. A lack of local amenities and services polarises communities
7. The power in communities is fragmented, difficult to access, and sometimes held in unexpected people and places

Finding 1. Every community has a history and story that influences what is happening now

Context is vital, every community is unique - you need to understand the history, geography and demography of a place to understand the dynamics of how things work

- Who is making up the community, and where they have come from
- How growth occurs and people's perceptions of growth
- How people engage with external change
- What brings new people into the community, why they want to stay or move away
- What opportunities there are for work
- How people live their lives
- How old and new communities are tied together
- History of relationship with authorities
- Red Lodge has a very different starting point

Finding 2. A feeling of belonging is crucial to a person's individual and community wellbeing

It affects how involved people are, how connected they are and their motivation to organise

- People who didn’t feel they belong, didn't want to stay
- Long-standing residents with a shared history talked differently from newer people about issues of pride and belonging
- People experience barriers differently
- Choice to move there or not is a factor – did I choose this place because I connect with it?
- We found different perspectives and experiences of the same communities
- Housing growth directly impacts on identity of villages
- Lots of volunteering happening – people do not necessarily recognise it as volunteering because it is happening organically

Finding 3. It is harder to organise outside of your own social and friendship groups

This can leave boundaries and gaps between groups leaving some people isolated and excluded

- It takes time and capacity to organise – not all villages have this in abundance
- People experience barriers to connecting differently, which might relate to low wellbeing and emerging needs
- Some communities were left out where they didn't have the capacity or resources to self-organise
- We observed newer residents bringing energy and capacity (time, experience and skills) to organise in a sustainable way. In some cases they were motivated by their desire to make new connections
- Larger organisations also brought these resources, filling gaps in community activity
- Covid has made it harder to extend personal networks – purposeful interactions vs serendipitous interactions
- These villages have now outgrown the village scale of organising – but no emerging new model to fit the scale

Finding 4. Informal encounters enable us to feel connected

Creating opportunities and places where informal encounters can happen is vital to connection

- 'Bump' spaces are important
    - Diverse in their nature (retail, café, park, walkway, waiting rooms)
    - Help you to feel like you know people and they know you
    - Informal encounters can be the entry point into formal activities for people who need encouragement
- Connectivity between natural congregating spaces is important
- Green spaces aren't as accessible as they might at first seem
    - Even in rural areas, it's not always easy to access green space designated for public use
    - Can be dependent on permission, access and pathways – and those pathways need to be accessible to all, including people with prams or mobility needs
- Covid changed and is changing how we meet
    - People met each other because they were out and about
    - This was short-lived and the behaviour has changed
    - Concern that people are not coming out post-Covid
    - Public services are now being organised to be Covid-safe – affecting the 'bump' space opportunities

Finding 5. Community facilities enable us to live connected lives

There is a marked difference in social capital in communities where they exist

- Housing growth has outpaced available facilities, but with marked differences in our two communities.
- Facilities have gone (bus services, pubs, youth groups, baby groups) and people have seen the impact
- People talked about the lack of spaces to meet and socialise – cafes; pubs; play-areas
- As well as lack of facilities for young people and older people
- Affects whether or not people are able to meet in their communities
- Can help you to feel like you matter as much as others
- Not all activities/services (formal or informal) have restarted since Covid
- People unsure why certain communities (of people) aren't using the facilities that are there
- We need to work together to connect or reconnect people into community facilities

Finding 6. A lack of local amenities and services polarises communities

The physical isolation of communities is compounded for those who are already experiencing some form of disadvantage or barrier

- This includes people with below average income, older people, young people, and those with no independent form of transport
- Newer social housing in the developments initially is more appealing than its urban counterparts, however people described how their experience of limited amenities and services impacted their individual and community wellbeing
- Multiplier effect of poverty leads to greater polarisation
  - Local shops are expensive
  - Declining bus services adversely impact teenagers, isolated older residents, low income families and individuals with no car
  - Safe walkways benefit people who can't afford or who are unable to drive
  - People are not accessing wellbeing activities: because cannot get to them, not available in the village, too expensive to access elsewhere

Finding 7. The power in communities is fragmented, difficult to access, and sometimes held in unexpected people and places

- The barriers for people to self-organise in a community can be high
- We saw different types of power: to organise, to provide resources, to share resources to make things happen
- Sometimes the power is deliberately hidden from view (to counter the problem of who gets to decide)
- Peer to peer power is disconnected
- Resources and knowledge is resting with a few people
- There is inequality of experience and access to decision-making: not everyone knows how to be heard in order to have an equitable share of voice in decisions about their community
- Bureaucracy and rules are barriers that stop people engaging
- Power is resting in
  - personal networks
  - who you know
  - who's got money/assets
  - positions of authority

Pen portraits
Engaging with narratives to connect and have impact

- We have chosen 3 individual stories to share in more detail here.
- They show some but not all of the diversity of experiences.
- Hearing them helps us to get a richer understanding of what is occurring.
- At the system partners workshop in June 2022, we had more time to listen to the stories - we're sharing abbreviated versions here, to give you a flavour of some of the narratives that we collected.
- The richness, the detail of storytelling is so important for understanding what's occurring.
- Engaging with these stories is a starting point for change.

Pen Portrait 1 - Matt
Middle aged man, resident of Red Lodge for c. 10 yrs

Matt's story is about surviving in a place where he had hoped it would be better for him than it's turned out. He was made homeless from a landlord in another Suffolk town, and chose Red Lodge because the flat was lovely and the woods are great for walking.

But he has found that the place has a lot of trouble going on which he describes as "because it's another overspill place where they are putting all the ***…..there is nothing to do for the kids, nothing to do for adults – there's a social club and a pub but nothing that opens until 3 in the afternoon. The shop is robbing you."

Matt does odd jobs here and there, which "keeps me sane". Matt went on to talk about the feel of the place with the people. "I know lots of people but I wouldn't call them all friends. The couple of friends I have, I met as neighbours." The in and out crowd and how things get done. "It's cliquey, once you get to know a certain crowd of people you will get on ok in Red Lodge, if you don't get on with that clique….." And…"I probably get things done quicker than the Parish Council!"

We rounded off the conversation with a look to the future. What do you think would make it better around here? "Getting a decent shop so that they don't rob you, get a social club for the kids so they have got something to do of a night so they aren't vandalising, something for them to communicate together and all that cause there's nothing round here for them. And a lot more people carrying poo bags if they've got a dog."

Pen Portrait 2 - Julia
In her 30s, Red Lodge resident for c. 10 yrs

Julia works in Red Lodge and lives there with her young family. She grew up in one of the nearby villages. Her story is both positive about the community and open about what's missing and would make a difference to how connected people are. She said she likes living in Red Lodge but ultimately would like to live in one of the villages nearby, to get more of 'that village-y feel'. "There's a good sense of community here, even though it's big....It's always been the old side and the new side here. People talk about "Oh it's Red Lodge" but it's a nice place to live."

She sees that people who used to come out and go to the community centre don't anymore "People have got used to staying at home since Covid". "People try really hard to put things on here, to get people out, but people just don't turn up." "I sometimes don't see anyone here [outside the community centre] during the day, people are commuting or working at the Air Base."

She talked about what there is and isn't in Red Lodge. There used to be a 'Stay and Play' parent and baby group, but that's now stopped. "There are a load of mums just at home who aren't getting out." The antenatal and postnatal services all happen in Newmarket and Mildenhall, which is ok if you can get a taxi or be driven "but the bus takes 50 minutes [to Newmarket] because it goes around all the villages…you'd think we'd have something here with all the people here." She moved into her house before the shops were built nearby. "It's so much better now there is a shop here, at least you can get a pint of milk."

Julia talked about new housing, what's been built, what's being planned. She said she was worried that "as the place gets bigger there won't be enough for people here". She said there's nothing open during the day here. "The restaurant is on a scheduled opening time. There's nowhere you can go to after the school drop off." A café would help people to get together "A café would build a community – you'd get the regular trade, you'd see familiar faces – or a bigger type of pub – something where you can just sit and watch the world go by." She talked about the future: "But what happens to today's children? When they are teenagers what will they do? There's nothing for teenagers around here."

As we were rounding off our conversation, Julia mentioned the Foodshare that has been set up in the Community Centre. It's well used and much needed. But as volunteers they also have to find the petrol money themselves, and can't get someone to do the run to one of the Thetford supermarkets because it's so expensive.

Pen Portrait 3 - Edna
91 yr old newly moved to Glemsford 18 mths ago

Edna moved to Glemsford to be closer to her daughter (in a nearby village), and her story is about adjustment and old age. She talked fondly about her old home where she could make use of green spaces, had a group of lifelong friends, and plenty of life to watch going by. Moving then to a new home where she is away from the street traffic and doesn't see people, her front drive is large gravel and scary to use with her 3-wheeler frame, and country lanes and half pavements that make walking difficult. "I miss my friends a lot. We used to go for a walk in the countryside, I was 10 minutes to the woods. There's nowhere to go here with my walker. I haven't tried the buses yet."

Edna was sanguine about her lot "you just have to accept that you aren't going to make any friends again at my age", and positive about what she does have "the shops up here are more expensive but you can get anything in there."

She was open about the support she gets from the GP. Grateful that they had done a home visit when she had a fall and had to go into hospital earlier in the year. But later was more concerned about being able to see someone face to face "They can tell a lot by looking at you, much more than a photo or over the phone. You can confide in a Doctor if you're worried. From looking and listening to you they can tell a lot." She was also reflective about the reality of the new systems: "But then I don't know everything, it would be nice for them to be able to explain why."

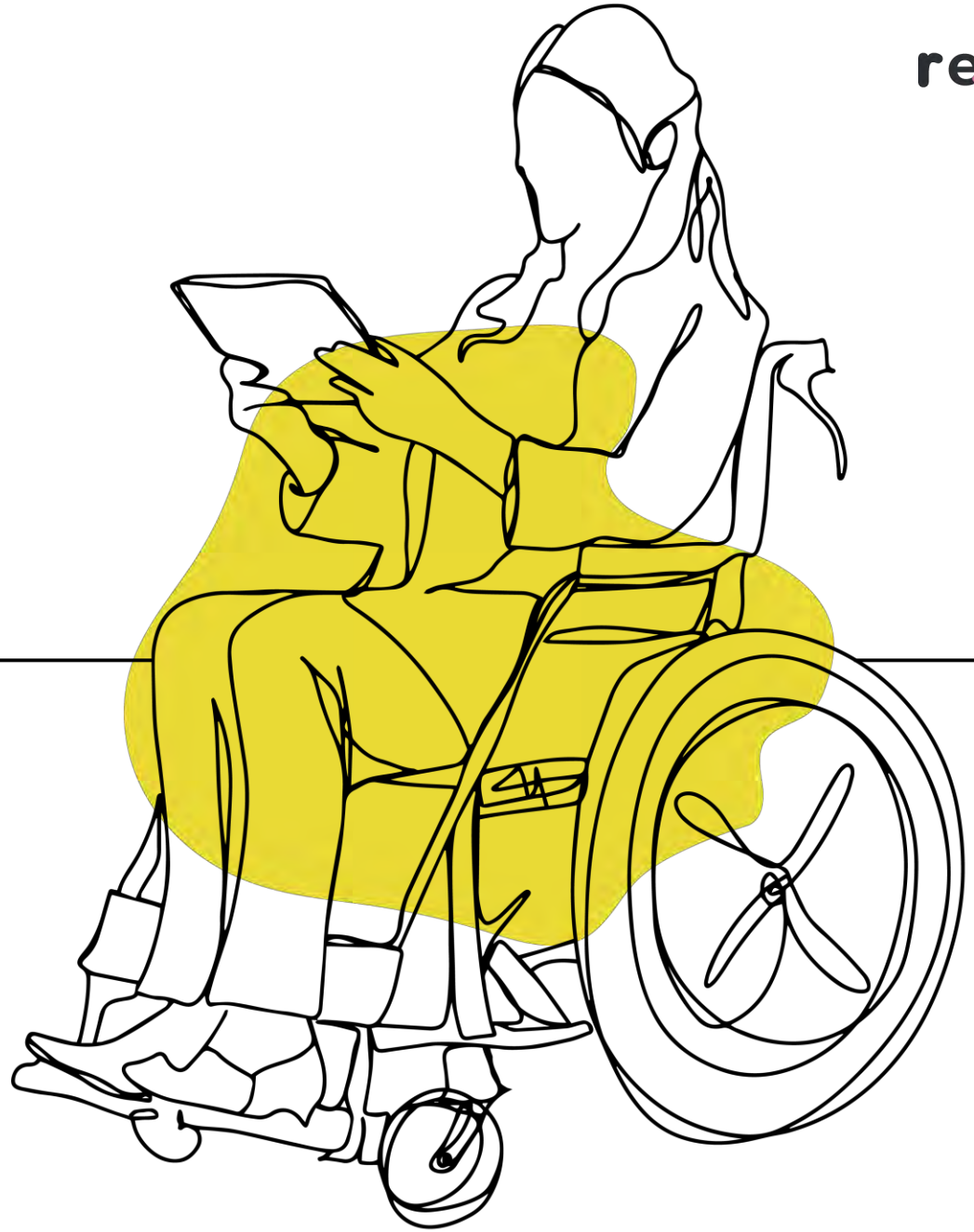
Edna talked about the coffee morning she has joined and how it's changed. "It dwindled to only 4 or 5 of us, and it wasn't worth us paying the £5 to use the Church Hall. So we started doing it in our own homes. But we're trying to find another venue to hold it. Because otherwise how does the community know where it is?"

Edna talked about using her tablet to keep in touch with her numerous children, grandchildren and great-grandchildren. She expressed her desire to use it more but that "young people haven't got the patience they won't show you twice or slowly, there's nowhere to go for someone to show you. It puts me off trying on my own in case I do something wrong."

We finished our conversation with Edna showing me around her garden that her son has been helping her with, and looking at the 3-wheeler which she uses to walk outside, and that troublesome gravel drive.

Chapter 3
What's Next?

- Priorities to work on:
  - Part 1: How to build and sustain community wellbeing through Social Prescribing
  - Part 2: How to work in Localities to wraparound and nurture community wellbeing
  - Part 3: How to scale and replicate discovery work for community wellbeing
- What happens next?



Part 1:

How to build and sustain community wellbeing through Social Prescribing

Know the Community's Story

Every community has a story that effects who they are, how people feel they belong, and what they do.

- Social Prescribers need to understand this story so they can work with the reality of this community in the here and now. What are the limitations, what are the opportunities.
- *In practice this looks like:* seeking out residents who are community organisers as a starting point. Taking the time to listen without judgement. Making sense of these stories. Budgeting for the time to do this ongoing work.

Prioritise Human Encounters

Covid has got many of us used to being less connected with other humans.

- Regular, informal encounters can be just as important as organised activities for feeling like we belong.
- Not everyone is ready for an intervention. It's an often-underrated skill to welcome people, wherever they come from. From that sense that 'I belong' we can start to build human relationships that sustain our wellbeing.

- *In practice this looks like:* getting to know the people and places who are most welcoming of strangers, and finding the connections between them and the people you are working for. [Be careful not to force people to take on more, work with what they have, and are able to offer as a solid start]

Uncover hidden Power

Individual and Community power can be held in unexpected places, it's not always those with formal roles that make things happen.

- Strengths, motivations and capacity may be hidden from view. In the same way that Social Prescribers get beneath the surface of what makes individuals tick, they can find and uncover hidden sources of community power.

- *In practice this looks like:* digging deeper, with an enduring curiosity for the unexpected story – what is happening in places of low wellbeing 'in spite of' the system.

Increase your impact

Informal Networks are how communities operate. Who knows who, how resources flow, how things get done. If you can tap into the people who are well networked, you can increase your impact. You can reach more people. You can get more done.

- Instead of setting up your role to work with as many patients as possible, and getting to the limit of who you can support really quickly. Think about how you work with people who are already nurturing and developing community wellbeing.
- *In practice this looks like:* Finding a few key connectors and working with them to build your reach into the community. Getting to know where the gaps are, where those connectors don't reach.

Use the Power of your unique role

Social Prescribers have a unique set of connections. Both the communities they work with and the systems partners. They operate across the boundary of community and system.

- Being able to spot opportunities, to notice what's important, and to pull the system in to help.
- Being imaginative about possibilities for the present and future.
- *In practice this means:* maintaining purposeful connections with system partners, advocating for communities and retelling stories that matter, being confident in the value of your unique role.

Part 2:
How to work in Localities to wraparound and nurture community wellbeing

Live with the messiness

Communities are messy, imperfect collections of humans. They have enduring problems, and stories that can't be easily untangled.

- Healthcare and Local Government have much more ordered ways of operating. But the tendency to rationalise the complexity in communities, all too often ends up masking the understanding of what is really happening and the opportunities to act.
- *In practice this means:* taking the time to listen to the breadth of what's occurring in the community you want to work with; noticing the tendency to fit the stories into boxes and discount outlying stories.

Community Wellbeing: act on the evidence

We now know that communities that don't have people and amenities to connect have low wellbeing. We have seen the impact of this in our discovery work. It deserves our attention.

- It's the connection between different types of people in a place, the spaces where people belong and can meet, and how welcome people feel. Locality partners need to understand and work with what it is, in each community.

- *In practice this means:* Have a focus on this in every conversation about priorities, resources, and operations. Be prepared to go to places which are outside of your traditional responsibilities, if the solution requires this.

Become more community

Communities are stronger when they are connected, where resources and information flow freely. Underlying values that are shared, but the purpose and the activity evolves and changes over time.

- System partners can be more effective and influential where they show some of these characteristics in working together, with communities. More cohesive around the issues encountered, less drawn to default boundaries.
- *In practice this means:* being confident to expand personal networks, beyond your organisational role; working on the cohesion, getting to know when it's worth compromising; budgeting for activities that take more time and intentionally build trusted relationships.

Find where you most need to be

Communities with lower health and wellbeing are often furthest away from where decisions about infrastructure and investment are made. They have less experience of collaborating with system partners, asking for and getting help.

- They don't know that the system has resources and influence that can help. Some problems need small shifts to solve. Others need the system and communities to work on them together, over time. It starts from closer relationships.
- *In practice this means:* Intentionally building relationships based on trust – across the system partners – in your community, to develop better understandings of each other and share information about what's occurring.

Convene the imaginative conversation, where it's needed

Some communities have big looming issues that need addressing. Some communities have the capacity to self-organise around these, to pull in the system partners to work with them. Others don't.

- Communities that have people and amenities to connect are more able to self-organise around important issues.
- System partners could convene the conversation with the community where it's needed.
- *In practice this means:* System partners looking ahead and agreeing which communities need this type of investment; co-designing a conversation with the community, so it builds their capacity at every step.

Part 3:

How to scale and replicate discovery work for community wellbeing

Understand the 'Why?'

Discovery work is part of transformation. What are we hoping to change or address? What's occurring now that we need to respond to?

- We can't do this type of engagement work everywhere, so we need to work out where, why and when.
- *In practice this means:* ongoing conversations with system partners (including locality partners) about the 'hot spots', and the value of this type of work vs other 'tools'.

Be open, authentic and curious

Discovery work is about understanding what is helping and hindering people connecting with each other for community wellbeing. It is about understanding the dynamics of the community (who makes decisions, gets things done, holds the power and resources).

- Going in without any preconceptions about what the issues are and how to solve them.
- Conversations are open, spending enough time with people to make sense of what's occurring

- Listening without judgement: not feeling the pressure to immediately find a solution
- Get on the phone and use your existing personal networks - get out to communities and create new ones
- *In practice this means:* people leading the work who are skilled in creating, hosting and making sense of these conversations.

Sweat and expand your network

This type of work needs a network of people to tackle it. You are not on your own. You must make use of the connections you already have into communities. Most certainly, you will have to find new people to expand your network.

- Start with who you know: warm welcomes enable the work to start. It works both ways, back into partner organisations for 'what is next'.
- Then keep expanding - this work should feel stretching – you'll be meeting people you don't know and some of those conversations will be challenging
- *In practice this means:* working iteratively to host conversations, making use of your known network at the start, to build up a rich picture of each community. Consider how your network can be part of 'what happens next'.

Intelligence not data

We have lots of bits of information held across different system partners. Narrative data, given and held by the community, is a different type of data. We need to draw in our 'regular' data when we scope the Discovery work. It is an opportunity to uncover and bring together the bits of information held in different places. To learn what is more and less important amongst the data we hold. To learn how we might make better use of it.

- *In practice this means:* Inviting partners to share the data they hold around the communities in scope. Learning how to adapt and join up the data, to have more impact.

Remember the 7 insights

We found 7 cross-cutting themes in the Red Lodge and Glemsford discovery work. These are likely to resonate with other communities in Suffolk, even though they are borne of these communities. Keeping them front and centre for further and ongoing discovery work enables us to keep learning and knowing what matters.

- *In practice this means:* sharing, talking about, working with the 7 insights, as part of other forums where community wellbeing is on the agenda.

What happens next?

Communicate	Embedding the findings	Scaling the approach (who?, when? where? how?)
- Digest the findings amongst the sponsors	- Work with the findings: • taking time to seat the insights and • consider how this shapes how you work as a system • and in collaboration with communities	- Agree if you want to repeat this work with other communities
- Share and communicate with others • who? when? how? and what is the desired outcome of this?	- Take forward the discussions from the workshop e.g.: • evolving model for social prescribing	- Who can be skilled-up to create a wider pool of people to work in this way?
- Consider the response to Glemsford and Red Lodge, particularly: • how you want to communicate and feedback to those involved in this work from within the communities and • potentially to recruit those stakeholders as new collaborators	- Wider community engagement work	— Be specific about where this approach is an element of other work — Embedding it as business as usual community engagement for the longer term
- Identify where these findings fit with other priorities and make the connections. e.g.: • new model for social prescribing • what else?	- Implications and opportunity for the voluntary / community sector	
- Share the work with system leaders		

Appendices

- Appendix 1 – Thanks
- Appendix 2 - Resources
- Appendix 3 – System Partners workshop: sense-making and feedback; Purpose & design; feedback from 3 sessions; Selected quotes from the day

Appendix 1: Thanks

Thank you to the passionate residents, professionals and volunteers from West Suffolk who supported this work with their experience, ideas, connections - and evidence of what is happening in their world.

Many thanks to the members of the West Suffolk Alliance Community Discovery Reference Group.

Special thanks to: Christine Abraham; Will Wright; Trisha Stevens; Jennie McCrory; Rebecca Jarvis; Davina Howes; Richard Baldwin; Richard Watson; Lightwave; The Red Lodge Millennium Centre and The Friday Café – your support has really helped us shape this work.

Massive thank you to the people living, working and volunteering their time in Red Lodge and Glemsford – there were so many of you and you included: residents; people working, volunteering, and accessing activities; councilors; educators; school and nursery staff and health staff.

Thank you to system partners across West Suffolk and Suffolk itself – to all the VCSE organisations; faith leaders; local voluntary organisations and groups (both formal and informal); colleagues at WSCCG, Babergh and Mid Suffolk District Council; West Suffolk Council and Suffolk County Council.

Appendix 2: Resources

People that we collaborated with during the community discovery work, shared with us and signposted resources and research that had shaped their views and evidence base of what is needed to support community organisation. These are shared in the following pages, plus a few more links we discovered during the course of this work.

Appendix 2: Resources

National
Bennett Institute What Works Wellbeing
Centre for Ageing Better - How community organisations contribute to healthy ageing webinar (YouTube)
Leeds Neighbourhood Networks Evaluation/Report
The English Village and Community Hall Survey 2020
Locality - The impact of community anchor organisations on the wider determinants of health BBC Radio 4 “Start The Week” podcast examining social inequality https://www.bbc.co.uk/sounds/play/m00187fm

Regional
Community Action Suffolk - State of the Sector report 2019
Suffolk Good Neighbour Network - Good Neighbours Good News & Case Studies
All Age Carers Strategy (WS)
Community Action Suffolk - Suffolk Volunteering Survey 2022 (Infographic and Executive Summary)
Suffolk Community Foundation - Hidden Needs reports, (2010, 2016, 2020)
Community Action Suffolk - Mutual Aid and Community Group Survey presentation
Active Lives - Sport England Suffolk results
Babergh Wellbeing Strategy
Babergh Sports Strategy
Suffolk Observatory Children and Young People report

Appendix 2: Resources

Glemsford
Sudbury INT Place Based Needs Assessment 2020

Red Lodge
Mildenhall and Brandon INT Place Based Needs Assessment 2020
West Suffolk Council Iceni Ward Report
Suffolk Observatory Iceni deprivation report
Suffolk Observatory Red Lodge Parish report

Appendix 3 Systems Partner Workshop, June 2022

- Purpose and Design
- Feedback from 3 working sessions
- Selected quotes from the day

Purpose and design of the workshop

30 system partners participated in a workshop held in one of the community centres in Red Lodge on 29 June, 2022. We had colleagues from across the VCSE, District Councils, Alliance, ICS, Primary and Secondary Care and the hospital.

The purpose of the workshop was 3-fold:

- To share the stories we gathered from Red Lodge and Glemsford, and our analysis.
- To make sense of the implications for community wellbeing, for these and other places.
- To step into some of the behaviours and skills we need to engage with communities where they are.

We ran three working sessions:

1) Engaging with the stories from across the 2 communities and the 7 cross-cutting findings;
2) Engaging with 3 individual's stories (the pen portraits); and
3) Making sense of these towards action in 5 groups that emerged on the day.

Feedback from working session 1:

Questions that came out in Session 1, stories and findings from across the communities

- What does it really mean for people to adapt their lives around not having any services in their community? Are these real choices people are making?
- Is it the people who are as, or more, important than the facilities? In connecting people? As being activists for their communities? Who are they? What do we know about them?
- Did people talk about the assets or deficits in their communities, in the main?
- If we notice that assets/services are there but not being used, is there something in how we communicate with people about what is on offer?
- If we know the community is divided, how or when do people come together?

Feedback from working session 2:

Questions that came out of session 2 – individual stories

- How do we do ‘with’ rather than ‘to’ – our defaults are often to ‘fix’ the ‘problem’ rather than accept and work with people where they are, the capacity they have for self-help?
- How do we recognise the value of residents/shop-keepers/workers who know and care about the people they meet, who can spot changes in people’s mental health, before it gets bad? How can we work with them, without ‘systemising’ and losing the value?
- How do we get obvious sources of support such as housing and planning engaged, in practice?
- How reflective of the community are we in this room, and how does that shape how we engage with them?
- How do we engage with community organisers where we can see the boundaries of who they work with? The gaps, the lack of inclusion?
- How can we know when we need to do something, that we could use our system partner networks and influence to tackle, and when it’s ok to join the dots for the community to tackle themselves?

Feedback from working session 3: 1/2

1. What would help Community Organisers reach in further?
    - How we recognise, value and work with them?
    - How we make it the default for 'formal services' e.g. GP to work with them?
    - How we help negotiate/make it easy to get practical access to physical assets/infrastructure?

2. How do we have more and ongoing conversations with other places?
    - How can we be really clear on purpose (we can't engage in this depth everywhere, but it is a tool we need)?
    - How can we have a sense of the important information for and about our communities (we have lots of bits of information)?
    - How can we keep the 7 [cross-cutting] insights front and centre (so we're building on what we're learning and knowing)?

3. How do hospital social prescribers operate most effectively?
    - How do they relate to the local social prescribers (common frameworks, processes, handovers, how follow-up happens)?
    - How do they understand their added value and name/identity (not the depth of local knowledge, not the sole focus on discharge, but what is it)?
    - How do they connect into the network of other Social Prescribers, so expertise is shared?

Feedback from working session 3: 2/2

4. What resources do we already have to do this work, and what do they need to do to adapt?
    - How do we help people feel a sense of belonging to their community, in what we do?
    - How do we relate to/communicate with people so we understand them (what their wants and needs are; where do we get our information from about what's happening?)?
    - How do we keep up with restructures, budget changes, who is who, so that we can be connected with each other, and provide the most useful info and support into communities?
5. What is our role as an integrated system for community wellbeing?
    - How do we reach and connect into communities, so we're leaving behind our assumptions and can really focus on the people?
    - How can we work on building trust and a sense of belonging, with us, with the communities?
    - How can we make the most of our influence, our investments, and how we work with each other?

And finally, a few quotes from the day:

For further information contact: liz@rethinkpartners.co.uk

rethinkpartners.co.uk

Comfort Break

4. ASSURANCE

4.1. Insight Committee Report - August & September, 2022 - Chair's Key Issues from the meeting

To Assure

Presented by Richard Davies

Chair's Key Issues

Originating Committee	Insight Committee	Date of Meeting	2nd August 2022
Chaired by	Richard Davies	Lead Executive Director	Nicola Cottington

Item	Details of Issue	For: Approval/ Escalation/Assurance	BAF/ Risk Register ref	Paper attached? ✓
Trust Business Information Strategy	The Trust needs to develop a business information strategy (in line with the new ICB strategy). But the information team are currently firefighting a large number of information requests and so have very limited time for strategic work. We need to consider resource capacity as part of strategic planning in view of the importance of the information team to organisational strategy, and its potential vulnerability It was agreed that: • The senior team would consider appropriate external resource to help with development of strategy, which will then underpin resourcing and workstreams • In the meantime, a small assurance group is to be set up to enable appropriate prioritisation of information requests (recognising that ultimately development of a self-service dashboard will help to reduce demands on the information team)	**Assurance**	**BAF 1**	
Increasing rates of staff turnover	Whilst this appears to be replicated across the NHS – it is a cause for significant concern. Further work is needed to analyse why this is happening (e.g. looking to see if particular groups or roles are most affected). A paper will be brought back to the next Insight Committee bringing together all of the work that the Trust is doing in relation to improving staff retention.	**Limited Assurance**	**BAF 6**	
Cancer recovery – results endorsement	High administrative workload in relation to cancer results endorsement and communication with patients is causing concern to clinical staff – particularly when results are negative (positive results are picked up and dealt with through appropriate treatment pathways).	**Information**	**BAF 3**	

	This is part of a much bigger issue around results endorsement throughout the Trust. Associate MD is working on this as a high priority – looking at a variety of QI options to resolve the situation			
Cancer services – recovery and improvement	The Trust received a letter from Clare Panniker (NHS Regional Director for EoE) on 19th July requesting assurance in relation to Cancer Services and particularly some aspects the 62 day target (potential harm reviews, appropriate communication and safe transfer to onward pathways – letter appended for information). A paper detailing the Trust's response was discussed. Whilst the paper provides some good assurance, there is also the need to develop further our processes in relation to long wait patients and hence the attached paper will be revised before submission. It was noted that the letter also potentially raises the possibility of more financial support, and the importance of detailing costs of the Trust recovery plan in our response was highlighted.	**Assurance**	**BAF 3**	**Letter - CP re Cancer Services - Recovery and Improvement**
104 Week Waits	Following a verbal report at the last Insight Committee it was noted that this was the first opportunity to receive formal confirmation in relation to the progress against 104 week waits – confirming that at month end although there were 45 patients breaching the 104 week target, ALL of these had either chosen to delay treatment (26) or were currently unfit for surgery (19). All those involved with this work deserve congratulations for an outstanding achievement.	**Assurance**	**BAF 3**	
Date Completed and Forwarded to Trust Secretary		**7.9.22**		

Chair's Key Issues

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

Item	**Details of Issue**	**For: Approval/ Escalation/Assurance**	**BAF/ Risk Register ref**	**Paper attached? ✓**
4 and 5	The majority of the September meeting was devoted to an in-depth discussion of: - The Trust Long-Term Capital Programme - The proposed Western Way Development Some key actions were agreed which will be the subject of ongoing work prior to further discussion by the Board	**Ongoing Review**		
7 Patient Access and Governance Group	- Community Paediatrics Performance - Pain Service provision Are both areas of concern and the focus of ongoing work. Both items will be monitored and reviewed at future Insight Committee meetings	**Limited Assurance**	**BAF 3**	
Date Completed and Forwarded to Trust Secretary		**7.9.22**		

NHS England
East of England

To: ICB Chief Executives
EoE Acute Provider Chief Executives
EoE Cancer SROs

NHS England – East of England
2-4 Victoria House
Capital Park
Fulbourn
Cambridge
CB21 5XB

19 July 2022

Dear Colleague,

Cancer Services: Recovery and Improvement

You will know that cancer services across the East of England are seeing record levels of referrals, exceeding pre-pandemic levels at 112%. I would like to thank both primary and secondary care teams who have been working hard to achieve the results we have so far; the average number of 31-day first treatment activity pre-COVID was just under 3,000 per month (all modalities) with c2,700 treatments delivered in April 2022 (EoE 96.5% in line with national position at 96.7%).

We all recognise the current challenges in cancer services, and our current cancer performance for 62-day backlog reductions remains concerning and, comparatively, we are the second worst performing region in the country with 13.3% of the 2ww PTL being comprised of patients waiting more than 62 days. The national position is 11.5% with all other regions shown below:

	Total waiting list (patients)	Number of patients waiting past 62 days	Proportion of waiting list past day 62	Change in >62 day volumes in last week	Change in >62 day volumes in last 4 weeks
Midlands	47,066	6,725	**14.3%**	8.6%	9.8%
East of England	34,748	4,614	**13.3%**	7.0%	5.9%
South West	28,608	3,292	**11.5%**	12.9%	15.9%
North West	38,230	4,316	**11.3%**	7.3%	4.9%
North East and Yorkshire	35,421	3,987	**11.3%**	7.8%	4.6%
London	40,912	3,816	**9.3%**	16.5%	5.6%
South East	34,940	3,065	**8.8%**	8.3%	6.7%
England overall	**259,925**	**29,815**	**11.5%**	**9.4%**	**7.5%**

Table: Urgent Cancer PTL (2ww), proportion of waiting list past 62 days - w/e 05 Jun 22

The number of patients waiting more than 62 days is the highest recorded and continues to increase. Across the East of England, we have over 4000 patients waiting for more than 62 days from the 2ww pathways (this doesn't include patients who have come into cancer

services from consultant upgrades and emergency presentation) of which more than 88% are patients without a decision to treat.

I must stress the importance of organisations providing assurances, through your existing governance processes, to your ICSs that for every patient waiting more than 62 days (with or without a DTT), that:

- Potential harm reviews and continued clinical prioritisation is in place for all cancer pathways;
- Appropriate communication is in place for every patient, who is waiting more than 62 day on a cancer pathway; and
- Safe transfer to onward pathways is clearly defined in the event a person is not diagnosed with cancer and/or does not proceed to treatment.

Can I please ask for this oversight to be in place by 5th August 2022.

I know that your teams are working hard to put solutions in place given the limitations of diagnostics capacity, administration and management of growing PTLs and the national directive to prioritise the reduction of elective 104ww. The use of waiting list initiatives, in-sourcing provision from the independent sector, additional diagnostic capacity where feasible, use of locum workforce, the use of funding for extra admin support and the acceleration of new pathways and clinics such as one-stop shops, and breast pain clinics are all making a difference and there are also strategic transformation programmes underway, including Community Diagnostic Centres, expansion and development of Endoscopy Units and the expansion of the Targeted Lung Health Checks for example.

Despite this huge effort the 62 day backlog continues to increase. Can I ask therefore that by 31st August 2022, you provide:

1. A clear trajectory of your anticipated position, month by month from July 2022 to March 2023 by main tumour site and provider. Note: this may not be the same as your 5 May or 20 June planning submissions but must be what you believe to be a realistic and achievable position.
2. A copy of your current, detailed improvement plans that demonstrate how you will make progress in reducing the backlog position. You should make clear the issues, risks and mitigations within this plan.
3. A determination of what is required to achieve these improvements e.g. additional diagnostic capacity and we ask that the impact of any additional requirements be quantified and costed.

We have asked the Cancer Alliances to support you with the production of these plans. For example, they will provide your current and historical performance position and continued support for improvement interventions and transformation programmes. Should there be any additional support you would find useful – please let us know.

The reduction of the 62-day backlog for cancer patients should be prioritised alongside the reduction of elective waiting lists. You will be aware of an imminent move, nationally, to a tiered approach (as per the approach taken for the successful reduction of 104ww electives).

Where necessary, for those ICSs impacted, we will immediately cease the current fortnightly KLOE approach and move to the national tiered approach. I will provide further information once I have further clarity on this.

As ever, thank you again for your continued focus and efforts.

Yours sincerely,

Clare Panniker
Regional Director
NHS England – East of England

4.2. Finance and Workforce Report

To Assure

Presented by Nick Macdonald

Board of Directors – 30 September 2022

Report Title:	Finance and Workforce Board Report – August 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 August is a small deficit against budget of £0.1m (YTD £0.4m deficit). At present, it is still appropriate to anticipate a break-even position for 22/23 in line with our budget. At present we anticipate there being sufficient mitigations to be able to offset any emerging risks to this position.

Audit FY 2021/22

The audit of the 2021/22 Accounts is now complete and our auditors have issued an unqualified audit opinion on the 2021/22 Accounts. Following a recommendation by the Audit committee, the accounts were approved by the Board on 14 September 2022 and the audit opinion signed on 16 September 2022.

Brokerage of System Capital

Through discussions within the ICS, the Trust has provisionally agreed to utilise additional capital of between £4-5m from the ICS's allocation in 22/23. In effect, the Trust will be utilising the anticipated in-year underspend from ESNEFT.

If agreed by the Board, the Trust will be using this capital to bring forward into 22/23 the replacement of items on the capital programme scheduled for later years. The area most acutely affected by this is Radiology where a number of items of equipment are beyond their expected life spans – MR1 & 2, CT 1, Mammo 1 & 2, the interventional Radiology suite and X-Ray room 4. It is anticipated that early replacement will mitigate against the risks associated with the continued use of ageing systems.

This capital will be repaid to ESNEFT through a reduction in the Trust's capital allocation in 23/24 but as this is an inter-year re-allocation there will be no net impact on the Trust. This also represents a positive example of working with ESNEFT and the brokerage is in the best interests of the SNEE ICS.

Recommendation – The board approve the brokerage of the capital of £4-5m from ESNEFT in 22/23, to be repaid from WSFT's capital allocation in 23/24.

Action Required of the Board

The Board is asked to review this report.
The Board is asked to approve the use of brokered capital within FY 22/23 to be paid back in 23/24

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

FINANCE AND WORKFORCE REPORT
August 2022 (Month 5)

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

Financial Summary

I&E Position YTD	£0.4m	adverse
Variance against Plan YTD	£0.4m	adverse
Movement in month against plan	£0.1m	adverse
EBITDA position YTD	£7.2m	favourable
EBITDA margin YTD	5%	favourable
Cash at bank	£14.4m	

SUMMARY INCOME AND EXPENDITURE ACCOUNT - August 2022	August 2022 Budget £m	August 2022 Actual £m	August 2022 Variance F/(A) £m	Year to date Budget £m	Year to date Actual £m	Year to date Variance F/(A) £m
NHS Contract Income	27.1	27.0	(0.1)	130.5	130.3	(0.2)
Other Income	3.0	2.9	(0.1)	15.3	14.6	(0.8)
Total Income	**30.1**	**29.9**	**(0.2)**	**145.8**	**144.9**	**(1.0)**
Pay Costs	19.2	19.0	0.2	95.8	93.8	2.0
Non-pay Costs	8.9	8.9	(0.0)	43.2	43.9	(0.6)
Operating Expenditure	**28.1**	**27.9**	**0.2**	**139.1**	**137.7**	**1.4**
Contingency and Reserves	0.0	0.0	0.0	0.0	0.0	0.0
EBITDA	**2.0**	**2.0**	**(0.0)**	**6.8**	**7.2**	**0.4**
Depreciation	1.5	1.5	(0.0)	4.5	4.9	(0.4)
Finance costs	0.5	0.6	(0.1)	2.2	2.7	(0.4)
SURPLUS/(DEFICIT)	**(0.0)**	**(0.1)**	**(0.1)**	**(0.0)**	**(0.4)**	**(0.4)**

Executive Summary

- The reported I&E for August is a £0.1m deficit against budget (YTD £0.4m deficit).
- Forecast break-even position for 2022/23
- Unqualified audit opinion given for 2021/22 accounts.
- **Approval requested for the recommended brokerage of system capital of £4-5m in 22/23**

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.
- Revenue costs associated with RAAC plank works
- Impact of unfunded inflation
- Achievement of ERF

FINANCE AND WORKFORCE REPORT – August 2022

Contents:

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

Key:

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

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

FINANCE AND WORKFORCE REPORT – August 2022

Income and Expenditure Summary as at August 2022

The reported I&E for August is a small deficit against budget of £0.1m (YTD £0.4m deficit). At present, it is still appropriate to anticipate a break-even position for 22/23 in line with our budget. Achieving break even does carry with it a number of risks:

- Ongoing impact of Covid on our capacity and operational capability
- Impact of unfunded Covid cost pressures such as temporary staffing, retained IP controls and staff sickness.
- Impact of unfunded inflation
- Impact of RAAC programme such as our operational capacity and revenue impact of the capital programme
- Achievement of ERF

At present we anticipate there being sufficient mitigations to be able to offset these risks. However, we continue to monitor the likelihood and impact of these risks arising so that we can plan for any impact on the financial position of the Trust as soon as possible. It should be noted that the plan YTD includes 5 months apportionment of the central CIP target of £7.5m.

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)	(75)	(75)	↓	Amber
YTD surplus/ (deficit)	(0)	(425)	(425)	↓	Amber
EBITDA YTD	6,781	7,183	402	↑	Green
EBITDA %	4.6%	5.0%	0.3%	↓	Green
Clinical Income YTD	(135,747)	(135,154)	(593)	↓	Amber
Non-Clinical Income YTD	(10,096)	(9,704)	(392)	↓	Amber
Pay YTD	95,812	93,801	2,011	↑	Green
Non-Pay YTD	50,035	51,494	(1,459)	↓	Red

Audit FY 2021/22

As previously noted, due to unanticipated issues caused by it being the 1st year of the engagement combined with resourcing constraints within KPMG over the summer holiday period it was deemed prudent to delay the signing of the accounts until early September. The audit of the 2021/22 Accounts is now complete and KPMG have issued an unqualified audit opinion on the 2021/22 Accounts. Following a recommendation by the Audit committee, the accounts were approved by the Board on 14 September 2022 and the audit opinion signed on 16 September 2022.

Brokerage of System Capital

Through discussions within the ICS, the Trust has provisionally agreed to utilise additional capital of between £4-5m from the ICS's allocation in 22/23. In effect, the Trust will be utilising the anticipated in-year underspend from ESNEFT.

If agreed by the Board, the Trust will be using this capital to bring forward into 22/23 the replacement of items on the capital programme scheduled for later years. The area most acutely affected by this is Radiology where a number of items of equipment are beyond their expected life spans – MR1 & 2, CT 1, Mammography Unit 1 & 2, the interventional Radiology suite and X-Ray room 4. The risk assessments for these ageing systems highlight significant risk with their continued use, namely:

- Extended downtime and reduced capacity
- Delays to patient diagnosis
- Degrading/Sub optimal image quality
- Increasing cost for repairs and parts

It is anticipated that this early replacement will mitigate against the impact and likelihood of these risks. Furthermore, bringing the purchase of these items forward reduces the risk that these items would incur a significant write down of their value (impacting our I & E) if they are not moved to any new facility.

This capital will be repaid to ESNEFT through a reduction in the Trust's capital allocation in 23/24. However by bringing items into 22/23 that were originally scheduled for 23/24 there will be no net impact on the Trust. It should also be noted that this represents a positive example of working with ESNEFT and the brokerage is in the best interests of the SNEE ICS.

Recommendation – The board approve the brokerage of the capital of £4-5m from ESNEFT in 22/23, to be repaid from WSFT's capital allocation in 23/24.

FINANCE AND WORKFORCE REPORT – August 2022

Trends and Analysis

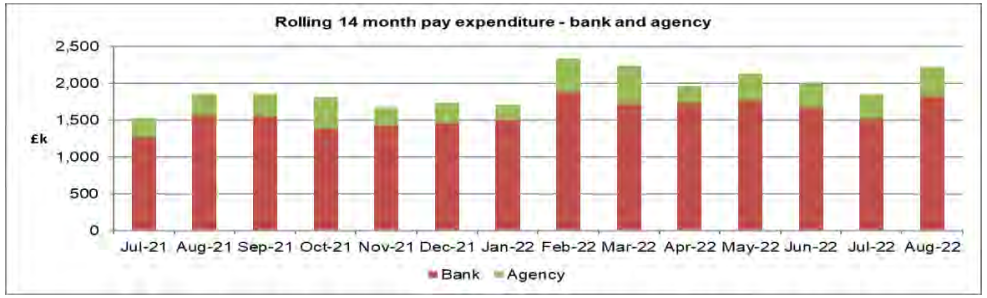
Workforce

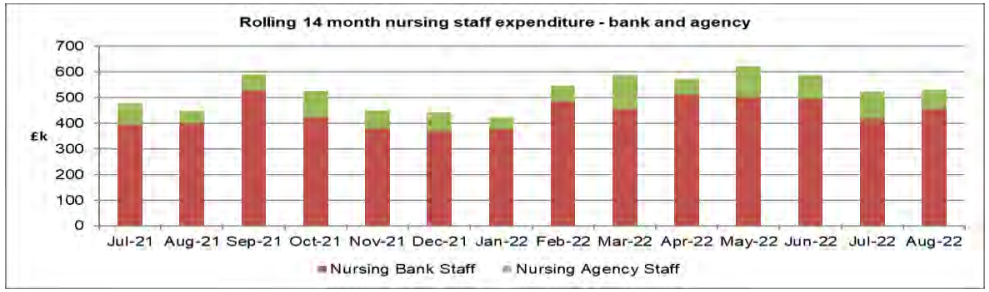
During August the Trust underspent by £0.2m on pay.

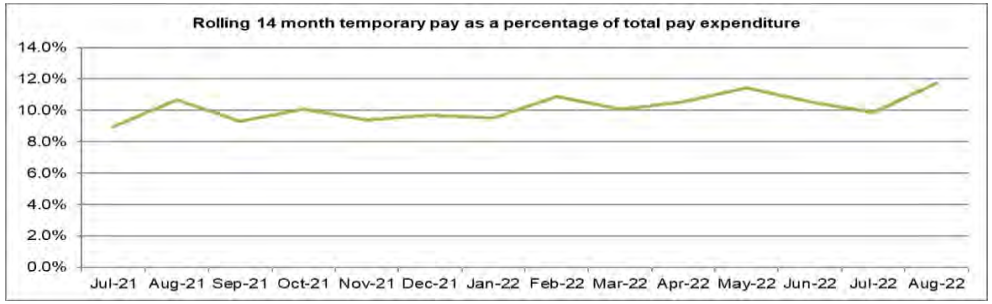
Monthly Expenditure (£)				
As at August 2022	Aug-22	Jul-22	Aug-21	YTD
	£000's	£000's	£000's	£000's
Budgeted Costs in-month	19,205	19,180	17,459	95,812
Substantive Staff	16,755	16,882	15,478	83,640
Medical Agency Staff	164	170	128	584
Medical Locum Staff	424	341	357	1,932
Additional Medical Sessions	406	270	338	1,497
Nursing Agency Staff	77	106	48	458
Nursing Bank Staff	454	417	400	2,376
Other Agency Staff	163	58	112	606
Other Bank Staff	230	200	181	1,124
Overtime	163	151	122	849
On Call	147	135	167	733
Total Temporary Expenditure	2,227	1,848	1,854	10,161
Total Expenditure on Pay	18,982	18,731	17,331	93,801
Variance (F/(A))	223	450	128	2,011
Temp. Staff Costs as % of Total Pay	11.7%	9.9%	10.7%	10.8%
memo: Total Agency Spend in-month	403	334	289	1,648

Monthly WTE				
As at August 2022	Aug-22	Jul-22	Aug-21	YTD
Budgeted WTE in-month	4,812.0	4,809.5	4,414.8	35,285.3
Substantive Staff	4,219.5	4,177.2	4,051.9	20,926.4
Medical Agency Staff	13.3	11.4	7.1	42.4
Medical Locum Staff	42.8	71.5	30.0	193.5
Additional Medical Sessions	7.5	6.2	5.1	17.6
Nursing Agency Staff	13.8	13.2	7.7	69.5
Nursing Bank Staff	118.4	114.3	116.3	624.3
Other Agency Staff	27.1	17.7	12.6	125.0
Other Bank Staff	79.8	74.4	68.6	388.3
Overtime	44.5	40.0	29.3	222.1
On Call	9.6	10.0	8.2	45.4
Total Temporary WTE	356.8	358.6	284.8	1,728.1
Total WTE	4,576.2	4,535.8	4,336.7	22,654.5
Variance (F/(A))	235.8	273.6	78.1	12,630.7
Temp. Staff WTE as % of Total WTE	7.8%	7.9%	6.6%	7.6%
memo: Total Agency WTE in-month	54.1	42.2	27.4	236.9

Pay Costs







FINANCE AND WORKFORCE REPORT – August 2022

Income and Expenditure Summary by Division

	Current Month			Year to date		
	Budget	Actual	Variance F/(A)	Budget	Actual	Variance F/(A)
MEDICINE	£k	£k	£k	£k	£k	£k
NHS Contract Income	(6,867)	(6,258)	(609)	(38,042)	(37,378)	(664)
Other Income	(382)	(340)	(42)	(1,747)	(1,591)	(156)
Total Income	**(7,249)**	**(6,598)**	**(651)**	**(39,789)**	**(38,969)**	**(820)**
Pay Costs	4,902	5,116	(214)	24,348	24,882	(534)
Non-pay Costs	1,581	1,992	(411)	7,671	9,510	(1,839)
Operating Expenditure	**6,483**	**7,108**	**(625)**	**32,020**	**34,392**	**(2,373)**
SURPLUS / (DEFICIT)	**766**	**(510)**	**(1,276)**	**7,769**	**4,577**	**(3,192)**
SURGERY						
NHS Contract Income	(5,652)	(6,068)	416	(27,782)	(28,601)	819
Other Income	(168)	(229)	61	(846)	(1,004)	158
Total Income	**(5,820)**	**(6,297)**	**477**	**(28,628)**	**(29,605)**	**977**
Pay Costs	3,962	3,687	275	19,873	18,957	916
Non-pay Costs	1,413	1,635	(222)	6,071	7,484	(1,412)
Operating Expenditure	**5,375**	**5,322**	**53**	**25,945**	**26,441**	**(496)**
SURPLUS / (DEFICIT)	**445**	**975**	**531**	**2,684**	**3,165**	**481**
WOMENS AND CHILDRENS						
NHS Contract Income	(2,703)	(2,733)	30	(11,170)	(11,314)	144
Other Income	(67)	(163)	96	(334)	(532)	197
Total Income	**(2,770)**	**(2,897)**	**127**	**(11,505)**	**(11,846)**	**341**
Pay Costs	1,669	1,702	(33)	8,367	8,142	225
Non-pay Costs	179	206	(27)	874	1,092	(218)
Operating Expenditure	**1,848**	**1,908**	**(60)**	**9,241**	**9,234**	**7**
SURPLUS / (DEFICIT)	**922**	**989**	**67**	**2,264**	**2,612**	**348**
CLINICAL SUPPORT						
NHS Contract Income	(1,022)	(1,031)	10	(3,545)	(3,173)	(371)
Other Income	(151)	(196)	45	(753)	(845)	91
Total Income	**(1,172)**	**(1,227)**	**55**	**(4,298)**	**(4,018)**	**(280)**
Pay Costs	2,261	2,253	7	11,239	11,155	84
Non-pay Costs	1,008	1,298	(290)	5,041	7,063	(2,023)
Operating Expenditure	**3,268**	**3,551**	**(282)**	**16,280**	**18,218**	**(1,939)**
SURPLUS / (DEFICIT)	**(2,096)**	**(2,324)**	**(228)**	**(11,982)**	**(14,200)**	**(2,218)**
COMMUNITY SERVICES						
NHS Contract Income	(2,968)	(3,045)	76	(14,820)	(15,258)	439
Other Income	(1,277)	(668)	(609)	(6,394)	(5,319)	(1,075)
Total Income	**(4,245)**	**(3,712)**	**(533)**	**(21,213)**	**(20,577)**	**(636)**
Pay Costs	3,024	2,934	90	15,078	14,664	414
Non-pay Costs	1,451	1,351	100	7,245	6,832	413
Operating Expenditure	**4,475**	**4,284**	**191**	**22,323**	**21,496**	**827**
SURPLUS / (DEFICIT)	**(230)**	**(572)**	**(343)**	**(1,110)**	**(919)**	**191**
ESTATES AND FACILITIES						
NHS Contract Income	0	0	0	0	0	0
Other Income	(488)	(384)	(105)	(2,441)	(1,427)	(1,013)
Total Income	**(488)**	**(384)**	**(105)**	**(2,441)**	**(1,427)**	**(1,013)**
Pay Costs	1,061	1,049	11	5,303	5,272	31
Non-pay Costs	773	987	(214)	3,866	4,276	(409)
Operating Expenditure	**1,834**	**2,037**	**(203)**	**9,169**	**9,547**	**(378)**
SURPLUS / (DEFICIT)	**(1,346)**	**(1,653)**	**(308)**	**(6,729)**	**(8,120)**	**(1,392)**
CORPORATE						
NHS Contract Income	(7,880)	(7,882)	2	(35,164)	(34,573)	(591)
Other Income	(482)	(919)	437	(2,786)	(3,941)	1,155
Total Income	**(8,362)**	**(8,801)**	**439**	**(37,951)**	**(38,514)**	**564**
Pay Costs	2,327	2,241	86	11,604	10,729	875
Non-pay Costs	2,454	1,386	1,068	12,460	7,531	4,928
Capital Charges and Financing Costs	2,043	2,154	(111)	6,783	7,794	(1,011)
Operating Expenditure	**6,824**	**5,782**	**1,043**	**30,847**	**26,054**	**4,793**
SURPLUS / (DEFICIT)	**1,538**	**3,020**	**1,482**	**7,104**	**12,460**	**5,356**
TOTAL						
NHS Contract Income	(27,093)	(27,018)	(75)	(130,522)	(130,298)	(224)
Other Income	(3,014)	(2,898)	(116)	(15,302)	(14,659)	(643)
Total Income	**(30,107)**	**(29,916)**	**(191)**	**(145,824)**	**(144,957)**	**(867)**
Pay Costs	19,205	18,982	223	95,812	93,801	2,011
Non-pay Costs	8,859	8,855	4	43,228	43,788	(559)
Capital Charges and Financing Costs	2,043	2,154	(111)	6,783	7,794	(1,011)
Operating Expenditure	**30,107**	**29,991**	**116**	**145,824**	**145,382**	**442**
SURPLUS / (DEFICIT)	**(0)**	**(75)**	**(75)**	**0**	**(425)**	**(426)**

Medicine (Sarah Watson)

At the end of August, the Medicine division is behind plan by £1.2m (£3.2m YTD).

Clinical income is behind plan by £609k in month (£664k YTD). Activity in A&E and Outpatients were outperforming plan in month. However a change in case mix in both (e.g. OP was telephone rather than F2F attendances) has resulted in negative variances to budget. Elective procedures were also below plan in month, mostly driven by Chemotherapy.

Excluding clinical income, the division is behind plan by £667k in the month (£2.5m YTD), almost entirely due to non-pay cost variances. Year to date non-pay reports a £1.8m adverse variance whilst pay budget variances total £534k (2.2% of budget).

The key drivers behind the non-pay budget variance for August are:

- £356k pressure on drugs occurring mainly in Rheumatology, Dermatology and Oncology driving a continued overspend on Drugs (£1.2m YTD). Investigations have identified a number of high cost drugs prescribed at the Trust whose funding status (either reclaimable from NHSE or now moved into ICB block) has changed in this financial year. We are reviewing the accounting treatment of these drugs to ascertain whether these should be showing as a cost pressure to Medicine with funding held elsewhere to offset.
- £70k on for the managed service contract within Cardiology following the M5 true up invoice.

Pay overspent against budget by £213k in month (YTD £534k), driven by

- £228k under budget for registered nurses.
- £73k overspend on unregistered nurses and overtime to compensate for registered nurses vacancies.
- £238k spend on temporary consultant spend across the division, including additional sessions across the division, agency staff in haematology & care of the elderly and Locum spend in A & E and care of the elderly.

Surgery (Moira Welham)

The division is £531k ahead of plan in month (£481k ahead of plan YTD).

Clinical income is ahead of plan by £416k in month (£819k YTD) driven by elective activity and high levels of non-elective activity. Whilst the division are making

improvements within its outpatient and elective activity, overperformance within the division is mainly driven by the high levels of emergency activity.

Pay expenditure reported an underspend of £275k in month (£916k YTD). Recruitment to vacant roles is ongoing with key areas of challenge being within Anaesthetics and Theatre ODPs. Temporary staffing is being used to fill some of these vacant posts and accounts for 9.3% of the total pay spend. The division are working up short term solutions such as insourcing to alleviate pressure within the existing workforce and bridge the gap.

Non-pay expenditure reported an overspend of £222k in month (£1.4m YTD). The overspend is driven by increased drug spend and the continued spend on recovery measures for elective services.

Women and Children's (Simon Taylor)

In August, the Division reported a favourable variance of £67k (YTD £348k).

Clinical Income was £30k ahead of plan in-month driven by elective Obstetrics, Paeds outpatients and Antenatal services being ahead of plan in month.

Other income was £96k ahead of plan in-month due to doctor and other training funding received being higher than anticipated. This is partially a catch-up relating to under-accrued income earlier in the year.

Pay reported a £33k overspend in-month. An underspend driven by vacancies within the Maternity Service is offset by higher than budgeted in-month pay costs in obstetrics, driven in turn by late submission of additional sessions claims.

Non-pay reported an unanticipated £27k overspend in-month due largely to overspends on drugs within Obstetrics and Paediatrics, partly a result of the increased activity noted above.

Clinical Support (Simon Taylor)

In August, the Division reported an adverse variance of £228k (£2.2m YTD). Income was £55k ahead of plan in-month, which is due to catch-up of activity which was behind in previous months.

Pay reported a £7k underspend in-month, with Pathology and Diagnostics both incurring additional costs, offset by vacancies in Pharmacy and Outpatients.

Non-pay reported a £290k overspend in-month as the Trust continued to overspend on recovery measures for CT and endoscopy, as well as increased activity in pathology. The service is continuing to progress replacement of CT 2 and the installation of the third CT scanner.

Community Services (Clement Mawoyo)

The Community Division reported an adverse variance of £343k in M5 of 2022/23 (£191k favourable YTD)

Income reported a £533k under recovery in August (£636k YTD). A non-recurrent adjustment of £480k was made in M5 to the income position. We anticipate clinical income to exceed budget in 2022/23 due to higher than budgeted growth and inflation funding. This uplift will contribute to additional inflationary-related costs to be incurred.

Pay reported a favourable variance of £90k in August (£414k YTD). Pay expenditure has continued to increase in line with budget, to reflect recruitment to externally funded urgent community (responsive) additional roles as well as new roles funded via external business case (such as roles supporting Autism Spectrum Disorder service recovery) or other external grant (such as MacMillan).

Despite the division's increased turnover (14% in August) and vacancies, temporary staff were used to cover some vacant roles across the division. Additional agency capacity has been allocated to the Early Intervention Team to provide additional capacity to support admission avoidance and urgent care response. Recruitment to vacant roles is ongoing despite recruitment challenges. A focused review group has been established to deliver improved recruitment and retention with a focus on staff engagement to inform next steps.

Non-pay reported a £100k favourable variance in August (£413k YTD). Pressures noted under community equipment costs (driven by increased need) were offset by additional collection credits for returned core stock items of equipment as well as a number of in-month underspends for Wheelchair Services. Reduced expenditure on Wheelchair equipment was enabled by increased recycling of equipment - a key initiative of the Division's Sustainability Programme. The annual 'true up' of cost exercise with NHS Property Services, released some additional credit in to the M5 position – a non-recurrent impact.

Estates and Facilities

In August, the division recorded an adverse variance of £308k, (YTD adverse variance of £1,392k). The financial year shortfall in income stands at £1,013k with non-pay costs overspent by £409k, pay costs are broadly in line with budgeted values.

The trend of car parking income (£82k) and Restaurant income (£86k) being adverse to monthly budget continued. With the decision to not re-instate car parking charges until April 2023, we are anticipating a forecasted shortfall of £650k for car parking for the full year. Catering income increased by 10% on July to £57k as a result of the removal of Time Out seating restrictions.

Non-Pay costs gave an adverse variance to monthly budget of £214k driven by canteen supplies (£75k) and consultancy fees (£112k). The variance for canteen supplies is a year-to-date correction for the position driven by accurate invoicing.
A review is now being undertaken as canteen supplies purchases are 118% of budget YTD whilst income in this area is only 35% of YTD target. The variance for consultancy fees relate to in-month receipt of annual invoices.

FINANCE AND WORKFORCE REPORT – August 2022

Statement of Financial Position at 31 August 2022

STATEMENT OF FINANCIAL POSITION	As at 1 April 2022	Plan 31 March 2023	Plan YTD 31 August 2022	Actual at 31 August 2022	Variance YTD 31 August 2022
	£000	£000	£000	£000	£000
Intangible assets	52,039	56,905	56,931	54,238	(2,693)
Property, plant and equipment	170,887	201,415	173,121	174,947	1,826
Right of use assets			14,896	14,881	(15)
Trade and other receivables	5,807	6,341	6,341	5,807	(534)
Total non-current assets	**228,733**	**264,661**	**251,289**	**249,873**	**(1,416)**
Inventories	3,574	3,689	3,689	3,679	(10)
Trade and other receivables	15,069	18,362	18,362	19,295	933
Cash and cash equivalents	33,323	10,767	9,937	14,406	4,469
Total current assets	**51,966**	**32,818**	**31,988**	**37,380**	**5,392**
Trade and other payables	(60,164)	(38,925)	(37,207)	(52,296)	(15,089)
Borrowing repayable within 1 year	(5,858)	(9,684)	(12,155)	(6,944)	5,211
Current Provisions	(38)	(46)	(46)	(12)	34
Other liabilities	(2,888)	(5,685)	(5,685)	(2,452)	3,233
Total current liabilities	**(68,948)**	**(54,340)**	**(55,093)**	**(61,704)**	**(6,611)**
Total assets less current liabilities	**211,751**	**243,139**	**228,184**	**225,549**	**(2,635)**
Borrowings	(44,002)	(47,927)	(49,697)	(52,974)	(3,277)
Provisions	(415)	(852)	(852)	(415)	437
Total non-current liabilities	**(44,417)**	**(48,779)**	**(50,549)**	**(53,389)**	**(2,840)**
Total assets employed	**167,334**	**194,360**	**177,635**	**172,160**	**(5,475)**
Financed by					
Public dividend capital	200,285	227,311	210,586	205,535	(5,051)
Revaluation reserve	11,704	11,704	11,704	11,704	0
Income and expenditure reserve	(44,655)	(44,655)	(44,655)	(45,079)	(424)
Total taxpayers' and others' equity	**167,334**	**194,360**	**177,635**	**172,160**	**(5,475)**

The opening balances shown in the table above are now final and the audit on the 2021/22 Accounts is now complete. KPMG issued an unqualified audit opinion on the 2021/22 Accounts.

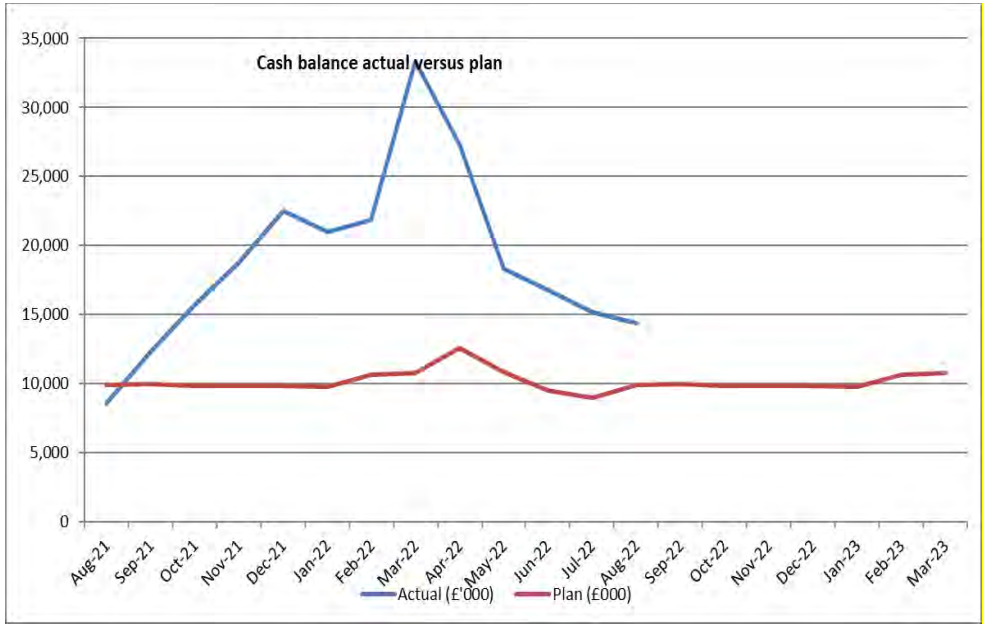
The right of use assets (leases) are now shown on the balance sheet and therefore the actual balances are now comparable with the plan.

Trade payables is higher than plan, but is in line with the year end position as at 31 March 2022, showing a small movement. This links to the fact that the cash position is slightly higher than plan.

We have not yet drawn down the PDC allocated to us in line with the plan and this will be drawn down in September.

Cash Balance Forecast for the year

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



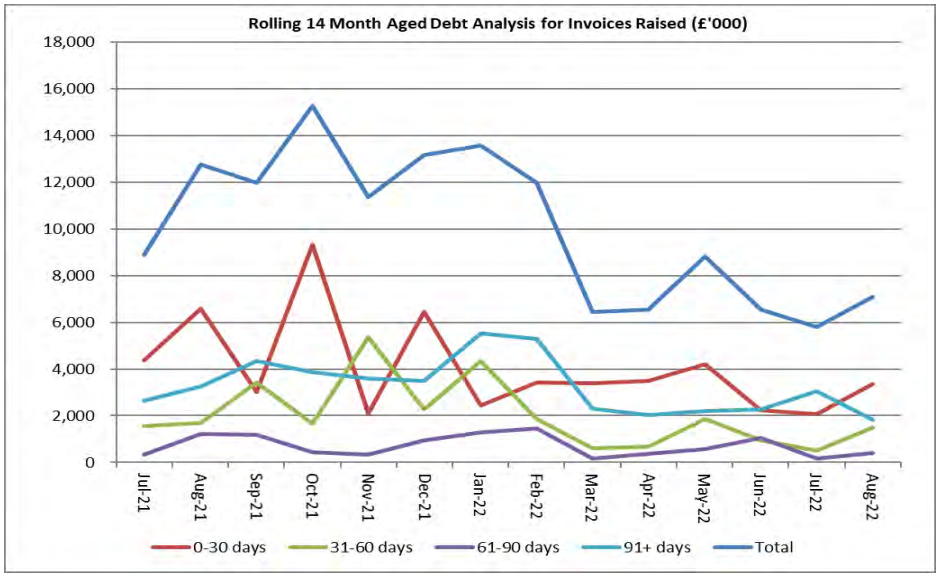
The cash position remains ahead of plan at month 5, however we will closely monitor the position to ensure that it remains in line with the year-end forecast of £10.7m.

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

FINANCE AND WORKFORCE REPORT – August 2022

Debt Management

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



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

The overall level of sales invoices raised but not paid has remained steady, with a slight increase in month 5. The large majority of the debts outstanding are historic debts, although these are reducing. Over 86% of these outstanding debts relate to NHS Organisations, with 21% of these NHS debts being greater than 90 days old. We are actively trying to agree a position with the remaining corresponding NHS Organisations for these historic debtor balances and a significant amount of work has been completed in this area to help reduce these historic balances.

Capital Progress Report

The 2022/23 Capital Programme has been set at £33.2m with £21m of this relating to structure works. An additional £4m has been awarded for RAAC works, taking the plan figure for RAAC to £25m.

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 year to date capital spend for month 5 was £13.2m. At this early stage the projects are all being forecast to come in at around the plan figure.

Capital Spend - 31 Aug 2022	Year to Date - Month 5			Forecast		
Capital Scheme	YTD Original Plan	YTD Actual	Variance	Full year Original Plan	Full Year Forecast 31 Mar 2023	Total Full Year Variance Against Forecast
	£000's			£000's		£000's
New Hospital (Future Systems)	444	1,435	- 991	1,060	2,060	- 1,000
RAAC	5,415	7,438	- 2,023	21,000	25,000	- 4,000
Estates	775	469	306	1,680	1,680	-
IM&T	2,705	3,303	- 598	5,430	5,430	-
Medical Equipment	250	400	- 150	400	400	-
Imaging Equipment	-	142	- 142	1,740	1,740	-
Other Schemes (incl. IFRS 16 Lease Additions)	1,891	-	1,891	1,891	1,891	-
Total Capital Schemes	11,480	13,187	-1,707	33,201	38,201	-5,000
Overspent vs Plan						
Underspent vs Plan						

It should be noted that the table above details the anticipated capital spend against the original plan submitted to NHSE. We have subsequently been informed that we will be supported with the extra £4m RAAC funding so we do not anticipate any overspend due to RAAC. Furthermore, the table above does not include any forecast regarding the bringing forward of capital spend from 23/24 that the board has been recommended to approve.

4.3. Improvement Committee Report - August & September, 2022 Chair's key issues from the meetings

To Assure

Presented by Jude Chin

Board of Directors Open – 30 September 2022

Report Title:	Improvement Committee report and Chair's Key Issues
Executive Lead:	Jude Chin – Non-Executive Chair Improvement Committee
Report Prepared by:	Rebecca Gibson – Head of Compliance & Effectiveness
Previously Considered by:	n/a

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

Executive Summary

The Improvement Committee met on August and September 2022. Attached is the Chair's Key Issues document which will constitute the standard template for Improvement Committee reports to Board.

The report includes two appendices:

- IQPR July and August data
- Presentation from the Stroke team

Action Required of the Board

To **receive** the report

Risk and assurance:	BAF risk 1. Quality governance or service failure 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
Legal and regulatory context	Well-Led Framework NHSI FT Code of Governance Health and Social Care Act 2008 (HSCA 2008)

Chair's Key Issues

Originating Committee	Improvement Committee	**Date of meeting**	8 Aug 22
Chaired by	Jude Chin	**Lead Executive Director**	Sue Wilkinson

Agenda item	Details of issue	For: Approval/ Escalation/ Assurance	BAF/ Risk Register ref	Paper attached? ✓
4.1	Stroke deep dive – noted successes and concerns / challenges. SSNAP (national audit (https://www.strokeaudit.org/) performance WSFT has previously always been a top performing trust, but this is now deteriorating. Key measure demonstrating impact of challenges is the deteriorating four-hour admission to Stroke unit (SSNAP data). Nurse staffing a concern (in common with other wards) Consideration of ring-fencing empty hyperacute stroke (HASU) beds discussed. Recent audit demonstrates multiple occasions where timely admission impacted by bed availability due to outlying medical patients in general stroke beds. Other risks include lack of CTA overnight for thrombectomy (new red risk RR5612). Thrombectomy service (also red risk for WSFT) now provided by CUH in hours and Royal London out of hours. Positives of service include 7-day Consultant cover and 24hour ESOT service.	Partial assurance	**RR4499 RR5612**	✓ Presentation in annex
4.2	IQPR Noted four items of special cause variation within the remit of PQAS MRSA (*improving*) Complaints response timeliness (*improving*): Patient safety incidents reported / resulting in harm (*concerning*). Consideration how assurance can be provided for subjects without duplicating effort. Reporting through governance groups should contain the detail and Improvement committee needs confidence that this is working. Applies for wider specialist committee measures not just those within the IQPR. Important that consistent achievement should be celebrated. Likewise targets that are 'hit and miss' regarding achievement as neither of these would trigger escalation.	Assurance		✓ IQPR in annex

Agenda item	Details of issue	For: Approval/ Escalation/ Assurance	BAF/ Risk Register ref	Paper attached? ✓
5.1	Patient Quality & Safety governance group (PQAS) – July report and minutes provided. Reports provided for: Thrombosis (shows improvement in compliance) Transfusion (some concerns have now been addressed), Patient safety incidents (some increase in harm, now reducing), DoC training progressing albeit with limitations due to staff availability), Mortality (new group).	Assurance		
5.2	Clinical Effectiveness governance group (CEGG) – July Report provided. Reports provided for: Pathology, CQUIN and QI. Noted a concern that digital systems reporting is not fully integrated within 3i governance structure and made aware that CQUIN data is subject to delays due to staff capacity and timely access to data. For positive escalation, recognise incredible transformation in Pathology service; working towards accreditation in the different disciplines and finally achieving required standards to end MHRA enhanced scrutiny. Product of much hard work should be recognised by the wider organisation. Pathology leaders report staff wellbeing improved and teams feel more supported now service is part of WSFT.	Assurance		
7.1	CQC insight publication – brings together in one place all information CQC holds (through publicly available datasets) about our services at provider, location, or core service level. CQC use to decide what, where and when to inspect and provides analysis to support evidence in inspection reports. Performance against national benchmarks uses scale of *Much better* to *Much worse*. Content can be sub-divided into Improvement, Insight and Involvement remit (report sent to all 3i). All (Improvement committee) indicators categorised as "worse" and one of better' relate to the national clinical audits which are overseen through CEGG. Other 'better' indicators relate to HSMR (overseen by Mortality group reporting to PQAS.) https://www.cqc.org.uk/guidance-providers/nhs-trusts/cqc-insight-nhs-trusts	Assurance		
8.1	First year review of 3i committee structure – received for information.	Assurance		

Originating Committee	Improvement Committee	**Date of meeting**	12 Sept 22
Chaired by	Jude Chin	**Lead Executive Director**	Sue Wilkinson

Agenda item	Details of issue	For: Approval/ Escalation/ Assurance	BAF/ Risk Register ref	Paper attached? ✓
4.1	IQPR Noted four items of special cause variation within the remit of PQAS MRSA (*improving*), VTE (*improving*), Patient safety incidents (PSI) reported (*concerning*). Noted that higher levels of reporting PSIs is acknowledged as a sign of a positive reporting culture. Options for widening the scope of IQPR reporting in future might include: a) Deep dive into subject which regularly shows special cause concern and/or consistently fails a target. Either through specialist committee reporting via the PQAS governance group or direct to Improvement committee. b) Oversight of subjects which consistently hit the target in our external assurance programmes to provide independent assurance of that status. c) How we might develop a deeper understanding of the subjects which do not flag as a concerning variation but equally do not reliably hit the targets either. Agreed that IQPR items reviewed by Improvement committee should not include complaints data (should fall in scope of Involvement committee instead).	**Assurance**		✓ IQPR in annex
5.1	PQAS August report and minutes provided. Reports provided for: Claims (numbers below national benchmark), Information Governance (reduction in incidents this quarter), Inquests (a case of note with potential for 'preventing future deaths' report will have local action/interventions articulated at hearing), End of Life (Implementation of ReSPECT will replace DNACPR and EPARS paperwork across ICB), Dementia & Frailty (retirement of clinical lead), Deteriorating Patient (resus trolley and basic life support training compliance both improving), Mortuary (Human tissue authority requirements following identified shortfalls, evidence submitted accepted by HTA).	**Assurance**		

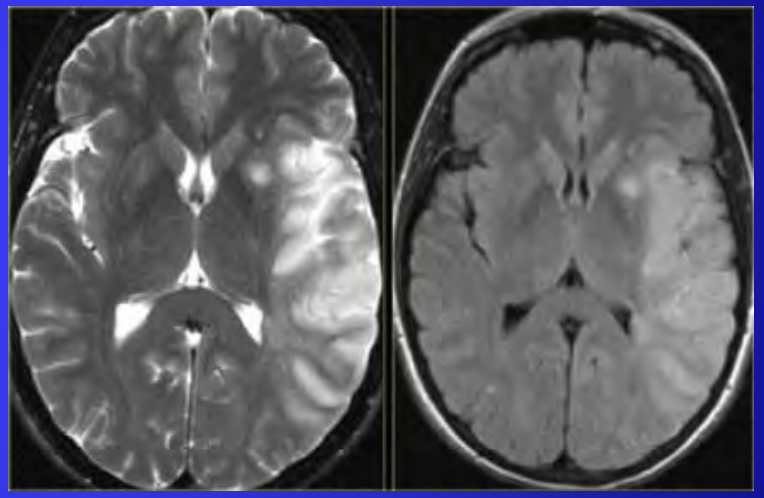
Agenda item	Details of issue	For: Approval/ Escalation/ Assurance	BAF/ Risk Register ref	Paper attached? ✓
6.1	Ockenden wider organisational impact Review undertaken which identified 30 recommendations with wider relevance to whole organisation. Main themes: Staffing, training, patient engagement, learning from incidents and complaints, psychological safety, civility and emotional support for staff, emotional and psychological support for patients, anaesthetics complications & record keeping. Next steps in progress include identifying key leads (and group/committee which oversees subject area), self-assessment and gap analysis, gathering assurance for compliant elements (including where a wider project already ongoing will address the non-compliance and so no standalone action is required).	**Partial Assurance**		
6.2	Mortality oversight Update provided by AMD (Patient safety) outlining programmes of work during 2022 to date to streamline and standardise processes for learning from deaths. Aims / anticipated outcomes are: Timelier review of deaths requiring scrutiny undertaken by the specialities that delivered the clinical care. Trust wide learning will be identified at Mortality oversight group and actions allocated to appropriate groups, Learning from deaths teams and systems aligned to patient safety and quality using PSIRF model to direct review pathways and prevent duplication of effort. Relatives contacted at an earlier juncture (achieved through more timely review process) and their views incorporated into learning.	**Assurance**		
8.1	Assurance committees review Trust secretary's office provided initial drafts of templates for terms of reference, reporting from committees and minutes with an aim to enable standardisation across the organisation. Organisational framework for governance will now be updated to reflect agreed changes including new model for the three assurance committees and SLT.	**Assurance**		
8.2	Quarterly review of future scheduling presented for information and discussion. Opportunities for deep dive into quality & safety topics to be considered on a month-on-month basis.	**Assurance**		

STROKE SERVICES

Dr A Azim

Stroke – the size of the problem

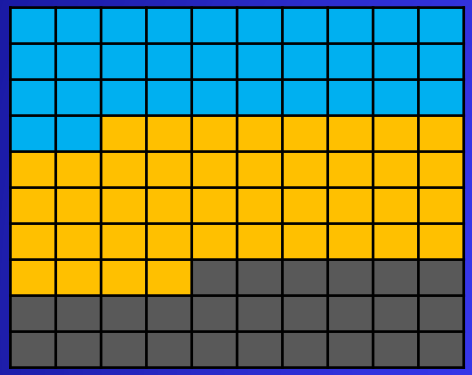
- 85,000 strokes per year / England
- 80% are ischaemic
- 1.1 million people have survived a stroke
- 600,000 are disabled
- Massive burden on patients, friends and family, healthcare and social care
- Cost >£26 billion per year UK



Patel A, BerdunovV, QuayyumZ, et al. Estimated societal costs of stroke in the UK based on a discrete event simulation. Age Ageing 2020;49(2):270e6.

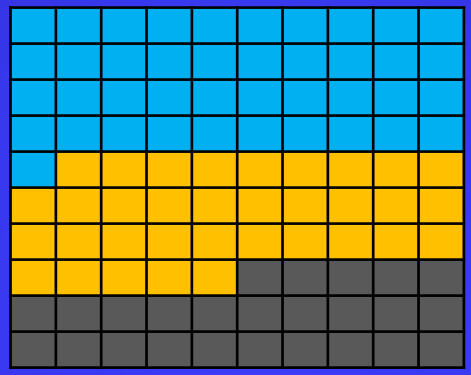
https://www.nice.org.uk/media/default/about/what-we-do/into-practice/measuring-uptake/nice-impact-stroke.pdf

IV thrombolysis (Alteplase) within 3 hours of ischaemic stroke

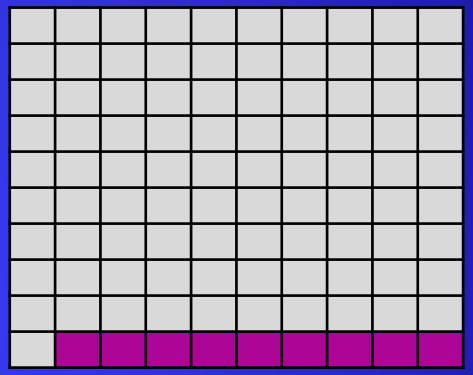


Control

(Untreated outcomes at 3 – 6 months)



Alteplase < 3 hours

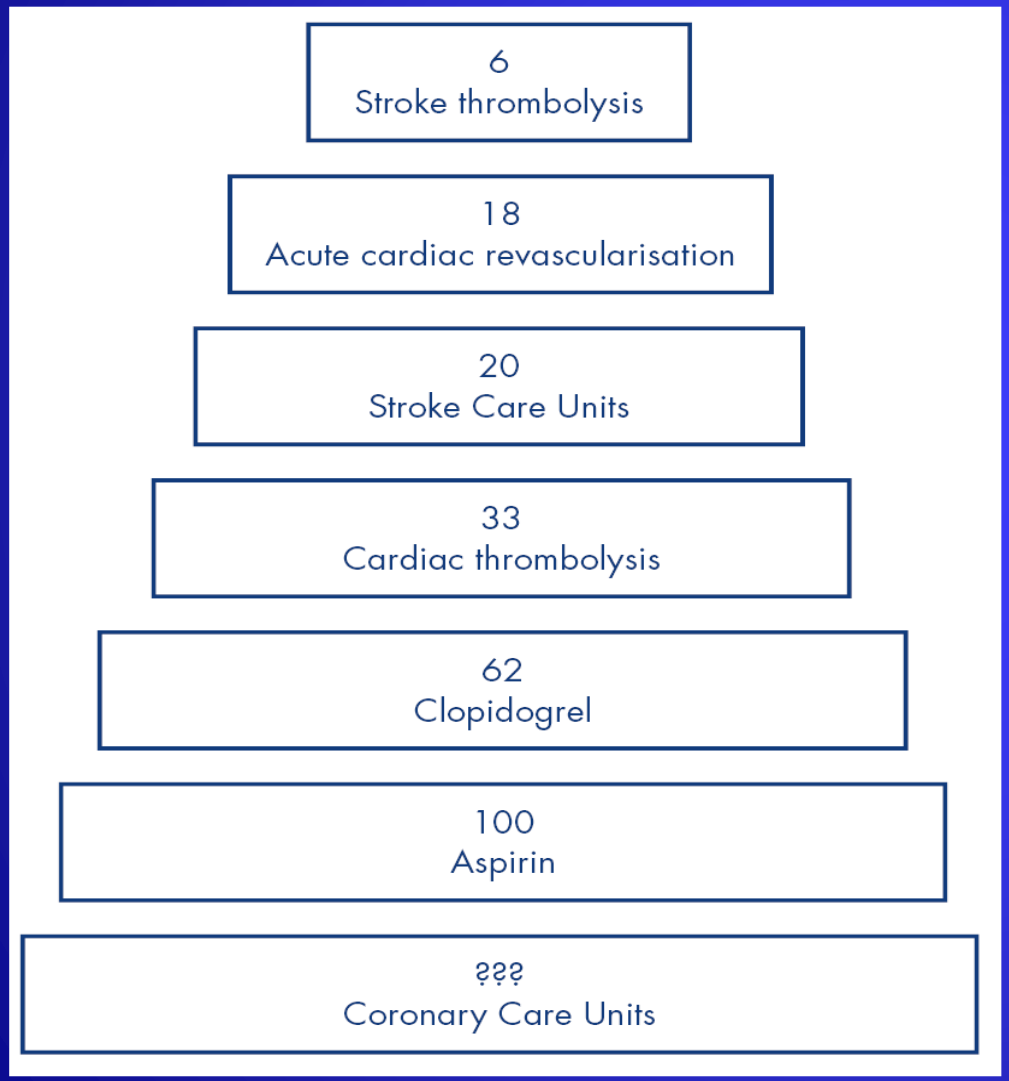


Net benefit

Treat 100

- Avoid dependency in about 1:10 (accounting for 3% serious bleeds)
- Less disabled - 3.3 in 10

Benefits of thrombolysis versus acute stroke care alone: NNT



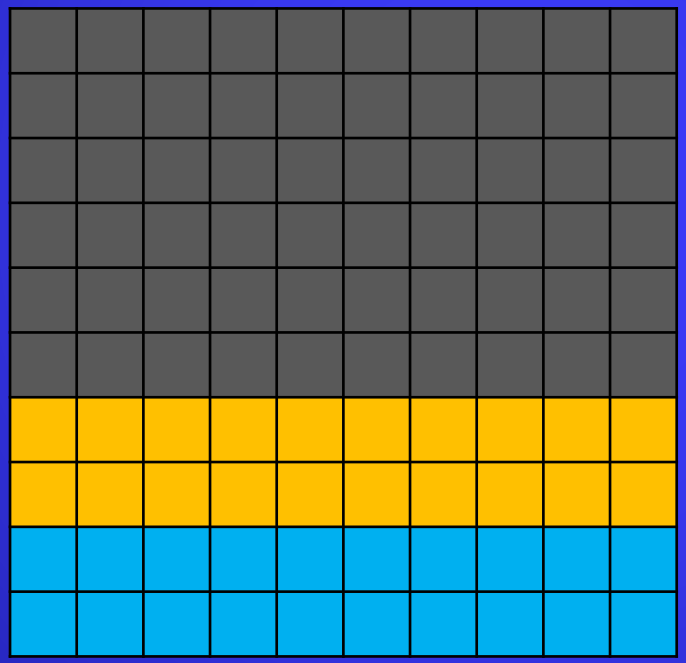
Thrombolysis compares highly favourably with other stroke therapies and established coronary interventions

Thrombectomy within 6 hours of ischaemic stroke

Not improved

Less disabled

Avoid dependency



Treat 100 patients

40 less with disability

20 avoid dependency

In addition to 10 who benefit from clot busting medication

7 fewer benefit with each hour of delay

It is 7x as efficacious as PCI for MI

NNT <1 in 3 for reduction in disability

NNT 1 in 5 for restored independence

Low procedural risks in experienced hands

7 day working

- Acute admission Consultant review day-time weekdays with weekend/BH PTWR by Consultants.
- 24 hour ESOT service, which facilitates:
  - early assessment
  - prompt imaging
  - timely transfer to HASU
  - standardised care both in-hours and out of hours
- Thrombolysis 24/7
  - In hours – in-house
  - OOH – Telemedicine
- Thrombectomy 24/7
  - Mon – Fri In-hours – Addenbrooke's
  - OOH / Weekend – RLH
- Therapy
  - SALT - 6 days but ……..
  - PT/OT - 7 days but either a PT or OT and not both

7-day TIA Service

- Fast track MRI as first line of imaging
- No carotid imaging on Sundays

MIMICS!! - workload

CATEGORY	ITEM	NATIONAL	WEST SUFFOLK HOSPITAL
CASEMIX	Number of mimic patients	6351	123
	Caseload	52.8%	69.5%
AGE	Age (median)	70	74
	Age (IQR)	55.0 - 81.0	57.5 - 84.0
MIMIC TYPE	Number of mimic patients	6351	123
	Migraine	593	13
	Migraine (%)	9.3%	10.6%
	Tumour	127	7
	Tumour (%)	2.0%	5.7%
	Seizure	358	2
	Seizure (%)	5.6%	1.6%
	Non-organic	340	10
	Non-organic (%)	5.4%	8.1%
	Peripheral Vestibular	235	9
	Peripheral Vestibular (%)	3.7%	7.3%
	Subdural Haematoma	77	1
	Subdural Haematoma (%)	1.2%	0.8%
	TIA	1209	16
	TIA (%)	19.0%	13.0%
	Other	3412	65
	Other (%)	53.7%	52.8%
THROMBOLYSIS	Number of thrombolysed mimics	47	0
	Median age for thrombolysed patients	58	
	Age for thrombolysed patients (IQR)	44.5 - 74.5	

Suffolk and North East Essex SSNAP performance review July 2022

National SSNAP performance data is usually published approximately 3 months after end of reporting period. We now therefore have performance for the full contract year 2021-2022 available.

Hospital	Overall SSNAP rating (rates A to E, A being being)			
	Apr - June 21-22	Jul – Sep 21-22	Oct – Dec 21-22	Jan – Mar 21-22
Colchester	A	A	B	A
Ipswich	A	B	D	C
West Suffolk	A	A	A	A

The below table shows overall SSNAP performance ranking of the Suffolk and North East Essex hospital sites when benchmarked against other East of England sites.

Hospital	East of England Ranking out of 14 acute hospital sites			
	Apr - June 21-22	Jul – Sep 21-22	Oct – Dec 21-22	Jan – Mar 21-22
Colchester	1st	4th	5th	2nd
Ipswich	4th	9th	14th	8th
West Suffolk	3rd	1st	1st	1st

WEST SUFFOLK FOUNDATION TRUST
SENTINEL STROKE NATIONAL AUDIT PROGRAMME
SSNAP

18/19	Apr-Jun 2018	Jul-Sep 2018	Oct-Dec 2018	*Jan-Mar 2019*
	A	A	A	A
19/20	Apr-Jun 2019	Jul-Sep 2019	Oct-Dec 2019	*Jan-Mar 2020*
	A	A	A	A
20/21	Apr-Jun 2020	Jul-Sep 2020	Oct-Dec 2020	*Jan-Mar 2021*
	A	A	A	A
20/21	Apr-Jun 2021	Jul-Sep 2021	Oct-Dec 2021	*Jan-Mar 2022*
	A	A	A	A

East of England Regional SSNAP data
April – Jun 2021

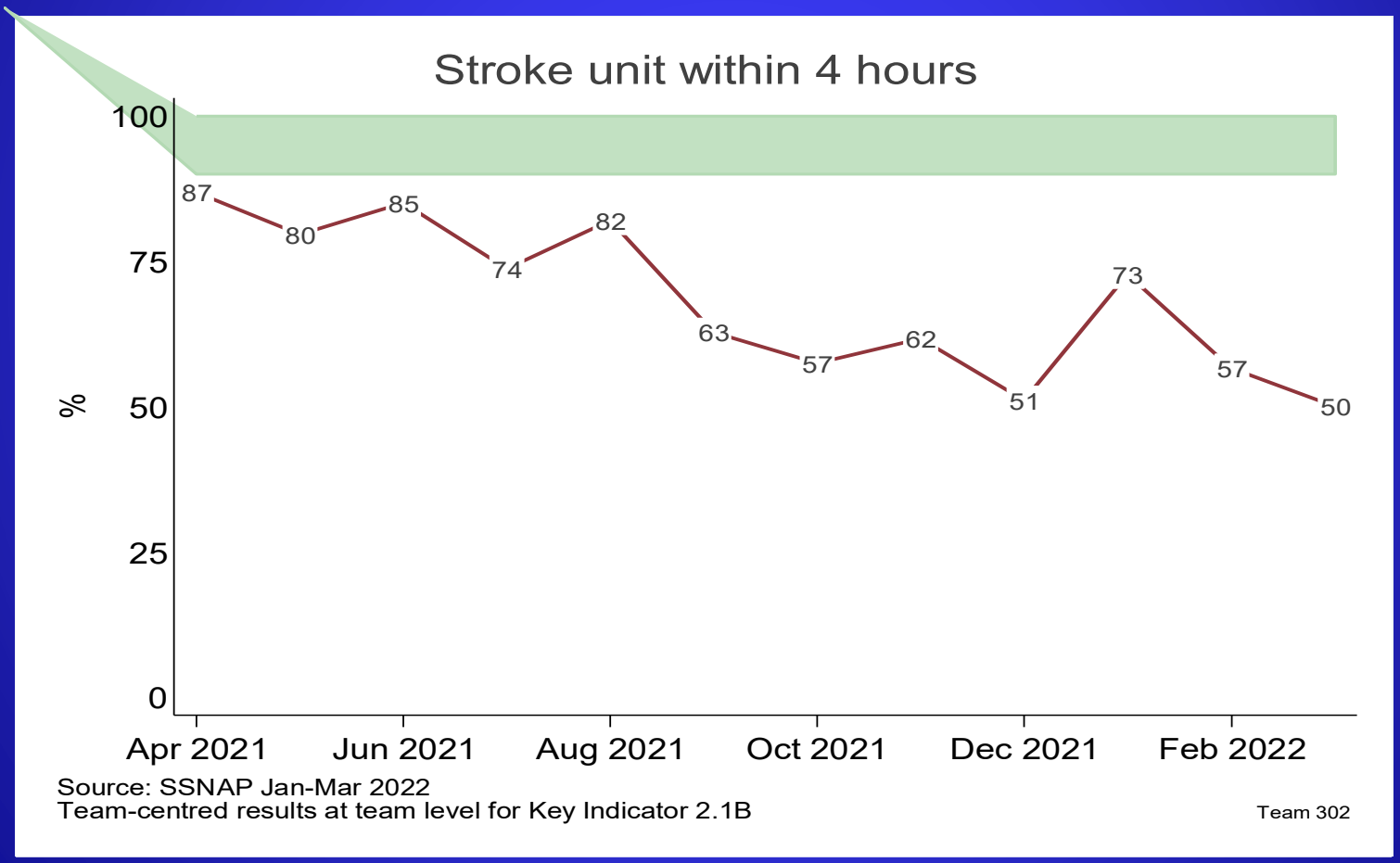
Team Centred Performance Table

Routinely Admitting Teams		Number of patients		Overall Performance				Team Centred Data										
Trust	Team Name	Admit	Disch	SSNAP Level	CA	AC	Combined KI Level	D1 Scan	D2 SU	D3 Throm	D4 Spec Asst	D5 OT	D6 PT	D7 SALT	D8 MDT	D9 Std Disch	D10 Disch Proc	TC KI Level
Midlands & East- East of England SCN																		
Bedfordshire Hospitals NHS Foundation Trust	Luton and Dunstable Hospital	163	180	A↑	A	B	A	A	C↑	B	B	A	A	B	B	B	A	A
Cambridge University Hospitals NHS Foundation Trust	Addenbrooke's Hospita	198	197	B	A	A	B	B	E	C↑	A	A	B↓	A	C	A	A	B
East Suffolk and North Essex NHS Foundation Trust	Colchester General Hospital	172	184	A	A	A	A	A	C↑	B	A↑	A	A	A↑	A	B	A	A
East Suffolk and North Essex NHS Foundation Trust	Ipswich Hospital	132	123	A	A	A	A	A	B	C	A	C	B	C	B↑	A	A	A↑
East and North Hertfordshire NHS Trust	Lister Hospital	156	183	C	A	A	C	A	C↑↑	E↓↓	B	E	C	B	E	B↑	B↓	C
James Paget University Hospitals NHS Foundation Trust	James Paget Hospital	119	124	C	A	A↑	C	B	E↓	D↓	B	A↑	B	E↓	B↑↑	B↑	B	C
Mid and South Essex NHS Foundation Trust	Basildon University Hospital	152	167	B↓	A	A	B↓	A	D↓	C↓	B	C↓	C↓	C↓↓	B↑	A	A	B↓
Mid and South Essex NHS Foundation Trust	Broomfield Hospital	179	188	A	A	A	A	A	B↑	B↑	B	A↑	A↑	B	B	A	A	A
Mid and South Essex NHS Foundation Trust	Southend Hospital	180	179	A↑	A	A	A↑	A	C	B↑	A	B↑	B	D↓↓	A	A↑	A↑	A↑
Norfolk and Norwich University Hospitals NHS Foundation Trust	Norfolk and Norwich University Hospital	274	280	C↑	A	C	C	A↑↑	C↑	C	B	C↑	C↓	E	C↑	B	A	C
North West Anglia NHS Foundation Trust	Peterborough City Hospital	184	191	D	A	A	D	C	E	D	C↓	C	D↓	D↑	D↑	A	A	D
Queen Elizabeth Hospital King's Lynn NHS Foundation Trust	Queen Elizabeth Hospital Kings Lynn	168	168	B	A	A	B	C	E	C↓	B	A	A	B↓	B	A	C	B
West Hertfordshire Hospitals NHS Trust	Watford General Hospita	180	197	B↓	A	A	B↓	A	E	D↓	A	A↑	A	C	C↓	A	A	B
West Suffolk NHS Foundation Trust	West Suffolk Hospital	134	128	A	A	A	A	A	B↑	B	B	A	A	B↓	B↓	B	A	A

WEST SUFFOLK FOUNDATION TRUST
STROKE TEAM
SSNAP RESULTS 30/05/2022

SSNAP Scoring Summary:		Apr-Jun 2021	Jul - Sept 2021	Oct-Dec 2021	Jan - Mar 22
SSNAP level		A	A	A	A
SSNAP score		88	91	89	85
Team-centred KI levels:					
Stroke unit		B	B	C	C

West Suffolk Foundation Trust
SSNAP Domain 2 Stroke Unit



AUDIT OF RING FENCED BEDS 16 JUNE – 11 JULY 2022		Of these times no available step down bed female	Of these times no available step down male	Out of these times there is a medical female on G8	Out of these times there is a medical male on G8	Times informed no capacity to move medicals off G8
Times checked and there is more than 1 HASU beds that are available	30	19	20	29 (lowest amount of patients on ward is 2 largest is 7)	15 (lowest amount is 1 patient and highest is 3)	2
Times checked and there is ONLY 1 HASU bed available	9	5	6	7 (lowest amount of patients is 4 most is 6)	3 (lowest amount 1 highest is 3)	0
Times checked and there is no HASU beds available	8	7	8	8 (lowest amount is 5 highest is 7)	3 (lowest amount is 1 and highest is 3)	4

- Long Term NHS Plan
- National Stroke Service Model - May 2021
- GIRFT – Speciality Report - April 2022

CHALLENGES - for WSH Stroke Service

- CTA - Lack of CTA over-night for thrombectomy
  - Red Risk Register
  - Risk of catastrophic harm to patients
  - Red Risk Registered with ICS Stroke Board

- Consistent transfer of patients to HASU within 4 hours, preferably within 2 hours
  - Lack of ring-fenced beds consistently
  - Need to be proactive rather than reactive

Stroke Unit within 4 hours

- Percentage of patients getting to the Stroke Unit in 4 hours, getting progressively worse and SSNAP score is dipping
- Lack of ring-fenced bed is the outstanding cause consistently
- Delay in Samba swabbing
- Delay in ED in referring
- Delay in outlier wards in referring

We need to change practice culture

- We need to be proactive ensuring there is always a HASU ring-fenced bed available rather than acting reactively when a patient is in A&E which inevitably leads to breaches.

- Poor care/poor outcome if not admitted to Stroke Unit including increased length of stay.

- Needs Executive Sponsor to drive Stroke Admission Pathway.

  Awareness of such issues within the Trust, Education, Training across disciplines involved in the pathway particularly those involved in bed management decision making.

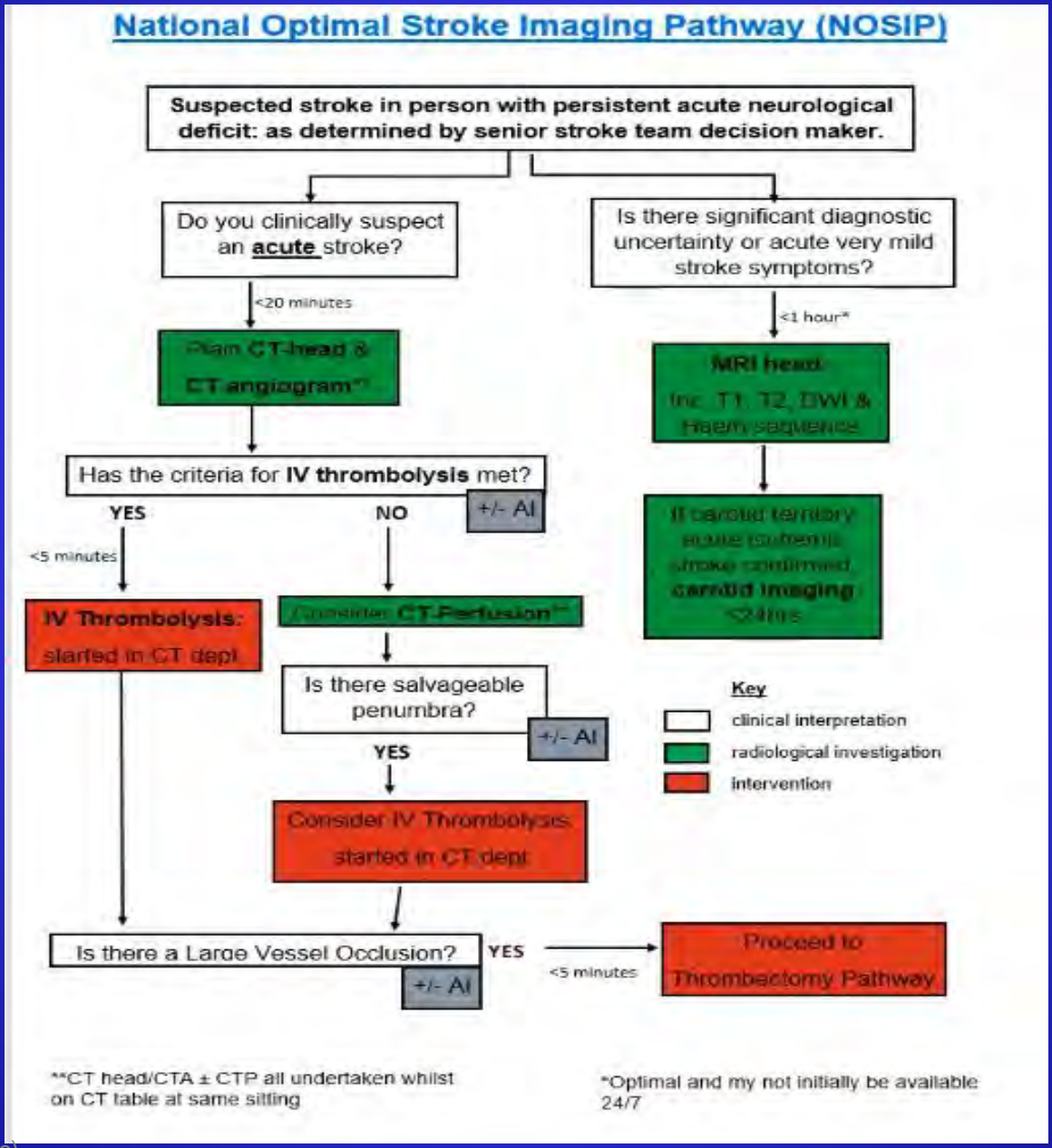
- Stroke team take-over stroke bed management eg CCU.

CHALLENGES

- Implement HASU SOP (ISDN – recommendations)
  - Ring-fenced beds
  - Medical patients transferred out of SU proactively
  - Criteria for medical outliers placement to SU

    eg patients with expected quick turn-over (LOS)
  - No patients with complex discharge needs
  - Active implementation of escalation procedure when no ring-fenced bed etc

CHALLENGES


National Optimal Stroke Imaging Pathway (NOSIP)
Suspected stroke in person with persistent acute neurological deficit: as determined by senior stroke team decision maker.
Do you clinically suspect an acute stroke?
Is there significant diagnostic uncertainty or acute very mild stroke symptoms?
<20 minutes
<1 hour*
Has the criteria for IV thrombolysis met?
+/- AI
YES
NO
<5 minutes
IV Thrombolysis: started in CT dept
Is there salvageable penumbra?
+/- AI
YES
Consider IV Thrombolysis started in CT dept
Is there a Large Vessel Occlusion?
+/- AI
YES
<5 minutes
Proceed to Thrombectomy Pathway
Key
clinical interpretation
radiological investigation
intervention
**CT head/CTA ± CTP all undertaken whilst on CT table at same sitting
*Optimal and my not initially be available 24/7

CHALLENGES

- Implementation of NOSIP
  - Imaging modalities including
    - CTA
    - CTP (CT perfusion)
    - MRI – acutely
  - Needs joint-up working with Stroke/Radiology supported by management
  - Will need gap analysis, resource implications, education and training
  - Artificial Intelligence – work on-going re procurement by ISDN - North

CHALLENGES

- Nursing Staffing:
  - Below core numbers consistently
  - ISDN Nurse Workforce Report and recommendations

- Wake-up strokes and extending time window for thrombolysis and thrombectomy

ISDN

- ISDN (National)
  - ISDN EoE
    - ISDN (North)
    - ISDN (South)
  - ISDN Sub-groups
    - eg CAG
      - Pre-Hospital Pathway
      - Hospital Admission Pathway
      - Nurse Workforce
      - AI
      - Thrombectomy Quality Review

- Achieving SSNAP A status for all 10 domains by February 2023 (see attached Action Plan)

- Thrombectomy Quality Review
  - Pathways
  - DIDO

- EoE ISDN Nurse Workforce Roles Report June 2022
  - Recommendations

ICS

- ICS - Stroke
  - Health Inequalities
  - Joint-up rehab pathway post stroke
  - Lack of Level 2B beds with delays in transfer
  - Follow-up of stroke survivors by ESD in the community with MDT input

4.4. Quality and Nurse Staffing Report

To Assure

Presented by Susan Wilkinson

Trust Board – 30 September 2022

Report Title:	Quality and Workforce Report & Dashboard – Nursing July and August 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 July and August 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

- Fill rates for RN remain static
- RN turnover has remained static; NA turn over continues to rise
- Summer SNCT has been completed and review meetings are underway with ward teams
- Improvement in vacancies across roles in community setting
- Improvement in NA vacancies following sustained period of decline
- WSHFT received national accreditation for international nursing program in August 22

Action Required of the Board

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

Risk and assurance:	Red Risk 4724 amended to reflect surge staffing and return to BAU
Equality, Diversity and Inclusion:	*N/A*
Sustainability:	*N/A*
Legal and regulatory context	*Compliance with CQC regulations for provision of safe care*

1. Introduction

Whilst there is no single definition of 'safe staffing', the NHS constitution, NHS England, CQC regulations, NICE guidelines, NQB expectations, and NHS Improvement resources all refer to the need for NHS services to be provided with sufficient staff to provide patient care safely. NHS England cites the provision of an *"appropriate number and mix of clinical professionals"* as being vital to the delivery of quality care and in keeping patients safe from avoidable harm. (NHS England 2015).

West Suffolk NHS Trust is committed to ensuring that levels of nursing staff, which includes Registered Nurses, Midwives and Nursing Associates and Assistant Practitioners, match the acuity and dependency needs of patients within clinical ward areas in the Trust. This includes ensuring there is an appropriate level and skill mix of nursing staff to provide safe and effective care using evidence-based tools and professional judgement to support decisions. The National Quality Board (NQB 2016) recommend that monthly, actual staffing data is compared with expected staffing and reviewed alongside quality of care, patient safety, and patient and staff experience data. The trust is committed to ensuring that improvements are learned from and celebrated, and areas of emerging concern are identified and addressed promptly.

This paper will identify the safe staffing and actions taken in July and August 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 July and August within the data submission deadline. Table 1 shows the summary of overall fill rate percentages for these months and for comparison, the previous four months. Appendix 1a and 1b illustrates a ward-by-ward breakdown for July and April.

	Day		Night	
	Registered	Care Staff	Registered	Care staff
Average fill rate March 2022	84%	78%	83%	96%
Average fill rate April 2022	84%	76%	81%	93%
Average fill rate May 2022	87%	80%	89%	98%
Average fill rate June 2022	87%	74%	88%	92%
Average fill rate July 2022	87%	70%	89%	91%
Average fill rate August 2022	87%	78%	87%	95%

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

Highlights

- RN fill rates are static this reporting period
- Fill rate for NA day shifts significantly low in July, recovering 8% in August
- Lowest fill rate of NA in critical care as their 2WTE both on long-term sick/leave which has continued in July and August

Care Hours per Patient Day (CHPPD)

CHPPD is a measure of workforce deployment and is reportable to NHS Digital as part of the monthly returns for safe staffing (Appendix 1). CHPPD is the total number of hours worked on the roster by both Registered Nurses & Midwives and Nursing Support Staff divided by the total number of patients on the ward at 23:59 aggregated for the month (lower CHPPD equates to lower staffing numbers available to provide clinical care). Using model hospital, the average Recommended CHPPD for an organisation of our size is 7.6. The chart below demonstrates our achievement of this. Since August 2021 we are not achieving this consistently and further demonstrates the staffing challenges over the last year.

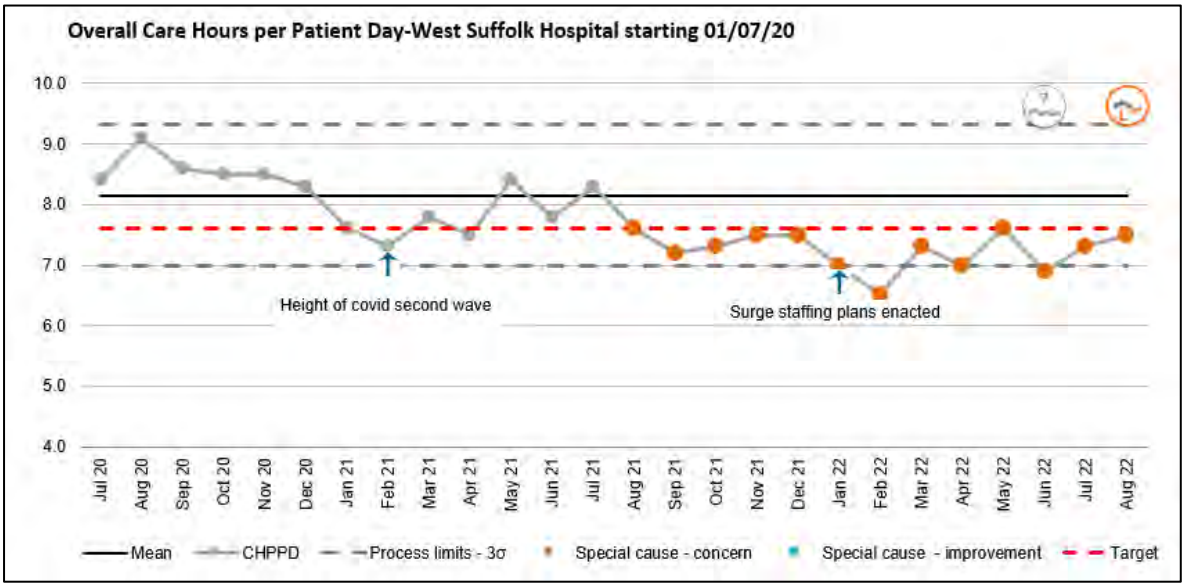


Chart 2: Adapted from model hospital/unify data

3. Sickness

A reduction in sickness was seen in August following a rise in July. Overall sickness levels are the lowest in 2022 thus far. This likely to be linked to the reducing community prevalence of covid 19.

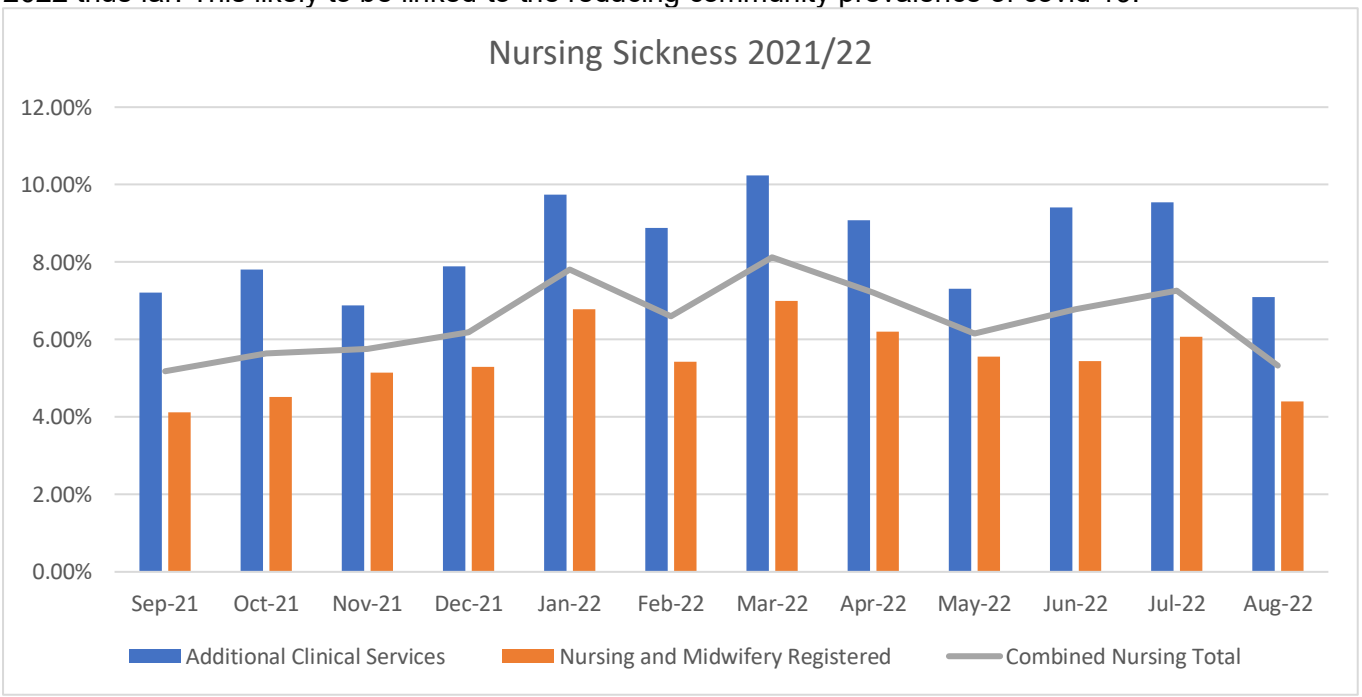


Chart 2.

	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22
Unregistered staff (support workers)	9.74%	8.89%	10.24%	9.07%	7.32%	9.40%	9.54%	7.10%
Registered Nurse/Midwives	6.79%	5.42%	7.00%	6.27%	5.63%	5.43%	6.07%	4.40%
Combined Registered/Unregistered	**7.80%**	**6.60%**	**8.12%**	**7.25%**	**6.20%**	**6.76%**	**7.26%**	**5.32%**

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). It should be noted that in May 2022, national guidance on self-isolation, following close contact with Covid 19, was amended and isolation is no longer mandatory. This is at the lowest level over the last 12 months, which is consistent and driven by the reduction in covid/covid contact isolation precautions.

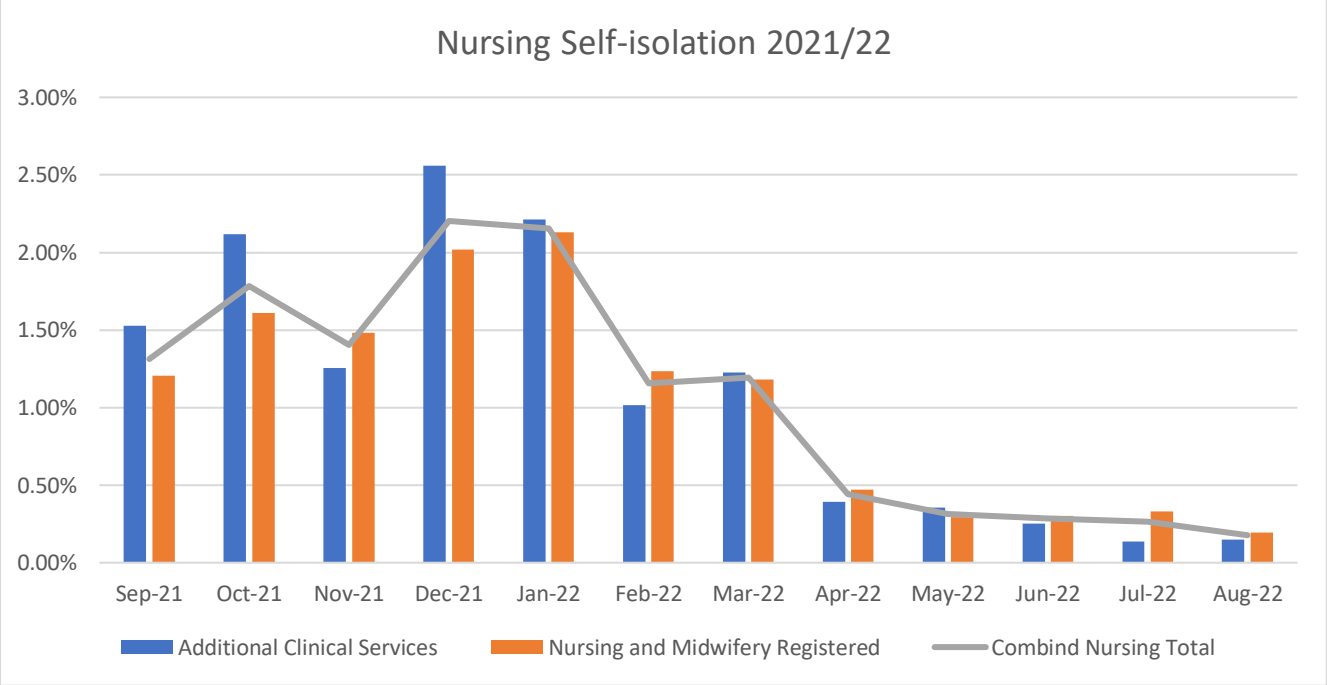


Chart 3

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.

No additional wards opened during this period which has greatly assisted in addressing staffing challenges. Surge areas as part of BAU have been used consistently in this reporting period which requires the sourcing of one RN and one NA for the duration of its function. While this appears small numbers, it is additional pressure on the current shortfall and reduces the efficacy of the same day emergency care pathway.

Ward relocations in this period.

- F8-F10
- Labour suite to F11 (F11 already relocated to F9)

5. Recruitment and Retention

Vacancies: Registered nursing (RN/RM):

- Substantive Inpatient RN/RM WTE has seen an increase in August; however, the vacancy percentage has risen due to increases in budget in F4 and Rosemary ward
- Inpatient ward RN vacancies (excluding RM) is 16.3%
- Inpatient ward NA vacancies (excluding maternity) is 13.1%
- Total Trust RN/RM vacancies (all areas) has marginally increased 13.1% to 13.3%
- Total Trust Nursing assistants and unregistered staff vacancies has decreased from 19% to 14%

	Inpatient	Sum of Actuals Period 12 (Mar)	Sum of Actuals Period 01 (Apr)	Sum of Actuals Period 02 (May)	Sum of Actuals Period 03 (Jun)	Sum of Actuals Period 04 (July)	Sum of Actuals Period 05 (Aug)	WTE VACANCY at period 5
RN/RM Substantive	Ward WTE	612.5	603.5	609.9	609.5	601.8	608.7	122.2
Nursing Unregistered Substantive	Ward WTE	385.9	376.7	373.1	364	374.4	387.9	63.1

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

Chart 4a demonstrates the total RN/RM establishment for the inpatient areas (WTE). The total number of substantive RNs has seen an improving trend until March this year. Full list of SPC related to vacancies can be found in appendix 2. Areas of concern remain within the non-registered staff group.

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

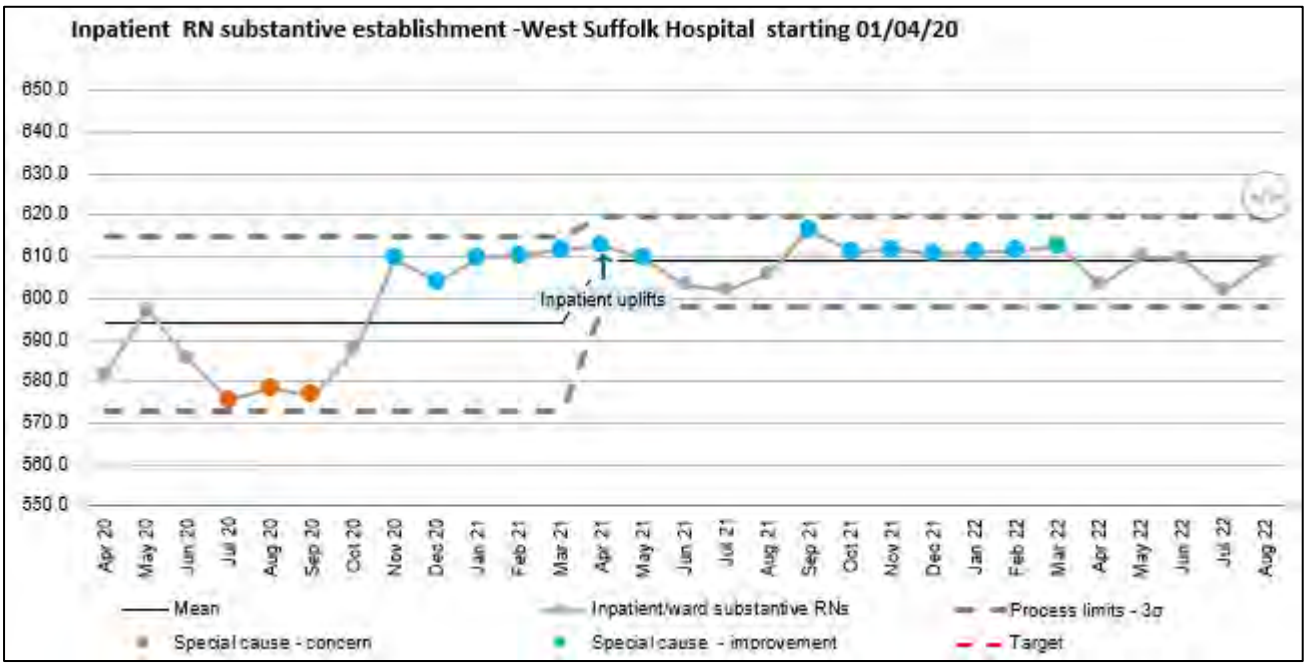


Chart 4a: SPC data adapted from finance ledger

6. New Starters and Turnover

International Nurse Recruitment:

We remain on trajectory to achieve our annual target as capacity with accommodation has increased to enable the arrival of ten nurses a month. This is made up of nurses supplied by agency engagement and direct recruitment where there is a shortfall. There is a national issue with delays in OSCE availability which is impacting on recruitment currently. However, this is likely to improve as more testing centres are opening. We have seen these delays increase the length of time from arrival to the trust to registered status. These delays are escalated to the regional and national teams.

In July 7 nurses arrived as two were deferred and joined the August cohort of 10 nurses. Currently 30 nurses are in the pipeline and interviews continue to ensure we are meet our annual ambition by March 2023.

In August the trust was accredited with the 'NHS Pastoral Care quality award'. This award recognises the quality of service provide by the organisation in both resourcing international nurses and how they are welcomed and developed after joining the NHS. We were one of the first trusts in the region to achieve this recognition of the quality of our international recruitment program.

New starters

	March 22	April 22	May 22	June 22	July 22	August 22
Registered Nurses*	23	23	7	16	18	18
Non-Registered	8	22	12	35	16	9

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

- In July, eighteen RNs completed induction; of these; fifteen were for acute services, and three for community services joined this cohort
- In July, sixteen NAs completed induction; of these thirteen NAs are for the acute Trust, one for bank services, one for midwifery and one for community.

- In August, eighteen RNs completed induction; of these; twelve were for acute services, four for bank services, two for midwifery and one for community
- In August, nine NAs completed induction; of these, five NAs are for the acute Trust, two for bank services and one for midwifery and one for community services

Turnover

On a retrospective review of the last rolling twelve months, turnover for RNs has remained static reporting 11.87% (11.91 last report) above the trust ambition of <10%. NA turnover has also increased again from 20.92% to 21.64. The escalating turnover has been escalated through the finance and workforce committee and is being captured at the Trust retention group

Staff Group	Average Headcount	Avg FTE	Starters Headcount	Starters FTE	Leavers Headcount	Leavers FTE	LTR Headcount %	LTR FTE %
Nursing and Midwifery Registered	1,306.50	1,127.08	97	72.89	163	133.83	12.48%	11.87%
Additional Clinical Services	574.00	481.31	208	193.49	126	104.15	21.95%	21.64%

Table 7. (data from workforce)

7. Quality Indicators

Falls

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

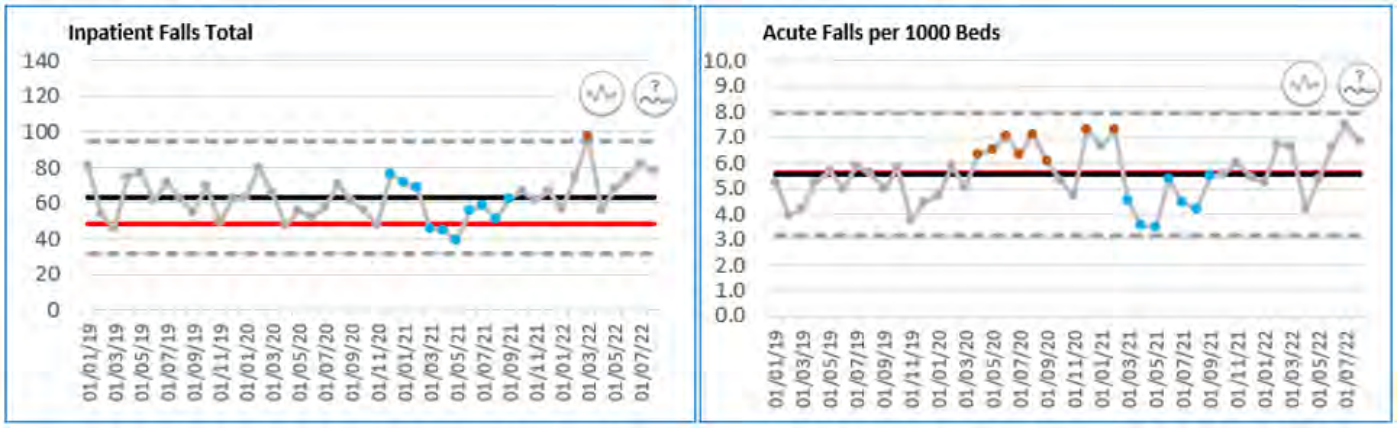


Chart 8

Pressure Ulcers

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

Community prevalence has maintained common cause variation for over a year. The senior nursing team have been working with the national would care collaborative on improvement methods within the community and will be presenting to Non-Medical Clinical Council (NMCC) in October.

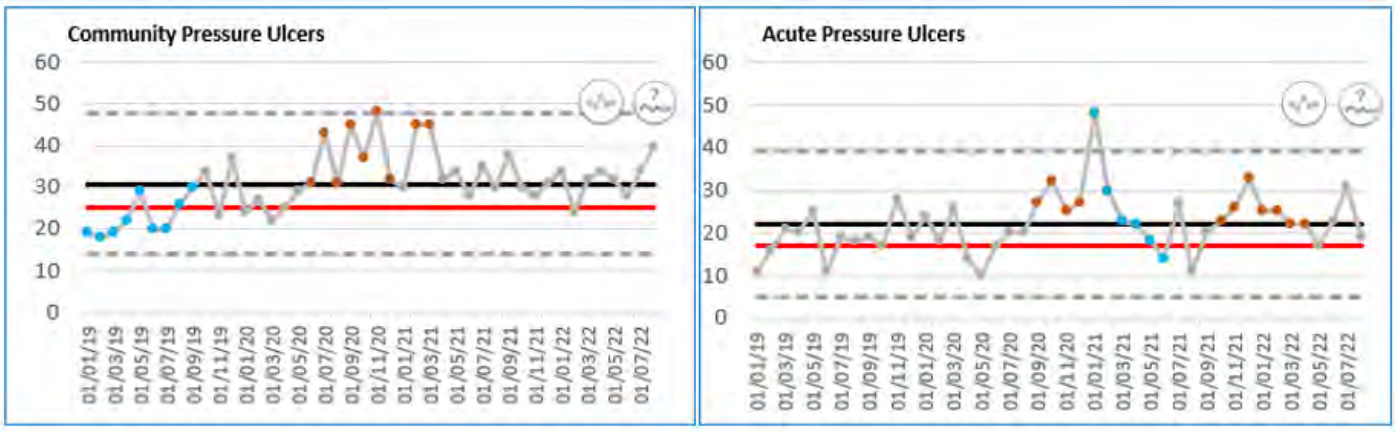


Chart 9a

8. Compliments and Complaints

In July the average number of calls to the clinical helpline was 104 and 101 per day in August the reduction in accessing the patient helpline is in keeping with the return to normal visiting times, however high numbers still indicate a positive need for the service.

Seventeen new complaints were received in July. The emergency department received the highest number of complaints with a total of four complaints. Ward F4 receive the second highest number of complaints with two complaints. The main theme for complaints received in July was patient care, with six complaints being listed under this subject heading. The highest sub-subject of complaints under this category was for care

needs not being adequately met with four complaints raised by patients or relatives who had concerns about the level of care being received.

Eighteen new complaints were received in August, one more than those received in July. The medical and surgical division both received eight complaints. Integrated community services and clinical support division each received one complaint. The areas to receive the highest number of complaints were the emergency department, ward F3 and the ENT department each receiving two complaints.

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

	Compliments	Complaints
February 2022	19	19
March 2022	24	15
April 2022	14	17
May 2022	17	15
June 2022	32	20
July 2022	42	17
August 2022	19	18

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 if necessary, reviewed retrospectively.

- In July there were 34 Datixs recorded for nurse staffing that resulted in a Red Flag event (see table 11.). No harm is recorded for these incidents at the time.

- In August there were 37 Datixs recorded for inpatient nurse staffing that resulted in a Red Flag event (see table 11). One incident was recorded as major harm, and this was reviewed at EIR. The division has reviewed and downgraded this to incident to no harm and staff support offered.

Red Flag	Feb 22	Mar 22	Apr 22	May 22	June 22	July 22	Aug 22
Registered nursing shortfall of more than 8 hours or >25% of planned nursing hours	9	16	10	1	7	12	7
>30-minute delay in providing pain relief	3	1	6	1	-	2	2
Delay or omission of intention rounding	5	8	2	-	5	3	3
<2 RNs on a shift	3	8	6	-	5	1	5
Vital signs not recorded as indicated on care plan	2	4	3	1	-	1	2
Unplanned omissions in providing medication	2	2	-	-	-	-	-
Lack of appointments (local agreed red flag)	0	0	-	1	3	1	-
Delay in routine care (new descriptor)	10	12	17	11	18	14	18
Impact not described	-	2	-	-	-	-	-
Total	34	53	44	15	38	34	37

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	January	February	March	April	May	June	July	August
Supernumerary Status of LS Coordinator	100%	99%	99%	98.3%	100%	100%	98.8%	99%	98%
1-1 Care in Labour	100%	100%	99.5%	100%	100%	100%	100%	100%	98%
MW: Birth Ratio	1:28	1:28	1:27	1:28	1:26	1:27.5	1:25	1:27	1:27
No. Red Flags reported		46	27	40	6	9	24	13	9

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 thirteen red flag events in July. No harm was recorded as in impact of these incidents
- There were nine red flag events in August. No harm was recorded as in impact of these incidents.

Midwife to Birth ratio

Midwife to Birth ratio was 1.27 in July and August, 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 care was achieved 100% in July but was 98% in August driven by high acuity in the unit combined with staff absences.

Supernumerary status of the labour suite co-ordinator

This is a CNST 10 steps to safety requirement and was highlighted as a 'should' from the CQC report in January 2020. The band 7 labour suite co-ordinator should not have direct responsibility of care for any women. This is to enable the co-ordinator to have situational awareness of what is occurring on the unit and is recognised not only as best but safest practice.

- In July 99% compliance against this standard was achieved
- In August 98% compliance was achieved.

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

11. Community & Integrated services division

12.1 Demand

Demand within the community setting can be illustrated by the number of referrals each service receives. Chart 12a and 12b are examples of the rise in demand for both community nursing and community therapy experienced in the last year. The demand on community healthcare teams, and community and integrated therapies in general remains high and above pre -pandemic averages. Referrals to therapy in the INTs had been reducing, although levels are still above our average. Other services such as Speech & Language therapy and Early Supported Stroke Discharge are of a similar picture.

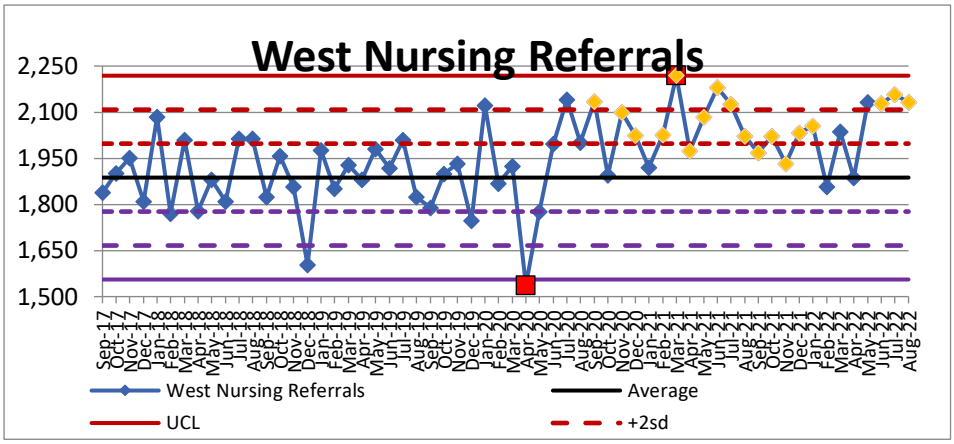


Chart 12a

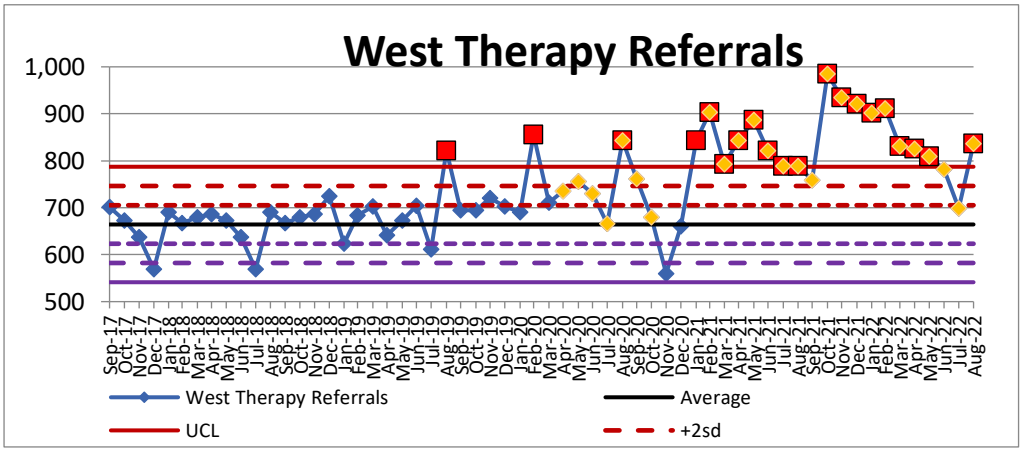


Chart 12b

12.2 Prioritisation of nursing patients

All patients are prioritised using rag rated care plans. This allows the senior team to identify, from the 120-140 number of visits expected to occur that day, which are most urgent and require prioritisation. This allows the team to have flexibility when managing nursing/therapy resource and can defer low urgency visits to the following day. There is currently no automated method to calculate the care hours. Care plan hours are calculated manually and balanced against WTE staffing levels. Long term plans include the sourcing a license for a national modelling tool to support better demand and capacity modelling.

12.3 Sickness

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

12.4 Vacancies in CHTS

Role	Vacancy percentage	
	Last reported	August
RNs	20%	17%
Physiotherapists	19%	17%
Occupational therapists	16%	13%
Generic workers /unregistered	15%	11%

12.5 Ongoing actions being taken by division

- Vacancies that have received no interest are being reviewed to assess if a change of skill mix may be more successful
- Rapid pool CHT nursing going live on 22/9/22
- Team leads focusing on staff well-being to help retain staff.
- Those teams on health roster are monitored and A/L is in line with guidance.

12. Biannual staffing review

The summer round of Safer Nursing Care Tool audit was completed in June/July and following analysis of outcomes, meetings have commenced with ward teams to triangulate the outcome with professional judgement and nursing quality metrics.

The results of the SNCT will be completed and presented at the next iteration of board, following approval and agreement of any changes to establishments at investment panel

13. Recommendations and Further Actions

- Note the impact of 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 (July 2022): Data adapted from Unify submission

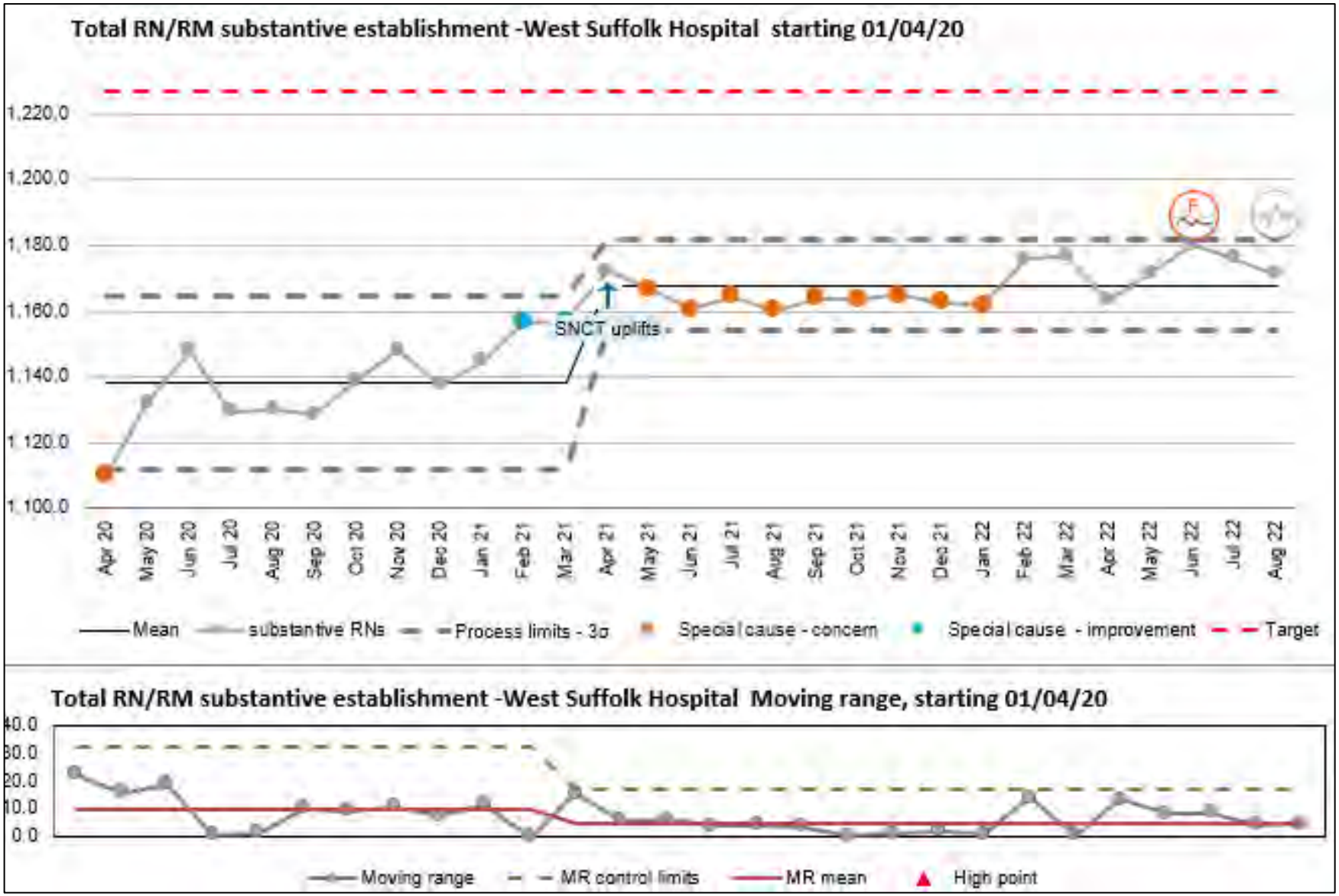
RAG: Red <79%, Amber 80-89%, Green 90-100%, Purple >100%

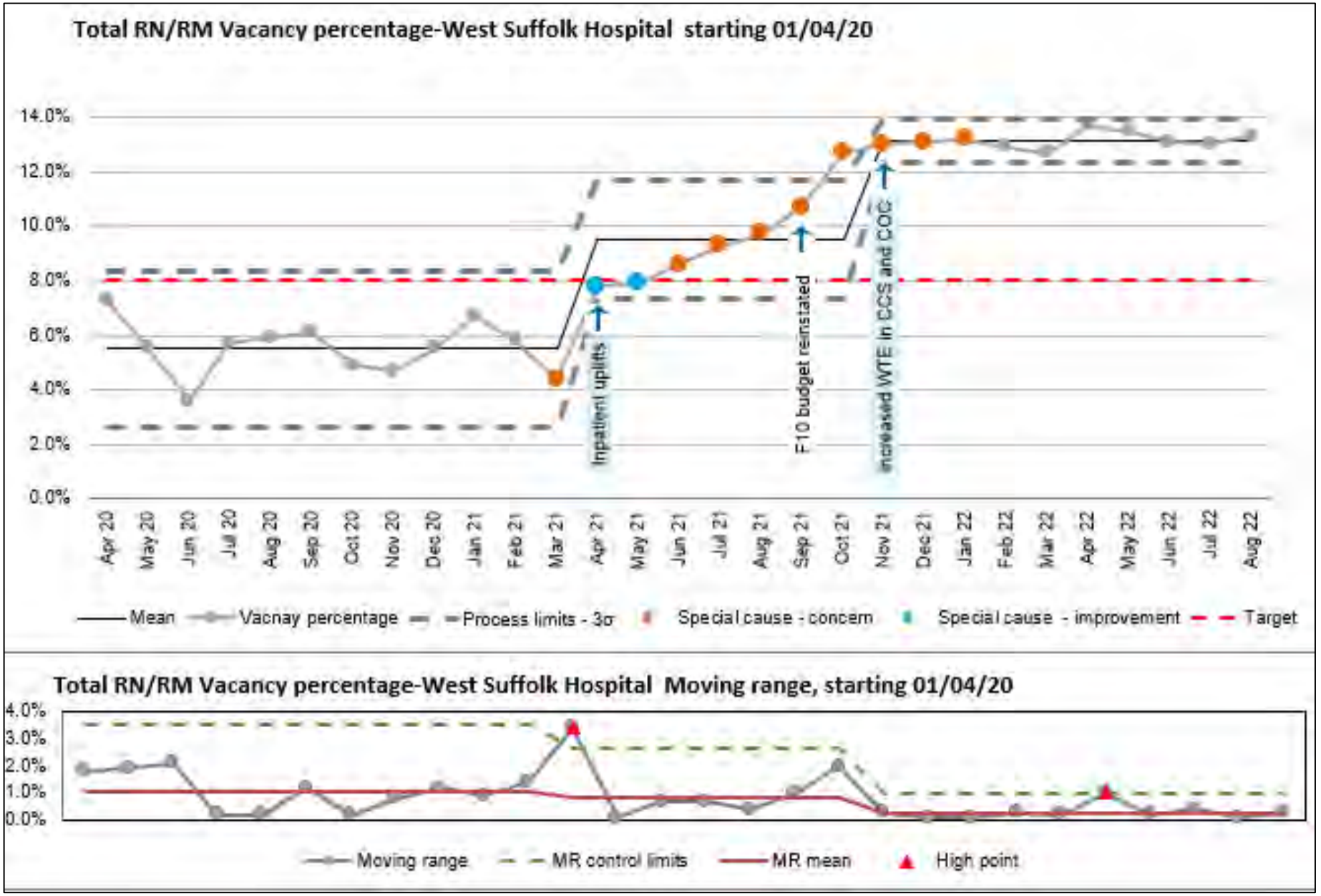
	Day				Night				Day		Night		Care Hours Per Patient Day (CHPPD)			
	RNs/RMN		Non registered (Care staff)		RNs/RMN		Non registered (Care staff)									
	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned 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 day	RNS/RMs	Non registered (care staff)	Overall
Rosemary Ward	971.5	923.5	2119.25	1242.5	1000.5	897	1426	1250.5	95%	59%	90%	88%	452	4.0	5.5	9.5
Glastonbury Cour	717	725	1071.5	959	713	708.5	542.5	525	101%	90%	99%	97%	384	3.7	3.9	7.6
Acute Assessmen	2135.5	1760.8333	2487	1220.75	1765	1632	1426	1091.5	82%	49%	92%	77%	761	4.5	3.0	7.5
Cardiac Centre	2916	2429.5	1362.5	978	1782.5	1468.5	704	495	83%	72%	82%	70%	632	6.2	2.3	8.5
G10	1415	1175.2833	1426	1082.75	1069.5	900	1426	1271.5	83%	76%	84%	89%	707	2.9	3.3	6.3
G9	1410	1211.5	1418	1048.5	1426	1115.5	1069.5	1248	86%	74%	78%	117%	752	3.1	3.1	6.1
F12	558	639.83333	356.5	201.75	708	571	356.5	307	115%	57%	81%	86%	240	5.0	2.1	7.2
F7	1759.5	1363	1690.5	1191	1422.5	1156	1782.5	1190.25	77%	70%	81%	67%	683	3.7	3.5	7.2
G1	1617.5	1030	359.5	281.5	701.5	724.5	356.5	299	64%	78%	103%	84%	485	3.6	1.2	4.8
G3	1779	1335.75	1769.5	1412.75	1069.5	943.9166667	1060	1337.75	75%	80%	88%	126%	864	2.6	3.2	5.8
G4	1795	1377.75	1840.5	1480.5	1069.5	891	1426.5	1220.5	77%	80%	83%	86%	896	2.5	3.0	5.5
G5	1771	1652.5	1768.16667	1337.9167	1058	962	1405	1219.5	93%	76%	91%	87%	760	3.4	3.4	6.8
G8	2495	1709.5833	1781.25	1324.25	1782.5	1351.25	1065.5	954.5	69%	74%	76%	90%	615	5.0	3.7	8.7
F8	1427.5	1386	2101	1397.5	1069.5	762	1426	1251	97%	67%	71%	88%	723	3.0	3.7	6.6
Critical Care	2837	2669.5	341	115	2852	2687.25	0	34	94%	34%	94%	*	388	13.8	0.4	14.2
F3	1768.5	1646	2139.5	1322.5	1069	1069	1426	1352.5	93%	62%	100%	95%	732	3.7	3.7	7.4
F4	954.5	904	954.5	597	713	690	598	494.5	95%	63%	97%	83%	633	2.5	1.7	4.2
F5	1782.5	1502	1426	1014.25	1064	904	1069.5	891.5	84%	71%	85%	83%	698	3.4	2.7	6.2
F6	2024	1735.0833	1647.66667	993.41667	1403	1116	713	751.5	86%	60%	80%	105%	942	3.0	1.9	4.9
Neonatal Unit	1038.5	1171	372	579	1020	1080	348	468	113%	156%	106%	134%	116	19.4	9.0	28.4
F1	1228.5	1502	710.25	694.75	1075.75	1213.75	0	220	122%	98%	113%	*	115	23.6	8.0	31.6
F14	770.5	821.43333	312	240	744	755	0	24	107%	77%	101%	*	106	14.9	2.5	17.4
Total	35,171.50	30,671.05	29,454.08	20,714.58	26,578.25	23,598.17	19,627.00	17,897.00	**87%**	**70%**	**89%**	**91%**	**12684**	**4.3**	**3.0**	**7.3**
* planned hours are zero, so additional support used on ward to mitigate unfilled nursing hours																

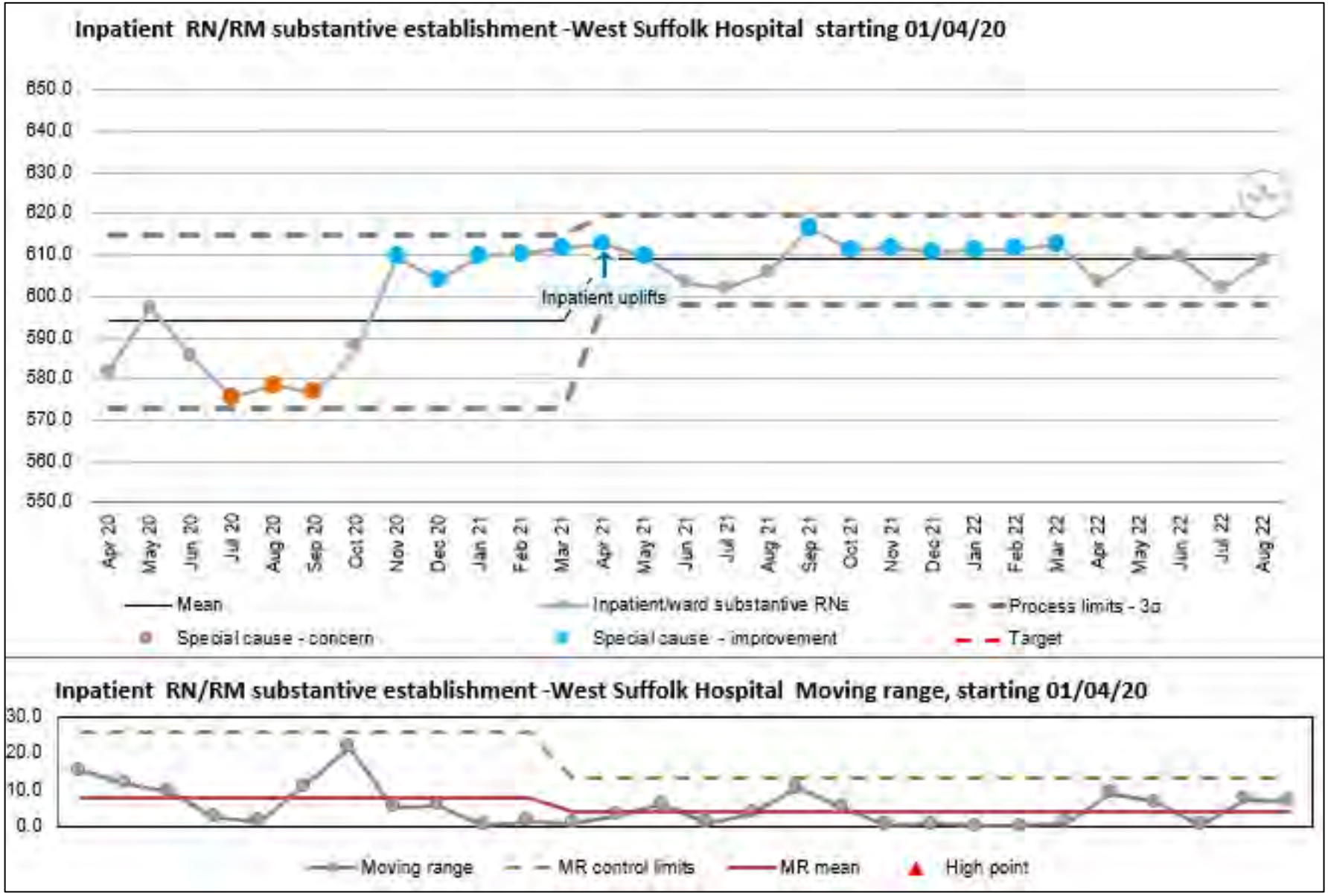
Appendix 1. Fill rates for inpatient areas (August 2022): Data adapted from Unify submission

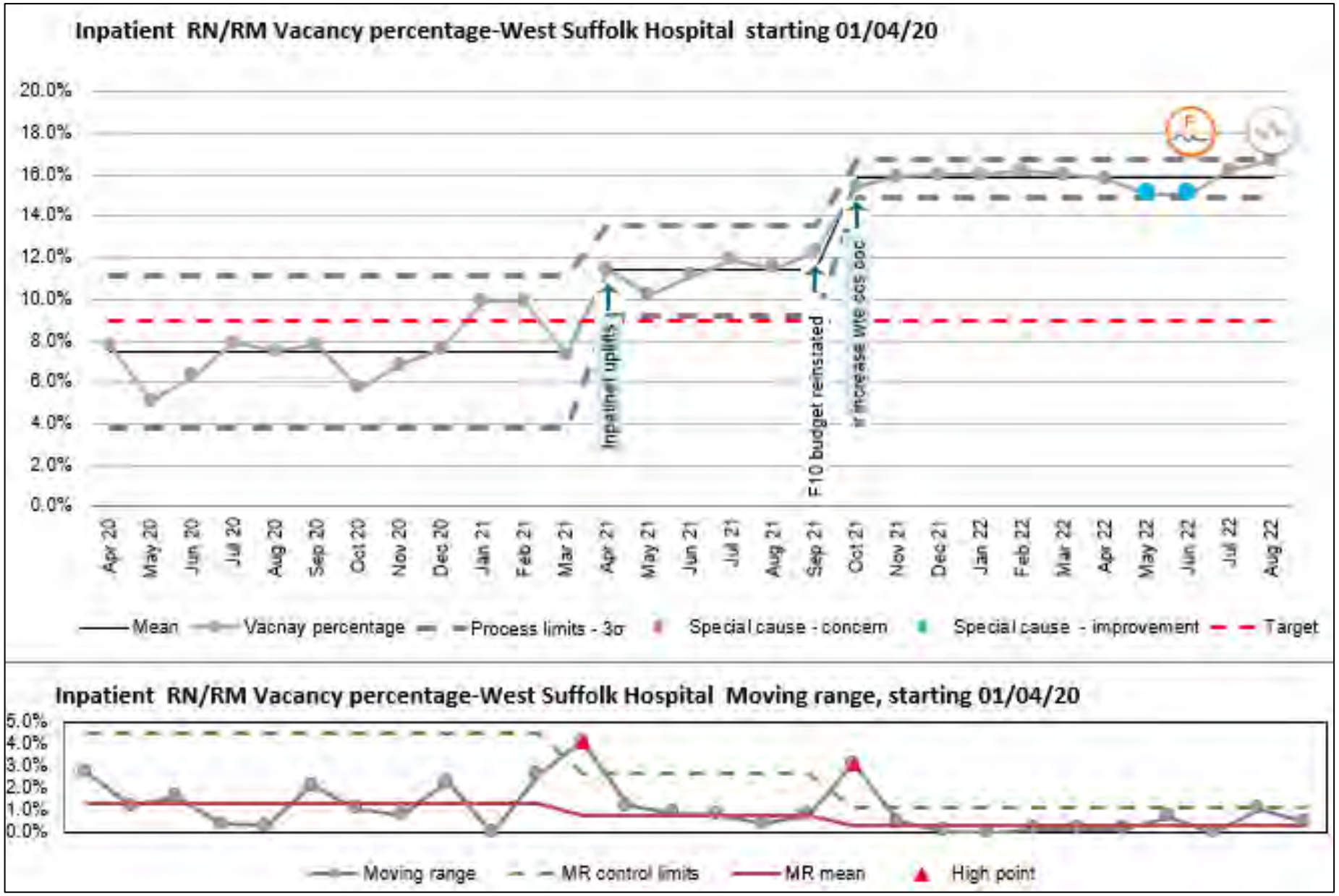
	Day				Night				Day		Night		Care Hours Per Patient Day (CHPPD)			
	RNs/RMN		Non registered (Care staff)		RNs/RMN		Non registered (Care staff)									
	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Average Fill rate RNs/RM %	Average fill rate Care staff %	Average Fill rate RNs/RM %	Average fill rate Care staff %	Cumulative count over the month of patients at 23:59 each day	RNS/RMs	Non registered (care staff)	Overall
Rosemary Ward	1048	1029.75	1980.75	1448	1035	934	1426	1218	98%	73%	90%	85%	452	4.3	5.9	10.2
Glastonbury Cour	711.5	719	1057	957.5	698.5	681.5	542.5	567	101%	91%	98%	105%	384	3.6	4.0	7.6
Acute Assessmen	2131.5	1762.75	1822.5	1344.25	1782.5	1548	1184.5	1124.5	83%	74%	87%	95%	761	4.4	3.2	7.6
Cardiac Centre	2959	2401.5	1315.5	1017.25	1782.5	1460.5	713	545.5	81%	77%	82%	77%	632	6.1	2.5	8.6
G10	1450.61667	1173.5	1453	1198.5	1070	898	1426	1240.5	81%	82%	84%	87%	707	2.9	3.4	6.4
G9	1424	1148.25	1421	1252	1426	1134.916667	1069.5	1111	81%	88%	80%	104%	752	3.0	3.1	6.2
F12	560.5	588	356.5	297.5	713	488.5	356.5	448.5	105%	83%	69%	126%	240	4.5	3.1	7.6
F7	1782	1339.5	1611.5	1383.1667	1426	1120	1772.016667	1362.51667	75%	86%	79%	77%	683	3.6	4.0	7.6
G1	1658.5	1075.1667	356.5	304.5	713	713	356.5	337	65%	85%	100%	95%	485	3.7	1.3	5.0
G3	1701.5	1286.5	1777.5	1522	1069.5	928.8333333	1069.5	1400.75	76%	86%	87%	131%	864	2.6	3.4	5.9
G4	1782.5	1441.5	1835	1594	1069.5	816.5	1445.5	1203	81%	87%	76%	83%	896	2.5	3.1	5.6
G5	1426	1490.5	1782.5	1571	706.5	1003	1386.25	1373.25	105%	88%	142%	99%	760	3.3	3.9	7.2
G8	2495.5	1771.5833	1790.5	1120.75	1782.5	1408.866667	1069.5	954.416667	71%	63%	79%	89%	615	5.2	3.4	8.5
F8	1426	1419.25	2117.25	1556.5167	1069.5	798.3333333	1426	1300.5	100%	74%	75%	91%	723	3.1	4.0	7.0
Critical Care	2852.5	2819.4167	333.5	151	2852	2684.5	0	45.5	99%	45%	94%	*	388	14.2	0.5	14.7
F3	1782.25	1610.4667	2129.25	1333	1069.5	1046.8	1426	1284.5	90%	63%	98%	90%	732	3.6	3.6	7.2
F4	977.5	906.58333	977.5	644	713	668.5	614.5	465	93%	66%	94%	76%	633	2.5	1.8	4.2
F5	1773	1441	1426	1014.25	1069.5	946.5	1052.5	883.5	81%	71%	88%	84%	698	3.4	2.7	6.1
F6	2018.25	1811.4167	1672.75	1152.5	1426	1122	713	786.5	90%	69%	79%	110%	942	3.1	2.1	5.2
Neonatal Unit	1068	1302	420	576.25	936	948	384	488.5	122%	137%	101%	127%	116	19.4	9.2	28.6
F1	1891.5	1541.75	713	662.5	1426	1150	0	211	82%	93%	81%	*	115	23.4	7.6	31.0
F14	772	815.5	324	298	744	744	0	84	106%	92%	100%	*	106	14.7	3.6	18.3
Total	35,692.12	30,894.88	28,673.00	22,398.43	26,580.00	23,244.25	19,433.27	18,434.93	**87%**	**78%**	**87%**	**95%**	**12684**	**4.3**	**3.2**	**7.5**
* planned hours are zero, so additional support used on ward to mitigate unfilled nursing hours																

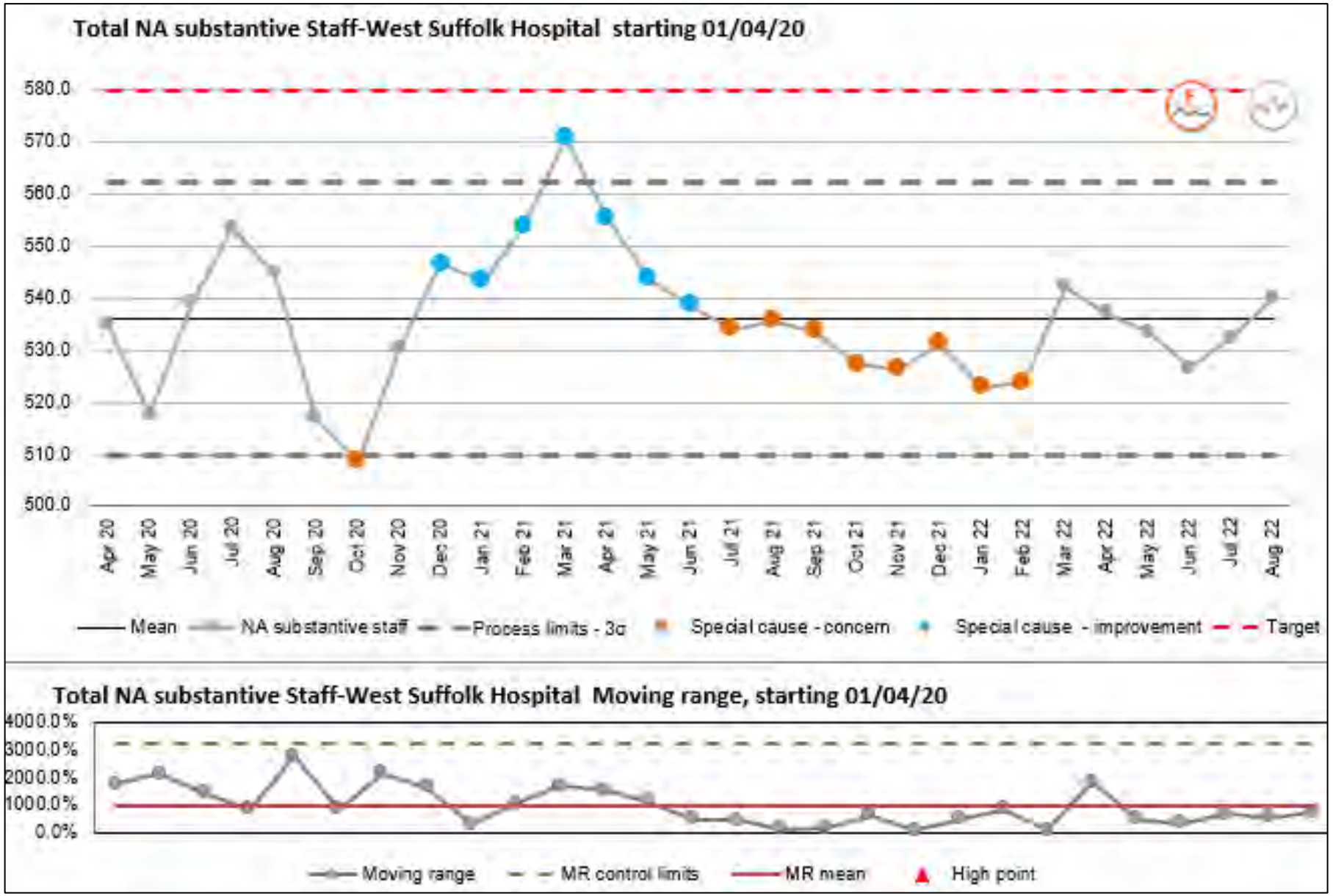
Appendix 2 SPC charts

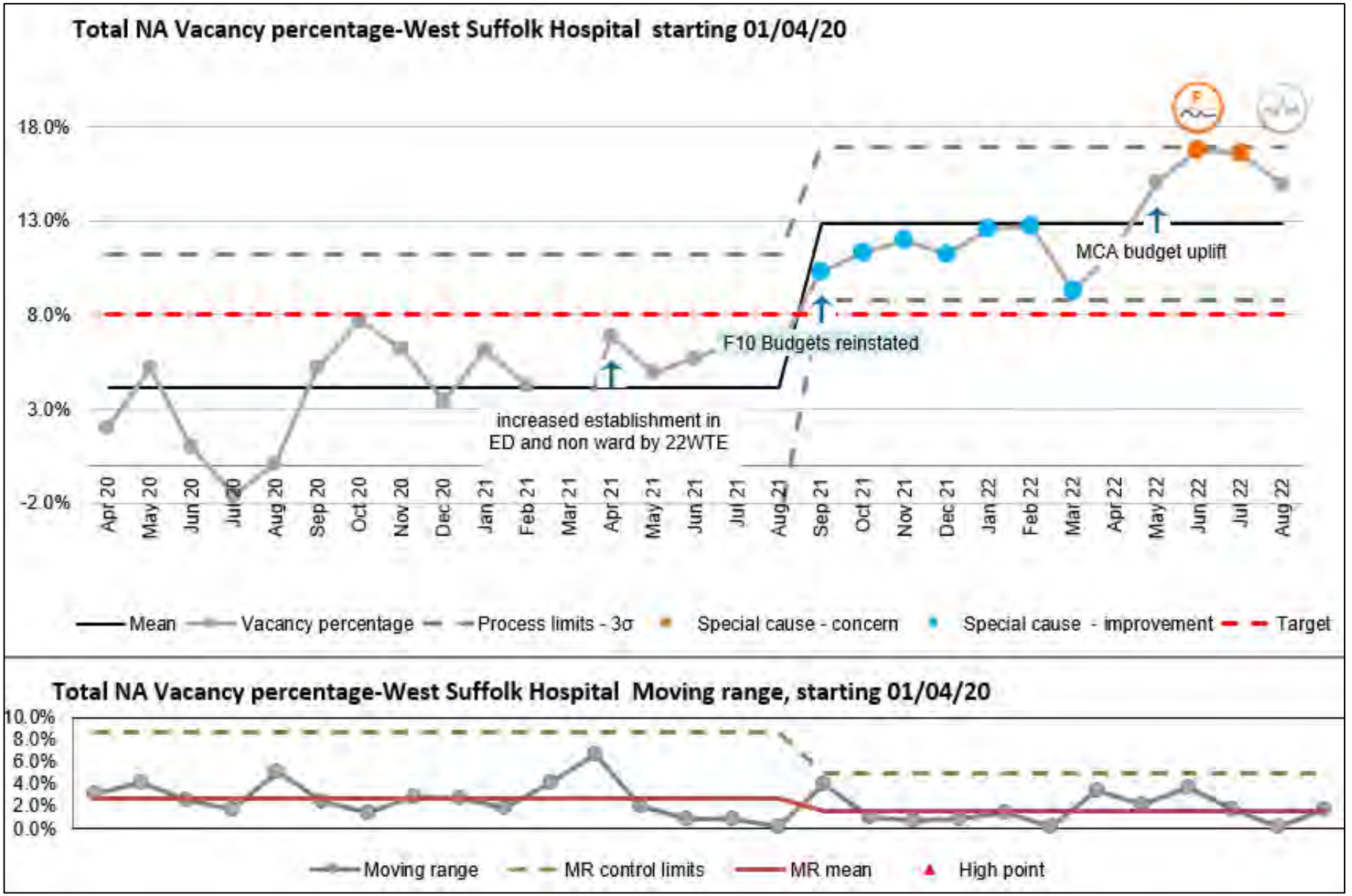


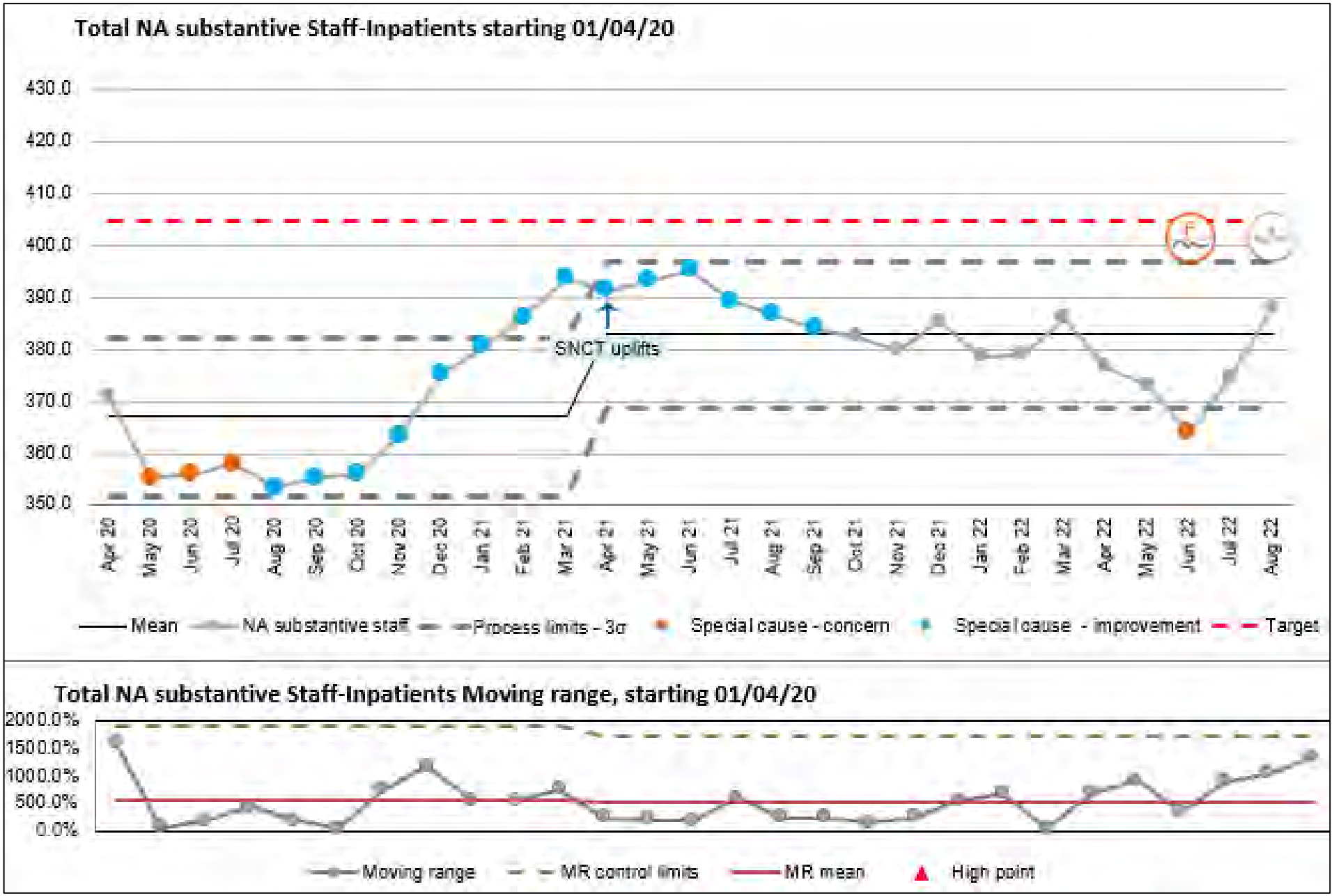

Total RN/RM Vacancy percentage-West Suffolk Hospital starting 01/04/20
14.0%
12.0%
10.0%
8.0%
6.0%
4.0%
2.0%
0.0%
Inpatient uplifts
F10 budget reinstated
increased WTE in CCS and COC
Apr 20
May 20
Jun 20
Jul 20
Aug 20
Sep 20
Oct 20
Nov 20
Dec 20
Jan 21
Feb 21
Mar 21
Apr 21
May 21
Jun 21
Jul 21
Aug 21
Sep 21
Oct 21
Nov 21
Dec 21
Jan 22
Feb 22
Mar 22
Apr 22
May 22
Jun 22
Jul 22
Aug 22
Mean
Vacnay percentage
Process limits - 3σ
Special cause - concern
Special cause - improvement
Target
Total RN/RM 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

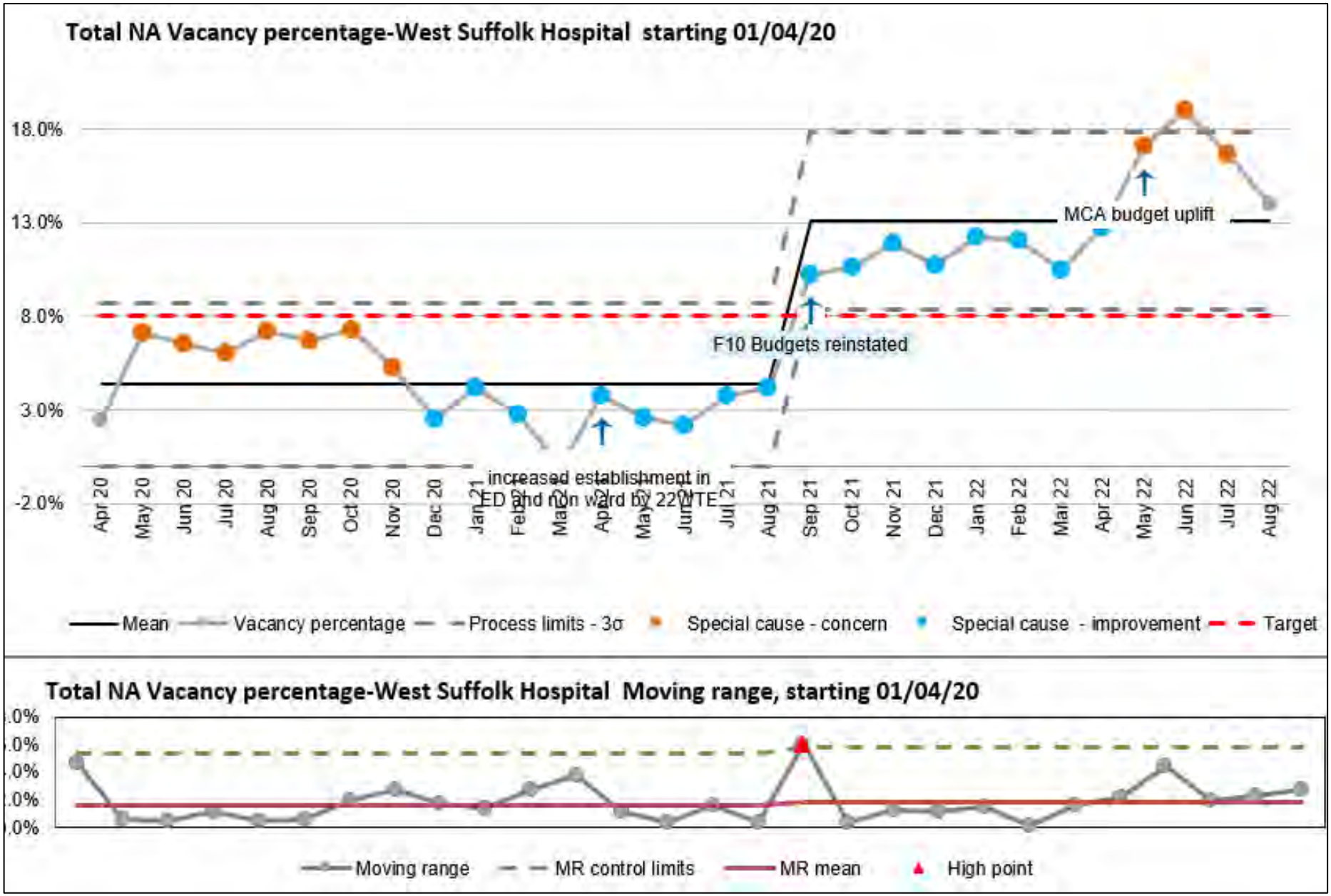

Inpatient RN/RM substantive establishment -West Suffolk Hospital starting 01/04/20
650.0
640.0
630.0
620.0
610.0
600.0
590.0
580.0
570.0
560.0
550.0
Inpatient uplifts
Apr 20
May 20
Jun 20
Jul 20
Aug 20
Sep 20
Oct 20
Nov 20
Dec 20
Jan 21
Feb 21
Mar 21
Apr 21
May 21
Jun 21
Jul 21
Aug 21
Sep 21
Oct 21
Nov 21
Dec 21
Jan 22
Feb 22
Mar 22
Apr 22
May 22
Jun 22
Jul 22
Aug 22
Mean
Inpatient/ward substantive RNs
Process limits - 3σ
Special cause - concern
Special cause - improvement
Target
Inpatient RN/RM 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%
Inpatient uplifts
F10 budget reinstated
Apr 20
May 20
Jun 20
Jul 20
Aug 20
Sep 20
Oct 20
Nov 20
Dec 20
Jan 21
Feb 21
Mar 21
Apr 21
May 21
Jun 21
Jul 21
Aug 21
Sep 21
Oct 21
Nov 21
Dec 21
Jan 22
Feb 22
Mar 22
Apr 22
May 22
Jun 22
Jul 22
Aug 22
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


Total 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
May 22
Jun 22
Jul 22
Aug 22
Mean
NA substantive staff
Process limits - 3σ
Special cause - concern
Special cause - improvement
Target
Total 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
18.0%
13.0%
8.0%
3.0%
-2.0%
MCA budget uplift
F10 Budgets reinstated
increased establishment in
ED and non ward by 22WTE
Apr 20
May 20
Jun 20
Jul 20
Aug 20
Sep 20
Oct 20
Nov 20
Dec 20
Jan 21
Feb 21
Mar 21
Apr 21
May 21
Jun 21
Jul 21
Aug 21
Sep 21
Oct 21
Nov 21
Dec 21
Jan 22
Feb 22
Mar 22
Apr 22
May 22
Jun 22
Jul 22
Aug 22
Mean
Vacancy percentage
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


Total NA substantive Staff-Inpatients starting 01/04/20
430.0
420.0
410.0
400.0
390.0
380.0
370.0
360.0
350.0
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
May 22
Jun 22
Jul 22
Aug 22
Mean
NA substantive staff
Process limits - 3σ
Special cause - concern
Special cause - improvement
Target
Total NA substantive Staff-Inpatients Moving range, starting 01/04/20
200.0%
150.0%
100.0%
50.0%
0.0%
Moving range
MR control limits
MR mean
High point


Total NA Vacancy percentage-West Suffolk Hospital starting 01/04/20
18.0%
13.0%
8.0%
3.0%
-2.0%
MCA budget uplift
F10 Budgets reinstated
increased establishment in ED and non ward by 22WTE
Apr 20
May 20
Jun 20
Jul 20
Aug 20
Sep 20
Oct 20
Nov 20
Dec 20
Jan 21
Feb 21
Mar 21
Apr 21
May 21
Jun 21
Jul 21
Aug 21
Sep 21
Oct 21
Nov 21
Dec 21
Jan 22
Feb 22
Mar 22
Apr 22
May 22
Jun 22
Jul 22
Aug 22
Mean
Vacancy percentage
Process limits - 3σ
Special cause - concern
Special cause - improvement
Target
Total NA Vacancy percentage-West Suffolk Hospital Moving range, starting 01/04/20
Moving range
MR control limits
MR mean
High point

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

Jul-22										
Ward/Department	Register Nurses/Midwives				Ward/Department	NA/MCA				Combined RN/NA
	Actual establishmet	Budgetted establishment	Vacancy rate (WTE)	Vacancy percentage %		Actual Establishment	Budgeted Establishment	Vacancy rate (WTE)	Percentage Vacancy %	Total Vacancy %
AAU	26.0	30.1	4.2	13.8	AAU	18.8	28.3	9.5	33.6	23.4
Accident & Emergency	53.2	69.5	16.3	23.5	Accident & Emergency	32.4	34.5	2.1	6.1	17.7
Cardiac Centre	33.5	40.7	7.2	17.6	Cardiac Centre	14.1	15.7	1.6	10.2	15.6
Glastonbury Court	11.9	11.7	-0.2	-1.6	Glastonbury Court	10.5	12.6	2.2	17.1	8.1
Critical Care Services*	44.2	50.0	5.8	11.6	Critical Care Services	2.4	1.9	-0.5	-25.0	10.3
Day Surgery Wards	12.3	11.0	-1.3	-12.2	Day Surgery Wards	2.9	3.9	1.0	26.0	-2.3
Gynae Ward (On F14)	15.0	14.1	-0.9	-6.5	Gynae Ward (On F14)	2.0	2.0	0.0	0.0	-5.7
Neonatal Unit	19.0	20.6	1.6	7.8	Neonatal Unit	9.2	10.1	0.9	8.5	8.0
Rosemary ward	15.4	15.4	0.0	0.0	Rosemary ward	21.1	27.0	5.9	21.9	13.9
Recovery Unit	25.3	27.3	2.0	7.4	Recovery Unit	0.9	0.9	0.0	1.2	7.2
Ward F1 Paediatrics	20.2	24.1	3.9	16.1	Ward F1 Paediatrics	7.5	7.7	0.2	3.0	12.9
Ward F12	8.7	11.9	3.2	26.8	Ward F12	5.1	5.9	0.7	12.1	22.0
Ward F3	21.7	22.2	0.4	1.9	Ward F3	20.7	25.8	5.2	20.0	11.6
Ward F4	12.8	13.6	0.8	6.2	Ward F4	11.3	14.6	3.3	22.6	14.6
Ward F5	19.4	22.2	2.8	12.6	Ward F5	13.8	18.1	4.3	23.6	17.5
Ward F6	22.5	26.6	4.1	15.5	Ward F6	14.1	17.4	3.3	19.0	16.9
Ward F7 Short Stay	19.6	24.9	5.4	21.5	Ward F7 Short Stay	21.5	25.8	4.3	16.6	19.0
Ward F9 (now G5)	19.7	21.8	2.1	9.8	Ward G5	18.5	23.2	4.7	20.2	15.1
Ward G1 Hardwick Unit	28.3	29.6	1.3	4.5	Ward G1 Hardwick Unit	10.2	10.5	0.3	3.1	4.1
Ward G3	20.2	22.1	1.9	8.4	Ward G3	26.2	23.0	-3.2	-13.8	-3.0
Ward G4	18.2	22.1	3.9	17.6	Ward G4	18.6	23.5	4.9	20.8	19.2
Ward G8	19.8	32.7	12.9	39.5	Ward G8	20.0	20.6	0.6	2.8	25.3
Renal Ward - F8	18.3	19.5	1.2	6.3	Renal Ward - F8	19.3	25.8	6.5	25.1	17.0
Ward G10	14.4	19.0	4.6	24.2	Ward G10	18.4	24.1	5.7	23.7	23.9
Respiratory Ward - G9	16.0	23.7	7.7	32.4	Respiratory Ward - G9	18.1	18.0	-0.1	-0.4	18.2
Total	535.4	626.2	90.8	**14.5**	Total	357.5	420.8	63.3	**15.0**	**14.7**
Hospital Midwifery	48.7	58.9	10.2	17.3	Hospital Midwifery	17.0	28.5	11.5	40.4	24.8
Community Midwifery	17.8	19.1	1.3	7.0	Community Midwifery	5.8	7.5	1.7	22.7	0.0
Midwifery management	12.7	13.3	0.6	4.5						
Continuity of Carer Midwifery*	16.8	31.0	14.2	45.8						
Total	96.0	122.3	26.3	**21.5**	Total	22.8	36.0	13.2	**36.7**	**25.0**

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

Aug-22									
Ward/Department	Register Nurses/Midwives				Ward/Department	NA/MCA			
	Actual establishmet	Budgetted establishment	Vacancy rate (WTE)	Vacancy percentage %		Actual Establishment	Budgeted Establishment	Vacancy rate (WTE)	Percentage Vacancy %
AAU	24.7	30.1	5.4	17.9	AAU	17.7	28.3	10.6	37.5
Accident & Emergency	54.5	69.5	15.0	21.5	Accident & Emergency	35.2	34.5	-0.7	-2.1
Cardiac Centre	33.6	40.7	7.1	17.5	Cardiac Centre	15.1	15.7	0.7	4.1
Glastonbury Court	11.4	11.7	0.3	2.1	Glastonbury Court	10.5	12.6	2.2	17.1
Critical Care Services*	43.2	50.0	6.8	13.6	Critical Care Services	2.0	1.9	-0.1	-3.7
Day Surgery Wards	10.9	11.0	0.1	0.8	Day Surgery Wards	2.9	3.9	1.0	26.0
Gynae Ward (On F14)	15.0	14.1	-1.0	-6.9	Gynae Ward (On F14)	2.0	2.0	0.0	0.0
Neonatal Unit	19.8	20.6	0.8	3.8	Neonatal Unit	8.7	10.1	1.4	13.7
Rosemary ward	14.8	18.4	3.6	19.6	Rosemary ward	20.9	24.8	3.9	15.6
Recovery Unit	27.8	27.3	-0.5	-1.7	Recovery Unit	0.9	0.9	0.0	1.2
Ward F1 Paediatrics	20.7	24.1	3.4	14.2	Ward F1 Paediatrics	7.5	7.7	0.2	2.9
Ward F12	7.1	11.9	4.8	40.6	Ward F12	5.1	5.9	0.7	12.1
Ward F3	21.7	22.2	0.4	1.9	Ward F3	20.1	25.8	5.8	22.3
Ward F4	12.8	15.0	2.3	15.0	Ward F4	12.1	12.4	0.3	2.7
Ward F5	19.3	22.2	2.9	12.9	Ward F5	14.3	18.1	3.8	20.7
Ward F6	20.4	26.6	6.2	23.2	Ward F6	14.7	17.4		#VALUE!
Ward F7 Short Stay	19.9	24.9	5.0	20.2	Ward F7 Short Stay	20.1	25.8	5.7	22.0
Ward G5	19.2	21.8	2.6	11.8	Ward G5	20.1	23.2	3.1	13.3
Ward G1 Hardwick Unit	28.6	29.6	1.0	3.3	Ward G1 Hardwick Unit	10.2	10.5	0.3	3.1
Ward G3	18.2	22.1	3.9	17.4	Ward G3	26.5	23.0	-3.6	-15.4
Ward G4	18.2	22.1	3.9	17.6	Ward G4	18.6	23.5	4.9	20.9
Ward G8	20.2	32.7	12.5	38.2	Ward G8	20.2	20.6	0.4	1.9
Renal Ward - F8	17.2	19.5	2.3	11.7	Renal Ward - F8	19.3	25.8	6.5	25.1
Ward G10	13.8	19.0	5.2	27.4	Ward G10	19.1	24.1	5.0	20.7
Respiratory Ward - G9	14.8	23.7	8.9	37.5	Respiratory Ward - G9	18.1	18.0	-0.1	-0.4
Total	527.9	630.6	102.7	**16.3**	Total	361.7	416.3	54.6	**13.1**
Hospital Midwifery	42.7	58.9	16.2	27.5	Hospital Midwifery	19.3	28.5	9.2	32.3
Midwifery management	16.9	17.4	0.5	2.9					
Continuity of Carer Midwifery*	37.0	39.1	2.1	5.4					
Total	96.6	115.4	18.8	**16.3**	Total	19.3	28.5	9.2	**32.3**

Appendix 4:

Ward by Ward breakdown of Falls and Pressure ulcers July and August 2022

HAPU

July 2022	Cat 2	Unstageable	Cat 4	Total
Cardiac Centre - Ward	1	0	0	1
F12 Isolation Ward	1	0	0	1
F3 - ward	1	0	0	1
G1 - ward	1	0	0	1
G3 - Endocrine and General Medicine	0	1	0	1
Rosemary Ward	1	0	0	1
Critical Care Unit	2	0	0	2
G8 - Stroke Ward	2	0	0	2
Renal Ward	2	0	0	2
G4 - ward	2	0	1	3
Gastroenterology Ward	3	0	0	3
Respiratory Ward	4	0	0	4
F7	7	1	0	8
Total	27	2	1	30

August 2022	Cat 2	Unstageable	Cat 3/4	Total
Cardiac Centre - Ward	1	0	0	1
F3 - ward	1	0	0	1
G1 - ward	1	0	0	1
G10	1	0	0	1
G8 - Stroke Ward	1	0	0	1
Labour Suite (CDS)	1	0	0	1
Renal Ward	0	1	0	1
G3 - Endocrine and General Medicine	2	0	0	2
Gastroenterology Ward	2	0	0	2
Critical Care Unit	3	0	0	3
Respiratory Ward	3	0	0	3
Total	16	1	0	17

Falls

JULY 2022	None	Negligible	Minor	Moderate	Major	Total
Cardiac Centre - Diagnostics	0	0	1	0	0	1
CHT Haverhill	1	0	0	0	0	1
CHT Newmarket	1	0	0	0	0	1
Community Cardiac Rehab Team	1	0	0	0	0	1
F10	0	0	0	0	1	1
Major Assessment Area (MAA)	0	1	0	0	0	1
F12 Isolation Ward	2	0	0	0	0	2
Cardiac Centre - Ward	3	0	0	0	0	3
F6 - ward	2	0	0	1	0	3
F3 - ward	3	0	0	1	0	4
F4 - ward	4	0	0	0	0	4
Renal Ward	2	0	2	0	0	4
Rosemary Ward	2	1	0	0	1	4
Emergency Department	3	0	1	0	0	4
G1 - ward	4	0	1	0	0	5
Respiratory Ward	2	2	1	0	0	5
G10	6	0	0	0	0	6
Glastonbury Court	4	0	2	0	0	6
G3 -	3	0	4	0	0	7
G4 - ward	5	0	3	0	0	8
Acute Assessment unit (AAU)	7	1	0	0	0	8
G8 - Stroke Ward	9	0	0	0	0	9
F7	10	0	0	0	0	10
Gastroenterology Ward	10	0	2	0	0	12
Total	84	5	17	2	2	110

August 2022	None	Negligible	Minor	Moderate	Major	Total
Cardiac Centre - Catheter Lab	1	0	0	0	0	1
Cardiac Centre - Ward	1	0	0	0	0	1
Community Paediatric PT	1	0	0	0	0	1
Emergency Department	1	0	0	0	0	1
F6 - ward	1	0	0	0	0	1
CHT Sudbury	2	0	0	0	0	2
F12 Isolation Ward	2	0	0	0	0	2
F4 - ward	2	0	0	0	0	2
Renal Ward	3	0	0	0	0	3
G1 - ward	3	0	1	0	0	4
G3 - Endocrine and General Me	3	0	2	0	0	5
Gastroenterology Ward	3	0	1	0	1	5
Glastonbury Court	5	0	0	0	0	5
F3 - ward	5	1	0	0	0	6
G8 - Stroke Ward	4	0	2	0	0	6
Rosemary Ward	4	0	2	0	0	6
Respiratory Ward	6	1	0	0	0	7
G10	8	0	0	0	0	8
Acute Assessment unit (AAU)	6	0	2	0	0	8
F7	8	0	1	0	0	9
G4 - ward	10	1	5	0	0	16
Total	79	3	16	0	1	99

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.

4.4.1. Maternity services Quality & Performance Report (10.00 am)

For Approval

Presented by Susan Wilkinson

Trust Open Board – 30th September 2022

Agenda item:	Maternity services quality & performance report			
Presented by:	Sue Wilkinson, Executive Chief Nurse/ Paul Molyneux, Interim Medical Director & Executive MatNeo Safety Champion/ Karen Newbury, Head of Midwifery, Justyna Skonieczny – Deputy Head of Midwifery, Simon Taylor Associate Director of Operations, Women & Children and Clinical Support Services & Kate Croissant, Deputy Clinical Director.			
Prepared by:	Karen Newbury, Head of Midwifery			
Date prepared:	15th September 2022			
Subject:	Maternity quality, safety and performance report			
Purpose:		For information	X	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. The papers presented are for information only and issues to note are captured in this summary report. All of the attached papers have been through internal governance process including the Maternity and Neonatal Safety Champions and will then be shared with the Local Maternity and Neonatal Set Board.

This report contains;

- Maternity improvement plan
- Safety champion feedback from walkabout
- Listening to staff
- Service user feedback
- Reporting and learning from incidents
- Maternity Dashboards (Annex A)
- HSIB/EN reporting Quarter 1 April-June 2022 (Annex B)
- ATAIN Q1 report – avoiding term admissions to NNU (Annex C)
- Neonatal Nursing Staffing Assessment Report (Annex D)
- Training Tracker and compliance Q1: April 2022-June 2022(Annex E)
- Exception Report – non-compliance with MSDS data submission for July 2022 - **CLOSED BOARD**
- Exception report for Neonatal Medical Staff Survey to Operational Delivery Network (ODN) (Annex G)
- Perinatal Mortality Report Q1 April-June 2022 **Full report to CLOSED BOARD**
- Transitional Care Q4 January- March 2022 (Annex H)
- Transitional Care Q1 April – June 2022 (Annex I)
- Digital Strategy for Maternity (Annex J)
- Perinatal surveillance toolkit – **CLOSED BOARD**
- HSIB quarterly review report – **CLOSED BOARD**

Maternity improvement plan

The Maternity Improvement Board receives the updated Maternity improvement plan on a monthly basis. This has been created through an amalgamation of the original CQC improvement plan with the wider requirements of Ockenden, HSIB, external site visits and self-assessment against other national best practice (e.g. MBRRACE, SBLCBv2, UKOSS). In addition, the plan has captured the actions needing completion from the 60 Supportive Steps visit from NHSE/I and continues to be reviewed by the Maternity Improvement Board every two weeks. It has been agreed with the proposed exit from the Maternity Safety Support Programme (MSSP) that NHSE regional team will be invited to attend the MIB monthly for additional assurance and scrutiny. An Assurance visit from the team is tentatively arranged for November this year.

Safety Champion Walkabout feedback

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

Individuals or groups of staff can raise the issues with the Board champion. An overview of the Walkabout content and responses is shared with all staff in the monthly governance newsletter 'Risky Business'.
Paul Molyneux (Executive Safety Champion & Medical Director) attended the Prompt training on 09/08/22 and his feedback is as follows;

While the subject matter around obstetric emergencies was rightly taken extremely seriously, there was a real sense of a safe space to learn in that it never felt intimidating or threatening. In this time no one raised any safety concerns to Paul and he wanted to share his observations of the day.

"There was so much professional behaviour demonstrated by the participants that it is hard to know where to begin in terms of describing it, but what most impressed me was that none of the participants ever forgot the need for human kindness and reassurance even in the face of simulated shoulder dystocia, breech delivery, Post-Partum Haemorrhage (PPH) and perinatal sepsis

It was a privilege to be able to join the Prompt training and something I will never forget."

Our NED Safety Champion Richard Davies visited the Community midwives in Haverhill on 08/09/22 and discussion points as follows;

- They feel very well supported by their managers
- Staffing issues are much improved following recruitment of admin support, a trainee midwife and a midwifery support worker. There is still only one full time midwife in Haverhill, so still short of midwives but much more manageable than it was.
- Accommodation is a key issue. The team had to move out of the Health Centre due to roof work and are 'temporarily' accommodated in the leisure centre. The accommodation is acceptable in an emergency but is not suitable for medium/long term and the team are concerned that they have no information about when this will be resolved (they feel they would cope better if they had a 'deadline').

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

The accommodation for all community midwifery teams is being reviewed by the operational team, however due to lack of suitable accommodation this is somewhat hindered.

Listening to Staff

The National Staff Satisfaction Survey results were published in April 2022 and the triumvirate team have collated an action plan in response to this. A very short temperature check survey will be sent to all midwifery staff this month.
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. Since the I-pads have been in place (August 22) we have seen an increase in returns. The patient experience team are working with the midwifery team to look at differing ways to increase returns further.

Ward/Dept	July Survey returns	July FFT score	Aug Survey returns	Aug FFT Score
F11	22	100	63	97
Antenatal	10	100	22	100
Postnatal Community	7	100	29	100
Labour Suite	0		22	100
Birthing Unit	0		9	100
NNU	0		0	

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

In July and Aug 2022, a total of 8 PALS enquiries and 0 complaints were received for maternity and Neonatal Unit (NNU).

Reporting and learning from incidents

During July there were nil cases and August 2022 two cases that were referred HSIB. Initial Patient Safety Reviews were undertaken with an external member on the panel and the immediate recommendations that were identified have been actioned. Once the full HSIB reports are available these will be shared with the Board as per Ockenden instructions.

Maternity dashboards (Annex A)

Indicators of maternity safety & quality are regularly reported and reviewed at monthly Maternity Governance meetings. A sub-set are provided for board level performance (the Performance & Governance dashboard). Red rated data will be represented in line with the

national NHSI model of SPC charts.

Indicators	Narrative
Decision to delivery times for grade 2 sections	Although the number of cases has not decreased the amount of time for the delay is decreasing. Out of the 9 cases that did not meet the expected target 8 occurred 'out of hours' weekends or nights. QI work continues.
Induction of labour	Policies have been reviewed to ensure National Guidance is followed and slight reduction in rate has been noted.
Post-partum haemorrhages >1500mls	In line with increase of caesarean section and induction of labour, however QI project continues. The Trust governance team has undertaken a thematic review for all cases in Feb 22 to identify any further learning, The draft report has been received. When reporting rates to LMNS and region, preterm, multiple pregnancies are excluded in line with their criterion.
Apgars of <7 @ 5 minutes	Number of cases is shared across the LMNS and although there is no 'target' we have identified an increase compared to other units in the LMNS. All cases reviewed to identify any learning. No themes or negative outcomes identified for these babies
Total women delivered who breastfed within first 48 hours	New breastfeeding peer supporters have now completed their training and now supporting feeding on the ward.
Smoking at the time of delivery	LMNS support requested to assist with reducing our rates of smoking in pregnancy. Awaiting to hear if additional funding has been allocated.
Pre-term births	Significant actions are required to meet the National aim of <6% by 2025. Neonatal QI lead for the LMNS now in post to support with addressing this.
Swab count compliance	All incorrect data entry is investigated to ensure no concerns with care. Data entry slowly improving.

HSIB/EN reporting Q 1 April-June 2022 (Annex B)

Two babies that required therapeutic cooling in this period of time were referred to HSIB for consideration for investigation. However, subsequent scans did not identify any hypoxic injury in these babies therefore HSIB referred the cases back to the Trust for local review and investigation. Subsequently they did not need referral to the Early Notification (EN) Scheme. This confirms that the Trust is identifying when babies need to be referred to HSIB or EN and is meeting its reporting requirements.

ATAIN Q1 report – avoiding term admissions to NNU (Annex C)

There were 17 babies admitted to the NNU in Q1 – April – June 2022. All but three of the admissions were classified as appropriate. Three babies were suitable for Transitional Care (TC) but were admitted to NNU as a consequence of the parents declining admission (in two cases) and staffing issues (in one case). Three additional babies were admitted for a place of safety, and 2 were not suitable to be cared for in conjunction with their parents due to

safeguarding issues, these were all deemed appropriate. One baby would have been suitable for an earlier step down to TC if TC were able to support care of babies with nasogastric tubes. Currently, transitional care is not operational full time due to staffing constraints. A number of nursery nurses are now appointed and are currently undergoing training. Once trained, TC will have the capacity to be staffed 24/7 facilitating a reduction in infant/parent separation. The main theme of learning this quarter was around thermoregulation which is discussed in more detail under quality improvement. Other, smaller, incidental opportunities for learning were identified that did not contribute to neonatal admissions but were felt to be valuable to care improvement; these included guidance around cannulation of babies, the optimal flow rate for vapotherm and syringe feeding in the community.

Neonatal Nursing Staffing Assessment Report (Annex D)

The purpose of this report is to provide evidence of the neonatal unit nursing staffing assessment and progress towards meeting safe staffing standards within the midwifery and neonatal nursing workforce. The report indicates that there is a shortfall of 1.40 WTE (6%) between the budget and staff in post. Whilst there is no budget for band 5 nurses who have completed the QIS (Qualified In Speciality) course, the staff in post at this level contribute to the shortfall in band 6 nurses. This vacancy has been advertised and going through the recruitment process.

The Unit has either a band 6 or band 7 shift leader. All of these staff are QIS. The shift leader is not routinely supernumerary but this is considered Gold Standard, and we aim to hopefully achieve this by the end of the year ones the vacancies post has been appointed to.

The findings of the toolkit indicate that the cot occupancy is 70.47% in this period of audit although the number of babies does not consider the neonates having Transitional Care who are still under the care of the neonatal nurses. With the continued aim to reduce Term admissions to the Neonatal Unit, this should not be ignored when calculating the number of staff who are required to deliver direct care.

Following successful approval of a business case to support further development of Transitional Care - 5.8 wte band 4 Nursery Nurses (or equivalent) have been appointed to provide 24-hour support on TC and have been enrolled onto the Transitional Care course starting in September 2022. On completion of this training and passing the competencies for TC, the aim is for TC to be independently staffed 24hrs per day to offer optimal support for Mothers, and further reduce separation of Mother and her baby. An annual staffing assessment will be completed

Training Tracker and compliance Q1: April 2022-June 2022(Annex E)

The Multi-Disciplinary Team (MDT) training was not achieved in June due to sickness. The requirements of Neonatal Life Support (NLS) compliance for neonatal medical staff has changed in Maternity Incentive Scheme (MIS) year 4. All staff in attendance at birth are now required to attend annual local neonatal life support training even if they are an NLS instructor. Significant improvement in attending the NLS up-date was noted in April and May however this dropped to none attending in June. 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;

Areas of significant concerns include fetal monitoring, NLS local training and obstetric compliance with Saving Babies Lives (SBL) training. To improve on compliance with fetal surveillance in labour, training was introduced as part of the one-day MDT training (PROMPT) from August 2022. MDT attendance at PROMPT has improved. The Standard Operational Procedure (SOP) for Maternity and Neonatal Training and Education Programmes is currently being updated to reflect the Core modules and 3 year rolling training plan approved in January 2022.

Exception Report – non-compliance with MSDS data submission for July 2022
CLOSED BOARD

The Trust is at risk of non-compliance with full submission of accurate data relating to the Maternity Services Data Set (MSDS) to NHS Digital for July 2022 maternity pregnant women. This risk relates to our electronic information system not having appropriate safeguards to provide accurate data on the smoking status and the BMI of women. Whilst the electronic information system provider have planned fixes for these issues, the timing of the fixes, testing of the efficacy of the fixes within the system and needing to complete the data submission from July by the end of September, there is a risk of non-compliance with this part of Safety Action 2 of the Maternity Incentive Scheme Year 4 (CNST). Whilst this is a one-off month of data that the Trust will be measured against for CNST, the MSDS should form part of the Trust's accurate reporting to the National Maternity Dashboard on an ongoing basis.

The Trust expects to receive a report on its submission of data in October 2022 and it will not be possible to change this status at all before NHSR receive the same report which will lead to our compliance status for the MIS submission and compliance in January 2023. This report outlines what is required and where the risks may currently be held.

Exception report for Neonatal Medical Staff Survey to Operational Delivery Network (ODN) (Annex G)

The Trust submitted non-compliance with NHS England's workforce templates for 2 out of 3 standards relating to medical staffing levels for neonatal care in June 2022. One of the areas of non-compliance is with consultant paediatricians providing neonatal care being required to have 8 hours of neonatal specific training and education per year. This has already been addressed and this is now part of the workplans for all relevant consultants. Attendance is recorded and a programme of learning for 2 hours per month is in place. All paediatricians involved in neonatal care are rostered to attend the in-house multidisciplinary neonatal resuscitation training as well as maintaining their compliance with the external neonatal life support (NLS) training programme every 4 years.

The remaining standard that has not yet been achieved is the requirement to have a dedicated neonatal Tier 1 practitioner available 7 days a week for 8 hours during daytime hours. Whilst this is not part of the BAPM standards currently, the Trust aspires to provide this if sufficient resources are available – financial and personnel - to allow this to happen.

Perinatal Mortality Report Q1 April-June 2022 Full report to CLOSED BOARD

The report outlines the details of Perinatal deaths occurring within the Trust and the reviews and actions of these. The report includes completed investigations and actions from Quarter 1 – 1st April 2022 to 30th June 2022 for West Suffolk NHSFT. In this period, the Trust has reported 4 losses directly associated with the Trust. In addition, losses at neighbouring centres have been included for information as the Trust provided elements of their care to the mothers and in one case, the baby.

The Trust has met all of the standards for reporting all relevant incidents of perinatal mortality to the relevant national platforms within the appropriate time frames with regard to compliance with reporting to MBRRACE (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK) and completion of the surveillance information within the required time frames when required to date. The Trust is also compliant with duty of candour and informing the women that a Perinatal Mortality Review Tool (PMRT) review will be undertaken when indicated and inviting comments or questions to aid the review process.

The Trust has completed all the PMRT reports that were due to be completed within this reporting timeframe and started the review process for all of the losses reported within 2 months of the loss.

Transitional Care Q4 January- March 2022 (Annex H)

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, learning to be shared.

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 nasogastric 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.

Transitional Care Q1 April – June 2022 (Annex I)

Overall the number of admissions remains fairly stable and consistent with previous quarters. All babies met the agreed criteria for admission according to the local guideline. The main reason for babies requiring transitional care are those with suspected / confirmed sepsis in either in the mother or baby at birth or soon after birth. This makes up around 38% of babies overall. Although a small number of babies have mild symptoms of sepsis the majority require septic screen and prophylactic antibiotics due to suspected maternal sepsis in labour.

The second highest group of babies were those re-admitted from the community, mainly with neonatal jaundice, 26% of babies overall. All babies required phototherapy. A recent audit showed robust processes in place for early identification of babies particularly those under 38 weeks, as well as the community teams having direct contact with the paediatric registrar for referral to the neonatal unit for assessment.

There appears to be a steady increase in babies meeting the criteria for step-down care from the neonatal unit. This reduces the amount of time babies are separated from a mother /parent. In addition, it reduces the number of babies unnecessarily being cared for on the neonatal unit.

However, there are a number of babies who could meet the criteria for transitional care, but have a nasogastric tube in situ. The service has been unable to accommodate these babies due to the inability to provide 24/7 transitional care cover. This has already been addressed and newly appointed staff are currently completing their transitional care training. Once this is established a significant number of babies with be able to step down their care much earlier.

The maternity and neonatal service is in the process of introducing the Kaiser Neonatal Sepsis calculator; a tool which establishes risk factors and neonatal condition to estimate each babies risk factor of early onset neonatal sepsis (EONS). Studies in the US have suggested that implementing this tool resulted in a reduction in antibiotic administration (48%) without evidence of adverse events (RCPCH).

Digital Strategy for Maternity (Annex J)

The Maternity Services have developed a Digital Strategy which reflects the Trust's Strategy and ambitions against the standards in 'What Good Looks Like' framework. This strategy

was reviewed by the Maternity and Neonatal Safety Champions on the 18th August 2022 and after some updates, this was approved at the Digital Services GDE meeting and submitted to The Local Maternity and Neonatal Systems (LMNS) for approval on the 7th September 2022.
Following noting of this at Trust Board, the Strategy will be published on the intranet.

Perinatal surveillance toolkit – CLOSED BOARD
Key elements of Safety and Quality in Maternity and Neonatal Services are submitted to the LMNS as evidence of our progress in Principle 1 of the Perinatal Quality Surveillance Model framework.
The tool has been developed from the National toolkit and the LMNS use the information to submit evidence from across the LMNS to the Regional team against Principle 2 of the model.
Previously information has been submitted as part of the Regional Perinatal Quality Oversight Group (RPQOG)and dashboards only.

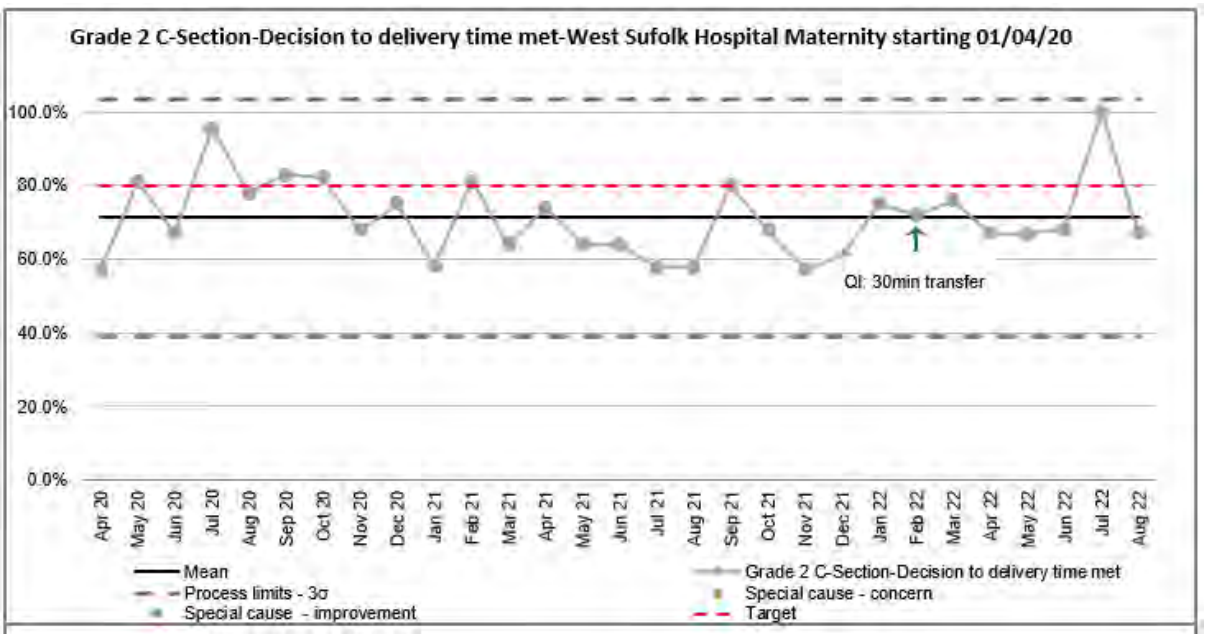
HSIB quarterly review report – CLOSED BOARD

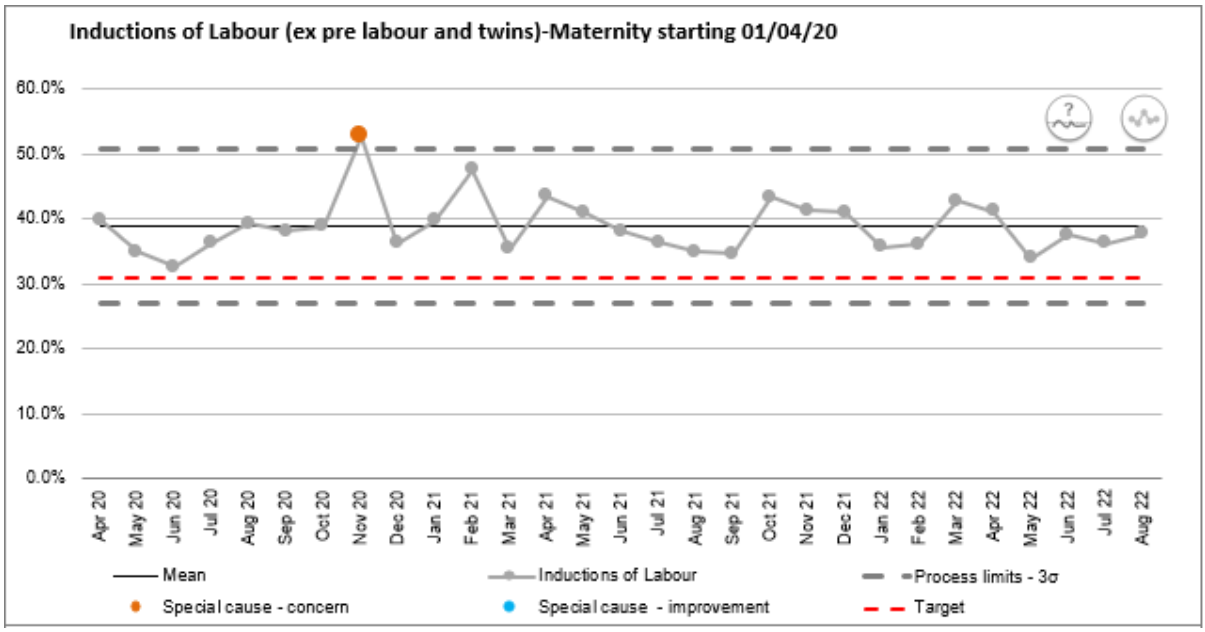
This meeting was held in August and the presentation was received and agreed. The presentation includes National data, Regional data and local Trust data. This demonstrates the referrals that have been made to HSIB, the progress made and key learning from the review process and family involvement.

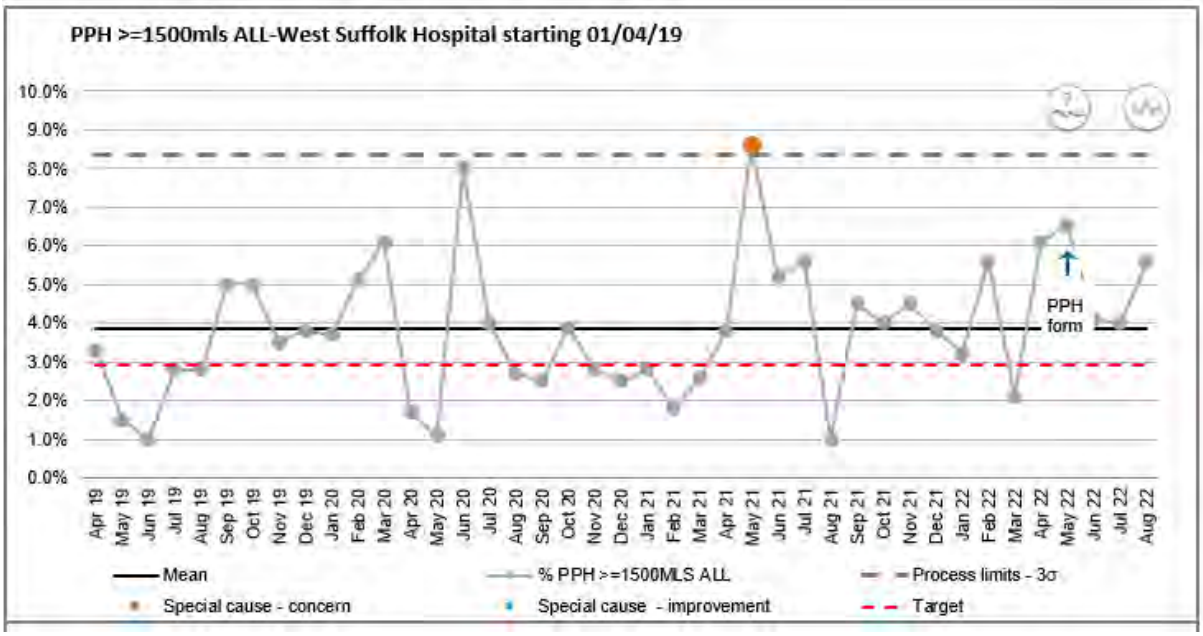
Trust priorities	**Deliver for today**		**Invest in quality, staff and clinical leadership**		**Build a joined-up future**		
Trust ambitions	*Deliver personal care*	*Deliver safe care*	*Deliver joined-up care*	*Support a healthy start*	*Support a healthy life*	*Support ageing well*	*Support all our staff*
Previously considered by:							
Risk and assurance:							
Legislation, regulatory, equality, diversity and dignity implications							
Recommendation: The Board to discuss content							

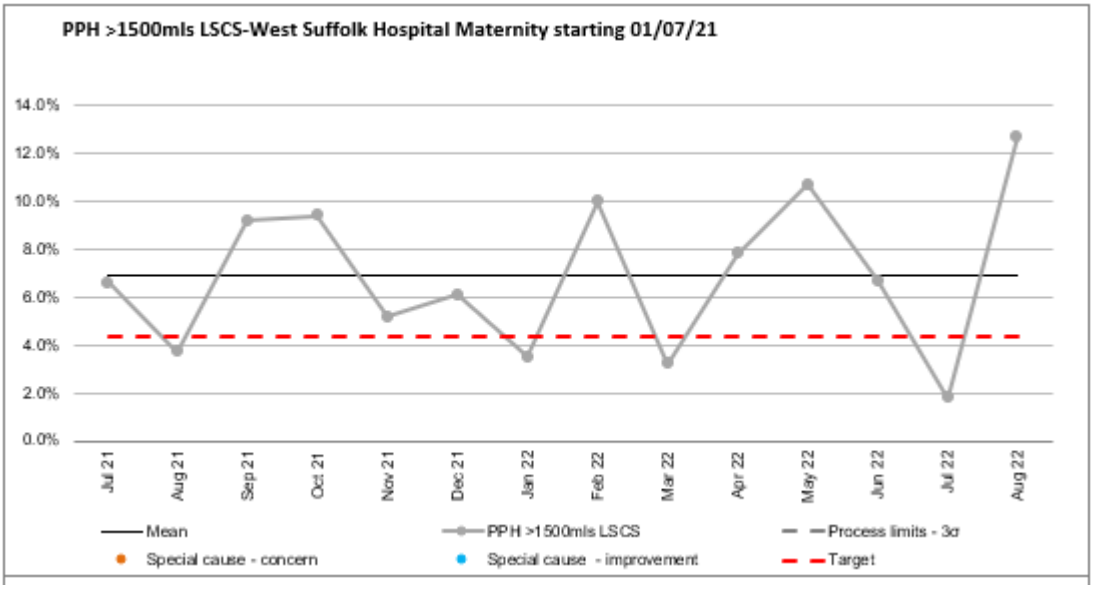
Annex A

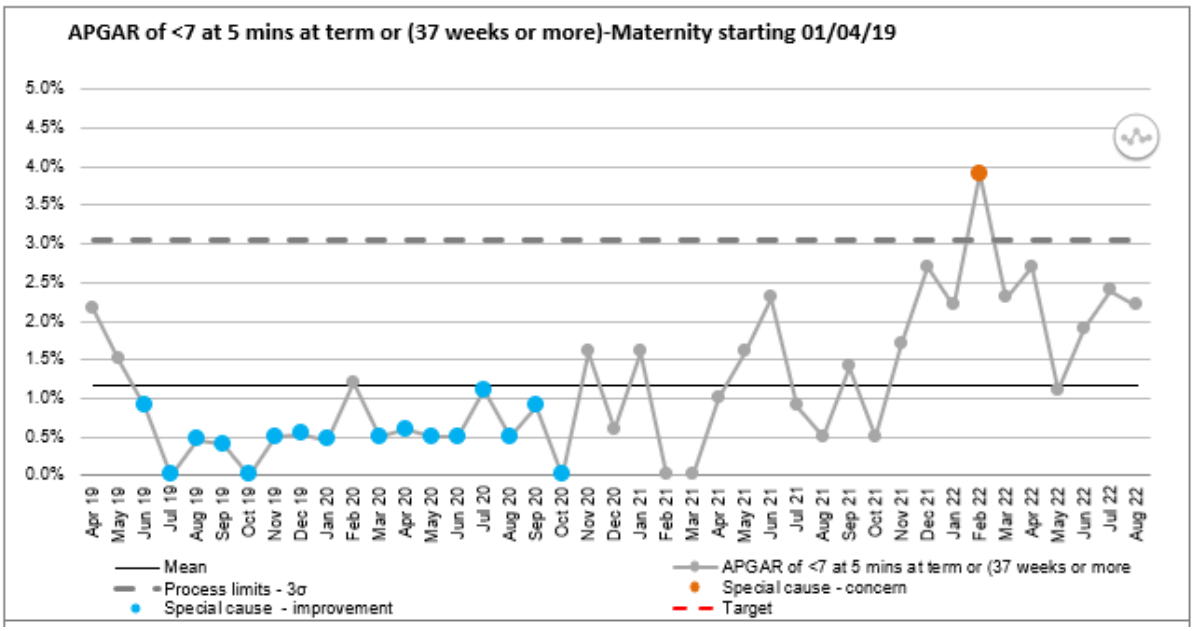
Maternity Dashboard SPC Charts;

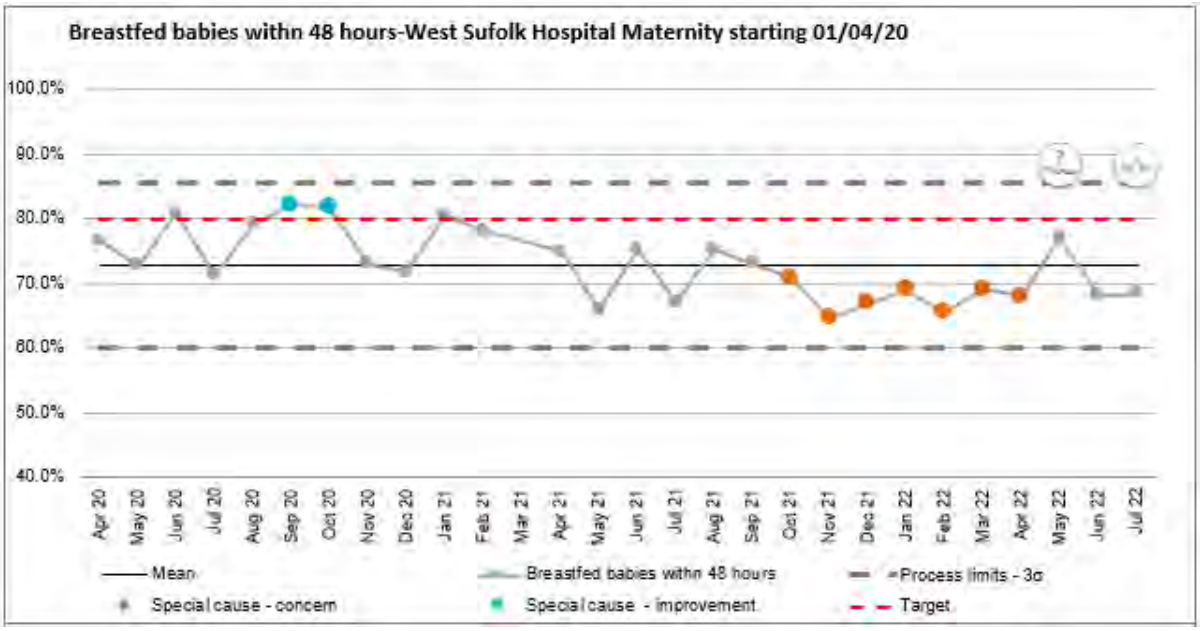


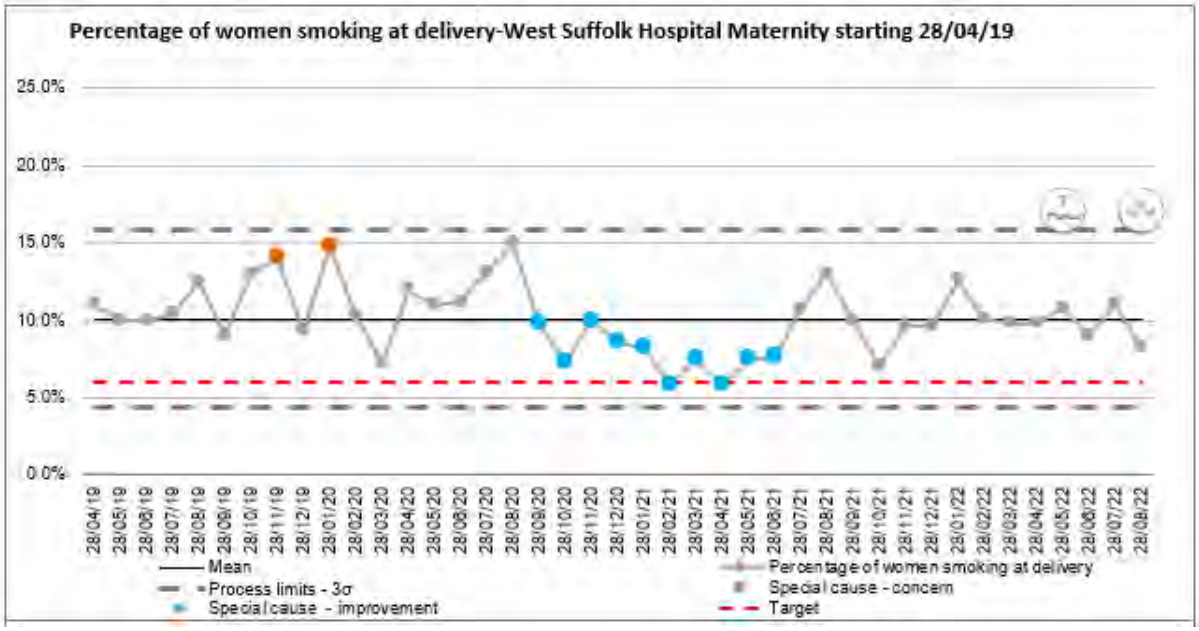


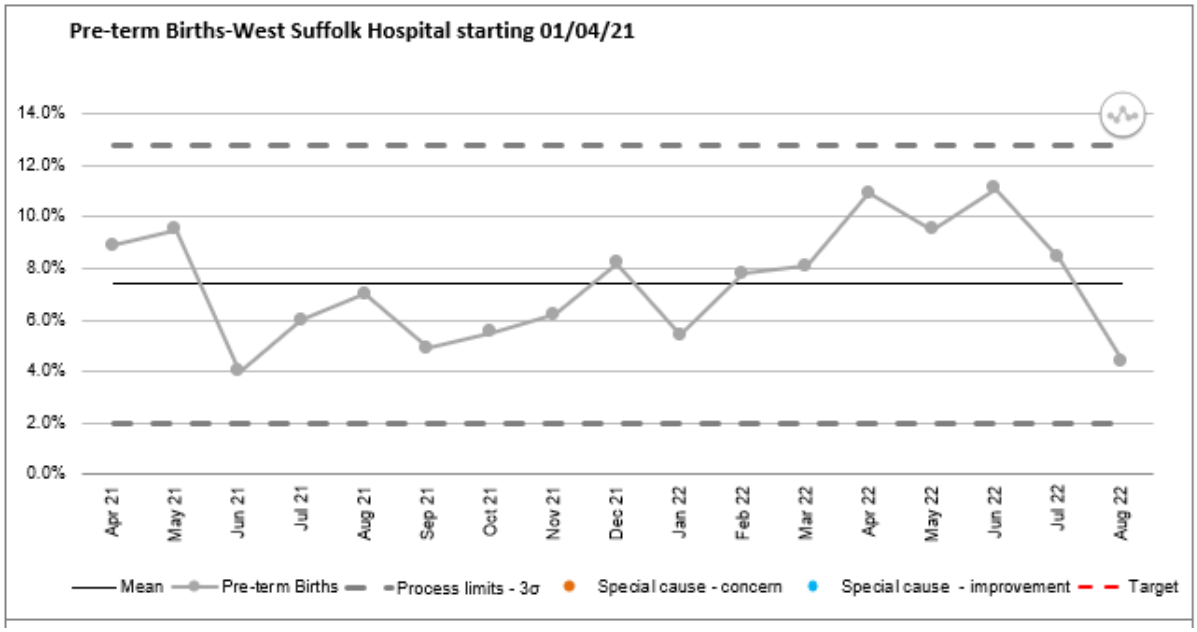

PPH >=1500mls ALL-West Suffolk Hospital starting 01/04/19
10.0%
9.0%
8.0%
7.0%
6.0%
5.0%
4.0%
3.0%
2.0%
1.0%
0.0%
PPH form
Apr 19 May 19 Jun 19 Jul 19 Aug 19 Sep 19 Oct 19 Nov 19 Dec 19 Jan 20 Feb 20 Mar 20 Apr 20 May 20 Jun 20 Jul 20 Aug 20 Sep 20 Oct 20 Nov 20 Dec 20 Jan 21 Feb 21 Mar 21 Apr 21 May 21 Jun 21 Jul 21 Aug 21 Sep 21 Oct 21 Nov 21 Dec 21 Jan 22 Feb 22 Mar 22 Apr 22 May 22 Jun 22 Jul 22 Aug 22
Mean
% PPH >=1500MLS ALL
Process limits - 3σ
Special cause - concern
Special cause - improvement
Target

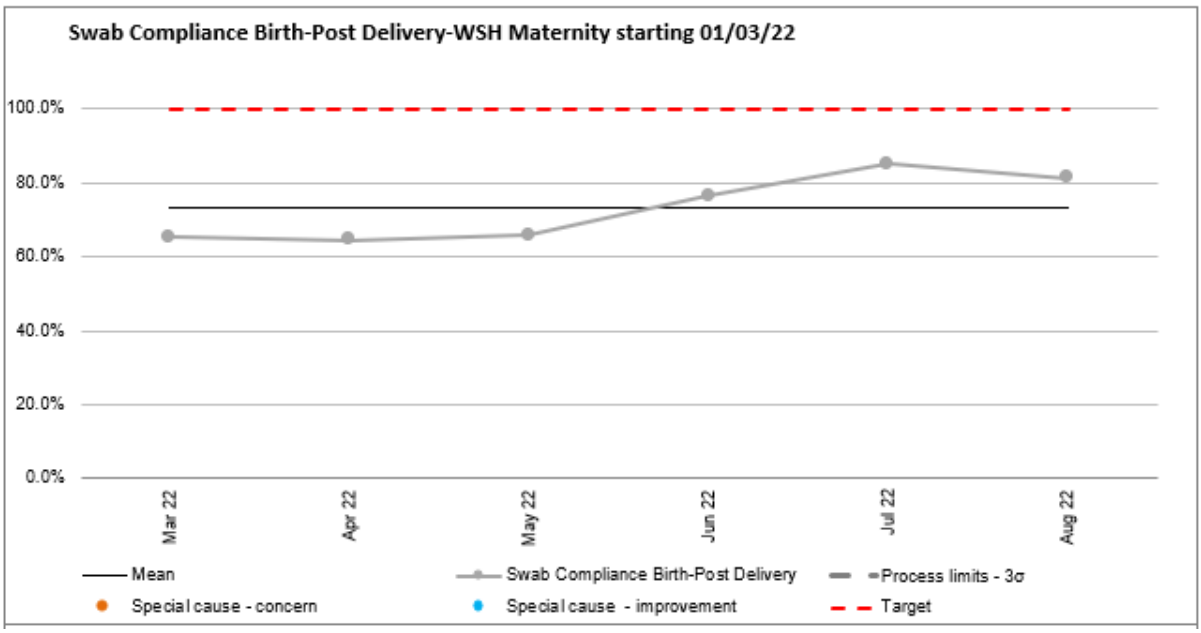

PPH >1500mls LSCS-West Suffolk Hospital Maternity starting 01/07/21
14.0%
12.0%
10.0%
8.0%
6.0%
4.0%
2.0%
0.0%
Jul 21 Aug 21 Sep 21 Oct 21 Nov 21 Dec 21 Jan 22 Feb 22 Mar 22 Apr 22 May 22 Jun 22 Jul 22 Aug 22
Mean
PPH >1500mls LSCS
Process limits - 3σ
Special cause - concern
Special cause - improvement
Target


APGAR of <7 at 5 mins at term or (37 weeks or more)-Maternity starting 01/04/19
5.0%
4.5%
4.0%
3.5%
3.0%
2.5%
2.0%
1.5%
1.0%
0.5%
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 May 22 Jun 22 Jul 22 Aug 22
Mean
Process limits - 3σ
Special cause - improvement
APGAR of <7 at 5 mins at term or (37 weeks or more
Special cause - concern
Target


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


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


Pre-term Births-West Suffolk Hospital starting 01/04/21
14.0%
12.0%
10.0%
8.0%
6.0%
4.0%
2.0%
0.0%
Apr 21
May 21
Jun 21
Jul 21
Aug 21
Sep 21
Oct 21
Nov 21
Dec 21
Jan 22
Feb 22
Mar 22
Apr 22
May 22
Jun 22
Jul 22
Aug 22
Mean
Pre-term Births
Process limits - 3σ
Special cause - concern
Special cause - improvement
Target


Swab Compliance Birth-Post Delivery-WSH Maternity starting 01/03/22
100.0%
80.0%
60.0%
40.0%
20.0%
0.0%
Mar 22
Apr 22
May 22
Jun 22
Jul 22
Aug 22
Mean
Swab Compliance Birth-Post Delivery
Process limits - 3σ
Special cause - concern
Special cause - improvement
Target

4.5. Involvement Committee Report - September 2022 Chair's key issues

To Assure

Presented by Alan Rose

Chair's Key Issues

Originating Committee:	Involvement Committee	Date of Meeting:	5 September 2022
Chaired by:	Alan Rose	Lead Executive Director:	Jeremy Over

Item	Details of Issue	For: Approval/ Escalation/Assurance	BAF/ Risk Register ref.	Paper attached?
Raising Concerns: (FIRST for Staff)	- Update from our Freedom to Speak Up (FTSU) Guardian, Amanda, including valuable and passionate inputs from 3 members of the workforce who are Speak-Up Champions. - Ambition to embed these ways of supporting each other; e.g. by: o aiming for Champions in all teams o providing them with psychological support o encouraging their managers and indeed ALL leaders across the Trust to be good listeners and supportive of the raising of concerns. - Update on the co-production of and engagement on the design and roll-out of "What Matters to You – Two", with more focus this time on values and behaviours.	**<u>Good assurance</u>, but encouragement to continue to expand and embed this to be the normal ways we all work together, reaching out to the Community teams, to night-shift staff and more; Consider ways of measuring the impact.**	BAF Risk 6 (Workforce wellbeing)	
Organisational development plan progress	- Updated tracker report received from Jeremy Over, executive lead - The committee scrutinised the progress of delivery of the plan and noted that the report would also be shared with the working group of the Council of Governors - This committee to strive for ongoing triangulation across FTSU activities, the Organisational Development "tracker", learnings from WMTY2 and other sources that give a sense of progress of the Trust's culture change journey.	**<u>Good assurance</u> of visibility and progress with the specified actions; some revisions of target dates with clear rationale**	BAF Risk 6 (Workforce wellbeing)	

Complaints & the Patient Advisory & Liaison Service (PALS) (FIRST for Patients)	- Summary from Head of Patient Experience, Cassia Nice, on recent complaints, the emerging themes and the way we manage them – including feedback from complainants about this. - Discussion of how we encourage and train staff to handle incidents in 'real time'. - Recognition that many patients and their families find it hard to take the step of formally complaining. - Craig expressed his support for the thoughtful balance that is taken in how we respond in writing to complaints (he reviews and signs every instance).	**<u>Good assurance;</u> more emphasis to be placed in letters on the learning and actions that may have resulted from patient feedback; Recommended that this report be shared with Governors.**	BAF Risk 1 (Governance structures: Safety & Quality)	
Library & Knowledge Services (FIRST for the Future)	- Jeremy updated the group on the wide and impressive array of Face-to-Face and On-line services we offer -- more extensive than typical of an organisation of our size. - Recent peer review of the Quality and Impact Outcomes of the service required action to address an administrative point (related to budget management), which is being dealt with.	**<u>Good assurance</u>, but consideration to be made of how to ensure improved awareness and access for Community and Alliance colleagues**	BAF Risk 6 (Workforce wellbeing)	
Next time: (17/10/22)	- Equality, Diversity & Inclusion (EDI) - CQC Inpatient survey - Consideration of appropriate workforce metrics that this Committee may "own", from an assurance standpoint, to take some load from the Insight Committee.			
Date Completed and Forwarded to Trust Secretary		**23 Sept 2022**		

4.6. Integrated Quality and Performance Report (IQPR) - See Annexes 7.0

To Note

Presented by Nicola Cottington and Susan Wilkinson

5. GOVERNANCE

5.1. Governance report

To inform

Presented by Richard Jones

Board of Directors – 22 July 2022

Report Title:	Item 5.1 - 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. CQC inspection of Glemsford GP Surgery
2. NED recruitment
3. Board development/seminar sessions
4. Joint governors and directors working group
5. Audit committee
6. Annual report and accounts, including General condition 6 and Continuity of Services condition 7 certificate
7. Board assurance framework (BAF) summary and risk report
8. Modern slavery statement 2022-23 annual review
9. Use of Trust seal
10. Draft agenda items for the next Board meeting

Annex A: CQC inspection report of Glemsford GP Surgery
Annex B General condition 6 and continuity of service certificate
Annex C: Modern slavery statement 2022-23
Annex D BAF summary
Annex E: Draft agenda items for the next Board meeting

Action Required of the Board

To note the report contents as outlined above and approve:

- the revised modern slavery statement

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

Governance Report

1. CQC inspection of Glemsford GP Surgery

Following an announced inspection of Glemsford GP Surgery, the CQC issued their report on 14 September 2022, overall the practice is rated as Good.

The team have an agreed action plan to address the areas of concern highlighted in the report, this will be submitted to the CQC by 27 September. The actions are largely complete and will be subject to audit to ensure that they are effective. The Improvement Committee will review progress and provide assurance to the Board that the areas of concern identified by the CQC are addressed.

A full copy of the report CQC report is appended to this report (Annex A).

2. Non-executive director recruitment

Final interviews were held on 7, 9 and 13 September. Based on the interviews and discussions, the Council of Governors approved appointment of the five recommended candidates at a meeting held on 20 September 2022.

The new appointments include Tracy Dowling, former chief executive of Cambridgeshire and Peterborough NHS Foundation Trust; Antoinette Jackson, previously chief executive of Cambridge City Council; Professor Hillary McCallion, a nurse by background who now runs her own consultancy business; Dr Geraldine O'Sullivan, a psychiatrist who has held numerous senior roles in the NHS; and Krishna Yergol, current chief technology officer for Suffolk County Council.

With two of our existing NEDs reaching the end of their term of appointment early in 2023, the Council of Governors have taken the opportunity to appoint their replacements, as well as filling gaps in the team.

3. 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.

A specific meeting was scheduled for 14 September to consider the annual report and accounts and the various opinions of our auditors on these. Following this consideration and finalisations by the auditors, the committee was able to recommend the annual report and accounts for approval by the Board.

4. Annual reports and accounts

As outlined in the report from the audit committee, recommendation was made for approval of the annual report and accounts and reports from the auditors. Following completion and reporting of all testing by the external auditors these documents were approved and have been submitted to NHSE in line with national requirements. Prior to making public the annual report and accounts the Trust is legally required to lay the document before Parliament. The period of national mourning and subsequently Parliament entering a planned recess, means that the Board will not be able to receive these until the meeting in November. As soon as they are laid before Parliament, the documents will be published on the Trust website.

Two documents linked to the annual report and accounts that we are able to publish at this time are appended to this report (*Annex A: General condition 6 and Continuity of Services condition 7 certificate).*

5. Joint governors and directors working group

A further meeting of joint governors and board directors working group took place on 5 September. The focus of discussion included:

- Review of progress and future plans for the Trust's response to the West Suffolk Review, structured around the organisational development plan and action tracker

- Review of the previous 'What Matters to You' (WMTY) programme. This was an intensive and focused programme of staff listening and feedback that took place during phase one of the Covid-19 pandemic.

  A working group has been meeting over the past two months to develop the plan for "WMTY2". The group recommends a high-level approach which encompasses three elements:

  1. *Look back* – how have we done with the WMTY priorities
  2. *How are things now* – staff's current priorities and concerns
  3. *Building our culture* – developing our FIRST values and behaviours

  The proposed approach was welcomed.

- Consideration was also given to the group's forward work plan.

6. Board development sessions

At the previous Board meeting it was requests that a summary of the framework/paradigm being crafted from our development sessions is prepared. The following points have been drawn-up to reflect this work.

- Discussion and challenge that prompts interest and deeper understanding without jumping to solution/action mode (**CRED zone** is where the magic happens):
  - Courageous
  - Respectful
  - Energised
  - Dialogue
- Assurance verses reassurance
  - What? – deepening **understanding** of the evidence and ensuring its **validity**
  - So what? – increasing **appreciation** of the **importance** and **impact** of the evidence – what this means for us
  - What next? – exploring what should be **done next** (or not), informing **future strategy**, agreeing follow-up and future **evidence of impact**
  - Phases of board **productive exploration** through questioning (linked to above). Normal board conversations – superficial (1st level thinking). Avoid jumping to 'solution mode' through questioning to support:
  - What
    - framing papers and subcommittees (evidencing of scrutiny already achieved)
    - implication analysis (scrutiny questions)
  - So what
    - Insight and new thinking (2nd level thinking)
    - Re-framing (3rd level thinking)
  - What next
    - Strategic options (chair's summary, decisions, clarity of action and follow-up)
- **Value** of evidence (usefulness) and **validity** of evidence (accuracy) – **diamond data**
- Balancing **support** and **challenge**
- Recognise our own **unconscious beliefs (lenses)** and how these impact on our interpretation and response:
  - **Mechanical** - focus on analytical, rational processes, eg structure, vision, strategic

    - planning, implementation
    - **Social** - focus on irrational processes eg micro-politics, relationships, group
    - dynamics, moods, gossip
    - **Constant flux** - focus on the organisation as part of its constantly changing environment
- **Map of organisations**: values; skills; leadership; structure; preoccupations; mission context; The worker; communication. Phases of development:
    - Phase 1: the hierarchical organisation
    - Phase 2: The institutional organisation
    - Phase 3: The collaborative organisation
    - Phase 4: The learning organisation

Feedback is requested on the emphasis described above and whether this could be used to help focus the board's reflections on how meetings have been delivered.

7. Board assurance framework (BAF) summary and risk report

The Board assurance framework is a tool used by the Board to manage its principal strategic risks. Focusing on each risk individually, the BAF documents the key controls in place to manage the risk, the assurances received both from within the organisation and independently as to the effectiveness of those controls and highlights for the board's attention the gaps in control and gaps in assurance that it needs to address in order to reduce the risk to the lowest achievable risk rating. The Board has an approved risk appetite statement which supports the organisation's approach to risk mitigation.

A programme of deep dives for red and BAF risks through the assurance committees and governance groups will provide great assurance to the Board on the effective management of the risk and control environment.

A summary of the BAF is provided in Annex D.

8. Use of Trust Seal

None since last meeting.

9. Modern slavery statement

Modern slavery is a serious crime being committed across the UK and the rest of the world. It refers to a form of slavery that can occur in any business sector and it is estimated there are 40 million victims around the world. Victims of modern slavery are exploited for the gain of others. This can take many different forms including the trafficking of people, forced labour, slavery and servitude.

With support from Carol Steed, deputy director of workforce, organisational development and learning the modern slavery statement (Annex C) has been updated and with the Board's approval will be amended on the Trust website.

10. Agenda Items for the Next Meeting (Annex D)

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

6. OTHER ITEMS

6.1. Any other business

To Note

6.2. Reflections on meeting

For Discussion

6.3. Date of next meeting - 25 November, 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

7. Annexes for information:

To inform

4.4.1 - Maternity Papers

West Suffolk NHS
NHS Foundation Trust

Maternity HSIB and Early Notification Reporting

Agenda item:				
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:	July 2022			
Subject:	**HSIB and Early Notification Reporting Quarterly Reports on Compliance – Report for Quarter 1 2022/23**			
Purpose:	X	For information	X	For approval

Executive summary:

This report provides details of the Trust compliance for Q1 2022/2023 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 – April1st 2022 to June 30th 2022 – there were two incidents of babies needing therapeutic cooling that met the initial criteria for reporting to HSIB and EN. However, when the babies were subsequently found to have no hypoxic injury, HSIB declined the investigation and the investigations reverted to a local Patient Safety Report as part of the Trust incident management processes.

The Trust is assured that the processes are being followed.

Previously considered by:	**Maternity Quality & Safety Group**	15/8/22
	Maternity and Neonatal Safety Champions	25/8/22
	Trust Board	30/9/22
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, 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 further updates in May 2022 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 – see Appendix 1 for reporting criteria

B) For qualifying cases (see Appendix 2) which have occurred during the reporting period 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

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 1 2022/2023 Compliance Report

A) Reporting of all qualifying cases to HSIB

Two cases met the criteria for referral to HSIB in this period of time due to needing therapeutic cooling but were declined by HSIB as the MRI scans were normal.

B) There are therefore no qualifying cases which have occurred during the period 1st April 2022 to 30th June 2022

Summary of WSH Compliance for Quarter 1 2022/23

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 October 2022 for Q2

As any changes occur to the reporting and notification criteria, the Trust processes will be updated.

Appendix 1 Reporting criteria for HSIB

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

Appendix 2 Criteria for reporting to NHSR Early Notification Scheme

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.'

NHS
West Suffolk
NHS Foundation Trust

ATAIN Programme

Avoiding Term Admissions to the Neonatal Unit

Progress Report
Quarter 1
April-June 2022

July 2022

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

Background to project

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

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

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

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

Local reviews

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

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

Process for review

The neonatal and midwifery team review the maternal and neonatal records prior to the ATAIN meeting using the approved NHS improvement tools.

Updated safety actions for CNST state that the care of all babies transferred or admitted to the NNU for *any period of time* should be reviewed, in some capacity, and reported under the ATAIN project. This is a change from previous guidance which required review only for babies admitted to NNU. Therefore, since May 2022 any baby that attends NNU briefly prior to transfer to TC has also been recorded. From July 2022 these babies, and any baby that attends NNU for care while an inpatient on the maternity unit will be recorded and reported to the East of England Neonatal operational delivery network along with information on reason for attendance, parental accompaniment and any emerging themes.

A Review of Terminology

In line with the newly implemented patient safety incident response framework (PSIRF), of which the Trust is an early adopter, the perspective of reviewing incidents and the terminology used has been amended to better promote shared learning and improved care. As such, we have moved away from the term “avoidable and unavoidable” and are instead looking at if the admissions were appropriate and if there is any learning to be gained from the circumstances around their admission; including what steps could be made to improve care, with the aim of reducing the overall term admission rate.

Findings

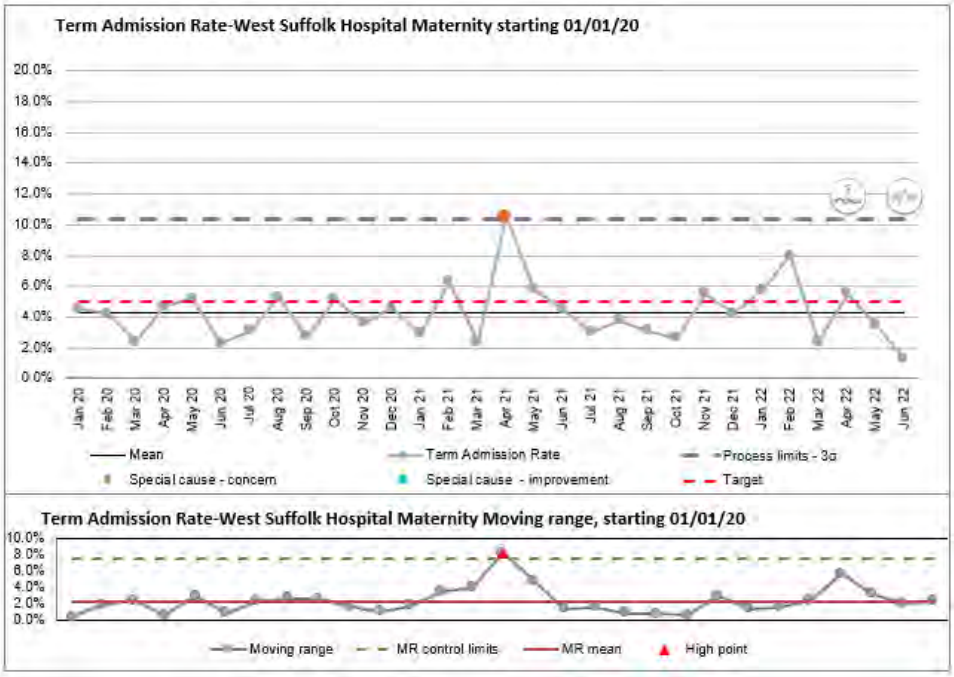
Term admission rates vary month on month. During the past quarter they have fluctuated, with only one month exceeding the target level of < 5%. It should be noted that in April when the admission rate was the highest (5.5%), two admissions were for social reasons and a place of safety but were not clinically indicated. Two other babies who were admitted, one from April and one from May, were admitted and transferred to a tertiary unit for therapeutic cooling. These cases no longer meet the ATAIN criteria due to undergoing independent investigations of care. All of the admissions this quarter were deemed appropriate based on their clinical or social needs.

Cases were reviewed carefully to identify any areas for learning and improvement. While respiratory distress remains the predominant reason for admission this quarter, no overarching themes or common denominators were identified amongst those admissions. All babies admitted for respiratory support also underwent a septic screen; the majority of whom had risk factors for sepsis (risk factors varied with no dominating themes apparent).

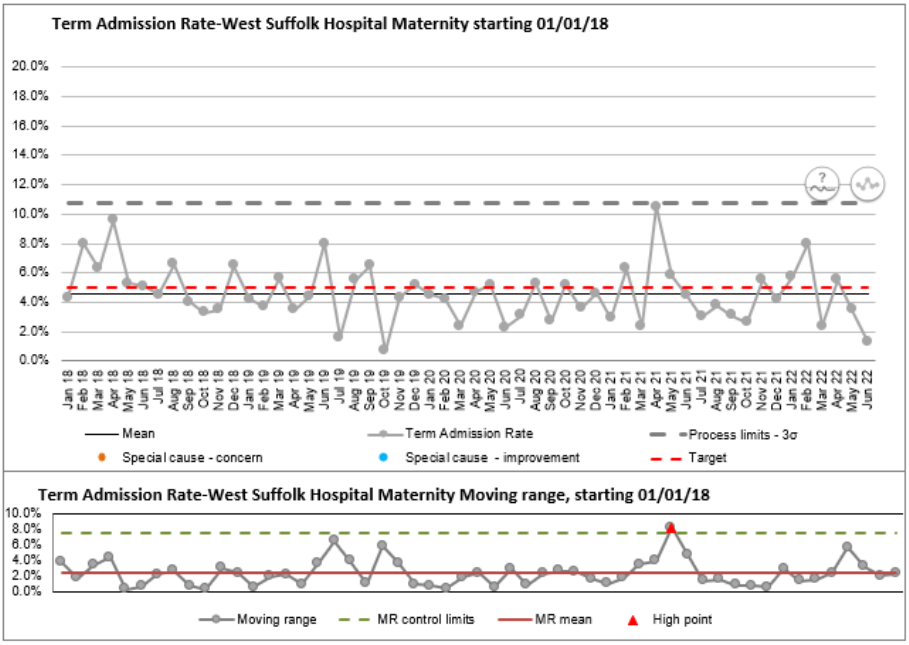
However, a trend of low admission temperatures remained this quarter with 29% of babies recording temperatures of ≤36.5°C on admission to NNU. While not the primary reason for admission, sub-optimal body temperature is recognised as a contributory and exacerbating factor to respiratory distress. These cases are discussed in more detail under the quality improvement section.

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

Progress



Overall progress since programme began (2018)



Opportunities for learning and improvement

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

Three babies this quarter were suitable for TC but were admitted to NNU as a consequence of the parents declining admission (in two cases) and staffing issues (in one case). Three additional babies were admitted for a place of safety, two of which also required Neonatal Abstinence Syndrome (NAS) observations, and were not suitable to be cared for in conjunction with their parents due to safeguarding issues. The latter three admissions were regarded as appropriate considering the social circumstances.

Additionally, one baby this quarter would have been suitable for an earlier step down to TC 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.

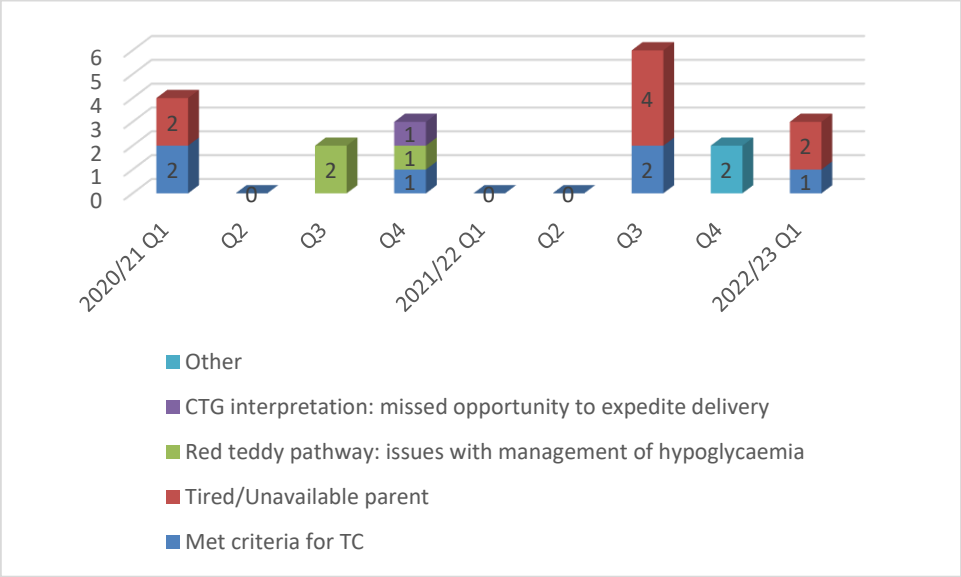
Currently, transitional care is not operational full time due to staffing constraints. Instead, nurses and nursery nurses visit the ward when care is required. However, a number of nursery nurses have now been hired and are currently undergoing training. Once trained, TC will have the capacity to be staffed 24/7 facilitating a reduction in infant/parent separation.

The main theme of learning this quarter was around thermoregulation which is discussed in more detail under quality improvement. Other, smaller, incidental opportunities for learning were identified that did not contribute to neonatal admissions but were felt to be valuable to care improvement; these included guidance around cannulation of babies, the optimal flow rate for vapotherm and syringe feeding in the community.

Reasons for admission to NNU

The graph below shows the reasons previously identified as being the cause of potentially avoidable term admissions. As discussed above, in this quarter, all admissions were appropriate in the clinical or social circumstances with the exception of two babies suitable for TC but without an available parent and one due to TC staffing issues.

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



Action Plans

The group uses cases that have flagged opportunities for learning and care improvement to guide learning and improvement actions in order to reduce unnecessary separation of mothers 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 clinical reasons previously identified as potentially contributing to term admission (as shown in the graph above) but there remains an unavoidable trend of admitting babies to the NNU when a parent either declines or is unavailable to stay with them under TC, or where TC is not currently suitable to provide care despite meeting criteria, due to staffing constraints. The three babies admitted this quarter for a place of safety are not included in the graph as this admission was in the infants' best interests.

Progress and learning with the key reasons for admission

Data collection during Quarter 1 (April-June) in 2022 demonstrates that respiratory issues (needing respiratory support in some form) continue to be the primary reason for the admission of term babies into the Neonatal Unit. This accounted for 11 of the 17 admissions and all were treated with vapotherm and IV antibiotics. One admission was for suspected infection and was observed on the NNU while being treated with IV antibiotics. Ten of the 12 babies treated with IV antibiotics had risk factors for sepsis, with no overarching theme apparent. The three admissions classified as "other" included two babies admitted for NAS observations, and one which was admitted for a place of safety. None were suitable for TC due to parental safeguarding issues. Two were admitted with suspected birth asphyxia and were transferred out for cooling and thus did not qualify for review under ATAIN.

Figure 1: Reasons for Admission Apr-June 2022

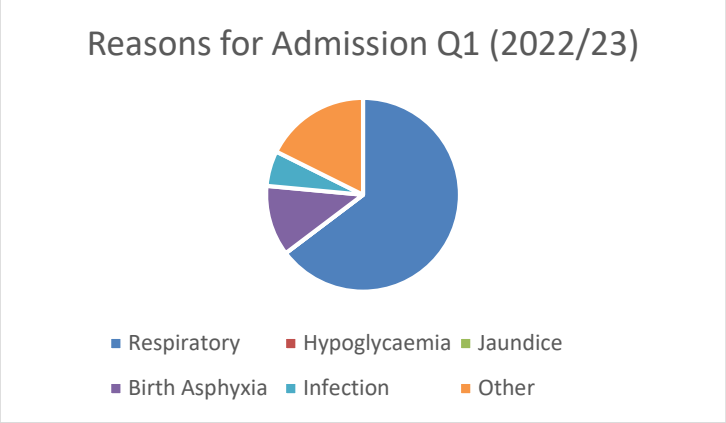


Figure 2: Risk Factors for Sepsis

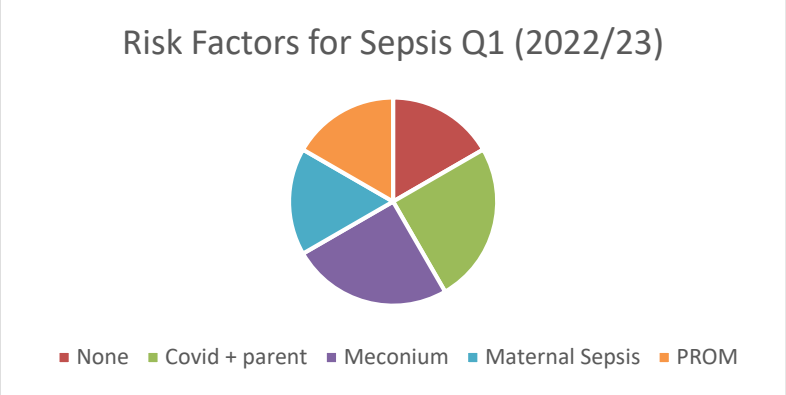
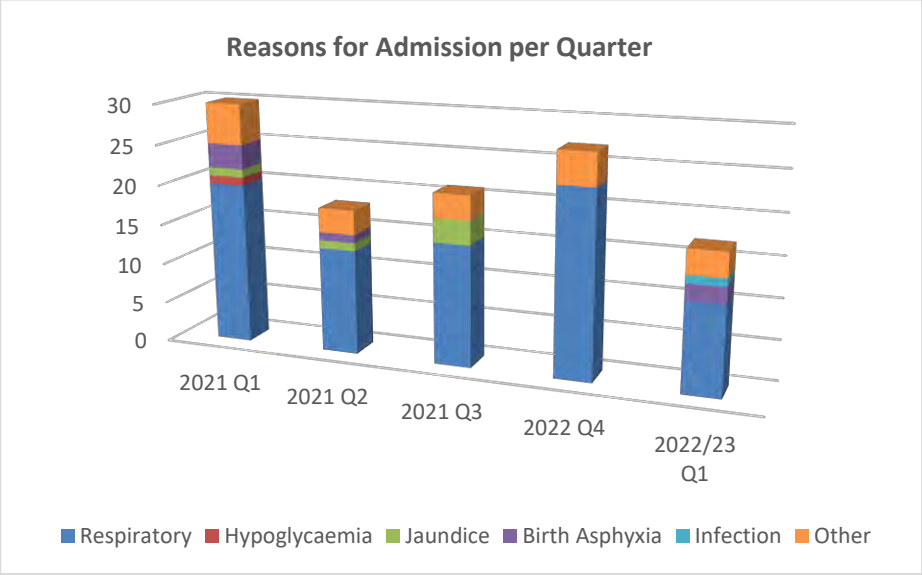


Figure 3: Reasons for Admission - Quarter by Quarter comparison



The chart above shows the reasons for admission per quarter in the 2021-2022 and 2022-23 year; demonstrating Respiratory issues as the prodominant reason for admisson each quarter. No underlying common theme has been identified to date but a rise in sub-optimal body temperatures on admission to NNU has been noted and is discussed under Quality improvement.

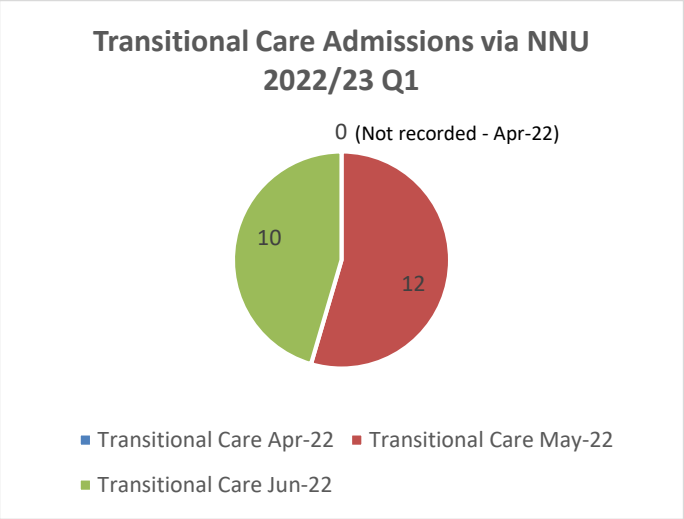
Transitional Care admissions via NNU

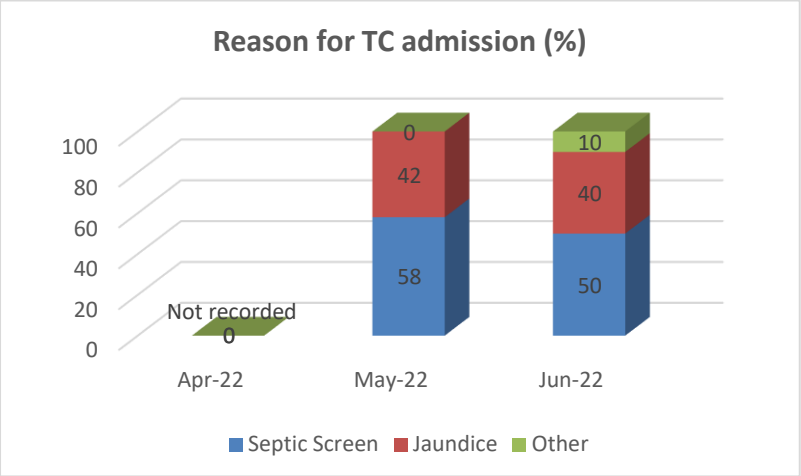
Since May 2022; new national guidance recommends that all babies transferred or admitted to the NNU for any period of time should be reviewed, in some form, as part of the ATAIN project. This includes any baby who visits the NNU prior to being admitted to transitional care, and any baby who attends NNU for care while an inpatient on the unit.

Further guidance from the regional clinical oversight group has clarified that any baby who attends NNU for care, without being admitted, (e.g. IV cannulation, repeat blood test) should have the following information recorded: parental acompaniment, reason for attendance and any themes or learning identified. Only babies who are admitted to NNU should be reviewed under the ATAIN framework which continues to involve a detailed review of antenatal, intrapartum and postnatal care using a new national proforma.

The Neonatal Unit are currently considering the best way to capture the parental attendance data that will be reported to the East of England Neonatal operational delivery network from July 2022.

The charts below detail the infants who attended NNU this quarter (inclusive of May and June only) prior to transfer to Transitional Care. Other attendances, as detailed above, are not yet recorded.





Quality improvement in this quarter

There has been an ongoing drive to improve admission temperatures of babies admitted to NNU. A trend of babies being admitted with low temperatures (≤36.5°c) was first identified in May 2021 and an action plan put in place, resulting in a notable improvement in the following months. Last quarter an increase was once again noted and further actions were developed to help increase awareness around the maternity unit (detailed below).

This quarter has remained stable with 29% of babies found to have a sub-optimal temperature on admission, the causes of which could not be conclusively determined but are suspected to be a combination of environmental and underlying infection.

All but one of the babies admitted with a sub-optimal temperature this quarter were admitted directly from Theatre after delivery. While theatre is known to be a cooler environment due to infection control purposes, it should be noted that each infant was receiving care on the resuscitaire under an overhead heater, which suggests potentially underlying issues that impacted their ability to maintain a normal body temperature, independent of environmental factors.

Quarter 4 (2021/22)	**No. of babies with sub-optimal temp (≤36.5)**	**%**
January 2022	2/10	20%
February 2022	5/13	38%
March 2022	1 /4	25%
Quarter 1 (2022/23)		
April 2022	2/9	22%
May 2022	2/6	33%
June 2022	1/2	50%

In all cases, hypothermia was not the primary reason for the admission, but a review of the notes identified this issue and appropriate actions have been made.

Historically, a number of actions were agreed and completed by the multi-disciplinary team. Some new actions have now been created and are on-going; these are highlighted in a separate table. This included engagement with, and support from Theatres, Labour Suite and NNU teams.

Historical Actions

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

a whole team responsibility / approach to this issue.	• Discussed on daily MDT safety huddles	
Monitor progress	• Continue to record admission temperatures for term admissions as part of ongoing monthly reviews in order to monitor this closely.	Admission temperatures continue to be reviewed, and a significant improvement has resulted from these combined actions.

Current/On-going Actions

Action	Plan	Comments
Raising awareness among the maternity team	• Educational piece in Risky Business • Message in Take 5	Monthly updates from ATAIN and learning in Risky Business – ongoing action.
Instructions added to Warming Cots on F11	• Add instructions to all warming cots to ensure correct usage of equipment	Updated warming cot instructions added to warming cots on unit. Action completed.
Explore possibility of procurement of Towel Warmer for Theatre	• Towel warmer for Theatre/LS	For Theatres/LS. Promote maintainance of appropriate temperature at delivery and in early newborn period. On-going Action
Information videos for Staff facebook page	• Informational video “Thermoregulation of the Newborn” on staff facebook page.	Video awaiting sign off. On-going action.
Handover “Hot Topic”	• Remind staff at handover about importance of keeping babies warm (in Theatre, LS and F11)	Facilitated by inpatient matron in communications to Band 7 area leads.
Parental Education Poster/Leaflet	• Poster/Leaflet to display in LS rooms/F11 bays to increase awareness in parents	In development.

Other Actions for Quarter 1

Additional actions identified in Quarter 1 are summarised below, and while it is acknowleged that this may not have prevented any of the term admissions these actions are in place to help improve future care, which will only serve to benefit parents and their babies.

Action	Plan	Comments
Cannulation guidance (appropriate number of attempts)	Highlight in Risky Business	Completed
Guidance around vapotherm flow rate	Highlight in Risky Business	Completed
Syringe/Cup feeding in the community	Update in infant feeding guideline	New guideline pending

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

Maternity Incentive Scheme – Year 4

Report Title	Report for Safety Action 4d - **Can you demonstrate an effective system of clinical* workforce planning to the required standard? Neonatal Nursing Staff**
Report for	Approval and Information
Report from	Maternity and Neonatal Services
Lead for Safety Action	Deputy Head of Midwifery
Report Author	Justyna Skonieczny, Deputy Head of Midwifery Karen Ranson, NNU Ward Manager Beverley Gordon, Project Midwife
Frequency of report:	The Trust is required to formally record to the Trust Board minutes the compliance to the service specification standards annually using the neonatal clinical reference group nursing workforce calculator. Neonatal nursing workforce review should be undertaken at least once during year 4 reporting period Reporting periods: **October 2021-March 2022**
Date of this report:	1st May 2022
Presented at:	May 2022 Operational Delivery Group for information 18th July 2022 Maternity and Gynaecology Quality & Safety 18th August 2022 Maternity & Neonatal Safety Champions 30th September 2022 Trust Board

Executive summary:

The purpose of this report is to provide evidence and give the Board assurance that work continues to be undertaken within maternity and neonatal services at West Suffolk, to demonstrate progress towards meeting safe staffing standards within the midwifery and neonatal nursing workforce. These standards are outlined in the British Association of Perinatal Medicine (BAPM) guidance and are assessed using the agreed CRG workforce tool.

The report indicates that there is a shortfall of 1.40 WTE (6%) between the budget and staff in post. Whilst there is no budget for band 5 nurses who have completed the QIS course, the staff in post at this level contribute to the shortfall in band 6 nurses. This vacancy has been advertised and going through the recruitment process.

The Unit has either a band 6 or band 7 shift leader. All of these staff are QIS. The shift leader is not routinely supernumerary, but this is considered Gold Standard, and we aim to hopefully achieve this by the end of the year once the vacant post has been appointed to.

The findings of the toolkit indicate that the cot occupancy is 70.47% in this period of audit although the number of babies does not consider the neonates having Transitional Care who are still under the care of the neonatal nurses. With the continued aim to reduce Term admissions to the Neonatal Unit, this should not be ignored when calculating the number of staff who are required to deliver direct care.

Following successful approval of a business case to support further development of Transitional Care - 5.8 wte band 4 Nursery Nurses (or equivalent) have been appointed to provide 24-hour support on TC and have been enrolled onto the Transitional Care course starting in September 2022. On completion of this training and passing the competencies for TC, the aim is for TC to be independently staffed 24hrs per day to offer optimal support for Mothers, and further reduce separation of Mother and her baby.

Recommendation:
This report is submitted for review and approval at the Maternity & Gynaecology Quality and Safety Group and then the Maternity and Neonatal Safety Champions Group and presented for information to the Divisional Board. Following this, the report will be presented at the Trust Board meeting and the Local Maternity and Neonatal Service (LMNS) Board.

The Trust board is asked to receive this report as evidence of progress towards safe nursing staff standards in the Neonatal Unit.

1. Background

The Maternity Incentive Scheme (MIS) run by NHS resolution is in its fourth year and builds on the progress made in the previous 3 years. The safety action that this report relates to Safety Action 4d to ensure that the neonatal nursing staffing meets BAPM standards. Year 4 safety actions were published in August 2021. In December 2021, the requirements for evidence and submission were put on hold due to the effects of the pandemic on maternity services across the country. In May 2022, the safety actions were republished with updated timeframes and requirements where required.

The West Suffolk Hospital Neonatal Unit is commissioned as a level one unit equipped to care for babies ranging from 30 weeks gestation to full term, according to their clinical conditions and needs. There are 12 cots: 1 Intensive care, 3 High Dependency Care and 8 Special Care. The designated Level Three 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 a designated transport service- PANDR (Paediatric and Neonatal Decision Support and Retrieval Service) once stable, the baby is transferred back for on-going care. Neonatal services at WSFT will follow agreed strategies and guidance as part of the wider East of England Neonatal Network, which encompasses the 17 Neonatal Units in the region of all levels.

Neonatal Unit capacity is planned in co-ordination with the local maternity service and the neonatal operational delivery network (ODN). This takes into account the level of care provided in the unit. Capacity should be planned on an average 80% occupancy where possible- this provided reserves to cope with the stochastic nature of NNU admissions, which are unpredictable in terms of quantum and intensity of care required.

This report presents nursing establishment for the Neonatal Unit at West Suffolk NHS Foundation and recommendation following completion of the audit.

The review was undertaken to:

- To provide evidence of safe neonatal nursing staffing levels against BAPM standards and action required as a result of the audit.
- Provide assurance to the Board that the care delivered on NNU at WSFT is safe and meets the national standards and recommendations.

The purpose of this report is to provide evidence and give the Board assurance that work continues to be undertaken within maternity and neonatal services at West Suffolk, to demonstrate progress towards meeting safe staffing standards within the midwifery and neonatal nursing workforce.

2. Methodology

The Neonatal Nursing Workforce Tool (2020) has been adapted from the CRG Workforce Calculator (Dinning) Tool (2013) and has been developed with the National Lead Nurses Group. It is intended to support neonatal nurse managers and their colleagues by providing a consistent method for the calculation of nursing establishment requirements which meet national standards i.e. NHSI (2018); NHSE Neonatal Service Specification e08 (2015); DH (2009); BAPM (2010); NICE (2010).

The safety element of this is to ensure that the neonatal unit has the required numbers and experience of staff in post to safely provide care for babies to the required standard. The Trust is required to ensure that there are safe staffing levels on the Neonatal Unit to manage the care of babies who require additional support after birth and to stabilise and

transfer in-utero or ex-utero babies who may need care and treatment outside the limitations of the unit.

Staffing on the Neonatal Unit consists of the Unit Manager, a Practice Development Nurse, a Neonatal Community Sister; Neonatal Intensive Care trained Nurses (Qualified in Speciality - QIS), supported by Staff Nurses, Nursery Nurses and a Ward Clerk. There are two lead neonatologists and designated middle grade doctors within the medical team to support the clinical elements.

Other health care professionals attend the unit to input into neonatal care and these include a physiotherapist; dietician; radiologist; ophthalmology specialist; pharmacist; speech & language therapist, and Clinical Psychology support.

3. Neonatal service requirements:

- Minimum 70% neonatal nurses qualified in speciality (QIS);
- All registered nurses are trained and up-dated in neonatal life support- NLS;
- There should be a supernumerary team leader on an early shift in addition to those providing direct clinical care;
- The Neonatal Nurses are required to support the resuscitation of sick new-born babies in the Labour Suite;
- NNU Skill mix:

Clinical Area	Day	Evening	Night
Neonatal Unit	2 Neonatal trained nurses (QIS) 1-2 Staff nurses (non-QIS) or Nursery Nurses 1 Ward clerk	2 Neonatal trained nurses (QIS) 1-2 Staff nurses (non-QIS) or Nursery Nurses	2 Neonatal trained nurses (QIS) 1-2 Staff nurses (non-QIS) or Nursery Nurses

Nurse/Patient Ratios for the Neonatal Unit:

- **Special Care** 1:4 (registered nurse: infant requiring special care)
- **High Dependency care** 1:1 (registered nurse: infant requiring high dependency care)
- **Intensive care** 1:1 (registered nurse: infant requiring intensive care)

A clear pathway of escalation to support safe, proactive management in times of increased activity, neonatal emergency, insufficient staffing and/or over capacity is set out in the Maternity Escalation Policy (CG10635) in a section specific to NNU. During working hours, it may be necessary for off-rota nursing staff such as the Lead Nurse, PDN, and Ward Manager to undertake clinical duties to support. The Maternity Bleep Holder should also be informed and asked to provide advice and assistance and DATIX should be completed.

The nursing establishment in the budget is usually set historically and based on the activity of the unit. The budget for this year was set on the number of posts in each band.

All band 6 senior nurses are Qualified in Specialty (QIS) trained and the band 5 nurses are given the opportunity to undertake the Qualified in Specialty (QIS) course after approximately 2 years of experience in a neonatal unit. The course takes about 1 year and requires a 12-week placement in a level 3 unit. The Unit used for this is the Tertiary Unit in the cluster group

where the QIS Course is being provided - Cambridge. There is a rolling programme to give all band 5 nurses the opportunity to undertake the course which runs each year. The Trust supports on average 2 nurses per year dependant on staff having the relevant pre-course experience. Due to the Covid crisis, the course for staff for the 19/20 year was suspended however this was re-commenced in January 2022 and 3 staff members are currently undertaking the course.
In addition, all band 4 Nursery Nurses are required to complete the Transitional or Special Care Module in order to provide a higher level of care within transitional care. Following successful approval of a business case to support further development of Transitional Care - 5.8 wte band 4 Nursery Nurses (or equivalent) have been appointed to provide 24 hours support on TC and have been enrolled on to the Transitional Care course starting in September 2022. On completion, and once all staff have completed the TC training and competencies for TC, the aim is for TC to be independently staffed 24hrs per day to offer optimal support for Mothers, and further reduce separation of Mothers and her baby, with a support from Neonatal Nurse.

The Unit has either a band 6 or band 7 shift leader. All of these staff are QIS. The shift leader is not routinely supernumerary, but this is considered Gold Standard, and the Trust has an aim to hopefully achieve this by the end of the year as this can be achieved once current vacancies are filled.

The number of cots and the breakdown of levels of care has not changed since changing from level 2 to level 1 unit.

4. MIS Safety action 4: Can you demonstrate an effective system of clinical* workforce planning to the required standard? – year 4

4d) Neonatal nursing workforce
The neonatal unit meets the service specification for neonatal nursing standards. 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 and share this with the Royal College of Nursing, LMS and Neonatal Operational Delivery Network (ODN) Lead.

Minimum Evidence

The Trust is required to formally record to the Trust Board minutes, the compliance to the service specification standards, annually, using the neonatal clinical reference group nursing workforce calculator (see above). For units that do not meet the standard, the Trust Board should evidence progress against the action plan developed in year 3 of MIS to address deficiencies.
A copy of the action plan, outlining progress against each of the actions, should be submitted to the Royal College of Nursing (doreen@crawfordmckenzie.co.uk), LMS and Neonatal Operational Delivery Network (ODN) Lead.

Time Frames

d) Neonatal nursing workforce
Nursing workforce review has been undertaken at least once during year 4 reporting period.

5. Findings

The audit was originally undertaken in May 2022 and based on the unit activity and staffing levels for the period 1st October 2021 to 31st March 2022. The audit was undertaken by the Ward Manager & Deputy Head of Midwifery. The results were generated electronically on the basis of the data submitted. The ODN requested that the tool was submitted to themselves for confirmation and verification of the data presented.

Input activity (HRG 2016)			Input staffing numbers (WTE) DIRECT PATIENT CARE ONLY		
	Activity	Declared cots		Budget	In post
HRG 1 (IC)	28	1	Total QIS	15.16	12.76
HRG 2 (HD)	134	3	Total Non QIS	3.44	4.44
HRG 3 (SC)	1,377	8	Total Non Reg	3.28	3.28
Total	**1,539**	**12**	**Total**	**21.88**	**20.48**

These results indicate that there is a shortfall of 1.40 WTE between the budget and staff in post. Whilst there is no budget for band 5 nurses who have completed the QIS course, the staff in post at this level contribute to the shortfall in band 6 nurses. However, the band 5 QIS will not be a shift leader so the requirement is for the band 6 posts to be filled to ensure that there is adequate shift leader cover. This vacancy has been advertised and is going through the recruitment process.
This calculation includes the shift coordinator who is not currently supernumerary but does not include management and education hours for the ward manager and the PDN.

Activity (HRG 2016)							
	Activity	*For calculations*		Declared cots	Occupancy for period	Cots required to meet activity at average 80% occupancy	Variance: declared cots against required
		80% of daily activity	*WTE (6.07 / BAPM)*				
HRG 1	28	*0.2*	*6.07*	1	15.38%	1	0
HRG 2	134	*0.9*	*3.04*	3	24.54%	1	2
HRG 3	1,377	*9.5*	*1.52*	8	94.57%	9	-1
Total	**1,539**			**12**	**70.47%**	**11**	**1**

The data presented above suggests that the cot occupancy is 70.47% which is below the expected standard of 80%. However, this data does not consider any babies having transitional care either in the unit or on the wards which accounts for approximately 16% of babies born each year.

The occupancy in the neonatal unit does not reflect any transitional care (TC) activity either on the ward or in the Special Care unit and admissions from home to TC, therefore this is an additional group of babies requiring oversight and care delivered by the NNU nursing staff. And included in the staffing model which should be a ratio of 1:4 Care of the baby should be overseen by a registered nurse whilst the mother is cared for by the midwife and maternity support staff. Joint working is in place to ensure care is delivered according to guidelines. The following table breaks down the figures for TC and the bed days.

Number of babies:	October 2021	November 2021	December 2021	January 2022	February 2022	March 2022
In TC	22	14	9	13	15	12
Bed days	73	57	27	52	60	74
Admitted from home	5	7	7	3	4	6
Bed days	21	51	34	14	15	8

Stepdown (NNU to TC)	6	5	7	10	12	3
Bed days	12	6	8	18	18	8
TOTAL	33	26	23	26	31	21
TOTAL Bed days	106	114	69	84	93	90

6. Nursing Staff against toolkit

Nursing workforce (WTE) DIRECT PATIENT CARE ONLY					
NB total nurse staffing required to staff declared cots = 33.39, of which 23.37 (70%) should be QIS					
	Current position		Required to meet activity at average 80% occ	Variance: budget against required	Variance: in post against required
	Budget	In post			
Total nursing staff	21.88	20.48	24.38	-2.50	-3.90
Total reg nurses	18.60	17.20	20.08	-1.48	-2.88
Total QIS	15.16	12.76	14.05	1.11	-1.29
Total non-QIS	3.44	4.44	6.02	-2.58	-1.58
Total non-reg	3.28	3.28	4.31	-1.03	-1.03
Reg nurses as % nursing staff	85.0%	84.0%	82.3%		
QIS as % reg nurses	81.5%	74.2%	70.0%		

The results show that 74.2% of staff have completed the QIS course which is above national target of 70% and the overall number of registered or trained staff is 84%.

The shift coordinators are either band 6 or band 7 nurses and are currently not supernumerary. Additional band 6 hours have been recruited to in order to work towards this being possible at least some of the time. This should lead to increased assurance of safe staffing levels when staff need to attend high risk births, allow the ward manager to participate in governance forums such as meetings, audits, case reviews, responding to urgent requests for updates and service developments and needs and to ensure that mandatory training and competencies are being met by all the relevant staff. This would also provide some additional support during escalation of activity or acuity when required.

7. Summary

Neonatal care is a high cost speciality commissioned by specialised services. It covers all levels of care from intensive through to care in the community. It should also include the support and education required for new parents/carers. Acuity and dependency vary according to the individual needs of the neonate.

The report indicates that there is a shortfall of 1.40 WTE (6%) between the budget and staff in post. Whilst there is no budget for band 5 nurses who have completed the QIS course, the staff in post at this level contribute to the shortfall in band 6 nurses. This vacancy has been advertised and going through the recruitment process.

The Unit has either a band 6 or band 7 shift leader. All of these staff are QIS. The shift leader is not routinely supernumerary but this is considered Gold Standard, and we aim to hopefully achieve this by the end of the year ones the vacancies post has been appointed to.

The findings of the toolkit indicate that the cot occupancy is 70.47% in this period of audit although the number of babies does not consider the neonates having Transitional Care who are still under the care of the neonatal nurses. With the continued aim to reduce Term

admissions to the Neonatal Unit, this should not be ignored when calculating the number of staff who are required to deliver direct care.

Following successful approval of a business case to support further development of Transitional Care - 5.8 wte band 4 Nursery Nurses (or equivalent) have been appointed to provide 24-hour support on TC and have been enrolled onto the Transitional Care course starting in September 2022. On completion of this training and passing the competencies for TC, the aim is for TC to be independently staffed 24hrs per day to offer optimal support for Mothers, and further reduce separation of Mother and her baby.

8. Recommendation

There should be a regular review of the staffing levels and skill mix to enable this to reflect the activity and acuity going forward. Establishment meeting have been scheduled to take place every two months.

Allowance made for staffing of TC and enabling staff to complete QIS.

The review should be confirmed by the ODN to ensure that the findings of the toolkit have been applied appropriately

An action plan should be formulated and agreed by all interested parties and submitted to the Divisional Management team for approval prior to submission to the Trust Board.

Complete Neonatal CRG Nursing Workforce Calculator or equivalent each year and report on findings to reflect staffing needs and budget setting.

Appendix 1 MIS (CNST) Safety Action 4d Technical guidance

Technical guidance	
Neonatal nursing workforce	
Where can we find more information about the requirements for neonatal nursing workforce?	Between 8 August 2021 until 5 January 2023, each neonatal unit should perform a nursing workforce calculation using the CRG work force staffing tool. Units that do not meet the service specification requirement for nursing workforce should have an action plan signed off by their Trust board, as per MIS year 3 requirements. Trust Board should evidence progress against the action plan and share those with the RCN, LMNS and Neonatal ODN.
Our Trust does not meet the relevant nursing standards and in view of this an action plan, ratified by the Board has been developed. Can we declare compliance with this sub-requirement?	If the requirements are not met, Trust Board should evidence progress against the action plan developed in year 3 of MIS to meet the recommendations. The action plan and related progress, signed off by the Trust Board, should be shared with the Royal College of Nursing (doreen@crawfordmckenzie.co.uk) and Neonatal ODN Lead. This will enable Trusts to declare compliance with this sub-requirement.

Appendix 2 Summary of Safety Action 4d - Compliance with Standards				
Clinical Workforce Group	**Standard to be met**	**WSH compliance**	**Progress Report**	**Evidence Source**
Neonatal nursing workforce	The neonatal unit meets the service specification for neonatal nursing standards. 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 and share this with the Royal College of Nursing, LMS and Neonatal Operational Delivery Network (ODN) Lead.	**GREEN – staffing assessment completed** **Amber- vacancies as staff recruited to posts have not yet commenced their employment**	Between 8 August 2021 until 5 January 2023, each neonatal unit should perform a nursing workforce calculation using the CRG work force staffing tool.	Units that do not meet the service specification requirement for nursing workforce should have an action plan signed off by their Trust board, as per MIS year 3 requirements. Trust Board should evidence progress against the action plan and share those with the RCN, LMNS and Neonatal ODN. If the requirements are not met, Trust Board should evidence progress against the action plan developed in year 3 of MIS to meet the recommendations. The action plan and related progress, signed off by the Trust Board, should be shared with the Royal College of Nursing (doreen@crawfordmckenzie.co.uk) and Neonatal ODN Lead. This will enable Trusts to declare compliance with this sub-requirement.

Appendix 3 Copy of CRG Workforce Calculator

Neonatal CRG Nursing Workforce Calculator (2020): West Suffolk

Input unit details			
Trust	West Suffolk NHS Foundation Trust		
Unit	West Suffolk		
Designation	SCU		
Completed by	J Skonieczny, K. Ranson,		
Date completed	12/05/22		
Activity period	1 October 2021- 31 March 2022	Days in period	182

Input activity (HRG 2016)			Input staffing numbers (WTE) DIRECT PATIENT CARE ONLY		
	Activity	Declared cots		Budget	In post
HRG 1 (IC)	28	1	Total QIS	15.16	12.76
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NB total nurse staffing required to staff declared cots = 33.39, of which 23.37 (70%) should be QIS					
	Current position		Required to meet activity at average 80% occ	Variance: budget against required	Variance: in post against required
	Budget	In post			
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Total reg nurses	18.60	17.20	20.08	-1.48	-2.88
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Reg nurses as % nursing staff	85.0%	84.0%	82.3%		
QIS as % reg nurses	81.5%	74.2%	70.0%		

Assumptions For further detail please refer to the narrative sheet.

- Calculations are valid for neonatal unit only - transitional care staffing and activity should be excluded.
- 6.07 WTE is required for 1 nurse per shift. The detail of how this multiplier was calculated is on a separate sheet.
- Staffing requirements are based on activity, and BAPM nurse to baby ratios are used, ie IC 1:1; HD 1:2; SC 1:4.
- Numbers are for nurses providing direct patient care only. Exclude additional roles e.g. management, outreach, education.
- A supernumerary nurse in charge is included for all units on all shifts.
- At least 70% of registered nurses should be Qualified In Specialty (QIS).
- All intensive and high dependancy care should be undertaken by registered nurses with QIS training.
- For special care, registered to non-registered staff ratios are calculated at 70:30.
- Cot calculations assume that cots can be flexed up but not down, so round up to the higher level cots. See narrative for more detail.

Appendix 4 Action plan:

Action plan lead	Name: Justyna Skonieczny	Title: Deputy Head of Midwifery	Contact: Justyna.skonieczny@wsh.nhs.uk

Recommendation	Actions required	Action by date	Person responsible	Comments/action status
There should be a regular review of the staffing levels and skill mix to enable this to reflect the activity and acuity going forward.	Regular staffing review to be undertaken including succession planning. Establishment meeting schedule every two months.	Ongoing review	Karen Ranson	
Complete Dinning tool or equivalent each year and report on findings to reflect staffing needs and budget setting.	Repeat staffing tool assessment yearly and compare findings with current staffing levels	June 2023	Justyna Skonieczny/ Karen Ranson	
Allowance made for staffing of TC and enabling staff to complete QIS.	Ongoing training	June 2023	Karen Ranson/ Maija Blagg	
The review should be confirmed by the ODN to ensure that the findings of the toolkit have been applied appropriately	Report to be submitted to ODN for review and confirmation of findings	July 2022	Justyna Skonieczny	Report approved by ODN on the 7th July 2022
An action plan should be formulated and agreed by all interested parties and submitted to the Divisional Management team for approval prior to submission to the Trust Board.	Report and action plan to be submitted to Quality and safety meeting, Safety Champion prior to submission to the Board	July 2022	Justyna Skonieczny	MNSC meeting August 2022

West Suffolk NHS
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TRAINING NEEDS ANALYSIS AND TRACKER

Justyna Skonieczny

Deputy Head of Midwifery

CORE COMPETENCY TRAINING FRAMEWORK TRAINING COMPLIANCE (TARGET 90%)

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

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SAVING BABIES LIVES CARE BUNDLE

MINIMUM REQUIREMENT	Number of attendees in month (TARGET 90%)	July 2022 - September 2021	October 2022– December 2021	January 2022- March 2022	April 2022	May 2022	June 2022	July 2022	August 2022	September 2022	Current % age completion
Smoke free pregnancy	Midwives	100%	99%	99%	97%	99%	98%				98%
	Obstetrician*	NA	NA	78%	71%	67%	81%				74%
Monitoring growth restriction (as for GAP)	Midwives	87%	95%	96%	94%	95%	96%				93%
	Obstetrician	95%	97%	92%	90%	95%	81%				91%
Fetal movements & Fetal monitoring	Midwives	90%	90%	84%	83%	77%	76%				83%
	Obstetrician	77%	80%	72%	92%	80%	66%				79%
Pre-term birth *	Midwives	NA	NA	99%	100%	100%	99%				99%
	Obstetrician	NA	NA	0%	0%	0%	0%				0%

GAP AND GROW TRAINING

MINIMUM REQUIREMENT	Number of attendees in month (Target 90%)	July 2022 - September 2021	October 2022– December 2021	January 2022- March 2022	April 2022	May 2022	June 2022	July 2022	August 2022	September 2022	Current % age completion
Training and competency assessment in: • Measuring SFH with a tape measure • Plotting measurements on charts • Appropriate interpretation • Appropriate escalation and referral (TARGET 90%)	MIDWIVES	87%	95%	96%	94%	95%	96%				93%
	CONSULTANT OBSTETRICIANS	95%	97%	92%	90%	95%	81%				91%

* 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 2022 - September 2021	October 2022– December 2021	January 2022- March 2022	April 2022	May 2022	June 2022	July 2022	August 2022	September 2022	Current %age completion
Risk assessment throughout labour Fetal monitoring – Intermittent auscultation (IA) Fetal Monitoring – Electronic Fetal Monitoring (EFM)	MIDWIVES	90%	90%	84%	83%	77%	76%				83%
	CONSULTANT OBSTETRICIANS	77%	80%	72%	92%	80%	66%				79%
	ALL OTHER OBSTETRICIANS										
Use of local case histories	MIDWIVES	13%	21%	66%	78%						45%
	OBSTETRICIANS	28%	50%	48%	72%						50%

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 2022 - September 2021	October 2022– December 2021	January 2022-March 2022	April 2022	May 2022	June 2022	July 2022	August 2022	September 2022	Current %age completion
Locally identified training needs relating to emergency scenarios which might include: Antepartum Haemorrhage and Postpartum Haemorrhage Impacted fetal head Pre-eclampsia/eclampsia, severe hypertension Uterine rupture Maternal resuscitation Vaginal breech birth Shoulder dystocia Cord prolapse Include: • The use of maternal critical care observation charts • Structured review proformas • Deterioration and escalation thresholds • Timing of birth and immediate postnatal care	OBSTETRIC CONSULTANTS	1	8	1	2	5	3				96%
	ALL OTHER OBSTETRIC DOCTORS CONTRIBUTING TO THE ROTA	4	10	5	0	2	0				
	OBSTETRIC ANAESTHETIC CONSULTANTS	2	5	0	1	1	1				96%
	ALL OTHER OBSTETRIC ANAESTHETIC DOCTORS CONTRIBUTING TO THE ROTA	3	6	3	2	1	2				
	MIDWIVES	30	49	31	17	15	13				97%
	MATERNITY SUPPORT WORKERS AND HEALTH CARE ASSISTANTS	7	8	10	5	5	3				96%

NB:

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

PERSONALISED CARE

MINIMUM REQUIREMENT	Number of attendees in month Target 90%	July 2022 - September 2021	October 2022– December 2021	January 2022-March 2022	April 2022	May 2022	June 2022	July 2022	August 2022	September 2022	Current %age completion
Ongoing antenatal and intrapartum risk assessment with a *holistic view from a woman's personal perspective, offering her informed choice.* *	Midwives	This topic will be covered within CNST year 5 training sessions starting from January 2023									
	Obstetrician										
Maternal mental health	Midwives	99%	99%	98%	97%	99%	98%				98%
	Obstetrician*	93%	94%	95%	90%	93%	93%				93%
Vulnerable women and families Social factors requiring referral	Midwives	99%	99%	98%	97%	99%	98%				98%
	Obstetrician	94%	87%	95%	90%	93%	93%				92%
Families with babies on NICU *	Midwives	This topic will be covered within CNST year 5 starting from January 2024									
	Obstetrician										
Bereavement care	Midwives	99%	99%	98%	97%	99%	96%				98%
	Obstetrician**	NA	NA	NA	NA	NA	NA	NA			NA

NB:

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

CARE DURING LABOUR AND THE IMMEDIATE POSTNATAL PERIOD

West Suffolk NHS
NHS Foundation Trust

MINIMUM REQUIREMENT	Number of attendees in month TARGET 90%	July 2022 - September 2021	October 2022– December 2021	January 2022- March 2022	April 2022	May 2022	June 2022	July 2022	August 2022	September 2022	Current %age completion
Management of labour	MIDWIVES	NA	NA	99%	100%	100%	96%				98%
	OBSTETRICIANS**	NA	NA	NA	NA	NA	NA	NA			NA
VBAC and uterine rupture	MIDWIVES	This topic will be covered within CNST year 5 training sessions starting from January 2023									
	OBSTETRICIANS										
GBS in labour	MIDWIVES	NA	NA	99%	100%	100%	96%				98%
	OBSTETRICIANS**	NA	NA	NA	NA	NA	NA	NA			NA
Management of epidural anaesthesia	MIDWIVES	This topic will be covered within CNST year 6 training sessions starting from January 2023									
	OBSTETRICIANS										
Operative vaginal birth – ROBuST	MIDWIVES	This topic will be covered within CNST year 6 training sessions starting from January 2024									
	OBSTETRICIANS										
Perineal trauma – prevention of and OASI pathway	MIDWIVES	This topic will be covered within CNST year 5 training sessions starting from January 2023									
	OBSTETRICIANS										
Maternal critical care including care of pregnant and postpartum women with suspected or confirmed Covid-19	MIDWIVES	97%	96%	98%	97%	96%	97%				97%
	OBSTETRICIANS	98%	90%	91%	88%	92%	96%				92%
Recovery care after general anaesthetic		This topic will be covered within CNST year 5 starting from January 2024									

NB:

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

NEONATAL LIFE SUPPORT

MINIMUM REQUIREMENT	Number of attendees in month	July 2022 - September 2021	October 2022– December 2021	January 2022- March 2022	April 2022	May 2022	June 2022	July 2022	August 2022	September 2022	Current %age completion
Identification of a baby requiring resuscitation after birth and support immediate neonatal resuscitation until specialist neonatal help is available Assessed ability to deliver inflation breaths Knowledge and understanding of the NLS algorithm How to call for help within the organisation Situation, Background, Assessment, Recommendation (SBAR) or equivalent communication tool handover on arrival of help Recognition of the deteriorating newborn infant with actions to be taken	NEONAL CONSULTANTS OR PAEDIATRIC CONSULTANTS COVERING NEONATAL UNITS	NA	2	5	2	1	0				65% **
	NEONATAL JUNIOR DOCTORS WHO ATTEND ANY DELIVERIES	NA	5	2	1	3	0				77% **
	NEONATAL NURSES BAND 5 AND ABOVE	3	16	0	7	6	0				92%
	ADVANCED NEONATAL NURSE PRACTITIONERS (ANNPs) *	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
	MIDWIVES	30	49	31	17	15	13				97%

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

SUMMARY

Unit: Maternity Service at West Suffolk NHS Foundation Trust

Reporting period (quarter): April 2022-June 2022

Was MDT nature of training achieved as required during the period?

No, MDT nature of the training was achieved in April and May unfortunately due to sickness this was not achieved in June.

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

- The requirements of NLS compliance for neonatal medical staff 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. Significant improvement in attending the NLS up-date was noted in April and May however this dropped to none attending in June.
- 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?

The areas of significant concerns in meeting the standard are within fetal monitoring and NLS up-date compliance. This is due to:

- Staffing absence some being related to Covid-19 and difficulties in releasing medical staff to attend the training which has been escalated to Clinical Leads and Safety Champion
- Training plans put in place from January 2022 to meet the recommendation of MIS year 4 this includes medical staff attending the NLS training sessions. Significant improvement was noted in April and May however non attended in June. This has been escalated to the Clinical Leads and a reminder was send to all non-compliance staff to book the session.
- 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.
- To improve on compliance within fetal monitoring- Fetal surveillance in labour training will be introduced as face to face session as part of the PROMPT from August 2022. This will be MDT training run by Fetal Monitoring Leads.

West Suffolk NHS
NHS Foundation Trust

Report Title	**Report on Submission of Neonatal Medical Workforce requirements to Operational Delivery Network**
Report for	Approval and Information
Report from	Neonatal Services
Lead for Report	Karine Cesar Jageer Mohamed Martina Noone
Report Authors	Jageer Mohamed, Neonatal Safety Champion Beverley Gordon, Project Midwife In collaboration with the Leads for Neonatal Care
Report presented for information and approval	Maternity Quality and Safety Group – 19th September 2022
	Maternity and Neonatal Safety Champions – 22nd September 2022
	Trust Board – 30th September 2022
Date of Report	August 2022
Risk and assurance:	There are no financial or healthcare risks associated with this report which outlines the Trust's position against Neonatal Medical Workforce standards set by the ODN/NHSE
Legislation, regulatory, equality, diversity and dignity implications	The information contained within this report has been obtained through due diligence. There are no equality and diversity issues related to this report

Executive summary:

The Trust submitted non-compliance with NHS England's workforce templates for 2 out of 3 standards relating to medical staffing levels for neonatal care in June 2022.

One of the areas of non-compliance is with consultant paediatricians providing neonatal care being required to have 8 hours of neonatal specific training and education per year. This has already been addressed and this is now part of the workplans for all relevant consultants. Attendance is recorded and a programme of learning for 2 hours per month is in place.

All paediatricians involved in neonatal care are rostered to attend the in-house multidisciplinary neonatal resuscitation training as well as maintaining their compliance with the external neonatal life support (NLS) training programme every 4 years.

The remaining standard that has not yet been achieved is the requirement to have a dedicated neonatal Tier 1 practitioner available 7 days a week for 8 hours during daytime hours. Whilst this is not part of the BAPM standards currently, the Trust aspires to provide this if sufficient resources are available – financial and personnel - to allow this to happen.

Recommendation:
The Trust Board is asked to receive this report as evidence of progress towards suggested safe staffing levels within the neonatal medical workforce.

1. Introduction

Trusts providing maternity and neonatal services should have the requisite numbers of suitably trained, competent staff – midwifery, medical and nursing – to deliver safe effective care to the required standards. The Trust has previously provided evidence against Safety Action 4c of the Maternity Incentive Scheme Year 4, to assure the Trust Board that the rota for medical staff providing neonatal care meets the British Association of Perinatal Medicine (BAPM) levels in all Tiers and 24/7. This report contains additional information on the Trust's compliance with workforce standards from NHS England.

2. Background

The Trust is designated as a level 1 Special Care Baby Unit (SCU) in accordance with the Operational Delivery Network (ODN) criteria and national guidance from British Association of Perinatal Medicine (BAPM), providing care to babies who are born at 30 weeks or more (singleton) or 32 weeks or more (multiples). The guidance in place for medical staffing of all neonatal units is based on BAPM standards which outlines the required staffing levels in all 3 levels in accordance with the level and activity of the unit.

Whilst the standards for Neonatal Intensive Care Units (level 3) were updated by BAPM in April 2021, the guidance and standards for Local Neonatal Units (LNU) and SCU staffing was last published in 2018. This states the following:

Tier 1

3.2.1b Special Care Units

• SCUs should provide 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 if this does not reduce quality of care delivery and safety to the neonatal unit assessed using national standards (39, 40)

• SCUs delivering higher than recommended activity levels should provide a dedicated Tier 1 practitioner as required for LNUs; see 2.1b • In stand-alone SCUs without co-located paediatric services this resident Tier 1 practitioner would be dedicated to the neonatal service alone

Tier 2

3.2.2b Special Care Units • SCUs should provide a resident Tier 2 to support the Tier 1 in SCUs admitting babies requiring respiratory support or of very low admission weight

A report was prepared which was based on these standards and provision of full rota cover against the standards from September 2021 to February 2022 which indicated that the Trust was compliant over the 6-month period of time that was reviewed. This included the use of agency/locums, staff undertaking additional hours, acting down and acting up. A declaration of compliance with rota cover was made and this was submitted to the Trust Board for approval in May 2022. Compliance with rota cover will continue to ensure that standards are maintained.

In June 2022, the Trust was requested to complete a self-assessment workforce template for the ODN and respond to state our compliance with three standards. These standards had been circulated by the NHS England Neonatal Implementation Board (NIB) and was developed with the CRG who provided medical expertise. The ODN are currently waiting for the findings of the data submitted in the templates and will then feedback on the findings.
There is a total of 50 million NHSE LTP funding that will be made available for allocation to both medical and AHP workforce, however this funding is not recurrent and is for a 2-year period only. The ODN are hoping to hear more details of how this allocation will be decided which will then be shared with Trusts in the ODN.

The template was completed by the Paediatric and Neonatal lead Consultants as being based on the Trust being a designated Special Care Unit (SCU) (formerly level 1) providing <1000 intensive or high dependency care days. In the last 13 months – July 2021- July 2022 - the Trust provided 512 intensive/high dependency care days. The SCU is co-located with the Maternity Unit on the main site of West Suffolk Hospital NHS Trust.

The 3 standards for self-assessment were:

- Resident Tier 1 (ANNP or junior doctor ST1-3) practitioner dedicated to the neonatal service 8 hours/day, 7 days/week during peak daytime hours.
- Tier 2 (ANNP or junior doctor ST4-8) can be shared across a co-located paediatric service but must be immediately available to the neonatal unit for babies requiring respiratory support or those <1.5kg
- There should be a Lead Consultant for the neonatal service and all consultants should undertake a minimum of continuing professional development (equivalent to a minimum of eight hours CPD in neonatology).

3. Submission of evidence against standards

The Trust were asked to provide 3 pieces of information against each standard:

- Compliance taking into consideration budgeted posts
- Whole time equivalent (WTE) shortfall
- Priority to achieve the standards

The Trust responded to these 3 standards in the following manner, being non-compliant in the first and third standards and compliant with the second standard. See table below.

Framework for SCBUs						
	BAPM standard	**Description**	**If all budgeted posts are fully recruited to (including Deanery or Trust funded), is the unit compliant with BAPM standard?**	**Where applicable, unfunded WTE shortfall to meet BAPM standards (based on WTE medical staffing)**	**Priority level for investment (agreed with ODN and Trust)**	**Comments eg. expected changes in activity which may be relevant to medical workforce**
		SCUs delivering ≥1000 IC/HD care days, please fill in the LNU standards instead				
Standards for all SCBUs	Tier 1 compliance	Resident Tier 1 (ANNP or junior doctor ST1-3) practitioner dedicated to the neonatal service 8 hours per day/ 7 days per week during peak daytime hours (for standalone SCBUs tier 1 practioner must be present 24/7)	Non-compliant	2 weekend days	Low	
	Tier 2 compliance	Tier 2 (ANNP or junior doctor ST4-8) can be shared across a co-located paediatric service but must be immediately available to the neonatal unit for babies requiring respiratory support or those <1.5kg	Compliant	N/A	Low	
	Tier 3 compliance	There should be a Lead Consultant for the neonatal service and all consultants should undertake a minimum of continuing professional development (equivalent to a minumum of eight hours CPD in neonatology)	Non-compliant	8hr /consultant	High	new lead consultant and hoping to increase CPD

4. Analysis of submissions

The 2 standards that the Trust are not compliant with and the reasons for non-compliance are detailed as follows:

Tier one dedicated to the NNU 8 hours /day 7 days/ week:

There is a dedicated SHO during the week but not always during the weekend. At weekends, the rota is prepared to try to have an SHO and an extra Children's Advanced Nurse Practitioner (CANP) and/or Physicians Associate (PA) to cover paediatrics and SCU but this is not always achievable. This standard will need to be addressed if this is going to be a national requirement. as it will come up in peer review and ultimately any external assessments or standards.

There is a designated Clinical Lead for neonates and a minimum of 8 hours of neonatal continuous professional development (CPD) for each consultant per year.

There is a designated Clinical Lead for neonates who is also the Neonatal Safety Champion. The designated lead retired in December 2021 and this role has been overseen by another Consultant Paediatrician working alongside a Staff Associate Specialist Doctor (SAS). A Consultant has been appointed and is in post from August 2022 and will be the Neonatal Clinical Lead and Neonatal Safety Champion but the SAS will continue to support these roles.

Up until the time of these standards being released, not all consultants had recorded 8 hours of neonatal CPD but from June 2022, mandatory face to face neonatal education and updates for consultants - 2 hours/ month (in their new job plan) - has commenced and this should cover the required 8 hours / year. The first neonatal CPD session occurred Tuesday 14th June 2022. A record of attendance will be kept although it will be the practitioner's responsibility to ensure they have evidence of their attendance as part of their professional practice.

5. Current status of Medical Staffing Vacancies

There is ongoing work to ensure that vacancies are recruited to and proposals and business cases are submitted to develop new and existing roles to meet the needs of the service and external assurances.

6. Next Steps

The rota has been updated to consistently provide Tier 1 daytime Neonatal cover for 8 hours per day at weekends as well as weekdays. This includes the use of Physician Associates (PA) and CANPs working alongside the SHO.

Embed the teaching programme/CPD hours for consultants who provide neonatal care and monitor compliance and attendance with the requirements.

Staffing levels and vacancies to be monitored and managed to ensure the neonatal service has appropriate cover and expertise is available when required. Active recruitment to the vacancies should continue. Further reports will be submitted to demonstrate how progress is being made against the requirements.

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.

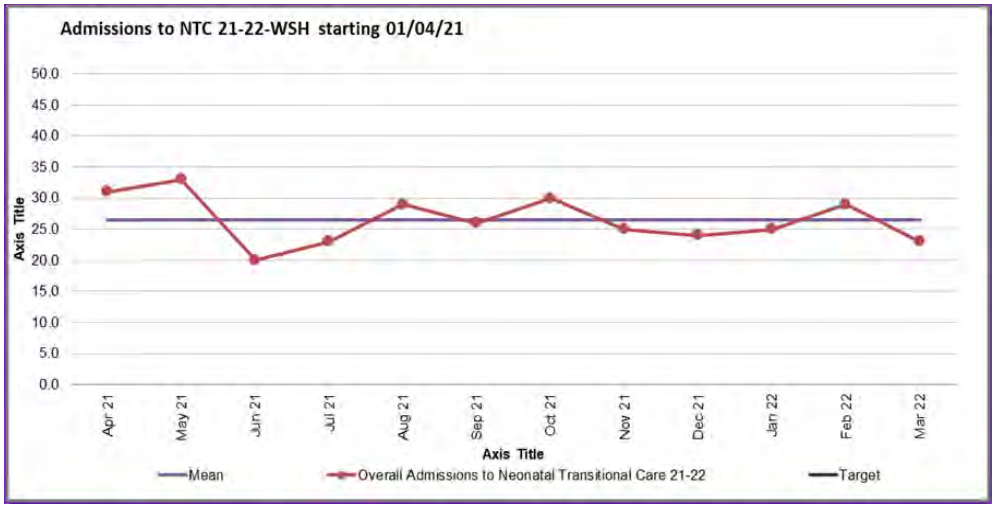
Aims of the Audit

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.

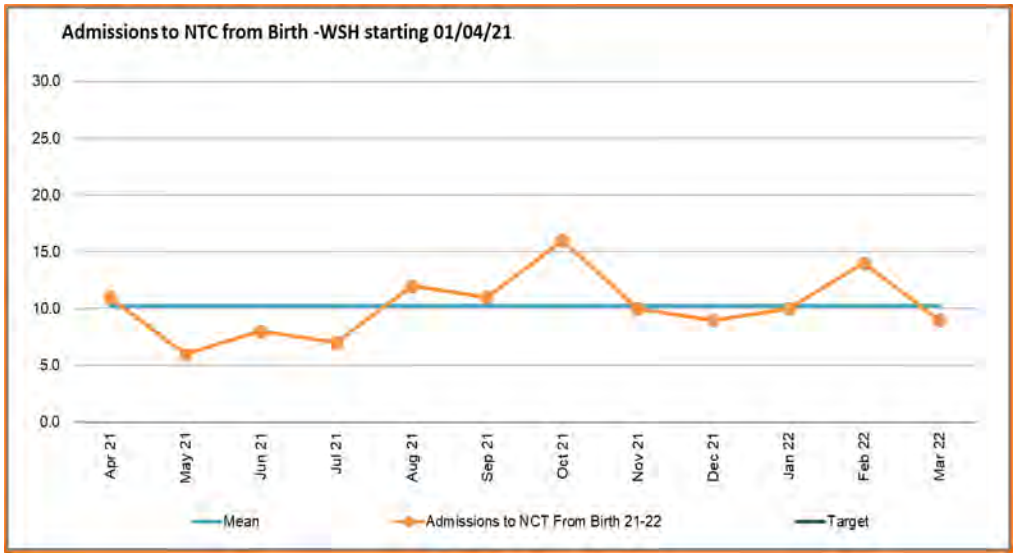
Brief Summary of Results for Quarter 4

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.

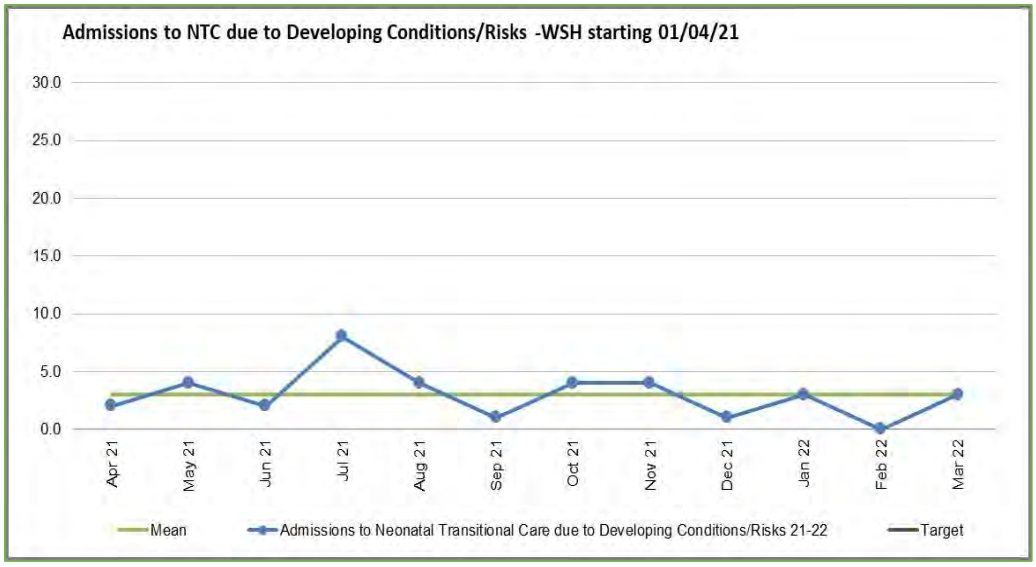
Two babies were just outside the criteria for TC on admission, gestation 34+6 and 1800gm.

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%



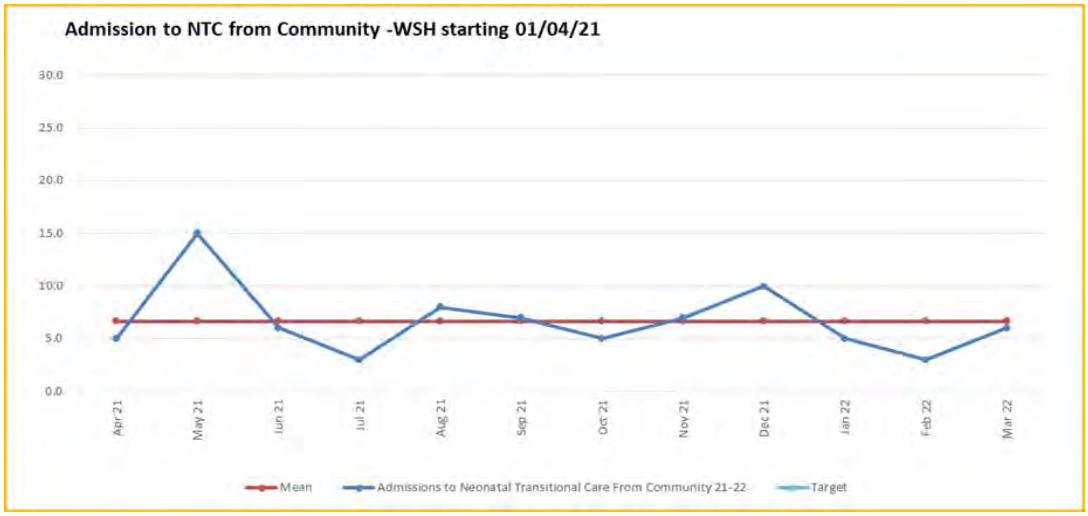
- 2 mothers women developed suspected/ confirmed sepsis postnatally requiring IV antibiotics as per the East of England Neonatal Antibiotic Policy 2019, all babies were appropriately transferred to TC for sepsis screening and commenced on IV antibiotics.

- 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

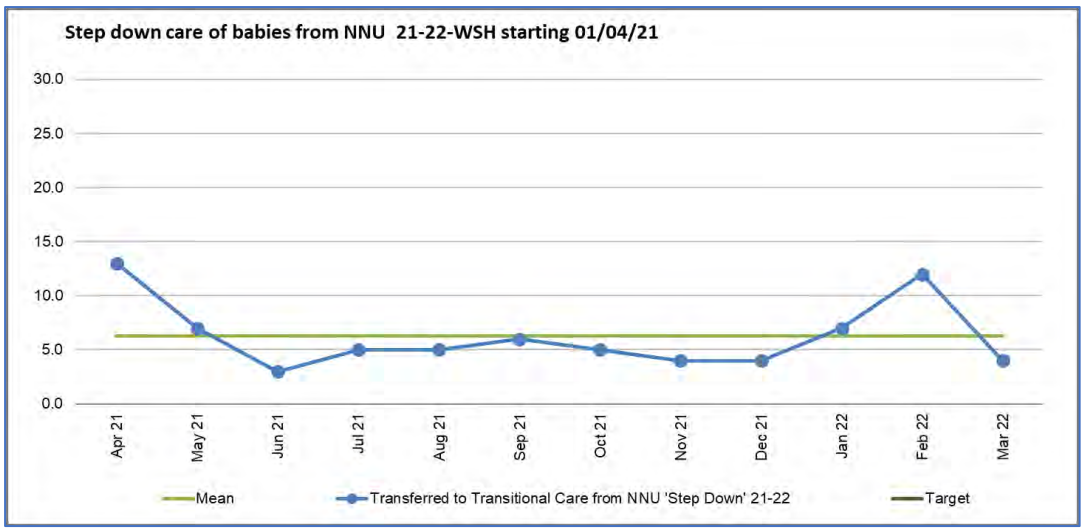
Clinical Standards		**Criteria met**
Criteria for readmission from community met:		
Requiring phototherapy and serum bilirubin monitoring	16 babies were admitted from the community setting. 14 admitted with jaundice all required phototherapy. • 5 premature < 37 weeks • 8 between 37 & 38 weeks • 2 between 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 (NNU) 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. Although there is no National/Regional target, it is anticipated that this percentage will increase due to earlier stepping down from NNU care.
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		Complete
		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		Complete
3	Local Maternity and Neonatal System and (LMNS),	Share findings and learning opportunities at the LMNS meeting.	31st July 2022	Karen Newbury HOM		Complete
4.	Quality Surveillance meeting and Trust Board.	Share findings at Trust Board	30th June 2022	Karen Newbury HOM		On track

Report Title	Audit of the Operational Pathway of Care into Neonatal Transitional Care April - June 2022 (Q1)
Report for	Information and Approval
Report from	Women's & Children's Services
Report Author	Jane Lovedale
Date of Report	August 2022
Presented to:	Maternity and Gynaecology Quality and Safety 19/9/22 Maternity and Neonatal Safety Champions 25/8/22 Trust Board 30/9/22

Audit of the Operational Pathway of Care into Neonatal Transitional Care April – June 2022

Introduction and Background

CNST maternity Incentive scheme

- Neonatal Transitional Care Safety Action 3
- CNST required standards revised May 2022
- Compliance with Maternity incentive scheme Year 4 published May 2022

Audit

- Aims
- Methodology
- Summary of Results for Quarter 1
- Conclusions for Quarter 1
- Summary Overall Findings and learning opportunities
- Appendix1- Overall data of reasons for admission to TC 2021-2022

- Changes and implementation of the revised CNST standard May 2022
- Improvements and future developments

- Midwifery staffing
- Neonatal staffing
- Neonatal medical teams

Audit of the Operational Pathway of Care into Neonatal Transitional Care April 2022 to June 2022

Report date: August 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 May 2022 to continue to support the delivery of safer maternity care.

Neonatal Transitional Care is included in Safety action 3: **Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies and to support the recommendations made in the Avoiding Term Admissions into Neonatal units**

CNST Required Standards revised and updated May 2022 (revised changes in blue)

A) Pathways of care into Neonatal Transitional Care have been jointly approved by maternity and neonatal teams with neonatal involvement with the focus on minimising separation of mothers

and babies. Neonatal teams are involved in decision making and planning care for all babies in transitional care.

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

C) A data recording process (electronic and/or paper based for capturing all term babies transferred to the neonatal unit, regardless of the length of stay, is in place.

D) A data recording process for capturing existing transitional care activity, (regardless of place - which could be a Transitional Care (TC), postnatal ward, virtual outreach pathway etc.) has been embedded. If not already in place, a secondary data recording process is set up to inform future capacity management for late preterm babies who could be cared for in a TC setting. The data should capture babies between 34+0-36+6 weeks gestation at birth, who neither had surgery nor were transferred during any admission, to monitor the number of special care or normal care days where supplemental oxygen was not delivered.

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

F) Reviews of babies admitted to the neonatal unit continue on a quarterly basis and findings are shared quarterly with the Board Level Safety Champion. Reviews should now include all neonatal unit transfers or admissions regardless of their length of stay and/or admission to BadgerNet. In addition, reviews should report on the number of transfers to the neonatal unit that would have met current TC admissions criteria but were transferred or admitted to the neonatal unit due to capacity or staffing issues. The review should also record the number of babies that were transferred or admitted or remained on Neonatal Units because of their need for nasogastric tube feeding, but could have been cared for on a TC if nasogastric feeding was supported there. Findings of the review have been shared with the maternity, neonatal and Board level safety champions, LMNS and ICS quality surveillance meeting on a quarterly basis.

Standards G) & H) have been excluded in this report as they relate to the ATAIN project relate.

Compliance with Maternity incentive scheme A-C

An operational Policy for Neonatal Transitional Care CG10602 is in place. This was reviewed and updated in October 2021. A data recording process captures transitional care activity each month by the Neonatal unit and the Maternity Quality and Safety team. A quarterly audit is undertaken to identify whether the agreed standard has been embedded. Audit findings are shared with the neonatal safety champion. Local Maternity and Neonatal System (LMNS), commissioner and Integrated Care System (ICS) quality surveillance meeting each quarter.

Aims of the Audit

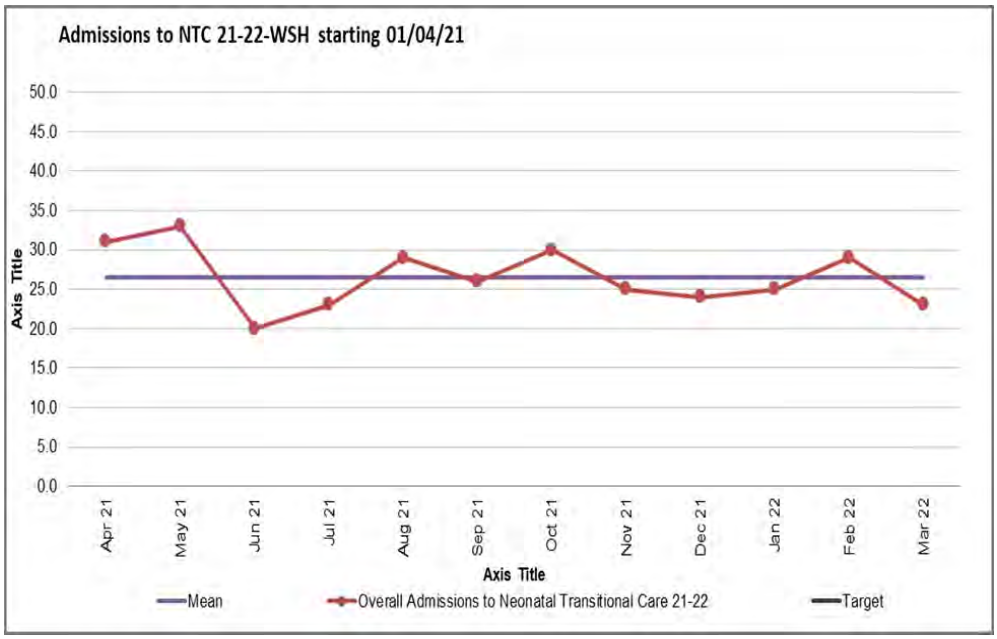
The objectives are to demonstrate whether the standards for clinical criteria for admission and the operational standards in relation to midwifery, neonatal and medical staffing are in accordance with the current policy.
The overall aim is to determine whether there are modifiable factors which can be addressed as part of an action plan 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.
NB. The audit noted that during this quarter the postnatal ward (F11) was relocated to another ward in the hospital to allow structural work to be undertaken. The new ward did not allow for a specific transitional care bay, however during this period all babies requiring transitional care continued to receive this type of care beside their mothers within the ward area.

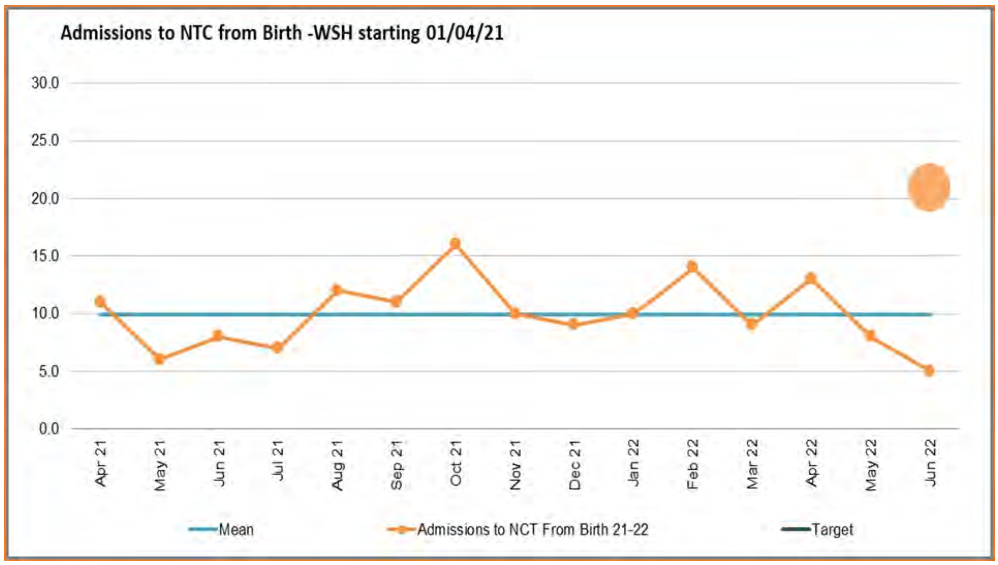
Brief Summary of Results for Quarter 1

74 babies received transitional care between April 22 and June 22



74 babies received transitional care during quarter 1 2022-23

26 babies received Transitional care following from birth from labour Suite / MLBU / Home

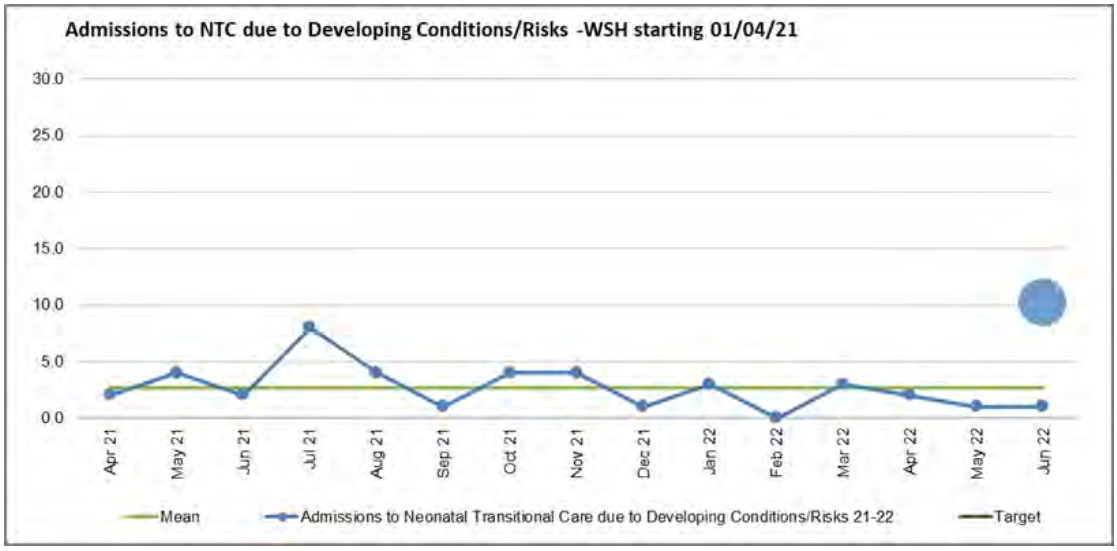


Clinical Standards		Criteria met
Criteria for immediate admission		
Gestational age >34+6 weeks	All babies were above 34+6	100%
Not requiring intensive or high dependency care	No babies required intensive care	100%
Birthweight >1800g	All babies had birthweights above 1800g	100%
Maternal suspected /confirmed sepsis in labour	15 /26 (56%)	100%
Neonatal risks of Sepsis.	6/26 (23%)	100%
Preterm	6/26 (23%)	100%

35% of babies received transitional care following their birth.

- 15 babies followed the local pathway for sepsis screening and intravenous antibiotics when the mother was treated for suspected or confirmed sepsis in labour.
- 6 babies followed the local pathway for sepsis screening due to risks associated with sepsis at birth.
- 6 babies were admitted due to prematurity with associated risks such as PPROM and reduced growth.

4 babies were transferred to receive transitional care due to clinical conditions developing on the Postnatal ward

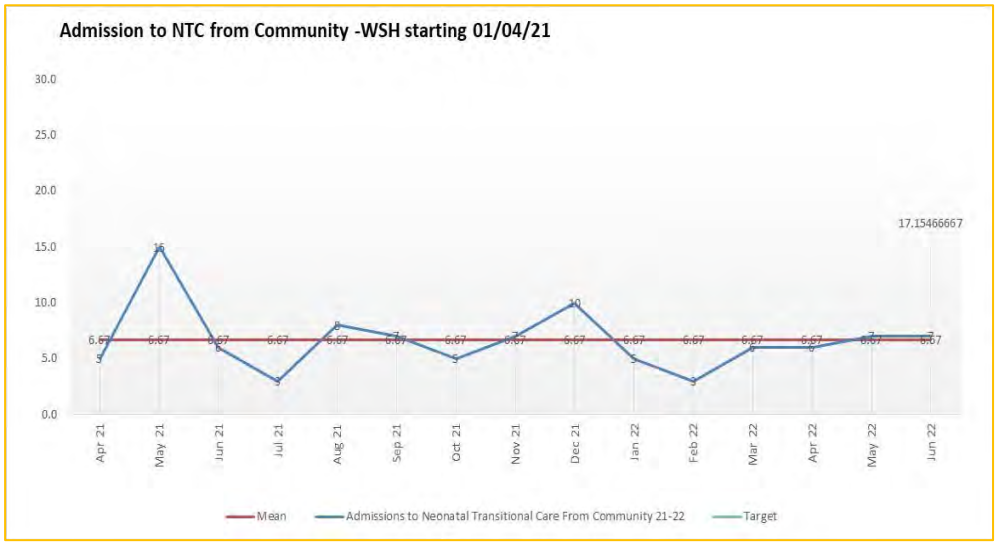


Clinical Standards		Criteria met
Criteria for admission – developing: Risk factors		
Risk factors for sepsis requiring IV antibiotics	2 babies developed or had persistent respiratory symptoms where sepsis was suspected.	100%
Neonatal hypoglycaemia	1 baby had persistent hypoglycaemia.	100%
Jaundice	1 baby developed neonatal jaundice 48 hours after birth requiring phototherapy.	100%

5.4% developed symptoms postnatally requiring them to transfer from normal care to transitional care.

- 2 babies developed or persisted with respiratory symptoms and followed the local pathway for sepsis screening and intravenous antibiotics. Neither baby required respiratory support and received transitional care allowing for closer observation and treatment with antibiotics.
- 1 baby had persistent hypoglycaemia suspected of being due to sepsis.
- 1 baby was identified with jaundice, with hypoglycaemia requiring phototherapy treatment. Both babies were transferred to transitional care allowing closer observation.

20 babies were re-admitted from the community setting and received transitional care



Clinical Standards		Criteria met
Criteria for readmission from community met:		
Requiring phototherapy and serum bilirubin monitoring	17 babies were re-admitted with jaundice.	100%
Weight loss poor feeding	3 babies were readmitted due to problems with feeding one baby had associated weight loss.	100%

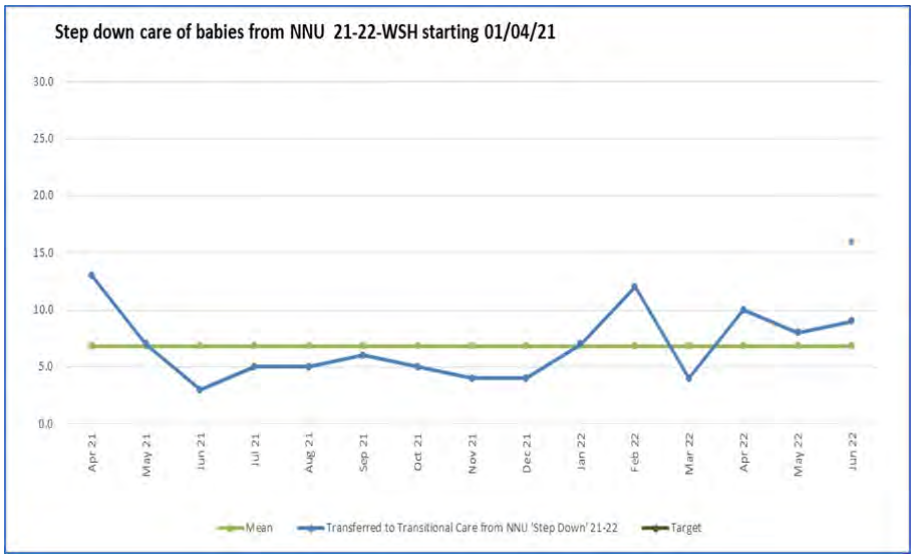
27% of babies required readmission from the community setting.

- The majority of the 17 were babies who the community teams had identified with jaundice. It was noted that thirteen of these were babies who were less than 38 weeks gestation.
  All required phototherapy treatment.

- 3 babies were admitted due to problems feeding their babies and requiring continuous support.

- All babies re-admitted from the community setting were cared for with their mothers in a side room on the neonatal unit. Although rare, where a mother is unable to remain in overnight with her baby and transitional care is therefore not possible babies were nursed within the neonatal unit.

24 babies had their care 'Stepped Down' from NNU to Transitional Care



Clinical Standards		Criteria met
Criteria for step down from NNU:		
Corrected gestational age > 33+0 and clinically stable.	All babies were within the agreed criteria for gestation.	100%
Observations required no more than 3 hourly	No babies required more than 3 hourly observations	100%
Stable baby with sepsis requiring antibiotics	All babies were continuing IV antibiotic treatment.	100%
Continuing phototherapy when bilirubin has stabilised	4 babies additionally continued with phototherapy treatment.	100%
Criteria for discharge met:		
Feeding established and baby is maintaining or gaining weight.	Criteria met	100%
Course of IV antibiotics is complete	All babies completed their antibiotics prior to discharge home	100%

32.4% babies of all babies who received transitional care were babies who had stepped down their care from the neonatal unit. All babies met the criteria for step down of their care.

Conclusions

Overall the number of admissions remains fairly stable and consistent with previous quarters. All babies met the agreed criteria for admission according to the local guideline.

The main reason for babies requiring transitional care are those with suspected / confirmed sepsis in either in the mother or baby at birth or soon after birth. This makes up around 38%

of babies overall. Although a small number of babies have mild symptoms of sepsis the majority require septic screen and prophylactic antibiotics due to suspected maternal sepsis in labour.

The second highest group of babies were those re-admitted from the community, the majority with neonatal jaundice, 26% of babies overall. All babies requiring phototherapy. A recent audit of babies readmitted with jaundice was very positive. It showed robust processes in place for early identification of babies particularly those under 38 weeks, as well as the community teams having direct contact with the paediatric registrar for referral to the neonatal unit for assessment.

Overall there appears to be a steady increase over the last few months in babies meeting the criteria for step-down care from the neonatal unit. This is important because it reduces the amount of time babies are separated from a mother /parent. In addition, it reduces the number of babies unnecessarily being cared for on the neonatal unit.

However, there are a number of babies who could meet the criteria for transitional care, but have a nasogastric tube in situ. The service has been unable to accommodate these babies due to the inability to provide 24/7 transitional care cover. This has already been addressed by the management team and newly appointed staff are currently completing their transitional care training. Once this is established a significant number of babies with be able to step down their care much earlier.

Implementation of the revised CNST standard May 2022

CNST Standards May 2022 for data recording and included in the quarterly reports

d) A data recording process for capturing existing transitional care activity, (regardless of place - which could be a Transitional Care (TC), postnatal ward, virtual outreach pathway etc.) has been embedded.

This is now embedded and data collected and reviewed by the Neonatal unit and Quality and Safety team each month. A report is generated quarterly.

If not already in place a secondary recording process is set up to inform future capacity management for late preterm babies who could be cared for in a TC setting. The data should capture babies between 34+0- and 36+6 weeks' gestation at birth, who neither had surgery or were transferred during any admission, to monitor the number of special care or normal care days where supplementary oxygen was not delivered.

The Maternity service developed a secondary data base in July 2021 to capture this group of babies.
The data base is populated each month. Data is included in the quarterly Transitional care report from 2022.

Month	Number of babies on Neonatal Unit	Number of Special Care / Normal care days where no supplemental oxygen was required.
April 2022	8	73
May 2022	12	75
June 2022	6	17
Total	**26**	**165**

f) Reviews of babies admitted to the neonatal unit continue on a quarterly basis and findings are shared quarterly with the Board Level Safety Champion. Reviews should now include all neonatal unit transfers or admissions regardless of their length of stay and/or admission to BadgerNet. In addition, reviews should report on the number of transfers to the neonatal unit that would have met current TC admissions criteria but were transferred or admitted to the neonatal unit due to capacity or staffing issues. The review should also record the number of babies that were transferred or admitted or remained on Neonatal Units because of their need for nasogastric tube feeding, but could have been cared for on a TC if nasogastric feeding was supported there.

The above standards are reviewed at the monthly ATAIN meetings and included within the ATAIN quarterly report.

Improvements and future developments

The audit saw some very positive improvements over the last year in accurate data input on BadgerNet in particular around place of admission and type of care received.

The maternity service is in the process of introducing the Kaiser Neonatal Sepsis calculator; a tool which establishes risk factors and neonatal condition to estimate each babies risk factor of early onset neonatal sepsis (EONS). Studies in the US have suggested that implementing this tool resulted in a reduction in antibiotic administration (48%) without evidence of adverse events (RCPCH). It goes on to say that 'investigation and monitoring of well infants remains challenging. True early onset neonatal sepsis is uncommon but the potential impact of sepsis can be disastrous' as a result, treatment rates far exceed the actual incidence of EONS and many infants receive antibiotics that are ultimately not necessary'.

The newly recruited staff for transitional care is towards the end of their training. Once in place we should see a more consistent monthly data collection of babies receiving transitional care. When staff are in place the guideline criteria for those babies suitable for transitional care guideline should be reviewed in particular those well babies with naso-gastric tubes in situ this will reduce the number of days babies need to remain on the Neonatal unit and separated from their mothers.

Audit of Operational standards staffing

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

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

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

Learning opportunities

There were no specific learning opportunities identified.

The findings of this audit to be shared with all staff via Risky Business monthly publication
Audit findings are shared with:

- Maternity and Neonatal Safety Champions
- Maternity and Gynaecology Quality & Safety meeting
- Neonatal teams
- Local Maternity and Neonatal System and (LMNS)
- Quality Surveillance meeting and Trust Board.

References:

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

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

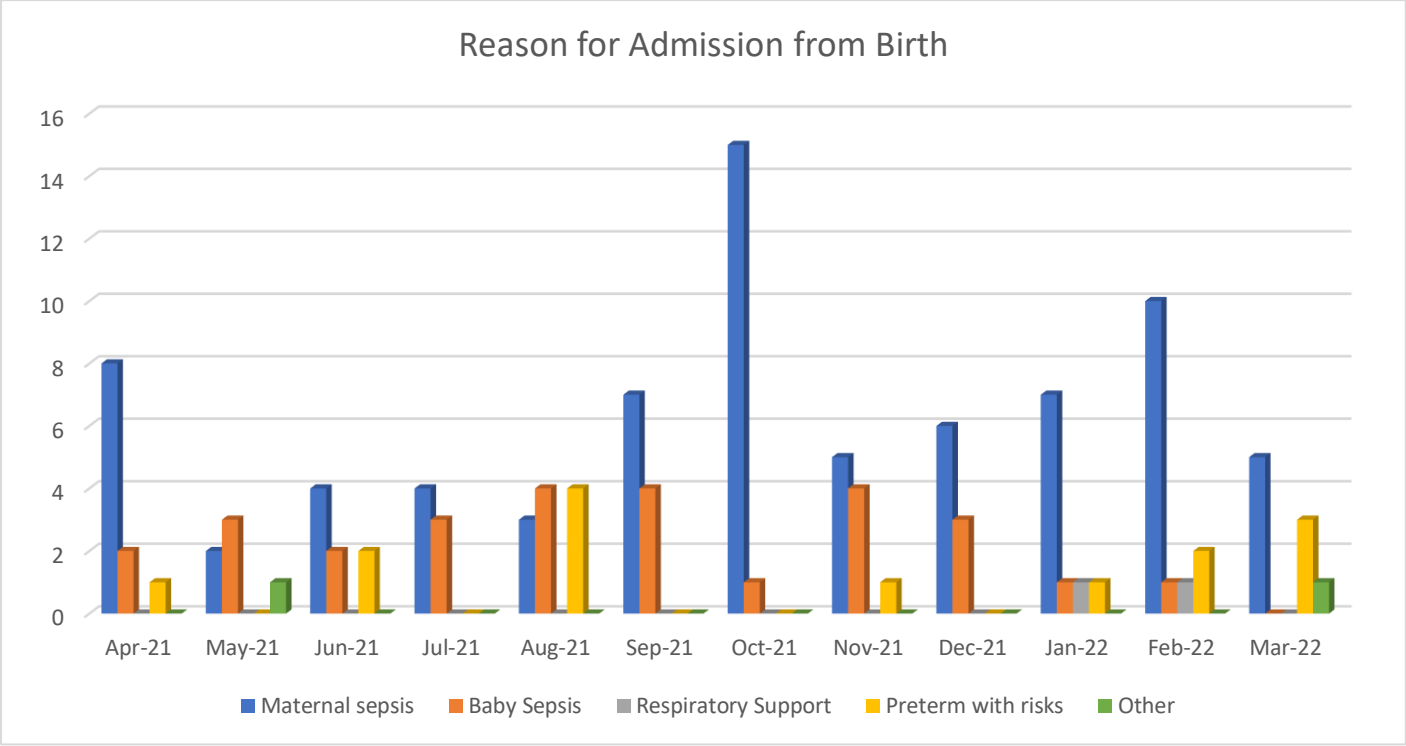
East of England Neonatal ODN East of England Neonatal Antibiotic Policy 24th October 2019 amended February 2020.

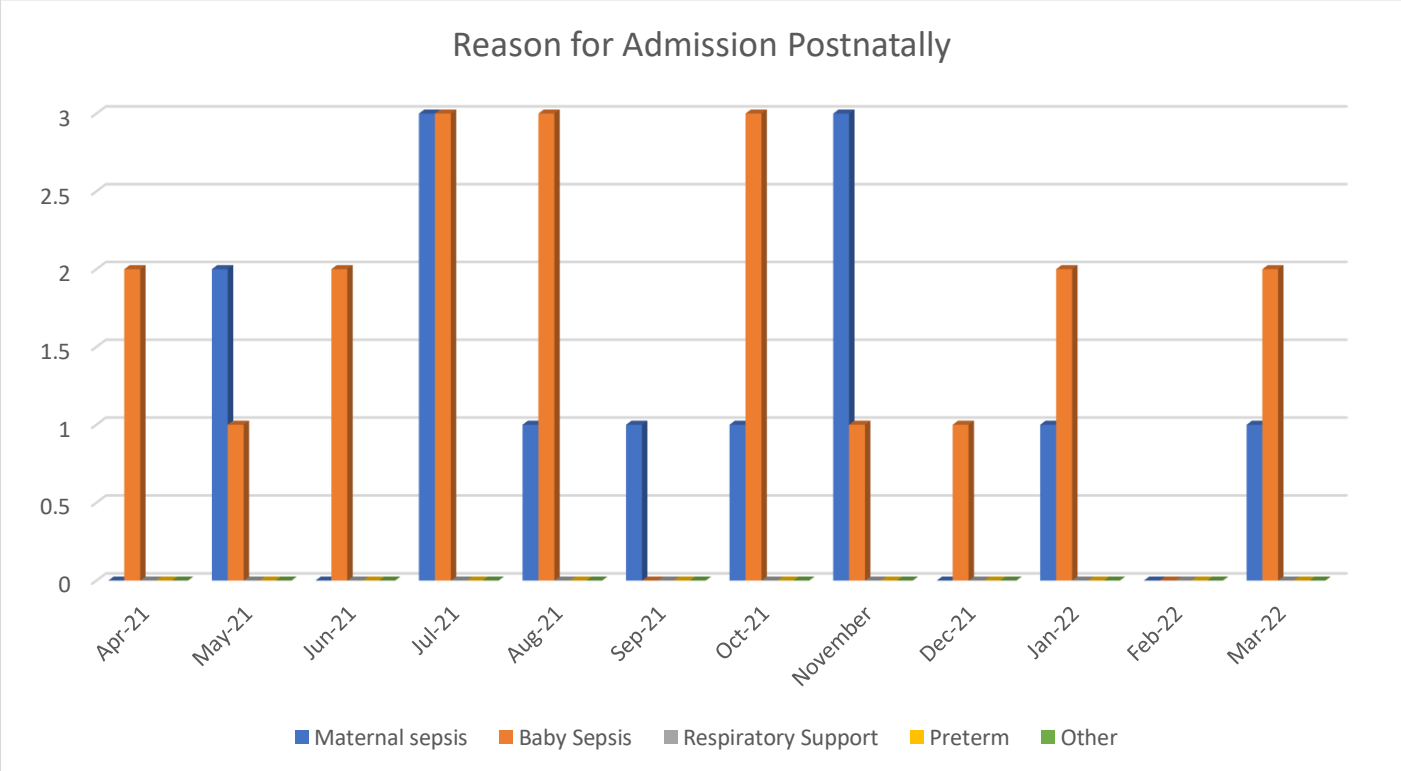
Maternity Incentive Scheme (CNST) Year Four Ten Maternity Safety Actions. Safety Action 3. May 2022

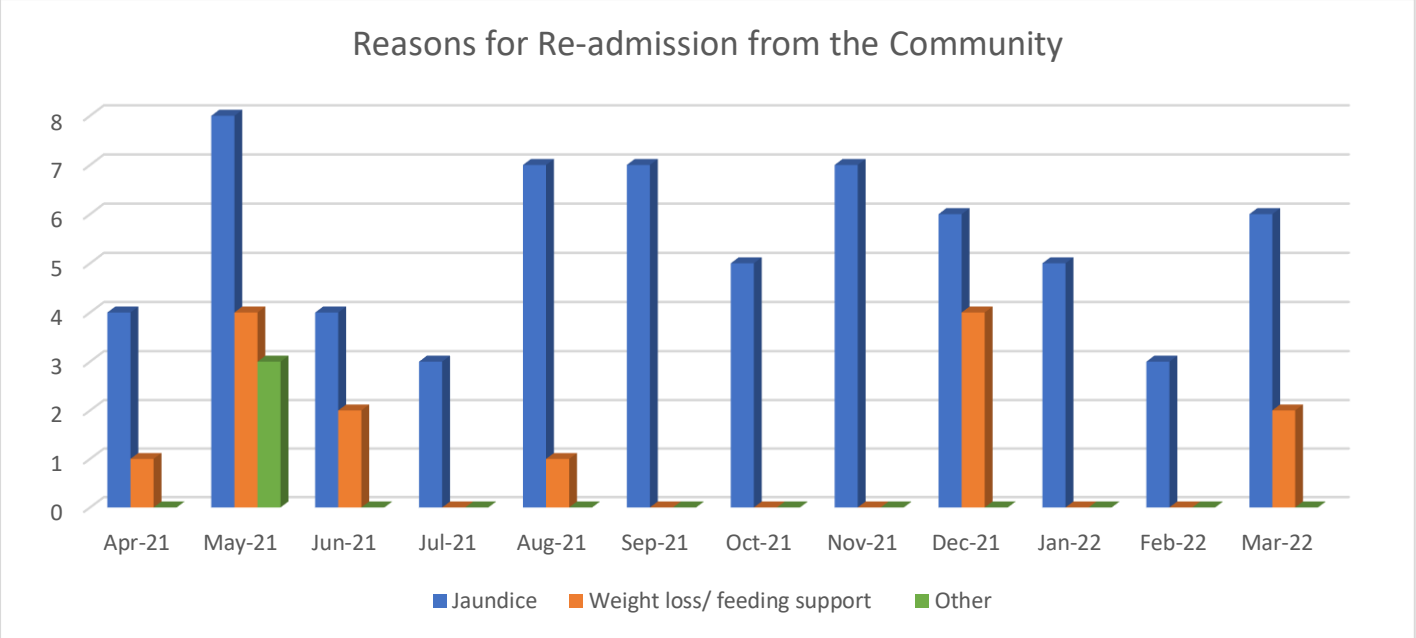
Safely Reducing Empirical Antibiotic Administration on Post-natal wards.
July 2020

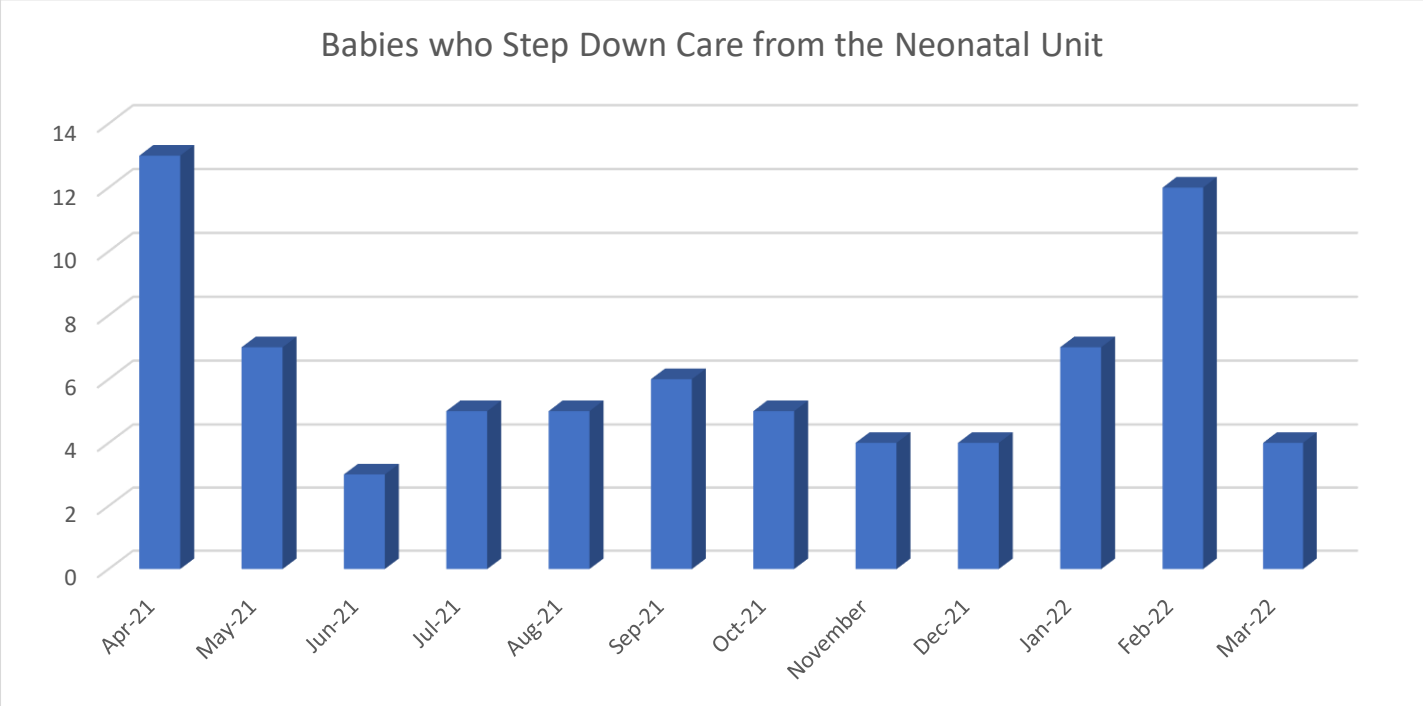
Appendix 1

Overall data of reasons for admission to TC 2021-2022






Reasons for Re-admission from the Community
8
7
6
5
4
3
2
1
0
Apr-21
May-21
Jun-21
Jul-21
Aug-21
Sep-21
Oct-21
Nov-21
Dec-21
Jan-22
Feb-22
Mar-22
Jaundice
Weight loss/ feeding support
Other


Babies who Step Down Care from the Neonatal Unit
14
12
10
8
6
4
2
0
Apr-21
May-21
Jun-21
Jul-21
Aug-21
Sep-21
Oct-21
November
Dec-21
Jan-22
Feb-22
Mar-22

Opportunities for Learning and Sharing

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

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

	Learning Opportunity	Actions required	Action by date	Person responsible	Comments/action status	Status of Action
1.	Share findings of the audit with all staff.	Risky Business publication	August 31st 2022	Rebecca Warburton Q&S Midwife		COMPLETE
		Maternity Quality & Safety meeting	August 31st 2022	Karen Green Q&S Manager		
2	Audit findings shared with the Maternity and Neonatal Safety Champions,	Shared audit findings at the MNSC meeting	25h August 2022	Karen Newbury HOM		COMPLETE
4	Local Maternity and Neonatal System and (LMNS),	Share findings and learning opportunities at the LMNS meeting.	September 2022	Karen Newbury HOM		COMPLETE
4.	Quality Surveillance meeting and Trust Board.	Share findings at Trust Board	30/09/2022	Karen Newbury HOM		On Track

WSFT Digital Strategy for Maternity

Author:	Emma Wright – Digital Midwife
Date approved by WSFT Digital Programme Board:	
Date approved by WSFT Trust Board:	
Approved by Local Maternity and Neonatal Systems (LMNS):	**7th September 2022**
Submitted to ICB:	

Author: Emma Wright – WSFT Digital Midwife

Published date: xxx (1st October 2022)

Review date: 1st October 2023

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Introduction and Background:

The Maternity Incentive Scheme for Trusts (CNST) is now in year 4 and the standards that were published in August 2021 were re-issued in May 2022.

Safety Action 2 relates to the Maternity Services Data Set (MSDS) and Trusts are required to record, analyse and report data collected regarding women and pregnant people who use the services within the Trust. This information needs to meet set criteria outlined within the NHSEI Digital Child Health and Maternity Programme.

Requirement:

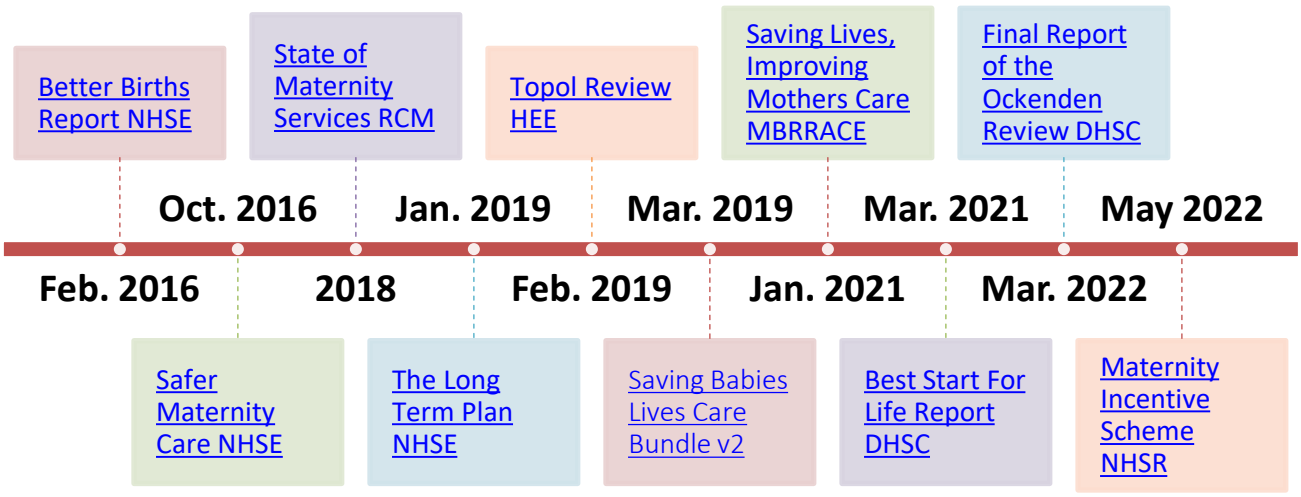
Standard 1 within the safety action requires:

1. By October 2022, Trusts have an up to date Digital Strategy for their maternity services which aligns with the wider Trust Digital Strategy and reflects the 7 success measures within the 'What Good Looks Like' Framework which was updated in October 2021. The strategy must be shared with Local Maternity and Neonatal Systems (LMNS) and be signed off by the Integrated Care Board (ICB). As part of this, dedicated Digital Leadership should be in place in the Trust and have engaged with the NHSEI Digital Child Health and Maternity Programme.

Strategies are not externally validated, but must have been approved by the Trust and the ICB.

This strategy is an integral part of the Trust's overall Digital Strategy and reflects the Digital Maternity Drivers and the Trust's ambitions and strategy.

Digital Maternity Drivers:



Our Trust values

Our First values are the guiding principles and behaviours which run through our organisation and will help us deliver our vision and ambitions in the right way. We will use them to always strive to improve the services we provide to our community and the way that we work as a team and with our partners.

Our Vision…

"… Is for care to be provided by high performing multi professional teams based on the needs of women, pregnant people and their families in an organisation that is well led within a culture of research and development, continuous learning, best practice and innovation."

Current State

In March 2021 WSFT implemented the Maternity module within Cerner Millennium, which is currently used throughout the Trust, in all areas including inpatient and community settings. Now live for 17 months, the hard work and perseverance of staff is being reflected in the data collected. Issues have been raised with the supplier in regards to our MSDS submissions which remain our top priority to resolve.

Work completed to date

- Launch of electronic Maternity module within eCare (Cerner Millennium) which includes use on the Neonatal Unit
- Launch of Centralised Cardiotocography (CTG) monitoring electronically using Fetalink
- Launch of the Patient Portal website for service users to access their care records
- Engagement of staff with at-the-elbow support
- Recruitment of a Digital Midwife
- System updates for CNST/MSDS/SBL/Ockenden requirements

Priorities for the Immediate Future

- Cerner Millennium fixes for MSDS submission requirements
- Workflow reviews
- Lights On network analysis to remove/reorder multiple unused fields
- Wall mounting of additional CTG equipment within the antenatal ward and day assessment unit
- Cerner and Perinatal Institute integration for GROW 2.0
- Cerner and BadgerNet integration for the Neonatal staff
- Connectivity optimisation within community areas, to include data only SIMs in laptops
- Printing of specimen labels in the community to enable use of eCare Order Comms therefore giving a better solution to endorsing all results
- Expansion of the Digital Maternity team

Priorities for the Mid-term Future

- Further engagement with service users to tailor patient facing Patient Portal website and to develop two-way communication and to gather feedback
- Further engagement with other community partners (e.g. Health Visitors) to improve collaboration and interconnectivity
- Further engagement with staff for feedback, ideas and dissemination of changes
- Continue development of digital leadership through Digital Midwife and an expanded team
- Keep eCare up-to-date for all local and national reporting requirements
- To include Level 3 Critical Care Neonatal beds within eCare
- Ability to manage own reporting dashboard for immediate oversight of information
- Introducing closed loop process for storage of breast milk

Priorities for the Long-term Future

- Further integration with other systems – Northgate NIPE Smart and CRIS (used by sonographers)
- Increased integration with Addenbrookes & Ipswich to enhance the shared care record using Health Information Exchange (HIE)
- Digital training for all maternity and neonatal staff to be included within mandatory training days

How does the Digital Strategy for Maternity align to the What Good Looks Like Framework?

1. Well led

What is happening now?	What will happen?
• LMNS wide Board that exists to steer the programme • Programme Board regularly reviews digital priorities • Programme Board is Chaired by lead clinicians and reports to Chief Nurse and Medical Directors • Programme Board receives feedback from staff, service users and other key stakeholders • Digital Midwifery leader in post • Digital Midwife attending Digital Midwives Expert Reference Groups (DMERGs)	• LMNS Digital Board transitions into an ongoing Digital Alignment Board to continue collaboration and alignment • LMNS Digital Board to own the Digital Strategy, commission further projects and programmes to continue its development and implementation • LMNS Digital Board will be clinically led, with strong links to the MVP and other user groups • Bespoke training for Digital Midwifery leader • Digital Midwifery team to be expanded within the Trust

2. Ensure smart foundations

What is happening now?	What will happen?
• Use of the Maternity module within a Trust wide EPR system that allows cross inpatient/community working, MDT working and delivers the ICB's digital ambitions for maternity • The system complies with the Technology Code of Practice and is cyber secure • Integration with other digital systems possible and being exploited – e.g. BadgerNet / Perinatal Institute • Provides a patient facing Patient Portal website with access to their care record and information	• Ongoing review of the use of the EPR system, with clinical input into its continual development and exploitation • Continued reduction of the use of paper within Maternity care • Development of the Patient Portal website to provide two-way communication

3. Safe practice

What is happening now?	What will happen?
• Current programme is compliant with Cyber security strategy and plans within the ICB and Trusts • Trust Cyber Security oversight is in place • System is compliant with Clinical Safety Standards • Training given on digital systems and workflows align with clinical practice • Business continuity in place for any periods of down-time	• Establishment of a clear process for reviewing and responding to safety recommendations and alerts, passed down from ICB/Trust Cyber leads • Process to be established to ensure compliance with NHS national contract provisions e.g. Admissions, Discharges & Transfers (ADT's) and clinical correspondence

4. Support people

What is happening now?	What will happen?
• Ongoing training and support for staff and users to be able to use the system well • Engagement of staff • Ensuring that the system allows staff to review information that helps them provide quality and safe care	• Continue to develop new and better ways of improving digital first approaches across the Trusts • Continue upskilling staff in the use of digital systems, encouraging the development of Digital Leaders and Super-users • Improve the information available within the system for clinicians to review, and tailor the mandatory questions and other data fields to make care safer, more data rich and better for the pregnant person • Invest in the next generation of digital maternity leadership

5. Empower citizens

What is happening now?	What will happen?
• Using a system that is accompanied by a complete patient facing handheld record • Focus on digital inclusion for those who cannot access the website	• Ensure that supplier commitments to integrate with the NHS app and NHS login are followed through • Introduction of new tools like the Pre-booking Questionnaire • Integrate with ICB shared care record solution of choice • Explore and where beneficial implement standardisation of care plans, appointment management and other aspects of care • Develop stronger inclusion strategies to tackle digital poverty and its impact on care

6. Improve care

What is happening now?	What will happen?
• Provide clinicians with a simpler, safer system that provides better advice during the care journey	• Engagement with other community partners and Primary Care to improve interoperability • Provide tools to staff to be able to use digital systems to provide remote care and monitoring

7. Healthy populations

What is happening now?	What will happen?
• Using a system that provides detailed information to the LMNS maternity dashboard	• Development of personalised care plans and continuity of carer that enable better outcomes for service users

How does the Digital Strategy for Maternity align to WSFT's Digital Strategy?

WSFT's digital strategy identifies three key ambitions that will be achieved over the next five years.

The thinking behind this is available in the attached reference document and here is a quick summary of how Women and Childrens' is aligned to this strategy.

Ambitions…	What Maternity will do
Digital empowerment for patients, carers and families	➢ Patient portal accessed via the NHS app with two-way communication ➢ Tools to capture and analyse patient experiences/journeys ➢ Interoperability of systems ➢ Wide adoption of Shared Care Records (HIE)
Digital first culture	➢ Clear pathways of care ➢ Visible digital Maternity leadership ➢ Accurate and timely information
Building strong digital foundations	➢ Provide tools for self-service access to data ➢ Wide range of tools to monitor cyber threats that are current and responsive

Reference Documents:

Organisation	Documents Available	Documents
WSFT	-WSFT Digital Strategy 2022 to 2026 (including Road Map)	WSFT Digital strategy 2022-2026.pptx
	-WSFT *Draft* Maternity Strategy	Clean DRAFT Maternity Strategy AP
	-WSFT Digital Services Governance	Governance slide 2021_v0.2.pdf
Local Maternity and Neonatal System (LMNS)	-LMS Strategic Digital Delivery Plan	STP Digital - LMS Strategic Digital Deliv
	-Unified Tech Fund Digital Maternity Bid	UTF_Digital Maternity Application Form_SNE
NHS Transformation Directorate	-Regional Digital Maturity Report 2018	Maturity Digital Maturity Report_Suffo
	-Regional Digital Maturity Report 2021	32_LMNS DMA Report Suffolk_NEEss
	-What Good Looks Like Framework	What Good Looks Like framework - What Good Looks Like - NHS Transformation Directorate (nhsx.nhs.uk)

4.6 - Integrated Quality & Performance Report (full)

Integrated Quality and Performance Report Report

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

Executive Summary:

The Integrated Quality and Performance Report uses the Making Data Count methodology to report on the following aspects of key indicators:
1. Compliance with targets and standards (pass/fail)
2. Statistically significant improvement or worsening of performance over time.
Narrative is provided to explain the drivers for performance, actions being taken and assurance mechanisms.
Please refer to the assurance grid on the next slide for an executive summary of performance.

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.

Assurance Grid

FAILING

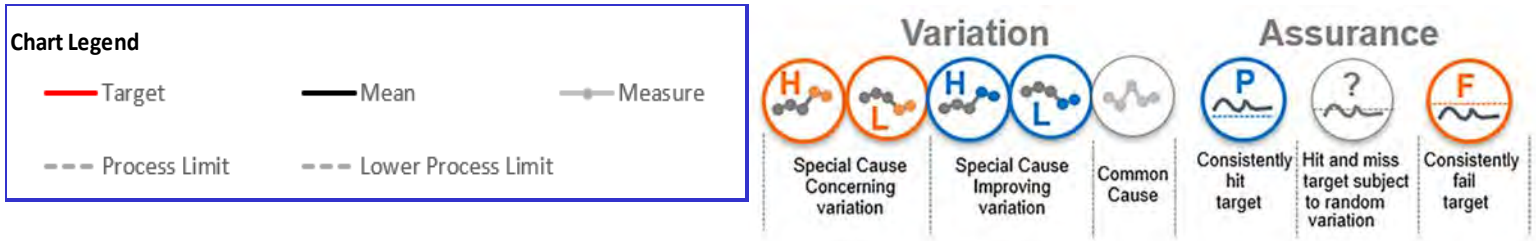
JULY 2022		ASSURANCE: Pass	Hit and Miss	Fail
VARIANCE	Special Cause Improvement		MRSA VTE - All Patients Overdue Responses Mandatory Training Monthly	RTT 104 Week Waits Appraisal Rate monthly
	Common Cause	2 Week Wait Rapid chest pain	See Box (right)	Ambulance Handover within 15 minutes Ambulance Handover within 30 minutes
WORSENING	Special Cause Concern	Staff Sickness – Rolling 12 months Turnover rate monthly	% Compliance 12 Hour Breaches Verbal Duty of Candour Staff Sickness – Monthly	Ambulance Handover within 60 minutes Incomplete 104 day waits Diagnostic Performance - % within 6 weeks total

This shows us these indicators will not reliably hit the target:

Cancer 2 Week Wait for Urgent GP Referrals Total
Cancer 2 Week Wait Breast Symptoms Total
28 Day Faster Diagnosis
Cancer 62 Day GP Referrals Total
Cancer 62 Day Screening
Cancelled operations
C-Diff
Hand Hygiene
Sepsis Screening for Emergency Patients
Mixed Sex Breaches
Community Pressure Ulcers
Acute Pressure Ulcers
Inpatient Falls Total
Acute Falls Per 1000 Beds
Nutrition- 24 hours
Written Duty of Candour

Items for escalation based on those indicators that are failing the target, or are worsening and therefore showing Special Cause of Concerning Nature by area:

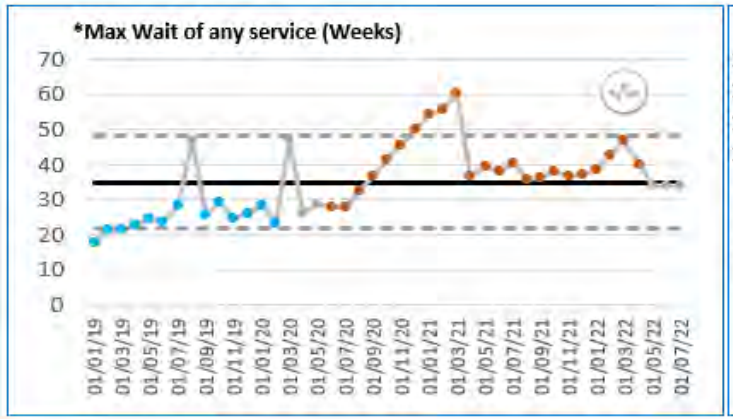
Community: % Compliance
Urgent & Emergency Care: Ambulance Handovers within 15, 30 & 60 minutes, 12 Hour Breaches
Cancer: Incomplete 104 day waits
Elective: Diagnostic Performance - % with 6 weeks total, RTT 104 week waits
Safe: Verbal Duty of Candour
Well-Led: Staff Sickness – Monthly, Appraisal Rate monthly

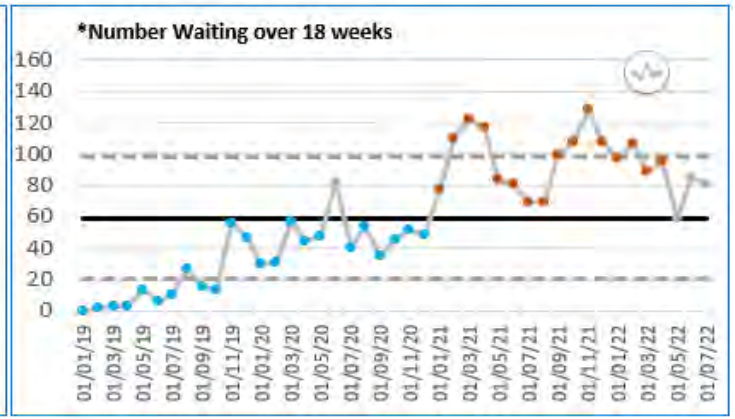


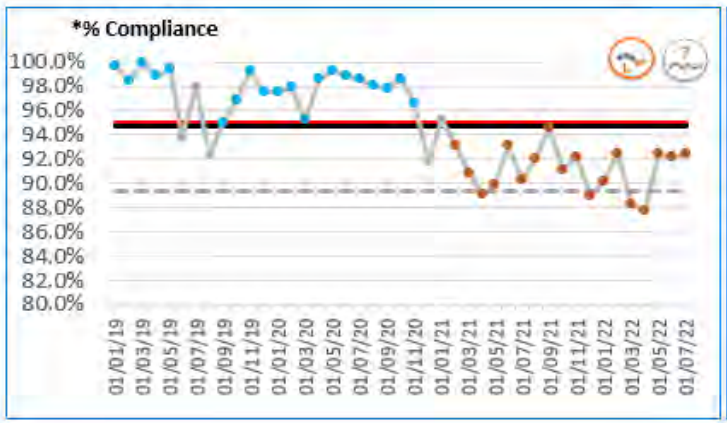
KPI	Latest month	Performance	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
*Max Wait of any service (Weeks)	Jul 22	34	-			35	22	48
*Number Waiting over 18 weeks	Jul 22	81	-			59	20	98
*% Compliance	Jul 22	92.4%	95.0%			94.8%	89.3%	100.2%
Urgent 2 hour response	Jul 22	86.0%	70.0%					

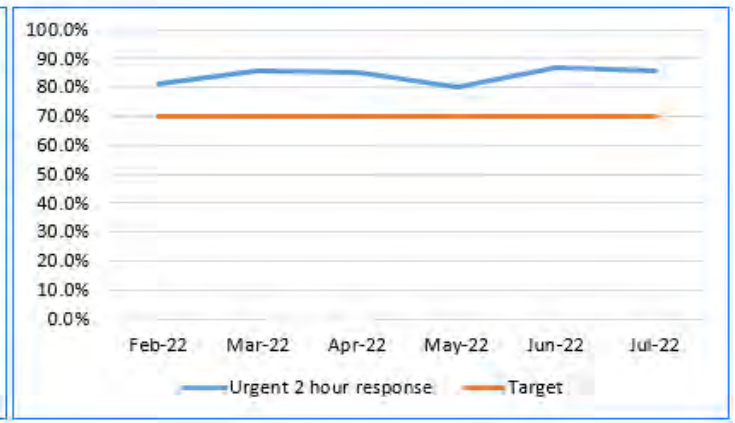
*The first 3 indicators cover all the non-consultant led community services of: Adult Speech and Language Therapy, Heart Failure, Neurology Service, Parkinson's Nursing, Wheelchairs, Paediatric OT, Paediatric Physio and Paediatric Speech and Language Therapy.

Community Access

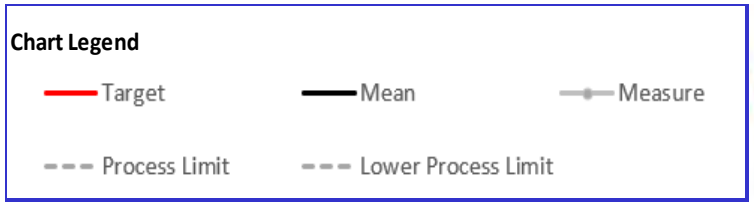


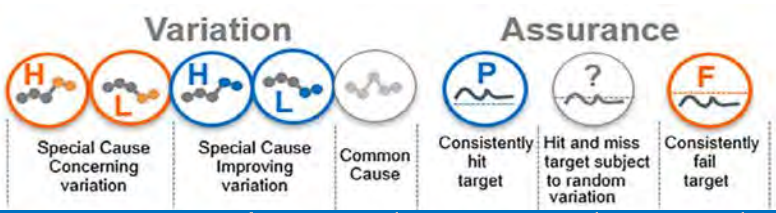






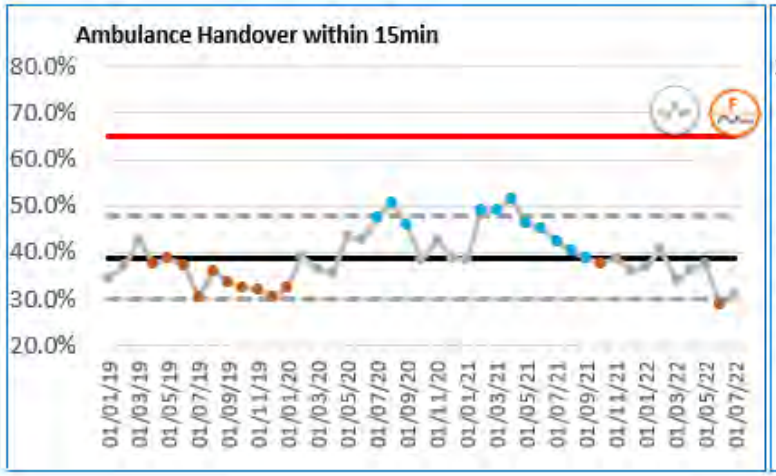
Summary	Action	Assurance
Paediatric Speech and Language therapy : improving compliance seen within paediatric SLT 18wks but this is impacting on access to subsequent therapy as conversion to caseload numbers are high which is 30 patients over 18 weeks. • Capacity in service is worsening due to delays in financial approval and recruitment. **Wheelchairs**: Compliancy is 85.97% with longest wait of 32.29 weeks against a target of 95% Improvement on previous months performance of 0.92% working towards trajectory plan. Additional work to achieve personal wheelchair budget (PWB) having a detrimental impact on 18-week target. PWB at 82.14% Shortage of team support worker due to long term sickness and admin to support PWB/RTT activity. **Urgent Care Response :** Compliancy is 86% against target of 70%. Since 1st Aug taken non-injury falls from EEAST stack (cat. 3&4). Numbers slowly increasing	**Paediatric Speech and Language therapy :** Prioritisation of those with higher clinical need and EHCP provision **Wheelchairs:** Division to fund 1 x WTE Team Support Worker in interim whilst longer term investment from Trust is sought from a business case for x 2 team support workers. Continue to manage demand and capacity in short term from existing workforce. **Urgent Care Response** : Advert for ACPs out. Consultation planned to increase therapy hours to 9.00pm 7/7.	**Paediatric Speech and Language therapy :** Service oversight. SLCN network **Wheelchairs:** Paper was presented at PAGG on 22nd July and shared at insight. Executive visit on 8th August by Craig Black to walk through service challenges. Assurance via Business unit meeting, Insight, divisional board, PAGG. **Urgent Care Response :** National and SNEE UCR reporting Insight/Board report

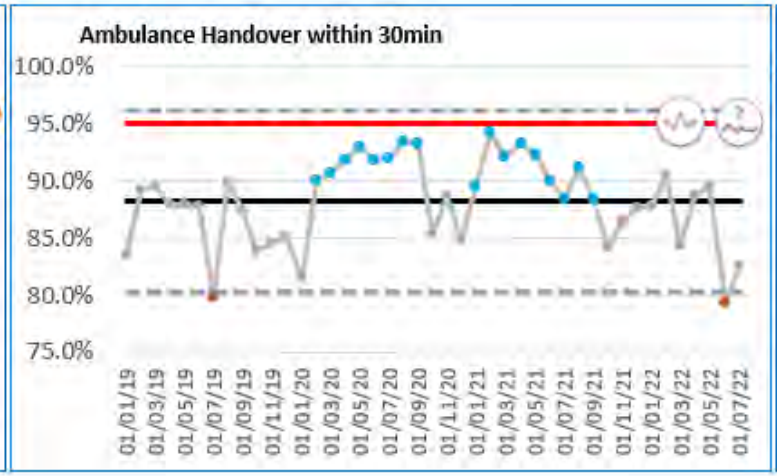


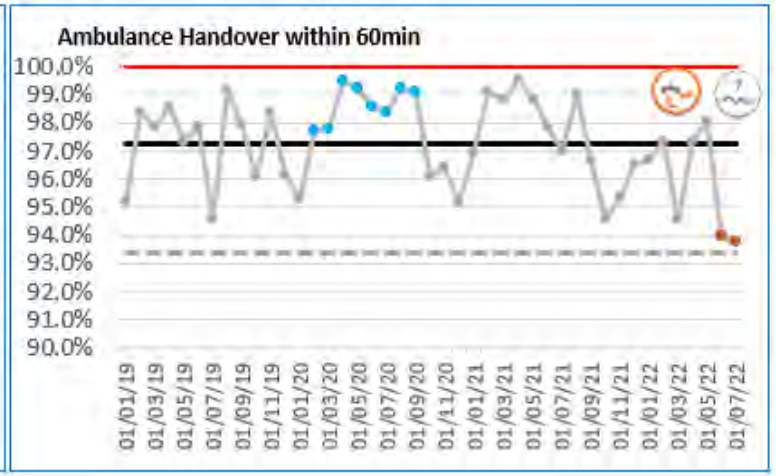


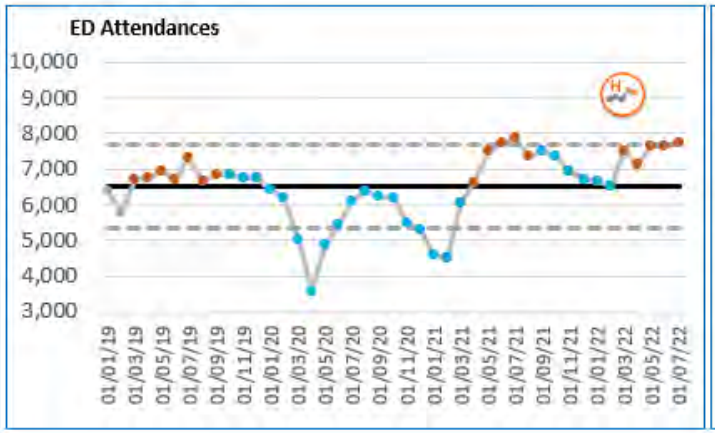
KPI	Latest month	Performance	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Ambulance Handover within 15min	Jul 22	30.8%	65.0%			38.9%	30.0%	47.8%
Ambulance Handover within 30min	Jul 22	82.5%	95.0%			88.2%	80.3%	96.1%
Ambulance Handover within 60min	Jul 22	93.8%	100.0%			97.3%	93.4%	101.1%
ED Attendances	Jul 22	7714	-			6489	5317	7662
12 Hour Breaches	Jul 22	624	0			95	-4	194
Criteria to reside (number without R2R on last day of month)	Jul 22	66	-					
Criteria to reside (average number per day without R2R)	Jul 22	16	-					

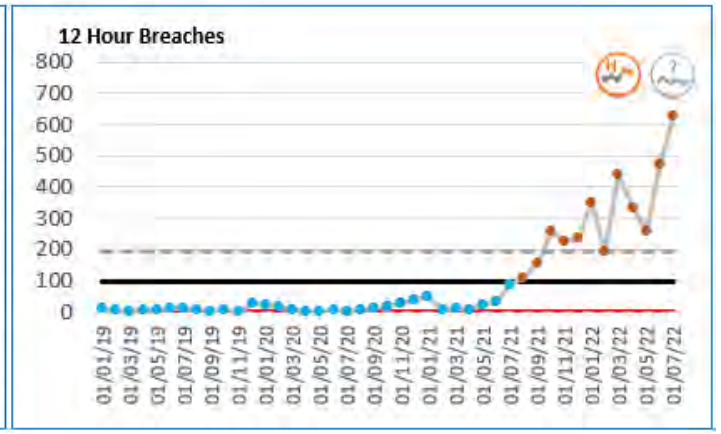
Urgent & Emergency Care



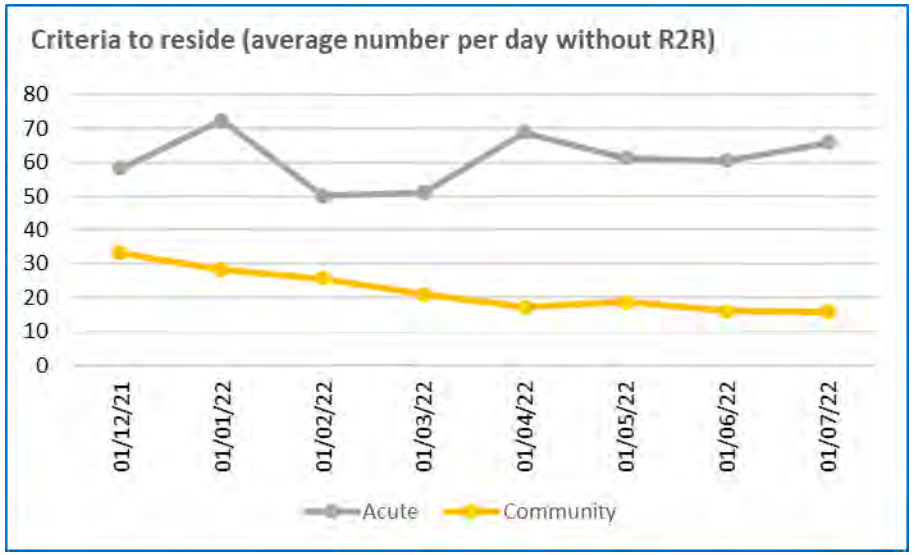






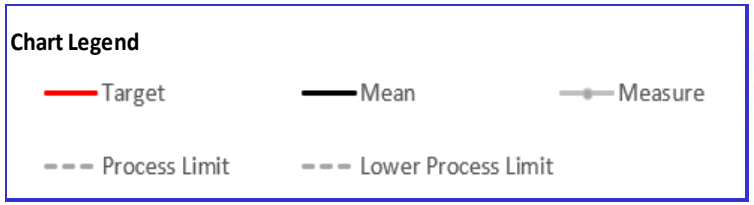


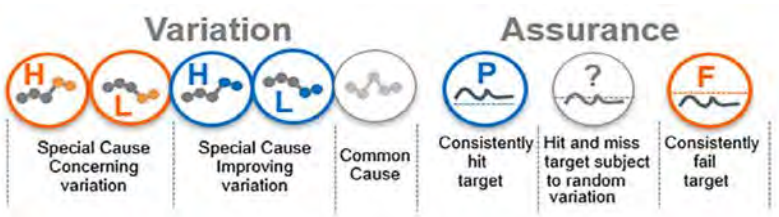
Summary	Action	Assurance
All Ambulance Handovers – Handovers continue to be a challenged picture. Primary cause is multiple long bed waits in the department leading to no capacity to offload. Have needed to resort to ambulance co-horting in the department on many occasions. **ED Attendances** – numbers slowly rising. Particular increase in non-admitted minor numbers. Utilisation of GP slots rising month on month. **12 Hour Breaches –** deteriorating picture. Clinically ready to proceed data demonstrates main area of concern causing breaches is patients waiting for inpatient beds. This is due to RAAC work and numbers of patients with no reason to reside which are key components in our ability to achieve this metric.	Making best use of the space we have. Work currently ongoing regarding focus on using a communication system which is a quick and succinct way of handing over. Task and Finish group in operation with the Ambulance service to look at improving handover times. Work continues with the streaming team - receiving training to promote re-signing patients to alternative services where appropriate. Regular reminders to our community regarding the correct use of ED on social media. Actions to reduce 12 hr Length of Stay (LOS) include a focus on Same Day Emergency Care (SDEC) and workstreams within UEC including virtual ward, criteria to admit and development of hot clinics. Risk remains to achievement of this metric due to the capacity lost for the RAAC programme.	Through analysis of daily and weekly data. Improvement team conducting audits around hand overs. Urgent and Emergency Care (UEC) metrics monitored via patient access insight group and through WSFT UEC steering group. System and Alliance focus on building capacity to enhance transfer of care arrangements through the Alliance Operational Delivery Group and the SNEE Urgent and Emergency Care group.



Summary	Action	Assurance
The average figure of patients without reason to reside remains fairly consistent over the past four months in both the acute and community settings. There is variation in day to day figures. Despite the transfer of care hub operating seven days a week care capacity challenges continue to create delays and increased length of stay – particularly with out of area discharges into the Norfolk system.	Daily patient review calls are undertaken with Norfolk system colleagues with additional Director to Director level escalation of delays. Capacity in reablement care services continue to be closely monitored in order to enhance pathway one discharges and admission avoidance. Transfer of Care hub review recommendations have been shared with Clement Mawoyo for review.	System and Alliance focus on building capacity to enhance transfer of care arrangements through the Alliance Operational Delivery Group and the SNEE Urgent and Emergency Care group.

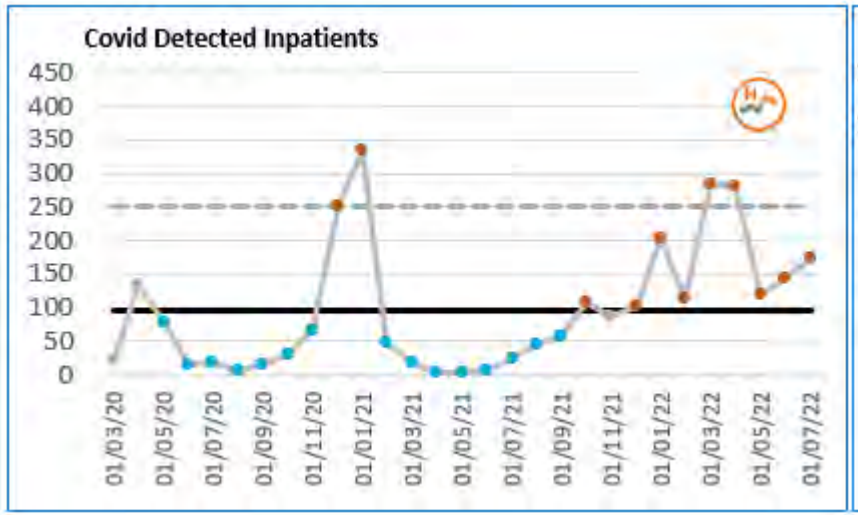
Covid Summary

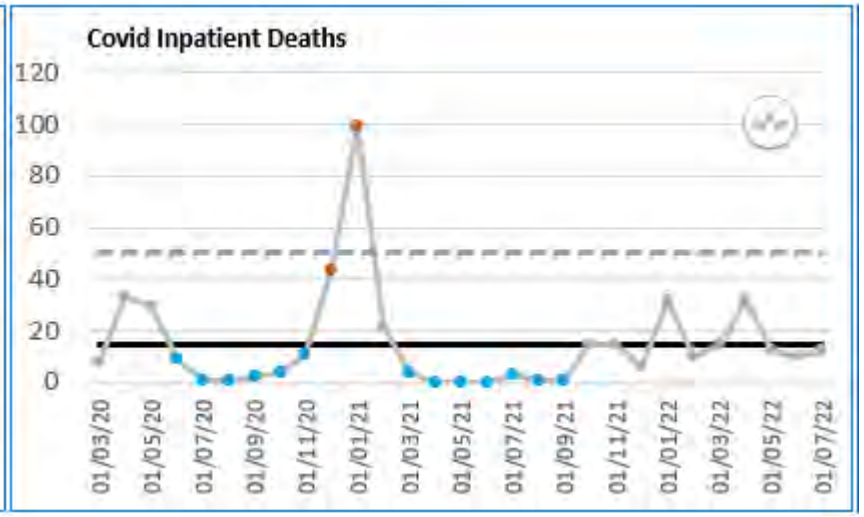




KPI	Latest month	Performance	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Covid Detected Inpatients	Jul 22	172	-	H		96	-58	251
Covid Inpatient Deaths	Jul 22	12	-			15	-21	51

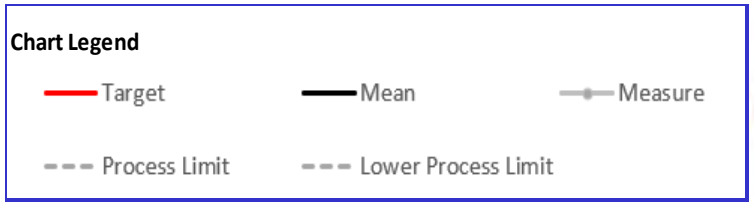
Covid

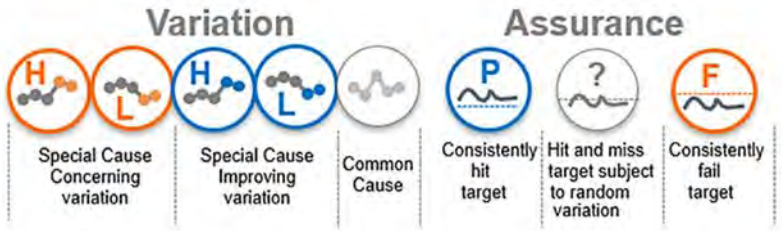




Summary	Action	Assurance
Rates of COVID in the trust are now falling in line with national rates following the spike in cases seen in July. As national prevalence of COVID is currently low, the government have advised that asymptomatic testing in hospitals should be paused from the end of August.	The infection prevention team are working to change trust policy in line with national guidance to pause asymptomatic COVID testing.	We will monitor the number of positive COVID tests in the trust among patients and staff to ensure that we do not experience a spike in cases with the change in trust policy.

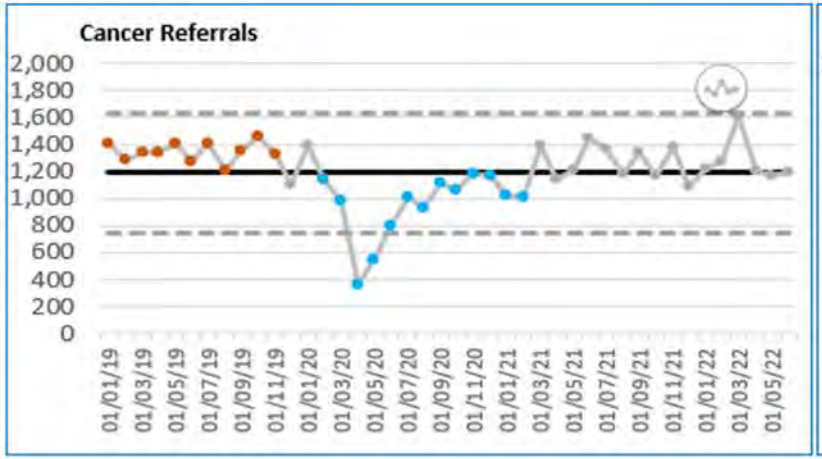
Cancer Access (Month Behind) Summary

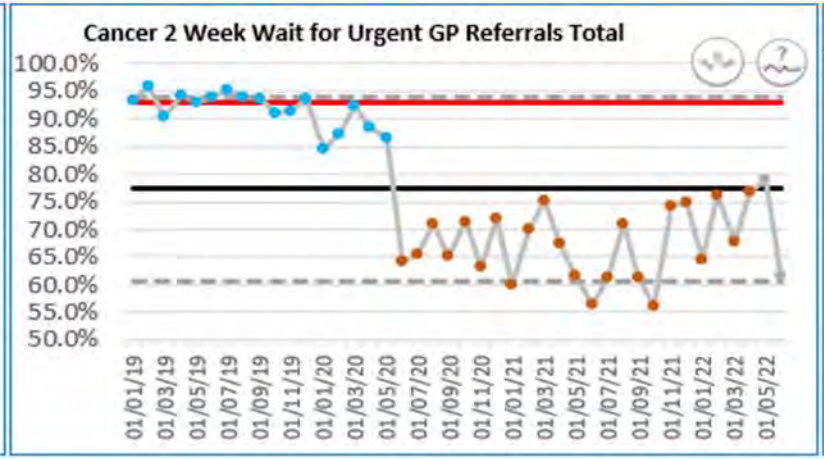


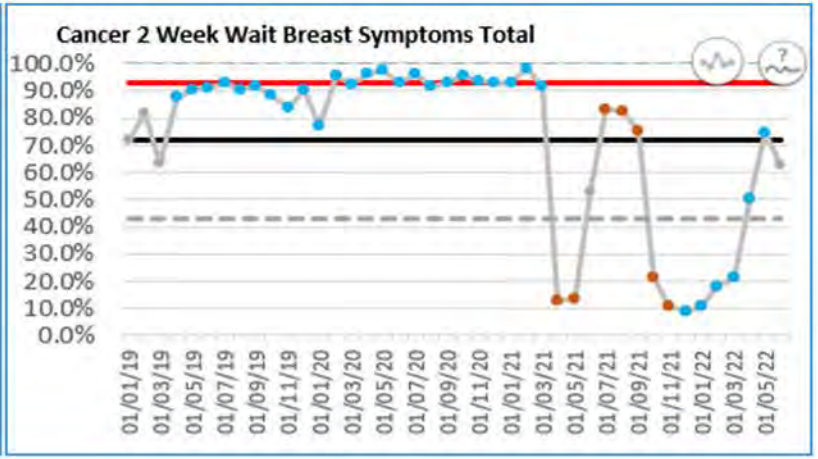


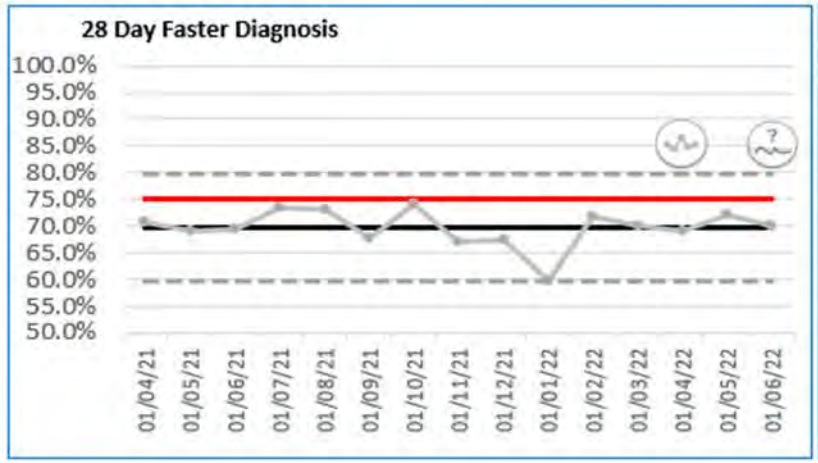
KPI	Latest month	Performance	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Cancer Referrals	Jun 22	1192	-			1191	743	1639
Cancer 2 Week Wait for Urgent GP Referrals Total	Jun 22	61.6%	93.0%			77.3%	60.7%	93.9%
Cancer 2 Week Wait Breast Symptoms Total	Jun 22	63.0%	93.0%			71.9%	42.8%	101.0%
28 Day Faster Diagnosis	Jun 22	70.0%	75.0%			69.6%	59.6%	79.6%
Cancer 62 Day GP Referrals Total	Jun 22	65.3%	85.0%			75.5%	56.3%	94.8%
Cancer 62 Day Screening	Jun 22	90.0%	90.0%			89.4%	64.5%	114.2%
Incomplete 104 Day Waits	Jun 22	30	0			23	6	40

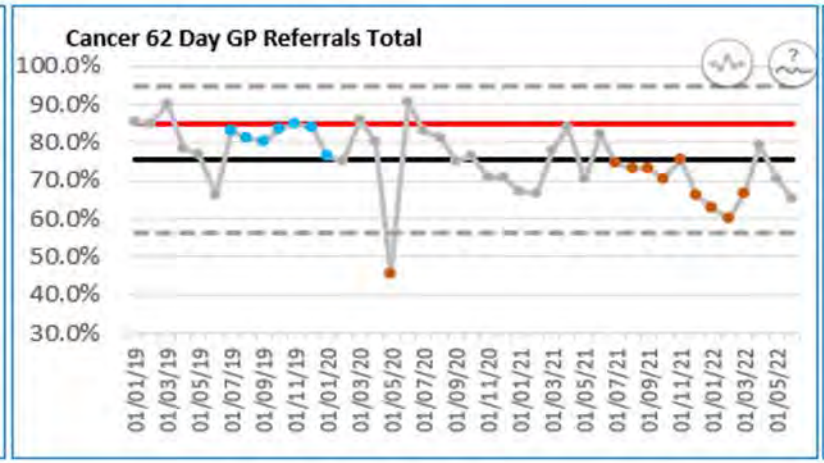
Cancer Access (Month Behind)

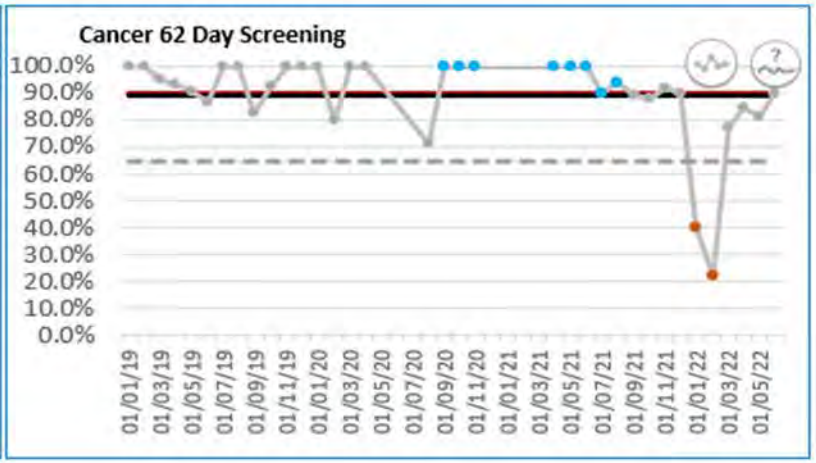


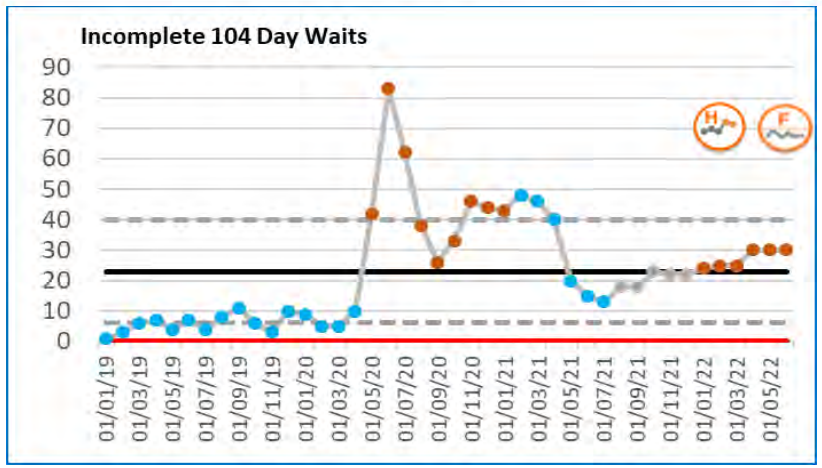








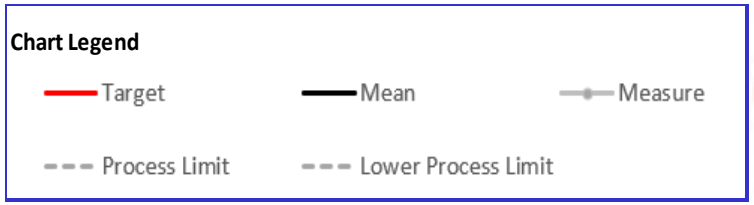


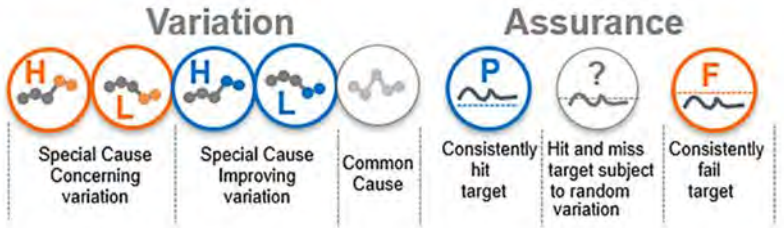


Cancer Access (Month Behind)

Summary	Action	Assurance
Cancer referral numbers demonstrated no significant change, and has been fairly stable across the first quarter. Whilst performance in 2 week waits has reduced this is not demonstrating significant variation. 28 day performance is not showing significant improvement, the overall recovery trajectory for this standard has been amended in light of the CTC issues and Covid still impacting performance throughout Q1. 62 Day Performance has deteriorated in June 2022, but is not demonstrating significant variation, there continued to be challenge in relation to Covid and clinical complexities. 62 day screening performance shows no significant improvement and is below target. It is important to note that this performance for screening is 11 patients, with 1 allocated breach over 62 days.	A full revised recovery action plan is in place, taking into account what has happened already across Q1, some of the key actions within this are: • Implementation of FIT pathway in Colorectal • Insourcing of template bioPatient Safety Incidents in Urology • Recruitment and equipment purchases in Breast 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), Best practice treatment pathways for 2022/23 and development of the SNEE wide and local WSFT 5 and 10 year cancer strategy.	Recovery is 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.

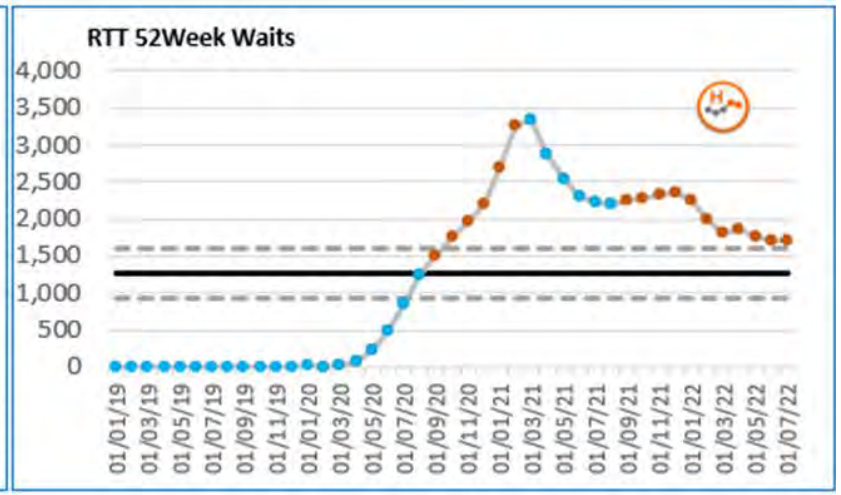
Elective Access Summary

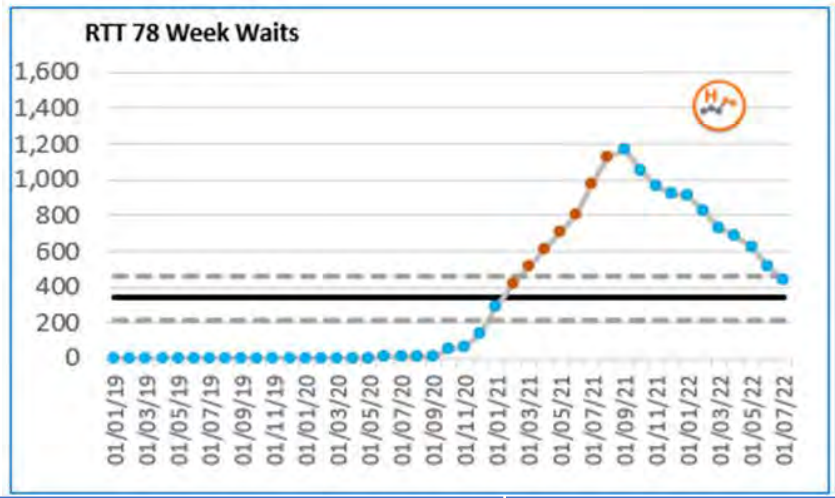


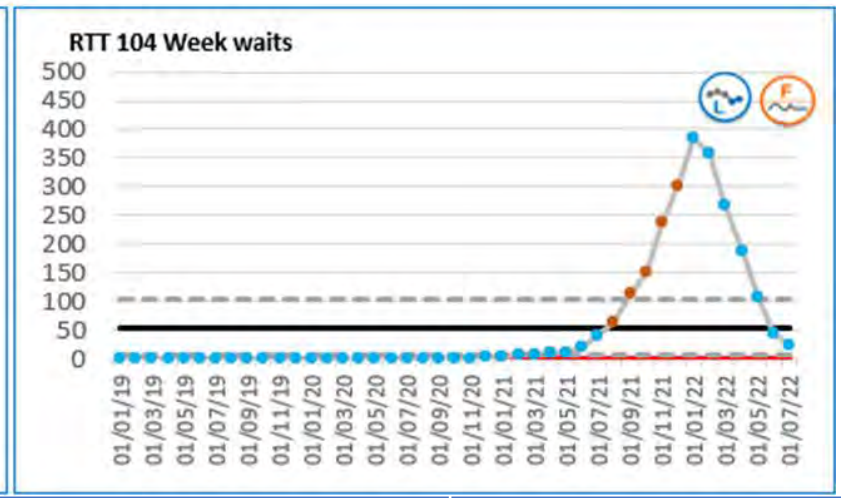


KPI	Latest month	Performance	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
RTT Waiting List	Jul 22	30709	-			21880	20492	23269
RTT 52Week Waits	Jul 22	1710	-			1257	916	1598
RTT 78 Week Waits	Jul 22	442	-			338	218	458
RTT 104 Week waits	Jul 22	23	0			54	7	102
2 week wait rapid chest pain	Jul 22	99.1%	95.0%			99.3%	96.5%	102.2%
Diagnostic Performance- % within 6weeks Total	Jul 22	59.4%	99.0%			70.4%	56.9%	84.0%
Elective Operations (Excluding Private Patients & Community)	Jul 22	869	-			763	460	1065
Cancelled Operations	Jul 22	22	0			19	-4	42

Elective Access

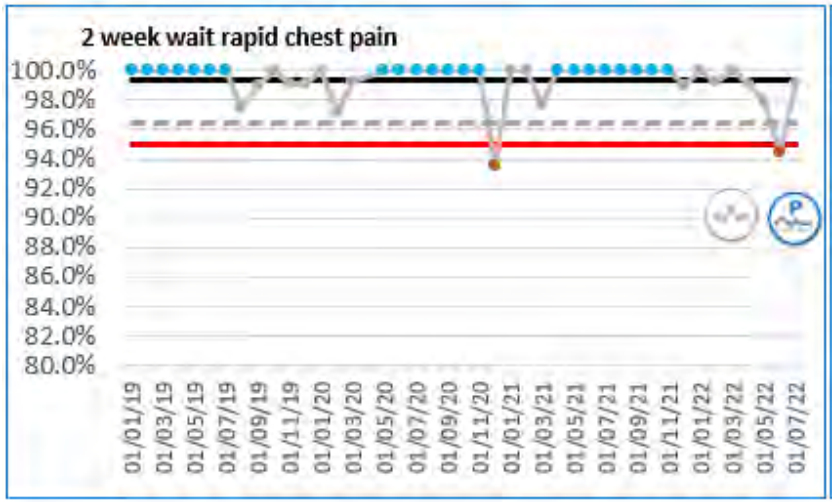


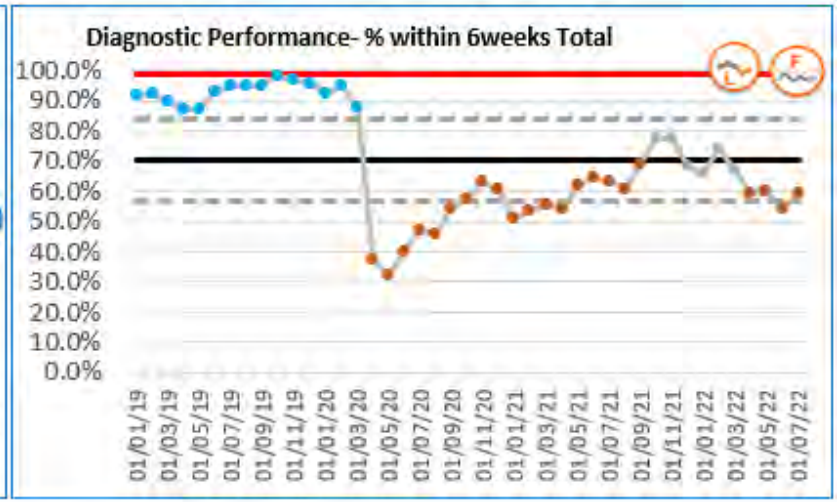


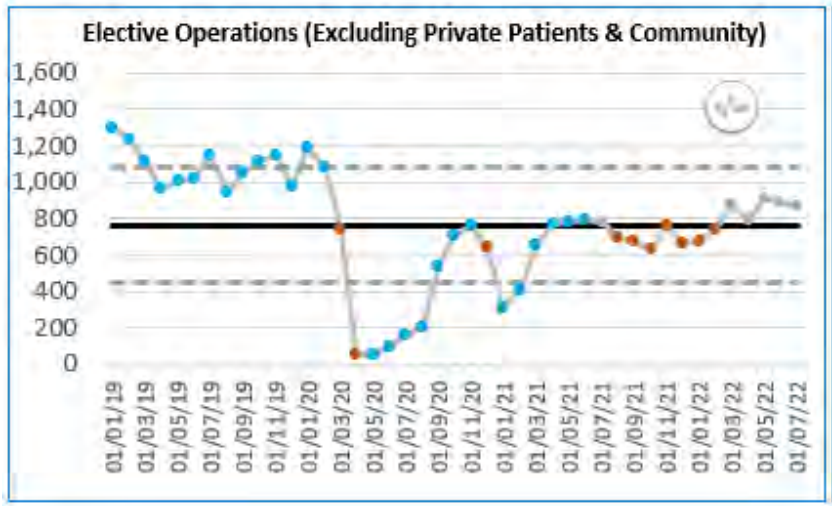


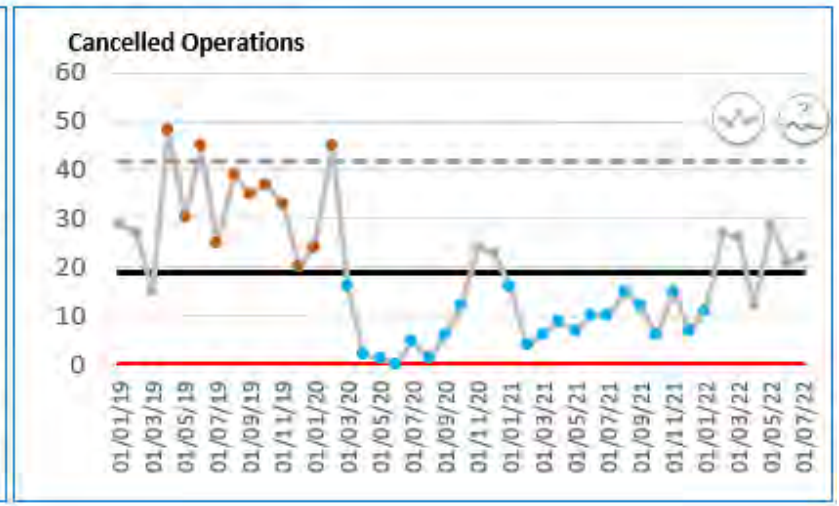
Summary	Action	Assurance
The total waiting list size continues to fail the standard and is now at nearly 30,000 against a standard pre-covid size of around 21.000, causing significant cause for concern. The number of patients over 104 week waits continues to fail to meet the target of zero, however is now demonstrating significant improvement and is in line with trajectory. The number of patients waiting over 78 weeks similarly fails to meet the target of 0 but is under the current recovery trajectory at 509 against 649 that was predicted.	The focus remains on the longest waiting patients and the and the continued management of patients over 104 weeks, and reducing the 78 weeks wait position. Actions to achieve this, include; extended theatre lists, weekend working, theatre productivity, use of the independent sector and mutual aid as well as a focus on activity targets.	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.

Elective Access



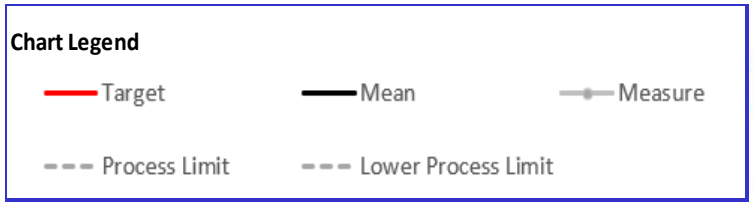


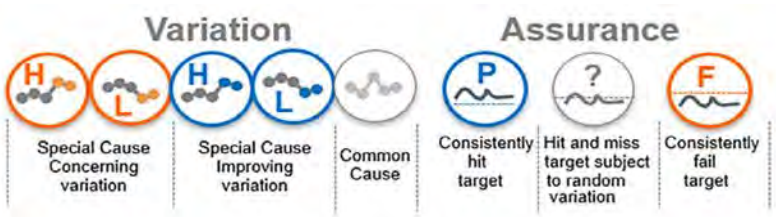




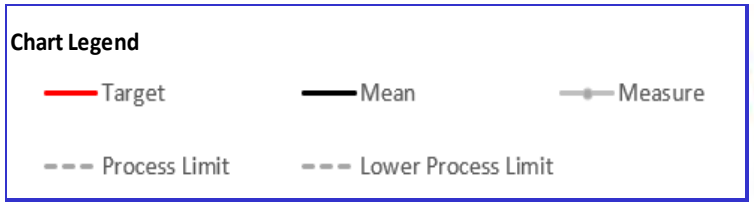
Elective Access

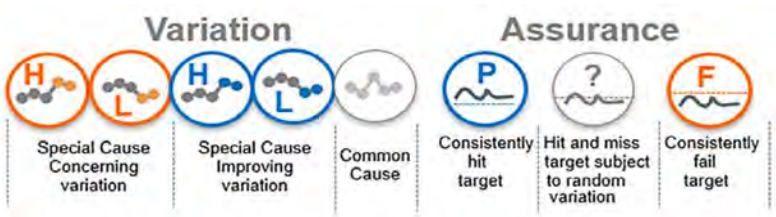
Summary	Action	Assurance
The SPC chart indicates special cause concerning variation for diagnostic performance with consistent failure to meet the 6 week target. CT performance has improved by 17% from June to July, with activity over 120% for the month of July. MRI performance has not improved in July and has reduced by 2%. There continues to be challenges with increased inpatient demand for patients with progressive diseases as well as sickness within the department. In ultrasound, ongoing vacancies constrain capacity despite active recruitment and the use of agency staff where available. Two sonographers are due to start in August 2022 and following training and induction should have a material impact on US performance. Endoscopy performance is fairly stable, with a full recovery plan being presented at investment panel in September. Echocardiography has shown significant improvement from 70% to 83% from June to July. On target to meet trajectory Mid September. Audiology, Urodynamics and Cystoscopy have all shown improvement in July 2022.	• A third CT scanner has been approved and is on order, delivery due in October 2022. This will assist in supporting recovery and provide resilience to unplanned scanner downtime. Increased staffing levels from July will allow greater utilisation of CT3 including additional weekend lists. • Options for mobile MRI capacity continue to be explored but are likely to be at a prohibitive cost c. £3000/day. With current capacity MRI DM01 performance will meet compliance by September 2023. A business case is being prepared around the options for a third MRI scanner in parallel to the CDC business case. • The business case for the Community Diagnostic Centre at Newmarket Community Hospital, with the aim of increased MRI and CT capacity as the particular focus, has received internal approval and will now proceed for ICB approval before submission to NHSE at the end of July 2022. • A full recovery plan for endoscopy is being presented at the investment panel in September 2022.	Ongoing performance will be monitored at the weekly CSS access meeting, Divisional PRM and the Elective Access Insight Meeting.





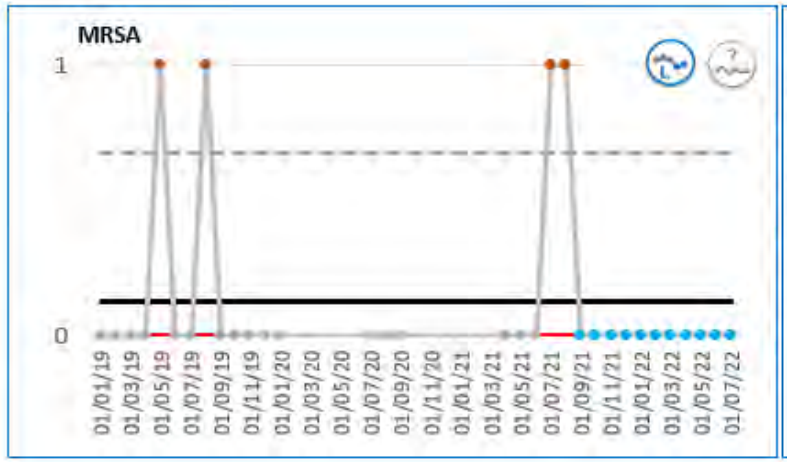
KPI	Latest month	Performance	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
MRSA	Jul 22	0	0			0	0	1
C-Diff	Jul 22	0	0			2	-1	6
Hand hygiene	Jul 22	100.0%	100.0%			99.5%	97.7%	101.3%
Sepsis Screening for Emergency Patients	Jul 22	87.5%	100.0%			86.5%	50.8%	122.3%
VTE - all inpatients	Jul 22	97.6%	95.0%			95.9%	93.8%	98.0%
Mixed Sex Breaches	Jul 22	12	0			4	-7	15
Community Pressure Ulcers	Jul 22	34	25			31	14	48
Acute Pressure Ulcers	Jul 22	31	17			22	5	39
Acute Pressure Ulcers per 1000 Beds	Jul 22	2.8	-			2.1	0.6	3.6
Inpatient Falls Total	Jul 22	82	48			63	31	95
Acute Falls per 1000 Beds	Jul 22	7.5	5.6			5.5	3.1	7.9

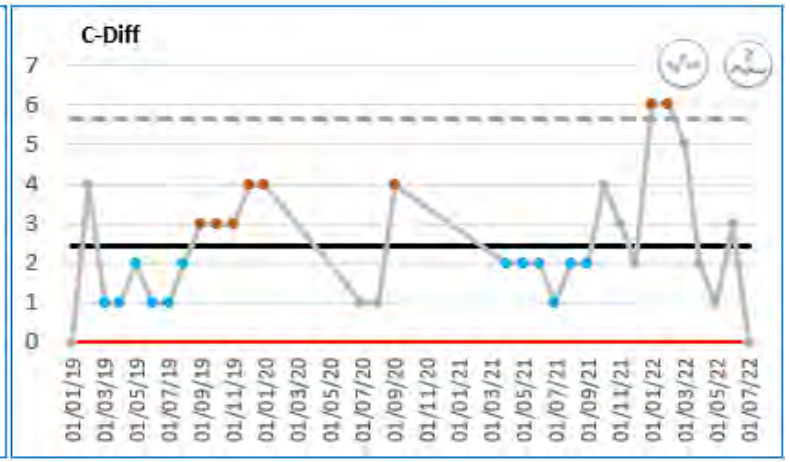


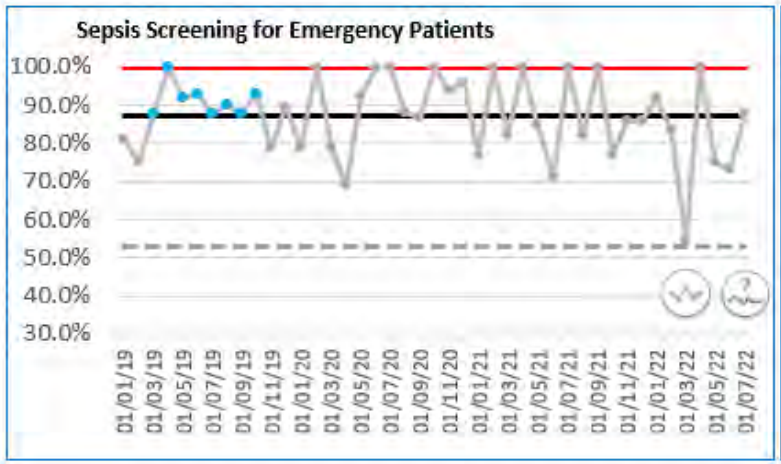


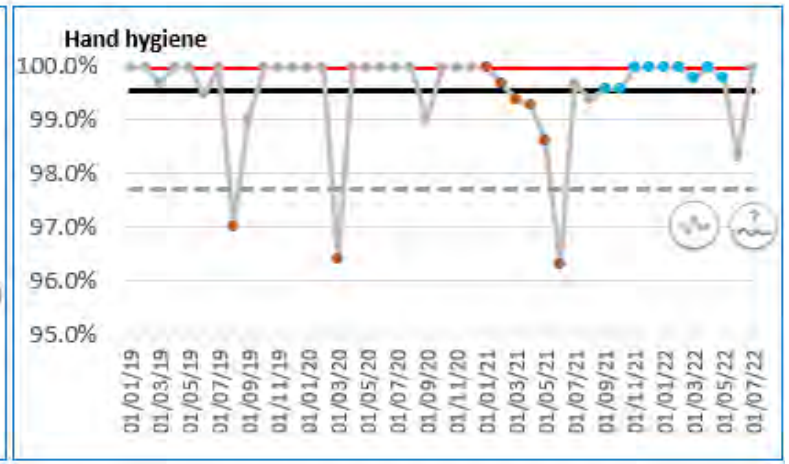
KPI	Latest month	Performance	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Nutrition - 24 hours	Jul 22	89.0%	95.0%			90.5%	85.8%	95.2%
Patient Safety Incidents per 1,000 OBDs	Jul 22	64.4	-			65.5	52.7	78.3
Patient Safety Incidents Reported	Jul 22	822	-			741	594	888
Patient Safety Incidents Resulting in Harm	Jul 22	177	-			150	113	186
Verbal Duty of Candour	Jul 22	12	0			5	-1	11
Written Duty of Candour	Jul 22	3	3			5	-1	10
Within 10 Days Duty of Candour	Jul 22	60.0%	-			57.1%	15.5%	98.8%
New Complaints	Jul 22	17	-			16	2	31
Closed Complaints	Jul 22	24	-			15	-2	31
Overdue Responses	Jul 22	3	0			8	-5	20

Safe



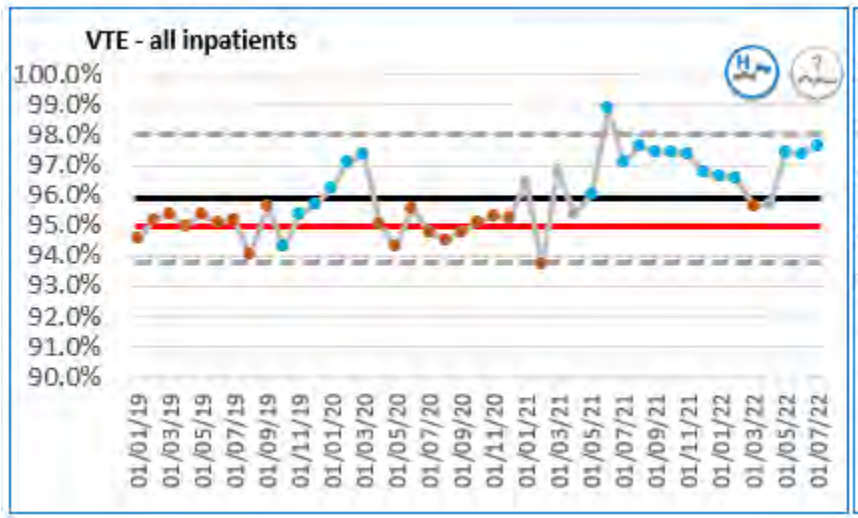


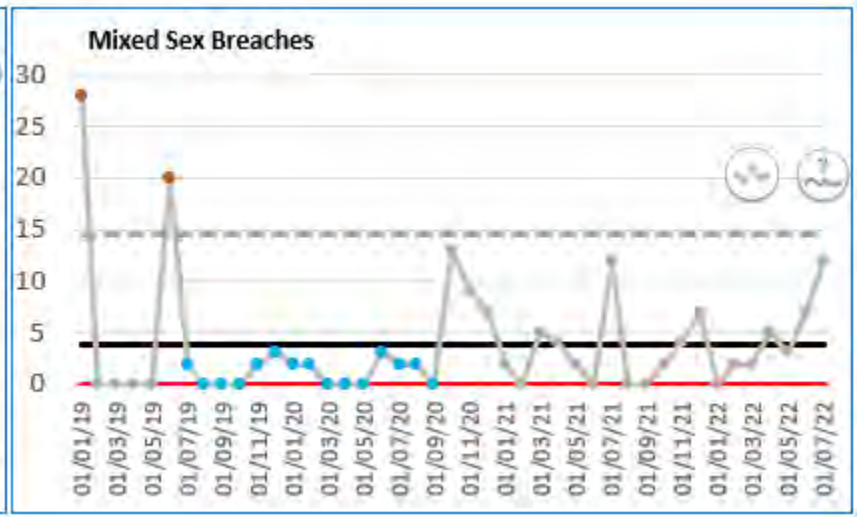




Summary	Action	Assurance
No special cause variation in either MRSA or C-diff cases. However we continue to monitor the number of cases monthly and identify concerns relating to specific cases as required for reporting purposes to the ICB. These are reviewed and discussed at the IPCC monthly. No special cause variation for sepsis screening, there is a move towards the trust average, however this data is reliant on a small sample size.	QI project to drive a C.Diff improvement plan to commence – 3 wards identified to be included in the project, (second meeting arranged), learning from this will be disseminated Trust wide. Review of cleaning wipes/products in liaison with purchasing dept and CCG, re-launch planned for 01/09/22, comms issued throughout August in preparation for this, green sheet, matrons, ward managers. Review and agree data capture that accurately reflects sepsis identification and treatment	Monitored through audit and reporting into the IPC committee, incident reporting and deteriorating patient group.

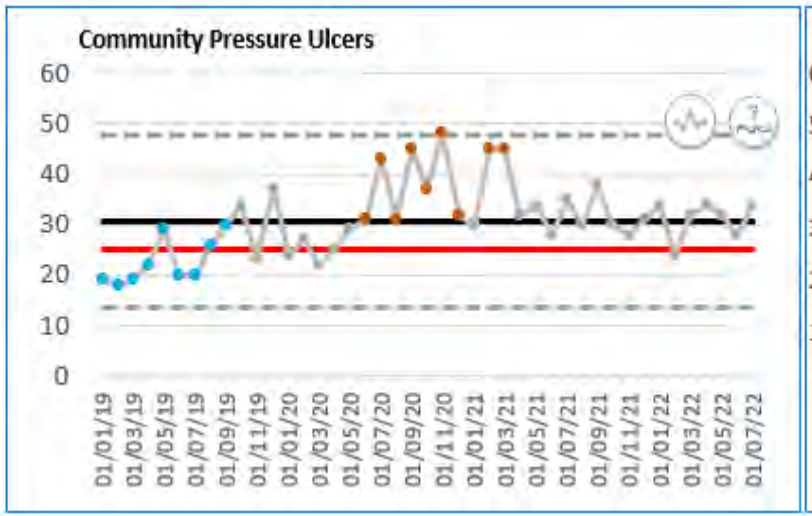
Safe

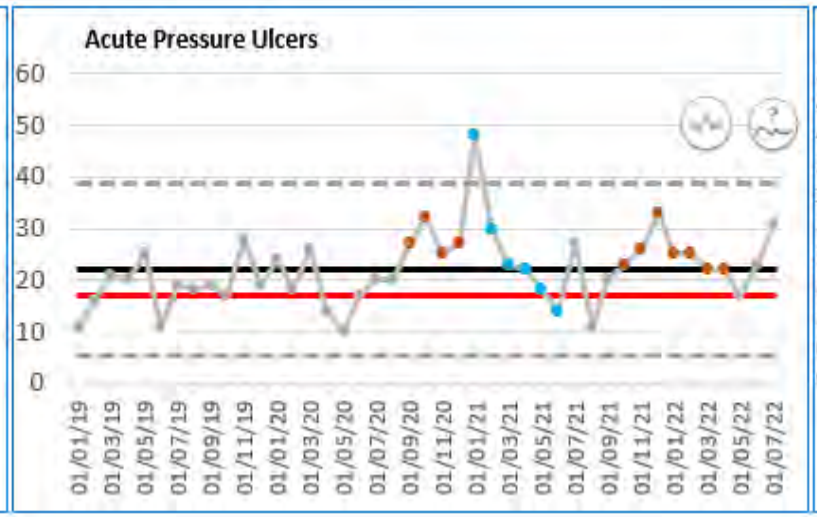


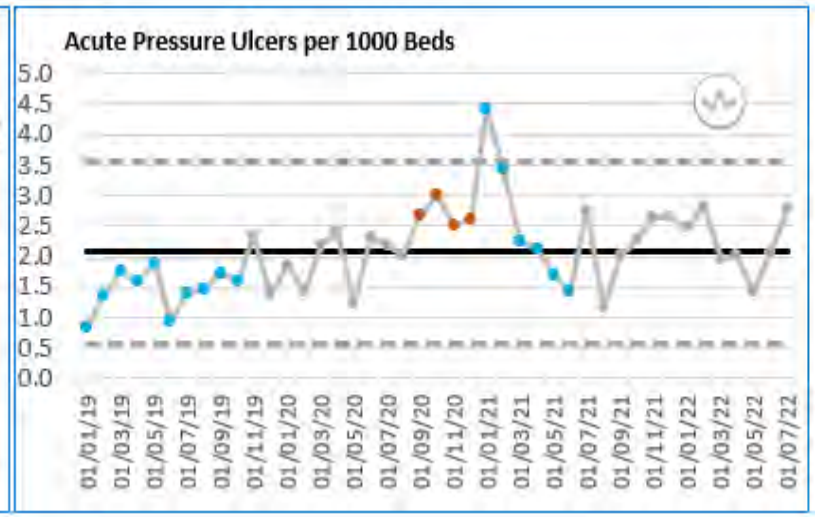


Summary	Action	Assurance
VTE Positive improvement following data cleanse and actions taken over the last couple of reports. Returning to positive cause variation. MSB Increase in incidence seen driven by delayed step down from ITU. Symptom of capacity challenges seen in July and internal incidents declared due to capacity	Continue to monitor sustainability of interventions and oversight particular in areas of previous low compliance. AAU for example MSB and patients ready for step out of ITU reviewed and discussed daily at safety huddle and achieved through collaboration with tactical team	VTE compliance oversight and monitoring through PQSGG. Daily review and escalation to tactical site team

Safe

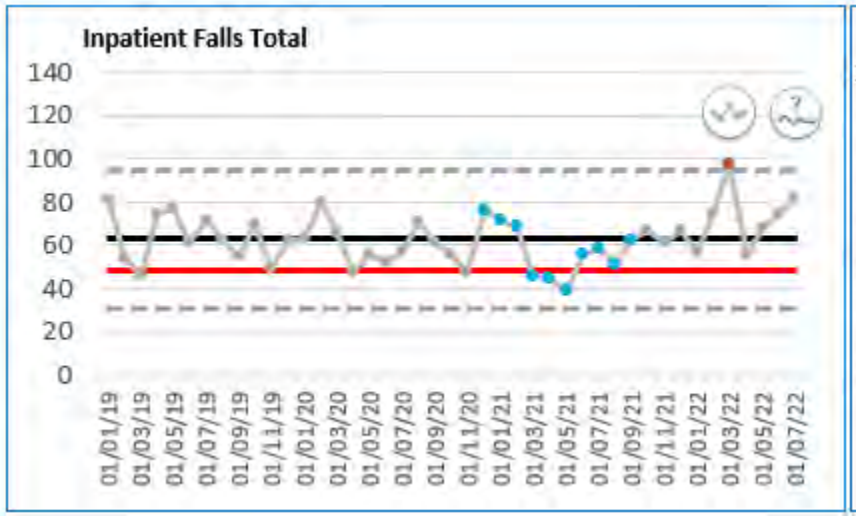


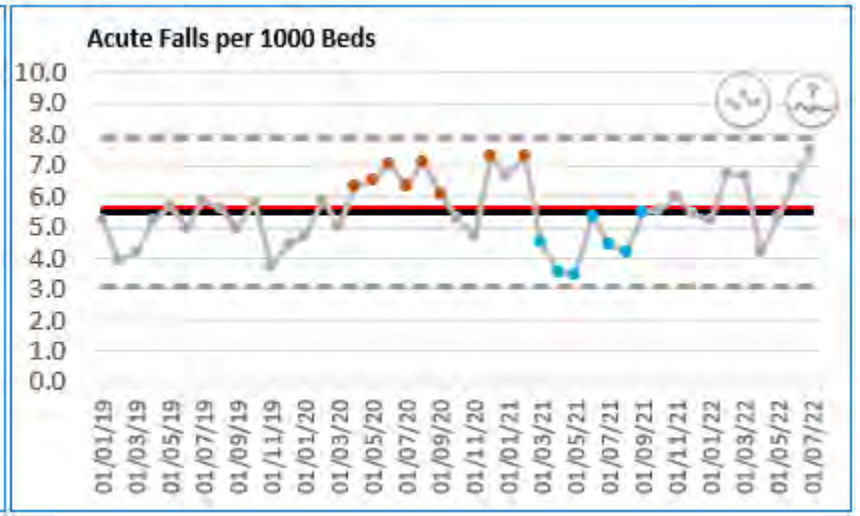




Summary	Action	Assurance
• No special cause variation in the acute or community. However there is a increase away from expected levels in July for the acute	• 'Tissue viability shorts' videos available on Totara over the next few weeks providing accessible support/training on wound dressing and pressure ulcer management. • First link nurse day since pandemic planned for September	Oversight and improvement plan monitored through PQSGG Area of higher incidents have been identified and will be approached to assess need for additional support and bespoke actions for their patient group. Interventions will be monitored and presented to PQSGG

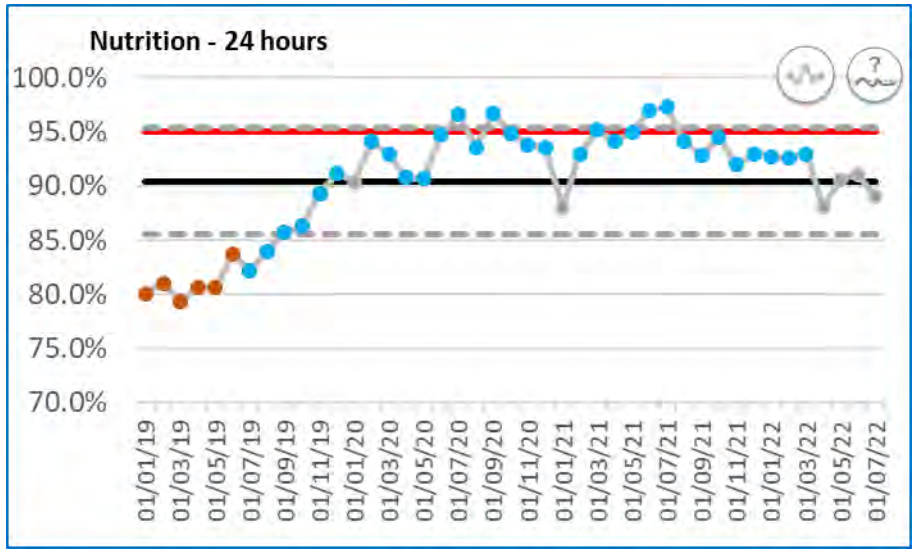
Safe





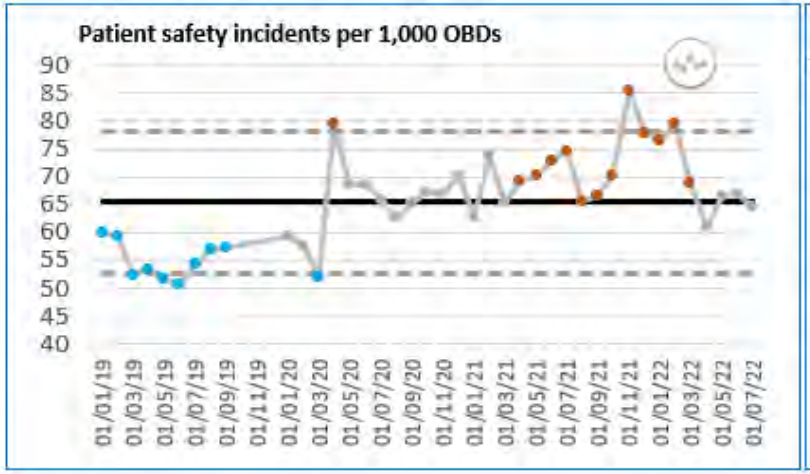
Summary	Action	Assurance
Although no special cause variation this month, there is an emerging concern that this may become an adverse trend. In July there were 18 falls reported as minor harm, 2 falls with moderate harm and 2 falls with severe harm (both fractured neck of femur). During the month of July there were 15 repeat fallers with 9 patients having two falls, 4 patient having three falls, 1 having four falls and 1 having six falls during the reporting month.	Learning from incidents has identified improvement required in post fall care, which should reduce patients that fall repeatedly • A redesigned post fall form is being piloted on F7. The aim of this is to improve post fall management, documentation and to ensure all MDT aware a fall has occurred so appropriate interventions can occur in a timely manner	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.

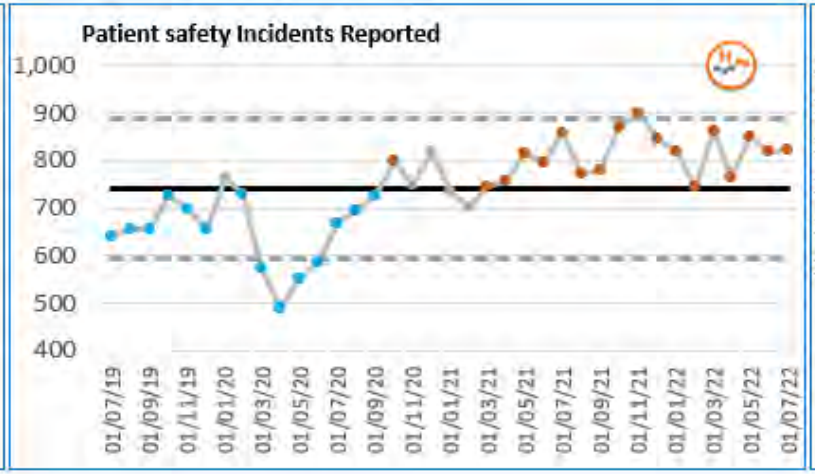
Safe

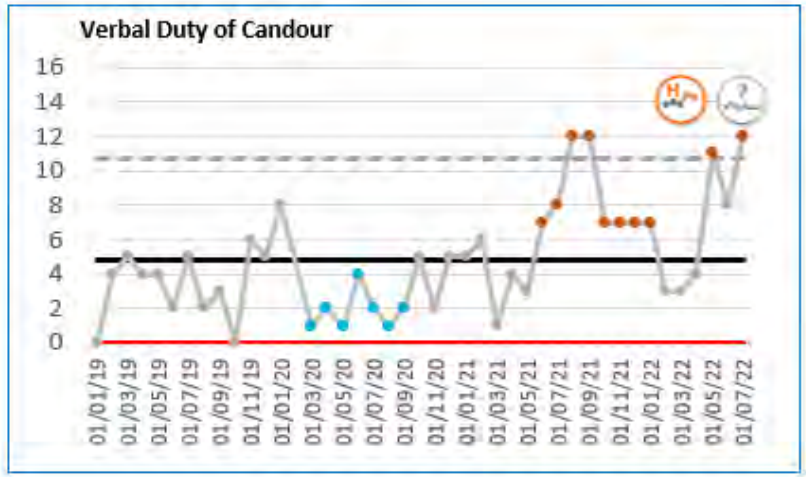


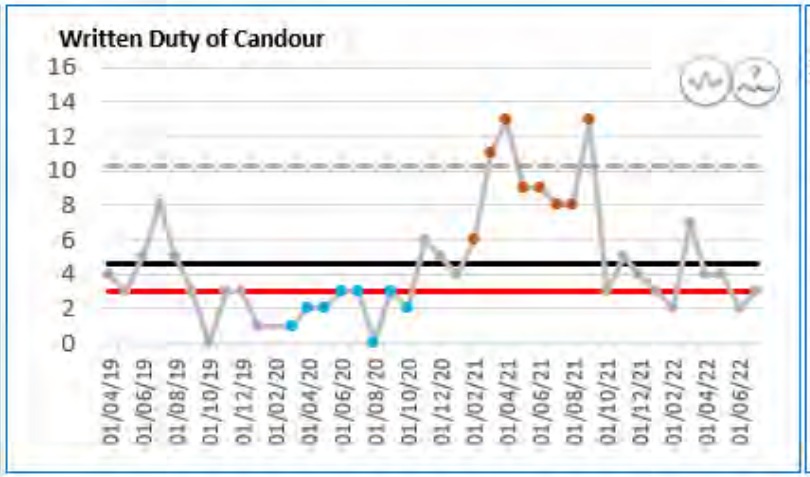
Summary	Action	Assurance
Although no special cause variation, the process limits need to be reviewed and updated. The Dietician team are also reviewing the accuracy of the assessments and working on a project to introduce eLearning on completing the assessments to teams. This will be part of a QI project to support the improvement of compliance with completion, as well as accuracy of the assessments. There will be some pilot wards to commence this work with.	• Share the data with teams • Promote the importance of timely and accurate assessments • Promote weighing patients on admission • Encourage teaching sessions on the wards from the dietician • Engage team to discover solutions to improve • Ongoing review of nurse staffing to support teams daily • Dieticians to work with Head of Nursing and nursing teams on QI project to improve education and training around nutritional assessment.	• Daily spot checks of compliance by Matron and WM • Monitor data and continue to share with teams • Liaise with Dieticians to monitor impact of delayed assessments and share learning.

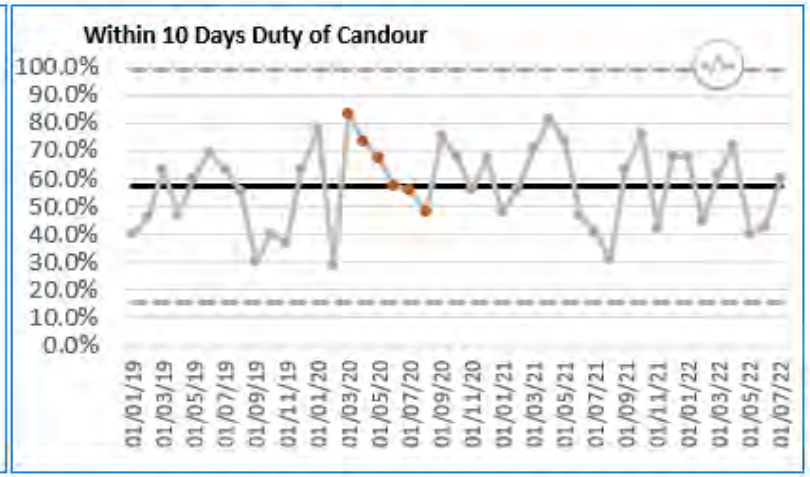
Safe











Summary

Patient Safety Incidents per 1000 bed days does not show significant variation and the number of Patient Safety Incidents reported indicates a positive reporting culture. We review all incidents reported with major or catastrophic harm through the EIR which has executive and ICB oversight and enables immediate safety mitigations to be put in place to prevent future harms.

Completion of verbal duty of candour outstanding has risen this month.

Action

Continue to develop the use of thematic analysis and engagement of subject matter experts as a learning response for Patient Safety Incidents. The first Safety Summit is taking place in September. This will be a half day event to share the learning from Patient Safety Incidents investigations across the wider trust.

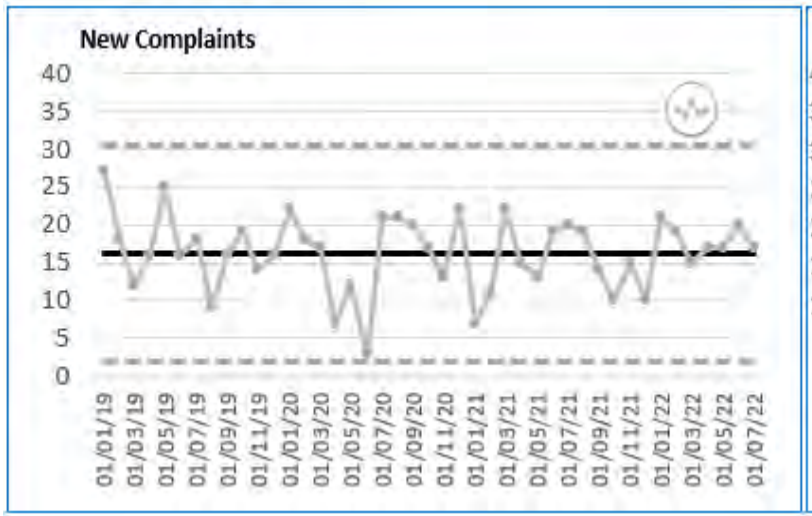
Duty of Candour-Clinical and operational staff are being supported to deliver Duty of Candour. More appropriate Duty of Candour measures are being scoped to better demonstrate the quality of these conversations within a reasonable timeframe.

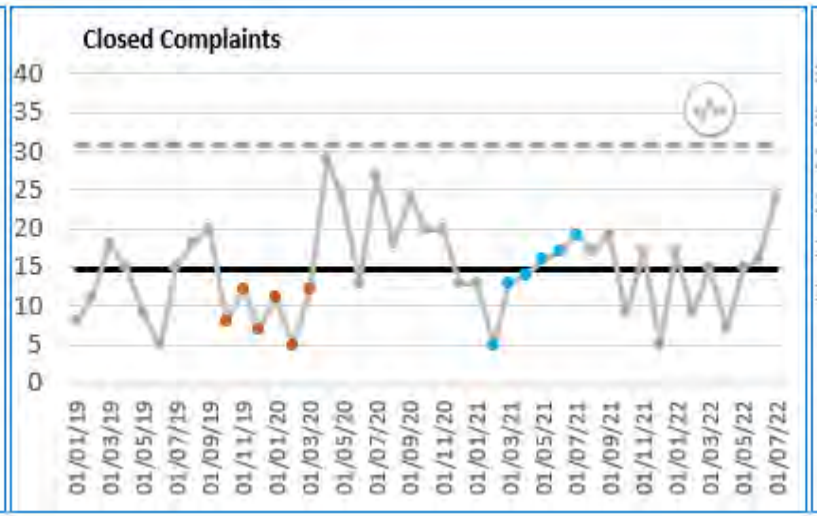
Assurance

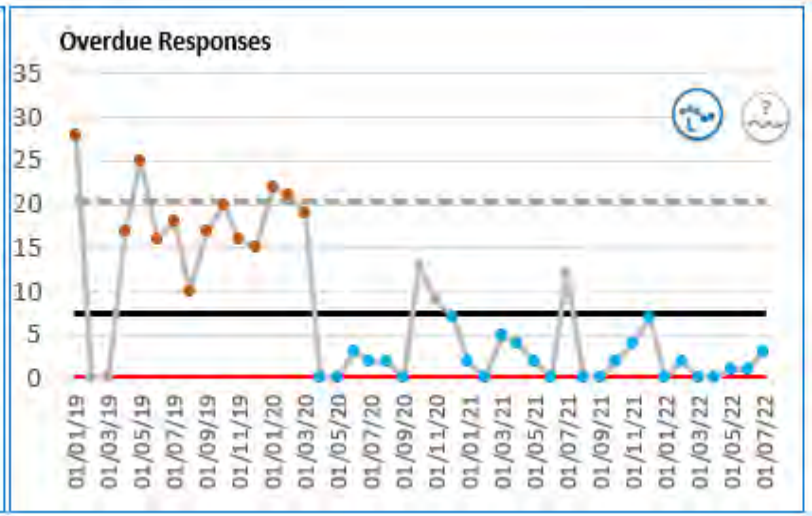
The trust Safety Improvement Group is newly established to support and monitor the translation of recommendations from investigations into measurable improvements.

Duty of Candour-An improvement project is in progress to increase our rates of Duty of Candour completion. This is being monitored through the LifeQI system.

Safe

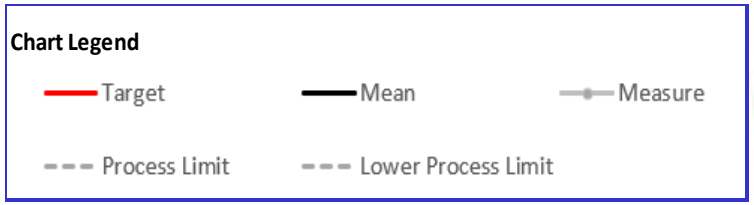


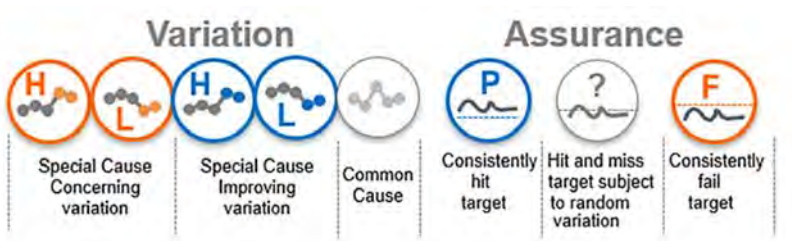




Summary	Action	Assurance
There are slightly more overdue responses this month, but it should be noted that performance is still within the lower control limit. This is partly due to pressures within the acute resulting in some delayed staff responses, coupled with increased workload within the patient experience team.	Complaints officer vacancy now filled enabling the team to provide enhanced support to investigating staff, as well as producing investigation responses.	Performance is expected to improve next month. Assurance should be taken that we still remain in the lower control limit (<5) and closure of open complaints increased significantly this month.

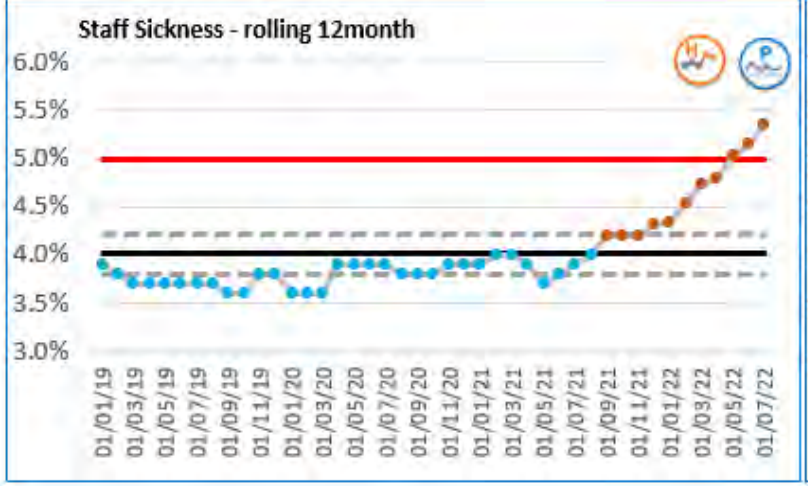
Well Led Summary

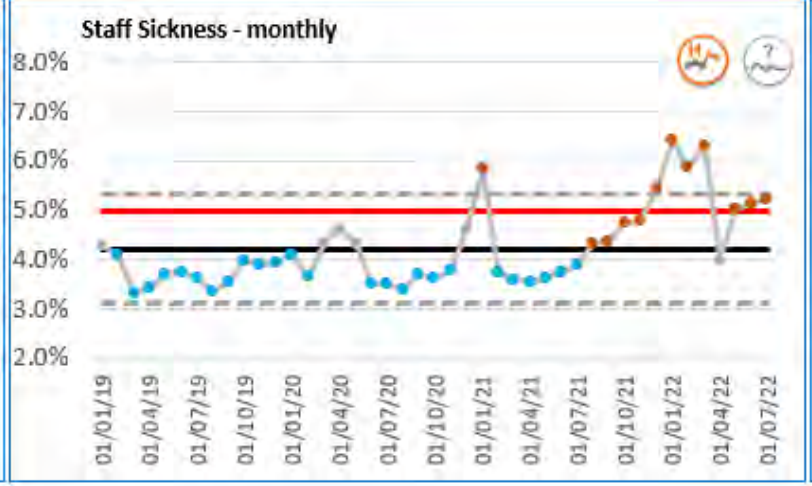


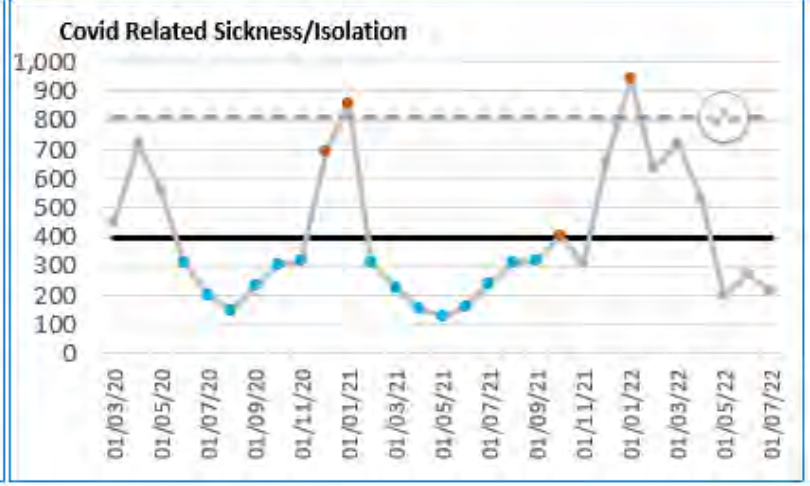


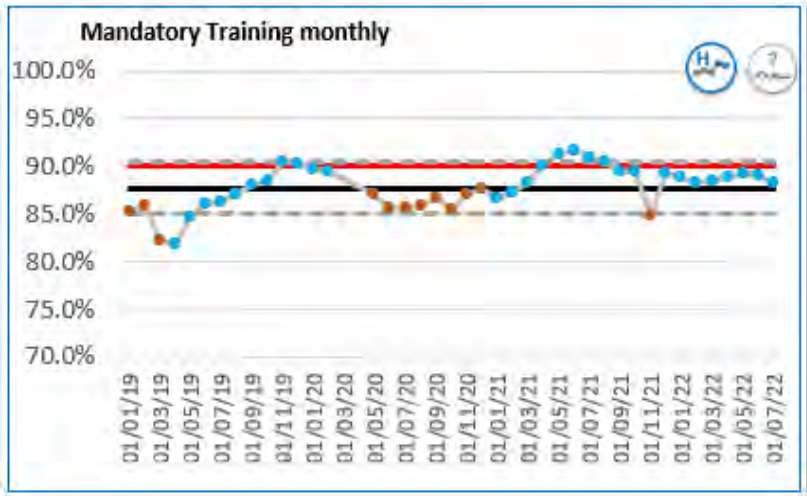
KPI	Latest month	Performance	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Staff Sickness - rolling 12month	Jul 22	5.3%	5.0%			4.0%	3.8%	4.2%
Staff Sickness - monthly	Jul 22	5.2%	5.0%			4.2%	3.1%	5.3%
Covid Related Sickness/Isolation	Jul 22	213	-			398	-13	809
Mandatory Training monthly	Jul 22	88.3%	90.0%			87.7%	85.0%	90.5%
Appraisal Rate monthly	Jul 22	79.9%	90.0%			78.4%	74.6%	82.2%
Turnover rate monthly	Jul 22	13.5%	10.0%			8.5%	7.9%	9.2%

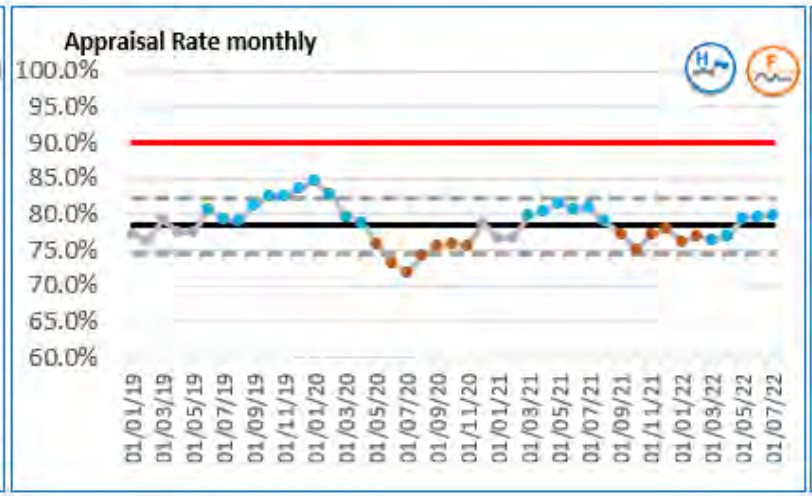
Well Led

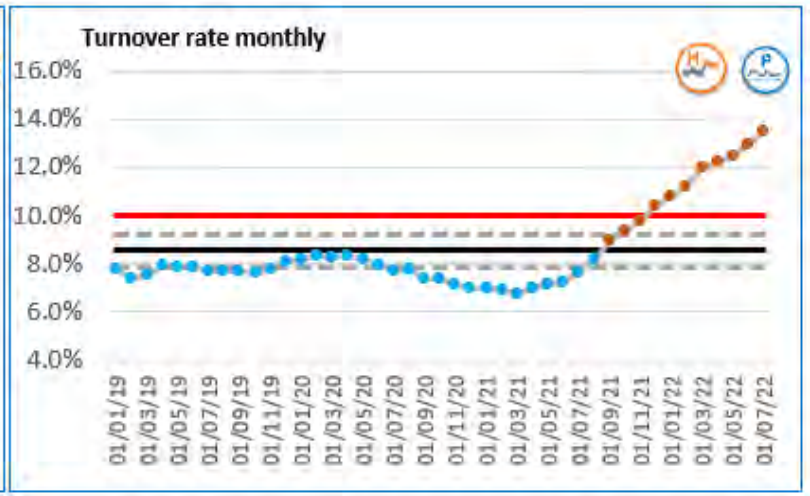












Summary	Action	Assurance
Sickness absence, 12 month rolling, has slightly increased to 5.3% at the end of July compared to 5.2% at the end of June. Mandatory training compliance remains slightly under the 90% target at 88.3%. Appraisal compliance remains below target at 79.9% increasing slightly from June which was 79.6%. Turnover continues on an upward trajectory.	We continue to monitor absence and our HR team discuss concerns with line managers, initiating supportive discussions with colleagues affected. An appraisal internal audit has been undertaken and an action plan has been formulated from the findings which is being worked through. We continue to review turnover data, focussing on areas of concern.	Sickness absence is monitored daily via the Sitrep. 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 form part of the monthly PRM's, with a need for divisions to identify actions for improvement.

5.1 - Governance papers

Glemsford Surgery

Inspection report

Glemsford surgery, Lion Road
Glemsford
Sudbury
CO10 7RF
Tel: 01787280484

Date of inspection visit: 20 August 2022
Date of publication: 14/09/2022

This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Good
Are services safe?	Requires Improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Overall summary

We carried out an announced inspection at Glemsford Surgery on Wednesday 20 July 2022. Overall, the practice is rated as Good.

Set out the ratings for each key question

Safe – Requires Improvement

Effective - Good

Caring - Good

Responsive - Good

Well-led – Good

When this provider, West Suffolk Foundation Trust (WSFT) registered Glemsford Surgery location with CQC, they inherited the regulatory history and ratings of the predecessor. This is the first inspection of Glemsford Surgery under the registered provider WSFT who became the provider from May 2020.

Following our previous inspection of the predecessor location on 01 November 2016, the practice was rated Good overall and for all key questions:

The full reports for previous inspections can be found by selecting the 'all reports' link for Glemsford Surgery on our website at www.cqc.org.uk

Why we carried out this inspection

This inspection was a comprehensive first inspection to rate a new location.

This included:

- Inspection of the key questions:
  - Safe
  - Effective
  - Caring
  - Responsive
  - Well-led

How we carried out the inspection

Throughout the pandemic CQC has continued to regulate and respond to risk. However, taking into account the circumstances arising as a result of the pandemic, and in order to reduce risk, we have conducted our inspections differently.

This inspection was carried out in a way which enabled us to spend a minimum amount of time on site. This was with consent from the provider and in line with all data protection and information governance requirements.

Overall summary

This included:

- Conducting staff interviews using video conferencing.
- Completing clinical searches on the practice's patient records system and discussing findings with the provider.
- Reviewing patient records to identify issues and clarify actions taken by the provider.
- Requesting evidence from the provider.
- A short site visit.

Our findings

We based our judgement of the quality of care at this service on a combination of:

- what we found when we inspected
- information from our ongoing monitoring of data about services and
- information from the provider, patients, the public and other organisations.

We have rated this practice as Good overall

We found that:

- We found patients with safeguarding identified had been discussed in safeguarding meetings however, we found no alerts on some patient's records.
- The practice lacked a process to review historical MHRA alerts effectively. We found some medicine reviews hadn't identified the safety alerts for the medicines prescribed.
- The practice had effective systems to ensure all emergency medicines and equipment were safe to use.
- We found some patients taking high risk medicines lacked consistent monitoring.
- We found some patients that had potential missed diagnosis of diabetes and chronic kidney disease. We also found some blood test results used when reviewing and monitoring some patients with long term conditions were out of date.
- Staff competency monitoring was carried out on a daily basis; however, this was not formally documented, and lacked the clinical oversight to ensure high risk drug monitoring was effective.
- Staff dealt with patients with kindness and respect and involved them in decisions about their care.
- The practice respected patients' privacy and dignity and patient confidentiality was maintained throughout the practice
- The practice adjusted how it delivered services to meet the needs of patients during the COVID-19 pandemic. Patients could access care and treatment in a timely way.
- The way the practice was led and managed promoted the delivery of high-quality, person-centre care, however some systems and processes introduced during or following our inspection needed to be embedded.

We found a breach of regulations. The provider **must**:

Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.

In addition, the provider **should**:

- Continue to embed the process to monitor the appropriate level of antibiotic prescribing for uncomplicated urinary tract infections.
- Continue to review and improve the opportunities for patients to access health screening checks.

Overall summary

- Continue to engage in patient feedback/survey exercises to gain and act upon patient opinion to improve patient satisfaction.

Details of our findings and the evidence supporting our ratings are set out in the evidence tables.

Dr Rosie Benneyworth BM BS BMedSci MRCGP

Chief Inspector of Primary Medical Services and Integrated Care

Our inspection team

Our inspection team was led by a CQC lead inspector who spoke with staff using video conferencing facilities and undertook a site visit. The team included a GP specialist advisor who spoke with staff using video conferencing facilities and completed clinical searches and records reviews without visiting the location.

Background to Glemsford Surgery

Glemsford Surgery is located in the village of Glemsford in the district of Sudbury in Essex at:

Glemsford Surgery,

Lion Road,

Glemsford,

Sudbury,

Suffolk,

CO10 7RF

The provider (West Suffolk Foundation Trust) is registered with CQC to deliver the Regulated Activities; diagnostic and screening procedures, maternity and midwifery services and treatment of disease, disorder or injury and surgical procedures.

The practice is situated within the NHS West Suffolk Clinical Commissioning organisation area and delivers a General Medical Services **(GMS)** to a patient population of about 4,900. This is part of a contract held with NHS England.

The practice is part of a wider network of four GP practices including Glemsford Surgery.

Information published by Public Health England shows that deprivation within the practice population group is the eighth decile (8 of 10). The lower the decile, the more deprived the practice population is relative to others.

According to the latest available data, the ethnic make-up of the practice area is 0.5% Asian, 98.7% White, 0.5% Black, and 0.3% Mixed.

The age distribution of the practice population closely mirrors the local and national averages. There are more male patients registered at the practice compared to females.

There is a team of three GPs who provide cover at the practice. The practice has a nursing team of three who provide nurse led clinics and a clinical pharmacist for long-term condition management. The GPs are supported by the practice manager, assistant practice manager and a team of reception/administration staff.

The practice is open between 8 am to 6:30 pm Monday to Friday. The practice offers a range of appointment types including book on the day, telephone consultations and advance appointments.

Extended access is provided by the practice health care assistant appointments from 7:30am - 8am on Monday and Friday and GP appointments from 6:30pm – 7pm on Tuesday, Wednesday and Thursday. Further extended access is available locally provided by Suffolk GP+, early mornings 6:30am to 8am Monday to Friday, late evenings 6:30pm to 9pm Monday to Friday and Weekends and Bank Holidays from 9am to 5pm are available.

Out of Hours Service is available between 6:30pm to 8am and is accessed via the NHS 111 service.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met:** The registered person had failed to ensure there were effective systems and processes in place to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity. Specifically: • The provider had failed to identify all safeguarding patients alerts on their records. • The provider had failed to identify all patients whose care and treatment should be modified by MHRA alerts, including historical alerts. • The provider had not used up-to-date blood results for long term condition management, and record in patient records. • The provider had not identified or undertaken consistent monitoring for all patients taking high risk medicines. • The provider had failed to run regular searches to reduce the possibility of missing long-term condition diagnosis. • The provider had failed to have in place a formal process to monitor staff competencies including clinical oversight of non-medical prescribers when monitoring patients care and treatment, This was in breach of Regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Open Board – 30 September 2022

Agenda item:	5.1 Annex			
Presented by:	Richard Jones, Trust Secretary and Head of Governance			
Prepared by:	Richard Jones, Trust Secretary and Head of Governance Pooja Sharma, Deputy Trust Secretary			
Date prepared:	12 September 2022			
Subject:	Certificate for NHS Improvement licencing (Self-certifications)			
Purpose:	X	For information		For approval

Executive summary:

NHS England / Improvement has two self-certification requirements for approval by the Board as part of the annual reporting arrangements. These follow a similar structure and content to previous years and sit alongside the general condition 6 certificate which to form part of the annual report approval on 14 September 2022 (Annex A & B).

The Board is required to approve the following annual statements and certifications as part of our licencing submissions to NHS Improvement. These are set out below and in greater detail within **Annex A & B**:

1. **Corporate Governance statement - *Confirmed***
   A range of statements are detailed covering compliance with corporate governance best practice; effective systems and processes; and having the correct personnel in place.

   It is proposed to indicate that the requirement has been met. This is supported by a range of assurances including annual governance assessment; internal and external audit opinions; review by external agencies, including performance and management information reported to the Board and its subcommittees.

2. **Training of governors - *Confirmed***
   The Board is asked to confirm that it is satisfied that during 2021/22 it provided the necessary training to its Governors, as required in s151(5) of the Health and Social Care Act, to ensure governors are equipped with the skills and knowledge they require.

   It is proposed to indicate that the requirement has been met. This is supported by the working and information received at the Council of Governors, its sub-committees and workshops; training provided during the year; and governor attendance at external events. This compliance position is supported by details in the Annual Report:

   - Governor training day with external trainer – governance, assurance and the role of governors; quality, accountability and relationship with the Board; effective questioning and challenge; governor feedback and action planning
   - Joint governor and non-executive director training session with external trainer
   - Sessions on finance with the Executive Director of Resources

Declarations required by General condition 6 and Continuity of Service condition 7 of the NHS provider licence

- **General condition 6 - Systems for compliance with license conditions (FTs and NHS trusts)**

Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS

Acts and have had regard to the NHS Constitution – ***Confirmed***

- **Continuity of services condition 7 - Availability of Resources (FTs designated CRS only)**

After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate – ***Confirmed***

Previously considered by:	General condition 6 and Continuity of Services condition 7 certificate approval as part of Annual Report & Accounts. Governor commentary, including training, approved for inclusion in Annual Quality Report.
Risk and assurance:	Governance and risk management framework underpinned by policy and procedures. Internal and external audit review of control environment. Annual governance review. Internal and External Audit opinions as part of Annual Report and Accounts.
Legislation, regulatory, equality, diversity and dignity implications	Set out in NHS Improvement Licence

Recommendation:

To receive in public the documents approved by the audit committee and Board on 14 September 2022

Annex A- Corporate Governance Statement (FTs and NHS Trusts) - Financial Year 2021-2022

Corporate Governance Statement

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements, setting out any risks and mitigating actions planned for each one

1	Corporate Governance Statement	Response	Risks and mitigating actions
1	The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	Confirmed	
2	The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time	Confirmed	
3	The Board is satisfied that the Licensee has established and implements: (a) Effective board and committee structures; (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation.	Confirmed	
4	The Board is satisfied that the Licensee has established and effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; (d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); (e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and (h) To ensure compliance with all applicable legal requirements.	Confirmed	

5	The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure: (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) The collection of accurate, comprehensive, timely and up to date information on quality of care; (d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	**Confirmed**	
6	The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	**Confirmed**	

Signed on behalf of the board of directors, and having regard to the views of the governors

Signature	**Signature**
Name Jude Chin	**Name** Craig Black

Certification on governance and training of governors

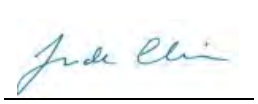
The Board are required to respond "Confirmed" or "Not confirmed" to the following statement. Explanatory information should be provided where required.

2 Training of Governors

The Board is satisfied that during the financial year most recently ended the Licensee has provided the necessary training to its Governors, as required in s151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role.

Confirmed

Signed on behalf of the Board of directors, and having regard to the views of the governors

Signature		Signature	
Name	Jude Chin	**Name**	Craig Black
Capacity	Chair	**Capacity**	Interim Chief Executive
Date	14/9/22	**Date**	14/9/22

B. Annex B General condition 6 and Continuity of Services condition 7 certificate- Systems for compliance with licence conditions and related obligations- Financial Year 2021-2022

Declarations required by General condition 6 and Continuity of Service condition 7 of the NHS provider licence

The board are required to respond "Confirmed" or "Not confirmed" to the following statements (please select 'not confirmed' if confirming another option). Explanatory information should be provided where required.

1 & 2 General condition 6 - Systems for compliance with license conditions (FTs and NHS trusts)

1	Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution.	Confirmed	Please Respond

3 Continuity of services condition 7 - Availability of Resources (FTs designated CRS only)

EITHER:

3a	After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate.	Confirmed	Please Respond

OR

3b	After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors (as described in the text box below) which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services.		Please Respond

OR

3c	In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate.		Please Respond

Statement of main factors taken into account in making the above declaration

In making the above declaration, the main factors which have been taken into account by the Board of Directors are as follows: **(Annex 1)**

Signed on behalf of the board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature		**Signature**	
Name	**Jude Chin**	**Name**	**Craig Black**
Capacity	**Chair**	**Capacity**	**Interim Chief Executive**
Date	14/9/22	**Date**	14/9/22

Annex 1 Statement of main factors taken into account in making the above declaration

In making the above declaration, the main factors which have been taken into account by the Board of Directors are as follows:

- After two years of some of the greatest challenges and extraordinary pressures of the pandemic, and the urgent need to recover from it, the Trust has ever faced, our strategy reflects what we have learned from our experiences, our staff and those who need our care

- To maintain patient care during COVID-19 meant we had to adapt many of our services and working practices, enhance our infection control measures, and respond as waves of the virus changed the levels of infection in the population. Ensuring our integrated community services and acute hospital teams work closely together to meet individual place-based needs; and developing the relationships with our alliance partners throughout Suffolk has been a vital part of maintaining services

- After making enquiries, the directors have a reasonable expectation that the Trust has adequate resources to continue in operational existence for the foreseeable future. The financial reporting framework applicable to NHS bodies, derived from the HM Treasury Financial Reporting Manual, defines that the anticipated continued provision of the entity's services in the public sector is normally sufficient evidence of going concern

- Technology and digital solutions have continued to be a key element, with online and phone contacts mixed with face-to-face care. In our community services, telehealth and the use of virtual wards have enabled us to safely look after patients where they live, preventing admission or readmission. We have been proactive in promoting and supporting self-care, recovery, and the "stay well" for surgery or treatment initiative led by Suffolk and North East Essex integrated care system (SNEE).

- The joining of community health and social care services into integrated neighbourhood teams, and a multi-disciplinary way of working across the system is improving the quality and efficiency of care the Trust can offer our patients and will be further developed this year

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

- We have also improved how we handle investigations to take a more supportive and compassionate approach; and developed our Patient Safety and Quality Improvement (QI) team and patient safety initiatives across the Trust. In February we marked the first anniversary of becoming a pilot organisation in the national Patient Safety Incidence Response Framework, which has given us many valuable insights into how better to learn from incidents

- In addition, the Trust has a borrowing arrangement in place with the Department of Health and Social Care (DHSC) to support its liquidity position. If the Trust no longer existed, health services funded by the DHSC would still be provided and ultimately all liabilities are underwritten by DHSC

- The Trust has invested more than £500,00 in staff support psychology team; and committed

further investment to a partnership with Abbeycroft Leisure to provide free gym membership for all staff, which has proved hugely successful. Free parking, hot drinks and other benefits have been welcomed, as well as a bi-annual wellbeing week called 'Love Yourself' which is run by our communications team. As well as supporting the work of the Trust, the Trust's hard-working My WiSH charity team have also done incredible work to support staff wellbeing, such as providing and equipping breakout areas

- One of the greatest achievements made during the pandemic has been the development of vaccines to protect against the transmission and effects of coronavirus. We successfully rolled out first, second and booster vaccines to our staff with an excellent take-up rate. Our vaccination taskforce continues to work with system partners throughout our community delivering vaccine in areas of low take-up and in settings such as supermarket car parks, village halls and colleges. They are also offering the vaccine to some of the most vulnerable and isolated people in west Suffolk

- Beyond caring for patients and staff, the WSFT is committed to playing a leading role in securing a healthy and sustainable Suffolk, and we have recently published our Green Plan 2021-2025. A truly sustainable health system is defined as working within available resources, to protect and improve health, now and for future generations

- The Council of Governors attended seminars, both internal and external to support learning and development which included a joint training session with NEDs held virtually through MS Teams. Informal meetings of Governors were arranged to ensure effective working relationships and preparations for meetings

- An externally facilitated programme for the Council of Governors was commissioned to review and support effective working and governance. The final report is expected later in the year

- Visits to clinical and non-clinical areas have been suspended during the pandemic. We have now been able to put in place plans to restart these visits in line with the national 15 steps challenge approach. 'Environmental Reviews 'were suspended due to Covid restrictions. 'Area Observations' have been suspended due to Covid restrictions

- The Governors have been engaged and supported the Trust in the Future System development to meet the future health requirements of the local population, in particular, the creation of a new hospital facility. We will continue to support this important work, including lobbying at national level for the funding

- Our community services have increasingly used telehealth to offer enhanced care to patients where they live, allowing them to have the clinical oversight and support they need to stay out of hospital. Through our integrated care networks and multi-disciplinary way of working, we are expanding our virtual ward beds which means people can receive the individual care they need at home

- We are active members of the West Suffolk Alliance, and are committed to an "alliance way of working" with our partners across the system. In July, Clement Mawoyo was appointed director of integrated community health and adult social care, as part of the work driving further integration with our social care and other alliance colleagues.

- Our Mildenhall integrated neighbourhood team is now based at the new Mildenhall Hub, co-located not only with social care, but also a school, leisure centre and other public services. The Brandon team is based at the town's health and leisure hub, and all our teams are able to refer patients directly to trained Abbeycroft Leisure instructors working at local Abbeycroft leisure centres and gyms.

- A network of integrated neighbourhood team co-ordinators has been established, who with our hospital-based locality liaison co-ordinator, support community teams and wards to facilitate admission and discharge. We are also working with partners to improve waiting times and ensure equity in access to treatment

- Working with the Suffolk and North East Essex integrated care system (SNEE) we have established a WSFT vaccine taskforce. After our successful vaccine rollout to our staff and colleagues from key partner organisations, the taskforce joined the campaign to vaccinate as many people as possible at the heart of their community. Giving people expert advice, taking time to answer questions and allay fears, the team has helped thousands to access the vaccines, including some of the most vulnerable

- The Trust recently marked the first anniversary of becoming an early adopter of the Patient Safety Incident Response Framework, a national initiative aimed at identifying risks and learning from incidents to improve quality and safety. Our Patient Safety and Quality Improvement (QI) team has been expanded and developed, and is undertaking projects across the Trust, embedding QI in all aspects of our work

- Improvements in our maternity services were noted by the Care Quality Commission after an unannounced inspection, which reported on progress being made, but also raised concerns which are being dealt with

- With our alliance partners East Suffolk and North Essex NHS Foundation Trust (ESNEFT) we have taken over the Early Supported Discharge service for stroke patients in the county, with the staff also transferred to the trusts

- The Trust continues to perform well on the National Hip Fracture Database, where the data puts us at the top of all hospitals in England, Wales and Northern Ireland for meeting best practice criteria when assessing patients with a hip fracture

- Our cancer care teams have extended the hours for people to access routine screening or referral appointments; and innovative screening tools using artificial intelligence are helping us to increase the numbers of patients we see and reduce waiting times

- The Macmillan Unit based at the hospital was recently awarded the Macmillan Quality Environment Mark for the third time. The award champions cancer environments that go above and beyond to create welcoming and friendly spaces for patients.

Modern Slavery Act – 2022/2023 Annual Statement

Our organisation

The West Suffolk NHS Foundation Trust (WSFT) provides acute and community healthcare services in West Suffolk, as well as running the West Suffolk Hospital, West Suffolk NHS Foundation Trust is joining up NHS care across the area providing many of the community services in West Suffolk.

The West Suffolk NHS Foundation Trust is committed to ensuring that no modern slavery or human trafficking takes place in any part of our business or our supply chain.

We are fully aware of the responsibilities we bear towards our service users, employees and local communities. We are guided by a strict set of values in all of our business dealings and expect our suppliers (i.e. all companies we do business with) to adhere to these same values.

We have zero tolerance for slavery and human trafficking. Staff are expected to report concerns about slavery and human trafficking and management will act upon them in accordance with our policies and procedures.

The West Suffolk NHS Foundation Trust supports the Government's objectives to eradicate modern slavery and human trafficking and recognises the significant role the NHS has to play in both combatting it and supporting victims. We are committed to ensuring our supply chains and business activities are free from ethical and labour standards abuses. Steps taken to mitigate the risk of modern slavery are outlined in the sections below.

Arrangements to prevent slavery and human trafficking

We are committed to ensuring there is no modern slavery or human trafficking in our supply chains or any part of our business activity.

Our commitment to social and environmental responsibility is covered by our approach to modern slavery and human trafficking, which is part of our safeguarding arrangements.

People

- Appropriate pre-employment checks on directly employed staff and agencies on approved frameworks are audited to provide assurance that pre-employment clearance has been obtained for agency staff
- A range of controls to protect staff from poor treatment and/or exploitation, which comply with all respective laws and regulations. These include provision of fair pay rates, fair Terms and Conditions of employment and access to training and development opportunities
- Consultation and negotiation with Trade Unions on proposed changes to employment, work organisation and contractual relations
- Appropriate adult and children's safeguarding policies are in place to ensure staff are alert to, and report any concerns about patients who may be subject to human trafficking or modern slavery

Speaking up at the Trust

- The Trust believes that every member of staff has a duty to raise concerns at the earliest reasonable opportunity about the provision of care or any other malpractice within the trust where care and/or behaviour/conduct is believed to be inadequate or unacceptable. In addition, staff have duties imposed upon them to raise such concerns through their respective professional regulatory bodies, such as the GMC, NMC, ACCA etc.

Safeguarding/Training

The following arrangements are in place within our safeguarding policies and procedures, training and operations:

- Trafficking is highlighted as a possible risk for unaccompanied asylum seeking children within our safeguarding children policy and there is a link to the Suffolk safeguarding children board's quick guidance on the safeguarding microsite. Any concerns where a child may be considered at risk of abuse follows the same pathway of referral.
- The Trust's domestic abuse and women at risk of social exclusion policies address the risk of modern slavery. The Trust safeguarding specialist midwife would be informed and a multi-agency referral completed. The role of safeguarding specialist midwife is to have concern for the safety and wellbeing of a child or unborn in these circumstances.
- The modern slavery and trafficking statement and information related to the NHS Safeguarding App is part of the WSFT trust induction for adult and children safeguarding training resource.

Supplies and tenders

The Trust complies with the Public Contracts Regulations 2015 and uses the mandatory Crown Commercial Services (CCS) Pre-Qualification Questionnaire on procurements which exceed the prescribed threshold. Bidders are required to confirm their compliance with the modern slavery act.

Sub-contractors

Our procurement and contracting team is qualified and experienced in managing healthcare contracts and have received appropriate briefings on the requirements of the Modern Slavery Act 2015, which includes:

- Requesting evidence of their plans and arrangements to prevent slavery in their activities and supply chain
- Using our routine contract management meetings with our providers to address any issues around modern slavery
- Implementing any relevant clauses contained within the standard NHS contract

Board Approval

This statement has been approved by the Trust Board, who will review and update it on an annual basis.

Approved by WSFT Board on XXX.

Board of Directors – 30 September 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 July 2022

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

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

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

Background

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

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

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

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

The role of the assurance committees

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

Risk Appetite Statement

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

Current risk profile

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

The amber risk relates to digital transformation. Assessed at Annual x Major = Amber, this has achieved its target risk and is within the Trust Board's agreed risk appetite.

Red Risk Report

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

Risk No.	Title	BAF Y/N	Risk level (current)	Risk Subcategory
24	Potential failure of the main building structure and front residencies structure (Oak, Cedar, Birch, Larch, Pine, Willow)	N	Red	Corporate Risk
4499	Provision of thrombectomy service for stroke patients in our region	N	Red	Corporate Risk
4724	Staffing shortfalls	N	Red	Corporate Risk
4917	Missing samples causing a delay to getting results to the right patient at the right time.	N	Red	Operational Risk
5092	Capacity and demand of the e-Care Meds Team	N	Red	Operational Risk
5136	Saving Not Signing Documents on e-Care	N	Red	Corporate Risk
5147	Aging CT Scanners	N	Red	Operational Risk
5148	Aging MRI scanners	N	Red	Operational Risk
5151	No availability of a second obstetric team outside the hours of 8am and 8pm Mon-Fri	N	Red	Operational Risk
5190	RAAC concerns within Antenatal	N	Red	Operational Risk
5230	Delay in Discharge Summaries being sent out	N	Red	Operational Risk
5381	Disharmonious working within Plastic Surgery team	N	Red	Operational Risk
5383	Non-endorsed results in ED pooled message centre	N	Red	Corporate Risk

All red risks are reviewed every 3 months with the relevant Executive.

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

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

Future reporting arrangements

The Board assurance committees will update the board at every meeting when they receive updates on any of the BAF strategic risks. The BAF risks have been allocated to the relevant assurance committee and governance/specialist group.

Appendix 1

Allocation of BAF Risks to Board Sub-Committees

BAF risk	**Board assurance committee** (Exec. lead)	**Governance (specialist) committee** (Specialist lead)
1. If we do not establish effective governance structures, systems and procedures over safety and quality, this will lead to poor standards of care to all patients and service users, potential harm, service failure, reputation damage, poor patient experience and regulatory action	**Improvement** (Sue Wilkinson)	**Patient Safety and Quality** (Dan Spooner)
2. If we do not manage emergency capacity and demand in the context of Covid activity and delivery of the RAAC remediation plan, this will affect our ability to deliver safe, effective and efficient services and care to patients	**Insight** (Nicola Cottington)	**Urgent and emergency care group** (Alex Baldwin)
3. If we do not deliver elective access standards based on clinical priorities in the context of Covid activity, this will affect our ability to deliver safe, effective and efficient services and care to patients	**Insight** (Nicola Cottington)	**Patient access** (Alex Baldwin)
4. If we do not progress our programme of work for digital adoption, transformation and benefits realisation, the digital infrastructure will become obsolete and vulnerable to cyber-attack, resulting in poor data for reporting and decision support, digital systems failure, loss of information and inability to provide optimum patient care, safety and experience [Risk is being considered for de-escalation by Insight Committee]	**Digital programme board** (Nick Macdonald)	**Digital board** (Liam McLaughlin)
5. External financial constraints (Revenue and Capital) impact on Trust and system sustainability and model of service provision in the west Suffolk system *(even when services delivered in the most efficient way possible).* This includes failure to identify and deliver cost improvement and transformation plans that ensure sustainable clinical and non-clinical services while delivering the agreed control total	**Insight** (Nicola Cottington + Nick Macdonald)	**Finance and workforce** (John Connelly (operational) / Charlie Davies (finance))
6. If we do not value our workforce and look after their well-being, particularly in the context of the Covid-19 pandemic, this may affect patient safety and quality of care due to lower levels of staff engagement and morale, and staff choosing to leave WSFT	**Involvement** (Jeremy Over)	**Senior Leadership Team** (Denise Pora/ Claire Sorenson)
7. If we do not implement the estates strategy to provide an adequately maintained building environment suitable for patient care caused by the deteriorating state of Trust buildings, lack of access to capital to fund the remediation programme, this may result in potential harm incidences, capacity pressures and improvement notices	**Core Resilience Team Red Risk Oversight Committee** (Craig Black)	**Core Resilience Team** (Barry Moss)

Appendix 2

Summary mitigating actions and gaps in assurance

	Residual Risk	Target Risk
1. Failure to maintain and further strengthen effective governance structures, systems and procedures over safety and quality, leading to poor standards of care to all patients and service users, potential harm, service failure, reputation damage, poor patient experience and regulatory action (BAF 1)	Quarterly x Major = Red	Annual x Major = Amber

Description of additional controls required (actions being taken)	Lead
Safe staffing - see separate BAF risk	-
Build assurance dashboard and framework for quality indicators to support development of ward accreditation programme	Sue Wilkinson
Development programme for ward managers and matrons to support ward accreditation	Sue Wilkinson
Align accreditation framework and KPIs with Nursing, midwifery and AHP strategy	Sue Wilkinson
Co-produce nursing, midwifery and AHP strategy to meet current and future system needs (reflecting the updated Trust strategy - pending)	Sue Wilkinson
Develop patient safety and learning strategy	Lucy Winstanley
Quarterly review of the CQC Insight publication with actions to address outlying indicators overseen by Insight Committee	Rebecca Gibson
IQPR refresh project (this will enable reinstatement of the previously listed control "IQPR including key quality indicators (including community) – reported to open board and also reported to Insight Committee. This supports timely identification, escalation and action to address issues of concern".	Sue Wilkinson
Review 2021/22 Quality Priorities and develop 2022/23 quality priorities through the Improvement Committee with Board sign-off as part of the Annual Report/Quality Accounts	Richard Jones
Review to be undertaken of the structure and strategies for quality, safety and experience of care	Sue Wilkinson

Assurances

- Organisational Framework for Governance approved by Board September 2021
- Serious incidents, complaints, claims and inquests report to board (every meeting)
- Maternity reporting to Board and attendance of head of midwifery (every meeting)
- Quality reporting to Board on key performance indicators e.g. infection prevention and control, maternity (every meeting)
- Learning from Deaths report to board
- Monthly breakdown of nurse staffing levels reported to board
- Programme of IPB external reviews
- External review of maternity services (CCG, region and CQC) – supportive (June '21)
- Maternity external support – reported as part of maternity plans to IPB
- Regulatory PSIRF sign-off of WSFT framework
- Internal audit reporting:
    - Responsive internal audit programme linked to IPB assurance requirements (draft programme for 2021/22)
    - Risk Management - Reasonable Assurance (Nov 2020)
    - CQC Improvement Plan – Stage 1 Substantial Assurance (Nov 2020)
    - Data Quality – Paused Activity and Recovery Reasonable Assurance (Jan 2021)
    - Fit and Proper Persons - Partial Assurance (Jan 2021)

	Residual Risk	Target Risk
2. If we do not manage emergency capacity and demand in the context of Covid activity and delivery of the RAAC remediation plan, this will affect our ability to deliver safe, effective and efficient services and care to patients	Weekly x Major = Red	Quarterly x Moderate = Amber

Description of additional controls required (actions being taken)	Lead
Operational and staffing plans to safely deliver winter escalation and surge capacity (see separate BAF risk)	Nicola Cottington
Implementation of: length of stay and discharge programme supported by ECIST to include system out of hospital capacity programme, frailty programme, the application of right to reside	Nicola Cottington
Transformation initiatives: - review of home IV therapy to inform business case (Apr 21) - expansion of the virtual ward concept	Nicola Cottington
Implement final versions of new ED access standard in line with national roll out	Nicola Cottington
Submitted a range of bids for funding to support admission avoidance and improved hospital flow – funding schemes to be implemented	Nicola Cottington

Assurances

- Access and performance reporting arrangements to Board e.g. IQPR, operational report and transformation report (qrtly)
- External monitoring of stranded and super stranded and medically optimised for discharge
- Monitoring of bed utilisation
- Attain report – informs and validates the decant plans to support RAAC remediation
- NHSE/I oversight meeting (quarterly)
- Internal audit reporting:
    - Civil Contingencies Act - Advisory (July 2020)
    - Risk Management - Reasonable Assurance (Nov 2020)
    - Data Quality – Paused Activity and Recovery Reasonable Assurance (Jan 2021)
    - COVID-19 Financial Governance & Key Financial Controls - Reasonable Assurance (Jul 2020)
    - Private and Overseas Patients - Reasonable Assurance (Nov 2020)

	Residual Risk	Target Risk
3. If we do not deliver elective access standards based on clinical priorities in the context of Covid activity, this will our ability to deliver safe, effective and efficient services and care to patients ***(emergency standard is considered separate BAF entry)***	Weekly x Major = Red	Quarterly x Moderate = Amber

Description of additional controls required (actions being taken)	Lead
Theatre 1 recommissioned (delayed due to RAAC remediation and Covid)	Nicola Cottington
Outpatient transformation programme with focus on digital and embedding of Covid learning – delivering benefits to key milestones. Advice and guidance virtual consultation PIFU	Nicola Cottington
Development of longer term contract for additional Orthopaedic capacity with the BMI	Nicola Cottington
Continue to progress opportunities to fund an elective hub at Newmarket	Nicola Cottington
Development of Ophthalmic injection suite	Nicola Cottington
Development of an additional clinical area within the JFDU	Nicola Cottington
Improve operational efficiency in line with the GIRFT HVLC	Nicola Cottington
Develop business case for community diagnostic hub at Newmarket	Nicola Cottington

Assurances

- Board reports and monitoring (every meeting)
- Weekly SNEE activity level review
- Cancer and diagnostics activity progress against trajectory (monthly)
- Internal audit reporting:
    - Data Quality – Paused Activity and Recovery Reasonable Assurance (Jan 2021)
    - COVID-19 Financial Governance & Key Financial Controls - Reasonable Assurance (Jul 2020)
    - Private and Overseas Patients - Reasonable Assurance (Nov 2020)

	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)

Annex A: Scheduled draft agenda items for next meeting – 25 November 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 safe staffing guardian and FTSU guardian reports	✓			Written	Matrix	JMO
Report of the West Suffolk Review – Governor/Director working group	✓			Written	Matrix	RD
Strategy						
Future System Board Report	✓			Written	Matrix	CB
Nurse staffing strategy review	✓			Written	Matrix	SW
System update: West Suffolk Alliance and SNEE Integrated Care Board	✓			Written	Matrix	CB
Digital programme board report (qrtly)	✓			Written	Matrix	NM
Assurance						
Annual report and accounts	✓			Written	Matrix	CB/NmacD/RJ
Report from 3i Committees: Insight, Improvement & Involvement	✓			Written	Matrix	RD / AR / JC
Insight Committee Report - Finance and workforce report - Operational report - IQPR: including appraisal and mandatory training	✓			Written	Matrix	NM/NC/RD
Involvement Committee Report - People and OD Highlight Report o Putting you First award o Staff recommender scores - Staff Health and Wellbeing annual update - National patient survey report and response - Equality annual report - Education report - including undergraduate training (6-monthly)	✓			Written	Matrix	JMO/AR
Improvement Committee Report - New CQC model of assessment *(action 2058)* - Maternity services quality and performance report (inc. Ockenden) - Antenatal and newborn screening annual report - Nurse staffing report - Quality and learning report	✓			Written	Matrix	SW / PM

Description	Open		Closed	Type	Source	Director
- Quality priorities progress report						
Integrated quality & performance report (IQPR) – annex to Board pack	✓			Written	Matrix	NM/NC/SW/PM
Serious Incident, inquests, complaints and claims report			✓	Written	Matrix	SW
Governance						
Governance report, including - Use of Trust's seal - Senior Leadership Team report - Council of Governors meeting report - Audit Committee report, including scheme of delegation review *(action 2035)* - Remuneration committee report - Board assurance framework and risk report - Annual review of governance - Meeting schedule for 2023 including use of appropriate locations across catchment area *(action 2060)* - Agenda items for next meeting	✓			Written	Matrix	RJ
Confidential staffing matters			✓	Written	Matrix – by exception	JMO
Reflections on the meetings (open and closed meetings)	✓		✓	Verbal	Matrix	JC